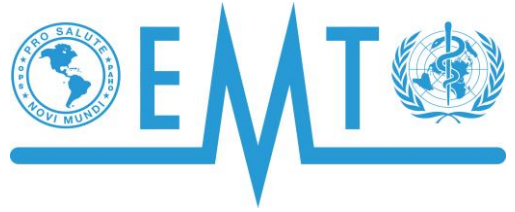*Emergency Medical Team Coordination Cell (EMTCC)*

COORDINATION HANDBOOK

2016

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*For use in the WHO EMT CC
Training Course in Italy*

Emergency Medical Team Coordination Cell (EMTCC)

COORDINATION HANDBOOK

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ACKNOWLEDGEMENTS

CONTRIBUTORS

LIST OF ABBREVIATIONS

DMO	District Medical Officer
EMT	Emergency Medical Team *(encompasses N-EMT and I-EMT)*
EMTCC	Emergency Medical Team Coordination Cell
ERC	Emergency Relief Coordinator
ERF	Emergency Response Framework
FMT	Foreign Medical Team
HC	Health Cluster
HEOC	Health Emergency Operational Centre
HR	Human Resources
IASC	Inter-Agency Standing Committee
I-EMT	International Emergency Medical Team *(subgroup of EMT)*
INSARAG	International Search and Rescue Advisory Group
MNMCC	Multi-National Military Coordination Cell
MOH	Ministry of Health
NEMA	National Emergency Management Agency *(also known as Local Emergency Management Agency, LEMA)*
N-EMT	National Emergency Medical Team *(subgroup of EMT)*
OSOCC	On-Site Operations Coordination Center
POA	Plan of Action
RDC	Reception and Departure Center
SOD	Sudden Onset Disaster
SOP	Standard Operating Procedure
UCC	USAR Coordination Cell
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNDAC	United Nations Disaster Assessment and Coordination

USAR	Urban Search and Rescue
WCO	WHO Country Office
WFP	World Food Program
WHO	World Health Organization

This first edition of the Coordination Handbook uses the term "**Emergency Medical Team (EMT)**" Coordination Cell, which is replacing the previously common use term "Foreign Medical Team" Coordination Cell (FMTCC). The EMT concept attempts to capture the National and International dimension of the response of Medical Teams as well as the variety of specialized and support teams that the definition can encompass.

"Emergency Medical Teams refer to groups of health professionals and supporting staff aiming to provide direct clinical care to populations affected by disaster or outbreaks and emergencies as surge capacity to support the local health system. They include governmental (both civilian and military) and non-governmental teams and can be sub-classified as either National or International dependent on area of response".

Note:

- The definition seeks to apply to everyone from the very small groups of medical personnel arriving with a back pack after watching the news on TV to the large professional teams from IOs, NGOs and Governments.

- It can apply to teams with or without Field Hospitals, an important change from previous PAHO guidelines. It describes the services and people more than the facilities that they may or may not bring.

1. INTRODUCTION

1.1 Evolution of Emergency Medical Team (EMT) Coordination

Coordination is fundamental to the effective delivery of emergency humanitarian assistance. In recognizing this, progressive steps have been made to strengthen humanitarian coordination over the last few decades: In 1991, the United Nations established the Emergency Relief Coordinator (ERC) position, which was conferred a stronger mandate and broader purview than the former Disaster Relief Coordinator position, and created the Inter-Agency Standing Committee (IASC) as a platform for coordination between agencies at the global level (General Assembly resolution 46/182, 1991). The 2005 Humanitarian Reform led to the adoption of the Cluster Approach which aimed to enhance coordination by clarifying the division of roles and responsibilities among organizations. The 2011 Transformative Agenda sought to further strengthen leadership and coordination as one of its five areas for additional reform. Specific to the health cluster, the 2013 WHO Emergency Response Framework (ERF) (WHO, 2013) set out the WHO's core commitments and performance standards for leading a coordinated and effective health sector response. However, despite these efforts, opportunities and need for further improvement remain.

Efforts to strengthen the specific coordination of Emergency Medical Teams (EMTs) have been a relatively recent initiative, catalyzed by shortcomings in existing international and national mechanisms to adequately filter and coordinate responding EMTs – an issue that was most starkly highlighted in the 2010 Haiti earthquake response (Gerdin et al., 2012). In addition, a lot has been learned and adapted from the experience of international search and rescue response operations and coordination as developed and agreed by the International Search and Rescue Advisory Group (INSARAG) together with the UN Office for the Coordination of Humanitarian Affairs (OCHA) in the past 25 years. INSARAG successfully established a peer review classification system of Urban Search and Rescue (USAR) teams and agreed to a commonly developed quality standards and coordination mechanisms.

Within this context, the "Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters" (WHO, 2013) was developed. This provided a common nomenclature for EMTs to communicate their capabilities and intended services, and established quality and service benchmarks. More recently, the EMT Global Classification was launched as a platform to pre-register and pre-verify EMTs with the aim of enhancing response speed and coordination efficiency following the onset of an emergency. Furthermore, given that National Emergency Medical Teams (N-EMTs) are usually better placed to provide immediate assistance, strengthening N-EMTs' capacity in responding to emergencies has become an additional objective of the EMT Initiative.

Progress has also occurred at the field level. During the 2013 Philippines Typhoon Haiyan (Yolanda) response, the EMT Classification and Minimum Standards were applied, for the first time, with demonstrable benefit to coordination (Brolin et al., 2015). More explicit EMT coordination, with defined registration and tasking processes, was employed during the 2014-15 West Africa Ebola Outbreak and the 2015 Vanuatu Cyclone Pam responses. During the 2015 Nepal earthquake response a formal EMT Coordination Cell (EMTCC), led by the Ministry of Health and Population supported by WHO, was established and utilized with very positive feedback from the National Authorities and the EMT responders. Finally, the 2016

Ecuador earthquake response was a great example of the importance of the preparation, as the Ministry of Public Health received training on the EMTCC methodology (called Célula de Información y Coordinación Medica, CICOM in Spanish) from WHO/PAHO few days before the disaster happened, and optimal application of the methodology and set up of the EMTCC (led by the same Ministry) for the coordination of both N-EMT and I-EMT.

This Handbook represents the next phase in the strengthening of EMT coordination at the field level. It aims to consolidate prior experience and current thinking into a practical guide with recommended procedures and standardized resources for the ready establishment and effective implementation of EMT coordination in the field.

1.2 Global EMT Quality Assurance and Classification

Since July 2015, WHO has launched the **EMT Global Classification,** a mechanism for verifying the stated EMT capabilities (and compliance with the agreed set of principles and technical standards for EMTs) of EMT-capable organizations including their status of readiness for deployment. Findings from reviews of latest EMT responses have suggested changes in the EMT Classification and proposed changes (e.g. Type 1 sub-grouped into Mobile and Fixed) have been endorsed during the EMT Global Meeting in Panama, in December 2015 representing the agreed nomenclature for the EMT Global Classification list.

Table 1. EMT Classification

Type	Description	Capacity
1 Mobile	Mobile outpatient teams Remote area access teams for the smallest communities	>50 outpatients a day
1 Fixed	Outpatient facilities +/- tented structure	>100 outpatients a day
2	Inpatient facilities with surgery	>100 outpatients and 20 inpatients 7 major or 15 minor surgeries daily
3	Referral level care, inpatient facilities, surgery and high dependency	>100 outpatients and 40 inpatients Including 4-6 intensive care beds 15 major of 30 minor surgeries daily

Specialist Cell	Teams that can join national facilities or EMTs to provide supplementary specialist care services	Any direct patient care related service can be termed as specialist cell when given in emergency response by EMT providers (e.g. rehabilitation, paediatric, surgery etc.)

The EMT Global Classification list will contain all those EMT organizations that have had their self-declared information cross-checked by a global peer review and completed a verification visit to validate their pre deployment capabilities. The EMT quality assurance occurs as well during deployment with joint WHO and Ministry of Health visits to ensure compliance with declared capabilities pre-arrival.

Figure 1. EMT Global Classification process
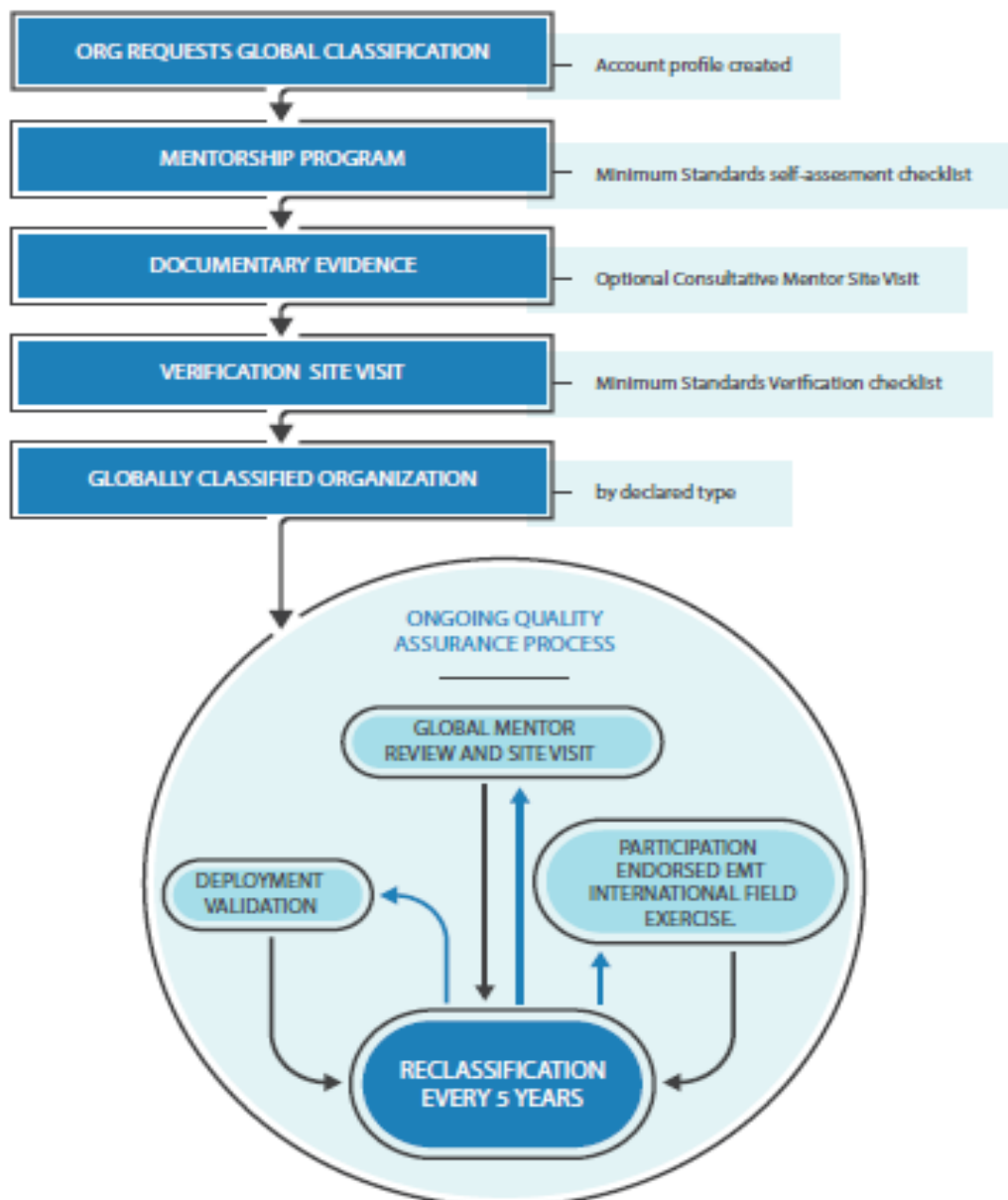
The Global Classification does not replace a country's own process of authorizing EMTs to enter and operate in their territory, but support this process with better information on the available EMTs and details of their adherence to standards, experience, capability and key contacts. Affected countries will be able to rapidly identify and accept pre-verified EMTs being their type and capabilities well known in advance. In general, Countries prone to natural disasters and outbreaks may use as well the EMTs minimum standards to improve the effectiveness of the immediate response of National Emergency Medical Teams.

For EMTs providers, benefits of global classification include easier invitation to be deployed, speed up the registration process, access to logistic support and guidance on-site as well as giving confidence to donors to fund classified EMTs.

1.3 The Need for an EMT Coordination Cell (EMTCC)

The coordination of EMTs presents unique complexities. In part, this stems from the increasing numbers of EMTs responding to large-scale emergencies, particularly sudden onset disasters (SOD), compounded by the wide variations in the size, experience, standard of service, medical and logistical capabilities, specializations, and mandate of each EMT (WHO, 2013). The EMT Classification and Minimum Standards and the Global Classification will help to address this.

However, complexity also arises from the varied population needs to which EMTs need to be adequately matched as part of coordination efforts. This means that effective coordination requires more than a simple, uni-dimensional matching of supply to demand, as encapsulated by common indicators such as number of hospital beds or healthcare workers per unit of population. The specific needs of the affected population can vary widely, influenced by a multitude of factors such as population composition, nature and phase of emergency, locality, geographical terrain, and pre-emergency health status and risks, to name a few.

Moreover, the coordination of incoming International Emergency Medical Teams (I-EMTs) must ensure integration with the existing national health system, which can vary significantly in structure, quality and capacity. It also needs to integrate with the coordination structures and methodologies for the overall coordination of international response, including the On-Site Operations Coordination Center (OSOCC) and health cluster, if existing and activated. From the affected population's perspective, the outcome of successful coordination would be the ability of patients to seamlessly access, across space and time, the different types and levels of care as required by their medical condition. An example would be the smooth and timely transfer of a patient from a Ministry of Health (MOH) clinic to an I-EMT field hospital for emergency surgery with appropriate, ongoing surgical follow-up and rehabilitation care after discharge back to the community, even after the departure of the original I-EMT who had performed the surgery.

Lastly, Emergency Medical Teams have certain unique logistical needs, such as oxygen supply and medical waste management, which may require specialized coordination to allow

for more efficient resource utilization and shared benefit across both National and International Emergency Medical Teams (EMTs).

Managing these specific needs of medical teams and negotiating the multiple layers of complexity involved in their coordination demand a high level of specialized expertise and experience. Therefore, effective EMT coordination would benefit from a specialized coordination cell that can address the specific coordination needs and challenges of EMTs.

1.3 Scope of the EMTCC

The core purpose of the EMTCC is the overall coordination of the surge of responding EMTs (both National and International) to best meet the excess healthcare needs resulting from increased morbidity due to the emergency, or from damage to existing capacity. Ideally, the EMTCC should be an entirely internal MOH (or national authority equivalent) entity that is activated, managed and staffed by trained and experienced personnel from within the MOH. However, in many cases, the MOH requires external support and expertise to operationalize an EMTCC. Where external support is utilized, the primary responsibility for coordination remains with the MOH or national authority. The external support is used to temporarily bridge gaps in the functioning of the EMTCC while working to build and transfer this coordination capacity back to the MOH.

The essence of coordination is the close matching of available resources to identified needs, which allows for optimal resource utilization and maximized collective outcomes. This forms the basis from which the scope of the activities of the EMTCC is derived. This scope can be divided into four broad areas:

1.   Leadership and Coordination

2.   Communication (with EMTs, the MOH, and other coordinating entities)

3.   Quality Assurance (by promoting and applying EMT Minimum Standards)

4.   Supportive Services (operational support for the EMTCC)

These four areas parallel the WHO's four core functions in emergency response (leadership, information, technical expertise and core services, respectively) as outlined in the ERF (WHO, 2013). The technical expertise function spans both the coordination and quality assurance functions of the EMTCC. From this respect, the expertise provided by the EMTCC relates to the technical aspects of coordinating EMTs in large-scale emergencies, and to the promotion and on-site verification of compliance with the EMT Minimum Standards and other national requirements.

1.4 Critical Assumptions for Successful EMT Coordination

Successful EMT coordination requires more than an effective Coordination Cell. There are four other critical requirements:

- **Acceptance and buy-in from the MOH (or national authority equivalent) of the affected country:**

  The responsibility and authority for coordination (including request and acceptance of I-EMTs) remain with the national authority. Therefore, any coordination mechanism must integrate with the national system, and must be agreed upon by the national authority. Routine discussions and establishment of agreements as part of preparedness and national capacity strengthening must also occur.

- **Acceptance and buy-in from the responding EMTs:**

  This requires open dialogue with EMTs (preferably prior to emergency onset) regarding the purpose and processes of EMT coordination. The collective benefits to EMTs and to the affected population should be emphasized, while commitment of the EMTCC to minimize additional administrative burden or compromise EMT 'autonomy of intervention' should be assured. Buy in is also achieved through the pre-registration in the Global EMT Registry.

- **Pre-positioned and/or rapidly deployable human resource, financial and information technology support:**

  This is important to facilitate the timely deployment of trained and experienced EMT Coordinators and other team members, and to support their in-country activities. An example for such pre-positioned support would be a pre-designed and ready-to-activate platform for information management.

- **Clear linkages with the wider coordination structure of the international humanitarian assistance:**

  This includes the required linkages and information exchange with the On-Site Operations Coordination Center (OSOCC) usually established in the disaster-affected area and managed by the UNDAC team and/or other response teams and health cluster if activated.

2. EMTCC WITHIN THE MULTI-AGENCY RESPONSE SYSTEM

2.1 Scenarios of response

Three scenarios can be observed according to the balance between needs for medical care and local availability of services and expertise:

1. The capacity of the health services at national level is clearly sufficient to provide timely care to the affected population;

2. The number of people requiring medical assistance is likely to exceed the treatment and care capacity of the affected country health system;

3. The complexity of the emergency requires an additional level of expertise and support that is absent or limited at the national level.

Scenario 1. This situation will be particularly noted in the larger, developed or emerging countries. Local teams are better placed to provide rapid and context-based assistance, but may lack the required support (for example, supplies, equipment, communication, transport, and personal subsistence) and the related systems to optimize the response. In these cases, the affected country must indicate very early that I-EMTs are not required. However, the limitations of initial information on the impact of the event and imprecise judgments of the national capacity to respond mean that caution should always be exercised by the national authorities before concluding that no external medical assistance may ever be needed. In fact, external specialized medical and public health expertise could facilitate and support the national health system to deliver life-saving and specialized services (for example, rehabilitation, spinal injuries care, burns care, or outbreak response).

Scenario 2. This situation is most likely to occur in countries with limited resources, or with poor health coverage and services in normal times. Countries prone to disasters and/or emergencies require adequate preparation in the reception and coordination of National and International Medical Teams (predictability). In addition, regional mechanisms should be strengthened to facilitate rapid deployment and mutual learning. The Global Classification of EMT providers can contribute to expediting requests for and deployments of EMTs committed to meeting agreed standards, including registration with relevant national authorities of the host country, who are the only body with the legitimate authority to accept or refuse a responding EMT.

Scenario 3. This situation is most likely to occur in both scenarios 1 and 2, in particular (but not limited to) an outbreak. The recent outbreak of Ebola in West Africa has demonstrated the wider role that N-EMTs and I-EMTs can play in health emergencies. Multi-disciplinary public health teams, aeromedical evacuation teams, or logistic support teams to EMTs are only three examples of potential future directions in terms of other specialized or support teams.

2.2 Field Response Mechanisms

Major emergencies and disasters require many aid agencies on the ground. Effective coordination can maximize the ability to avoid gaps or duplications, and to address the needs of the affected population based on urgency. Streamlined coordination mechanisms, adapted to operational needs and context, are essential to facilitate the delivery of life saving services.

Humanitarian coordination seeks to improve the effectiveness of humanitarian response by ensuring greater predictability, accountability and partnership. The schematic representation of the EMTCC within the Humanitarian Response System (shown in *Figure 1*) is an attempt to address all three core objectives. Other key 'operational' partnerships that the EMTCC must or is likely to establish are listed below, although many other actors, systems and networks are also involved in supporting the population affected by a disaster and/or an emergency:

- WHO Country Office

- Health Cluster

- Multi-National Military Coordination Cell (MNMCC)

- District Health Officers/Hospitals Directors

- Field Coordination/Humanitarian Hubs

Figure 2. EMTCC within the Humanitarian Response System
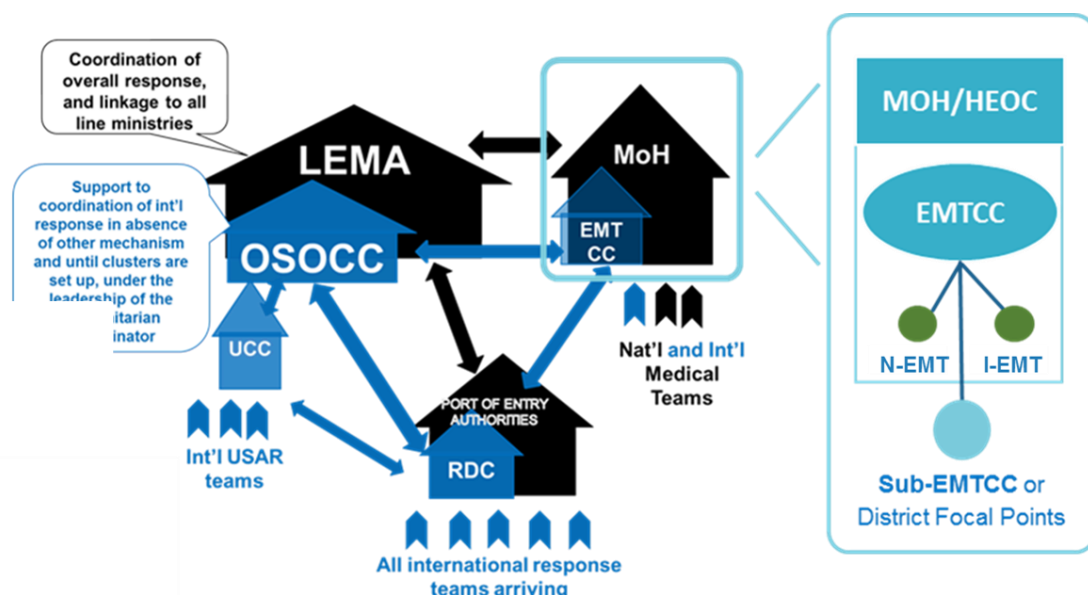
This proposed set up suggests the use of a single approach and a common technical platform for the coordination of both N-EMTs and I-EMTs, at least during the mission phase. During this period, working alongside both national and international teams allows for the sharing of knowledge and best practices. Co-location of the EMTCC within the MOH

structure provides opportunities for face-to-face interaction, which facilitates joint analysis and planning, and fosters relationship development and mutual learning. Both the single EMTCC approach and the co-location contribute to the objective of strengthening national capacity, both in terms of promoting an inclusive coordination mechanism (within an existing HEOC) and increasing capabilities at the N-EMT level as well as facilitating the integration (and connection) of the I-EMTs with the existing national health services.

In case of different layers of complexity of an emergency such as geography of affected country (e.g. multiple points of entrance in-country), areas of operations (e.g. high concentration of EMTs in some districts), specific technical support requirements (e.g. logistic support to EMTs), the model contemplates the presence of a sub-EMTCC or EMTCC Focal Points at district level. The degree of decentralization should take into consideration the National response structure (thus the transfer of authority and responsibility for decision-making and/or implementation of the health response) and the strategic approach adopted (e.g. presence of humanitarian hubs).

Despite the benefits of this model (as described above), and the strong links with key stakeholders that can be generated for the EMTCC, there may be situations in which national authorities will separate the coordination of National and International Medical Teams.

Following a major disaster, an On-site Operations Coordination Center (OSOCC) is established as soon as possible by a United Nations Disaster Assessment and Coordination (UNDAC) team deployed by OCHA. In earthquake responses, this role may be carried out by the first arriving international urban search-and-rescue team until alternatives arrive.

As part of the OSOCC, a Reception and Departure Center (RDC) is also typically established at the point of entry of international teams (ie. usually the international airport or seaport). The RDC is run by the UNDAC team or the first arriving response team, trained in the RDC methodology. INSARAG classified USAR teams have the responsibility to establish the initial RDC if they are the first to arrive and/or support the RDC operations throughout. Similarly, EMTs shall support the set-up and running of the RDC or carry out a similar role and function where none exists already until such roles can be taken over by the MOH with support of the WHO for the coordination of the health response.

The ideal set up explained above assumes that the MOH and/or relevant national authority has the capacity to manage the full cycle of EMT deployment from the initial offer of assistance to their exit. It is well known that the arrival of I-EMTs becomes overwhelming without clear standard operating procedures (SOP) and coordination mechanisms in place.

If the MOH coordination capacity requires temporary assistance, WHO together with OCHA and other partners, will strongly support the establishment and running of the EMTCC at least during the acute phase of a response or until national capacity allows for smooth coordination of activities and delivery of services. In the event of activation of the EMTCC in a context of complex or protracted crisis, it is foreseen its establishment under the Health Cluster in a form of 'sub-cluster'.

Table 2. Coordination Mechanism and establishment of the EMTCC

Coordination Mechanism	EMTCC	Comment
Government coordination capacity is adequate and not constrained	Set up and run by MOH	Liaison function and/or remote support from WHO
Government coordination capacity require temporary support	Set up and run by MOH	A different level of support (minimum to high) from WHO, OCHA and other partners
Government coordination capacity is limited or constrained	Sub-cluster under HC	Conflict or protracted crises

Recent events have shown the importance of MOH ownership of the EMTCC and/or presence of an appointed focal point to facilitate the role of the EMTCC.

2.3 Relational partnerships and roles of the EMTCC

Foundational to the operations of the EMTCC, as a coordinating entity, is the establishment of relational partnerships with all stakeholders relevant to the health sector response. These stakeholders range from other entities within the MOH (for example, Health Emergency Operation Center (HEOC)) to entities of the national authority (for example, Customs and Immigration Department(s), and NEMA) to components of the international multi-agency response system (for example, OCHA, OSOCC, RDC, and Health Cluster) to the N-EMTs and I-EMTs. The diverse relational partnerships of the EMTCC also have the important function of strengthening linkages (connectivity) between stakeholders. This forms the basis of the facilitative leadership role of the EMTCC (*Figure 2*).

Figure 3. Relational partnerships and relational roles of the EMTCC

*KEY: **Nat. Auth.** National Authorities (including Customs, Immigration, Foreign Affairs etc.); **IMT** International Medical Team (FMT); **NMT** National Medical Team*

Facilitative Leadership

Advisory

Informative

Representative

Nat. Auth.

EMTCC

IMT

NMT
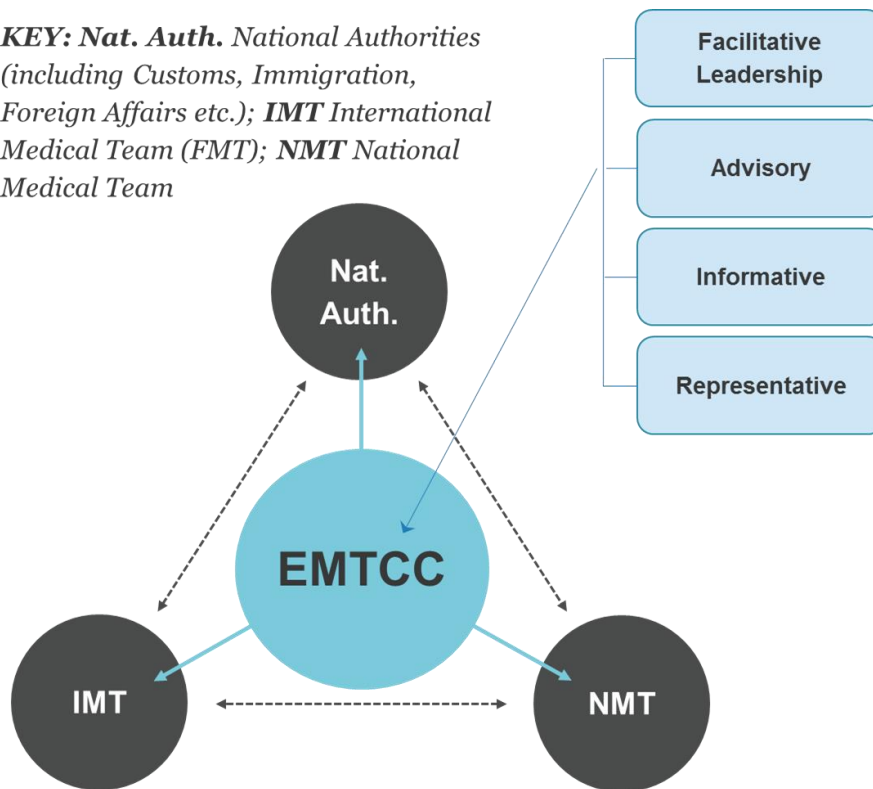
Even though the EMTCC is primarily purposed to hold a supportive or facilitative role (such as in providing guidance, contributing to strategy development and connectivity) as part of the MOH, it may be required to adopt a range of roles or approaches within its relationships, depending on the stakeholder(s) involved and the objective(s). The four key relational roles of the EMTCC are:

1. **Facilitative Leadership**

   This is the predominant role of the EMTCC in its leadership and coordination of I-EMTs and N-EMTs. The objective is to facilitate the activities of the relational partners to the ultimate benefit of the affected population. This can be achieved by providing direct guidance or assistance to the relational partner, or by providing the linkage between partners (connectivity). While facilitative leadership is generally useful, there are situations in which the approach requires being directive rather than facilitative, that is, providing instructions (rather than guidance) in line with the requirements set by the MOH.

   Examples:

2. Advisory

The EMTCC, as a specialized cell with unique technical expertise, also holds an advisory role. Its general expertise includes the mechanisms and processes for coordinating EMTs, the EMT Classification and Minimum Standards as well as all identified areas of support required by EMTs during their deployment.

Examples:

Advising the MOH on the ideal mechanism for managing the arrival and registration of incoming EMTs.

Advising EMTs on guidelines for improving case management or Infection Prevention and Control requirements.

3. Informative

The EMTCC has a role (or even an obligation) to disseminate relevant information to relational partners, especially to the EMTs. This information may be primary (such as situation reports generated from EMT daily reporting, or maps of EMT deployment) or secondary (such as updated security information from the UN, or visa and customs instructions from the national authorities).

Example:

Generating and distributing EMTCC situation reports to the EMTs and all relevant stakeholders involved in the response.

4. Representative

This is an implicit role of the EMTCC, and is a critical coordinating function in facilitating connectivity, speed and 'visibility' of the N-EMTs' and I-EMTs' response. The EMTCC should be perceived as a representative focal point for the MOH as well as for the EMTs in the attempt to always reach a win-win status.

Example:

Presenting the concerns of the I-EMTs to the coordinating bodies regarding the landing permission of I-EMTs during the initial critical hours of the response.

> *Reprimanding or correcting unacceptable behavior from rogue EMTs to maintain a positive image of the EMTs' response.*

3. EMTCC STRUCTURE

3.1 Functions of a EMT Coordination Cell

1. Collecting and updating data for the classification of the actual type, capacity and services of the incoming EMTs throughout the whole response.

2. Screening incoming EMTs based on approved global professional standards leading to their eventual on site authorization by the MOH or national authorities.

3. National registration of authorized EMTs, based on the global classification and registration formats, including self-declaration from the EMT leader that the team adheres to the global standards.

4. Ensuring and reinforcing the EMTs accountability to the health authorities, including compliance with existing or forthcoming national guidelines and reporting requirements.

5. Providing background and up to date information on the situation and assigning a place of operations and local reporting/liaison contact.

6. Providing sound and valuable support to speed up all the related authorizations during the mission of 'authorized' EMTs.

7. Providing standardized forms for periodic reporting, exit reporting, and referral of patients to national facilities.

8. Providing and supporting the strategic and operational framework of the EMTs response.

9. Formulating priorities on the basis of analysis.

10. Mapping of 'who does what, where, and when' and 'how' through quality assurance field visits.

11. Informing NEMA and other national or international authorities, to ensure embedding in the broader health sector emergency coordination (including the health cluster if there were a need for its activation).

Figure 4. Coordination Cell Structure (Functions)
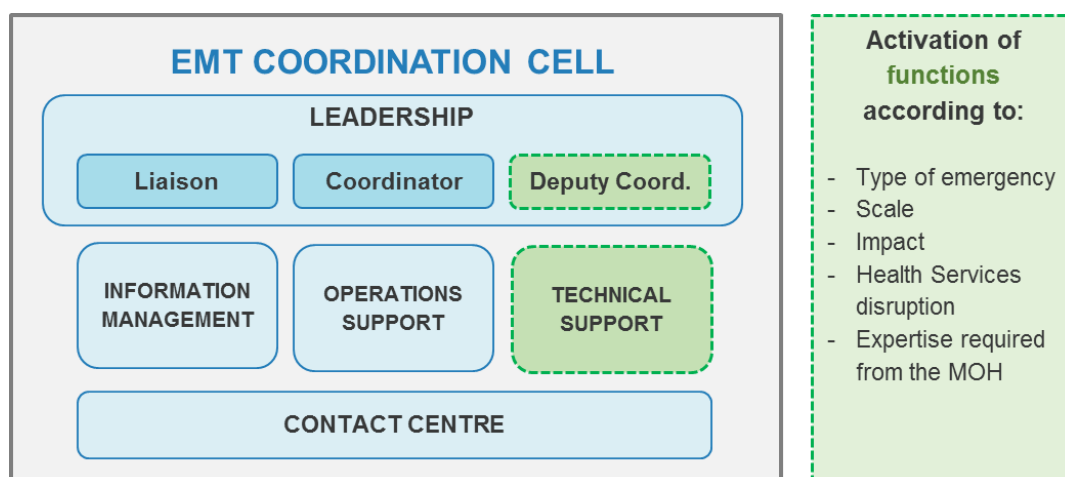
The functions* within the EMTCC are:
* Leadership function is presented through the roles to facilitate the understanding of duties and responsibilities

Coordinator	- Operational strategy and updates - Strategic planning and direction - Coordination of EMTs - Direct link with main stakeholders including Ministry of Health, OSOCC, UNDAC team, Health Cluster, and other partners
Deputy Coordinator	- Daily management of operations - Oversee reporting and information management - Safety and Security planning for the cell - Manage the cell members' handover and replacement process
Liaison Officer (and/or Focal Points)	- Identify and link up with key stakeholders from local agencies and affected communities to international responders - Establish the link between the Civilian and Military components of the response, including through the OSOCC and/or the Humanitarian Civil Military Coordination Cell - Provide a forum for stakeholder groups to provide input into the response process
Information Management	- Reporting and information management - Establish the filing and archiving system - Provide daily/weekly data analysis to support

	- the monitoring of the response
	- Mapping of deployed teams and resources
Operations and Team Support	- Office set up and logistic support to CC including management/admin of CC resources
	- Support the set up and running of the contact center (daily contact and correspondence with EMTs)
	- Coordination of required logistic support for EMTs (including local procedures regarding customs, immigration and access to affected areas) and medical response *(could be a separate function)*
Contact Center	- Registration of EMTs, and filing
	- Managing daily contact and correspondence with EMTs
	- First point of contact for EMTs
Technical Support	- Rehabilitation Advisor
	- Clinical Advisor
	- Epidemiologist
	- Public Health Advisor
	- Logistic Advisor
	- Water, Sanitation and Hygiene (WASH) Engineer
	- Structural Engineer
	- Safety and Security Advisor
	- Infection Prevention and Control (IPC) Advisor
	- Training Advisor

3.2 Staffing Mechanisms and Cell Surge Capacity

As indicated in the previous section, the EMTCC needs to be staffed with a variety of skill sets in order to meet the various functional roles within the EMTCC, such as information management or liaison, which are essential for its operations. However, all EMTCC members must also have a common baseline understanding and working knowledge of the principles and processes of EMT coordination (as detailed in this Handbook) and the EMT Classification and Minimum Standards, as a minimum. In addition, the EMTCC must have the ability to adapt its size and composition according to the context and needs, both through the various phases of an emergency as well as across different emergencies (examples of previous EMTCC size and composition are presented in **Annex XI**). This capacity for adaptation and surge requires a pre-existing pool of trained personnel (which not only includes coordinators but also supporting staff with EMT coordination training) from which team members can be readily accessed and deployed to rapidly operationalize an EMTCC,

where one is required, for any type of emergency and in any context. This pre-positioned human resource capacity not only fulfills a critical assumption for effective EMT coordination (as stated in **Chapter 1**), but also aligns with and contributes to the development of the Global Health Emergency Workforce envisioned by the WHO (WHO, 2015).

The potential pool of trained EMTCC personnel may be derived from various avenues, with the top options being:

1. From within the **MOH or national authorities** of the affected country. This is ideal given that local responders are able to be mobilized most rapidly, and are already adapted to the local context. The aim should be to build this capacity within every MOH or national authority as part of emergency preparedness.

2. From the **WHO standing and surge staff capacity**, as intended by the Global Health Emergency Workforce agenda.

3. From **partners with standby agreements** with WHO including the UNDAC team.

4. From **other EMTs or organizations** that may second trained personnel with a needed skill set to the EMTCC on voluntary basis.

The establishment of this flexible pool of trained EMTCC personnel, accessible through various staffing mechanisms is the purpose of the EMT Coordination Training Course(s), which is intended to be offered to a broad range of adequately qualified personnel, who can meet the various skill sets and roles (not just coordinators), from a wide range of organizations and response teams, including MOHs, NEMAs, WHO, UNDAC, EMTs providers and other partners with standby agreements.

3.3 Activation of the EMTCC

A variety of pre-crisis data collection initiatives exist, are implemented in several countries and represent essential references for secondary data review as well. At the onset of an emergency, when only limited information may be available, maximizing the use of pre-crisis information and baselines is highly important including building on existing national health system defined priorities. Effective contingency planning and preparedness measures identify and map key vulnerabilities and risks. Besides that, a series of assumptions such as estimation of health infrastructures damages, the level of risk exposure of affected areas, possible incidence rate of diseases among others can be made to speed up the internal mobilization of Medical Teams and the call for international assistance (*Figure 5*).

Figure 5. Level of information available and activation of EMTCC
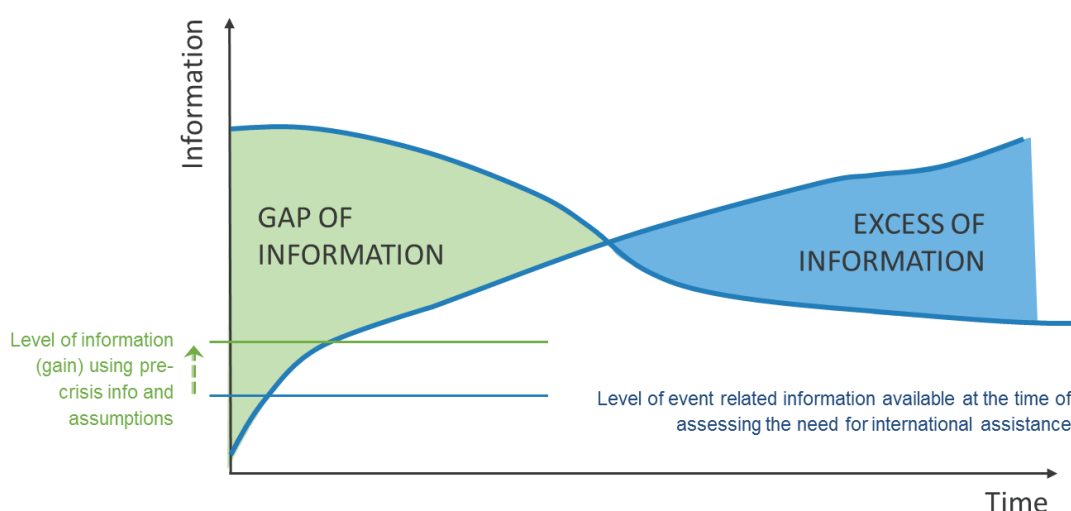
A no-regrets approach should be applied to the activation, deployment and staffing of the EMTCC at the onset of an emergency or even during the alert phase. MOH (and other related national authorities) with the support of WHO should err on the side of activating or deploying an EMTCC and ensuring more than sufficient staff initially, with the option of rapidly scaling down or de-activating the EMTCC once the true needs of the emergency are better established, rather than risk failure by initial under-resourcing while awaiting further information. The implementation of the No-regrets Policy is dependent on the establishment of adequate surge capacity (as described in the prior section), and closely linked to the fulfillment of the critical assumption of pre-positioned or rapidly accessible human resources and funds.

4. RECEPTION AND DEPARTURE CENTER (RDC)

As the first contact point for incoming international assistance, the RDC needs to be established in a systematic manner that imparts a level of organization in the chaotic environment of the disaster. The RDC is set-up at major entry points for international assistance by the first arriving UNDAC team, INSARAG-trained USAR team or Emergency Medical Team.

RDC operations are focused on:

> ➢ *Registering incoming teams and passing this information to the EMTCC and OSOCC to facilitate operational planning.*
> ➢ *Briefing arriving teams on the evolving emergency situation.*
> ➢ *Providing arriving teams with available information related to practicalities such as logistical support, airport/port procedures and services, security and EMTCC/OSOCC location.*

> ➢ *Supporting point of entry authorities in coordinating the arrival of international resources, including air/ground traffic control, ground services, storage, procedures and liaison.*

Generally at least two team members will staff the RDC. Being the first point of contact, it is vital that the RDC is well organized, informed and facilitating as it sets the tone for the arriving teams. The staff managing the RDC needs to be familiar with the VOSOCC and its functions and be able to update information on the VOSOCC; and it shall be aware of the EMTCC methodology including the OSOCC concept.

Where indicated by the realities of the emergency, more than one RDC can be established. The decision to open additional RDCs is based on practicalities. For example, are there multiple points of entry (airports, seaports, roads, etc.) where a significant number of teams or relief items are arriving? If so, does it make sense to divert addition-al trained staff to these locations to open an RDC? These decisions must be made based on operational realities.

Having the capacity to establish and run an initial RDC requires the following as a minimum:
a. Being able to dedicate 2 staff full-time to the RDC
b. Office in a box with stationary material
c. ITC capacity (laptop computer, BGAN, mobile, satphone at minimum)
d. RDC flag
e. RDC forms and documents
f. Self-sufficiency including food and water for at least 2 days, as well as sleeping bag, tents, as necessary

All incoming I-EMTs should be registered prior to deployment using the established protocols through the VOSOCC and confirmed upon arrival at the RDC where an initial cross check of declared capabilities and requested assistance should be performed. Thus, considering the specific nature of EMT registration and depending on the legal registration process for EMTs in each country, dedicated EMT personnel is required at the RDC to support the process.

Ideally a 'one-stop-shop' approach could be used at the RDC to cover the initial phases of the EMT mission cycle (see point 5.1) including the full registration, the authorization to practice for medical staff and the assignation of a field location. However, due to the complexity and the resources required for its implementation, large responses will most probably adopt the dual approach such as initial registration at the RDC followed by the completion of all required authorizations at the EMTCC.

5. COORDINATION ACTIVITIES

5.1 EMTCC Life Cycle

The typical life cycle for the EMTCC is shown in *Figure 5* below. As shown, the activities of an EMT CC progress through seven key stages, which are grouped into three broad phases.
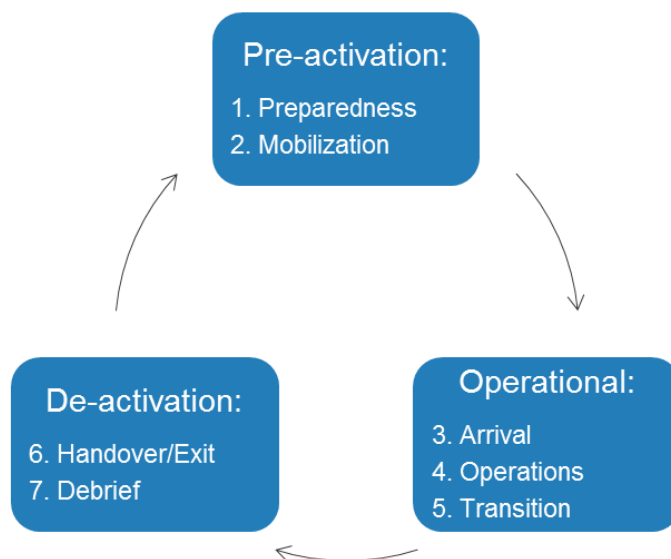
Figure 6. EMTCC Life Cycle

The table below shows the typical s mission cycle of an EMTs and the life cycle of the EMTCC and the anticipated activities within each phase.

Emergency Medical Team	Coordination Cell
1. Preparedness	(Not activated)
Achieve and maintain Minimum Standards: Building and strengthening EMT capabilities during the Preparedness Phase is important to ensure the maintenance of a ready workforce for efficient and effective emergency response. EMTs should work to achieve and maintain the FMT Minimum Standards combined with the highest level possible of readiness.	EMT Initiative: Provide mentorship and support to EMTs through the WHO Global Registry process and keep the active discussion on the Minimum Standards.
Register on the EMT Global Classification: The Registry provides a database of pre-verified EMTs that meet the minimum standards. Registration does not confer automatic approval to respond to an event, but allows visibility on a central avenue through which national authorities can solicit assistance, and may expedite the approval and acceptance of offers of assistance by recipient national authorities.	Mentor and verify EMTs to be registered on the EMT Global Classification
Brief analysis of the possible scenario and	Assess the needs for international

evaluation of internal capability for intervention Brief analysis of the complexity of the emergency, context of operations and initial availability of resources to support the deployment.	assistance. Initial brief analysis of the scenario and discussion about **activation** of the CC within the HEOC supported by trained EMT people at National level.
2. Mobilization	**(Activation)**
Submit Offer of Assistance: Formal Offers of Assistance should be submitted to the recipient Ministry of Health, and mobilization should not occur until the Offer of Assistance has been accepted and approved. Essential information, such as EMT number, type and expected duration of stay, provided on a standardized online form will assist the Coordination Cell in matching incoming assistance with identified needs, and to call for further assistance (general or specific) or stand down as appropriate.	• Conduct preliminary **needs analysis** • **Collate information** on the capabilities (include type, logistical support, and duration of stay) of EMTs offering assistance • **Match and task** approved EMTs to identified needs
Obtain essential information for mobilization: This includes EMT arrival and registration standard operating procedures, registration requirements, and visa and customs procedures. Where possible, the Coordination Cell will support the Ministry of Health in disseminating this information to all EMTs.	• Confirm EMT Arrival and **Registration SOPs** with MOH • Disseminate essential information to all EMTs
3. Arrival	
Report to the Reception and Departure Centre (RDC) or support establishment of initial RDC: Initial registration at the RDC flags the in-country arrival of an EMT. Here EMTs can obtain essential information, such as EMTCC location and contact details, and coordination meeting locations and times. An EMT may be requested to support the RDC operations, particularly as it pertains to the EMT coordination role of the RDC, or even, if the RDC does not yet exist, support the establishment thereof.	• Ensure continuous EMTCC **representation at the RDC** • Compile and disseminate through the RDC essential arrival information for EMTs
Register at the EMTCC/Ministry of Health: The EMT team leader should report to the EMTCC/MOH office to complete EMT Registration and submit required documents (e.g. copies of passports, licenses for clinical practice etc.). Required logistical support and other operational support needs should be raised to the EMTCC at this point.	• Collate and input EMT operational information on **central database** to provide overview of available resources
Obtain tasked assignment: The EMTCC/MOH will liaise with the EMT to match and task them to an identified area of need based on the EMT capabilities. This matching and tasking process expedites EMT deployment to an area of need, optimizes resource utilization, and allows matching of available resources (e.g. logistical support to EMT needs).	• Match and task EMT to identified areas of need • Negotiate or obtain available **logistical support** and other relevant resources

4. Operations	
Deploy to tasked site and begin operations Information provided in the previous steps can facilitate the deployment to assigned sites (e.g. through logistic support and liaison with local authorities). Reducing the time between deployment and beginning of operations is crucial at this stage for life saving service delivery.	• **Map in real-time** all EMT deployments • Establish and maintain **regular contacts** with EMTs and local (districts) authorities. • Conduct **Field Quality Assurance and Support** visits to EMTs
Maintain adequate patient notes and discharge/referral documentation: Ideally, all medical documentation should be made in duplicate or triplicate: Patient, EMT, and referral destination (if applicable). This is particularly important for patients needing longer term rehabilitation needs, ongoing follow-up beyond departure of treating EMT or transfer to another facility.	• Establish **referral system** including SOPs • Provide standardized **Referral Forms** (if none pre-existing from the MOH), sample Patient Referral Form template available in **ANNEX I.**
Periodic Reporting: Standardized periodic reporting (initially on a Daily basis) to the EMTCC/MOH allows monitoring of the service demands and rapid identification of residual gaps. It also allows notification of urgent issues to the EMTCC/MOH so that appropriate response or support can be given.	• **Collate, input** and **analyze reporting data** from EMTs • Compile **situation reports** to inform EMTCC/MOH leadership and Humanitarian System, and feedback to EMTs
Confirm Operational Plan and Exit Strategy (including informing EMTCC of anticipated departure date): Coordinated departure is important to ensure smooth handover of care and continuity of service provision. Early communication of exit strategy and of anticipated departure date (at least 1-2 weeks prior) to the EMTCC/MOH will assist in coordinating either handover of services to another EMT or MOH, or closure if appropriate.	• Keep **track** of all anticipated **EMT departure dates** and identify/ address **possible gaps** in service provision • Identify **key steps for transitioning** (mainstreaming) **the EMTCC** within the National Health System and/or HC • Conduct **Field Quality Assurance and Support** visits to EMTs • Provide **Departure Package**, including departure SOPs
5. Transition	
Prepare all communications and documentations for handover and exit: - Ensure medical notes are complete and up to date - Compile list of patients needing ongoing follow-up or longer term rehabilitation, and of patients needing handover or transfer at EMT departure - Compile data for Exit Report	• Confirm **handover** and **exit plan of EMTCC** in liaison with the EMT and MOH
6. Handover/Exit	
Handover all medical notes to incoming EMT or MOH Handover of medical notes is essential to ensure continuity of patient care following EMT departure	• Confirm handover of all medical notes as declared by EMT on Exit Report

Compile and submit List of Donated Items Provision of a Donated Items List strengthens accountability, and allows the MOH to re-distribute equipment to areas of specific need	• Support the compilation of a **master list of donated items** and their re-allocation according to needs.
Submit Exit Report to EMTCC/MOH The Exit Report is an important mechanism for EMT to report their contribution and services in a standardized manner to the MOH. Standardized reporting across all EMTs also allow this data to be aggregated, analysed and reported	• **Collate, input** and **analyse Exit Report data** from all EMTs, and generate overall Exit Report • **Confer Letter of Appreciation** (from MOH) on receipt of all exit documents
6. Debrief	**(Deactivation)**
Ensure completion of EMTCC Evaluation Survey The EMTCC Evaluation Survey is important to provide feedback to the EMTCC with the view of further improving the EMT coordination mechanism for future responses	• Collate, input and analyse Evaluation Survey data from all EMTs • Generate Lessons Learned Report to inform improvements to Coordination

5.2 Pre-deployment Preparations

The EMT Secretariat and the relevant Regional counterpart will be heavily involved in the necessary supportive activities to facilitate the rapid deployment, establishment and operationalization of the EMTCC at the outset of an emergency. These supportive activities include activating the online registration system, establishing initial contact with the MOH and relevant national authorities, disseminating Informational Invitation Letters (available template in **Annex I**) to all EMT-capable organizations, identifying and assembling the EMTCC team appropriate for the context (if required), and obtaining relevant background information on the affected country, such as structure of the health system, baseline health status and risks, and national treatment protocols and guidelines.

However, there are a number of critical activities that should be undertaken by EMTCC international members prior to deployment or on route to the affected country. These are:

- Ensure current travel and personal health status is suitable for deployment to the context, including valid passport and visa, adequate insurance cover, good physical and mental health, necessary vaccinations, and sufficient routine and prophylactic medications;

- Obtain and digest available information relevant to current context, including background information on country health system and status, relevant national protocols and guidelines, existing EMT coordination protocols or procedures, and most updated situation report(s);

- Develop an initial Plan of Action (POA), including identifying immediate needs for EMTCC operationalization (for example, critical national staff or local logistical support) that must be addressed once in country;

- Assign initial roles and responsibilities to identified team members.

5.3 Arrival and Setup

The first 24 hours after arrival is critical in establishing the credibility and functionality of the EMTCC as well as the RDC. The top three priorities (which may be undertaken simultaneously given sufficient staff) are:

1. **Establish key contacts and relational partnerships:**

   The obvious primary contact to be established is that with or within the MOH. However, other high priority contacts include the coordinating entity for the international response (the agency for which can vary or be absent, depending on the context), the national authority Immigration and Customs department(s) and coordination mechanisms. The establishment of initial agreements and understanding with these key contacts are essential for the other two priority activities, and for clarifying the position of the EMTCC within the multi-agency response system (which may differ depending on the scenario, as discussed in **Chapter 2**).

   There will be varying degrees of prior knowledge of the EMTCC by the national authorities (including the MOH) depending on country, and varying degrees of existing processes for the management of EMTs (ranging from completely absent to ad hoc in response to the present emergency to fully pre-developed protocols). The EMTCC needs to be sensitive to these potential variations and adapt their approach accordingly.

   At the point of entry, a decision is to be taken whether an RDC be established, supported or not. For this purpose, primary contact to be established with the airport authorities and immigration, customs departments, etc. to facilitate the arrival of incoming EMTs and other response teams.

2. **Establish EMT arrival and registration process:**

   This is the priority action to be undertaken by MOH in collaboration with other entities (if relevant), ideally prior to the arrival in country of the first EMTs, or within 24-48 hours of emergency onset. The contribution of the WHO in supporting the MOH in establishing this process may range from minor guidance to some adjustments to complete importation with context-specific adaptations, depending on the strength of existing mechanisms. The final procedure needs to be easy to implement from the EMTCC/MOH side, simple with minimized administrative burden from the EMT perspective, and collect sufficient information to allow for effective coordination, tasking and quality assurance (for example, contact details, team type, capacity, and experience).

   Once confirmed, the EMT arrival and registration procedure must be rapidly communicated to all EMTs (including those already in country), and made available at all potential points of contact with EMTs, such as the airport, RDC, OSOCC, MOH, Virtual OSOCC, and the WHO EMT Initiative website.

3. Establish base of operations:

Apart from basic office set up for EMTCC operations (see **Annex II**), one of the priority supportive functions to operationalize it is the Contact Centre, which is essentially a well-publicized local contact phone number and email address that is staffed to respond to all EMT enquiries and to disseminate essential information. Past experience has shown that the volume of enquiries can be very high in the initial phase of the emergency response, requiring up to three dedicated full-time staff to manage all enquiries. Despite the staffing demands, the ability to reliably respond to the information needs of EMTs, particularly in the earliest stages of the response, is extremely valuable for building visibility, credibility, and EMT confidence in the EMTCC.

5.4 Registration

EMT registration is critical to several of the EMTCC's coordination functions: 'filtering' of incoming EMTs (according to capability and identified needs), matching and tasking them based on their type and services and maintaining constant communication. Without an accurate accounting of overall EMT capacity (current and anticipated), including EMT type, services and logistical capabilities, optimal planning and efficient allocation of EMTs to meet the varied and specific needs of the affected population will be difficult to achieve. It will also make it difficult to anticipate and coordinate the logistical resources needed by EMTs. Some EMTs will be present in-country prior to the establishment of the registration process (existing organizations or early arrivals) or remain unregistered (due to ignorance or non-compliance). These EMTs must be identified and registered (type, services, duration of stay, activities conducted and field location) however the Ministry of Health or related National Authority is the only body entitled to refuse the later registration.

The EMTCC/MOH registration of EMTs is a response-specific registration; it is the mechanism by which an EMT indicates their intention to offer assistance (including type and capabilities) for a specific emergency response. This registration is completed for each EMT rather than for each organization offering EMTs.

The EMT Registration should collect information about the EMT's contact details, type, medical service and logistical capabilities, and intended duration of stay, as a minimum. This information is necessary for effective coordination. Information should be collected on a standardized form, which may be offered in paper, electronic and/or online formats. A sample Registration Form is provided in **Annex I**. Certain additional documents are required by the EMTCC/MOH to accompany the registration forms. This may include:

- Copies of passport of each team member
- Current practice license (i.e. medical, nursing or relevant license) for clinical staff
- Letter of Introduction/Invitation from a national counterpart organization

Registration requirements should be clearly communicated as soon as possible to all EMTs. Ideally, I-EMTs should complete the registration online or submit it electronically prior to mobilization from their country, which allows time for EMTCC processing (and MOH/national authority acceptance), and allows for the EMT to be tasked and deployed to the site of operations more rapidly after their arrival.

As mentioned earlier, the RDC registration serves as a quick check-in point at the arrival in country to receive first information on the situation and guidance on the next step (that is, complete registration at the EMTCC) unless a "one-stop-shop" system is implemented (chapter 4).

National authorities seeking emergency assistance may expedite the approval and acceptance of EMTs from pre-verified and registered organizations on the Global Classification that are already working in country prior to the emergency may have passed through an in-country registration, a routine process usually meant to 'legalize' the status and related work of national and international Non-Profit organizations in country. This process does not replace the EMT registration and all the organizations already present in country should communicate their intention to respond in way to maximize the complementarity and reduce the burden to an affected system.

5.5 Tasking

Tasking is the process of assigning EMTs to a specific site of operation based on the EMT's type and capabilities and the identified needs or gaps, which allows for optimal resource utilization to maximize assistance to the affected population. Tasking is the core operational function of the EMTCC and its key guiding principles are the comparative advantage (or added value each EMT can bring to the response), complementarity (or strengthening existing services and filling gaps) and predictability (or preset of potential at-risk areas and/or facilities).

The tasking process should be applied as a periodic (rather than continuous) cycle with the tasking of EMTs occurring a set time(s) of the day. The frequency of EMT tasking (that is, length of the tasking cycle) will depend on factors such as the emergency context, volume of incoming EMTs, and the availability and quality of information. For example, once or twice daily tasking may be required for SODs with a moderate to high volume of responding EMTs, but may be less frequent for slow onset emergencies. Periodic tasking is both more effective, in terms of having a pool of accumulated EMTs to allow for better matching to most updated needs, and more efficient, in terms of time demands on the EMTCC leadership, compared to a continuous, first-come-first-tasked approach. However, this means registered EMTs, no matter time of arrival, will have to wait until the next tasking meeting to receive their Letter of Deployment (which specifies their allocated site of operations, authorized by the MOH). This waiting period may cause frustration for some EMTs, and should therefore be pre-empted with clear explanations to EMTs of the tasking process and underlying logic.

Tasking is in reality a more consultative and participatory process than the term suggests. The final site allocation should be reached in discussion between the EMTCC leadership, MOH and the relevant EMT, and should also take into consideration the EMT's concerns

and interests. For example, the EMT may already have pre-existing working experience or partnerships in specific localities within the country, which can be an asset to their effectiveness in providing assistance in those particular localities.

Factors that can facilitate an effective and efficient tasking process are:

- Pre-identify at-risk areas and facilities;
- Assign EMTs during the pre-registration phase;
- Ensure EMT capabilities (and self-sufficiency) are cross-checked;
- Verify site availability using local contacts and virtual maps (if possible);
- Verify the primary and secondary risks associated with the event for each location;
- Consider proximity with existing health facilities;
- Correlate between levels of care and the importance of the three levels and EMT types (see *Figure 7* below)

Figure 7. Correlation of Levels of Care and EMT Type
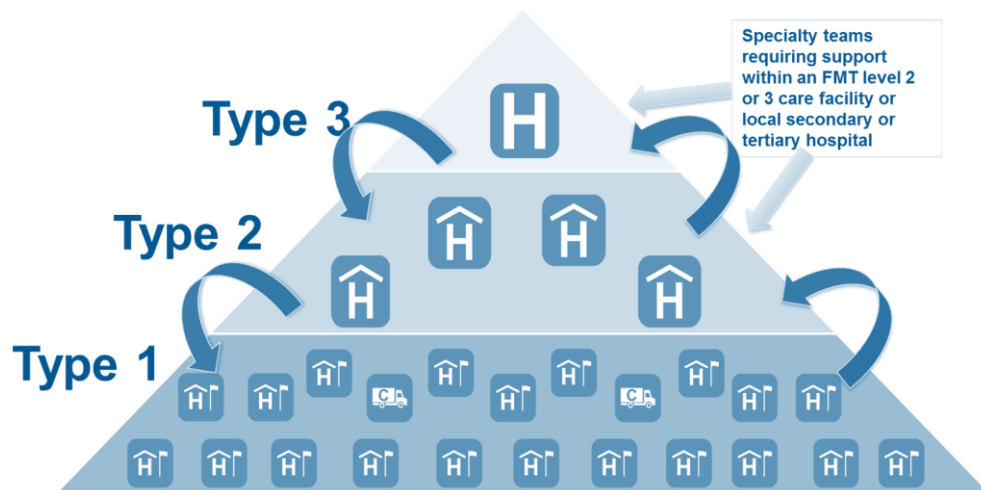
The tasking of teams is usually based on the "Hub-and-Spoke" model that consists in placing larger teams at strategic and district focal points and smaller teams (both fixed and mobile) fanning out from these points. During the 2015 Nepal earthquake response, the strategic location for each hub was chosen based on previously existing health facilities or areas with high trauma load. The smaller EMT1 facilities or EMT1-mobile were dispatched to more remote areas to treat trauma cases or to refer cases to higher level of care. These included the district hospital if the case was manageable at that level or to the tertiary care facilities in the capital Kathmandu.

Figure 8. Hub and Spoke model
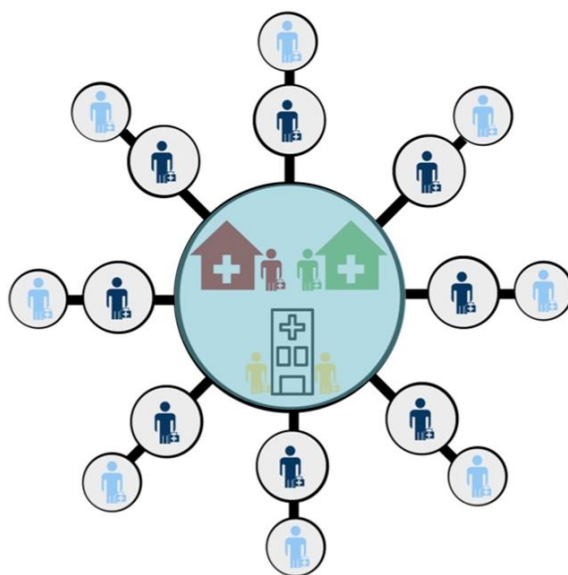
Tasking of teams could be done as well following the so called "point-to-point" approach in which only specific selected teams (including specialist cells) are allocated to a pre-assigned site of operations. It is often the case of responses that required limited surge due to the scale of the event, emergencies that require specific expertise (e.g. cholera outbreak) or a well-structured emergency preparedness plan.

5.6 Information Management

Information management is one of the key support functions for EMT coordination. EMTCC requires readily accessible and up-to-date information about all responding EMTs (and their type) in order to make decisions about the optimal distribution of the EMTs. In reality, there are multiple additional layers of information (such as EMT logistical capabilities, anticipated departure dates, and locations of already deployed EMTs) and pragmatic information (such as the EMT contact details) that need to be collected, processed and packaged in a readily accessible format in order for the EMTCC to operate effectively. The 'Master List' remains the key tool for collecting and sharing within the EMTCC all the info related to the EMTs and at support of the 4W mapping.

Information management encompasses all steps from data collection (in which the contact centre plays a key role) to dissemination, as shown in Figure 9. Specific examples relevant to the EMTCC operations are also shown for each step. Dissemination of produced information (from collected, processed and analysed data) is one of the most important steps within the cycle. This information should not be limited to the EMTCC or the EMTCC direct reporting line, but should be widely disseminated to all relevant stakeholders, including the EMTs, to also support and inform their actions. Note that under the EMTCC structure, information dissemination is a function of the Contact Centre, which is responsible for

managing all incoming and out-going communications, rather than a function of Information Management.

Figure 9. Information Management Cycle
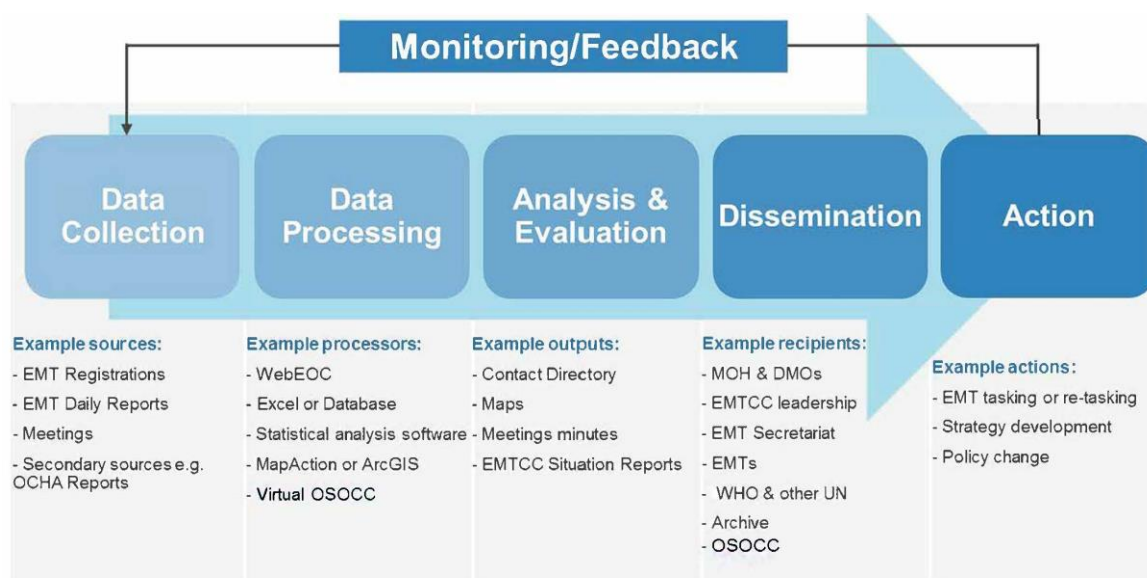
Specific elements of the EMTCC Information Management cycle that warrant further discussion are addressed in the following sections.

EMT Reporting

Reported information from deployed EMTs is extremely valuable for multiple purposes, which includes:

- Providing real-time situational and needs assessments at the local or district level, which informs the EMTCC in their tasking or re-tasking decisions, as well as the overall humanitarian situation analysis;

- Providing an indication of longer term needs when rehabilitation indicators, such as number of lower limb amputees, spinal cord injuries (SCI) and complex fractures, are included in the reporting. This can be used to guide the development of longer term strategies;

- Contributing to and strengthening the national communicable disease surveillance and early warning system;

- Forming part of the quality assurance and accountability of EMT activities.

Therefore, EMTs should be requested to participate in periodic reporting, which may be daily in the acute phase of the emergency and transitioned to weekly after the situation has stabilized. EMT reporting should be conducted using a standardized form. Standardized reporting allows for meaningful aggregation of reports across EMTs, which is required for

effective situational overview. A sample [EMT Daily Reporting Form](#) is provided in **Annex I**. This form should be reviewed and adapted to suit the context and the emergency. Alternatively, the form may need to be integrated with existing MOH reporting forms. The final reporting form and process should be established in collaboration with the MOH to avoid confusion and duplication.

Meeting reporting requirements can be challenging for EMTs, as seen in previous experiences. Lack of time due to clinical workload, duplicated reporting requirements, and limited access to internet or telecommunications are common barriers. It is therefore important to keep the reporting process simple and flexible (for example, allow submission via paper, phone, email, and online), and to balance the coverage of questions with the overburdening of EMTs. Providing an explanation of the purpose and value of EMT reporting, and feeding back generated reports to the EMTs should be standard practice to encourage reporting. Active collection of reports via daily phone calls to the EMTs from the EMTCC has also been applied with success in the past. However, this can be difficult to implement during the acute phase of an emergency due to high workload of the Contact Centre.

Data Management Platforms

Data management platforms vary in complexity and accessibility, including:

- Basic paper forms and records with an organized, physical filing system;

- Simple Excel database with manual data entry and report generation;

- Electronic document collection (including scanning of paper forms), stored and organized on a hard drive, networked drives, or a web-based shareable drive, such as GoogleDrive (although caution is necessary in relying on a third-party controlled platform. For example, there is a risk of being locked out of the account);

- More complex, purpose-built data management platforms, such as WebEOC. (This platform is already being used by some organizations, and is currently being explored as a platform for the EMTCC).

The choice of platform will depend on the available infrastructure, such as reliable electricity and/or internet connectivity, and the available expertise within the EMTCC team.

Mapping

Maps are a powerful means of presenting summary information in a readily absorbable manner. They are increasingly used as part of reporting in humanitarian emergency responses, particularly for reporting the 4Ws (who, what, when and where). For the EMTCC, mapping of the locations of all deployed EMTs and their types, as a minimum, would be a useful tool for visualizing potential coverage gaps, which will help inform tasking decisions. Additional layers of information, including location, status and capabilities of pre-existing healthcare facilities, areas of need, and transport or supply routes, may be added.

Mapping services may be available through other response organizations however, given the value of mapping and the specific information required by the EMTCC, it would be ideal to have an Information Officer with mapping expertise as a designated core position or requirement within the FMTCC team. Even in the absence of mapping expertise, collecting GPS coordinate information for FMT deployments and/or ensuring that the recorded location names for the sites of operations (village, sub-district, district etc.) match the names being used by the mappers (or used in existing map/shape files for the country or region) from the outset will help ensure compatibility and ease of mapping at later stages (by an external partner, for example).

EMTCC Situation Reports

The EMTCC Situation Report is an important information product of the EMTCC. The report is generated from the summation and evaluation of information from EMT Reports, EMT coordination meetings, and reports from other agencies, among other sources. The report should highlight the current capacity and distribution of EMTs, and any priority issues and residual needs (gaps). A suggested template for the EMTCC Situation Report is provided in **Annex I**, although this should be adapted to the specific context.

The target recipients of the Report are all the operational partners illustrated in *Figure 1*, although the Report should also be widely disseminated to other components of the international response system. Ideally, the first EMTCC Situation Report should be generated at the end of the first day in country, with a second report on Day 3, at the latest. Thereafter, regular reporting should be established, with frequency determined by context and need.

EMT Coordination Meetings

Meetings can be extremely useful for information sharing and coordination. Potential uses of EMT Coordination Meetings include:

- Establishing key strategic directions of the response;
- Disseminating information (including situation updates, SOPs, contact details);
- Obtaining and sharing of information from and between EMTs;
- Tasking of EMTs;
- Coordinating logistical resources;
- Networking between EMTs

However, it is important to ensure that meetings are time efficient and useful to all. This includes publishing and adhering to an agenda, beginning and ending on time, and employing good meeting facilitation skills to ensure equal participation.

Potential meeting agenda items include:

1. Welcome and opening remarks
2. Situation Overview
   Updates from co-chairs of the meeting (ideally WHO and MOH, MNMCC if relevant)
3. Response Overview (EMTs)
   Dissemination of new or updated information, such as SOPs or treatment guidelines
4. Discussion of specific issues (as needed):
   - Safety and security
   - Transport and common logistical needs
   - Remote area access
   - Cultural issues and guidance
   - Environmental issues
   - Gender issues
   - Reporting requirements
   - Other issues as raised
5. EMT Tasking/Update from EMTs
   Including introduction of newly arrived EMTs
6. Any other business

In terms of practicalities, meeting location, time and agenda should be set and widely publicized (including online, at the airport, RDC, OSOCC, Virtual OSOCC, MOH, Health Cluster etc.) beforehand. Meetings may need to be ad hoc in the initial days, but should rapidly become formalized and regular. Meeting minutes should be compiled and disseminated to all participants and the EMT Contact Directory the following day.

Archiving

Meticulous archiving of documents is an essential component of information management. It facilitates ready access to original data and protects against loss of information both for current operational and future needs. A standardized document naming and archiving system should be applied from the outset of the mission. A suggested archiving and naming system is provided in **Annex III**, and may be applied across all EMTCC responses. This approach utilizes key activities as the first level of organization, followed by the involved participants, geographical area, or time period.

Ideally, all documents and information should be archived electronically, including scanning or phone pictures of paper forms, and backed up on an external hard drive for permanent storage at the end of the response.

5.7 EMT Field Quality Assurance and Support Visits

Joint field visits with MOH representatives to all EMT sites of operation should be undertaken once EMTCC operations are reasonably well established, ideally after the first week of operations. Field visits should not only focus on verification of EMT operations (quality assurance), but also on providing support and guidance. The three main objectives of the field visits are to:

1. Share information (including, district and overall situation updates, new or updated SOPs and guidelines);

2. Confirm EMT operations, including:

   - Site of operation (compared to allocated site);
   - Type(s) of service (compared to declared type and services);
   - Compliance with minimum standards, including medical record keeping, reporting and referral requirements;
   - Compliance with recommended or national treatment protocols;
   - Acceptance from the community;
   - Integration with local services providers and coordination mechanisms;
   - Exit strategy (including anticipated date of departure)

3. Support EMT operations, including:

   - Feedback on potential improvements (including addressing Minimum Standard shortfalls);

   - Updated guidelines or treatment protocols;

   - Assistance with any operational issues, such as referral gaps, logistical needs, or safety and security;

   - Coordination of other complementary assistance needed by the affected population, as identified by the EMT(s), such as food distribution, non-food items, water and sanitation etc.

Documentation and observation of variance or compliance with National protocols and EMT Minimum standards form the basis for analysis of the quality of the services delivered. Any intervention must be based on carefully documented information and should include praise for good work, as well as education when needed and restriction of function when necessary.

(Sample Form verification check list to be added)

Note: In a complex and/or conflict environment, field quality assurance visits should be adapted to a peer and cluster review.

5.8 Management of EMT Departures

The careful coordination of EMT departures and handover is equally if not more important than the coordination of EMT deployments. This is to ensure that gaps in service coverage to the affected population do not emerge after the departure of an EMT, and that inadequate follow-up or rehabilitation care does not occur due to poor handover of care or medical documentation from the departing EMT. Departure SOPs and requirements should be clearly communicated to all EMTs, ideally as early as their arrival in country. These requirements include:

- Informing the EMTCC of the EMT's anticipated end-of-operations date as early as possible, or at least 1-2 weeks prior to that date if different from the one initially communicated at the time of the registration;

- Developing an appropriate transition strategy, including addressing local capacity building needs during their period of operations;

- Developing and implementing an appropriate exit plan, including plans for handover of all medical documentation (or duplicates), donation of any medical equipment, transfer of care for any residual inpatients, and arrangement of follow-up review or ongoing rehabilitation care as indicated;

- Receiving a Letter of Recommendation (or equivalent) from the DMO (if appropriate);

- Submitting an Exit Report (a sample pro-forma of which is provided in **Annex I**);

- Completing and submitting an Evaluation Survey of the EMTCC.

Instructions on all these requirements and associated forms should be compiled as a Departure Package to be disseminated to all EMTs. These requirements should all be met before EMTs are issued with their Certificate of Service and Appreciation from the MOH or national authority.

The handover of all medical documentation can be particularly challenging for EMTs. However, apart from the obvious need for prior medical notes in the planned follow-up and rehabilitation care of patients, unexpected complications or future care that require prior medical notes may also occur. Ideally, all medical notes should be made in triplicate: One for the EMT, one for the patient, and one for the local MOH health service that would usually be responsible for that patient's care.

Each EMT Exit Plan should be discussed and confirmed in conjunction with the EMT, the handover partner (if relevant), DMO, MOH and the EMTCC. Options for EMT exit include closure of services (if appropriate), matched handover to an incoming EMT (which will require EMTCC coordination and tasking), handover to a N-EMT, or handover to an existing or re-established MOH health service.

5.9 Transition and Exit

Transition and exit planning for the EMTCC should begin at the earliest possible opportunity, typically after the second or third week when EMTCC operations are reasonably well-established. The transition and exit plan should consider whether functions are to be handed over, terminated or returned to baseline; to whom the identified functions will be handed over; and what capacity building activities need to be undertaken during EMTCC operations to ensure smooth handover. These considerations are best broken down by activity or function. Examples of transition options by activity or function are provided in the table below:

Activity or Function	Transition Options
Customs and Entry Visa Procedures*	Return to normal procedures from fast tracked or special humanitarian access procedures during acute phase
EMT Enquiries	Return to normal MOH general enquiries
Registration	Handover to MOH/HEOC **OR** return to normal NGO registration procedures
EMT Tasking	Handover to MOH/HEOC **OR** terminate
EMT Coordination Meetings	Terminate and return to Health Cluster meetings if activated (advise time and location)
EMT Daily Reporting	Handover to MOH/HEOC to collect **AND/OR** return to normal health service reporting procedures
EMTCC Contact	Terminate phone line, but continue email to receive outstanding Evaluation Surveys
EMTCC Office	Terminate

This is not a specific function of the EMTCC, but is relevant to EMT operations, and therefore need to be considered and communicated

The transition and exit plan (including timing) should be confirmed in collaboration with the MOH/HEOC, and communicated widely to the EMTs and relevant components of the international response system.

5.10 Summary of Activities by Timeframe

Certain types of disasters can be predicted, an early warning can be issued and pre-positioning activities undertaken based on calculated risks, uncertainty and rough estimation of the impact. Despite the considerations on effective early warning system and its critical role to disaster risk reduction are not part of this document, it has to be stressed the importance of identified and trained National EMT Focal Point and EMTCC personnel in normal time to facilitate the EMTCC activation and reduce the time for action presented in the following pages. Below some key tasks/activities to be undertaken during the alert phase.

	CRITICAL TASKS / ACTIVITIES	✓
	Alert phase	
1.	Communications with MOH (activation of HEOC) and WCO established	
2.	Decision on activation of the EMTCC	
3.	N-EMTs pre-alerted	
4.	Revise/establish OPS support mechanism for EMTs	
5.	I- EMTs informed about the monitoring of the situation	
6.	Discard or Activate response (communication to EMTs)	

A summary of the EMTCC activities is provided in the following pages in the format of two checklists grouped by phase and recommended timeframes followed by a schematic representation of the operational support required/to be provided to the responding EMTs. The two checklists consider the onset of a disaster as the starting point and the blended option of National leadership with international support.

1. EMTCC Operationalization Checklist
2. EMTCC Transition and Exit Checklist
3. OPS Support to EMTs

Checklist 1. Operationalization Checklist

Timeframes are relative to time of Emergency Event Onset, unless otherwise specified

		CRITICAL TASKS / ACTIVITIES	✔
Pre-Arrival		**Onset to 12 Hours**	
	1.	Communications with MOH and WCO established	
	2.	Decision on activation of the EMTCC	
	3.	Informational Invitation Letter to all EMTs sent	
	4.	Online Registrations activated	
	5.	Available Country SOPs shared or posted in the website	
	6.	CC team members contact for availability	
		12 to 36 Hours	
	7.	Coordination Cell and RDC Team Members identified	
	8.	Coordination Cell and RDC Team Co-lead deployed	
Arrival		**36 to 48 Hours** (IN-COUNTRY **Day 1**)	
	9.	Decision on RDC establishment	
	10.	Initial access and coordination meeting with MOH	
	11.	MOH Coordinator appointed	
	12.	EMT Arrival and Registration process confirmed	
	13.	EMT CC established	
		48 to 60 Hours	
	14.	EMT Registration Database fully operational	
	15.	Coordination Office and Contact Centre established	
	16.	First list of all in-country EMTs generated	
	17.	Contact List established	
	18.	Deployment SOPs and key information sent to all EMTs	
	19.	Preliminary needs analysis with EMT matching conducted	
	20.	First Situation Report	
Operational		**60 to 72 Hours** (IN-COUNTRY **Day 2**)	
	21.	First EMT Coordination meeting	
	22.	EMT Tasking fully operational	
	23.	Contact Centre staffed to demand and fully operational	
		Days 4 to 5 (IN-COUNTRY **Day 3-4**)	
	24.	Regular EMT reporting established and enforced	
	25.	Real-time map of all EMTs and healthcare assets and needs	
	26.	Second Situation Report to HQ	
	27.	Needs reassessed and further Surge or Stand-Down called	
		Week 1	
	28.	Referral system fully established	
	29.	First EMT Reporting data analysis conducted and reported	
	30.	Departure SOPs sent to all EMTs	
		Weeks 2 to 3	
	31.	Compliance of all EMTs with minimum standards verified	

Checklist 2. Transition and Exit Checklist

*Transition includes management and coordination of departing EMTs

		CRITICAL TASKS / ACTIVITIES	✓
Transition		**Onset of EMT Departures or Last 2-4 Weeks**	
	1.	Exit Strategy finalized with MOH and initiated	
	2.	All EMT departure dates collected	
	3.	Coordinated exit or transition plan for each EMT completed	
	4.	Departure SOPs re-iterated and enforced	
	5.	Plan for Coordination Cell Office step down established	
Exit		**Last 1 Week**	
	6.	Coordination Cell functions transitioned to local MOH	
	7.	Collection of Exit Reports from FMTs completed	
	8.	EMTCC Evaluation Survey sent to all EMTs	
	9.	EMTCC Internal Feedback Survey distributed to all staff	
	10.	Electronic archiving of all mission documents completed	
	11.	EMTCC Office closed	
		Post-Deployment	
	12.	EMTCC Final Report completed	
	13.	Evaluation and Feedback data collected and analysed	
	14.	Lessons Learned Report generated	

OPS SUPPORT TO EMTs

SHARING INFO ON TRANSPORT AND COMMON LOGISTICAL NEEDS, REMOTE AREA ACCESS AND SAFETY/SECURITY

ACCESS TO MEDICAL EVACUATION AND WIDER REFERRAL SYSTEM

EXPEDITE CUSTOMS AND IMMIGRATION PROCEDURES, LANDING AUTHORIZATIONS

GLOBAL EMTs IDENTIFIED NEEDS

TECHNICAL SUPPORT FOR THE MEDICAL WASTE MANAGEMENT, INFECTION PREVENTION AND CONTROL, MANAGEMENT OF DEAD BODIES

FACILITATE ACCESS TO SUPPLY ROUTES INCLUDING WATER, FOOD, FUEL AND CONSUMABLES

SUPPORT THE DISSEMINATION OF NATIONAL STANDARD OPERATING PROCEDURES AS COUNTRY SPECIFIC SET OF RULES THAT GOVERN THE DEPLOYMENT OF EMTS

FACILITATE ACCESS TO MEDICAL GAS AND CONSUMABLES (RESUPPLY)

EMTS, Global Meeting Report (Panama, December 2015)

6. SPECIFIC CHALLENGES

6.1 Management of Non-Compliant Teams

Despite the reinforcement of the national regulations, SOPs outlining the expectations and responsibilities of EMTs and minimum standards, some EMTs will most likely continue to arrive unsolicited and/or work in an uncoordinated manner. Examples of non-compliance include:

- Arriving in country unannounced and/or without approval from the national authority
- Failing to complete EMT registration
- Establishing operations at a site without being tasked, or in contradiction to their tasked site
- Failing to meet EMT Minimum Standards in their activities
- Failure to meet all reporting requirements
- Failing to provide adequate handover and medical documentation for patient referrals or transfers
- Departing without informing the EMTCC and/or without appropriate transition or handover

There are a range of strategies and approaches that can be employed to improve compliance, although not all of these are within the scope or authority of the EMTCC alone. These strategies escalate from the more cooperative and supportive "persuasive" approaches at one end up to the more adversarial and confrontational "punitive" approaches

at the other. This hierarchy is depicted in a basic version of the Enforcement Pyramid in *Figure 9* below.

Figure 10. Basic Enforcement Pyramid.
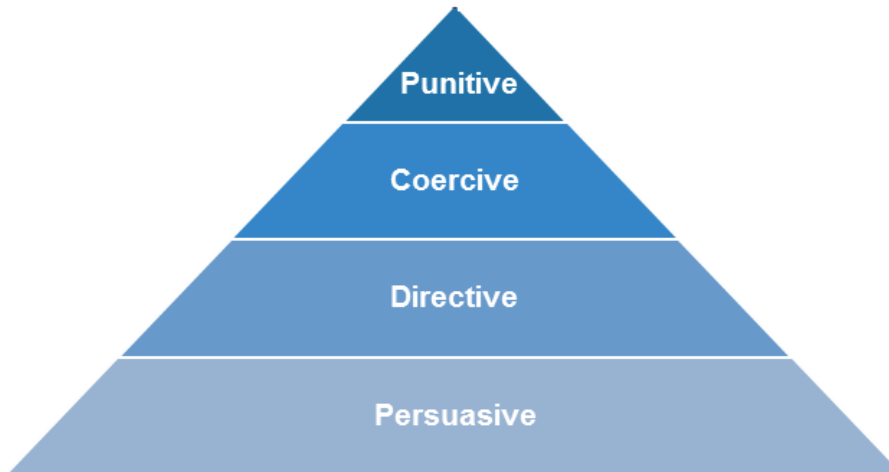
The employment of each level of enforcement as applied to EMT coordination is outlined below:

Persuasive

The persuasive approach forms the core of the strategies available to the EMTCC in improving compliance, and should be the standard starting point for engaging the non-compliant EMT, unless there are immediate, serious harm(s) or risk of harm. These strategies align with the facilitative leadership role of the EMTCC, and largely involve educating, encouraging, communicating, and negotiating with the EMT to comply. This approach protects (or even builds) the working relationship between the EMTCC and the EMT, which is important for collaboration in the current and future emergency responses, but its effectiveness remains dependent on the willingness and ability of the EMT to comply.

> *Examples:*
>
> *Clarifying and widely disseminating SOPs and requirements to ensure all EMTs are well-informed*
>
> *Identifying and contacting unregistered EMTs about the need to register, in case they were unaware of this requirement*
>
> *Providing technical advice on how to achieve the EMT Minimum Standards at the request of the EMT*

Directive

This approach is more assertive and authoritarian than the persuasive approach, but is still well within the scope of the EMTCC. In this approach, the EMTCC exerts its implicit authority, which is derived from the conferral of responsibility for EMT coordination to the EMTCC by the MOH/national authority and/or the international response system, and from the EMTCC's technical expertise. This approach can cause relational tensions due to its intrusion on the autonomy of the EMT, and should be applied with tact and diplomacy. However, a directive approach is sometimes required, especially when the actions of the EMT are generating clear harm or risk of harm, or when the persuasive approach fails.

> *Examples:*
>
> *Issuing a report to the EMT with mandatory changes to meet EMT Minimum Standards following a field verification visit*
>
> *Actively enforcing daily reporting from EMTs through daily phone calls to collect required reporting data*

Coercive

This approach makes explicit the potential negative consequences of non-compliance for the EMT, and presents the threat of punitive measures. This approach cannot be undertaken by the EMTCC in isolation: It requires prior agreement with the MOH and/or national authorities, whose authority to execute the punitive measures is being leveraged to make credible the threat to non-compliant EMTs. Effective application of the coercive approach requires a clear, pre-determined course of escalation from threat to punitive action, which must be made transparent and explicit to the EMTs beforehand. Coercive strategies can be damaging to relationships, and should therefore be employed with due consideration.

> *Examples:*
>
> *Issuing a warning with threat of revoking the approval for the EMT to be working in country by the MOH if FMT Minimum Standards remain unmet*

Punitive

The punitive approach is the most adversarial, and can terminate working relationships. This approach is beyond the scope and authority of the EMTCC; the authority and legitimacy to invoke punitive action against a EMT remains solely with the MOH and national authorities. However, the EMTCC has an important role in ensuring that punitive measures by the MOH and/or national authority are employed judiciously and fairly, and as a third-party mediator to prevent avoidable escalations to punitive measures, which can be damaging not only to the bilateral relations

between the national authority and the EMT, but also to the wider reputation of EMTs and the international response system.

> *Examples:*
>
> *Legal action by the national authority against a EMT for negligent medical practice*

The enforcement mechanism for EMT compliance will likely require a combination of strategies from all four levels of approach, and will therefore require involvement and consensus from the EMTCC, MOH, national authorities and other relevant entities. Factors for consideration in the establishment of any enforcement mechanism include feasibility (for example, time and resource costs to the EMTCC and MOH for implementation), likely effectiveness, and potential impacts on the operations of the emergency response (for example, coverage gaps due to deportation of a EMT). Additionally, the resultant mechanism must be transparent, timely in effecting compliance, flexible in allowing proportional response, and credible to maintain the confidence of the affected population and other stakeholders. Most importantly, any enforcement action must be grounded on the principle of ensuring and protecting the best interests of the affected population (rather than mere adherence to established rules or guidelines).

6.2 Management of Complaints against Teams

The formal channel for lodging complaints against any healthcare service, including EMTs, should remain with the MOH or relevant national authority. However, complaints may potentially be lodged directly to the EMTCC, and therefore an approach for managing these from the EMTCC's position is necessary. The three key steps for the EMTCC are to:

1. **Acknowledge and respond**
   Acknowledgement of lodged complaints is not only important for documentation and tracking, but also for conveying appropriate regard for the concerns of the complainant. The priority for response is to ensure the safety and care of the affected population. Beyond this, the appropriate action will depend on the nature of the complaint, and vary from raising the issue with the respective EMT to escalating to the MOH.

2. **Verify and Report to the MOH or relevant authority, if required**
   Given that the EMTCC is not established as the formal channel for health service complaints, any complaints that are significant or require management beyond the scope of the EMTCC must be passed onto or re-directed to the appropriate MOH channel(s) and/or national authority. Reaching this decision from the part of the EMTCC involves initiating communications with the relevant EMT, verifying the nature and context of the complaint, and assessing the required management level, depending on factors such as nature of the problem and the potential implications. Keeping a clear documentation of the findings and actions, and maintaining open channels of communication and transparency with all stakeholders are essential.

3. Document

The EMTCC should maintain its own record of lodged complaints, including nature of the complaint, name of complainant, name of EMT and their site of operation, any EMTCC findings and actions, and the findings and outcomes of MOH or national authority investigation (if undertaken). It is important that the information recorded by the EMTCC is kept as objective and as factual as possible.

Overall, it is important to consider the role of the EMTCC in complaints management as primarily one of quality assurance in terms of compliance with FMT Minimum Standards and relevance of operations (based on needs). The EMTCC should respond to a complaint by assessing the potential harm(s) or risk of harm to the affected population, including service quality and coverage shortfalls, and provide appropriate supportive or directive guidance to the EMT to improve quality and prevent harm.

6.3 Managing across Cultural Differences

Extensive amounts of literature discussing aspects of individual cultural awareness, adaption to new cultural environments, and cross-cultural communication, among others, already exist and are readily available elsewhere.

The purpose of this section is to highlight the specific challenge and important role of the EMTCC in managing and bridging cultural differences between organizations. These cultural differences are not only ethno-geographic, but also organizational, derived from each organization's specific operating principles, history, mandate, and training, among other drivers. For example, organizational culture is likely to differ between a local EMT, an international faith-based NGO, and a government military team. The EMTCC, in maintaining a coordinated EMT response, must work to strengthen working relationships, bridge communication gaps, and resolve conflicts across these various cultural differences between organizations. The achievement of this may be assisted by applying the following framework, which is comprised of four sequential and dependent steps:

1. Preparation:

This is the common starting point for many cross-cultural engagements, and involves developing an understanding of one's own cultural profile, including personal and organizational culture.

2. Awareness:

This next step involves developing an awareness and understanding of the culture of others, but without assuming stereotypes. A useful depiction of the continuum of cultural types is presented in *Figure 10* below. This example is based on the Lewis Model (Lewis, 2006).

3. Identify cultural differences between organizations:

Building upon the understanding of each culture, this step involves identifying the gaps or differences that may contribute to barriers in communication and cooperation between organizations.

4. Bridge differences:

Lastly, having developed an understanding of the cultural gaps between organizations, strategies can be applied by the EMTCC to bridge these gaps. For example, the EMTCC can act as an intermediary that is able to relay communications between two organizations using the most culturally effective manner for each.

Figure 11. An Example Model of Cultural Types
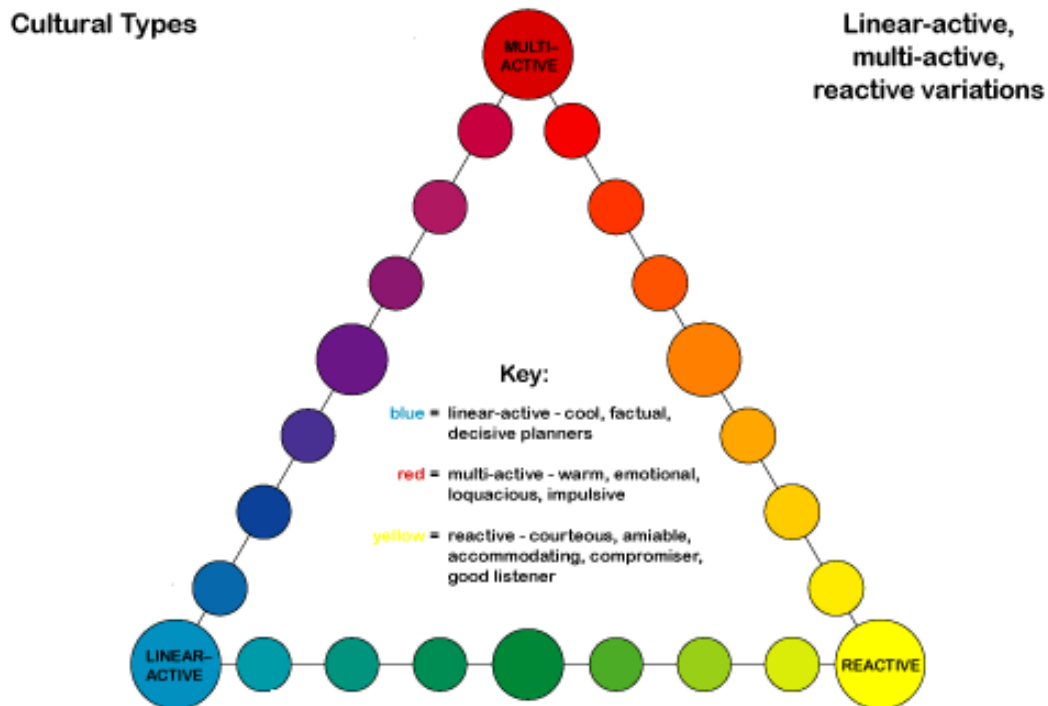
ADDITIONAL RESOURCES

Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters (WHO, 2013).
http://www.who.int/hac/global_health_cluster/fmt_guidelines_september2013.pdf

Guidelines for Essential Trauma Care (WHO, 2004)
https://extranet.who.int/fmt/sites/default/files/documents/WHO%20guidelines%20for%20essential%20trauma%20care.pdf

On-Site Operations Coordination Centre (OSOCC) Guidelines (OCHA, 2014).
https://docs.unocha.org/sites/dms/Documents/2014%20OSOCC%20Guidelines_FINAL.pdf

UNDAC Field Handbook (UNDAC, 2013).
http://reliefweb.int/sites/reliefweb.int/files/resources/UNDAC%20Handbook%202013_english_final.pdf

Global EMT Classification Process (EMT Initiative website, WHO, 2016)
https://extranet.who.int/emt/page/understanding-global-emt-classification-process

INSARAG Guidelines (INSARAG, 2015)
www.insarag.org

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General Assembly resolution 46/182, *Strengthening of the coordination of humanitarian emergency assistance of the United Nations*, A/RES/46/182 (19 December 1991)

Gerdin M, Wladis A, von Schreeb J. Foreign field hospitals after the 2010 Haiti earthquake: How good were we? *Emerg Med J*, 2012. Doi:10.1136/emermed-2011-200717

Lewis R. When Cultures Collide: Leading Across Cultures. 3rd edition. Boston, MA: Nicholas Brealey Publishing, 2006.

United Nations Office for the Coordination of Humanitarian Affairs (OCHA). *Interoperability: Humanitarian Action in a Shared Space.* Geneva: OCHA, 2015.

World Health Assembly provisional agenda item 16.1. *Global health emergency workforce: Report by the Director-General*. Geneva: WHO, 2015 (http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_27-en.pdf, accessed 17 September 2015).

World Health Organization (WHO). *Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters*. Geneva: WHO, 2013.

WHO. *Emergency Response Framework*. Geneva: WHO, 2013.

WHO. Understanding the Global EMT Classification Process https://extranet.who.int/emt/page/understanding-global-emt-classification-process

ANNEX I. SAMPLE FORMS AND TEMPLATES

Available Sample Forms and Templates:

TEMPLATE: Informational Invitational Letter to EMTs

SAMPLE FORM: EMT Registration Form

SAMPLE FORM: EMT Daily Reporting

SAMPLE PROFORMA: EMTCC Situation Report

SAMPLE FORM: EMT Exit Report

SAMPLE FORM: Patient Referral Form

SAMPLE PROFORMA: EMT Meeting Minutes

Date: ## Month, 20##

Ministry of Health
Address Line 1
Address Line 2
City
Country

EMERGENCY MEDICAL TEAM (EMT) RESPONSE TO EVENT

Dear Colleagues,

Thank you for your interest in assisting Country in responding to the impact of Event.

In the interest of an effective response, the Government of Country currently requires all international assistance to be coordinated through official government channels. International teams should not mobilize until their offer of assistance has been approved and accepted.

Emergency Medical Teams are invited to register their offer of assistance by returning the attached Registration Form to Name (email: example@moh or fax: + ##-#-##-####), the MOH focal point for EMT coordination. Approval to mobilize will be expedited for teams that are already on the WHO Global EMT Registry. Regardless of registration status, all teams must comply with the FMT guiding principles and minimum standards, which are available at: https://extranet.who.int/emt/sites/default/files/EMT_guidelines_september2013.pdf

Based on preliminary assessments, the priority needs in the health sector are ….

We thank you again for your offers of assistance, and hope you understand and respect our efforts to coordinate incoming assistance to ensure a more effective response.

Yours sincerely,

Name

Minister of Health

EMERGENCY MEDICAL TEAMS REGISTRATION FORM

A. Organization Details

EMT Global Classification ID# *(if applicable)*: _____

Organization: _____
Please also include official acronym and English translation, if applicable

Country: _____   Organization Type: _____
Select from local non-governmental, international NGO, government civilian, or military

Number of Teams: ##
*Please complete a separate **Team Details** section for **each** team deployed or anticipated to be deployed.*

Organization Primary Contact

Please provide contact details of the primary contact person for the organization for this response.

Name: _____

Position: _____

Location (or address): _____

Email: example@who.int _____   Phone: + country - area - phone number

EMT Global Classification

☐ We agree to comply with FMT guiding principles and standards, available at
https://extranet.who.int/emt/sites/default/files/EMT_guidelines_september2013.pdf

EMT Global Classification Status:
☐ No Account   ☐ Account opened   ☐ EOI submitted   ☐ Mentorship   ☐ Classified

Previous deployment experience (up to last 5 deployments):
Skip if have submitted EOI, pre-registered or registered on EMT Global Classification

Year	Country	Event	Team Type(s) and Number	Duration

Existing or previous working relationships in *Country*:

Organization	Location	Relationship

Name of Person Completing Form: _____   Date: ##/##/20##

B. Team Details

Organization: _____

Team number: ## out of ##

Team Leader Contact

Name: _____   Email: example@who.int _____

Local Phone: + country - area - phone number   Satellite Phone: _____

Service Capacity

EMT Type: ☐Type 1 Mobile (mobile clinic) ☐Type 1 Fixed (clinic) ☐Type 2   ☐Type 3
☐Specialized cell *(Please specify)*:_____

(Refer to http://www.who.int/hac/global_health_cluster/fmt_guidelines_september2013.pdf for FMT category definitions)

Will your team bring a field facility or field hospital?
☐Yes (if so, state bed capacity ###, and estimated number of tents ###, and size of each tent ###m^2)
☐No

Outpatient Capacity: *Number of patients to be seen per day*		Other Capabilities: ☐General Anaesthesia ☐Intensive Care
Inpatient Capacity: *Number of hospitalized patients at any one time (i.e. bed capacity)*		☐X-Ray Facility ☐Laboratory Facility
Surgical Capacity (if relevant): *Number of procedures (major or minor) per day*		☐Blood Bank ☐Pharmacy

What Clinical Services will this team offer?

Additional Public Health capabilities?

Deployment Details

Time to arrival in country: ## days   **OR**   Date Arrived dd/mm/20yy

Time to start of service provision: ## days   **OR**   Date Services Begun dd/mm/20yy

Maximum Length of Stay: ## days

Any logistical limitations or support required:
Consider capabilities for self-sufficient deployment to rural or remote areas; food, accommodation, fuel and transportation needs; supply chain and cold chain capabilities; and medical waste management

☐Manifest or 'cargo document' attached

Staffing Details

Type	Number of International Staff	Expected Number of Local Staff
Medical Doctors/Physicians		
Nurses		
Allied Health Personnel		
Logistics and Operational Support		
Administrative and Other Staff		

Document Checklist for International Staff: ☐Current Practice License (e.g. Medical, Nursing etc.)
☐ *CV of all practitioners (if applicable)*
☐Copy of Passport
☐ *Visa Documents (if applicable)*
☐ *Other required documents as per government*

END OF **SECTION B**

Internal Office Use Only				
Team Status:	☐Approved	☐Pending	Reason:	
	☐Tasked	☐Declined	Reason:	
Allocated Site:	*Location* *GPS Coordinates*		**Allocation Date:**	dd / mm / yyyy
Other Comments:	*(e.g. reason for changing type vs the self-declaration from the team)*			

Country, Event, Year

World Health Organization

DAILY REPORTING FORM

A. Reporting Details

Date: dd/mm/yyyy

Reporting Period: dd/mm/yyyy to dd/mm/yyyy

Daily reporting is for the 24-hour period up to 4.59pm range instead

*If **NOT** using for daily reporting, please insert date range instead*

Reporting site (e.g. name of hospital or EMT plus Type #): _____

District: _____

Site Type: _____

Select public or private; district hospital, community/primary health center, or field hospital

Name of Focal Point: _____

Organization: _____

Email: example@who.int _____

Phone: + country - area - phone number

B. Summary Indicators

Outpatient **Consultations**	New Inpatient **Admissions**	Hospital Deaths		Bed Capacity (at 5pm)	
		<5 years old	>=5 years old	Occupied Beds	Total # of Beds

C. Service Demands

	Total	<5 years old	>=5 years old
Outpatient Consultations			
Inpatient Admissions			
Referrals (to another facility)			
Surgical and Trauma Services:			
Minor Surgery			
Major Surgery *Excluding Caesarean sections*			
Trauma Cases (event-related)			
Lower Limb Amputations* *Excluding toe amputations*		Male: Female:	Male: Female:
External Fixation* *Proxy for complex orthopedic fractures*		Male: Female:	Male: Female:
Spinal Cord Injuries*		Male: Female:	Male: Female:
Other Activities:			
Insert any other relevant activities e.g. Caesarean Sections, Deliveries etc.			

*Indicators to anticipate longer-term rehabilitation service demands

Please fax or email Daily Reports to Dr. *Insert Name* at ##-###-#### or *example@moh*, by **6pm** each day
If you have any questions, please contact Dr. *Insert Name* at ##-###-####.

D. Communicable Disease Surveillance

Number of NEW Cases	<5 years	>=5 years	Total
Acute Respiratory Tract Infection			
Acute Watery Diarrhoea			
Acute Bloody Diarrhoea			
Other Diarrhoea			
Fever with Jaundice			
Fever with Rash			
Fever of Unknown Cause			
Insert Other Conditions of Importance for Location or Context			

Does the data above suggest a potential outbreak?
☐Yes (if so, what outbreak: _____ and where: _____)
☐No

E. Situation Overview

1. Overall situation in vicinity (major needs, infrastructure affected etc.):

2. Any immediate needs or support required:

3. Other issues:

Report Compiled by: _____ **Signature:** _____

Position: _____

END OF **REPORT**

Case Definitions

Condition	Definition
Major Surgery	Surgical procedure that involves incision of deep tissue structures (beyond deep fascia) or entry into a body cavity, and usually requires general or regional anaesthesia (e.g. open reduction internal fixation, trauma laparotomy)
Minor Surgery	Surgical procedure that involves incision of the skin or mucus membranes and superficial connective tissues only, and can be acceptably performed under local anaesthesia or conscious sedation (e.g. simple abscess incision and drainage, superficial wound closure)
Spinal Cord Injury	Temporary or permanent sensory and motor deficit clinically consistent with injury to the spinal cord within the context of recent, acute trauma to the back
Acute Watery Diarrhea	At least 3 non-bloody stools with abnormal or watery consistency every 24 hours
Acute Bloody Diarrhea	At least 3 bloody stools every 24 hours
Fever with Jaundice	Fever over 38°C with yellowish discoloration of eyes, tongue or skin
Insert Additional Conditions	

Please fax or email Daily Reports to Dr. *Insert Name* at ##-###-#### or *example @moh*, by **6pm** each day
If you have any questions, please contact Dr. *Insert Name* at ##-###-####.

Page **2** of 2

World Health Organization

Emergency Medical Team Coordination Cell

SITUATION REPORT

Reporting Period:

☐ **Daily** (24-hour period up to and including 16.59pm)   Date: dd/mm/yyyy

☐ **Weekly** (7-day period up to and including day of report) Week End Date: dd/mm/yyyy

Location: _____

A. Situation Overview

B. Emergency Medical Teams

1. Current EMT Capacity (number of teams):

	NEW this Period	EXITS this Period	Current TOTAL	Type 1 Mobile	Type 1 Fixed	Type 2 No Facility	Type 2 with Facility	Type 3	Special Cell: *Specify*	Special Cell: Other
Operational *Tasked and deployed to site*										
Awaiting *Awaiting tasking or deployment*										
TOTAL										

2. Map of Deployed EMTs
[Attach map of geographical distribution of currently operational and tasked FMTs, color-coded by type. If possible, include existing local resources as well as areas of need or residual gaps]

C. Priority Needs

Location	Needs and Gaps

D. Key Indicators

Number of EMTs Reporting: ### out of ### teams *(i.e. proportion of EMTs that are reporting)*

Service Demand		Mortality and Morbidity	
Total Outpatient Consultations		Overall (Inpatient) Mortality Rate	
Total Inpatient Admissions		Under 5 (Inpatient) Mortality Rate	
Total Bed Capacity		New Cases of Event-related Trauma	
Average Bed Occupancy		New Cases with Rehabilitation Needs*	
Total Surgical Procedures			
Insert Other Service Indicators		*Insert Other Relevant Conditions*	

*New Cases with Rehabilitation Needs estimated by sum of new lower limb amputations, external fixations and spinal cord injuries (some duplicate counting will occur)

Are there any indications of a potential outbreak?
☐ Yes (if so, what outbreak: _____ and where: _____)
☐ No

E. Other Issues

Consider, for example, Safety and Security situation, Environmental issues, Remote Area Access, Gender issues etc.

Report Compiled by: _____ **Signature:** _____

Position: _____

END OF **REPORT**

F. EMT Arrival and Departure List (Supplement)

Reporting Period: dd/mm/yyyy to dd/mm/yyyy

EMT Arrivals this Period

Team Name (Country)	Type	Deployment Location	Date of Arrival
Insert Rows as Needed			

EMT Departures this Period

Team Name (Country)	Type	Deployment Location(s)	Date of Departure
Insert Rows as Needed			

World Health Organization

Country, Event, Year

EMERGENCY MEDICAL TEAM EXIT REPORT

Insert Team/Organization Name

A. Team Details

Name of Team Leader: _____

Current or Most Recent

Original Registration: ☐WHO   ☐Ministry of Health   ☐Other: _____

Select all that apply

Team Classification: ☐Type 1 Fixed   ☐Type 1 Mobile
                        ☐Type 2
                        ☐Type 3
                        ☐Special Cell(s): *(Please specify)* _____

Date of Arrival (in-country): dd/mm/20yy
Date Service Provision started: dd/mm/20yy   Operational Duration: ### Days
Date (or intended date) of Departure: dd/mm/20yy   **Total Duration of Mission: ### Days**
Contact Person post-deployment: *(For follow-up after return home)*

Name: _____   Position: _____

Email: _____   Phone: + ### - ## - ### - ####

B. Activities and Services Provided

Deployment(s):

If the team provided services at a fixed facility, but simultaneously provided mobile or outreach services to another site, please document as separate entries

Dates	Location	Fixed or Mobile	On-site Partner(s) *I.e. with existing agreements*
Start: dd/mm/20yy End: dd/mm/20yy	District: Site: *e.g. Name of Facility or Village*	☐Fixed Facility ☐Outreach/Mobile	☐MOH/District Health ☐National EMT ☐International EMT
Start: dd/mm/20yy End: dd/mm/20yy	District: Site: *e.g. Name of Facility or Village*	☐Fixed Facility ☐Outreach/Mobile	☐MOH/District Health ☐National EMT ☐International EMT
Start: dd/mm/20yy End: dd/mm/20yy	District: Site: *e.g. Name of Facility or Village*	☐Fixed Facility ☐Outreach/Mobile	☐MOH/District Health ☐National EMT ☐International EMT

Please return to **EMT Coordination Cell (*example@who.in*)**. If you have any questions, please contact *Name* at *example@who.int* or ##-###-####

Start: dd/mm/20yy End: dd/mm/20yy	District: Site: *e.g. Name of Facility or Village*	☐Fixed Facility ☐Outreach/Mobile	☐MOH/District Health ☐National EMT ☐International EMT
Start: dd/mm/20yy End: dd/mm/20yy	District: Site: *e.g. Name of Facility or Village*	☐Fixed Facility ☐Outreach/Mobile	☐MOH/District Health ☐National EMT ☐International EMT

Services and Outcomes:

Services	Total	Outcomes	Total
Outpatient Consultations		Facility Deaths	
Inpatient Admissions		Patients with ongoing Rehabilitation Needs	
Major Surgical Procedures		Referrals/Transfers	
Minor Surgical Procedures		*Specify Referral/Transfer Destination(s):*	

Other Services: ☐WASH   ☐Nutrition

☐Health Education   ☐Psychosocial Support

☐Surveillance   ☐Other: _____

C. Experience and Feedback

1. Needs Identified and Addressed

2. Challenges and Issues Encountered

3. Remaining or Ongoing Needs

4. Recommendations and Remarks

Please return to **EMT Coordination Cell (*example@who.in*)**. If you have any questions, please contact *Name* at *example@who.int* or *##-###-####*

Page **2** of **3**

D. Transition and Exit

1. Services and Facilities of EMT have been:

☐ Closed

☐ Handed over to MOH

☐ Handed over to a National EMT: _____

☐ Handed over to an International EMT: _____

☐ Other: *(Please specify)* _____

2. Post-operative Surgical Follow-up Arrangements:

☐ Yes, specify: _____

☐ No, reason: _____

☐ Not Applicable

3. Number of Remaining Inpatients at Departure: ###

   Transfer Destination, if applicable: _____

   Please complete and attach Section E. Transferred Patients at Exit (if applicable)

4. Have all relevant medical files and notes been handed over? *(Includes medical files of transferred patients, patients requiring follow-up, and patients with ongoing rehabilitation needs)*

☐ Yes, specify: _____

☐ No, reason: _____

☐ Not Applicable
Please complete and attach Section F. Patients with Ongoing Follow-up or Rehabilitation Needs (if applicable)

5. Equipment and Supplies Donated at Departure?

☐ Yes, specify recipient(s): _____
If yes, please complete and attach Section G. Donated Medications List and/or Section H. Donated Equipment or Supply List

☐ No

Report by: _____ **Signature:** _____ **Date:** dd/mm/20yy

END OF **EXIT REPORT**

Please return to **EMT Coordination Cell (*example@who.in*)**. If you have any questions, please contact *Name* at *example@who.int* or *##-###-####*

E. Transferred Patients at Exit (Exit Report Supplement)

Name	Age	Gender	Address (Village/Town)	Diagnosis	Transfer Destination	Medical Files Handed over
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

F. Patients with Ongoing Follow-up or Rehabilitation Needs (Exit Report Supplement)

Name	Age	Gender	Address (Village/Town)	Diagnosis	Follow-up or Rehabilitation Needs	Medical Files Handed over
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

G. Donated Medication List (Exit Report Supplement)

Please complete a separate sheet for each Recipient Facility

Recipient Facility Name: _____

Person Responsible for Receiving Donations: _____

Medication *State generic and brand name, dosage and form, e.g. Amoxicillin (Amoxil) 250mg capsules*	Quantity *Include units, e.g. tablets, ampules*	Expiry Date *DD / MM / YYYY*	Additional Notes

H. Donated Equipment or Supply List (Exit Report Supplement)

Please complete a separate sheet for each Recipient Facility

Recipient Facility Name: _____

Person Responsible for Receiving Donations: _____

Item	Quantity	Training*	User Manual*	Additional Notes

*Please indicate **Yes/No** for whether **training** has been provided to local staff and/or a **user manual** provided in relation to the donated medical equipment; or **N/A** if not applicable.*

Please return to **EMT Coordination Cell (*example@who.in*). If you have any questions, please contact Name at *example@who.int* or ##-###-####**

Country, Event, Year

World Health Organization

PATIENT REFERRAL FORM

Date: dd/mm/yyyy

Referral to: Name of facility or service

Focal point: Full name   Phone: + country - area - phone number

Location: Address/Site/District   Email: example@who.int

Referring from: Name of facility or service

Focal point: Full name   Phone: + country - area - phone number

Location: Address/Site/District   Email: example@who.int

Patient Information

Full Name		Phone	+ country - area - phone number
Date of birth	dd/mm/yyyy	Gender	
Address of discharge destination (if known)			
Accompanied by care provider ☐ Yes ☐ No			

Primary Diagnoses: 1. _____

2. _____

3. _____

Other Diagnoses: _____

_____

Treatments initiated:

- _____ ☐ Ongoing
- _____ ☐ Ongoing
- _____ ☐ Ongoing
- _____ ☐ Ongoing
- _____ ☐ Ongoing
- _____ ☐ Ongoing

For questions regarding referrals, please contact *Insert Name* at *##-###-###* .

*Please attach copy of medication chart at discharge **or** list of current medications (including dose and time of last dose)

Reason for referral: ☐ Inpatient ☐Outpatient ☐Community

_____

_____

Transportation needs: Transfer requirements, special considerations, frequency

Follow-up requirements Such as date of surgical review, removal of cast, or removal of external fixator

Functional Status

Mobility   ☐Bed bound ☐Wheelchair ☐Crutches ☐Walking frame ☐Requires assistance ☐Independent

Precautions: Such as weight bearing restrictions or spinal precautions

Self-care   ☐Carer dependent ☐Requires commode ☐ Requires modified latrine/washroom ☐Independent

Cognitive impairment ☐No ☐Yes _____

Assistive devices(s) provided:_____

Assistive device(s) required:_____

Compiled by: _____   **Signature:** _____

Position: _____

NOTE: This form must accompany the patient's medical file and a copy of the form should be retained by the referring team.

END OF **REFERRAL FORM**

For questions regarding referrals, please contact *Insert Name* at *##-###-###* .

World Health
Organization

EMT COORDINATION MEETING MINUTES

Date: dd/mm/yyyy

1. Welcome and opening remarks

This aims to be an operationally focused Coordination meeting for teams providing medical and health related care to the population affected by the event.

2. Updates from the chair (MoH) and co-chairs

Situation overview, requests from MoH/National Authorities, identified needs.

3. Response Overview (EMTs)

 # EMTs (both National and International) with breakdown by type and location, feedback on daily reporting, sharing of SOPs and treatment guidelines.

4. Standing Items

- *Safety and security*
- *Transport and common logistical needs*
- *Remote area access*
- *Cultural issues and guidance*
- *Environmental issues*
- *Gender issues*
- *Reporting requirements*
- *Other issues*

5. EMT Tasking/Update from EMTs

Key updates by location, introduction of newly arrived EMTs

Meeting practicalities (next meeting, time and location)

ANNEX II. OFFICE SETUP AND EQUIPMENT CHECKLIST

The EMTCC Office requires basic office supplies, telecommunications, information technology, and utilities. Some of these requirements may be obtained from the location and/or entity within which the EMTCC is situated. Ideally, the EMTCC Office should be co-located within the MOH (preferably within or in close proximity to the HEOC).

The following provides a checklist of possible office needs. This is neither exhaustive nor prescriptive.

Office Location Requirements:

- Proximity to MOH (and other UN coordinating entities if possible)
- Sufficient floor space (depending on anticipated size of team, average of 10 members)
- Telecommunications and internet connectivity
- Reliable electricity supply

Information Technology:

- Laptops
- Printer and spare ink cartridges
- Scanner
- Digital camera
- External hard-drive (for archiving)
- USB Drives
- Projector
- Speakers

Basic equipment:

- Tables and chairs
- White boards/flipcharts
- Maps
- Stationary (notebooks, paper etc.)
- Pens, markers etc.
- Miscellaneous office supplies (scissors, tape, glue, stapler, folders)
- Filing cabinet
- Adaptors
- Power cables and multi-plugs
- Chargers
- Batteries and portable power banks
- Lighting

Telecommunications:

- Phone (landline)
- Mobile (cell) Phones
- Satellite Phone
- Wireless router and modem
- Radio

Miscellaneous:

- Tent (if field office required)
- Safe box
- First Aid kit
- Basic Maintenance kit
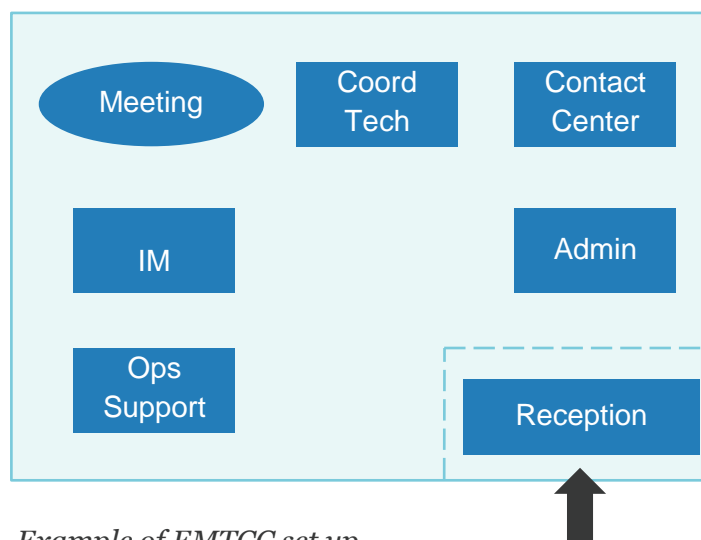
*Example of EMTCC set up*

ANNEX III. INFORMATION ARCHIVING SYSTEM

EMTCC Mission Archive <Year_Country_Event>
- 📁 00 Team Administration
    - + **<Surname_First Name**> of each team member
        - - Scanned passport, visa, medical record, vaccinations etc.
- 📁 01 EMT Registrations
    - + **<EMT Name**>
        - - Registration Forms, accompanying documents etc.
- 📁 02 EMT Tasking and Deployments
    - - Letters of Deployment **<YYMMDD_EMT Name_ Letter of Deployment.doc**>
- 📁 03 EMT Daily Reports
    - + <Locality or District Name>
        - + **<EMT Name**>
            - - <YYMMDD_EMT Name_ Daily Report.doc>
- 📁 04 Quality Control
    - + **EMT Field Visits and Verification**
        - + **<EMT Name**>
    - + **Complaints**
        - - **<YYMMDD_EMT Name_Complaint.doc**>
- 📁 05 EMT Exit Planning and Reports
    - + **<EMT Name**>
        - - **<YYMMDD_EMT Name_Exit Plan.doc**>
        - - **<EMT Name_Exit Report.doc**>
- 📁 06 Liaisons and External Relationships
    - + **Ministry of Health**
    - + **WCO**
    - + **OSOCC**
    - + **Civil Military Coordination**
    - + **Media**
    - + *Insert Other*
- 📁 07 Meeting Minutes
    - + **EMT Coordination Meetings**
        - - **<YYMMDD_EMT_Meeting_Minutes.doc**>
    - + **EMTCC Internal Meetings**
        - - **<YYMMDD_EMTCC_Meeting_Minutes.doc**>
- 📁 08 EMTCC Situation Reports and Maps
    - - **<YYMMDD_EMTCC_Situation_Report.doc**>
- 📁 09 External Reports and Maps
    - + **UN OCHA**
    - + **MOH**
    - + *Insert Other Source Organizations*
- 📁 10 Transition and Exit
    - + **EMTCC Transition and Exit Planning**
    - + **EMTCC Evaluation Surveys**
    - + **EMTCC Internal Feedback**
    - - **<EMTCC_EndofMission_Report.doc**>
- 📁 11 Other External Resources
- 📁 12 Pictures and Other Media

ANNEX IV. EXAMPLES OF EMTCC TEAMS

Examples of EMTCC team size and composition from previous emergency responses are provided below. This provides an idea of the scaling up or down, and varying compositions of the EMTCC team depending on the situation and needs.

Example, 2015 Nepal Earthquake Response (Number of operational EMTs = 137), at one point:
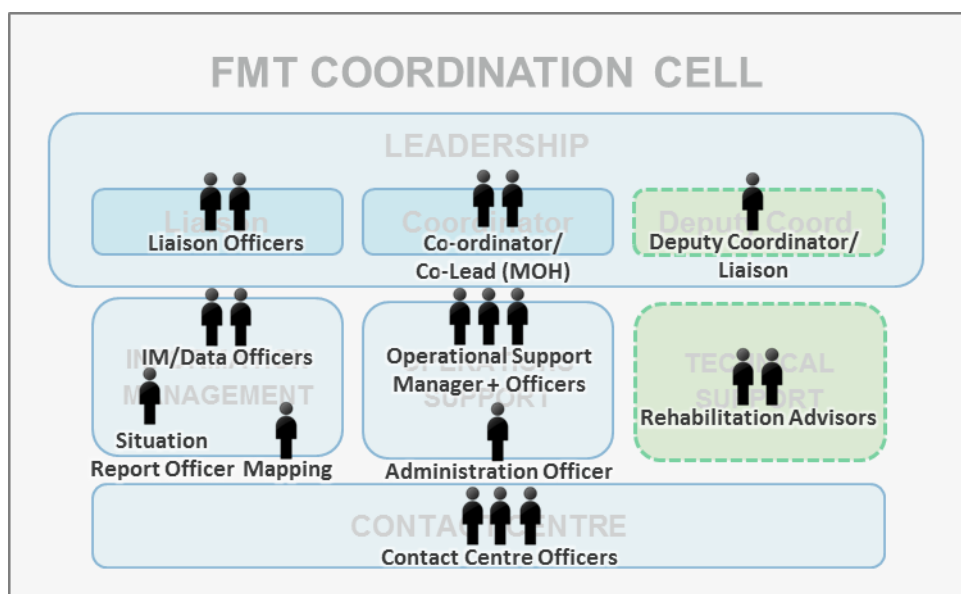
Example, 2014-2015 Guinea Ebola Response (Number of operational EMTs = 7), at one point:
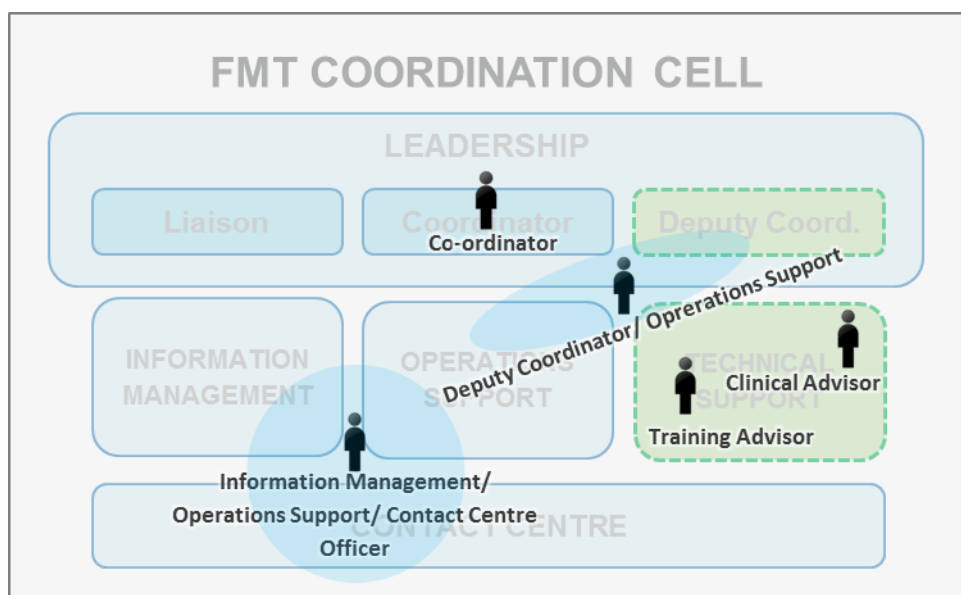
ANNEX V. EMTCC MEMBER RESPONSIBILITIES

This provides a guideline of the common responsibilities of individual team members, regardless of their function or position within the EMTCC.

Pre-Mission (International Staff)

- Hold a valid passport (more than 6 months from expiry) and appropriate visa

- Have appropriate travel insurance coverage

- Ensure necessary vaccinations are up to date

- Obtain pre-travel medical check-up, if required (to ensure appropriate physical and mental health status, and sufficient routine and prophylactic medications)

- Understand role and responsibility in initial POA

- Understand the current country and emergency context

On Mission

- Fulfil roles and responsibilities of assigned function, as detailed in the Terms of Reference (TOR), but maintain flexibility to expand or change roles according to the evolving needs of the EMTCC

- Identify MOH and local capacity gaps relating to assigned function, and actively work to build needed capacity (for example, through training and knowledge transfer) throughout the duration of the mission

Mission End

- Complete and submit an individual End of Mission Report (which is essential for effective handover and transfer of knowledge to the incipient). This should include:

    - Details of the role and responsibilities

    - Outline of immediate next steps, including priorities

    - Anticipated issues and challenges

    - Key lessons learned

    - Essential resources and information sources for specific role

- Complete and submit EMTCC Internal Feedback Survey

- Debrief with EMTCC lead and EMT Secretariat (if required)

- Obtain post-travel check-up, including assessment of psychosocial and mental health needs

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