

**RRT MF2FW Skills drill facilitation**

**guide**



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RRT Management Training Package

**Scenario-based skills drill:**

***“Unexplained death***

***of children in Karan Province, Salam”***



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# 1. Introduction to the scenario-based skills drill

## 1.1 Skills drill objective

This RRT Management Training Package aims to provide RRT managers with the knowledge, skills, attitudes (KSA) and tools they need to ensure that RRTs are effectively established, run, tested, and maintained during preparedness phase; and that RRTs are operational according to set procedures during response phase.

This skills drill uses a scenario to provide participants the opportunity to reflect on learnings and consider the RRT management principles required to enhance RRT functionality and operationalization. The skills drill was designed to be conducted after participants have completed the RRT Managers Training Package and acquired the necessary knowledge and skills on the various content areas covered. The skills drill has been developed from the skills drill in the RRT Advanced Training but aims to provide the RRT management perspective to the scenario.

*Note: Running this scenario-based skills drill* *as described in this guide requires approximately 2 hrs.*

## 1.2 Group work and facilitation

* Participants will work through the skills drill in groups of 5 or 6 participants.
* **A facilitator** will be assigned to each group to:
* Manage time.
* Make sure that participants come up with the expected outputs.
* Provide clarification on tasks as required.
* **Role-players** are facilitation team members who have been asked to play different script-based “roles” during the scenario-based skills drill. Role players will:
* Use the information provided in the scripts, as well as their knowledge of the whole scenario, to respond to participants’ questions, if any.
* They are not expected to invent any new information/developments to the scenario.



## Resources needed to facilitate the skills drill

* **Facilitation guide** (this document): a detailed step-by-step guide to facilitate the skills drill.
* **Participant guide:** a guide that includes the information and instructions to be given to participants.

**Note:**

*The Facilitators guide should be printed out TWO sided, stappled, and distributed to all facilitators at least one day in advance of running the session. Facilitators should meet the day before to run through the session and clarify anything that is not clear.*

*The Participant guide should be printed out TWO sided, stappled, and distributed to participants at the start of the session.*

# 2. Scenario and step-by-step guide

## 2.1 Country context

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| **Area** | **630,278 sq. Km** |
| **Population** | **30,5 million** |
| **Capital** | **Mando City** |
| **People** | **Agawid (72%), Thowar (22%), British decent, tribal groups and others (6%)** |
| **Language** | **Arabic, English, Thowari and 102 local languages for each tribe** |
| **Religion** | **Islam (65%), Christian (20%), others (15%)** |
| **Currency** | **1 USD= 500 Salam pounds** |
| **Weather** | **Tropical with 2 rainy seasons (May -June, August –September)** |

**Salam** has a long coastline. It shares boundaries with Monogo to the east, Barry to the west, Bamboka to the north, and the Bay Ocean to the south. The country lies between latitude: 6 degrees, 30 minutes north and longitude: 0 degrees, 20 minutes east. The coastline is 539 km long, with a total area of 238,540 km2 and a land area of 230,020 km2. Salam is endowed with various water bodies, including rivers. The two main rivers are the Puti and Bughaw rivers.

The capital city of Salam is Mando, which also has the largest population density in the country. The national airport is located in the suburb of the city. The second largest city is Tomogo, which is located along the coast.

Salam gained its independence from the British in 1948.



*Figure 1: Salam map*

**Climate**

The climate in Salam is tropical. The coastal belt is warm and moderately dry. The Northwest corner has a hot and humid climate, while in the East, the climate is hot and dry. In Salam, there are 2 distinct rainy seasons: May to June, and August to September. In the north, the rainy seasons tend to be merged. In January and February, there is a dry north-easterly wind. There is an annual rainfall in the coastal region that averages 83 centimetres.

The rainy season could be considered as a challenge for many people. Heavy rains could plunge many parts of the country in darkness due to power cut-offs. Villages and small cities would be totally isolated and inaccessible as the transportation network will be affected. Damaging floods associated with heavy rainfall events have been reported in Salam over the past 10 years.

Moreover, tropical cyclones pose a serious threat to Salami communities and industry. The coastline of Salam is close to the equator, a region where cyclones tend to form.

In 2011, over one-night, heavy rainfall occurred over the southern Province, Puti river catchments, resulting in flash flooding along the river. A rapid river rise damaged the Bughaw River railway bridge, causing a 20-wagon freight train to derail while crossing over it. The train was carrying 1,500 tonnes of copper concentrate when it derailed, and up to 1,200 tonnes of the substance spilled into the Bughaw River.

Despite the heavy raining, some parts of the country are exposed to recurrent droughts that severely affect the agriculture. Moreover, deforestation and soil erosion deeply affect the land, water, and people of the Salam.

**Population**

Salam has an estimated population of 30,500,420 (2015 Population and Housing Census) and an average population density of 102 per km2 (varying from 1,205 per km2 in the central region to 35 per km2 in the border regions). The male to female ratio is 1.2. An estimated 75% of Salami are under the age of 25, with just 3% over the age of 65, making it one of the most youthful populations in the world.

Salami population is composed of Agawid (72%), Thowar (22%), and British descent, tribal groups and others (6%). **Agawid** people are the largest and most powerful ethnic group in Salam. They effectively control the Salam Government, the National Military Army, as well as the economic/industrial sector in Salam.

**Thowar** arrived in Salam as part of the 16th century migration that occurred due to the great tribes’ war in the region. During this timeframe, the slave trade was becoming more prominent within Salam. The Thowar were so opposed to slavery within their own tribe members that many committed suicide rather than face enslavement. The remaining 6% of the Salami population are divided into over one hundred ethno-linguistic groups, some with their own justice and political systems.

Over the past ten years, there has been a resurgence of ethnic conflict, particularly in the Karan province in the Northeast corner of the country, which is primarily populated by Thowar people. The Thowar liberators, known as the Thowar armed liberty movement (Thulib), have been gaining popular support from the disaffected Thowar people. Thulib have been fighting for an independent state. Most young men have either joined this armed movement or fled from this conflict. Since last year, more than 50,000 people have been internally displaced, while 37,000 have become refugees at the neighbouring countries.

**Economy**

The economy in Salam is dominated by the agriculture sector, which includes 55.8% of the adult labour force. The economy also consists of a small capital-intensive industrial and mining sector, and a growing informal sector (small traders and artisans, technicians and businessmen). Major oil discovery off the coast of Salam in 2007 has led to significant international commercial interest in Salam. Oil is expected to account for 6% of the revenue for 2016.

Despite some progress, security and political uncertainty remain formidable challenges. The rule of law continues to be fragile and uneven. The inability to deliver even basic services on a reliable basis, often exacerbated by systemic corruption, has severely eroded confidence in the government.

**Culture, beliefs and practices**

Salami people have an extended family structure. It is not unlikely that a household be composed of 30 – 40 members. Decision-making on big family issues are the domain of male elders (grandfather, eldest son), while caring and day-to-day household decisions are the function of the mothers/grandmother. In case of an ill member of the family, the closest female member will be assigned to care for the sick (mother for children and husband, sister or mother for females).

The literacy rate is 46 % overall (58% for men and 36% for women). Girls generally receive less education than boys, as families often consider it more valuable for their daughters to learn domestic skills and to work at home.

Food is an important part of many social interactions. Visits typically include tea, coffee, or soda, if not a full meal. It is customary to eat from a common serving bowl, using the right hand rather than utensils. Communal eating is the norm, even when somebody is sick. People sit on pillows around a low table. Before the meal, towels and a pitcher of water are passed around for hand washing.

In the Salam tradition, death is followed by several days of mourning when friends, relatives, and neighbours pay their respects to the family. Salami place very important regard in burying their dead (“It is NOT a dead body, but the body of a person who died.”). Preparing the deceased is a time to show respect and share condolences and is done by the next-of-kin in the presence of the influential members of the community.

**Health**

Life expectancy in Salam is estimated to be 66 years for men and 77 years for women. The mission of the Ministry of Health is to contribute to socio-economic development and wealth by promoting health and vitality, ensuring access to quality health, population, and nutrition services for all people living in Salam, and promoting the development of a local health industry. Its mission shifts the focus of health beyond the limits of clinical care to other socio-economic determinants of health.

The well-being of Salami is greatly impacted by the poor environmental conditions they live in, work in, and go to school in. A serious threat to public health is the poor air, water, and soil quality caused by the improper disposal of waste, the emission of dangerous gases from industries and vehicles, and smoke from the burning of waste and from bush fires.

Salam’s infrastructure for waste management has not kept pace with its population growth. Only one-third of the waste produced in the urban centers is collected, leaving the rest to pollute the environment. Access to potable water is also a problem. Less than half of the population in Salam have access to potable water. The rest of the population accesses water from streams and rivers, which are often contaminated with organic and inorganic substances. The situation is more pronounced in communities located around mining areas, in which substances such as cyanide flow to pollute the water. Therefore, due to poor lifestyle and environmental factors, morbidity and mortality rates are high.

Salam, like other developing countries, can be described as being in an epidemiologic transition characterised by a high burden of infectious (communicable) diseases, rising incidence of non-communicable diseases, having a slow but gradual reduction in child mortality, and an increasing ageing population. Even though Malaria accounts for approximately 30-40% of outpatient visits and approximately 20% of deaths, Salam is prone to epidemic diseases, and this continues to be a public health problem. Frequent outbreaks of Cholera, Cerebro-spinal meningitis, and Yellow Fever are among the top causes of death and disability each year. Other emerging diseases at risk of an epidemic, posing to cause serious health insecurity include SARS (2003), Avian Influenza (2005- 2006), Pandemic H1N1 2009, (2009-2010), Rift Valley Fever (2012), as well as the recent Ebola Virus Disease (2015) and Covid-19 since 2020.

There are many challenges facing the health system in Salam. There are serious leadership and governance challenges that include weak public health leadership and management, inadequate health-related legislations and enforcement, limited community participation in planning, management, and monitoring of health services, weak inter-sectorial action, horizontal and vertical inequities in health systems, inefficiency in resource allocation and use, and weak national health information and research systems.

Moreover, there are extreme shortages of health workers. This issue has been exacerbated by inequities in workforce distribution and brain drain. Thus, the delivery of effective public health interventions to people in need is compromised, particularly in remote rural areas. The ability to access quality medical care can be quite difficult for most of the population in Salam. Cost is another aggravating factor that contributes to the healthcare accessibility issue. It is estimated that over 70% of Salami people rely on traditional medicine for the treatment of both communicable and non-communicable diseases. Herbalists are supposed to register with the National Council of Chiefs and Elders of Salam to practice and open a clinic, although many are not registered.

## 2.2 Step-by-step facilitation guide

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| Overview and breakdown |

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| **Section/step** | **Duration** | **Comments** |
| **Country context (pages 4-8)** | 30’ | To be send to participants to be read the day before the skills drill |
| **Introduction to the skills drill (page 3)** | 10’ |  |
| **Step 1 Activation and pre-deployment – Introduction**  **(page 9)** | 5’ |  |
| **Step 1 Group work/questions 1 to 4, inject 1 and 2** | 35’ | Injects are provided while groups work on questions |
| **Step 2 Deployment – Introduction** | 5’ |  |
| **Step 2 Group work/inject 3, question 5** | 20’ | Inject is provided before groups start working on the question |
| **Step 3 Post-deployment – Introduction** | 5’ |  |
| **Step 3 Group work/question 6** | 10’ |  |
| **Debriefing** | 20’ |  |
| **TOTAL** | **120’** |  |

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| Introduction to the RRT management skills drills (5 min) |

**Objectives**

This skills drill uses a scenario to provide participants the opportunity to reflect on learnings and consider the RRT management principles required to enhance RRT functionality and operationalization. The skills drill was designed to be conducted after participants have completed the RRT Managers Training Package and acquired the necessary knowledge and skills on the various content areas covered. This skills drill has been limited to 1.5 hrs duration for feasibility.

**Group work and facilitation**

* You will work through the skills drill in groups of 5 or 6 participants.
* **A facilitator** will be assigned to each group to:
* Manage time.
* Make sure that participants come up with the expected outputs.
* Provide clarification on tasks as required.
* **Role-players** are facilitation team members who have been asked to play different script-based “roles” during the scenario-based skills drill.

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| Step 1: Activation and pre-deployment (35 min) |

**1.1 Information provided in the participant guide**

(The box below contains the text of the newspaper’s article)

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| **Title: Mysterious Virus Harvesting Children and women in Sayan**  **Date: Thu 22 July 2021**  **Source: Salam Times, Late edition**  Governmental officials have declared the deaths of more than 100 people in Karan province in Northern Salam. The recorded deaths were caused by a mysterious virus. Severe acute diarrhoea and vomiting are the main symptoms of this strange epidemic. Salam officials stated that there have been about 65 deaths, mostly children and women, reported from one village called Syan. The remaining deaths were recorded in the neighbouring villages.  An independent medical source (who requested anonymity) confirmed that the virus started to spread to other regions, threatening the life of mainly young children. She added, “I expect to witness similar cases infected by this strange virus in Mando city, the capital of Salam, soon.” |

**1.2 Instructions for participants and questions to be discussed**

Instruct participants to read the information provided and answer the questions below. They should allocate a timekeeper to ensure they keep to the time allocated for each question, and a note taker to record the discussion to feed back to the group at the end of the session and be ready to present them in plenary.

***Instructions***

You as the RRT Manager (management team) at the Emergency Operations Centre (EOC) you consider activating the RRT.

**Question 1: What are some of the criteria you consider when deciding whether to activate the RRT? (10 minutes)**

Based on these criteria you decide to activate the RRT and ask the team to investigate, confirm, or discard the rumours, and take initial control and prevention measures as required.

**Question 2: What SOPs and/or tools do you need to review prior to activating the RRT? (10 min)**

**Question 3: What additional information do you need to gather prior to bringing the team together for a pre-deployment briefing? (10 min)**

**Question 4: What information do you need to provide in the pre-deployment briefing? (10 min)**

You work with the RRT team lead and RRT members that will be deployed to develop the outputs listed below (due to time constraints there is no need to do this in this skills drill, the list is provided to remind you of outputs that are expected prior to deployment):

1. Agree on the RRT composition and Terms of Reference of various members
2. Discuss further information that is needed prior to deployment
3. Develop a basic plan of action
4. Develop a Logistic checklist for deployment
5. Develop a communication plan
6. Finalize the format for the SITREP and schedule for dissemination to the RRT Manager of the Emergency Operations Centre (EOC)

The RRT team lead reaches out to health workers in the affected area to verify the newspaper report.

**1.3 Inject 1: The newspaper is “wrong”**

Phone call from Hospital Manager (HM): he says that the information given in the newspaper is “wrong.”

**Role-play:** A facilitator plays the role of the HM, holding a phone and indicating they are making a call. Another facilitator holds a second phone and explains to the group that they have a call from the HM in Syan district and asks a participant to play the role of the RRT team leader receiving the call.

***Script for RRT team lead, role play:***

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| “The condition is not as bad as described by the newspaper. The hospital did not observe any deaths or cases of any mysterious virus infection. The only thing that is worth reporting is the admission of a family suffering from food poisoning earlier this week. Four individuals from the same family, complaining of acute diarrhoea and vomiting, were referred from the Syan primary health unit. Their condition has improved, except for the mother and young boy. Food and waterborne illnesses are extremely common in the region due to damaged infrastructure by the current conflict. Some cases of acute diarrhoea were seen in the outpatient clinics as well.” |

**1.4 Inject 2: Email from the Head of the Communicable Disease Department at Karan province:**

The RRT manager receives an email from the Head of the Communicable Disease Department at Karan province (HCDD): He says that investigation efforts might be hampered. The email text below is included in the participant guide.

***Script for HCDD at Karan province:***

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| “We are currently investigating these rumours, but we might face some challenges as some parts of Karan province lie under the control of Thulib rebels, which could hamper any investigation/ response efforts.  I don’t want to jump to conclusions, but I think that there are no unusual cases or deaths, and it is just a rumour.” |

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| Step 2: Deployment (20 min) |

The RRT team has deployed to the field. It has been two days since they deployed, and the management team receive a phone call from the RRT team lead.

**2.1 Inject 3: Update from the RRT team lead:**

The RRT manager receives a call from the RRT team lead.

**Role play:** A facilitator plays the role of the RRT team lead, holding a phone and indicating they are making a call. Another facilitator holds a second phone and explains to the group that they have a call from the RRT team lead and asks a different participant to play the role of the RRT manager and receive the phone call.

***Script for RRT team lead at Syan district:***

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| “As a result of my team’s efforts, we have received some interesting information. The team contacted the health officer at the Syan primary health unit, who is the attending physician at Karan General Hospital, and works at Syan health units twice a week, due to the absence of medical staff in Syan. He stated that several cases of acute watery diarrhoea were seen at the PHU, mostly of moderate intensity. Only two cases were referred to Karan General Hospital. He has heard rumours of more cases in the community.  He also complained of shortages of staff, medical supplies, and diagnostic tools in his unit. We will send through a situation report at the end of the day.” |

**Question 5: As the RRT manager what action do you take? (10 min)**

You work with other members of the RRT management team to (due to time constraints there is no need to do this in this skills drill, the list is provided to remind you of outputs that are expected during the deployment phase):

1. Ensure you receive regular SITREPs from the RRT team to be shared with EOC
   1. Monitor the situation and response activities to ensure response activities are making an impact.
2. Ensure the process for monitoring and evaluating RRT staffing, and response needs is clear and actively reviewed.
   1. Identify surge capacity from the roster to meet identified needs
   2. Use the deployment tracker
   3. Review and update the Logistic checklist to meet identified needs
   4. Make note of challenges and actions taken to address challenges
3. Regularly monitor the team’s safety, security and well-being.
4. Update the communication plan as needed.

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| Step 3: Post-deployment (15 min) |

The RRT team has returned from the field. The team successfully investigated and contained an outbreak of cholera that had spread to three villages in Syan district.

The response took 4 weeks, and the team faced security threats when the Thulib rebels blocked road access to one of the affected villages, preventing medical supplies from reaching the village. Four people in the village subsequently died of dehydration, 2 young children, their mother and a village elder.

**Question 6: As the RRT manager what is your responsibility in the post-deployment phase? (10 min)**

You work with other members of your team to develop the outputs listed below (due to time constraints there is no need to do this in this skills drill, the list is provided to remind you of outputs that are expected during the post-deployment phase)

1. Final response report
2. Update of RRT roster / deployment tracker
3. After action review report
4. Action plan for recommendations

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| Debriefing – Instructions for facilitators (20 min) |

Take 20 minutes to discuss the answers, asking one group to report back on each answer, and inviting other groups to add anything that was not previously mentioned.

**Response 1: What are some of the criteria you consider when deciding whether to activate the RRT?**

* Severity of disease/public health impact
* Size of outbreak
* Risk of transmission
* Location or geography
* Local capacity to respond
* National capacity to respond
* Funds
* Media attention/public concern and political will
* Leadership decisions.

**Response 2: What SOPs and/or tools do you need to review prior to activating the RRT?**

* RRT activation and pre-deployment SOP
* RRT roster, job profiles and description of RRT members
* RRT financial and administrative SOP

**Response 3: What additional information do you need to gather prior to bringing the team together for a pre-deployment briefing?**

* Assess the local capacity to respond.
* Identify appropriate skill sets needed to respond to the alert.
* Need to identify the most appropriate team members based on skill sets needed.
* Ensure selected team members medical clearance / vaccinations/ RRT training etc. up to date.
* Need to consult with finance and logistics team to arrange travel and lodging arrangements, funds/advances, administrative paperwork, others?
* Gather as much detail on the current situation as possible– background on location, what is known about the situation, key contacts, safety and security, health and wellbeing considerations for RRT members.
* Consider the need for just-in-time training and arrange as needed.

**Response 4: What information do you need to provide in the pre-deployment briefing?**

* Provide information on the current situation
* Description of the current situation and available data
* Review of prior response to the same situation or interventions
* Identification of key stakeholders and affected populations
* Language, religious beliefs in the affected area
* Identify key contacts
* Safety and security issues and strategies
* Health and wellbeing considerations
* Roles & responsibilities of each team member and designate a team lead.
* Code of conduct
* Preparation before deployment
* Actions in the field
* Use of standardized tools or equipment needed to complete the actions
* Coordination between team members and relevant partners
* Communication plan.
* Develop clear well-defined objectives for response activities with relevant indicators/metrics.
* Identification of possible challenges and actions to address them
* Clearly articulate reporting mechanisms, format and frequency including emergency evacuation plans.
* Identify necessary equipment and supplies needed by the team – including personal protective equipment, communication, technical. Confirm the team are trained on the use of necessary equipment
* Discuss supply and distribution plan during deployment.
* Schedule for any just-in-time training.

**Response 5: As the RRT manager what action do you take?**

* Ask for more details on specific logistical and HR needs on the ground.
* Discuss with logistics and finance identified needs and establish a distribution plan.
* Review the RRT roster to identify surge capacity to address specific HR needs.
* Provide an update to the EOC.

**Response 6: As the RRT manager what is your responsibility in the post-deployment phase?**

* Conduct a post-deployment briefing with the RRT team
* Check in on the health and wellbeing of team members and refer for additional support as needed (healthcare, psychosocial support)
* Finalization of residual response activities
* Conduct an after-action review after the response ends
* Documentation of outputs from debriefs and after-action reviews
* Develop an action plan for implementing recommendations from team debriefs and after-action reviews.