



# Good practice on medical response against COVID-19 outbreak

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**Concept Note:****Good Practice Documentation and Sharing on Emergency Medical Response to the COVID-19 Pandemic in ASEAN (ARCH extension phase)****1. Rationale**

ARCH Project has been focusing on strengthening Disaster Health Management mainly for large-scale natural disaster in the ASEAN region. On the other hand, the SOP developed by the ARCH defines EMT as “groups of health professionals and supporting staff aiming to provide direct clinical care and public health services to populations affected by disasters or outbreaks and emergencies as surge capacity to support the local health system”. It means that the EMT doesn’t work only for case of natural disaster, but also for outbreaks to provide public health services as well as clinical care. Given the situation that national EMTs have been mobilized to reinforce domestic response to COVID-19 in many AMSs, it is necessary for the ARCH to contribute more to addressing outbreaks of infectious diseases as well as complex emergency with natural disaster.

**2. Scope of Works in the ARCH**

The purpose of the ARCH is to improve medical response in cases of emergencies and the ARCH focuses mainly on the response operation management such as EMT management, EMT deployment procedures, medical information management or logistical capacity, but does not target directly at treatment methods. Therefore, if the ARCH consider activities against the COVID-19, ARCH should work for knowledge sharing relating to medical response operation in cases of emergencies by outbreaks, but not focusing on medical technology or medical science such as researches on therapeutic modality, medication and epidemiology or development of vaccine and diagnostic technology (PCR or Antibody testing) .

**3. Expected output and Proposed case category for Good practice**

Collection of Good practices and knowledge sharing on emergency medical response to the COVID19 pandemic in ASEAN.

Good practice case refers to the activity conducted responding to COVID-19 outbreak which is considered effective, efficient, replicable and cost effective, and could be collected on the following aspects of emergency medical response.

**① Infection control (Zoning, Isolation, Disinfection)**

Prevention of Health care–associated infection; Infection control in Health/ Medical facility, Flow of outpatients and prevention rules in the reception, layout and prevention measures in wards for Confirmed COVID-19 patients.

Isolation of Confirmed, Probable and Suspected cases based on severity (mild, moderate, severe, critical) and Asymptomatic cases as well as Close contact of Confirmed cases.

- ② **Triage/ Diagnosis/ Treatment/ Specimen collection**  
Set-up of special unit or external tent of first triage for Suspected outpatients.  
Effective specimen collection protocol, Selection criteria for PCR targets, Drive-thru or Walk-in methods for safe sample collection.
  - ③ **Isolation facility/ Evacuation center**  
Establishment of temporary isolation facilities for mild and asymptomatic cases as well as designation of special hospitals for treatment of Confirmed COVID-19 patients.
  - ④ **Prehospital/ Transport**  
Prehospital care and Transport of Confirmed, Probable and Suspected cases; Assessment protocol of Suspected cases, PPE and preventive measures for crews of ambulance.
  - ⑤ **Deployment of EMT or Specialist team**  
Deployment of EMT or Specialist team to conduct direct intervention, or to support medical facility responding to the COVID-19 outbreak
  - ⑥ **Information management**  
Patient data, including health events, medical procedure and outcomes, is properly managed and regularly reported in order to increase monitoring and data-based response capacity of relevant coordination bodies such as EOC.
  - ⑦ **Risk Communication/ Advocacy**  
Effective and timely transmission of information, advice and instruction by government authority/ health experts to enable general public facing threats in the COVID-19 outbreak to take informed decisions to protect themselves.
  - ⑧ **Response/ Preparedness to other disasters during pandemic**  
Complex emergency by COVID-19 and natural disaster; Management of evacuation center, Special consideration for EMT.
  - ⑨ **Others**  
Other relevant issues such as coordination, logistics or cross- cultural issues.
4. **Proposed activities to document, share or disseminate identified good practices**
- ① Collecting good practices according to the above case category (as per attached Documentation Form); Request shall be done to each AMS in the PWG meeting.
  - ② Holding an online conference for sharing information on good practices against COVID-19
  - ③ Searching good practices in other regions including Japan
  - ④ Selecting good practices for presentation in the ASEAN Academic Seminar and inviting the presenters.
  - ⑤ Holding a session of Good Practices on Medical Response Operation against COVID-19 pandemic as a special session of the ASEAN Academic Seminar.
  - ⑥ Publishing "Good Practices Collection on Medical Response Operation against COVID-19 pandemic".
- 【Attachment】 Good Practice Documentation Form



【Attachment】

Good Practice Documentation Form

This form aims to collect "Good practice" on medical response against COVID-19 outbreak in order to share knowledge and experience among AMSs through ARCH Project.

Kindly complete the below reporting template and submit to ARCH Project Team no later than 31 July 2020.

To: ARCH/ JICA Project Office

E-mail: archpro1@outlook.com

National focal point for Questionnaire on COVID-19 response	
Country	Choose an item.
Name	
Position	
Email	

Good practice report (No.1)			
Title			
Category	Choose an item.		
	Specify if you select "others" in the above.		
Section level	<input type="checkbox"/> National <input type="checkbox"/> Provincial/ District		
	<input type="checkbox"/> Facility <input type="checkbox"/> Field/ Prehospital		
Period	From	Click or tap to enter a date.	To Click or tap to enter a date.
Reported by	Name		
	Position		
	Email		
Key word	1)	2)	3)
Abstract (maximum 1,000 characters)			
Please include the following contents in the abstract;			
1. Brief description of the good practice			
2. Problem/ Issue			
3. Result / Outcome			
4. Monitoring/ Evaluation methodology			
5. Financial considerations			

\* If you are willing to share two or more cases of "Good practice", please copy the template above.

## Good Practices on COVID-19

COUNTRY	CATEGORY	SECTION LEVEL	TITLE	Remark
Brunei Darussalam	Information management	National Level	Responding to COVID-19 in Brunei Darussalam: Lessons for small countries	2nd Webinar
Cambodia	Risk Communication	National Level	The Good Practice for COVID 19 Response in Cambodia	1st Webinar
Indonesia	Logistics	National Level	Distribution of Logistic (PPE) as a response to COVID-19 management	2nd Webinar
Indonesia	Infection control (Zoning, Isolation, Disinfection)	Provincial/ District	Impact of Large-Scale Social Restrictions in Communities on COVID-19 Patients Visits in Hospital	2nd Webinar

## Good Practices on COVID-19

COUNTRY	CATEGORY	SECTION LEVEL	TITLE	Remark
Indonesia	Dead Bodies Management of COVID-19	Facility Level	Dead Bodies Management of COVID-19: "Stigma vs Proper Procedure"	2nd Webinar
Philippines	Infection control and Specialist team	Facility Level	Occupational Safety and Health for Healthcare Workers of the COVID-19 Response Team	1st Webinar
Singapore	Isolation facility/ Evacuation center	National Level	Community Care Facility	
Thailand	Prehospital/ Transport	National Level	SCOT: Special COVID-19 Operation Team	1st Webinar

## Good Practices on COVID-19

COUNTRY	CATEGORY	SECTION LEVEL	TITLE	Remark
Thailand	Isolation facility/ Evacuation center	National Level	Thailand Quarantine Facility	2nd Webinar
Viet Nam	Infection control	Facility Level	Good practice for control of Covid-19 spreading in Bach Mai hospital	1st Webinar
Japan	Deployment of EMT or Specialist team	National Level	DMAT Activities for COVID-19 Response	2nd Webinar
Japan	Information management	National Level	MDS for COVID-19	2nd Webinar



## **Good Practice in Brunei Darussalam**

- 1) *Responding to COVID-19 in Brunei Darussalam; Lesson for small countries*
  - *Good Practice Form*
  - *Presentation*

【Attachment】

Good Practice Documentation Form

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Kindly complete the below reporting template and submit to ARCH Project Team no later than 31 July 2020.

To: ARCH/ JICA Project Office

E-mail: archpro1@outlook.com

National focal point for Questionnaire on COVID-19 response	
Country	Brunei Darussalam
Name	Dr Linawati Haji Jumat
Position	Chief of Emergency Services, Ministry of Health
Email	

Good practice report (No.1)			
Title	Responding to COVID-19 in Brunei Darussalam: Lessons for small countries		
Category	Others		
	Specify if you select “others” in the above.		
Section level	<input checked="" type="checkbox"/> National <input type="checkbox"/> Provincial/ District <input type="checkbox"/> Facility <input type="checkbox"/> Field/ Prehospital		
Period	From	1/1/2020	To 6/30/2020
Reported by	Name	Dr Justin Wong	
	Position	Disease Control Division, Ministry of Health	
	Email		
Key word	1) Brunei Darussalam	2) COVID-19	3) Lessons
Abstract (maximum 1,000 characters)			
<p><b>Responding to COVID-19 in Brunei Darussalam: Lessons for small countries</b></p> <p>Small countries face different and specific challenges and opportunities in responding to COVID-19. This includes Brunei Darussalam, a country with a population of 459400, that recorded its first imported case on March 9, and as of April 20 has detected 138 cases. Assessed against several parameters including a slowing trajectory since the 100th confirmed case, Brunei compares favorably with other countries considered to have implemented a successful response operation, with limited local transmission, and the absence of cases with no known epidemiological links.</p> <p>This article reviews Brunei’s response across three thematic areas, including challenges faced and propose lessons for other small countries. Brunei has leveraged on its small population to operationalize <b>effective incident management, planning and multi-sectoral coordination, surveillance and laboratory testing</b>, and <b>risk communication</b> strategies. While the country has advantages including its relative wealth, a very high human development index, and universal health coverage, there are specific set of challenges for small countries like Brunei (see Table 1).</p>			



## Responding to COVID-19 in Brunei Darussalam

### Brunei COVID-19 Summary



#### 151 total cases

First case identified on  
9 March



#### 64 imported cases

87 cases resulting from local  
transmission. Last locally  
transmitted case 6 May



#### 147 recovered

1 cases remain at  
National Isolation Centre



#### 78,030 persons tested

TPR  $\approx$  0% since May 7

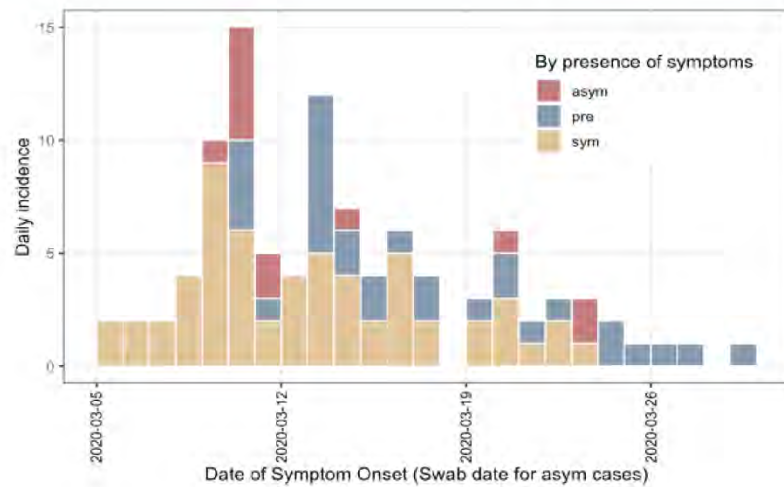


#### 3 deaths

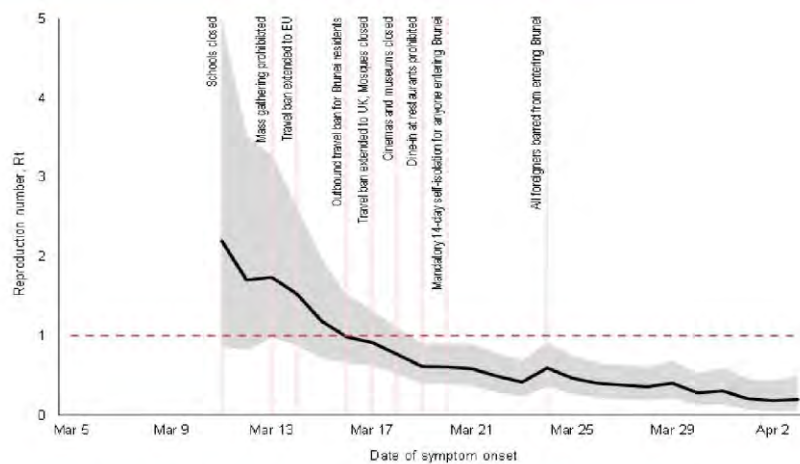
Information as of 7 December

## Epidemic curve

Symptomatic – 58%  
Presymptomatic – 30%  
Asymptomatic – 12%



## Key control measures



RO estimate  
between 3.88  
to 5.96

Mean Serial  
Interval of  
5.39 days

Median  
incubation  
period of 5.0  
days

**Importantly, no complete lockdown or internal movement restrictions were implemented suggesting that moderately stringent NPIs alongside robust test, trace, isolate approaches were able to control the first wave in Brunei**

## CONTEXT



Brunei's government is highly centralised – dedicated ringfenced budget for outbreaks & public health emergencies



National Disaster Council has oversight for emergency response

## PROBLEM



Lack of updated resource map & resource-pooling arrangements hampered initial efforts



Lack of clarity on responsibilities for securing operational logistics arrangements



Despite the range of legislation that support crisis management, we lack experience due to infrequent activation of existing coordination mechanisms.

## OPPORTUNITY



Strong interpersonal relationships can mitigate the lack of more formal structures, evident in Brunei's ad-hoc multi-agency arrangements at the technical level.

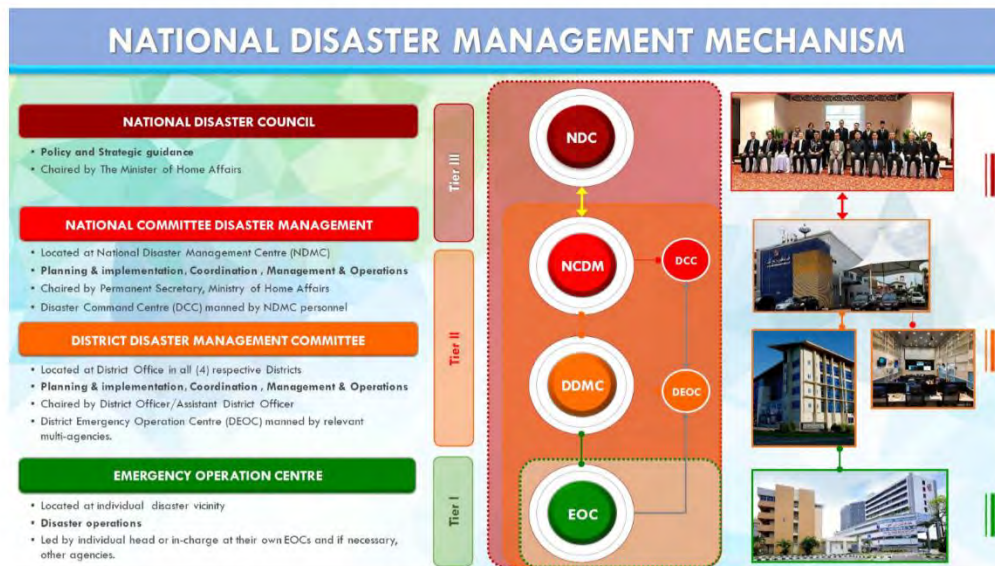


Leveraging these informal networks, at least in the initial phases, can allow for more formal mechanisms to emerge naturally over the course of the outbreak.

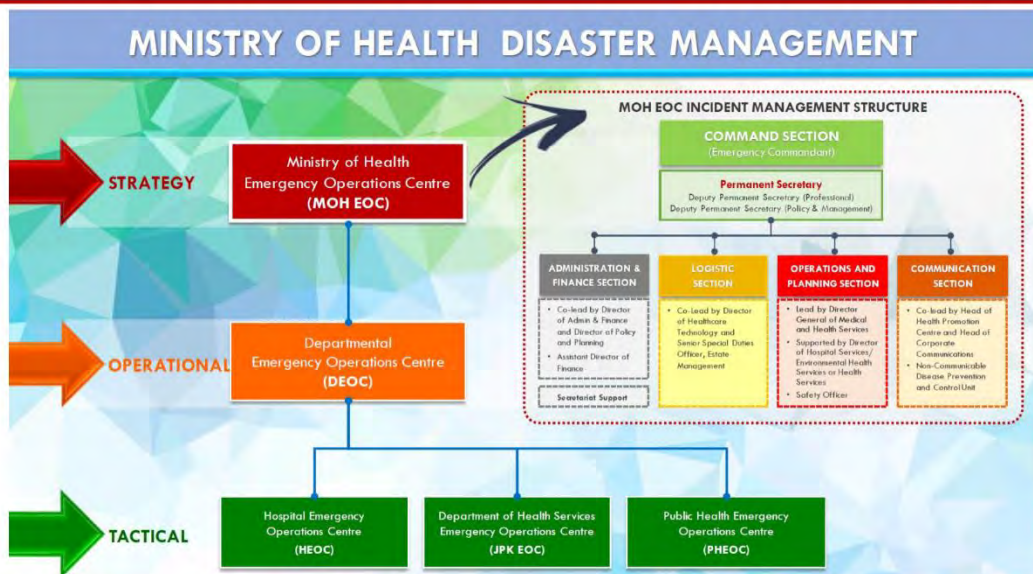


This should be supplemented by efforts to establish clear lines of accountability and documentation of processes to preserve institutional memory.

## Incident Command System



## System linkages





## Lessons from the field: BruHealth Mobile Application



420,049 unique sign-ups

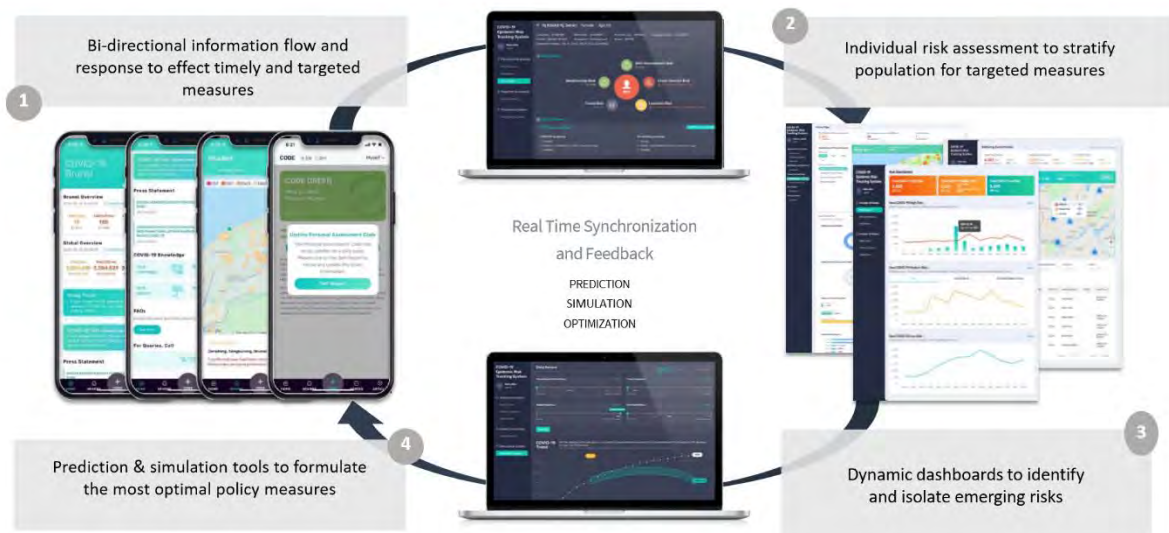
### FRONT-END

- **Personal assessment code:** This code reflects the infectious risk of the user and will determine the type of activities the user can take part in.
- **Daily self-assessment tool:** A tool that assesses your risk for COVID-19
- **Friday Prayers Code:** This code is used to book Friday prayer, control capacity at mosques and determine if users are healthy and well enough to attend Friday prayers.
- **Health Advice:** Includes press releases related to COVID-19, as well as key updates and FAQs on COVID-19
- **Nearby:** Shows the activity map of the confirmed cases in Brunei and locations of medical resources.
- **Scan QR Code:** allows users to scan the QR codes at business premises Entry to the premise is determined by the personal assessment code of the user.

### BACK-END

- **Tracking:** tracks the user, and those nearby using Bluetooth technology to assist in contact tracing in event of confirmed cases
- **BruHIMS link:** links with the national health information database to determine personal health profile, risk, attendances at flu clinics – collates this information along with the daily self-assessment tool to assign the personal assessment code

## Dynamic Population Management

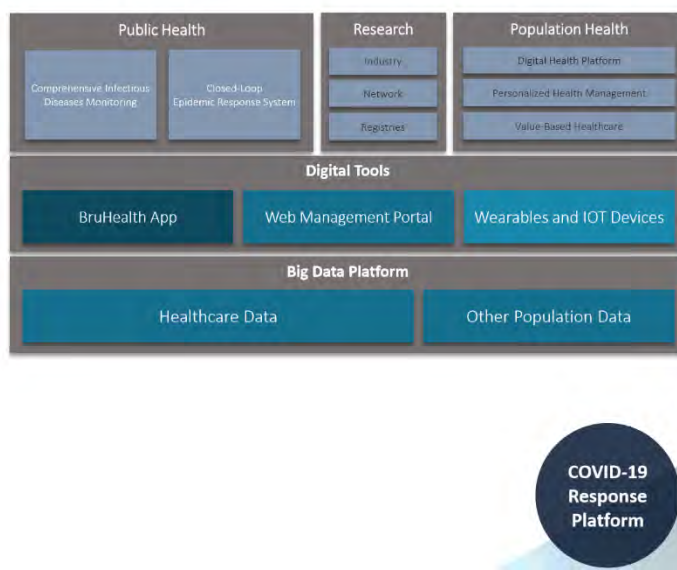




## National De-Escalation Plan

	MAY – JUNE 2020	JUNE 2020	JULY 2020				AUG 2020					SEPT 2020
		Week beginning 29 June	Week beginning 6 July	Week beginning 13 July	Week beginning 20 July	Week beginning 27 July	Week beginning 3 Aug	Week beginning 10 Aug	Week beginning 17 Aug	Week beginning 24 Aug	Week beginning 31 Aug	Week beginning 7 Sept
Mosques (subject to MUIB)	Wk of 11 May to Wk of 22 June (TOTAL: 7 weeks)	LEVEL 2	LEVEL 3		LEVEL 4			NORMAL				
Other religious gatherings (e.g. temples, churches)		LEVEL 2	LEVEL 3		LEVEL 4			NORMAL				
Schools, other educational institutions		LEVEL 3		LEVEL 4			NORMAL					
Technical, vocational and higher education		LEVEL 3		LEVEL 4			NORMAL					
Tuition school, music schools		LEVEL 3		LEVEL 4			NORMAL					
Special needs classes		LEVEL 1	LEVEL 2		LEVEL 3			LEVEL 4		NORMAL		
Driving schools		LEVEL 2	LEVEL 3		LEVEL 4			NORMAL				
Child care centres		LEVEL 1	LEVEL 2		LEVEL 3			LEVEL 4		NORMAL		
Activity centres for the elderly		LEVEL 1		LEVEL 2			LEVEL 3		LEVEL 4		NORMAL	
Museums, galleries, libraries		LEVEL 1	LEVEL 2		LEVEL 3			LEVEL 4		NORMAL		
Gyms, fitness centres		LEVEL 2	LEVEL 3		LEVEL 4			NORMAL				
Indoor sports facilities		LEVEL 2	LEVEL 3		LEVEL 4			NORMAL				
Outdoor sports facilities, including outdoor playground		LEVEL 2	LEVEL 3		LEVEL 4			NORMAL				
Golf courses		LEVEL 2	LEVEL 3		LEVEL 4			NORMAL				
Swimming pools		LEVEL 0	LEVEL 1		LEVEL 2			LEVEL 3		LEVEL 4		
Restaurants, café and food courts		LEVEL 2	LEVEL 3		LEVEL 4			NORMAL				
Cinemas		LEVEL 0	LEVEL 1		LEVEL 2			LEVEL 3		LEVEL 4		
Arcade, indoor playground		LEVEL 0		LEVEL 1			LEVEL 2		LEVEL 3		LEVEL 4	
Internet cafés		LEVEL 1	LEVEL 2		LEVEL 3			LEVEL 4		NORMAL		
Open air stalls and markets		LEVEL 2	LEVEL 3		LEVEL 4			NORMAL				
Mass gatherings		LEVEL 0	LEVEL 1		LEVEL 2			LEVEL 3		LEVEL 4		
Travel restrictions			LEVEL 1									

## PUBLIC HEALTH BIG DATA PLATFORM ROADMAP



## Lessons from the field: risk communication



### DAILY PRESS CONFERENCES BROADCAST LIVE

Attended by press, new media, local influencers, public have opportunity to ask questions



### LEVERAGING ON PUBLIC SUPPORT FOR FRONTLINERS

Frontliners deliver key health messages



### Brunei introduces new features for AI enabled Covid-19 web application



### USE OF NON-TRADITIONAL METHODS TO RALLY THE COMMUNITY

## Two-way risk communication

- National COVID-19 risk survey (June 2020)
- 32,381 respondents
- Highlight results:
  - **Risk perception** - 87% believed COVID-19 to be very dangerous, 35% believed they would get COVID-19 at some point in the epidemic, 92% suggested senior citizens were at highest risk
  - **Transmission** - 78% identified droplets as primary mode of transmission, 28% indicated airborne
  - **Prevention** - 98% identified hand hygiene, 93% identified cough etiquette, 64% identified using a face mask as a preventive measure
  - **Sources of information** - 80% reported getting information on COVID-19 from TV, 75% from radio, 72% from social media. 85% perceived MOH as trusted information source, 45% perceived WHO as trusted information source
  - **Stigma** - Tourists (47%) and religious groups (37%) were most likely to have stigma associated with COVID-19

**We continue to be alert and prepare for future waves of the pandemic by adopting a whole-of-government approach to dealing with COVID-19:**

- Find, track, and trace every case
- Health education and promoting social distancing
- Ensure health service resilience to manage surge in cases
- Protect the vulnerable



## **Good Practice in Cambodia**

### *2) The Good Practice for COVID-19 in Cambodia*

- *Good Practice Form*
- *Presentation*

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To: ARCH/ JICA Project Office

E-mail: archpro1@outlook.com

National focal point for Questionnaire on COVID-19 response	
Country	Cambodia
Name	Dr. Lak Muy Seang
Position	Deputy Director of Preventive Medicine Department
Email	

Good practice report (No.1)			
Title	The Good Practice for COVID 19 Response in Cambodia		
Category	⑦ Risk Communication/ Advocacy		
	Specify if you select “others” in the above.		
Section level	<input checked="" type="checkbox"/> National		<input type="checkbox"/> Provincial/ District
	<input type="checkbox"/> Facility		<input type="checkbox"/> Field/ Prehospital
Period	From	Click or tap to enter a date.	To Click or tap to enter a date.
Reported by	Name	Dr. Lak Muy Seang	
	Position	Deputy Director of Preventive Medicine Department	
	Email		
Key word	1)	2)	3)

#### Abstract (maximum 1,000 characters)

National health security system of Cambodia has been strengthened to prevent the importation of COVID-19 through the activation of incident management system in all sub-national level to be ready for response as well as establishing national committee to respond to COVID-19 through strengthening existing surveillance and response systems, ensuring that rapid response teams are in place to respond, restriction measures at point of entry, designation of laboratory and hospital. The Ministry of Health, Cambodia, has established 2 Working Groups. Group1 is for technical operation education training and public relations, group 2 is for technical operations and supply. Under group 1, there are 6 task teams. The outcome of the task team is to work on the risk communication and community engagement as task team 2 of the 6 task teams is to prevent and save lives and protect wellbeing of the population in Cambodia. There are certain challenges that Cambodia found were dealing with fake news, some peoples did not practice training, education messages on COVID19 prevention, difficult to manage people under quarantine who have contacted with COVID19 patient, and budget limitation. The monitoring system used are from central level to sub national level and communities by conducting TOT on the risk communication and community engagement on data collection, Surveillance system, from central level to sub national level and communities by conducting TOT on the risk communication and communities engage and data collection of COVID 19 from communities to central level. Cambodia considered the governmental budget, charity fund and donors (partner) budget.

\* If you are willing to share two or more cases of “Good practice”, please copy the template above.

14 July 2020





## **The Good Practice for COVID 19 Response in Cambodia**

**15 September 2020, ASEAN Webinar**

**Presented by:**

**Dr. Lak Muy Seang  
Dr. Teng Srey**

**Deputy Director of PMD  
Deputy Director of CDC**

2

### **Background**

In late December 2019, Chinese health authorities reported an outbreak of pneumonia unknown origin in Wuhan. On January 27, 2020, Cambodia discovered the first case of COVID19 on a Chinese passenger in Sihanouk ville. The man was treated at the provincial hospital until he recovered on February 10 of the same year and was released from the hospital with three other direct contact family members after being isolated with under close monitoring. On January 30, 2020, the World Health Organization declared the outbreak of pneumonia caused by the new coronavirus to be a "global pandemic", with more than 9,700 cases in the country. China and 106 other confirmed cases in 19 other countries. On 11 February, 2020, the World Health Organization (WHO) named a disease caused by a new strain of coronavirus called Coronavirus-2019, or COVID-19.

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## 1. The description of good practice:

Progress is noted for Cambodia's efforts to strengthen the national health security system to prevent the importation of COVID19 through the activation of incident management system to all sub-national level to be ready to response and establish national committee to response to COVID-19, strengthen existing surveillance and response systems, including event-based and case-based surveillance and sentinel sites for influenza like illness and severe acute respiratory infection, fever with rash system, rapid response team are in place to response, restriction measures at point of entry, laboratory, assigned designated hospital. Using hotline 115 and other 2 mobile phone for receive, response to and report information on COVID19 to public with free of charge. Hospitals ready to receive patients. For risk communication, develop and produce IEC's material, radio spots,

TV pots updated regular website page and Facebook pages. Conduct regular meeting for committee members.

Regular press conference with media, dialing with rumor and fake news. Administrative management for budget and logistic by engagement private sector and fund raising leaded by Prime Minister for fighting COVID-19. The successful come from strong government leadership and support lead by Prime Minister, national, sub-national, inter-ministerial committee, strong investment from government and donated fund from personals, private sectors and companies and donors, strong health system in place and function well, good risk communication and community engagement, good preparation a head.

On 2 March 2020, Prime Minister of the Kingdom of Cambodia, declared that the fight against pandemic of COVID19 virus is the highest priority of the Royal Government.

## **The Mechanism to Response to COVID19 Virus in Cambodia**

Under leadership of the Prime Minister of the Royal Government of Cambodia has issued regulations and measures as well as an emergency response to be implemented throughout the country to prevent the spread of the virus. COVID-19, the coordination and management mechanism, including:

- First: Decision No. 29, dated 18 March 2020, on the Establishment of the National Committee for Combating COVID-19, Directed by Prime Minister
- Second: Decision No. 26, dated 10 March 2020, on the Establishment of the Inter-Ministerial Committee for Combating COVID-19, chaired by Minister of Health
- Third: Notification letter of the Ministry of Health No. 040, dated 16 March 2020, on the establishment of the Capital-Provincial Committee for combating COVID-19, led by the Governor of each Capital-Province Board of Governors.

**For the Public Health Response to the COVID-19 outbreak The Ministry of Health of Cambodia, in consultation with the World Health Organization (WHO) and other stakeholders, focused on the COVID-19 National Response Plan. These include:**

- 1) Immediate event planning and management,
- 2) Risk monitoring and assessment,
- 3) Laboratory capacity building,
- 4) Health care services and treatment management,

- 5) Infection prevention and control diseases
- 6) Public health measures
- 7) Risk communication
- 8) Management of border crossings
- 9) Operation of logistics, medicine and medical equipment.

**In The Ministry of Health, Cambodia, have been established  
2 Working Group :**

**1/The working group 1:**

On technical operation education training and public relations under the Inter- Ministerial Committee for Combating COVID-19. Under the working group 1 there are 6 task team as following:

- ✓Coordination, Planning, Reporting, M&E
- ✓Risk Communication and Community Engagement
- ✓IEC development
- ✓Training
- ✓Public Relations and Press Release
- ✓Responsible for managing the data collection system for migrant workers returning to



#### The role and responsibilities of the working group 1:

- Organize training sessions and conduct exercises to raise awareness among health officials and stakeholders.
- Provide the comprehensive information on prevention and necessary measures for the response to COVID 19 disease.
- Managing social media, including taking necessary action in collaboration with relevant authorities at both national and sub-national levels.
- Increase the capacity of the emergency response team and set up breaking system using a complete mechanism that can fight back fake news.
- Provide immediate information on the current state of disease and epidemic among travelers national, international and community.
- Keep in touch extensive relationship on risk mitigation by providing important information and messages to the public and other stakeholders.
- Follow up national and international media, breaking news, patient feedback to reduce the worries and fears of the people.

## **2/ The working group2:**

On technical operations and supply under the Inter- Ministerial Committee for Combating COVID-19.

#### The role and responsibilities of the working group 2:

- Incident management and develop operational planning
- Assess the risk according to the actual needs
- Coordinate the incident management team and submit on time
- Develop human resource planning, material resources and budget resources to respond in a timely manner.
- Monitor the status of infections and assess the risks and develop strategies to prevent them in a timely manner.



- Monitor the status of infections and assess the risks and develop strategies to prevent them in a timely manner.
- Manage laboratory services in consultation with all international partners
- Manage treatment and care services by developing an emergency response plan for the hospital.
- Manage infection prevention and control by implementing effective measures
- Update to responses for airports, ports and land way
- Ensure the supply of human resources, equipment, medicine, financial and all operation

**As I m a member of task teams 2 responsible on risk communication and communities engagement. The role and responsibilities such as:**

- Develop a strategic plan for risk prevention and community engagement in responses to COVID19 disease.
- Manufacturing tools and guidelines on risk communication and community engagement work, including prevention Infection and waste management COVID19.
- On going repeat assessment to seek information on risks and Challenges group.
- Organize training to increase health officials and authorities knowledge of risk communication and community engagement, including prevention of communicable diseases and waste management with COVID 19.
- Follow up on fake news and respond
- Perform other duties as instructed by the executive team leader

## **The detail of task team 2**

### **1-Develop a strategic plan for risk commination and community engagement in responses to COVID19 disease.**

- 1.1.Develop a strategic plan for risk commination and community engagement in responses to COVID19 disease.
- 1.2.Printing Strategic Plan for Risk commination and Community Action in Response to COVID19 disease.
- 1.3.Dissemination Workshop on Strategic Plan for Risk commination and Community Action in Response to COVID19 disease.
- 1.4.Monitor and review educational messages, educational materials to ensure the consistency of educational messages in accordance with the Ministry of Health (Poster, leaflet, TV, Radio Spot) of all stakeholders, NGOs, UN, relevant ministries, COVID 19 to the organization Partner

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- 1.5.Create a message or update a talking point message for a spokesperson for the Ministry of Health.
- 1.6.Participate in weekly meetings with other task teams to know and sharing how to communicate risks and progress.
- 1.7.Weekly meeting with WHO,UN, NGOs to review the implementation progress and mobilize resources and sharing management area responsibilities.

### **2.Manufacturing tools and guidelines on risk communication and community engagement work, including prevention Infection and waste management COVID19.**

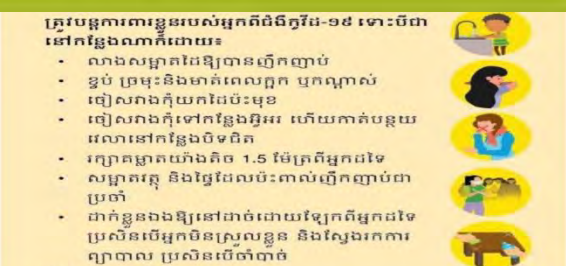
- 2.1.Produces educational materials on prevention of COVID19 infection for the general public
- 2.2.Prevention of COVID19 infection for hotel workers, restaurants, street food sell
- 2.3.Prevention of COVID19 infection for all types of businesses and workplaces
- 2.4.Prevention of COVID19 infection for chronic patients (diabetes, hypertension, cardiovascular disease and people living with HIV and tuberculosis)

14

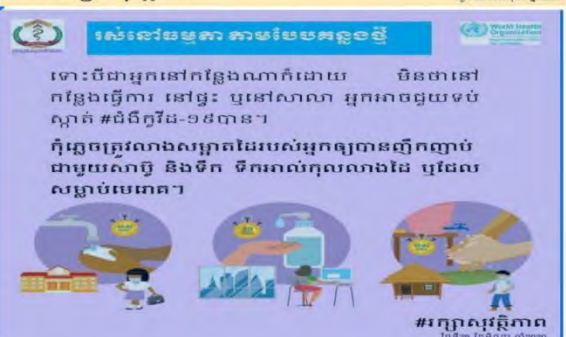
- 2.5.Daily practice for individuals, isolated at home for 14 days (contact tracing twice a day, monitor symptoms and immediately report hot line 115 when any symptoms)
- 2.6.Daily practice for hospitalized patients (take temperature twice a day, monitor symptoms and report to physician)
- 2.7.How to wear and remove PPE for hospital staff
- 2.8.How to mix disinfectant water for hospitals and the public
- 2.8.COVID19 patient waste management for the general public
- 2.9.COVID19 waste management in the hospital
- 2.10.Create an education message not to leave the house in case of mild symptoms and how to care at home during the community epidemic.
- 2.11.Create educational messages, search for essential food items at designated locations
- 2.12.Produces educational materials on risk communication, infection prevention and waste management for COVID19 at hospitals
- 2.13.Broadcast and post produced material on TV Radio and social media (facebook)
- 2.14.Distribute production materials to health departments, ODs, health centers and related institutions, NGO, UN, Telegram, messenger group, individual



Cover mouth and nose when coughing or sneezing with elbow joint to prevent COVID 19



#រក្សាសុវត្ថិភាព



#រក្សាសុវត្ថិភាព





### 3. On going repeat assessment to seek information on risks and Challenges group.

- 3.1. Prepare assessment tools
- 3.2. Conduct assessment
- 3.3. Risk analysis and challenge group

### 4. Organize training to increase health officials and authorities knowledge of risk communication and community engagement, including prevention of communicable diseases and waste management with COVID 19.

- 4.1. Training and education on risk communication and community mobilization, including prevention of communicable diseases and waste management related COVID19 to village chiefs and local authorities, police and relevant departments and NGOs.
- 4.2. Regular governance to monitors the implementation of health centers, local authorities relevant institutions on risk communication and community mobilization, including prevention of communicable diseases and waste management related to COVID19





### **5-Follow up on fake news and respond**

- 5.1 Purchase Internet service to operate as an individual
- 5.2 Group 1 to track fake news on Facebook
- 5.3 Group 2 to track fake news on the radio
- 5.4 Team 3 to track fake information on internet
- 5.5 Group 4 to track fake news in the other press release
- 5.6 Report to the Executive Team Leader

### **2. Problem/Issues:**

- ❖ Difficulty to manage the fake new
- ❖ The task team of Ministry of Health worked hard on education training dissemination information on COVID19 to prevention, some peoples are known and heart information but did not afraid and practice with COVID19.
- ❖ Difficulty to manage the quarantine the people whose have contacted direct and indirect with COVID19 patient.
- ❖ Budget limited

### **3 . Result /Outcome:**

The outcome of task work on the risk communication and community engagement is to prevent and save life and wellbeing of the population in Cambodia.

### **4 . Monitoring and Evaluation Methodology.**

- Monitoring system from central level to sub national level and communities by
- conducting TOT on the risk communication and communities engage and data collection of COVID 19 from communities to central level.
- Hotline 115
- Surveillance system.
- Inter-ministerial Committee Regular meeting at national, provincial level.
- Health center management committee

## **Good Practice in Indonesia**

- 3) *Standard Operating Procedures for Mobilization of Health Officers to Cope with Health Crisis in Pandemic*
  - *Good Practice Form*
- 4) *Guidelines for community empowerment in disaster management and health crisis on the time of COVID-19*
  - *Good Practice Form*
- 5) *Logistics Management in COVID-19 Respond*
  - *Good Practice Form*
  - *Presentation*
- 6) *Impact of Large-Scale Social Restrictions in Communities on COVID-19 Patients Visits in Hospital*
  - *Good Practice Form*
  - *Presentation*
- 7) *Dead Bodies Management of COVID-19*
  - *Good Practice Form*
  - *Presentation*

Ocotber 30, 2020

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【Attachment】

Questionnaire on COVID-19 response in ASEAN

This questionnaire aims to collect "Good practice" on medical response against COVID-19 outbreak in order to share knowledge and experience among AMSs through ARCH project.

Kindly please complete the below reporting template and submit to ARCH project no later than XX YY 2020.

To: ARCH/ JICA Project Office

E-mail: archpro1@outlook.com

National focal point for Questionnaire on COVID-19 response	
Country	Indonesia
Name	Dr. Rakhmad Ramadhanjaya
Position	Head of Emergency Response Facilitation Sub Division, Center For Health Crisis MoH Indonesia
Email	

Good practice report (No.1)	
Title	Standard Operating Procedures for Mobilization of Health Officers to Cope with Health Crisis in Pandemic COVID-19 Situations (under development)
Category	Response/ Preparedness to other disasters Specify if you select "others" in the above.
Section level	<input type="checkbox"/> International <input checked="" type="checkbox"/> National <input type="checkbox"/> Provincial/ District <input type="checkbox"/> Facility <input type="checkbox"/> Field/ Prehospital
Period	From 7/1/2020 To 8/17/2020
Reported by	Name Dr Rakhmad Ramadhanjaya Position Head of Emergency Response Section, Center for Health Crisis Unit, MoH Email
Key word	1)SOP 2) crisis 3)COVID-19

Abstract (maximum 1,000 characters)

Indonesia is a country prone to disasters, both natural and non-natural. Disasters can occur in pandemic conditions like those in Indonesia today, floods, landslides, tornadoes and other disasters occur in the COVID-19 pandemic.

Disasters can have many impacts, ranging from decreasing individual health status and creating public health problems. Health workers must be mobilized to help disaster victims as well as to overcome various public health problems. But at the same time, health workers who help disaster

victims must prevent themselves from contracting COVID-19.

It is well understood that COVID-19 transmission to health workers can be prevented and minimized by the use of Personal Protective Equipment (PPE) according to standards. The use of PPE must be carried out by health workers when helping disaster victims in areas with many positive cases of COVID-19, especially in areas where COVID-19 local transmission has occurred.

PPE for prevention of COVID-19 transmission consists of several items, ranging from coveralls, various masks, protective goggles, face shields, head protectors, gloves, protective shoes and others. Not all of them must be used at the same time by health workers, it all depends on the activities carried out by them.

When required physical contact with people such as when providing medical services, health workers must use PPE in full. Unlike the case when physical contact can be limited such as when health workers empower the community or provide technical assistance to the local health office, then health workers do not have to use PPE completely.

In order to provide guidance for preventing COVID-19 transmission for health workers in carrying out their duties in overcoming health crises, the Ministry of Health is in the process of developing Standard Operating Procedures for Mobilization of Health Officers to Cope with Health Crisis in Pandemic COVID-19 Situations. The process involves all stakeholder (member of health cluster).

The activity of preparing the Standard Operating Procedure will be carried out during July to August 2020 and will be continued by guiding EMT facilitators at the provincial level in the implementation of the SOP in September to November 2020. Later, EMT facilitators at the provincial level will socialize the implementation of this SOP to the EMTs in their working area.

\* If you are willing to share two or more cases of "Good practice", please copy the template above.

Good practice report (No.2)			
Title	Guidelines for community empowerment in disaster management and health crisis in the time of COVID-19		
Category	Response/ Preparedness to other disasters		
	Specify if you select "others" in the above.		
Section level	<input type="checkbox"/> International	<input checked="" type="checkbox"/> National	<input type="checkbox"/> Provincial/ District
	<input type="checkbox"/> Facility	<input type="checkbox"/> Field/ Prehospital	
Period	From	6/1/2020	To 10/31/2020
Reported	Name	Dr. Eko Mediantanto, M. Epid	



by	Position	Head of Prevention & Mitigation Section, Center for Health Crisis Unit, MoH		
	Email	r		
Key word	1)Community empowerment	2)Disaster	3)COVID-19	
Abstract (maximum 1,000 characters)				
<p>The community has an important role in the effort overcoming and manage disaster and health crisis in their community or region. Capacity building and community empowerment at disaster-prone areas become very important to minimize the impact and reduce the risk of casualties.</p> <p>Especially in the current COVID-19 pandemic, which role the community is very big in cutting off the transmission chain of the COVID-19. In the country like Indonesia which is very prone to this disaster, if a disaster occurs during the COVID-19 pandemic, it is potentially to have an impact such as high number of casualties and increase of COVID-19 cases. The risk will be higher if the community is not prepared and have low capacity to cope with disasters with applying health protocols prevention of COVID-19.</p> <p>Therefore, there needs to be a guideline that can be used by the community, health cadres and volunteer as a guide for implementation in the field that can be used before the crisis as mitigation and preparedness, at health crisis emergency to reduce fatalities and post health crisis for recovery. Increased implementation of community empowerment in disaster and health crisis management in the time of COVID-19, is expected to reduce fatalities and cutting off the transmission chain of COVID-19 in the community.</p> <p>This guideline directs the community how to prepare for disaster in COVID-19 situation (making plans, preparing Disaster Family Kit, etc.), how to effectively respond after early warning, what to do and don'ts during evacuation and in IDPs camp, and post disaster activities.</p> <p>All activities are integrated with COVID-19 prevention health protocol efforts such as physical distancing, wearing masks and washing hands in running water.</p> <p>The development process involves all stakeholder (all related programs in MoH, academics, NDMA, WHO and NGOs).</p> <p>Currently the guideline has already finished, published and disseminated to stakeholders, health worker and community at all levels (national, province, district/city).</p>				

Good practice report (No.3)	
Title	Logistic Management in COVID-19 Respond

Category	Logistics		
	Specify if you select "others" in the above.		
Section	<input type="checkbox"/> International	<input checked="" type="checkbox"/> National	<input type="checkbox"/> Provincial/ District
level	<input type="checkbox"/> Facility	<input type="checkbox"/> Field/ Prehospital	
Period	From	1/6/2020	To 10/31/2020
Reported by	Name	Mr Adithya Manggala	
	Position	Health Crisis Analyst	
	Email		
Key word	1)Logistic	2)PPE	3)COVID-19
Abstract (maximum 1,000 characters)			
<p>Since the first case reported in Wuhan, China on December 2019 and declared as an outbreak, Indonesia started the preparedness response to strengthening prevention and detection to response the pandemic, especially in the points of entry. Indonesia also develop contingency plans, and conduct Table Top Exercise (TTX) for Novel Coronavirus Diseases prevention cooperation with the hospitals, health services unit, and related cross sectoral bodies (District Health Office, National Disaster Management Agency/NDMA, Ministry of Social Affairs, Ministry of Agriculture, Indonesian National Army and Indonesian National Police).</p> <p>The first case in Indonesia was identified on March 2, 2020, therefore Ministry of Health developed Coronavirus Disease Task Force and develop operational plan across related sectors. Ministry of Health preparing health service facilities and health logistics, namely PPE for health workers so they can work safely to prevent the virus transmission.</p> <p>Indonesia is an archipelagic country with the largest land area and habited over 267 million peoples. This fact is a challenge to handle the spreading of the virus as well as logistics distribution. The Ministry of Health estimating the logistic requirements using the WHO standard tool, Essential Supplies Forecasting Tool (COVID-ESFT) to fulfill the requirement with obtain quick, accountable and valid, furthermore trained the provincial government to able operating the tool. The work flow of stockpiling and distributing logistics as follows, the Indonesian Government coordinates regularly with the local government to conduct requirement assessment, open the procurement, and distributed to the province and district.</p> <p>The Ministry of Health cooperated with NDMA and Indonesian National Army for the procurement and logistics distribution. Logistics are distributed using Indonesian National Army aircraft, Hercules, since some airport access and provincial road access are temporarily closed for large-scale social restriction. Recording, reporting and evaluating logistics distribution is proceed regularly using an online information system and integrated with the information system at NDMA. Logistical needs</p>			

Ocotber 30, 2020

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assessment updates are also conducted regularly based on case developments to assess the logistics of COVID-19 detection and response.

# DISTRIBUTION MANAGEMENT OF PERSONAL PROTECTIVE EQUIPMENT & OTHER LOGISTICS TO RESPOND COVID-19

2<sup>nd</sup> Webinar on Good Practice on Medical  
Response Against Covid-19 Outbreak

8 December 2020

CENTER FOR HEALTH CRISIS  
MINISTRY OF HEALTH OF THE REPUBLIC OF INDONESIA

## INDONESIA



Population : 269,603,400 (2020) → 4<sup>th</sup> biggest population in the world after China, India and USA

- Ethnic : more than 300 ethnic from Aceh to Papua
- Languages : more than 700 local languages



Wide Area total : 7,81 million km<sup>2</sup>  
Ocean : 3,25 million km<sup>2</sup>  
Land : 2,01 million km<sup>2</sup>

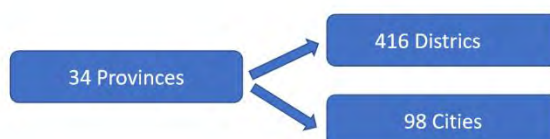


Islands : 17,499 islands





## INDONESIA TERRITORY ADMINISTRATION



## INDONESIA HEALTH FACILITY



HOSPITAL : TOTAL 2,877 UNITS (2019)



COMMUNITY HEALTH CENTER : TOTAL 10,134 UNITS (2019)

Source : Ministry of Health Republic of Indonesia

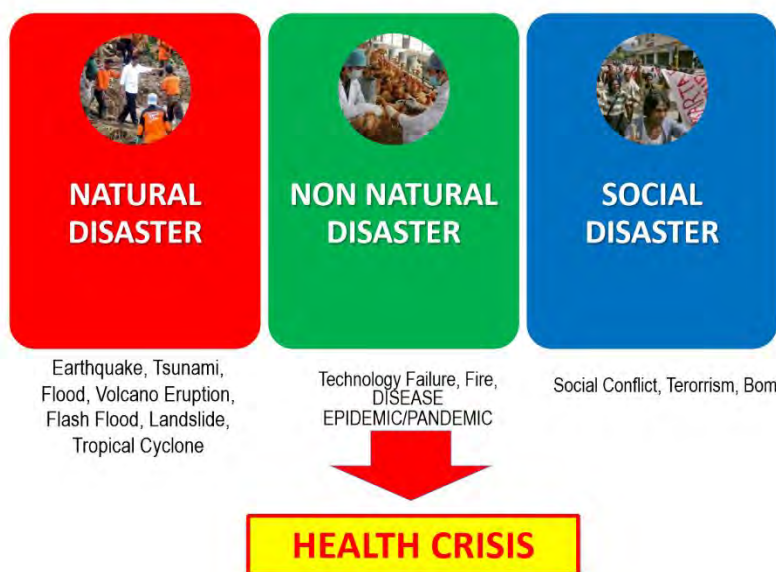
## INDONESIA HEALTH WORKERS DATA (2019)



NO	TYPE OF HEALTH WORKER	NUMBER	RATIO TO POPULATION
1	General Practitioner	29,613	1 : 11 – 1 : 269
2	Nurse	345,508	1 : 77 – 1 : 1813
3	Midwife	210,268	1 : 42 – 1 : 756
4	Public Health	28,306	1 : 5 – 1 : 124
5	Environmental Health	16,886	1 : 2 – 1 : 67
6	Nutritionist	24,593	1 : 3 – 1 : 36

Source : Ministry of Health Republic of Indonesia

## INDONESIA IS PRONE TO DISASTER

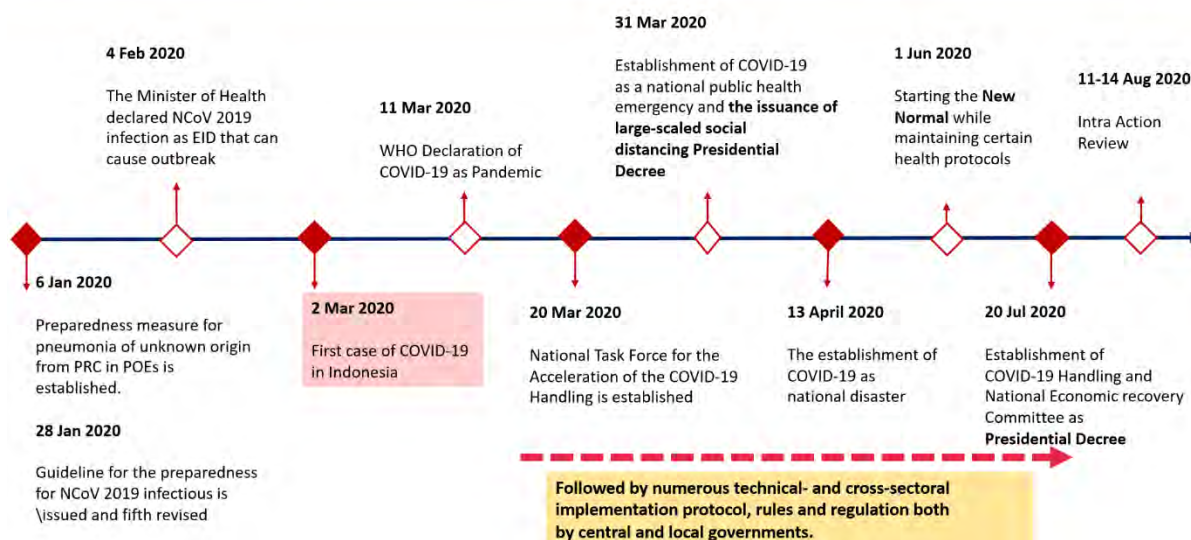


# DISASTER DATA (As of 6 December 2020)















Source : National Disaster Management Agency

## Public Health Policies Measures





## COVID 19 CASES IN ASIA (As of 5 December 2020)

Name	Cases - cumulative total	Cases - newly reported in last 24 hours	Deaths - cumulative total	Deaths - newly reported in last 24 hours	Transmission Classification
Global	65,879,030	605,211	1,523,583	10,264	
 India	9,644,222	36,011	140,182	482	Clusters of cases
 Indonesia	509,707	6,027	17,589	110	Community transmission
 Bangladesh	475,879	1,888	6,807	35	Community transmission
 Philippines	438,069	1,724	8,526	17	Community transmission
 Nepal	239,885	1,024	1,577	10	Clusters of cases
 Japan	160,088	2,424	2,315	32	Clusters of cases
 Myanmar	96,520	1,502	2,059	31	Clusters of cases
 China	94,160	122	4,753	0	Clusters of cases
 Malaysia	71,359	1,123	380	4	Clusters of cases
 Singapore	58,255	13	29	0	Sporadic cases
 Republic of Korea	37,546	631	545	5	Clusters of cases
 Australia	27,956	7	908	0	Clusters of cases

Source : World Health Organization

## COVID 19 CASES DISTRIBUTION IN INDONESIA (as of 7 December 2020)

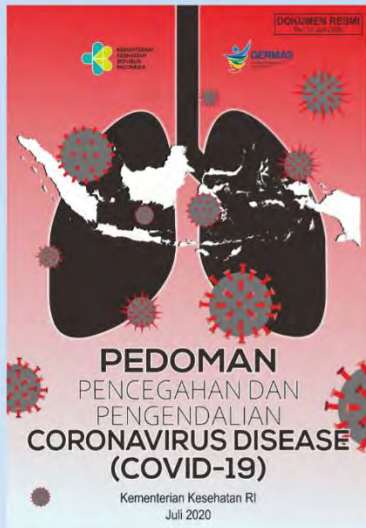


Source : Ministry of Health Republic of Indonesia



## 9 PILLARS FOR COVID 19 PREVENTION AND CONTROL STRATEGY FROM WHO

UPDATED GUIDELINES



## LOGISTIC MANAGEMENT

- Fulfilling the needs of health logistics is crucial to support diagnosis and medical treatment as well as the other components in COVID-19 response
- Health Crisis Center, Ministry of Health is assigned to coordinate the planning, provision, pooling and distribution of Personal Protective Equipment (PPE) and other logistics needed for handling COVID-19 pandemic in Indonesia

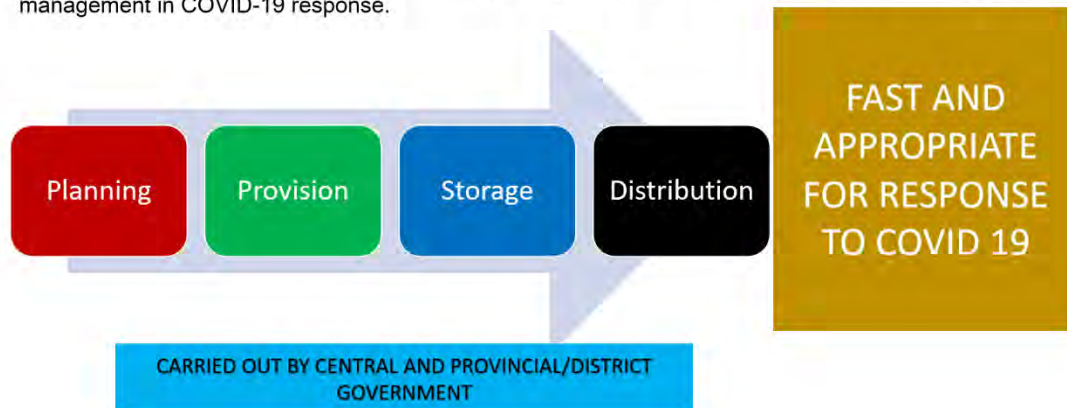
## CHALLENGES IN LOGISTIC DISTRIBUTION

1. At the beginning of the pandemic in March 2020, there were difficulties in providing PPE because the need was very high, while the number of PPE providers at that time was only 2 companies, but at this time there were 327 PPE providers so it was easier to procure PPE.
2. We must distribute PPE to 34 Provinces and 514 districts/cities in Indonesia which requires a large budget and a hard effort.

## LOGISTIC MANAGEMENT FOR COVID-19 RESPONSE

Fulfilling the needs of health logistics is crucial to support diagnosis and medical treatment as well as the other components in COVID-19 response.

Health Crisis Center, Ministry of Health is assigned by the Central Government to coordinate logistic management in COVID-19 response.



## 1. PLANNING

1. Identify and compile the need for PPE & other logistic in 34 Provinces which is updated in every month according to the development of the cases (number of cases, regional risk zones, availability of logistics in the regions).
2. Calculate the number of PPE & other logistic needed, using Essential Supplies Forecasting Tools (ESFT) Version 2 from WHO. This calculation is conducted by Central Government as well as Provincial Health Offices.
3. The Ministry of Health has trained the local province health officers to be able to operating the tools.

(cont'd)

The logistic covers the needs for:

1. Health workers, ambulance officers, laboratory workers, patients and their families for health services related to the COVID-19 (Inpatient and Triage)
2. Conducting contact tracing, surveillance and epidemiology investigation
3. Dead body management due to Covid-19
4. Provision of the Essential Health Service, consist of:
  - Maternal and children health care
  - Family Planning health care
  - Immunization services
  - Blood Transfusion services
  - Ambulance services (non Covid-19 cases)
  - Health Quarantine services

## INDONESIA PPE LOGISTIC NEEDS

Results of the PPE Needs in Indonesia for the period  
October 2020 - March 2021, based on needs assessment  
results using ESFT

TYPE OF PPE	UNIT	TOTAL NEEDS
Gown, protective	Pcs	22,311,035
Scrubs, tops	Pcs	254,598
Scrubs, pants	Pcs	254,598
Apron, disposable	Pcs	9,397,149
Apron, heavy duty, reusable	Pcs	79,148
Gum boots	Pair	79,148
Gloves, heavy duty	Pair	76,104
Gloves, examination	Pair	253,009,346
Gloves, surgical	Pair	9,397,149
Goggles, protective	Pcs	261,646
Face shield	Pcs	15,827,855
Respirator	Pcs	9,397,149
Mask, medical / surgical for healthworker	Pcs	76,229,927
Mask, medical / surgical for patient	Pcs	236,190,282

## 2. PROVISION

Provision of PPE & other logistic needs is conducted by:

### 1. Procurement

Health Crisis Center carries out PPE procurement, among others Coverall, N-95 Respirator, Non Medical Mask and Medical Mask





(cont'd)

## 2. Acceptance of Grants

Health Crisis Center received PPE  
& other logistic grants from:

1. Development partners
2. Ministry and other government institutions (domestic)
3. Private Sector/Companies (CSR)
4. State-owned companies
5. Universities
6. NGOs
7. Community Organizations
8. Other country (Japan, USA, Singapore, Australia)

The PPE & other logistics form grants among others: Coverall, Face shield, Head Cover, N-95 Respirator, Medical/Surgical Mask, Non Medical Mask, Goggle, Handscoon (sterile and non sterile).

The Centre of Health Crisis should ensure that all types of PPE from procurement and grants meet the standards set by the Government.



## PHOTOS OF HANDOVER OF LOGISTIC GRANTS



Handover of Ventilator, grant by US Government through USAIDS to Ministry of Health of Indonesia

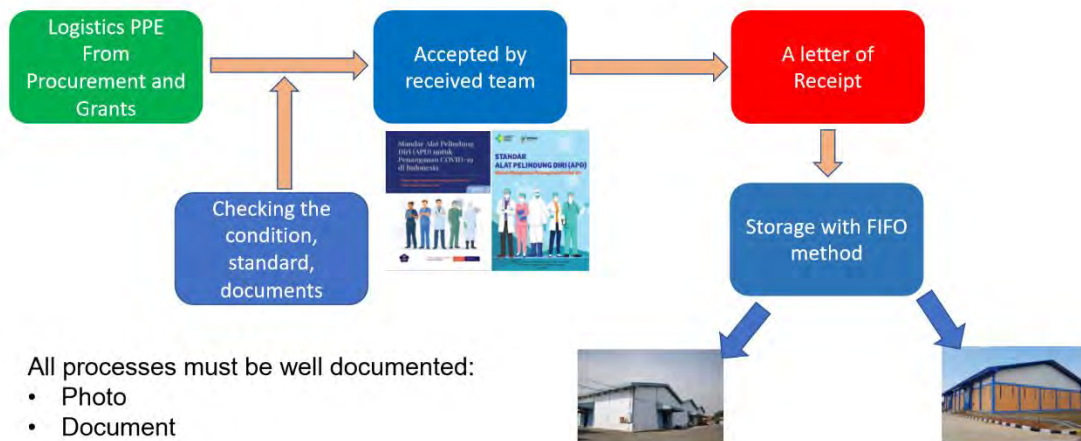
## GUIDELINES FOR PPE STANDARD

Ensure that all types of PPE, whether fulfilled through procurement or through receipt of donations meet the standards set by the government.



### 3. STORAGE

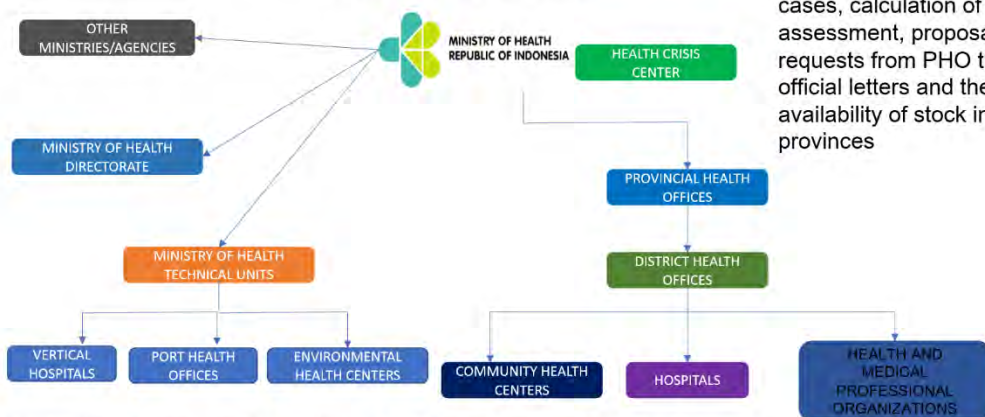
Flows of Logistics Receiving and Storage



- To store logistics, 3 warehouses at the center are used, besides that, we also use storage warehouses in 34 provinces and 514 districts/cities throughout Indonesia
- Logistics section/receiving team makes a letter of receipt of goods signed by the provider/expeditioner and the consignee, complete with date, time, quantity and type.
- Logistics received and documented by the logistics section.
- Entry date, source, quantity, type, volume and expired date noted and submitted to the data and information section
- Logistics are neatly arranged in a warehouse to make it easy to release goods with the FIFO (First In First Out) principle

## 4. LOGISTIC DISTRIBUTION

### Flow of Logistic Distribution



Based on: distribution plan, the number of COVID-19 cases, calculation of needs assessment, proposals/ requests from PHO through official letters and the availability of stock in the provinces

- Logistics distribution is carried out by air, sea and land mode of transportation
- The distribution process is carried out in collaboration with the National Army and the Provincial Health Office



(cont'd)

- Logistic distribution is based on the distribution plan, the number of COVID 19 cases, calculation of needs assessment, proposals/ requests from Provincial Health Office through official letters and availability (stock) in the provinces.
- Logistic distribution must have the approval from The Director of Health Crisis Center
- Logistics distribution is carried out by air, sea and land
- The distribution process is carried out in collaboration with the National Army and the Provincial Health Office, NDMA
- The distribution process is carried out using :
  1. National Army owned means of transportation (for example Hercules aircraft)
  2. Delivery by using expedition

(cont'd)

- Ensure that all processes of receiving and distributing logistics are well recorded, documented and completed through Handover Notes, photos of the logistic handover, record the number of incoming and outgoing goods
- Create an infographic map of information on the distribution of PPE& other logistic
- The distribution, the usage and stock update are monitored using the real-time Covid-19 Logistics System, operated by the Health Crisis Center
- Distribution data and logistic availability reported regularly by the Health Crisis Center to the National Disaster Management Agency

## PHOTOS OF LOGISTIC DISTRIBUTION



PPE logistics distribution in collaboration with Indonesian National Army, using Helicopter owned by National Army

## PHOTOS OF LOGISTIC DISTRIBUTION

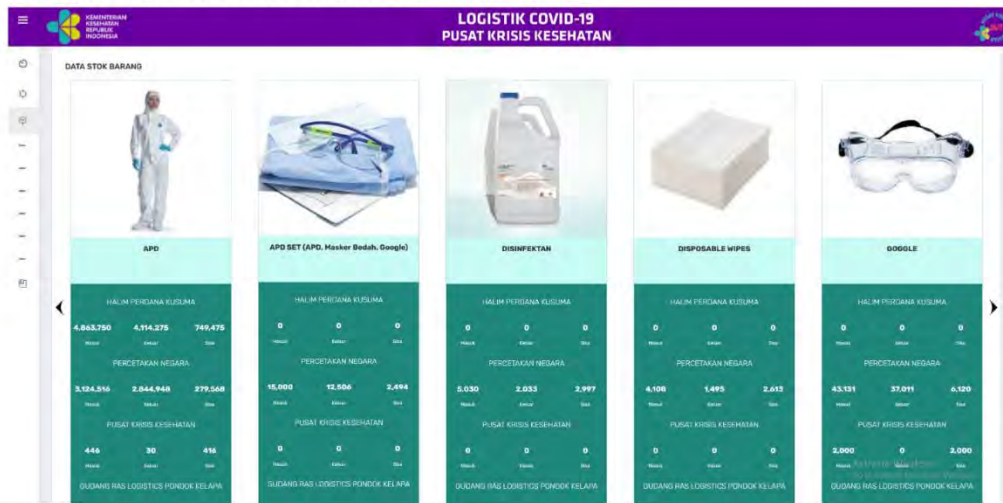


PPE logistics distribution in collaboration with Health Provincial Office

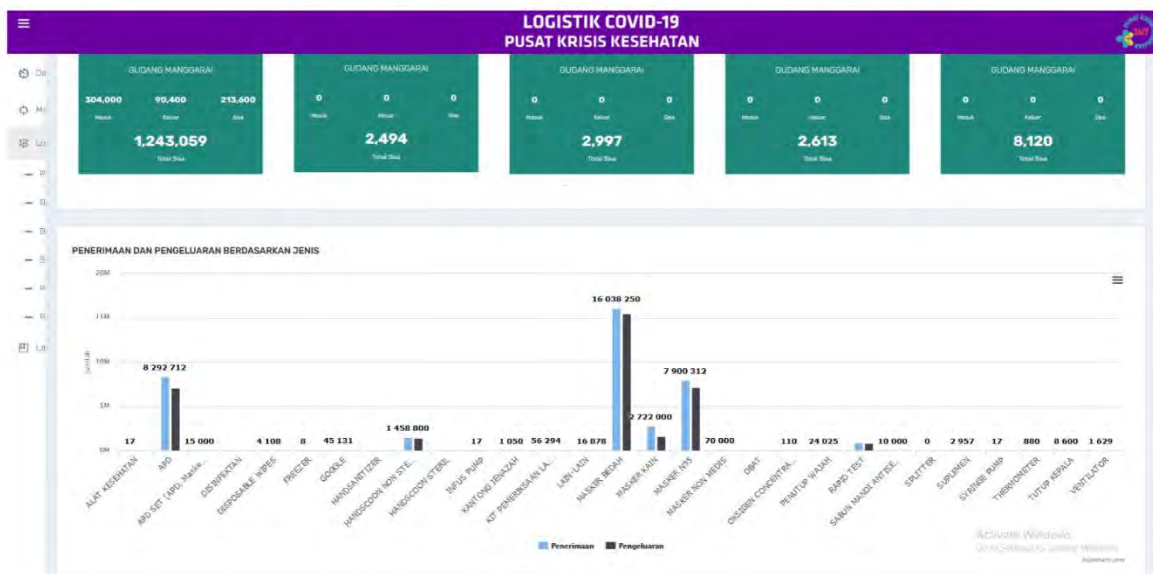


## COVID-19 LOGISTIC INFORMATION SYSTEM

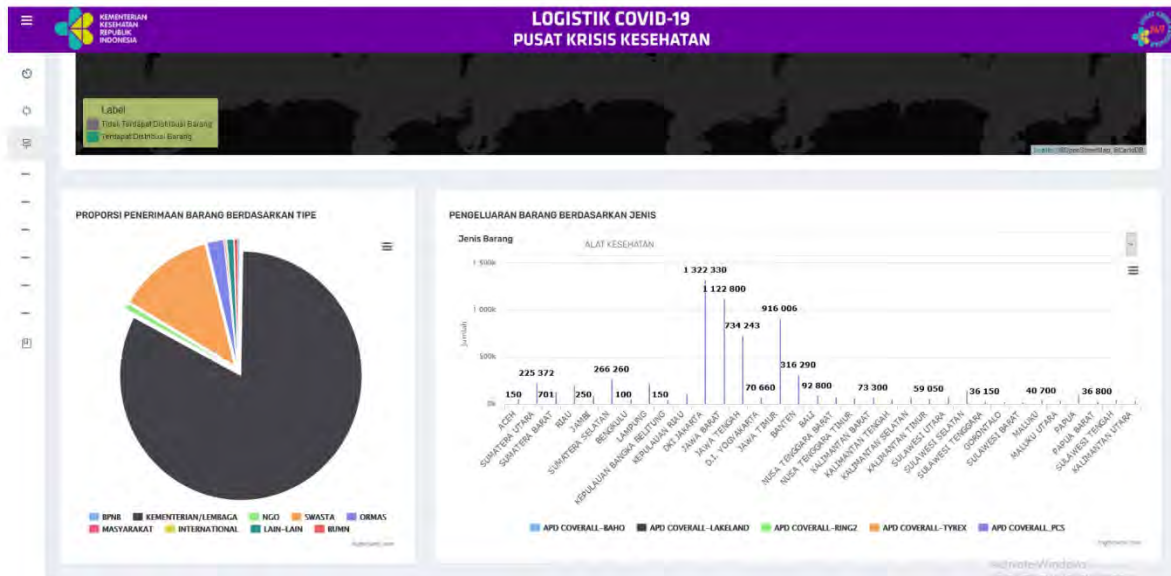
The Covid 19 logistics information system functions to monitor and supervise incoming and distributed logistics. This information system can monitor logistic distribution from Jakarta to all provinces and districts/cities in Indonesia



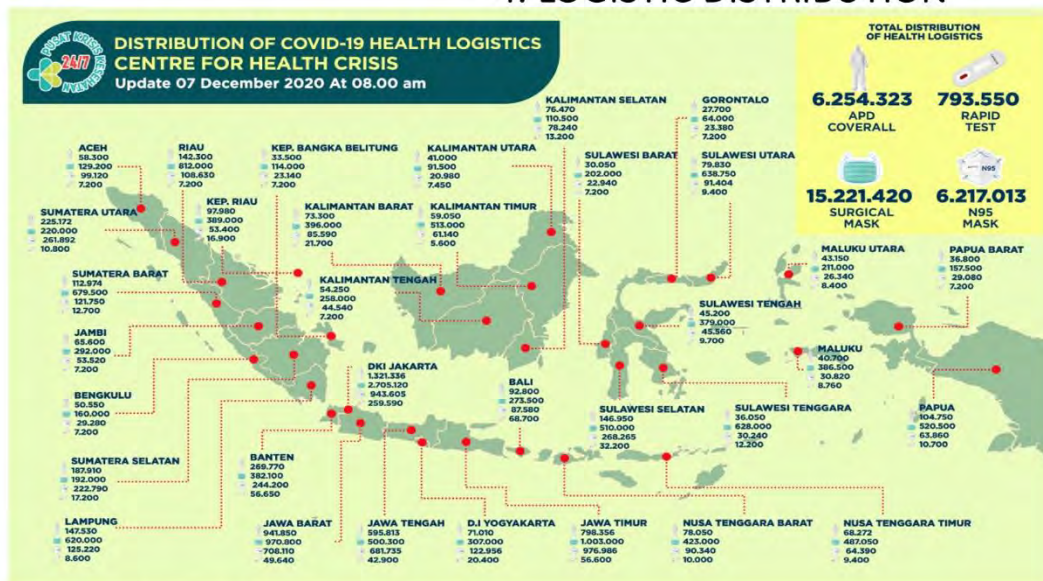
## COVID 19 LOGISTIC INFORMATION SYSTEM



# COVID 19 LOGISTIC INFORMATION SYSTEM



## 4. LOGISTIC DISTRIBUTION



Source : Center For Health Crisis, Ministry of Health



T H A N K   Y O U

**CENTER FOR HEALTH CRISIS MINISTRY OF HEALTH  
REPUBLIC OF INDONESIA**

Jl. HR Rasuna Said Blok X 5 Kav. 4-9 Sujudi Building  
6 th Floor, Jakarta 12950

Contact us at

Call Center : 0812 1212 3119

Email : [ppkdepkes@yahoo.com](mailto:ppkdepkes@yahoo.com)

Website : [pusatkrisis.kemkes.go.id](http://pusatkrisis.kemkes.go.id)

Facebook : [pusatkrisiskesehatankemenkes](https://www.facebook.com/pusatkrisiskesehatankemenkes)

Twitter : [@infoppkk](https://twitter.com/infoppkk)

Instagram : [@ppk\\_kemkes](https://www.instagram.com/ppk_kemkes)

【Attachment】

Good Practice Documentation Form

This form aims to collect “Good practice” on medical response against COVID-19 outbreak in order to share knowledge and experience among AMSs through ARCH Project.

Kindly complete the below reporting template and submit to ARCH Project Team no later than 31 July 2020.

To: ARCH/ JICA Project Office

E-mail: archpro1@outlook.com

National focal point for Questionnaire on COVID-19 response	
Country	Indonesia
Name	Belladona, MD, MPH; Gde Yulian Yogadhita, Madelina Ariani, MPH
Position	Researcher at Center for Health Policy and Management, Faculty of Medicine Public Health and Nursing, Gadjah Mada University
Email	

Good practice report (No.1)			
Title	Impact of Large-Scale Social Restrictions in Communities on COVID-19 Patients Visits in Hospital		
Category	① Infection control (Zoning, Isolation, Disinfection) Specify if you select “others” in the above.		
Section level	<input type="checkbox"/> National <input checked="" type="checkbox"/> Provincial/ District <input type="checkbox"/> Facility <input type="checkbox"/> Field/ Prehospital		
Period	From	3/25/2020	To 7/5/2020
Reported by	Name	Belladona, MD, MPH; Gde Yulian Yogadhita, Madelina Ariani, MPH	
	Position	Researcher at Center for Health Policy and Management, Faculty of Medicine Public Health and Nursing, Gadjah Mada University	
	Email		
Key word	1) Large-Scale Social Restrictions	2) patient visits	3) Covid-19

Abstract (maximum 1,000 characters)
<p>Covid-19 pandemic has been going on for more than six months, and new cases emerge in various regions. In Indonesia, the number of positive case patients continues to increase, and there is no sign of epidemic curve to be flattened. There have been many public health intervention policies applied by the central government and local governments to prevent the transmission. In areas that are categorized as red zones, Large-Scale Social Restrictions considered to be a major intervention strategy to reduce the transmission of COVID-19. The government's policy in implementing the Large-Scale Social Restrictions give hope for health facilities on reduction of the number Covid-19 increasing cases in hospitals.</p>



**Objective:** to document the impact of large-scale social restrictions related policies on COVID-19 cases admission in the Special Province of Yogyakarta and Special Capital Province Jakarta areas.

**Methods:** This study uses a quantitative research approach with descriptive research analysis. The sampling technique is non-probability sampling using the snowball method.

**Result:**

From January to August 2020, there were 241 regulations at the national and regional levels, of which 100 policies on Large-Scale Social Restrictions. During the implementation of this policy, on 25 March – 5 July 2020, the number of COVID-19 cases in health facilities fluctuated. Government and local government policies are not sufficient communicated by the lowest levels of government, such as the head of neighbourhood level or sub-village level and health cadres to the community, so that the community has not fully understood and involved in implementing these policies.

**Conclusion:**

During March to July the government and local governments of Special Province of Yogyakarta and Special Capital Province Jakarta have attempted to implement various social restriction intervention policies, while on the other hand COVID-19 cases and patients under surveillance visit to health facilities have not shown a significant decrease. However, it appears that there has been no extreme surge in number of patients who have exceeded local health capacities. This means that this social restriction policy is able to reduce the level of patient visits to health facilities, and this public health intervention policy able to provide enough time for local governments to prepare surge capacity by improving the capacity of health local services.

\* If you are willing to share two or more cases of “Good practice”, please copy the template above.



UNIVERSITAS GADJAH MADA

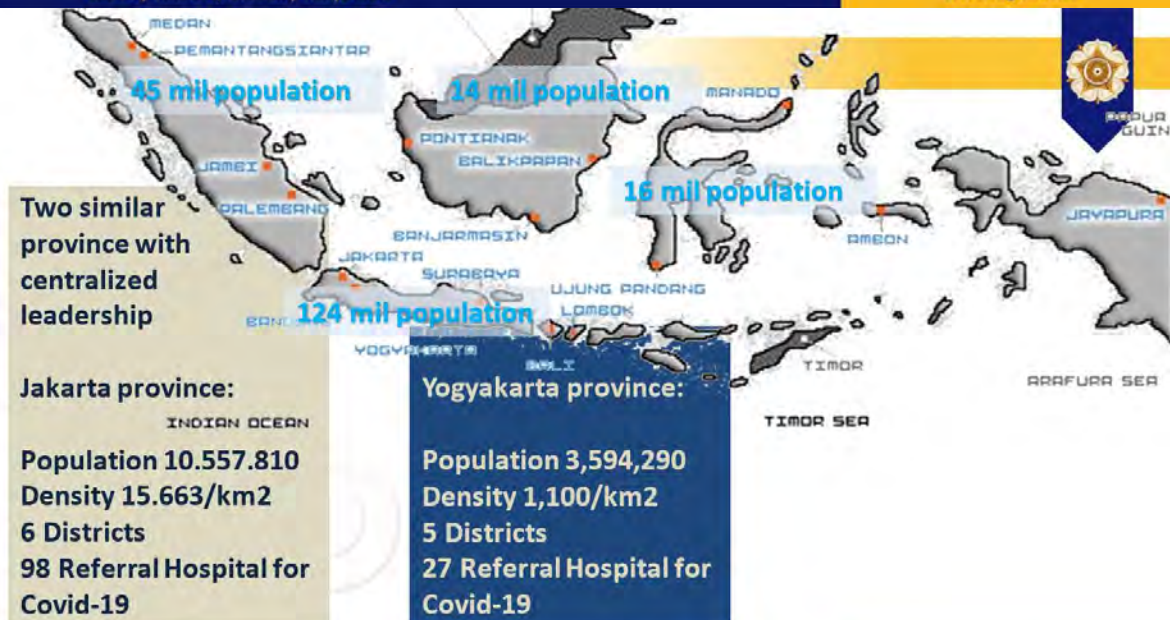


# Impact of Large-Scale Social Restrictions in Communities on COVID-19 Patients Visits in Hospital

Center for Health Management and Policy University Of Gadjah Mada, Yogyakarta - INDONESIA

Locally Rooted, Globally Respected

[www.ugm.ac.id](http://www.ugm.ac.id)



Locally Rooted, Globally Respected

[www.ugm.ac.id](http://www.ugm.ac.id)



## Background

Problem and the background of this research are

- How central and local government policies (DKI Jakarta and DI Yogyakarta) related to social restrictions affect covid-19 visits to hospitals.
- There has been no research specifically documenting how policies related to social restrictions are related to a decrease in Covid-19 cases.
- How the community responds to social restriction policies and suppresses the rate of increase in Covid-19 cases can be used to prepare surge capacity in the health sector.

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## OBJECTIVE

The general purpose of this study is to document the impact of policies related to large-scale social restrictions (PSBB) in community on the reduction of hospitalized Covid-19 cases.

## OBJECTIVE

## OUTCOME

Get an overview of policies related to social restrictions in the community.

Get an overview of daily trends in hospitalized Covid-19

Impact of social restriction policies to the hospitalized Covid-19 case

Get an overview of the public's understanding of the social restriction policy

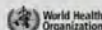
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# Literature Review

## Considerations in adjusting public health and social measures in the context of COVID-19

Interim guidance  
16 April 2020



### Background

Across the globe, countries have implemented a number of control measures to comprehensively prepare for and respond to COVID-19. The overarching goal of the WHO global COVID-19 response strategy is for all countries to control the pandemic by slowing down transmission and reducing severity associated with COVID-19, with the ultimate aim of reducing and suppressing a wave of low-level or no transmission. Based on local epidemiology, control measures are in the process of scaling up public health and social measures, while others are at capacity considering scaling down these measures.

Although the goal in all countries is to suppress transmission and provide care for all patients, the intensity of implementation of control measures to achieve this — including identification, testing, isolation and care for all cases, closing and operation of all contexts, public health and social measures at individual and community levels, etc. — varies based on the transmission scenario each country is facing (the cases, first case, cluster of cases, or community transmission).

### Public health and social measures

Public health measures include personal protective measures (hand hygiene, respiratory hygiene), environmental measures, etc. (e.g. infection control, community, population, etc.).

WHO recommends scaling up public health and social measures, while others are at capacity considering scaling down these measures.

Adjusting these measures, in an effort to trigger a re-evaluation of COVID-19 cases and preparedness for health of the population. Until specific and effective pharmaceutical interventions (e.g. therapies and vaccines) are available, countries may need to continue to balance or reassess measures throughout the pandemic.

Decisions to tighten or loosen or re-open PSBM should be based on scientific evidence and real-world experience and take into account other critical factors, such as economic factors, security-related factors, human rights, food security, and public resistance and adherence to measures.

Individual measures, including medical needs for symptomatic people, isolation and treatment of ill individuals, and hygiene measures (hand hygiene, respiratory hygiene) should be continued.

This document is intended for national authorities and decision makers in countries that have introduced large scale PSBM and are considering adjusting them. It offers guidance for adjusting public health and social measures, while managing the risk of resurgence of cases.

### Scenarios

WHO has previously defined four transmission scenarios to describe the dynamics of the epidemic: no reported cases (whether such cases are in the hospital or not), sporadic cases,



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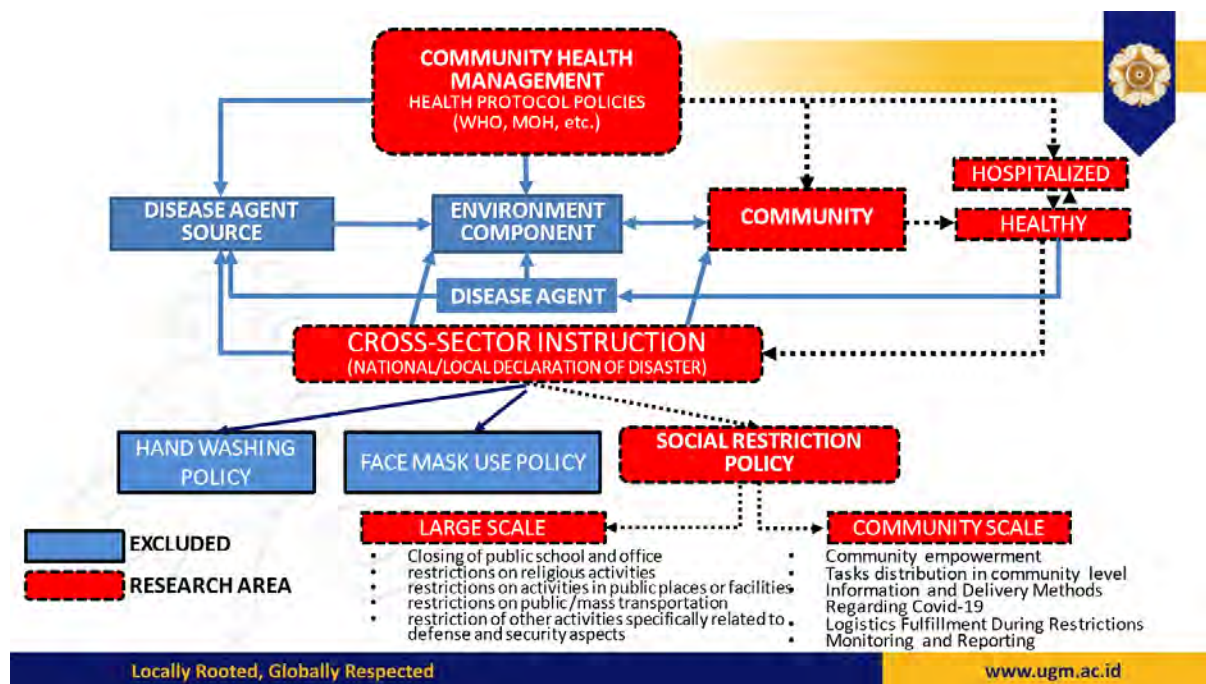
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## RESEARCH QUESTION



1. What are the existing social restriction policy models at the central and regional levels?
2. How is the perception or understanding of the social restriction policies issued by the government communicated by RT and RW officials to the community?
3. What is the picture of the trend of daily cases of Covid-19 hospital visits during a pandemic situation?
4. How is the social restriction policy related to the visit rate of Covid-19 patients in hospitals?



# 1 Social Restriction Policies

*In national level and Jakarta & Yogyakarta provincial level*

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## Legal product on Covid-19 (from February to August 2020)



Level of policy	Content		Total
	Social restrictions	On others	
National	68	94	162
Jakarta Province	21	27	48
Yogyakarta Province	11	20	31
Total	100	141	241

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Level of Regulation	Total
Governor Regulation	10
Governor Decree	17
Governor Instruction	5
Circular	6
Governor Exclamation	10
<b>Total</b>	<b>48</b>

Sumber: disarikan oleh tim peneliti



- **There were 48 policies for prevention and management of Covid-19 in Jakarta Province, of which 21 policies indirectly regulate restrictions on community activities** before & after the PSBB policy is set in the Jakarta area.
- **The Ministry of Health regulated the PSBB for the DKI Jakarta area on April 7, 2020** through the Minister of Health Decree No. 239/2020 concerning the Stipulation of PSBB in the DKI Jakarta Province.
- **There are sanctions in the implementation of the PSBB policy** in DKI Jakarta (Through Governor Regulation No 41/2020)



## Table Description of PSBB Policy in DKI Jakarta



	Jakarta Province	
	Total	Content
Before PSBB Policy Implemented	1	Governor Instruction Optimizing Anticipation and Prevention of Covid-19 Transmission by Maintaining a Safe Distance between Residents in society (social distancing measure)
	3	Circular Postponement of Duty and Official Travel Abroad, Temporary Closure of Public Library Building Services & Temporary Closure of Tourism Industry Operational Activities
	6	Governor Exclamation Increased Awareness of the Risk of the Spread of Covid-19 in Organizing Events, Maintaining Safe Distance between Residents in society (Social Distancing Measure), Temporary Abolition of Worship and Religious Activities in Houses of Worship, Temporary Cessation of Office Activities

Sumber: diolah oleh peneliti, 2020

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## Table Description of PSBB Policy in DKI Jakarta



	DKI Jakarta	
	total	Content
Before PSBB Policy Implemented	5	Governor Regulation Imposition of Sanctions for PSBB Violations, Limitation of Travel Activities Out of and / or Entering the DKI Jakarta Province, Implementation of PSBB during the Transition Period Towards a Healthy, Safe and Productive Society, Control of Travel Activities in DKI Jakarta Province
	4	Governor Decree Enforcement of PSBB Implementation, PSBB Extension, Enforcement, Stages and Implementation of PSBB Activities / Activities during the Transition Period
	1	Circular Imposing disciplinary laws for civil servants who carry out activities outside the region and / or homecoming activities
	1	Governor Exclamation Implementation of the Covid-19 Health Protocol in Religious Activities

Sumber: diolah oleh peneliti, 2020

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## Level of Yogyakarta Province Regulation on COVID-19 Management



Level of Regulation	Total	Content
Governor Regulation	8	Abolition of Administrative Sanctions on Motor Vehicle Taxes and Transfer of Motor Vehicle Title Fees; Task Force Work Mechanism; Guidelines for Preparing Guidelines for Implementation of Public Service Activities and the Community's Economy in DIY in the Prevention and Control of Covid-19
Governor Decree	11	Determination of Referral Hospitals, Establishment of Task Force Teams, Determination of disaster emergency response status, Regionalization of inspection laboratories, transportation, Determination of Potential Recipients of Incentives and Death Compensation from the Central Government, Determination of Extension of Disaster Emergency Response Status, Recipients of Social Assistance for Former Assisted Community Organizations and Students Outside Covid-19 Affected Areas, Recipients of Social Assistance for the Community, for Former Prisoners and Students from Outside Areas Affected by Covid-19
Circular	5	Education Policy, Increased awareness,
Mayor Regulation/ Circular	7	Increased Vigilance, Anticipation of Spread, Adjustment of work systems, awareness of risk of transmission, restrictions on market / store operating hours, Guidelines for Admission of Students from Outside the Region
<b>Total</b>	<b>31</b>	

Sumber: disarikan oleh tim peneliti

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## Table Description of PSBB Policy in Yogyakarta



Level of Policy	Yogyakarta Province	
	Total	Content
Governor Regulation	1	Guidelines for Preparing Guidelines for Implementation of Public Service Activities and the Community's Economy in DIY in the Prevention and Control of Covid-19
Governor Decree	1	Formation of an Integrated Transportation Control Command Post Team in the Context of Preventing the Spread of Covid-19 on Roads and Bus Station
Circular	9	Limitation of Operational Hours of Shopping Centers and Shops as well as People's Markets, Additional Distance Learning Time (Online), Guidelines for Admission of Students from Outside the Region

Sumber: diolah oleh peneliti, 2020

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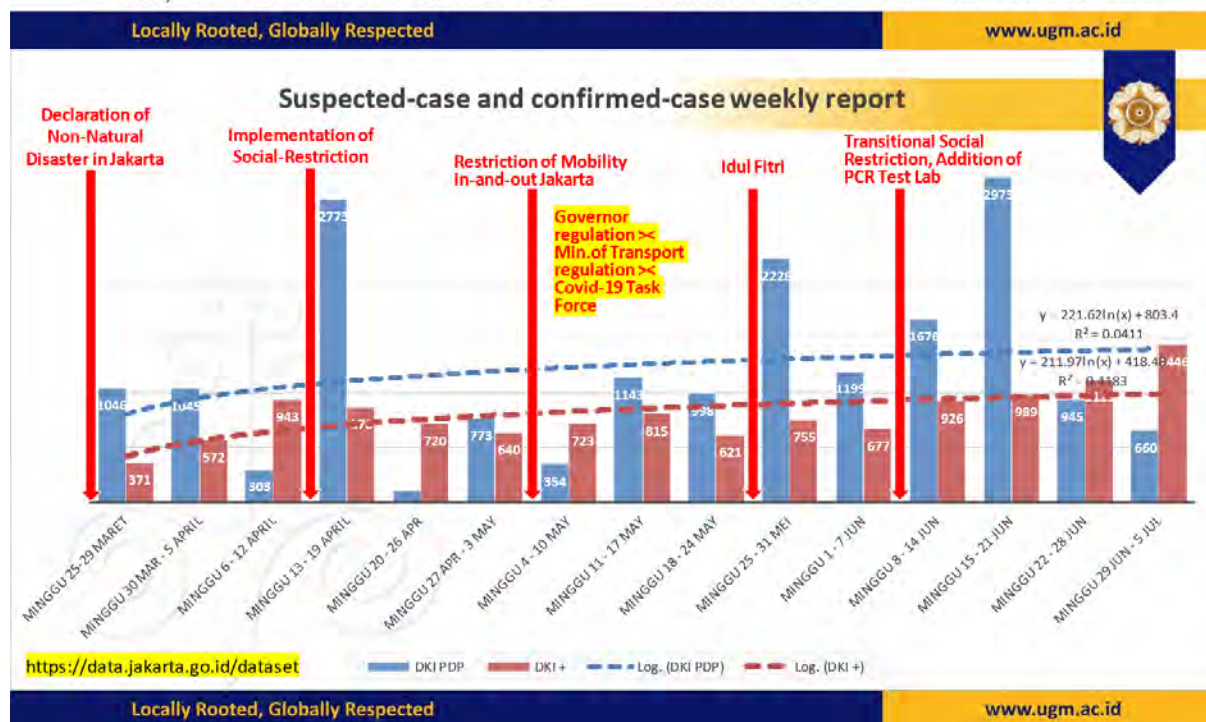
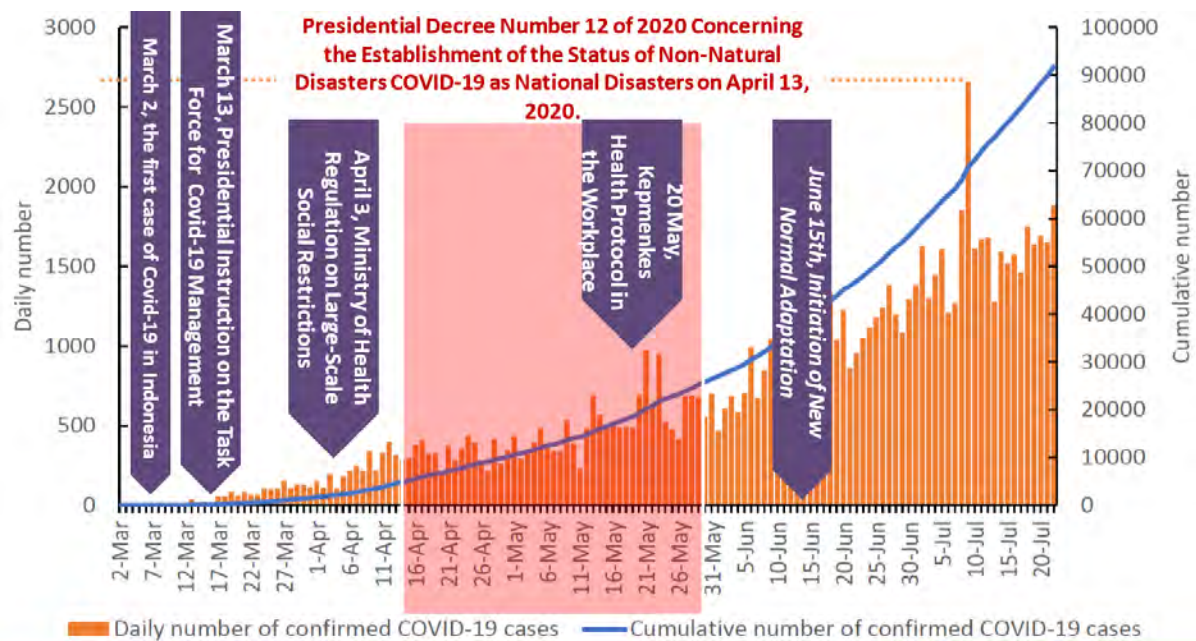
- There are 11 policies in Yogyakarta Province that indirectly limit community activities.
- Since the first Covid-19 patient was found in Yogyakarta, the number of cases has reached 1,059 people. The Yogyakarta provincial government has not yet proposed a PSBB policy in its region.
- However, based on the identification of legal products / policies for handling Covid-19, since March 15 the Yogyakarta provincial government has issued precautionary instructions, work system adjustments, Implementation of Education Policies in an Emergency for the Spread of Covid-19, and the Formation of an Integrated Transportation Control Post Team in the Context of Preventing the Spread of Covid -19 in the Road and Bus Station.



## 2 Documentation of Suspected-case and confirmed-case hospitalized

*In National level and Jakarta & Yogyakarta provincial level*





<https://data.jakarta.go.id/dataset>

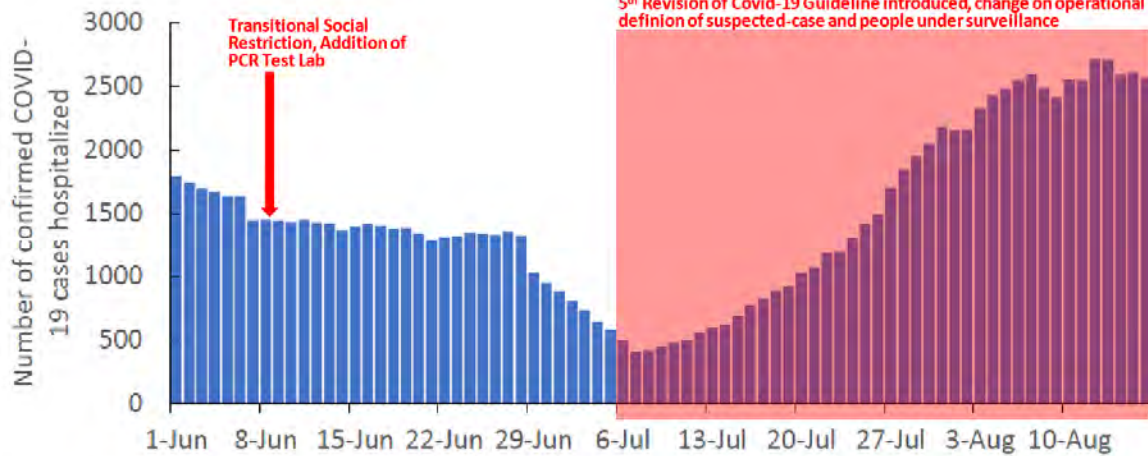
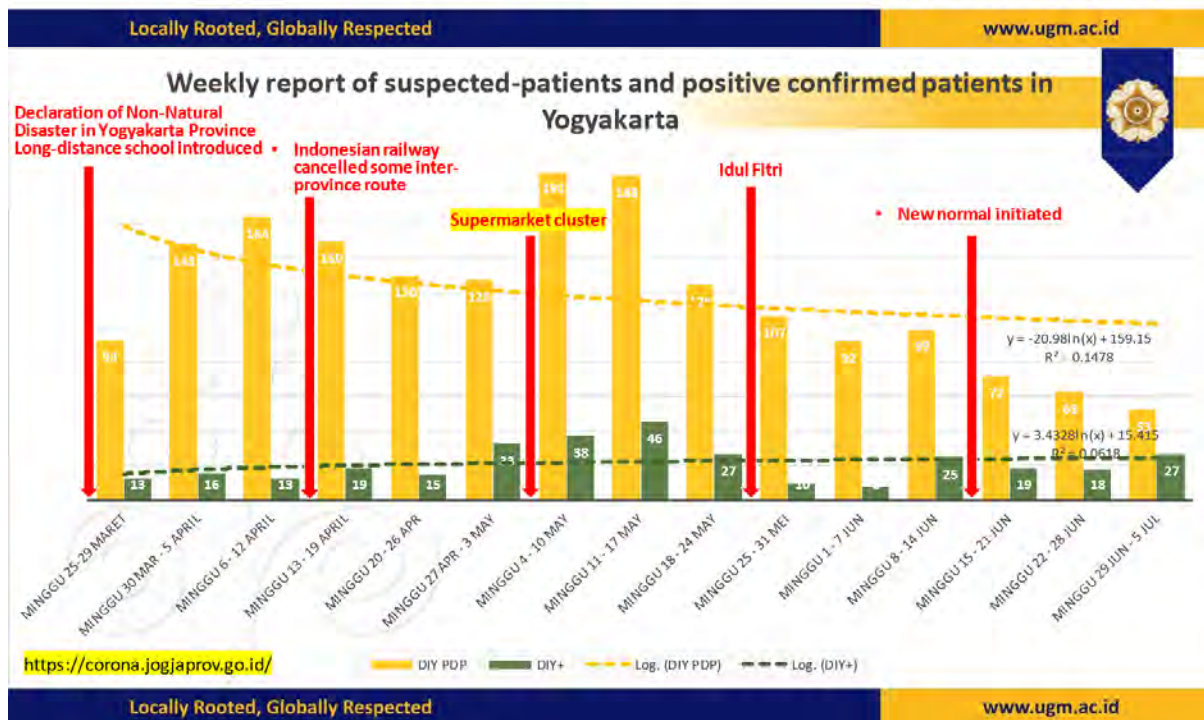



Figure 14: Number of confirmed COVID-19 cases hospitalized in DKI Jakarta from 01 June to 16 August 2020. [Source of data](https://data.jakarta.go.id/dataset)


<https://data.jakarta.go.id/dataset>





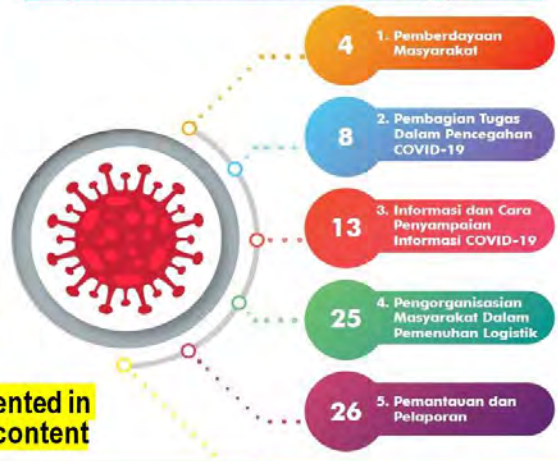


## PEDOMAN PEMBERDAYAAN MASYARAKAT DALAM PENCEGAHAN COVID-19 DI RT/RW/DESA



**Disclaimer: not all of the findings presented in this session due to relevancy with the content**

**Although this is a policy-based research, researcher team tried to extrapolate the result with questionnaire to 120 respondents in Jakarta and Yogyakarta.**



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Overall the respondents' knowledge and understanding was higher in DIY compared to DKI and Greater Jakarta Bodetabek (Jakarta satellite cities: Bogor-Depok-Tangerang-Bekasi). **Community leaders, village / RT/RW (community level) are active in providing information about COVID-19** to residents of Yogyakarta, DKI and Bodetabek.

About 73% of respondents stated that there was information provided from community leaders, sub-district / RT / RW to residents about Covid-19 in DIY, DKI and Jabodetabek. **The highest source of information is obtained from social media and printed media.**



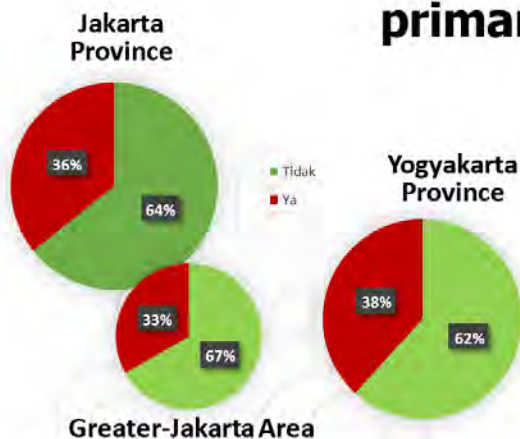
About 65% of respondents stated that the policy of social restrictions regulated by the government did not interfere with the family's livelihood. In fulfilling the family's primary daily needs, **people spend more on traditional markets and supermarkets.**

Fulfilling the needs of family health services, respondents prefer to go to the doctor's clinic / primary health center / hospital and buy medicine at a pharmacy. **Respondents said that they were going out of the house mostly to work and to do exercise.**

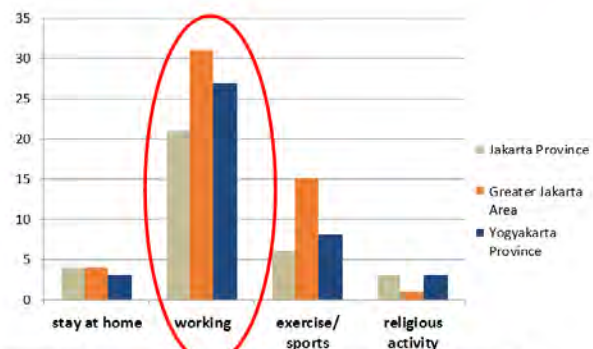
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## fulfilling the family's primary daily needs



Is the social restriction recommended by the government that your routine income fulfillment is disrupted?



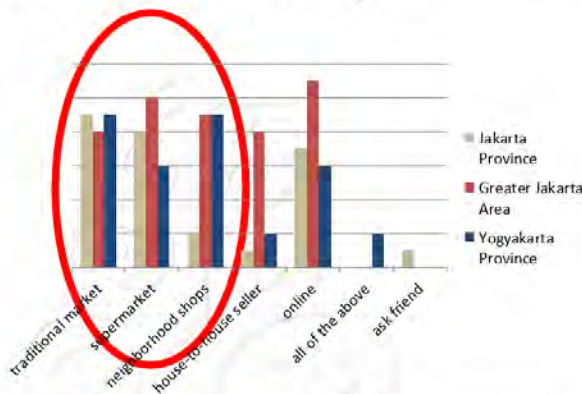
Apart from meeting your primary needs and getting health care, what are the things that make you travel outside the house?

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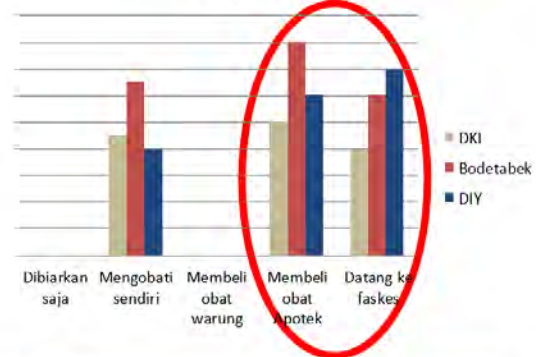


# Logistic management in community



How do you meet your family's primary daily needs?

Chart Title



How do you meet your family's health service needs if someone has a health problem?

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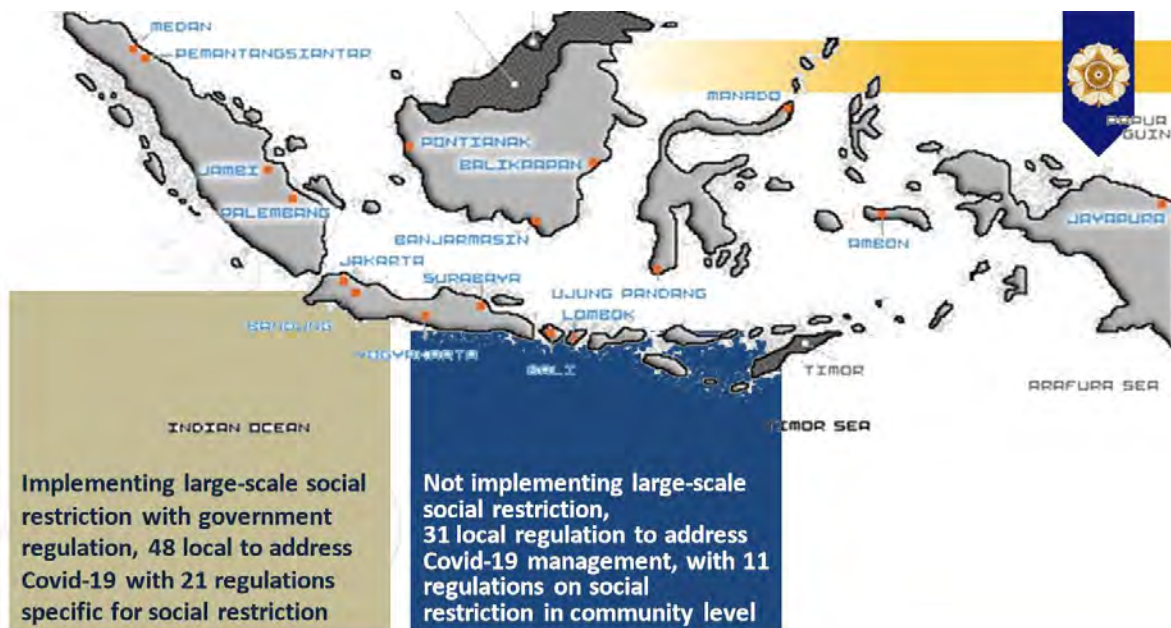
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## Conclusions:

From the results of secondary data collection, it was found that regulations related to Covid-19 from Jakarta and Yogyakarta local governments, as well as the central government, **were sufficient, in particulate to regulate social restrictions**, both large-scale social restrictions and community scale.

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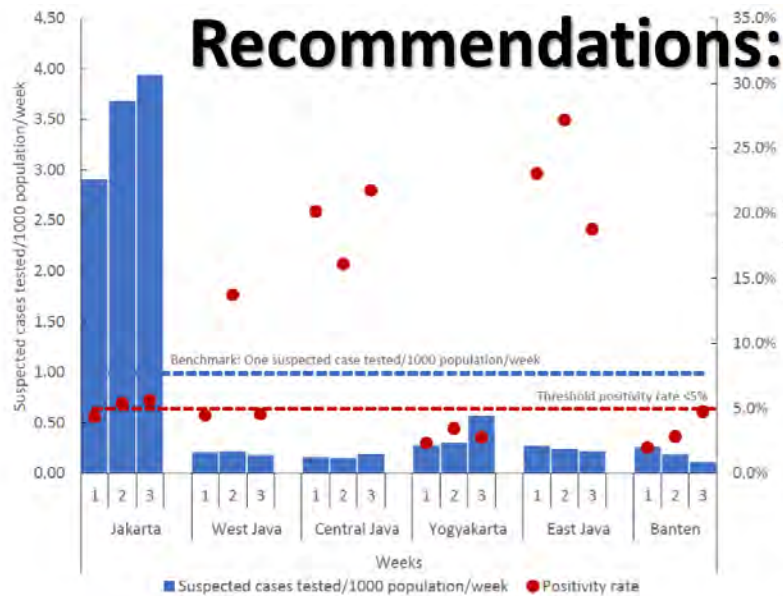


During March to July, it can be seen that with social restriction policies, suspected-patient (PDP) visits and positive confirmation can be suppressed so that **there is no extreme growth in the community spread, thus, this condition provide local governments time to prepare, to improve and increase the surge capacity of health service**

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It should also be noted regarding the coherence of other regulations, such as **TLI (test, trace and isolation) as a top-down approach**, and to improve community compliance with **3M (keeping distance, using masks, and washing hands) with intense education as a bottom-up approach** using massive social media campaign

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# TERIMAKASIH



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## 【Attachment】

## Good Practice Documentation Form

This form aims to collect "Good practice" on medical response against COVID-19 outbreak in order to share knowledge and experience among AMSs through ARCH Project.

Kindly complete the below reporting template and submit to ARCH Project Team no later than 31 July 2020.

To: ARCH/ JICA Project Office

E-mail: archpro1@outlook.com

National focal point for Questionnaire on COVID-19 response	
Country	Indonesia.
Name	dr. Corona Rintawan
Position	International EMT Muhammadiyah Coordinator
Email	

Good practice report (No.1)			
Title	Dead Bodies Management of Covid-19: " Stigma vs Proper Procedure"		
Category	Others		
	Dead Bodies Management of Covid-19		
Section level	<input type="checkbox"/> National <input type="checkbox"/> Provincial/ District		
	<input type="checkbox"/> Facility <input type="checkbox"/> Field/ Prehospital		
Period	From	March	To October
Reported by	Name	Corona Rintawan	
	Position	Lamongan Muhammadiyah Hospital Covid-19 Task Force	
	Email	-	
Key word	1) Stigma	2) Dead Bodies	3) Covid-19
Abstract (maximum 1,000 characters)			

The Covid-19 outbreak over the past 6 months has taken a toll. High levels of transmission cause many procedures to be changed and improved. This level of transmission can also be caused by incorrect treatment of dead patients. The negative stigma of the funeral process of the corpse and the process of bathing the body becomes one of the obstacles especially when communicated to the community and the patient's family. Cases of violent rejection emerged in a number of areas. Good experience at Muhammadiyah Lamongan Hospital in terms of handling corpses is proven to reduce rejection from the community and families of patients.

Understanding the reasons for rejection is important in changing covid-19 body handling procedures. Most people refuse funerals with the procedure of covid-19 on the grounds that the body is not bathed, even if it is bathed but the family cannot come to see it, the family cannot be buried in the burial site, and the family cannot have the body buried. Understanding these reasons, Muhammadiyah Lamongan Hospital performs procedures such as:

1. all bodies are bathed after decontamination and then continued the next procedure,
2. families are allowed to follow bathing procedures with PPE level 3, after the decontamination and bathing process is complete,
3. families are allowed to transport the remains with health protocols, and
4. permitted to attend the funeral service at the burial site under certain conditions.

During the handling of covid-19 bodies in the past 4 months showed a decrease in rejection cases with regular medical supervision of the funeral team. And the results of the funeral team's health monitoring showed no cases of exposure to Covid-19 due to bathing and burial procedures carried out by the team. The funding spent is regular examination of the burial team, while the funeral costs of the corpse are free.



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**COVID-19**  
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# Good Practice on Dead Bodies Management Procedures of Covid-19

Corona Rintawan

Lamongan Muhammadiyah Hospital, East Java, Indonesia

## Backgrounds

- The Covid-19 outbreak over the past 6 months has taken a toll.
- High levels of transmission cause many procedures to be changed and improved.
- This level of transmission can also be caused by incorrect treatment of dead patients.
- The negative stigma of the funeral process of the corpse and the process of bathing the body becomes one of the obstacles especially when communicated to the community and the patient's family.
- Cases of violent rejection emerged in a number of areas.



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## What cause of negative stigma?

- The family doesn't believe this pandemic
- the body is not bathed properly,
- if it is bathed, the family cannot see the process of the dead body being bathed, cleaned and wrapped
- family cannot be present at the burial site
- Family can't do "shalat jenazah"
- The community afraid to see burial officer wearing cover all uniform



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## Adapt and modify procedure

- Add procedures of bathing after dead bodies being decontaminated
- Dead bodies were wrapped 5-6 times with plastic before being wrap with white cloth and put in the coffin
- One of family are allowed to see bathing process of dead bodies with specific term: <60 y.o, no comorbid, wearing cover all, etc
- family can do "shalat jenazah" with physical distancing min 2 mtr
- Family can attend the funeral process at burial site with specific term: <60 y.o, no comorbid, keep physical distances
- Graveyards officers wearing only hand gloves and surgical mask



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## Safety and Health monitoring

- All burial/graveyards officers were examined regularly (CBC, Chest x-ray, serology test)
- There no cases of spreading comes from dead bodies procedures so far

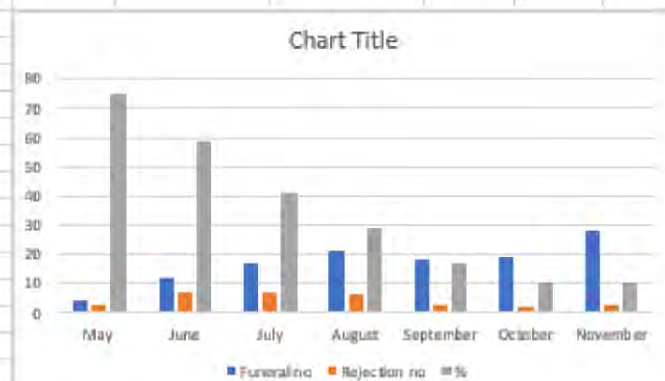



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## Result

Month	Funeral no	Rejection no	%
May	4	3	75,00
June	12	7	58,33
July	17	7	41,18
August	21	6	28,57
Septemb	18	3	16,67
October	19	2	10,53
Novemb	28	3	10,71





Thank you



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**COVID-19**  
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## **Good Practice in Philippines**

### *8) Deployment Protocols for Healthcare Workers assigned in the COVID-19 Response Team*

- *Good Practice Form*
- *Presentation*



【Attachment】

Good Practice Documentation Form

This form aims to collect “Good practice” on medical response against COVID-19 outbreak in order to share knowledge and experience among AMSs through ARCH Project.

Kindly complete the below reporting template and submit to ARCH Project Team no later than 14 August 2020.

To: ARCH/ JICA Project Office

E-mail: archpro1@outlook.com

National focal point for Questionnaire on COVID-19 response	
Country	<b>Philippines</b>
Name	ALFONSO C. DANAC, MD
Position	Chief of Medical and Professional Staff
Email	

Good practice report (No.1)			
Title	DEPLOYMENT PROTOCOLS for Healthcare Workers assigned in the COVID Response Team		
Category	⑤ Deployment of EMT or Specialist team		
	Policy		
Section level	<input type="checkbox"/> National <input type="checkbox"/> Provincial/ District		
	<input checked="" type="checkbox"/> Facility <input type="checkbox"/> Field/ Prehospital		
Period	From	March	To Present
Reported by	Name	ALFONSO C. DANAC, MD	
	Position	Chief of Medical and Professional Staff	
	Email		
Key word	Healthcare Worker Deployment		
Abstract			
<p>Jose B. Lingad Memorial General Hospital (JBLMGH) developed a system of deployment of our healthcare workers to minimize infection and community transmission among them. The COVID Response Team is composed of doctors, nurses, nursing attendants, medical technologist, respiratory therapists, radiologic technologists and ambulance drivers. The team gives medical care exclusive for COVID related patients only. These include COVID confirmed and suspect cases. The medical doctors are composed of residents from various specialties including internal Medicine, Pediatrics, General Surgery, Obstetrics and Gynecology, Orthopedic Surgery, Otorhinolaryngology-Head and Neck Surgery, Ophthalmology, Emergency Medicine (EM) and Family Medicine (FM). The EM and FM is assigned to the Triage Area. The bulk of medical management is handled by the Internist and the Pediatrician. The rest of the specialty residents serves as monitoring teams for the</p>			

asymptomatic and mild to moderate patients with co-morbidities. However, should the need arise for their specialty, they are required to attend to the patient. For example, patients requiring surgery will be operated by the Surgeon and pregnant patients are handled by the Obstetrician. Once the task is finished, the specialist becomes part of the monitoring physicians. As monitoring physicians, they monitor and assess the patients and refer the medical concerns to the Internist or Pediatrician as the need arises. Nurses are also mobilized as general nurses. Those who have special training in Critical Care are assigned in the Critical Care Unit for those with severe to critical status. Those with training in Dialysis are assigned as Dialysis Nurse when needed.

#### Pre-Deployment Phase:

All HCWs for deployment to the COVID Response Team are assessed by the Employees' Health and Wellness Clinic (EHWC) for physical examination and psychological assessment. Once deemed fit for deployment, they are endorsed to the COVID Response Team Operations Center. 1 day prior to deployment, all personnel undergo a deployment briefing that includes orientation on infection control protocols, donning and doffing of PPE, review of challenges encountered of past deployments, update on guidelines being implemented, patient management flow and other COVID-19 Response Guidelines of the hospital. All personnel are also asked to sign a Confidentiality Agreement in compliance with the Data Privacy Act.

#### Deployment Phase

All personnel are deployed for 7 days straight. During the tour of duty, they are assigned to a specific floor depending on their training. The internists and pediatricians are assigned at the ER and Critical Care Units, while the rest are assigned in the monitoring floors for the moderate cases. While they have decking of schedule during their duty, all personnel are on 24 hours on-call status. Definitive management of patients is directed by the Internist and Pediatrician. Should a need for specific specialty arises, the appropriate specialist within the COVID Response Team is mobilized. The team handles only COVID-19 related patients and are not allowed to handle the non-COVID cases until such time that they have been cleared and demobilized by the COVID Response Team. All HCWs are monitored by the EHWC for signs and symptoms and daily reminders on adherence to infection control protocols are given.

#### Post Deployment Phase

All personnel are demobilized after 7 straight days of duty. One day before deployment, they are asked to prepare their written endorsement notes and post it in their respective bulletin board and send soft copies to the Output Messenger. Each HCW is asked to accomplish a risk assessment form to determine the probability of contamination during their tour of duty. These include symptom check and answering questions regarding compliance to infection control protocols. Each HCW is also interviewed by the Mental Health and Psychosocial Support (MHPSS) Team to determine any post-

deployment related stress or mental health issues. All HCWs also undergo swabbing for RT-PCR test and undergo post duty rest in designated facility. Each HCW are isolated in their own rooms, provided food and access to the internet to allow them to communicate with family members and avail of entertainment platforms. A team of physical therapists also conducts physical exercises activity and Zumba classes every morning while on quarantine. This is part of Team Welfare activities. Once the results are released and the HCW is negative for SARS-COV2, they are allowed to go home and are given a mandatory three-days off from work plus the two (2) days weekend off before they report to their regular duties. The rest of the computed overtime work during their 24/7 deployment are credited as compensatory offset that can be availed by the HCW for the next 365 days. This can be used as substitute for their vacation and sick leaves.

The deployment program has been implemented for the past five (5) months and has proven to minimize the infection of our HCWs. Each batch of deployment is about 30-35 staff. To date, we have deployed about three hundred (300) HCWs in the COVID Response Team. Most of the HCWs have been deployed more than once. To date, of the one thousand five hundred nineteen (1519) employees of the hospital, a total of twenty eight (28) HCWs who became COVID confirmed. Of these, five (5) acquired the infection due to COVID duties, five (5) became symptomatic during their regular duty, two (2) were asymptomatic HCWs who underwent voluntary testing as medical frontliner, and sixteen (16) were asymptomatic HCWs who were contact trace of HCWs who became COVID confirmed. Noteworthy also that during contact tracing done for COVID confirmed HCWs, the identified HCWs who are contact trace were tested negative for SARS-COV2. This is a good indicator that strict adherence to infection control protocols and the separation of HCWs who are deployed as COVID Response Team from the non-COVID personnel is an effective measure in minimizing community transmission.



Occupational  
Safety and Health in



## Occupational Safety and Health for Healthcare Workers of the COVID-19 Response Team: *sharing the Jose B. Lingad Memorial General Hospital (JBLMGH) Experience*

ALFONSO C. DANAC, MD, FPCS, FPSGS, FPALES, FPCHA, MHM, MBA

Chief of Medical and Professional Staff

Jose B. Lingad Memorial General Hospital



### Objectives

- To give an overview of the Philippine Health Response Program for COVID-19
- To share the Occupational Safety and Health (OSH) practices for Healthcare workers deployed to COVID-19 Facilities of a government regional health facility





## Disclosure

- None



## Outline

1. Philippine COVID-19 Situational Update
2. The Philippine Health Response Activities for COVID-19
3. Overview of Healthcare Response in a Tertiary Government Health Facility
4. Occupational Safety and Health (OSH) for Healthcare Workers

## The Philippine Situation

Filter Epidemiology data by Region: (All)

As of September 14, 2020

### Nationwide Cases Data

Total Cases

**265,888**

+4,699 added on 09/14

Active Cases

**53,754**

Recovered

**207,504**

Died

**4,630**

[View Detailed Cases Information](#)

RT-PCR Positive by DOH-RITM certified lab.

### Daily Cases by Date of Onset of Illness

For 69.2% or 183,915 of cases where date of onset of illness is unreported date of specimen collection was used as proxy.

☒ Cases

☐ Recoveries

☐ Deaths

We urge caution when interpreting data during the highlighted period below, which may be incomplete because of delays in reporting.

## The Philippine Situation

Cumulative Samples Tested

**3,116,131**

+24,728 samples tested on 09/13  
2,014,291 remaining available tests

Individuals Tested

**2,931,967**

+23,634 individuals tested on 09/13

Positivity Rate

**10.6%**

Testing Labs

**114**

95 submitted on 9/13

Facilities  
**1,909**

Bed Occupancy

**45.7%**

21,500 Total

Occupied

**9,823**

Vacant

**11,677**

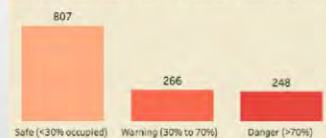
[More Information coming soon](#)

### Nationwide Facilities Data

by Facility: (All)

Occupancy Rate Level: All

Number of Facilities for each level, based on occupancy rate



Note: This graph excludes facilities with either no dedicated COVID beds as of yesterday or no ICU beds, such as infirmaries.

### Availability of Beds



### Availability of Equipment

Mechanical Ventilators: 2,198 Total

Note: These are beds and equipment dedicated exclusively for COVID-19 patients. Please interpret the graphs with caution as we improve data submission of all hospitals through the app. For PPE distributions, kindly refer to the Office of Civil Defense (OCD) data.

100.0% of facilities submitted to the DOH DataCollect App.

Testing Capacity: 30,000 per day

### Minimum Health Standards

1. Face masks
2. Physical distancing
3. Alcohol based hand rub
4. Face shield



## Four Pillars to control COVID 19

### Test

*(Who is infected?)*

### Quarantine

*(Prevent the contacts from infecting others)*



### Isolate

*(Prevent those infected from transmitting the disease)*

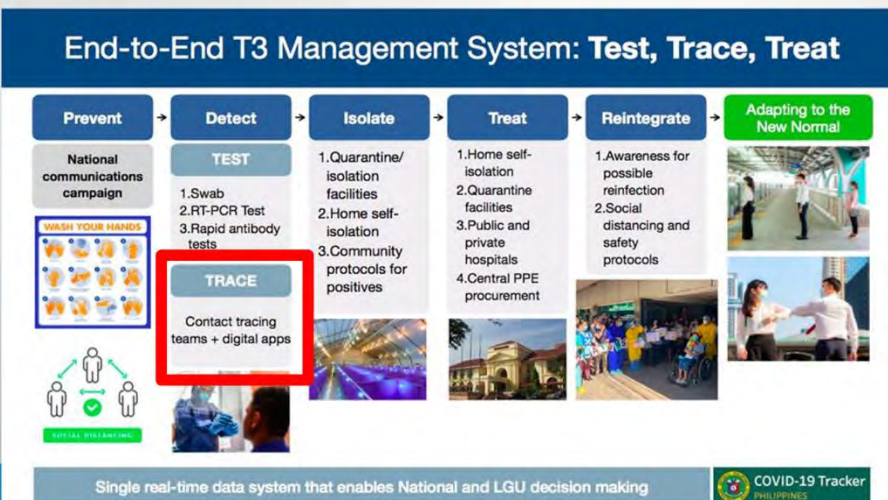
### Trace

*(Who are those in contact with the infected?)*

Tomas Pueyo: <https://medium.com/@tomaspueyo/coronavirus-how-to-do-testing-and-contact-tracing-bde85b64072e>



Contact Tracing is an integral part of the government's response to manage the pandemic



## Area Classifications and Interventions

CRITICAL ZONE (CRZ)	CONTAINMENT ZONE (CZ)	BUFFER ZONE (BZ)	OUTSIDE BUFFER ZONE (OBZ)
ECQ	Modified ECQ	GCQ	Modified GCQ
MINIMUM PUBLIC HEALTH STANDARDS SHALL BE COMPLIED ALL THE TIME			
POLICIES AND PROTOCOLS ARE BASED ON EXISTING OMNIBUS GUIDELINES			
<ul style="list-style-type: none"> <li>No movement regardless of age &amp; health status</li> <li>Minimal economic activity except for utility services (ie., food, power, water, etc) and critical economic sector</li> <li>No transportation activity except for utility services</li> <li>Suspension of physical classes</li> </ul>	<ul style="list-style-type: none"> <li>Limited movement within zone for obtaining essential services &amp; work</li> <li>Operation of selected manufacturing and processing plants up to maximum of 50% of workforce</li> <li>Limited transporting services for essential goods &amp; services</li> <li>Suspension of physical classes</li> </ul>	<ul style="list-style-type: none"> <li>Limited movement to services &amp; work within BZ &amp; OBZ</li> <li>Operation of government offices &amp; industries up to a maximum of 75 % workforce</li> <li>Limited transporting services to support government and private operations</li> <li>Flexible learning arrangements; operate at limited capacities to cater to students</li> </ul>	<p><b>Permissive socio-economic activities with minimum public health standards</b></p>





REPUBLIC OF THE PHILIPPINES  
**INTER-AGENCY TASK FORCE FOR THE MANAGEMENT OF  
EMERGING INFECTIOUS DISEASE**

- Policy direction
- Assessment
- Resolutions



# **ONE HOSPITAL COMMAND CENTER**

**(COVID-19 RESPONSE)**

- Launched August 6
- latest effort of the task force to improve access of Filipinos to medical care and treatment for COVID-19.
- coordinating with all hospitals and isolation facilities in Metro Manila to know how many available COVID-19 beds they have.
- the command center's coordinators can inform COVID-19 patients where to go for treatment.



**JOSE B. LINGAD MEMORIAL GENERAL HOSPITAL**

1000 bed capacity tertiary hospital

Located 80 kms away from Manila

12 accredited Residency Training Programs  
Anesthesiology, Emergency Medicine,  
Internal Medicine, Family and Community  
Medicine, General Surgery,  
Obstetrics-Gynecology,  
Ophthalmology, Orthopedics,  
Otorhinolaryngology- Head and Neck  
Surgery, Pathology, Pediatrics

Critical Care Facilities  
SICU, NICU, PICU, MICU, Maternal ICU

Radiology, Ultrasound, CT Scan, MRI

Molecular Laboratory

## BED CAPACITY

- 1000 Bed Capacity (during normal times)
- 650 Implementing Beds during the pandemic (in compliance with physical distancing)
- 195 Beds dedicated for COVID-19 Cases
  - Includes 70 beds for critical cases
- additional 120 beds ready for conversion as COVID facility in case of surge
- Separate 21 beds dedicated for HCWs of the hospital



© Wuhan Central Hospital Weibo



3000 Testing

Full capacity as of  
June 2020

- Admitted Patients
- Post Deployment
- Expanded Targeted Testing

*Launching and Turnover  
Ceremony of the*  
**Molecular and Diagnostic  
Pathology Laboratory**

Saturday, May 9, 2020, 10:00 am  
Jose B. Lingad Memorial General Hospital  
7<sup>th</sup> Floor, New OPD Building  
City of San Fernando, Pampanga

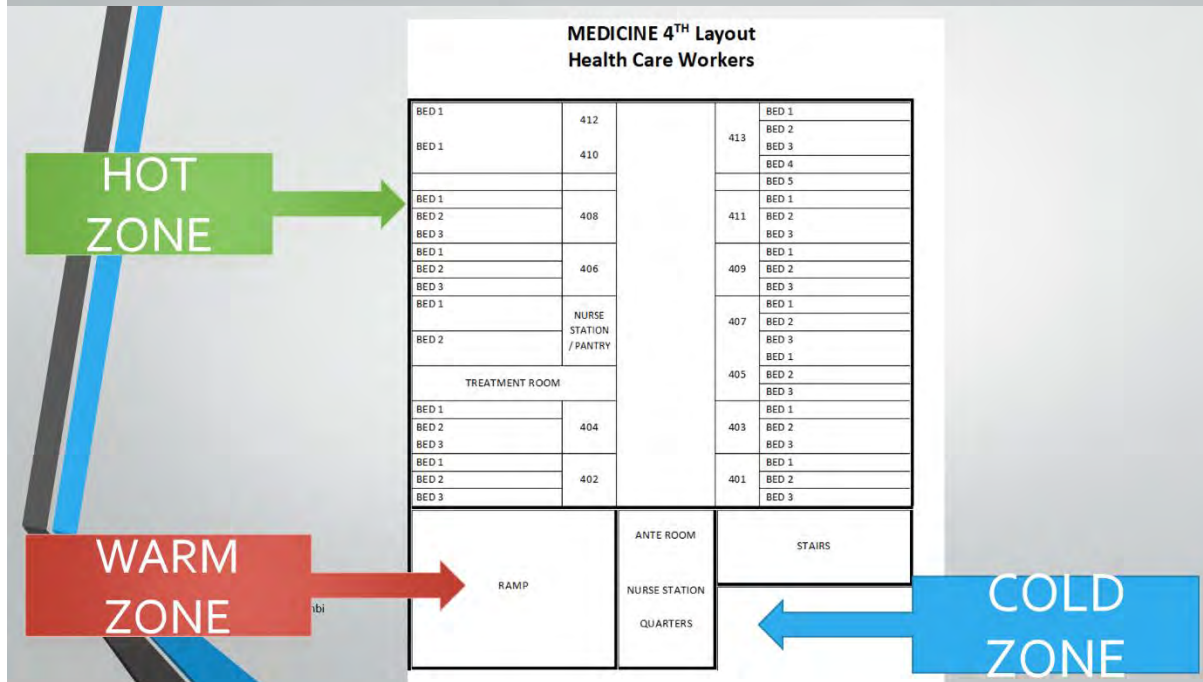


## FACILITY

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# JBLMGH CONVERTED FACILITY

PREVIOUS FACILITY	COVID DESIGNATION	TYPE OF PATIENT
Main ER lobby and isolation / decontamination room	Main ER Triage	Covid Related Screening
Isolation II (Old Dietary Building)	Covid ER and Operating Room	Admission and Resuscitation Surgical Procedure
Medical ICU	ICU	Intubated and Standby intubation Critical patient
Internal Medicine Ward	4TH	Moderate to Severe With active comorbid (dialysis)
Internal Medicine Ward	5TH	Mild confirmed Overflow Floor
Family Medicine Ward	6TH	Suspect and Probable Electives





## DONNING AND DOFFING AREA

### ISOLATION

- ISO 1 DONNING AND DOFFING AREA

### ICU

- DONNING AREA AT ENTRANCE, DOFFING AT EXIT

### 4<sup>TH</sup>, 5<sup>TH</sup>, 6<sup>TH</sup>

- DONNING IN BETWEEN QUARTERS AND WARD
- DOFFING AREA AT THE RAMP

## LOGISTICS

- Appropriate allocation of Covid related equipment and supply
- Personal protective equipment
- Closed suction system
- Mechanical ventilator
- Video laryngoscope
- Dialysis machine
- Continuous Renal Replacement Therapy machine
- Convalescent Plasma
- Medicines
  - Tocilizumab
  - Remdesivir
  - Favipiravir



# SERVICES OFFERED

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- Triaging (prehospital and onsite)
- Isolation of Covid related patient
- Covid admission and management
- Operative procedure
- Provision of PCR result & medical certificate

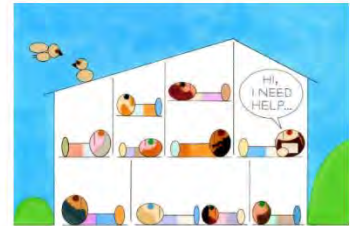


## OTHER SERVICES

- Pre-operative PCR testing for elective cases requiring Aerosol Generating Procedure
- Expanded targeted testing (Mass swab testing) for employees
- Monitoring of Covid responders
- Activation of contact tracing team for exposed personnel

## OTHER SERVICES

- PCR Test
- Convalescent plasma extraction and banking
- Mental Health Support



## Ensuring the safety of employees while at COVID Duty

The Role of the Employees' Health and Wellness Center and the COVID Coordinating Team

## COVID Duty

- 7 days straight of COVID-related Duty Assignment (35-40 personnel)
  - ER Triage Station (Gate Keeper)
  - COVID ER
  - COVID Wards & ICU
  - Molecular Laboratory



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## Pre-deployment process

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**All scheduled employee must report to the EHWC ONE WEEK prior**

Physical examination (by EHWC physician)

Psychological evaluation

Completion of required documents (CIF,, General Data Sheet)

## SIGNING OF CONFIDENTIALITY AGREEMENT

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DEPARTMENT OF HEALTH  
General Health Center 3  
**JOSE B. LINGAD MEMORIAL GENERAL HOSPITAL**  
Dolores, City of San Fernando, Pampanga  
Telephone No. (045) 409-6688



### CONFIDENTIALITY AGREEMENT

I, NAME, agree with the following statements:

I understand that I may have access to or come in contact with personal/confidential information during my time at JBLMGH. As part of the condition of my work with JBLMGH, I hereby agree to handle any information in a confidential manner during and after my employment/training/contract regarding any patient or employee of JBLMGH or any other restricted information that comes to my attention while at JBLMGH.

I shall not discuss, disclose, use, share, and or release personal/confidential information in any form, except as required by the management of JBLMGH or as permitted by law.

Any and all electronic data systems that contain patient protected health information, including patient information found in the computer and reporting programs are confidential. Only the Health Information Management Unit has the authorization to release documents.

I shall dispose all personal/confidential information collected, including those pictures of patients' records and any other confidential records of the hospital after it served its purpose.

By signing below, I agree to comply with all confidentiality policies and procedures set in place by Jose B. Lingad Memorial General Hospital in accordance with the Data Privacy Act, and all other applicable laws.

**NAME**

Printed Name & Signature

**DESIGNATION**

Designation

Date



Doctors will act as  
General Practitioner,  
if with arising  
progressing symptoms,  
refer to specialist



Nurses act as general  
nurse  
May handle Pedia and  
Adult Patient



Support staff  
Helps each other on all work  
FOOD DELIVERY  
DECONTAMINATION

## TEAMWORK

- Works together to keep everybody safe
- Help each other in all work at Covid ward
- 100% negative Covid 19 infection post duty



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# PREPARATION

## Do's

- Clothes for 14 days (comfortable and presentable)
- OWN RESPIRATOR
- Toiletries
- Slippers and shoes
- Bed sheet and blanket
- Food and snack
- Utensils
- Detergent for laundry

## Don't

- Expensive clothes and shoes
- Jewelries (suggested)



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# LAUNDRY PROVISION



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- ISOLATION ER
  - Automatic Washer and Dryer
- 5<sup>TH</sup> FLOOR
  - 2 tub washing Machine
- ICU
  - Automatic Washer and Dryer

## HOW TO AVOID INFECTION



The ward are divided into Hot zone, Warm zone and Cold zone



Eat alone, decking



Always wear your mask, (change mask after doffing)



Protect your cellphones



Do not be in a hurry to wear PPE



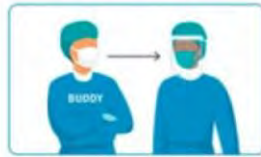
Buddy system on PPE

## Health care worker monitoring COVID RESPONDER

- Inform once with symptoms
  - Floor team leader
  - Over all team leader
  - Covid Response Team
- May be pulled out and replaced



## COVID-19: BUDDY SYSTEM PROTOCOLS



Ask your buddy to **watch you don PPE** before you enter the patient's room to make sure you are in compliance.



**Need supplies?** Knock on the glass while you are in the room to alert an available buddy. Open the door for them, and have them hand you the supplies.



When your patient **needs medications**, ask an available buddy to add the medications to the IV poles outside of the room, while you assist the patient inside.



When you're **ready to exit**, knock on the window to alert an available buddy. Doff to minimize risk of error.

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### FULL FACE MASK



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IDEALLY USED BY HEALTHCARE WORKER WHO WILL GO ON PROLONG EXPOSURE AT COVID WARD  
OPERATIVE PROCEDURE  
MOVEMENT / TRANSFER OF PATIENT  
PROLONG INTERACTION WITH PATIENT  
DECONTAMINATION OF ROOMS

DEPLOYED INDIVIDUALLY

PROVIDED WITH N95 FILTER MASK GOOD FOR 8 HOURS  
USED; FULL FACE SHIELD, PAPR

MUST BE TAKEN CARE OF, REGISTER ON LOGBOOK  
WHO WILL USE FOR THE WEEK

DECONTAMINATED DAY BEFORE DEPLOYMENT BY  
DECON TEAM AND RELEASED ON THE DAY OF DAY 1  
DUTY

# POST DUTY DECORUM

CLEAN AS  
YOU GO



DO NOT ENDORSE PHYSICALLY TO  
INCOMING



PROVIDE BREAKFAST TO PATIENT



CLEAN YOUR WARD



EAT BREAKFAST



TAKE A BATH

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THE JOSE B LINGAD MEMORIAL GENERAL HOSPITAL EXPRESSES THEIR GRATITUDE FOR YOUR  
SERVICE IN BEING PART OF THE COVID DUTY TEAM.

PLEASE FILL OUT FOR SOME TIME TO REFLECT ON THE 1 WEEK DUTY

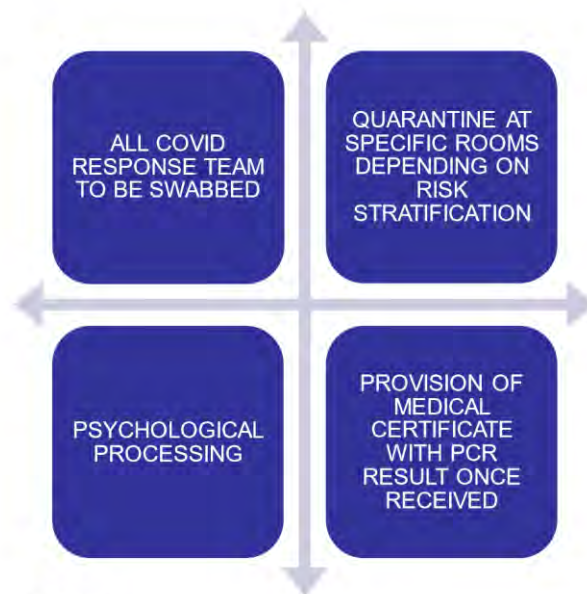
WARD	DATE DEPLOYED:		
	WHAT WENT WELL	WHAT WENT WRONG	WHAT NEEDS TO BE IMPROVED
ENCOUNTER			
PT (S)			
OUT DUTY			
OPERATION CENTER			
ICU			
OFFICE TO KILLER HPC AND MEDICAL SUPPORT			
LABORATORY W/ PATIENT			
PATIENT FLOW			
ADULT			
OTHER CONCERNS SAY WHAT TO CONTRIBUTE			
MESSAGE FOR THE GENERAL EXPERIENCE			

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WHAT WENT WELL,  
WHAT WENT WRONG,  
WHAT NEEDS TO BE IMPROVED

- PRE-DEPLOYMENT
- ON DUTY
- POST DUTY
- OPERATION CENTER
- FOOD
- SUPPLIES
- MANAGEMENT OF PATIENT
- PATIENT FLOW
- FACILITY
- OTHER CONCERNS THEY WANT TO CONTRIBUTE
- GENERAL MESSAGE FOR THE GENERAL EXPERIENCE

# POST DEPLOYMENT PROTOCOL



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## Infection Control Committee/HESU/IDS

**JBLMGH HESU**  
**HOSPITAL EPIDEMIOLOGY SURVEILLANCE UNIT**

You may inquire regarding  
RT - PCR Testing related concerns

📍 Dolores, City of San Fernando, Pampanga  
☎ +63 933 498 6602

### Infection Control Benefits

- Hand Hygiene Compliance
- Contact Tracing
- Asset Management
- Medical Scope Management
- Environmental Monitoring
- Surgical Sterile Processing

### How Contact Tracing Works

1. Infected person shown symptoms, tests positive

2. Infected person asked about contacts

3. Contacts are alerted of their exposure and risk for infection

4. Contacts self-quarantine, contact their healthcare provider and monitor for symptoms

**LABORERS**





- 16 Rooms/32 beds
  - 2 beds per room w/ comfort room
  - Common dining and kitchen area
  - With laundry area

## Control Measures

- **Daily Transportation Service every work shift**
- **Housing Accommodation**
  - In-house Quarters for on-duty (24-H shift)
  - Outside Hospital Accommodation
- **Work Accommodation**
  - Flexible Time Schedule
  - Work from Home & Work Reassignment
  - Telemedicine & Online Outpatient Consult



## Activities for Employees Assigned to COVID Duty

- **Pre-deployment Activities**
  - Transfer Health Assessment (EHWC)
  - Mental Health Assessment (APU)
  - Pre-deployment orientation (COVID Coordinating Team)
    - Task Orientation, Special Workflow Protocols, IPC
- **COVID Duty Welfare Monitoring**
  - OHP Daily Health Monitoring
  - Reiteration of IPC Protocol

## Activities for Employees Assigned to COVID Duty

- **Post-deployment Activities**
  - **Post Duty Rest/Hospital Quarantine**
    - RT-PCR Swab (Molecular Lab & HESU)
    - Mental Health Assessment (APU)
    - Risk Assessment Stratification
    - Reiteration of IPC Protocol
    - Early Morning Exercise (Rehab Med)
  - **Post-deployment Clearance**
    - RT-PCR Swab Result & Symptom-based Assessment
- **Return to Work Health Assessment**

## Lessons learned from the hospital setting:

- Activation of the Health & Safety Committee
- Clear-cut protocols on COVID-19 Concerns
- Delegate the task base on expertise
- Collaborate with other agencies to fulfill the deficiencies
  - LGU for contact tracing & referrals
  - Hospitals for case referral and testing

## Overall Knowledge Skills and Attitude

- Knowledge (Correct and Accurate Information)
- Adjustment (Provide the Necessary Control Measures)
- Responsibility & Accountability (Delegate task base on skills and duty)
- Collaboration (Tap Experts for Quality Output)

• **RESILIENCE**



## **Good Practice in Singapore**

- 9) *Community Care Facility*
  - *Good Practice Form*



**【Attachment】**

**Good Practice Documentation Form**

This form aims to collect “Good practice” on medical response against COVID-19 outbreak in order to share knowledge and experience among AMSs through ARCH Project.

Kindly complete the below reporting template and submit to ARCH Project Team no later than (to be updated).

To: ARCH/ JICA Project Office

E-mail: archpro1@outlook.com

National focal point for Questionnaire on COVID-19 response	
Country	Singapore
Name	Ng Hock Sing
Position	Director
Email	

Good practice report (No.1)			
Title	Community Care Facility		
Category	③ Isolation facility/ Evacuation center		
	Specify if you select “others” in the above.		
Section level	<input checked="" type="checkbox"/> National <input type="checkbox"/> Provincial/ District		
	<input type="checkbox"/> Facility <input type="checkbox"/> Field/ Prehospital		
Period	From	Click or tap to enter a date.	To Click or tap to enter a date.
Reported by	Name	Lim Ghee Hian	
	Position	Senior Consultant (Emergency Department) Director, Clinical Risk Management (NTFGH)	
	Email		
Key word	1)	2)	3)
Abstract (maximum 1,000 characters)			
<p>As part of the national response to the Covid-19 pandemic in Singapore, the multi-ministry taskforce had sanctioned the set-up of mass purpose-built facilities to support hospitals in the management of Covid-19 patients who do not require acute hospital care. This approach had allowed our acute hospitals to focus their response on their Covid-19 patients, and to take care of all other non-Covid-19 patients.</p> <p>Reliance on existing hospitals facilities would have inadvertently stretched hospitals beyond designed capacities. The comprehensive medical strategy to ensure that individuals infected with Covid-19 receive prompt and quality medical treatment includes developing guides for admission of patients into the appropriate tiered facilities, the transfer of patients between these facilities according</p>			

to their needs, and the discharge of patients who are well and no longer infectious.

Three mass purpose-built facilities were developed; Community Care Facility (CCF), Community Recovery Facility and Swab Isolation Facility (SIF):

- Majority of patients picked up by our testing have mild or no symptoms. Such patients are generally admitted to a Community Care Facility (CCF) where most recover with minimal intervention. Patients in these facilities are monitored closely in case they need to be transferred to hospital for better management and support. Those with severe conditions are cared for in Intensive Care Units (ICU) in hospitals. Such patients may display serious symptoms or have other risk factors and co-morbidities. Vital Sign Monitoring (VSM) system are also deployed to CCF. This allows large number of patients in CCF teams to monitored with minimal staffing.
- Patients who remain well at Day 14 of illness are likely to remain clinically stable and generally do not require any further medical care. We transfer such patients to a step-down Community Recovery Facility (CRF). Those who have been previously admitted into our hospitals may also be transferred to a CRF when they recover from their acute illness.
- Persons with acute respiratory infections but are clinically well are issued with five-day medical certificates and are asked to isolate themselves at home. Those who meet the clinical case definitions for COVID-19 are tested and asked to self-isolate at home as they await their test results. Those who are unable to self-isolate in their homes can do so in a Swab Isolation Facility (SIF) while awaiting their test results.

Besides the above facilities, IT support system was also designed to best support the care and workflow in the facilities mentioned. Though the existing hospital IT systems are well established, the hospital systems are complex and would had taken a longer time to deploy. The facilities needed a solution that was relatively easy to teach, learn, provision and deploy and scale up quickly when needed.

The solution came in the form of GPConnect, an integrated Clinical Management System (CMS) and Electronic Medical Records (EMR) system currently being used by 200+ general practitioner clinics in Singapore. GPConnect is an integrated system that can handle patient registration and storing of the patient's medical records, including the dispensation of medicine. It can be deployed quickly and provides efficiency through its features for both administration as well as clinical consult workflows, such as its ability to access National Electronic Health Record (NEHR) for Covid-19 patients' continuity of care, followed by record of key patient data after the consult.

The set-up of the mass purpose-built facilities ensured the hospitals' capacities remain available to address the needs of Covid-19 and non-Covid-19 related patients who needed the hospitals' services. This was enabled by an IT system to manage the workflows at the facilities. This strategy had played an instrumental role in the national response to the Covid-19 pandemic

\* If you are willing to share two or more cases of "Good practice", please copy the template above.

## **Good Practice in Thailand**

- 10) *SCOT: Special COVID-19 Operation Team*
  - *Good Practice Form*
  - *Presentation*
  
- 11) *Sharing Experience: Quarantine Facility in Thailand*
  - *Presentation*



## 【Attachment】

## Good Practice Documentation Form

This form aims to collect “Good practice” on medical response against COVID-19 outbreak in order to share knowledge and experience among AMSs through ARCH Project.

Kindly complete the below reporting template and submit to ARCH Project Team no later than 31 July 2020.

To: ARCH/ JICA Project Office

E-mail: archpro1@outlook.com

National focal point for Questionnaire on COVID-19 response	
Country	Thailand
Name	Mr. Surachai Silawan
Position	ARCH Project Manager
Email	

Good practice report (No.1)			
Title	SCOT: Special COVID-19 Operation Team		
Category	④ Prehospital/ Transport		
	Specify if you select “others” in the above.		
Section level	<input checked="" type="checkbox"/> National <input type="checkbox"/> Provincial/ District		
	<input type="checkbox"/> Facility <input type="checkbox"/> Field/ Prehospital		
Period	From	Click or tap to enter a date.	To Click or tap to enter a date.
Reported by	Name	Mr. Surachai Silawan	
	Position	ARCH Project Manager	
	Email		
Key word	1)	2)	3)

## Abstract (maximum 1,000 characters)

The SCOT meant to be a substitute team for Emergency Medical Service to transfer or transport a COVID-19 infected or Patient Under Investigation (PUI), including an emergency medical case during pandemic, especially in the case of inadequate number of the ALS. The team responsible to transport the PUI with no severe symptom from their residence or accommodation to a hospital, to transport the PUI who arrives at Suvarnabhumi Airport to a State Quarantine, to transport the PUI from a State Quarantine for an outbreak investigation at a hospital, to stand-by for 24 hours a day awaiting a command by a provincial dispatch center and to operate under a medical director in critical case. There are currently total of 63 teams and 1,800 Emergency Medical Personals were certified as SCOT by NIEM. According to a few cases of COVID-19, there has been only 23 operations by SCOTs in six months. The Certified SCOT, with ALS skill and knowledge of infectious disease prevention is still essential for the EMS in Thailand as a back-up plan once the COVID-19 case gets too overwhelmed

for ALS to function properly.

\* If you are willing to share two or more cases of “Good practice”, please copy the template above.



# SCOT

## Special COVID-19 Operation Team



ARCH Project  
National Institute for Emergency Medicine  
Thailand  
September 2020



## BACKGROUND

- In Thailand, it was first reported of the Corona Virus Disease 2019 (COVID-19) on the 8<sup>th</sup> January 2020 at the Suvarnabhumi Airport.
- On 26<sup>th</sup> February 2020 (49 days later), Thai Ministry of Public Health declared the disease as "a dangerous Communicable Disease" .
- On 20 March 2020, there were 1,245 infected, 6 deaths. Averagely, 100 new infections daily with 17,140 cases under surveillance nationwide. Meanwhile, other countries had shown serious infection with high death rates.
- To transfer or transport an infected or Patient Under Investigation (PUI), medical teams or medical assistance teams are needed to be armed with specific skills relevant to an "Advance Life Support" **only**.
- Presuming that the outbreak gets worse, Thailand may not have an adequate number of the ALS to transport the cases.
- An initiative of the SCOT is; therefore, necessary in order to be a back-up plan once the case is overloaded.



## OBJECTIVE

To be a substitute team for Emergency Medical Service to transfer or transport a COVID-19 infected or Patient Under Investigation (PUI), including an emergency medical case during COVID-19 pandemic, especially in the case of inadequate number of the ALS.



## PROCEDURES

1. Teams of First Responder and Basic Life Support, under a private voluntary foundation, who registered in EMS system, are called for SCOT registration, by their own willing.
2. NIEM provides a 1-day course of specific and necessary knowledge and skill in communicable disease prevention and protection. The course is composed of:
  - I. How to put on, take off and clean a special Personal Protective Equipment (PPE) and other equipment (lecture /workshop)
  - II. Infectious Waste Management and Pre and Post-operation vehicle cleaning (lecture /workshop)
  - III. Infection prevention; pre, post and during operation.
  - IV. Safety management
3. The Committee of Emergency Medicine announced the Specification and Condition of Compensation, and allocated more than half a million USD for SCOT operation; 2 times as much as normal medical operation, an "on duty" 14-day quarantine , stand-by operation and specific medical equipment relative to COVID-19.





4. Ministry of Public Health commanded every Provincial Health Office to set up its own SCOT, as NIEM requested.
5. With collaboration with NIEM, Provincial Health Office conducted the course to arm medical team to transport any Patient Under Investigation (PUI) to a definite hospital.
6. NIEM provided a manual, standard operating procedure on infectious disease, report, command, communication, and relevant organization coordination, including a pre-operation checklist.
7. NIEM collaborated with an Insurance Company to provide insurance of not exceeding to USD 500,000 for on-duty infection, with no premium needed.
8. The SCOT has been activated since 1<sup>st</sup> April 2020- 30<sup>th</sup> September 2020. The activated period may get extended depending upon the COVID-19 situation.



## ROLE AND RESPONSIBILITY

1. To transport the Patient Under Investigation (PUI) with no severe symptom from their residence or accommodation to a hospital;
2. To transport the Patient Under Investigation (PUI) who arrives at Suvarnabhumi Airport to a State Quarantine;
3. To transport the Patient Under Investigation (PUI) from a State Quarantine for an outbreak investigation at a hospital;
4. To stand-by for 24 hours a day awaiting a command by a provincial dispatch centre;
5. To operate under a medical director in critical case.





## PERFORMANCE

- Of all 77 provinces in Thailand, there are 63 SCOTs from 57 provinces.
- 1,800 Emergency Medical Personnel were certified as SCOT by NIEM.
- NIEM provided more than 2.5 millions face masks and 6,600 PPEs
- According to a few cases of COVID-19, there has been only 23 cases of SCOTs in six months.
- 15 Emergency Medical personnel, in 5 provinces, got quarantined for 14 days. (None of SCOT has)
- No COVID-19 infection found in SCOT.



## A preparation for expecting COVID-19

- Certified SCOT, with ALS skill and knowledge of infectious disease prevention, is still essential for the Emergency Medical System in Thailand as a back-up plan once the COVID-19 case gets too overwhelmed for ALS to function properly.
- There has been continuous course and training on the infectious disease prevention for patient transportation in provinces.
- There are adequate medical equipment and PPE for infectious disease for the SCOT operation.

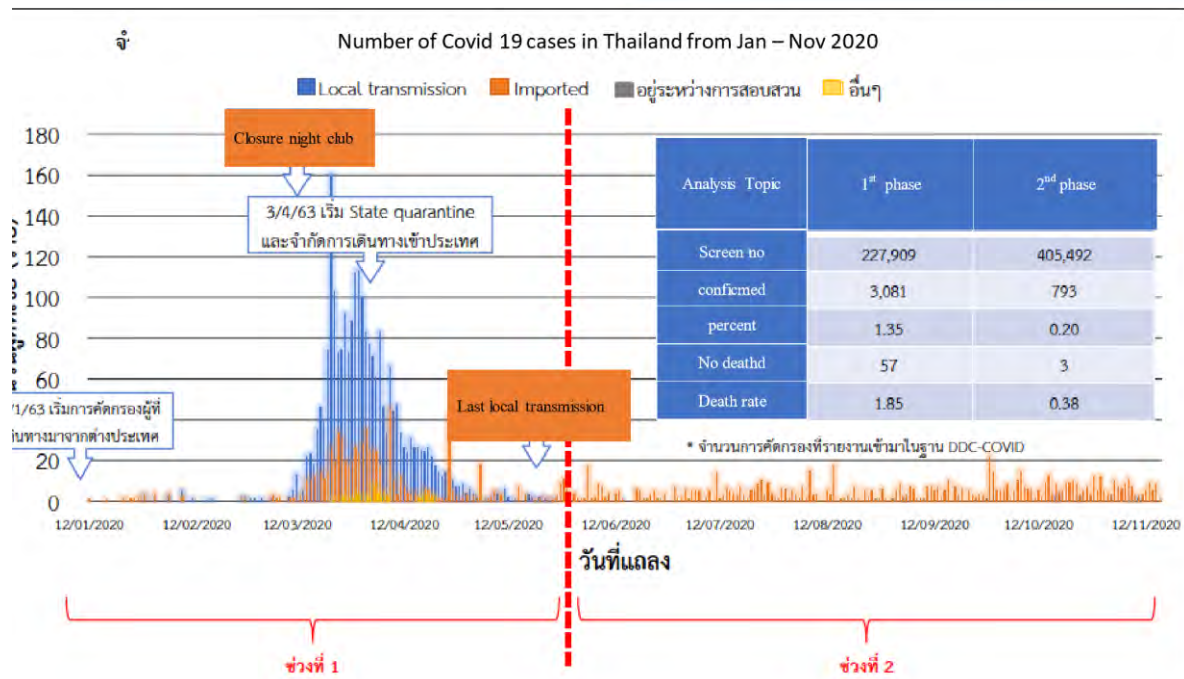


Thank you for your kind attention.....



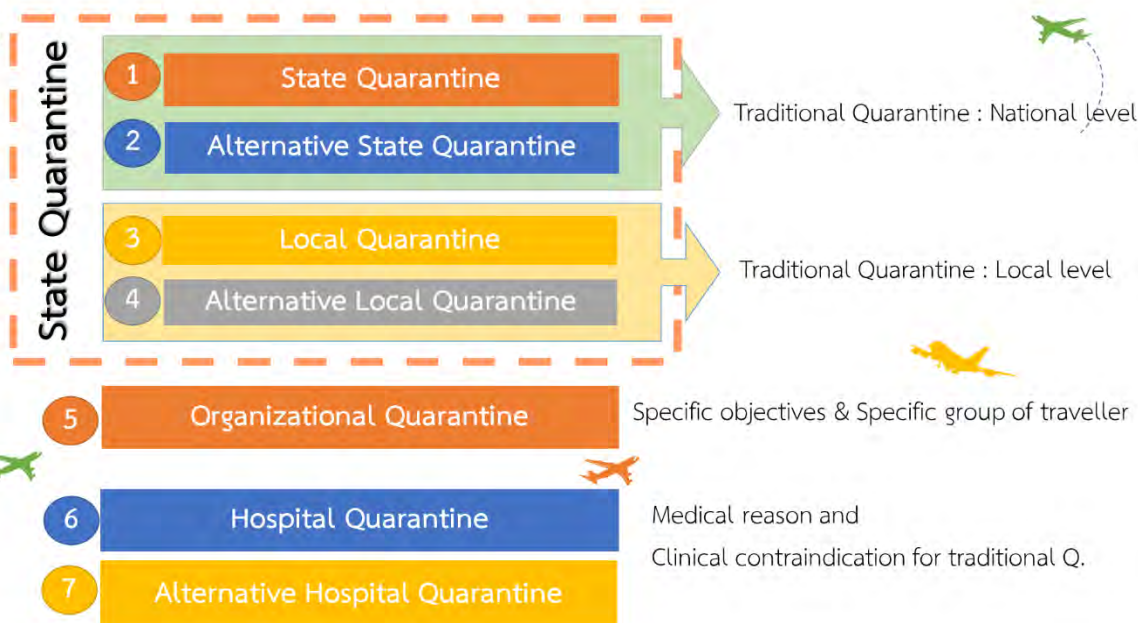
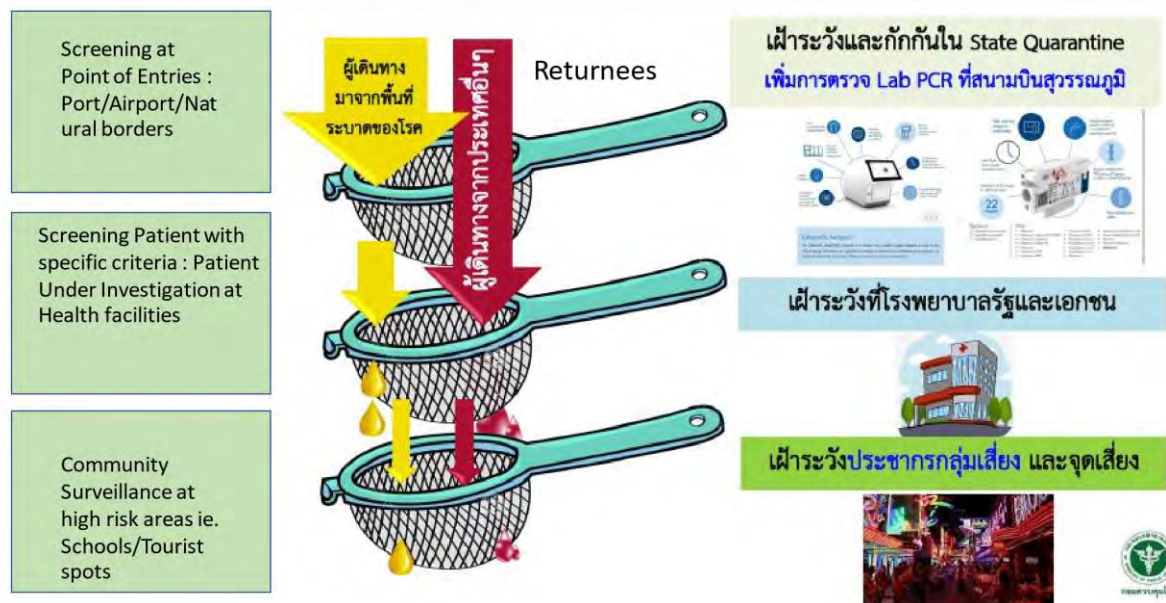


DPHEM , DDC  
MOPH Thailand

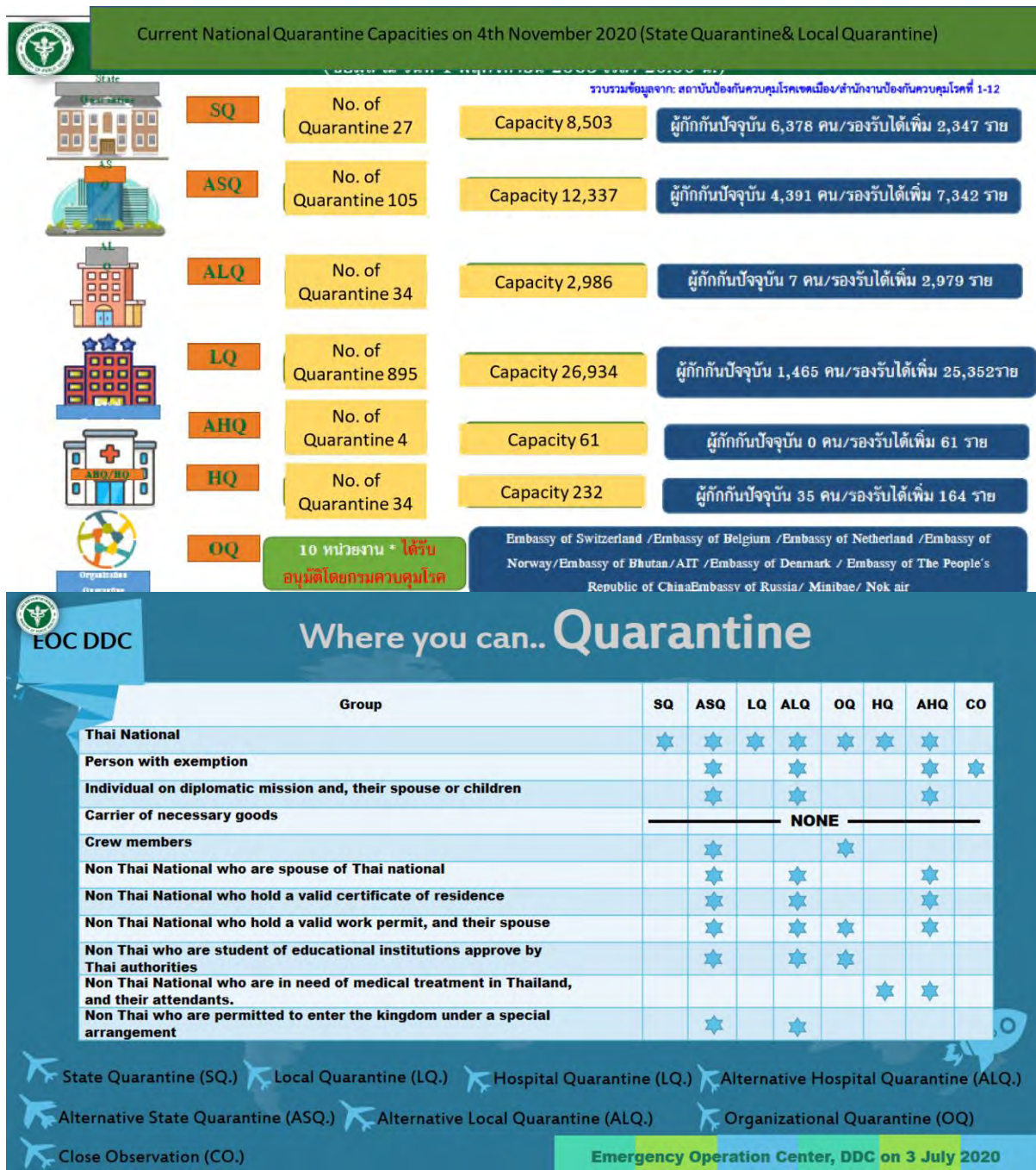




## Strengthening the Covid-19 Control Measures in Thailand









## Characters of returnees to the Kingdom of Thailand (Total detected cases 1,030 on Nov 2020)

Quarantine Facilities	No. Of returnees	Rate of infection	Thai		Foreigner		
			Confirmed cases	Rate of infection	Common origin countries	Confirmed cases	Rate of infection
SQ	82,197	0.86	708 (+9)	0.86	India	-	-
LQ	32,805	0.25	80	0.24	Indonesia	2	0.01
ASQ	40,851	0.50	33 (+5)	0.08	England, UAE, Brasil, Hongkon, USA	172 (+4)	0.42
ALQ	30	13.33	1	3.33	USA	3	10.00
AHQ / HQ	2,412	1.12	1	0.04	Saudi Arabia	26 (+1)	1.08
OQ	4,396	0.14	2	0.05	Sweden	4	0.09
รวม	162,691		825 (+14)	0.51		207 (+5)	0.13

หมายเหตุ : - อื่นๆ 2 ราย (ร้อยละ 0.19) - ไม่สามารถแยกผู้เดินทางสัญชาติไทย และต่างชาติ

แหล่งข้อมูล: กรมควบคุมโรค กระทรวงสาธารณสุข

กลุ่มเป้าหมาย & วัตถุประสงค์

Target group  
Thai returnee

ผู้เดินทางเข้าประเทศ ที่เป็นชาวไทย

Disease Prevention & Control measure "Guideline from DDC"

แนวทางการบริหารจัดการสถานที่กักกันซึ่งทางราชการกำหนด

ลพ 21 กรกฎาคม 2563

ฉบับปรับปรุง เวอร์ชัน 3 (รออนุมัติ)

Authorization

กระทรวงกลาโหม  
Ministry of Defense

## State Quarantine

Publication

CCSA's Website  
: Thai embassies

การจัดการข้อมูลผู้ถูกกักกัน

Excel file  
COSTE.  
Paperless & real-time DB.

Covid manager / Field Commander

Covid manager : Hotel Incident  
commander from MOD



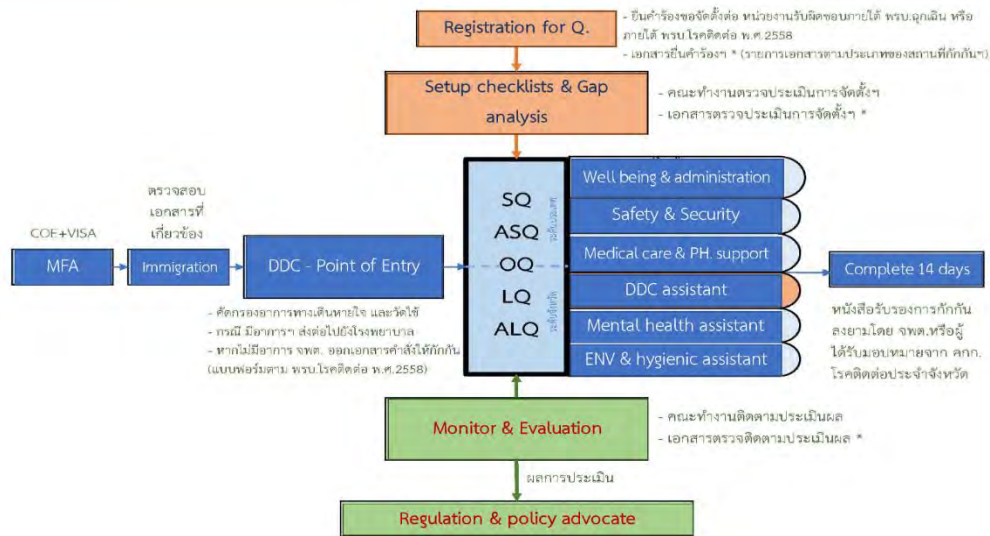








## Quarantine Flow



“less service – less contact”  
concept

- ☐ Self daily activity & normal well being
  - ☐ room clean up
  - ☐ Self washing
  - ☐ Meal in the private room
  - ☐ Waste management





### “less service – less contact” concept

- ☐ Daily PUI screening & report
  - ☐ Signs & Symptoms by PUI definition
  - ☐ Body temperature measurement
  - ☐ Other physical and mental health evaluation



### “less service – less contact” concept

- ☐ Personal hygiene care
  - ☐ Hand hygiene and alcohol hand rub
  - ☐ Always face mask
  - ☐ Self care of secretion and area contamination



## Regulation

- ☐ 14 days – 15 nights
- ☐ 2 times swab for RT-PCR : SAR-COV-2
  - ☐ 3 times swab in some ASQ. Depend on hospital protocol
- ☐ Q. Staff skill training (offline & online)
- ☐ Gap analysis compare with standard protocol

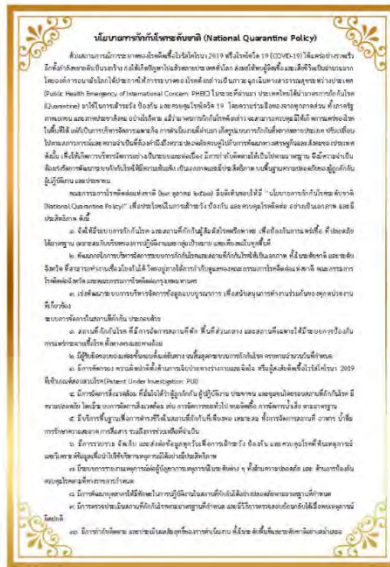


## Additional SOP specified for all quarantine staffs (health & non-health)

- 1) Daily PUI screening for all staff working in the Q.
- 2) Personal protective equipment is required.
- 3) Personal decontamination before leaving from Q. Site
- 4) Self monitoring for any signs & symptoms by PUI definitions.
- 5) Keep social distance
- 6) Safety officer is required during PPE. removal process.
- 7) Working on quarantine activity only, other activity is not allowed.



## National Quarantine Policy



### National Quarantine Policies

1. Provide appropriate quarantine facilities for disease prevention and control
2. Developing a unify management system for Quarantine facilities at national level
3. Integration of Data sharing to support management and decision making (Interministerial)

# THANK YOU



**D**istancing



**M**ask  
wearing



**H**and  
washing



**T**esting &  
**T**racing



## **Good Practice in Viet Nam**

### *12) Good Practice for Control of COVID-19 spreading in Bach Mai Hospital*

- *Good Practice Form*
- *Presentation*

## Good Practice Documentation Form

This form aims to collect "Good practice" on medical response against COVID-19 outbreak in order to share knowledge and experience among AMSs through ARCH Project.

Kindly complete the below reporting template and submit to ARCH Project Team no later than 31 July 2020.

To: ARCH/ JICA Project Office

E-mail: archpro1@outlook.com

National focal point for Questionnaire on COVID-19 response	
Country	Viet Nam
Name	
Position	
Email	

Good practice report (No.1)			
Title	Mr. MD		
Category	① Infection control (Zoning, Isolation, Disinfection)		
	Specify if you select "others" in the above.		
Section level	<input checked="" type="checkbox"/> National <input type="checkbox"/> Provincial/ District		
	<input type="checkbox"/> Facility <input type="checkbox"/> Field/ Prehospital		
Period	From	Click or tap to enter a date.	To Click or tap to enter a date.
Reported by	Name	NGUYEN DUC CHINH, MD, PhD	
	Position	Chief of department, EMT team leader of Vietnam	
	Email		
Key word	1) <b>Novel Coronavirus Pneumonia (NCP)</b>	2) <b>Prevention of Nosocomial infection</b>	3) <b>Preparedness to control Covid-19 spreading</b>
Abstract (maximum 1,000 characters)			
Please include the following contents in the abstract;			
1. Brief description of the good practice:			
<p>Covid -19 (Novel Coronavirus Pneumonia – NCP) has been affecting worldwide, causing the high morbidity and mortality in both community and hospital, impacting to the health care system. Bach Mai Hospital (BMH), one of the biggest general hospitals in Vietnam, located in the center of Hanoi Capital, has been assigned for providing medical services to 3,200 beds. Every day, BMH receives thousands of people to examine and treat. Unfortunately, from March 20th to April 4th 2020, BMH was becoming the place with the largest number of NCP infections nationally.</p> <p>With good deployment of resources from MOH and Hanoi Capital, strict compliance of health workers and patients in NCP prevention, strong support and cooperation of other medical facilities, finally BMH has controlled the cross-infection of NCP and re-opened after 14 days of quarantine isolation.</p>			

<p>2. Problem/ Issue</p> <p>On March 20, 2020, two nurses of BMH were detected to be infected with NCP (F0), resulting 46 related persons (F1). From the trace, hospital found the cause of spreading is from the employees of one Company that provides catering and logistics to Bach Mai Hospital, and they went through whole hospital. Until the date of re-open, there were 9 infected persons in hospital.</p> <p>It's very challenging because BMH is always crowded with patients and visitors. More than 1000 inpatients were locked down during the quarantine isolation.</p> <p>From the beginning it was difficult to trace the F0. The Hospital has taken samples to test 5,000 staff members, workers and patients who are still in the hospital in short time,</p> <p>The location is in the Capital, therefore the hospital was at high risk of Covid-19 spreading to community</p> <p>Deal with the fake news</p> <p>3. Result / Outcome</p> <p>Finally, the hospital has controlled the cross-infection at 9 cases (F0) within the hospital areas, There are no NCP spreading to Hanoi community and other medical facilities. All the Covid-19 patients were all caring and recovering.</p> <p>From BMH case, we have the following achievements:</p> <p><b>i) Introduction of guidelines on NCP prevention for all health staff (ii) Re-organization of patient- flows from emergency and outpatient through the hospital until they discharged or died. (iii) Improve of surveillance capacity for preventing the NCP cross-infection. (iv) Promotion of IT application for hospital management and patient's care</b></p> <p>4. Monitoring/ Evaluation methodology</p> <p>Monitoring system from central level to sub national level and community</p> <p>Reporting system to PHEOC at MOH</p> <p>By Hotline</p> <p>Regular meeting among Inter-ministerial Steering Committees leading by Government</p> <p>5. Financial considerations</p> <p>Financial supports from Hanoi Capital and Government</p> <p>Other NGO and private</p>
--

\* If you are willing to share two or more cases of "Good practice", please copy the template above.

# **Good practice for control of Covid-19 spreading in Bach Mai hospital**

Ministry of Health of Vietnam

## **Content**

- **About Bach Mai hospital**
- **Management of Covid-19 pandemic in Bach Mai hospital**
- **Lessons learned**



## About Bach Mai hospital

### About Bach Mai hospital

One of the largest general and referral hospitals in Vietnam, 105 years of history

Located in Hanoi City

3.200 beds with nearly 3000 staff

03 institutes, 08 centers,

12 functional departments / departments,

23 clinical departments,

06 subclinical departments,



## About Bach Mai Hospital

In collaborating Hanoi Medical University, Bach Mai hospital (BMH) was assigned the following tasks :

1. Patients Service;
2. Training and education;
3. Scientific research ;
4. International Cooperation ;
5. Direction of Health Activities ;
6. Economic Management ;
7. Medicine Prevention ;
8. Hospital management



## About Bach Mai Hospital

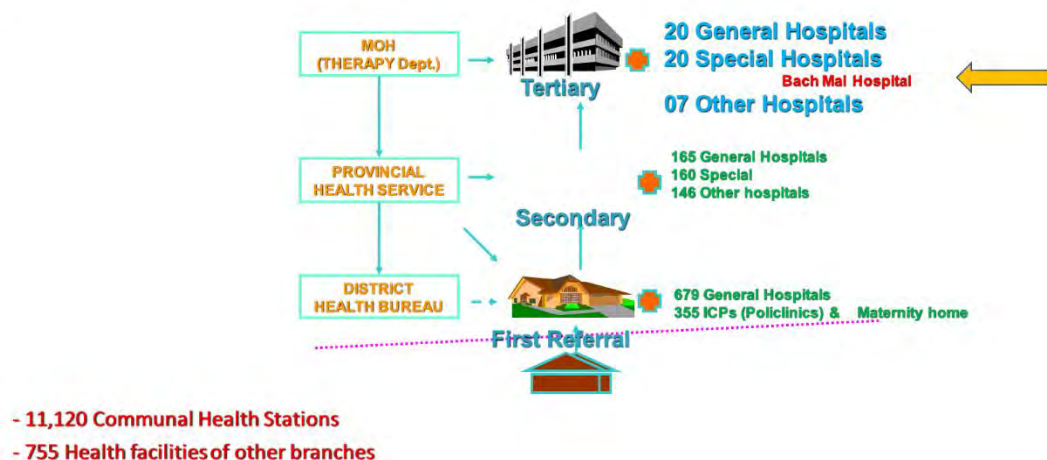
- Every day, BMH receives thousands of people for health check and medical treatment.
- Besides: BMH provides the training course and education to medical students and doctors
- As one of four first class hospitals in Vietnam, BMH has implemented many high technologies in diagnosis and treatment





## About Bach Mai Hospital

PUBLIC HOSPITAL NETWORK IN VIETNAM



6/23

## Management of Covid-19 pandemic in Bach Mai hospital

## **HISTORY**

- On March 20, 2020, 02 nurses from the Tropical Disease Center, Bach Mai Hospital, were positive with test for detection of Corona virus (Covid-19) infection.
- Resulting 46 F1 (employees of Truong Sinh Company) providing catering and logistics to Bach Mai Hospital
- BMH gets more attention from media from this date as one place had highest Covid-19 infection nationally.

## **IMPLEMENTING PLANS**

- Stopped receiving new patients, check all patients travelling to, and left BMH from 12/3/2020 for medical isolation in order to control spreading to the community,
- 5,000 staff members, workers and patients still in the hospital were tested for Corona virus
- Inpatient's family are isolated and tested.
- Hanoi also organized rapid tests in the community to promptly detect the new cases.



## IMPLEMENTING PLANS

- Until March 29, 2020, there were 9 cases of Covid-19 detected, BMH was officially locked down, reduced number of patients it receives, and keep patients already inside the hospital
- In such situation, care for inpatients and outpatients is still well maintained. BMH staff provided comprehensive care for the patient such as serving food, toilets ..., due to the companions to patients is only one
- Necessary medical supplies serving the medical treatment are transferred to the hospital daily by assigned organizations



First day quarantine isolation at Bach Mai hospital



BMH during the quarantine isolation



Maintaining the daily work at Bach Mai Hospital during the quarantine isolation





Assigned companies providing basic necessities and medical supplies for medical treatment by

Health workers are doing exercise for keeping healthy



Health workers of the BMH maintain social distancing as they wait until midnight

## IMPLEMENTING PLANS

Epidemiology footage : Finding main sources of infection

- Employees of the catering and logistics companies in the hospital
- Professional caregivers of BMH

With their task, above mentioned persons can go from ward to ward, meet numerous patients, patient's family members within BMH

They can go from hospital to hospital to provide services to patients

=> Soon they are localized to quarantine isolation

On 12<sup>nd</sup> April, the hospital was re-opened.

From 4<sup>th</sup> May, 2020, medical examination and treatment activities at BMH returned to normal.







Medical staff and patients in BMH, a Covid-19 hotspot, cheered as its 14-day lockdown ended Sunday morning.

## IMPLEMENTING PLANS

- On the first day of re-open, BMH has examined more than 1,700 patients, most of them have chronic diseases (high blood pressure, diabetes, cancer ...) been interrupted in medical examination and treatment during the Covid-19 affecting hospital.
- Both patient and family (one member) have to follow through the process of safe examination from gate to gate or from gate to ward and discharge.

## IMPLEMENTING PLANS

The patients are

- Immediately screened if all symptoms of Covid-19 they have such fever, cough, respiratory signs,
- Required to have a compulsory hand hygiene and temperature check. Also required to fill up the medical and epidemiological declaration.
- 100% required to comply with that regulation safety as much as possible during examination and hospitalization



Scanning and hand hygiene at the entering gates



Social distancing

## **IMPLEMENTING PLANS**

- Arranged the isolated areas/wards for patients positive with Covid-19 or suspected case so the hospital does not need to quarantine all.
- Medical staff have been trained and equipped with adequate PPE for any an unfortunate situation.
- Reduce maximum the numbers of family members staying, (medical staff is in charge of patient care), to assure the good air condition in ward, to arrange distancing in ward

## **RESULTS**

- SOON CONTROLLED THE SITUATION
- NO DEATH DUE TO COVID -19
- RE-OPENED AFTER QUARANTIN 14 DAYS

## **Lessons learned from Bach Mai Hospital**

### **Lessons learned from Bach Mai Hospital**

- Timely policy / regulations from Ministry of Health, updated in the world and WHO ...to be implemented; Strong support from Hanoi city and community
- Compliance of medical staff to instructions seriously
- Scanning carefully patients from the reception
- Control strictly people passing (going in and leaving out) hospital



## **Lessons learned from Bach Mai Hospital**

- Pay more attention to providers of services in health facilities (foods, logistic..) => Dangerous sources of infection from the community
- Close coordination with other medical facilities when receiving the patients from pandemic hospitals.
- Experienced experts and good procedures for nosocomial infection



THANK YOU FOR YOUR KIND ATTENTION



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

**Good Practice on Medical Response Against COVID-19 Outbreak, ARCH Project**

**Tentative Programme**

**Date:** Tuesday 15 September 2020 (2hrs)

**Time:** GMT+ 7 Bangkok 9.00-11.05 (Test Run 8.45)

**Platform:** Microsoft Teams

Time (GMT+7)	Agenda
8:45 – 9:00	Test Video and Sound System
9:00 – 9:05	Welcome Remark Mr. Shuichi Ikeda, Chief Advisor of ARCH Project
9:05 – 9:35	SCOT: Special COVID-19 Operation Team + Q&A National Institute for Emergency Medicine, Thailand
9:35 – 10:05	Medical Response Against COVID19 in Cambodia + Q&A Dr. Lak Muy Seang, Deputy Director of Preventive Medicine Department, Deputy Director of Communicable Disease Control Department, Ministry of Health, Cambodia
10:05 – 10:35	Deployment Protocols for Healthcare Workers Assigned in the COVID Response Team + Q&A Dr. Alfonso C. Danac, Chief of Medical and Professional Staff, Jose B. Lingad Memorial General Hospital, Philippines
10:35 – 11:05	Good Practice for Control of Covid-19 Spreading in the Special General Hospital + Q&A Dr. Pham The Thach, Vietnam



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

**2<sup>nd</sup> Webinar on Good Practice on Medical Response Against COVID-19 Outbreak  
Tentative Programme**

**Date:** Tuesday 8 December 2020 (2hr 20mins)  
**Time:** GMT+ 7 Bangkok 9.00-11.20 (Test Run 8.45)  
**Platform:** Cisco WebEx  
**Chairman:** Dr. Alisa Yanasan

Time (GMT+7)	Agenda
8:45 – 9:00	<b>Test Video and Sound System</b>
9:00 – 9:05	<b>Welcome Remark</b> Ministry of Public Health Thailand
9:05 – 9:25	<b>Responding to COVID-19 in Brunei Darussalam: Lessons for small countries</b> Dr Justin Wong, Dr Fathi and Dr Linawati Haji Jumat – MOH Brunei
9:25 – 9:55	<b>DMAT Activities for COVID-19 Response</b> Mr. Yoshiki Toyokuni – MHLW Japan DMAT Secretariat  <b>MDS for COVID-19</b> Dr. Tatsuhiko Kubo – Hiroshima University
9:55 – 10:55	<b>Distribution of Logistics (PPE) as a response to COVID-19 management</b> dr. Budy Sylvana - Director of Center For Health Crisis Ministry of Health of Indonesia  <b>Impact of Large-Scale Social Restrictions in Communities on COVID-19 Patients Visits in Hospital</b> Center for Health Management and Policy University Of Gadjah Mada Yogyakarta  <b>Dead Bodies Management of Covid-19: Stigma vs Proper Procedure</b> dr. Corona Rintawan - Muhammadiyah Hospital Lamongan, East Java (Muhammadiyah Disaster Management Center)
10:55 – 11:15	<b>Thailand Quarantine Facility</b> Dr. Prakit Sarathep, MOPH Thailand
11:15 – 11:20	<b>Wrap-up</b>