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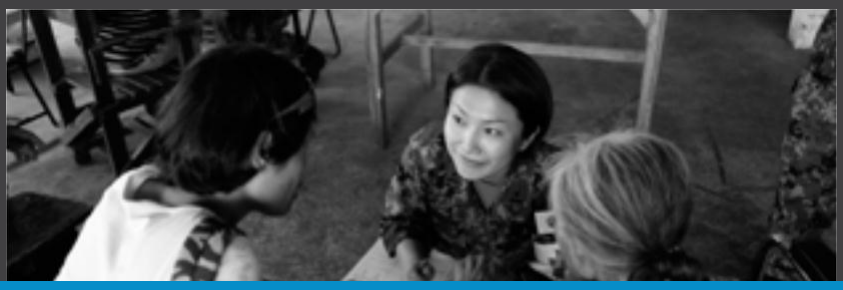

Initial Review of the Effectiveness and Coordination of Foreign Medical Teams in Response to Typhoon Yolanda

Mr Charles Blanch, Dr Nevio Zagaria, Dr Sasha Peiris

World Health Organization

FEbRuaRY 2015

DRAFT

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TIMELINE OF SIGNIFICANT FMT EVENTS

November 2013

7/11
Team Leader EHA WPRO informal request for FMT standby

8/11
Yolanda makes landfall

9/11
Official request from WHO to Australia on behalf of Philippines DOH

10/11
German ISAR and Belgian BFAST arrive
Manila Mammoth deploy to Tacloban area

11/11
State of National Calamity declared

15/11
Self contained Referral FMT2 operational at Tacloban airport

19/11
Additional sub-cluster coordinator in Tacloban, Cebu and Roxas Cities

21/11
Additional sub-clusters est Ormoc, Borongan, and Guiuan

22/11
918 FMT medical staff
51 Type 1 FMTs
6 Type 2 FMTs
1 Type 3 FMT
Plus 72 domestic teams operational

29/11
First 13 FMTs have demobilised

December 2013

06/12
EVRMC Hospital Laboratory operational

Referral Type 2 FMT at Tacloban airport informs partners of planned departure.

Concern that other facilities still not at capacity for exit

10/12
Peak of FMT deployments:
75 Type 1 FMTs
7 Type 2 FMTs
2 Type 3 FMTs
72/85 deployed to Region VIII
148 domestic medical teams concurrently deployed

18/12
FMTs decreased to 55

January 2014

05/01
Approximate date when both Tacloban public hospitals recommenced outpatient services
4/6 private hospitals fully functioning now

Taskforce Cadaver complete
Temporary mass burial in Tacloban for planned exhumation and formal identifcation

09/01
52 FMTs operational
41 Type 1 FMTs
6 Type 2 FMTs
1 Type 3 FMT
4 mobile

17/01 -19/01
Approximately 1000 IDP move into temporary accommodation

20/01
25 FMT operating
13 Type 1 FMTs
3 Type 2 FMTs
9 mobile and Mental Health Service teams

February 2014

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abbreviations and acronyms

Civ-Mil	Civilian-Military; Function providing coordination between civilian and military actors in humanitarian emergencies
DoH	Department of Health Philippines
EvRMC	Eastern Visayas Regional Medical Centre
FMT	Foreign Medical Team
ICRC	International Committee of the Red Cross
MSF	Médecins Sans Frontières
nDRRMC	National Disaster Risk Reduction Management Council
oCHa	Office for the Coordination of Humanitarian Affairs
oSoCC	On-site Operations Coordination Centre
RDC	Reception and Departure Centre
SoD	Sudden Onset Disaster
un	United Nations
unDaC	United Nations Disaster and Assessment Coordination
uSaR	Urban Search and Rescue
WaSH	Water and Sanitation for Health
WHo	World Health Organization
WPRo	World Health Organization Western Pacific Regional Office

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	Ou[illegible]rgen[illegible]re – initi[illegible]emerge[illegible] signif[illegible] care needs[illegible]
	[illegible]patie[illegible]ergen[illegible] obstetric sur[illegible]uma [illegible]
T[illegible]T	Inpa[illegible]l care – [illegible] [illegible]luding [illegible]tensiv[illegible]
FM[illegible]ell	[illegible]osed [illegible] [illegible]local or national level [illegible]tion w[illegible] [illegible]or UN OCHA (Office for the Co[illegible]) structures (OSOCC) to coordinate reg[illegible]r offered or accepted FMTs.
[illegible]andar[illegible]	Th[illegible] Minimum Standards for Foreign Medical Teams i[illegible] comprise guiding principles, core standards [illegible]ndards, including on initial assessment and [illegible]ent stabilisation and referral, wound care, fracture [illegible]ery.

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Composition of Team Evaluation

Mr. Charles blanch	Director of Emergency ManagementMinistry of Health, New Zealand
Dr. nevio Zagaria	Team Leader, Emergency and Humanitarian Action, World Health Organization, Western Pacific Regional Office
Dr. Sasha Peiris	Consultant, World Health Organization, Philippines Country Office

acknowledgements

The review team would like to thank all personnel with whom they were able to speak or interview. In particular, we would like to acknowledge the support and welcome from the Philippines Department of Health, local health providers in Leyte province and the WHO Philippines Country Office with whom interviews were conducted during an ongoing disaster.

Dr Natasha Murray at the New Zealand Ministry of Health provided invaluable support with a technical edit of the report prior to submission to the WHO Western Pacific Regional Office.

Much of the analysis has been made possible by the provision of data and registration of Foreign Medical Teams. While the report has identified some areas for data improvement, the detail on deployed teams was a significant improvement from previous sudden onset disasters.

We would like to thank Dr Nevio Zagaria, Team Leader, Emergency Humanitarian Action of the WHO Western Pacific Regional Office, for initiating this report and for being the force behind the FMT coordinating team during Typhoon Yolanda. Coordination of all FMTs, in line with the global FMT Working Group, as well as with the country-specific humanitarian response, was challenging but successful under his leadership and guidance.

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Executive Summary

Typhoon Yolanda, known internationally as Super Typhoon Haiyan, made landfall on 8 November 2013. It affected over 16 million people across six regions of the Philippines, and displaced more than four million people from their homes.

The disaster was quickly declared a Level 3 emergency. Prompt action by the World Health Organization (WHO) Country Office, with backup from the regional office and headquarters, ensured that the Philippine Department of Health was supported in the overall response to such a disaster, in particular with a dedicated full-time medical officer to manage the influx of Foreign Medical Teams (FMTs) right from the beginning.

The global Health Cluster "Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters" (the Minimum Standards) provided an essential starting point for the registration and coordination of FMTs. However, the Minimum Standards are intended predominantly for surgical and trauma care teams. Processes were subsequently strained when they became the default registration system for all medical teams. A total of 150 FMTs were monitored, of whom 83 teams were formally registered.

Further rollout of the Minimum Standards is essential in ensuring that affected countries and the wider United Nations (UN) system develop the capability to request, approve and coordinate the deployment of FMTs alongside their domestic response. Countries affected by sudden onset disasters (SODs) should be confident that those FMTs deployed to assist them are appropriately trained, self-sufficient and will operate alongside and in support of local health providers within their licensed scope of practice.

Whilst the response was a significant improvement from that seen in Haiti, many deployed teams were inadequately trained, prepared or equipped. Ensuring that FMTs meet the Minimum Standards for the level of service they intend to offer would address many of the concerns identified.

Further work is required to consider the applicability of these Minimum Standards or equivalent to non-surgical teams, for example teams delivering mental health psychosocial services and mobile medical services.

Key Lessons & Recommendations:

1. The current global Health Cluster Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters is fit for purpose. However, awareness and operationalization of the Minimum Standards needs to be raised with all stakeholders.

2. The Minimum Standards have an emphasis on the provision of a surgical response to sudden onset disasters. They provide little guidance on the provision of essential health services that complete the health sector response. A critical example is the provision of outpatient and inpatient care for patients with acute mental health disorders.

3. The Minimum Standards provide specific guidance on the transition from the relief phase (initial life-saving interventions and essential

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health services) to early recovery. In the absence of any other system, the Minimum Standards (including registration system) were applied to a wide spectrum of medical teams that arrived several weeks after the onset of the disaster.

4. An emerging range of actors operate across many clusters, functioning outside the humanitarian space. These actors, at least in the FMT space, must be engaged and coordinated as for any other FMT.

5. There is a low cost of entry for FMTs and no control over their identified affiliations (country association or branding). FMT coordinators must be prepared to manage emerging issues (both positive and negative).

6. The deployment of significant numbers of FMTs requires additional coordination. FMT focal points should be provided at the national level, and where appropriate at local coordination hubs, in support of health coordinators and Department of Health representatives.

7. In support of FMT coordination and these focal points, there should be a common registration, mobilisation and tasking process. This process needs to include the possibility of a SOD affecting more than one country, with available FMTs to be allocated according to need.

8. National medical teams will also be deployed and this support may range from providing additional staffing to existing facilities and completely self-sufficient teams. The mechanism for FMTs to coordinate and work alongside national medical teams needs to be further developed.

9. Enhancements to the registration and coordination processes should provide a framework for the registration of all possible types of FMTs.

10. The pre-registration process needs to support the alerting, standby and possible deployment of FMTs prior to the impact of disasters and hazards that can have an early warning.

11. National and sub-national FMT coordination, as a critical function of the Health Cluster, has to have strong relationships with the decentralized On-site Operations Coordination Centre (OSOCC) and the Reception and Departure Centre (RDC).

12. FMT coordination and health service delivery is specialised, as with other technical humanitarian services. In support of national and local FMT focal points, the development of a small FMT coordination cadre with experienced clinical and technical staff should be considered on a regional or global basis.

13. The deployment of a Type 2 or 3 FMT is comparable to an Urban Search and Rescue (USAR) heavy deployment, with a likely deployment length at least two to three times longer than that of a USAR mission. Re-supply and rotation of personnel and medical supplies is highly likely. These teams will benefit from the development of a small FMT coordination cadre which includes an experienced logistician.

14. Whilst some teams demonstrated the ability to deploy 'fast and light' and managed a range of surgical cases in improvised facilities, they quickly faced logistical issues and rapidly exhausted medical consumables and team supplies. For some teams, their small size resulted in difficulties with post-operative care and they failed to meet the Minimum Standards. Such teams need to partner effectively with other

facilities or teams and implement a triage and referral system for surgical cases as soon as possible. Delivery of surgery, particularly major surgery at a Type 1 FMT, is contraindicated.

15. Further work is required to better define the breadth of the Type 1 FMT role. In particular, there appears to be a number of 'mobile' medical teams that operate outside an outpatient clinic role and are involved in a range of community based triage, primary care and public health. These teams still need to operate under appropriate Minimum Standards.

16. The Minimum Standards should include more explicit requirements and standards for self-sufficiency. As minimum, FMTs must have the ability to function for an initial two week period in an austere environment with no re-supply. Fuel requirements should be clearly stated (against agreed ratios) and met by the host country as a condition of deployment.

17. Teams need to review the composition, capability and capacity of their deployed team based on their likely task and time of arrival. Health services normally available in that area, as well as the disaster epidemiology, should be considered during this process. In particular, this is relevant for Type 2 FMTs that may find acute surgical presentations decline and where there is a greater need to support outpatient services.

18. Teams need to consider how they will address language issues during a deployment, in coordination of FMTs and delivering health services. Outpatient and mental health services will require consultations in the host language and teams with medium/long-term deployment may need to focus on capacity building and/or recruitment and local staff.

19. Exit planning was well considered. However, it was clear that health clusters need to consider a quick fix or full rehabilitation of damaged health care facilities at an early stage of the response as an enabling activity for the withdrawal of teams.

20. Data collection on FMTs shows a significant improvement from previous disasters. An assessment of deployed FMTs within two weeks of the onset of a major response will ensure a better collection of lessons learned on donor support in going forward and serve as a verification tool.

21. An assessment of FMTs should be commenced within two weeks of the onset of another major response, ensuring lessons are identified while the bulk of FMTs are still responding in the field.

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1.0

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An evaluation team was established to:

- Evaluate FMTs' response to Typhoon Yolanda and the effectiveness of FMT classification, registration and coordination.
- Outline the key lessons learned from FMT deployments in response to Typhoon Yolanda and operational recommendations for best practice.
- Document the stages of warning, requests, activation, arrival and tasking of FMTs in response to Typhoon Yolanda.
- Review reporting, departure and hand-over phase of FMTs who responded to Typhoon Yolanda, and the transition of care from initial acute trauma to routine inpatient, outpatient and public health care.

2.0 background

2.1 The PhiliPPines

The Philippines is located on the Pacific Rim of Fire. The population of 99 million is subject to a range of hazards, including earthquakes, volcanoes, landslips and typhoons. The country experiences an average of twenty typhoons annually.

The Philippines was ranked as the seventh most affected country between 1993 and 2012 and the third most disaster prone country in the world (The world risk report, 2013), according to the World Risk Index. The Philippines was ranked third with an overall World Risk Index of 27.52 per cent, following Vanuatu (36.43 per cent) and Tonga (28.23 per cent).

In the month before Typhoon Yolanda, a powerful earthquake measuring 7.2 on the Richter scale struck the central Philippines Bohol area, less than 200km from the path of Yolanda. This earthquake resulted in damage to buildings and infrastructure. More than 40,000 residents still living in temporary accommodation following the earthquake were then moved to evacuation centres as a result of Yolanda. Whilst the eye of the storm did not directly pass over this region, its effects disrupted ongoing relief efforts.

27.52%

Philippines' World Risk Index, third in the world after Vanuatu and Tonga

3rd

Philippines' ranking for the most disaster prone country in the world (The world risk report 2013)

7th

Philippines' ranking for the most affected country between 1993 and 2012

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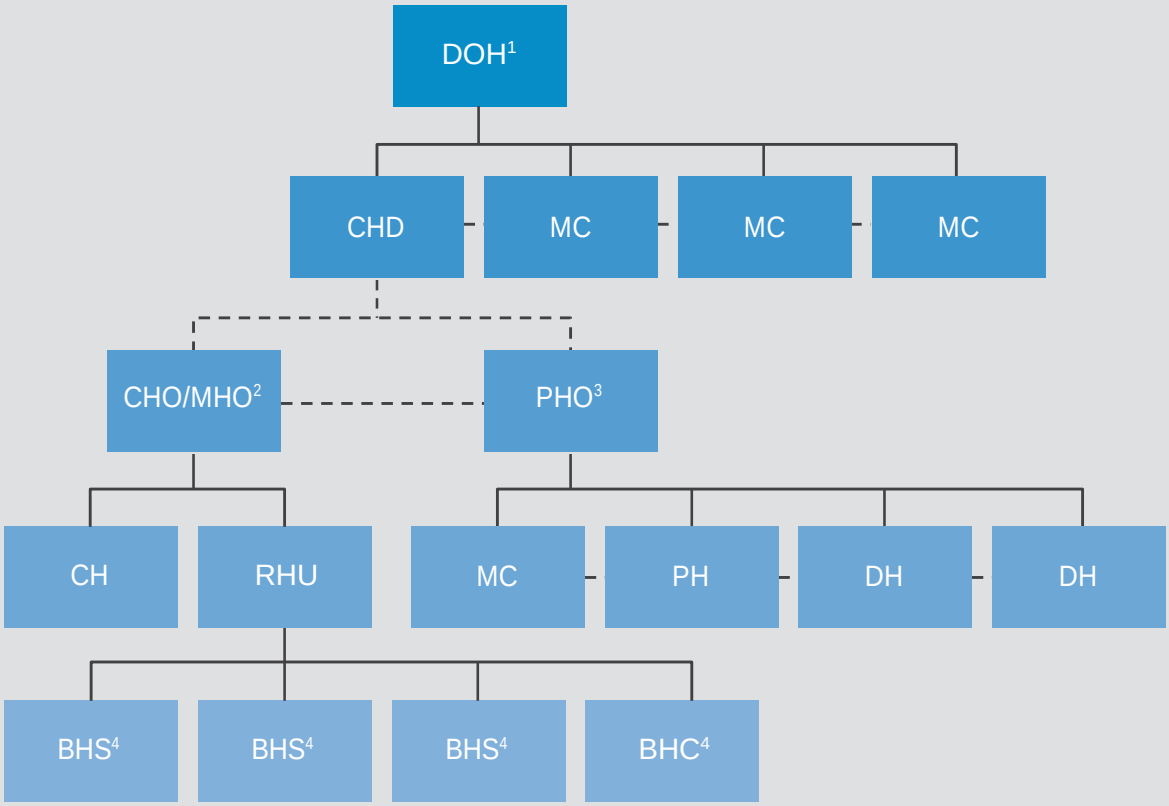
2.2 Structure of the Philippine health sector

The Philippine health sector comprises of a mix of private and publically funded health care, with a range of private facilities available in larger towns. The structure is comprehensively described in the Philippines Health Service Delivery Profile. Within the public system, services are built around three main levels within each region (see Figure 1).

Figure 1: Diagram showing structure of health care delivery within regions[1]



DOH	Department of Health
CHD	Center for Health Development
MC	Medical Center (Lv3/4)
PHO	Provincial Health Office
CHO	City Health Office
MHO	Municipal Health Office
PH	Provincial Hospital (Lv2)
DH	District Hospital (Lv1)
CH	City Hospital (Lv1/2)
RHU	Rural Health Unit (PC)
BHC	Barangay Health Center (PC)

BHS	Barangay Health Station (PC)
(Lv4)	Training hospitals
(Lv3)	with subspecialties
(Lv2)	Pedia/IM/OB/Surgery
(Lv1)	PC+admissions
(PC)	Primary Care

[1] Under the President
[2] Under the Mayor
[3] Under the Governor
[4] Midwives, nurses and technical staff under the CHO/MHO; BHWs under the Barangay captains

1 WHO / Philippines DOH 2012, available at: http://www.wpro.who.int/health_services/service_delivery_profile_philippines.pdf

400,000 to 2 million

Population range for each Philippine province

Hospital services are usually based in larger cities. Each region has a tertiary care hospital that provides a range of hospital services and acts as a regional referral centre.

Each province has a population ranging from 400,000 to two million, with secondary care provincial hospitals and several district hospitals (20-50 beds, Level 1 - Level 2), coordinated by the elected Governor.

Key primary care infrastructure is based in a rural health unit for every 20,000 to 50,000 people. This is managed by a medical doctor, the Municipal Health Officer (MHO), who reports to the Mayor.

The MHO manages the network of Barangay Health Stations in the catchment area, which are served by one village midwife, a nutritional scholar, an environmental officer and a variable number of barangay health workers.

EXaMPlE 1:

Preparedness activity in the Eastern visayas Regional Medical Centre (EvRMC)

At the EVRMC in Tacloban the Emergency Department Clinical Director also leads the local Health Emergency Management Bureau (HEMB). They undertake preparedness activities, including development of a hospital emergency plan, training of key response personnel in a Health Incident Command System, and development of a thorough understanding of their hazards cape. The team was aware that the hospital was at risk of storm surge inundation. The HEMB team ran regular disaster drills and issued an internal Code White on 6 November and a Code Red on 8 November. The HEMB director is well engaged with rehabilitation plans for the hospital, including relocation to an inland location where it is less prone to storm surges.

EXaMPlE 2:

approach to the implementation of the WHo Safer Hospitals initiative/ evaluation within the Philippines

The WHO Safer Hospitals evaluation provides an index score based on a health care facility's readiness assessed against a range of indicators grouped under structural, non-structural and functional headings. These are summed to provide an index score out of one for the resilience of the facility. As the index was developed specifically for larger facilities, there is some limitation in applying it to smaller Barangay Health Stations. The Philippine Department of Health (DOH) therefore does not use the index score. However, hospital administrators do undertake evaluations to understand the resilience of their own facility. By answering the detailed questions in the absence of a consolidated index score, the ability to rank health care facilities in order to prioritise investment to improve resilience is lost, risking the value of the programme.

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3.0 Methodology

A variety of methods were used in this evaluation, including semi-structured interviews and focus group discussions, open-source material and document review, as well as questionnaires.

In general, where conclusions are non-critical, or response data drawn is from WHO reporting, FMT names have been used. Where conclusions are drawn that FMTs have deviated from or failed to meet the Minimum Standards, they have been described generically in terms of their declared FMT type and demographics.

3.1 unstructured interviews, semi-structured interviews and focus group discussions

Individual unstructured interviews, semi-structured interviews and focus group discussions were used by the evaluators to gain in-depth insight into the perspectives of local and international representatives involved in the FMT coordination and response.

3.1.1 sampling method and data collection

A purposive convenience sampling method was used to gather the perspectives of a variety of key officials from the DOH and local medical coordinators, in order to evaluate the integration of FMTs within the coordinated DOH response, and international stakeholders based in Manila. The evaluation team also undertook field visits to Tacloban and Guiuan to interview existing FMTs, UN Office for the Coordination of Humanitarian Affairs (OCHA) and UN Disaster and Assessment Coordination (UNDAC) staff regarding coordination and transition.

Gathered perspectives of a variety of key officials from DOH and local medical coordinators.

Participation was entirely voluntary. One, two or three of the lead evaluators facilitated the 18 interviews or focus group discussions (see Appendix A). They took place in various locations (depending on convenience of the participant) between 2 to 8 February 2014. Detailed notes were taken by the evaluators during interviews and focus group discussions.

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3.1.2 data analysis and limitations

Interviews and focus group discussions took place 11 weeks post-typhoon.

Notes from interviews and focus group discussions were reviewed by evaluators. Language and content was analysed, with key themes extracted. The potential for interviewer bias was introduced as the three main evaluators completed all interviews and focus group discussions, as well as analysed their content.

Interviews and focus group discussions also took place 11 weeks post-typhoon. At this stage, the majority of FMTs had demobilised and those still operational had transitioned into longer-term programmes. In addition, many staff in remaining teams had rotated. Search and rescue, as well as surgical teams, were demobilised, with existing teams largely focused on outpatient care. Thus, the composition of the FMT coordinators and team members participating in interviews and focus group discussions may not have been reflective of the entire FMT response.

n-sourc And

Prior to and during the evaluation period, a variety of documents and open-source materials were reviewed. This included detailed maps of the region and location of responses, Health Cluster bulletins, FMT reports and media releases, internet blogs written by different FMTs, social media sites (including Facebook) and timeline charts of the response.

Content analysis was the method most readily used to analyse these documents, with common themes developed and relevant details extracted.

3. T re f iTy

3.3.1 data collection

The WHO Philippines Country Office monitored 150 FMTs, of which 83 were registered at national level, using the registration form of Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters (see Appendix D). Seven out of the 11 Type 2 and one out of two Type 3 FMTs filled in the form before departure from their country of origin. Completed forms were emailed initially to Dr Peiris' official email account, and at a later stage to a generic email account for the WHO Health Cluster coordinator in Manila. FMT registration responses were consolidated into a continually

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83

Total number of FMTs who were able to register

Total number of FMTs who did not follow the proper registration process

6

updated Microsoft Excel® spreadsheet, which also tracked details of whether the team was operational or demobilised and the region, province and municipality the FMT was deployed to.

This effort allowed an effective coordination, and in particular an informed decision by DOH on the final destination for each FMT, based on critical information on the type of team and their capabilities, as indicated by the above mentioned form. These efforts were documented and shared publicly on the web in the form of maps twice a day, with information on which FMTs, by type, were in the pipeline, which had just arrived, which ones had a final destination assigned, and the ones already operational on the ground in their locations.

A total of 67 FMTs did not follow this process and showed up directly in the field and at the health cluster coordination meetings in the different hubs. Information on their capacities, date of arrival and departure, and geographical areas where they operated are incomplete. None of these 67 FMTs had bed capacities, and they can all be considered as Type 1. Almost no information has been received on the health services that they delivered, and for 16 of them it was not possible to know if they operated as mobile teams or in fixed positions.

FMT activity reports was all entered into a Microsoft Excel® spreadsheet.

A deployment questionnaire was also emailed to team coordinators or members of all FMTs. It focused on pre-deployment, post-deployment and technical aspects of FMTs. Exit questionnaires were also submitted by some teams. Finally, deployment data was obtained from FMT activity reports. Data from the deployment questionnaire, exit questionnaire and FMT activity reports was all entered into a Microsoft Excel® spreadsheet.

3.3.2 *data analysis and limitations*

Results from the deployment questionnaire, exit questionnaire (see Appendix E and F) and FMT activity reports were only received from the 83 nationally registered FMTs, and 55 FMTs from the nationally registered cohort submitted the exit questionnaires. These were all collated and analysed simultaneously. Registration data was analysed separately. Descriptive statistics were established for all using Microsoft Excel®. Where records contained missing data, these were excluded from analysis and relevant denominators were always clearly indicated.

Despite considerable effort to maintain data, there were many incomplete data fields, particularly for the 67 FMT that self-deployed. Some data cleansing was undertaken and social media, such as FMT Facebook postings and press releases (see 3.2), was used to confirm details, for example FMT arrival or departure dates.

Limited responses were received to the deployment questionnaire (22 FMTs completed), likely due to the short time period between distributing the survey and collating results, and because the survey was conducted three months after Haiyan.

The evaluation benefited considerably from a significant registration database of deployed and available FMTs.

There was also limited submission of the exit questionnaires and FMT activity reports by FMTs, which impacted the ability to review performance data for all teams.

The evaluation benefited considerably from a significant registration database of deployed and available FMTs. However, there was some missing data in what was recorded, which is likely to have impacted on achieving accurate results.

4.0 The Response to Typhoon Yolanda

At 04:40 hours on 8 November 2013 Typhoon Yolanda made landfall over Guiuan, Eastern Samar. The typhoon entered the Philippines area of responsibility on 6 November and intensified over the next two days. The track of the typhoon had been well anticipated and official agencies had issued a series of warnings, escalating to the highest Level 4 storm warning, and four preparatory messages had also been issued by the National Disaster Risk Reduction Management Council (NDRRMC) on 6 and 7 November. President Aquino III also issued a Presidential Statement. He told those in known hazardous areas to evacuate and emphasised that the resources of the Armed Forces of the Philippines were available.

"Yolanda was the deadliest typhoon in the Philippines since Typhoon Haiphong in September 1881."

The typhoon caused widespread catastrophic damage throughout its track, especially through Samar and Leyte provinces within Region VIII. Philippine government officials met over the weekend and a briefing for partner agencies was organised by UN OCHA on Sunday morning. On Monday, as the first meeting of the national health cluster took place at the WHO Country Office, the President declared a State of National Calamity.

Forty-four provinces out of a total of 81 were affected across the country, with the Eastern Visayas regions mostly affected. Within Region VIII, nearly 3.5 million people, or 85 per cent of the region's population, were affected by the disaster.

Yolanda was the deadliest typhoon in the Philippines since Typhoon Haiphong in September 1881[1], which killed an estimated 20,000. The final economic impact of Typhoon Yolanda is likely to exceed the previous highest, Typhoon Bhopal.

According to the final update (#108) from the NDRRMC on 3 April 2014, 6,293 people were reported dead, 1,061 remained missing and 28,689 were injured.

In the early stages, accurate information on the effects of Yolanda was difficult to establish. For example, the first health cluster bulletin on 19 November noted that information had only been received from 41 per cent of the hospitals in the

1 Typhoon Haiphong is estimated to have killed up to 300,000 people, the majority in Vietnam.

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affected area and from 47 per cent of rural health units. Only 27 per cent of the barangay health services in the affected area provided information.

Internal displacement from the most heavily affected regions also added to the strain on local health services. On 19 November alone, 650 persons moved to Cebu city, with an additional 240 going to Lapu-Lapu city.

The Philippine DOH manages in normal times an average of 300 foreign surgical and medical missions each year, and has a range of well-developed processes for these routine visits. The requirements for regular visiting medical teams have been taken into account, and "Documentary and procedural requirements for humanitarian assistance and donations from foreign organizations during disasters and in emergency situations" have been developed, in response to Typhoon Ondoy that struck in the latter part of 2009. Appendix C presents the full document released by the DOH Bureau of International Health Cooperation in 2009 after close consultations with the Department of Foreign Affairs, the Department of Social Welfare and Development, the Department of Finance and the Bureau of Customs.

On Tuesday 12 November, four days after the typhoon struck, the Secretary of Health directed Under Secretary (USEC) Dr Ted Herbosa to establish a special taskforce to manage offers of FMT assistance. USEC Herbosa tasked Dr Joel Buenaventura, Chief Health Program Officer in the International Relations Division, to work with Dr Sasha Peiris from the WHO Country Office to undertake the coordination of FMTs, both supported by Dr Nevio Zagaria, Team Leader of the Emergency and Humanitarian Action of the WHO Western Pacific Regional Office.

This ad-hoc team utilised an adapted version of the current FMT registration form (see Appendix D) within the Minimum Standards and provided it to FMTs that had expressed an offer of assistance. They also attempted to get FMTs that were already deployed in-country to register their presence. They established an Excel spreadsheet tracking deployed team and locations they had been deployed to, as well as standby teams. This information was shared with the DOH and the health cluster and formed the basis of the FMT mapping.

1 Wh[illegible]lAr[illegible] [illegible]rgen[illegible]

The WHO Country Office was already responding to the Bohol earthquake as a Level Two emergency, according to the WHO Emergency Response Framework. WHO graded the event as Level 3 according to the Emergency Response Framework (ERF) on Sunday 9 November, before the declaration as a Level Three response by the Emergency Relief Coordinator for the humanitarian system of the Interagency Standing Committee. The timely WHO decision on the Grade 3 response activated the ERF procedures and allowed the mobilization of an appropriate level of resources in support of the emergency management team of the WHO Philippines Country Office, with surge deployment of staff and the immediate release of emergency funds to activate the first phases of the response. In particular, the ability to re-purpose WHO staff with a minimum of bureaucracy was essential in

"WHO graded the event as Level 3 according to the Emergency Response Framework (ERF)"

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establishing subsequent health sub-clusters. At one stage, five out of the six WHO regional Emergency and Humanitarian Team Leaders were operational in country.

The WHO Country Representative commented that the Health Clusters had to establish their own parallel logistics supply chain for some critical items in the very early first days in order to support both FMTs and local/national teams, as the UN logistics cluster was not fully operational in the beginning. The WHO Country Office was successful in establishing fuel supplies from the Philippines Shell Foundation, but during the early stages of the response the Health Cluster had significant difficulty in transporting FMTs onto aircrafts, who were prioritizing the shelter and food clusters. Whilst shelter and food were considered essential to establishing security within the affected region, it was felt there was not a clear mechanism to prioritise logistical support for the health cluster, including FMTs.

4.2 UN OCHA Coordination Framework And Applicability To The FMT Response

The international humanitarian response was coordinated through the UN OCHA system. One of the challenges was coordinating between the international community and national and sub-national coordination functions that were established within different clusters.

Within the Tacloban area of operation a WHO responder took the lead on engaging with arriving FMTs. However, this was not a formally recognised role. The majority of FMTs that arrived in Tacloban passed through the Reception and Departure Centre (RDC) at the airport and declared their capability. It was unclear from the interviews conducted how this declared capability was matched against what had been submitted during registration at the national level (if this had occurred), or how local allocation of an area of operation was conducted. The RDC was able to provide some support for fuel, logistics and transport. UN staff interviewed recognised that while the logistics and support requirements for FMTs were similar, they were not the same as those required for Urban Search and Rescue (USAR) teams.

Within the Tacloban region, the deployment of the Australian Type 2 FMT provided essential inpatient surgical capability, described by colleagues as timely.

The On-site Operations Coordination Centre (OSOCC) included dedicated civilian-military (Civ-Mil) liaison officers, who were essential in managing the large military humanitarian assistance and disaster relief (HADR). This included liaison with the armed forces, dedicated foreign military HADR units making available military assets critical to augment national capacities in terms of engineering, general duty troops operating in a manpower role, as well as significant rotary and fixed wing military aircraft, sea and land transportation. Coordination between civilian and military teams was improved from previous responses, although many civilian teams still struggle to engage with the military in terms of communicating desired outcomes.

"English was the predominant operating language for coordination."

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English was the predominant operating language for coordination. Some language difficulties became evident between FMTs with varying levels of English. FMTs not only need to consider local language issues, they also need to recognise that future disasters may not have English as a common responding language.

The Philippine DOH managed the deployment of approximately 100 domestic teams. This included those deployed from public hospitals under the direct control of the DOH and those formed by other national groups.

These teams had significant variation in capacity, capability and self-sufficiency and included a broad range of health services, including primary care, public health and surgical teams. Self-sufficiency ranged from personnel operating out of existing facilities to fully supported tented teams.

Local teams are well placed to deploy fast and light, understand the culture and resilience of the affected population and are often better able to source supplies or improvise resources than a FMT.

There were some views that FMTs did not understand or appreciate the difficulties faced by some local teams who reportedly continued to operate in spite of no access to food or rest for several days. Whilst this is understandable, FMTs have an obligation not to be a burden on the affected population and need to ensure their self-sufficiency. Inevitably, this may mean them having access to food, water and shelter of a much higher standard than local responders or the affected population. While the implications of this need to be managed operationally by teams on the ground, it is however a requirement for them to remain effective. Although local teams are not bound by the Minimum Standards, the applicability of the standards (or components of them) could be considered to ensure their ability to practice effectively.

"Local teams... understand the culture and resilience of the affected population..."

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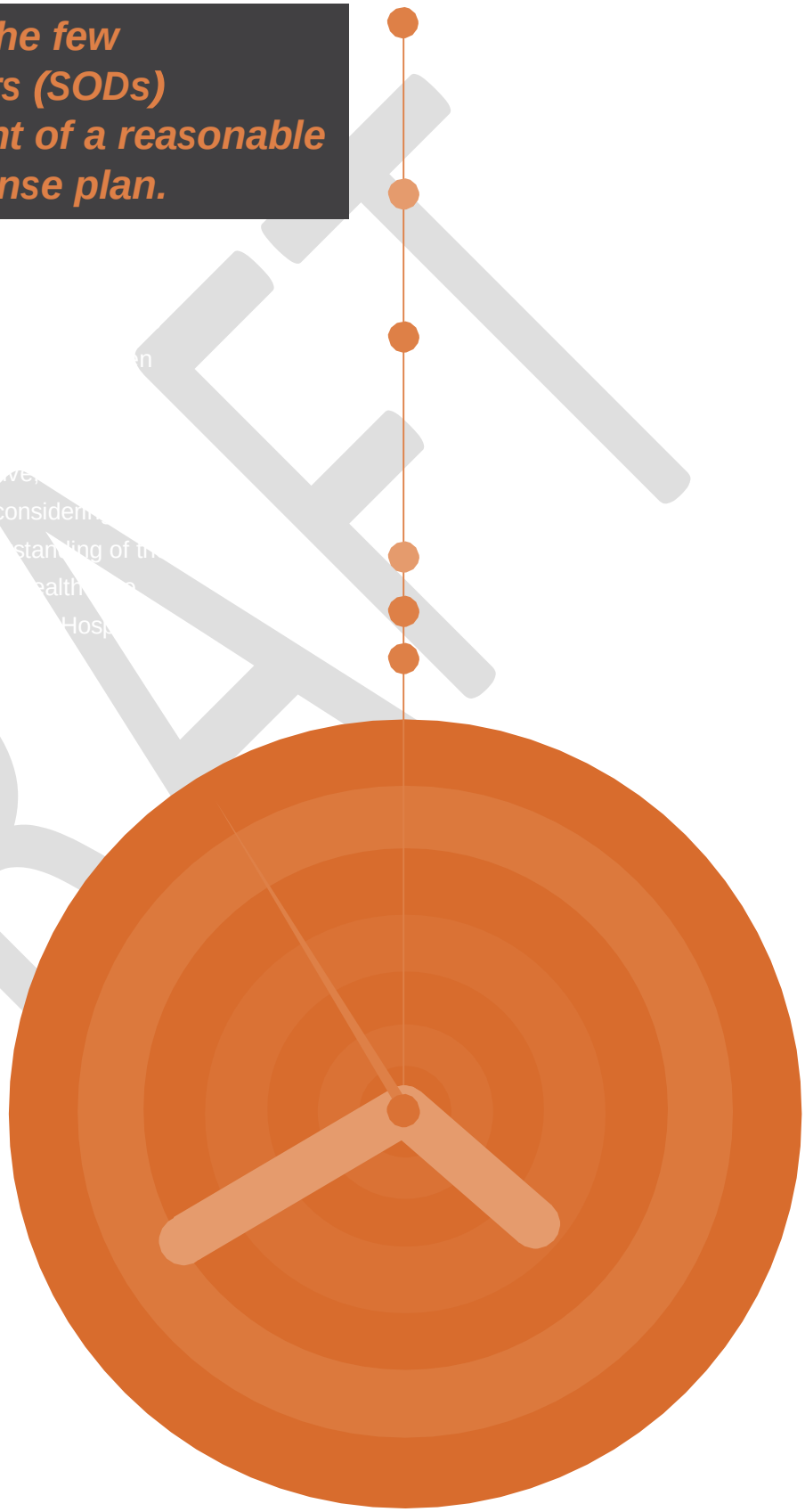
Typhoons are one of the few sudden onset disasters (SODs) that allow development of a reasonable intelligence-led response plan.



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08 November 2013
04:40am

This chronology is based on snapshots of activities extracted from interviews, focus group discussions, as well as the information collated from within the health cluster bulletins.

Thursday 7 November

Dr Nevio Zagaria, Team Leader of Emergency and Humanitarian Action, WHO Western Pacific Regional Office (WPRO), correctly identified the destructive potential of Yolanda and recommended that local health authorities request international community Type 3 FMTs to be placed on standby.

Dr Zagaria contacted Dr Ian Norton (at the time Director of Disaster Preparedness and Response for the Australian National Critical Care Trauma and Response Centre that managed elements of the Australian FMT capability) and Charles Blanch (the New Zealand Government FMT lead) three days before the landfall of the typhoon, alerting them to the possibility of the need for fast deployment of FMTs. Both communicated an informal request to their respective foreign affairs departments and undertook very early response option planning. However, they were restricted in their ability for a proactive response without an official request.

This contact was based on pre-existing relationships through both the FMT Working Group and the WHO WPRO Health Emergency Risk Management Framework. The absence of both a global and regional FMT registry and formal mechanism for 'standby' notifications meant that other FMTs could not be informed at this early stage.

Saturday 9 November

Dr Patricia Kormoss, working in support of the WHO Country Representative Dr Julie Hall, contacted Dr Ian Norton to make an official request on behalf of the Philippine DOH for assistance.

Request for WHO assistance provided from NDRRMC.

Sunday 10 November

One of the first international FMTs to deploy was the German ISAR and the Belgian BFAST team, who arrived in the Philippines on 10 November. The well-equipped, self-sufficient 37 person Type 1 German ISAR team was unable to be deployed from Manila for four days, due to not being able to co-deploy personnel and 6.5 tonnes of self-sufficient equipment, including fuel and medical supplies, they had arrived with. Whilst this was frustrating for the team involved, they were eventually deployed for 11 days in Palo, Leyte.

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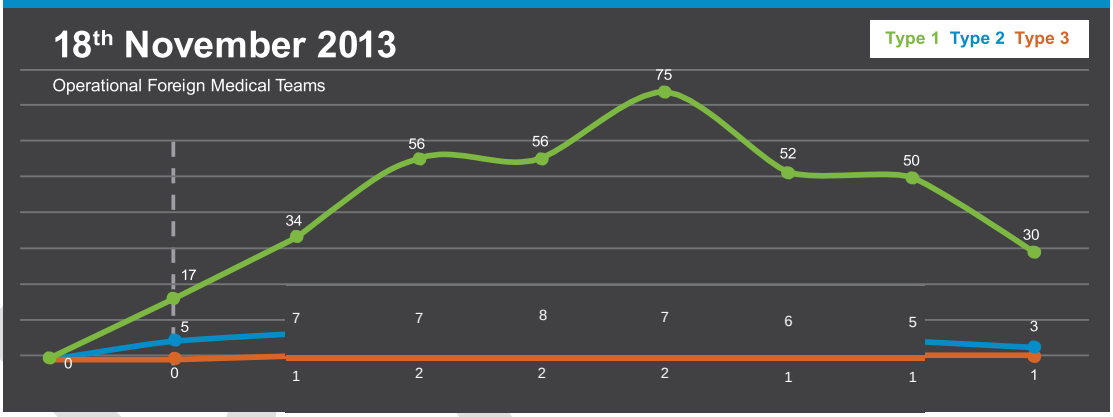
Monday 18 November



Tuesday 19 November

Additional sub-national Health Cluster coordination teams were established in Tacloban city (Region VIII), Cebu city (Region VII) and Roxas city (Region VI), which enabled incoming FMTs to be better allocated within a health cluster, amongst other functions.

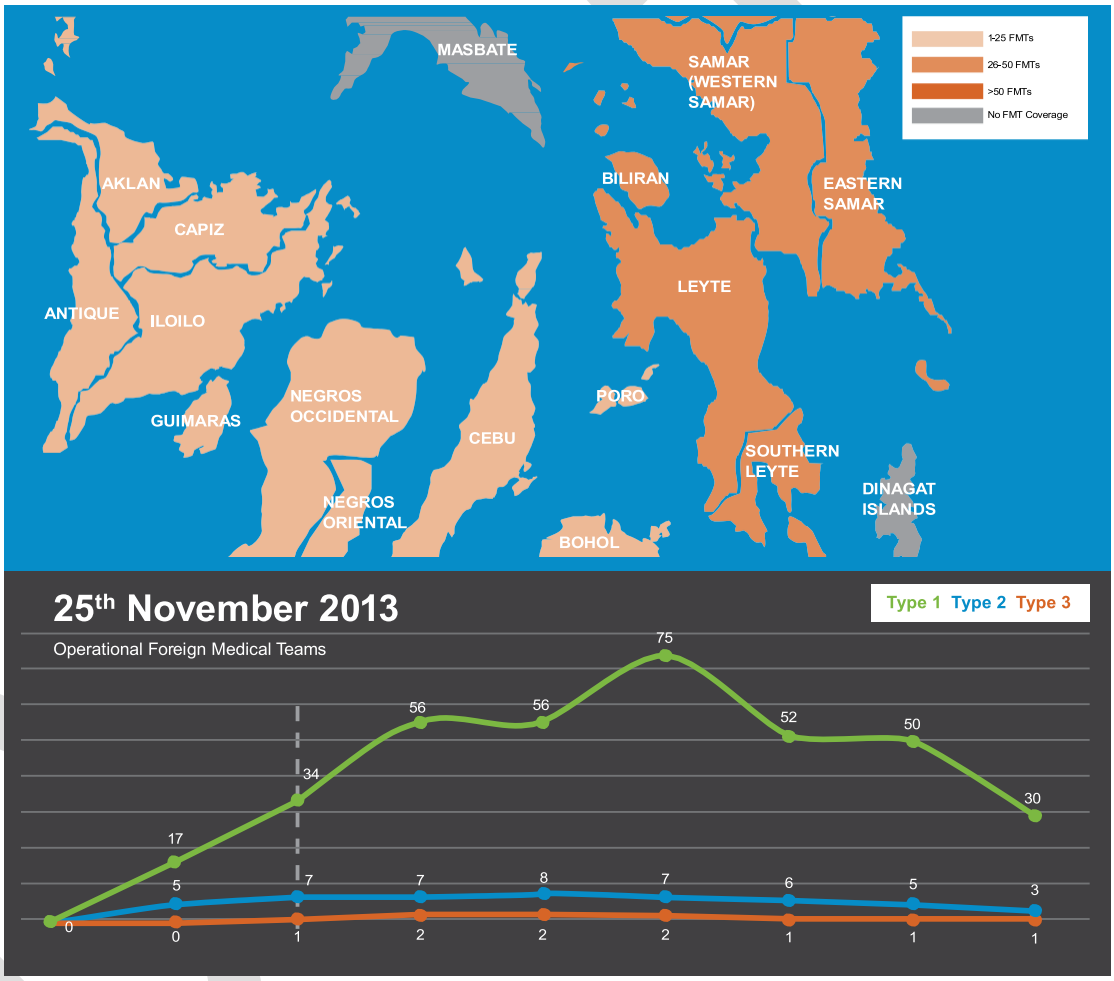
Friday 22 November

At this point, 61 FMTs were operational with over 918 medical staff. These were allocated across 51 Type 1 FMTs, with an additional three Type 1s in the process of deployment, six Type 2s and one Type 3. Concurrently, 72 national and local medical teams had also been deployed under the coordination of the emergency management unit within DOH.

It was made clear that any FMT deploying needed to be self-sufficient for the duration of their stay. In particular, the provision of fuel and its inherent difficulties in being flown was a major limitation to teams.

Additional FMTs that had declared their availability at this time but not yet deployed were requested to remain on standby in their own country, whilst changing health sector support was identified. Additional sub-national Health Cluster coordination teams were also deployed to Ormoc and Borongan.

Monday 25 November



Tuesday 26 November

The health needs of the affected population had shifted from immediate trauma careto broader public health issues. The five main causes of illness were acute respiratory infection, fever, diarrhoea, hypertension and skin disease.

The number of registered FMTs operational had decreased slightly from 61 to 55. However, the number of medical staff had increased to 1,100 from 918. In addition, a further 12 FMTs were operating that were not registered. Forty-seven of the field hospitals established were Type 1. There were six teams with Type 2 hospitals and two teams with a Type 3 hospital. There were five more teams on standby outside of the country. An additional 103 national and local medical teams had also been deployed to the affected areas.

Friday 29 November

A total number of 58 registered FMTs were in the affected areas as of 28 November 2013. There were an additional 12 medical teams that had not yet registered.

The first wave of FMTs had begun to phase out. Many FMTs were scheduled to leave affected areas by 9 December, making coordination and planning important to ensure transition. As of 28 November 2013, 13 FMTs had been demobilised.

A guidance note was issued by DOH on the entry and exit strategy of FMTs, in light of a shifting of priorities from immediate trauma care to primary care and public health issues.

Tuesday 3 December

The most frequently reported reasons for visits to health facilities across all affected regions were acute respiratory infection, fever, diarrhoea, hypertension, skin disease and wounds. Wounds included both new injuries from cleaning debris and follow-up care for those injured in the typhoon.

A total of 61 registered FMTs were in the affected areas as of 2 December. There were also 118 national and local medical teams. An additional five out-of-country teams were on standby. Sixty-three of the teams were functioning with basic Type 1 services. There were six teams functioning with more sophisticated Type 2 services and two teams with specialty Type 3 services.

As of 2 December 2013, 21 FMTs had demobilised. Many FMTs were scheduled to leave affected areas by 9 December.

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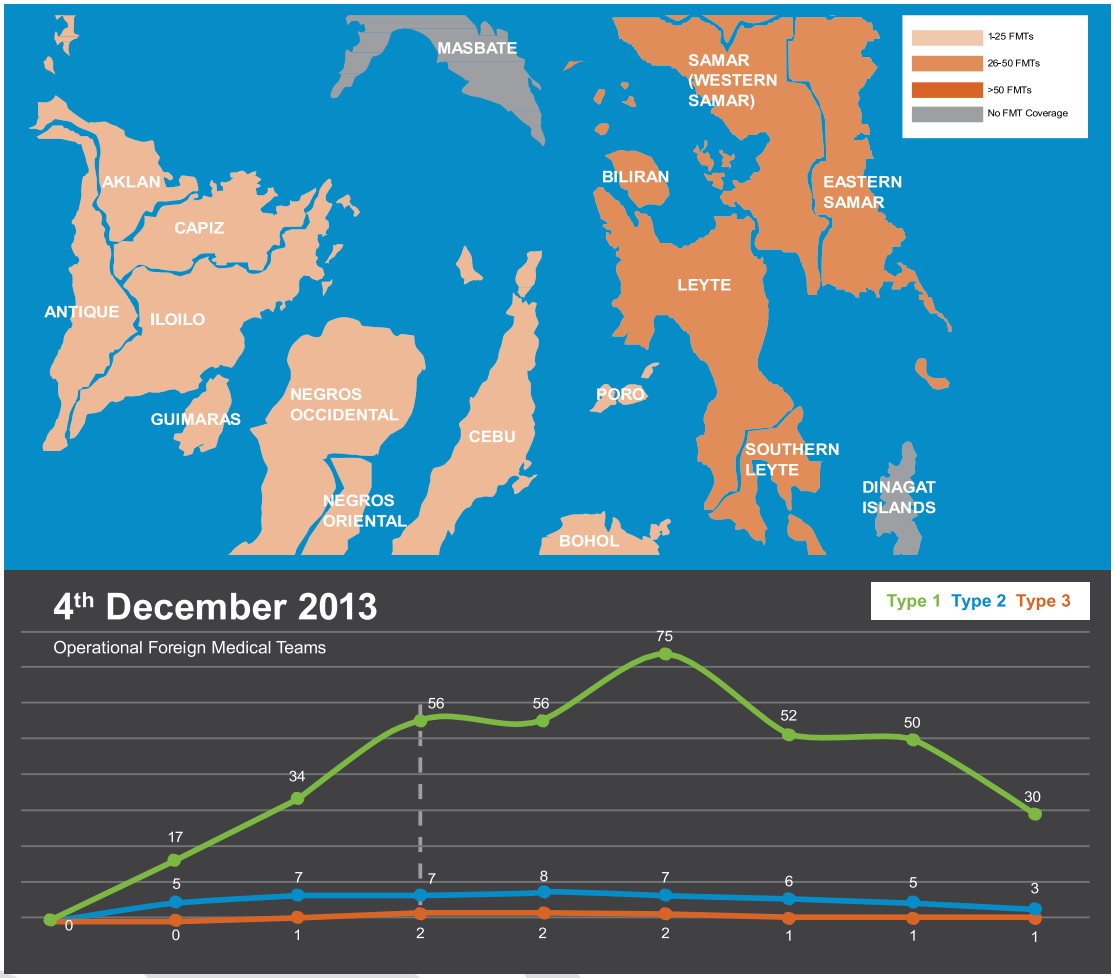
Wednesday 4 December

DOH downgraded the situation from Code Red to Code Blue



Friday 6 December

The Médecins Sans Frontières (MSF) France field hospital in Tacloban reported having to amputate limbs of patients who had lost access to diabetic medications.

In Region VIII, acute watery diarrhoea was observed in Kananga and acute bloody diarrhoea in Tanauan.

The EVRMC laboratory, supported by a Japanese university, conducted rapid tests for rotavirus, norovirus, cholera, typhoid, hepatitis A, leptospirosis, dengue, tuberculosis and respiratory syncytial virus.

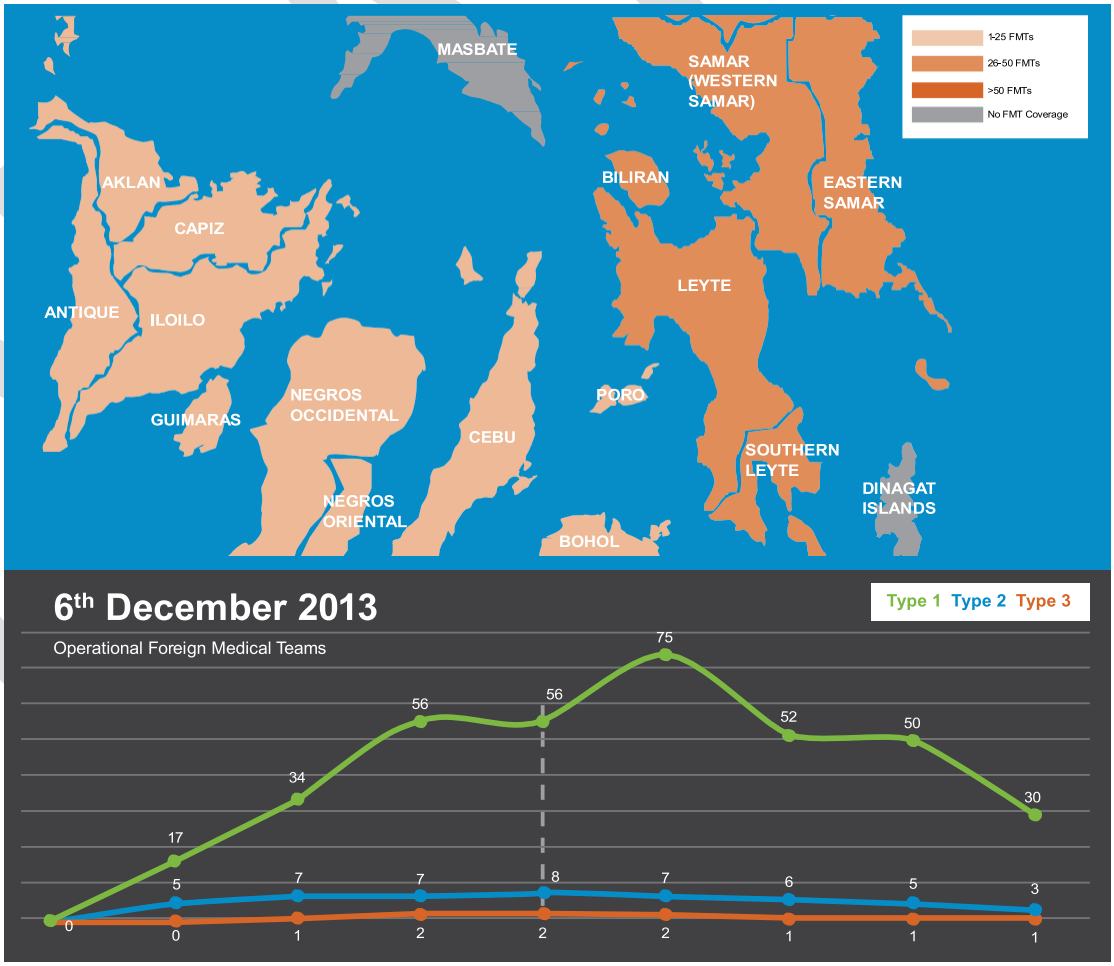
According to DOH some FMTs were requested to extend their missions. Protocols were also established by DOH for handover to local medical teams. Discussions were underway to establish a system to donate medical goods/equipment left by FMTs.

WHO in the Philippines signalled their intention to release an end-of-assignment reporting template for FMTs to complete before they exited the country.

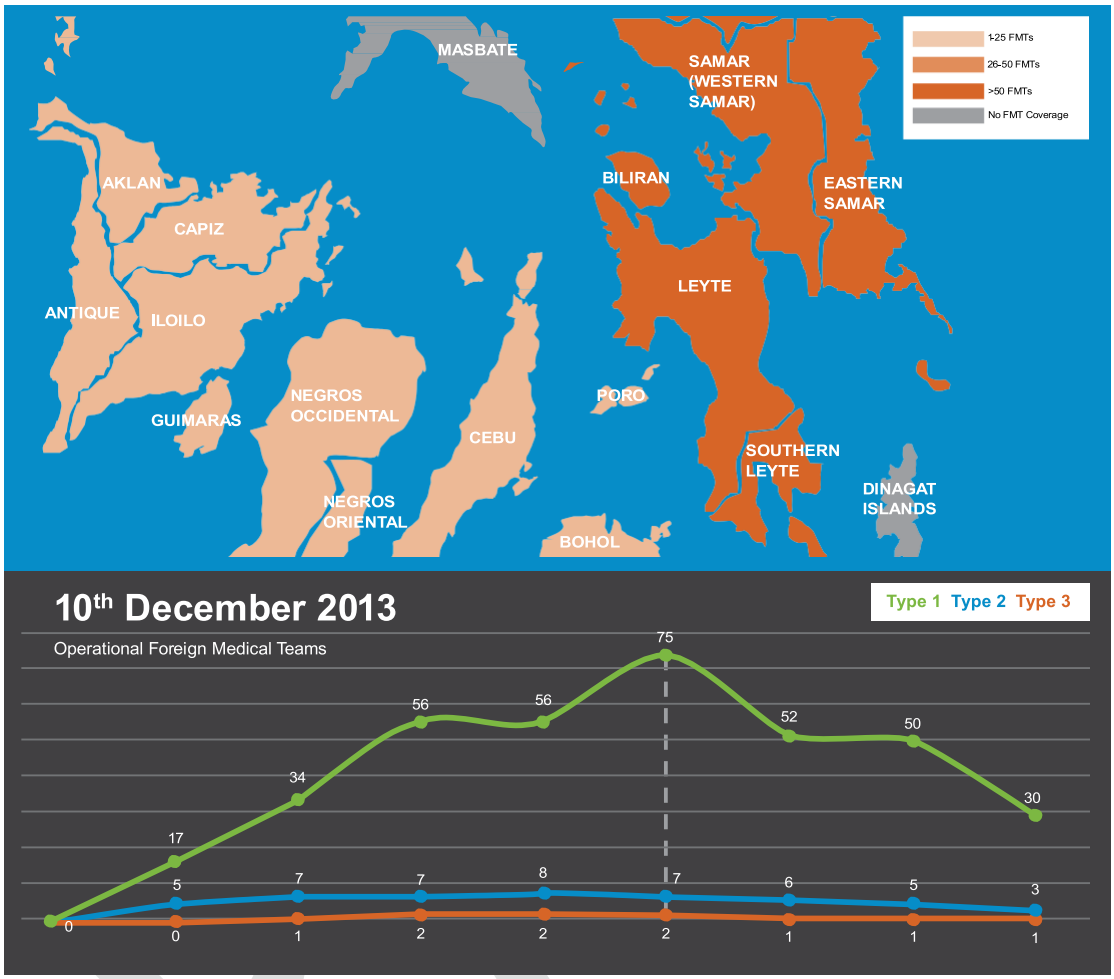
Medical Team International donated large tents to Balangiga District Hospital in Eastern Samar.

In Tacloban, a Type 2 FMT informed partners that they would be discontinuing their services. The facility was initially used for referral and medical evacuation. An alternative health facility, Remedios Trinidad Romualdez (RTR) was identified for referral and medical evacuation. RTR was partially functional and staffed by international and local doctors. RTR had access to an ambulance and three helicopters on standby for medical evacuations to Cebu. However, the sub-national health cluster partners in Tacloban expressed concern that the closure of the field hospital would put extra pressure on the remaining health services, as they were not functioning at full capacity.

EVRMC had a 24 hour functional isolation ward for TB patients with simple x-ray capabilities, four operating rooms, neonatal intensive care units and two adult intensive care units. The centre was functioning 24 hours per day.



Tuesday 10 December



Wednesday 11 December

By 11 December, 1,068 of the 9,297 health facilities in the affected regions were registered as assessed. Among those facilities there was substantial damage, with 402 facilities found to be partially damaged and a further 188 completely destroyed. Many of the remaining facilities will not be assessed as they were outside the Yolanda corridor or otherwise assumed to not be damaged.

Eighty-five registered FMTs and 148 local medical teams were in the affected areas as of 9 December. Seventy-five of the teams were functioning with basic Type 1 services, seven teams were functioning with more sophisticated Type 2 services and two teams with specialty Type 3 services. Seventy-two of the 85 FMTs were in Region VIII.

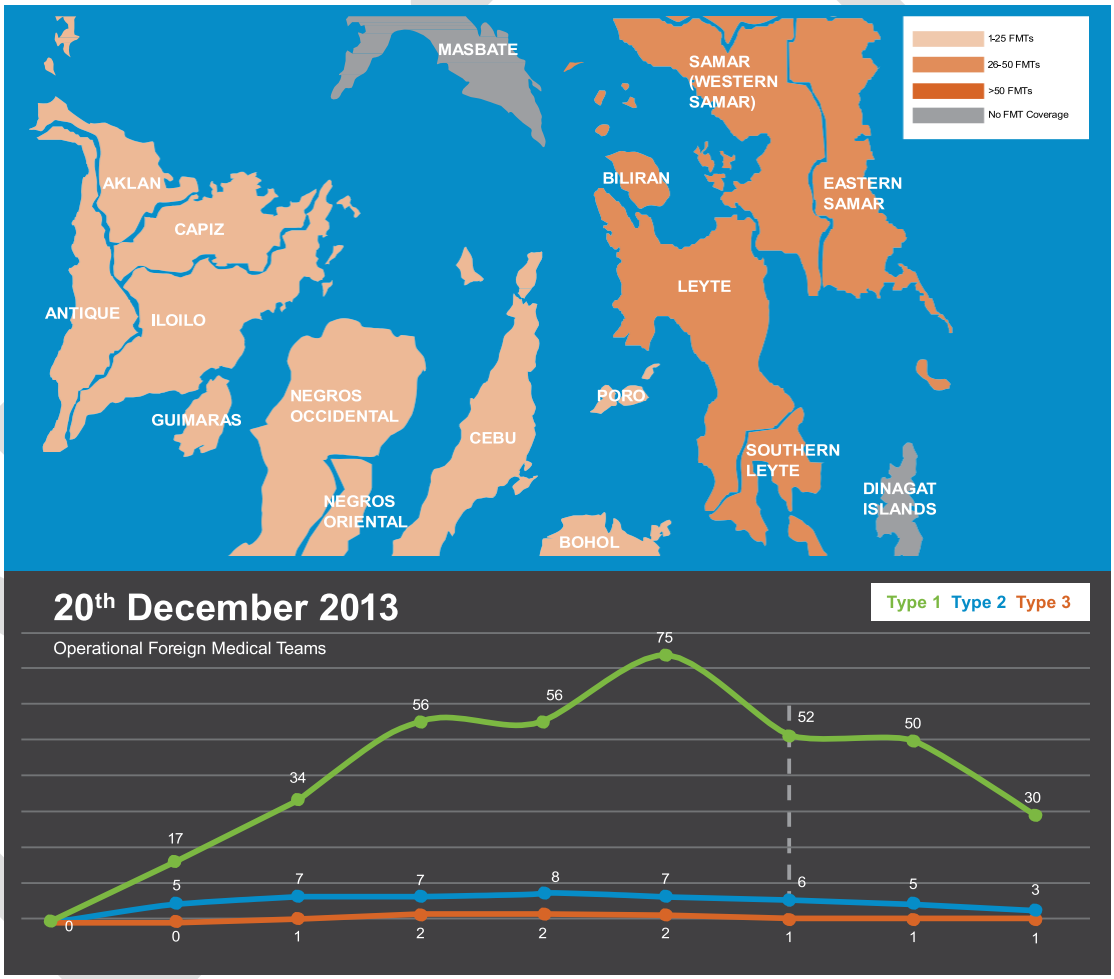
Wednesday 18 December

The number of registered FMTs in the affected areas had decreased to 55 as of 18 December (refer to map C, D and E). Forty-nine of the teams were functioning with basic Type 1 services, five teams were functioning with more sophisticated Type 2 services and one team with specialty Type 3 services.

FMTs that wished to donate equipment and supplies to local services were requested to go through DOH to register their donations.

The number of rapid assessments had been decreasing over the previous two weeks, as there was a transition from the acute phase of the emergency into early recovery.

Friday 20 December



Friday 27 December

The next phase of the operations was guided by the latest addition of the public health risk assessment. WHO released this to follow the 16 November rapid assessment.

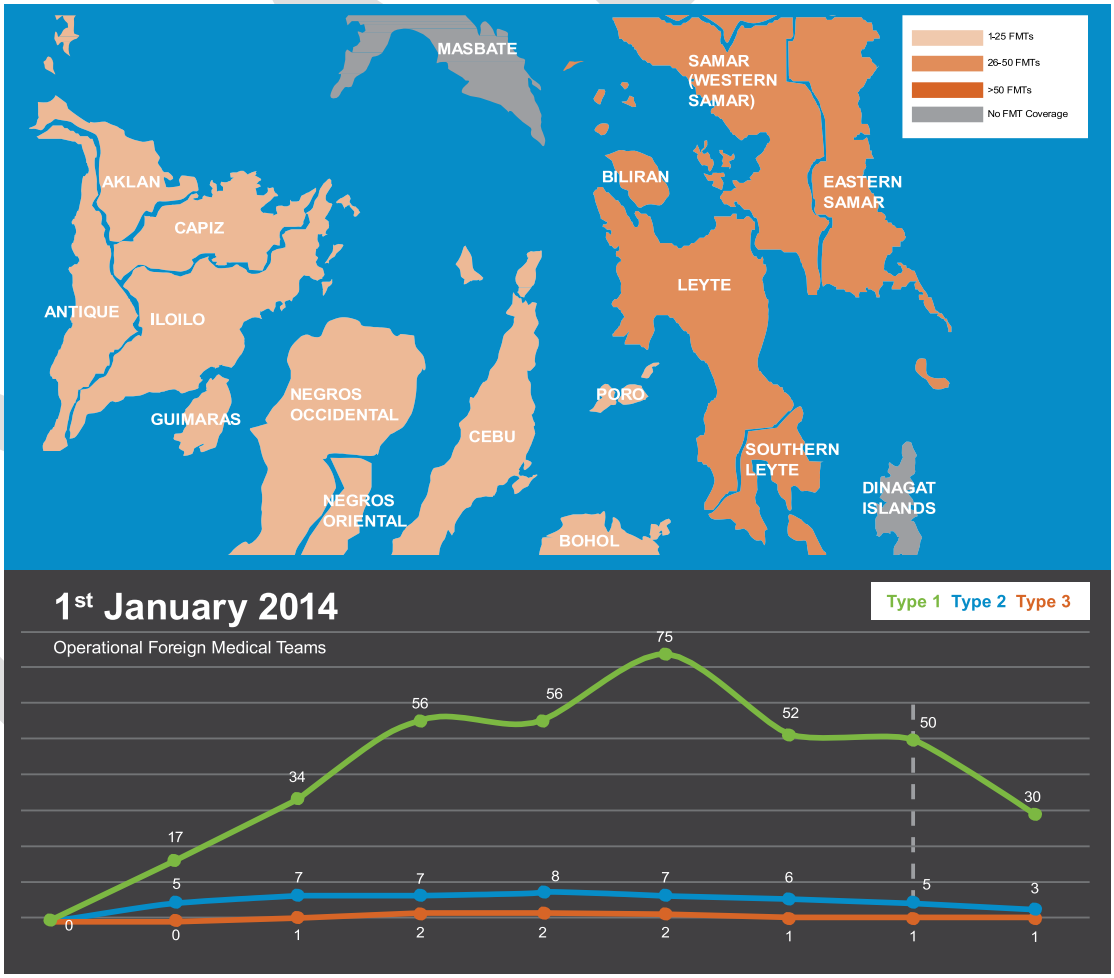
On 26 December 2013, the NDRRMC reported 6,106 deaths, 28,626 injured and 1,779 missing. A total of 16,078,181 people had been affected, 4,095,280 displaced and 101,527 remained in 381 evacuation centres.

Fifty-five registered FMTs were operating in the affected areas as of 23 December (refer to map A, B and C). Forty-eight of the teams provided basic outpatient care (Type 1), five teams had surgical capacity (Type 2) and one team provided specialty services (Type 3).

The Philippines Red Cross Society had been providing blood bank services in Guiuan and Borongan, Region VIII, with free blood donation to Yolanda victims. This required a blood donation request form with diagnosis and physician signature, as well as a cold box for storage and transport.

The sub-national health cluster in Eastern Samar was reporting that ambulances had been delivered to Guiuan and Balangiga.

Wednesday 1 January 2014



Friday 10 January 2014

Before the typhoon, Tacloban city had eight main hospitals, of which two were public and six were private. Post-Yolanda, out of the two public hospitals EVRMC was functioning and Tacloban City Hospital only started providing outpatient consultations in the first week of January.

Post-Yolanda, three of the private hospitals had been supported by international organizations in reopening the partially damaged infrastructure and delivering life-saving health care to the affected population free of charge. Mercy Hospital was functioning as a private hospital, while Humedica was providing free medical care out of their premises. Bethany Hospital was closed for reconstruction for six months. However, MSF France established a temporary hospital with inflatable tents, using the undamaged premises of the hospital.

St Paul's was operational very early and was providing free care, as well as housing a Korean team and a group of Philippine surgeons who were performing orthopaedic procedures under sterile conditions in functioning theatres. RTR Hospital was functioning at pre-typhoon levels providing private health care. CareMed Maternity Hospital was closed due to extensive damage. The Tacloban Doctors Hospital only provided outpatient consultations, due to extensive damages to the infrastructure.

As of 9 January 2014 there were 52 FMTs operating in the affected areas of Regions VI, VII and VIII. Forty-one teams provide basic outpatient care, six teams provided more advanced health services including surgeries, one team provided specialty services and four teams provided mobile services.

In Guiuan, MSF was developing temporary health facility rehabilitation plans using deltawood (a typhoon-resistant medium), in line with a DOH priority of ensuring that health facilities are built stronger than they were before the typhoon, with a great level of resilience.

The DOH National Centre for Pharmaceutical Access and Management was developing an accounting system for donated medicines.

The Task Force Cadaver, in coordination with DOH, the National Bureau of Investigation (NBI) and the City of Tacloban, completed the burial of bodies at the selected mass grave areas on 5 January 2014. The bodies were temporarily buried for easy retrieval and identification by the NBI.

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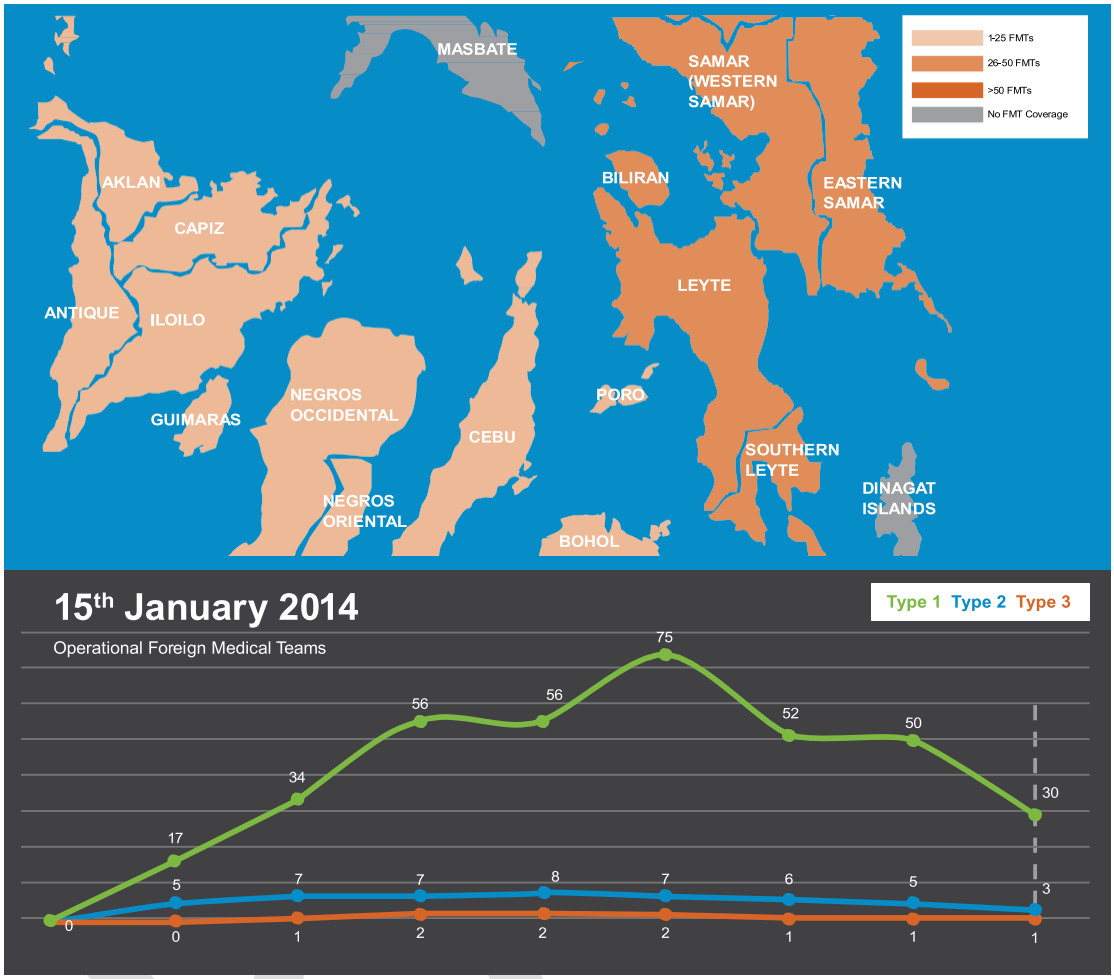
Wednesday 15 January 2014



Friday 17 January 2014

As of 14 January 2014, NDRRMC reported 6,201 deaths, 28,626 injured and 1,785 missing. An estimated 16,078,181 people had been affected and 4,095,280 had been displaced.

The DOH was planning to move EVRMC to a higher location in the next two years. The plan included measures to ensure that the new medical centre is more resilient to coming disasters and can serve as a future evacuation centre.

As of 14 January 2014, 40 FMTs were operating in Regions VI, VII and VIII. This was a decrease from 52 over the previous five days. Twenty-eight teams provide basic outpatient care (Type 1), three teams provide more advanced health services including surgeries (Type 2), and one team provides specialty services (Type 3). Six teams provided mobile health clinics and mental health and psychosocial support.

Friday 24 January 2014

From 17 to 19 January in Eastern Samar Typhoon Agaton forced over 1,000 people to leave their temporary shelters, tents and bunk houses and move to improvised evacuation centres. The wet climate was expected to lead to an increase in respiratory tract infections.

noTE: The timeline is not a complete record of all activity but a snapshot of activity from the health cluster reports and as remembered by interviewees.

CaSE STuDY 1: a FMT'S RESPonSE To ITS FIRST DISaSTER

An ad-hoc FMT established itself to respond to the Yolanda disaster. The team remained unregistered with approximately 10 staff in country for 25 days. The team was deployed with the backing of an existing commercial aero-medical evacuation provider (as a foundation) that operated on a regional basis, as well as provided a range of domestic medical services in their country of origin.

Whilst all staff were competent within their normal roles, the selection process appears to have been an initial call for volunteers via social media. This attracted approximately 500 applicants from which 50 were assessed (format unknown) and 10 selected.

It is likely that even if a team was selected from personnel with appropriate qualifications, experience, training and vaccinations, the effectiveness of the team was likely to be reduced by their ad-hoc nature and lack of pre-deployment training and Standard Operating Procedure.

The team deployed light, and with the aid of some corporate sponsorship from trauma pack manufacturers appears to have delivered a range of effective mobile clinics at Type 1 FMT level. However, their self-sufficiency, logistics and team support capability was unknown. In addition, although deployed in team uniform appropriate to the tropics, this included a prominent country flag and large embroidery on the back stating "XXX COUNTRY–MEDICAL RESCUE". This uniform was extremely similar in style and format to their country's official FMT response.

As control over uniform, branding and national flags is difficult to achieve for most jurisdictions, FMT focal points and embassy staff are likely to have to manage both the positive and negative effects of future FMTs being perceived as an 'official government' FMT.

CaSE STuDY 2: MajoR SuRgICal CaSES ConTRaInDICaTED In TYPE 1 TEaMS

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6.0 analysis of the FMT Response

The adoption of the FMT guidelines[1] and the request of DOH to WHO to support the coordination of the international teams that started to arrive spontaneously in country during the very first days after the typhoon allowed a considerable improvement in coordination of FMTs, for example if comparing to Haiti.

In particular, the distribution of the FMT registration form to all FMTs before their departure from the country of origin, when possible, or immediately at arrival in the Philippines, as a mandatory step to identify and decide the final destination site, allowed the registration of 83 out of the overall 150 FMTs that operated during the international humanitarian response to Typhoon Haiyan.

But most importantly, this allowed the adoption of a common terminology to define the types of FMTs, and it facilitated enormously the decision process of selecting the final geographical areas of deployment of the FMTs, based on their service delivery capacities (Type 1, 2 or 3).

It is important to underline that the more complex FMTs (Type 2 and 3) have all been registered and deployed taking into account their capacities. More than half of the Type 1 FMTs have also been centrally coordinated through the registration process.

The FMTs that did not register at the national level and showed up directly at the field hubs health cluster coordination mechanism have been also coordinated and deployed following the same terminology, highlighting that all of them had the capacity of FMT Type 1, often with a number of staff far lower that the suggested ones by the FMT global health cluster guidelines mentioned before.

6.1 registration

FMTs deployed during Yolanda response

Type	Type 1		Type 2	Type 3	Specialized	unknown	Total
	Fixed	Mobile					
FMT Registered	57	12	11	2	1	0	83
FMT Non-registered	40	11	0	0	0	16	67
Total	97	23	11	2	1	16	150

1 Classification and Minimum Standards fro Foreign Medical Teamd in Sudden Onset Disasters, http://www.who.int/hac/global_health_cluster/fmt_guidelines_september2013.pdf

Of the 150 FMTs, 83 had formally registered whilst 67 had not.

It was not possible to ascertain the reasoning for non-registration of teams during this evaluation, but it is an area worthy of further follow up. Possible reasons for non-registration are the lack of familiarity with the process and perceived reporting burden.

It is important to note that data on team composition, delivered health services and deployment dates are all exclusively from the registered cohort. Many of the unregistered teams did not submit any report, did not fill in and return the distributed monitoring form, nor the exit report that was requested at time of departure, and rarely attended the health cluster meetings.

Of the 67 unregistered teams that were known to be operating in the Philippines, 16 did not declare an FMT level and 51 were classified as FMT Type 1, out of which 40 were fixed and 11 mobile.

Among the 83 registered FMTs, 69 were a Type 1 FMT (57 fixed and 12 mobile), 11 were Type 2 FMTs and two were Type 3 FMTs. One team has been allocated as a specialist team.

It is important to underline that the more complex structures deployed as FMT Type 2 and 3 were all registered and all submitted reports that documented their activities.

Despite considerable effort to maintain data, for the unregistered FMTs there were many incomplete data fields. Some data cleansing was undertaken and social media, such as team Facebook postings or press releases, was useful in confirming arrival or end dates.

Some international NGOs that deployed FMTs in the initial phase of the response, and that provided at a later stage a range of programmes across health, shelter and WASH clusters, had difficulties in keeping satisfactory reporting of health services delivered directly during the transition from relief to early recovery.

6.1.1 Team composition of registred fmTs

Registered FMTs deployed during Yolanda response					
FMT Type	**Type 1**	**Type 2**	**Type 3**	**Specialized**	**Totals**
Total Registered	69	11	2	1	83
# Reporting only the totals of HR	45	8	0	1	54
# Reporting breakdown of HR	24	3	2	0	29
# MD	100	26	22	0	148
# Nurses	91	53	21	0	165
# Paramedics	3	0	0	0	3
# Midwives	0	2	1	0	3
# Pharmacists	6	0	0	0	6
# Support Staff	170	81	112	0	363
# Total Personnel	1,268	610	166	40	2,084
average Personnel/FMT	18	55	83	NA	

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Of the 83 registered FMTs, all reported the number of staff used to run the structure during the field operations. Of these, 54 reported the total number while 29 FMTs also reported the breakdown of human resources of their team by type.

number of national Staff Reported by the Registered FMTs						
FMT Type	Type1		Type 2	Type 3	Specialized	Totals
	Fixed	Mobile				
Total Registered	57	12	11	2	1	83
Total Reporting	17	3	4	0	1	25
Total Staff (international and national)	522	44	368	NA	40	974
National Staff	231	28	220	NA	20	499
Professional of national staff	RNs, support staff	ND	RNs, support staff	NA	NA	

All registered FMTs reported the number of international staff. Twenty five out of the 83 registered teams reported the number of national staff recruited, mainly nurses , mainly nurses.

The monitoring form of the FMT needs to be improved in order to capture the turn-over of staff, as well as the incremental increase of national staff recruited during the operation by several teams and not captured in the numbers above, which give only the figure reported at the beginning of the operation. An update of this information had not been asked at the later stages of the response.

Figure XX presents the incremental increase and decrease of the total number of staff deployed with the FMT, by type of FMT, and over the time of the response.

There were over 2,000 personnel from the 83 registered teams providing health services in the affected regions. Although the global health cluster registration form had a column for the teams to include the number of international and local staff numbers it did not request the team composition, resulting in the low number of teams that provided a breakdown of their human resources.

The average number of staff for a Type FMT 1 was 18, for a Type 2 55 and for a Type 3 83 staff. It is important to note that these numbers constitute the initial team that was deployed. Once deployed, many of the teams either scaled up or decreased the numbers according to the health needs on the ground. Neither do the numbers include the turnover of international staff that was necessary to maintain the structures. During the initial phase several FMTs had a turnover time frame of two weeks, suggested by the very hard living and working conditions, while the time of deployment became longer once the situation had stabilized for those FMTs with a longer period of deployment, such as MSF. As a policy, several teams had already decided to have a maximum of one or two turnovers of their teams, considering also

the opportunity to adjust the composition of the professional capacities of the teams in order to meet the evolving health needs of the population.

The suggested standard number of medical doctors for a FMT Type 1 is three. Data shows that of the 24 Type 1 FMTs who reported their team composition there were 100 medical doctors, resulting in a ratio of four doctors for each team.

Type 2 teams had an average of one nurse or midwife available for every five beds, showing a better ratio than the recommended one of eight.

6.1.2 number of beds for Type 2 and Type 3 fmTs

number of beds by FMT Type			
Type	Type 2	Type 3	
		Inflatable structure	Hospital ship
Total number of teams reporting	10	1	1
Total number of beds	279	80	600
Average beds per team	28	NA	NA

Type 2 and Type 3 FMTs provide surgical care and all the Type 2 FMTs, excluding one, deployed with field hospitals, ward beds and operating theatre facilities. MSF Switzerland was the only Type 2 FMT that operated in an existing permanent structure, Balasan hospital in Region VI.

The average number of beds for Type 2 teams was 28, exceeding the requirement of 20 inpatient beds. The two Type 3 FMTs were also above the recommended 40 inpatient beds, as stated in the minimum technical standard report on FMTs.

The number of beds by type of FMT, suggested by the global Health Cluster MT guidelines, needs to be considered as minimum standards, and reflect efficiency criteria which the FMT should adhere to. In this case, the higher number of beds for both Type 2 and 3 FMT deployed in the Haiyan response indicates the huge reduction of beds due to the impact of the typhoon, and the need to temporarily supplement inpatient capacities to respond to the health needs of the population affected. A challenge for the recovery effort is to maintain these capacities at time of departure of the FMTs, using the window of the FMT deployment to rehabilitate the public health hospitals and reopen wards. This has not been the case in some areas and this need to be monitored during the medium- and long-term recovery process.

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6.2 mobilisation and length of deployment

Crude analysis of the data recorded in FMT registration forms was conducted to determine the mobilisation times for different types of FMTs. Due to these only being recorded as a date, there is potentially 48 hours of variance, taking into account that a departure and arrival time could be at any point within the 24 hour period.

Further work to understand FMT deployment processes and time frames for mobilisation is warranted.

6.2.1 onset of disaster to arrival in the Philippines

Days from onset of disaster to arrival in country and from arrival to be operational from reporting FMTs						
FMT Type	Type 1		Type 2	Type 3		Specialized
	Fixed	Mobile		Inflatable Structure	Hospital ship	
Total reporting teams	57	12	11	1	1	1
Mean (days) from onset to arrival in country	9	5	6	2	15	75
Min-max number of days from onset to arrival in country	2-66	2-14	2-21	NA	NA	NA
Mean (days) from arrival to be operational	3.5	3	3	13	0	2
Minimum to maximum number of days to be operational	0-10	0-8	0-10	NA	NA	NA

**disaster onset was taken to be 8th november 2013*

The first time period examined was between Typhoon Yolanda making landfall (8 November) and the arrival of a FMT within the Philippines. This initial arrival point was often not the final destination or area of operation of a FMT. The main international port of entry is Manila airport at the beginning, and some FMTs experienced delays deploying from there.

Other FMTs arrived directly to the Cebu coordination hub, following direction provided by the DOH based on the difficulties of the logistics at Manila airport, and the national and international military assets that had been used to strengthen Cebu airport and the logistic hub, including the set-up of the “One-Stop-Shop”. The “One-Stop-Shop” convened on 11 November 2013 and it brought together in a single location the key staff, necessary for expediting customs clearances for the humanitarian response. A number of teams were operational within this region but many others who had reached Cebu were still reliant on official transport, utilising the multinational military cargo aircraft or organising their own forward transport. Several anecdotal stories have been published of teams utilising the ferry service between Cebu and Ormoc city.

The mean time from onset of disaster to arrival in the Philippines according to type of FMT is listed below:

- Type 1 Fixed: mean of nine days (n57), range 2-66 days
- Type 1 Mobile: mean of five days (n12), range 2-14 days
- Type 2: mean of six days (n11), range 2-21 days
- Type 3 Inflatable structure: two days
- Type 3 Hospital ship: 15 days

In spite of some teams being able to arrive within the first couple of days, the majority of teams were only able to arrive after a week or so, well in to the second phase of the disaster. FMTs need to ensure that they are correctly configured for the likely presentations at the time of their arrival. If this is in the second phase, they need to move beyond a trauma response that they are unlikely to be able to achieve. With the majority of assistance therefore present in the second phase, there is an opportunity to ensure excellent coordination, logistics and high technical standards of these teams from the second week of the response.

6.2.2 Time to deploy once in the Philippines

Data was held for 83 teams on the time between arrival in the Philippines and deployment to their allocated area. Time to deployment once in the Philippines was only collected to the nearest day, which is a good compromise between precision, which would even require the timing in addition to the date, and too detailed information to process.

Mean days from arrival in the Philippines to being operational were:

- Type 1 Fixed: mean 3.5 days (n57), range 0-10 days
- Type 1 Mobile: mean three days (n12), range 0-8 days
- Type 2: mean three days (n11), range 0-10 days
- Type 3 Inflatable Structure: 13 days
- Type 3 Hospital Ship: was operational from the day of arrival in the Philippines

6.2.3 Length of deployment

Length of stay from reporting FMTs

FMT Type	Type 1		Type 2	Type 3	Specialized	
	Fixed	Mobile				
Total Reporting teams	57	11	11	1	1	1
Mean length of stay (days)	40	47	32.5	140	17	15
Minimum to Maximum number of days	2-171	30-95	5-66	NA	NA	NA

Data on the length of deployment was difficult to acquire as many teams did not submit the exit report nor debriefed with WHO or DOH before departure from the Philippines. Departure dates of the teams were extracted from information provided by the teams' evaluation reports, social media and from the records of the five WHO hubs that were established in the affected regions post-typhoon.

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6.3 service delivery by TyPe of fmT

aggregated services delivered by reporting registered-FMTs									
FMT Type	Type 1			Type 2	Type 3			Specialized	Totals
	Fixed	Mobile	Total		Hospital ship	Inflatable structure	Total		
Total registered	57	12	69	11	1	1	2	1	83
Total reporting teams	36	8	44	9	1	1	2	0	55
Total consultations	82,850	22,892	105,742	41,822	48	46,035	46,083	NA	193,647
Total admissions	341	0	341	2,247	48	591	639	NA	3,227
Total deliveries	73	0	73	538	4	651	655	NA	1,266
Total C-sections	2	0	2	47	ND	72	72	NA	121
Total surgeries	2,852	0	2,852	1,810	ND	504	504	NA	5,166
Total major surgeries	7	0	7	490	40	412	452	NA	949
Total referrals	2,018	12	2,030	93	NA	NA	NA	NA	2,124

A total of 193,647 consultations were recorded by the 83 reporting teams, including 1,266 vaginal deliveries, 121 caesarean sessions, 5,166 minor surgeries and 949 major surgeries.

It is important to note the difference in service delivery between the two Type 3 teams. A Type 3 FMT is normally capable of performing 15 major or 30 minor surgeries daily. One Type 3 FMT performed 412 major surgeries, whilst the other Type 3 hospital ship deployed only performed 40 major surgeries.

Analysis of the post-deployment online survey

A FMT post-deployment online survey was conducted in the last week of January 2014, nearly three months after Haiyan. The survey was requested to be completed by the team leader/coordinator responsible for the day-to-day management of the respective FMT. The questions were intended to build on the information that teams provided in their exit forms and were based extensively on Core Standards and Minimum Technical Standards. Only 22 teams completed the online questionnaire. The low response rate could be due to the limited time that was given from emailing the questionnaire to submission deadline, and the fact that most FMTs had already left the Philippines by the time the survey was disseminated and was deployed elsewhere. Due to the low response rate the evaluation team decided to not draw any conclusions from this data.

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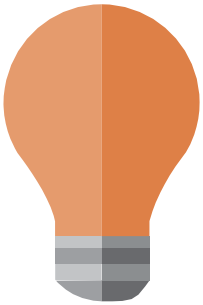
7.1 Lessons Learned and Recommendations



1. The current Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters (the Minimum Standards) is fit for purpose. However, awareness and operationalization of the Minimum Standards needs to be raised with all stakeholders.

   The Minimum Standards were published electronically in September 2013, with a very limited physical print run. Little publicity or implementation of the Minimum Standards had occurred between the time of their publication and the response to Typhoon Yolanda. Therefore, FMT awareness of the Minimum Standards and FMT registration was poor. The lead author, Dr Ian Norton, has commenced a secondment to WHO Geneva in January 2014 to lead the roll out and operationalization of the Minimum Standards. This includes consideration of the most effective mechanism for FMT coordination within the existing frameworks, and the delivery of a series of regional workshops on the Minimum Standards.

2. The Minimum Standards have an emphasis on the provision of a surgical response to sudden onset disasters. They provide little guidance on the provision of essential health services that complete the health sector response. A critical example is the provision of outpatient and inpatient care for patients with acute mental health disorders.

   The Minimum Standards were written to address issues identified in the Haiti earthquake response, and as such are clearly focused on the surgical response to a SOD. In the absence of other relevant standards, these were seen to underpin all medical responses to Typhoon Yolanda.

   Personnel on the ground identified the need for a rapid transition within the first one to two weeks to fixed and mobile outpatient medical teams providing a full range of basic health care, including mental health services. Such services present unique challenges, with a stronger focus

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on delivery by clinicians with language and cultural skills relevant to the affected population, which suggests the need to plan and prepare for mixed international and national medical teams as part of national emergency preparedness plans.

These services may be better supported by either specific guidelines for other medical teams (including mental health) in humanitarian crises or an attempt to expand the current guidelines to a wider focus. Either way, many of the core and minimum technical standards relating to personnel training, self-sufficiency, integration and support to the affected local health providers are applicable to all types of medical response.

The significant gap in the provision of minimum technical standards for the provision of mental health and broader psychosocial services was highlighted in interviews with International Committee of the Red Cross (ICRC) and MSF personnel (who remained operational at the time of evaluation).

3. The Minimum Standards provide specific guidance on the transition from the relief phase (initial life-saving interventions and essential health services) to early recovery. In the absence of any other system, the Minimum Standards (including registration system) were applied to a wide spectrum of medical teams that arrived several weeks after the onset of the disaster.

Two of the larger NGOs provided five of the eleven Type 2 FMTs and these teams stayed for the longest duration (range of 51 to 66 days). Whilst these services provided for disaster-related trauma in the initial stages of deployment, it would be useful to examine whether the Minimum Standards (or an alternate) need to provide specific guidance on the transition to longer-term services from the initial relief phase.

Specific guidance beyond inpatient surgical care for SODs would be beneficial (for both outpatient and acute presentations) in the area of:

- Non-communicable diseases (for example diabetes, chronic obstructive pulmonary disease, cardiovascular disease, cancer)
- Maternal and neonatal care, particularly at time of delivery
- Public health and outpatient care for simple infectious disease presentations
- Mental health care (continuation of care of long-term mentally ill patients and the provision of mental health support to affected population)
- Care of the aged
- Rehabilitation and care of injured and disabled people

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4. An emerging range of actors operated across many clusters, functioning outside the Inter-Agency Standing Committee humanitarian coordination mechanism. These actors, at least in the FMT arena, must be engaged and coordinated like any other FMT.

In the period when traditional international NGOs are still considering their deployment, a number of humanitarian actors are establishing their delivery capability to meet unmet needs.

Many of these teams pride themselves on their speed of action, lack of bureaucracy and ability to utilise social media or informal networks for funding, logistical support, recruitment of volunteers and other areas that have been traditionally more restricted.

Some of these organisations specifically recruit ex-military personnel. They have personnel who are legitimately experienced with a range of trauma, able to live and operate in austere environments, familiar with communications and personal security, and possess a 'can do' attitude.

Extensive personal and professional networks can see these teams overcome logistical delays affecting other teams and subsequently become operational at an earlier stage. Teams utilising such an approach must be careful that they do not exceed their supply lines or become operational with no support in place and an inevitable abrupt exit.

The pioneering spirit and 'can do' attitude of these teams must be supported, but also met with a clear professional and moral expectation that they meet the standards. It is important that any FMT coordination model is able to capture and engage all deploying teams, and that even those who deploy in a swift manner feel that they should coordinate their activity through a member of the team clearly appointed to cover the function of the FMT focal points.

5. There is a low cost of entry for FMTs and no control over their identified affiliations (country association or branding). FMT coordinators must be prepared to manage emerging issues (both positive and negative).

Several teams demonstrated their ability to deploy for the first time to a disaster, and often this response was as timely as more experienced teams. Whilst many international NGOs have very clear branding policies, especially when it comes to identifying, displaying or aligning with sponsoring countries' aid programmes, many of the smaller 'professional interest' or

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ad-hoc teams displayed national emblems, flags or otherwise aligned themselves clearly to their country of origin.

Whilst this was not a problem from a security perspective post-Typhoon Yolanda, it may have become a problem from an accountability perspective had any of these teams undertaken inappropriate activity in the field.

In the response to Typhoon Yolanda, there were at least two teams from the same country; one was the official government-funded and mandated FMT, the other was established out of a private foundation. They wore very similar tropical uniforms, both embroidered with a prominent country name, flagand medical team tag.

The registration process should clearly identify teams that are part of an official government mission from those that may be part funded (such as NGOs), or who have simply received embassy support in deployment. Registration could perhaps include submission of a photo of any identifying team uniforms.

It is entirely foreseeable that FMT coordination points may be asked to identify and manage transgressing teams by the host country agencies and accurate registration and deployment data (dates and area of deployment) is vital to do this.

6. The deployment of significant numbers of FMTs requires additional coordination. FMT focal points should be provided at the national level and where appropriate at local coordination hubs in support of health coordinators and DOH representatives.

In December 2012 WPRO ran a regional workshop on the Regional Framework of Action for Health Emergency Risk Management. Within the goal for policy and coordination was an aim to:

- Develop policies and procedures for pre-crisis registration of FMTs, with clear indication of services that can be made available in case of rapid deployment after a sudden onset disaster.

Within the region this work had not been significantly progressed prior to Typhoon Yolanda. As a result, there were no formal coordination mechanisms in place for FMTs before the event.

On Monday 11 November, three days after the impact, Dr Sasha Peiris from the WHO Philippines Country Office was directed by the WHO Western Pacific Region, Emergency Humanitarian Action team leader to work with the

Philippine DOH, Bureau for International Health Cooperation, in managing the national coordination of FMTs.

This coordination was based on the FMT registration form issued for teams who had identified that they intended to or were deployed. Completed forms were emailed initially to Dr Peiris' email account, and at a later stage to a generic email account to the WHO Health Cluster coordinator in Manila.

FMT registration responses were consolidated into a continually updated Excel spreadsheet which also tracked details of whether the team was operational or demobilised and the region, province and municipality the FMT was deployed to, and reported trough maps uploaded on the web for the general public twice a day.

WHO established five coordination hubs in Manila, Tacloban, Ormoc, Eastern Leyte, Cebu and Roxas. During the early stages of an emergency, accurate and comprehensive initial assessments are likely to be extremely difficult to obtain. Acceptance of a FMT at the national level may need to be based on the anticipated impact of the disaster, informed where available by hazard mapping, demographics and Hospital Safety Index assessments, before actual needs are identified. These teams may be tasked to likely response areas based on the anticipated need. However, they will need more specific tasking provided at the local level in order to avoid service overlap, and (hopefully) to provide the provision of a referral system.

Coordination of FMTs at the national level, with support from sub-national health clusters, was almost universally supported, although there were some stakeholders who thought the teams could be coordinated by current OCHA/UNDAC staff.

Further work is required to determine the competencies and optimum location for national and local FMT coordination functions.

7. In support of FMT coordination and these focal points, there should be a common registration, mobilisation and tasking process. This process needs to include the possibility of a SOD affecting more than one country, with available FMTs to be allocated according to need.

It is important that information on deploying teams and their status is available to national, regional and local health departments. This information ensures the most effective and efficient use of available resources and helps to ensure that all needs are met, helps identify existing service gaps and ensures that local health providers remain an informed stakeholder.

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Although attending the Health Cluster meetings in Tacloban, the City Health Officer did not receive details of FMTs deployed to the city health hospitals under his control. This information was passed to the DOH Regional Director and a health officer appointed by the Mayor, not in communication with the City Health Officer. Recognising the complexity of administrative and operational responsibility in any jurisdiction, it is important to ensure that, subject to operational security concerns, the deployment status and location of FMTs is shared in a timely fashion with as many stakeholders as possible.

In addition, a real time mechanism for the international FMT community to remain appraised of requests for assistance, status of deploying teams (i.e. on standby, deploying, operational), and rotation and exit of teams will ensure that coordination of these teams is maintained, as was the case during the Yolanda response. FMT thematic maps were produced twice a day, with an indication of the key information of the FMT in standby in the country of origin, the ones newly arrived but not yet with a final destination assigned, the ones under deployment, the ones operational at their final destination, and the ones that had left their operational area and the country. This system was set up in the first week and was maintained during the first four months by the FMT coordination team of the Health Cluster, in constant contact with DOH at national, regional and local levels. It is understood that a similar system works well for UNDAC team members and USAR teams via the virtual OSOCC, but considering also the much more limited time frame of their mission.

Consideration will need to be given as to whether this flow of information replicates, replaces or supports routine reporting functions from FMTs to the host country agencies whilst deployed. The system may also have an important role in facilitating logistics support, especially in theatre air lifts and daily fuel requirements.

8. National medical teams will also deploy and this support may range from providing additional staffing to existing facilities and completely self-sufficient teams. The mechanism for FMTs to coordinate and work alongside national medical teams needs to be further developed.

FMTs will be operational after some local medical teams have already responded and consideration needs to be given as to how all teams are coordinated effectively through local and national focal points. Local teams need to be able to refer or receive referrals from FMTs and FMTs should consider under what circumstances they would request or respond to requests to embed local staff within their structure. FMTs and local medical

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teams need to be able to communicate with each other and coordinate.

- Total number of DOH medical teams deployed in response to Yolanda – 70
  - (Medical doctors: 568, registered nurses: 411, total staff: 2,321)
- Total local medical teams – 32
  - (Medical doctors: 343, Registered nurses: 167, total staff: 588)
  - 13 FMTs worked with local medical teams and nine FMTs worked with local volunteer medical teams

Although the DOH teams were self-sufficient, some of the local teams and volunteer organizations were not and this limited the teams working to their full capability.

The Minimum Standards provide a useful reference point for local medical teams to consider their own levels of self-sufficiency, capability and capacity.

9. Enhancements to the registration and coordination processes should provide a framework for the registration of all possible types of FMTs.

It was evident that the FMT registration process had been used to capture all offers of assistance from health teams, regardless of whether the teams formally identified themselves as an FMT or operated primarily within the surgical area. It was observed during the evaluation that the scope of FMTs being coordinated included not just primary care and surgical related teams, but also a range of mental health services and other medium/long-term health services, which are classified under the specialized FMT, on top of the minimum standards presenting the capabilities of Type 1, 2 and 3 FMTs.

Enhancements to the registration process should be aimed at ensuring that sufficient information is captured to enable the efficient deployment of any type of FMT, including the ones devoted to specialized services. This should include, where appropriate, specific detail on different services offered. A technical group should identify the optimum level of detail. Whilst excessive information requirements may not be met by FMTs in the response to an emergency, there should be strong consideration given to pre-registration and the benefits of advanced information for strategic, coordinated planning.

Specific information that could be useful would include weight and volumeof the deployed cache grouped by temporary health care facility, base of operation (accommodation and self-sustainability), fuel requirements, team food, medical equipment, consumables and drugs, as well as the capability

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and capacity of the team. Such detail would enable the FMT focal points to better deploy FMTs by coordinating logistics support or prioritising deployment of fully self-sufficient teams.

In future response evaluations it would also be valuable to attempt to define the reason for non-registration of FMTs. This would likely need to include a qualitative evaluation.

10. The pre-registration process needs to support the alerting, standby and possible deployment of FMTs prior to the impact of disasters and hazards that can have an early warning.

There are some limited hazards and scenarios, such as increasing typhoon and storm systems, where some period of pre-impact intelligence is available. This could suggest when FMTs may be required. Further work is required to identify the thresholds and mechanisms for FMTs to be placed on alert or begin to mobilise as part of a coordinated response to another extremely severe storm system. This is a strong rationale to explore the modalities for a regional and/or sub-regional registration and coordination mechanism for FMTs. The Pacific is an example of building this possible sub-regional scenario.

11. National and sub-national FMT coordination, as a critical function of the Health Cluster, has to have strong relationships with the decentralized sub-OSOCC and the RDC.

The International Search and Rescue Advisory Group-accredited USAR teams are required to be able to set up and establish an OSOCC and/or RDC in the event that they are the first team into an affected area.

Further work is required to enhance the Health Clusters' FMT coordination capacities with strong synergies and communication flows within these structures, particularly during the very first days, during which the overall humanitarian coordination system is going to be set up in a Level 3 crisis.

12. FMT coordination and health service delivery is specialised, as with other technical humanitarian services. In support of national and local FMT focal points, the development of a small FMT coordination cadre with experienced clinical and technical staff should be considered on a regional or global basis.

It is difficult to predict the number of FMTs that will respond to a major disaster. A single region may see 10 or so of these teams, with perhaps one or two larger Type 3 FMTs and perhaps up to 100 Type 1 FMTs requiring management.

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At the national level, FMT coordination will require engagement with a range of ministries and departments such as on health, foreign affairs, customs and immigration, as well as agencies such as those responsible for pharmaceutical control and registration or licensing of health practitioners, as well as representatives from other countries' foreign affairs departments or aid agencies.

At the local level coordination will be with local equivalents to agencies already listed, as well as a range of existing private and public health providers and other humanitarian health actors operating.

Coordination is a specialist role, with the potential for the FMT response to be severely impeded by the role being performed ineffectively.

13. The deployment of a Type 2 or 3 FMT is comparable to a USAR heavy deployment, with a likely deployment length at least two to three times longer than that of a USAR mission. Re-supply and rotation of personnel and medical supplies is highly likely. These teams will benefit from the development of a small FMT coordination cadre, which includes an experienced logistician.

A truly self-sustainable Type 2 FMT, able to operate in an austere environment without resupply (other than fuel) in a temporary facility, will likely require in the order of 30-40 personnel and 25 tonnes or greater of equipment. This is comparable to a medium-sized USAR team. In addition, the length of deployment will be at least three times as long and there may be a greater number of FMTs deployed. The inclusion of a logistician in the FMT coordination allows for the prompt facilitation of the processing and release of medical supplies intended for use by FMTs.

14. Whilst some teams demonstrated the ability to deploy 'fast and light,' providing a range of surgical cases in improvised facilities, they subsequently faced logistical issues. This highlighted the requirement to consider the balance between deployment ability and sustainability. Delivery of surgery, particularly major surgery, at a Level 1 facility is contraindicated.

One team deployed as a Type 2 FMT, with only the equipment they could physically carry, or at least relay between them, and established an improvised surgical facility in a small town south of Tacloban.

Their response and the challenges they faced are openly described by the team logistician in an article published online [2], and their official website

2 http://www.takepart.com/feature/2014/01/09/philippines-typhoon-haiyan-medical-relief-diary-part-1

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shows an encouraging awareness of the issues they faced and a willingness to improve their effectiveness. Nonetheless, during Haiyan the team did not meet many of the minimum technical standards (see page 42-43). In this time they performed several caesarean sections and amputations. However, they lacked appropriate post-operative care capability. From their article, their referral process and post-operative care capacity appeared to have opportunities for improvement.

In reviewing the issues described in their media releases and articles, this FMT's initial effectiveness appears to have been compromised and cut short by their extremely light deployment.

Whilst being fast, light and operational within 72 hours are highly desirable; self-sustainability and mission duration must be planned for.

One Type 2 FMT reported in personal correspondence that they received many referred cases that had been inappropriately managed at other Type 2 FMTs. Examples include a patient that required interventions following misadministration of analgesics and anaesthetics, as well as early wound closures. Type 2 FMTs need to ensure that they are capable of providing post-operative care 24 hours per day throughout their deployment, unless they have a pre-agreed transfer plan to another facility that is capable and willing to receive stabilised patients. The Minimum Standards clearly document a ratio of inpatient beds to operating theatres.

15. Further work is required to better define the breadth of the Type 1 FMT role. In particular, there appears to be a number of 'mobile' medical teams that operate outside an outpatient clinic role and who are involved in a range of community-based triage, primary care and public health. These teams still need to operate under appropriate minimum standards.

It was evident that many teams operated in a mobile and light role and outside any formal outpatient clinic facility to provide a range of services within the community. Whilst this has the potential to reach a large number of people who may otherwise not have access to services, mobile teams should consider the following:

- In order to enable the local health authorities to identify unmet needs, there is an enhanced need for recording and reporting presentations and areas of operation on a daily basis.
- Reporting can also provide enhanced epidemiological surveillance and information on other needs – provided it is shared with other agencies.

- How they will meet the Minimum Standards for patient safety, privacy and recording of treatment when delivering services outside of a clinic or hospital setting.

- To ensure they treat within their capability and consider what their referral and treatment protocols will be if they encounter cases beyond this capability.

16. The Minimum Standards should include more explicit requirements and standards for self-sufficiency. As minimum, FMTs must have the ability to operate for an initial two week period in an austere environment with no re-supply. Fuel requirements should be clearly stated (against agreed ratios) and be met by the host country as a condition of deployment.

With the exception of fuel, which must be arranged by the host country or FMT focal points (due to the inherent difficulties in air transport, but subject to a normal range based on capability and capacity of the team), teams should be fully self-sufficient against their declared capability. As a minimum, this should provide for the accommodation, communication, potable water and feeding of the team, so as not to be a burden on the receiving community.

From interviews, document review and open source material, it was clear that many teams had not fully considered the requirements for full self-sufficiency, nor had they accurately conveyed their ongoing support requirements prior to deployment.

Whilst there was a general transparency in support requirements, many of these could not be met. As a result, teams were not deployed to the areas of greatest need. For example, one FMT registered stating that their team required 500 litres of water a day. This kind of support is unlikely to be met by the affected country in the early stages of a response. FMTs need to have the capability to generate fresh water for their deployed staff and patients themselves.

Many FMTs, even those well prepared, faced supply chain challenges. As a minimum, teams must deploy with sufficient pre-packaged medical and drug consumables to support a Type 1 or Type 2 role against their declared capacity, for at least a 14 day period without resupply. The Minimum Standards requires Type 1 FMTs to be deployable for two to three weeks, and Type 2 FMTs should be available for at least three weeks, ideally longer. A Type 3 team, which the Minimum Standards consider is only appropriate to deploy for at least two months, will need to establish re-supply arrangements

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within this period.

There are likely to be few opportunities to fully utilise additional staff-only FMTs. Even if a deployable health care facility is not offered, staff-only FMTs should be self-sufficient for medical consumables. There are probably a range of models to deliver this, ranging from totally self-sufficient (such as the Australian AUSMAT or Israeli Defence Forces base of operations) through to what can be physically carried by the individual.

Additional detail on teams that needs to be captured during registration is important in this regard.

Hypothetically, a self-sufficient Type 1 FMT could carry sufficient food, medical consumables, personal shelter, water generation and fuel for five to seven days, in perhaps two large wheeled duffel bags and a backpack for each person. This is likely the maximum practical deployment kit that a reasonably fit person can manage over short distances (i.e. backpack on, bag pulled in each hand whilst cross loading between transport modes). Such a team could be deployed quickly by a couple of helicopters and operate for a finite period. By contrast, a self-contained Type 2 FMT has a significant logistics footprint, but will likely be able to operate for at least two weeks once established. Through personnel rotation and consumable resupply from week two, it could operate in excess of 12 weeks.

It is worth noting that the first team would, by virtue of being able to physically carry everything, be living in more arduous conditions (smaller personal tents, no recreation facilities, ration packs, basic ablutions) and would likely not have the endurance of the better accommodated second team. Coordination in this hypothetical example should see the small and light Type 1 FMT deployed prior to the establishment of the Type 2 FMT, whilst a plan is also developed for the extraction and replacement of the first Type 1 FMT after five days.

This is only possible with accurate and honest documentation of an FMT's capability and capacity.

Further work is required to document and agree the process for fuel support for deployed FMTs.

17. Teams need to review the composition, capability and capacity of their deployed team based on their likely task and time of arrival. Health services normally available in that area, as well as the disaster epidemiology, should be considered during this process. In particular, this is relevant for Type 2 FMTs that may

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find acute surgical presentations decline and where there is a greater need to support outpatient services.

One large Type 2 FMT rotated their personnel after approximately two weeks and specifically considered their ongoing and anticipated presentations when it came to determining the competencies of the second team. Other FMTs from the international NGO community were also able to quickly establish capability with staff on high readiness before replacing them with those on contract for longer periods.

The registration and tasking process must be two-way and provide detailed real time intelligence for FMTs to refine their team structure until the time of deployment.

18. Teams need to consider how they will address language issues during a deployment, in coordination of FMTs and delivering health services. Outpatient and mental health services will require consultations in the host language and teams with medium/long-term deployment may need to focus on capacity building and/or recruitment and local staff.

A large Type 2 FMT embedded a significant contingent of Philippine DOH nursing staff that assisted with both consultations and supported their 24/7 post-operative care. Other teams also embedded local clinical staff or allowed them to operate within their temporary facilities.

The requirement for language support may need to be a specific registration requirement, and possibly a requirement for the host country. The rationale for this was not always understood by all stakeholders. Senior DOH staff commented that the larger Type 2 FMT requesting rotation of Philippine staff was a burden on the host nation and that they considered that the Type 2 FMT was under-resourced. Other senior DOH stakeholders seemed more comfortable with the situation.

There is some level of expectation that should be further defined from host countries who request FMTs to ensure they can operate effectively. The amount of support they require relative to the capacity they provide is of course critical, and this assumes a surviving host country health agency.

19. Exit planning was well considered. However, it was clear that health clusters need to consider quick fix or full rehabilitation of damaged health care facilities at an early stage of the response as an enabling activity for the withdrawal of teams.

During interviews, teams discussed that they had been engaged in a

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range of quick fixes to health care facilities that they were either operating in or were adjacent to, with a view to ensuring health services could be transitioned safely when their team withdrew. Whilst facility redevelopment or replacement is a longer-term aid issue, teams will have a vested interested in ensuring that there is sufficient capacity to enable their exit.

In this regard, self-sufficient teams are those with a logistics element, including not only 'pure' logisticians but those skilled in establishing, operating and maintaining the base of operations and health care facilities (including equipment as diverse as generators, tents, medical equipment, heating ventilation and air conditioning, communications and water purification). These tend to be multi-skilled technicians often with trade qualifications such as carpenters, plumbers or electricians. Such personnel can also make significant contributions to the rehabilitation of damaged facilities. In larger teams this means that FMTs can not only provide acute services but also support temporary repairs to allow existing facilities to resume services until longer-term measures are established.

20. Data collection on FMTs shows a significant improvement from previous disasters. An assessment of deployed FMTs within two weeks of the onset of a major response will ensure better collection of lessons learned, continued donor support in going forward and serve as a verification tool.

The reporting exit format needs to improve to include dates of arrival in the country, start of operations, end of operations and return to base.

21. An assessment of FMTs should be commenced within two weeks of the onset of another major response, ensuring lessons are identified while the bulk of FMTs are still responding.

The first assessment, an online survey and subsequently the interviews and focus groups discussion on the evaluation of FMTs in response to Typhoon Haiyan, occurred more than two months following the sudden onset disaster. With the relief phase transitioning to a recovery phase, the majority of FMTs had demobilized and those still operational had transitioned with a new turnover of staff and were unable to provide the appropriate data. In times of a disaster, an assessment needs be conducted within two weeks of the disaster onset so as to identify lessons learned, gaps and recommendations. This will aid in gaining donor support going forward and serve as a verification tool.

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appendices

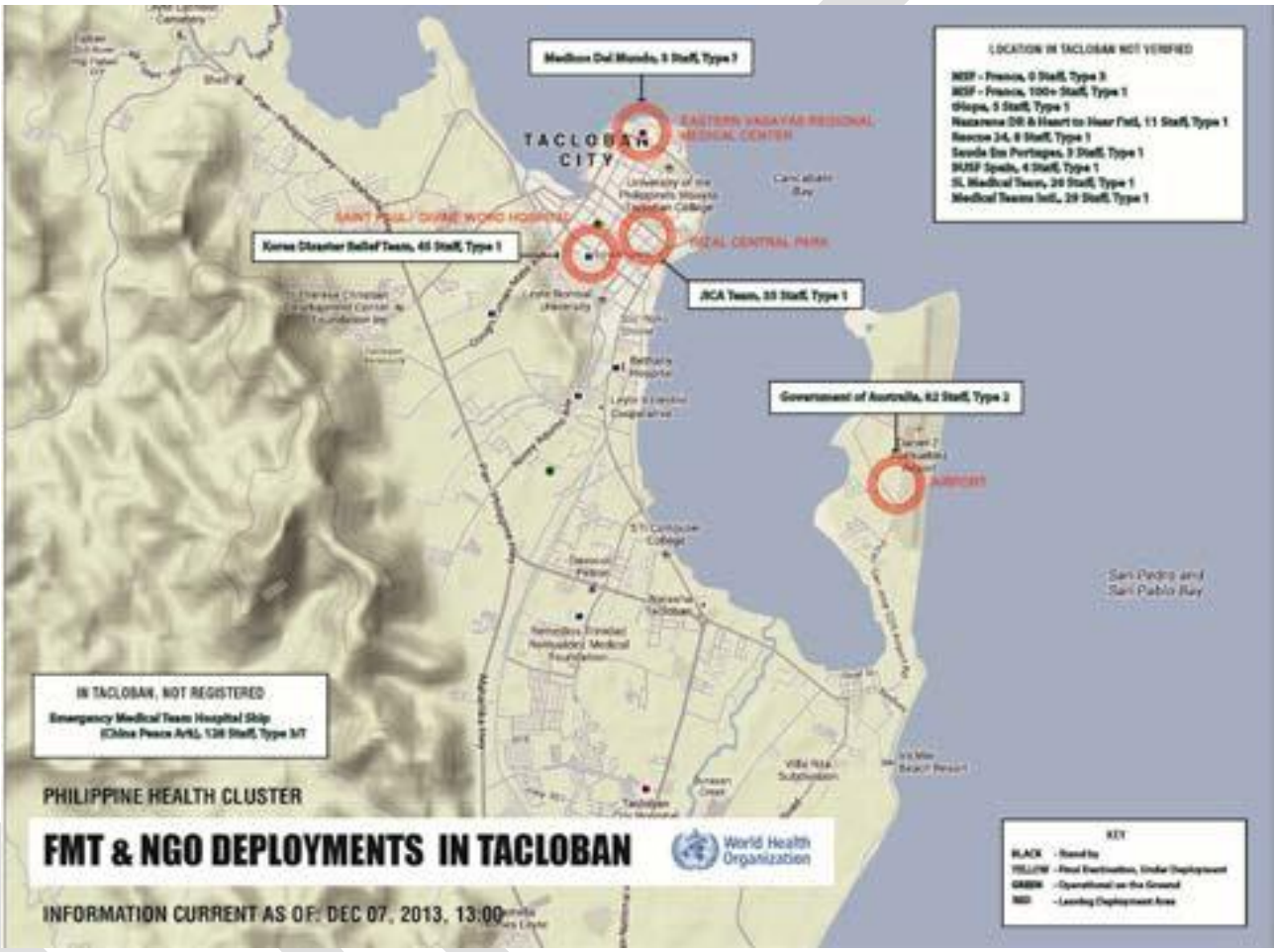
Appendix A: Details of interviews and focus group discussions undertaken for the evaluation

Date	name, Title, Role, agency	Comments
Sun 2 Feb	Jasper Llanderal, OCHA Coordinator, Tacloban Coordination Hub	**Semi-structured interview with Cb, nZ, SP** Discussion on coordination and role of FMTs within the region
Mon 3 Feb	Tina, Medical Officer, Team Leader, Finnish Red Cross, ICRC Unit Type 2 facility @ Balangiga, Region VIII	**Semi-structured interview with Cb, nZ, SP** Discussion on FMT response and transition to longer-term response
	MSF Type 2 facility @ Guiuan	**Focus group discussion with Cb, nZ, SP** Discussion on FMT response and transition to longer-term response
	Gary, Civ-Mil coordinator, Tacloban Coordination Hub, UNOCHA	**unstructured interview (breakfast) with Cb** Discussion on civ-mil liaison and FMT coordination
	Kaoruko Seki, UNOCHA team member, Tacloban	**unstructured interview with Cb** Discussion on civ-mil liaison and FMT coordination
	Dr Laguna, Director, DOH Regional Office, Region VIII	**unstructured interview with Cb, SP, nZ** Discussion on health cluster coordination and FMT response
	Dr Gloria, Mayor's Medical Officer, Health Cluster Coordinator, Tacloban City	**unstructured interview/observation at Health Cluster with Cb, SP**
	Dr Lorie Ruetas, ED Clinical Director/Director Health Emergency Management Service, EVRMC	**unstructured interview with Cb, SP**
	Dr Opinion, City Health Officer, Tacloban	**unstructured interview with Cb, SP**
	HUMEDICA Coordinator, Alexandra Vlantos	**unstructured interview with Cb, SP**
Thu 6 Feb	Dr Ailan Li, Director, Health Security and Emergencies, WPRO	**unstructured interview with Cb and nZ** Wide range of discussion including FMT and the Philippines response
	Dr Joel Buenaventura, Philippine DOH, Bureau for International Health Cooperation (BIHC) / FMT coordinator	**Semi-structured interview with Cb** Joel worked alongside Sasha from the WHO Country Office in coordinating FMT BIHC is the existing programme that coordinates visiting medical teams in peacetime
	Dr Carmencita Banatin, Director, Health Emergency Management Staff, Philippine DOH	**unstructured interview with Cb, nZ, SP** Discussion on FMT and domestic medical team coordination

Fri 7 Feb	Spanish Embassy / AECID, Mercedes Cornejo Bareas	**Structured interview with Cb and SP** Discussion on Spanish FMT response and coordination with health Cluster
	jICa – jDRT **From jICa HQ:** • Mr Hitoshi Otomo, Senior Advisor, Secretariat of Japan Disaster Relief Team, JICA (Joined as member of Medical team) • Ms Kazune Takashima, Secretariat of Japan Disaster Relief Team, JICA (Joined as a member of Medical team) • Mr Hayato Sato, Secretariat of Japan Disaster Relief Team, JICA (Assisted operation of the Medical team from JICA HQ) **From jICa Philippines office:** • Ms.Yuko Kuno (Supported logistic arrangement of the Medical team) • Ms. Atsuko Itsuki (Accompanied medical team to support coordination)	**Structured interviews: Cb, SP** Discussion on Japanese FMT response and coordination with Health Cluster
	Dr Jorge Martinez, WHO Philippines	**Informal discussion: Cb** Discussion on WHO Country Office response, FMT response and coordination with Health Cluster
	Dr Maria Guevera, MSF, Regional Humanitarian Representative (coordinator for the various MSF units that deployed)	**unstructured telephone interview with Cb** Discussion on coordination of multiple responding MSF units and FMT coordination
Sat 8 Feb	Under Secretary Dr Ted Herbosa, DOH Philippines – senior official in charge of the overall health response	**unstructured interview with Cb and nZ** Discussion on national coordination frameworks and role of DOH in requesting or accepting FMT
Thu 1 May	Australia (AUSMAT) **Department of Foreign affairs and Trade** • Celia Hevesi, Manager, Deployable Capability • Thanh Le, Director, Humanitarian Response Section • Jonathan Ball, Director, Emergency Operations • Raymond Bojczuk, Emergencies Manager **Emergency Management australia** • Roger Lye, Assistant Director • Matthew Harper, Director **Department of Health** • Sharon Flannigan, Director, Emergency Preparedness and Response	**Structured telephone interviews with Cb, SP and nZ** Discussion on FMT mobilisation and registration processes, deployment of Australian FMT response

Appendix B: Maps of FMT deployment in chronological order

Available from http://www.wpro.who.int/philippines/typhoon_haiyan/maps/en/



Appendix C: Philippines DOH Entry Procedure for Visiting Medical Teams

Documentary and Procedural Requirements for Humanitarian Assistance and Donations from Foreign Organizations During Disaster and Emergency Situations

A. Humanitarian Assistance:

1. Intention to provide humanitarian assistance to the country should be coordinated directly with the Bureau of International Health Cooperation (BIHC) of the Department of Health. Request should include the following:
   a. Letter of intent
   b. Curriculum vitae to include area of expertise or specialization of each of the mission team members
   c. Current and valid licenses
   d. Flight details of the mission team (to include date and time of arrival and the name of the airlines)

2. Upon review and receipt of the documentary requirements, the BIHC shall forward the list of the mission team to the District Collector's Office of the Bureau of Customs located at the Old MIA Road, Pasay City. The BOC shall in turn facilitate the entry of foreign mission team to the country.
3. Once the foreign mission team had arrived in the Philippines, the teams shall proceed directly to BIHC located at Building No. 3 DOH Compound, Sta. Cruz, Manila which shall accompany the group to the Health Emergency Management Service (HEMS) located at Building No. 12, DOH Compound, Sta. Cruz, Manila.
4. HEMS Shall conduct a brief situationer of the extent of damages brought about by the disaster and the areas where medical assistance are needed. Upon orientation, the mission team shall be dispatched based on the current health needs. HEMS shall also coordinate directly with Regional HEMS Coordinator for the actual conduct of humanitarian assistance in the field. A post mission report shall also be provided to the mission team members for reporting purposes.
5. BIHC shall also provide a Letter of Authority to the mission team members and shall take the responsibility of maintaining and updating a database of the foreign humanitarian assistance provided to the country.
6. A feedback and reporting system shall also be instituted in order to further improve the system being implemented. A post travel report shall be submitted to HEMS copy furnished BIHC.
7. Upon completion of the mission, the BIHC shall also prepare a Letter of Appreciation to all humanitarian assistance by foreign mission group.

B. Foreign Donations (drugs/medicines, medical supplies, medical equipment, processed foodstuff, micronutrients, environmental supplies)

1. Acceptance of donation of drugs and medicines should comply the following minimum requirements:
   a. shelf life of at least twelve (12) months from the time of arrival to the Philippines

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b. labeling and formulation with English translation
c. documentary proof of compliance to applicable quality standards
d. documentary proof that the items were obtained from reliable source

2. Acceptance of donation in medical equipment for purposes of emergency and disaster situation should comply with the following minimum criteria:
   a. manual of instructions for installation and operation that is written or translated in English; and
   b. list of service centers in the Philippines where services and spare parts are available

3. Intention to provide donation of drugs/medicines should be coordinated directly with the BIHC-DOH which should comply with the following documents:
   a. airway bill
   b. itemized packing list together with expiration dates
   c. pro-forma or commercial invoice

4. Acceptance of donation in drugs/medicines should be coordinated with BIHC- DOH and should comply with the following minimum criteria:
   a. shelf life of at least twelve (12) months from the time of arrival to the Philippines
   b. labeling with English translation or in a language that is understood by Philippine health professionals

5. Upon submission of the donor of the complete documentary requirements, the BIHC shall endorse the request together with the documentary requirements to the Presidential Management Staff (PMS) located at 4th Floor, PMS Building, Arlegui Street, Malacanang, Manila. The PMS will in turn forward the request to the One Stop Shop to facilitate the release of donated items located at BOC- NAIA Room 304, 3/F, Customs Building, NAIA, Pasay City.
6. In response to the creation of a One Stop Shop by the Office of the President, the DOH shall assign representatives from the Bureau of Food and Drugs and the Bureau of Health Devices and Technology at the BOC-NAIA room 304, 3/F, Customs Building, NAIA, Pasay City. BFAD and BHDT representatives shall report from 10:00 AM to 7:00 PM and shall be responsible for the issuance of a clearance for the entry of donated drugs/medicines, medical supplies, processed foodstuffs, medical equipment, micronutrients and environmental supplies.
7. BIHC shall take the responsibility of maintaining and updating a database of the foreign donations provided to the country.
8. For reporting purposes, the BFAD and BHDT representatives shall also provide the BIHC on the list of donated items which are directly received by the One Stop Shop.
9. The BIHC shall also prepare a Letter of Appreciation to all foreign donors who provided donations to the country.

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Appendix D: FMT Registration Form used during Yolanda response

Date:

Country/Agency:

Recent deployment experience:

Name and position of person reporting:

Contact details:

Agreement to comply with FMT guiding principles and standards: Y/N

FMT Type	Outpatient Capacity	Inpatient Capacity	Surgical Capacity	Length of Stay	No. of International/ local staff	Time to deploy	Estimated time to be operational	Logistics and support required	List services offered/ field hospital (Y/N)
1. Outpatient Emergency Capacity									
2. Inpatient Surgical Emergency Care									
3. Inpatient Referral Care									
Additional Specialized Care FMT									

Explanatory Note:

- Comply to standards: Y/N. All FMTs that want to register must comply with a) FMT guiding principles and standards b) minimal service standards
- Outpatient capacity: Maximum number of patient that may be seen per day
- Inpatient capacity: Maximum number of patients that can be hospitalized at one time (i.e. bed numbers)
- Surgical staff: maximum number of major and minor surgical procedures per day
- Length of stay: Maximum number of days that you may be deployed
- No. of international/local staff: number of all staff that will accompany the FMT and the number of local staff required to run FMT (and their specialty)
- Time to deploy: Indicates how long (hours) it will take you to be deployed from origin after disaster has occurred
- Estimated time to be operational at the site of disaster: Indicated how long (hour/weeks) you estimate from the disaster onset to provision of patient care: Choose either: <72, within 1 week or within 1 month
- List services offered: specify functions, capacities, services and that are available with FMT. Include also whether field facility is provided or not
- Logistics and support required: list element not supplies by FMT but required on site to be operational (e.g.: water, fuel, sanitation, transportation, security, ect.)

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Appendix E: Foreign Medical Team reporting form

Used for weekly reporting from both domestic and FMTs

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

MEDICAL TEAM MONITORING FORM
Reporting Date: _____

Name of Medical Team	
Team Classification	**[ ] DOH Team [ ] Foreign Team [ ] Local Volunteer Team**
Area of Deployment	
Other Medical Teams in Deployment Area	
Date/Duration of Mission	
Number of Consults	**Total Consults: ____ ER Consults: ____ OPD Consults: ____**
Total Number of Admissions (If applicable)	
Total Number of Referrals	
Number of Surgeries	**Total Surgeries: _____ Major: _____ Minor: _____**
Number of Deliveries	**Total Deliveries: _____ NSD: _____ C/S: _____ Others: _____**
Total Number Provided Psychosocial Services	
Top 5 Cases/Morbidities	**1. _____** **2. _____** **3. _____** **4. _____** **5.**
Other Services Provided	
Gaps/ Immediate Needs/ Problems Encountered	
Remarks/ Recommendations	

*Please submit forms to dohyolanda.medmission@gmail.com

San Lazaro Compound, Rizal Avenue, Sta. Cruz, Manila, 1003 Philippines
Tel. No. 711-95-02/03; Fax: 743-1829 Trunkline: 6517800 loc. 1125
E-mail Address: osec@central.doh.gov.ph Web site: http://www.doh.gov.ph

Republic of the Philippines

Department of Health

EOREI.Gl!I..MED.LCAL TEAMEXITREPORT FORM

Reported by: _____

Date or Rcpo11.: _____

MEDICAL TEAM DETAILS	
Nameof Medical tam	
Contacc Pcrson/lktails	
Registration of TC'am	☐ En,hassy ☐)WIIO ☐ DOH ☐ LGU
Team Class,r1catfon	☐) Type I ☐) TyJ)C 2 ☐ J Tri>c 3 ☐ Other:
Date of DC'poymcnt	
Date/Duration of M1ion	
Area of Deployment	Hospitol/Lo<arion: _____ Munici1,ality: _____ Province: _____ Region:
Wotkcd Wil.11 Other Medical Teams in Deployment Area	IocJIT("Jm ☐ No ☐) Ye< _____ rorcign Team ☐ No ☐ J Yes _____ Volunteer Team f] No (J Yes _____ Remarks: _____
Outreach/Mobil e Teams and Location	
Equipmen t and SuppliC'S with Team uno11atl'iva l	
Equipment and Supplies aftet endof Dcnlovmcnt	Donated? ☐ No ☐ Yes ☐ Yes rcasc c:ifv:
SERVICES RENDERED BY MEDICAL TEAM	

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Number of Consulls	Total Consults:_____ER Consults:_____OPO Consults:_____
Total Numbec·of Admissi<>ns f If anolfcahlc)	
Number of Surgc-ries	Total Surgeries:_____ Major: Minor:
Number of	Total Oeliverie:s:_____ NSD,_____Cf S,_____Oci,ers,_____
10▷ 5 C:ases/Morhid iLies	1. _____ 2. _____ 3. _____ 4. _____ 5.
Top s causes or MMtallty	1. _____ 2. _____ 3. _____ 4. _____ 5.
Total Numbec·of Mortalitv	
Total Nl1mhe1· ProYidcd Psychosocial Ser1,1ic:cs	
Other Services Provided	Va ccdnatioo ❙ ❙No ❙ ❙Yes WASH (❙No (❙Yes Nutrition r ❙No (J Yes Health Educalion ( ] No (❙Yes Others: _____
SPt:EO Reporting	(J No [❙Yes
MEDICAL TEAM FIELD EXPERIENCE	
Gaps/ Immediate Needs Identified	
Problems Encountere d	

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Soluliuu.:sto Problems F.ncnunt N!d	
Remarks/ Recommen-dation.s	
Endorsement to Ne.xtTeam	
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Tot.ti Number of Referrals	

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OPERATIONS ORDER NO. SBM – 2013 ..23_7

GUIDELINES ON EMERGENCY RESPONSE TRAVEL FACILITATION (Task Force Yolanda}

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SIEGFRED B. MISON
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