POLICY ON EMERGENCY MEDICAL SERVICES (EMS)

IN NIGERIA

FEDERAL MINISTRY OF HEALTH, ABUJA

MARCH 2016

Forward

Acknowledgement

LIST OF STAKEHOLDERS

Federal Ministry of Health

State Ministries of Health

National Emergency Management Agency

Federal Road Safety Corps

Nigeria Security and Civil Defence Corps

Nigeria Police Force

Federal Fire Service

Nigeria Armed Forces Medical Corps

FCT Health and Human Services

Federal Tertiary Health Institutions

World Health Organization

Civil Society Organization

International Committee of the Red Cross

Private Ambulance Service Organizations Operators

List of Abbreviations

A & E   Accident & Emergencies

ACLS   Advance Cardiac Life Support

ALS   Advance Life Support

BLS   Basic Life Support

CSO   Civil Society Organization

CT/CR   Counter Terrorism/ Crisis Response

DHQ   Directorate Head Quarters

DMIC   Deputy Medical Incident Commander

DSS   Department of State Services

ECC   Emergency Contact Centre

EMS   Emergency Medical Service

FCT   Federal Capital Territory

FFS   Federal Fire Service

FMOH   Federal Ministry of Health

FRSC   Federal Road Safety Corps

HMH   Honourable Minister of Health

IDP   Internally Displaced Persons

ICRC   International Committee of the Red Cross

IHT   Inter Hospital Transfers

MDAs   Ministries, Department and Agencies

MIC   Medical Incident Commander

NACRIS   National Crash Information System

NAS   National Ambulance Service

NCC   Nigerian Communication Commission

NDLEA   National Drug Law Enforcement Agency

NEMA   National Emergency Management Agency

NGO   Non Governmental Organization

NHIS   National Health Insurance Schemes

NPF   Nigerian Police Force

NRCS   Nigerian Red Cross Society

NSCDC   Nigerian Security and Civil Defence Corps

NURTW   National Union of Road Transport Workers

PHS   Port Health Services

RTCs   Road Traffic Crashes

SMOH   State Ministry of Health

1. INTRODUCTION

1.1 Emergency Medical Services System in Nigeria

The goal of emergency care is to get people safely from the world into the hospital, from the site of acute injury or illness to definitive care. There are emergency components at every level of the health system, from bystander response through to tertiary interventions. Emergency Medical Service (EMS) provides emergency medical care for all types of emergencies such as medical, surgical, Obstetrics & gynaecological, paediatric emergencies, accident and intentional injuries, disasters and epidemics. The objective of the EMS is to reach those in need of urgent medical care in order to satisfactorily treat the presenting conditions, from the scene of the incidents to the point of definitive care, most likely an emergency department of a hospital. EMS thus involves a continuum of pre-hospital, hospital and rehabilitative care and the linkages between the components, including but not limited to emergency personnel, emergency communication system, Emergency Infrastructure, integrated emergency ambulance service system, emergency equipment and a functional trauma system in the receiving facility.

The EMS pathways is to be managed by a crop of highly trained professionals, and consist of the following components:

a. Pre-hospital personnel (paramedics and paramedic technicians)
b. Hospital Physicians, nurses, and other health workers
c. Administrators and health managers
d. Emergency Service infrastructure:

i. Ambulances in good working conditions,
ii. Equipped Accident & Emergency units,
iii. Emergency drugs and consumables,

iv.   Side laboratory,

v.   Mobile X-ray machines, etc.

e. An informed public that knows what to do in emergency situations. The emergency medical personnel in the ambulances are the Paramedics, Paramedic technicians, paramedic nurses and paramedic physicians based on the level and type of Ambulance service provided.

The EMS system is triggered by :

i.   a member of the public through a call to an emergency phone number 112, which puts them in contact with Emergency Contact Centre (ECC).

ii.   ECC dispatches a suitable ambulance service closest to the incidence to deal with the situation anywhere within the system coverage.

iii.   The ambulance service provides resuscitative care and transfers the patient to definitive care centre

iv.   The Accident and emergency units of hospital/ health facility provide definitive care.

Situation Analysis

Although a lot of progress has been made in emergency medical service delivery in Nigeria through private efforts and Government initiatives such as the training of paramedics; accreditation of paramedics training institutions, construction of trauma centres; and establishment of call centres; Nigeria has no policy direction on an integrated EMS system as an institution. This policy on EMS system is therefore to coordinate all the medical emergency services in Nigeria and to **integrate** all the various National entities providing emergency services. This will integrate medical emergency components of the following stakeholders:

i. The Federal Ministry of Health as Custodian of the health Sector Policies and lead agency.

ii. National Emergency Management Agency, hosting the National Call centres 112 in collaboration with National Communication Commission.

iii. Federal Road safety Commission, regulator and provider of road safety.

iv. Paramedics' schools and training activities., producing trained emergency personnel.

v. Accident and Emergency units of all Hospitals (A&Es).

vi. Trauma centres at National and State levels.

vii. Emergency service section in all MDAs' Medical Services including the Armed forces medical systems, Security Services, the Police medical systems, NSCDC, Federal Fire Service, Customs, Prison Services, NDLEA, NCDC, Port Health Services and Aviation medical systems.

viii. Private organizations operating Ambulance services.

ix. Private Health Facilities

x. State Government Health facilities.

xi. Local Government Health facilities

xii. All PHC Centre

xiii. University Health Systems.

xiv. Non Governmental Organizations including International Agencies.

This EMS policy shall coordinate a seamless system of emergency medical care for the country. The policy defines the relationship and responsibilities among these operators of emergency medical services, and will ensure timely and coordinated intervention to medical and surgical emergencies, averting preventable deaths due to delayed access to emergency care. The EMS is integral to reducing morbidity and mortality, essential to traffic mobility, and key to ensuring prompt emergency response to any type of incident. Thus, Nigeria's best preparation for any incident is the implementation of this comprehensive EMS policy.

1.2   Justification of the Policy

Nigeria, in recent times, has witnessed a rise in morbidity and mortality due to Insurgency, Bomb blasts, Road Traffic Crashes, Armed Robbery, Collapsed Buildings, Floods, Disease Epidemics and non-violent emergencies such as Cardiac arrests, Stroke and Sudden Deaths, Ectopic Pregnancies, Domestic Accidents, Asthmatic attacks, amongst others. The policy on emergency medical services is necessary for a functional pre-hospital care system in Nigeria. It will ensure improved and coordinated response to health emergencies as well as reduce *response time,* as patient's chances of survival are greatest if they receive care within the golden hour, following a severe injury. This will also ensure effective and efficient utilization of resources and create jobs for teeming Nigerians and reduce poverty.

There shall therefore be an Emergency Medical Services for Nigeria known as EMS, to coordinate all the medical emergency services in Nigeria. The EMS System in Nigeria shall have its components stakeholders as FMOH, SMOHs, NEMA, FRSC, FFS, NPF, NSCDC, NCC, Nigeria Armed Forces, State Security Services, all MDAs' medical services, NACRIS, Private and Voluntary organizations providing emergency Ambulance services.

i. The Federal Ministry of Health is to coordinate the management of all medical emergencies in the Country.

ii. The NEMA is to carry out her mandate of coordinating the management of emergencies in the country by way of anticipation, assessment of risk, prevention, preparation, response and recovery; while HMOH handles the health component

iii. EMS to leverage on the NEMA's Call Centre (112) provided by the NCC for all communications. The toll free call centres in NEMA are to be configured to receive all distress call and **link** same to the emergency ambulance service system for action

iv. The operational guideline for national ambulance service is to guide the implementation of EMS.

v. The National Trauma systems, comprising Accident & Emergency units of all hospitals, Trauma centres, Specialty care centres and rehabilitation facilities to be linked to the 3-digit number 112. All Ambulances must have this toll free number written boldly

vi. The EMS system to be managed by trained professionals, including
   a. Pre-hospital personnel (paramedics and paramedic technicians)
   b. Paramedic Physicians, nurses, and other health workers
   c. Administrators and government officials
   d. An informed public that knows what to do in a medical emergency.

2 POLICY GOAL AND OBJECTIVES

Policy Goals And Objectives.

2.1 Goal

To coordinate and integrate emergency medical services in Nigeria

2.2 Objectives

i.   To put in place an Emergency Medical services (EMS) systems in Nigeria.

ii. To regulate the operations of emergency medical service providers in Nigeria.

iii. To prescribe and regulate the type of Ambulance to be used by operators and service providers.

iv. To guide ambulance usage plan during mass casualty incidence and disaster scenario

v.   To stipulate the role of various stakeholders in the emergency medical service system for Nigeria.

vi. To put in place the funding plan for emergency medical service system for Nigeria.

vii. To formulate, regulate and implement guidelines for integrated National Ambulance Service system in Nigeria.

viii. To ensure a systematic implementation of the Nigerian Health Act 2014.

ix.

3. COMPONENTS OF EMERGENCY MEDICAL SERVICES SYSTEM IN NIGERIA

3.1 Emergency Services Personnel and Administrations.

These shall comprise of Paramedics, Paramedic technicians, Paramedic Nurses, and paramedic Physicians. Their detail qualifications and operations shall be as detailed in chapter 3.4.2, 3.4.3, 3.5.2, 3.5.3, 3.6.2, 3.6.3, 3.7.1, 3.7.5 and 3.8.1 of the operational guidelines for the national Ambulance Service.

3.2 National Ambulance Service System (NAS).

The Ambulance Service System has evolved over the years from simply systems of ambulances providing only patients' transportation, to a system, in which actual medical care is given on scene and during transport. Thus the NAS is responsible for providing pre-hospital care and providing transportation and linkages with the health facilities. The role of NAS also involves Inter hospital transfer (IHT), usually, to facilitate the provision of a higher level or more specialised field of care. In such situations, the NAS is summoned by:

i. clinical professionals such as doctors
ii. Nurses in the referring facility
iii. A medical assistance
iv. An Insurance company if they are not satisfied with the level of care

The ambulance services are classified based on the level of services provided, the equipment in the ambulances and the level of competency of the crewmembers as follows:

i. Basic Life Support (BLS) Ambulance Service

ii. Advanced Life Support Ambulance Service

iii. Mobile Intensive Care Service

iv. Boat Ambulance Service

v. Air Ambulance Service

vi. Hearse Services

The requirements for designs, sanitation, supplies and maintenance of the ambulances, are as contained in chapter 3.0, 3.1, 3.2, 3.4.1, 3.5.1, 3.6.1, 3.6.4, 3.7.2 and 3.7.3 of the operational guidelines for the National Ambulance Services. The requirements for communication are as contained in chapters 3.7.6 and 7.0 of the operational guidelines for National Ambulance Service System in Nigeria.

3.3 National Trauma System

The National Trauma System is responsible for definitive care of trauma patients. It shall comprise of the following:

i. Trauma Centres
ii. Accident & Emergency units of all secondary and Tertiary hospitals
iii. Orthopaedic Specialty care centres
iv. Specialized post trauma rehabilitation centres

The National Trauma System receives patients from the ambulance services and provides adequate medical care promptly. The National Trauma System is also linked to the Emergency Communication System, so that, the facilities are in-formed before the arrival of patients for adequate preparation for the patients. When the patient cannot be taken at a level of care the patient is referred through the ambulance systems and re-directed to the appropriate hospital with minimal time lag (less than one HR)

3.4 The **National Emergency Communication System**

The EMSS shall leverage on the toll free Call Centre (112) of National Emergency Management Agency provided by the Nigeria Communication Commission (NCC) for all communications. The toll free call centres in NEMA are to be configured to receive all distress call and **link** same to the emergency ambulance service system and the National Trauma System for necessary actions. All agencies shall configure their emergency lines to this national number for uniform coordinated communications.

3.5   **The National Crash Information System (NACRIS)**

The National Crash Information System (NACRIS), chaired by Hon. Minister of Health and with the Secretariat at Federal Road Safety Commission (FRSC), shall coordinate the generation of all crash data for monitoring, evaluation and evidence based planning for health and medical emergencies in Nigeria.

i.   NACRIS is responsible for Compilation, standardization and harmonization of all data collected by EMS implementing agencies, including State Committees on Crash Information System.

ii.   NACRIS Shall give authentic national figure on casualties of all crashes: Land, Air and Sea.

iii.   The NACRIS Database is the national repository that will be used to store EMS data from all the States and MDAs in the Nigeria, and shall be domiciled in the Secretariat.

4. EMERGENCY MEDICAL RESPONSE IN DISASTER AND MASS CASUALTY INCIDENTS

4.1 Disaster and Mass Casualty Incidents

Disaster is a catastrophic event, serious or great enough to overwhelm a community, and resulting in loss of life and injury and extensive disruption to the social structure of a community. A disaster exceeds the capabilities of the normal emergency services and therefore requires the mobilisation of special arrangements to deal with the consequences. In mass casualty incidents, the number of patients overwhelms locally available resources and routine procedures, extraordinary emergency arrangements and additional assistance are thus required in such situation.

4.2 Emergency Medical Service in Disasters Response

Emergency medical services play a key role in reducing morbidity and mortality in disaster and mass casualty incidents.

i. EMS in disasters must ensure an effective, timely and coordinated response to save lives and prevent further injury in the early critical phase of a disaster.

ii. The commander shall clarify the individual responsibilities amongst the response team thus ensuring everyone is familiar with their role and that of other team members.

iii. He shall Identify what resources might be required in the response to the disaster and where they are located.

4.3 Mass Casualty Evacuation in Disaster Response shall have the following distinct sectional arrangements.

      i. At least 100 Paramedics for Primary evacuation

ii. At least 20 doctors available for Triage/ Resuscitation

iii. At least 20 ALS Ambulances for Secondary evacuation

iv. Management of Dead bodies by the Police

v. Nearest health facility identified and fastest route located.

vi. Forensic Assessment by Police/FMOH or experts designated by her.

4.4. Command and Control, Co-ordination and Communications

For humanitarian responses to be effective, coordinated, dependable and timely emergency preparedness is a prerequisite. Effective command and control of all first responders is critical to the response outcomes. For efficiency, the Commander shall be the Minister of Health, or his representative and shall ensure:

i. A clear understanding of the roles and mission of the different organisations in the field.

ii. Use of mutually agreed known standards and operating procedures and communicated to all concerned

iii. Regular meetings between different organisations who are stake holders.

iv. Joint Training in BLS, ALS, Simulations exercises, teamwork, communications, planning, Perfect co-ordination and co-operation among stakeholders.

5. ROLES AND RESPONSIBILITIES

The EMSS is a system requiring collaborative efforts of many independent actors or stakeholders which includes:

5.1   Federal Ministry of Health:

i.   Shall be responsible for coordination and implementation of EMS Policy

ii.   Shall be the lead agency and chair of EMS system

iii.   Coordinate the management of all medical emergencies and health response within the Country

iv.   Carry out Advocacy and leadership in promoting a system approach to the development of emergency medical services through consensus building, collaboration and leveraging of limited resource.

v.   Shall be responsible for Formulation of policies, guidelines and strategic plans for the EMSS and its components.

vi.   Shall provide the frame work, general guidelines and reviews for policy direction relating to personnel, curriculum development, scheme of service for staff of the national ambulance service, standard of vehicle types, equipment required for each category of service and responsibilities of each tier of Government. These shall be as stipulated in the guidelines for National Ambulance Services.

vii.   Shall be responsible for Human resource for health development, including
    o   Paramedics training
    o   Trainings in ACLS, ALS, and BLS

viii.   Shall Lead other agencies for effective EMS implementation during disaster and other emergencies

ix.   Develop and implements programs to support and enhance EMS systems

x.   Shall maintain a health emergency database and disseminate to all levels of governance.

xi.   Establish a rapid response team, which shall forecast, prepare and respond to health emergencies and disaster.

5.2   State Ministries of Health

   i.   The State Ministries of Health shall step down the emergency medical service system in their states. The Commissioner of Health of the State shall play leadership roles in medical emergencies and disasters in their states.

  ii.   Each state commissioner shall update the Hon. Minister of Health with the state of affairs of the Emergency and Disasters in their state.

 iii.   The Commissioner of Health shall lead the EMS at the State level.

 iv.   Take the lead and coordinate the health sector response to emergencies and disaster in their state unless the magnitude is of such level that FMOH is called, in which case FMOH becomes the lead agency

  v.   Ensure implementation of EMS Policy at state level

 vi.   Collaborates with the Federal Team during disaster and emergency response

 vii.   Establish clear communication links with the Federal Ministry of Health for prompt data transmission within 24 hours

viii.   Operate and coordinate a state wide communications system that connects EMS providers in the field with hospitals as well as trauma and specialty centres

 ix.   Formulation of state wide medical protocols for EMS providers, or otherwise establishing the scope of EMS practice within the State

  x.   Planning for and coordinating the medical response to disasters and mass casualty incidents in the state

 xi.   Provision of leadership for state wide trauma systems or other specialty care systems

 xii.   Provision of health personnel to man camps and provide psychological support to affected population at IDPs

xiii.   Ensure Collection of data from local agencies, hospitals, and trauma centres, and submit same to NACRIS.

xiv. Form state health emergency response team comprising relevant stakeholders

xv. Develop capacity for emergency preparedness and response

xvi. Establishment of local resilience forum in all local governments areas, with the District Medical officer as leader.

5.3 National Emergency Management Agency (NEMA):

f. Shall be the Co-ordinating agency for disaster and national crisis

g. Shall Co-ordinate the management of emergencies in the country by way of anticipation, assessment of risk, prevention, preparation, response and recovery.

h. Shall Houses the National Call Centre 112.

i. Shall be Responsible for coordinating distress calls in EMS system

j. Shall with the FMOH and FRSC, map out Ambulance services points nationawide.

k. Shall be responsible for provision of logistic support to other agencies during disaster and national crises.

5.4 First Responder Agencies (FFS, FRSC, NPF, NSCDC, DHQ, DSS) etc:

The following agencies are lead first responders in various emergencies and disasters as indicated:

i. Federal Fire Service – In all Flood & Fire Disaster;

ii. Nigeria Police Force – In Bomb blast also responsible for providing Security at all emergency response activities

iii. Nigeria Security & Civil Defence Corps – In Civil unrest, Crowd control, Search and rescue evacuation of victims

iv. d. Federal Road Safety Corps – Road traffic crash, and also Traffic control during emergencies.

v. DHQ – War and insurgencies.

vi. DSS Health Services

These agencies shall hand over patients to paramedics in the ambulance services who are responsible for evacuating the Victims to the hospital. They shall also assist in evacuation of victims during mass casualty

5.5 Voluntary Organisations, International Non-Governmental Organisations

This group shall comprise of international non-governmental organisation such as the International Committee of the Red Cross (ICRC), Nigeria Red Cross Society (NRCS) and any other organisation duly registered by the Corporate Affairs Commission and approved by the Federal Ministry of Health.

i. They shall assist in rescue and evacuation of victims.

ii. They shall assist in Triage

iii. They shall assist in camp of IDPs in providing emergency care under the supervision of the health team leader.

iv. Collaborates with Government Agencies in emergency response as defined by their mandates

v. Take orders from the incident commander during mass casualty operations

5.6 Trade Unions (NURTW, RTEAN, CSO)

i. The FMOH shall Sensitize Trade Unions and its members on various medical emergency and disaster.

ii. The FMOH shall organize or coordinate training on BLS and ALS for members of the union and Civil Society organizations from time to time.

iii. All Health product donation, drugs and medical consumables to IDPs, Prisons and Hospitals, shall be approved by the Minister of Health.

It is an offence punishable under the penal code to dump expired health products in the name of donations to IDPs etc.

5.7 Hospitals, Trauma Centres, Specialty Care Centres and Rehabilitation facilities

i. The A&E units of all hospitals (Federal & States) must be ready to receive patients 24/7

ii. Must have qualified emergency personnel on ground 24hrs a day

iii. Shall Provide definitive care to the patient

iv. Shall have emergency lines open 24/7

v. Shall be connected to the 3-digit 112 line

vi. Shall ensure Compulsory prompt treatment of emergency patient. without requesting for Police report or payment deposit

5.8 Private Health Facilities

i. Must have emergency care units

ii. Must receive patients during mass casualty and treat.

JOINT STANDARD OPERATING PROCEDURE (JSOP) for Mass Casualty Evacuation

National Level

A) During Counter Terrorism / Crisis Response/Flood/Mass Casualty:

A call will be put to the toll free line 112, who then activates the various responding agencies, including the medical response team.

1. All medical responders to converge at the Initial Holding Area of the incident. The Medical Incident Commander (MIC) is the Minister of Health or his agent; and commands the medical emergency response through out the crisis period. He is to be assisted by NEMA as Deputy MIC. The DMIC should be an individual with medical background, as a paramedic physician, paramedic Nurse or Paramedic.

In the absence of the MIC, the DMIC takes charge.

2. Functions of the Medical Emergency Responders are as follows:

   i.   Casualty Evacuation

   ii.   Triaging

   iii. First Aid

   iv. Establishing contact with a receiving health facility

   v.   Transportation of the injured and the dead to health facilities

3. Functions of MIC

A. To appoint assistants to manage evacuation process:

   i.   In- charge documentation, to document officers sent into the crisis area

   ii.   An FRSC officer to be In- charge of ambulance loading:

       a. Allocate ambulances to victims

       b. Keeps record of victims and their hospital of destination

       c. Ensures that hospitals are contacted, and briefed on state of victims being sent to them and the nature of their injury

iii. A police officer to be in charge of the dead :

   a. Ensure scene preservation for forensic investigations.

   b. Ensure Police forensics capability are involved

iv. Organize other responders needed to ensure effective mass casualty management

B. Designate triage areas, ambulance-loading point etc. in conjunction with the Incident Commander.

C. Decide appropriate hospital for victims and direct the FRSC as in 1(ii)

4. Functions of the Deputy Medical Incident Commander:

i. Assists the Medical Incident Commander in carrying out his roles

ii. Acts as the Medical Incidence Commander in his absence

iii. **Appoints an officer from NEMA who will**

- co-ordinate medical resources at the Initial Holding Area

- Screen volunteer medical personnel before allowing them to the site of incidence

5. Triage: The victims will be assessed quickly based on the criteria and colour code for action:

- *Red (Immediate)* or Priority 1 evacuation as they need advanced medical care at once or within 1 hour. These people are in critical condition and would die without immediate assistance.

- *Yellow (Delayed*) or Priority 2 can have their medical evacuation delayed until all *immediate* persons have been transported. These people are in stable condition but require medical assistance.

- *Green (Minor)* or Priority 3. These are the walking wounded. They are not evacuated until all *immediate* and *delayed* persons have been evacuated. These will not need advanced medical care for at least several hours. These people are able to walk, and may only require bandages and antiseptic.

- *Black (Dead)*

6. Handing over of victims at the Hospital:

i. There must be a proper handing over of victims to staff of emergency unit of the health facility, who will sign that he/she received the victim and indicate the condition of the victim received.

ii. Original Copies of the handing over document will be submitted to the Director, Hospital Services, FMOH, who will use them for authentication during payment and other purposes.

B) Post Crisis: Procedure

i. Debriefing involving actual key actors in the crisis management is to be done within 24 hours of the crisis.

ii. The HMH is solely responsible for announcing the number of casualties (living and dead) to government and the public. The MIC, must therefore collate and agree on accurate data from his team members, and give it to the HMH, who has the sole authority to brief the press on the casualty figures. It is an offence for any other MDAs, apart from the HMH or his agent, to announce casualty figures.

iii. A Post crisis report should include documentation of all victims alive and dead, with details of the receiving health facilities. This should be sent through the Director, Hospital Services, FMOH to the HMH for further actions.

iv. All bills from the receiving hospitals to be sent through the Director, Hospital Services, FMOH to the HMH for authentication and payment.

C. Communications during crisis:

1. NEMA is to provide hand held radio communication equipment for medical responders during crisis: Minimum of 25 sets is required for mass casualty evacuation process. One each for:

> MIC
> DMIC
> Officers appointed by MIC
> IHA Medical Commander
> All Ambulances in use (minimum of 20).

2. NPF to provide Additional radio Communication to the MIC

3. Communication between the Medical Responders and Hospitals should be by personal GSM

4. NEMA to properly organize their volunteer arm by registering them and organizing regular trainings for them. All interested volunteers should register with NEMA

Ambulances Supply During CT/CR.

i. A minimum of 20 ambulances is to be provided by all responder MDAs during CT/CR.

ii. Each Ambulance to report with 4 crew- members as 4 paramedics. One (1) paramedics each to join the triage team, while 3 paramedics manages an Ambulance.

iii. The following MDAs to provide the number of ambulances as indicated during mass casualty evacuation:

FMOH 2

FCT EMS 2

NEMA 3

FCT SEMA 2

FFS Medical 2

NPF Medical 2

NSCDC Medical 2

FRSC 3

NRCS 2

Armed Forces Ambulances shall be on Standby only.

STATE LEVEL

Each State is to leverage on the national standard, and organize the agencies located in their states and performing similar duties as indicated for the national.

6.0 Funding

Effective and Efficient EMS requires adequate timely funding. The Ambulance service providers must be funded, because the emergency patient needs to be moved immediately without paying.

6.1. 5 Percept of the Basic Health Care Provision Fund shall be used for Emergency Medical treatment as administered by the Committee appointed by the National Council on Health.

6.2. National Health Insurance Scheme **(NHIS)** is to **e**nsure appropriate insurance cover for all staff deployed on emergency duty.

6.3. NHIS shall put in place benefit packages for emergency services.

6.4. Each Ambulance operator should be registered and accredited by NHIS as either primary or secondary provider or both.

6.5. Each receiving health facility shall be NHIS accredited.

6.6. Each health facility shall keep a logbook for all patients brought in by an Ambulance service provider, indicating the ambulance services type, the distance covered and time spent.

6.7. When the patient's bill is to be settled by relations, it shall carry a first charge as Ambulance service provider's bill, and shall be remitted accordingly to the provider by the receiving hospital.

6.8. Those patients that are NHIS enrolees shall benefit from the NHIS benefit package but the Ambulance service provider must have been accredited by the scheme, and capitation or fee for service shall be so processed for the health facility.

7.0 Monitoring and Evaluation

The National Ambulance Service System shall monitor all Ambulance Service providers including Private health facilities.

7.1   Monitoring Indicators shall be scored on the basis of the following:

i. Record keeping,

ii. Response time

ii. Number of trips,

iv. Lives saved outcomes of the patient,

v. Customer satisfaction,

vi. Assessment of equipment,

 vii. Vehicle and staff,

viii. Timed drills,

ix. Regular training/ exams/ continuing education

7.2   Evaluation Indicators shall be based on:

i. Activity output and outcome,

ii. Certification and re certification,

iii. Audits of process,

iv. Staff and equipment and Training standards,

v. Response times,

vi. Statistics on prevalence of various emergency cases attended to.

8.0   SANCTIONS AND APPEAL

8.1 i. Sanctions and Appeal matter shall be handled by the Minister of Health or his agent at the Federal level.

ii. Sanctions and Appeal matters shall be handled by the Commissioner of Health or his agent at the State level

iii. Sanctions and Appeal matters shall be handled by the District Medical officer or his agent at the Local Government level.

8.2 Sanctions and Appeals shall occur in cases of:

i. Malpractice,

ii. Negligence

iii. Non-compliance with regulations

iv. Abuse of patient's confidentiality

v. Theft and Fraud

vi. Serious Misconducts by the Operator.

8.3 It may be in form of:

i. Suspension of licence

ii. Withdrawal of license of operations

iii. Banned from operation

iv. Fined

v. Combination of the above

8.4 Where a sanction has been applied, the organization concerned shall have opportunity to appeal to the Hon, Minister of Health or Hon. Commissioner for Health of a State

9.0 Policy review

This policy shall be review at intervals of five (5) years