Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management

Progress Report

Phase1 - Transition to Extension / Extension Phase

April 2019 – March 2020

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OUTPUT 3: TOOLS FOR EFFECTIVE REGIONAL COLLABORATION ON DISASTER HEALTH MANAGEMENT ARE DEVELOPED

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ASEAN Collective Measures

OUTPUT 5: CAPACITY DEVELOPMENT ACTIVITIES FOR EACH AMS ARE IMPLEMENTED

Standard Curriculum Development

Study for capacity development on DHM in AMS

Field study in Lao PDR and Cambodia

PROJECT WORKING GROUP MEETINGS

GLOSSARY

AADMER	ASEAN Agreement on Disaster Management and Emergency Response
ACDM	ASEAN Committee on Disaster Management
ACM	ASEAN Collective Measures
AHA Centre	ASEAN Coordinating Centre for Humanitarian Assistance on Disaster Management
AHMM	ASEAN Health Ministers Meeting
AJDRP	ASEAN Joint Disaster Response Plan
ALDDHM	ASEAN Leaders' Declaration on Disaster Health Management
AMS	ASEAN Member States
ARCH	Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management
APCDM	Asia Pacific Conference on Disaster Medicine
ASEC	ASEAN Secretariat
CD	Capacity Development
CLMV	Cambodia, Lao PDR, Myanmar, Vietnam
C/P	Counterpart
CPR	Committee of Permanent Representatives (ASEAN)
CTI	Comprehensive Team Information
DELSA	Disaster Emergency Logistics System for ASEAN
DHM	Disaster Health Management
DOH	Department of Health (in Philippines)
DPHEM	Division of Public Health Emergency Management (MOPH)
EMT	Emergency Medical Team
EMTCC	Emergency Medical Team Coordination Cell
EOC	Emergency Operation Centre
ERAT	Emergency Response and Assessment Team
HC2	Health Cluster 2 (meeting)
HNA	Health Needs Assessment
I-EMT	International Emergency Medical Team
JAC	Japanese Advisory Committee
JADM	Japanese Association for Disaster Medicine
JCC	Joint Coordination Committee
JDR	Japan Disaster Relief
JICA	Japan International Cooperation Agency
JOCCA	Joint Operations and Coordination Centre of ASEAN
MDS	Minimum Data Set
MOH	Ministry of Health (AMS)
MOPH	Ministry of Public Health (Thailand)
MR	Minimum Requirements
NDMO	National Disaster Management Organization
NIEM	National Institute for Emergency Medicine
OSOCC	On-Site Operations Coordination Centre
PDM	Project Design Matrix
PO	Plan of Operation
POA	Plan of Action (for ALDDHM)
PRWG	Preparedness and Response Working Group
PWG	Project Working Group

QAV	Quality Assurance Visit
RCC	Regional Coordination Committee
RCCDHM	Regional Coordination Committee on Disaster Health Management
RCD	Regional Collaboration Drill
RDC	Reception and Departure Center
REMPAN	Radiation Emergency Medical Preparedness and Assistance Network
R/D	Record of Discussions
SASOP	Regional Standby Arrangements and Coordination of Joint Disaster Relief and Emergency Response Operations
SOMHD	Senior Officials Meeting for Health Development
SOP	Standard Operation Procedures
SPEED	Surveillance in Post Extreme Emergencies and Disasters
SWG	Sub Working Group
TOR	Terms of Reference
TSI	Tentative Schedule of Implementation
TTX	Table-Top Exercise
UNDAC	United Nations Disaster Assessment and Coordination
VOSOCC	Virtual On-Site Operations Coordination Center
WADEM	World Association for Disaster and Emergency Medicine
WHO	World Health Organization

OVERVIEW

- Project Monitoring Report
- Timeline of Activities

PROJECT MONITORING REPORT

Project Monitoring Report for ARCH Project

1. Duration of Report
   April 1st, 2019 to September 30th, 2019

2. Progress of Activities

Output	Progress	Remarks
Output 1 Coordination platform on disaster health management is set up.		
Reviewing TOR of RCC for ALD (Re; Activeity1-1)	Joint PWG meeting on July 10th discussed on this. ASEAN Ministers Meeting at the end of August endorsed the POA and set-up of RCC.	Thailand will serve as secretariat for the RCC. It is necessary to discuss how Thailand will organize the secretariat.
Activity1-2 Drafting Work Plan on the POA of ALD	Joint PWG meeting on July 10th discussed on first draft of Work Plan prepared by Thailand.. ASEAN Ministers Meeting at the end of August endorsed the POA	
Preparation of the RCC Meeting (Re; Activity1-1, 1-2)		It is necessary for each AMS to nominate the members and to fix the date for 1st meeting (maybe on Jan., 2020)
Output 2 Framework of regional collaboration practices is developed.		
Activity2-1 Planning and Preparation for Drill	4-5 April; 1st Mentors team visit in Bali 14-15 May; Consultation meeting between Ikeda & Katsube and MOH in Jakarta and selection of the hotel in Bali 9th July; Consultation meeting between Mentors and Indonesia preparation members in Bangkok 5-7 August; 2nd Mentors team visit in Bali and Jakarta	Close email communication between mentors and Indonesia preparation members shall be continued for the documents for plan of the RCD. Each AMS must submit its Comprehensive Team Information by Oct. 24th.
Activity2-2 Reginal Coordination Drill		
Activity2-5 Develop a format for sharing of lesson learned	First draft of template for lessons learned was submitted to PWG 2 on July 9.	Revised version should be submitted to PWG 2 on Nov. 29.
Activity2-5 Conduct a research on experience of response for disaster		
Output 3 Tools for effective regional collaboration on disaster health management are developed.		
Activity3-5 Endorsement for the Tools	SOMHD on April 2019 has endorsed the SOP and PRWG also recognized it.	
Joint Workshop and TTX for SOP by HC2 & PRWG (Re; Activity3-5)	Joint TTX between HC2 and PRWG in collaboration with AHA center was required to be organized on 6-7 Nov. in Jakarta.	JICA shall bear the cost of flight for AMS participants. 2partcipants, one from MOPH and one from NDMO will be invited from each AMS.
SWG meeting for ASEAN standards and methods (Re; Activity 3-6)	PWG 1 on July 11 confirmed the TOR of SWG and discussed on members of SWG. Indonesia, Myanmar, Philippines, Thailand and Vietnam were selected as countries which should assign the representatives for the SWG	5 countries had to nominate their focal points for SWG by 30 Aug. ASEC reminded 5countries for the nomination.
Hiring consultants for information collection and facilitation of the SWG	JICA HDQ has completed the selection process of consultant firm. KRC was selected.	Consultants will start working from the beginning of Oct.
Finalizing recommendation on ASEAN standards and methods (Re; Activity 3-6)		
Output 4 Academic network on disaster health management in AMS is enhanced.		
Activity4-2 Academic Seminar		
Output 5 Capacity development activities for each AMS are implemented.		
Clarifying the roles and functions of the Regional Disaster Health Management training center		

Development of standard training curriculum (Activity5-1)	PWG Joint meeting on July 10 discussed on the concept of the standard training curriculum and regional training center as well as ASEAN Academic Network. Thai ARCH Taskforce developed the draft concept paper on the curriculum development including curriculum committee/taskforce and timeline for next step	It is necessary to circulate the draft concept paper through ASEC to AMS. It is hoped that AMS will be able to nominate members of the committee by the next PWG 2 meeting on 29 Nov.
Questionnaire Survey for CD in AMS (Re; Activity 5-3)	PWG 2 on July 9 discussed the contents for Questionnaire. Questionnaire already circulated to each AMS on 15 Aug from ASEC.	AMS are required to submit the result of questionnaire to the project by 15 Oct.
Clarifying requirements for academic/training institute which conducts training programs on DHM in AMS (Re: Activity 5-3)		
Field trips for Needs and Potential Study on CD in some AMS (Re; Activity 5-3)	PWG 2 on July 9 decided to select 4countries(CLMV) for field trips.	Plan for Field trips will be discussed in PWG 2 on Nov.29.
Identifying an academic/training institute in each AMS which is expected to be the member institute for ASEAN Academic/Training Center Network on DHM (Re; Activities 4-2 & 5-3)	PWG Joint meeting on July 10 endorsed the concept for the Academic Network for DHM.	Result of the study for CD by Activity 5-3 will contribute to identify the member institutes for ASEAN Academic/Training Center Network. Identified institutes shall be invited to Academic seminar(Activity 4-2)

3. Project Management

Meetings (JCC, Bilateral meeting, RCC, PWG1, 2, Bilateral meeting and etc.); Bilateral Meeting; First meeting between JAC and Thai Taskforce was held on June 10-11 to discuss how to implement 8 main activities in the extension phase. PWG; PWG meetings were held on July 9-11(PWG 2 meeting on 9, PWG 1meeting on 11 and Joint PWG meeting on 10)

JCC; July 22. The meeting discussed main activities in the extension phase.
Other Important issues; Two Project assistants have started working since 17 June (Mr. Valintorn) and 1 July (Ms. Ninuma). Second long term expert (Mr. Taro KITA; International Disaster Collaboration/ Project Coordinator) has been dispatched since 29 Aug.

Attachment; Schedule of Implementation (Monitoring Sheet) in the Extension Phase of the ARCH

S. Silawan.

Acknowledged by Project Manager

Mr. Surachai SILAWAN

Director, Bureau of Emergency Medical Operation Support, NIEM

Project Monitoring Report for ARCH Project

1. Duration of Report

   October 1st, 2019 to March 31th, 2020 (2nd Term of the Extension Phase)

2. Progress of Activities

Output	Progress	Remarks
Output 1 Coordination platform on disaster health management is set up.		
Reviewing TOR of RCC for ALD (Re; Activeity1-1)	(1st Term; April 1st, 2019 to September 30th, 2019) Joint PWG meeting on July 10th discussed on this. ASEAN Ministers Meeting at the end of August endorsed the POA and set-up of RCC.	Thailand will serve as secretariat for the RCC. It is necessary to discuss how Thailand will organize the secretariat.
Activity1-2 Drafting Work Plan on the POA of ALD	(1st Term) Joint PWG meeting on July 10th discussed on first draft of Work Plan on DHM for the next Health Agenda prepared by Thailand. ASEAN Ministers Meeting at the end of August endorsed the POA	
	(2nd Term) PWG 1 meeting on January 21st discussed on proposed draft of Work Plan prepared by Thailand. The Draft of Work Plan also presented in 1st RCC-DHM January 23rd for consideration.	
Preparation of the RCC Meeting (Re; Activity1-1, 1-2)		(1st Term) It is necessary for each AMS to nominate the members and to fix the date for 1st meeting (maybe on Jan., 2020)
	(2nd Term)	
	The RCC-DHM fixed the date for nominate the members on 6th January 2020. The 1st meeting was implemented on 22-23 January 2020 at Novotel Siam Square which consisted of 2 representatives from 10 AMS, ASEAN Secretariat and other related organizations.	2nd RCC-DHM shall be set in August 2020 as back to back meeting with HC2 meeting in Manila, Philippines.
Output 2 Framework of regional collaboration practices is developed.		
Activity2-1 Planning and Preparation for Drill	(1st Term) 4-5 April; 1st Mentors team visit in Bali 14-15 May; Consultation meeting between Ikeda & Katsube and MOH in Jakarta and selection of the hotel in Bali 9th July; Consultation meeting between Mentors and Indonesia preparation members in Bangkok 5-7 August; 2nd Mentors team visit in Bali and Jakarta	Close email communication between mentors and Indonesia preparation members shall be continued for the documents for plan of the RCD. Each AMS must submit its Comprehensive Team Information by Oct. 24th.
	(2nd Term) 28 Nov; Project Team discussed with host country of 5th RCD, Myanmar 29 Nov; PWG 2 meeting in Bali, Myanmar has presented their proposal and officially announced their expression to host the 5th RCD. 20th January 2020; 1st Consultation meeting for Myanmar hosting 5th RCD was done at Novotel Siam Square. The Consultation meeting decided that 5th RCD should be conducted in Mandalay in the week of 26 Oct.	The proposal shall be sent by Myanmar by 13 March 2nd Consultation meeting and Mentors visit shall be set on 7-10 April in Myanmar. 1st Consultation meeting discussed that 2nd Mentors visit shall be set on Aug and an EMTCC training for Myanmar RCD members shall be conducted together on that occasion.
Activity2-2 Reginal Collaboration Drill	(2nd Term) 25-28 Nov; The 4th RCD wad conducted in Bali. 46 EMT members from AMS, 16 Japanese, 16 Thai, 2 Philippine mentors and approximately 250 Indonesian participated in this event.	Prior to the 4th RCD, Pre-deployment practice for "Offer of Assistance" was conducted. 8 countries submitted their documents.
Activity2-5 Develop a format for sharing of lesson learned	(1st Term) First draft of template for lessons learned was submitted to PWG 2 on July 9.	Revised version should be submitted to PWG 2 on Nov. 29.

	(2nd Term) The Second draft template for lessons learned was presented to PWG 1 members on 21st January.	PWG 1 members were requested to provide feedback/ inputs by the end of February 2020. Actually, no comments from AMS.
Activity2-5 Conduct a research on experience of response for disaster		
Output 3 Tools for effective regional collaboration on disaster health management are developed.		
Activity3-5 Endorsement for the Tools	(1st Term) SOMHD on April 2019 has endorsed the SOP and PRWG also recognized it.	
Joint Workshop and TTX for SOP by HC2 & PRWG (Re; Activity3-5)	(1st Term) Joint TTX between HC2 and PRWG in collaboration with AHA center was required to be organized on 6-7 Nov. in Jakarta.	JICA shall bear the cost of flight for AMS participants. 2partcipants, one from MOPH and one from NDMO will be invited from each AMS.
	(2nd Term) 7-8 Nov; Joint TTX between HC2 and PRWG in collaboration with AHA center was organized in Jakarta. Based on the results of the TTX, the SOP was revised and discussed in the PWG 1 on Jan 21.	
SWG meeting for ASEAN standards and methods (Re; Activity 3-6)	(1st Term) PWG 1 on July 11 confirmed the TOR of SWG and discussed on members of SWG. Indonesia, Myanmar, Philippines, Thailand and Vietnam were selected as countries which should assign the representatives for the SWG	5 countries had to nominate their focal points for SWG by 30 Aug. ASEC reminded 5countries for the nomination.
	(2nd Term) The members with relevant expertise were nominated from each country. 20th January 2020; 1st SWG meeting for ASEAN standards was done in Bangkok consisted of members from	Mr. Kita and short-term consultant participated in the 1st SWG to co-facilitate the session. 2nd SWG meeting for ASEAN standards shall be set in June 2020.
	Indonesia, Myanmar, Philippines, Thailand, Vietnam and ASEC. The SWG agreed on expected output/ products, and methodology and process ahead.	
Hiring consultants for information collection and facilitation of the SWG	(1st Term) JICA HDQ has completed the selection process of consultant firm. KRC was selected. (2nd Term) The consultant conducted information collection on relevant policy and guideline. Based on the conclusion of the 1st SWG, Questionnaire was finalized and distributed to SWG focal points.	Consultants will start working from the beginning of Oct.
Finalizing recommendation on ASEAN standards and methods (Re; Activity 3-6)		
Output 4 Academic network on disaster health management in AMS is enhanced.		
Activity 4-1 Present outcomes of the Project activities at academic conferences such as JADM, APCDM and WADEM()	(2nd Term) 4 Thai task force members participated to make presentations in the JADM	NIEM SG and Mr. Kita visited Kansai to attend the international session of JADM and arrange Meetings with JAC and President of 25th JADM to establish/ strengthen ties with DHM focal points in Japan. Visits to 3 DM-related facilities were arranged for NIEM SG and 4 Thai participants to learn and increase knowledge in Disaster management.
Activity4-2 Academic Seminar		
Output 5 Capacity development activities for each AMS are implemented.		
Clarifying the roles and functions of the Regional Disaster Health Management training center		

Development of standard training curriculum (Activity5-1)	(1st Term) PWG Joint meeting on July 10 discussed on the concept of the standard training curriculum and regional training center as well as ASEAN Academic Network. Thai ARCH Taskforce developed the draft concept paper on the curriculum development including curriculum committee/taskforce and timeline for next step	It is necessary to circulate the draft concept paper through ASEC to AMS. It is hoped that AMS will be able to nominate members of the committee by the next PWG 2 meeting on 29 Nov.
	(2nd Term) 13th-14th February 2020 ; 1st meeting of SWG was held at Pullman Sukhumvit Hotel. Each AMS nominated 2 representatives to attend the meeting. The meeting decided to initially develop 2 courses; Basic Disaster Health Management Training Courses and EMT coordination during disasters training course.	The Chulabhorn Institute sponsored the meeting. 2nd and 3rd SWG meeting will be scheduled in May and June. 1st training course for Coordination of Disaster medical operation shall be organized on August in Myanmar to strengthen their EMTCC.
Questionnaire Survey for CD in AMS (Re; Activity 5-3)	(1st Term) PWG 2 on July 9 discussed the contents for Questionnaire. Questionnaire already circulated to each AMS on 15 Aug from ASEC.	AMS are required to submit the result of questionnaire to the project by 15 Oct.
	(2nd Term) The result of the questionnaire survey was presented during the PWG2 meeting 29 Nov in Bali with the result from 9 out of 10 countries. The result was also presented in 1st RCC-DHM meeting in Bangkok, 22-23 January.	
Clarifying requirements for academic/training institute which conducts training programs on DHM in AMS (Re: Activity 5-3)		

Development of standard training curriculum (Activity5-1)	(1st Term) PWG Joint meeting on July 10 discussed on the concept of the standard training curriculum and regional training center as well as ASEAN Academic Network. Thai ARCH Taskforce developed the draft concept paper on the curriculum development including curriculum committee/taskforce and timeline for next step	It is necessary to circulate the draft concept paper through ASEC to AMS. It is hoped that AMS will be able to nominate members of the committee by the next PWG 2 meeting on 29 Nov.
	(2nd Term) 13th-14th February 2020 ; 1st meeting of SWG was held at Pullman Sukhumvit Hotel. Each AMS nominated 2 representatives to attend the meeting. The meeting decided to initially develop 2 courses; Basic Disaster Health Management Training Courses and EMT coordination during disasters training course.	The Chulabhorn Institute sponsored the meeting. 2nd and 3rd SWG meeting will be scheduled in May and June. 1st training course for Coordination of Disaster medical operation shall be organized on August in Myanmar to strengthen their EMTCC.
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Clarifying requirements for academic/training institute which conducts training programs on DHM in AMS (Re: Activity 5-3)		

Field trips for Needs and Potential Study on CD in some AMS (Re; Activity 5-3)	(1st Term) PWG 2 on July 9 decided to select 4countries (CLMV) for field trips.	Plan for Field trips will be discussed in PWG 2 on Nov.29.
	(2nd Term) PWG 2 on Nov 29 in Bali discussed and decided the date for field study. 3 countries (Malaysia, Singapore and Brunei) will visit Lao and Cambodia and 2 (Indonesia and Philippines) countries will visit Myanmar and Viet Nam. 11-19 Feb 2020; The field trips in Lao PDR and Cambodia was done with the members from Malaysia, Thailand, ARCH Project, JICA, JAC and Consultant, Due to the situation of epidemic causing Singapore and Brunei to unable to join the field trips.	The field trips in Myanmar and Viet Nam have postponed due to the situation of COVID-19.
Identifying an academic/training institute in each AMS which is expected to be the member institute for ASEAN Academic/Training Center Network on DHM (Re; Activities 4-2 & 5-3)	(1st Term) PWG Joint meeting on July 10 endorsed the concept for the Academic Network for DHM.	Result of the study for CD by Activity 5-3 will contribute to identify the member institutes for ASEAN Academic/Training Center Network. Identified institutes shall be invited to Academic seminar(Activity 4-2)

3. Project Management

Meetings (JCC, Bilateral meeting, RCC, PWG1, 2 and etc.);
(1st Term)
Bilateral Meeting; First meeting between JAC and Thai Taskforce was held on June 10-11 to discuss how to implement 8 main activities in the extension phase.
PWG; PWG meetings were held on July 9-11(PWG 2 meeting on 9, PWG 1meeting on 11 and Joint PWG meeting on 10)
JCC; July 22. The meeting discussed main activities in the extension phase.
(2nd Term)
Bilateral Meeting; Second meeting between JAC and Thai Taskforce was held on October 24-25 to discuss how to implement 8 main activities in the extension phase.

PWG2; PWG 2 meeting was held on 29 November 2019 as a back to back meeting with 4th RCD.
PWG1; PWG 1 meeting was held on 21 January 2020 as a back to back meeting with SWG, Consultation meeting and RCC-DHM.
RCC-DHM; RCCDHM was held on 22-23 January 2020 as a back to back meeting with PWG1.

Other Important issues;
(1st Term)
Two Project assistants have started working since 17 June (Mr. Valintorn) and 1 July (Ms. Ninuma).
Second long term expert (Mr. Taro KITA; International Disaster Collaboration/ Project Coordinator) has been dispatched since 29 Aug.
(2nd Term)
Due to the situation of COVID-19, some events and activities on Feb and March were affected. Mr.Kita had to work at home for 2 weeks after he came back from Japan on Feb. 23.

Attachment; Schedule of Implementation (Monitoring Sheet) in the Extension Phase of the ARCH

S. Silawan.

Acknowledged by Project Manager

Mr. Surachai SILAWAN

Director, Bureau of Emergency Medical Operation Support, NIEM

TIMELINE OF ACTIVITIES (APRIL 2019 - MARCH 2020)

DATE	*EVENT*	*PLACE/ VENUE*	*PARTICIPANTS*
3-5 Apr 2019	1st Mentor Visit for RCD	Indonesia	ARCH Project, Thai TF, JAC and Indonesia
13-16 May 2019	2nd Mentor Visit for RCD	Indonesia	23 Participants from ARCH Project, Thai TF, JAC and Indonesia
10-11 Jun 2019	1st Bilateral Meeting	Ramada Plaza, Bangkok	37 Participants from ARCH, Thai TF and Japanese TF
9 Jul 2019	6th PWG2 Meeting	Sukosol, Bangkok	40 Participants from AMS, ARCH, JAC and ASEC
10 Jul 2019	Joint PWG1&2 Meeting	Sukosol, Bangkok	60 Participants from AMS, ARCH, JAC and ASEC
11 Jul 2019	8th PWG1 Meeting	Sukosol, Bangkok	40 Participants from AMS, ARCH, JAC and ASEC
22 Jul 2019	4th JCC Meeting	NIEM, Thailand	NIEM, MOPH, JICA, TICA and related organization
4-8 Aug 2019	3rd Mentor Visit for RCD	Indonesia	25 Participants from ARCH Project, Thai TF, JAC and Indonesia
24-25 Oct 2019	2nd Bilateral Meeting	Ramada Plaza, Bangkok	40 Participants from ARCH, Thai TF and Japanese TF
7-8 Nov 2019	TTX to Test EMT SOP	Pullman Hotel, Jakarta	40 Participants from AMS, ARCH, ASEC and AHA
25-28 Nov 2019	4th RCD	Grand Inna, Tanah Ampo Pier, Bali	290 Participants from AMS, ARCH, ASEC, AHA, JICA, JAC, JDR, and Indonesian participants
29 Nov 2019	7th PWG2 Meeting	Grand Inna Hotel, Bali	29 Participants AMS, ARCH, JAC, ASEC and AHA
20 Jan 2020	1st SWG meeting on collective measure (CM)	Novotel Siam, Bangkok	10 Participants from ARCH, Indonesia, Myanmar, Philippines, Thailand, Viet Nam, ASEAN Secretariat and Consultant
20 Jan 2020	1st Consultation Meeting for 5th RCD	Novotel Siam, Bangkok	20 Participants from Myanmar, Indonesia and Philippines Mentors, Thailand, Japan and ASEC
21 Jan 2020	9th PWG1 Meeting	Novotel Siam, Bangkok	40 Participants from AMS, ARCH, JAC and ASEC
22-23 Jan 2020	1st RCCDHM Meeting	Novotel Siam, Bangkok	50 Participants from AMS, ARCH, ASEC, JAC and related organization
11-19 Feb 2020	Field Study for Capacity Development on DHM	Vientiane (Lao PDR) and Phnom Penh (Cambodia)	11 Participants from ARCH, Thai TF, Malaysia, JICA, JAC and Consultant
13-14 Feb 2020	1st SWG meeting on curriculum development (CD)	Pullman Sukhumvit, Bangkok	40 Participants from AMS, JICA, Chulabhorn Royal Academy

OUTPUT 1: COORDINATION PLATFORM ON DISASTER HEALTH MANAGEMENT IS SET UP

- **Regional Coordination Committee on Disaster Health Management**

OUTPUT 1: COORDINATION PLATFORM ON DISASTER HEALTH MANAGEMENT IS SET UP

Event	**1st Meeting of Regional Coordination Committee on Disaster Health Management (RCC-DHM)**
Dates	22-23 January 2020
Venue	Novotel on Siam Square Hotel, Bangkok Thailand
Participants	AMS, JICA, ASEC
Agenda	● Governance Issues ○ Brief on Governance and Implementation Mechanism (GIM) of the ASEAN Post-2015 Health Development Agenda ○ Background of ASEAN DHM and relevant documents ● Collaboration and Partnership; ARCH Project, WHO, AHA Centre and ACDM, ACMM and ASEAN EOC Network ● Strategic Movement ○ Lesson Learnt from Actual Disaster ○ Roadmap for ASEAN Health Cooperation's Contribution to the realization of One ASEAN One Response ○ Integration of SOP to SASOP ○ Collective Approach of AMS I-EMT ○ Regional Collaboration Drill ● Capacity Building. Networking and Regional Cooperation ○ Academic Systems and needs for capacity development on DHM in AMS ○ ASEAN Academic Network and international seminar on DHM ● Special Session: ASEAN Work Plan and ARCH Collaboration ○ Draft ASEAN Work Plan on DHM 2021-2025 ○ ARCH Project Extension Phase and future cooperation ○ Possible Collaboration with other programme under the ASEAN Health Cooperation ● Summary and way forward
Summary of Discussion	The meeting noted that RCCDHM is the coordination mechanism for all initiatives/projects related to disaster health management, therefore ARCH Project is under supervision of RCC-DHM.

	The meeting noted and expressed support to DHM initiatives under ARCH Project, through PWG1&2. Furthermore, the meeting agreed that activities that contribute to realizing the 19 targets of the POA/ALD on DHM (2019-2025) be proposed to JICA as part of ARCH Phase 2. RCCDHM will consider these in the development of work plan (POA) through the drafting group. ASEAN Health Sector will develop collective measures and approaches to enable AMS to fulfill WHO EMT Standards and will not create regional standards.
Important Decisions	• Interested RCCDHM members express their interest to be part of drafting group to develop the work plan to operationalize the POA by 8 February 2020 • RCCDHM Secretariat will draft brief TOR to guide the work by end of February 2020 • The next RCCDHM Meeting will tentatively be held on the third week of August in Philippines as back to back with 6th meeting of ASEAN Health Cluster 2
Attachments	• List of Participants • Overall Programme • Summary and Way Forward • Presentations and Documents

The 1st Meeting of the Regional Coordination Committee on Disaster Health Management (RCC-DHM)
22nd- 23rd January 2020 Novotel Hotel, Siam Square, Bangkok,

Guest No	Country	Group	Title	Name	Signature 22 January 2020	Signature 23 January 2020
1	Myanmar	RCD	Dr.	Htun Tin Nyunt		
2	Myanmar	RCD	Dr.	Than Latt Aung		
3	Myanmar	RCD	Dr.	Moe Khaing		
4	Myanmar	RCD	Dr.	Maw Maw Oo		
5	Philippines	SWG	Ms.	Elmie Joy T. Villegas		
6	Philippines	RCD,PWG1,RCC	Dr.	Alfonso Danac		
7	Philippines	RCD,PWG1,RCC	Ms.	Janice Feliciano		
8	Singapore	PWG,RCC-DHM	Mr.	Ng Hock Sing		
9	Singapore	PWG,RCC-DHM	Dr.	Lim Ghee Hian		
10	Viet Nam	RCC-DHM&PWG1	Dr.	Nguyen Duc Chinh		
11	Viet Nam	SWG&RCC-DHM&PWG2	Mr.	Tran Quang Hung		
12	Singapore	PWG, RCC-DHM	[illegible]	[illegible]		

The 1st Meeting of the Regional Coordination Committee on Disaster Health Management (RCC-DHM)
22nd- 23rd January 2020 Novotel Hotel, Siam Square, Bangkok,

Guest No	Country	Group	Title	Name	Signature 22 January 2020	Signature 23 January 2020
1	Thailand	RCC-DHM	Dr.	Phusit Prakongsai	[redacted]	
2	Thailand	RCC-DHM	Dr.	Jirot Sindhvananda		
3	Thailand	RCC-DHM	Dr.	Anupong Sujariyakul		
4	Thailand	RCC-DHM	Dr.	Narumol Sawanpanyalert		
5	Thailand	RCC-DHM	Dr.	Suriya Wongkongkathep		
6	Thailand	RCC-DHM	Dr.	Alisa Yanasan		
7	Thailand	RCC-DHM	Dr.	Witoon Anankul		
8	Thailand	RCC-DHM	Dr.	Prakit Sarathep		
9	Thailand	RCC-DHM	Dr.	Patcharaporn Klongklaew		
10	Thailand	RCC-DHM	Dr.	Ratchakorn kaewpramkusa .		
11	Thailand	RCC-DHM	Ms.	Rungtipa Jaitrong		
12	Thailand	RCC-DHM	Ms.	Hataya Kohkiatpong		
14	[illegible]	[illegible]	[illegible]	[illegible]		

The 1st Meeting of the Regional Coordination Committee on Disaster Health Management (RCC-DHM)
22nd- 23rd January 2020 Novotel Hotel, Siam Square, Bangkok,

Guest No	Country	Group	Title	Name	Signature 22 January 2020	Signature 23 January 2020
1	ASEC	ASEC	Mr.	Jim Catampongan	[redacted]	
3	ARCH Project	ARCH Project	Mr.	Shuichi Ikeda		
4	ARCH Project	ARCH Project	Mr.	Taro Kita		
5	ARCH Project	ARCH Project	Mr.	Valintorn Chewasuchin		
6	ARCH Project	ARCH Project	Ms.	Ninuma Dullaphan		
7	Japan	JICA HQ	Ms.	Asuka Tsuboike		
8	Japan	JICA HQ	Mr.	Tsukasa Katsube		
9	Japan	JICA HQ	Mr.	Sho Amemiya		
10	Japan	JAC	Dr.	Tatsuro Kai		
11	Japan	JAC	Dr.	Yuichi Koido		
12	Japan	JAC	Mr.	Yosuke Takada		
13	Japan	KRC	Ms.	Chiaki Kido		

The 1st Meeting of the Re nal Coordination Committee on Disaster He h Management (RCC-DHM)
22nd- 23rd January 2020 Novotel Hotel, Siam Square, Bangkok,

Guest No	Country	Group	Title	Name	Signature 22 January 2020	Signature 23 January 2020
1	Brunei	RCC-DHM	Dr.	Hajah Lailawati Haji Jumat	[redacted]	
2	Brunei	RCC-DHM	Ms.	Julita Abdul Fata		
3	Brunei	PWG1	Dr.	Linawati Haji Jumat		
4	Brunei	PWG1	Ms.	Chiang Mei Mei		
5	Cambodia	RCC-DHM	Mr.	Ean Sokoeu		
6	Cambodia	PWG1&RCCDHM	Dr.	Lak Muy Seang		
7	Cambodia	PWG1	Dr.	Teng Srey		
8	Indonesia	PWG1&RCCDHM	Mr.	Agus Hendroyono		
9	Indonesia	SWG&PWG1	Dr.	Rakhmad Ramadhanjaya		
10	Indonesia	RCD	Dr.	Ina Agustina Isturini		
11	Lao PRD	PWG,RCC-DHM	Dr.	Daovilay Banchongphanith		
12	Lao PRD	PWG,RCC-DHM	Dr.	Oulaivanh Phonesavanh		
13	Malaysia	RCC-DHM	Dr.	Kasuadi bin Hussin		
14	Malaysia	RCC-DHM&PWG1	Dr.	Maria Suleiman		

The 1st Meeting of the Regional Coordination Committee on Disaster Health Management (RCC-DHM)
22nd- 23rd January 2020 Novotel Hotel, Siam Square, Bangkok, Thailand

Guest No	Country	Group	Title	Name	Signature 22 January 2020	Signature 23 January 2020
1	Thailand	WHO	Dr.	Richard Brown	[redacted]	
2	Thailand	NIEM	Dr.	Phummarin Saelim		
3	Thailand	NIEM	Dr.	Phumin Silapunt		
4	Thailand	NIEM	Ms.	Sansana Limpaporn		
5	Thailand	NIEM	Ms.	Kittima Yuddhasaraprasiddhi		
6	Thailand	NIEM	Ms.	Dangfun Promkhum		
7	Thailand	RCC-DHM	Dr.	Ratchakorn kaewpramkusa		
8	Thailand	RCC-DHM	Mr.	Wattana Masunglong		
9	Thailand	RCC-DHM	Ms.	Pitchapa Kleeblumjeak		
10	Thailand	RCC-DHM	Ms.	Kunyarut Comnan		
11	Thailand	RCC-DHM	Ms.	Huttaya Suttayathon		
12	Thailand	DDPM	Ms.	Jittaporn Wilaijit		
13	Thailand	DMS, MOPH	MS.	KANOKPORN CHUCHERD		
14	Thailand	AMF, ACDM	LTC	Komolkan Mahawichai		

The 1st Meeting of the Regional Coordination Committee on Disaster Health Management (RCC-DHM)
22nd- 23rd January 2020 Novotel Hotel, Siam Square, Bangkok, Thailand

Guest No	Country	Group	Title	Name	Signature 22 January 2020	Signature 23 January 2020
1				[illegible]	[redacted]	
2				[illegible]		
3				MR. POTE AIMPUN		
4				MS. BORNORNWAN DIREKMOKE		
5				MR. ANUWAT JONGSEM		
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(Tentative Program)

The 1st Meeting of the Regional Coordination Committee on Disaster Health Management (RCC-DHM)

22nd- 23rd January 2020

Novotel Hotel, Siam Square, Bangkok, Thailand

22nd January 2020: Day 1

Time	Activities	Presenter
08.30-0.900	Registration	
09.00-09.20	Welcome and Opening remarks by host country Business arrangement Introduction of delegates	Permanent Secretary, Ministry of Public Health of Thailand RCC-DHM secretariat
09.20-09.30	Group Photo	
AGENDA ITEM 1: GOVERNANCE ISSUES		

09.30-10.30	Call to order for the RCC-DHM meeting
	• Election of the Chair
	• Adoption of Agenda
	Background of ASEAN DHM and relevant documents (15 minutes)
	• ASEAN Leader's Declaration on One ASEAN One Response
	• ASEAN Post 2015 Health Development Agenda and DHM (12th Health Priority)
	• ASEAN Leader's Declaration on Disaster Health Management (2017)
	  • Plan of Action
	  • TOR of RCC-DHM
	• Joint Statement of the 14th ASEAN
		Thailand
		
		RCC-DHM Secretariat

	Health Ministers Meeting (2019) Q&A and open discussion (15 minutes)	
10.30-10.45	Coffee break	
AGENDA ITEM 2: COLLABORATION AND PARTNERSHIP		
10.45-12.20	Collaboration and Partnership • ARCH project and JICA (15 minutes) • ASEAN-WHO collaboration (15 minutes) • AHA Centre and ACDM (15 minutes) • ASEAN Center of Military Medicine (10 minutes) • ASEAN EOC Network (10 minutes) Open discussion (40 minutes)	Representative from JICA WHO Representative AHA Centre representative ACMM representative Malaysia
12.30-13.30	Lunch	
AGENDA ITEM 3: STRATEGIC MOVEMENT		
13.30-14.30	Lesson Learnt from Actual Disasters (10 minutes for each presentation) • Identifying gaps and challenges Template to collect lesson learnt (Product of ARCH extension phase) Open discussion (30 minutes)	Haiyan Typhoon (Philippines) Sulawesi Earthquake (Indonesia) Attapeu Collapse Dam (Laos PDR) Representative of ARCH Project
14.30-15.30	Roadmap for One ASEAN One Response • Presentation of the Roadmap Open discussion	RCC-DHM Secretariat
15.30-15.45	Coffee Break	
15.45-17.00	Integration of SOP for EMT to SASOP Collective Approach of AMS I-EMT Regional Collaboration Drill Open discussion	RCC-DHM Secretariat Representative of ARCH project Representative of ARCH project
18.00 RECEPTION DINNER		

Dress code: Smart casual

23rd January 2020: Day 2

Time	Activities	Responsible person
08.30-09.00	Recap of Day 1	ASEC
AGENDA ITEM 4: CAPACITY BUILDING, NETWORKING AND REGIONAL COOPERATION		
09.00-10.30	Academic Network initiatives • Presentation: Survey on potential needs for capacity development on DHM • Concept note of ASEAN Academic Network • Development & way forward	JICA RCC-DHM Secretariat
10.30-10.45	Coffee break	
AGENDA ITEM 5: SPECIAL SESSION: ASEAN WORK PLAN and ARCH COLLABORATION		
10.45-12.00	Presentation of 12th Health Priority Work plan 2021-2025 The Future cooperation after ARCH phase 1	Representative of ARCH PROJECT JICA
12.00-13.00	Lunch	
13.00-13.30	The 2nd RCC-DHM meeting • Arrangements and venue • Tentative date and time Wrap up and way forward	ASEC
13.30-13.40	Closing remarks	Chair

	Country	Name	Title	Contact
1.	Brunei Darussalam	Dr Lailawati Jumat	1st Appointed Representative Primary Representative - (director level)	Director of Hospital Ministry of Health Email: lailawati.jumat@moh.gov.bn
2.	Brunei Darussalam	Ms Julita Abdul Fata	2nd Appointed Representatives (officers with experiences on building/strengthening capacity on DHM) Primary Representative -	Nursing Officer Office of the Director General of Medical and Health Services Ministry of Health Email: julita.fata@moh.gov.bn
3.	Cambodia	Dr. Lak Muy Seng	Primary Representative	Deputy Director Department of Preventive Medicine Email:srenglak@yahoo.com Tel :885 17999 586
4.	Cambodia	Mr.Ean Sokoeu	Alternate Representative	Chief of Disaster Management and Environmental Health Email:sokoeu.ea@gmail.com Tel :885 -12472 470
5.	Indonesia	Mr. Agus Hendroyono	Alternate Representative	Deputy Director for Prevention, Mitigation and

				Preparedness, CHC, MoH hendroyonoagus@gmail.com
6.	Indonesia	dr Rakhmad Ramadhanjaya		Head of Emergency Response Section, CHC, MoH mamad_42942@yahoo.com
7.	Lao PDR	Dr. Daovilay Banchongphanith		Deputy Director of Department of Legislation, Cabinet Office, MOH. Email: daovilay@yahoo.com
8.	Lao PDR	Dr. Oulaivanh Phonesavanh		Doctor Emergency Division, Mittapharb Hospital. Email: oulaivanhphonesavanh@yahoo.com
9.	Malaysia	Dr. Maria Suleiman	Primary Representative:	Head of the Sector Disaster, Outbreaks, Crisis and Management SectorDisease Control Division Ministry of Health Malaysia Email:Mariasuleiman@moh.gov.my
10.	Malaysia	Dr. Kasuadi bin Hussein		Head of Unit Surgical and Emergency Medical Services Medical Development Division Ministry of Health Malaysia
11.	Myanmar	Dr. Nyan Win Myint,		Deputy Director Department of Public Health
12.	Myanmar	Dr Maw Maw Oo		Professor Department of Emergency Medicine

				University of Medicine ,Yangon Email: drmawmawoo@googlemail.com
13.	Philippines	Dr. Alfonso Cruz Danac		Chief of Medical Professional Staff II Jose B. Lingad Memorial Regional Hospital Email: jblmrhcomps@gmail.com
14.	Philippines	Ms. Janice Palad Feliciano		Nutritionist-Dietitian V Health Emergency Management Bureau Email: janicepfeliciano@yahoo.com
15.	Singapore	Mr Ng Hock Sing	1st Appointed Representative Primary Representative - (director level)	Director, Emergency Preparedness & Response Division, Ministry of Health Singapore Email : NG_Hock_Sing@moh.gov.sg
16.	Singapore	Mr Raihan Rafiek	2nd Appointed Representatives (officers with experiences on building/strengthening capacity on DHM) Primary Representative -	Senior Assistant Director, Emergency Preparedness & Response Division, Ministry of Health Singapore Email:Raihan_RAFIEK@moh.gov.sg
17.	Thailand	Dr.Phusit Prakongsai		The senior advisor on health promotion for the Office of Permanent Secretary, Ministry of Public Health of Thailand

				Email: phusit@ihpp.thaigov.net
18.	Thailand	Dr.Phumin Silapunt		Deputy Director of Chulabhorn Hospital Email: puminsila@gmail.com
19.	Viet Nam representatives	Mr. Nguyen Duc Chinh		Assistant Professor, Chief of Departmanr, Viet Duc Hospital Email:duc_chinh1960@yahoo.com
20.	Viet Nam representatives	Mr. Tran Quang Huong	Alternate Representative	Dept of International Cooperation, MoH of Viet Nam E-mail: heritran@heritran.vn, mobile no (+84) 933119933

SUMMARY REPORT OF THE
FIRST MEETING OF THE REGIONAL COORDINATION COMMITTEE ON
DISASTER HEALTH MANAGEMENT (RCC-DHM)

22 – 23 JANUARY 2020 | BANGKOK, THAILAND

INTRODUCTION

1. The Meeting was Chaired by Myanmar, as current Chair of ASEAN Health Cluster 2 on Responding to All Hazards and Emerging Threats, and co-chaired by Thailand, as Lead Country of the development and adoption of the ASEAN Leaders Declaration on Disaster Health Management (ALD on DHM) and the development and endorsement of the Plan of Action (POA) to implement the ALD on DHM. The Meeting was attended by representatives from Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam, and the ASEAN Secretariat. Invited partners, namely World Health Organization (WHO), Japan International Cooperation Agency (JICA), and ASEAN Centre for Military Medicine (ACMM) also attended the Meeting. The List of Participants appear as **ANNEX 1**.

OPENING REMARK

2. Dr. Narong Apikulwanich, Deputy Director General of the Department of Medical Services, Ministry of Public Health of Thailand, welcomed the participants and delivered opening remarks. He emphasized the importance of strengthening capacity in disaster health management in ASEAN, which is a disaster-prone region. He underscored the attention accorded by ASEAN Member States and the ASEAN including the ASEAN Health Sector in strengthening national and regional capacities and regional cooperative mechanisms to prepare for and respond to needs of disaster-affected populations. He wished the Meeting to have open and productive exchanges, and looked forward to the outcomes and recommendations. His complete remark appears as **ANNEX 2**.

AGENDA 1: GOVERNANCE ISSUES

1.1. Call to order for the RCC-DHM Meeting

3. The Meeting noted the briefing from the ASEAN Secretariat on the Governance and Implementation Mechanism (GIM) of the ASEAN Post-2015 Health Development Agenda (APHDA), and particularly on the creation of ASEAN Health Clusters which are tasked to operationalize the APHDA and the Health Priorities under their purview. The Meeting also noted the POA - ALD on DHM that was endorsed during the 14th ASEAN Health Ministers Meeting (AHMM) on 29 August 2019 in Siem Reap, Cambodia, which stipulates the creation of the Regional Coordination Committee on Disaster Health Management (RCC-DHM) as its main operational mechanism to implement the POA-ALD on DHM. The Meeting further noted that the leadership of the RCC-DHM will follow the two-year chairpersonship rotation of the ASEAN Health Cluster 2.

4. In view of the above, Myanmar assumed as chair of the Meeting. Thailand, as Lead Country of the ALD on DHM and its POA, as well as host country of the Meeting, served as co-chair. The co-chairs looked forward to a productive two-day Meeting and encouraged delegates to actively participate in the Meeting.

5. The Meeting reviewed and adopted the agenda, which appears as **ANNEX 3.**

1.2. Disaster Health Management – A Health Priority of the ASEAN Health Cooperation

6. The Meeting noted the presentation of the ASEAN Secretariat on the ongoing implementation of the APHDA with all project activities under respective ASEAN Health Clusters. The Meeting further noted the ALD on DHM which was adopted during the 31st ASEAN Summit in November 2017 which serves as the anchor with political commitment for all related initiatives and efforts on DHM, including the ASEAN Health Sector's articulation of their contribution to the realization of the ASEAN Declaration on One ASEAN One Response: Responding to Disasters Within the Region and Outside the Region. The Meeting also noted the

operationalization of the ALD on DHM through the adoption of the POA-ALD on DHM. The presentation and relevant document appear as **ANNEX 4.**

7. Co-Chair Thailand sought clarification on the [a] relationship between the Project for Strengthening ASEAN Regional Capacity for DHM (ARCH Project) with the RCC-DHM, taking into consideration that the ARCH Project is a bilateral cooperation between Thailand and Japan through JICA, and [b] oversight mechanism for the existing Project Working Groups of the ARCH Project.

8. The ASEAN Secretariat briefed the Meeting on the ASEAN mechanism and procedures for the acknowledgement of projects and activities. First, the project undergoes endorsement by relevant ASEAN sectoral body, in this case the ASEAN Health Sector through the ASEAN Health Clusters and ASEAN Senior Officials Meeting on Health Development (SOMHD). Second, the project is subsequently subjected to the ASEAN Project Appraisal and Approval Process (PAAP) culminated by the endorsement by the Committee Permanent of Representatives to ASEAN (CPR).

9. In the case of the ARCH Project, while it was originally planned as a bilateral cooperation, it has evolved into an ASEAN Health Sector initiative after Thailand proposed that it be one of the project activities that contributes to advancing Health Priority 12 on DHM under ASEAN Health Cluster 2, as articulated in its Work Programme 2016-2020 which was endorsed by the 12th SOMHD in April 2017 and adopted during the 13th AHMM in September 2017. The ARCH Project also underwent the ASEAN PAAP and endorsed by the CPR.

10. During the first phase of implementation of the ARCH Project, a Regional Coordination Committee (RCC-ARCH Project) was created to provide strategic oversight to the project and the Project Working Groups, and to report project developments as well as concerns to ASEAN Health Cluster 2 for consideration. Towards the end of the implementation of the first phase and when the POA-ALD on DHM was being developed, the RCC-ARCH Project in line with their imminent dissolution in connection with project completion agreed that their function be handed over to RCC-DHM which is mandated to facilitate regional collaboration and coordination related to strengthening DHM in the region. As such, since the ARCH Project also contributes to meeting most of the regional target of POA-ALD on DHM, the Project Working Groups of the ARCH Project will report to the RCC-DHM, and RCC-DHM will report project development and elevate relevant matters to ASEAN Health Cluster 2.

AGENDA 2 COLLABORATION AND PARTNERSHIP

11. Partners and relevant sectors were invited to share and inform the Meeting on their respective organizational overview and relevant issues on Disaster Health Management.

2.1. Project for the Strengthening ASEAN Regional Capacity in Disaster Health Management (ARCH Project)

12. The Meeting noted the presentation delivered by JICA's Senior Adviser on the ARCH Project which purpose is to strengthen regional coordination on DHM in the ASEAN Region. The Meeting also noted that the first phase between July 2016-July 2019 has been completed and has achieved agreed outputs, including the creation of regional coordination committee, conduct of regional collaboration drills, development of regional collaboration tools, among others.

13. The JICA representative further informed that the ARCH Project is now on its extension phase (July 2019-March 2021) to support the completion of activities, particularly the integration of the ASEAN EMT SOP and its relevant tools into the ASEAN Regional Standby Arrangements and Coordination of Joint Disaster Relief and Emergency Response Operations (SASOP), and to support the initial implementation of the Plan of Action to implement the ASEAN Leaders Declaration on Disaster Health Management. The presentation appears as **ANNEX 5.**

2.2. ASEAN-World Health Organization (WHO) Collaboration

14. The representative from WHO Thailand Office who agreed to deliver a presentation on their Emergency Health Programme sent last minute absence due to emergency calls related to the evolving outbreak of coronavirus in Thailand. In this connection, the ASEAN Secretariat briefed the Meeting on the ASEAN-WHO

which has been articulated through the Memorandum of Understanding (MOU) on the collaborative framework between ASEAN and WHO. The ASEAN Secretariat further informed that the MOU has already expired, and discussions have been initiated for the review and development of a plan of action (POA) which will guide the cooperation between ASEAN and WHO in the coming years.

15. The Meeting noted that in consideration of the adoption of the Joint Declaration on Comprehensive Partnership between ASEAN and the United Nations (UN) in 2011, ASEAN's cooperation with any UN agency will be guided by POA and there is no longer a need to agree and sign MOU. The Meeting further noted the ASEAN-UN Plan of Action to implement the Joint declaration on Comprehensive Partnership between ASEAN and the United Nations (2016-2020) on Public Health issue as follows:

a. Encouraging coordination and collaboration between UN agencies and the ASEAN Health Sector through project initiatives relevant to the 2030 Agenda for Sustainable Development and the ASEAN Post-2015 Health Development Agenda, including on Cross-cutting concerns such as the prevention and control of non-communicable diseases; advocacy and capacity building on maternal, new-born, child and adolescent health and nutrition, reproductive health, disaster health management; and prevention, detection and response to communicable diseases/emerging infectious diseases, HIV/AIDS, pandemics and other potential public health threats; and,

b. Promoting exchange of best practices, advocacy initiatives, technical cooperation and capacity building in promoting health systems, access to care and enhancing food safety, nutrition and water, sanitation and hygiene.

16. The presentation from ASEAN Secretariat appears as **ANNEX 6.**

2.3. ASEAN Committee on Disaster Management (ACDM) and ASEAN Coordination Centre for Humanitarian Assistance in Disaster Management (AHA Centre)

17. The ASEAN Secretariat, as requested by AHA Centre and in absence of ACDM representatives, presented the overview of the ASEAN Disaster Management Framework in ASEAN, highlighting the ASEAN Agreement on Disaster Management and Emergency Response (AADMER) which serves as a common platform and regional policy backbone for disaster management in the ASEAN region. The AADMER is operationalized by AADMER Work Programme 2016-2020 developed and implemented by ACDM through five working groups, and which outlines a detailed structure of activities of the region's disaster management priorities over a five-year period. The ASEAN Vision 2025 on Disaster Management, with institutionalization and communications, partnerships and innovations, and finance and resource management as strategic elements, was also presented.

18. The presentation also highlighted the establishment of ASEAN Coordinating Centre for Humanitarian Assistance on disaster management (AHA Centre), which serves as the regional hub for information and knowledge for disaster management, the center point for mobilization of resources to disaster-affected areas and the coordination engine to ensure ASEAN's fast and collective response to disasters within the region. Following the video presentation on the organizational profile of AHA Centre, the principles and elements to operationalize the One ASEAN One Response, including the role of the ASEAN Secretary General as the ASEAN Humanitarian Assistance Coordinator.

19. The Meeting also noted the ASEAN Standard Operating Procedure for Regional Standby Arrangements and Coordination of Joint Disaster Relief and Emergency Response Operations (SASOP) which provides operational guidance among parties to ensure coordinated disaster response, and which the ASEAN Health Sector intends to further strengthen through the development of the ASEAN EMT SOP that defines the deployment and mobilization of emergency medical services in disasters and its integration with SASOP. The presentation appears as **ANNEX 7.**

2.4. ASEAN Centre of Military Medicine (ACMM)

20. The ACMM, represented by the Centre's Secretariat Chief, presented an overview of the establishment and the operation of the Centre. The Meeting noted that the mission of ACMM is to establish practical, effective, and sustainable cooperation among military medical services of ASEAN Member States and Plus countries, both in normal circumstances and in times of crises. The Meeting further noted the governance

and operational mechanisms of the ACMM through its Board of Directors and Liaison Officers, which lead the implementation of the ACMM Roadmap 2016 – 2020.

21. The ACMM representative further outlined that one of the services of the military sector in disaster response and humanitarian assistance is emergency health services. The representative emphasized that during deployment, the military follows and abides with the requirements and protocols of the Host Country. In the ASEAN, the presentation further elaborated that the contribution of the military sector has been defined in SASOP Chapter 6 on the Facilitation and Utilisation of Military Assets and Capacities. The Meeting also discussed the ASEAN EMT SOP which is in the process of integration with the ASEAN SASOP, and noted that this component will subsequently guide the deployment and mobilization of civilian and military medical teams in ASEAN.

22. The Meeting also noted that during peace time, ACMM contributes to capacity building and data management among ASEAN Member States. The presentation appears as **ANNEX 8.**

2.5. ASEAN Emergency Operations Centre (EOC) Network

23. Malaysia, as Lead Country, presented the ongoing ASEAN Emergency Operations Centre (ASEAN EOC) Network which was created as part of regional surveillance and response mechanism of ASEAN. An initiative under the Work Programme 2026-2020 of ASEAN Health Cluster 2, the Network aims to be a cooperation of public health EOC of all AMS with trained, functioning, multi-sectoral rapid response teams, access to real-time information system, and capacity to attribute outbreak sources. The Meeting noted that as part of regional mechanism, the Network aims to provide surveillance, early warning and information sharing with a view of enhancing the management of infectious disease outbreaks and public health emergencies in a borderless ASEAN. The presentation appears as **ANNEX 9.**

24. The Meeting exchanged views on specific initiatives of the ASEAN EOC Network designed for Cambodia, Lao PDR, Myanmar, and Viet Nam (also collectively called CLMV Countries). The Meeting was made to understand that at ASEAN-wide level, the Initiative for ASEAN Integration (IAI) was launched in 2000 to assist the four Member Countries in making the most of the potential benefits of regional integration that includes a component on Health and Well-Being, while also helping them cope with the associated challenges and economic risks. The Meeting noted that the Network has an existing project that provides technical and material support to ASEAN Member States, and further noted that the ASEAN Health Sector also have specific projects designed for CLMV Countries.

AGENDA 3: STRATEGIC MOVEMENT

3.1. Lessons Learned from Actual Disasters

25. The Meeting noted the presentations from the Philippines, Indonesia and Lao PDR which provided insights on practices and lessons learned from recent disaster response experiences that contribute to strengthening the delivery of emergency medical services, including the enhancement of the health components of One ASEAN One Response.

a. Philippines: Typhoon Haiyan

26. The Philippines shared their experience from Typhoon Haiyan, a Level 3 Emergency by the Inter-Agency Standing Committee (IASC) which generated an overwhelming international support including the deployment of 150 EMT. The Philippines shared that the coordination of EMT response was faced with issues on the non-registration of deployed EMT with unknown capacity and quality of services; on communication, logistics and transport; on poor data reporting and documentation of services; and on non-self-sufficient causing additional burden to local authorities.

27. While the WHO EMT classification and registration was used for the first time for such an emergency, the Philippines stressed on the importance of EMT registration with enhanced matching of health needs of

affected areas, ensuring facilitation of arrivals by the logistics hub, and prevention of oversupply of EMT in one location. The Philippines also stressed on the need to institutionalise the EMT registration and coordination, to come up with a common standard procedures across stakeholders and information dissemination to all actors and players, and to strengthen the capacity of national EMT. In this regard, the Philippines has carried out efforts to strengthen EMT for national response, to enhance disaster response plans and their dissemination, to enhance national response through the organization of the Philippine International Humanitarian Assistance Cluster (PIHAC). The presentation appears as **ANNEX 10.**

b. Indonesia: Tsunami in Central Sulawesi

28. Indonesia shared their experience from the Tsunami in Central Sulawesi, which resulted to heavy damages to health facilities and the deployment of 386 EMT consisting of national civilian and military teams. The presentation cited on insufficient capacity of authorities and response in affected areas (health needs assessment was conducted for the first time in the area to identify needs of affected population), and the difficulty in accessing emergency funds for health response. Indonesia also shared on the need to update laws and operating procedures to meet operational requirements, to respond based on the Health Cluster approach, to employ a composite EMT approach in response, and to establish buffer stocks in every district. The presentation appears as **ANNEX 11.**

c. Lao PDR: Saddle dam in Attapeu

29. Laos PDR shared their experience from the saddle dam in Attapeu which resulted to flash floods in 13 villages. The presentation stressed on the strong political leadership through the public health EOC which facilitated authoritative decision-making, the response capacity of MOH resulting from trainings and frequent exercises, and the rapid deployment of medical services, disease surveillance and reporting. The presentation also outlined challenges including unclear lines of command, governance and reporting which led to confusion and delays, weak multi-sectoral coordination mechanisms at various levels, many non-health response actions delegated to MOH, and limited capacity in disaster response and logistics management. The presentation appears as **ANNEX 12.**

30. The Meeting further discussed and exchanged views on the process to requesting or accepting international medical assistance which could be dependent on or affected by multiple agreements, relationships and mechanisms which varies among countries. In addition, the deployment of underqualified international EMT was pointed out as one of the challenges faced by receiving countries. On the other hand, the capacity of EMT Coordination Cells (EMTCC) not only on deployed EMT was also raised as a concern in coordinated and responsive EMT response. The Meeting agreed to further discuss the matter in the next RCC-DHM or through relevant meetings of relevant Project Working Groups under the ARCH Project to address the issues.

d. Template to collect lesson learnt

31. The Meeting noted the presentation of the ARCH Project Team through the JICA Senior Adviser on the review of disaster response deployments of ASEAN EMT to contribute to continuous learning and development in the delivery coordination of emergency medical services. The presentation pointed out that the draft ASEAN EMT SOP stipulates the conduct of operational reviews and sharing of findings for learning, and revisions and updating of the EMT SOP.

32. The Meeting noted the draft format of the AMS I-EMT Lessons Learnt Report as presented by the ARCH Project Team, which main sections request information on the event, team and services provided, process evaluation for the deployment of AMS EMT, good practices on collaboration in each phase, and recommendation for the EMT SOP and ASEAN Collective Measures. The Meeting further noted the request from the ARCH Project Team for inputs and feedback to the draft format. The presentation appears as **ANNEX 13.**

3.2. Roadmap for the ASEAN Health Cooperation's contribution to the realization of One ASEAN One Response

33. The Meeting noted the RCC-DHM Secretariat presentation on the proposed Roadmap for the ASEAN Health Cooperation's Contribution to the Realization of One ASEAN One Response, as the strategic plan for

the RCC-DHM. The proposed roadmap, anchored on existing ASEAN policy documents on disaster management and disaster health management, as well as global frameworks and instruments, focuses on strategic priorities on governance and policy, prevention and disaster risk reduction, preparedness and response, recovery, and knowledge management and innovation. The presentation appears as **ANNEX 14.**

34. The Meeting discussed that the RCC-DHM is the implementing mechanism of the POA-ALD on DHM which focuses on strengthening the collaboration of AMS in enhancing national and regional capacities in DHM, and which is under the purview of ASEAN Health Cluster 2; the POA-ALD on DHM also outlines the terms of reference of the RCC-DHM. The Meeting agreed that the vision, mission and strategies of the proposed roadmap shall be aligned with this mandate.

35. The Meeting also agreed on the creation of a drafting group composed of RCC-DHM members which will develop the workplan to operationalize the POA-ALD on DHM, which includes proposed working relations with other bodies within the ASEAN Health Sector and non-health sectors. The Meeting further agreed that RCC-DHM members will communicate their interest to be part of the draft group to the RCC-DHM Secretariat by 8 February 2020, and the RCC-DHM Secretariat will draft a brief TOR to guide the work of the drafting group by the end of February 2020.

Action Line: RCC DHM Secretariat

3.3. Integration of EMT SOP to SASOP

36. The Meeting noted the presentation from the ARCH Project Team on the conduct and outcomes of the *Tabletop Exercise to Test the Draft Standard Operating Procedure for the Coordination of Emergency Medical Teams in ASEAN (EMT SOP)* that was conducted on 7-8 November 2019 in Jakarta, Indonesia. One of the steps for the integration of the EMT SOP to ASEAN SASOP, the ARCH Project Team also shared [a] the concerns raised during the exercise, the recommendations and ways forward, which have been considered in the updating of the EMT SOP, and [b] the next steps which includes the consultation with ACDM regarding the need for the testing of the EMT SOP in the ASEAN Regional Disaster Emergency Response Simulation Exercise (ARDEX) scheduled in June 2020 in Manila. The presentation and its relevant documents appear as **ANNEX 15.**

37. Malaysia sought clarification if the SOP on Medical Equipment will be included in the EMT SOP, particularly the list of equipment and supplies which can be lengthy and will possibly change from time to time. The Meeting noted the decision by the PGW 1 that the SOP on Medical Equipment will not be included in the EMT SOP, and further noted that the list of equipment will be an annex to the EMT Registration Form that will form part in the Offer of Assistance and/or Contractual Arrangements (ASEAN SASOP Forms) that will be completed by the Assisting Country.

38. The Meeting appreciated the progress made and noted the next steps for the inclusion EMT SOP into SASOP, and encouraged AMS to sustain active engagement and support to the integration of EMT SOP to ASEAN SASOP. The Meeting further agreed for the ARCH Project to continue to lead and to coordinate the process until its completion.

3.4. Collective Approach for AMS I-EMT

39. The Meeting noted the update from the ARCH Project Team on the progress of the ASEAN Collective Measures/Approach for AMS I-EMT which aims to address perceived logistics, legal and technical issues that affect AMS ability to deploy EMT which fulfill the WHO EMT minimum standards. The ARCH Project Team further reported that PWG 1 created a Sub-Working Group (SWG) to dedicate discussions on issues related to [a] customs compliance on all goods and materials for EMT operation, [b] waste management, [c] indemnity and malpractice, [c] logistic support, and [e] registration of medical practitioners to practice in affected countries, and to propose regional collective measures to address these issues.

40. The Meeting further noted that the SWG has already convened where, with the support of an external consultant contracted by the ARCH Project, the expected outputs with timeline of June 2020 were agreed. The Meeting also noted the presentation from the consultant on the interim report on the results of information collected from [a] a situation analysis of international guidelines; roles of assisting and receiving countries, and [b] detailed survey on five targeted components. The presentation appears as **ANNEX 16.**

41. The Meeting exchanged views and agreed on the following:
    a. The Meeting acknowledged the recent EMT certification of Thailand by WHO. In this connection, Thailand was requested and agreed to share their experience and lessons in addressing issued related medical malpractice and waste management, among others.

Action Line: Thailand

    b. Further to medical malpractice insurance and the possibility of Government-to-Government arrangements, the SWG will consult and seek guidance with WHO to ensure that all recommendations are consistent with and contribute to meeting WHO standards.

Action Line: ARCH Project Team/Sub-Working Group

    c. On the issue of temporary medical license for I-EMT deployed to affected countries in ASEAN region, the ASEAN Economic Community (AEC) has come up with Mutual Recognition Arrangement (MRA) under the stipulates that a foreign medical practitioner may apply for registration in the host country to be recognized as qualified to practice medicine in the host country in accordance with their Domestic Regulations and subject listed in the MRA for Medical Practitioners. The Meeting agreed that Thailand will raise this concern and seek guidance from the next ASEAN Joint Coordinating Committee on Medical Practitioners (AJCCM) which is scheduled to meet in March 2020.

Action Line: Thailand

    d. Considering that the MRA may be limited to medical practitioners and nurses, and taking into account that deployed EMT included other health professionals, the SWG was requested to consider other health specialization in exploring mechanisms for temporary registrations and permissions to practice in disaster and emergency settings.

Action Line: Sub-Working Group/ARCH Project Team

3.5. Regional Collaboration Drill (RCD)

42. The Meeting noted the update from the ARCH Project Team on the conduct of the Fifth RCD on 27-30 October 2020 in Mandalay, Myanmar. The Meeting further noted that the annual conduct of the RCD is one of the activities supported by the ARCH Project Extension Phase, as well as one of the regional targets in the POA-ALD on DHM. The presentation appears as **ANNEX 17.**

AGENDA 4: CAPACITY BUILDING, NETWORKING, AND REGIONAL COOPERATION

4.1. Academic/training systems and needs for capacity development on DHM in AMS

43. The Meeting noted the presentation from the JICA representative on the on-going study which aims to identify possible educational/trainings institutions capable of conducting domestic trainings programmes on DHM, training and competency needs for DHM personnel, and needs for external support in the conduct of domestic trainings; and to specify AMS educational/training institutes that can be members of the ASEAN academic/training centre network. The presentation shared the preliminary key results of the study through questionnaire, such as:

a. All countries which responded answered that they have training curricula, at least for medical doctors; and institutes have been identified to deliver trainings.
b. Training needs have been identified for each competency category, while need for training on overall management (DHM or response) had been observed
c. Multi-cultural issues in DHM education also requires special consideration, including multi-sectoral coordination and support
d. Selection of national focal points for the ASEAN Academic Network is seen to be critical to networking with multisectoral stakeholders in capacity development.

44. The Meeting further noted the details of the proposed field visits to Cambodia, Lao PDR, Myanmar and Viet Nam which was agreed by the PWG 2 to complement the questionnaire-based study. The proposed countries to be visited were identified based on the outcomes of the Survey on the Current Situation of

Disaster/Emergency Medicine System in the ASEAN Region (2014-2015), and which will be an opportunity to see the progress of DHM in these countries. The presentation appears as **ANNEX 18.**

45. The Meeting exchanged views and agreed on the following:
    a. Explore if the field visits can also be utilized for the sharing of national DHM systems to maximise learning;
    b. Explore if the field visits can be conducted in all AMS, as an opportunity to review national capacity guided by the results of the 2014-2015 Survey; and
    c. The survey reports be elevated to RCC-DHM, and subsequently to AHC 2 and SOMHD for consideration.

4.2. ASEAN Academic Network

46. The ARCH Project Team presented the proposed terms of reference (TOR) of the ASEAN Academic Network on DHM which aims to facilitate and support academic activities on DHM in ASEAN, both at regional and national levels, as well as support the achievement of relevant targets of the POA-ALD on DHM. The Meeting noted the proposed mandate and functions, structure and membership, as well as criteria for the selection of the institute that will serve as focal point of the network.

47. The ARCH Project Team also presented the proposed International Seminar on DHM, which aims to facilitate knowledge exchanges on disaster and emergency medicine, and which was scheduled to take place in early 2021. The Meeting noted that further arrangements will be discussed during the PWG 2 meeting in July 2020. The presentation appears as **ANNEX 19.**

48. The Meeting agreed to support the design and set-up of the Academic Network that will be coordinated by the ARCH Project Team, as well as on the organization of the International Seminar which the ARCH Project Team will serve as focal points for the organization.

AGENDA 5: SPECIAL SESSION: ASEAN WORK PLAN AND ARCH COLLABORATION

5.1. Draft ASEAN Workplan on DHM 2021-2025

49. The ARCH Project Team presented the draft of Workplan on DHM 2021-2025, which will form part of project activities under Health Priority 12 of the Work Programme 2021-2025 of ASEAN Health Cluster 2. The proposed Workplan aligns with the five priority areas of the POA-ALD on DHM and aims to contribute to the realization of the 19 of the 21 targets of the POA, and is also proposed to be considered for ARCH Project Phase 2 support.

50. The Meeting agreed that activities that contribute to realizing the 19 targets of the POA-ALD on DHM be proposed to JICA as part of ARCH Project Phase 2. In consideration of the creation of a drafting group for the development of an RCC-DHM roadmap for the POA-ALD on DHM, the Meeting further agreed to take the proposal of the ARCH Project into account. The presentation appears as **ANNEX 20.**

Action Line : RCC DHM Secretariat and ARCH project

5.2. ARCH Project Extension Phase and Future Cooperation

51. The Meeting noted the presentation from JICA regarding on-going discussions for continued cooperation in the further strengthening of regional DHM capacity through support in the ARCH Project Phase 2 covering October 2021 – March 2026. JICA representatives added that the sustained cooperation aims to secure the sustainability of DHM capacity which has been reinforced by the ALD on DHM, and now operationalized through the adoption of the POA and establishment of RCC-DHM.

52. The Meeting further noted that proposed next phase will mainly to support the implementation of the POA-ALD on DHM, particularly three of its five priority areas, and may focus on three outputs:
    a. Regional collaborative frameworks on Disaster Health Management are strengthened.
    b. Disaster Health Management frameworks/concepts are integrated into national and sub-national legal and regulatory framework in each AMS.
    c. Knowledge Management on DHM is enhanced.

53. The Meeting noted with appreciation the information from JICA on potential continuation of cooperation, and further noted the proposal for RCC-DHM as the coordinating platform to oversee the implementation of ARCH Project Phase 2. The presentations appear as **ANNEX 21.**

5.3. Possible collaboration with other programmes under the ASEAN Health Cooperation

54. The Meeting noted the presentation from ASEAN Secretariat on the Governance and Implementation Mechanism of the ASEAN Health Sector, and existing mechanisms and platforms for cooperation and response to all hazards and emerging threats. The Meeting also noted that ASEAN Health Sector cooperates with a range of partners, including sectors and bodies within ASEAN, UN agencies, dialogue partners and development partners.

55. The Meeting further noted on possible ways forward for RCC-DHM to coordinate with relevant initiatives within and outside the ASEAN Health Sector, taking into account that DHM, as well as other hazards and public health threats, requires a multi-sectoral approach and there is a need for the identification and establishment of appropriate coordination mechanisms. The presentation appears as **ANNEX 22.**

5.4. Other Matters

56. The Meeting noted and endorsed the reports of the 7th Meeting of PWG 2 conducted on 29 November 2019 (**ANNEX 23**) and the 9th Meeting of PWG1 on 21 January 2020 (**ANNEX 24**).

57. The Meeting also noted that the next meeting of RCC DHM will tentatively be held on the third week of August 2020 in Manila, back to back with the 6th Meeting of AHC 2.

WRAP-UP AND WAYS FORWARD

58. The Meeting reviewed and adopted the Summary of Agreements and Ways Forward, as presented by ASEAN Secretariat.

AGENDA ITEM	SUMMARY OF AGREEMENTS AND WAYS FORWARD
Agenda Item 1. Governance Issues	• Clarify the relationships between RCC DHM and ARCH Project working groups, and other bodies within the ASEAN Health Sector [This may be guided by the review of APHDA and GIM] • Proposed that projects under Health Priority 12/APHDA be under the supervision/oversight of RCC DHM
Agenda Item 2. Collaboration and Partnerships	• Explore ways to collaborate with relevant sectors and partners to maximise strengthening of disaster health management and ensure coordinated health response in ASEAN
Agenda Item 3. Strategic Movement	• Noted and expressed support to DHM initiatives under the ARCH Project, through Project Working Groups: - Integration of SOP for EMT to SASOP (PWG 1) - Collective approach of AMS I-EMT (PWG 1) - Regional Collaboration Drill (PWG 2) • Put in place mechanism to capture and share experiences of and lessons learned by ASEAN Member States in disaster health management • Create a drafting group composed of RCC DHM members to develop the workplan to operationalise the POA [including working relations with other bodies within the ASEAN Health Sector and non-health sectors] - Interested RCCDHM Members to communicate their interest to be part of the drafting group to RCCDHM Secretariat by 8 February 2020

AGENDA ITEM	SUMMARY OF AGREEMENTS AND WAYS FORWARD
	- RCCDHM Secretariat to draft brief TOR to guide the work of by end of February 2020 • AMS to sustain active engagement and support to the integration of EMT SOP to ASEAN SASOP; ARCH Project to lead and coordinate until completion of the process • Encouraged SWG on Collective Measures to consider other health specialisations in exploring mechanisms for temporary registrations and permissions to practise in disaster and emergency settings in affected countries
Agenda Item 4. Capacity Building, Networking and Regional Cooperation	• Noted and expressed support DHM initiatives under the ARCH Project, through Project Working Group 2: - Survey on potential needs for capacity development on DHM - Establishment of an ASEAN Academic Network • Endeavour that the field visits are opportunities for sharing of national DHM systems to maximise learning • Explore if the field visits on capacity development on DHM can conducted in all AMS, as an opportunity to review national capacity guided by results of the survey conducted in 2014-2015 supported by JICA • Recommended that survey reports be elevated to RCCDHM, and subsequently to AHC 2 and SOMHD for consideration • Agreed to support the design and setup of the academic network that will be coordinated by the ARCH Project • Agreed for PWG 2 Members/ARCH Project to be focal points for the organisation of international DHM conference
5. Special Session: RCC DHM and ARCH Collaboration	• Agreed that activities that contribute to realising the 19 targets of the POA/ALD on DHM (2019-2025) be proposed to JICA as part of ARCH Project Phase 2. RCCDHM will consider these in the development of workplan (POA) through the drafting group • Noted that the ASEAN Health Sector will develop collective measures and approaches to enable AMS to fulfil WHO EMT standards and will not create regional standards • Noted the potential continuation of cooperation with JICA through ARCH Project Phase 2 (October 2021-March 2026), and the role of RCCDHM as body to oversee the project
Others	• Noted and endorsed the reports of the 7th Meeting of PWG 2 conducted on 29 November 2019, and the 9th Meeting of PWG 1 on 21 January 2020 • Noted the next meeting of RCC DHM, tentatively on the third week of August 2020 in Manila, as back to back with the 6th Meeting of AHC 2 • Agreed that the draft meeting report will be circulated by RCCDHM Secretariat through ASEAN Secretariat for editorial inputs and/or endorsement by 30 January 2020 - 1st Meeting of RCC DHM participants to revert by 14 February 2020

ADOPTION OF THE MEETING REPORT

59. The Meeting adopted the Summary Report of the First Meeting of the Regional Coordination Committee on Disaster Health Management through ad referendum.

CLOSING

60. Dr Maw Maw Oo, Chair of the Meeting, delivered closing remarks. He expressed gratitude and appreciation to all delegates of ASEAN Member States, ARCH Project Team, ASEAN Secretariat and JICA for their valuable inputs and contribution to the success of the Meeting.

61. The Meeting was held in the traditional spirit of ASEAN solidarity and cordiality.

XXX

Future Cooperation

Overall Achievement of the ARCH Project

Recap from the RCC in December 2018...

1. Conclusion of the Evaluation of ARCH Project

- ✔ Most of the Activities have been implemented and the Outputs have been almost achieved as planned.
- ✔ ***If the POA to implement the ALD is approved and the RCC & AIDHM to operationalize the POA start up, the Impact and Sustainability for the ARCH could be ensured further.***
- ✔ On the other hand, it is necessary to continue testing the products thorough the ARCH such as the collaboration tools or the RCD whether those can be functional and effectively applied to an actual disaster.
- ✔ ***It is also necessary to improve the capacities on DHM in each AMS and to consider the regional collective measures in order to complement the incomplete capacities of AMS until each AMS could fulfill capabilities necessary for the disaster medical response.***

Overall Achievement of the ARCH Project

Recap from the RCC in December 2018...

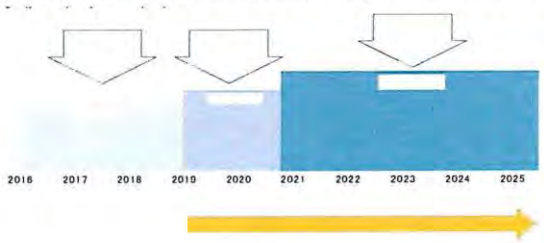
2. Recommendation

- ✔ It is recommended that the ARCH Project should extend the cooperation period ***until the POA is approved and the main Mechanism of the POA (RCC & AIDHM) can start and get its actual activities on track so that the ARCH could ensure the Impact and Sustainability***.
- ✔ It is recommended that continuous testing for the tools and study on the capacity development needs in each AMS should be conducted and the regional approach to complement the capabilities of ASEAN-EMT should be discussed during the extension period.

Further Challenges

- ▯ How to secure the **sustainability** for the activities such as RCC, regional drill(RCD) or training programs
- ▯ In this regard, the POA for the ALD on DHM and the RCC to operationalize the POA are very important.

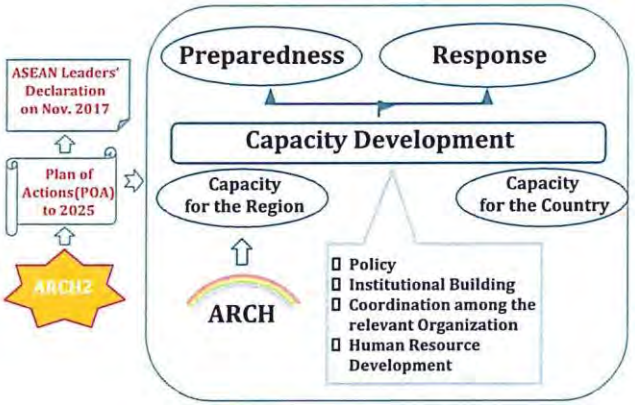
Steps to ASEAN Collaboration Mechanism on DHM



Rationale and key issues for further cooperation

- ✔ Contribution to the ASEAN collective approach
- ✔ Ensure coherence and consider the contribution to the ALD and POA
- ✔ Ensure the sustainability of the regional cooperation in the long term
- ✔ Ownership and active contribution from the member countries as mentioned in the TOR of the RCC

Overall Purpose of the ARCH and Post-ARCH



Academic/Training Systems and Needs for Capacity Development on DHM in AMS

Regional Coordination Committee on DHM

January 23rd, 2020

Objectives of Study

1) To identify **possible educational/training institutes** which are capable to conduct domestic training programs on DHM in each AMS
2) To identify **training/competency needs** of personnel in DHM
3) To identify **needs for external supports** in case that the above institutes will organize domestic training programs on DHM
4) To specify AMS educational/training institutes which will be **members of ASEAN academic/training centers network** on DHM whose purpose is to strengthen regional and domestic capacities on DHM in collaboration with ASEAN reginal disaster training center which is considered to be established in the POA on DHM

Progress of Study

Sep. 2019
(Start)

Curriculum

Bilateral Meeting (Japan&Thailand) → PWG2 (Nov.2019) → RCCDHM → ・CD survey in CLMV (Feb, Mar) → ・PWG2

Questionnaire Survey on 10 AMS countries

●PWG2
- Confirmed the detail of the Field Survey in CLMV
- Shared the result of Questionnaire Survey

Presentation Outline

- Results of the *Questionnaire* survey (6 categories) *revised
- Detail of Field Survey in CLMV
- Questions and Comments

Results of the *Questionnaire* survey (6 categories) *revised

Results of the *Questionnaire* survey (6 categories) Questions*revised

1. Current **medical education system** in each AMS
2. Educational institutes providing **emergency medicine program**
3. Current **education and training** for disaster health management (DHM) for EMT members including medical personnel
4. Education and training **needs for DHM/Needs for external supports**
5. Potential **core educational institute(s)** to develop curriculum and conduct training courses for DHM in each AMS
6. Others: Special attention to **multicultural setting**

Q1: Current **medical education system**

Questions

1.1 Steps to become a Doctor/Nurse

1.2 Agency/organization managing ambulance services

1.3 Ambulance Member

1.4 Ambulance Crew Training

1.5 # of Educational Institutes (doctors/nurse/related occupation)

1.6 License

National Exam for License

Q2: Educational institutes providing **emergency medicine** program

Questions

2.1 Availability of training curriculum for Emergency Medicine (Doctor/Nurse)

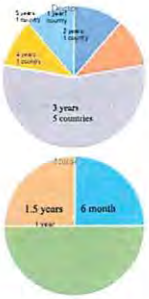
2.2 Training Institute

2.3 Training Period

2.4 Training Certificate

2.5 Challenges in emergency medicine education

2.6 Other educational qualification for competency on Disaster Health Management



Training period for Emergency Medicine

Q3: Current **education and training** for disaster health management (DHM) for EMT members

Questions

3.1 Training Program available for medical personnel

3.2 Training Institute/Organizer

3.3 Training period

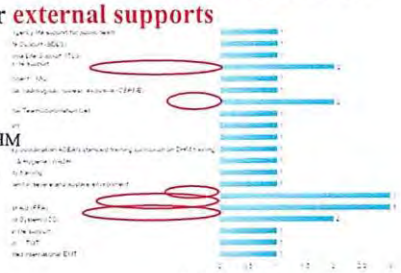
3.4 Training frequency

Q4: Education and training needs for DHM/Needs for **external supports**

Questions

4.1 Training needs for DHM

4.2 Support needed from Curriculum Committee



Training needs for DHM

Q5: Potential **core educational institute(s)** to develop curriculum and conduct training courses for DHM in each AMS

Questions

5.1 Leading institute for training & networking in ASEAN

5.2 Reason for 5.1

5.3 Academic society/NGO that provide DHM training

Country	Potential core institute	Reason
Brunei	University or Institute	
Indonesia	University of Gadjah Mada	- They have curriculum and conduct trainings for disaster health for undergraduate and postgraduate program. - Involved in ARCH (PWG, RCC, 4th RCD)
Malaysia	Hospital Serdang	Coordinates the nationwide training under MOH
Myanmar	Emergency Medical Service Training Center (NAY PYI TAW)	That is the only training center
Phillipines	DOH led by the Health Human Resource Development Bureau and HEMB in collaboration with other training providers	HEMB is mandated to conduct competency training in relation to Disaster Health Management / Disaster Risk Reduction Management in Health

Q6: Special attention to **multicultural setting in DHM training**

Questions

6.1 Special consideration to multicultural issues in DHM

6.2 Example for 6.1

6.3 Topics to be included in multicultural issues in DHM

6.4 Challenges in DHM education

	Yes	No
6.1	3 countries	6 countries
6.2	Culture, Gender, Multiracial	-
6.3	-	Culture, Religion, Laws/Regulation, Elderly, Minor Ethnic

Summary

1. Possible educational/training institutes

→ through Q2, All countries which responded the questionnaire answered that they have training curriculum at least for doctor. Besides, the institutes are identified.

2. Training/competency needs & 3. Needs for external supports

→In general, training needs are identified for each category

(e.g. coordination mechanism, team management, personal capacity development of EMT members)

- Needs are also stronger for the overall management of the training at the ASEAN level (e.g. standardization of curriculum, tools) than strengthening specific clinical skills/knowledge.
- Needs are identified. Further consideration will be required for "training to whom" (e.g. Logistics)
- Special consideration should be given to multicultural issues in DHM education.

Summary (cont'd)

4. members of ASEAN academic/training centers networking

→Through Q5, the institutes which have the potential to be core are identified.

5. Others

- Training program of some issues are implemented by non-health, non-government stakeholders. We need multisectoral coordination and support and resources would be from private sector, CSO as well as government (MOH) in order to make DHM more effective and practical.
- Special consideration should be given to the selection of national focal point(s) for ASEAN academic network. The role of national focal point will be very important in networking with multisectoral stakeholders in capacity development in DHM.

Detail of Field Survey in CLMV

Why CLMV?

- Previous survey (2014): Stronger needs for strengthening the capacity for Emergency Medicine

Why CLMV? (cont'd)

Reference: **Disaster Health Management in AMS (prior study)**

	Indonesia	Philippines	Thailand	Cambodia	Laos	Myanma	Vietnam	Brunei	Malaysia	Singapore

Why CLMV? (cont'd)

- Previous survey (2014): Stronger needs for strengthening the capacity for Emergency Medicine
- Progress in DHM in AMS since ARCH started in 2016 especially in CLMV (e.g. Vietnam: hosting a drill, Myanmar: DHM training)
  - ➡Need to understand the current training needs for planning standard training curriculum/Regional Training Institute.
  - ➡Need to understand the **current situation** properly on the **progress and efforts in DHM**
- Follow-up the questionnaire survey to identify a potential core institute for Academic network in ASEAN/training needs in DHM

Interviewees (Plan)

Country	MOH + Potential core institute(s)	Other Candidates
Cambodia	MOH - Disaster Management and Environmental Health Bureau, Preventive Medicine Dept. - ASEAN Bureau, Dept. of International Cooperation (DIC)	・Calmette Hospital ・National Center for Disaster Management (NCDM) ・Cambodia Red Cross
Lao PDR	MOH Cabinet office, Dept. of Health Care	・Mittarphab Hospital (Emergency Department) ・University of Health Science ・Lao Red Cross

Interviewees (Plan)

Country	MOH + Potential core institute(s)	Other Candidates
Myanmar	• Ministry of Health and Sports (Dr.HtUN TIN) • Emergency Medical Service Training Center (NAY PYI TAW)	・North Okkalapa General Hospital and teaching Hospital. Yangon ・University of Medicine 1, Yangon ・Myanmar Medical Association (MMA), emergency medicine society
Vietnam	・MOH, Department of planning and finance Management, Department of Adiminsitration ・National Burn Hospital (Department of Disaster medicine)	・Hanoi University of Public Health (HUPH) ・Vietnam Red Cross

Proposed Schedule

Lao PDR &Cambodia

Feb.11th (Tue) – 19th (Wed)

Day 0 (Tue) Feb.11th	Day1 (Wed) 12th	Day2 (Thur) 13th	Day3 (Fri) 14th	Day4 (Sat) 15th	Day5 (Sun) 16th	Day6 (Mon) 17th	Day7 (Tue) 18th	Day 8 (Wed) 19th
Arrival Lao PDR	MOH, Medical Univ. Training institute, etc.,			After Survey meeting	Move to Cambodia Internal Meeting	MOH, Medical Univ. Training institute, etc.,		Late PM: Leaving for home country

Proposed Schedule

Myanmar(Yangon & Naypyidaw) & Vietnam

Mar. 3rd (Tue) – 11th (Wed)

Day 0 (Tue) Mar.3rd	Day1 (Wed) 4th	Day2 (Thur) 5th	Day3 (Fri) 6th	Day4 (Sat) 7th	Day5 (Sun) 8th	Day6 (Mon) 9th	Day7 (Tue) 10th	Day 8 (Wed) 11th
Arrival Yangon	MOH, Medical Univ. Training institute, etc.,			Move to Vietnam Internal Meeting		MOH, Medical Univ. Training institute, etc.,		Late PM: Leaving for home country

Survey Team Member

Team Member : Thailand & Japan +

Field Survey in	Participating countries		
Laos/Cambodia(Feb.)	Brunei	Malaysia	Singapore
Myanmar/Viet Nam(Mar.)	Indonesia	Philippine	

Interview items

MOH	1.Country Policy	2.Budget	3.Educational Institute	4.Training Needs	5.External Support so on.
Hospital	1.Basic Info	2.Training Needs	3.External Support	4.Educational Institute	so on.
Educational	1.Basic Info	2.Training Curriculum	3.Current Training Program	4.SWOT analysis	so on.
NGO, etc	1.Training Program	2.Target of Support	3.Challenges in the country	4.Future plan	so on.

Methodology

- Key Informant Interview
- FGD (SWOT analysis)

Question and Comments

Thank you

CONCEPT OF ARCH PROJECT PHASE 2

By: Shuichi IKEDA
Chief Advisor of ARCH Project

JANUARY 2020

Duration

- OCTOBER 2021 TO MARCH 2026

March 2026

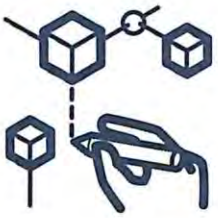
OCT 2021

Basic Policy

- ARCH Project Phase 2 will support to implement POA for ALD (~2025)

Project Framework

- ✔ Overall Goal
- ✔ Project Purpose
- ✔ Outputs
- ✔ Activities



Project Framework

Overall Goal of the ARCH Phase 2 should be the same of the Goal of POA.

"Disaster resilient health system is established in the ASEAN community."

Project Framework

Project Purpose "Regional capacity on disaster health management is strengthened in ASEAN."

Project Framework

Three (3) **Outputs** should be selected among five (5) Priority Areas of POA.

- **Output 1** Regional collaborative frameworks on disaster health management are strengthened. *(Follow the Priority Area 1 of the POA)*
- **Output 2** Disaster health management frameworks/concepts are integrated into national and sub-national legal and regulatory framework in each AMS. *(Follow the Priority Area 3 of the POA)*
- **Output 3** Knowledge management on disaster health management is enhanced. *(Follow the Priority Area 5 of the POA)*

Project Framework

- **Activities** of the ARCH Phase 2 should conduct activities which could contribute to the eighteen (18) Targets (12 targets at the regional level & 6 targets at the national level) among the twenty one (21) Targets of the POA.

- Output1 Five (5) Activities
- Output2 Three (3) Activities
- Output3 Eight (8) Activities

Project Implementation

- Discussion and Coordination among AMS and other Stakeholder

RCCDHM established under the Health Cluster 2 should be regarded as a main coordinating platform to oversee of the implementation of the phase 2.

In addition, Project Working Groups (PWG) shall be established for the smooth implementation of the Project as follows;

- PWG-RC "Regional collaboration frameworks and regional cooperation" (responsible for Output 1 & 2)
- PWG-KM "Knowledge Management" (responsible for Output 3)

ARCH

Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management

THANK YOU!

Concept Note

for Development of ASEAN DHM Academic network

RCC DHM Secretariat

Background

- ASEAN prone to natural disaster
- ASEAN capacity to disaster management –
  : ACDM, AHA Center
- DHM situation was not well-defined, identified potential gap and level of preparedness within each Member States,
- Starting with the 12th health priority of ASEAN Post 2015 Health Development Agenda 2016-2020, followed by ASEAN-JICA Regional Conference on DHM x 3 meetings, then ARCH project was established and function.
- ALD DHM
- POA and establishment of RCC-DHM

Target of POA : Regional targets

11. A network of national academic institutions is established to organize training activities at national level.

12. A Regional Conference on Disaster Health Management is organized every two years.

13. At least one joint research is proposed and conducted in a year.

14.An ASEAN Journal/E-Bulletin of Disaster Health Management is established and published twice a year.

National target :

5.Each ASEAN member state has a disaster health training system responsible for the implementation of capacity development, knowledge management, research and development initiatives in collaboration with other designated training centers of AMS and with relevant academic networks, as appropriate.

Objective

1. To identify gap and potential need within ASEAN health cooperation on Disaster Health Management, including national academic and technical capacity both public and private.
2. To propose structural and functional models and institutional options to enhance and sustain academic and technical capacity in order to support ASEAN and National DHM function.
3. To promote strong collaboration with development partners, NGO and faith-based organization in technical area of DHM

Points to be cosideration

1. **Proposed structural model**
   a. Structure of network
   b. Academic network and coordination with RCC-DHM
   c. Financial model of the network
2. **Proposed functions and activities**
   - Providing training activities, training curriculum and material supply.
   - regional conference and technical meetings on DHM
   - producing publication on DHM
   - Conduct research and technical consultations.

Academic Network and **International seminar** on DHM

Dr. Phumin Silapunt
Thai project team (ARCH Project)

TOR of ASEAN Academic network on DHM

Dr.Phumin Silapunt
ARCH project team
Thailand

Objective

- To Facilitate and support academic activities on DHM in ASEAN both regional and national level.

Mandate and functions

- Promote and support training activities by mobilize resource persons or provide training curriculum and material as requested by a member state.
- Organize regional conference on DHM every 2 years
- Establishment ASEAN Journal/E-Bulletin on DHM and published twice a year
- Conduct joint research
- conduct consultations in supporting and assisting the development and implementation of disaster health management activities.

Structure and membership

- Each member state shall assign at least 1 institute to be national focal point member of the academic network
- All national focal point will be coordinated and facilitated by secretariat of RCCDHM.
- Members of the network are not limit to only 1 institute from each AMS and also open for non-ASEAN institute.

Selection criteria for institute to be the National focal point member of the academic network

- The institute shall have capability to take roles and responsibilities as follow:
  - Collaborate with the academic network and other designated training centers of AMS
  - Facilitate or organize training activities at national level.
  - Participate and promote Regional conference on DHM to related local institutes
  - Participate in joint research, as appropriate
  - Participate in Establishment ASEAN Journal/E-Bulletin on DHM, as appropriate
  - Translate regional collaboration tools or learning material to local language, as appropriate

International seminar on DHM

Objectives

- To exchange knowledge on Disaster and Emergency medicine

Participants

- 3-5 representatives from each AMS
- Japanese Advisory Committee
- Any Emergency/Disaster enthusiasts(Any nationalities)
- Speakers from other countries, other than ASEAN

Duration

- 3 days: January-March 2020

International Seminar on DHM

(Draft) Content and format of the event

- 3 presentations a country: 10 mins to presents and 5 mins Q&A
- 3 Special lecture (eg.AHA,ASEC ,WHO or non-ASEAN speakers)
- Workshop
- City tour / Study visit

Drafted agenda

	Morning session	Afternoon session
Day 1	Registration/Opening Ceremony/ 3 Special lectures	Workshop
Day2	1 presentation a country of AMS/Japan = 165 mins. (Round 1)	1 presentation a country of AMS/Japan = 165 mins. (Round 2)
Day 3	1 presentation a country of AMS/Japan = 165 mins. (Round 3)	City tour or Study visit

Point for consideration

- Coordinating body of the network
  - Apart of Coordination,This body should be responsible for establishment of E-Learning,E-bulletin,Joint research,etc.
  - Source of financial support

Suggestion

- ARCH project team will be coordinating body for the first stage while RCCDHM design and setup the appropriate body
- Issue of the coordinating body will be discussed in Next pwg2 meeting and present to next RCCDHM meeting in the Phillipines.
- Members of RCCDHM(2nd appointed representative) will be focal point for organizing the seminars next years.

Roadmap for the ASEAN Health Cooperation's contribution to the realization of One ASEAN One Response

RCC DHM Secretariat

Session Objectives

1.ASEAN vision on Disaster Management

2.Review the relevant frameworks on Disaster Management

3.Proposal for RCC DHM Strategic movement

4.Consideration and the way forward

ASEAN vision 2025 on Disaster Management

- Endorsed by 27th ACDM Meeting and adopted by the 3rd AMMDM
- Maps the broad direction and policy guidance on implementing AADMER in the next 10 years in particular, it outlines 3 strategic elements, that ASEAN would need to address in order to position itself as a global leader in Disaster Management
  - Institutionalization and Communications
  - Partnerships and Innovation
  - Finance and Resource Mobilization

Relevant frameworks on Disaster Management

Sendai Framework for Disaster Risk Reduction 2015 - 2030

Priorities for Action

Priority 1 : Understand Disaster Risk

Priority 2 : Strengthening Disaster Risk governance to manage disaster risk

Priority 3 : Investing in disaster risk reduction for resilience

Priority 4 : Enhancing disaster preparedness for effective response, and to "Build Back Better" in recovery, rehabilitation and reconstruction

The ASEAN Agreement on Disaster Management and Emergency Response (AADMER) 2016 - 2020

Priority Programme 1 : Aware
Priority Programme 2 : Build Safety
Priority Programme 3 : Advance
Priority Programme 4 : Protect
Priority Programme 5 : Response as one
Priority Programme 6 : Equip
Priority Programme 7 : Recover
Priority Programme 8 : Lead

PLAN OF ACTION TO IMPLEMENT THE ASEAN LEADERS' DECLARATION ON DISASTER HEALTH MANAGEMENT (2019-2025)

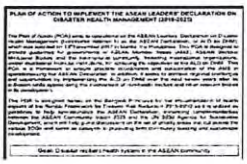
Priority 1 : Strengthening & Enhancing of regional collaborative frameworks on DHM

Priority 2 : Multi-sectoral participation in DHM

Priority 3 : 3.Promote the integration of DHM framework/concepts into national and sub-national legal and regulatory framework

Priority 4 : Promotion of investment to develop and improve critical health facilities and Infrastructure at national level

Priority 5 : Knowledge management on DHM



Relavant Framework and Priority Programme

Sendai Framework Priorities for Action	AADMER Priority programme	POA to ALD on DHM Priority area	Regional targets	National targets
Priority 1 Understand Disaster Risk	Priority 1 Aware (Risk Aware ASEAN Community) Priority 4 Protect(Protecting Economic and Social Gains of ASEAN Community integration through Risk Transfer and Social Protection)	Priority 1 : Strengthening and enhancing of the regional collaborative frameworks on DHM Priority 5 Knowledge management on DHM	Curriculum of Bangkok principles for implementation of the health aspects of the Sendai Framework	
Priority 2 Strengthening Disaster Risk governance to manage disaster risk	Priority 5 Respond as ONE (Transforming Mechanisms for ASEAN's Leadership in Response) Priority 6 EQUIP (Enhanced Capacities for One ASEAN One Response) Priority 8 LEAD (ASEAN Leadership for Excellence and Innovation in Disaster Management)	Priority 1 : Strengthening and enhancing of the regional collaborative frameworks on DHM Priority 2 Multi-sectoral participation in DHM Priority 3 Integration of DHM framework/concepts into National/sub-national legal and regulatory framework		Integration DHM framework into national/sub-national legal & regulatory framework
Priority 3 Investing in disaster risk reduction for resilience	Priority 3 AdvanceA disaster resilient and climate adaptive ASEAN community) Priority 2 Build Safely (Building Safe ASEAN Infrastructures and Essential Services) Priority 7 Recover (ASEAN Resilient Recover)	Priority 4 Promote investment to improve and develop critical health facilities and infrastructure at national level		DHM concept introduced in health education Safe hospital projects and program
Priority 4 Enhancing disaster preparedness for effective response, and to "Build Back Better" in recovery, rehabilitation and reconstruction	Priority 2 Build Safely (Building Safe ASEAN Infrastructures and Essential Services) Priority 7 Recover (ASEAN Resilient Recovery)	Priority 2 Multi-sectoral participation in DHM Priority 5 Knowledge management on DHM	- SOP for coordinating - SOP for Civil-military EMT Operation Database of EMT - Standard reporting form : MDS - ASEAN Standard of HEMTs -ASEAN Disaster Drill -Standard Training Curriculum for EMT, EMTCC -Website of ADHM, e-learning -Network of academic institutions -Regional Conference on DHM -Co-conducting Research -ASEAN journal/E-Bulletin	- Each AMS has at least 3 HEMT -EMTCC established -National SOP for EMT coordination -Standard reporting system -Each AMS : Disaster Health Training Center -Training course of Hospital Preparedness for Emergencies

Vision of ASEAN Disaster Management

1.ASEAN Leader Declaration on One ASEAN One Response

2.Goal of POA TO IMPLEMENT THE ASEAN LEADERS' DECLARATION ON DISASTER HEALTH MANAGEMENT (2019-2025)

- Disaster Resilient Health System in ASEAN Community

Proposal for RCC DHM Strategic movement

Vision : ASEAN as a Global Leader in Disaster Health Management ?

Mission : 1.DHM One ASEAN One Response

2.Disaster Resilient Health System in ASEAN Community

Strategies	Governance & policy	Prevention & Disaster Risk Reduction	Preparedness & Response	Recovery	KM and Innovation
Goal	Good Governance in DHM, Coordination & Collaboration all phase of disaster.	- ASEAN communities' engagement in Health literacy on DHM - Culture of preparedness - Safe Hospital project	Timely, Lean and Seamless response, standard medical practice	Swift recovery with sufficient resources - Health - Mental health - Environmental health - Health facilities	ASEAN as a global leader and center for excellence and innovations in Disaster Health Management
Key Strategic Outcome					
Priorities?	?	?	?	?	?

Consideration and the way forward

1. Vision, 5 strategies, Key Strategic Outcome and Timeline ?

2. How to achieve Vision, 5 strategies, Key Strategic Outcome, Timeline ? and the way forward ?
   - Working group ?

Progression note : Integration of SOP to SASOP

Session Overview

- ASEAN EMT Coordination SOP
- Table Top exercise at AHA Center
  - Scenario
  - Matrix of concerns/recommendation
  - Next steps

ASEAN-EMT Coordination SOP

The ASEAN-EMT SOP through ARCH project

- **SOPs for ASEAN-EMT coordination** with 4 regional collaboration tools were developed and **tested** through **4 Regional Collaboration Drills**
- **Table Top Exercise at AHA Centre 7th-8th November 2019**

Standard Operating Procedure (SOP)
for Coordination of Emergency Medical Teams (EMTs) in ASEAN
(Working Title)

Document Status: Draft for Circulation
Version: 2
Date: 19 April 2019

Please submit your feedbacks via email

To: Dr Alisa Yanasan
Ms Dangfun Promkhum

Table of Contents:

List of Acronyms & Abbreviations
I. Introduction
II. Institutions
III. Disaster Preparedness
A. National Focal Units for Emergency Medical Team (EMT) Coordination
B. Inventory of Emergency Medical Team (EMT) Assets and Capacities

ASEAN-EMT coordination SOP

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C. Emergency Medical Team (EMT) Capacity Building and Strengthening
IV. Emergency Response
A. Request for Assistance/Offer of Assistance and Registration of EMTs
B. Mobilization of Emergency Medical Teams (EMTs)
C. On-Site Operations of Emergency Medical Teams (EMTs)
D. (Rapid) Health Needs Assessment
E. Direction and Coordination of Assistance
F. Periodic Reporting/Daily Report
G. Demobilization of Assistance
H. Reporting (Handover and Exit Phase)
I. Review of Operations, Experiences and Lessons Learnt (Post-deactivation Phase)
V. Review
VI. Annexes

The Scope of ASEAN-EMT SOP

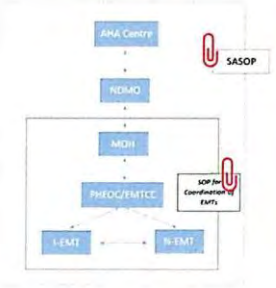

Table Top Exercise to test EMT SOP

AHA Centre
Jakarta, Indonesia

Concept not of TTX for coordination EMTs in ASEAN

- **Background**
- The AHA Centre shall be established for the purpose of facilitating cooperation and coordination among the Parties, and with relevant United Nations and international organisations, in promoting regional collaboration as per ASEAN Agreement on Disaster Management and Emergency Response (AADMER) signed by ASEAN Minister of Foreign Affairs on 26 July 2005 in Vientiane, Lao PDR.
- In an effort to operationalise the One ASEAN One Response vision, the ASEAN Committee on Disaster Management (ACDM) endorsed the ASEAN Joint Disaster Response Plan (AJDRP) at the 29th Meeting of the ACDM in October 2016 in Manado, Indonesia. The AJDRP serves as a framework for strengthening regional collective

- Through the ARCH Project, the draft of Standard Operating Procedure for Coordination of Emergency Medical Team in ASEAN (ASEAN EMT SOP) is developed with aims to ensure the quality and consistency of EMT operations in the affected country, and to complement the operating procedures and protocols developed by the international community, the East Asia region, and the ASEAN region. The ASEAN EMT SOP will contribute to the AJDRP by filling the gaps in the expertise required. This also to acknowledge the contribution from the health sector as part of the One ASEAN One Response.
- As per above, the AHA Centre proposed to conduct a Tabletop Exercise (TTX) to resolve issues pertaining to the EMT SOP and to achieve common understanding from disaster management sector and health sector. This event may provide opportunity to explore the inclusion of the draft EMT SOP into Standard Operating Procedure for Regional Standby Arrangements and Coordination of Joint Disaster Relief and Emergency Response

- Enhance collaboration between disaster management and health sectors in the area of disaster management to ensure ASEAN's collective response.
- Explore integration and operationalisation of the proposed draft EMT SOP as per of SASOP and AJDRP.

Table Top Exercise

Date : 7 – 8 November 2019
Place : Jakarta, Indonesia

Participants/Players :

- ASEAN Member States (NDMO and Ministry of Health)
- ASEAN Center of Military Medicine (ACMM)
- AHA Centre
- ASEAN Secretariat (HD, DMHA, SCD 2)

Scenario

- Sunda Megathrust (scenario of ARDEX-18)

Objective

- To include JOCCA in the SOP and to be tested in the TTX
- To include Public Health issues
- To test interoperability with ACMM and AMRG

Point of discussion/comments

Concerns raised	Recommendations and way forward
Cost of deployments, expense of EMTs from assisting country	Agreement • EMT should be self sufficient
Health Sector disaster information sharing	Agreement • ASEAN EOC network to subscribe AHA center information sharing product • Web EOC requires training and passwords • NDMO is a single contact point • Executive briefing by AHA center
EMT registration form	Agreement • EMT registration form should be attached to the offer of assistance or contractual agreement form

Concerns raised	Discussion
EMT medical equipment	Agreement • Include the list as an annex in the EMT SOP • Affected AMS will only receive one form (contractual arrangement) which will be as detailed as possible including EMT registration forms as annex
EMT development/management	Agreement • Development should build toward WHO classification • Development/management depend on each country • RCC DHM and ARCH project can support

Concerns raised	Recommendation
RDC Management	Agreement • Further review the EMT SOP if there is a missing component related to RDC management
Field Multi-sectoral Coordination	Agreement • Include JOCCA and EMTCC at the local level in the EMT SOP
Pre-agreed arrangement	AMS are moving towards nationally led responses, regional response is primarily aimed to reinforce national response Agreement • Requires further discussion

Concerns raised	Recommendation
Code of conduct for EMT deployment	Agreement • General code of conduct in line with socio cultural context of country • WHO EMT minimum standard : EMT must sign code of conduct to work oversea
SG-AHAC (The Secretary General as the ASEAN Humanitarian Assistance Coordinator)	Agreement • Role of SG-AHAC is bigger than EMT SOP, if there is any challenges faced by EMTs, the SG –AHAC can be tapped on political push
Role of WHO and Health partners	Agreement • Discuss with WHO/ future collaboration

Minor revision of SOP

- Adding JOCCA into the institutions
- Adding Public Health Service into EMT operations
- The NDMO of assisting countries will include EMT RegistrationForm in the submission of SASOP Forms : Offer of Assistance and contractual Arrangement

Next Steps

Tabletop Exercise to Test the Draft Standard Operating Procedures for the Coordination of Emergency Medical Teams in ASEAN
7-8 November 2019, Jakarta, Indonesia

Next Steps

Action	Timeline (by)
1. ARCH Project Team, AHA Centre and ASEAN Secretariat to revise draft EMT SOP based on recommendations from the TTX	December 2019
2. Consultation with TTX participants for inputs/feedback and/or endorsement of revised draft EMT SOP	January 2020
3. Consultation with ASEAN Health Cluster 2 Country Coordinators, and ACDM Working Group on Preparedness and Response for inputs/feedback and/or endorsement of revised EMT SOP (for testing)	February 2020
4. Consultation with ACDM regarding: [a] need for testing of EMT SOP in ARDEX 2020; and [b] form which EMT SOP will be integrated with ASEAN SASOP	March 2020
5. If testing in ARDEX not needed, consultation with SOMHD and ACDM for inputs/feedback and/or endorsement of revised EMT SOP [integration into SASOP may be deferred after ARDEX?]	**March 2020**
6. If testing needed, inclusion of EMT SOP in ARDEX 2020	June 2020
7. If no further changes proposed after ARDEX 2020, consultation with SOMHD and ACDM for inputs and/or endorsement a. Integration of EMT SOP to ASEAN SASOP, according to guidance by ACDM	July 2020 **August 2020**
8. If there further changed after ARDEX, the following are the indicative next steps a. ARCH Project Team, AHA Center and ASEAN Secretariat to revise EMT SOP accordingly b. Final consultation with AHC2CC and ACDM WG P&R for inputs and/or endorsement c. Final consultation with SOMHD and ACDM for inputs and/or endorsement d. Integration of EMT SOP to ASEAN SASOP, according to guidance by ACDM	 July 2020 August 2020 September 2020 October 2020

Thank you

1st Meeting of Regional Coordination Committee on Disaster Health Management

OUTPUT 2: FRAMEWORK OF REGIONAL COLLABORATION PRACTICES IS DEVELOPED

- **Regional Collaboration Drill**

OUTPUT 2: FRAMEWORK OF REGIONAL COLLABORATION PRACTICES IS DEVELOPED

Event	**1st Mentors Visit for 4th RCD**
Dates	3 -5 April 2019
Place/Venue	Bali, Indonesia
Participants	Mentors/ARCH Project; Thailand: Dr. Phumin Silapunt, Dr. Prakit Sarathep, Ms. Sansana Limpaporn Philippines: Dr. Alfonso Danac, Ms. Janice Palad Feliciano Japan: Dr.T. Kai, Mr. Takada, Mr. T. Katsube and S.Ikeda Indonesia Preparation Team Mr. Agus Hendroyono, Dr. Ina Agustina, Mr. Adithya Raja Manggala, Ms. Febri Endah Lestari, Representatives from Health Office of Bali Province, Health Office of Karangasem District, Gadja Mada Univ., WHO Indonesia
Agenda/Schedule	April 3 Arrival at Bali, Indonesia April 4 AM Meeting with Indonesia Preparation Team PM RCD Field site visit and visit of candidates of Hotel venues (Prime Plaza Hotel and Suites and Grand Inna Bali Beach) April 5 Meeting with Indonesia Preparation Team
Summary of Discussion	- The meeting confirmed that 'Comprehensive Team Information' of all AMS should be introduced to the RCD. - The meeting decided that Quality Assurance Visit should be included in the RCD. - The meeting decided that Pre-deployment procedures should be tested prior to arrival of the participants of the RCD in Bali. - The meeting confirmed the scenario for the RCD which is by a Volcano Eruption of Mt. Agung. - The meeting decided the actual exercise field will be conducted in Tanah-Ampo Harbor. - The meeting discussed whether ASEAM Joint team proposed by Indonesia team could be tested in the RCD. - The meeting discussed about selection of the hotel venue.

Event	**2nd Mentor Visit for 4th RCD**
Dates	13 -16 May 2019
Place/Venue	Jakarta and Bali, Indonesia
Participants	23 Participants from ARCH Project, Thai Taskforce, JAC and Indonesia
Agenda	13 May Arrival to Jakarta, Indonesia 14 May Preparatory meeting with Indonesia's MOH 15 May Arrival to Bali, Indonesia and inspection the at Grand Inna Bali Beach
Summary of Discussion	- The discussion of the meeting with MOH Indonesia was divided into four topics, overall program activity, composite team arrangement, gap analysis of preparation activities and cost sharing. - The arrangement of composite EMT, the MOH decided to choose the scenario which, during the drills exercise, one member of the AMS – EMT will join the composite team as an international NGO member/individual (incomplete team) in order to build a new complete team - On 15th May, ARCH Project team, JICA Indonesia and staffs from MOH had the venue inspection at Grand Inna, Bali. - The team had discussed with the hotel representative about the hotel contracts, meeting package, meeting arrangement, catering, etc., and inspected the accommodation, conference rooms and open spaces for outdoor activities. - ARCH Project team and Indonesia's MOH have agreed to setup the next preparatory visit during August 5 – 7, with the purpose of following up the preparation activities.
Attachments	- Minute of Meeting

Minutes of Meeting
Preparatory Meeting of the 4th RCD
15 May 2019 | Jakarta, Indonesia

1. Overall Information of the 4th RCD

- The meeting noted that the 4th Regional Collaboration Drill will be conducted during 25 – 28 November 2019 and followed by the 7th Meeting of Project Working Group 2 on 29 November. Both events will be taken place at Grand Inna Bali Beach, Bali Province, Indonesia

- The MOH had introduced the Indonesia Committee, which highlighted on the following;

a. Chairman: Mr. Agus Hendroyono
b. Administration, Finance and Logistics Division: Dr. Yudhi Pramono
  - 2 sections;
    - Administration & Finance Section: Setiorini
    - Logistics Section: Ery Gunawan
  - Responsible for correspondence, budget planning, managing accommodation & finance, preparing logistics for meetings and simulation

c. Capacity Building and Operation Division: Dr. Rita Djupuri
  - 2 sections;
    - Capacity Building section: Dr. Rahmad
    - Operation section: Dr. Ina Agustina
  - Responsible for preparing curriculum for local capacity training and RCD, organizing training activities for local capacity in preparation of the 4th RCD, designing concepts and details of drill activities and supervising the drill implementation

d. Reception and Documentation Division: Dr. Ira Tresna
  - 2 sections;
    - Reception section: Dr. Widiana
    - Documentation section: Anang Subur
  - Responsible for preparing to welcome ASEAN and VIP guests, organizing dinner party, preparing the remarks, publishing documentation, being a backup Master of Ceremony and being responsible for photo session and recording video during activities

2. Overall Program of the 4th RCD

- The meeting noted the Overall Program as presented by MOH; details are as following;

24 Nov: Arrival of participants
25 Nov: Day 1 Preparation Workshop
26 Nov: Day 2 Opening Ceremony and Table – Top exercise
27 Nov: Day 3 Field exercise at Tanah Ampo
28 Nov: Day 4 Review Workshop and Closing Ceremony
29 Nov: Meeting of PWG 2

- However, after exchanging of views, there are some activities that have been revised and edited, as following;

a. Day 1 Preparation Workshop
  - 'SASOP Orientation Session' is moved from Day 2 to Day 1, and will be conducted after the session of 'Practice in Filling-up Various Forms'. However, AHA Centre will summarize the results for pre-deployment (submission of Offer of Assistance by AMS) on Day 2 during 14.15 – 14.30
  - 'Composite Team Presentation' is added to the program and will be conducted during 15.30 – 16.15. During this session, the details of composite team and job description of each team member will be presented to the AMS EMT

b. Day 2 Opening Ceremony and Table – Top Exercise
  - The opening remarks will be prepared by Indonesia Committee
  - 'Map Exercise' activity has been changed the name to 'Demonstration of the Situation Awareness', in which the participants will observe and be informed for the current situation of the field exercise
  - Indonesia Committee will invite speakers from WHO or JAC for the session of 'Orientation of WHO Quality Assurance'. The responsible organization for the preparation of Invitation Letter will be discussed later if the speaker is invited from WHO

- The 'Presentation of Comprehensive Team Information' session is prolonged for another 30 minutes because the 'SASOP Orientation Session' is moved to Day 1
- The last session of Day 2 will be 'RDC Practice' which will last for 90 minutes and will be held at Grand Inna Hotel.

c. Day 3 Field Exercise
- Press conference on this day will be confirmed later
- Preparation of lunchbox and on-site coffee breaks will be confirmed later by Grand Inna Bali Beach
- The venue and details of Dinner Party will be informed later by Indonesia Committee

3. Update on the arrangement of Composite Team

- The meeting noted that Indonesian Team chose to take the different scenario for the additional members of AMS provided by JICA which will be participating in the Composite Team. and roleplaying as a member/individual of international NGO or other country (as an incomplete team), not as a member of AMS I – EMT. These individuals from different countries/NGOs will form a new complete Composite Team under Indonesian supervision during the practice

  a. All 5 AMS members continue practicing Health Need Assessment (HNA)
- Indonesia Committee agreed to clarify the purpose for the practice on the Composite Team and to prepare the scenario of Composite Team and will report in the PWG Meeting in July, in order to get the understanding from all AMS.
- JICA agree to provide some people to roleplay as tourists.
-
- Indonesia Committee will prepare the details of Composite Team and job description of each team member in advance, and this information will be presented to the AMS participants on Day 1 at the session 'Composite Team Presentation'

4. Overview of Cost Sharing

- The meeting noted the overview on the Cost Sharing previously proposed by MOH, which is similar to previous RCD, and agreed to change in some sections:
  - Hotel Contracts for the Meeting Package is separated. ARCH Project will be responsible for the meeting package of AMS participants, while, MOH will responsible for the Indonesian ones
  - Interpreter will be necessary for Day 2 only
  - Regarding the costs of Lunchboxes and Coffee Breaks on Day 3 (Field Exercise), ARCH Project is responsible for AMS parts, while MOH is responsible for the part of Indonesian participants

5. Overview of Program Curriculum

- Indonesia Committee informed that WHO Indonesia will financially support them for hiring consultants from university in order to help Indonesia Committee to draft the program, design the curriculum and involves in an injection plan making process

- The meeting noted the Program Curriculum proposed by MOH and Indonesia Committee agreed to prepare the necessary various documents of implementation plans for the RCD and will present these forms to the mentor team for further feedback/comment during the next Preparatory Visit in August

- Regarding Indonesian various forms, Indonesia Committee would like to test those forms in this RCD. However, since these forms are available only in Bahasa language which would be difficult for other AMS participants. On the other hand, according to Indonesian guideline, each I-EMT must be accompted by at least 1 Indonesia health worker. In this RCD, this Indonesia health worker will be assigned to AMS Teams, and will be responsible for filling in the Indonesia forms based on the data or information prepared by AMS Team, and will submit the Indonesia forms to EMTCC.

- Indonesia Committee agreed to prepare the English version of the forms and will introduce them on Day 1

6. Mentor Team Preparatory Visit for the 4th RCD

- The meeting agreed to set up the next Preparatory Visit of the Mentor Team to Indonesia during 5 – 7 August 2019
- The main aim of this visit is to check all drafted documents prepared for the planning of the RCD and discuss on further improvements
- The meeting will be held at MOH, Jakarta. After the meeting some of the members will go to Bali for the final check of the venues.

Event	**3rd Mentors Visit for 4th RCD**
Dates	4 - 8 August 2019
Place/Venue	Jakarta and Bali, Indonesia
Participants	25 Participants ARCH Project, Thai Taskforce, JAC and Indonesia
Agenda	Aug 4 Arrival at Bali, Indonesia Aug 5 Meeting with Hotel manager at Grand Inna Bali beach Aug 6 RCD Site visit, Depart to Jakarta, Indonesia Aug 7 Attendance of the preparatory meeting with Indonesia's MOH
Summary of Discussion	- The meeting with Hotel manager was to confirm about the detail in the Contract, Venue set-up and logistics arrangement. - The site visit held on 6th August at Tanahampo Harbor. The site plan for each activity were discussed and planned. - In conclusion, both ARCH Project's mentor team and Indonesia's MOH have agreed to finished up the Inject Matrix by the end of August, 2019. The detail for 4th RCD were discussed and the rehearsal will be conduct before November. - The meeting with AHA center relating the SASOP topic came to conclusion that the Table Top Exercise (TTX) need to be conducted Date and Location will be finalize.

3rd Mentor Visit for 4th RCD

Event	**4th Regional Collaboration Drill**
Dates	25-28 November 2019
Venue	Grand Inna Hotel (Bali), Tanah Ampo Pier (field exercise)
Participants	90 International participants from AMS, ASEAN Secretariat, AHA Centre, JICA, JAC, JDR Medical Team, and 200 Indonesian participants
Programme	● Day 1; Preparation Workshop ○ Health Information System of Indonesia, and Communication Exercise ○ Comprehensive Team Information ○ The Composite Team ● Day 2; Fourth Regional Collaboration Drill ○ Presentation on AMS Comprehensive Team Information ○ Orientation on WHO Quality Assurance ○ Indonesia Health Crisis Management Policy ○ Reception & Departure Centre (Presentation of Indonesian Protocol) ○ RDC Practice ○ Current Situation Briefing for the field exercise with Map (Demonstration of the Situation Awareness) ● Day 3 ○ EMT Patient Care and Quality Assurance -Round 1,2 ○ EMTCC Meeting No.1,2,3 ○ Health Needs Assessment, and Composite EMT Exercise ○ Exit Report ● Day 4 ○ Demobilization ○ After Action Review Presentations ○ SASOP Orientation & The summary on the submission of the Request and Offer of Assistance by AMS ○ Presentation by the ARCH Project Team and ARCH Indonesia Working Committee

	○ Summary
Summary and Review Result	The 4th RCD was hosted in Bali, Indonesia on 25th-28th November 2019. The drill employed the eruption of Mount Agung as a main scenario. The activities include Pre-Deployment, TTX, FTX and AAR. Key recommendations for the next drills include ● more patient details e.g. result of electrocardiogram, chest x-ray. ● consider mass casualty incident and management ● enhance information management ● consider the inclusion of injects requiring response to acute outbreaks ● more public health components e.g. CBRNE ● improve the practice quality assurance visits ● EMTCC operation should be included in actual exercise
Attachments	● List of Participants ● Overall Programme ● Presentations and Documents

Participants Registration Sheet The Forth Regional Collaboration Drill, Grand Inna Beach Hotel								
	Country	**Group**	**Title**	**Name**	**25 Nov**	**26 Nov**	**27-Nov**	**28-Nov**
1.	Brunei	RCD	DR.	ABDUL RASHID MOHAMMAD				
2.	Brunei	RCD	DR.	MD NOH HJ LATIP				
3.	Brunei	RCD	MS.	SHURIANI HAJI ALI				
4	Brunei	RCD	MR.	SEMIUN BIN AWAT				
5.	Brunei	RCD	MS.	NUR HASLENDA BINTI ABDULLAH MORIS				
6.	Brunei	PWG2	DR.	LINAWATI HAJI JUMAT				
7.	Brunei	PWG2	MS.	CHIANG MEI MEI				
8.	Cambodia	RCD	MR.	EAN SOKOEU				
9.	Cambodia	RCD	DR.	MENG HUT HUY				
10.	Cambodia	RCD	DR.	KHATHDUN DARAPHAL				
11.	Cambodia	RCD	DR.	KIM LEAN KEAT				
12.	Cambodia	RCD	MR.	SREM RITHY				
13.	Cambodia	PWG2	DR.	MUY SEANG LAK				
14.	Cambodia	PWG2	DR.	TENG SREY				

	Country	Group	Title	Name	25 Nov	26 Nov	27-Nov	28-Nov
15.	Lao PRD	RCD	DR.	PHONEXAY KHEUABPHAPHONE				
16.	Lao PRD	RCD	DR.	SOMCHANH PHENGMOUAKHOUN				
17.	Lao PRD	RCD	DR.	BOUNKONG KEOKHAMHONG				
18.	Lao PRD	RCD	MS.	MOUNTHALA SYHANATH				
19.	Lao PRD	RCD	MR.	VINLY XAYAPHET				
20	Lao PRD	PWG2	DR.	PATHUMPHONE SITHAPHONE				
21.	Lao PRD	PWG2	DR.	VILAYPHANH SOUNANTHA				
22.	Malaysia	RCD	DR.	ZAINAL EFFENDY BIN ZAINAL ABIDIN				
23.	Malaysia	RCD	DR.	MARIA SULEIMAN				
24.	Malaysia	RCD	DR.	NOR MASHITAH BINTI JOBLI				
25.	Malaysia	RCD	MS.	EMELIA YEP AI LEE				
26.	Malaysia	RCD	MR.	MOHD SYAHRIZAL BIN MOHD NADZIR				
27.	Malaysia	PWG2	DR.	KASUADI BIN HUSSIN				
28.	Malaysia	PWG2	DR.	KHAIRI BIN KASSIM				

	Country	Group	Titl	Name	25 Nov	26 Nov	27-Nov	28-Nov

			e					
29	Myanmar	RCD	DR.	MYO HEIN				
30.	Myanmar	RCD	DR.	SU SU HLAING				
31.	Myanmar	RCD	DR.	WIN PA PA HTAY				
32.	Myanmar	RCD	DR.	MIN THIHA KYAW LYNN				
33.	Myanmar	RCD	MS.	CHO CHO				
34.	Myanmar	PWG2	DR.	HTUN TIN				
35.	Myanmar	PWG2	DR.	THAN LATT AUNG				
36.	Philippines	RCD	DR.	HENA ALDABA PAPIO				
37.	Philippines	RCD	MR.	RYAN GIL COLUMNA CABULAY				
38.	Philippines	RCD	MR.	ERIC JOHN DELA PENA CAPITO				
39.	Philippines	RCD	MS.	ROSANNA SETENTA ROSELL				
40.	Philippines	RCD	DR.	MA IVY DACLIZON LOZADA				
41.	Philippines	PWG2	MS.	MARIA CARISSA LUNA OCAMPO				
42.	Philippines	PWG2	DR.	AIMEE LACAMBRA AGNER				
43.	Philippines	Mentor	MS.	Janice Palad Feliciano				
44.	Philippines	Mentor	DR.	Alfonso Cruz Danac				
	Country	**Group**	**Title**	**Name**	**25 Nov**	**26 Nov**	**27-Nov**	**28-Nov**

45.	Singapore	RCD	DR.	LIM GHEE HIAN				
46.	Singapore	RCD	DR.	TAY WEE MING				
47.	Singapore	RCD	MS.	KAREN GOH TSUNG YEN				
48.	Singapore	RCD	MS.	EUNICE TAY ZHI RUI				
49.	Singapore	RCD	MS.	NADIRAH BINTE ISHAK				
50.	Singapore	PWG2	MR.	ROYSTON CHNG				
51.	Thailand	RCD	DR.	GAVIN TIYAWAT				
52.	Thailand	RCD	MR.	SUPALERK SATTHAPHONG				
53.	Thailand	RCD	MS.	NATTHANICHA PONGPAMON				
54.	Thailand	RCD	MR.	PANJASILPA SOMBOON				
55.	Thailand	RCD	MS.	WARIN PHUNGBALLANG				
56.	Thailand	PWG2	MR.	JIROT SINDHVANANDA				
57.	Thailand	PWG2	MR.	PHUMMARIN SAELIM				
58.	Thailand	PWG2	MR.	PRASIT WUTHISUTHIMETHAWEE				
59.	Thailand	Taskforce	DR.	KRIANGSAK PINTATHAM				
60.	Thailand	Taskforce	DR.	WEERASAK PHONGPHUTTHA				
61.	Thailand	Taskforce	DR.	RAPEEPORN ROJSAENGROENG				
62.	Thailand	Taskforce	DR.	KANIN KEERASTIPONGPHIBOON				

63.	Thailand	Taskforce	MS.	HATHAIRAT RANGSANSARIT				
64.	Thailand	Taskforce	DR.	NOPMANEE TANTIVESRUANGDET				
65.	Thailand	Taskforce	MS.	PHATSAWAN SAIRAI				
66.	Thailand	Taskforce	MS.	DUANGPON THEPMANEE				
67.	Viet Nam	RCD	MR.	NGUYEN TIEN DUNG				
68.	Viet Nam	RCD	MR.	LE QOUC CHIEU				
69.	Viet Nam	RCD	MR.	BUI VAN CUONG				
70.	Viet Nam	RCD	MR.	NGUYEN DUC CHINH				
71.	Viet Nam	RCD	MR.	PHAM GIA ANH				
72.	Viet Nam	PWG2	MR.	NGUYEN NHU LAM				
73.	Viet Nam	PWG2	MR.	TRAN QUANG HUNG				

Ministry of Health
Republic of Indonesia

Project for Strengthening
the ASEAN Regional Capacity on Disaster Health Management
(ARCH Project)

Overall Programme (Tentative)
Fourth Regional Collaboration Drill and
Seventh Meeting of Project Working Group 2

Date: 25 to 29 November 2019
Location: Bali, Indonesia
Venue: Grand Inna Hotel(Bali), Tanah Ampo Pier (field exercise)
Participants: ASEAN Member States, ASEAN Secretariat, AHA Centre, JICA

Day 1; Preparation Workshop
Monday, 25 November 2019

Time	Activity	Speaker/PIC
08:00 – 08:50	Registration	
08.50 – 08.55	Briefing on Hotel Safety Procedure	Grand Inna Hotel
08.55 – 09.00	Indonesia National Anthem	
09:00 – 09:20	Opening Remarks Remarks	Director of CHC, MOH-Indonesia Representative, NIEM (Project Director) Head of Bali Provincial Office
09:20 – 09:35	Participant Introduction	Deputy Director of Prevention, Mitigation and Preparedness, CHC, MoH-Indonesia
09:35 – 09:45	Group Photo	Indonesia
09:45 – 10:00	Coffee Break	
10:00 – 10:45	Health Information System of Indonesia, and Communication Exercise	Deputy Director of Evaluation and Information, CHC, MOH-Indonesia
10:45 – 12:15	Practice in filling up various forms (SASOP, MDS, ARCH and Indonesia)	JICA, Thailand, Indonesia
12:15 – 13:30	Break and Lunch	
13:30 – 14:15	Practice in filling up various forms (continued)	JICA, Thailand, Indonesia
14:15 – 15:00	The Composite Team	Dr. Achmad Yurianto (Secretary of Director General of Disease Control, MOH-Indonesia)
15:00 – 15:30	Coffee Break	
15:30 – 16:00	Comprehensive Team Information: JDR medical team	Dr. Yuichi Koido (National Disaster Medical Center, Executive Advisor for JDR Medical Team)
16:00 – 17:30	Group Work on Comprehensive Team Information	JICA

Day 2 to 4 : The Fourth Regional Collaboration Drill
Day 2 : Tuesday, 26 November 2019

Venue: Grand Inna Hotel		
Time	**Activity**	**Speaker/ PIC**
07:30 – 08:00	Registration	Indonesia and supported by ARCH secretariat
08.00 – 10.00	Presentation on AMS Comprehensive Team Information	AMS Facilitator: JICA (Tsukasa)
10:00 – 10:10	Opening Dance (Traditional Bali Dance)	Indonesia
10:10 – 10:20	Indonesian National Anthem	Indonesia
10:20 – 10:25	Prayer	Indonesia
10:25 – 10:30	Video Show : Overview of Disaster Health Management in Indonesia	Indonesia
10:30 – 10:35	The committee chair's report	Health Expert Advisor for MoH
10:35 – 10:45	Welcome address	Governor of Bali Province
10:45 – 10:55	Opening Remarks	Minister of Health of Republic of Indonesia
10:55 – 11:15	Group Photo	Indonesia
11:15 – 11:30	*Break & Doorstop Interview*	
11.30 – 12.15	Orientation on WHO Quality Assurance	WHO (SEARO)
12:15 – 13:30	*Lunch*	
13:30 – 14:00	Indonesia Health Crisis Management Policy	Director of CHC, MOH-Indonesia
14:00 – 14.45	Reception & Departure Centre (Presentation of Indonesian Protocol)	• Bali Port Health Office, MOH-Indonesia • Indonesia NDMA Moderator : Deputy Director of Emergency Response & Early Recovery, CHC, MoH-Indonesia
14:45 – 16:15	RDC Practice	AHA Center + CHC MoH + BNPB (NDMA) • The main facilitator : CHC MoH
16.15 – 16.30	*Break*	
16:30 – 18:00	Current Situation Briefing for the field exercise with Map (Demonstration of the Situation Awareness)	Dr. Achmad Yurianto (Secretary of Director General of Disease Control, MOH-Indonesia)

Day 3 : Wednesday, 27 November 2019

Field Exercise Venue: Tanah Ampo, Karangasem District		
Time	**Activity**	**Speaker/ PIC**
06:30 - 08:00	Participants travel from Grand Inna Hotel in Sanur Bali to Tanah Ampo	
08:00 - 08:25	Opening ceremony - Welcome Speech & Remarks	Karangasem Regent
08:25 - 09:10	Briefing at the HEOC	Indonesia Team
09:10 - 10:55	EMT Patient Care and Quality Assurance - Round 1 (Exercise for 10 AMS EMT and 1 Japan EMT)	AMS, JICA & Indonesia Team
10:55 – 11:30	EMTCC Meeting No. 1	WHO- Indonesia, MOH, Bali PHO, AMS
11:30 - 12:30	*Lunch*	
12:30 - 14:25	EMT Patient Care and Quality Assurance - Round 2 (Exercise for 10 AMS EMT, 1	AMS, JICA & Indonesia Team

	Japan EMT)	
14:25 - 15:00	EMTCC Meeting No. 2	WHO-Indonesia, MOH, Bali PHO, AMS
15:00 – 16:30	Health Needs Assessment, and Composite EMT Exercise	WHO-Indonesia MOH, Bali PHO
16:30 – 16:45	EMTCC Meeting No. 3	WHO-Indonesia, MOH, Bali PHO, AMS
16:45 – 17:00	Exit Report	WHO-Indonesia, MOH, Bali PHO, AMS
17:00 – 18:00	Participants travel from Tanah Ampo to Grand Inna Hotel, Sanur	Indonesia
20:00 – 22:00	Gala Dinner	Indonesia

Day 4 : Thursday, 28 November 2019

Review Workshop Venue: Grand Inna Hotel		
Time	**Activity**	**Speaker/ PIC**
08:00 – 08:30	Registration	
08:30 – 09:15	Demobilization	Indonesia
09.15 – 09.30	*Coffee Break*	
09:30 - 10:00	SASOP Orientation & The summary on the submission of the Request and Offer of Assistance by AMS.	AHA Centre
10:00 - 12:00	Preparation for After Action Review Presentation	AMS Facilitator: JICA
12:00 - 13:15	*Lunch*	
13:15 - 15:00	Presentation of After Action Review (continuation)	AMS Facilitator: JICA & Mentor Team
15:00 – 15:30	*Coffee Break*	
16:00 - 17:00	Presentation by the ARCH Project Team and ARCH Indonesia Working Committee	ARCH Project Team Deputy Director of Prevention, Mitigation and Preparedness, CHC, MoH-Indonesia
17:00 – 17:15	Summary	ASEAN Secretariat & ARCH Project Team
17:15 - 17:30	Closing remarks	Director of CHC, MOH-Indonesia

Day 5: Friday, 29 November
PWG 2 Meetings (Venue: Grand Inna Hotel)

Time	**Agenda**
08:30 - 09:00	Registration
09:00 - 09:10	Welcome Remarks
09:10 - 09:20	Introduction of the Participants
09:20 - 09:50	Conclusions, Recommendations from the Fourth Regional Collaboration Drill
09:50 – 10:00	Group Photo
10:00 - 10:15	*Break*
10:15 - 10:40	Host Country and Concept Plan for the Next RCD in 2020
10:40-11:20	Guidebook for RCD Preparation
11:20-12:00	Work Plan for POA to Implement the ALD on DHM
12:00 - 13:00	*Lunch*
13:00-14:00	Regional Disaster Health Training Centre and Development of Standard Training Curriculum
14:00 - 15:15	Results of Questionnaire for Academic/Training, Systems, and Needs for Capacity Development on DHM in AMS

15:15-15:30	Plan for Field Visits in CLMV on Capacity Development for DHM
15:30 - 15:45	*Break*
15:45-16:00	Schedule Setting and Members of the Field Trips in CLMV on Capacity Development for DHM
16:00 - 16:15	Wrap-up and Way Forward
16:15 - 16:30	Closing Remarks

Fourth Regional Collaboration Drill and
Seventh Meeting of Project Working Group 2

Date: 25-29 November 2019
Location: Bali, Indonesia
Venue: Grand Inna Hotel(Bali), Tanah Ampo Pier (field exercise)
Participants: ASEAN Member States, ASEAN Secretariat, AHA Centre, JICA

Minutes for Day 1; Preparation Workshop
Monday, 25 November 2019

Time	Activity
08:00	Registration
08.50	Briefing on Hotel Safety Procedure by staff of Grand Inna Hotel
08.55	Indonesia National Anthem
09:00	-MC welcomes all of the representatives of ASEAN Member States, ASEAN Secretariat, AHA Center, and colleagues from host country Indonesia. -MC invites Director of CHC to deliver opening remarks
09:10	**Opening remarks by Director of Health Crisis Center Dr. Budi Sylvana, MARS** -Delivers remarks in Indonesian as per the Indonesian regulation -Welcomes all delegates from Brunei Darussalam, Cambodia, Laos, Malaysia, Myanmar, the Philippines, Thailand, Vietnam, Singapore, and Indonesia, and all representatives and participants. -Health crisis management is carried out in every health crisis procedure -The management covers a pre-health crisis, emergency response and post-crisis, with emphasis on risk reduction -The crisis risk reduction has 3 main strategies: reducing hazards, reducing vulnerability and increasing the capacity of all stakeholders -Risk reduction is carried out through inter-sectoral collaboration, utilizing information technology, carrying out continues monitoring activities and improving the quality and equity of Human Resources -The emergency response is carried out in a cluster system, which is conducted by a Health Cluster, aimed at increasing coordination, collaboration and integration in Health Crisis Management -Related to preparedness measurement, in order to improve coordination and cooperation in health disaster risk reduction, Indonesia through the Ministry of Health has established collaboration with other countries and development partners, such as ASEAN Member States, JICA, WHO and related organizations and institutions in conducting health disaster management simulation, among other is the Regional Collaboration Drill -This activity is a series of activities of the ASEAN Regional Capacity on Disasters Health Management, ARCH Project, consisting of sub-activities, namely: Preparation Workshop, Fourth Regional Collaboration Drill, Field Exercise, Review Workshops and Project Working Groups **Opening remarks by Head of Bali Provincial Office Dr. Ketut Suarjaya** -Mt. Agung eruption in mid-2017 is a disaster worth noting -There was poor disaster management -This condition had a huge impact on tourism in Bali -After the crisis passed, better attention to health crisis management was given by the local government -In line with the Balinese belief and principle that humans must maintain the nature, in this case the sacredness and harmony of Balinese nature to create health and well-being in the society

	-To improve health crisis management during a disaster, every year the local government carries out programs to strengthen the health networks and also the communities in disaster-prone areas so that such crisis as what happened in 2017 will not occur again -With these programs, Bali hopes to be more prepared in handling disasters within the next 5 years. **Opening remarks by Mr. Atchariya Pangma, the Secretary-General of the National Institute for Emergency Medicine of Thailand (NIEM), and also the Director of the ARCH Project.** -Last year when we came together in Manila, I encouraged and supported the idea to make a collaboration in the area of disaster health management sustainable -ARCH Project has been carried out for almost four years -It is the act of growing a close collaborative relationship between the people of ASEAN -Now we have seen the outcome: the ASEAN Leaders' Declaration on Disaster Health Management has been endorsed, and now the Regional Coordination Meeting or RCC has now been approve -Soon, we will have a sustainable mechanism that will further this cooperation until our region is strong for unexpected occurrences of disasters. -This time, I encourage everyone of us here to look further beyond our region. This time we will use this drill to become a symbol representing our will to the whole world that we will ensure that "**no one will be left behind**". Victims of disasters will be treated and cared regardless of their gender, class, age, economic status or ethnicity. Their area of residency will not discriminate them from accessing disaster relief objects. We will keep in mind that disasters can lead to shocks and fragility. No one will be left behind. Disaster-affected population will not be left alone.
09:20	**Participant Introduction by Mr Agus Hendroyono, Deputy Director of Prevention, Mitigation and Preparedness, CHC, MoH-Indonesia** >Invites the delegates of each country to introduce themselves -Brunei Darussalam: 5 representatives from hospitals and MoH -Indonesia: 4 representatives from Bali Mandara Hospital, Klungkung Hospital, Karangasem Hospital, MoH of Bangli Regency -Cambodia: 5 representatives from Research & Development institute, hospitals, MoH -The Philippines: 5 representatives from hospitals -Myanmar: 5 representatives from hospitals -Malaysia: 4 representatives from hospitals, MoH -Laos: 5 representatives from hospitals -Singapore: 6 representatives from hospitals -Thailand: 5 representatives -Vietnam: 5 representatives from hospitals >Self-introduction by all speakers and partners, and JICA project team members and supporters
09:40	Group Photo session
10:00	Coffee Break
10:20	**Presentation of Health Information System of Indonesia, and Communication Exercise by dr. Ira Cyndira Tresna, M.I.Kom Deputy Director of Evaluation and Information, CHC, MOH-Indonesia** 1. Background for Disaster Health Information and Communication System in Indonesia 1. Located on boundaries of 3 moving Tectonic Plates and Ring of Fire, there are 3-5 reports of earthquakes including in the Phillipines 2. Has 139 active volcanoes, but still recounting

	3. Has high mobility of people and animals. 4. Has 3 nuclear reactors 5. Has thousands of chemical industrial factories 6. Diverse cultures and peoples Therefore, Indonesia is prone to disasters, including non-natural disasters such as IHR relevant hazards/PHEIC. Any kind of disasters can be found in Indonesia. -Health crisis management, especially because of disasters, can be done quickly and precisely if supported by a good information and coordination system -To obtain data and information quickly and precisely, appropriate information systems are needed and aligned with the needs and developments of technology and can be integrated with other systems -Center for Health Crisis as the Health Cluster Coordinator has an intended information system that is used as a tool to assist in reporting and policy making. The system is called Health Crisis Management Information System -Health Crisis Management Information System is a set of arrangements that include data, information, indicators, procedures, tools, technology, and human resources that are interconnected and managed in an integrated manner to direct actions / decisions that are useful in supporting the health crisis management. -The provision of information is organized through a cluster approach integrated in health crisis management information system, called SIPKK -District/City Health Office, Provincial Health Office is required to report events of Health Crisis events in their area and its development information in stages to the Minister of Health through the National Health Cluster coordinator. -Presents Health Cluster Organization Structure. The clusters are at the provincial and municipal levels -In Indonesia the cluster is divided into 6 sub-clusters, managed by colleagues from the Indonesian Police and supported by 3 teams: logistics, health information -The objectives are to ensure the availability of integrated Health Crisis data and information, to ensure the availability and access to health crisis information, and to empower the participation of academics, the private sector and the public in the implementation of the Health Crisis Management Information System. -We always coordinate with all stakeholders to realize the implementation of the Health Crisis Management Information System within the scope of the Health Information System and the Disaster Information System that is efficient and effective -The targets are: healthcare cluster executor at national, provincial, district/city levels, implementers in healthcare facilities such as hospitals, health centers, secondary clinics, village clinics, field hospitals, medical posts, and other parties involved in the response to the health crisis. -The benefits are: provision of data and information that is fast, precise, accurate, identification/mapping of threats, vulnerabilities, capacities, and gap analysis, assistance in mitigation and preparedness prevention efforts, especially in disasters -Response System consists of Data, Information, Indicator, Procedure, Equipment, Technology, and Human Health Resources, wich are interrelated and managed altogether for desicions and actions in health crisis management 2. Health Crisis Flow and Reporting Health Crisis Management Information System is divided into: 1. Pre Health Crisis Information System 2. Emergency Health Crisis Response Information System 3. Post Health Crisis Information System >Pre-Health Crisis -Information needed includes: 1. Risk Assessment Information → health crisis management profile (hazard, vulnerability, capacity)

	2. Early Warning Information → circular letter, alarms, other agreed markers 3. Preparedness Information → resource inventory, evacuation location information. -Benefits: for risk mapping, planning, capacity building, monitoring, early warning systems -Forms used: Form 1 (Health Crisis Risk Assessment for Provinces), Form 2 (Health Crisis Risk Assessment for District/City) >Emergency Health Crisis Response -Initial Health Crisis Report (form 3). Made and delivered soon after the health crisis incident occured by health officer or by any parties knowing from the crisis location (institutions, the public). Stages of information at this stage can be ignored. They can contact the Health Service of the city/province or even the MOH at the health crisis facilities. -Rapid Need Assessment Report (form 4). Made and delivered by Rapid Health assessment Team (RHA) soon after initial report is received. -Health Crisis Progress Report (form 5). Made and delivered by health officer if there is any progress of situation on health crisis incident. Compiled and delivered every time a health crisis relief information is developed. >Post Health Crisis The report consist of: -Damage and Lost Assessment and post health crisis need assessment -Post health crisis rehabilitation and reconstruction plan -Monitoring and evaluation based on Post health crisis rehabilitation and reconstruction plan > adjusted to the standard formats of each program 3. Daily healthcare service activity report forms to health cluster post/National EMTCC Flow of Daily Health Data and Information: -EMTs are distributed to places that need community health facilities, hospitals, public health facilities, -First, register with the EMTCC -At 4 p.m. reports must be ready to be delivered -The list must be updated every day -The capacity of the volunteers and health personnel involved must be identified and recorded -Distribution Map: whether there is a crisis accumulation in a location, useful for even distribution of health assistance -Every day the number of casualties must be updated -For hospital services, the area, number of outpatients and inpatients, referral hospitals, and diagnosis of patients must be mentioned -Data on damaged health facilities must be mentioned -Impacts of the damage must be mentioned -Logistics: recapitulate medicines and health equipment -Logistics team must record all inventories and report everything needed and stocks that need to be replenished -The 3 major diseases and potential epidemic diseases must be reported -The health cluster coordinator asks for a summary of needs and recommendation to leaders in province and districts/cities. In the case of a national disaster, directly to the President. *The e-PKK Application* -E-PKK is an Android-based application used by the RAH, health office at the province and city levels, and health volunteers

	-After users log in, a verified location of disaster will appear -To access, after registration users will be verified and given access -In the app the menus are: disaster reporting, health crisis, ordinate points, details of the location, date and time of the event, number of casualties -To find a disaster or a hospital in the menu, enter the time and location information -Multimedia users can upload pictures and videos of the disaster at the location -Therefore, direct reporting is done via this application
	-Before the presentation starts, a supporter from JICA Japan is to sit with each team at each table to assist with the practice
10:50	**Practice in filling in various forms** (SASOP, MDS, ARCH and Indonesia) -Submit Offer for Assistance and EMT Registration form for the affected country's consideration. If accepted, they will sign a contractual arrangement and send it back to NDMO to be countersigned, and also a Letter of Acceptance -When you arrive at the affected country, bring all the documents (4 copies). Go to the immigration and then directly to RDC. You will be assigned to the local coordination center and to the affected area -When you arrive at the disaster site, you take care of the patients, fill in the medical records, and do the daily report and the tally sheets, and refer the patients -Every day a meeting with EMTCC must be held and update the situation, or with any coordination center of the affected country, to be updated to the system. -Update the situation every 3 hours to AHA Center or the system. Update assessment and why you've done, reports, meeting minutes. -In two weeks you should be ready to be demobilized -Demobilization: fill in the exit report, submit it to the local coordination center, end of mission form sent to AHA Center within 2 weeks of departure from disaster site -This is the most recently updated and the result of our 3-4 years' work. -Invites participants to ask questions -Question: For the assessment, is it mandatory to do it? -Answer: Actually if a country has a team specialized for the assessment it is unnecessary for you to do it, but sometimes you need to do multitasking in a disaster area. For example if you are assigned to an area and there is some village nearby, it's better to send some team members to do the assessment and bring back the information to the team and set up some facilities. It depends on the situation but for our SOP it is better to have this capability so that when need to do it we will be able to do it (more flexible in disaster situations).
11.15	**Practice filling in the forms** -Forms distributed to all tables -Situation: Assume that you are NDMO and the affected country requests for international assistance. What should you do next? -Fill up Offer for Assistance and do EMT registration -Letter of Acceptance and Contractual Arrangement -Provide information into these 4 forms -Arrive at the affected country and bring all the documents -Debriefed by RDC and coordination center at the location -Assigned to the affected area and need to take care of the patients first

	Practice -Divide group into 3 and 2. Medical records provided of 2 types of patients, namely trauma patients and chronic disease patients. 5 cases for each set. -Fill in the report form. Choose someone from the team to be in charge of data management (MDS Manager) -All EMTs to fill in the tick boxes of the medical assistance received in the daily report form -MDS Daily Report Form: A form to report when, where, which. Consists of 4 parts, with the most important being team information, team name, and where you operate. -MDS statistics, figures can be copied from the tally sheet -Daily summary: basic statistics not from the MDS Step 1: Tick boxes on Medical Records -Medical doctors will tick. Check all that apply: sex, diseases, diagnosis, medical follow-up, directly or indirectly related to disasters. This is how to generate data and record the patients into statistic figures -MDS Items with classifications: major, moderate, minor, directly, indirectly, not related Characteristics of the MDS items: -Practical judge to select MDS items is acceptable -Items capture universally major issues only, not all issues -Every MDS module will have more than one tick Step 2: -Tally the ticks using the Tally Sheet & Tally Mark -After we get all the numbers from all the ticks, copy and paste the numbers to the report form -When the form is completed, send it to EMTCC EMTs Cycle: Medical records > Tally sheet > Daily report > Summary > Feedback > Medical reports Tools used: Paper, PC & Excel, Smartphone. We used all of them in our previous programs. Excel is much easier to organize than paper. In this drill we use paper form The MDS Makers: MDS Maker: Excel to enable EMT CSV data reporting MDS Free Maker: Excel to enable EMTCC summary
12:20	Lunch Break
13:30	**Practice filling in various forms (continued)** -Step 2: Open MDS Maker, and input team information and patient data, step by step exactly the same information as on the paper.1 line is used for 1 patient. The MDS Manager to input the patient data into this table. Type in what is stated on the paper. -Step 3: Make CSV File, Print Tally Sheet, Print Tally Report -Email the data to EMTCC. EMTCC will receive the data in the form of sheets -After the data is analyzed, feedback will be provided, the current situation can be understood and the next response can be decided.

	-Key Message: The WHO EMT MDS is a tool: to let EMTCC do data coordination, to make one response, to enable knowledge sharing -Next, fill in the referral form. Practice with 2 sets of patients. Set A: trauma case patients Set C: patient no. 7 -MDS Daily Report When you refer the patient don't forget to attach the medical records as they are very important *On handling assessment form and summary (by dr. ... from Thailand):* >Health Need Assessment (HNA) Definition: The systematic approach to ensuring that the health service uses its resources in the most efficient way Steps: -Collect primary data: identify the vital needs of the affected population -Define the needs-based response -The information from HNA can be useful to mitigate the crisis impacts and as a precaution to potential health risks -The main role of EMTs is to provide medical services and therefore conducting HNA is compulsory -HNA can be an option for EMTs: EMTs shall conduct HNA only when they have the capacity (time, personnel and skills) and depending on the needs and the decisions of the local authority. -EMTs may conduct HNA at any time How to collect information: -Daily observations -Interviews with the key informants Tips for assessment: Collect just brief information and also the safety and security concerns HNA Tools: -Assessment forms In ARCH Project's HNA, 2 forms are used: -HNA form: collect information that is relevant and available, raw data for summary -HNA Summary Report: determine critical areas for support in Health (communicable diseases, child health, sexual & reproductive health, non-communicable diseases), WASH (Water, Sanitation, Hygiene), Food Security, Nutrition, Shelter It is important to follow these forms to ensure completeness of important information
14:25	**The Composite Team by Dr. Achmad Yurianto, Secretary of Director General of Disease Control, MOH-Indonesia** -EMT Composite is a policy created by the Indonesian Government in response to disasters occurring in Indonesia -It is adopted from the WHO manual to respond to medical emergencies in the field -Indonesia is located on the pacific ring of fire and three major faults, has 127 active volcanoes with 5 million people live next to them. Throughout 2017, there were 2.372

	disasters in Indonesia and in 2018 there were 11.417 earthquakes. This calls for a better and quicker response to disasters -Population Density: uneven distribution of population. Very dense in the area of Java Island, Bali, NTB, Lampung, North and West Sumatra, North and South Sulawesi. These are also disaster-prone areas and hence the great impact potential -Disaster Risk Index: almost 72% of regencies and districts are at a high risk of disasters -In 2018: 2,572 disasters, 4,800 casualties, 10.2 million refugees, 106 health care facilities were damaged -Therefore, health clusters must be arranged based on the past experiences and the existing government policies -Our disaster response: health responses are grouped/composited into health clusters, search and rescue clusters, refugee clusters -Health cluster is divided into the following sub-clusters: health service, disease control, reproductive health, death victim, mental health, nutrition -As health and medical issues are not independent from one another, we collaborate with other departments such as the public works and infrastructure departments for provision of water and electricity in disaster areas (integrated approach) -Emergency Responses (the basic management): when a disaster happens, the first thing to do is to rescue and keep people away from hazards. This is 'life-saving, limb-saving', the primary thing to do. Upon recovery, restore all health care functions despite the minimality. When things are under control, rehabilitation comes next -When a natural, non-natural, or social disaster happens to an area with an inadequate capacity, external health assistance is needed. Example: in case of a disaster at a provincial level, assistance from outside of the province is provided. This assistance is organized in the form of EMTs -2 Disaster Responses: Emergency Response & Public Health Response -Emergency Response: Focused on LIFE SAVING, LIMB SAVING - Public Health Response: Ensure that NO OUTBREAK is happening -In the emergency transition, ensure that all have received proper health care and that outbreak potentials are controlled -This is the concept of our EMT -Therefore in disaster areas, there are 2 things to do: extraction from the area, management in a temporary shelter or triage resuscitation at the location, before evacuation to hospitals. -Conclusion: Selective responses: life-saving limb-saving. Focusing on major cases. -Emergency Medical Team: The term EMTs refers to groups of health professionals providing direct clinical care to populations affected by disasters to improve the regional capacity -These professionals may include governmental (both civilian and military) and non-governmental personnel and can be comprised of both national and international staff. Restrictions on EMTs: -should not be involved in the health cluster system managerial works. Provide only direct clinical services. -groups of health professionals providing direct clinical care -under the leadership and control of national health cluster. Under the coordination of the local health system. -should be a composite EMT (pre-deployment or ad-hoc arrangement) -include governmental and non-governmental. Because volunteers are not always in the form of a team. They need to be composited into a team. Many come as individual doctors, paramedics, and other specialists. Type 1 EMT, both mobile and fixed Primary Tasks: EMT-1 mobile – find, identify, stabilize/treat, refer EMT-1 fixed – provide health service in IDP camp

	Oriented in the live saving-limb saving principle Type 2 EMT -inpatient acute care, general and obstetric surgery for trauma and other major conditions -complex inpatient referral surgical care including intensive care capacity -prevention of infections Oriented in surgical emergency, surgical elective services, and intensive hospitality Type 3 EMT Hospital vessels owned by the Indonesian navy with surgical rooms, ICU beds and patient beds with all the necessary facilities. Oriented in all medical services and intensive hospitality There is also the specialized care cells within the EMT 2 or EMT 3 for local hospitals. Specialized cell: a composite of expert teams in certain fields to strengthen and restore affected health-care facilities (pre-hospital transport, primary medical care, maternal child health, surgical specialists, dialysis, rehabilitation, medivac retrieval, etc.).
15:00	Coffee Break
15:30	-Comprehensive Team Information is a fact sheet of your teams. Teams can be established EMTs in your country, and some may be international or national EMTs -Each team will give a presentation tomorrow morning about their EMTs, e.g. about what kind of training they have -CTI practice will be based on the submitted CTI -Some teams have completed their CTI but other teams will be given 90 minutes for preparation of their presentation tomorrow morning -Of the 10 member states some are already accredited as international EMTs, such as Thailand, and some others have never established any EMTs -We want to ensure each team has a Type 1 EMT -By using this practice each team is going to be given an opportunity to determine what kind of EMT to establish -To give an example, JDR Team will be introduced **Comprehensive Team Information: JDR medical team by Dr. Yuichi Koido (National Disaster Medical Center, Executive Advisor for JDR Medical Team)** -In 1982 JDR was established -After many disaster responses, JDR needed to expand capacity -After going through improvements in the last 30 years we have authorized type 2 teams in 2015 -Team building takes a long time and JDR took time to establish. JDR has accumulated experiences in the past 30 years and has developed to become the current team -Japan also has domestic disaster and medical teams -Domestic teams were established after the international team -JDR is under the Ministry of Health, and is a government-owned team -We have responded 59 times. Most recent: hurricane in Mozambique.Within AMS countries: in 8 different times in different AMS countries -JDR is authorized as Type 1 and Type 2 EMTs -Number of team members: Type 1: 27 members, Type 2: 519 members, as the standard -The team leader is appointed sometimes from among a JICA member -2 subleaders: a medical coordinator who manages medical operations, and 1 subleader from JICA who manages all logistics for all operations of medical activities -9 members in the outpatient care and within the 9 members, there are 3 doctors and the rest are nurses -Type 2 EMT: the number of team members: 69. Maintains medical resources

	-Type 2 Team operates 24 hours -JDR uses aircrafts and military forces, and has charter contracts with Japanese air companies Nippon Airways and Japan Airlines and other Japan companies for international responses -Departs from Narita airport, sometimes Haneda, and warehouse is located in Narita -For logistics support in disaster sites: we use JICA worldwide networks -JICA has 69 offices worldwide. Logistics include transportation, interpreters, translators, medical workers, and anything that can be procured in the country -JDR training mechanism: reviewing new developments and keeping up with the updates in order to try to match the needs of affected countries -3 trainings are held: introduction course every year, and speed up course. -Presents Type 1 Footprint, Type 2 Footprint. These are the basic footprints, but depending on the situation setups can be different. -For the operation manual, JDR has a JDR book as the SOP -JDR adapts the common procedures between national and international EMTs -In 2020 Japan will host Tokyo Olympics, and members will participate in the medical response for that event. Will be using the same procedures for the event -This is how Japan makes a swift and efficient development of our EMTs
16:00	**Group Work on Comprehensive Team Information** Instructions: 90 minutes to complete the task mentioned previously Firstly, complete 7 presentation slides Each team is expected to deliver a presentation tomorrow morning, each for 8 minutes

Fourth Regional Collaboration Drill and
Seventh Meeting of Project Working Group 2

Date: 25-29 November 2019
Location: Bali, Indonesia
Venue: Grand Inna Hotel(Bali), Tanah Ampo Pier (field exercise)
Participants: ASEAN Member States, ASEAN Secretariat, AHA Centre, JICA

Minutes for Day 2
Tuesday, 26 November 2019
Venue: Grand Inna Hotel

Time	Activity
07:30	Registration
08:05	Opening Dance (Traditional Bali Dance)
08:20	Indonesian National Anthem
08:25	Video Show : Overview of Disaster Health Management in Indonesia
08:30	**Opening Session** **Committee Report by Director of Health Crisis Centre of the Ministry of Health of the Republic of Indonesia** -The 4th Regional Collaboration Drill and the 7th Meeting of the Project Working Group 2 are a series of the ARCH Project activities, conducted in collaboration between the MoH of Indonesia and JICA -The ARCH Project is an ASEAN regional capacity-building project in Disaster Health Management to realize the vision of ONE ASEAN ONE RESPONSE -The 4th Regional Collaboration Drill is held from 25-29 Nov 2019 in Denpasar and Karangasem -The drill has 2 objectives: the national goal and the ASEAN goal -At national level, the aim is to practice the established national mechanism, the administration of foreign assistance, including the administration of Reception and Departure Centre (RDC) -At regional level, the aim is to practice the ARCH Project's SOP: pre-deployment, development of CTI for each ASEAN Member State, Quality Assurance, and discussing the Indonesian SOP's concept of the Joint EMT -Field Exercise of the 4th Regional Collaboration Drill will be carried out in Karangasem Regency, with a scenario based on the real major volcanic eruption in 1963 -This activity is guided by mentors from JICA, NIEM, and representatives from the MoH of the Philippines.
08:40	**Welcome Address by Representative of Bali Province Mr. I Wayan Suarjana** -Governor of Bali Mr I Wayan Koster is prevented from attending the event and the speech is delivered on his behalf -Indonesia is a disaster-prone country because of its geographical conditions and therefore we need to be constantly prepared for disasters -Government of Bali is committed to establishing regulations on the provision of healthcare services for the people affected by disasters. and has carried out activities in this field -The focus is on increasing the alertness and capacity of health personnel in Disaster Management -This is in line with the vision of Bali Province: Towards the New Bali, under the principle of giving back to nature which is Balinese local wisdom
08:50	**Opening Remarks by Senior Advisor to the Ministry of Health on Decentralization** -The Minister of Health of the Republic of Indonesia Mr. Terawan Agus Putranto is prevented from attending the event due to a meeting at the House of Representatives -Indonesia is one of the ASEAN Member States that is prone to disasters, both natural and non-natural. -Indonesia's geographical conditions are the reason Indonesia has many active volcanoes (139 volcanoes) and earthquakes.

Time	Activity
	-From 2010 to 2018, there were fourteen disasters resulting in health crisis. -The global disaster management paradigm has shifted since the Hyogo Framework 2000-2015, which was continued by the Sendai Framework 2015-2030 -Previously, disaster management was emphasized on emergency response, now it focuses on risk reduction that is integrated in country's development program -Indonesia as one of the countries with the highest frequency of disasters in the world has also adopted the framework -The MoH of Indonesia has established policies and programs to increase national and sub national capacities in disaster health reduction by implementing integrated health crisis management, applying a health cluster approach and strengthening the Integrated Emergency Management System (SPGDT). -The purpose is to speed up response time and minimize mortality and disability as well as strengthen policies on EMT -Indonesia has many experiences in health crisis management in major disasters, involving neighboring countries to provide health assistance -Indonesia has also delivered assistance for disaster response in other countries (2008 cyclone in Myanmar, 2010 flash floods in Pakistan, 2013 floods in the Philippines) -Regarding preparedness, Indonesia has conducted several disaster and epidemic simulations, including the ASEAN Regional Forum Disaster Relief Exercise in 2011, Mentawai Megathrust Direx in 20[illegible] Simulation Exercise in 2016, Epicentre Pandemic Influenza Simulation in 2017 and the ASEAN Regional Disaster Emergency Response Simulation Exercise (ARDEX) in 2018 -This year, Indonesia has the opportunity to host the 4th Regional Collaboration Drill and the 7th Meeting of Project Working Groups under the ARCH Project. This activity is important for Indonesia and ASEAN to share experiences, increase knowledge from international experts, as well as strengthen collaboration between ASEAN Member States and partners as one region under the vision *One ASEAN, One Response*
09:00	Sounding of Gong to officially open the event for the day
09:05	Giving of Tokens of Appreciation and Photo Group Session
09:10	*Coffee Break & Doorstep Interviews*
09.30	**Presentation on AMS Comprehensive Team Information** **Facilitator: JICA (Tsukasa)** Presentation time: 8 minutes for each state 1. Brunei At the moment we have no national EMT, but we have a medical emergency response team a have sent the team to Aceh and Jogja and also some doctors to go there. The team is Independent of our MoH. Establishment of EMT: we have not established one but thanks to ARCH Project we now wish to establish an EMT. Issues around establishing an EMT: -Not enough manpower; for the whole country we have 7 local emergency divisions. We heavily rely on expat doctors to fill in the gaps and we have only around 100 paramedics for the whole country. -Lack of experience -No budget for the establishment of a national EMT -Limited resources Estimated time: in 5 years' time when we have enough manpower and resources Organization chart: 5 members consisting of 1 leader, 1 doctor/specialist, 2 paramedics, 1 nurse Planning to have 5 deployable EMTs, but at the moment we have no registered members deployable. Team members are selected ad hoc depending on the availability and the situation in the country Specialized capability: we have no experience and currently we have no specialized units

Time	Activity
	Support required: transport, communication, sanitation, water. We don't have the expertise to come up with all these facilities. Most difficult to achieve: lack of experience, lack of personnel, lack of preparedness. Brunei is not prone to disasters and we lack support from the authorities esp. the national disaster management committee. We act independently at the moment and are not working with them. Footprint of EMT: reception, triage, medical equipment storage We have no established EMT training program 2. Cambodia No EMT yet Establishment of national EMT for deployment abroad: No EMT to cooperate in domestic situations: No EMT Issues around establishing EMT: many challenges to establish EMT in Cambodia - need support and commitment from the government Organization chart: Team leader (should be a doctor), and tasks are divided into 3 parts: public health unit, medical unit (midwife, paramedic, pharmacist, psychiatrist), logistics unit. Team consists of 18 members: 1 Team Leader, 3 doctors, 6 nurses, 1 pharmacist, 2 midwifes, 1 lab technician, 1 psychiatrist, 2 public health officer, 2 logistics officers. All are deployable. No specialized unit. We need support and commitment from the local authorities (fuel, food, water, generator, translator, security). Translators especially are difficult to find. Footprint: Triage in the front, 2 consultation rooms, treatment rooms, pharmacy, lab, restroom and rooms for staff supplies and logistics. Establishment of Training Programs: need support with Disaster Health Management and Public Health Management. 3. Indonesia Country plan: Yes, we are planning to establish a national EMT to deploy to ASEAN regions by 2020. Not only to ASEAN countries but also to other countries. Establishment of national EMT for deployment: yes, but no registration and standardization yet Establishment of national EMT to operate at home: Yes, but no registration and standardization yet Issues around the establishment of EMT: registration and standardization Estimated time: 2 years National roadmap for EMT: 2020: mobilization 2021: national EMT 2022: forming of national EMT and province EMTs (34 provinces) 2023: forming of regency EMTs (more than 500 regencies) 2024: forming of regency and district EMTs Organization: we collaborate with civil and military, government and non-government organizations Minister with the leading role: MoH in coordination with National Disaster Management Agency. Deployment: 8 times to Myanmar, Nepal, the Philippines, Pakistan, Haiti, Bangladesh, Iran Standard staff: 5 members. We have guidelines and SOP in human development book - fast response team in health support Specialized unit: EMT Type 1 Fixed: one NGO i.e. Muhammadiyah which is still in the process of WHO registration Logistics support: We apply the concept of EMT composite. Logistics are mainly provided by the local government in accordance with the clusters. Every EMT is expected to complete service with their own logistics (medical & non-medical) Most difficult item to achieve: transport logistics to remote areas, since Indonesia is a large country with many islands, and to pass medical clearance for medical equipment. Expertise & training program: ongoing. We have a module handbook, we do trainings for before and after deployment, and also evaluation after deployment 4. Laos We don't have EMTs but we have a country plan, we try to have a law and regulation and make an

Time	Activity
	organization Issues around establishment of EMT: not enough personnel, no adequate law or regulation, no capacity, no management, poor facilities, operations need to be improved, and education about disasters is not enough Estimated time: in a year or may be more than a year Organization chart: NDM committee, vice prime minister, MoH, disaster management committee Staff number: we want to have 30 members deployable Specialist capacity: Plan to construct a specialized unit in 5 years Logistics support required: Medical equipment, water supply, clothing, food, electricity, shelter, toilet, medication, communication facilities Most difficult item to achieve: communication and management, finance, transportation, human resources and team work Footprint: Commander at the top, supplies, logistics, waiting are, kitchen, consultation room, isolation Training program: we have EMT training for first responders, paramedics, disaster management Don't leave us behind, we need help from you 5. Malaysia Country plan: 5 years to improve capacity and capability of our EMTs We have been deployed abroad many times, most recently to Bangladesh Now planning to make a more independent team and to build up capacity up to WHO standards We have operated in domestic situations Issues around the establishment of EMT: limited resources, in terms of human resources, equipment, training, budget, specialized personnel for logistics Estimated: time: by the year 2025 we hope to have an EMT ready Staff number: 18 members, a minimum number for EMT type 1 mobile At the moment there are 414 staff members registered under the crisis & response center, consisting of specialists from various disciplines We have a specialized unit: surgeon, psychosocial, nutrition teams Support required: transportation, communication, communication, power generator Transportation is the most difficult item to achieve because we don't have office all over the world that can support the affected country. For the moment for Type 1 Mobile we respond with our military and specialist teams Footprint: reception, triage, consultation, pharmacy We have training for national deployment but the problem is the training is focused mainly on medical personnel. We are in the middle of updating and integrating important components for disaster management 6. Myanmar Country plan: we have no established national EMT so we plan to establish one in 5 years We are at the initial phase now and we have no experience of deployment abroad However, we have a response team instead of an EMT Our country is prone to disasters and we deploy our response team to affected areas. Our MoH has 2 important departments: dept. of medical care & dept. of public health Under the dept. of medical care: dept. of emergency medicine, under the dept. of public health: dept. of disaster and health emergency response division The 2 units unite to form an EMT We are preparing for the EMT Type 1 Fixed so we have no other specialized team We are not a rich country so we need a lot of support from other countries Support required: we need transport vehicles, since we are only a type 1 fized EMT so we need vehicles to transfer patients to EMT type 2 or 3. We also need power, medical, sanitation, interpreters Most difficult item to achieve: human resource. We need to time to develop HR and also the budget support from the government Footprint: waiting area, reception, triage, consultation room, treatment room, pharmacy, logistics and medical equipment supplies area

Time	Activity
	Specific training for EMT: on the medical side, we have training for emergency specialists, surgeons, epidemiologists, microbiologists, and general physicians. We need to unite these specialists to form a systematic EMT 7. The Philippines Country plan: Yes, since 2017 we have been organizing emergency medical assistance team based on the WHO's EMT initiative Establishment of national EMT for deployment: we have sent EMTs to other countries, for example to Banda Aceh (tsunami), Sri Lanka, Myanmar, Haitian earthquake, the Middle East during the Iraq war, etc. Organization chart: team leader who is a doctor, public health (nurses), clinical, logistics (sanitation engineer), admin (clerks) Team members: 27 members, with a team leader, a public health leader, admin clerks, clinical leader, nursing leader, 4 doctors, 5 nurses, 1 midwife, 1 paramedic, 1 social worker, 1 medical technologist, 1 pharmacist, 1 logistics leader, and 4 logistics members (sanitation engineer, cook, drivers, security officer) and 1 admin finance clerk. There are 6 posts for PEMAT Logistics support required: safe water, WASH facility, toilet, interpreters, staff, transport, food, coordination with local officers Most difficult item to achieve: WASH equipment and trainings Footprint: 3,066 sqm, with 30 + 12 tents Training program: We have established training programs as per our PEMAT guidelines. To form a team, the members should undergo induction course, adaptation to severe austere environment, special leadership training For the coming year we will have a series of trainings, example: WASH, communication, mass casualty management 8. Singapore EMT: we plan to have an EMT in 2 years (2022) Currently locally we have EMT type 1 Organization chart: when we deploy our EMT, policy-wise: ministry of foreign affairs, logistics: Singapore armed force and defend force Type of EMT capability: we are looking at type 1 fixed, with duration of operation: 14 days Standard staff: 2 doctors, 4 nurses, 1 pharmacist For any form of disaster relief deployment, our hospitals are required to roster themselves on a bi-monthly basis Logistics support required: basic necessities such as water, food, diesel for the vehicles Most difficult item to achieve: to maintain the EMT readiness once classified, also the coordination inter-ministry between countries for the disaster relief effort Footprint: will depend on the landscape that we are working on Training: currently our hospitals are required to maintain certain basic competencies For deployment during disaster relief, we have pre-deployment training focusing on familiarizing the team with the country's culture, and the situation in the country 9. Thailand Country plan: Thailand MOPH has completed the verification process for our international EMT, which was established in 21st July 2019 and is ready to be deployed at the moment Operation and domestic situation: medical response team for domestic situations Total estimated time: 8 months to establish from December 2018 to July 2019 Organization chart: EMT Type 1 fixed: team leader, clinical leader (physician), safety officer,, nurse, pharmacist, technical logistics leader Total team composition: 32 members, 4 doctors, 9 nurses, 1 pharmacist, 6 medical technicians, 12 technical logistics and support (WASH, power, etc.) Registered staff: a total of 96 staff in roster, 32 persons ready to be deployed Log support required: ambulance, translator, oxygen tanks, transportation, security guards Most diffclut item to achieve: coordination due to the fact that we need cooperation between MOPH

Time	Activity
	which has their own chain of command. So to make it fluent we need to close the gap and need better coordination between the two departments Footprint: water supply, ambulance bay, emergency room, delivery area, triage area, observation area, pharmacy office at the back, isolation area, rest room for personnel, restroom for patients, resting area for beds and tents. Total area: 2,500 sqm Training program: we have MER training program consisting of a total of 7 days (3 days lecture and discussions 4 days field training) and drill are carried out International: we got help from the mentor and expert form WHO for the training 10. Vietnam Country plan: no EMT yet but plan to set up one in 5 years EMT Type 1 Fixed Doctor, emergency doctor, general physicians to do minor procedures, and also nurses who have had emergency trainings We can collaborate with both sides (with the military and civil) We try to build EMT and the number is flexible and depends on the situations Local support: transportation, interpreters, and qualified communication devices (which are very difficult to find) Footprint: Command: biomedical, dining, kitchen, logistics, accommodation, kitchen Training program: at home and overseas (in Thailand and Japan) >*Questions & Answers:* 1. Brunei Do your higher authorities have any role in the establishment of your EMT? If yes, what are their roles and how do they achieve that? Answer: Our political leaders are already aware of it so we can use it as a leverage. 2. Indonesia How to convince your MoH to establish your national EMT? Answer (by dr. Prawira from WHO SEARO): Before going to financial and equipment support, the first support needed is the regulative support. At ASEAN we have the level of health ministry. WHO SEARO has a regional commitment signed by the ministers of health on strengthening EMT capacity in each member state. Each member state will support the establishment of EMT within their country. As to how to convince the MoH, just approach them by showing the declaration first and also show the case of other countries such as Thailand which already has a national EMT established and fully supported financially and administratively by the MoH. Answer by Thailand: We never tried to convince but we already had a policy by the government who gives us full support and cooperation support with finance and equipment and they solve everything for us. 3. The Philippines What are the initiatives you have started in your country in terms of creating an EMT? Answer by dr. Prawira: Thailand's EMT did not come from the government; the NDMC, a non-govt team, started their initiative 100 years ago and they just celebrated the 100th anniversary of their emergency response team. Looking back, it started from just a small team with one aim to help other people during the eruption of a volcano in Java. So from one occasion you can start small ad build your own capacity. The Philippines: Congrats Thailand for being the 1st state among the AMS to be verified by the WHO. How are you able to hurdle all the challenges? We want to know your experience, concerns, issues, and challenges. Do members of the team come from one institution or more? Thailand: The initiative to create the EMT began when we experienced tsunami in the south of the country. We

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	got help from everywhere, we began to create our own MER team to respond to the disaster. After that, we deployed our team to Nepal. We see that our team is not fully established, and we see also confusions, so we began to create and establish international EMTs. 4. Malaysia 1) For the purpose of drill: Who can provide incineration, clean, Type 2 EMT, ambulances? Answer by the Philippines: For the drill, our team provides everything from sterilization facility, clean water, etc., because the deployment is local, we follow the principle that we are supposed to provide everything. There's also a manual and the team should be able to find out how to provide logistics. Ensure our team has enough funds when they are deployed to international communities. 2) General questions: a) How long did Thailand take to be accredited by WHO? b) How to convince the government to support the establishment of EMT? Answer by dr. Prawira: It took 8 months (end of 2018 until July 2019) for the process of fulfilling the standards, but the process itself started in 2017, the lobbying, etc. already started a long time before that because to convince the higher authority it takes time. It is not a short process. The EMT initiative does not require any specific timeline, neither minimum or maximum length of time. You can start early and develop based on your progress, funds availability, etc. But usually a team needs 2 years to be able to be classified. 5. Myanmar How do you organize the team for effective EMT in the initial phase? Answer by dr. Kai (JDR) No preparation before deployment and the initial phase is most important. 6. Vietnam What is the most important issue you should consider for deployment of EMT? Moderator: Maybe save this question for later on in the discussion. 7. Thailand How many international EMTs should be established in our country in general? Is it possible to create more than 1 team? The Philippines: As long as you comply with the minimum requirements by WHO and as long as you pass the mentoring stage you can create more than one. In our case, we have 3 teams localized and we hope next year we can be classified by WHO. Answer by dr. Prawira: Correct, there is no limit as to how many EMTs can be established and it is possible to create more than one team. This is the case with the European countries. For example, Germany has 18 teams, but none of them is from the govt. All of them are from NGO. In our regional context in ASEAN, the important thing is not to create as many as international EMTs as they need a lot of resources, but rather strengthen your capacity, and in case of a lack of capacity, agree to accept EMTs from the neighboring countries, for example EMT from Thailand which is already established, and EMT from the Philippines (coming soon).
11.30	**Orientation on WHO Quality Assurance by dr. John Prawira from WHO (SEARO)** -Quality Assurance (QA) is a management method that is defined as "all those planned and systematic actions needed to provide adequate confidence that a product, service or result will satisfy given requirements for quality and be fit for use". -A Quality Assurance program is defined as "the sum total of the activities aimed at achieving that required standards" (ISO, 1994) -WHO EURO, 2008 came up with the definition "A quality health service is one which organizes

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	resources in the most effective way to meet the health needs of those most in need, for prevention and care, safely, without waste and within higher level requirements" -This definition recognizes the need for safe care and for higher-level laws stating high level standards and human rights. It also covers the three perspectives on quality to highlight: • patient quality (what patients want and experience); • professional quality (what patients need and following best practice) •management quality (efficiency and meeting regulations) -Reasons we need quality assurance: • Evidence of suboptimal outcomes below standards • Evidence that quality methods can help to solve these and other challenges to solve the challenges: standard practices and defined methodology • To ensure the right approaches for the circumstances, that there are structures, resources and skills to test and make the changes needed, and that there are regular reviews and renewals -Because sometimes they forget that they come to help people so instead of helping they add to the burdens of the affected country. So EMTs need to have self sufficiency -Pre-deployment > a process of EMT mentorship and classification. Thailand has gone through this process. Currently Indonesia's NDMC and NGO are in the process of mentorship and classification, and so are the Philippines -EMT mentorship & classification: the process starts from the request submitted by the country (the MoH, the Public Health Dept., or an NGO). Next: the mentorship program - verification by peer review - classification for international deployment -The intention of QA is not to judge but to be well prepared, the most important process is not the final classification but the mentorship process. If successful, the team will be classified and included in the WHO directory of classified teams -There are now 4 classifications: Type 1: outpatient facility, basic emergency services including maternal and child health. Working time: during daytime Type 2: similar to secondary hospitals, has to have inpatient capability, operates 24 hours for :more than 40 days Type 3 similar to tertiary hospital operating in field, has ICU capability. In the world there are only several countries that have this: China, Israel -There is also specialized cell that can be attached to any existing facility or EMT (type 2 or 3). -On deployment > Field visit has to be led by MoH or the focal point should be the EMTCC coordinator -Objectives of field visit: • Corrective measure and see if you need support from the coordinator or other teams. Share information on the overall situations as during disasters situations change rapidly. Includ district and overall situation updates, new or updated SOPs and guidelines • Confirm EMT operations to check whether there are any problems - site of operation (compared to the allocated site); - type(s) of service (compared to declared type and services); - compliance with minimum standards, including medical record keeping, reporting and referral requirements; - compliance with recommended or national treatment protocols; - acceptance from the community; - integration with local services providers and coordination mechanisms; and - exit strategy, including anticipated date of departure. • Support EMT operations -The methods are divided into 3: • Direct observations - will allow for a first-hand review of the EMTs facility/site layout, patient flow, systems and operational procedures in practice in the core and technical areas relevant to the type of EMT. Observe whether the EMT has the capacity and capability • Documentation review - will allow for the revision of the status of registration, report, medial report, reporting forms and help to determine the appropriateness of care being provided

Time	Activity
	• Interviews with EMT staff as the service providers and with the patients. Sometimes rumors can be reported by the media so this is the time to confirm if the rumors are true. -Key Points during the QA visit • Select a date/time and inform in advance about your visit to the EMT • Ensure that key personnel, for example the team leader or the logistician, will be available during your visit. • Interviews should remain confidential and should not be published without consent. Ensure you have a special place to interview the patients so that they will not feel too exposed and vulnerable
12:15	*Lunch*
13:30	**Indonesia Health Crisis Management Policy by Director of CHC, MOH-Indonesia** -Indonesia has standards for Disaster Management just like every other country but not all countries have the same standards because we are different -Indonesia is located on the boundaries of 4 moving Tectonic Plates and Ring of Fire (127 volcanoes), sas high mobility of people and animals (more than 300 PoEs), has 3 nuclear reactors, has thousands of chemical industrial factories -Therefore Indonesia is prone to disaster and must have good standards -Definition of Disaster: events or series of events that threaten & disrupt the lives & livelihoods of the people caused by natural disasters (Earthquake, tsunami, volcano eruption, flood, drought, landslide, etc), non-natural disasters (Technology Failure, Fire, Epidemic, etc) and social disasters (social conflict, terrorist attacks, bombings) -Government Responsibility in Disaster Management • carrying out disaster management • disaster risk reduction • adequate allocation of disaster management budget in both national and regional budgets • allocation of on-call budget for emergency response • fulfillment of community rights according to the minimum service standards -Disaster health management: Change of paradigm from emergency response to disaster risk reduction -Strategy to decrease the risk index: manage hazards - decrease vulnerability - improve capacity -Our Disaster Management Programs 2015 – 2024 • Improve Policy • Improve Human Resources • Improve Quality Assurance -Disaster Management is implemented using the Cluster System -There are 8 clusters: Health - Search & Rescue – Logistics - IDPs and Protection – Education – Infrastructure - Early Recovery - Economy -Emergency Response for All Disasters • Central Government provides assistance for national level disasters • Province Government provides assistance for provincial level disasters • District/City Government is the first responsible party (as 99% disasters in Indonesia happen in this level) Budget: on call -Emergency Response Activities in Indonesia: Rapid assessment - Rescue - Keep away from hazards - life saving & evacuation - protection of vulnerable groups - early recovery of vital facilities
14:00	**Reception & Departure Centre (Presentation of Indonesian Protocol)** Panel of Discussion: • Bali Port Health Office, MOH-Indonesia • Indonesia NDMA (National Disaster Management Agency) Moderator: Deputy Director of Emergency Response & Early Recovery, CHC, MoH-Indonesia

Time	Activity
	1st Presentation by Dr. dr. Lucky Tjahjono, M.Kes, Head of Bali Port Health Office -Indonesia is an archipelagic country, consisting of 17,504 islands, 45 health ports, located strategically in international trade traffic with many points of entries (PoEs) to Indonesian territory. This gives opportunities as well as challenges as there is a greater risk of the spread of diseases -Globalization of transport and trade which increases the volume and frequency of travel between countries means increased risk of spread and transmission of diseases -Aviation environment is not the natural human environment. Physiological changes that occur can lead to new diseases/health problems, as well as aggravate the existing conditions/diseases. This increases incidence of emerging infectious diseases and requires adequate Detect, Prevent & Response capacity -The states' commitment in implementing International Health Regulation (IHR) 2005 requires adequate Health Quarantine Program Why attention is needed to the prevention of the spread of diseases: -Emergence/re-emergence of infectious diseases -Globalization – public health event at one location can be a threat to other locations -serious and unusual disease events are increasing -biological and chemical agents use (industrial accidents, etc.) -impacts on national health, economy, security -As for the legal aspect, for the national law we have acts, govt. regulations, ministerial decisions, ministerial regulations. We are currently drafting the Quarantine Health Law at the House of Representatives -As for the international law, there are: ▪ International: International Health Regulations (2005) • International Civil Aviation Organization (ICAO) • International Maritime Organization (IMO) • International Air Transport Association (IATA) -Our main tasks are: Detect-Assess-Report-Respond, not only infectious diseases but other hazards too such as non-natural disasters. -We have many programs and activities as well as collaborations with the authorities, customs, immigration, and local governments ***2nd Presentation by Pambudi Suroyo Jati from Indonesia National Disaster Management Agency (NDMA)*** Procedures and Process in Indonesia for International Assistance during Disaster Emergency -Indonesia is one of the countries with a high rate of disasters. There were 3,302 natural disasters in 2019 with a high number of casualties. 400 died and 3,000 were injured due to these disasters -This is due to the 3 tectonic plates across the archipelago which cause all islands in Indonesia to have volcanoes (only the island of Kalimantan has no volcanoes) -For this reason Indonesia has to be prepared in terms of the logistics and operations to manage disasters -NDMA was established after the Indonesian government's realization of the need to form a dedicated agency following the Aceh tsunami disaster. NDMA Missions: -to increase the resilience of the Indonesian people against disasters -to protect the country from disaster hazards through risk reduction -to build a management system for Disaster Management that is integrated, planned and coordinated, and comprehensive (continuous) NDMA Key Functions:

Time	Activity
	-Establish formulas for policies -Handle disaster victims at shelters -Coordinate with other agencies for disaster management NDMA Duties: -Provide guidelines and directions on disaster management -Develop SOP for disaster management -Deliver information to communities -Report to the president -Carry out other obligations -NDMA is the agency at the national level which -At the provincial and regency levels, we have the Regional DMA -NDMA strengthens all Regional DMAs so that they are prepared Every year we support Regional DMAs with human resources, logistics, and equipment The cluster system is adopted and we have 8 clusters: 1. Health > MoH 2. Search and rescue > National SAR Agency 3. Logistics 4. Shelter > Ministry of Social Affairs 5. Education > Ministry of Education and Ministry of Religious Affairs 6. Infrastructure > Ministry of Public Works 7. Communication > Ministry of Communication 8. Recovery > Ministry of Health -With these agencies and system, Indonesia is capable of managing disasters at both levels (national and provincial) -However, we may offer (not request) other countries to give assistance -For international assistance to enter, first there will be a declaration of the president that we are open for international assistance for the disaster -Next, the coordinators in NDMA collaborate with the Ministry of Foreign Affairs to inform our needs to other countries. If what other countries offer match our needs, we will accept the assistance. Otherwise, we will reject it. -The Government of Indonesia (NDMA and related Ministries) has the right to: a. turn down international assistance b. instruct international assistance donors to re-export if the assistances are expired, broken and harmful to humans & the environment. c. impose sanctions on international assistance donors breaking the rules and laws in Indonesia d. oversee regularly e. conduct monitoring and evaluating -Latest experience in receiving international assistances: Earthquake - Tsunami in Central Sulawesi on 28 September 2018. On 1 October 2018, after coordinating a meeting, Government of Indonesia welcomed international assistance. There were 29 countries, UN organizations, international NGOs, partners and international communities that provide assistance in the form of air transportations, logistics, equipment and finance. On 3 October 2018, Ministry of Foreign Affairs announced that Government of Indonesia has decided to receive selective assistances as follows 1. Air transportations (preferably C-130 or alike which is capable to land in short runway). 2. Tents (shelter kits) 3. Water treatment 4. Electric generators

Time	Activity
	5. Financial donation *>Comments & Questions* Q: Do you have a list of service providers for international organizations to partner with, for water supply, gasoline, etc.? A: There is not a standard list for disasters because what is needed is only concluded after assessment at the affected area. So we don't have a list for it, it depends on the situation and every disaster has different requirements. So we have to do assessment first. Q: But if for example we cannot bring a huge amount of water, etc., do you have a list of service providers that we can get supplies from? A: We coordinate with the local government about that, because there are many donors joining the team in the field, and the local government will liaise with the local coordination center to find out which team has water supply, for example. We have national companies to coordinate with for the supply of water, gas, etc. So we coordinate with the local government concerning supplies. Q: What about the logistics supplies from our country? A: You can declare all the supplies that you will bring such as medicines or medical equipment before you come so we can check and prepare for the checking with the customs. Mr. Pambudi added: In every disaster, we set up posts so we can get the info on with whom we can collaborate from these posts. Donors/voluenteers cannot go directly to the affected region/district. They must first go to the NDMA and then NDMA will coordinate with the Regional DMA. So the list will be determined by the posts at the disaster location.
14:45	**RDC Practice** **by AHA Center + CHC MoH + BNPB (National Disaster Management Agency or NDMA)** **Main Facilitator: dr Rina Agustina from CHC of MoH of Indonesia** -This is the 1st simulation for RDC after the Mt. Agung eruption -Mt. Agung in Karangasem Regency of Bali Province is an active volcano -It erupted in 1963 after being dormant for 123 years and was the most devastating eruption that killed more than 1,000 people -2 years ago it erupted again and people from 21 villages were evacuated *>Video presentation the eruption* Situation for the simulation: You have landed and is going through the immigration. Dr. Della and Mr. Manggala will direct you through the immigration customs and health registrations. Use one lift for one team.
15.15	*Coffee Break*
15:50	**Current Situation Briefing for the field exercise with Map (Demonstration of the Situation Awareness) by Dr. Achmad Yurianto (Secretary of Director General of Disease Control, MOH-Indonesia)** Situation for tomorrow's simulation: After the big eruption, warnings have been sent to all people to evacuate from the locationdue to the volcanic materials from the mountain. Since it is in the middle of the night, it is very difficult to organize the evacuation and the number of victims keeps increasing. Meanwhile eruptions continue for more than 10 hours spewing volcanic materials, ash, and hot clouds traveling to the south and north, to the regencies nearby (Buleleng, Bangli, Klungkung, Karangasem regencies). As per the data collected, there are 4.2 million people affected by the volcanic materials. More than

Time	Activity
	4,000 people are injured seriously, mostly burn injuries due to the volcanic materials. People leaving the location are more than 150,000. 4 days after the first eruption the disaster is decalred a national disaster. All national capacity is sent to respond: -To the north of the mountain, health capacity from Sulawesi is sent to respond -To the west of the mountain, health capacity from Java is sent to respond -To the east of the mountain, health capacity from NTB Province is sent to respond -To the south of the mountain, the ASEAN EMTs are sent to respond The EMTs have landed in Mataram of NTB Province and are going to leave for the southern sector by ship to Tanah Ampo. All EMT members will be posted in Tanah Ampo to respond to the disaster in the southern area. At Tanah Ampo an EMTCC is established and the team is tasked with evacuating victims to the hospital in Denpasar by sea only. Members of the ASEAN EMTs will be sent out to the villages in the southern sector where there are victims and shelters. EMT Brunei to be sent to Antiga village EMT Myanmar to be sent to Ulakan village EMT Philippines to be sent to Sengkibu village EMT Vietnam to be sent to Nyuh Tebel village EMT Malaysia to be sent to Tenganan village EMT Singapore to be sent to Pasegahan village EMT Cambodia to be sent to Manggis village EMT Thailand to be sent to Selumbang village EMT Indonesia to be sent to Ngis village EMT Laos to be sent to Kedalan village Tasks of the EMTs: -search, find, help, and refer victims -treat victims and evacuate them by sea to Denpasar if needed -Team is expected to understand the situation in each area and will be assisted by an officer from the provincial health office who understands the character, culture, and situation of the location Questions 1. Brunei Will there be use of radio? Because there was no mention of radio communication Answer: Yes, radio communication will be provided for each EMT for direct communication with EMTCC 2. Malaysia Data recording: manual or using apps? Answer: Use manual data. After completion of tasks, this data will be entered to Excel. In this situation there is no electricity 3. Vietnam What is the policy to protect the international team in disaster areas? Is there any protocol to protect the EMT personnel? Answer: We will prepare protection for the EMT members. 4. Myanmar Which team is needed, type 2 or type 3? Where to refer the patients to? Answer: For evacuation, type 2 and type 3 will be made ready. Therefore, EMT personnel will just stand by at the village or location where they are placed. 5. Malaysia Is there any ambulance to transport patients with and what is the waiting time? Answer: Ambulances will stand by, no need to call one because they are already available.

Time	Activity
	So EMTs just decide whether they should evacuate certain patients. 6. Singapore What is the expected casualties in each village? Answer: For the purpose of the training, we will prepare 20 victims for each EMT because the time s also limited. But the total number of victims is 250 which will be distributed among the EMTs. Tomorrow we will leave at 6.30 by bus to Tanah Ampo.

Fourth Regional Collaboration Drill and
Seventh Meeting of Project Working Group 2

Date: 25-29 November 2019
Location: Bali, Indonesia
Venue: Grand Inna Hotel(Bali), Tanah Ampo Pier (field exercise)
Participants: ASEAN Member States, ASEAN Secretariat, AHA Centre, JICA

Minutes for Day 4: Review Workshop
Thursday, 28 November 2019
Venue: Grand Inna Hotel

Time	Activity
08:00	Registration
08:30	Demobilization
09:15	**Preparation for After-Action Review Presentation by dr. Kriangsak from Thailand** 2 tasks assigned this morning for the AAR: 1. Enter the forms about AAR individually 2. Prepare for the presentation: every EMT should present an after-action review for each team Questions for comments and suggestions: 1. Tabletop exercise: what is good about the tabletop exercise? What is the gap? In your opinion, for each group, what is your suggestion for tabletop exercise for the next drill? 2. Field exercise: what is good about the field exercise? What is the gap? What is your suggestion? 3. Forms: what is good about the forms? 1) Offer of Assistance Form 2) Contractual Arrangement Form 3) EMT Registration Form 4) Medical Records Form 5) MDS Daily Report Form 6) MDS Tally Sheet 7) Patient Referral Form 8) Health Need Assessment Form 9) Health Need Assessment Summary Form 10) Situation Report Form 11) Coordination Meeting Minutes Form 12) Exit Report Form 13) End of Mission Report Form 4. How about the drill or program of the 4th RCD? 5. What are your suggestions and comments for each topic? 6. How about the personal capacity building? Ex: what you need to train in the future 7. How about the team capacity building? What is essential for the team to build capacity? 8. How about the coordination process? What needs to be improved? 9. Other comments on the 4th RCD Time for preparation: 1 hour Time for presentation: 8 minutes each
09:30	**SASOP Orientation & the summary on the submission of the Request and Offer of**

Time	Activity
	Assistance by AMS – by AHA Centre *>On ASEAN Disaster Mechanism* -According to SASOP, the first 2 forms mentioned in the presentation earlier are supposedly filled in and submitted by NDMO. However, you need to feed NDMO with complete information -ASEAN Agreement on Disaster Management and Emergency Response > the guidelines that we are using to respond to ASEAN region, signed by 10 Ministries of Foreign Affairs of the ASEAN member states -AADMER is the main umbrella to run the disaster mechanism -Below AADMER there is SASOP (SOP for standby arrangements), the only mechanism we are using in ASEAN region for deployment during emergency response -SASOP is the procedure to follow for joint emergency response, also to be used when deploying resources (human and assets, civilian and military) -SASOP is tested every 2 years during the ARDEX exercise -The latest version of SASOP was tested in ARDEX held in Indonesia in 2018 -Next year in 2020 ARDEX will be held again in Manila, the Philippines to test the SASOP -Steps in SASOP: Notification of Disasters, Request for Assistance, Offer of Assistance, Situation Updates, Joint Assessment, Mobilization of Assets and Capacities, Demobilization of Resources, Assistance and Reporting -Notification of Disasters is sent by the affected state to AHA Center to be notified to other states -In the newest version of SASOP, there is no longer Request for Assistance because all countries agreed that during the emergency response the affected country is overwhelmed and has no time to request -In the Situation Updates, the affected country may state whether they are open for regional or international assistance. If they are, states will offer assistance -Offer of Assistance can be sent directly by the assisting country to the affected state or sent through AHA Center. In this exercise: to AHA Center -The main difference between SASOP 1.0 and SASOP 2.0 is the number of forms. In the former there were 7 forms, in the latter 6, because there is no Request for Assistance. Also, in the list of modules -As mentioned earlier, there are 2 channels for the Offer of Assistance: go straight to the affected country or through AHA Center -If straight to the affected country, the person responsible is the national focal point, that is, the head of NDMO, not the head of the Ministry of Health or others -If through AHA Center, we will forward the Offer of Assistance to the national focal point -Advantage of sending through AHA Center: we will follow up very closely because we have channels to the 10 states or their NDMO -If sent directly to the state (the NDMO), we hope you also cc us so we can help speed up the process for approval of the Offer of Assistance -If the Offer of Assistance is accepted by the affected country, a contractual arrangement will be signed -If the Offer of Assistance is declined, it will be sent back to the assisting country -In the SASOP's Annexes, there is the designation of national focal point (NDMO) and competent authorities. -The head of the NDMO is responsible for filling in the data and list the competent authorities, if they are willing to share them -In the new SASOP, all lists of standby arrangements are changed including the JDR modules. SASOP 2.0 now follows the ASEAN joint disaster response plan modules. -Health falls under Annex D: Health and Medical Services. Each member state is requested to state their capacity to be put in standby arrangements, and the list of resources ready to be deployed -We have identified lists of EMT Type 1, Type 2, Type 3, data on the medical plans, aerial

Time	Activity
	medical evacuation for cadavers, and also DVI -These details may be changed in the workshop next year, where we will invite MoH from each country and reconfirm whether the lists need to be changed (expanded or reduced) -We hope you can send your reps next year because your inputs on these lists are important -For this exercise, we receive updates from BNPB (the Indonesia NDMC) and BNPB put general descriptions of the disaster event and state that they need help (in the Situation Updates form). This will be signed by the national focal point -Upon receiving updates from the state, AHA Center will forward them to the other 9 states -AHA Center will also put in the recommendations what are needed -Now we have 5 countries listed their resources that are ready for mobilization: Singapore, Thailand, Philippines, Indonesia, Malaysia -3 of them have listed EMT capacity: Philippines, Indonesia, Malaysia -We hope each country can share with us the list of resources to be mobilized during a disaster -Offer of Assistance: in this exercise the Health Ministry is the one filling it in, but in the real situation the form is normally filled in by the NDMO. All heads of sectors must also understand how to fill the form -In the Offer of Assistance form: general description, personnel, equipment & materials (must be approved prior to the deployment and must match with the actual items and personnel deployed), administrative arrangement (must be self-sufficient so as to not add burdens to the affected state), funding arrangement -This form is then signed by the national focal point -Once this form is sent, contractual arrangement is signed and agreed by both parties prior to departure. Hopefully in the next drill we can exercise on this -EMT Registration form becomes mandatory when your country offers medical assistance -3 to 1 week before departure the form must be signed -Golden time for EMT arrival: 48-72 hours -Preapproval needs to be granted, AHA Center will speed up the process because arrival of EMT must be made in 72 hours of the disaster -End of Mission Report Form: to be filled in by the NDMO >*Questions & Comments* Question: Sometimes some teams may find it difficult to decide on a fixed return date and may need extension. Answer: Yes, we need a fixed return date. The country offering the assistance must state for how many days the team will be deployed. However, if the team needs to stay longer, revise can be made by sending a letter to the NDMO of the assisting country. Send it through EMTCC to be forwarded to the national EOC and then the national EOC will say yes or no.
10:00	*Coffee Break*
10:40	**Presentation of After-Action Review by AMS** **Facilitator: JICA & Mentor Team** **1. Vietnam** -Tabletop Exercise: well organized -Forms are fine, except for the Medical Report in terms of the coding of some chronic diseases like stroke, COPD, diabetic complications -Field Exercise: The tent exercise is well organized, with good facilitators and good communication. However, check list for supplies and medications should be improved.

Time	Activity
	Guideline and protocol to use these supplies and protocol for waste management are not available. -Overall Program: well-organized, especially the nice arrangement at RDC and field exercise -Personal Capacity Building: There should be standard EMTs for ASEAN countries in terms of the medical procedures, uniforms, doctors, nurses, personal equipment -Team Capacity Building: Improve the mechanism of deployment for all ASEAN countries -Others: There should be cultural orientation, and also information on the weather of the location **2. Thailand** -Tabletop Exercise: the participants should be given a longer time to understand how to use the forms and also the hard copy material of the presentation -Field Exercise: • Area for participants and observers/facilitators should be clearly assigned • Data used in the EMTCC meeting minutes should be the data gathered from the scene • Venue for conference or meeting should be more comfortable and convenient • Backup communication method should be provided for the participants • There should be more than one facilitator/coordinator for each team • There should be more space between the operation areas of each EMT -Overall Program: community and village should be separated for each country (HNA) -Personal Capacity Building: We suggest that there be a basic disaster health management course for standardization of the ASEAN EMT members -Team Capacity Building: We suggest that there be an EMTCC training and EMT Quality Assurance **3. Brunei** -Tabletop Exercise: There were limited time to fill in all sections in the forms, and it takes time to familiarize ourselves with the different forms and letters -Field Exercise: There were limited supplies for trauma care, lack of coding for chronic diseases, no vitals on patient presentation, and variables that are not coded when using Excel. Despite all these challenges, we are now able to use all the forms -Forms are simple, comprehensive, and easy to use, but there was lack of time allocated to complete them during the tabletop exercise The manual MDS daily report is slow to fill in, and the electronic is faster but some variables are not coded -Overall Program: well-organized, good timekeeping, informative and comprehensive. Realistic simulation activities with real props and environment. Fun and very stimulating break sessions -Personal Capacity Building: there is a need for additional training and improved core, basic and advance disaster life support skills -Team Capacity Building: needs more involvement in ARCH project as Brunei EMT **4. Indonesia** -Tabletop Exercise: it is important in order for every AMS to understand every form used. These forms will make us do our job more smoothly, because they are designed and revised every year through the ARCH Project. Suggestion: there should also be a death declaration form, and a mechanism that should be used to send a victim to the shelter -Field Exercise: We have been in that position before (Mt Agung from near eruption to real eruption), so we know exactly the chaotic situations, and the unpreparedness of the local government with disaster management. This exercise helped us understand the disaster management better especially within the health cluster

Time	Activity
	-Overall Program: This program is very useful to enhance the capability and capacity of each AMS in managing good coordination during a health crisis disaster, and also enhances the relation between AMS where we can get to know the other countries' SOP and ethics -Personal Capacity Building: This program lets us know how to give optimal medical services during emergency response and how to coordinate within EMT members, with EMTCC, HEOC, and the local government -Team Capacity Building: This program lets every EMT understand the standards of International EMT, and pushes them to become a classified EMT. Within the team, we trained to work based on our roles systematically, spontaneously and follow a one-line commando -Coordination Process: Communication using a one-line HT was a little bit troublesome as many people used it at the same time. There was also a language barrier among the participants, and the coordination process is actually different for each country. Internet connectivity in some tents didn't work -Others: The temperature control in the participant tent didn't work properly. The weather in the field was extremely hot
12:00	*Lunch Break*
01:30	**Presentation of After-Action Review by AMS (continuation)** **Facilitator: JICA & Mentor Team** **5. Singapore** -Tabletop Exercise: Good orientation and guidance by the facilitator, and adequate time for the team to practice filling the forms and get familiar with them. -Field Exercise: We faced quite a few issues: • During Mass Briefing: no sound system, so we were unable to hear clearly and understand the situational updates, and there was also lack of structured agenda. We recommend providing pictures of affected area and a structured agenda covering situational updates, updates for forward planning and review of daily operations • Simulation of exercise area: the footprint of the tent and EMTs area of operation did not simulate actual operations. We suggest distributing the exercise area so that EMTs can simulate and plan on their area of operations as well as prioritizing logistics. Also, the workflow for logistics request from EMTCC was not exercised. We suggest simulating the flow of casualties with security checkpoints • Communication: there was only a single channel for all coordination between EMTs, EMTCC and ambulance coordinator. Ambulance staff were unaware where the casualties would be referred to. There was also lack of operation staff support for EMTs. This is an important as many countries depend on the doctors and nurses who have to do dual jobs. We suggest providing a radio walky-talky with different channels for ambulance and logistics, and including operational staff for logistics, admin, and operations of EMT. -Forms: For the Medical Record and Patient Referral forms, we suggest indicating the compulsory fields with (*) so that we don't miss filling them in. -Overall Program: well-coordinated and we enjoyed the hospitality -Personal Capacity Building: We hope there will be preparatory courses on Disaster Relief Operations coordinated at ASEAN level to maintain medical competencies and standardizing medical competencies requirement among all EMTs in ASEAN countries -Team Capacity Building: Need orientation on the country's culture, the health regulation/laws, and the overall concept of crisis operations of that country. Singapore will give feedback to MoH on the experience and lessons learnt from this RCD

Time	Activity
	6. Philippines -Tabletop Exercise: Overall good. Instructions were delivered thoroughly. All of the forms were introduced properly and steps for filling them in were explained meticulously. Database was user-friendly -Field Exercise: We were able to experience Indonesia's Customs Quarantine Immigration process. During the EMTCC meeting, appropriate information was provided and radio communications were good. However, as a team we think we should learn the basic language of the host country to address the language barrier -Forms: All were good -Overall Program: Very good. It went according to the plan, objectives were met, and resource speakers are very knowledgeable -Personal Capacity Building: This program enhanced our skills in terms of coordination with other ASEAN state members, and we gained more knowledge with the information given and put it in to application in terms of international deployment -Team Capacity Building: The drill is appropriate and congruous to our current plan for the refinement of our EMT. It gave us more exposure to different cultures and opportunity to establish network and partnership with other AMS -Coordination Process: It made us realize that being one of the ASEAN Nations we must be unified with other member states, in line with our theme "One ASEAN, One Response". The coordination process was made easy for all. There may be some language barrier in some aspects, but the host made sure that needs were met. Others: The scenarios might be a little overwhelming for some, maybe because the number of personnel were limited, but they were managed very well and coordination was done satisfactorily. There were also challenges in mobile communications especially the Internet connection on the site, but these were addressed appropriately. **7. Myanmar** -Tabletop Exercise: The exercise was systematic, handy, and conclusive, but needs more time for new participants to fill in the forms -Field Exercise: The exercise was systematic, well prepared and well organized. Facilitators were very helpful, responsible and friendly. Local surrogates were very smart, cooperative and coordinated. Ambulance crews were well trained and performed as in real situations. Logistic support was great. The problems that may need to be addressed include communication problems due to busy network (each EMTCC group should have an individualized channel) and language barrier, delay in transporting for referral, lack of social workers/police officers for sexual abuse and IVDU cases, disinfection for infectious cases and for the shelter -Forms: The medical record form in particular is time consuming during patient surge -Overall Program: Very good. Even though the weather was hot, it ended up well because of program was well planned. We also enjoyed the traditional Bali dance entertainment. The sessions are enjoyable and strengthen our team spirits on One ASEAN One Response. -Personal Capacity Building: The program is very useful for all team members in disaster management -Team Capacity Building: The program is a great opportunity for the development of our country's national and international EMT -Others: We got a lot of experiences from this drill, and we appreciate the local authorities, organizers, and ARCH project committee members **8. Malaysia** -Tabletop Exercise: MDS tool is user friendly and helps a lot in managing data. However, the time given for filling in the forms and MDS tool exercise was not enough. -Field Exercise: • The process of registration at the EMTCC went smoothly, but in the EMTCC meeting it was a noisy so some info was not delivered clearly and we could not

Time	Activity
	hear properly. The 1st situational report was also conducted in a noisy area and therefore some information was not delivered. We suggest providing a paper copy of the situational report for every team and a list of important information such as the response site (incl. longitude/latitude), the referral hospital, and the cultural customs and belief • In the coordination process, management of certain cases like PTB & dead body needs to be briefed earlier as different country may have different management • The use of the communication device, call signs, and protocols need to be briefed. The internet access/Wi-Fi provided was not accessible. We had to use our own mobile Internet -Forms: Good coordination and no problem in filling up the forms. However, the variables in the patient referral form need to be clearly defined and standardized as they may refer to different things according to the host or WHO. The coordination meeting minutes were not given during the exercise. We suggest providing more info to the team and the minutes should be delivered via email. The situation report was not given in written form -Overall Program: the demobilization was smooth -Personal Capacity Building: More training like this needs to be carried out in the future and more personnel should be involved -Team Capacity Building: The team needs to have more comprehensive training in international EMT mobilization for the familiarization with the whole process including filling up the forms -Coordination Process: Overall, the coordination process is good. We suggest providing a bigger space for the EMTCC briefing/meeting so everyone can participate -Others: The venue of the training is great, nice view. The facilitators were very helpful. Excellent and delicious food **9. Lao PDR** -Tabletop Exercise: Teamwork and team management were good. We got to improve more skills about MDS. However, we had difficulties filling in the form because there are so many forms. Due to the limited time we could not finish all forms on time -Field Exercise: Teamwork was good, but there were communication problems: when the patients came, we could not communicate -Forms: we had limited understanding but people are helpful -Overall Program: We learned more about SOPs for EMT coordination. We need to take more time to learn about the forms -Personal Capacity Building: We want to have more trainings in our country, to have students exchange program (between AMS), and scholarship to study abroad -Team Capacity Building: We want training and support for human resources, improve human resources with technical knowledge -Others: We could not get more detail during the meeting with EMTCC because it was so noisy and there was not any speaker. Also, there were not enough medical equipment and other facilities **10. Cambodia** -Tabletop Exercise: Well conducted -Field Exercise: Well organized, well conducted Suggestions: • The tent was a little bit small so it was difficult to move • Communication between EMT and EMTCC was a bit challenging because it was crowded • The meeting room of EMTCC had no audio system and the room was a bit dark -Forms: All forms are appropriate -Overall Program: Fine -Personal Capacity Building: We need refresh trainings on life basic support, Disaster

Time	Activity
	Health Management including SASOP, logistics management, and paramedics trainings -Team Capacity Building: We need support from the politicians and technical support, and to improve team quality to raise the standard -Coordination process: SASOP awareness to all EMTs to understand the procedures for team deployment
14.25	**Conclusions, Recommendations from the fourth Regional Collaboration Drill** **ARCH Project Team** -Thank you for making it easier for us to collect the data and all inputs from the teams will be collected and summarized to identify how we can improve the next drill -We had our start-up drill in 2016 in Bangkok, Thailand. Next, we held the RCD as follows: • 1st RCD: in 2016 in Phuket, Thailand • 2nd RCD: in 2017 in Danang, Vietnam • 3rd RCD: in 2018 in Manila, Philippines • 4th RCD: in 2019 in Bali, Indonesia -Based on the 44 responses from the participants, the following are the conclusions of the 4th RCD: -Most participants find that the duration of the 4th RCD is appropriate. We had our first drill in 2016, and next year we will have our 5th drill in Myanmar, with a duration of 3-4 days -Most participants find that the format of activity is appropriate for the content presented. In the next drill we will finalize the format of activity, improve the tabletop exercise, and practice before going to the exercise field -Most participants find that the introductory sessions for the first 2 days are helpful. Introduction to everything: we need to know the system of the host country. Indonesia has informed us about their system. If we know the system, we can understand how to improve our system in the future -Most participants find that the drill scenario is well-planned -Most participants find that the drill activities are well-managed throughout the day -Most participants find that the documents are well prepared -Most participants find that the drill materials and equipment are enough and well prepared -Most participants find the overall activity satisfying -Most participants want to attend the 5th RCD -Most participants will recommend this activity to friends and colleagues -Personnel need to be educated and trained. Set up regional training courses, regional training programs, student exchange programs, scholarships and seminars to share knowledge and skills of EMT -For the standard drill: just learn about each other and the system. We had our 1st drill in Phuket, Thailand, our 2nd drill in Vietnam, after which we learned about the gaps and improved -It will be better if we can trim more and more. It will benefit all countries, trim the costs and help the actual person that will act and help in the real situations -Composite team: this is the challenge of how we can work together, set up SOP or standard coordination in advance, and how we can work inside a team together with people from different cultures -Form filling: we are now familiar with the forms. Medical records will need assessment. In the next drill there will be improvements. Thank you all for all your inputs.
14.40	**Feedback from dr. ... from the Philippines** -Presents the results of the QA visit conducted yesterday -What went well: • Awareness of the team members of the QA visit. The QA visit gave AMS insight of

Time	Activity
	the quality assurance process itself. The purpose and objective of the QA visit is to give overview and support and assist AMS. • Application of the EMT and EMTCC concepts. EMTs were applying the standards • Quality Assurance team as mentors were supportive and willing to assist. QA visit team members come from different countries with various expertise. -Issues and challenges: • Problems with medical management • Language barrier (need to find a way to make it simpler for everyone to understand) • Different levels of understandings among the AMS members • Not everyone has the same level of awareness of the EMT -Recommendations: • All AMS should be familiar with the contents of the Blue Book • Learn from the experiences of Thailand EMT. We encourage Thailand EMT to present the process and challenges so the other AMS will be able to see what they can do. • Go through the different documents and logistics. Hopefully will be able to share SOPs and get some inputs from the JDR team • Create a roadmap to illustrate how the AMS will be able to form EMTs. Identify in which part of the roadmap we are in now. Those who have reached the end of the roadmap can assist the other AMS with the steps in the roadmap This roadmap will be the basis for assisting different member states and mentor them for the different stages in the roadmap • For the 5th RDC: Dedicate time for the conduct of QA visit so that it will not interfere with the disaster management • There should be a clear scenario on what the role of the AMS is, to avoid confusion • You can access the VOSOC, to get all the information and questions that you will answer during the QA visit
14:50	**Feedback from ARCH Project Mentor Team** -Presents the mentor team's evaluation based on direct observations and interviews with some participants -We find that most EMTs can fill in the forms very well and take a short time to fill them in -However, due to different experiences for each country we need more time to practice filling in forms -We find that most countries have the data and team information from their home country, which we suggest doing next time before the exercise so they can take a short time to prepare their presentation
15:00	**Feedback on the 4th RCD from Japanese mentors – Planning and Conducting the RDC by Dr. Tomoaki Natsukawa - Japanese Advisory Committee** -Practice filling up the forms: The challenge is the short time to fill up the forms. Recommendation is to narrow down some part of the forms and simplify the patient's information -Comprehensive Team Information: The challenge is the short time to fill up the CTI. Recommendation is to narrow the items down based on the time frame -Comments: Trying 'CTI' first time was great. To make use of this experience, we are expected to pick up the challenges and to solve them -Reception & Departure Center: The challenge is there were only few injections. Recommendation is to refer to the injections in the 3rd RCD in the Philippines -Field exercise: The challenge is concerning the unsafety of the informant

Time	Activity
	-Comments: Trying 'composite team and QAV' first time was great. To make use of this experience, we are expected to pick up the challenges and to solve them -Demobilization: The challenge is that there were few injections. Recommendation: Refer to the injections in the 3rd RCD in the Philippines -Overall: The challenge is the participants' insufficient understanding of EMTCC. Recommendation is to provide a lecture on the concept of EMTCC on Day 1 of the drill -Comments: Energizers like the dancing and exercise were very nice
15:15	**After Action Review (AAR): 4th RCD EMT MDS - by Tatsuhiko Kubo MD, PhD, ARCH Japanese Advisory Committee** -Two accomplishments: • On the EMTs: The MDS daily reporting rate (reporting by the AMS EMTs) is 10 out of 10 AMS (100%), which is great • On the MoH/EMTCC: Surprisingly, the EMTCC prepared the data of National EMT. They did analysis of the EMT and produced the data, and this is the first drill in the world that is conducted with the MDS data prepared by the host country Indonesia, which is great -Reason to report the MDS: to support the MoH in reporting health activity within a wider emergency or disaster response to the National disaster management authorities -Challenges observed: How to maximize use of the MDS form, how we can cope with multiple health issues, how to add some diseases that are not captured by the MDS systematic compact communication between EMT and EMTCC -For the real time analysis: -Items of MDS should be: Countable by every EMT (clear and concise definitions); Clearly useful for the current response coordination; Not too detailed but provide "good enough" information; Focus on emergency to acute phase (phase of EMT deployment); Tick box selectable (recordable by Tick-box on medical) -MDS Standard Forms: There is a mixture of file formats observed during the drill (needed data cleaning). We got many data in many formats. We need some clarification for this methodology and we need some Data Manager for this situation. The tools used include paper, USB, SNS, email, and to enhance systematic and efficient communication we need data manager -Recommendations: Provide separate training for MDS/info manager for EMTCC/EMT in a separate session to be beneficial
15:25	**Remarks by Mr. Kai from JICA** -This drill is a success -The most important is capacity building of human resources and system of disaster management and how to relay the knowledge to the young generation -This project is a good opportunity for capacity building and will be very useful for the ASEAN member states -Myanmar, Vietnam, Lao, and Cambodia: ARCH Project has expanded the capacity building program to these countries -Unfortunately, Donggala in Sulawesi Island had tsunami last year. Over 2,000 were killed and this time the Indonesian government did not request international EMT assistance, unlike usual. Indonesia was able to manage and control their national EMT system because Indonesia had stepped up in disaster health management. I think the final goal of disaster management is the self-sufficiency of the country itself. Indonesia is already at this stage.
15:30	*Coffee Break*
15:45	**Short Evaluation of the 4th Regional Collaboration Drill - ARCH Indonesia Working Committee - by Dr. Ina Agustina, MoH-Indonesia**

Time	Activity
	-All of the programs in the agenda are delivered, starting from the pre-deployment practice, pre-workshop, and finally the 4th RCD -There were some changes in the schedule, due to some reasons such as changes in the speakers' schedule and the dynamics of the activity -All of the programs started 5-10 minutes late and finished on time or earlier -The objectives of each session based on the curriculum are achieved. However, survey is needed to determine the learning outcomes from these activities -In the Pre-Deployment Session, 8 of 9 countries have submitted through the EOC website: first Malaysia, and then Brunei Darussalam, Philippines, Lao PDR, Vietnam, Thailand, Singapore, and Myanmar. 7 of 8 countries submitted Annex M Form & EMT Registration Form (Lao PDR submitted EMT Registration Form only) -Field Exercise: Overall it went well and the learning objectives were achieved, though not perfect as there are many things that need improvement, but I hope it will not be a big issue -Some logistical problems: Lao did not get a stethoscope, poor radio communication facilities and not enough channels, some vehicles were still going during the HNA and composite team simulation -During Session 1 and 2, the HNA and composite team simulation, the temperature was very hot, but it did get cooler so we felt more comfortable -Some actors who were supposed to act as victims did not come. This is a problem for us and we had to improvise so that each EMT can have enough victims -There was an additional session initiated by Indonesia, the Composite Team Field Exercise, which was practiced parallel with the HNA simulation -In this exercise, the participants were from Indonesia, Japan and Thailand, which were composited to be 1 team -The process was as follows: 1. There was an emergency situation and a need for additional doctors & nurses 2. EMTCC reviewed the existing capacity and decides to form a composite team 3. EMTCC invited 3 leaders from 3 locations and negotiated with them 4. Additional doctors and nurses came to the location and reported to the leader of the existing EMT Type 1 Mobile, and they officially became 1 team as an EMT Type 1 Mobile Composite Team So, a composite team can be formed in two ways. When the situation is getting more demanding and we don't have additional resources, after we review the capacity, we can ask each team to send members to form a new team as a composite team. 5. The leader gave a briefing and assignments. The members were divided into several small teams and went on foot to some sub-villages, because in this scenario the road was heavily damaged so they could not go by ambulance. The team was under the leadership of EMT Command and they communicated using a radio. 6. After the team finished the task, they returned to the post, and had a meeting with the leader -Lessons learned: We are of the view that it is possible to implement the composite team and it can be the idea to form an ASEAN Team, with some notes to be followed up: 1. What is the best set up for composite? 2. Need complete data about the teams that will be composited 3. Who will provide the logistic support? 4. Manage the language barrier with the local assistance team 5. Need ASEAN SOP to break down technical issues, ex: who is the leader? SOP for dispatching foreign logistic? 6. Need a support officer to help the composite team leader to manage communication, logistic or transportation issues 7. Limited simulation time could not represent the real time disaster situation.

Time	Activity
	So next time, in Myanmar maybe, we need more time for composite team simulation -Suggestions from us: -For the upcoming drill, we need to conduct a drill for various types of disaster, including pandemic, in collaboration with WHO and ASEAN EOC -It is essential to draw the whole process of AMSs EMT deployment in one graphic that shows the coordination among AHA Centre and ASEAN health sector response -Aside of EMT, we might need to discuss logistic assistance mobilization arrangement within ASEAN -The EOC Focal Point needs to be invited as a participant
16:15	**RCD in the Future - by S. Ikeda from JICA** -Thank you and appreciation to the preparation team, dr. Ina, dr. Manggala, for their effort, hard work, and dedication to do this very challenging task -About RCD in the future: Plan of Action (POA) -POA means a plan to implement the ASEAN Leaders' Declaration on Disaster health Management -The POA 2019-2025 was endorsed by AHMM on August 2019 -In this POA, we have 14 targets at the regional level, some of which are: Target 2. A set of SOP for the Coordination of International Emergency Medical Teams (EMTs) in ASEAN is regularly reviewed, tested through regional exercises or lessons learned from actual disaster responses, and updated every three years Target 4. A database of EMTs in ASEAN is maintained and updated annually for utilization in disaster situations. Target 5. Standard reporting forms of EMTs, such as Minimum Data Set, Medical Record and Health Needs Assessment forms are developed and regularly reviewed, tested and updated. Target 6. An ASEAN Standard for I-EMTs is developed and regularly reviewed, tested and updated. Target 7. An ASEAN drill for the coordination of EMT in disasters is scheduled and conducted annually. Someday all the countries will have hosted the RCD, we hope. -Some of the targets in the POA at the national level are (out of 7 targets): Target 1. Each ASEAN Member State has at least one I-EMT that is compliant to either ASEAN or WHO I-EMT minimum standards. All of the countries already agreed that all countries should establish the EMT Type 1. Target 2. EMTCC has been established in each country, so that when a disaster happens the EMTCC is ready to coordinate EMTs coming from other countries Target 3. National SOPs for the coordination of EMTs which determine the protocol in EMT coordination; such as, the request and offer of assistance, RDC process, CIQ process, or the authorization of healthcare professional have been developed. These national SOPs need to be ready in case our country becomes an affected country, so it is very important Target 4. The standard reporting system for EMTs has been developed. -ARCH Project Extension Period continues to March 2021, and during this extension period some activities will be added, as follows: 1. SOP for Coordination of EMTs in ASEAN should be integrated into the SASOP. AHA Center in cooperation with us will organize a tabletop exercise inviting the people from the member countries to discuss the SOP and its incorporation into the SASOP. It could be included as a separate chapter in the SASOP. After approval, the final check will be done in the next ARDEX in Manila. 2. ASEAN Collective Measures for AMS I-EMT should be discussed • Customs compliance on all goods and materials for EMT operations

Time	Activity
	• Waste management • Indemnity and malpractice • Logistic support Since EMTs should declare themselves self-sufficient for their deployment, some logistics arrangements among AMS are necessary in case of shortcomings • Registration of medical practitioners to practice in affected countries Also very important for the quick implementation by the AMS EMT -5th RCD in 2020: a very important meeting. Tomorrow on the 29th the PWG 2 meeting will discuss the next RCD, the host country, the venue, the timing -Myanmar already submitted an expression of interest in hosting the 5th RCD -Have a safe journey back to all the participants and see you again next year in Myanmar *>Remarks from Dr Ina:* -Learned many things from the mentors, who gave me new insights and knowledge, without whom Indonesia would not be able to conduct this activity. Thank you very much. -Very glad to meet with all of you, hope that in the future we can meet again (but not in a disaster situation!)
16:30	**Summary and Recommendations - ASEAN Secretariat** -On Day 1, in the Comprehensive Team Information session, we learned how countries can initiate the establishment of National EMT. We learn how at the regional level ASEAN can contribute in terms of advocacy materials and advocacy support in establishing National EMT -Improvement of Disaster Health Management in ASEAN: We have undergone tabletop exercises and practiced with the forms and SOP, and I think it's time for the ARCH Project team to clean up unnecessary details in the forms and enhance the EMT SOP before it is tested in ARDEX and in the Preparedness and Response Working Group to be included as part of the SASOP -The new component introduced by Indonesia, the Composite Team of the EMT: in the future are we going to have an ASEAN composite team? -We heard all feedback in the After-Action Review. We hope all inputs, lessons, and best practices are well recorded and well documented for future planning activities of ARCH project including the 2020 RCD -Reflecting backwards, if our aim is to test SOP and other tools, we already did that. There have been very minor changes and revisions since Vietnam. So now it's the time to think of redefining or redesigning the drill itself and what will be the next objectives. -We also understand that the RCC is endorsed by health sectors, and will oversee all disaster health management including EMT. -We are also pleased to let you know that on the other hand from the public health sector perspective we also have a project called Mitigation of Biological Threats, focusing on biosafety, biosecurity enhancement, preparedness, surveillance components through sophisticated tools called bio diaspora, that incorporate all data: IATA, flight schedules, demographic data, world development index data from World Bank -All relevant data are available on the website and all ASEAN member states can access them -In the near future, we will be in the concluding phase of our work plan of cluster 2 in 2020. It's an opportunity to include the EMT component into the disaster management components, and also in particular to expand it for all hazards, because from the first to the fourth drill, they have all been natural disaster impacts such as wounds, open wounds, burns, etc. It is time for chemical leaks or biohazards that can threat the population -We try to facilitate all of these things, and try to involve all of the relevant sectors (disasters, security, livestock) when operationalizing everything. That is why we are trying

Time	Activity
	our best to support and to complement the One ASEAN One Response -Ways Forward: the ARCH Project team will review and revise the ASEAN EMT and the tools based on the inputs in this RCD and other consultation avenues, such as the consultation between the health sectors by Thailand and Malaysia for the EOC, an interagency consultation with AHA center in Jakarta to discuss the operationalization of the inclusion of the public health components into the ASEAN EMT SOP -We also want to emphasize that all of the lessons and best practices and recommendations from this drill need to be captured well and presented to get support and endorsement -RCD: a divergent concept and objective for the future RCD
16.45	-Representatives of ASEAN Member States' EMTs and representatives of all participating organizations are invited to come up to the stage to receive certificates and for a group photo session
17:00	**Closing Remarks by Director of CHC, MOH-Indonesia** -Appreciation to JICA, AHA Center, WHO (SEARO), WHO Indonesia Representatives, NIEM, and AMS for the active participation and good coordination -Gratitude to all mentors for support and guidance, and to the facilitators, the government of Bali province, BNPB (Indonesia NDMO) -Hopefully, this activity will be beneficial for all parties.

Instruction for your Presentation

-You are expected to deliver a presentation on your EMT (or your desire EMT).
-You have only **8mins sharp** to deliver your presentation.
-Please fill your information in the given questions in the following slides.
-Please do not hesitate to ask questions with supporters at the same table.
-You have **90 mins to prepare** for the presentation tomorrow morning.
-Please do not only answer with YES/No,
your imagination and thinking process is the most important.
-Please use this template for your presentation.

Workshop for Comprehensive Team Info 2019 Bangkok

WHAT ?

- ☐ NAME OF THE SHEET
  -"Comprehensive Team Information"
- ☐ ASSUMPTION
  -Not many teams are clear about detail planning of their EMT
- ☐ PURPOSE OF THE SHEET /CONCEPT
  -For all the AMS to be able to consider potential EMT establishment
  -to prepare for the detailed information
  -To facilitate the process by answering the sheet
- ☐ SET OF QUESTIONS
  -There are 40+ questions
  -Based on WHO's existing forms, complemented by ARCH project
- ☐ THEN WHAT IS THIS?
  -A planning tool
  -Memo to share with your colleagues in home country and record relevant discussion histories
  -Presentation Report

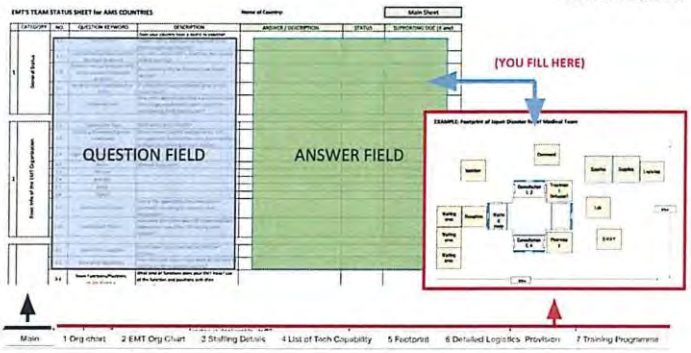
Template for Compre...Info.xlsx

COMPOSITION

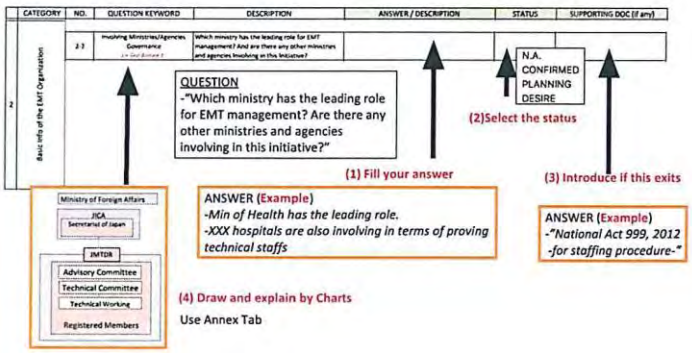
Main Sheet
- Key Questions

7 Subset of appendix
- Org Chart
- EMT Org Chart
- Staffing Details
- List of Tech Capability
- Footprint
- Detailed Log Provision
- Training Programme

Overview of the Sheet



EXAMPLE: HOW TO FILL THE FORM



(4) Draw and explain by Charts
Use Annex Tab

Country Name Here

Country flag here

1 General Status	1-1	Country Plan	Paste/fill in your answers here
	1-2	Establishment of National EMTs deployed to abroad	
	1-3	Establishment of National EMTs, which operates in domestic situation	
	1-4	Issues around establishment of EMTs	
	1-5	Estimated time	

Organization Chart

EXAMPLE: GovernmenOrganization Chart, Japan Disaster Relief Team

3-4 Standard Staff Number How many team members are in your EMT? Is there any fixed number for the standard operations?

Your answer here:

3-5 Registered Staff Roster How many team members are registered in the roster as deployable staff?

Your answer here:

3-14 Other Specialized Unit Is there any other specialized capability than type 1 fixed?

Your answer here:

4-10 Logistics support required Is there any identified logistics support that you intend to acquire from local environment?

ANNEX6: LIST OF DETAILED LOGISTICS PROVISION

NO	LOGISTICS PROVISION	AVAILABILITY STATUS	STATUS DESCRIPTION	Unit	Standard Number
1	Water, Portable Drinking, Hand washing				
2	Power & Lighting				
3	Food				
4	Shelter				
5	Medical & General Waste Disposal				
6	Sanitation				
7	Communication				
8	Transport				
9	Interpreters				
10	Oxygen				
11	Emergency Procurement				
12					
13					
14					

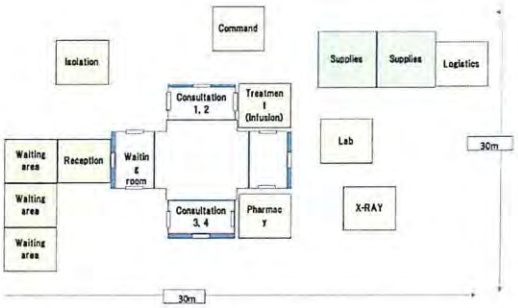
*The list is designed based on the EMT Type 1 Fixed, Outpatient Emergency Care, "Self-Assessment Minimum Standards"

What is the most difficult item to achieve?

Your answer here:

Footprint

EXAMPLE: Footprint of Japan Disaster Relief Medical Team



5-1 Establishment of Training Program Does your team have an established training program for keeping and developing capability?

ING PROGRAMM FOR EMT, Japan Disaster Relief Team

as of 2017

Course

on in overseas training
ed temporary

Skill-up Course

- Target: JDR medical team registrants
- Participants: 150 participants
- Time: per year
- Based on training curriculum (only for First and Second)

Induction Course

- Target: JDR medical team interim registrants

EXAMPLE

Your Questions to Other Teams

Supporters in pair		*Red indicates those who submitted
Hathairat	Dr. Yamanouchi	Brunei and Cambodia
Dr.Rapeeporn	Dr. Nakamori	Lao PDR and Indonesia
Dr.Kriangsak	Dr. Oba	Malaysia and Myanmar
Dr.Bhumarin	Takamura	Philippines and Singapore
Dr.Nopmanee	Taguchi	Thailand and Vietnam
Dr. Danac	Janice	Progress checker

Instruction for the EMT MDS Daily Report

WHO EMT MDS Working Group/Japan Disaster Relief EMT Initiative Corresponding Unit
Contact window Tatsuhiko Kubo MD. PhD. (University of Hiroshima)

Please select your MDS Manager

✔ MDS Manager
- Good at handling information or data(Excel)
- Good knowledge about EMT/EMTCC coordina

MDS Manager

MDS – Forms&Tools

EMT MDS Gateway https://www.mdsgateway.net/

- MDS Forms
- Brief Instruction (PowerPoint)
- SIMEX Excon Guide (PowerPoint)
- MDS Maker/Feedback Maker (Excel)
- Protocol for eDATA reporting

EMT MDS Gateway

Aim of Website:

What is the MDS?

The WHO EMT Minimum Data Set

"The EMT Minimum Data Set (MDS) is a package of essential data items for EMT reporting derived from medical records of patients treated by EMTs. "(Feb. 2017)

1. **50 standard items to be reported by EMT to EMTCC**
2. **Daily Reporting Form**

Tick box on the Medical Record.

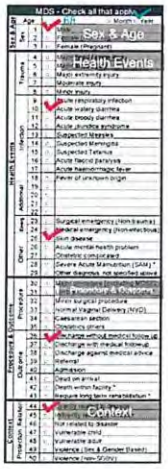
The MDS Daily Report Form

A form to report, "When, Where, Who(Which EMT) treats What sort of patients for How many" for a day.

Steps for MDS daily reporting

1. Get the MDS Forms and Tools
2. Tick in the MDS tick box for every consultation
3. Use the MDS Maker (Excel program) to make MDS Daily Report data files(CSV)
4. Send the data files to EMTCC by Email

- Files to be sent: Two types of CSV data files (IP, DR) made by the MDS-Maker.
- Send files by 7PM daily until further instructions.
- In case there is no network, please bring the files to EMTCC physically.
- Forms and tools available at https://www.mdsgateway.net/



EMT(Medical Doctor)

Step1: Tick-box on Medical Record

- Medical Doctors will tick.
- "Check All that apply."

Patient- 68 year old
- ✔ Male (1),
- ✔ Acute Watery Diarrhea(10), Skin disease(25)
- ✔ Requiring Medical Follow up(37)
- ✔ Indirectly related to disaster(45).

MDS Items with classifications

Trauma

4-6	Major	Require hospitalization and/or general anesthesia (EMT Type 2&3)
7	Moderate	Require conscious sedation or regional blocks (EMT Type 1 Fix)
8	Minor	No needs for any anesthesia (EMT Type 1 Mobile)

Procedure

30	Major	Procedures usually needs general anesthetics and/or hospitalization.
32	Minor	Procedures acceptably performed without general anesthetics nor hospitalization.

Relation

44	Directly	Patient visit with injury or illness directly caused by an emergency event.
45	Indirectly	Patient visit caused or worsened by situational change after an emergency event. e.g.) Environmental exposure
46	Not related	Patient visit not caused by the event. . e.g.) NCD

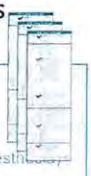
EMT(Medical Doctor)

Step1: Tick-box on Medical Record

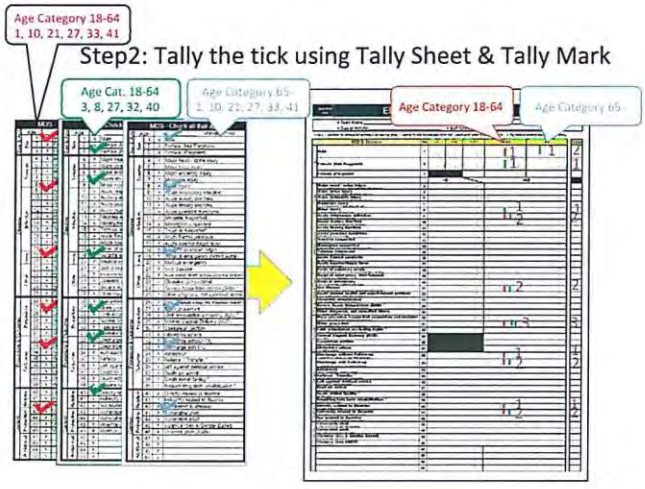
- Medical Doctors will tick.
- "Check All that apply."

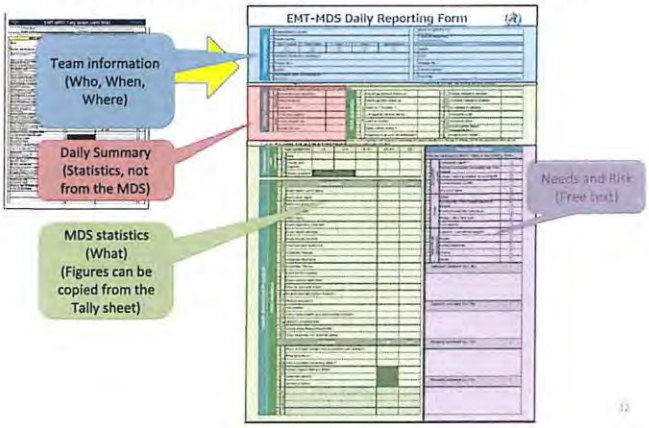
Patient - 24 years old
- ✔ Female Non-pregnant (2),
- ✔ Torso trauma (needs hospitalization)(5)
- ✔ Surgery with general anesthesia (31)
- ✔ Admission(39)
- ✔ Directly related to disaster(44).

(FAQ) Characteristics of the MDS items

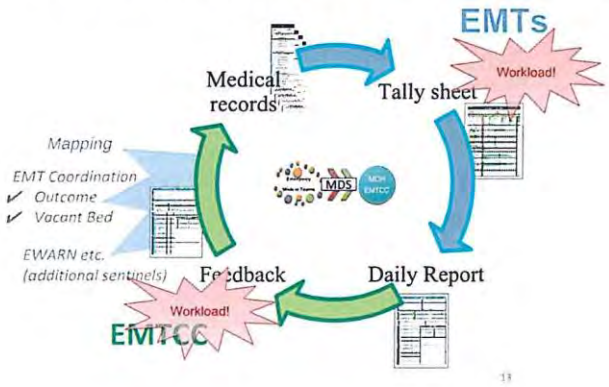


1. Medical Doctor will tick on medical record
2. "Check all that apply" is the only instruction to tick
3. Practical judge to select MDS items is acceptable
   - Ex. Major trauma (requiring hospitalization/care with general anesthesia)
4. Items capture universally major issue only, and not all issue.
   - To count context specific issue, EMTCC will suggest item's name and its definition for Additional items (MDS19-22)
5. Every MDS module will have more than one tick([1]sex, [2]health events, [3]discharge with/without medical follow-up and [4]relation to disaster).
6. If one patient visit twice a day, data will be generated twice
   - MDS count medical resource in need(not patients but consultations).
7. Data is anonymous

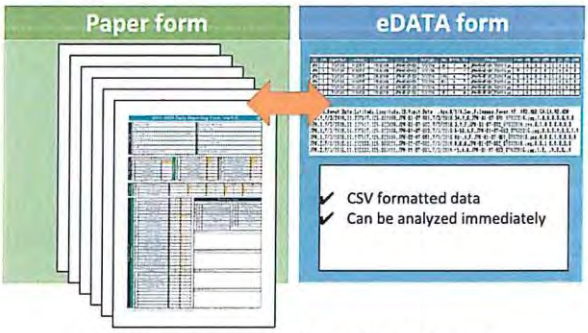




Information processing of the MDS



How can we process the data easily?



WHO has standardized both formats

Steps to enhance MDS reporting

- ✔ Paper is platinum standard in terms of cost, feasibility, simplicity.
- ✔ eReporting allows immediate statistics at ETMCC.
- ✔ Smartphone app allows utilizing Picture/GPS information.

WADEM

Sansana Limpaporn et al. WADEM, Brisbe. (2019)

Feed back from the participants

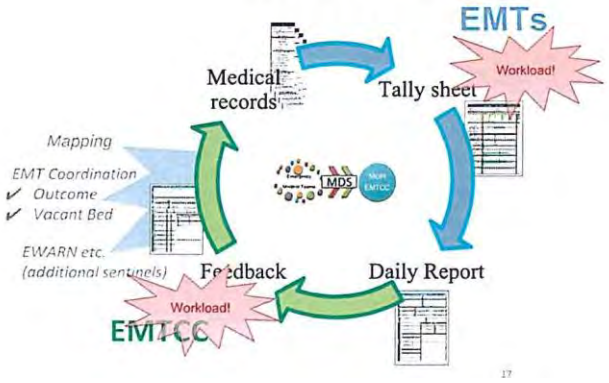
1st RCD: Thailand	2nd : Viet Nam	3rd : Philippines
Too small font (3	-	-
Require more space to wri (3/10)		
Different understanding in terminologies (6/10)	WASH-Water, Sanitary, Hygiene (1/10)	-

Number of comments to be improved decreased.

1) Compared to paper form, using an excel is a lot more comfortable and timely. can produce a statistic summary in one click.
2) Not even one negative comment was mentioned. 10 out of 10 ASEAN Member States agreed on the MDS in form of mobile application; convenient, user-friendly, easy to access

*Remarkable point: In disaster area may not have electricity provided, paper form is still needed

MDS cycle



The MDS Makers

- MDS Maker
  - -Excel to enable EMT CSV data reporting.

- MDS Feedback Maker
  - -Excel to enable EMTCC summary statistics

Latest version:
- MDS-Maker_typeA(MedicalRecord)_191116B
- MDS-FeedbackMaker_TypeB(DR)_191116B

MDS Maker – EMT

A) Open The MDS maker (enable Editing/Macro)

B) Go to the INSTRUCTION page on the tab "00INSTRUCTION"

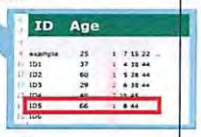
C) Go to the Tab "01 INPUTBASIC" and input "EMT Team information"
- ✔ [Team name] EMT Your name etc...

D) Go to the Tab "02 INPUTMDS" and input one patients data
- ✔ Patient ID5: 66yo MDS 1, 8, 44

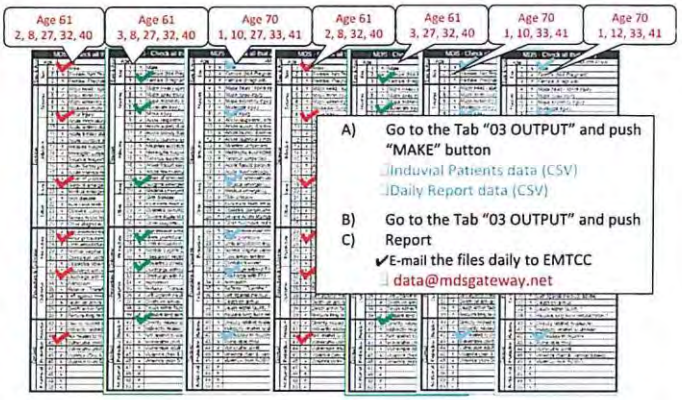
E) Go to the Tab "03 OUTPUT" and push "MAKE" button
- Induvial Patients data (CSV)
- Daily Report data (CSV)

G) Report
- ✔ E-mail the files daily to EMTCC
- data@mdsgateway.net

EMT MDS Gateway https://www.mdsgateway.net/



Go to the Tab "02 INPUTMDS" and input 7 patients data



A) Go to the Tab "03 OUTPUT" and push "MAKE" button
- Induvial Patients data (CSV)
- Daily Report data (CSV)

B) Go to the Tab "03 OUTPUT" and push
C) Report
- ✔ E-mail the files daily to EMTCC
- data@mdsgateway.net

MDS Feedback Maker – For EMTCC

A) Input EMTCC information
- ✔ [Team name]
- ✔ [Date of Activity]

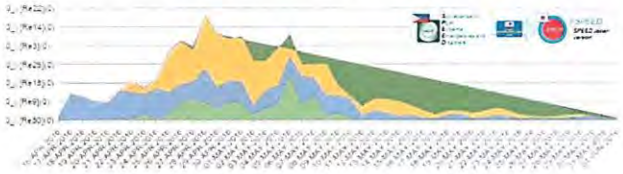
B) Put the following files in one folder
- ✔ Data CSV files reported by EMTs to EMTCC
- ✔ MDS Feedback Maker

C) Import files
- ✔ Push the "Import" button
- ✔ Push the "Needs and Risks View" button

D) Do feedback
- ✔ Print Feedback Report Form
- ✔ Print Needs and Risks list

Japan: J-SPEED reporting at Kumamoto earthquake 2016

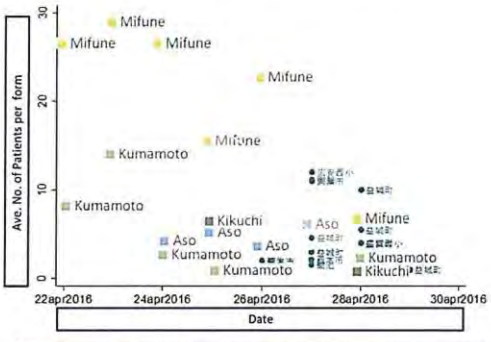
Number of patients by areas/day



■全県

Kumamoto Earthquake, Japan. 2016

Average No. of Patients per EMT



Refine tasking /Supporting EMT operation

Disease Early Warning

Date	N	Num. of patients with gastrointestinal infection by area				
		Aso	Kikuchi	Kumamoto	Mifune	Total
16-APR-2016	23					0
17-APR-2016	142	1				1
18-APR-2016	127	4				4
19-APR-2016	98	1				1
20-APR-2016	95	7				7
21-APR-2016	160	11		2		13
22-APR-2016	207	13			2	15
23-APR-2016	173	11	1	2	1	15
24-APR-2016	225	9			2	11
25-APR-2016	365	7	1	1	4	13
26-APR-2016	427	6		2	5	13
27-APR-2016	390	4		3		7
28-APR-2016	561			7	7	14
29-APR-2016	460	1			1	2
30-APR-2016	435	1		1	2	4
01-MAY-2016	448			3	4	7
02-MAY-2016	317				1	1
03-MAY-2016	315	1		1	1	3
04-MAY-2016	384	1				1
05-MAY-2016	457	2		1		3
06-MAY-2016	297	3			2	5
07-MAY-2016	299			1		1
08-MAY-2016	300	1			2	3
09-MAY-2016	190					0
10-MAY-2016	132					0
11-MAY-2016	73					0
12-MAY-2016	116	2				2
13-MAY-2016	114					0
14-MAY-2016	102				3	3

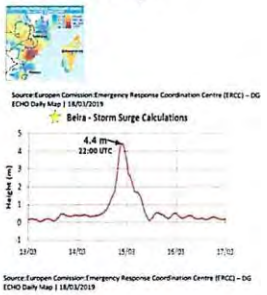
Supporting EMT exist strategy.
"No Relation to disaster"

Date	Total patients	Non-relation to disaster	
	N	N	%
26-APR-2016	427	32	7.5%
27-APR-2016	392	52	13.3%
28-APR-2016	563	89	15.8%
29-APR-2016	460	77	16.7%
30-APR-2016	435	52	12.0%
01-MAY-2016	448	74	16.5%
02-MAY-2016	317	53	16.7%
03-MAY-2016	315	37	11.7%
04-MAY-2016	384	64	16.7%
05-MAY-2016	457	111	24.3%
06-MAY-2016	297	91	30.6%
07-MAY-2016	299	67	22.4%
08-MAY-2016	300	100	33.3%
09-MAY-2016	190	55	28.9%
10-MAY-2016	132	36	27.3%
11-MAY-2016	73	23	31.5%
12-MAY-2016	116	49	42.2%
13-MAY-2016	114	34	29.8%
14-MAY-2016	102	37	36.3%
15-MAY-2016	79	38	48.1%
16-MAY-2016	52	24	46.2%
17-MAY-2016	32	17	53.1%

- ✔ Clear trends observed in
  - Number of patients
  - proportion of patients *"not-related to disaster"*
- ✔ This figures helps local officers for their decision making over EMT exist strategy.

EMT Reporting system
The essence is
Support Local government
For their decision making

Mozambique Cyclone Idai (2019)



1.85M	>12,800	31,107	>1.8M	>550K	>1,100
People in need	People living in accommodation centres	Malaria cases in Sofala Province	People reached with food assistance	Children screened for malnutrition	Classrooms repaired

MOZAMBIQUE: Cyclone Idai & Floods Situation Report No. 22

Mozambique Cyclone Idai (2019)

2019-June-11

EMT MDS Daily Reporting

Final Summary

- EMT Minimum Data Set (MDS) daily report has been officially activated for the first time on 31th March 2019.
- Until 11th June, key information which are essential for coordinating EMT was collected by 240 daily reports, which includes data of 14,178 consultations.

Contributing teams for the EMT MDS Daily reporting
Arbeiter Samariter Bund (ASB-FAST), Asistencia Medica Internacional(AMI), Canadian Red Cross, China Search and Rescue, Italian Civil Protection (EMT2-ITA Regione Piemonte), Japan Disaster Relief (JICA), Johanniter International Assistance(EMT Johanniter), Portuguese INEM, Portuguese Red Cross, Rescue Net, Samaritan's Purse, Spain (START-AECID), Team Rubicon.

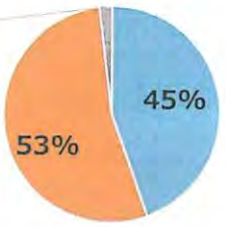
100% of Registered EMTs made MDS daily report

Mozambique Cyclone Idai (2019)

Sex

Total : 13618

- Male
- Female non-preg.
- Female pregnant



MDS statistics	No	Age Categories	<1	1-4	5-17	18-64	65-	Total
Sex & Age	1	Male	230	751	1023	3733	345	6082
	2	Female non-preg.	262	695	984	4918	418	7277
	3	Female pregnant			17	242	0	259

- *MDS proved Female patients have more access to EMT services*

Findings from the on-sight quick analysis*

Mozambique Cyclone Idai (2019)

Table 2019-04-04A
Distribution of injuries by EMT types

EMT	Major	Moderate	Minor
Type2	4	4	13
Type1Fix	0	4	33
Type1Mobile	0	4	61

- *Distribution of types of injury by EMT classification proves referral system among operating EMTs is well functional.*

Classification of injury by the EMT MDS

MDS4-6	Major injury	Trauma require hospitalization and/or general anesthesia (needs for EMT Type 2or3 care)
MDS7	Moderate injury	Can be treated as an outpatient requiring conscious sedation etc. (needs for EMT Type 1 Fix care)
MDS8	Minor injury	Injury that requires first aid and light dressing care. (needs for EMT Type 1 Mobile care)

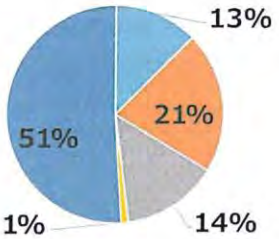
*Distance to maternity clinics after Cyclone Idai's landfall

Mozambique Cyclone Idai (2019)

Health Events

Total : 11321

- Trauma
- Infectious disease
- Additional
- Emrg.
- Other key diseases



- *MDS enable MoH/EMTCC to capture proportion of health events of patients treated by EMTs. (21% infectious diseases > 13% trauma, Acute watery diarrhea was the most prominent among infectious diseases.)*

*Other key diseases include skin disease, acute mental health problem, obstetric complications, severe acute malnutrition and other diagnosis not specified by the MDS such as chronic pain and so on.

Findings from the on-sight quick analysis* Mozambique Cyclone Idai (2019)

Transition in prevalence of consultations which were directly related to the emergency event (cyclone).

Period	N	Directly reationed to the event	%
Mar-28_31	237	19	8.0%
Apr-01_07	2383	89	3.7%
Apr-08_18	4169	63	1.5%

- *Prevalence of consultations which were directly related to the cyclone is decreasing.*
- *Suggesting, each EMTs should set up their exit strategy timely.*

Classification by the EMT MDS.

MDS44	Directly	Patient visit with injury or illness directly caused by an emergency event.
MDS45	Indirectly	Patient visit caused or worsened by situational change after an emergency event. e.g.) Environmental exposure
MDS46	Not related	Patient visit not caused by the event. e.g.) NCD

EMTCC Japan Disaster Relief Expert Team 24

"Golden Ratios"

- West Japan Heavy Rain(2018)
  - Dead/nEMT consultation=230/3,620= 1:15.7
- Hokkaido EQ(2018)
  - Dead/nEMT consultation=41/591= 1:14.4

1 dead : 15 nEMT consultation

Findings form the J-SPEED reporting, Japan (2018)

Reason to report the MDS

⑦ To support the needs of MOH to report health activity within a wider emergency or disaster response to the National disaster management authorities

EMERGENCY MEDICAL TEAM MINIMUM DATA SET(2017)

Feedback to MoH (EMTCC) was made every morning by printed form on the directors desk

Ways of Feedback to EMT

EMTCC Meeting (verbally)

e-mail / V-OSOCC (PDF file)

Findings from the on-sight final summary analysis*

Proportions and Ratios

- Proportion of consultations requiring medical follow-up =20.0%
- Proportion of consultations requiring long term rehabilitation among consultations requiring medical follow-up = 1.6%
- Proportion of consultations with discharge against medical advice among total consultations = 0.3%
- Male : Female ≈ 1 : 1.2
- Prevalence of pregnancy among female consultations = 3.4%
- Prevalence of pregnancy among total consultations = 1.9%
- Prevalence of vulnerable child among consultations of age 17 or under = 1.3%
- Prevalence of vulnerable adult among consultations of age 18 or over = 0.6%
- Major : Moderate : Minor trauma ≈ 1 : 3 : 22
- Direct : Indirect : No relation ≈ 1 : 5 : 28

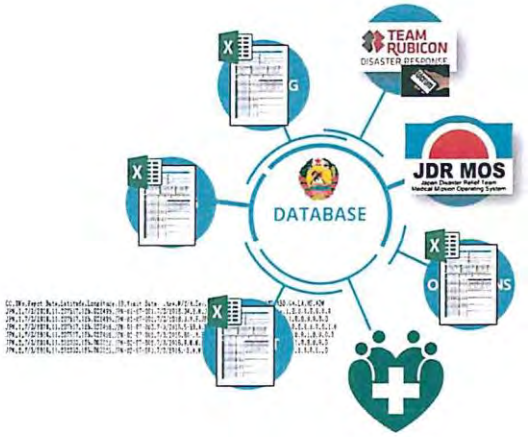
*Until 11th June 2019

These data would contribute in planning future response.

EMTCC Japan Disaster Relief Expert Team 29

Key message

- The WHO EMT MDS is a tool
  - to make all n/i-EMTs sentinels to national system during SOD
  - to let EMTCC do data-based coordination
  - to make one response
  - to enable knowledge sharing by data after/toward disaster

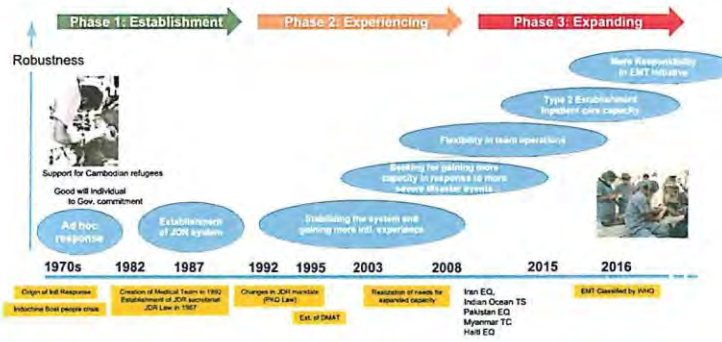

TEAM RUBICON
JDR MOS
DATABASE

JDR Team
on Comprehensive Team Information

ARCH Drill 2019, Bali, Indonesia

Dr. Yuichi Koido

Progress of JDR Response Capacity



	CATEGORY	NO.	QUESTION KEYWORD	DESCRIPTION	
1	General Status	1-1	Country Plan	Does your country have a plan to establish National EMTs, which can be deployed for the ASEAN region and beyond?	Yes
		1-2	Establishment of National EMTs deployed to abroad	Are there National EMTs, which can be deployed already existing?	Yes, Japan Disaster Medical (JDR) Team
		1-3	Establishment of National EMTs which operates in domestic situation	Are national EMTs for domestic use already existing?	Yes, Disaster Medical Assistance Team (DMAT)
		1-4	Issues about establishment of EMTs	If no the EMTs not established, what are the main issues?	N.A.
		1-5	Estimated time	How many years do you think it would take these EMTs to get established in your country? Or accredited by WHO classification?	N.A.

Japan's Medical Assistance System:

I-EMT = JDR team (JDR Law since 1987, and earlier)
N-EMT = DMAT (Since 2005)

Disaster medical teams set by Japanese government

Japan Disaster Relief(JDR) Medical Team	Disaster Medical Assistance Team (DMAT)
International	National
• Since 1987	• Since 2005
• Based on JDR team Law 1987 ←1970s Cambodian refugees mission	• Around 1,400 team set up(2015)
• Set by JICA(Japan International Corporation Agency), Ministry of Foreign affairs (MoFA).	• Based on Disaster Management Basic Plan
	• Set by Ministry of Health, Labor and Welfare(MoHLW).


Great Hanshin EQ 1995
(C) Kobe-np.co.jp

✔ Much overlap in human resources / educational program.
✔ DMAT now become giant capacity, JDR is a small & experimental team.

Legal Basis for Team Deployment

Law Concerning of Dispatch of Japan Disaster Relief Team (JDR Law), 1987 --国際緊急援助隊の派遣に関する法律(JDR法)

Unofficial Translation by the MOFA

Article 1. Purpose

Provide for necessary measures relating to the dispatch of JDR Teams…in the event of large-scale disasters occurring or which threaten to occur overseas…in response to a request…, and thus to contribute to the promotion of international cooperation.

Article 2. Activities of JDR Teams

JDR team shall engage in the following disaster-related activities;

i) search and rescue
ii) medical care (including epidemic-prevention activities)
iii) activities to mitigate damage from the effects of a disaster, rehabilitation activities

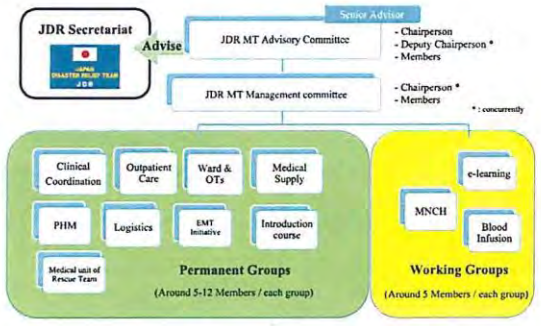
http://law.e-gov.go.jp/htmldata/S62/S62HO093.html (only available in Japanese)

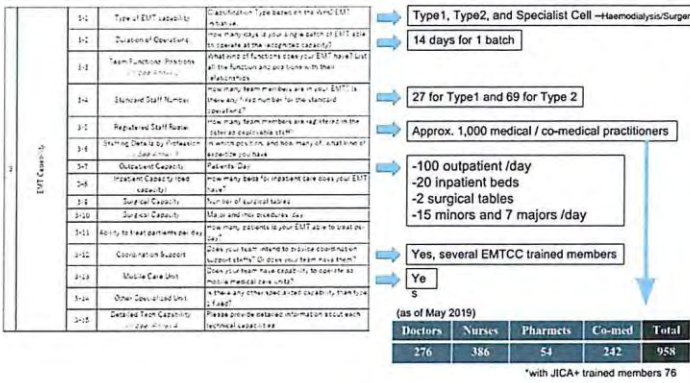
2	Basic info of the EMT Organization	2-1	Organization Type	GOVT/NGO/ MIL/ OTHERS?
		2-2	Involving Ministries/ Agencies Governance	Which ministry has the leading role for EMT management? And are there any other ministries and agencies involving in this initiative?
		2-3	Organization Primary Contact	
		2-4	Name	Name of Focal point
		2-5	Position	
		2-6	Address	
		2-7	Email	
		2-8	Phone	
		2-9	Headquarter Function	Who in the organization has a headquarter function in managing the team, or while deployment?
		2-10	Deployment Record	How many times have your EMTs been deployed international operations? When and which disaster?

→ Gov.
→ MOFA, JICA and Members
→ JICA HQ, Tokyo (Secretariat of JDR)
→ TBC
→ JICA HQ, Tokyo (Secretariat of JDR)
→ 59 times since 1987 Incld.
-Mozambique FL 2019
-Nepal EQ 2015
-Vanuatu TC 2015
-Haiti EQ 2010

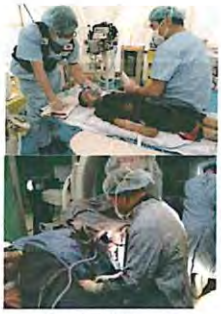
Deployment to AMS countries:
(1) 1990 Philippines EQ <8>
(2) 1991 Philippines TC <6>
(3) 2000 Indonesia EQ <19>
(4) 2004 Thailand <22>, Indonesia <9>
(5) 2005 Indonesia EQ <11>
(6) 2008 Myanmar TC <23>
(7) 2009 Indonesia EQ <23>
(8) 2013 Philippines TC <23>

Governance of JDR team





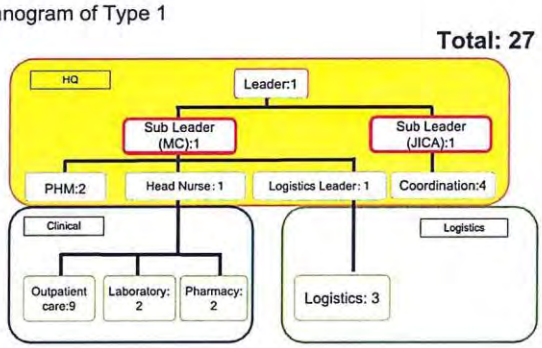
Specialist Cell –Haemodialysis/Surgery (Nepal,2015)



Surgical Operation

Hemodialysis

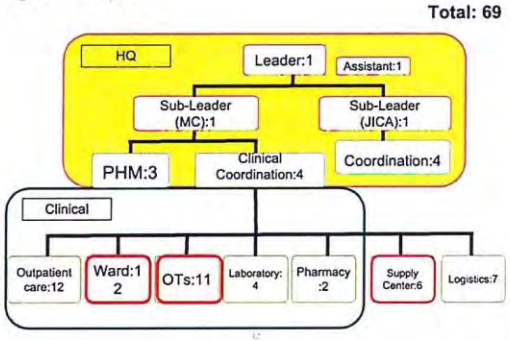
Organogram of Type 1



JDR Medical Team: Type 1 Composition

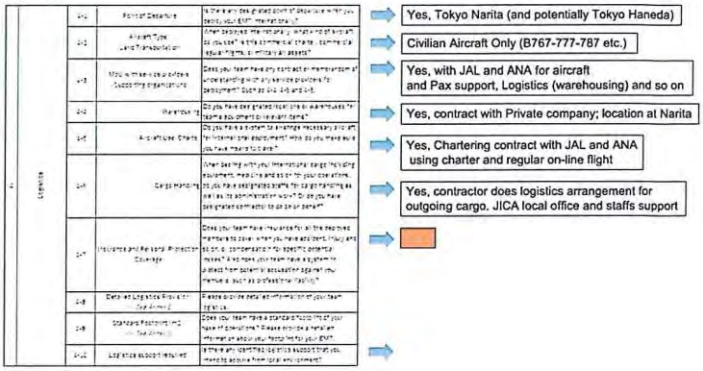
		Dr.	Ns.	Pharmacist	Radiographer	Laboratory technician	Logs	Coord	Sub-Total
1 Leader/Sub-Leader/Assistant	Leader 1 Sub-Leader 1	Sub -Leader (MC) 1	Chief Nurse 1			Logistics Leader 1			5
2 PHM				2					2
3 Clinical Coordination		3	6						9
4 Laboratory					1	1			2
5 Pharmacy				2					2
6 Logistics							3		3
7 Coordination								4	4
Sub-Total									27

Organogram of Type 2



JDR Medical Team: Type 2 Composition

		Dr	Ns	Pharmacist	CT	Radiographer	Laboratory Technician	ECST	Logs	Coord	Sub-Total
1	Leader/Sub-Leader/Assistant	3	1								4
2	PHM		1	1						1	3
3	Clinical Coordination		1	1					1	1	4
4	Outpatient Care		3	7				2			12
5	Ward		2	10							12
6	Operation Theatre		4	6		1					11
7	Laboratory						2	2			4
8	Pharmacy				2						2
9	Supply Center			2	2	1			1		6
10	Logistics							1	6		7
11	Coordination									4	4
	Sub-Total	3	12	27	4	2	2	2	3	8	6	69

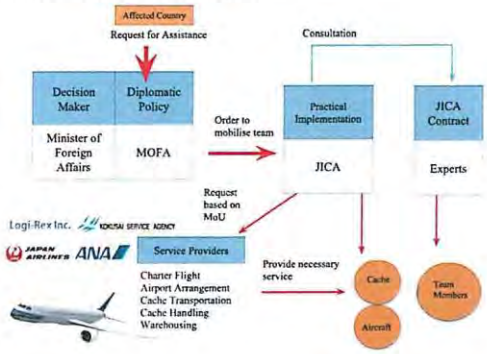


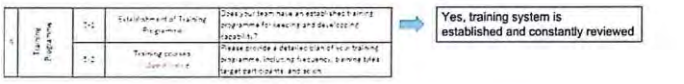
JICA's Overseas Network

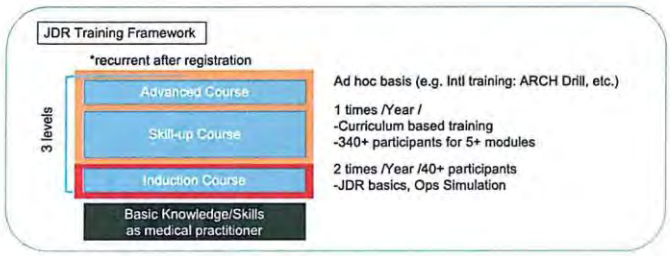
HQ: Tokyo
Overseas Office: 96 locations
No. of Staff: 6,000

-Local Procurement Arrangement in affected countries
-Utilize overseas offices as frontline

Who Does What for Team Deployment



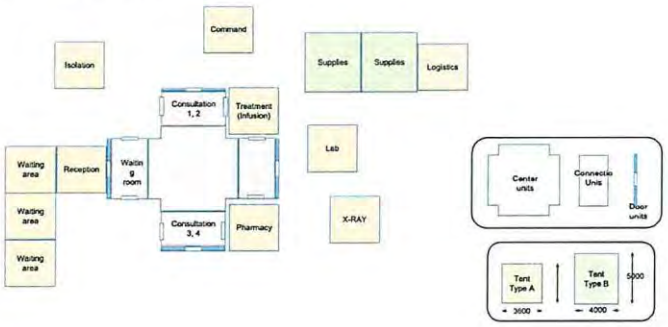


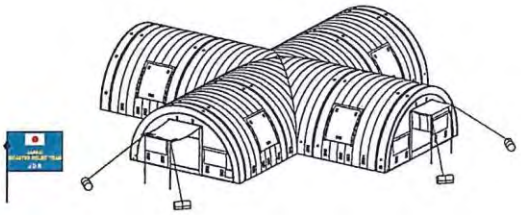


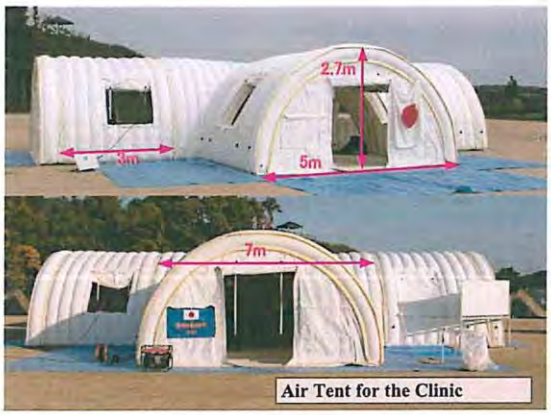
List of Technical Capability

NO.	TECHNICAL SERVICE	AVAILABILITY STATUS	DETAILS DESCRIPTION
1	Initial Assessment & Triage	Available	
2	Resuscitation	Available	
3	Patient Stabilization & Referral	Available	
4	Wound Care	Available	
5	Fracture Management	Available	
6	(General) Anesthesia	Available	
7	Surgery	Available	
8	Intensive Care		
9	Communicable Disease Care	Available	
10	Emergency Obstetric Care		
11	Emergency Paediatric Care	Available	
12	Emergency Care Chronic Disease	Available	
13	Mental Health		
14	Rehabilitation	Available	
15	Laboratory & Blood Transfusion (bank)		
16	Pharmacy & Drug Supply	Available	
17	Radiology	Available	
18	Sterilization	Available	
19	Xray	Available	
20	Ultrasound	Available	
21	CT Scan		
22	Isolation Area	Available	

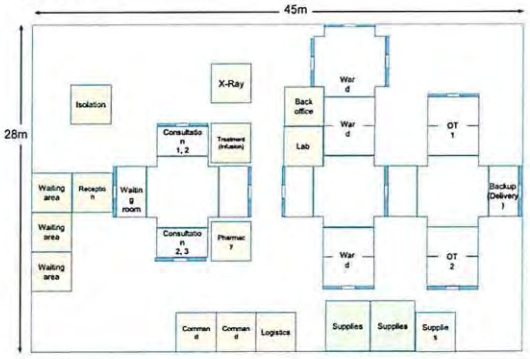
Footprint: Type 1







Footprint: Type 2



Operation Manual

Chapter 1: General Information about Japan Disaster Relief Medical Team
- 1-1. Why we must foreign countries when disasters happen?
- 1-2. Principle of International Emergency Relief
- 1-3. Overview of Japan's International Emergency Relief
- 1-4. Overview of Japan Disaster Relief Team
- 1-5. Overview of Japan Disaster Relief Medical Team
- 1-6. Principle of Japan Disaster Relief Medical Team Field Operation
- 1-7. Structure of Japan Disaster Relief Medical Team

Chapter 2: Activation and Mobilization Process, Individual Team Member Check list
- 2-1. Individual Readiness (prior to deployment)
- 2-2. Activation
- 2-3. Mobilization
- 2-4. Team Members traveling to the departure airport
- 2-5. Tips at the departure airport

Chapter 3: The flow of Field Operation
- 3-1. Arrival in the affected country
- 3-2. Identify the Work Site
- 3-3. Set up the medical facility
- 3-4. Field Operation Management
- 3-5. Demobilization/Replacement (Dispatch of 2nd batch team)
- 3-6. Report Record
- 3-7. Post Mission Evaluation

Chapter 4: Equipment Management
- 4-1. Preface
- 5-8. Communication
- 5-7. Food
- 5-8. Lodging
- 5-9. Toilet
- 5-10. Waste Management
- 5-11. Local Staff/Volunteer Management
- 5-12. Drinking Water, Water Analysis

Chapter 6: Safety & Security
- 6-1. Basic information on Safety & Security
- 6-2. Information Analysis regarding Safety & Security
- 6-3. Safety & Security Measures
- 6-4. General Security Information (by regions, countries)

Chapter 7: Personal Health
- 7-1. JDR Medical Team Health Management
- 7-2. Prevention of needle piercing accident
- 7-3. Safe food & Water

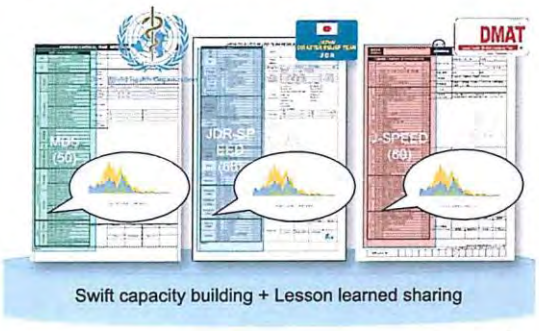
Chapter 8: Miscellaneous
- 7-1. Cultural Sensitivity
- 7-2. Media
- 7-3. Gender Sensitivity

Annex
- JDR Law
- Status and Compensation for JDR Medical Team Members
- Project Design Matrix
- Mission Report Format
- Equipment list
- Health and Hygiene Condition in Developing Countries
- Safe Water and Hygiene in Emergency Situation
- Safety and Security Check List
- Psychological Wellbeing
- Guide for preventing Malaria
- Guide for preventing HIV, needle piercing accident
- Principle of medical operation at night time

4) Clinical care & patients management

Clinical Guidelines・SOPs

Adapting common procedures between national/international EMT.



Swift capacity building + Lesson learned sharing

TOKYO 2020 TOKYO 2020

J-SPEED/MDS
Math-gathering event
version.

Thank you very much
for your attention.

Terima Kasih

Steps for MDS daily reporting

1. Get the MDS Forms and Tools
2. Tick in the MDS tick box for every consultation
3. Use the MDS Maker (Excel program) to make MDS Daily Report data files(CSV)
4. Send the data files to EMTCC by Email

- Files to be sent: Two types of CSV data files (IP, DR) made by the MDS-Maker.
- Send files by 7PM daily until further instructions.
- In case there is no network, please bring the files to EMTCC physically.
- Forms and tools available at https://www.mdsgateway.net/

(FAQ) Characteristics of the MDS items

1. Medical Doctor will tick on medical record
2. "Check all that apply" is the only instruction to tick
3. Practical judge to select MDS items is acceptable
   - Ex. Major trauma (requiring hospitalization/care with general anesth
4. Items capture universally major issue only, and not all issue.
   - To count context specific issue, EMTCC will suggest item's name and its definition for Additional items (MDS19-22)
5. Every MDS module will have more than one tick([1]sex, [2]health events, [3]discharge with/without medical follow-up and [4]relation to disaster).
6. If one patient visit twice a day, data will be generated twice
   - MDS count medical resource in need(not patients but consultations).
7. Data is anonymous

MDS Maker – EMT

A) Open The MDS maker (enable Editing/Macro)

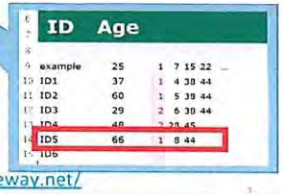
B) Go to the INSTRUCTION page on the tab "00INSTRUCTION"

C) Go to the Tab "01 INPUTBASIC" and input "EMT Team information"
   ✔ [Team name] EMT Your name etc...

D) Go to the Tab "02 INPUTMDS" and input one patients data
   ✔ Patient ID5: 66yo MDS 1, 8, 44

E) Go to the Tab "03 OUTPUT" and push "MAKE" button
   - Induvial Patients data (CSV)
   - Daily Report data (CSV)

G) Report
   ✔ E-mail the files daily to EMTCC



EMT MDS Gateway https://www.mdsgateway.net/

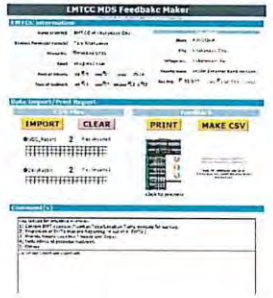
MDS Feedback Maker – For EMTCC

A) Input EMTCC information
   ✔ [Team name]
   ✔ [Date of Activity]

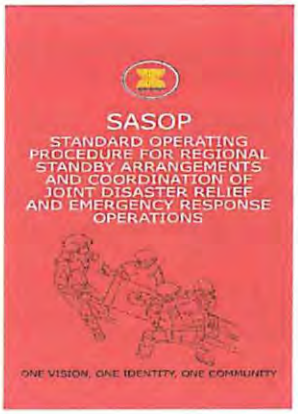
B) Put the following files in one folder
   ✔ Data CSV files reported by EMTs to EMTCC
   ✔ MDS Feedback Maker

C) Import files
   ✔ Push the "Import" button
   ✔ Push the "Needs and Risks View" button

D) Do feedback
   ✔ Print Feedback Report Form
   ✔ Print Needs and Risks list



Standard Operating Procedures (SOP) for I-EMT coordination in ASEAN



ARCH Project

The Project for Strengthening

the ASEAN Regional Capacity

on Disaster Health Management

ONE ASEAN ONE RESPONSE

Background of the project

- The Survey on the Current Situation of Disaster/Emergency Medicine System in the ASEAN Region

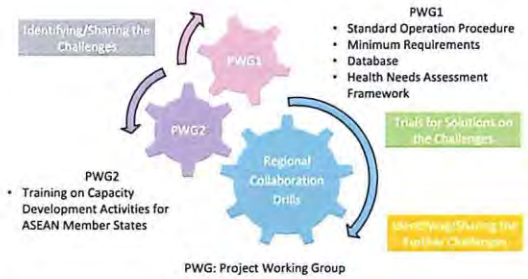
1. Period: Nov. 2014 – Aug. 2015
2. Methodology
   1) In-country survey in all AMS (Dec. 2014 – Mar. 2015)
      - Field visit for three to five days per country
      - Document review
   2) Collection of relevant international trends (UN, WHO, ASEAN, etc.)
   3) Meetings
      - The First Regional Meeting (Phuket, December 2014)
      - The Second Regional Meeting (Tokyo, March 2015)
      - The Third Regional Meeting (Bangkok, July 2015)

The Survey on the Current Situation of Disaster/Emergency Medicine System in the ASEAN Region

- Every country has different situation; needs, priority, capacity, development plans, institutional arrangements, human resources, etc.
- Needs for collaboration mechanism on disaster health management to exchange information in peacetime and emergency were pointed by many interviewees.
- Disaster health management should be well coordinated with other sectors, especially disaster management and emergency response.

The Project will flourish through the four Drills

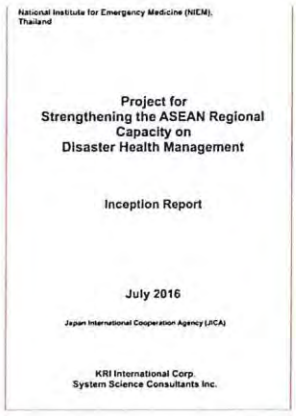
Process to the Goal



PWG: Project Working Group

Outcomes of each phase

Phase 1	**Identify gaps** **Coordination platform (SOP)** **Necessary forms development: Medical record, Health need assessment**
Extension phase	**Capacity building: personal & team** **Additional necessary SOPs** **Academic network**
Phase 2	**Capacity building: personal & team** **Strengthening academic network**
Phase 3	**Standardize I-EMT including deployment if any opportunity**



National Institute for Emergency Medicine (NIEM), Thailand

Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management

Inception Report

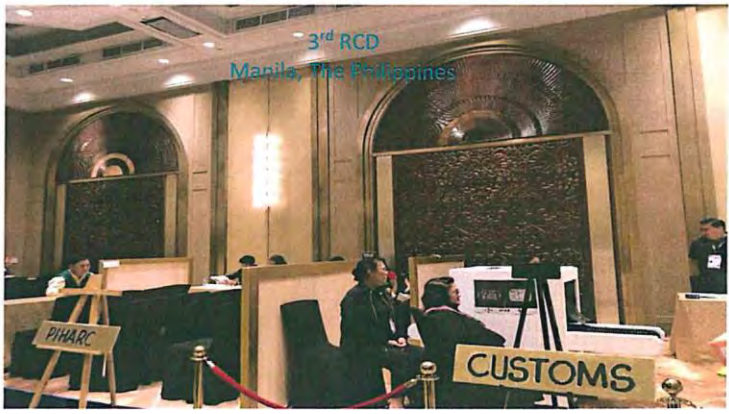
July 2016

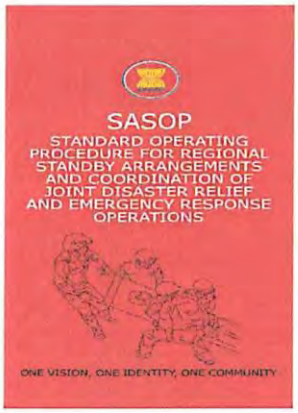
Japan International Cooperation Agency (JICA)

KRI International Corp.
System Science Consultants Inc.

On site situation

2nd RCD
Danang, Vietnam **Shelter**






Version 2.0, April 2018

STANDARD OPERATING PROCEDURE FOR REGIONAL STANDBY ARRANGEMENTS AND COORDINATION OF JOINT DISASTER RELIEF AND EMERGENCY RESPONSE OPERATIONS (SASOP)

Forms

SASOP forms

- Situation update to AHA center (12): Optional
- Situation update of AHA center to the national focal point (NDMO) (13): Optional
- Offer for assistant (1): I-EMT
- Contractual arrangement for assistance(2): NDMOs
- End of mission (3): Summarize of EMT operation

ASEAN forms

Medical record form (4): Patient information

Health Need assessment & Summary (5): I-EMT


"UPDATE" NO____#
TO AHA CENTRE

1. General Information

Office Reference Number:
From:
To:
Day / Date / Time:
Disaster Event Name/ Location(s)

2. Submitting Authority

National Focal Point
Name:
Designation:
Institution:
Address:
Phone/ Fax:
Email:

3. General Description of Disaster Event (Please state briefly the type(s) of hazard, the specific location(s), date, time and duration of impact, and the factors or circumstances that triggered or brought about the disaster event.)

Delete where applicable.


SITUATION "UPDATE" NO____#
FROM THE AHA CENTRE

1. General Information

Office Reference Number:
From:
To:
Day / Date / Time:
Disaster Event Name/ Location(s)

2. Summary of Disaster Event (Please state briefly the type of hazard, the specific location(s), date, time and duration of impact, the factors or circumstances that triggered or brought about the disaster event, and the general extent of losses.)

See attachment. (Please attach relevant information.)
Delete where applicable.

3. Assessment of Disaster Impact (Please assess and summarise the impact of the disaster event on human lives, housing and livelihoods, children and public infrastructure, and the environment.)

See attachment. (Please attach relevant information.)

ANNEX M

"OFFER" OF ASSISTANCE

1. General Information

Office Reference Number:
From:
To:
Day / Date / Time:
Disaster Event Name/ Location(s):

2. Assisting Entity

National Focal Point / Country / Organisation:
Name:
Designation:
Institution:
Address:
Phone/ Fax:
Email:

Head of Assistance Operation
(Please inform the name and contact details of the Head of Assistance Operation in the field, in line with paragraph no. 43)
Name:
Designation:
Institution:
Address:
Phone/ Fax:
Email:

ANNEX N

CONTRACTUAL ARRANGEMENTS FOR ASSISTANCE

1. General Information

Office Reference Number:
From:
To:
Day / Date / Time:
Disaster Event Name/ Location(s):

2. Resources to be Mobilised

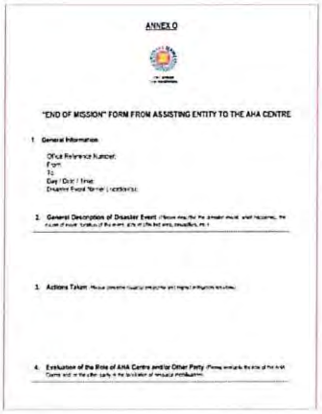
a. Personnel

No.	Name/ ID number	Designation/ institution	Description	Destination location(s)
1	2	3	4	5

b. Equipment and Materials

No.	Type	Description	Quantity	Destination Location(s)
1	2	3	4	5

Add additional sheets as necessary



ANNEX O

"END OF MISSION" FORM FROM ASSISTING ENTITY TO THE AHA CENTRE

1. General Information

Office Reference Number:
From:
To:
Day / Date / Time:
Disaster Event Name/ Location(s):

2. General Description of Disaster Event

3. Actions Taken

4. Evaluation of the Role of AHA Centre and/or Other Party

Medical Record for Emergency and Disaster

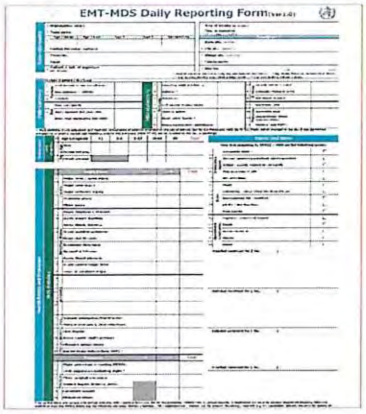
Health Needs Assessment Form by EMT

Forms

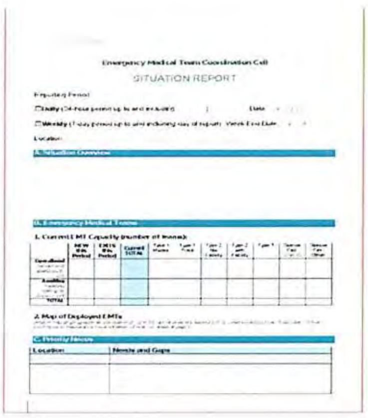
EMTCC forms

- EMT registration (6): AMS EMT information
- Daily report (7): Collect from medical record
- Situation report (8): Situation
- Exit report (9): Summarize of EMT operation
- Patient referral form (10): Referred patients
- EMTCC coordination minute (11): Conclusion of cases and situation, provide information

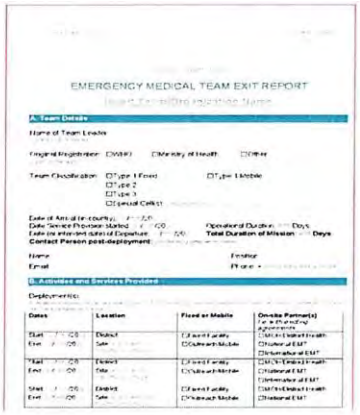

EMT INFORMATION
ORGANIZATION PRIMARY CONTACT (HQ)
EMT TEAM LEADER

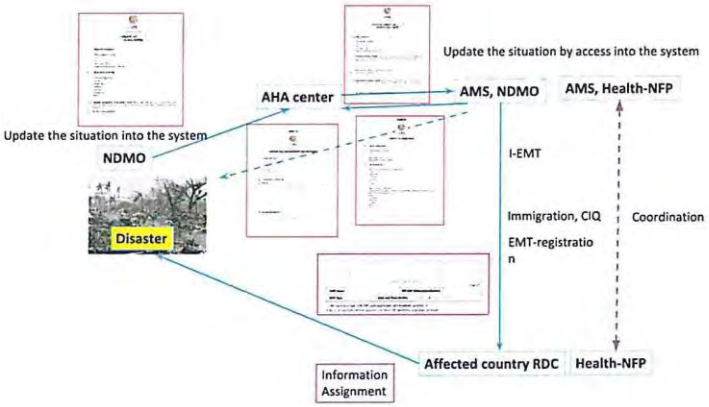

EMT-MDS Daily Reporting Form

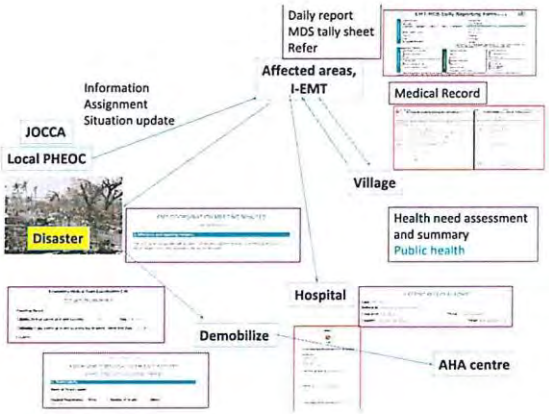

PATIENT REFERRAL FORM


Emergency Medical Team Coordination Cell
SITUATION REPORT


EMERGENCY MEDICAL TEAM EXIT REPORT







Thank you for your attention

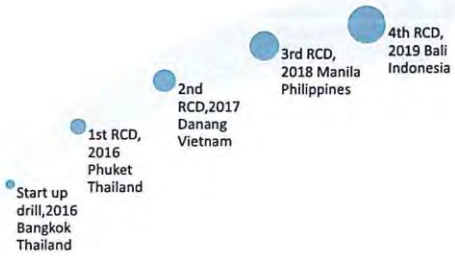
Conclusions, Recommendations from the fourth Regional Collaboration Drill

Project for Strengthening the ASEAN Regional Capacity on Disaster Health Management (ARCH project)

Objective

- To report the conclusion of 4th regional collaboration drill
- To report comments, suggestions and recommendations for the next drill

Drills



4th Regional Collaboration Drill

25 November 2019

- Introduction
- Health information system of Indonesia
- Practice in filling forms
- Composite team

26 November 2019

- RDC
- Comprehensive team information

4th Regional Collaboration Drill

27 November 2019

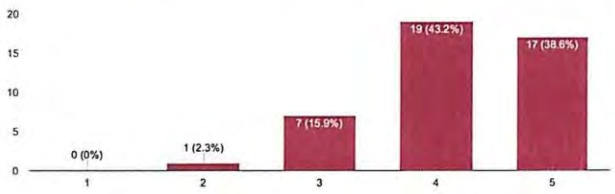
- Field exercise at Tanah Ampo
  - Medical care
  - Form filling
  - EMTCC
  - HNA
  - Composite team

28 November 2019

- Demobilization
- AAR
- Evaluation

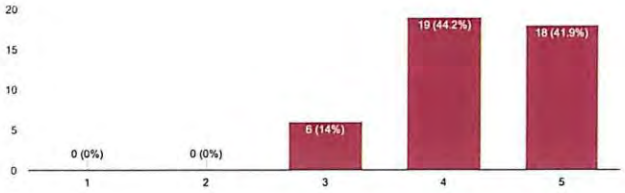
6. The format of the activity (introductory session, SOPs, Table top exercise, field exercise and AAR) is appropriate for the content presented.

44 responses



7. Introductory sessions (25-26 November 2019)are helpful to keep up with issues associating with the 4th regional collaboration drill.

43 responses



Pre-deployment

- 6 countries sent "Offer of Assistance form" to AHA Centre (WebEOC) via NDMO
- 3 countries sent "Offer of Assistance form" from respective MOH directly to MOH Indonesia
- Some AMS encountered coordination problem in their countries (between NDMO and MOH)

4th Regional Collaboration Drill

- Forms filling
  - Most of AMS are familiar with the forms
  - Need more time to practice without facilitator and coaching
  - More practice in home country of each EMT

4th Regional Collaboration Drill

- Comprehensive team information
  - Most country have their team and equipment, easy to fill questionnaire
  - Take only short time to do the answer; some EMT search for the answers before exercises

Suggestion

- Differentiation of experience and acknowledge between each country

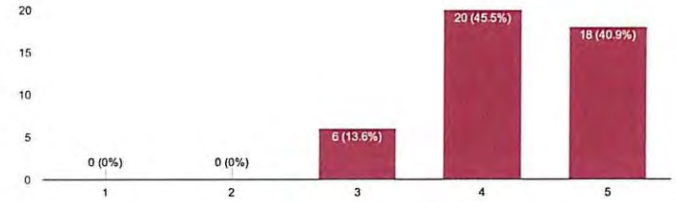
4th Regional Collaboration Drill

- Reception Departure Centre (RDC)
  - Every drill team reported to RDC to complete EMT registration and submit WHO EMT registration form, copies of passport of each team member and other registration requirement

FIELD EXERCISE

10. The drill scenario is well-planned and encouraging.

44 responses



4th Regional Collaboration Drill

- Public Health Emergency Operation Center (PHEOC)

4th Regional Collaboration Drill

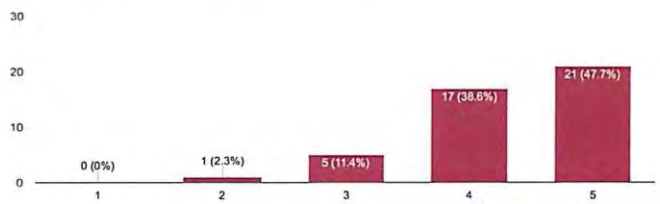
- Health need assessment (HNA)
  - Most EMTs could fill the forms very well and used them easily.
  - Most EMTs have experienced
  - Too small HNA site to direct observe

4th Regional Collaboration Drill

- EMT operation
  - Every drill team took care patients at field hospital and used standard form (Medical Record Form, EMT-MDS Tally Sheet and Patient Referral Form)

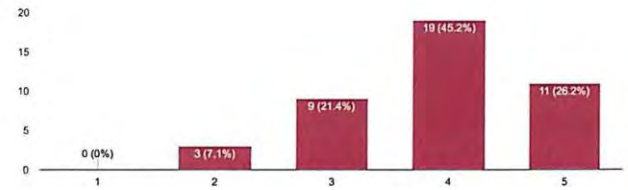
12. Drill activities are well-managed throughout the day.

44 responses



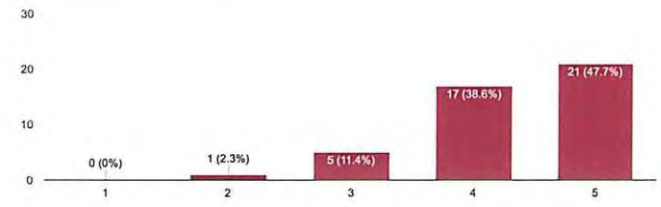
14. Drill materials and equipment (i.e. radios, tents, medical equipment, etc.) are enough and readily prepared.

42 responses



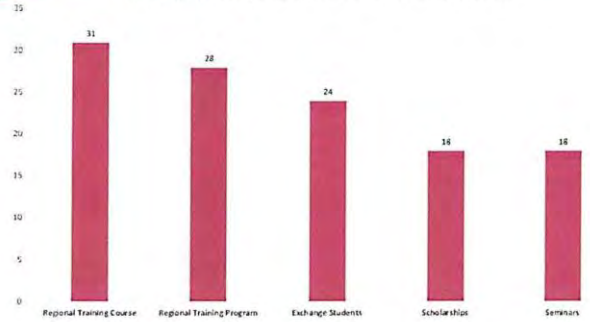
16. The overall activity is satisfying.

44 responses



Training needs

How should the personnel be educated and trained?



Skill/knowledge of EMT

	1st DRILL Phuket, Thailand	2nd DRILL Danang, Vietnam	3rd DRILL Manila, Philippine	4th DRILL Bali, Indonesia
Pre-deployment process	+	+	++	+++
RDC process	+	+	+++	+++
EMTCC	++	++	++	++
Composite team	-	-	-	++
EMT quality assurance	-	-	-	++

Skill/knowledge of EMT

	1st DRILL Phuket, Thailand	2nd DRILL Danang, Vietnam	3rd DRILL Manila, Philippine	4th DRILL Bali, Indonesia
Forms filling	++	++	+++	+++
Health need assessment	++	++	+++	+++
Information and data management	+	+	++	++
Demobilization phase	+	++	+++	+++

Recommendations for next drill

- More patient detail e.g. EKG, CXR, etc
- Mass casualty incident (more number of patients/composite team)
- Separate area/Separate EMTCC
- Information management should be included.

Recommendation for next drill

- Endemic for diseases e.g. diarrhea, poisoning, etc (call for help from the head of community)
  - include chemical/biological threats due to impact of disaster
  - include public health component in the EMT SOP, therefore to expand and enhance the capacity of EMT, the future drill can include different scenario among others CBRN threats, that will expand the capacity of EMT to all hazards.
- Actual data submit to EMTCC for analysis and presentation
- Set up RDC at the airport
- Using contractual arrangement form

ARCH

Quality Assurance Visit

Review of the results of the 4th RCD

What went well?

- **Awareness about the quality assurance visit**
  - Appreciation of its purpose and objectives
  - Something unique for the 4th Regional Collaboration Drill, and related to the Comprehensive Team Information towards the goal of strengthening/organizing EMTs in the ASEAN

What went well?

- **Application of the EMT and EMTCC concepts**
  - Ownership by the Ministry of Health of the host country
  - Result of the EMTCC Training conducted in 2019

What went well?

- **Quality Assurance Team acts as mentors**
  - Friendly environment
  - Willingness to assist and support the ASEAN Member States
  - Mixture of members from different organizations/countries (with various expertise)
  - Stimulus for the AMS to initiate/organize EMTs in their country

Issues and challenges

- Interferes with clinical management
- Language barrier
- Different level of understanding
- Not scheduled with the EMTs of the AMS
- Not everyone is aware of the EMT Blue Book principles

Recommendations

1

- **Familiarization with the Blue Book**
  - Buy-in of the AMS focusing on the benefits of organizing the EMTs for their country
  - Guiding principles, core and technical standards
  - Self-assessment checklist
  - Team composition
  - Logistics requirements
  - Capacity building requirements
  - Possible through e-learning method/workshop

Recommendations

2

- **Learn from the experience of Thailand EMT**
  - Presentation from the Thailand EMT on their experiences and challenges in forming their team
  - Possible ocular visit of the camp set-up with complete logistics, and meeting with the members
  - Sharing of the Standard Operating Procedures, list of logistics, team composition, and others

7

Recommendations

3

- **Roadmap for the organization of the EMTs for each AMS**
  - Guide on the steps that each AMS will undergo in organizing their EMTs
    - Identify the actual status (what they have, don't have, and should have)
    - Basis for the assistance needed by the AMS (ASEAN level mentoring)

8

Recommendations

4

- **For the 5th RCD**
  - Dedicated time for the conduct of the quality assurance visit (not while the patient care is ongoing)
  - The conduct of the QAV to be included during the EMTCC meetings/briefings
  - Clear scenario for the AMS to avoid confusion

9

Recommendations

4

- **For the 5th RCD**
  - Close to real deployment of EMT Type 1 Fixed, from registration to deployment to demobilization
  - Familiarity on the QAV Tool
  - Bringing/preparation of the SOPs, Comprehensive Team Information, layout, manuals etc.
  - Accessing the VOSOCC for the QAV

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Recommendations

4

- **For the 5th RCD**
  - Host country to train and practice the EMTCC concepts and principles, as part of the learning environment
  - The real members of the EMTCC should be member of the QAV Team
  - The participants of the EMTCC Training (in 2019) to join the drill

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You're QAV Team

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CONGRATULATIONS

TEAM INDONESIA

for the SUCESSFUL CONDUCT of the

4th REGIONAL COLLABORATION DRILL
&
7th MEETING OF PROJECT WORKING GROUP 2
BALI, 24-28 NOVEMBER 2019

Promoting

through the ARCH Project

Thank you!

4TH RCD Evaluation

ARCH Project Mentor Team

Day 1 Session (25th, November)	Evaluation	Suggestion
1.Form filling up practice	1Most of AMS are familiar with the forms -Some AMS had already filled some forms from their home countries. -Well-prepared before drill -The form are easy to use. -Participants pay good attention and did very well. -Previously trained in EMT can understand easily. 2.All the EMT know about the medical records and MDS very well, as they did the original of i-SPEED and they've seen the medical record in the 3rd RCD. 3.The EMT didn't fill the Contractual arrangement form because their NDMO did it.	1.Need more time to practice without facilitator and coaching 2.More practice in home country of each EMT because - -Great number of form : make teams confuse -Limited time to practice (Filling Form) -Gaps between each country, need more practice or more acknowledge for some countries who are new for the form

Day 1 Session (25th, November)	Evaluation	Suggestion
Form filling up practice (cont.)	4.Deployment and response -The Medical records and MDS 5.Pre-deployment phase -Some AMS encountered coordination problem in their countries (between NDMO and MOH)	Revise some items in medical record form The Medical records and MDS should be mention the multiple trauma or multiple complaint (such as Trauma, infectious disease and mental health in the same time).

Day 1 Session (25th, November)	Evaluation	Suggestion
2. Comprehensive team information practice	-Most country have their team information and equipment, easy to fill questionnaire -Take only short time to do the answer; some EMT search for the answers before exercises	-Differentiation of experience and acknowledge between each country - Some country should have some data before exercise. - Need to fallow up this practice with relevant organizations in their countries.
3. Comprehensive Team information Presentation	-Every AMS prepared presentation very well -Forms or questionaire are easy to answer -Need more time for experience sharing.	-Need more time more time for experience sharing.

Day 2 Session (26th, November)	Evaluation	Suggestion
1. Orientation on WHO Quality assurance	-Useful topic and very skilled instructor.	-Need practice/exercise
2. RDC Practice	- Some EMT don't have copy of essential document. - Risk for infection at RDC	-Isolated RDC Exercise and CIQ process training/exercise. -Need liaison before CIQ -Infection control process at RDC

RDC PRACTICE

Day3 Drill (27th, November)	Evaluation/Suggestion
1.Every AMS's NDMO submitted form (Offer for Assistance , Contractual Arrangement for assistance +/-EMT Registration form)	Most country submitted form. (Offer for Assistance , Contractual Arrangement for assistance +/-EMT Registration form)
2.Every drill team reported to RDC to complete EMT registration and submit WHO EMT registration form, copies of passport of each team member and other registration requirement (Annex2) (para.25).	-All country reported. -Need completely -Can provided exercise at the airport.
3.RDC tasked drill teams to provincial PHEOC	RDC Completely tasked the EMTs to PHEOC.
4.Host country set up provincial PHEOC and JOCCA at affected area	Completely set up.
5.Every drill team reported to provincial PHEOC& JOCCA to receive their assignment and obtain essential information for on-site operation (Annex4) (para.29, 30).	-Most EMTs reported. -Need more assignment tools.

Day3 Drill (27th, November)	Evaluation/Suggestion
6.Every drill team took care patients at field hospital and used standard form (Medical Record Form, EMT-MDS Tally Sheet and Patient Referral Form	-All EMTs used the form. -Easy to use. - Useful -Some major medical disease may be adding on. -Can develop to relate phase of event.
7.Every drill team performed health need assessment at villages and used Health Need Assessment and Summary Forms	-All EMTs performed HNA form.
8.Every drill team prepared Daily Reporting Form.	-Most EMTs prepared daily report before EMTCC meeting

EMT Coordination: Regional Collaboration Tools

Tools	Evaluation/Suggestion
1.SOP *Examples:* - Completing / Submitting Registration Form / other registration requirements/Quality Assurance - Tasking EMTs. - Reporting to PHEOC - Completing all forms. - Organizing EMT coordination meeting and fill in forms - Performing Exit strategy	-Well prepare process. -Host country should show complete SOP to EMTs prior to the drill . -May be inject some scenario to test SOP 'S function
2.Health Needs Assessment and summary	-Most EMTs could fill the forms very well and used them easily. -Most EMTs have experienced -Too small HNA site to direct observe

EMTCC MEETING

The way forward

- More patients detail e.g. EKG , CXR , etc.
- Injected scenario
  - Mass Casualty incident
  - Endemic disease
  - Call for help from village
- Separated area of EMT deployment and EMTCC.

- Real data submit to EMTCC for analysis and presentation
- Set up the RCD at the airport.
- Real contractual arrangement form in pre-deployment procedure
- Increase HEOC activity
- Real Coordination in table top exercise.

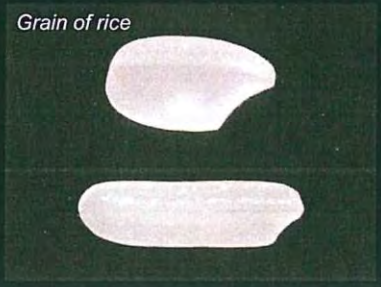
Thank You For Your Attention

Feedback to the 4th RCD from Japanese mentors

Planning and Conducting the RCD

Dr. Tomoaki NATSUKAWA
Japanese Advisory Committee

Not big issue, but detailed one



Practice in filling up various forms

Challenges
- Shortage of time to fill up forms

Recommendations
- Narrowing down some part of the forms
- Simplifying the patient's information

Comprehensive Team Information

Challenges
- Shortage of time to fill up the CTI

Recommendations
- Narrowing the items down more based on the time frame

Comments
- Trying 'CTI' first time was great. To make use of this experience, we are expected to pick up challenges and to solve them.

Reception & Departure Centre

Challenges
- Few injections

Recommendations
- Referring injections in the 3rd RCD in the Philippines

Field Exercise

Challenges
- Concerning about unsafety of informant

Recommendations
- Keeping safety of informant

Comments
- Trying 'composite team and QAV' first time was great. To make use of this experience, we are expected to pick up challenges and to solve them.

Demobilization

Challenges

- Few injections

Recommendations

- Referring injections in the 3rd RCD in the Philippines

Overall

Challenges

- Insufficient understanding of EMTCC for participants

Recommendations

- Lecturing concept of EMTCC in the day1

Comments

- Energizers were very nice.

Terima Kasih

We would like to thank all those involved in the drill.

4th Regional Collaboration Drill