Emergency Medical Teams
World Health Organization EMT Initiative

November 2016

Special feature:
Workings of the EMT Initiative

Nepal:
Reaching new heights in coordination

How Ebola changed the nature of Emergency Medical Responses

Faster deployment of EMTs saves lives
YOUR JOB IS TO SAVE LIVES

You and your colleagues on an existing emergency medical team – or a newly formed team – can apply to be classified and quality assured by WHO.

We’ll provide mentorship and training to assist teams in achieving quality assurance and becoming ready to deploy to the places where they are needed most and can do the most good.

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

Details on Mentorship and Classification can be found at [https://extranet.who.int/emt/page/understanding-global-emt-classification-process](https://extranet.who.int/emt/page/understanding-global-emt-classification-process)

WHO EMERGENCY MEDICAL TEAM (EMT) INITIATIVE

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

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

[https://extranet.who.int/emt/](https://extranet.who.int/emt/)
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I have enjoyed observing the rapid evolution of the Emergency Medical Team Initiative. Through this initiative, international preparedness to provide clinical care during emergencies has been structured, standardized, and aligned with a set of overarching principles.

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

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

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

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

--- Dr Margaret Chan

The WHO EMT Initiative wishes to thank the following groups and individuals, without whose support this initiative would not have been possible:

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

The Strategic Advisory Group

The Core Support Group

Working Groups:
Clinical Working Groups:
Infectious Diseases, Maternal and Child Health, Mental Health, Noncommunicable Diseases, Surgery, Rehabilitation
Operational Working Groups:
Logistics, Mentorship and Verification, Minimum Data Set, Public Health, Rapid Response, Training

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

Countries/affected populations

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

Medical team benefits

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

Timely response

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

Donor benefits

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

Operational research and development

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

NATIONAL EMERGENCY MEDICAL TEAMS – THE MOST APT RESPONDERS

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

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

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

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

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

**AUSMAT becomes the fifth quality-assured EMT**

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

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

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

**Ecuador: National teams lead earthquake response**

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

On 16 April, a 7.8-magnitude earthquake struck Ecuador and left a trail of destruction. According to Ecuador’s National Secretariat for Risk Management, 655 people died, another 4500 were injured and more than 30 000 displaced. Damage to infrastructure was extensive. More than 900 buildings were destroyed, including 25 health facilities.

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

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

**Chinese and Russian EMTs quality assured**

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

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

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

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

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

**European Medical Corps inaugurated**

On 15 February 2016, at a high-level ceremony in Brussels, Belgium, the European Medical Corps (EMC) was launched. This is the European Union (EU) framework for mobilizing medical and public health teams to respond to public health emergencies and crises with health consequences inside and outside the EU. With its inauguration, the EMC was added to the list of Member States seeking quality assurance from WHO’s EMT initiative.

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

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

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

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

Biggest emergency simulation ever held in Norway

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

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

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

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

Israeli Type 3 team gets verified

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

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

“This is a team that can deploy fast, and has massive capacity. They have 200 personnel and carry with them 100 metric tonnes of equipment,” said Dr Ian Norton, who heads the EMT Initiative.

Although the Israeli team already had a reputation for excellence, they said the verification process allowed them to reconsider some aspects of their work and make improvements.

Teams from the IDF Medical Corps and Home Front Command have provided rescue and medical services after a number of disasters, including the Haiti earthquake in 2010, typhoon Haiyan in the Philippines in 2013 and, most recently, the 2015 earthquake in Nepal.
A catastrophic earthquake in Haiti causes hundreds of thousands of injuries. The international response is unprecedented, but coordination between teams is poor. Lives that could have been saved are lost, and the global development community is awaken to the need for better-coordinated responses to emergencies.

WHO EMT INITIATIVE // NOV 2016

JANUARY 2010
A working group on FMTs meets for the first time and commits to the need for a registration process for teams and minimal quality assurance systems that would allow receiving countries to identify teams able to meet and adhere to those minimal standards and meet their needs.

DECEMBER 2010
WHO, the Pan American Health Organization (WHO Regional Office for the Americas) and partners convene a meeting in Cuba to discuss the Haiti response and determine the need to set standards and a coordination mechanism for Foreign Medical Teams (FMTs).

NOVEMBER 2013
WHO issues the first ever Classification and Minimum Standards for Emergency Medical Teams (then called Foreign Medical Teams) in sudden-onset disasters such as earthquakes and typhoons. These guidelines outline principles and set forth core standards for how registered Emergency Medical Teams must function; and declare their operational capabilities.

JULY 2014
As the Ebola outbreak in West Africa spreads exponentially, WHO mobilizes FMTs. Teams with no previous history of dealing with Ebola bravely step forward, but need guidance and assistance. WHO ultimately brings in a total of 58 teams, building treatment units with the help of the United Kingdom and the United States of America.

FEBRUARY 2014
With support from UK and Australia, a new unit at WHO dedicated to enhancing the impact of Emergency Medical Teams (still called FMTs at that time) is tasked with building a new system allowing teams to register and be classified; and to run regional training exercises. Another goal is closer collaboration with UN and other partner organizations.

MARCH 2015
Severe Tropical Cyclone Pam causes one of the worst national disasters in the history of Vanuatu, a southern Pacific archipelago nation with a quarter-of-a-million people spread over more than 80 islands. With coordination from the Ministry of Health, supported by WHO, 28 teams including 169 medical staff are deployed.

DECEMBER 2015
At a global meeting in Panama, participants reach key agreements on the strategic governance and direction of the EMT Initiative. They abandon the previously used term “Foreign Medical Teams” and adopt the term “Emergency Medical Team” to reflect an emphasis on building national teams and establishing ties between teams in neighbouring countries.

APRIL 2016
As a response to the lessons learnt from Ebola and an outcome of WHO Reform the EMT unit is markedly expanded as part of a new emergencies section of the Organization. Trainings, capacity building and working groups become more active, and the mentorship and peer review verification process expands.

JUNE 2016
A magnitude 7.8 earthquake strikes Nepal. WHO and partners respond rapidly, collaborating with WHO, the Nepalese Ministry of Health coordinates and registers 149 medical teams. Despite the scale of the disaster, care for the injured and restored access to health services are well coordinated between local and international responders.

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FEBRUARY 2015
The first Global meeting of FMTs is hosted in Geneva, mainly focusing on the ongoing Ebola outbreak; and also addressing next steps for the WHO initiative and its national and regional approaches.

JULY 2015
WHO launches the FMT Classification List which sets minimum standards and allows teams to clearly outline their services and skills, and on an online system where they can register. More than 70 organizations or teams apply in the first year to be supported and mentored and subsequently demonstrate their quality and be verified.

APRIL 2016
Super-typhoon Haiyan ravages the central part of the Philippines archipelago. WHO activates an organization-wide mobilization to work closely with the government. The WHO standards are used successfully for the first time. The Department of Health Philippines coordinates the deployment of 151 medical teams and finds the new classification system fit for this purpose.

FEBRUARY 2016
Severe Tropical Cyclone Winston, a powerful cyclone, ravages Fiji. At least 88 of the 214 health facilities throughout Fiji are damaged. Collaborating with WHO’s EMT Initiative and the Ministry of Health, Australia’s National Critical Care and Trauma Response Centre deploys the day after landfall, bringing in emergency physicians and surgeons among others, to support national EMTs.
Nepal Earthquake: reaching new heights in coordination

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

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

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

Government takes the lead

WHO had previously supported the Ministry of Health and Population (MoHP) of Nepal to create an earthquake resistant Health Emergency Operations Centre (H-EOC). This sprang into action after the earthquake and began deploying national EMTs and coordinating trauma care.

WHO set up and ran an EMT - Coordination Cell to provide support within the H-EOC for the first time in its history.

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

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

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

Crucial aspects of team verification

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

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

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

The standards for qualifying EMTs were developed through a highly consultative process among global health partners, said Saaristo. “We are very pleased with the product that came out of this process, and have adopted its standards. It has even allowed us to fill in some gaps, such as for surgical teams.”

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

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

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

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

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

“We were unable to bring all the equipment from our hospital for wound dressing and sutures. But the new mobile hospital was well equipped. The Norwegian Red Cross deployed a large team to Chautara, including doctors, nurses and logisticians. But Ranveig Tveitnes, deputy team leader of the mobile hospital, said the critical ingredient was the teaming up with the area’s local health staff.

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

Teamwork helps meet challenges

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

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

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

Nepal earthquake EMT response times

[Graph showing response times with labels for military, civilian, and NGO]
The event that changed the meaning of public health emergencies

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

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

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

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

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

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

Even before Ebola hit, these countries had only a few doctors per each 100,000 of population, and these doctors were heavily concentrated in urban areas. As the outbreak progressed, the Ebola virus would relentlessly whittle that meagre number down even further, sometimes picking off medical staff one by one, sometimes killing them in groups as several became simultaneously infected in clinical settings lacking proper infection control. “We have a limited capacity and our health workers are not well prepared” Dr Brima Kargbo, Sierra Leone Chief Medical Officer, said at the time.

WHO takes the lead

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

Director General of WHO Dr Chan clearly stated that WHO, acting alone, could not respond to an outbreak of this complexity, which demanded a greatly intensified response. The needs in Guinea were estimated at an additional 482 national staff and 77 international staff; in Liberia at an additional 579 national staff and 95 international staff; in Sierra Leone, an additional 645 national staff and 98 international staff.

EMT Initiative deploys

At this point the outbreak was experiencing its second major wave of transmission. A third wave of even more intense transmission was expected to emerge soon. In July, Dr Ian Norton, who heads WHO’s Emergency Medical Team (EMT) initiative was deployed to West Africa to help find and coordinate Emergency Medical Teams (then identified by WHO as Foreign Medical Teams) to treat people with Ebola virus disease. He was in for a shock.
There was a number of serious practical matters to address. For one, organizations apart from MSF had no experience in care for patients sick with Ebola. Yet they were supposed to be self-sufficient (staff, supplies, space and systems). ‘We had to fill all those gaps,’ Norton said. “The first was the space; they didn’t know how to build Ebola treatment units. So we built treatment units for them, and then got help from the United Kingdom and the United States of America to build more. The second was training. They had staff, but none of these staff were trained. So we put in place a training module.”

This training included:

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

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

“We had to do a lot of coaching, advocacy through governments and the very largest donors in the world who in turn advocated with government teams and NGOs, but eventually 59 Foreign Medical Teams deployed. This was an incredible response,” Norton said.

A quality assurance for future emergencies

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

With WHO’s recently developed approach to verifying and quality-assuring teams, countries can look forward to a time when teams specially equipped to handle such diseases as SARS, cholera or dengue, will be ready to step forward. WHO will coordinate the quality assured list, which means that the government affected can draw from effectively an à-la-carte menu of all the world’s teams. There are some that are good at trauma disaster response, some that are.

WHO will coordinate the quality assured list, which means that the government affected can draw from effectively an à-la-carte menu of all the world’s teams. There are some that are good at trauma disaster response, some that are good at public health and outbreak response, some have specialty skills. It also allows for the country and the population accepting the team, that they meet a minimum standard.

On the frontlines of Ebola

Paediatrician Dr Michael Mawanda was no stranger to Ebola when the disease struck in Sierra Leone in 2014. The Ugandan native had already cared for patients affected by Ebola during the outbreak in Caku, Uganda in 2010. When the first cases appeared in Sierra Leone in March, 2014, Mawanda was working in Freetown’s Hospital run by the NGO Emergency. He did not hesitate to volunteer. He joined his NGO’s task force on case management, worked closely with the WHO country office to help set up an isolation unit which he went on to manage, and treated patients sick with Ebola.

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

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

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

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

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

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

They should:

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

How teams reach the quality assurance designation

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

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

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

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

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

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

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

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

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

Type 2 Fixed
Same as Type 2 Mobile but work out of a fixed structure and provide up to 12 hours per day of care, 7 days a week.

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

Building capacity

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

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

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

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

3 options for EMT coordination during an emergency response:

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

Spotlight - Coordination Cell Training in Italy

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

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

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

Coordinating EMTs during outbreak and disaster responses

Trauma specialists play a critical role in the immediate aftermath of sudden-onset disasters. The EMT Initiative classifies surgical and trauma teams according their capacities and mobility before deploying them to responses – and then coordinates with the affected government to ensure the teams are placed where the need is greatest in hours not days.

In many cases, a longer-term response is needed, and teams with appropriate skills must be deployed. For example, EMTs capable of providing rehabilitation services are critical in many responses. Such support can help a person recover the use of a limb, or regain mobility through use of a prosthesis.

Response to a disaster or outbreak is always complicated, and requires careful coordination of different teams. EMTs include medical evacuation teams, logistics and other emergency services. The Ebola response was the largest deployment of EMTs for an outbreak. In total, 58 teams and more than 4000 staff members joined the effort and received training and support from WHO.
EMT Training

National EMT training

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

EMT Coordination Cell (EMT-CC) training

The EMT-CC is a relatively new concept, built on existing OCHA mechanisms to coordinate search and rescue and other types of rapid response teams that arrive within hours to a disaster zone. The WHO EMT secretariat has worked with OCHA to create a method to rapidly deploy EMTs using the virtual On-Site Operations Coordination Centre (virtual OSOCC) and the Reception and Departure Centre (RDC), and to set up an EMT-Coordination Cell within the Health Emergency Operations Centre and emergency management structure of an affected government. A handbook and specialist training have been developed. After a pilot in October 2015 in the Pacific, training sessions were held in Europe (Italy) and South Asia (India). Additional courses will be conducted in Africa, the Americas and Europe in 2017.

Global Health Emergency Workforce (GHEW) coordination training

Ministries of health and governments need skilled managers and an emergency management system to be able to recognize an emerging threat or mount a response to an emergency with health consequences. Their first reaction should be to deploy national response teams with clinical and public health expertise. They also need to understand what is available from neighbours who might offer help, and from regional and global networks that can provide teams such as EMTs and public health rapid response teams (governmental or NGO), staff and experts from WHO and the UN, laboratories, logistics support or experts from the Global Outbreak Alert and Response Network (GOARN).

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

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

Regional workforce training and capacity building

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

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

Training simulations

Regional earthquake exercises

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

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

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

Other regional exercises

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

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

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

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

Disaster strikes
Initial communications when an emergency occurs come in various forms. The Virtual On-Site Operations and Coordination Centre (VOSOCC) has been gaining ground as the platform of choice among emergency teams, including EMTs, to offer assistance together with the declaration of their capabilities to affected governments. In most cases, an affected government will put out a request, which EMTs can answer with offers of assistance.

Packing & Deployment
As soon as the offer of assistance is accepted, the EMT will assemble the team members and organise the transportation of packed equipment and supplies from its warehouse. The turnaround time between team assembly and supply transportation, and deployment should be 6 to 12 hours.

Move to location
As soon as they have received their location assignment, the EMT will move to the location and set up their field hospital or clinic.

Location assigned
Once teams are approved and have their medical license in country, they are assigned a specific location to conduct their work by the Ministry of Health EMT Coordination Cell (EMT CC). This is determined by matching the current needs in the emergency with the capabilities of teams using the Type 1,2,3 classification system.

Treatment of patients
While it may take up to 24 hours to set up a fully functioning field hospital, EMTs are expected to start treating patients as soon as they arrive in the field. Sometimes patients with more serious injuries are referred to another functioning health facility.

Arrival
Upon arrival there are several steps for the EMT to go through to ensure they are as effective as possible. Reception and Departure Centres have streamlined this process. EMTs are asked to go to the Ministry of Health’s EMT Coordination Cell (EMT CC) to complete registration and to familiarise their teams with the team coordination mechanisms in place. Teams classified by WHO will be processed faster than those unable to show their adherence to minimum quality standards.

Regular reporting and monitoring
Throughout the EMT’s time in the field, they are expected to submit daily reports on outpatient or inpatient numbers, cases seen, and referrals accepted or sent. Quality assurance visits can also be conducted by the Ministry of Health throughout the deployment. EMTs must be ready and available for these visits. EMTs are likewise expected to be represented during scheduled coordination meetings at the MoH EMT-CC.

Handing over
Towards the end of the EMT’s deployment, the health facility set-up can either be taken down or handed over to another organization or the Ministry of Health. In-kind donations of medications, equipment, and supplies can take place. Patients who need follow up are referred, as needed. EMTs are expected to submit a final report to the Ministry of Health before leaving.

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

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

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

TRUE OR FALSE?

1) Surgeons are the main health professionals needed for responses to emergencies with health consequences.

2) The Ebola response was the largest deployment ever of EMTs for an outbreak.

3) Any health professional with a strong desire to provide humanitarian assistance is encouraged to deploy on his or her own to a sudden-onset disaster or disease outbreak.

4) A growing number of countries have national EMTs that can provide most or even all care needed in an emergency.

5) WHO is encouraging all countries to create national emergency medical teams as part of their health system capacity building efforts.

6) EMTs are not generally meant to require logistic support or even food from the affected country.

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

**AUSTRALIA**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**JAPAN**

Q: Could you tell readers something about your organization?

JDR: Japan’s disaster relief activities date back to the late 1970s, when medical teams were dispatched to assist Cambodian refugees. In September 1987, the Japanese Disaster Relief Infectious Disease Response Team was established. There are more than 1000 medical professionals in the roster managed by the Secretariat of JDR, the Japan International Cooperation Agency.

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

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

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

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

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The WHO EMT Initiative: Looking ahead

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

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

An offer-based approach

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

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

Faster coordination of deployments

In past responses, arrival of teams for a sudden-onset disaster could take as long as 15 days. Things move faster now, and we know what it takes to achieve this. Countries need to be able to deploy their own national response teams as quickly as possible and, at the same time, to reinforce existing political ties when deployed to each other’s countries.

Growing the number of verified EMTs

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

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

National capacity building

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

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

New horizons

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

WHAT YOU CAN DO TO IMPROVE EMERGENCY MEDICAL RESPONSES

**Governments**
- Work with WHO to develop your national medical response team capacity and procedures for accepting international teams if necessary.
- Publicly declare that you will send and receive only medical teams that have reached the minimum standard of quality.
- Establish mutual agreements with countries in your region for deployment of classified EMTs in the event of a disaster or outbreak.

**EMTs**
- If you have not done so already, apply to classify your EMT at https://extranet.who.int/emt/user/register
- Encourage sister organizations to do the same.

**Donors**
- Support the WHO EMT Initiative.
- Ensure contributions for international emergency responses go to EMTs that are undergoing the verification process.

**Individuals**
- If you’re a health worker or have other critical skills, join a verified EMT and volunteer for local responses.
- Help raise funds. Lead a drive in your school, workplace or community to raise funds for a local or international EMT that meets WHO minimum standards.
- Be prepared. Learn about your community’s and country’s procedures for responding to an emergency.
The World Health Organization (WHO) divides the world into six regions for the purpose of reporting, analysis, and administration. This includes the regions of Europe/Middle East/Africa, Asia-Pacific, and the Americas. This aligns with the existing response regions of other rapid response modalities, for example search and rescue (INSARAG) teams and OCHA’s UN disaster assessment and coordination teams (UNDAC).

Mr. Jesper Lund, Chief of Field Coordination Support Section (FCSS), OCHA, states: "It’s impressive to see the geographic spread of member states and regional NGOs that have EMTs across the areas where disasters and emergencies are most frequent, this will speed up response."