|  |
| --- |
| **Supplemental Table 1. Arrangements in place for health register implementation.** |
|  | **England**  | **France** | **Italy** | **Netherlands** | **USA** |
| **Protocol** | In place; being reviewed. Implementation Group will be tasked by the Incident Director to operationalise. | Systematic registering of exposed persons at key points of the management during response. | Health-related quality of life survey. | Several protocols for biomonitoring, health impact assessments, and systematic registering of exposed persons. | RRR has been developed using experience gained after several large incidents. |
| **Minimum dataset** | Under review; contains incident date and location, exposed person’s name, date of birth, address, next of kin, registered medical practice, location at time of incident and potential exposure, and medical care sought.  | Name, address, contacts, space-time budget, protective actions.  | Respondents' perceptions, opinions, knowledge, attitudes about health behaviours, and whether their doctors provide them with appropriate medical advice. | Name, address, gender, age and zip-code. Collection of individual, self-reported exposure within 3-4 weeks. Surveys on health effects after 3-4 months. In practice the minimum appears to be ± 200 persons. A reference group of GP patients is continuously available in order to collect controlled baseline health data. | RRR Survey Form collects contact details, demographics, self-reported exposure, illness, disability and comorbidities.In mass casualty events, four critical fields are sufficient and requires only 90 seconds per registrant (name, sex, home address, and telephone numbers). |
| **Team structure (including leadership / chain of command)** | Incident Director maintains overall command and control. Implementation Group (chaired by Director of the Field Epidemiology Service) will be convened to initiate the rapid collection of a minimum data set from those people affected by or exposed to the incident, guided by the epidemiology protocol. | Governmental representative centralising data coming from team chief (shelter centre, chief of confined or evacuated community, hospital, firefighter or emergency health unit chief, telephone responder of a dedicated number at the Health Regional Agency and the InVS website). | LA officials.  | de facto ‘rules of engagement’ are established. Competent authorities (LA or Minister of Health) can ask an Expert Committee, a network organization under the auspices of the Centre for Environmental Safety and Security at RIVM to advice within 72 hours on the need and necessity of registry for organised health follow-up of victims or relief workers.  | Dependent on incident; e.g., World Trade Center Health Registry involved a collaborative effort between ATSDR and the New York City Department of Health and Mental Hygiene, which has staff dedicated exclusively to the registry. The Oklahoma City Federal Building Bombing registry was carried out by highly qualified staff from the State Department of Health, Injury Prevention Service. |
| **Types of team members (specialties, government employees, academics, volunteers, etc…)** | Implementation Group members may include public health specialists, scientists, emergency planners, communications support, administrative support and others as appropriate. | Dedicated person at LA and regional health office. For the French nationals in the Fukushima response, it was the post-disaster epidemiological preparedness team and the information technology service from the InVS. | Epidemiologists, public health officials, nurses and staff at LA and regional level. | LA epidemiologists, Expert Committee (scientists, public health- and communication specialists). Two specialised response centres were established: a) the National Knowledge Centre for Post-Disaster Psychosocial Care (Impact), and b) the National Centre for Health Impact Assessment of Disasters. The Netherlands Institute for Health Services Research (NIVEL) plays a key role in general health follow-up, establishing links to primary care registration. The National Poison Control Centre is an essential partner in advising on acute toxicological risks of accidental exposure to chemicals and radiation.  | Epidemiologists, database specialists, communications and administrative staff. Others as appropriate. |
| **Size of teams**  | Dependant on need; varies by size and type of incident and the number of people affected.  | Dependant of the size of the targeted population as well as the registering tool. | 21 | Dependant on nature and size of the incident. Usually 2-8 members. | Depends on number of affected persons, type and place of event. |
| **Source(s) of funding** | No specific funding. | National, regional, or local funds.. | Dependent on register. |

*Abbreviations: LA – Local Authority; RIVM – Dutch National Institute for Public Health and the Environment (Rijksinstituut voor Volksgezondheid en Milieu); RRR - Rapid Response Registry; ATSDR – Agency for Toxic Substances and Disease Registry; InVS - Institut de Veille Sanitaire (French Institute for Public Health Surveillance).*