World Health Organization

Strengthening capacities through Rapid Response Teams and Emergency Medical Teams

Global consultation report
Lyon, France
12-15 December 2023

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Group photo of diverse national representatives that participated during the global consultation ©WHO

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Contents

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List of abbreviations

CDC	Centers for Disease Control and Prevention
CRS	Country Readiness Strengthening
EMT	Emergency Medical Teams
EMRO	Regional Office for the Eastern Mediterranean
LST	Learning Solutions and Training Unit
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation, and Learning
RRT	Rapid Response Teams
SOP	Standard Operating Procedures
WHE	WHO Health Emergencies Programme
WHO	Word Health Organization

Executive Summary

The global consultative meeting on strengthening rapid response capacities through Rapid Response Teams (RRT) and Emergency Medical Teams (EMT) was held in Lyon, France, from 12 to 15 December 2023. The meeting was jointly held by the Emergency Medical Teams Secretariat and the WHO Learning Solutions and Training Unit from the Country Readiness Strengthening Department of the WHO Health Emergencies Programme and US Centers for Disease Control and Prevention (CDC).

Building on the momentum of the global scoping project to evaluate management and operations and explore possible integrations of the national RRT and EMT programs for enhanced efficiency. The meeting brought 60 national representatives from 18 countries and offered an in-depth understanding of the RRTs and EMTs programmes, touching upon their definitions, operational scopes, benchmarks for integration, and the pivotal role of monitoring and evaluation in enhancing programme efficacy.

During the meeting, countries presented their integrated RRT and EMT models, demonstrating real-life applications and underscoring the necessity of developing national and subnational alongside international support. Participants engaged in detailed dialogues on the subject of integration across various operational aspects of programmes.

The global meeting achieved its objectives by defining the scope of national RRTs and their relationship with national EMTs, reaching a consensus on possible integration, and developing benchmarks for partial and full integration models. It also established an initial framework for monitoring and evaluating RRTs

Introduction

Background

Since all responses to health emergencies start locally, ensuring a timely, high-quality, lifesaving, cost-effective, and contextually appropriate first-line response to emergencies requires investing in national and local preparedness and operational readiness. While international surge serves important response functions, developing national and subnational rapid response capacities must be a matter of priority.

Rapid Response Capacities (RRC) are the medical, healthcare, and public health services and functions that can be deployed at short notice and on a non-routine basis to address health needs during and/or after a health emergency. This can encompass a wide range of capacities, including emergency medical teams (EMTs), specialized care teams, public health rapid response teams (RRTs), mobile laboratories, and community-based volunteer and health teams.

RRTs and EMTs are multidisciplinary teams trained and equipped to deploy rapidly acting as surge capacity during public health emergencies. While RRTs focus on investigating, preventing, and controlling public health events, such as outbreaks, EMTs provide direct clinical care to affected communities to support the healthcare system.

Adopting a systematic approach to building EMT and RRT capacities is vital for their sustainability, efficiency, and effectiveness, which will then contribute to strengthening the health emergency workforce, achieving International Health Regulations (IHR) requirements and Global Health Security.

Meeting Overview

In 2022, the emergency medical teams and other rapid response capacities at WHO-HQ Country Readiness Strengthening (CRS) Department of the WHO Health Emergencies Programme (WHE) and the United States Centers for Disease Control and Prevention (US-CDC) conducted a global scoping project to understand the perspectives of management and operations of national RRT and EMT programmes, with a critical focus on the possible integration of the two programmes. Concomitantly, the Learning Solutions and Training (LST) unit from the same department collaborated with the WHO Regional Office of the Eastern Mediterranean (EMRO) and the US CDC to develop a draft framework for Monitoring, Evaluation and Learning (MEL) for RRT programmes, entitled “Fundamentals of Monitoring Evaluation and Learning”.

Hinging on the success and appetite ignited by both projects, on December 12-15, 2023, a global consultative meeting was organized in Lyon, France, to discuss strengthening rapid response capacities through RRTs and EMTs. The meeting brought together over 60 national representatives and WHO regional and country office colleagues from 18 countries across all six WHO regions, with an overall goal to expand recommendations for strengthening RRT and EMT programme integration and begin discussions to develop a framework for monitoring and evaluation (M&E) of RRT programme.

The meeting was an opportunity for countries to present their operational models of integrated RRTs and EMTs programmes. These practical examples, tailored to their specific context, demonstrated the real-life applications of these models. The meeting underscored the importance of local preparedness for effective emergency responses, stressing the need to develop national and sub-national capacities alongside international support organizations. The discussions covered various topics, including the definition and scope of RRTs and EMTs, benchmarks for establishing and operating integrated RRTs and EMTs programmes, and the role of M&E in enhancing the programme's effectiveness and efficiency.

The discussions delved into the role of public health RRTs and their relationship with national EMTs, exploring the specific functions of these teams using their operational cycle as a framework. This in-depth analysis provided a comprehensive understanding of the topic. Furthermore, the meeting broadened its focus beyond RRT and EMT, examining additional examples of rapid response capacities that are pivotal for effective health emergency responses.

Participants engaged in detailed conversations about integration, dissecting the concept across various operational sections of programmes. This approach allowed for a comprehensive understanding of how integration could be practically implemented and operationalized. As a result, benchmarks were drafted to reflect both partial and full integration scenarios.

This report presents an account of the meeting, highlighting the main discussion points and outcomes. **Part A covers the discussions on EMT and RRT integration held on days 1 and 2, and Part B covers RRT MEL on days 3 and 4.**

Meeting objectives

- **To present the results of the global scoping project evaluating the integration of management and operations of national RRTs and EMTs**
- **To review and achieve consensus on descriptions of the scope of national RRTs and their relationship with national EMTs**
- **To define and describe benchmarks for the establishment, management, and operations of integrated RTs and EMTs**
- **To review the draft of the RRT Monitoring, Evaluation and Learning (MEL) Framework**

Expected outcomes

- **Consensus on descriptions of the scope of national RRTs and their relationship with national EMTs**
- **Expansion of recommendations for strengthening RRTs and EMTs integration**
- **Identify benchmarks for the establishment and operations of RRTs and EMTs**
- **Develop a framework for RRT Monitoring and Evaluation**

Part A
RRT and EMT integration

Opening remarks

***Speaker**: Nedret Emiroglu, Director, WHO Country Readiness Strengthening Department, WHO Health Emergencies Programme*

"I welcome all participants from Member States, countries, and regions to this meeting that unites rapid response teams and emergency medical teams, our key rapid response capacities. A special welcome to our main partners, the US CDC and the African CDC, whose collaboration is vital in preparing for future health emergencies. This gathering is an opportunity to leverage lessons from past emergencies to enhance global health emergency workforce capacities.

It's encouraging to see progress in countries involved in the scoping project, which offers essential guidance for WHO's Health Emergencies Programme to aid other nations. The project's outcomes underline the importance of adopting the EMT mechanism to bolster national and regional emergency responses and capabilities, including rapid response teams, thus building a stronger global health emergency workforce."

***Speaker**: Ashley Greiner, Team Lead, Emergency Response Capacity Team, Global Public Health Emergency Branch, United States Centers for Disease Control and Prevention*

"Our team is actively supporting over 30 countries and spearheading initiatives to elevate public health emergency response standards. Despite our efforts, the challenge of having a sufficiently trained and ready workforce remains compounded by inefficiencies and coordination difficulties. This workshop is crucial for devising a solution by merging public health rapid response teams with emergency medical teams. Your expertise is invaluable as we aim to create global guidance that fosters synergy between these entities despite potential obstacles. We eagerly anticipate your insights and recommendations to navigate these complexities together."

EMT Initiative at global, regional and national levels

Speaker: *Flavio Salio, Network Leader, Emergency Medical Teams Secretariat, Health Care Readiness, Country Readiness Strengthening Department, WHO Health Emergencies Programme*

The EMT Initiative is a global programme led by WHO, in collaboration with the EMT network, that works to improve the timeliness of health services provided by EMTs in response to health emergencies and to strengthen national systems and capacities for rapid mobilization, interoperable surge deployment, and effective coordination. Three main areas underpin the work of the EMT Initiative: capacity building, standard setting and quality assurance and emergency response.

The EMT 2030 Strategy[1] sets out the strategic direction and priorities for the EMT Initiative at global, regional, and national levels, envisioning "a world in which every country has the capacity to respond rapidly, effectively and flexibly to national emergencies, leveraging regional and subregional capacities to support vulnerable population and the people most in need". It calls for greater regionalization and a stronger focus on context appropriate national capacity building through adoption/adaption of a systematic approach.

Overall, the EMT Initiative represents a comprehensive approach to strengthening the health emergency workforce and building rapid response capacities that are quality oriented, interoperable, and standardized.

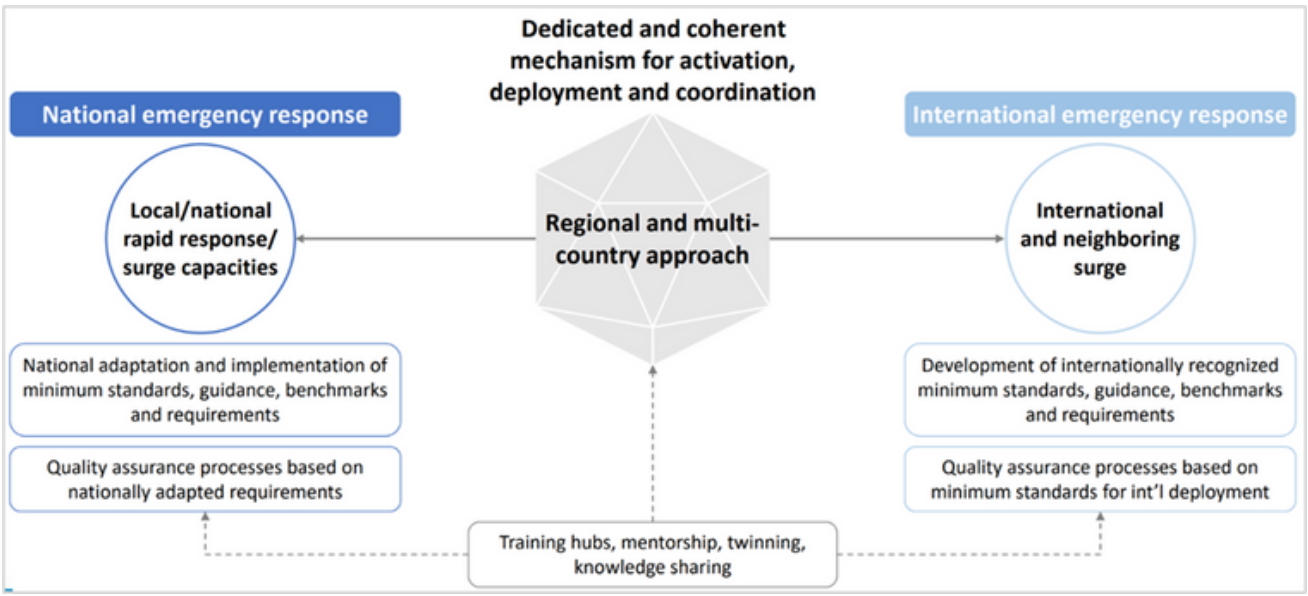


Figure 1. *An integrative approach of setting international standards for emergency response focusing on quality of care; fostering adoption and adaptation at national levels and facilitating the interaction and exchange through multi-country hubs.*

Results of the global EMT-RRT integration scoping project

Speakers: *Pryanka Relan, Technical Officer, Emergency Medical Teams Unit and Mays Shamout, Middle East and North Africa Regional Lead, Emergency Response Capacity Team*

This session provided an overview of the project results, highlighting the importance of learning from countries that have both RRT and EMT programmes – siloed or integrated. The Global RRT-EMT Integration Scoping Project, jointly conducted by the WHO EMT Secretariat and the US CDC, was groundbreaking in that it discussed integrating the management and operations of national RRT and EMT programmes. Despite their distinct mandates, RRTs and EMTs share a similar preparedness and response operational cycle, especially from a management standpoint. Mindful of the similarities and differences in each step, the team at the WHO EMT Secretariat and the US CDC delved into identifying if both programmes could be integrated and which areas in the operational cycle would be feasible and beneficial for integration.

Integration was defined as integrated programmes that utilize the same management team, funding, roster database, training, standard operating procedures, or other possible areas of integration within the management cycle. Areas of possible integration included management team, legal framework, administration, staffing and roster database, standard operating procedures, equipment/supplies, training, activation and pre-deployment procedures, deployment procedures, and post-deployment procedures (Fig 2.a&b).

The scoping project used a convenience sample of countries within each WHO region. Investigators selected the countries based on their knowledge of existing RRT and EMT programsme, identified focal points within each country, sent out a short online survey, and followed up with a 20–30-minute one-on-one interview. The survey focused on gathering information about the participants, the country's RRT and EMT programmes, and areas of integration. The interview focused on the programmes' similarities and differences, the pros and cons of RRT and EMT integration, and the facilitators and barriers to RRT and EMT programme integration.

Survey results

23 participants
(14 RRTs, 9 EMTs)

14 countries across all WHO regions

Cote d'Ivoire, Ecuador, Egypt, Ethiopia, Georgia, Iraq, Japan, Nigeria, Philippines, Qatar, Saudi Arabia, Senegal, Sierra Leone, Thailand

Oversight of the programme

Survey results

The integration of RRT and EMT programs was fully implemented in only two countries, Thailand and the Philippines. Six countries, including Georgia, Ethiopia, Senegal, Côte d'Ivoire, Qatar, and Saudi Arabia, expressed a positive stance towards integration. Three countries, Sierra Leone, Egypt, and Iraq were uncertain about the possibility of integration, while Nigeria and Ecuador mentioned that integration of programs was not possible.

The survey participants highlighted the importance of administrative considerations in improving the integration of RRT and EMT programs. Sustainable funding was identified as a critical area that needs attention for successful implementation. Other important areas included resource allocation, standardization of training and capacity building, and the development of a common platform for data sharing and communication among different programs.

Interview Results

During the interview, 82% (19/23) of participants actively shared their views on the integration process. The interview primarily focused on discussing the integration process, and the questions asked were aimed at exploring the various aspects of integration. The participants were asked to identify the similarities, the differences, and the pros and cons associated with it. The interview also included a detailed exploration of the facilitative and barrier factors that affect the integration process. Through sharing their insights, the participants shed light on the factors that face the integration process, such as effective communication, collaboration, shared vision, and goals. They also highlighted the factors that challenge the integration process, such as cultural differences, language barriers, and lack of resources.

Conclusions

The Global RRT-EMT Integration Scoping Project showcased the potential for integrating national RRT and EMT programs, identifying key areas for possible integration. Feedback from 23 participants across 14 countries revealed varied perspectives on integration, with a full integration model in Thailand and the Philippines. The project emphasized the need for administrative strategy, sustainable funding, and a unified platform for data sharing and communication to facilitate effective integration. This groundwork sets the stage for future efforts to enhance the coordination of health emergency response teams globally.

Potential models of integration

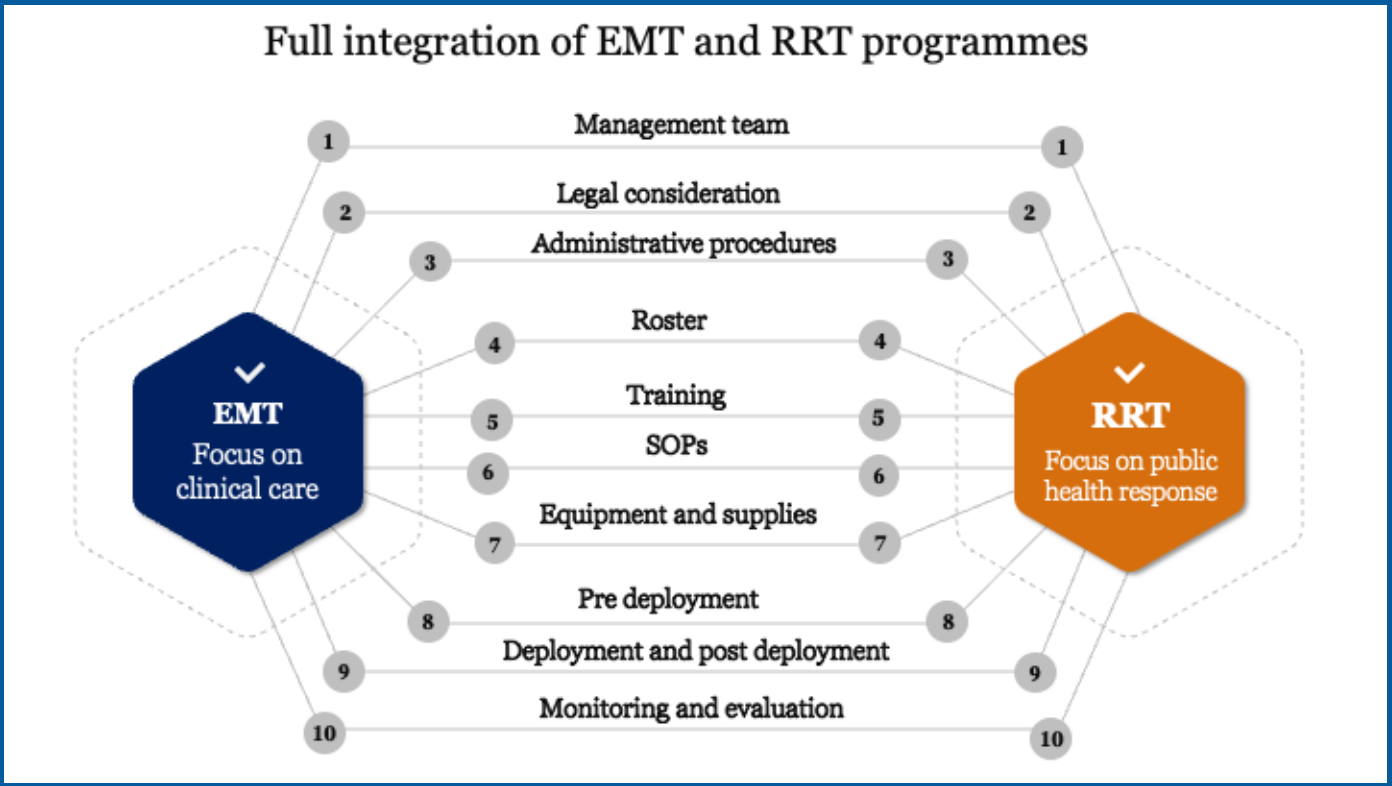


Figure 2.a. *Diagram showing full integration of EMT and RRT programme, all steps in the management cycle are integrated*

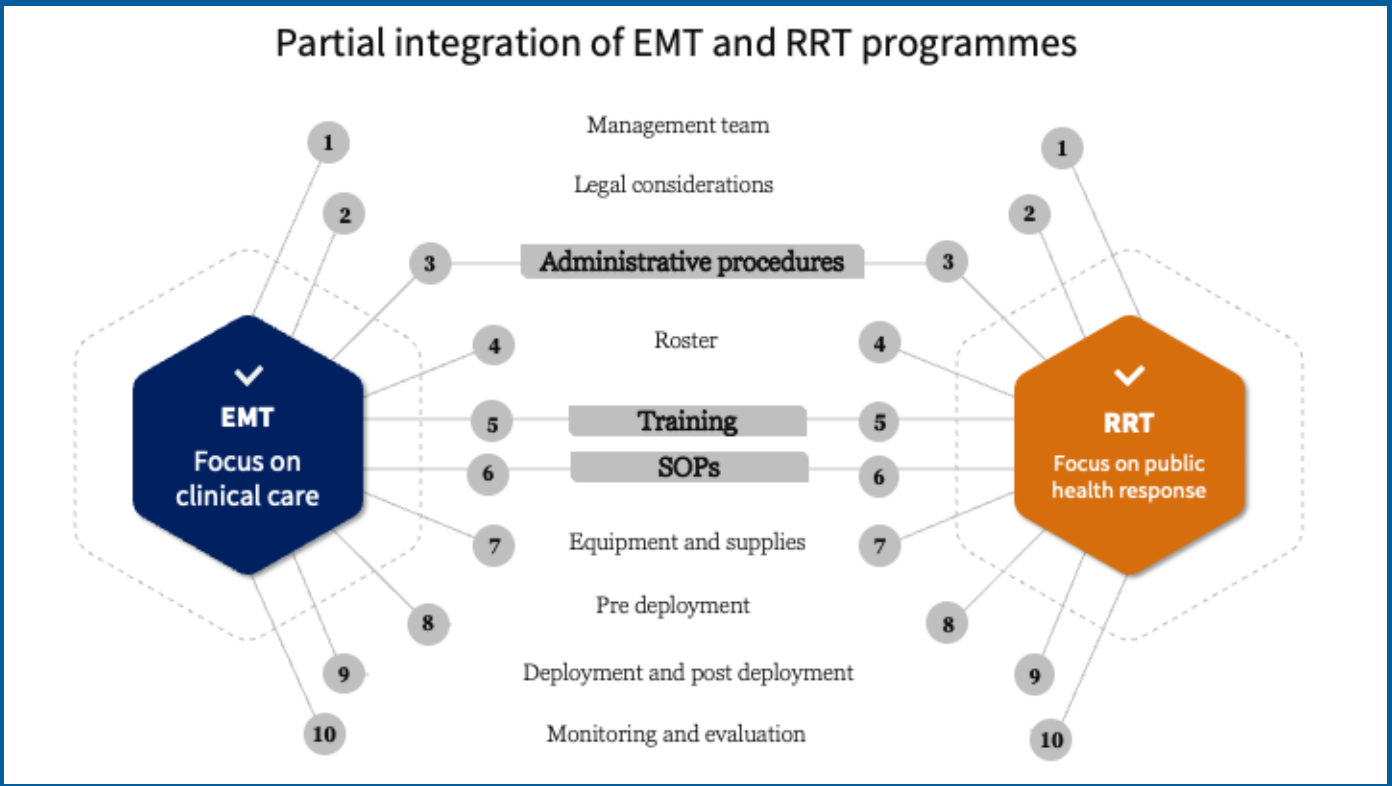


Figure 2.b. *Diagram showing partial integration of EMT and RRT programme, only some steps in the management cycle are integrated*

Regional experiences - Americas Region

***Speaker**: Luis De La Fuente, EMT Regional Focal Point, Regional Office for the Americas (AMRO)*

The speaker presented a brief on the III Americas EMT Regional Meeting, with 189 participants from 26 countries and 14 organizations. The meeting was a significant step towards implementing the EMT 2030 strategy in the region. Representatives from health ministries engaged in fruitful discussions on the integration of EMTs and RRTs and their alignment with the EMT 2030 strategic objectives. Mexico, Ecuador, and Chile shared their experiences with RRT and EMT integration following climate-related emergencies, showcasing the potential for positive change.

The discussions reiterated the importance of local and national responses, recognizing the unique contexts and challenges each country faces. The meeting emphasized the importance of adopting the EMT in standards as a common language across countries, ensuring a unified approach while respecting national adaptations.

Group photo during the 3rd EMT Regional Meeting of the Americas. Mexico City, Mexico. ©PAHO/WHO.

Country examples

Speakers: *Khalid Elkhateeb and Baher Eldesouki (Egypt), Yuichi Koido and Yoshi Toyokuni (Japan), Saidu Ahmed and John Oladejo (Nigeria), Jameel Talal (Saudi Arabia), Kasemsuk Yothasamutr and Charuttaporn Jitpeera (Thailand)*

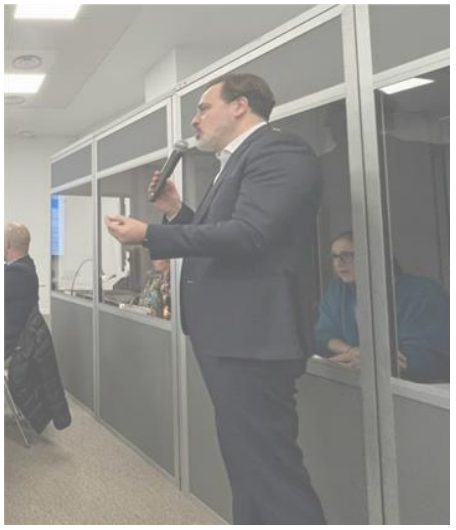
Five countries (Egypt, Japan, Nigeria, Saudi Arabia, and Thailand) shared insights on the role of EMT and RRT programmes in responding to health emergencies and how these programmes aligned in each country. Both programmes are well-established, with areas of collaboration such as:

- Directed by the common incident management center with support from national government organizations.
- Data sharing between EMTs and RRTs during climate-related and public health emergency response and mass gathering events.
- Having personnel with a background in public health as a member of the EMT.

Integrating RRTs and EMTs comes with challenges. Differences in legal frameworks, management practices, and operational models can complicate the process. The following country examples highlighted the main actions to overcome such challenges and achieve a successful integration.

Figure 3. *Diagram displaying the actions for successful integration derived from countries' experiences*

This meeting was instrumental in defining and understanding the concept of RRT-EMT integration into the national context. For instance, during the scoping project, two countries stated that they can't have integrated RRT-EMT programmes. However, consensus was reached on the importance of aligning both programmes and taking the initial steps toward the integration process.





Various moments of the workshop from member state presentations to facilitated discussions ©WHO.

Plenary discussion

Achieving consensus on the scope and relationships of national/sub-national EMTs and RRTs

Facilitators: *Camila Philbert Lajolo, Technical Officer, Emergency Medical Teams Unit, Country Readiness Strengthening, WHO Health Emergencies Programme*

It is crucial to grasp the distinct roles of EMTs and RRTs, as they are often referred to by different names and assume varying responsibilities within different countries. It is widely recognized that both EMTs and RRTs are indispensable in emergency response, with EMTs primarily focusing on direct clinical care and RRTs addressing broader public health aspects. Their collaboration is vital for enhancing overall emergency preparedness and response.

This session actively sought inputs from participants to achieve a consensus on the scope of national and subnational RRTs and EMTs. The process involved an online survey followed by a facilitated plenary discussion. Table 1 below presents the outcome of the discussion.

EMT is

- Multidisciplinary team
- Rapid clinical surge team, provides direct clinical care to patients affected by a large-scale health emergency and may conduct public health activities (detect and alert)
- Defined by guiding principles and core standards of WHO EMT Blue Book

EMT is not

- The same as a prehospital care team
- The same as an emergency medical technician

RRT is

- Multidisciplinary and multisectoral (One Health) team
- Provides public health support and coordinates with other response efforts for public health threats and health emergencies at the local level (all hazards)
- Advises on clinical management of patients, may initiate clinical care (not primary focus) but does not provide direct clinical care

RRT is not

- A rapid clinical surge team
- Hospital-based team
- Focused only on communicable diseases

Consensus from meeting participants about the scope and non-scope of EMTs and RRTs

Group work

Defining partial versus full integration of rapid response capacities for each segment of the operational cycle

Facilitator: *Mays and Pryanka. Group moderators: Latifa Arfaoui, Sherein El-Nossery, Paula Gomez, Hind Ezzine, Luis de la Fuente, Camila Philbert Lajolo*

In this highly interactive session, participants were divided into six groups. Each group was assigned one moderator and 1-2 areas in the EMT and RRT operational cycle. Moderators then guided the groups toward developing operational definitions of partial and full integration for their respective areas. The session culminated in each group presenting their definitions for discussion in plenary, while these are still working definitions, they capture the collective progress made. Table 1 below presents the outcomes of the group discussion, which will be further refined.

Table 1. *Working definition of partial and full integration per topic area*

Area	Operational definition	
	Partial	Full
Financial, administrative, and logistical considerations	Joint programme managers for common operations support but different logistics in the supply chain	Joint legal framework; governance & leadership; funding mechanisms; management teams; operational support teams; log (procurement, warehouse, etc.)
Staffing and rostering	Sharing to some extent exclusion/inclusion criteria depends upon the criteria of selecting staff	Sharing and integrating all the operation activities using central database
Training	Joint programme managers for common operations support but different logistics in the supply chain	That everyone knows the subjects of the curricular content, at basic or advanced levels according to their functions and competencies, budget, political will, and national regulations; full knowledge of each other's functions; exchange of international facilitators

Area	Operational definition	
	Partial	Full
Activation and pre deployment	Integration of activation procedures and pre-deployment briefing processes. Integration will not cover authority, activation criteria and resources	A single authority, common processes, integrated resources
Deployment	The definition of partial and full integration depends on the nature, duration, and continuum of deployment. If administratively coordinated, SOP-well defined, certain resources shared, and working in one information system, we can regard it as fully integrated; otherwise, it is partial.	
Post deployment	Following same procedures and structures but done in separate places and timing, mental and physical checks still the same, structure of debriefs is different, follow the same process for improvement but different person responsible but share information, share gaps and ideas.	All activities conducted by the same department with proper authority, following the same process for physical/mental health checks, for planning and improvement and structure of debriefs is the same and done together.
Monitoring and evaluation	Common data but also EMT/RRT specific data, which will reflect in the ME framework, share software/platform and IT infrastructure. Separate data managers. Separate budget plans but same fund source and separate HR. and IT infrastructure. Shared /budget plan and HR resources.	One department, one dataset applicable to both RRT and EMT, same person managing data/info, same ME (combined) framework, share software/platform and IT infrastructure. Shared /budget plan and HR resources.

Key Outcomes

- A Guidance Document to help streamline civil and military medical interactions in emergency response should be developed
- Challenges exist around establishing a common language and in aligning standards in different types of scenarios
- Increased cross-training as well as joint civil-military simulation exercises are needed

Group work

Benchmarks for integrated programmes

***Facilitators**: Pryanka Relan, Technical Officer, Emergency Medical Teams Unit and Mays Shamout, MENA Regional Lead, Emergency Response Capacity Team*

In this session, the groups advanced the discussions from the previous day. As integration was defined, participants developed benchmarks for the ten areas of possible integration between RRT and EMT programmes. These benchmarks will facilitate monitoring progress towards integration.

Financial, administrative and logistics considerations

- Appointment of joint Programme managers for common operations support and logistics in the supply chain
- Appointment of an admin support unit to cover financial and legal considerations according to established mechanisms and procedures for HR mobilization, compensation, medical, disability, and life insurance, safety and security, and emergency evacuation.
- Appointment of procurement team/unit compiling needs identified by Programme Managers, identifying suppliers, and ensuring the procurement of supplies and equipment
- Establishing a common warehouse and database run by an appointed warehouse management team (tracking items, expiration dates, resupplying needs, quantities, packaging, etc.).

Staffing and rostering

- A common shared database platform (roster) managed by a roster manager
- Agreement on key functions and ToRs
- Common agreed procedures (SoPs) for running the roster
- Established staffing strategy as per identified threats
- Safety and security requirements for HR

Group work: benchmarks for integrated programmes

Training

- Create a specific chapter for training within the national health regulations
- Generate a fixed budget for team training
- Develop a differentiated training plan that considers general topics and topics specific to each team
- The training plan should consider target groups, including team members and administrative and technical operational decision-makers.
- Establish an integrated annual schedule of training activities.
- Create a group of trainers/facilitators with in-depth knowledge of the 2 teams and their administrative and operational functioning.
- Institute a periodic certification and recertification system (the periodicity may vary depending on the type of team).
- Establish a monitoring procedure for continuous improvement of training and evaluation of results.

Activation and pre deployment

- Create a regulatory framework to integrate the two programs and designate the responsible authority
- Designate a lead for activation and pre-deployment aspects
- Develop a joint pre-deployment activation standard operating procedure for both teams, including:
- Activation criteria.
- The process for determining the composition of the teams to be deployed (to be defined according to the type of emergency)
- Just-in-time training
- Allocation of human and material resources and budget to the integrated programme

Deployment

- Development of a common travel logistics plan
- Development of common team deliverables taking into account the specific functions/ details of the EMT and RRT
- Development of a similar/ common approach for team evolution
- Process must be established for

Post deployment

- Combined final mission report with key activities conducted, outcomes, and recommendations for RRT and EMT.
- One “clinic” conducting mental/physical checks post-deployment for RRT and EMT, using the same checklists and other tools, identified the healthcare team with clinical and psychological skills. Confidentiality protocols in place
- Team formally assigned to manage the post deployment debriefs and improvement planning and action using standardized common tools.
- Coordinator identified to communicate the results to the leadership and to oversee post deployment activities for both.

Monitoring and evaluation

- Common team formally assigned to manage ME
- A common coordinator was identified to communicate the results to the leadership and to oversee ME activities for both.
- Common updated database for RRT/EMT contemplating logistical, technical, training, and rostering aspects hosted in one department. Shared access.
- Set of Key performance indicators (KPI) identified and monitored for programme management and response; set is shared by both teams.
- Common platform for managing data from response including a set of shared indicators and a set of function-specific indicators (ex: MDS for EMTs and specific data RRT) - epidemiological, clinical, facility capacity/lab data
- Joint evaluation form analyzing the performance of both teams
- Data privacy protocols in place

Plenary discussion

What does your country need to integrate EMT and RRT programmes?

***Facilitators**: Pryanka Relan, Technical Officer, Emergency Medical Teams Unit and Mays Shamout, MENA Regional Lead, Emergency Response Capacity Team*

To wrap up the first two days of the global consultation, facilitators inquired about the resources or tools the participants believed would be beneficial in helping their country establish or enhance an integrated RRT-EMT programme. The participants suggested the following as essential levers for integration:

- **Leadership advocacy**
- **Country mentorship (i.e., twining approaches)**
- **Global, regional, and national frameworks**
- **Guidance on partial and full integration, adaptable to country's context, including benchmarks**
- **Case studies highlighting the impact of integration on aspects such as efficiency and effectiveness**
- **Development of integrated training curriculum, including managers training and joint simulation exercises**
- **Funding mechanisms**



Above: Presentations of response experiences to different sudden onset disasters. ©WHO.

Part B
Monitoring, evaluation and learning for rapid response teams

RRT management overview and introduction to 7-1-7

***Speaker**: Mays Shamout, MENA Regional Lead, Emergency Response Capacity Team*

Establishing in-country RRTs increases capacity to respond to public health events, meets the International Health Regulations (IHR) requirements, and ultimately contributes to a more prepared community. RRTs can be an effective response mechanism and have historically been used for a wide range of public health emergencies, including influenza, mass gatherings, and COVID-19. RRT management is an important first step in ensuring a sustainable and effective RRT programme. RRT management requires a dedicated and motivated staff to oversee the development and updating of SOPs, management of the RRT roster, training of RRT members, implementation of critical operations, instituting M&E of the programme, and advocating for funding and resources to support the RRT programmes and its members.

The speaker provided a wider context for the establishment of the Global Rapid Response Team (GRRT) at the US CDC as a response to lessons learned from the 2014 West Africa Ebola epidemic to strengthen the response to public health emergencies. Three common challenges in emergency response and workforce management were identified and justified the establishment of the US CDC RRT programme:

- **Lack of developed and maintained functional emergency roster**
- **Shortage of trained staff with relevant competencies needed to be effective in an emergency**
- **Lack of defined plans and standard operating procedures for the non-emergency and emergency phases**

RRT management

RRT management is an important first step in ensuring a sustainable and effective RRT programme. The three main goals of management are:

- **Coordination:** integrate and/or align RRT planning and operations with emergency response infrastructure.
- **SOP development:** plan and standardize RRT preparedness and response activities for a more efficient public health response.
- **Implementation:** identify and prepare a trained and ready public health workforce.

The steps in the RRT programme management can be divided into two phases: the non-emergency phase and the emergency phase, as shown in (Fig 4).

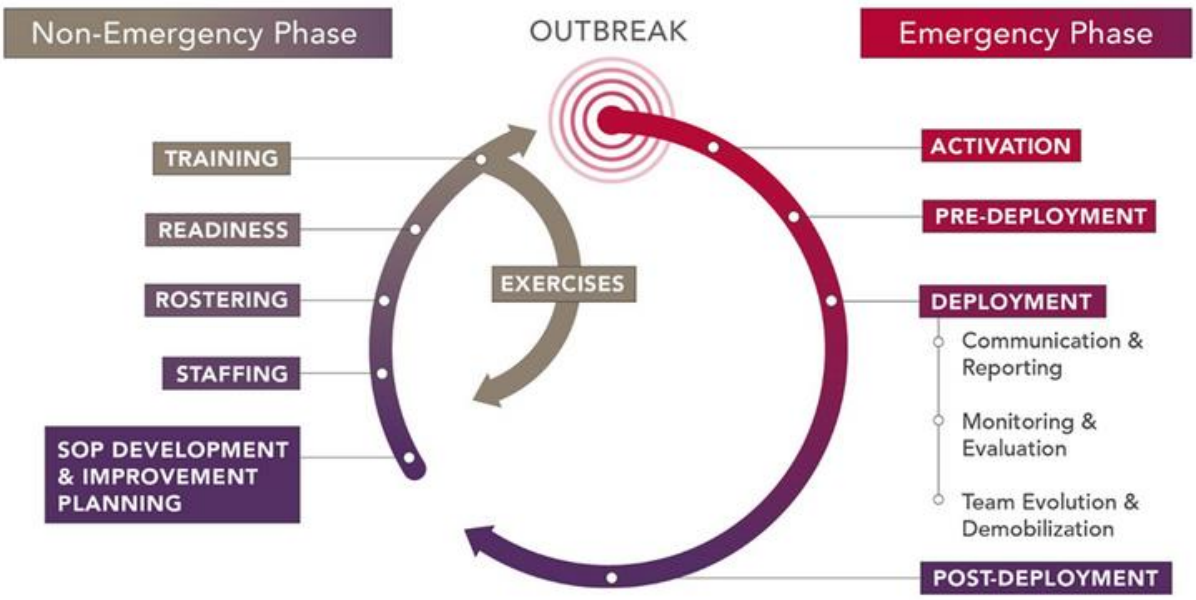


Figure 4. *RRT (and EMT) operations in non-emergency and emergency phases*[2]

RRT management and 7-1-7

The 7-1-7 is an approach developed by "Resolve to Save Lives" based on the idea that every public health event is an opportunity to learn and improve.[3] This approach can be utilized by the RRT management programmes to assess systems performance for detection, notification, and response to disease outbreaks or other public health emergencies and identify challenges and enablers for rapid performance improvement.[3] It was It includes three timeliness metrics and targets (Fig 5):

- **Time to detect**: Seven days to identify a suspected public health threat (time between emergence of a public health threat and detection)
- **Time to notify:** One day to inform the appropriate public health authorities (time between detection and notification)
- **Time to complete early response:** Seven days to initiate an effective response (time between notification and early response completion)

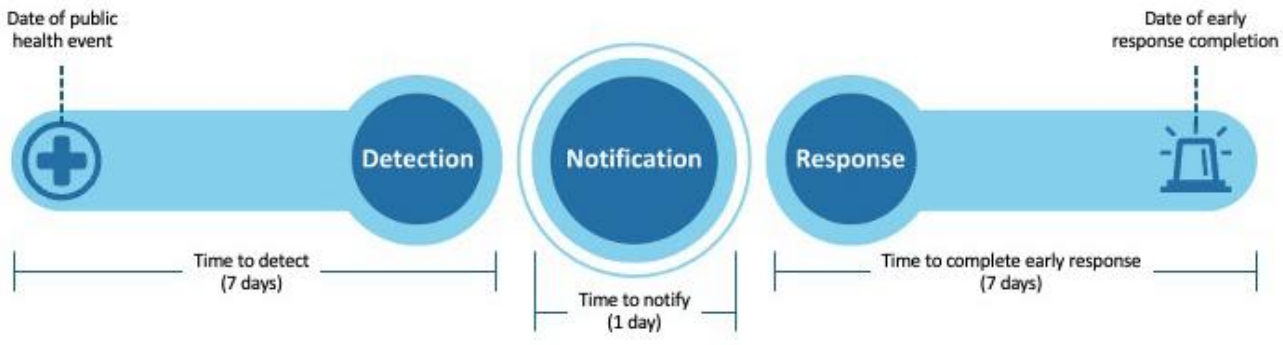


***Figure 5**. 7-1-7 timeliness metrics and milestones*

RRT competency framework and its relationship with RRT monitoring and evaluation framework

***Speaker**: Paula Gomez, Technical Officer, Learning Solutions and Training Unit (LST), Country Readiness Strengthening (CRS), WHO Health Emergencies Programme (WHE)*

A competency framework offers a structured description of competencies required in an area of work; they may be organized by: competency domains, competencies and behavioral indicators. Competency is the ability of a person to integrate knowledge, skills, and attitudes in performing tasks in each context. Competencies are durable, trainable, and measurable through the expression of behaviors.

The LST/WHO developed in 2022, an RRT Competency Framework (Fig 6) to be used for:

- Workforce development: as a standardized reference for RRT workforce development.
- Training programme development: as a foundation for learning programmes and curricula development for RRTs, including credentialing.
- Creating learning pathways towards the professional development of RRT members/managers/trainers.
- Needs assessment: as guidance in developing a self-assessment or observer assessment tool to identify individual or group needs and guide staff development planning.
- Self-assessment: as guidance for individuals in assessing their current knowledge, skills, and abilities, identifying areas in need of improvement.
- Specific job descriptions: as guidance in writing standardized job descriptions.
- Performance assessment: as guidance in developing tools to assess performance.

In parallel, WHO developed a new RRT Training programme in 2022. This programme is a structured collection of learning resources, including learning materials, guidance, and tools, enabling Member States to plan, implement, and evaluate customized training for RRT managers and members at national and subnational levels.

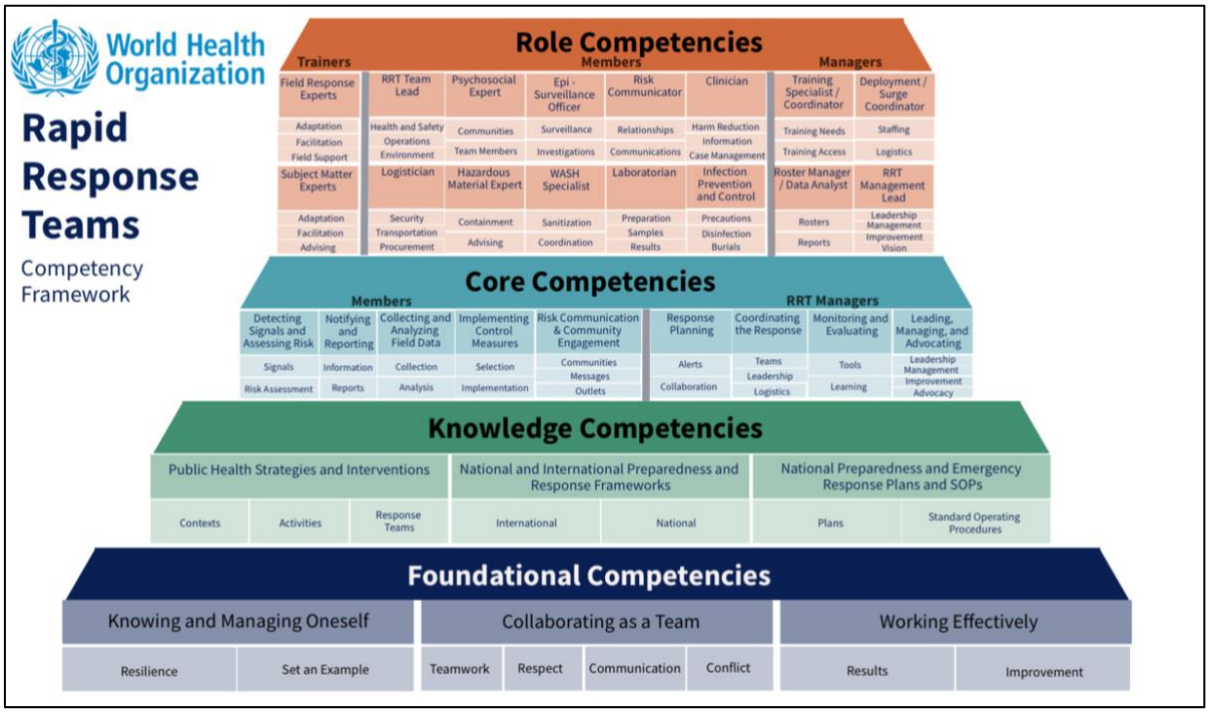


***Figure 6**. RRT competency framework*[4]

It is recommended to include indicators pertaining to competencies in the monitoring and evaluation framework for RRT programs. Key performance indicators should also be employed for this purpose. Examples of indicators to assess certain competencies outlined in the RRT competency framework (RRT CF) include:

Role competencies

- Percentage of outbreaks that reported logistic challenges
- Multidisciplinary score of the RRT programme
- Percentage of the RRT members who received capacity building
- Percentage of the RRT members with demonstrated competencies
- Percentage of the deployed RRT members pulled from the roster
- Hospital admission rate by outbreak
- Percentage of outbreaks completed the timely response steps within seven days
- Average duration of receiving sample results by outbreaks
- Percentage of the samples delivered to the Lab in appropriate condition
- Percentage of outbreaks detected within seven days of emergence

Knowledge competencies

- Readiness score of the RRT programme

Core competencies

- Percentage of requested emergency assistance fulfilled by RRT programme
- Number of evidence-based strategies\approaches that strengthened RRT programme
- Percentage of outbreaks with actively engaged communities
- Percentage of outbreak fulfilling timely response standards (7-1-7)
- Average duration of response by outbreak type
- Percentage of the outbreaks notified to the health authority within one day of detection

Foundational competencies

- Satisfaction rate of RRT members

Monitoring and evaluation overview

***Speaker**: Camila Philbert Lajolo, Technical Officer, Emergency Medical Teams Unit, Country Readiness Strengthening, WHO Health Emergencies Programme*

Monitoring and evaluation[5] are essential to gauging whether outcomes have been achieved, identifying improvement opportunities, and fostering transparency and accountability. There are many models and definitions for M&E, but the overarching goal is the same: Is the programme performing as expected? Below is one possible definition:

MONITORING is a continuous function that uses the systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress in achieving objectives and progress in using allocated funds.

EVALUATION is the systematic and objective assessment of an ongoing or completed project, programme, or policy, including its design, implementation, and results. The aim is to determine the relevance and fulfillment of objectives, development efficiency, effectiveness, impact, and sustainability. An evaluation should provide information that is credible and useful, enabling the incorporation of lessons learned into the decision-making process of both recipients and donors.

This session presented participants with a practical approach to understanding the performance of their RRT programme. It started with an engaging pool to gauge their knowledge about M&E, revealing that most participants had intermediate knowledge about the subject. The approach used during the session encompassed three questions based on the Model for Improvement[6], to define a M&E framework, as shown in (Fig 7).

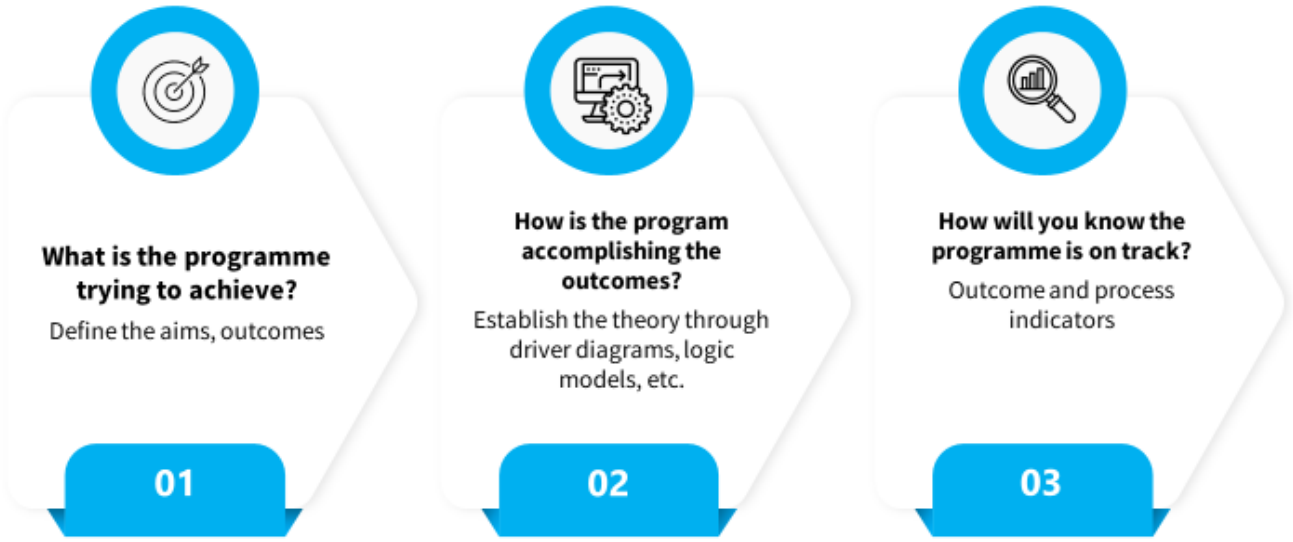


***Figure 1**. Three questions to think about when planning for M&E*

The speaker recalled that there is no consensual definition of what an indicator is, but there are three possible types[7]:

- **Outcome indicators:** inform how the programme is performing and what results it achieved.
- **Process indicators:** the voice of the workings of the system. Are the parts or steps in the system performing as planned?
- **Balance indicators:** looking at the system from different directions/dimensions. Unintended consequences of the programme or project.

Group work: what is the RRT programme trying to achieve?

***Speaker**: Camila Philbert Lajolo, Technical Officer, Emergency Medical Teams Unit, Country Readiness Strengthening, WHO Health Emergencies Programme*

This hands-on group work session will discuss the RRT programme aims/outcomes and their respective indicators. Participants were divided into five sub-groups and carried out the work in two steps:

Step 1: Sharing the aims/outcomes of their RRT programme by answering the question: What is your RRT programme trying to achieve? What does success look like for your RRT programme? Followed by brainstorming what should be the aim(s)/outcome(s) of an all-hazards RRT programme.

Most groups agreed that the RRT programme aims to respond effectively and timely to public health events in coordination with other response efforts. Two groups expanded the aim to efficient emergency preparedness and recovery, two included risk assessments and only one group emphasized the role of this programme in the detection of public health events.

After discussing in plenary, participants agreed that an RRT programme aims to:

- **Sustain the management of the RRT programme by embedding the plans, policies, and procedures as part of the public health structure.**
- **Increase efficiency and effectiveness of RRT response to public health events.**

Step 2: Based on the RRT programme outcomes defined in the first step, each group was assigned one outcome to define its indicator(s) that would be relevant to measure if the programme has achieved the outcome(s) with a focus on what is it important to measure. It was recommended to consider measures/indicators already being collected and/or feasible to collect.

Draft indicators for outcome 1: "To sustain the management of the RRT programme through the institutionalization of the plans, policies, and procedures as part of the public health structure", the groups suggested the following indicators:

GROUP 1	• Existence of decree/legal instrument on the institutionalization of the programme, addressing financial issues, operations, training, information management, and chain of command (SOPs should be mentioned on the decree/legal instrument) • % of After-Action Reviews conducted after public health events • % of RRTs established at the subnational levels • Existence of certification requirements for RRTs • % of RRTs that meet the certification requirements • Existence of a programme management and infrastructure for the RRT programme • Existence of an identified budget line/contingency fund for the management and mobilization of the RRTs (for preparedness and response phases) • % of trained and skilled workforce available to deploy upon request
GROUP 2	• Publication of the regulatory framework for the implementation of the EIR programme: Yes/No • Degree of implementation of the regulatory framework (%) • Allocation of a budget line for the RRT programme: Yes/No • Development/update of a strategic plan for the RRT programme: Yes/No • Degree of implementation of the strategic plan (%) • Proportion of standard operating procedures developed (%) • Proportion of human resources profiles required for the RRT management team • Degree of implementation of the RRT training plan(%)
GROUP 3	• Presence of official document endorsed by government indicating existence and integration of RRT programme into public health structure (yes/no) • % RRT members certified as at least basic RRT responder (annual) • # subnational regions signed official document to adopt RRT programme • 10% increase in annual activities conducted by RRT programme • Annual allocation of budget to RRT programme (existence: yes/no) • Presence of RRT programme inclusion in flexible funding mechanism (yes/no) • % of trained and skilled workforce available to deploy upon request

Draft indicators for outcome 2: "To Increase efficiency and effectiveness of RRT response to public health events", the groups suggested the following indicators:

GROUP 4	• % of events that meet the last 7 of the 7-1-7 metrics • Average time to initiate programme activation • % of deployers arriving the field withing 24 - 48 hours from programme activation • % of public health event responded by a well-equipped team • % of RRT members who received pre deployment briefing • % of RRT members who met their field objectives • % of public health event
GROUP 5	**Effectiveness** • Data quality (accuracy, specificity and sensitivity) • Safety and medical coverage (number of occurred incident and % of medical care practioners covered) • Timeliness of IM • Manuals templates guides • Coordination • Training • Surge capacity (Staff, space, system, supplies) • Well-being basic human needs (Food, place to rest, psychosocial) **Efficiency** • Time (activated deployment) • Finance (Covered incident) • Materials & Equipment • HR (% of qualified staff)

Group work: what could be measured for each step in the operational cycle?

***Speaker**: Camila Philbert Lajolo, Technical Officer, Emergency Medical Teams Unit, Country Readiness Strengthening, WHO Health Emergencies Programme & Mays Shamout, MENA Regional Lead, Emergency Response Capacity Team, US CDC*

This session focused on identifying process indicators for the RRT programme management cycle steps (Fig 8). Participants were divided into six groups and assigned to a set of steps in the management cycle. Using the checklist outlined for each step, each group brainstormed a list of indicators to measure whether the steps were performing as expected, with a focus on the critical things to measure. Both quantitative and qualitative methods could be used.

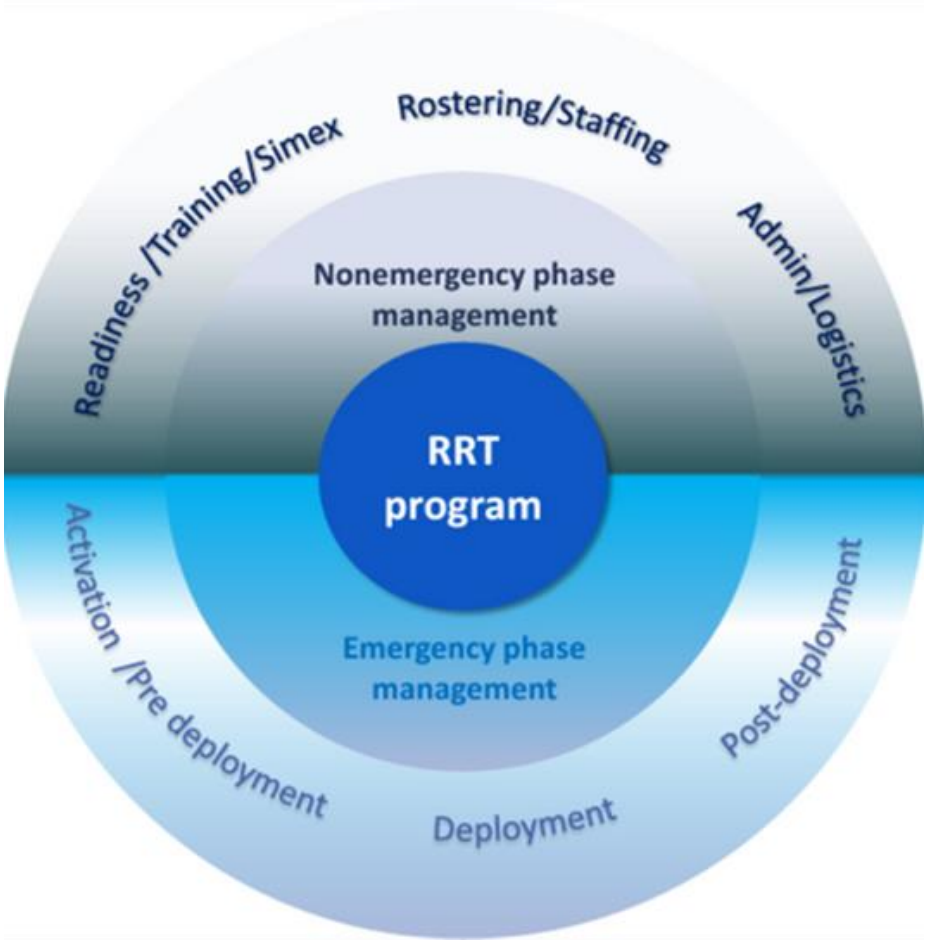


***Figure 2.** The RRT management cycle*

Group work: what could be measured on each step of the operational cycle

Group 1: RRT administration

Goals

- Create a specific chapter for training within the national health regulations
- Address administrative obstacles to the rapid mobilization of staff
- Fairly compensate RRT members (given available resources)
- Protect and support mobilized RRT members

Indicators

- Development of a standard operating procedure for administrative and logistical considerations: Yes/No
- Approval of said SOP by the competent authority: Yes/No
- % mobilization of funds necessary for the deployment of RRT
- % of RRT members with up-to-date contracts
- % of RRT members whose medical monitoring is up to date
- Number of days out of stock of equipment required for deployment (per item)
- Availability of means of transport for the deployment of RRT

Group 2: Staffing and rostering

Goals

- Maximize response efficiency by rapidly identifying staff with needed skills for the emergency response
- Maximize response effectiveness by broadening response capacity through identification of staff with special skills needed for rare events
- Identification of additional surge staff for large or long-term responses

Indicators

- Average time to identify and deploy staff with the required skills
- Percentage of recruited staff with expertise in multiple sectors
- Percentage of rare events where identified staff with special skills are deployed.
- Percentage of RRT members with complete data profiles.

Group 3: Training and readiness

Goals

- **Technical training**
  - Scientific and public health content
  - What RRT members need to know to be effective public health responders
  - Can be role-specific
- **Readiness**
  - What RRT members need to know for a safe and efficient mobilization
  - Usually, the same for all members, regardless of role

Group work: what could be measured on each step of the operational cycle

Group 3: Training and readiness

Indicators

- **Technical training (relevant to all)**
  - Percentage of RRT members trained on IMS
  - Percentage of RRT members trained in basic IPC and PPE donning and doffing
  - Number of RRT members who completed basic self-learning mandatory technical training
  - Number of RRT members that have gone through simulation exercise every year/two years

- **Technical training (relevant to all)**
  - Number of RRT team leads who have gone through leadership training
  - Percentage of epidemiologists who have completed FETP/national epi training
  - Percentage of RRT members that have completed specialized training in their technical area (IPC, risk communication, laboratory, CBRN, etc.)

- **Readiness training, Percentage of RRT members who have completed**
  - Safety and security training
  - Communication means
  - Policies and procedures
  - Information management
  - Coordination with other partners
  - Mental health

Group 4: RRT activation & Pre-deployment

Goals

- **RRT activation**
  - Maximize response efficiency by reducing the time needed for activation processes
  - Maximize response efficiency by identifying appropriate team composition, minimizing the human resources used by strategically selecting staff
  - Maximize response effectiveness by selecting staff with the skills to effectively address the response needs

- **RRT pre-deployment**
  - Maximize response efficiency by standardizing processes in preparation for RRT member deployment
  - Maximize response effectiveness by providing RRT members with information, equipment, and supplies necessary to respond appropriately to the specific emergency

Group work: what could be measured on each step of the operational cycle

Group 4: RRT activation & Pre-deployment

Indicators

- **Existence of SOP for activation including responsible authority and procedure flowchart for decision making (yes/no)**
- **Timestamps**
  - Time of alert of event / time of request for RRT
  - Time of acknowledgment of request / offer of the team to deploy
  - Time of financial / logistic mechanism activation
  - Time of customs / border activation (as applicable)
  - Time of contacting the on-call team for activation
  - Time RRT arrives at the ground / operation start
- **# staff who deployed to a response meeting pre-set minimum criteria for a specific hazard**

Group 5: Deployment

Goals

- Maximize response efficiency by reducing duplication of response efforts through coordination with the EOC and response partners
- Maximize response effectiveness by monitoring the emergency status and response activities to ensure response efforts are making an impact
- Maximize response effectiveness by modifying team composition and structure to effectively address evolving response needs

Indicators

- % of events responded to by the RRT programme
- % of daily reports shared with the RRT manager
- Average time between deployments by team / by person
- Average time during deployment
- Number of disciplinary actions taken by RRT manager due to unethical behavior
- Number of logistical challenges experienced during deployment
- % of RRT members who received handover

Group 6: Post-deployment

Goals

- Maximize the health and well-being of returning responders
- Maximize response efficiency and effectiveness by identifying
- What activities functioned well, so they can be continued
- What activities did not function well / gaps exist, so they can be improved

Indicators

- % of deployed RRT members who de-briefed post-deployment
- % of RRT members that required physical / mental health support post-deployment
- % of logistical / operational challenges experienced by RRT members
- % of completed RRT mission report / participated in the after-action review
- % of RRT members satisfied with the programme support received during deployment

Regional experience in drafting RRT M&E results framework, EMRO

***Speaker**: Sherein Elnossery, Technical Officer, Infectious Hazard Prevention and Preparedness (IHP), Regional Office for the Eastern Mediterranean Region (EMRO)*

This session provided an overview of a Monitoring, Evaluation, and Learning (MEL) framework for the RRT programme drafted by the WHO EMRO region. It addressed the draft framework's objectives, development methodology, conceptual design, and proposed indicators. it also described the validation process the framework went through. EMRO developed the MEL framework for RRT programmes in a three-phased approach (Fig 9) to allow for common understanding and reliability and adopted a results framework as its underpinning methodology.

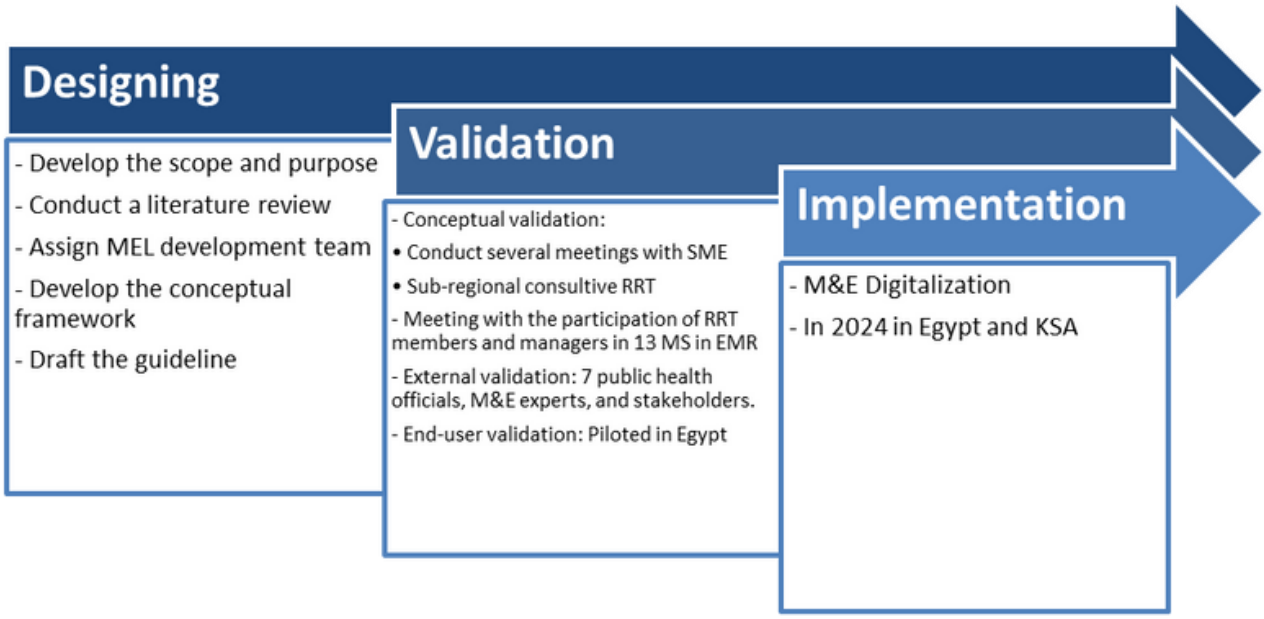


***Figure 3.** Three-phased approach for the development of the EMRO MEL framework for RRT*

The results framework (Fig 10) allows managers to monitor the achievement of results and adjust relevant programme activities when necessary. It gives the reader an instant idea of what a programme is trying to achieve. The speaker recalled that this guidance offers the basic structure for the results framework; more outcomes or indicators could be added or removed to match the country context. It was built based on the RRT management cycle considering the following outcomes:

- **For the preparedness phase:** efficient operation of the RRT programme
- **For pre-deployment and deployment:** successful response to the public health emergency
- **For post-deployment:** institutionalization and sustainability of RRT programmeme

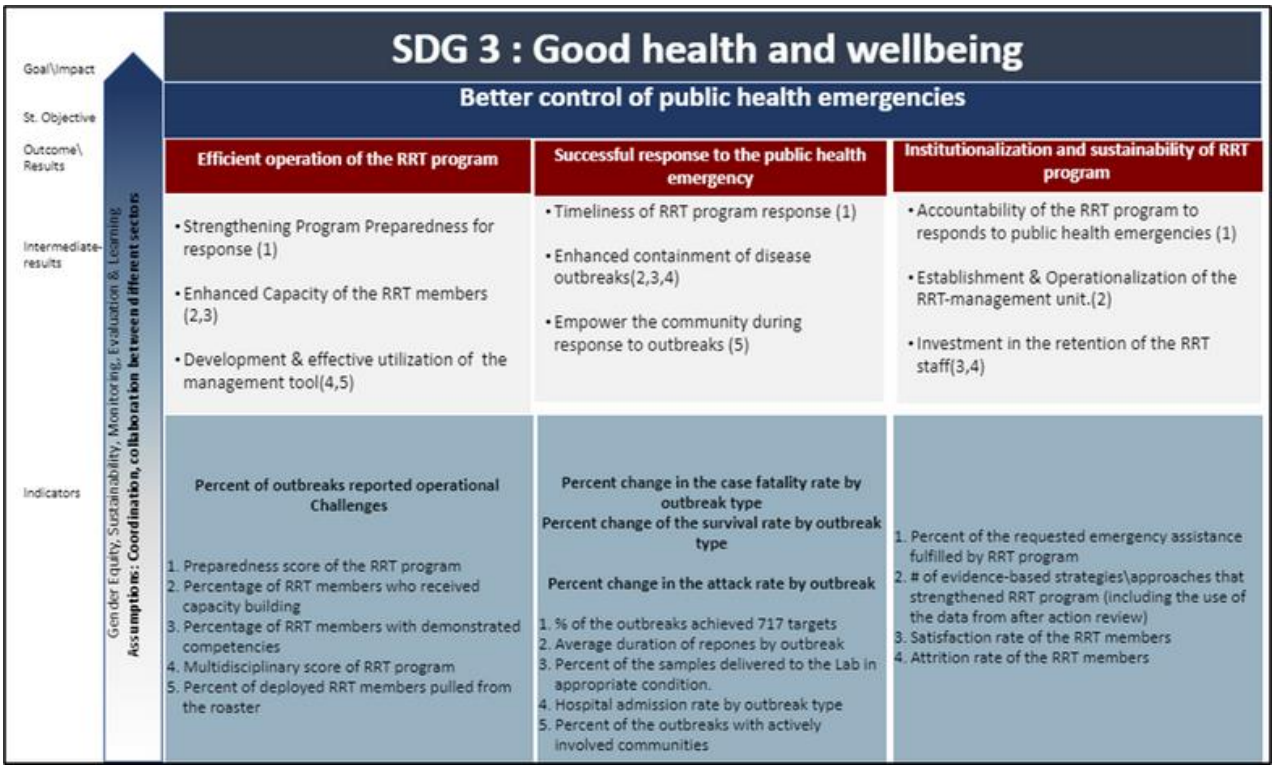


Figure 10. The EMRO RRT results framework

Furthermore, the framework suggests data collection tools, including a preparedness score checklist, an operational challenges checklist, an RRT multidisciplinary checklist, community engagement tools, an RRT satisfaction score, and an early action assessment tool. At the end of the session, the speaker emphasized the importance of MEL as a continuous improvement process to enhance the team's performance. MEL serves as a tool to showcase the contribution of the RRT toward achieving its objectives, and it should not be used for attribution, blame, or punishment. It's crucial to adapt MEL to the context of the country where it's being implemented. Furthermore, using core indicators with standard definitions and calculation processes allows countries to participate in wider learning opportunities and the sharing of experiences, thus exchanging knowledge.

Participants provided feedback on indicators outlined in the EMRO draft MEL framework through an online survey. For each one of the 27 indicators, the survey asked the following yes/no questions:

1. Is this an RRT programme management level indicator?
2. Is this indicator applicable to all hazards?

The survey was run twice to ensure a clear understanding of the question and the validity of the results. (Annex 3).

Egypt national RRT programme monitoring, evaluation and learning

***Speaker**: Sherif Shamseldein, National RRT Manager, MoHP, Egypt*

This session started by recalling that RRT MEL is a priority in Egypt. Decision makers and communities were asking about RRTs' efforts to overcome the pandemic and how they help the communities against the COVID-19 pandemic. The speaker explained the National RRT programme steps for MEL and the important milestones (Fig 11).

Egypt undertook a meticulous process of adopting and adapting the basic RRT result framework, originally developed by EMRO, to its unique national context. This process began with a careful selection of just 20 indicators, marking the initial step in piloting its system and data collection tools, and integrating them into its Database.

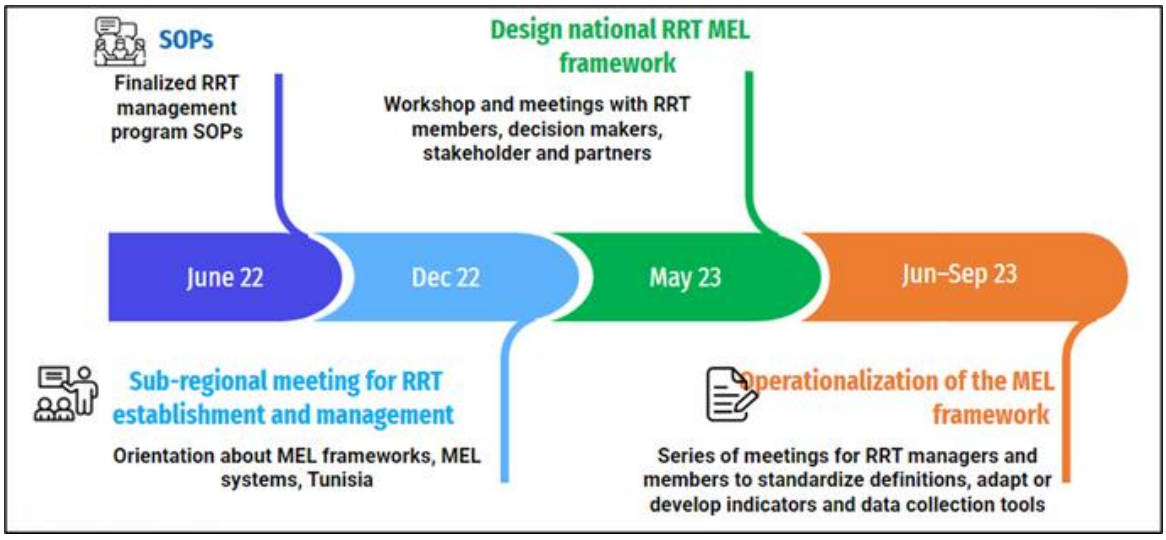


***Figure 11.** Egypt national RRT programme's steps in MEL*

With a keen focus on national needs, Egypt strategically considered around 15 core indicators and five tailored indicators. These indicators were chosen to comprehensively cover the main activities, including aspects related to communities, accountability, indicators for the decision-makers, and advocacy. The current focus is on seamlessly integrating these indicators into their main Database.

Based on their experience, the speaker explained that MEL is not only about measuring the programme's performance and progress, but it also contributes to:

- **Standardizing tools (e.g., Assessment of progress in RRT member satisfaction through the application overtime of a standard survey).**
- **Improving data quality allowed for a less narrative and more data-informed report.**
- **Using evidence-based data for advocacy efforts.**
- **Planning: prioritized our activities based on the findings e.g., prioritizing training of the technicians in the field after tracking the indicator of percentage of laboratory samples submitted to the laboratory in appropriate conditions.**

MoH representatives are presenting Egypt's national RRT program MEL / ©WHO.

Conclusion and future perspectives

Conclusion & future perspectives

The meeting was a tangible step forward, demonstrating substantial progress in shaping the RRT/EMT integration and a global RRT MEL framework. It sets the stage for developing actionable global guidance on both themes, highlighting the promising path ahead (Annex 4). Regarding integrating RRT and EMT programmes, the way ahead includes refining the integration definitions and benchmarks and designing, piloting, and rolling out national consultations. The way ahead for the MEL framework for RRT programmes involves developing a globally applicable framework.

Integrating RRT and EMT programmes is a pivotal step towards interoperable, effective, and efficient rapid response capacities, strengthening the overall response to public health emergencies. This integration amplifies the overall capacity to manage crises, from outbreak control to patient care, ensuring a streamlined operation. It also fosters improved communication, coordination, and resource allocation, leading to enhanced health outcomes and a reduction in the morbidity and mortality associated with disasters and outbreaks. The collaboration between these teams is not just beneficial but essential for building resilient health systems that can effectively combat emerging health threats.

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Annexes

Annex 1: Meeting agenda

Day 1 – 12 December 2023		
Time	**Topics to be covered**	**Presenter(s)**
0830-0900	Registration	Participants
0900-0930	Welcome and Introductions	Nedret Emiroglu
0930-0945	EMT Initiative at global, regional, and national levels	Flavio Salio
0945-1000	RRT programme development at national level	Ashley Greiner
1000-1020	Presentation of results of Global RRT EMT Integration Scoping Project	Pryanka Relan & Mays Shamout
1020-1030	Regional experiences: AMR	Luis de la Fuente
1030-1100	Break	
1100-1115	Country example 1: Eastern Mediterranean Region	Saudi Arabia / Egypt
1115-1130	Country example 2: South-Esat Asia Region	Thailand
1130-1145	Country example 3: Western Pacific Region	Japan
1145-1200	Country example 4: African Region	Nigeria
1200-1330	Lunch	
1330-1430	Panel	Moderator: Camila Philbert Lajolo
1430-1500	Plenary discussion: Achieving consensus on scope and relationships of national/sub-national RRTs and EMTs	Moderator: Camila Philbert Lajolo
1500-1600	Didactic: Group work instructions and example Breakout groups: Defining partial vs full integration of RRT-EMT for each segment of operational cycle	Pryanka Relan and Mays Shamout 7 groups, 5 persons per group:
1600-1630	Summary in plenary	Moderator: Pryanka Relan and Mays Shamout

Day 2 – 13 December 2023		
Time	**Topics to be covered**	**Presenter(s)**
0900-0930	Summary of Day 1	
0930-1100	Didactic: Group work instructions and example Breakout groups: Benchmarks for partial vs full integrated programmes	Pryanka Relan and Mays Shamout 7 groups, 5 persons per group
1100-1130	Break	
1130-1200	Summary in plenary + discussion	Moderator: Pryanka Relan and Mays Shamout Facilitators of 7 groups; 10 minutes per group
1200-1330	Lunch	
1330-1430	Summary in plenary + discussion (continued)	Moderator: Pryanka Relan and Mays Shamout Facilitators of 7 groups; 10 minutes per group
1430-1530	Plenary discussion: What does your country need to integrate programmes?	Moderators: Pryanka Relan and Mays Shamout
1530-1600	Summary of day 1 and 2	Pryanka Relan and Mays Shamout
1600-1630	Next steps and closing remarks	Flavio Salio and Ashley Greiner

Annex 1: Meeting agenda

Day 3 – 14 December 2023		
Time	**Topics to be covered**	**Presenter(s)**
0900-0930	Welcome & Introduction and objective of the meeting	Adela Hoffman and Flavio Salio
0930-1000	RRT Management overview and introduction to 7-1-7	Mays Shamout
1000-1030	RRT Learning Competency Framework	Paula Gomez
1030-1100	Break	
1100-1200	Demystifying monitoring and evaluation	Camila Philbert Lajolo
1200-1330	Lunch	
1330-1415	Didactic: Defining the outcomes of the RRT programme Group work: discuss RRT programme outcomes – **What is the RRT programme trying to achieve?**	Mays Shamout and Camila Philbert Lajolo
1415-1500	Plenary: Group presentation and feedback	Moderator: Sherein Elnossery
1500-1530	Coffee	
1530-1615	Didactic: Identifying process indicators for the RRT programme Group work: Identifying the indicators of the RRT programme	Camila Philbert Lajolo
1615-1700	Plenary: Group presentation and feedback	Moderator: Paula Gomez
Day 4 – 15 December 2023		
Time	**Topics to be covered**	**Presenter(s)**
0800-0830	Recap of day 1	
0830-1000	Didactic: What are we measuring Group work: **What could be measured for each step in operational cycle?**	Camila Philbert Lajolo
1000-1030	Break	
1030-1200	Plenary: Group presentation and feedback	Moderator: Mays Shamout
1200-1330	Lunch	
1330-1400	Didactic: EMRO RRT MEL framework	Sherein Elnossery
1400-1530	Group work: Review draft MEL + global output from past 2 days and provide feedback	All
1530-1630	Plenary: Group presentation and feedback	Moderator: Camila Philbert Lajolo
	Egypt- National RRT Programme Monitoring, Evaluation, and Learning	
1630-1700	Wrap up and next steps	Flavio Salio and Adela Hoffman
1700	End	

Annex 2: Meeting participants

All external participants provided a signed form of declaration of interest (DoI), disclosing any relevant conflicts to other meeting participants and in the resulting report or work product.

List of participants

#	Name	Country	Affiliation
1	Dr Flavio SALIO	Global	WHO HQ
2	Ms Melinda FROST	Global	WHO HQ
3	Dr Pryanka RELAN	Global	WHO HQ
4	Ms Paula GOMEZ	Global	WHO HQ
5	Dr Camila LAJOLO PHILBERT	Global	WHO HQ
6	Ms Mousse GARNIER	Global	WHO HQ
7	Ms Seyede Zahra SEIFOSADAT	Global	WHO HQ
8	Dr Hind EZZINE	Global	WHO HQ
9	Dr Philomena RAFTERY	Global	WHO HQ
10	Dr Clemens ANDREAS	United States of America	WHO PAHO
11	Dr Luis DE LA FUENTE	United States of America	WHO PAHO
12	Dr Sherein ELNOSSERY	Egypt	WHO EMRO
13	Dr Latifa ARFAOUI	Egypt	WHO EMRO
14	Dr Oleg STOROZHENKO	Denmark	WHO EURO
15	Dr Sugandhika PERERA	New Delhi	WHO SEARO
16	Dr Yui SEKITANI	Manila	WHO WPRO
17	Dr Leilina AYALEW	Ethiopia	WHO Ethiopia
18	Dr Kumshida BALAMI	Nigeria	WHO Nigeria
19	Dr Mays SHAMOUT	United States of America	US-CDC
20	Dr Adriana ROMANI	Sweden	ECDC
21	Dr Florian SCHWÖBEL	Germany	Robert Koch Institute
22	Dr Jonathan RIVADENEIRA	Ecuador	Ministry of Health
23	Dr Fredy COYAGO	Ecuador	Ministry of Health
24	Dr Sherif SHAMSELDEIN	Egypt	Ministry of Health
25	Dr Khaled EL KHATIB	Egypt	Ministry of Health
26	Dr Baher ELDESOUKI	Egypt	Ministry of Health

Annex 2: Meeting participants

#	Name	Country	Affiliation
27	Dr Yuichi KOIDO	Japan	Japan National DMAT
28	Dr Yoshiki TOYOKUNI	Japan	Japan National DMAT
29	Mr Zhanibek YERUBAYEV	Kazakhstan	National Center of Public Health, Ministry of Health
30	Ms Madina AITKULOVA	Kazakhstan	National Coordination Center of Emergency Medicine, MoH
31	Col. Dr Nabin SHAKYA	Nepal	Ministry of Health
32	Dr Dipendra SINGH	Nepal	Ministry of Health
33	Mr Daniel ATABO	Nigeria	National Emergency Management Agency
34	Dr Saidu AHMED	Nigeria	Ministry of Health
35	Dr John OLADEJO	Nigeria	NCDC Nigeria
36	Dr Hena A. PAPIO	Philippines	Ministry of Health
37	Dr Jameel ABUALENAIN	Saudi Arabia	Ministry of Health
38	Dr Hani Ali ALMALKI	Saudi Arabia	Ministry of Health
39	Mr Sami ALENAZI	Saudi Arabia	Ministry of Health
40	Dr Pape Samba DIEYE	Senegal	Ministry of Health
41	Dr Youssou Bamar GUEYE	Senegal	Ministry of Health
42	Dr S. Mahendra ARNOLD	Sri Lanka	Ministry of Health
43	Dr P.W. Lal PANAPITIYA	Sri Lanka	Ministry of Health
44	Dr Charuttaporn JITPEERA	Thailand	Ministry of Health
45	Dr Kasemsuk YOTHASAMUTR	Thailand	Ministry of Health
46	Dr Henda CHEBBI	Tunisia	Ministry of Health
47	Dr Nejib CHARAA	Tunisia	Ministry of Health

Annex 3: EMRO MEL survey results

Percentage agreement for each indicator

#	Indicator	Is this an RRT management level indicator? - Yes%	Is this indicator applicable for all-hazards? - Yes%
1	Percent of outbreaks that reported operational challenges	70%	57%
2	Preparedness score of the RRT programme	91%	87%
3	Percentage of RRT members who received capacity building	96%	91%
4	Percentage of RRT members with demonstrated competencies	87%	91%
5	Multidisciplinary score of RRT programme	96%	91%
6	Percent of deployed RRT members pulled from the roster	78%	91%
7	Percent change in the case fatality rate by outbreak type	38%	39%
8	Percent change of the survival rate by outbreak type	35%	39%
9	Percent change in the attack rate by outbreak	35%	30%
10	Percentage of the outbreaks achieved 717 targets	87%	61%
11	Average duration of response by the outbreak	64%	50%
12	Percent of the samples delivered to the Lab in appropriate condition	48%	43%
13	Hospital admission rate by outbreak type	26%	39%
14	Percent of the outbreaks with actively involved communities	48%	61%
15	Percent of the requested emergency assistance fulfilled by RRT programme	87%	91%
16	Number of evidence-based strategies/approaches that strengthened RRT programme (including the use of the data from after action review)	100%	100%
17	Satisfaction rate of the RRT members	91%	100%
18	Attrition rate of the RRT members	96%	91%
19	Percent change in the RRT knowledge score in the capacity building programmes	91%	96%
20	Average duration of outbreak by outbreak	39%	43%
21	Percent of the Lab sample results received within 48 hours of their collection	48%	48%
22	Stockout rate of the RRT response equipment/materials	87%	87%
23	Percentage of the lab samples results received within 48 hours from their submission to the lab.	39%	48%
24	Average score of basic community empowerment standers applied during RRT response	57%	78%
25	Percentage of the outbreaks operated completely by decentralized team	57%	57%
26	Average competency score of the RRT managers	100%	100%
27	Percentage of outbreaks with timely comprehensive report submission	65%	74%

Annex 4: Work plan and concept notes

Ethiopia – National Consultative Meeting on *Strengthening rapid response capacities through Rapid Response Teams and Emergency Medical Teams*

22-23rd April 2024 | Addis Ababa, Ethiopia | Face-to-face

Participant profiles/Attendees

National representatives involved in the management of RRT and/or EMT programmes, national representatives in charge of monitoring and evaluation of RRT and/or EMT programmes; WHO staff; partner organization representatives.

Background

Since all emergency health responses start local first, ensuring a timely, high-quality, lifesaving, cost-effective and contextually appropriate first-line response to emergencies requires investing in national and local preparedness and operational readiness. While international surge support organizations serve important response functions, national and sub-national capacities must be developed as a matter of priority. Strong national rapid response capacities (RRC), also called surge capacities, are the primary and most critical building blocks to an effective response, including their ability to respond to a sudden or incremental demand for (health) services, such as in a health emergency or mass casualty incident, where additional capacities (in terms of staff, supplies and space) and/or capabilities (in terms of specialized expertise) are required.

Every country requires RRC defined as medical, healthcare, and public health services and functions that can be deployed at short-notice and on a non-routine basis to address health needs during and/or after a health emergency. This can encompass a wide range of capacities, including emergency medical teams (EMTs), specialized care teams (SCTs), public health rapid response teams (RRTs), mobile laboratories, and community-based interventions and resources. RRTs are multidisciplinary teams, trained and equipped, with the capacity to deploy rapidly to respond to public health emergencies efficiently and effectively in coordination with other response efforts. EMTs are multidisciplinary teams of health professionals trained and equipped to rapidly deploy to provide direct clinical care to populations affected by disasters, outbreaks, and other health emergencies as surge capacity to support the local health system. The continued building of national RRTs and EMTs – including workforce rostering, management, training, and program operations are vital components of an effective public health response. Both programs aim to enhance emergency management and build response capacity globally to respond to public health events, meet the International Health Regulations requirements, and ultimately contribute to strengthening Global Health Security. As countries globally look for ways to enhance their health emergency capacities to respond to current emergencies as well as be ready for future events, RRTs and EMTs are critical aspects of any emergency preparedness planning.

An integrative approach in the management and operations of RRTs and EMTs has been delineated in a joint US CDC-WHO study. The study, conducted across 14 countries, including Ethiopia, spanning all 6 WHO regions, demonstrated a strong appetite for synergizing the two programmes and thus facilitating more holistic and efficient emergency responses by enhancing necessary collaborations and interoperabilities between clinical care (by EMTs) and public health management (by RRTs). This was further emphasized at a global consultation meeting in December 2023, attended by over 60 participants from 18 countries, including Ethiopia. There was strong consensus that considering effectiveness (through streamlined health operations from detection, investigation, isolation, treatment, and recovery), efficiency (through shared resources) and sustainability (through shared financing), countries should explore integrating RRT and EMT programmes nationally and sub-nationally.

Meeting objectives, expected outcomes and outputs

1. To identify gaps and opportunities for improvement in the EMT and the RRT national programs that might require support.
2. To achieve consensus on areas of possible integration of RRTs and EMTs.
3. To develop set of recommendations and framework for integration of RRTs and EMTs.
4. To review results and update Ethiopia inputs to global scoping project evaluating integration of management and operations of national RRTs and EMTs

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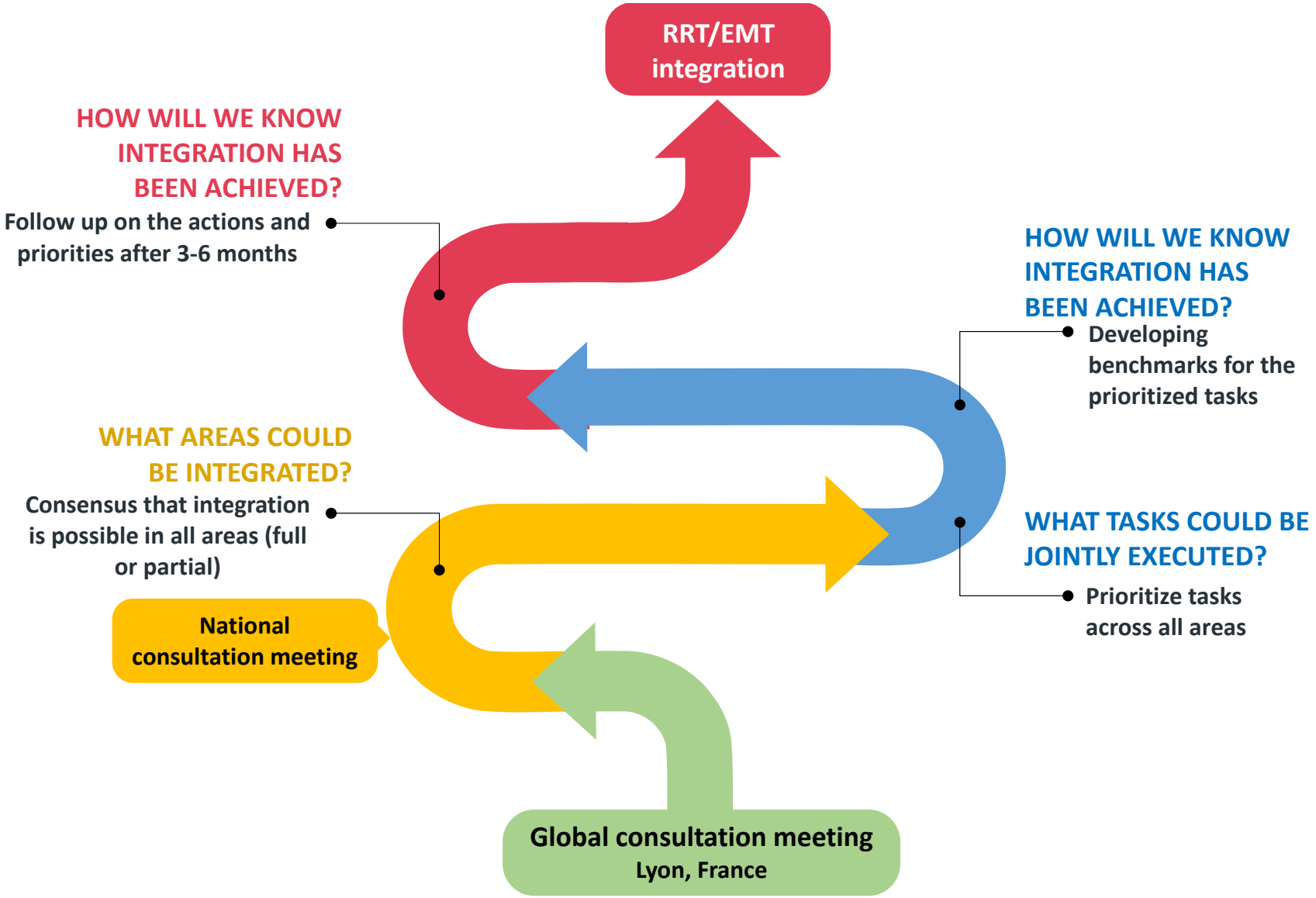
RRT/EMT integration
HOW WILL WE KNOW INTEGRATION HAS BEEN ACHIEVED?
Follow up on the actions and priorities after 3-6 months
HOW WILL WE KNOW INTEGRATION HAS BEEN ACHIEVED?
Developing benchmarks for the prioritized tasks
WHAT AREAS COULD BE INTEGRATED?
Consensus that integration is possible in all areas (full or partial)
WHAT TASKS COULD BE JOINTLY EXECUTED?
Prioritize tasks across all areas
National consultation meeting
Global consultation meeting
Lyon, France

Emergency medical Teams
World Health Organization
Avenue Appia 20
1211 Geneva 27
Switzerland
Email: emteams@who.int
Web: https://extranet.who.int/emt/

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