



International Federation
of Red Cross and Red Crescent Societies

Review

of Emergency Health
Asia Pacific Training

Commissioned by

The International Federation
of Red Cross and Red Crescent Societies

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May 2015



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Acronyms and abbreviations

APEHT: the Asia Pacific Emergency Health Training

AP: the Asia Pacific

CBHFA: Community-based health and first aid

EARD: East Asia Regional Delegation

ECV: Epidemic Control for Volunteers

EH: Emergency health

ERU: Emergency Response Unit

DM: Disaster Management

DR: Disaster response

FACT: Field Assessment Coordination Team

IFRC: International Federation of Red Cross and Red Crescent Societies

IT: Information technology

HPAI A: highly pathogenic avian influenza A

LET: Learning Education and Training

MoPH: Ministry of Public Health

NDRT: National Disaster Response Team

NS: National Societies

PHiE: public health in emergency

PoA: Plan of Action

PNS: Partner National Societies

RCRC: Red Cross Red Crescent

RDRT: Regional Disaster Response Team

SARD: South Asia Regional Delegation

SEARD: South East Asia Regional Delegation

SOP: Standard Operating Procedures

TOR: Terms of reference

TOT: Training of trainers

WatSan/HP: Water, Sanitation and Hygiene promotion

WHO: World Health Organization



Executive summary

Asia Pacific is a region mostly affected by natural disasters¹ and is where the International Federation of Red Cross and Red Crescent Societies (IFRC) has worked on improving emergency preparedness and response for many years. Capacity building in this area has predominantly been in the areas of risk reduction, developing early warning and response systems, establishing contingency, response strategies and pre-positioning of essential items in high-risk countries. Emergency health is considered a growing sub-sector and has received substantial attention and capacity building at country and regional level as a whole. Prioritized areas for emergency health response in emergencies include the management of mass casualty and medical response, communicable diseases, water, sanitation and hygiene promotion, nutrition, sexual and reproductive health, and psychological support. While the specificities of these areas are in line with the public health standards in the sector, it is coordinated and seen as an essential part of emergency health preparedness and response.

Between 2005 and 2008, National Societies (NS) in Asia Pacific with support from the IFRC regional delegations conducted six regional emergency health trainings under the name “Public Health in Emergencies (PHiE) Training”. In 2008, a review was carried out by the IFRC Secretariat’s Emergency Health Unit² to identify lessons learnt and areas for improvement moving forward. In 2010 a standard curriculum that was adapted to local context by the IFRC Asia Pacific Zone Health Unit called the Asia Pacific Emergency Health Training (APEHT) as was rolled from 2010.

The APEHT aims to enhance the IFRC’s emergency health preparedness and response capacity in the Asia Pacific by preparing a pool of emergency health professionals, who can be deployed as surge capacity in a timely manner within the Regional Disaster Response Team (RDRT) system. The trained professionals can participate in a variety of emergency health activities such as needs assessment, program planning and coordination of emergency health interventions. The APEHT has also contributed to strengthening the emergency health preparedness and response capacity of NS through its trained staff, who have in many cases led emergency health operations in country, delivered emergency health training to staff and volunteers, and deployed internationally.

The APEHT was carried out in Singapore, Philippines and Hong Kong in 2010, 2011 and 2013 respectively. These training courses were co-organized by the National Societies and IFRC. To date, more than 69 participants from the Asia Pacific NS have been trained in the APEHT from 2009 to 2013 (see Table 1).

¹ IFRC. 2013. World Disasters Report: Focus on Technology and the future of humanitarian action, p. 230.

²(IFRC. 2008. Review paper on Training on Emergency Health: Building the capacity of National Societies to respond to

²(IFRC. 2008. Review paper on Training on Emergency Health: Building the capacity of National Societies to respond to health aspects of emergencies),



Table 1: Number of trained participants through APEHT by region, training year and location

	2010 in Singapore	2011 in the Philippines	2013 in Hong Kong	Total
East Asia	7	6	10	23
Pacific	2	2	3	7
South Asia	5	4	4	13
South East Asia	14	7	5	26
Total	28	19	22	69

The main purpose of the review was to determine the extent to which the APEHT conducted by the IFRC Asia Pacific zone office during 2010 – 2013, contributed to building capacity of National Societies in responding to emergency health needs national and regionally. Alongside this, the review has focused on identifying the level of effectiveness, efficiency and quality of the APEHT in equipping trained participants with the required knowledge and skills to carry out key tasks expected in emergency health operations as RDRT members.

Key Successes

Throughout the review process of the APEHT it was apparent in the findings that significant successes and positive progression had been made from 2010 to date. It is important to give recognition and praise such progress, as much of it was achieved on a minimal budget and limited human resource capacity. In saying this though, it is hoped that moving forward, greater institutional attention and financial commitment be directed to support what is a regional strategic area of interest to ensure the adequate scaling up in emergency health preparedness and response capacity.

Asia Pacific Emergency Health Training

Utilization of curriculum & content

The APEHT curriculum and content has been seen to be valued by many NS as a beneficial resource, providing a platform to strengthen knowledge and skills in emergency health. Examples throughout the review process whereby the APEHT was utilized beyond its original regional training platform include, NS choosing to adapt the training curriculum and materials into local language and local context to deliver at a national level to staff and volunteers. There have also been instances with some NS delivering ToTs and developing a pool of master trainers.

Knowledge & skills development

Analysis showed that APEHT participants increased their knowledge and skills in emergency health and had grown in confidence to carry key tasks associated with deployment in emergencies at a national level as a result of participating in the APEHT.

Emergency Health Surge Capacity

Emergency Health NDRT/RDRT

The APEHT was successful in scaling up surge capacity of a regional pool of emergency health RDRT members which has also indirectly resulted in increased national surge capacity in emergency health for NS within their National Disaster Response Team (NDRT) system. To date the total of emergency health RDRT surge capacity stands at 172 across the Asia Pacific region.



Areas for Improvement

Throughout the review process there were a number of key issues that presented regularly related to the APEHT training but which also cut across the wider RDRT system that need to be further explored moving forward.

Asia Pacific Emergency Health Training

Training curriculum, content and learning objectives

The review process highlighted the need of further improvement in strengthening the curriculum and content against the learning objectives of the APEHT, in order for it to remain relevant to the risks and trends of the Asia Pacific.

Alongside this, analysis of the RDRT induction curriculum, content and materials against the APEHT showed there were most certainly areas that need to be further improved in providing a more harmonised approach to essential knowledge and skills required of RDRT & specialised RDRT members.

The review process also highlighted weaknesses in the methodological approach adopted by the APEHT which predominately used a pedagogy classroom based education model to adult learning, which in turn limited its ability to maximize learning and development outcomes for participants.

Review of the selection criteria and recruitment process of the APEHT highlighted a number of key issues from differing approaches across regions, to it being seen by many as a controversial and challenging minefield to navigate which is not only limited to the APEHT alone.

Emergency Health Surge Capacity

Whilst the APEHT has been successful in establishing a pool of emergency health RDRT members there is yet to be a deployment of such surge regional as part of an RDRT team.

A critical component of any effective surge capacity is having in place a performance management system. Analysis showed there was a lack of harmonization in both register and roster management, tracking performance and retention of skills of RDRT members across the overall system. A lack of harmonization between RDRT system and the specialized sectors could be seen quite clearly.

Moving forward

The key findings and recommendations have been grouped into several key areas below and will require a collaborative effort moving forward as they are not mutually exclusive to the emergency health training or Asia Pacific Zone Health Unit alone.

Emergency Health Preparedness and Response Capacity	
Key area	Key follow up action/deliverable
R1: Strategic Direction	Develop and approve strategy, which clearly articulates emergency health surge capacity in Asia Pacific and its future direction.
R2: Operational SoPs, Contingency plans	Increase inclusion of emergency health surge within NS SoPs and contingency plans to reflect better the reality of high mobilization rates of emergency health members currently deploying as NDRT, and to reinforce multi-sectorial guidance and operational processes and procedures for future operations.



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R3: Regional, National Surge Capacity	Discuss and agree between Zone, Region & National levels (DM, Health and other specialized disciplines) on the IFRC strategic direction to strengthening overall emergency preparedness and response capacity in Asia Pacific and agree on the distribution of resource allocation to achieve this.
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Asia Pacific Emergency Health Training	
Key area	Key follow up action/deliverable
R4: Learning Objectives	Review and clearly define the learning objectives to reflect a more balanced inclusion of knowledge and capabilities, skills, attitudes and values, and behavioural outcomes that are more closely aligned with the overall purpose of the APEHT.
R5: Training Curriculum & Content	Agree and establish a learning and development pathway that allows the APEHT to be much more harmonized with the RDRT to enhance overall learning and development outcomes for emergency health RDRT members. * refer to the proposed RDRT training pathway model in report
	Revise and align the curriculum and content to better reflect the linkages between emergency health and the overall purpose and expected deliverables 'to participate in the assessment, planning, implementation and coordination of timely and appropriate emergency health interventions '.
	Revise and allocate sufficient time within the design of the curriculum and content for necessary evolutionary learning and development requirements .
	Revise and establish within the curriculum and content a multi-dimensional methodology that offers the potential to enhance a combination of key competencies and skills that encompasses knowledge and capabilities, skills, attitudes and values, and behavioural outcomes.
	Establish learning and development assessment framework (Rubrics) to be able to better assess and measure participants learning and development against the learning objectives.
R6: Methodology	Revise and establish an innovative methodological learning and development model that is dynamic, multi-dimensional and combines e-learning platform (online & webinar), field based and residential components to maximize participants learning and retention of knowledge, competences and skills on key theoretical and practical aspects. * refer to the proposed RDRT training pathway model in report
R7: Trainers & Facilitators	Develop a ToT program that equips trainers/facilitators with essential skills and knowledge in adult learning to be able to deliver high quality trainings
	Establish a sufficient pool of qualified and skills regional APEHT trainers/facilitators in each of the regions, which consist of representatives from various NS . This will create opportunities for NS to develop knowledge and skill that can be utilized at a national level too.
R8: Selection criteria	Review and remodel the selection criteria to better reflect operational competencies and skill requirements of relevant emergency health profiles.
	Assess, identify and better align selection criteria with NS existing emergency health profiles and existing gaps so as to strengthen the continuum between emergency health NDRT and RDRT profiles.
R9: Selection and recruitment process	Make necessary changes required to the current selection and recruitment process in place in order to be more relevant, robust, transparent and clearly articulates to all, the strict selection criteria framework and agreed conditions related to availability for deployment which nominated candidates must meet and commit to , in order to submit an application.
	Develop a formal agreement to be signed as part of the final stage of the recruitment process by all parties, which outlines clearly expected roles and responsibilities in committing to being part of the Asia Pacific emergency health surge capacity.
	Develop and disseminate a clear communication strategy , which articulates the expected selection and recruitment process and timeframe, shortlisting of candidates, interview and assessment of candidates, final shortlisting, final selection and communication to successful and unsuccessful candidates.



Emergency Health Surge Capacity	
Key area	Key follow up action/deliverable
R10: Register Database & Roster Management	Carry out a audit of the emergency health RDRT surge capacity register database from 2002- 2014 to identify existing distribution, relevancy and adequacy of profiles and gaps, total capacity of active and non-active members, NDRT, RDRT trained distribution, gender distribution, history of members NDRT and RDRT deployments and learning and development pathway progression. Profiles should also be matched with the competencies-based framework.
	Establish a functional roster management framework with agreements in place with surge members and NS around availability for each month.
R11: Emergency Health RDRT members	Discuss and agree with DMU an interim solution for emergency health RDRT members that have been on the waitlist since the APEHT commenced due to insufficient quality and availability of RDRT inductions. A proposed interim solution would be to offer access to the e-learning DM course.
R12: Performance management	Establish a robust performance management system that is able to assess overall success, measure performance across the training pathway continuum, monitor operational application and retention of knowledge and skills of individuals and teams.
	Assess existing approaches and models, develop and resource a formalized framework for retention of knowledge and skills that encompasses key areas such as; community of practice which offers emergency health RDRT members a collective environment for continued learning, development and interaction between members; coaching and mentoring pre, during, post missions; bilateral cooperation agreements between NS in Asia Pacific region include emergency health RDRT deployment as a condition tied to accessing DREF
	Develop a competency-based framework to attract, recruit and retain quality talent , incorporating quality and applied application of technical and operational (assessment, planning, coordination and implementation) knowledge and skills.
R13: Emergency Response Units (FMTs, MHTs)	Assess, analyse and develop a research paper on medical mobile units that looks into current trends in Asia Pacific region, models and approaches, strengths, dynamics and key considerations.
	Carry out strategic level workshop between the Asia Pacific Zone Health Unit and key NS in the region with existing and interest in future potential operational surge capacity in the form of national Emergency Response Units (ERUs) and Foreign Medical Teams (FMTs). The aim of this strategic workshop should be to discuss and identify ways of moving forward by taking into account the following aspects; mapping out current and future planned operational FMT capacity; lessons learned from experienced NS in the region that have had in place such operational capacity long term (Afghanistan, Pakistan, Japan); added value of the APEHT contributing to in strengthening emergency health preparedness and response capacity; future implications for RDRT emergency health surge capacity if NS with operational ERU surge capacity would prefer use their resources to deploy bilaterally; agreement on plan of action moving forward

RDRT System	
Key area	Key follow up action/deliverable
R14: Strategic Direction	Develop and establish an Asia Pacific surge capacity strategy, which clearly articulates the future strategic direction of the Asia Pacific surge capacity tools (BDRT, NDRT, RDRT) and operational national ERUs/FMTs.
R15: RDRT & Specialization Trainings Pathway	Discuss in RDRT taskforce the evolutionary process of the RDRT induction and specialized trainings (such as APEHT and others) and agree on a comprehensive integrated RDRT/Specialization trainings learning and development framework that aligns the set curriculum, content and learning objectives within the various trainings to avoid duplication across the various disciplines and instead enhance overall learning and development outcomes in a more harmonized way.



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	Combine resources that advance the establishment of a quality APEHT and broader RDRT learning and development framework .
	Discuss in RDRT taskforce and agree on a standardized selection and recruitment process which aligns the RDRT, APEHT and specialized trainings to ensure there is consistency and transparency of the process to all stakeholders; this will also avoid setting precedence between the various disciplines.
R16: Strengthening relationships, engagement and communication	Develop an integrated communications and advocacy strategy and disseminate out to NS. It is imperative the key NS representatives respected in the region are identified and supported as being leading advocates for disseminating such key messages alongside regional and zonal staff.



I. Background

1.1. Public Health in Emergencies Context in Asia Pacific

The Asia Pacific region hosts more than half of the world's population. Despite of a wide variation between countries in terms of country size, demographic characteristics, economic development etc, the region shares a common trend in terms of risks that require emergency responses. In a broad picture, the regional risks can not be isolated from the global projection (as presented in Table 2). Concerning the specifics of the regional risk, the Asia Pacific is projected to face an increase in urbanization, exposure to climate extremes, economic and population risks, spreading of infectious diseases and continued migration and displacement.

Earthquakes and severe cyclones do not occur frequently but cause serious impacts to the affected countries and population. From 2000-2010, it was recorded many deaths and losses in big cities in the region due to natural disasters. Earthquakes, tsunami and typhoons have taken away many thousands of lives in cities of Banda Aceh (Indonesia, 2004), Sichuan (China, 2008), Yangon (2008), Muzaffarabab (Pakistan, 2005). The impacts of a disaster on urban areas, if happen, are also higher in terms of the number of affected people, disruption of basic services, economic, social activities as well as destruction of infrastructure. Moreover, it is anticipated that process of climate change will add unforeseen complexities to emergency response to natural disasters with regard to human mobility and displacement. The threats of rising sea levels in many areas in the mega-deltas of Asia, and islands in the Pacific are serious with different projection for migration, worsening floods and storms, sea erosion and water scarcity². The interaction between the impacts of climate change on the population, urbanization and natural disaster poses an additional challenge that humanitarian emergency response will need to address.

Concerning infectious diseases, the Asia Pacific is the host of various pathogens for zoonotic diseases, which are the primary source of emerging infectious diseases. From 2003 to present, the region has undergone some major outbreaks including severe acute respirator syndrome (SARS), highly pathogenic avian influenza A (HPAI A). Countries like China, Cambodia, Indonesia, or Vietnam have reported several occurrence and reoccurrence of human cases HPAI A H5N1, and H7N9. Disease surveillance shows that viruses continue to circulate in animals and mutate in different strains. Sporadic infection in human cases is reported from time to time in different countries³.

Beside zoonotic diseases, the region was reported to have a number of cholera outbreaks. India, Bangladesh, Pakistan, Afghanistan, Papua New Guinea were among countries where outbreaks occurred. Additionally, the region is endemic to dengue fever. In the period from 2004-2010, Asian countries made up the majority of most endemic countries (see Figure 1).

² Intergovernmental Panel on Climate Change. 2007. Fourth Assessment Report: Climate Change 2007 Working Group II: Impacts, Adaptation and Vulnerability, p.11-12.

³ WHO. 2014. Weekly epidemiological record, Issue 2014, 89, p.309-320.

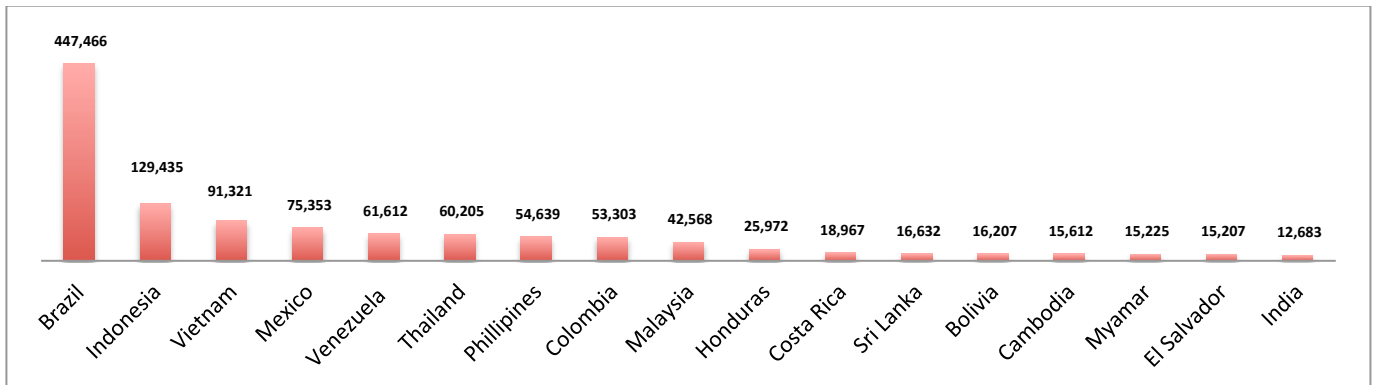


Figure 1. Average number of dengue cases in the most highly endemic countries/territories as reported to WHO, 2004-2010⁴.

Another important issue to public health is the increasing trend in non-state conflicts, violence in low and low-middle income countries in the region. In the last 10 years, the number of armed conflicts in the region does not increase although situations in some countries with active armed conflicts like Afghanistan, Pakistan have yet to resolve. Non-state conflicts seem to be on the rise, with incidences in Thailand, China, Philippines, India and Myanmar⁵.

1.2. National response capacity

One key aspect to consider in emergency is the national capacity, which consists of not only the national government but also the RCRC NS. Having mandated to be auxiliary to the government in emergency preparedness and response is an unique role of many RCRC NS in the region. The variation between countries, from small population, small area like Tuvalu or Maldives to large countries with very high population like India and China, makes the comparison of national response to emergency inappropriate. In a search for a regional perspective on response capacity, it was found that the region as a whole was reported as more prepared for natural disasters and emerging diseases than other types of disasters like conflicts or technological hazards. In the Global Risk 2015 report by the World Economic Forum, it was highlighted that the Asia Pacific region is the least prepared for interstate conflicts followed by failure of urban planning. A less recent assessment by WHO in 2008 on the national health sector emergency preparedness and response found that almost all countries in the region had experiences in response to emergencies related to earthquakes, flood and typhoons, less than 70% of them had the national emergency health preparedness and response plan. Of those had a plan, many did not adopt the 'all-hazard' approach as disasters like conflicts and technology related were not included⁶. A separate assessment on the level of preparedness and response of RCRC NS was not available up to point of the review. However, information about their prioritization for emergency health and training is presented in the section for findings of this report.

⁴ WHO. 2012-2020. Global strategy for Dengue prevention and control, p.5.

⁵ UNDP. 2008. Armed violence in Asia and the Pacific: An overview of the causes, costs and consequences, p5-9.

⁶ WHO. 2008. Global assessment on national health sector emergency preparedness and response, p.6.



Table 2: The evolving risk landscape (2007-2015)⁷

Top 5 Global Risk in terms of likelihood

	2007	2008	2009	2010	2011	2012	2013	2014	2015
1st	Breakdown of critical information structure	Asset price collapse	Asset price collapse	Asset price collapse	Storm and cyclones	Sever income disparity	Severe income disparity	Income disparity	Interstate conflict with regional consequences
2nd	Chronic disease in developed countries	Middle East instability	Slowing Chinese economy (<6%)	Slowing Chinese economy (<6%)	Flooding	Chronic fiscal imbalances	Chronic fiscal imbalances	Extreme weather events	Extreme weather events
3rd	Oil price shock	Failed and failing states	Chronic disease	Chronic disease	Corruption	Rising greenhouse gas emission	Rising greenhouse gas emission	Unemployment and under-employment	Failure of national governance
4th	China economic hard landing	Oil and gas price spike	Global governance gaps	Fiscal crises	Biodiversity loss	Cyber attacks	Water supply crises	Climate change	State collapse or crisis
5th	Asset price collapse	Chronic disease in developed countries	Retrenchment from globalization (emerging)	Global governance gaps	Climate change	Water supply crises	Mismanagement of population ageing	Cyber attacks	High structural unemployment or under-employment

Top 5 Global Risk in terms of impact

	2007	2008	2009	2010	2011	2012	2013	2014	2015
1st	Asset price collapse	Asset price collapse	Asset price collapse	Asset price collapse	Fiscal crises	Major systematic financial failure	Major systematic financial failure	Fiscal crises	Water crises
2nd	Chronic disease in developed countries	Retrenchment from globalization (developed)	Retrenchment from globalization (developed)	Retrenchment from globalization (developed)	Climate change	Water supply crises	Water supply crises	Climate change	Rapid and massive spread of infectious diseases
3rd	Interstate and civil wars	Slow Chinese economy (<6%)	Oil and gas price spikes	Oil price spikes	Geopolitical conflict	Food shortage crises	Chronic fiscal imbalances	Water crises	Weapons of mass destruction
4th	Pandemics	Oil and gas price spike	Chronic diseases	Chronic diseases	Asset price collapse	Chronic fiscal imbalances	Diffusion of weapons of mass destruction	Unemployment and under-employment	Interstate conflict with regional consequences
5th	Oil price shock	Pandemics	Fiscal crises	Fiscal crises	Extreme energy price volatility	Extreme volatility in energy and agriculture prices	Failure of climate change adaptation	Critical information infrastructure breakdown	Failure of climate change adaptation

Economic ■ Environment ■ Geopolitical ■ Societal ■ Technological ■

Note: Global risk may not be strictly comparable across years, as definition and the set of global risks have evolved with new issues emerging on the 10-year horizon. For example, cyber attacks, income disparity and unemployment entered the set of global risks in 2012. Some global risks were reclassified: water crises and rising income disparity were re-categorized as societal risks and as a trend, respectively, in 2015. The 2006 edition of the Global Risks did not have a risks landscape.

⁷ World Economic Forum. 2015. Global Risks report 2007-2015.



II. Purpose and Objectives

2.1. The Review

The review's Terms of Reference (ToR) (see Annex 1) is extensive with four key objectives and a total of 16 supplementary questions. The report takes the four objectives as broad headings exploring in greater depth the supplementary questions and beyond to draw upon key findings and identify recommendations.

2.2. Purpose and Objectives of Review

Objective 1: To assess the relevance of the APEHT:

- To have an in-depth assessment of the training modules and methodologies.
- To assess the relevance of the APEHT in building up the required knowledge and skills of participants to undertake IFRC emergency health activities and to what extent the APEHT was relevant?
- To assess how and to what extent the APEHT was filling the existing knowledge gaps of selected participants in delivering the expected health services.
- To assess the recruitment and selection process of participants in terms of relevance and effectiveness.

Objective 2: To assess the effectiveness, efficiency and quality of the APEHT:

- To what extent the training outputs, objectives, outcomes, performance indicators and evaluation been achieved? What are the quality and quantities of those elements?
- To assess the effectiveness and efficiency of the APEHT and to what extent (e.g. training contents, curriculum, methodologies, plans, quality, facilitators, venues, equipment) the APEHT was effective and efficient?
- To identify difficulties and challenges of the APEHT in achieving the training objectives?
- To assess the quality of the APEHT and to what extent the quality was contributing to the outcomes?
- To assess the effectiveness of the performance assessment of participants at the end of the APEHT.

Objective 3: To assess the impact and sustainability of the APEHT:

- To determine if trained participants were able to utilize the knowledge and skills obtained from the APEHT in their emergency health work and to what extent and where the knowledge and skills were applied?
- To assess the sustainability of the impact of APEHT and to determine how can the sustainability be ensured
- To identify and describe mechanism to sustain as well as further strengthen the established capacity of trained participants
- To assess post-training follow-up and opportunities for trained participants and to determine potential learning opportunities
- To identify other enabling factors which contribute to developing NS and IFRC's staff and volunteers' capacities and competencies in emergency health operations



Objective 4: To identify lessons learnt and areas of improvement for future directions:

- What are the areas of improvement for the IFRC in developing training plans for future direction?
- To suggest a training plan (framework, methodologies and modules) for the way forward?

III. Approach and Methodology

The review utilized a mixed methodology, consisting of both quantitative and qualitative approaches. Data collection techniques included in-depth interviews, survey and desk review for analysis and interpretation.

3.1. Online Survey

The quantitative data was collected through the online survey (see annex 2 for the survey form), which was circulated out to all NS in the Asia Pacific region. The online questionnaire was targeted at 37 National Societies with the aim of filling the gaps of information from existing secondary data. 19 National Societies took part in the online survey. Data from the online survey and previous surveys were analysed by Excel and Stata 12.1. The findings of the online survey have been included throughout the narrative of the report as appropriate.

3.2. Desk Review

An extensive desk review was carried out by the review team at the early onset. The documents covered training materials, strategies, review and evaluation reports across the spectrum of emergency health and RDRT, which assisted in setting in place a clear direction for the review taking into account the overall objectives set out in the ToR.

3.3. Key informant interviews

The qualitative data was collected from key informants, who met the selection criteria. The guidelines tool (see annex 3) was developed to ensure that interviews with key informants were carried out in a consistent and coherent manner and in line with the objectives of the ToR. Requests were made to 37 potential key informants, of which, a total of 26 were interviewed. Interviewees are professionals from RCRC NSs, their counterpart Ministry of Public Health, IFRC at country, regional, zonal and secretariat levels. The key selection criteria for key informants included: i) responsible for emergency response in IFRC, NS or MoPH; ii) knowledgeable of APEHT and emergency response; iii) knowledgeable of Red Cross Red Crescent; vi) willing to participate in an interview in English via Skype or email. Throughout the process, triangulation of relevant primary and secondary data occurred in order to identify clear commonalities surfacing and ensure analysis remained relevant and in line with the ToR.

3.4. Review team

The review team consisted of 2 members:

Nuran Higgins, Team Leader and Thuan Nguyen, Health Specialist



IV. Review of surge capacity and the IFRC's priorities for emergency health

4.1. Understanding Surge Capacity in Asia Pacific

The RDRT was developed in 1998 with the aim of acting as an effective and efficient regional disaster response surge capacity, consisting of experienced NS staff and volunteers available to deploy in the region to emergencies. Over the years the capacity of RDRT has grown as showed in the table below with the number of trained RDRT and APEHT participants (Table 3). Along side this, additional specialized profiles have evolved over the years to further compliment RDRD capacity which include DM, WatSan, logistics, shelter and IT/Telecommunications.

Table 3: Total number of trained RDRT Induction and APEHT Emergency Health members between 2001 and 2013

	National Societies	2001	2004	2006	2007	2008	2009	2010	2011	2013	Total
South Asia	Afghan Red Crescent			2		4				1	7
	Bangladesh Red Crescent			6		2		1		1	10
	Indian Red Cross			2		1					3
	Maldivian Red Crescent									1	1
	Nepal Red Cross			3		1					4
	Pakistan Red Crescent			3		6			2	1	12
	Sri Lanka Red Cross			3		3				1	7
	Sub-total										
South East Asia	Cambodian Red Cross							2			2
	Cruz Vermelha Timor Leste			1							1
	Lao Red Cross			1				1			2
	Malaysian Red Crescent			2			1				3
	Myanmar Red Cross							3			3
	Palang Merah Indonesia			2				2		1	5
	Philippine Red Cross			1		3		2	6		12
	Singapore Red Cross			1				1			2
	Thai Red Cross	2	1	4				1	2	1	11
	Vietnam Red Cross			2							2
	Sub-total										
East Asia	Red Cross Society of China				6	16	3	3	1		29
	DPRK Red Cross				3						3
	Hong Kong RC, China			1	2	2		1	2	5	13
	Japanese Red Cross				4	4	1			2	11
	Macau Red Cross, China					1					1
	Mongolian Red Cross				3	4			1		8
	Republic of Korea Red Cross					2		2		1	5
	Taiwan Red Cross, China					2				2	4
	Sub-total										
New Zealand Red Cross							1		2	3	



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	Samoa Red Cross			1							1
	Sub-total										4
PNS	Canadian RC - Pakistan					1					1
	Danish RC - Pakistan					1					1
	French RC - New Caledonia								2		2
	German RC - Pakistan					1			1		2
	German Red Cross – South East Asia Region			1							1
	Sub-total										
IFRC	IFRC Bangladesh			1		1					2
	IFRC Myanmar							1			1
	IFRC Pakistan					1					1
	IFRC Timor Leste							1			1
	Sub-total										5
Total		2	1	37	18	56	5	22	17	19	172⁸

The table below provides an overview of the total number of trained PHiE from the NS in the AP region in that period.

Table 4: Total number of trained PHiE and APEHT members from National Societies in the Asia Pacific between 2001 and 2013

East Asia		Pacific		South Asia		South East Asia		IFRC country delegations		PNS	
RC Society of China	30	Australia RC	1	Afghanistan RC	8	Cambodian RC	2	IFRC Bangladesh	2	American RC	1
DPRK RC	3	Kiribati RC	1	Bangladesh RC	10	Cruz Vermelha Timor Leste RC	1	IFRC Myanmar	1	Canadian RC	1
Hong Kong RC	14	New Zealand RC		India RC	3	Lao RC	4	IFRC Pakistan	1	Danish RC	1
Japan RC	14	Papua New Guinea RC	3	Maldivian RC	1	Malaysian RC	15	IFRC Timor Leste	1	French RC	2
Macau RC, China	1	Samoa RC	1	Nepal RC	4	Myanmar RC	4			German RC	3
Mongolian RC	8	Tonga RC	2	Pakistan RC	12	The Philippines RC	17				
Republic of Korea RC	5	Tuvalu RC	1	Sri Lanka RC	7	Palang Merah Indonesia	7				
Taiwan RC, China	4		1			Singapore RC	7				
						Thai RC	23				
						Vietnam RC	2				
Total	79		11		44		82		5		8

⁸ 57 participants were not included in the total figure due to incomplete information from the dataset provided to the review team.



4.2. IFRC strategic priorities in emergency health in Asia Pacific

Strengthening emergency health preparedness and response capacity is clearly outlined as a key priority for the IFRC in the Asia Pacific region, with the APEHT identified as key contributing component towards achieving this overarching goal. At global level, emergency health preparedness and response is supported through the following strategic aims:

- **Strategic aim 1**, which aims to ‘**save lives, protect livelihoods and strengthen recovery from disasters and crisis**’ and;⁹
- **Strategic aim 2**, which aims to ‘**enable healthy and safe living**’.

In Asia Pacific, emergency health is led by the zone health unit, working together with disaster management unit in emergency health, water and sanitation in disaster response, recovery and preparedness. To improve the regional response capacity to disasters and crisis events, the zone provides NSs with adequate access to material resources and skilled human resources for implementation of multi-sectorial disaster relief and recovery actions¹⁰.

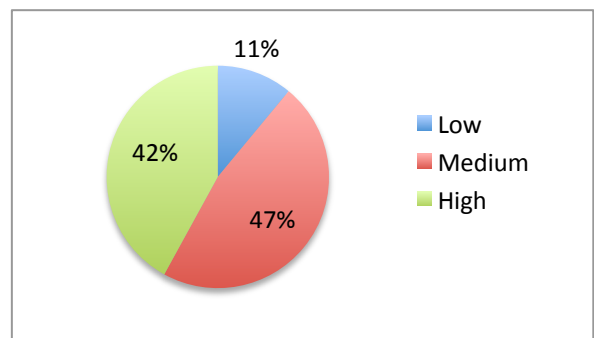


Figure 2. Levels of priority accorded by NS on emergency health

NS’s DM and Health Departments across the Asia Pacific region were asked via survey to take part in the review to share insight into their areas of strategic priority in emergency preparedness and response and in particular where they saw the area of emergency health. Health is one the core services of many NSs. 19 NS who responded to the online survey prioritized emergency, even though at different levels. The graph below (Figure 2) demonstrates the proportion of NS in the AP with different level of prioritization for emergency health.

V. Findings

5.1. Assess the relevance of the Asia Pacific Emergency Health Training

5.1.1. Learning objectives, training curriculum and methodology

The overall purpose of the APEHT is to **contribute to the enhancement** of the IFRC’s emergency health preparedness and response capacity in Asia Pacific by **preparing a pool of public health/medical professionals** who can be **quickly deployed to participate in the assessment, planning, implementation and coordination of timely and appropriate emergency health interventions** that meet internationally-accepted standards in humanitarian assistance¹¹.

⁹ IFRC. Strategy 2020. Saving lives changing minds

¹⁰ IFRC. Long term Planning Framework 2012-2015: Asia Pacific Zone

¹¹ IFRC. Asia Pacific Emergency Health Training Concept Note 2012



APEHT specifically aims to contribute to the strengthening of the RDRT system by providing a pool of qualified emergency health RDRT members who have been committed by their nominating NS to be part of the RDRT roster. Whilst it is important to ascertain how relevant the APEHT has been towards achieving its set purpose, this section will also consider a range of broader issues that are critical to reflect on for the overall success of the APEHT and wider RDRT system.

Learning objectives

Learning objectives are an essential component of any training development, setting in place how the intentions of the training will be fulfilled. It also establishes the parameters of the knowledge and capabilities participants have acquired and are able to apply and demonstrate at the completion of the training.

In reference to the learning dimensions¹², it is commonly seen in adult training the four elements of learning objectives: i) Knowledge and capabilities outcomes, ii) Skills outcomes, iii) Attitudes and values outcomes, iv) Behavioural outcomes.

For the APEHT, the learning objectives include the following;

- **Understand** and be able to **explain the key concepts and principles** of emergency health, and its relationships with other emergency/disaster preparedness and response actions.
- Be **knowledgeable** of, and be able to **apply different assessment processes, tools and methods** at various stages of an emergency/disaster.
- **Understand** and **describe key components** of Federation policies related to emergencies, emergency health response tools, mechanisms and services which RC/RC deliver in emergency and post-emergency situations.
- Be **familiar** with the **key health issues** that public health and humanitarian organizations need to address in emergency situations, and the evidence-based tools and best practices employed to manage these issues.
- Be able to **explain the roles and responsibilities** of a health member of a disaster/public health emergency response team in an event of deployment for emergency assessment and/or coordination.

Educational effectiveness and quality standards

When comparing the learning objectives against the overall purpose it was apparent that there were anomalies, with the overall purpose focused on preparing “a pool of emergency professionals who can be quickly deploy and carry out key tasks such as assessment, planning, implementation and coordination of emergency health interventions”, against the learning objectives which were predominantly focused on enhancing knowledge and understanding of key concepts and issues.

These variances between the purpose and learning objectives were also reflected in the analysis from the feedbacks provided by key informants across the country, regional, zonal and secretariat levels *‘need to take a more problem based approach’, ‘more time needs to be allocated for practical application’, and ‘need to balance better the theoretical aspects and practical application of the knowledge learnt’.*

¹² Dimensions of learning Trainer’s Manual 2nd Edition. Marzano R.J. et al. 1997. Virginia, USA



However, when considering the relevance of the APEHT in delivering against the stated learning objectives highlighted above from a knowledge and capabilities lens, analysis has shown that the training has achieved its desired result with points highlighted such as '*APEHT has contributed to enhance the knowledge of NS staff in emergency health*', '*curriculum and content very informative*', and '*gained a sense of confidence in emergency health programming and activities*'.

Whilst knowledge and capabilities learning objectives are required to enhance technical competencies required of specialized emergency health professionals deployable as part of RDRT, skills based learning objectives are just as critical to ensure the appropriate application and performance of such knowledge and capabilities. Understanding and setting in place parameters to revise the current learning objectives to be more closely aligned to the overall purpose of the APEHT will assist in mitigating against potential issues that can arise in the next phase of the process in curriculum design and methodology.

5.1.2. Training curriculum and content

Curriculum, content and learning objectives

The APEHT is comprehensive, covering a wide range of public health and emergency health topics. The curriculum is structured into thematic modules and organized in a logical sequence. The training has been designed closely aligned with the IFRC Secretariat emergency health framework and RDRT induction and adapted to suit the Asia Pacific regional context, specificity and priorities.

The APEHT is an intensive classroom based training delivered over 6.5 days. The training modules are divided as follows:

- Introduction to emergency health
- Emergency health assessments
- Key themes and issues in emergency health

When considering the relevance of the curriculum and content against the learning objectives it is apparent there are areas that can be further improved in strengthening the overall purpose of the APEHT. To start we will analyze the structure of the curriculum and content. So how does the APEHT curriculum and content relate in terms of relevance? NS/APEHT members were asked to rate the relevance of the content. 29 people responded to the question as follows:

Table 5: Perceptions of the APEHT training content by former APEHT participants (Data source: IFRC Asia Pacific Tracking Survey 2014)

Response	For national deployment	For regional/international deployment
1. Moderately irrelevant	8%	6%
2. Neither irrelevant or relevant	25%	12%
3. Moderately relevant	42%	35%
4. Very relevant	25%	47%



5.1.3. Review of curriculum, content and materials

Introduction to emergency health

The main focus of the module is to set the scene with *'basic concepts and practical application of health in the context of disasters and public health emergencies'*, and covers key features of major hazards and public health threats in the Asia Pacific and their effects to public health and to vulnerable groups. The introduction to emergency health module is allocated 3 hours, and covers global, regional and Movement aspects related to emergency health. As an introduction to emergency health it provides a good overview of basic foundational aspects relevant to support emergency health RDRT members.

Emergency health assessments

The main focus of the module is to *'introduce concepts and principles of assessments in emergencies, the information needs, methodologies and requirements of an assessment at the various stages of an emergency response, including recovery'*. Whilst the current curriculum and content cover basic level knowledge and skills, it does fall short of providing more intermediate level knowledge and skills that would produce quality deliverables expected of emergency health RDRT members deployed to emergencies. The emergency health assessment module is allocated about 8 hours, plus an outdoor exercise (about 5 hours), which provides participants the opportunity to test their skills in emergency health assessment.

Given the time allocation, the level of complexity in acquiring such technical knowledge and skills in emergency health assessment, the multi disciplinary composition of RDRTs, and comparability with specialised trainings in assessment, it is felt that the level and quality of knowledge and skills acquired and retained would be of a basic level. This has also been supported in the analysis with comments such as; *'needs assessment very relevant but not enough time given to fully understand what is required, very weak at the moment'*.

With assessment identified as one of the expected deliverables of emergency health RDRT members, additional time should be allocated towards this important module both in terms of theoretical knowledge and practical application of skills, which are critical to ensure that emergency health RDRT members are equipped and confident to be able to carry out the task at hand. If the expectation is instead that NS staff responding to the emergency be responsible for carrying out emergency health assessments, with RDRT members taking on a more coordinated role with the development of PoA, the curriculum content related to emergency health assessment will need to again then reflect a more advanced level of knowledge and skills transfer.

Key themes and issues in emergency health

The final module covers *'issues on mass casualties and emergency medical response, communicable diseases prevention and control, water, sanitation and hygiene promotion, and nutrition, sexual and reproductive health (including HIV/AIDS), mental health and psychosocial support and health in recovery program'*, highlighting considerations for assessment and response programming using evidence-based practice, tools and mechanisms.



The largest module with 12.5 hours allocated, it comprehensively covers key issues relevant to emergency health, providing participants with sufficient knowledge to assist them in being able to plan for such emergency health interventions. Whilst the outdoor exercise provides the opportunity for participants to utilize knowledge gained in developing a plan specific to a emergency health scenario, the duration allocated for skills application is minimal in being able to ascertain whether the relevant knowledge and skills has been retained on the level required for an RDRT deployment, which in most cases would be months later. Bearing this in mind it would be beneficial to explore additional ways to utilize this skill in the APEHT, especially given this is a core expected deliverables of an emergency health RDRT member on deployment.

It was found from the online survey that not all training topics provided in the APEHT had the same level of training priority by NSs (Figure 3). In this light, the time distribution for each training topic should be adjusted to be adequate to NS's training priorities.

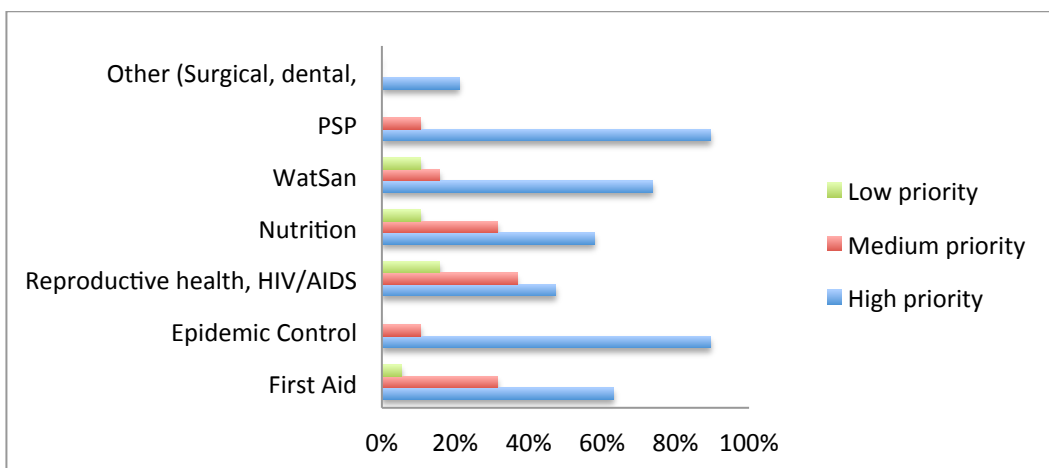


Figure 3. Distribution of areas of prioritisation for NS in emergency health training (n=19)

More broadly focused considerations that need to be taken into account include; recognising that due to the diverse technical background of participants from public health professionals to medical and specialised fields, levels of knowledge and skills related to specific areas of the training will vary. This needs to be taken into account in the overall development of the curriculum and content so as to ensure as best as possible a standardised level.

With any type of training development there is often a tendency in the early stages of curriculum design to fall into the trap of including too much into the design and content of a training. The reality is learning takes time, especially to retain the knowledge and skills acquired, so a good rule to remember is, less with greater quality and focus. Another aspect to support this is with regards to spacing out trainings by putting in place a learning and development framework. By doing so opens up greater opportunities for sustainable capacity building through a pathway of professional development.

This point was also highlighted with feedback such as '*danger of covering too much content leaving less people equip to be deployed*' and '*too many topics not sufficient time allocated to grasp knowledge and skills development*'.



5.1.4. Utilization of curriculum and content by National Societies

In understanding the extent to which the APEHT has been relevant it is important to take into consideration the perspective of its primary target group, NS staff and volunteers. Whilst the direct purpose of the APEHT is to develop a pool of emergency health RDRT members deployable to emergencies, its impact can be seen indirectly in a number of positive ways, which are important to highlight.

Curriculum and content

The APEHT curriculum and content is valued by many NS as a beneficial resource providing a platform to strengthen knowledge and skills in emergency health. 16/19 NS had national training courses in emergency health. Examples of the APEHT being utilized beyond its original regional training platform can be seen with NS in the Asia Pacific choosing to adapt the training curriculum and materials into local language, and local context to deliver at a national level to staff and volunteers (Figure 4). There have also been instances with some NS delivering ToTs and developing a pool of master trainers.

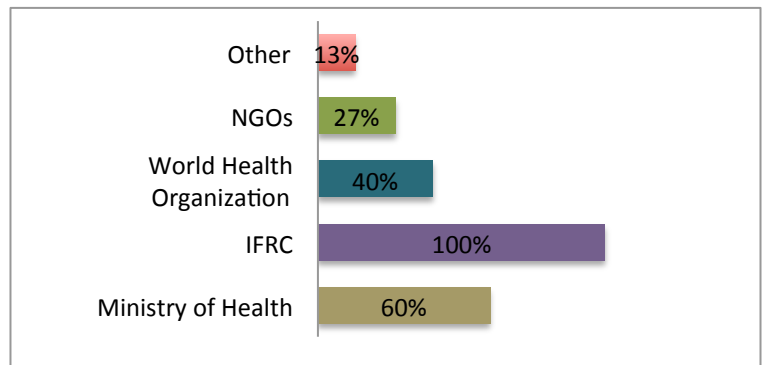


Figure 4. Main sources of training materials for emergency health utilized by NS (n=19)

Very recently, the Asia Pacific region has seen the emerging presence of FMTs as part of humanitarian health organization's key operational surge intervention. In 2013, content related to medical service provision, alongside drug and medical supplies in emergency was included into the APEHT. Feedback from participants and interviews with key informants across all levels highlighted

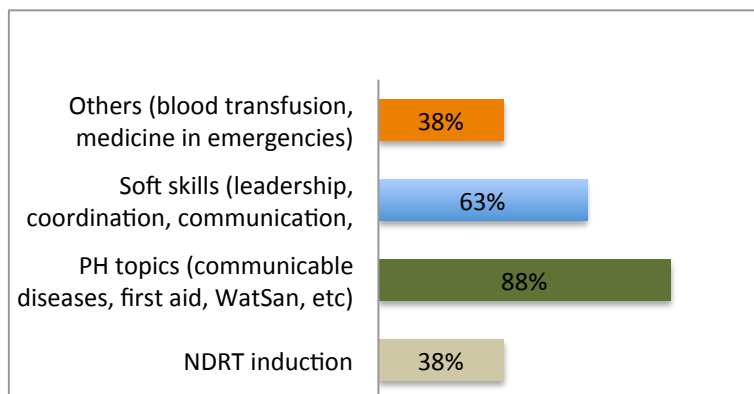


Figure 5. Training topics delivered by NSs in national training on EH (n=19)

that this was viewed favorably, particularly with growing interest by NS in the region which in some cases have

considered investment in FMTs a great opportunity for bilateral support. Given the growing interest by NS in the Asia Pacific region to establish such operational capacity, it will be imperative for the APEHT to take this into account in any future modifications of the APEHT so as to remain relevant.

It is also important to highlight with such adaptation of the APEHT materials NS have also diversified topics to be much more aligned with the country context and operational needs, which in some cases were not covered in the APEHT (Figure 5).

Feedback from key informants also suggested that in emergency health response include to a large extent medical logistics and supply chain, which would require some additional focus and content



revision in the current training curriculum. At a country level, responses from online surveys showed that 17/19 NS had a health component in their past emergency operations. Areas of emergency health responses were demonstrated below (Figure 6).

Knowledge and skills development

Analysis has shown that APEHT participants have increased their knowledge and skills in emergency health and grown in confidence to carry key tasks associated with deployment in emergencies at a national level. The tracking survey in 2014 by IFRC showed that 21/29 previously trained participants of the APEHT found the training relevant for national deployment.

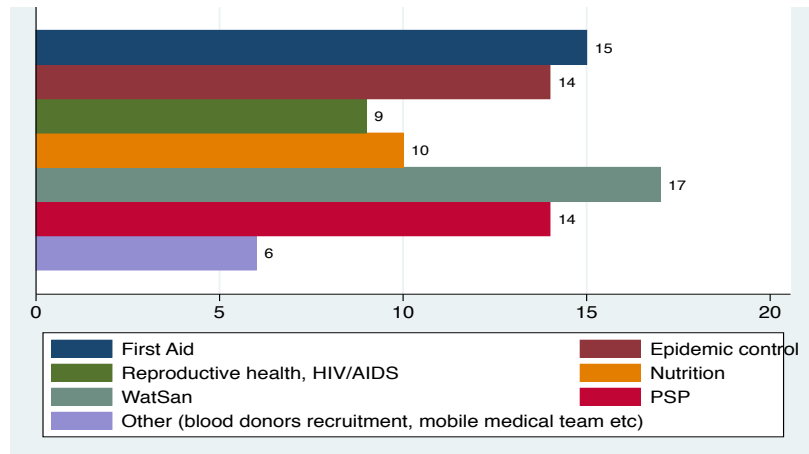


Figure 6. Emergency health components covered by NS in emergency operations

Surge capacity

The APEHT has also been successful in scaling up surge capacity of a regional pool of emergency health RDRT members, which has also indirectly resulted in increased national surge capacity in emergency health for NS within their NDRT system. 50/69 participants to APEHT were deployed nationally.

Operational capacity

Whilst it is difficult to attribute overall operational effectiveness and quality of NS emergency health NDRT members solely to the knowledge and skills acquired particularly in areas such as; assessment, planning, coordination and implementation from participation in the APEHT, it would be fair to assume from analysis that the APEHT has most certainly contributed to a great extent to the overall result of operational deliverables. There have also been instances of emergency health deployments regionally (cross-border) and internationally (ERUs).

Harmonisation of RDRT induction and specialisation curriculum, content

The concept of RDRT was developed in Asia Pacific in 2002 with the aim of developing a pool of qualified and skilled DM members deployable at short notice in the region to support NS responding to major disasters beyond their local coping capacities. Over the years the RDRT system has evolved in all aspects through a continuous learning process, including with the RDRT curriculum. One of the major areas in which the RDRT curriculum has evolved over the years, beyond its standard RDRT induction and refresher trainings has been with the expansion of the curriculum to incorporate specialised RDRT curriculums in technical areas such as; emergency health (APEHT), water and sanitation, logistics, IT & telecoms and shelter. Analysis of the RDRT induction curriculum, content and materials against the APEHT show there are most certainly areas that can be further improved in providing a more harmonised approach to essential knowledge and skills required of RDRT & specialised RDRT members.



International Federation of Red Cross and Red Crescent Societies

The success of applying effective, efficient and quality application of such tasks requires strong team cohesion within a multi-sectorial RDRT team. Yet in both curriculums there seems to be little harmonisation in design and inclusion of practical multi-sectorial application, to maximize learning and development for all as highlighted in feedback; *'the RDRT and APEHT should be more harmonised to avoid areas of overlap'*, *'RDRT induction needs to move beyond the traditional approach of DM and relief in training simulation to reflect better the reality of RDRT which is multi-sectorial'*. In this instance it has been a missed opportunity to reflect better, and equip RDRT members with the reality of an operation.

The other aspect to note is related to the RDRT training professional pathway process, which incorporates specialised trainings like the APEHT. Lack of harmonisation in the curriculums and inconsistencies in roll out of the RDRT training pathway process (order of completion required to be deemed deployable) hinders the opportunity for RDRT members to acquire a quality and standardised level of knowledge and skills necessary to perform their expected roles individually but also as a team.

5.1.5. Methodology

Teaching and learning methods

When choosing the type of training methodology to deliver a training, it is important to keep in mind that it provides a means for the participant to learn the specific content and opportunity to remain interested and engaged in the training. Analysing the APEHT, it is evident that the training is based on a pedagogy classroom based education model to adult learning.

When examining the methods used, a traditional passive approach to teaching and learning seems to be dominant drawing on lectures, presentations, audio-visuals with elements of active learning included such as group discussions, case studies and practical exercises. This does fit in line with the learning objectives, which are more knowledge and capabilities based, however it limits the expected purpose of the APEHT from being achieved due to the gap in active learning required to complement the passive learning. This is further supported in the analysis with feedback such as; *'Methodology of APEHT needs to combine better the theoretical and practical sessions'*.

Learning styles, retaining knowledge and skills

How we learn as individuals varies due to our preferential way in which we absorb, process, comprehend and retain information. Individual learning styles depend on cognitive, emotional, educational and environmental factors as well as our individual prior experience. Designing a curriculum and selecting the appropriate and relevant methods that will be used need to take these critical aspects into account to maximize the learning opportunity for APEHT participants.

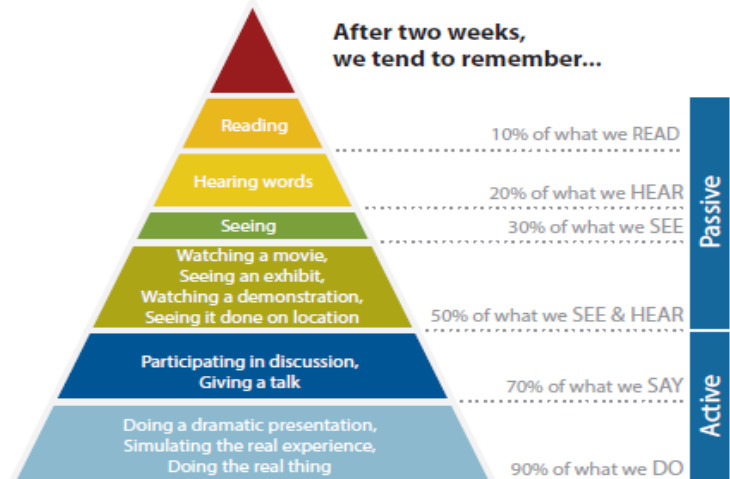
Methodological approaches to trainings across the RC/RC Movement

IFRC is grounded in 150 years of knowledge, skills and experience in designing and delivering trainings that cross a broad range of areas, to develop capacity staff and volunteers at national, regional and international levels. Having such a wealth of institutional knowledge and learning available to access is an asset that should be more widely utilized across the IFRC, particularly in pushing the boundaries of applying innovation to learning methods for trainings.



International Federation of Red Cross and Red Crescent Societies

Some of the existing IFRC trainings that share varying commonalities with the APEHT and or are aligned in terms of professional development pathways to compare in terms of methodological approaches adopted for learning include; RDRT induction, Watsan RDRT, e-learning course in emergency health, Field School (international), Emergency Health Preparedness for Response Field Based Mission Training (national level), NDRT, ECV, and Community Based Health and first aid to name a few.



(Based on the research of Edgar Dale, originator of "The Cone of Learning.")

Figure 7. The cone of learning

Online learning

From analysis of such trainings it's clear to see that online learning is increasingly being embraced as one of the primary innovative models to teaching and learning. Across all levels of the IFRC, learning was highlighted to be an important area of growth for the evolution of the APEHT with feedback such as; *'need to draw more on e-learning platforms'*, *'part of the APEHT and RDRT training could be done online as a integrated approach'* and *'use of e-learning could provide greater opportunity to learning theory in greater depth than trying to cover lots of topics in a short period of time'*.

The IFRC Learning Education and Training (LET) hub, is a resource accessible to IFRC staff, volunteers and members, as well as the general public. The LET hub is used by all 189 NS around the globe and has over 130,000 active learners and has over 5,000 courses completed each month¹³. Given evidence on global trends in information technological advances and the changing nature of the humanitarian landscape, utilizing such an approach opens up the opportunity to bridge the global divide in education, learning and development.

"Learning by doing"

Another methodology which in recent years has gained traction across IFRC trainings, moving beyond the traditional 'desktop based simulation' model is that of a 'field based' model. With the aim of providing practical real time learning-by-doing experiences, field based models are the ultimate in enhancing professional learning and development. Examples of where this model has been adopted include the Field School Training (international focused) and the National Emergency Health Preparedness for Response Field Based Mission Training (national focused in Afghanistan). Feedback from the questionnaire shows the preferred methodology for learning and development from NS participating in the APEHT, which favor significantly a practical based approach (Figure 8).

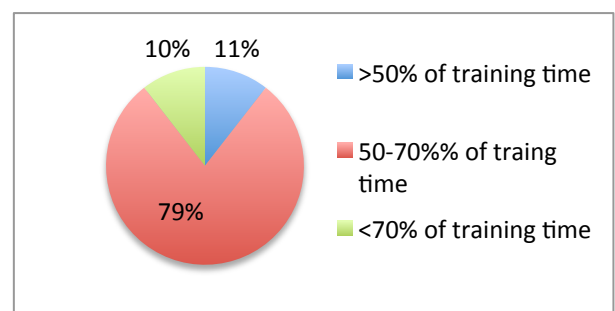


Figure 8. NS's preference in using a practical methodology for emergency health training

¹³ IFRC Learning platform. Accessed on 29 May 2015 at <https://www.ifrc.org/en/get-involved/learning-education-training/learning-platform1/>



Integrating theory and practice

Trainings that integrate both theory and practice using a methodological framework that utilizes innovation to maximize teaching and learning is the direction the APEHT needs to be moving towards. Doing so, equips staff and volunteers with opportunities for personal and professional development pathways, essential knowledge and skills to perform optimally in emergency health. An example of a RCR/RC training, which is currently attempting this in the Asia Pacific region that the APEHT could learn from, is the Emergency WATSAN RDRT training. Though there is room for improvement the training has mapped out a clear professional development pathway continuum, which combines well the theoretical and practical learning requirements.

Its methodological model encompasses:

- E-learning modules + webinar sessions (combined self-guided and interactive online learning with peer –to-peer exchange).
- Practical field based module.
- Coaching, mentoring and guidance throughout the learning process, assessment feedback.

5.1.6. Selection criteria, recruitment process and trained capacity

Selection criteria

The effectiveness and success of any humanitarian organisation undoubtedly relies on its ability to attract, recruit and retain quality talent that is aligned with the organisations overall strategic direction. For the IFRC Asia Pacific zone, the calibre of its operational surge teams be it from the pool of RDRT members, which emergency health is included, or NDRTs, securing and retaining such personnel is critical, particularly in the early days following an emergency where key operational strategic decisions are made.

The APEHT is targeted at NS health staff and/or volunteers, who must be met with the following qualifications and competencies. Selection priority is given to those that have either received RDRT induction training or deployed as part of RDRT but have not received the training as yet. Alongside meeting these criteria, participants must obtain commitment from their NS to be deployable as part of the RDRT surge roster as a specialized emergency health RDRT member. So how aligned and relevant is the selection criteria and recruitment process in providing a pool of qualified and skilled emergency health members?

While on paper this may seem straight forward, a closer look reveals that the challenge remains turning this it into reality, which from feedback from both the online questionnaire and key informants suggest comments such as; *'Selection should take into consideration the needs from operations, often NS requested someone with strong capacity to do assessment, capacity to transfer collected data to a response plan and not just the technical competencies'* and *'I think we need to be stricter and more serious about selection criteria and reject people if they did not meet selection criteria'*.

Core competencies and standards

Over the last decade there has been growing discussion and debate within the humanitarian sector regarding the greater professionalization of the sector, which is considered today to be an expanding industry. Naturally, with such a move towards professionalization comes the importance of setting in



place a set of core competencies and standards by which to measure performance and capacity. When examining further the selection criteria, analysis and feedback provided from NS staff, volunteers and key informants, it was evident that there are some significant gaps institutionally in this area. Efforts have commenced by the Emergency Health Unit in Geneva towards this direction, which is positive news.

From a technical perspective there needs to be a clear direction and understanding on i) is the APEHT focused on recruiting participants with a diverse range of emergency health specialized profiles and equipping them with a set of generalized core competencies (assessment, planning, coordination, implementation) or ii) recruiting participants with a diverse of emergency health specialized profiles and equipping them with set baseline of core competencies (technical – emergency health) plus the generalized core competencies (assessment, planning, coordination, implementation). Based on which of the two is the prioritized, a specific plan will need to be put in place to address the current gaps.

Lack of understanding of the added value emergency health RDRT members offer as being a critical member of RDRT missions was also reflected across the various levels of the IFRC from key informants interviewed. Without clear communication, advocacy and understanding by all of the extent existing such capacity offers as a key component of an RDRT deployment, lack of requests will continue to be an issue. Some of the feedback highlighted this with comments such as; *'I think IFRC needs to sensitize NS to nominate the right persons through national, regional and international meetings by highlighting what type of role and value emergency health members play in emergencies'*.

Selection and recruitment process

Selection and recruitment processes require a solid framework in place that takes into account key elements such as; well defined information outlining training and key selection criteria so as to mitigate the potential and risk of attracting the wrong type of candidates, clear communication and dissemination of the expected recruitment process and timeframe, shortlisting of candidates, interview and assessment of candidates, final shortlisting, final selection and communication to successful and unsuccessful candidates.

Review of secondary data, and feedback provided from the questionnaire and key informants across all levels of IFRC highlight strongly the controversial and challenging nature of the selection and recruitment process of the APEHT. However, this was not limited to the APEHT, as there was mention on many occasions of this being a systematic issue faced by other trainings in the Asia Pacific region. Comments with regard to the selection of participants to regional training in general suggested: *'the selection process is the most controversial and challenging issue across all trainings in the Asia Pacific region and not just the APEHT'*, *'selection of participants by NS is often political and seen as a reward'*, and *'many people in the training were not suitable, they got selected because of political decision'*.

Delving deeper into this issue, it was also clear that there were differences in approaches taken regionally to deal with and mitigate as best as possible what is known as common knowledge. Some regions were more advanced in breaking down NS's political rewarding/incentive approach, which



endorses the opportunity to travel outside their countries, by putting forward nomination of candidates for trainings that do not meet the criteria set. One of the ways, this has been addressed, has been by putting in place more rigorous and lengthy selection and recruiting processes which have included assessment and interviews with candidates as well as competency based frameworks. The opposite of this effect was also visible across some regions, which had NS which had a strong interest in emergency health, the quality of the nominations put forward were often much more aligned to the selection criteria.

Another issue noted was that related to language and the restrictions and challenges this has placed in being able to access otherwise suitable candidates for the APEHT that miss the opportunity as a result. The visible knock on effect that has been seen from this across the various regions when taking into account emergency health preparedness capacity is that such capacity in most cases has remained restricted to headquarter staff.

Learning and development assessment processes

Feedback from the questionnaire and interviews across all levels of the IFRC highlighted not only inconsistencies in selection and recruitment process, but also with regards to learning and development assessment processes. Currently assessment processes between RDRT and APEHT is different, with the APEHT assessing participant's skills and competencies by observing against the selection criteria at various times throughout and at the end of the training. Whereas for the RDRT, induction daily assessment was carried out. There are also no clear linkages between the two trainings. Moving forward it is paramount that a comprehensive training pathway outlining the learning, development and assessment processes between RDRT induction and specialization streams are discussed and agreed.

Performance management

Establishment of a performance management system for any organization is an essential aspect of being able to assess its success and improve organizational performance by developing both the performance of individuals and teams. Formation of systematic processes embedded within a performance management system also acts as a platform for which mutual understanding of the evolutionary cycle is known by all whereby, review and modifications can be made accordingly to ensure that recruitment, availability and retention of relevant skilled people exist and are utilized in a way that maximizes an organizations success. Alongside this, exploration of additional innovative approaches that offer the opportunity to retain and strengthen key skills and competencies such as coaching and mentoring should be considered, particularly in drawing on existing RC/RC surge tools. When reviewing the RDRT system and the pool of specialized emergency health RDRT, it was evident that much work is to be done in this area.

Analysis showed there was a lack of harmonization in both register & roster management, tracking performance and retention of skills of APEHT members across the overall system. There also seemed to be a lack of clarity around roles and responsibilities for the management and maintenance of such a system, which has resulted in certain processes being duplicated at zone and regional level.



Some of the feedback provided in interviews with various stakeholders have included; *'Tracking needs to be strengthened, at present there is no systematized tracking system/process in place to track key aspects required', 'RMS system is in place but is not being utilized systematically across RDRT and Specialised sectors which in turn has delayed operational processes for mobilization and deployment' and 'greater coordination in management between RDRT and Specialised sectors such as health. Currently regional delegations hold a list of trained EH participants as well as the AP Health Unit on separate databases. This slows the process down (effectiveness) due to multiple rosters in place'.*

Current data on the number of deployments of specialized emergency health RDRT/cross border member's stands at 0. However in spite of this, it is well known across the Asia Pacific region that there have been deployments of emergency health RDRT members deployed nationally as NDRT, bilaterally by their National Society and in some cases, internationally as members of health ERUs. This critical information is not currently captured in the system, however, it offers the potential to explore beyond the traditional framework to be greater aligned to the emerging trends as highlighted in section 2 in the report.

This type of information would be invaluable in not only capturing performance but also helping to inform strategic direction and ongoing adaptation required. Embedding such a process would also open up the opportunity to promote more active engagement of NS instead of the current passive role they seem to have currently. *'We knew in Sri Lanka floods, APEHT participants were deployed nationally. We have no official data for this deployment, but we knew that the deployment was good, the person was effective and useful to the operation'. 'We often have national deployment and cross border deployment. We have no regional deployment. When we deploy people, we do so through NDRT. The trend is an increase in NDRT and cross border deployment'.*

5.2. Assess the effectiveness, efficiency and quality of the Asia Pacific Emergency Health Training

5.2.1. Effectiveness

In ascertaining the effectiveness of the APEHT it's important to take into account not only how well it achieved its overall objective, but also how well it achieved alignment with the larger strategic direction and business lines of which it fits under. When looking closely at the AP Zone Long Term Planning Framework 2012-2015, we can see that investment in the APEHT as a key activity has contributed towards the following business line, outcome and outputs.

Business line 2: "To grow Red Cross and Red Crescent services to vulnerable people".

Outcome: Improved aid effectiveness through increased National Societies capacity to work in communities and respond to disasters and crises events.

- Output 1.2: NS have adequate access to material resources and skilled human resources for implementation of multi-sectoral disaster relief and recovery actions.
- Output 2.2: Selected national societies have increased their ability to provide humanitarian aid internationally and have contributed to international operations with better quality, higher scale and better coordination and effectiveness



A review of the all Asia Pacific Regional Long Term Planning Frameworks revealed consistency in terms of set outputs and indicators with some minor differences. It was evident under business line 2 that the priority was focused on strengthening emergency health/disaster response mechanisms and human resource capacity through delivery of trainings such as APEHT, RDRT, NDRT, establishment of SoPs, contingency plans, and prepositioning of relief items and equipment. How has this been demonstrated alongside lower level objectives, we will discuss further below.

Emergency health preparedness and response capacity

Substantial evidence has been provided throughout the report supporting to a great extent the effectiveness of the APEHT in achieving its set objective, by contributing to the enhancement of emergency health preparedness and response capacity in Asia Pacific. This has been demonstrated not only in the quantifiable total of emergency health RDRT members trained, but also in strengthening emergency health preparedness and response capacity both at regional and national levels. *‘Despite of some drawbacks, APEHT has made positive impacts on developing NS capacity in PHiE. Some good examples of this are the Philippines, Laos, Vietnam and Thailand’. ‘NDRT health specialists are able to make great contribution to operations. They were able to work very effectively as a team and as technical leaders’.*

Whilst the APEHT has demonstrated its ability to contribute towards strengthening the IFRC’s emergency health preparedness and response, the frequency and availability of delivering the APEHT and more so the RDRT induction is an area identified as a critical gap that needs to be addressed urgently. Currently, there are inadequate RDRT inductions carried out to meet the demands and requirements of specialised RDRT profiles. This has resulted in a significant backlog of trained APEHT members, along with other specialised profile waiting for years on end to complete what is a key requirement to be deployed as a RDRT member. The inadequacy has a two-pronged effect, one - being the lack of availability to participate in the RDRT induction training, and the second - being a weakening in skills and knowledge originally acquired from the APEHT due to the significant delay. This impacts also on overall efficiency resulting in a loss for both trainings. Therefore, is it essential that opportunities for greater harmonisation between the RDRT and APEHT is done so sooner rather than later.

The APEHT has proved to be effective is with regards to its training content and curriculum. Whilst it has been highlighted that the APEHT is in need of an overall revision, it is important to mention the added value it has provided to NS in strengthening their overall emergency health preparedness and response capacity through local adaptation and utilization of the APEHT training resources. *‘NS are keen on developing response capacity, they use trained APEHT in delivering further trainings nationally and have use trained APEHT to deploy nationally’.*

At the same time, it is important to note that the APEHT provides an initial entry point for establishing both regional and national emergency health preparedness and response capacity. Securing and retaining candidates for the APEHT proved to be an area that has not delivered as effective as anticipated. Further investment is, therefore, required in order to explore ways in which to optimize overall performance this area, particularly if the IFRC is to maintain a stronghold in what is today a competitive industry in the region. *‘Selection is very essential and I think a large part of low probability of deployment is because we did not have the right persons in APEHT’.*



Emergency health surge capacity

Moving beyond the APEHT as a deliverable activity, to instead explore the effectiveness of its expected outcome by preparing a pool of emergency health professionals for deployment has shown some interesting findings.

Operational SoPs, contingency plans

When analysing the APEHT against the backdrop of emergency preparedness, response and recovery systems built in Asia Pacific National Societies, there have been some irregularities, which ultimately have influenced overall effectiveness. When looking at the table below we can see that across the Asia Pacific Region there are 11/19 NS that have established SoPs (Table 6). However, a closer look reveals that only 2 NS that have included emergency health within the SoPs. What makes this interesting is that does not match the reality of how NS are responding in emergencies, where in such cases, 18/19 NS, have included emergency health members as part of their NDRT deployments.

Table 6. NS that has SOPs inclusive of emergency health and deployment of emergency health NDRT members

NS with no SOP	8/19
NS with SOP	11/19
NS with SOP and inclusion of EH surge	2/19
NS has deployed EH specialist(s) nationally	18/19

From the analysis we can clearly see the substantial role emergency health NDRT members play nationally, yet institutionally this valued contribution is yet to be recognised within key operational documents such as SoPs and contingency plans. Such information is also telling in better understanding some of the perceptions and barriers behind NS absence to request emergency health RDRT and lack of committed to approve mobilization of emergency health RDRT. Of course this is only one level and needs to be taken into account alongside regional and Zonal perceptions as well. *‘Advocacy is required to strengthen NS perception to receive a RDRT health. We need to be able to influence views that receiving such asset is seen more as working in solidarity rather than weakness’.*

RDRT register database and roster management

As highlighted above the register database and roster management is an area that has shown in the analysis to be weak for the APEHT and RDRT in terms of overall effectiveness. A roster is only as good as the investment put into it both in terms of financial contribution, technical expertise and ongoing maintenance. In order to achieve a higher level of effectiveness and performance it is imperative that a standardised RDRT system is developed that promotes greater harmonisation between the pool of specialised profiles such as emergency health and the standard RDRT profile. Capturing deployments of NDRT would also provide a much more comprehensive overview of surge capacity across the region and assist in providing greater insight into key aspects relating to the ongoing strategic direction of surge tools in the Asia Pacific region.

Alongside this, the ability to rapidly deploy qualified personnel is seen as a critical aspect overall operational effectiveness and a key investment in any surge capacity. This of course relies on the ability to have a strong foundational database and roster in place. The inability to mobilize and deploy rapidly also impacts on overall confidence by influential stakeholders, which over time



impacts on overall effectiveness and sustainability. *'The deployment procedures are slow and need to be strengthened especially with the initial request to deploy', and 'there is a deficiency in roster management in general for the RDRT system which make it even more so when taking into account specialised areas'*.

Gender

A vital aspect in strengthening emergency health preparedness and response is to ensure that gender issues in emergencies have been incorporated at all levels of an organisation, especially in particular with surge capacity. Substantial evidence exists today highlighting the impact emergencies has particularly for women and girls whom often face additional barriers and inequalities to access and control resources as well as decision making powers. As first responders, it is essential that surge team composition reflect the necessary diversity required to be able to access and address appropriately the gender specific needs of those affected. From the analysis of the current pool of APEHT participants, it is evident that gender has clearly been taking into consideration (Figure 9), with the pie chart below highlighting a relatively well-balanced composition, which is great to see.

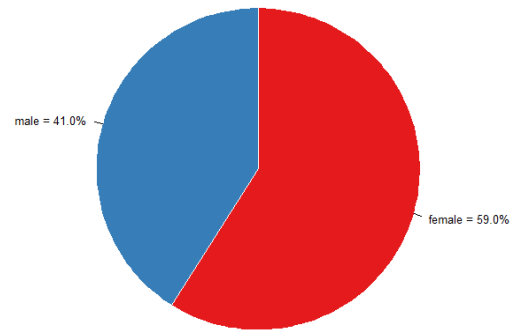


Figure 9. Distribution of gender among the participants to the APEHT from 2010-2013 (n=69)

APEHT profiles

One of the more subtle factors that contribute significantly to the effectiveness of the APEHT achieving its overall purpose is related to the selection and recruitment process and the distribution of APEHT technical profiles. As seen in Figure 10, the current APEHT technical profiles are largely distributed between nurses, public health professionals and medical doctors. From the analysis there were a number of issues that arose that need to be taken into account moving forward. The first was around the current technical spread of the profiles. Given the trends, risk and vulnerabilities highlighted earlier in the report it is important to ask the question of whether the current distribution of profiles are relevant and adequate in numbers to be able to respond effectively? An essential question that goes hand in hand with this is understanding the current capacity of NS at a national level and whether they too have sufficient preparedness capacity in place.

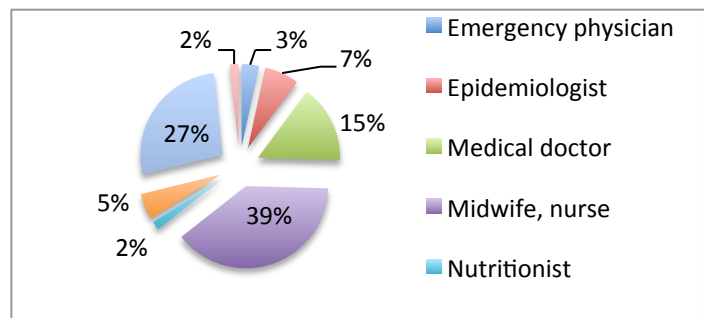


Figure 10. Distribution of APEHT participant's training background (n=69)

The other aspect closely analysed was related to the expected deliverables of emergency health RDRT members and whether the current distribution of profiles have the right competencies and skills to adequately carry out such tasks. These are critical questions that need to be further explored



and discussed as part of the overall future direction of the APEHT. Lastly, was unpacking a comparative analysis of the current growing emergency health and preparedness capacity of NS in the region. It has been highlighted throughout this report the growing interest and investment of NS scaling up capacity particularly in the area of FMTs. Given the likelihood of such capacity continuing to grow in the coming years ahead it is imperative that the APEHT consider sooner rather than later what will be the added value the APEHT. If NS in Asia Pacific continue to go down this direction how will this impact the likelihood of NS choosing to mobilize their surge capacity for regional tools over opportunities for bilaterally cooperation? Understanding where the gap will be in the coming years now is critical to the future direction of the APEHT.

Strengthening relationships, engagement and communication

From the analysis we can see that perceptions are not always aligned with reality. When taking into account the high level strategic direction it is critical that further exploration into such anomalies are better understood in order to develop relationships built on trust and platforms that promote productive engagement. To achieve this effective and open communication as well as a tailored advocacy strategy needs to be in place and disseminated in a coherent and transparent manner by both DM and Health departments of the IFRC to support NS in future development of their surge capacity. *‘There is also a lack of confidence at all levels of the RDRT system which needs a strong advocacy platform developed to follow up with NS. There needs to be a more strategic approach to utilizing RDRT capacity’.*

5.2.2. Efficiency

Cost and Effort

The APEHT is carried out over 6.5 days, for about 25 participants and covers key components such as: i) introduction to emergency health, ii) emergency health assessments, and iii) key themes and issues in emergency health. Overall the budget to deliver the APEHT is set at approximately CHF30,000. A cost benefit analysis was carried out to ascertain how efficient the APEHT has been. In doing so the cost of delivering the APEHT was compared with similar training also delivered by the IFRC during the review period. From the analysis it was evident that the APEHT was comparable to other trainings and in some instances was slightly lower.

When taking into consideration overall efficiency in terms of effort, the APEHT has delivered some great results particularly in providing opportunities to involve facilitators from the region throughout three courses. In 2010, the IFRC and Singapore RC co-organized the APEHT, some of the facilitators were from the NS. In 2013, a group of 07 facilitators and support facilitators from Hong Kong RC were involved in delivering the training. From this information we can see clearly that the APEHT has demonstrated the beginnings of capacity building trainers level the region. Though, when comparing against other similar trainings in the Asia Pacific region, it was evident that the APEHT could improve its efficiency through by better utilization of alternative methods of delivery.

When analysing the APEHT against other the RDRT induction and other specialised trainings, there seemed to be areas of variance with curriculum and content, which is to be expected to some degree. However, an area in which they all seemed to be deficient, including the APEHT was in exploiting opportunities for integration of resources to enhance overall efficiency.



Given the overall purpose of the APEHT, RDRT and other specialised trainings is strengthen emergency preparedness and response capacity in AP region through the establishment a set pool of RDRT members, one would assume that there would be greater harmonisation and utilization of resources in areas of commonality as a means to strengthen the quality and capacity of RDRT member. This is most certainly an area that should be discussed in further detail moving forward as it offers the potential to provide all RDRT members the opportunity to be exposed to the multi-sectoral nature of operations, rather than the current isolated approach, which is far from reality.

The graph below shows the different regional training courses for emergency response in a range from four to nine-day duration, organized by IFRC AP Zone office from 2011-2014¹⁴.

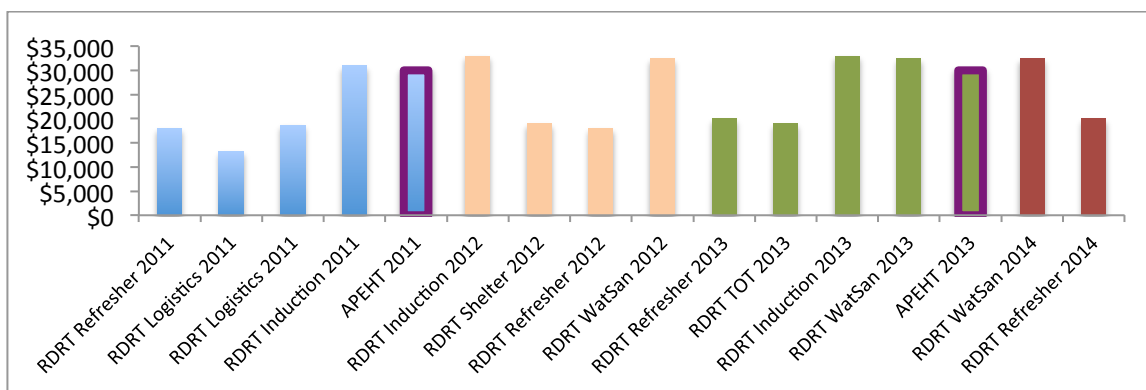


Figure 11. Average budget for RDRT, APEHT and other RDRT specialisation trainings between 2011 - 2014

5.2.3. Quality

Trainers/Facilitators

For any training to be successful, it requires several key elements of which trainers/facilitators are one of them. You can have in place a solid curriculum, great content and a diversified methodology chosen, but it will only be as good as the quality of your trainers/facilitators. Currently the APEHT predominantly draws on a pool of technical experts from the zone, including from the IFRC and partner agencies. When taking into consideration the quality aspect, it is often assumed having technical expertise about a topic automatically provides you with the ability to disseminate the relevant content at hand. This is not the case. Delivering any training is much more than disseminating information about the topic at hand; it requires in itself key skills and competencies in which the trainers/facilitators must have in place in order to harness the power of learning and development.

Alongside the importance of having in place a pool of qualified and skilled trainers/facilitators is the necessity to have in place a sufficient quantity spread across the Asia Pacific region. This is also another area in which the APEHT is falling short. A key concern of this is first and foremost sustainability, but also in that it hinders the ability to maximize the geographical reach of the APEHT to NS and create opportunities for NS to develop skills and capacities to deliver such training at a national level. *‘There is a need to develop a pool of skilled trainers to carry out trainings instead of relying on a small pool of external trainers from within IFRC’.*

¹⁴ Data before 2011 for the courses was not provided to the review team, thus, it is not included the APEHT training in 2010 in the graph.



Facilities and location

The training facilities were seen to be appropriate and as a result provided the opportunity to cut back on the overall cost in delivering the APEHT. However when considering the practical application of key skills and knowledge opportunities to engage with real communities, real scenario settings were seen to be lacking.

5.3. Assess the impact and sustainability of the Asia Pacific Emergency Health

Training

Applied knowledge and skills

Review of key data and feedback from APEHT participants and key informants indicated that the APEHT has played a pivotal role in providing such emergency health RDRT members and NS with comprehensive knowledge and skills in emergency health. However, the opportunities for participants to put their skills and knowledge into practice have come into play more so at a national level. From 2008-2013, 14/19 NS indicated that they had deployed previously trained participants through national emergency operations. Alongside this 18/19 of surveyed NS indicated that they had emergency operations that were inclusive of emergency health.

Responses from the online survey of NS also showed that half of the NS (8/19) perceived the trained APEHT had skills and competencies to work effectively in emergency operations. The remaining NS responded that participants had average competencies and skills for emergency work. From this we can see that the APEHT has indeed contributed effectively to enhancing the skills and competencies of emergency health RDRT members and long-term sustainability through developing capacity that will be embedded and retained within NS. Important to note is that over the period from 2010-2013, 97% of the APEHT participants (67/69) had not been trained in RDRT induction. Within the review period, 3 out of 69 APEHT participants were deployed for emergency operations as emergency health specialists for the Ebola response in West Africa.

In a region with very high number of emergency operations every year, the number of deployed emergency health RDRT members is considered very low. In spite of the keen interest highlighted by emergency health RDRT members and NS for RDRT deployment, a key obstacle mentioned was not having completed the RDRT induction. This argument is unfortunately valid as to be considered available to deploy, as RDRT a specialised RDRT member should have completed also the RDRT induction. As highlighted above, RDRT induction trainings are organized every 1 or 2 years, with about of 30 participants each training. Due to the high need and priority by NS in having DM professionals trained in RDRT it limits the opportunity, in most cases 3-5 places for specialised profiles like emergency health to be nominated and subsequently selected for RDRT. Currently there are 172 emergency health RDRT members alone, not including other specialised profiles that are waiting for a place to attend the RDRT induction. This is a critical aspect to take into consideration in terms of impact and long-term sustainability.

Retention of knowledge and skills

There have been three APEHT training carried in the Asia Pacific region yet deployments of emergency health RDRT members within the region currently stands at 0. With the current low percentage of regional deployment opportunities, chances for APEHT emergency health RDRT members retaining their skills and knowledge long term are low, particularly if there are no



opportunities provided at a national level. A key component critical in facilitating a platform for opportunities for retention of skills and knowledge is having in place a solid database system and a functional roster.

National emergency health preparedness and response capacity

To gain greater insight into the extent emergency health preparedness and response capacity had been strengthened at a national level, the review took a closer look at a few countries across the Asia Pacific region that had varying capacities when it came to emergency health. The case study countries chosen were the Philippines, Afghanistan and Vietnam.

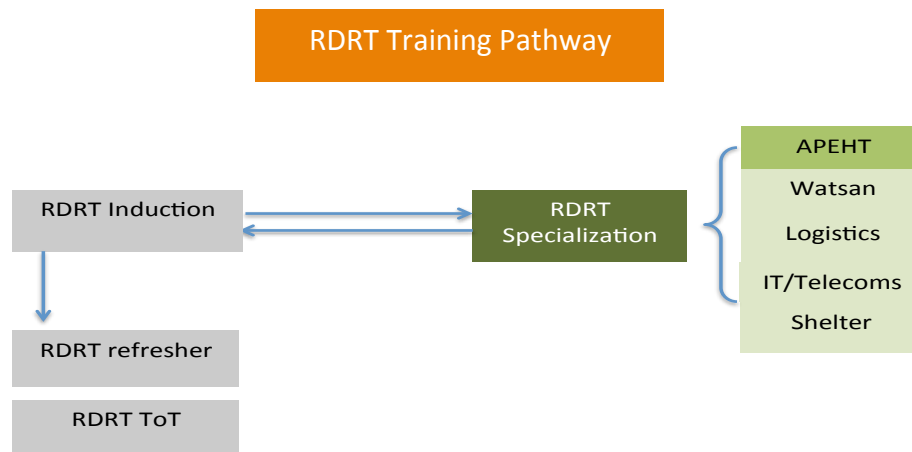
In all cases the NS had utilized resources from the APEHT in further strengthening their national emergency health trainings by adapting the content and materials into the local language and context. All of the countries had also gone through a process of adaptation of other IFRC's training tools for emergency health like CBHFA, ECV which offered opportunities for learning and reflection, highlighting the important role locally adapted resources provide to a country's context and a network of trained national trainers and volunteers, particularly when needing to scale up. There was also examples of where such capacity had been taken further with ToT carried out by APEHT emergency health RDRT members so as to further decentralise the knowledge and skills beyond the headquarter level to the field where it is most needed. Taking this valuable information into consideration, the APEHT should really be looking at where it can offer additional value to filling gaps in knowledge and skills so as to complement current investment being made at a national level.

At an operational level it was clear among the 3 NS that integration between DM and health was a central to their success in strengthening emergency health preparedness and response capacity, starting with SoPs where emergency health had been included and acknowledged as being central to optimising a multi-sectorial approach. Alongside this, experiences indicated successful examples where emergency health had been inclusive in needs assessments, developing PoA and trainings were in promoting opportunities for greater integration and standardisation of operational effectiveness and efficiency.

5.4. Identify lessons learnt and areas of improvement for future directions

Current training model

The following section provides recommendations for consideration. The review examined in great detail key aspects directly and indirectly associated with the current APEHT training model. From the analysis it has shown to be limited in a number of areas that have impacted its relevance, effectiveness, efficiency, quality and sustainability which will be discussed further on in this section.



Curriculum, content and methodology

From the analysis, the APEHT curriculum and content has proved to be somewhat relevant and effective particularly taking into account its expansion from a regional to national resource with its adaption and utilization by a number of NS in the Asia Pacific region. However, in spite of the positive results there still remains areas within the curriculum that require further adjustments, as well as new additional areas that need to be further expanded. The overall methodology applied in the APEHT's was identified as a key lesson to be learned and an area in serious need of revitalization. Drawing on innovation models that offer the potential to accentuate greater integration between theory and practice is one of the most important aspects moving forward for the APEHT. By doing so emergency health RDRT members will have greater learning and development opportunities to enhance their knowledge and skills where needed most.

Harmonisation between APEHT and RDRT

Throughout the review there was clear evidence of a lack of harmonisation between the APEHT and RDRT. With the APEHT providing emergency health RDRT specialists it is essential that such members are adequately equip with the same level of knowledge and skills, particularly when it comes to key team tasks such as assessment, planning, coordination and implementation. The success of being able to apply effective, efficient and quality application of such tasks requires strong team cohesion.

Future training model

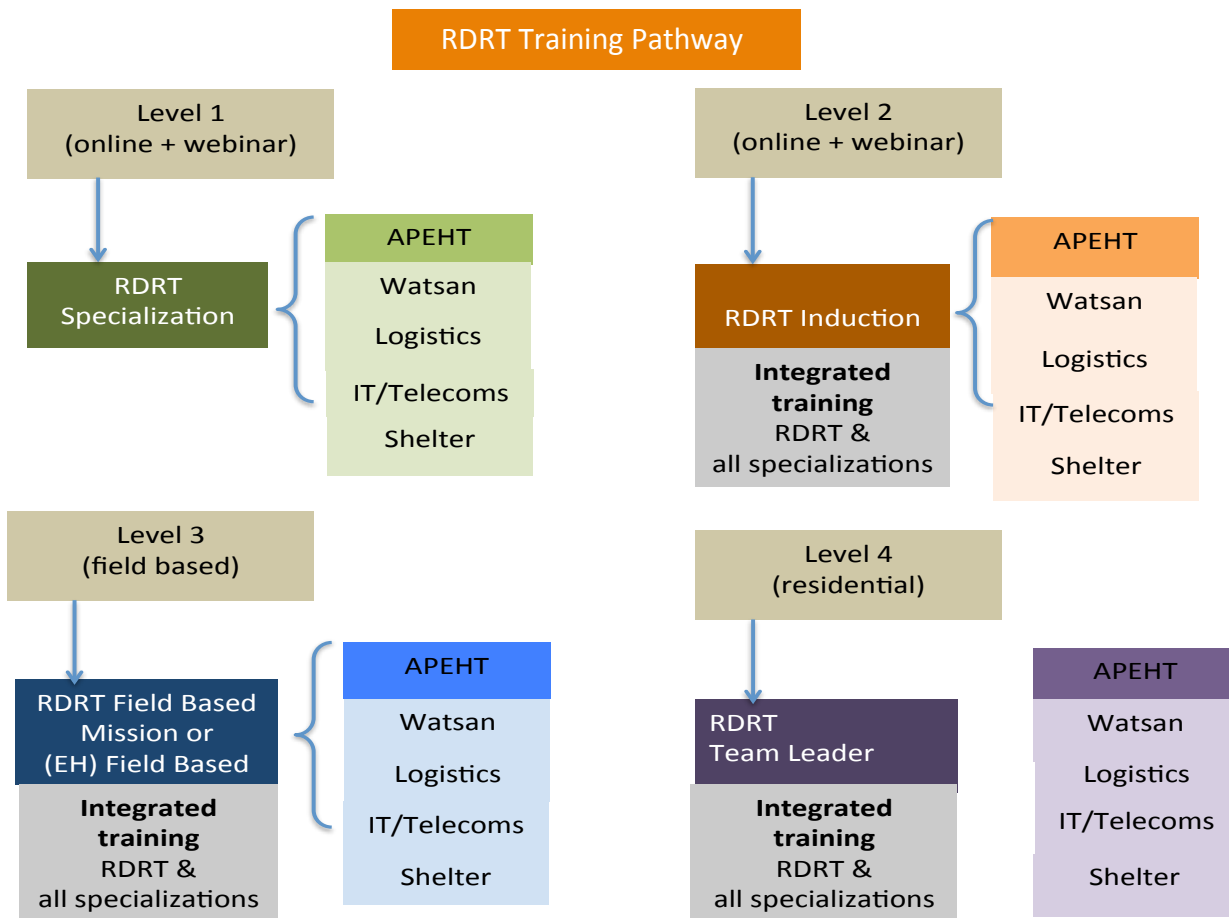
The humanitarian landscape is changing not only in terms of the risks, trends and vulnerabilities, but also with regards to the operational platform, dynamics and dilemmas in which emergencies are delivered. For those trained and deployed as emergency health RDRT it is vital to be aware, equipped and prepared for both the internal and external dynamics and dilemmas that challenge the ability to operate effectively on the frontline. Some of the external trends which will continue to be much more prevalent in the future include greater capacity of national governments, regional cooperation agreements and increasing presence of the private sector and new players, as well as challenges surrounding access to humanitarian space, and increasing presence of civil and foreign military engagement.



Some of the more internal trends across the humanitarian system include stronger capacity of NS and national humanitarian organisations, resulting in a greater shift in bilateral surge/operational capacity with more taking the forefront of response to support their neighbouring partners. As highlighted above and from the key lessons highlighted throughout the review there is a significant shift in mind- set required moving forward. In doing so it will require a multi- departmental commitment across IFRC if the fundamental change essential to success is to come to fruition. Below is an example of a new training model for consideration moving forward.

Rolling out future training model

Rolling out the below training model offers a number of benefits and opportunities to strengthening IFRC emergency health preparedness and response capacity. The first notable area is greater pooling of resources between DM and various specialisation streams such as emergency health to maximize the relevance and quality of learning and development opportunities for RDRT members. The second is working much more collaboratively to establish a harmonised framework that capitalizes a mixed methodological approach and training pathway by offering knowledge-based learning through online and webinar methodology and skill-based development through practical application of field based methodology. Some areas will remain the responsibility of specific departments to maintain and deliver, whilst in other areas it be offered through a harmonised approach. Adopting such a model offers a win-win solution for all from APEHT-trained emergency health RDRT member, to the receiving NS and beneficiaries.





Level 1 – RDRT Individualised specialist sectors

Curriculum & content – Utilizing a combination of APEHT, EH online and other

Methodology – as online training with webinar sessions

Target group – specific health specialist sector

Budget – From specific health department

Level 2 – RDRT Induction

Curriculum & content – Utilizing a combination of RDRT, and specialisation profiles

Methodology – delivered as an integrated online training with webinar sessions

Target group – integrated with RDRT and specific specialisation profiles

Budget – from Emergency health budget of Health Department

Shared budget between DM and specific specialisation department

Level 3 – RDRT Field Based Mission or Emergency Health Field Based Mission

Curriculum & content – Utilizing a combination of RDRT, and specialisation profiles

Methodology – delivered as an integrated field based mission training

Target group – integrated with RDRT and specific specialisation profiles

Budget – Shared budget between DM and specific specialisation department

Level 4 – RDRT Team Leader

Curriculum & content – Utilizing a combination of RDRT, and specialisation profiles

Methodology – delivered as an integrated residential

Target group – integrated with RDRT and specific specialisation profiles

Budget – Shared budget between DM and specific specialisation department

Level 1 – RDRT Emergency Health Specialised Sector

Level	Methodology	Module Theme	Module Content Detailed
Module 1: INTRODUCTION TO EMERGENCY HEALTH			
1	Online + webinar	Introduction to emergency health	1.1 Effects/impact of disasters and complex emergencies to human health 1.2 Health systems and infrastructure in humanitarian emergencies 1.3 Approaches in emergency health management – public health, primary health care, health system and coordination 1.4 Essential public health priorities during emergency response, early recovery and recovery programming
1	Online + webinar	RCRC Movement Operational Framework in emergencies	2.1 IFRC DR tools – emergency health (ERUs, RDRT, NDRT) Medical Mobile Teams – AP region
Module 2: EMERGENCY HEALTH RESPONSE			
1	Online + webinar	Emergency health response	3.1 Operational team building - RDRT members - NS focal points (health department) - other RC/RC response tools (FACT, ERU, NDRT) 3.2 Establishing operational team plan and coordination mechanisms with NS - NS mandates, NS emergency health strategic focus &



			priorities - NS operational capacity (NDRT, BDRT, volunteers, resources ect)
Module 3: EMERGENCY HEALTH: ASSESSMENT, PLANNING & COORDINATION			
1	Online + webinar	Assessment	5.1 Epidemiology and surveillance 5.2 Control of communicable disease? 5.3 Emergency health assessment
1	Online + webinar	Planning	5.1 Plan of Action – emergency health priorities 5.2 Budgeting 5.3 DREF and Emergency Appeal
1	Online + webinar	Coordination	6.1 Ministry of Public Health 6.2 Cluster coordination (Health, Nutrition, Water, Sanitation & Hygiene, Food Security)
Module 4: DISASTER RESPONSE: IMPLEMENTATION			
1	Online + webinar	Emergency health programming	SPHERE standards
1	Online + webinar		Communicable diseases in emergencies
1	Online + webinar		Water, sanitation & hygiene promotion in emergencies
1	Online + webinar		Mental health & psychosocial support in emergencies
1	Online + webinar		Sexual & reproductive health in emergencies
1	Online + webinar		Nutrition in emergencies
1	Online + webinar		Health recovery in emergencies

Level 3 – RDRT Field Based Mission or Emergency Health Field Based Mission

Level	Methodology	Module Theme	Module Content Detailed
Module 1: RDRT PREPAREDNESS			
Day 0	Field based	RDRT mobilization & preparedness	0.1 Breaking news – disaster 0.2 RDRT sms alert 0.3 RDRT sms deployment (team composition) 0.4 RDRT ToR, deployment essentials 0.5 Health advice 0.6 SITREP
Module 3: DISASTER RESPONSE			
Day 1	Field based	RDRT response	1.1 Arrival in Country 1.2 Establishing operational base - Security, Safety & Wellbeing - Accommodation/Logistics
Day 2	Field based	RDRT response	2.1 Operational briefing - NS 2.2 Operational team building - emergency health RDRT members - NS focal points - other RC/RC response tools (FACT, ERU, NDRT) 2.3 Review of secondary data (rapid assessment NS vols, OCHA SITREP ect) 2.4 MoPH coordination meeting 2.5 IT/Telecoms for the field 2.6 Establishing operational team plan and coordination mechanisms with NS - NS mandates, strategic focus & priorities - NS operational capacity (NDRT, BDRT, volunteers, resources ect) 2.7 Operational reporting and communication (Zone)



			- Reporting (Sitrep, DMIS ect) - Media and communication (internal, external)
Module 4: DISASTER RESPONSE: ASSESSMENT, PLANNING & COORDINATION			
Day 3	Field based	Assessment	3.1 Head to the field to carry out EH assessment (theme focus) 3.2 Meeting with community leaders 3.3 Mobilize RC/RC volunteers for EH assessment 3.4 Beneficiary communications 3.5 Carry out EH assessment 3.6 Head back to NS HQs for debrief
Day 4	Field based	Planning & Coordination	4.1 Develop Plan of Action – integrated planning 4.2 Budgeting 4.3 DREF and Emergency Appeal – integrated EA 4.4 Coordination meetings - Cluster coordination - RCRC Movement coordination meeting
Day 5	Field based	Coordination & implementation	5.1 Coordination meetings - MoPH coordination meeting (findings & PoA) 5.2 Preparation of operational emergency health intervention (theme focus) 5.3 Mobilize RC/RC volunteers + carry out training required
Module 5: DISASTER RESPONSE: IMPLEMENTATION			
Day 6	Field based	Implementation	6.1 Head to the field to carry out operational emergency health intervention (theme focus) 6.2 Meeting with community leaders 6.3 Mobilize RC/RC volunteers 6.4 Beneficiary communications 6.5 Carry out operational emergency health interventions (theme focus) 6.6 Head back to NS HQs for debrief
Day 7	Field based	Debrief	7.1 Debrief from Mission

5.5. Secretariat Roles & Responsibilities

Below is a table outlining key roles and responsibilities related to maintaining effective surge capacity. The emergency surge capacity covers three key aspects; i) learning and development, ii) register & roster management, and iii) performance management and iii) supplies & equipment all of which are fundamental to establishing and maintaining an effective, efficient and quality surge tool. Alongside this will also be the need to have in place clear, coherent strategic direction and communication around roles and responsibilities of all key players.



Areas	Roles & Responsibilities	
	Regional Delegation	Zone Office
Learning and development	APEHT Training Delivery Surge emergency response & preparedness capacity building	Operational quality & standards Advisory, advocacy & support
Register & roster management	Register & roster management entry & maintenance Surge emergency response & preparedness capacity building	Operational response & coordination Management, mobilization & deployment
Performance management	Assessment, monitoring & retention Surge emergency response & preparedness capacity building	Operational quality & standards Advisory, management & support
Supplies & Equipment	Pre-positioning equipment & supplies Surge emergency response & preparedness capacity building	Operational quality & standards Operational response & coordination Advisory, advocacy & support

VI. Conclusion and Recommendations

6.1. Conclusion

The humanitarian landscape is changing, alongside what continues to be a competitive growing industry. With increasing presence of regional cooperation mechanisms expanding across the region the question remains, will the RC/RC Movement step up and take the lead in the Asia Pacific region by drawing on its unique advantage over other humanitarian organizations, or will it be left behind?

To truly succeed will require a shift in mind-set. It will require openness and trust by all across the Movement, as well as the ability to know when to pay respect and let go to old traditional habits that are just not as relevant anymore, in order to embrace positive change and exploration of new innovative ways to deal with the complexity of humanitarian crises that lie ahead.

NS in the Asia Pacific region are ultimately the owners of the surge capacity in the region, however this is often not reflected in reality both in terms of ownership, responsibility and alignment between the various surge tools. Greater investment strategically should be directed at national level to scale up NDRT capacity particularly at the branch level given the frequency of disasters occurring being small scale. With resources often drawn for RDRT coming from NDRT, it makes sense to invest and spread this capacity as priority, leaving regional surge capacity more focused on operational leadership roles that support NS and in cases where NS capacity is insufficient mobilizing from the larger RDRT capacity for operational technical support.

If overall effectiveness is to be achieved, all key stakeholders be it NS, IFRC, PNS and others need to be willing discuss openly and challenge some of the more traditional mind-sets that have hindered progress to date, so as to truly move forward with action that is endorsed and supported by all not only in words but also with the necessary resources required



6.2. Recommendations

Emergency Health Preparedness & Response Capacity			
Key area	Key follow up action/deliverable	Timeframe	Responsibility
R1: Strategic Direction	Develop and approve strategy, which clearly articulates emergency health surge capacity in Asia Pacific and its future direction.		Asia Pacific Zone Health Unit
R2: Operational SoPs, Contingency plans	Increase inclusion of emergency health surge within NS SoPs and contingency plans to reflect better the reality of high mobilization rates of emergency health members currently deploying as NDRT, and to reinforce multi-sectorial guidance and operational processes and procedures for future operations.		Asia Pacific Health, DM Zone, Regional Delegations & Country Delegations
R3: Regional, National Surge Capacity	Discuss and agree between Zone, Region & National levels (DM, Health and other specialized disciplines) on the IFRC strategic direction to strengthening overall emergency preparedness and response capacity in Asia Pacific and agree on the distribution of resource allocation to achieve this.		Asia Pacific Zone, Regional National levels

Asia Pacific Emergency Health Training			
Key area	Key follow up action/deliverable	Timeframe	Responsibility
R4: Learning Objectives	Review and clearly define the learning objectives to reflect a more balanced inclusion of knowledge and capabilities, skills, attitudes and values, and behavioural outcomes that are more closely aligned with the overall purpose of the APEHT.		Asia Pacific Zone Health Unit in consultation with DMU, Health Regional Delegations
R5: Training Curriculum & Content	Agree and establish a learning and development pathway that allows the APEHT to be much more harmonized with the RDRT to enhance overall learning and development outcomes for emergency health RDRT members. * refer to the proposed RDRT training pathway model above in report		Asia Pacific Zone Health Unit in consultation with DMU, Health Regional Delegations
	Revise and align the curriculum and content to better reflect the linkages between emergency health and the overall purpose and expected deliverables 'to participate in the assessment, planning, implementation and coordination of timely and appropriate emergency health interventions '.		Asia Pacific Zone Health Unit in consultation with DMU, Health Regional Delegations
	Revise and allocate sufficient time within the design of the curriculum and content for necessary evolutionary learning and development requirements .		Asia Pacific Zone Health Unit
	Revise and establish within the curriculum and content a multi-dimensional methodology that offers the potential to enhance a combination of key competencies and skills that encompasses knowledge and capabilities, skills, attitudes and values, and behavioural outcomes.		Asia Pacific Zone Health Unit
	Establish learning and development assessment framework (Rubrics) to be able to better assess and measure participants learning and development against the learning objectives.		Asia Pacific Zone Health Unit



R6: Methodology	Revise and establish an innovative methodological learning and development model that is dynamic, multi-dimensional and combines e-learning platform (online & webinar), field based and residential components to maximize participants learning and retention of knowledge, competences and skills on key theoretical and practical aspects. * refer to the proposed RDRT training pathway model above in report		Asia Pacific Zone Health Unit in consultation with DMU, Health Regional Delegations
R7: Trainers & Facilitators	Develop a ToT program that equips trainers/facilitators with essential skills and knowledge in adult learning to be able to deliver high quality trainings		Asia Pacific Zone Health Unit in consultation with DMU
	Establish a sufficient pool of qualified and skills regional APEHT trainers/facilitators in each of the regions, which consist of representatives from various NS . This will create opportunities for NS to develop knowledge and skill that can be utilized at a national level too.		Asia Pacific Zone Health Unit & Health Regional Delegations
R8: Selection criteria	Review and remodel the selection criteria to better reflect operational competencies and skill requirements of relevant emergency health profiles.		Asia Pacific Zone Health Unit in consultation with DMU, Health Regional Delegations
	Assess, identify and better align selection criteria with NS existing emergency health profiles and existing gaps so as to strengthen the continuum between emergency health NDRT and RDRT profiles.		Asia Pacific Zone Health Unit & Health Regional Delegations
R9: Selection and recruitment process	Make necessary changes required to the current selection and recruitment process in place in order to be more relevant, robust, transparent and clearly articulates to all, the strict selection criteria framework and agreed conditions related to availability for deployment which nominated candidates must meet and commit to , in order to submit an application.		Asia Pacific Zone Health Unit in consultation with DMU, Health Regional Delegations
	Develop a formal agreement to be signed as part of the final stage of the recruitment process by all parties, which outlines clearly expected roles and responsibilities in committing to being part of the Asia Pacific emergency health surge capacity.		Asia Pacific Zone Health Unit & Health Regional Delegations
	Develop and disseminate a clear communication strategy , which articulates the expected selection and recruitment process and timeframe, shortlisting of candidates, interview and assessment of candidates, final shortlisting, final selection and communication to successful and unsuccessful candidates.		Asia Pacific Zone Health Unit & Health Regional Delegations



Emergency Health Surge Capacity			
Key area	Key follow up action/deliverable	Timeframe	Responsibility
R10: Register Database & Roster Management	Carry out a audit of the emergency health RDRT surge capacity register database from 2002- 2014 to identify existing distribution, relevancy and adequacy of profiles and gaps, total capacity of active and non-active members, NDRT, RDRT trained distribution, gender distribution, history of members NDRT and RDRT deployments and learning and development pathway progression. Profiles should also be matched with the competencies-based framework.		Asia Pacific Zone Health Unit & Health Regional Delegations
	Establish a functional roster management framework with agreements in place with surge members and NS around availability for each month.		Asia Pacific Zone Health Unit & Health Regional Delegations
R11: Emergency Health RDRT members	Discuss and agree with DMU an interim solution for emergency health RDRT members that have been on the waitlist since the APEHT commenced due to insufficient quality and availability of RDRT inductions. A proposed interim solution would be to offer access to the e-learning DM course.		Asia Pacific Zone Health Unit & Health Regional Delegations
R12: Performance management	Develop a competency-based framework to attract, recruit and retain quality talent , incorporating quality and applied application of technical and operational (assessment, planning, coordination and implementation) knowledge and skills.		Asia Pacific Zone Health Unit & Health Regional Delegations
	Assess existing approaches and models, develop and resource a formalized framework for retention of knowledge and skills that encompasses key areas such as: <ul style="list-style-type: none"> • Community of practice which offers emergency health RDRT members a collective environment for continued learning, development and interaction between members; • Coaching and mentoring pre, during, post missions; • Bilateral cooperation agreements between NS in Asia Pacific region • Include emergency health RDRT deployment as a condition tied to accessing DREF 		Asia Pacific Zone Health Unit in consultation with DMU
R13: Emergency Response Units (FMTs, MHTs)	Assess, analyse and develop a research paper on medical mobile units that looks into current trends in Asia Pacific region, models and approaches, strengths, dynamics and key considerations.		Asia Pacific Zone Health Unit
	Carry out strategic level workshop between, the Health Unit and key NS in Asia Pacific region with existing and with interest in future potential operational surge capacity in the form of national ERUs (Medical Mobile Teams). The aim of this strategic workshop should be to discuss and identify ways of moving forward by taking into account the following aspects; <ul style="list-style-type: none"> • Mapping out current and future planed operational MHT capacity; 		Asia Pacific Zone Health Unit



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	<ul style="list-style-type: none"> • Lessons learned from experienced NS in the region that have had in place such operational capacity long term (Afghanistan, Pakistan, Japan); • Added value of the APEHT contributing to in strengthening emergency health preparedness and response capacity; • Future implications for RDRT emergency health surge capacity if NS with operational ERU surge capacity would prefer use their resources to deploy bilaterally; • Agreement on plan of action moving forward. 		
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RDRT System			
Key area	Key follow up action/deliverable	Timeframe	Responsibility
R14: Strategic Direction	Develop and establish an Asia Pacific surge capacity strategy, which clearly articulates the future strategic direction of the Asia Pacific surge capacity tools (BDRT, NDRT, RDRT) and operational national ERUs/MHTs.		Asia Pacific DMU
R15: RDRT & Specialization Trainings Pathway	Discuss in RDRT taskforce the evolutionary process of the RDRT induction and specialized trainings (such as APEHT and others) and agree on a comprehensive integrated RDRT/Specialization trainings learning and development framework that aligns the set curriculum, content and learning objectives within the various trainings to avoid duplication across the various disciplines and instead enhance overall learning and development outcomes in a more harmonized way.		Asia Pacific Zone Health Unit, DMU & RDRT Taskforce
	Combine resources that advance the establishment of a quality APEHT and broader RDRT learning and development framework.		Asia Pacific Zone, Health Unit & DMU
	Discuss in RDRT taskforce and agree on a standardized selection and recruitment process which aligns the RDRT, APEHT and specialized trainings to ensure there is consistency and transparency of the process to all stakeholders; this will also avoid setting precedence between the various disciplines.		Asia Pacific Zone, Health Unit, DMU & RDRT Taskforce
R16: RDRT Register Database & Roster Management	Discuss in RDRT taskforce and agree on a establishing a comprehensive Register Database & Roster Management System. Agree on the key aspects that need to be captured as information for RDRT surge, but also look beyond to take into account capturing NDRT surge as well.		Asia Pacific Zone, Health Unit, DMU & RDRT Taskforce
R17: Performance management	Discuss in RDRT taskforce establishment of a robust performance management system that is able to assess overall success, measure performance across the training pathway continuum, monitor operational application and retention of knowledge and skills of individuals and teams.		Asia Pacific Zone, Health Unit, DMU & RDRT Taskforce



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R18: Strengthening relationships, engagement and communication	Develop an integrated communications and advocacy strategy and disseminate out to NS. It is imperative the key NS representatives respected in the region are identified and supported as being leading advocates for disseminating such key messages alongside regional and zonal staff.		Asia Pacific Zone, Health Unit & DMU
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Annex 1. Terms of reference

Purpose

To review the Asia Pacific Emergency Health Training (APEHT) conducted by the International Federation of Red Cross and Red Crescent Societies (IFRC) Asia Pacific zone office during 2010 - 2013.

Background

Asia Pacific is the most disaster-prone region in the world, with natural disasters causing more deaths and damage every year. Timely deployment of qualified people is vital to avoid delay in delivering emergency assistance in the areas of relief materials distribution, health, WatSan, shelter, logistics, communications, etc. The APEHT aimed to enhance the IFRC's emergency health preparedness and response capacity in the Asia Pacific by preparing a pool of medical/public health professionals who can be deployed in timely manner. The trained professionals can participate in a variety of emergency health activities such as needs assessment, program planning and coordination of emergency health interventions. The training design were based on the objectives of further develop the RDRT system by increasing the number of health professionals in the pool as well as enhancing the emergency health capacities of people already existing in the pool.

Since 2005, the National Societies and IFRC regional delegations in Asia Pacific (AP_ conducted a series of emergency health trainings under the name of "Public Health in Emergencies (PHiE) training" which expanded proportion of health professionals in the RDRT roster and built up capacities of members of National Societies in undertaking emergency health programs. During 2005 to 2008, four regional trainings (two in East-Asia, one in South-Asia and one in South East-Asia) took place in Asia Pacific. Globally, the PHiE trainings were also conducted in other regions including the Americas, Africa and the Middle East and North Africa. In 2008, a review was conducted by the IFRC Secretariat's Emergency Health Unit to identify lessons learnt, improvement areas and to suggest a way forward. The reviewed areas encompassed selection and evaluation of participants, content and curriculum, methodology, trainers, funding, follow-up of participants, partners and duties and monitoring and evaluation.

After the review in 2008, the IFRC Asia Pacific zone office formulated a new training curriculum on emergency health training for the Asia Pacific. The design of the new curriculum was based on the lessons learnt in previous years and the review conducted by the IFRC Secretariat's Emergency Health Unit.

The new training led by the IFRC Asia Pacific zone office is named as Asia Pacific Emergency Health Training (APEHT). The revised training assured a system linking the emergency health and Regional Disaster Response Team (RDRT) trainings for further qualification of participants in additional disaster management aspects. The launch of the first APEHT took place in 2009 with Singapore Red Cross as the host National Society. The second and third trainings were held in the Philippines (2011) and Hong Kong (2013).

More than 60 participants from the Asia Pacific National Societies were trained in the APEHT from 2011 to 2013. Some participants were involved, before or after the training, in various kinds of health activities at national, regional and global level for the IFRC or other aid organizations while



there were trained participants who were not involved in any health operation over the past few years. This review exercise will look into how the APEHT contributed to the preparing a pool of medical/public health professionals to enhance the IFRC's emergency health preparedness and response capacity in AP.

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

Strategic aim 2: Enable healthy and safe living

As an effort to prepare the pool size of medical/health professionals with the required skills and knowledge in coping with health emergencies, the APEHT contributes to building the capacities of the IFRC in coping with emergency health needs at domestic and regional levels. With emerging health needs and challenges, continuous review, improvement and learning are vital to ensure quality standards and outcomes.

Project objectives

The overall objectives of this assignment is to review the APEHT to report Key Findings, Factors Contributing to Success, Factors Hindering Success, Factors maximising its potential, Key Learning, Recommendations for future directions.

The **scope** of the review will cover:

- To determine the extent to which the APEHT is contributing to the capacity building of participants and National Societies in responding to emergency health needs domestically and regionally
- To determine the effectiveness, efficiency and quality of the APEHT to equip the participants with the required knowledge to carry out their tasks of emergency health operations
- To determine future direction and next step in emergency health training development

Objectives and key evaluation questions are:

To assess the relevance of the APEHT:

- 1.1. To have an in-depth assessment of the training modules and methodologies.
- 1.2. To assess the relevance of the APEHT in building up the required knowledge of participants to undertake IFRC emergency health activities and to what extent the APEHT was relevant?
- 1.3. To assess how and to what extent the APEHT was filling the existing knowledge gaps of selected participants in delivering the expected health services.
- 1.4. To assess the recruitment and selection process of participants in terms of relevance and effectiveness.

To assess the effectiveness, efficiency and quality of the APEHT:

- 2.1. To what extent the training outputs, objectives, outcomes, performance indicators and evaluation been achieved? What are the quality and quantities of those elements?
- 2.2. To assess the effectiveness and efficiency of the APEHT and to what extent (e.g. training contents, curriculum, methodologies, plans, during, quality, facilitators, venues, equipment) the APEHT was effective and efficient?
- 2.3. To identify difficulties and challenges of the APEHT in achieving the training objectives?
- 2.4. To assess the quality of the APEHT and to what extent the quality was contributing to the outcomes?
- 2.5. To assess the effectiveness of the performance assessment of participants at the end of the



APEHT.

To assess the impact and sustainability of the APEHT:

- 3.1. To determine if trained participants were able to utilize the knowledge obtained from the APEHT in their emergency health work and to what extent and where the knowledge was applied?
- 3.2. To assess the sustainability of the impact of APEHT and to determine how can the sustainability be ensured
- 3.3. To identify and describe mechanism to sustain as well as further strengthen the established capacity of trained participants
- 3.4. To assess post-training follow-up and opportunities for trained participants and to determine potential learning opportunities
- 3.5. To identify other enabling factors which contribute to developing IFRC's staff and volunteers' capacities and competencies in emergency health operations

To identify lessons learnt and areas of improvement for future directions:

- 4.1. What are the areas of improvement for the IFRC in developing training plans for future direction?
- 4.2. To suggest a training plan (framework, methodologies and modules) for the way forward?

Desired outcomes

The IFRC particularly the Asia Pacific zone have identified key improvement areas and a way forward to develop training plans to strengthen their preparedness and response capacity to health emergencies.

Consultancy outputs

The consultant will be expected to produce the following deliverables:

- Inception report: A 2-3 page inception report consistent with the terms of reference detailing scheduling and study design including methodology, tools, interview guides and proposed outlines of the report.
- Draft report: A draft report summarising findings for discussion and consultation with the IFRC Health Unit in Asia Pacific zone.
- Final report with a proposed training plan: The final report (25-30 pages) with similar contents and outlines as the draft report (but including changes/corrections as requested by the IFRC) with a detailed description of the review methodologies and limitations, findings in relation to the evaluation scope, conclusions, lessons learned and clear recommendations. A proposed training plan for a way forward will be included in the final report.

Duration: The consultant will undertake 25 full days of work as divided as appropriate over the project timeframe of four weeks.

Timeframe: The consultant's work will take place between October/November 2014 and the consultant will hand in the final report by 30 November 2014.



Consultant's outputs	Timeline
- Review of documents and preparation of inception report	3 days
- Developing of tools and preparation of data collection	4 days
- Data collection and analysis of data	10 days
- Draft report, debriefings and feedback collection	5 days
- Finalization of the report based on management response and feedback	3 days

Method of delivery and reasons for selecting that method

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

1. **Utility:** Evaluations must be useful and used.
2. **Feasibility:** Evaluations must be realistic, diplomatic, and managed in a sensible, cost effective manner.
3. **Ethics & 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.
4. **Impartiality & Independence;** Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.
5. **Transparency:** Evaluation activities should reflect an attitude of openness and transparency.
6. **Accuracy:** Evaluations should be technical accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be determined.
7. **Participation:** Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.
8. **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.

Support to be provided to the consultant

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

- Detailed briefings and information support throughout the whole period
- Relevant documents and data
- Connection with relevant people and contact lists
- Cost on communications such as IDD, mailing fee, etc. (The cost of standard IT and telecommunication equipment such as laptop and mobile phone shall be borne by the consultant)
- Administrative support

Schedule for payment of fees

(Indicate deliverables and timeframe, e.g. milestones, reporting deadlines, etc.) The fee shall be paid upon satisfactory completion of the work in accordance with these terms of reference and the consultancy agreement between the consultant and the IFRC.



Time Allocation, for budget purposes

As mentioned above.

Management of consultancy

Management:

The consultant team will report to the Health Unit of the IFRC Asia Pacific zone Office, with the Emergency Health Coordinator as the focal person. Health advisers in IFRC selected 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 final evaluation report should be delivered no later than 30 November 2014.

Required qualifications of consultant:

Selection of the external evaluation consultant will be based on the qualifications outlined below. The IFRC would also look for one to two National Societies team members who have a level of evaluation, public health and emergency health experience to join the evaluation team. The required qualifications of the external consultant are:

- Minimum qualification of a master degree or equivalent combination of education in public health or similar and relevant work experience;
- Minimum of 10 years in humanitarian or development work;
- Good understanding of the International Red Cross and Red Crescent Movement;
- Demonstrated experience with proven record in research and evaluation of public health programs particularly trainings and capacity building programs;
- Demonstrated experience in planning and implementing health related training programs in the humanitarian settings;
- Proven experience and knowledge about the situation of human resources for health emergencies in the humanitarian settings;
- Strong analytical skills and ability to clearly synthesize and present findings, draw practical conclusions, make recommendations and to prepare well-written reports in a timely manner;
- Knowledge of the Asia and Pacific region, and experience in working with the Red Cross and Red Crescent would be an advantage;
- Immediate availability for the period indicated Interested candidates should submit their application material by 28 October 2014 to: eva.lam@ifrc.org. Application materials should include:
 - Cover letter clearly summarizing your experience as it pertains to this assignment, your daily rate, and two to three professional references
 - One to two examples of an evaluation report that candidate has prepared in the past



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Annex 3. Guidelines for key informant interviews

1. Interview guideline for key informants from IFRC Geneva

<p>Purpose:</p> <ol style="list-style-type: none"> 1. To understand the global strategic direction of strengthening NS emergency preparedness and response capacity to PHiE. 2. To assess the relevance, effectiveness, efficiency, impact and lesson-learned of the Asia/Pacific Emergency Health Training. 	
Question focus	Questions
Relevance	<p>Training curricula and content</p> <ol style="list-style-type: none"> 1. How relevant has the APEHT curricula and content (modules, methodology ect.) been in developing the regional capacity of NS in emergency health to be deployable under RDRT, taking into account emerging trends in the Asia Pacific zone, and existing gaps in emergency preparedness and response? 2. To what extent has the APEHT been consistent with the global strategic direction of PHiE capacity building of NS? 3. What relevance do you see the e-learning platform health topics contributing to the global strengthening of NS emergency preparedness and response capacity? <p>Selection and recruitment process</p> <ol style="list-style-type: none"> 1. To what degree is there alignment and standardization between the APEHT approach in the selection criteria and recruitment process to that of other zones globally? Factors responsible for achievements and challenges?
Effectiveness, efficiency and quality	<p>Delivery of Emergency Health Training</p> <ol style="list-style-type: none"> 1. What are some of the factors (both positive and negative/challenges) that have contributed to the effectiveness and efficiency in the delivery of EH training across the zones? How effective and efficient has the APEHT compared with other zones? <p>Emergency health response capacity</p> <ol style="list-style-type: none"> 1. What are some factors (both positive and negative/challenges) that have contributed to the effectiveness and efficiency of the global approach to strengthening NS EH capacity in responding to PHEs? <p>Surge deployment mechanisms</p> <ol style="list-style-type: none"> 1. How effectively and efficiently have EH trained personnel been mobilized



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	<p>globally throughout the various zones EH and DM surge capacity mechanisms?</p> <p>2. To what extent are such EH and DM surge capacity mechanisms aligned and standardized to support NS emergency preparedness and response capacity?</p> <p>3. Key achievements and challenges?</p>
Impacts and sustainability	<p>1. What have been some of the positive and negative changes that have occurred as a directly or indirectly of the APEHT, compared to other zones?</p> <p>2. What key aspects would you recommend for consideration towards sustainability of strengthened emergency preparedness and response capacity of NS to PHiEs at a national, regional and global level?</p> <p>3. What role do you see the AP Health Unit/APEHT contributing towards such sustainability?</p>
Lesson learned and areas of improvement	<p>1. What areas of improvement do you envisage is required in the Asia Pacific zone to maximize the impact of APEHT, and the effectiveness and efficiency of emergency preparedness and response capacity regionally and nationally?</p> <p>2. What areas of improvement do you envisage is required globally to maximize the impact of NS to respond effectiveness and efficiency to PHEs regionally and nationally using an innovation model?</p>

2. Interviews with IFRC AP Zone

<p>Purpose:</p> <p>1. To understand the AP zone's operational strategic focus in the strengthening emergency preparedness and response capacity to PHiEs.</p> <p>2. To assess the relevance, effectiveness, efficiency, impact and lesson-learned from APEHT.</p>	
Question focus	
Relevance	<p><u>AP Zone DMU</u></p> <p>Training curricula and content</p> <p>1. How relevant is the APEHT (modules, methodology ect.) in taking into account emerging trends in the Asia Pacific zone, and existing gaps in emergency preparedness and response requirements for RDRT deployments?</p> <p>2. To what degree have the APEHT and RDRT training's core curricula been aligned to ensure complementary of necessary of skills and knowledge development required to strengthen AP emergency preparedness and</p>



response capacity regionally and nationally?

Selection and recruitment process

1. What is the rationale behind the current RDRT selection criteria and recruitment process?
2. How relevant is the current selection and recruitment process in nominating the most relevant candidates for RDRT? Factors responsible for achievements and challenges?
3. To what degree is there alignment between the RDRT system and Specialized RDRT elements such as APEHT with selection criteria and recruitment process?

AP Zone Health Unit

Training curricula

1. How relevant is the APEHT (modules, methodology ect.) in taking into account emerging trends in the Asia Pacific zone, and existing gaps within NS capacity in emergency preparedness and response? – What have been the most prevalent gaps of NS in PHiE? How have they been incorporated into the APEHT?
2. How relevant is the learning objectives of the APEHT in strengthening required skills and knowledge development of EH trained participants to respond to PHEs regionally and nationally? (*technical skills and knowledge development, understanding of DM cycle and role within the surge team and operational capacity – role/responsibility individually and within team*)
3. To what degree have the APEHT and RDRT training's core curricula been aligned to ensure complementary of necessary of skills and knowledge development required to strengthen AP emergency preparedness and response capacity regionally and nationally?

APEHT selection and recruitment process

1. What is the rationale behind the current APEHT selection criteria and recruitment process?
2. How relevant is the current selection and recruitment process in nominating the most relevant candidates for the APEHT? Factors responsible for achievements and challenges?
3. How relevant and aligned is the selection criteria to the skills and competencies required of EH participants to respond to health emergencies?
4. What mechanism is currently in place to track APEH trained member's frequency of deployments (post APEHT) nationally and regionally? How has such information been used in guiding ongoing adaptation and strategic



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	<p>direction of the APEHT and AP emergency preparedness and response capacity?</p> <p>5. To what degree is there alignment between the RDRT system and Specialized RDRT elements such as APEHT with selection criteria and process?</p>
<p>Effectiveness, efficiency and quality</p>	<p><u>AP Zone DMU</u></p> <p>Delivery of RDRT training</p> <p>1. What are some of the factors (both positive and negative/challenges) that have influenced the effectiveness and efficiency of RDRT implementation and achievement of intended objectives and outcomes? (<i>training content, methodology - online, F2F, simulation, facilitators - # ToT?, equipment</i>) – overlapping with ERU, RDRT, Field School/NDRT trainings</p> <p>2. How cost efficient is the RDRT in relation to the overall expected results?</p> <p>3. To what extent have the RDRT, APEHT, field school and other specialized surge trainings been effective and efficient in pooling resources where alignment of objectives are the same to enhance performance management of NS staff mobilized for emergency response regionally or nationally?</p> <p>4. What mechanisms have been put in place between AP DMU and AP Health Unit to ensure alignment of the career development of NS EH trained personnel to access RDRT training?</p> <p>Surge deployment mechanisms</p> <p>1. What do you consider key elements of an effective deployment of an RDRT deployment, which includes specialized EH trained member/s?</p> <p>2. What are some of the factors (positive and negative/challenges) that have influenced the effectiveness and efficiency of Asia Pacific’s surge deployment mechanisms, such as RDRT, and specialized pool members? (<i>Zonal, regional and national levels</i>)</p> <p>3. How efficiently have EH trained personnel been mobilized for RDRT deployments? What mechanisms have been put in place between APDMU and AP Health unit? What are some of the key factors (positive/negative/challenges) that have influenced the effectiveness of EH trained personnel to be mobilized regularly through RDRT deployments? (<i>Zonal, regional, national factors</i>)</p> <p>Emergency health response capacity</p> <p>1. To what extent (positive and negative) has the APEHT been effective and efficient in contributing to EH trained personnel for RDRT deployments to respond effectively in PHEs in the Asia Pacific?</p>



	<p><u>AP Zone Health Unit</u></p> <p>Delivery of APEHT</p> <ol style="list-style-type: none"> 1. What are some of the factors (both positive and negative/challenges) that have influenced the effectiveness and efficiency of APEHT implementation and achievement of intended objectives and outcomes? (<i>training content, methodology - online, F2F, simulation, facilitators - # ToT?, equipment</i>) – overlapping with ERU, RDRT, Field School/NDRT trainings 2. How cost efficient is the APEHT in relation to the overall expected results? 3. To what extent has the APEHT, RDRT, field school and other specialized surge trainings been effective and efficient in pooling resources where alignment of objectives are the same to enhance performance management of NS staff mobilized for emergency response regionally or nationally? 4. What mechanisms have been put in place between AP DMU and AP Health Unit to ensure alignment of the career development of NS EH trained personnel to access RDRT training? <p>Surge deployment mechanisms</p> <ol style="list-style-type: none"> 1. What do you consider key elements of an effective deployment of an RDRT deployment, which includes specialized EH trained member/s? 2. What are some of the factors (positive and negative/challenges) that have influenced the effectiveness and efficiency of Asia Pacific’s surge deployment mechanisms, such as RDRT, and specialized pool members? (<i>Zonal, regional and national levels</i>) 3. How efficiently have EH trained personnel been mobilized for RDRT deployments? What mechanisms have been put in place between AP DMU and AP Health Unit? What are some of the key factors (positive/negative/challenges) that have influenced the effectiveness of EH trained personnel to be mobilized regularly through RDRT deployments? (<i>Zonal, regional, national factors</i>) <p>Emergency health response capacity</p> <ol style="list-style-type: none"> 1. To what extent (positive and negative) has the APEHT been effective and efficient in contributing to EH trained participants skills development and capacity to respond effectively in PHEs in the Asia Pacific regionally and nationally?
<p>Impacts and sustainability</p>	<p><u>AP Zone DMU</u></p> <p>Professional development, retention of EH specialized skills and knowledge</p> <ol style="list-style-type: none"> 1. To what extent has the RDRT established a quality assurance mechanism to track the quality of skills retained and frequency of utilization of EHT



	<p>personnel through RDRT deployments?</p> <p>2. What have been some of the factors (positive/negative/challenges) that have influenced the overall impact and learning opportunities of AP emergency preparedness and response capacity?</p> <p>APEHT impact and sustainability</p> <p>1. What have been some of the unanticipated positive and negative changes that have arisen directly or indirectly from the RDRT system?</p> <p>2. What have been some of the critical factors responsible for achievements and challenges of the RDRT overall impact and sustainability?</p> <p><u>AP Zone Health Unit</u></p> <p>Retention of EH specialized skills and knowledge</p> <p>1. To what extent has the APEHT established a quality assurance mechanism to track the quality of skills and competencies retained and frequency of utilization of EHT personnel through national and regional emergency response surge deployment in measuring the overall performance management of EH trained personnel?</p> <p>2. What have been some of the factors (positive/negative/challenges) that have influenced the overall impact and learning opportunities of AP emergency preparedness and response capacity?</p> <p>APEHT impact and sustainability</p> <p>1. What have been some of the unanticipated positive and negative changes that have arisen directly or indirectly from the APEHT?</p> <p>2. What have been some of the critical factors responsible for achievements and challenges of the APEHT overall impact and sustainability?</p> <p>3. How do you see APEHT being sustained long term with the necessary resources required (HR, financial ect.)? What additional resources do you feel are required to further develop the APEHT?</p>
<p>Lesson learned and areas of improvement</p>	<p>1. What areas of improvement do you envisage is required in Asia Pacific zone to maximize the impact of APEHT, and the effectiveness and efficiency of emergency preparedness and response capacity regionally and nationally?</p> <p>2. What areas of improvement do you envisage is required in Asia Pacific zone between the DMU, Health unit and other specialized sectors to maximize the impact, effectiveness and efficiency of emergency preparedness and response capacity regionally and nationally using an innovation model?</p>

3. Interviews with NS



Note: It is expected previously trained or deployed APEHT participants will join the interviews.

Purpose:

1. To understand how relevant and effective the APEHT has been in meeting the needs of NS emergency health preparedness and response capacity to respond to EH need nationally and regionally.
2. To assess NS's priorities and needs for future capacity building in PHiE taking into account emerging trends national and regionally.

Question focus	Questions
Relevance	<ol style="list-style-type: none"> 1. Please describe you NS's current emergency preparedness and response capacity to respond to emergency health needs nationally and regionally? (Skills & Knowledge, APEH trained) 2. To what degree has the APEHT strengthened your NS's capacity to be better prepared to respond to emergency health needs nationally and regionally? (Capacity taking into account DM cycle, systems, procedures, roll out nationally of EHT)?
Effectiveness, efficiency and quality	<ol style="list-style-type: none"> 1. What is your perception of an effective deployment of NDRT or a NDRT specialized in emergency health? What factors are needed to allow an effective deployment of NDRT specialized in emergency health? 2. Has your NS deployed trained EHT participants nationally or regionally in PHEs? How has your National Society utilized these skills and knowledge of trained APEHT participants? If yes, what was learnt as a result? If not, why not? Key factors hindering? Was the person sufficient in leading the assessment and developing plan of action for emergency health? Was the person sufficient in working in collaboration with other sectors involved in emergency response?
Impacts and sustainability	<ol style="list-style-type: none"> 1. What have been some of the positive and negative changes produced as a result of EHT participants having been trained under the APEHT? 2. To what extent has your NS taken steps to take into consideration sustainability of such capacity in PHiEs?
Lesson learned and areas of improvement	<ol style="list-style-type: none"> 1. Reflecting on your NS experience of the APEHT what areas for suggestion could be further strengthened in building capacity of EH participants to respond to PHEs nationally or regionally? 2. What areas are of priority for your NS to further improve in emergency preparedness and response capacity to respond in PHEs in the future?

4. Interviews with partner NS



Purpose:

1. To understand the strategic interest, priorities and perspective of partner national societies whom have supported long term initiatives in and/or emergency preparedness and response, emergency health capacity building at national, regional or zonal levels. (NDRT, field school, APEHT, RDRT ect.)
2. To understand the perspective and priorities of partner national societies in contributing to the sustainability of APEHT and a pool EH trained RDRT members.

Question focus	Questions
Relevance	<ol style="list-style-type: none"> 1. How have you seen the APEHT contributing towards strengthening emergency preparedness and response capacity throughout the Asia Pacific? 2. What is your opinion about current capacity building for NS in Asia Pacific region in PHIE?
Effectiveness, efficiency and quality	<ol style="list-style-type: none"> 1. To what extent do you feel that the AP RDRT system is meeting its key objectives and outcomes? What are some of the key achievements and areas for improvement? 2. In your opinion, is there a variation in sectoral capacity and knowledge in RDRT pool? If so, please elaborate.
Impacts and sustainability	<ol style="list-style-type: none"> 1. What have been some positive and negative changes produced as a result of the AP RDRT system when considering emergency preparedness and response capacity? 2. To what degree has the importance of sustainability of the RDRT system in the AP zone, regionally and nationally been considered over the years? What measures have been put in place with this in mind?
Lesson learned and areas of improvement	<ol style="list-style-type: none"> 1. What areas within the RDRT system require the most improvement? (roster, data management, sharing information, coordination ect.) 2. What role do you see partner NS playing in further developing and sustaining the AP RDRT capacity?

5. Interviews with MoPH/IFRC country delegation

Purpose: To understand the MoPH strategic priorities and perception of a NS and its effectiveness to respond nationally to PHEs, and areas of potential improvement.

Question focus	Questions
Relevance	<ol style="list-style-type: none"> 1. To what extent to you see the NS emergency preparedness and response capacity in emergency health?



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Effectiveness, efficiency and quality	1. How effective has the NS emergency health capacity been in supporting the MoPH when responding to PHEs?
Impacts and sustainability	1. How do you describe the relationship between MoPH and NS in the area of public health response to emergency situations? 2. What have been some positive and negative changes produced as a result of collaborative efforts between NS and MoPH in PHEs?
Lesson learned and areas of improvement	1. What areas do you see could be further strengthened in building emergency preparedness and response capacity between MoPH and NS?

6. Interviews with previously trained APEHT participants who have been deployed and/or have not been deployed nationally, regionally and internationally

Purpose: To understand how APEHT has contributed to providing skills and knowledge development to those have been deployed as RDRT or NDRT health specialists comparing to those have not been deployed.

Question focus	Questions
Relevance	1. How relevant has APEHT been in providing you with the necessary skills and knowledge required to deploy and respond effectively to health emergencies regionally or nationally?
Effectiveness, efficiency and quality	1. How well did the APEHT prepare you to deploy and respond effectively as a emergency health specialist as part of a RDRT, NDRT member or internationally? 2. In what areas do you feel you were most effective in responding to an emergency as a RDRT or NDRT member as a result of the skills and knowledge development received under the APEHT? 3. In what areas to you feel that you were less effective in responding to an emergency as a RDRT or NDRT member that needs further strengthening and that was lacking from the skills and knowledge opportunities offered under the APEHT?
Impacts and sustainability	1. What have been some of the positive and negative changes produced as a result of having received the APEHT for emergency health specialists deploying as RDRT or NDRT members?
Lesson learned and areas of improvement	1. What areas do you see could be further strengthened in building emergency preparedness and response capacity for RDRT and NDRT health specialists?



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Annex 4. List of key informant interviews

RCRC NS:

1. Clara Dadulla, Focal Person for Community-Based Health and First Aid, Philippines RCS
2. Deidre Ballinger, Austrian Red Cross ALLINGER
3. Evelyn Paasa, Afghan Red Crescent Society
4. Karen Poon, Hong Kong Red Cross
5. Saliab Ayubi, Afghan Red Crescent Society
6. Vu Huu Tuyen, Health Program Officer, Vietnam Red Cross
7. Dao Thanh Tam, Director of Health Department, Vietnam Red Cross

Former APEHT participants:

8. Ingrid Mijlof, Delegate of the Netherlands Red Cross, former AHETP training
9. Susan Fanton, Delegate, IFRC Delegation in Vietnam
10. Bhanu Pratap, Health Delegate, IFRC Delegation in Philippines

MoPH:

11. Lien Pham, Former Director, National Center for Health Promotion and Communication, Ministry of Health of Vietnam

IFRC

12. Abhishek Rimal
13. Amanda McClelland
14. Annemaree Delaney, Regional Disaster Management/Health in Emergencies Delegate, IFRC regional delegation in Pacific
15. Baktiar Mambetov
16. Hong Chen
17. Jay Matta
18. Jim Catampongan
19. Kathryn Clarkson
20. Leif Jonsson
21. Manish Pant
22. Nelson Casatano
23. Sanjeev Kafley,
24. Van Nguyen
25. Vijaykumar Ummidi
26. Vuli Gaula, Disaster Management Delegate, Pacific