



**C1.1**

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**Participant guide**

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**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 The skills within the Rapid Response Teams Advanced Training Package

The Rapid Response Teams Advanced Training Package (RRT ATP) is composed of four learning units, including unit A RRT in context, unit B Technical modules, unit C RRT skills drill, and unit D Evaluation and way forward, that are described below:

**Learning Unit A – RRT in Context** **(didactic)**

Learning unit A prepares RRTs for field deployment, providing them with a good understanding of national and international emergency coordination mechanisms, the composition of an RRT and the roles of its members, response stakeholders in the field, common RRT deliverables, as well as the role of RRTs within the country’s national emergency response coordination structures.  This learning block also enables RRT members to prevent and manage occupational health risks and safety hazards; to follow ethical rules and prevent sexual exploitation and abuse during their intervention in the field.

**Learning Unit B – Technical modules** **(didactic)**

Learning unit B focuses on strengthening participant’s knowledge and skills in the following technical modules: epidemiology and surveillance, including active case finding and contact tracing, data management, outbreak investigation, rapid risk assessment, infection prevention and control, laboratory sample management, social mobilization and community engagement, risk communication, and psychosocial first aid.

**Learning Unit C – Scenario-based skills-drill** **(practical)**

Learning unit C enables RRTs to apply and practice the knowledge and skills from the various content areas covered in the didactic component of the RRT ATP (learning blocks A and B), including RRT composition and deployment, logistics needed for deployment, active case finding and contact tracing, data management, outbreak investigation, infection prevention and control, laboratory sample management, community engagement and risk communication, psychosocial first aid and ethics.

**Learning Unit D – Evaluation and way forward**

Learning unit D provides methodologies and tools for evaluating RRT training in terms of participant satisfaction, learning and application to the job. It also provides information on next possible steps, especially on how to join the RRT Knowledge Network, a community of practice of RRT members who have been trained by WHO, international and national RRT facilitators, relevant partners.

The skills drill was designed to be conducted after participants/RRTs have completed the RRT Essentials Online Learning Programme and acquired the necessary knowledge and skills on the various content areas covered in the didactic component of the RRT ATP (units A and B).

## 1.2 Skills drill objectives

This scenario-based skills drill uses a progressive scenario, together with a series of scripted injects, to enable multidisciplinary Rapid Response Teams (RRTs) and their individual members to practice and demonstrate the knowledge and skills needed for early detection and effective response to any public health event.

The scenario illustrates the detection of different potential hazards such as chemical and environmental, in addition to communicable disease outbreaks, in an imaginary country (Salam). All information used is fictitious and was specially created for learning purposes.

Both the didactic and the skills drill components of the RRT Advanced Training Package enable RRTs to acquire and demonstrate the knowledge and skills needed for early detect and timely response of potential public health hazards. More specifically, the package enables RRTs and their individual members to:

* Act as a functional multidisciplinary team when requested by the relevant public health authority.
* Conduct a rapid risk assessment at the beginning of a public health event and periodically throughout to guide evidence-based decisions for the response.
* Carry out an epidemiological investigation of suspected cases either to confirm or disprove an outbreak.
* Collect, analyze and interpret data to support decision making for response to public health events.
* Conduct active case finding and contact tracing activities to effectively control a potential outbreak.
* Apply Infection Prevention and Control measures based on risk assessment findings.
* Perform safe collection of samples from suspected cases and arrange for packaging and transportation to reference laboratory.
* Prevent and manage occupational health risks and safety hazards during field work.
* Follow ethical practices while responding to public health events.
* Communicate risk effectively using messages and channels adapted to the audience and the situation.
* Engage communities, with regards to their culture, in response activities using approaches and tools adapted to different phases of a public health event.

## 1.3 Group work organization

* Participants will work through the skills drill in groups of 6 or 8 participants, ideally representing multidisciplinary backgrounds (e.g., Case management, epidemiology, laboratory, risk communication, social mobilization, and infection prevention and control) (1 group = 1 RRT)
* Team coach and team evaluator:
* A coach will be assigned to each RRT
* An evaluator will be assigned to each RRT.

# 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 is 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). The overall education level of the population has increased since independence. In the mid-1950s, fewer than 150,000 children were enrolled in primary school, compared with more than 2 million today. However, the north still has fewer schools than the south. Most of the schools in the south were established during colonial times and the government continues to run these schools. 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.

**Salam Ministry of Health organogram**



## 2.2 Step-by-step guidance

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| **C1 RRT activated (2h)** |

**1. Information to be given to participants**

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| **Title: Mysterious Virus Harvesting Children and women in Sayan**  **Date: Thu 22 July 2021**  **Source: Salam Times, Late edition**  <http://www.salamtimes.sal.html>  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.” |

**2. Instructions for participants, session outputs and references**

***Instructions***

Your group is the national RRT in Salam. Alerted by rumours spread by the media, Dr Zaher, the RRT Manager at the Emergency Operations Center (EOC) activates the RRT and asked the team to deploy to investigate, confirm, or discard the rumours, and take initial control and prevention measures as required. Dr Zaher calls the RRT for a meeting this afternoon, 23 July 2021, for a pre-deployment briefing. The RRT should gather all possible data and information about the situation before deployment. The team must prepare an action plan and discuss it at the pre-deployment meeting. The action plan should be updated as the scenario moves forward, based on new information received. The team - through the RRT team leader - should update Dr Zaher, RRT Manager at the EOC, with a situation report (SITREP).

***Outputs (to be presented by the team at the end of the session)***

1. RRT composition and Terms of Reference of various members defined (Session C1 Annex 1).
2. Topics to be discussed/information to be gathered at pre-deployment briefing (Session C1 Annex 2).
3. Basic plan of action developed (Session C1 Annex 3).
4. Logistic checklist for deployment developed
5. SITREP for the RRT Manager at the EOC for next steps developed (Session C1 Annex 4).

***References***

* First steps in managing of acute diarrhoea. WHO <https://www.who.int/publications/i/item/first-steps-for-managing-an-outbreak-of-acute-diarrhoea>
* Foodborne disease outbreak, Guideline for investigation and control. WHO. <https://apps.who.int/iris/bitstream/handle/10665/43771/9789241547222_eng.pdf?sequence=1&isAllowed=y>
* Outbreak Investigation Team Roles and Responsibilities. Communicable Disease Outbreak Manual. New Jersey’s Public Health Response <https://www.nj.gov/health/cd/edu_training/disease_investigator_video_res_guide.pdf>

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| **C2 At Karan General Hospital: interview with medical staff (1h30)** |

1. **Information to be given to participants**

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| The RRT goes to the field to investigate the event. The team decides to start by visiting Karan General Hospital. At Karan General Hospital, the team should meet with the Hospital Manager to introduce themselves and explain the objectives of their mission to ensure his cooperation. They will also meet with the Medical Doctor who was present at the Emergency Room when the cases were admitted. |
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**2. Instructions for participants, session outputs and references**

***Instructions***

At Karan General Hospital, teams will interview:

* The **Hospital Manager,** to introduce the team and explain the objectives of the mission to ensure his cooperation.
* The **Medical Doctor,** to obtain data about the admitted cases.

Hospital registry will be distributed by the hospital manager and medical records will be distributed by the medical doctor. RRTs should review the medical records and hospital registry to summarize the clinical features and construct a functioning case definition and line listing. They should consider active case finding to identify more cases.

***Outputs:***

1. Develop a case definition
2. Develop a line listing tool
3. Recommend initial prevention and control measures to the Hospital Manager

***References:***

* Lesson 6: Investigation of an outbreak. Principle of epidemiology in public health practices.

<http://www.cdc.gov/ophss/csels/dsepd/SS1978/Lesson6/Section2.html>

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| C3 At Karan General Hospital: interview with patient/ sample collection (1h30) |

**1. Information to be given to participants**

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| Now the RRT is going to interview the patient (Mrs. Laila Samy) to collect more information and obtain the appropriate laboratory sample. |

**2. Instructions for participants, session outputs, and references**

***Instructions***

Before entering the patient’s room, you should prepare all the required forms and materials that you will need. When you enter the patient’s room, ensure that you apply the appropriate IPC measures, and most importantly, that you are aware of the patient’s anxiety, and the need for respectful and dignified treatment. You will then interview the patient to obtain more data and to collect the appropriate sample.

***Outputs:***

1. Relationship with the patient: respectful of the patient’s culture, situation, and fears.
2. Initial case investigation form completed, including patient’s personal information, history, clinical picture, exposure, and possible contacts recorded (Session C3 Annex 1).
3. Appropriate material for sample collection selected and properly disposed after use; laboratory test request form properly completed (Session C3 Annex 2).
4. Correct selection, practice of donning and doffing PPE observed, proper management after use, correct hand hygiene practice.

***References:***

* + Laboratory methods for diagnosis of dysentery epidemic and cholera. https://www.cdc.gov/cholera/pdf/Laboratory-Methods-for-the-Diagnosis-of-Epidemic-Dysentery-and-Cholera.pdf
  + Laboratory Methods for the Diagnosis of Vibrio Cholerae Centers for Disease Control and Prevention: Chapters 4 to 7, accessible at: <http://apps.who.int/iris/bitstream/handle/10665/66885/WHO_CDS_CSR_EDC_99.8.pdf;jsessionid=EE8FB1C128C0DEAB4AE5900F7E5069EB?sequence=1>

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| **C4 Communication and community engagement (1h 00)** |

**1. Information to be given to participants**

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| There has been very little information sharing with the communities affected, as neither the community leaders nor the officials have sufficient information to share. Rumours have started to spread, and the RRT must address rumours and concerns to gain the community’s trust.  As a first step, the RRT will meet with the community leader and elders. The team will identify rumours that are spreading, key informants and/or influencers, listen to community issues and concerns, understand community traditional practices. Trust should be built early so the community becomes part of the solution. |

**2. Instructions for participants, exercise outputs and references**

***Instructions***

Before visiting the community, the RRT should review relevant pieces of Salam’s country context, including key elements of the social dimension, cultural practices, kinship, mode of communication, and taboos of Salami, to better understand community dynamics. Upon arrival at the community, the RRT will meet the community leader as a courtesy call, and then request to visit different areas in the community to talk to people.

***Outputs***

1. Appropriate IPC measures to be applied when visiting the community.
2. Rumors and issues related to outbreak captured (Session C4 Annex 1).
3. Community practices that can help controlling the spread of the outbreak (Session C4 Annex 1).
4. Community practices that may contribute to spreading the outbreak (Session C4 Annex 1).
5. Appropriate tools to encourage community participation determined (Session C4 Annex 2).

***References***

* Communication for behavioural impact (COMBI). A toolkit for behavioural and social communication in outbreak response, available at: https://apps.who.int/iris/bitstream/handle/10665/75170/WHO\_HSE\_GCR\_2012.13\_eng.pdf?sequence=1&isAllowed=y
* Bringing the community together to plan for Disease Outbreaks and other Emergencies: A step-by-step guide for community leaders. https://www.paho.org/hq/dmdocuments/2011/Risk-Comm-Bringing-Community-Together.pdf

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| **C5 Active case finding and contact tracing** (1h30) |

**1. Information to be given to participants**

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| The RRT received a fax from an official at the Ministry of Environment reporting that the water sample from the Bughaw river showed an amount of cadmium below the poisoning level, and that the gastrointestinal manifestations of villagers in Guntana was not related to cadmium.  After identifying and listing some potential cases in the community during the interview with the hospitalized case, the RRT will start actively finding cases and conducting contact tracing and monitoring activities in the community. In addition, the team needs to involve the community to limit the spread of the disease. |

**2. Instructions for participants, exercise outputs and references**

***Instructions***

The RRT will interview:

**1. Mrs. Fatma (Laila’s mother-in-law) and Nelly, Mrs. Fatma’s daughter**

The team has arranged to visit Mrs. Fatma, Laila’s mother-in-law. Her address was obtained from Laila, the patient admitted at the hospital, who shared that Mrs. Fatma was also suffering from similar symptoms. The RRT now arrives at her house.

* What PPE should you wear, if applicable? How are you going to protect yourself but not alienate the community at the same time?
* You will start a dialog with Mrs. Fatma. What advise may you give her about measures to prevent the spread of infection?
* Nelly, Mrs. Fatma’s daughter is now taking care of her sick mother. What kind of advice should you give her?
* Nelly is a young, good looking, gentle woman. The team wants to advise her on precautionary measures she should take while caring for her mother. When the team is leaving the house, one of the male RRT members gets back to the house and speaks privately with Nelly: he proposes to Nelly to meet him in the evening at the park near the house. He says that if she accepts, he could easily get some medicines for her mother. You have heard this conversation.
* How would you call/qualify the behaviour of the male RRT who approached Nelly?
* What should be done to prevent such situations?
* What should be done to respond to such situations?

**2. Neighbour (language barrier)**

After arranging to visit the neighbours as part of your active case finding activities, you find out that they speak a dialect language you are not familiar with. What should you do?

**3. Community member(s)**

Many outbreaks can be more quickly controlled when the public understands how to help limit the spread, and when the RRT understands more about the community. Health education is crucial to ensuring the participation of the community, but it will have its impact when the RRT has an understanding of the community. The community leader has asked you to conduct health education sessions to advise people about:

* How to protect themselves when caring for a sick member
* What to do when they have symptoms.

***Outputs***

1. Data collection form for initial case investigation completed (Session C3 Annex 1).
2. Contacts listed and contact monitoring initiated (using Annexes 2 and 3 below).
3. Responses to inappropriate behaviour by RRT team members listed.
4. Key messages of a health education campaign (e.g., promote health hygienic practices as part of daily life routine rather than extraordinary outbreak/disease-linked measures) listed.

***References***

* First steps in managing of acute diarrhoea. WHO <https://www.who.int/publications/i/item/first-steps-for-managing-an-outbreak-of-acute-diarrhoea>
* Foodborne disease outbreak, Guideline for investigation and control. WHO. <https://apps.who.int/iris/bitstream/handle/10665/43771/9789241547222_eng.pdf?sequence=1&isAllowed=y>
* Communication for behavioural impact (COMBI). A toolkit for behavioural and social communication in outbreak response <https://apps.who.int/iris/bitstream/handle/10665/75170/WHO_HSE_GCR_2012.13_eng.pdf?sequence=1&isAllowed=y>
* Nations, M.K. & Monte, C.M., 1996. “I’m not dog, no!”: cries of resistance against cholera control campaigns. Social Science & Medicine (1982), 43(6), pp.1007–1024.

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| **C6 Investigation report writing (2h) and presentation (1h)** |

**1. Information to be given to participants**

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| The RRT is notified by the hospital staff that the laboratory result of the samples collected from Mrs. Laila Samy tested positive for Cholera. New Cholera cases were identified through surveillance and active case finding activities. To determine the true geographic extent of the problem and the populations affected, you should conduct a descriptive epidemiological analysis based on the collected data.  Based on the information available, you will write an investigation report and implement the required control measures to stop this outbreak.  The team will be requested to present their investigation report to Dr Zaher, the RRT Manager at the EOC, during a meeting in 8-10 minutes. |

**2. Instructions for participants, exercise outputs and references**

***Instructions***

Each RRT must write an investigation report that includes all findings, conclusions, data tables, and charts (PPT format, 8 slides maximum) and present the summary report in plenary (8 to 10 minutes presentation).

***Outputs***

1. A comprehensive investigation report that integrates the results and conclusions of the various investigation phases in a systematic way, addressing the following points:

* Cholera prevention and control measures, including technical and community-oriented interventions.
* The need to establish a cholera treatment center, its structure, and calculations for required medical supplies, as well as oral rehydration posts.
* Considerations on how community members can provide support.
* Data should be presented in tables and graphics as appropriate.
* Highlight the IHR measures regarding restriction on international trade and population movements due to cholera outbreak.
* Plan for hypothesis testing.

1. An 8-to-10-minute presentation of the investigation report based on a PPT slideshow.

***References:***

WHO Cholera outbreak toolbox

<https://www.who.int/emergencies/outbreak-toolkit/disease-outbreak-toolboxes/cholera-outbreak-toolbox>

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| **Conclusion** |

Cholera remains a global threat in many developing countries. Access to safe drinking water and adequate sanitation is one of the most effective measures to prevent cholera outbreaks.

In Salam, the Ministry of Health stepped up its response efforts to treat and prevent the further spread of the disease. Patients are being treated with Oral Rehydration Salts, infusions, and antibiotics as appropriate.

Interventions to control the outbreak include increased surveillance at the community level for case finding, provision of safe drinking water, improving sanitation through disinfecting septic tanks, and better waste disposal. As part of the containment effort, the ministry supported widespread communication campaigns to encourage families to purify water, prepare food carefully, and wash their hands.

This success could not have been achieved without your efforts as an RRT.

***Thank you for being a member of the Salam Rapid Response Team!***



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