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GSDRC Report 2026/1

Emergency Deployments Team 2 (EDT2) Learning Review

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Governance and Social Development Resource Centre (GSDRC)

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About this Review

The Foreign, Commonwealth and Development Office (FCDO) commissioned the University of Birmingham's Governance and Social Development Resource Centre (GSDRC) to undertake a learning review of the Emergency Deployments Team 2 (EDT2) programme. The programme comprises the UK's Emergency Medical Team and International Search and Rescue team. The learning review utilised Development Assistance Committee (DAC) criteria of relevance; coherence; effectiveness; efficiency; impact and sustainability to undertake a 'light touch' evaluation of EDT2, using existing programmatic and administrative documents. This review reports on the findings of the evaluation and includes recommendations and lessons learned from the EDT2 evaluation.

Policy relevance

This learning review focuses on the UK's Emergency Medical Team and International Search and Rescue programme (EDT2), which delivers rapid humanitarian assistance during international disasters. It provides policy-relevant insights on the effectiveness and impact of deployable EDT2 teams in saving lives when deployed.

Keywords

evaluations of rapid response programmes; learning review; evidence review; Emergency Medical Teams; International Search and Rescue

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List of abbreviations

Abbreviation	Meaning
AFAD	Disaster and Emergency Management Authority
CDC	Centre for Disease Control
DAC	Development Assistance Committee
DoDMA	Department of Disaster Management Affairs
EDT2	Emergency Deployments Team 2
EMTCC	Emergency Medical Team Coordination Cell
EMS	Emergency Management Services
FCDO	Foreign, Commonwealth and Development Office
GSDRC	Governance and Social Development Resource Centre
IPC	Infection Prevention Control
INSARAG	International Search and Rescue Advisory Group
LEMA	Local Emergency Management Authority
MoH	Ministry of Health
MoPH	Ministry of Public Health
ToR	Terms of Reference
UK-EMT	United Kingdom's Emergency Medical Team
UK-ISAR	United Kingdom's International Search and Rescue
USAR	Urban Search and Rescue
UNHAS	United Nations Humanitarian Air Service
UNICEF	United Nations Children's Fund
WASH	Water Sanitation and Hygiene
WHO	World Health Organisation

Executive summary

This learning review focuses on the Emergency Deployments Team 2 (EDT2) programme. EDT2 saves lives by providing rapid humanitarian assistance during international disasters. The programme provides the UK with a deployable emergency medical team, and international search and rescue team. This learning review offers insights that highlight the significant impact of EDT2-funded teams during deployment.

The learning review draws on existing programme documentation, including deployment reports, and other programme monitoring information to investigate deployments. The Development Assistance Committee (DAC) framework of evaluating programmes was utilised to explore programme relevance, efficiency, effectiveness, impact, coherence and sustainability.

The following findings emerged from the learning review:

- There was sufficient evidence to synthesise and draw emerging conclusions on how impactful EDT2-funded teams are on deployment.
- More costly deployments are those that required the installation of medical facilities, such as field hospitals, clinics and equipment, and the utilisation of specialised medical personnel.
- Although UK-ISAR (international search and rescue) missions were typically shorter in duration, they were more costly when compared with UK-EMT (emergency medical team) deployments. This is likely because of larger deployment team size and the use of various rescue assets such as aircraft, boats and other equipment.
- With respect to the DAC framework used to assess EDT2, the following key findings emerged:
 - **Programme relevance:** there was evidence that deployments were relevant with good alignment to local emergency and rescue needs.
 - **Programme coherence:** evidence suggested that programme coherence was satisfactory with deployments being aligned to local and international organisations and support agencies, and that deployments filled health and rescue gaps.
 - **Programme effectiveness:** evidence indicated that deployment objectives were met, and teams demonstrated a high degree of adaptability in responding to changing needs and contexts on the ground.

- **Programme efficiency:** overall, deployments were found to be reasonably efficient. Some challenges were encountered, in the domains of logistics, budgetary reporting, and licence processing delays.
- **Programme impact:** there was sufficient evidence of programme impact to support medical and rescue interventions in target countries.
- **Programme sustainability:** many practices were implemented that promoted sustainability. These activities included capacity building and the promotion of local ownership by utilising local resources and skills where possible.
- **Key lessons:**
 - Whilst DAC criteria provide a useful framework for synthesising learnings from EDT2 team deployments, there are differences between rapid/emergency response programmes and longer-term aid projects that are supported by programme planning documents such as log frames and theories of change. Understanding local contexts and the fluid nature of deployments means that performance and implementation indicators within the DAC framework are not always clear-cut. Consideration should be given to this aspect if DAC is to be used in future to evaluate the programme.
 - There was sufficient evidence to show that EDT2 had a substantial impact on the overall success of rescue operations and medical emergency interventions. This was documented in the deployment reports through the outputs achieved and the successes reported.
 - The ability of missions to rapidly deploy teams to affected countries was a key achievement, and the composition of the teams allowed for some flexibility on the ground as circumstances changed.
 - Coordination between local actors and deployment teams on the ground were important contributory factors to the success of teams promoting coherence and effectiveness.
 - Whilst there were measures to promote the sustainability of interventions, even after teams had left, the lasting effects of interventions would need to be assessed over time. The sustainability of interventions depends on the level of resources available in countries to support ongoing improvements to emergency medical and rescue practices.

- There is a need for the use of a standardised set of tools/instruments to more rigorously assess stakeholder satisfaction with deployments. This would improve the strength of evaluations in future.
- There is a need to strengthen project reporting templates to ensure reporting consistency, and to enable evaluators to track key project success measures—such as outputs, outcomes, and impacts.

Introduction

The Foreign, Commonwealth and Development Office (FCDO) commissioned the University of Birmingham's Governance and Social Development Resource Centre (GSDRC) to undertake a learning review of the Emergency Deployments Team 2 (EDT2 – see Box 1) programme. A learning review is a "lighter touch" approach to assessment compared to a formal evaluation. This learning review is designed to provide surface-level insights, enabling learning on how EDT2 deployments are working. Within FCDO, learning reviews form part of the broader Monitoring and Evaluation toolkit used to establish ongoing and timely feedback loops.

Box 1: EDT2

The EDT2 programme is a £39 million, seven-year (2022-2029) initiative funded by the FCDO to provide rapid, and high-quality humanitarian assistance during international disasters. It is the successor to the EDT programme and serves as a key part of the UK's humanitarian response toolkit.

Within EDT2, there are two emergency response capabilities that will be the focus of this learning review. The two capabilities are:

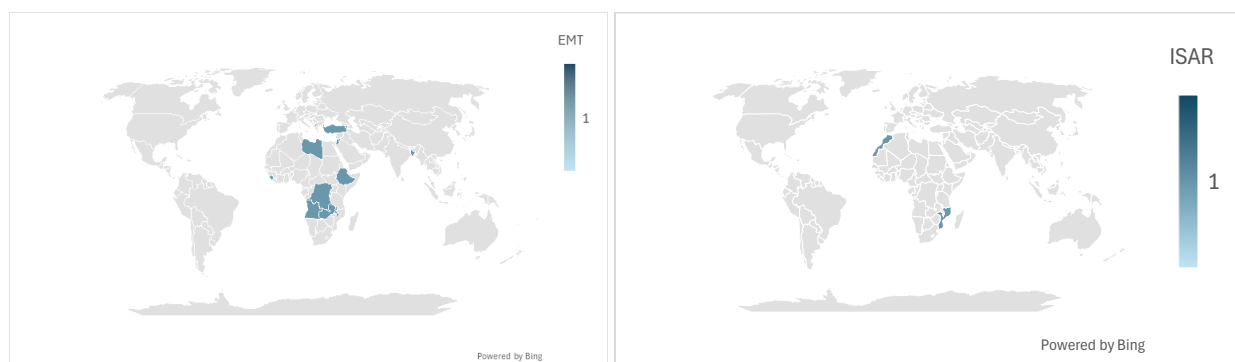
- The United Kingdom Emergency Medical Team deployments: UK-EMT
- The United Kingdom International Search and Rescue projects: UK-ISAR

See **Table 1** for high-level overview of EDT2, and **Figure 1** for an overview of the programme's geographic scope (to date).

Table 1: Total days, people, dogs, and cost of deployment during EDT2

Total days of deployment (indicative)	Total team deployed (people)	Total team deployed (dogs)	Total cost of deployment
826	307	8	£6,376,207

Figure 1: Geographic scope of EDT2 (EMT left, ISAR right)



The project Terms of Reference (ToR) specifies that the learning review must utilise the criteria set out by the Development Assistance Committee (DAC). Evaluation criteria set out by the DAC describe the desired attributes of all interventions, these are laid out in more detail in **Table 3** below:

Table 3: DAC criteria and main question

DAC Criteria	Main Question
Effectiveness	Is the programme achieving its objectives?
Efficiency	How well are the resources used?
Impact	What difference is the deployment making?
Relevance	Is the deployment doing the right things to address needs of the beneficiaries?
Coherence	Is the deployment compatible/complementary to existing programmes within the target country?
Sustainability	Will the benefits of the deployment last?

Whilst the DAC criteria provide a useful framework for drawing out learning from EDT2, there are nuanced differences between rapid/emergency response programmes, and longer-term aid projects that are typically underpinned by theories of change. As such, sub-components of the DAC criteria (e.g., whether targets or outputs were met, or whether planned outcomes were achieved) should be interpreted considering the rapid/emergency nature of deployments and evolving on-the-ground contexts.

Report structure

This report will first describe the methodology used in the review. Secondly, the report will review the available evidence for each of the DAC criteria for the EDT2 programmes to answer the key questions outlined by the DAC (see **Table 3**). The analysis will disaggregate the findings for each of the subprogrammes (UK-EMT and UK-ISAR). For each of the DAC criteria,

there will be an overall assessment/rating on the extent to which deployments have achieved the desired outcomes and impacts as specified in project ToR. Recommendations will be provided for each DAC criteria after each assessment.

Section 2 of the report will assess the strength of the evidence and provide lessons from the deployments, drawing on findings from the evaluation of the two sub-programmes. It will also offer recommendations to strengthen future reporting on deployments.

Methodology

There were several phases leading to the development of this Learning Review report.

Initial scan of documentation:

In the first phase, there was an initial scan of documentation provided to the research team. This comprised documentation from EDT2 country deployments and missions.

For each deployment, there was a package of documentation to be analysed and reviewed comprising the following:

- Deployment Terms of Reference and Concept Notes,
- End of Deployment Report.

Following an initial scan of all deployment documentation, a scoping report was developed. The purpose of the scoping phase was to achieve the following:

- Agree on the final research question and the scope of the Learning Review.
- Refine the approach to the systematic literature search.
- Conduct a pilot search to ascertain whether the research question and methodology for the learning review were congruent.
- Assess the feasibility of the review based on the size of the evidence base to agree on the project workplan.

This was then presented to the FCDO at a meeting on the 25th February 2026, where the Terms of Reference (ToR) for the learning review were clarified and refined.

An accompanying rapid evidence review was also commissioned to examine international emergency deployment frameworks and comparator programmes relevant to the UK's EDT-2. This review synthesises available evidence on how international medical and search and

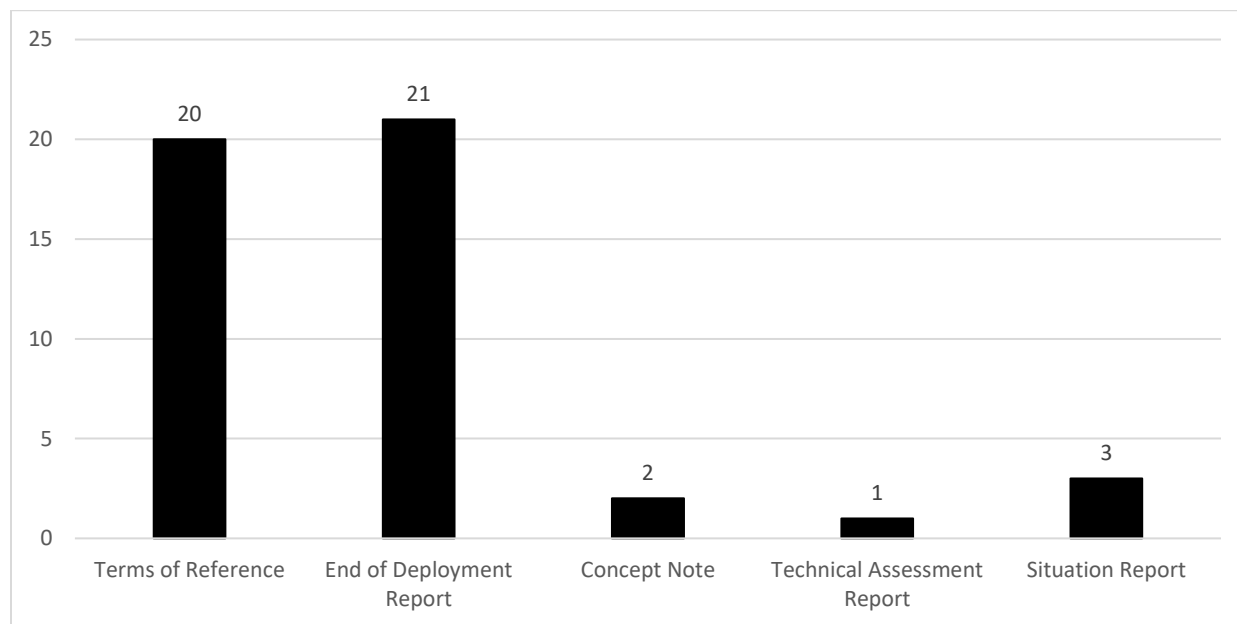
rescue teams are structured, coordinated, and evaluated in disaster and humanitarian contexts (see **Box 3** and Mujuru & Ismail, 2026)¹.

Programme documentation review and analysis

The DAC criteria (**Table 3**) provided the framework and set of indicators for the review of deployment documentation. The learning review was supported by AI-enabled document analysis using Microsoft CoPilot (Enterprise Data Protection Licence – see **Box 2**). The approach involved grounding/context restricted generation to support 'knowledge retrieval' from programme documentation. This reduced the risk of hallucinations, and ensured learnings were based on provided data only. The approach entailed the research soliciting outputs based only on documents provided/uploaded (n=47). All deployments were examined to draw out available lessons from the programme.

A summary of available documents is provided below (see **Table 4** and **Figure 2**):

Figure 2: Document types pertaining to EDT2



¹ Mujuru, S and Ismail, Z. (2026). Evidence and evaluations of international emergency and search and rescue deployment systems. Governance and Social Development Resource Centre

Table 4: Documents pertaining to EDT2

UK-EMT													UK-ISAR									
Document Descriptor	Malawi Cholera	Malawi Cyclone Freddy	Türkiye Earthquake	Libya Flooding	Armenia NK Blast	Zambia Cholera	Bangladesh Protests 2024	Rwanda Marburg Virus Disease	Israel-Lebanon Conflict	UK-EMT DRC Goma	North Macedonia Fire	Angola Cholera	Bangladesh Plane Crash 2025	Gaza Medevac	Sierra Leone Mpox	Hurricane Melissa	Ethiopia Marburg Virus Disease	Türkiye Earthquake	Malawi Cyclone Freddy	Morocco Earthquake	Mozambique Flooding	Total
Terms of Reference	1	1	1	1	1	1	1	1	1		1	1	1	1	1	1	1	1	1	1	1	20
End of Deployment Report	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	21
Concept Note				1						1												2
Technical Assessment Report											1											1
Situation Report											1			2								3
Total Documents																						47

The learning team tested a range of prompts to identify those that were most useful/successful at retrieving accurate and verifiable information from the documents. The content generated from this process was then verified manually by the researchers (see **Box 2**). Though this process, the learning review was able to identify key themes, issues, and notable cases from country deployments as part of the analysis.

A draft report was developed and presented to FCDO for validation, feedback and refinement. A final report was submitted at the end of March 2026.

Box 2: Document analysis using Microsoft CoPilot

The research team iteratively developed a series of prompts to guide and frame document analysis. This process, known as prompt engineering, focuses on designing, refining, and optimising user inputs to ensure the AI tool produces accurate, relevant, and context appropriate responses.

Multiple important considerations framed the use of Microsoft CoPilot in this learning review:

- The tool should only draw on documents provided (i.e., not draw on information from other sources).
- The tool should not be informed by past use of CoPilot. In this instance, the researcher deleted past CoPilot chat history to ensure that documents uploaded were the sole source of information.
- The tool should provide outputs in a consistent form, which is guided by a template provided by the research team.

Whilst the tool was able to provide useful outputs, the process of refining prompts was time consuming and involved a period of trial and error. The tool excelled at extracting factual information (such as length of deployment, deployment outputs, and human resources involved). The tool, however, provided overly deterministic or positivist interpretations of more subjective areas, i.e., the relative impact of deployments.

The research team concluded that, while the AI tool had clear utility in analysing the documents, it was essential to provide clear guidelines and to treat the outputs with caution, particularly when the tool engaged with more subjective data or attempted to infer meaning.

Data limitations

The learning review was undertaken using existing programme documentation that was provided to researchers. This documentation included deployment Concept Notes, Terms of Reference, and End of Deployment Reports. For the purposes of this learning review, detailed budgetary data was not provided to the researchers given time limitations. In future, consideration could be given to using this material in assessing deployment efficiency. The documents reviewed were administrative in nature and, while they contained valuable evidence for the review, they exhibited inconsistencies in the information reported and gaps in content that limited the depth of learning possible. For example, the reports were not aligned with the DAC criteria, and not all indicators were reported in sufficient detail. The End of Deployment Reports further lacked consistency in report format titles, and no author details were provided, making it difficult to follow up with authors if queries arose later.

Deployment types and key observations

Table 5 below highlights the EDT2 deployments under the UK-EMT (n=17²) programme. The table shows that the most costly deployments (listed in descending order) are those requiring the installation of field hospitals and clinics, as well as the deployment of specialised personnel such as surgeons and other clinical staff (e.g., the Lebanon, Türkiye, and Jamaica deployments). Large deployment teams were also the most-costly (Israel/Lebanon, Rwanda, and Angola). Smaller teams and those deployments focusing on Primary Health Care (PHC) over a shorter period are least costly.

It should be noted that there were fewer missions/deployments evaluated in this learning review under the UK-ISAR programme (n=4) and these are not depicted in **Table 5** because of their limited number. These missions were of a shorter duration (7–14 days), but were comparatively more costly, ranging from £380,000 to £719,000. This is likely because of large team sizes, ranging from 27–62 people, and the use of various rescue assets such as aircraft, boats, drones, dogs, and other equipment and medicines.

² Gaza Medevac 1–4 are treated as one deployment for the purposes of this learning review.

Table 5: UK-EMT deployments

Country	Intervention type	Duration	Team/type	Cost
Türkiye /Earthquake	Primary Health Care support	2 Months	Type 1 field hospital 50- member team	£1,190,629
Israel-Lebanon/ Conflict	Specialised Care Team (STC) trauma/rehab, burns	3 months	14 people: 8 experts and 6 support staff	£927,586
Malawi/Flooding	Surgical and Primary Health Care support	3 months	Mobile clinic & 13 specialists	£544,280
Jamaica/Hurricane	Mobile clinic team	7 weeks	13-person team	£468,886
Rwanda/Disease	Marburg virus. Clinical deployment, and Infection Prevention control (IPC) support and training	6 weeks	16 people: 10 experts	£450,125
Angola/Disease	Cholera outbreak	7 weeks	10 specialists and support staff	£386,217
Malawi/Disease	Cholera outbreak	3 months	Disease Care Team - 23 members	£341,804
UK-EMT DRC, Goma/ Conflict	Surgical Specialised Care Team (SCT)	2 months	11-person team: 8 experts and 3 support staff	£336,806
Sierra Leone/Disease	Mpox - Surgical/Rehabilitation team	4 weeks	9-person team	£195,161
Gaza Medevac	Medevac team	8 weeks	24 persons	£138,276
Gaza Type 1+/Conflict	Type 1+ Field Clinic ³			
Bangladesh/Plane Crash 2025	Burns, Surgical and rehab, and capacity building on IPC	3 weeks	9 experts: Doctor, Infectious Disease Doctor, Nurse and Rehab specialists	£100,000
North Macedonia/ Fire	Rehab/Burns Capacity building	6 weeks	6 specialists and support staff	£100,000
Zambia/Disease	Cholera outbreak	2.5 months	5 people deployed:	£73,000

³ Although this was reported as one of the most substantial and demanding deployments with high complexity for the period. At the time of writing the learning review there was limited documentation available on this deployment.

Country	Intervention type	Duration	Team/type	Cost
			specialists and support staff	
Armenia/Conflict - Blast	Burns	3 weeks	Burns Specialised Care Team (SCT) 6-member team	£50,000
Libya/Flooding	Primary Health Care support	6 weeks	PHC 21 members deployed	£39,000
Bangladesh /Protests 2024	Surgical, trauma/ rehab - injured students	16 days	4 people: 2 specialists and 2 support staff	£22,564
Ethiopia/Disease	Medical Logistician	1 week	1 person	£4,395

Box 3: Findings from International Emergency Deployment Frameworks and Comparator Programmes

An accompanying evidence review synthesised available evidence on how international medical, and search and rescue teams are structured, coordinated, and evaluated in disaster and humanitarian contexts, key findings were as follows (Mujuru & Ismail, 2026):

The WHO Emergency Medical Teams (EMT) framework establishes standards for international medical response, with a strong emphasis on accountability, coordination, and the delivery of safe and ethical care during disasters. Similarly, the International Search and Rescue Advisory Group (INSARAG) and Urban Search and Rescue (USAR) guidelines provide operational standards for search and rescue teams responding to disasters involving collapsed structures.

Comparator programmes consistently emphasise the importance of early mobilisation, the ability to operate independently of local resources, and strong coordination with national authorities to ensure effective and timely response.

Programmes highlight the value of multidisciplinary training, simulation exercises, and continuous preparedness activities in strengthening team performance and coordination in disaster environments.

In many cases, effectiveness depends on how well teams adapt to the context. This includes adjusting clinical services, logistics, and operational models in response to changing needs, especially in complex or resource-constrained environments.

Systems designed to organise international assistance can reduce duplication and improve alignment with national priorities, but practical challenges remain, including information-sharing gaps, and variability in how coordination procedures are applied.

Monitoring approaches tend to focus on operational data and routine reporting. Programme-level assessments are often based on internal reviews, with relatively limited use of external or independent evaluation.

Although emerging approaches aim to improve evaluation, current systems lack consistency, making it difficult to compare programmes or assess performance.

While there is broad agreement on what contributes to effective deployments, limitations in evaluation frameworks constrain the ability to assess impact, compare approaches, and determine value for money.

Evidence from the DAC Criteria

This section reviews the evidence drawn from the main documentary sources that inform the learning review. These are the End of Deployment Reports and/or Support Reports, Deployment Terms of References, and Concept Notes. Each of the DAC criteria are analysed across 22 deployments. Each DAC criteria is given an overall rating, which indicates the extent to which ED2 has achieved its goals.

Relevance

To assess programme **Relevance** the following sub-themes were explored:

- Did deployments assess local needs before they were implemented?
- Were stakeholders consulted before the deployments?
- Were deployment plans/activities adapted to changing circumstances once implemented?
- Were stakeholders satisfied with deployments?

The DAC indicator of **Relevance** explores the relevance of deployments to the needs of target countries and investigates whether deployments have been doing the right things to support crises interventions. All the EDT2 deployments appeared to have well-tailored missions to support the specific needs in affected countries.

UK-EMT Findings

Did deployments assess local needs before they were implemented?

All the country deployments were a response to a request/need, communicated either directly via country's Ministry of Health (MoH), or indirectly through the World Health Organisation (WHO) or other bodies, such as the resident British embassy, United Nations Resident Coordinator or other agency/body. Therefore, at this level the deployments were relevant.

In some deployments, there was evidence that a rapid needs assessment had been conducted in-country prior to the deployment. This was to match the country needs and local context together with resources available to respond to the emergency. The needs assessment usually included a stakeholder consultation and coordination process with various role players like World Health Organisation (WHO), and Ministry of Health (MoH); local affected hospitals; Non-Government Organisations (NGOs), for instance, Médecins Sans Frontières or the Red Cross.

Were deployment plans/activities adapted to changing circumstances on the ground?

In most deployments, there was good evidence of adaptation to the needs and circumstances of the deployments.

Examples to illustrate this include:

In the Rwanda Marburg Virus outbreak, it was reported that “teams were flexible allowing for a change in roles and merging positions to navigate political sensitivities” (UK -EMT Marburg Response Rwanda Report, 2024, p.7).

The Angola Cholera Outbreak it was reported that the team composition was flexible and that allowed adaptability of roles (UK-EMT, Cholera Response, End of Deployment Report, 2025).

During the Türkiye Earthquake, it was reported that “integrating Turkish institutions from UMKE and the MoH was key to the success of the UK-EMT approach” (Türkiye Earthquake response, End of Deployment Report, 2023, p.9).

In the, Democratic Republic of Congo, “the team worked closely with the hospital’s⁴ management staff, adapting its focus based on evolving trauma caseload and building strong partnerships with local and international actors” (UKEMT -Goma Response DRC Report, 2025, p.19).

Were stakeholders satisfied with deployments?

In many of the deployments, various stakeholders (including patients, health officials and medical staff) expressed satisfaction with deployments through stakeholder satisfaction surveys. For example, stakeholders reported that deployment objectives were clear, training was context-appropriate, high-quality technical support was provided, and the needs of affected people were generally met.

Examples of deployments where high satisfaction was reported across multiple questions include the Lebanon deployment (2025), Türkiye’s earthquake deployment (2023), and the Jamaica Hurricane Melissa deployment (2025).

UK-ISAR Findings

In the Malawi Cyclone Freddy deployment, a needs assessment was undertaken entailing extensive stakeholder engagement with Ministry of Health (MoH), World Health Organisation (WHO), (Emergency Medical Team Coordination Cell), camp leaders, the District Health Office, and WFP among others. The response showed adaptability because following a needs assessment coverage was expanded from 2 IDP (Internally Displaced Person) camps to 6 camps and support for 1 health post. ISAR also adapted boat operations as water levels changed. Positive beneficiary satisfaction was recorded through patient interviews.

⁴ Hôpital Général de Référence Charité Maternelle

In the Morocco Earthquake, deployment needs were assessed through earthquake impact reports together with risk and threat analysis performed by UK-ISAR. There was also coordination and engagement with stakeholders, including local responders and the military. The deployment showed adaptability by altering its operational areas in response to aftershocks and reducing the team size when requested.

There was stakeholder satisfaction in the form of positive feedback from Moroccan authorities.

The Mozambique flood response included a needs assessment prior to the team's deployment. In addition, the response involved early consultation with a range of stakeholders, including Mozambican authorities, UN partners, and others. The deployment was designed for adaptability because of evolving threats requiring a flexible response.

Türkiye's Earthquake deployment involved site assessments to ensure the deployment was aligned to the needs of the local context. There was also continuous coordination with different bodies, including AFAD (Disaster and Emergency Management Authority), and LEMA (Local Emergency Management Authority). During the deployment, the team demonstrated adaptability by adjusting operations in response to unsafe working conditions and aftershocks that caused further damage in urban areas.



GREEN RATING:

Existing evidence suggests that deployments were relevant with good alignment to local emergency and rescue needs. Needs assessment and consultations were undertaken with country authorities to align deployment activities with local contexts. Deployments showed adaptability and high levels of satisfaction were reported by stakeholder groups.

Recommendations

There is a need for a standard reporting format/template for the writing of deployment ToRs. Some ToRs specify that needs assessments (rapid assessments) were undertaken before an appropriate deployment response was agreed to (for example, the EMT Gaza response, 2023; and Türkiye Earthquake response, 2023). In contrast, other ToRs only refer to communications (direct or indirect) between officials in affected countries and UK-EMT/ISAR (e.g., Libya Emergency Response, 2023; and Bangladesh, 2024).

There is a need for a standard satisfaction survey ('customer' survey) to be undertaken after each deployment, with representative stakeholders to be interviewed. This information could

be used to adapt deployments in future based on feedback from a variety of sources, including UK-EMT/ISAR staff, beneficiaries of the deployment, local officials, and representatives of other agencies providing support (including local and international NGOs).

Coherence

To assess **Coherence** the following sub-indicators were explored:

- Was the deployment aligned to existing programmes/internal policies?
- Were there well-defined roles and responsibilities, and coordination mechanisms for deployment implementation?
- Did the deployment assess local context needs before implementation?
- Was the deployment complementary? Did it fill programme gaps/avoid duplication?

UK-EMT findings

The DAC indicator of **Coherence** assesses the broader ecosystem of deployments. In aggregate, there was very good coherence across all the sub-indicators with respect to UK-EMT deployments.

Were deployments aligned to existing programmes/internal policies?

Deployments appeared to be aligned to existing programmes/internal policies in target countries.

The following examples of deployments highlight alignment to existing policies and programmes:

- The deployment in Armenia responded to country's Ministry of Health (MoH) need requests and the WHO EMT-CC (World Health Organisation Emergency Medical Teams Coordination Cell) call for assistance within its own operating framework.
- In Türkiye, the proposed deployment was aligned with WHO EMT principles. The response also worked closely with the local health system and applied local protocols to deliver a range of services.
- In North Macedonia, the deployment was aligned to EMT standards and embedded with MoH pathways for designated receiving facilities.
- In Goma, the deployment was designed to fully align with the "WHO EMT 'Red Book' standards (care in conflict zones) that sets out clinical, ethical, and equipment standards" (Concept Note, U EMT Surgical Specialised Care Team -DRC, 2025)

- In Lebanon, it was reported that “UK-EMT worked in close collaboration with the Ministry of Public Health (MoPH) and other stakeholders to align its activities with national priorities” (UK-EMT, End of Deployment Report, 2025, p.2).

Were there clearly defined roles and responsibilities?

Evidence reviewed from End of Deployment Reports indicates that deployment teams had clearly defined roles and responsibilities based on needs assessments that were undertaken before missions:

The following examples highlight the clearly defined deployment team roles and responsibilities:

- In Armenia, a specialist team was deployed with distinct subspecialties with the aim of improving surgical care and building capacity in the health care system.
- In Türkiye, a team of experienced clinical and operational staff was assembled in accordance with a Type 1 response. The overall approach was to work alongside Turkish authorities and with Turkish clinicians to maximise the impact of the deployment.
- In North Macedonia, the UK -EMT was designated as a technical capacity builder, while the MoH (Ministry of Health) was the coordinator of the deployment.
- In Angola, there was: “Coordination with MoH (Ministry of Health) at provincial and municipal levels, alongside strong engagement with World Health Organisation (WHO) and other partners, ensured aligned and efficient operations” (UK-EMT Support to Cholera Response in Angola, End of Deployment Report, 2025, p.11).

Were deployments complementary and did they fill implementation gaps?

Evidence from existing documentation suggests that deployments were complementary and filled gaps in medical emergency responses.

The following examples highlight the complementarity of deployments with local responses:

- In Türkiye, health activities were targeted through liaising with the MoH, WHO and UN bodies together with other organisations on the ground to map and analyse humanitarian gaps and provide UK-EMT response measures that addressed some of these gaps. The overall approach was to work alongside Turkish authorities and with Turkish clinicians to maximise the impact of the deployment.
- In North Macedonia, following consultations with national authorities, hospital leaders, and other key stakeholders, UK-EMT identified priority gaps in burns rehabilitation and

IPC (Infection Prevention Control). Surgical deployment was not required (UKEMT - Burns Rehab Response North Macedonia Report, August 2025).

There was some evidence that indicates that in a minority of deployments there were external coordination challenges that may have led to implementation gaps, such as in the following deployments:

- In Zambia, coordination needed to be strengthened, “Response coordination involved multiple actors which led to some confusion over where the UK-EMT specialists could best provide their expertise” (UKEMT Cholera Outbreak Response Zambia Report, 2024, p.5).
- In Malawi, the lack of EMTCC (Emergency Medical Team Coordination Cell) was initially picked up by WHO EMTCC and there was some ambiguity within the response and coordination mechanisms, which was later improved (UK-EMT Cholera Outbreak Response, Malawi, 2023).
- In the Malawi Cyclone Freddy response, coordination challenges were evident. These included difficulties in identifying cluster leads and their contact details, the proliferation of WhatsApp groups across organisations, and the need to strengthen information-sharing mechanisms and establish clearer communication protocols (UK-EMT, Cyclone Freddy Primary Health Care Mobile Response, Malawi Report, 2023, p.7).

UK-ISAR Findings

In aggregate, UK-ISAR deployment operations showed good coherence with existing interventions in target countries. Missions appeared to be in line with existing programmes and internal policies; roles and responsibilities were well-defined, and local context needs were assessed to support the rescue operations. The following deployment examples highlight UK-ISAR’s coherence with the wider rescue-mission ecosystems in target countries, as well as the challenges encountered, including coordination gaps that may have affected overall coherence:

- The Morocco Earthquake response conformed to UN INSARAG standards and the deployment was in line with UK-ISAR best practice (UK-ISAR End of Mission Report, Morocco Earthquake, 2023).
- Malawi’s Cyclone response was aligned with various international standards including the UK’s Humanitarian Framework, the WHO EMT guidelines, and INSARAG (International Search and Rescue Advisory Group) standards (UK-ISAR End of Mission Report Malawi, 2023). There were some coordination challenges. For example, it was reported that the Department of Disaster Management Affairs (DoDMA)

representatives were achieving good results in the rescue efforts, and that information was generally shared with the relevant teams and clusters, although this was not always consistent. (UK-ISAR End of Mission Report Malawi, 2023).

- In the Mozambican Floods, UK-ISAR worked closely with helicopter operators, UNHAS (United Nations Humanitarian Air Service), and Mozambican authorities to expedite the rescue operation. UK-ISAR did not operate aviation assets directly, but their personnel provided ground coordination support. This illustrated well defined roles in deployment (UK-ISAR, End of Mission Report, 2026). The team also contributed through situational awareness; reduction of misinformation, identification of displacement centres, and isolated populations to support communications and humanitarian planning (UK-ISAR, End of Mission Report, 2026).



GREEN RATING:

Overall, coherence was good. Deployments were well integrated/aligned with other bodies such as MoH, WHO and local health systems and NGO support agencies. Deployments filled health and rescue gaps in target countries. There is evidence of complementarity with national and international structures.

Recommendations

There was a need to improve coordination mechanisms in some deployments to support response cohesion. Coordination gaps affected the cohesion of responses in some instances because of communication gaps between cluster leads. Coordination weaknesses also affected the allocation of specialists and skills to areas where there was greatest need.

Effectiveness

The DAC criteria of **Effectiveness** focuses on the extent to which the deployments achieved their objectives.

To assess **Effectiveness** the following sub-indicators were explored:

- Were targets/outputs met?
- Were planned outcomes achieved?

UK-EMT finding

Findings from End of Deployment Reports indicated that, overall, deployments were successful in meeting their targets and objectives outlined in Project Concept Notes and deployment Terms of Reference.

Were targets/outputs met?

An analysis of deployment activities and aims, as outlined in the project Terms of Reference, showed that while the size of the deployment team was described numerically, the ToRs typically listed only the activities that will be undertaken and do not specify numerical targets to be achieved for each activity (this will be discussed later). Furthermore, many ToRs do not describe planned outcomes for deployments.

With respect to assessing outputs numerically as described in End of Deployment Reports, it was not possible to assess the success rates of deployments according to this measure, because there was no specificity in planned numerical targets for services to be delivered. Evidence from analysis of End of Deployment Reports, however, indicates that there was generally substantive/strong delivery of services when compared with activities described in ToRs. Where planned outcomes were described in ToRs, the success-rates in achieving these outcomes appeared to be good. Where feedback was solicited from stakeholders (deployed teams, patients, hospital staff, Ministries of Health, local government officials, and other external bodies and agencies, including supporting NGOs) satisfaction with services and interventions in deployments appeared to be high.

Key successes mentioned most often concerned technical achievements and hands-on services delivered. Technical achievements typically included the successful recruitment and deployment of medical experts and other supporting staff, while successful hands-on services covered a spectrum, including specialist medical and psychological services, WASH (Water, Sanitation and Hygiene) services, training and mentorship activities, Primary Health Care services, among others. Examples where there were notable achievements in hands-on services were the Zambian and Angolan Cholera deployments, as well as the Türkiye Earthquake deployment.

In very few deployments, numerical targets were estimated for the delivery of services. This included for example the Democratic Republic of the Congo (DRC), Goma where these targets were not achieved, and the Rwanda deployment, where envisaged estimates were exceeded. It may be that specific numerical targets for service delivery are not specified (either in project Terms of Reference, Concept Notes, and End of Deployment Reports) because of the fluid situation and rapidly changing contexts that teams encounter once operations begin. This is illustrated in the two examples below, where planned numerical targets were provided initially, but these were either exceeded or not met:

In the DRC, it was anticipated that surgical treatments should be between 140-160 over the four-week deployment (Concept Note: UK-EMT Surgical Specialised Care Team -DRC, 2025). However, these targets were not met. In this instance, some 49 surgical interventions were achieved (UK-EMT -Goma Response DRC, 2025, p.10). A constraint was that surgeons were unable to operate for much of the deployment due to licensing delays. Mentorship was provided instead of surgical interventions until licences arrived in April 2025 (UK-EMT -Goma Response DRC, 2025).

In the Rwanda deployment for the Marburg outbreak, the delivery of services exceeded initially planned targets. For example, there were 1,370 comprehensive nursing interventions provided versus the initially planned for 720 after an initial assessment was undertaken. The same was true in supporting surgical cases, where initially 10 were planned for, but over the 6-week period there was support for 60 surgical cases. This was due to the changing situation on the ground: "Changes in the political, operational and epidemiological environment meant UK -EMT had to be flexible and reactive to adjusting to and adapting objectives at short notice and run a response that would provide the greatest benefit to the Rwanda MoH" (UK -EMT Marburg Response Rwanda Report, 2014, p. 5).

The following examples highlight the ways in which deployments were effective:

In the Türkiye Earthquake deployment, the establishment of a Type 1 fixed facility was planned and that services should be integrated and coordinated with WHO EMTCC, and other health providers. Improved Primary Health Care services through this fixed facility should also be provided. The End of Deployment Report confirms that these outputs were delivered effectively. For example, a Type 1 fixed facility was established next to the district hospital. Turkish institutions, UMKE (Turkish Emergency Medical Team -EMT) and the Ministry of Health (MOH) worked well together, and this was reported as the key to the success of the UK-EMT approach in Türkiye. In addition, the provision of WASH services, such as clean drinking water, handwashing points and toilets for patients and staff were also highlighted as a success. This was particularly important because the health facility and staff camp could not be linked to the city water supply and sewer system. A feedback survey was undertaken with the deployment team. Respondents reported that UK-EMT was able to meet the most urgent community and health needs of the affected population (UK-EMT - Türkiye Earthquake Response, End of Deployment Report, 2023).

In the Zambia Cholera response, delivery was effective across both technical and hands-on services. For example, clinicians were deployed in a way that ensured no gaps in rotational staffing, and specific workplans were developed upon arrival in country. Needs assessments for Cholera management were conducted. Mini guidelines were developed for case management, and the team integrated well into existing local structures to deliver the mission objectives, coordinating effectively with WHO and MoH (UK-EMT Cholera Outbreak Response Zambia Report, 2024).

UK-ISAR Findings

Although numerical mission targets, such as the number of rescues or evacuations, were not typically set in advance, evidence from these operations indicates that effectiveness was strong, as mission objectives were achieved and outputs were high.

The two examples below highlight the effectiveness of UK-ISAR missions:

- In the Mozambican floods operation in 2026, 53 people were rescued in the Gaza province, and 8 people were rescued in Maputo province (UK-ISAR Mozambique Flood Response 2026, End of Mission Report, 2026, p.8). UK-ISAR worked closely with helicopter operators, UNHAS (United Nations Humanitarian Air Service), and Mozambican authorities to expedite the rescue operation. UK-ISAR also contributed by enhancing situational awareness, reducing misinformation, and identifying displacement centres and isolated populations to support communications and humanitarian planning. It was concluded that UK-ISAR successfully delivered targeted, professional and coordinated flood response in Mozambique. The deployment contributed directly to saving lives, enhancing situational awareness, and strengthening the international response to the country's most significant flood emergencies in recent years (UK-ISAR Mozambique Flood Response 2026, End of Mission Report, 2026).
- In the Türkiye Earthquake rescue in 2023, rescue and body recovery operations were undertaken in the Hatay province. The missions saved the lives of 8 casualties, and the recovery of 3 deceased Turkish nationals from complex collapsed buildings during rescue operations. The team also supported other domestic and international rescue teams with canine dog support (UK-ISAR End of Mission Report, 2023, p.11).



GREEN RATING:

The overall effectiveness of deployments was high. Nearly all objectives of deployments were met. Objectives included activities, services, and resources provided.

Recommendations

There is a need to standardise deployment Terms of Reference, so that where possible expected deployment outcomes and impacts are described. These can then be used as a reference point and as a measure for evaluating the effectiveness of deployments.

Efficiency

The DAC criteria of **Efficiency** examines how well resources are used. To assess efficiency the following sub-indicators were covered:

- Were activities delivered on time?
- What was the planned budget and what was actually spent?
- Were resources used optimally?

UK-EMT findings

Findings from End of Deployment Reports showed that deployments were reasonably efficient in the utilisation of resources. Efficiency-levels depended on a number of contextual factors. These included factors that affected efficiency included supply chain delays (for example, equipment delays), slow licence processing, and staffing shortages. Assessing efficiency in terms of expenditure/budgetary data was not possible because, although deployment Terms of Reference sometimes included budgets for deployments, the End of Deployment Reports did not capture actual expenditure data. This was a weakness with project reporting, which will be discussed in the next section.

Were activities delivered on time?

In most deployments, where time frames were reported in End of Deployment Reports, missions-times were broadly consistent with the deployment dates. Where missions were delayed or extended, a range of reasons were cited. These included:

- slow turnaround times with the importation of equipment slowing mobilisation (such as, critical surgical and medical equipment);
- delays in funding decisions causing planning uncertainties; licensing bottlenecks affecting prompt starting times;
- delays in the allocation of tasks and coordination with country Ministries of Health (MOH), and visa and security constraints.

What was the planned budget and was it spent?

In some deployments, the planned budget was specified in the project Terms of References. In others, budget allocations were reported as having to be confirmed, for example in the cases of deployments in Bangladesh (2024), Zambia (2024), and Israel/Lebanon (2024). There was no evidence of actual expenditure being reported in the deployment documentation, including the End of Deployment Reports. The assessment of this criterion was therefore not possible, highlighting a weakness of deployment reporting documentation.

Were resources used optimally?

In most deployments, optimisation in the use of resources was embedded in the roll-out of operations. Pre-deployment assessments of needs and the local context were important steps to avoid duplication of effort and effective integration of services with existing local structures, for example with the UMKE (Ulusal Medikal Kurtarma Ekibi -the Turkish EMT) and MoH in Türkiye (Türkiye Earthquake Response, End of Deployment Report, 2023). Effective coordination of deployed teams helped optimise the use of resources. This involved teams responding to on-the-ground staffing shortages and filling critical gaps. For instance, this was the case with the Malawi Cholera Deployment (2023), where a larger team was deployed to respond to Cholera case management in various areas (UK-EMT Cholera Outbreak Response, Malawi Report, 2023).

Teams had high levels of flexibility in role allocations and were able to adapt roles depending on changing context on the ground (UK-EMT Marburg Response Rwanda Report, 2024). Staff rotations also enabled some deployments to split into multiple sub- teams to cover several treatment sites and run activities concurrently (UK-EMT Support to Cholera Response Angola, End of Deployment Report, 2025). Efficient logistical operations further supported the optimal use of time. This was evident in the Ethiopia deployment, where a high-performing warehouse operation completed complex 'pick-and-pack tasks' using pre-loaded pallets and met tight delivery deadlines (UK-EMT Final report, Support to Marburg Outbreak, Ethiopia, 2026, p.3). Unused equipment (such as, trauma and surgical kits, and rehabilitation equipment) were donated, thereby saving costs. Examples of this were the Sierra Leone Mpox deployment, Angola's Cholera deployment, and Gaza's Medevac deployment. In some deployments, the use of local resources, such as translators reduced costs. This, for example, was the case with the North Macedonia deployment, where local translators were used (UK-EMT, Burns Rehab Response North Macedonia Report, 2025). In the Lebanon deployment, savings were also achieved through the local procurement of equipment, the use of local skills such as physiotherapists, and multi-partner collaborations with organisations on the ground, including MedGlobal and Interburns, which helped avoid duplication and maximise delivery capacity (UK-EMT, End of Deployment Report, 2025).

Operational Management: were systems, processes and decision making effective?

For most deployments, operational management was strong, with reporting systems, such as workplans and security protocols, and processes in place for effective decision-making. There was evidence of strong coordination on projects that supported effective decision-making. Coordination included regular meetings with the main stakeholders such as local authority structures, hospital management and staff, international bodies, including the WHO EMTCC, and UN structures. Examples of coordination activities in deployments that support operational management include:

- North Macedonia deployment: there were weekly situation report meetings and regular meetings with the Ministry of Health and hospital staff. This facilitated effective decision-making and enabled the deployment to change focus rapidly from a planned hands-on care model to a mentorship-led approach (UK-EMT Burns Rehab Response, North Macedonia, 2025).
- In Angola, there was good coordination with regular engagement with key role players, including MoH, WHO, UNICEF, Africa CDC, the Red Cross. Besides frequent coordination meetings, a WhatsApp WASH task force was to coordinate activities and respond to evolving local contexts (UK-EMT Support to Cholera Response in Angola, End of Deployment Report, 2025).
- In Sierra Leone, security plans were developed and updated periodically, and there were 28 structured coordination meetings during the deployment to ensure that there was good alignment between MoH, NPHA, WHO, and other partners. However, a weakness was the lack of pre-deployment coordination with the target hospital, which resulted in delays (UK-EMT Mpox Surgical Response Sierra Leone, 2016, p.30).

Weaknesses in operational management were licensing delays, and challenges affecting delivery models, and deployment speed including a lack of local support structures. Examples include:

- Zambia deployment: Licensing obstacles that prevented clinicians from practising in-country resulted in a shift from hands-on clinical service delivery to on-the-job training, capacity building, and clinical management (UK-EMT, Cholera Outbreak Response Zambia Report, 2024).
- In DRC, the procurement of medical licenses for EMTs to practise, combined with restrictions on UK-EMT staff to access Goma, caused delays and resulted in short staffing at points in the response. In the DRC, the WHO EMTCC was not in place to negotiate access, and this support-role had to be taken up by FCDO Kinshasa, placing increased administrative burden on this office, resulting in delays (UK-EMT, Goma Response DRC Report, 2025).

UK-ISAR Findings

Evidence suggests that resources were used efficiently and anticipated deployment times were accurate with missions ending at planned times. However, with respect to budget efficiency, there was insufficient evidence to assess this because forecast budgets specified in project ToRs and Concept Notes could not be verified in End of Mission Reports due to the absence of reported actual expenditure data.

In terms of the optimal use of resources, the sharing of facilities and resources during missions reduced logistical complexity and costs. For example, the Malawi Flood rescue operation (Cyclone Freddy) resource-use was intensive because of the deployment of helicopters and boats. However, through coordination with the Tanzanian Air Force and DoDMA (Department of Disaster Management Affairs), resources were used optimally.

In general, there was good operational management in ISAR deployments, with effective coordination that included regular situational reporting and coordination with other agencies to ensure the alignment of tasks with other rescue bodies, and effective use of resources. For example, in the Türkiye mission, there was daily situational reporting, and a command structure was in place. Risk assessments were undertaken with updated security briefings (UK-ISAR, End of Mission Report Türkiye, 2023).



ORANGE RATING: Overall, deployments were reasonably efficient in the utilisation of resources. However, some weaknesses were identified. These included: supply chain delays, license processing delays, and operational deficiencies- such as local support gaps.

Recommendations:

- Several weaknesses in deployment efficiency were identified through project documentation. These included supply chain delays affecting deployment times of designated resources (equipment); slow license and visa processing, and a related issue, i.e. staff shortages. There should be greater efforts to improve supply chain processes, and increased use of local resources could be considered more to simplify logistical and supply chain operations.
- Though sometimes beyond the control of UK-EMT/ISAR, addressing licensing issues in advance of deployments, particularly as it relates to permits for specialist staff to

practice in target countries, should receive attention. This can affect the delivery times in envisaged services, and lead to adaptation/changes to deployment outputs and design. Ensuring a close understanding of licensing requirements in the pre-deployment assessment phase may facilitate resolution of licensing bottlenecks and avoid delays. It may be useful for the WHO EMT mechanism to engage in advance with countries (such as, in Zambia, and the DRC), where additional licensing requirements exist, to understand these requirements and identify ways to address them before teams are deployed. Additionally, whilst licensing issues are being resolved, the deployed team could be repurposed so that medical staff provide capacity building opportunities to local staff as was done in the DRC deployment.

- A weakness identified in the documentation reviewed was the presence of gaps in budgetary data. Whilst some of the deployment ToRs provide information on the budget amounts allocated to deployments, the actual expenditure is not reported in the End of Deployment Reports. Consideration should, therefore, be given to providing expenditure data in End of Deployment Reports. Financial reports are collated, but were not part of this learning review.

Impact

The DAC criteria focusing on **Impact** examines the positive changes that the deployment has brought about:

- Has the deployment made a difference beyond immediate outputs?
- Has the impact had lasting, sustainable effects?

UK-EMT

Evidence suggests that deployments had a substantial impact in the target countries. For example, where hands-on medical care was provided, interventions had an impact on reducing morbidity and mortality. Some deployments, such as in Malawi, to support local health services after Cyclone Freddy, technical/systemic support was provided together with clinical support. Technical support included an assessment of WASH conditions that guided the development of the ToR, and the identification of WASH needs, as well as the necessary equipment and tools. A needs assessment involving the identification of health facilities that would receive medical donations for quality health care at the end of the deployment was also undertaken. The needs assessment also enabled the EMT to expand its services from 2 to 6 camps with available resources. Clinical services (hands-on services) took the form of health care consultations, leading to on average 100 patients being treated per day in makeshift clinics (UK-EMT Cyclone Freddy Primary Health Care Mobile Response, Malawi Report, 2023).

Only a few ToRs provided details of intended outcomes and impacts, and therefore the overall success of deployments are difficult to assess. Where impacts and outcomes were mentioned in project ToRs, they were of a general description without specific targets stated to measure success/impact. Specific targets may not be included in ToRs due to the relatively short deployment durations (<3 months) and the rapidly evolving field contexts, which make it difficult to define precise targets at the outset, even after rapid pre-deployment assessments.

Where stakeholder feedback surveys were carried out (with a variety of stakeholders - including clinical staff, government officials, and patients), these were positive. For example, in the Türkiye Earthquake deployment, respondents felt that UK-EMT was able to meet the most urgent community and health needs in the affected communities (UK-EMT Türkiye Earthquake Response, End of Deployment Report, 2023).

With respect to longer term and systemic impacts of deployments, there was evidence of success in this regard. The following examples highlight this:

- In Zambia, the deployment team assisted in rewriting national policy on guidance for cholera case management (UK-EMT Cholera Outbreak Response Zambia Report, 2024).
- In the Lebanon deployment, the trauma and burn rehabilitation interventions have resulted in increased access to high quality care and rehabilitation services. Through addressing challenges and recording successes in these services, this was expected to have a meaningful impact that should continue to benefit the people living in Saida (UK-EMT Rehabilitation Specialised Care Team and Intensive Care Unit Development, End of Deployment Report, Lebanon, 2025).
- In Jamaica, during the Hurricane Melissa deployment, the training of local healthcare staff increased their capacity to manage clinical presentations in the future. Donations of diabetes testing kits for 3 mobile clinic kits and the procurement of TESK kits (Trauma and Emergency Surgery Kit) supported improved services and care after the deployment intervention had ended (UK-EMT Hurricane Melissa Response, Jamaica, End of Deployment Report, 2025, p.14).
- In the Sierra Leone Mpox deployment, a significant donation was made to the Connaught hospital at project closeout. The donation included medical equipment, drugs and antibiotics, nursing and wound care supplies. Additionally, the deployment team remained in contact with medical staff at Connaught after the deployment to support with any information about patients to hospital staff that was needed (UKEMT Mpox Surgical Response Sierra Leone Report, 2026).

UK-ISAR

Evidence reviewed from project Terms of Reference and End of Deployment Reports indicates that UK-ISAR missions had good impacts and supported rescue operations in target countries. Support included use of dogs in search and rescue operations, assets deployed including helicopters and boats to affect rescues, veterinary support to medical teams, as well as medical treatment and casualty evacuation. The examples below highlight the types of support that were offered:

- Mozambican flood rescue mission: an initial rapid assessment was undertaken to identify needs. There were drone deployments to map the extent of flooding and undertake reconnaissance missions. UKISAR worked closely with helicopter operators, UNHAS, and Mozambican authorities to support the rescue operation. UK-ISAR also contributed by enhancing situational awareness, countering misinformation, and identifying displacement centres and isolated populations to support communication and humanitarian planning. Active flood rescue operations and humanitarian support were provided. Though the project ToRs did not mention intended outcomes and impacts of the mission, the End of Deployment Report noted that the deployment contributed directly to saving lives, (53 people were rescued in Gaza province and 8 people rescued in Maputo province), and enhanced situational awareness, and strengthened the international response (UK-ISAR Mozambique Flood Response, End of Mission report, 2026, p.8)
- Malawi, Cyclone Freddy: the team undertook rapid assessments to identify worksites in areas that were cut off by the floods. The mission supported coordination efforts through the Emergency Operations Centre and DoDMA (Department of Disaster Management Affairs) and shared information with relevant clusters. The mission successfully deployed a team to provide effective support. Some 358 people were rescued and there were 3 complex medical extractions. The mission also donated equipment and supported a wider humanitarian response (UK-ISAR End of Mission Report, Malawi, 2023, p.7).

**GREEN RATING:**

There was evidence of significant impact of UK-EMT and ISAR deployments/ missions to support local and international medical and rescue operations in target countries.

Recommendations

It is recommended that project Terms of Reference should consistently report on intended project impacts and outcomes to facilitate future evaluations, enabling assessments of whether the services and support provided aligned with what was originally intended.

Sustainability

The **Sustainability** criteria in DAC assesses whether deployment benefits will last even after deployments end:

- Has institutional capacity been developed.
- Is there evidence of local resources being used.
- Were resources used optimally.

UK-EMT

Evidence reviewed from programme documentation indicates that many of the deployment interventions promoted sustainability and longer-term medical improvements in countries deployed to. Across all the deployments, there were four main approaches that facilitated the sustainability of EMT interventions (either directly or indirectly) after teams had left countries.

These were:

- Capacity building
- Promoting local ownership
- Use of local resources/optimal use of resources
- Facilitating systemic changes

Capacity building

In terms of capacity building, a Training of Trainers (ToT) model was used to train local staff enabling them to pass on skills to other health care workers and creating a virtuous cycle of ongoing staff development. For example, in Armenia, a Training of Trainers on burns rehabilitation was provided to 26 trainers, equipping these staff to provide burn rehabilitation skills across the country. This intervention reportedly increased the knowledge in this area of care and the ability of the initial training team to train others (UK-EMT Armenia Response Burns SCT, 2023. p.7). The Libyan deployment team had also planned to implement a ToT system before the deployment ended (UK-EMT, Storm Daniel Response, Libya Report, 2023). Similarly in the Rwandan deployment, a ToT programme was implemented targeting emergency service workers (UK-EMT, Marburg Response Rwanda Report, 2024).

Formal training was also offered to local health workers. For example, in Sierra Leone, it was reported that national staff improved their ability to provide care independently even after the deployment team had left over the December break (UK-EMT Sierra Leone Mpox Response, 2025). Training through mentorship was another successful approach to promote lasting effects of deployment interventions. In Angola, for example, it was reported that 731 ambulance staff were mentored to expand their 'first contact' capacity (UK-EMT Support to cholera Response Angola, End of Deployment Report, 2025, p.15). Informal training also included the development of posters, educational materials, and digital libraries (UK-EMT Support to cholera Response Angola, End of Deployment Report, 2025). In Libya, there was formal midwifery training together with training on data management, and clinical mentoring to support sustainable changes in healthcare (UK-EMT, Storm Daniel Response, Libya Report, 2023).

Systemic change

Sustainability was promoted by supporting broader systems change in the medical services provided and within health facilities across different levels of government. For example, in the Lebanon deployment, referral pathways were developed together with Standard Operating Procedures (SOPs), and clinical protocols (UK-EMT Lebanon Rehab-burns and paediatric trauma specialised care teams, 2024). In Malawi, SOPs were developed, and visual aids that were developed were adapted to national standards to ensure their applicability. In addition, a local data clerk was trained and able to support health services in the future by the end of the deployment. IPC and waste systems were also established and handed over at the end of the deployment (UK-EMT Cholera Outbreak Response, Malawi, 2023). In Zambia, the team facilitated sustainable change through the rewriting of national guidelines on cholera case management (UK-EMT Cholera Outbreak Response Zambia, 2024). In Rwanda, the close collaboration with Rwanda Emergency Management Services (EMS) resulted in UK-EMT supporting the Rwanda EMS team in the development of the new EMS strategic plan (UK-EMT Marburg Response Rwanda Report, 2024). In Rwanda, the UK-EMT exit strategy focused on

sustainability through the development of a framework for ongoing rehabilitation services after the EMT's departure. This included individualised patient rehabilitation continuation plans to ensure treatment beyond UK-EMT exit (UK-EMT Marburg Response Rwanda Report, 2024).

Use of local resources and optimal use of resources

Another approach that supported the longevity of interventions after teams had left was through the use of local resources. By using local services and materials, resources could also be optimised. Local resources included local staff working alongside the UK-EMT deployment team (nurses and clinicians). Local infrastructure, including health care facilities and available spaces, were used, and in some cases upgraded, during the Malawi Cholera deployment. (UK-EMT Cholera Outbreak Response, Malawi, 2023). In Angola, local ownership was promoted through the use of locally adapted materials, particularly in the production and distribution of posters (UK-EMT Support to Cholera Response Angola, End of Deployment Report, 2025). In the DRC deployment, resource use was optimised through soliciting donations of medical supplies and local purchase of key items. Most of the rehabilitation items were made in the country. Suitable suppliers in DRC were found through the application of international best practices and regulations (UK-EMT, Goma Response DRC Report, 2025).

Donating equipment, medicines and facilities

In the Malawi Cyclone Freddy deployment, health facilities were identified to receive high quality medical and pharmaceutical supplies to use in their services (UK-EMT, Cyclone Freddy Primary Health Care Mobile Response, Malawi Report, 2023). In Jamaica, diabetes test kits were procured for donated mobile clinics. In this way resource-use was also optimised (UK-EMT Hurricane Melissa Response, Jamaica, 2025). In Angola, the distribution of WASH materials, IPC, and case management facilities across the province was designed to reinforce the training activities conducted by UK-EMT (UK-EMT Support to cholera Response Angola, End of Deployment Report, 2025). In Sierra Leone, there was a significant donation to the Connaught Hospital (the main site of the deployment) at project closeout. This included the supply of medical equipment, drugs and antibiotics, nursing and wound care supplies. This ensured that the local medical team could continue providing quality treatment beyond the deployment (UK-EMT Sierra Leone Mpox Response, 2025).

Risks to sustainability

Despite overall good practices that supported sustainability, various risk factors to sustainability were identified. These included: a high dependence on UK-EMT staff during peak caseload times and ongoing supply chain bottlenecks, the need to appoint permanent data clerks to support case management (Malawi Cholera deployment) (UK-EMT Cholera Outbreak Response, Malawi, 2023). In the North Macedonia deployment, sustainability risks included the absence of a national focal point for rehabilitation services, shortages of IPC

supplies, and staffing gaps. In addition, data management systems needed strengthening, and there was also ongoing funding pressure for equipment purchases (UK-EMT Burns Rehab Response North Macedonia Report, 2025). In the Angolan deployment, there were supply chain gaps, including equipment for chlorine testing, PPE, and cholera beds. Additionally, weak national policy guidelines for case management posed a threat to future sustainability, and UK-EMT recommended that these policies be developed and finalised. This included the need to institutionalise Standard Operating Procedures (UK-EMT Support to Cholera Response Angola, End of Deployment Report, 2025). In Sierra Leone, risks to the future sustainability of services included a lack of hospital equipment and reliance of the supply of medicines through donations.

UK-ISAR

With respect to the UK Fire and Rescue Services, there was less evidence of efforts to promote the sustainability of interventions after missions had departed. This may be because UK-ISAR missions are of much shorter duration, providing fewer opportunities for capacity building and for driving systemic change through the development of new policies and operating procedures. Facilitating sustainability through the donation of equipment for future events was the more common practise. Nevertheless, there were instances where interventions supported the long-term sustainability of practices in countries where missions had taken place. These include the following examples:

- In the Malawi and Mozambique flood responses, ISAR donated all boats and rescue equipment (UK-ISAR End of Mission Report -Malawi, 2023 and UK-ISAR End of Mission Report -Mozambique, 2026).
- In the Morocco deployment, there was some training offered through mentoring of the Moroccan UCC (Coordination Cell) personnel through its support of provincial coordination. Equipment was also donated, such as tents, generators, and medical supplies to support longer term recovery. Evidence of systemic strengthening of the Moroccan ability to manage future USAR (Urban Search and Rescue) operations was also found through the mentoring of its personnel (UK-ISAR End of Mission Report, Morocco Earthquake, 2023).
- In the Türkiye mission, local ownership was facilitated through the donation of tents, generators, medical equipment and fire extinguishers to AFAD (Disaster and Emergency Management Authority of Türkiye), and this supported ongoing emergency response capacity. The team also worked with LEMA (Local Emergency Management Authority) and AFAD to strengthen disaster management structures (UK-ISAR End of Mission Report Türkiye EQ, 2023).

**GREEN RATING:**

Overall, there were good sustainability practices in deployments across UK-EMT and UK-ISAR programmes. These focused on capacity building, systemic measures, such as the introduction of SOPs, the promotion of local ownership using local skills, and other resources, and the optimal use of resources.

Strength of evidence

This section assesses the strength of evidence using the documentation provided for the Learning Review. The table below evaluates the DAC criteria across the sub -indicators by colour-coding the quality of evidence analysed:

- The Red column indicates that little or no evidence of sufficient quality was provided to draw conclusions on these criteria.
- The Orange column indicates there is some evidence to generate findings on these criteria, but this could be strengthened with more data.
- The Green column indicates that the evidence is sufficiently robust enough to draw conclusions on the data for these criteria.

DAC Criteria	Red	Orange	Green
Relevance			
Were local needs assessed before deployments?			X
Was the local context assessed before deployments?			X
Did deployments adapt to changing circumstances?		X	
Were stakeholders satisfied with deployments?		X	
Efficiency			
Were activities delivered on time?		X	
What was the planned budget and what was spent?	X ⁵		
Were resources used optimally?		X	

⁵ No evidence was provided to assess this indicator

DAC Criteria	Red	Orange	Green
Effectiveness			
Were planned outcomes achieved?		X	
Were targets/outputs met?		X	
Impact			
Are deployments making differences in outcomes?		X	
Have impacts had lasting sustainable effects?		X ⁶	
Coherence			
Are deployments aligned with existing programmes in the country?		X	
Are there well-defined roles and responsibilities and coordination mechanisms?		X ⁷	
Did deployments assess local needs?			X
Were deployments complementary (fill gaps and avoid duplication)?		X ⁸	
Sustainability			
Is there evidence of capacity building?			X
Has institutional capacity been developed?		X	
Is there evidence of local resources being used and promoting local ownership?			X



RED: Little evidence
ORANGE: Some evidence
GREEN: Sufficient evidence

With respect to the DAC criteria of **Relevance**, the evidence provided on needs assessments before deployments was sufficiently strong. The needs and local context of target countries were described in some detail in most of the deployments. There was some evidence that missions were adapted to changing circumstances once deployments were on the ground.

⁶ It would be useful to explore the legacy of such deployments where capacity building and resource development components are included. Most deployments have capacity building built in through on the job training, Training of Trainers or formal training.

⁷ WHO EMT, for example, are meant to have coordination cells set up in advance to support deployment effort.

⁸ Deployment reports could state explicitly when this is the case.

This evidence was usually reported within the End of Deployment Reports, such as in the Malawi Cyclone Freddy response where boat operations were adapted as the situation on the ground changed. With respect to stakeholders being satisfied with deployments, many of the End of Deployment Reports indicated that surveys had been undertaken with a range of stakeholders on the ground. However, there is no systematic approach to reporting stakeholder perceptions of deployments, nor is it clear how stakeholders were selected or whether a standardised tool was used to gather their views. A standardised approach/methodology to sampling views would support the strength of this information.

There were weaknesses with **Efficiency** indicators because there was a lack of consistent reporting on budgetary data in the documents assessed. In some cases, anticipated budget amounts were provided, however, there was no data on actual expenditure, making it difficult to assess deployment efficiency on this measure. Although reports illustrated the ways in which resources were used optimally in their descriptions of deployment rollouts, there is a lack of independent data to support this. For example, it would be useful to assess stakeholder views including local staff, officials, and other stakeholders - such as local and international NGOs providing support.

With respect to deployment **Impact**, there is some evidence that can be used to measure this aspect. Whilst Impacts are often described in End of Deployment Reports by reporting on deployment outputs for example in terms of how many people trained, rehabilitation and patient treatment services, overall impacts are not reported on, and deployment Terms of Reference frequently do not specify intended outcomes or impacts (for example the Libya and Angola deployment ToRs). Therefore, there is insufficient information to measure deployment success fully because no impacts and outcomes have been consistently identified or described in Concept Notes or Terms of Reference.

There is some evidence to generate findings on **Coherence**. The strongest evidence in this measure is the assessment of local needs, where deployments usually undertake rapid pre-deployment assessments in the country to inform the type of deployment and also provide good descriptions of deployment contexts. With respect to the other indicators in this measure, some evidence is provided from the deployment reports, for example how deployments are complementary to existing interventions and the extent to which WHO EMT coordination cells have been established and are providing adequate support to ensure coordination of deployment-efforts and the filling of gaps in the emergency response. However, a more rigorous approach would be to assess stakeholder views on coherence as an independent source of information on this dimension.

In terms of **Sustainability**, the end of deployment reports usually provides detailed information (including numerical data) of local staff trained and mentored and also concrete examples of capacity building initiatives. In addition, the use of local resources and the promotion of ownership in types of assistance provided is described. It would be useful to explore

respondent views on sustainability through more structured stakeholder surveys to strengthen the evidence base.

Key lessons from the evidence

A number of key learnings and lessons can be extracted from the available deployment documentation. These cover the two major aspects of programme reporting and programme implementation and impact.

Programme reporting

- Programme documentation (Terms of References and End of Deployment Reports) should be written in a consistent way, with a prescribed set of themes to be covered.
- If programme outcomes and impacts are to be evaluated in the future, these themes need to be described in both project Terms of Reference and End of Deployment Reports.
- It is difficult to assess the success of some broader outcomes that were mentioned in deployment Terms of Reference and from data reported in End of Deployment Reports. A typical example was a reduction in mortality and morbidity that was sometimes mentioned in deployment ToRs as an intended outcome. These measures are too vague and there is a lack of reported data to assess this properly. Reporting on these types of indicators in future should therefore be carefully assessed if data cannot be provided to assess whether these types of outcomes have been achieved.
- If deployment efficiency is to be assessed by using budgetary data, these need to be reported consistently in programme documentation. This could be achieved by including anticipated budgets in ToRs and then details of actual expenditure against budgets. In this learning review, this information was not available to researchers. Efficiency based on the anticipated duration of deployments and actual length of deployments should also be evident in programme data.
- In respect of reporting on stakeholder satisfaction with deployments, consideration should be given to tightening up the methodology for assessing stakeholder satisfaction with a standard set of questions aligned to the DAC criteria. The methodology for administering the surveys, whilst bearing in mind the contextual difficulties of missions themselves in administering surveys, could be tightened up with a Standard Operating Procedure for undertaking these survey assessments. By strengthening the approach to soliciting the views of stakeholders, this would lead to

an overall strengthening of the evaluative data available to inform future deployments reliably.

- Deployment team compositions were flexible and adaptable as circumstances changed on the ground and this sometimes-caused changes to the original set of planned activities. Changing circumstances may also have an impact on intended deployment impacts and outcomes. Reporting data used in evaluations should highlight this aspect more explicitly in reports so that evidence can be assessed more effectively.
- Finally, documents used for this evaluation are programme administrative documents. Whilst containing valuable data for the learning review, they had limitations in the level and depth of information and in the consistency of information reported. This made the evaluation more superficial. The reports were for example not aligned to the DAC criteria and not all indicators were reported in detail in the documentation. The End of Deployment Reports further lacked consistency in report format titles and there were no author details so that if there were later report queries the author could be contacted. It is suggested that if existing documents are to be used in future evaluations, reporting, content-detail and consistency should be reviewed.
- Consideration could be given to undertaking interviews with programme officials in future evaluations to obtain a high-level perspective on the way deployments were undertaken and overall challenges and achievements.

Programme implementation and Impact lessons

- There is some evidence to suggest that UK-EMT and UK-ISAR deployments and missions are having an impact on the success of overall rescue operations and medical emergencies in target countries. This is evident in reported outputs achieved and in broader outcomes and impacts where they are reported on.
- The lasting effects of these deployments after teams had left countries was dependent on resources available to continue to implement improvements in rescue and medical services and the strength of local coordination structures after deployment teams have left. There is a risk that local capacity relies too much on UK-EMT support, especially in longer deployments and where a surge of support and care is needed during emergencies. When teams leave, the ability to cope with increased needs during emergencies may still not be adequate.
- With respect to deployment implementation there was evidence to suggest that delays in deployment were most likely to be caused by license processing issues (for

example the ability of specialist staff to work in target countries), logistical delays in the supply of key equipment necessary for the deployment. These aspects need to be refined where possible to reduce the risks of unplanned delays. However, it should be noted that one of the most frequently cited achievements mentioned in missions was the ability of missions to deploy quickly.

- Coordination between deployment teams and local actors on the ground can be important for deployment coherence and effectiveness. Where multiple actors are involved when there is poor coordination, this can affect the most efficient allocation of expertise as was the case in the Zambia deployment (UK-EMT Cholera Outbreak Response, Zambia report, 2024).