2024

Handbook
Public Health ERU
Community Based Surveillance (CBS)

Norwegian **Red Cross**

Contents

Abbreviations

AWD Acute Watery Diarrhea
CBHFA Community Based Health and First Aid
CBS Community Based Surveillance
CCMC Community Case Management of Cholera
CEA Community Engagement and Accountability
CP3 Community Epidemic and Pandemic Preparedness Program
CTC Cholera Treatment Center
DREF Disaster Response Emergency Fund
DRM Disaster Response Management
ECV Epidemic Control for Volunteers
EoM End of Mission Report

EMT Emergency Medical Teams
EPoA Emergency Plan of Action
ERU Emergency Response Unit
EVD Ebola Viral Disease
EWARS Early Warning and Response System
FAD Finance and Administration
GPS Global Positioning System
HMIS Health Management Information System
HP Health Promotion
ICRC International Committee of the Red Cross
IDSR Integrated Disease Surveillance and Response
IFRC International Federation of Red Cross and Red Crescent Societies

IGER Implementation Guide for Epidemic Response IPC Infection and Prevention Control
M&E Monitoring and Evaluation
MoH Ministry of Health
NGO Non-Governmental Organization
NS National Society
ORP Oral Rehydration Point
ORS Oral Rehydration Salt
PH Public Health
PH ERU CBS: Public Health Emergency Response Unit with community-based surveillance
PNS Partner National Society
RC Red Cross or Red Crescent
SBCC Social Behavioural Change Communication
SIM Subscriber Identification Module
SMS Short Message Service
SOP Standard Operating Procedures
TL Team Leader
ToR Terms of Reference
TWG Technical Working Group
WASH Water Sanitation and Hygiene
WHO World Health Organization
WORC World of the Red Cross

Terminology

Alert: the message sent by the platform or by an individual to one or several pre-defined people in the CBS hierarchy, when the number of reports has reached a pre-agreed threshold (e.g. 1 for Ebola or measles, but a higher number for acute watery diarrhea (AWD)).

Case: this is part of the facility-based surveillance system and usually refers to clinically or laboratory confirmed cases of a disease.

Signal/Rumor/Report: this is the term for the primary message transmitted from the volunteer to its supervisor on a person in the community who has signs and symptoms meeting the community case definition for a specific health risk. A report can also be a message of an unusual event (group of animal or human deaths, floods, fires, etc.), as per the particular CBS protocol in that NS.

PART I Concept and context

1. Introduction

How to read this handbook

This handbook is intended for:

a) Delegates trained in Community Based Surveillance or with equivalent experience and knowledge, who will be deployed as part of the Public Health Emergency Response Unit with community-based surveillance (PH ERU CBS) or as part of a modular PH ERU, for which one of the modules would be CBS.

b) National Society (NS) staff who will be involved in the set up and/or running of a PH ERU CBS or as part of a modular PH ERU that includes CBS.
c) Partner National Societies who wish to hold a PH ERU CBS module.

The handbook intends to be a guideline for understanding a PH ERU CBS. It is complemented by several other documents, which are mostly focused on CBS in non-emergency contexts, with which the reader should become familiar. These documents are cited repeatedly throughout the handbook.

BOX 1. KEY CBS DOCUMENTS TO KNOW

- IFRC. The CBS Guiding Principles. 2017 (revised version 2020). Available in English, French and Spanish[1]

- IFRC. CBS Assessment Tool and Template. Not published, for internal use only. Available from PH ERU CBS trainers[2]

- IFRC. CBS Protocol tool. Not published, for internal use only. Available from PH ERU CBS trainers[3]

This handbook is divided into 3 sections, as follows:

Part 1 – Concept and context (chapters 1 to 3) lays out the conceptual framework that supports the development of PH ERU's, including strategic frameworks, guiding principles, and minimum standards. It then focuses on the concept of the PH ERU CBS configuration, explaining what CBS is, the ERU's activities and objectives, how it integrates with other ERUs, and how it can be linked with other types of surveillance systems.

Part 2 – Operational Framework (chapters 4 to 6) lays out the information needed by ERU deploying National Societies to develop and maintain their PH ERU CBS, including human resources needed, training, equipment and financial resources.

Part 3 – Operational Management (chapter 7), is intended for deploying National Societies as well as delegates, as it details the deployment phases, and explains key issues and procedures.

The document was revised in December 2024, as the result of coordination between the International Federation of Red Cross and Red Crescent (IFRC) technical lead and the Norwegian Red Cross, a member of the Global Surge Working Group (GSWG) and the CBS Technical Working Group, whose aim is to maintain up to date standards of the ERU regarding trainings, staff, equipment needed and according to operational objectives.

Background–development of Public Health ERUs

The IFRC and Red Cross partners (collectively referred to as 'the Movement') have long acknowledged the impact of disasters on the health of populations and the importance of disease outbreaks at local, regional and global levels.

[1] Community-Based Surveillance: Guiding Principles | Community Based Surveillance
[2] IFRC CBS assessment tool
[3] IFRC CBS protocol template

The Movement has not only vast experience in emergency response but also in preparedness, recovery and development. The Movement is a major player among humanitarian organizations and has the world's largest network of volunteers and staff. Collectively, it has also the largest pool of trained and experienced specialists[4] ready to deploy within short notice. The IFRC has been coordinating the deployment of Health Emergency Response Units (ERUs) since 1996.

During annual technical working group meetings, IFRC and ERU National Societies (NS) have observed that clinical care alone in an emergency setting is not enough to mitigate health risks at the community level, suggesting a need for public health-focused tools.

Moreover, the International Red Cross and Red Crescent Movement[5] has been a major player in some of the largest outbreak responses such as the Ebola outbreaks in Uganda or Democratic Republic of the Congo, the cholera outbreaks in Somalia and Haiti, as well as smaller scale epidemics including the plague outbreak in Madagascar, cholera in Malawi or Ghana and many others. In 2017, the Council of Delegates of the International Red Cross and Red Crescent Movement, the IFRC and NSs committed to strengthen effective community engagement in disease outbreak prevention and response.

The Red Cross and Red Crescent Movement believes that epidemic preparedness and response begins and ends with and in communities. Community-driven efforts are essential to prevent, detect and respond to infectious disease threats, especially when government actions may face delays or limitations[6].

In this context, a review of lessons learnt has led to the recommendations for improved RCRC Movement Public Health response capacity. To ensure the IFRC RCRC Movement remains 'fit for purpose' and can meet the demands of global trends and requests for support from National Societies, multi sectoral Public Health (PH) ERU configurations have been proposed.

IFRC in collaboration with ERU NSs have outlined seven spheres of activities that are needed in order to better respond to public health emergencies, that have been submitted to the Global Surge Working Group, the Human Resources Group for International Deployment of Delegates and the Disaster Management Working Group[7].

Four standalone, multi-sectoral PH ERU configurations have been prioritized for development and deployment:

1. Community Case Management of Cholera (CCMC)

3. Community Based Surveillance (CBS)

4. Safe and Dignified Burials (SDB)

6. Infection and Prevention Control

[4] The pool consists of specialists from diverse domains needed in order to respond to emergencies, including health, WASH, logistics, finance/admin, IT, communication and others.
[5] Further in the text, the Red Cross and Red Crescent Movement will be referred to as the Movement.
[6] IFRC, Council of Delegates of the International Red Cross and Red Crescent Movement; Working towards an International Red Cross and Red Crescent Movement Approach to Epidemics and Pandemics, Resolution, 2017
[7] IFRC, Briefing note on Improving Response to Public Health in Emergencies, 2016

IFRC has invited National Societies with the capacity, or the willingness to develop capacity in one or more of the PH ERU configurations. An overview of available PH ERUs can be found in the IFRC surge catalogue[8] and a list with all ERU configurations and leading as well as supporting NS can be found in Annex 1.

This handbook focuses on **Configuration 3 of the PH ERU's: Community Based Surveillance**. It reflects standard operating procedures that are particular for the PH ERU CBS configuration and complements the general IFRC ERU standard operating procedures (IFRC, ERU Standard Operating Procedures, revised version 2024) as well as the IFRC handbook for delegates (IFRC, Handbook for delegates, 2002).

Multi-modular PH ERUs

The PH ERU CBS and any of the PH ERUs can be deployed together as the components of a multi-modular PH ERU. The objective of a multi-modular tool is always to reduce morbidity and mortality linked to the impact of events threatening the health of communities (i.e. the objective of PH ERUs). This configuration guarantees greater flexibility and ensures that public health activities can be adapted (scaled up, scaled down, modified) in line with the changing dynamics of health emergencies, particularly epidemics.

Articulation between PH and clinical ERUs

Within the health domain, ERU NS have Red Cross/Red Crescent hospitals and clinics ready to deploy, and public health ERUs and surge profiles. The PH ERU CBS configuration will not replace but complement these elements. Neither do they replace capacity building of NS or contingency planning. Figure 1 shows articulation between clinical and PH ERU's from the perspective of the PH ERU CBS. The PH ERU CBS will have close linkages to other response activities (i.e., red arrows within Figure 1), including other ERUs. Indeed, the PH ERU CBS can articulate with many ERUs, whether these are clinical, for water, sanitation and hygiene (WASH), or other PH ERUs. For example, the data collected via CBS can be useful for decision-making, particularly in deciding where to implement the activities of a WASH ERU such as the WSR ERU[9], when an epidemic is dynamic, and the locations affected change over time. It can also link detected community cases for referral to a clinical ERU[10] or to another PH ERU such as the PH ERU community-case management of cholera (PH ERU CCMC)[11].

[8] https://go.ifrc.org/surge/catalogue/health
[9] Water Supply Rehabilitation (WSR)
[10] Red Cross Red Crescent Emergency Clinic and Red Cross Red Crescent Emergency Hospital
[11] Community Case Management Of Cholera (CCMC)

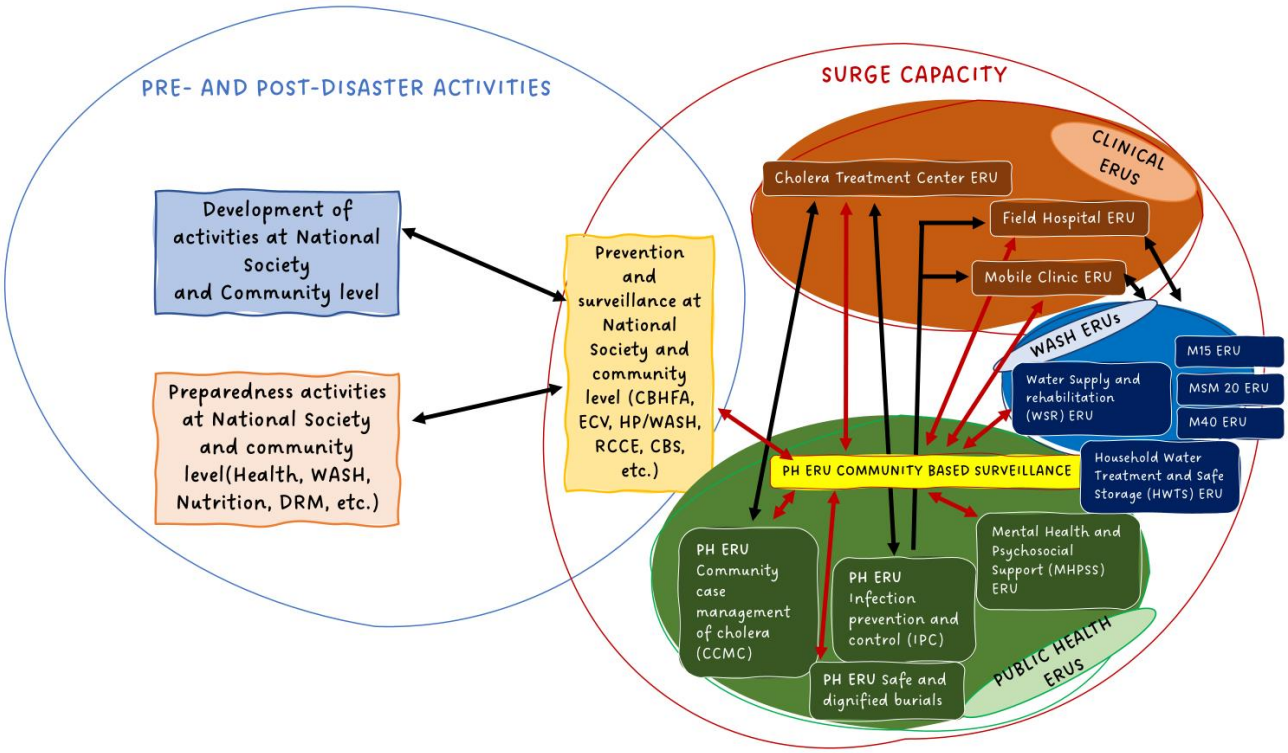


Figure 1: Complementarity of ERUs and link to pre and post disaster activities

The CBS tool as such can also be integrated as a module within other ERUs such as the CCMC ERU, where it is used for data collection, monitoring and decision making regarding oral rehydration points (ORPs) (See 3. The PH ERU CBS configuration, general design and operation).

2. Framework for Public Health ERU's

Strategic and institutional framework

IFRC's Strategy 2030 "Platform for change. Global reach, local action" renews the commitment to humanitarian aid and calls for more action to prevent and reduce the underlying causes of vulnerability[12].The PH ERU CBS configuration unites strategic goal 1: people anticipate, respond to and quickly recover from crises and with strategic goal 2: People lead safe, healthy and dignified lives and have opportunities to thrive.

The Movement bases its activities on the seven Fundamental Principles: humanity, impartiality, neutrality, independence, voluntary service, unity and universality.

The IFRC adheres to the following standards:

[12] IFRC (2030). *Strategy 2030; Platform for change Global reach, local action*.

- The Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations in Disaster Relief[13]

- The Humanitarian Charter and Minimum Standards in Disaster Response (The Sphere Project, 2018)[14]

Moreover, the Public Health ERUs also ensure that deployments adhere to:

- Standard Operating Procedures for ERU[15]

- Data protection principles[16]

- Surge Guidelines and Standard Operating Procedures[17]

- Implementation Guidelines for Epidemic Response (IGER)

Strategic goals and Fundamental Principles

The PH ERU CBS configuration follows strategic goals of the IFRC Strategy 2030 that are rooted in IFRC Fundamental Principles and aligned with the IFRC Strategy 2030[18].

Goal 1: People anticipate, respond to and quickly recover from crises. Responding only is no longer enough and the Movement is looking to directly act on the underlying causes of crises, understand the changing nature of vulnerability, reduce their impacts, better address new and emerging risks, or even prevent them from occurring.

Goal 2: People lead safe, healthy and dignified lives, and have opportunities to thrive. The Movement will facilitate opportunities for social inclusion, to enhance people's resilience and their ability to thrive. The PH ERU CBS contributes to early detection and referral for treatment improving health outcomes and reducing further disease spread and impact on the community. The local volunteer training further helps to build community capacity to recognise and reduce public health threats.

Goal 3: People mobilize for inclusive and peaceful communities. Across our global network the Movement will promote and support more inclusive, equitable and cohesive societies.

Minimum core standards

All the PH ERU NSs are expected to confirm that they are able and willing to adhere to IFRC ERU SOP[15] and to the defined minimum standards for each PH ERU.

Table 1 shows the minimum core standards are criteria to which the PH ERU CBS team must adhere. They describe structure and performance during deployment, but they should be acknowledged and implemented prior to deployment. This allows the affected country to have confidence in the

[13] IFRC/ICRC. (1994). Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations in Disaster Relief.
[14] Sphere Handbook (spherestandards.org)
[15] IFRC. Standard Operating Procedures for ERU. Final Draft 2024
[16] IFRC. Data Protection Policy. Draft 2019 – unpublished.
[17] IFRC. Emergency Surge personnel deployments. Deployment Guidelines and Standard Operating Procedures. Final Draft 2019 – unpublished.
[18] IFRC (2030). *Strategy 2030; Platform for change Global reach, local action*.

capabilities of the PH ERU CBS and an opportunity to hold PH ERU CBS accountable if they do not meet their stated capability.

Table 1. Minimum core standards

Standard 1	Adhere and follow IFRC ERU SOP
Standard 2	Collaborate and coordinate with inter-agency response coordination mechanism at global, regional and national level, as well with other response team and health system if appropriate
Standard 3	Ensure regular reporting to designated stakeholders during the response in accordance to IFRC deployment order
Standard 4	Ensure data protection rules and regulation followed appropriately
Standard 5	A. Adhere to professional guidelines – all delegates have the appropriate knowledge, skills and relevant formal education to practice the work they are assigned to. B. Adhere to IFRC Humanitarian Health Competency Framework in selection, training and evaluation of delegates C. Ensure that delegates deployed within the PH ERU CBS are appropriately trained in accordance to agreed training requirements
Standard 6	Ensure that all equipment deployed complies with international quality standards
Standard 7	Ensure that the PH ERU CBS have arrangements in place for care of the team members health and safety including repatriation and exist strategies if required
Standard 8	Ensure that the PH ERU CBS is self-sufficient and do not put demand on logistic support from the affected National Society, unless agreed otherwise before deployment
Standard 9	Ensure integration of crosscutting approaches are included in the response such as CEA, gender, diversity and protection.
Standard 10	Ensure system for compliance mechanism and plans for evaluation are in place during response and undertake evaluation of deployment to ensure learning and enhance good practice.

3. The PH ERU CBS configuration

What is CBS?

Outbreaks normally begin with a cluster of sick people, or sudden deaths in a community, that is not detected in a timely manner by formal surveillance systems[18]. This may be aggravated in scenarios where formal surveillance systems have limitations or there is inadequate coverage of communities by health facilities. This allows the volunteers to start an immediate response (i.e., hygiene, prevention, referrals etc), while waiting for support from the Authorities.

[18] IFRC. CBS Guiding principles. Draft 2019 - unpublished

Meanwhile, trained staff and delegates can monitor in real-time the notifications being sent in by volunteers and carry out an appropriate and timely response in conjunction with health authorities or other partners.

The Movement has several years of experience with CBS, starting from 2012 during the cholera outbreak in Sierra Leone. CBS programs have now been implemented by the Movement and its partners in Africa, Asia, Middle East, Pacific and South and Central America. They have been adapted to contexts and used to detect outbreaks of water-borne diseases, vector-borne disease, respiratory diseases, vaccine preventable diseases, viral hemorrhagic fevers, zoonotic diseases, and environmental events.

CBS has both emergency or preparedness applications (Annex 2) and CBS efforts have been set up (as emergency or long-term development projects) by IFRC or NSs with PNS support, in over 20 Red Cross and Red Crescent National Societies that are now actively implementing CBS. For more information and examples of CBS implementation within the Movement, refer to: Implementations | Community Based Surveillance.

Recently, in 2024, the PH ERU CBS as part of the first multi modular PH ERU, together with the PH ERU IPC, was deployed for a Public Health Emergency, a Cholera outbreak in Comoros Islands.

Purpose and Objectives of the PH ERU CBS

The overall purpose of the PH ERU CBS is to reduce the loss of lives by preventing or contributing to reduction of outbreaks or potential outbreaks of diseases or their negative impacts in sudden-onset disasters, protracted crises, or health emergencies/outbreaks, where there is a defined need for surveillance of diseases.

The general objective of the PH ERU CBS is to support the establishment of a CBS system for detecting and reporting of events of public health significance within a community, by community members, to strengthen the response during an emergency.

Specific objectives:

- Assess the need and the feasibility for a PH ERU CBS in the specific context.

- Determine the configuration of the data collection, flow, protection and response, and other components of the CBS system that will be put into place.

- Set up the data collection and analysis tools.

- Train delegates, NS staff and volunteers who will support data collection, analysis and response.

- Maintain ongoing analysis and use data for decision-making.

- Ensure program Monitoring and evaluation, including calculating indicator

- Early detection of potential cases of disease at community level, and appropriate preventive responses, referral, early community case management, as necessary.

- Ensure that a robust ERU exit strategy is put in place for CBS activities, including the extension or absorption of the activities, the maintenance and monitoring, the funding of the activities and the roles and responsibilities within the NS.

Activities

• Assessment of needs, feasibility and capacity for response of the CBS based on initial request by NS or IFRC (CBS assessment report)

• Coordination with MOH and all relevant stakeholders

• Design of CBS system (CBS protocol)

• Set up of CBS system adapted to context and need

• Training of RC volunteers, supervisors and managers in CBS methodology

• Depending on the situation, support training for community volunteers using epidemic control for volunteers (ECV) or community-based health and first aid (CBHFA) training

• Development of exit strategy/plan

Key characteristics

• Light team and agile set up, adaptable to context and need

• System set up adapted to context and scale

• Staffed and equipped as a stand-alone unit

• Self-sufficient for 4 months

• Estimated deployment time dependent on needs

General design and operation

The general design of CBS activities starts with CBS-trained volunteers working in their own communities to detect pre-agreed health risks – based on community case definitions – or events (e.g. deaths, fires, floods). Volunteers are trained to collect and pass on this information (i.e., including health risk, age and gender) to the NS staff/delegates. Volunteer supervisors or RC staff (usually branch level) cross-check the reports sent by volunteers.

Meanwhile, the volunteer takes action, informing the sick persons and their families of preventative measures to put into place to avoid transmission, and recommending referrals if needed. Volunteers base their response actions on ECV and CBHFA trainings.

When a pre-agreed threshold of reports is met (which can be a single report such as for measles or Ebola), the NS then informs health authorities (or clinical ERU personnel, or other clinical partners, as agreed), and supports an investigation in the community, with the participation of the RC volunteer(s) who sent the report(s), in order to foster trust in the community.

The NS maintains a database of all reports sent and investigated and communicates this information back to the volunteers and communities, as well as to health authorities, cluster and others.

Link to other surveillance systems

PH ERU CBS is part of the surge capacity toolbox. By definition, it will be deployed when existing surveillance capacity is not available or not functional (temporarily or permanently). However, in most scenarios, it is likely that some part of the facility-based national surveillance system is still working. And other health information systems may have been set up as part as of the emergency response, both inside the Movement, if an ERU field hospital/CTC have been deployed, or by outside partners (e.g. EWARS).

CBS can be linked to these systems in different ways (See Annex 3 for a non-exhaustive list of surveillance systems). The simplest way to share the CBS information is though daily or weekly reports showing aggregated community-based cases (with age, sex, and geographical distribution, for instance). Other set-ups can be envisioned depending on time and technology available. For instance, some data collection and monitoring tools provide a linkage with other surveillance tools (e.g., Nyss® with DHIS2; project proposal for integrating AVADAR with SORMAS in Nigeria[19]). It will also be possible, once the NS CBS platform is fully developed, to grant authorized outside parties' access to aggregated data reports in real time. Data protection principles must be fully respected during these sharing practices, and if the local Authorities or another partner needs access to raw data (i.e. data that is not identifiable for the vast majority) to improve the use of data in decision-making during operations (e.g., via better visualization, joint production of info graphics or to work actively as a CBS manager if needed), a signed General Data Protection Regulation (GDPR) form will be required, guaranteeing the confidentiality and security of the data.

It is key to clarify to all parties involved that facility and community cases should NOT be counted together, as the former have been seen by a clinician while the latter are based only on community case definitions. The possibility of "double counting"[20] must also be taken into consideration, if cases seen in the community are referred to a health facility or are seen in the community by a clinician during an investigation.

CBS in ORPs

CBS used as a data collection and monitoring system in an ORP is one of the situations that CBS delegates may encounter, and especially when delegates are deployed within the CCMC PH ERU[21].

CBS can be used in an ORP to provide valuable, real-time information on Acute Watery Diarrhea (AWD) cases seen at an ORP. Since only up to 20% of cholera/AWD cases will be symptomatic and only a part of them will be then referred to and seen in a health facility, this information from ORPs is crucial to estimate the real size of the outbreak. It is also useful in programmatic terms, helping to make evidence-based decisions on where to open or shut down ORPs and where to reposition them, as cases increase, decrease, or are transmitted to new locations.

When CBS is used in ORPs, the use of the tool slightly differs from a CBS as used in communities as an active detection or an early warning tool. First, reports will be linked to an ORP site, and not to an individual volunteer in his community, as several volunteers may be working in the same ORP.

[19] Redesigning of AVADAR server for IDSR reporting at community level in Nigeria (ungm.org)

[20] In reality, «double counting» would only be a concern if facility-based and community-based cases are mistakenly counted together.

[21] Community Case Management of Cholera (CCMC)

Second, more data may need to be collected than in a classic CBS reporting, either through regular SMS to the digital CBS toolkit (i.e., Telerivet® app linked to Nyss®) or via other data collection and monitoring tools (paper-based, phone calls, apps, and survey apps). This information includes the number of signals reported at ORPs, disaggregated by age group and sex, the number of people referred to a health facility (i.e. number of people with severe dehydration, disaggregated by age group and sex). Some variables can be added, such as the home village, a fatal outcome, or the number of ORS and/or water purification tablets distributed, among others.

Third, the response activities for CBS are very well defined in the ORPs (distribution of clean water, water purifying tablets, ORS, etc.), and some of these activities correspond to early case management, which go beyond the prevention and health promotion messages that may be the only response provided by the CBS volunteers in other outbreaks.

Fourth, when ORPs are deployed with CBS as a data collection tool, it will be in an active outbreak setting, with the number of AWD signals coming from the ORPs likely expected to be high. A daily aggregated reporting with a zero reporting would be required (i.e., zero reporting to signify they were active, but they have not seen any individuals with AWD that day).

Finally, a good communication with any Clinical ERUs (Cholera Treatment Centers or Units) or any healthcare structure dedicated to the treatment of AWD cases which are more severe is also needed, ensuring follow up of referred cases, and avoiding “double counting” (of cases seen in community and in facility).

Data protection

Data protection principles must be fully respected during these sharing practices, and if the local Authorities or another partner needs access to raw data (i.e. data that is not identifiable for the vast majority) to improve the use of data in decision-making during operations (e.g., via better visualization, joint production of info graphics or to work actively as a CBS manager if needed), a signed General Data Protection Regulation (GDPR) form will be required, guaranteeing the confidentiality and security of the data.

PART II Operational framework

Developing and maintaining a PH ERU CBS

1. Human resources

The composition of the PH ERU CBS team will be dependent on context and scope of the deployment. Table 2 describes the list of profiles, competencies and responsibilities required for deployment, in relation to the Deployment phases that are discussed in Section 7.

PH ERU CBS Team profiles

To set-up and run the CBS module, four different profiles might be needed. However, an experienced NS staff or delegate may be able to cover two or more profiles. It is important that each individual member is fully aware of and comfortable with his/her responsibilities. Moreover, the team needs to function very well as an entity. Every team member is responsible for ensuring good working as a team, and this is one of the main responsibilities of the team leader. The profiles are aligned with the IFRC Surge profiles, while being adapted to the tasks undertaken within the framework of the PH ERU CBS.

Table 2. Profiles required in a PH ERU CBS

Phase	Role / Corresponding IFRC Surge Profile	Responsibilities	Competencies (from HHCM)	Training
Advance team – feasibility assessment Design Implementation	Team leader ERU / Public Health coordinator	Team management, program design and coordination	1. General / RCC 1. General/COOR 1. General / AQA 1. General / OM 1. General / AA 1.General /CP 6. FE/ops management	ERU TL, PH ERU CBS, CBS training, PHiE, IMPACT/security
Advance team – feasibility assessment **Design** **Implementation**	Epidemiologist ERU / Public Health Officer	Epi analysis, support program design and implementation, data analysis and trainings	6.Field Epi / ES. B2 6.Field Epi / ES. B3 6.Field Epi / ES. B5 6.Field Epi / ES. B7 6.Field Epi / ES. B8 6.Field Epi / ES. B9 6.Field Epi / ES. B10 7. Epidemics /G.B1-B10	PH ERU CBS, CBS training, PHiE, IMPACT/security
Depending on needs and context	Logs ERU/ Logistics Officer	Log Support (if needed)	6. Field Epi/ET. B1-C1	IMPACT/Security
Depending on needs and context	Finance - Admin ERU	Admin and finance support (if needed)		IMPACT/security,

Team leader ERU: The team leader is responsible for assessing, coordinating and overseeing quality implementation of the ERU. The TL delegate must have solid humanitarian RC and health knowledge; public health experience (including CBS, equipment and tools, coordination, assessment, and analysis); operational management experience specific to health issues; minimum skills in information management and knowledge of how to operationalize CEA. A PH background is required, as well as RC understanding, and ability to negotiate with MoH, health cluster and networks. It should correspond to the **Public Health coordinator Surge profile** with a CBS knowledge.

Epidemiologist ERU: The epidemiologist is responsible for implementing quality CBS intervention in response to emergencies, in conjunction with the NS. This profile requires solid knowledge and experience in epidemiology and surveillance, particularly CBS, capacity to analyze, interpret and disseminate data to inform decision making; familiarity with information management, data collection/management; RC knowledge; public health (including CBS, equipment and tools, coordination, assessment, and analysis); operational management specific to health issues. It requires a public health or epidemiology background. It should correspond to the **Public Health Officer Surge profile** with a CBS knowledge.

Logs ERU: The logistician is responsible for providing logistics supports including ensuring safe reception, storage, distribution and reporting of goods needed during the ERU deployment (i.e., especially goods related to CBS trainings). This delegate is also responsible for organizing transportation of ERU personal and goods, as well as accommodation, and must have a humanitarian RC knowledge. It should correspond to the Logistics Officer Surge profile.

Finance - Admin ERU: The finance/admin is responsible for the smooth functioning of HR processes in conjunction with the NS, including payment of per diem to NS staff or volunteers and setting up contracts with external partners needed for the response. This profile requires humanitarian RC knowledge, administrative and financial skills in emergency settings. It should correspond to the HR **officer Surge profile.**

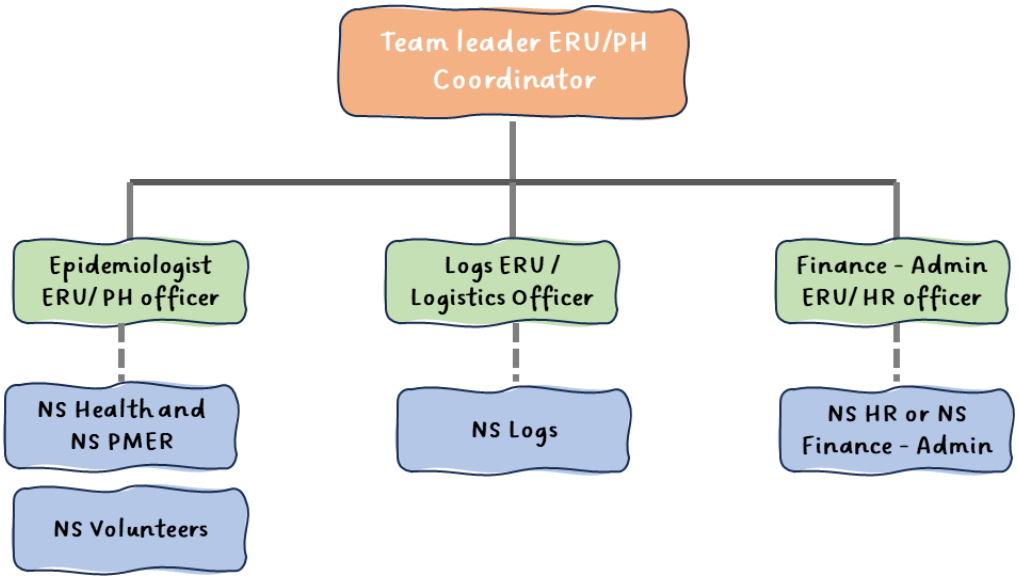


Figure 2. CBS PH ERU team - Organizational chart

National Society Counterparts

Potential counterparts from the Host National Society need to be identified at the beginning of the mission for every position covered by ERU delegates. Counterparts and delegates need to work closely together from the beginning of the mission. If no counterparts are available, it should be discussed if available NS staff can be trained. Once counterparts are ready, they should take over responsibilities so that the delegates role can gradually shift from management towards mainly facilitating tasks where still required.

The delegate team could ideally be reduced in numbers soon after the NS counterparts feel comfortable with the management and running of the PH ERU CBS. An important pre-condition for this gradual fade-out of delegate presence and overall exit strategy is the involvement of NS counterparts in all decision-making processes right from the start.

The ERU Team

The complete team of ERU delegates can consist of 3 or 4 to more delegates (e.g., several persons having the same profile - such as the epi delegate profile - could be required if the operation would have an important geographic coverage) but can be reduced where NS capacities are available. Also, depending on context, size of response and delegate's skills and training, more than one position may be covered by a single delegate. Expatriate delegates should be replaced by NS counterparts as soon as the situation allows. There is no static scheme for the team composition as each situation is different and calls for individual solutions, but the minimum would be 3 delegates: TL / Epi / fin-admin or log profile.

A high degree of flexibility is expected from the team. Each delegate must be aware that in particular during the set-up phase that everyone has to perform various tasks regardless of their individual professions. Having a broad vision of the work that needs to be done is essential. Independent from the individual job descriptions, other duties and tasks may be assigned. General responsibilities can be delegated among team members. This does not mean that delegates will be asked or are allowed to exceed their professional capacities.

Decisions by the team leader shall be transparent to all team members and local counterparts. Regular information flow toward and from the team leader is key. Regular meeting shall be held on management level as well as meetings with all staff to facilitate a structured exchange of information.

The main tasks of delegates are to get the CBS system up and running, as well as training and capacity building of local counterparts and volunteers. In addition, if the ERU cannot cover all the necessary CBS activities, delegates, in collaboration with their NS counterparts, should promote a scale-up of CBS activities by involving other partners. The equipment and methods used need to be introduced to local counterparts and volunteers, ensuring they feel comfortable within the working environment provided. Delegates will need to maintain flexibility in order to best adapt the system to context and local customs.

Training of human resources

Delegates need to comply with mandatory Red Cross Red Crescent training such as WORC, Stay Safe and Fraud and Corruption online trainings. All delegates, independently of their profile would have undergone IMPACT training, to ensure understanding of the Red Cross Red Crescent Movement prior to deployment. The table below shows additional training pathways for each team profile.

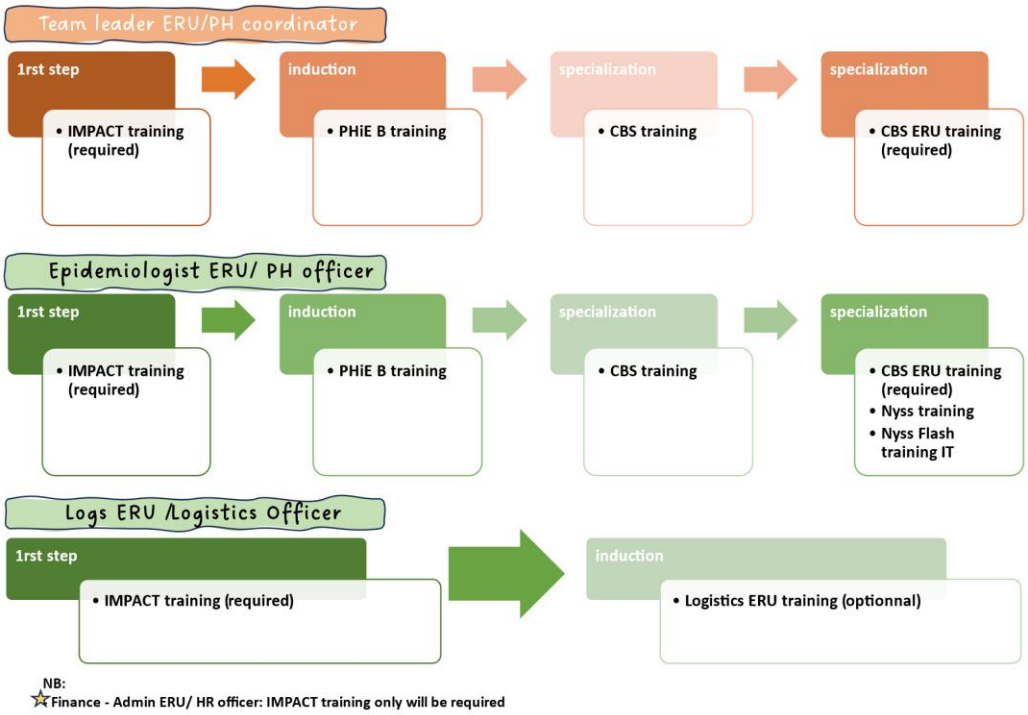


Figure 3. Training pathways for different team profiles

A PH ERU CBS operational training has been developed. This 4-day training prepares delegates to conduct a CBS assessment, design a CBS system, implement, and run a PH ERU CBS in a public health emergency. This training is required for all the profiles except for Logs ERU and Finance - Admin ERU delegates.

Briefings, debriefing & end of missions

Briefings, debriefings, and end of mission tasks follow normal ERU SOPs and/or surge SOPs.

Briefings[22,23]

According to the IFRC Guidelines and SOPs, every delegate shall receive a quick briefing at the start of the mission. This briefing can be done remotely and includes:

- Administrative/financial briefing shall be carried out either by their own NS or the IFRC office processing the deployment. This will include the handing over of the working advance and any equipment.

- Onboardings or operational briefings, including security briefings, shall be organized at field level and/or before departure (e.g., through remote onboarding) by the NS deploying the PH ERU CBS, whether the delegates belong to this NS or to another PNS. In the context of Multi-modular PH ERUs, with one PH ERU CBS module, for instance, operational briefings should also be provided to delegates

[22] IFRC. Standard Operating Procedures for ERU. Final Draft 2024
[23] IFRC Guidelines for deployment of Rapid Response personnel (Nov 2019)

of the PH ERU CBS module, by the PNS leading the ERU, before departure (e.g., through remote onboarding) or at the field level, whether the delegates belong to the leading NS or to another PNS.

For all the CBS PH ERU profiles, the operational briefing can cover current situation and needs, security matters, communications, public relations, as well as the current state of the PH ERU CBS operation on the ground if it has already been deployed.

In addition to these Standard requirements, PH ERU CBS briefings should include:

- Timeline of the operation and tasks expected

- Key topics/issues that can come up in the field along with advice on solutions.

- Lines of communication and hierarchy between deploying National Society, IFRC, ERU team and delegates.

- Create a WhatsApp/SMS/ group with the deploying delegate(s), and one or two key contact persons in the CBS team or CBS TWG.

- Finally, the Norwegian Red Cross IT staff will provide IT onboarding to the ERU epidemiologist/public health officer to install the SMS gateway, whether this delegate belongs to the NS sending the PH ERU CBS or not (i.e., and for Multi-modular PH ERUs, whether the delegates belongs to the NS sending the PH ERU CBS module or not), especially if the CBS digital tool (i.e., Telerivet® app linked to Nyss®) is very likely to be used. This short session may include a brief refresher on Nyss®, depending on the needs of the delegates, but the knowledge on the gateway and Nyss® will already have been acquired during the PH ERU CBS training.

Debriefings[24]

Operational debriefing must be done at field level, or in the closest IFRC office if there is no permanent presence in country. When debriefing is with technical counterparts and operational management at regional or country cluster office, it can be carried out through teleconference. In the case of global deployments, the technical counterparts in GVA should be invited if the time difference permits. When IFRC is the deploying entity, there will also be a financial/administrative debrief to return the equipment provided as well as provide the required clearance of the working advance provided. The Rapid Response personnel need to ensure that a Handover document, a Rapid Response Mission Feedback form and a Mission Appraisal shall be completed two days before departure from the field (Templates can be found in IFRC Guidelines for deployment of Rapid Response personnel, Nov 2019)

• Handover Document: Good documentation of the performed activities from the beginning of the mission will prevent information loss and gaps between rotations. The handover document must contain a list of pending activities to be carried out, detailing to which part of the Plan of Action they belong, as well as financial commitments, agreements and the contact information of the people involved in each activity. Such documents shall be shared with the replacement as well as with the direct line manager.

• Performance Appraisal: every personnel deployed for a minimum of 3 weeks needs to have a

[24] IFRC Guidelines for deployment of Rapid Response personnel (Nov 2019)

performance appraisal completed prior to departing. The template needs to be initiated by the team member and then sent to the line manager and technical counterpart who grades and include comments. This process needs to be completed by a one-to-one meeting between team member and line manager. Once completed and signed off,
the line manager will send the completed form to the Surge focal point in the Region and/or Geneva who will also share it with the personnel's supporting NS (for a regional deployment, the region will do so, for a Global one Geneva will do), the technical counterpart and the sending regional office. The same entity sharing it with the NS is responsible for uploading the performance appraisal in the database. The technical focal points will use the information accumulated in the mission appraisals to update the information about the person's competencies in the Rapid Response register system.

• Rapid Response Mission Feedback: this should be completed to facilitate gathering information for the continuing optimization of Rapid Response deployments. This report will be shared with the Surge focal point (including Geneva Surge Desk for Global deployments) and their technical counterpart. If the deploying entity is a National Society, the report will also be shared with their Surge focal point (i.e., this is the case for ERU).

Safety and security of deployed staff

Safety and security for CBS PH ERU team members follow ERU SOPs[26]. Security regulations as established by the IFRC operational manager in the field (and referred to in the ERUs ToR, which contains the context of the operation; location, security, contact information) and is applicable to all ERU members from the moment they are deployed, as well as being non-negotiable.

It is the duty of the PH ERU CBS TL to inquire after existing security regulations when arriving in-country. It is the responsibility of the Team Leader to ensure that the team members have been briefed on the security regulations and remain up to date following any changes. If there is no or limited IFRC field structure in-country, the ERU TL will prioritize adherence to the security regulations for the ERU operation in coordination with the IFRC's field security unit in the RO/CCD/CD. It is also the responsibility of each delegate to request a security briefing if none is initially offered and keep themselves updated on changes in the situation. As per ERUs SOPs, all ERU members must have completed the IFRC Stay Safe 2.0 Global Edition23 Level 1: *Fundamentals* and Level 2: Personal and *Volunteers training course prior to deployment* and must sign an *Acknowledgement of Risk form*. ERU TLs must have also completed Level 3: *Security for Managers*.

Any breaches of security shall be dealt with according to the IFRC Code of Conduct for staff.

Remote support and lines of communication

It is expected that the team on the ground will have enough diverse skills to cope with most situations autonomously. However, remote support will be available to team members from PH ERU CBS task team, as well as the CBS Technical Working Group.

Recommendations[25]:

[25] Based on lessons learnt from previous deployments

- Establish a technical focal point responsible for following/supporting the delegates in the field (especially the Epidemiologist ERU delegate), from the PH ERU CBS technical working group, or the CBS TWG. The technical support should have the technical knowledge to support with the CBS digital tool (i.e., Telerivet® app linked to Nyss®) when this one is most likely to be implemented or has already been chosen. The same logic should apply to other tools.

- Before deployment, i.e. during the administrative briefing and/or the onboarding with the Norwegian Red Cross IT (i.e. when it is highly likely that the CBS digital tool will be used), be sure to confirm to the delegate who will be the technical person designated to monitor/technically support the operation.

Also, as said previously, a WhatsApp/SMS/ group with the deploying delegate(s), their key contact persons should be created and the delegates should know the lines of communication and hierarchy between deploying National Society, IFRC, ERU team and delegates.

2. Equipment

The PH ERU CBS is a light configuration. It is not expected that there will be a need for tented delegate accommodation. In areas where tented accommodation is the only option, the team will pair up with existing response configurations such as the field hospital, health clinic or other relevant configurations that deploys with a tented structure. Equipment needed to ensure a fast and portable operational response would be:

- Delegate personal kit (standard ERU, see Annex 4)
- CBS digital toolkit (see description below)
- If needed, Finance/admin kit and health promotion kit (adjusted to epidemic control)

Logistic requirements for deployments include availability of accommodation and access to cars.

CBS digital toolkit

The aim of the CBS digital toolkit (also called “CBS in a rucksack”, which includes the equipment needed to work with Nyss®, i.e., a phone with Telerivet® app) is to provide an out-of-the-box solution that can be set up without the need of an IT technician. The equipment will be self-configured and up to date. In a first phase, some remote IT support can be available to support the Epidemiologist ERU delegate in troubleshooting both hardware and software issues, especially when the CBS digital tool has been chosen.

"CBS in a rucksack" is created to ensure all the necessary equipment is available to the national society when setting up CBS. In addition to setting up the local CBS platform connection, CBS in a rucksack supports training of volunteers; digital data collection; information sharing and emergency power supply. The equipment is packed in a protective carry-on rucksack, for easy deployment (See figure 3). One kit can support a national scale CBS implementation.

Figure 4. The CBS in a rucksack.

Characteristics:

- Much lighter and smaller than normal deployable field kits

- Easy to set up

- Adapted to emergency settings

- Very little equipment is enough to support a national level response (*e.g., the kit can support until 10 supervisors and 250-300 volunteers in an ongoing outbreak).*

Set up

The CBS digital toolkit kit takes around one hour to set up and can be set up by any PH ERU CBS trained Epidemiologist ERU / Public Health Officer delegate. Annex 5 lists some of the tasks to be carried out to guide the delegate in setting up the CBS toolkit.

Additional materials required to set it up include:

- An unblocked local SIM card with a known phone number and an unlimited number of SMS messages or equivalent. This setting will depend on the SIM card's expected activity in terms of the number of SMS messages received and sent for feedback and to the authorities (i.e. if the alert escalation system is activated).

- An ethernet connection or stable Wi-Fi.

Table 4. List of contents in the CBS digital toolkit

Item	Description	Quantity
Lowepro fastpack bp 250 aw ii	This is the backpack. It is well padded and allows us to pack all the CBS equipment safely, while still allowing it to pass as hand luggage and have space for personal belongings.	1
Projector + charger	The pocket size projector is needed for configuration and set up of the eagle (which would normally require a computer screen). The projector can also be used for training purposes.	1 + 1
Extension cord	The extension cord ensures that all chargers and plugs (which are Norwegian) can be used in the country where the CBS system is deployed without complications.	1
Universal wall adaptor	The universal wall adaptor goes on the extension cord to provide Norwegian plugs to all devices.	1
Microphone	The microphone attaches to the phone and allows for simple media content creation and participation in meetings and trainings from a distance.	1
Mobile Phone + charger (same as charger for the tablet)	The mobile phone is used for testing of the configuration; for training purposes; and can be used digital data collection; and for generating media content	1 + 1
Tripod	The tripod attaches to the phone and allows for simple media content creation and using the mobile phone for remote support/video calls	1
Powerbank	The powerbank ensures that devices are charged, even during power cuts	1
USB to miniUSB	For charging of phone and tablet	1
Notebook	The notebook stores the passwords, IP address needed to configure the system, and be used for other useful notes about the system.	1
HDMI cables	Connects computer to devices	1
HDMI to mini-USB	Connects computer to devices	1
HDMI/VGA to thunderbolt	Connects computer to devices	1
Speaker (w/charger)	The speaker enables training/dissemination, allows for media content creation and participation in meetings and trainings from a distance.	1
AAA batteries		1
USB flash drive 32 gb	Used for back-up, electronic data transfers	1
Mini jack to minijack	Used for sound transfer between devices	1
Ethernet/USB/HDMI to USB-C	Used to ensure that any device type can connect to the system	1
Tablet + charger + cable	The tablet is used for monitoring of data collectors and validation of reports and is given to the supervisors for the duration of the CBS PH ERU; it can also be used for training purposes; and can be used for generating media content. It can also be used as a backup SMS Gateway in case of emergencies.	10+10+10
AC to USB (multi plug)	Used to ensure that all USB charged devices can be charged at the same time directly in the wall socket	1
Spare Laptop	The spare laptop is used in case the laptop of the CBS PH ERU epi delegate is not functioning properly.	1

The rucksack should be given to the Epidemiologist ERU delegate by the NS sending the PH ERU CBS or the NS leading the Multi-modular PH ERU.

Other equipment

In addition to the CBS digital toolkit, other small equipment – not included in the kit -may be required to implement CBS activities. This equipment can be purchased locally once the CBS design has been agreed upon.

- Simple mobile telephones (non-smartphones) for the CBS volunteers doing data collection and reporting

- SIM cards for the phones

- Credit for the phones or a group deal arrangement (closed user group) with the local operator where all SMS and calls to the CBS digital toolkit number are free of charge.

- Solar chargers for the phones if assessment shows these are needed.

- Red Cross/Red Crescent T- shirts or bibs for volunteers

- Notebooks and pens for the volunteers

A full list of all material resources to consider for budgeting purposes is listed in the financial chapter below.

3. Financial

Financial aspect of the ERU

As per ERU SOP's[26], the ERU National Society funds all deployment or costs of an ERU, including the equipment, the personnel and the running costs, for the full period of its deployment.

Running costs are those incurred in making the ERU functional, in the case of the PH ERU CBS, these may include:

- International staff costs including salaries, flight to assignment, insurance, per diem, and ac-accommodation costs

- Nationally hired staff costs – salaries and other benefits

- Volunteers – per diems and other benefits

- Communication costs including satellite and mobile phones, internet connections, for the team

- CBS digital toolkit

- Phones, solar chargers for the phones, SIM cards and phone credit for the volunteers, if needed.

[26] IFRC. Standard Operating Procedures for ERU. Final Draft 2024

- T-shirts or bibs or other Red Cross/Red Crescent-identifying items for the volunteers

- Maintenance costs required by the CBS digital tool, if needed.

- Vehicles including fuel, rental, maintenance, spare parts, insurance, etc. (Note that support for fuel is also normally requested by MoH clinicians carrying out investigations of reports).

- Training expenses for volunteers and NS staff.

Operational costs in the country affected are funded by the IFRC's emergency appeal (i.e., those are costs incurred for goods and services which are part of the emergency appeal, and which would be provided by the IFRC regardless of an ERU presence). The ERU shall not commit the IFRC funding for operational costs without prior approval from the emergency appeal project manager (i.e. the "budget holder"). Also, ERUs which are incurring operational costs should be reimbursed by the IFRC field office before the end of their deployment. In some cases where the ERU do not have sufficient cash on hand to incur operational costs, a working advance may be requested[27].

The deploying NS will ensure the self-sufficiency of all team members and ensure a working advance is provided or a mechanism for cash transfers is in place.
All administrative and financial functions of the ERU shall be handled by the responsible administration officer of the designated ERU with all reports and accounts kept in the forms and standards of the ERU National Society.
The total implementation costs will vary depending on the number of team members to be sent, place of deployment, and needs on site.

PART III Operational management

Deploying a PH ERU CBS

1. Deployment mechanism

Overview of the deployment mechanism

The PH ERU CBS is applicable for both public health emergencies and public health in emergencies. It can be deployed under the auspices of the IFRC global surge mechanism, bilaterally or under the auspices of ICRC upon request. Subsequently, it follows the Standard Operating procedures (SOP) for ERU[27]. Deployments can be initiated under DREF, and then included in Emergency appeals.

Although timescales vary considerably depending on the context and complexity of the emergency, the time between the arrival of the advance team (i.e., responsible for carrying out the feasibility study, drafting the CBS assessment report and putting in place the CBS strategy with the approval of local authorities and partners) and the start of implementation, with data being entered into the CBS system, can be as little as two weeks[28].

[27] IFRC. Standard Operating Procedures for ERU. Final Draft 2024
[28] Based on lessons learnt from previous deployments

The phases of the deployment mechanism are shown in Box 2.

Box 2. Deployment phases

1. Activation criteria
2. Needs and Feasibility study/ Assessment (and writing of the CBS Assessment report)
3. Design, Set-up (and writing of the CBS Protocol)
4. Trainings and Implementation
5. Exit of ERU – Handover to operation/ NS

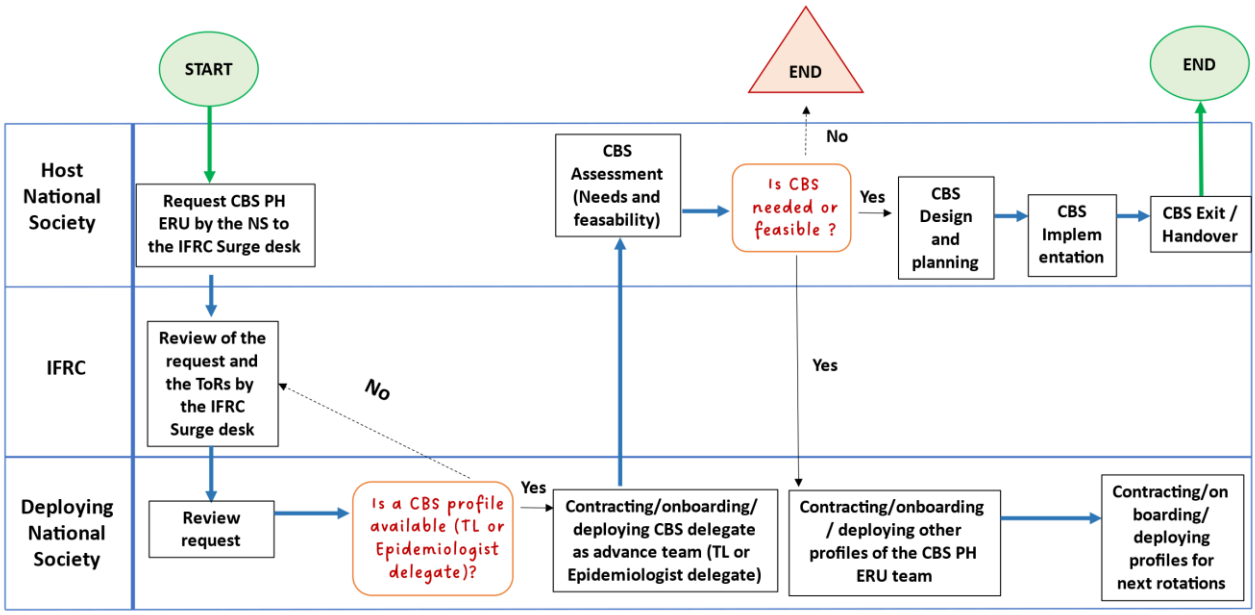


Figure 5: Deployment flowchart

Activation

Activation of the CBS PH ERU can be initiated either in contexts where the risk of disease outbreaks is imminent or in an ongoing disease outbreak.

Acceptance of deployment includes sending an advance team and having the capacity (and delegate availability) to deploy a complete PH ERU CBS if the assessment shows CBS is needed and feasible. Timeline from alert to deployment should not be more than 48 to 72 hours. The timeline might be different for protracted crises.

Deployment of advance team/CBS assessment (needs and feasibility study)

Deployment of a PH ERU CBS will start with a CBS assessment (i.e., needs and feasibility) by an advance team. This team will assess the situation on the ground and validate the need and/or relevance of deploying a PH ERU CBS. It will also describe the operational feasibility of deployment of a complete PH ERU CBS (including capacity of NS, MoH, WHO, NGOs, private actors; and technical assessment).

The scope of services will be defined in the CBS assessment report.

The PH ERU CBS advance team consists of a 1 or 2-person team (i.e., preferably the profiles of Team leader ERU/ Public Health coordinator and / or the Epidemiologist ERU / Public Health Officer; see roles and competencies described in Table 2 in the Human Resources section). Timeline for completement the study aims to be less than 1 week, and no longer than 2 weeks.

The CBS assessment can be guided by the CBS assessment tool and template[29], always taking into consideration that this tool was devised for longer term programming and not emergencies.

Table 5. Main deliverables of the assessment (needs and feasibility study)

Situation	**Main deliverables:**
CBS is not needed	An assessment report documenting why CBS is NOT needed or feasible is to be submitted to relevant partners. It leaves open the door for a later review of needs if the situation changes.
CBS is needed but not feasible	An assessment report documenting why CBS is NOT feasible is to be submitted to relevant partners. It leaves open the door for a later review of feasibility if the situation changes.
CBS is needed and feasible	An assessment report documenting why CBS is feasible is to be submitted to relevant partners. The team uses all data and findings to support the development of the CBS design and set up (i.e., which will be documented in the CBS protocol).
Minimum tools requirements: • CBS assessment (CBS assessment tool and template)	
Equipment requirements: • Delegate personal equipment (Annex 2) • To ensure smooth and quick implementation if CBS is deemed needed and feasible, it would be advisable to bring a CBS rucksack.	

Site selection

The PH ERU CBS will be mobilized either when there is clear risk of a potential outbreak during an emergency or once an outbreak has been declared. The CBS assessment (i.e., needs and feasibility study) will provide risk assessment information on areas of outbreak, or areas in impending risk of outbreak based on current cases and/or epidemic risk assessments.

Site selection for deploying CBS-trained volunteers should consider other partners carrying out epidemic surveillance activities and be cleared with the authorities. It is key to ensure the collaboration with clinicians in the closest health care facilities or other available clinicians (whether MoH, partner or Movement ones), to carry out the investigations.

[29] IFRC CBS assessment tool

Important information to collect during the CBS assessment to facilitate site selection and scale of response is detailed into the CBS assessment guidance, including the CBS advocacy to other partners.

2. Design and set up

If CBS is deemed feasible, the advance team will continue into the design phase. The team will use information collected during the feasibility study (such as health risk assessment, site information and NS and partner capacity) to establish the design of the CBS project. The team will work closely with NS and other partners such as IFRC and/or ICRC.

The design phase is guided by the CBS Protocol tool [30], taking into account that this tool was developed for long term programming and may require adjustment for CBS in emergencies.

The design phase will deliver a completed CBS protocol and a PH ERU CBS section for the Emergency Plan of Action (EPoA) (Table 6).

Table 6. Main deliverables of the design phase

<table>
<tr><td colspan="2">Main deliverables:
Development of the PH ERU CBS Protocol (possibly signed by MoH/NS)
PH ERU CBS EPoA, including operational budget and HR plan</td></tr>
<tr><td>The PH ERU CBS protocol will include:
Objectives
Project structure, priority health risks and community case definitions
Projection location and stakeholders (i.e., including coordination with MOH)
NS capacity and roles within the NS, including volunteer management
Data collection, management, and analysis, including tools, technical components
Trainings
Legacy, to ensure sustainability beyond ERU operation is considered and planned for with required support (transition/ exit of ERU)
Resources</td><td>The PH ERU CBS EPoA will include:
Operational plan of the PH ERU CBS protocol
Plan for PH ERU CBS rotation
Operational budget</td></tr>
<tr><td colspan="2">Minimum tools requirements:
PH ERU CBS Protocol template (guidance)
PH ERU CBS template EPoA with M/E</td></tr>
</table>

[30] IFRC CBS protocol template

3. Community Engagement and Accountability (CEA)

A CBS system will not work without community and volunteer support. Communities must understand the benefit of the system, and that their input is valued and helps improve, or adapt, the system to work better for the community.

Acceptability of CBS activities by the community is essential and requires early and continuous engagement with the community from the feasibility study onwards. As a minimum, CBS activities need to be discussed with the communities, explaining its value. If local volunteers don't exist in the communities targeted, they need to be chosen by community members/leaders based on agreed criteria.

Accountability is also key. Communities need to be assured that they will receive feedback, reports and responses to their concerns if they are feeding information into the system. Responses and feedback include the preventive measures at community level set up by the volunteers (based on ECV or CBHFA) after notification of a health risk or event and reporting back to the communities on the results of outbreak investigations. It also needs to include adequate responses (preventive health messages, referrals, etc.) to health risks or events reported by the community that have not been included as part of CBS reporting system.

For example, if a volunteer reports a community member showing fever and bleeding (or other community case definition criteria used for hemorrhagic fevers), and after the investigation the results show that this was not a viral hemorrhagic fever, this information not only needs to be shared back to the community, but adequate measures (e.g. a referral) need to be put in place nevertheless to support the sick community member. This is key to maintaining community trust.

Proper CEA measures need to be included at each step of the design protocol, balancing this need with the time pressures set by the emergency or outbreak.

4. Implementation

The team composition in the implementation phase (see roles and competencies described in table 2 in the Human Resources section) will be determined by context and need, the results of the CBS assessment and the choices made in the design phase.

The PH ERU CBS team is tasked with implementing the CBS plan laid out in the EPoA and the CBS protocol. This will mostly require the setup of the system, training of staff and volunteers, supervision of reporting, CEA, monitoring and evaluation duties, covering coordination efforts and organizing subsequent rotations (See Table 7).

Table 7. Implementation deliverables, outputs, tools and equipment.

Deliverables:	Output:	Tools required:	Equipment requirements:
- Implementation of the EPoA and the CBS Protocol - Stakeholder meetings/ coordination - Training of trainers - Training of CBS volunteers - Set up of CBS platform or data collection tool - Ensure information sharing: CBS data informs overall response - Ensure safe information sharing - Monitoring / supervision/ volunteer management - Continuous monitoring of the CBS system, data also through the calculation of CBS indicators - Plan subsequent rotations of the ERU and ensure handover	- No. of people trained - Hardware set up, running and maintained as needed - Functional CBS system is set up and running (hardware and software) - CBS reports (dashboard, weekly/ daily paper reports) provided to the operation, MOH, other stakeholders as appropriate to inform response - Monitoring and support system in place, indicators are being calculated	- PH ERU CBS Assessment and Protocol templates - PH ERU CBS template EPoA with M/E - CBS Handbook, CBS toolkit training material (for guidance) - ECT material	- Field volunteer equipment and visibility - Ideally volunteers use their own phones - Phone/ SIM is the only essential items - Agreement with one or several telecom companies - Toll free no. can take long time to set up - Hygiene promotion as needed - Finance admin kit as needed

Training of volunteers

The PH ERU CBS training for delegates delves into the training of trainers (usually NS staff, including supervisors and managers) and training of volunteers (data collectors) for CBS.

If the option exists, volunteers with previous basic first aid training, CBHFA training and/or ECV training should be prioritized for CBS training. Trainings in emergency settings should be kept short (1-2 days) and focused on the most important operational activities: detection (understanding and use of community case definitions), reporting (data collection by SMS and in paper format) and community level response (prevention and health promotion messages, referrals. Training must include safety and infection control practices for volunteers, so that they know what measures to take to protect themselves, as well as good practices of communication toward their community and soft skills, essential in a sensitive epidemic context.

Recommendations for training of volunteers:

- Revise the community case definitions with the volunteers, in the local language, to make sure they make sense to the volunteers and communities

- Ensure the training on SMS data collection includes common mistakes and obstacles and how to troubleshoot these.

- As much as possible, ensure training of volunteers are carried out in the local language.

- Ensure that volunteers are assigned to a zone/neighborhood each, not overlapping with another volunteer´s zone/neighborhood when they are several volunteers per village

- Ensure that volunteers record the telephone number to which reports can be sent if data collection includes sending SMS messages.

- Ensure that volunteers are registered as data collectors (with their respective phone number) on the CBS digital toolkit during the training, especially if the data collection tool includes sending SMS messages. Therefore, number of volunteers should be checked as well as their location (e.g., including GPS coordinates).

- Ensure admin/finance requirements as per-diem are followed and provided during the training.

CBS Operation

The specifics of running a PH ERU CBS will vary depending on the agreed upon CBS design. Usual tasks and responsibilities are described below.

Volunteers: Responsible for detecting a) individuals in their own communities who present signs and symptoms compatible with pre-agreed community case definitions of health risks and/or b) detecting specific events (e.g. floods, fires, groups of animal deaths). They are also responsible for reporting these health risks or events following a pre-agreed channel (if a CBS digital tool is being used, this would involve SMS). They give adequate prevention, health promotion messages to individuals, families and communities where a health risk is detected, and they support the investigation team when it comes to the community, acting as a liaison between outbreak investigation team and affected community members.

In emergency settings, including CBS in an ongoing outbreak, volunteers may be supported with financial allowances (pre-agreed with the NS) to dedicate more hours a week than normal volunteering hours to detection and health promotion activities. In this case, house- to- house or other resource intense detection activities can be implemented. Zero reporting should be included to maintain updated databases on volunteers that are active and monitor the performance.

Volunteer supervisors: Tasked with supporting the volunteers, confirming reports sent by them, problem-solving any challenges volunteers may be experiencing, monitoring performance, and maintaining volunteer motivation and acting as liaison between volunteers and branch staff, and volunteers and outbreak investigation teams if necessary.

Branch NS staff: They support volunteer supervisors and monitor reports coming in. They may also be the link between the communities and the local health authorities, passing on an alert once a threshold has been reached, supporting the investigation, and ensuring the liaison between the

investigation team and the volunteer in the village takes place. They also support with CEA. They can act as liaison with national NS staff and ERU delegate team.

National NS staff: Together with the PH ERU CBS delegate team they will be responsible for coordination and communication with health authorities and partners, carrying out or supporting data analysis and interpretation, calculation of CBS indicators, development and disseminating of reports, ensuring adequate supervision and monitoring of CBS activities including the performance of volunteers, advocating for a common CBS tool (if CBS is being considered by other partners), and advocating at national and local level for investigations where cases have been detected by Red Cross/Red Crescent volunteers, if these are not taking place as expected.

Data collection, analysis, reporting and sharing

Data to be collected will be defined in the CBS design. It may include three layers of data:

1) Data collected in the CBS digital toolkit. Data that can be collected in the CBS toolkit is limited, as it is intended to be easy to fill out by volunteers, and to allow automatic development of simple analysis and graphs. The CBS digital toolkit can collect the following data:

- Volunteers' name, phone number, area of activity/community (collected during training) – this information is key, as it allows for providing feedback to volunteers when the data they are inputting into the CBS toolkit is not in the correct format.

- Date of report (automatic, from SMS)

- Location (obtained through the area of activity of volunteer reporting, or by GPS)

- Health risk being reported

- Sex of individual presenting health risk

- Age of individual presenting health risk (divided into under-five and five and over categories)

- ORP setting. In the case of CBS in ORPs, the CBS digital toolkit will include the capacity to collect data referrals. Meanwhile, these data can be collected by volunteers on paper-based registries (see below) and transmitted by phone to supervisors or branch officers.

2) Paper-based registries at volunteer level. Volunteers may collect names and addresses and other contact information of affected individuals in notebooks, to ensure proper support and follow up when an investigation is carried out. It is good practice to train them to register in their notebooks all the SMS they send, as this allows for quality assurance later on. The collection of this data must comply with data protection principles and the training given to volunteers must provide them with advice on how to protect the data (e.g., password, coding of identifiable data) and store it securely (e.g., safe or other), as well as the length of time required to store it. Recommendations for storing data (i.e., format and length of time) can differ according to the NS and the country where the ERU is deployed (i.e., according to the Ministry of Health rules).

They may also report on any activity they carried out as a response (prevention messages, community wide health promotion or prevention activities, etc).

In an ORP setting they may have pre-prepared registries that include data on the place of residency, deaths, referrals, ORS distributed, etc.

3) Other data to collect on paper or digital format by supervisors and branch officers may include:

- If an investigation was carried out, and if yes, date, result of the investigation, investigation team and RC person who accompanied the investigation team.

- If a sample was taken, date of sample taking, result of the laboratory test, date of the result and date when it was communicated to the community.

Data analysis must be carried out in an ongoing fashion by the ERU PH CBS team (or ideally by the national NS health counterpart). The CBS digital toolkit (i.e., Telerivet® app linked to Nyss®) will eventually provide automatic reports, but to date still requires exporting data and analyzing it in another software (e.g. Excel, Stata, SPSS, R). Reports aggregating data by time, person (age/sex) and place (location) should be updated daily. Daily or weekly reports can be sent to the MoH and other partners as agreed.

It is important that PH CBS ERU delegates have a generic data sharing agreement that can be easily amended to a particular context. All use of data and all data sharing agreements need to be in line with the IFRC Policy on the protection of personal data[31].

Addressing fear and stigma during outbreaks

Communities can be frightened during outbreaks, in particular in the case of new diseases previously unknown to them or those with a high case fatality rate. If the community has recently experienced a natural disaster or other emergency, this can compound the situation. Stigma related to certain diseases can also be high and has been seen in cholera and Ebola outbreaks in particular.

Both fear and stigma in the communities may affect the ability of the RCRC and authorities to respond. Communities are less likely to report to volunteers, implement behavior change, seek treatment or work together on prevention activities. RCRC volunteers are in a unique position to work with communities and help address fear, stigma, and misinformation as they are a trusted source of information. Sometimes communities can react badly to authorities or outside agencies, especially if isolation units are established in the community. The RCRC plays a vital role in ensuring the cooperation and under-standing of the community for CBS and other outbreak response and prevention activities.

CBS volunteers can work with communities in addressing fear and stigma. In addition, psychosocial support (PSS) trained volunteers can also be brought in to help communities deal with grief if there have been deaths from the outbreak.

Psychosocial First Aid (PFA) for volunteers themselves should be considered if there are high levels of fear and stigma attached to the outbreak or the community is experiencing a high number of deaths. Volunteers are part of the affected community and may be dealing with a lot of pressure, stress and grief themselves.

Coordination and communication

Initial communication during the CBS assessment and design phase is key. CBS advocacy to external partners can be challenging. Advocacy documentation has been developed to support with this.

[31] IFRC Data protection: overview and best practices and Data Playbook Toolkit module 7: Responsible data practices and data protection

Collaboration agreements with MoH (and other partners if appropriate) need to be put into place and should include data sharing agreements in line with IFRC Data protection policy[32].

The use of CBS and CBS tools is now more widespread across NSs and countries, however PH ERU CBS team members should not assume that other delegates or NS staff know about or understand CBS. PH ERU CBS delegates, particularly the team leader, need to ensure proper communication and advocacy around CBS to both NS staff and other ERU team leaders and delegates, explaining clearly what its added value is.

Ongoing coordination and communication need to happen in a systematic and regular way. Adequate measures need to be put in place and roles should be clarified in the CBS protocol and EPoA to plan for regular opportunities to strengthen this communication and coordination (e.g. meetings, phone calls, etc.), at several levels:

a) Inside the PH ERU CBS team, including delegates, national and branch NS staff and volunteers.

- SMS or WhatsApp groups have been shown to be effective and fast communication and problem-solving channels for the team, and also allow to be in touch with supervisors and branch level staff.

- As with other ERU delegate positions, or deployment of surge personnel, PH CBS ERU deployment kits can be linked with email address per CBS kit (or per delegate) that follow the deployment and is passed over to next rotations.

b) Within the whole ERU operation, if it includes more configurations than the PH ERU CBS (e.g., multi modular PH ERUs, PH ERUs such as CCMC PH ERU, clinical ERUs, other PH ERU delegates, WASH ERU/delegates, etc).

- Daily briefings are a good way of keeping activities connected and improving coordination between the various players.

- SharePoint proved to be essential for sharing up-to-date information on the operation and for storing documents, including handover, to ensure a good transfer of knowledge between the different rotations.

c) With the NS governance and senior officials.

d) With health authorities and other partners invested in CBS, surveillance, outbreak investigation and response.

- An important forum for communication and cooperation are the weekly (or during an outbreak, daily) epidemiological surveillance meetings chaired by the MoH or highest surveillance authority, including WHO. Presence of someone from the PH ERU CBS team together with their respective NSs counterparts is key to the visibility and performance of CBS undertaken by the RCRC.

5. Monitoring and Evaluation

A monitoring and evaluation plan for CBS needs to be included in the CBS protocol and EPoA. An M&E tool, including a list of indicators (i.e., with their means of measurement and calculation), for CBS that

can guide this plan is currently under development, and general M&E guidance is available in the CBS guiding principles.

Monitoring. In CBS, the system itself is designed to monitor a specific health risk, thus by default a part of the monitoring and evaluating data is automatically collected and analyzed as part of a CBS operation. This data can feed into production or quality (of an activity) indicators.

In addition, M&E sometimes requires data collection beyond the one obtained by the CBS digital toolkit (i.e., Telerivet® app linked to Nyss®) (see section above for additional data to collect) that will allow to monitor project and volunteer performance.

Qualitative data can be collected through regular communication (informal interviews, semi-structured interviews and focus group discussions) with branch, volunteer supervisors, volunteers, the communities, and local health authorities. Supervision and field visits can also be sources of information. Qualitative data from volunteers and the community is an essential part of contextualizing and understanding quantitative CBS data and explaining CBS indicators.

The aim of monitoring activities is to ensure CBS is working as originally planned. Data allows to tweak the system as needed, for example with refresher trainings for volunteers, supporting volunteers through more engaged supervision/coaching, strengthening non-SMS based data collection, advocating for adequate follow by local health authorities, and verifying that adequate CEA is happening on the ground, in particular reporting back to the communities on the outcomes of outbreak investigation.

Depending on the context where CBS will be implemented, the Table 8 lists common indicators for monitoring of CBS, including CBS core indicators[32].

Table 8: CBS indicators and contexts

Indicator type	Indicator statement	CBS as early warning system (i.e., in an ongoing disaster with a risk of disease outbreaks) With alerts	CBS as active case detection system (i.e., in an ongoing outbreak) without alert	CBS as active case detection system (i.e., in an ongoing outbreak) with alerts	Status
Project coverage and monitoring	% or # of villages covered through active CBS volunteers	✓	✓	✓	**Required**

[32] IFRC CBS core indicators

Project activity output	# of trainers trained in CBS TOT	✓	✓	✓	**Required**
Project activity output	# of volunteers trained in CBS	✓	✓	✓	**Required**
Project activity output	# of people trained in CBS (inclusive of MOH and partners not involved in data collection)	✓	✓	✓	Optional
Project activity output	% of CBS volunteers who are deployed (if using CBS digital toolkit)	✓	✓	✓	Optional
Project monitoring and evaluation	% of **Signal/Rumor/Report** or alerts cross-checked	✓	✗	✓	**Required**
Project monitoring and evaluation	% of CBS **Signal/Rumor/Report** sent correctly by active volunteers	✓	✓	✓	**Required**
Project monitoring and evaluation	% active CBS volunteers per community	✓	✓	✓	**Required**
Project monitoring and evaluation	% of active volunteers submitting **Signal/Rumor/Report** "in time" according to the CBS protocol	✓	✓	✓	Optional
Project effectiveness	# of suspected or confirmed cases that were identified by CBS volunteers per community (i.e., % of CBS **Signal/Rumor/Report** verified as confirmed cases)	✓	✓	✓	Optional
Project effectiveness	% of community **Signal/Rumor/Report** that were referred to health centres/ for treatment by CBS volunteers	✓	✓	✓	Optional

Project effectiveness	% of "true" alerts escalated within 24 hours	✓	✗	✓	**Required**
Project effectiveness	% of CBS alerts escalated triggering an investigation	✓	✗	✓	**Required**
Project effectiveness	% of CBS alerts escalated triggering an investigation in 24 or 48 hours	✓	✗	✓	Optional
Project effectiveness	% of CBS alerts responded to through public health action or measure (i.e., including investigation)	✓	✗	✓	Optional

Evaluation. Where possible, the PH ERU CBS missions should undergo a formal evaluation, either as part of the larger evaluation planned for the whole mission or a smaller, specialized one. The aim of the evaluation is to improve service provision in the future. This is particularly important as the PH ERU CBS is in its early phases in the Movement and collection of lessons learned is key. Relevant findings shall be discussed at the PH technical ERU meetings and CBS TWG, as well as at the general ERU working group. Relevant documents shall be published as agreed to by the organizations involved.

CBS-trained staff not involved in the mission, or external evaluators with experience in CBS in the RC Movement can carry out such an evaluation, based on the original CBS protocol and EPoA, as well as all reports and data collected through operational and monitoring activities. This data can be triangulated against information especially collected during the evaluation through key informant interviews and focus group discussions.

6. Exit of ERU –Handover to operation/ NS

Exit strategy will be determined by context and need. The nature of CBS may change over time (e.g. from active case finding to longer term CBS in a stable context, as an Early Warning System). There will be a need to redesign the CBS protocol. Options can be addressed in a transition plan but should already have been incorporated to a certain extent from the start in the original EPoA and PH ERU CBS protocol. The PH ERU CBS team leader of the second or third rotation is expected to prepare for the eventual transition and exit-planning. The exit strategy needs to be prepared in consultation with the NS and other relevant partners. The CBS TWG should also be consulted if needed.

Many countries with gaps in their facility surveillance systems are now trying to implement long term CBS activities as a way to reinforce epidemic surveillance. Several NS supported bilaterally by PNS or the IFRC are participating in such efforts. As such, there might be considerable interest in transforming the emergency PH ERU CBS into longer-term activities once the emergency is over.

In preparing this exit, focus should be placed upon capacity building of the National Society in-country. All efforts to ensure long-lasting effects, contributing to strengthening the National Society's response

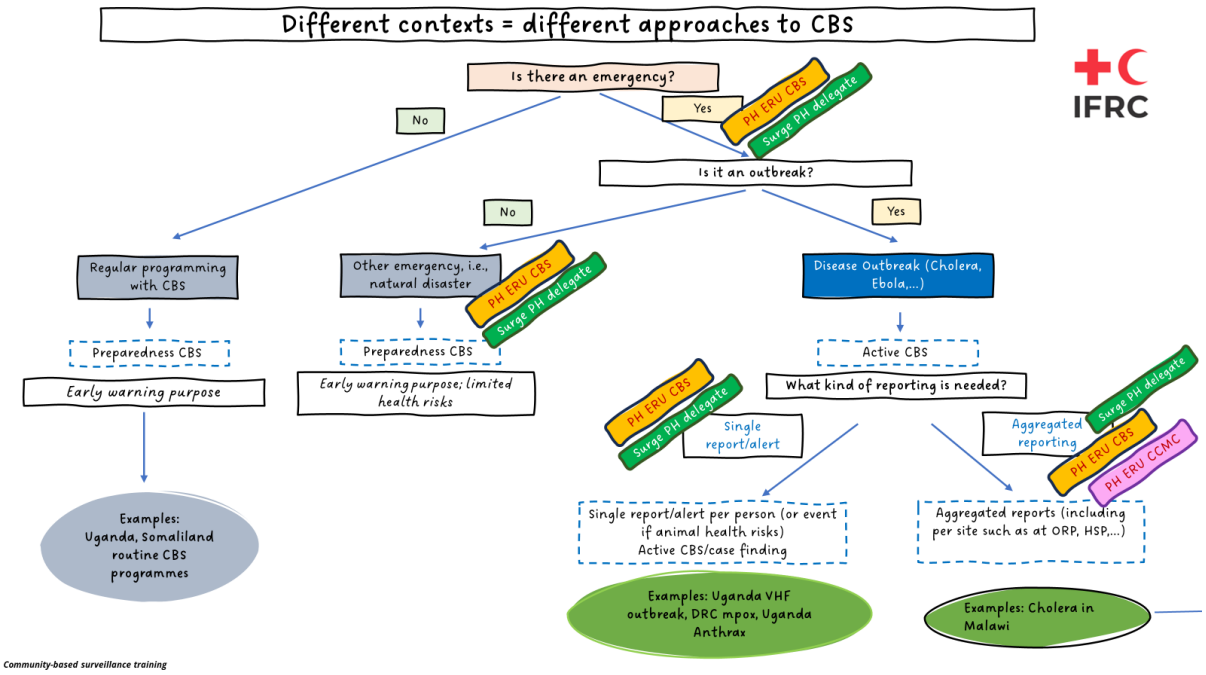
capacity-building and to reducing vulnerability should be undertaken. Additional trainings can be envisaged, to strengthen or refresh original trainings, as well as to solidify CBS management capacities.

Annexes

Annex 1: List of PH ERU Configurations

PH ERU configuration	Objective	Lead NS	Supporting NS
Community Case management of Cholera	Community case management of outbreaks.	Swiss RC	British RC Canadian RC French RC Norwegian RC Spanish RC Swedish RC
Community Based Surveillance	Establishment of event or syndromic surveillance	Norwegian RC	
Safe and Dignified Burials	Support the training and management of Burials for or in highly infectious disease context or mass casualty events	Canadian RC	

Annex 2: Different approaches using CBS



Annex 3: Different surveillance tools (source: CBS training TOT IFRC)

Software Tool	AVADAR	CommCare	Community Health Toolkit	DHIS2 Tracker	EWARS	KOBO Toolbox	Nyss	SORMAS
Description	For detection and reporting of AFP* (potential polio) in communities by community members	For use by CHW** which prompts them in their community health activities and collects data	For use by CHW** which prompts them in their community health activities and collects data	A module of DHIS2 for individual level data at community or health facility level	For emergency settings to facilitate early detection and response to outbreaks	For data collection and reporting. Not specific for surveillance - used for any type of mobile data.	Specific for CBS, for detection and reporting of health risks in communities by community members	For disease control and outbreak detection in an emergency
Main purpose of tool* **	CBS	Community Health Activities	Community Health Activities	Community Health Activities	Data collection/ surveillance	Data collection	CBS	Data collection/ Surveillance
Devices for use	Computer and mobile phone	Computer and mobile phone	Computer and mobile phone	Computer and mobile phone	Computer and mobile phone	Computer and mobile phone	Computer and Mobile phone (web not app)	Computer and mobile phone
App vs SMS	App	App or SMS	App or SMS	App	App or unstructured SMS	App	SMS	App
Phone Requirements (smart vs feature)	Smart	Smart	Feature or Smart	Feature or Smart	Smart	Smart	Feature or Smart	Smart
Case Management	No	Yes	Yes	Yes	Yes	No	No	Yes
Integration with DHIS2	No	Yes	Yes	Yes	No	No	Underway	Yes
Geolocation	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Guided report form	Yes (one question)	Yes	Yes	Yes	Yes	Yes	No	Yes
Dashboard with data analysis	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Data entry into platform by	**Volunteers**	CHW/ HCW	CHW	CHW	CHW/ HCW	Multi-disciplinary	**Volunteers**	HCW/ surveillance officers
Strengths	- Automated escalation of alerts - One question assessment prompt	- Data entry through SMS or app - DHIS2 integration - Case management capabilities -Assessment prompts	- Data entry through SMS or app - Automated escalation of an alert to a supervisor - Can be used on a feature phone - Assessment prompts	- Part of DHIS2 - Case management capabilities - Can be used on a feature phone	- Designed for quick set up - Automated bulletins	- Simple - Assessment prompts for supervisors	- Simple - Can be used of feature phone - Program monitoring - Automated escalation of alerts to a supervisor - Feedback messages to volunteers	- Case management capabilities - DHIS2 integration
Limitations	- Requires smart phone	- Complex tool - Subscription fee - Not specific for CBS	- Tested in two country contexts	- Complex tool - Not specific for CBS - No SMS data entry	- Complex tool - No examples of being used for CBS	- No SMS data entry feature - No automated alerts - Not specific for CBS	- No mobile application	- No SMS data entry feature - No automated alerts - Not specific for CBS

* AFP = Acute Flaccid Paralysis (potential Polio)
** CHW = Community health workers, HCW = Health care workers
*** Some of the tools main purpose is for more general data collection or community health activities. All tools have CBS capabilities

Annex 4: PH ERU CBS delegate personal box content

Item number	Item	Quantity
1	Backpack	1

2	Bottle, aluminum, 600 ml	1
3	Cap	1
4	Cup, plastic	1
5	Detergent pouch of 5	1
6	Ear plug	1
7	First aid kit	1
8	Glass, plastic	1
9	Hand disinfection, Anti-bacterial gel 100 ml	1
10	Head lamp w/batteries+ spare batteries	1
11	Knife, fork and spoon, set	1
12	Mattress inflatable	1
13	Mosquito dome	1
14	Mosquito repellent	1
15	Multi tool (Gerber or similar)*	1
16	Note pad and pen	1
17	Pad lock	1
18	Pillow	1
19	Pillow cover	1
20	Plate, plastic	1
21	Rain poncho	1
22	Sew kit	1
23	Sheet, cotton, 140x240 cm	1
24	Sheet, cotton, stretch	1
25	Sheet, sleeping bag, silk	1
26	Sleeping bag suitable for climate	1
27	Thermos 500 ml	1
28	Thirst quencher powder (20 bags)	1
29	Toilet paper roll	1
30	Torch w/ batteries + spare batteries	1
31	Towel 50 x70 cm, microfiber	1
32	Towel 60x120 cm, microfiber	1
33	Vest cotton with multi pocket, red	1
34	Vest reflective	1
35	Water purification kit	1
36	Water purification tab, Aqua-tab for 10 ltr	1
37	Wet tissue, disinfection pkg	1
38	Working gloves	1
39	Box aluminum 60x40 x40 cm	1
Options:		
*	Only for technician	
Knife, pocket, Victorinox	1	
Money belt (Fin/adm+ TL)	1	

Annex 5: CBS Toolkit Set up

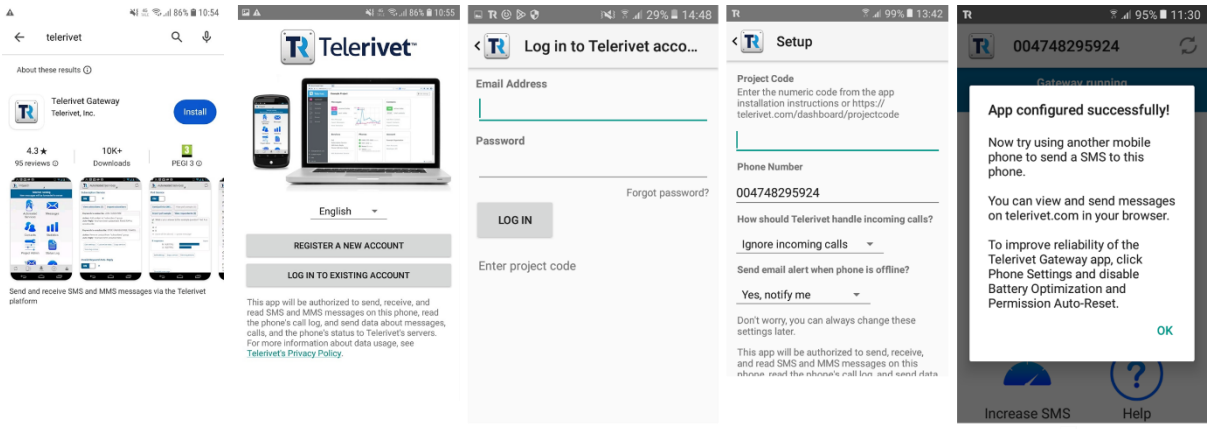
The Epidemiologist ERU delegate will receive equipment and will attend an onboarding with the Norwegian Red Cross IT team and the technical person responsible for support/follow up of the operation.

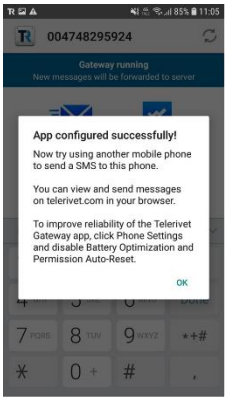
Integration will take place prior to deployment, either online or, preferably, in person.

During the integration, the delegate will assist with the creation of a Nyss® account for the NS and will ensure that the phone that will be used for the SMS gateway is configured with all the necessary applications.

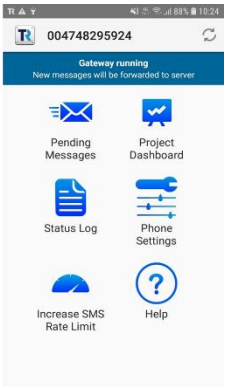
In the field, the ERU epidemiologist delegate will follow the steps below, with the help of the online IT team.

1. Run the Telerivet® application on the smartphone.
2. The first window you will see is in image 2.
3. Click on “LOG IN TO EXISTING ACCOUNT”.
4. Enter the “project code” you received from the IT team
5. Enter “Gateway phone number” which is the number of the SIM card that is in the smartphone. Remember to enter country code. See image 4.
6. For the other boxes, select values same as you see in image 5.
7. Optimize the smartphone by disabling battery optimization and permission auto-reset in the Telerivet® app settings
8. After clicking “continue”, you will see the confirmation message in image 6.
   (If you do not see the same, ensure you have entered everything correctly)
9. Press ok and you will see the main window of application same as image 7. At the top of this window, you should see the Blue bar with the message “Gateway running”. If not, contact the technical team in head office Oslo (nyss@redcross.no)
10. Ensure that the gateway phone's RCS messages setting is turned off. This is a feature that allows the phone to send RCS messages via Wifi when available, instead of SMS. Telerivet® cannot consume RCS messages, so the messages will not get through. This can normally be turned off in the message app's internal settings. Look for RCS Chats and turn the feature off.

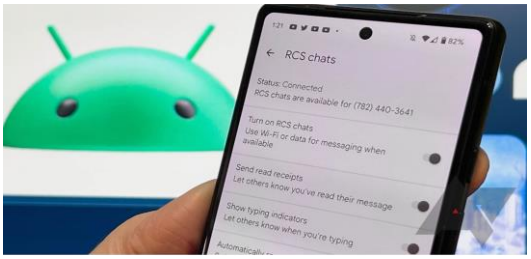



004748295924
Gateway running
New messages will be forwarded to server
App configured successfully!
Now try using another mobile phone to send a SMS to this phone.
You can view and send messages on telerivet.com in your browser.
To improve reliability of the Telerivet Gateway app, click Phone Settings and disable Battery Optimization and Permission Auto-Reset.
OK

6


004748295924
Gateway running
New messages will be forwarded to server
Pending Messages
Project Dashboard
Status Log
Phone Settings
Increase SMS Rate Limit
Help

7


RCS chats
Status: Connected
RCS chats are available for (782) 440-3641
Turn on RCS chats
Use Wi-Fi or data for messaging when available
Send read receipts
Let others know you've read their message
Show typing indicators
Let others know when you're typing

8