

GUIDANCE FOR U.S. CENTERS FOR DISEASE
CONTROL AND PREVENTION STAFF FOR THE

Establishment and Management of Public Health Rapid Response Team Programs

VERSION 2



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Abbreviations

AAR	After Action Review
CAPE	Capabilities Action Planning for Emergencies
CDC	U.S. Centers for Disease Control and Prevention
CFR	Case Fatality Rate
DHIS2	District Health Information Software 2
EAR	Early Action Review
EMT	Emergency Medical Team
EOC	Emergency Operations Center
FETP	Field Epidemiology Training Program
GIS	Geographic Information System
GPS	Global Positioning System
GOARN	Global Outbreak Alert and Response Network
IAP	Incident Action Plan
IAR	Intra-Action Review
IHR	International Health Regulations
IMS	Incident Management System
IPC	Infection Prevention and Control
IT	Information Technology
JEE	Joint External Evaluation
JiT	Just-in-Time
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
NAPHS	National Action Plan for Health Security
NGO	Non-Governmental Organization
PHEOC	Public Health Emergency Operations Center
PPE	Personal Protective Equipment
PoE	Points-of-Entry
RCCE	Risk Communication and Community Engagement
RRT	Rapid Response Team
SOP	Standard Operating Procedure
SME	Subject Matter Expert
SMS	Short Message Service
SPAR	State Party Annual Reporting
STAR	Strategic Toolkit for Assessing Risks

SitRep	Situation Report
THIRA	Threat and Hazard Identification and Risk Assessment
UN	United Nations
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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» Executive Summary

Under the International Health Regulations (IHR 2005), all countries must maintain core capacities to detect, assess, notify, and respond rapidly to public health emergencies.¹ Public Health Rapid Response Teams (RRTs)—multidisciplinary teams trained and equipped to deploy quickly—are essential to meeting these obligations and controlling outbreaks before they escalate.^{2,3} Their importance has been recognized in various IHR tools and global health security frameworks.^{2, 4-6}

Despite their critical role, many RRT programs are hindered by persistent challenges, including unclear mandates, inconsistent procedures, inadequate rostering, and fragmented coordination.³ These limitations lead to delayed mobilization, undermining both national and global health security. Evidence shows that countries with structured, well-managed RRT programs can deploy responders efficiently, whereas ad hoc approaches often result in critical delays.^{3, 7}

To address these gaps, this document provides guidance for U.S. Centers for Disease Control and Prevention (CDC) staff supporting the establishment and strengthening of RRT programs at the local, subnational, national, regional and global levels. In the absence of a single, comprehensive, and globally endorsed standard for RRT program management, this guidance consolidates best practices and lessons learned from the agency's extensive field experience to ensure a consistent and evidence-informed approach.

Purpose of this Guidance

This updated guidance builds upon the 2020 U.S. Centers for Disease Control and Prevention (CDC) guidance on RRT establishment and management.² It offers evidence-based recommendations and best practices to help countries/organizations transition from a reactive, ad hoc response model to a systematic and sustainable RRT capability. It serves two primary functions:

1. **For RRT programs in development**, it provides a step-by-step framework for establishing a new RRT.
2. **For established RRT programs**, it offers strategies to enhance efficiency, effectiveness, and sustainability.

By providing key recommendations and tools, this guidance aims to enable countries to build a resilient and measurable defense against ongoing and future health threats.

Version 2.0 Updates

This second version of the guidance was developed by synthesizing the best available operational evidence since 2020 through a multi-faceted approach. This included a literature review and an environmental scan of peer-reviewed and grey literature to identify the latest evidence-based standards in rapid response workforce development.^{4-6, 8-23} Additionally, the guidance incorporated findings from operational research conducted or supported by CDC to build an evidence base for RRT best practices.^{3, 7, 24-30} Finally, these findings were supplemented by synthesizing lessons learned from case studies of CDC's direct technical support to over 30 countries and organizations, which provided critical insights into common operational challenges and successful implementation strategies.

Drawing on this evidence, Version 2.0 has been enhanced to provide a comprehensive operational toolkit with key updates focused on strengthening the foundational elements of a successful RRT program:

- **Governance and Structure:**
 - **Mandates and Authority:** Clarifies the legal and organizational frameworks necessary for RRT establishment.
 - **Foundational Elements:** Defines the core components of the wider emergency system that support effective RRT operations.
- **Operations and Performance:**
 - **Activation Protocols:** Outlines systematic processes for rapid, efficient mobilization.
 - **Monitoring and Evaluation:** Establishes frameworks for performance tracking and continuous improvement, aligned Joint External Evaluation (JEE) and State Parties Self-Assessment Annual Report (SPAR) indicators.^{4,5}
- **Sustainability and Readiness:**
 - **Attrition Management:** Addresses strategies for managing turnover and sustaining roster readiness.
 - **Training Advances:** Incorporates updated curricula and competency frameworks for responder development.

The guidance also includes a suite of tools, templates, and integration strategies to support implementation and alignment with IHR, emergency response plans and other relevant plans such as National Action Plans for Health Security (NAPHS).³¹

Organization of the Document

This guidance is designed for CDC staff supporting emergency personnel in organizations and countries in the development and management of multidisciplinary RRTs. The recommendations should be adapted to fit each country's or organization's specific context. The document is organized into five main sections, which guide users from foundational planning to post-deployment analysis.

1. RRT Program Foundation

Prerequisites, mandate, governance, and standard operating procedures

2. RRT Preparedness Operations

Administrative considerations, staffing, rostering, training, and readiness

3. RRT Emergency Operations

Activation, pre-deployment, deployment and field operations

4. RRT Program Performance

Monitoring, evaluation, continuous improvement, and operational research

5. Appendices

Assessment tools, templates, and reference materials to support implementation

This is not a document that must be read from start to finish. It is designed to be a practical toolkit that can be applied in multiple ways, depending on the status and needs of the RRT program. Below are three recommended pathways for navigating the guidance.

- **For Organizations Establishing an RRT Program for the First Time**

If the organization is building an RRT program for the first time, a systematic approach is recommended. Begin with the RRT Program Foundation sections and relevant appendices. Then proceed systematically through the guidance. This may include,

- [Section: Overview of RRT Program Development](#) to understand prerequisites for effective RRT systems
- [Section: RRT Program Methodology](#) to plan systematic capacity building
- [Appendix A: CDC Capacity Assessment Tool – RRT Excerpt](#) to conduct an RRT program gap analysis

- **For Organizations Strengthening Existing RRT Programs**

If the organization has an RRT program already, diagnostic tools below can be used to identify the most relevant sections.

- If RRT program gaps are already identified (e.g., through assessments): Navigate directly to the relevant sections addressing priority areas.*
 - » [Appendix B: RRT Program Alignment Across IHR Assessments](#) can help with identifying the specific sections in this guidance
- If RRT program gaps are unknown or a more granular assessment is needed, consider the use of the following diagnostic tools in the appendices to help guide what priority sections to use in this document.
 - » [Appendix A: CDC Capacity Assessment Tool – RRT Excerpt](#) for systematic gap analysis*
 - » [Appendix C: RRT Program Maturity Model](#) to assess overall development stage*
 - » [Appendix D: RRT SOP Checklist and Rubric](#) to identify procedural revisions needed

*Note: If gaps are significant and/or the maturity model level is low (<3), recommend beginning with the RRT Program Foundation Sections. If gaps are minimal, and the RRT program is at an advanced maturation level (<4), focus on RRT Program Performance Sections to establish and enhance performance measurement and continuous improvement.

- **For Organizations Responding to Imminent Public Health Threats**

Although this document focuses on RRT program development, several sections are designed to provide immediate operational support during an active response.

- [Section: RRT Emergency Operations](#) for operational guidance on activation, pre-deployment, and deployment
- [Section: RRT Pre-Deployment](#) for just-in-time training materials and checklists.

»» Overview of RRT Programming

For this guidance, a public health RRT program is defined as an organized system that maintains multidisciplinary personnel who are trained, equipped, and supported to deploy rapidly and perform essential public health functions during emergencies. The program includes the structures, processes, and resources necessary to ensure teams can respond efficiently and effectively in coordination with other response efforts.

RRT programs can vary significantly across organizations, countries, and regions. While many have a mandate focused on addressing public health issues only—often associated with outbreaks—some programs are designed to be more expansive, covering a broader range of hazards. Programs may also be composed of a single sector, commonly housed within public health institutions, or multisectoral, drawing expertise from multiple sectors to address multifaceted emergencies (e.g. animal health, environmental health).

RRT programs are most effective when they do not operate as standalone systems; rather, they should be integrated into a country's larger emergency response strategy and system (e.g. an Incident Management System (IMS) or an equivalent coordination mechanism). This integration ensures strong linkages to multisectoral coordination.²

What constitutes a fully functional RRT program has yet to be globally standardized. Recognizing this gap, this guidance establishes working criteria that countries can adapt to their specific contexts⁷:

Management Structure

The program has dedicated RRT management personnel with clearly defined authority and responsibilities for both preparedness and emergency response phases. Management should possess the authority to activate teams, approve expenditures, and make personnel decisions.

Training System

A structured, competency-based training program is established and actively maintained. This includes orientation for new members, regular refresher training, simulation exercises, and just-in-time training before deployments. Training should be documented in a tracking system linked to the roster.

Standard Operating Procedures

Comprehensive SOPs are developed, disseminated, and regularly updated to guide all phases of RRT operations across Preparedness and Emergency phases.

Roster Management

An up-to-date, searchable roster of multidisciplinary personnel is maintained with current information on skills, availability, training status, and deployment readiness. The roster should function as both a deployment selection tool and a capacity monitoring system.

These four domains represent example minimum requirements for a program to be ready and function reliably during emergencies. More detailed assessment criteria and indicators for potentially measuring RRT program maturity can be found in [Appendix C: Example RRT Program Maturity Model](#).

Administrative Levels

RRT programs often exist and/or operate at multiple administrative levels within a public health emergency system. Each level may have distinct roles, competencies, and coordination requirements. These differences depend largely on the RRT's mandate (domestic versus international) and the government structure (centralized versus decentralized). This serves as an example solely to illustrate the variations that may be observed across different administrative levels of RRT programs.

Regardless of the administrative level, RRT programs are more effective when designed to ensure horizontal integration and coordination with other emergency preparedness and response capacities at the same level, as well as vertical integration with strong linkages and ease of coordination with levels above and below

Local/Community Level RRTs

- **Scope:** Village, district, or municipal coverage
- **Primary Functions:** Rapid assessment, initial case investigation, community engagement, basic IPC
- **Coordination:** Report to district/provincial health authorities
- **Deployment:** Same-day response within catchment area
- **Size:** 2-5 members

Sub-National RRTs

- **Scope:** Provincial, state, or regional coverage
- **Primary Functions:** Support local teams, conduct complex investigations, laboratory coordination, surge capacity
- **Coordination:** Link local and national levels; coordinate with subnational EOC/IMS
- **Deployment:** 24-48 hour response within province/region
- **Size:** 5-10 members per team

National RRTs

- **Scope:** Nationwide coverage, international support to neighbors (if applicable)
- **Primary Functions:** Support sub-national responses, manage large-scale outbreaks, coordinate international assistance, build sub-national capacity
- **Coordination:** Operate through National IHR Focal Point, national EOC/IMS, coordinate with global and regional bodies
- **Deployment:** 48-72 hour national deployment; 3-7 days international
- **Size:** 10-20+ members for major events

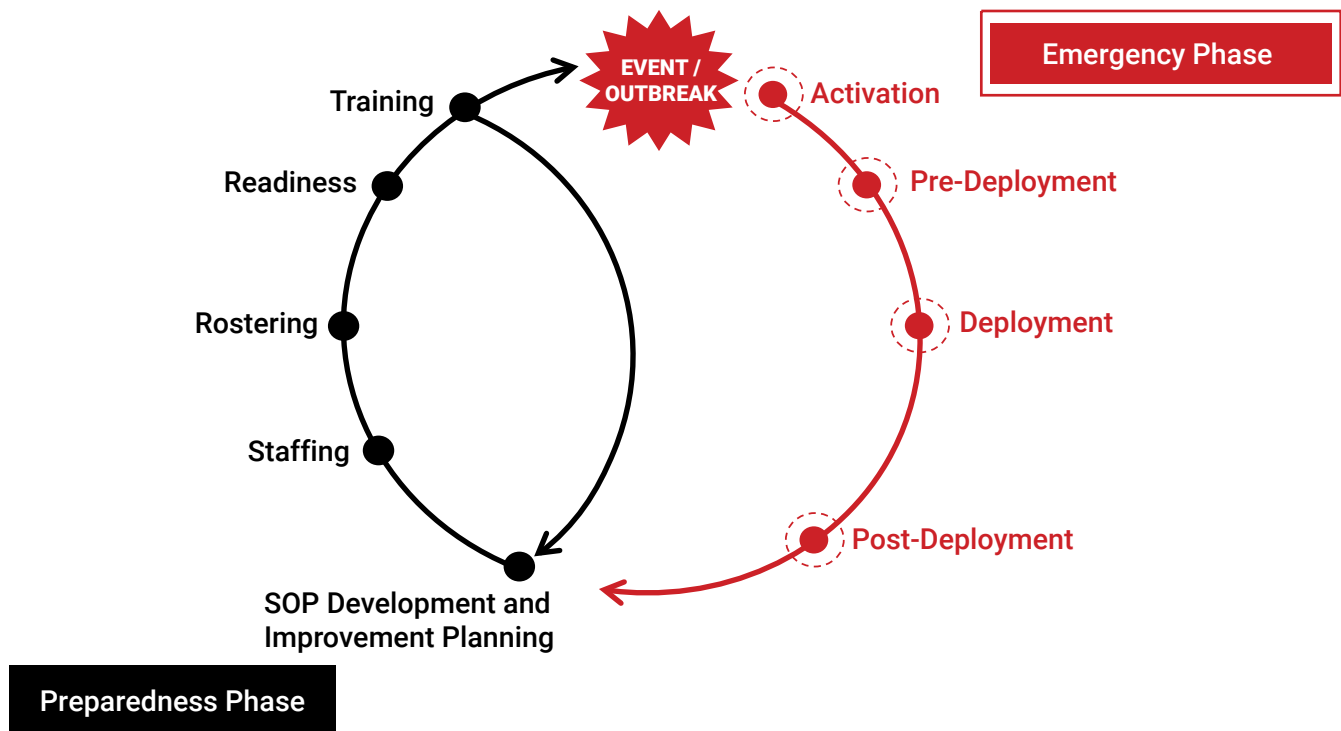
Regional/Global RRTs

- **Scope:** Cross-border, regional, or global deployment
- **Primary Functions:** Surge support for overwhelmed countries, specialized technical expertise, coordination with international response architecture
- **Coordination:** United Nations partners, bilateral governmental agreements, Humanitarian Cluster System
- **Deployment:** 30 days (includes diplomatic clearances, visas, etc.)
- **Size:** Variable based on request and mandate

Program Operations

For the purposes of this guidance, RRT program operations are organized into two interconnected phases: the preparedness phase and the emergency phase (Figure 1). Aligning this framework with the emergency management cycle phases, mitigation activities are incorporated into preparedness, while recovery activities are included under the emergency phase.³² The cyclical nature of these processes highlights the need for continuous support to ensure RRT programs remain functional, even during non-emergency periods.

Figure 1. RRT Program Operations

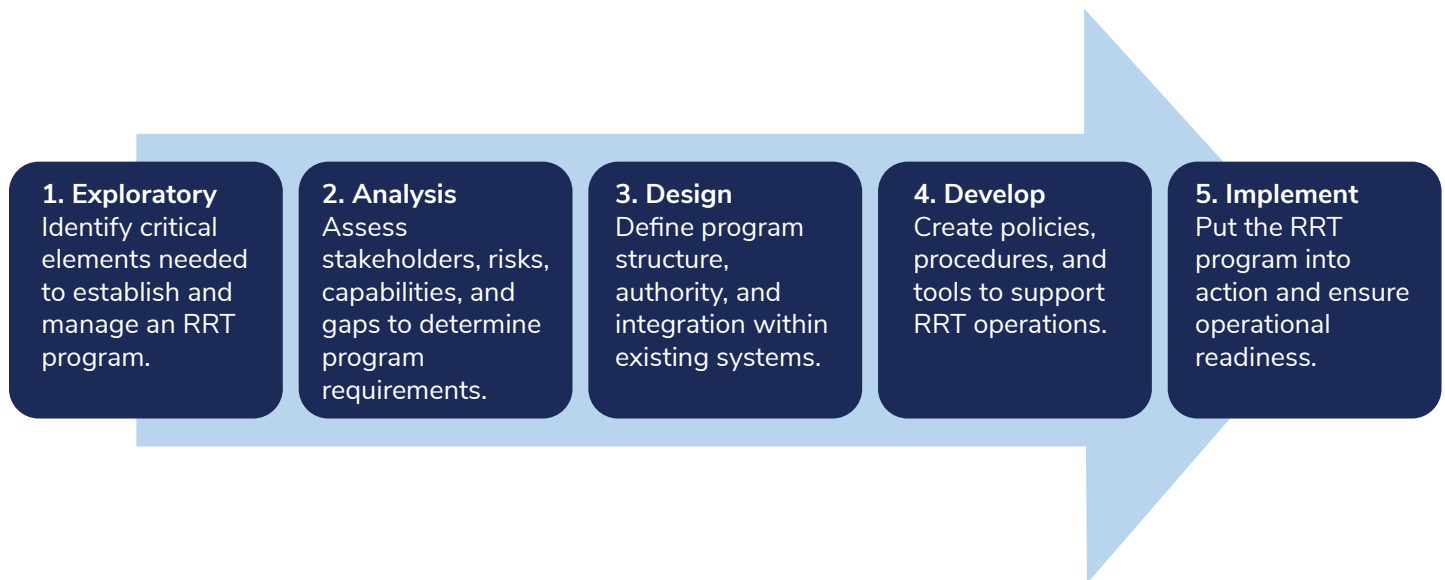


RRT Program Foundation

»» RRT Program Methodology

While no single global standard exists, building sustainable RRT program capacity is best achieved through a systematic, phased approach. This guidance model uses a sequence of five phases—Exploratory, Analysis, Design, Development, and Implementation—followed by continuous evaluation for ongoing improvement (Figure 2).^{27, 33}

Figure 2. RRT Program Development Methodology – Five Phases Of Development



Each phase described uses checkpoints to confirm quality, feasibility, alignment with global standards, and leadership buy-in, integrating principles of Knowledge to Action and a Stage-Gate process to ensure impactful programmatic change.^{34, 35}

Exploratory Phase

During the exploratory phase, the goal is to assess the foundational elements within the broader emergency response system that will enable an RRT program to be established and managed effectively. The IHR Monitoring and Evaluation Framework and Global Health Security related benchmarks outline comprehensive emergency response capabilities that can support RRT implementation.^{6, 36} These include the following, with leadership support and financing identified as the most critical.⁷

- **Strategic and Operational Planning:** Review existing emergency response plans to identify where RRT roles need to be defined or integrated.
- **Leadership Engagement and Governance:** Gauge the level of leadership support and identify governance structures that can enable RRT activation.
- **Financing and Resource Availability:** Assess available funding streams, logistical resources, and staffing capacity.
- **Stakeholder Inclusion:** Identify key partners and sectors to engage in RRT planning and operations.
- **Legal and Policy Frameworks:** Review existing mandates and policies that provide the legal basis for the RRT.



Exploratory Phase Checkpoint

If critical foundational elements—particularly leadership support and financing—are missing, it is strongly recommended to address these gaps before proceeding. Strengthening these dependencies early ensures that subsequent RRT development is built on a stable foundation.

Analysis Phase

The analysis phase focuses on identifying the current emergency preparedness and response capabilities and any gaps to determine what is necessary to build or enhance an effective RRT program. This phase ensures that the RRT program is tailored to the country's specific risks, resources, and operational realities. It establishes a baseline understanding of strengths and weaknesses, informs resource allocation and planning for sustainable RRT operations, and facilitates coordination across sectors by identifying key stakeholders and their roles.

Countries are encouraged to explore the following thematic areas during this phase:

1. Assess Capacities and Risks

- Review existing emergency response system documents and frameworks.
- Draw on existing data and previous assessments, such as:
 - Action Reviews: Early-, Intra-, and After-Action Reviews.³⁷⁻³⁹
 - IHR Assessments: States Parties Self-Assessment Annual Report (SPAR) and Joint External Evaluation (JEE).^{4, 5}
 - Threat/Hazard Analysis: Strategic Toolkit for Assessing Risks (STAR) and Threat and Hazard Identification and Risk Assessment.^{40, 41}
 - Disease Prioritization Exercises: eCDC tool for the prioritization of infectious disease threats.⁴²
- Analyze capabilities and vulnerabilities to understand operational challenges.
 - WHO Capabilities Action Planning for Emergencies (CAPE) tool.²⁰
 - CDC Capacity Assessment Tool ([Appendix A. RRT Capacity Assessment Tool](#))
 - Key Performance Indicators from the WHO/Eastern Mediterranean RRT Capabilities¹²

2. Identify and analyze RRT program stakeholders

- Map all relevant multisectoral stakeholders and clarify their roles in RRT program preparedness and response.
- Identify and/or establish memorandums of understanding or formal agreements as needed.



Analysis Phase Checkpoint

Before moving to the Design Phase, confirm that the analysis accurately reflects the current situation and that prioritized actions are feasible and financed. If significant time has passed, reconfirm leadership buy-in to ensure continued support.

Design Phase

The design phase is the blueprint for the RRT program. The decisions made here will shape the program’s structure, authority, and integration within the broader emergency response system. This process involves defining the core components of the program across several key thematic areas.

Program Purpose and Scope

Establishing a clear purpose provides strategic direction and ensures alignment with national health security priorities. This involves defining why the RRT exists, what it does, and who is involved.

Component	Key Considerations
Mission & Objectives	Define the RRT’s core goals (e.g., rapid outbreak detection, coordination support), articulate its value to the overall emergency response system, and alignment with existing emergency response plans/frameworks.
Emergency Scope	Determine the hazards the RRT will cover (all-hazards vs. specific threats) and its geographic area of operation (national, subnational, international).
Multisectoral Composition	Identify the essential technical disciplines (e.g., epidemiology, lab science, IPC) and ensure representation from human, animal, and environmental health sectors. ⁴³

Governance

Effective governance structures ensure accountability, transparency, and strategic direction, which promote stakeholder confidence and sustained political commitment.

Component	Recommended Actions
Program Management	Designate a lead agency (e.g., Ministry of Health) to hold primary responsibility and appoint an RRT Program Manager with appropriate decision-making authority (see Section: Management Personnel).
Oversight Body	Establish a multisectoral oversight committee with a clear terms of reference to provide strategic guidance, budget oversight, and performance monitoring.
Decision-Making	Define clear decision-making mechanisms for routine operations and emergency activation. For example, activation criteria, resource allocation protocols, and the authority for key personnel decisions (e.g., recruitment, deployment).
Accountability	Implement robust systems for performance monitoring (dashboards, reviews) (see Section: RRT Program Performance), financial oversight (audits), and external reporting to national and international bodies.

Legal Authority

A clearly defined legal basis is critical to ensure that RRT operations can proceed without unnecessary delays. It provides legitimacy, defines responsibilities, and establishes boundaries. During the design phase, programs should:

- Identify and document the specific legal basis for RRT operations (e.g., primary legislation, decrees).
- Establish interagency agreements or MOUs to formalize roles and responsibilities.
- Clearly define the authorities and legal protections for responders during a deployment.

Financing and Resource Planning

Predictable funding streams and rapid financing mechanisms are key to maintaining readiness, enabling rapid deployment, and sustaining RRT operations. This is covered in detail in the [Section: Budget Planning and Financing](#).

Program Integration

Effective integration ensures that the RRT operates seamlessly within existing emergency coordination mechanisms, maximizing efficiency and reducing duplication. This involves integrating the RRT at the system, governmental, and global levels.

Type of Integration	Example Key Actions
System Integration Into the formal emergency management framework	IMS Positioning: Place the RRT within the Operations Section of the Incident Management System (IMS) with clear reporting lines. Operational Interoperability: Ensure seamless operations by using common terminology, compatible data systems, and collaborative resource management processes.⁴⁴ Standing Coordination: Actively participate in standing preparedness committees and contribute to national emergency plans.
Governmental Integration Across different levels and sectors of government	Vertical Integration (Across Levels): Establish clear coordination mechanisms between national, subnational, and local teams, including direct links to district health offices. Horizontal Integration (Across Sectors): Foster collaboration with human health, animal health, and disaster management sectors. Formalize these roles through interagency working groups and MOUs.
Global Integration With international partners and initiatives	Awareness: Consider how international agencies/RRTs may offer additional assistance during a large-scale emergency. Coordination: Understand and link with global disaster and humanitarian coordination systems, such as the Health Cluster.⁴⁵

**Design Phase Checkpoint**

Before advancing to the Develop Phase, it is a good practice to test the design against various scenarios to ensure flexibility and effectiveness under different emergency conditions. Testing scenarios could encompass a range of emergency types (such as infectious disease outbreaks or natural disasters), scales of response, geographic challenges, and other contextual factors typically encountered in the field.

Develop Phase

The develop phase focuses on drafting and formalizing Standard Operating Procedures (SOPs) and supporting materials that will guide the operationalization of the RRT program (see [Section: RRT Standard Operating Procedure Development](#)). These deliverables should be practical, context-specific, and aligned with national systems to ensure seamless integration. Collaboration and consensus-building are critical during this stage to promote ownership and sustainability.

Because this phase covers a wide range of topics—including budgeting and financing, staffing and resource allocation, training development, and response processes—a multidisciplinary approach is essential. Subject matter experts beyond emergency management, such as human resources, finance, and training specialists, should be actively engaged to ensure that all components are comprehensive and feasible.

This phase is inherently iterative, involving drafting, stakeholder review, consensus-building, and formal approval of plans, policies, and procedures. Engaging all relevant stakeholders early and throughout the process helps ensure that the tools developed are accepted and operationally sound.

**Develop Phase Checkpoint**

To validate functionality before the implementation phase, organizations are encouraged to conduct a tabletop exercise to validate the draft SOPs and related processes in a simulated environment. Including leadership, human resources, and other key stakeholders in this exercise is critical to confirm that all components work as intended.

Implementation Phase

The implementation phase focuses on operationalizing the components developed in earlier phases and ensuring that the RRT program is fully functional. This is when plans, policies, and procedures move from paper to practice. The goal is to establish a system that can quickly and effectively deploy trained, equipped, and ready responders when public health emergencies occur. Common actions during this phase include:

- **Staffing the RRT:** Finalizing the RRT roster and ensuring that all positions are filled with qualified personnel.
- **Securing Rapid Funding Release:** Establishing mechanisms for quick access to financial resources to support RRT activities.
- **Procurement of Essential Equipment:** Acquiring necessary supplies and equipment to ensure responders are adequately equipped for deployment.
- **Launching the RRT Training Program:** Implementing training sessions to prepare team members for their roles and responsibilities during emergencies.

Continuous Evaluation

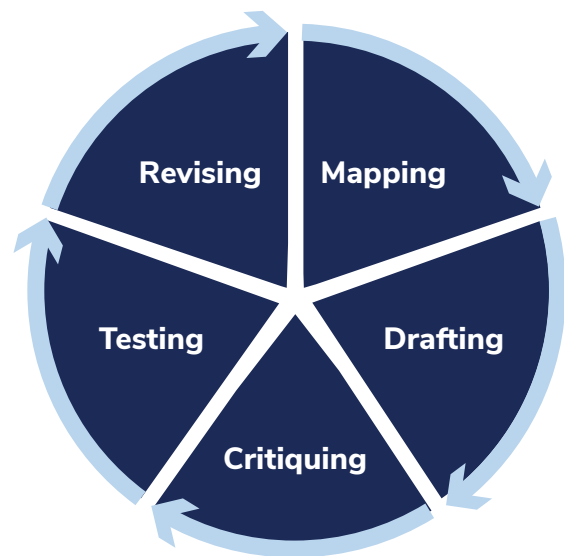
Evaluation is best viewed as a continuous process that occurs throughout the RRT program lifecycle, rather than being confined to a single phase. As highlighted throughout this guidance, there are key opportunities for testing RRT designs and protocols. The goal of evaluation is to ensure that each response experience contributes to strengthening the system. This ongoing process helps enhance the effectiveness, efficiency, and resilience of the RRT program over time (see [Section: RRT Program Monitoring and Evaluation](#)).

» RRT Standard Operating Procedure Development

SOPs are crucial for ensuring that RRT operations are consistent, efficient, and effective. The lack of SOPs can create ambiguity during emergencies, leaving teams vulnerable.^{3,7} SOPs should complement organizational and country-level emergency strategic and operational plans, fostering both vertical integration between national and subnational levels and horizontal integration across relevant agencies.

Developing SOPs for RRT programs is a structured, iterative process aimed at creating clear and actionable procedures aligned with the broader emergency response system. This development should occur during the preparedness phase and be continuously updated to remain relevant and effective. The following five steps are recommended (Figure 3):

Figure 3. RRT SOP Development Cycle



- 1. Mapping:** Identify existing plans, policies, and gaps to ensure SOPs integrate with the country's emergency management systems and align with national, subnational, or global frameworks. SOPs should complement, not duplicate, existing emergency plans.
- 2. Drafting:** Create SOPs with clear, step-by-step instructions that balance detail and conciseness. Use consistent formatting, headings, and numbering to improve usability. The content should be tailored to the country's context and the specific needs of the RRT program. Example content aligned to the RRT Operational Cycle (Figure 1) can be found in [Appendix D. RRT Standard Operating Procedure Checklist](#).
- 3. Critiquing:** Review SOP drafts for completeness, clarity, and operational relevance against key criteria: purpose, scope, inclusivity, content completeness, clarity, conciseness, and formatting. Refer to [Appendix D. RRT Standard Operating Procedure Checklist](#).
- 4. Testing:** Validate SOP functionality through tabletop or simulation exercises, reflecting various emergency types, scales, geographic challenges, and scenarios with or without Incident Management System (IMS) activation.
- 5. Revising:** Incorporate lessons learned and feedback from exercises and real responses into updated SOP versions. Continuous review is necessary to reflect new policies, technologies, and insights. While developing SOPs requires sustained time and resources, proactive efforts ensure readiness and resiliency.

RRT Preparedness Operations

» Administrative Considerations

Numerous financial and administrative decisions concerning personnel-related processes are necessary for RRT establishment, maintenance, and response activation. These decisions are particularly critical when RRT members are not full-time dedicated responders but are employed in non-emergency positions and/or come from organizations not usually involved in emergency response activities.

Without adequate administrative planning, RRT programs face significant operational barriers including delayed deployment while securing approvals and funding; inability to compensate responders fairly for emergency work; lack of protection for responders who become ill or injured; unclear employment terms leading supervisors to block staff deployment; and inadequate support for responders' health and well-being during and after deployment.

Management Personnel

A dedicated person or team responsible for RRT management and coordination is strongly recommended to ensure that RRTs are effectively established, sustained during non-emergency periods, and ready for rapid deployment during emergencies. This role is critical for maintaining operational continuity and integrating RRT activities into the broader emergency response system.

The number of personnel required to manage an RRT program depends on several factors. First, the size of the RRT roster will influence staffing needs—the more responders enrolled, the greater the administrative workload for maintaining readiness and deployment processes. Second, the chosen deployment model matters. Systems such as on-call or tiered approaches require additional oversight to manage scheduling, availability, and surge capacity ([Section: Staffing and Rostering](#)). Finally, existing support from the emergency coordination unit or IMS can reduce the need for dedicated RRT management staff if some functions are shared.

For larger programs, it may be necessary to assign specialized roles to ensure smooth operations. For example:

- Training Coordinator can oversee curriculum development and delivery to maintain responder competencies.
- Roster/Data Manager for maintaining the RRT database, tracking readiness indicators, and ensuring accurate, up-to-date information for rapid mobilization.
- Logistics Officer manages equipment, supplies, and field support to guarantee that deployed teams have the resources they need to operate effectively.

Roles and Responsibilities

The primary objective of RRT management is to provide robust operational support, which allows deployed RRT members to focus on applying their technical expertise in the field. To maximize effectiveness, RRT management personnel should possess a specific profile that combines technical knowledge with significant organizational authority. Ideally, managers should have familiarity with emergency coordination systems, an understanding of public health emergency management principles, and strong coordination skills to liaise effectively with partners across all levels of government and the international community.

To execute their duties, it is critical that managers are granted sufficient authority. This includes decision-making authority to set RRT priorities and deploy teams, financial authority to approve emergency funds and procure resources, and personnel authority to manage staffing and address performance issues.

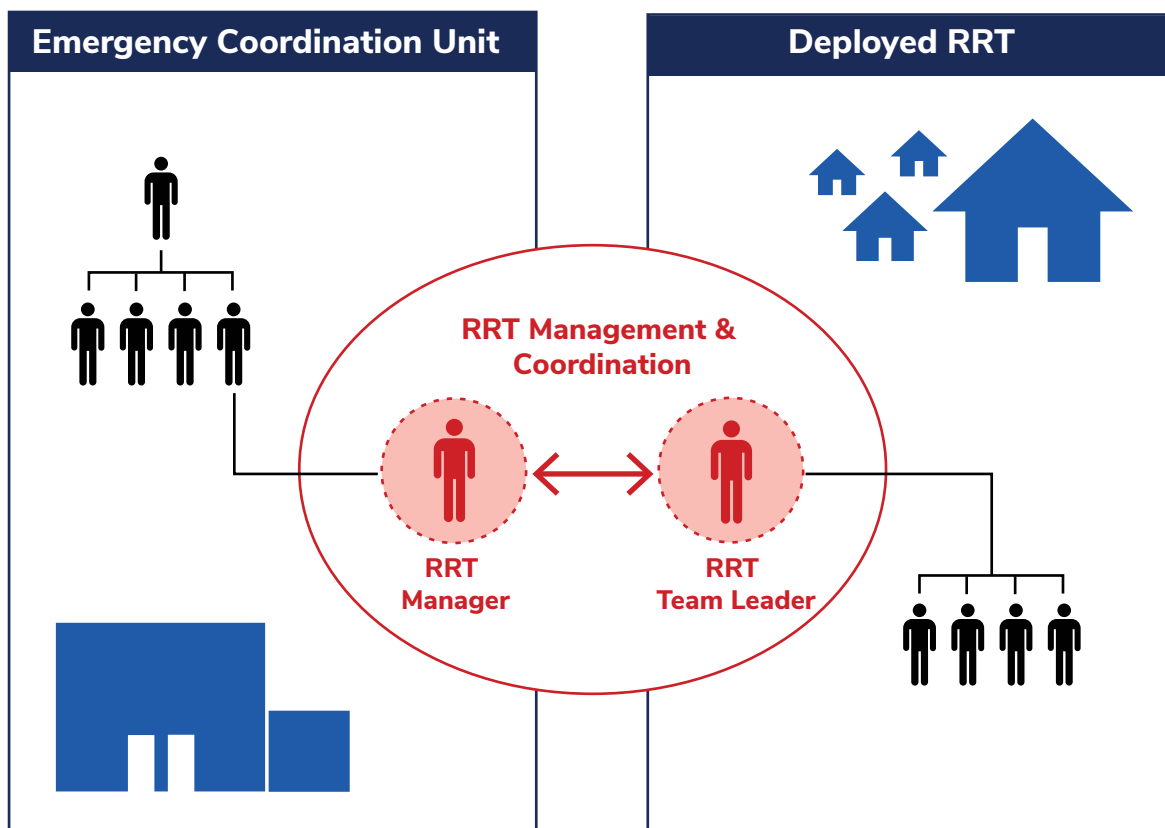
The core responsibilities of RRT management are divided by operational phase.

- During the Preparedness Phase, management is responsible for:
 - Planning and improving Standard Operating Procedures (SOPs) and other operational processes.
 - Overseeing staffing and rostering, including the maintenance of all readiness requirements.
 - Organizing regular training and simulation exercises to ensure the RRT is prepared for deployment.
- During the Emergency Phase, management's focus shifts to direct response support, including:
 - Identifying and selecting the right RRT members for a specific deployment.
 - Providing or procuring all necessary logistical support, technical guidance, equipment, and human resources.
 - Coordinating RRT activities with the central emergency coordination unit and other partners.
 - Facilitating clear communication between deployed teams and headquarters.
 - Monitoring RRT performance to ensure its activities remain aligned with the response's strategic priorities.

Positioning within the Emergency Response System

RRT management is ideally embedded within the national emergency coordination unit (such as an IMS or country equivalent).

Figure 4: RRT Management Coordination Example



During an active emergency RRT management typically falls under the Operations Section of the IMS. This ensures a clear chain of command and effective integration into the broader emergency framework. The specific management structure may vary depending on the scale of the response, as illustrated in the examples below for local, regional, and national-level events.

Small-Scale Response	Medium-Scale Response	Large-Scale Response
• Characteristics: Limited geographic area, manageable case numbers, local capacity may suffice with minimal external support. • Management Structure: • RRT may operate semi-independently, reporting directly to local health authorities. • IMS activation may be minimal or simplified. • RRT Manager coordinates from headquarters with local counterparts.	• Characteristics: Multiple districts affected, sustained transmission, requires multi-sectoral coordination. • Management Structure: • Full IMS activation with RRT housed in the Operations Section. • RRT Manager reports to the Operations Section Chief. • Coordination with Planning, Logistics, and other IMS sections. • Daily coordination meetings and structured reporting.	• Characteristics: Nationwide or cross-border emergency, overwhelmed health systems, international assistance required. • Management Structure: • Fully activated national IMS/EOC with sub-national EOCs. • Integration with the Humanitarian Cluster System (if applicable). • Coordination with international responders and donors.

Employment Policies and Agreements

As discussed in the [Staffing and Rostering](#) section, there may be variable sources of candidates for an RRT program. Regardless, clear employment policies and agreements are essential to ensure RRT members can deploy quickly and effectively during emergencies. These policies should minimize administrative delays, clarify responsibilities, and protect both responders and their organizations. Programs may wish to consider the following:

- Funding salary source
- Supervisory approval process if needed for deployments
- Workload management for regular duties during deployment
- Deployment durations maximum
- For external organizations – interagency agreements and/or memoranda of understanding

Budget Planning and Financing

RRT budget planning requires addressing both the preparedness phase financing—to maintain RRT readiness—and emergency phase financing—for rapid and sustained deployment (see [Appendix E: RRT Example Budget Costing Tool](#)).

Preparedness Phase Financing

- Personnel costs: Salaries for RRT management staff; compensation for part-time RRT coordination roles; administrative support staff
- Training and capacity development: Orientation/onboarding programs; continuing education sessions; simulation exercises; travel and accommodation for training events
- Roster management: Database or software platforms; staff time for roster maintenance and updates; recruitment and vetting processes
- Readiness maintenance: Medical clearances and vaccinations; passport and visa fees; background checks and security clearances
- Equipment and supplies: General field equipment stockpiles; communication devices; personal protective equipment (PPE); office space and supplies
- Planning activities: SOP development workshops; stakeholder coordination meetings; assessment and evaluation activities

Emergency Phase Financing

- Deployment costs: Per diems for deployed responders; transportation (flights, ground transport, fuel); accommodation and meals; hazard pay or overtime compensation
- Emergency procurement: Disease-specific supplies and equipment; additional PPE; laboratory materials; communication equipment
- Salary payment: Which organization pays salary during deployment (home organization vs. deploying entity); procedures for reimbursement if applicable
- Overtime and hazard pay: Compensation for extended hours (18+ hour days); additional payment for high-risk deployments (e.g., highly infectious diseases)
- Travel allowances: Coverage for travel to/from deployment sites; baggage fees; visa costs
- Field operations: Local transportation and drivers; translators; security personnel (if needed); emergency supplies and consumables
- Logistics support: Storage and distribution of supplies; customs and importation fees; waste management and disposal

Integrating RRT funding into broader emergency preparedness and response frameworks is strongly recommended to promote sustainability and operational efficiency. To achieve this, governments can consider the following actions:

- Include Dedicated Budget Lines: Incorporate RRT operations into national health budgets. This provides predictable funding for essential activities such as training, readiness checks, and roster management.
- Create Emergency Contingency Funds: Establish contingency funds with pre-authorized rapid disbursement procedures. These funds enable immediate access to resources during outbreaks, minimizing bureaucratic delays that could compromise response timeliness.

Responder Health, Safety, and Well-being

Maintaining the health, safety, and well-being of RRT members is a critical consideration for any emergency response program. Responders often work in high-risk, resource-limited environments, which can expose them to infectious diseases, physical hazards, and psychological stress.^{46, 47} Specific considerations should be addressed across the continuum of the emergency and can be found in relevant sections of this guidance: [Pre-Deployment](#), [Deployment](#), and [Post-Deployment](#).

Insurance Protection

While insurance and compensation policies are often determined by the government entity or organization that houses the RRT, programs may wish to explore options that help protect responders and their families during deployment. These measures are not mandatory but can serve as useful recommendations for strengthening responder support and building confidence in the program. Programs might consider including the following types of coverage:

- Medical Insurance to address illness or injury during deployment.
- Disability Insurance to provide financial assistance if a responder becomes unable to work due to deployment-related conditions.
- Life Insurance to support families in the event of a responder's death.
- Liability Insurance to protect responders and the program against legal claims arising from field activities.

Policies may also outline suggested approaches for financial and administrative support in the event of serious incidents. Examples include:

- Family Support and Death Benefits – Guidance on benefits for families of responders in case of death, including timelines and responsible authorities.
- Workers' Compensation – Clear procedures for claims, documentation requirements, and designated points of contact to ensure timely processing.

These recommendations aim to promote responder well-being and preparedness. Programs can adapt them based on local context, available resources, and existing legal frameworks.

Code of Conduct

Establishing a code of conduct is a key practice for ensuring RRT members act with integrity and professionalism. A well-defined code sets clear expectations, protects both responders and communities, and is grounded in core ethical and legal principles.

When developing a code of conduct, programs may wish to include the following key areas:

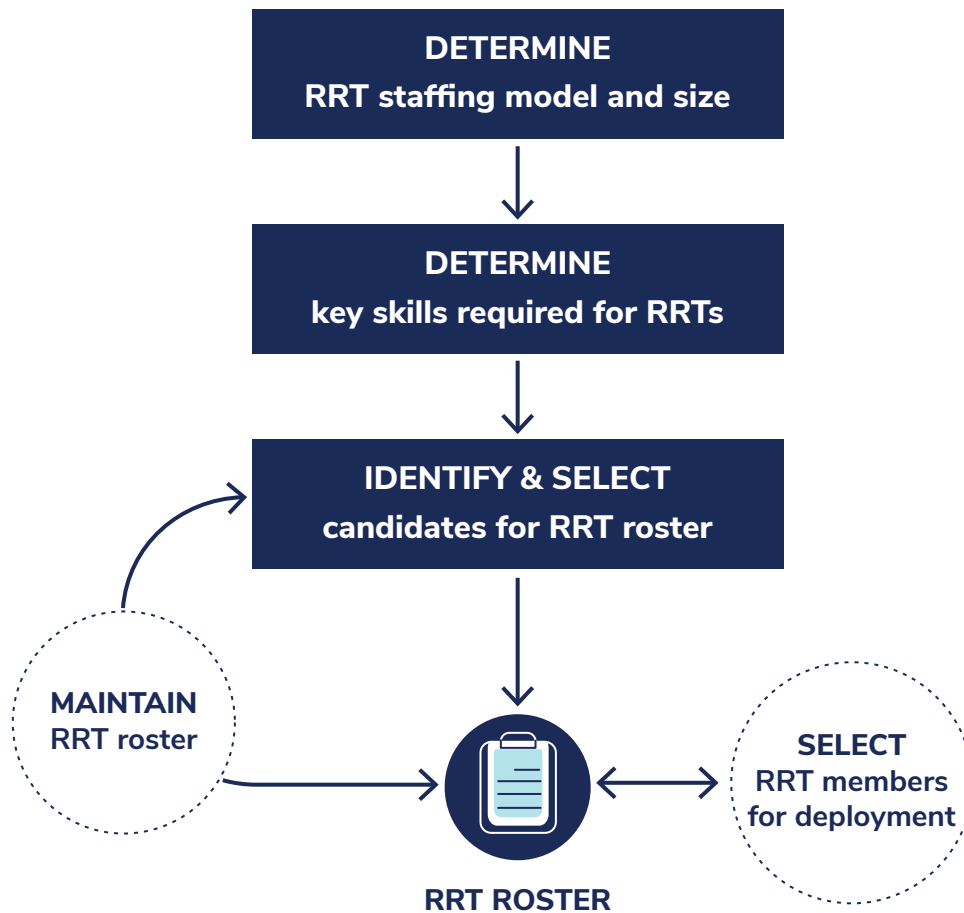
- Ethical Commitment: A pledge to maximize benefits, minimize harm, and ensure all actions are just, equitable, and transparent.⁴⁸
- Professional Integrity: Upholding standards of teamwork, scientific accuracy, and accountability, while maintaining confidentiality and respecting cultural customs.⁴⁹
- Safety and Compliance: A requirement to adhere to all safety protocols, including proper PPE use, and to comply with national laws and international standards (e.g., IHR).
- Personal Conduct: Clear guidelines on respectful community interactions and appropriate behavior during off-duty hours.

- Prohibited Actions: An explicit ban on behaviors such as harassment, discrimination, sexual exploitation or abuse, and the misuse of organizational resources or data.⁵⁰

»» RRT Staffing and Rostering

Staffing and rostering ensure that RRT programs have responders with the right mix of skills. It follows a multi-step process (Figure 5). This section explains how to design, staff, and maintain an RRT roster, including practical considerations, pros and cons of different approaches, and tips for sustainability.

Figure 5. RRT Staffing And Rostering Process



Staffing Models

Before recruiting, it is helpful for a program to determine its RRT staffing model. This step clarifies how the team will be structured and how it will function. There are several common approaches, each with different implications for cost, speed, and administrative effort.

Each model offers different trade-offs between cost, speed, and administrative burden, and are discussed in more detail below:

Attribute	On-Demand	On-Call	Tiered System
Roster Size	Variable	Large (30–60+)	Medium (15–40)
Administrative Burden	Low	High	Medium
Predictability	Low	High	Very High (for core)
Cost	Low	Medium	High
Deployment Speed	Variable (48–96h)	Fast (24–48h)	Very Fast (<24h for core)

On-Demand System

In this model, responders maintain their regular duties and are only contacted during an emergency to confirm their availability.

- **Ease of Setup:** This is the easiest model to establish due to its low administrative requirements during the preparedness phase.
- **Administrative Burden:** While easy to set up, this model carries a high administrative burden during an emergency. It has the lowest predictability of personnel availability and often requires contacting a large number of members to assemble a single team, which can cause significant delays.

On-Call System

In this model, responders formally commit to being available for deployment during designated periods (e.g., specific months).

- **Ease of Setup:** This model is more complex to establish because it requires significant administrative oversight to create and manage schedules.
- **Administrative Burden:** The high upfront administrative work during preparedness is offset by a lower burden during an emergency. This approach increases predictability and reduces the time needed to assemble a team.

Example Oversight	Description
Determine Coverage Periods	Decide on the length of on-call shifts (e.g., monthly, quarterly) and plan around seasonal disease patterns, holidays, or other high-risk periods.
Balance Skills Across Periods	Use a skill matrix to ensure each on-call period has an adequate representation of all critical skills and meets minimum team composition requirements.
Assign Staff to Periods	Survey staff preferences for on-call months, balance the workload (e.g., limit on-call time to 2-3 months per person per year), and document all assignments in writing.
Maintain Accountability	Require responders to confirm their on-call status before the period begins with their supervisory approval. Establish clear policies for what constitutes an acceptable vs. unacceptable reason for unavailability.
Monitor and Adjust	Track activation data to identify gaps in skill coverage and adjust assignments as needed (e.g., quarterly or annually).

Tiered System

This model uses a small, core team of dedicated, full-time responders supported by a larger group of surge staff for specialized or large-scale events.

- **Ease of Setup:** This is the most complex and costly model to establish due to the need to fund and manage dedicated, full-time positions.
- **Administrative Burden:** The preparedness burden is high, but it ensures the lowest possible burden during an emergency for the initial response, as the core team is always ready. Of note, there may be an additional administrative burden during the preparedness phase in terms of determining what the core team does when not deployed.

Tier	Design Considerations
Core Tier	Sizing: Typically consists of 5–15 dedicated, full-time responders. Composition: Should include representation from all critical technical areas. Responsibilities: Core members respond to all emergencies, maintain team readiness, and conduct training.
Surge Tier	Sizing: Can be 2–5 times the size of the core tier. Composition: Often includes specialists for specific scenarios (e.g., chemical exposure) or generalists for large-scale needs. Responsibilities: Surge members maintain their regular duties and deploy only when activated.

Hybrid Approaches

Some programs find that combining deployment models offers greater flexibility and efficiency than relying on a single approach. Several hybrid configurations have been used in different contexts. For example:

- An on-call plus on-demand hybrid maintains a core roster of on-call personnel who commit to availability during designated periods, supplemented by on-demand specialists who can be contacted as needed. This approach balances predictability with access to broader specializations.
- A tiered plus on-call hybrid combines a core tier of dedicated responders with a surge tier organized through an on-call system. This model helps ensure immediate response capability while maintaining scalable surge capacity.

Program Size

The size of an RRT roster will vary by country and program context. There is no universal number; instead, programs should consider several factors when deciding how many responders to include:

- **Funding and Management Capacity:** Larger rosters require more resources for training, readiness tracking, and administrative support. Programs should ensure they have sufficient budget and staff to maintain the roster effectively.
- **Expected Emergencies:** Estimate how often the RRT will be activated based on historical data and anticipated public health events. Countries with frequent outbreaks or seasonal surges may need a larger roster to maintain rapid response capability.
- **Availability of Staff:** Not all rostered members will be available when needed. Programs can plan for this by estimating the percentage of responders likely to be unavailable at any given time—often ranges from

30-50%, varying based on operational experience and organizational context. Therefore, if you need 10 responders available at any time, roster 14-20 people. This helps ensure enough personnel remain ready for deployment.

- **RRT Program Design:** The chosen model affects roster size (see the above table).

Regardless of size chosen when initially designing the RRT program, size should not be a static figure. As a best practice, programs should implement a system for continuous monitoring. By regularly tracking RRT activation requests against actual deployment data, managers can make evidence-based adjustments to the roster's size and skill mix over time. This iterative process ensures the team remains fit-for-purpose and responsive to the country's evolving needs.

Roles and Skills

A job title alone does not guarantee proficiency in all tasks associated with that role. For example, an epidemiologist may have strong statistical analysis skills but lack experience in contact tracing. Similarly, a laboratory specialist may be highly skilled in bench testing but unfamiliar with rapid diagnostic tools commonly used in outbreak settings. These gaps can lead to inefficiencies if responders are assigned tasks based solely on their title. See examples in [Appendix F: Rapid Response Team Common Roles and Skills](#).

Responder Sources

To ensure a program can address complex public health threats, responders should be intentionally multidisciplinary and multisectoral, drawing on a “One Health” approach that includes human, animal, and environmental health expertise. To facilitate timely mobilization, it is critical to formalize these relationships in advance through mechanisms like Memorandums of Understanding (MoUs) or other interagency agreements. Potential responders can be drawn from both internal government bodies and external partner organizations.

Internal Sources

The primary pool for RRT candidates typically consists of personnel from within the government's own structure. For example:

Source	Role and Contribution to the RRT
Ministry of Health	Forms the core of the RRT, providing experts from infectious disease departments, public health laboratories, and epidemiology units.
Other Ministries (One Health)	Critical for a multisectoral approach. Includes veterinarians and animal health specialists from the Ministry of Agriculture and experts from environmental protection or wildlife agencies. Personnel from border protection and customs are also key for points of entry.
Disaster Management Authorities	Provide essential expertise in logistics, coordination, and field operations within the national incident management system.
Field Epidemiology Training Programs (FETPs)	Graduates and current trainees are excellent candidates, bringing strong skills in surveillance and investigation. However, to be fully effective, they often require supplementary operational training in deployment protocols, field logistics, and RRT-specific procedures. ^{13, 51}

Source	Role and Contribution to the RRT
Emergency Medical Teams (EMTs)	As government-affiliated or independent teams of health professionals, EMTs provide direct clinical care to affected populations. While traditionally separate, integrating EMTs and RRTs is an emerging model to streamline resources and improve coordination during large-scale emergencies. ^{25, 52}

External Sources

Supplementing government staff with external partners can fill critical gaps, add specialized capacity, and enhance surge capabilities.

Source	Role and Contribution to the RRT
Public Health Organizations	National and international public health bodies can provide technical experts or experienced responders.
Universities & Research Institutions	Offer access to faculty, researchers, and students with specialized knowledge in areas like data science, social science, and laboratory diagnostics.
Non-Governmental Organizations (NGOs)	Both local and international NGOs often have deep field experience, community trust, and specific expertise (e.g., in risk communication or logistics) that can be invaluable.
Professional Associations	Medical, nursing, veterinary, or public health associations can help identify and credential skilled professionals for deployment.

Responder Selection

RRT programs use different approaches to select RRT members. Some programs accept anyone interested, while others use a formal application process. The choice depends on available resources, desired level of rigor, and the operational needs of the RRT. Below are suggested considerations for designing a selection process:

• Example Option 1: Open Enrollment

- In this model, anyone interested can join the roster after completing basic requirements (e.g., training, medical clearance).
- Potential Benefits: This approach can be quick and inclusive, helping to build a large pool of responders.
- Potential Challenges: It may result in an uneven skill distribution and require more effort later to match specific skills to response needs.

• Example Option 2: Formal Application Process

- Prioritizing High-Demand Skills: A program could assign higher scores to skills identified as critical for outbreak response (e.g., data analysis, IPC, laboratory diagnostics).
- Vetting and Supervisor Approval: A step to confirm that candidates can be released for deployment and meet organizational requirements.
- Defining Decision Authority: It is helpful to clearly state who makes the final selection and what criteria will be applied.
- Setting Inclusion/Exclusion Criteria, such as:
 - » Education and certifications.

- » Emergency response experience.
- » Language proficiency.
- » Physical and medical benchmarks for austere environments.

Regardless of the approach, it is valuable to consider how to identify leadership potential. A program can determine how team leaders will be selected from the pool of responders. Leadership candidates may include people with prior emergency experience, and they could receive additional training in coordination and decision-making.

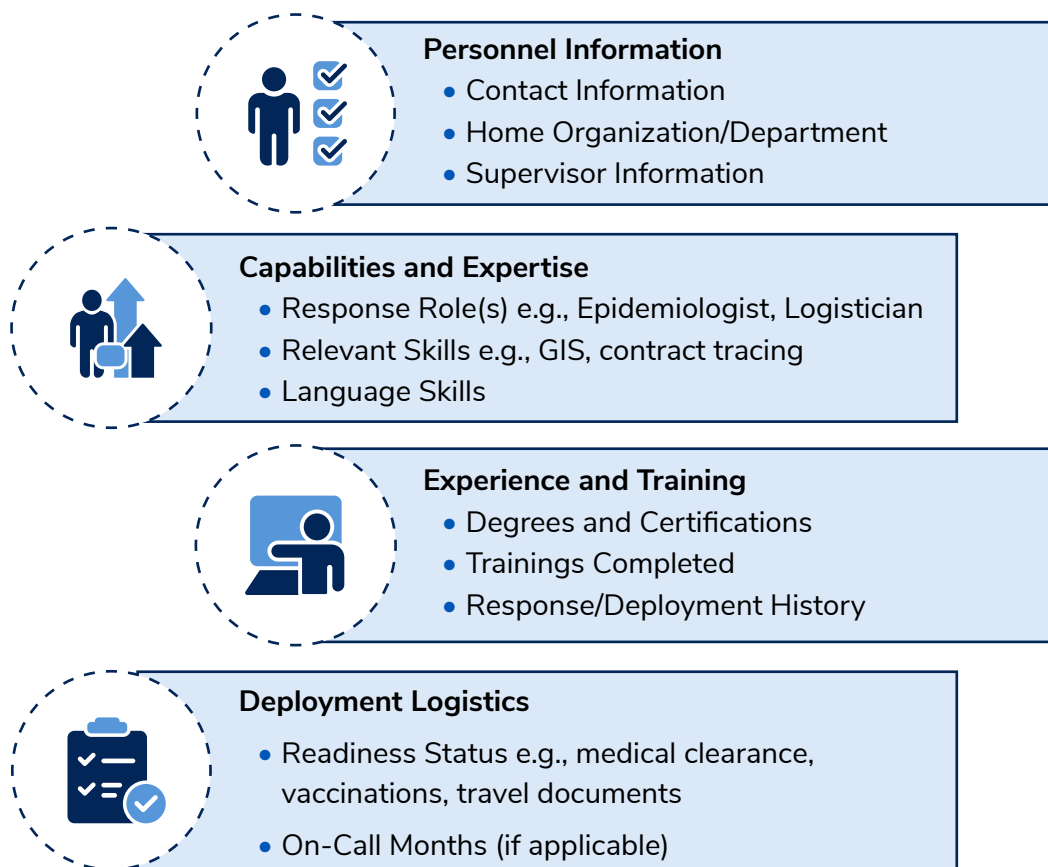
RRT Roster

A well-designed roster is a cornerstone of an effective RRT program. To maximize its utility, the roster should be developed to serve two primary functions: first, as a searchable database to quickly match response needs with qualified personnel, and second, as a real-time readiness monitoring tool to ensure responders are prepared for deployment at all times.

Roster Variables

A key first step is to determine how information will be collected and which variables are needed to identify the most appropriate responder for a given emergency. Using a standardized application form during recruitment is a practical approach to capture essential details in a consistent, searchable format.

While some rosters are simple, others host over 100 variables to capture a wide range of skills. The number of variables should align with program needs, but best practice suggests including a core set of helpful data elements. For example:



The roster should be treated as a dynamic tool. It is recommended to establish an iterative process where lessons learned from emergencies inform the inclusion of new variables to address evolving skill and role requirements.

Roster Platform

Selecting the platform to host the roster is an important decision. The RRT roster may be a standalone system or be included within a larger surge staffing roster held in the Public Health Emergency Operations Center (PHEOC). If the latter option is chosen, it is critical to ensure that the roster can be accessed even when a full PHEOC activation has not occurred, as RRTs may need to be deployed for events that do not trigger a full PHEOC response.

For maximum efficiency, linking the roster with existing surveillance and health information systems is highly recommended. Integrated systems allow managers to quickly identify available responders, match their skills to outbreak needs, and monitor readiness in real time. This data-driven approach supports rapid deployment and helps ensure resources are allocated efficiently. For example, hosting the RRT roster on a surveillance platform like DHIS2 can enable faster RRT decision making.⁵³

Regardless of the system chosen, an effective platform must be a dynamic operational tool. Key features should include:

- Easy Data Management with robust search and filtering capabilities.
- Built-in data validation to ensure information is accurate.
- Secure data sharing for multi-agency collaboration.
- Dashboards and reporting for real-time readiness monitoring and informed decision-making.

Roster Operations

To ensure the roster remains accurate and functional, it is highly recommended to assign a dedicated Roster/Data Manager. This individual's responsibilities would typically include overseeing data quality, regularly updating readiness indicators, monitoring attrition, initiating recruitment to fill gaps, and producing periodic reports for leadership on program capacity.

Establishing a clear update schedule is also a best practice for maintaining a current and reliable roster. A robust maintenance plan could include:

- Routine Updates (Quarterly or Biannually): To verify training status, readiness requirements, and contact details.
- Event-Driven Updates: Occurring immediately after deployments or major training exercises.
- Annual Comprehensive Review: To ensure the roster is up-to-date and accounts for any personnel changes or attrition over the year.

Responder Attrition Management

Retaining trained and experienced responders is critical for program sustainability. High turnover, or attrition, undermines response capacity and increases costs associated with repeated recruitment and training.

Common drivers of attrition often include career changes, heavy workloads and burnout, unclear expectations, and challenges with work-life balance. While no single standard exists for retention, programs can proactively

address these issues by implementing strategies to support and motivate their workforce. The table below outlines several recommended approaches to help maintain a skilled and ready response team.

Retention Strategy	Key Actions
Mentorship & Professional Growth	Pair junior responders with experienced subject matter experts (SMEs) to provide guidance and in-field support. Establish Communities of Practice for specific roles (e.g., epidemiology, logistics) to foster professional growth.
Recognition & Awards	Formally acknowledge responder contributions through certificates, internal newsletters, and leadership briefings. Public recognition, when appropriate, boosts morale and reinforces the value of their work.
Training & Career Development	Offer opportunities for advanced technical training (e.g., GIS, analytics), leadership development, language proficiency, and operational refreshers to invest in career progression.
Rotation & Rest Policies	Implement mandatory rest periods and clear rotation schedules for high-stress or prolonged deployments. These measures prevent burnout and align with responder well-being standards.
Workload Management	Formalize handover and backfill processes to ensure responders are not expected to maintain their regular duties while deployed. Clear agreements with home departments prevent dual workloads and reduce stress.

»» Readiness and Training

Training is a foundational component of an effective RRT program. It is beneficial for all RRT members to undergo regular, continual training throughout their membership and prior to deploying for an outbreak response. A well-structured training system helps ensure that responders are not only technically competent but also operationally prepared to function in high-pressure, resource-limited environments. A key goal of an RRT training program is to help ensure that members are trained and ready to deploy before a public health emergency occurs.²⁸

A well-designed training program can achieve several objectives:

- It helps ensure all RRT members have a consistent level of basic knowledge and skills.
- It provides opportunities to learn new competencies and practice existing ones.
- It keeps skills current with evolving methods, technologies, and scientific guidance.
- It can encourage team interaction and cohesion through joint exercises.
- It helps translate subject matter expertise into practical applications in field response settings.

An RRT training program is often most effective when tailored to the country's operational context and leverages existing resources to ensure that the most appropriate personnel receive up-to-date and relevant training.

Readiness

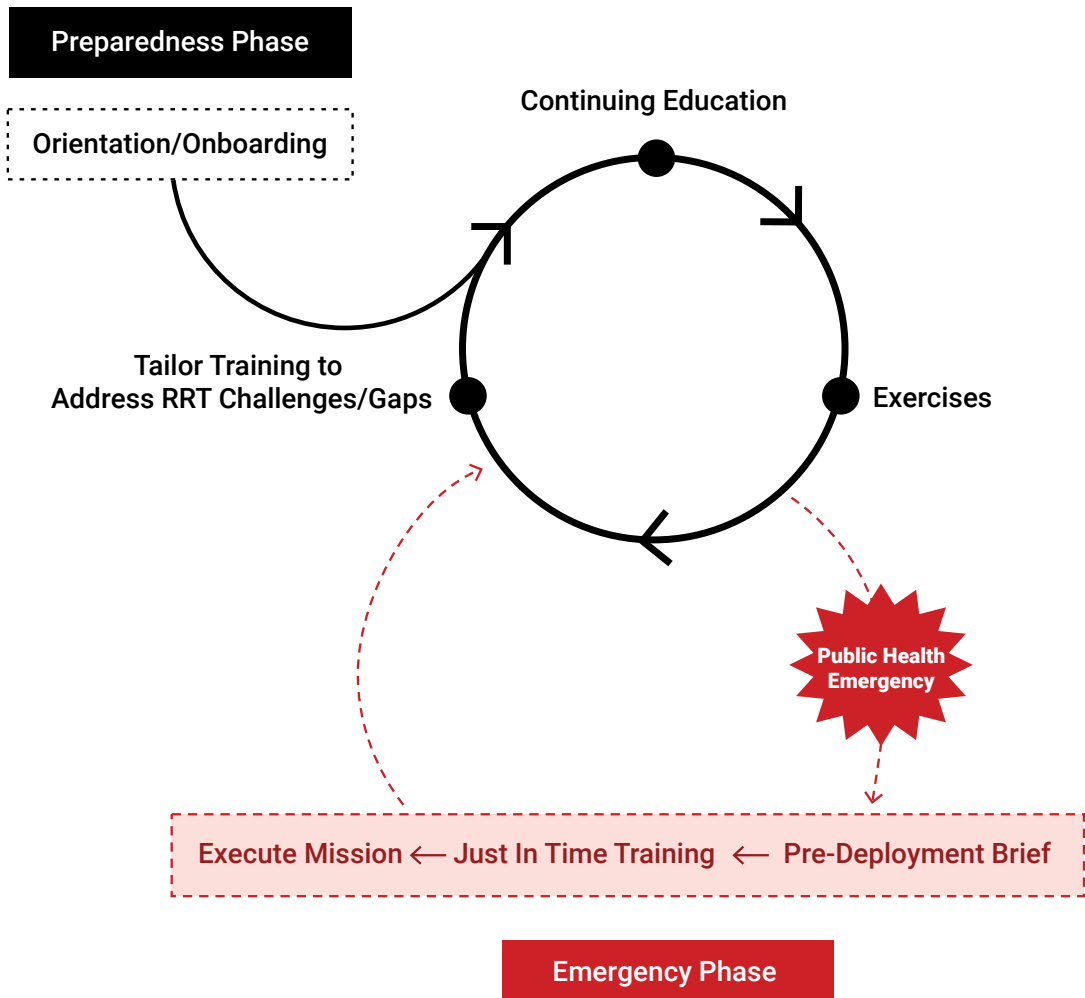
Readiness refers to the set of requirements that help ensure an RRT member is fully prepared and authorized to deploy for an emergency response. These requirements are often organization-specific and may vary depending on the mandate, scope, and operational context of the RRT program. In addition to operational readiness, some organizations require specific trainings to meet “deployment readiness.” Common examples of readiness checks include:

- Medical clearance and, if appropriate, psychological screening.
- Up-to-date vaccinations for relevant health threats.
- Completion of safety and security training (e.g., occupational safety or protocols for high-risk environments).
- Administrative readiness, such as having a valid passport and any necessary visas.

RRT Training Cycle

A well-structured training cycle is a helpful framework for ensuring RRT members maintain readiness and competency throughout both preparedness and emergency phases. This cycle can include four key components: Orientation and Onboarding, Refresher Trainings, Exercises, and Just-in-Time Training (Figure 6). Each component serves a distinct purpose in preparing responders for effective deployment.

Figure 6. RRT Training Cycle



Orientation and Onboarding

Orientation and onboarding introduce newly rostered RRT members to the program, its mandate, and operational framework. This initial training provides an overview of the RRT mission, scope, and its integration within the national emergency response system. It also covers emergency response structures such as the Health Cluster System and Incident Management System (IMS), along with coordination mechanisms. Operational basics—including reporting requirements, communication protocols, and responder well-being—are emphasized, alongside cross-cutting topics like ethics in emergencies, cultural competence, and professional conduct expectations. Orientation should occur shortly after roster enrollment and before any deployment.

Refresher Trainings

Refresher trainings maintain and update responder skills through a combination of technical and operational modules. Technical components include role-specific training in priority public health functions such as epidemiology and surveillance (e.g., outbreak investigation, case definition, line listing), laboratory skills (safe specimen collection and biosafety), clinical management and infection prevention and control (IPC), and risk communication strategies. Operational modules focus on deployment readiness, safety and security protocols, and psychological first aid to support resilience in high-pressure environments. These trainings should be conducted regularly—typically annually—and whenever SOPs or guidelines are updated.

Exercises

Exercises validate SOPs and allow responders to practice coordination and decision-making under realistic conditions.⁵⁴ Ideally, exercises should be scheduled during preparedness periods when teams are available and prepared for testing. Exercises can vary in complexity, ranging from simple drills to full-scale simulations. When deciding what type of exercise to conduct, start by asking: *What aspect of the RRT program needs to be tested?*

Example options may include:

- **Drill:** To practice a specific, hands-on RRT skill and validate a single team function.
- **Tabletop Exercise:** To test an RRT's decision-making, coordination, and communication processes in a low-stress, discussion-based environment.
- **Functional Exercise:** To test multiple RRT functions, coordination, and decision-making in a simulated, real-time environment, often involving communication between different locations (e.g., a mock EOC and a simulated field team).
- **Full-Scale Exercise:** To test all RRT systems, personnel, and equipment in a realistic, hands-on field environment, as close to a real deployment as possible.

Just-in-Time Training

Just-in-Time (JiT) Training occurs when there is an emergency. The training provides rapid, targeted instruction immediately before deployment, tailored to the specific emergency context. See [Section RRT Pre-Deployment Just-in-Time Training](#) for more details.

RRT Competency Frameworks

Competency frameworks provide structured guidance for RRT training programs by defining the essential knowledge, skills, and behaviors needed for effective emergency response. By using a framework, training can be intentionally designed to target higher levels of learning—such as those described in Bloom’s Taxonomy—moving beyond simple recall to ensure responders can apply knowledge, analyze information, and evaluate courses of action in real-world scenarios.^{55, 56} While specific program designs can vary, most comprehensive frameworks are built around a common set of core competency domains.^{11, 24, 28, 57, 58}

Core Competency Domains

Interpersonal and Cross-Cutting Skills

These skills are essential for all team members to enable effective team functioning, ensure responder well-being, and promote positive engagement with affected communities.

Competency	Description
Communication	Deliver clear, concise, and culturally appropriate messages to diverse audiences.
Cultural Competence	Demonstrate respect for local customs and perspectives to adapt activities and build trust.
Teamwork & Collaboration	Work effectively across disciplines, sectors, and agencies to achieve shared objectives.
Responder Well-being	Apply stress management and psychological first aid to support personal and team resilience.

Technical and Role-Specific Skills

These skills ensure that responders can effectively apply their subject matter expertise in emergency settings. Competencies are aligned with specific functions as detailed in [Appendix F: RRT Common Roles and Skills](#).

Competency	Description
Subject Matter Expertise	Apply specialized knowledge in functions like epidemiology, IPC, case management, and risk communication.
Technology & Digital Tools	Utilize field technology (e.g., Open Data Kit (ODK), KoboToolbox, GIS) for data collection, analysis, and visualization.

Deployment and Operational Skills

These skills ensure responders can mobilize quickly, operate safely, and function effectively in austere or resource-limited conditions.

Competency	Description
Deployment Readiness	Maintain all administrative, medical, and legal requirements for rapid mobilization.
Field Safety & Security	Adhere to safety protocols, maintain situational awareness, and follow emergency procedures.
Logistics & Resource Mgmt.	Manage equipment, coordinate supply chains, and utilize resources efficiently.

Competency	Description
Operational Reporting	Adhere to protocols for providing accurate and timely information through established channels.

Leadership and Coordination Skills

These competencies are critical for team leaders, coordinators, and management staff responsible for guiding response efforts and ensuring team effectiveness.

Competency	Description
Strategic Decision-Making	Analyze complex information and prioritize actions effectively under uncertainty.
Coordination & Delegation	Assign tasks based on skills, monitor progress, and maintain team efficiency.
Complex Problem-Solving	Identify and address technical, operational, and personnel challenges in dynamic settings.
Stakeholder Engagement	Liaise effectively with government officials, partners, and community leaders to align efforts.

Additional Competencies for Cross-Border Response

In addition to the core domains, frameworks for RRTs operating across international borders must place special emphasis on preparing responders for the unique challenges of humanitarian and diplomatic settings. Key competencies may include:

- **Understanding Humanitarian Architecture:** Navigating international coordination mechanisms (e.g., the Health Cluster) and operational standards.
- **Navigating Diplomatic Protocols:** Collaborating effectively with embassies and international partners to secure clearances and coordinate deployments.
- **Working in Diverse Environments:** Demonstrating cultural sensitivity and adaptability in field operations across different cultural and linguistic settings.
- **Applying International Standards:** Using frameworks such as Sphere to help ensure compliance with global humanitarian principles.⁴⁹
- **Adhering to Global Norms:** Upholding standards for ethics and data governance, including confidentiality, informed consent, and responsible data sharing.

Examples of Applied Frameworks

Two widely recognized models that CDC supported development of and often employs when building RRT training capacity are:

- **National-Level RRTs:** A current standard for national RRTs was developed through an evidence-based process that incorporated input from 17 countries and multiple partners.²⁴ The open-access training program can be found at [WHO Rapid Response Teams Training Programme](#).
- **Global-Level RRTs:** Global RRT programs, such as the framework developed by the Global Outbreak Alert and Response Network (GOARN), integrate the core and cross-border competencies discussed above to address the complexities of international deployment.¹¹ Related online trainings can be found at the [GOARN Learning Management System](#).

RRT Training Program Operations

Establishing a functional RRT training program requires more than developing a curriculum. It involves creating systems and processes that make training accessible, relevant, and sustainable. Operationalization ensures that training is not a one-time event but an ongoing cycle that supports responder readiness across all phases of emergency management.

RRT Training Repository

A training repository is a valuable component of RRT preparedness and sustainability. It helps ensure that all training resources are organized, accessible, and aligned with operational needs, risk assessments, and evolving response priorities. An effective repository is often designed to support continuous learning, rapid deployment readiness, and role-specific competency development.

It is beneficial for the repository to be risk-informed, drawing on outputs from STAR, THIRA, and other national risk assessments.^{40, 41} A comprehensive repository also incorporates lessons learned from AARs, recent emergencies, and simulation exercises. Continuously improving the repository helps to reflect evolving guidelines, scientific evidence, and operational best practices.

Examples of repository components may include:

- Standardized curricula mapped to priority hazards and emergencies (e.g., cholera, measles, influenza, and zoonotic diseases).
- SOP templates, checklists, and quick-reference guides for field use.
- Digital resources for virtual learning and just-in-time training.

To remain relevant and effective, it is a best practice to actively maintain the training repository. Consider scheduling regular updates to incorporate new guidelines and lessons learned. Implementing version control is important for clarifying which materials are current. Accessibility can be enhanced through a centralized, searchable platform, potentially with tiered access for different roles. It is also helpful to establish clear governance by assigning responsibility for repository management. Finally, embedding monitoring and evaluation mechanisms—ideally through dashboards linked to the RRT roster—can help track training completion and readiness status. These measures can help sustain the repository as a living resource that supports operational readiness and continuous improvement.

RRT Training Facilitators

The success of RRT programs is often enhanced by a dedicated group of facilitators who understand both technical content and operational realities. Maintaining a list of qualified facilitators is a key practice for ensuring consistent delivery, scalability, and sustainability of the RRT training program. It is often beneficial for this list to be multidisciplinary and structured to support both routine capacity building and surge needs during emergencies.

Potential facilitators may include:

- Field Response Experts: Experienced responders who can translate operational realities into practical learning and lead scenario-based exercises.
- Technical Specialists: Subject matter experts in areas like epidemiology, laboratory diagnostics, and risk communication who can deliver role-specific modules.

- **Training Coordinators:** Staff who can assist with scheduling sessions, tracking completion, and maintaining records.
- **External Partners:** Representatives from universities, NGOs, and international agencies who may offer specialized content and surge support, often through formal agreements.

To help the facilitation list remain effective and scalable, it is good practice to actively manage it. This can include conducting annual reviews to refresh the list and address attrition, helping to ensure qualified facilitators are available when needed. Providing ongoing professional development is a good way to keep facilitators current with evolving guidelines and best practices. Securing adequate funding is also important for covering costs associated with facilitators, venues, and learning platforms. Finally, monitoring and evaluation systems can be used to track facilitator performance and training outcomes, for instance, through dashboards linked to the RRT roster, to support accountability and continuous improvement.

RRT Training Tracking

A Training Tracker is a valuable tool to ensure RRT members remain prepared for deployment. This system may be a standalone database or, in some cases, combined directly into the RRT roster or linked as a relational database. Regardless of its structure, a centralized tracker allows managers to monitor training progress, assess competencies, and confirm the team's overall readiness.

Maintaining an integrated tracker promotes accountability by confirming responders meet training requirements, improves efficiency by allowing managers to quickly identify qualified personnel, and helps drive continuous improvement by highlighting potential gaps in the training curriculum.

A well-designed tracker might incorporate the following key functions:

1. **Record Completion of Mandatory Training:** The tracker can capture whether each RRT member has completed key components, such as orientation, technical modules, operational safety training, and leadership courses. To help maintain compliance, some programs find it useful to configure automated alerts that flag overdue or incomplete training.
2. **Map Competency Attainment:** Beyond simply tracking completion, the system can be enhanced by linking training records to specific, role-based competencies (e.g., laboratorian, risk communicator). Using a proficiency matrix can further clarify each responder's skill level.

RRT Response Operations

»» RRT Activation

The shift from the preparedness phase to emergency phase for RRT programs begins with an alert of a potential public health threat and the decision to activate the team. Activation is a critical step that demands substantial resources—human, financial, and logistical—and should follow a structured framework that reflects the complexity of public health emergencies rather than relying solely on the initial alert.

The activation process determines when and how the RRT moves from readiness to deployment. While activation often aligns with broader emergency management structures such as the IMS or equivalent, RRT activation can also occur independently. Many public health alerts do not require full IMS activation but still call for rapid technical support or investigation.

Key considerations when determining the RRT activation process may include:

- **Alert Verification:** Establish procedures for verifying alerts and communicating outcomes to RRT leadership before activation decisions are made.
- **Assess Emergency Triggers:** Define and apply pre-established thresholds or national guidelines to determine whether the event warrants RRT deployment. See [Criteria](#) below.
- **Jurisdiction and Authority:** Confirm whether a formal request or invitation is required for deployment and ensure compliance with legal mandates and interagency agreements.
- **Determine Activation Pathway**
 - **With IMS Activation:** Integrate the RRT into the IMS structure, typically under the Operations Section, when full-scale response criteria are met.
 - **Without IMS Activation:** Activate independently for smaller-scale events, verification missions, or technical assistance needs.
- **Authority to Activate:** Determine who has the authority to activate the RRT (e.g., RRT Manager, Incident Manager, designated official) to avoid delays and confusion.

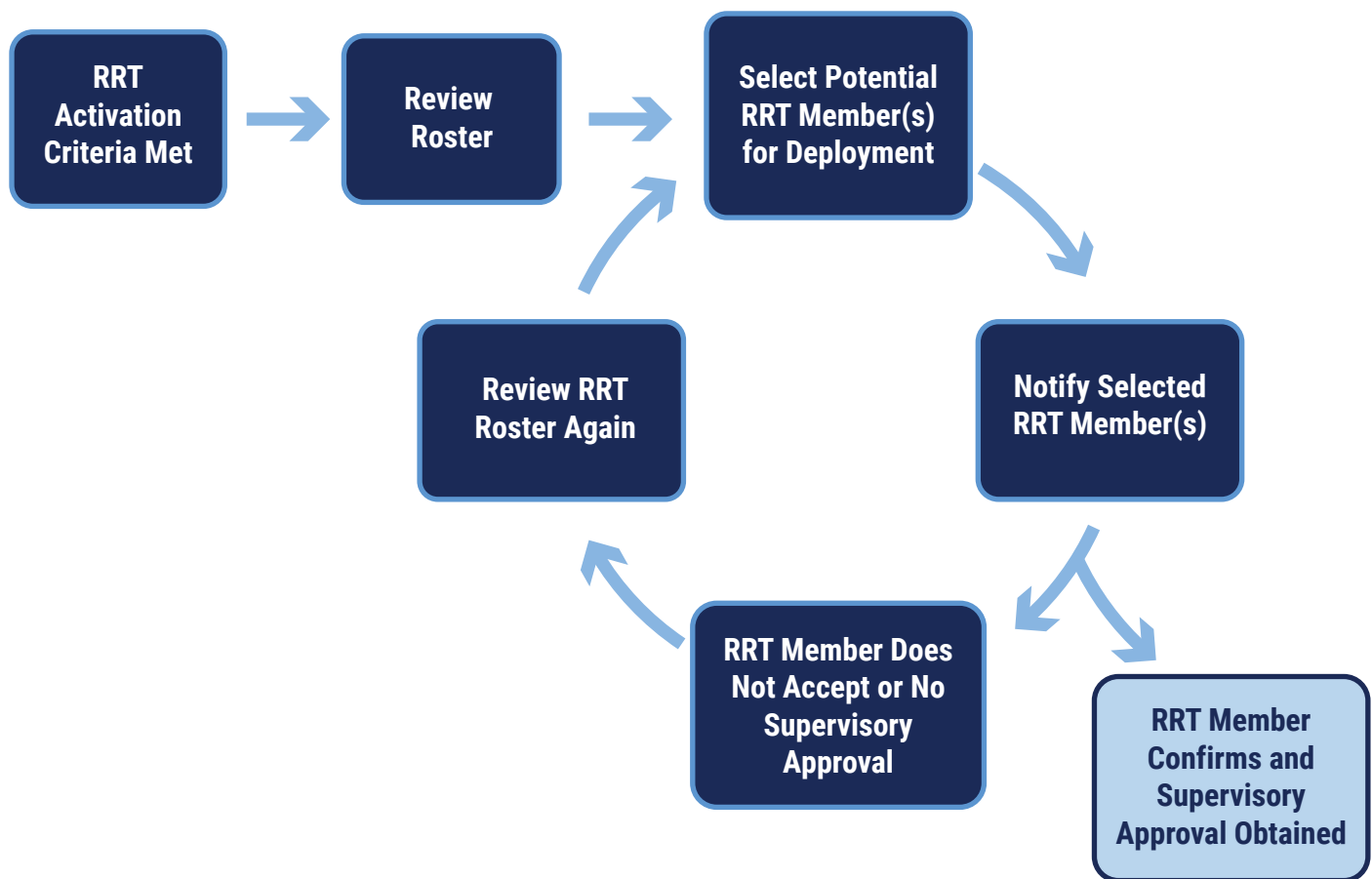
Criteria

Activation decisions are ideally guided by a structured framework that considers epidemiologic, operational, and contextual factors. While these decisions differ from IMS activation criteria, there may be areas of overlap. Importantly, these factors are dynamic and can change as an event evolves. For example, a low-severity outbreak may escalate if transmission risk increases or media attention intensifies. Because of this variability, activation decisions should remain flexible, context-driven, and thoroughly documented for accountability. Programs are encouraged to consider factors such as:



Process

Once activation criteria are met and the decision to deploy the RRT is confirmed, the next step is to determine who will deploy and in what configuration. This process can be guided by response needs, available resources, and contextual factors. A structured approach ensures speed, efficiency, and alignment with operational priorities (Figure 7).

Figure 7: RRT Activation Process

Roster Review

The roster is the primary tool for selecting team members. Deployment strategies may vary based on the clarity of response needs.

For Specific and Defined Needs

If requirements are clear—such as laboratory support for cholera testing or an epidemiologist for case investigation—the roster can be used to quickly identify individuals with the required technical expertise. This targeted approach can help minimize delays and ensure the right skills are deployed.

For Unclear or Evolving Needs

If response needs are not fully defined, the roster can be used to fill gaps between local capacity and anticipated requirements. For example, if local authorities can manage basic surveillance but lack risk communication expertise, the roster can be used to identify specialists that complement existing efforts.

Alternative Approach: Pre-Selected Multidisciplinary Teams (“Go Teams”)

Some programs maintain pre-assembled teams on the roster, ready to deploy regardless of the disease type. These teams typically assess needs upon arrival and if needed, can request additional specialists who are required. This model can help speed deployment when time is critical but often benefits from strong planning and flexibility to adjust team composition in the field.

RRT Responder Deployment Selection

When selecting members for deployment, it is helpful to ensure that the team's composition matches the specific needs of the response.

RRT Technical Composition

It is often useful to consider the technical roles and skills needed for standard response-related activities. For example, epidemiologists may be helpful for case investigation, infection prevention and control (IPC) specialists for healthcare settings, and risk communication experts for community engagement.

It is also helpful to consider the characteristics of the outbreak, including its scale and geographic distribution. Large or widespread events may call for multiple teams to deploy simultaneously to different locations, which can be factored into planning.

Finally, considering population characteristics can be beneficial. If vulnerable groups are affected—such as children, pregnant women, the elderly, or communities with specific cultural or language needs—including specialized expertise in the team can be advantageous. This can help ensure that the RRT provides targeted, effective support while addressing both technical and contextual challenges.

RRT Supporting Roles

Beyond technical experts, certain support roles can be very helpful to the security, safety, and operational efficiency of the RRT during deployment. These roles can help protect team members, maintain continuity of operations, and address risks that go beyond disease control.

- **Safety Officers:** This role focuses on preventing accidental harm and environmental hazards. Responsibilities might include:
 - Assessing field conditions for risks such as unsafe roads or hazardous materials.
 - Implementing protocols for personal protective equipment (PPE) use.
 - Monitoring compliance with safety standards.
- **Security Officers:** This role often addresses intentional threats and team protection in volatile environments. Responsibilities could involve:
 - Conducting security risk assessments prior to deployment.
 - Coordinating with local law enforcement or other security agencies.
 - Developing evacuation plans and managing security incidents.
- **Logistics Experts:** This role helps ensure operational continuity by managing resources and supply chains. Key tasks may include:
 - Arranging transport for personnel and equipment.
 - Securing accommodation and field supplies.
 - Maintaining inventory of critical items like PPE and communication tools.

Manage RRT Responder Availability

Once personnel are identified for deployment, programs can benefit from following a structured process to support timely mobilization and accountability.

Notify Selected Staff

After selecting team members, a good practice is to promptly notify them of their deployment and provide essential details, such as:

- The nature of the event and their expected roles
- The deployment location and duration

Clear and timely communication can help responders prepare and may minimize delays. It is also helpful to obtain confirmation that the selected staff accept the assignment and are available to deploy.

Obtain Supervisory Approval (if required)

Depending on the RRT program design, supervisory approval may be part of the process. This step can help ensure organizational alignment and accountability. The process often involves:

- Verifying that staff can be released from their regular duties without compromising essential services.
- Ensuring compliance with organizational policies and chain-of-command requirements.
- Documenting approval for accountability and resource tracking purposes.

Plan for Declines and Unavailability

Declines and unavailability are common and can be anticipated in the planning process. Programs can consider the following to mitigate the effect on a timely deployment:

- **Establish a Process:** It is useful to have a clear process to document the reason for non-deployment and to quickly select an alternate with the required skills.
- **Anticipate Unavailability:** As a planning assumption, some programs anticipate that 30–50% of rostered staff may be unavailable when called. This value is often based on operational experience and may be unique to specific programs and country contexts. Maintaining a sufficiently large roster can help compensate for this.
- **Define Reasons:** Some programs find it helpful to define acceptable versus unacceptable reasons for declining a deployment. For example:
 - Acceptable reasons might include deployment for another emergency, personal emergency leave, illness, or a leadership directive.
 - Unacceptable reasons might include: “I don’t want to,” “I’m busy with other work,” or a scheduled vacation during on-call months (if using an on-call system).
- **Plan for Escalation:** It can be beneficial to have a pre-defined escalation process if supervisory approval is denied or if staff repeatedly decline, outlining how best to escalate the issue to leadership for resolution.

»» RRT Pre-Deployment

Delays in response efforts for certain diseases can lead to widespread exposure and rapid transmission, overwhelming local response capacities. To mitigate these risks, the primary goal of pre-deployment processes is to quickly and effectively prepare and equip RRT members for a safe, coordinated, and impactful field response.

When an RRT is included within an IMS, many logistical elements are already managed. However, if not integrated into IMS, specific deployment logistics and information will need to be addressed within the RRT program.

Pre-deployment activities should comprehensively address deployment readiness, technical readiness and operational planning to ensure RRTs are able to deploy safely and effectively. For RRTs deploying internationally or regionally, additional considerations may include:

- Visa and diplomatic clearance processes
- Host country coordination protocols
- Language capabilities and interpreter support
- Cultural competency and diplomatic protocols
- Data sharing agreements and sovereignty considerations
- Adherence to host country laws and international conventions
- International specimen transport regulations
- Cross-border communication systems
- International medical evacuation insurance and procedures
- Security assessments and conflict considerations
- Repatriation procedures

Pre-Deployment Briefing

The pre-deployment briefing is a critical step to ensure all RRT members have situational awareness, understand the outbreak context, and are clear on their roles and responsibilities before entering the field. A well-structured briefing helps align the team with response priorities, reduces confusion, and enhances operational efficiency.

Operational Considerations

Ideally, briefings occur immediately before deployment, with mandatory attendance for all deploying members and completion tracked in the RRT Training Database. Whenever possible, conducting briefings in person can help foster interaction and team cohesion. If teams are deploying from dispersed locations, virtual sessions may be a practical alternative. In situations where time is limited, providing hard copy or digital materials for review en route can help maintain preparedness. Briefings often work best when they are interactive—for instance, by using slides, SOP templates, and scenario-based exercises—and when printed and digital resources are available for reference.

It is recommended that the briefing be facilitated by the RRT Manager or a designated Training Coordinator, with support from Team Leads and Subject Matter Experts for outbreak-specific content. Including a separate leadership session for team leads can help strengthen decision-making and coordination.

Briefing Content

Content is most effective when adapted to the emergency type, geographic context, and deployment level (national, subnational, or international). Common topic areas include:

Current Situation and Epidemiology	Latest surveillance data and situation reports, including case counts, geographic hotspots, and vulnerable populations. Early response updates from the IMS, such as Incident Action Plans (IAPs) and SitReps, which provide real-time operational priorities and resource allocations.
Response Gaps and Priorities	Known gaps in data quality or response activities that RRT members will address in the field. Lessons learned from previous deployments or similar emergencies.
Objectives and Activities	Clear, measurable objectives linked to specific tasks. Indicators for monitoring progress and effectiveness.
Tools and Resources	Standardized tools for field use, such as case investigation forms, data collection software, evaluation checklists, and national guidelines. Templates for reporting and documentation.
Reporting and Communication	Leadership structure and reporting mechanisms Channels for urgent communication and escalation including low-connectivity Working with local health authorities. Data ownership and sharing agreements.
Safety and Security	Current security situation and any identified risks. Evacuation plans and emergency contacts. Safety protocols, including PPE use, medical checks, and psychosocial support resources.
Team Lead Briefing (Separate for Team Leaders)	Review leadership responsibilities and decision-making authority. Discuss coordination with local stakeholders and partner organizations. Anticipate operational challenges and contingency planning.

Just-in-Time Training

Just-in-Time (JIT) training is a focused, quick briefing that equips responders with the most current, disease-specific, and operational guidance immediately before deployment and can be used as a reference during deployment. It is designed to supplement, not replace, comprehensive RRT training. It builds upon the foundational knowledge responders already have by providing concise, actionable updates tailored to the unique characteristics of the current emergency. It assumes that responders have already completed their orientation and foundational modules (e.g., IMS principles, ethics, responder safety). JIT training does not dive deep into technical content; instead, it provides concise, actionable updates tailored to the nuances of the current emergency.

Operational Considerations

To be most effective, JIT training is ideally delivered as close to deployment as possible.

- **Delivery Method:** An in-person session is often preferred to allow for interactive discussion. However, if time or location constraints exist, training can be provided virtually or through digital/hard-copy materials for review during travel.
- **Content Management:** To maintain consistency and version control, all JIT materials should be drawn from and stored in a central training repository (see [Section Training Cycle](#)). If specific materials are unavailable, consider having subject matter experts present existing information, ensuring the content is carefully curated to cover only what is essential for the immediate deployment.
- **Documentation:** It is good practice to document the completion of JIT training in the RRT Training Database to support accountability and readiness monitoring.

Content

Content should be tailored to the specifics of the current situation. Common topics covered in JIT trainings include:

- **Biological and Epidemiologic Characteristics:** An overview of the disease's transmission dynamics, risk factors, and clinical presentation.
- **Role-Specific Protocols and Tools:** A review of activities, SOPs, and equipment use tailored to each responder's role (e.g., epidemiologist, IPC specialist).
- **Updated National Guidelines:** A summary of current country-specific protocols and global standards to ensure alignment.
- **Health and Psychosocial Support Resources:** Information on available measures for responder well-being, stress management, and mental health during deployment.

RRT Equipment

Ensuring responders have the right equipment is critical for both their safety and technical effectiveness during a public health emergency. Delays in procuring essential items can significantly hinder response efforts, so proactive planning and resource allocation during non-emergency periods are strongly recommended.

RRTs require a range of equipment to perform their duties in challenging field conditions. While a comprehensive list can be found in [Appendix G: RRT Deployment Checklists](#), Key categories to consider include:

Category	Examples of Key Items
Communication Tools	Mobile phones, radios with chargers, satellite phones for remote areas, and international calling/data plans.
Safety Gear	Personal Protective Equipment (PPE) appropriate for the threat, first aid kits, insect repellent, and antibacterial hand sanitizer.
Technical Supplies	Sampling kits, diagnostic tools, laptops, encrypted USB drives, GPS devices, and data collection instruments.
Field Essentials	Durable backpacks or luggage, international power adapters, and weather-appropriate clothing and gear.

Beyond a simple list of items, effective equipment management involves addressing several logistical and procedural questions. Best practice suggests considering the following during your planning phase:

- **Stockpile Management:** Does your organization maintain a dedicated stockpile of commonly used RRT equipment? Is there an emergency release mechanism that bypasses routine procurement delays?
- **IT and Data Security:** Are all field devices (laptops, phones, drives) encrypted? Have secure data transfer and storage protocols been established, especially for handling sensitive health data and accessing government systems?
- **Distribution and Procurement Plan:** Which resources will responders carry to the field versus what can be procured locally? It is advisable to assign a logistician to manage resource distribution and troubleshoot any supply issues that arise during deployment.

»» RRT Deployment

The deployment phase, which begins at mobilization and concludes with demobilization, is centered on the effective management of field operations. This guidance covers three key components to support a successful deployment: Operational Support, RRT Communication and Reporting, and Deployment Monitoring. Together, these elements help ensure an effective response, promote responder safety, and maintain accountability.

Operational Support

Operational support helps deployed teams function efficiently and safely while remaining aligned with response priorities. While many of these functions are typically managed under the IMS when activated, in situations where RRTs deploy independently or before full IMS activation, these components are often required to be delivered and monitored by the RRT management team. It can be beneficial to monitor personnel, resources, and finances.

- **Deployment Logistics:** Consider monitoring travel arrangements, lodging, and supply chain status to help ensure the timely and safe movement of personnel and materials.
- **Resource Tracking:** It is often helpful to oversee equipment and supply distribution, manage emergency procurement, and track funding disbursement. This supports operational readiness and financial accountability.
- **Deployment Details:** Documenting deployment dates, costs, roles, and locations in a centralized RRT Deployment Tracker is a recommended practice. Linking this tracker to the team roster can provide a comprehensive record for operational reporting, financial oversight, and future planning.

RRT Communication and Reporting

Clear and timely communication is essential for coordination and accountability during deployment. Effective communication ensures that field teams remain aligned with response priorities and that headquarters can provide operational support when needed.

Reporting Protocols

A consistent reporting rhythm provides leadership with situational awareness, helps track progress, and identifies challenges. When developing a reporting protocol, it can be helpful to consider the following:

- **Frequency:** Establish a regular reporting schedule (e.g., daily Situation Reports or “SitReps”) alongside a process for urgent updates on critical issues like security threats or major operational gaps.
- **Content for Mission Reporting:** Standardized reports, such as SitReps, ensure clarity and comparability. Recommended elements often include mission-related activities completed, planned next steps, operational challenges, and any logistics or resource needs.
- **Channels for Responder Status:** It is also common practice to have separate, often more frequent, check-ins focused on personnel. This can include daily health monitoring for symptoms and regular safety or security checks to confirm the well-being and location of team members.
- **Format and Channels:** Using standardized templates for mission reports can improve consistency. These are typically submitted via secure platforms, with contingency plans like SMS or phone calls if connectivity is disrupted. Responder status checks may use more immediate channels like radio or text messages.

- **Chain of Command:** It is important to define a clear reporting structure. For example, Team Leads could compile inputs for a consolidated SitRep and submit it to the RRT Manager. This communication should be bidirectional, allowing headquarters to provide timely feedback and operational decisions.

Handoff Reports

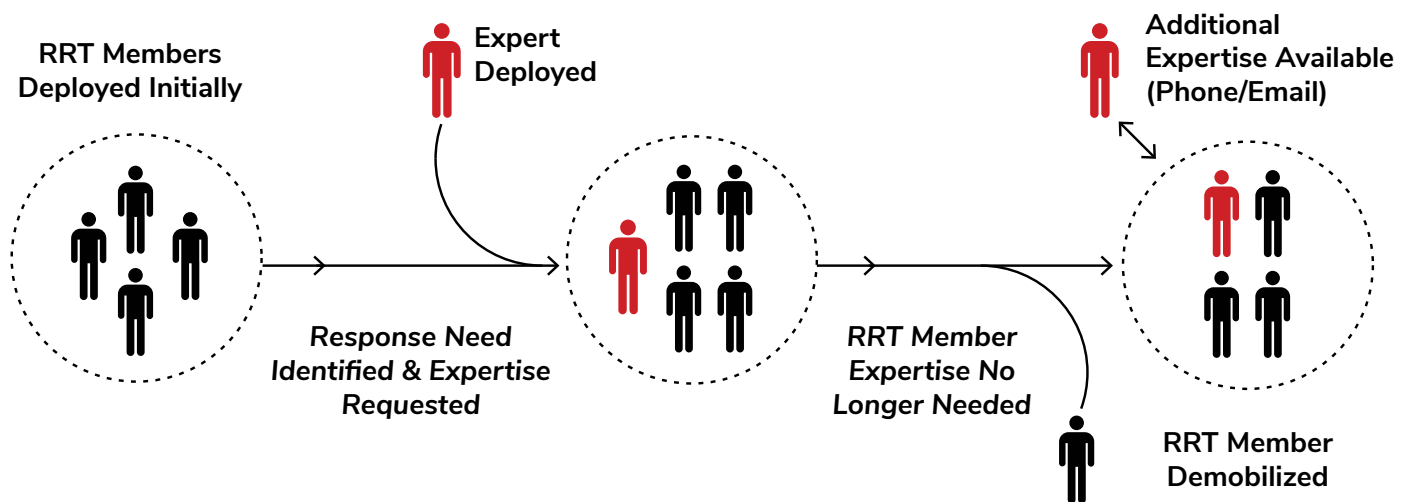
Handoff reports are a valuable tool for helping to maintain continuity and avoid gaps in response activities when team members demobilize or rotate. A well-structured handoff can help incoming staff quickly understand the current situation and continue operations smoothly. If an overlap in the field is possible, an in-person briefing is often ideal. If not, teams can use a written report and/or schedule a virtual handover call. Recommended components of a handoff report often include:

- **Key Contacts:** A list of local authorities, partners, and community leaders, noting any existing agreements or sensitive relationships.
- **Summary of Activities:** A concise overview of completed, ongoing, and outstanding activities, highlighting any that require urgent follow-up.
- **Current Challenges:** A description of operational, technical, or contextual challenges (e.g., supply chain delays, security concerns) with recommended next steps.
- **Resource Status:** An account of available resources, equipment, and supplies, along with any known shortages or pending requests.

RRT Deployment Monitoring

Effective management of an RRT during a deployment relies on the continuous monitoring of several key data streams. This process enables RRT leadership to track team performance, assess the evolving outbreak situation, manage operational logistics, and ensure the well-being of responders. By actively analyzing data related to the mission, the outbreak, and responder status, managers can make informed, adaptive decisions that are crucial for a successful public health response (Figure 8).

Figure 8: RRT Deployment Monitoring Example



This section provides a guide to these critical monitoring areas. More information on establishing monitoring systems is included in section [RRT Program Monitoring and Evaluation](#).

RRT Mission Data

Each RRT mission and intervention should have clear objectives and measurable indicators, so activities are not only implemented but also evaluated for effectiveness in real time. This ensures that RRT efforts remain aligned with response priorities and can be adapted as needed. Indicators are ideally tailored to the emergency context and agreed upon pre-deployment. Whenever possible, it is more useful to use percentages or proportions rather than raw numbers to measure coverage and identify gaps. Performance indicators will vary by response context and role, though there are many common ones typically seen (see [Appendix F: Rapid Response Team Common Roles and Skills](#)).

Outbreak Data

Real-time outbreak data is a valuable tool for managing RRTs and supporting adaptive deployment. RRT managers may find it useful for guiding decisions on team location, composition, and resource allocation. Examples of how outbreak data can inform RRT-related decisions include:

- **Surveillance Trends:** Monitoring data on case counts, geographic hotspots, and changes in transmission can help inform decisions, such as whether to preposition teams to emerging hotspots or add epidemiologists if transmission patterns shift.
- **Laboratory Testing:** Analyzing test results, turnaround times, and any identified capacity gaps might lead a program to deploy lab specialists to address delays or preposition diagnostic kits where capacity is limited.
- **Contextual Factors:** Information on environmental conditions (e.g., flooding) or population displacement could prompt decisions to include WASH experts on teams, move teams to affected zones, or stage essential resources.
- **Data Quality Issues:** Identifying gaps or inconsistencies in field data might lead a program to add data managers or IT specialists to a team, institute new data quality trainings, or augment leadership with senior epidemiologists.

»» Post-Deployment

The post-deployment phase is critical for closing out response activities, supporting responder well-being, and strengthening future operations through evaluation and improvement planning. These activities ensure continuity, accountability, and organizational learning.

Demobilization

The decision to demobilize an RRT is often based on several factors, including the end of the emergency itself. Common considerations for demobilization can include:

- Local capacity is sufficient to meet response needs.
- Objectives have been achieved or the outbreak is controlled.
- Safety or security concerns, or the need for medical evacuation.
- Rotation for rest and recuperation in protracted emergencies.

While the specific steps can vary depending on the geographic scope and overall response structure, a typical demobilization process may involve the following activities:

- Assess demobilization triggers.
- Notify affected parties and communicate timelines.
- Complete handover documentation to ensure continuity.
- Close out financial and administrative tasks.
- Conduct an exit briefing with responders.
- Initiate post-deployment support activities.

RRT Mission Report

The mission report is a valuable post-deployment deliverable that provides a comprehensive record of the RRT's activities, outcomes, and lessons learned. It can serve as a helpful reference for leadership, partners, and future response planning by offering a clear picture of what was achieved, what challenges were encountered, and what gaps may remain. The mission report also functions as an official record for accountability, donor reporting, and institutional learning. Unlike routine situation reports, it consolidates the entire deployment experience and can inform future evaluation and improvement efforts. To maintain accuracy and timeliness, completing and submitting reports within 7–10 days post-demobilization is a recommended practice.

While mission report templates are often provided by the organization, recommended content typically includes:

- Deployment Details: Dates, team composition, roles, and geographic coverage.
- Summary of Activities: Final status of interventions and any handoff to local staff or partners.
- Accomplishments and Impact: Major achievements and contributions to outbreak control.
- Gaps and Challenges: Operational, technical, or contextual barriers encountered.
- Recommendations and Lessons Learned: Actionable suggestions for improving future deployments.
- Resource and Staffing Considerations: A summary of resources used, outstanding needs, and logistical issues.

Resources for Returning Members

Responders often face physical, psychological, and emotional stress during deployment. Providing comprehensive post-deployment support is essential to protect their well-being and ensure successful reintegration. Recommended support measures include:

- **Medical Care:** Offer health screenings for illness or injury, access to treatment, and follow-up care as needed. Include testing for communicable diseases if exposure occurred during the response.
- **Psychosocial Support:** Provide counseling services, mental health resources, and stress management programs. Peer support groups can help responders share experiences and coping strategies.
- **Clear Instructions:** If self-isolation or symptom monitoring is required, give clear guidance on signs to watch for, reporting requirements, and when to seek medical care.
- **Administrative Support:** Facilitate rest days, reintegration assistance, and provide information on benefits or entitlements.
- **Recognition and Professional Development:** Implement programs to recognize responder contributions, boost morale, and offer opportunities for career advancement within public health organizations.

RRT Responder Feedback

An operational debrief is a critical step in the post-deployment phase and should occur as soon as possible after responders return from the field. The goal is typically to capture lessons learned, identify gaps, and improve future response efforts while experiences are still fresh. It may not be necessary to wait for all responders to return; holding multiple sessions can be an effective approach.

It is helpful to structure debriefs to collect actionable feedback that can feed directly into improvement planning. Ensuring confidentiality for sensitive information and documenting findings for integration into training and SOP updates are key considerations. Using a combination of methods is often recommended, such as individual or group debriefs held soon after return. Surveys can also be a useful tool for gathering input from responders, partners, and requesting authorities, especially for collecting anonymous feedback.

Examples of topics that debriefs can cover include:

- What worked well and what did not during the response.
- Operational challenges, team dynamics, and resource gaps.
- Actionable recommendations for improving SOPs, training, and deployment processes.
- Options for anonymous feedback to address sensitive issues.
- Participation by behavioral health professionals to address stress-related concerns.

When possible, it can also be beneficial for RRTs to participate in formal review processes such as IHR Monitoring and Evaluation activities, including Early Action Reviews (EARs), Intra-Action Reviews (IARs), and After Action Reviews (AARs), which involve all major actors in the response.

More in [Section: RRT Program Performance](#).

RRT Program Performance

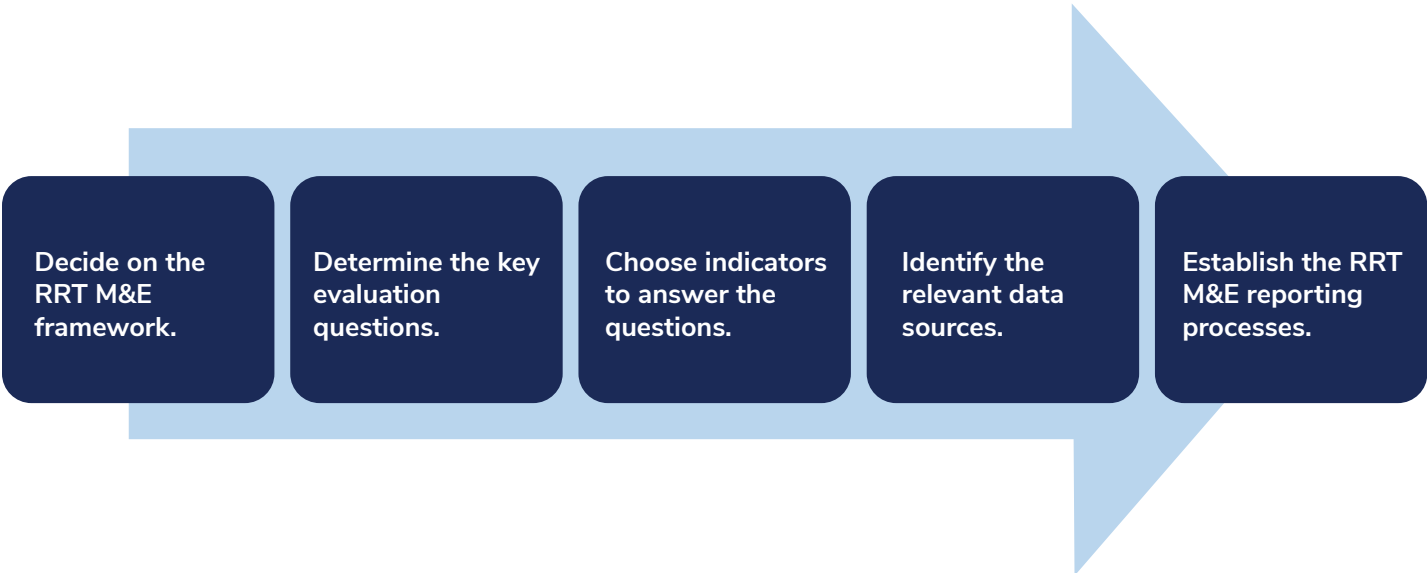
»» RRT Monitoring and Evaluation System Development

Monitoring and Evaluation (M&E) is a core management function that provides a systematic way to track the performance of a Rapid Response Team (RRT), demonstrate its impact, and drive evidence-based improvements. Developing a dedicated M&E system can offer several key benefits to an RRT program.

Benefit	Description
Performance Management	Tracking metrics like activation times, deployment efficiency, and intervention timeliness helps to identify bottlenecks and allows for rapid corrective actions.
Impact Demonstration	Providing clear, quantifiable evidence of the RRT’s contributions to outbreak control and health security capacity is critical for engaging leadership, donors, and partners.
Quality Improvement	Using findings from deployments and exercises helps refine SOPs, training curricula, resource strategies, and coordination mechanisms.
Accountability & Transparency	Ensuring transparent reporting to funders, government partners, and affected populations builds trust and confidence in the RRT program.
Strategic Optimization	Informing data-driven decisions on team composition, training priorities, and equipment procurement enhances the effective use of resources.

While every RRT M&E system should be tailored to a program’s specific context, a systematic approach is essential for it to be effective. Without a globally accepted process, the following steps offer a structured approach for developing a new RRT M&E system or strengthening an existing one (Figure 9). Each step is outlined in more detail in the subsequent sections.

Figure 9. RRT Monitoring And Evaluation System Development Approach



RRT M&E Frameworks

Several existing M&E frameworks can be applied to RRT programs.^{12, 25, 30, 59-61} At its core, RRT M&E often relies on a clear Theory of Change, the narrative explaining how a program’s interventions are expected to lead to desired outcomes.⁶² To operationalize this theory, a hybrid approach that integrates two M&E frameworks—the Logic Model⁶³ and the Results Framework⁶⁴—may offer a comprehensive approach for RRT program M&E

The Logic Model: The “How”	The Results Framework: The “What” and “Why”
• Provides a detailed, ground-level view of an RRT program’s operations. It can visually represent the Theory of Change, connecting resources and activities to a chain of RRT program results (outputs, outcomes, and impact). • This often makes it a valuable tool for operational planning and day-to-day management.	• Provides a high-level, strategic view of a program’s goals. It helps articulate what the program intends to achieve and how that success might be measured, aligning the RRT’s work with broader national health security priorities. • This can be vital for advocacy, reporting, and resource mobilization.

The primary value of each model may depend on the maturity of the RRT program.

- **For New or Developing RRT Programs:** The Logic Model is often the most critical starting point. When a program is being established, the Logic Model forces planners to think critically about the necessary inputs (staff, funding, supplies), the specific activities to be performed, and the direct outputs they will produce. It provides an operational blueprint that helps ensure the program is built on a solid and logical foundation before it is scaled up.
- **For Established RRT Programs:** An existing program with well-defined operations may find greater value in emphasizing the Results Framework. For these programs, the priority often shifts from how to do the work to demonstrating what was achieved and why it matters. The Results Framework is ideal for linking the RRT’s activities to high-level national health security goals, communicating impact to leadership and donors, and making a strong case for continued investment and sustainability.

Regardless of the RRT program’s status, though, by using these frameworks in tandem, RRT programs can better link their daily operations to their strategic value. This approach can help create a powerful system for enhancing effectiveness, accountability, and long-term sustainability.

RRT Program Evaluation Questions

The foundation of an effective M&E program is a clear set of evaluation questions that the program aims to answer. These questions guide what is measured and why, ensuring that data provides meaningful insights into the RRT program’s functioning, performance, and impact.

Key Domains

A helpful approach is to frame questions across a spectrum of three interconnected domains.

1. **RRT Program Functions.** This domain examines the operational efficiency of the RRT program itself.
Questions to consider:

- How effective are the internal processes of the RRT program (e.g., recruitment, logistics, management)?
- What specific actions are being taken during a deployment, and how well are they being executed against established SOPs?

2. **RRT Program Outcomes.** This domain focuses on the direct, short- and medium-term results of the RRT's activities.

Questions to consider:

- What are the short- and medium-term results achieved by the program and its responders (e.g., number of cases investigated, local staff trained)?
- To what extent did the RRT's outputs reflect the deployment's official objectives?

3. **RRT Program Impact.** This domain assesses the broader, long-term contributions of the RRT program to public health.

Questions to consider:

- What long-term changes can be attributed to the RRT program's interventions (e.g., strengthened local surveillance capacity)?
- How does the RRT program contribute to overall national emergency management goals?

Application Across Emergency Phases

These evaluation domains can be applied across the emergency cycle, though the focus of the questions will often shift depending on the operational phase.

- During the Preparedness Phase, the focus is on documenting and assessing the RRT's capacity and readiness before a deployment.
 - Example questions:
 - » Are responders trained in core competencies and administratively ready for deployment?
 - » Is the roster complete, multidisciplinary, and up to date?
 - » Are equipment and supply caches fully stocked and ready for immediate use?
- During the Response & Recovery Phases, the emphasis shifts to operational performance and the results of the intervention.
 - Example questions:
 - » How timely was the RRT's deployment and integration with local response structures?
 - » Were the technical outputs (e.g., data analysis, patient care) delivered as planned?
 - » What was the quality of the response in terms of coverage, community acceptance, and overall contribution to controlling the event?

Considerations for Alignment

To ensure findings are relevant and useful, evaluation questions can be aligned with existing organizational priorities, local demand, and international standards. Such alignment promotes consistency and comparability,

which can contribute to broader health security goals. Examples of this may include,

- **Leadership Priorities:** Align questions with the strategic goals and critical decision-making needs of organizational leadership.
- **Donor Requirements:** Frame questions to ensure accountability and transparent reporting to funding bodies.
- **International Health Regulations (IHR) and Global Standards:**
 - **7-1-7 Targets:** How does the RRT’s performance contribute to detecting threats within 7 days, notifying within 1 day, and responding within 7 days?
 - **JEE & SPAR:** How does the RRT’s capacity support the country’s progress on Joint External Evaluation (JEE) indicators and State Party Self-Assessment Annual Reporting (SPAR)?
 - **WHO Benchmarks:** Incorporate global standards for emergency preparedness and response into the evaluation framework.
- **National Frameworks:** Reflect country-specific public health policies, emergency response plans, and reporting requirements.

By addressing these questions and integrating relevant standards, RRT programs can generate actionable insights on operations, outcomes, and long-term impact, strengthening preparedness and response capacity.

RRT M&E Indicators

Once evaluation questions are established, the next step is to define indicators that will provide the measurable data needed to answer them. An indicator is a specific, observable, and measurable characteristic that can be used to show changes or progress a program is making.

A helpful way to categorize these indicators is by the type of information they provide. This ensures the M&E program captures a balanced view of the RRT’s activities, its immediate results, and its overall contribution. While the indicator categories below are similar to the evaluation domains mentioned previously, they work together in a flexible way. A single evaluation question from one domain (e.g., a question about Program Functions) may be answered by using multiple indicator types. For example, the effectiveness of a training function can be measured by a process indicator (# of people trained) and an outcome indicator (% knowledge gained). Consider categorizing indicators into three main types:

Process Indicators	Outcome Indicators	Impact Indicators
Measure the operational aspects of the RRT program—the resources used and the activities performed. They help answer questions about program functioning and efficiency. <u>Example</u> # of RRT members trained; % of roster positions filled; time from alert to RRT activation.	Measure the short- and medium-term results of the RRT’s activities. They help answer questions about the direct effects and quality of the response. <u>Example</u> % of outbreak alerts investigated within 24 hours; case fatality ratio during the response; % of target population reached with risk communication messages.	Measure the long-term, broader changes that the RRT program contributes to. They help answer questions about the program’s ultimate value and contribution to health security. <u>Example</u> Reduction in outbreak-related mortality; time to outbreak control; improvement in national health security capacity scores (e.g., JEE/SPAR).

More example indicators are available in [Appendix H: RRT Indicator Reference Table](#). Given the many aspects of an RRT program, hundreds of potential indicators could be tracked. Therefore, prioritization is a critical step for organizations to undertake to ensure data collected is actionable.

RRT M&E Data

A key aspect of developing an effective M&E program is the identification of relevant data sources and collection methods needed for the evaluation process. It is beneficial to identify where the data will come from and how it will be collected, ensuring that methods are reliable and feasible.

Data Sources

M&E data sources can be categorized into primary and secondary categories, each providing unique insights into RRT operations and outcomes.

Primary Data Sources

These sources involve the direct collection of new data specifically for M&E purposes. They can offer detailed, targeted insights into team performance and stakeholder perspectives. Examples include:

- RRT roster database (responder profiles, skills, availability, deployment history)
- Deployment tracker (deployment dates, locations, activities, outcomes)
- Request tracker (who requested RRT support, for what, when, fulfillment status)
- RRT field reports (situation reports, mission reports, SMS updates)
- Training database (courses completed, certifications, expiration dates)
- AAR and IAR reports (lessons learned, recommendations, implementation status)
- Post-deployment surveys (responder feedback, partner assessments)
- Simulation exercise reports (participants, scenarios, gaps identified)

Secondary Data Sources

These sources involve the analysis of existing data that was collected for other purposes but is relevant to the M&E questions. Leveraging secondary data can be a highly efficient way to monitor performance. Sources may include:

- National disease surveillance system (case counts, alert data, investigation records)
- Laboratory information system (specimens tested, turnaround times, test results)
- Health facility data (admissions, bed occupancy, stock levels, service utilization)
- Emergency Operations Center logs (activation times, coordination meetings, situation reports)
- Population surveys (community knowledge, attitudes, practices related to health threats)
- Administrative records (budget execution, procurement, human resources)
- IHR assessment tools (JEE scores, SPAR submissions, benchmarking data)

Data Collection

For an M&E program to be successful, a well-defined and feasible data collection plan is essential. The integration of the above diverse data sources underscores the importance of fostering interagency agreements and ensuring data interoperability. A robust RRT M&E framework typically employs a mixed-methods approach, integrating both quantitative and qualitative data collection across all phases of the emergency management cycle. Examples of different methods may include the following:

Preparedness Phase

- **Quantitative Methods**

- **Roster Audits:** Use a tracking database to monitor RRT member readiness, including the status of vaccinations, certifications, and valid travel documents.
- **Training Assessments:** Administer pre- and post-training surveys to measure knowledge gain and confidence levels on core RRT competencies (e.g., epidemiology, infection control).
- **Simulation Metrics:** Track performance metrics during simulation exercises, such as the time required to activate the team, correctly pack go-kits, or establish a field base of operations.

- **Qualitative Methods**

- **Key Informant Interviews:** Conduct structured interviews with RRT members and leadership to identify perceived gaps in team readiness, equipment, or administrative support.
- **Simulation Debriefs:** Facilitate detailed debrief sessions immediately following a training or simulation exercise to capture insights on team coordination, communication, and decision-making processes.
- **SOP & Document Review:** Analyze RRT-specific Standard Operating Procedures (SOPs) and field manuals to assess their clarity, completeness, and relevance to potential deployment scenarios.

Response Phase

- **Quantitative Methods**

- **Performance Dashboards:** Track key RRT performance indicators (KPIs) in real-time, such as the timeliness of deployment, number of case investigations supported, or laboratory samples collected per day.
- **Resource Tracking:** Use standardized logs to monitor the consumption (“burn rate”) of RRT-specific supplies, equipment, and personal protective equipment (PPE).

- **Qualitative Methods**

- **Intra-Action Reviews (IARs):** Facilitate brief, periodic reviews (e.g., daily or weekly huddles) with the deployed RRT to capture immediate operational challenges and on-the-ground lessons learned.
- **Analysis of Field Reports:** Systematically review daily RRT situation reports or field notes to identify emerging themes, information gaps, and challenges encountered by the team.
- **Direct Observation:** Have team leaders or designated observers use structured checklists to record observations on critical procedures, such as adherence to PPE protocols or data collection practices.

Recovery Phase

• Quantitative Methods

- **Post-Deployment Surveys:** Administer confidential surveys to RRT members upon their return to assess their physical and mental well-being and gather feedback on logistical and administrative support.
- **Analysis of Epidemiological Data:** Analyze surveillance or laboratory data collected by the RRT to assess the impact of their interventions on the outbreak (e.g., changes in case incidence).

• Qualitative Methods

- **After-Action Reviews (AARs):** Conduct a comprehensive post-deployment AAR with the entire RRT and key partners to perform a root-cause analysis of systemic successes and failures.
- **Host-Partner Interviews:** Conduct interviews with in-country counterparts or host-agency staff to gather their perspective on the RRT's effectiveness, integration, and competency.
- **RRT Focus Group Discussions (FGDs):** Hold facilitated discussions with the returned RRT to explore team dynamics, leadership effectiveness, and challenges that may not be captured in formal reports.

Mitigation Phase

• Quantitative Methods

- **Recommendation Tracking:** Use a database or dashboard to monitor the implementation status and completion rate of recommendations generated from RRT AARs.
- **Cost-Effectiveness Analysis:** Analyze financial data to compare the costs of a deployment against the estimated public health impact to inform future resource allocation.

• Qualitative Methods

- **SOP & Curriculum Review:** Systematically review RRT training materials and deployment SOPs to verify that they have been updated to incorporate lessons learned from recent deployments.
- **Policy Analysis:** Analyze changes in RRT activation or administrative policies to assess whether they successfully address previously identified barriers or bottlenecks.

RRT Operational Research

Indicators alone may not be enough when examining ways to measure and answer key evaluation questions. In this case, operational research may be required to generate evidence to improve the effectiveness, efficiency, and sustainability of RRT programs.

Research questions can address many aspects of an RRT program—from internal operations to its overall impact. Example questions may include:

• Efficiency Questions:

- What is the average time from alert to RRT activation? What factors cause delays?
- How does pre-positioning equipment affect deployment speed?
- What is the cost-benefit ratio of on-call versus on-demand systems?

- **Effectiveness Questions:**
 - Do RRT deployments improve outbreak control speed (e.g., compliance with 7-1-7 targets)?
 - What is the association between RRT training hours and field performance ratings?
 - How does team composition affect achievement of response objectives?
- **Sustainability Questions:**
 - What factors predict RRT member retention versus attrition?
 - How do different funding mechanisms affect program sustainability?
 - What is the return on investment for RRT capacity development?

There is no single globally accepted approach for conducting RRT operational research. Instead, programs can adapt existing methods commonly used in public health and emergency response. Examples of this may include:

Method	When to Use	Example Application
Descriptive Analysis	Characterize program status	Calculate % roster filled, deployment frequency by region
Time Series Analysis	Track trends over time	Identify seasonal patterns in RRT requests
Comparative Analysis	Compare groups or periods	Compare activation times before vs. after SOP implementation
Cost-Effectiveness Analysis	Evaluate resource allocation	Calculate cost per outbreak contained by RRT vs. without
Regression Modeling	Identify predictors	Determine factors associated with faster deployment
Qualitative Methods	Understand experiences and barriers	Explore responder burnout causes

RRT M&E Reporting

Effective M&E reporting translates field data into timely, actionable insights that drive decision-making and foster the RRT’s continuous improvement. The process involves tailoring the content, frequency, and format of reports to meet the specific needs of different audiences and operational phases. A fundamental feature of all RRT M&E reports is the inclusion of clear recommendations and a plan for tracking corrective actions.

The cadence of reporting should align with the RRT’s operational cycle, providing timely information for both strategic readiness oversight and immediate deployment needs. Examples include:

Preparedness Phase

- **Monthly RRT Readiness Dashboard:** A high-level, visual report tracking key readiness metrics such as deployable roster status (by skillset), training compliance rates, and go-kit inventory levels.
- **Quarterly RRT Readiness Review:** An analytical report presenting trend analysis on readiness indicators to identify recurring gaps (e.g., specific certification lapses) and inform resource allocation for the upcoming quarter.

- **Annual RRT Program Evaluation:** A comprehensive summary of the RRT's overall capacity, evaluating the effectiveness of the annual training and exercise plan against established benchmarks.

Response Phase

- **Daily/Weekly RRT Situation Report (SitRep):** Delivers critical operational data from the field, including epidemiological data (e.g., epicurves), key response activities (e.g., number of contacts traced), resource "burn rates," and urgent logistical or security support requests.
- **Intra-Action Review (IAR) Summary:** Provides rapid, qualitative feedback from deployed RRT members to enable immediate course correction on operational strategies, team dynamics, or logistical challenges.

Recovery and Mitigation Phases

- **RRT After-Action Report (AAR):** Presents a formal, comprehensive analysis of a deployment, detailing successes, challenges, and root causes to generate strategic recommendations for the RRT program.
- **Recommendation Implementation Plan:** Acts as a living document that tracks progress on the implementation of corrective actions for the RRT, ensuring lessons learned are integrated into future training, SOPs, and go-kit composition.

Conclusion

»» Conclusion

The development of an effective and sustainable RRT program is a critical investment in national and global health security. It requires deliberate preparation, moving beyond plans on paper to build a true operational capability.

The most significant hurdles—securing sustainable financing and obtaining strong leadership commitment—are best addressed from the outset through a proactive change management strategy. This approach is foundational, enabling program leaders to build a broad coalition of support by positioning the RRT as an essential public health and economic asset. For decision-makers and financial authorities, this means underscoring the RRT's role in minimizing illness and death, maintaining public confidence, and reducing the immense societal and economic costs of health emergencies.

With that high-level support secured, successful implementation hinges on two parallel efforts: systemic integration and personnel readiness. Integrating the RRT within existing emergency management frameworks improves coordination and optimizes resource use. Just as critically, prioritizing responder health, safety, and well-being ensures the resilience and operational readiness of the workforce—the program's most vital asset.

Finally, a truly sustainable RRT program functions as a learning system, institutionalizing continuous improvement through exercises, formal reviews, and real-world deployments. This iterative process is what strengthens program capacity and responsiveness over time.

By applying the principles in this guidance, countries can build adaptable RRT programs that not only fulfill International Health Regulations requirements but are capable of protecting public health when it matters most. Achieving and maintaining this readiness demands ongoing commitment and collaboration, ensuring that when the next emergency occurs, the response is swift, effective, and decisive.

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»» Disclaimer

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Appendices

Appendix A. CDC Capacity Assessment Tool – RRT Excerpt

This appendix is an excerpt from a larger CDC tool examining public health emergency capabilities. The list of RRT capacities in this tool is not exhaustive and should be complemented by other data sources (e.g., risk assessments, action reviews, IHR assessments, etc.) and may have variability depending on the context. This excerpt examines two attributes for each element listed:

Capacity

This describes how well the country has developed the required capability for a specific element. It's about the existence, not whether it's currently being used. In this tool, it is scored as follows:

- No Capacity: Country has no competency or proficiency. Equivalent to a JEE score of 1.
- Partial Capacity: Country has demonstrated limited competency or proficiency. Attributes are currently in the development stage and/or established, but sustainability has not been ensured. Equivalent to a JEE score of 2 or 3.
- Implemented Capacity: Country has demonstrated full competency or proficiency. Attributes are in place and sustainable and can be measured and secure funding source is ensured. Equivalent to JEE score of 4 or 5.
- Not Applicable: The element does not yet exist and therefore, the capacity field is not applicable currently.
- Unknown: The capacity of the element is not known currently.

Operational Status

This describes whether the element is functioning as intended—its ability to perform operational tasks when needed. In this tool, it is scored as follows:

- Not operational: Element is not operational (i.e., has not been used).
- Limited operational functions: Element is restricted in its ability to function as expected/ as needed.
- Fully operational: Element is in or ready for use and has demonstrated ability to function as expected/ as needed.
- Not applicable: Element does not require operational function or does not yet exist.
- Unknown: The operational status of the element is not known currently.

Plans and Processes

Element	Capacity	Operational Status
National RRT Program included in country’s strategic emergency plan		
National RRT Program included in country’s operational emergency plan		
Established legal contracts/agreements with other national ministries/ agencies for multisectoral RRT mobilization		
National RRT SOPs drafted and finalized by all relevant stakeholders and leadership		
Subnational RRT SOPs drafted and finalized by all relevant stakeholders and leadership		

Element	Capacity	Operational Status
National RRT trained, organized, and ready to deploy at the national level		
Subnational RRT trained, organized, and ready to deploy at the national level		

Administrative Considerations

Element	Capacity	Operational Status
Identified human resources to manage/support the RRT program in both preparedness and response phases		
RRT management staff are equipped with the necessary technological tools to collect and manage data and information pertaining to the RRT members (i.e., laptops, internet, survey tools, dashboards, etc.)		
RRT management staff have been trained on operating a sustainable RRT program		
Established RRT budget considering the requisite preparedness and response operations (i.e., salary, per diem, training programs, travel, equipment, vaccinations, database maintenance, etc.)		
Established sustainable internal financial support for the RRT program to support RRT administrative costs, member readiness, and deployments		
Identified resources and mechanisms to ensure RRT safety, health, and well-being, including in RRT planning (e.g., medical/disability/life insurance, medical care, mental health care, emergency evacuation, etc.)		

Staffing and Rostering

Element	Capacity	Operational Status
Recruitment process targets multisectoral staff with differing technical expertise to best utilize a One Health approach to outbreak response		
Formalized RRT recruitment process with inclusion/exclusion criteria and aligned with country risk assessment		
Established process for continual recruitment based on attrition		
Established process for data collection of RRT members skills, experience and contact information		
Developed up-to-date database (aka roster) of key information about RRT members to allow for rapid and tailored selections based on the public health event		

Training Program

Element	Capacity	Operational Status
Established continual RRT training program aligned to standardized emergency competencies		
Implemented onboarding training for new RRT members, including the provision of initial all-hazards technical, operational, and administrative training		
Established continual training provision for existing RRT members on supplementary technical skills related to field deployments, soft skills, and response updates		
Developed internal repository of disease or event-specific just-in-time trainings		

Activation and Pre-Deployment

Element	Capacity	Operational Status
Developed pre-deployment standard operating procedures (SOPs) (e.g., RRT composition, briefing, just-in-time training, equipment, etc.)		
Established defined, written criteria for activation of RRT program to deploy RRT members to the field		
Established RRT pre-deployment briefing process		
RRT pre-deployment disease-specific trainings identified and conducted for priority diseases		
Established system for identifying and procuring necessary RRT equipment		

Deployment

Element	Capacity	Operational Status
Developed deployment SOPs (e.g., communication, reporting, team evolution, etc.)		
Defined mechanisms (e.g., templates, modality, etc.) for RRT reporting to the RRT manager and EOC or other coordination unit		
Developed standard terms of reference for commonly deployed positions		
Developed field information sharing protocols and procedures		
Defined criteria for demobilization of RRT member(s) to return home from the field		
Developed demobilization procedures (e.g., notification, handover, and close-out procedures)		

Post-Deployment

Element	Capacity	Operational Status
Developed post-deployment SOPs (e.g., demobilization criteria, debriefs, etc.)		
Developed process for providing medical and/or mental health resources after deployment		
Established debrief and/or after-action review process		

Monitoring and Evaluation

Element	Capacity	Operational Status
Developed monitoring, evaluation, and improvement planning of the RRT program (e.g., Surveys, focus groups, interviews, observation, after-action review, post-deployment debrief, etc.)		
Established system for data collection and data management of RRT activities conducted		
Developed process for updating SOPs with lessons learned from evaluation of RRT pre-deployment, deployment, and post-deployment activities		
Developed corrective action planning leading to administrative/training changes in the RRT program		

Cross-Border (if applicable)

Element	Capacity	Operational Status
Established a cross-border collaborative agreement, legal frameworks, memoranda of understanding, or other to facilitate bilateral, multilateral, or other regional RRT deployments		
Participation of national RRT members in joint cross-border training, table-top and/or simulation exercise [2]		
Training of national RRT personnel on the implementation of response plans and corresponding SOPs.		

Appendix B. RRT Program Alignment Across IHR Assessments

Rapid Response Team (RRT) programs intersect with multiple preparedness and response functions, and their performance is reflected across several indicators in the Joint External Evaluation (JEE) and State Party Self-Assessment Annual Reporting (SPAR) tools.^{4 5} These assessments provide a high-level view of system capacity and can highlight gaps and opportunities for strengthening RRT programs. This mapping can also serve as a planning and reporting tool: when enhancing an RRT program, identify which JEE/SPAR indicators are being advanced. For more detailed analysis of root causes and granular improvements, complementary tools and approaches are recommended.²⁶

Below are examples of relevant indicators that may apply depending on the scope and design of an RRT program:

RRT Element	JEE Indicator (v3.0) ⁴	SPAR Indicator (v2.0) ⁵
Activation and coordination of RRTs	R.1.4 — Activation and coordination of health personnel and teams in public health emergency	C2.2 — Multisectoral coordination mechanisms C7.2 — Management of health emergency response
Governance and multisector coordination	P.3.2 — Multisectoral coordination mechanisms P.3.3 — Strategic planning for IHR, preparedness or health security	C2.2 — Multisectoral coordination mechanisms C2.3 — Advocacy for IHR implementation
Financing for rapid deployment	P.2.2 — Financial resources for public health emergency response	C3.2 — Financing for public health emergency response
Workforce surge and staffing model	D.3.4 — Workforce surge during a public health event	C6.2 — Workforce surge during a public health event
Operational research and innovation	R.1.6 — Research, development & innovation	Not applicable
Workforce strategy & training	D.3.1 — Multisectoral workforce strategy D.3.2 — Human resources for IHR implementation D.3.3 — Workforce training	C6.1 — Human resources for IHR implementation C6.2 — Workforce surge during a public health event
Risk assessment and deployment readiness	R.1.1 — Emergency risk assessment and readiness	C7.1 — Planning for health emergencies C7.2 — Management of health emergency response
Points-of-Entry (PoE) Deployment	PoE.2 — Public health response at PoEs	C11.2 — Public health response at PoEs C11.3 — Risk-based travel-related measures
One Health and zoonotic response	P.5.2 — Response to zoonotic diseases	C12.1 — One Health collaborative efforts

Appendix C. Example RRT Program Maturity Model

The appendix provides an example of an RRT program maturity model. Organizations can adapt these benchmarks based on their organizational context, the administrative level at which the RRT operates (national, subnational, or local), available resources and existing emergency infrastructure. Terminology is clarified in the guidance.

Level	Domain 1: Integration	Domain 2: SOPs	Domain 3: Budget	Domain 4: Management	Domain 5: Staffing	Domain 6: Roster	Domain 7: Training	Domain 8: M&E
1 - Initial	RRT program is not included in the country's emergency response plan and is not formally integrated into the emergency response system.	No standard operating procedures (SOPs) exist for pre-deployment, deployment, or post-deployment phases.	No dedicated budget for RRT an RRT program has been considered or established.	No designated RRT coordinator, manager, or management team identified.	No formal process exists for selecting RRT candidates.	No roster of multidisciplinary RRT responders exists.	No standardized training is provided for RRT members.	No monitoring and evaluation (M&E) plan for the RRT program exists.
2 - Developing	RRT program is mentioned in the emergency response plan, and a framework for formal integration is under development.	Draft SOPs for pre-deployment, deployment, and post-deployment phases have been created.	A draft RRT program budget is being developed.	An RRT coordinator or management team has been identified.	A formal recruitment process is established, prioritizing skills aligned to threat assessment.	An initial roster of multidisciplinary RRT candidates is developed.	Orientation/onboarding training is developed and aligned with emergency response competencies.	A draft M&E plan for the RRT program is developed.
3 - Defined	RRT program is formally included and integrated into the emergency response system.	SOPs are finalized, approved, and have been tested through simulation exercises.	A dedicated RRT budget is approved, covering both preparedness and response operations.	RRT management team is incorporated into the emergency coordination unit.	RRT members are actively recruited to represent the key disciplines needed for response.	A functional roster is established to track RRT members and key information for rapid deployment.	A standardized, competency-based training program is implemented for all RRT members.	An M&E plan is implemented with defined indicators and data collection processes.
4 - Managed	The RRT is routinely activated as a standard component of emergency responses; its role is well-understood by all partners.	SOPs are consistently applied in all deployments and exercises, with adherence being actively monitored.	Budget execution is actively tracked, and multi-year funding is secured to ensure program sustainability.	Management team is active and fully embedded in emergency coordination structures.	RRT members are administratively and operationally ready.	The functional roster is used regularly during a response.	Regular training and exercise cycles are conducted and tracked for all members to ensure skills are maintained and validated.	M&E data is systematically collected, analyzed, and regularly used to inform programmatic decisions and improvements.
5 - Optimizing	RRT program's role and integration are reviewed annually and updated in relevant plans based on lessons learned.	SOPs are reviewed and updated annually, incorporating feedback from deployments and exercises.	Budget is reviewed annually, with an immediate release mechanism, and adjusted based on operational experience.	Management roles and responsibilities are reviewed and updated regularly.	Recruitment processes and criteria are updated regularly; country participates in regional/international surge agreements.	Roster is actively maintained with regular updates and enhanced to improve deployment information needs.	Training programs are reviewed annually and updated to reflect evolving emergency competencies and findings after emergency responses.	M&E plan is updated annually; continuous improvement processes are actively applied.

»» Appendix D. RRT Program Standard Operating Procedure Checklist

This appendix provides an example checklist of key content areas for Rapid Response Team (RRT) Standard Operating Procedures (SOPs). The checklist is not exhaustive and should be adapted to the organizational context. Clearly defined, context-driven SOPs are essential for maintaining reliable RRT operations across all phases of emergency response. In addition to the checklist, an example rubric is provided to assess the functionality and completeness of SOPs, supporting quality assurance and continuous improvement.

Example SOP Checklist

SOP Title	Key Content Areas
Administrative Considerations	☐ Management Personnel Roles and Responsibilities ☐ Employment Policies and Agreements ☐ Compensation and Incentives ☐ Responder Health, Safety, and Well-being ☐ Insurance and Legal Protection ☐ Code of Conduct
Staffing and Rostering	☐ Determine RRT Program Design and Size ☐ Identify Roles and Skills ☐ Recruitment and Selection Criteria ☐ Develop and Maintain Roster (readiness indicators) ☐ Attrition Management (mentorship, recognition)
Training and Readiness	☐ Readiness Requirements (medical clearance, security training) ☐ Training Cycle (orientation, refresher, exercises, JiT) ☐ Competency Frameworks ☐ Training Repository and Facilitator List ☐ Training Tracker
Activation and Pre-Deployment	☐ Activation Criteria and Authority ☐ Activation Process and Workflow ☐ Pre-Deployment Briefing (content and delivery) ☐ Just-in-Time Training ☐ Equipment Checklist and Logistics
Deployment	☐ Operational Support (logistics, stakeholder engagement) ☐ Communication and Reporting (SitReps, handoff reports) ☐ Deployment Tracker ☐ Deployment Monitoring (objectives, indicators) ☐ Safety and Security Protocols ☐ Responder Well-being Support
Post-Deployment	☐ Mission Report (timeline and content) ☐ Responder Support (medical, psychosocial, reintegration) ☐ Feedback and Debrief Process ☐ Improvement Planning and SOP Updates
Monitoring and Evaluation	☐ M&E Framework (logic model, results framework) ☐ Indicators (process, outcome, impact) ☐ Data Sources and Integration ☐ Continuous Improvement Processes ☐ Operational Research

Example SOP Assessment Rubric

Indicator	No Evidence (0 point)	Beginning (1 point)	Developing (2 points)	Proficient (3 points)
Purpose	The purpose and reason are not defined in the SOP	The purpose and the reason are stated but not what and why	The purpose and reasons are stated in the SOP but does not include either the what or why	The purpose is clearly defined, clearly states the reason for doing the activity. Includes both the what and why.
Scope	The scope is not defined in the SOP	The scope is included but not who and when	The scope is stated in the SOP and outlines but does not include either the who or when	The scope is clearly defined, including both the who and when.
Inclusivity	Key stakeholders are not defined in the SOP	Some key stakeholders are defined but not all	All key stakeholders are included but does not include what they are doing	Key stakeholders are clearly identified and what they are doing is defined
Content	The SOP does not answer any Who, What, Where, When, How questions	The SOP contains less than three of the Who, What, Where, When, How questions	The SOP contains more than three of the Who, What, Where, When, How questions	The SOP includes all the main elements: Who, What, Where, When, How
Conciseness	The SOP is not concise	The SOP is concise some of the time (<50% of the time)	The SOP is concise most of the time (>50% of the time)	The SOP is concise throughout (i.e. at all times)
Formatting	The SOP does not use consistent formatting	The SOP uses similar formatting some of the time	The SOP uses similar formatting most of the time	The SOP uses consistent formatting throughout
Clarity	The procedure is not outlined in a sequential step-by-step format	The SOP is sometimes outlined in a step-by-step format	The SOP is most of the time outlined in a step-by-step format that is easy to follow	The SOP consistently utilizes a step-by-step format that is easy to follow

Appendix E. RRT Example Budget Costing Tool

This appendix provides an example budget-costing tool designed to support the planning and implementation of Rapid Response Team (RRT) activities during both preparedness and emergency phases. The tool serves as a practical framework for estimating and organizing costs associated with personnel, training, equipment, deployment, and cross-cutting needs such as insurance and health coverage. By using this template, organizations can ensure comprehensive financial planning, improve resource allocation, and maintain readiness for rapid mobilization during public health emergencies. The structure allows for flexibility to adapt to specific country contexts, operational requirements, and available resources.

Budget Summary

Category	Amount
Preparedness Phase Total	0.00
Emergency Phase Total	0.00
Grand Total	0.00

Preparedness Phase

Personnel Costs

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
RRT Management Staff (monthly salary)	person-months			
Part-time RRT Coordination Roles	person-months			
Administrative Support Staff	person-months			
Category Subtotal:				

Training and Capacity Development

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
Orientation/Onboarding Programs	sessions			
Continuing Education Sessions	sessions			
Simulation Exercises	exercises			
Training Travel and Accommodation	person-trips			
Category Subtotal:				

Roster Management

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
Database/Software Platform (annual license)	licenses			
Staff Time for Roster Maintenance	hours			
Recruitment and Vetting Processes	candidates			
Category Subtotal:				

Readiness Maintenance

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
Medical Clearances and Vaccinations	persons			
Passport and Visa Fees	persons			
Background Checks and Security Clearances	persons			
Category Subtotal:				

Equipment and Supplies

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
General Field Equipment Stockpiles	kits			
Communication Devices	units			
Personal Protective Equipment (PPE)	sets			
Office Space (monthly)	months			
Office Supplies	sets			
Category Subtotal:				

Insurance and Health Coverage

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
Healthcare Insurance (annual)	persons			
Disability Insurance (annual)	persons			
Injury Insurance (annual)	persons			
Medical Care and Treatment	budget			
Mental Healthcare Services	sessions			
Medical/Security Evacuation Coverage	persons			
Category Subtotal:				

Response Phase

Deployment Costs

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
Per Diems for Deployed Responders	person-days			
International Flights	tickets			
Domestic Flights	tickets			
Ground Transportation	days			
Fuel	liters			
Accommodation	room-nights			
Meals and Incidentals	person-days			

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
Hazard Pay	person-days			
Overtime Compensation	hours			
Category Subtotal:				

Emergency Procurement

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
Disease-Specific Supplies and Equipment	kits			
Additional PPE (emergency stock)	sets			
Laboratory Materials	kits			
Emergency Communication Equipment	units			
Category Subtotal:				

Salary Payments During Deployment

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
Home Organization Salary Continuation	person-months			
Deploying Entity Salary Support	person-months			
Reimbursement Processing Costs	transactions			
Category Subtotal:				

Travel Allowances

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
Travel to/from Deployment Sites	person-trips			
Baggage Fees	trips			
Emergency Visa Costs	visas			
Category Subtotal:				

Field Operations

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
Local Transportation and Drivers	days			
Translators	days			
Security Personnel	days			
Emergency Supplies and Consumables	sets			
Category Subtotal:				

Logistics Support

Line Item	Unit of Measure	Quantity	Unit Cost	Total Cost
Storage and Distribution of Supplies	days			
Customs and Importation Fees	shipments			
Waste Management and Disposal	days			
Category Subtotal:				

Appendix F. Rapid Response Team Common Roles and Skills

This appendix provides an overview of common Rapid Response Team (RRT) roles, their essential skills, typical activities, and examples of monitoring and evaluation (M&E) indicators linked to those actions. Skills can vary widely within the same role; identifying and addressing core response activities is critical for operational readiness. Linking to M&E examples helps programs track performance, improve accountability.

Roles	Skills	Common Activities	Monitoring and Evaluation
Epidemiologists	Epidemiology, Data management, Statistical analysis, GIS mapping, Interview techniques, Database management, Report writing, Line listing, Contact tracing	Case investigation, Line list review, Data cleaning and analysis, Report writing, Data visualization, Emergency surveillance, Risk assessments, Rapid needs assessments, Emergency survey methodologies	• % of line lists updated per day • # of rapid risk assessments conducted • % of cases with complete epidemiological data • % of contacts traced within 48 hours
Laboratory Specialists, Technicians	Molecular diagnostics, Serology, PCR techniques, Biosafety, Sample packaging and shipping, Quality assurance, Rapid diagnostic testing, Culture techniques, Antimicrobial resistance testing, Laboratory information systems	Sample collection and transport, Rapid diagnostic testing, Biosafety procedures, Quality assurance, Laboratory setup in field settings, Training on specimen collection, Result interpretation and reporting	• # of specimens collected • % of specimens processed within target turnaround time • % of invalid or rejected samples (indicator of quality)
Case Management Specialists, Infection Prevention and Control (IPC) Specialists	Clinical medicine, IPC protocols, Safe specimen handling, Triage, Patient care, Safety training, PPE donning/doffing, Healthcare facility assessment, Outbreak management in healthcare settings, Disinfection and sterilization	Patient care, Specimen collection, Triage, Implementation of IPC measures, Healthcare worker training, Monitoring compliance with IPC protocols, Isolation ward setup, Clinical case management	• # of healthcare facilities supported • % of healthcare workers trained • # of PPE kits distributed

Roles	Skills	Common Activities	Monitoring and Evaluation
Risk Communication Specialists, Social Mobilizers, Behavioral Scientists	Health communication, Social mobilization, Cultural competency, Media engagement, Message design, Rumor management, Behavioral change theory, Crisis communication, Social media management	Developing health messages, Managing rumors and misinformation, Conducting focus groups, Media briefings, Creating communication materials, Social media monitoring, Community dialogue facilitation	• # of communication messages disseminated • % of rumor reports logged • % of misinformation investigated within 48 hours
RRT Team Leaders	Leadership, Emergency management, Negotiation, Logistics coordination, Budget management, Resource allocation, Multi-sectoral coordination	Delegating tasks, Decision-making, Managing team dynamics, Liaising with partners, Coordinating with government authorities, Strategic planning, Resource prioritization, Conducting team meetings	• # of field coordination meetings held • % of situation reports submitted on time

» Appendix G. RRT Deployment Checklists

This appendix includes checklists for pre-deployment, deployment and post-deployment that are intended as a general reference. Specific requirements will vary depending on the organization, response context, RRT scope (e.g., global vs. national), and other operational factors.

Pre-Deployment

- ☐ Complete health screening/medical clearance
- ☐ Ensure vaccinations are up to date
- ☐ Pack personal medications (30-day supply + copy of prescriptions)
- ☐ Identify mental health support resources
- ☐ Attend pre-deployment briefing and just-in-time training
- ☐ Review national response guidelines and deployment SOPs
- ☐ Confirm role-specific responsibilities
- ☐ Verify passport validity (6+ months) and obtain necessary visas
- ☐ Make copies of critical documents (passport, vaccination card, insurance card)
- ☐ Arrange work handover and supervisor approval
- ☐ Confirm flight and accommodation details; review ground transportation plan
- ☐ Obtain emergency contact list, including medical evacuation information
- ☐ Research cultural sensitivities for deployment country
- ☐ Set travel alerts on credit cards and notify bank
- ☐ Update personal legal documents (will, power of attorney)
- ☐ Complete security briefing
- ☐ Request equipment
- ☐ Packing (see below)

Deployment

- ☐ Ensure PPE is appropriate for outbreak
- ☐ Keep copy of security protocols and emergency contact card
- ☐ Have case investigation forms and specimen collection supplies
- ☐ Bring diagnostic test kits and disinfectant supplies
- ☐ Carry sampling/testing equipment, labels, markers, and specimen transport containers
- ☐ Prepare risk communication materials (posters, pamphlets)
- ☐ Attend daily team briefings and submit daily situation reports
- ☐ Conduct security check-ins and coordinate with local authorities
- ☐ Document field activities (notes, photos if authorized)

- ☐ Monitor own health daily, stay hydrated, and get adequate rest
- ☐ Manage receipts as needed for reimbursement
- ☐ Obtain signed photo waiver before using pictures
- ☐ Prepare in-country debrief presentation for local partners
- ☐ Access resilience resources (APA Road to Resilience, Psychological First Aid guide)

Post-Deployment

- ☐ Complete handoff report and submit mission report
- ☐ Return all issued equipment
- ☐ Submit travel voucher for reimbursement
- ☐ Complete post-deployment survey
- ☐ Upload field documentation to secure server
- ☐ Complete post-deployment health screening and follow self-monitoring protocols
- ☐ Attend psychological debriefing and access mental health resources if needed
- ☐ Take mandated rest days and report any delayed symptoms
- ☐ Participate in operational debrief and contribute to After Action Review
- ☐ Brief supervisor on deployment and resume regular work responsibilities
- ☐ Reconnect with family/friends and request peer support if helpful

RRT Packing List Example

Personal Documents

- Passport (6+ months validity)
- Visa documents
- Proof of Vaccination (yellow shot card)
- Government/organizational ID (CDC ID Badge)
- Medical/health insurance card (international coverage)
- Emergency contact information
- Deployment orders/authorization
- Photocopies of all documents (kept separately)

Clothing & Personal Items

- Quick-dry clothing (pants, shirts, raincoat, jacket, socks, underwear)
- Long pants and long-sleeve shirts (sun/insect protection)
- Hiking boots and/or rain boots
- Sturdy closed-toe footwear
- Flip flops for showering
- Office shoes
- Hat/visor
- Watch
- Sleepwear
- Modest clothing (culturally appropriate)
- Light sweater or fleece
- Sleeping bag insert or sheet
- Pillowcase
- Quick-dry travel towel

Health & Hygiene

- Prescription medications (carry-on luggage)
- Medical clinic issued meds (e.g., malaria prophylaxis)
- GI medicines (antacids, anti-diarrheal, upset stomach)
- Cold/allergy medicine
- Oral rehydration salts
- First aid kit
- Sunscreen (SPF 50+)
- DEET-based insect repellent
- Hand sanitizer
- Clorox wipes & wet wipes
- Toothbrush/toothpaste
- Bar soap/shampoo
- Deodorant
- Razor
- Toilet paper

- Contact lenses/cleaner
- Eyeglasses + backup pair
- Lip balm with SPF

Communication & Technology

- Unlocked smartphone
- Phone charger (wall and car)
- Portable power bank
- Plug adaptors (2–3 total)
- Laptop computer (encrypted)
- Laptop charger and mouse
- USB flash drives (encrypted and non-encrypted)
- Headphones/earbuds
- Satellite phone (if issued)
- Two-way radio (if issued)
- Flashlight and LED keychain light

Safety & Protection

- Personal protective equipment (PPE)
- Safety glasses
- Personal alarm/whistle
- Water purification tablets

Field Work Supplies

- Office supplies (pens, notebooks, highlighters, sticky notes)
- Clipboard
- Case investigation forms
- Ziploc bags
- Tape
- Pocket knife

Food & Comfort

- Fiber bars/power bars/dried fruit/snacks (rodent-proof containers)
- Thermos and/or water bottle
- Book/magazine
- Personal comfort items (photos, journal, stress ball)

Financial & Practical

- Combination of bills (\$1, \$5, \$10, \$20, \$50, \$100 – year 2009+, no tears)
- Credit card (may not work in rural areas)
- Money belt or hidden pouch
- Laundry detergent (powdered or travel packets)
- Sewing kit
- Padlock for luggage

Appendix H. RRT M&E Indicator Reference Table

This appendix provides a reference table of example indicators for an RRT M&E program, organized by operational phase. These indicators are intended to be illustrative and can be prioritized or adapted based on a specific program’s context and objectives. More detailed information is in the guidance.

Example Preparedness Indicators

Indicator	Definition	Data Source	Frequency	Indicator Type
% of RRT members who are “deployment ready”	The percentage of rostered members who have completed all administrative and medical readiness requirements (e.g., valid passport, medical clearance, core training).	Roster Database, HR Records	Monthly	Process
% of core disciplines represented on the roster	The percentage of essential skillsets (e.g., epidemiology, lab, IPC, clinical) that have at least one qualified member assigned to the roster.	Roster Database	Quarterly	Process
Attrition rate of RRT members	The percentage of members who leave the RRT program over a one-year period.	HR Records, Roster Database	Annually	Process
% of RRT go-kits that are fully stocked and certified ready	The percentage of mission-ready kits that have passed a formal inventory check and are confirmed to be complete and not expired.	Logistics/Supply Database, Inventory Checklists	Quarterly	Process
% of RRT members with demonstrated competencies	The percentage of members who have successfully passed a practical, role-specific skills assessment (e.g., in a simulation).	Training Records, Simulation Reports	Annually	Outcome
% improvement in RRT knowledge scores (pre/post-test)	The average percentage increase in scores on standardized knowledge tests administered to RRT members before and after a training course.	Training Records, Test Results	Per Training Course	Outcome
Average time from RRT activation alert to deployment (during a simulation)	The average time taken during a drill, from the official notification to activate the RRT, until the team is dispatched with all personnel and equipment.	Simulation Exercise Reports	Per Exercise	Outcome
RRT member satisfaction rate	The percentage of RRT members reporting satisfaction with program management, training, and support through an anonymous survey.	Annual Member Survey	Annually	Impact
Overall RRT Program Readiness Score	A composite score derived from a standardized assessment (e.g., WHO checklist) that evaluates all aspects of the RRT program.	Readiness Assessments, External Evaluations	Annually	Impact

Example Response Indicators

Indicator	Definition	Data Source	Frequency	Indicator Type
Average time from official request to RRT arrival in-field	The number of hours or days from the receipt of an official request for assistance to the arrival of the RRT at the designated deployment location.	Deployment Logs, SitReps	Per Deployment	Process
% of deployed RRT members pulled from the official roster	The percentage of individuals in a specific deployment who were active and pre-vetted members of the formal RRT roster.	Roster Database, Deployment Orders	Per Deployment	Process
Stockout rate of critical RRT equipment/supplies	The percentage of days during a deployment where a critical item for RRT safety or operations (e.g., PPE, testing reagents) was unavailable.	Field Logistics Logs, SitReps	Weekly (during response)	Process
% of outbreak alerts investigated by the RRT within 24 hours	The percentage of new suspected case alerts in the RRT's area of operation that were investigated (in-person or remotely) by the team within a 24-hour period.	Case Investigation Forms, Field Logs	Daily (during response)	Outcome
% of laboratory samples collected by the RRT that are viable upon arrival	The percentage of all samples collected by the RRT that arrive at the designated laboratory without compromising specimen integrity (e.g., proper temperature, no leakage).	Lab Records, Field Logs	Weekly (during response)	Outcome
% of target population reached with RRT-supported RCCE messages	The estimated percentage of the population in the RRT's operational area that was exposed to risk communication and community engagement messages.	RCCE Partner Reports, Community Surveys	Per Deployment	Outcome
Case Fatality Ratio (CFR) among cases in RRT-supported areas	The proportion of deaths among confirmed cases in the specific geographic areas where the RRT provided direct clinical or public health support.	Surveillance Data, Clinical Records	Per Deployment	Impact
Time to outbreak control in RRT-supported areas	The duration from the RRT's arrival until the outbreak's effective reproductive number (R) is sustained below 1 in the areas where the team was active.	Epidemiological Data, Modeling Reports	Post-Deployment	Impact
% of outbreaks with active community involvement in RRT activities	The percentage of RRT deployments where community leaders or members were actively involved in planning or implementing response activities.	AARs, Community Feedback Reports	Per Deployment	Impact

Example Recovery/Mitigation Indicators

Indicator	Definition	Data Source	Frequency	Indicator Type
% of deployments with a completed debrief	The percentage of all official RRT deployments that are followed by a formal debrief process within a defined timeframe (e.g., 30 days).	AAR Reports, M&E Records	Post-Deployment	Process
% of returning RRT members completing post-deployment health screening	The percentage of deployed members who undergo a mandatory physical and mental health check-up upon their return.	HR Records, Medical Unit Reports	Post-Deployment	Process
Timeliness of final deployment report submission	The average number of days between the end of a deployment and the submission of the final, comprehensive RRT deployment report.	M&E Records, Report Archive	Post-Deployment	Outcome
% of AAR recommendations fully implemented	The percentage of all actionable RRT program recommendations from past AARs that have been successfully implemented and closed out.	Recommendation Tracker, Program Documents	Quarterly / Annually	Outcome
% of SOPs or training curricula updated based on lessons learned	The percentage of key program documents (e.g., IPC SOP, Triage Protocol) that have been revised to incorporate specific findings from AARs.	Document Version Control, M&E Records	Annually	Outcome
Reduction in reported administrative or logistical challenges over time	A year-over-year reduction in the number or severity of logistical and administrative issues reported during deployments.	AARs, SitReps, Deployment Logs	Annually	Impact
Demonstrable contribution to national health security capacity scores	Citing specific RRT-led improvements (e.g., establishing a local EOC, training local staff) that contributed to an increased score on a relevant JEE or SPAR indicator.	JEE/SPAR Reports, External Evaluations	Annually / Bi-Annually	Impact