Registration and coordination of Foreign Medical Teams responding to sudden onset disasters

The way forward

Foreign Medical Team Working Group

5 May 2013
I. Executive summary

Sudden onset disasters (SOD) are natural disasters that occur with little or no warning and can cause excessive injuries far surpassing the residual response capacity of the affected country. The demand for rapid trauma care is particularly critical in the aftermath of earthquakes. In recent disasters, a large number of Foreign Medical Teams (FMTs) arrived at the crisis location to provide emergency care to patients with trauma, injuries and other life-threatening conditions. In most cases, the deployment of these teams was not based on the needs of the situation and there was significant variation in capacities, competencies and professional ethics.

There are several factors at the root of this problem: the absence of agreed international standards and criteria for humanitarian surgical-trauma response; the lack of reliable information on existing bilateral or international response capabilities and their criteria for deployment; and a host country and Health Cluster not yet operational and/or unprepared to coordinate and ensure quality control of the external surgical-trauma response.

Against this background of concern is an even stronger desire to improve.

Several initiatives have already prepared the ground for change;

- Following the recommendations from a Technical Expert Group meeting in Cuba in December 2011, the Global Health Cluster (GHC) endorsed the need to address these issues and created a FMT Working Group (FMT-WG).
- The work of the International Search and rescue Advisory group (INSARAG) has ensured that the concepts of registration, classification and training are already understood by the international community, and INSARAG is welcoming collaboration with WHO on FMTs, connecting these to the existing operational structures: the On-Site Operational Coordination Centres (OSOCC) and Reception and Departure Centres (RDC).
- Operational aspects for managing the virtual OSOCC and deploying FMT experts to establish FMT Coordination Cells under the OSOCC/RDC will be integrated in the WHO surge mechanisms as per the Emergency Response Framework.
- In 2012, the Pan American Health Organisation (PAHO) passed resolution CSP28.R19 that recommends “a flexible mechanism for registration and accreditation of rapid-response foreign medical teams with the goal of improving the quality of the medical response in coordination with WHO”.
- The commitment to predictable service delivery and accountability is in line with WHO humanitarian reform and the Interagency Standing Committee (IASC) Transformative Agenda.

The FMT-WG has already developed a classification system for FMTs based on capabilities, and there is a first edition of professional standards. Furthermore, there is an outline for the process for on-site coordination and registration with national authorities, and mechanisms for authorising arriving teams. The way forward for this initiative will build on those foundations laid out by the FMT-WG. It will:

1. Promote wide ownership of and compliance with the classification system and standards for FMTs;
2. Develop and manage a global registry of potential providers of FMTs based on their capabilities and the agreed upon classification, including self-declared commitment to adhere to the standards;
3. Strengthen the capacity of potential host countries to request, register, and coordinate the FMTs in the aftermath of a Sudden Onset Disaster (SOD);
4. Enable WHO and international partners to provide technical and/or operational on-site support to coordinate and monitor the activities of FMTs in case of a SOD requiring significant external surgical-trauma assistance.

II. BACKGROUND AND OVERVIEW

II.1 Problem statement

FMTs are broadly defined by the GHC/FMT WG as ‘groups of health professionals and supporting staff outside their country of origin, aiming to provide health care specifically to disaster affected populations. They include governmental (both civilian and military) and non-governmental teams. A FMT has staff to provide basic and/or advanced healthcare based on international classification levels and minimum standards during a limited time period in existing or temporary structures, with or without field hospitals.’

For this proposal for the way forward the focus of FMTs is limited to surgical trauma teams, providing clinical care arriving within first 3-4 weeks after a Sudden Onset Disaster.

Sudden onset natural disasters causing mass casualties occur in both developed and developing countries. The numbers of wounded requiring immediate trauma and/or surgical attention can be staggering and occasionally exceed the response capacity of even larger affected countries. The table below summarizes the health impact of the most recent large disasters. The statistics are impressive but not always based on objective, systematic data collection.

<table>
<thead>
<tr>
<th>Country (Disaster Type and Year)</th>
<th>Population (in millions)</th>
<th>Number of people killed or missing</th>
<th>Number of people injured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indonesia (Tsunami 2004)</td>
<td>228</td>
<td>167 740</td>
<td>25 572</td>
</tr>
<tr>
<td>Sri Lanka (Tsunami 2004)</td>
<td>20</td>
<td>35 322</td>
<td>21 441</td>
</tr>
<tr>
<td>Pakistan (Earthquake 2005)</td>
<td>161</td>
<td>73 338</td>
<td>128 309</td>
</tr>
<tr>
<td>Haiti (Earthquake 2010)</td>
<td>10</td>
<td>From 65 275 to 300 000</td>
<td>&gt;300 000</td>
</tr>
<tr>
<td>Japan (Earthquake/tsunami 2011)</td>
<td>126</td>
<td>19 334</td>
<td>27 074</td>
</tr>
</tbody>
</table>

These figures reflect the scale of the challenge for national health services, which is compounded by the fact that the health facilities that provide life-saving services for trauma and injuries in the affected areas are often damaged or destroyed. Health professionals and their families may also be affected, further affecting the capacity to provide services.

The main type of SOD causing mass casualties is earthquakes. While most fatalities occur at the time of impact of an earthquake, early trauma and surgical care can save
lives, e.g. appropriate management of crush injury at scene during extraction, early amputation to avoid crush syndrome, basic resuscitation, etc. In addition, a large number of deaths occur days or weeks after the impact (up to one third of the total number of deaths in Haiti, according to a study from the University of Michigan). A significant proportion of those deaths could be prevented by improved trauma care. Data is not available on permanent sequels and handicaps that could have been prevented. There is evidence that surgical trauma teams are more cost effective in saving lives compared to Urban Search and Rescue teams.

Larger countries, with developed or emerging economies, have sufficient health resources, and sometimes the capacity, to respond and treat the injured. A case in point is the earthquake in Bam (2003, Iran) where approximately 13,000 casualties were evacuated to several health facilities across the country before the first external medical team could arrive on site. Major events in smaller or poorer countries, such as the earthquake in Haiti, completely overwhelmed the health facilities that were able to function after the earthquake. Although fortunately rare, this situation is likely to reoccur in large metropolitan disasters.

The international medical response to sudden onset disasters is increasingly generous. The magnitude of the response is often influenced by the emotional impact of the SOD on the public opinion of donor countries rather than by the data from an assessment of those needs that cannot be met locally. As an example, a large number of FMT arrived after the Indian Ocean tsunami, far above what was needed given the rapid mobilization of trauma teams from within the countries. In Haiti, hundreds of foreign medical teams are believed to have responded, most of them unregistered with the coordination mechanisms in place.

The quality of the incoming FMT and the standard of their services are also extremely variable. On one side there are well equipped facilities with fully trained staff that have been established by donor governments, the International Red Cross and Red Crescent system or specialized medical NGOs. On the other side, the response to these large scale disasters has revealed unacceptable practices in the delivery of international emergency medical assistance. Serious questions have been raised about the clinical competencies and practices of some of the FMTs deployed in recent years.

It is now recognized that there needs to be greater accountability, more stringent oversight and better coordination of the work of FMTs. In particular with regards to FMTs providing trauma and surgical care, as their clinical interventions have the highest potential for saving lives but also the highest risk of doing direct harm to the patients treated.

There are two main challenges. One is to ensure that organizations that intend to provide FMTs with surgical and trauma services are able to communicate the services and capacities they have to offer, and that they agree to commit to international standards of performance. These standards include a commitment to coordinate with and report to national health coordination mechanisms. Awareness raising campaigns in professional networks will contribute to discouraging potential providers of FMTs or medical individuals that are not adequately prepared or without experience in these contexts, will provide connections with professional organizations that do have a professional track record for such interventions. The second challenge is to manage and
coordinate the activities of the many FMTs arriving, solicited or not, on the site of the disaster. This would include ensuring adherence to minimum standards of quality by not providing authorization to those FMTs with no relevant competence or added value.

II.2 Background

At cross-sectorial level, in 2004 the humanitarian community launched an independent Humanitarian Response Review of the global humanitarian system. On the recommendation of the Review, the Inter Agency Standing Committee (IASC) set up the cluster approach. The clusters are seen as “a way of clarifying the division of labour among external organizations, and better defining their roles and responsibilities within the different sectors of the response”.1

As outlined in the 2011 IASC Guidance Note on Working with National Authorities, “wherever possible, clusters should support and/or complement existing national coordination mechanisms for response and preparedness”. In large disasters (e.g. the Pakistan and Haiti earthquakes2) both the national and international mechanisms failed to properly filter, monitor or coordinate the incoming assistance. In the health sector, this was especially problematic for responding agencies that were providing primarily surgical and trauma care. More recently, the IASC Transformative Agenda seeks to strengthen predictability and accountability in large scale disaster response.

In the health sector in 2003, WHO and PAHO developed the Guidelines on the use of Foreign Field Hospitals3, in consultation with experts from donor as well as disaster affected countries. The health response to the Indian Ocean tsunami in 2004 and the earthquake in Haiti (2010) suggested that those technical guidelines are mostly ignored at the time of the political decision to send FMTs. The scope of those guidelines (hospitals only) was also seen as too narrow and they do not address issues related to coordination, quality control and oversight.

Based on the recommendations from a global Technical Consultation on Foreign Medical Teams held in Havana, Cuba in December 20104, the Global Health Cluster (GHC) resolved to explore the creation of an international register of organizations offering or providing FMTs. The GHC established a FMT Working Group (FMT-WG) to guide and monitor the progress. A global register should allow faster deployment of FMTs, as crisis-affected countries will be able to rapidly identify and approve FMTs from the register. This should contribute to a better matching of supply and demand, and stronger interaction of FMTs with national authorities. The providers of FMTs that register would be able to communicate clearly what type of FMT they have to offer, which services it can provide and its capacity. Furthermore, by registering they would commit to engage with national coordination mechanisms, and adhere to predefined standards for performance.

1 http://oneresponse.info/COORDINATION/CLUSTERAPPROACH/Pages/Cluster%20Approach.aspx
2 PAHO/WHO 2011 Health Response to the Earthquake in Haiti, January 2010
3 http://www.who.int/hac/techguidance/pht/FieldHospitalsFolleto.pdf
4 This meeting was organized by WHO with the technical support from the Pan American Health Organization PAHO Proceedings: Key Points Summary 1. Introduction - PAHO/WHO
Before exploring the creation of such a global register, the FMT-WG first launched two technical initiatives that are required as foundation for a global registration:

a) The drafting of criteria for the classification of FMTs and minimal standards of service delivery for FMTs deployed to trauma producing, sudden onset natural disasters. Countries prone to sudden onset natural disasters, can also use the international standards to improve the effectiveness of the immediate response of national medical teams and field hospitals.

b) The development of guidelines for national authorities of the affected country to register, approve and monitor the arriving FMTs, including templates for reporting by those FMTs.

Both technical documents have been endorsed by the FMT-WG. Widening the consultation on and endorsement of the processes launched by the GHC through its FMT-WG is an ongoing process.

Noteworthy is the extensive consultation that has already taken place in Asia and Latin America through dialogue at conferences and meetings. The overall reception to the establishment of a register and the proposed capacity building of the coordination mechanisms at host country level (Ministry of Health and Health Cluster) are encouraging. It clearly suggests that the time has come to address globally and locally this longstanding issue of improving the quality and effectiveness of the external surgical-trauma assistance in the aftermath of large SODs.

There were many partners contributing to this initiative:

- The humanitarian organizations or Governments traditionally providing FMTs. Among them, are the donor countries providing civilian or military teams or hospitals, the International Red Cross and Red Crescent System, Médecins sans Frontières, and many others. It should be noted that countries providing FMTs increasingly include a large number of emerging economies (for instance from Asia or Latin America) that have developed a domestic medical response capacity and wish to express their solidarity internationally. Those countries can also be listed in the next category of donor countries.
- The donor countries in their capacity as funding institutions;
- The UN partners such as OCHA, of which the successful International Search and Rescue Advisory Group (INSARAG) initiative inspired this project. Other UN actors are involved through the IASC.
- Many other NGOs involved in the clinical care of trauma patients in development settings.
- Academic and professional associations (already partly represented by the World Association of Disaster and Emergency Medicine - WADEM)\(^1\)

Most of those partners are already represented in the GHC\(^2\) and/or in the FMT WG.

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\(^1\) WADEM was already member of the FMT WG since 2011, also of GHC since beginning

\(^2\) Countries with emerging economies are becoming major providers of humanitarian assistance, including FMTs, but are not represented in the IASC or GHC
meetings and even the formal discussion of the issue at the WHO Regional Committee in the Americas. This led to the adoption of a Resolution endorsing the principles by the Ministries of Health from the Region.\textsuperscript{1}

II.3 Project beneficiaries and benefits

The population injured by the SOD will be the main beneficiaries from any improvement in the quality and effectiveness of the trauma and surgical services in the first few weeks following the impact. The project has the potential to save lives, and reduce complications and disabilities for people with trauma and injuries after SODs. The project will also reduce the risk of harmful surgical practices.

Host countries’ health authorities will benefit from the guidelines and technical support and will increase their own capacity to coordinate a more effective trauma response. By seeking collaboration with potential providers of FMTs before the disaster occurs, countries prone to disasters will be able to seek support to increase their national capacity to respond with pre-hospital services and mass trauma care. In the future, the most timely and effective international medical response is likely to come from neighbouring countries within the region or sub-region rather than from the traditional but far-away donors. They will also have improved capacity and clear procedures to request and welcome FMTs.

Humanitarian operational partners providing quality FMTs and participating in the Global Register will find a better-managed, rapid and efficient authorization process and a mutually supportive working relationship with local health services.

Bilateral or multilateral agencies with on-going quality control of their own national responders will benefit from the umbrella of international standards and norms that were inspired from their own efforts to improve quality and the cost-effectiveness of their response.

For providers of FMTs that will engage in the global registration process, registration may give confidence to donors to fund registered FMTs. Furthermore, registration will facilitate the invitation to be deployed and authorization to operate on arrival in the disaster location. On arrival, the FMTs will be able to benefit from logistic support on-site and receive guidance on what the best place is to set up their units so they don’t lose time to start working on a designated site.

In Level 3 crises, as defined in the Transformative Agenda adopted by IASC Principals, the Global Health Cluster and its Cluster Lead Agency (WHO) will enhance its leadership, by a rapid field presence to assist the health authorities in the screening and coordination of FMTs, and increasing predictability and accountability of the response. The project will lead to closer collaboration between INSARAG, UNDAC and the health sector response, including surge mechanisms and the health cluster coordination. In the longer term, there are possible implications for quality improvement of FMTs in the broader sense of the FMT definition

\textsuperscript{1} CSP28.R19 (http://new.paho.org/hq/index.php?option=com_docman\&task=doc_download\&gid=18953\&Itemid=270\&lang=en)
III. Programme Goal and Objectives

III.1 Overall goal

The goal of the project is to reduce the mortality, injury complications and disabilities caused by SODs.

III.2 Project Purpose

The purpose of the project is to improve the effectiveness and quality of the surgical and clinical care of trauma provided by foreign teams in the early aftermath of a SOD causing a large number of wounded.

III.3 Specific project objectives/expected results

There are four specific objectives to this programme:

1. **To finalise and secure support from main stakeholders for the classification, standards, and criteria for deployment of Foreign Medical Teams (FMTs);**
   Under this objective, the programme will finalise the classification systems and standards for FMTs, through further consultations and a dissemination strategy, to promote wide ownership of the classification and standards for FMTs. The standards will be core rather than optimal. Increased awareness in professional networks will contribute to discouraging providers of FMTs or individuals that do not have the expertise to work in such contexts. To this end we will also work with national medical registration authorities.

2. **To develop and manage a global registry of potential providers of FMTs.**
   The registry will be based on the agreed classification system that specifies surgical-trauma services and capabilities. This registry is based initially on self-reported data on the capacity of the FMT that the agency may be able to provide. The registry is not directed only to traditional providers of FMTs but also to disaster-affected countries that are increasingly developing a capacity for surgical-trauma response - first domestically then internationally. The information in the registry should be accessible to partners including host countries, donors, and if circumstances permit, to the public. Database transparency is the best guarantee of minimum quality of the data supplied by the providers of FMTs. Entering a capacity in the register will clearly not imply a commitment from the agency to provide the services in any given SOD. Furthermore, providers of FMTs that register will commit to adhering to the standards, including the one referring to engaging in national coordination mechanisms.

3. **To strengthen the capacity of potential host countries and foster regional cooperation**
   Long term benefits will only be achieved through improved local preparedness. It is a two-fold objective:
• Building the capacity of national health authorities and other emergency coordination institutions to request, register on arrival, and coordinate the FMTs in the aftermath of a SOD. This will be achieved by including a FMT component in the national/international On Site Operations Coordination Centre (OSOCC) that are linked to the Reception and Departure Centres (RDC).

• Developing capacity at host country level for deploying national and/or local surgical-trauma teams for rapid response (first nationally and later regionally).

4. To provide on-site support to the host country for the coordination of incoming FMTs in the case of a SOD.

WHO and partners will provide technical and operational field support to the host country, the Health Cluster and OCHA to coordinate and monitor the activities of FMTs in the case of a SOD requiring external surgical-trauma assistance. Many affected countries will not be able or prepared to invest the necessary human resources in the immediate aftermath of a large scale SOD. The international community, through the Health Cluster and WHO, should be ready to provide concrete support and immediate expertise.

III.4 Cooperation with field partners

Close cooperation and buy-in by partners is critical to the effective implementation of the programme. There are many key decision-makers in the provision of medical assistance to a disaster-affected country.

To be successful, the programme will: ensure the broad endorsement of the proposed classification system and standards through consultations with relevant stakeholder groups; the participation of potential providers of FMTs in the global registration process; as well as cooperation with organisations involved in the on-site coordination of FMTs actually deployed and arriving in country to respond to a sudden onset disaster.

The Global Health Cluster

The project is the result of an initiative launched by the Global Health Cluster which is comprised of humanitarian agencies and donors. Its implementation will be closely monitored by this forum.

It will be proposed to the GHC to review the terms of reference and structure of the FMT Working Group in order to transform the FMT-WG into a leaner Steering Committee. The leading providers of FMTs, donor countries funding this project and representatives of potential host countries (particularly those vulnerable to trauma-producing SODs) will be represented. This Steering Committee will provide policy guidance to the project and periodically oversee its progress.

A Technical Advisory Group of experts individually selected based on their particular competence will also be established to assist the project on more technical or scientific matters such as the norms, criteria and questionnaires for the registry or templates for patients’ record/referral and reporting by FMTs. Most of the consultation will take place electronically.
The membership of the GHC will be kept up-to-date on the progress and pending issues through annual meetings or Core Group meetings. The programme will continue to actively involve the partners mentioned in section III.3 (p.7). A special effort will be made to seek collaboration from the scientific community and the mass media.

**Other UN Agencies and INSARAG**

A direct dialogue between WHO/HQ and OCHA will be established to ensure that the FMT registration and on-site coordination process be closely coordinated with OCHA, UNDAC and INSARAG initiatives, especially when a cross-sectorial On Site Operational Coordination Center (OSOCC) and Reception and Departures Centre (RDC) are established.

The health sector can benefit from the more than 20 years experience and functional mechanisms established by OCHA and the International Search and Rescue Advisory Group (INSARAG) network. They developed the On-Site Operations Coordination Centre (OSOCC) concept, initially to assist affected countries in coordinating international search-and-rescue efforts following an earthquake. However, OSOCC’s emergency management principles made it a valuable tool in any sudden-onset disaster involving international relief resources. Following a disaster, the OSOCC is established as soon as possible by the first arriving international urban search-and-rescue team or United Nations Disaster Assessment and Coordination (UNDAC) team deployed by OCHA. In many disasters there is a need to establish a Reception and Departure Centre (RDC) as a part of the OSOCC. The RDC are usually located at the arrival point of international relief teams and relief items to facilitate and coordinate their arrival and further deployment.

The RDC’s primary responsibility is to register teams, provide an information briefing, direct teams to the OSOCC, and pass processed information of incoming teams to the OSOCC in order to facilitate its operational planning. The OSOCC can have task specific coordination cells under it, such as an Urban Search and Rescue Coordination Cell (UCC). Similar to this, a FMT Coordination Cell (FMT-CC) can be established.

The FMT initiative has been in part inspired by the INSARAG registration and classification to improve the coordination and quality of Urban Search and Rescue (USAR). This cooperation and learning process will continue. However, it is recognized that surgical-trauma assistance presents different challenges but also different opportunities than USAR. The heavy regulation of medical practice, the complexity and variety of professional skills required, the increasing number of incoming teams and the inseparable link of trauma care with long term health care are only some of the factors influencing the adaptation of INSARAG approaches into the health sector.

**Donor countries**

Donor countries participating and/or funding this project will be represented in the Steering Committee. Cooperation with other countries, foundations and other institutions funding the deployment of FMTs will be done directly and through the forum of the IASC. It is foreseen that the IASC will brief the Ministries of Foreign affairs, which make the bilateral decisions on deployment, through the Economic and Social Council and the United Nations General Assembly, when appropriate.
Providers of FMT:
Main providers of large FMTs, donor countries and professional associations will be invited to provide human resources for on-site coordination of the incoming teams at the port of entry as soon as possible after the impact of a SOD.

Ministries of Health of WHO Member States
As early as 1991 and 1993, UN Resolution 46/182 and in 48/57 recognized that “the affected State has the primary role in the institution, organization, coordination and implementation of humanitarian assistance within its territory”. The responsibility of requesting, authorizing and monitoring foreign medical assistance lies with the National Health Authorities (usually the Ministry of Health), but also with the National Emergency Management Authority (NEMA) or Ministries of Foreign Affairs. The affected countries are increasingly attempting to coordinate and assume their responsibilities, a task made more difficult by the rapidly increasing number of foreign field hospitals or medical teams, but also by the political and diplomatic implications of offering, accepting or rejecting medical assistance.

The support of the Ministries of Health to this initiative will determine its effectiveness as a local management and coordination tool. This support will be obtained through briefing of authorities, a strong component of capacity building (preparedness) and by the formal endorsement of the process by all Member States (donor or recipient) in the governing bodies of WHO (Regional Committees, Executive Committee and World Health Assembly). This programme will be integrated in the wider Health Emergency Risk Management (HERM) framework that is currently being developed by WHO and its partners.

Local humanitarian partners
Cooperation of local humanitarian partners will be channelled through the country health cluster when activated. The health cluster locally and its partners may support the health authorities with human resources for the local coordination of incoming FMTs at the port of entry, the analysis of data and their use.

III.5 Organisational support and institutional integration of the FMT agenda

This FMT initiative is well supported by a number of institutional changes, both within WHO as within the wider humanitarian community. Developing global standards in emergencies already fits well within WHO’s normative mandate. On the initiative of WHO as Global Health Cluster Lead Agency, health partners approved establishing the FMT-WG that reports to the GHC governing structure, the Core Group. This also fits with the WHO and GHC mandate to convene partners around health topics that require further guidance.

Of importance to the way forwards for this FMT proposal is the fact that it is consistent with the WHO reform and the IASC Transformative Agenda. Both strive for more timely, effective and predictable responses. One of the pillars of the new WHO Emergency Response Framework, and a priority under the workplan of the Global health cluster, is to manage surge mechanisms together with partners. The operational aspects of managing the virtual OSOCC and deploying FMT experts to establish FMT Coordination Cells under the OSOCC/RDC will be integrated in the WHO surge mechanisms as per the
Emergency Response Framework. WHO and the GHC acknowledge that the need for this improved coordination on FMTs would need to be maintained beyond the initial three years of this proposal, similar to the experiences of the coordination of Search and Rescue teams. WHO plans to integrate this work in its broader coordination and surge functions.

For SODs, the deployment of FMTs and their on-site coordination is in fact the initial step for establishing broader health sector coordination by the national coordination mechanisms, supported by the cluster approach as indicated. For example, FMTs will need to become part of the mapping of health partners through the Who does What Where and When, that is a core deliverable for coordination to ensure complementarity of activities and to avoid overlap.

The management and coordination of FMTs, requires also close connection with UNDAC and INSARAG. While WHO has been a member of the INSARAG Medical Working Group since 2010, the operational aspects had not yet received much attention. Since the FMT-WG meeting in November 2012, WHO has already established initial collaboration with OCHA/INSARAG/UNDAC around this work. At their Advisory Group meeting in January 2013, this closer collaboration was very much welcomed by INSARAG.

Connections will also be sought with the Health Emergency Risk Management framework and national Disaster Risk Management functions, including the safe hospital approach and building national capacity for trauma and other surgical care after a SOD.

Last but not least, in 2012 PAHO passed resolution CSP28.R19 that requests the regional Director to “establish a flexible mechanism for registration and accreditation of rapid-response foreign medical teams with the goal of improving the quality of the medical response in coordination with WHO, and to support Member States with training to develop the capacity of national teams to assist neighbouring and other countries in the event of a disaster.”

III.6 Longer term vision in broader quality assurance processes

A first priority for this proposal is to establish the registration processes, both at global level as well as in the country where FMTs will arrive. With regards to the global registration, the classification will be based on self-declared capacities, range of services and adherence to the standards. The authority to screen arriving teams and approve or reject their entry lies with the national health and/or disaster management authorities. The current papers on the national registration process and on classification and standards will provide them with an objective references to do so.

Depending on future support, at a later phase we can explore other quality assurance mechanisms, as for example the peer reviewed external classification done by INSARAG. Another example that may be explored more systematically is that several governments are planning to register their national medical teams that have intentions to deploy in large scale crises, including prequalification approaches for those that may want to benefit from rapid funding mechanisms for SODs.
Another longer term opportunity that may be created by this proposal is to explore the expansion of the scope for the registration and quality assurance processes to include the broader range of health services beyond surgery and trauma care. The mandate to pursue such expansion would be with WHO and/or the Global Health Cluster.

III.7 Expected results and activities

Expected result #1: Classification, standards, and criteria for deployment of Foreign Medical Teams agreed and supported by key stakeholder groups

Activity 1.1. Finalization of the classification (types of FMTs based on the capacities – primary, secondary or tertiary trauma care), and definitions of corresponding terms. Once finalized, this simple classification will determine the structure of the global register and its detailed questionnaire. The classification should be simple to understand but broad enough to include all types of FMTs, from the small medical team to the most sophisticated ship hospital or single purpose unit (renal dialysis unit for instance). It should remain a stable cornerstone for the entire programme.

Activity 1.2. Finalization of the provisional standards (core and optional) including ethical (accountability, informed consent, second opinion, etc.), professional (license for type of procedure, experience, etc.), technical (nursing support, anaesthesia, rehabilitation, etc.) or managerial (logistics, self-sustainability, record keeping, etc.). Those standards have been endorsed by the FMT-WG of the GHC. They will be reviewed internally by WHO prior to the start date of the project. Time frame: three to six months.

Activity 1.3. Mid-term review of the standards through broad consultation and a global meeting with members of the Steering Committee, the experts of the technical advisory and others, as required to ensure broad geographical coverage. Should a major SOD occur, a real time evaluation may serve as a case study to determine the validity, relevance and practicality of the existing standards. Time frame: end of second year.

Activity 1.4. Further consultations and broad dissemination of the classification system and standards both before and after the midterm review through:

- A limited number of consultations in strategic locations around the world with selected stakeholder groups such as through ALNAP, the Breakout Group in Madrid, the initiative for Enhancing Learning and Research for Humanitarian Assistance (ELRHA),¹ among others.
- Posting in WHO dedicated website or page and linkage with Reliefweb, OCHA online and other humanitarian websites
- Publications in scientific journals, preferably those electronic reviews accessible at no cost (shareware)
- Preparation of standard PowerPoint presentations for inclusion in WHO and other partners meetings or training courses
- Selective participation, when cost effective, in regional or global meetings and conferences

¹ http://www.cerahgeneve.ch/conferences/colloques/Finalreport.pdf
• Others as appropriate

Activity 1.5. Securing political support in the health sector. The health authorities of WHO Member States supporting this initiative will be encouraged to request the inclusion of the topic in the agenda of the meetings of WHO Regional committees and World Health Assembly (May 2014). The formal endorsement of those bodies will provide WHO with the legitimacy and mandate for pursuing this initiative further. This activity includes, as required, the preparation of background documents for WHO Governing Bodies (WHO HQ).

Time frame: first two years.

Activity 1.6. Securing political support outside the health sector. The health sector often has a limited authority in terms of requesting or approving medical assistance. The Ministries of Foreign Affairs, National Disaster Management Agencies, and Civil Protection play a major role in both receiving and donor countries. Reporting to and briefing of the IASC will be pursued to create awareness of the process and stimulate support in donor countries and UN Member States. It is anticipated that the IASC will be in a position to brief and present the health case at the meetings of ECOSOC and in the Annual Report to the UNGA. See also activity 3.7. timeframe: within the first two years.

Expected result # 2: Global registry of potential providers of FMTs established

Activity 2.1. Establishing a small secretariat at WHO to manage the global register, including organizing meetings of the SC and TAGs

Activity 2.2. Formulation and testing of an electronic questionnaire (form) for self-registration by organizations potentially providing FMTs. This form will be based on the classification developed under Activity 1.1. Specific questions will be asked to gauge the commitment of the provider to abide with norms and standards developed under Activity 1.1. The activity should be completed within nine months of the start of the project.

Activity 2.3. Development of the data validation process. Although the register is based on data provided by the potential provider, a simple minimal validation system (requirement of official references or sponsors, review of unknown providers or other mechanism) will be developed to screen out questionable claims by unknown entities. As was the case with INSARAG, the self-classification could be complemented by peer review or other certification process whereby an external review validates all claims of the applicant. This step will be contemplated in a follow-up project.

Activity 2.4. Design and beta-testing of the global register website. This activity can progress in parallel to the development of final questionnaire / form. Timeframe: six to twelve months.

Activity 2.5. Maintenance of the global register (timeframe: second and following years) including requesting periodic updates and data confirmation from the registered agencies.
Expected result #3: Capacities of National Health Authorities and Disaster Management Authorities strengthened to coordinate arriving FMTs through their integration in OSOCC and to deploy their own medical response

Prepared the countries to coordinate the arriving FMTs is only one aspect of the international cooperation towards overall sectoral preparedness. Bilateral and regional mutual assistance agreements and protocols will be another essential component.

The coordination of arriving FMTs implies an institutional and sectoral presence at the point of entry as in the coordination of Search and Rescue teams within the OSOCC/RDC approach.

One of the technical challenges that requires further work is the determination of the numbers of the different types of FMTs that may be required. This will need to be based on the available historic evidence of injury patterns and case load from past SODs, the capacity of the national mass casualty management and the first judgments on how this is affected by the SOD. Given that such estimates need to be made within 24-48 hours, as this is required to send out requests for FMTs, in a period that information on the disaster impact is often far for complete, this will be a best possible estimate, that will need to err on the side of caution, and a ‘no regrets’ approach. The requests will be adapted as better real time information becomes available.

Criteria will need to be formulated to assist the national health and/or emergency management authorities in selecting FMTs from the global register in situations where the offer from FMTs is higher than the demand. This could include for example proximity to affected country, time required to arrive and be operational, language, etc.

The specialized role of an on-site FMT Coordination Cell in the cross sectoral OSOCC/RDC is as follows:  
- Assist the national health and/or emergency management authorities in issuing statements on the disaster impact with regards to numbers of injured, and translating this into requests for numbers of different types of FMT needed.
- Collecting or, in the case of providing institutions already registered globally, updating data for the classification of the actual type, capacity and services of the incoming FMT;
- Screening incoming FMTs based on approved global professional standards leading to their eventual on site authorization by the National Health Authorities/NEMA.
- National registration of authorized FMTs, based on the global classification and registration formats, including signed MoU by the FMT leader that the team adheres to the global standards.
- Ensuring that the FMTs are professionally accountable to the health authorities and comply with existing or forthcoming health care guidelines and reporting requirements;
- Providing background information on the context, ethical and technical norms and standards regarding surgical-trauma care (including medical evacuation,

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1 The functions of a cross sectorial OSOCC can be found in OCHA OSOCC guidelines 2009, see also the FMT WG paper on registering and monitoring FMT arriving in the aftermath of SOD
salary scales for local personnel, etc.) in the country, and other information management products such as maps, contact details, etc.

- Assigning a place of operations and local reporting/liaison contact.
- Providing forms for periodic reporting and on-departure debriefing as well for referral of patients to national facilities;
- Mapping of ‘who does what, where, and when’.
- Briefing on the location, needs, priorities, operations, role and focal point of the Health Cluster, etc.
- Informing NEMA and other national or international authorities, to ensure embedding in the broader health sector emergency coordination (including the health cluster if there was a need for its activation).

Establishing a functional FMT Coordination Cell linked to an OSOCC/RDC at the point of entry requires the investment of health manpower that smaller countries affected by a large magnitude SOD may not be able to spare. Operational international support (through the Health Cluster) will remain necessary as was the case in Haiti. Nevertheless, authorities of those countries should be made aware in advance of the problem they will face and be ready to provide political support, leadership and oversight of the OSOCC process. Only the national health authorities can give legitimacy to an international authorization and coordination process. The global registry will facilitate bilateral contacts and agreements including for preparedness and training (as in the case of Search and Rescue) between most advanced providers and the Ministries of Health.

Other larger countries or emerging economies with sufficient human resources should be sensitized and adequately prepared as the time-sensitive process of coordinating external medical teams can hardly be improvised after the impact. Those countries that may be both the recipient and the source of FMTs should also serve as providers of coordinating personnel and expertise in the case of a large SOD in a neighbouring country. Again by listing themselves in the global registry those countries will be encouraged to upgrade their own capacity and enter into South-South cooperation agreements before a SOD. The regional organizations and offices will play a key role in this regard.

Activity 3.1. Formulation of practical guidelines for the process of registering, authorizing and coordinating FMTs on-site (FMT Coordination Cell linked to OSOCC/RDC) at the point of entry in the affected country (timeframe: 0-6 months). A special provision for expeditious processing will be considered for FMTs included in the global register.

Activity 3.2. Development and dissemination of standard training material (timeframe: end of first year). The development of material would be best delegated to a regional office, for instance PAHO, while the dissemination is an activity for all regional offices.

Activity 3.3. Selection of up to six pilot countries in several WHO regions for intensive capacity building in preparedness (timeframe: 2nd and 3rd year). The selection will be based on the vulnerability of countries, their capacity and commitment to provide necessary human resources and finally the commitment and capacity of the WHO regional offices to provide direct technical cooperation.
to this activity. The prior existence of a disaster preparedness office program in the Ministry of Health will be a prerequisite. FMT coordination is one of the many challenges and responsibilities of the sector and should be part of the overall national preparedness process. Preferably pilot countries should already be benefiting from the presence of WHO technical experts in disaster preparedness which will reduce staff requirements of the project. This includes designation of a FMT focal point in each Ministry of Health of the selected priority countries;

Activity 3.4. Dedicated training workshops and simulations in the selected pilot countries. The main topic will be the set-up of a functional FMT Coordination Cell linked to OSOCC/RDC, and linking FMTs with national capacity for trauma response. (timeframe: on-going). At least one national training workshop with 25 participants in each of the 6 pilot countries, one simulation in the second year of the first three pilot countries, and three regional intercountry sectoral meeting (or one full day session in a broader event) will be organized.

Activity 3.5. Inclusion of the concept of FMT coordination and OSOCC/RDC principles in on-going preparedness courses, workshops and other events from WHO regional offices and, subject to approval, in training or awareness activities of other key partners such as IFRC, OCHA, main medical NGOs, etc. (timeframe in all countries: on-going).

Activity 3.6. Liaison with and sensitization of non-health national institutions (Ministry of Foreign Affairs, National/Local Emergency Management Authorities (NEMA/LEMA), Red Cross Society, etc.) and regional disaster management organizations through visits, contribution to their meetings or training workshops, invitation to project activities or jointly sponsored events. For training workshops and simulations, we will also seek additional opportunities for Member States and providers of FMTs to participate in relevant events organised by INSARAG and UNDAC.

**Expected result #4:** Technical and operational support for the coordination of incoming FMTs, to ensure integration in OSOCC/RDC and subsequent sectoral disaster health coordination mechanisms, supported by the health cluster as indicated.

As shown by the experience gained from the 25-year post disaster implementation of the Supply Management System (SUMA/LSS), many countries affected by a large SOD are not able to assign qualified health personnel (pharmacists in the case of SUMA) to the task of sorting out incoming medical supplies at the airport or other point of entry. The same may be expected for the reception of foreign medical personnel. External support (usually from the region in the case of SUMA) will be required from the international community. This deployment should be mobilized and coordinated by WHO on behalf of the Ministry of Health and the Health Cluster.

The sources for support include:
- WHO staff and consultants
- Pre-arranged loan of experts by a donor country
- Assignment of personnel to this function by first-arriving pre-registered FMTs (on the model of INSARAG)
- Other countries from the region
• Professional associations, such as WADEM

Activity 4.1. Developing a network of and MoUs with countries and institutions willing to dispatch trauma care experts to the disaster affected country to assist in the coordination of arriving FMTs. This network could follow the model of INSARAG whereby people in the first-arriving FMT would be assigned to this function. This approach may be more practical than relying only on the development of a roster of individual experts. (WHO/HQ and relevant regional offices – timeframe: on-going).

Activity 4.2. Training of experts from those institutions/countries including participation in OCHA-organized OSOCC/RDC and UNDAC workshops (timeframe: the second and following years).

Activity 4.3. Formal agreement with main providers of FMTs, who are in the global register, to detail one or more staff upon arrival in the affected country (WHO/HQ – first year).

Activity 4.4. In the case of a qualifying SOD\(^1\), there will be an immediate deployment of health personnel with, when required, support staff (e.g. IT, logistics) who will support the national health authorities to establish a FMT Coordination Cell to manage arriving FMTs. This team will work closely with the general OSOCC/RDC, if and when activated, and ensure their integration in the health sector coordination mechanisms supported by the health cluster. (WHO regional offices with HQ support); This activity will present a greater challenge in the first year of the project.

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\(^1\) All SOD classified as Level 3 according to the Transformative Agenda of the IASC will qualify. Ad hoc decision will be taken in other cases.