National Institute for Emergency Medicine (NIEM), Thailand

Association of Southeast Asian Nations (ASEAN)

Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management

Progress Report (2)

April 2018

Japan International Cooperation Agency (JICA)

Koei Research & Consulting Inc.

Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management

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Glossary

AADMER	ASEAN on Disaster Management and Emergency Response
ACAPS	Assessment Capacities Project
ACDM	ASEAN Committee on Disaster Management
AHA Centre	ASEAN Coordinating Centre for Humanitarian Assistance on Disaster Management
AMS	ASEAN Member States
APCDM	Asia Pacific Conference on Disaster Medicine
ARDEX	ASEAN Disaster Emergency Response Simulation Exercise
ARF Direx	ASEAN Regional Forum Disaster Relief Exercise
ASEAN	Association of Southeast Asian Nations
Blue Book	Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters
C/P	Counterparts
CPR	Committee of Permanent Representatives
CPRC	Crisis Preparedness and Response Centre (Malaysia)
DF/R	Draft final report
DMAT	Disaster Medical Assistance Team
DSS	Disaster Summary Sheet
EAS	East Asia Summit
EMT	Emergency Medical Team
EMTCC	Emergency Medical Team Coordination Cell
ERAT	Emergency Response and Assessment Team (ASEAN)
F/R	Final Report
FACT	Field Assessment Coordination Teams
HADR	Humanitarian Assistance and Disaster Relief
HCT	Humanitarian Country Team
HEMB	Health Emergency Management Bureau (Philippines)
IASC	Inter-Agency Standing Committee
IC/R	Inception Report
ICT	Information and Communication Technology
IER	INSARAG External Reclassification
IFRC	International Federation of Red Cross and Red Crescent Societies
INSARAG	International Search and Rescue Advisory Group
JADM	Japanese Association for Disaster Medicine
JCC	Joint Coordinating Committee
JDR	Japan Disaster Relief
JICA	Japan International Cooperation Agency
LEMA	Local Emergency Management Authority
MIRA	The Multi-Cluster/Sector Initial Rapid Assessment
MOPH	Ministry of Public Health
NDMO	National Disaster Management Offices
NFP	National Focal Point
NIEM	National Institute for Emergency Medicine (Thailand)
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
P/R	Progress Report
PDCA	Plan-Do-Check-Action
PDM	Project Design Matrix
PO	Plan of Operation
PPKK	Center for Health Crisis Management (Indonesia)
PWG	Project Working Group
RCM	Regional Coordination Meeting
RDRT	Regional Disaster Response Teams
SARS	Severe Acute Respiratory Syndrome
SASOP	Regional Standby Arrangements and Coordination of Joint Disaster Relief and Emergency Response Operations
SFDRR	Sendai Framework for Disaster Risk Reduction

SOP	Standard Operating Procedure
SOMHD	Senior Officials Meeting on Health Development
SimEX	Simulation Exercise
The Project	Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management (ARCH)
The Project Team	A team consisting of Thai counterparts and Japanese experts
The previous survey	The Survey on the Current Situation of Disaster/Emergency Medicine System in the ASEAN Region
TICA	Thailand International Cooperation Agency
TOR	Terms of Reference
UN	United Nations
UNICEF	United Nations Children's Fund
UNDAC	United Nations Disaster Assessment and Coordination
UNISDER	United Nations Office for Disaster Risk Reduction
USAR	Urban Search and Rescue
WADEM	World Congress on Disaster and Emergency Medicine
WHO	World Health Organization

Executive Summary

ASEAN Leaders' Declaration on Disaster Health Management

The ASEAN leaders made a Declaration on Disaster Health Management at the 31st ASEAN summit. The majority of statements in this declaration are aligned with our project activities and aims. This endorsement is clearly an important milestone for the project and the AMS as it will expedite the formulation of the vision and mechanism for regional collaboration. Though this is not the part of the Project Purpose indicators, this declaration officially recognizes the relevance of the project activities to achieving the project purpose.

Regional Collaboration Drill

From March 26 to March 28, the 2nd Regional Collaboration Drill was conducted in Da Nang, Vietnam. The Ministry of Health and Department of Health (Da Nang City) displayed strong initiative in planning, preparing, and organizing the drill. Since hosting an event of this scale involves painstaking coordination and preparation, it clearly contributed to raising the confidence level of the Vietnamese counterparts with regard to their capacity building. After witnessing the positive impact of this drill, JAC suggests rotating the drill in the future among the ASEAN Member States. The 3rd Regional Collaboration Drill will be hosted by the Philippines in December 2018. Through this drill, the Philippines' Department of Health will validate the national emergency plan for the Metro Manila Earthquake (The Big One), and also test iSPEED for electronic data reporting and analysis during emergency.

Collaboration with the WHO

To benefit from technical inputs, the Project will pursue a closer collaboration with the WHO. For the 4th AMS training in February 2019, the EMTCC training will feature relevant personnel from the WHO. This should give an added value to the ARCH Project activities and enable all AMS to update themselves to the WHO standards on the disaster health management operations.

Chapter 1 Outline of the Project

1.1 Background

The ASEAN has continued to attach the great importance to the cooperation related to prevention of and response to disasters. The ASEAN formulated the ASEAN on Disaster Management and Emergency Response (AADMER) in 2005 and the ASEAN Declaration on Enhancing Cooperation in Disaster Management in 2013. In addition, the ASEAN defined disaster health management as one of the priority issues in the health sector in the ASEAN Post-2015 Health Agenda. And collaboration for disaster health management in the ASEAN region has just started and the capacity of disaster health management varies widely among the ASEAN Member States (AMS) since each country has different needs and priorities in the health sector.

AMS attempt to strengthen their system or capacity for disaster health management when they are faced with turning points such as the outbreak of severe acute respiratory syndrome (SARS) in 2003, Sumatra Earthquake (2004), and Cyclone Nargis in Myanmar (2008). In Thailand, the Thai Disaster Medical Assistance Team (DMAT) was established in 2008, which is based on the Japanese DMAT model in order to apply the lessons from responding to the Indian Ocean Earthquake and Tsunami (2004). The Government of Thailand aims to strengthen its capacity of domestic disaster health system and also to assume a lead role in the disaster health cooperation in the ASEAN region.

The Government of Japan has committed to enhance cooperation in disaster management with the ASEAN as stated in the Vision Statement of the ASEAN-Japan Commemorative Summit. Japan has a plenty of experiences and knowledge in all aspects of disaster management such as DMAT for domestic incidents as well as the Japan Disaster Relief (JDR) Team for international response.

Against this background, the Government of Thailand requested the Government of Japan for a technical cooperation project in establishing a collaboration mechanism of disaster health management in the ASEAN region. Based on the request, the Japan International Cooperation Agency (JICA) conducted “the Survey on the Current Situation of Disaster/Emergency Medicine System in the ASEAN Region (the previous survey) from 2014 to 2015. Through the survey and regional meetings, all AMS and the ASEAN Secretariat reached a common understanding on the importance of regional collaboration mechanism in disaster health management and necessary actions. Based on the common understanding and a series of discussions with stakeholders, the Project of Strengthening the ASEAN Regional Capacity on Disaster Health Management (the Project) was formulated. The Project was officially endorsed by Senior Officials Meeting on Health Development (SOMHD) of ASEAN in September 2015 and the Committee of Permanent Representatives (CPR) in January 2016.

1.2 Overview of the Project

Table 1-1 shows the outline of the Project according to PDM Version 1 presented in Attachment 1. Although the Project is conducted based on the agreement between JICA and the National Institute for Emergency Medicine (NIEM) in Thailand, the activities related to Output 1, 2, 3 and 5 (except Activity 5-5) are conducted with participants from AMS and other related organizations for the purpose of strengthening regional collaboration.

This Project has been regarded as the first step for ten-year vision of the ASEAN and Japan collaboration mechanism on disaster health management. To achieve the future vision, the Project aims to strengthen the regional coordination on disaster health management in the ASEAN region and to develop common tools and mechanism for efficient collaboration. Through the Project activities, the Project tries to build up a consensus among AMS and to identify needs for the next steps.

Table 1: Outline of the Project

Overall Goal
ASEAN and Japan collaboration mechanism on disaster health management is developed.
Project Purpose
Regional coordination on disaster health management is strengthened in ASEAN.
Outputs and Activities
Output 1 Coordination platform on disaster health management is set up.
1-1 Regional coordination meetings are organized every year to share the progress and discuss the direction of the Project.
Output 2 Framework of regional collaboration practices is developed.
2-1 Develop and prepare the program of the regional collaboration drill with project working group
2-2 Conduct the regional collaboration drill every year in AMS
2-3 Compile recommendations on regional collaboration on disaster health management based on the discussion and knowledge sharing through project activities
2-4 On site practice is conducted when disaster occurs in ASEAN (if possible).
Output 3 Tools for effective regional collaboration on disaster health management are developed.
3-1 Formulate project working groups for regional collaboration tools at the beginning of the project
3-2 Develop a draft regional SOP and minimum requirements for disaster health management with the project working group
3-3 Prepare databases of emergency medical teams of AMS
3-4 Draft framework of health needs assessment in emergencies with the project working group
Output 4 Academic network on disaster health management in AMS is enhanced.
4-1 Present outcomes of the Project activities at academic conferences such as JADM, APCDM and WADEM
Output 5 Capacity development activities for each AMS are implemented.
5-1 Prepare training plan, curriculum and materials on disaster health management and emergency medical system based on needs survey with the project working group
5-2 Conduct trainings on disaster health management and emergency medical service for AMS
5-3 Conduct monitoring survey and evaluation on capacity development on disaster health management in each AMS
5-4 Conduct a study tour in Japan for AMS
5-5 Conduct training program in Japan for the Thai counterpart personnel

In August 2017, the Record of Discussion signed on 19 February, 2016 was amended. Major amendment includes adding of MOPH as the counterpart institution as shown in Attachment 2. With regards to the PDM, a minor change was made to add one verifiable indicator in Output 5, [5-4: Number of participants to attend to the counterpart training courses (Target :20 pax)] as shown in Attachment 2.

1.3 Overall Flow

The Project was commenced in July 2016. Plan of operation (Version 1) enclosed in Attachment 1. Attachment 3 presents the work flow of activities for each outcome of the Project. The work schedule and the latest dispatch schedule of the Japanese Experts are shown in Attachment 4 and Attachment 5, respectively. The following sections describe progress, challenges and efforts of each activity between March 2017 to March 2018 along with the work flow.

1.3.1 Preparatory Works (July 2016-February 2017)

(1) **Preliminary Meetings with JICA**

In July 2016, the Project Team had meetings with JICA and the Japanese Advisory Committee on implementation policy and the latest situation of operating environment of the Project, as well as relevant issues to build consensus on the methodology and confirmation of the communication strategy.

(2) **Inception Report (IC/R)**

Based on the consensus achieved in the above meetings, the work plan and methodology were compiled in an inception report (IC/R) which was submitted to JICA, NIEM, ASEC, and AMS.

(3) **Discussion on IC/R and Work Plan with Thai Stakeholders**

The background, outlines, and work plan of the Project was presented to Thai stakeholders along with IC/R to have discussions on the work plan, especially, on the members of each project working group, the schedule, outline and preparation of the first Joint Coordinating Committee (JCC) meeting, the first Regional Coordination Committee (RCC) meeting, and the Start-up Drill were discussed in detail.

Table 2: Official meetings summary (March 2017-March 2018)

Meetings	Date	Venue	No. of participants
3rd PWG 1	July 20, 2017	Phuket, Thailand	38
2nd PWG 2	July 20, 2017	Phuket, Thailand	33
2nd RCC	July 21, 2017	Phuket, Thailand	41
2nd JCC	August 28, 2017	Bangkok, Thailand	27
4th PWG 1	November 28-29, 2017	Bangkok, Thailand	45
3rd PWG 2	November 9, 2017	Bangkok, Thailand	40
5th PWG 1	March 29, 2018	Da Nang, Vietnam	38
4th PWG 2	March 29, 2018	Da Nang, Vietnam	33
3rd RCC	March 30, 2018	Da Nang, Vietnam	40

1.3.2 Output 1: Coordination platform on disaster health management is set up.

(1) **Activity 1-1 Regional coordination committee meetings are organized every year to share the progress and discuss the direction of the Project.**

The first RCC meeting was held in Bangkok on 29 and 30 September 2016. In the first RCC meeting, objectives, expected outputs and activities were presented and the terms of reference (TOR) of RCC and Project Working Groups (PWG) 1 and 2 were agreed. Then, the TORs were endorsed in ASEAN Health Cluster 2 Meeting on 29 and 30 November 2016 in Putrajaya, Malaysia.

The Second RCC was held on July 21, 2017, summarized and demonstrated the progress of the ARCH project activities during nine months after the first RCC meeting in September 2016. The activities were namely the start-up and the regional collaboration drills, AMS training, PWG1 and 2 meetings, development of regional collaboration tools. Also, the RCC meeting approved the proposal of the Philippines to host the third RCD in October 2018, while the approval of Viet Nam to host the second RCD will be requested through online basis.

1.3.3 Output 2: Framework of regional collaboration practices is developed.

(1) **Activity 2-1 Develop and prepare the program of the regional collaboration drill (RCD) with project working group**

Objectives of Regional Collaboration Drills are 1) To examine the current regional collaboration mechanism on disaster health management; 2) To develop necessary tools to enhance the collaboration; 3) To draw and establish common understanding on relevant issues; and 4) To Promote a relationship based on mutual trust. Therefore, 1st RCD and 2nd RCD were planned based on the objectives with a full understanding of the lesson learnt from Start-up Drill.

a. 1st Regional Collaboration Drill

1st RCD was planned from 17 to 19 July 2017 in Phuket, Thailand. The main objective was to enhance knowledge, skills and capacities of the International Emergency Medical Team (I-EMTs) using common reporting forms in I-EMTs' reporting activities. Moreover, special concept was "Being Realistic" that means "Realistic Scenario, Realistic Communication and Real Reporting Forms."

Drill planning was mainly conducted by Thai project team. In addition, Japan Advisory Committee and Japanese expert team were expected technical support of drill planning and an advisory note based on observation of the drill and PHEOC management.

The project team provided 16 common report forms: seven forms form SASOP, four forms in EMT Coordination Handbook _June 2017 FINAL, three forms in WHO MINIMUM DATA SET, and two forms drafted by the project team (Table 3).

Table 3: 16 common report forms for 1st RCD

Resource material	Form
SASOP	FORM 1: Initial Report/Situation Update to AHA Centre
SASOP	FORM 2: Initial Report/Situation Update of AHA Centre to the National Focal Points
SASOP	FORM 3: Request for Assistance
SASOP	FORM 4: Offer of Assistance
SASOP	FORM 5: Contractual Arrangements for Assistance
SASOP	FORM 6: Report of Status of Provision of Assistance
SASOP	FORM 7: Final Report from Assisting Entity to AHA Centre
WHO MINIMUM DATA SET	EMTCC-MDS Feedback Form
WHO MINIMUM DATA SET	EMT-MDS Tally Sheet
WHO MINIMUM DATA SET	EMT-MDS Daily Reporting Form
EMT Coordination Handbook	Emergency Medical Team Registration Form
EMT Coordination Handbook	EMTCC Situation Report
EMT Coordination Handbook	Emergency Medical Team Exit Report
EMT Coordination Handbook	Patient Referral Form
Thai side new product	Medical Record with MDS Tick box (draft)
Japan side new product	Health Needs Assessment Sheet (draft)

In order to offer adequate opportunities of a full understanding of the forms to participants, the drill was designed, that aligned with the regional and global collaboration mechanism for emergency response as follows: 1) request for assistance/ offer of assistance, 2) mobilization/ on-site deployment of assets and

capacities, 3) providing medical care/ patient referrals/ health needs assessment, 4) demobilization of assistance.

On day1, a Table-Top Exercise was conducted in the hotel. Each AMS was deployed into one of three rooms such as three provinces, and then they experienced filling the forms based on the simulated patient cards. During the Field Training Exercise on Day2, same scenario as day1 was basically planned to use in order that all participants could get experience step by step; and take more time for 3) providing medical care/ patient referrals/ health needs assessment as mentioned above.

The purpose of Day3 "After Action Review" was to consolidate feedbacks on the forms, which should include 1) modifying framework of form, 2) adding items/topics, and 3) situation that who/when use each form.

In the same session, the project team expected that participants would comment on "Pyramid model of ARCH project" that was drafted based on the lessons learnt from Start-up Drill. Propose of proposing the model was to share the "common" picture for navigating ARCH project in accordance with existing regional mechanisms. Because Disaster Health Management and "One ASEAN One Response" are quite new concepts. On the other hand, AMS have different opinions on the disaster health management. Then it could be basic evidences on developing tools, and planning for Regional Collaboration Drills and AMS trainings.

b. 2nd Regional Collaboration Drill

2nd RCD was planned from 26 to 28 March 2018 in Da Nang, Vietnam. The objectives were 1) to use common forms: medical record, WHO forms, SASOP; 2) to validate "ASEAN SOP"; 3) to know each other more in a situation to work together; 4) to conduct "EOC" by Vietnam actual representatives; and 5) to identify the issues to be discussed on regional collaboration mechanism. The expectations were a) to consolidate findings on the Reporting Forms; b) to concrete feedbacks on Regional Collaboration Tools; c) to configure the ideas on capacity building; and d) to create the further ideas for the Next RCD.

Drill planning was mainly conducted by Vietnam team, therefore Thai and Japanese expert team were expected technical support of drill planning. Also, Thai NIEM team and Japan Advisory Committee would evaluate the drill management. Five regular meetings were planned to share progress on preparation of scenarios, materials/equipment, roles of management staffs in Attachment 7.

According to the lessons learnt from 1st RCD, firstly, the expert team revised some forms and consolidated number of "Common Reporting Forms" as below:

Table 4: Common Reporting Forms

Common Reporting Forms
SASOP Form 1: Initial Report/Situation Update to AHA Centre
SASOP Form 3: Request for Assistance
SASOP Form 4: Offer of Assistance
Emergency Medical Team Registration Form
EMTCC Situation Report
EMT Coordination Meeting Minutes
Medical Record with MDS Tick box
EMT-MDS Tally Sheet
EMT-MDS Daily Reporting Form
Patient Referral Form
Health Needs Assessment (HNA) Form/ Summary Report
Emergency Medical Team Exit Report
SASOP Form 7: Final Report from Assisting Entity to AHA Centre

Secondly, providing methods on Table-Top Exercise (TTx) and Field Training Exercise (FTx) were changed to enhance each EMTs' experiences maximally. In the TTx, learning session should be intended for all participants to fill the all forms based on the given information by themselves. After completing every form, each EMT ought to explain one form to the others in random order. These processes were arranged using active learning method. And then, same scenarios on medical care and health needs assessment were repeated in the morning and afternoon session of the FTx. In addition, team building time could be planned before each session. As a result, each AMS could plan/operate/reflect their performance such like Deming cycle throughout the drill.

Meanwhile, PHECO training for actual Vietnamese representatives was planned by certificated Thai and JAC EMTCC members; to enhance the capacities for conducting domestic PHEOC at actual disaster responses.

c. 3rd RCD

3rd RCD will be conducted in Manilla, Philippines. Philippines' representatives have already proceeded the drill preparedness before 1st RCD, therefore, the drill management body have been organized cooperating with relevant authorities. Therefore, Thai and Japan expert team with JAC should be supportive on drill planning and preparedness. Alternatively, the team could contribute pre-education for participants, that is providing leaning materials, "How to use the regional collaboration tools."

A Scenario based on national response plan to Metro Manila Earthquake includes primary objective; to test the regional collaboration tools such as SOPs, Medical record and health needs assessment from. Secondary

objectives are 1) to test electronic reporting system for ISPEED and 2) to refine EMT team operations at all levels in terms of the following: a. command and control b. coordination and collaboration c. communication.

(2) **Activity 2-2 Conduct the regional collaboration drill every year in AMS**

a. 1st RCD

The 1st RCD was conducted from 17 to 19 July 2017. Eleven emergency medical teams participated in table-top exercise, field exercise, and review workshop. A drill design was almost well planned. The proceedings of the 1st RCD is presented in Attachment X. The conclusions and recommendations is presented in Attachment 8. And also advisory note on drill and PHEOC management from Japan Advisory Committee was submitted as in Attachment 9.

Table 5: Summary of 1st Regional Collaboration Drill

Title	1st Regional Collaboration Drill
Objectives	To enhance knowledge, skills and capacities of the International Emergency Medical Team (I-EMTs) using common reporting forms in I-EMTs' reporting activities
Dates	17 to 19 July 2017
Participants	10AMS, Japan, ASEC, AHA Centre, Thai MOH, NIEM Thai, JICA and Japan expert team
Venue	Duangjitt Resort & Spa (Days 1, 3), Phuket Mining Museum (Day 2) in Phuket, Thailand
Activities/ Topics	DAY 1: Table Top Exercise DAY 2: Field Training Exercise DAY 3: After Action Review
Expected Output	- Feedbacks on the proposed reporting forms from all participants for further development of these forms - Advisory note on drill and PHEOC management from Japan Advisory Committee

Lessons learned	- Project team cooperation
	  - Discrepancy in information sharing on preparation of progress and materials, roles of management staffs
	  - Using common language within radio communication among exercise controllers
	  - Uncertainty of contact person responsibilities on drafting medical record and health needs assessment form
	  - Misunderstanding of roles among staffs during the drill
	- TTx
	  - Provision for opportunities to understand how to use the forms; to conduct realistic CIQ processes
	  - Insufficient providing procedure in the health needs assessment session
	- FTx
	  - Discrepancy of special concept "Being Realistic" that simulated patients were well prepared in comparison with background information on affected area situations such as hospital locations and domestic referral sysytem
	  - Lack of precise guidance on rule of engagement to the exercise among participants, facilitator and exercise controllers, that could formulate common understanding and expectation to the scenario and exercise control
	  - Consideration for the exercise environment such as weather, temperature and humidity, as for the safety and security of participants

b. 2nd Regional Collaboration Drill

The 2nd RCD was conducted from 26 to 28 March 2018. Twelve emergency medical teams participated in table-top exercise, field exercise, and review workshop. The proceedings of the 2nd RCD is presented in Attachment 6.

Table 6: Summary of 2nd Regional Collaboration Drill

Title	2nd Regional Collaboration Drill
Objectives	To use common forms: medical record, WHO forms, SASOP To validate "ASEAN SOP" To know each other more in a situation to work together To conduct “EOC” by Vietnam actual representatives To identify the issues to be discussed on regional collaboration mechanism
Dates	26-28 March 2018
Participants	10AMS, Japan, ASEC, AHA Centre, Vietnam MHO, Da Nang PHO, NIEM Thai, JICA and Japan expert team
Venue	Grand Tourane Hotel (Day1, 3), Hoa Xuan Stadium (Day2)
Activities/ Topics	DAY 1: Table Top Exercise DAY 2: Field Training Exercise DAY 3: After Action Review
Expected Output	- To consolidate your findings on the Reporting Forms - To concrete feedbacks on Regional Collaboration Tools - To configure the ideas on capacity building - To create the further ideas for the Next RCD.
Lessons learned	- Preparation - TTx - Less time to complete all the forms, and should provide teaching template/concept for all the teams - Implementation of process of RCD/PHEOC using provision of flow chart on CIQ, RDC and EMTCC procedures - FTx - Less understanding of filling medical record, patient referral form and HNA form/summary - Improving communication problem by pre-education - Clear clarification of facilitators and interpreters’ role - Distributing information on host country resources such as hospital beds/ medical equipment - Diversifying in standard/basic knowledge and skills of HNA including role and responsibility of I-EMT

(3) **Activity 2-3 Compile recommendations on regional collaboration on disaster health management based on the discussion and knowledge sharing through project activities**

Ideally, next dill participants should be same as 1st/2nd RCD participants, because most of new comers didn’t understand reasons to use common forms in the regional collaboration; and were unfamiliar with using the

common forms. As a result, they would be burdens for drill planning, that is they need some time to learn why/how to use the forms.

However, pre-education materials for participants could be useful to save the time. No Emergency Medical Team (EMT) complete Emergency Medical Team Registration Form at 1st RCD, but all teams submitted the form perfectly at the 2nd RCD because of pre-announcement that each EMT ought to fill the form before arriving the hotel.

For maximizing the outcomes of the next drill, the project team should request AMS/ Japan to select the former drill participants; provide pre-learning materials on the regional collaboration tools; and offer the opportunities to learn the forms for new comers just before the drill.

1.3.4 Output 3: Tools for effective regional collaboration on disaster health management are developed.

(1) Activity 3-1 Formulate project working groups for regional collaboration tools at the beginning of the project

The PWG 1 and 2 were formulated based on the TOR. In the first meetings, both PWG 1 and 2 shared understanding on the TOR and agreed the overall work plan. PWG 1 agreed on the conceptual framework, purpose, goal, targets and work plan of the draft tools to be developed during the Project. The proceedings of the first PWG 1 meeting is presented in Attachment 5.

(2) Activity 3-2 Develop a draft regional SOP and minimum requirements for disaster health management with the project working group

SOP ver.1 and Minimum Requirements were developed and approved in the 4th PWG1 meeting to be tested in the 2nd RCD. The 5th PWG1 meeting invited AMS members to acknowledge the changes as well as providing comments and feedbacks to the Standard Operating Procedures. More detailed discussions about the revisions are shown in the proceedings of the meeting (Attachment 6). For SOP ver.1 and Minimum Requirements, please refer to Attachment 12.

(3) Activity 3-3 Prepare database of emergency medical teams of AMS

The form was developed, finalized and approved at the 4th PWG1 meeting. Now at the stage of collecting information for the database. For the format, please refer for to Attachment 13.

(4) Activity 3-4 Draft framework of health needs assessment in emergencies with the project working

group

a. The 1st / 2nd PWG1 Meeting (20 January / 4 May 2017)

The draft Health Needs Assessment Framework including the purpose, roles, and methodologies was discussed in the 1st PWG1 (20 January 2017) and the 2nd PWG1 (4 May 2017) meeting. It was clarified that the primary role of EMTs was to provide the medical services to save people's lives; therefore, the assessment by EMTs should be supplemental and should not be their primary task; the main users of the information from the Health Needs Assessment (HNA) would be local authorities or other relevant parties for further action and support. The first draft HNA Form and Guidance Notes for "Key Informant Interview" and "Observation" were discussed in the 2nd PWG1 Meeting.

b. The 1st RCD / The 3rd PWG1 Meeting (17-19 July / 20 July 2017)

Based on the agreed draft HNA Framework, a revised draft HNA Form (version 1) was tested by the AMS teams in the 1st RCD in 17-18 July 2017. The feedback on the draft HNA Form was discussed in the subsequent 3rd PWG1 meeting, especially on the role of ASEAN-EMTs in HNA and the contents of the form. It was reiterated that the ASEAN-EMT role was primarily the delivery of medical services; hence, the conduct of health needs assessment was supportive and if there was capacity to address pressing needs assessment gaps. In this context, it was suggested that ASEAN EMT intending to include HNA in their services may also consider:

- Public Health Officers in their roster for the conduct of HNA during deployment.
- Training programs to enhance competencies of HNA.

In addition, the suggested options for HNA reporting, e.g., a filled HNA Form or an EMT-MDS Daily Reporting Form were discussed in the meeting. It was agreed that a reporting form would be decided in the next 4th PWG1 meeting.

The revised draft HNA form and a draft Guidance Note were circulated among AMS through ASEC on 18 August and the comment from AMS was incorporated into the revised HNA (version1-2) for discussion in the 4th PWG1 meeting in November 2017.

c. The 4th PWG1 Meeting (28-29 November 2017)

In the 4th PWG1 meeting, it was pointed out that the HNA tool and guidelines would be used if the EMT was requested to support the conduct of assessment and that local health authorities had no existing forms. It was also agreed that the draft HNA Form (version 1-2) would be further revised incorporating the suggestions from the meeting, and also the draft Guidance Note (Version 0) would include instructions how

to fill the HNA Form and definitions of terms. The options for reporting of HNA were suggested by the Project Team, and the meeting agreed that a simple reporting form designed for easy use by EMTs would be tested in the 2nd RCD. The revised versions of HNA Form and Guidance Note were circulated among AMS through ASEC in 14 January 2018.

d. The 2nd RCD / The 5th PWG1 Meeting (26-28 March / 29 March 2018)

A revised HNA Form (version 2), a draft Summary Reporting Form (version 0) and Guidance Note (version 1) were tested in the 2nd RCD. In the subsequent 5th PWG1 Meeting, the Project Team emphasized that the HNA Form could be used as "A Guide" for EMTs when conducting HNA upon request from a local authority, and necessary action or further assessment would be taken by other relevant parties. Some of the AMS pointed out that the current HNA Form was too detailed for EMTs to use; however, the Meeting agreed to maintaining most of the questions in the HNA Form. The agreed revisions include; consolidating the form that is used for the assessment of a village or a shelter as the areas of inquiry are similar; consolidating the question on food items; clarifying the terms, e.g. health facilities, and simplifying the Summary Report. The revised HNA Form (version 2-1), Summary Report (version1) will be circulated among AMS for comments by 20 April. All the revised HNA tools will again be tested in the 3rd RCD in December 2018.

For HNA Form ver.2-1, Summary Report ver.1 and Guidance Note, please refer to Attachment 10.

1.3.5 Output 4: Academic networking on disaster health management in AMS is enhanced.

(1) Activity 4-1 Present outcomes of the Project activities at academic conferences such as JADM, APCDM and WADEM

The Project Team participated in the 23rd annual meeting of Japanese Association for Disaster Medicine (JADM) and held the session of "ASEAN- Japan collaboration for future vision of ASEAN Disaster Medical System."

In this session, the delegates of the Project Team shared the experiences of success and challenges mainly through the regional collaboration drills, which have been conducted for better cooperation/coordination on the disaster health management among ASEAN Member States.

Subsequently, the delegates explained about ASEAN Leaders' Declaration on Disaster Health Management, which has been adopted in the 31st ASEAN Summit in Manila, Philippines in November 2017. The delegates shared with the audience how ASEAN and Japan collaborate in making the vision come to fruition.
Presentations at JADM are presented in Attachment 14.

Table 7: Summary of JADM

Session Title	ASEAN-Japan collaboration for future vision of ASEAN Disaster Medical System
Date	1 February 2018
Participants	- Members of JADM (about 100 participants) - Ten (10) Thai C/Ps observed the session as part of the C/P training course (Pl. see (4) Activity 5-5)
Venue	Pacifico Yokohama
Chairperson	Dr. Tatsuro Kai, Chair of Japanese Advisory Committee ARCH Project
Speakers	JICA ARCH Project 1) Dr.Yasushi Nakajima 2) Dr.Prasit Wuthisuthimethawee 3) Dr.Phumin Silapunt
Session Overview	1) Introduction (Dr.Nakajima) （5 min.) - Overview of this session - Background of ARCH Project - Introduction of Thai speakers 2) Presentation: Wrap up ASEAN Member States (AMS) disaster health management drill (Dr.Prasit) (8min.) AMS disaster health management drill concepts and objectives - Outcomes and what we learned from previous drills - Next coming drill concepts and expected outcomes 3) Presentation: ASEAN Disaster Medical System; How does vision become reality? (Dr.Phumin) (8 min.) - Future vision of ASEAN Disaster Medical system - ASEAN Leaders' Declaration on Disaster Health Management - ASEAN -Japan collaboration; how can we walk together? 4) Q&A (5 min.) 5) Conclusion & Suggestion from Japanese Advisory Committee, ARCH Project (Dr.Kai) (4 min.)
Feedback, Questions from Participants	The audience was very keen to learn how Japan can contribute to strengthening ASEAN disaster medical system. Q&A - Are there any NGOs involved in ARCH Project? (Dr.Ukai) →No NGOs involved (Dr.Nakajima) - If required, we are willing to create a relevant and customized JDR training programme for AMS training of ARCH. (Dr.Tomioka, JDR)

1.3.6 Output 5: Capacity Development Activities for each AMS are implemented.

(1) **Activity 5-1 Prepare training plan, curriculum and materials on disaster health management and emergency medical system based on needs survey with the project working group**

a. Plan of the Second AMS training

In the second PWG 2 meeting held in July 2017, the members discussed and agreed on the second AMS training plan based on the overall training plan, which was agreed in the first PWG 2, and the feedback of the fist AMS training. It was decided that the theme of the second training would be capacity development of emergency medical team (EMT) with a special focus on "on-site team management".

Since there is no standard training module for disaster health management in ASEAN, the members discussed on the knowledge/skills AMS must have for developing EMT.

b. Plan of the Third AMS training

In the third PWG 2 meeting held in November 2017, the members discussed and agreed on the theme and topics of the third AMS training, which were finalized in the fourth PWG 2 meeting in March 2018 by reflecting the lessons learned from the 2nd Regional Collaboration Drill (RCD) in Viet Nam. Training needs identified from the 2nd RCD includes health needs assessment and PHEOC training, which focuses on the role/responsibility of EOC. Detailed plan is shown in the table below.

Table 8: Plan of the 3rd AMS Training

Title	The Third AMS Training
Theme	International Emergency Medical Team (I-EMT)
Objectives	1. To learn the process and efforts for deploying International- EMT from experienced countries. 2. To understand core/common requirements of I-EMTs during deployment. 3. To understand minimum Pre-Deployment and Post- Deployment requirements to ensure the requirements during deployment are met. 4. To uunderstand the role of receiving country/how receiving country coordinates with I-EMTs.
Dates	28 – 31 May 2018
Participants	Four (4)* representatives from each AMS - 1 team leader of EMT - 3 team members *Ideally, • Members will include actual deployment person or person in charge of training • Some of the 3rd AMS Training participants will be same as the participants of the 3rd RCD in Philippines, which will be held in December.
Resource Persons	Mainly selected from the countries, which have experiences of deploying/receiving I-EMT including Indonesia, Malaysia, Myanmar, Philippines, Singapore, Thailand, Japan
Venue	Pullman Hotel, Bangkok, Thailand
Activities/ Topics	DAY 1: 1) WHO standard, 2) Presentation recent experiences of receiving I-EMT & challenges, recent experiences of deploying I-EMT & challenges DAY 2: PHEOC training DAY 3: 1) Personal preparation of EMT, 2) Logistic requirement, 3) Table Top Exercise: pre-deployment, deployment, post-deployment process & procedure, SOP, registration of EMT, exit strategy, 4) filling the forms

	DAY 4: 1) Group Discussion on ASEAN Standard (1. Standard of team, 2. Standard of curriculum), 2) Feedback, course evaluation from participants, 3) Wrap-up and Way forward

(2) **Activity 5-2 Conduct trainings on Disaster health management and emergency medical service for AMS**

The second AMS training was held in November 2017. It focused on team management, while the fist training aimed to strengthen the individual professional competence. Based on the feedback of the first AMS training, consideration was given to the resources available and the topics/activities selected for training program to be effective for team management. Examples include:

- use of modified or simplified version of existing training module (e.g. DMAT) due to lack of standard training module in ASEAN
- paying special attention to practices, which are required for on-site team management in the local setting (e.g. logistics, radio communication)
- specifying the exact role of each participant in EMT in selection criteria (e.g. 1 team leader, 1 team member, 1 actual deployment person)

Overview of the second AMS training is shown in the table below.

Table 9: Overview of the Second AMS Training

Title	The Second AMS Training	
Theme	Capacity Development of Emergency Medical Team (EMT) – On-site Team Management-	
Objectives	The course focused on **national** disaster response. Specific objectives are (1) To understand what EMT is expected to do when deployed to disaster area (2) To get the competency to build an effective domain for right directions of disaster management, especially for team management (3) To share the concept of EMT Response (4) To evaluate this training course as a first step for standardizing ASEAN EMT Training	
Dates	5 – 8 November 2017	
Participants	Three (3) representatives from each AMS NIEM staff, relevant officials and JICA staff	
Resource Persons	Specialists in disaster health management in AMS AHA Centre	
Venue	Grande Centre Point Ploenchit Hotel, Bangkok, Thailand	
Activities/ Topics	1. Country Report on Current Situation of Emergency Response System 2. On-site Team Management (lectures/exercise/simulation)	
	- Definition/mission/objective of EMT - Role of medical team - Preparation of medical team - Activation and response - Supplies and logistic preparation, satellite - Documentary management skill - Security and safety	- Psychological preparation, PFA - CSCATTT Concept - Communication tools - Field triage - Transportation/refer/coordination - Simulation (from activation to withdrawal) - Post incident evaluation
Lessons	1) There is a wide gap among AMS in the level of knowledge about concepts and	

learned	practices, which require different capacity building intervention (special attention is needed for countries with less experiences such as CLMV). In order to establish standard training package in ASEAN, further consideration will be needed to identify what are the core knowledge/skills in disaster health management in the region. 2) Many participants don't fully understand WHO standard, which is the global standard for EMT. The Project needs to ensure that all AMS familiarize themselves with WHO standard, which would enable them to think how ASEAN can bring together to achieve the standard.

(3) **Activity 5-4 Conduct a study tour in Japan for AMS**

The Project Team proposed to conduct a study tour in Japan for AMS in 2018 and it was agreed in the fourth PWG 2 meeting. Proposed plan is shown in the table below.

Table 10: Proposed Plan for the Study Tour in Japan

Title	Study Tour in Japan
Objectives	(1) To understand the system of disaster health management in Japan (2) To identify the challenges and to consider the measures for further strengthening the disaster health management and regional collaboration in ASEAN (3) To establish a network of medical professionals involved in disaster health management in Japan and ASEAN
Dates	17- 20 October 2018
Participants	3 participants/each AMS ASEC and other relevant institutions
Venue	Kobe, and surrounding area
Activities/ Topics	The Programme will consist of 1) Participating Asia-Pacific Conference on Disaster Medicine (APCDM) 2) Understanding lessons learned from the Great Hanshin Awaji Earthquake - Japanese system (e.g. Hospital disaster preparedness and response, EOC at prefectural/municipal (e.g.Kobe) level 3) Participating JDR Training or relevant training

(4) **Activity 5-5 Conduct training program in Japan for the Thai counterpart personnel (CPs)**

The Project conducted the second Thai counterpart training in Japan from 25 January to 03 February 2018.Based on the feedback of the first Thai counterpart training, the programme was designed to be more practical with a special focus on on-site team management and fill the gap which exists in disaster health management training system in Thailand. Detailed training programme is shown in Attachment 15.

Table 11: The Second Thai Counterpart Training in Japan

Title	The Second Thai Counterpart Training in Japan
Objectives	1) To identify the issues and challenges in the disaster health management in Thailand through understanding the Japanese system. 2) To consider the measures for capacity development in the disaster health management in Thailand through understanding the training system, the situation and the activities of institutes for human resource development in Japan. 3) To enhance the recognition of the Project among the concerned organizations in Japan and build relationships with them
Dates	25 January to 03 February 2018
Participants	Ten (10) Thai counterpart personnel, who are engaged in /are expected to be trainers for human resource development in disaster health management in Thailand
Venue	JICA HQ JICA Tokyo International Center (JICA Tokyo) National Disaster Medical Center, Tachikawa Joetstu General Hospital, Niigata Pacifico Yokohama, etc.
Activities/ Topics	1. Training for Disaster Health Management 2. Lecture/Exercise - Overview of Center for Disaster Medicine and Education, Niigata Uni. Faculty of Medicine - Role and function of Ministry of Health, Labor and Welfare during disasters as well as peacetime - History of disaster health management in Japan - Overview of Disaster Medical Assistance Team (DMAT) and the role of a disaster base hospital - Logistics and team management - Overview of Japan Disaster Relief (JDR) - Observation of JDR Stockpile in Narita - WHO Minimum Data Set (MDS) – progress in Japan- 3. The 23rd Annual Meeting of Japanese Association for Disaster Medicine (JADM) - Presentation by ARCH Project
Training Institution	- JDR Secretariat - DMAT Secretariat - National Disaster Medical Center, Tachikawa - Center for Disaster Medicine and Education, Niigata University Faculty of Medicine - Other organizations related to human resource development in disaster health management
Feed-back from participants **Lessons learned**	■ In general, the participants were satisfied with the contents of the training, especially they appreciated learning; 1) importance/effectiveness of multidisciplinary and multi-agency coordination 2) team management: in particular, logistics management is a key to successful disaster health management 3) different types of teaching methods Those above are not paid so much attention in disaster health management training in Thailand. 1) and 2) are one of the key messages from Japanese resources and it was very meaningful that Thai participants understand the importance. ■ The participants presented their action plan to strengthen the capacity of miniMERT by utilizing DMAT concepts, programme of Center for Disaster Medicine and Education, Niigata Uni. Faculty of Medicine. They conducted a training for miniMERT in Phang-Nga Province after the counterpart training, which is a good indication that the

participants are taking initiatives in capacity development in disaster health management in Thailand by applying the knowledge and experiences acquired from the counterpart training programme.

- Throughout the entire training period, the Thai counterparts could broaden their network with the medical professionals in disaster health management in Japan. Many of them are JDR registered personnel and it is expected that they will provide technical inputs and cooperate with ARCH Project in conducting upcoming events including RCD, AMS training, Study Tour in Japan. Such human relationship/network could be the basis for strengthening the regional collaboration/coordination in the future.

Chapter 2 Project Management

2.1 Joint Coordination Committee (JCC)

The first JCC meeting was held on 04 August 2016 to share the outlines of the IC/R, and the annual work plan from July 2016 to September 2017 was endorsed.

The second JCC meeting was held on 28 August 2017. The meeting shared the progress of the project and laid out the further annual work plan. For detailed discussion, please refer to the proceedings shown in Attachment 6.

2.2 Communication among the Stakeholders

Communication flow was modified as shown in Figure 1 because Thai counterparts would like to be fully involved in drafting and preparation process of project activities. Also, ASEAN Secretariat is involved in communication with AMS because the Project is an official project under the ASEAN Health Cluster 2.

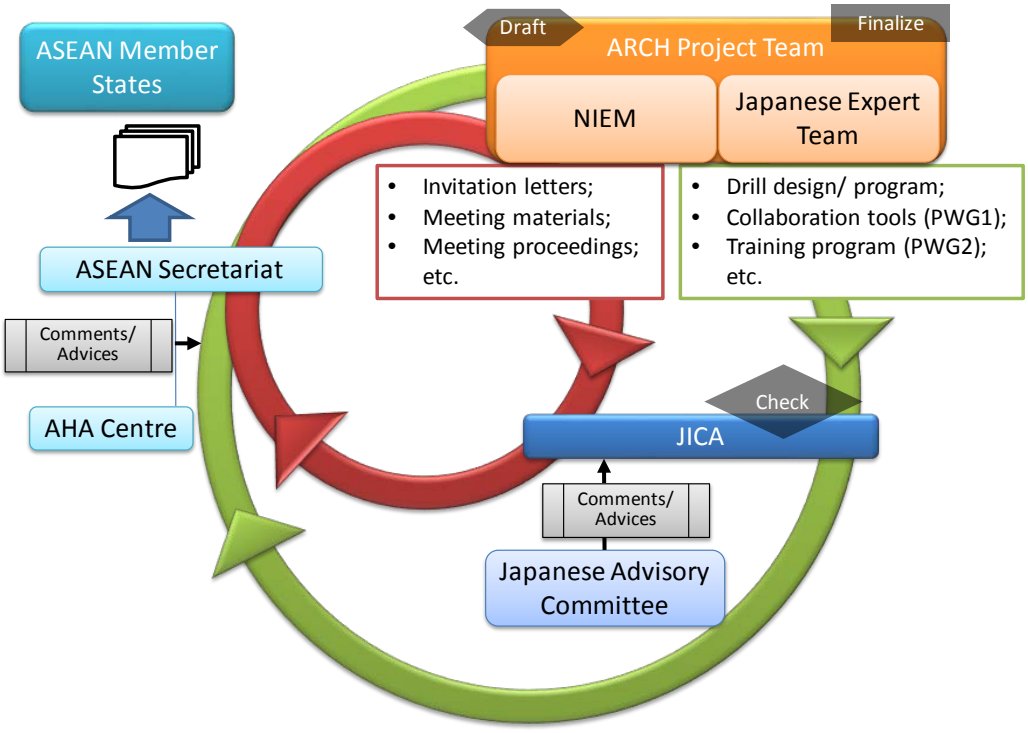


Figure 1 Revised Communication Flow of the Project

In addition, the Project Team decided to have monthly meetings to maintain effective and efficient communication. The first team meeting was held in February 2017, among the key members.

2.3 Counterpart Staff

NIEM is a coordinating agency of emergency and disaster medicine, therefore, most of technical staff are mobilized from academic institutions and hospitals as counterparts of the Project. Since it was still in the

initial stage, the technical staff were not stable and consistent. NIEM has been trying to improve such situation by increasing number of technical personnel in their permanent staff and strengthening cooperation with the above academic institutions and hospitals.

Because the Project needs close communication with ASEAN and Thailand is working as one of the lead countries of the Project in Health Cluster 2 of ASEAN, the Project Team has been aware that MOPH should be more actively involved in the project activities.

2.4 Japanese Expert Team

To respond to the modification of the communication flow as mentioned in Section 3.2, the dispatch schedule of Japanese Expert Team was revised as shown in Attachment 5.

Chapter 3 Planned Activities for April – October 2018

Plan of operation for April-October 2018 is as follows.

Highlights of the activities for March 2017-March 2018

- 1st Regional Collaboration Drill in Thailand
- 2nd AMS Training
- Counterpart Training in Japan
- Finalization of collaboration tools
- JADM presentation (International Conference)
- 2nd Reginal Collaboration Drill in Vietnam

For overall project implementation

- Project committee meetings
- Monitoring of project indicators
- Support for implementation of ASEAN declaration on Disaster Health Management

Output 1: Coordination platform on disaster health management is set up

- 3rd RCC meeting in the Philippines in December 2018

Output 2: Framework of regional collaboration practices is developed

- 3rd Regional Collaboration Drill in the Philippines in December 2018

Output 3: Tools for effective regional collaboration on disaster health management are developed

- Standard Operating Procedure, Minimum Requirement, Health Needs Assessment Form to be finalized upon completion of the 3rd RCD in the Philippines
- Information collection for EMT-Database

Output 4: Academic network on disaster health management in AMS is enhanced

- APCDM in Kobe, Japan in October

Output 5: Capacity development activities for each AMS are implemented

- 3rd AMS Training in May 2018
- Japan Study Tour in Kobe in October
- 4th AMS Training in February 2018

Deliverables

- Progress report 3 (December 2018)
- Project PR Video

- Monitoring sheet (June 2018)

Attachment 1

- **Project Design Matrix (PDM) (Version 1, approved on 04 August 2016)**
- **Plan of Operation (PO) (Version 1, approved on 04 August 2016)**

Project Design Matrix (PDM): PROJECT FOR STRENGTHENING THE ASEAN REGIONAL CAPACITY ON DISASTER HEALTH MANAGEMENT

Version 1
as of 04 Augst 2016

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumption
Overall Goal ASEAN and Japan collaboration mechanism on disaster health management is developed.	1. Roadmap of ASEAN regional collaboration mechanism on disaster health management is finalized and proposed to SOMHD. 2. Hub organization in-charge of coordination of ASEAN and Japan collaboration mechanism is identified, and its role is clarified. 3. Necessary staff and budget of hub organization of ASEAN and Japan collaboration mechanism are proposed. 4. Activities based on ASEAN and Japan collaboration mechanism works if large scale disaster occurs.	1 Monitoring/review survey report 2 Agreement documents in ASEAN SOMHD 3 Summary of related meetings/ conferences (SOMHD or Summit etc)	
Project Purpose Regional coordination on disaster health management is strengthened in ASEAN.	1 Coordination meetings on disaster health management in ASEAN are held at regular basis. 2 Activities needed for regional collaboration are clarified and approved in the coordination meeting. 3 Recommendations for developing regional collaboration mechanism in disaster health management is proposed to SOMHD. 4 Regional collaboration tools are developed and approved in the coordination meeting.	1 Agreement and/or summary of coordination meeting	1 Policy of ASEAN on disaster health management is not changed. 2 Commitment from AMS is assured. 3 Serious political problem will not happen among ASEAN.
Output			
Output 1 Coordination platform on disaster health management is set up.	1-1 Number of regional coordination meeting during the Project (Target: at least once a year) 1-2 Clarification of focal point of each AMS 1-3 Agreement of set-up of regional coordination platform on disaster health management in ASEAN	1-1 and 1-3 Records of coordination meetings 1-2 List of focal points	1 Commitment of AMS for is assured.
Output 2 Framework of regional collaboration practices is developed.	2-1 Regional collaboration drill is conducted. (basically, once a year) 2-2 Recommendations/lessons learned for the regional collaboration drills are concluded . 2-3 Mechanism of regional collaboration among emergency medical teams in disaster affected area is clarified.	2-1 Records of the regional collboration drills 2-2 Monitoring/review survey report 2-3 Draft regional agreement of the regional collaboration on disaster health management	
Output 3 Tools for effective regional collaboration on disaster health management are developed.	3-1 Standard Operating Procedure (SOP) (draft) 3-2 Minimum requirements for disaster health management personnel (draft) 3-3 Framework of health needs assessment in emergencies (draft) 3-4 Preparation of database of emergency medical teams in ASEAN	3-1, 3-2, 3-3, and 3-4 Regional collaboration tools such as SOP, minimum requirement, framework of health needs assessment, database Records of coordination meetings Monitoring/review survey report	
Output 4 Academic network on disaster health management in AMS is enhanced.	4-1 Number of presentation(s) made at academic conference(s) (Target: at least 1 paper/year)	4-1 Academic conference/journal such as JADM, APCDM, and WADEM Monitoring report	
Output 5 Capacity development activities for each AMS are implemented.	5-1 Number of trainings (Target:4 courses) 5-2 Number of participants to attend to the training courses (Target:150 pax) 5-3 Lessons learned from the training courses was utilized in each AMS	5-1 and 5-3 Training report(s) 5-2 Monitoring/review survey report	

Activities	Inputs		
1-1 Regional coordination meetings are organized every year to share the progress and discuss the direction of the Project. 2-1 Develop and prepare the program of the regional collaboration drill with project working group 2-2 Conduct the regional collaboration drill every year in AMS 2-3 Compile recommendations on regional collaboration on disaster health management based on the discussion and knowledge sharing through project activities 2-4 On site practice is conducted when disaster occurs in ASEAN (if possible). 3-1 Formulate project working groups for regional collaboration tools at the beginning of the project 3-2 Develop a draft regional SOP and minimum requirements for disaster health management with the project working group 3-3 Prepare databases of emergency medical teams of AMS 3-4 Draft framework of health needs assessment in emergencies with the project working group 4-1 Present outcomes of the Project activities at academic conferences such as JADM, APCDM and WADEM 5-1 Prepare training plan, curriculum and materials on disaster health management and emergency medical system based on needs survey with the project working group 5-2 Conduct trainings on disaster health management and emergency medical service for AMS 5-3 Conduct monitoring survey and evaluation on capacity development on disaster health management in each AMS 5-4 Conduct a study tour in Japan for AMS 5-5 Conduct training program in Japan for the Thai counterpart personnel	Japanese side 【Experts】 (1)Expert Consultant team (a) Dispatch of Experts 1.Leader 2.Specialist in medical system 3.Specialist in disaster health management/emergency medicine 4.Specialist in planning/organizing regional collaboration drill 5.Specialist in planning/organizing trainings 6.Project coordinator 7.Others, if necessay (b) Provision of necessary equipment (if necessary) (2)Japanese Advisory Committee 1.Provide advice and technical support to JICA on the project management. 2.Join the project working groups 3.Participate ~~to~~ in the regional collaboration drills 4.Conduct advisory survey 【Local cost】 1.Expense mutually agreed upon as necessary	Thailand side 【Counterpart Personnel】 1.Project Director 2.Project Manager 3.Officer(s) in charge 4.Secretary at the project office 【Facilities and Equipment】 1.Project office space for JICA experts 2.Facilities and equipment necessary for trainings/regional drills 3.Equipment mutually agreed upon as necessary 【Available data and information related to project】 【Local cost】 1.Expense mutually agreed upon as necessary	

Plan of Operation

Project Title : PROJECT FOR STRENGTHENING THE ASEAN REGIONAL CAPACITY ON DISASTER HEALTH MANAGEMENT

Overall Goal	ASEAN and Japan collaboration mechanism on disaster health management is developed.
Project Purpose	Regional coordination on disaster health management is strengthened in ASEAN.
Duration of the Project	3 years

Ver. 1
(04 August 2016)

Schedule		2016						2017												2018												2019								
		6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Outputs	**Activities**																																								
1. Coordination platform on disaster health management is set up.	1-1 Regional coordination meetings are organized every year to share the progress and discuss the direction of the Project.				■									■									■												■					■	
2. Framework of regional collaboration practices is developed.	2-1 Develop and prepare the program of the regional collaboration drill with project working group			―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―											
	2-2 Conduct the regional collaboration drill every year in AMS								■S.U					■									■												■						
	2-3 Compile recommendations on regional collaboration on disaster health management based on the discussion and knowledge sharing through project activities								―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―
	2-4 On site practice is conducted when disaster occurs in ASEAN (if possible).								-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Tools for effective regional collaboration on disaster health management are developed.	3-1 Formulate project working groups for regional collaboration tools at the beginning of the project				―																																			
	3-2 Develop a draft regional SOP and minimum requirements for disaster health management with the project working group					―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	-	-	-	-	-	-	-	-	-	-	-	-	―	―	―	―	―	―	―	―
	3-3 Prepare databases of emergency medical teams of AMS								―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―
	3-4 Draft framework of health needs assessment in emergencies with the project working group								―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Academic network on disaster health management in AMS is enhanced.	4-1 Present outcomes of the Project activities at academic conferences such as JADM, APCDM and WADEM					■ APCDM			■ JADM			■WADEM									■JADM									■APCDM										
5. Capacity Development Activities for each AMS are implemented.	5-1 Prepare training plan, curriculum and materials on disaster health management and emergency medical system based on needs survey with the project working group			―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―											
	5-2 Conduct trainings on disaster health management and emergency medical service for AMS											―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―	―											
	5-3 Conduct monitoring survey and evaluation on capacity development on disaster health management in each AMS																												―											
	5-4 Conduct a study tour in Japan for AMS															■																									
	5-5 Conduct training program in Japan for the Thai counterpart personnel								■												■																			

Attachment 2

- **Project Design Matrix (PDM) (Version 2, approved on 30 August, 2017)**
- **Amendments of Record of Discussion (signed on 30 August, 2017)**

Project Design Matrix (PDM): PROJECT FOR STRENGTHENING THE ASEAN REGIONAL CAPACITY ON DISASTER HEALTH MANAGEMENT

Version 2
as of 17 August, 2017

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumption
Overall Goal ASEAN and Japan collaboration mechanism on disaster health management is developed.	1. Roadmap of ASEAN regional collaboration mechanism on disaster health management is finalized and proposed to SOMHD. 2. Hub organization in-charge of coordination of ASEAN and Japan collaboration mechanism is identified, and its role is clarified. 3. Necessary staff and budget of hub organization of ASEAN and Japan collaboration mechanism are proposed. 4. Activities based on ASEAN and Japan collaboration mechanism works if large scale disaster occurs.	1 Monitoring/review survey report 2 Agreement documents in ASEAN SOMHD 3 Summary of related meetings/ conferences (SOMHD or Summit etc)	
Project Purpose Regional coordination on disaster health management is strengthened in ASEAN.	1 Coordination meetings on disaster health management in ASEAN are held at regular basis. 2 Activities needed for regional collaboration are clarified and approved in the coordination meeting. 3 Recommendations for developing regional collaboration mechanism in disaster health management is proposed to SOMHD. 4 Regional collaboration tools are developed and approved in the coordination meeting.	1 Agreement and/or summary of coordination meeting	1 Policy of ASEAN on disaster health management is not changed. 2 Commitment from AMS is assured. 3 Serious political problem will not happen among ASEAN.
Output			
Output 1 Coordination platform on disaster health management is set up.	1-1 Number of regional coordination meeting during the Project (Target: at least once a year) 1-2 Clarification of focal point of each AMS 1-3 Agreement of set-up of regional coordination platform on disaster health management in ASEAN	1-1 and 1-3 Records of coordination meetings 1-2 List of focal points	1 Commitment of AMS for is assured.
Output 2 Framework of regional collaboration practices is developed.	2-1 Regional collaboration drill is conducted. (basically, once a year) 2-2 Recommendations/lessons learned for the regional collaboration drills are concluded . 2-3 Mechanism of regional collaboration ~~of~~ among emergency medical teams in disaster affected area is clarified.	2-1 Records of the regional collboration drills 2-2 Monitoring/review survey report 2-3 Draft regional agreement of the regional collaboration on disaster health management	
Output 3 Tools for effective regional collaboration on disaster health management are developed.	3-1 Standard Operating Procedure (SOP) (draft) 3-2 Minimum requirements for disaster health management personnel (draft) 3-3 Framework of health needs assessment in emergencies (draft) 3-4 Preparation of database of emergency medical teams in ASEAN	3-1, 3-2, 3-3, and 3-4 Regional collaboration tools such as SOP, minimum requirement, framework of health needs assessment, database, Records of coordination meetings Monitoring/review survey report	
Output 4 Academic network on disaster health management in AMS is enhanced.	4-1 Number of presentation(s) made at academic conference(s) (Target: at least 1 paper/year)	4-1 Academic conference/journal such as JADM, APCDM, and WADEM Monitoring report	
Output 5 Capacity development activities for each AMS are implemented.	5-1 Number of trainings (Target: 4 courses) 5-2 Number of participants to attend to the training courses (Target: 150 pax) 5-3 Lessons learned from the training courses was utilized in each AMS 5-4 Number of participants to attend to the counterpart training courses (Target :20 pax)	5-1 and 5-3 Training report(s) 5-2 Monitoring/review survey report 5-3 Training report(s)	
Activities	**Inputs**		
1-1 Regional coordination meetings are organized every year to share the progress and discuss the direction of the Project. 2-1 Develop and prepare the program of the regional collaboration drill with project working group 2-2 Conduct the regional collaboration drill every year in AMS 2-3 Compile recommendations on regional collaboration on disaster health management based on the discussion and knowledge sharing through project activities 2-4 On site practice is conducted when disaster occurs in ASEAN (if possible). 3-1 Formulate project working groups for regional collaboration tools at the beginning of the project 3-2 Develop a draft regional SOP and minimum requirements for disaster health management with the project working group 3-3 Prepare databases of emergency medical teams of AMS 3-4 Draft framework of health needs assessment in emergencies with the project working group 4-1 Present outcomes of the Project activities at academic conferences such as JADM, APCDM and WADEM 5-1 Prepare training plan, curriculum and materials on disaster health management and emergency medical system based on needs survey with the project working group 5-2 Conduct trainings on disaster health management and emergency medical service for AMS 5-3 Conduct monitoring survey and evaluation on capacity development on disaster health management in each AMS 5-4 Conduct a study tour in Japan for AMS 5-5 Conduct training program in Japan for the Thai counterpart personnel	Japanese side 【Experts】 (1)Expert Consultant team (a) Dispatch of Experts 1.Leader 2.Specialist in medical system 3.Specialist in disaster health management/emergency medicine 4.Specialist in planning/organizing regional collaboration drill 5.Specialist in planning/organizing trainings 6.Project coordinator 7.Others, if necessay (b) Provision of necessary equipment (if necessary) (2)Japanese Advisory Committee 1.Provide advice and technical support to JICA on the project management. 2.Join the project working groups 3.Participate in the regional collaboration drills 4.Conduct advisory survey 【Local cost】 1.Expense mutually agreed upon as necessary	Thailand side 【Counterpart Personnel】 1.Project Director 2.Project Manager 3.Officer(s) in charge 4.Secretary at the project office 【Facilities and Equipment】 1.Project office space for JICA experts 2.Facilities and equipment necessary for trainings/regional drills 3.Equipment mutually agreed upon as necessary 【Available data and information related to project】 【Local cost】 1.Expense mutually agreed upon as necessary	

MINUTES OF MEETINGS

BETWEEN

JAPAN INTERNATIONAL COOPERATION AGENCY

AND

NATIONAL INSTITUTE FOR EMERGENCY MEDICINE

FOR AMENDMENT OF THE RECORD OF DISCUSSIONS

ON

PROJECT FOR STRENGTHENING THE ASEAN REGIONAL CAPACITY ON DISASTER HEALTH MANAGEMENT

The Japan International Cooperation Agency (hereinafter referred to as "JICA") and National Institute for Emergency Medicine (hereinafter referred to as "NIEM") hereby agree that the Record of Discussions on Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management (hereinafter referred to as "the Project") signed on 19 February, 2016 will be amended as follows;

1 Implementation Structure

Before	Amended Version
(1)NIEM (a)Project Director Secretary General, NIEM (b)Project Manager Deputy Secretary General of NIEM will be responsible for overall administration and implementation of the Project. (c) Counterpart Personnel Counterpart Personnel of NIEM will be assigned.	(1)NIEM (a)Project Director Secretary General, NIEM (b)Counterpart Personnel Counterpart Personnel of NIEM will be assigned. (2)MOPH (a)Co-Project Director Permanent Secretary, Ministry of Public health (b)Counterpart Personnel Counterpart Personnel of MOPH will be assigned.

	(3)Project Manager(s) Project Manager, who is responsible for overall administration and implementation of the Project, will be assigned by the Project Director and Co-project Director, and to be informed to JICA. Also, Co-Project Manager will be assigned by the Project Director and Co-project Director when necessary. (4)Other organization Other organization will be added when necessary. Also. Co-Project Manager will be selected from other organization than NIEM and MOPH when the Project Director and the co-Project Director mutually assign.
Reason: Through the initial implementation, the importance of the involvement of MOPH in the Project has been more recognized both for international and domestic environment considering the following situations: The Project has been approved by ASEAN Committee of Permanent Representative (CPR) as an official project under ASEAN Health Cluster 2. The focal point of SOMHD of each AMS has been involved in communications relevant to the Project. Also, the Project will facilitate future vision of ASEAN collaboration in disaster health management, that should be further discussed among AMS. In Thailand, MOPH is responsible for disaster health management in coordination with NIEM. Therefore, discussions on disaster health management in ASEAN in the Project and capacity development through mutual cooperation through the Project should involve the above two agencies, MOPH and NIEM. Taking into account the above situation, the three parties, MOPH, NIEM and JICA agreed to additionally include the Permanent Secretary, Ministry of Public Health as Co-Project Director.	

2 Proposed member of joint Coordinating Committee (JCC) : Annex IV

Before	Amended Version
2. Chairperson and Members (1) Chairperson Secretary General, National Institute for Emergency Medicine(NIEM) (2)Members <u>The Thai side</u> (a) Ministry of Public Health (MOPH) Thailand (b) National Institute for Emergency Medicine (NIEM) (c) Thailand International Cooperation Agency (TICA) <u>The Japanese side</u>	2. Chairperson and Members (1) Chairperson Secretary General, National Institute for Emergency Medicine(NIEM) (2)Co-Chairperson, Permanent Secretary , Ministry of Public Health (2)Members <u>The Thai side</u> (a) Focal point of SOMHD, Thailand (b) Director General, Department of Medical Services, MOPH (c) Director General, Department of Disease Control, MOPH (d) Director, Division of Public Health

(a) JICA Thailand Office (b) JICA Expert Team (c) Embassy of Japan in Thailand (Observer)	Emergency Management (DPHEM), Ministry of Public Health (MOPH) Thailand (e) Director, Division of Global Health, MOPH (f) Deputy Secretary General, National Institute for Emergency Medicine (NIEM) (g) Director, Bureau of Academic Affairs and Quality Management, NIEM (h) Director, Bureau of Policy and Strategy, NIEM (i) Officer, Thailand International Cooperation Agency (TICA) (j) President, College of Emergency Physician (k) President of Nursing Association (l) Representative from Paramedic Council The Japanese side (a) Chief Representative, JICA Thailand Office (b) Leader, JICA Expert Team (c) Long Term Expert (d) Embassy of Japan in Thailand (Observer)
Reason: As the same reason above, MOPH will be assigned as the Co-Chairperson of Joint Coordinating Committee. Also, both sides agreed that the members of the JCC will be added and confirmed as above so that the coordination among concerned organizations will be strengthened.	

3 Input by JICA : Appendix 1 Project Description, 5. Input

Before	Amended Version
5 Input (1) Input of JICA (a) Dispatch of Expert	5 Input (1) Input of JICA (a)Dispatch of Expert (b)Dispatch of Long Term Expert for ASEAN Coordination in Disaster Health Management to the Division of Public Health Emergency Management
Reason: The Japanese long-term expert is expected to play a role of communication hub among the regional and international society to support the Project Team. The Project has various stakeholders in the regional and international society, such as AMS, ASEAN Secretariat, AHA Center, and WHO. And it aims to be consistent with existing consensus and discussions on disaster health management. The long-term expert will build and maintain good relationship with various stakeholders and facilitate discussions in regional and international society on future vision of ASEAN regional collaboration on disaster health management in line with relevant visions such as "One ASEAN, One Response".	

4 Input by Thai side

Before	Amended Version
(2)Input by NIEM (g)Part of running expenses necessary for the implementation related to the Project, but limited to only Thai personnel;	(2)Input by NIEM (g) Part of running expenses necessary for the implementation related to the Project, but limited to only Thai personnel which needed for activities in Thailand (for the international travel, the number of Thai personnel whose cost will be covered by JICA is equivalent to other AMS); (3)Input by MOPH MOPH will take necessary measures to provide at its own expense: (a)Services of MOPH's counterpart personnel as referred to in Ⅱ-6; (b)Suitable office space with necessary equipment for the long term expert; (c)Part of running expenses necessary for the implementation of the Project, but limited to only MOPH personnel;
Reason: ・ At the project initial stage, all the project activities were planned to be conducted in Thailand and therefore, both parties agreed that travel cost for Thai personnel would be borne by Thai side. After commencement of the project, possibility to conduct some of the project activities outside Thailand has been considered. Given the current situation, both parties agreed to cover international travel cost for Thai personnel by the project budget. Both parties also agreed that the number of personnel whose international travel cost covered by JICA is limited to equivalent to other AMS. ・ NIEM, MOPH, and JICA agreed to add the inputs by MOPH since MOPH will enhance its role and involvement in the Project Implementation Structure.	

5 Project monitoring and discussions.

Before	Amended Version
JICA and/or NIEM were responsible for monitoring and evaluation of the progress of the Project, for taking appropriate measures to make the Project widely known to the people of Thailand, mutual consultation.	In addition to JICA and NIEM, MOPH will be included in the responsible parties for monitoring and evaluation, taking appropriate measures to make the Project widely known to the people of Thailand, mutual consultation, and any other issues arise from the project.
Reason: To ensure more involvement of MOPH in the project management activities and discussions,	

6 PDM

Before	Amended Version
PDM version 1.0	PDM version 2.0
Reason: The capacity development of Thai personnel was added in the indicator of Output 5.	

7 Amendments of RD

Before	Amended Version
The RD may be amended by the MM between JICA and NIEM.	The RD may be amended by the MM among NIEM, MOPH. and JICA.
Reason: Since the MOPH will be additional signer of RD, MM will also necessary to be signed by MOPH.	

This amendment will become effective as of August, 2017.

Annex 1 : Record of Discussions (signed on 19th February, 2016)

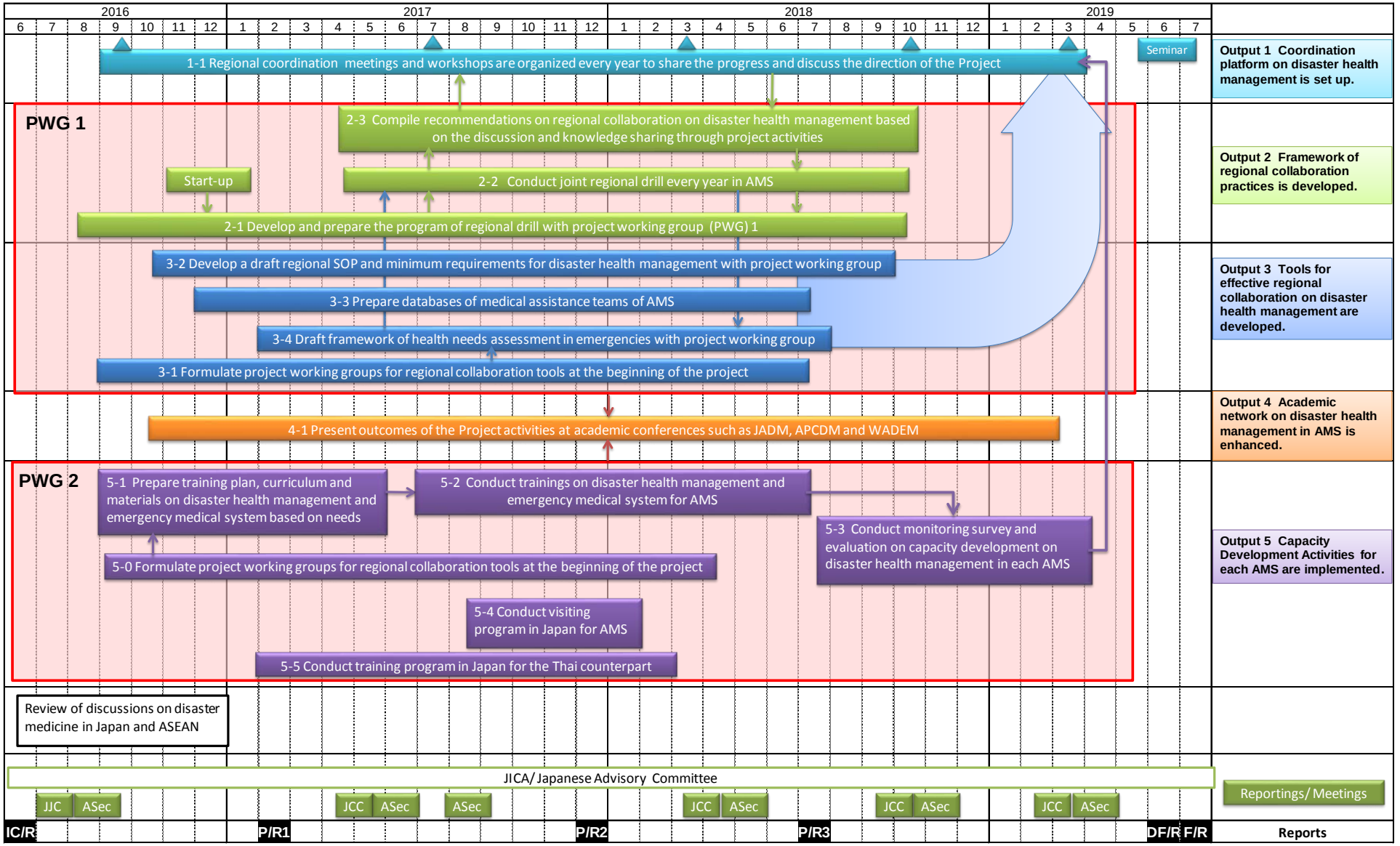
Annex 2 : PDM (ver. 2.0)

Bangkok, 30 August, 2017

Mr. Hiroo Tanaka Chief Representative Japan International Cooperation Agency, Thailand Office	Flt.Lt.Dr. Atchariya Pangma Secretary General National Institute for Emergency Medicine, Thailand	Dr. Sopon Mekthon Permanent Secretary Ministry of Public Health, Thailand

Attachment 3

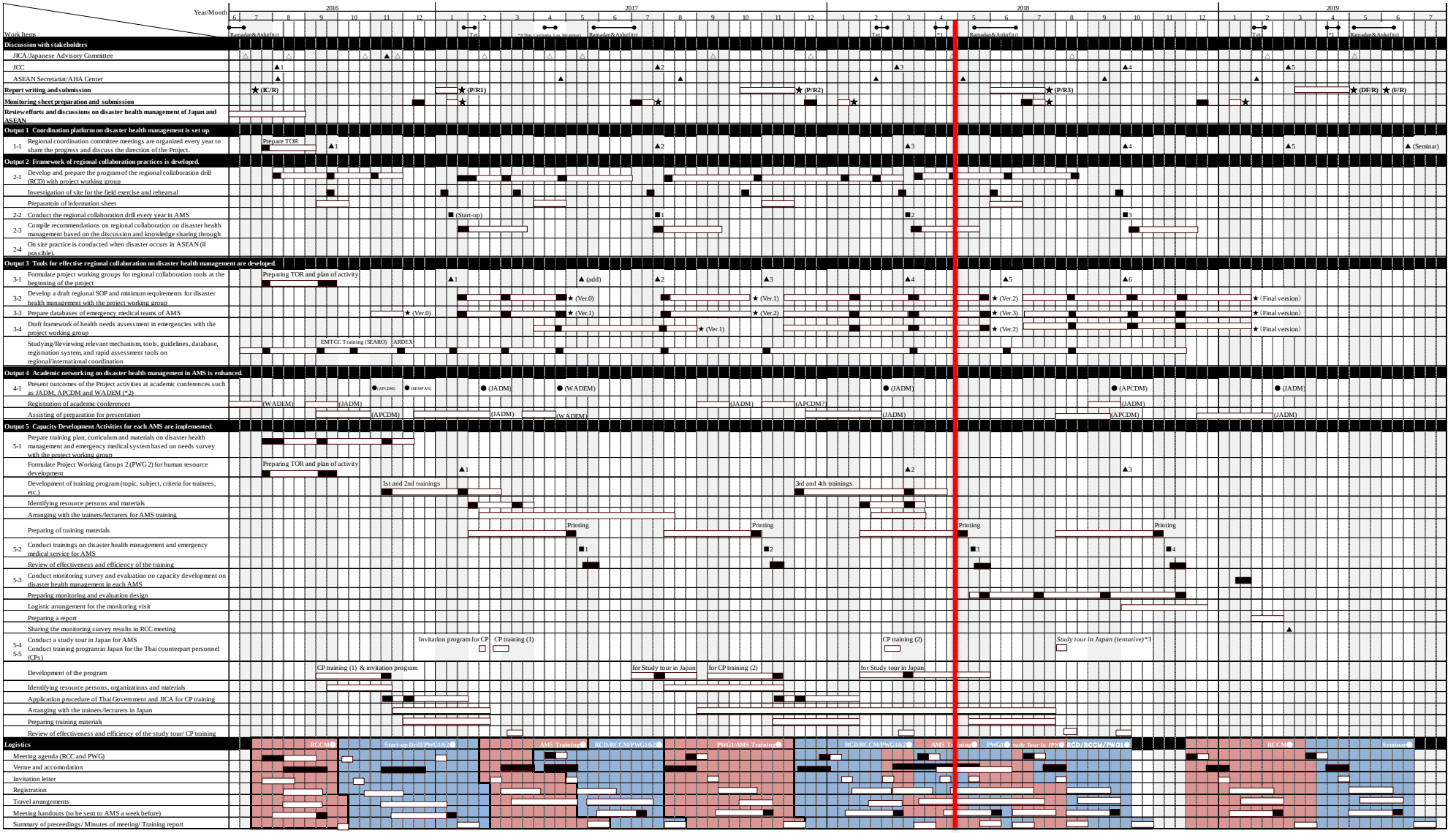
Work Flow



Note: Activity 2-4 On site practice is conducted when disaster occurs in ASEAN (if possible) will be inserted when it is applicable.

Attachment 4

Work Schedule



Legend : ☐Work in Japan ■Field work △Meeting in Japan ▲Meeting (in Field) ★Submission of a report Note: Meetings, workshops, drills, trainings and study tours will be scheduled based on the discussion with stakeholders.

*1: JADM (Japan Association for disaster medicine), APCDM (Asia-Pacific Conference on Disaster Medicine), WADEM (World Association for Disaster and Emergency Medicine) *2:One PWG 2 will endorse two AMS training programs. *3: Details of the study tour in Japan to be decided

Attachment 5

Dispatch Schedule of Japanese Expert Team

1. Activities in Field

Assignment	Name	2016							2017												2018												2019								
		6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7		
Team Leader	Keiko Nagai		5	9	2 2	1	4	6	9			4	6 7	5	11	5 8																								84	2.80
			10~14 (5)	1~9 (9)	25,26/29,30 (2) (2)	1 (1)	6~9 (4)	5~10 (6)	13-21 (9)			3~6 (4)	7~12,21~27 (6) (7)	6-10 (5)	12-22 (11)	8-12, 23-30 (5) (8)																								84	2.80
Team Leader	Fude Takayoshi																		10		10	5	15	5	7	7	7	5	7	15	7	5	7	12	10	6	5	16	15	176	5.87
																			26-30 (5)	1, 10-17 (1) (8)	15~20 (6)	5~11,19-24 (7) (6)	24-31 (8)	1 (1)																42	1.40
Disaster Health Managemant/Regional Collaboration Tools (1)	Yasushi Nakajima		1	5	3	1	5		13		3	7	4	4	12	4			7		7	7	15		6		6	6	6	15		5			6			7		155	5.17
			31 (1)	1~5 (5)	28~30 (3)	1 (1)	6~10 (5)		9~21 (13)		22~24 (3)	24~30 (7)	7~10 (4)	7~10 (4)	11~22 (12)	24~27 (4)			3~11 (9)		16-19 (4)		5-7 22-31 (3) (10)	11-13 (3)															91	3.03
Capacity Development Planning (1)	Junko Sato		1	5	6	5	6	8	10		10		19	6	16	8		5	15		7	7	15	7	19		7		7	30			20		10			10		259	8.63
			31 (1)	1~5 (5)	25~30 (6)	1~5 (5)	6~11 (6)	7~14 (8)	12~21 (10)		13~22 (10)		10~28 (19)	19~24 (6)	11~26 (16)	26~31 (6)	1~2 (2)	9-13 30-31 (5)	1~12 26~30 (2) (12) (5)	1~5 (5)	9-12 (4)	19-24 (6)	23-31 (9)	1,7-14,30 (1) (8)(1)																158	5.27
Regional Collaboration Tools (1)	Junko Yamada		1	9	11	12	6	5	15		9	9	9	9	14		4																							113	3.77
			31 (1)	9 (9)	20 (11)	5 16-22 (5) (7)	6-11 (6)	6-10 (5)	8-22 (15)		16-24 (9)	3-7,19-22 (5) (4)	2-10 (9)	5-13 (9)	10-23 (14)		27-30 (4)																								113	3.77
Regional Collaboration Tools (2)	Yumiko Kashiba		1	5	6	1	6		10			4	8	5	10		4	5	7		7		10		7	7			10	10					8			10		141	4.70
			31 (1)	1~5 (5)	25~30 (6)	1 (1)	6~11 (6)		12~21 (10)			19-22 (4)	3~10 (8)	6~10 (5)	13~22 (10)		27~30 (4)		26~30 (5)				22-31 (10)																75	2.50
Capacity Development Planning (2)	Takashi Senda		14	16	20	8	12	12	19		14		28	7	22	7		5	20	8	12	12	25		10	10	15		10	10	20		10		20		5	19		390	13.00
			10~15/24~31 (6) (8)	1~16 (16)	11~30 (20)	1~8 (8)	6~17 (12)	6~17 (12)	9~27 (19)		12~25 (14)		2~29 (28)	7~13 (7)	5~26 (22)	27~31 ~2 (5) (2)		9~13 30~31 (5) (2)	1~12 19~30 ~2 (12) (12) (2)		14-23 (10)		4-31 (28)	1-2,29-30 (2) (2)															254	8.47
Regional Collaboration Drills	Masako Tani		1	5	4	1	3	2	15		4		5	4	13	5			7		7	8	15		7	8	8	8	8	15					10			10		173	5.77
			31 (1)	~5 (5)	27~30 (4)	1 (1)	28~30 (3)	~2 (2)	8~22 (15)		21~24 (4)		7~11 (5)	7~10 (4)	10~22 (13)	23~27 (5)			9~11 26~30 (9) (5)	17~21 (5)	16-20 (5)		5-8,19-31 (4) (13)	1-2 15-18 (2) (4)															109	3.63
Project Coordinator	Mami Wakabayashi		8	12					10				11																										41	1.37
			24~31 (8)	~12 (12)					12~21 (10)				18~28 (11)																										41	1.37
Project Coordinator	Shinya Abe														12																								12	0.40
															11~22 (12)																								12	0.40
Project Coordinator	Ayako Yoshimitsu																		7			7	10		7		7			7			7		7			8		67	2.23
																			22~30 (9)	~1 (1)			22-31 (10)																20	0.67
																																					Sub total	Plan	1611	53.71
																																						Actual	999	33.31

2. Activities in Domestic

Assignment	Name	2016							2017												2018												2019								
		6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7		
Team Leader	Keiko Nagai	5					3	5		5			10		5	8																									41	2.05
		21-25 (5)					25,28,29 (3)	1,2,19,20, 26 (5)		8,9,13-15 (5)			8-19 (10)		25-31 (5)	1-8, 14,21,2 2,31 (8)																									41	2.05
Team Leader	Fude Takayoshi																			3		3			4			4		4				4			4	4			30	1.50
																				19-21(3)		27-28(2)	1 (1)																		6	0.30
Disaster Health Managemant/Regional Collaboration Tools (1)	Yasushi Nakajima		1	1	3		5	3		5	1	3		5				3		2	2	2					2	4	5							3				50	2.50
			4 (1)	17 (1)	7,8,9 (3)		10,13,19, 24(5)	26,27,29 (3)		13,14,15, 25,26(5)	6 (1)	9,13,17 (3)		15,12, 15,28(5)				4,5,26 (3)		7-8(2)	30-31 (2)	26,27 (2)																		36	1.80
Capacity Development Planning (1)	Junko Sato	5					5			10	9	3		5		3		7				5	4	3		5		7							3				72	3.60
		22-24 (3)					21,22,24, 25,28 (5)			19-28(10)	1-9(9)	12-14(3)		5-9 (5)		2-4 (3)		4-8,18,19 (7)			25-29(5)	1-2,4-5 (5)	19-20,22 (3)	25-27 (3)																60	3.00
Regional Collaboration Tools (1)	Junko Yamada			5	5	5	5			5			5	6		10	5	2																						53	2.65
				15-19 (5)	12-16 (5)	24-28 (5)	14-18 (5)			9,10,13,14,15 (5)			15-19 (5)	19-23, 26 (6)		1-4,7-9,29-31 (10)	4,5, 20-22 (5)	13, 16 (2)																						53	2.65
Regional Collaboration Tools (2)	Yumiko Kashiba	3		5	5		5			5	5		8	2			5									5							5			3				57	2.85
		23,26-27 (3)		12,16,17,22,23 (5)	12,7,8,15 (5)		1,2,15,16, 21(5)			9,11,13 (3)	4,16,22 (3)		2,12,13,19,20, 26,27,30 (8)	13, 17 (2)			1,4,6,24,26 (5)				17,18,24 (3)			11,12,19 (3)															45	2.25
Capacity Development Planning (2)	Takashi Senda	3								5					3	1	1		7	3		5						3				3			3				36	1.80
		21-23 (3)								17,21,25, 27,28 (5)					3 (3)	27, 28 (3)	11 (1)		4-8,18,19 (7)	10 (1)	11 (1)	31(1)	1,9 (2)																	24	1.20
Regional Collaboration Drills	Masako Tani		1	1	3	4	1	2		4		2	3	2	4		1	3	3	3	3	3			2	2	3	3	3						3				59	2.95
			4 (1)	17 (1)	7,8,9 (3)	11,27-29 (4)	25 (1)	15,27 (2)		13-16(4)		19,27 (2)	15,25,30 (3)	16,19 (2)	3,6,7,28 (4)		6 (1)	10,18,19 (3)	15,16,21 (3)	10,11,23 (3)	9,10,15 (3)	9, 28 (2)	1 (1)															43	2.15
Project Coordinator	Mami Wakabayashi								5	6																														11	0.55
									9,23-26 (5)	17,20-24 (6)																																11	0.55
Project Coordinator	Shinya Abe															3			0.4																						3.4	0.17
																2,7,21 (3)			1 (0.7-0.4)																						3.4	0.17
Project Coordinator	Ayako Yoshimitsu																			5			7		5			5			5					5	5				40	2.00
																				18-22 (5)		1-2,7-9,28 (6)	1 (1)																		12	0.60

Sub total	Plan	452.4	22.62
	Actual	334.4	16.72
Total	Plan	2063.4	76.33
	Actual	1333.4	50.03

Attachment 6

Proceedings

1. **1st RCD and 3rd PGW1, 2nd PWG2, 2nd RCC meeting (July 19-21, 2017)**
2. **2nd JCC meeting (August 28, 2017)**
3. **3rd PWG2 meeting (November 9, 2017)**
4. **4th PGW1 meeting (November 28-29, 2017)**
5. **2nd RCD and 5th PWG1, 4th PWG2, 3rd RCC meeting**

The First Regional Collaboration Drill,
the Third Project Working Group (PWG) 1 Meeting and the Second PWG 2 Meeting, and
the Second Regional Coordination Committee Meeting
on the Project for Strengthening the ASEAN Regional Capacity on
Disaster Health Management (ARCH Project)

17 – 21 July 2017
Duangjitt Resort & Spa and Phuket Mining Museum, Phuket, Thailand

Summary of Proceedings

1. The first regional collaboration drill (RCD), the third project working group (PWG) 1 meeting, the second PWG 2 meeting, and the second regional coordination committee (RCC) meeting on the Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management (ARCH Project) were held in Phuket, Thailand from 17 to 21 July 2017. The overall programme of activities is presented in **Annex I**.

2. The first RCD, the third PWG 1 meeting, the second PWG 2 meeting, and the second RCC were attended by participants from ASEAN Member States (AMS): Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Singapore, Thailand, and Viet Nam, along with ARCH Project Team consisting of the National Institute of Emergency Medicine (NIEM) of Thailand and Japanese expert team, as well as representatives of the Department of Disaster Prevention and Mitigation (DDPM) of Thailand, Ministry of Health of Thailand, ASEAN Secretariat (ASEC), ASEAN Coordinating Centre for Humanitarian Assistance on Disaster Management (AHA Centre), the World Health Organization (WHO) Headquarters and Thailand Representative Office, the Japanese Advisory Committee, as well as the Japan International Cooperation Agency (JICA). The list of participants is enclosed in **Annex II**.

3. The summary of proceedings consists of three parts: 1) the first RCD, 2) the PWG meetings, and 3) the second RCC meeting.

Part 1 First Regional Collaboration Drill: from 17 to 19 July 2017

1. The first RCD was conducted by ARCH Project Team, and participated by teams from ten ASEAN Member States (AMS); Brunei, Cambodia, Laos PDR, Malaysia, Myanmar, Indonesia, Philippines, Singapore, Thailand, and Viet Nam, as well as Japan Disaster Relief (JDR). Also, participants from ASEAN Secretariat, AHA Centre, WHO, JICA, and Japanese Advisory Committee were involved. The first RCD consisted of the introductions and the table-top exercise (TTX) (Day 1), the field exercise (Day 2), as well as the review workshop (Day 3).

I. OPENING REMARKS / GROUP PHOTO

2. Mr. Norraphat Plodthong, Phuket Governor greeted and welcomed participants and honored guests. He appreciated ARCH Project to provide great opportunity to Phuket for strengthening of ASEAN regional coordination capacity on disaster health management and capacity development on disaster response for public health personnel of Thailand including Phuket and other southern provinces. Mr. Plodthong also expressed the expectation on future collaboration in disaster response based on experiences and learnings from this important event.

3. Dr. Atchariya Pangma, Secretary General, NIEM made opening remarks. He mentioned the outlines of the three-day program which consists of table-top exercise, field exercise and the review workshop. Dr. Atchariya also emphasized the objective of the first RCD to offer practical experiences in which you can learn about information management along with practicing effective collaboration among the emergency medical teams and with the concerned local agencies in a simulated disaster-affected area.

4. From JICA Thailand, Mr. Masato Koinuma, Senior Representative expressed sincere appreciation to close cooperation of all the stakeholders of ARCH Project. He mentioned that three RCD will be conducted during the three-year project and the first RCD was designed based on practical experiences of the Start-up Drill in January 2017. Mr. Koinuma emphasized that ARCH Project could contribute to enhance regional collaboration on disaster health management in ASEAN, one of the most disaster prone area in the world.

5. Then, the group photo was taken followed by the safety and security briefing by JICA Thailand Office.

II. INTRODUCTION TO THE FIRST REGIONAL COLLABORATION DRILL: CONCEPT, PURPOSES AND EXPECTED OUTCOMES

6. Dr. Phumin Silapunt, ARCH Project Team, made an introduction to RCD with and the overall picture of ARCH Project. The presentation of Dr. Silapunt can be found in **Annex III**.

III. INTRODUCTION TO ASEAN MECHANISM ON DISASTER MANAGEMENT

7. Mr. Arnel Capili, AHA Centre, presented on concept of collective response in ASEAN. His presentation included ASEAN Joint Disaster Response Plan (AJDRP) and ASEAN Military Ready Group (AMRG) as well as proposed mechanism for emergency medical teams (EMT). Also, he provided procedure and forms in SASOP relevant to the first RCD. Dr. Capili's presentation can be found in **ANNEX IV**.

IV. INTRODUCTION TO EMT CONCEPT AND COORDINATION MECHANISM (ESPECIALLY, FORMATS TO BE USED IN THE DRILL)

8. Mr. Flavio Salio, Emergency Medical Teams, Emergency Operations Department, WHO Headquarters, made presentation on EMT concept and coordination mechanism. Also, he explained the forms in the EMT Coordination Handbook, especially on those to be used in the first RCD. Then, Dr. Tatsuhiko Kubo from JDR presented on EMT Minimum Data Set (MDS). Presentations of Mr. Flavio and Dr. Kubo can be referred in **ANNEX V**.

V. INTRODUCTION TO TABLE TOP EXERCISE (TTX), AND BASELINE SCENARIO AND GUIDELINES, ETC.

9. Dr. Prasit Wuthisuthimethawee, the Project Team, provided introduction to TTX. He also explained baseline scenario and guidelines for TTX. Dr. Phumin Silapunt, briefed the participants on the system for request and receive international assistance in Thailand, because the first RCD will be conducted in accordance with the Thai system. Presentations of this session can be found in **ANNEX VI**.

VI. TABLE-TOP EXERCISE (TTX)

10. TTX was conducted facilitated by Thai task team. Three provincial public health emergency operating centre (PHEOC) and one national EOC/EMTCC were set in separate rooms. After arriving at the Suwannapumi Airport, emergency medical teams (EMT) from AMS submitted WHO EMT registration form and took necessary procedure at Receiving and Departure Centre (RCD) conducted by Department of Disaster Prevention and Mitigation (DDPM), Thailand. Then, RDC allocated EMT to the provinces. The participants learned the formats required to the field activities and coordination such as medical record, tally sheet, daily report, patient referral form, and exit report.

VII. INTRODUCTION TO THE FIELD EXERCISE

11. Dr. Prasit Wuthisuthimethawee make presentation on introduction to the field exercise including schedule, field layout, and logistics. Dr. Yasushi Nakajima presented the overall objectives of the series of RCD based on lessons learned from the start-up drill and will contribute to One AESEAN, One Response. Their presentation is included in **ANNEX VI**.

VIII. FIELD EXERCISE

12. The field exercise was conducted in the Phuket Mining Museum. EMT dispatched to three provinces and provide medical services as Type 1 fixed. Only Japan EMT played Type 2. Each team also visited the nearby village for health needs assessment. EMT referred the patients under coordination of provincial PHEOC. National EOC/EMT Coordination Cell (EMTCC) and Regional EOC collected and integrated information and reports.

IX. REVIEW WORKSHOP

13. The review workshop was conducted as the follow-up reflection of TTX and the field exercise, to review the exercises to identify the gaps, challenges and difficulties of each country team, as well as draw lessons learned for the following RCDs and the other project activities including development of regional collaboration tools and trainings.

a. National PHEOC/EMTCC Meeting Demonstration

14. The session comprised representatives from Provincial PHEOC from Krabi, Phangnga and Phuket in addition to representatives from eleven countries' EMT. Then, simulated meetings were demonstrated between them and Surat Thani Regional PHEOC, and Bureau of Public Health in Emergency Response of Ministry of Public Health (BPHER) as National PHEOC.

1) Krabi PHEOC

15. The following feedbacks were received from EMT from Malaysia, Brunei and Indonesia which were operating in Ao Nang, Koh Lanta and Phi Phi Island districts, and Krabi PHEOC.

- There was a delay in transportation process due to confusion in communication during the referral process. EMT would like PHEOC to give more attention to the referral process.
- Each stage of actions and processes needed frequent communications from PHEOC to EMT members to keep everyone at the same pace. One translation may not be enough to explain the sense of simulation.
- PHEOC suggested that because in actual disaster situation, mobilization of helicopter, ambulance and other transport could be slow, communication should be effective to enhance patient transportation. Under such severe situation, management of transportations may be difficult.

2) Phangnga PHEOC

16. The following feedbacks were received from EMT team from Singapore, Vietnam, Philippine, Thailand which were operating in Koh Pratong, Thai Meung, Khaolak and Ban Nam Kem districts, and Phangnga PHEOC.

- Due to severe damage of the health centre, impact to the local population was a certain level.

- National PHEOC was tense in the day-to-day operation due to high number of patients to be transferred. Therefore, patient transportation had to be done on foot, although vehicle should be provided in the actual situation. Because the number of medical personnel was not sufficient against the number of patients, EMT faced difficulty in site management.
- Because the shelter was too crowded and foreign volunteers had registration problem, the situation was getting worse. Some shelters (especially Khaolak affected by Tsunami) were too overwhelmed to control the situation and manage the environment, especially the water and sanitation issues. In addition, other problematic issues were there such as inadequate food, communication, road accessibility, irritating insects and rabies. Vaccination and medication should have been more well-equipped.
- As the spectrum of disease changed from acute phase to the later phase, EMT should be aware of it and adapt their services accordingly.

b. Phuket PHEOC

17. The following feedbacks were received from EMT team from Japan, Laos, Myanmar, Cambodia which were operating in Patong Beach, Kamala Beach and Mai Khao Beach districts, and Phuket PHEOC.

- Patient referral information should have been more clearly communicated from one EMT to another. In this event, because Japan EMT (type 2) received referred patients with little or no information from other type 1 EMT, operation of Japan EMT was affected to be less efficient.
- Security should be kept in mind during site operation. Considering the incidence that the Japanese EMT team leader was kidnaped, measures need to be taken to ensure EMT security. Security information should be communicated to all PHEOC and EMT in a reliable manner.
- In addition to the speed of referral process, the information regarding the vehicle load per trip was important in terms of planning and management of the number and severity of the patients.
- Language is the most common barrier during the operation.
- Foreign/Local volunteers and other health personals can be enhanced for effective contribution in emergency.

c. BPHER

18. The reports of the international EMT (I-EMT) deployment, operation and the management in three southern provinces were reported by Surat Thani Regional PHEOC to BPHER, National PHEOC with the observation of WHO. Surat Thani Regional PHEOC reported the status of impacts on casualty, I-EMT deployment capacity, infectious disease, and other public health problems, as well as challenges. Highlighted problems were communication among EMT and PHEOC, and ineffective transportation system. BPHER recommended to collaborate with the Regional Infection Control Office. Another administration challenge reflected from the field was the completion of standardized

forms for I-EMT which could interrupt the treatment. The suggestion from BPHER was to assist the I-EMT in explaining the form.

19. At the final stage, all I-EMT submitted the exit report to RDC at Suvarnabhumi Airport and left the country.

20. Ms. Sutapak Sulsabai, Policy and Plan Analysis from DDPM, appreciate the first RCD as it was important for Thai DDPM to be able to coordinate with health sector in emergency. Active participations of all EMT were very much beneficial for an effective drill. In actual disaster event, there would be other issues including physical and mental health issue when dealing with loss of family member and disability, therefore, collaboration is cross sectorial which DDPM would have to further their learning to include other sectors especially at the multi-national level.

21. On behalf of WHO, Dr. Richard Brown expressed appreciation to JICA and MOPH who invited several parties to the first RCD. As South East Asia is a disaster-prone region and the challenge on the scale and complexity of disaster, the drill would benefit the region's emergency response to disaster in collaboration with other countries. Although EMT at the national level are well-trained and prepared, the capacity may not be enough given the impact of vast areas. ARCH Project is crucial in supporting and empowering regional level coordination to achieve familiarity and guidance on practical steps towards I-EMT deployment. Spirit of AMS towards the One ASEAN, One Response initiative is prominent. Additional inputs to be considered could be the inclusion of clinicians on infectious disease to prevent post-disaster disaster outbreak. However, WHO is in full support for the project in response to WHO's EMT Initiative.

X. COUNTRY PRESENTATIONS

22. Following the group discussion in accordance with brainstorming guidance and template, each AMS presented the results of the group discussion. The guidance and template for the brainstorming are presented in **Annex VII**. And presentations of AMS could be referred in **ANNEX VIII**.

a. Brunei

23. **Program Evaluation:** Brunei reflected that the venue, the length, the format of the program was appropriate, especially the drill scenario was well-simulated and prepared although it needed more facilitation.

24. **Capacity Building:** Brunei may need more capacity building as the team is lacking all aspects of EMT coordination both in receiving and offering, thus trainings are needed.

25. **Coordination Process:** In the EMT coordination for this event, the process was clearly explained and simple although Custom, Immigration and Quarantine (CIQ) process should be acknowledged before the deployment. Communication between EMT and PHEOC, referral system and transportation were common challenges of the drill. For example, the number of people which can be loaded in certain vehicle (ship/boat/helicopter/ambulance) should be clearly stated.

26. **Reporting Form:** The registration form was easy to understand but not clear whom to submit to. Brunei team did not use forms of EMT-Minimum Data Set (MDS), Daily Report and Situation Report. The Referral Form was too complicated and not clearly explained; particularly the patient history part was difficult to find information. There should be free-text room in the medical record section. The Health Need Assessment (HNA) Form had some duplication and contains too many text boxes.

b. Indonesia

27. **Programe Evaluation:** Tsunami was a challenging scenario for the operation, but it was well-prepared. The overall program was successful.

28. **Capacity Building:** In management aspect, capacity to operate under a standard operating procedure (SOP), legal issue and WHO technical guidance should be developed. In addition to the AMS training by ARCH Project in the first stage, more knowledge can be obtained through academic conference and student exchange through scholarship grant.

29. **Coordination Process:** Logistic and other supporting technicians would make coordination process smoother. The process for EMT coordination among other sectors such as public health, security and social welfare should be clearer.

30. **Reporting Forms:** In MDS Statistics, referral patient in Type1 EMT should be included in outpatient or new admission. As for HNA format, the estimated total number of population should be included and indicator for food availability maybe revised other than the type of food provided. Also, the type of vaccination, serum and medication for dog and snake bites should be more described. Medical staff types can be categorised more detail. In the environmental health section for instance, cleanliness of water which may not be tested with bare eyes, confirmation will be need from public health sector.

c. Japan

31. **Program Evaluation:** TTX was useful to prepare teams for field exercise. The field exercise can be longer to reflect the actual field operation. In this case, presentations can be shortened to allow longer Q&A session and accommodate more time for the field exercise.

32. **Capacity Building:** JDR is the only type 2 EMT which all severe patients were referred to although the team did not have sufficient equipment. In the actual operation, type 2 EMT will not be adequate for covering the all trauma cases.

33. **Coordination Process:** Patients were being transferred with little/no background information. Referral system can be more developed for smoother operation. The management of public health issues such as animal bites, food poisoning, and management of corps as well as security-related issues required further development.

34. **Reporting Form:** Some terminologies in the referral form need to more clarifications, such as “assistance device provided”. In the referral form, “contact person” was recommended to be used

instead of “focal point”, JDR is developing an e-tally sheet to make daily report automatically. In future, it could be shared through a cloud server.

d. Lao PDR

35. **Program Evaluation**: All aspects of program are satisfactory.

36. **Capacity Building:** Capacity development programmes are necessary for legal matters, EMT coordination, institutional settings, international deployment arrangements, and roles and responsibilities of affected country for EMT coordination.

37. **Coordination Process:** There’s no further recommendation on the EMT coordination process as it was already well-organized.

38. **Reporting Form:** Some forms can be revised to be more concise, but those still keep important points.

e. Malaysia

39. **Program Evaluation:** The overall exercise was well-organized especially the usefulness of TTX. However, feedback may need more time for further improvement. In addition, the availability of tools can be more explained for more effective use with considering the influx of patients.

40. **Capacity Building:** There should be a standardized training material for new member in EMT on SOP. It would also benefit EMT to know function of other agencies under ASEAN during disaster within and outside the health sectors to avoid duplication and streamline the operations.

41. **EMT coordination process:** The well-versed instructions on command, control, coordinate, communicate can be useful in the overall operation. Health Need Assessment done by EMT can be quite overwhelming as EMT has a medical discipline, trainings on HNA will useful in familiarizing EMTs with the assessment. The result of the assessment should anyway be confirmed from the public health personals.

42. **Reporting Form:** The Medical Record should use bigger fonts and provide free-text space. Malaysia reflected that patients’ names required in the exit form is unnecessary and suggest change to only total number of patient. There was confusion in EMT registration form queries to whether it refers to in-country relationship or receiving country relationship. To make the flow of information goes more naturally, EMT member details should be placed in earlier section of staff details.

f. Cambodia

43. **Program Evaluation:** Overall arrangement of the program including venue, drill scenario, facilitation and instructions are satisfactory.

44. **Capacity Building:** Some training courses should be introduced for public health personnel such as legal provision, liability concern, SOP, and roles and responsibility on EMT coordination of the

affected country. Cambodia highlighted that curriculum of the regional training courses and student exchange programs among AMS need to be developed for long-term capacity building.

45. **Coordination Process:** There's no further recommendation in the EMT coordination process as all are satisfactory for Cambodia.

46. 26. **Report Form:** All EMT should ensure capacity to complete the relevant forms. In the Exit Form, part E, F and G are not necessary. Additionally, the font of farms particularly Tally Sheet should be bigger.

g. Myanmar

47. **Program Evaluation:** The field exercise should be three days for practicing actual reflection, trail- and error-process, actual clinical assessment. Shelters could be prepared with considering patients who had difficulty in working. In the preparation process, access to electricity should be ensured to enable communication devices including satellite phones and internet. Other aspect of the drill was very well prepared

48. **Capacity Building:** EMT were required basic knowledge to operate under legal agreement, SASOP, and other international cooperation arrangement. Given that different countries have different EMT capacity, international deployment agreement may not be complied by every country.

49. **Coordination Process:** In the case of phone communication loss, alternative communication approach e.g. satellite phone or radio should be considered.

50. **Reporting Forms**: Several forms required too many data which caused stress to the EMT. Guidance for forms completion can be attached at the back of forms or as separate attachment. Myanmar EMT had the problem completing the registration form as the team does not comply with several items. Exit form and HNA form were already well developed.

h. Singapore

51. **Program Evaluation:** The overall arrangement on venue and facility is good. The drill was very well executed although it was a one-week load of incident condensed into one day.

52. **Capacity Building:** A standardized step-by-step approach and simplified flow of work should be established to facilitate the process. Singapore suggested a set of instruction card for each action which are easily drown out such as supply request procedures, evacuation, radio operation, patient referral and others. However, TTX helped smother work flow in the ground. The briefing from PHEOC should be done using a map as reference. In addition, other EMT operating in surrounding area should be acknowledged about the existence of one another in case assistance needed.

53. **Coordination Process:** Communication among EMTs and EOC can be enhanced by two-way communication approach. Singapore's concern was on how EMT link with logistic supply. The

transport to and from the venue should be guided by local authorities. With the language barrier, patient identifications were difficult to obtained.

54. **Reporting Form:** The possibility of cloud or web based document template should be considered where the area has Wifi coverage to increase reliability and accuracy of entered information. Clarification of children's age is needed e.g. 5 year or older. The Exit Form and HNA form need free text space.

i. Thailand

55. **Program Evaluation:** The presentations should be shortened to allocate more time to the exercises. Form completion should be demonstrated and well-guided.

56. **Capacity Building:** Thailand agreed to all capacity building program listed by ARCH Project. However, additional subjects were proposed such as preparedness and measures for robbery, suicide attempts, electricity black-out. The authority responsible for curtain issues should be clearly identified e.g. PHEOC, local government and others.

57. **Coordination Process:** Radio can be one option, but the radio channel should be managed not to interfere each other. In the referral system, time and logistics management were paramount. Referral units should be able to calculate time consumption for each transportation as well as the suitable areas to load patients.

58. **Reporting Forms**: Type 1 and Type 2 EMT should have separate set of form to avoid confusion. Registration form may include information of all team members. Daily Report can be made more concise to cope with the number of patients that EMT need to concentrate on. The management among team should be better to handle Exit Report as there should be one person who can report the overview of the situation even though one may not be there from the beginning.

j. Philippine

59. **Program Evaluation:** There was a shortage of ambulance and the availability of supply. There should be more clarification on the role of entities involved in the referral process i.e., EOC, referral team, and referral hospital. For this, the referral directory can be useful, in addition to the establishment of Incident Command Center (ICC) as coordination point. CIQ should have a separate station to enhance the learning.

60. **Coordination Process:** It is suggested that universal radio language code to enhance effective communication especially the referral process among EMT. Moreover, protocol for reporting back to PHEOC should be strictly followed by EMT.

61. **Reporting Form:** Common feedbacks to the reporting forms are to increase font size, bold lines in each section. In Daily Report form, the answer boxes are very specific to EMT type 1 fixed and 2; several items are not applicable to EMT type 1 mobile. The risk assessment in the reporting form does not clearly reflect on the tally sheet. The HNA form should be filled in separately from one

village to another to include top ten consultations for mortalities and morbidities, solid and liquid waste management and breast feeding facility, source of water, types of toilet facility, number of population by age breakdown and others.

62. **Capacity Building:** EMT member should be trained according to the skill pyramid in the training courses which include radio operation and trauma management that fit EMT competencies.

k. Vietnam

63. **Program Evaluation**: Check list of availability of supply should be developed such as medical equipment especially pain killer and injection. Regarding the drill arrangement, facilitator skills can be enhanced to properly guide the flow of activities.

64. **Capacity Building:** Training Course on SOP and EMT Coordination could be introduced for the public health personnel in ASEAN.

65. **Coordination process**: There was a lack regular communication as well as local human resources, staff and availability of equipment and facilities. CIQ can be enhanced to inform the process to EMT in advance.

66. **Reporting form**: Rapid Neurology Assessment (AVPU) practice could be adopted in one of the reporting form. It is still unclear if EMT refers to WHO accredited type as referred to in several reporting forms such as EMT-MDS.

67. After all the presentations, representative from WHO mentioned that Registration form and the inquiry process are very useful within the team for both receiving country for tasking and the EMT that can be reflected in Registration form. As EMT type 2 referred patients to other location, such referral information should be reported to EMTCC in Exit Report. EMTCC observed that the referral process could be done correctly. However, the information received by all EMT types will post crucial information for EMTCC. In addition, EMTCC should emphasize facilitation on coordination of N-EMT and I-EMT as well as guiding throughout the process.

68. AHA Centre congratulated the Project Team for successful simulation exercise which had built capacity AMS in deployment experience. The design of the exercise was excellent, from TTX to the field exercise in rotations to many tasks and missions. An idea to consider for next drill was to have a debriefing session to allow EMT to reflect on their own operation to foster learning. Emergency response is as if a project management in brief timeline where management of team member, resources and time are to be considered. This time, F imitates actual disaster situation where challenges related to communication media, security, supplies, sanitation, food and shelter occurred. These issues can be considered to improve preparation of the next RCD. Disaster Health Management is an important initiative which includes not only emergency medicine but also other aspects such as public health, communicable disease control, media management, and security.

Nonetheless, all aspects need integration under All Hazard One Approach and One ASEAN, One Response.

XI. SUMMARY

69. Ms. Keiko Nagai made a final summary of the after-action review of the first RCD with the highlighted objective to conduct the test on the use of common forms. According to the cycle of Plan, Do, Check, Act (PDCA) framework, the first RCD has achieved all target. During the planning process, Thailand PHEOC has collaborated with other sectors including DDPM and MOFA. The plan was put into action through TTX and the field exercise. Through the review session, all the participants and the Project Team could draw valuable lessons to achieve the exercise objective, to practice the use the common forms. Thailand will share the experience in hosting RCD to Viet Nam and the Philippines which will host the second and third RCD consecutively. The presentation document can be referred in **ANNEX IX.**

XII. CLOSING REMARKS

70. Dr. Jirot Sindhvananda delivered a closing remark by expressing sincere appreciation and gratitude for every party which contributed to the success of the first RCD. The experience on the drill will guide EMT with different backgrounds to common expectations, preparation and training towards effective coordination in the field.

Part 2 Project Working Group (PWG) Meetings

XIII. OPENING REMARKS

1. Dr. Jirot Sindhvananda, the chair, delivered welcome remarks. The second meeting of PWG 1 which was held in May 2017 covered discussions on the draft regional collaboration tools and the ASEAN Leaders' Declaration on Disaster Health Management. The first meeting of PWG 2 in January 2017 had discussed the plan for the first AMS Training which was conducted in May 2017. Both PWG 1 and 2 meetings would continue the discussions on the mentioned topics with PWG 1 objective to gather feedbacks on the latest version of four tools and PWG 2 objective to discuss further planning of AMS Training. The chair declared the opening of the meetings and wish participants for fruitful results.

XIV. OVERVIEW OF ARCH PROJECT

2. Dr. Phumin Silapunt presented background, relevant ASEAN initiatives, scope, objective, expected outputs, and implementation process of ARCH Project. The presentation document can be referred to in **ANNEX X.**

XV. CONCLUSION AND RECOMMENDATION FROM THE FIRST REGIONAL COLLABORATION DRILL

3. Dr. Yasashi Nakajima made a presentation on review of the Start-up Drill and the first RCD. The review the Start-up Drill was intended to identify gaps of both individual and team assessing 1) team capacity; 2) individual capacity; 3) intra-team collaboration and; 4) inter-team collaboration using common forms. All capacities and skills will constitute ARCH Project pyramid model from the first, second and third layer underlying the One ASEAN, One Response. In the review of the first RCD, all teams provided feedbacks based on; 1) program evaluation, 2) coordination process, 3) capacity building, and 4) reporting forms. Through the presentation by each country team, some comments were made for further improvement of the relevant forms, management of referral system, further capacity development on necessary knowledge and skills. In addition, the knowledge about other agencies that function within ASEAN will enable EMTs to operate more effectively in the field. Based on discussion in the review workshop, some key factors of the pyramid model were modified. The presentation document can be referred to in **ANNEX XI.**

XVI. THE THIRD PWG 1 MEETING

a. Session 1: Introduction

4. After the self-introduction of participants, Dr. Jirot Sindhvananda, reviewed and summarized the agreed points from the second Meeting of PWG 1 in May with a focus on the four (4) kinds of Regional Collaboration Tools; SOP for Coordination of EMT in ASEAN, Health Need Assessment (HNA) Framework, Database of EMTs in ASEAN, and Minimum Requirements for EMT Members. Then, Dr. Sindhvananda presented the objectives of this third Meeting of PWG 1, which are to discuss the Regional Collaboration Tools, to provide inputs for further development of the tools, and to reach consensus and agree on the way forward until the next meeting of PWG 1 in November 2017. The presentation document can be referred to in **ANNEX XII.**

b. b. Session 2: Regional Collaboration Tool (1) - Standard Operating Procedure (SOP) for Coordination of EMT in ASEAN

5. Ms. Junko Yamada explained the progress of development of SOP. The current draft version 0 was developed by incorporating the inputs and feedback from the second Meeting of PWG 1 as far as possible. The inputs included 1) SOP is a component of and aligned to SASOP and AJDRP; and 2) Project Team will consolidate feedback from the Meeting, and consider: a) Articulation of scope and limitation of the SOP in the introduction section; b) Presentation of process flowcharts; and c) Role of affected and assisting countries.

6. Then, Ms. Yamada presented the draft version 0 by focusing Chapters I. Introduction, II. Institutions, III. Disaster Preparedness and IV Emergency Response. The presentation can be referred to in **ANNEX XIII.**

7. To collect necessary information for Section A “National Focal Points for Emergency Medical Team (EMT) Coordination” of Chapter III., AMS representatives were asked to present its in-country mechanism of EMT coordination including the national focal point. The presentations were made based on the format which was created by the Project Team. The presentations can be referred to in **ANNEX XIV.**

8. The points of discussion are summarized as followings:

- The scope of the SOP needs to be further defined. Currently it is illustrated in Figure 1, and briefly indicated in Paragraph 4 (‘areas covered’). It is suggested that these are further elaborated. Also, in practice, national and international EMT interact and cooperate in the field. Connecting National EMT (N-EMT) and International EMT (I-EMT) through an arrow is suggested.
- There are operational linkages with the ASEAN EMT and military medical services. Re-phrase Paragraph 5 to indicate coordination with military EMT, as well as EMT of other organisations.

- ASEAN EMT register with health authorities of the affected country and/or through AHA Centre. Revise Paragraph 18.
- Form 7 of SASOP (Final Report from Assisting Entity to AHA Centre) shall serve as reference for ASEAN EMT in the preparation of final report to be submitted to their own National Disaster Management Office (NDMO).
- The Public Health Emergency Operations Center (PHEOC) referred to in the SOP are Emergency Operations Center (EOC) at different levels that under the Ministry of Health/health authorities responsible for the coordination and management of health aspects of disasters. This is may need to be highlighted considering that these are named differently by AMS.
- Considering procedures in offering and receiving international assistance, which engages diplomatic/policy, as well as operational (in this case sector health) channels, the SOP may consider mechanisms that facilitate expedient activation and deployment of EMT.

9. Regarding the next step, PWG 1 members will provide feedback to the draft version 0 by 11 August 2017. The Project Team will draft the version 1 by incorporating the inputs and comments from PWG 1 members. The draft version 1 will be distributed to PWG 1 members by October. By the 4th Meeting of PWG 1 in November, PWG 1 members will provide inputs to the draft version 1.

c. Session 3: Regional Collaboration Tool (2) - Health Needs Assessment (HNA) Framework

10. Ms. Yumiko Kashiba presented the recommendations on the draft HNA version 0 and agreed points on the HNA framework in the second PWG1 meeting. The key points of suggestions and recommendations include: 1) HNA should focus on health aspects related to EMT activities and should be more concise; 2) the users of the information collected through HNA should be clearly identified; 3) HNA should be designed to complement and not duplicate the task of ASEAN ERAT; and 4) the main role of EMTs is to provide medical services and save lives, therefore HNA should be a supporting role of EMTs. The agreed timing to conduct HNA could be after the acute phase of disaster; however, it can be conducted at any critical time of disaster if required or requested by local authorities.

11. The revised draft, version 1 is more concise, focusing on health aspects, but also includes water, sanitation and hygiene (WASH), food security, nutrition and shelter. The version 1 was tested in the first RCD and feedbacks were received from each AMS team. Many of the drill participants think that HNA should be a supplemental role of EMT. Other feedback and recommendations were: 1) public health personal should be included in EMT if EMT are required to conduct HNA; 2) training for selected members of EMT in HNA may be needed; 3) coordination with other clusters should be considered; 4) the information on other clusters should not to be too detailed in the HNA form; and 5) the current draft form should be improved and some of the definitions and indicators should be refined. The comments received from this third PWG1 meeting will be incorporated into the HNA draft version 2. The revision will be shared with the PWG1 members in August and further

comments will be expected by mid-September. The revised HNA draft version 2 will be tested in the second RCD in March 2018. The final draft version will be presented in October 2019. The presentation document can be referred to in **ANNEX XV.**

12. The meeting had discussed and provided the following comments;

- The chair suggested that the instruction or guide which showed how to conduct HNA be attached to the NHA form.
- Psychological and mental aspects of EMT members should be addressed.
- The age categories in the draft HNA form should be changed according to those widely used for mortality, e.g., Under 5 Mortality.
- Although only a concern of duplication of work between ERAT and HNA by EMTs was raised, two parties can complement each other and work together.
- Local PHEOC may request EMT to do HNA, and in that case, EMTs should have capacity for HNA.
- The function of EMT to conduct assessment was not stated in WHO EMT guideline, so EMT should focus on deviling health services. Instead, the receiving country should conduct HNA to dispatch EMT to appropriate areas.
- It is true that affected countries conduct a rapid assessment; however, HNA by EMT will complement such assessment and also ERAT; so if EMTs have time and capacity, HNA by EMT will be helpful.
- The chair stated that the main role of EMT was to provide medical services so that conducting an assessment can be one of the options for EMT. However, in the field, if someone can do an assessment, that will benefit to the others.
- EMT may provide both clinical and public health services. In fact, “EMT plus” includes public health services including NHA on the top of the WHO EMT definition.
- According to the WHO diagram, the situation in the affected area will quickly shift from the trauma cases during the first two weeks to more public health needs such as infectious diseases. Therefore, in terms of the role of EMTs in HNA, we should consider timing and length of period of the deployment (e.g., a few weeks or a few/several months), which might depend on their capacity and decision of the authority. Also, it will be ideal that public health personnel with emergency experience is a part of EMT.
- If EMT will have a role of HNA, the training for EMT should include public health aspects. It should be build consensus among AMS.
- Reliability of information of could be concerned. EMT can conduct HNA within an available capacity under limited resources, but the information should be later confirmed with public health teams or concerned cluster teams. And the operation should be left to such concerned teams in case there is no public health personal in the deployed EMTs.
- The type of food cited in the NHA form should be revised according to ASEAN context.

- HNA information could be useful to EOC. Among three options proposed by the Project Team, handing detailed information of HNA to PHEOC may be agreed. However, it should be discussed further.

d. Session 4: Regional Collaboration Tool (3) - EMT Database in ASEAN

13. Ms. Junko Yamada reviewed the agreed points at the second meeting of PWG1 in May 2017 and introduced the objectives of this session. This session aims 1) to present a proposal from the Project Team based on the result of consultation with the AHA Centre; and 2) to discuss and agree on the way forward of database. Then, she presented the proposal for the database development. The Project Team proposed that the database be managed by the Project Team and the data collection be conducted by the PWG 1 members in total of four times during the project period. An exit strategy will be discussed for an endorsement by RCC. The database will include data on government military and non-governmental EMT organization. However, the scope of data collection will be at the discretion of each member state.

14. The purposes of database were proposed as follows: 1) to strengthen the regional disaster preparedness by providing the up-to-date information on EMT assets and capacities potentially available for deployments to the affected country; 2) to inform the discussion for setting up the coordination platform on disaster health management (Output 1 of ARCH Project); 3) to facilitate the identification of EMT assets and capacities for mobilization and the future decision making and action for enhancing EMT assets and capacities by stocktaking the current status and update of the progress; 4) to enhance health response to disasters by providing information about EMTs in advance; 5) Complement AJDRP by possibly speeding up the process of identification of EMT assets and capacities and; 6) contribute to the operationalization of SASOP and the implementation of AJDRP for the realization of “One ASEAN, One Response” in the spirit of AADMER.

15. The Project Team also proposed the schedule of database development. According to the proposed schedule, the draft version 0 will be presented in the fourth meeting of PWG 1 in November 2017. Finally, the draft database is to be prepared with defined criteria and data categories and approved by the third RCC in March 2018. The presentation document can be referred to in **ANNEX XVI.**

16. The points of discussion are summarized as followings:

- The database intends to capture EMT regardless of WHO Global Classification status.
- Proposed EMT DB matrix contain limited information, more data categories need to be included, as well as inclusion criteria for organisations to be included in the DB (particularly NGO).

e. Session 4: Regional Collaboration Tool (4) - Minimum Requirements for EMT Members

17. Ms. Junko Yamada presented the progress of the development of the Minimum Requirements for EMT members. The objectives of the session are; 1) to review the draft version 0 and seek comments and feedback from the PWG 1 members; and 2) to agree on the next step until the 4th

Meeting of PWG 1 in November. Subsequently, Ms. Yamada presented the draft version 0 which was developed based on the results of questionnaire survey in April 2017.

18. The Minimum Requirements consists of 3 Tiers as already presented in the previous two PWG 1 meetings; Tier 1 Professional competence and license to practice; Tier 2 Adaptation of technical and non-technical professional capacities into low resource and emergency context and; Tier 3 Preparation for and effective team performance in the field. The current draft version 0 covers Tier 1 and has five (5) chapters including purpose, scope, key terms and terminology, structure of the document, and Tier 1. After the brief explanation of each chapter, the Project team invited the PWG 1 members for their comments and inputs.

19. Lastly, Ms. Yamada presented the next step until the 4th Meeting in November. The PWG 1 members will provide inputs and feedback to the draft Version 0 by 11 August 2017. The Project Team will incorporate inputs and feedback into the draft version 1 and distribute it to the PWG 1 members for review in October 2017. The presentation document can be referred to in **ANNEX XVII.**

20. The points of discussion are summarized as followings:

- Current version focuses on Tier 1 of the minimum requirements. Tiers 2 and 3 will be further defined in future versions.
- Each deployed EMT is expected to be self-sufficient. Therefore, EMT composition includes logistics, administrative and other non-health staff.
- Some AMS have medical teams which are fully operated by health staff. The ASEAN may need to explore mechanisms in the provision of logistics and admin support.

f. Summary of Discussions and Agreements

21. The Project Working Group 1 members had discussed and agreed on the details of four Regional Collaboration Tools; SOP, HNA Framework, Minimum Requirements, and Database of EMT in ASEAN. The summary of decisions and agreements is as follows:

1) SOP for the Coordination of EMT in the ASEAN

- AMS that have not completed the 'request for information on in-country mechanism for EMT coordination' to submit accomplished form by 11 August 2017.
- AMS will provide feedback on the draft SOP via e-mail by 11 August 2017.
- Project Team will circulate updated version to PWG 1 Members in October, after incorporating feedback from PWG 1 Members, and participants of the First Regional Collaboration Drill.

2) Health needs assessment framework

- ASEAN EMT role is primarily the delivery of medical services. The delivery of public health services is an option depending on their capacity. Hence, the conduct of health needs assessment is supportive and if there is capacity to address pressing needs assessment gaps.

- Revise the form to be aligned with ASEAN context (such as food basket composition) with instructions and guidelines.
- Revised form will be shared with PWG 1 Members in 11 August.
- PWG 1 Members to provide feedback by 08 September.

3) Database of EMT in ASEAN

- PWG 1 Members to propose categories for the database, and criteria for inclusion of organisations in the database by 11 August.
- Project Team to review inputs and propose a data collection form, and circulate the draft form by 15 September.
- PWG 1 Members/AMS to provide feedback on the form by 02 October.
- Project Team to finalise the form and circulate to PWG 1 Members/AMS for collection of data by 09 October.
- PWG 1/AMS to submit completed form by 27 October.

4) Minimum requirements for EMT Members

- PWG 1 Members to submit feedback to the draft minimum requirements by 11 August.
- Project Team to consolidate feedback and produce version 1 by 20 October.

5) Next Meeting

- The fourth meeting of PWG 1 was proposed by the Project Team from 2 to 3 November 2017 (1.5 days). PWG 1 Members will internally consult with their offices and get back within a week (by 27 July) on their availability of these dates. If there are conflicts in schedule, PWG 1 members shall propose alternate dates between 30 October and 3 November.

XVII. THE SECOND PWG 2 MEETING

a. Introduction

22. Dr.Narain Chogirosniramit, the chair greeted all participants of the second meeting of PWG 2. He reiterated program and agenda of the meeting as for; 1) to share the outcomes and feedback of the first AMS Training in May 2017, 2) to discuss and agree on the plan of the second AMS Training in November 2017, and 3) to discuss and agree on the revised plan of upcoming meeting of PWG 2. The presentation document can be referred to in **ANNEX XVIII.**

b. Report on the First AMS Training

23. Dr.Narain Chogirosniramit began the session with a review of the first AMS Training in Chiang Mai, Thailand between from 22 to 26 May 2017. Twenty five (25) participants were engaged and lecturers were invited from Indonesia, Malaysia, Philippines, Singapore, Thailand, Vietnam and Japan. The presentation can be referred to in **ANNEX XIX.**

24. Day 1 offered a chance for each AMS to introduce the current system of human resource development on disaster health management, both pre-service and continuing professional development (CPD). Day 2 involved the discussion on best practices in both pre-service training and CPD. On Day 3, the current CPD system of Japan was introduced and an educational simulation game in the form of TTX called “Thai Sim” was executed. The entire Day 4 was dedicated to a site visit at Faculty of Medicine, Chiang Mai University. Sessions on the last day were workshop on the “standardized” training/knowledge in disaster health management for both the national level of each AMS and the regional level. Course evaluation was carried out by the end of the session.

25. Dr.Narain Chogirosniramit explained the objectives of the first AMS training. The objectives were set as; 1) To understand the current training system for human resource development in disaster health management; 2) To identify the issues and challenges of the current training system in each country; 3) To share the best practices in capacity development and related training courses conducted by other countries and stakeholders; 4) To identify the priority areas in each country for planning effective human resource development program to strengthen capacity of AMS on disaster health management; and 5) To understand how to set up the training system on disaster health management system.

a. Highlights of each training days

26. The highlighted activities and training content of each day included the following;

Day 1: A presentation from each AMS on current training system in DHM and challenges within the country received a positive feedback from participants in term of experience sharing.

Day 2: Presentations on Best Practices in Pre-service Training and CPD in ASEAN were carried out with lecturers invited from 5 different countries on 5 interesting topics, namely;

- Indonesia: Disaster Management for Health Cluster Faculties in University of Indonesia

- Malaysia: Advanced Diploma in Emergency Care
- Philippines: Country Adaptation of the ADPCs PHEMAP Training
- Singapore: EMS and EMT Training in Singapore Civil Defence Force
- Viet Nam: Basic Public Health and Emergency Management Course for Bachelor of Public Health Students

Day 3: In the morning session, lectures on CPD in Japan were presented by 3 presenters, focusing on human resource development for disaster medicine, disaster nursing and the role of Japanese Disaster Medical Assistance Team (DMAT).

In the afternoon, a tabletop exercise relating to CPD in Thailand called "Thai Sim" was conducted with assistance from Thai Side. This educational game aimed for the participants to learn about real time disaster management. The session received a positive feedback from all participants such as acknowledgement on differences among AMS in managing disaster medicine and better understanding on the procedures during disaster response.

Day 4: Participants paid a visit to Faculty of Medicine, Chiang Mai University. Three main topics focused on the day were 1) Disaster preparedness for Earthquake in Chiang Mai 2) Drill 2017 for mass emergency response in Maharaj Nakorn Chiang Mai hospital 3) Visit Emergency Care Room.

Day 5: In the morning, there were two discussions. Firstly, discussion was held by country to answer whether they got some new idea during this AMS Training and how to apply those newly-acquired in each country. Then, a following discussion was divided into 4 groups (by profession) to attempt to answer whether it is necessary to establish the common module in ASEAN for human resource development in DHM. All groups addressed the necessity to establish the common module in ASEAN.

c. Participants' Feedbacks from the first AMS Training

27. The number of respondents to the questionnaire survey of the first AMS training was 19 out of 25 participants. The results are as indicated below. For extensive detail, please refer to **ANNEX XX.**

28. Main responses from the evaluation on program output are as followed; 1) good sharing experiences among AMS 2) valuable chance to learn how to conduct DHM course as well as develop curriculum, certification system and skill standard. Nevertheless, there were some participants who still did not fully understand about the training system and need further clarification on the subject.

29. On program design, the feedbacks were as followed; 1) the design of training course was appropriate to achieve the course objectives 2) the length of the training was appropriate with some disagreement that the course was a little too long 3) the number of participants was appropriate 4) the course allowed each member to have enough direct experiences such as site visit and practices. However, 3 from 19 participants felt the opportunities were a little too few. 5) Almost all of

participants had enough opportunities to participate actively. 6) All participant saw the quality of the lectures was good enough to understand clearly.

30. Requests for the second AMS Training were made on 1) modified or simplified version of DMAT or MERT training 2) the next training should focus on how to develop EMT and train them 3) AMS must possess useful tools, skill and knowledge needed for EMT responding to a disaster in other country 4) AMS should focus on the most feasible goal. That is for each AMS to have at least one Type 1 mobile team or Type 1 fixed team that could respond both in the local setting and in international deployment. 5) Database, logistic deployment plan, and standardized DTM must be developed. And lastly, 6) participants of the second AMS training should consist of medical team, EMT team leader, same participants as the first AMS Training (for continuity in action), developer of EMT (for proper guidance), and more doctors and nurses who work directly in DHM.

31. The feedback included important suggestions such as developing clear objectives on scope of training before the implementation such as setting a focus on acute or delayed phase.

d. Plan for the Second AMS Training

32. Ms. Junko Sato began with the session's objectives that were to discuss and agree on the detailed plan, as well as to share the schedule of the second AMS training in November 2017. She restated the overall goal of the AMS training and expected the national capacity would be strengthened after the completion of all four trainings. The presentation and reference documents can be referred to in **ANNEX XXI.**

33. Proposed dates of the second training will be November 5th – 8th, 2017. All participants are asked to share any objections before the confirmation. This upcoming event will consist of 4, instead of 5 training days and the 5th day will be dedicated to the third PWG2 meeting. The venue will in Bangkok, Thailand and there will be 3 representatives from each AMS.

34. The theme of the training will be on Capacity Development of Emergency Medical Team with a special focus on "On-site Team Management". There are 4 tentative objectives as followed; 1) To understand what EMT is expected to do when deployed to disaster area 2) To get knowledge and skills required for team management when deployed 3) To learn the training system of EMT and 4) To evaluate this training course as a first step for standardized ASEAN EMT Training. Since there was no standard training mojo in ASEAN for DHM, all participants from the first AMS training agreed to have a standardized version of the training program.

35. Representatives from the Philippines suggested to add competency into 2) objectives to build an effective domain for right directions of disaster management. Targeted participants from each AMS, in principle, consist of 1 doctor, 1 nurse and 1 paramedic. Due to differences among AMS, it is ultimately up to the countries to choose their representatives. Preferably, there should be at least 1 person who can train EMT in each team (e.g person who completed the initial. Selection criteria of each attendance are as followed; 1) At least 3 years' experience on DHM and emergency medical

system, 2) At least Bachelor's degree holder in health sector, 3) Good command of spoken and written English, 4) Must attend all 4-day-training program, 5) To be under 55 years of age, and 6) Use for non-military purpose.

- Current duties: The Philippines suggested to specify the exact role of each participants from AMS to get different perspectives i.e. 1 team leader (to set directions), 1 team member, 1 actual deployment person. Agreed by other AMS, selection criteria should rather not be based on profession, but on actual responsibility. Language skill of nurses and paramedics in some AMS can be the barrier of training. Thailand added that good English proficiency of each participant must be compulsory.
- Educational background: In some AMS, nurses and paramedics may not obtain bachelor degree. Thus, the agreement was made to have at least one of the three members, who holds a bachelor degree. Malaysia suggested to add the word, "Preferable" into the selection criteria to have more flexibility for each AMS condition.
- Age: Singapore disagreed with age criteria as it is a form of discrimination. Putting "preferable" would be a good solution on this issue.
- Use for non-military purpose: ASEAN secretariat required on clarification of the use for non-military purpose. The chairperson explained that this is the requirement from JICA that all trainings and developments will not be used in the military purpose. The agreement was made to rephrase it to be non-military personnel.

36. In sum, the chairperson suggested to divide the selection criteria into 2 categories as;

- Compulsory: Good language skills, Attendance must attend the entire 4-day-training, Non-military personnel
- Preferable: Current duties (and profession), Educational background, Under the age of 55

37. Before the morning session ended, group discussion was separated into 3 groups and each one Japanese advisory committee member joined in each group namely;

    Group A: Indonesia, Philippines, Thailand
    Group B: Brunei, Malaysia, Singapore
    Group C: Cambodia, Lao PDR, Myanmar, Viet Nam

38. The objectives were to discuss possible topics for the second AMS Training and the outline of tentative program with the main theme of team management capacity. Each group must select one presenter, one facilitator and one note taker for the upcoming presentation.

e. Presentation on Plan for AMS Training

39. The proposed plan by each group is summarized as follows:

GROUP C: Cambodia, Lao PDR, Myanmar, Viet Nam

The proposed plan was separated into two categories; skills and knowledge and practice. Despise some disagreement among group members; Group C produced the summary as follows:

Table: Training Topics on Skill and knowledge

No.	Topics	Duration (hours)
1	On-site assessment (Situation analysis, health need assessment)	1
2	Emergency practical skills (the 3T – Triage, Treatment & Transport)	2
3	Team management skills (Leadership, team building)	1
4	Safety & Security	1
5	Documentary management skills (Recording, reporting and analysis)	2
6	Communication equipment use	1
7	Coordination and collaboration	1
8	Supplies & Logistics Preparedness	2
9	Survival skills in the affected areas	1
Total		**12**

For practical aspect, Group C emphasized on the practice of 3"T" Simulation, Communication Equipment Use, Reporting (standard form), Coordination (among team members and among different teams), Field Visit (EMS Center) and Tenting or Camping. Each topic takes approximately 20 minutes.

GROUP B: Brunei, Malaysia, Singapore

The proposed plan was brainstormed through the major medical events and incident activation process of each AMS of group B. The presenter proposed different topics on skill and knowledge requirement to be lectured during the morning sessions of Day 2 and Day 3, while the afternoon sessions of both days will be dedicated on tabletop exercises. Day 4 will see a simulation on disaster management. Details of Group B discussion are as follows:

Day 2: Morning lecture will focus on 1) Activation and response when disaster occurs, focusing on domestic disaster 2) Roles of medical team consisting of doctor, nurse and paramedics as well as leadership assignment 3) Preparation of medical team on physical equipment and psychological condition and 4) Reporting on disaster site. Lecture on each topic will take approximately 30 minutes.

In the afternoon session, the first 2 hours will focus on putting skill and knowledge from the AM session into tabletop exercise such as activation and response when domestic disaster occurs, deployment of medical teams and reporting from the site. The last hour of the session will be a class lecture on radio communication and actual demonstration on how to use the walkie-talkie radio device.

Day 3: Morning lectures will focus on On-site Process, or CSCATTT concept (Command and Control, Safety, Communication, Assessment, Triage, Treatment, Transport) Skill stations will be conducted in the first 2 hours of afternoon session with 25 minutes in each session. Topics are as followed; 1) radio communication 2) field triage 3) patient assessment and treatment 4) medical record (documentation). Afterwards, the table-top exercise will focus on evacuation process of the patients.

Day 4: A huge simulation will be conducted, which allows participants to apply the skills and knowledge from the first two days into practice. Training members will be divided into groups and participate in the simulation as a whole scenario.

GROUP A: Indonesia, Philippines, Thailand

Day 1: In addition to the topics that have been mentioned in the outline, Group A members suggested to add some other topics such as legal basis for EMT, ICS country adaptation, EMT-based structure/organization, and example of practice (drill, exercise, tabletop and simulation). The objectives are to learn from the experience of each AMS, and to prioritize on fundamental sessions. Each AMS will have 10 minutes for presentation, and 5 minutes of Q&A session. Facilitators will synthesize and summarize after all presentations.

Day 2 and Day 3: The focus will be on EMT management for on-site team deployment. Mission is defined for each EMT on what to do and how to deploy. The discussion is summarized into the following table.

Table: Summary of Proposed Curriculum

Curriculum	Reason
Definition, mission/objective of EMT	• To define for each EMT on what to do and how to deploy.
Team dynamics	
• Team Composition/ Team Building	• To put an order on EMT deployment in a given scenario (which team goes first, next and last) • To support communication among team members and among different teams
• Competencies – Basic Knowledge, Skills, attitude each EMT member (Interpersonal Skills)	• To identify appropriate team with specific skills to match the need during the actual disaster • To prevent conflicts that may arise due to lack of interpersonal skills
• Roles and Responsibilities	• To determine team leader and roles/responsibility of each EMT member.
Guidelines and procedures for team deployment including safety, security, welfare of the team	• To emphasize on step-by-step procedure on team organization and deployment, by following checklists

Curriculum	Reason
Basic principles on the various systems for team deployment	
• Information Management System	• To ensure team members know what, when, how and to whom to report to, during the deployment.
• MCI Management: Cs = command + control, coordination, communication, and collaboration • 3 Ts = Triage, Treatment, and Transport	• To ensure familiarity on the MCI Management for all EMT members
• Logistic management system	• To identify minimum requirement for deployment during disaster to be self-sufficient and self-reliant
• Code alert system	• To determine the best time to deploy
Post deployment evaluation (including PFA)	• To evaluate on how well the EMT responded in the event and to identify strength, weakness and suggestion for protocol development and improvement
Scenario building	• To train participants on how to conduct future training

Day 4: Both morning and afternoon sessions will focus on the application of acquired skill and knowledge into practice on how to manage scenario, and to decide which type of EMT to be deployed. The sessions' emphasis is on basic principles in responding to special situation. Then, advance deployment procedures will be in play. For example, CBRNE, outbreak/epidemics, emerging or re-emerging infection disease.

40. After presentations of all group were completed, suggestions and comments were made;

- Many similar topics were found among the suggestions from all the three groups such as team management skill and preparation of medical team.
- ASEAN secretariat representative though the presentations from three groups were very comprehensive and questioned whether the participant tended to focus more on response aspect, rather than team building aspect.
- Team preparation should include both physical aspect (person equipment) and psychological aspect (stress coping).

f. Proposed Plan for the Second AMS Training

41. After the break, Dr. Chogirosniramit proposed the draft topics to be lectured/ discussed during the second AMS Training as shown in the following table.

Table: Summary of Proposed Draft Training Programme

Days	Topics
Day 2	1. Definition/ mission / objective of EMT Role of the medical team: leadership, composition and responsibility 2. Preparation of the medical team: equipment, competency building, psychological preparation 3. Activation and response: deployment of the medical team On-site assessment (situation analysis, health need assessment) 4. Supplies and logistic preparation 5. Documentary management skill (recording, reporting and analysis)

Days	Topics
	6. Security: survival skill, welfare of the team, PFA (Psychological first aids to the responder and community) 7. Management of dead and missing person CBRNE (Scenario based)
Day 3	1. CSCATTT concept C - Command and control C - Communication T – Triage S - Safety A - Assessment T - Treatment T- Transport
	2. Practice 1) Communication tools (Radio: How to talk) 4) Transportation/referral/coordination 2) Field triage 5) Tenting (Shelter) 3) Documentation (Forms)
Day 4	Morning session: simulation day Afternoon session: after-action review (AAR) and wrap-up

42. Some comments and suggestions were made for adjusting the proposed plan of the second AMS Training.

- Some of the proposed lectures should be conducted as scenario-based discussion, due to limited attention span from long lecture session.
- Transportation should end with referral because you need to transfer in the end.
- Suggested topics for Day 1 training will be assessed and the final schedule of Day 1 will be sent to participants for review/approval.
- Representative from Brunei stressed the importance of radio communication as necessary skills to be learned and practice (how to identify yourself and address the matter) to avoid radio jam during disaster event.
- Post-incident evaluation should be conducted at the end of day 4.

g. Plan of Upcoming Activities of PWG 2

43. Ms. Sato informed the objective of the session, which is to discuss and agree on the proposed/revised plan of PWG2 activities. There were two agenda as for; 1) AMS Training and 2) PWG2 Meeting.

1) AMS Training: 1st Training: May 2017 (completed)
2nd Training: November 2017
3rd Training: May 2018
4th Training: November 2018

The theme of the second AMS Training is on capacity development of emergency medical team. While initially the theme of the third AMS Training was on capacity development of government, it has not been confirmed as the theme can be amended based on the output of second AMS

Training. The theme of the fourth AMS Training will be discussed in the third PWG2 meeting. The presentation can be referred in **ANNEX XXII**.

2) PWG2 Meeting

Ms. Sato proposed to add two more PWG2 meetings (five in total) and to change Day 5 of the second AMS Training (conducted on November 2017) to be the third PWG2 meeting. There was no objection on the two additional meetings.

XVIII. SUMMARY OF DISCUSSIONS AND AGREEMENTS

44. Dr. Chogirosniramit wrapped up the second PWG2 Meeting. Main discussions included participant introduction, feedback on first AMS training, group discussion for 2.5-day programme (Day 2, 3 and 4) in the second AMS training to be held from 5 to 8 November 2017, and finalizing date of the third meeting of PGW 2 on 9 November 2017. The Project Team will finalize the schedule and name of the lecturers, before sending to participants for approval. The invitation letters of the above events will be separated because participants of the training and the meeting are not the same persons. The Invitations of the third meeting of PWG 2 and the second AMS training will be sent around 8 weeks before the event. Lastly, Dr. Chogirosniramit closed the meeting and showed appreciation to all participants.

Part 3 Regional Coordination Committee Meeting

I. OPENING REMARKS

1. 4. Dr. Jirot Sinhvananda, greeted and express appreciation to AMS, ASEAN Secretariat, JICA, and the Project Team. RCC is the coordinating body which oversees the implementation of ARCH Project. In the second RCC, the committee member gathered to acknowledge progress of the past nine months since the first meeting of RCC, as well as to exchange views on the on-going project activities and the ASEAN Declaration on Disaster Health Management. The meeting had paved the way forward to achieve the outcome of ARCH Project as well as the recognise on the initiative of One ASEAN, One Response.

II. OVERALL PROGRESS OF ARFCH PROJECT

2. Ms. Keiko Nagai outlined the framework of ARCH Project and reported progresses along with the five expected outcomes as follows:

   Output 1 Coordination Platform: The first and second RCC meetings were conducted. TOR of RCC was endorsed in the second ASEAN Health Cluster 2 Meeting on November 2016.

   Output 2 Regional Collaboration Framework: The Start-up Drill was conducted to develop a prototype of RCD (January 2017). The first RCD was designed and conducted under strong initiative of Thai Project Team (July 2017). Some AMS have presented their interest to host the second and third RCD.

   Output 3 Regional Collaboration Tools: The draft version 0 of SOP, Minimum Requirement, and Health Needs Assessment have been prepared and shared with PWG 1 members. The content and management of database for EMT are under discussion.

   Output 4 Academic Networking: The project outline was to be presented in the 13th Asia-Pacific Conference on Disaster Medicine (APCDM) in Bangkok, of Radiation Emergency Medical Preparedness and Assistance Network (REMPAN) in South Korean, Japanese Association for Disaster Medicine (JADM) in Japan, and World Association for Disaster and Emergency Medicine (WADEM) in Canada.

   Output 5 Capacity Development: The first AMS training was held focusing on human resource development for emergency medical team by the planning of PWG 2 members. The second AMS training in November 2017 has been under preparation.

3. Ms. Nagai also mentioned that the major upcoming activities in November 2017 are the fourth PWG1 meeting, the third PWG2 meeting (newly proposed), and the second AMS Training. PWG 2 proposed to have two additional meetings to ensure the completion of training content. Proposed period of the additional PWG 2 meeting are November 2017 and after March 2018 (tentative).

4. During the second RCC meeting, discussions and acknowledgement would like to be met on the following topics: communication approach among AMS; official focal points of ARCH project in each AMS; and future vision of the regional coordination platform on Disaster Health Management. The presentation document for this section can be referred in **ANNEX XXIII.**

5. ASEAN Secretariat mentioned that the progress and outputs of ARCH Project and the draft ASEAN Declaration on Disaster Health Management have been recognised and updated to ASEAN Joint Task Force on Humanitarian Assistance and Disaster Response (HADR).

III. REPORT ON THE START-UP DRILL AND THE FIRST RCD

6. Based on the inputs provided by AMS, Dr. Yasushi Nagajima presented the modification of the four-layered pyramid model of ARCH Project which reflected targeted capacities and tools necessary for AMS to achieve. The modifications were made in the previous model as follows. The presentation document can be referred to in **ANNEX XXIV**.

   The first level: Five items were adjusted to include; 1) intercultural skill, 2) compliance with quality accountability standard, 3) coordination conflict resolution skill, 4) language skill, and 5) IT communication skill.

   The second level: Three items were adjusted to include; 1) Information management including IT, 2) Austere critical care and field medicine, and 3) Reporting with MDS

   The third level: Two items were adjusted to include; 1) Common SOP and minimum requirement for EMT and 2) EOC EMTCC system

7. The modified pyramid model of ARCH Project demonstrates complex relationships with vertical and horizontal relevance which present linkage among all the project activities. It will be modified according to the latest discussions and experiences throughout of ARHC Project.

8. The discussions following this section are summarized below;

- A proposal was raised regarding radio as a mean of communication especially for the referral system. For that purpose, radio operation skills should be provided for EMT members; for example, basic operation, international radio language, and frequency given to each AMS.
- A concern was raised toward a necessary skill of EMT members to adopt themselves to natural and manmade environment in the field which may include unexpected situation. A stress management kit may be one of the possible solutions.
- Life support skills could include; Basic Life Support (BLS), Advanced Life Support (ALS), Advanced Trauma Life Support (ALTS), Disaster Life Support (DLS), and Mental Health and Psychosocial Support (MHPSS).

- ASEAN Secretariat commented that it will be appreciated for all the stakeholders to be able to study relationship among items in the pyramid model through a brief document. Then, the Project Team will prepare and share it.
- An item on evaluation and research can be included in the third layer. The consolidation of lesson learned and feedbacks are necessary for policy review and enhance further development process.
- An item on logistic and management skills may be included as logistic team is essential either provided by central PHEOC or within EMT.

IV. PROGRESS AND OUTPUTS OF PWG 1

9. Dr. Jirot Sindhvananda, Chair of PWG 1, presented progress and outputs of PWG 1. Regarding draft regional collaboration tools, version 0 of SOP for Coordination of EMT in ASEAN and Minimum Requirements have been developed. PWG 1 members will provide feedback on these drafts by 11 August 2017 and the revised drafts will be circulated in October 2017. The draft Health Needs Assessment Framework will be revised and circulated with draft instructions and guidelines by 11 August 2017 for feedback from the members by 8 September 2017. As for Database of EMT in ASEAN, PWG 1 members will propose categories and inclusion criteria in the database by 11 August 2017. The Project Team will propose the data collection form by 15 September 2017 and start data collection in October 2017. The presentation document for this section can be referred in **ANNEX XXV**.

V. PROGRESS AND OUTPUTS OF PWG2

10. Dr. Navin Surapakdee, made a presentation on progress and outputs of PWG 2. And two additional meetings were proposed because the existing plan cannot accommodate the content of the work to meet the set timeline. The presentation document for this section can be referred in **ANNEX XXVI.**

11. RCC did not have objections towards the proposal, therefore two additional meetings of PWG 2 were granted by the meeting.

12. Discussion points following the session are summarized below;

- Regarding the 5th PWG 2 meeting, it shall be held together with the fourth AMS training (November, 2018) to save time and resources. The date shall be finalised with participants but should be within the decided month to align with other activities set within the project timeline.
- Any plans regarding the training shall not be held during the first and second week of June 2018 as it would be inconvenient for Muslim participants.
- Cambodian delegates cannot attend if the dates are decided later than the first week of June 2018 as officials are not allow to exit the country due to the general election.
- The training period shall be later decided after the confirmation from AMS. However, AMS can arrange their personals to fit their appropriate time, for example, some can attend the training while other attends the PWG 2 meeting.

- AHA Centre suggested that the second AMS training may include logistic coordination using Incident Command System (ICS).
- The training will reflect elements according to the ARCH pyramid model. Certain training should be responding to the objectives and covered by the end of the training programme. The trained personals in ARCH Project should be equipped with adequate skills for EMT deployment as well as capable of training their team members.

VI. ASEAN LEADERS' DECLARATION ON DISASTER HEALTH MANAGEMENT

13. Dr. Phumin Silapunt presented the progress of the ASEAN Leaders' Declaration on Disaster Health Management which draft version 0 was presented in during the second PWG1 meeting in May 2017. It is currently under the process of consolidating comments.

14. The declaration needs a few steps to be taken. In June 2017, inputs were provided by ASEAN Health Cluster 2 via referendum. In July 2017, inputs were received by Senior Officials Meeting on Health Development (SOMHD). Then, it will be submitted for endorsement by Senior Officials Meeting for the ASEAN Socio-Cultural Community (ASCC) (SOCA) in September 2017. The declaration is expected to be adopted in the 31st ASEAN Summit in November 2017.

15. The chair encouraged AMS delegates to facilitate the internal process for in-country representative to submit the third referendum to Health Cluster 2 to endorse the declaration by the end of July 2017. After the adoption, the declaration will be operationalized by a plan which will be developed under SOMHD in consultation with other sectors and ASEAN partners including Japan, the ministries of foreign affairs, and military medicine sector. The presentation and documents for this section can be referred in **ANNEX XXVII.**

VII. HOSTING OF THE UPCOMING REGIONAL COLLABORATION DRILLS

16. Ms. Nagai updates of the relevant situation to host countries of the project events. During the first meetings of PWG1 and 2 in January 2017, the Project Team invited AMS to submit a proposal to host upcoming RCD. The Philippines submitted a proposal to host the third RCD and later Viet Nam showed an interest to host the second RCD. Both AMS were invited to observe the preparation of the first RCD in Thailand while informal discussions were made. After the review of Philippine's proposal, the Project Team had acknowledged the capacity to host the third RCD, whereas Viet Nam was required to submit proposal by middle of August 2017. Philippine and Viet Nam were invited to make presentation on their proposals or conceptual plan. The presentations document for this section can be referred in **ANNEX XXVIII.**

17. According to the proposal of the Philippines, the proposed RCD will not only be useful for AMS for the EMT deployment preparation under ARCH Project, but will also be beneficial for Metro Manila to be prepared for high impact of the possible West Valley Fault earthquake. The proposed venue is at the Armed Force facility of the Philippine Grand Stand, Metro Manila. Tentative duration is

within the second to third week of October 2018. The Project Team will visit Philippines in later September 2017 for initial preparation.

18. Viet Nam is interested in hosting of the second RCD and therefore, was invited to observe the planning of the first RCD. Viet Nam has learned a lot from Thailand and glad to host the next RCD. Ministry of Health of Viet Nam and People's Committee of Danang City granted approval for the hosting of the second RCD. The next step will be an approval of the Prime Minister's Office. The second RCD objective will be defined along the development process through discussion with the Project Team. Viet Nam believe that the drill will raise awareness and preparation of concerned personals including police, fire department, local authority and others on disaster health management issue.

19. RCC members endorsed the Philippines to host the third RCD as they have adequate capacity and willingness. As regards the proposal from Viet Nam for hosting the second RCD, the referendum will be conducted through online basis by September 2017, once official reviews by the Project Team finish.

VIII. RELEVANT EVENTS IN ASEAN

20. AHA Centre provided the overview of the ASEAN Disaster Emergency Response Simulation Exercise (ARDEX). The presentation document for this section can be referred in **ANNEX XXIX.**

21. As for the next ARDEX in November 2018 in Indonesia, AMS health sector will be invited to Jakarta for the preparatory meeting. Although the timing between ARDEX and third RCD may not match, the gap between both exercises should be more than four weeks so that AMS attend both exercises to learn and improve from one another.

IX. COMMUNICATION CHANNEL OF ARCH PROJECT, AND OTHER RELATED ISSUES ON DISASTER HEALTH MANAGEMENT

22. Dr. Phumin Silapunt invited discussions regarding the method for communication under ARCH Project. The Project Team proposed a parallel information communication channel; formal flow via ASEAN Secretariat, and informal one to exchange technical information and resource persons, as well as facilitate the application process. The presentation document for this section can be referred in **ANNEX XXX.**

23. ASEAN Secretariat will communicate to ASEAN Health Cluster 2 Country Coordinators for the designation of contact points for ARCH Project activities. And the Project Team can communicate with identified resource persons based on agreements with/endorsement by relevant PWG. ASEAN Secretariat may be copied for information or potential follow up. When these focal points will take roles as national focal points for Disaster Health Management, terms of reference should be reviewed.

X. WRAP UP AND WAY FORWARD

24. The second RCC meeting had summarised and demonstrated the progression of the ARCH project activities during nine months after the first RCC meeting in September 2016. The activities are namely the start-up and the regional collaboration drills, AMS training, PWG1 and 2 meetings, development of regional collaboration tools.

25. Highlighted proposals and agreements included two additional meetings requested by PWG 2 to be held in November 2017 and 2018.

26. The ASEAN Declaration on Disaster Health Management is in the process of endorsement by AMS Health Cluster 2 which will be acknowledged and enforced at the 31st ASEAN Summit in November 2017. AMS delegate shall facilitate the in-country process for endorsement.

27. The RCC meeting had approved the proposal of the Philippines to host the third RCD in October 2018, while the approval of Viet Nam to host the second RCD will be requested through online basis.

28. The agreement regarding communication channel of ARCH Project was that the project focal point would formally be designated by facilitation of ASEAN Secretariat. The next RCC meeting will be held in Danang City, Viet Nam, after the second RCD. Key Discussions and Action Points can be referred in **ANNEX XXX.**

XI. CLOSING REMARKS

29. Dr. Achariya Pangma, expressed gratitude for JICA for facilitating ARCH Project in close collaboration with NIEM. In this event, the first RCC as well as RCD were planned and executed very well with kind advice from Japan. Delegates from AMS have so far contributed in the drafting process of SOP, Minimum Requirement, HNA and database to complement SASOP. The ASEAN Leader Declaration on Disaster Health Management will soon be enforced to operationalize the mechanism. The AMS training was held for the first time in May, providing them with useful skills and the later training will be developed according to the recommended framework. Philippine was endorsed the official hosting of third RCD and Vietnam to be endorsed for the second RCD in March 2018. All project future activities from this point will also be expected to contribute to the One ASEAN, One Response, seeking mutual contribution which other AMS can obtain. On behalf of the Project Team, Dr. Achariya encouraged constant active participation of AMS and appreciated that support of all stakeholders for successful outcome.

End

List of Annex

MINUTES OF MEETING OF
THE SECOND JOINT COORDINATING COMMITTEE MEETING
FOR
THE PROJECT FOR STRENGTHENING THE ASEAN REGIONAL CAPACITY ON DISASTER HEALTH MANAGEMENT

28 August, 2017

Dr. Atchariya Pangma
Secretary General
National Institute for Emergency Medicine
(NIEM)

Ms. Keiko Nagai
Team Leader.
JICA Expert Team for
the Project for Strengthening the ASEAN
Regional Capacity on Disaster Health
Management

The second Joint Coordinating Committee (hereinafter "JCC") meeting on the Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management was held as follows:

Date:	28 August 2017
Time:	13:30 – 15:30
Venue:	Room 601, Fl. 6, National Institute for Emergency Medicine (NIEM)
Attendance:	A list of attendants is presented in Annex 1.
Chaired by:	Secretary General, NIEM

The meeting was conducted according to the following agenda:

1. Welcome by the Chair, Secretary General, NIEM
2. Opening Remarks
   2.1 Secretary General, NIEM
   2.2 Senior Representative, JICA Thailand
3. Introduction of the Attendants
4. Follow-up of the First JCC Meeting
   4.1 Progress of the Project in the first year
   4.2 First and second monitoring sheets submitted to JICA
   4.3 Progress of the annual plan of the first year
5. New Business
   5.1 Up-coming events for the second years
   5.2 Annual plan for the second year
6. Next Meeting
7. Conclusion

Handouts (Presented in Annex 2):

4.1 Progress of the Project
4.2 Monitoring sheets for first and second terms
4.3 Progress of the annual plan
5.1 Up-coming events for the second year
5.2 Annual plan for the second year

Firstly, the Chair welcomed all the attendants. Then, Secretary General from NIEM and Senior Representative from JICA Thailand made opening remarks. Following to introduction of all the attendants, the agenda was agreed by all the participants. The Chair proceeded the meeting. The points of discussions are summarized as follows:

Points of discussions along with the agenda are summarized below.

Introduction

- Each participant introduced himself or herself.

4.1 Progress of the Project in the first year

- Mr. Surachai Silawan presented the overall progress of the Project in the first year along with five outputs, implementing structure, and the progress of each output.
- Dr. Jirot pointed that some of the activities are currently behind the schedule so we have to notify the AMS again regarding the deadline or we can give them more time to consider. Ms. Nagai replied that as we need to develop 4 tools (SOP, Minimum Requirements, Database, HNA Framework) during 3 years of the Project for PWG 1 so it takes time and consideration. Ms. Nagai added that we also need more participation in PWG 1 members, while PWG 2 members are very participatory and more motivated. Currently there are several drafts and issues to discuss so the Project Team would like to gain more involvement for PWG 1.
- Dr. Phumin agreed with Ms. Nagai due to the last PWG meeting in Phuket was obviously different. Compared to PWG 1, PWG 2 meeting included the brainstorming session. Therefore, we can share the meeting style between these two Project working groups. Dr. Prasit added that most of the tools are nearly finished, just need more comments and suggestion from AMS as we aim to finish before the next PWG 1 meeting in this November also we need to adapt with the next RCD in Viet Nam as well.
- Dr. Jirot added that in PWG 1 many participants kept silent because it was more complicated compared to PWG 2, also some participants have to consult many units internally before making any comments so they cannot explain or show their opinion evidently. Ms. Nagai responded that some countries compiled the comments before they coming to the meeting. So next time we can compile and set the deadline around 4 weeks before bringing the comments to the venue.
- Mr. from TICA inquired regarding the draft version zero, Ms. Nagai responded that version zero is the preparation contents from Project Team but version one includes the comments from AMS in order to compile and bring to Health Cluster II for the endorsement. Dr. Prasit added that version zero can be modified and not finalized by every AMS yet.
- Dr. Anupong recommended that it is better to have the main focal point as the high rank personnel, based on the nomination, which is very important.
- Everyone agreed with Dr Bhijit that Training is an important key for the capacity development, so it should be more strict and intense in the second year of the Project. He advised to include the area

management or medical rescue for the trainings. However, even there are differences among the AMS, the training can increase the capacity building for them properly.

- Regarding the SOP, Dr. Bhijit pointed that it is better to identify more about the SOP on the business side such as an international coordination among the AMS, also with AHA Centre. And when we understand all elements, we can create a master diagram how the Project is demanding along with the tier so other countries understand easily.
- Ms. Nagai added that for the Training, our project is implemented by the framework for emergency medical team in AMS countries. For SOP- focusing on the management of EMT on site and how to collaborate others as we already have SASOP – our SOP can be related linked to the SASOP – it can be the attachment but we consider the consistency of the SASOP as well. Good idea to encourage the commitment of each country. Dr. Bhijit said that AHA centre is revising the SASOP – so it's the good time to consider the SASOP in the local area.
- Dr. Phumin added that when we look at SASOP – it is not enough details for Disaster Health Management, which we aim to establish specific SOP but it has to be in the same line with SASOP, for example, mostly we start the process from the airport as we follow SASOP to avoid the confusion.
- Dr. Boriboon added that regarding the PWG 2 activities; there were differences even within the same team, therefore, we need common language for effective training.

4.2 First and second monitoring sheets submitted to JICA

- Ms. Nagai presented that we have already submitted two monitoring sheets, which consisted of summary sheet and achievement of progress; the video of the Start-Up Drill and the first Regional Collaboration Drill were presented as well.
- The next Project monitoring sheet will be submitted in December 2017.

4.3 Progress of the annual plan of the first year

- Ms. Nagai presented the accomplishments of the first year target along with the handout.

5.1 Up-coming events for the second year

- Mr. Surachai presented the upcoming events for the second year of the Project along with the handout. Ms. Nagai added that the Project Team already visited Da Nang for venue inspection regarding the second Regional Collaboration Drill in March 2018. The Viet Nam side still considers the detailed tasking and budget sharing internally. The Project Team will have several meetings with Viet Nam so the technical group discussion will be finalized before PWG 1 meeting in this November.
- Ms. Sato clarified that regarding the next C/P Training in February 2018; it depends on Thai side for the personnel who would join the Training. If participants will be same as the 1st C/P Training, the course will be an advanced course; while it will be a basic course if new participants attend the training.

5.2 Annual plan for the second year

- Ms. Nagai presented the annual target for the second year along with the handout.
- Dr. Bhijit suggested considering the capacity building and increasing more topics of the training issues. Ms. Sato responded that there are four Trainings for AMS, each training has its own theme, which had been decided according to the previous study. When the Project Team finds out new needs based on the outcomes and lessons learned from other ARCH activities such as drill and tool development, we will modify and adapt with the decided topics appropriately.
- Dr. Bhijit added that we should consider regarding the differences in capacity and experience among each AMS, as we can bring common weakness of some countries. Ms. Sato agreed and responded that JICA has another scheme, which is apart from ARCH Project and focuses on the capacity building of Cambodia, Myanmar, Viet Nam, and Laos in emergency medicine as they have more needs.
- Dr. Bhijit recommended having the same direction for each AMS in order to enhance the capacity development in the region.

6. Next Meeting

The next JCC meeting will be held tentatively around August or September next year according to the Project work plan. Dr. Atchariya informed that the next JCC would be consisted of three main parties, which are MOPH, NIEM, and JICA according to the new MOU, which will be signed soon.

7. Conclusion

Dr. Atchariya concluded the discussion and the meeting was closed at 15.30.

Annex 1: List of Participants

Name	Position	Organization
Dr. Bhijit Rattakul	Senior Advisor	MOPH
Dr. Jirot Sindhavananda	Senior Advisor	MOPH
Flt. Lt. Dr. Atchariya Pangma	Secretary General	NIEM
Dr. Phumin Silapunt	Public Health Technical Officer, Bureau of Public Health Emergency Response (BPHER)	MOPH
Mr. Wattanawit Gajaseni	Representative of TICA	MOFA
Mr. Park Boonnuch	Second Secretary	ASEAN Division, MOFA
Mrs. Suttapak Suksabai	Representative	DDPM
Asst. Prof. Boriboon Chaintanakit	Representative	Thai College of Emergency Physician
	Representative	Thai Red Cross
Dr. Kanda Limitlaohaphan	Representative	Thai Red Cross
Ms. Dutsadee Arunrakthavon	Representative from PWG 1	Price of Songkla University
Dr. Prasit Wutthisuthimethawee	Chief of Information Section	Asian Centre of Military
Sr. Col. Watanauth Sanpanich	Director, Bureau of Emergency Medicine Management System	NIEM
Mr. Surachai Silawan	Manager, Bureau of Emergency Medicine Management System	NIEM
Ms. Sansana Limpaporn	Acting Director, Infrastructure and Peace building	JICA Headquarters
Ms. Akiko Sanada	Special Advisor, Infrastructure and Peace building	JICA Headquarters
Ms. Junko Nakaji	Senior Representative	JICA Thailand Office
Mr. Masato Koinuma	Team Leader	JICA Expert Team
Ms. Keiko Nagai	Capacity Development Planning	JICA Expert Team
Ms. Junko Sato	Capacity Development Planning	JICA Expert Team
Mr. Takashi Senda	Project Secretary	JICA Expert Team
Ms. Sukrita Tangkunapipat		

Observer

Dr. Sanchai Chasombat	Assistant Secretary	NIEM
Dr. Anupong Sujariyakul	Focal Point of Thai Health Cluster II	MOPH
Ms. Suwanna Navajaroen	Program Officer	JICA Thailand Office
Ms. Kittima Yuddhasaraprasiddhi	Section Chief, Bureau of Emergency Medical Coordination and Alliance Relation	NIEM
Ms. Kunpalee Sopeng	Coordinator	NIEM
Ms. Dangfun Promkhum	Project Coordinator	NIEM

Annex 2: Handout

3RD PROJECT WORKING GROUP 2 MEETING

PROJECT FOR STRENGTHENING THE ASEAN REGIONAL CAPACITY ON DISASTER HEALTH MANAGEMENT (ARCH PROJECT)

09 NOVEMBER 2017
GRANDE CENTER POINT HOTEL PLOENCHIT, BANGKOK, THAILAND

I. WELCOME REMARK

Mr.Masato Koinuma, Senior Representative of JICA Thailand greeted all participants of the 3rd Project Working Group (PWG) 2 meeting and expressed his gratitude for their kind participation in the event. The participants of the meeting involved; 2 representatives from each AMS (namely; Brunei, Cambodia, Indonesia, Lao PDR, Malaysia, Philippines, Singapore, Thailand and Viet Nam), representatives of ASEAN Secretariat, JICA, NIEM and Japanese experts. Mr.Koinuma believed that the continuity of support for ARCH project from all related individuals/agencies and will lead to the achievement of the goal. Finally, according to the ongoing flooding incidences in some AMS such as Thailand, Malaysia, and the Philippines, Mr.Koinuma took this opportunity to offer his sincere empathy for the affected countries and best wishes for the situation to return to normalcy soon.

II. INTRODUCTION

Dr.Narain Chotirosniramit, Head of Trauma and Critical Care Unit, Emergency Medicine Department, Faculty of Medicine, Chiang Mai University, Thailand requested each participant to introduce oneself to the meeting with name, affiliated agency, and country of origin in clockwise direction. Then the objectives of the 3rd PWG2 meeting were explained as followed; (1) to share the outcome and feedback of 2nd AMS training, (2) to agree on the theme of 3rd and 4th AMS training, (3) to discuss and agree on the plan of the 3rd AMS training, (4) to discuss on vision and roadmap of capacity building/training in disaster health management (DHM) in ASEAN and lastly (5) to share the upcoming events/activities of PWG2.

III. REPORT ON THE 2ND AMS TRAINING

Ms.Junko Sato, Capacity Development Planning expert of ARCH Project Team, presented a report on the 2nd AMS Training, conducted during November 5th – 8th, 2017 in Bangkok Thailand. In addition to the activity report, participants' feedback and suggestions for the future AMS training program were shared in the meeting. Ms.Sato reiterated the theme of the training as Capacity Development of Emergency Medical Team (EMT) – On-site Team Management. 29 participants from all AMS were attending the training while lecturers were invited from Indonesia, Malaysia, Philippines, Thailand, Japan and AHA centre.

As a stepping stone to achieve the ultimate goal of AMS Training, which is to strengthen national capacity for disaster management, the 2nd AMS training was executed. The course objectives were as followed; (1) to understand what EMT is expected to do when deployed to disaster area, (2) to get the competency to build an effective domain for right directions of disaster management, especially for team management, (3) to share the concept of EMT Response and lastly (4) to evaluate this training course as a first step for the ASEAN standardized EMT training development. Activities covered shown in the below table;

Date	**Session**	**Contents**	**Remark**
Day 1	AM & PM	Country Report on Current Situation of Emergency Response System - Emergency Response System - Current Situation of EMT - Quality Assurance - Capacity Development - Challenges in Developing EMT - Follow-up Action after the 1st AMS Training	- Presentation from each AMS gave a clear picture on need and challenges each country faces in developing EMT - The progress on implementation of what was covered in the 1st AMS training from each AMS was appreciated
Day 2	AM	On-site Team Management Focusing on Domestic Disaster Response - Definition/mission/objective of EMT - Role of the Medical Team - Preparation of the Medical Team - Activation and Response - On-site Assessment	- These topics were identified as the essential issues from the previous PGW2 meeting. - Advanced efforts in EMT management and EMT response practiced in ASEAN were shared with the participant.
	PM	On-site Team Management Focusing on Domestic Disaster Response - Supplies and Logistic Preparation, Satellite - Documentary Management Skill - Security and Safety - Psychological Preparation, PFA	
Day 3	AM	On-site Team Management - CSCATTT Concept - Communication Tools	- CSCATTT concept was a relatively new topic for some AMS. Thus, it was a good opportunity to learn from it. - Radio training session, led by Ms. Tnunay was enjoyed by all trainees due to its active and exciting nature.

	PM	On-site Team Management - Field Triage - Transportation/refer/coordination	- Great excitement shown from the participants proved the simulation-type and case-based exercise a good learning method.
Day 4	AM	On-site Team Management • Simulation	• Simulation was a scenario-based exercise, designed by Japanese advisory committee members and necessary advice was given by Thai C/Ps..
	PM	On-site Team Management • Post Incident Evaluation (AAR)	• The session of AAR was provided by a representative from AHA Center.

At the end of the Day 4's presentation, the questions of whether the participants think their countries need a core curriculum in health management, and which topics/contents should be included in the core curriculum, if needed, were raised for group discussion. Participants unanimously agreed that each AMS needs a core curriculum for disaster health management, and the topics shall be the similar to the 2nd AMS Training course.

Questionnaire: Feedbacks, Suggestions and Challenges

The questionnaire survey was conducted for all AMS participants regarding the 2nd AMS training. According to the results of the survey, the acquired knowledge is useful, simple, and easy to remember and practice as it encompassed the important aspect of the disaster management (e.g. CSCATTT). Practical trainings (e.g. field triage, simulation, radio training) were much enjoyed by the participants. The training equipped all participants with a good direction for organizing oncoming activities, as part of each country's capacity enhancement.

From the questionnaire survey, a large proportion of responders pointed out that more practical trainings, for example simulations and table-top exercises can offer a more-rounded picture of the EMT standard. In addition, it is unanimously agreed that AMS should have a common EMT response system, which complies with the global standard. ASEAN in collaboration with JICA may introduce or establish its own EMT training version. Moreover, for fulfilling the capacity gap among all AMS, the training should increase the number of participants from CLMV countries because they do have little experience and low capacity building regarding EMT and response.

Challenges that AMS are encountering are for example the lack of training experts in the country to conduct disaster management courses and failure on convincing higher authority to invest for this concern. And lastly, quality assurance on disaster response is one of the main concerns because there is no domestic department/agency which is willing and able to supervise EMT response management.

Feedback and Suggestions from the meeting

Japanese advisory committee member suggested that the logistic aspect of the EMT management should be given a considerable attention because there are many related issues and they can be complicated. The Philippines and Indonesia voiced the concern regarding a high standard of WHO's EMT management, which perceived as un achievable for many AMS due to problems such as a lack of resources. To overcome this huddle, a compilation of ASEAN's EMT standard was encouraged. In addition, Singapore suggested that despite of the comprehensiveness of the training, the success of national EMT management depends on the program initiation, taken by the representatives of each AMS. Therefore, it is important to develop Standard Operation Procedure (SOP) to become a targeted goal for each AMS to make attempts to achieve. And lastly, representatives from ASEAN Secretariat ensured that SOP for EMT management, database system, and minimum requirement for health professional as EMT team members are currently underway as the main tasks of the PWG1.

IV. THEME OF THE 3RD AND 4TH AMS TRAINING

Ms.Junko Sato continued the meeting with the proposal on dates and themes of the 3rd and 4th AMS Training from the ARCH project. The 3rd AMS training is proposed to be convened on May 28th – 31st, 2018 with a theme of international EMT. The main focus will be placed on those who are actually deployed, such as EMT team members and a person in charge of deployment. However, it is difficult to realize final conclusion on the theme and topics, even among the project members. Thus, inputs from all AMS are much needed.

The 4th AMS Training is expected to take place in November 2018 with a theme of effective incident and emergency management, emphasizing on the emergency operation center. Unlike the 3rd Training, the focus group is placed on people who will receive EMT.

Questions, Answers and Suggestions

Lao PDR raised up a question of whether participants of the 3rd AMS Training should be the same persons of the 1st and 2nd AMS Training. Ms.Sato reiterated that this topic is currently in the discussion process and none of the conclusion has been realized. However, the participants might include a person who is in charge of deployment such as MOH and actual deployed person.

Thailand suggested that, for the management, it is easier to have a common ASEAN's EMT standard than different standards in each AMS. Without a clear vision from the related personnel, the way forward will be difficult.

Japanese advisory committee member suggested that since ASEAN has a close proximity from one country to another, the WHO standard is not needed. During the disaster, national EMT can be the first responders and then the international EMT joins the work later on. For such a case, the ASEAN standard is a requirement. Moreover, he added that one of the concerns for the 3rd AMS Training is on the fact that some countries might find it irrelevant to their situation due to many reasons such as lack of resources, if the training's focus is on international EMT.

PLAN FOR THE 3RD AMS TRAINING

Group Discussion

A session of group discussion was conducted to discuss and agree on training needs as well as training outline for the 3rd AMS Training. The topics of discussion were (1) challenges in deploying EMT, especially from the country with experience of deploying EMT internationally, (2) possible topics and resources and (3) target. Participants from all AMS were divided into 2 groups as followed;

Group A: Brunei, Cambodia, Indonesia and Thailand

Group B: Lao PDR, Malaysia, Philippines, Singapore and Viet Nam

Presentation: Group A

Topics	Detail
Challenges in deploying IEMT	i. Financial support ii. No standardized EMT Criteria iii. WHO's EMT Criteria is too difficult to meet the standards iv. Deployment decision making on the number of deploying personnel, expertise and background, and Type of EMT v. Time of deployment/response, which involves multiple decision makers, coordination and dynamic process vi. Language barrier, as well as cultural and religious consideration vii. Coordination between I-EMT responders and affected country, which needs to be strengthened.
Topics and Resources	i. Comparison between domestic and international EMT definition ii. I-EMT standard criteria iii. Minimum Standard Operation Procedure requirement (to be discussed by PWG1 and SASOP) - Manpower - Logistics (equipment) - Administration (reporting/monitoring) - Coordination - Response and evaluation iv. Table-top and simulation exercise of the above-mentioned topics
Target	i. The person who decides to deploy I-EMT ii. The person who will be deployed (Team leader/member) iii. Policy maker/ human resources/educator

Presentation: Group B

Topics	Detail
Challenges in deploying IEMT	i. Pre-deployment - I-EMT's personnel selection criteria - Deployment process and procedure (SOP) - Logistical requirement and standard - Conflict with affiliated agency and employer, due to interrupted ordinary work - Coordination and communication arrangement (security and safety) ii. During deployment - Language and cultural barrier - Logistic requirement for I-EMT such as communication, accommodation, food and transportation, etc. - Insurance policy - Registration of I-EMT in the affected country - Safety and Security - Contingency Plan - Local policy - Deployment plan - Reporting for accuracy and precision - Command and control coordination - Exit strategy and waste management (e.g. blood and needles) iii. Post-deployment - Lesson learn and documentation - Debriefing
Topics and Resources	i. AMS presentation for current situation analysis including, experience sharing, policy and regulation, and gaps ii. Selection criteria for EMT for I-EMT organization iii. Preparation of the I-EMT (JICA) iv. Deployment, including activation process and deactivation process, logistic requirement, and coordination and communication v. Solutions for the challenges during deployment vi. Standard form and documentation vii. Flow Chart of ASEAN's I-EMT mechanism (AHA Center) viii. Experience of PKO during operation, including WHO classification of EMT ix. Experience of JDR, regarding insurance policy, database and financial management x. Survival in austere environment
Target	i. MOH ii. Team Leader iii. Logistician

Dr. Narain Chotirosniramitr concluded that the topics do not need to be finalized for now. Due to limited resources, only one certain focus must be placed onto the training, whether it is on

I-EMT deployed persons, or coordinating personnel or the logisticians. Thus, the consensus topics from participants, such as SOP is needed. In response to that, Dr. Silapunt gave an update on the SOP development, which is in now in the feedback evaluation process. Then it will be revised and made into a complete version.

V. VISION AND ROADMAP OF CAPACITY BUILDING/TRAINING IN DISASTER HEALTH MANAGEMENT IN ASEAN "REGIONAL DISASTER HEALTH TRAINING CENTER"

The session was co-lectured by Ms.Fude Takayoshi, who elaborated on the bigger picture of ASEAN's future regional collaboration, and Dr.Phumin Silapunt, who explained in detail on the steps needed to be taken to achieve such a goal.

Firstly, the structure of ASEAN Disaster Health Management, which consists of PWG1 and PWG2. The former emphasizes on developing SOP, minimum requirement, database and health needs to be used in the disaster management, while the latter focuses more on human resource training and capacity development. The combination of the work from both groups will constitute a regional collaboration mechanism for ASEAN.

The goal of achievement is that the affected country should have effective management to coordinate and support the foreign emergency medical team. To achieve this goal, four areas need to be developed, namely; (1) SOP for I-EMT, (2) National EMTCC training course, (3) MIS of health need assessment, and (4) Preparedness oh hospital and EMS (hospital need to be functioning even in disaster)

ASEAN Leaders' Declaration on Disaster Health Management will be submitted to the 31st ASEAN SUMMIT on 10th November 2017 in Manila, Philippines. The summary of the Declaration's key points are as followed;

(1) Strengthen close coordination and collaboration with relevant ASEAN Sectoral Bodies and other partners.

(2) Develop SOP for regional collaboration on Disaster Health Management and promote the establishment and coordination of International Emergency Medical Team,

(3) Develop national SOP and coordinating body for the coordination of I-EMT,

(4) Strengthen disaster risk-management programme as part of national health systems,

(5) Promote public and private investment in Disaster Risk Reduction to support the resilience of health system,

(6) Endeavor to build safe, resilient hospitals and health facilities

(7) Strengthen active Academic Network among Disaster Health Management Programme,

(8) Strengthen national and regional capacities in Disaster Health Management, including through the establishment of a Regional Disaster Health Training Center,

(9) Increase efforts to operationalize financial resources to fill gaps in national responses,

(10) Call on development partners including all stakeholders and

(11) Task the concerned ASEAN Sectoral Ministerial Bodies as well as other relevant bodies for monitoring the implementation of the declaration.

VI. GROUP DISCUSSION: VISION AND ROADMAP OF CAPACITY BUILDING/TRAINING IN DISASTER HEALTH MANAGEMENT IN ASEAN

Meeting participants were then requested to participate in a group discussion session, regarding the establishment of a Regional Disaster Health Training Center and designed simulation and joint operations, to increase capacities in Disaster Health Management. The objective of the session is to derive inputs to draft and develop the Plan of Action of the ASEAN Leaders' Declaration on Disaster Health Management. The topics of discussion were as followed; (1) scope of target, (2) selection of methodology alternatives, (3) administration, (4) financial support and (5) content of curriculum. One representative from each AMS joined one group and another joined another group, with both groups discussing on all mentioned topics.

Presentation: Group A

Topics	Detail
Scope of Target	i. I-EMT ii. Decision makers / policy makers (including MOH and other stakeholders such as MOFA and academics) iii. Community
Methodology Selection	i. Combination of alternative 1 and 2 - Use of e-learning or online learning before going to Regional Training Center - Samples of training methodologies are interactive presentation, drills and simulation exercises, Question and Answer session, role plays, table-top exercises, and administration of pre- and post-test and other training evaluation.
Administration	i. Host country to maintain the Regional Training Center
Financial Support	i. AMS and external supports, including JICA, WHO, NGOs and non-NGOs are financing the center. ii. AMS should allocate fund for the operationalization of the center. iii. AHA Center – pooled funds
Content of Curriculum	i. Objectives and expected outcome of the training ii. Importance and rationale of the training iii. Key content - Basic skills

	- Team capacity to respond - Collaborative capacity - Topics related to the hazard, each trainee country is likely to encounter - Adopt modular approach

Presentation: Group B

Topics	Detail
Scope of Target	i. I-EMT (personnel and coordinators) ii. Public health personnel iii. Senior official iv. MHPSS v. WASH
Methodology Selection	i. Arranged by Training Center - Curriculum and lecturers or chief instructors ii. AMS - Conduct training - Lecturers from Training Center can be requested
Administration	i. Host country manage ii. Co-host manage together iii. Networking with other ASEAN Training Center
Financial Support	i. AMS to share expenses with other external source
Content of Curriculum	i. Basic individual skills such as intercultural skills, compliance with ICS ii. Team management such as leadership, teamwork and logistics iii. Collaboration capacity training among AMS such as integration with local EMTCC, common SOP, and standardized reporting format iv. Nutrition v. WASH vi. MHPSS

VII. WRAP UP AND WAY FORWARD

Dr.Narain Chotirosniramitr presented the 3rd PWG 2 meeting wrap-up and future schedule to all participants. He started with the agenda of the meeting, which were; (1) to review the 2nd AMS Training, (2) to discuss on the themes for the 3rd and the 4th AMS Training, (3) to constitute a plan for the 3rd AMS Training and (4) to share a Vision and Roadmap of capacity building/ training in disaster health management in ASEAN. All agenda were successfully completed, as a result of the active participations of all related personnel and organization.

SUMMARY OF PROCEEDINGS

THE FOURTH PROJECT WORKING GROUP ONE (PWG1) MEETING ON REGIONAL COLLABORATTION TOOLS AND CAPACITY DEVELOPMENT

PROJECT FOR STRENGTHENING THE ASEAN REGIONAL CAPACITY ON DISASTER HEALTH MANAGEMENT (ARCH PROJECT)

28 NOVEMBER 2017

Pullman Grand Sukhumvit, Bangkok Thailand

I. INTRODUCTION

1. The Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management (ARCH project) was the result of a survey conducted during December 2014 - March 2015 for all ASEAN Member State. The survey also collected relevant international trends from UN, WHO and ASEC, as well as regional meeting in Phuket, Tokyo and Bangkok respectively. One major challenge was identified from the survey that although different parts of the region confront different disaster challenge, collaboration in disaster emergency response was needed. Hence, ARCH Project was designed accordingly. ARCH Project mainly focuses on the coordination and team management of Emergency Medical Team (EMTs) of the offering and receiving countries. Major concerned agencies of ARCH Projects include JICA, ASEAN Secretariat, ASEAN Centre for Humanitarian Assistance (AHA Centre), and National Institute of Emergency Medicine (NIEM, Thailand). The intended outputs of the project are the coordination platform on disaster health management; the framework of regional collaboration practices; the tools for effective regional collaboration on disaster health management; academic networks on disaster health management in AMS and; capacity development activities implemented for each AMS.

2. The 4rd Meeting of Project Working Group (PWG) 1 was held on 28-29 November 2017 in Bangkok, Thailand. The meeting was the follow-up event from the 1st, 2nd and 3rd PWG 1 meeting held in January, May and July, 2017 respectively. The 4rd meeting was held to continue discussions, raised previously on the draft Regional Collaboration Tools including the Standard Operating Procedure (SOP), Health Needs Assessment (HNA) Framework, Minimum Requirements (MR), and Database of Emergency Medical Teams (EMT) in ASEAN and other ASEAN common forms. The meeting aimed to present drafted tools and invite comments and inputs in order for the project to achieve output's progress. The agenda of the discussion is presented as **Annex I**.

3. The meeting was participated by delegates from ASEAN Member States (AMS); Brunei Darussalam, Cambodia, Indonesia, Malaysia, Philippines, Singapore, Thailand, and Viet Nam; the Japanese Advisory Committee; the Project Team consisting of the National Institute for Emergency Medicine (NIEM) of Thailand, Ministry of Public Health (MoPH); Department of Disaster Prevention and Mitigation, Thailand and; Japan International Cooperation Agency (JICA). The List of Participants is attached as **Annex II**.

a. Opening Remarks

4. Dr. Jirot Sindhvananda, meeting chair, delivered welcome remarks to all delegates from ASEAN Member State (AMS) as well as honourable delegates from institutes who are the member of PWG 1. The chair thanked PWG1 participants for continuous contribution towards the outcome of the project. The 4th PWG 1 meeting had the objective to follow-up discussions from the 3rd PWG 1 meeting in May 2017, regarding the Database of EMT and its management, HNA, SOP, Medical Records form, ASEAN Standard of I-EMT and Standard Training, Introducing Future Collaboration Options under ASEAN Disaster Health Management Framework, and lastly the 2nd Regional Collaboration Drill in Danang Vietnam, March 2018. The chair expressed sincere appreciation for active participations and declared the 4th PWG 1 meeting open.

II. REVIEW OF THE FIRST REGIONAL COLLABORATION DRILL (RCD) IN JULY 2017, THAILAND.

5. The 1st Regional Collaboration Drill (RCD 1) was held in Phuket, Thailand in July 2017 with the objective to use common report forms namely Medical Record, Daily Report and Referral Form in reference with World Health Organisation (WHO) EMT coordination handbook (also known as the Blue Book). The 3 days activities had put developed tools to test. Day 1 main exercise was the Table Top Exercise conducted to practise paper procedures in dispatching EMT to affected countries. Table top exercise introduced the importance of SASOP forms and WHO EMTCC handbook to use in reference. The Field Exercise in Day 2 was held at Phuket Mining Museum using simulated Tsunami scenario affecting the southern provinces of Thailand as the theme, in which participants practised AMS request, Custom Immigration Quarantine (CIQ) process, EMT coordination with local EOC, deployment to mission; the 3-affected area in Phuket, Krabi and Phanga. This was a realistic drill using simulated patients, and the sense of timeframe (delivery circle of 3 hrs equivalent to 1 day). Day 3 mains objective was to conduct the After Review Workshop that each country team gave feedbacks specifically to the common forms and summarise lesson learned. The presentation of the 1st RCD review was listed as **ANNEX 3**

6. The evaluation of the RCD 1 summarised the following good points; appropriate time and venue; well-organised accommodation and transportation; well-planned introduction session, good presenter and facilitator, well-prepared scenario and table top exercise, well-prepared common forms. However, the evaluation suggested improvements in the introduction to EMT types, referral system, tasks of HNA, standardization of common communication, realistic CIQ process. It also suggested more number of experienced facilitators, more referral hospital, development of medical checklist and others.

7. Gaps identified generally from the RCD1 include language barrier, training of simulated patients, malfunction communication equipment and engagement of participants. Gaps in the coordination processes were the infrequent communication with social welfare, ERAT and other sector, difficulty in referral system and stand protocol failed to follow. The challenge for next time would be to attempt on transferring all common forms into electronic /cloud/ App-based use.

8. Thus, to fill the gaps, capacities in management and technical aspects for instance team management and workflow, legal knowledge, equipment and medicine and others. In this light, technical curriculums of EMTs are to be designed and implemented.

III. DATABASE OF EMTS IN ASEAN

9. In following up with the EMT Database discussion from the 3rd PWG 1 meeting, AMS were required to feedback on data collection sheet as the first step of Database establishment. EMT Database Data Collection Sheet and its instruction were circulated on September 15th , 2017, and so far have received a number of feedbacks. The managing arrangement of the Data collection was agreed that the project team is responsible to arrange data collection from AMS in further coordination with AHA Centre according to the following schedule; 1st round Aug-Oct 2017; 2nd round Dec 2017 – Feb 2018; 3rd round Apr-May 2018 and; 4th round Jul-Sep 2018. Beyond the operation of the ARCH project, Ministry of Public Health would be responsible for collecting data from related agencies, in collaboration with National Disaster Management Organisation (NDMO). NDMO further coordinate with AHA Centre for the data transfer and management. Document for this section included; 1) Presentation on Database of EMTs in ASEAN **ANNEX 4**; 2) Draft Instruction for Data Collection **ANNEX 5** and 3) Data Collection sheet **ANNEX 6**.

10. The chair invited consensus on the content of data collection sheet. AMS agreed that the 2-paged sheet is generally user-friendly, adequately simple, relevant, hence, no objection in using the sheet. A small comment from Japanese Advisory Board suggested that in deployment history (No.4), the Date/Month/Year title should be added in order to keep track of update for each EMT. The meeting agreed that Date/Month/Year should be added, but EMTs are required to input at least the year of update if other information was not recorded. The AMS is required to provide at least 1 out of 3 deployment event in 4-2. Moreover, a clarification was made regarding the sheet that, one data collection sheet is meant to be used by one EMT organisation, and hence separate piece of information update. It is also suggested that the sheet could be provided in soft copy form, or in database platform if there's future development. **As Lao PDR and Myanmar delegates are absent, the consensus shall be consulted though email communication.**

11. Regarding the management of the data collection task during and beyond the implementation of the ARCH project, ARCH project team is responsible in coordinating the data collection event until the end of project. Beyond September 2018, MoPH in collaboration with NDMO from each country communicate with AHA Centre for the delivery of information through formal mechanism (ASEAN Secretariat, AHA Centre, NDMO and MoPH). The data collection will consistently be held twice a year, in January and July each year. This is suggested that countries' NDMO should be acknowledged and familiarised with the duty and process prior to the end of the project. NDMO should be informed and therefore delegate the task to suitable line Ministry (MoPH) in charge. For the effectiveness of the mechanism, ASEAN Secretariat will convey the process to SOMHD, ASEAN health cluster 2, ACDM and other joint taskforce to ensure formal process can be carried out.

IV. HEALTH NEEDS ASSESSMENT FRAMEWORK

12. The Health Needs Assessment aimed to collect primary data to identify vital needs in disaster and facilitate relief teams in different sectors for effective response. This session objective was to update the draft HNA and guidance note, reiterate draft framework and key

recommendations from the 3rd PWG 1 meeting, agree on revision in HNA forms, discuss reporting arrangement and format, and to confirm overall output timeline. Document used for this section can be referred to: 1) The presentation for Session 4 HNA **ANNEX 7**, 2) Draft HNA **ANNEX 8** and, 3) Guidance Note **ANNEX 9**

13. From the last PWG 1 meeting, feedbacks for HNA were received and incorporated into Version 1-1. The HNA Version 1-1 was circulated among AMS along with Guidance Note. Comments received from AMS will be incorporated and developed into Version 1-2. Key recommendations from 3rd PWG 1 meeting concluded that ASEAN EMT intending to include HNA in their service may consider including public health officer in their roster for deployment and include training programs to enhance competencies. The information collected through HNA can be passed on to EMTCC, PHEOC and MoH in an agreed reporting format, also discussed in the 4th PWG1 meeting.

14. The consensus was reached that HNA P3. 2-11 food items to be included in HNA is appropriate in ASEAN context, while the meeting agree that listing of food item shouldn't burden the operation while giving the emphasis to essential food availability. P4.3 Health Facility and Service to list the number of working staff instead of percentage.

15. The meeting Chair invited discussions on HNA reporting arrangement and format by giving the 3 options for AMS delegate to consider; Option 1) To submit a filled HNA Form as is. This option may place difficulties for EMTCC/EOC as recipients as details are not summarised; Option 2) To incorporate essential information into the EMT-MDS Daily reporting form. This option thus facilitate the understanding for the handover agencies; Option 3) To create separate HNA reporting form which is simple to fill in and read. The meeting had diverse perspective on this matter. One opinion suggested separate reporting form that highlights risks and needs. Another suggested that if the assessment was carried out without the support of local authority whose reporting form would be primarily used, the HNA information should be summarized and delivered in the daily reporting form.

16. The project team will incorporate the following suggestions.
    1) Under 'Action required by other cluster', it was suggested to include sub-area in health such as 'communicable disease', 'sexual and reproductive health' and others.
    2) Under 'Situation in Shelter', HNA shall be assessed considering number of shelter in that area and conduct assessment as see fit.
    3) As EMT team comprise of non-public health practitioner, training curriculum can be customised for efficiency and accountability of HNA information.

17. The Chair reiterated that HNA form is not expected to be completely filled out. Reporting should be summarized in simplified format while team will need time to draft and the objective of HNA according to SASOP should be emphasised only to summarise brief messages on needs and risks to handover agencies.

V. STANDARD OPERATING PROCEDURE (SOP) Doc PPT/ draft SOP/ Annex

18. The objective of this session is the review the Draft SOP Ver.1 and to seek feedbacks from PWG1 members. The SOP Draft 1 was circulated on October 30th, 2017 and currently awaiting AMS feedbacks. Referred document for this section comprised of: 1) Presentation

on Standard Operating Procedure (SOP) **ANNEX 10** and, 2) Standard Operation Procedure (SOP) **ANNEX 11**.

19. The agreed points to revise and concerns raised regarding the current draft SOP are as follows
    - Para 16 : project team agreed with the feedback to change word “and” to “or”.
    - Para 18 : AHA Centre agreed to this paragraph to speed up process of MoPH request to NDMO and MoFA.
    - Para 19: further clarification on ‘self-sufficiency for EMT’ should be considered as there’s some concerns towards the extent of coordination capability to other agency to incorporate into EMT.
    - Para 23: to consider “designated representatives” in addition to “national focal point” recognizing that custom clearance processes are carried out by other agencies.
    - Para 26: the ASEAN Mutual Recognition Agreement for Medical Professionals will be shared by ASEAN Secretariat to NIEM and ARCH Project Team as there may be relevant disaster and humanitarian practices.
    - Para 32, 33 and 34 regarding the On-Site Operation of EMT were agreed
    - Annex 2: List of Essential Information for Mobilisation, Annex 4: List of Essential Information for On-Site Operation and; Annex 5: List of Supporting Functions of the EMTCC or Sub-EMTCC, were added to the draft SOP.

20. It is noted that to ease the CIQ process, receiving countries requesting EMT should set a mechanism internally for EMT to mobilize resources in country. The receiving countries are to contact medical professional council to issue temporary licence for humanitarian response situation prior the situation. All EMT should consider the issue of insurance for the mission. The discussion regarding ASEAN I-EMT Standard was discussed in section 8: Group Discussion.

VI. Medical Record

21. In reference to the Regional Collaboration Drill 1 (RCD 1), the Thai Medical Record was used for the exercise. At that, comments as well as feedbacks and concerned were raised. Thus, an agreed AMD Medical Record was concluded. The objective of this session was to review the Draft Version 1 of the common Medical Record.

22. The meeting noted an opprtunity to further develop Medical Record into electronic format using free software. The future plan has the potential to be developed in support of the Japanese Advisory team for the conveniences of analysis. In terms of standardization of Medical Records, the meeting was also informed by Japanese Advisory that WHO have no standard medical record, but guide that country design their own medical record with core data set to fit proper context and distribute prior the EMT deployment. The meeting agreed that drafted Medical Record is to be tested on the 2nd RCD with the following revisions: 1) To include ‘Last Menstrual Period (LMP)’ in ‘Past History’; 2) In the second note page, revise nurse & doctor note to ‘progress note’ to facilitate case transfer and; 3) Include neurological assessment such as the Glasgow Coma Scale (GCS), the Alert, Voice, Pain, Unresponsive (AVPU) for paediatric cases.

23. As regards the feedback on Medical Record Form, the chair reminded that the deadline for feedback submission is 14 February 2018.

VII. MINIMUM REQUIREMENT

24. Previously on the 3rd PWG 1 meeting, the Minimum Requirement draft version 1 consolidated the meeting feedbacks and circulated on October 30th, 2017, and currently awaiting AMS feedbacks. Revision of Minimum Requirements and Qualifications for Members of EMT proposed 3 Tiers of Minimum Requirement. The document for this session can be referred to; 1) Presentation on Minimum Requirement and **ANNEX 12**; 2) Draft Minimum Requirement **ANNEX 13**

    - Tier 1 : Medical professionals register as member; having basic knowledge of disaster medicine and EMT operations.
    - Tier 2: Medical professional pass standard for domestic deployment; having the adaptability of technical and non-technical capacities to operate in low resource situation
    - Tier 3: Medical professional pass standard for international deployment; being able to perform as EMT member on mission in foreign countries.

25. To have further clarification on Minimum Requirement, the meeting raised the following 3 points among AMS delegate to discuss in group discussion;

    - Should standardized theoretical course be developed for Tier 1, and standardized domestic deployment training course for Tier 2, and how?
    - How ASEAN standardized training curriculum should be developed for Tier 3?

VIII. GROUP DISCUSSION: ASEAN STANDARD OF I-EMT AND STANDARD TRAINING CURRICULUM OF ASEAN I-EMT

26. Delegates from AMS countries separated into 2 groups to discuss ASEAN Standard of I-EMT and Standard Training Curriculum of ASEAN I-EMT. The outcomes of discussions were as follows.
    - Group 1 ASEAN Standard of verification system group agreed to review WHO EMTCC handbook as reference while ASEAN EMT assess those that are achievable and non-achievable in ASEAN context. In the meantime before the 2nd RCD, AMS delegate should review WHO Minimum Requirement and make notes to discuss during the next PWG 1 meeting next time.
    - Group 2 Standard training curriculum of ASEAN I-EMT group agreed that standard curriculum training for Tier 1,2 and 3 are needed.
        - Tier 1: for any medical professional with minimum knowledge of ITLS/SDLS/PHDLS can become member. Standard training on primary and theoretical framework of disaster health medicine knowledge should be established.
        - Tier 2: for medical professional who are the member of Tier 1 e.g. N-ÉMT including nurse, logistic, logistic as tam member to manage training in order to carry out for national EMT deployment. Standard

training on field deployment for disaster health response should be established.

- Tier 3: medical professional who are the member of Tier 2.Standard training on I-EMT knowledge, minimum requirement, common forms, agencies e.g. AHA centre, WHO guideline are established.

27. WHO standards are the reference for AMS to reach as the goal. However, ASEAN Standard should be developed while national capacities are enhanced. It is also suggested that a survey within AMS is conducted to see the extent ASEAN should follow WHO standard. All standard training curriculums should be collaborated with Project Working Group 2.

IX. PLAN OF THE SECOND REGIONAL COLLABORATION DRILL, MARCH 2018 VIETNAM

28. It was agreed previously that Viet Nam would host the second Regional Collaboration Drill (RCD) in Danang City, Vietnam between 25th – 28th March, 2018. The objectives of the drill are to use and put to test the revised Regional Collaboration Tools as well as to validate ASEAN SOP. The proposed scenario is the Super Typhoon and Direct Landfall event with over 1000 casualties. Venue for the drill is the Hoa Xuan Stadium, located in Cam Le district. The 2nd RCD will adopt lesson learn from 1st RCD and try to fill in the gaps and improve efficiency. The 3-day event comprises of Day1 Table Top Exercise; Day 2 Field Exercise; Day 3 Wrap-up exercise. Vietnam representative invited comments from AMS to discuss whether EMT team from each country work independently or work together as mixed team. Presentation for the 2nd RCD is attached as **ANNEX 14**.

29. The meeting agreed that EMT deployed for the drill should work independently for the 2nd RCD as mix team may post different challenges and may distract the achievement of objective to test the regional collaboration tools. The Philippine showed interest in experimenting the mix team challenge in the 3rd RCD. Based on the experience in Vietnam, the 3rd RCD hosted by the Philippines may include elements on multi-country EMT collaboration. If the concept is reconsidered during the 2nd RCD, SOP on multi-country EMT collaboration is to be drafted and put to test during the 3rd RCD. As regards to Viet Nam proposed to arrange team performance review for each country in order for them to address their capacity and challenge. Project team will assist the provision of experts to evaluate and provide feedback to country's EMT team performance.

X. MECHANISM OF FUTURE COLLABORATION

30. The presentation from ASEAN Secretariat on governance and Implementation mechanism of the ASEAN Health Cooperation on Disaster Health Management noted the future mechanism for future collaboration within the ASEAN Framework after the termination of ARCH project. The presentation described the existing environment in which Disaster Health Management Agencies and ARCH project co-exist i.e. Sector 1; ASEAN has the SOMHD and Health Cluster 2 Priority 12 on Disaster Health Management which is enabling the implementation of ARCH project; Sector 2: The Social Welfare & Development Defence Sector which acts as platforms for other sectors and Joint Task Force. AHA Centre, in operation of its own autonomy, reports to ASEAN Committee on Disaster Management

(ACDM) while coordinate with the ARCH project. The presentation of Future of Future Collaboration is listed as **ANNEX 15**

31. The ASEAN Secretariat presentation also explored potential mechanism and how to sustain beyond the ARCH project as well as maximizing those operations within the health sector and non-health sector. To enhance operational coordinative mechanism could be done through ASEAN EOC network which can enhance and sustain policy development, capacity building, knowledge management and coordination with AHA Centre. DHM Mechanism work with ASEAN Health Cluster 2 as well as AHA Centre as partner agency for response, preparedness and strengthening capacity in the context of health needs, response and coordination.

32. ASEAN collaboration in Disaster Health Management aims to achieve faster response. AHA Centre as Primary regional coordination agency has been initiated to strengthening ASEAN regional capacity in disaster management by having the following functions; planning and procedures, monitoring and information management, supplies and logistic, simulation exercise (ARDEX). This mechanism promotes paradigm shift towards inclusive and integrated response. Being able to sustain and enhance the gains from ARCH project into the ASEAN Health Cluster 2 work programme on Responding to All Hazards and Emerging Threats from 2021 and 2025 are the potential ways forwards. The following are to be anticipated from the implementation of ASEAN Leader's Declaration on Disaster Health Management; 1) Strengthening all hazard health emergency as part of national public health system; 2) Promote public and private investment in disaster risk reduction to support public health infrastructure; 3) Build resilient hospital capable in handling disaster event; 4) Strengthening Academic network and establishing regional disaster health training centre and 5); Mobilise sufficient international and financial resources to fill national response gaps.

XI. ASEAN LEADER DECLARATION AND PLAN OF ACTION

33. The ASEAN Leader Declaration and Plan of Act, led by Thailand, was drafted and proceed through the process of reviews and revisions. After the last revision of the draft in July 2017 in Phuket, the declaration was officially adopted by at the 31th ASEAN Summit in Manila, the Philippines in November 2017. The next process to bring the declaration into practice is the development of Plan of Action. The project working group, therefore, set the following timeline; 29 November 2017 draft consultation in the 4th PWG1 meeting; December-February 2018 submit for consultation with ACDM, AHA Centre and relevant ASEAN sectoral body; May 2018 submit for consultation for the ASEAN Health Cluster 2 and SOMHD. The document related to this session is 1) Meeting Presentation of the ASEAN Leader Declaration **ANNEX 16**; 2) Plan of Action **ANNEX 17**.

34. Dr. Phumin, ARCH Project Manager NIEM, briefly outlined the essences in each section of the Plan of Action before the meeting chair drew attentions to an exercise for AMS delegates to provide inputs on the Plan of Action's target Vs. activities matrix **ANNEX 18**.The meeting chair invited delegates to exchange ideas, add to the matrix on regarding potential targets and activities to be implemented as the result of the ASEAN Declaration on Disaster Health Management. The meeting agreed that the exercise will be completed by AMS delegate before *24 December 2017* for further development. Meanwhile, the meeting chair invited immediate comments delegate may have on the Plan of Action matrix.

35. The Declaration is another milestone to achieve in the ARCH project. In this light, a few discussion points were raised and agreed in the meeting. It was suggested that other sub-health sector such as reproductive health and mental health should be included in the workplan. It was emphasised that the drill is the essential part of the Plan of Action and most coordination, logistic, technical, finance and communication element can be carried out to test through the drills. It was suggested that the drill can be carefully studied from to extract lesson learned, and identify knowledge gaps. Consequently, research and studies can be carried out to fill the gaps and feed into the academic empowerment component of the project. Another suggested point from the discussion was to emphasise the importance of online means of communication such as telemedicine, logistic, common form database so that there's a common share of information and harmonize ASEAN response system.

36. In regards to the current Target Vs. Activity matrix, there are currently 7 activities, once inputs have been received and items are settled, the timeframe of the overall implementation will be designed per items of activities and targets. This matrix will be once again discussed in the 5th PWG 1 meeting, March 2018.

XII. CONCLUSION AND WAY FARWARD

37. The presentation by ASEAN Secretariat on Conclusion and Way Forward outlined the summary of the 2 days meeting as well as reiterate discussions and agreed points. This session document is referred to in **ANNEX 19**.

XII. CLOSING REMARKS

38. The meeting Chair, Dr. Jirot Sindhvananda expressed appreciation in active participation of the 2-day meeting by ASEAN Member State delegates, JICA, ASEAN Secretariat, Japanese Advisory Committee, Department of Disaster Prevention and Mitigation (DDPM) Thailand, and the ARCH Project team. This 4th PWG 1 meeting has come to an end but members are still actively progressing toward refinement of Regional Collaboration Tools in their own capacities before the next meeting in Danang, Vietnam in March 2018. The chair declared PWG 1 meeting close.

SUMMARY OF PROCEEDINGS

THE FIFTH PROJECT WORKING GROUP ONE (PWG1) MEETING ON REGIONAL COLLABORATTION TOOLS AND CAPACITY DEVELOPMENT

PROJECT FOR STRENGTHENING THE ASEAN REGIONAL CAPACITY ON DISASTER HEALTH MANAGEMENT (ARCH PROJECT)

29 March 2018

The Grand Tourane Hotel, Danang City, Vietnam

I. INTRODUCTION

1. The Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management (ARCH project) was the result of a survey conducted during December 2014 - March 2015 for all ASEAN Member State. The survey also collected relevant international trends from UN, WHO and ASEC, as well as regional meeting in Phuket, Tokyo and Bangkok respectively. One major challenge was identified from the survey that although different parts of the region confront different disaster challenge, collaboration in disaster emergency response was needed. Hence, ARCH Project was designed accordingly. ARCH Project mainly focuses on the coordination and team management of Emergency Medical Team (EMTs) of the offering and receiving countries. Major concerned agencies of ARCH Projects include JICA, ASEAN Secretariat, ASEAN Centre for Humanitarian Assistance (AHA Centre), and National Institute of Emergency Medicine (NIEM, Thailand). The intended outputs of the project are the coordination platform on disaster health management; the framework of regional collaboration practices; the tools for effective regional collaboration on disaster health management; academic networks on disaster health management in AMS and; capacity development activities implemented for each AMS.

2. The 5rd Meeting of Project Working Group (PWG) 1 was held on 29 March 2018 in Danang City, following the 2nd Regional Collaboration Drill hosted by Vietnam. The meeting was the follow-up event from the 1st, 2nd 3rd and 4th PWG 1 meeting held in January, May, July, and November 2017 respectively. The 5rd meeting was held to continue discussions, raised previously on the draft Regional Collaboration Tools including the ASEAN Leaders' Declaration on Disaster Health Management and its Plan of Actions, the Standard Operating Procedure (SOP), Health Needs Assessment (HNA) Framework, Minimum Requirements (MR), and Database of Emergency Medical Teams (EMT) in ASEAN and other ASEAN common forms. The meeting aimed to present drafted tools and invite delegates to provide inputs for their progress. In addition the 5th PWG1 meeting, delegates from the Philippines updated their progress in the hosting of the 2nd Regional Collaboration Drill to be held in December 2018. The agenda of the discussion is presented as **Annex I**.

3. The meeting was participated by delegates from ASEAN Member States (AMS); Brunei Darussalam, Cambodia, Indonesia, Malaysia, Philippines, Singapore, Thailand, and Viet Nam, Laos, Myanmar the Japanese Advisory Committee; the Project Team consisting of the National Institute for Emergency Medicine (NIEM) of Thailand, Ministry of Public Health (MoPH); and Japan International Cooperation Agency (JICA). The List of Participants is attached as **Annex II**.

4. The ARCH project had reached its half-life milestone out of the 3 years span and it is a successful on-going process of achieving the 5 project outputs. The progresses had been presented vis à vie the 5 outputs as follows;

Output 1: Coordination Platforms are setting up. Indicators including number of regional coordination meeting, clarification of focal points of each AMS are an on-going process until the end of March 2018.
Output 2: Regional Collaboration Drills (RCD) are carried out on track. The drill included start-up drill in Bangkok, 1st RCD in Phuket, 2nd RCD in Danang, 3rd RCD to be held in the Philippine. From the RCDs, lesson learned and recommendation are incorporated for future reference for the of regional collaboration mechanism among EMTs.
Output 3: Tools, standard Operating Procedure (SOP), minimum requirement, health needs assessment, EMT database.
Output 4: Academic network are setting up. Six academic presentations on the ARCH project and 6 academic conferences have been participated so far by ARCH project team.
Output 5: Capacity Development Activity for AMS's EMTs are being developed to reach the indicators of 4 training courses, the number of training for 150 team members as team and the training course on EMTCC in Feb 2019.

5. The project overall outcomes are expected to achieve within the span of 5 years in 2022 when the ASEAN and Japan collaboration mechanism on disaster health management is developed and effectively operating. The next schedule of the ARCH project is 28-31 May for its 4-days AMS Training held for the 3rd time in Bangkok on the topic of International EMT. On 17-20 October 2018, a 4-days study tour to Japan is to be conducted where 3 participants per AMS are expected to join. On 3-7 December, the 3rd Regional Collaboration Drill is to be held in the Philippines, followed by (PWG1/2 meeting and RCC meeting). Tentative schedule for the 4th AMS training is in February 2019, and project Seminar in June 2019. The presentation of project output achievements and next schedule is in **Annex III**

II. Conclusions and Recommendations for 2nd Regional Collaboration Drill

6. The 2nd Regional Collaboration Drill (RCD) and the Table Top Exercise (TTX) are held and later received survey comments from participants. The results are as follows; The TTX good points are creativity of activity using good learning and teaching processes, the good orientation on Electronic Minimum Data Sheet (E-MDS) makers and the introduction to RDC, EMTCC steps before deployment. The TTX's points to improve included; more time needed to complete forms; materials should be provided prior the exercise; provision of flow charts on CIX, RDC and EMTCC procedures. In the Field Training Exercises, the good points included; adequate logistics as well as facilitators and interpreters, appropriate drill time. While the points to future improvement were on communication problem i.e. radio frequency, role clarity needed for facilitators and interpreters and information regarding hospital beds and medical equipment. Dr. Kai, Japanese Advisory Committee added that in times of disaster management, communication failures are common challenge. If AMS take communication into serious account and find possible solutions to anticipated problems, the disaster is halfway managed. The full presentation of participant feedback on the 2nd RCD and TTX is presented as **ANNEX IV.**

III. Project Working Group 1 Meeting

7. The Project Working Group 1 meeting was held for the 5th time after the 2nd RCD in Danang. The 5th meeting was co-chaired by Dr. Jirot Sinthuwanon and Dr. Nguyen Duc Chinh. The chair invited AMS delegate to introduce themselves and commence the meeting, starting with the presentation of the 3rd RCD by the Philippines. Later, the ASEAN declaration on DHM and its Plan of Action, Standard Operating Procedures (SOP), EMT Database for ASEAN, EMT Minimum Requirements, Health Needs Assessment (HNA), and Medical Record Form were discussed respectively.

IV. Review of the Second Regional Collaboration Drill and Planning of the 3rd Regional Collaboration Drill in the Philippines

8. According to the World Risk Index, Philippines is ranked number 3 in 2013 as it was hit by 16 disasters and the most destructive one is Typhoon Haiyan with 26 million affected and 8000 casualties. It has been very challenging for the Philippine in terms of response when one disaster happen after another. According to study funded by JICA the movement of West Valley Fault in Metro Manila which is anticipated to cause a 7.2 earthquake in the near future. The Health Emergency Management Bureau of the Philippines which is a coordinating entity for all emergencies and disaster including human and non-human harm together with the government of Philippine is working on how to response. Metro Manila area is the heart for businesses and essential government offices. Study was estimating 35000 death, 115000 injuries, and 170,000 building collapse, 500 fire break, where capacity that hold evacuations and response is only 30%. Contingency plan for earthquake preparedness entitled “Oplan Metro Yakal Plus”. The said plan divides manila to 4 quadrants (North, East, West, South). The government will declare state of national calamities and need ASEAN EMT resource mobilizations.

9. It was acknowledged by every AMS members that the 3rd Regional Collaboration Drill in the Philippines will be held during 3-7 December 2018. The drill has the primary objective to examine the current regional collaboration mechanism on disaster health management including the SOP, HNA, and other EMT forms. The secondary objective, however, aims at testing the electronic reporting system called ISPEED which is the alternative to paper form and excel format. It also aims at improving collaboration and coordination. The tentative schedule include Table Top Exercise held on Dec 3, Regional Collaboration Drill on December 4th, review of forms on December 5th, PWG 1 and 2 meeting on December 6th and Regional Collaboration Meeting on December 7th.

10. The design of the drill and the Table Top Exercise are drafted and to be finalised in the later stage. However, it will incorporate the concept of EMTCC in all level of EOC as well as the incident command system (e.g. check-in, operation briefing etc). It will use Philippine data and alert reporting system. Philippines will also show AMS its Rapid Health Assessment they regularly use for familiarization while the ARCH project HNA would normally be used for the drill. The Table Top Exercise, on the other hand, focus on the assistance and registration. AMS is required to register at the Philippines International Humanitarian Assistance (PIHAC) as the reception center using Visial VOSOCC system and receive briefing at the national EMTCC. The second focus is on demobilization process including preparation of the exit report and other appropriate exit plans. The 3rd focus is on the discussion and practice of ISPEED reporting system, completion of common forms and communication exercise. ISPEED is another tool to be tested for use, however, in real response situation it is suggested that all means of communication i.e. paper, electronic, cloud and radio should all be applied as appropriate and available. Full presentation of the RCD plan in the Philippines is presented in **ANNEX V**

11. Recommendations towards the presentations were raised. Dr. Phumin, Project Manager, suggesting that to avoid the Pre-Deployment phase to be left out of the drill before the project ends, more stakeholders should be more involved to make the drill completed especially the coordination process among Philippines NDMO and AHA centre to acknowledge mobilization request. For this, it was *agreed that 1 month before the 3rd RCD in December in Philippines* as well as other AMS should contact their NDMO to contact AHA Centre to acknowledge deployment. Additional emphasis should be placed on logistics of medical supply for the custom process which is a great delay factor as well as the logistic arrangement for the mobilized EMT i.e. clean water for operation. It was therefore suggest that the mechanism should involve other entities in DHM field e.g. UN agencies, NGOs and military for realistic collaboration during the time of disaster. It was also suggested that Day 1 of the RCD in Philippines allocated for forms completion training could be skipped, but instead incorporate it in the AMS training to be held in May 2018 in Bangkok in order to lengthen the time for the drill. It was requested and agreed that those joining the AMS training in

May 2018 will be required to participate in the RCD in Philippines in December 2018 to transfer the trained skills and knowledge to practice.

V. Implementation of ASEAN Leaders' Declaration on Disaster Health Management

12. The ASEAN Leaders' Declaration on Disaster Health Management was submitted and endorsed by the SOMHD in November 2017. As the result its Plan of Action is being developed and to be submitted in April 2018. The Plan of Action has the overall 11 tasks in 5 priority areas to be implemented through 2 mechanisms; 1) Regional Coordination Committee on Disaster Health Management and; 2) ASEAN Institute for Disaster Medicine. The priorities to be implemented though Regional Coordination Committee on Disaster Health Management mechanism include; 1) Strengthening and enhancing of the regional collaborative frameworks on disaster health management, 2) Multi-sectoral participation in disaster health management, 3) Integration of disaster health management framework/concepts into national and sub-national legal and regulatory framework. Whereas, the priorities to be implemented under ASEAN Institute for Disaster Medicine mechanism include; 1) Investment to improve and develop critical health facilities and infrastructure and 2) Education and training on disaster health management.

13. The session draws discussions toward the formation of Regional coordination Committee on Disaster Health Management beyond the ARCH project which could sustain the project mechanism and ASEAN Disaster Health collaboration. Although not yet agreed on the definite title, the committee will have 4 main functions being; 1) facilitation of the development of any regional collaboration on disaster health management which occurs in the future; 2) Collaboration with related ASEAN Sectoral bodies in health and non-health sectors and other international organisations; 3)Development of any other Standard Operating Procedures (SOP) and other collaboration tools if appropriate in the future and; 4) Organization or attendance to joint drills. The committee consists of 20 representatives from AMS, ASEAN Secretariat and AHA Centre. The host country of events and chairmanship are in rotation. And the RCC meeting shall be held twice a year, while the drill should be accustomed to be organized as necessary. The possible financing model for the committee is either though AMS donation to host and outside funding. ASEAN Institute for Disaster Medicine

14. A concern was raised in response to the various taskforce to be form under ASEAN Secretariat. The clarity was sought through discussion and settle into an agreement that as Disaster Health Management is one of the identified priorities AMS can come together and address to different contact on specific issues. The taskforce (committee) do not have to formally report to ASEAN Secretariat but instead report to ASEAN Health Cluster 2 which is the working cluster various health related networks (professional, academic and diplomatic) can form under. This committee is necessary for SOP development, drills, development of any collaborated trainings, capacity building and various others as stated in the 4 main functions. Although still not settle for the title, the word "*Network"* can be considered instead of "Committee".

VI. **Regional Collaboration Tool: Standard Operating Procedure (SOP) for the Coordination of EMT in the ASEAN**

15. The 5th PWG1 meeting invites AMS members to acknowledge the changes as well as providing comments and feedbacks to the Standards Operating Procedures. The discussions have yielded the following results

- **The list of Acronyms and Abbreviations** stays at the beginning of the SOP before Introduction in order for readers to relate to throughout the text.
- **Part I**. Introduction has no revision.
- **Part II. Paragraph 6** Agreed to change the word "Ministry of Health" into "Ministry of Health/ public health" to cover every AMS naming system

- **Paragraph 7** Agreed to change from "…and information tools" to "…information tools and information sharing"
- **Paragraph 8** Agreed to use the previous content but revise text to "The EMTCC should be activated managed and staffed by trained and experience personnel"
- **Part III. Paragraph 12** Agreed to add the phase "The national focal unit for EMT coordination in time of disaster should be officially designated" A concern was raised about the designated person in case the person moves to other roles. It should therefore be made clear that the designation should be to a position or working unit while not to a person. However, official designation should be made in order to firmer the role and responsibility.
- **Paragraph 15** Agreed to delete contents in the bracket
- **Part IV Paragraph 18** Agreed to revise the text "The MOH may send the request for assistance or initiate the offer of assistance…" to "The MOH may send the request for assistance through NDMO following SASOP mechanism."
- **Paragraph 19** A concern was raised in the word "self-sufficient" in the practical way of deploying EMTs. It is suggested no change in word but a remark for future reference to find coordinating platform e.g. NGO, UN agencies, WHO, Red Cross to provide EMT with logistic support in the field where the EMT can focus on medical operation more intensely. Coordination with other platform would also make the deployment more practical and in line with existing players in the field.
- **Paragraph 20** Agreed to change the word "Virtual On-Site Operations Coordination Centre (OSOCC)" to "Virtual On-Site Operations Coordination Centre (VOSOCC)"
- **Paragraph 25** Agreed to change the phrase "I-EMT shall report to the EMTCC to complete EMT…" to "In the event that, the registration of the incoming I-EMT cannot be done, at RDC, the concerned I-EMT shall be report to the EMTCC to complete registration".
- **Paragraph 26** Agreed to revise the text from "I-EMT registration needs an approval from the Professional Medical Regulatory Authority (PMRA) and Nursing Regulatory Authority (NRA)…" to "I-EMT registration needs an approval from relevant Health Professional Regulatory Authorities through National Focal Points facilitating mechanism"
- **Paragraph 33** Agreed to change the phrase "If EMTCC is not capable, the I-EMT shall organize regular meetings…" to "I-EMTS shall contact PHEOC/MOH/MOPH for assistance when EMTCC capability is limited."
- **Paragraph 44** Agreed to change the phase "utilize a single triage system" to "utilize a standard triage system", with more clarification that every country can use *any* "standard triage system"
- **Part IV. D.** Agreed to change from "(Rapid) Health Needs Assessment" to "Health Need Assessment" and replace texts in the brackets to "The I-EMTs shall provide additional Health Needs Assessment when EMTCC requests. [Annex 9]"
- **Part IV. Paragraph 37** Agreed to change the phase from "The EMTCC or Sub-EMTCC, shall exercise the overall direction…" to "The EMTCC or Sub-EMTCC, shall *conduct* exercise *(meeting)* for overall direction, coordination and supervision of the EMTs operations within its territory"
- **Paragraph 40** Agreed to move the phase "EMTCC Situation Report (Annex 11)" to place after "The EMTCC or Sub-EMTCC shall submit to the PHEOC…". And remove the phrase "at the end of the first day and the third day" as well as the word "Thereafter".
- **Part IV Flowchart** Agreed to remove flow chart.
- **Paragraph 40** Agreed to revise phrase to "The EMT shall inform the EMTCC to sub-MTCC the anticipated end of…"
- **Part IV. I.** Agreed to delete content in the bracket
- **Part V.** Agreed to replace content in the bracket to "SOP for Coordination of Emergency Medical Teams (EMTs) in ASEAN member states shall be revised and updated concurrent with SASOP, or deemed if necessary"
- **Part VI. Annexes** Information will be collected by the Project to complete the list.

Part V Annexes 15 Agreed to revise Acronyms & Abbreviation. Please refer to the full presentation to see complete lists of change in **ANNEX VI.**

VII. Regional Collaboration Tool: ASEAN EMT Database

16. This session aimed to report the progress on the development of Database of Emergency Medical Teams (EMTs) in ASEAN and thus to revise Data Collection Sheet Draft Version 1. So far, Data Collection Sheet was circulated to focal points of ASEAN Member States on January 19th, 2018. The project team has not received any comments or feedbacks on the revised Data Collection Sheet. In the course of the project timeline, EMT related data collections are to be conducted in 2 rounds. In the first round, the project team circulated data Collection Sheet to the ASEAN Member States on February 27, 2018, and received 2 questionnaires back out of 10 AMS. The 2nd round will be conducted in July-September 2018, where AMS is firmly requested to return filled questionnaires in order to complete the ASEAN EMT database. The full presentation for this session is presented in **ANNEX VII.**

VIII. Regional Collaboration Tool: Minimum Requirement and Qualifications for Members of Emergency Medical Team (EMT)

17. The current version of the Minimum Requirements and Qualifications for Members of Emergency Medical Team (EMT) is the version that has been presented in the 4th PWG 1 Meeting in November 2017. It, however, received a revision after the 2nd Regional Collaboration Drill. The revision summaries are as follows.

- **Tier I Registered as a member of EMT**: It was agreed to include induction or pre-registration course (Basic Disaster Management). Hence, the phrase "…such as basic disaster management, etc." is added to the text "EMT members are required to successfully complete an induction or pre-registration course."
- **Tier II Ready to deploy domestically:** It was agreed to include examples of the courses such as ICS, self-sufficiency in disaster, working in limited resources, etc.) and hence revised texts accordingly.
- **Tier III Ready to deploy to any members states:** It was agreed to revise texts into "EMT members must complete a standardized training curriculum to be developed and accepted by all ASEAN Member States (such as medical treatment, intercultural management, resource management, communication skill, health care system in all AMS, AADMER, Standard Operating Procedure (SOP) for Coordination of Emergency Medical Teams (EMTs) in ASEAN, Team coordination (e.g. SASOP, EMTCC), etc.)". The full presentation for this session is presented in **ANNEX VIII.**

18. Recommendations and concerns were raised by AMS members towards the Minimum Requirement. Firstly, a concern was voiced that Tier 3 requirements maybe too high and thus difficult to achieve. Despite the fact that it was common that I-EMT requirements are high in being able to deploy to other ASEAN countries, it should be taken into consideration the practicality in achieving requirements. It is also difficult for everyone to complete the standard course and so it was recommended that the requirements to take course should be on competency basis. Development standardised training curricula that will be tailored for different members of the ASEAN EMT will be developed by PWG 2 of the ARCH Project. Another recommendation point was raised that all courses should be accessed and studied online where course, exams and certificates can be accessed online to save resources in mobilization.

IX. Regional Collaboration Tool: Health Need Assessment Framework

19. The Project Team first emphasized that the role of EMTs in collecting information was supplemental, and the HNA Form could be used as "A Guide" for EMTs when conducting HNA upon

request from a local authority; necessary action or further assessment would be taken by other relevant parties. Subsequently, the meeting discussed revisions on the draft HNA Form and Summary Report Form based on the feedback and comments from the 2nd RCD.

20. The revisions include;

For the HNA Form:

- It was agreed that the HNA form for village or town and the form for shelter(s) would be consolidated into one form. A section of "Number of patients with mental health and psychosocial problems" was added in Page 2, 1-7
- **P3, 2. Public Health 2-13: "What kind of food available or provided":** The meeting agreed that food items listed here should be categories into rough clusters, and add question ""How long will the available food last?"
- **P4, 3-1. Health Facilities and Services:** It was suggested that for the health facility which is partially functioning, add question "What services are available?"
- **P4, 3-2. "Access to Referral Facilities by Road":** The meeting agreed to change the question to "Is the health facility accessible" and "If yes, by what means?"
- **P4, 3-3. "Availability of Communication, Transportation":** The meeting agreed to keep the questions on Communication and Transportation, as communication was important in sending information to EOC, and transportation was also important for referring patients.
- **P4. 3-4. "Availability of Essential Drugs" and "Availability of Vaccines", "Availability of Medical Equipment" and "Availability of Supplies":** The questions in this section will be kept. Potential key informants should be identified.
- **P4. 3-5.** "**Health Staff Working":** The meeting agreed that Number and Percentage should be kept as it has its own advantage to know the situation. However, if information cannot be gathered, it can be left blank.
- It was suggested that additional information can be included in "Remarks/Notes" section under each set of questions.

For Summary Report Form:

- It was agreed that in the Check Box, use "WASH" instead of "Water", "Sanitation" and "Hygiene", and include MHPSS (Mental Health and Psychosocial Support).

21. The proposed schedule for the Health Need Assessment Framework;

-20th April -The Project Team will revise the HNA Form and Summary Reporting Form by incorporating the comments from the PWG1 members, and the revised versions will be circulated among the PWG1 members of AMS through ASEC.
-14th May - Deadline for feedbacks on the revised versions of the HNA Form and Reporting Form by the PWG1 members.
-July (Tentative) -The revised forms will be discussed in the 6th PWG1 meeting.
-December - The re-revised forms will again be tested in the 3rd Regional Collaboration Drill (RCD).
The presentation of the HNA is attached as **ANNEX IX.**

Regional Collaboration Tool: Medical Record

22. Similar to other Regional Collaboration Tools, the Medical Record Form received another round of revision after the 2nd RCD. This session sought feedbacks and comments to the forms. General comments received are for example; difficulties in reading the form due to small letters and others. It was also found that information such as Number of site, team, date, name, age, sex, record date and signature are often left blank, which indicate possible difficulties that the

project team have to address. It is also noted that the right side is essential for data to be filled in order to plan resource mobilization. The left side is optional. In this occasion, the sections on vital sign and past history, as well as the medical examination and nurse /doctor notes received no revisions. Other revisions in each section are as follows;

- Simplification of patients' details based on Thai Medical record for Emergency and Disaster
- In "Hazards (if any)" section, mechanism of injury e.g. traffic injury, falling etc. is added.
- In "Chief Complaint" section, replace boxes of conditions to free form space.
- In "Investigation, Management, and Procedure" sections, replace boxes of conditions to free form space.
- In "Disposition" Section, add Discharge home or shelter > go to 32-33.
- In "Disaster related", disaggregate the section into "Follow up, Outcome, and context" and refer completion to the left side (Procedure and Outcome).

23. The up-coming schedule to address Medical Record form are; distribution of the revised version for PWG1 members for their reviews on 30th April, deadline for feedback submission on 31st May and, feedback received from PWG1 meeting in June 2018. This Medical Record Form is subjected to the test in the next RCD received other rounds of revision. The full revision details and presentation on Medical Record is presented as **ANNEX X.**

XI. Wrap Up and Way Forward

24. ASEAN Secretariat Representative kindly delivered the 5th PWG1 meeting wrap-up messages and way forwards. The conclusions are drawn to the following contents discussed in the meeting;

- The progress in the implementation of the project, and achievement of project outputs was noted;
- The project activities scheduled in 2018 and 2019 were presented and agreed;
- The committee on the conduct of Second Regional Collaboration Drill was discussed;
- The focus of the next AMS Training will focus on EMT Coordination Cell, including communication and management was presented and agreed;
- The plan of Philippines in the hosting of the Third Regional Collaboration Drill in December 2018 in Manila, Philippine;
- The Third RCD and Related Meetings agreed to be held on 3-7 December 2018;
- The Third Regional Collaboration Drill was agreed on the proposed concept and design;
- The possibility of organising a meeting of PWG 1 to finalise detailed plan for the upcoming drill was discussed;
- The proposed Plan of Action to implement the ALD on DHM, and the Regional Coordination Committee (RCC) on DHM was presented by Thailand, Lead Country for the ALD on DHM;
- The documents and further discussion were presented during the Third Meeting of RCC, ARCH Project, on 30 March 2018;
- The proposed revisions of the draft SOP based on experiences from the Second RCD were agreed;
- The report on the development of the forms for the database of EMT in ASEAN, and the on-going data collection were noted;
- The report of the ARCH Project Team in the development of Minimum Requirements and qualification for members of EMT, and proposed revisions were noted;
- The proposed revisions of the HNA form based on feedback from the Second Regional Collaboration Drill were noted and agreed upon;
- The presentation of ARCH Project Team on the proposed revisions of the medical record form based on feedback from the Second RCD was noted;

25. The ARCH Project Team will produce updated versions of the draft regional collaboration tools, incorporating agreements from the Meeting, and circulate to PWG 1 Members through ASEAN Secretariat by 20 April 2018. The PWG 1 Members will review and provide further feedbacks to the tools by 14 May 2018. The PWG 1 Members will also facilitate the submission of data/information for the Database of EMT in ASEAN by 14 May 2018. The revised tools will be further discussed during the Sixth Meeting of PWG 1 tentatively scheduled in June 2018. It is to note that the revised tools produced by the 6th Meeting of PWG 1 will be tested during the Third RCD on 3-5 December 2018 in the Philippines. The presentation of this section on way forward and conclusion is i**n ANNEX XI**

26. Closing Remarks were delivered by the meeting co-chair The meeting Chair, Dr. Jirot Sindhvananda expressed appreciation in active participation of PWG1 meeting by ASEAN Member State delegates, JICA, ASEAN Secretariat, Japanese Advisory Committee, Department of Disaster Prevention and Mitigation (DDPM) Thailand, and the ARCH Project team. This 5th PWG 1 meeting has come to an end but the Project Team and members will continue their work in refining the Regional Collaboration Tools in their own capacities before meeting again in the next meeting in June 2018.The chair declared the 5th PWG 1 meeting close.

THE FOURTH PROJECT WORKING GROUP TWO (PWG2) MEETING ON REGIONAL COLLABORATTION TOOLS AND CAPACITY DEVELOPMENT

PROJECT FOR STRENGTHENING THE ASEAN REGIONAL CAPACITY ON DISASTER HEALTH MANAGEMENT (ARCH PROJECT)

29 March 2018

The Grand Tourane Hotel, Danang City, Vietnam

I. INTRODUCTION

Dr.Nguyen Nhu Lam as the chair of Project Working Group 2 (PWG2) meeting introduced himself, and his co-chair, Dr.Narain Chogirosniramit, greeted participants of the PWG 2 meetings from all ASEAN Member States (AMS) and delegates from ASEAN Secretariat. Dr.Nguyen reiterated the agenda of today's PGW2 meeting as followed; (1) Dissemination of Inputs from the 2nd Regional Coordination Drill (RCD), (2) Planning of the third AMS training in May, focusing on I-EMT, (3) Discussion on the 4th AMS Training, (5) Discussion on the Implementation of ASEAN Leader Declaration on DHM: Training Center, (6) Discussion on Training and Study Tour in Japan, and finally (7) Wrap-up and Way Forward session. The introduction session ended with each AMS team members performing self-introduction.

II. INPUT FROM THE 2ND REGIONAL COLLABORATION DRILL

Dr. Nopmanee Tantivesruangdet, Emergency Physician of Rajavithi Hospital, Bangkok took this opportunity to share with all participants the input from the 2nd RCD, conducted between March 26th-28th, 2018 in Danang City, Vietnam. She began her presentation with a brief introductory explanation about EMT members' minimum requirements and qualifications, as followed; (1) EMT members must undertake field training courses to practice on how to operate within limited resources and emergency context, and (2) EMT members are required to complete pre-registration and theoretical courses such as basic disaster management to enhance knowledge on disaster medicine and EMT operation. EMT membership is categorized into three tiers, namely; (1) TIER I, registered member of EMT, (2) TIER II, ready to be deployed domestically, and (3) TIER III, ready to be deployed to any member states. In order for the EMT of each AMS to qualify for being deployed to other AMS, such an EMT must complete a standardized training course curriculum, including medical treatment (trauma and non-trauma care), intercultural management, resource management, communication skill, health care system in affected country, AADMER, SASOP, SOPs for Coordination of EMTs in ASEAN. Such a curriculum would be developed under the ARCH project.

On March 26th, 2018, tabletop exercises were the main activities, which included SOPs for operation Registration and Departure Center (RDC), EMTCC steps before deployment. The form filling included standard forms such as SASOP1, 3, 4, and 7, Exit Report form, Daily report form, Situation Report, Patient Referral Form, and Medical Record Form (MDR). In addition, the orientation on Electronic Minimum Data Sheet (EMDS) was also conducted.

For field exercise on March 27th, 2018, communication failures and gap among the organization for triage and treatment zone were some of the most common issues rose during the session. Moreover, there was a diverse range of knowledge and skill in regard of Health Need Assessment (HNA). During the so-called HNA session, triage was found to be the main problem, as only a small proportion of the participants chose to use triage system, while most of them preferred clinical method. Additionally, triage tag cards usage rate was only at 64%, which was initially expected to be at 100%.

During the After Action Review session, the questionnaire was given to all AMS to gather opinions on which issues are to be included in the EMT training. The survey results reveals that (1) Roles and

Responsibilities for affected country in EMT coordination (100%) and SOPs for EMT coordination (81.82%) were two of the most necessary issues for AMS's EMT training. In addition, the survey reveals that AMS felt the most appropriate channels of training would be (1) Regional Training Program (81.82%) and Regional Training Course with Curriculum (72.73%).

Then, Dr. Kanin Keeratipongpaiboon, Orthopedic Physician from Bangjak Hospital Thailand, continued the session by elaborating on the HNA procedure. As a method for primary data collection used primarily by EMT during the disaster response, HNA helps to identify the vital needs of the affected population and define the need-based response. The information collected from HNA is used to mitigate the crisis impact, precaution for potential health risks and share with local authority and other sectors in disaster response. The consensus among AMS suggested that HNA is non-compulsory and EMTs shall conduct HNA only if they have capacity to do so. Local authority of the receiving country may determine whether EMT shall conduct HNA.

From the drill exercise, there turned out to be some points for improvement regarding on the HNA, such as gap of HNA-related skills and knowledge existing among EMTs. Thus, capacity building can be done through the development of knowledge and skill for HNA and form utilization, as well as acknowledgement about roles and responsibilities of EMT for HNA.

Comments

- Philippines shared their opinion that HNA should be prioritized and other non-medical needs should be assessed too. The Philippines understood that there have been some constraints within AMS, so scoping on what AMS have already got for this particular issue can be much helpful. The Philippines can share the forms and methodology that have been developed. Without HNA, disaster response would not have been this successful.
- Indonesia shared the experience and raised a question whether international EMTs that are deployed to a foreign country should also conduct the HNA, or leave the task to the receiving country and only follow the policy from the host country. Ms.Junko Sato, ARCH expert team added that so far the importance and instruction of HNA have not been discussed. Nonetheless, such matters can be put as one of the topics for the 3rd AMS training.

III. PLANNING OF THE THIRD AMS TRAINING IN MAY (ON I-EMT)

Dr.Narain Chogirosniramit began by reiterating on the objectives of this particular session as; (1) the finalization of the 3rd AMS Training programmeand schedule and (2) the finalization of resource persons for the training. Dr.Chorirosniramit referred all the PWG 2 meeting participants to ANNEX 1 for Discussion Points for the 3rd AMS Training, as well as to ANNEX 2 for the Proposed Program for the 3rd AMS Training.

The 3rd AMS Training will be conducted between May 28th-31st, 2018 at Pullman Hotel in Bangkok, Thailand, where each AMS is expected to send 4 participants, including 1 team leader and 3 members. There are 4 main objectives of the 3rd AMS Training, namely; (1) to learn the process and efforts for deploying International- EMT from experienced countries, (2) to understand core/common requirements of I-EMTs during deployment, (3) to understand minimum Pre-Deployment and Post-Deployment Requirements to ensure the requirements during deployment are met, and (4) to understand the role of receiving country/ how receiving country coordinates with I-EMTs.

In terms of participants from AMS, resource persons are to be selected mainly from experienced countries (e.g. I-EMT deploying country), who will be included as one of the four participants from that particular AMS.

Meeting participants from all AMS were requested to separate into two groups to conduct the discussion session on program and topics of the training and possible resources, based on the discussion of the previous PWG 2 meeting and inputs from the 2nd RCD. Group A consisted of representatives from

Brunei, Cambodia, Indonesia, Thailand, and Myanmar while Group B consisted of representatives from Lao PDR, Malaysia, Philippines, Singapore, and Viet Nam.

Ms. Junko Sato added that the reason for putting WHO standard requirement in Day 1 of the 3rd AMS training was because we learned, in November 2017, that many participants did not fully understand WHO standard. There a brief review could be useful for the participants in order to give some thought over, whether the WHO standard would be too hard to achieve, considering each AMS's capacity.

Presentation of Group A

Dr.Phummarin Saelim suggested that as Group A the authority personnel in MOH of each AMS as a target group of the 3rd AMS training in May 2018. Therefore, the discussion was based on the plausible need of those big authority. On Day 1, experienced countries would be divided into two groups, namely; (1) the countries with I-EMT deploying experience consisting of Japan, Malaysia,Thailand, and Philippines and (2) the countries which received aids from other I-EMT, consisting of Indonesia, Myanmar and Philippines. And Group A agreed with the WHO classification, and it should be taught to the participants.

On Day 2, Dr.Lam from Vietnam was invited to talk about the PHEOC training course and Group A realized that such a training would be invaluable for all AMS. However, the group saw it was necessary to add a topic on ASEAN Emergency Operating Center, experienced by Malaysia, which can depict a picture for bio-safety and CBRNE.

On Day 3, Group A realized that the authority personnel do not need to acquire a full knowledge of EMT personal preparation and logistic requirement. Thus, only a brief summary of idea would suffice. On the other hand, according to the experience in the 2nd RCD, form filling forms activities would be beneficial, especially of the SASOP form 1 – 4, and exit form. Such activities would equip them with knowledge on I-EMT deployment mechanism. All topics suggested in the 2nd RCD questionnaire should be included into the content of the 3rd AMS Training.

Day 4 would be spent on after action review, wrap-up session and way forward. Group A had no other comments on this issue.

Presentation of Group B

Group B suggested that Day 1 should be divided into two parts. The morning session should place an emphasis on the WHO standard and health needs assessment. The topic can be in the framework level. The afternoon session shall be allocated for the presentations of the experienced countries, such as Japan, Philippines, Indonesia, Malaysia and Vietnam. After the presentations, discussion panel can be used for identifying on key challenges and improvement points.

On Day 2, apart from lectures, the training could be done in the forms of scenario, case study and table top exercises. Moreover, in the information management section, the training shall include reporting structures both for the templates and flows. Information requirement and report mechanism should be made clear for all participants in the early stage of the training (from EMT, EMTCC, PHEOC, etc)

On Day 3, an emphasis should be placed on the standardization of the forms, which all AMS would use during the operation in order to lower the work of PHEOC in acquiring information. The use of technology could be applied for reporting and information exchange such as database and checklists. For the lectures, Japan and JICA should not be responsible for all lectures. Some AMS can offer the course, depending on the finalized syllabus. Additionally, for topic 3 and 4 of the proposed program, table top exercises should also be included.

Finally on Day 4, the session should focus on course evaluation, and after action review. Then, the meeting/training could recap on the proposed way of deployment of logistics, whether it can be self-sufficient, or where to receive additional supplies etc.

Comments

- The Philippines emphasized on the change of Day 1 schedule, from having the WHO standards and HNA in the morning instead of having them in the afternoon as the initial plan suggested. By doing so, a comparison between the WHO standard and AMS's EMT actual deployment experience could be made. Moreover, from previous experience, the Philippines have been very weak at documenting experiences, challenges, best practices. Therefore, it is important to have a standard documenting procedure. This issue shall be focused during the training of topic 3 on Day 3.

The finalized schedule of the 3rd AMS Training, to be held in Bangkok Thailand, is shown below;

Day	Program	Resources
1	Morning Session	
	❖ Opening Remarks (10 minutes)	Thai personnel
	❖ Introduction of all AMS participants (20 minutes)	
	❖ WHO Standards Part 1 (1 hour)	WHO (TBD)
	❖ Break	
	❖ WHO Standard Part 2 (1 hour)	Japan
	❖ Group Discussion: Challenges in meeting WHO EMT standards	All AMS
	Afternoon Session	
	❖ Receiving countries, on experience and challenges (20 minutes each)	Philippines, Myanmar, Indonesia
	❖ Deploying countries on (1) experience and challenges, (2) I-EMT preparation for deployment, and (3) challenges in obtaining WHO classification (20 minutes each)	Japan, Thailand, Philippines, Malaysia
2	PHEOC Training (whole day) ❖ Background of EMT initiative & EMTCC ❖ Basic Skill of PHEOC (sequencing) ❖ Quick view of EMT ❖ Core purpose and role of EMTCC ❖ Flow of EMT response ❖ Basic knowledge of PHEOC ❖ Functions of PHEOC ❖ Component (person) of PHEOC ❖ Equipment needed in PHEOC ❖ Information management(MDS→I-SPEED) ❖ Using the WHO EMT Minimum Data Set ❖ Incorporating Health Needs Assessment ❖ Meeting agenda ❖ Media collaboration (as suggested by Philippines) ❖ ASEAN EOC Network establishment (15 minutes)	Japan, Thailand Malaysia
3	Morning session	
	❖ Personnel preparation of EMT (Activation →Deployment) (30 minutes)	Singapore
	❖ Logistic requirement: food, accommodation, communication, coordination, waste management, survival tips, transportation	JDR Secretariat, Japan
	❖ Tabletop exercise: Pre-deployment, Deployment, Post deployment (demobilization) process & procedure, SOP, registration of EMT, exit strategy handover process	Japan Advisory Committee, ARCH

	Afternoon session ❖ Tabletop exercise(cont'd) ❖ Safety and security, command & control ❖ Filling the forms (briefing) (major forms) Exercise: filling the forms	 Japan Philippines Thailand
4	Morning Session ❖ Group Discussion on ASEAN Standard	 All participants
	Afternoon Session ❖ Feedback, course evaluation from participants ❖ Wrap-up and Way forward, ❖ ❖ Upcoming Events/Activities of ARCH Project ❖ Closing remark	 All participants ARCH Project Team ARCH Project Team ARCH Project Team

IV. PLAN FOR THE 4TH AMS TRAINING

Dr.Narain Chogirosniramit started the session by ensuring all AMS participants had received all of the handouts needed, namely: (1) ANNEX 3: WHO, EMTCC Concept Note and (2) ANNEX 4: WHO, EMTCC Training Agenda & Learning Outcome. This session's main objective was to discuss training needs and agree on the program of the 4th AMS Training, of which main theme would be based on "Effective incident and emergency management at EMTCC".

The training needs for the 4th AMS Training included (1) Issues and challenges in receiving I-EMT, and (2) necessary skills and knowledge, derived from the feedback of the 2nd RDC and tool development. These two factors would constitute the knowledge on roles and responsibilities of receiving country, i.e. how receiving country coordinates with I-EMTs. The proposal of this training is to use the EMTCC Training Course of WHO. Please refer to more detail in ANNEX 3 and ANNEX 4.

The 4th AMS Training will be held in February 2019, which has been changed from the original plan of November 2018. The host venue would be in Bangkok, Thailand. Three representatives from each AMS would be invited to the training.

The ARCH project team will observe the WHO EMTCC training in April 2018, Macau. The advantage of following WHO's training course is that the participant, who completes such a course, will join a pool of responders available for secondment to EMT Coordination Cells during emergencies
Thus, WHO are willing to support the ARCH project for the pursuit of such a goal. The revision of the program could not, however ensure the trained country to qualify for the WHO standard.

Comments

- Philippines suggested to put additional topics such as legal, and inter-cultural aspects into scenario exercise. Ms.Sato clarified that the ARCH project team would observe the training in Macau and discuss for the essential points that might not be included in the WHO's EMTCC course. However, additional topics imply longer training session, which will need to be discussed again.
- Philippines had conducted some trainings, of which course evaluations could be shared, specifically the recommendation parts. The conducted trainings were also supervised by the WHO so the recommendations could be helpful for the project.

V. TRAINING AND STUDY TOUR FOR AMS in Japan

Ms. Junko Sato gave a presentation on the proposed overall plan of the study tour in Japan. The main objectives of this session were (1) to agree on the overall plan of the tour and (2) to discuss the training needs and topics. There are altogether 3 objectives for the study tour, namely; (1) to understand the system of disaster health management in Japan, (2) to identify the challenges and to consider the measures for further strengthening the disaster health management and regional collaboration in ASEAN and (3) to establish a network of medical professionals involved in disaster health management in Japan and ASEAN.

Tentative proposal has been summarized in the below table.

Period	17- 20 October, 2018 (4 days)
Place	Kobe, and surrounding area, Japan
Program	The Program will consist of 1) Participating Asia-Pacific Conference on Disaster Medicine (APCDM) 2) Understanding lessons learned from the Great Hanshin Awaji Earthquake - Japanese system (e.g. Hospital disaster preparedness and response, EOC at prefectural/municipal (e.g. Kobe) level 3) Participating JDR Training or relevant training
Participants	3 participants from each AMS, consist of 1 team leader, 1 team member and 1 actual deployment personnel. All members must be good at communicating in English and must not be military personnel (according to Japanese ODA policy)

Tentative itinerary is summarized as followed;

Day	Itinerary
16 October (Tue)	Arriving at Kansai Airport
17 October (Wed)	AM : Briefing PM : Attend the APCDM at Kobe City and some AMS are requested to do presentations.
18 October (Thu)	Visit to - Disaster Reduction and Human Renovation institution - Hyogo Emergency Medical Center (HEMC) - Hyogo Prefectural or Kobe Municipal office (EOC at local level)
19 October (Fri)	Participating JDR training - Clinical training
20 October (Sat)	Visit to Awaji Island (epicenter of the Great Hanshin- Awaji Earthquake in 1995) - Memorial Museum - Awaji Hospital
21 October (Sun)	Leaving from Kansai Airport

Comments and Requests

Philippines made a request of including the documentation procedure and mechanism of experiences and curriculum formation of the disaster medicine into the study tour. Ms.Sato responded that the Japan Disaster Relief (JDR) team has been revising the training curriculum, so the project team will see whether the experience and reason of revision can be shared with all AMS.

VI. IMPLEMENTATION OF ASEAN LEADER DECLARATION ON DHM: TRAINING CENTER

Dr.Phumin Silapunt, Deputy Director, Chulabhorn HospitalThailand, greeted all participants and started his presentation by reconfirming the handouts needed for this session, which were (1) ASEAN Leaders' Declaration, (2) Plan of Actions (POAs) to implement the ASEAN Leader's Declaration and (3) ASEAN Institute for Disaster Medicine.

The objectives of this session were (1) to review and seek comments on POAs to implement the ASEAN Leaders' Declaration on Disaster Health Management and (2) to seek feedbacks on the initiative to establish the training center as a mechanism to implement the POA. The POAs are supposed to be submitted to Senior Officials Meeting on Health Development or SOMHD in April 2018.

In the ASEAN Leaders' Declaration on Disaster Health Management, there are in total 11 articles, categorized into 5 different Areas. These five areas are as followed; (1) Strengthening and enhancing of the regional collaborative frameworks on disaster health management, (2) Multi-sectoral participation in disaster health management (3) Integration of disaster health management framework/concepts into national and sub-national legal and regulatory framework, (4) Investment to improve and develop critical health facilities and infrastructure and (5) Education and training on disaster health management.

The Plan of Action to implement the ASEAN Leaders' Declaration on Disaster Health Management consists of 2 mechanisms, namely; (1) Regional Coordination Committee on Disaster Health Management, responsible for Area 1 - 3 and (2) ASEAN Institute for Disaster Medicine, responsible for Area 3-5. The first mechanism was presented in the PWG 1 meeting. Please refer to the PWG 1 report for more detail.

The second mechanism, ASEAN Institute for Disaster Medicine, would place an emphasis on academic aspect of DHM, through consultation, research, knowledge management and training. All functions would operate in the interest of National Capacities Development. In summary, there are altogether 4 main functions of the ASEAN Institute for Disaster Medicine, namely; (1) organizing academic seminars to share knowledge and best practices, (2) constructing academic network and co-conducting research, (3) organizing training activities and (4) conducting consultation.

Focusing on the 3rd function i.e. organizing training activities, the scope of applicant is I-EMTs, decision and policy maker, public health personnel, and community health worker or volunteer. The methodology could include E-Learning, and applying the Standard Curriculum, developed by the Institute. Guest lecturers could be invited to the AMS or training could also be held at the host country. Mixed methodology can also be applied. Thus, for such matters, the institute can act as a coordinator.

For the institute's organization structure, the host country shall be sourced through volunteering method. If there are more than one volunteering country, the selection will be brought into SOMHD meeting in 2019. In term of management, there should be a Board of Committee, consisting of one representative from each AMS. Chairmanship is to be rotated among AMS.

The roles of the committee are to (1) identify operational policies, (2) approve the operational and financial plan and (3) monitor the progress of operation. Under the Board of Committee, the director should be appointed by the host country, with specific roles of (1) managing internal affairs of the institution, (2) proposing operational and financial plan, (3) managing operational and financial plan and (4) reporting the progress to Health Cluster 2.

For financial management, the establishment and internal affair cost should be responsible by the host country, while the expenses on organizing activities should be shared among AMS. External financial support are welcome in all aspects.

Comments:

- The Philippines can support the design of the institution. With a good relationship with NDMO, the Philippines is going to establish a training center in disaster management. Moreover, there

is also a master program on disaster management. A collaboration with academia will bring about the disaster management curriculum in compliance with the laws. With these elements, the Philippines can provide expertise on the matter, focusing on data management. The Philippines, hereby would like to volunteer to be the host country, starting with a small office at first due to limited resources.

- Delegate from ASEAN Secretariat suggested to circulate the proposed POAs to SOMHD prior to their meetings in April 24th-26th, 2018 for the review and provision of feedbacks. At the same time, it should also be circulated to Health Cluster 2 for the same agenda. After receiving feedbacks from both parties, one consolidated input can then be derived accordingly.

VII. WRAP UP AND WAY FORWARD

Dr. Ferdinand M. Fernando, a delegate from ASEAN Secretariat introduced a brief summary of the 4th PWG 2 meeting, covering all of the topic discussed in today's sessions. For more detail, please refer to "Key Discussions and Action Points of The Fourth Meeting of Project Working Group 2 (PWG 2)" note.

VIII. CLOSING REMARKS

The chair of the 4th PGW 2 meeting, Dr.Nguyễn Như Lâm announced the end of the meeting by congratulating all AMS participants and showing gratitude toward all resource persons and organizing committee.

SUMMARY OF PROCEEDINGS

THE THIRD REGIONAL COORDINATION COMMITTEE MEETING

PROJECT FOR STRENGTHENING THE ASEAN REGIONAL CAPACITY ON DISASTER HEALTH MANAGEMENT (ARCH PROJECT)

30 March 2018

The Grand Tourane Hotel, Danang City, Vietnam

I. WELCOME REMARKS

Dr. Nguyen Duc Chinh, chief of planning department, Viet Duc Hospital, Vietnam and chair of the today's RCC meeting, welcomed every participant from all AMS and reiterated the significance of the meeting, as to review and discuss on the inputs from the two Project Working Group (PWG) meeting. Moreover, a review and discussion on the implementation of ASEAN Leaders' Declaration on Disaster Health Management (DHM) would also be conducted in today's session. By the end of the meeting, the Philippines would give an introduction to the 3rd Regional Collaboration Drill (RCD), which will be held in Manila, Philippines in December 2018. After a welcome remark speech, all participants were requested to take a group photo.

II. REPORT ON THE PROGRESS AND OUTPUTS FROM PWG 1 AND PLANNING OF THE 3RD RCD

Dr.Anupong Sujariyakul, senior expert of Department of Disease Control, Thailand, greeted all meeting participants and started by elaborating on the agendas of this session, which included; (1) report on the progress and outputs from PWG 1 meeting, conducted on March 29th 2018, (2) report on the plan for the 3rd RCD, (3) report on the Implementation of ASEAN Leaders Declaration on DHM and lastly (4) introduction to the upcoming events of PWG 1.

The 2nd RCD was conducted March 26th-28th, 2018 in Da Nang, Vietnam, with a strong collaboration between Vietnamese, Thai and Japanese organizing teams. Drill activities facilitated the learning on ASEAN disaster response processes and tools such as the reporting forms. Experiences and lessons learned from the drill become inputs for the development of regional collaboration tools. Capacity building needs were identified on areas of EMT coordination, medical response planning and incident management.

The 5th PWG1 meeting organized March 29 in Da Nang, Vietnam. The topics that were discussed in the meeting were as followed; (1) SOPs for coordination of EMT, (2) database of EMT in ASEAN, (3) minimum requirement and qualifications of EMT members, (4) Health Needs Assessment (HNA) and (5) Medical Record form.

For SOPs for the coordination of EMT, the revision was made to ensure that EMT is self-sufficient during deployment and to ensure registration and documentation of incoming I-EMT through RDC or EMTCC (when registration with RDC is not possible). In addition, the SOPs were also revised to ensure the use of standardized triage system in the affected area and finally the provisions were added under Section D and Section I.

For EMT Database in ASEAN, there have been only two countries that submitted the database to the project team in the 1st round of collection. Therefore, the participants from each AMS were requested

to facilitate the submission of database by May 14th, 2018. The 2nd round of data collection will last from July 2018 to the 3rd RCD in December 2018.

For the minimum requirements and qualification section, the revisions on the standard training curriculum were made as followed;

- Add Basic Disaster Management course as examples to training curriculum of TIER I.
- Add ICS, self-sufficiency in disaster, working in limited resources as examples to the field training topics of TIER II.
- Add intercultural management, resource management, communication skill, health care system in all AMS, Team coordination, etc. as examples to the training curriculum of TIER III.

Moreover, it was agreed that health professionals registered as EMT are licensed and qualified, and required trainings may focus on disaster management and on non-medical/ non-treatment aspects and online courses for some of the required trainings can be delivered for EMT members.

For Health Needs Assessment, the inputs from the 2nd RCD were discussed. The revisions for the HNA Form and Summary Report include;

For the draft HNA Form:

- Consolidating the form that is used for the assessment of a village or a shelter as the areas of inquiry are similar
- Consolidating the questions on food items
- Clarification on the terms for health facilities.
- On Q3.2, on Health Facilities and Services, the inquiry should be 'Is the health facility accessible?' and 'If yes, by what means?'

For the draft Summary Report:

- The Check Box for the Critical Area is included in the Summary Report instead of the HNA Form.
- Use "WASH" instead of Water, Sanitation and Hygiene, and add MHPS (Mental Health and Psychosocial Support) in the Check Box for the Critical Area.

For Medical Report form, inputs from the 2nd RCD were incorporated and the revisions were made as followed;

- Increasing font size
- Inclusion of mechanism of injury
- Make free text cells and agenda in chief complaint
- Reduction of items under 'chief complaint' by categorizing to organ system or making free text cell
- Further clarifying 'discharge' under 'disposition' whether this is discharge 'home' or 'shelter'

In summary, all of the revisions will be circulated among PWG 1 members on April 20th, 2018 and the deadline of feedback submission will be on May 14th, 2018. The revised tools will also be discussed in the 6th PWG 1 meeting and they will be tested in the 3rd RCD.

For the 3rd RCD, the PGW 1 meeting agreed that the RCD program will be between December 3rd – 5th, 2018, followed by PWG meeting on December 6th, and RCC Meeting on the 7th. The drill venue will be the Armed Forces of the Philippines Grandstand, Quezon City, Manila. The scenario will be the movement of the West Valley Fault generating 7.2 magnitude earthquake and affecting Metro Manila and

surrounding provinces. Primary objectives of this 3rd RCD are to examine the effectiveness of regional collaboration tools such as SOP, HNA form and Medical Record form, while the secondary objectives are to test the electronic reporting system of ISPEED. In addition, the 3rd RCD will include a real offer of assistance by AMS and coordinated by AHA Center. The concept of EMTCC and ICS will be included in all levels of the EOC. In term of participants, the PGW 1 meeting agreed that at least one of the participants of the 3rd AMS training in May should participate in the 3rd RCD and information discussed during the training and drills will be disseminated among AMS.

For the Implementation of the ASEAN Leaders' declaration on disaster health management, there are 5 priority areas and 2 Mechanisms to make declaration operationalized. The PWG 1 is responsible for the first mechanism, which is Regional Coordination Committee on Disaster Health Management. Please refer to **IMPLEMENTATION OF ASEAN LEADER DECLARATION ON DISASTER HEALTH MANAGEMENT** part for more information.

III. REPORT ON THE PROGRESS AND OUTPUTS FROM PWG 2 & PLANNING OF THE 3RD AND THE 4TH AMS TRAINING, STUDY TOUR IN JAPAN

Dr.Narain Chogirosniramit, on behalf of the PWG 2 meeting, greeted all RCC participants and started his report presentation by reiterating the agenda of this session, as to; (1) update the progress and outputs from PWG2, (2) update the planning of training, (3) report on the update of the training center and (4) update the upcoming events and activities of PWG 2.

For the progress and outputs of PWG 2, the 3rd and 4th meetings were help on November 9th, 2017 and March 29th, 2018, respectively. The 3rd PWG 2 meeting emphasized on the planning of the 3rd AMS Training and the vision and roadmap of capacity building in DHM in ASEAN, while the 4th meeting was focusing on finalizing the 3rd AMS Training program, planning of the 4th AMS Training and study tour in Japan, as well as a discussion on future direction of Regional Disaster Health Training Center and Standard Training Curriculum.

Previously, the 2nd AMS Training was conducted between November 5th – 8th, 2017 in Bangkok, Thailand. The main theme was based on capacity development of EMT – On-site Team Management. Twenty-nine participants from all AMS were taking part in the training while the resource lecturers were invited from Indonesia, Malaysia, Philippines, Thailand, Japan and AHA Center.

The outcomes of the 2nd AMS Training were (1) understanding of what EMT is expected to do when deployed to disaster area, (2) competency to build an effective domain for right directions of disaster management, especially for team management, (3) sharing of the concept of EMT Response, and (4) the evaluation of this training course for standardizing ASEAN EMT Training. The feedback of the training were expressed for the need for more practical training such as simulation and tabletop exercise, and for the common EMT response system among AMS, etc.

As for the planning of the 3rd AMS Training, which will be held in Bangkok, Thailand between May 28th-31st, 2018, the main theme will be based on I-EMT and there will be 4 participants from each AMS. Resource person from any experienced AMS should be included as one of the four participants of those particular countries. The objectives of this training are (1) to learn the process and efforts for deploying I-EMT from experienced countries, (2) to understand core requirements of I-EMTs during deployment, (3) to understand minimum Pre-Deployment and Post- Deployment Requirements to ensure the requirements during deployment are met, and lastly (4) to understand the role of receiving country/ how receiving country coordinates with I-EMTs. The training schedule is as below;

Day	Program	Resources
1	Morning Session	
	❖ Opening Remarks (10 minutes)	Thai personnel
	❖ Introduction of all AMS participants (20 minutes)	
	❖ WHO Standards Part 1 (1 hour)	WHO (TBD)
	❖ Break	
	❖ WHO Standard Part 2 (1 hour)	Japan
	❖ Group Discussion: Challenges in meeting WHO EMT standards	All AMS
	Afternoon Session	
	❖ Receiving countries, on experience and challenges (20 minutes each)	Philippines, Myanmar, Indonesia
	❖ Deploying countries on (1) experience and challenges, (2) I-EMT preparation for deployment, and (3) challenges in obtaining WHO classification (20 minutes each)	Japan, Thailand, Philippines, Malaysia
2	PHEOC Training (whole day)	
	❖ Background of EMT initiative & EMTCC	Japan, Thailand
	❖ Basic Skill of PHEOC (sequencing)	
	❖ Quick view of EMT	
	❖ Core purpose and role of EMTCC	
	❖ Flow of EMT response	
	❖ Basic knowledge of PHEOC	
	❖ Functions of PHEOC	
	❖ Component (person) of PHEOC	
	❖ Equipment needed in PHEOC	
	❖ Information management(MDS→I-SPEED)	
	❖ Using the WHO EMT Minimum Data Set	
	❖ Incorporating Health Needs Assessment	
	❖ Meeting agenda	
	❖ Media collaboration (as suggested by Philippines)	
	❖ ASEAN EOC Network establishment (15 minutes)	Malaysia
3	Morning session	
	❖ Personnel preparation of EMT (Activation →Deployment) (30 minutes)	Singapore
	❖ Logistic requirement: food, accommodation, communication, coordination, waste management, survival tips, transportation	JDR Secretariat, Japan
	❖ Tabletop exercise: Pre-deployment, Deployment, Post deployment (demobilization) process & procedure, SOP, registration of EMT, exit strategy handover process	Japan Advisory Committee, ARCH
	Afternoon session	
	❖ Tabletop exercise(cont'd)	Japan
	❖ Safety and security, command & control	Philippines
	❖ Filling the forms (briefing) (major forms) Exercise: filling the forms	Thailand
4	Morning Session	
	❖ Group Discussion on ASEAN Standard	All participants
	Afternoon Session	
	❖ Feedback, course evaluation from participants	All participants
	❖ Wrap-up and Way forward,	ARCH Project Team
	❖ Upcoming Events/Activities of ARCH Project	ARCH Project Team
	❖ Closing remark	ARCH Project Team

For the 4th AMS Training in Bangkok, Thailand, the schedule has been changed from the original plan in November 2018 to the new date on February 2019 due to the tight schedule of study tour in Japan and the 3rd RCD. The training's main theme will be based on effective incident and emergency management at EMTCC. Each AMS is expected to send 3 participants to attend the training, while resource personnel and program shall be delivered by WHO EMTCC training course.

Study tour in Japan will take place between October 17th-20th, 2018 in Kobe and the surrounding area. Each AMS is expected send 3 participants to attend the tour. The objectives of the study tour are (1) to understand the system of disaster health management in Japan, (2) to identify the challenges and to consider the measures for further strengthening the disaster health management and regional collaboration in ASEAN, and (3) to establish a network of medical professionals involved in disaster health management in Japan and ASEAN.

The program will consist of (1) Participating APCDM, (2) Understanding lessons learned from the Great Hanshin Awaji Earthquake - Japanese system (e.g. Hospital disaster preparedness and response, EOC at prefectural/municipal (e.g. Kobe) level and (3) Participating JDR Training or relevant training.

For the Implementation of the ASEAN Leaders' declaration on disaster health management, the PWG 2 is responsible for the second mechanism, which is the plan on Training Center. Please refer to **IMPLEMENTATION OF ASEAN LEADER DECLARATION ON DISASTER HEALTH MANAGEMENT** part for more information.

IV. IMPLEMENTATION OF ASEAN LEADER DECLARATION ON DISASTER HEALTH MANAGEMENT

The session was facilitated by Dr. Phumin Silapunt, Deputy Director of Chulabhorn Hospital, Thailand. Dr.Silapunt started by iterating the objectives of this session as (1) to review the timeline to implement the ADL on DHM; (2) to develop common understanding and agreements on the Plan of Action (POA) to Implement the ADL on DHM, which will be submitted to the SOMHD; (3) to seek comments and ideas on the coordination platform for the purpose of developing the draft/concept paper for the Meeting of Health Cluster 2, (4) to seek comments and ideas on the training center initiative for the purpose of developing the draft/concept paper for the Meeting of Health Cluster 2; and (5) to review the targets of the implementation of the ADL on DHM by the year 2025.

TIMELINE

Firstly, Dr.Silapunt presented the timeline of the implementation of ADL on DHM. Please refer to **SESSION_3 IMPLEMENTATION OF ALD ON DHM** for more information. Dr. Silapunt also mentioned that ASEAN and JICA collaboration under ARCH project will end in 2019. However, JICA has shown their intention to continue the further collaboration. Thus, should there be some agreements on the ASEAN's 2025 achievement goals, JICA can consider the possible collaboration to realize them.

In this RCC meeting, the final draft of POAs is presented to seek some comments from the meeting participants. After revision, the POAs will then be circulated to ASEAN Health Cluster 2 for revision and then to be submitted to SOMHD for endorsement in April. The revised drafts after SOMHD will be presented again in the PWG1 meeting, which will be held in July 2018, followed by the ASEAN Health Cluster 2 in August of the same year. If there can be an agreement among all AMS regarding the host country of the training center, the proposal of finalized detail will then be put up in SOMHD in 2019. The proposed timeline was accepted by all AMS participants.

Comments

- ASEAN Secretariat noted that the timeline is appropriate to the schedules, based on the Work Programme of ASEAN Health Cluster 2. In term of submission, ASEAN Secretariat reiterated that the submission could not be done directly from RCC to SOMHD, without the mediation of Health Cluster 2. Since the HC 2 will take place in July or August, 2018, the revision of POAs by HC2 cannot wait until the actual meeting. Thus, the POAs will be circulated to the HC 2 and SOMHD within April 2018 via e-mail, so that the revision can be done in time for the submission to SOMHD in late April, 2018.

The Plan of Action To Implement The ASEAN Leaders' Declaration On Disaster Health Management

The POAs is divided into two mechanisms, namely; (1) Regional Coordination Committee (RCC) on DHM, and (2) ASEAN Institute for Disaster Medicine. These two mechanisms operate under 5 Priority areas. The meeting discussed some revision on these priorities as followed;

Suggestion for Revision or Comments on the Priority Area

- Priority 3: Indonesia suggested to delete Priority 3 from the 2nd mechanism of AIDM, as it supports the RCC only. Thailand, however, thinks otherwise as it should be included in the mechanism 1 only. Through much debate, the meeting agreed Priority 3 can be realized through the work of both proposed mechanisms. Some clarification on the reason for each mechanism will be documented by Thailand with the assistance of ASEAN Secretariat.

- In Priority 3.1.3, Philippines suggested to move this point to Priority 5

- Priority 4: Thailand and Vietnam suggested to add "Promote" in the front of the sentence and to add "at national level" by the end of the sentence.

- Priority 5: The wording of "Knowledge management on disaster health management" is proposed instead of "Education and training on disaster health management". ASEAN Secretariat will however help to revise the wording again.

- In Priority 5.3, Thailand suggested to delete "Establish Regional Disaster Health Training Center" because the training center has already been taken as one of the two mechanisms. And by doing so, the emphasis will be on strengthening the capacity.

Regional Coordination Committee on Disaster Health Management

Dr. Silapunt presented a proposed RCC on DHM plan as followed. The members of RCC shall include 20 representatives from AMS, and delegates from ASEAN Secretariat and AHA Center. Host country and chairmanship shall rotate among AMS, following the HC2 Chairmanship rotation. For the activities, RCC shall conduct meetings twice a year and drills shall be organized as necessary. In term of financing, the cost of meeting organizing shall be divided into two parts, namely; (1) accommodation and travel expenses, borne by each member and (2) meeting organizing expense, borne by host country. For the drill, the expenses shall be sourced through external sources.

For the 1st mechanism, there are altogether 4 functions as followed; (1) Facilitate the development of regional collaboration on disaster health management - Members of the committee share, discuss and monitor the progress of the regional collaboration; (2) Collaborate with relevant ASEAN Sectoral bodies both in health and non-health sector and other international organization -organize or participate in meetings of other ASEAN collaborative platforms; (3) Develop Standard Operating Procedures (SOP) and other collaboration tools - develop the SOPs for regional collaboration on DHM

and other tools; (4) Organize or join disaster drills - to pilot and test the collaborative tools, while involves other health and non-health sectors relevant to the collaboration on disaster health management.

Suggestion for Revision or Comments for 1st Mechanism

- Function 1: ASEAN would assist Thailand in development additional statement on this topic in term of TOR development, reporting and monitoring mechanism. ASEAN will also mention about the adopted language of ASEAN Declaration, which appeared in these 4 functions.

- Function 2: ASEAN mentioned that this articulation was also based on the Declaration , particularly from task 9 to 11. ASEAN informed that the RCC recently had a meeting in ASEAN agreement on disaster risk reduction (DRR) and review the implementation of the declaration on One ASEAN One Response. One particular point is the improvement of the joint task force for DRR, participated by health, social welfare, and military sector, etc. This joint task force is expected to go beyond the mere information sharing to set up collaborative mechanism to involve all 4 sectors. ASEAN will again assist Thailand in improving the function 2 wordings to ensure that the collaboration here is also aligning with the One ASEAN One Response declaration.

- Function 3: Malaysia raised a concern over the use of the word “SOP”, as it may be difficult for some ASM to follow because of different capacity level among AMS. However, Dr. Silapunt clarified that SOP is for regional activities. When the I-EMT is being deployed, AMS need to have common SOPs. Nonetheless, this SOP may or may not be applied within the internal affair because each country has different context. Thus, national SOP can be developed separately.

- Function 4: The revised title was agreed to be “Organize, participate disaster drills and develop standardized approach and methodology in the preparation and after action review of joint disaster drills”

ASEAN Institute for Disaster Medicine

For the institute’s organization structure, the host country shall be sourced through volunteering method. If there are more than one volunteering country, the selection will be brought into SOMHD meeting in 2019. In term of management, there should be a Board of Committee, consisting of one representative from each AMS. Chairmanship is to be rotated among AMS.

The roles of the committee are to (1) identify operational policies, (2) approve the operational and financial plan and (3) monitor the progress of operation. Under the Board of Committee, the director should be appointed by the host country, with a specific roles of (1) managing internal affairs of the institution, (2) proposing operational and financial plan, (3) managing operational and financial plan and (4) reporting the progress to Health Cluster 2.

For financial management, the establishment and internal affair cost should be responsible by the host country, while the expenses on organizing activities should be shared among AMS. External financial support are welcome in all aspects.

For the 2nd mechanism, which is ASEAN Institute for Disaster Medicine, there are altogether 4 proposed functions, as followed; (1) Organize academic seminars to share knowledge and best practices - organizes academic seminars, conferences or symposium;(2) Construct academic network and co-conducting research - supports co-conducting research studies to extract lessons learned from disaster health management in multiple events and countries; (3) Organize training activities - Develop the standard training curriculum and provide training course; and (4) Conduct consultation - Provide consultation services in supporting and assisting in the development and implementation of disaster health management activities.

Suggestion for Revision or Comments for 2nd Mechanism

- Function 3: Vietnam suggested to add "and establish network with national academic institutions to provide training services at national level" to the end of the last sentence.
- Function 4: Philippines suggested to use the word "Disaster Health Management" instead of "Disaster Medicine". However, Dr. Silapunt explained that Disaster Medicine is an internationally-recognized academic term.

Targets of the Plan of Action by 2025

The targets are separated in two levels, namely; (1) Regional level and (2) national level. For regional level target, there are three sub-categories, namely; (1) RCC on DHM, (2) Regional Collaboration Tools and (3) AIDM. For the detail of the proposed targets of the POA by 2025, please refer to **SESSION_3 IMPLEMENTATION OF ALD ON DHM.** The RCC members were requested to review the proposed targets and supply feedback to the committee to revise by April 2018.

Introduction to the 3rd Regional Collaboration Drill

Janice P. Feliciano, RND MPH, congratulated Thailand and Vietnam for successfully hosted the previous two RCD and introduced a brief background of the Philippines. This archipelagic country was ranked as the 3rd disaster-prone country in the world, after only Vanuatu and Tonga. In 2013 alone, there were 16 disasters, including the famous typhoon Haiyan.

The finding of Metro Manila Earthquake Impact Reduction Study, funded by JICA, revealed that a movement of the West Valley Fault (WVF) will cause a 7.2 magnitude earthquake ("The Big One", with intensity VIII ground shaking) in Metro Manila and nearby provinces. The estimated active phase of the event is between 1858-2058. Geographically, Manila is a host of many national government agencies, including the department of health and NDMO, etc. Moreover, Metro Manila is highly populated and also a business hub. Great destruction can be expected in the case of such a disaster.

The predicted impact of the events included 35,000 death and 115,000 injuries. Residential structure of more than 170,000 may collapse, resulting to a dislocation of 42% of Manila residents outside the evacuation camps, and only 8,628 out of 13,751 individuals who will face life-threatening injuries would be accommodated into hospitals within Metro Manila. The rest must be transported to hospitals in other regions.

The design of the drill is based on Metro Manila Earthquake Contingency Plan, locally known as "*Oplan Metro Yakal Plus".* The plan aims to institutionalize an effective and efficient system of earthquake disaster preparedness and response. It is predicted that the government will declare state of national calamity and request supports from AMS for humanitarian assistance. The 3rd RCD will be hosted at the Armed Forces of the Philippines Grandstand, Quezon City, Manila between December 2 – 8, 2018. The proposed program is shown below.

Date	Day	Activity
Dec 2	Sunday	Arrival of the participants
Dec 3	Monday	Conduct of table-top exercise
Dec 4	Tuesday	Conduct of Regional Collaboration Drill (RCD)
Dec 5	Wednesday	Review/Processing/Feedback of the RCD and Gala Dinner
Dec 6	Thursday	Meeting of the Project Working Group 1 and 2
Dec 7	Friday	Meeting of the Regional Collaboration Committee
Dec 8	Saturday	Departure of participants

Primary objective is to examine the current regional collaboration mechanism on disaster health management (SOP) including Health Needs Assessment form, Medical record, SASOP Forms, and EMT Forms. Secondary Objectives are to test electronic reporting system for ISPEED and to refine EMT team operations at all levels in terms of Command and control, Coordination and collaboration, and Communication.

Tabletop exercise is designed to place an emphasis on the offer of assistance and registration process, the demobilization process, discussion and practice of ISPEED and filling out HNA and the conduct of communication exercise. For the drill, the concept of EMTCC will be incorporated in all levels of EOC, so will the ICS. In the morning session of the drill, 10 EMTs Type 1 from AMS and 2 EMT Type 2 from Japan will conduct the check-in activity at each assigned quadrant, orientation briefing, collaboration with other EMTs and sub-EMTCC meeting. Each EMT will have around 20-30 patients. The afternoon session will focus on the public health village. The concept of 4 sub-clusters, including (1) Public Health, (2) Water, Sanitation and Hygiene, (3) Mental Health and Psychosocial Support Services and (4) Nutrition in Emergencies will be incorporated. In addition, sub-EMTCC meeting and national EMTCC meeting will also be conducted in the afternoon part of the drill.

Ms. Faliciano wrapped up her session with the benefit of organizing the 3rd RCD to the Philippines, such as a contribution to the National Contingency Plan for The Big One, and the enhancement of inter-agency collaboration both in the national and international level.

V. WRAP-UP AND WAY FORWARD

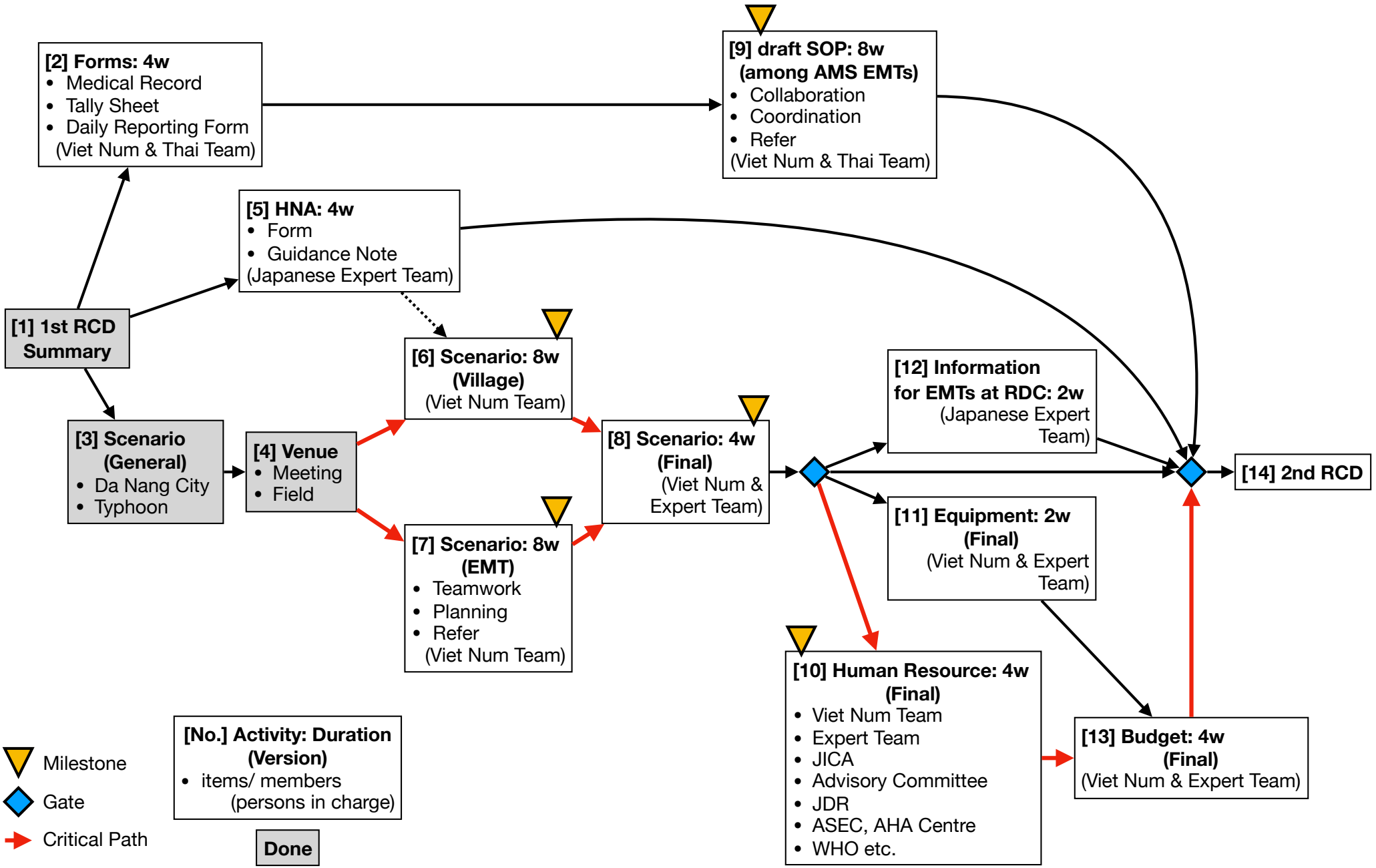
Dr. Ferdinand M. Fernando, a delegate from ASEAN Secretariat introduced a brief summary of the RCC meeting, covering all of the topic discussed in today's sessions. For more detail, please refer to "**Session 5_RCC_3rd_Meet_Conclusions_WayForward_Final**" note.

VI. CLOSING REMARKS

Dr. Jirot Sindhvananda, Senior Advisor of Ministry of Public Health Thailand, announced the closing remarks for the fruitful RCC meeting as a panel for sharing progress of ARCH project. Dr.Sindhvananda expressed deepest appreciation to delegates from all AMS, ASEAN Secretariat, working group, and the host country, Vietnam, for active collaboration and warm hospitality. He wished all RCC participants a safe journey back home.

Attachment 7

2nd Regional Collaboration Drill Network Diagram


[2] Forms: 4w
• Medical Record
• Tally Sheet
• Daily Reporting Form
(Viet Num & Thai Team)
[9] draft SOP: 8w
(among AMS EMTs)
• Collaboration
• Coordination
• Refer
(Viet Num & Thai Team)
[5] HNA: 4w
• Form
• Guidance Note
(Japanese Expert Team)
[1] 1st RCD Summary
[6] Scenario: 8w
(Village)
(Viet Num Team)
[12] Information for EMTs at RDC: 2w
(Japanese Expert Team)
[3] Scenario
(General)
• Da Nang City
• Typhoon
[4] Venue
• Meeting
• Field
[8] Scenario: 4w
(Final)
(Viet Num & Expert Team)
[14] 2nd RCD
[7] Scenario: 8w
(EMT)
• Teamwork
• Planning
• Refer
(Viet Num Team)
[11] Equipment: 2w
(Final)
(Viet Num & Expert Team)
[10] Human Resource: 4w
(Final)
• Viet Num Team
• Expert Team
• JICA
• Advisory Committee
• JDR
• ASEC, AHA Centre
• WHO etc.
[13] Budget: 4w
(Final)
(Viet Num & Expert Team)
Milestone
Gate
Critical Path
[No.] Activity: Duration
(Version)
• items/ members
(persons in charge)
Done

Attachment 8

Conclusions of 1st regional Collaboration Drill

Conclusions, Recommendations from the First Regional Collaboration Drill

Project Team
Dr Yasushi Nakajima

Conclusions, Recommendations from the First RCD

1. Review of the Start-Up Drill
2. Review of the first Regional Collaboration Drill

1. Review of the Start-Up Drill

Checkup Sheet

- To identify the gaps of the teams/individuals
  - How About Table Top Exercise /Field Exercise?
  - What have you learned from Table Top Exercise /Field Exercise?
  - What will you improve on the lessons learnt?

A. Team Capacity Building (Possible Topics for the AMS Trainings)	**C. Team/Collaboration Capacity Building** (ARCH Project Tools: SOP)
B. Personal Capacity Building (ARCH Project Tools: Minimum Requirements)	**D. Collaboration Capacity Building** (e.g. ASEAN SOPs/ WHO EMTCC Handbook)

A. Team Capacity Building

- Toward the common activity goal, development of training using **common** text, terms, medical information management and medical treatment methods
  - Training for EMT, EMTCC Team, Rapid Health Assessment Team, risk management and disaster management
  - Leadership and teamwork
  - Surviving, self-safety and sanitation skills
  - Learn to adapt in a disaster situation (working/living in disaster affected areas)
- Equipment for survival/ medical operation
- Logistics and supply management
- Communication management (basic use of radio)
- FDA-accreditation and referral system of each country
  (*FDA=food and drug administration)

B. Personal Capacity Building

- Skills comply with the **Standard Protocols** for
  - Health Emergencies Management (focused on medical treatment)
  - Basic Skills required for advance trauma life support for doctors and nurses
  - Public Health Emergencies Management
  - Risk Assessment (safety and survival skills)
- Understandings of
  - **ICS concepts**
  - International Standards on Quality and Accountability on Humanitarian Assistance (Sphere standard, Core Humanitarian Standard, Good enough guide etc.)
- Share the latest international trend and disaster response experiences

C. Team/Collaboration Capacity Building

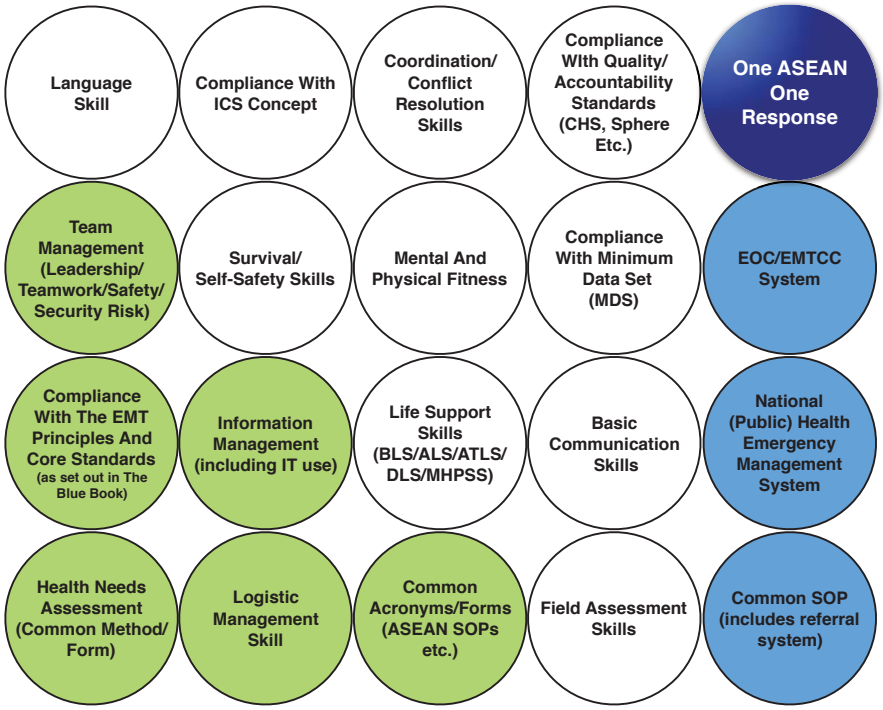
- Using the **same standard forms**
  - Daily reporting
  - Registration form
  - Rapid health assessment form
  - Medical record form
  - Referral form
  - Summary reporting form
- SOP between EMTs (Type 1, 2, 3)
- SOP among coordination organizations (EMTCC, EOC, AHA Centre, UN OCHA etc.)
- **Information management and sharing methods**
- Conflict resolutions

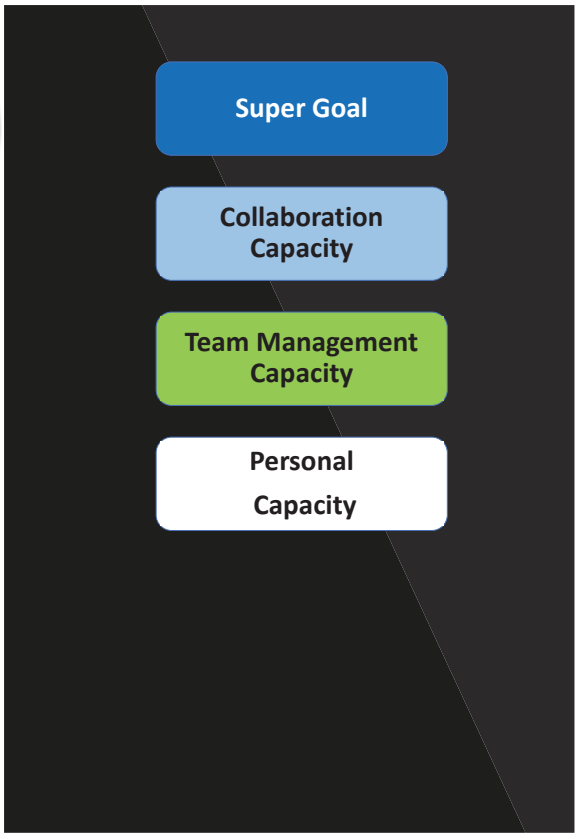
D. Collaboration Capacity Building

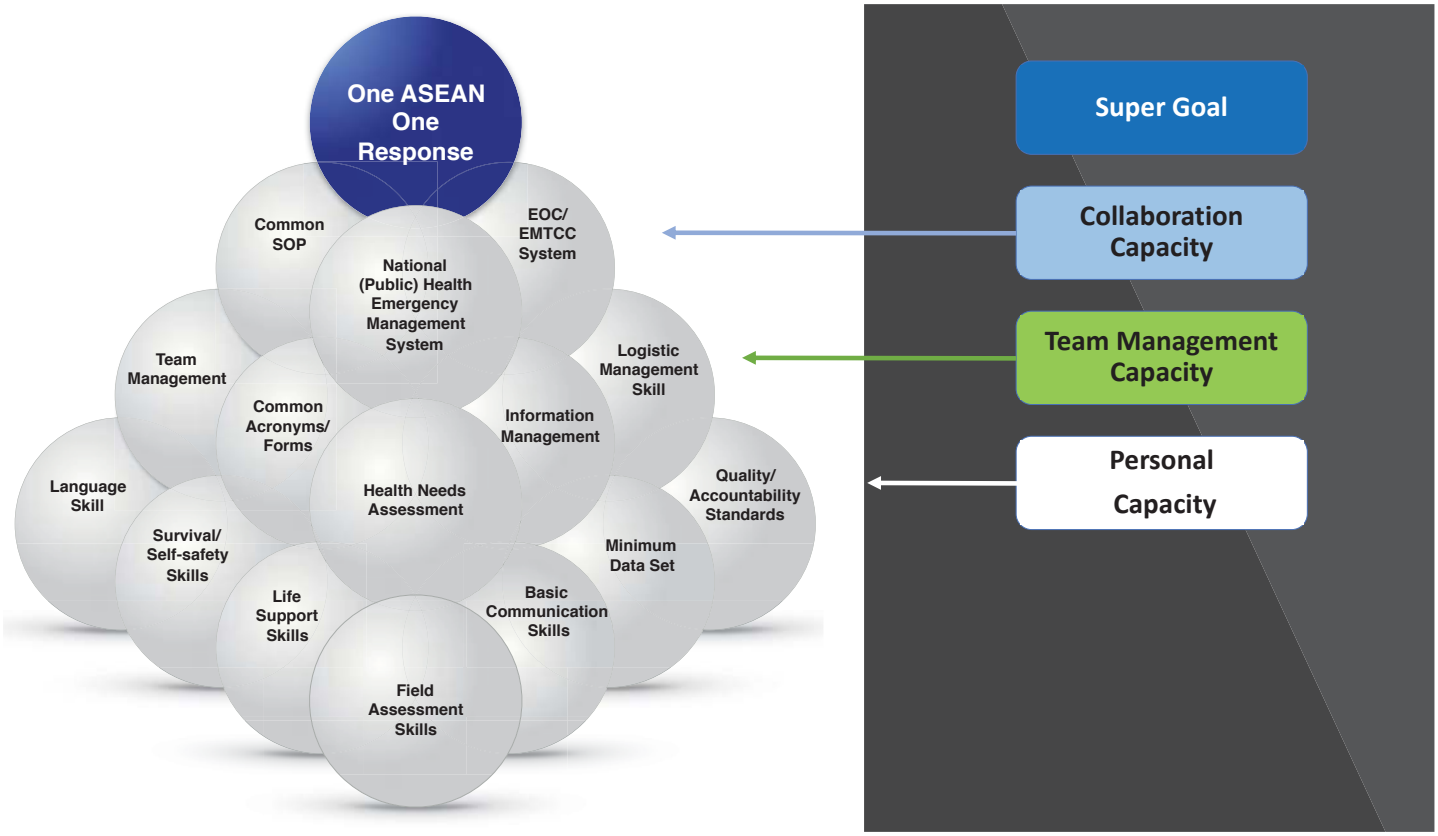
- SOP for collaboration in ASEAN because AMS belong to two WHO Regions; SEARO and WPRO
- Essential information package for international EMT
- Available SOPs and handbook should be concise and informative
- Development of common glossary including acronyms and technical terms
- **Standardization of forms:** assessment form, medical record forms, and daily Reporting forms in ASEAN Region. And it must be compatible with existing international (WHO-MDS) and regional (AHA Centre) formats.
- Balance between ”standardization” and “contextualization”. Contextualization should come after standardization; but it still must be easily understandable for each international EMTs.
- Collecting and sharing the good practice on EMT coordination

Issues to be Considered

- To involve all AMS to participate in the training
- To extend drill period and conduct the training annually
- Practical training by participating in teams from multiple countries
- Good cooperation under SOP with WHO, JDR, AHA Centre, and other organizations
- Sending report of the training to MOH
- Dissemination the lessons learned to health facilities
- Meeting with MOH on how to set up and develop EMS and EMT
- Funding and support for EMT
- Making/Upgrading existing trainings to be the one for registered volunteers







2. Review of the first Regional Collaboration Drill

Expectations of the Regional Collaboration Drill

- Feedback
  - Using common report forms
  - Using draft Health need assessment form
    - Framework of form
    - Items/topics
    - Situation to use etc.
  - Revising Pyramid model
    - Changing items' name/ categories' name
    - Adding new items
    - Moving the levels/layers of items etc.

Analytic Framework

Program Evaluation	Reporting Forms
EMT Coordination Process	Capacity Building

Program Evaluation

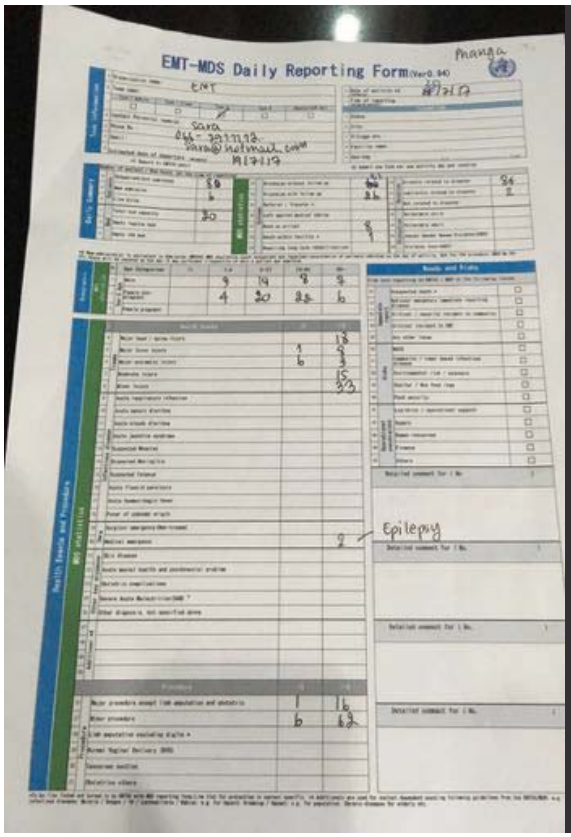
Good Points

- Time and Venue
- Accommodation & transportation
- Introduction session
- Scenario well planned, table top → field exercise
- Format/Well prepared forms
- Presenter/Facilitators

Opportunities

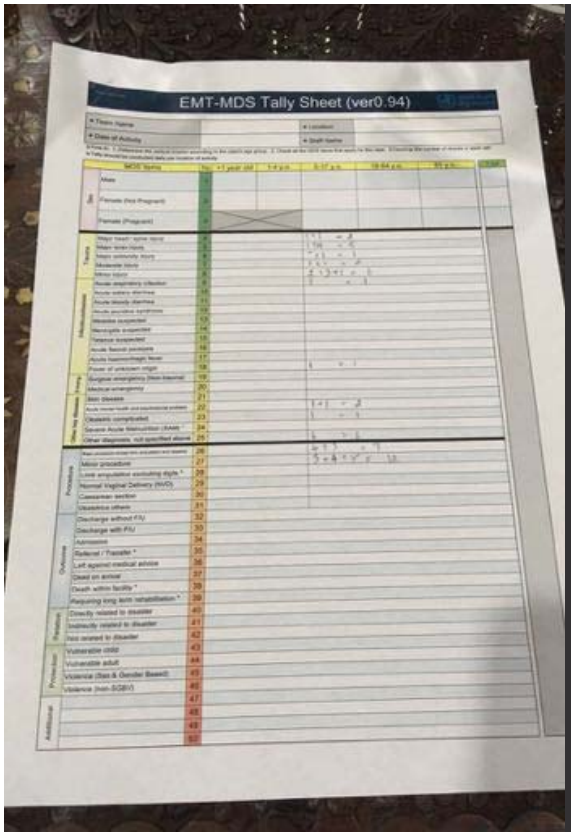
- EMT type summary
- Task of HNA
- More facilitators, common focus, experienced, skills
- Longer FTX, Clinical enhancement, overlap of team in same area
- Standardize the common communication discipline, exercise, manual
- Discussion how to use the form
- Realistic CIQ processes
- Supply area/Recreation station
- Referral system/More referral hospital
- Medical checklist

Forms



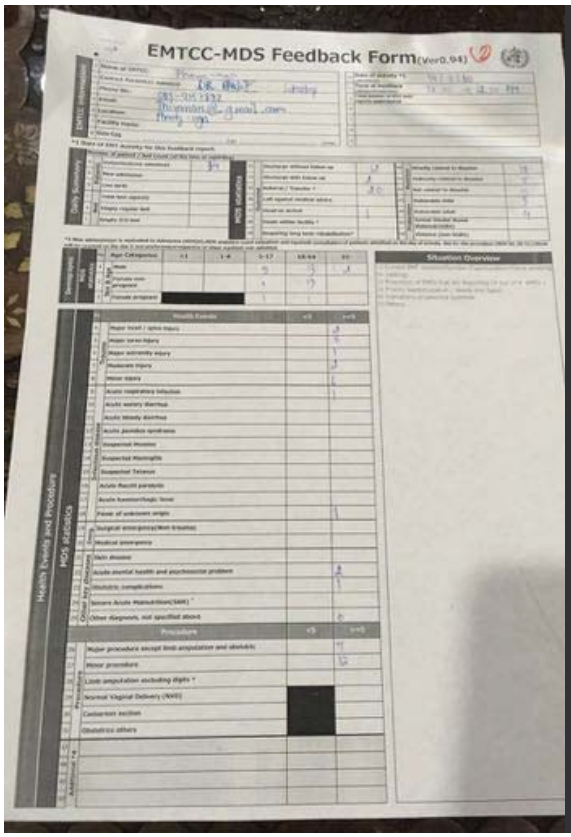
EMT-MDS Daily Reporting Form

- Duplicate and change to tick box
- Should be revise
- O to T not in tally sheet
- Terminology/definition is unclear
- Categorize, increase font size



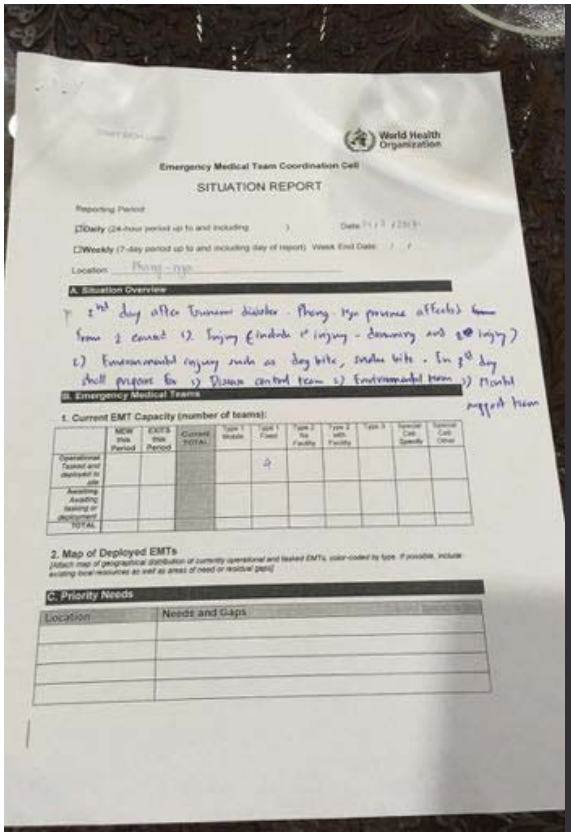
EMT-MDS Tally Sheet

- OK
- Version 0.94 is better than version 0.94a



EMTCC-MDS Feedback Form

- Daily summary box not suitable for EMT type I mobile

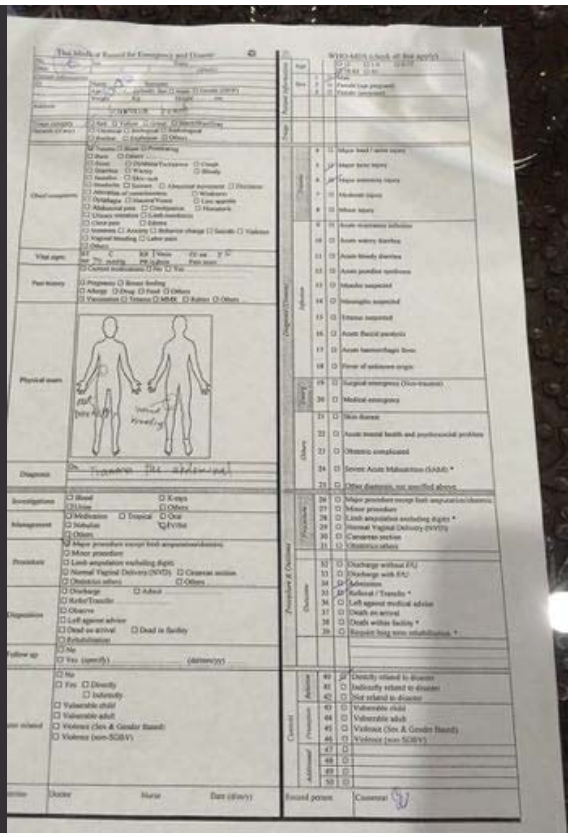


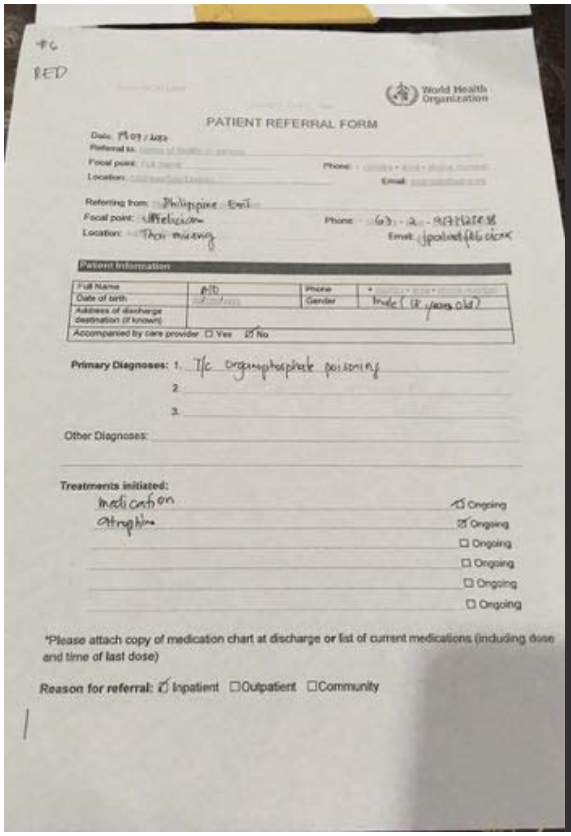
EMTCC Situation Report

- Almost agree

Thai Medical Record for Emergency and Disaster

- Blank the chief complaint
- Font too small, lack of space to write additional information, arrange CC in alphabetical





PATIENT REFERRAL FORM

World Health Organization

Referring from: Philippine EMT

Patient Information

Primary Diagnoses: 1. T/c organophosphate poisoning

Treatments initiated:

*Please attach copy of medication chart at discharge or list of current medications (including dose and time of last dose)

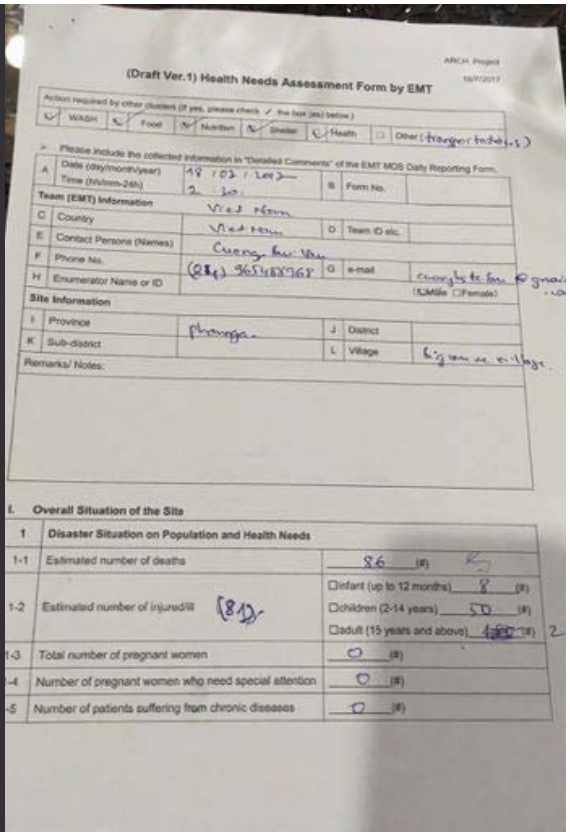
Reason for referral: ☑ Inpatient ☐Outpatient ☐Community

Patient Referral Form

- Some detail unclear
- No part where can fill in the history
- Confusion “referral to” and “focal point”

Health Needs Assessment Form by EMT

- Duplication
- Should add estimated number of patient
- Material, drugs, vaccines, and supplier should be more described
- Indicators for food availability
- Address the outbreak
- Separate village and shelter
- Include more information



(Draft Ver.1) Health Needs Assessment Form by EMT

I. Overall Situation of the Site

1 Disaster Situation on Population and Health Needs

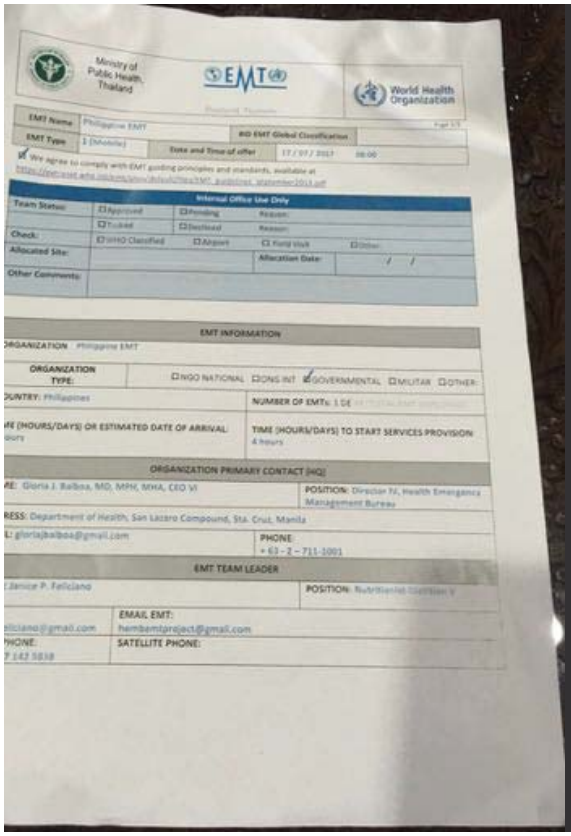
1-1 Estimated number of deaths 86

1-2 Estimated number of injured/ill (81)

1-3 Total number of pregnant women

1-4 Number of pregnant women who need special attention

1-5 Number of patients suffering from chronic diseases


Ministry of Public Health, Thailand

EMT

World Health Organization

EMT Name: Philippine EMT

EMT Type: 1 (Mobile)

WHO EMT Global Classification

Date and Time of offer: 17 / 07 / 2017 08:00

We agree to comply with EMT guiding principles and standards, available at http://extranet.who.int/ihr/sites/default/files/EMT_guidance_september2013.pdf

Internal Office Use Only

Team Status: ☐Approved ☐Pending Reason:

☐Listed ☐Declined Reason:

Check: ☐WHO Classified ☐Airport ☐Field Visit ☐Other:

Allocated Site: Allocation Date: / /

Other Comments:

EMT INFORMATION

ORGANIZATION: Philippine EMT

ORGANIZATION TYPE: ☐NGO NATIONAL ☐NGO INT ☑GOVERNMENTAL ☐MILITAR ☐OTHER:

COUNTRY: Philippines

NUMBER OF EMTs: 1 DE

TIME (HOURS/DAYS) OR ESTIMATED DATE OF ARRIVAL: hours

TIME (HOURS/DAYS) TO START SERVICES PROVISION: 4 hours

ORGANIZATION PRIMARY CONTACT (HQ)

NAME: Gloria J. Balboa, MD, MPH, MHA, CEO VI

POSITION: Director IV, Health Emergency Management Bureau

ADDRESS: Department of Health, San Lazaro Compound, Sta. Cruz, Manila

EMAIL: gloriajbalboa@gmail.com

PHONE: + 63 - 2 - 711-1001

EMT TEAM LEADER

Janice P. Feliciano

POSITION: Nutritionist-Dietitian V

EMAIL: feliciano@gmail.com

EMT: hembemtproject@gmail.com

PHONE: 7 142 5838

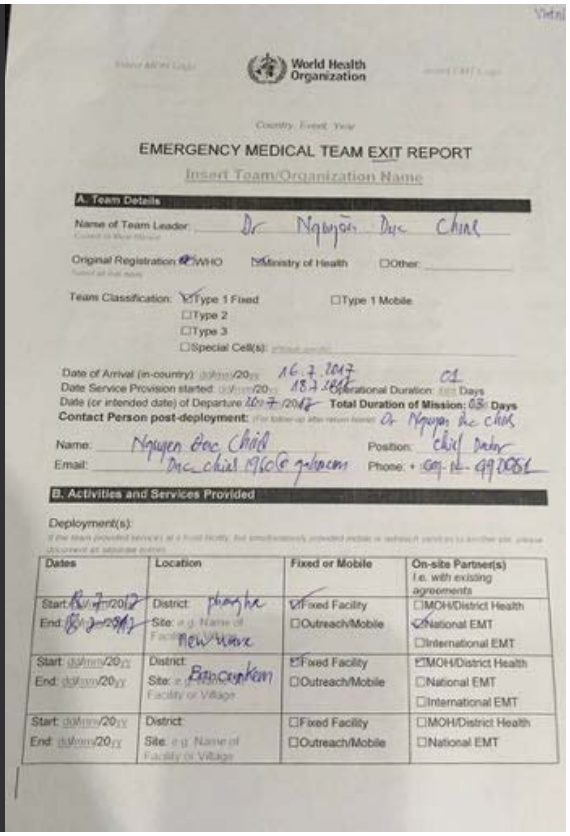
SATELLITE PHONE:

Registration From

- Easy to every country or agreed forms
- Easy to understand
- More space for free text
- Do we send the documents with the registration forms?
- Who verifies?
- Multiple queries

Emergency Medical Team Exit Report

- Excellent
- A lot of detail
- Part E F G not necessary
- Revise (transferred patient)
- Increase column


World Health Organization

Country, Event, Year

EMERGENCY MEDICAL TEAM EXIT REPORT

Insert Team/Organization Name

A. Team Details

Name of Team Leader: Dr Nguyen Duc Chinh

Original Registration: ☐WHO ☑Ministry of Health ☐Other:

Team Classification: ☑Type 1 Fixed ☐Type 1 Mobile ☐Type 2 ☐Type 3 ☐Special Cell(s):

Date of Arrival (in-country) dd/mm/20yy: 16.7.2017

Date Service Provision started dd/mm/20yy: 18.7.2017 Operational Duration: 01 Days

Date (or intended date) of Departure dd/mm/20yy: 20.7.2017 Total Duration of Mission: 05 Days

Contact Person post-deployment: (For follow-up after return home) Dr Nguyen Duc Chinh

Name: Nguyen Duc Chinh Position: Chief Doctor

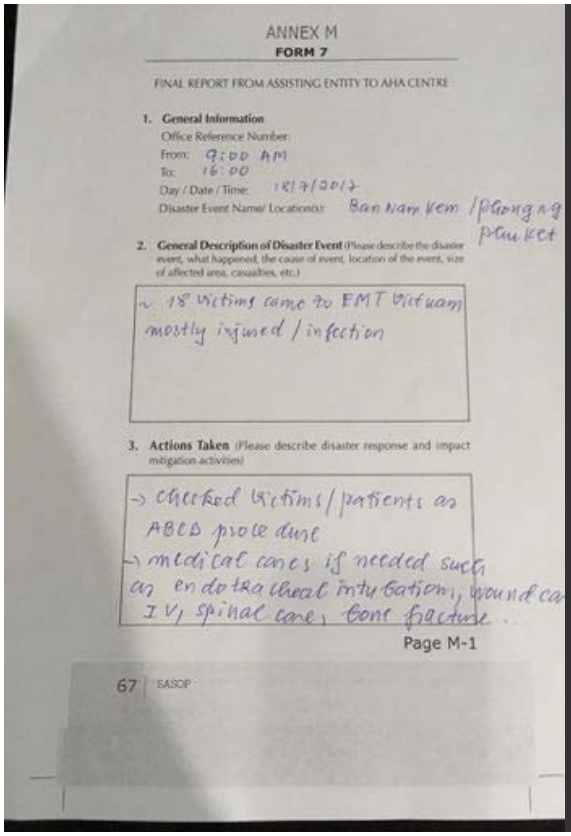
Email: Duc_chinh.MSG@yahoo.com Phone: + 84-91-4970851

B. Activities and Services Provided

Deployment(s):

If the team provided services at a fixed facility, but simultaneously provided mobile or outreach services or transferred patients to another site, please document all separate entries.

Dates	Location	Fixed or Mobile	On-site Partner(s) i.e. with existing agreements
Start: 18/7/2017 End: 18/7/2017	District: phuy tho Site: e.g. Name of Facility or Village: new wave	☑Fixed Facility ☐Outreach/Mobile	☐MOH/District Health ☑National EMT ☐International EMT
Start: dd/mm/20yy End: dd/mm/20yy	District: Site: e.g. Name of Facility or Village: Bach Cong Kem	☑Fixed Facility ☐Outreach/Mobile	☑MOH/District Health ☐National EMT ☐International EMT
Start: dd/mm/20yy End: dd/mm/20yy	District: Site: e.g. Name of Facility or Village:	☐Fixed Facility ☐Outreach/Mobile	☐MOH/District Health ☐National EMT



ANNEX M
FORM 7

FINAL REPORT FROM ASSISTING ENTITY TO AHA CENTRE

1. **General Information**
   Office Reference Number:
   From: 9:00 AM
   To: 16:00
   Day / Date / Time: 18/7/2017
   Disaster Event Name/ Location(s): Ban Nam Kem / Phang-nga Phuket

2. **General Description of Disaster Event** (Please describe the disaster event, what happened, the cause of event, location of the event, size of affected area, casualties, etc.)

~ 18 victims came to EMT Vietnam mostly injured / infection

3. **Actions Taken** (Please describe disaster response and impact mitigation activities)

→ checked victims / patients as ABCD prole dure
→ medical cares if needed such as endotracheal intubation, wound ca IV, spinal cares, bone fracture.

Page M-1

67 | SASOP

SASOP FORM 7

- Good and concise

Electronic Forms, Cloud, App based

To be more user friendly

Coordination processes

- With others; SAR, social welfare, ERAT
- Referral system
- Public health
- RDC; more information
- Standard protocol were not followed
- Good organized
- Language barrier
- Alternative communication

Capacity building

- Management aspect
  - EMTCC, EOC, EMT coordination
  - Team management
  - Know the functions of other agencies under ASEAN during disaster
  - Workflow of working

Capacity building

- Technical aspect
  - SOP for EMT
  - Checklist for tasks and action card (roles & responsibilities)
  - Standardize equipment & pharmacy
  - Legal provision

  - Basic skills, exchange student
  - Academic conference and seminar

Capacity building

- Technical aspect (cont'd)
  - EMT curriculum (clinical lead, nursing lead), classification
  - 5Cs (command, control, coordinate, communicate, cooperation)
  - Standardize triage categories

Photo: fmt_guidelines_september2013

Attachment 9

1st RCD Advisory Note from JAC

Japan International Cooperation Agency

Advisory Note from Japanese Advisory Committee

ARCH Project
The 1st Regional Collaboration Drill

17 -19 July, 2017

The Japanese Advisory Committee congratulates NIEM, MOPH Thailand, and all stakeholders who dedicated to organize the 1st Regional Collaboration Drill on the successful implementation and achieving its purpose.

We are highly grateful for all of your good planning, tireless work, and significant hospitality to lead this outstanding result.

This advisory note is provided from the Japanese Advisory Committee to the ARCH project team members, the exercise controllers, and the exercise players to be developed for the next drills; and to optimize Thai ECO system in the future.

25 September, 2017

Tatsuro Kai

Signed by Dr. Tatsuro KAI on behalf of;

Japanese Advisory Committee to the ARCH Project,

Dr. Tatsuro KAI
Dr. Yuichi KOIDO
Dr. Satoshi YAMANOUCHI
Dr. Tomoaki NATSUKAWA
Ms. Eiko YAMADA
Mr. Yosuke TAKADA

And Dr. Tatsuhiko KUBO as the regional PHEOC(EMTCC) staff.

1 Overall

(1)Observation:

In general, the drill was very well planned, prepared, and organized to achieve its purpose. All AMS utilized the common forms, and provided valuable feedback for the sake of strengthening the regional coordination on disaster health management. However, one of the challenges was to have common exercise expectations among all drill participants. It was particularly observed in the rules of engagement, understanding of the intention of each scenario/inject, and the roles of each personnel involved in the field exercise. It was due to different backgrounds, rules, technical languages, and experiences among AMS in field exercise.

Regarding the drill environment, the venue of the field exercise on DAY2 was excellent; and it was appreciated that each tent was equipped with air conditioner. Neverthless, due to the heat weather, it was observed that some participants claimed suspected heatstroke during and after the exercise.

Regarding the performance at PHEOC(EMTCC), in general, at each provincial and regional PHEOCs (EMTCC), personnel well understood the mission and roles within the EMTCC described in the the WHO/EMTCC Handbook. Also, their performances were remarkably developed on the DAY2 (field exercise) based on the experience and the after action review on the DAY1 (TTX).

(2)Recommendation:

Given the different background and experience of each participants regarding the field exercise, it may be preferable if the scenario and the injects were simpler. For instance, if the number of severe patients would be smaller, each participant (= EMT member) could have more time to concentrate on preparing and to be familiar with the forms, which was the purpose of the 2nd RCD, rather than treatment of patients.

Also, more precise guidance on rules of engagement to the exercise may be beneficial to the participants in order to have common understanding and expectation to the scenario and exercise control. Likewise, it would be better to show some clear mark (e.g.

training bib) with the instructors/observers to let the participants identify their instructors easily.

As for the safety and security of the participants, the exercise controllers may further consider the exercise environment such as weather, temperature and humidity.

As for the performance of PHEOC(EMTCC), more familiarization and reference to the EMTCC handbook is essential to make the work of PHEOC(EMTCC) personnel easier and more effective. (e.g. Referring to the potential EMTCC meeting agenda items written in the Handbook.)

2 Observation areas in accordance with the WHO EMT Coordination Handbook.

The following 4 areas are highlighted in the WHO EMT Coordination Handbook. The Japanese Advisory Committee wish to recommend to the Thai EOC and exercise organizers for potential areas of development as well as best practice in each area, as requested by Thai side. Please refer to the attached check list for the detailed check points/criteria which the Japanese Advisory Committee set and used to observe the performance of Thai EOCs as well as the drill organizers mainly at the field exercise on DAY2 (and partially on DAY1).

➢ Informative

(1) Definition in the WHO/EMTCC Handbook:

The EMTCC has a role (or even an obligation) to disseminate relevant information to relational partners, especially to the EMTs. This information may be primary (such as situation reports generated from EMT daily reporting, or maps of EMT deployment) or secondary (such as updated security information, or visa and customs instructions where relevant).

Example:

Generating and distributing EMTCC situation reports to the EMTs and all relevant stakeholders involved in the response.

(2) Observation:

Information dissemination (in accordance with the WHO/EMTCC Handbook, this particularly means the producing of EMTCC situation report.) was well conducted, especially by the regional PHEOC(EMTCC). The provincial PHEOCs(EMTCC) also provided information to EMTs at the respective EMTCC meetings.

It was also observed that the data process was excellently conducted at both PHEOCs and the regional EMTCC. They always investigated the reliability of information gathered from EMT daily reports when they had any suspicious information. Also, at the regional PHEOC (EMTCC), the staffs succeeded in making informative graph using the EMT MDS.

It was also observed that the provincial PHEOCs(EMTCC) provided adequate and necessary briefing to EMTs on their arrival at the DAY2 field exercise.

(3)Recommendation:

It would be more helpful for PHEOC (EMTCC) if any information shared within PHEOC (EMTCC) is recorded, in addition to the verbal communication among EMTCC staff, for memory and subsequent review.

Likewise, it would be more benefit of EMTs if EMTCC post any information at suitable place with good visibility so that EMTs can have easy access for necessary information.

Also, PHEOCs (EMTCC) are encouraged to gather and analyze information for strategic operation. Moreover, PHEOCs (EMTCC) may prioritize information on safety and security, because safety and security issues reported by EMTs should be taken into consideration in order to ensure safety of EMTs.

- **Representative**

(1) Definition in the WHO/EMTCC Handbook:

This is an implicit role of the EMTCC, and is a critical coordinating function in facilitating connectivity, speed and 'visibility' of the N-EMT and I-EMT response. The EMTCC should be perceived as a representative focal point for the EMTs in the attempt to always reach a win-win status.

Example:

Presenting the concerns of I-EMTs to the coordinating bodies regarding the landing permission of I-EMTs during the initial critical hours of the response.

Reprimanding or correcting unacceptable behaviour from rogue EMTs to maintain a positive image of the EMT response.

(2) Observation:

Both regional and provincial PHEOCs (EMTCC) managed to adequately follow EMTs activities. They effectively utilized equipment such as a map and TV monitoring to grasp the

real time situation of EMT activities.

Although the planned communication equipment such as walky-talky and wire-less LAN had technical difficulties sometimes, all provincial PHEOCs could adequately report to and communicate with their supervising organization (in this drill, the regional EMTCC.) about establishment of EMTCC in their province. Also, both regional and provincial PHEOCs (EMTCC) made the contact list with other relevant sectors / stakeholders on DAY2.

The Japanese Advisory Committee did not observe one of the representative roles of EMTCC: coordination with relevant parties regarding the necessary assistance for EMTs on behalf of EMTs (e.g. Presenting the concerns of I-EMTs to the coordinating bodies regarding the landing permission of I-EMTs during the initial critical hours of the response.) However, this seemed to be performed in Thai language at the regional PHEOC(EMTCC) .

Also, the provincial PHEOCs(EMTCC) well managed transportation for patients transfer and referral.

(3) Recommendation:

In preparation for the actual deployment in the future, Thai PHEOC may consider to have an alternative method/tool to grasp the situation of EMT activities instead of real time TV monitoring. It may be difficult in a real disaster situation to follow TV while it is very good from a view point of training. For the next exercise opportunity, it is suggested to include more scenario and injects related to this role of EMTCC.

- **Advisory**

(1) Definition in the WHO/EMTCC Handbook:

The EMTCC, as a specialised cell with unique technical expertise, also holds an advisory role. Its general expertise includes the mechanisms and processes for coordinating EMTs, the EMT Classification and Minimum Standards as well as all identified areas of support required by EMTs during their deployment.

Examples:

Advising partners on the ideal mechanism for managing the arrival and registration of incoming I-EMTs.

Advising all EMTs on guidelines for improving case management or Infection Prevention and Control requirements.

(2) Observation:

Both the regional and provincial PHEOCs (EMTCC) actively and effectively gathered the wide range of information. At the regional PHEOC (EMTCC), information was gained from the EMT MDS Daily Report/Situation report. Based on those information, the provincial PHEOCs (EMTCC) provided advices to EMTs on infectious disease control, safety & security concerns, and guidelines for improving case management.

Also, the provincial PHEOCs successfully provided an important alert such as epidemic of infectious disease via situation report.

(3) Recommendation:

For easier data collection/analysis/evaluation, using equipment such as a writing sheet would be suggested.

Also, it may be better to share those important alerts by other means such as EMTCC meeting in addition to the situation report.

- **Facilitative Leadership**

(1) Definition in the WHO/EMTCC Handbook:

This is the predominant role of the EMTCC in its leadership and coordination of N-EMTs and I-EMTs. The objective is to facilitate the activities of the relational partners to the ultimate benefit of the affected population. This can be achieved by providing direct guidance or assistance to the relational partner, or by providing the linkage between partners (connectivity). While facilitative leadership is generally useful, there are situations in which the approach requires being directive rather than facilitative, that is, providing instructions (rather than guidance) in line with the requirements set by the MOH.

Examples:

- *Negotiating with other national authorities to establish a streamlined visa and customs procedure for all I-EMTs. This facilitates the rapid deployment of I-EMTs into the affected country, and reduces the workload of the national authorities in dealing with each EMT.*

(2) Observation:

In this 1st RCD, the component of scenario related to the EMTCC's role of Facilitative Leadership was limited.

END

Attachment 10

Health Needs Assessment form
Summary Report form
Guidance note

Health Needs Assessment Form by EMT (Draft Ver.1-3)

<This box could be moved to the summary form>

Action required by other clusters (if yes, please check ✓ the box (es) below.)											
☐	Health	◇	Communicable Diseases	◇	Non-communicable Diseases	◇	Sexual& Reproductive Health	◇	Child Health	◇	Other ( )
☐	WASH	☐	Food	☐	Nutrition	☐	Shelter	☐	Other ( )		

- It is not mandatory to fill out all the questions; only relevant information in the area can be collected.
- Please include the collected information in the HNA Summary Report.

A	Date (day/month/year) Time (hh/mm-24h)	/ / :	B	Form No.	
Team (EMT) Information					
C	Country		D	Team ID etc.	
E	Contact Persons (Names)				
F	Phone No.		G	e-mail	
H	Enumerator Name or ID	（☐Male ☐Female）			
Site Information					
I	Province		L	Village	
J	District		M	City/Town	
K	Sub-district		N	Other	
Access and Security					
O	Road access	☐Yes ☐No			
P	Special arrangement required	Transportation ☐Yes (e.g., 4WD, boat) _____ ☐No			
		Communication tool (e.g., satellite phone) ☐Yes _____ ☐No			
Q	Any other security concerns	☐Yes (Specify _____ ☐No _____)			
Remarks/ Notes:					

I. Overall Situation of the Site

1	**Disaster Situation on Population and Health Needs**	
1-1	Estimated number of death	_____(#)
1-2	Main causes of death by the disaster	▪ ▪
1-3	Estimated number of injured/ill	☐infant & children (Under 5 years) _____(#) ☐children & adolescent (aged 6-19) _____(#) ☐adult (older than 19 years of age)_____(#)
1-4	Total number of pregnant women	_____(#)
1-5	Number of patients suffering from chronic diseases	_____(#)
1-6	Any unusual increased illness or rumors of outbreaks	☐Yes (specify)_____ ☐No
1-7	Main health concerns	1._____ 2._____ 3._____
Remarks/ Notes: Observation points/Significance/Possible action and follow-ups etc.		

2	**Public Health**	
Water		
2-1	Main sources of water for drinking	☐piped water ☐tube well ☐spring ☐bottled water ☐other _____
2-2	Main sources of water for basic hygiene practices (bathing etc.)	☐piped water ☐tube well ☐spring ☐rainwater ☐other _____
2-3	Safe water for drinking	☐Adequate (2.5-3ℓ/person/day) ☐Not Adequate
2-4	Safe water for basic hygiene practices	☐Adequate (2-6ℓ/person/day) ☐Not Adequate
2-5	Potential risk of water contamination	☐Yes (_____) ☐No
Remarks/ Notes: Observation points/Significance/Possible action and follow-ups etc.		

Sanitation and Hygiene			
2-6	Functional latrine or toilet (20 persons/toilet)	☐Yes	☐No
2-7	Problem with garbage/waste	☐Yes	☐No
2-8	Stagnate water in the area	☐Yes	☐No
2-9	Vector problem (e.g. mosquitoes, dogs, snakes)	☐Yes	☐No
Remarks/ Notes: Observation points/Significance/Possible action and follow-ups etc.			

Food Security and Nutrition			
2-10	Number of population required food	_____(#)	
2-11	Any food assistance since the event	☐Yes (go to 2-10)	☐No (go to 2-11)
2-12	For how long provided food sufficient	☐days_____	☐weeks_____
2-13	What kinds of food available or provided	☐Rice and/or wheat and/or corn ☐Cassava ☐Noodle ☐Biscuits ☐Salted/canned fish ☐Chicken/other meat ☐Eggs ☐Fruits and/or vegetables ☐Cooking oils and/or fats ☐Breast-milk substitutes ☐Other_____ ☐No food stocks	
2-14	Food and Nutrition	☐Adequate ➢ (e.g.) People eating 3 meals a day. Babies get enough milk.	
		☐Not adequate ➢ (e.g.) People eating smaller meals since the event. People eating fewer meals a day. People eating limited varieties of foods.	
2-15	Obvious signs of malnutrition in children aged 6-59 months	☐Yes	☐No
Remarks/ Notes: Observation points/Significance/Possible action and follow-ups etc.			

3	Health Facilities and Services			
Type of Facility (Name of Facility)		Community Hospital ( )	Primary Care Unit ( )	Other ( )
3-1. Impact on Health Facilities		☐Functioning ☐Partially functioning ☐Not functioning	☐Functioning ☐Partially functioning ☐Not functioning	☐Functioning ☐Partially functioning ☐Not functioning
3-2. Access to Referral Facilities by Road		☐Yes ☐No ☐Other means_____	☐Yes ☐No ☐Other means_____	☐Yes ☐No ☐Other means_____
3-3. Availability of	Electricity	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Water	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Oxygen Gas	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Communication	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Transportation	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
3-4. Availability of	Essential Drugs	☐Yes (_____) ☐No	☐Yes (_____) ☐No	☐Yes (_____) ☐No
	Vaccines	☐Yes (_____) ☐No	☐Yes (_____) ☐No	☐Yes (_____) ☐No
	Medical Equipment	☐Yes (_____) ☐No	☐Yes (_____) ☐No	☐Yes (_____) ☐No
	Supplies	☐Yes (_____) ☐No	☐Yes (_____) ☐No	☐Yes (_____) ☐No
	Other (_____)	☐Yes (_____) ☐No	☐Yes (_____) ☐No	☐Yes (_____) ☐No
3-5. Health Staff Working	Doctor	_____persons (#)	_____persons (#)	_____persons (#)
		☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%
	Nurse	_____persons (#)	_____persons (#)	_____persons (#)
		☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%
	Pharmacist	_____persons (#)	_____persons (#)	_____persons (#)
		☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%
	Lab technician	_____persons (#)	_____persons (#)	_____persons (#)
		☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%

	Midwife	_____persons (#)	_____persons (#)	_____persons (#)
		☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%
	Community Health Worker	_____persons (#)	_____persons (#)	_____persons (#)
		☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%	☐Less than 50% ☐More than 50%
	Remarks/ Notes: Any observation on health staff in the facilities etc.			
Remarks/ Notes: Observation points/Significance/Possible action and follow-ups etc.				

II. Situation of Shelter

<u>If you find a shelter</u> in the site, fill out the information in the "4. Shelter".

If there are more than one shelter, use additional forms.

4.	**Shelter**		
General Information			
4-1	Shelter Name:	4-2	GPS Coordinate:
4-3	Location of Shelter:	4-4	Number of People:
4-5	Type of Shelter	☐Public ☐Pre-existing building ☐Temporary structure ☐Other (specify)_____	
4-6	Capacity	☐Adequate (>3.5m^{2}/person)	☐Not adequate
Health			
4-7	Estimated number of injured/ill	☐Infant & children (Under 5 years) _____(#) ☐children & adolescent (aged 6-19) _____(#) ☐adult (older than 19 years of age)_____(#)	
4-8	Estimated number of deaths	_____(#)	
4-9	Main causes of death	▪ ▪	
4-10	Total number of pregnant women	_____(#)	
4-11	Number of patients suffering from chronic diseases	_____(#)	
4-12	Any unusual increased illness or rumors of outbreaks	☐Yes (specify)_____ ☐No	
4-13	Main health concerns	1._____ 2._____ 3._____	
Water			
4-14	Main source of water for drinking	☐piped water ☐tube well ☐spring ☐bottled water ☐other _____	
4-15	Main source of water for domestic use (bathing etc.)	☐piped water ☐tube well ☐spring ☐rainwater ☐other _____	
4-16	Safe water for drinking	☐Adequate (3ℓ/person/day)	☐Not adequate
4-17	Safe water for domestic hygiene	☐Adequate (2-6ℓ/person/day)	☐Not adequate
4-18	Potential risk of water contamination	☐Yes (_____)	☐No

Remarks/ Notes: Observation points/Significance/Possible action and follow-ups etc.			
Sanitation and Hygiene			
4-19	Number of functional Latrines/Toilets	☐Adequate (50～20 persons/latrine) (women/men:3:1)	☐Not adequate
4-20	Safe access to latrines or toilets at night	☐Yes	☐No
4-21	Stagnant water at the site	☐Yes	☐No
4-22	Common waste dump in the site	☐Yes	☐No
4-23	Vector problem (e.g. mosquitoes, dogs, snakes)	☐Yes	☐No
Food Security and Nutrition			
4-24	Number of population required food	_____(#)	
4-25	Any food assistance since the event	☐Yes (go to 4-25)	☐No (go to 4-25)
4-26	For how long provided food sufficient	_____weeks	_____ months
4-27	What kinds of food provided	☐Rice and/or wheat and/or corn ☐Cassava ☐Noodle ☐Biscuits ☐Salted/canned fish ☐Chicken/other meat ☐Eggs ☐Fruits and/or vegetables ☐Cooking oils and/or fats ☐Breast-milk substitutes ☐Other_____ ☐No food stocks	
4-28	Food and nutrition	☐Adequate ➢ (e.g.) People eating 3 meals a day. Babies get enough milk. ☐Not adequate ➢ (e.g.) People eating smaller meals since the event, People eating fewer meals a day. People eating limited varieties of foods.	
4-29	Obvious signs of malnutrition	☐Yes	☐No
4-30	Lighting	☐Available	☐Not available
4-31	Communication	☐Available	☐Not available

4-32	Priority needs in the shelter	
Remarks/ Notes: Observation points/Significance/Possible action and follow-ups etc.		

Draft Health Needs Assessment (HNA) Summary Report (Version-0)

1. General Information

Date of Assessment	dd/mm/yy	Date of Submission	dd/mm/yy
Site			
Security concerns if any			
EMT Information	Country:	Contact Person:	
	Contact number & email:		

2. Situation of the Site

Sector	Sub-area	Critical Problems	Actions required	Detailed Assessment for Action
Health	-			
WASH	Water			
WASH	Sanitation & Hygiene			
Food & Nutrition	-			

Remarks if any:

3: Situation of the Shelter (if HNA was conducted for a shelter(s).)

Date of Assessment	dd/mm/yy
Name & Site of the Shelter	
# of People in the Shelter	

Sector	Sub-area	Critical Problems	Actions required	Detailed Assessment for Action
Health				
WASH	Water			
WASH	Sanitation & Hygiene			
Food & Nutrition				

Remarks if any:

ARCH Project
Version0-1

Regional Collaboration Tool
Guidance Note for Health Needs Assessment

Objective of Conducting Health Needs Assessment (HNA)

To collect primary data which will identify the vital needs of the affected population and define the needs based response.

The information from HNA can be useful to mitigate the crisis impacts and take precaution for potential health risks. The relevant information can be shared with the local authority and other clusters/sectors for coordinated action

Role in Standard Operating Procedure (SOP)

One of the on-site operations described in “Emergency Response” in the draft SOP.

Primary Users

Emergency Medical Teams (EMT)

Consensus among AMS on HNA by EMTs

Although HNA by EMTs can be useful in actual operation:

- The main role of EMTs is to provide medical services so that conducting HNA is not compulsory; HNA can be one of the options for EMTs; and
- EMTs shall conduct HNA only if/when they have capacity (time, personnel and skills) and depending on the needs and decision of the local authority or the receiving country.

Intended Timing of Conducting HNA

EMTs may conduct HNA at any critical time of the disaster as required and/or requested by a local authority (e.g. PHEOC). However, it is more likely that EMTs conduct HNA after the acute phase of the disaster, as the main task of EMTs is to provide medical service to save lives in disaster affected areas.

Methodology

Primary Data Collection: The field data collected through community-level assessment.

The specific data collection techniques for Primary Data Collection are as follows.[1]

a. Direct Observation (DO): Structured (looking for) and unstructured (looking at) observation of

[1] Other technique will be Community Group Discussion, an interview of a group of individuals to obtain information through group interaction.

the impact and situation of the affected community and population.

b. Key Informant Interview (KII) (and/or Community Interview): An individual with prior knowledge of the affected community is questioned to gather key information on the impact of the disaster and on priority community needs.

Please see Annex I and II for the brief descriptions of DO and KII.
Please see Annex III for the list of supplies and equipment for the field assessment.

Suggested Contents

The contents of HNA will include the following health and public health aspects (health related clusters[2]).

- Health Impact and Condition of the Affected Population
- Health Facilities and Services
- WASH (Water, Sanitation and Hygiene)
- Food Security
- Nutrition
- Shelter/Living Condition

Reporting Options

The results of HNA should be presented to the local authority and other concerned parties so as to take prompt and appropriate action. The information on other clusters should be later confirmed with public health teams or concerned cluster teams, and necessary operation/action should be left to them in case there is no public health personnel in the deployed EMTs.

The following are the suggested reporting options.

Option 1. Submit the filled HNA Form (maybe as an attachment to the EMT-MDS form)

Option 2. Incorporate the collected information into the EMT-MDS Daily Reporting Form "Needs and Risks" Part as shown below

[2] Clusters are groups of humanitarian organizations, both UN and non-UN, in each of the main sectors of humanitarian action, e.g. water, sanitation, hygiene (WASH), health, food security, nutrition, shelter, logistics, protection, education etc. They are designated by the Inter-Agency Standing Committee (IASC) and have clear responsibilities for coordination.

Needs and Risks							
Immediate Report	51	☐	Unexpected death	Risks	59	☐	Shelter/Non food Item
	52	☐	National mandatory reporting diseases		60	☐	Food security
	53	☐	Critical / security incident to community	Operational Constrains	61	☐	Logistics /Operational support
	54	☐	Critical incident to EMT		62	☐	Supply
Risks	55	☐	Any other issue		63	☐	Human resources
	56	☐	WASH		64	☐	Finance
	57	☐	Community/rumor based infectious diseases		65	☐	Others
	58	☐	Environmental risk or exposure				
Detailed Comment for (No.)							
Detailed Comment for (No.)							
Detailed Comment for (No.)							

"EMT-MDS Daily Reporting Form (Ver0.94)"

Option 3. As discussed and agreed, a draft HNA Summary Format will be tested in the 2nd Regional Collaboration Drill.

Other Option. If a local authority has an existing reporting format, EMTs may also utilize it.

Submission and Sharing the HNA Report

HNA findings and report will be submitted by concerned EMT to EMTCC/PHEOC/MOH of the area of operation.

Interpretation of Some of the Terms in the draft HNA Form

Page1

✓ **Check Box**

On completion of the HNA, check the clusters in the box which your team thinks actions or furtherer investigations/assessment by the concerned local authorities and/or agencies in charge of other clusters are required. For the Health Cluster, also check the sub-areas as necessary.

✓ **Site Information**

Since the administrative divisions vary country to country, replace the terms with ones most suitable in the local setting.

✓ **Access and Security**

"Q" Any other security concerns

Examples can be the existence of hazardous objects and unexclusive ordinance, a tension among the population, environmental destruction (e.g., landslides) etc.

Page2

2. Public Health

✓ **Water**

2-1 Main sources of water for drinking

List of the sources for drinking water

- Piped water
- Public tap/standpipe
- Water well/ borehole (A borehole is a long, narrow well drilled to access underground water. The borehole is covered with a hand-pump to prevent contamination and to ease access.)
- Dug well (If a dug wells are open and unprotected, they can become very contaminated from spilt water, animal excreta and objects thrown into the well, posing a major risk to public health.)
- Spring
- Rainwater collection
- Bottled water
- Vendor-provided water
- Tanker truck water
- Surface water (river, stream, dam, lake, pond, canal, irrigation channel)

Sources: UNICEF, Projectacwa,

Basic Survival Water Use

Survival needs: Water intake (drinking and food)	2.5-3 litres per day	Depending on the climate and individual physiology
Basic hygiene practices	2-6 litres per day	Depending on social and cultural norms
Basic cooking needs	3-6 litres per day	Depending on food type and social and cultural norms
Total basic water needs	7.5-15 litres per day	

Source: The Sphere Project, p98

Page 3

✓ **Sanitation and Hygiene**

2-7 Problem with garbage/waste

All waste generated by populations living in the settlements is removed from the immediate living environment on a daily basis. If waste is to be buried on-site, it should be covered daily with a thin layer of earth to prevent it attracting vectors such as flies and rodents.

2-8 Stagnant water in the area

Stagnant water provides a better incubator than running water for many kinds of bacteria and parasites and can become a breeding ground for the mosquitoes.

✓ **Food and Nutrition**

2-13 What kinds of food available or provided

The food items listed here can be replaced with ones most suitable to the local context.

2-14 Food and nutrition

Assess the changes in frequency, quantity and quality of meals compared to the situation before disaster.

2-15 Obvious signs of malnutrition in children aged 6-59 months

The most widely accepted practice is to assess malnutrition levels in children aged 6-59 months as a proxy for the population as a whole.

Annexes

Annex I: Direct Observation Guidance Note

Annex II: Key Informant Interview Guidance Note

Annex III: Checklist of Supplies and Equipment for the Field Assessment

Annex I

Guidance Note of Direct Observation

**This is a general description of the Direct Observation.*

1. Brief Description of Direct Observation

Direct observation (DO) is a process of observing objects, people, events and relationships. Observation provides immediate information on water points, health facilities and other infrastructure such as public services and sanitation systems. It can be an easy means of gathering data on people's physical condition, activities and economic circumstances, power relationships within the community as well as coping mechanisms and access to aid. Direct observation can be done individually or with community members.

DO is used throughout the assessment process. It includes "structured (looking for) and unstructured (looking at) observation (sounds, smells, visual impression, taste and touch)." It is the fastest way to gather data in the immediate aftermath of an emergency, although it must be complemented by and verified against secondary data and local knowledge. It can be carried out in three ways: on foot, in ground vehicles, or by aerial observation. If possible, pre-crisis baselines should be established in order to ensure that observational analysis does not confuse acute and chronic problems.

Observation is a continuous process. However, certain points should be recorded systematically. These observations should be used to validate information obtained from other sources, for instance finding that what people say may be different from what they do. DO should pay additional attention to risks to impact affected communities. Observation can also provide new areas of investigation and sources of information (e.g. help identify key informants and how they interact with the community).

2. Strengths and Limitations

As explained, direct observation is a quick and cost-effective data collection method in an emergency. It helps to frame future discussions and cross-check people's answers in case of inconsistency between what you see and what you are told during interviews. However, as a data collection technique, it only provides a snapshot of the situation and has therefore limited use when the crisis evolves rapidly. Similarly, it provides only partial information about community's capacities and priorities. Finally, while it does not require specific training, some preparation is necessary to ensure that the observers are aware that their own perceptions and expectations are subjective and have an impact upon how they report and interpret their observations.

3. Process and Basic Principles of Direct Observation

The following is the process and basic principles of conducting DO.

<u>STEP1: Decide what areas you are going to focus your observations on</u>

While the team should always be carrying out informal observation, make a list of things to look for specifically.

STEP 2: Assign tasks

Make sure that all members of the team are assigned to observe certain things, although all members should be observing all aspects as well. By assigning specific areas to different team members, the team will ensure that all aspects are covered.

STEP 3: Start observation

The observer explains why they want to observe people at the site, asks permission from the people living there, and explains how the information collected will be used. A respectful entry to the affected area will aid in securing access and cooperation. Invite people living at the site to join the observation. Ask them questions about what you observe on the way and why things are as they are.

It is important to observe and detect conditions and particular features of the affected area from a range of viewpoints and places in order to get a representative view of the site, including an overall impression of the urgency of the situation. Look at what is there, what is not there and what should be. Depending on the security situation, walking across the site along a transect that does not follow existing lines such as roads or paths will provide a cross section of points for observation and provide a balanced view of conditions. Household visits should also be included if necessary.

Observation can be done on the area, demography, infrastructure, health, sanitation, water and other essential services, daily activities, visible vulnerabilities and capacities of the affected population etc. (For EMTs, observation may be focused more on health related aspects.). Key sites for observation include water collection points, markets, food distribution queues, latrines, communal showers, storage facilities, grave sites, and drug stocks in health facilities. If feasible, compare the observation with the key informant interviews as much as possible.

STEP 4: Record the data and review the progress

The team should be constantly observing, whether in a structured way or informally, and always take notes as details as possible. This will help the team to remember the context and increase the validity of the observation.

The team should aim to meet up at least once during the fieldwork at each site, to review progress and decide which parts of the checklist or which sources of information still need attention before leaving the site, so as to avoid gaps in essential data or avoidable uncertainty about important points. The team will probably not be completely effective during the first site visit. There are likely to be a number of problems such as the time allocations at the site, roles and responsibilities within the team, assessment methods etc. that should be addressed before moving on to the next location. After every successive site visit, there should always be a rapid team meeting to review progress and ensure the most effective use of precious time in the field.

Step 5: Debrief and summarize the information

Finally, a debriefing with all team members should be organized to tally up observations and pull together the final conclusions, as a first level analysis. Areas where team observations and population responses do not match can be highlighted so that discrepancies can be analyzed and

triangulation needs identified.
At the end of the day, all notes should be put in a clean and concise format. This should be done by each individual so that the entire group will be able to understand the observations made during the data systematization. Careful recording and systematization of the information will contribute significantly to proper verification of the information by the community.

4. Aspects and Points of Observation

The following checklist helps to pick up visual clues. This is an overall list of observation, not limiting to health and health related aspects.

■ General area observations

- Terrain (dessert, mountain, etc.)
- Ground cover (grassy, sandy, barren, etc.)
- Presence of surface water (lakes, rivers)
- Status of local crops and vegetation
- Green spaces and playgrounds
- Road types and conditions, road blocks, amount of traffic
- Signs of flooding, environmental degradation, etc.
- Signs of fighting, landmines

■ Affected area observations

- Layout and organization (esp. living areas)
- Size and possibility for expansion
- Density (crowding)
- Population movements
- Geographic location (on hill, in valley, etc.)
- Air condition (too cold/too hot)
- Markets
- Religion – churches, mosques, temples, etc.
- Location of health facilities
- Water sources and sanitation
- Condition of electricity supply
- Condition of roads both at present and in rain
- Overall cleanliness
- Signs of gardens (crops) and animals (in field or roaming loose)
- Level of relief agency activity (e.g., people working, presence of relief supplies, trucks, etc.

■ Location observations

Visualize the information by a rough drawing of a map.

- Proximity to: any important site (e.g. border, main road, port, river)

- Towns/villages
- Roads/railways
- Surface water (lakes, rivers)

■ Affected population observations

- Overall condition (healthy, active, obviously malnourished, etc.)
- Friendliness/hostility/fear/depression
- Presence and appearance of children less than 5 years (skinny/oedema/normal)
- Presence and appearance of pregnant and lactating women
- Presence of elderly
- Appearance of wounded / traumatized

■ Detailed observations per sector

- Shelter: type, materials, number of shelter and number of homeless or other affected population displacement patterns
- Water: source, distance, quality and quantity, queuing, storage, spillage
- Sanitation and Hygiene: number, type and usage of defecation facilities, cleanliness, drainage and stagnant water, refuse disposal, availability of running water, functionality and type, washing facilities, soap availability and usage, vectors (flies, mosquitoes and rodents)
- Food and Food Security: presence of food stock at household level, malnourishment, markets, food distributions
- Health Services: number and types of facilities and level of functioning, number of patients waiting, staff presence, drug stocks
- Logistics and Security: condition of roads, transport, communication means, power supply, number, size and condition of warehouses, conditions of storage (pallets, temperature, etc.), supplies on hand, evidence of pests, security (guards, fences, lightening) and record keeping.

Annex II

Guidance Note of Key Informant Interview

1. Brief Description of Key Informant Interview

In addition to direct observation, Key Informant interview (KII) is a commonly used data collection technique for rapid or initial assessments. A KII is one where an individual with prior knowledge of the affected community is questioned to gather key information on the impact of the disaster and on priority community needs. KIIs can provide information about a community in a fairly short period of time and without a large number of people needing to be interviewed. It is important to carefully select informants so as to minimize bias in the assessment results. When time allows, more individual interviews should be conducted to get a range of opinions. Furthermore, cross-checking is necessary and should include a few interviews with members of vulnerable groups, wherever possible.

2. Strengths and Limitations

KIIs can be organized quickly and carried out with few resources. They have particular value in gaining a perspective of the impact of the disaster on a community where access to affected populations has been compromised or is difficult. They also provide a holistic and qualitative overview of the impact of a disaster on community members. The greatest limitation of a KI interview is that it provides a subjective perspective on the impact of a disaster. As with all individual responses, information will have both an individual and a cultural bias which needs to be considered when analyzing KII responses.

3. Process and Basic Principles of Key Informant Interview

<u>Step1: Before the assessment</u>

Plan the field data collection carefully. It is important for the team to inform the authorities of the assessment itinerary and bring credential letters to the assessment locations which explain the assessment objectives. Team members should be briefed on and understand the objectives, methodology and principles of the rapid assessment and the possible interventions that could be implemented as a result of it. Upon arrival in a location, the team should meet with community leaders to explain the visit and assessment methodology and request the leaders' support. Where there are no such obvious starting points, contacts with people in the street or in/around the administrative place can help identify people knowledgeable on the community situation

Step2: During the assessment

Selection of Key Informants (KIs)

The number of key informants (KIs) selected per site will depend on the range of issues about which each one has expertise/perspective. KIs must be selected to cover population profiles and figures/trends, security/access, protection, as well as water, environment and sanitation, food security/nutrition, shelter and health. When identifying KIs, remember to arrange interviews with individuals of different genders, ages, and religious and/or ethnic minorities to ensure a full picture of the affected community. Traditionally, KIs are religious or community leaders, or representatives of community-based organizations. Other KIs at each site would normally include health workers, teachers, community development workers, relief workers, traders and NGO program managers. All are likely to be sources of important information. Regular citizens can also be valuable KIs because they can share their representative and personal experience. For example, a young female household head may be able to highlight priority needs from the perspective of a mother.

Key Informants Checklist

- government officials / authorities
- embassies / donors
- UN Agency like UNHCR, UNICEF
- director of health, representative of Ministry of Health, health workers
- WFP and/or food distributors / relief agency
- administrator / senior relief officer
- representative humanitarian agency
- police/army/fire service/rescue services
- representatives of community (formal and informal leaders/members)
- village elders
- religious leaders
- doctors/nurses
- traditional birth attendants (TBAs)
- evacuation center focal point
- teachers, etc.

Conducting Interviews

After selecting KIs, give them an introduction to make sure that they understand the objectives of the interview and get their informed consent. Arrange place and time convenient for KIs.

The introduction includes:

- The survey objectives
- The estimated duration of the interview (no longer than 50 min)
- What the respondent can expect from the interview (compensation etc.)
- Information on how the survey results will be used and how the respondent can access the findings
- Confidentiality of the interview
- Informed consent:
  - All respondents know how the information will be used, why it is being collected, and by whom.
  - All are guaranteed that their participation will not jeopardize their safety or security.

All team members should convey a sense of empathy and respect. Good eye contact, confidence, and an approachable demeanor are all ways to achieve a positive interview experience. Express interest in the respondent's answers and be an active listener while remaining patient if/when an interviewee is having a difficult time answering questions. Start the interview with general questions about the situation and allow the interviewee to raise issues of concern to them before guiding the conversation to the subjects of interest to the assessment team. Be flexible and allow a natural flow of the discussion. Pausing allows respondents to think more about the questions. Take notes throughout the interview.

Combine interviews with observation to verify information and correct inconsistencies. Consider the needs of different groups and individuals, seek out marginalized groups and ensure their interests are taken into account. However, do not ask questions that may stigmatize people or endanger them and be careful not to raise unrealistic expectations of aid. Do not interpret, correct, argue, discuss, or judge respondents. When an interview does not yield the overall perspective needed, politely bring the discussion to an end, thank the interviewees for their time, and seek other KIs to talk with. Do not limit information to one KI's response. Triangulate by asking other KIs until you are confident that there is consensus on this point. At the end, make sure you summaries and feedback the most important points. Do not prevent KIs from asking you questions at the end of the interview. Finish with an informal chat and thank your respondent.

<u>STEP3: After the assessment</u>

Record metadata (such as date, location of interview, social role of interviewee, group represented by the interviewee, etc.) for each KI, as this information will be used in the interpretation of the data. As with direct observation, a debriefing should be organized to give team members the opportunity to discuss the strengths and weaknesses of the interviews and the interview process and compare findings, views and impressions. The team leader should gather observational information, anecdotes, or concerns not captured in the data collection form. Consider the reliability of the key

informants as well as the team bias. All of this information should be considered and included in the final report.

Annex III

(Suggested) Checklist of Supplies and Equipment for the Field Assessment

The field assessment teams (EMTs) require appropriate logistics, administrative planning and support to complete the job properly and safely. The following is a suggested checklist with supplies and equipment the team may need while carrying out primary data collection in the field.

	No	✓	Note
Team Supplies			
Name tag, badge, or an identification/authorization from the local or health department etc.			
Visibility material (t-shirts, flags, stickers)			
Backpack			
First aid kit, Hand sanitizer			
Radio and/or satellite phone			
Cell phones and chargers, SIM card, phone credits			
Flashlights (torches)			
Camera			
Compass/GPS unit/area maps (plastic, if available)			
Laptop computer (if security conditions permit and power is available)			
Spare batteries and chargers for all devices			
Fuel			
Water and food (snacks), if supplies may be difficult to obtain in the areas to be visited			
Mosquito nets and/or repellants, if needed			
Internet sticks, backup storage devices			
List of contacts			
Items for Each Team Member's Use for Data Entry			
Phone/smartphone+applications (if applicable)			
Clipboard			
Paper			
Notebooks/notepads			
Calculator			
Pens, pencils and pencil sharpeners			
Erasers			
Stapler and pins			
Ruler			
Items for Community level Interviews			
Sufficient copies of:			
Key informant interview guide and HNA form			
Observation (transect walk) guide and checklist			

Reference Materials

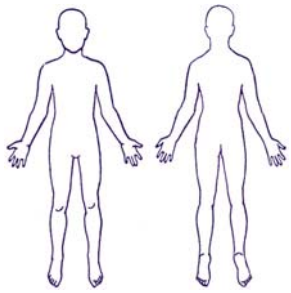
- The ASEAN - Emergency Response and Assessment Team (ERAT) Guideline
- Multi-Cluster/Sector Initial Rapid Assessment (MIRA) - the United Nations Disaster Assessment and Coordination (UNDAC)
- Initial Rapid Assessment (IRA) materials by Inter-Agency Standing Committee-IASC
- Initial rapid multi-sectoral assessment materials of International Federation of Red Cross and Red Crescent Societies
- Assessment materials by the Assessment Capacities Project (ACAPS), Medicins Sans Frontieres (MSF) and others
- Community Assessment for Public Health Emergency Response (CASPER) Toolkit –Second Edition (Centers for Disease Control and Prevention National Center for Environmental Health Environmental Hazards and Health Effects Health Studies Branch)
- Rapid Health Assessment Form (Indonesia)
- Regional Rapid Health Assessment (Health Emergency Management Bureau, Republic of the Philippines Department of Health)
- The Sphere Project, Humanitarian Charter Minimum Standards in Humanitarian Response (2011)

Attachment 11

Medical record

Team Name: Site: Date: / / (d/m/y)

Medical Record for Emergency and Disaster

ID:	Name:
Age:	Sex ☐ Male ☐ Female (Non-pregnant / Pregnant)
	Weight Kg Height cm
Address:	
Triage category	☐ Red ☐ Yellow ☐ Green ☐ Black/Blue/Gray
Hazards (if any)	☐ Chemical ☐ Biological ☐ Radiological ☐ Nuclear ☐ Explosion
Chief complaints	TIME :
	Trauma ☐ No ☐ Yes
	(☐Blunt ☐ Penetrating ☐ Fall ☐ Traffic accident ☐ Burn ☐ Others)
Vital signs	BT: ℃, RR: /min, O2 sat: % GCS : E V M
	BP : mmHg, PR: /min, Pain score:
Past history & Comorbidity	☐ DM ☐ HTn ☐ Asthma ☐ Breast feeding
	☐ Other ( )
Medication	☐ No ☐ Yes ( )
Vaccination	☐ Unknown ☐ Tetanus ☐ Measles ☐ Mumps ☐ Rubella ☐ Rabies
Allergy	☐ Unknown ☐ Drug ☐ Food ☐ Others (
Physical exam.	
Diagnosis	
Investigations	
Management	
Procedure	
Follow up	☐ No ☐ Yes (specify: dd/mm/yy: / /)
Outcome	☐ Discharge home/shelter --> go to 37 or not
	☐ Referral --> go to 38 ☐ Admission --> go to 39
	☐ Left against medical advice --> go to 40
	☐ Dead on arrival --> go to 41 ☐ Death within facility --> go to 42
	☐ Require long term rehabilitation --> go to 43
Context	Disaster relation: ☐ Direct ☐ Indirect ☐ Not related
	Vulnerability: ☐ No ☐ Yes --> go to 47-48
	Violence: ☐ No ☐ Yes --> go to 49-50

WHO-MDS Ver1.0 (check all that apply)

Sex & Age	Age			☐ <1 ☐ 1-4 ☐ 6-17 ☐ 18-64 ☐ 65<
	Sex	1	☐	Male
		2	☐	Female (not pregnant)
		3	☐	Female (pregnant)
Health Events	Trauma	4	☐	Major head / spine injury
		5	☐	Major torso injury
		6	☐	Major extremity injury
		7	☐	Moderate injury
		8	☐	Minor injury
	Infection	9	☐	Acute respiratory infection
		10	☐	Acute watery diarrhea
		11	☐	Acute bloody diarrhea
		12	☐	Acute jaundice syndrome
		13	☐	Suspected Measles
		14	☐	Suspected Meningitis
		15	☐	Suspected Tetanus
		16	☐	Acute flaccid paralysis
		17	☐	Acute haemorrhagic fever
		18	☐	Fever of unknown origin
	Additional	19	☐	
		20	☐	
		21	☐	
		22	☐	
		23	☐	
		24	☐	
	Emerg	25	☐	Surgical emergency (Non-trauma)
		26	☐	Medical emergency
	Others	27	☐	Skin disease
		28	☐	Acute mental health and psychosocial problem
		29	☐	Obstetric complicated
		30	☐	Severe Acute Malnutrition (SAM) *
Procedure & Outcome	Procedure	31	☐	Major procedure except limb amputation/obsteric
		32	☐	Minor procedure
		33	☐	Limb amputation excluding digits *
		34	☐	Normal Vaginal Delivery (NVD)
		35	☐	Caesarean section
		36	☐	Obstetrics others
	Outcome	37	☐	Requiring medical follow up
		38	☐	Referral *
		39	☐	Admission
		40	☐	Left against medical advise
		41	☐	Dead on arrival
		42	☐	Death within facility *
		43	☐	Require long term rehabilitation *
Context	Relation	44	☐	Directly related to disaster
		45	☐	Indirectly related to disaster
		46	☐	Not related to disaster
	Protection	47	☐	Vulnerable child
		48	☐	Vulnerable adult
		49	☐	Violence (Sex & Gener Based)
		50	☐	Violence (non-SGBV)

Signature	Record person	Comment

Nurse note		Doctor order sheet	
Date/Time	Information	One day	Continuous

Attachment 12

Standard Operation Procedure/Minimum Requirement

Standard Operating Procedure (SOP) for Coordination of Emergency Medical Teams (EMTs) in ASEAN (Working Title)

Document Status: Draft for Circulation
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Date: 19 April 2018

Please submit your feedbacks via email

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Table of Contents:

List of Acronyms & Abbreviations

AADMER	ASEAN Agreement on Disaster Management and Emergency Response
ACDM	ASEAN Committee on Disaster Management
AHA Centre	ASEAN Coordinating Centre for Humanitarian Assistance on Disaster Management
AJDRP	ASEAN Joint Disaster Response Plan
AMS	ASEAN Member States
CIQ	Custom, Immigration and Quarantine
DOH	Department of Health
EMTs	Emergency Medical Teams

EMTCC	Emergency Medical Team Coordination Cell
HNA	Health Needs Assessment
I-EMT	International Emergency Medical Team
MDS	Minimum Dataset
MOH	Ministry of Health
MOPH	Ministry of Public Health
N-EMT	National Emergency Medical Team
NDMO	National Disaster Management Organization
OSOCC	On-Site Operations Coordination Center
PHEOC	Public Health Emergency Operations Center
RDC	Reception and Departure Center
SASOP	Standard Operating Procedure for Regional Standby Arrangements and Coordination Of Joint Disaster Relief and Emergency Response Operation
VOSOCC	Virtual On-Site Operations Coordination Center

I. Introduction

1. ASEAN Member States have been committed to provide effective mechanisms to achieve substantial reduction of disaster losses, and to jointly respond to disaster emergencies through concerted national efforts and intensified regional and international cooperation as stipulated in the ASEAN Agreement on Disaster Management and Emergency Response (AADMER) under the vision of “One ASEAN, One Response” as adopted in the ASEAN Declaration on One ASEAN, One Response: ASEAN Responding to Disasters as One in The Region and Outside The Region on 6 September 2016.

2. Emergency medical responses provided by Emergency Medical Teams (EMTs) have a critical role to play in saving lives and reducing mortality and morbidity. To ensure that EMT operations are reliable and trustworthy and their operations meet the needs of the affected populations, concerted and explicit coordination and collaboration among both international and national EMTs directed by the Ministry of Health of the affected country is indispensable.

3. This Standard Operating Procedure (SOP) aims (i) to ensure the quality and consistency of EMT operations in the affected ASEAN Member State(s) in order to contribute to the vision “One ASEAN, One Response” and (ii) to complement the operating procedures and protocols developed by the international community and the ASEAN and East Asia regions.

4. This SOP is a component of the ASEAN Standard Operating Procedure for Regional Standby Arrangements and Coordination of Joint Disaster Relief and Emergency Response Operations (SASOP). This SOP covers the area shown in the figure below.

5. This SOP applies specifically to civilian EMTs with no consideration whether civilian EMTs might utilize military assets and capacities to support team operations. The facilitation and utilization of military assets and capacities including military EMTs is set out in Chapter VI of SASOP.

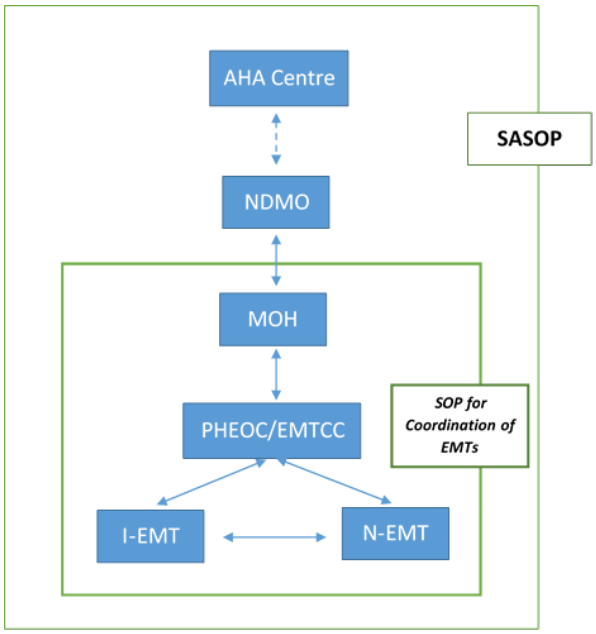

Figure 1: Scope of SOP (draft)

II. Institutions

A. Ministry of Health/Ministry of Public Health/Department of Health

6. The terms Ministry of Health (MOH)/ Ministry of Public Health (MOPH) and Department of Health (DOH) in this SOP will collectively be referred as Ministry of Health (MOH). The MOH shall be the primary entity responsible for the overall coordination of National Emergency Medical Teams (N-EMTs) and International Emergency Medical Teams (I-EMTs) under its purview.

B. Public Health Emergency Operations Center (PHEOC)

7. A public health emergency operations center (PHEOC) is a central location for coordinating operational information and resources for strategic management of public health emergencies and events. PHEOCs provide communication and information tools and services and a management system during a response to an emergency or event. PHEOCs also provide other essential functions to support decision-making and implementation, coordination, and collaboration[1]. PHEOCs can be established and managed by both national and local authorities (which is referred to in this SOP as local PHEOC), depending on the administration of the MOH of the affected country.

C. Emergency Medical Team Coordination Cell (EMTCC)

8. The core purpose of the Emergency Medical Team Coordination Cell (EMTCC) is the overall coordination of the surge of responding EMTs (both National and International) to best meet the excess healthcare needs resulting from increased morbidity due to the emergency, or from damage to existing capacity. The EMTCC should be activated, managed and staffed by trained and experienced personnel.

9. Integration of the EMTCC within the existing national PHEOC is ideal for an effective integration of the I-EMTs with existing national health services. The EMTCC can be established and managed in the local level (which is referred to in this SOP as Sub-EMTCC) if the local PHEOC is activated.

[1] WHO, A Systematic Review of Public Health Emergency Operations Centre (EOC), 2013.

D. Emergency Medical Team (EMT)

10. The Emergency Medical Team (EMT) refers to groups of health professionals and supporting staff aiming to provide direct clinical care to populations affected by disasters or outbreaks and emergencies as surge capacity to support the local health system[2]. In this SOP, EMTs include government civilian and non-governmental EMTs and they can be subclassified as either National (N-EMT) or International (I-EMT) depending on area of response.

E. AHA Centre

11. The AHA Centre shall facilitate cooperation and coordination among the relevant entities including the affected and assisting ASEAN Member States, and with relevant United Nations and international organizations, in promoting regional collaboration.

III. Disaster Preparedness

A. National Focal Units for Emergency Medical Team (EMT) Coordination

12. The MOH shall identify the first contact point responsible for managing offers and requests for EMT deployments. The national focal units for EMT coordination in times of disaster should be officially designated in MOH/MOPH structure. The list of contact information is provided in **Annex 1**.

B. Inventory of Emergency Medical Team (EMT) Assets and Capacities

13. The inventory of EMT assets and capacities is managed by the AHA Centre as part of ASEAN Standby Arrangements. The AHA Centre requests the ASEAN Committee on Disaster Management (ACDM) Focal Units or Heads of National Disaster Management Office (NDMO) to list all resources for the ASEAN Standby Arrangements including EMT assets and capacities in the form of List of Modules of ASEAN Joint Disaster Response Plan (AJDRP).

14. The MOH shall identify EMT assets and capacities and submit relevant information and data on EMT assets and capacities to respective NDMO in a timely manner when required.

C. Emergency Medical Team (EMT) Capacity Building and Strengthening

15. The MOH shall ensure that the EMTs achieve and maintain the EMT minimum standards as set out in Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters (WHO, 2013) and other relevant existing national and regional standards and requirements.

16. The MOH shall take necessary measures to enhance EMT assets and capacities and to facilitate the EMT organizations to register their EMTs within existing national coordinating structure or on the EMT Global Classification.

IV. Emergency Response

A. Request for Assistance/Offer of Assistance and Registration of EMTs

17. The MOH shall send the request for assistance or initiate the offer of assistance through the NDMO, following the procedures stipulated in the existing SASOP.

18. The MOH may send the request for assistance or initiate the offer of assistance directly to the

[2] Ibid.

national focal units for EMT Coordination within health sector only in conjunction with the aforementioned channel referred to in Paragraph 17 of this SOP.

B. Mobilisation of Emergency Medical Teams (EMTs)

19. When mobilising EMTs, the organizations which deploy EMTs shall ensure that the assets and capacities of EMTs provided to the affected country meet the standards set out in Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters (WHO, 2013) and other relevant existing standards and requirements of the affected country. The organizations shall also ensure that EMTs are self-sufficient with their subsistence requirements so as not to further burden the affected country in the course of operating within its territory.

20. The I-EMTs shall obtain essential information for mobilisation including registration requirements, visa and customs procedures and other information as provided in **Annex 2** via Virtual On-Site Operations Coordination Centre (VOSOCC) or AHA Centre's mechanisms such as ASEAN WebEOC or National Focal Units of the affected member states.

21. The I-EMTs has to register and obtain clearance from affected member states prior of departure from origin country through the National Focal Units or AHA Centre.

22. To ensure the effective and timely response of assistance upon the confirmation of the request for assistance, the EMTs shall ensure coordinated efforts are made with the MOH for the immediate response.

23. The I-EMTs arriving in the territory of the receiving country via air, land or sea entry checkpoints shall immediately proceed to the Customs, Immigration and Quarantine (CIQ) facility for necessary immigration procedures, customs clearance and quarantine checks. In this regard, the MOH shall coordinate with relevant entities to facilitate the CIQ processes and also ensure that the National focal units or their designated representatives are available on standby during the clearance process of the medical supplies and equipment brought to the territory of the requesting country.

24. The MOH shall designate official(s) to provide an initial briefing to the I-EMTs at a staging point or Reception and Departure Center (RDC) immediately after the completion of the CIQ processes, to ensure seamless on-site coordination. The incoming I-EMTs shall be registered at the staging point or RDC and shall obtain essential information including the EMTCC location and contact details, and coordination meeting locations and times.

25. The I-EMTs shall report to the EMTCC to complete EMT registration and submit required documents including **EMT Registration Form (Annex 3)**, copies of passport of each team member and other registration requirements as referred in Annex 2.

26. Regarding the authorization to practice for medical professionals, I-EMT registration needs an approval from relevant Health Professional Regulatory Authorities through National Focal Points facilitating mechanism. The I-EMTs shall follow the regulation of the receiving country. If the I-EMTs would like to receive the authorization prior to their deployment, the I-EMTs can request the receiving country, through National Focal Units, to facilitate the approval process.

27. The EMTCC shall liaise with the EMTs to match and task them to an identified area based on the EMT type and capabilities and the identified needs or gaps. The EMTCC shall also facilitate in-country movement of I-EMTs to disaster sites.

28. Full registration, authorization to practice for medical professionals, and tasking processes may be conducted at the RDC if the affected country has enough capabilities.

C. On-Site Operations of Emergency Medical Teams (EMTs)

29. The I-EMTs shall report to the local PHEOC, if existing and activated, to receive their assignment and essential information for on-site operations.
30. The EMTCC or Sub-EMTCC, if capable, shall provide the I-EMTs essential information for on-site operations such as situation update to the extent known, secured access to operating grounds and others as provided in **Annex 4**.
31. The EMTCC or Sub-EMTCC, if capable, shall support the operations of the I-EMTs such as providing local medical coordinator, language interpreters and others as provided in **Annex 5**.
32. The EMTCC or Sub-EMTCC, if capable, shall organize EMT coordination meetings for information sharing and effective and efficient coordination among EMTs and relevant entities.
33. If EMTCC is not capable, the I-EMTs shall organize regular meetings with other EMTs to share information and resources and also to collectively plan EMT operations such as setting up Patient Referral System.
34. All the EMTs operated in the affected area shall utilize standard triage system.
35. The EMTs shall maintain adequate patient notes and discharge and referral documents after starting its operations. For the ease of compiling Emergency Medical Team - Minimum Dataset (MDS) Daily Reporting Form (Annex 10), the EMTs shall use the standardized **Medical Record Form (Annex 6)** and **EMT-MDS Tally Sheet (Annex 7).** Also in case of patient referral, the EMTs shall use **Patient Referral Form (Annex 8)**.
36. The EMTs shall prepare and confirm its Operational Plan and Exit Strategy and inform the EMTCC or Sub-EMTCC of anticipated transition or departure date.

D. Health Needs Assessment

37. The I-EMTs shall provide additional Health Needs Assessment when requested by the EMTCC **[Annex 9]**.

E. Direction and Coordination of Assistance

38. The EMTCC or Sub-EMTCC, shall conduct the overall direction, coordination and supervision of the EMTs operations within its territory.
39. The EMTCC or Sub-EMTCC shall map in real-time all EMT deployments and keep track of all anticipated EMT transition and departure; establish and maintain regular contacts with EMTs and local authorities; and conduct field quality assurance and support visits to EMTs.

F. Periodic Reporting/Daily Report

40. The EMTs shall submit **Minimum Dataset (MDS) Daily Report Form (Annex 10)** to the EMTCC or Sub-EMTCC to report their activities on daily basis.
41. The EMTCC or Sub-EMTCC shall submit **EMTCC Situation Report (Annex 11)** to the PHEOC of the

MOH at the end of the first day and the third day. Thereafter, a reporting frequency shall be determined by context and need. Also EMTCC shall send feedback form to I-EMTs in timely manner.

G. Demobilisation of Assistance

42. The EMTs shall inform the EMTCC or Sub-EMTCC the anticipated end-of-operation date as early as possible, or at least 1 to 2 weeks prior to that date if different from the one initially communicated at the time of the registration.

43. The EMTs shall implement an exit strategy including plans for handover of all medical documentation, donation of any medical equipment, transfer of care for any residual inpatient and others in accordance to the affected country by liaising with the EMTCC for the withdrawal of the team from the operations.

H. Reporting (Handover and Exit Phase)

44. The EMTs shall submit to the EMTCC or Sub-EMTCC with **Emergency Medical Team Exit Report (Annex 12)** which contains transferred patients at exit list, donated medication list and donated equipment or supply list to specify the details of the handover or re-tasking of duties and record of the operational tasks performed during the deployment before its final withdrawal from the site.

45. The I-EMTs shall also upon final withdrawal prepare their final report using **FORM 7 of SASOP (Annex 13)** as reference and furnish them to the AHA Centre via their MOH and the NDMO for consolidation within two weeks of departure from the affected country.

I. Review of Operations, Experiences and Lessons Learnt (Post-deactivation Phase)

46. I-EMTs shall conduct Operational reviews of EMT response and share the report to all AMS to support learning as well as revision.

V. Review

47. SOP for Coordination of Emergency Medical Teams (EMTs) in ASEAN member states shall be revised and updated concurrent with SASOP and/or as necessary.

VI. ANNEXES

		Note
Annex 1	List of National Focal Units for EMT Coordination and Information on PHEOC	Information will be collected by the Project to complete the list.
Annex 2	List of Essential Information for Mobilisation	Drafted by the Project Team
Annex 3	Emergency Medical Team Registration Form	WHO EMTCC Handbook
Annex 4	List of Essential Information for On-site Operation	Drafted by the Project Team
Annex 5	List of Supporting Functions of the EMTCC or Sub-EMTCC	Drafted by the Project Team
Annex 6	Medical Record Form	Drafted by the Project Team
Annex 7	Emergency Medical Team (EMT) - Minimum Dataset (MDS) Tally Sheet	WHO EMT MDS Working Group Report
Annex 8	Patient Referral Form	WHO EMTCC Handbook

Annex 9	Forms for (Rapid) Health Needs Assessment	Drafted by the Project Team
Annex 10	Emergency Medical Team - Minimum Dataset (MDS) Daily Reporting Form	WHO EMTCC Handbook
Annex 11	EMTCC Situation Report	WHO EMTCC Handbook
Annex 12	Emergency Medical Team Exit Report	WHO EMTCC Handbook
Annex 13	Form 7 of SASOP	-

Reference

· Standard Operating Procedure for Regional Standby Arrangements and Coordination of Joint Disaster Relief and Emergency Response Operations (SASOP) (ASEAN, 2010)
· Emergency Medical Team Coordination Cell (EMTCC) Coordination Handbook (Version 0.12) (WHO, June 2017)

ANNEX 2

List of Essential Information for Mobilisation

[The following table provides an example for developing a list of essential information for mobilization.]

	Topic
1.	Registration requirements - EMT Registration Form - Copies of passport of each team member - Authorization to practice for medical professionals - Malpractice insurance - etc.
2.	Visa and customs procedures
3.	Authorization to practice for medical professionals
4.	Situation overview to the extent known
5.	Identification of health services which assistances might need
6.	General information of incident area including geography, weather, language, politics and government, religion, culture and prohibited activities
7.	Essential information on the arrival and registration procedures at RDC
8.	Airport/port procedures and services
9.	EMTCC/OSOCC location
10.	National Focal Units and Contact information
11.	Primary and secondary risks associated with the event in each location
12.	Available communication channels
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ANNEX 4

List of Essential Information for On-site Operations

[The following table provides an example for developing a list of essential information for on-site operations.]

	Topic
1.	Situation update to the extent known
2.	Secured access to operating grounds
3.	Status of health facilities in the affected area
4.	Details on the coordination with local hospitals for patient referral
5.	EMTs in operations
6.	Meeting schedule and venue
7.	Details on the coordination with EMTCC
8.	Medical waste management
9.	Management of dead bodies in disaster
10.	Provincial medical incident command system and local authorities
11.	Maps and information on incident sites, operation sites, law enforcement station, drug store, shops, patrol stations.
12.	Contact person/focal units/liaison personnel/interpreter
13.	Available channels of communication
14.	Sanitation concern including epidemic disease, endemic disease, sporadic disease, tap water purification, excretion and toilet management
15.	Security and mobile escort
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ANNEX 5

List of Supporting Functions of the EMTCC or Sub-EMTCC (if existing and capable)

[The following table provides an example for developing a list of supporting functions of the EMTCC or Sub-EMTCC.]

	Topic
1.	Provide language interpreters
2.	Oversee securities
3.	Set up communication channels
4.	Facilitate patient referral to local hospitals
5.	Provide local medical coordinator
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Minimum Requirements and Qualifications for Members of Emergency Medical Team (EMT)

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Version: 2
Date: 19 April 2018

Please submit your feedbacks via email

To: Ms Hathairat Rungsansarit rnpatong1@gmail.com
Ms Dangfun Promkhum dangfun.prom@gmail.com

I. Purpose

This document sets out the minimum requirements and qualifications for ASEAN Member States and relevant organizations for the selection and registration of health professionals as members of emergency medical team (EMT). These minimum requirements aim at providing guidance for ASEAN Member States to develop and strengthen their EMTs to be deployed to the affected foreign country in order to realize the vision "One ASEAN, One Response".

The capacity of individual members is equally important as that of the team as a whole and is vital to ensure the quality of care provided by EMTs. These minimum requirements are developed to provide clear and appropriate minimum eligibility standards for EMT members with the aim of ensuring that EMT is composed of eligible members.

II. Scope

As is clear from its purpose, this document focuses on minimum requirements and qualifications for individual EMT members. The minimum requirements for EMT as a team are not covered in this document as they are defined in *the Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters* (Blue Book) (WHO 2013). The Blue Book provides the standards for a team as a whole such as the team composition (e.g. at least three doctors trained in emergency and primary care for Type 1), but does not refer in detail to the capacity of individual team members.

In addition, given that government military and non-governmental (NGO) EMT organizations have their own criteria to recruit and register their members, these minimum requirements primarily targeted governmental civilian EMTs to be deployed both domestically and internationally.

III. Key Terms and Terminology

For the purpose of this document, the key terms are defined below.

Minimum Requirements

The lowest level of acceptable education, training and experience needed to be enrolled as a member of emergency medical team (EMT) which can be deployed domestically and internationally.

Emergency Medical Teams (EMT)

The term Emergency Medical Teams (EMTs) refers to groups of health professionals and supporting staff aiming to provide direct clinical care to populations affected by disasters or outbreaks and emergencies as surge capacity to support the local health system. They include governmental (both civilian and military) and non-governmental teams and can be subclassified

as either National or International dependent on area of response[1].

EMT Members

In general, EMTs are composed of: 1) Medical Doctors/Physicians, 2) Nurses, 3) Allied Health Personnel, 4) Logistics and Operational Support Staff, and 5) Administrative and Other Staff[2].

IV. Structure of the document

This document is organized based on the three tiers of the minimum requirements as clarified below and in figure 1;

Tier 1. Professional competence and basic knowledge of disaster medicine and EMT operations
Tier 1 has to be ensured by EMT organizations before anyone to be registered as a member.

Tier 2. Adaptation of technical and non-technical professional capacities into low-resource and emergency context
Tier 2 has to be ensured by EMT organizations before domestic deployment of members.

Tier 3. Preparation for an effective team performance in foreign countries
Tier 3 has to be ensured by EMT organizations before international deployment of members.

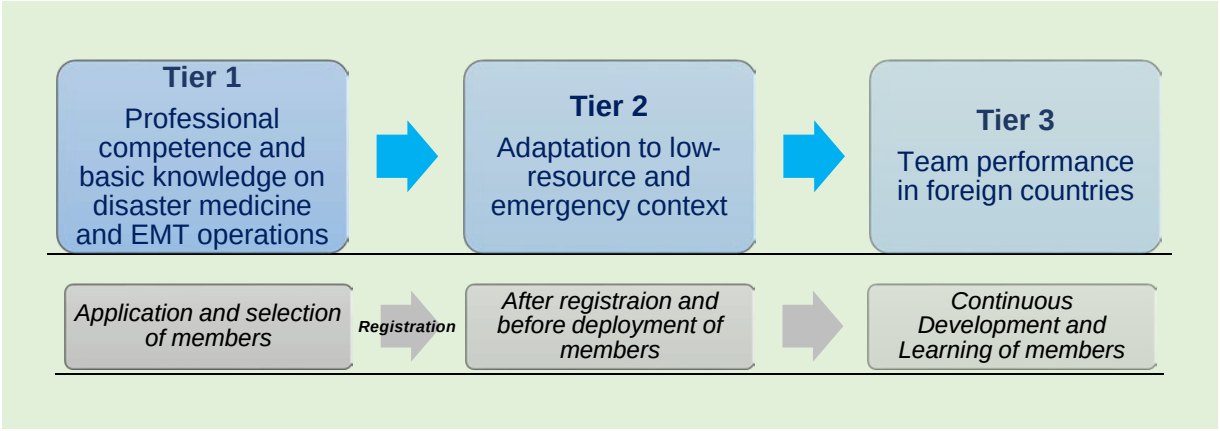


Figure 1. Tiers of Minimum Requirements

Tier 1 (can be registered as a member of EMT)

This section presents the minimum requirements and qualifications of Tier 1, which are relevant to the individuals at the stages of recruitment and selection before placing them on a roster of EMT organizations.

a. Age

Preference between 20 to 60 years old.

b. License

EMT organizations must ensure that all team members are registered and licensed to practice

[1] WHO, Emergency Medical Team Coordination Cell (EMTCC) Coordination Handbook, Version 0.12, June 2017.
[2] WHO, Emergency Medical Team Coordination Cell (EMTCC) Coordination Handbook, Draft Version 10, 2016.

in their home country[3].

c. Specialty

EMT organizations must ensure that all team members are specialists in their field[4].

The specialists required for EMT depend on its size, capability and capacity. The medical specialists include: medical doctors trained in emergency and primary care, general surgery, orthopedics, orthoplastic reconstruction, anesthetics, intensive care, obstetrics, pediatrics, and rehabilitation. In addition, nurses, paramedics, laboratory technicians, logistic staff and other support staff are included depending on the type of EMT. The specialty of EMT members must be registered in each country.

d. Practical Experience

EMT organizations must ensure that the majority of EMT members to be deployed internationally have experience in domestic or international deployment to disaster affected area. However, applicants who lack experience in actual disaster response may not necessarily be excluded from registration. By organizing a team of members with different professional backgrounds, skills, grades, qualifications, expertise and experience, or by skill mix, EMT organizations can accept inexperienced applicants with appropriate qualification.

e. Training (as part of requirements)

EMT members are required to successfully complete Basic Life Support (BLS) and Standard First Aid Training.

f. Training (as part of selection process)

EMT members are required to successfully complete an induction or pre-registration course such as Basic Disaster Management, etc. Applicants are required to undertake theoretical courses and/or workshops, provided by EMT organizations, to enhance their knowledge on disaster medicine and EMT operations. Each ASEAN Member State can set out their own curriculum as appropriate or collectively develop a standardized curriculum among ASEAN Member States.

g. Physical and Mental Fitness

Deployment to and delivering care in austere and resource-poor environments require physical and mental fitness. EMT organizations must ensure that team members are physically and mentally able to perform required tasks.

The status of physical and mental fitness is often self-declared at the stage of application and will be evaluated in the later stage during an induction course or by a pre-deployment health screening.

[3] WHO, Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters, 2013.
[4] Ibid.

V. Tier 2 (ready to deploy domestically)

a. Pre- requisite

EMT members must pass the registration requirement as demonstrated in Tier 1.

b. Training course

EMT members that have successfully completed the registration must undertake field training courses and/or field training exercises such as Incident Command System (ICS), Self-sufficiency in Disaster, Working in Limited Resources, etc. to practice their skills and learn how to operate within low-resource and emergency context. Each ASEAN member state can set out their own curriculum as appropriate or collectively develop a standardized curriculum among ASEAN member states.

c. Teamwork

EMT members must be able to work well with others as a part of the team. Therefore, they should concentrate on building up teamwork and fostering team-to-team communication and collaboration.

VI. Tier 3 (ready to deploy to any members states)

a. Pre- requisite

EMT members must pass the registration requirement and qualification as demonstrated in Tier 1 and Tier 2.

b. Training course

I-EMT members must complete a standardized training curriculum which has been widely accepted by all ASEAN Member States.

As a consequence, the EMT members who have undertaken this curriculum would be qualified to operate in every ASEAN Member States. The content of this training curriculum may consist of relevant topics including Intercultural Management, Resource Management, Communication Skill, Health care System in ASEAN Member States, AADMER, SASOP, Standard Operating Procedure (SOP) for Coordination of Emergency Medical Teams (EMTs) in ASEAN and Team Coordination (e.g. SASOP and EMTCC), etc.

c. Teamwork

EMT members must be able to work well with others as a part of the team. Therefore, applicants should concentrate on building up teamwork and fostering good communication and collaboration with the EMTs of the affected countries and between International Emergency Medical Teams (I-EMTs).

d. Language Skills

For the purpose of international deployments, some EMT members are required to have language skills, especially English language skills. EMT members must have a TOEIC score of a minimum ??? (The issue will be discussed in the 6th Meeting of PWG1). In the case where the required language proficiency score cannot be met, EMT members can still be deployed internationally if there is a narrator in the team.

e. Vaccination

In the case where some vaccine-preventable communicable diseases are found to be endemic to the affected country, EMT members are required to either obtain or provide documented proof that they have received the following vaccinations.

Attachment 13

EMT Database

Database of Emergency Medical Teams (EMTs) in ASEAN
Data Collection Sheet

Document Status: Draft for Circulation
Version: 1
Date: 11 January 2018

Please submit your feedbacks via email

To: Ms Hathairat Rungsansarit rnpatong1@gmail.com
Ms Dangfun Promkhum dangfun.prom@gmail.com

Respondent

Date (dd/mm/yy):		**Country:**	
Name:		**Title and Position:**	
Organisation:		**Email address:**	

** If there are more than three (3) EMT organisations, please copy and paste the table below to add more organisations.*

EMT Organisation #1			
1. Organisation and Contact Information			
1-1	Organisation Name		
1-2	Organisation Type *Tick only one box*	☐ Government Civilian ☐ Government Military ☐ National NGO ☐ International NGO ☐ Other (specify)_____	
1-3	Team Name		
1-4	Organisation Headquarters Contact	Contact Name	
		Contact Position	
		Email	
		Telephone	
1-5	Organisation Operation Contact (if different from 1-4)	Contact Name	
		Contact Position	
		Email	
		Telephone	
1-6	Organisation Donor or Government Official Contact (if applicable)	Contact Name	
		Contact Position	
		Email	
		Telephone	
1-7	First point of contact for deployment requests *Tick only one box*	☐ Organisation Headquarters Contact (1-4) ☐ Organisation Operation Contact (1-5) ☐ Organisation Donor or Government Official Contact (1-6) ☐ Other (specify)_____	
2. EMT Information			
2-1	Available EMTs within the organisation	**EMT Type[1]**	**Number of Available Teams**
		Type 1 Mobile	

[1] See "Specification of EMT Type" in "Instructions for Data Collection".

		Type 1 Fixed	
		Type 2 with Health Facility	
		Type 3	
		Specialised Cell	
		Not specified as above	
2-2	Specialised cell details (if applicable)		
2-3	Maximum number of EMTs that the organisation can deploy simultaneously	( ) teams	
3. Operational Capacity and Willingness			
3-1	Operational willingness to deploy; geographical region *Tick only one box*	☐ Globally ☐ ASEAN Region only ☐ Asia-Pacific Region only ☐ Other (specify)_____	
3-2	Emergency situation in which the team is currently capable to deploy *Tick all that apply*	☐ Sudden Onset Disaster (SOD) ☐ Protracted crisis ☐ Conflict/complex emergencies ☐ Outbreak ☐ Chemical, biological, radiological, or nuclear (CBRN) events ☐ Other (specify)_____	
3-3	Duration of operational capacity	( ) days	
3-4	Organisation operational language(s)		
4. Deployment History			
4-1	International deployment experience *Tick only one box*	☐ Yes ☐ No *If Yes, please provide information below:*	
4-2	International deployment experience **If there were more than three events, please add more rows.*	**Event**	**Date** (dd/mm/yy) / **Country of deployment**
4-3	Domestic deployment experience *Tick only one box*	☐ Yes ☐ No *If Yes, please provide information below:*	
4-4	Domestic deployment experience **If there were more than three events, please add more rows.*	**Event**	**Date** (dd/mm/yy)
5. Global Classification Status			
5-1	WHO EMT Global Classification Status *Tick only one box*	☐ Not Applicable (N/A) ☐ Expression of Interest (EOI) submitted ☐ Mentorship ☐ Classified	

EMT Organisation #2

1. Organisation and Contact Information

1-1	Organisation Name		
1-2	Organisation Type *Tick only one box*	☐ Government Civilian ☐ Government Military ☐ National NGO ☐ International NGO ☐ Other (specify)_____	
1-3	Team Name		
1-4	Organisation Headquarters Contact	Contact Name	
		Contact Position	
		Email	
		Telephone	
1-5	Organisation Operation Contact (if different from 1-4)	Contact Name	
		Contact Position	
		Email	
		Telephone	
1-6	Organisation Donor or Government Official Contact (if applicable)	Contact Name	
		Contact Position	
		Email	
		Telephone	
1-7	First point of contact for deployment requests *Tick only one box*	☐ Organisation Headquarters Contact (1-4) ☐ Organisation Operation Contact (1-5) ☐ Organisation Donor or Government Official Contact (1-6) ☐ Other (specify) _____	

2. EMT Information

		EMT Type[2]	Number of Available Teams
2-1	Available EMTs within the organisation	Type 1 Mobile	
		Type 1 Fixed	
		Type 2 with Health Facility	
		Type 3	
		Specialised Cell	
		Not specified as above	
2-2	Specialised cell details (if applicable)		
2-3	Maximum number of EMTs that the organisation can deploy simultaneously	( ) teams	

3. Operational Capacity and Willingness

3-1	Operational willingness to deploy; geographical region *Tick only one box*	☐ Globally ☐ ASEAN Region only ☐ Asia-Pacific Region only ☐ Other (specify)_____
3-2	Emergency situation in which the team is currently capable to deploy *Tick all that apply*	☐ Sudden Onset Disaster (SOD) ☐ Protracted crisis ☐ Conflict/complex emergencies ☐ Outbreak ☐ Chemical, biological, radiological, or nuclear (CBRN) events ☐ Other (specify)_____
3-3	Duration of operational capacity	( ) days

[2] See "Specification of EMT Type" in "Instructions for Data Collection".

3-4	Organisation operational language(s)			
4. Deployment History				
4-1	International deployment experience *Tick only one box*	☐ Yes ☐ No *If Yes, please provide information below:*		
4-2	International deployment experience **If there were more than three events, please add more rows.*	**Event**	**Date** (dd/mm/yy)	**Country of deployment**
4-3	Domestic deployment experience *Tick only one box*	☐ Yes ☐ No *If Yes, please provide information below:*		
4-4	Domestic deployment experience **If there were more than three events, please add more rows.*	**Event**		**Date** (dd/mm/yy)
5. Global Classification Status				
5-1	WHO EMT Global Classification Status *Tick only one box*	☐ Not Applicable (N/A) ☐ Expression of Interest (EOI) submitted ☐ Mentorship ☐ Classified		

EMT Organisation #3

1. Organisation and Contact Information

1-1	Organisation Name		
1-2	Organisation Type *Tick only one box*	☐ Government Civilian ☐ Government Military ☐ National NGO ☐ International NGO ☐ Other (specify)_____	
1-3	Team Name		
1-4	Organisation Headquarters Contact	Contact Name	
		Contact Position	
		Email	
		Telephone	
1-5	Organisation Operation Contact (if different from 1-4)	Contact Name	
		Contact Position	
		Email	
		Telephone	
1-6	Organisation Donor or Government Official Contact (if applicable)	Contact Name	
		Contact Position	
		Email	
		Telephone	
1-7	First point of contact for deployment requests *Tick only one box*	☐ Organisation Headquarters Contact (1-4) ☐ Organisation Operation Contact (1-5) ☐ Organisation Donor or Government Official Contact (1-6) ☐ Other (specify) _____	

2. EMT Information

		EMT Type[3]	Number of Available Teams
2-1	Available EMTs within the organisation	Type 1 Mobile	
		Type 1 Fixed	
		Type 2 with Health Facility	
		Type 3	
		Specialised Cell	
		Not specified as above	
2-2	Specialised cell details (if applicable)		
2-3	Maximum number of EMTs that the organisation can deploy simultaneously	( ) teams	

3. Operational Capacity and Willingness

3-1	Operational willingness to deploy; geographical region *Tick only one box*	☐ Globally ☐ ASEAN Region only ☐ Asia-Pacific Region only ☐ Other (specify)_____
3-2	Emergency situation in which the team is currently capable to deploy *Tick all that apply*	☐ Sudden Onset Disaster (SOD) ☐ Protracted crisis ☐ Conflict/complex emergencies ☐ Outbreak ☐ Chemical, biological, radiological, or nuclear (CBRN) events ☐ Other (specify)_____
3-3	Duration of operational capacity	( ) days

[3] See "Specification of EMT Type" in "Instructions for Data Collection".

3-4	Organisation operational language(s)			
4. Deployment History				
4-1	International deployment experience *Tick only one box*	☐ Yes ☐ No *If Yes, please provide information below:*		
4-2	International deployment experience **If there were more than three events, please add more rows.*	**Event**	**Date** (dd/mm/yy)	**Country of deployment**
4-3	Domestic deployment experience *Tick only one box*	☐ Yes ☐ No *If Yes, please provide information below:*		
4-4	Domestic deployment experience **If there were more than three events, please add more rows.*	**Event**		**Date** (dd/mm/yy)
5. Global Classification Status				
5-1	WHO EMT Global Classification Status *Tick only one box*	☐ Not Applicable (N/A) ☐ Expression of Interest (EOI) submitted ☐ Mentorship ☐ Classified		

Attachment 14

JADM Presentation

Regional Collaboration Drill

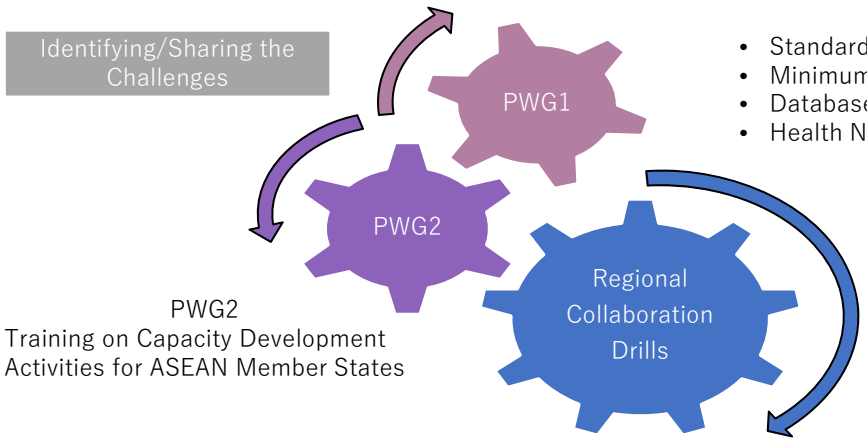
Overview from previous drills and the way forward

The Project will flourish through the four Drills

Objectives of the Four Drills

1. **Start-up Drill (SD)**
   - To identify different gaps between medical procedures provided at a hospital and in the field.
   - To understand that the regional coordination and collaboration tools in the health sector need to be more in details than the existing tools such as the SASOP/EAS toolkit/ the EMT guidelines.
2. **Regional Collaboration Drill 1 (RCD1)**
   - To report the activities of each team to the EMTCC using a common reporting form.
3. **Regional Collaboration Drill 2 (RCD2)**
   - To provide a referral between the teams using a common medical record form.
4. **Regional Collaboration Drill 3 (RCD3)**
   - To assess the situations of affected communities using the common assessment tools.

Process to THE Goal



PWG1
- Standard Operation Procedure
- Minimum Requirements
- Database
- Health Needs Assessment Framework

Trials for Solutions on the Challenges

PWG2
- Training on Capacity Development Activities for ASEAN Member States

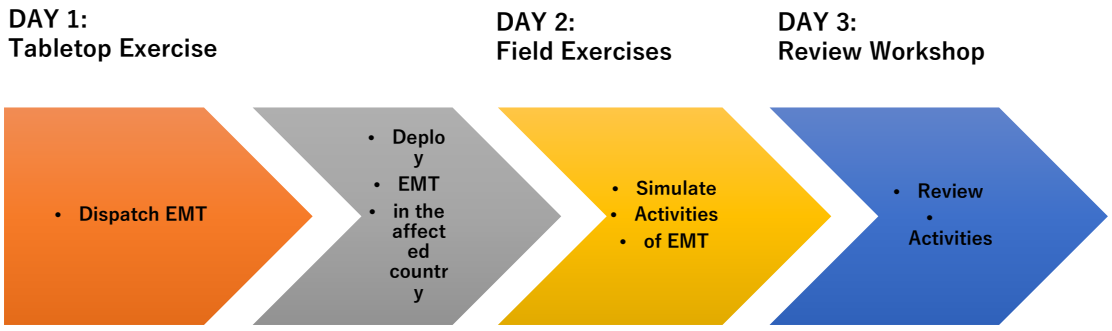
Identifying/Sharing the Further Challenges

PWG: Project Working Group

Tools Used in Each Drill

1. **Start-up Drill (SD)**
   - Existing tools such as SASOP/ EAS toolkit/ WHO EMT guidelines
2. **Regional Collaboration Drill 1 (RCD1)**
   - Common reporting form, WHO EMTCC handbook, Health need assessment form
3. **Regional Collaboration Drill 2 (RCD2)**
   - Common medical record form, WHO EMTCC handbook, Health need assessment form
4. **Regional Collaboration Drill 3 (RCD3)**
   - Common assessment tools

Drill Schedule



Start-up Drill

The most important drill in the project

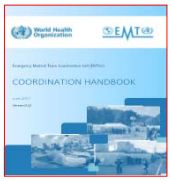
Four Stations in the Start-up Drill

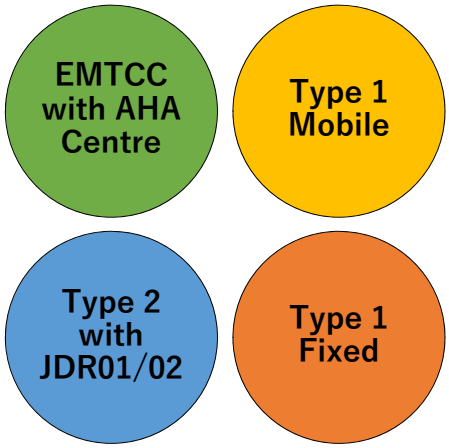
Station 1: EMTCC with AHA Center

Station 2: Type 1 Mobile

Station 3: Type 1 Fixed

Station 4: Type 2 with Japan (JDR) 01/02





Malaysia Team Capacity Building (Possible Topics for the AMS Trainings)	Team/Collaboration Capacity Building (ARCH Project Tools: SOP)
Disaster training among AMS Standardise clinical management bin disaster	– For AMS participants to frequently train together to improve our response during disaster.
Personal Capacity Building (ARCH Project Tools: Minimum Requirements)	Collaboration Capacity Building (e.g. ASEAN SOPs/ WHO EMTCC Handbook)
• Disaster Life Support • Learn to adapt in a disaster situation (working/living in disaster affected areas) • Learn to be self-sufficient, and basic survival skills	• Standardise training module among AMS • EMTCC/EOC functions handbook distribute to all AMS • Guidelines distribute to all AMS

Issues for the future consideration
• Send report of this training to MOH . • Dissemination this lessons learned to Health facility • Meeting with MOH how to set up and develop EMSs and EMT • To include all AMS to participate in the training • To lengthen drill period • Practical training by participating in teams from multiple countries • Taking ongoing training as a registered volunteer of a given training course • Good cooperation SOP with WHO, JDR, and AHA Centre • Funding and support for EMT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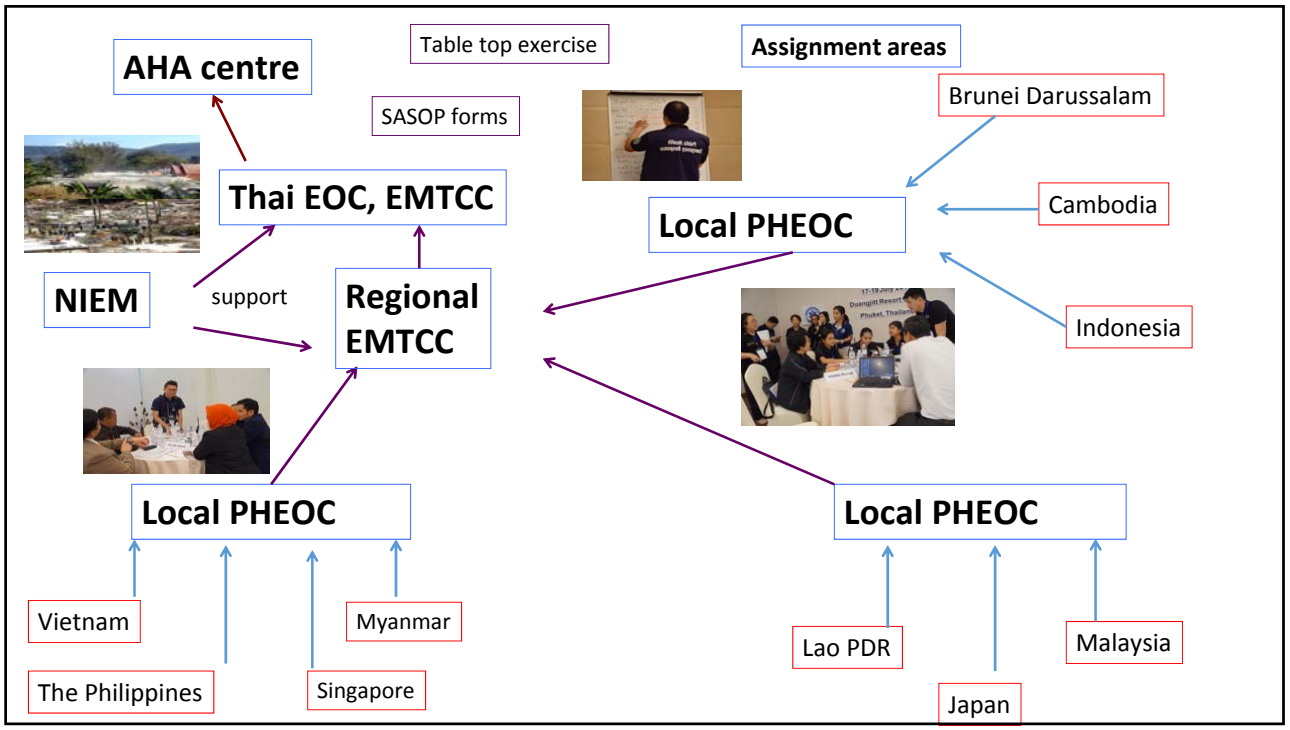
www.yutphuket.com


AHA centre
Table top exercise
Assignment areas
SASOP forms
Brunei Darussalam
Thai EOC, EMTCC
Local PHEOC
Cambodia
NIEM
support
Regional EMTCC
Indonesia
Local PHEOC
Local PHEOC
Vietnam
Myanmar
Lao PDR
Malaysia
The Philippines
Singapore
Japan

Good	Opportunity
Time and Venue	
Accommodation & transportation	
Introduction session	EMT type summary Referral system
Presenter 	
Format	Task of HNA
Facilitators	More facilitators, common focus, experienced, skills
Scenario well planned, table top → field exercise	Longer FTX, Clinical enhancement, overlap of team in same area
Well prepared forms	

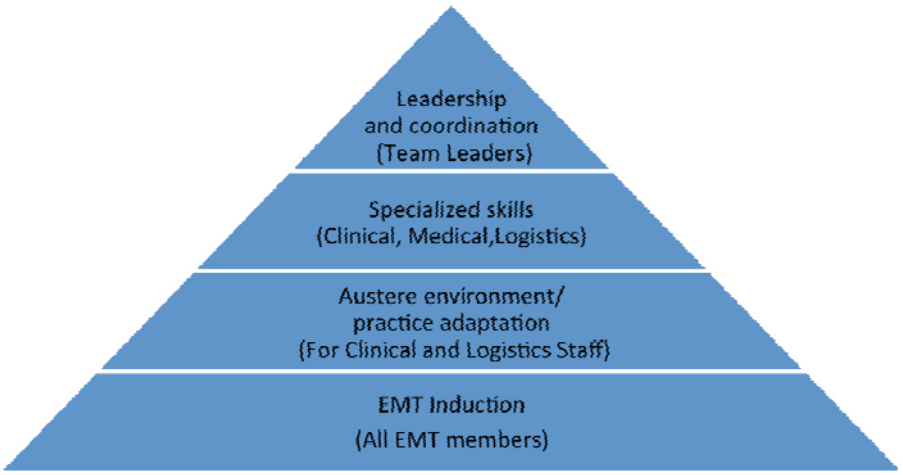
Good	Opportunity
	Standardize the common communication discipline, exercise, manual
Objective is achieved	Discussion how to use the form Realistic CIQ processes Supply area Recreation station More referral hospital
	Medical checklist

Forms	Coordination processes
Should be concise, no duplication Clear definition Increase text size Cloud, Application, Electronic forms	Coordination with other relevant organizations Referral system Alternative communication
Technical Capacity Building	**Management Capacity Building**
• Basic skills • Standardize equipment and medicine • Checklist for tasks and action cards • Standardize triage system • 5Cs training	• Team management • EMTCC/EOC/EMT coordination • Workflow

Capacity building

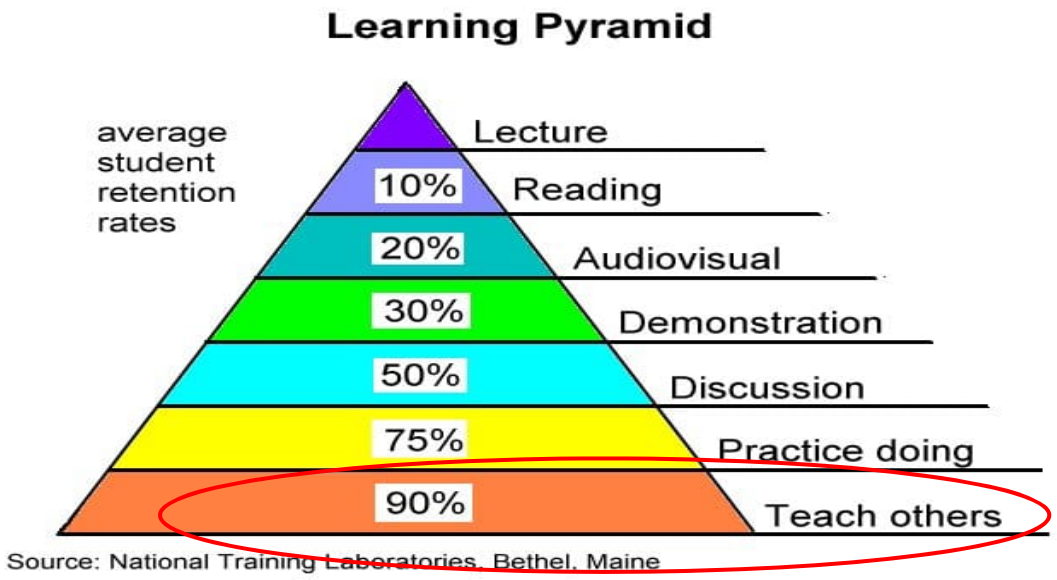
- **Technical aspect**
  - **EMT curriculum, classification (clinical lead, nursing lead)**
  - **SOP for EMT**
  - **5Cs (command, control, coordinate, communicate, cooperation)**
  - **Standardize triage categories**

EMT Training Pyramid



17-19 July 2017 17

Concept of 2nd RCD



The Way Forward

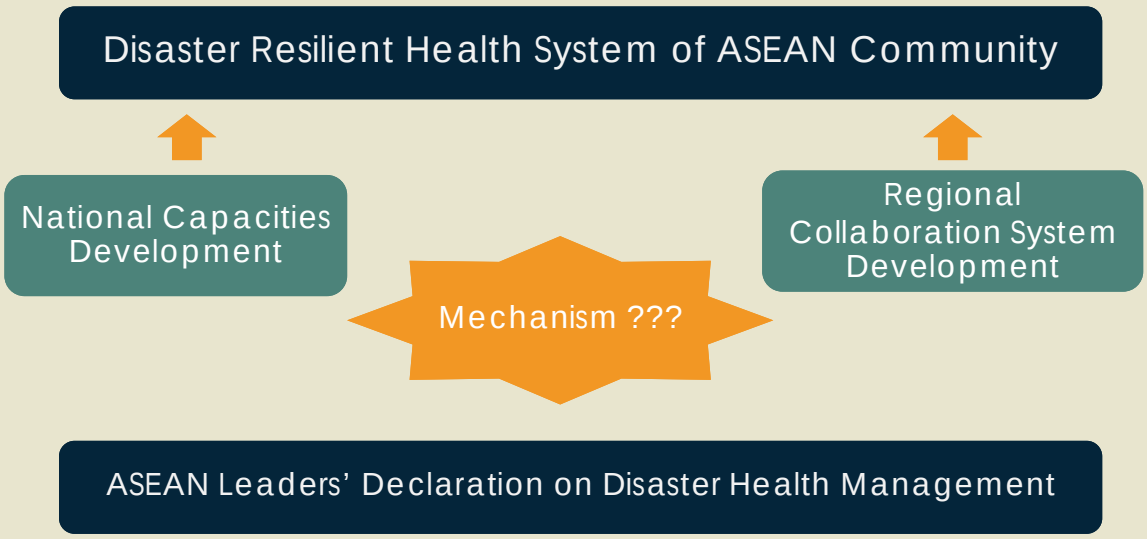
- The AHA centre coordination
- Common triage system
- More activities in EMTCC coordination and

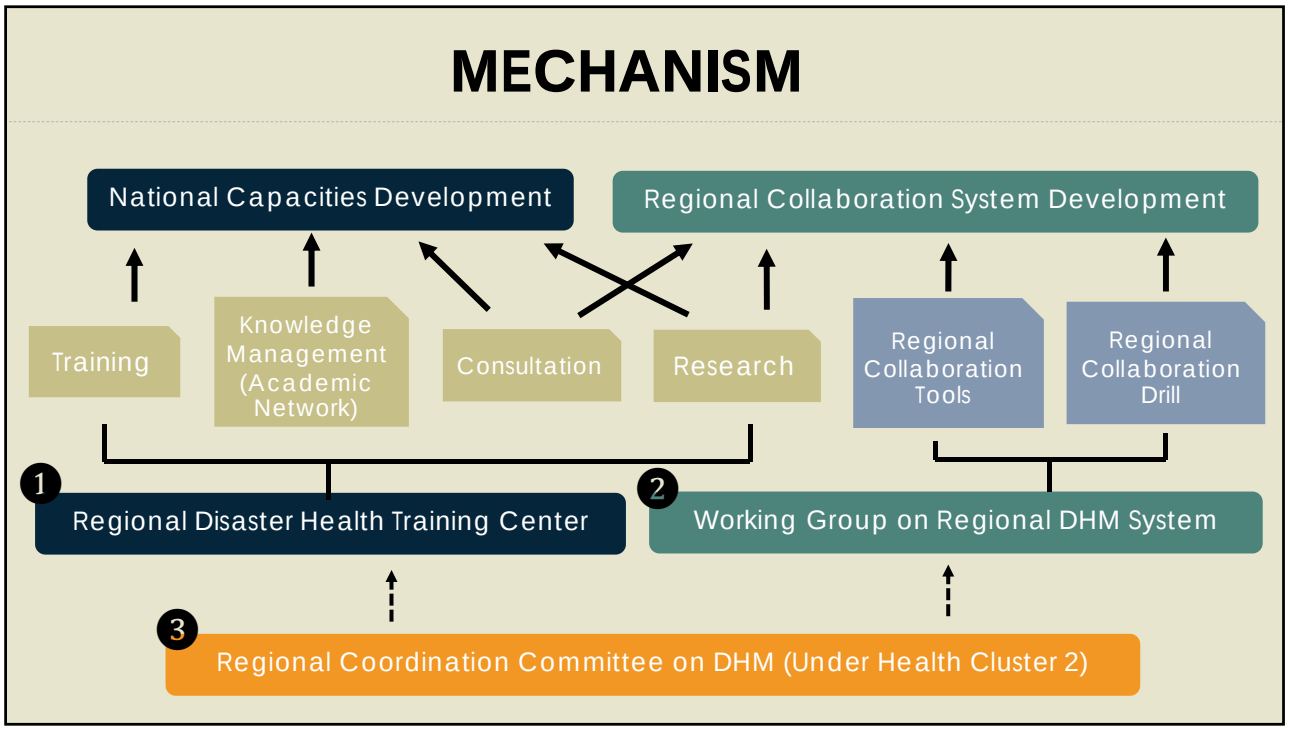
ASEAN
DISASTER MEDICAL SYSTEM

How does vision become reality?

Dr. Phumin Silapunt

ULTIMATE GOAL





VISION by 2025

"ASEAN has the effective regional collaborative mechanism for the sustainable development of disaster resilient health system."

MECHANISM

1) Regional Disaster Health Training Center
2) Working Group on Regional Disaster Health Management System
3) Regional Coordination Committee on Disaster Health Management

HOW CAN WE WALK TOGETHER?

1) Academic Network

2) Consultation Group

3) Training

4) Co-conducting Research

THANK YOU

Attachment 15

Program of counterpart training in Japan
(January 2018)

ARCH Project
Training Programme in Japan for Thai C/Ps

Date		Time	Programme	Lecturer/Facilitator		Venue	Accomodation
Jan. 24th	Wed	22:55	Leaving BKK (NH850)				
25th	Thu	6:30	Arrival in Japan (@Haneda Airport)				ART Hotel Joetsu
		8:00 ～	Haneda to Niigata Prefecture (by bus)				
		15:30 ～ 16:30	Briefing	Mrs.Miyuki Nozaki	Coordinator	Conference Room at ART Hotel Joetsu	
		16:30 ～ 17:00	Programme Orientation	Ms.Junko SATO	ARCH Project		
26th	Fri	8:20 ～	Departure from Hotel to Joetsu General Hospital (by taxi)			Joetsu General Hospital, Joetstu City, Niigata	ART Hotel Joetsu
		9:00 ～ 12:00	Observation: Training for Disaster Health Management ＊Pls.see Annex 1 for the details	Ms.Mayumi SATO	Joetsu General Hospital		
		12:00 ～ 13:00	Lunch				
		13:00 ～ 17:00	Observation: Training for Disaster Health Management (Cont'd)				
		17:15 ～	Departure from Joetsu General Hospital to hotel				
27th	Sat	6:40	Departure from Hotel to Niigata City (by bus)				
		10:00 ～ 12:00	Lecture: "Overview of Center for Disaster Medicine and Education, Niigata University Faculty of Medicine"	Dr. Masashi Takahashi	Vice Director, Center for Disaster Medicine and Education, Niigata University Faculty of Medicine	Center for Disaster Medicine and Education, Niigata University Faculty of Medicine	
		12:00 ～ 13:00	Lunch				
		13:00 ～ 13:45	Tour: Center for Disaster Medicine and Education, Niigata University Faculty of Medicine				
		14:00 ～ 15:00	Discussion: "Significance of establishing the center and its background"	Dr. Masashi Takahashi	Vice Director, Center for Disaster Medicine and Education, Niigata University Faculty of Medicine		
		15:00 ～ 15:20	Departure from Niita University to Niigata Station				
		16:00 ～	Leaving for Tokyo by Shinkansen, Japanese bullet train				
28th	Sun		Holiday				JICA Tokyo
29th	Mon	9:00 ～ 9:40	Departure from JICA Tokyo to Ministry of Health, Labor and Welfare				JICA Tokyo
		10:00 ～ 11:00	Lecture: "Role and function of Ministry of Health, Labor and Welfare during disasters as well as peacetime"	Dr.Satoshi Kotani	Ministry of Health, Labor and Welfare (MHLW)	Conference Room, 9F, MHLW	
		11:15 ～	Departure from MHLW to JICA HQ				
		12:00 ～ 13:00	Lunch				
		13:00 ～ 14:15	Lecture: "History of disaster health management in Japan"	Dr. Tatsuro Kai	Senior Advisor, Emergency & Disaster Management, Osaka Saiseikai Senri Hospital	Conference Room 108, JICA HQ	
		14:30 ～ 15:00	Courtesy call to JICA HQ	Ms. Junko Nakaji	Development Group Infrastructure and Peacebuilding Department, JICA		
		15:00 ～ 15:15	Review of the Day and brieing on Action Plan	Ms.Junko SATO	ARCH Project		
		15:20 ～	Departure from JICA HQ to JICA Tokyo				

ARCH Project
Training Programme in Japan for Thai C/Ps

Date		Time	Programme	Lecturer/Facilitator		Venue	Accomodation
30th	Tue	8:00 ～	Departure from JICA Tokyo to National Disaster Medical Center			National Disaster Medical Center, Tachikawa/ Tokyo	JICA Tokyo
		9:30 ～ 10:30	Lecture: "Overview of Disaster Medical Assistance Team (DMAT) and the role of a disaster base hospital"	Dr. Yuichi Koido	Director of Institute for Clinical Research,National Disaster Medical Center, Japan Director of DMAT Secretariat		
		10:30 ～ 11:00	Tour in National Medical Center				
		11:30 ～ 12:30	Lunch				
		12:30 ～ 14:30	Lecture: "Logistics and Team Management"	Mr.Yoshiki Toyokuni	DMAT Secretariat		
		14:30 ～ 14:40	Review of the Day	Ms.Junko SATO	ARCH Project		
		14:45	Departure from National Medical Center to JICA Tokyo				
31st	Wed	10:00 ～ 11:30	Lecture: “Overview of Japan Disaster Relief (JDR)" ・Organization structure and activities of JDR ・Human resource development for	Mr.Shota Suzuki	Secretariat of Japan Disaster Relief Team, JICA	JICA Tokyo	JICA Tokyo
		12:00 ～ 13:00	Lunch@JICA Tokyo				
		13:00 ～ 14:30	Departure from JICA Tokyo to Narita JDR stockpile				
		14:30 ～ 15:30	Observation: JDR Stockpile in Narita			JDR Stockpile in Narita	
		15:30 ～ 17:00	Departure from Narita to JICA Tokyo				
Feb.1st	Thu	10:00 ～ 11:30	Departure from JICA Tokyo→JICA Yokohama				JICA Tokyo
		11:30 ～ 12:15	Lunch@JICA Yokohama				
		12:30 ～ 14:00	Health data collection during disaster - The WHO EMT Minimum Data Set -	Dr.Tatsuhiko Kubo	Lecturer Department of Public Health, School of Medicine, Univeristy of Occupational and Environmental Health, Japan	Conference room @Yokohama Landmark Tower	
		15:00 ～ 15:30	The 23rd Annual Meeting of Japanese Association for Disaster Medicine (JADM) - Presentation by ARCH Project (Dr.Phumin, Dr.Prasit)	Dr.Yasushi Nakajima	ARCH Project	Conference room 511-512, 5F Pacifico Yokohama Hotel	
		15:45 ～	Departure from Pacifico Yokohama Hotel to JICA Tokyo				
2nd	Fri	9:30 ～ 10:30	Presentation of Action Plan	Ms.Junko SATO	ARCH Project	JICA Tokyo	JICA Tokyo
		10:30 ～ 11:30	Evaluation Meeting	Ms. Junko Nakaji	JICA HQ	JICA Tokyo	
		11:30 ～ 12:00	Closing Ceremony	Ms. Junko Nakaji	JICA HQ	JICA Tokyo	
3rd	Sat	11:00	Departure for BKK（NH847）				JICA Tokyo

The programme is subject to change.

ART Hotel Joetsu (Jan.25-26th) http://www.art-joetsu.com/?cid=l_pc_ya_se_c_ah_joe__ENG=Yahoo__CAM=JP_JA_B_Hotel_AHJOE_Joetsu_Exact__ADG=AHJOE_Joetsu_Alone_Exact__FKW=BH00542__CRT=177344365195__DEV=c__KWD=%E3%82%A2%E3%83%BC%E3%83%88%20%E3%83%9B%E3%83%86%E3%83%AB%20%E4%B8%8A%E8%B6%8A