

November 2016

# Emergency Medical Teams

*World Health Organization EMT Initiative*

**Special feature:**  
**Workings of the EMT Initiative**

**Nepal:**  
**Reaching new heights in  
coordination**

**How Ebola changed the  
nature of Emergency Medical  
Responses**

**Faster deployment of EMTs  
saves lives**







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TO SUPPORT COUNTRIES AFFECTED BY EMERGENCIES AND OUTBREAKS BY PROVIDING CLINICAL CARE TO WOMEN, MEN AND CHILDREN WHO NEED YOUR HELP?

**THE WORLD HEALTH ORGANIZATION (WHO) EMERGENCY MEDICAL TEAM (EMT) INITIATIVE ENCOURAGES TEAMS THAT HAVE BEEN DEPLOYED IN PREVIOUS EMERGENCIES OR OUTBREAKS TO JOIN AND BE CLASSIFIED AS A QUALITY ASSURED TEAM.**



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To be classified, an organization or a country must agree to comply with the Minimum Standards and Principles of Emergency Medical Teams, [http://www.who.int/hac/global\\_health\\_cluster/fmt\\_guidelines\\_september2013.pdf](http://www.who.int/hac/global_health_cluster/fmt_guidelines_september2013.pdf)

Details on Mentorship and Classification can be found at <https://extranet.who.int/emt/page/understanding-global-emt-classification-process>

## WHO EMERGENCY MEDICAL TEAM (EMT) INITIATIVE

**OUR VISION:** to preserve health, protect dignity and save lives.

**OUR MISSION:** to reduce the loss of lives and prevent disability in sudden-onset disasters and outbreaks through rapid deployment and coordination of quality-assured EMTs.

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**The EMT Secretariat:**

Marina Appiah, Dr Roy Cosico, Luis de la Fuente Martin, Daniela Martini, Dr Ian Norton, Leong O, Flavio Salio  
**Our Consultants, Interns and Volunteers**

**The Strategic Advisory Group**

**The Core Support Group**

**Working Groups:**

**Clinical Working Groups:**

Infectious Diseases, Maternal and Child Health, Mental Health, Noncommunicable Diseases, Surgery, Rehabilitation

**Operational Working Groups:**

Logistics, Mentorship and Verification, Minimum Data Set, Public Health, Rapid Response, Training

All of the generous donors who have supported the EMT Initiative in each of its stages

## Note from the WHO Director-General



I have enjoyed observing the rapid evolution of the Emergency Medical Team Initiative. Through this initiative, international preparedness to provide clinical care during emergencies has been structured, standardized, and aligned with a set of overarching principles.

I congratulate the six teams, two from Russia and one each from China, Japan, Australia, and Israel, who have successfully completed verification and have become a source of great national pride. I thank the additional 75 teams who have signed up for the verification process.

This initiative makes a practical and visible contribution to the International Health Regulations, and in doing so, contributes to global health security. Its national and regional focus is a major strength, as it helps build capacity and national and regional self-sufficiency. In addition, responders acting domestically or regionally have a better understanding of local culture, context, and language. The best motto for us in this matter comes from OCHA - "keep responses as local as possible, as international as needed".

I thank the IFRC, ICRC and OCHA for their collaboration, which lends added authority, grounded in experience, and has greatly extended the initiative's reach.

Finally, I thank the numerous countries that have provided funding and in-kind support. My special thanks go to The Hong Kong Jockey Club Disaster Preparedness and Response Institute for their support to the Global Emergency Medical Teams meeting in November 2016.

-- Dr Margaret Chan

## Letter from the EMT Secretariat

As we look back on the two-and-a-half years since the Emergency Medical Teams (EMT) unit was created within WHO, it would be fair to say that this project has played an unprecedented role in organizing responses to the health consequences of emergencies. Innovation often arises in response to a tragedy. In this case, that tragedy was



the earthquake in Haiti in 2010. The unsatisfactory outcome of efforts to confront the health consequences of this sudden-onset disaster prompted the global community of international medical responders to realize that we could not continue with an ad hoc approach to medical team deployment. It became clear that professional standards and quality of care matter, especially in a disaster.

A competent response is not about the skills of an individual, but rather about the safe and professional deployment of teams and their operational support. In short, good intentions are not enough. This awakening led to the creation of a Foreign Medical Teams Working Group, which was the precursor of the current EMT Initiative.

The EMT Initiative has since engendered a sea-change in the world's approach to confronting the medical consequences of emergencies. It is now clear that teams need to be registered, undergo a mentoring process and then be quality assured.

It takes 15-20 minutes to explain this approach and the necessary process to a minister of health before or during a crisis. Without fail, their immediate reaction is "of course I agree with it" and, "this really helps us".

EMTs have also understood this change and have joined us in large numbers. Over 75 teams have started the mentorship process, and six have progressed to full verification.

We have ever-expanding partnerships with major actors in disaster response. An agreement reached with the International Federation of the Red Cross and Red Crescent Societies will mean the enormous capacities of this organization and the national societies it represents will participate in the mentorship and peer review process. We also have strong operating relationships with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and the International Committee of the Red Cross (ICRC); and regional bodies such as the Association of Southeast Asian Nations, the European and African Unions and the Community of Latin American and Caribbean States. Capacity building, mentorship and training lie at the heart of the EMT Initiative. National and regional teams make up the largest segment of a global health emergency workforce. They need to be trained to respond quickly when disasters and emergencies strike. Their managers and the emergency operations centres of their countries need to know where they are needed and how quickly. Countries need to be able to call on neighbouring governments and international EMTs without complexity.

The EMT Initiative includes 11 working groups, some of which are in the planning stages and others of which are already functioning. Those in operation are producing tangible results in very short time frames. The working groups on minimum data sets, orthopaedic and wound care of limb injuries in disasters and conflict (in collaboration with the ICRC and AO foundation) and the rehabilitation working group have collaborated tirelessly and produced superb products. The working groups on training, mentorship/verification, infectious disease treatment, public health rapid response teams and logistics are starting their work in an atmosphere of high expectations.

We thank the EMTs that have so selflessly responded to disasters and outbreaks over the last three years. We look forward to 2017 as a year that will see more EMTs undergo peer review and verification, and a year that national and regional EMTs increase in strength and deployability.

-- Dr Ian Norton



# Benefits of the EMT Initiative



## Countries/affected populations

Governments and people affected by disasters and public health emergencies can be assured of a predictable and timely response by well-trained and self-sufficient teams.



## Medical team benefits

Medical teams that reach minimum standards and are quality assured through a peer-review process will be more likely to be requested to respond by affected countries and have a streamlined arrival process.



## Timely response

Qualification of national and regional teams by the EMT Initiative plus coordination at the national, regional and international levels shortens the time needed for teams to arrive in the field and begin their work.



## Donor benefits

Organizations, governments and individuals that make contributions can be confident the teams they are supporting have reached an international minimum standard.



## Operational research and development

An EMT community of practice is growing. The result is that EMTs now have an opportunity to share standard operating procedures and best practices. Operational research by WHO partners will improve EMT performance.



## NATIONAL EMERGENCY MEDICAL TEAMS – THE MOST APT RESPONDERS

When a disaster strikes or an outbreak flares, the more rapid the response, the better the outcome. That is why the EMT Initiative places such a strong focus on helping every country develop its own teams, who can arrive where they are needed in the shortest time. Additional teams from neighbouring countries may be needed, but they too can move in quickly. WHO's viewpoint is that international teams need be deployed only in the case of an emergency of overwhelming proportions.

National teams have other distinct advantages. They are culturally sensitive, know the terrain, speak the local languages and are already licensed to practice. Teams from neighbouring countries in the region bring similar advantages.

The establishment of regional emergency networks between countries can also speed up response time. Reciprocal agreements between national governments regarding deployment of Emergency Medical Teams speeds up offers and acceptance of teams using national Emergency Operations Centres.

### *Building WHO quality-assurance of Emergency Medical Teams has other general benefits to a country's health system because the process:*

- enhances national capacity for surveillance and response;
- builds national capacity to request, register and coordinate teams ideally within a Health-Emergency Operations Centre structure;
- makes EMTs and PHRRTs part of the national surge planning and with an all-hazard approach;
- develops regional mechanisms for deployment;
- leads to cost saving through collaboration between countries; and
- develops teams that are predictable, timely and self-sufficient.



# Emergency Medical Teams news

## AUSMAT becomes the fifth quality-assured EMT

In November 2016, the Australian Medical Assistance Team (AUSMAT) became the fifth team to be verified by the WHO EMT Secretariat as capable of deploying and setting up a fully staffed Type 2 team and field hospital in the event of a natural disaster or other emergency.

The field hospital was displayed on 7-8 October 2016 in Darwin, in time for the visit of the WHO verification team composed of representatives from the EMT Secretariat, Regional Focal Points, and previously verified teams.

The verification follows AUSMAT's completion of WHO's rigorous classification process. "This means that, when a disaster strikes and an affected country requests help, we can quickly deploy medical teams that we know are quality assured," said Concetta Fierravanti, Minister for International Relations and the Pacific.



## Ecuador: National teams lead earthquake response

On 8 April 2016, Luis de la Fuente Martin, the Regional Adviser on EMTs at the WHO Regional Office for the Americas, was sent to Ecuador on a training mission. His objective: to educate 50 professionals from the Ecuador Ministry of Health, during a rigorous two day training course, on the essentials of coordinating EMTs. The timing of this training would turn out to be fateful.

On 16 April, a 7.8-magnitude earthquake struck Ecuador and left a trail of destruction. According to Ecuador's National Secretariat for Risk Management, 655 people died, another 4500 were injured and more than 30 000 displaced. Damage to infrastructure was extensive. More than 800 buildings were destroyed, including 25 health facilities.

Ecuador's efforts, with support from WHO, on preparing and coordinating teams for an emergency response, bore fruit. The government was able to deploy 22 teams, and thousands of patients were seen during the first six hours after the quake. They were joined by seven international teams, which had been invited by Ecuador's national authorities and coordinated in the Medical Information and Coordination Cell (CICOM/EMT-CC) within the EOC with help from WHO.



"Other teams wanted to travel in to help, but the government declined their offer. They were not needed, because the national teams were doing such a fantastic job," says Dr Ian Norton, who heads WHO's EMT Initiative. "Ecuador's emergency provides a great example of how things are supposed to work. WHO is helping countries build their own capacities to respond to an emergency. If needed, they can get help from other countries in the region. If this is not enough, a global response is needed, and we activate it."

## Chinese and Russian EMTs quality assured

In May 2016, WHO Director-General Dr Margaret Chan presented letters of certification to Emergency Medical Teams (EMTs) from China and Russia confirming that they are capable of providing mobile emergency field hospitals and staff members in response to natural disasters and disease outbreaks.

"I would like to thank both countries for their participation in this process and congratulate them on this worthy achievement," Dr Chan said.

The Emergency Medical Teams (EMTs), one from China and two from Russia, completed WHO's rigorous classification process.

"This means that, when a disaster strikes and an affected country requests help, we can quickly deploy medical teams that we know meet our high standards," Dr Chan added.



China and Russia were among the first countries to sign up for the classification process. China's and Russia's teams demonstrated commitment to the Organization's guiding principles for patient care and met the standards outlined in the Classification and Minimum Standards for Foreign (Emergency) Medical Teams in Sudden Onset Disasters.

## European Medical Corps inaugurated

On 15 February 2016, at a high-level ceremony in Brussels, Belgium, the European Medical Corps (EMC) was launched. This is the European Union (EU) framework for mobilizing medical and public health teams to respond to public health emergencies and crises with health consequences



inside and outside the EU. With its inauguration, the EMC was added to the list of Member States seeking quality assurance from WHO's EMT Initiative.

WHO has been working closely with the EU to establish standards to classify medical teams from its Member States. "Any health worker coming from another country to support the response needs to be a part of a team; individuals are not deployed. Each team must be adequately trained and self-sufficient so that resources are not taken from the affected country," says WHO EMT Initiative's Flavio Salio.

Through the EMC, EU Member States can make medical teams and assets available for rapid deployment. The EMC will include Emergency Medical Teams, public health experts, mobile laboratories, medical evacuation planes and logistical support teams.



**Japan Disaster Relief team verified**

A five-person verification team visited Japan on 1-2 June 2016 to formally classify the Japan Disaster Relief Team as EMT Type 1 and Type 2 capable of providing an emergency field hospital for disaster response and to provide specialist cells for haemodialysis and surgery.

As a WHO-classified EMT, the Japan Disaster Relief Team has, through a peer review process, demonstrated a practical commitment to the guiding principles for patient care, as well as a high-level of adherence and capability to implement the core and technical standards for EMTs.



Japan was one of the first countries to sign up to the WHO classification process, and the Japan Disaster Relief Team is among the first teams to have been formally classified. This follows months of engagement with WHO through the EMT peer-to-peer mentoring programme, which provides EMTs with access to technical experts committed to supporting an EMT as it progresses through the classification pathway.



**Biggest emergency simulation ever held in Norway**

It takes a simulated emergency of colossal proportions to test the ability of multiple teams and partners from across the world to coordinate their response. That is exactly what happened in southern Norway in September 2016 at an exercise, known as TRIPLEX, hosted by the Norwegian civil defence.

WHO staff, including staff from the EMT Initiative Secretariat, were among the 500 participants from 76 countries working in over 40 organizations, including national civil protection and civil defence, the Red Cross/Red Crescent Movement, UN agencies, NGOs, donors and military organizations. The TRIPLEX was organized by the International Humanitarian Partnership (IHP), of which Norway is a member.

From 24 to 30 September, 11 WHO staff played the role of the UN health organization and health cluster leader for the response to the health consequences of a flood and hurricane disaster. The scenario provided a number of challenges, including infectious disease outbreaks, inadequate access to health services, shortage of supplies and medical equipment, overcrowded conditions due to displacement, shortage of health workers and lack of access to clean water and sanitation.

During the exercise, 11 Emergency Medical Teams were registered and activated and worked in a coordinated fashion with 10 health cluster partners and other humanitarian clusters. They provided medical supplies and drugs and established a disease surveillance system and public health laboratories, among other activities.

**Israeli Type 3 team gets verified**

On 9 November 2016, the WHO EMT Initiative recognized the Israeli army's field hospital, which provides emergency medical services at disaster sites abroad and civil protection at home, as quality assured. It is the first organization to be verified as Type 3. The team, staffed by the Israeli Defence Force (IDF) Medical Corps Reservists, can provide tertiary level care for almost 100 inpatients including a 12 bedded intensive care unit. They have up to four surgical theatre tables for trauma and complex surgical care, and specialists ranging from paediatricians and obstetricians to ophthalmologists and infectious disease experts as well as trauma and orthopaedics.

"Our field hospital has the same capabilities as an advanced, permanent hospital but can be set up almost anywhere in under 12 hours," Lieutenant Colonel (res.) Dr Ofer Merin, commander of the hospital, told The Israeli Times.

"This is a team that can deploy fast, and has massive capacity. They have 200 personnel and carry with them 100 metric tonnes of equipment," said Dr Ian Norton, who heads the EMT Initiative. Although the Israeli team already had a reputation for excellence, they said the verification process allowed them to reconsider some aspects of their work and make improvements.

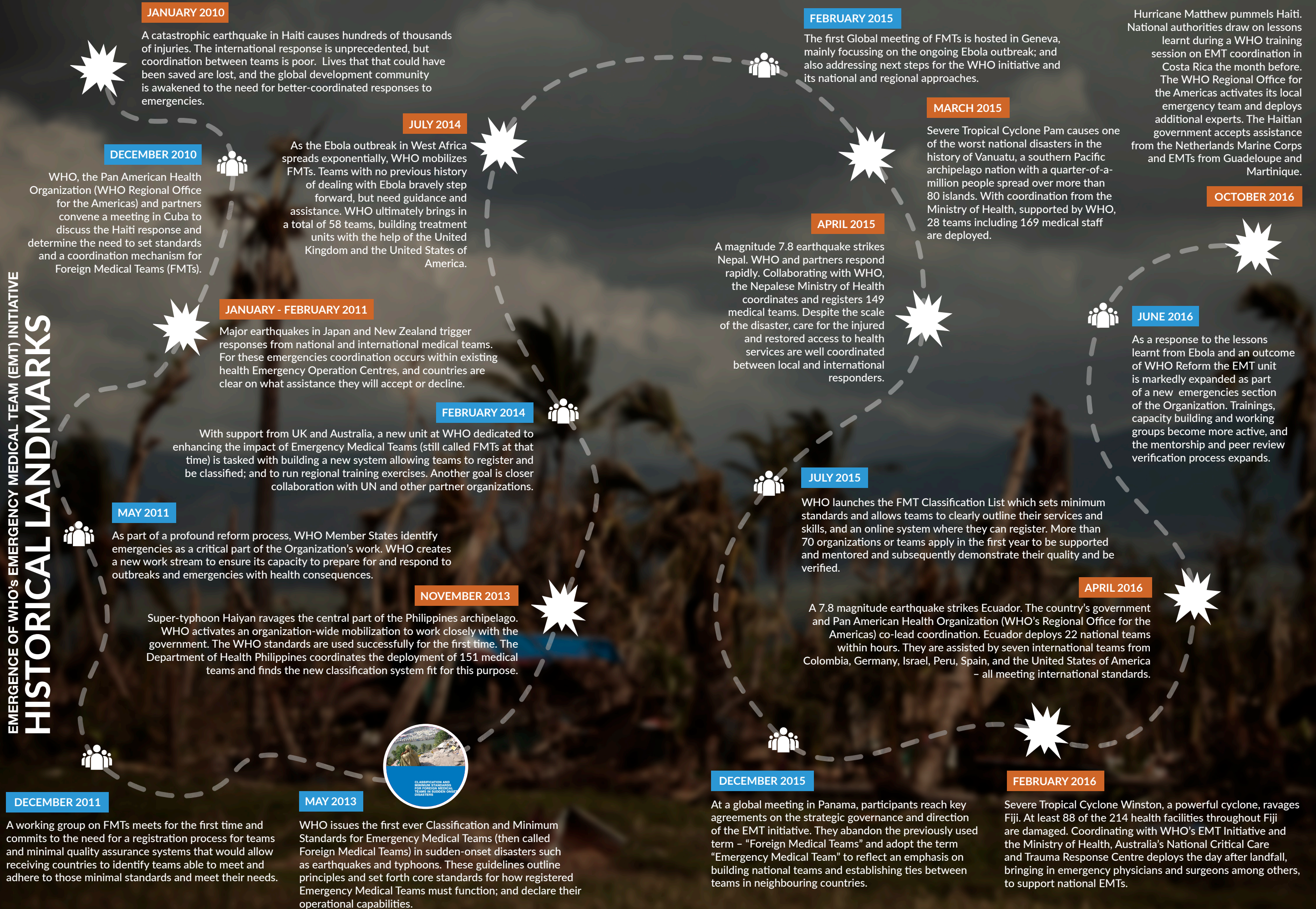


Teams from the IDF Medical Corps and Home Front Command have provided rescue and medical services after a number of disasters, including the Haiti earthquake in 2010, typhoon Haiyan in the Philippines in 2013 and, most recently, the 2015 earthquake in Nepal.





EMERGENCE OF WHO'S EMERGENCY MEDICAL TEAM (EMT) INITIATIVE  
**HISTORICAL LANDMARKS**





# Nepal Earthquake: reaching new heights in coordination

*The potential health consequences of the earthquake that struck Nepal in 2015 were too dreadful to imagine. But high-quality teams whose deployment was centrally coordinated made all the difference.*



At 11:56 on 25 April 2015, a 7.8 magnitude earthquake struck Nepal. Its epicentre was east of Gorkha District, at the heart of the country. It was the worst earthquake to strike the region in more than 80 years. Homes and historic temples crumbled, hospitals and health centres were rendered unusable, while roads and communications networks were damaged.

The international global health community sprang into action. WHO's Regional Director for South-East Asia held an emergency meeting with the Minister of Health and Population within two hours of the disaster. And just four hours after that, at 18:00, there was an emergency coordination meeting.

### Government takes the lead

WHO had previously supported the Ministry of Health and Population (MoHP) of Nepal to create an earthquake resistant Health Emergency Operations Centre (H-EOC). This sprang into action after the earthquake and began deploying national EMTs and coordinating trauma care. WHO set up and ran an EMT - Coordination Cell to provide support within the H-EOC for the first time in its history.

"The creation of this coordination cell was very valuable," said Dr Ian Norton, who heads WHO's Emergency Medical Team (EMT) initiative. "It allowed WHO and partners to help the Ministry to address gaps. And instead of waiting for teams to find their own space, as has happened in many other past emergencies, we could task them where they were really needed most."



The key advantage of this structure, Norton said, is that people in a government are the only ones who know within a few hours where hospitals have fallen and replacement facilities are needed. "They have the names of every doctor and nurse, and know where they work and where there are gaps," he said. The result was that Emergency Medical Teams – including national, international, and military – moved swiftly and nimbly to where they were needed.

The International Federation of Red Cross and Red Crescent Societies (IFRC) participated actively in this process, appointing one of the coordinators. "This was a great learning experience, mainly because it demonstrated something to which we are fundamentally committed at IFRC: when teams meet clearly established international standards and classification and are well coordinated, we can achieve really good results," said Panu Saaristo, Team Leader, Community and Emergency Health and Care Department, IFRC, Geneva.

### Crucial aspects of team verification

Good intentions are not enough when it comes to emergency medical care, agrees Norton, which is why standards are so crucial. "If a team is not prepared as it should be, it can cause chaos instead of helping. Teams deploying to an earthquake or other emergency need to be professionally trained, meet minimum standards and be prepared logistically. To get on board, we want them to think about this, become quality assured and present their willingness to offer deployment to affected countries," he said.

Johanna Sandwall, Preparedness Director, National Board of Health and Welfare, Sweden, explains that this offer-based approach allows countries to match their need with the right offers, which creates the best possible conditions for the right response at the right time. "The professionalization and verification of responders makes it easier for affected countries to trust and choose the right support," she said.



**EMT Initiative approach**

WHO's EMT Initiative seeks to help countries build their national capacity to respond to emergencies at home and be prepared to offer to deploy their teams, as needed, to countries in their region. "Only if that system turns out to be insufficient for the scale of an emergency should there be a need for international teams to travel half-way around the world," Norton said.

The standards for qualifying EMTs were developed through a highly consultative process among global health partners,

said Saaristo. "We are very pleased with the product that came out of this process, and have adopted its standards. It has even allowed us to fill in some gaps, such as for surgical teams."

The results of deploying high-quality, well-coordinated teams speak for themselves. "We believed the worst-case scenario for a Kathmandu valley earthquake was that half a million people would die, but thankfully the quake was moderate and the response excellent," Norton said. "In the end there were 8800 deaths, which is tragic, but there could have been so many more."



**Nepali and international medical teams join forces to fill health care gaps in quake-ravaged Sindhupalchok**

*Working side-by-side to treat the injured, heal the sick, and deliver babies, Nepali medical staff and international teams delivered vital health services in the earthquake-ravaged district of Sindhupalchok.*

In the district capital of Chautara, around 320 kilometres northeast of Kathmandu, the main hospital was badly damaged by the earthquake on 25 April 2015. WHO, with the support of international Emergency Medical Teams, including the Norwegian Red Cross, stepped in. They arranged for the deployment of a 60-bed mobile medical unit to deliver a wide range of essential health services, from treating wounds and setting broken bones to delivering babies and dispensing medicines.

"The Sindhupalchok district was the worst affected in all of Nepal, with over 2000 people dead and many more injured," said Dr Elena Mulmi, a medical officer from Chautara District Hospital. "Our entire hospital was totally damaged and we shifted here," she added. The temporary structures included a large rainbow-coloured big top, dubbed the 'circus tent' by locals.

"We were unable to bring all the equipment from our hospital for wound dressing and sutures. But the new mobile hospital was well equipped. The Norwegian Red

Cross deployed a large team to Chautara, including doctors, nurses and logisticians. But Ranveig Tveitnes, deputy team leader of the mobile hospital, said the critical ingredient was the teaming up with the area's local health staff.

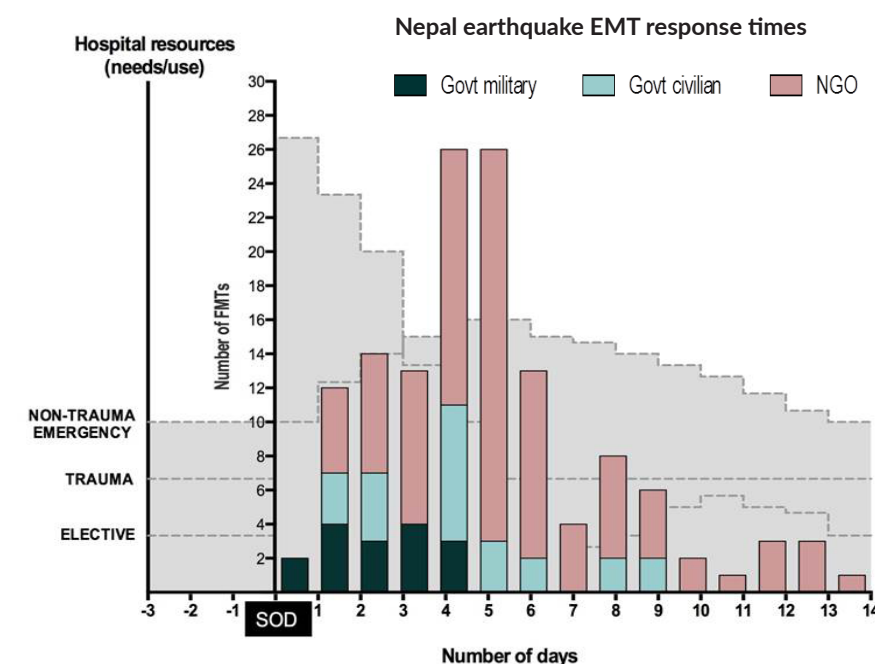
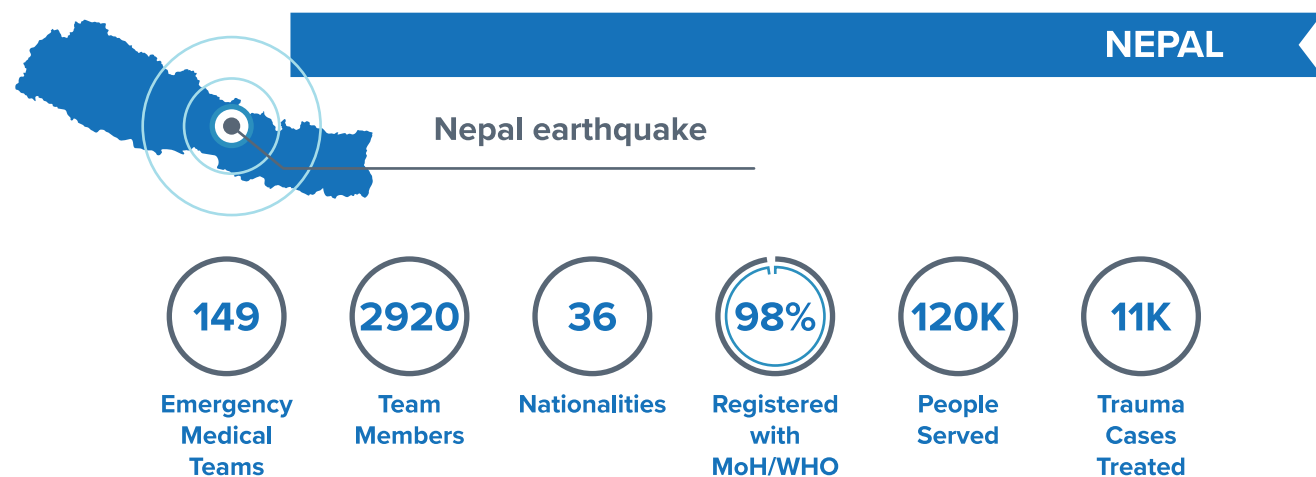
"The Nepali doctors worked in a nearby makeshift clinic for the first week after the earthquake, and they did a fantastic job," she said. "Then they integrated with us, and we worked as one team," she said in the aftermath of the earthquake.

**Teamwork helps meet challenges**

There were various challenges setting up the new mobile hospital. They had to wait several days for their equipment and medical supplies to pass through the congested Kathmandu airport, which saw an enormous increase in traffic after the earthquake. And delivering the materials to the remote Chautara township meant navigating rubble-covered roads that snake through the mountainous region.

"The mobile hospital was organized to address hygiene and sanitation concerns and the risk of communicable disease outbreaks, including diarrhoeal diseases. Coordination of the various medical teams – Nepali and international – was key," said Dr Ramesh Vikram Singh, Director of Health for Nepal's Central Region.

"It was really impressive how the Nepali and Norwegian Red Cross worked together as a single team," Norton said. "That is what I consider ideal in an emergency."







# The event that changed the meaning of public health emergencies

*When Ebola struck, the world recognized the need to recruit, train and coordinate Emergency Medical Teams in the context of an outbreak with potential international consequences.*

In the public imagination, Ebola virus disease is equated with science-fiction-movie-like scenarios, where a deadly bug wipes out an entire city or country. The Ebola virus is indeed one of the world's most virulent pathogens. Yet, until 2014, all previous Ebola outbreaks had been controlled within three weeks to three months.

In March 2014, the West African country Guinea reported to WHO that it had detected 49 cases of Ebola virus disease and 29 deaths from the illness, traced to an index case in December 2013. The World Health Organization (WHO) publicly announced this outbreak – the first ever in Guinea. Staff at WHO were concerned but also optimistic that this new outbreak could be contained rapidly.

In late March the Guinea outbreak did not appear to be out of line with previous outbreaks during the 38 years since the virus was identified. However, no one in Guinea had ever seen an Ebola patient, managed the very demanding and potentially dangerous clinical care imposed by the disease, or run an Ebola diagnostic test.

Within weeks, the Ebola virus crossed borders into Liberia and Sierra Leone. At that point the landscape began to look different and more potentially dangerous. Even before Ebola arrived, all three countries had only recently emerged from years of conflict, civil war and civil unrest, leaving health systems severely disabled; and much of the population distrustful of public programmes, including health programmes.

The scarcity of basic public health infrastructures and capacities was quickly recognized as a major barrier to rapid containment. Isolation wards, and even basic infection and control measures as part of routine hospital procedures, were virtually non-existent in these countries.

Even before Ebola hit, these countries had only a few doctors per each 100 000 of population, and these doctors were heavily concentrated in urban areas. As the outbreaks

progressed, the Ebola virus would relentlessly whittle that meagre number down even further, sometimes picking off medical staff one by one, sometimes killing them in groups as several became simultaneously infected in clinical settings lacking proper infection control. "We have a limited capacity and our health workers are not well prepared" Dr Brima Kargbo, Sierra Leone Chief Medical Officer, said at the time.

## WHO takes the lead

By June it was clear the epidemic was spinning out of control. In late July WHO organized a conference with potential donors of financial and other forms of support, including the deployment of foreign medical staff. Most urgent needs: more properly trained and equipped medical staff and more Ebola-specific treatment centres. Under the leadership of WHO, institutional partners were also asked to do much more.

Director General of WHO Dr Chan clearly stated that WHO, acting alone, could not respond to an outbreak of this complexity, which demanded a greatly intensified response. The needs in Guinea were estimated at an additional 482 national staff and 77 international staff; in Liberia at an additional 579 national staff and 90 international staff; in Sierra Leone, an additional 645 national staff and 98 international staff.

## EMT Initiative deploys

At this point the outbreak was experiencing its second major wave of transmission. A third wave of even more intense transmission was expected to emerge soon. In July, Dr Ian Norton, who heads WHO's Emergency Medical Team (EMT) initiative was deployed to West Africa to help find and coordinate Emergency Medical Teams (then identified by WHO as Foreign Medical Teams) to treat people with Ebola virus disease. He was in for a shock.



"I've been to several major disasters in the past, particularly typhoon Haiyan in the Philippines, the Pakistan floods and other disease outbreaks. But this was almost like going into a warzone. The Ebola response was not able to function because of one key element, a lack of treatment capacity. Ebola would have overwhelmed any country in the world if it hit their capital and went through the streets like it did in Monrovia, Conakry and Freetown," Norton said.

He discovered that in Monrovia, Liberia people were being told to bring their loved ones forward to have care, to have a chance of survival and to decrease the risk of that family member giving the disease to the rest of the family. They would arrive at the one or two facilities in the city and be told they were full and to take their loved one home.

The messaging was contradictory: when they followed the advice provided in the response – they had nowhere to go.

"This was undermining our entire response. People were coming forward – all they could hear on the radio was how bad the disease was and how unsafe it was. Yet their friends and relatives were dying on a mattress next to them, in some cases in small, shantytown dwellings in the middle of a crowded city which was being flooded every day by massive rains," he recalled.



#### Few medical teams prepared to treat Ebola

There is a long history of non-government organizations, government and military teams responding to sudden-onset disasters. The question was: could WHO bring in Foreign Medical Teams to confront the Ebola epidemic? For two decades, the only team that could manage Ebola effectively, was Médecins sans Frontières (MSF). But it was clear they could not manage an epidemic on this scale by themselves.

Norton put out a call and asked other teams to come forward. "But at first, there was silence – nobody was prepared to come, which is understandable, considering how many health workers had already died while caring for sick patients. But to have nobody, I mean nobody, answering, was truly awful," he said. Then, the International Federation of Red Cross and Red Crescent societies (IFRC) bravely stepped forward. They were followed by International Medical Corps (IMC) and a few other non-government organizations (NGOs) with no previous history with Ebola.



By early January 2015, the following had been achieved by WHO and partners:

**Guinea:** Two treatment units were functioning and five others under construction giving a total capacity of over 400 beds. 75 doctors had been trained to supervise health-care workers conducting contact tracing.

**Liberia:** WHO, working with WFP and UNICEF and using local contractors, designed and built over 500 extra Ebola treatment unit beds in Monrovia. Training was conducted for over 1000 national and international staff. 16 facilities were open and a further 10 under construction across the country providing over 1500 beds. This would not have been possible without multiple governments and NGO teams working alongside the Liberian Government's Incident Management System.

**Sierra Leone:** The Ministry of Health with the UK and other Governments and NGOs rapidly created 1200 beds in 22 Ebola treatment units with a further four under construction. Over 4000 national and international health care workers had been trained for work in Ebola treatment units and clinics.

By the end of human-to-human transmission in November 2016 over 5000 international staff had been deployed through EMTs from over 40 organizations to manage 58 Ebola treatment units.

There were a number of serious practical matters to address. For one, organizations apart from MSF had no experience in care for patients sick with Ebola. Yet they were supposed to be self-sufficient (staff, supplies, space and system). "We had to fill all those gaps," Norton said. "The first was the space; they didn't know how to build Ebola treatment units. So we built treatment units for them, and then got help from the United Kingdom and the United States of America to build more. The second was training. They had staff, but none of these staff were trained. So we put in place a training module."

#### This training included:

- providing curricula for multiple partners on trainings in the field covering case management, contact tracing, safe and dignified burials and social mobilization;
- providing trainings on contact tracing; and
- working with partners (the Governments of France, United Kingdom, United States of America) to train thousands in the classroom and in simulations.

WHO also provided thousands of sets of personal protective equipment for the health workers to wear.

"We had to do a lot of coaxing, advocacy through governments and the very largest donors in the world who in turn advocated with government teams and NGOs, but eventually 58 Foreign Medical Teams deployed. This was an incredible response," Norton said.

#### A quality assurance for future emergencies

Ebola represented a turning point for the EMT Initiative. Previously its focus was on sudden-onset disasters such as earthquakes and devastating storms. Now it became clear that its role was also to increase the world's capacity of medical teams able to deliver care to patients during a dangerous infectious disease outbreak and other emergencies.

With WHO's recently developed approach to verifying and quality-assuring teams, countries can look forward to a time when teams specially equipped to handle such diseases as SARS, cholera or dengue, will be ready to step forward. WHO will coordinate the quality assured list, which means that the government affected can draw from effectively an à-la-carte menu of all the world's teams. There are some that are good at trauma disaster response, some that are good at public health and outbreak response, some have specialty skills. It also allows surety for the country and the population accepting the team, that they meet a minimum standard.



#### On the frontlines of Ebola

Paediatrician Dr Michael Mawanda was no stranger to Ebola when the disease struck in Sierra Leone in 2014. The Ugandan native had already cared for patients affected by Ebola during the outbreak in Gulu, Uganda in 2010.

When the first cases appeared in Sierra Leone in March, 2014, Mawanda was working in Freetown's Hospital run by the NGO Emergency. He did not hesitate to volunteer. He joined his NGO's task force on case management, worked closely with the WHO country office to help set up an isolation unit which he went on to manage, and treated patients sick with Ebola.

"I knew there were risks – because we did not have the best equipment for infection control. But we were careful, and had a low infection rate among health workers, compared to other facilities fighting Ebola," he said. In September, he became the first health professional in the unit to become sick with Ebola. After five days as a patient on his own ward, his situation was life-threatening.

WHO staff tasked with deployment to the Ebola outbreak worked with the governments of Germany and Sierra Leone to have Mawanda airlifted to Frankfurt's university hospital, which contains one of the world's most expert units for the specialized treatment of Ebola. After many weeks on life support, followed by a month of rehabilitation, Mawanda was able to return home to Uganda.

But his commitment to preventing deaths from Ebola was unstoppable. In March 2015, he returned to West Africa, this time to work as clinical manager of the Ebola case management unit, coordinating EMTs for WHO in Liberia. Looking back, Mawanda believes that if EMTs specially trained to confront Ebola had stepped in at the start of the epidemic, it would never have reached the same proportions. "Now we know – in an outbreak, we need to have EMTs ready to support countries in need of help before things spiral out of control. They are critical to the response," he said.



# Processes of the EMT Initiative

*In an emergency, it is critical to get the team with the right skills to the right place at the right time, WHO's EMT classification list requires that all EMT's clearly outline their services and skills.*


Populations affected by disasters or public health emergencies need to be provided with quality health care by qualified professionals with established standards.


**The WHO EMT Initiative requires that all teams and their members are:**


- licensed to practice in their home country;
- specialists in their field and have suitable malpractice insurance; and
- registered (and obtain licensing) with national authority and lead international agency.


**They should:**


- declare skills and services provided;
- report regularly during the response;
- maintain confidential patient records and arrange referral plans;
- collaborate with the existing health system and be self-sufficient;
- ensure supplies and medications meet international standards;
- maintain standards for hygiene, sanitation and medical waste management; and
- be prepared to care for team member's health and safety and repatriation if needed.

**Type 1 Mobile**  
 Provide outpatient initial emergency care of injuries and other significant health care needs.  
 The team, including all equipment, can be easily moved throughout the mission deployment.

**Type 1 Fixed**  
 Same as Type 1 Mobile but work out of a fixed structure and provide up to 12 hours per day of care, 7 days a week.

**Type 2**  
 Provide emergency care including surgery, 24 hours per day.  
 Deploy field hospitals with at least 20 beds and can replace or support small district hospitals.

**Type 3**  
 Provide inpatient referral care including intensive care and complex surgery.  
 Provide large 40-100 bed facilities and can support or replace tertiary hospitals.

**Specialized Teams**  
 Specialize in a specific medical area. May be as small as two or three senior specialists, or a specialist facility eg. Ebola or rehabilitation.  
 Must bring appropriate equipment and supplies with them.

## How teams reach the quality assurance designation

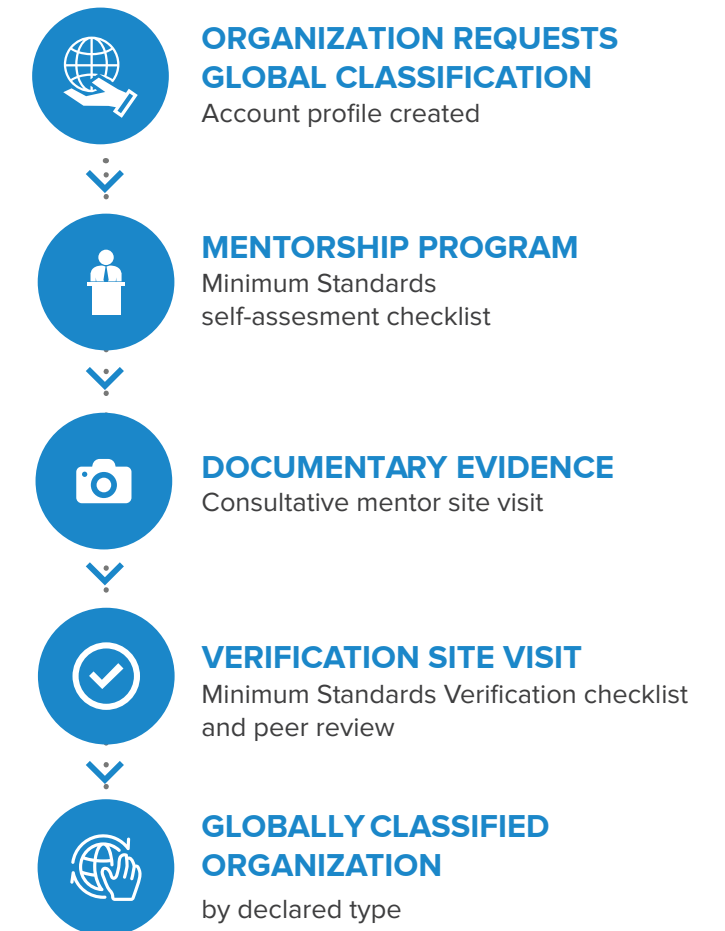
The first step for any team is to submit an expression of interest to join the WHO Global EMT list. The EMT secretariat at WHO then selects and assigns a suitable mentor who will lead and support the organization through the peer-review process towards the quality assurance designation in a Mentorship Programme. Following the mentoring process, it will receive a verification site visit by a verification team of its peers and if successful will be considered Quality Assured and classified according to its capacity.

To date six teams have completed the verification process (from Australia, Peoples' Republic of China, Israel, Japan and the Russian Federation). More than 75 teams are going through the mentorship process and seeking quality assurance. The entire process can take up to a year. By the end of 2017, it is expected that at least 50 additional teams will have been verified for quality assurance, and over 100 will be in the mentorship programme.

A fundamental objective of the Global EMT Classification process is to discourage individuals from arriving unannounced to an emergency. Instead the WHO Global EMT Initiative encourages these individuals to join recognized organizations. Only users representing an organization that provides emergency medical services can apply for a user account. Individuals or individual members of an EMT will not be Quality Assured.



*Emergency Medical Teams that have gone through mentorship and verification are awarded a cloth identification badge for their uniforms.*



## ONGOING QUALITY ASSURANCE PROCESS



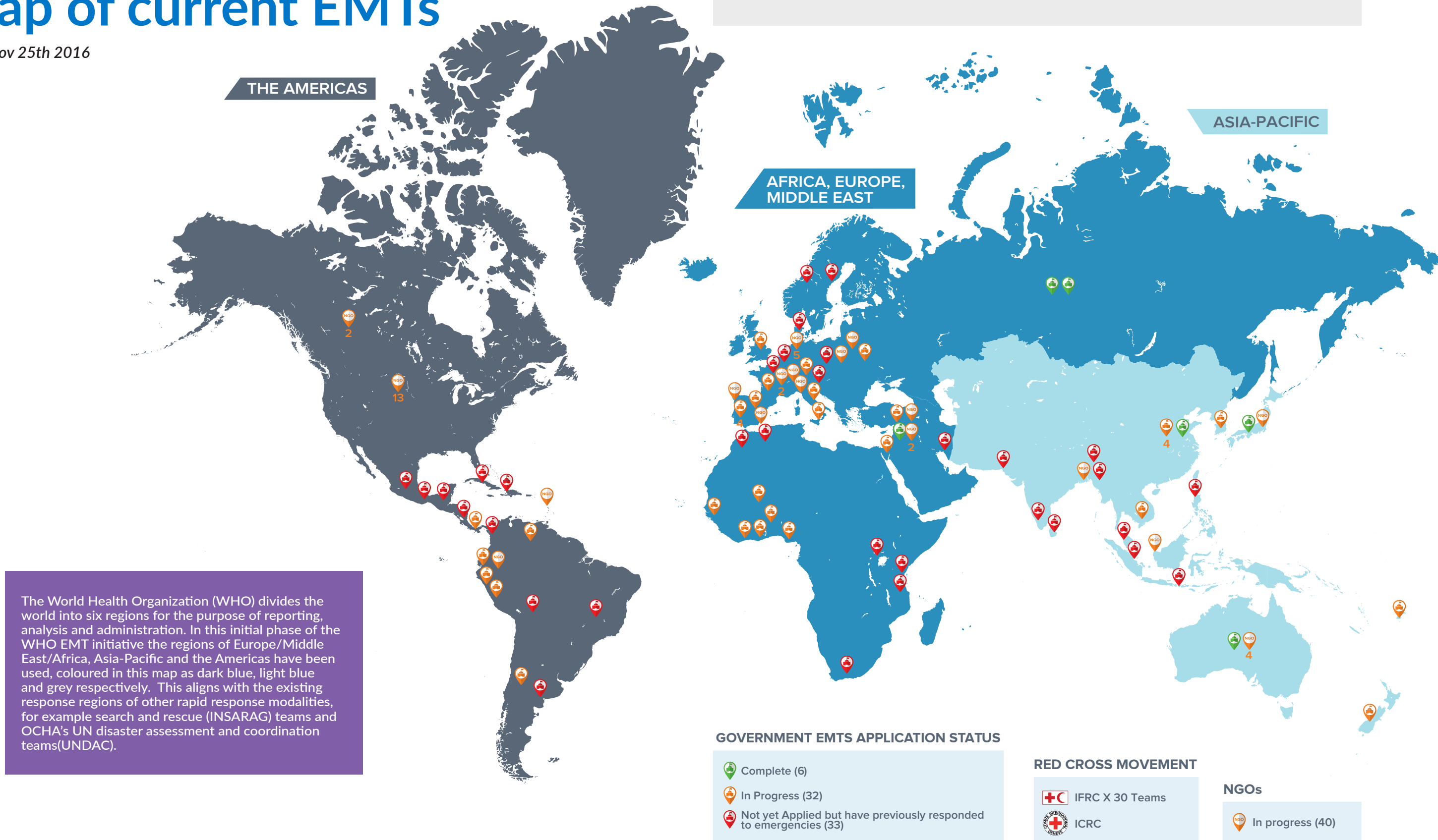


# Map of current EMTs

as of Nov 25th 2016

"It's impressive to see the geographic spread of member states and regional NGOs that have EMTs across the areas where disasters and emergencies are most frequent, this will speed up response"

Mr. Jesper Lund, Chief of Field Coordination Support Section (FCSS), OCHA



The World Health Organization (WHO) divides the world into six regions for the purpose of reporting, analysis and administration. In this initial phase of the WHO EMT initiative the regions of Europe/Middle East/Africa, Asia-Pacific and the Americas have been used, coloured in this map as dark blue, light blue and grey respectively. This aligns with the existing response regions of other rapid response modalities, for example search and rescue (INSARAG) teams and OCHA's UN disaster assessment and coordination teams(UNDAC).



# Key activities of the EMT Initiative

## Building capacity

*One of the key objectives of the EMT Initiative is to work with partners on the design of appropriate training curricula and organize training sessions.*

The EMT Secretariat coordinates collaboration between national and international EMTs for training and preparation of their own rostered personnel. We promote a standardized curriculum framework, including for training of trainers, and work with partners in developing quality benchmarks.

We believe that ideally, responses to disasters and outbreaks should be handled primarily by national teams and, if need be, assisted by teams from neighbouring countries. Therefore, our focus is chiefly on improving national and regional preparedness. Training of national teams is one of our strongest priorities.

We also organize training in Emergency Medical Team coordination, mentoring EMTs to achieve verification, and preparedness training for international emergency deployment, among other training sessions.



**Spotlight - Coordination Cell Training in Italy**

The second Emergency Medical Team Coordination Cell (EMT CC) training was held in Novara, Italy from 4-8 July with 24 participants from 13 countries across Europe and as far away as Fiji and Nepal. The training was hosted by the Research Centre in Emergency and Disaster Medicine and held in partnership with the Directorate General for Humanitarian Aid and Civil Protection of the EU.

The aim of the training was for participants to learn about the function of an EMT Coordination Cell during an emergency and the role it plays in supporting a host government to accept, register, quality assure and task EMTs. During the intensive five-day programme participants were introduced to the humanitarian landscape and current coordination platforms; undertook an interactive mentoring exercise; and completed some skills-based learning on integrating within existing coordination mechanisms. The final two days of the programme involved a simulation exercise where participants were provided with an opportunity to consolidate their learning.

There are now 75 trained EMT CC personnel who are ready and available for secondment to an EMT CC during an emergency – but more are needed. That is why, thanks to a generous contribution from Macao SAR, additional courses are being rolled out across the Americas, Asia-Pacific and Africa.

### 3 options for EMT coordination during an emergency response:

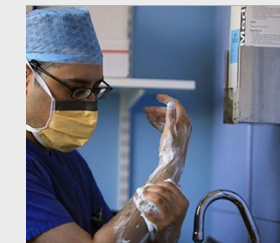
- » The government of an affected country has mechanism in place for EMT coordination at their own Emergency Operations Centre.
- » If the government of an affected country has no such mechanism in place, it will be supported to create a Reception and Departure Centre and an EMT Coordination Cell, with the support of WHO and the UN Office for the Coordination of Humanitarian Affairs (OCHA) and partner agreements.
- » EMTs are grouped in a sub-cluster under WHO coordination.

Order of preference

## Coordinating EMTs during outbreak and disaster responses



When large-scale disasters strike, overwhelming national resources, governments can get help quickly by asking WHO to help coordinate the deployment of Emergency Medical Teams (EMTs). One of the key roles of the initiative is coordinating the teams, making sure the professionals with the right skills are deployed where they are needed and that all efforts are coordinated in concert with the affected government, the UN and other partner organizations.



Trauma specialists play a critical role in the immediate aftermath of sudden-onset disasters. The EMT Initiative classifies surgical and trauma

teams according to their capacities and mobility before deploying them to responses – and then coordinates with the affected government to ensure the teams are placed where the need is greatest in hours not days.

In many cases, a longer-term response is needed, and teams with appropriate skills must be deployed. For example, EMTs capable of providing

rehabilitation services are critical in many responses. Such support can help a person recover the use of a limb, or regain mobility through use of a prosthesis.



The EMT Initiative ensures skilled teams are deployed to respond to sudden-onset disasters and other emergencies. WHO can match and help coordinate skilled medical teams in response to natural disasters and disease outbreaks.

For effective responses, three levels of coordination are needed – at local, regional and global levels.

Response to a disaster or outbreak is always complicated, and requires careful coordination of different teams. EMTs include medical evacuation teams, logisticians able to rebuild hospitals, information managers, mobile laboratories and supplies.



The Ebola response was the largest deployment of EMTs for an outbreak. In total, 58 teams and more than 4000 staff members joined the effort and received training and support from WHO.

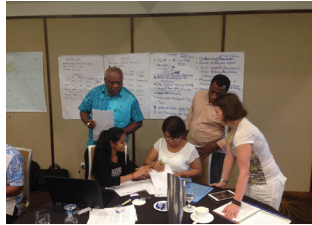




# EMT Training

## National EMT training

National Emergency Medical Teams are the first to deploy and can be mobilized quickly from unaffected areas of a country into the disaster or outbreak zone with the right training and logistics support. WHO supports strategic planning for the establishment of National EMT systems in countries and provides training for senior staff who will lead and train their national teams in the future. Training sessions were held in Fiji and the Philippines in September and November 2016 and will occur in an additional eight countries early in 2017. This training will be one of the primary focuses of the EMT initiative; and an extensive increase in support will be needed in 2018-19 as more countries develop their national EMTs.



## EMT Coordination Cell (EMT-CC) training



The EMT-CC is a relatively new concept, built on existing OCHA mechanisms to coordinate search and rescue and other types of rapid response teams that arrive within hours to a disaster

zone. The WHO EMT secretariat has worked with OCHA to create a method to rapidly deploy EMTs using the virtual On-Site Operations Coordination Centre (virtual OSOCC) and the Reception and Departure Centre (RDC); and to set up an EMT-Coordination Cell within the Health Emergency Operations Centre and emergency management structure of an affected government. A handbook and specialist training have been developed. After a pilot in October 2015 in the Pacific, training sessions were held in Europe (Italy) and South Asia (India). Additional courses will be conducted in Africa, the Americas and Europe in 2017.

## Global Health Emergency Workforce (GHEW) coordination training

Ministries of health and governments need skilled managers and an emergency management system to be able to recognize an emerging threat or mount a response to an emergency with health consequences. Their first



reaction should be to deploy national response teams with clinical and public health expertise. They also need to understand what is available from neighbours who might offer help, and from regional and global networks that can provide teams such as EMTs and public health rapid response teams (governmental or NGO), staff and experts from WHO and the UN, laboratories, logistics support or experts from the Global Outbreak Alert and Response Network (GOARN).

All these entities make up the Global Health Emergency Workforce, and countries need to be able to understand what support is available and the mechanisms for its deployment and coordination. Training has been developed and piloted in Turkey and Fiji in 2016 and will be rolled out throughout 2017 in at least another eight countries. It occurs in three phases:

1. Introduce the GHEW and mechanisms used to activate and coordinate it, examine existing national structures to manage emergency response and coordination of teams and experts, and run a table-top exercise to practice activation in real time.
2. Provide funding to hire national emergency management and public health experts to write standard operating procedures and guidance within the Ministry of Health regarding acceptance of international health assistance when needed.
3. Return with a training and simulation team to test the new arrangements in a simulation exercise.

## Regional workforce training and capacity building



Multiple regional medical workforce initiatives are underway to help prepare teams for response at a regional level. The WHO EMT Secretariat has begun contributing to regional trainings and capacity building for regional workforces in collaboration with:

- the European Union
- the African Union and sub-regions (ECOWAS and the West African Health Organization)
- countries in South America
- countries in South East Asia under the ASEAN and East Asian Summit arrangements

# Training simulations

## Regional earthquake exercises

In the last two years the WHO EMT initiative has worked with UN-OCHA to prepare and conduct earthquake exercises in high-risk countries across the world. In 2016, three simulations took place in Turkey, Indonesia and Colombia (after successful exercises in Mongolia and Chile the year before). Each had at least 10-15 national EMTs with another 10 international teams "deploying" in the simulation. These exercises were previously used exclusively to train Search and Rescue teams under the International Search and Rescue Group (INSARAG).



Highlights included the chance to learn in detail the mechanisms of deployment for the region and, in particular, the risks for that country and the on-the-ground mechanisms for deploying national response teams and accepting and coordinating international responders. The exercises also allowed other actors in the international system to participate and to learn about the value of EMTs and the coordination mechanisms they use. These include the humanitarian coordinator role and humanitarian country team, the UN Disaster Assessment and Coordination team (UNDAC), the pre-arrival On-Site Operations Coordination Centre (virtual OSOCC), Reception Departure Centre (RDC) and coordination mechanisms (OSOCC). It also allowed for collaboration with the host Government and for recently trained EMT coordinators to set up an EMT-Coordination Cell (EMT-CC).

More exercises are planned for 2017, and all EMTs are encouraged to send two to three leaders to take part in the exercise most relevant to their region of deployment.



## Other regional exercises



The EMT community and the WHO EMT secretariat have joined exercises to practice the mechanisms of deployment and coordination during the health-related European Union "Modex" exercises over the last two years. These simulations involve several EMTs deploying from their home base to another part of the region, setting up part or all of their response and treatment capacities and going through a multi-day simulation exercise. WHO EMT secretariat staff, European experts and EMT coordinators have attended these exercises, often as a first step towards the quality assurance and verification of European EMTs through a joint process agreed with the European Commission.



Each year the International Humanitarian Partnership (IHP) holds a large-scale simulation known as Triplex, which was held in Norway in 2016 (see the EMT News section for more details). It gave 500 participants from 76 countries working in over 40 organizations opportunities to practice their collaboration abilities. EMTs participating in the exercise got the opportunity to set up a coordination cell. The IHP was vital in supporting EMTs deploying to Ebola in 2014 and 2015, and in supporting the set up and functioning of the EMT-CC in Nepal.

PAHO has conducted several EMT coordination trainings and exercises in recent years, the biggest of which took place in Costa Rica in September 2016, with participants from more than a dozen countries taking part in a 36-hour simulated emergency response conducted entirely in Spanish.



# Deploying to disasters: The EMT deployment process

For EMTs work starts well before an emergency takes place, preparedness is key. After team members are selected based on expertise, experience and competencies, they usually go through training and simulation exercises. More and more EMTs are now also going through WHO's verification and quality assurance process. Other preparation includes ensuring all of the necessary equipment is organised and packed ready for rapid deployment at short notice.

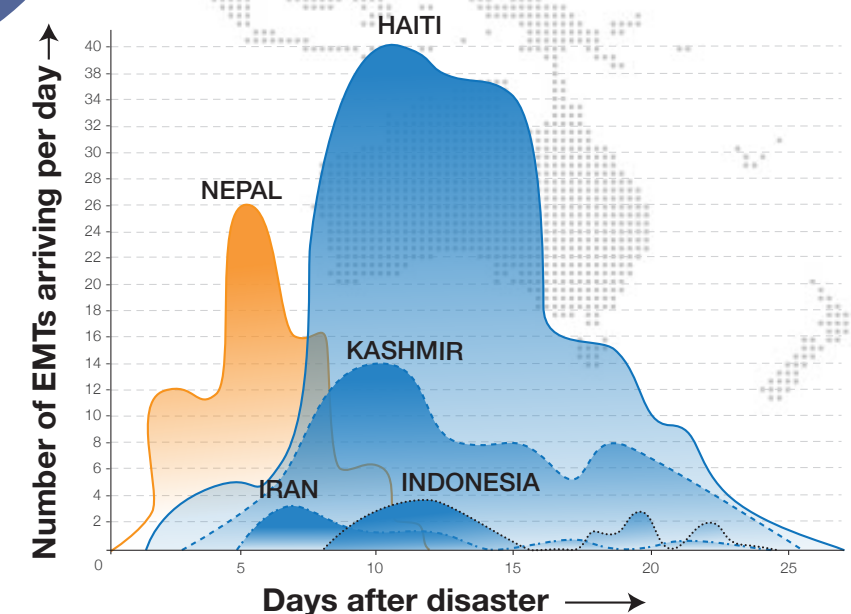


While the EMT has finished their role in the emergency, their job is far from done. They will go on to assess lessons learned and ensure continuous improvement, to ensure they are ready for the next deployment.

The first 72 hours after a sudden-onset disaster are vital for trauma care; but in the past medical teams deploying to affected countries arrived and started their operations too late to prevent the greatest number of deaths and disabilities.

The graph below, which represents a conceptual model, shows the number of teams arriving each day during five recent sudden-onset disasters. They are: the 2003 Bam earthquake in Iran, the 2004 tsunami disaster in Aceh, Indonesia, the 2005 Earthquake disaster in Kashmir, the 2010 earthquake in Haiti and the 2015 earthquake in Nepal.

The data points are estimated according to the day of EMT arrival. As illustrated, the earthquake in Nepal represented the first occasion when teams arrived and began caring for patients on day 1. By day 5, there were sufficient teams on hand operating at full speed and the EMT coordination cell within the Ministry of Health asked teams to stand-down.





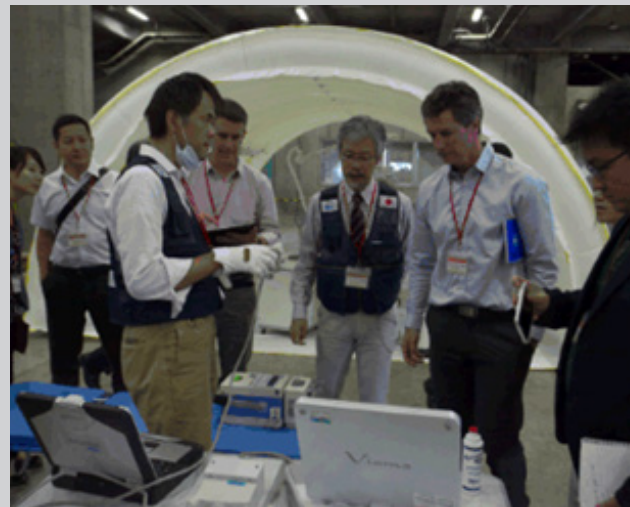
# Are you EMT-wise? Take this quiz.

**TRUE OR FALSE ?**

- 1) Surgeons are the main health professionals needed for responses to emergencies with health consequences.
- 2) The Ebola response was the largest deployment ever of EMTs for an outbreak.
- 3) Any health professional with a strong desire to provide humanitarian assistance is encouraged to deploy on his or her own to a sudden-onset disaster or disease outbreak.
- 4) A growing number of countries have national EMTs that can provide most or even all care needed in an emergency.
- 5) A health professional who already has a license to practice at home is automatically authorized to provide hands-on patient care during an emergency in another country.
- 6) EMTs are not generally meant to require logistic support or even food from the affected country.

Answers:

1. False. - A variety of different professionals are needed to make up an emergency medical team - ranging from logisticians to physical therapists to infectious disease specialists. The type of emergency will dictate what type of team is needed and how it should be composed.
2. True - In total, 58 teams and more than 4000 health professionals joined the effort and received training and support from WHO.
3. False - A fundamental objective of the Global EMT Classification process is to discourage individuals from arriving unannounced to an emergency. Instead the WHO EMT Initiative encourages these individuals to join recognized organizations and for the organization to seek WHO verification.
4. True - Responders acting domestically and within a region have a better understanding of local culture, context, and language. WHO is encouraging all countries to create national emergency medical teams as part of their health system capacity building efforts and additionally, to create regional networks where neighbouring countries can deploy quickly to help address an emergency.
5. False - All EMT staff must register and obtain licensing with the national authority before caring for patients. One of the advantages of verifying teams through the EMT Initiative is that national authorities proceed with licensing faster because they know a team has met minimum international standards.
6. True - To meet WHO's minimum standards, EMTs must agree that they will be self-sufficient, unless a prior agreement has been made before deployment.



## Australian and Japanese organizations talk about their experience with EMT quality assurance.

**AUSTRALIA**

**Q: Australia has a long tradition of preparing health workers to deploy for disasters in other countries. What is the background to this commitment?**

NCCTRC: The North coast of Australia is near one of the most disaster-prone areas in the world, so it has been very fitting for us to be involved. We work through two major organizations: the National Critical Care and Trauma Response Centre (NCCTRC) and the Australian Medical Assistance Teams (AUSMAT).

The NCCTRC was established following the 2002 Bali bombings. Funded by the Australian Government, the NCCTRC is focused on enhancing Australia's capacity to provide clinical and academic leadership in disaster and trauma care. The NCCTRC provides a local response capability and an internationally unique education, training and exercising capacity.

AUSMATs are designed to be self-sufficient, experienced teams that can rapidly respond to a disaster zone to provide life-saving treatment to casualties, in support of the local health response. The NCCTRC prepares AUSMAT clinical

**JAPAN**

**Q. Could you tell readers something about your organization?**

JDR: Japan's disaster relief activities date back to the late 1970s, when medical teams were dispatched to assist Cambodian refugees. In September 1987, the Japan Disaster Relief Team Law (the JDR Law) was enacted to enhance dispatch systems for rescue and expert teams.

Based on the response to the spread of Ebola in West Africa, in October 2015 the Japan Disaster Relief Infectious Disease Response Team was established. There are more than 1000 medical professionals in the roster managed by the Secretariat of JDR, the Japan International Cooperation Agency.

**Q: What did verification of your group by the WHO EMT Initiative involve?**

JDR: WHO's verification visit for the JDR Medical team was held in Tokyo from 1-2 June 2016, and the team was successfully verified as EMT Type 1 and 2 with Specialist Cells (haemodialysis and surgery).

It took us four months to prepare. In February, we had a visit by our mentor, during a simulation exercise for field deployment. In addition, we were in continual contact with the JDR Medical Team's EMT Advisory Committee and the EMT Secretariat.

and logistics personnel for overseas deployment in teams.

**Q: How many Australian health workers have the qualifications to deploy to an emergency?**

NCCTRC: We have a database of approximately 600 medical professionals who work in a range of specialities.

**Q: Considering you were already active in emergency responses, what made you decide to seek verification through WHO's EMT initiative?**

NCCTRC: We support minimum standards and want to ensure we adhere to and maintain them. The importance of doing what you say you can do in the field is essential, and providing quality care throughout a disaster deployment should be expected. Verification provided an opportunity to evaluate our procedures and equipment against the minimum standards.

**Q: What impact do you believe WHO's EMT initiative is having on countries' ability respond quickly and professionally to disasters and outbreaks?**

NCCTRC: The WHO EMT initiative is clearly defining the guidelines for medical disaster response. The emphasis on national capability is essential. The international community will have a more focused role on being the supporters of a national response - augmenting and increasing capacity only when resources are overwhelmed rather than "taking over" the response.

We were in continual contact with our Lead Mentor, who helped us prepare evidence documents and operation manuals and making arrangements for the visiting verification team. We also needed to coordinate, of course, with the Ministry of Foreign Affairs of Japan.

**Q: What were the challenges you faced during the verification process, and how did you address them?**

JDR: We were only the third country to receive a verification visit, so we were uncertain about how things would go exactly. But our wonderful Lead Mentor, Ms Bronte Martin of AUSMAT, strongly supported us and facilitated matters by coordinating with the EMT Secretariat.

**Q: Any advice for teams undergoing or planning to be verified?**

JDR: It is very important to fully understand the Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters. Consulting and staying in close contact with the Lead Mentor is also crucial. In future, teams planning to be verified would benefit from the opportunity to observe another team's verification visit.



# The WHO EMT Initiative: Looking ahead



The global development community has learned many lessons over the past two decades about responding to sudden-onset disasters and infectious disease outbreaks. In our view, there are two top considerations.

The first is that timing is crucial in an emergency response, especially when trauma is involved. If teams are not on the ground treating patients within 48-72 hours, they will save far fewer lives. The second and no less critical consideration is that those teams need to meet minimum international standards and be self-sufficient. Quality matters.

## An offer-based approach

We have also learned that when a country has no existing arrangements for bringing in EMTs, it takes more time than would be ideal for minimizing morbidity and mortality. It may be politically sensitive for any government to ask for assistance, especially when that request needs to be fulfilled within hours. Accepting an offer from a friend and neighbour is much simpler, especially if mutual agreements and arrangements for assistance have been made in advance.

This offer-based approach, built on pre-agreed triggers according to hazard impact and severity – and based on regional alliances and geographic and cultural affinity – can increase the speed of response times. Teams from the same region can often arrive within hours with minimal difficulty and reinforce existing political ties when deployed to each other's countries.

## Faster coordination of deployments

In past responses, arrival of teams for a sudden-onset disaster could take as long as 15 days. Things move faster now, and we know what it takes to achieve this. Countries need to be able to deploy their own national response teams as quickly as possible and, at the same time, to perform a rapid assessment of needs that guide a "no regrets" offer and acceptance of assistance by regional or international teams.

We have seen these processes work well. After the earthquakes in Ecuador and Nepal, acceptance, registration/

licence to practice and tasking of teams were arranged through each country's Health Emergency Operations Centre (EOC), with assistance from WHO. This model was also applied in some countries affected by Ebola in West Africa, the yellow fever response in Angola and the recent hurricane/cyclone responses in Haiti, Fiji and Vanuatu. The WHO EMT Initiative will continue its work building national capacity to accept and coordinate arriving EMTs and to develop a cadre of international experts from WHO and partners who can assist ministries and EOCs in setting up EMT-CCs.

## Growing the number of verified EMTs

An impressive number of EMTs have applied for mentorship and verification. Completing the process with them is an important priority for WHO's Health Emergencies Programme. We are working hard to complete the verification process for EMTs that have requested it – but in truth we have not yet been able to hire enough staff or raise sufficient funds to achieve this goal as quickly as we would wish. We are working hard to bring needed staff and consultants on board and speed up the process.

Mentorship and verification depend on peer support. Experts from teams are offered to other teams to improve areas of operations that they may find challenging, and as part of a community of practice dedicated to improving health care of people affected by disasters and emergencies. We thank the expert mentors and their organizations for their dedication and support.

## National capacity building

At least 10 Member States will have specific programmes on national medical team development in 2017. And at least 10 countries will have courses and capacity building programmes to be able to identify and coordinate appropriate teams and experts from the global health emergency workforce and EMTs.

We have a strong commitment to training teams or operational units. But we wish to be clear: This training is not intended for individuals who may never be sent to the field, or worse, may think that their training prepares them to deploy solo. Training is critical, but it is just one component of the process of safe operations and deployment and must be linked to deployment agencies.

## New horizons

Looking ahead, we believe the role of EMTs will expand. EMTs have mostly, up to now, been focused on acute emergencies like sudden-onset disasters or outbreaks. Yet the need for emergency medical care is greatest during protracted and complex emergencies. The EMT Initiative Secretariat and the initiative's working groups will be looking at how we can expand the remit of EMTs to addressing chronic emergencies where the health needs are greatest and supporting national EMTs that continue to work in complex and/or protracted emergencies.

# GET INVOLVED

## WHAT YOU CAN DO TO IMPROVE EMERGENCY MEDICAL RESPONSES



### Governments

Work with WHO to develop your national medical response team capacity and procedures for accepting international teams if necessary.

Publicly declare that you will send and receive only medical teams that have reached the minimum standard of quality.

Establish mutual agreements with countries in your region for deployment of classified EMTs in the event of a disaster or outbreak.



### EMTs

If you have not done so already, apply to classify your EMT at <https://extranet.who.int/emt/user/register>

Encourage sister organizations to do the same.



### Donors

Support the WHO EMT Initiative.

Ensure contributions for international emergency responses go to EMTs that are undergoing the verification process.



### Individuals

If you're a health worker or have other critical skills, join a verified EMT and volunteer for local responses.

Help raise funds. Lead a drive in your school, workplace or community to raise funds for a local or international EMT that meets WHO minimum standards.

Be prepared. Learn about your community's and country's procedures for responding to an emergency.

Photo credits: AUSMAT, DFAT, European Medical Corps, International Humanitarian Partnership, JDR, WHO, WHO/Nyka Alexander, WHO/Christopher Black, WHO/Pieter Desloovere, WHO/Francisco, WHO/Rob Holden, WHO-Syria/B Khabbie, WHO/Amer Khan, WHO/Ian Norton, WHO/AMRO/David Spitz.





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