**RRT training package**

**A3.2 Logistics checklist exercise**

**Facilitator guide**

**Learning objective:**

* Identify the equipment, materials and supplies needed by RRT members for a specific public heath event.

**Duration:** 60’ total (Intro: 5’; group work: 15’; debrief: 5’ per group, wrap-up: 10’).

**Method**: Group work involving flip boards and different disease syndromes.

**Groups**: 3-6 groups will be formed depending on participant numbers.

1/Each group will be given a brief description of a syndrome to which they are responding (see Annex 1 below):

* + Suspected Ebola Virus Disease (EVD)
  + Suspected Rift Valley Fever
  + Suspected Anthrax
  + Suspected Severe Acute Respiratory Syndrome (SARS)

2/Each group should prepare a checklist of materials and equipment to bring to the field.

**Full debriefing by each group**. Comparison between the different needs depending on syndrome.

**Training tips:** Identify what critical materials/equipment/supplies is always required for the RRT, independently of the type of event to be investigated, and highlight them.

Highlight the materials/equipment/supplies that are disease and/or context specific.

Also discuss what the RRT should do in the field if they need to source further or get new materials/equipment when they are already deployed.

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**Annex 1: Syndromes description** (to be printed out for participants).

**Suspected EVD**

EVD, formerly known as Ebola haemorrhagic fever, is a severe, often fatal illness in humans. The virus is transmitted to people from wild animals and spreads in the human population through human-to-human transmission.

The average EVD case fatality rate is around 50%. Case fatality rates have varied from 25% to 90% in past outbreaks.

The first EVD outbreaks occurred in remote villages in Central Africa, near tropical rainforests, but the most recent outbreak in West Africa has involved major urban as well as rural areas.

Community engagement is key to successfully controlling outbreaks. Good outbreak control relies on applying a package of interventions, namely case management, surveillance and contact tracing, a good laboratory service, safe burials and social mobilisation.

Early supportive care with rehydration, symptomatic treatment improves survival. There is as yet no licensed treatment proven to neutralise the virus but a range of blood, immunological and drug therapies are under development.

There are currently no licensed Ebola vaccines but 2 potential candidates are undergoing evaluation.

**Suspected Rift Valley Fever**

Rift Valley fever (RVF) is a viral zoonosis that was first identified in Kenya in 1931. This mosquito-borne disease primarily affects animals but that also has the capacity to infect humans. The vast majority of human infections result from direct or indirect contact with the blood or organs of infected animals. Such contact may occur during the care or slaughtering of infected animals or possibly from the ingestion of raw milk. Human infection can also result from the bites of infected mosquitoes.

While most human cases are relatively mild, a small percentage of patients develop a much more severe form of the disease that appears as one or more of three distinct syndromes: ocular disease, meningoencephalitis and viral haemorrhagic fever. For the most severe cases, the predominant treatment is general supportive therapy.

**Suspected Anthrax**

Anthrax is primarily a disease of herbivorous mammals, although other mammals and some birds have been known to contract it. Until the introduction and widespread use of effective veterinary vaccines, it was a major cause of fatal disease in cattle, sheep, goats, camels, horses, and pigs throughout the world. Anthrax continues to be reported from many countries in domesticated and wild herbivores, especially where livestock vaccination programmes are inadequate or have been disrupted.

Humans generally acquire the disease directly or indirectly from infected animals, or occupational exposure to infected or contaminated animal products. Control in livestock is therefore the key to reduced incidence. The disease is generally regarded as being non-contagious. Records of person-to-person spread exist, but are rare.

**Suspected SARS**

Severe Acute Respiratory Syndrome (SARS) is a disease of unknown etiology that has been described in patients in Asia, North America, and Europe.

The incubation period of SARS is usually 2-7 days but may be as long as 10 days. The illness generally begins with a prodrome of fever (>38°C), which is often high, sometimes associated with chills and rigors and sometimes accompanied by other symptoms including headache, malaise, and myalgias. At the onset of illness, some cases have mild respiratory symptoms. Typically, rash and neurologic or gastrointestinal findings are absent, although a few patients have reported diarrhoea during the febrile prodrome.

After 3-7 days, a lower respiratory phase begins with the onset of a dry, non-productive cough or dyspnea that may be accompanied by or progress to hypoxemia. In 10%-20% of cases, the respiratory illness is severe enough to require intubation and mechanical ventilation. The case fatality among persons with illness meeting the current WHO case definition for probable and suspected cases of SARS is around 3%.