EMERGENCY MEDICAL TEAMS

COORDINATION HANDBOOK

World Health Organization

EMT

Emergency Medical Team Coordination Cell (EMTCC)

COORDINATION HANDBOOK

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ABBREVIATIONS

EMT	Emergency Medical Team *(encompasses N-EMT and I-EMT)*
EMTCC	Emergency Medical Team Coordination Cell
HEOC	Health Emergency Operational Centre
HuMOCC	Humanitarian-Military Operations Coordination Cell
I-EMT	International Emergency Medical Team *(subgroup of EMT)*
INSARAG	International Search and Rescue Advisory Group
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 Centre
PAHO	Pan American Health Organization
RDC	Reception and Departure Centre
SOD	Sudden Onset Disaster
SOP	Standard Operating Procedure
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNDAC	United Nations Disaster Assessment and Coordination
USAR	Urban Search and Rescue
VOSOCC	Virtual On-Site Operations Coordination Centre
WHA	World Health Assembly
WHO	World Health Organization

This edition of the Coordination Handbook uses the term Emergency Medical Team (EMT) Coordination Cell. 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.

The EMT definition seeks to apply to everyone from very small groups of medical personnel arriving with back packs to large professional teams from international and nongovernmental organizations and governments. This can apply to teams with or without field hospitals, an important change from previous Pan American Health Organization (PAHO) guidelines, and describes the services and people more than the facilities that they may or may not bring.

EMT refers 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 nongovernmental teams and can be sub classified as either national or international, dependent on the area of response.

1. INTRODUCTION

1.1 Evolution of Emergency Medical Team Coordination

Emergencies with health consequences are increasing. Natural disasters, disease outbreaks, civil conflicts and rising global population and urbanization means more people than ever find themselves in harm's way, with the poor and marginalized most vulnerable.

In the immediate aftermath of the 2010 earthquake in Haiti, hundreds of medical response teams descended on an overwhelmed national health system. Many of these teams were poorly prepared, unlicensed for clinical practice within the country and lacking in basic self-sufficiency. Attempts to coordinate the deployment and operational management of these medical teams failed, which in turn led to wholly unsatisfactory outcomes for the affected population. As a result, the global medical community made a collective vow never to repeat the same mistakes again. Hence, the first seeds of the Emergency Medical Team (EMT) Initiative were sewn.

In today's multilateral response environment, coordination is at the heart of an effective rapid response to health-related emergencies and for the delivery of humanitarian assistance. Governments have a primary role and responsibility in developing robust domestic health systems, integrating all-hazards health emergency and disaster risk-management programmes into national or subnational health plans and institutionalizing capacities for coordinated responses during health-related emergencies, disasters and other crises (WHA 64.10; WHA 68.27). . For most sudden onset disasters, disease outbreaks or civil conflicts, national EMTs (N-EMTs) are almost always better placed to provide immediate assistance to those in need. During large-scale disasters, national authorities often turn to the international community for additional help, which brings in more trained, self-sufficient medical teams as surge capacity, to provide the fastest and most effective response possible for victims in affected areas.

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 granted a stronger mandate and broader scope 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 Sendai Framework for Disaster Risk Reduction 2015-2030 calls for a renewed focus on improving relevant laws and regulations as well as strengthening their implementation and enforcement. However, despite these efforts, a need for further improvement remains.

WHO established the Emergency Medical Teams Initiative with the goal of ensuring rapid deployment of quality-assured medical personnel to emergencies. These EMTs, composed of health professionals, including doctors, nurses, paramedics and supportive staff come from governments, nongovernmental organizations (NGOs), militaries and international organizations, such as the International Red Cross and Red Crescent Movement. They comply with the classification and minimum standards set by WHO and its partners, and arrive pre-trained and self-sufficient, in order to avoid further burdening an often overwhelmed national health system.

EMTs have a long history of responding to sudden onset disasters, such as the Haiti earthquake, the Indian Ocean Tsunami and floods in Pakistan. Although EMTs have traditionally had a trauma and surgical focus, the Ebola crisis highlighted their value in outbreak response and other types of emergencies.

Coordination is the key to deploying EMTs to widely varying emergencies in the most efficient way. Local training in the coordination of EMTs avoids duplication of effort and wasted resources, ensuring the right teams and appropriate resources

are swiftly despatched to where they are needed most, providing effective help to the greatest number of victims and saving the most lives.

Efforts to strengthen the coordination of EMTs, however, have been a relatively recent initiative, catalysed by the shortcomings of existing international and national mechanisms to adequately filter and coordinate responding EMTs. This was starkly highlighted during the 2010 Haiti earthquake response (Gerdin et al., 2012). In addition, much has been learnt and adapted in the past 25 years from the experience of international search and rescue response operations and coordination, as developed and agreed upon by the International Search and Rescue Advisory Group (INSARAG), together with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA). INSARAG successfully established a peer review classification system for Urban Search and Rescue (USAR) teams and agreed to develop common quality standards and coordination mechanisms.

The Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters (WHO, 2013) was also developed. This provided a common nomenclature for EMTs to communicate their capabilities and intended services, and established quality and service benchmarks. More recently, an EMT Global Classification mechanism was launched as a platform to pre-register and pre-verify EMTs to speed-up and enhance emergency response and coordination.

Given that National Emergency Medical Teams (N-EMTs) are usually better placed to provide immediate assistance, the core objective of the EMT Initiative is both strengthening N-EMTs' response capacity to emergencies and the capacity of the national health authority to coordinate N-EMT response.

Progress has also occurred at the field level. During the 2013 Typhoon Haiyan (Yolanda) response in the Philippines, for the first time the EMT Classification and Minimum Standards were applied with demonstrable benefit to coordination (Brolin et al., 2015). More explicit EMT coordination, with defined registration and tasking processes, was employed during the 2014–2015 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 and supported by WHO, was established and utilized with very positive feedback from national authorities and EMT responders. Having recently been trained in EMTCC by WHO, Ecuador's Ministry of Public Health was well prepared and able to deploy 22 N-EMTs within hours of a 7.8-magnitude earthquake that struck the country in 2016. They were assisted by seven International Emergency Medical Teams (I-EMTs) dispatched from Colombia, Germany, Israel, Peru, Spain and the United States of America. The response highlighted the importance of preparation, as the training on EMTCC allowed for near optimal application and set up of the EMTCC by the ministry for the smooth coordination of both N-EMTs and I-EMTs.

This revised edition of the Handbook represents the next phase in strengthening EMT coordination at the field level. Following a collaborative review process in early 2017 involving EMT stakeholders from all regions, this revised edition aims to provide a practical guide with recommended procedures and standardized resources to ensure the establishment and effective implementation of EMT coordination in the field. Major revisions include more prominent positioning of the EMT Life Cycle within the Handbook and a readjustment of all terminology to ensure equal applicability for all EMTCC users, regardless of scenario.

1.2 Global EMT Quality Assurance and Classification

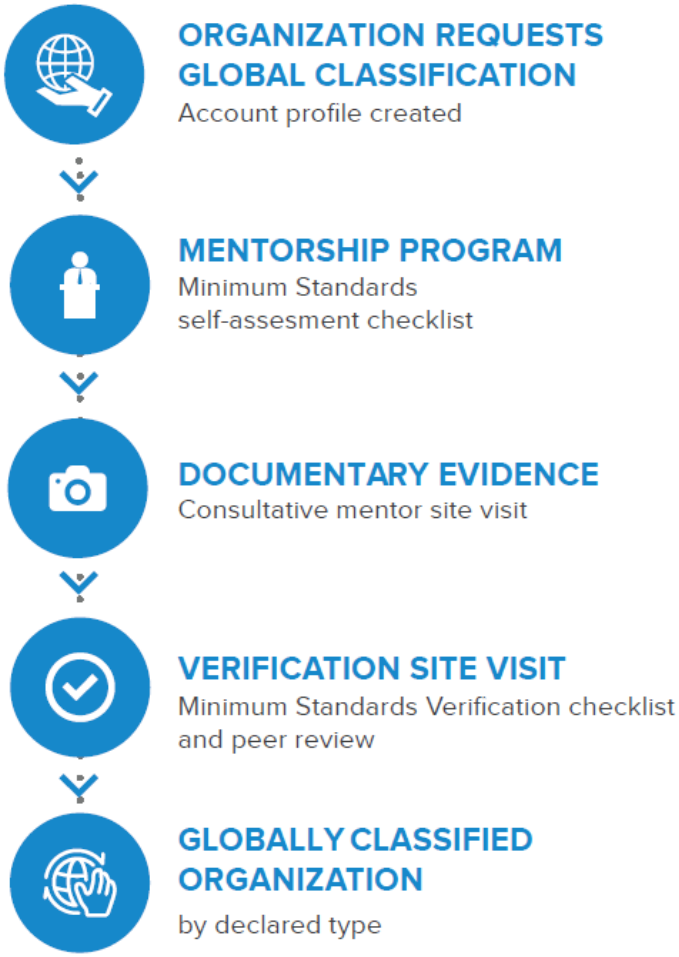
In July 2015, WHO launched the EMT Global Classification mechanism for verifying stated capabilities (and compliance with the agreed set of principles and technical standards for EMTs) of EMT-capable organizations, including their status of readiness for deployment. Findings from reviews of the latest EMT responses have suggested changes in the EMT Classification and these proposed changes, such as Type 1 sub-grouped into Mobile and Fixed, were 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 a specialist cell when given in emergency response by EMT providers, such as rehabilitation, paediatric or surgery.

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

Fig. 1 EMT Global Classification process



Global Classification does not replace a country's own process of authorizing I-EMTs to enter and operate within their territory, but supports it with better information on available EMTs and details of their adherence to standards, experience, capability and key contacts. Affected countries can rapidly identify and accept pre-verified EMTs, having full knowledge of their type and capabilities well in advance. In general, countries prone to natural disasters and outbreaks may also use the EMTs minimum standards to improve the effectiveness of the immediate response of N-EMTs.

For EMT providers, the benefits of global classification include: easier invitation to be deployed; an expedited registration process; access to logistic support; on-site guidance; and increased confidence for donors funding classified EMTs.

1.3 The need for an EMT Coordination Cell (EMTCC)

The coordination of EMTs presents unique complexities. This in part stems from increasing numbers of EMTs responding to large-scale emergencies, particularly sudden onset disasters (SOD), compounded by 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 address this.

Complexities also arise from the varied population needs EMTs must be adequately matched to as part of coordination efforts. This means that effective coordination requires more than a simple, one-dimensional pairing of supply to demand, as encapsulated by common indicators, such as the number of hospital beds or health-care workers per unit of population. Specific needs of an affected population are influenced by many factors, including population composition, nature and phase of the emergency, locality, geographical terrain, and pre-emergency health status and risks.

When I-EMTs are requested, coordination efforts must ensure their integration with the host country's existing national health system, which can vary significantly in structure, quality and capacity. Deployment of I-EMTs also needs to integrate with the mechanisms and methodologies for the overall coordination of the international response, including the On-Site Operations Coordination Centre (OSOCC) and health cluster, if existing and activated. Successful coordination means those affected seamlessly access various 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 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 that performed the surgery.

Lastly, EMTs have unique logistic essentials, such as oxygen supply and medical waste management, which may require specialized coordination for efficient resource utilization and shared benefit across both N-EMTs and I-EMTs.

Managing these needs and negotiating the complexity involved in their coordination demands a high level of specialized expertise and experience. Therefore, effective EMT coordination benefits from a dedicated coordination cell that can handle the unique challenges of EMTs.

1.3 Scope of the EMTCC

The core purpose of the EMTCC is coordinating the surge of responding EMTs, both national and international, to best meet excess health-care needs resulting from increased morbidity or from damage to existing capacity.

Ideally, the EMTCC should be an entirely internal ministry of health entity (or a national authority equivalent) that is activated, managed and staffed by trained and experienced personnel from within the ministry of health. However, in many cases, the ministry requires external support and expertise to operationalize an EMTCC. Where external support is utilized, the primary responsibility for coordination remains with the ministry of health or national authority. External support temporarily bridge gaps in the functioning of the EMTCC while working to build and transfer this coordination capacity back to the ministry of health.

The essence of coordination is accurately matching available resources to identified needs, resulting in optimal resource utilization and maximum effectiveness. This forms the basis for the scope of EMTCC activities which can be divided into four broad areas.

1. Leadership and Coordination

2. Communication (with EMTs, the ministry of health 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 are akin to WHO's critical functions for emergency response (leadership, partner coordination, information and planning, health operations and technical expertise, operations support and logistics, finance and administration) as outlined in the *Emergency Response Framework* (WHO, 2017). The technical expertise function spans both the coordination and quality assurance functions of the EMTCC and relates to the technical aspects of coordinating EMTs in large-scale emergencies, as well as the promotion and on-site verification of compliance with EMT Minimum Standards and other national requirements.

1.4 Critical assumptions for successful EMT coordination

Successful EMT coordination requires four other critical requirements beyond an effective Coordination Cell.

- **Acceptance and buy-in from the ministry of health (or national authority equivalent) of the affected country**
  The responsibility and authority for coordination (including request and acceptance of I-EMTs) lies with the national authority. Therefore, any coordination mechanism must integrate with the national system and be agreed upon by the national authority. Routine discussions and the establishment of agreements need to take place as part of preparedness and national capacity strengthening.

- **Acceptance and buy-in from responding EMTs**
  This requires open dialogue with EMTs (preferably prior to emergency onset) regarding the purpose and processes of EMT coordination. The collective benefits for EMTs as well as affected populations 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 pre-registration in the Global EMT Classification.

- **Pre-positioned and/or rapidly deployable human resources, financial and information technology support**
  It is important to facilitate the timely activation and deployment of trained and experienced EMT Coordinators and other team members, and to support their in-country activities. An example of pre-positioned support is a pre-designed and ready-to-activate platform for information management.

- **Clear linkages with the wider coordination structure of international humanitarian assistance**
  This includes the required linkages and information exchange with the On-Site Operations Coordination Centre (OSOCC), usually established close to the disaster-affected area and managed by the United Nations Disaster Assessment and Coordination (UNDAC) team and/or other response teams, and health cluster if activated.

2. EMTCC WITHIN THE MULTI-AGENCY RESPONSE SYSTEM

2.1 Response scenarios

Three scenarios can occur depending on the balance between the need for medical care and the local availability of services and expertise:

- the capacity of health services at the national level is clearly sufficient to provide timely care to the affected population;
- the number of people requiring medical assistance is likely to exceed the treatment and care capacity of the affected country's health system; and
- the complexity of the emergency requires an additional level of expertise and support that is absent or limited at the national level.

Scenario A. This situation is seen particularly in larger, developed or emerging countries. Local teams are better placed to provide rapid and context-based assistance, but may lack the required support (such as supplies, equipment, communication, transport and personal subsistence) and related systems to optimize response. In this case, the affected country must indicate very early on that I-EMTs are not required. However, limited initial information on the impact of the event and imprecise judgments about the national capacity to respond mean that caution should be exercised by national authorities before concluding that no external medical assistance is needed. In fact, external specialized medical and public health expertise can facilitate and support the national health system to deliver life-saving and specialized services, including rehabilitation, spinal injuries care, burn care, or outbreak response.

Scenario B. This situation is most likely to occur in countries with limited resources or poor health coverage. Countries prone to disasters and/or emergencies require adequate preparation for predictable reception and coordination of N-EMTs and I-EMTs. 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, I-EMTs committed to meeting agreed standards, including registration with the relevant national authority of the host country, which is the only legitimate authority able to accept or refuse a responding I-EMT.

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

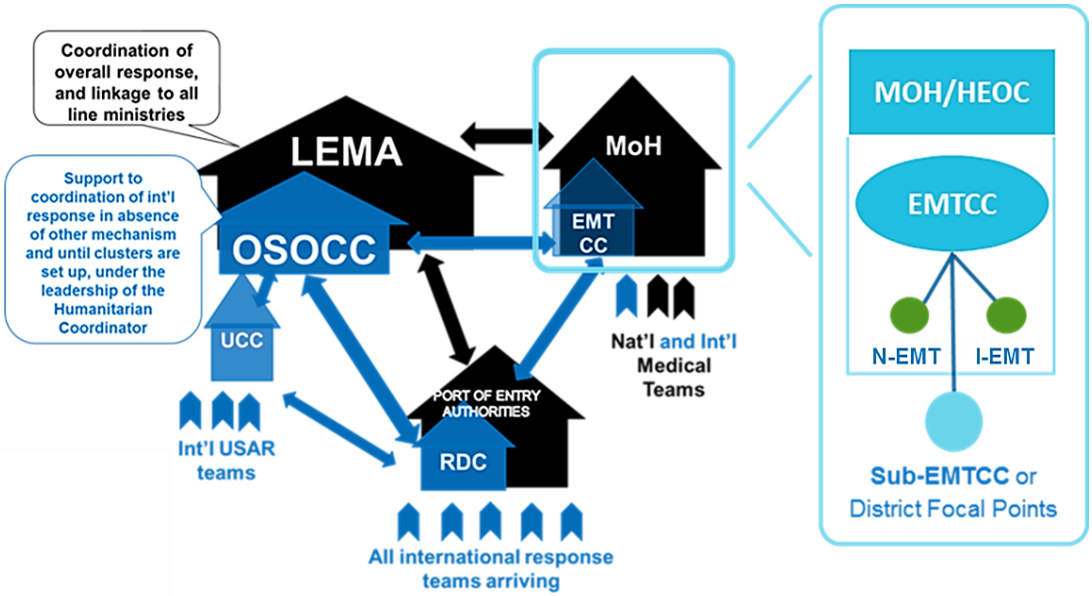
2.2 Field response mechanisms

Major emergencies and disasters require many aid agencies on the ground. Effective coordination can help avoid gaps or duplication, and 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 the response by ensuring greater predictability, accountability and partnership. The schematic representation of the EMTCC within the Humanitarian Response System (see Fig. 1) is an attempt to address all three of these core objectives. Other key operational partnerships that the EMTCC is likely to establish are listed below, although many other actors, systems and networks are also involved in supporting the population affected by the disaster and/or emergency.

- WHO Country Office
- Health Cluster
- Humanitarian-Military Operations Coordination Cell
- District Health Officers/Hospitals Directors
- Field Coordination/Humanitarian Hubs

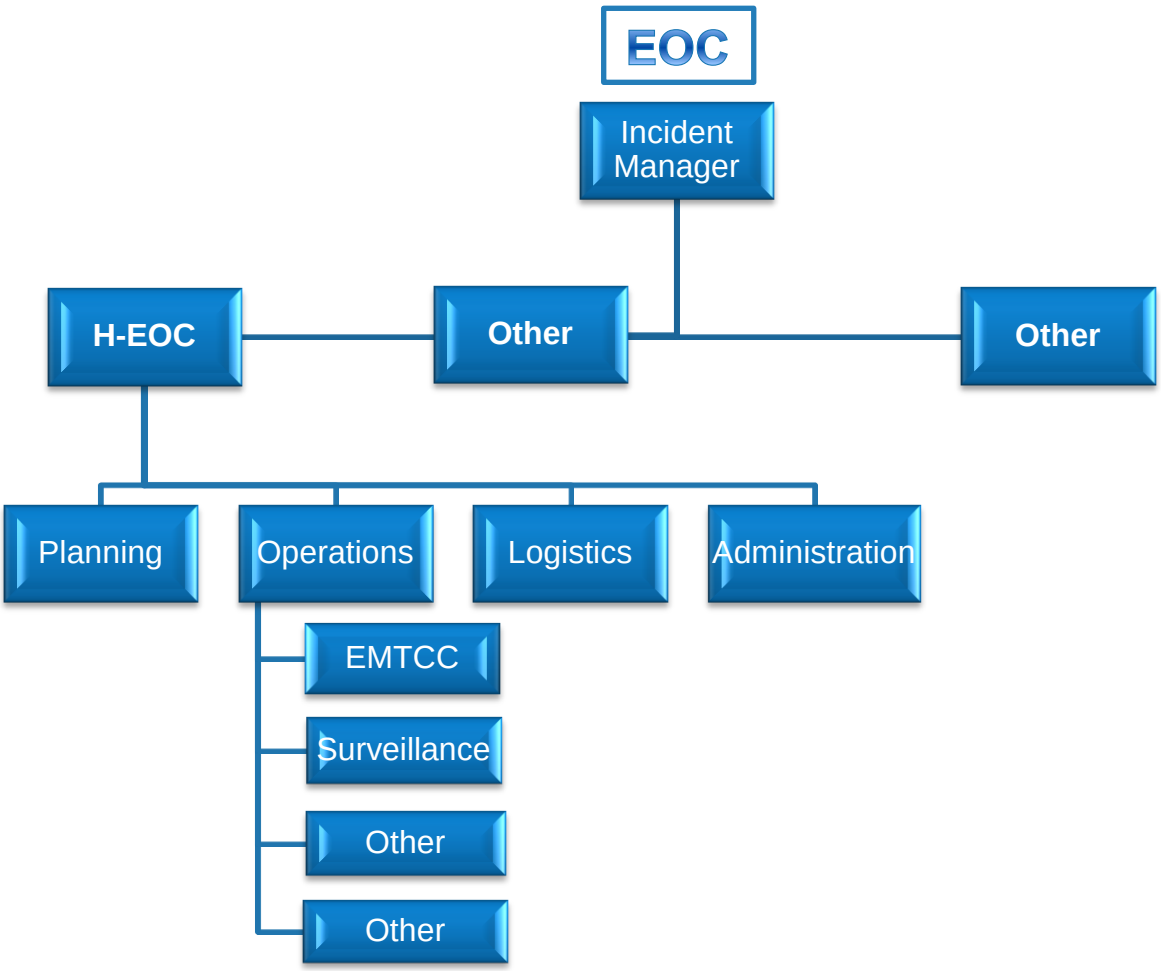
Fig. 2 EMTCC within the Humanitarian Response System



This method 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 operations phase. During this period, national and international teams working alongside each other encourages sharing of knowledge and best practices.

Co-location of the EMTCC within the ministry of health structure provides opportunities for face-to-face interaction which, in turn, 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 by promoting an inclusive coordination mechanism within an existing Health Emergency Operational Centre (HEOC). Benefits include increased capabilities at the N-EMT level as well as more effective integration and connection of I-EMTs with existing national health services.

Fig. 3 EMTCC integration within the H-EOC (example)



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

Despite the benefits of this model and the strong links with key stakeholders potentially generated for the EMTCC, there may be situations in which national authorities will separate the coordination of N-EMTs and I-EMTs.

Following a major disaster, an OSOCC is established as soon as possible, often by the UNDAC team deployed by OCHA. In earthquake responses with the deployment of international urban search and rescue teams, a USAR Coordination Cell (UCC) will also be established, either by the government or by the first arriving trained USAR or UNDAC team. The first arriving international urban search and rescue team may also support the establishment of a provisional OSOCC.

As part of the OSOCC, a Reception and Departure Centre (RDC) is also typically established at the point of entry for I-EMTs, usually the international airport or seaport, with a view to guiding arriving teams to the relevant coordination mechanism for further tasking—the process of assigning a location, a specific role and a reporting channel to arriving EMTs. Ideally, the

RDC is set-up by national authorities with support from the UNDAC team or the first arriving response team trained in RDC methodology. INSARAG-classified USAR teams are responsible for establishing the initial RDC if they are the first to arrive, and may continue to support RDC operations throughout. Similarly, incoming I-EMTs support the set-up and running of the RDC, or carry out a similar role if none already exists, until it is taken over by the ministry of health with the support of WHO for coordination of the health response. Further guidance on the specific coordination challenges involved in RDC management is provided in Chapter 5 of the Handbook.

The ideal set-up explained above assumes that the ministry of health and/or the relevant national authority has the capacity to manage the full cycle of I-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 (SOPs) and coordination mechanisms in place.

If ministry of health 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 complex or protracted crisis, its establishment will occur under the Health Cluster in the form of a "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 the ministry of health	Liaison function and/or remote support from WHO
Government coordination capacity requires temporary support	Set up and run by the ministry of health	A different level of support (minimum to high) from WHO, OCHA and other partners
Government coordination capacity is limited or constrained	Sub-cluster under Health Cluster	Conflict or protracted crises

Recent events have shown the importance of ministry of health ownership of the EMTCC and its positioning within the national health emergency response system. Thus, the EMTCC should be perceived as an entity in which all functions are performed within its life cycle, including activities related to the preparedness phase (see Chapter 3).

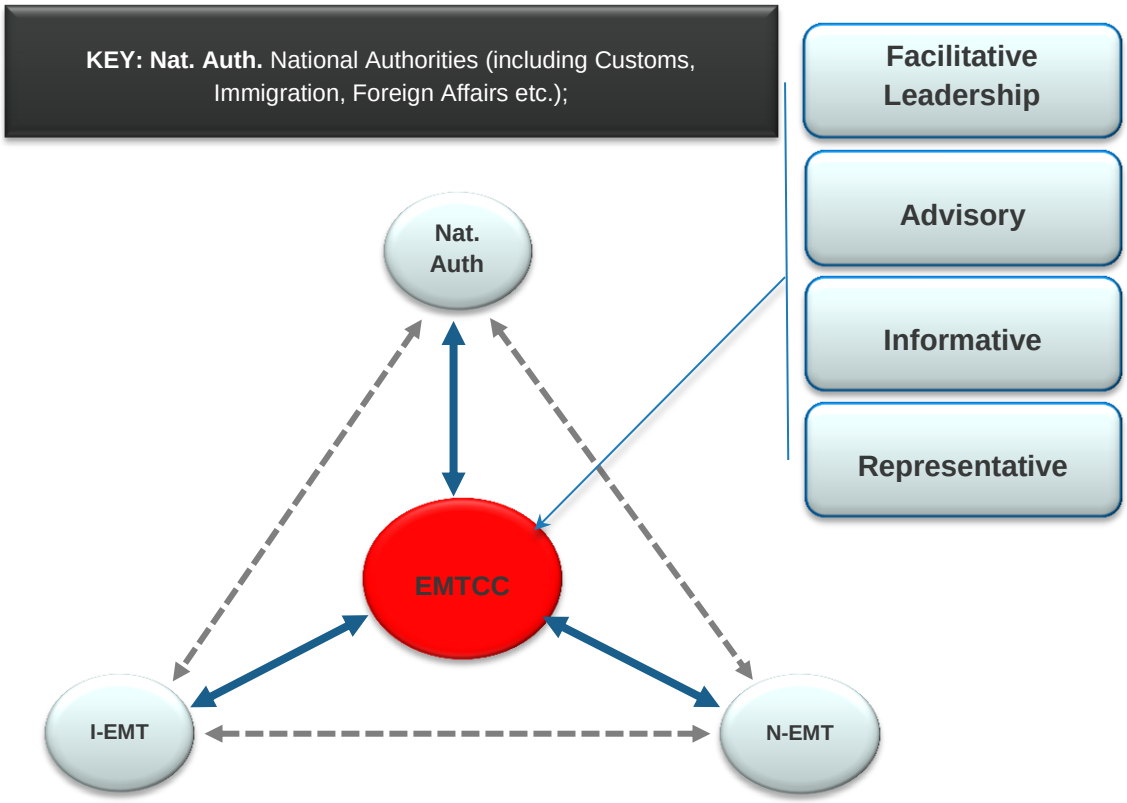
The assessment of country capacity (the development of the framework and related tools is on-going) to ensure the overall coordination of responding EMTs (both national and international) and the quality of care provided, should include as a minimum the following elements:

- legal framework as a set of legislations, regulations and laws to support the implementation and maintenance of the EMT coordination mechanism;
- adoption of the EMT Minimum Standards and related required technical standards at national level;
- identification of National EMT Focal Point(s) and definition of a strategy to train personnel on EMT/EMTCC;
- establishment and regular testing of SOPs for the EMTCC mechanism; and
- definition of clear processes and protocols for EMT reporting.

2.3 Relational partnerships and roles of the EMTCC

Essential 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 include: other entities within the ministry of health (for example, the HEOC); entities of the national authority (such as customs and immigration departments), and the National Emergency Management Agency (NEMA); components of the international multiagency response system (for example, OCHA, OSOCC, RDC, and Health Cluster); and N-EMTs and I-EMTs. The diverse relational partnerships of the EMTCC also strengthen linkages and connectivity between stakeholders. This forms the basis of the facilitative leadership role of the EMTCC (see Fig. 3).

Fig. 4 Relational partnerships and roles of the EMTCC



Even though the EMTCC primarily carries out a supportive or facilitative role, such as providing guidance, contributing to strategy development and connectivity as part of the ministry of health, it may be required to adopt a range of roles or approaches within its relationships, depending on the stakeholders involved and the objectives. The four key relational roles of the EMTCC are as follows.

- **Facilitative leadership**

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

Examples:

Negotiating with other national authorities to establish a streamlined visa and customs procedure for all I-EMTs. This facilitates the rapid deployment of I-EMTs into the affected country and reduces the workload of national authorities in dealing with each EMT.

Establishing and reinforcing requirements for entry and exit procedures as well as daily reporting from I-EMTs.

- **Advisory**

The EMTCC, as a specialized cell with unique technical expertise, also holds an advisory role. Its general expertise includes 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 partners on the ideal mechanism for managing the arrival and registration of incoming I-EMTs.

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

- **Informative**

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

Example:

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

- **Representative**

This is an implicit role of the EMTCC, and is a critical coordinating function in facilitating connectivity, speed and "visibility" of the N-EMT and I-EMT response. The EMTCC should be perceived as a representative focal point for EMTs.

Examples:

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

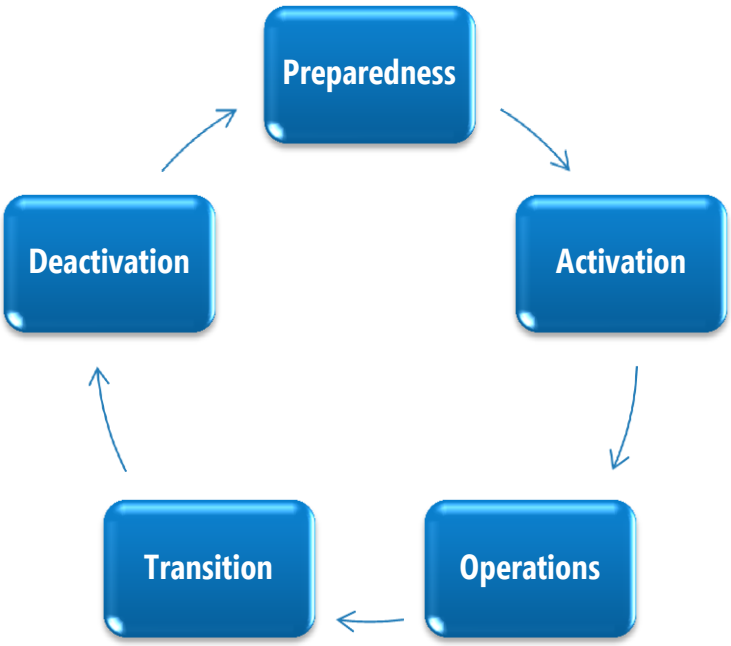
Reprimanding or correcting unacceptable behaviour from rogue EMTs to maintain a positive image of EMT response.

3. THE EMTCC LIFE CYCLE

For many users, the EMTCC life cycle is perhaps the most important section of the EMTCC Coordination Handbook. The aim is to lay out potential coordination activities in a chronological sequence as they might typically occur before, during and immediately after an emergency response.

As shown in Fig. 5 below, this chronology can be viewed as a continuous flow through five key stages.

Fig. 5 EMTCC Life Cycle



The following sections tabulate the standard activities to be conducted by the Coordination Cell and EMTs within each stage of the life cycle. Note that the exact combination of activities will differ according to the scenario of response (see Handbook Chapter 2.1) and the degree of support needed to supplement national ministry of health coordination capacity (see Handbook Chapter 2.2). Where international assistance is not requested some activities may not apply.

For those readers who require further information on specific coordination activities within the life cycle stages, additional detail is provided in Chapter 5.

3.1 Preparedness

Coordination Cell	National EMT	International EMT
EMT Initiative to provide mentorship and support to EMTs through the WHO Global Classification process and maintain an active discussion on Minimum Standards.	**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 EMT Minimum Standards, combined with the highest possible level of readiness.	
EMT Secretariat to coordinate the mentorship and verification phases of I-EMTs to be classified and listed in the EMT Global Classification.	**Register within existing national coordination structures** Knowledge of and engagement in the National Disaster Response Plan. Enrolment in the national N-EMT accreditation process and simulation exercises.	**Register on the EMT Global Classification** The EMT directory provides a database of pre-verified I-EMTs that meet 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.
Ministry of health to identify EMTCC focal point(s) to lead on national preparedness measures, supported by a trained cadre. Identify where the cell would be **structurally positioned** and activated within the HEOC, and ensure that SOPs for coordinating both N-EMTs and I-EMTs are included in national response planning processes and documentation. Assess the **potential need for international assistance**, including initial brief analysis of higher risk scenarios.	**Brief analysis of the possible scenario and evaluation of internal capability for intervention.** Brief analysis of the complexity of the emergency, context of operations and initial availability of resources to support deployment.	

3.2 Activation

Coordination Cell	National EMT	International EMT
Formally **activate EMTCC** in accordance with recommended guidance. Establish **a physical base for EMTCC coordination activities** – see Annex II. One of the priority supportive functions to operationalize is the **Contact Centre**, 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. Conduct preliminary **needs analysis.** **Collate information** on the capabilities (including type, logistical support, and duration of stay) of all available EMTs.	**Confirm status and capability to respond** Confirmation of status (availability) and capability as per National Disaster Response Plan. N-EMT not formally included in the plan should submit an offer of assistance using the appropriate registration form and comply with the process.	**Submit Offer of Assistance** Formal offers of international assistance should be submitted to the recipient ministry of health and where required, to the recipient ministry of foreign affairs. Deployment 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. This online form is also available on the Virtual OSOCC and EMTs should register and update their information there for coordination purposes (vosocc.unocha.org).
Confirm I-EMT Arrival and **Registration SOPs**. This is a priority action to be undertaken by the ministry of health in collaboration with other entities (if relevant), ideally prior to the arrival in country of the first I-EMTs, or within 24–48 hours of emergency onset. EMT Secretariat to help disseminate essential information about the arrival and registration procedures to all I-EMTs (including those already in-country), and make this available at all potential points of contact with EMTs, for example, Virtual OSOCC and the WHO EMT Initiative website.		**Obtain essential information for deployment** This includes I-EMT arrival and registration SOPs, registration requirements, and visa and customs procedures. The Coordination Cell will support dissemination of this information to all EMTs via Virtual OSOCC.

Ensure continuous EMTCC **representation at the RDC**		**Report to the RDC or support establishment of initial RDC** Initial registration at the RDC flags the in-country arrival of an I-EMT. Here, I-EMTs can obtain essential information, such as EMTCC location and contact details, and coordination meeting locations and times. I-EMTs may be requested to support the RDC operations, particularly as it pertains to the I-EMT coordination role of the RDC, or even – if the RDC does not yet exist – support the establishment thereof.
Collate and input EMT operational information on the **central database** to provide an overview of available resources.	**Register at the EMTCC** The EMT team leader should physically report to the EMTCC to complete EMT Registration and submit required documents. Required logistical support and other operational support needs should be raised with the EMTCC at this time.	
Match and task EMT to identified areas of need, in accordance with recommended guidance. Negotiate or obtain available **logistical support** and other relevant resources.	**Obtain tasked assignment** The EMTCC will liaise with the EMTs 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, for example, logistical support to EMT needs.	

3.3 Operations

Coordination Cell	National EMT	International EMT
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.	**Deploy to tasked site and begin operations** Information provided in the previous steps can facilitate deployment to assigned sites, such as through logistic support and liaison with local authorities. Reducing the time between deployment and the beginning of operations is crucial at this stage for life-saving service delivery.	

Establish **referral system** including SOPs. Provide standardized **Referral Forms** (if none pre-existing from the ministry of health), sample Patient Referral Form template available in Annex I.	**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, ongoing follow-up beyond departure of treating EMT or transfer to another facility.
Collect, analyse, process and **disseminate reporting data** from EMTs. Compile **situation reports** to inform EMTCC leadership and Humanitarian System, and feedback to EMTs.	**Periodic Reporting** Standardized periodic reporting (initially on a daily basis) to the EMTCC allows monitoring of service demands and rapid identification of residual gaps. It also allows notification of urgent issues to the EMTCC to ensure the appropriate response or support can be given.
Keep **track** of all anticipated **EMT transition/departure dates** and identify/address **possible gaps** in service provision. Identify **key steps for transitioning the EMTCC** to mainstream structures within the National Health System and/or Health Cluster. Conduct **Field Quality Assurance and Support Visits** to EMTs. Provide **Departure Package for EMTs**, including departure SOPs.	**Confirm Operational Plan and Exit Strategy (including informing EMTCC of anticipated transition/departure date)** Coordinated departure is important to ensure the smooth handover of care and continuity of service provision. Early communication of transition strategy and of anticipated departure date (at least 1–2 weeks prior) to the EMTCC will assist in coordinating either handover of services to another team or closure, if appropriate.

3.4 Transition

Coordination Cell	National EMT	International EMT
Confirm **handover** and **exit plan of all EMTs.**	**Prepare all communication and documentation for handover/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 of all **medical notes** as declared by EMT on Exit Report.	**Handover all medical notes to incoming EMT** Handover of medical notes is essential to ensure continuity of patient care following EMT departure.
Support the compilation of a **master list of donated items** and their re-allocation according to needs.	**Compile and submit List of Donated Items** Provision of a Donated Items List strengthens accountability, and allows the ministry of health to re-distribute equipment to areas of specific need.

3.5 Deactivation

Coordination Cell	National EMT	International EMT
Collate, input and **analyse Exit Report data** from all EMTs and generate overall Exit Report. **Confer Letter of Appreciation** on receipt of all exit documents.	**Submit Exit Report to EMTCC** The Exit Report is an important mechanism for EMT to report their contribution and services in a standardized manner to the ministry of health. Standardized reporting across all EMTs also allow this data to be aggregated, analysed and reported.	
Collate, input and analyse Evaluation Survey data from all EMTs and generate Lessons Learnt Report to inform improvements to Coordination. **Deactivate** the EMTCC	**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.	

3.6 Summary of activities by time-frame

In conclusion, certain types of disasters can be predicted, an early warning issued and pre-positioning activities undertaken based on calculated risks, uncertainty and a rough estimation of the impact. Having an identified and trained National EMT Focal Point and EMTCC personnel during non-emergency periods is crucial to facilitating activation of the EMTCC and thereby reducing delays in EMT operations. Below are some key tasks/activities to be undertaken during the alert phase.

	CRITICAL TASKS/ACTIVITIES	✓
	Alert phase	
1.	Communications within the ministry of health (activation of HEOC) and WHO Country Office 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 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 time-frames, followed by a schematic representation of the operational support required or to be provided to the responding EMTs. The two checklists consider the onset of a disaster as the starting point and the 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

**Time-frames are relative to time of Emergency Event Onset, unless otherwise specified*

		CRITICAL TASKS/ACTIVITIES	✓
Activation		**Onset to 12 Hours**	
	1.	Decision on activation of the EMTCC	
	2.	Informational Invitation Letter to all EMTs sent	
	3.	Online Registrations activated (VOSOCC)	
	4.	Available country SOPs shared or posted on the website	
	5.	Coordination Cell team members contacted for availability and mobilized	
	6.	EMT Coordinator appointed	
	7.	Initial contact/information with affected area	
	8.	N-EMT registration process (capabilities)	
		12 to 24 Hours	
	9.	Decision on RDC establishment	
	10.	Preliminary needs analysis with N-EMT matching conducted	
	11.	I-EMT arrival and registration process confirmed	
	12.	Coordination Office and Contact Centre established	
Operations		**24 to 48 Hours**	
	13.	EMT Registration Database fully operational	
	14.	First list of all in-country EMTs generated	
	15.	First Situation Report	
	16.	Deployment SOPs and key information sent to all EMTs	
	17.	Preliminary needs analysis with I-EMT matching conducted	
	18.	First EMT Coordination meeting	
	19.	Integration of international EMTCC trained personnel (if requested)	
		> 48 Hours	
	20.	EMT Tasking fully operational	
	21.	Contact Centre staffed to demand and fully operational	
	22.	Regular EMT reporting established and enforced	
	23.	Real-time map of all EMTs and health-care assets and needs	
	24.	Referral system fully established	
	25.	Needs reassessed and further surge or stand-down called	
	26.	Daily Situation Report issued	
	27.	Initial Plan for Quality Assurance field visits developed	
		> Week 1	
	28.	First EMT reporting data analysis conducted and reported	
	29.	Departure SOPs sent to all EMTs	
	30.	Quality Assurance field visits conducted according to agreed plan	
	31.	Assess possible needs for EMTs re-tasking	

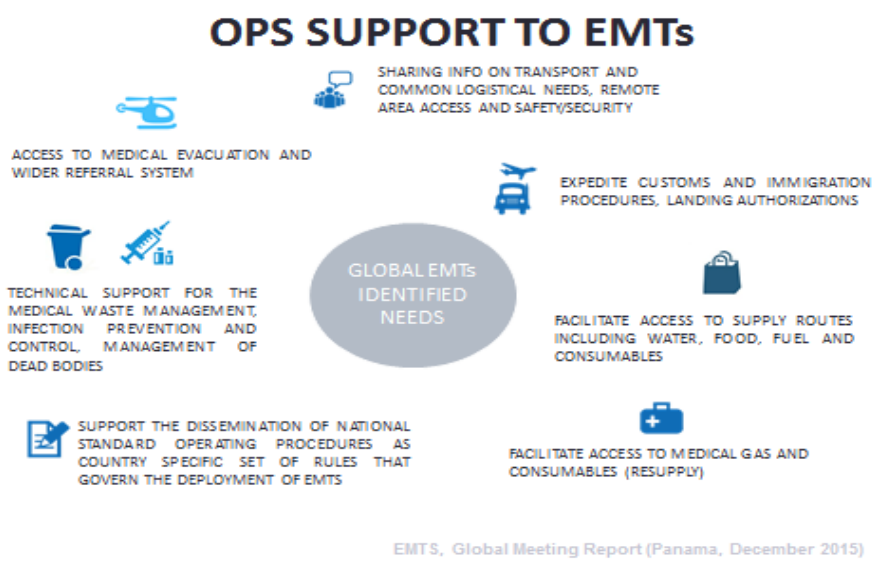
Checklist 2. Transition and Exit Checklist

**Transition includes management and coordination of departing EMTs*

Transition

Exit

	CRITICAL TASKS/ACTIVITIES	✓
	Onset of EMT departures or last 2–4 weeks	
1.	Exit Strategy finalized with ministry of health (HEOC) and initiated	
2.	All EMT departure dates collected	
3.	Coordinated exit or transition plan for each EMT completed	
4.	Departure SOPs reiterated and enforced	
5.	Plan for Coordination Cell Office step-down established	
	Last Week	
6.	Coordination Cell functions transitioned as per plan	
7.	Collection of Exit Reports from EMTs 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-deactivation	
12.	EMTCC Final Report completed	
13.	Evaluation and Feedback data collected and analysed	
14.	Lessons Learnt Report generated	
15.	Implementation of identified actions for future EMTCC activation	



4. EMTCC STRUCTURE

4.1 Collective functions of a EMTCC

a. Collecting and updating data for the classification of the actual type, capacity and services of EMTs throughout the entire response.

b. Screening incoming I-EMTs based on approved global professional standards leading to their eventual on-site authorization.

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

d. Ensuring and reinforcing EMT accountability to health authorities, including compliance with existing or forthcoming national guidelines and reporting requirements.

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

f. Providing sound and valuable support to speed up all related authorizations during operations of "authorized" EMTs.

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

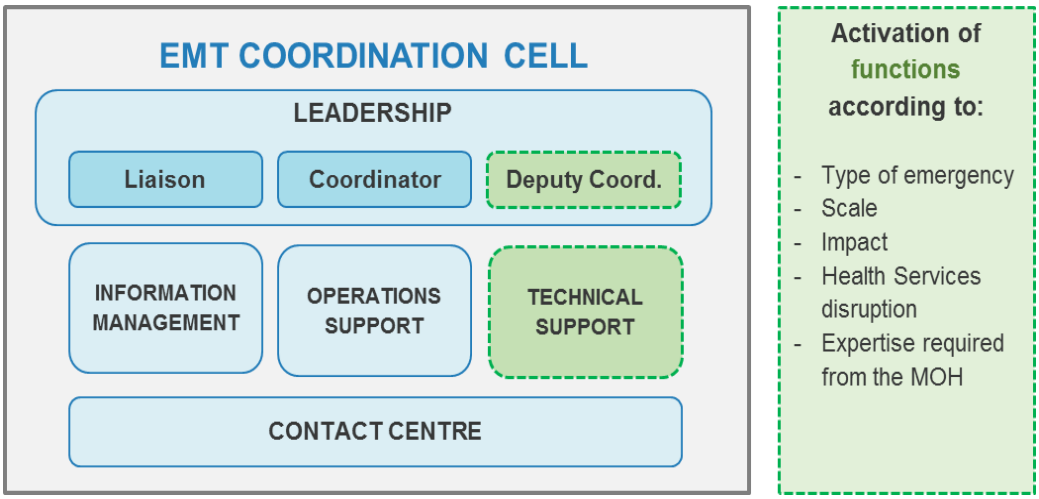
h. Providing and supporting the strategic and operational framework of the EMT response.

i. Formulating priorities on the basis of analysis.

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

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

Fig. 5 Coordination Cell Structure (Team Roles)



Team roles* within the EMTCC

* Leadership role is presented through 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 other national authorities, OSOCC, UNDAC team, Health Cluster, RDC 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 civilian and military components of the response, including through the OSOCC and/or the Humanitarian – Military Operations Coordination Cell (HuMOCC) - 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/administration of CC resources - Support the set up and running of the contact centre (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 Centre	- Registration of EMTs, and filing - Managing daily contact and correspondence with EMTs - First point of contact for EMTs - Note: 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 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.
Technical Support	- Rehabilitation Advisor - Clinical Advisor - Epidemiologist - Public Health Advisor - Logistics Advisor - Water, Sanitation and Hygiene (WASH) Engineer - Structural Engineer - Safety and Security Focal Point - Infection Prevention and Control (IPC) Advisor - Training Advisor

4.2 Staffing mechanisms and cell surge capacity

As indicated in the previous section, the EMTCC needs staff with a variety of skill sets to fulfil various functional roles, 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 context and needs, both through the various phases of an emergency and across different emergencies (examples of previous EMTCC size and composition are presented in Annex IV). This capacity for adaptation and surge requires a pre-existing pool of trained personnel (which not only includes coordinators but also support staff with EMT coordination training) from which team members can be readily accessed and deployed to rapidly operationalize an EMTCC where required, for any type of emergency and in any regional context. Pre-positioned human resources capacity not only fulfils 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 as follows.

- From within the **ministry of health 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 local context. The aim should be to build this capacity within every ministry of health or national authority as part of emergency preparedness.

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

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

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

Establishment of this flexible pool of trained EMTCC personnel accessible through various staffing mechanisms is the purpose of the EMT Coordination Training Courses, which are intended to be offered to a broad range of adequately qualified personnel who meet the various skillsets and roles (not just coordinators), from a wide range of organizations and response teams, including the ministry of health, NEMAs, WHO, UNDAC, EMTs providers and other partners with standby agreements.

5. SPECIFIC COORDINATION CHALLENGES

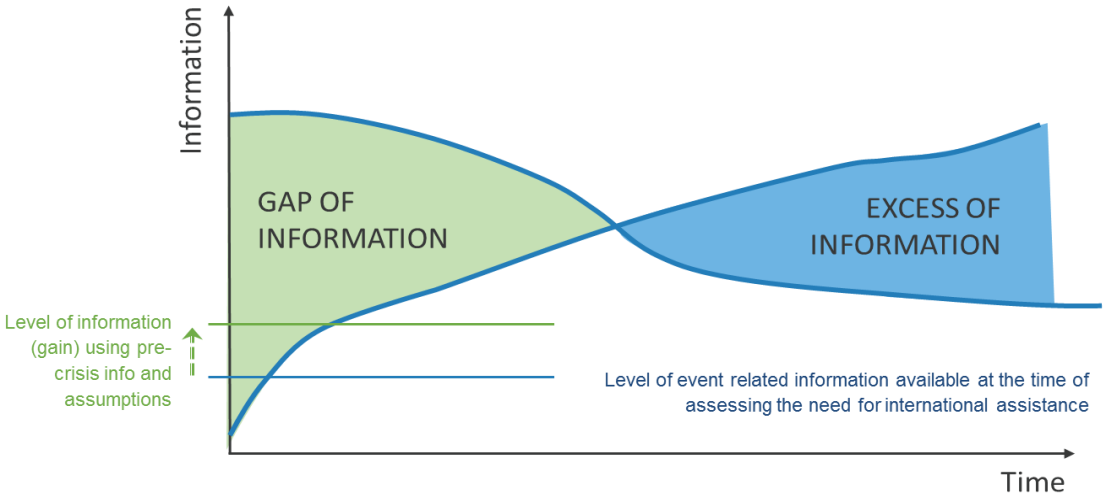
5.1 Activating the EMTCC

A variety of pre-crisis data collection initiatives exist, are implemented in several countries and represent essential references for secondary data review. At the onset of an emergency, when only limited information may be available, maximizing the use of pre-crisis information and baselines is vital, 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 should be made to speed up internal mobilization of N-EMTs and the call for international assistance (Fig. 6). The factors that can guide activation are, among others:

- estimation of health infrastructures damages, such as a secondary-level hospital partially damaged may require a EMT type 2 to substitute or augment its current capability;

- possible incidence rate of injuries and/or diseases (in an earthquake scenario, for example, the estimated ratio dead/injury is 1:3); and
- level of risk exposure of affected areas, for example, a high risk increases the likelihood of EMTs requirement.

Fig. 6 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. The ministry of health (and other related national authorities) with the support of WHO should err on the side of activating 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 and closely linked to the fulfilment of the critical assumption of pre-positioned or rapidly accessible human resources and funds.

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 (VOSOCC); establishing initial contact with the ministry of health and relevant national authorities; disseminating Informational Invitation Letters (available template in Annex I) to all EMT-capable organizations; identifying and assembling the EMTCC teams 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.

5.2 Registration of I-EMTs

When a request for international assistance is generated, additional registration procedures will become necessary for "filtering" incoming I-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. This will also make it difficult to anticipate and coordinate the logistical resources needed by EMTs. Some I-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 a late registration.

The EMTCC registration of EMTs is a response-specific registration and 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 to accompany the registration forms. This may include:

- passport copies of each team member;
- current practice license (meaning medical, nursing or relevant license) for clinical staff; and
- 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 activation from their country, which allows time for EMTCC processing (and ministry of health/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 arrival in-country to receive the 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 I-EMTs from pre-verified and registered organizations on the Global Classification already working in-country prior to the emergency that 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 organizations already present in-country should communicate their intention to respond in a way that maximizes complementarity and reduces the burden on an affected system.

5.3 Management of the Reception and Departure Centre

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 EMT.

RDC operations focus on the following.

- *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 this sets the tone for 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 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) where a significant number of teams or relief items are arriving? If so, does it make sense to divert additional 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 two staff full-time to the RDC;
b. office in a box with stationary material;
c. ITC capacity (laptop computer, BGAN, mobile, satellite phone at minimum);
d. RDC flag;
e. RDC forms and documents; and
f. self-sufficiency, including food and water, for at least two days, as well as sleeping bags and 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 are 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, including full registration, authorization to practice for medical staff and 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.

5.4 Tasking of EMTs

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 pre-set 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 at 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 the 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 ministry of health). 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 discussions between the EMTCC leadership, other stakeholders within the ministry of health 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; and
- correlate between levels of care and the importance of the three levels and EMT types (see Fig. 7 below).

Fig. 7 Correlation of levels of care and EMT type

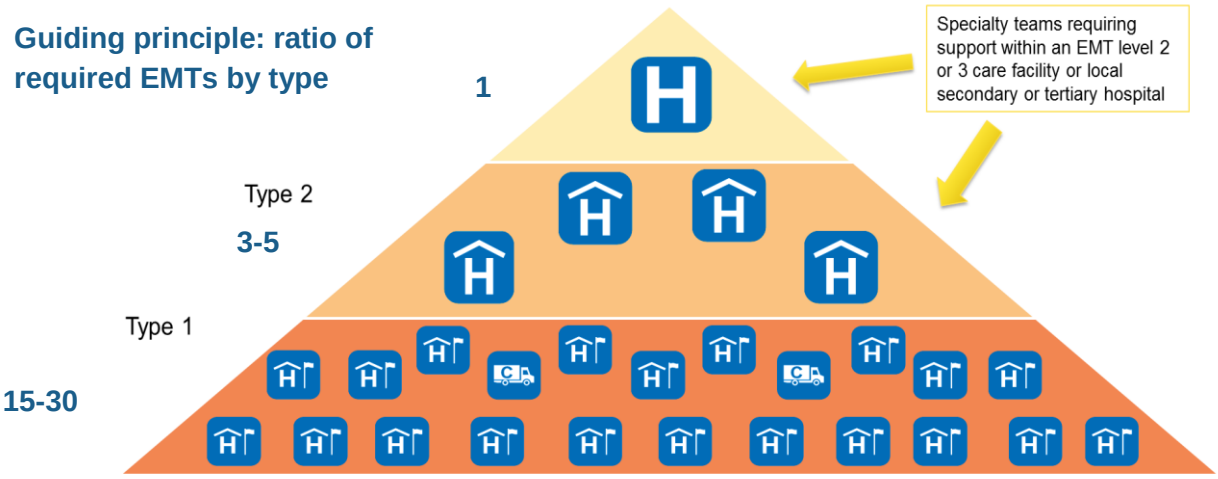
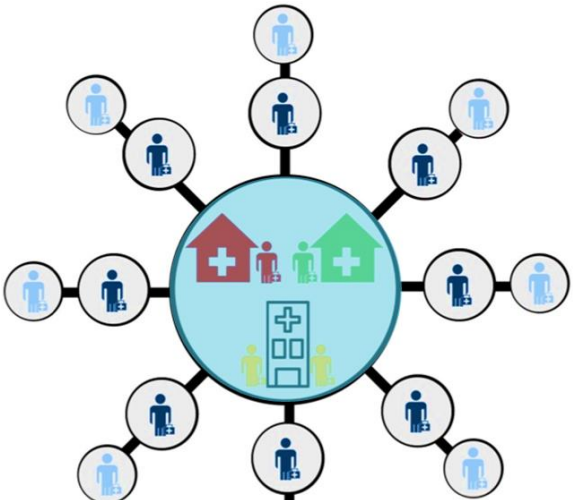


Fig. 8 Hub-and-Spoke model

The tasking of teams is usually based on the “Hub-and-Spoke” model that consists of placing larger teams at strategic locations with smaller teams (both fixed and mobile) fanning out from these points.



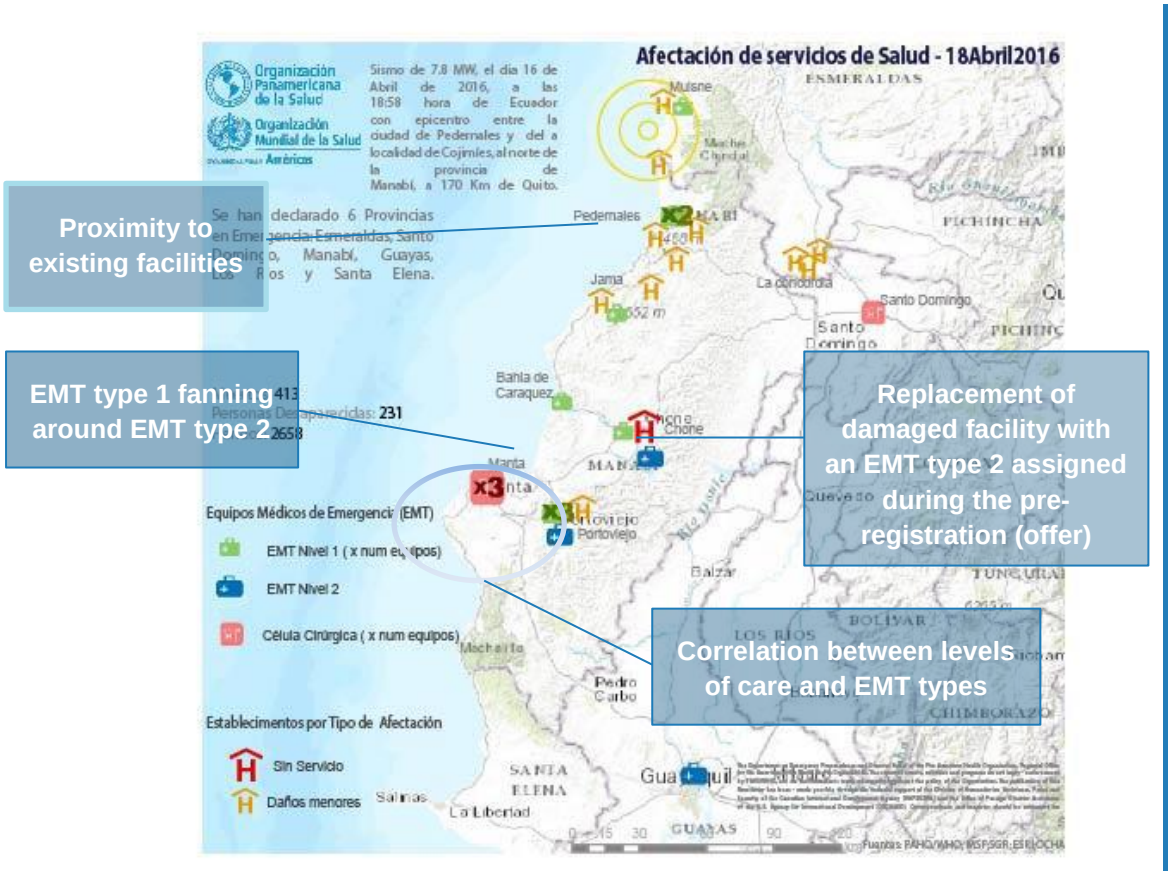
Case Study: Nepal Earthquake Response 2015

During the 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 a higher level of care. These included the district hospital, if the case was manageable at that level, or tertiary care facilities in the capital Kathmandu.

Case study: Ecuador Earthquake Response 2016

During the Ecuador earthquake response, the EMTCC tasked N-EMTs (17 within the first 24–48 hours) and selected a limited number of I-EMTs based on identified needs. Tasking of EMTs was based on the health administrative zones using the Hub-and-Spoke model and the factors mentioned above for an effective and efficient process.

Fig. 9 Tasking of N-EMTs and I-EMT (WHO/PAHO Situation Report n.3)



Tasking of teams can also be done 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. This was often the case in responses that required limited surge due to the scale of the event, emergencies that require specific expertise (cholera outbreak, for example), or a well-structured emergency preparedness plan.

Case Study: West Africa Ebola Response 2014–2015

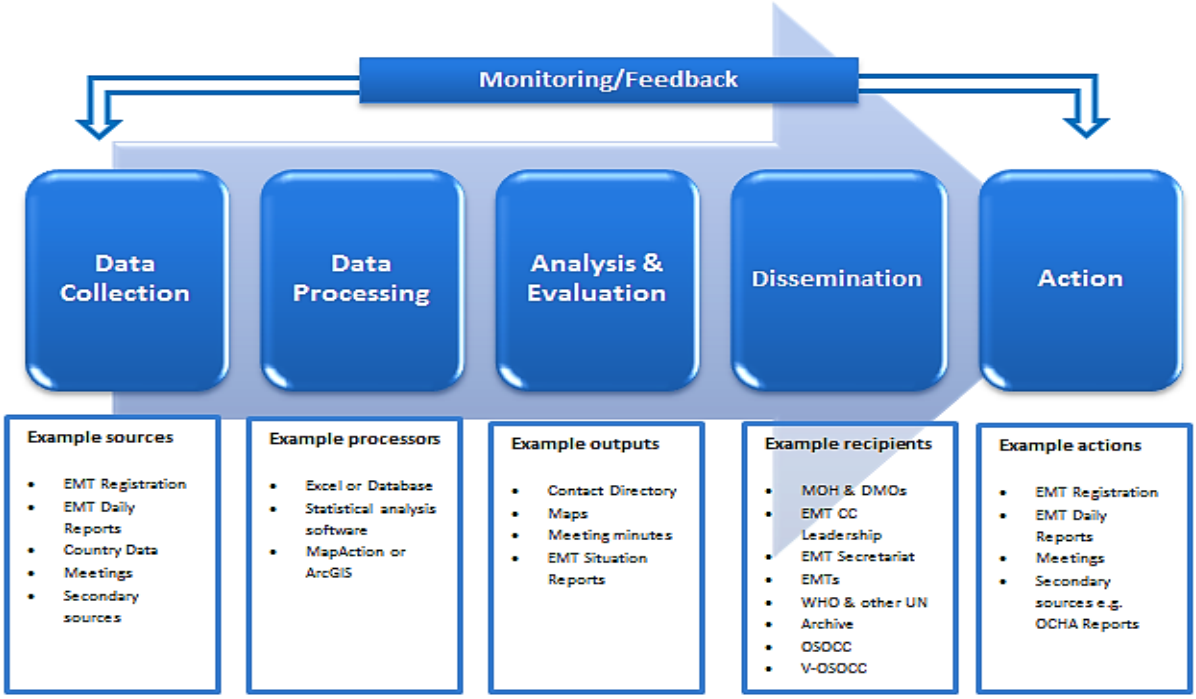
The escalating outbreak was set against the backdrop of already severely compromised health systems and significant deficits in capacity within the region. The locations of the Ebola Treatment Centres (ETCs) run by EMTs were chosen based on incidence rate, case load, population catchment area, access and community acceptance, to name few.

5.5 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 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 practical information (such as EMT contact details) that need to be collected, processed and packaged in a readily accessible format for the EMTCC to operate effectively. The Master List remains the key tool for collecting and sharing within the EMTCC all information related to EMTs and for support of 4W mapping (who, what, when and where).

Information Management encompasses all steps from data collection (in which the contact centre plays a key role) to dissemination, as shown in Fig. 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 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.

Fig. 9 Information Management Chain



Specific elements of the EMTCC Information Management chain that warrant further discussion are addressed in the following sections.

EMT Reporting

Reported information from deployed EMTs is extremely valuable for multiple purposes, including the following.

- 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 the 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 of the emergency. Alternatively, the form may need to be integrated with existing ministry of health reporting forms. For additional information please refer to the Minimum Data Set report.

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 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 a high workload at 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, although caution is necessary in relying on a third-party controlled platform; and
- more complex, purpose-built data management platforms that allow storage and analysis of all the information provided by EMTs.

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. 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 health-care 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 EMTCC team. Even in the absence of mapping expertise, collecting GPS coordinate information for EMT deployments and/or ensuring that the recorded location names for the sites of operations (village, sub-district and district) 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 or 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 Situation Report are all the operational partners illustrated in Fig. 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 the following.

1. Welcome and opening remarks
2. Situation Overview
   Updates from co-chairs of the meeting (ideally WHO and Ministry of Health, 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 beforehand, including online, at the airport, RDC, OSOCC, Virtual OSOCC, ministry of health and Health Cluster. 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.

DO's and DON'Ts
√ Start with the agenda and objective of the meeting (operational)
X Tasking of EMTs during the meeting
√ Provide clear instructions on operational requirements for EMTs
X Discuss specific requirements of one EMT
√ Present maps and data analysis outcomes
X Discuss topics outside the scope of the EMTCC
√ Be practical
X Updates from EMTs and questions outside of the allocated time
√ Choose a facilitation style that sets the right tone and appeal to your meeting attendees
X Become defensive if meeting participants provide critical feedback (instead, use this opportunity to better understand their needs)

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.

5.6 EMT field quality assurance and support visits

Field visits 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 field visits are as follows.

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; and
    - 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; and
    - coordination of other complementary assistance needed by the affected population, as identified by EMTs, such as food distribution, non-food items, water and sanitation.

Documentation and observation of variance or compliance with national protocols and EMT minimum standards form the basis for analysis of the quality of 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.

5.7 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 ensures 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 at the earliest opportunity. These requirements include the following.

- 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 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 hand-over 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 District Medical Officer (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. In the case of I-EMTs, these requirements should all be met before teams are issued with their Certificate of Service and Appreciation from the ministry of health or national authority.

The hand-over 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 ministry of health or 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 exiting EMT, the handover partner (if relevant), District Medical Officer and the EMTCC. Options for EMT exit include closure of services (if appropriate), matched handover to another EMT (which will require EMTCC coordination and tasking), or handover to an existing or re-established ministry of health or health service.

5.8 Deactivation of the EMTCC

In addition to coordinating the departure of EMTs, transition and deactivation planning for the EMTCC itself should begin at the earliest possible opportunity, typically after the second or third week when EMTCC operations are reasonably well-established. Deactivation planning 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 a 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 ministry of health general enquiries
Registration	Return to normal ministry of health/HEOC **OR** normal NGO registration procedures
EMT Tasking	Return to normal ministry of health/HEOC structures **OR** terminate
EMT Coordination Meetings	Terminate and return to Health Cluster meetings if activated (advise time and location)
EMT Daily Reporting	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 needs to be considered and communicated.*

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

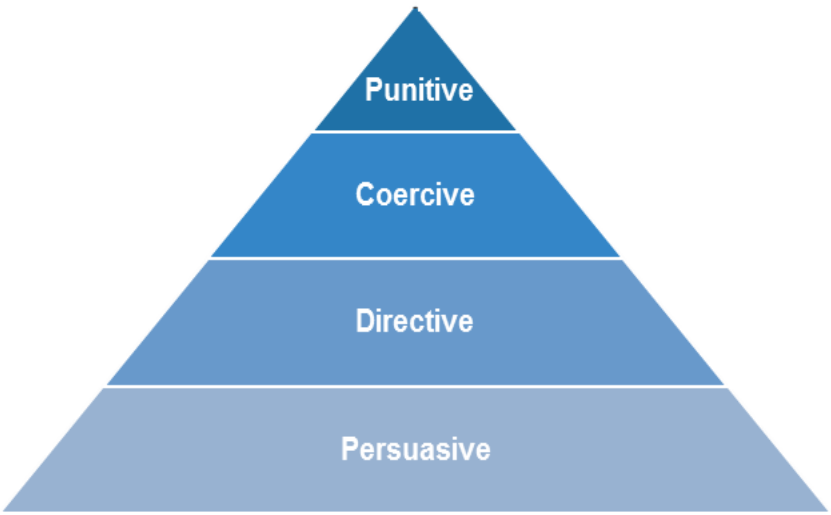
5.9 Management of non-compliant teams

Despite the reinforcement of national regulations, SOPs outlining the expectations and responsibilities of EMTs and minimum standards, some EMTs may 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 (specific to I-EMTs);
- 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; and
- departing without informing the EMTCC and/or without appropriate transition or handover (specific to I-EMTs).

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 Fig. 10 below.

Fig. 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 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 its position within the ministry of health/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 requires prior agreement within the ministry of health and/or other national authorities about how such punitive measures would be executed. 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 if EMT Minimum Standards remain unmet.

- **Punitive**

The punitive approach is the most adversarial, and can terminate working relationships. This approach may be beyond the scope and authority of the EMTCC alone. Depending on the situation, the authority and legitimacy to invoke punitive action against an EMT usually requires support from other entities within the national authorities. However, the EMTCC has an important role in ensuring that punitive measures are employed judiciously and fairly, and in preventing avoidable escalations which can be damaging, not only to 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 an 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 various relevant entities. Factors for consideration in the establishment of any enforcement mechanism include feasibility (for example, time and resource costs to the EMTCC for implementation), likely effectiveness, and potential impacts on the operations of the emergency response (for example, coverage gaps due to deportation of an 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).

5.10 Management of complaints against teams

The formal channel for lodging complaints against any health-care service, including EMTs, should remain with the ministry of health or relevant national authority. Therefore, complaints may potentially be lodged initially through the EMTCC, in which case the following three key steps become necessary.

- **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 further.

- **Reporting to other relevant authorities, if required**
  Any complaints that require management beyond the scope of the EMTCC must be passed onto, or re-directed through, the appropriate channel(s) within the national authority structure. Reaching this decision on 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 the nature of the problem and potential implications. Keeping a clear documentation of the findings and actions and maintaining open channels of communication and transparency with all stakeholders are essential.

- **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 any further national authority investigations (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 EMT 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.

5.11 Managing across cultural differences

Extensive amounts of literature discussing aspects of individual cultural effectiveness, 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 important role of the EMTCC in managing cultural differences between stakeholders. These cultural differences are not only ethnogeographic, but also organizational, derived from each group'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 cultural interfaces. The achievement of this may be assisted by applying the following framework, which is comprised of four sequential and dependent steps.

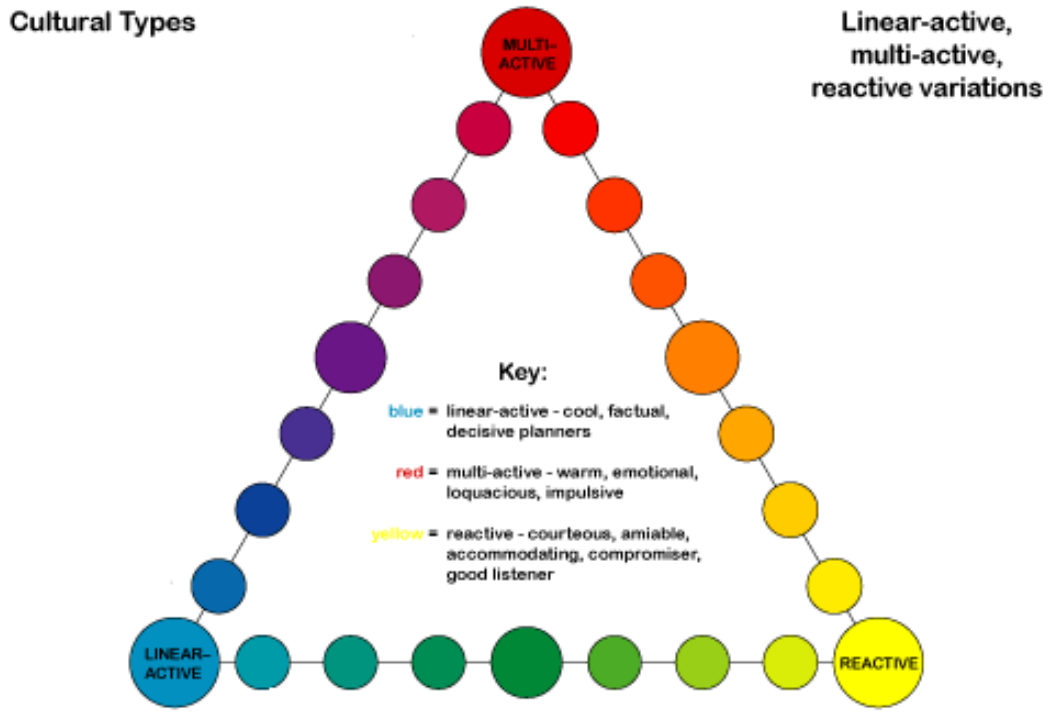
- **Preparation**
  This is the common starting point for many cross-cultural engagements, and involves developing an understanding of one's own cultural profile, including personal and organizational culture.

- **Awareness**
  This 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 Fig. 11 below. This example is based on the Lewis Model (Lewis, 2006).

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

- **Bridge differences**
  Lastly, having developed an understanding of cultural gaps between organizations, strategies can be applied by the EMTCC to bridge such 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.

Fig. 11 An example model of cultural types



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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 Coordination Meeting Minutes

SAMPLE PROFORMA: EMTCC Quality Assurance Checklist

Insert MOH Logo

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 Ministry of Health focal point for EMT coordination. Approval to mobilize will be expedited for teams that are already on the WHO Global EMT Classification List. Regardless of registration status, all teams must comply with the EMT guiding principles, core and technical 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

Insert MOH	EMT Country, Event, Year	World Health Organization

EMT Name		#ID EMT Global Classification	###
EMT Type		Date and Time of offer	dd / mm / yyyy HH:MM

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

Internal Office Use Only				
Team Status:	☐Approved	☐Pending	Reason:	
	☐Tasked	☐Declined	Reason:	
Check:	☐WHO Classified	☐Airport	☐ Field Visit	☐Other:
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)*			

EMT INFORMATION	
ORGANIZATION	
ORGANIZATION TYPE:	☐NGO NATIONAL ☐NGO INT ☐GOVERNMENTAL ☐MILITARY ☐OTHER:
COUNTRY:	**NUMBER OF EMTs:** ## DE ## (TOTAL EMT DEPLOYED)
TIME (HOURS/DAYS) OR ESTIMATED DATE OF ARRIVAL:	**TIME (HOURS/DAYS) TO START SERVICES PROVISION:**
ESTIMATED LENGHT OF STAY (DAYS):	
ORGANIZATION PRIMARY CONTACT (HQ)	
NAME:	**POSITION:**
ADDRESS:	
EMAIL:	**PHONE:** + country - area - phone number
EMT TEAM LEADER	
NAME:	**POSITION:**
EMAIL:	**EMAIL EMT:**
LOCAL PHONE:	**SATELLITE PHONE:**

EMT	EMT CAPABILITY	NAME EMT/ID WHO CLASSIFICATION

EMT TYPE
☐TYPE 1 Mobile ☐TYPE 1 Fixed ☐TYPE 2 ☐TYPE 3 ☐Specialized Cell *(Specify)*: ☐The team brings a field facility (state bed capacity ###, estimated number of tents/containers ###/###, total ####m^2 required)

LOGISTIC SUPPORT
Any logistical limitations or support required: ☐**NO** ☐**YES** **Specify** (e.g. transport should include total volume and weight).

Outpatient Capacity (patients/day):		Other Capabilities: ☐General Anaesthesia ☐Intensive Care ☐X-Ray ☐Ultrasound ☐CT Scan ☐Laboratory ☐Blood bank ☐Pharmacy ☐Rehabilitation ☐Isolation area
Inpatient Capacity (bed capacity):		
Surgical Capacity (number of surgical tables)		
Surgical Capacity (major and minor procedures/day):		

CLINICAL SERVICES OFFERED	PUBLIC HEALTH CAPABILITIES

EMT	EMT DETAILS	(EMT NAME)

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

EMT GLOBAL CLASSIFICATION STATUS:

☐No Account ☐ EOI Submitted ☐ Mentorship ☐ Classified ☐ ID:

PREVIOUS DEPLOYMENT EXPERIENCE (LAST FIVE ONLY)

YEAR	COUNTRY	EVENT	EMT(s) TYPE	DURATION (DAYS)

EXISTING OR PREVIOUS WORKING RELATIONSHIP IN COUNTRY

ORGANIZATION	LOCATION	RELATIONSHIP

STAFFING DETAILS		EXPECTED LOCAL STAFF REQUIRED	
PHYSICIANS		PHYSICIANS	
SURGEONS		SURGEONS	
NURSES		NURSES	
MIDWIVES		MIDWIVES	
PSYCHOLOGISTS		PSYCHOLOGISTS	
ALLIED HEALTH PERSONNEL		ALLIED HEALTH PERSONNEL	
MANAGEMENT		MANAGEMENT	
LOGISTICS		LOGISTICS	
ADMINISTRATION		ADMINISTRATION	
Other		Other	
Other		Other	

DOCUMENTS CHECKLIST	NAME (person compiling the form):
☐Professional Practice Licence ☐ CV or Resume (if applicable) ☐Copy of Passports ☐Visa documents (if applicable) ☐Packing List ☐Others required by the authorities	**Email:** **Signature:**

END OF REGISTRATION FORM

EMT-MDS Daily Reporting Form (Ver0.94)

World Health Organization

Team information

a	【Organization name】	h	【Date of activity】dd/mm/yy
b	【Team name】	i	【Time of reporting】dd/mm/hh:mm(24h)
c	【Type】□ Type 1 mobile □ Type 1 fixed □ Type 2 □ Type 3 □ Specialized cell	j	【Location】 (State:)
d	【Contact Person(s) name(s)】	k	(City:)
e	【Phone No.】	l	(Village etc.:)
f	【Email】	m	(Facility name:)
g	【Estimated date of departure】dd/mm/yy	n	【Geo-tag】 (Latitud) (Longitu)

1. Report to EMTCC until (:)

2. Submit one form per one activity day and location.

Daily Summary

		Number of patient / Bed Count (at the time of reporting)		MDS statistics							
o	Patients	Outpatient (not admitted)		32	Outcome	Discharge without F/U		40	Relation	Directly related to disaster	
p	Patients	New admission		33	Outcome	Discharge with F/U		41	Relation	Indirectly related to disaster	
q	Patients	Live birth		35	Outcome	Referral / Transfer *		42	Relation	Not related to disaster	
r	Bed	Total bed capacity		36	Outcome	Left against medical advice		43	Protection	Vulnerable child	
s	Bed	Empty regular bed		37	Outcome	Dead on arrival		44	Protection	Vulnerable adult	
t	Bed	Empty ICU bed		38	Outcome	Death within facility *		45	Protection	Sexual Gender Based Violence (SGBV)	
				39	Outcome	Requiring long term rehabilitation *		46	Protection	Violence (non-SGBV)	

New admission(p) is equivalent to Admission (MDS34) . MDS statistics count daily outpatient and inpatient consultations/admissions. Procedures (MDS No. 26-31) will be counted on the day they were performed, irrespective of when a patient was admitted.

Demographic

MDS statistics

No.		Age Categories		<1	1-4	5-17	18-64	65-
1	Sex & Age	Male						
2	Sex & Age	Female non-pregnant						
3	Sex & Age	Female pregnant						

Health Events and Procedure

MDS statistics

No.		Health Events		<5	>=5
4	Trauma	Major head / spine injury			
5	Trauma	Major torso injury			
6	Trauma	Major extremity injury			
7	Trauma	Moderate injury			
8	Trauma	Minor injury			
9	Infectious disease	Acute respiratory infection			
10	Infectious disease	Acute watery diarrhea			
11	Infectious disease	Acute bloody diarrhea			
12	Infectious disease	Acute jaundice syndrome			
13	Infectious disease	Suspected Measles			
14	Infectious disease	Suspected Meningitis			
15	Infectious disease	Suspected Tetanus			
15	Infectious disease	Suspected Tetanus			
16	Infectious disease	Acute flaccid paralysis			
17	Infectious disease	Acute haemorrhagic fever			
18	Infectious disease	Fever of unknown origin			
19	Emerg.	Surgical emergency (Non-trauma)			
20	Emerg.	Medical emergency			
21	Other key diseases	Skin disease			
22	Other key diseases	Acute mental health and psychosocial problem			
23	Other key diseases	Obstetric complications			
24	Other key diseases	Severe Acute Malnutrition (SAM)*			
25	Other key diseases	Other diagnosis, not specified above			
		Procedure		<5	>=5
26	Procedure	Major procedure except limb amputation and obsteric			
27	Procedure	Minor procedure			
28	Procedure	Limb amputation excluding digits*			
29	Procedure	Normal Vaginal Delivery (NVD)			
30	Procedure	Caesarean section			
31	Procedure	Obstetrics others			
47	Additional 4				
48	Additional 4				
49	Additional 4				
50	Additional 4				

Needs and Risks

Free text reporting to EMTCC/MOH on the following issues.

Immediate report	51	□	Unexpected death *	Risks	59	□	Shelter / Non food item
Immediate report	52	□	National mandatory reporting disease	Risks	60	□	Food security
Immediate report	53	□	Critical / security incident to community	Operational constraints	61	□	Logistics/operational support
Immediate report	54	□	Critical incident to EMT	Operational constraints	62	□	Supply
Immediate report	55	□	Any other issue	Operational constraints	63	□	Human resources
Risks	56	□	WASH	Operational constraints	64	□	Finance
Risks	57	□	Community/rumor based infectious disease	Operational constraints	65	□	Others
Risks	58	□	Environmental risk / exposure				

Detailed comment for (No.)

Detailed comment for (No.)

Detailed comment for (No.)

Detailed comment for (No.)

* To be line listed and submitted to EMTCC with MDS reporting form. Line list for protection is context specific. 4. Additionals are used for context dependent counting following guidelines from the EMTCC/MOH; e.g. for infectious diseases: Malaria / Dengue / TB / Leptospirosis / Rabies; e.g. for hazard: Drowning / Hazmat; e.g. for population: Chronic diseases for elderly etc.

Insert MOH Logo

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 EMTs, 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			

Insert MOH Logo

World Health Organization

Insert EMT Logo

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
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

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

6. Waste Management Arrangements completed:

☐Yes, specify: _____

☐No, reason: _____

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

END OF **EXIT REPORT**

E. Transferred Patients at Exit (Exit Report Supplement)

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

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
						☐
						☐
						☐
						☐
						☐
						☐
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						☐
						☐
						☐
						☐

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.*

Insert MOH Logo

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

*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**

Insert MOH Logo

World Health Organization

Country, Event, Year

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)

EMTCC FIELD QUALITY ASSURANCE CHECKLIST

Section to follow

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 ministry of health (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 ministry of health (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

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

Information Technology:

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

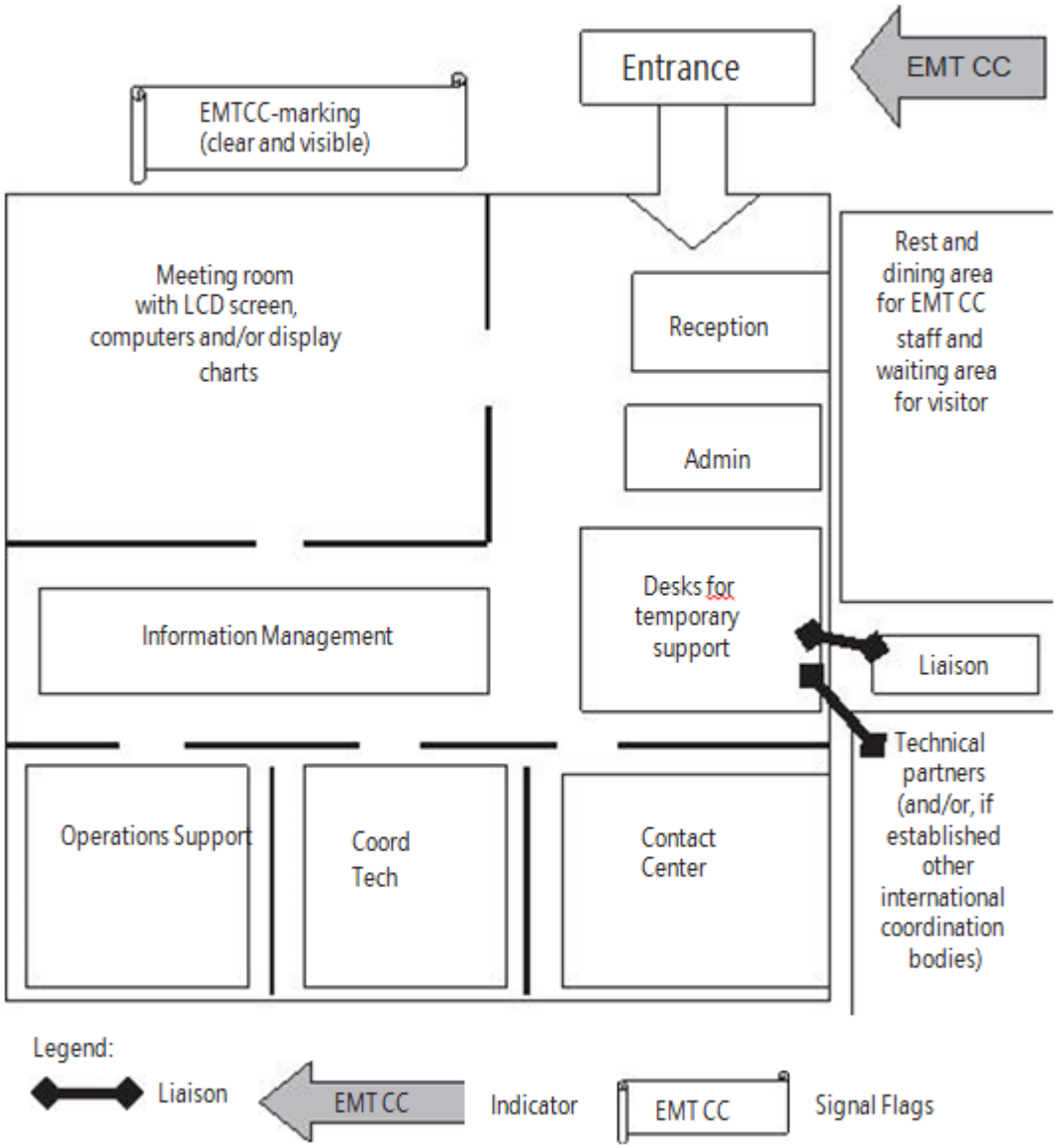
Telecommunications:

- 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 EMT CC Setup



ANNEX III. INFORMATION ARCHIVING SYSTEM

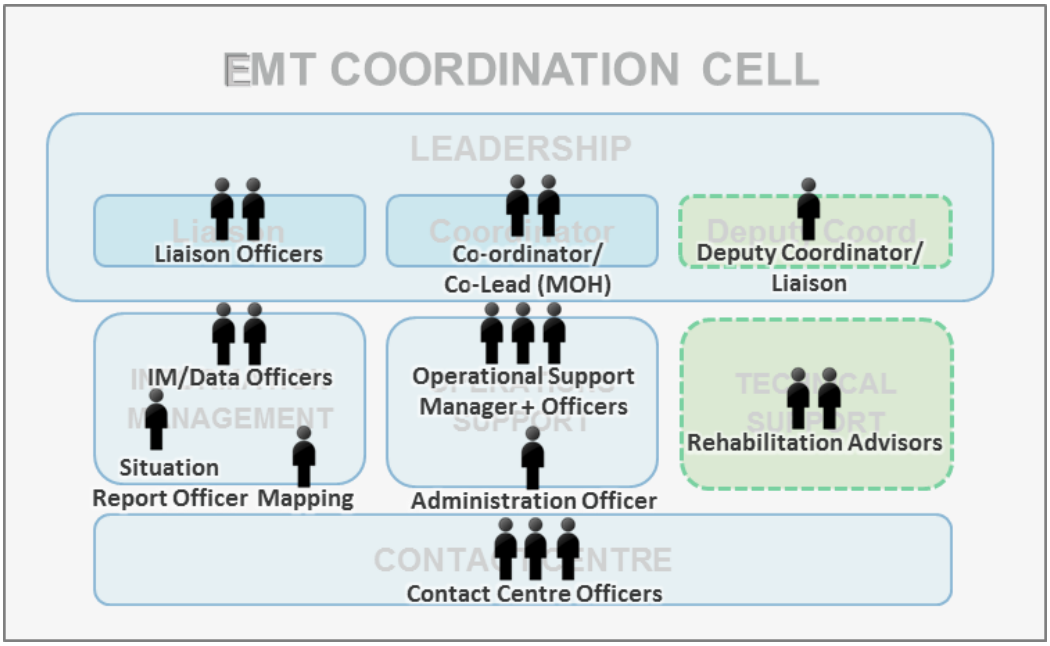
EMTCC Mission Archive <Year_Country_Event>

- 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**
  - + **WHO Country Office**
  - + **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**
  - + **Ministry of Health**
  - + *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

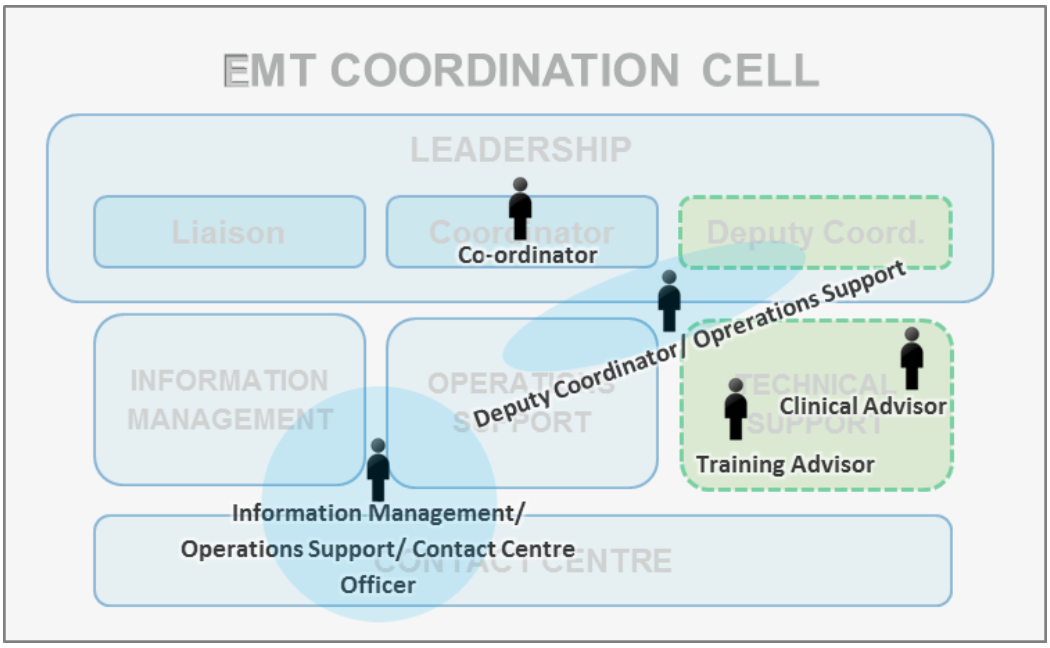
ANNEX IV. EXAMPLES OF EMTCC TEAMS

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 six 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 Plan of Action
- 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 ministry of health 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 role and responsibilities
    - Outline of immediate next steps, including priorities
    - Anticipated issues and challenges
    - Key lessons learnt
    - 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

World Health Organization

EMT

http://extranet.who.int/EMT