



Pan American
Health
Organization



World Health
Organization

EMERGENCY MEDICAL TEAMS

Global Meeting

Panama, 1-3 December 2015



Introduction

The Emergency Medical Teams (EMT) Secretariat of the World Health Organization together with the Pan American Health Organization organized the EMT Global Meeting in Panama City, Panama from 1-3 December 2015. The meeting provided an opportunity for 150 participants drawn from Government (over 30 member states teams), civil society and the private sector (over 40 teams) and international organizations, to participate in discussion and debate on a number of issues relating to the current implementation and ongoing development of the EMT initiative.

Topics covered

The topics covered over the three days included updates on the EMT global initiative and the Reform of WHO work in outbreaks and emergencies, including the Global Health Emergency Workforce (GHEW). The meeting also included discussion on strengthening global collaboration and capacity, the EMT quality assurance framework including registration, mentorship and verification processes and procedures, national mechanisms for team registration and coordination, and minimum standards for national and international teams. The plenary sessions were supported by a number of smaller breakout parallel sessions covering topics spanning clinical, governance, logistics and training. Updates and information were provided by representatives from the Americas, Europe Africa and Middle East, and the Asia-Pacific Region followed by Regional consultations.

Main issues of discussion and agreement

Naming convention

The use of the term 'Foreign' was considered outmoded and inappropriate for ongoing use. There was agreement with the proposition that the initiative should be referred to as 'Emergency Medical Teams' and that teams within this category can be either national medical teams or international medical teams using a pre-fix if required (N-EMT, I-EMT).

Enhanced governance mechanisms

It was agreed that strategic guidance of the EMT Initiative should be available through the establishment of an Emergency Medical Teams Strategic Advisory Group (SAG) and the Global Secretariat hosted by WHO. The SAG should be formed in time for the first meeting in early February at UN-partners week in Geneva. Regional meetings and chairs should be initiated during the 2016 in the three defined Regions: Americas, Asia-Pacific and Europe-Africa-Middle East. Regional chairs represent regional constituents on the SAG together with a broad cross-section of EMT stakeholder groups.

The suggested make-up of the SAG would include at least; Regional chairs (and regional chairs in waiting for meeting prior to hand-over), chairs of any working groups, 2 support group (donor) representatives, Govt. representatives of two countries recently affected by sudden onset disaster requiring EMT deployment, representatives of regional bodies with specific EMT mechanisms complying with the global initiative, and representatives of the following organizations: IFRC, ICRC, Global Health Cluster, UN-OCHA, GOARN and WHO/PAHO.

Clarity on EMT Types of classification

The Global EMT meeting participants agreed with the findings of reviews of EMT responses to Philippines, Vanuatu and Nepal that suggested the following changes:

- Type 1 will be further sub-grouped to Mobile (50 patients/day) or Fixed (100 patients/day). It is clarified that Type 1 Mobile requires a base of operations (where teams depart and come back) and self-sufficiency for at least two weeks, in a similar manner to Type 1 fixed.
- Type 2 remains Inpatient Surgical (with infrastructure).
- Type 3 no change.
- Specialist cells are to include surgical capabilities without infrastructure: definition of minimum standards for each specialist cell should be developed. General positive feedback on the proposition of including in the registry teams involved in support to other EMTs rather than direct care (e.g. medical evacuation provision, logistic/operations support to others especially N-EMT).

Coordination of EMTs

Three scalable options for EMTs coordination have been identified as follows in order of preference:

- Host Government has pre-existing mechanism for EMT Coordination at their (Health) Emergency Operation Center.
- Host Government supported to create Reception and Departure Center (RDC) and EMT-Coordination Cell (EMT-CC or CICOM¹ in the Americas) by WHO/PAHO with UN-OCHA and partner support.
- EMTs coordinated in a sub-cluster approach in a case of Government coordination capacity limitation or constraint.

PAHO held in April 2015 a course for EMT coordinators in the Americas. This course was jointly organized with Health Cluster coordinator course. After the pilot training for EMT Coordination Cell (EMTCC/CICOM) operations, based on the new EMT Field Coordination Handbook, held in Asia-Pacific Region in October 2015, additional trainings will roll out during 2016 in other Regions.

Further clarification of the interaction between the EMT-CC/CICOM and a health cluster if jointly activated is required, acknowledging the operational focus and time-bound nature of tasking and coordinating those EMTs providing clinical care (surge in support of an affected Government) as compared to the longer term coordination functions of a health cluster. An EMT-CC/CICOM activation in direct support to the ministry may occur without the need for health cluster activation and vice versa.

Clarity of focus

It was agreed the EMT initiative should remain focused in the near-term on supporting member states affected by sudden onset disasters and/or outbreaks (for the purpose of direct patient contact/services). There is a need for more global capacity for clinical care of infectious diseases. Public health expertise

¹ Cell of Information and Medical Coordination – Célula de Información y Coordinación Médica

should be included in clinical care teams to allow them to act as “sentinel surveillance sites” even if their focus is primarily trauma, and the focus on public health and related clinical interventions should increase for those teams responding to non-trauma related emergencies such as floods, typhoons and disease outbreaks. The meeting clarified that pure public health teams designed for outbreak investigation, etc (ie non clinical) should not be considered an EMT, and should be managed through another mechanism and in close collaboration with the Global Outbreak Alert and Response Network (GOARN).

The role and name of the Global EMT pre-registered list (List of Classified Teams)

The purpose of the Global pre-registered list is to provide member states with a list of pre-validated and quality checked clinical teams to empower them with the information they need to ensure that international medical assistance is carried out in a manner that meets internationally agreed standards and frameworks. It was agreed the term “Registry” is not suitable for such a list due to confusion with host country registration process for National Teams and upon arrival and should be replaced by the term “Classification”. This term also aligns with the term used for a similar quality checked list of Search and Rescue teams managed by UN-OCHA. The EMT Quality Assurance Framework and the classification pilot process were presented and endorsed during the meeting. The model of the EMT Classification system will be based on a peer-review/peer-support methodology, and members of the EMT stakeholder community will be given the opportunity to participate as mentors and/or members of a verification team, in line with their skills, experience and the specific needs of the EMTs undergoing classification.

Main technical topics of discussion and agreement/recommendation

The following are brief excerpts from the break out session chairs of sessions held during the three days of meetings.

Public Health capacity

Need to support continuum of health services and to facilitate the integration of public health across the health system to improve response and resilience.

Public Health expertise in clinical care teams supports the assessment of results of interventions such as the isolation and treatment of Ebola and intelligence of how cases demonstrate societal needs.

Main functions and skill sets required include broad public health capacity such as WASH and nutrition.

Minimum Standards

Minimum standards for Rehabilitation have been developed and presented during the meeting with very positive feedback from the participants. The standards call for:

- At least one rehabilitation professional per 20 beds at the time of the deployment;
- allocation of a purpose-specific rehabilitation space of at least 12 m² for deployment exceeding 3 weeks;

- deployment of EMTs with at least the essential rehabilitation equipment and consumables;
- reporting of patients with notifiable injuries (spinal cord injury, lower limb amputation or complex fracture) to the host ministry of health of the host country/coordination cell at stipulated intervals (to allow protracted rehabilitation and support planning).

Additional working groups will be set up for the development of minimum standards for outbreaks, mental health, maternal and child health, non-communicable diseases and surgery.

Recommendations to include minimum standards for Infection Prevention and Control (IPC) as well as logistics and team readiness have been put forward.

Quality is paramount

EMTs who are providing emergency clinical care must strive to meet the standards of care as outlined in the 'Minimum Standards for Emergency Medical Teams in Sudden Onset Disasters' working with the local health systems. Furthermore that the EMT mentorship program, which is designed to support national and international medical teams achieve a level of internationally agreed technical competency, should be strengthened and expanded as a matter of priority.

Training is a key component to improving standards, accountability, co-ordination and performance of EMTs. A proposed framework for EMT training includes 3 main pillars:

- Professional, technical (e.g. nurse, medical doctor, physiotherapist, etc)
- Context specific training (e.g. resource limited setting, humanitarian response coordination, disaster medicine, epidemiology, etc.)
- EMT specific training – Team focus (e.g. EMT specific guidelines, safety and security, team building, stress management, etc.)

Mentorship and Verification Programme

Mentorship and Verification timelines are flexible, scalable and dependant of type and individual team preparedness. It is foreseen a maximum of 12 months to complete the process. Key verification criteria are divided in:

- Core standards and guiding principles (HR & Team management, Clinical capability and capacity, Medical records and reporting, Operational capability and capacity, Activation plans).
- Essential and Desirable (Team health and Welfare, Training and Exercise, Deployment history).

National capacity building

In the event of a sudden on-set disaster speed is paramount. The EMT initiative will focus on building national capacity to respond to sudden on-set disasters. Furthermore, priority country (countries prone to disasters) preparedness missions will be commencing in early 2016 engaging government ministries and other relevant national authorities in identify tailored to country-specific mechanisms for reception and coordination of Emergency Medical Teams (both national and international) as well as the development of National-EMTs and related establishment of Emergency Medical Team Coordination Cells.

EMTs Deployment (logistic and operations support)

The importance of the provision of logistic and operation support to EMTs during the alert and deployment phase was recognized. Particular importance has been given to:

- expedite customs and immigrations procedures, and landing authorizations;
- facilitate access to supply routes including water, food, fuel and consumables;
- support the dissemination of national standard operating procedures as country specific set of rules and regulations that govern the deployment of EMTs;
- access to medical evacuation;
- technical support for the medical waste management, infection prevention and control, management of dead bodies.

Reporting and Information Management

Compliance with the Minimum standards includes reporting at regular intervals during a response and prior to departure, to the national authorities using national reporting formats. A process of standardization of recommended reporting formats is in process to facilitate the regular reporting of EMTs. However, it needs to be recognized that regional and country specific needs and differences exist. Initial disruption of IT services can't justify gaps in reporting however a solution should be identified to facilitate the compliance with the national requirements (e.g. offline report system, optical scan).

Other topics of discussion and agreement/recommendation

Continuation of the initiative

EMT initiative should continue to evolve, supported by a strengthened Secretariat function, to develop the policies, standards and frameworks required to ensure the effective implementation of the initiative in a manner that is inclusive, consultative and respectful of the divergent opinions and views of members states, EMT recipients, EMT providers, donor governments, and non-governmental as well as international organizations.

Global engagement to continue

The Global Emergency Medical Team Meeting has provided an appropriate forum for the WHO EMT Secretariat to engage with members of the global EMT community, and that such events should continue on an annual basis into the future to provide opportunities to share experiences, exchange lessons learned, and benefit from updates to best practices in clinical guidelines and standards, and operational methodologies.



Future Events

Humanitarian Networks and Partnerships week, Geneva (Switzerland), 1-4 February 2016.

INSARAG (Simulation Exercise), Turkey, 9-13 May 2016.

Course for Regional EMT Coordinators in the Americas, LAC, 2nd quarter 2016.

TRIPLEX (Simulation Exercise), Norway, September 2016

INSARAG (Simulation Exercise), Colombia, September 2016.