Proceedings of the

WHO/PAHO

Technical Consultation on

International Foreign Medical Teams (FMTs)

Post Sudden Onset Disasters (SODs)

December 7-9, 2010

Havana, Cuba

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Proceedings: Key Points Summary

Acronyms

ATLS	Advanced Trauma Life Support
FFH	Foreign Field Hospital
FMT	Foreign Medical Team
HeRAMS	Health Resource Availability Mapping System
INSARAG	International Search and Rescue Advisory Group
ISEA	Institute of Social and Ethical Accountability
NGO	Non Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
OSOCC	On-Site Operations Coordination Centre, OCHA
PAHO	Pan American Health Organization
SOD	Sudden Onset Disaster
UN	United Nations
UNDAC	United Nations Disaster Assessment and Coordination
WADEM	World Association Disaster and Emergency Medicine
WHO	World Health Organization

Proceedings: Key Points Summary

1. Introduction

a. Background

Many Foreign Field Hospitals (FFHs) were deployed to Haiti following the earthquake on January 12, 2010 as well as after several other recent disasters such as the earthquakes in Pakistan (2005), Iran (2003) and China (2008). The number of Foreign Field Hospitals and international medical teams mobilized in those sudden-onset disasters has increased. While they have been beneficial in many situations, they have also been frequently questioned regarding their timeliness, self-sufficiency, ability to adapt to the local system or even the quality of service provided.

In 2003, WHO/PAHO created the Guideline for the Use of *Foreign Field Hospitals in the Aftermath of Sudden-Impact Disasters.* Although this guideline remains valid, it needs to be updated in order to better take into account disasters that completely destroy health services as well as new technology and changing needs. In addition, the current guide is too limited to field hospitals and must include parameters for foreign medical teams (FMT) in order to ensure quality of care.

An improved guideline with the abovementioned additions will not have significant impact without describing a mechanism to coordinate the deployment of such FFH or medical teams. The urgency of that need has been exacerbated by the increasing number of actors and the will of the international community to make assistance more efficient. While creating this mechanism, it is essential to take into account the increased capacity of local authorities, that if not recognized, could be seriously disrupted by overwhelming external assistance.

The WHO/PAHO guided consultation was held in Havana, Cuba from December 7-9, 2010. The three day technical meeting is considered to be the initial consultation of a much larger inclusive process. The meeting brought together various actors from the humanitarian community involved in sudden onset disasters. Some partners were unable to attend for various different reasons, and will be included in future activities throughout this process.

b. Aim / Objectives of the technical consultation

The aim was to provide technical, authoritative guidelines to external providers

as well as national recipients of medical care teams or facilities by enhancing and broadening the WHO/PAHO 2003 guidelines on Foreign Field Hospitals (FFH), contribute to the formulation of minimum standards for medical care teams and facilities and outline possible mechanisms for global registration/accreditation and national coordination of medical care teams or facilities. This occurred through consultation, brainstorming and discussion in the following topic areas; accountability, quality control, reporting, deployment, logistics, registration, accreditation and coordination.

c. Executive Summary: Key Points and Concepts

- Long term aim: unanimous support for the revision of the 2003 *WHO/PAHO guidelines for the use of Foreign Field Hospitals* (FFHs).
- The concept and the term Foreign Field Hospitals needs to be expanded to incorporate the diversity of settings in which foreign medical teams work after large emergencies and disasters. For this reason, the revised document will now refer to the term Foreign Medical Teams (FMTs) instead of FFHs. This term still incorporates FFHs but also expands the role of the foreign medical team.
- Unanimous support for the concept of an International Registration process for Foreign Medical Teams. Registration of FMTs is considered to be a step towards the accreditation of FMTs.
- The focus should be on health services offered or provided rather than type of field hospital to be mobilized.
- This process should be inclusive and transparent. Acknowledgement that some key actors and donors were not able to participate in this initial meeting and that full participation and inclusiveness are expected and intended.
- This is the beginning of a longer term process that will lead to the development of minimum standards for FMTs after sudden impact disasters.
- The focus on the guidelines initially will be sudden onset disasters, with an emphasis on earthquakes. This will later include other large emergencies such as floods etc.
- The ultimate role of all FMTs is to support national governments who should be coordinating and directing the FMTs.
- A strategic framework for the process is needed. A structure should be nested within an international recognized body (example: Inter Agency Standing Committee). The ownership of the process should include the medical profession and the WHO/PAHO.
- Foreign health care teams are intended to support and reinforce the national health care system, not replace it. Every attempt to be made to collaborate and when appropriate, capacity build.

2. Proceedings of the Meeting

a. Recent Experience

Recent experiences following the 2010 earthquake in Haiti (Annex 1) regarding the realities, challenges and concerns were highlighted and discussed. Some of the questions and challenges highlighted were the need for improved coordination, needs assessments, cooperation between health facilities, quality of care (in some cases), contextually appropriate health care, record keeping and patient follow up. These challenges and concerns raise questions about the accountability of different foreign medical teams in Haiti post earthquake.

b. Conceptual Models

The utilization of a conceptual model to develop a foundation upon which to build guidelines for FMTs working in the SOD context was considered beneficial. A well defined, clear model can help provide a common framework to analyze and improve quality and coordination of relief efforts. For example, if consensus can be obtained with respect to the types/timing of health services required after SODs, then this information would assist with the development of the guidelines.

Two models were proposed and identified as ones that could help inform the process by which the minimal standards and guidelines for FMTs are developed. Model #1 is a model that describes the Level of Health Care with respect to timeline after SODs. (Annex 2) Model #2 is a Health Resource Availability Mapping System (HeRAMS) in Sudden Onset Scenario Humanitarian Crisis. (Annex 3) This model is derived from the standard health cluster tool that is used for collection, collation and analysis of health sector information but focused on a checklist for SODs.

The consensus was that if both of these models were integrated together, the outcome could be a model that could be extremely valuable to use as the guidelines are developed. There still needs to be discussion and consensus about *which* health services are important for each level of care for what time period after a SOD.

c. Accountability, Quality Control and Reporting

Accountability, quality control and reporting are important topics that all need to be integrated into the revised guidelines for the use of foreign medical teams in disasters. Each of these topics requires minimal standards to be developed as part of the guidelines. A clear consensus emerged that these issues are all

closely embedded in ethical principles and values. In particular, ethical principles underlie the issue of responsiveness[1]. Other values may need to be identified as key values in humanitarian medical response. These values and ethical principles can help to inform the development of minimal standards for foreign medical teams.

i. Accountability

There is no single official definition of accountability in the humanitarian context. The definition used during the technical consultation was one developed by the Institute of Social and Ethical Accountability (ISEA) and accepted with minor modifications. (Annex 4) Accountability is defined as having three components; transparency, responsiveness and compliance. (Annex 4) *Responsiveness* was the most difficult concept to define. Determining *to whom* responsiveness is best directed is an ongoing challenge. This concept needs to be further explored.

Minimal standards for Accountability: transparency, responsiveness and compliance

During the consultation, using small working group format, the groups discussed and suggested some initial minimal standards. (Annex 5) These current ideas create a starting point on which more detailed standards can be explored, expanded and developed over time.

ii. Quality Control

Quality control includes the principle that techniques and activities that sustain service quality are present. It was agreed that quality control measures must also incorporate the principles of quality improvement which is based on a continuous quality improvement process. This process incorporates corrective actions when necessary. Minimal standards for quality control have also been suggested as a springboard for further development. (Annex 6)

d. Deployment and Logistics

i. Deployment

Two phases of deployment were identified; pre-deployment coordination and post deployment integration with health services. The concept of 'Consultation-coordination- integration' for deployment was acknowledged. Consultation should

[1] *responsiveness* concerns the responsibility of the organization *(and individuals)* for its acts and omissions. This was the working definition of the group however this definition may need to be re-considered- does responsiveness vary depend on context?

occur with the affected country prior to deployment; coordination should occur with national officials and activities should be integrated within the national health system. Also recognized was the idea that there must be certain pre-disaster expectations of foreign medical teams. Some examples include: articulation of capacities and team organization, timelines, culturally and contextually appropriate care available, coordinated effort, institutional responsibility to qualifications of team members, security plans,(code of conduct of individuals/organization and disciplinary rules), transport requirements, needs assessments and quality standards. (Annex 7) These pre-departure expectations of FMTs need to be further expanded and discussed.

ii. Coordination

Coordination efforts should start before deployment. It was agreed that the role of FMT is to consult with the National health authorities or coordinating body, also to communicate with a broader group, such as civil defence, national authorities and other FMTs as appropriate. National health authorities are the lead when possible and coordinate the players. When this is not possible, or this coordination is weak, coordination with other actors is important. The Health Cluster was identified as important in the onsite coordination role. FMTs need to be willing to 'be coordinated.'

Examples of deployment strategies (Annex 8) from INSARAG (International Search and Rescue Advisory Group), OSOCC (On-Site Operations Coordination Centre, OCHA), a country example (Spain) and potential role of the cluster in having a list of teams were discussed. The UK has developed an International Emergency Trauma Register for medical personnel who respond to large scale international emergencies. (http://www.uk-med.org) Understanding other examples of what deployment strategies are working well would be helpful in developing the guidelines.

Communication was identified as being important within the team, from team to outside (cluster, other), contact with home and appropriate contact with the media.

iii. Damage and Needs assessment

The opinion that FMTs should be able to conduct and utilize information obtained from damage and needs assessments was supported. Damage and needs assessments need to include health demand, personnel, supplies and facilities. Types of services required and offered should be assessed, although it was identified that this is not always easy to determine and information often is not available. The issue that standards need to be developed when the information is

not available was discussed and therefore FMTs should be easily able to access and utilize reports from OCHA, PAHO/WHO etc. (Chile example, Annex 9)

iv. Logistics

The principle that logistics must be based on a self- sufficiency model was supported during the consultation. The utilization of the INSARAG document to inform the development and minimum standards for logistics was considered a valuable approach. When considering deployment and logistics, the use of these different phases of preparedness, mobilization, deployment, operations, demobilization and post mission were identified as being helpful. (Annex 10) A strong preparedness phase must include a mission statement, objectives, a plan of action, and personal preparation including kits and insurance as examples. The INSARAG document would be a helpful tool to develop logistics guidelines and standards adapted for the health sector.

These components of logistics were supported and should be incorporated into guidelines: customs regulations/documentation, physical inventory and inspection of facility, equipment and supplies, transport and handling, storage facilities, selection and preparation of the destination site, security and safety aspects, capacity of existing logistics systems, and timeframes.

e. Registration

Registration is considered an important first step to a goal of accreditation, training and standards. There was strong support for the voluntary registration of FMTs for SODs. Subsequent criteria will need to be developed. Two parts to the registration process were identified; a pre-disaster and post disaster registration.

A pre-disaster database should be shared in a transparent manner and the Ministry of Health in the affected country should be able to access it. The issue of *who* should do the registration was discussed. There was consideration that under the secretariat of the WHO with a steering committee from, for example, the Red Cross and other NGOs which would support the local Ministry of Health. It was understood that as time progresses, the list will exclude organizations with sub-standard quality. Also considered was the fact that if bigger actors agree on minimal standards, then there will be an ‘unspoken pressure’ for smaller actors to conform.

The second registration process includes the post disaster registration. The consensus was that there needs to be a registration upon arrival. Concepts identified for further discussion were; OSSOC should have 2 medical members that work on the registry for medical teams possibly, to have WHO/cluster/UN presence for the registration process, and supporting involvement of the Ministry

of Health. Perhaps the pre-disaster questionnaire can serve as the basis for post-impact registration.

Next steps include the revision of Annex 4 (Global Register of providers of Medical and Surgical Care in foreign disasters) from the working document, (Working groups Background Paper: Registration, Certification and Coordination.) An example includes adding 'other' to section 4.2. (Annex 11 this document.)

f. Certification, Accreditation or Classification

There was strong consensus that certification and an accreditation process is desirable and needed for FMTs. Accreditation is the ultimate goal to ensure quality and accountability of FMTs. Defining standard services would also support the accreditation concept. (Annex 12) The concepts of self-certification and self evaluation were discussed.

The self-certification process is the initial step that could be used as a tool/ checklist for teams to start to self analyze their performance but does not connote quality in itself. The tool should be developed at an international level, possibly by the WHO. The team would also need to be certified in the home country's Ministry of Health. The role of universities, the Ministries of Health and even the donor/multilateral community needs to be examined in more detail.

The concept of self-evaluation emerged. Consideration of a self-evaluation tool that is conducted with a more formalized instrument and format could be further explored. Some kind of real time evaluation may be one method towards the accountability process.

There is a role that universities could play in order to provide academic support in self-certification, self-evaluation as well as strengthening the process of accreditation. The peer review concept was considered as a concept that could be further explored.

Discussion occurred around who should be in charge of the process of certification or accreditation. It was suggested that WHO should be in charge, with an advisory board, group of experts or committee. Institutional membership within the committee was discussed and individuals could be involved in the steering committee.

The funding mechanism of such a process was not discussed in detail. This needs to be explored. Will institutions fund or donor community? The example of UNDAC is that countries pay into the process before so that they don't pay at the time of deployment. Should there be an incentive for certification or accreditation?

It was agreed that there needs to be a clear coordination mechanism for medical teams in the field but that mechanism is yet to be defined. It was deemed premature to consider this mechanism at this time. It was suggested that the health cluster does need to be strengthened and that the health cluster should include an OSSOC counterpart. Questions include; if the health cluster sometimes takes one week to be efficient, then who is best to coordinate health care efforts initially in these contexts? It is variable and will depend on the context. Next steps include developing 3 or 4 suggested mechanisms and then have discussion and debate about what is the most feasible.

g. Next steps:

1. Identify ad hoc working group to develop early concept paper draft. (ad hoc working group being identified from the Cuba meeting participants)

2. Meeting proceedings to be summarized in a document that will help to inform the process of the concept paper. (this document)

3. Identification of partners to be included in next meeting in Beijing- invitations to be sent.

4. Early concept paper; to be developed in more detail at working group meeting in Brussels February 2011.

- Need to define/ consensus for terms and definitions.
- Need to further develop the conceptual model.
- Need further discussion about the focus of the new guidelines: Will it be sudden onset disasters only or expanded to other emergencies?
- Concept paper needs to be ready to discuss with larger group of partners at May 2011 Beijing pre-WADEM meeting.

5. Follow up Meetings

- Working group teleconference: January 11, 2011 at 12pm EST.
- Working Group in person meeting- Geneva February 16, 2011.
- Larger group meeting. Planned as a pre-WADEM meeting, Beijing May 30 2011.

h. Glossary of terms:

Term	Working Definitions*
Accountability	A process which has 3 main components: transparency, responsiveness and compliance.
Accreditation	(Formal process) which recognizes competence through a respected organization.
Coordination	Synchronization and integration of activities, responsibilities and command and control structures to ensure that resources are used most effectively in response to disasters and emergencies.
Certification	(Technical process)
Damage and Needs Assessment	An assessment that is done soon after a disaster to help determine needs in the disaster affected area.
Deployment	The process of positioning personnel (supplies) for readiness to respond to a disaster.
Logistics	The management of supplies and goods needed to respond to a disaster or emergency.
Quality Control	The principle that techniques and activities that sustain service quality are present.
Registration	(Filing process)

- These definitions were not all discussed during the meeting. These terms need to be more clearly defined and consensus built for the concept paper.

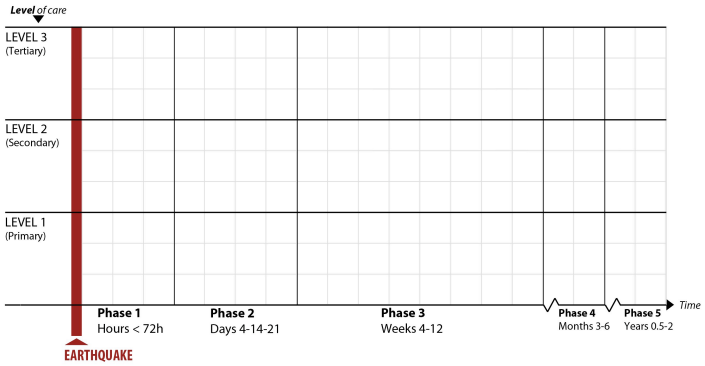
3. Annexes

Annex 1 – Experience of a recent sudden onset disaster event Haiti 2010

The Karolinska group highlighted the 2010 recent experience of the post earthquake scenario in Haiti. Haiti is a very vulnerable country, has little resistance and has been affected by many natural disasters over the recent years. Post earthquake Haiti was chaotic, with many different foreign medical teams, including seventeen foreign field hospitals arriving sometimes without proper planning, coordination and cooperation. Needs assessments were not always conducted or if done, not always thorough and contextualized. Initial coordination was difficult and as a consequence not initially done well. Cooperation between organizations was initially poor and few patients were initially transferred between facilities. The quality of care varied significantly, and was not always appropriate for the context. As an example, a large number of amputations were performed and there remains a question about if those could have been avoided. Records were not always used, available or transparent. Another concern was the perceived lack of appropriate medical and surgical follow up for patients. Some surgical teams left without having appropriate orthopaedic follow up available. These challenges and concerns raise questions about the accountability of different foreign medical teams in Haiti post earthquake.

Annex 2 – Model #1: Level of Health Care / Timeline SODs (Karolinska)

Model #1
Level of HealthCare/ Timeline SODs (Karolinska)



Summary points regarding model #1

- This conceptual model was accepted with some modifications (already incorporated, removed a potential 4th level of care and revised timelines).
- Guideline development should focus initially on level two and three during phase one and two, but acknowledge that standards and guidelines are needed for Level 1.
- Work is needed to define the health care needs in the different phases, burden of trauma care versus all other health care needs (primary health care, mental health care, public health interventions etc.)
- Standards for type of *service* per level of care and phase are needed. (not modalities of providing the care which is determined by organizations independently)
- Learning about developing and enforcing standards can be derived from other known processes like ATLS, INSARAG, ICAO as examples. INSARAG also is a strong entity from which to learn.
- Standards should be generic-for all and specific depending on discipline. Standards should be attainable, rather than “ideal”.

Annex 3 – Model #2 Health Resource Availability Mapping System in Sudden Onset Scenario Humanitarian Crisis

Primary Care: P81				Injury care: treatment of open wounds, fracture stabilization, patient stabilization and proper referral
S. Secondary Care	S 1	General Clinical Services	S11	OPD with surgical triage + Inpatients services (medical, pediatrics and ob & gyn wards)
			S12	Emergency and elective surgery: at least 1 operating theatre with or without gas anesthesia
			S13	Laboratory services
			S14	Blood bank service
			S15	X-Ray service
	S 2	Child Health	S21	Management of children classified with severe or very severe diseases (parenteral fluids and drugs, O2)
	S 6	Mat & Newb Health	S61	**Comprehensive emergency obstetric care**: BEOC + caesarean section + **safe blood transfusion**
	S 8	NCD, Injuries and Mental Health	S81	Disabilities and injuries rehabilitation
			S82	Outpatient psychiatric care and psychological counseling
			S83	Acute psychiatric inpatient unit
T. Tertiary Care	T 1	General Clinical Services	T11	OPD with surgical triage
			T12	Laboratory services with NA/K, emogas (including public health laboratory)
			T13	Specialized inpatients units: ICU, orthopedic/trauma ward for advanced orthopedic and surgical care, large burn patients management
			T14	MEDEVAC procedures, transport means & network for referral for highly specialized care
			T15	X-ray with stratigraphy, ecography, RMG and/or CT scan
			T16	Elective and emergency surgery through 2 or more operating theatres with gas anesthesia
	T 8	Injuries	T81	Disabilities and injuries rehabilitation, including early follow up at home with mobile team for post operatory care
			T82	Early discharge of post operatory patients through referral to secondary hospitals, in mass casualty scenarios

Summary points regarding model #2

- This specific model has been modified in a draft form from the Health Services checklist , based on the Health Resources Availability Mapping System (HeRAMS)
- This model needs to be further delineated to the exact role that each line would have in a SOD context
- The modality (how the delivery will happen is not deemed as important in this model, more important is to consider the level of care, who, where, when but not how)

Annex 4 – Accountability and definitions of transparency, responsiveness and compliance

It was agreed that the accountability itself was mainly at an organization level but also there should be some component of individual accountability. Secondly, the concept of responsiveness may need to be modified based on the context and may even include a liability component.
Revised Definitions include having both organizational are; (Institute of Social and Ethical Accountability)

a. **Transparency**: "transparency concerns the duty of organizations *and individuals* to account to those with a legitimate interest
b. **Responsiveness**: responsiveness concerns the responsibility of the organization *(and individuals)* for its acts and omissions *which may need to be modified based on context*
c. **Compliance**: compliance concerns the duty to comply with agreed standards regarding both organizational *and individual* policies and practices

Transparency: **Minimum Standards of Organizations working as Foreign Medical Teams after Sudden Onset Disasters**
Registration upon arrival to the existing coordination mechanism (possibly local health authorities, Ministry of Health) (as a first step to an accreditation process)
Engagement in the coordination mechanism
Ensuring data collection
Reporting basic activities and capacities to coordinating group, to headquarters. (frequency to be determined, daily/other)
Completion and submission of an end of mission report- to coordinating group, possibly local health authorities, headquarters, others.
Financial reporting

Responsiveness : **Minimum Standards of Organizations working as Foreign Medical Teams after Sudden Onset Disasters**
To pre-established guidelines
Possibly to local health authorities, as appropriate
To Professional colleges
To Professional colleagues
To Professional ethics
To Patient, beneficiaries

Compliance: **Minimum Standards of Organizations working as Foreign Medical Teams after Sudden Onset Disasters**
Organizational guiding principles and adherence to standards
Concept of the '*greatest good for the greatest number of people'*
Documentation for the justification of actions of medical and surgical interventions
Sustainability of treatment plan and realistic follow up
Uses local pharmacopeia if appropriate and available
Compliance to certain procedures: (ex. Amputations-last resort, double opinion if possible, report need for rehabilitation etc.)

Annex 5 – Minimum standards for Quality Control

Quality Control: **Minimum Standards of Organizations working as Foreign Medical Teams after Sudden Onset Disasters**
Adapted technology
Registration of teams
Registration of deaths
Quality assurance tools- checklists, guidelines
Development of appropriate indicators, dependent on context
Documentation of service availability per level of care (ex. Bed capacity)
Medical reports- minimum standard
Patient satisfaction? Audit? (how to measure?)
Psychological support for FMT (1 group)/ for beneficiaries

Annex 6 – Pre-disaster expectations of FMTs – initial thoughts

- Determine and articulate capacity of and timeline for the FMT, including type of service to be provided, culturally competent care etc.
- Coordinated effort to delineate and list capacities of FMTs to share with coordinating body
- Institution to determine the competencies and qualifications of individuals on the team
- FMTs would respond after the dimension of the event is assessed, capacity of national government has been determined and needs assessments have been completed.
- Quality standards for equipment, people etc. for the health teams in all phases – agree on common Sphere standard 2, 3,5,8 -at a minimum the same quality than host country.

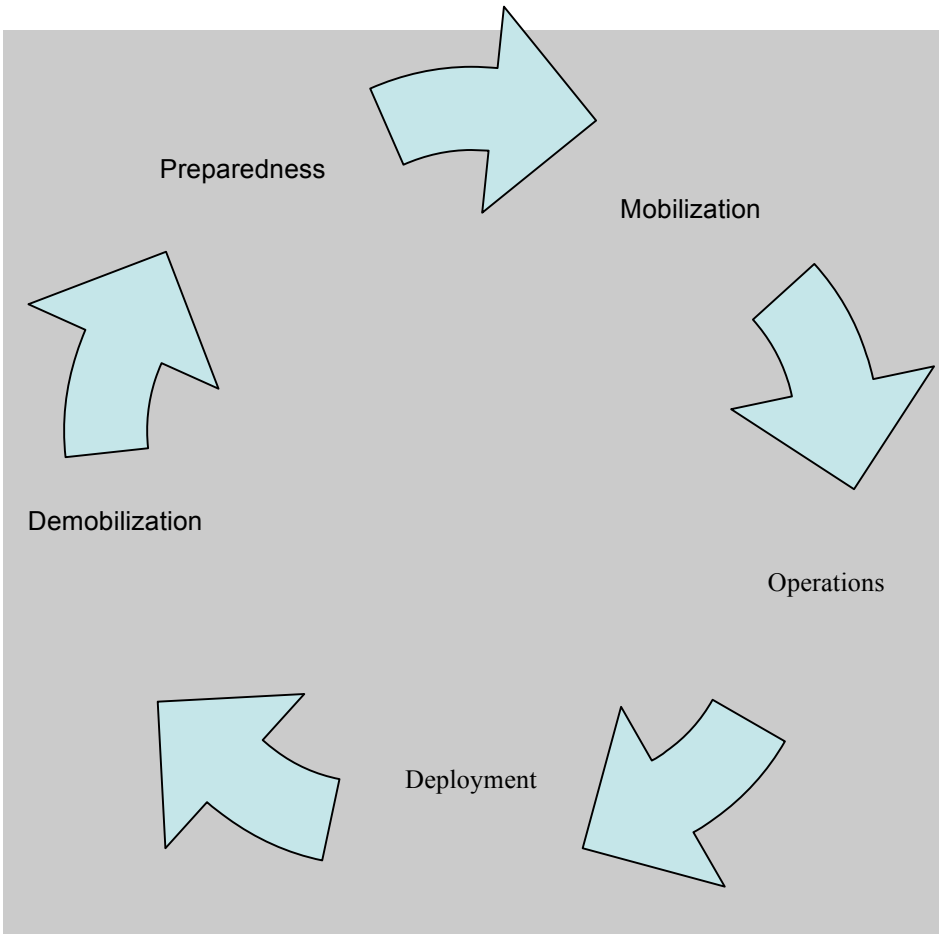
Annex 7 – Examples of what is happening now re: deployment and standby

- INSARAG – all teams write their capacities, functions and level of deployment/standby
- INSARAG classification system – light, medium, heavy and is on a national level; medium and heavy are deployed on international level.
- Virtual OSOCC- (On-Site Operations Coordination Centre, OCHA) VIRTUAL site open after 48hrs that shows the status of teams- could this include a health/medical representative?
- Spain – Consults the affected county's embassy
- In Cluster – predictability – responsibilities of people being deployed and of international organizations; have a list or classification of potential teams

Annex 8 – Example of Chile: Needs assessment

- For example: Chile – field hospital arrived thinking that most people needed trauma or surgical care but this wasn't true; national authorities of Cuba coordinated with Chile; first sent 35 member brigade and then decided where to deploy hospital; then sent surgical facility
- There was analysis made on what to bring into Chile; airport was closed at first; Chile government at first said didn't need help so then didn't receive as much help later on.

Annex 9 – INSARAG phases when considering logistic needs



Annex 10 – Taken from Annex 4 from *Working groups Background paper: Registration, Certification and Coordination* – for consideration and revision

Global Register of providers of Medical or surgical care in foreign disasters.

4.1 Agency offering the services

- Name
- Acronym
- Type (Government, registered NGO, Red Cross System, University, other)
- Affiliation: civil , military
- If NGO: registered in (Country) since (year)
- Address
- Name of contact, phone, email

4.2 Type of services provided

- Field hospital (definition)
- Medico-surgical team (definition)
- Medical team (definition)
- Advanced medical posts (definition – see EC)
- Health curative personnel
- ?add 'other' category here as an example

4.3 Field Hospital

- Type of facility (tents, etc) total weight
- Number of beds
- Population targeted (all, women, children, senior, handicapped,)
- Main orientation: Immediate Trauma and orthopedic surgery, general emergency medicine, General health care in substitution to existing damaged hospitals, others (definitions)
- Facilities:
    - Operating rooms (number)
    - RX (number)
    - Laboratory (define complexity?)
    - General anesthesia
- Operational capacity:
    - Once decision is taken, time to be deployed
    - Once arrived on site, time to treat first patient
    - Duration of operation: weeks / months

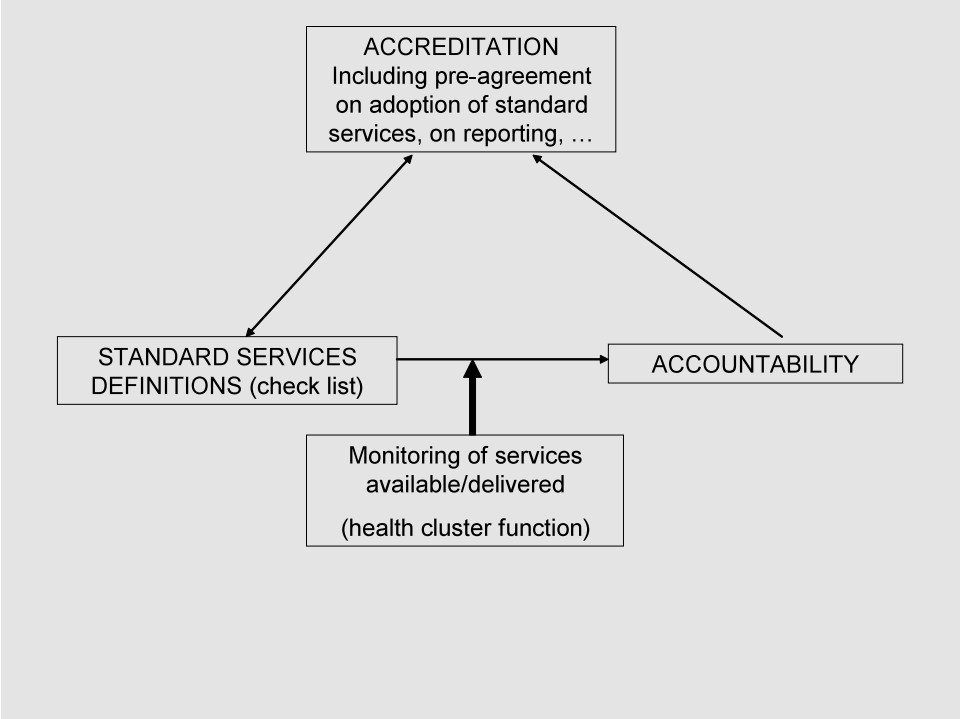
- Where and when last deployed? Time elapsed between impact of sudden disaster and treatment first patient?

- Personnel: typical or proposed structure
  - Total MD and number of female doctors
    - Number of surgeons: Orthopedic, general
    - Internist
    - Gynecology-Obstetric
    - Pediatrician
    - Other specialties
  - Para medical personnel:
    - number of nurses,
    - Pharmacists
    - Laboratory technician
    - EMT (how to differentiate US and European training?)
  - Others
- Capacity to communicate with patients, colleagues and national health staff in:
  - English (fully able, majority of the staff, with interpreters only)
  - Others
- Quality control:
  - Proof of qualification of personnel available on request from authorities?
  - Team has prior experience in disaster: Foreign? Domestic? Which ones?
  - Training of potential staff conducted : periodicity and duration
  - Incorporation of Local medical staff into the team: In clinical and / or co-managerial function? (a priority… a possibility – not considered)
  - Monitoring and Daily Reporting of activities to health authorities:
    - Willing and able to report
    - Pre-existing reporting format available?
    - After action report delivered to authorities before departure
- Support required from local health authorities:
  - Transport from airport (not required, yes at own cost, yes at cost of recipient country)
  - Facilities (building)
  - Suitable location to set up own facilities, any particular requirement?
  - Medical personnel
  - Nursing personnel
  - medicines

- Translators
- Food
- Water
- Waste disposal
- Electricity
- Fuel
- Security
- Other

- Handover Policy: Are you planning to donate the equipment and/or supplies on departure? To a public health services? To an NGO or other?

Annex 11 – Model linking accreditation, standard services and accountability



Annex 12 - References

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    a. Annex 1 Arrival report to the cluster coordinator
    b. Annex 2 Daily Report of Activities

3. Working Group Background Paper Foreign Medical Teams (FMT) Guidelines Post Disaster.

4. Conceptual framework model for foreign field hospitals and hospital care demand in Sudden onset disasters. (Karolinska)

5. Health Resource Availability Mapping System (HeRAMS) in Sudden onset Scenario Humanitarian Crisis.

6. WHO/PAHO Guidelines for the Use of Foreign Field Hospitals in the Aftermath of Sudden impact Disasters.

Annex 13 – Participant List

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