World Health Organization
REGIONAL OFFICE FOR Africa

Technical note for WHO African Region Member States on building operational national emergency medical teams in Africa

Participants at the EMT retreat in Brazzaville, Republic of the Congo (courtesy: Tabi Marriane)

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Contents

Abbreviations

EMT	**emergency medical team**
ICU	**intensive care unit**
I-EMT	**international emergency medical team**
IFRC	**International Federation of Red Cross and Red Crescent Societies**
IPC	**infection prevention and control**
MoH	**ministry of health**
N-EMT	**national emergency medical team**
OSL	**operations support and logistics**
PAHO	**Pan American Health Organization**
PHC	**primary health care**
PHE	**public health emergencies**
PPE	**personal protective equipment**
RCCE	**risk communication and community engagement**
SOPs	**standard operating procedures**
ToRs	**terms of reference**
WCO	**WHO country office**
WHO	**World Health Organization**

Introduction

Emergency medical teams (EMTs) are groups of health professionals such as doctors, nurses, paramedics etc. from the government, nongovernmental organizations, the military and international organizations that provide direct care to populations affected by public health emergencies (PHEs) such as evens with mass casualties, natural disasters, disease outbreaks and emergencies, and humanitarian situations *(1)*. EMTs comply with the classification and minimum standards set by the World Health Organization (WHO) and its partners and should be trained and self-sufficient so as not to burden the national system *(1)*. The EMT initiative works to strengthen national (and in the process regional) surge capacities and facilitate the deployment of nationally and internationally classified teams of health care professionals to countries and territories during emergencies to provide immediate assistance when national health systems are overwhelmed *(2)*, especially in disease outbreaks and natural disasters. The initiative aims to support the provision of quality clinical care services to populations affected by PHEs. EMTs should be provided with resources, including finances and equipment, allowing them to professionally undertake the requested task.

The EMT initiative came into being in 2015 following the recognition of its need from the lessons learnt during the health response to the 2010 earthquake in Haiti *(3)* and from the experts' meeting to review foreign field hospitals in the aftermath of sudden-impact disasters convened by the Pan American Health Organization (PAHO) that same year *(4)*. From the lessons learnt in Haiti, the coordination and responses of the medical teams were seen to lack standardized care *(3)* and concerns were raised on their lack of accountability, standardization and coordination *(5)*. This laid the groundwork for developing the principles, criteria and standards for foreign medical teams and propelled the publication of the classification of and minimum standards for foreign medical teams in sudden-onset disasters *(6,7)*, which led to the establishment of the EMT initiative. The EMT initiative focuses on ensuring timeliness and quality service provision in emergencies while building capacity and strengthening health systems by coordinating the deployment of qualified medical teams *(8)*. The first use of this classification system was during Typhoon Haiyan in the Philippines in 2013 *(9)*.

Background to the EMT initiative in the African Region

The EMT initiative in Africa was launched in December 2017 to reinforce the emergency response operation capacities of Member States and partners. Between 2018 and 2021, most of the Member States were informed of the initiative's nature, strategies, tools and approach. The first EMT introductory workshop in December 2017 comprised 10

Member States and four operational partners.[1] A regional training for national EMTs (N-EMTs) for 15 West African Member States was conducted in June 2018 and individual EMT awareness workshops thereafter in 11 Member States. Moreover, a regional training centre for EMTs is currently under development in Addis Ababa and will be operational in June 2022.

In the face of the increasing potential for health emergencies in different regions, such as those from virus-related outbreaks, human-generated environmental accidents, natural catastrophes and events with mass casualties, developing emergency preparedness and response systems and the associated EMT structures is imperative for African countries. The WHO Regional Office for Africa seeks to support its Member States in developing N-EMTs. The lessons learnt from the deployment of international EMTs (I-EMTs) in the Democratic Republic of the Congo and Mozambique for Ebola and other PHEs such as cholera and cyclones and the deployment of 22 I-EMTs in the Region for the COVID-19 response all provided the impetus for the development of the EMT initiative. Delays in the deployment of I-EMTs to countries, logistical challenges within the Region, or the countries' specific contexts and cultural complexities all highlighted the need for the countries to establish their own N-EMTs to help bypass some of these challenges.

This technical brief seeks to outline the process for developing and implementing N-EMTs for Member States in the Region focusing on the Region's three major types of emergencies: disease outbreaks, humanitarian crises and natural disasters. Given the heterogeneric nature of the Member States in terms of sociodemographic, physical and environmental situations, the proposed N-EMT initiative will seek to tailor the response to the health emergencies to their unique needs. Additionally, it will incorporate the flexibility that the process should have right from awareness creation up to intervention implementation, as there will be no fixed pathway. In particular, the initiative will strengthen EMT financing, leadership appointments, human resource management, logistics and information management, plus the demobilization of the teams after an emergency. This technical note provides guidance to Member States and relevant regional organizations for setting up or enhancing N-EMT capacity.

[1] West Africa: Senegal, Burkina Faso, Côte d'Ivoire, Nigeria; Central Africa: Cameroon, the Democratic Republic of the Congo; East Africa: Kenya, Rwanda; Southern Africa: Madagascar, South Africa and operational partners: International Federation of Red Cross and Red Crescent Societies (IFRC), Save the Children, Magen David Adom in Israel (MDA) and Alliance for International Medical Action.

Methodology

This document is a culmination of a series of activities that have taken place since the initiation of the EMT initiative in the WHO African Region, that is awareness creation, training, deployment of I-EMTs and gathering of the experience from the response to all major PHEs that have affected the Region over the past 5 years, including the COVID-19 pandemic. It was developed in two steps: a literature review and generation of expert consensus on the process and components of a N-EMT.


@courtesy of WHO AFRO

Review of literature and processes

A review was conducted of all the presentations on EMTs and related resources on the EMT initiative such as articles, reports, guidelines, forms available on the WHO website and presentations in the aforementioned meetings. The articles and presentations published between 2018 and 2022 also were considered as were full-text publications and presentations published in English, French and Portuguese. This review ensured that the data elements considered for inclusion in the analysis were comprehensive and were not just the currently or commonly used elements *(10)*.

Classification of the data elements using expert consensus

A group of experts comprising those who had worked on EMT deployment and other initiatives such as EMT research, management and classification at the Regional Office reviewed the current evidence, steps and processes for establishing an N-EMT during an EMT retreat held in Brazzaville, 23–29 February 2022. Based on both their experience and the desk review, 10 key steps were identified for an N-EMT establishment. Corresponding activities for each of the steps also were identified, discussed and agreed upon, notwithstanding the need for a country and case-specific approach.

Proposed actions for Member States

Ten tasks were considered essential in setting up or enhancing N-EMT capacity. They consist of various activities and timelines, including for defining the human resources composition and training needs, knowledge management, logistics and N-EMT demobilization. Although activities may be undertaken within the proposed timelines, these may vary per country based on the context, type of emergency and the governance system in place to prepare and respond to a PHE. The 10 steps are proposed to the Member States to guide their N-EMT set-up and they are presented in the following section. But given Member States' heterogeneity, the countries are encouraged to adapt this guidance based on their institutional settings, implementation priorities and priority level of their emergencies.

Task 1: Create a human resources team of the right composition

The need for and the nature and range of EMT deployment are defined in accordance with the nature of a crisis. In this sense, the identification and appointment of an EMT core team at the national level is an important step. Notwithstanding the differences among the countries and the types of emergencies, the N-EMT core team is proposed to be composed of five high-level experts from the ministry of health (MoH) and the WHO Country Office (WCO). For WCO, there is a need to hire two dedicated experts, one as the EMT technical liaison officer and the other one as the operations support and logistics officer. The MoH will need to have a minimum of three designated high-level officials who, for sustainability and continuity reasons, will be dedicated to the initiative and who will each have one of these roles:

- the EMT lead will be responsible for general oversight and guidance
- the technical/medical lead will be responsible for providing the necessary technical guidance
- the administrative lead with expertise in operational support will provide the necessary human resource, administration and logistics support.

Once established, this core team will oversee the establishment of the N-EMT and the implementation of its activities. This will include identifying its hosting structure, working in close concertation with the MoH and according to the national capacities and the health services' architecture and legal status. The core team will also identify potential members of the N-EMT, generally comprising the following profiles:

- team leads (medical doctors with administrative experience)
- emergency doctors, trauma doctors, infectious diseases doctors, critical care doctors or anaesthetists and general physicians
- nurses with different types of experience, e.g. ICU nurses, trauma nurses and general nurses
- pharmacists
- logisticians
- administration officers and human resources officers
- risk communication and community engagement and social and behaviour change communication specialists *(11)*
- medical anthropologists/sociologists
- infection prevention and control (IPC) and water, sanitation and hygiene experts

With the support of the WHO Regional Office's EMT, the N-EMT core team and other major stakeholders will develop, monitor, adjust and adapt the work plan for setting up the N-EMT. The list of members needed for an N-EMT can be modified based on the country context. Given the limited availability of experts for the identified N-EMT roles, it would be useful and relevant to create an N-EMT roster. Once the experts are identified, the administrative lead in the core team will develop a functional and regularly updated N-EMT members' database.

The core team will develop a joint work plan for the N-EMT in line with the terms of reference, taking into consideration the types of emergencies, whether they are disease outbreaks, humanitarian crises or natural disasters with mass casualties. Based on the context, the main role of the core team will include monitoring, adapting and adjusting the work plan for implementation and follow-up. The core team or a medical emergency taskforce will have up 3 months to identify and clarify the status of the country's crisis management structure, including its EMT core management team and organogram, in addition to the country's enabling environment for the N-EMT's rapid deployment and response (Table1).

Table 1: Human resources for the N-EMT and their roles

			Year 1											
			Months (based on when started)											
			1	2	3	4	5	6	7	8	9	10	11	12
Detail	**Activities**	**Responsible party**												
Task 1: Create the human resources team of the right composition														
Identification of key members of the N-EMT multidisciplinary team (team lead, clinical doctors, nurses, administration lead, logistician, support staff), depending on the focus of the N-EMT	• Identifying and recruiting members of the N-EMT core management team (3 MoH officials – team lead, technical lead, administrative/HR lead) and 2 WHO officials (technical liaison, operations support and logistics)	WCO Emergency Team, lead or person designated by the WRs with the support of Regional Office EMT												
	• Defining/clarifying the structure of the N-EMT core management team	Core team, MoH, WCO and Regional Office												
	• Drafting the TORs for the functioning of the N-EMT core management team	WCO Emergency Team lead												
	• Developing the roster of the teams (constructing a database composed of a multidisciplinary team – team lead, clinical doctors, nurses, administration staff, logistician, support staff)	Core team												
	• Managing the tasks based on the key components of the emergency													
	• Developing a joint work plan in line with the TORs, taking into consideration the three types of emergencies (outbreaks, humanitarian crises, natural disasters/mass casualties)	Core team												
	• Working on adaptability of the team for each emergency (outbreaks, humanitarian crises, natural disaster/mass casualties)	Core team												

Participants in the simulation exercise at the EMT training centre in Ethiopia at WHO (courtesy: Boniface Oyugi) @courtesy of WHO AFRO

Task 2: Train, mobilize, deploy, structure and manage your N-EMT

The core team or the medical emergency task force must identify the types of training required for different responses. Experience in the African Region and other regions indicates that each N-EMT requires at least three mandatory training events: the EMT induction training, the 10 steps training for building an N-EMT, and the EMT field deployment training. These three can be complemented with additional training in the areas of basic emergency and critical care, IPC, security, logistics and communications, based on the N-EMT's needs. The N-EMT core team will organize training with the support of the Regional Office, the EMT secretariat and potentially some I-EMTs. In addition to the training, it will be necessary to draft the functional chart of the EMT, coupled with a set of standard operating procedures (SOPs) for the functioning of the N-EMT before and during deployment. A summary of the activities is shown in Table 2.

Table 2: Activities relating to training, mobilizing, deploying, structuring and managing the N-EMT

			Year 1											
			Months (based on when started)											
			1	2	3	4	5	6	7	8	9	10	11	12
Detail	**Activities**	**Responsible party**												
Task 2: Train, mobilize, deploy, structure and manage your N-EMT														
Training of the EMT, managing the team during normal times, roster preparation, organization of the team once it is deployed (architecture and log chart)	• Conducting the 3 identified mandatory training events (EMT induction training, 10 steps training for building an N-EMT and EMT field deployment training) based on the needs and the country's emergency context	**Core team with the support of WCO, Regional Office and WHO headquarters**												
	• Working on the partnership with international EMTs for training, capacity building and procurement/donations of materials and equipment	**Regional Office EMT**												
	• Managing the team through drafting an operational agreement for the functioning of the N-EMT	**Core team**												
	• Establishing the organogram of the N-EMT members													
	• Working on the modalities of the deployment of the EMT before, during and after the emergency, based on the context and types of emergencies	**Core team**												
	• Conducting simulations/field deployment of the N-EMT for certification	**Core team**												

Task 3: Mobilize, organize, store and transport (and maintain) medical materials and equipment

This component involves the procurement and storage of medications, personal protective equipment (PPE), medical kits for various conditions and other medical materials. With support from the WHO Regional Office, the N-EMT core team will ensure the procurement of the required core package of medical materials and equipment independently of the nature of the crisis and according to the list of materials created during risk analyses. Storage facilities for easy access to and safe storage of medical equipment must be identified before its arrival. As such, the team must develop SOPs for its storage, which should also be aligned with the national emergency response legislation to secure funding and enable the development of partnerships and resource mobilization to that effect (Table 3). The lack of adequate warehousing could pose a challenge and so liaising with partner organizations such as the Global Fund may help to secure adequate funding and resolve warehousing logistics. Annex 1 shows the list of the necessary and required medical materials and equipment for the establishment of N-EMTs.

Table 3: Activities for mobilizing, organizing, storing and transporting N-EMT medical materials and equipment

			Year 1											
			Months (based on when started)											
			1	2	3	4	5	6	7	8	9	10	11	12
Detail	**Activities**	**Responsible party**												
Task 3: Mobilize, organize, store and transport (and maintain) medical materials and equipment														
Procurement and storage of drugs, tents, kits, PPE, medical materials etc.	• Defining and procuring the package of the needed medical materials and equipment	Core team												
	• Defining and implementing SOPs for the storage and management of materials and equipment	Core team												
	• Based on the context and opportunities, engaging partners for procurement and donation of materials	Core team with the support of Regional Office and WHO headquarters EMT												
	• Defining and implementing SOPs for the transportation of the materials for the N-EMT	Core team												
	• Defining the mechanism for ensuring the replenishment of stockpiles	MoH and WCO												

Tent setting during the simulation at the EMT training centre in Ethiopia at WHO (courtesy: Thierno Baldé) @courtesy of WHO AFRO

Task 4: Mobilize, organize, store and transport non-medical materials and equipment

This task relates to the operational and logistics requirements of EMTs in the field, such as their access to water and food, lodgings and transportation. The budgeting activity and the organizational framework checklist should follow the established guidelines as recommended by the Logistics Operations Guide published by the United Nations Joint Logistics Cluster and guided by the basic principle that a humanitarian crisis generally entails a coordinated, multifaceted response. In this sense, observing economies of scale as much as possible is recommended. However, while medical aspects of an emergency may require more specific or time-sensitive logistics or close adherence to sanitary conditions, such as the setting up of field hospitals, food and accommodation should be organized within a whole-of-response approach.[2]

SOPs for medical emergency preparedness and response under different scenarios should be agreed upon among the core team, the MoH, the WCO and partners. Equally important, the operational costs for patients must be calculated based on the nature of the crisis, bearing in mind their calorie and water intake per day and the type of required nutrition for different age groups etc. e.g. in situations of famine (Table 4). Annex 1 shows a list of necessary and required non-medical materials and equipment for the establishment of N-EMTs.

Table 4: Activities for mobilizing, organizing, storing and transporting non-medical materials and equipment

			Year 1											
			Months (based on when started)											
			1	2	3	4	5	6	7	8	9	10	11	12
Detail	**Activities**	**Responsible party**												
Task 4: Mobilize, organize, store and transport non-medical materials and equipment														
Provision of access to food for the team and patients, transportation means and lodgings for the team	• Addressing how to meet the operational cost of the team (food and lodging) with resources from WHO or MoH and partners	Core team, MoH, WCO and partners												
	• Addressing the operational cost of patients (patient stabilization and management for 1 day. The target is to have referral for the patient ASAP).	Core team, MoH, WCO and partners												
	• Considering having alternative lodgings for EMT members within the N-EMT facility (tents, beds) based on country context and the emergency	Core team												
	• Defining the transportation means for the EMT members during mobilization, deployment and operation	Core team												

[2] Humanitarian library, 2018; The logistics operations guide: https://www.humanitarianlibrary.org/resource/logistics-operations-guide-log-0

Task 5: Provide access to water and power for an effective, self-sufficient N-EMT

This step pertains to all issues regarding the power supply, transportation and access to clean water for both patients and team members. In this component, the core team will have up to 4 weeks to identify the power source, be it a generator, solar panel or any existing local power system, and to identify the possible water sources such as a borehole, water truck or any other source, ensuring water cleanliness and safety. The core team will define the scenarios and mechanisms for preparing and establishing an onsite EMT. These scenarios cover light onsite construction work for living and work facilities, e.g. for building toilets and showers for both patients and N-EMT members etc., paying attention to gender desegregation concerns (Table 5).

Table 5: Activities relating to ensuring access to needed water and power for an effective and self-sufficient N-EMT

			Year 1											
			Months (based on when started)											
			1	2	3	4	5	6	7	8	9	10	11	12
Detail	**Activities**	**Responsible party**												
Task 5: Provide access to water and power for an effective, self-sufficient N-EMT														
Provision of access to a generator, transportation, clean water for both for patients and team members	• Leveraging existing sources – the outfit can be a surge in a hospital if facilities are available in the area of the emergency. It could include a biomedical engineer (OSL member) on the surge team.	Core team												
	• Identifying the power source (generator, solar panel, or using the existing local power system)	Core team												
	• Identifying the possible water sources (borehole/water truck) and ensuring the cleanliness and the safety of the water	Core team												
	• Identifying the security mechanism for the team. The government to make security arrangements for the team	MoH												
	• Defining the mechanisms for the preparation and establishment of the N-EMT on the site (light onsite construction work; building of toilets and showers for both the patients and N-EMT members)	Core team												

Task 6: Activate the deployment of the N-EMT and maintain effective links with local health care systems

The MoH is the primary party responsible for triggering the deployment of an EMT, with such triggers being mainly new events surpassing the capacity of the regional/provincial/district health system in terms of clinical case management. Providing SOPs linking EMTs to the local health system is a key ingredient in ensuring continuity of services and cooperation during a public health response. With the support of the WCO, the Regional Office and WHO headquarters, the core team or taskforce will have up to 2 weeks to define the SOPs for the deployment team's mobilization and activation and to define the functional link between the N-EMT and the local health facilities and health systems.

Integrating local health professionals and structures within the N-EMT framework will be essential for its functioning. In this regard, the core team will have up to 2 weeks to define the mechanism for such integration. The team will outline the plausible links to the community, with a link to specific community focal point who will interact with community health workers and health facilities, whether they are inpatient, outpatient, community based, voluntary, institutional, governmental, hospice or comprehensive health maintenance agencies (Table 6).

Table 6: Activities for defining N-EMT the deployment scenarios and maintaining effective and functional links with the local health system

			Year 1											
			Months (based on when started)											
			1	2	3	4	5	6	7	8	9	10	11	12
Detail	**Activities**	**Responsible party**												
Task 6: Activate the deployment of the N-EMT and maintain effective links with local health care systems														
Definition of the triggers for the deployment of the team and who will take the decision	• Defining the SOPs for the mobilization of the team and to trigger the deployment of the team	Core team with the support of WCO, Regional Office and WHO headquarters												
	• Defining the functional link between the N-EMT and the local health facilities and the health systems	Core team and MoH												
Development of SOPs for the linkage with the local health system, including with public health response systems	• Defining the transportation means (seek agreement with the regional, county or district authorities)	Core team												
	• Planning for procurement and provision of internet and phones for communication (includes walkie talkies)	Core team												
	• Defining the mechanism for integrating local health professionals/structures for the functioning of the N-EMT	Core team												
	• Defining the linkage with the community – dedicating one member to link the team with community; using available systems and making linkages with the surveillance/data manager of the facility; linking with the RCCE community (for engagement with the community); leveraging available resources	Core team												
	• Engaging partners to support the deployment of the N-EMT	Core team												

Task 7: Create and maintain proper IPC measures in the N-EMT

Given the high proportion of epidemics due to infectious pathogens in the Region, this step is crucial for the safety of the N-EMT members and their patients. It involves developing and implementing SOPs for the establishment and maintenance of IPC measures in triage and isolation rooms. In performing this task, the core team, WCO and the Regional Office will have 3 weeks to define the personal protective equipment to be used by the N-EMT based on the type of emergency, outline the other IPC measures to be implemented based on the type of emergency and establish the stabilization and isolation room. That is, the core team will establish screening areas and systems and set up or designate stabilization or resuscitation areas or tents and crash carts with all the necessary IPC equipment and personal protective equipment (Table 7) (Refer to the "WHO guidance on designation of a resuscitation area" *(12)*).

Table 7: Activities for creating and maintaining proper and effective IPC measures in your N-EMT

			Year 1											
			Months (based on when started)											
			1	2	3	4	5	6	7	8	9	10	11	12
Detail	**Activities**	**Responsible party**												
Task 7: Create and maintain proper IPC measures in the N-EMT														
Creation and observance of IPC measures, triage, isolation rooms etc.	• Determining the PPEs to be used by the N-EMT based on the type of emergency	Core team, WCO and Regional Office												
	• Defining other IPC measures to be implemented based on the type of emergency	Core team, WCO and the Regional Office												
	• Establishing the stabilization and isolation room (a tent to stabilize patients or a ward or crash carton) stocked for all necessary IPC measures	Core team, WCO and Regional Office												

Tent setting in a camp in Mozambique at WHO (curtesy: Thierno Baldé)

Task 8: Create and maintain a referral system for patients

Defining the referral pathways from EMTs to other health care services will take the core team and MoH 3 weeks and will take into consideration the type of EMT, nearby health facilities and the country context. It includes having agreements on the locally available transportation to the closest hospital and leveraging existing structures and services such as public and private ambulance services and establishing referral networks amongst the national and the international EMTs and the different levels of public and private health facilities.

Lessons learnt from past emergencies such as those on the Ebola virus disease, HIV/AIDS, Zika, cholera and mass casualty events such as bombings and major accidents highlight the need for keen concertation with the military and civil police, in addition to the emergency response cluster within the United Nations Country Team and other international actors. In this regard, applying a community referral systems methodology such as the surveillance based on events in the community as developed by the United States Centres for Disease Control and Prevention (CDC) and adopted by Africa CDC can lay the groundwork for information management. Contact with the United Nations Office for Disaster Risk Management, the Office of Humanitarian Affairs, UN-SPIDER and others is essential for access to risk management-related GIS support if or when this is not available nationally (Table 8).

Table 8: Activities for creating and maintaining a referral system for patients

			Year 1											
			Months (based on when started)											
			1	2	3	4	5	6	7	8	9	10	11	12
Detail	**Activities**	**Responsible party**												
Task 8: Create and maintain a referral system for patients														
Identification of the referral pathways from the N-EMT to other health care services	• Defining the referral pathway taking into account the capacities of nearby health facilities and the country context	Core team and MoH												
	• Defining the agreement mechanism for using locally available transport means for taking patients to the closest hospital	Core team and MoH												
	• Defining the mechanism for leveraging the transportation means of the surge project teams, including for the transportation of the materials	Regional Office, regional EMT and Core team												

Task 9: Create and manage suitable health information systems for patients

To establish, replicate or extend the health information management system in the local health system, the core team will have 2 weeks, and in that period it will make available the health information and patient reporting tools with a functional linkage to the local health system. This could mean either adapting nationally used reporting tools such as those in the WHO Emergency Care Toolkit e.g. the emergency checklists, interagency triage tools and standard reporting forms *(13)*. The team will have 2 weeks also to plan on the acquisition of a dedicated team member to be in charge of the management and implementation of the health information system for the N-EMT. In situations of political instability where citizens' records may be used for political gain, WHO must adhere to strict privacy protocols for patient information and case management (Table 9).

Figure 9: Activities to create and manage a proper health information system for patients

			Year 1											
			Months (based on when started)											
			1	2	3	4	5	6	7	8	9	10	11	12
Detail	**Activities**	**Responsible party**												
Task 9: Create and manage suitable health information systems for patients														
Establishment/replication/extension of the health information management system of the local health system with the appointment of a dedicated data manager who is provided with the needed materials and resources	• Making available health information and patient reporting tools with a functional linkage to the local health system	Core team												
	• Planning for a dedicated team member to be in charge of the management and implementation of the health information system for the N-EMT	Core team												

Task 10: Demobilize an N-EMT and document the lessons learnt from its implementation

Decisions on the question as to who will decide when to demobilize the N-EMT, the organization that will do it and how the lessons learnt will be shared will be guided by the Regional Office's emergency team in the form of SOPs for N-EMT demobilization. That document should be contextualized by the country medical emergency taskforce based on the team members' maximum period in the team or their turnover, the ongoing needs of the population affected by the emergency and whether alternative structures/measures to address the needs have been identified. The core team may use 2 weeks to define the specific steps and set of actions to carry out the clearing, cleaning and storage of the tents and equipment. The core team will also use 2 weeks to outline the mechanism for providing psychosocial support to team members during and after their deployment. Together with the MoH, the core team will plan for the N-EMT's communication *(11,14)* and interaction with the community health authorities after the team's deployment. With the support of WCO, the Regional Office and WHO headquarters, the core team will plan for the gathering and sharing the lessons learnt and will document the N-EMT mobilization and deployment activities. This is expected to take 2 weeks (Table 10).

Table 10: Activities to demobilize the N-EMT and document the lessons learnt

			Year 1											
			Months (based on when started)											
			1	2	3	4	5	6	7	8	9	10	11	12
Detail	**Activities**	**Responsible party**												
Task 10: Demobilize an N-EMT and document the lessons learnt from its implementation														
Definition of the triggers for the demobilization of the team and who will take the decision to demobilize the team	• Defining the SOPs for demobilizing the team (all in one document), based on a determined period of time and/or turnover of the team members.	Regional Office EMT												
	• Defining the specific steps and set of actions for clearing, cleaning and storing tents and equipment	Core team												
	• Defining the mechanism for the provision of psychosocial support to the team members during and after the deployment	Core team												
Capturing of the lessons learnt	• Planning for communication and interaction with the communities and local health authorities after the deployment	Core team and MoH												
	• Planning for and conducting the pooling of the lessons learnt and undertaking the documentation of the process of mobilization and deployment of the team	Core team with the support of WCO, Regional Office and WHO headquarters												

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Annexes

Annex 1: Medical and non-medical materials

No.	Items	Quantity	Remarks
1	Xpert multipurpose tent (24 m^2)	5	For waiting, triage, ICU, emergency and administration areas
2	Xpert multipurpose tent (48 m^2)	3	For male and female consultation rooms, and ICU and emergency rooms
3	Hospital bed	8	3 for male rooms, 3 for female/children's rooms, 1 for ICU, 1 for resuscitation area
4	Surgical gown	50	For donning in the areas where full PPE is not needed
5	Medical panel (vertical)	5	For setting between beds
6	Defibrillator	1	For cardiovascular emergency (ICU and resuscitation areas)
7	Monitor	1	For ICU
8	Drugs and therapeutics (anti-inflammatories, antibiotics, fluids etc.)		Based on the needs and on the purpose of the event
9	Kit IAEHK	1	Applicable for different types of emergencies
10	Cholera kit	1	To be used in case of a cholera outbreak
11	Trauma kit	1	For mass casualties and PHC deployments
12	Stethoscope	10	For clinical use by doctors and nurses
13	BP machine	10	For clinical use by doctors and nurses
14	Oxygen concentrator	2	For resuscitation and ICU (exchangeable between male and female/children's rooms)
15	Haemoculture	2	To be used at any place at the centre
16	Oximeter	15	To be used as needed in the centre
17	Thermometer	10	To be used as needed in the centre
18	PPE	600	To be used under IPC guidelines
19	Glucometer	3	To be used as needed in the centre

20	Weighing scale (adults')	6	For triage/consultation area, ward, ICU and emergency rooms
21	Weighing scale (kids')	2	For triage/consultation area, ward, ICU and emergency rooms
22	First aid kit	5	For triage/consultation area, ward, ICU and emergency rooms
23	Bench	2	For the waiting room
24	Fence tape roll of 100 m	4	For fencing off the EMT work space
25	Inflatable camping mattress	15	For doctors and nurses resting at the centre while on call
26	Sleeping bag	15	For doctors and nurses resting at their place of stay
27	Hand washing station with pedal	10	For the waiting bay and in the tents (or as needed)
28	Foldable table	20	To be distributed according to the needs of the mission or by the EMT core team's decision
29	Foldable chair	40	To be distributed according to the needs of the mission or by the EMT core team's decision
Total			

Additional generic essential emergency equipment from the WHO Essential Emergency Equipment List *(13)* can be considered. Also, the WHO Resuscitation Area Designation Tool, the WHO Trauma Care Checklist, the WHO Standardized Clinical Form, the WHO Medical Emergency Care Checklist, and the Interagency Integrated Triage Tool all form imperative advisory resources *(13,15)*.

Annex 2: Contributors and participants in the EMT retreat at WHO Regional Office for Africa, Brazzaville, 23–25 February 2022

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Participants at the WHO Regional Office for Africa EMT retreat (courtesy: Marriane Tabi)

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