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EMERGENCY MEDICAL RESPONSE SYSTEM

PROVINCIAL GUIDE LINES AND STANDARD OPERATING PROCEDURES.

HEALTH DEPARTMENT SINDH BRANCH

2025

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INTRODUCTION & SCOPE

Establishing A Resilient Emergency Medical Response System (EMRS)

PRCS Sindh acknowledges the pressing need for a standardized, globally-aligned approach to managing health emergencies. While advances in public health have created new opportunities, challenges persist—particularly in ensuring coordination across sectors, bridging gaps between response tiers, and delivering high-quality healthcare to underserved populations.

A district-level assessment of existing capacities and challenges underscored the necessity of this document as a strategic roadmap for health emergency preparedness and response.

This guide serves as both a framework and a toolkit, addressing the core concepts of health emergencies, response structures, operational tools, and the roles and responsibilities of key stakeholders. Drawing on international guidelines and adapting them to the unique local context, this document ensures practical applicability and relevance.

Lastly through a guided process, PRCS Sindh aims to establish an Emergency Medical Response System (EMRS) to strengthen its capacity for responding to medical emergencies. As an essential first step, it is crucial to document best practices and implementation strategies before proceeding with staffing, training, and structuring the department

Health Emergencies & Role of RCRC

A public health emergency is any adverse event (natural or man-made) that impacts the health of the population and has the potential to cause widespread illness, such as:

- Illness amongst the public that can occur naturally, (such as flu), or is man-made, (such as and intentional release of anthrax)
- Illness amongst the public that may cause a larger number of deaths and/or serious disabilities
- Illness due to a hard to control infectious agent, (such as flu)
- Illness due to a chemical attack on the public, (such as cyanide gas)
- Illness due to release of nuclear material, (such as radiology materials used in hospitals)
- Other illnesses of health hazards that can severely impact the health of the public, whether resulting from natural hazards (tornadoes, floods, etc.) or emerging infectious diseases.[1]

WHO defines health in emergencies as "The range of actions required in situations that disrupt normal living conditions and that threaten the lives and well-being of a community, including public health, medical care, sanitation, nutrition, and mental health." A situation becomes emergent when its health consequences have the potential to overwhelm routine community capabilities to address them. [2]

Public health emergency preparedness encompasses preparation, mitigation and recovery activities as well as operational capabilities to enable a swift response to events.

Guidelines can provide direction to the health care provider in ensuring completeness and standardization of care. Adherence to standard operating procedures ensures that all components of health care are delivered in the correct order from counseling to follow up and audit. The principles underlying the IFRC's work in health and WASH emergencies are timeliness, coordination, and quality. Prompt interventions are critical to save lives and so is proper coordination, internally and with other responders. Quality is of extreme importance in emergency programs; interventions implemented by Red Cross Red Crescent volunteers and staff should always meet or exceed internationally agreed quality standards.

This guide for health in emergencies will serve as an essential document to guide provincial office health staff and representatives on how to effectively respond to various types of health emergencies or crises while maintaining the health and safety of individuals and communities.

CRISIS CATEGORIZATION

The system of categorization of disasters and crises is aimed at facilitating the activation of the appropriate disaster response standard operating procedures (SOPs) and improving the lines of management for a disaster response operation. This approach is also seen as the clearest way in which to objectively identify the scale and complexity of a disaster or crisis and to mobilize an appropriate level and pre-agreed structure of response in advance of a disaster.

Risk based approach depends on:

1. Scope and scale of the population potentially exposed to the health risk
2. Vulnerability of the population
3. Morbidity and Mortality of the epidemic disease
4. Impact on the health system, including secondary health impacts
5. Government and health systems capacity to address the risk
6. Complexity of the outbreak and amplifying factors
7. Engagement of other humanitarian actors

Yellow – responds to a localized emergency covering a small area or number of beneficiaries. This is normally managed at a country level (by a NS), with any necessary technical or management support provided by the RO (e.g. RDRT mobilization).

Orange – responds to an emergency affecting a wider area (or areas) and a higher number of beneficiaries (including potential spread), and may also receive a level of international attention or experience a level of complexity.

Red– responds to an emergency of scale, affecting a wide area and high number of beneficiaries, with level of complexity or risk that makes it an organization-wide priority for the IFRC secretariat at all levels. Based on the assessment and recommendation of the Regional Director and USG Programs and Operations, the SG will declare a Red level disaster or crisis, and may appoint an "Emergency Coordinator" at the level of a Regional Director or above to direct and manage the IFRC response. Regional and global surge capacity is activated per default (in consultation with the NS).

Yellow	Responds to a localised emergency covering a small area or number of beneficiaries. This is normally managed at a country level (by a NS), with any necessary technical or management support provided by the RO (e.g. RDRT mobilisation). If necessary, the RO seeks support from HQ (e.g. DREF).
Orange	Responds to an emergency affecting a wider area (or areas) and a higher number of beneficiaries (including potential spread), and may also receive a level of international attention or experience a level of complexity. Technical and management support is still provided by the RO, but HQ is engaged at the start-up of the operation to provide DREF, technical quality assurance on Emergency Appeals and technical support or global surge capacity as required and ensure global coherence and compliance with standards.
Red	Responds to an emergency of scale, affecting a wide area and high number of beneficiaries, with level of complexity or risk that makes it an organisation-wide priority for the IFRC secretariat at all levels. Technical and management support is coordinated by the RO, but provided by both RO and HQ, and regular task force meetings are held to ensure effective management and information flow. Regional and global surge capacity is activated per default (upon the request of the NS). HQ takes on a stronger role in terms of global coherence and compliance with standards and there may be the need to establish support functions at the HQ level, as well as the regional level.

CRITERIA TO DETERMINE DISASTER CATEGORY:

The table below by the "IFRC Secretariat Emergency Response Framework" depicts the criteria and corresponding indicators that determine the decision of category for disaster or crisis. The triggers are kept as straightforward and objective as possible and in line with external assessment factors.

	Yellow	Orange	Red
1. Number of people affected	Less than 200,000	200,000 to 2,000,000	More than 2,000,000
2. Extent of geographical area affected	Limited to a specifically defined or smaller geographical area	• Moderate to large geographical area • Moderate to large urban centre • Possible cross border impact	• Large geographical area • Large urban centre • Multiple countries • More than one region involved
3. Population density	Low population density	High population density	Very high population density
4. Level of media attention	• Local media • Limited international media interest	International media attention	Major global headline attention
5.Government response	• No disaster declaration • Possible disaster declaration	• Declared a national disaster • International assistance requested	• Declared a national disaster • International assistance requested
6. Engagement of other humanitarian actors	• Local • Regional	• Local • Regional • International • Cluster may be activated	• Local • Regional • International • Cluster activated

Each level (country, regional and global) has a specific set of roles and responsibilities during health emergency. The scope of the document is however limited to responsibilities at country level (i.e. provincial and district branches) in order to ensure a smooth response

LEVELS	EMERGENCY MEDICAL SERVICES	PUBLIC HEALTH
Global (SURGE) FACT, ERU	Medical Coordinator (FACT), RCRC Emergency clinics	Public Health FACT, Public Health ERU
Regional	Health RDRT	Public Health RDRT
National Society	NS Health Staff Trained First Aiders & PFA Ambulance & Pre-Hospital Care Mobile Clinics Static Clinics Blood Services PSS in Emergencies	NS Health Staff trained in CBHFA/ECV/CBS/ORP Community Based PSS

GLOBAL RESPONSE STRUCTURES

An Emergency Response Unit (ERU) is a standardized package of trained personnel and modules of equipment, ready to be deployed at short notice. They are designed to provide an essential, basic and standardized service platform for use in any part of the world. The units are fully self-sufficient for one month and can be deployed for up to four months. Whenever there is a situation that requires a quick response to which the delegation or National Society cannot respond alone. The ERUs are part of the Federation's disaster response tools and provide a specific support or direct service function when local facilities are either destroyed, overwhelmed by needs, or do not exist. They are used in emergency situations to cover a gap only until the function is no longer required, or until either the Federation delegation and/or the host National Society can take over.

BASIC HEALTH CARE ERU

This ERU provides immediate curative, preventive and community health care. It can deliver basic outpatient clinic services, maternal-child health (including uncomplicated deliveries), community health outreach, immunization and nutritional surveillance. The unit must have a mechanism for referral of more serious cases for hospitalization, i.e. a hospital within reasonable distance. Existing health care structures are assisted, rehabilitated and further developed. This ERU can serve the primary health care needs of up to 30,000 people, and works with local health staff.

REFERRAL HOSPITAL ERU

This ERU functions as a first level referral hospital, providing essential services for a population of up to 250,000 people. The inpatient capacity ranges from 120 -150 beds, providing surgical and medical care, intensive observation, anesthesia and operating theatre, x-ray, laboratory, maternal-child health, pharmacy, sterilization and outpatients clinics. This ERU works on the basis of an agreement with the health ministry of the country affected, and welcomes national health staff to work alongside the ERU personnel from overseas countries.

For larger populations, two existing referral hospital ERUs can be combined. A modular Rapid Deployment Hospital, consisting of two 4x4 Land Cruisers and trailers, with all the necessary medical and logistics supplies to cover the crucial first ten days after a disaster, can expand the capacity of a referral hospital ERU or be converted for community outreach.

RED CROSS RED CRESCENT EMERGENCY CLINIC

Capacity

Day time clinical services with observation capacity possible for 100 outpatients/day for 1 month, before replenishment needed, and operational for up to 3-4 months (depending on length of operation).

Emergency Services

Outpatient emergency clinic to provide initial emergency care of injuries and other significant health care needs for adults and children. Services include:

- Triage.
- Assessment.
- First aid.
- Stabilization and referral of severe trauma and non-trauma emergencies.
- Definite care for minor trauma and non-trauma emergencies.

Designed For

Unit can be deployed within 48 hours upon receiving a deployment request, can be setup within hours once on site, is self-sufficient for 1 month and can operate for up to 4 months. Designed for the provision of fixed emergency health services in communities with limited access to health care as a result of:

- Population movement to areas where there are no pre-existing health facilities.
- Health infrastructure damages following natural disaster(s).

- Existing health facilities are overwhelmed by influx of patients and/or particular health needs following a crisis (could include an epidemic or similar public health emergency).

Personnel

Total

Typically, 19-23 people from sending National Society + 38 contracted locally per unit.

Composition

Deployed team composed of nurses, doctors and midwives trained in emergency and primary care, with the remainder non-medical staff including logisticians, administrators and site technicians. Clinical staff is skilled in emergency and trauma care, maternal and child health, and has knowledge of endemic disease management. In addition to deployed team, local health care professionals are integrated into unit as soon as possible, ideally reaching a doctor: nurse ratio of 1:3. Contracted local personnel include medical coordinator, head nurse, gate control, security guard, registration clerk, nurses, midwives, pharmacist, admin, and others.

STANDARD COMPONENTS

Specific module names and components may vary but generally include the following services:

- Outpatient Department (OPD) Module

Contains the equipment and supplies needed to carry out initial triage, basic first aid and life support, stabilization for patients, as well as initial wound care, basic fracture management, minor surgical procedures, basic outpatient care of communicable disease, basic outpatient pediatric care, basic/outpatient chronic disease care; diagnostics done through clinical examination and basic point-of-care laboratory tests.

- Maternal/Newborn Care Module

Contains the equipment and supplies needed to provide care to women in childbirth including basic emergency obstetric care with includes administering antibiotics, uterotonic drugs (oxytocin) and anticonvulsants (magnesium sulphate); manual removal of the placenta; removal of retained products following miscarriage or abortion; assisted vaginal delivery, preferably with vacuum extractor; basic neonatal resuscitation care.

- Pharmaceutical and Medical Consumables Module(s)

Contains a minimum one-month supply of the medications and medical consumables needed to provide services according to the MSF Clinical Guidelines; quantities also largely based on Interagency Emergency Health Kit calculations for coverage of health needs in a population of 30,000.

- Psychosocial Support (PSS) Module

Contains essential equipment and materials needed to carry out a rapid needs assessment to identify vulnerable groups, and support an operating NS to implement volunteer-driven PSS activities; activities focused on training up volunteers as needed, coordinating closely with social institutions and other humanitarian actors, assisting adults in affected communities with practical information, emotional and

social support through PFA and referral, and setting up play and recreational activities for children where relevant.

- Medical stores/warehousing Module

Contains the equipment and materials needed to set up a warehouse space to store and manage drugs and medical consumables.

- Waste Management Module

Contains the equipment and materials needed for the safe management of medical waste in a low-resource setting; includes a portable incinerator.

- Water Treatment Module

Contains the equipment and materials needed to maintain a safe water supply for patients and staff within the ERU facility; generally, includes a water filtration unit able to produce a volume of water that is aligned with Sphere standards for health facilities as a minimum, along with chlorine-based agents to treat water as per international norms.

- Sanitation Module

Contains the essential equipment and materials needed to set up temporary latrines for patient and staff use in a ratio that is aligned with Sphere standards for health facilities as a minimum

- Infrastructure

Temporary tented, water repellent infrastructure of varying sizes (3x3m to XXX); tents can be metal-framed or inflatable depending on context and needs.

- Power/lighting Module

Equipment/materials needed to provide self-sufficient power and light generation throughout the temporary health facility; typically, petrol/gas run generators with associated cabling and energy-efficient lighting.

- Administration Module

Equipment/materials to set up a field office.

- IT/Telecommunications Module

Contains portable laptops, satellite communications equipment, mobile telephones and VHF handsets for two-way field communications, as well as essential equipment to set-up a local wireless network within the health facility and field office.

- Vehicles

4x4 Toyota Land Cruisers as per IFRC specifications for team field movements, and possibly patient transportation (where context dictates);

- Basecamp/accommodation Module

Equipment/materials needed to set-up temporary living accommodations for ERU team in contexts where commercial accommodations are not available.

UNDERSTANDING THE ROLE OF PRCS

NATIONAL HEADQUARTERS:

National Societies, which are auxiliary to their authorities in the humanitarian field, respond to humanitarian and health emergencies and provide support and assistance to vulnerable people within their respective countries. They are active at the national level and rooted within local communities. National Societies support the operations and assist vulnerable people by contributing staff, providing technical and financial support during disaster relief, health and social programs.

NSs are the lead actors in preparing for and responding to emergencies (through provincial and district entities). Country offices or country cluster support teams (CO/CCST), as the nearest actor to the response, take the primary role in supporting the NS and in planning and coordinating and (where requested) delivering IFRC and PNS support during a response.

In the event of a national disaster or emergency, the PRCS National Headquarters (NHQ) assumes the primary role of leading the response, focusing on coordination and providing technical and financial assistance. The implementing branches act as operational arms, executing the response on the ground. Their specific responsibilities are outlined below:

1.1 Survey and assessment of the disaster situation.

1.2 Mobilization of manpower and resources.

1.3 Immediate and adequate emergency relief aid for disaster victims according to their needs.

1.5 Assistance in operating Control and Relief Centers.

1.6 Tracing

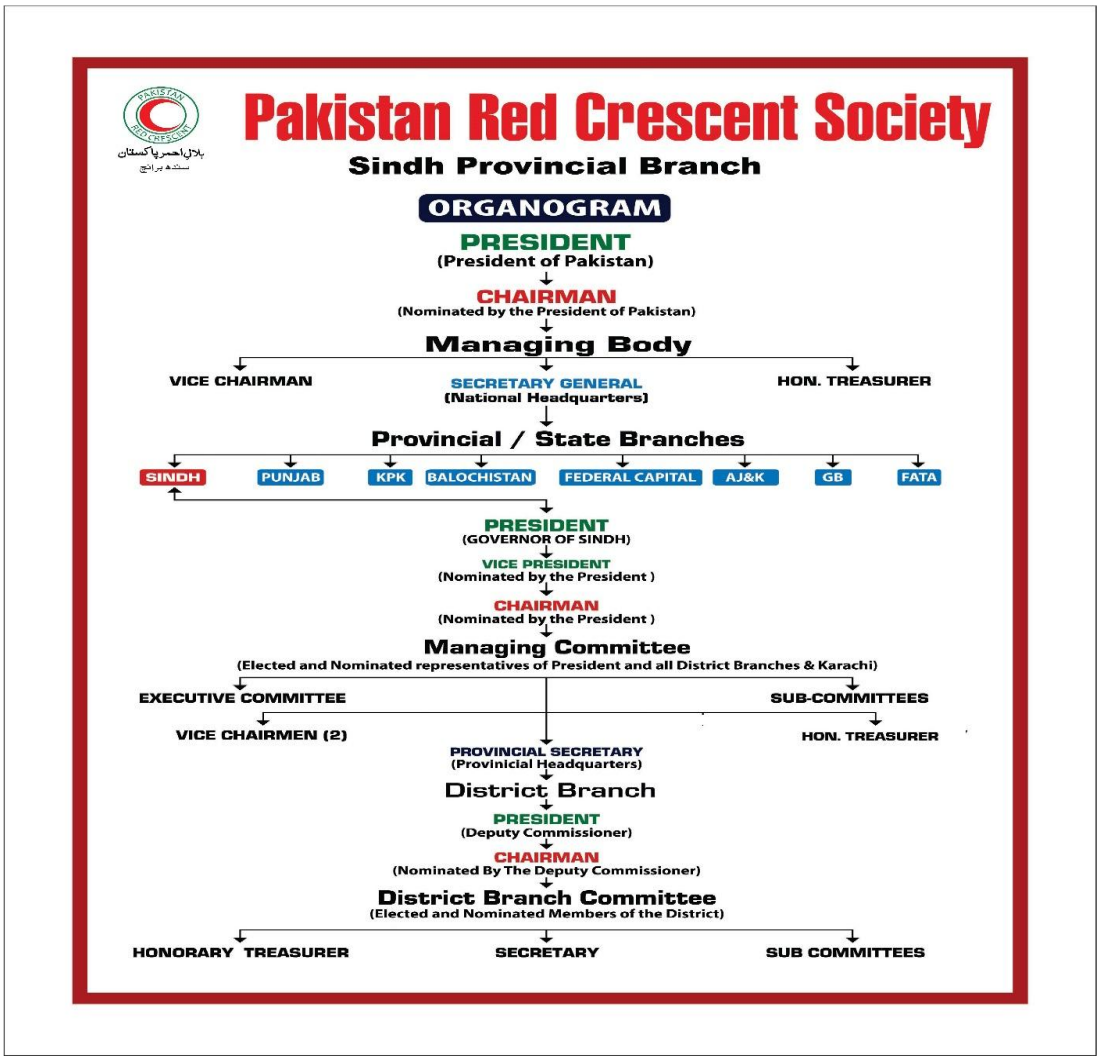
1.7 Information Management.

1.8 Psychological Support.

1.9 Coordination with Partners & Other Agencies.

2.0 Advocacy

ORGANISATION STRUCTURE PRC SINDH:



EMERGENCY HEALTH SERVICES:

The scope of service of PRCS's response in emergency health settings includes:

1. Rapid Needs Assessment:
    - When an emergency occurs, PRCS conducts rapid needs assessments to determine the health and medical needs of the affected population.
    - This assessment understands the scale of the emergency and tailor response accordingly.
2. Emergency Medical Services:
    - PRCS provides emergency medical services through mobile medical units/MHTs and temporary medical facilities set up in disaster-stricken areas.
    - These services include immediate medical care, wound dressing, basic surgeries, and the treatment of injuries and illnesses.

3. First Aid and Trauma Care:
    - Trained PRCS volunteers and staff provide first aid and trauma care to injured individuals at the scene of emergencies.
    - This rapid response can significantly improve survival rates and reduce the severity of injuries.
4. Medical Evacuation:
    - In situations where medical facilities are overwhelmed or inaccessible, PRCS facilitates the safe evacuation of critically ill or injured individuals to appropriate medical centers.
5. Disease Outbreak Response:
    - During disease outbreaks, PRCS responds by setting up isolation units and providing medical care to those affected.
    - The organization also conducts awareness campaigns to educate communities about preventive measures and hygiene practices.
6. Mobile Health Clinics/Emergency Medical Camps:
    - PRCS deploys mobile health clinics to provide medical consultations, distribute essential medications, and deliver primary healthcare services to displaced populations or those in remote areas.
7. Psychosocial Support:
    - PRCS recognizes the emotional toll that emergencies can have on individuals and communities. As such, it offers psychosocial support and counseling services to help people cope with trauma and stress.
8. Water, Sanitation, and Hygiene (WASH):
    - PRCS addresses the vital need for clean water and sanitation in emergencies by providing safe drinking water, promoting hygiene practices, and preventing the spread of waterborne diseases.
9. Vulnerable Populations:
    - PRCS pays special attention to vulnerable populations such as children, women, the elderly, and people with disabilities, ensuring they receive appropriate medical care and support.
10. Coordination and Collaboration:
    - PRCS collaborates with government agencies, other humanitarian organizations, and international partners to ensure a coordinated and effective response.
    - This collaboration helps prevent duplication of efforts and maximizes the impact of emergency health interventions.
11. Capacity Building and Training:
    - PRCS continuously trains its staff and volunteers in emergency response techniques, including medical care, first aid, and disaster management.
    - This training ensures a skilled and prepared workforce ready to respond to emergencies.

12. Recovery and Rehabilitation:
    - After the initial emergency response phase, PRCS remains involved in the recovery and rehabilitation process, helping affected communities rebuild their healthcare infrastructure and systems.
13. Data Collection and Reporting:
    - PRCS collects and shares real time data with EOC on health needs, interventions provided, and outcomes to assess the effectiveness of its emergency health response and make informed decisions for future responses.

EMERGENCY OPERATIONS CENTRE

The following tasks are undertaken by EOC in the context of a health emergency/disaster:

1. Activation: To be activated upon the directive of Provincial Secretary or Manager Operations in response to a declared health emergency.
2. Information Management: Serve as the central hub for collecting, managing, and analyzing all health-related information during the emergency.
3. Record and Disseminate Data: Accurately log all incoming information and promptly disseminate updates to field operation rooms and relevant National/Provincial/Chapter branches.
4. Information Updates: Ensure continuous updating and validation of health emergency data to maintain situational awareness.
5. Activation of Status Color Codes: Implement status color codes (e.g., Amber, Red) based on decisions made by the National Health Task Force, reflecting the severity and response level of the emergency.
6. Interagency Coordination: Facilitate effective liaison with key agencies, including health departments, hospitals, law enforcement, emergency medical teams, disaster management authorities, and media outlets.
7. Bulletin Issuance:
    - Amber: Issue regular situation reports at intervals of 3-4 hours.
    - Red: Provide hourly updates alongside detailed daily situation reports.
8. Situation Status Reporting: Compile and deliver comprehensive health emergency status reports, summarizing critical developments and response actions.
9. Briefing and Debriefing: Conduct regular briefing sessions to inform teams on current developments and expectations. Facilitate debriefing sessions post-operations to evaluate performance and identify areas for improvement.

STAFFING DURING EMERGENCIES

Staffing shortages during public health emergencies can have severe consequences, as a well-prepared and adequately staffed healthcare system is crucial for responding effectively to such crises. These shortages can result from various factors, including increased demand for healthcare services, the risk of healthcare worker illness, and the need for specialized skills to address the emergency.

In order to have a skilled worked force for emergency deployments the following measures shall be undertaken:

a. Mapping and formulating a data base of medical doctors, nurses, lady health workers, pharmacist, community mid wives employed in PRCS medical facilities (at district level)

b. Coordinating with district branches and respective health facilities to formulate a provincial emergency health roster and enlisting these medical professionals in this registry.

c. Periodic trainings of relevant staff on emergency health provision standards and various modules.

d. Signing a charter with PRCS health facilities to ensure Red Crescent staff is made available on locum for emergency health deployments.

e. Include a specific clause in staff contracts/appointment letters, ensuring their availability for deployment during emergencies or disasters. As compensation they shall be provided a separate Perdium in addition to their regular salaries.

COMMUNICATION DURING EMERGENCIES

A media and communication response to a public health emergency must be swift, and good preparation is key to enabling rapid and effective action.

Building strong contacts with emergency responders, health organizations, and experts who are skilled communicators ensures readiness when a crisis occurs. Additionally, media and communication personnel should familiarize themselves with the basics of the health emergency, including its prevention, transmission, and treatment. While journalists are not the subject-matter experts, identifying credible sources that can provide accurate information and deepen understanding of the topic is essential for delivering reliable communication during emergencies.

The following list outlines some of the things that media programming can usefully do in public health emergencies.

Audience Segmentation:

1.1 Identify different audience groups based on factors like age, gender, education level, language, culture, and geographic location.

1.2 Recognize vulnerable populations, such as people with disabilities, elderly individuals, or marginalized communities, to address their unique needs.

Behavioral Insights:

1.3 Understand the perceptions, beliefs, and attitudes of the audience towards health issues and interventions.

1.4 Conduct rapid assessments, surveys, or focus groups to gather insights on audience concerns, motivations, and barriers to action.

Cultural and Linguistic Customization:

1.5 Adapt messages to resonate with local cultural and religious norms.

1.6 Use local languages to ensure communication is accessible and relatable.

Strategic Communication Planning:

1.7 Develop a communication strategy that aligns with audience characteristics and the nature of the public health emergency.

1.8 Select the most appropriate and effective communication channels (e.g., social media for younger audiences, radio for rural areas, posters for visually-oriented campaigns)

Mass Reach Through Multiple Channels:

1.9 Combine traditional and digital media platforms to reach a broad audience

1.10 Collaborate with trusted community figures, such as religious leaders, educators, or local influencers, to amplify message

Communication Norms

1.11 Communication should be clear, accurate, trusted, consistent and solution oriented.

1.12 Uphold the “Do No Harm” principle.

1.13 Counter dangerous rumors and misconceptions by providing verified facts from trusted sources and correcting misinformation.

1.14 Engage with the audience to address questions through credible experts, and setting realistic expectations to prevent frustration or disappointment.

1.15 Facilitate community access to health and support services by highlighting unmet needs and advocating for responsible parties to address and resolve these issues.

Iterative Feedback Mechanisms:

1.16 Implement systems to gather audience feedback on the effectiveness and clarity of communication efforts.

1.17 Use this feedback to refine messages and strategies continuously.

Key Implementation Tools:

1. Risk Communication Plans: Establish Pre-define communication protocols and stakeholder roles before an emergency occurs.
2. Media Engagement: Train communication personnel on reporting ethically and responsibly during health crises.
3. Community Mobilization: Engage community influencers, health workers, and educators to disseminate accurate information locally.

For more detailed information and procedural specifics, please refer to PRCS Communication SOPs.

ACTIONS IN EMERGENCY RESPONSE BY TIMELINE

STEP 1: ENDORSE OR DEVELOP POLICIES

Categories	Actions By Timelines					
	Preparedness:24 hrs/As Soon As Possible	72 hours	Week 1	Week 2-4	Week 5-8	Week 9-1year
POLICIES, INTERNATIONAL RECOMMENDATIONS AND GUIDELINES	Review and assess national health policies, implementation plans, and contingency frameworks relevant to Emergency Medical Response (EMR), ensuring alignment with EMT operations during emergencies. Facilitate the establishment of a **pharmaceutical management system**, including	Develop concise **EMT-specific operational briefs** or guidance notes tailored to various emergency scenarios, ensuring all EMT staff are informed	Disseminate the **EMT operational guidance** to all team members, tailored to their specific roles, ensuring clarity on emergency protocols, ethical	Collaborate with health cluster leads to support the development, adaptation, and timely endorsement of **inter-agency joint statements** related to emergency health interventio		

	protocols for monitoring and reporting any misuse of essential medicines, medical supplies, and controlled substances in the field	and prepared to execute their roles effectively.	practices, and patient care standards.	ns, ensuring a unified response strategy.		
RESOURCE MOBILIZATION	Star identification of resources such as Emergency Fund.	Identify internal and external sources of funding.	Seek support for early funding requests.	If needed define fundraising strategy.		

STEP 2 TRAIN STAFF

Categories	Actions By Timelines					
	Preparedness: 24 hrs/As Soon As Possible	72 hours	Week 1	Week 2-4	Week 5-8	Week 9-1year

HUMAN RESOURCES, ORIENTATION & TRAININGS	Assess Emergency Medical capacities and update the EMT roster, identifying available medical staff and resources. Ensure provincial/district focal points are included if no national capacity is on the ground. Identify and maintain an updated list of district health focal points and contacts. Ensure provincial or district focal point is included in the deployed response team if no national capacity is on ground. Identify district health focal points and have list of contacts ready.	Finalize and adapt EMT job descriptions for specific emergency roles. Designate a provincial EMT coordination focal point. Deploy the early response medical team. Provide rapid orientation and essential training for deployed EMTs.	Communicate estimated HR needs.	Collaborate with other sectors for the recruitment of medical staff and volunteers. Finalize a comprehensive HR plan for staff recruitment and specialized training. Conduct detailed onboarding for new staff and sensitization sessions for existing team members as needed. Deploy additional staff based on operational needs.		Continue capacity building provide refresher training (after 6 months)

STEP 3 CO-ORDINATE OPERATION

Categories	Actions By Timelines					
	Preparedness:24 hrs/As Soon As Possible	72 hours	Week 1	Week 2-4	Week 5-8	Week 9-1year
COORDINATION	Liaise with Government health focal point. Identify existing in-country coordination mechanisms at different levels.	Liaise with in country coordination or cluster lead. Evaluate EMT coordination capacity and identify any gaps that need immediate attention. Brief EMT and cross-sector staff (e.g., WASH, Nutrition, Shelter) on **medical supply protocols**, including monitoring of **essential medical donations** and prevention of mismanagement.		Sensitize related sectors (Nutrition, WASH, Shelter, MHPSS, and PGI) on basics of Health In Emergencies Response.		Evaluate functionality of coordination mechanisms

COMMUNICATION & ADVOCACY	Create alerts to stay updated on health related issues during emergency. Brief media team on dos and don'ts of communication during Health Emergencies	Collaborate with Communications team to discourage inappropriate use of medical supplies and donation.	Support initial communications and media on Health Emergencies Response briefings.	Uphold ongoing communication and advocacy efforts. Develop and share key messages on Public Health Emergencies.		Share lessons and evidence of evaluation and success in Emergency Health Response

STEP 4 IMPLEMENTATION

Categories	Actions By Timelines					
	Preparedness:24 hrs/As Soon As Possible	72 hours	Week 1	Week 2-4	Week 5-8	Week 9-1year
PROGRAMME	Review services/programmes to align existing initiatives.	Develop scenario-based response strategy	Identify supply chain and HR bottlenecks.	Determine caseload, HR and supply needs. Develop early response plan Develop detailed implementation plan	Revise response plan as needed	Conduct detailed review and refine SOPs Plan for long term sustainability

PROGRAMME IMPLEMENTATION	Activate early response teams and brief stakeholders. Mobilize essential kits, equipment's and medicines.	Start early response team activities	Implement basic interventions Test and finalize supervision tools.	Develop integrated multi-sectoral approaches. Collaborate with sectors like WASH.	Scale up technical interventions.	Institutionalize best practices. Organize capacity building sessions.

STEP 5 ASSES AND MONITOR

Categories	Actions By Timelines					
	Preparedness: 24 hrs/As Soon As Possible	72 hours	Week 1	Week 2-4	Week 5-8	Week 9-1year
SITUATION ANALYSIS AND ASSESMENTS	Gather and organize pre- crisis health system data (e.g., health infrastructure, HR availability).	Assess government and partners' EMT response capacity.	Disseminate rapid assessment results to EMT stakeholders.	Analyze EMT assessment data and prepare a detailed report.	Support/undertake detailed EMT assessments (e.g., disease surveillance)	Conduct in-depth assessments for long-term EMT strategy and effectiveness.

	Collect data from key informants and field observations (e.g., disease burden, population needs).	Map stakeholders Conduct multi-sector rapid health needs assessments,				
MONITORING EVALUATION AND LEARNING	Identify relevant EMT-specific monitoring indicators (e.g., patient care, service delivery, staff deployment).	Define initial monitoring framework.	Develop and implement EMT monitoring and supervision plans. Initiate evidence building (Baseline data collection).	Finalize and refine monitoring tools.	Strengthen evidence base by conducting performance reviews, gathering patient feedback.	Conduct evaluations of EMT operations and outcomes (e.g., health impact, efficiency, sustainability).

TASK FORCE MODEL

Component	Description
Structure	Provincial Task Force: Led by the Provincial Headquarters (PHQ), comprising representatives from health, logistics, operations, and communications. District-Level Task Forces: Operational units under provincial guidance, focusing on localized implementation. Sub-Task Groups: Specialized teams for tasks such as disease surveillance,

Component	Description
	case management, supply chain etc.
Roles and Responsibilities	Leadership (PHQ): Provide provincial-level coordination, technical guidance, and resource allocation. Liaise with the National Headquarters (NHQ) for technical and financial support. Monitor and evaluate the provincial response to ensure alignment with national directives and health protocols. District Branches: Implement the response at the district level, focusing on medical services, supply distribution, and community mobilization. Technical Support Teams: Conduct health risk assessments, manage data, and develop localized protocols for emergency response.
Coordination Mechanisms	EOC (PHQ): Serve as the provincial command center for real-time updates and data sharing with district branches and NHQ. Interagency Collaboration: Coordinate with provincial health departments, hospitals, NGOs, and other relevant organizations. Regular Updates: Conduct routine briefings to align efforts across districts and stakeholders.
Resource Mobilization	Financial Assistance: Mobilize provincial funds and seek additional support from NHQ for emergency operations. Logistics Support: Manage the distribution of medical supplies, equipment, and staff across affected districts.
Monitoring and	Situation Reports: Compile and share provincial updates with NHQ to assess

Component	Description
Evaluation	progress and identify challenges. Post-Emergency Review: Conduct debriefing sessions at the provincial level to document lessons learned and recommend improvements.
Activation and Deactivation	Activated by the PHQ upon declaration of a health emergency in the province. Deactivated after resolution of the emergency and implementation of recovery measures at the provincial and district levels.

CORE SET OF STANDARDS FOR EMERGENCY MEDICAL TEAMS

This document expands on the core set of standards for medical (static and mobile) camp-based health care delivery.[4] These fundamentals include:

A. Awareness and Availability of 6S (Survey, Space, Sanitation, Services, Sterility, Staff)

B. Basic Training – All staff must be trained and sensitized to deliver services in an effective way

C. Checklist- A checklist of each station must be available and completely filled and implemented before the necessary action

D. Delivery – Delivery of health care services must be done in a standardized fashion to bring uniformity in approach

E. Emergency & Exit services – Emergency services must be readily available in case of referral. Counseling regarding dos and don'ts apart from danger signs must be done at exit.

F. Feedback, follow up and Future strategy- Exit client interview must be done for feedback and clients must be followed up on a regular basis by means of follow up clinics.

Each Mobile Health Unit shall ensure MINIMUM/MAXIMUM OUTREACH:

Depending on the catchment population:

- 70-100 patients/day (9am-5pm)

- 350-500 patients/week
- 1540-2200 per month

SITE ASSESSMENT, considering the following aspects:

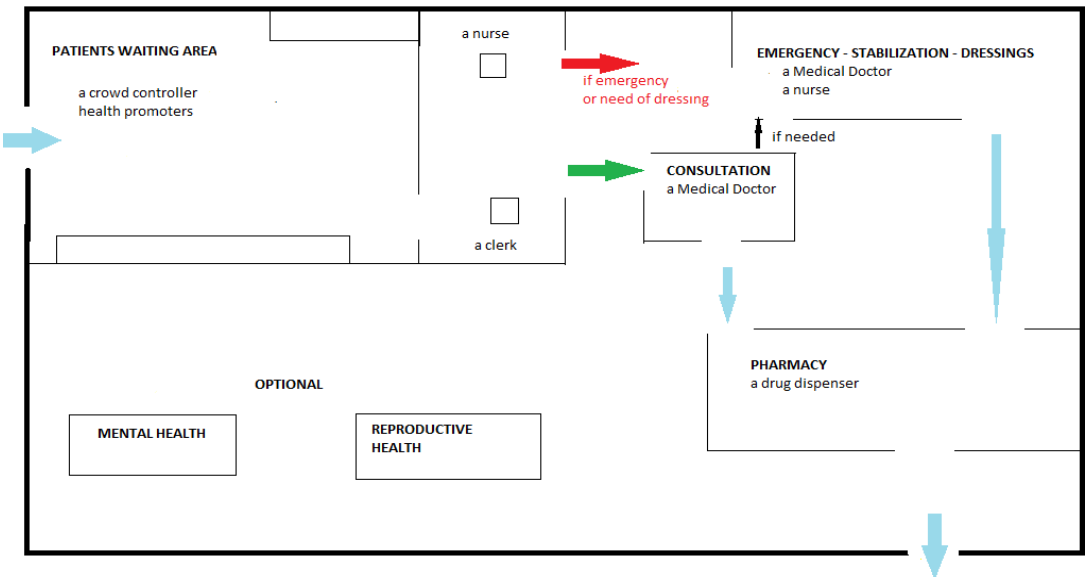
1. Nearest hospital or PHC to know availability of HR and services provided
2. Security:
   - Security situation on the site
   - Any protection from the authority or international agency?
   - Number of reports of violent events (rape, beatings, robbery, gunshots etc.)
3. Hygiene and sanitation:
   - Current facilities for excreta disposal, type and number
   - General hygiene on the site
   - Availability and use of soap
   - Presence of vector transmitting communicable diseases
   - Is access to water for free?
   - Quantity (liters/person/day) and quality
   - Proportion of families having sufficient and adequate water transportation and storage means
   - Number, type and location of water points
4. Shelters
   - Types of shelter in use, proportion of household with protective shelter
   - Number of people per shelter
   - Proportion of households with cooking utensils, blanket, clothes etc.
   - Availability of energy/fuel.

MEDICAL UNIT ACTIVITIES

The following activities should be taken to consideration at the same time keeping in view capacities of national society, resources and available technical expertise to ensure optimum quality of service delivery. In addition, all activities should be designed incorporating minimum standards for protection gender and inclusion.

Triage, stabilization, general consultation, Baby nutrition counselling, ANC/PNC services, EPI, ORS point, drugs dispenser and if needed arranging referrals to the nearest healthcare facility for advanced treatment and specialized care.

ORGANIZATION & PATIENT FLOW IN MEDICAL CAMP



CAMP STRUCTURE: would usually consist of one or more tents in emergency setting or a big area with folding privacy screens. The following set of standards apply for each camp area:

WAITING & TRIAGE

1.1. Infrastructure-

- Large space with bench or chairs
- Adequate temperature (ventilated and shade if hot, close and warm if cold)
- Tables + chair for registration and triage nurse
- Drinking water + hand washing
- Provision of separate toilets or in close safe proximity.
- Disability access in the form of ramps, wide doors, handrails, sufficient space inside the toilet, seating for latrines and artificial lighting.

1.2. Human Resource

- Crowd controller
- Community Mobilizer
- Nurse

1.3. Medical Equipment

- Weighing Scale
- Thermometer
- Stethoscope
- Oximeter

- MUAC scale
- BP Machine
- Health reporting and referral cards, registration book, pens.

1.4. Activities & Team Responsibilities

a. CROWD CONTROLLER AND HEALTH PROMOTER

- Welcomes and informs patient and the families about the patient flow from triage to consultation
- Orients the patients to the triage per the order of arrival (in general women and children first, then elderly and men the last),
- Does crowd control if necessary.
- Health promotion
- If emergency case, the patient is sent directly to the stabilization room

b. CLERK REGISTER

- Documents contact data in the registration book: date, site, identification number, name/surname, age, village/union council/district etc.
- Fill in the health card with contact data (only if new patient or for patient has lost the health card)

c. NURSE

- Measures and fills in the health card with vital signs: body temperature, pulse rate, respiratory rate, oxygenation, and, if adult, blood pressure. If the patient has already the health card, new vital signs, MUAC (if needed) and weight are taken and registered with the current date.
- If there are any signs or symptoms of emergency, the patient is sent to the emergency room.
- Performs and records anthropomorphic measurements as weight (pediatric and adult scale) and brachial perimeter-MUAC (from 6-month age to 5 years old of age).
- Checks EPI status (EPI package of BCG, DTP, oral polio and measles vaccine for children and TT for women of childbearing age) and if needed refers to the nearest immunization center (or MC EPI once a week)
- Data collection (to be given to the mobile clinic supervisor)

STABILIZATION ROOM FOR EMERGENCY CASES (FIRST AID & DRESSINGS & INJECTIONS)

1.5. Infrastructure

- Separate room
- Examination bed/Portable Stretcher
- Hand washing provision (soap/washbasin or sanitizer dispenser)
- Mini fridge for maintaining cold chain for vaccination

1.6 Human Resource

- Vaccinator
- Dressing Nurse

1.7 Medical Equipment

- First Aid Kit
- IV stand
- Thermometer, BP App, Stethoscope
- Hemoglobinometer
- Otoscope
- Glucometer
- Ambu bag
- Portable ECG machine
- Abscess suture set
- Dressings
- Referral forms
- Nebulizer
- Suction Machine
- Pregnancy testing kits
- Medical waste bins

Medical protocols include:

Initial management of tachypnea, dyspnea; hyper/ hypothermia; hypo/ hypertension; tachy / bradycardia; unconscious patients; signs of dehydration; convulsions; severe vomiting; severe diarrhea, anaphylaxis, snake /scorpion bites etc.

1.8 Activities & Team Responsibilities-

1.81 Medical Doctor and Nurse will ensure that first aid treatment and

resuscitation of patient. Once stabilized document and refer to nearest heath facility.

1.82 Vaccinator will be administered by vaccinator as per instructions of clinic doctor.

1.83 Rapid tests (urine strip, glucometer) are performed, per the doctor's request. The result is noted in the health card.

1.84 Dressings are performed as advised by doctor and under aseptic conditions.

OPD COUNSULTATION ROOM

1.9. Infrastructure

- Separate room
- Examination bed/Portable Stretcher
- Hand washing provision (soap/washbasin or sanitizer dispenser)

1.10 Human Resource

- Medical Doctor

1.11 Medical Equipment

- Stethoscope
- Otoscope
- Medical documentation forms (prescription, referral cards, lab slips, ANC cards)
- Medical Waste bins

Medical protocols: Clinical guidelines, Essential drug list.

1.12 Activities & Team Responsibilities

MEDICAL DOCTOR

- Collects a complete medical history.
- Assess and performs comprehensive clinical examination of the patient with the aid of diagnostic tests and tools available
- Assess mental health status with particular attention to anxiety and depression; behavioral disorders; somatic disorders; functional complaints; psychotic disorders. Refer to mental health clinician if considered necessary.
- Refers suspected SGBV cases

- Prescribes appropriate treatment and plan a proper follow up (if the date of the next clinic is known)
- Data collection/tally sheet (to be given to the mobile clinic supervisor)
- Ensure a proper hand over written for transfer of patient.

PHARMACY

1.13 Infrastructure

- Separate and well-ventilated room protected from direct extreme sunlight.
- Table, Chairs, Cabinet

1.14 Human Resource

- Pharmacist

1.15 Medical Equipment

- Tablet Cutter
- Plastic boxes for drugs
- Plastic jugs and cups for ORS preparation

Medical Protocols include: Essential Drug list

1.16 Activities & Team Responsibilities

DRUG DISPENSOR

- Provides drugs to the patient according to doctors' prescription.
- Checks right drug is being dispensed to right patient,
- Checks right dosage, route and timing of drug is being administered. In case of unclear prescription, the drug dispenser has to cross check with the doctor.
- Responsible for preparing ORS solution and checking the patient taking the first dose for any signs of anaphylaxis.
- Explanation and education are provided to the patient about his/her treatment and disease.
- Fill in drugs daily consumption (to be given to the mobile clinic supervisor)

- Ensures proper storage of drugs and inventory management.

OTHER SERVICES (REPRODUCTIVE, MENTAL HEALTH)

Reproductive Health Service Pre requisites	*Mental Health Service Pre requisites*
Human Resource: Female Doctor accompanied by midwife Activities & Team Responsibilities ANC (Ante Natal Care) ○ Questioning and carrying out examinations (check for hypertension, edema, abdominal palpation of fundus) of patients during consultations. ○ Referring to the nearest EPI in case of need of anti-tetanus vaccinations in accordance with the vaccination calendar ○ Providing necessary information to future mothers, for example on: ○ The importance of vaccination and following prophylactic treatment, the importance of pregnancy follow-ups and early detection of signs of delivery, the detection of all anomalies during the pregnancy (signs of infection, blood loss, etc.)	Human Resource: Volunteers/Counsellors trained in Mental health & Psychosocial support. Activities & Team Responsibilities: ○ Conduct a mental state assessment and risk screen ○ Initiate basic assessment and Psychological First Aid ○ Assessment and treatment with ○ brief (very limited) psychological interventions as appropriate to context. For instance: Motivational interviewing Structured Problem Solving Brief Supportive Psychotherapy Consider referral to secondary service where appropriate

○ Identify potentially complicated deliveries for early referral (previous scar in uterus, multiple gestation, severe pre-eclampsia, abnormal lie at term, poor obstetric history etc.) the nearest gynecologist (referral letter) ○ Updating the patients' register and follow up forms ○ Provide Ferrous Sulphate + Folic acid (Medical Doctor prescription) PNC (Post Natal Care) Maternal Review: ✓ Vital Signs ✓ Uterine Involution ✓ Secondary post-partum hemorrhage ✓ Anemia, Sepsis or Breast Complication ✓ Any concurrent illness example urinary incontinence ✓ Contraception Options ✓ Assessment of psychosocial wellbeing Neonatal Review: ✓ Maternal History (fever, past treatments, prolonged rupture of membranes) ✓ Head to toe vital (eyes, palate,	

genitilia, reflexes) ✓ Temperature ✓ Weight and Height ✓ Head Circumference ✓ Cord Care (keep clean and allow to dry) ✓ Feeding ✓ Signs of danger illness (sepsis, convulsions, congenital defect)	

DEPLOYMENT SOPs

A. DEFINITION

Emergency Medical Teams (EMT) consist of healthcare professionals trained to provide clinical care in health emergencies such as epidemics, disasters, or other large-scale incidents requiring medical intervention. EMTs can be national, international, civilian, military, or NGO-based.

B. EMT SCOPE AND COMPOSITION

The EMT will comprise healthcare professionals including doctors, nurses, paramedics, and support staff. (Please refer to guide above for emergency medical camp and associated HR requirement) The team leader will ensure the effective deployment and coordination of medical teams in emergencies such as epidemics, natural disasters, or other public health emergencies.

C. OVERALL ADMINSTRATIVE SETUP IN DISASTERS/HEALTH EMERGENCIES

District Level: The District Secretary or Deputy Commissioner will be in charge of all emergency response related activities at the PRCS district branch level, including EMT operations.

Provincial Level (PHQ): The Health Coordinator/Health In charge will oversee all disaster/emergency-related activities, including the deployment of EMTs, and report issues to the National Headquarters (NHQ). The PHQ will also supervise and assist NHQ staff and volunteers in all disaster operations in the province.

National Level (NHQ): At the National Headquarters level, the Director Health will be responsible for all disaster/emergency management activities, including EMT operations. They will report to the Secretary General and coordinate with NDMA, MoH, IFRC, ICRC, and other Movement Partners. Movement of any stocks or resources will require their approval, and they will update the IFRC GO platform accordingly.

Communication Channels:

PRCS will establish communication with MoH at all levels (national, provincial and district) for early detection and alerts regarding potential health emergencies (e.g., outbreaks, epidemics). PRCS district branches will be responsible for further disseminating this information to the vulnerable population to ensure timely preparedness and response.

Media Coverage during Health Emergencies:

Authorized Communication: Only PHQ-authorized personnel will be permitted to issue any press releases or media notes related to health emergencies or PRCS's response actions. However, PRCS district branches may issue district-specific press notes, provided they are confined to the situation within their district and do not conflict with overall PRCS/IFRC response SOPs.

Stocking & Warehousing for Health Emergency Response:

PRCS Health Care logistics and warehousing will guide the management and storage of medical supplies, emergency health kits, and other related equipment.

- **Stock Locations**: NHQ will maintain stocks of medical and health-related supplies at strategic locations. PHQs are responsible for collecting these stocks once released by NHQ.
- **Stock Requisition**: NHQ stocks will be requisitioned following the defined communication channels and reporting requirements, ensuring timely provision of supplies to the PHQ as needed.
- **Distribution of Medical Supplies**: On-site distribution of medical supplies (medicines) should be avoided. Patients and affected populations should be directed to health facilities or mobile health units for organized and supervised care and assistance.
- **Stock Utilization**: NHQ's health emergency supplies placed in shared warehouses or branches cannot be used without prior approval from NHQ.

Procurement for Health Emergencies: PRCS will follow **PPRA rules** and its approved SOPs for **emergency procurement** of medical supplies, equipment, and services in response to health emergencies.

Perdium for Health Emergency Response: PRCS will adhere to the approved per-diem rates for staff involved in health emergency response, including EMT members. For volunteers, the applicable per-diem rates as outlined in the **PRCS Youth & Volunteers Policy** will be followed during health emergencies.

D. EMT ACTIVATION

The activation of the EMT is a critical step in emergency response and must follow a clear protocol to ensure effective and safe deployment.

Decision to Activate:

The PRCS Health & Operations Department, in coordination with disaster management and health authorities at all levels, will assess the situation to determine the necessity for EMT deployment, based on the scale and severity of the health emergency

Notification and Readiness Check:

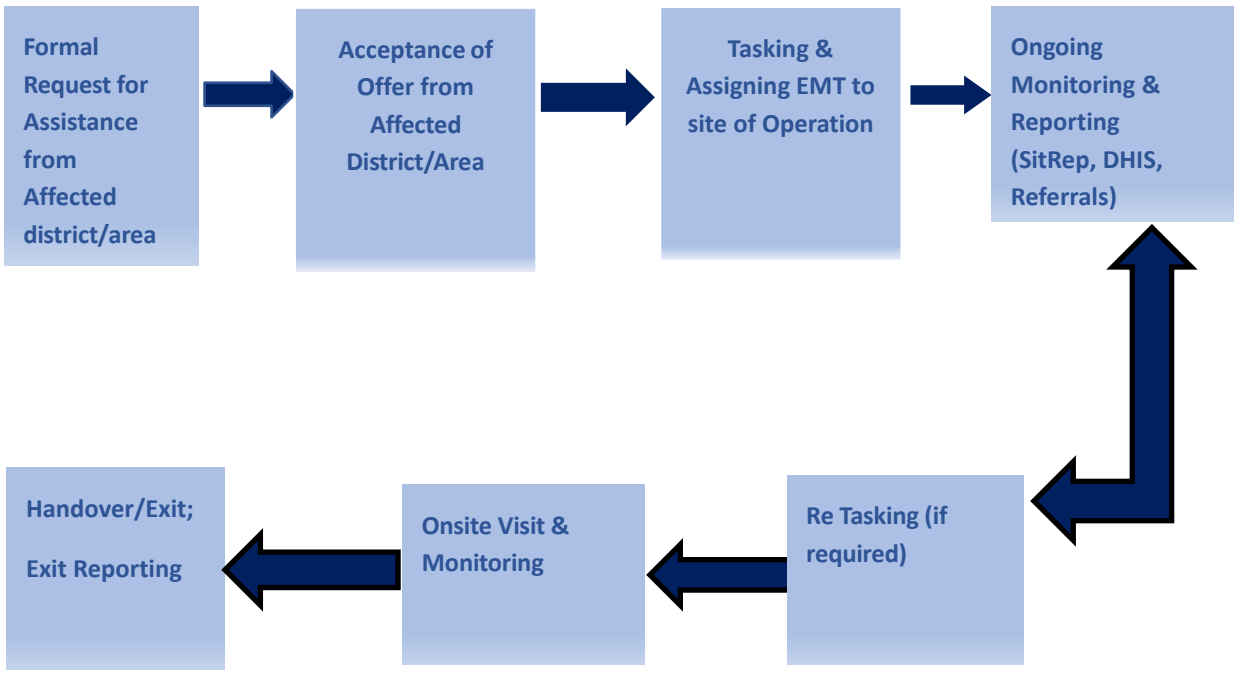
The EMT leader will be notified immediately of the decision to activate the team. Upon receiving this notification, the leader must:

- Confirm the availability and readiness of all EMT members.
- Ensure all medical supplies, equipment, and vehicles are prepared for immediate deployment.

Coordination with Authorities

The EMT leader will coordinate closely with provincial authorities, including local health departments and disaster management units, to confirm the deployment site and ensure all logistical arrangements are in place.

Deployment Roadmap



E. *REPORTING & CHAIN OF COMMAND*

- **Position Title**: EMT Leader

Reporting Channel:

Line Manager**:** Provincial Secretary,
Technical Manager: to Provincial Health Coordinator & Manager Operations.

F. PURPOSE

The EMT Leader is responsible for coordinating with EMT members, overseeing the response, and ensuring the team's operational readiness and compliance with medical standards.

G. DUTIES, RESPONSIBILITIES, AND ACCOUNTABILITIES OF EMT LEADER

1. Coordinate closely with the Provincial Health Department and Disaster

Management Department for deployment and response activities.

2. Lead the EMT and ensure all members are equipped and prepared for deployment.
3. Oversee the logistical arrangements for team deployment, including transportation and medical equipment.
4. Ensure EMT members are trained and briefed on emergency response protocols.
5. Liaise with provincial and local authorities to ensure effective coordination during deployment.
6. Provide regular updates/Sitrep as per defined frequency to the PRCS Health Department on the response efforts.
7. Submit a post-deployment report to the relevant authorities detailing the EMT's activities and outcomes.

H. EMT REGISTRATION

All EMT members must be registered with the PRCS Health Department, and official identification cards shall be issued to each team member.

EMT members must carry their dedicated medical equipment and wear designated uniform (Lab coats for Doctors, Jackets/Caps for rest of team members) during response operations.

I. EMT DEPLOYMENT

In the event of a health emergency (e.g., epidemics, disasters), the EMT will be deployed to the affected areas to provide clinical care and support local health facilities.

- The EMT leader will coordinate with the Provincial Health Department and local authorities to confirm deployment.
- Ambulances and medical transport will be organized by the provincial headquarters, and the EMT leader will maintain communication with deployed teams.
- Additional teams may be deployed on need base on the scale of the emergency.

J. EMT REPORTING

The EMT leader must complete a deployment report detailing the event, response activities, and outpatient consultations. This report will be submitted to the Line and Technical Managers. (Reporting Formats are attached as Annexure B)

K. EMT DEBRIEFING

After each deployment, the EMT leader will conduct a debriefing with team members and provincial management to evaluate the response and identify areas for improvement.

L. EMT TRAININGS

EMT members must undergo mandatory and recommended training:

- **Mandatory**: Basic Life Support (BLS), Health Camp Management, Infection Control, Mass Casualty Management.
- **Recommended**: Community Based Health & First Aid, Epidemic Control, Leadership, Communication, and Mental Health support during emergencies.

M. EMERGENCY RESPONSE EQUIPMENT FOR EMT

A list of essential medical supplies required for EMT deployment is attached as Annexure A.

N. MANAGEMENT OF EQUIPMENT FOR EMTS

- EMT equipment will be maintained by the Provincial Health Department.
- The EMT leader is responsible for issuing equipment to team members upon deployment, ensuring proper documentation through handover reports, and ensuring the kits are returned after use.
- Following each deployment, the EMT leader will submit a detailed utilization report, and the Provincial Health Coordinator will oversee the restocking of the essential equipment as needed.

EXIT STRATEGY

It is important that the demobilization phase of each EMT is synchronized with the exit strategy and the phasing out or transition of clinical care provision to local providers or agreed alternative. EMTs require a planning framework for demobilization, which must cover the necessary human and financial resources, to ensure that EMT can be efficiently demobilized without disruption of health services.

This important phase, often referred to as “reverse logistics”, includes repackaging within an acceptable time frame to facilitate readiness for future operations.

A step wise approach to Exit Planning is as follows:

Return to Normalcy

The following key parameters, along with declarations by the Ministry of Health (MoH) and Disaster Management authorities, signal the need to execute Exit Strategy:

Reduction in Disease Burden:

- Health indicators show consistent declines in infectious diseases, including respiratory infections and vector-borne illnesses, returning to baseline levels.

Healthcare Accessibility:

- Primary healthcare facilities in affected areas are operational, adequately staffed, and equipped to handle routine patient loads.

Supply Chain Stability:

- Essential medicines, medical supplies, and nutritional support are restored and accessible through local and regional supply chains.

Public Health Infrastructure:

- Water, sanitation, and hygiene (WASH) systems are restored to pre-emergency standards, minimizing the risk of disease outbreaks.

Monitoring and Evaluation

Monitoring processes should continue based on funding and manpower availability.

Disease Surveillance:

The PRCS Sindh Branch will monitor epidemiological data, including disease trends and vaccination coverage, to evaluate the need for continued emergency response.

Health Team:

- On-ground teams will assess healthcare facility functionality, supply chain status, and community health needs.

Regular Reporting:

- Updates on health conditions, service delivery, and community needs will be shared internally and with health authorities.

Phased Transition

Based on on-site reports and alerts from MoH and Disaster Management authorities:

1.Scaling Down Emergency Measures:

- Gradually reduce the number of deployed mobile health teams.
- Shift focus from emergency medical services to health promotion, disease prevention, and capacity building.

2.Integration with Local Health Systems:

- Collaborate with district health offices to ensure a seamless transition of healthcare delivery responsibilities.
- Provide training and resources to local health workers if needed.

3.Financial Closure:

- Complete financial reporting and settle accounts related to the health emergency response.

Handover and Post-Emergency Activities

1.Handover to District Branches:

- Collaborate with district branches to ensure the transfer of essential medical supplies as per PRCS reporting requirements.
- Plan with branches and communities to sustain essential, low-cost, high-impact initiatives such as disease prevention and health promotion campaigns.

2.Post-Emergency Activities:

- Conduct detailed health impact assessments, including exit surveys, to inform future emergency preparedness.
- Store and maintain medical supplies and equipment as per Health Warehousing SOPs for future emergencies.
- Document lessons learned to enhance the PRCS Sindh Branch's readiness for future health crises.
- Prepare, submit, and disseminate comprehensive reports on the health emergency response, highlighting achievements and areas for improvement.

Additional Considerations

Exit Planning should begin as soon as the deployment is considered:

- Coordinate exit and handover of services, equipment and consumables with local health authorities **at least seven days** before shutdown.
- Community engagement should be undertaken well in advance with clear messages about alternative service plans, nearby health facilities and other EMTs.
- Prior to deployment, plan and prepare a description and analysis of the elements to be discarded, reused or donated.

ANNEX A (ESSENTIAL MEDICINES & EQUIPMENT)

MEDICAL SUPPLIES	
Blood lancet	Box
Cotton roll 500 g	Roll
Crepe bandage 5 cm	Roll
Crepe bandage 10 cm	Roll
Crepe bandage 3 cm	Roll
Gauze roll	Roll
Gauze swab 4*4	Piece
Polyvidone iodine, 10%, solution, 200 ml	Bot
Glucometer Strips	Piece
Glucometer	Piece
Hb Strips	Piece
Hemoglobinometer	Piece
ENT set	Piece
Examination torch	Piece
Pulse Oximeter	Piece
Disposable gloves	Box
Latex gloves (Sterile)	Box
Zinc Oxide Adhesive Plasters	Piece
Pregnancy Testing Strips	Piece
Urine Collection Bottles (Transparent)	Piece
Urine Testing strips	Piece
Protective mask	Box
Sharp containers (large)	Piece
Sharp containers (small)	Piece
Thermometer	Piece
Tongue depressor	Box
B.P Apparatus clock	Piece
Stethoscope	Piece
Otoscope	Piece
Patient stool (Standard Stainless steel)	Piece
Weight machine child digital	Piece
Weight machine adult digital	Piece
Nebulizer Machine	Piece
Nebulizer mask adult and pediatrics	Piece
Dressing tray with Lid large size	Piece
MUAC tape	Piece
Scissor general	Piece
Artery forceps straight	Piece

Artery forceps curved	Piece
Surgical knife	Piece
Needel holder forceps	Piece
Surgical set	Set
Alcohol swab (Square Pad, 2.5 x 2.5 cm)	Piece
Alcohol gel hand sanitizer for medical teams 500 ml	Piece
Megaphone for the health/hygiene education	Piece
IEC materials for health/hygiene education	Piece
Pens	Piece
Reporting Formats (Hard Copy)	Copy
Clinical Guide Book	Book
Waste Bags (Color Coded for Infectious and Non-Infectious Waste)	Piece
Waste Bins (Green- Non-Infectious Waste)	Piece
Waste Bin (Yellow-Infectious Waste)	Piece
Rapid Testing Kits (Need Based)	Kits

Essential Medicines	
Oral Drugs	
Aluminum Hydroxide syp +Magnesium hydroxide 200mg syp	Syrup
Aspirin 75mg	Tab
Atenolol 50mg	Tab
Amoxicillin cap 250mg	Cap
Amoxicillin cap 500mg	Cap
Azithromycin cap 250mg	Cap
Artemeter /Lumefantrine 20/120mg tab	Tab
Artemeter /Lumefantrine 15/90mg ,30ml syp	Syrup
Amoxicillin +Clavulanic acid tab 625mg	Tab
Amoxicillin 250mg/5ml, Clavulanic acid 62.5mg/5ml	Syrup
Amlodipine 5mg tab	Tab
Ascorbic acid tab	Tab
B complex with lysin ,120ml	Syrup
Cefixime syp 200mg/5ml	Syrup
Cefixime cap 400mg	Cap
Ciprofloxacin tab 250mg	Tab
Ciprofloxacin tab 500mg	Tab
Ciprofloxacin syp 125mg/5ml,60ml	Syrup
Cephradine 125mg/5ml, syp 60ml	Syrup
Chlorpheniramine tab 4mg	Tab
Chlorpheniramine 2mg/5ml/120ml	Syrup
Calcium carbonate with vitamin D3 chewable tab	Tab

Calcium + Vit C	Tab
Dimenhydrinate syp 12.5mg/4ml	Syrup
Dimenhydrinate 50mg tab	Tab
Doxycycline cap100mg	Cap
Diclofenac Sodium 50mg	Tab
Drotaverine tab 40mg	Tab
Ferrous gluconate 250mg, vitamin B12, Fefolvit	Tab
Cough syp expectorant 120ml (Aminophylline plus)	Syrup
Folic acid tab 5mg	Tab
Ibuprofen syp 100mg/5ml, 120ml	Syrup
Ibuprofen tab 200mg	Tab
Iron hydroxide polymaltose complex 50mg/5ml	Syrup
Lactulose syp	Syrup
Loperamide 2mg tab	Tab
Labetalol 100 mg	Tab
Metronidazole 400mg tab	Tab
Metronidazole suspension 125mg/5ml,100ml	Syrup
Metformin 500mg	Tab
Mebendazole 100mg/5ml, 30ml	Syrup
Multivitamin tab	Tab
Mefenamic acid tab 250mg	Tab
Metoclopramide tab 10mg	Tab
Nitroglycerin sublingual, 500 mcg	Tab
Nystatin oral drops 30ml	Drops
ORS sachet	Sachet
Omeprazole cap 20mg	Cap
Paracetamol 120mg/5ml syp, 60ml	Syrup
Paracetamol 500mg tab	Tab
Paracetamol drop 30ml	Drop
Sodium acid citrate syp	Syrup
Salbutamol inhaler 100mcg	Inhaler
Zinc sulphate 20mg/5ml, syp 60ml	Syrup
Topical Drugs	
Betamethasone sodium phosphate 0.1% w/v, Neomycin sulphate 0.5% w/v, 5gm eye ointment	Oint
Betamethasone cream 0.1 %	Cream
Clotrimazole cream topical 10gm	Cream
Clotrimazole vaginal cream 35gm	Cream
Ketoconazole lotion	Lotion
Permethrin lotion, 50mg/ml, 5%	Lotion
Piroxicam gel 0.5%	Gel
Polymyxin B 10.000IU+Bacitracin Zinc 500IU, Skinoint	Oint

Polymyxin B 10.000IU+Bacitracin Zinc 500IU Eyeoint	Oint
Silver Sulfadiazine,50gm Cream	Cream
Miscellaneous	
Ciprofloxacin + Dexamethasone 0.3/0.1% ear drops	Bottle
Chloramphenicol Eye 0.5%; Drops (Sterile), Drops with HPMC, 10 ml	Bottle
Norethisterone	Tab
Levonorgestrel and Ethinyl Estradiol	Tab
Dydrogesterone 10mg	Tab
Condoms	Piece
Tranexamic acid 500 mg	Tab

ANNEX B (REPORTING TEMPLATES & FORMS)

OPD REGISTER TEMPLATE

بلاڑاحسرپاکستان

Date:_____

S.No	Name	Phase	Gender	Age	OPD / Emergency	If OPD New Case / Follow Up	Follow Up Date if	Diagnosis	Refferd Yes / No	Examined By	Remarks

Name:	Age:	Gender:
OPD No:	Phase:	Lab No:
Test:		

Laboratory Report

Date: _____

Test	Result	Ref: Values
HBs		
HCV		
Malaria (MP)		
SBR		0.99 mg/dl
Hemoglobin (HB)		11.5 – 16.5 g/dl
ESR		20 mm
Sugar. F (FBS)		80 - 110 mg/dl
Sugar. R (RBS)		80 - 180 mg/dl
Pregnancy		
Blood Group		
CBC		
Rbc		3.50 – 5.50 mill/ul
Platelet		150,000 – 375,000 cmm
WBCs		3,500 – 10,000 /cmm
Neutrophils:		45 – 65 %
Lymphocytes:		20 – 40 %
Monocytes:		04 – 08 %
Eosinophils :		02 – 06 %
Basophils:		00 – 01 %
Absolute Value		
HCT		38 -55 %
MCV		75 – 100 FL
MCH		25 – 35 pg
MCHC		31.0 – 38.0 gm/dl

URINE ANALYSIS

Physical Examination	Chemical Examination	Microscopic Examination
Color:	Albumin:	Red Cells: /HPF
PH:	Sugar:	Pus Cells: /HPF
Sp Gravity:	Bile Salts:	Epithelial Cells:
Quantity:	Bile Pigment:	Casts:
		Granular: /HPF
		Hyaline: /HPF
		Crystals:
		Others:

Vidal	
TO:	
TH:	

Any Comments:

_____

MEDICAL PRESCRIPTION TEMPLATE

Patient Name		**Age**	**Sex**
Union Council	**Village**	**Settled** ☐	**TDP's** ☐
Diagnosis		**Visit:** Follow Up: ☐	Routine: ☐

Vitals

- BP
- Pulse
- Temp
- SPO_2
- R/R

Children Under 5 Years

- MUAC
- Height
- Weight
- Vaccination Hx

Past Hx

Investigation

- UPT
- Blood MP
- Urine D/R
- Blood Cp
- HBS/HCV
- RBS

Presenting Complain

Clinical Examination

℞

Antenatal Card

Yearly Serial No.	Date:
Hospital/Health center's Name:	District:
Name:	Age:
Husband's Name:	
Address:	

LMP:	EDD:	Gravida:	Para:
Years Married:	Blood Group:	Husband's Blood Group:	

A. Obstetric History

Year of Delivery	Outcome			Mode of deliveries			Complications (if any)		
	Live birth	Still birth	Abortion	NVD	Forceps / Vacuum	CS	Pregnancy	Labor	Puerperium
1	2	3	4	5	6	7	8	9	10

B. Menstrual History

1. Menarche		2. Cycle	
		3. Regular/Irregular	

C. Past History: Medical /Surgical/Gynecological, etc.

1. Present Pregnancy Antenatal Record

Date	Weeks Pregnant	Fundal Ht.	Fetal Heart Sound / Fetal Movements	Presentation	Engaged/ Not Engaged	Hb %	HBV/ HCV	Urine		Blood Sugar	BP	Weight	Edema	Next visit	Signature
								Sugar	Albumin						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

Advice

2. USG Findings/ Pregnancy test Result / Finding of ohter Test	TT Vaccinations	
	TT-1	
	TT-2	
	TT-3	
	TT-4	
	TT-5	
	Booster	
	Fully Immunized	

3. MANAGEMENT PLAN

☐ Await Spontaneous Delivery ☐ Induction of Labor ☐ Trial of Labor ☐ C-Section ☐ Delivery at tertiary level hospital

Doctor:

Signature:

Date:

MEDICAL REFERRAL FORM TEMPLATE

Referral Form

Reg No._____

General Information

Date		S/o, D/o, W/o	
Patient Name		Contact no.	
Weight		Date of Birth/Age	
Gender		Referral Hospital	

Section I: Filled by PRCS Medical staff before leaving the Facility

Reasons for Referral	**Clinical diagnosis and history**
.....	.....
Patient vital signs Blood pressure: ..... Temperature: ..... Pulse:	**Any allergies?** .....
Patient condition at exit Conscious ○ Unconscious ○	**Drugs administrated /treatment given** .....

Doctor/LHV Name & Signature .....

Note for the referral hospital medical staff: Dear Doctor/medical/paramedical staff, we are referring this patient for health care services to your health facility. We will kindly follow up his/her situation with you in 24 hours; in case you need additional information or support please do not hesitate to contact us on: .....

Section II: Filled by Referral hospital Medical staff

Name &Position of the Referral Hospital staff receiving the patient:	Hour of reception:	Signature:

Section III: Filled by PRCS Medical staff after 24 hours of the referral

Follow up call time and date: Name of the staff doing the follow up:	Name of the referral staff receiving the call: .....
Patient situation:	

PSYCHOSOCIAL SUPPORT (GROUP COUNSELLING FORM)

Date		**Location**	
Objectives of Session			
No of Participants	**Male:**	**Female:**	**Children:**
Time			
Proceedings			
Summary of Session			
Individual Counselling Case Identified			
Name	**Contact Number**	**Gender**	**Phase**

Psychosocial Support Officer Name & Signature: _____

PSYCHOSOCIAL SUPPORT (INDIVIDUAL COUNSELLING FORM)

Individual Assesment & Counselling Form Date: _____

S. No	Step –I: Preliminary Assessment	
1	Name	
2	Father Name	
3	Father Occupation	
4	Family system	
5	Occupation/Designation	
6	Gender	
7	Education	
8	TDPS Camp Residency	
9	Duration in Camp	
11	Tribe	
12	Refer by Doctor/Hygiene Promotor/Self / Other (Govt. Hospital/BHU /INGO and NGOs)	

Psychological S/S	Response	Psychological S/S	Response
Stress		Negative thinking	
Feeling of sadness		Issues with friends	
Feeling of fear		Suicidal ideation	
Disturb Sleep		Drug/Anti-psychotic	
Palpitation		Half head pain	
Burden feeling		Shyness	
Personality issues		Hopeless feeling	
Paranoid thinking		Poor Self-Concept	
Adjustment issues		Impulsivity	
Low Confidence		Complex of Inferiority,	
Lack of concentration		Pervious Psychiatry history	
Feeling of Inferiority		Sweating	
Family and Personal issues		**Psychological Analysis**	
Aggression			
Feeling of Hopeless			
Overthinking			

STOCK REPORT TEMPLATE

Pakistan Red Crescent Society MHT , Supported by IRFC Consupmtion of the Medicines

District: Dadu **Province: Sindh**

S.No	Description	Total Quantity	Feb-23																								Balance
			W	T	F		M	T	W	T	F		M	T	W	T	F		M	T	W	T	F		M	T	
			1	2	3		6	7	8	9	10		13	14	15	16	17		20	21	22	23	24		27	28	
1	Paracetamol Syp																										0
2	Panadol Drops																										0
3	Tab. Mefenamic Acid																										0
4	Syp. Amoxicillin/																										0
5	Syp. Metronidazole																										0
6	Tab. Albendazole																										0
7	Multi vitamins/ Ascorbic acid																										0
8	Amlodipine/Captopril																										0
9	SYP. PARACETAMOL																										0
10	CEFIXIME, 100mg/5 ml, suspension																										0
11	AMOXICILLIN, 125 mg/5 ml,																										0
12	CEFIXIME, 400 mg, tab.																										0
13	(ORS)																										0
14	IBUPROFEN, 200 mg, tab.																										0
15	METRONIDAZOLE, 400mg, Tab																										0
16	METRONIDAZOLE 125mg/5ml,																										0
17	OMEPRAZOLE, 20 mg, caps.																										0

HANDING/TAKING OVER FORM TEMPLATE FOR EQUIPMENT/SUPPLIES

Pakistan Red Crescent Society
Sindh Provincial Branch
Handing Over / Taking Over

MHT Badin

S#	Article	Qty	Remarks
MEDICINES			
1	Aluminium hydroxide Syp +Magnesium hydroxide 200mg/5ml, 120ml Syp		
2	Albendazole 400mg tab		
3	Amoxicillin 500mg		
4	Amoxicillin 125 MG/5ML		
5	Metronidazole, 400 mg, tab.		
6	B complex with lysin ,120ml		
7	Cefixime cap 200mg		
8	Cough Syp expectorant 120ml		
9	Ciprofloxacin 250 mg		
10	Ciprofloxacin 500 mg		
11	Calcium carbonate with vitamin D3 chewable tab		
12	Ibuprofen tab 200mg		
13	Ibuprofen Syp 100mg/5ml, 120ml		
14	Iron hydroxide polymaltose complex 50mg/5ml		
15	Mefenamic acid tab 250mg		
16	Chlorpheniramine 2mg/5ml/120ml		
17	ORS sachet		
18	Dimenhydrinate 12.5 mg/4ml , 60 ml		
19	Omeprazole cap 20mg		
20	Paracetamol 120mg/5ml Syp, 60ml		
21	Paracetamol 500mg tab		
22	folic acid 5mg tab		
23	Captopril tablets		
24	Permethrin cream 5%		
25	Multivitamin tab		
26	Amlodipine 5mg		
27	Betamethasone Valerate 0.1%		
28	IODINE POVIDONE, 10%, solution		
29	Surgical Gauzes ,Gauze swabs/Sponges 10cm*10cm*8 ply, 10pcs /pack		
30	Metformin 500 tab		
31	Metronidazole syrup 200mg/5ml		
32	Polymyxin B 10.000IU + Bacitracin Zinc 500IU Eye Oint		
33	Nilstatin oral drops		
34	Drotaverine 40mg tab		
35	Zinc Sulphate 20mg/5ml, Syp 60ml		
36	Gauze Bandage Roll		

Any other remarks:

Handed Over By	Taken Over By
Name	Name
Designation	Designation
Date	Date
Sign	Sign

WEEKLY TALLY FORM TEMPLATE

Name of Area/Village	HR Details				Number of patients treated												Total
	Mobile Camps by PRCS				<1 Month		1-11 Month		1-4 Years		5-14 Years		15-49 Years		50+ years		
	# of Camps	Doctors	Paramedics	Volunteers	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	

DHIS-Form (PRCS)

Disease wise break up of the patients

Gastroenteritis		Skin infection		Chest Infection		Hypertension		Diabetes		Diarrhea		Suspected Cholera		Suspected Dengue		Suspected Malaria		Suspected Typhoid	
Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female

Suspected Typhoid		Fever (PUO)		Snake Bite		Dog Bite		Injuries		Others	Total	Laboratory Investigations				Referred Yes/ No
													Confirmed			
Male	Female	Male	Female	Male	Female	Male	Female	Male	Female			Rapid Testing kits Use	Positive	Negative		

ANNEX C (DASHOBOARD & TRACKING INDICATORS)

Categories	Adult (15-49 years) Male	Adult (15-49 years) Female	Elderly (50 and above) Male	Elderly (50 and above) Female	Child (less than 1-month up to 14 years) Male	Child (less than 1-month up to 14 years) Female	Total
OPD							

Categories	Male	Female	Total
Health & Hygiene Awareness			
PSS Individual			
PSS Group			

Total # of MHT Patients who underwent Nutrition screening					
Referral Categories	Pregnant & Lactating Female (PLW) with MUAC less than 21cm	Moderate Acute Malnutrition (MAM) Male Child	Severe Acute Malnutrition (MAM) Male Child	Moderate Acute Malnutrition (MAM) Female Child	Severe Acute Malnutrition (MAM) Female Child
# Referred					

Malaria Rapid Testing				
Week/Month	_____	_____	_____	Total

# of Tests Conducted				
# of Confirmed Positive				

Disease Dashboard					
		# of Cases			
S#	Disease	Month___	Month___	Month___	Total
1	Gastroenteritis				
2	Skin Infection				
3	Chest Infection				
4	HTN				
5	Diabetes				
6	Diarrhea				
7	Suspected Cholera				
8	Suspected Dengue				
9	Suspected Malaria				
10	Suspected Typhoid				
11	Fever of Unknown Origin				
12	Snake Bite				
13	Dog Bite				
14	Injuries				
15	Others				

REFERENCES

1 *IFRC Secretariat Emergency Response Framework - Roles and Responsibilities April 2017*
2 *Disaster Response SOPs, Malaysian Red Crescent Society*
3 *Classification and Minimum Standards for Emergency Medical Teams, World Health Organization (WHO)*
4 *IFRC Health and Care Framework 2030*
5 *Guidelines for the Operationalization of Mobile Medical Services (MMS), Health & Nutrition Cluster- IRAQ*
6 https://itemscatalogue.redcross.int/emergency-preparedness--7/health-eru--6/bhc-information-per-ns--8.aspx
7 https://www.chicago.gov/city/en/depts/cdph/supp_info/health-protection/what_is_a_publichealthemergency.html
8 https://pmc.ncbi.nlm.nih.gov/articles/PMC1854988/
9 *iHFG_part_b_mobile_healthcare_unit.pdf*
10 *IFRC CommunityHealthStrategy 2020-2030.pdf*
11 *https://www.ifrc.org/our-work/health-and-care/emergency-health*
12 *IFRC Tool Community Engagement & Accountability Toolkit; Tool 20: Exit Strategy Guidance*
13 *International Federation of Red Cross and Red Crescent Societies Guidelines / Communicating in emergencies*
14 *Pan American Health Organization Information management and communication in emergencies and disasters: manual for disaster response teams*
15 *A Guide on Communicating in Public Health Emergencies, BBC Media Action*