



Review of the Epidemic Control for Volunteers' Toolkit

Rollout in Asia Pacific, 2011 – 2014

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Cover photo: A volunteer presenting outcomes of a group exercise during an epidemic control training organised by the Afghan Red Crescent Society (ARCS) for its volunteers in Khewa District, Nangarhar province in Nov 2014. ARCS is the first National Society in Asia Pacific to roll out the ECV toolkit. Photo credit: ARCS.

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Acronyms

APZ	Asia Pacific zone (IFRC)	H2P	Humanitarian Pandemic Preparedness
APZO	Asia Pacific zone office (Kuala Lumpur)	IEC	information, education and communication
ARI	acute respiratory infection	IFRC	International Federation of Red Cross and Red Crescent Societies
CBDRR	community-based disaster risk reduction	ICBDRR	integrated community-based disaster risk reduction
CBHFA	community-based health and first aid	KAPB	knowledge, attitude, practice and beliefs
CHW	community health workers	LTPF	Long-Term Planning Framework (IFRC)
DALY	disability-adjusted life years	MoH	Ministry of Health
DF	dengue fever	MNCH	maternal, newborn and child health
DFID	Department for International Development (UK)	PHAST	participatory hygiene and sanitation transformation
DM	disaster management	PNS	Participating National Society
DMIS	Disaster Management Information System	PPHSN	Pacific Public Health Surveillance Network
DREF	Disaster Relief Emergency Fund	RDRT	Regional Disaster Response Teams
DRR	Disaster risk reduction	SARS	severe acute respiratory syndrome
ECV	Epidemic Control for Volunteers	SPC	Secretariat of the Pacific Community
EMU	Emergency Medical Unit	SPEED	Surveillance Programme in Post Extreme Emergencies and Disasters
EPP	Epidemic Preparedness Project	TOR	Terms of Reference
ERU	Emergency Response Unit	UHC	Universal Health Coverage
FACT	Field Assessment and Coordination Team	VCA	vulnerability and capacity analysis
FGD	focus group discussion	WATSAN	water and sanitation
FMR	first medical responder (Indian Red Cross Society)	WHO	World Health Organization
HNS	Host National Societies		
HWT	household water treatment		

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The review team would also like to recognize representatives from other National Societies who were quick to provide information on the rollout of the Epidemic Control for Volunteers Manual and Toolkit in the context of their National Society and to the IFRC secretariat staff in Geneva, Kuala Lumpur and other offices in Asia Pacific – as well as selected offices outside the region – who generously gave of their time to participate in interviews to discuss the rollout.

Without the positive engagement of all those supporting the rollout of the ECV Manual and Toolkit in the Asia Pacific zone this review would not have been possible.

“However secure and well-regulated civilized life may become, bacteria, protozoa, viruses, infected fleas, lice, ticks, mosquitoes, and bedbugs will always lurk in the shadows ready to pounce when neglect, poverty, famine, or war lets down the defenses.

And even in normal times they prey on the weak and the very old, living along with us, in mysterious obscurity waiting their opportunities”.

Hans Zinsser, 1934

1. Executive summary

The Epidemic Control for Volunteers (ECV) Manual and Toolkit is a resource that has, since 2008, been developed and promoted by the International Federation of Red Cross and Red Crescent Societies (IFRC) to assist National Societies and their volunteers rapidly and efficiently prevent and respond to epidemics and outbreaks. It is a simple and easy-to-use information and training package that helps National Societies quickly train staff and volunteers, giving definitions, simple symptoms, prevention and epidemic management for a range of diseases. Accompanying action tools instruct the volunteers on what actions to use to address the spread of the disease, and community tools contain messages that volunteers need to disseminate to contain or prevent the further spread of the disease.

ECV was first introduced into Africa zone and the Americas zone in 2008 but it was not until 2011 that the first ECV training occurred in the Asia Pacific zone (APZ) in Afghanistan. Since 2011, the tool has quickly gained favor and has been actively promoted by the IFRC Asia Pacific zone office (APZO). By September 2014 it had been introduced and rolled out in 20 National Societies in the APZ.

In order to assess its impact, the APZO decided in August 2014 to commission a review of the ECV rollout from 2011 to 2014. This review involved a total of 41 semi-structured interviews with IFRC and National Society management, staff and volunteers and a Ministry of Health representative. Interviews were conducted either face-to-face or via Skype. The review also benefited from eight written submissions from National Society health managers in the APZ and from IFRC health coordinators in the Africa zone. The review team travelled to Bangladesh and Indonesia and met with National Society management and staff at headquarters, provincial and local branch (chapter) levels. The review team also carried out focus group discussions with ten Red Cross volunteers in a branch in Indonesia that is planning on implementing the rollout at the community level. Over 25 documents including project-planning documents, quarterly and monthly reports and policy papers were consulted to better understand the ECV rollout in the APZ taking into account relevance and appropriateness, effectiveness, impact, efficiency and sustainability.

The rollout has been very effective. At the close of 2014, 20 National Societies¹ had been introduced to the ECV manual and toolkit. The material has undergone significant national adaptation – including a regional adaptation in the Pacific – and by September 2014 had been translated into 19 languages. A rollout of this scope would not have been possible without close coordination and collaboration between all those involved. Contributors to the review were very satisfied with the delineation of roles and responsibilities and indicated that this was a key factor in the success of the rollout.

¹ At the time of the review (September 2014) the ECV annual and toolkit had been or was in the process of being rolled out in Afghanistan, Bangladesh, Cambodia, China, DPRK, Fiji, India, Indonesia, Laos, the Maldives, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka, Thailand, Timor-Leste, Tonga and Viet Nam.

National Societies and IFRC staff were very positive about the manual and toolkit, typically referring to them as being useful, clear, simple and easy to use. The ECV material is seen as being complementary to existing material and a valuable addition to their “suite of tools” particularly in National Societies with longer-term programmes in health, disaster management, and disaster risk reduction.

National-level relevance has been enhanced in most National Societies by translating the material into local languages and adapting graphics and illustrations to better reflect the national demographic. By inviting Ministries of Health to participate in the adaptation of working groups, National Societies have ensured that the material is appropriate and in line with national health policies. National Societies clearly recognize the threat of epidemics (particularly those emerging in tropical and sub-tropical areas) and appreciate the efforts made by the IFRC to initiate and manage a systematic rollout of material.

For the majority of National Societies the rollout at national and branch level has followed a similar sequence of stages as recommended by the APZO Health Unit in its guidance note: 1. the sensitization of management, staff and volunteers to the material; 2. consultation with national health authorities;² 3. translation and adaptation; 4. field testing; 5. printing; 6. training of master facilitators and volunteers; and 7. a community-level rollout. Although some delays have been experienced due to a number of internal and external factors that have necessitated no-cost extensions, the rollout has generally been systematic and smooth.

It was a challenge to assess effectiveness at the National Society and community levels since many National Societies had only recently engaged in volunteer training, and very few had cascaded the training down to the community. There is clear evidence that using ECV in conjunction with other programmes is a key factor in enhancing its effectiveness. Likewise, the incorporation of ECV into contingency planning allows it to become an effective vehicle for improving the capacity of National Societies to prepare for and respond to epidemics.³ More reflection and support is required to enable National Societies to use the tool in disease prevention – especially in those lacking the advantage of having long-term programming such as community-based health and first aid and integrated community-based disaster risk reduction.

The rollout of the ECV Manual and Toolkit has been achieved using a combination of funding mechanisms including Emergency Appeals (Pakistan, Philippines and Vietnam), Disaster Relief Emergency Fund (DREF) allocations⁴ (Timor-Leste⁵) and Long-Term Planning Frameworks (China, DPRK and Mongolia). Red Cross Red Crescent bilateral and multilateral support and external funding via the Department for International Development (DFID) were also applied. The IFRC Long-Term Planning Framework underpinned the systematic rollout and additional funds from emergencies provided National Societies with expansion opportunities. The role of the IFRC has been vital in ensuring a coordinated approach and avoiding duplication of effort and funding.

² and with regional health agencies in the case of the rollout in the Pacific region

³ The ECV rollout in APZ has been focused largely on ‘preparedness’ efforts and not on response to an outbreak or disaster.

⁴ DREF – Disaster Relief Emergency Fund (DREF) is a fund set up by the IFRC to ensure immediate financial support is available for disaster response. Allocations may be made as start-up loans for large-scale disasters or grants for small-scale emergency operations.

⁵ DFID provided funds for the toolkit adaptation and initial trainings, the DREF allocation enabled further roll out of the toolkit.

The ECV rollout in the Asia Pacific zone built upon similar rollouts in Africa and the Americas between 2008 and 2011. It is apparent that the APZ studied these very different rollout approaches and devised a mechanism that best suited the situation in Asia Pacific. Key stakeholders have also mentioned the *Epidemic Control for Volunteers Manual and Toolkit: Evaluation of Rollout 2008 – 2010* as an important reference document that facilitated the process. The lessons learnt have paid dividends since the ECV toolkit, within a relatively short period of three years, is now firmly positioned as an important resource in National Societies who have been quick to recognize its value. If the initial rollout in Africa and the Americas was affected by “the lack of a coherent strategy”⁶ the same cannot be said of its rollout in the Asia Pacific zone. Care must be taken however to ensure the tool remains relevant for National Societies through continuing technical support, particularly in the initial stages of the rollout.

A number of National Societies have successfully utilized the ECV toolkit and mobilized trained volunteers during emergency operations. An effective mobilization mechanism and knowledge of disaster operations staff on the functions of ECV are vital to the effectiveness and efficiency of its mobilization during an emergency.

Note: Given the fact that over 20 National Societies are involved in the rollout, this review does not pretend to be an in-depth analysis of challenges and successes of each individual National Society. The review team, through a desk review, interviews with key stakeholders, and observations made during field visits to two participating National Societies, has drawn conclusions about the rollout process from zone and regional perspectives. It has however, been apparent that similar successes and challenges have been experienced by all participants in the review – an indication of the consistency the rollout has achieved.

⁶ *Epidemic Control for Volunteers Manual and Toolkit: Evaluation of Rollout 2008 – 2010. IFRC 2011*

2. Methodology

• Evaluation matrix

As a first step, an evaluation matrix was developed. It broke the objectives in the Terms of Reference into specific research questions. It then specified how each research question was to be answered through various sources of information including interviews, literature reviews, etc.

• Literature and document review

Review and analysis of secondary data was an important task in this assignment and was used for the appraisal of the rollout. Materials such as project-planning documents, monthly reports and all internal ECV planning, reporting and monitoring documents were reviewed and are duly referenced in this final report.

• Semi-structured interviews of key stakeholders (phone/Skype and face-to-face interviews)

Semi-structured interviews (see Annexes 5 and 6) were the central method for gathering information to ensure the team collected in-depth and quotable feedback in the key areas of relevance and appropriateness, effectiveness, efficiency, impact and sustainability. Brief, simple interview guidelines were used to guide conversations. A large pool of interview questions was developed with different guidelines for different types of respondents. Subsets of these questions, those that were most relevant to each type of respondent (IFRC, National Society management, National Society staff and volunteers, community leaders and members and other stakeholders such as Ministry of Health) were selected. The guidelines were printed and respondent's replies were directly documented by the interviewer to avoid potential errors and ensure proper registration.

Key stakeholders within the IFRC and National Societies were interviewed by phone/Skype or face-to-face as per availability. Key stakeholders of the Bangladesh Red Crescent and Palang Merah Indonesia, including project management staff, volunteers and senior management staff were interviewed face-to-face as part of field visits. Interviews were also arranged and conducted with national and regional stakeholders including municipal and regional health representatives, to get their opinions of how the rollout of ECV contributed towards saving lives and improving health.

Feedback from donor National Societies was also solicited to understand their interest in supporting ECV rollout and to get their insights.

- **Focus group discussions**

Focus group discussions (FGD) were organized in the field with volunteers in those branches preparing to roll out ECV in local communities. A FGD guide, focusing on perceptions of how ECV activities supported specific changes in the National Societies at branch level and in communities, was used to facilitate the discussions.

- **Shortened most significant changes methodology**

The consultant captured narratives about the most significant results the programme was able to achieve for the users and beneficiaries themselves. Stories were sought from and about both women and men. These narratives are captured in a number of case studies in the body of the report.

- **Questionnaires and guides**

Examples of interview guidelines and focus group discussion guidelines are included in Annexes 5 and 6. Questions were refined to reflect identified ECV planning documents and monthly and annual reports.

Most of the questions in the guidelines were open-ended and did not need to be covered in strict formulation or in the order set out in the annexes. A small set of closed questions (e.g. ratings on a scale of 1-5) was also included. Shortened questionnaires were sent to National Society focal points and answers were tabulated.

- **Field visits**

Visits were made to one district in Bangladesh and to three provincial branches (Bandung, Jakarta and Banten) and one local chapter in Indonesia. The team also met with a medical epidemiologist from the Indonesian Ministry of Health.

Limitations:

A number of limitations had to be taken into account in this evaluation. While all the National Societies who have rolled out ECV were approached via various communication methods, due to limited resources only two countries (Bangladesh and Indonesia) were selected for field visits. Qualitative findings from field visits to these two countries might not be sufficient to represent all National Societies who have rolled out the ECV toolkit. The evaluation team tried to spend the same amount of time on each interview with representatives of National Societies via Skype or phone interviews as those interviewed in the field. In those countries with special successful stories or lessons to be highlighted, the evaluation team spent more time studying the cases.

There may also be some recall bias. In some National Societies the ECV rollouts were done less recently. There were also cases where key project staff involved in the rollout had left their National Societies and their successors could only provide limited information about the rollout process. To mitigate the above-mentioned risk, the evaluation team contacted a few former staff members who had previously worked on the ECV rollout but had since left their positions.

3. The Epidemic Control for Volunteers (ECV) Manual and Toolkit

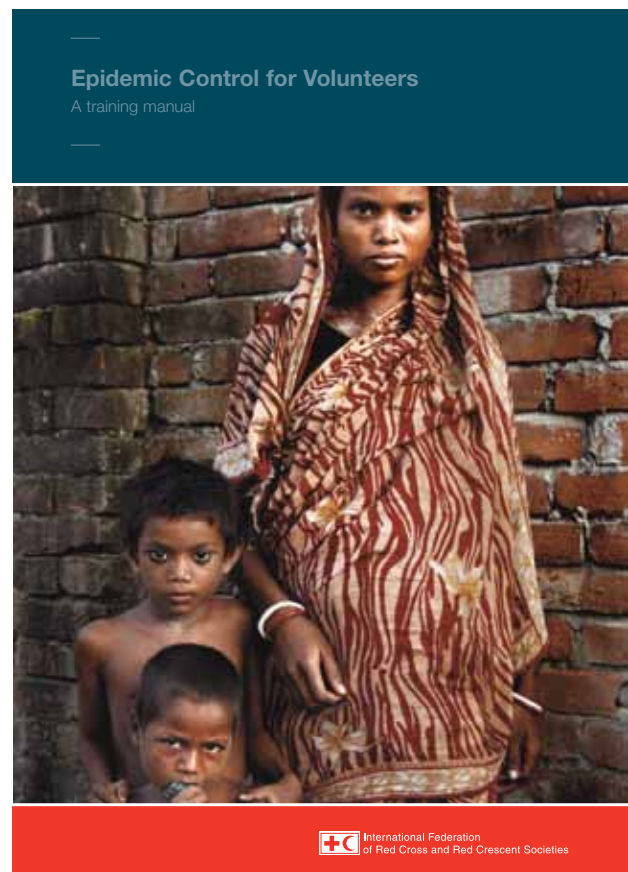
The Epidemic Control for Volunteers (ECV) Manual and Toolkit was developed by the Emergency Health Unit of the Health Department in 2008 as an information and training package focusing on epidemic disease management. It was designed to familiarize Red Cross Red Crescent staff and volunteers with the most common epidemics and to assist them in limiting these diseases impact. In addition to responding to epidemics, the tools emphasized how diseases spread and suggested ways to prevent them and mitigate their negative effects.

The toolkit was designed to support and complement the IFRC longer-term community health methodology community-based health & first aid (CBHFA) by providing National Society staff and volunteers with a quicker more concise instrument to use in the event of disease outbreaks and epidemics. It was designed with easy-to-follow, simple, action-orientated instructions to enable National Society volunteers to immediately respond to epidemics. The design and illustrations were kept purposefully simple to allow for the material to be easily and inexpensively photocopied and shared with volunteers.

In the rollout in the Pacific region, the use of the ECV Manual and Toolkit was called a “Low Cost/Low Tech Approach”, promoting sustainable National Society community-based actions. The low cost in reproducing the adapted materials proved to be a big advantage for the small island Pacific National Society.

To keep the material flexible, relevant and country-specific, National Societies could choose to remove some diseases not appropriate to their context and add others that were more relevant. Many National Societies also decided to adapt the material to their own country-specific context by translating it and altering illustrations and graphics.

National Societies were well aware of the need to add new disease tools anytime disease patterns changed in their countries, as was the case during the Ebola outbreak in West Africa in 2014. The Cruz Vermelha de Timor-Leste (CVTL) translated the Ebola disease tool (which is part of the IFRC ECV toolkit) and included in the adapted ECV toolkit in view of the Ebola outbreak in West Africa. Palang Merah Indonesia (PMI) also planned to include Ebola to the adapted ECV toolkit which is a component of



their National Society's Ebola preparedness plan. This demonstrated the flexibility of the ECV toolkit to add or remove diseases according to the local needs.

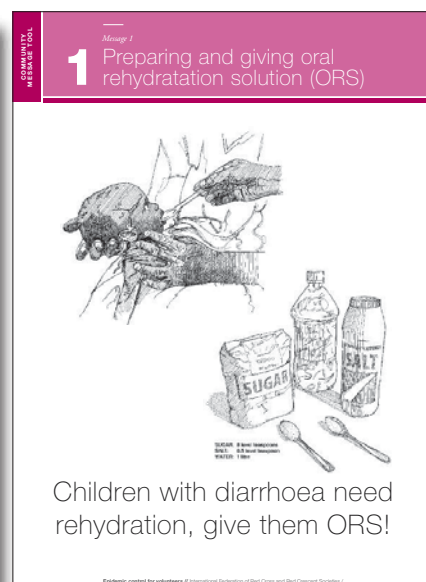
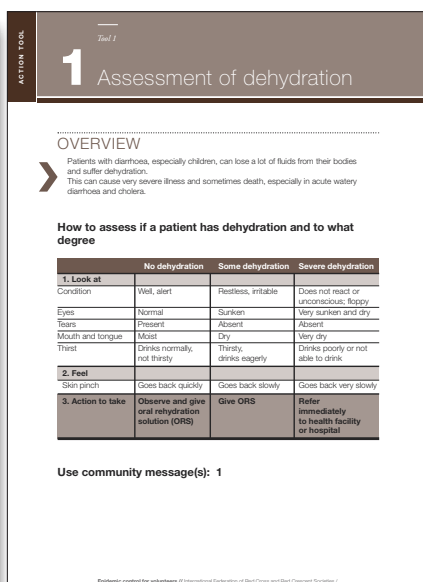
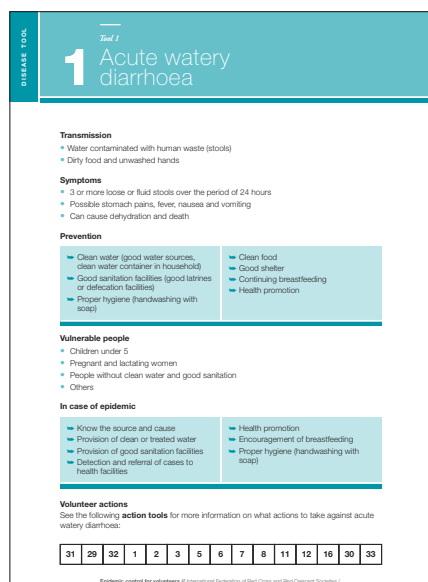
ECV consists of three types of tools:

Disease tools: These are 17 separate sheets, each including a definition, simple symptoms, prevention, and epidemic management tactics of a single disease. There is one sheet per disease, so users can select the specific tools required for any particular operation. Each disease tool is cross-referenced with the most appropriate action tool for that scenario or disease.

Action tools: These are 35 separate sheets, each including an action that should be taken in response to the relevant disease. Actions include the preparation of Oral Rehydration Solution, hand-washing in epidemics and vector control.

Community message tools: These are 25 separate sheets, each containing a message that volunteers need to disseminate to contain or prevent the further spread of the disease. Each sheet contains illustrations and concise, simple statements designed for use as posters or leaflets to be displayed or handed out at public gatherings.

The toolkit also comes with a facilitators manual that details the planning and organization of sessions that provide volunteers with an understanding of what an epidemic is, how it spreads, the conditions that help it spread and the actions that need to be taken in the event of one.



Examples of the Disease Tools, Action Tools and Community Message Tools – left, middle and right images, respectively – that comprise the ECV toolkit. The toolkit comes with a training manual – see image on page 9.

4. Initial rollout in Africa and the Americas

The ECV materials were initially field tested in Nigeria but received their first operational test during the Zimbabwe cholera outbreak in 2008 and 2009. In Zimbabwe, the material proved to be of significant use in providing the local Red Cross volunteers with a tool to understand cholera, its prevention and treatment and then to clearly transmit these messages to the communities they were supporting. Mobile Health Teams travelled to communities and conducted health promotion activities using relevant material. At the community level the material was well received. A subsequent review of the operation found that using ECV and additional IEC material contributed significantly to the enabling of communities to practice proper hygiene, thereby decreasing the spread of cholera.⁷

The ECV toolkit was introduced to 26 African National Societies through ECV workshops held in Malawi and Nairobi in 2010 and 2011. The National Societies viewed ECV as a good fit with the CBHFA material that was being rolled out at more or less the same time. There was a significant emphasis on humanitarian pandemic preparedness (H2P) and a number of African National Societies took part in this initiative. ECV was seen as a tool that National Societies could usefully employ against this imminent threat. Malawi Red Cross Society used ECV as part of its response to a measles outbreak and lessons coming from this response were shared with the nine other Southern Africa National Societies through presentations at meetings of the regional Red Cross Health Network.

Since 2010 in Central Africa, health managers in all the 8 National Societies (Cameroon, Gabon, Congo Brazzaville, Democratic Republic of the Congo, Equatorial Guinea, Sao Tomé and Príncipe, Chad and Central African Republic) have been trained in ECV and it has proven very popular with staff and volunteers. Over the past two years the toolkit has been used in emergency operations in Gabon (chikungunya), Cameroon (yellow fever and cholera), in Congo Brazzaville (IDP camps) and the Democratic Republic of the Congo (polio). In the Sahel Region, ECV has been successfully used in Guinea (measles and more recently Ebola), Senegal (yellow fever and now Ebola), Mali (yellow fever, cholera) and Burkina Faso (meningitis). In southern Africa, 3 National Societies (Malawi, Namibia and Zimbabwe), have rolled out ECV since its inception in 2008 and it has proven very useful and appropriate in addressing cholera outbreaks. In east Africa the ECV Manual and Toolkit has been rolled out in eight National Societies including Kenya, Uganda, South Sudan, Somalia, Sudan, Burundi, Madagascar and Comoros. It has been used mainly in cholera and measles responses, although the National Society in Uganda has used it in Ebola and other viral haemorrhagic fever outbreaks.

⁷ *Review of the ERU Deployments in the Zimbabwe Cholera Operation. Conducted by Libertad Gonzalez and Marilyn Abraham. 2009.*

In the Americas, the ECV toolkit was introduced as part of a training package within the emergency health programme that focused on capacity building and the raising of awareness in National Societies. The training package strengthened National Disaster Response Team systems, educating National Intervention Team (NIT) members in ECV and in a range of other emergency tools. The rollout benefited from a number of factors including the technical advice given by the Regional Red Cross Reference Centres⁸, good links between National Societies, funding to support the rollout and sharing Spanish as a common language. The involvement of the Reference Centre was vital in that it meant that the ECV material was peer reviewed and approved by regional colleagues and did not appear to have been imposed by the IFRC. This led to increased ownership and uptake. By mid-2009, 46 ECV trainers were certified and acted as a regional resource assisting National Societies in sharing the training from national to branch level with interested National Societies.

Since its introduction ECV has been used in a number of National Societies in epidemic response including in dengue operations and in response to chikungunya in El Salvador in 2014. The focus placed on the rollout and dissemination of tools such as ECV strongly contributed to a standardized and validated approach in health interventions and to a coherent community-based strategy and implementation in coordination with IFRC, National Societies, Partner National Societies and other non-Red Cross Red Crescent partners.

Initially the ECV toolkit was only introduced into 20 Spanish-speaking National Societies who recognized its relevance both in response and in preparedness activities. In order to introduce ECV to the English-speaking Caribbean, in November 2011 a regional Trainer of Trainers workshop on Epidemic Control for Volunteers and Water & Sanitation and Household Preparedness was held in Trinidad and Tobago. Water & sanitation and emergency health focal points from all 12 Caribbean English-speaking National Societies, the Canadian Red Cross and the French Red Cross disaster platform in the Caribbean (PIRAC) participated in the event. ECV also became an important tool for the Haitian Red Cross in its response to the devastating cholera outbreak that hit the country in December 2010 (see Case Study 1).

Case Study 1

Using ECV to combat Cholera and Chikungunya Fever in Haiti

In response to a cholera outbreak that claimed the lives of over 8,540 people, the Haitian Red Cross (HRC) decided to introduce the ECV package in 2011 and trained over 1,700 volunteers throughout the country in the methodology.

The HRC, with support from the IFRC, hired a consultant to translate the French version to Haitian Creole and to ensure it was adapted to the Haitian context by reviewing language, expressions and graphics. The Ministry of Health was involved in the process from the beginning and regular meetings were held with them to share information and update them on progress.

HRC continues to utilize ECV in high-risk communities including the remaining IDP camps, emphasizing prevention and assisting health authorities with

⁸ The Reference Centre for Institutional Disaster Preparedness (CREPD) assisted in the contextualization of the material paving the way for its adaptation in the National Intervention Team (NITs) training curriculum.

surveillance. As of January 2014, Haiti still hosted the largest number of suspected cholera cases worldwide with 698,893 cases⁹.

The first cases of mosquito-borne chikungunya were confirmed in Haiti during the last week of April 2014. The Pan-American Health Organization (PAHO) indicated that by 28 May 2014 suspected chikungunya cases in Haiti rose from 3,460 to 6,312. The epidemiological report of the Haitian Ministry of Public Health and Population (MSPP) from 16 June 2014 reported a cumulative total of 39,343 cases. It is estimated that at least 150,000 cases may have spread countrywide.

The Haitian Red Cross, with support from the IFRC and Movement partners, began to work with the MSPP, PAHO and other agencies to combat the spread of the disease – deploying volunteers trained in CBHFA, ECV, PHAST and other methodologies.

“Already having such a large number of volunteers trained in ECV made it relatively easy to mobilize to face the threat of Chikungunya Fever” stated Dr. Agenord Clerge, the Head of the Health Department of HRC. “Chikungunya being a vector-borne disease meant we had to familiarize our volunteers with key prevention messages. Because of the cholera operation we had already used the ECV material in dengue campaigns; it was quite easy to orientate staff and volunteers to work with communities on chikungunya prevention”.

⁹ UN Fact Sheet: *Combating Cholera in Haiti. January 2014 (Updated February 2014)*

5. The ECV Manual and Toolkit Evaluation of Rollout 2008 – 2010

The evaluation of the ECV Rollout 2008 – 2011 was commissioned by the IFRC Health Department to evaluate “the use of the Epidemic Control for Volunteers Manual and Toolkit in National Societies and in IFRC operations”.

The evaluation was carried out in the last quarter of 2011, 2 years after the launch of the manual and toolkit. At this time ECV had only been introduced to Latin American and Latin Caribbean National Societies and in a number of African National Societies. Elsewhere the manual and toolkit had limited application.

While the review team recognized the initial rollout as having been “patchy and slow”, positive feedback was received from National Society and IFRC health staff on the usefulness and relevance of the material. According to the review team there was consistently positive feedback from National Societies and IFRC Health Delegates that the material was “clear, straightforward and fully appropriate for its use and understanding at volunteers’ levels.”¹⁰

The evaluation found the original English language text to be clear and simple to understand. Mention was made of duplication between sections of Session 2 and Session 3 especially as it related to the roles and expectations of volunteers. The graphics and drawings required contextualization but this was to be expected in a generic document. National Societies were advised to adapt these illustrations to their own settings. Recommendations were also made to ensure that the action tools, disease tools and community messages tools were laminated to make them more durable. A number of errors and inconsistencies were noted in material and corrections were suggested. Mention was made of the lack of guidance in how to use the action tools in the community with community members. As the facilitators guide was still in development at the time of the evaluation, there was a lack of teaching plans and guidelines to assist facilitators in targeting messages to different audiences.

The main recommendations were:

- **Keep it simple.**

The team advised the ECV toolkit should be viewed as being complementary to other guidelines, methodologies and approaches and should not be used as a separate, stand-alone product. They recommended that it be included in and used as part of a more comprehensive “public health tool bank”. They recommended the development and inclusion of teaching plans to assist facilitators in targeting the appropriate level of information to the audience.

¹⁰ *Epidemic Control for Volunteers Manual and Toolkit. Evaluation of Rollout 2008 – 2011. IFRC 2011*

- **Keep it flexible.**

The package was designed to be user-friendly and to facilitate flexible implementation depending on the context and disease being addressed. The reviewers found the toolkit was flexible enough to allow National Societies to adapt the material to their local context.

- **National Societies need to consider it as their tool, not an IFRC programme.**

The ECV Manual and Toolkit was found to be valuable in assisting National Society staff and volunteers to carry out the work that many of them were already engaged in. National Societies were advised to explore ways to roll out the toolkit in more innovative cost-effective ways without relying on associated funding for costly training and replication. Some National Societies interviewed as part of the evaluation had secured funding from their own government agencies with which they had shared the material.

- **Keep the training timeframe adaptable.**

One advantage of ECV is its relative simplicity and adaptability and the training of volunteers in its use should follow suit. The team suggested, for instance, that during an epidemic, volunteers could be quickly trained in the use of the material thus enabling the National Society to rapidly mobilize volunteers with sufficient basic knowledge to respond to the emergency.

- **Consider additional options – online training, offline CD etc.**

To reduce training costs the evaluation team reflected on the value of online training but decided that while it may be useful for refresher training, it was preferable to continue face-to-face training and support for new volunteers. It was suggested that an online package could be developed and added to the IFRC online Learning Platform.

- **Improve advocacy and dissemination of the materials.**

Given the overwhelming support for the material from National Societies and IFRC the review team suggested that the toolkit would be equally relevant and positively received in other National Societies and that it should be shared and promoted for use in other zones, regions and National Societies. They recommended that National Societies already using the material share and promote it with their governments as this could provide unexpected funding opportunities.

The team suggested: “It is not very hard to see that it would have a significant impact in many parts of Asia...”¹¹

¹¹ *Epidemic Control for Volunteers Manual and Toolkit. Evaluation of Rollout 2008 – 2011. IFRC 2011*

6. Epidemic threats in the Asia Pacific

Although non-communicable diseases such as cardiovascular disease, cancer, chronic respiratory disease and diabetes are becoming more common, communicable diseases remain the leading cause of mortality and morbidity in less developed countries. Despite decades of economic growth and development, most countries in the Asia Pacific zone still have a high burden of communicable diseases. WHO estimates that the South-East Asia region contributes 27 per cent of the global burden of infectious and parasitic diseases and 30 per cent of respiratory infections.¹²

Among the 17 diseases addressed with ECV disease tools, the risks vary in different countries and in different parts of the world. Some diseases are of particular risk to Asia Pacific countries.

• Diarrhoea

Diarrhoea occurs worldwide and causes 4 per cent of all deaths and 5 per cent of all health loss due to disability. It is most commonly caused by gastrointestinal infections that kill around 2.2 million people globally each year, mostly children in developing countries. Cholera and dysentery cause severe, sometimes life-threatening forms of diarrhoea. Diarrhoea due to infection is widespread throughout the developing world. Diarrhoeal disease is the leading cause of death in the South-East Asia region, accounting for 26 per cent of all deaths from infectious and parasitic diseases.¹³

Cholera is an acute diarrhoeal infection caused by ingestion of food or water contaminated with the bacterium *Vibrio cholerae*. Every year, there are an estimated 3 to 5 million cholera cases and 100,000–120,000 deaths. The short incubation period of two hours to five days enhances the potentially explosive pattern of outbreaks. Effective control measures rely on prevention, preparedness and response with the provision of safe water and sanitation being critical in reducing the impact of cholera and other waterborne diseases.

The South-East Asia region, which includes Bangladesh and India, has the largest populations at risk for cholera.¹⁴ Reported cases in Asia increased nearly threefold from 2010 to 2011 and included an increased number of deaths.¹⁵ Many countries in the South-East Asia region face challenges with known risk factors for cholera outbreaks including poverty, lack of development, and high population density. Additionally, the region is susceptible to extreme environmental factors such as

¹² The WHO South-East Asia region differs from the IFRC in that it has 11 Member States: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, and Timor-Leste.

¹³ Indrani Gupta and Pradeep Guin *Communicable diseases in the South-East Asia Region of the World Health Organization: towards a more effective response. Bulletin of the World Health Organization* 2010; 88: 199-205.

¹⁴ Ali M, Lopez A, You Y, Kim Y, Sah B, Maskery B, Clemens J. *The global burden of cholera. WHO* 2012; 90: 209-18A.

¹⁵ WHO. *Cholera 2011. [PDF - 16 pages] Wkly Epidemiol Rec.* 2011;87: 289–304.

frequent and widespread flooding that can contaminate water sources and dislocate populations.

• Vaccine-preventable diseases

The most important vaccine-preventable diseases in Asia Pacific include (but are not limited to) polio, hepatitis A, hepatitis B, measles, rabies and Japanese encephalitis.

Until recently, the global polio eradication program appeared to be on track, with fewer than 500 cases worldwide in 2001, but its final goal remains elusive. Since 2006, polio has been endemic in only 4 countries: Nigeria, India (Uttar Pradesh and Bihar), Pakistan and Afghanistan, but periodically polio “leaks” into nearby countries. For example, although China had been free of polio for 10 years, there was an outbreak in September 2011, probably resulting from importation from West Pakistan.

Every year, 280,000 people in China die from liver cancer or cirrhosis, accounting for almost one third of all Hepatitis B-related deaths worldwide. Overall, approximately 60 per cent of the population has a history of HBV infection. Almost 10 per cent, or 120 million people, are chronically infected with HBV and risk early death from liver disease.

As of 2007, there were still 197,000 measles deaths occurring annually – 69 per cent of them in the WHO South-East Asia region¹⁶ – because mass vaccination campaigns have not yet begun in India. In addition, while routine measles vaccination coverage grew from 61 per cent in 2000 to 73 per cent in 2007, the South-East Asia region was the lowest among all 6 WHO regions.

Japanese encephalitis (JE) is the most serious form of viral encephalitis in Asia. A recent literature review estimates nearly 68,000 clinical cases of JE occur globally each year causing up to 20,400 deaths.¹⁷ JE primarily affects children since most adults in endemic countries have natural immunity after childhood infection, but individuals of any age may be affected. Twenty-four countries in the WHO South-East Asia and Western Pacific regions have JE transmission risk (which includes more than 3 billion people). According to the WHO, major outbreaks of JE occur every two to five years.¹⁸

About 3.3 billion people live in the 100 or so countries where dog rabies is endemic (enzootic). A conservative estimate puts the annual number of rabies deaths occurring in Asia and Africa at 55,000. More than 60 per cent of the total annual rabies deaths occur in Asia (the majority in India), and the rest occur mainly in Africa.¹⁹ Rabid dogs account for more than 98 per cent of the deaths in people. Children aged 9 to 15 are the most common victims of dog bites.

Volunteers have a vital role to play in addressing vaccine-preventable diseases. They can initiate and support community-based surveillance, assist in getting messages to difficult-to-reach populations and in countering false or unsubstantiated rumours about vaccine safety which can undermine immunization programmes and cost lives.

¹⁶ Dabbagh A et al. *Progress in Global Measles Control and Mortality Reduction, 2000–2007. Morbidity and Mortality Weekly Report*, 2008, 57(48):1303–6.

¹⁷ *Bulletin of WHO*, October 2011

¹⁸ *Japanese encephalitis WHO Fact Sheet No 386 March 2010*

¹⁹ Knobel D et al. *Re-evaluating the burden of rabies in Asia and Africa. Bulletin of the World Health Organization*, 2005, 83(5):360–370.

- **Diseases transmitted by vectors**

Dengue fever (DF) is the fastest emerging arboviral infection. It is spread by the *Aedes aegypti* mosquito and has major public health consequences for the South-East Asia and Asia Pacific regions. Of the 2.5 billion people globally at risk of dengue fever and severe dengue, South-East Asia accounts for approximately 1.3 billion or 52 per cent. As the disease spreads to new geographical areas, the frequency of the outbreaks has increased along with a rapidly changing disease epidemiology.²⁰ Based on officially reported surveillance data, dengue continued to show sustained activity in the Western Pacific region. In 2011, member states reported a total of 244,855 cases, of which 839 died.²¹ More than 1,000 cases were reported each from Cambodia, the Federated States of Micronesia, and the Lao People's Democratic Republic, Malaysia, the Philippines, the Marshall Islands, Singapore and Viet Nam. Cambodia, the Federated States of Micronesia and the Marshall Islands reported more cases relative to 2010.

Chikungunya is an emerging, epidemic-prone, vector-borne disease of considerable significance and prevalence in the South-East Asia region. The disease has been reported from countries of South and East Africa, South Asia and South-East Asia. In the WHO South-East Asia region, outbreaks have been reported from India, Indonesia, Myanmar, Sri Lanka, Thailand and Maldives. Massive outbreaks of chikungunya fever have occurred in recent years in India, in the Pacific and in the island countries of the Indian Ocean. Maldives reported outbreaks of chikungunya fever for the first time in December 2006. Although not a deadly disease, high morbidity rates and prolonged polyarthritides leading to considerable disability in a section of the affected population due to chikungunya fever can have a substantial socioeconomic impact in affected countries.²²

Zika virus infection is a disease of concern in the Pacific - the only region in the world to have a documented epidemic. According to the Secretariat of the Pacific Community (SPC), this mosquito-transmitted disease first emerged in 2007 in the Federated States of Micronesia. This was the first time the Zika virus epidemic was detected.

Malaria epidemiology in this region exhibits enormous geographical heterogeneity with Myanmar and Cambodia remaining high-burden countries. Within each country, malaria distribution is also patchy, exemplified by 'border malaria' and 'forest malaria' with high transmission occurring along international borders and in forests or forest fringes, respectively. 'Border malaria' is extremely difficult to monitor, and frequent malaria introductions by migratory human populations constitute a major threat to neighbouring, malaria-eliminating countries.²³

Japanese encephalitis (JE) was already mentioned in vaccine-preventable diseases.

²⁰ *Comprehensive Guidelines for the Prevention and Control of Dengue and Dengue Haemorrhagic Fever*. WHO Regional Office for South-East Asia 2011

²¹ Yuzo Arima, Zoe Rebecca Edelstein, Hwi Kwang Han et al *Epidemiologic update on the dengue situation in the Western Pacific Region, 2011*. WPSAR Vol 4, No 2, 2013

²² *Guideline for the Prevention and Control of Chikungunya Fever*. WHO Regional Office for South-East Asia 2009.

• Respiratory infections

In 2003, South-East Asia's combination of strong links with other Asian countries alongside a multitude of intercontinental connections (Three of the world's 30 busiest airports are now found in South-East Asia: Bangkok, Jakarta, and Singapore) facilitated the regional and global spread of the Severe Acute Respiratory Syndrome (SARS) coronavirus from its origins in southern China. Outbreaks occurred in Singapore and Viet Nam, although Singapore was the most severely affected with 33 deaths compared with 11 across the rest of South-East Asia. Singapore was also implicated in international transmission to outside the region. Although the global outbreak ended in July 2003, a further laboratory-acquired infection was reported in Singapore in September 2003.²⁴

• Highly contagious diseases

This group includes Ebola, Marburg virus and Rift Valley fever. At the time of the review an unprecedented outbreak of Ebola Fever was affecting West Africa – primarily in Guinea, Liberia and Sierra Leone. There had been no confirmed cases in the Asia Pacific region as of 10 October 2014.

• Avian and pandemic influenza

The same year SARS spread through South-East Asia, the region began to experience outbreaks of another emerging infectious disease, H5N1 influenza, which had again spread from southern China. Although the very high mortality rate in domestic poultry (approaching 100 per cent) was alarming, the number of human infections that were occurring and the deaths of many of those infected (human fatalities in South-East Asia were just under 70 per cent) caused greater concern. The virus continues to circulate in wild birds worldwide, causing outbreaks in poultry in several South-East Asian countries, and, in 2010, cases in human beings were reported in Cambodia, Indonesia, and Viet Nam.²⁵

Since its re-emergence in 2003 and 2004, avian influenza A (H5N1) has spread from Asia to Europe and Africa. Globally, among the 15 countries that reported human cases of avian influenza A (H5N1) virus infection, four were in the South-East Asia region: Bangladesh, Myanmar, Indonesia and Thailand. In the South-East Asia region, the total number of human avian influenza A (H5N1) cases reported since the beginning of 2004 through 31 December 2013 was 228, with 181 fatalities. In 2013 alone, there were four cases, all of them fatal, of human influenza A H5N1 reported to WHO from Bangladesh and Indonesia. The total number of human avian influenza A (H5N1) cases reported in Indonesia from the beginning of 2005 through December 2013 was 195, with 163 fatalities.²⁶

Other diseases mentioned by National Societies interviewed during the review included Hand, Foot and Mouth Disease (HFMD), a common infectious disease of infants and children. It is characterized by fever, painful sores in the mouth, and a

²³ Cui L, Yan G, et al. *Malaria in the Greater Mekong Subregion: heterogeneity and complexity*. *Acta Trop*. 2012 Mar;121(3):227-39

²⁴ Horby PW, Pfeiffer D, Oshitani H *Prospects for emerging infections in East and southeast Asia 10 years after severe acute respiratory syndrome*. *Emerg Infect Dis*. 2013 Jun; 19 (6):853-60.

²⁵ Richard J Coker, Benjamin M Hunter, James W Rudge, Marco Liverani, Piya Hanvoravongchai *Emerging infectious diseases in Southeast Asia: regional challenges to control*. *www.thelancet.com Vol 377 February 12, 2011 ;599-609*

²⁶ Fact sheet WHO http://www.searo.who.int/entity/emerging_diseases/topics/avian_influenza/en/

rash with blisters on hands, feet and buttocks. Countries with recent large increases in the number of reported cases in Asia include: China, Japan, Hong Kong (China), Republic of Korea, Malaysia, Singapore, Thailand, Taiwan (China) and Viet Nam. The Viet Nam Red Cross carried out an emergency response operation from April to December 2012 in response to a large HFMD outbreak that resulted in 151,100 cases and 45 deaths.

Leptospirosis is largely a water-borne disease with outbreaks mainly related to flooding. Although trends indicate successful control of leptospirosis in some areas, there is no clear evidence that the disease has decreased in the last decade. The efficiency of surveillance systems and data collection varies significantly among the countries and areas within the region, leading to incomplete information in some instances.²⁷

²⁷ Victoriano AF, Smythe LD, Gloriani-Barzaga N, Cavinta LL et al *Leptospirosis in the Asia Pacific region. BMC Infect Dis.* 2009 Sep 4;9:147. doi: 10.1186/1471-2334-9-147.

7. Rollout of ECV in the Asia Pacific

The Asia Pacific zone office supports the work of 37 National Red Cross and Red Crescent Societies through its office in Kuala Lumpur, 4 regional offices (Bangkok, Beijing, Delhi and Suva) and 13 country offices. It provides coordination as well as financial and technical support for disaster operations and longer-term development programmes.

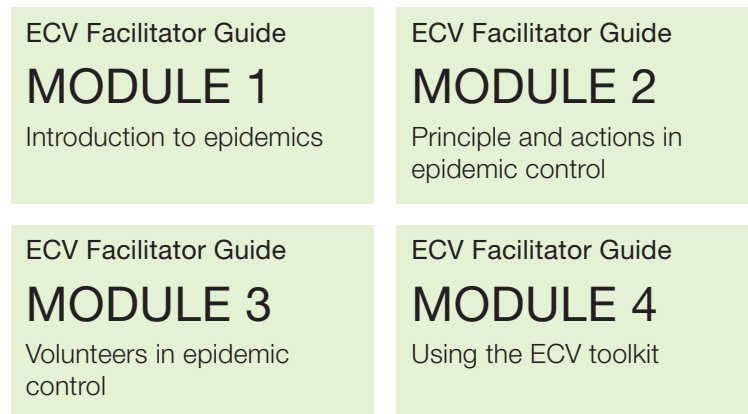
Recognizing the threat of epidemics in the Asia Pacific zone (APZ) and the utility of the ECV toolkit, in 2011 the health team decided to embark on a systematic rollout of ECV in priority National Societies. The ECV Rollout 2008 – 2011 Evaluation was studied and recommendations were taken into careful consideration, specifically those relating to:

- advocacy and promotion of the toolkit,
- further development of the training manual,
- the importance of local adaptation,
- the need to correct inaccuracies and inconsistencies.

Preliminary discussions were held with National Societies through regional meetings and on an individual basis to assess levels of interest and to better plan the rollout.

These initial consultations resulted in the development of a number of additional guides and aids to facilitate the planning of the rollout, advocacy of the toolkit, local adaptation and effectiveness of trainings of volunteers and master trainers including:

- a guidance note telling National Societies how to organize the adaptation processes including points on integration in an effort to ensure sustainability of investment, (Annex 4),
- session guides for training facilitators that build on the ECV manual, the structure of which follows that of the CBHFA training guide for facilitators,
- visual aids, which were later adopted or translated by National Societies.



Four modules of session guides for ECV training of facilitators were developed.

The guidance note served as a very important guide for National Societies and suggested that thorough planning was needed to ensure the relevance of ECV toolkits to their countries, and to achieve sustainability, effective trainings, and integration with other health or disaster preparedness and response programs. It was recommended that the rollout process be divided into three main phases. For details, please refer to Annex 4.

i. Pre-conditions for rollout:

- Identify a designated **focal person** who is responsible for a relevant programme – most likely a community-based health programme - into which the tool can be integrated, someone who can dedicate a proportion of her or his time and who has the support to lead the planning and implementation of a rollout.
- **Garner buy-in and supported from the leadership** and relevant sectors of the National Society.
- Develop a workplan with the active involvement of relevant programmes and departments of the National Society and define their roles in the ECV toolkit adaptation, rollout and integration processes.
-

ii. Possible steps and actions:

- **Localize** the ECV toolkit to ensure that the material focuses on diseases that are relevant to the country, is translated to local languages and uses terms and illustrations that consider local norms and culture.
- **Reproduce the localized toolkit and training manual** and distribute to selected master trainers and priority provincial or district branches.
- **Develop a group of ECV master trainers** by engaging **National Society CBHFA facilitators and master trainers**.
- **Engage with programmes** to institutionalize and expand epidemic control capacity.
- **Review and document** ECV toolkit rollout, integration and utilization to capture practices and lessons learnt that will guide and inform similar processes in the future.

iii. Further rollout:

- Engage with Movement and other partners for the **potential integration** of epidemic prevention and control, and the introduction of the ECV toolkit, in their relevant programmes.
- Consider the inclusion of ECV-related activities as part of the health component of **an emergency operation supported by the IFRC** DREF or emergency appeal.

In all National Societies rolling out ECV, all of the recommendations from the guidance note were followed. Some National Societies that had not yet rolled out ECV in their country were also able to implement ECV during emergencies to address the urgent need to prevent an epidemic.

Though a well-designed workplan is the key to rolling out the ECV systematically with ideal results and sustainability, the use of the toolkit during emergencies demonstrated the ability of the toolkit to be made operational in a short period of time. The use of it in DREF and emergency appeal operations also reflected the recognition of the benefits of the toolkits in those National Societies affected by epidemics.

To facilitate a more effective and quality training, the APZO adjusted the proposed training programme. It maintained the suggested three-day training but re-ordered the training flow based on the experience of the Afghan Red Crescent, the first Asia Pacific National Society to initiate the rollout. Teaching and learning methods were also clarified by producing session guides with interactive modules and by including case study analyses and exercises.

In selecting priority National Societies for rollout assistance, the APZO did not use a specific set of criteria. The two main considerations were the prevalence of outbreaks and epidemics in a given country and the readiness and interest of the National Society to include ECV as part of its “suite of epidemic preparedness and response tools”. The rollout was also influenced by the fact that the APZ did not have dedicated funding for the rollout process. Despite this limitation, by the end of 2013, through the collective efforts of the IFRC and the active engagement and commitment of interested donor National Societies, more than half of the National Societies in the APZ had completed initial rollouts.



* Afghan Red Crescent Society had their first ECV training in 2011

Figure 1: Rollout of ECV in the Asia Pacific zone

East Asia

The ECV rollout in **China** was initiated in 2013 with the adaptation, translation and printing of materials. Unfortunately it has yet to be introduced beyond National Society headquarters and no training has been done. Opportunities do exist however to integrate ECV within the established CBHFA programme initiated after the Sichuan Earthquake of 2008.

ECV was introduced into the Democratic People's of Republic of Korea (**DPRK**) in 2012 and is seen as being extremely relevant in a country where the health system has the ability to be supported in an epidemic by the DPRK Red Cross Society, especially in prevention and response activities. The manual and toolkit were translated and photos were changed making it more relevant and user friendly. The DPRK, like Mongolia and large areas of China, has a different epidemic risk profile than tropical and sub-tropical countries, meaning that many diseases in the original toolkit were omitted with a focus placed on acute respiratory infections (ARIs) and other more relevant diseases. The National Society had used CBHFA already so ECV was quite easy to introduce. The DPRK Red Cross is planning to integrate ECV with DRR and response mechanisms. ECV will be administered by disaster management (DM) and will receive technical oversight from the health department.

In **Mongolia** the CBHFA programme was quite large and proved to be a good fit with ECV but is now focusing more on urban areas with an increased emphasis on non-communicable diseases (NCD). Translation of the material began in 2013 and is now complete. ECV is seen as relevant, but Mongolia, given its cold climate, is not prone to tropical or semi-tropical epidemics and suffers instead from seasonal acute respiratory infections (ARIs). A unique challenge is trying to roll out a tool in a country where the majority of people live a nomadic existence.

South Asia

The first training in the Epidemic Control for Volunteers Toolkit in the Asia Pacific zone took place in **Afghanistan** in late December 2011 when 25 CBHFA supervisors, trainers and regional health officers from the Afghan Red Crescent Society received a 4-day training as master facilitators in ECV in addition to a further day's instruction in household water treatment (HWT) and safe storage in emergencies. The participants were strategically chosen from ten of the most at risk provinces with an emphasis placed on gender (an equal number of males and females were invited). The training was based on recommendations from an internal evaluation of the Emergency Medical Unit (EMU) programme that called for more strategic planning to strengthen the emergency health preparedness and disaster response of the Afghan Red Crescent Society (ARCS). The Ministry of Public Health (MoPH) also recognized the existing countrywide gaps in emergency health and encouraged the ARCS to focus on capacity building in this area. The specific objectives of the training were: to train CBHFA supervisors and selected CBHFA trainers as Master Trainers in ECV and HWT, to ensure they had the skills to replicate the training in their respective geographical locations and to ensure that they could develop and implement epidemic response plans based on the context and trends in their locations. Prior to the workshop, the material was translated and printed into both the Pashto and Dari languages. ECV remains a well-utilized tool within the ARCS, particularly with Mobile Health Teams.

In **Bangladesh** the first rollout began in 2012 and continued into late 2013 in 9 districts.²⁸ Due to political unrest in the whole country, project implementation was delayed and activities such as training were slowed down. Progress was made however on sensitizing management and staff at headquarters and the district level to the toolkit. Sixteen volunteers were selected for ToT training and 160 volunteers for basic ECV training. By the end of January 2014 volunteers from the 9 target districts had received ECV training. A ToT and refresher training course were also offered. All trained volunteers received the toolkit (in English) plus protective and visibility material. Progress was also made on the translation of the toolkit to Bangla. In early 2014 the Bangladesh Red Crescent Society (BDRCS) committed to implementing the project in 9 additional districts²⁹ and training the Youth Department of the BDRCS at headquarters in Dhaka. A total of 21 youth were trained in ECV in February with an emphasis placed on training those from disaster prone areas. Links were established between trained ECV volunteers and government health programmes by having ECV volunteers report suspected disease outbreaks and other health issues to the health chief³⁰ in all districts. The BDRCS also encouraged student ECV volunteers to disseminate information on epidemic prevention and control within their schools to fellow students. The National Society also publicized ECV activities and promoted epidemic control in local newspapers. By the end of June, 221 volunteers had been trained in the toolkit. Due to the unforeseen delay in starting the project, the National Society sought and was given a no-cost extension until September 2014.

The ECV roll out began in the **Maldives** in July 2013 as a one-year programme. The Maldivian Red Crescent Society (MRCS) committed to adapting the ECV toolkit to the local context, training 20 ECV Master Facilitators and 100 volunteers and aiming reach 10,000 beneficiaries in 3 island villages. The project obtained a no-cost extension until September 2014. By early September 2014 MRCS had completed the adaptation of the toolkit by removing 3 less common diseases and adding 2 (chickenpox and hand foot and mouth disease) plus conjunctivitis to the kit. The National Society worked in close collaboration with their Health Protection Agency (HPA), who gave technical oversight to the adaptation and advised on the use of the national vaccinations schedule. The adapted version was then translated to the national language, Dhivehi, and field-tested in branches and communities before being presented for validation by the HPA and printed. With a total of ten branches reached, the MRCS hopes to continue the rollout to cover an additional three branches per year. Funding remains an issue however.

Case Study 2

Integration of ECV and disaster risk reduction in The Maldives

The Maldivian Red Crescent Society (MCRS) made the decision to train their Emergency Response Teams (ERT) in the ECV toolkit because many of the emergencies they responded to had the potential for disease outbreaks and epidemics. Given the logistical challenges of one of the world's most dispersed countries consisting of 192 inhabited islands, MRCS decided it was imperative that volunteers were skilled in the use of a range of tools that enabled them to be ready to respond to a variety of threats. ECV was seen as a valuable addition to their training. Many of the ERT volunteers trained in ECV received instruction in disaster

²⁸ Bhola, Noakhali, Chittagong, Cox's Bazar, Dhaka, Rangpur, Sirajganj, Mymensing and Jamalpur.

²⁹ Sunamganj, Sylhet, Panchagarj, Takurgaon, Tangail, Munshiganj, Magura, Barisal, Jhalokathi.

³⁰ The Civil Surgeon

management as part of the Canadian Red Cross-funded community-based disaster risk reduction (CBDRR) Project. The integration of health and disaster risk reduction has worked very well in the context of the Maldives and has produced some interesting spin offs.

One of the most remote communities in which the CBDRR project was implemented expressed an interest in being trained in epidemic control. Given that they were not one of the original communities prioritized in the ECV rollout, the MRCS was unable to cover the cost of sending trainers to the island. The community took the initiative to cover the cost of the training themselves and paid for the trainers to come from the capital, Male, to their community.

“We were very happy to supply trainers to assist the community with training in ECV and view the integration of ECV and DRR as very important in promoting sustainable programs and multi-skilled staff and volunteers” stated Fathimath Himya Abdul Majeed, the Maldivian Red Crescent Society Program Field Officer responsible for the ECV rollout. “Given that the Maldivian Red Crescent Society is only five years old, the ECV rollout also provided us with a great opportunity to engage with state health agencies and particularly the Health Protection Agency who now recognizes the Maldivian Red Crescent Society as a valuable partner.”



Maldivian Red Crescent Society volunteers were engaged in the field-testing of the translated disease, action and community message tools as part of the adaptation process. Here National Society volunteers, after being briefed, talk with a community members to get feedback on the text and illustration of community message tools.

In **India** the ECV toolkit has been integrated into the Indian Red Cross Society (IRCS) first medical responder (FMR) programme model where it aligns with the FMR goal of having volunteers as the first responders when addressing emergency health needs, including those associated with epidemics. Since the IRCS plans to roll out FMR as its flagship programme in every branch and district, ECV will eventually be introduced across the country as part of a broader health in emergencies programme.

From 2011 to 2012, **Nepal**, under their health development programme, implemented CBHFA in a number of districts along with ECV and other national health campaigns. Several ECV trainings were conducted at headquarters as well as in districts.

As **Pakistan** has high infant and maternal mortality rates, the priorities of the National Society lie in maternal, newborn and child health. This resulted in an initially poor response to the introduction of ECV. Despite these reservations, in 2012 training in ECV was offered to CBHFA coordinators and an adaptation and translation process leading to the printing of the material in Sindi and Urdu began. The rollout was focused on locations where CBHFA was already being carried out, which

meant ECV was well accepted at branch and headquarters. Discussions were also held with WHO and UNICEF, as they were impressed with the material and its relevance. Pakistan operates a community-based health system but doctors in the national health system are heavily overburdened so anything at the community level that can assist in task shifting is welcomed. The Pakistan Red Crescent Society also sees strong potential in including ECV as a component within its integrated community-based disaster risk reduction (ICBDRR) programme. Training at the headquarters level has been positively received and combining ECV with nutrition training has helped improve efficiency. More advocacy is required with MoH to assess the value of the material, as it was not involved in its adaptation.



Bangladesh Red Crescent Society ECV volunteers prepare the seasonal calendar on anticipated outbreaks in Barisal District, Bangladesh.

ECV was introduced into **Sri Lanka** in February 2012 with orientation and sensitization sessions attended by all Sri Lankan Red Cross Society programme managers. The National Society adapted and translated the material into Sinhalese and Tamil and carried out an ECV Master Facilitator Training using the contextualized material. It was subsequently printed in both languages and distributed to 13 branches. Over the course of the following year the Sri Lankan Red Cross Society rolled out ECV in 8 districts and trained a total of 313 staff and volunteers in the use of the toolkit.



Adapted ECV Manual in Sinhala



Adapted ECV Manual in Tamil



The pictures on personal hygiene practice were adapted to the local practice. (Left: Bangladesh, Right: Nepal)

South-East Asia

The **Cambodian Red Cross Society (CRCS)** translated the ECV toolkit into the Khmer language and held training in August 2011. In 2012, they organized ECV training that was also attended by the MoH Deputy Director for Communicable Diseases and Control. The objective of the training was to build on experiences gained from the introduction and implementation of the CBHFA methodology and to enable CRCS to act quickly and effectively in the event of a disease outbreak or epidemic. Following the training, participants were tasked with developing individual branch preparedness and response plans for epidemic control, cascading the methodology through branch-level training in ECV, reinforcing response team capacities and strengthening networking with communities and other stakeholders at the branch level.

Palang Merah Indonesia (PMI) began their ECV rollout in May 2013. PMI has close relations with their Ministry of Health and as the only non-government entity on the National Zoonotic Commission plays an important role in communicable disease prevention and control. The health team in PMI met with MoH, who committed to assist with technical support for the adaptation of the material. Four provincial branches were chosen to pilot the rollout. They were selected based on epidemic risk mapping and their capacity and interest in supporting the introduction of the manual and toolkit. By the end of May 2014, the first ECV Adaptation Workshop was attended by a cross-section of departments and support bureaus within PMI and representatives from three departments within the MoH.³¹ An agreement was reached on removing some diseases from the toolkit (Ebola, Marburg virus and Rift Valley fever) and adding three others (chikungunya, leptospirosis and rabies). A second adaptation workshop was held in June and a consultant hired by the project to complete the translation, graphic design and layout of the adapted material attended.

Case Study 3

ECV in urban contexts in Indonesia

Indonesia is one of the most disaster-prone countries in the world. Increasingly the potential for major disasters to occur in Indonesia's dense urban areas is growing and is exacerbated by rapid population growth, urbanization, poverty, poor adherence to building codes and regulations, informal settlements and extreme weather events caused by climate change. Java is the most highly populated island on earth and Jakarta, with an official population of 10 million, lies at the center of an urban conurbation with a population of more than 27 million people. Migrants arriving in search of work and better opportunities settle in high-risk locations without basic services such as water and sanitation. They typically live in high-risk areas along riverbanks and drainage canals exposing themselves to climatic hazards such as flooding and secondary hazards such as epidemics – mainly diarrhoeal diseases, dengue and leptospirosis. Overcrowding provides a fertile environment for the spread of airborne infections such as acute respiratory infections and tuberculosis. Recent studies have recognized the threat of epidemic or disease outbreaks as a secondary hazard and have recommended that they should be included in contingency plans.³²

³¹ Representatives from the MoH Communicable Diseases, Zoonotic and Vaccine & Immunization Departments participated in the adaptation process.

³² Urban Desk Study Report, Palang Merah Indonesia. 2014

Although his formative training and experience has been in the field of disaster preparedness and response, Oktariaoi, Head of Services Division of the PMI Jakarta Provincial Branch, is well aware of these secondary threats. “When we have carried out vulnerability analysis and mapping in these marginalized communities the population regularly indicate that diarrhoea and dengue are a big concern – especially after flooding. I have had the opportunity to become familiar with the ECV Manual and Toolkit as a member of the working group carrying out the national-level adaptation of the tools to the Indonesian context. In my role as Head of the Services Division I have overall responsibility for the planning and implementation of DM / DRR and health activities and we, as the Provincial Branch for Jakarta are planning to include ECV in our contingency planning.”

In the **Lao Red Cross Society's** ECV training, a representative of the Lao Ministry of Health gave an overview of epidemic threats and the surveillance system of MoH. The MoH emphasized that a strengthening of existing partnerships between provincial health authorities and the Red Cross Red Crescent was vital for the early detection of cases necessary for increasing the likelihood of adequate and timely responses.

The **Myanmar Red Cross Society** initiated their ECV rollout in 2013. The rollout followed a similar format as in other National Societies with an emphasis placed on sensitization of staff and volunteers to the toolkit, translation and adaptation of selected parts of the material, followed by field testing, validation by the MoH, printing, and training of Myanmar Red Cross Society facilitators and volunteers and community volunteers. The Myanmar Red Cross Society has a large and well-established CBHFA program, which means many staff members and volunteers are already quite familiar with community-based health approaches.

The **Philippines Red Cross (PRCS)** found the ECV to be very relevant and appropriate in the wake of Typhoon Haiyan (known in the Philippines as Typhoon Yolanda) that devastated the Philippines on 8 November 2013. It is the deadliest Philippine typhoon on record, killing at least 6,300 people in that country alone. The IFRC and PRCS addressed a number of outbreaks during the initial ERU deployment that led to training on epidemic control in Tacloban and Cebu. The Department of Health asked the Red Cross to hold epidemic control training for department staff. This led the PRC in Tacloban to conduct inter-organizational training in ECV with a particular emphasis on acute watery diarrhoea and dengue. A total of 30 people from the Department of Health were trained and new volunteers received “flash training” to confront a measles outbreak. The Tacloban Chapter of the PRC was integrated into the government SPEED³³ system, thus reinforcing its auxiliary role. ECV training has also been offered to national and international NGOs: MSF and Save the Children have received instruction in the tools. At the time of the review, approximately 350 people had been trained in ECV and it was linked to ongoing long-term CBHFA programming.

The **Cruz Vermelha de Timor-Leste (CVTL)** carried out a review of the existing training curriculum for branch volunteers in 2013. The review identified the need for CVTL staff to receive more in-depth instruction on preventing and responding to disease outbreaks. CVTL consequently translated the ECV material into the local Tetum language and contextualized it to the Timor Leste reality, taking into account

³³ Surveillance Programme in Post Extreme Emergencies and Disasters

MoH health policy. ECV training took place in November 2013 and the participants also gave feedback on drafts of the ECV material in Tetum. The material was subsequently field tested in a district of the capital, Dili, and was then finalized and printed. Early in 2014 CVTL had an opportunity to use the ECV toolkit when the IFRC allocated a total of CHF 32,204 from the Disaster Relief Emergency Fund (DREF) to assist with the response to a large dengue outbreak (as outlined in Case Study 4).

Case Study 4

Using ECV to deliver a dengue outbreak response in Timor-Leste

In January 2014 a dengue fever outbreak occurred in Dili, the Timor-Leste capital. There were 70 per cent more cases of dengue than at the same time the previous year. The Ministry of Health requested that the CVTL assist in the response by carrying out social mobilization activities focusing on prevention in two districts of the city. This was subsequently increased to four districts. The IFRC allocated CHF 32,204 from the Disaster Relief Emergency Fund on 24 January 2014 to support the Cruz Vermelha de Timor-Leste (CVTL) deliver a dengue campaign to the Dili district.

CVTL trained 50 volunteers in the Epidemic Control for Volunteers methodology, sharing the training with representatives from the IFRC, WHO and the Ministry of Health. The focus was prevention and referring people with dengue-like symptoms to the hospital or nearest health facility, as well as engaging in a cleaning campaign with other stakeholders. A CVTL volunteer who had received training in ECV in November 2013 was the lead facilitator for the event.

CVTL participated in regular coordination meetings and was able to provide MoH with information on households reached, patients referred and the number of dengue cases found in the target areas. A total of 6,881 households were visited and a total of 45,013 beneficiaries were reached.

CVTL carried out a baseline study in the areas where volunteers were operating to gauge improved knowledge, attitudes, practice and beliefs around dengue and its prevention as a result of the campaign. To avoid bias, volunteers not involved in the campaign were chosen to carry out the baseline and endline studies. These studies indicated an increase in KAPB in all four target areas.

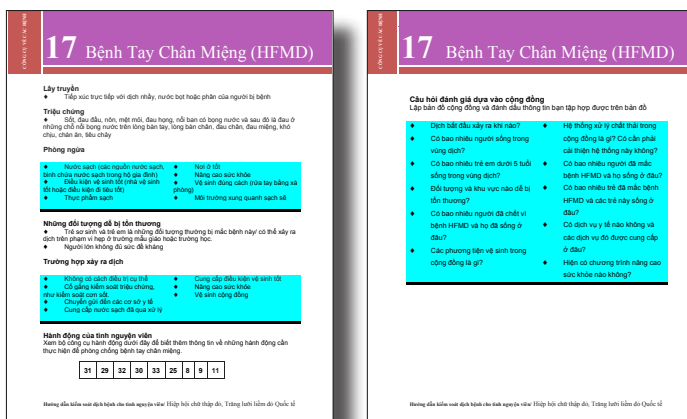
A lessons learnt workshop examined the CVTL contribution to the campaign and focused on program management, administration & finance, logistics management, volunteer management and IEC material. Lessons coming from this workshop were shared with the MoH to assist them coordinate future campaigns.

Apart from the important role played by CVTL in limiting the spread of dengue, the operation assisted CVTL by forming closer links with their MoH and WHO and by forming alliances with other groups such as academia, as public health students from Universidade de Paz also participated in the campaign.

“The rollout of ECV has improved the position of CVTL as a key player during outbreak response activity. CVTL was well recognized by the Timor-Leste

Government and UN Agencies as well as other organizations who work in country” says Dewindra Widiamurti, the former IFRC Health Delegate in Timor-Leste. “Through the rollout, which includes interactive training in local languages, the staff and volunteers’ capacity to respond to future outbreak was strengthened”.

In **Viet Nam** the National Society used ECV as part of its response to Hand Foot Mouth Disease (HFMD) in 2011 and 2012, which were DREF and an emergency appeal supported respectively. In early to mid 2011, a sudden increase in HFMD cases among young children under the age of 5 was recorded; this was the first time the country had such an increase. The Viet Nam Red Cross (VNRC), who had gained experience rolling out global toolkits for epidemic control in the response to avian and human influenza, worked closely with the IFRC to carry out assessments and implement community mobilization. The ECV toolkits were instrumental in this response activity, especially in the absence of a national risk communication guideline for HFMD. With support from the IFRC via DREF, within 5 months, trained volunteers had reached 103,400 families with children aged under the age of 5 and delivered up to 120,000 copies of communication material with clear instructions for preventive actions. Behaviour change was the final target of the operation, and resulted in a 30 per cent increase in key hygiene behaviours among parents and caregivers in 5 of the most affected provinces. In early 2012, Viet Nam observed a second surge of HFMD cases, where incidence was 7.5 times higher than the same period of the previous year. The disease had a more severe impact on children under the age of three and resulted in school closures and panic in many provinces. ECV was once again used as a beneficial tool to assist in the response of the VNRC to the escalating situation. During a 9-month operation that started in April 2012, volunteers assisted 52,255 beneficiaries, including 196,200 direct beneficiaries. Besides using adapted ECV and communication materials, the usage of a behaviour change strategy was found to be very helpful. During the 2 outbreak, more than 5,000 volunteers on the ground were trained and became active in risk communication at the community level. A network of national and provincial trainers for public health in emergency was further developed. The National Society also achieved increased visibility in the community via its timely response to the HFMD epidemic and it expanded its relationship with donors and government.



In response to the hand, foot and mouth disease (HFMD) outbreaks in 2011 and 2012, Viet Nam Red Cross produced health communication tools for their volunteers. An HFMD volunteer tool consisting a compilation of disease, action and community messages tools of the ECV toolkit was produced in 2011. In addition to reproducing the volunteer tool for the response in 2012, the whole ECV toolkit was adapted as part of a wider epidemic preparedness measure of the National Society.

Pacific

Currently the ECV toolkit is being adapted for use in 14 Pacific Island National Societies. The process began in February 2014 and is due to be completed by the end of 2014. The adaptation process has received technical advice from the WHO Pacific regional office in Suva, Fiji and the UNICEF Pacific Multi-country who have benefited from referencing the “Pacific Outbreak Manual” developed by the Pacific Public Health Surveillance Network (PPHSN). The IFRC Pacific regional office also consulted with the Secretariat of the Pacific Community (SPC). The plan was to adapt the material to the Pacific demographic using Fiji (Melanesian) and Tonga (Polynesian) as pilots with the intent to use this material in a broader Pacific-wide rollout. Given the recent spate of disease outbreaks in the Pacific – mainly dengue but also chikungunya – there is a need for epidemic control tools and ECV can potentially fill an important gap not only in National Societies but also in government health agencies. It may also prove to be a good fit with existing initiatives such as the climate change adaptation programme of the Fiji Red Cross Society, “Climate Change Champions”. The Pacific National Societies run various health programmes and are utilizing the Low Cost Low Tech activities at the branch level. The adoption of the Low Cost Low Tech approach also enables tools to be easily adapted to meet the unique needs of different Pacific Islands for better long-term impact. To allow for integration and consistency of the ECV toolkit in the other on-going Low Cost Low Tech tools already in use, the same approach was also used for ECV toolkit development. The use of the same approach will increase acceptability of the ECV toolkit in the Pacific National Societies, who have been using such approaches in their on-going programmes (community-based health programmes, first aid activities, disaster risk reduction programmes).

8. Key Findings

Relevance and appropriateness

The adaptation of the toolkit

National Society staff and volunteers, as well as IFRC personnel at zone, regional and country levels, have been unequivocally positive as to the relevance of the Epidemic Control for Volunteers Manual and Toolkit and its value for target communities. Individuals interviewed by the review team repeatedly commented the toolkit was simple, clear and easy to use. Relevance has been significantly enhanced by the adaptation of the material to national and local realities and through its translation to local languages. This has involved much time and effort and has increased the degree of ownership that National Societies now place on the material. Apart from translating and contextualizing the material by focusing on the most common diseases (and adding others where necessary) National Societies, in consultation with their national health authorities and other key health partners in epidemic control, have ensured the material has been tailored to suit each country's epidemic risk profile.

The original ECV Toolkit and Manual covers 17 of the most common diseases occurring during epidemics globally. There are some diseases with epidemic potential such as chikungunya, rabies, leptospirosis, typhoid fever, conjunctivitis in Asia Pacific and ciguatera fish poisoning and zika virus infection (particularly in the Pacific) that are not included in the toolkit. Some National Societies such as PMI and the Pacific decided to add additional diseases after consultation with their national health authorities. The addition required a significantly higher degree of work compared to those disease pages that required translation and adaptation only. Apart from writing up the disease tool page, additional work had to be put in to identify the relevant action tools and community action tools for the additional disease tools. The addition of new diseases to the tool took time and in some cases delayed the whole production process.

Disease Tools of original edition of ECV Manual and Toolkit:

1. Acute water diarrhoea	10. Respiratory infections
2. Cholera	11. Ebola
3. Bloody diarrhoea	12. Marburg virus
4. Polio	13. Rift Valley fever
5. Yellow fever	14. Avian influenza
6. Meningitis	15. Pandemic influenza
7. Measles	16. Hepatitis A
8. Malaria	17. Hand, foot and mouth disease
9. Dengue fever	

While this tailoring of the material to suit a given countries' epidemic risk is a sensible approach, the ECV toolkit provides the great advantage of the addition of disease tools which were taken out during the previous adaption process. For example, many National Societies in Asia Pacific decided to remove the Ebola disease tool during their first adaptation process since Ebola was not a disease of concern in Asia Pacific. When Ebola became a public health emergency of international concern in August 2014, CVTL added Ebola to their ECV package, as there was a need to raise awareness of the disease in their communities. CVTL was able to solicit emergency funds from various sources to support their addition of Ebola disease tools and to organize additional trainings for volunteers. Another National Society that planned to add Ebola to the ECV toolkit was PMI. It is expected that more National Societies may follow suit.

In the regional rollout in the Pacific, the review team was impressed with the care taken to ensure the material was adapted to the Pacific reality. Illustrations representative of both Melanesian and Polynesian National Societies were incorporated, contributing to what will become a truly regional resource.

The use of ECV toolkit in operations

After the rollout of the ECV toolkit, the trained volunteers and the toolkit should be ready to be mobilized for epidemic prevention. While most National Societies have not mobilized the trained volunteers and toolkits in real epidemic operations, those National Societies that had real operational experience gave positive feedback. For instance in the Philippines, Timor-Leste and Viet Nam where the material has been used in response to diarrhoeal diseases, dengue and hand, foot and mouth disease, communities viewed the toolkit as having been highly relevant and useful in assisting them in responding to these epidemics.

National Societies have mentioned that their health authorities have supported the tool as "filling a gap" in many countries and have assisted in trainings and adaptations and displayed a willingness to use the material as part of their own epidemic responses. The community volunteer network of National Societies supported the health authorities by providing a direct communication channel (word-of-mouth) of the trained volunteers. While the health authorities can focus on more communication with the communities through mass media and mass public events, the volunteer network of National Societies played an important complementary role in disseminating disease information to the communities.

During the whole rollout process, from adaptation to mobilization of the ECV toolkits and volunteers in real epidemic operations, close collaboration and coordination occurred between National Societies and health authorities. Once the ECV toolkit has been rolled out, National Societies who have regular meetings with health authorities and WHO in health clusters can also keep promoting the use of the toolkit if needed and advocating for the role of the Red Cross Red Crescent in epidemic response.

Effectiveness

Integration and harmonization with other on-going community programmes

The Asia Pacific ECV rollout has been very effective in a relatively short period of three years. The manual and toolkit has been successfully introduced into 20 diverse

National Societies and the Pacific Region from Mongolia to Fiji. During this short period it has been translated into at least 19 languages and has been adapted to the context of each country. All respondents have stressed that the tool itself is most effective when mainstreamed into longer-term community health or disaster risk reduction programmes and most National Societies have incorporated or are planning to incorporate ECV into these programmes. National Societies have stated that where CBHFA³⁴ has been already been introduced, the ECV material is more readily accepted by volunteers and communities. National Societies have been quick to make linkages with on-going programmes in health (including Mobile Health Teams), water and sanitation, climate change adaptation, Human Pandemic Preparedness (H2P) and disaster risk reduction (DRR). The review team was impressed by the way National Societies have sought to increase relevance by mainstreaming the material. For instance, ECV will be used in Fiji as part of a wider climate change adaptation programme. The Fiji Red Cross Society has already developed a climate change toolkit that can be used in conjunction with the ECV toolkit. In Afghanistan, India and Pakistan, ECV is part of the training curriculum for mobile health teams and first medical responder teams. In the Maldives, Indonesia and Myanmar, ECV is being linked with community-based disaster risk reduction programmes. The inclusion of ECV in the Maldivian Red Crescent Society Emergency Response Team (ERT) training is also a good example (see Case Study 2).

Sensitization of leadership levels and involvement of relevant work units

Ensuring there is a good mix of health, disaster management, organizational development and non-programme staff and support staff in the adaptation process and initial training has provided National Societies with a cadre of multi-skilled personnel familiar with the toolkit and has greatly assisted in the mainstreaming efforts. In most National Societies, the health departments undertook the responsibility of the ECV project with the support of other relevant departments. Apart from cross-departmental support, recognition from the leadership of the National Society and health authorities and utilization of the toolkit were key factors in ensuring the effectiveness of rollout. Most National Societies that rolled out ECV in non-emergency times followed the guidance note issued by the Asia Pacific zone office to obtain buy-in and support from leadership by involving key leadership persons in the initial discussions. For example, the Bangladesh Red Crescent Society started the rollout by inviting key leadership members from the National Society governing board, executive committee at district levels and government health authority and representatives from other community-based organizations at district levels. The Bangladesh Red Crescent Society program staff reported that the buy-in of the leadership brought about the success of the whole rollout project. At the district level, executive committee members played an important role in disaster relief activities in Bangladesh. Because they understood the functions and importance of the ECV toolkit and the trained community volunteers, the decision to mobilize the tool and volunteers could be made quickly in the aftermath of a disaster. At the national level, the ECV toolkit was introduced to health cluster meeting members by the IFRC health manager from the Bangladesh delegation. In Indonesia, the PMI conducted the sensitization workshop as a start of the rollout process. The sensitization workshop was attended by the PMI health board members, the head of PMI Health Division, the head of

³⁴ Community-based health and first aid (CBHFA) is defined by IFRC as a community-based approach to long-term capacity building for improved health programmes and community development. ECV has been designed to harmonize with CBHFA and to provide quicker more agile tools to deal with emergency health issues involving outbreaks and epidemics.

Planning Bureau, other PMI divisions (youth and volunteers, disaster management, training unit and organizational development) as well as representatives from IFRC country delegation in Indonesia, IFRC South-East Asia Delegation and Asia Pacific zone office. The sensitization ensured a common goal was shared by leaders and managers of the project, and led to an understanding of the roles played by different units to support the rollout.

Robust work plan to ensure achievable outcomes

For all National Societies rolling out ECV in non-emergency times, work plans were developed to clearly outline the key activities, timeline, budget, and roles of responsible departments in carrying out specific activities and tasks. The work plan allows National Societies to monitor progress and ensure outputs are achieved according to the desired timeline. Progress reports on a monthly or quarterly basis were also in place to ensure monitoring and reporting of progress. Challenges and difficulties were also recorded for knowledge management and evaluation purposes. Below is an example of the work plan from the Bangladesh Red Crescent Society.

Outcome 1. The capacity of National Societies to support communities in epidemic preparedness and response is improved.

Output 1. National Society leadership and management are sensitized to, and support strengthening the role of the National Society in epidemic prevention and control.

Output 2. Epidemic prevention and control tools are adapted and available in strategic locations.

Output 3. Community volunteers in priority areas are trained in epidemic prevention and control.

Outcome 2. Effective regional mechanisms are in place to support national level epidemic preparedness and response efforts.

Output 1. Targeted technical and program management support is provided to National Societies.

Output 2. National Society best practices in epidemic preparedness and response are documented and disseminated.

Project workplan, Epidemic Preparedness Project: Rollout of ECV Toolkit by Bangladesh Red Crescent Society

ECV trainings

In general, the expected outputs of ECV training activities will include the following:

- The knowledge and skills of staff and volunteers in epidemic control will be increased.
- Staff and volunteers will be trained in utilization of the ECV toolkit.
- Health focal persons and volunteers will become familiar with the mobilization procedures and use of the ECV toolkit in an epidemic control operation.

According to training reports and interviews with volunteers, there was a high degree of satisfaction with the National Society staff and volunteer training in respect of content and time allocation, but there was a variance of opinion on the issue of delivery. Some praised the “practical hands-on approach” and others commented on the “strict lecturing style”. Few National Societies carried out workshop pre- and post testing. The ones that did registered a significant improvement in participants’ levels of knowledge of epidemics and control. Interviews with community volunteers in Bangladesh showed that volunteers were in general confident in sharing the knowledge of diseases they gained in trainings. However, considering that volunteers might have been trained months or even years ago, there was the common phenomenon that volunteers needed extra time to figure out how to set up the ECV toolkit while being asked to prepare the material require for some specific disease situations.

Community volunteers are usually trained with the various skills required to respond to different needs after a disaster. For instance, in Bangladesh, volunteers were trained to carry out a number of roles in their communities. Their capacities included epidemic control and prevention, first aid, relief distribution and psychosocial support. After a disaster, instructions are to be given by the district-level disaster management staff to the community volunteers on what their roles would be. Building on the existing community volunteer pool and providing them with additional skills offers the advantage of flexibility of roles of volunteers and better utilization of resources. However, some volunteers in the focus group interview showed confusion about the roles of epidemic control and first aid. Short refresher trainings that can be quickly prepared could be one way to refresh the memories of trained volunteers on how to rapidly set up the toolkit and make them aware of their main roles during emergency operations.

The inclusion of ECV as part of the range of tools available for responders (but not necessarily incorporating a session on ECV) in RDRT training and its incorporation into the ERU Community Health Module training will promote a standardization of approach across the zone in respect to disaster response and health.³⁵

Use of the ECV during epidemic operations

The majority of National Societies involved in the rollout have focused on in-house sensitization, material translation and adaptation followed by field testing and training of staff and volunteers. Trained volunteers were on stand-by for mobilization in case of an epidemic that required them to use the knowledge and skills gained from ECV trainings. For National Societies such as CVTL, Viet Nam, and the Philippines who had experience in mobilizing the ECV volunteers in epidemic operations, results were positive in terms of the effectiveness of community activities. They have indicated that communities found the messages to be clear and informative. However, adaptation of the toolkit took time in the case of Viet Nam, as the toolkit was rolled out in an emergency manner under the emergency appeal. There was also a new National Society that had their ECV master trainers identified and trained but had not started to disseminate the ECV manual and toolkit to target communities. Some of them mentioned that additional technical support and mentoring would be required to enable a smooth community level rollout.

³⁵ This is already happening in the zone and is supported by DM and health programmes.

Efficiency

Funding

The ECV rollout in the Asia Pacific zone was primarily designed as a preparedness initiative. Nonetheless, at the zone and regional levels, the IFRC and National Societies have been efficient in using a variety of funding mechanisms to fund the rollout - from Emergency Appeals, DREFS and long-term planning frameworks at the country level, to working with bilateral donors and soliciting multi-country funding through Red Cross and non-Red Cross donors such as Hong Kong Red Cross (Bangladesh, Indonesia, Maldives and Myanmar) and DFID (Timor-Leste and the Pacific Region). Partner National Societies such as the Canadian Red Cross, the Danish Red Cross and the Finnish Red Cross have also supported the systematic rollout and focused their support on specific National Societies. The Canadian Red Cross also supported the regional rollout as a multi-lateral donor. Most of the funding has been spent on material adaptation, field-testing and printing, with the remainder allocated to internal training at headquarter and branch levels and at the community level. This is viewed as normal in a rollout of this type. Focusing on 2 (out of 14) National Societies in the Pacific to develop a regionally contextualized manual and toolkit was a very efficient use of resources.

Timeline

Implementation delays were experienced in at least two National Societies that had to seek no-cost extensions. These delays were due to internal issues (delays in signing the project agreement) and external factors (civil unrest). Evidence from both these National Societies indicates a willingness and commitment to complete the project on time, but will require monitoring and support to ensure the new deadlines are met. In some National Societies the adaptation process will require this as well because they have had to move at the speed of their MoH and some government agencies have complicated internal structures. By review time all National Societies were on course to having the material adapted and approved by their respective health authorities. Despite the delays, the review team considers this to have been time well spent, as active MoH involvement is vital for the long-term success of the rollout.

Adaptation process of the toolkit

Translation and full-colour printing costs have been high but unavoidable given the importance of having a concrete product to share with National Societies, donors, MoH and other government agencies and as a template for branch replication and copying, as well as for marketing purposes.³⁶ National Societies have suggested that they will use more economical means of replicating the initial print run by photocopying or printing from a softcopy on a USB memory stick or flash drive.

There are some opportunities to bring some innovation into the rollout through the increased use of social media and technology. Palang Merah Indonesia for instance is piloting the use of a handheld android mobile application that contains information on, amongst other things, first aid and epidemic control. The use of this type of technology and social media such as Twitter and Facebook (amongst others) will increase the efficient reach and effect of ECV (and other tools) amongst technologically savvy staff and volunteers.

³⁶ Some National Societies such as the Afghan Red Crescent, Pakistan Red Crescent Society and Sri Lankan Red Cross Society have translated, adapted and printed in two languages.

Training costs

Training costs were the second biggest budget line, but National Societies used a variety of means to reduce costs, such as combining ECV with other training (in nutrition and household water treatment) and by inviting regional resources to carry out the training (the Viet Nam Red Cross invited a Master Trainer from the Cambodian Red Cross to facilitate their ECV workshop). This peer exchange is worthy of further investigation and development where feasible.

Coordination and supervision

In such a complicated rollout across so many National Societies coordination and collaboration is vital. Interviewees and respondents were generally clear and happy as to their defined roles and responsibilities in the rollout. Where there were initial issues, such as in Indonesia, these have gradually been ironed out and there is a willingness and commitment to move the project forward to a successful conclusion of this rollout phase. National Societies were appreciative of the support, both financial and technical, offered by the IFRC and Partner National Societies. At a country level the branches that were visited as part of the review, both provincial and local, were clear as to their roles in the process and were satisfied with the support from headquarters.

In terms of management of community volunteers, one programme staff member of the Bangladesh Red Crescent Society expressed the difficulty of continuously supervising the community volunteers from more than ten districts after they completed the ECV trainings. The community volunteers questioned their progress in their roles as ECV-trained volunteers. The community volunteers also voiced out that they would like to have some senior volunteers to guide them in further steps, especially in how they could continue to gain new knowledge and practice what they had already learned. The volunteers suggested that they would be interested in practising their skills and knowledge during non-epidemic times.

Support to community volunteers

During focus group interviews with Bangladesh Red Crescent Society community volunteers, the need was found to equip the ECV-trained volunteers with a “go-to” bag for action. The “go-to” bag should contain the ECV toolkit and some essential fieldwork items required for the ECV activities. Some items suggested included personal protective equipment (mask, gloves), personal hygiene items (tissues, hand sanitizer, etc.), first aid box, torch and a water bottle.

Impact

Mobilization of ECV-trained volunteers

Promising initial results have come out of the Philippines, Timor-Leste and Viet Nam regarding the impact of ECV activities during epidemic operations. In these three National Societies the community-level activities have been successful in respect to responses to three outbreaks.

National Societies have mentioned the strengthening of links and reinforcing their auxiliary role with their health authorities (especially MoHs) as well as with academia, NGOs and other agencies as being an important impact of the rollout so far. Concrete examples of strengthened links include Palang Merah Indonesia having an important role in their National Zoonotic Commission, Maldivian Red Cross

developing a mutually beneficial working relationship with their Health Protection Agency, Bangladesh Red Crescent working closer at the local level with Civil Surgeons, CVTL establishing a working alliance with a local university and the Philippines Red Cross working with the MoH in their National Surveillance Programme in Post Extreme Emergencies and Disasters. These strengthened links can greatly improve the relevance and impact of National Societies in the event of outbreaks by clearly defining their role in national prevention and response guidelines and protocols.

To ensure ECV-trained volunteers can be mobilized effectively and efficiently, mobilization procedures should be in place. The mobilization procedures should not be merely standalone procedures for ECV activities, but additional procedures on top of the existing mobilization ones for other emergency-related tools and community volunteers. A few National Societies have already included the mobilization of ECV-trained volunteers in their emergency response team mobilization. In Bangladesh, the National Society planned to include in a new HR structure included in their emergency medical team, that one ECV-trained volunteer should be included in each emergency medical team to carry out epidemic prevention activities while the clinicians focus on providing medical treatment to the target communities.

More attention must be paid to monitoring and evaluation of the rollout. Ideally, all ECV trainings, be they at Master Facilitator, Red Cross volunteer or community level, should be assessed both before and after to gauge increased knowledge. In emergency operations, baseline and endline studies must be instituted as per IFRC protocols. Lessons learnt workshops (such as those organized by CVTL after the dengue DREF) are also valuable in gauging the effectiveness of interventions and helping to improve performance.

National Societies are increasingly including ECV as an element in their contingency planning; this training is being organized and supported technically by the IFRC. ECV will have an increased impact if it is mainstreamed into National Society emergency planning guidelines and protocols. It was surprising that National Societies did not highlight the extensive work that went into the H2P contingency planning process that led to the development of national plans and contingency plans³⁷ in a number of National Societies including India, Indonesia, Nepal, Philippines, Viet Nam, Cambodia and Fiji.

Sustainability

Funding support

For National Societies with robust long-term programmes such as community-based health, disaster risk reduction or emergency medical team development, financial support of ECV would also be facilitated by mainstreaming it into existing long-term programmes. Some ECV-related expenses can be shared by ongoing programmes where appropriate. The challenge will be in supporting a rollout extension in National Societies without ongoing programmes. These National Societies face greater challenges and will, in all likelihood, require further external financial support to take the tool to other branches. Long-term funding to further advance the rollout of ECV in these National Societies should be explored.

³⁷ *The Humanitarian Pandemic Preparedness initiative in the Asia Pacific Zone (June 2009 – September 2010) involved nine National Societies (India Red Cross Society, Palang Merah Indonesia, Nepal Red Cross Society, Philippines National Red Cross, Viet Nam Red Cross, Afghan Red Crescent Society, Bangladesh Red Crescent Society, Cambodian Red Cross Society and Fiji Red Cross Society) who undertook long and comprehensive projects and accelerated or shorter projects involving the development of contingency plans for influenza pandemics.*

Trainings and knowledge management

Given that the Red Cross Red Crescent, like other large organizations, suffers from frequent staff changes and changing priorities, it is vital that the IFRC and National Societies manage the accumulated knowledge coming out of this rollout and that this institutional memory remains within the National Society. To assist with this, it's important that the rollout process is adequately documented and data on workshops, volunteers trained and communities reached is recorded and archived.

In addition to traditional training of master trainers and community volunteers, National Societies have suggested several ways to ensure the sustainability of knowledge and skills and to obtain updated epidemic resources. For example, PMI and a number of National Societies have developed the use of a mobile phone app to promote first aid knowledge and other important health knowledge in communities. It is worth exploring the use of such mobile phone app programmes for epidemic news and knowledge. ECV-trained volunteers can also benefit from getting the most updated epidemic knowledge for further dissemination to their communities. With such continuous knowledge enhancement, volunteers can maintain their passion and enthusiasm for their epidemic control missions.

Another suggestion is the use of an online training mode to introduce the ECV toolkit to new users or to deliver new knowledge on epidemic control. It could be conducted through the IFRC e-learning platform, IFRC webinar or any similar platforms.

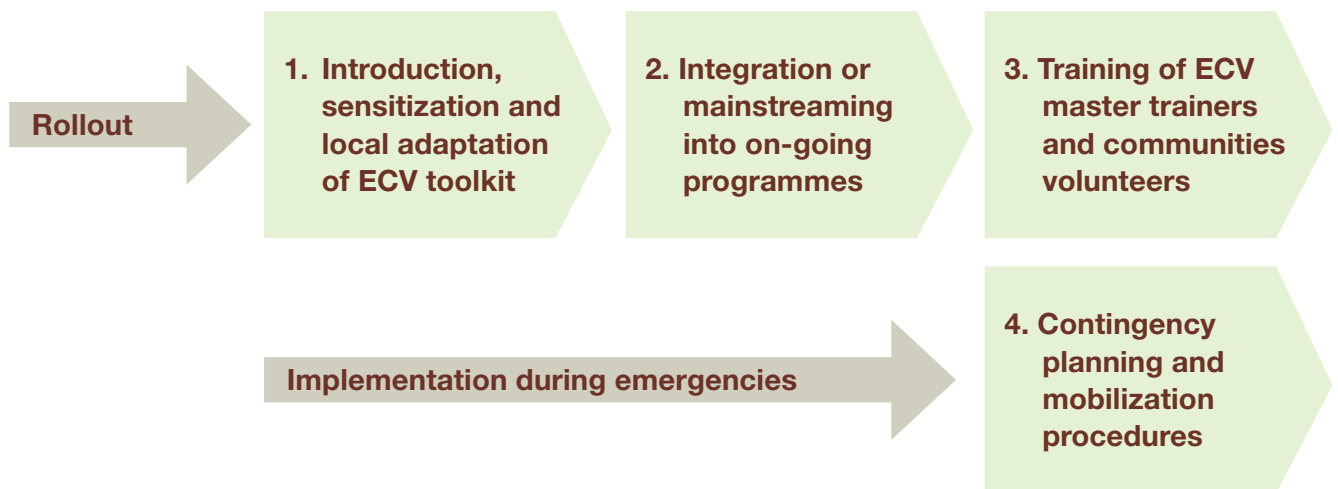


Mobile phone app launched by PMI in 2014

At the national or regional level, the use of the ECV toolkit as a community health tool during emergencies can be integrated into various kinds of IFRC or National Society emergency response trainings. For example, the introduction of the ECV toolkit has already been included in the health Emergency Response Unit and other workshops related to emergency health in Asia Pacific. By continuously sensitizing staff and volunteers at different levels to the importance of epidemic control and the functions of ECV, sustainability can greatly be enhanced.

The way forward

ECV has been successfully introduced from the IFRC global health team in the secretariat to the Asia Pacific zone office and further to National Societies. At the National Society level, the whole process from rollout to becoming operational in emergencies is summarized in the following four steps:



After successfully rolling out the ECV toolkit, National Societies should ensure it can be mobilized in a timely and structural manner when there is a need. As mentioned under “impact” some National Societies have already started introducing ECV activities and its mobilization system into their contingency plan. Only with a pre-agreed mobilization mechanism in place can the National Society mobilize trained volunteers effectively and ensure sustainability of the rollout. After the initial rollout, review of the toolkit needs to be done regularly; revisions may be required. For instance, PMI recently reviewed their adapted version and decided to add Ebola to the toolkit. Continuous involvement with national health authorities and concerned National Society departments is required to ensure impact is sustained. The regular presence of the IFRC and National Society health staff in the WHO health cluster meeting in Bangladesh is a good example of a way to ensure continuous communication and involvement with relevant working partners in epidemic control.

9. Conclusions

A tremendous amount of hard work has gone into the rollout of the Epidemic Control for Volunteers Manual and Toolkit in the Asia Pacific zone. Within a short 3-year period 20 National Societies have adapted the manual and toolkit to their national circumstances. The material has been translated into at least 19 languages including Bahasa Indonesia, Bangla, Burmese, Dari, Dhivehi, Khmer, Korean, Laotian, Mandarin, Mongolian, Nepalese, Pashto, Sindi, Sinhalese, Tamil, Tetum, Thai, Urdu and Vietnamese. National Society staff and volunteers at headquarters and branch levels have been trained in its use and community-level training has occurred in a number of National Societies – with more community trainings anticipated in the next few months in those National Societies who have received no-cost project extensions. Many stakeholders have been involved in adapting the material and in giving advice on the national and regional contextualization.

The tool has been used and proven effective in a number of epidemic situations including hand, foot and mouth disease (Viet Nam), dengue (Timor-Leste) and water-borne diseases (Philippines). National Societies have been quick to recognize its potential and have incorporated it into existing programmes and initiatives such as the First Medical Responder Programme (India) and Mobile Health Teams (Afghanistan). It has found acceptance in both health and disaster risk reduction programming (the Pacific, Bangladesh, Pakistan, India, Maldives and Indonesia) and national (and regional) health authorities have commended the tool as filling an important gap and have sought training from National Red Cross and Red Crescent Societies (such as in the Philippines) in its use – as have reputable NGOs.

The rollout process was likely highly relevant and effective to countries' needs, epidemic priorities and contexts of the community programmes. The strategy of sensitizing the leadership of National Societies and relevant national authorities as the first step has proven to be highly effective in beginning the rollout of ECV as the sensitization process helped pave the way for the future steps of mainstreaming it into National Societies' or national authorities' health programmes as well as emergency contingency planning. The approach of mainstreaming and integration into existing health or disaster management programmes was also highly recognized as appropriate to ensure sustainability and optimal use of resources.

There was much potential in sustaining and maximizing the epidemic preparedness and response work by use of the ECV toolkit and trained volunteers. Many lessons were learned from the rollout in the Asia Pacific zone. Those lessons included: more coordination and support at community levels, the need of including the ECV toolkit and trained volunteers in National Societies' and national authorities' contingency plans, better supervision and monitoring, more sustainable impact and knowledge sharing.

In essence it is a simple and effective tool that has proven itself to be effective in training volunteers in the basics (identification, prevention and control) of the most common diseases in their countries which enables them to quickly respond to outbreaks – and ideally prevent them in the first place.

10. Recommendations

Many lessons were learned from the rollout of the ECV Toolkit and Manual in Asia Pacific from 2011 to 2014, adding to the experience of the rollout in the African and America zones from 2008 to 2010. The following recommendations come from the consultant team of this review for improving effectiveness, efficiency, impact and sustainability of the use of ECV and IFRC's epidemic preparedness and response work.

For improving effectiveness, relevance and efficiencies:

Strengthening community-level activities

- (1) Sharing best practices and/or case studies may be beneficial in assisting National Societies to become more adept and confident in working with communities in epidemic surveillance, preparedness and control. This is especially relevant in National Societies which do not have longer-term health or DR programming.
- (2) Support ECV trainers by providing additional guidance to assist them to facilitate and organize trainings for community volunteers. Training in behaviour change communication should be incorporated into ECV training giving volunteer's additional skills for encouraging health behaviour change. The IFRC-produced Behaviour Change Communication (BCC) for Community-Based Volunteers (Trainers and Volunteers manual) is a good resource but National Societies will require training in its application.
- (3) Some National Societies such as Bangladesh and the Maldives will require assistance as they move to extending the rollout to districts where there is little branch or community-level activity.
- (4) Pre-position list materials such as personal protective equipment and personal hygiene items required for volunteer to carry out community activities during epidemics.
- (5) Develop monitoring tools for community levels activities during emergency operations as well as in peacetime when volunteers may wish to prepare their skills through practicing with communities in non-emergency situations.

Improving training and readiness

- (6) National Societies must ensure that trained volunteers are retained and motivated and that Master Facilitators in particular receive refresher training – particularly when there is an elevated threat of epidemics.
- (7) National Societies can incorporate epidemic prevention and control in disaster simulation exercises and similar trainings.
- (8) National Societies must ensure that 'soft' copies of the material exist to be shared with all branches on USB /memory sticks to allow for quick printing in event of epidemic threat. Each branch should have a trained ECV focal point to carry out flash training of volunteers in the event of an outbreak.

- (9) Since epidemic trends may change, updated trends and the use of ECV to deal with potential epidemics can be promoted on social media (Facebook and Twitter for example). Exploring the use of technology such as a handheld android system is being piloted in Indonesia.
- (10) Continually review and adapt ECV Manual and Toolkit content to reflect emerging epidemic threats and advances in prevention and treatment.

For improving sustainability and enhancing impact:

- (11) National Societies should ensure that the ECV Manual and Toolkit continues to be mainstreamed within existing programmes such as CBHFA and ICBDRR and ERT, ERM and RDRT systems. Good examples of this mainstreaming can already be found in Afghanistan (Emergency Response Team, ERT), Myanmar (CBHFA), Maldives (ERT), India (First Medical Responder) and Indonesia (ICBDRR).
- (12) Continued support should be given to National Societies to assist them in developing contingency planning instruments. Reference should be made to the work which was carried out as part of the Humanitarian Pandemic Promotion (H2P) projects in which National Societies were involved in the development of national inter-agency plans and local plans (Nepal Red Cross), in inter-agency plans at national and provincial levels which was integrated in the national plan led by the Department of Health (Philippines Red Cross), pandemic contingency plans (Viet Nam Red Cross) and response and business continuity plans (Fiji Red Cross).
- (13) ECV should be incorporated into National Society contingency planning processes – either in health or, more likely, in disaster risk management and response plans. To achieve this, DM/DRR practitioners and National Society management, staff and volunteers must be exposed to the ECV material and understand its added value in respect of post disaster outbreaks.
- (14) Additional financial support will be required to ensure a continuing rollout occurs in National Societies without the benefit of long-term health and DRR programmes. IFRC can act as a bridge-builder in sourcing additional funding although the National Societies must assume responsibility in marketing the tool to national agencies.

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12. List of Interviewees

International Federation of Red Cross and Red Crescent Societies (IFRC)	
Dr. Ayham Alomari	Senior Health Officer, Community Health and Non Communicable Diseases, IFRC Geneva
Evelyn Paasa Lacsina	Health Delegate, Afghanistan
Jessie Kanhutu	Health Delegate, Myanmar
Anne-Maree Delaney	Disaster Management / Health in Emergencies Delegate, Pacific Regional Office, Fiji
Dewindra Widiarmurti	Former IFRC Health Delegate, Timor-Leste
Gopal Mukherjee	Health Delegate, Democratic People's Republic of Korea (DPRK)
Dr. Abu Taher Muhammad Faruq	Health Manager, Bangladesh
Dwi Handayani	Health Officer, Indonesia
Van Nguyen	Manager PMER, Viet Nam
Dr Syed Jamal Shah	Health Coordinator, Pakistan
Keti Khurtsia*	Programme Coordinator, Sri Lanka
Jim Catampongan	Health Coordinator, Asia Pacific Zone Office, Kuala Lumpur
Eva Lam	Emergency Health Coordinator, Asia Pacific Zone Office, Kuala Lumpur
Dr. Bhanu Pratap	Health Coordinator, Philippines.
Nelson Castano	Head of Disaster Management Unit, Asia Pacific Zone Office, Kuala Lumpur
Hong Chen	Regional Health Manager, East Asia Regional Office, Beijing
Olivera Burgess*	Regional Programmes Coordinator, South Asia Regional Delegation, New Delhi
Abhishek Rimal	Regional Health Officer, Southeast Asia Regional Office, Bangkok
Dr. Viviane Nzeusseu*	Regional Health Coordinator, Central Africa Regional Representation
Dr. Aissa Fall*	Regional Health Manager, Dakar Regional Office
Dr. Willy Amisi*	Regional Health Coordinator, East Africa
Dr. Michael Charles	Regional Programme Coordinator, Southern Africa Region
Thuan Thi Nguyen	Former Healthcare Programme Manager, Viet Nam

*Correspondence by email.

Bangladesh Red Crescent Society (BDRCS)	
Alhaj Md. Shahjahan Gazi	Secretary, Executive Committee, Munshiganj Unit, BDRCS
Md. Abusayeed Shohan	Advocate, Ex-Youth Chief, Red Crescent Youth (RCY), Munshiganj Unit, Bangladesh Red Crescent Society
Matiul Islam Hiru	Vice Chairman, Executive Committee, Munshiganj Unit, Bangladesh Red Crescent Society
S. M. Zahidur Rahman	Unit Level Officer, Munshiganj District Bangladesh Red Crescent Society
Fazlur Rahman	Junior Assistant Director, Bangladesh Red Crescent Society
Dr. Md. Abdur Rob Howlader	Director, Health & Blood Programme, Bangladesh Red Crescent Society
Md. Belal Hossain,	Director, Disaster Response, Bangladesh Red Crescent Society
Md. Nurul Amin	Assistance Director, Disaster Response, Bangladesh Red Crescent Society

Palang Merah Indonesia	
Dr. A. Arfan	Head of Health Division, National Headquarters
Taufik Deremias	Head of Health in Emergencies Sub-division Subdivision, National Headquarters
Eka Wulan Cahyasari	Head of Public Health Sub-division Subdivision, National Headquarters
Dewi Ariyani	Public Health Subdivision, National Headquarters
Rafiq Anshori	Disaster Preparedness Subdivision, National Headquarters
Heri Sujana	Manager, Bandung Provincial Branch
Azis Krisnadi	Volunteer Manager, Bandung Provincial Branch
Tri Martani	Disaster Management Coordinator, Bandung Provincial Branch
Embay Bahriyah	Head of PMI Banten Provincial Branch
Yulia Sayanthi	Warehouse Manager/ CBHFA Practitioner, Banten Provincial Branch
A Baldhowi	Health and Social Services, Banten Provincial Branch
Oktariaoi	Head of Services Division, Jakarta Provincial Branch
Pandu Priyatno	Head of Communication and Information, Jakarta Provincial Branch
Heri Hidayat	Head of Cianjur Local Branch
Teguh WS	Program staff, Cianjur Local Branch
Muhamad Nur	Volunteer, Cianjur Local Branch
Ima Mafaraz	Volunteer, Cianjur Local Branch
Ismail	Volunteer, Cianjur Local Branch
Devi Setrawan	Volunteer, Cianjur Local Branch
Iloan Ridwansyah	Volunteer, Cianjur Local Branch
Everng Suryana	Volunteer, Cianjur Local Branch
Otmeg Karyona	Volunteer, Cianjur Local Branch
Anton M Salihin	Volunteer, Cianjur Local Branch
Dewi Lesnasari	Volunteer, Cianjur Local Branch

Other Red Cross Red Crescent National Societies	
Fathimath Himya Abdul Majeed	Program Field Officer, Maldivian Red Crescent
Agenord Clerge	Head of Health Department, Haitian Red Cross
Hang Chansana	Head of Emergency Health Sub-Department, Cambodian Red Cross
Naing Naing	Programme Coordinator (CBHFA), Myanmar Red Cross Society

Other Stakeholders	
Ira Wignjadiputro	Medical Epidemiologist, Ministry of Health, Indonesia

13. Annexes

13.1. Terms of Reference

Terms of Reference

Consultancy for the Review of the Epidemic Control for Volunteers' Toolkit Rollout in Asia Pacific, 2011 – 2014

1. Purpose

It serves as a review of the rollout of the Epidemic Control for Volunteers' (ECV) toolkit and training manual carried out by National Red Cross and Red Crescent Societies in Asia Pacific between 2011-2014, as well as evaluate the effectiveness, efficiency and sustainability of the approaches and processes being employed, and the toolkit's relevance and appropriateness in National Societies' support in national response to epidemics. The review will also investigate areas to further develop the toolkit, and National Societies' capacity to prepare for and respond to epidemics using the toolkit.

2. Background

The ECV toolkit is a community-based response set of materials developed by the International Federation of Red Cross and Red Crescent Societies (IFRC) to reinforce the community-based health and first aid (CBHFA) toolkit, a comprehensive training and resource package for National Societies in community health development and health risk reduction programming. The ECV toolkit ensures that volunteers have the proper training and essential communication tools (among other materials) before they are engaged in epidemic response in their communities. It is designed as practical and action-oriented, simple, and easy-to-follow tools, taking into account that volunteers will have limited time to remember everything they have learned during trainings or to develop effective response materials in the middle of an epidemic.

The ECV toolkit consists of three major components:

- **Disease tools:** Seventeen pages, each describing a disease with epidemic potential, such as mode of transmission, symptoms, prevention measures, people vulnerable to infection, and suggested questions to ask during community assessment. The disease tool is linked to a set of actions that volunteers can carry out in and with communities.
- **Action tools:** Thirty-five pages, each describing a specific action that needs to be taken during an epidemic of a specific disease. Each sheet includes an overview of the specific action, guidance on how these actions – which are preventive, home care and community mobilization in nature – are to be properly and effectively carried out. Each action tool is also linked to a list of messages that communities need to know.

- **Community message tool0ls:** A compilation of 25 pages, each containing a message for volunteers to disseminate to communities to contain or prevent the further spread of an outbreak or epidemic. Each sheet contains illustrations, and concise and simple statements.

After field-testing in Nigeria (2008) and application in the cholera outbreak operation in Zimbabwe the same year, the toolkit underwent a number of improvements, including the development of a ten-page facilitator's guide. The toolkit was then launched and rolled out in different parts of the world, primarily Africa and Americas. Rollout in a number of countries in Africa zone spurred by existing epidemics and emergency operations were funded through the Disaster Relief Emergency Fund (DREF), while developments in the Americas were made as part of community preparedness initiatives and components of CBHFA programmes.

An evaluation of the ECV rollout from 2008 to 2010 was conducted in 2011². The evaluation reported that the ECV toolkit was clear, simple, and flexible to use. A range of areas for improvement and recommendations was also produced. For example: in regards to the design of the toolkit, there was duplication of roles in some modules, inconsistencies and inaccuracies in some disease information and a lack of training guides for trainers. With regard to the rollout preparation, more advocacy work on the local adaptation and promotion of integration into current programmes was recommended.

The ECV toolkit rollout in Asia Pacific started in 2011, largely as part of community preparedness to epidemics and health emergencies. To date, some 17 National Societies in the zone have already conducted an initial rollout, and the toolkit is being translated and adapted for rollout in the Pacific region. Guided by findings of the 2011 ECV evaluation, a guidance note for adaptation and rollout and session guides were produced to assist National Societies in the process. Regional health meetings were also utilized to facilitate knowledge sharing among National Societies undertaking roll out processes. These rollouts were supported through a combination of health and disaster risk reduction funding.

Alignment to the IFRC's objectives and strategy (IFRC's Strategy 2020)

Strategic aim 2: Enable healthy and safe living

Epidemics are health emergencies that can have a harmful effect on lives, assets and livelihoods, arising from community exposure and vulnerability to natural and human-made hazards. We encourage comprehensive community action to eliminate disaster risks where possible and to reduce the occurrence and impact of disasters where primary prevention is not feasible.

As a toolkit to reinforce one of the IFRC's integrated primary health care approaches to community health promotion, CBHFA, and to facilitate timely response to epidemics during the onset of disease outbreaks, the ECV toolkit contributes to the building of safer, resilient communities.

3. Objectives of the review

The **specific objectives** of the review were to report key findings, factors contributing to success, factors hindering success, factors maximizing its potential, key learning and recommendations for next steps. These included:

- determining how well the strategies, processes and activities in the adaptation and rollout of the ECV toolkit undertaken by National Societies have contributed to preparing and equipping volunteers for epidemic response in communities including:
 - describing how National Societies have worked with different sectors within the organization to ensure the toolkit and established capacity – through trained volunteers and available materials after the rollout – are integrated in community health and disaster risk reduction efforts,
 - describing if National Societies have collaborated and consulted with health authorities, health communication bodies and partners,
 - indentifying critical factors that facilitate or hinder successful similar exercises in future or in other countries,
- indentifying elements to further develop in the toolkit – these may include diseases, actions or messages that need to be incorporated or programming guidance for National Society health managers at headquarter or branch levels, as well as volunteer supervisors,
- describing whether or not the ECV toolkit and volunteer teams were integrated into existing community programs and/or contingency plans,
- describing which volunteers were trained in epidemic control (ECV) and what mechanisms were in place to facilitate their mobilization in response to outbreaks (if there were epidemic response operations so far),
- indentifying and describing mechanisms to sustain, as well as further strengthen, the established capacity of communities in epidemic response,
- indentifying lessons learnt and drawing recommendations for next steps.

4. Methodology

The methodology of the review will consist of a series of approaches, including:

- review of background documents concerning the ECV toolkit rollout exercises (including different reports from the IFRC, zone office, regional offices and National Societies),
- analysis of activities, training materials and other relevant resources,
- conduction of telephone interviews or teleconference with various National Societies engaged in the use of ECV, the different levels of staff and volunteers involved, Ministry of Health and other health authorities involved, beneficiaries, IFRC staff who have been engaged in the rollout, Partner National Societies, donors, and so forth,
- design and conduction of online surveys,
- review of records of training and operational documents with the assistance of program staff of the National Societies engaged in the rollout of the ECV toolkit.

5. Guiding questions for the interviews

5.1. Relevance and appropriateness

- How relevant was the ECV toolkit to the communities at risk of epidemics?
- How do the National Societies' staff and volunteers feel about the value and potential use of the ECV toolkit to respond to emergencies?
- Has the ECV toolkit been used to respond to epidemics? If yes, how relevant was the training in terms of using the toolkit? If not, is there a mobilization plan in place for the ECV toolkit in the event of an outbreak or epidemic?
- How substantial were the contents of the ECV toolkit? Was there anything lacking or was there too much information?
- How user-friendly was the toolkit?
- Are there elements of the ECV toolkit that need to be changed, cut or added in order to be more relevant and appropriate for community volunteers?

5.2. Effectiveness

- How was the harmonization of the ECV toolkit in other long-term community-based health or disaster risk reduction programs?
- How effective were the training sessions of the ECV toolkit? (training of trainers and community volunteers)
- Have the volunteers increased their knowledge and capacity in delivering health promotion activities?
- Were the training sessions sufficient to prepare the community volunteers to provide health promotion and disease prevention activities?
- Was the training of trainers sufficient to prepare them to provide training to community volunteers?
- Were there any challenges faced by the volunteers in utilizing the ECV? Was the ECV toolkit effective in aiding volunteers in responding to epidemics in communities? What are the areas that can be improved in the ECV rollout process to enhance the efficacy of the process?

5.3. Efficiency

- How efficiently were human and financial resources utilized in the rollout exercise?
- How efficient were the training events?
- How efficient was the response to epidemics, if any?
- What challenges were faced at different levels of staff and volunteers to implement the rollout of the ECV toolkit?
- Were the roles, responsibilities and expectations at each level (secretariat, zone, regional, country, National Societies, and branches) clear?

5.4. Impact

- Are there any mobilization plans for the ECV toolkit and for volunteers to respond to an epidemic when it comes?
- Is there any pre-positioning of the materials or equipment required for epidemic outbreak (personal protective gowns, personal hygiene items, etc.) in the communities?
- Is there a pre-printed ECV toolkit kept for use during epidemic outbreak?

- What impact or foreseeable impact has the rollout of ECV toolkit had on the health of the communities?
- What impact has the rollout had on the community volunteers, i.e. knowledge, capacities, management, enthusiasm?
- What impact did the rollout of the ECV toolkit have on partner organizations, particularly the Ministry of Health and other regional and local health partners?
- Were there any unexpected outcomes of the ECV rollout?

5.5. Sustainability

- Are there any plans in place to help sustain the results or impact of the rollout of ECV?
- Has the ECV rollout influenced the way local authorities and other health partners address issues relating to epidemic prevention and response, and if so how?
- How will the experience of the ECV rollout contribute to other community-based health or disaster risk reduction programs in the community or country?

6. Deliverables

The review will be expected to produce the following deliverables:

6.1. Inception report

A two-to-three page inception report consistent with the terms of reference detailing major activities, interview guides and proposed questions and outlines for the targeted interviews, interview guidance for the team, data collection plans and tools, allocation of roles and responsibilities within the team and timeframe with set dates for deliverables will be written.

6.2. Debriefings and feedback to management at all levels

The team will report the preliminary findings to the IFRC Health Unit in Asia Pacific zone and health staff of regional and country offices through face-to-face meetings or teleconferences. Follow-up activities may be required to enrich the report after this preliminary discussion of findings.

6.3. Draft report

A draft report summarizing findings from the document reviews, interview results, and comparative analysis that answers the evaluation questions will be submitted by the team leader within two weeks of the debriefing meeting with the IFRC Asia Pacific Health Unit.

6.4. Final report

The final report (less than 50 pages) with similar content and outlines as the draft report (but including changes and corrections as requested by the IFRC) covering the background of the intervention evaluated, a detailed description of the evaluation methodologies and limitations, findings in relation to the evaluation scope, conclusions, lessons learnt and clear recommendations will be produced. The report should also contain the appropriate appendices such as interview questions, surveys, a list of reviewed documents, a list of people interviewed and any other relevant materials. The final report will be submitted one week after receipt of the consolidated feedback from the IFRC.

7. Schedule

The review is estimated to take 30 full days, spread over a period of 7 weeks – tentatively 25 August to 10 October 2014. The final evaluation report should be delivered no later than 30 October 2014.

8. The review team

The evaluation will be carried out by a team consisting of an external consultant and two members who are staff or professional volunteers seconded by National Societies from Asia Pacific zone.

8.1. External consultant

The review team will be led by an external consultant who will be selected based on the following qualifications:

- a minimum qualification of a masters degree or equivalent combination of education in public health or similar and relevant work experience,
- demonstrated experience in leading evaluations of public health or health risk communication programmes that support community-based preparedness and/or response to outbreaks, epidemic and other health emergencies,
- knowledge of strategic and operational management of emergency health operations and a proven ability to provide strategic recommendations to key stakeholders,
- strong analytical skills and the ability to clearly synthesize and present findings, draw practical conclusions, make recommendations and prepare well-written reports in a timely manner,
- experience in qualitative data collection and data analysis techniques, especially in community-based programs,
- a demonstrated capacity to work both independently and as part of a team,
- knowledge of the Asia Pacific region (working with the Red Cross and Red Crescent would be an advantage),
- immediate availability for the period indicated.

8.2. Members of the review team

The IFRC would also look for one or two National Society team members who have an adequate level of evaluation, public health and emergency health experience to join the evaluation team. The team members will have the following skills:

- experience in performing reviews and evaluations,
- experience and technical skills in the field of public health emergency preparedness and response,
- strong analytical skills and the ability to put together and present findings in a clear way, draw conclusions and make recommendations,
- excellent writing skills in English.

8.3. Management of and support of the review

The review team will report to the Health Unit of the IFRC Asia Pacific zone office, with the Emergency Health Coordinator as the focal person (see contact details in Section 10). Health advisers in selected IFRC regional and country offices will comprise the reference group, which will provide advice and guidance on the evaluation, as well as feedback and recommendations on the evaluation results.

The Health Unit, IFRC Asia Pacific zone office, will provide the following support to the review team:

- detailed briefings and information support throughout the whole period,
- relevant documents and data,
- connection with relevant people and contact lists
- costs for communications such as IDD, mailing fee, etc. - the cost of standard IT and telecommunication equipment such as laptops and mobile phones shall be borne by the consultant,
- administrative support.

8.4. Schedule for payment of consultant fees

The fee shall be paid upon satisfactory completion of the work in accordance with this Term of Reference and the consultancy agreement between the consultant and the IFRC.

9. Evaluation quality and ethical standards

The evaluation team's methodology will be in line with the evaluation practices and standards outlined in the IFRC Management Policy for Evaluation. The IFRC evaluation standards are:

- **Utility** – Evaluations must be useful and used.
- **Feasibility** – Evaluations must be realistic, diplomatic, and managed in a sensible, cost-effective manner.
- **Ethics and legality** – Evaluations must be conducted in an ethical and legal manner, with particular regard for the welfare of those involved in and affected by the evaluation.
- **Impartiality and independence** – Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.
- **Transparency** – Evaluation activities should reflect an attitude of openness and transparency.
- **Accuracy** – Evaluations should be technically accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be determined.
- **Participation** – Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.
- **Collaboration** – Collaboration between key operating partners in the evaluation process improves the legitimacy and utility of the evaluation.

It is also expected that the evaluation will respect the seven Fundamental Principles of the Red Cross and Red Crescent: 1) humanity, 2) impartiality, 3) neutrality, 4) independence, 5) voluntary service, 6) unity, and 7) universality;

13.2. Research Matrix

Research Matrix

Main sources of information are dark blue, additional sources are light blue

Source of information Criteria and research questions	Desk review	IFRC interviews	Community visits/field inspection	National Society interviews	FGD	MSC (Most significant change)
Criteria I. Relevance and appropriateness						
Research questions:						
How relevant has the ECV toolkit been to the communities at risk?	Light blue	Light blue	Light blue	Light blue	Dark blue	Light green
How do National Society staff and volunteers feel about the value and potential use of the ECV toolkit to respond to emergencies?	Dark blue	Light blue	Light green	Dark blue	Light blue	Light green
Was the ECV toolkit used to respond to an epidemic?	Light blue	Light blue	Light blue	Light blue	Dark blue	Dark blue
If so how relevant or appropriate were the trainings in its use?	Light blue	Light blue	Light blue	Light blue	Dark blue	Dark blue
If not what mobilization plans are in place?	Light blue	Light blue	Light green	Dark blue	Light green	Light green
How were the contents of the ECV toolkit? Was there anything missing or was there too much info? How user friendly was it?	Light blue	Light blue	Light blue	Dark blue	Light blue	Light green
Criteria II. Effectiveness						
Research questions:						
How was the harmonization of the ECV toolkit with other long-term community-based or disaster risk reduction programs?	Light blue	Dark blue	Light blue	Dark blue	Light blue	Light green
How were the trainings on the use of the toolkit (ToT and community volunteers)?	Light blue	Light blue	Dark blue	Dark blue	Dark blue	Dark blue
Have volunteers increased their knowledge and capacity to deliver health promotion activities?	Light green	Light blue	Light green	Dark blue	Dark blue	Light green
Were the trainings sufficient to prepare the community volunteers to provide health promotion and disease prevention activities?	Light green	Light blue	Light blue	Dark blue	Dark blue	Light green
Was the training of trainers (ToT) sufficient to prepare the trainers to provide trainings to community volunteers?	Light green	Light blue	Light blue	Dark blue	Dark blue	Light green

Source of information Criteria and research questions	Desk review	IFRC interviews	Community visits/field inspection	National Society interviews	FGD	MSC (Most significant change)
Criteria III. Efficiency						
Research questions:						
How efficiently were human and financial resources utilized in the rollout exercise?						
How efficient were the training events?						
How efficient were the responses to epidemics, if any?						
What challenges were faced at different levels for staff and volunteers to implement the rollout of the ECV toolkit?						
Were the roles, responsibilities and expectations at each level (secretariat, zone, regional, country, National Society and branches) clear?						
Criteria IV. Impact						
Research questions:						
Is there a mobilization plan for the ECV toolkit and for volunteers' responses to an epidemic should one arise?						
Is there any prepositioning of material or equipment required for epidemic outbreaks (such as personal protective equipment, personal hygiene kits, mosquito nets, chlorine etc.) in the communities?						
Is there a supply of pre-printed ECV toolkit materials kept for use in the event of an epidemic?						
What impact or foreseeable impact has the rollout had on the health of the communities?						
What impact has the rollout had on the community volunteers - knowledge, capacities, management, enthusiasm etc?						
What impact did the ECV rollout have on partner organizations, particularly the Ministry of Health, and other regional / local / health partners?						
Were there are unexpected impacts?						

Source of information Criteria and research questions	Desk review	IFRC interviews	Community visits/field inspection	National Society interviews	FGD	MSC (Most significant change)
Criteria V. Sustainability						
Are there plans to help sustain the results of impact of the rollout of ECV?						
Has the ECV rollout influenced the way local authorities and other health partners address issues related to epidemics prevention and response and how?						

13.3. Research questions

Research questions

Criteria I. Relevance and appropriateness
Research questions:
How relevant has the ECV toolkit been to the communities at risk?
How do National Society staff and volunteers feel about the value and potential use of the ECV toolkit to respond to emergencies?
Was the ECV toolkit used to respond to an epidemic?
If so how relevant or appropriate were the trainings in its use?
If not what mobilization plans are in place?
How were the contents of the ECV toolkit? Was there anything missing or was there too much info? How user friendly was it?
Criteria II. Effectiveness
Research questions:
How was the harmonization of the ECV toolkit with other long-term community-based or disaster risk reduction programs?
How were the trainings on the use of the toolkit (ToT and community volunteers)?
Have volunteers increased their knowledge and capacity to deliver health promotion activities?
Were the trainings sufficient to prepare the community volunteers to provide health promotion and disease prevention activities?
Was the training of trainers (ToT) sufficient to prepare the trainers to provide trainings to community volunteers?
Criteria III. Efficiency
Research questions:
How efficiently were human and financial resources utilized in the rollout exercise?
How efficient were the training events?
How efficient were the responses to epidemics, if any?
What challenges were faced at different levels for staff and volunteers to implement the rollout of the ECV toolkit?
Were the roles, responsibilities and expectations at each level (secretariat, zone, regional, country, National Society and branches) clear?

Criteria IV. Impact

Research questions:

Is there a mobilization plan for the ECV toolkit and for volunteers' responses to an epidemic should one arise?

Is there any prepositioning of material or equipment required for epidemic outbreaks (such as personal protective equipment, personal hygiene kits, mosquito nets, chlorine etc.) in the communities?

Is there a supply of pre-printed ECV toolkit materials kept for use in the event of an epidemic?

What impact or foreseeable impact has the rollout had on the health of the communities?

What impact has the rollout had on the community volunteers – knowledge, capacities, management, enthusiasm etc?

What impact did the ECV rollout have on partner organizations, particularly the Ministry of Health, and other regional / local / health partners?

Were there any unexpected impacts?

Criteria V. Sustainability

Are there plans to help sustain the results of impact of the rollout of ECV?

Has the ECV rollout influenced the way local authorities and other health partners address issues related to epidemics prevention and response and how?

13.4. Guidance note on rollout and integration of the ECV Manual and Toolkit

Roll out and integration of the epidemic control for volunteers toolkit

This document aims to provide focal persons of National Societies – and their partners – with a few possible steps to adapt and roll out the IFRC Epidemic Control for Volunteers (ECV) Toolkit, as well as to ensure that the tools and initial capacity developed through this process are integrated and built into National Society risk reduction programmes and emergency response plans and contingency plans. This document is based on experience from community-based pandemic preparedness projects and recent ECV rollout by National Societies.

1. The ECV toolkit and training manual

Many national Red Cross and Red Crescent societies in Asia Pacific operate in countries that continuously face infectious disease threats with outbreak and epidemic potential. Through their networks of branches and volunteers, they have assumed key roles in responding to these threats – such as outbreaks of diarrhoea, dengue, chikungunya, or malaria – by mobilizing communities for action through the timely communication of risks, the prevention and care measures in communities, among others.

The ECV Toolkit was developed to reinforce the IFRC community-based health and first aid (CBHFA) toolkit, a comprehensive training and resource package for volunteers in community health development and health risk reduction programming. The toolkit ensures that volunteers have proper training and essential communication tools (among other materials) before they are engaged in outbreak and epidemic response in their communities. It is designed as practical and action-oriented, simple, and easy-to-follow tools keeping in mind that volunteers have limited time to remember everything they have learned during trainings or to develop effective response materials in the middle of an outbreak or epidemic.

The **ECV Toolkit** consists of three major components:

- **Disease tools:** Seventeen pages, each describing a disease with outbreak or epidemic potential, such as mode of transmission, symptoms, prevention measures, people vulnerable to infection, and suggested questions to be asked during community assessment. The disease tool also outlines a list of actions that volunteers can carry out in and with communities.
- **Action tools:** Thirty-five pages, each describing a specific action that needs to be taken during outbreaks and epidemics. Each sheet includes an overview of the specific action, guidance on how these actions – which are preventive, home care and community mobilization in nature – are properly and effectively carried out. Each action tool is also linked to a list of messages that communities need to know.
- **Community message tools:** A compilation of 25 pages, each containing a message which volunteers need to disseminate to communities to contain or prevent the further spread of an outbreak or epidemic. Each sheet contains illustrations, and concise and simple statements.

The toolkit comes with a training manual which details a three-day workshop that provides volunteers with an understanding on what an epidemic is, how it spreads and the conditions that help it to spread, and what actions to take in the event of an epidemic. The manual is split into modules and sessions, and includes small group activities, scenario analyses and role-playing, including exercises on the assembly and use of the toolkit.

The complete ECV Toolkit is available in the FedNet: <https://fednet.ifrc.org/en/resources-and-services/health-and-care/emergency-health/communicable-diseases-in-emergencies/epidemic-control-for-volunteers/> (registration needed in order to access the intranet), while the CBHFA Toolkit is available on the IFRC public website: <http://www.ifrc.org/en/what-we-do/health/community-based-health/>.

2. Pre-conditions for rollout

Like any other initiative, the following should be in place if the ECV rollout and integration are to be successful:

- a. There should be a designated **focal person** who is responsible for a relevant programme in which the tool can be integrated – most likely a community-based health programme. He or she should be able to dedicate a proportion of his or her time and should have the support to lead and coordinate the planning and implementation of a rollout and integration workplan. The focal person will also work with relevant departments within the National Society – particularly disaster management or the community development department – and with the Ministry of Health and other health partners. It is also essential that the focal person has, or will have, a thorough knowledge and understanding of the toolkit, the accompanying training manual, and an appreciation of how the tools can be used in outbreak or epidemic situations and be mainstreamed into National Society community-based programmes.
- b. There should be **buy-in and support from the leadership and relevant sectors of the National Society**. The rollout process will undoubtedly develop initial capacity – human resources and communication materials – that the National Society may mobilize in an outbreak or epidemic event. To appropriately build and sustain this capacity, they need to be nurtured and institutionalized through relevant programmes or departments of the National Society. It is important for

the latter to be convinced of the value of said capacity, and for the National Society to reinforce this process. This can be attained by engaging and involving them in sensitization sessions, consulting with them on a rollout's outline and integrated plan of action, and keeping them informed of the progress.

- c. There should be a **workplan** that is developed with the active involvement of relevant programmes and departments of the National Society that contribute to the ECV toolkit adaptation, rollout and integration processes. The workplan outlines the key activities, timeline, budget, and names of responsible persons or departments tasked to carry out specific activities and tasks.

3. Possible steps and actions

- a. First, **localize the ECV Toolkit** to ensure that the material focuses on diseases that are relevant to the country, that it is translated to the national language (and/or regional languages widely spoken by certain regions in the country), and that it uses terms and illustrations that consider (and are sensitive to) local norms and culture. This step may also consider the development of relevant tools for diseases of national importance but not yet included in the toolkit. For example, chikungunya and leptospirosis are important to many countries in Asia Pacific. This may also involve the following actions:
 - Appoint one or two technical persons from health and relevant departments at National Society headquarters who will support the designated focal person in the overall rollout and integration process.
 - Consult with and receive guidance from the health ministry on the relevance, appropriateness or alignment of the messages and measures contained in the toolkit and training manual with relevant national programmes, guidelines and protocol. It is very likely that health ministries, through their health education or communication departments, or national disease prevention and control programmes, have already produced risk and outbreak communication materials which health partners are encouraged to adapt and use in their programmes and activities, health authorities in some countries are also leading and coordinating inter-agency health communication committees or task forces, consisting of representatives from line ministries, UN agencies, civil society and non-governmental organizations, where strategies, approaches and tools related to public awareness and communication are agreed upon (it is recommended that the different aspects of the localization and adaptation process elaborated on below take into account the above-mentioned mechanisms and materials).
 - After determining which diseases are important to the country, translate the relevant sections of the toolkit and training manual. Many National Societies have developed the internal capacity to translate English resources into their national language; they may also opt to engage a translation company with a proven track record in the translation of health or medical materials. Illustrators and artists may also be considered to adapt drawings and pictures to local context. For additional details on the translation and adaptation of materials, please refer to Translating and adapting the CBHFA in action materials, Chapter 7 in Implementation Guide for Community-based Health and First Aid in Action, pages 29-31, and which can be accessed via: http://www.ifrc.org/PageFiles/53437/145600-1-CBFA-IG-en_LR.pdf?epslanguage=en.
 - Field-test the translated or adapted material with a few groups of branch and community volunteers to see if the language and illustrations are

understandable and appropriate. This may involve the focal person asking branch and community volunteers to go through the translated toolkit and training manual, to demonstrate the assembly and use of the toolkit, and to facilitate feedback sessions. On the basis of the field test, finalize the material and produce templates of the toolkit and training manual for reproduction.

- b. **Reproduce the localized toolkit and training manual** and distribute it to selected master trainers and priority provincial/district branches.
- c. **Develop a group of ECV master trainers by updating National Society CBHFA facilitators and master trainers** – The CBHFA in action trainings include modules on 'community mobilization', 'assessment-based action in my community', 'community mobilization in major emergencies' and 'disease prevention and health promotion', which are important foundations for the modules and topics covered in the ECV training. Hence, the most efficient approach in quickly rolling out the ECV toolkit is through the involvement and mobilization of CBHFA facilitators and master trainers in the process.

The same is true with the training of community volunteers – the assimilation of the toolkit in community health efforts will be more expedient in priority areas and communities with volunteers trained in CBHFA. Volunteers trained in CBHFA in action have also received modules that are important foundations in understanding epidemic control.

- d. **Engage with programmes to institutionalize and expand epidemic control capacity** – There is no point in undertaking the rollout if the initial gains – localized tools and volunteers trained, aren't maintained. There are two possible ways for National Societies to secure this:

- **National Society contingency planning and emergency preparedness priorities** – While there has been a long-standing desire for National Societies to be more engaged in outbreak and epidemic prevention and control, the ECV toolkit, along with relevant tools and guidelines (such as the business continuity and preparedness guideline developed through the Humanitarian Pandemic Preparedness programme) will be a valuable resource for National Societies when integrating these public health issues into its emergency plans.

Beyond the localization of the toolkit and training of staff and volunteers, management and operational mechanisms need to be in place to guide National Society actions at headquarter and branch levels before, during or after an outbreak or epidemic. Resources – financial, human and materials – also need to be identified to put these mechanisms into motion in an effective and efficient manner. All these need to be reflected on as part and parcel of a National Society's emergency response plan or contingency plan.

- **Community-based risk reduction programmes** – Many risk reduction programmes that have health or disaster as entry points have identified outbreaks and epidemics as important public health issues in many communities in Asia Pacific, considering that the latter are usually under-invested and weak. The ECV toolkit, along with other guidelines and tools will be a valuable resource for communities in the development of emergency response plans or contingency plans, the preparation of community members as responders, and the mobilization of communities to carry out initiatives to prevent, mitigate or respond to occurrence of outbreaks and epidemics.

- e. **Review and document ECV toolkit rollout, integration and utilization** to capture practices and lessons that will guide and inform similar processes in the future, in other countries and regions. This may lead to the production of factsheets and case studies on outbreak and epidemic preparedness and response capacity development, which will be utilized by the IFRC in its knowledge management and sharing initiatives.

4. Further rollout

Opportunities for the rollout of the ECV toolkit in a country may be constrained by time, financial and human resources, and may result in covering only a limited number of provincial or district branches or reaching out to a small number of partners. National Society focal persons may consider the following as possibilities for the further roll out of the ECV toolkit:

- a. If not done so yet in line with Section 3.d, engage with Movement and other partners for the potential integration of epidemic prevention and control, and the introduction of the ECV toolkit, in their relevant programmes.
- b. Consider the inclusion of ECV-related activities as part of the health component of an emergency operation supported the IFRC disaster emergency response fund (DREF) or emergency appeal (EA).

13.5. Interview Guide for ECV Project Management Staff and Volunteers

Interview Guide for ECV Project Management Staff and Volunteers

Number (with gender segregation) of participants: _____

Date / Location: _____

(Warm-up conversation, introduction, explanation of purpose of research, timeframe, extent of anonymity, respondent rights, assent to be interviewed, etc.)

1. How many of you have been directly involved in ECV activities? Ask two or three participants to describe what they have done.

Register involvement in planning, baseline, community mobilization, training etc.

2. Are you still involved in those activities? If not, explain why.

Yes / No – Record the reasons why they are not active.

3. Are you aware of any other agencies/organizations supporting the same type of activity in this area? If yes, which ones?

Yes / No – Record names.

4. What training have you received in the past two years?

Record number and types of training (Red Cross, health, CBHFA, ECV, water and sanitation and other, even external training).

5. What difference has this training made to your confidence in carrying out your duties (use as an example some of the activities described in question 1) as a Red Cross volunteer?

Score 1 to 5, not confident to very confident.

6. Have you put the training into practice? Can you give some examples?

Yes or No. If yes, Record examples (at least three). If no, record reasons why they did not translate training into practice.

7. What do you think should be added to the training to help you carry out your duties?

Record answers.

8. Other than what you learned from the training, what else have you learned from this program? How did you learn this?

Record answers.

9. Do you remember everything from your training, or do you think you would benefit from refresher training?

Record numbers of responses.

10. Have you or your branch received any equipment to help you carry out your duties? Is it still currently operative or used? If not, explain why.

Record equipment/ Record the reasons why the equipment is not operative or used.

11. What other equipment do you think would help you successfully carry out your duties?

Record answers.

12. What is the biggest challenge for you in carrying out your duties as a Red Cross Red Crescent staff or volunteer?

Record answers.

13. While conducting the ECV activities in your community, did you face any problems, misunderstandings, etc.?

Record answers.

14. Any other observations, questions?

(Please note that subsequent to agreement on the research matrix, above, these interview questions would be fine-tuned to fit individual research questions from the matrix).

13.6. Interview Guide for Focus Group Discussions with Community Members

Interview Guide for Focus Group Discussions with Community Members

Please note these are just outlines for questions. They will be localized and made less formal with the help of the national staff.

Number (with gender segregation) of participants: _____

Date / Location: _____

(Warm-up conversation, introduction, explanation of purpose of research, timeframe, extent of anonymity, respondent rights, assent to be interviewed, etc.)

Depending on discussions with national staff, the first activity will probably be a community mapping exercise either by taking a walk through the community or using pen and paper or drawing on the ground as appropriate.

1. How many of you have been directly involved in ECV activities? Ask two or three participants to describe what they have done.

Register involvement in community mapping, program planning; community mobilization, ECV training, baseline study etc.

2. Are you still involved in those activities? If not, explain why.

Yes / No – Record the reasons why they are not active.

3. Are you aware of any other agencies or organizations supporting the same type of activity in this area? If yes, which ones?

Yes / No – Record names.

4. Do you feel more aware of health risks affecting your community as a result of the ECV initiative?

Yes / No – Record the reasons why they do not feel more aware of risks.

5. Do you now feel better prepared to face potential epidemic or health threats?

Score 1 – 5, much safer to not safer at all.

6. Have you conducted a risk analysis?

Yes / No – Invite community to describe.

7. Were women and children involved in any risk assessment?

Yes / No – numbers if possible, if not record reasons why they were not involved.

8. Which of the statements are true? Bring statements written in A4 cards to show to participants. Register number of participants who agree with each statement. Take notes on strong disagreements.

- a. I have gained knowledge of the main health issues and risks in my community.
 - b. I know how to conduct a health risk analysis in my community.
 - c. I know how to put in place prevention or mitigation activities (from planning to project implementation). – Ask participants to give examples and visit some of them if possible.
 - d. I have received training and I have put in practice some of the learning. - Ask participants to give examples.
 - e. I have a better understanding of epidemics and how to respond to them. - Invite community to describe this.
 - f. I am aware of ways to prevent disease outbreaks and epidemics in my community. - Ask participants to give examples.
9. Have you made any changes at the household level to reduce risk? What factor/s made you deciding to undertake those changes?

Yes / No – If yes, get examples of changes and the motivations or driving forces that led to those changes. If no, register the reasons why they did not undertake changes.

10. Have you heard any public campaigns about managing risk?

Get examples, including those implemented by other agencies/organizations/Government.

11. What can be done to improve the community programme?

List their answers.

12. While conducting the ECV activities in your community, did you face any problems, misunderstandings, conflict, etc.?

Record answers.

13. Any other observations, questions?

(Please note that subsequent to agreement on the research matrix, above, these interview questions would be fine-tuned to fit individual research questions from the matrix).

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.

For further information, please contact:

**International Federation
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