



Ukraine Mission 2022

Mission Final Report



SAMU EMT

July 2022

Contents

1. Introduction	4
2. Situation	4
2.1. Romania	4
2.2. Moldova	5
2.3. Poland.....	6
3. Organization.....	8
4. Intervention.....	9
4.1. Romanian	9
4.1.1. Logistics	9
4.1.2. Organizational	10
4.1.3. Attendance.....	10
4.2. Moldova	12
4.2.1. Logistics	12
4.2.2. Organizational	14
4.2.3. Assistance.....	15
4.3. Back Office.....	17
5. Human Resources.....	17
5.1. Ready.....	17
5.2. Staff	19
6. Coordination.....	20
6.1. Romanian	20
6.2. Moldova	20
6.3. Back Office.....	21
7. Assistances	21
7.1. Overall	21
7.2. Romanian	22
7.3. Moldova	25
8. Assistance Analysis.....	28
8.1. Technical description	28
8.2. Data collection.....	28
8.3. Results	28
8.3.1. Sociodemographic data.....	28

8.3.2.	Pathology.....	29
8.3.3.	Relationship to the event.....	30
8.3.4.	Other relevant data.....	30
9.	Development Proposals and Health Support.....	31
9.1.	Development Proposals.....	31
9.2.	Health Support.....	31
10.	Expenses.....	32
11.	Exit-Plan and Hand-Over.....	32
11.1.	Romanian.....	32
11.2.	Moldova.....	33
12.	Conclusions.....	33
13.	References.....	34

1. Introduction

It is important to have a comprehensive vision of the regional situation regarding the mobilization of migrants for political reasons in search of refuge and asylum, so that they can be planned in health planning in the event of possible humanitarian crises, with the aim of improving the current world situation. situation.

The number of refugees, asylum seekers and internally displaced people in the world has exceeded 50 million people for the first time since World War II in 2016 due to the conflict in Syria. Likewise, new and significant displacements were registered in Africa, particularly in the Central African Republic, and at the end of 2018, also in South Sudan in 2020 (UNHCR, 2021).

These events have given rise to the so-called "Migration Crisis in Europe", which has become a critical humanitarian situation, which worsened in 2015, due to the increase in the uncontrolled flow of refugees, asylum seekers, economic migrants and other migrants in a condition of vulnerability, shared jointly by irregular migration routes to the countries of the European Union (Villaseñor-Bayardo, Alarcón, & Rohlof, 2016).

If Europe has mostly developed countries, the sudden demand for political asylum and refuge due to the conflict between Russia and Ukraine has represented a saturation in the social response capacity of those affected. The countries with the greatest tendency to apply are Poland, Romania, Slovakia and Hungary, which caused a saturation of the population in these four territories.

At this point, it is imperative to understand how the human tides that seek to supply basic needs exceed the response capacity of the community to meet demand and keep services running normally.

This report aims to highlight the most common health and protection impacts found among migrants and refugees in the cities of Tulcea (Romania), Ivangia (Moldova) and Chisinau (Moldova) during March 3 and June 18, 2022. It focuses on the composition of the displaced, mostly motivated to mobilize due to the situation during the deployment of the Russian invasion on Ukrainian soil and the pro-Russian conflict generated in the bordering regions of Donbass and Transnistria.

The results are based on data obtained among migrants in refugee centers and border points, carried out by the SAMU Foundation support staff in collaboration with Project HOPE and supported by the Romanian Ministry of Security and the WHO EMT Initiative.

2. Situation

2.1. Romania

Upon arrival in Romania, the Ministry of Defense declares the assistance and logistics capabilities of the team, for which the Port of Isaccea in Tulcea is assigned, to support the incoming displaced persons.

The port of Isaccea is the only river border point between Romania and Ukraine, so the crossing is made by ferry. The boats take approximately 90 to 180 minutes to return (since

there was only one boat in operation) and each boat could accommodate between 100 and 700 people depending on the number of vehicles it carried.

During the first weeks temperatures of 5°C and lower were perceived, reaching -10°C on the coldest day. This was subject to considerable logistical and attendance constraints.

This is the Tulcea border post and it is where we focused our first attention and where we continue to work at that moment. Once we acquired everything necessary to set up a medical post that was more than adequate for the needs, we were able to realize that the number of inflammations was being reduced even though the number of displaced people was being very high.

In the following days we were able to quickly perceive that the device was oversized for the needs and it was decided to explore the possibility of a second location, in this case in Moldova, a reconnaissance team moved to this country and after contacting the authorities they assigned us an area where to develop our exercise.

At that time the activity in Isaccea was scarce, even going so far as to consider the use of our team since there were days when the number of returnees was greater than the newcomers.

The Romanian Civil Protection / Fire authorities who came to request the extension of services to all border posts in the country requested that they remained in the presence of the health team, so that the activity is maintained until its closure by management decision, the May 28.

2.2. Moldova

The initial point of care by order of the Ministry of Health was a shelter with 80 beds where a medical post was set up with little assistance for the disabled, since there was no activity, the main cause for concern. Identified the problem that we needed to coordinate with the Ministry of Health, to increase our assistance capacity, through the configuration of a mobile team with which the different shelters distributed throughout the country could be attended.

The team visited about 10 shelters, and yet the level of patient care we understand could be higher, maximizing the usefulness of our effort. The proposal was to maintain the medical post in the Ivancea shelter to the north of the capital and at the same time be able to provide mobile team services.

Meanwhile, a second contingent was being deployed that would continue the service in both locations at the same time that a reconnaissance team was planned in Poland, more specifically in the city with the largest refugee population in Europe, Krakow.

The second contingent was divided into two, the first team will continue to provide assistance at the border post, since the Medical Post has known to have a great reputation and respect within the well-organized assistance device of the Romanian government through its fire department.

The displaced team from Moldova provided assistance on this occasion at the Moldexpo Convention Center, where an emergency shelter for 450 people had been set up and which was being cared for by the health services of the Chisinau City Council, in the capital. Whose staff were already very exhausted from having to extend their actions to this type of resource and for which reason the country's government had requested assistance from foreign health teams.

The EMTCC was established and SAMU was assigned to collaborate with SWISSAID to assist at MoldExpo. After exactly one month of service, SWISSAID decided to close its mission, so SAMU's service in this location expanded, taking into account that it covered the entire population residing in the facilities plus those in transit who request documentation at the UNHCR offices.

2.3. Poland

Poland has received around 3,500,000 refugees and in this case most of them have continued their progression towards third countries of the European Union. Still, there are a large number of people who have decided to stay in the vicinity of their country.

The problems that were observed in the shelters arranged in order to receive them, in the lack of knowledge in managing them, were directed by volunteer personnel with no previous experience in the development of similar situations, and this is what they are. fed by an extensive volunteer staff that collaborates without planning or order.

Through Sarah Griffith we contacted a shelter run by 3 NGOs and funded by the Bayer Foundation in Germany. This foundation asked Sarah to advise on the management of this shelter that had to be opened urgently due to the great need for spaces at that time and the scarce resources available and reported cases of human trafficking.

Upon the arrival of the director of SAMU in Poland, the shelters that had been open since the crisis are mostly at 70% capacity, and possible new avalanches of refugees were expected depending on the conditions in which they will evolve. war

The problems exposed by the local authorities at this time were:

- The eventual resources created, and the foster families began to be deactivated due to lack of funds or due to the fatigue of the volunteers or the foster families.
- There were 12 hour shelters, to a maximum stay of one month, with which the refugees in many cases found themselves in a situation of abandonment, changing from one place to another, hence many of them decided to return to their country or move to a third country.

The options that were raised were aimed at obtaining funds for the opening, together with collaborating local entities, of long-stay centers, our initial approach would be aimed at a one-year stay.

There were three hosting options considered at the time were:

1. A building, a former seminary, of 6000 square meters with capacity for 200 people and a wide list of services, given on its surface. Unreformed and unfurnished. Its price initially amounted to 30,000 euros net per month.
2. A hostel with capacity for 100 people, equipped and functional, but with few spaces for common use, basically the dining room, the reception, the English patio and the office. The cost of this space was 15,000 euros per month.
3. A three-star hotel could be a magnificent small-sized center, but with more possibilities since it had a dining room, conference room, outdoor space and office area. Likewise, there is a large 2-room apartment for possible use by personnel in transit.

The cost of this resource was calculated at €10,000/month, equipped and with all services in order. It is a pleasant space with immediate availability.

The projects that were being considered at that time were a long-term center based on the seminar with a different capacity of places. In this center we intended to develop educational, therapeutic, social work, family reunification, and active job search activities for refugees, there is a great need for labor in a country with a high rate of aging of its population.

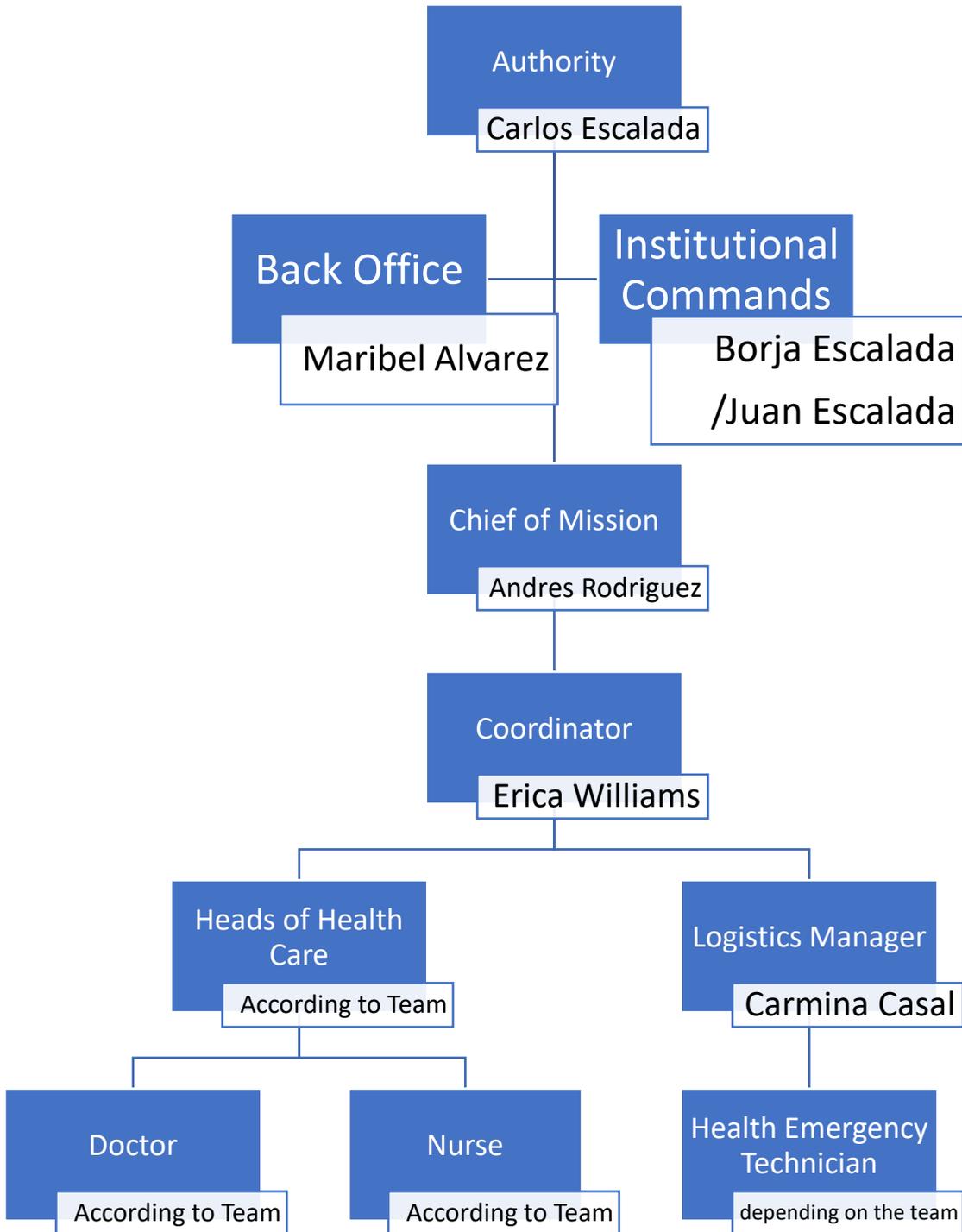
Krakow is historically a population with a different rate of immigration from Ukraine, students and emigrants from the neighboring country make obtaining a workforce according to needs a facilitating factor. Among the initiatives, it would be desirable to hire the refugees themselves for this same purpose. To provide a powerful holistic environment where all residents' needs and aspirations are met by a powerful multi-disciplinary team that would be initiated, trained and supervised by SAMU staff.

The first estimate of the annual budget for this device placed it at around 1.3 million euros per year. This project was designed to be carried out in conjunction with Project Hope and the Bayer Foundation.

A request for help was received from a small local NGO for a refugee center for people who have fled the war with physical or mental disabilities and no one wanted to house them.

In the end, no resources were allocated to put the project in motion.

3. Organization



4. Intervention

4.1. Romanian

4.1.1. Logistics

Locations

As of March 4, 2022, a health support point will be established in Port of Isaccea, Tulcea in the arrival area of the border crossing with Ukraine at the request of the Romanian Ministry of Defense. By order of the local camp commander, Cnl. Daniel Petrov, to maintain the homogeneity of any deployed structures, SAMU must take advantage of two of the tents deployed by the Romanian fire brigade.

Both premises, identical to those found in the area, measure 6.30x9.10mts. They are called Store 1 and Store 2.

Store 1 is distributed as a storage area for medical supplies and medication, a command table, food preparation area and a seating area for receiving visitors.

Tent 2 is distributed with five stretchers, two pediatric, two adults and one for critical patients. In addition, it has a table with the first intervention material, medication ordered according to the WHO recommendations and along with the critical stretcher equipped to provide advanced life support such as: multipurpose adult, pediatric and air handling bag, mechanical ventilator, monitor / defibrillator, hooks for serums, heater, among others.

Waste management

Common waste was discarded at specific containers assigned to the team just outside the service tents, which were emptied every day by the local utility.

The waste of the health care product was collected when its recycling was requested by the company arranged for said service for local hospitals and health centers.

Maintenance

The maintenance of electricity, structures and air conditioning was carried out mainly by the bomber corps, who have daily staff for these tasks.

The collection of waste, cleaning of surfaces, collection of water and handling of biohazardous waste was carried out by SAMU personnel, through a rotating distribution of tasks among the team.

Transportation

During the first assistance session, two vehicles were used, a 9-seater van and a 5-seater car. Both were contracted in Bucharest, so at the end of the contract and its renewal, they should return to Bucharest for the change and/or sign an extension. There were no vehicle rental services in the area (Tulcea) and its surroundings, so a monthly renewal or monthly vehicle change was maintained.

Communications

Since the country had a good communications network, all of SAMU EMT's internal communication was managed via mobile, and since the area was within the Schengen Area, roaming was free. This allowed each team member to use their own data line.

In the Puerto de Isaccea camp, at the beginning, good coverage was provided and high-quality WiFi was offered to the workers. Due to the proximity to Ukraine, the WiFi network could be accessed from across the border and mobile phones could connect to the Ukrainian network. This represented a security breach, for which the local authorities deployed mobile signal jammers and limited access to the WiFi network. During the first days of transition it was almost impossible to maintain communication within the camp. After a week the conditions improved, maintaining the security requirements.

The accommodation had a reliable Wi-Fi network to be able to attend internal meetings or with the Emergency Command.

At the beginning of the deployment, and due to the insecurity of the situation, a 2G telephone was taken, to have redundancy of communications. Due to the high quality of access to mobile service, it was discontinued.

Security

SAMU EMT has a security POE that includes behavior rules, areas to avoid, key numbers and evacuation protocol. Upon the arrival of the contingents, they were informed of the rules to be observed and the main risks. I also talked about the details of the evacuation that I was designed with a security specialist from the WHO. He assured that the only thing he personally knows in detail is the plan. Risk information is managed through the SAMU EMT hierarchy, and through the Romanian Ministry of Defense.

4.1.2. Organizational

As established by the minimum standards of the EMT initiative, the external coordination of SAMU EMT with the host country and other entities has been carried out through the Command Post.

SAMU EMT had the same internal organization throughout the mission. The figures of authority, institution command, delayed cabinet, head of mission, coordinator and head of logistics were fixed. The teams of medical personnel, nurses and emergency health technicians changed according to the contingents, although the roles remained the same.

4.1.3. Attendance

Essentially primary health care was provided. We also attended health emergencies, hospital referrals and patient transfers. We attended exclusively to

the Ukraine conflict. Assistance was provided from 9:00 a.m. to 9:00 p.m., 7 days a week. The team is made up of a coordinator, a doctor, a nurse and a TES.

Translators

From the command post, a volunteer coordinator was assigned, who among several roles to fill, found the translators. Everyone must be able to translate from Russian to Ukrainian, however a grand majority had a third and fourth language, predominantly English, also Spanish, French, Italian and Polish.

Every day the coordinator on duty assigned the different translators at strategic points and they had the order that whenever they took anyone who received medical attention, they had to be accompanied by a translator. Preferably that he mastered Spanish or, failing that, English.

Triage/ Filiation

The Filiation of the patient was made at the beginning of the consultation, with the interview. It is the basic record of SAMU EMT with essential information to facilitate the follow-up of patients, their referral or the study of the needs of the center.

Medical consultation

The consultations were all carried out in Store 2. The patient was assigned a stretcher and the nurse initially assessed the patient while the doctor requested the data.

The consultations could be decisive, either because they provided a solution to the patient's problem, or because Romania was not their final destination and they would continue to another EU country.

Pharmacy

In the pharmacy it was distributed by store. A first part of quick access to daily and emergency medications located in Store 2, and a storage area in Store 1. An updated inventory of medications was available to facilitate the search through TEAMS in a database made in Excell. In both sites the medication was arranged in the same order. Since certain patients required more treatment to be covered until their arrival at their destination, the medication could be given directly from the warehouse.

Transportation

In an emergency, it was carried out with the assistance of the fire department ambulance. If the doctor decided to keep him under observation, he was transferred to Store 2 or transferred to the pertinent hospital using the same ambulance or air-transportation was requested.

Depending on the situation, there are different transfer options:

Tulcea Hospital (38km/40min by land)

- Mild trauma.
- Exacerbated chronic pathologies that respond to *in situ treatment* but require observation for more than 24 hours.
- Observation and Assessment of the healthy pregnant woman.
- Non-emergent acute pathology that does not require surgical intervention.

Constanza Hospital (153km/2h20min by land or 15min HEMS)

- moderate trauma.
- Exacerbated chronic pathologies that did not respond to *on-site treatment*.
- Pathology of pregnancy and obstetric problems.
- Cardiological and neurological processes are not surgical and are not defibrinolizable.
- Hemodynamically stable respiratory process.
- Surgical, medical, pediatric and psychiatric emergent acute pathology.
- Patients with non-surgical or pediatric critical care needs.

Bucharest Emergency University Hospital (290km/4h by land or 25min HEMS)

- Serious trauma and polytrauma.
- Haemodynamically unstable exacerbated chronic pathologies.
- Pregnancy pathology and high mortality obstetric problems.
- Emerging cardiological, neurological and respiratory processes of high mortality and time dependent.
- Surgical, medical, neonatal and serious pediatric emergent pathology.
- Patients in need of Advanced Intensive Support and Critical Care.
- Cancer patients with emerging needs.
- Infectious diseases with mandatory declaration.
- Decompensated and/or exacerbated orphan diseases.

The transfers were carried out in conjunction with the fire service and medical and nursing personnel from SAMU. In case of traveling without a doctor, a team of paramedics from SMUR, a nurse and TES from SAMU would be confirmed, with the telephone presence of the doctor responsible for the transfer. A record of transfers modified by the relevance of the concentrated information was kept.

4.2. Moldova

4.2.1. Logistics

Mobile Team

During the first phase of deployment in Moldova, SAMU was a mobile team because its logistics were light and transportable. Transportation was a key part since the team had to travel from their place of accommodation to the assistance point every day, covering distances of about 40 km. In case of staying several consecutive days in the same place, it can be left in the deployed clinic, as long as it can be locked. The spaces that were used were provided by the shelters that housed Ukrainian refugees, mainly.

Fixed Team

Locations

As of March 28, SAMU EMT began providing medical care at MoldExpo. The space that was used was located in the larger of the two pavilions. It consisted of a room delimited by removable panels, near the main entrance, with large windows, and a lockable door. The consultation had been operated by the team of Moldovan health personnel, as a consultation 24 hours a day because it had a bed, a screen, medication cabinets, a sink, and consultation tables. Upon arrival, SAMU EMT redistributes the furniture to delimit the work spaces, such as space for critical patients, consultation table, pharmacy, preparation table, clean point and personal space. The waiting room was left outdoors to maintain patient privacy given the small size of the space available.

As of April 15, the SWISS AID EMT consultation space (which was located in the other pavilion) remained in the hands of SAMU EMT during the Hand-Over, and was used until June 17, the last day of assistance. It was a much larger space, subdivided, closer to the entrance to the exhibit hall and the UNHCR space. When he had a lockable door, he moved to the SAMU EMT clinic in the second space, where he provided assistance for the remainder of the deployment. The space was organized with the same logic. The entrance was separated from the rest of the pavilion by a curtain. The waiting room may be located in the consultation area, in front of the consultation and file counter and the dispatch counter. Behind, an examination room with material for the care and monitoring of critical patients. It also had a work surface with cleaning material and medication administration and preparation. In addition, the clinic space has four rooms delimited by panels, with locks and communication between them. Among them, the observation with the reserve pharmacy, the rapid use reserve, the staff room and the reserve of little-used material or logistics with the clean point were distributed.

Following the minimum standards for EMTs, the SAMU was deployed with enough medication to start care. Also available from medication left by the Moldovan team, and later from medication provided by SWISS AID EMT. However, the supply of medical supplies and medicines presents certain difficulties. When there was a need to stock up in the area Given that the quantities required were small, and in agreement with CC and MS, it was decided to manage them locally through the network of pharmacies. There was the possibility of going directly to the pharmacy to buy the medicine, of calling the pharmacy management center (Farmacia Felicia, Farmacia Familiei) to obtain information on the availability of certain products or asking through the website, so that you could pick up the order at the nearest pharmacy or deliver it directly to the clinic. Certain materials or medicines could not be obtained because they were not available in the country. These could be traitors by incoming contingents.

Waste management

The management of medical waste was a critical point. It was difficult to find information on waste management at the national level. The end is managed in part through the other EMT and the other part through the Felicia Pharmacy network.

Maintenance

The maintenance of the clinic was carried out by MoldExpo, which provided electricity, light, Wi-Fi, water, services and space. There was a cleaning service for the common areas, but the clinic areas were maintained by SAMU staff.

Transportation

During the deployment at MoldExpo, the team also had an 8-seater rental vehicle, which transported all staff from the accommodation to MoldExpo. This vehicle is also used for personnel changes between Tulcea/Romania and Chisinau/Moldova. The technicians had the responsibility of running the equipment.

Communications

Since the country had a good communications network, all SAMU EMT's internal communication was handled by mobile, each member of the contingent had a local Orange SIM card with credit that covered data and calls/SMS. More data was used than calls/SMS. The accommodations and MoldExpo had a reliable Wi-Fi network to attend the internal meetings of the CC. At the beginning of the deployment, and due to the insecurity of the situation, a 2G telephone was taken, to have redundancy of communications. This phone did not work optimally in Moldova, so it was decided to do without it.

Security

SAMU EMT has a security POE that includes behavior rules, areas to avoid, key numbers and evacuation protocol. Upon the arrival of the contingents, they were informed of the rules to be observed and the main risks. I also talked about the details of the evacuation that I was designed with a security specialist from the WHO. He assured that the only thing he personally knows in detail is the plan. Information about the risks was managed through the SAMU EMT hierarchy and through the EMTCC, in conjunction with the Government of Moldova. The security alert day was May 9.

4.2.2. Organizational

As stipulated in the minimum standards of the EMT initiative, the external coordination of SAMU EMT with the host country and other EMTs is carried out by the EMTC.

SAMU EMT had the same internal organization throughout the mission. The figures of authority, institution command, delayed cabinet, head of mission, coordinator and head of logistics were fixed. The teams of medical personnel, nurses and EMTs changed according to the contingents, although the roles remained the same.

4.2.3. Assistance

Essentially primary health care was provided. They also attended health emergencies, referred specialists and transferred patients. They attended exclusively to the Ukraine conflict. Assistance was provided during daylight hours, between 12 and 8 hours a day as needed, 7 days a week. The team consisted of a coordinator, a doctor, a nurse, one or two EMTs, and a translator. It allowed to maintain balanced schedules with rest times for the staff.

Translators

In addition to healthcare personnel, SAMU's EMT team worked with local translators who spoke English, Romanian, and Russian. They were a fundamental support for dialogue with patients and the development of a therapeutic relationship with chronic patients. They were also essential in understanding the workings of the Moldovan system. For a while there were no translators for the entire day, so tables were translated and computerized translators were used in real time to be able to communicate at a basic level with patients.

The waiting room

In the waiting room there was less space for the relatively small number of patients. Waiting times were very short, less than 5 minutes for most patients. However, the space consisted of 4 chairs and games for children.

Costume/Affiliation

The affiliation of the patient was made at the beginning of the consultation, with the interview. A registry was created with essential information to facilitate patient follow-up and referral to the center's study of needs.

Medical consultation

For most of the consultations, the patient had to be explored. The constant taking was performed on the consultation table and the examination was performed on the examination table with a partition to preserve the patient's privacy. The exploration space was also the treatment space, with adequate lighting, for the care of more serious patients.

The consultations could be decisive, either because they provided a solution to the patient's problem, or because the patient traveled to another destination or lived outside the center. He could have a follow-up appointment to adjust a medication or observe the evolution of a pathology. It could require a specialized consultation, for example, pediatrics, psychiatry, cardiology, etc. external, from the National Health System of Moldova, which was managed together with the Ministry of Health. If the patient is in serious condition, refer to the local health emergency system by calling 112.

The patients were treated mainly in the consultation, although in the event that a patient could not move, the team could go to the boxes or to another pavilion.

Taken to consultation, if there was a need for chronic medication or for a complete treatment, enough medication could be given for up to a month. Treatment is typically given for two weeks, depending on the patient's condition, where to obtain the medication, and travel plans. In the case of patients with inadequate treatment or patients with uncontrollable chronic diseases, strict control was exercised, and patients could be summoned every day for treatment and cash receipts.

At the request of the administrators of MoldExpo to deliver a first aid kit with basic care material etc.

Pharmacy

As indicated, the contents of the pharmacy were distributed in two places. A first part of quick access and a storage area. An up-to-date drug inventory was available to facilitate searching. In both sites the medication was arranged in the same order. Since certain patients required more treatment to be covered until their arrival at their destination, the medication could be withdrawn directly from the warehouse. Both pharmacies were locked up to secure them at night when the medical center ran out of staff.

The ambulance

In addition to the outpatient clinic, SAMU EMT had an ambulance equipped for the medical transfer of patients as a second resource. It was an English ambulance with a large storage capacity inside, and adequate space for work.

Transportation

Two types of transfers were made. The first, from points outside Chisinau for patients referred to SAMU EMT by the EMTCC. The second type of transfer was coordinated by SAMU, within the capital for patients who required support to travel to outpatient clinics.

The transfers were carried out by the technical and nursing staff, with the telephone presence of the doctor responsible for the transfer. A record of transfers modified by the relevance of the concentrated information was kept.

Borders

SAMU EMT provided health care, as a mobile team, at the Leuseni border point. This intervention was carried out at the request of the Moldovan government and with the EMTCC due to the accumulation of more than 600 trucks on the road before the land border crossing with Romania. Some had been waiting for more than a week. The assistance consisted of a predictable risk device during which it was possible to evaluate, identify the need and treat the truckers who requested it. Specifically, he personally passed along the line of trucks, in both directions of traffic, several times during the day. This activity lasted 2 days, a total of 18 hours and was carried out by technical and nursing staff.

4.3. Back Office

Daily communication was maintained by telephone with the Retired Cabinet and the head of mission, as well as frequent meetings between the chief and the coordination of assistance points.

Communication was maintained with the Management of the SAMU Foundation through a WhatsApp group, where relevant information was published for their knowledge, press material and social networks, and the *Situation Report* (Sitrep).

A total of 88 Situation Reports were prepared, consisting of brief information on the daily activities of the mission in general, separated by locality. The contents were distributed by:

- Date
- D+ day
- activities
- Incidents
- Pending tasks
- Critical points
- Controlled by Expenses
- Additional remarks

5. Human Resources

5.1. Ready

A roster was drawn up based on the minimum requirements established by the EMT regulations based on the expected attendance and foreseeable potential risks. Three rosters were run:

- Command and control
 - directive
 - Chief of Mission
 - Coordinator
 - Social Protection and Risk
 - Press and Communication
- Moldova
 - medical
 - nurse
 - tess
 - Logistics
- Romanian
 - medical
 - nurse
 - Logistics

According to the activities generally counted for the mission with the following profiles according to their functions:

- Managerial
 - Institutional functions
 - Management of economic funds
 - Mission Objective Layout
 - Media Relations
 - Direct communication with the SAMU Foundation Management
 - Reception of visits from deep-sea freighters from other entities.
- Chief of Mission
 - Compliance and execution of objectives
 - Internal operational coordination
 - Operational coordination with local managers
 - Coordination with WHO, OCHA, EMTCC and other international agencies.
 - Resource distribution.
 - Management of material donations received and delivered.
 - Development of local protocols
 - Activity reports
 - Substitute staff when necessary.
 - Preparation of personnel charts.
 - Local contract management
 - costs control
 - Preparation of daily reports.
 - Attendance tracking analytics.
- Coordinator
 - Management of personnel activities.
 - Distribution of daily logistics tasks
 - Substitution of command in his absence.
 - Substitute staff when necessary
 - Support in the daily management of the command
 - Support in the preparation of staff quadrants
 - Control of assists released.
 - Coordination of evacuation and transfer of patients.
 - Stock control
- Social Protection and Risk
 - Identify Protection, Shelter and Risk needs.
 - Analysis of possible social interventions.
 - Management support.
- Press and Communication.
 - Documentary activities carried out by the team.
 - Disclose the assistance provided by SAMU EMT
- Medical, Nursing, TES and Logistics
 - Compliance with the activities of your profile based on the assigned positions.

In total, there are five contingents spread over the 108 days of mission. Personally rotated every 21 days (except for the mission chief and coordinator who remained throughout the mission except

for 15 days of their own business each), allowing 2 days of overlap between teams to complete the handover of activities and induction of incoming personnel prior to departure of the contingent.

5.2. Staff

Number	Name	Profile	Position	Team
1	Borja Gonzalez Escalada	ADDRESS	SAMU Foundation Director	first
2	Juan Gonzalez Escalada	ADDRESS	Director of the Emergency Department	Third
3	Andres Rodriguez	NURSE	Mission Command	first
4	Erica Williams	NURSE	Coordination	second
5	Adrian Moreno v.	SW	Support/Social Work	first
6	Juan Rodriguez v.	DOCTOR	Attendance	first
7	Patricia Gonzalez	DOCTOR	Attendance	second
8	Maria Luisa Hermoso	DOCTOR	Attendance	second
9	Pedro Guerrero	DOCTOR	Attendance	Third
10	Rogelio Garrido	DOCTOR	Attendance	Third
11	Noah Romaní	DOCTOR	Attendance	Third
12	Fernando Perez	DOCTOR	Attendance	Fourth
13	Oscar Martin	DOCTOR	Attendance	Fourth
14	Salustiano Garcia	DOCTOR	Attendance	Fourth
15	crisrina gonzalez	DOCTOR	Attendance	Fifth
16	Carlos Alvarez Leyva	DOCTOR	Attendance	Fifth
17	Clara Avila	NURSE	Attendance	First
18	Miguel Angel Lopez	NURSE	Attendance	First
19	Alfonso Becerra	NURSE	Attendance	Second
20	Sergio Bottle	NURSE	Attendance	Third
21	Juana Gil	NURSE	Attendance	Fourth
22	Naomi Gil	NURSE	Attendance	Fourth
23	Sonia Perez	NURSE	Attendance	Fourth
24	Pilar Diaz	NURSE	Attendance	Fifth
25	Pilar Sergio	NURSE	Attendance	Fifth
26	Carmina Casal	EMT	Assistance/Logistics	First
27	Alvaro Grillo	EMT	Assistance/Logistics	First
28	Carlos Carcamo	EMT	Assistance/Logistics	Second
29	Eduardo Romero	EMT	Assistance/Logistics	Third
30	Javier Dominguez	EMT	Assistance/Logistics	Third
31	Alberto Dominguez	EMT	Assistance/Logistics	Fourth
32	Andres Ramirez	EMT	Assistance/Logistics	Fourth
33	Manuel Fernandez	EMT	Assistance/Logistics	Fourth
34	Jorge Garcia	EMT	Assistance/Logistics	Fifth
35	Gonzalo Garcia	COM	Journalist/Communication	Second

6. Coordination

6.1. Romanian

The initial coordination was carried out through the Romanian Ministry of Defense, finally moving to the operational level to the Directorate of Eventual Emergency Affairs and to the local level with the command of the Bomber Corps attached to Isaccea.

Bimonthly meetings were held at the command post in which a representative from each organization participated:

- Bombing
- border police
- Gendarmerie
- NGO representative
- samui
- save the children
- ANCUR
- Social work
- UNICEF
- Romanian Red Cross
- volunteer coordinator
- Donations Coordinator
- Maintenance Managers

Every Friday before 7:00 p.m., a weekly report detailing the assistance, activities, team needs and risks for the identified population must be submitted.

In addition, he was part of a WhatsApp group where all the aforementioned managers were present. Through this, they share relevant information such as scheduled institutional visits, the arrival time of each ship and the approximate number of participants, critical points, among others.

Whenever it was necessary, he was always kept informed at the time about incidents to the Command of the area and the Directorate.

6.2. Moldova

Coordination was initially carried out through the Ministry of Health until the establishment of the EMTCC. From this moment on, *the Minimum Data Set* (MDS) was presented daily with the record of daily attendance grouped by different variables, the weekly report that was delivered every Thursday before 5:00 p.m., and telematic and occasionally face-to-face attendance. the meetings with the coordinator of the EMTCC and heads of the other EMT's every Monday and Thursday at 3:00 p.m.

In addition, coordination was maintained with other teams for the management of patient transport, reception and delivery of material, attention to common local incidents, provision of support in certain circumstances such as delivery of personnel and/or resources, among others.

6.3. Back Office

In addition to direct communication with the head of the Retired Cabinet, information on costs and assistance was shared through the TEAMS platform, in a specific group for the mission. Daily information was also documented in the Sitrep.

Expenses were reflected globally and specifically by assistance point, as well as assistance

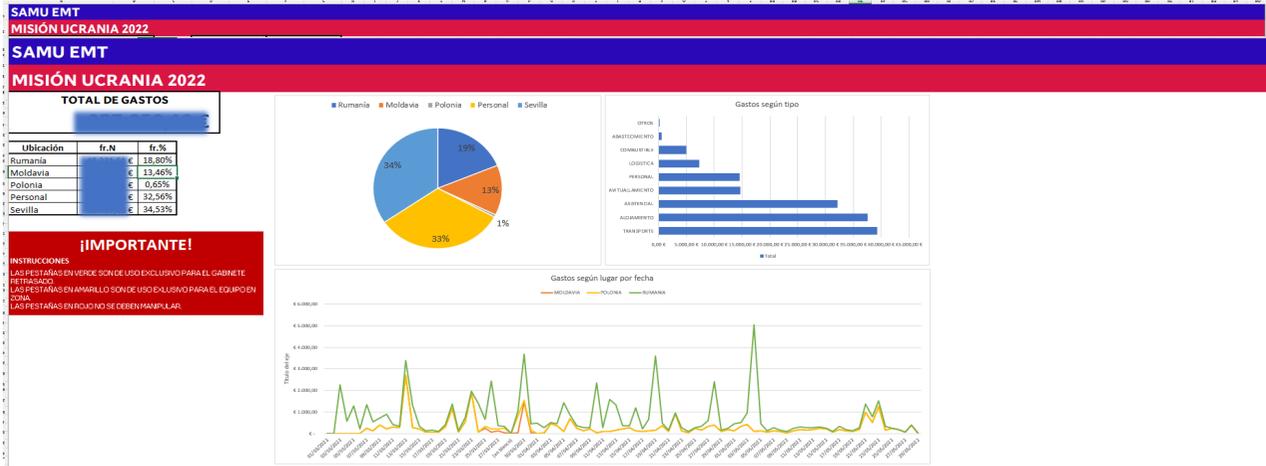


Figure 2: Attendance Display in TEAMS
Ilustración 1: Display de Gastos en TEAMS

7. Assistances

7.1. Overall

Distribution by sex according to locality

Sexy	Moldova		Romanian		TOTAL	
	brother north	fr.R%	brother north	fr.R%	brother north	Percentage
Male	576	27.47%	87	4.15%	663	31.62%
Female	1282	61.13%	152	7.25%	1434	68.38%
Total	1858	88.60%	239	11.40%	2097	100.00%

Age distribution according to locality

Age groups	Moldova	Romania	Total	Percentage
<1	15	4	19	0.91%
1 to 4	140	23	163	7.77%
5 to 10	193	30	223	10.63%
11 to 17	140	37	177	8.44%
18 to 24	84	19	103	4.91%
25 to 34	188	24	212	10.11%
35 to 64	516	61	577	27.52%
65 to 84	545	37	582	27.75%

> 85	37	4	41	1.96%
Total	1858	239	2097	100.00%

Distribution by groups of pathologies according to location

<i>Pathologies</i>	Moldova	Romanian	Total	Percentage
<i>trauma</i>	139	23	162	7.72%
<i>nurse Infectious</i>	424	95	519	24.74%
<i>nurse Non-infectious</i>	1132	57	1189	56.67%
<i>Emergency</i>	48	46	94	4.48%
<i>Surgical</i>	16	1	17	0.81%
<i>others</i>	99	18	117	5.58%
Total	1858	240	2098	100.00%

Distribution by relationship with the event according to location

<i>Relationship to the event</i>	Moldova	Romanian	Total	Percentage
<i>Directly related</i>	52	25	77	3.68%
<i>indirectly related</i>	883	178	1061	50.64%
<i>Not related</i>	921	36	957	45.68%
Total	1856	239	2095	100.00%

7.2. Romanian

Distribution by sex

<i>Sexy</i>	brother north	Percentage
<i>Male</i>	87	36%
<i>Female</i>	152	64%
Total	239	100%

Distribution by age according to sex

<i>Age groups</i>	Male	Female	Total	Percentage
<1	3	1	4	1.67%
1-4	15	8	23	9.62%
5-10	20	10	30	12.55%
11-17	13	24	37	15.48%
18-24	5	14	19	7.95%
25-34	5	19	24	10.04%
35-64	11	50	61	25.52%

65-84	13	24	37	15.48%
≥ 85	2	2	4	1.67%
Total	87	152	239	100.00%

Distribution of injuries by traumatic plane according to sex

<i>Trauma</i>	Male	Female	Total	Percentage	father R
Severe head/spinal injury	0	0	0	0.00%	0.00%
Serious chest injury	1	0	1	4.35%	0.42%
Serious abdominal and/or pelvic injuries	1	0	1	4.35%	0.42%
Serious limb injuries	1	3	4	17.39%	1.67%
moderate injury	4	3	7	30.43%	2.93%
minor wound	3	7	10	43.48%	4.18%
Total	10	13	23	100.00%	9.62%

Distribution of infectious diseases according to sex

<i>Infectious Pathologies</i>	Male	Female	Total	Percentage	father R
acute respiratory disease	42	47	89	93.68%	37.24%
Acute watery diarrhea	2	2	4	4.21%	1.67%
acute bloody diarrhea	0	0	0	0.00%	0.00%
acute jaundice	0	0	0	0.00%	0.00%
suspected measles	0	0	0	0.00%	0.00%
suspected meningitis	0	0	0	0.00%	0.00%
suspected tetanus	0	0	0	0.00%	0.00%
Acute flaccid paralysis	0	0	0	0.00%	0.00%
tuberculous bronchitis	0	0	0	0.00%	0.00%
Fever of unknown origin	1	1	two	2.11%	0.84%
Total	Four. Five	fifty	95	100.00%	39.75%

Distribution by type of emergency according to sex

<i>Emergency</i>	Male	Female	Total	Percentage	father R
Surgical Emergency (No Trauma)	1	0	1	2.17%	0.42%
Medical Emergency (No Trauma)	18	27	45	97.83%	18.83%
Total	19	27	46	100.00%	19.25%

Distribution of non-infectious diseases according to sex

<i>Other relevant diseases</i>	Male	Female	Total	Percentage	father R
Acute/sudden skin disease	1	1	2	3.51%	0.84%
acute mental disorder	8	25	33	57.89%	13.81%
obstetric complication	0	0	0	0.00%	0.00%
severe acute malnutrition	0	0	0	0.00%	0.00%
Other unclassified diagnoses	5	17	22	38.60%	9.21%
Total	14	43	57	100.00%	23.85%

Distribution by procedure according to sex

<i>Procedures</i>	Male	Female	Total	Percentage	father R
<i>Major surgical procedure</i>	0	0	0	0.00%	0.00%
<i>Amputation excluding digital</i>	0	0	0	0.00%	0.00%
<i>Minor surgical procedure</i>	0	1	1	100.00%	0.42%
<i>Normal vaginal delivery (NVP)</i>	0	0	0	0.00%	0.00%
<i>Caesarean section</i>	0	0	0	0.00%	0.00%
<i>Other obstetricians</i>	0	0	0	0.00%	0.00%
Total	0	1	1	100.00%	0.42%

Distribution by result and/or follow-up according to sex

<i>Results</i>	Male	Female	Total	Percentage
<i>other no tracking</i>	65	121	186	77.82%
<i>Other with tracking</i>	2	0	2	0.84%
<i>another volunteer</i>	2	1	3	1.26%
<i>The reference</i>	14	29	43	17.99%
<i>Accepted</i>	4	1	5	2.09%
<i>death to the</i>	0	0	0	0.00%
<i>Death on the premises</i>	0	0	0	0.00%
<i>Requires long-term rehabilitation</i>	0	0	0	0.00%
Total	87	152	239	100.00%

Distribution by traumatic plane according to sex

<i>Relationship to the event</i>	Male	Female	Total	Percentage
<i>Directly related to the event.</i>	8	17	25	10.46%
<i>Indirectly related to the event.</i>	71	107	178	74.48%
<i>Not related to the event.</i>	8	28	36	15.06%
Total	87	152	239	100.00%

Distribution by traumatic plane according to sex

<i>Protection and other social</i>	Male	Female	Total	Percentage
<i>vulnerable child</i>	3	2	5	62.50%
<i>Vulnerable Adults</i>	0	3	3	37.50%
<i>Gender Violence (GV)</i>	0	0	0	0.00%
<i>Violence (Not GBV)</i>	0	0	0	0.00%
Total	3	5	8	100.00%

Distribution of pregnant women according to age

<i>years</i>	Total	Percentage
<i><15</i>	0	0.00%

15-17	2	11.11%
≥18	2	88.89%
Total	18	100.00%

7.3. Moldova

Distribution by sex

<i>Sexy</i>	brother north	Percentage
<i>Male</i>	576	31%
<i>Female</i>	1282	69%
Total	1858	100%

Distribution by age according to sex

Age groups	Male	Female	Total	Percentage
<1	10	5	15	0.81%
1 to 4	75	65	140	7.53%
5 to 10	112	81	193	10.39%
11 to 17	79	61	140	7.53%
18 to 24	21	63	84	4.52%
25 to 34	64	124	188	10.12%
35 to 64	76	440	516	27.77%
65 to 84	117	428	545	29.33%
> 85	22	15	37	1.99%
Total	576	1282	1858	100.00%

Distribution of injuries by traumatic plane according to sex

trauma	Male	Female	Total	Percentage	father R
<i>Severe head/spinal injury</i>	0	0	0	0.00%	0.00%
<i>Serious chest injury</i>	0	0	0	0.00%	0.00%
<i>Serious abdominal and/or pelvic injuries</i>	0	0	0	0.00%	0.00%
<i>Serious limb injuries</i>	0	0	0	0.00%	0.00%
<i>moderate injury</i>	15	3	18	12.95%	0.97%
<i>minor wound</i>	59	62	121	87.05%	6.51%
Total	74	65	139	100.00%	7.48%

Distribution of infectious diseases according to sex

<i>Infectious Pathologies</i>	Male	Female	Total	Percentage	father R
<i>acute respiratory disease</i>	97	167	264	62.26%	14.21%
<i>Acute watery diarrhea</i>	42	72	114	26.89%	6.14%
<i>acute bloody diarrhea</i>	0	0	0	0.00%	0.00%
<i>acute jaundice</i>	0	0	0	0.00%	0.00%
<i>suspected measles</i>	0	0	0	0.00%	0.00%
<i>suspected meningitis</i>	0	0	0	0.00%	0.00%
<i>suspected tetanus</i>	0	0	0	0.00%	0.00%
<i>Acute flaccid paralysis</i>	0	0	0	0.00%	0.00%
<i>tuberculous bronchitis</i>	0	0	0	0.00%	0.00%
<i>Fever of unknown origin</i>	22	24	46	10.85%	2.48%
Total	161	263	424	100.00%	22.82%

Distribution by type of emergency according to sex

<i>Emergency</i>	Male	Female	Total	Percentage	father R
<i>Surgical Emergency (No Trauma)</i>	1	0	1	2.08%	0.05%
<i>Medical Emergency (No Trauma)</i>	fifteen	32	47	97.92%	2.53%
Total	sixteen	32	48	100.00%	2.58%

Distribution of non-infectious diseases according to sex

<i>Other relevant diseases</i>	Male	Female	Total	Percentage	father R
<i>Acute/sudden skin disease</i>	18	20	38	3.36%	2.05%
<i>acute mental disorder</i>	10	45	55	4.86%	2.96%
<i>obstetric complication</i>	0	0	0	0.00%	0.00%
<i>severe acute malnutrition</i>	0	0	0	0.00%	0.00%
<i>Other unclassified diagnoses</i>	288	751	1039	91.78%	55.92%
Total	316	816	1132	100.00%	60.93%

Distribution by procedure according to sex

<i>Procedures</i>	Male	Female	Total	Percentage	father R
<i>Major surgical procedure</i>	0	0	0	0.00%	0.00%
<i>Amputation excluding digital</i>	0	0	0	0.00%	0.00%
<i>Minor surgical procedure</i>	3	13	16	100.00%	0.86%

Normal vaginal delivery (NVP)	0	0	0	0.00%	0.00%
Caesarean section	0	0	0	0.00%	0.00%
Other obstetricians	0	0	0	0.00%	0.00%
Total	3	13	16	100.00%	0.86%

Distribution by result and/or follow-up according to sex

<i>Results</i>	Male	Female	Total	Percentage
other no tracking	459	1042	1501	80.96%
Other with tracking	78	187	265	14.29%
another volunteer	0	3	3	0.16%
The reference	36	47	83	4.48%
accepted	two	0	two	0.11%
death to the	0	0	0	0.00%
Death on the premises	0	0	0	0.00%
Requires long-term rehabilitation	0	0	0	0.00%
Total	575	1279	1854	100.00%

Distribution by traumatic plane according to sex

<i>Relationship to the event</i>	Male	Female	Total	Percentage
Directly related to the event.	21	31	52	2.80%
Indirectly related to the event.	262	621	883	47.58%
Not related to the event.	293	628	921	49.62%
Total	576	1280	1856	100.00%

Distribution by traumatic plane according to sex

<i>Protection and other social</i>	Male	Female	Total	Percentage
vulnerable child	1	2	3	23.08%
Vulnerable Adults	0	4	4	30.77%
Gender Violence (GV)	0	3	3	23.08%
Violence (Not GBV)	3	0	3	23.08%
Total	4	9	13	100.00%

Distribution of pregnant women according to age

<i>years</i>	Total	Percentage
<15	0	0.00%
15-17	2	11.76%
≥18	15	88.24%
Total	17	100.00%

8. Assistance Analysis

8.1. Technical description

Data analysis was performed with the statistical program SPSS v.27.0. Frequencies and percentages are used for categorical variables. For continuous variables, the values of central tendency (mean, median and mode) and the standard deviation are used.

To establish relationships between qualitative variables, the Chi-Square test (χ^2) was used, for which confidence intervals were determined for a confidence level of 95%, and in the event that it was not applied, the Fisher test was used.

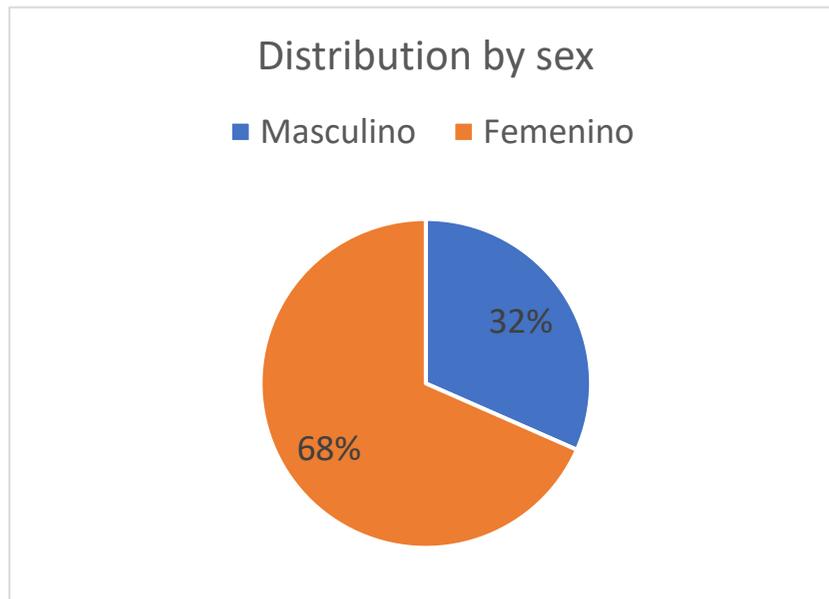
8.2. Data collection

The instrument used for data collection was the clinical history, designed for SAMU EMT interventions, according to the *Classification and Minimum Standards for Emergency Medical Teams* (WHO, 2021). Adheres to Principle No. 4: Responsible Response and Minimum Quality Standard No. 5: Data Collection, Medical Records, and Safekeeping of Health Records. This includes: Serial Number, Daily Number, Date, Place of Assistance, Age, Sex, Nationality, Diagnosis 1, 2 and 3, Affected System, Actions, Treatment and Observations. It was adapted for its digital version, stored in TEAMS and on paper when necessary.

8.3. Results

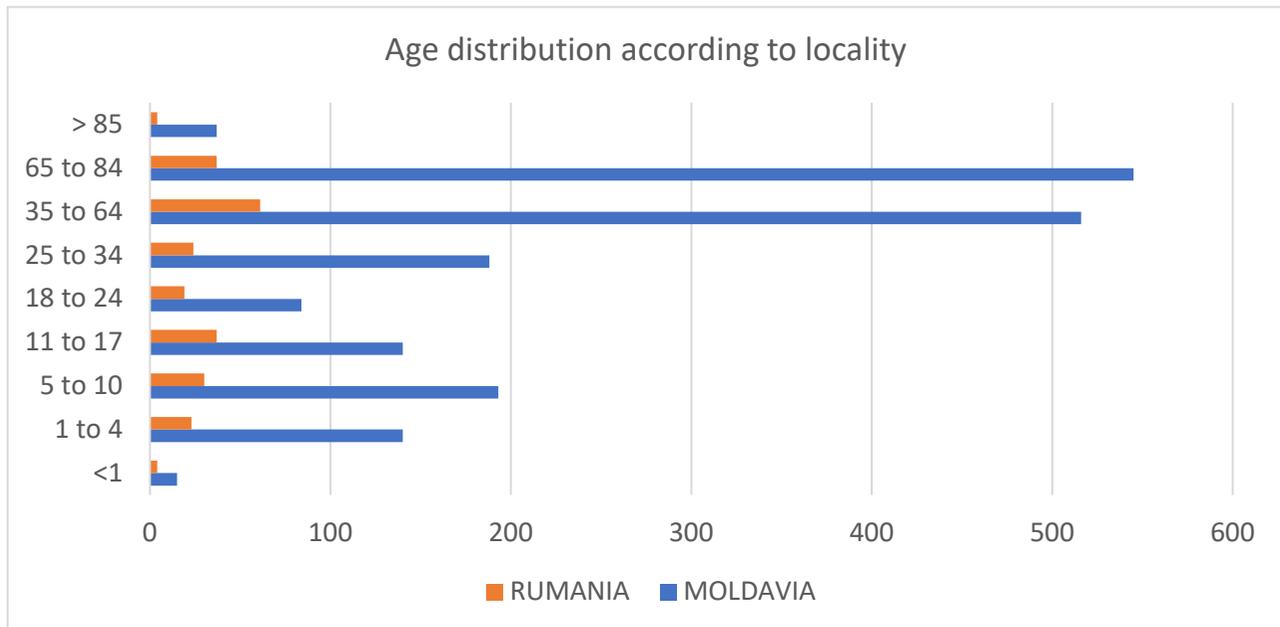
8.3.1. Sociodemographic data

A total of 2,097 attendances were made between March 4 and June 17, 2022, distributed geographically between Romania and Moldova. 68.38% of the attendees were women.



The age range of the population served ranges from 4 days old to 96 years old. The mean age of the population is 41.9 years, with a standard deviation of 26.7 years and a median of 43.0 years.

The highest percentage of attendance was made among adults from 65 to 84.99 years old, representing 27.75%, followed by the age group from 35 to 64.99 years old, representing 27.52% of the total. Those under 10 years of age accounted for 19.31% of the visits. Only 4.91% occurred between 18 and 24.99 years.

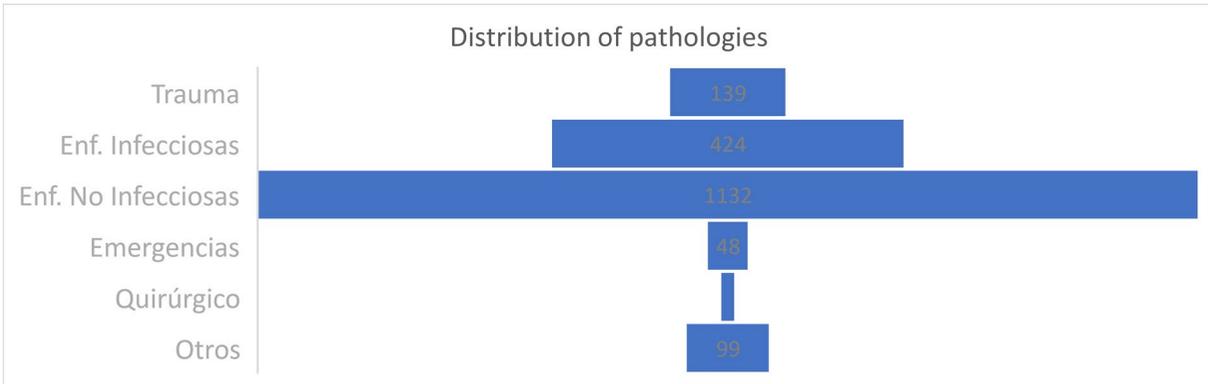


Regarding the place where health care was provided, 88.6% corresponds to Moldova. The smallest population served was in Romania, accounting for 11.4%. In both localities, the majority of women were treated, distributed homogeneously in approximately two thirds of the population.

8.3.2. Pathology

Given the variety of pathologies treated, they have been transferred to groups according to the Classification for the Surveillance of Diseases in Disaster Situations (OCHA, 2018), which facilitates their analysis and study.

Non-infectious diseases have been the group of diseases with the highest prevalence, manifesting as the cause of assistance in 56.67% of the population attended, followed by infectious diseases (24.74%) and traumatic injuries (7.72%).



Among the infectious diseases, acute respiratory diseases (14.21%), acute watery diarrhea (6.14%) and fevers of unknown origin (2.48%) predominate.

Regarding emergencies, a total of 94 patients were treated between both venues, of which 2% were non-traumatic surgical emergencies, 0.3% serious injuries and the rest medical emergencies. The latter primarily due to exacerbation or decompensation of chronic diseases such as high blood pressure, diabetes mellitus, epilepsy, anxiety and hyperthyroidism.

8.3.3. Relationship to the event

The definition grouped by three criteria was used to determine the pathology with the relationship of the event, according to the WHO criteria.

61.03% of the population attended presented pathologies indirectly related to the fact that it was an injury or illness caused or aggravated by a change in situation after an emergency event. p. eg) Environmental exposure; ARI/diarrhoea/skin disease, debris injury during treatment of a pre-existing conflict injury, patient who has lost access to their regular doctor or essential medication due to the disaster.

Patients not related to the event represented 32.34%, who attended the clinic for a health problem not directly/indirectly related to the emergency event. For example, noncommunicable diseases (NCDs) without acute or essential exacerbation, cancer, appendicitis, etc. medication loss, appendicitis, etc.

Finally, 6.63% were patients who presented an injury or illness directly caused by an emergency event, mainly traumatic and pregnancy complications.

8.3.4. Other relevant data

It is important to recalculate the following points:

- Less than 0.5% of the population showed symptoms consistent with COVID-19.
- 8% of the population served received care 2 or more times.
- 45% of the population served had the request for medication for chronic diseases as a reason for consultation.
- 2.3% were assistance to pregnant women for prenatal monitoring.
- 18% of the people attended had some related component of psychiatric/psychological origin as their main reason for consultation.
- A total of 46 minor procedures were performed.

9. Development Proposals and Health Support.

9.1. Development Proposals

In Moldova, we participated in meetings with the Center for Prehospital Medicine, at the request of this institution, to propose courses to develop the skills of local staff.

Among them discussed:

- BLS, Cardiac ALS, Trauma ALS, Pediatric ALS and Multiple Victim courses.
- Critical patient transfer management.
- Neonatal transfer.
- HEMS

We received a visit from the institution's staff at MoldExpo to show the ambulance and explain the distribution of the material, professional profiles and high skills, and expose the dynamics and assistance of a primary emergency.

In Romania, he participated in the development of contingency plans, as well as in the design of the Predictable Risks Document in the event of an Incident with Multiple Victims. In collaboration with the Bomber Corps, it helped design the distribution of resources in the event of receiving a hostile impact and the activities and location of the elements necessary to manage the evacuation of possible victims.

At both points, a link was established with the local authorities and an open invitation was left to visit the facilities of the SAMU School, at their convenience.

9.2. Health Support

They provided extraordinary financial means and coverage for three cases in particular:

- A hearing aid for a 93-year-old man with hearing loss.
- Orthopedic shoes for a 47-year-old woman with osteomalacia.
- Maxillofacial and dental intervention for a 30-year-old man with cavitations and caries that compromise the integrity of the bone substance of the jaw.

10. Expenses

A control of expenses was maintained through invoices and bills, which were grouped by date, week, valid credit card and location. We registered in TEAMS through an Excel spreadsheet shared with the Back Office. Later, with each contingent, they were invoiced.

In total, the expenses according to location were:

<i>Location</i>	<i>Total</i>	<i>Percentage</i>
<i>Romanian</i>	€48,331.51	18.80%
<i>Moldova</i>	€34,592.32	13.46%
<i>Poland</i>	€1,669.81	0.65%
<i>Staff</i>	€83,707.13	32.56%
<i>*Seville</i>	€88,757.35	34.53%
Grand total	€257,058.12	100.00%

*Many expenses are marked as Seville given that in most cases plane tickets and rental spaces were secured by our back office.

And, depending on the type of expense:

<i>Type</i>	<i>Total</i>	<i>Percentage</i>
<i>WEAR</i>	€49,760.18	19.36%
<i>ACCOMMODATION</i>	€42,107.32	16.38%
<i>ATTENDANCE</i>	€41,831.32	16.27%
<i>TO UPDATE</i>	€20,240.42	7.87%
<i>LOGISTICS</i>	€8,715.48	3.39%
<i>GAS</i>	€5,613.37	2.18%
<i>STAFF</i>	€88,218.52	34.32%
<i>SUPPLY</i>	€528.12	0.21%
<i>OTHER</i>	€43.40	0.02%
Grand total	€257,058.12	100.00%

11. Exit-Plan and Hand-Over

11.1. Romanian

During the week of May 20, Cnl was notified. Daniel Petrov on the retirement of the SAMU of the Port of Isaccea due to the closure of the mission. This notification was formalized through a telematic meeting with representatives of the Ministry of

Defence, the Eventual Emergency Center and the Directorate of the Romanian Fire Department.

On May 21, the distribution of cargo began between material that was projected to Spain, Moldova, material on loan that was returned and local donations.

The relevant documentation was prepared for the return of the material and the file for the company that delivers the donated material.

On May 26, the assistance activity ends and on May 27, the material is palletized and loaded for the respective projection. Personnel from Moldova are sent to Tulcea to support the retreat and it is decided to send the equipment directly on the same day, together with the material, directly to Bucharest. He personally from Moldova returned to Chisinau on May 28 without incident.

The Hand-Over does not take place due to the fact that there is no team to continue attending in Isaccea.

11.2. Moldova

The Exit Plan is coordinated through the EMTCC and is notified on June 16 as the last assistance activity. It is determined that three EMTs are distributed to the activity in MoldExpo, being INTERSOS, CUUAM and International Medical Teams.

On the 15th and 16th, different representatives of the three organizations are received to explain the dynamics, show the distribution of the plant, transfer the documentation of the chronic patients and deliver the material. On the 17th, the Hand-Over was signed between the heads of mission, coordinators and coordinators of the EMTCC. There is already a signed copy for each team and another for SAMU. The keys to the facilities and donated assistance material are delivered.

12. Conclusions

After 108 days of participation in this humanitarian project, whose main objective was to alleviate the health needs of the refugees affected by the war, it can be said that the profile of the behavior of the masses has been that of those of the same nature, with particularity of the place where it happened. Being a situation that occurs at the borders of the European Union, it is to be expected a warm welcome and an avalanche of donations, just as it yielded.

The profile of assisted subjects has remained within the expected range, however, the predominance of acute episodes of mental disorders has been the most relevant in the subsequent analysis. Even though, mental health needs, early anxiety disorders, and post-traumatic stress are expected, they were less prevalent in the early stages of conflict. This has meant a considerable variable that deserved to change and adjust to the needs of the population.

The reception and treatment received by the local governments has been a very satisfactory experience. The mechanisms to respond to a situation of this caliber were

outstanding in the Roman territory, more so in the Moldovan they were non-existing. This was subject to adjustment by the central administration of Moldova that took weeks to regulate. However, at all times they were attentive to the needs of the teams and the refugees, with an attitude of improvement and coping with the situation.

The most notable operational elements have been the use of technologies for communication between the area team and the back office, and the use of local, regional and global coordination mechanisms of the EMT, both internally and between the teams and the different countries involved. in support of the Ukrainians.

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