Panel 2.5 Mass casualty and hospital care
Norimasa Seo

Second draft:
Panel 2.5 Mass casualty management and hospital care

Japan Disaster Relief (JDR) Medical Teams For the Tsunami Disaster in Asia

Norimasa Seo, M.D.1, Yasuhiro Yamamoto, M.D. 2 Masahiro Hashizume, M.D. 2, Hisayoshi Kondo, M.D. 2, Yuichi Koito, M.D. 2, Hiroyuki Yokota, M.D. 2, Yasuhumi Asai, M.D. 3, Nobuaki Matsuo, M.D. 4,


Introduction:
On December 26, 2004, a major earthquake magnitude 9.1 triggered a devastating tsunami. And it caused about 300,000 deaths and several million injured in both Asian and African countries Seven JDR medical teams were dispatched to four countries within first month after the divesting tsunami

Primary medical cares of JDR medical teams in the tsunami disaster in Asia

A Total of 95 health personnel were dispatched to the tsunami
disaster sites. 24 doctors, 44 nurses, 6 pharmacists, 21 medical assistants and 6 logisticians were included in the relief efforts.

In Sri Lanka, JDR Medical Team was the first to arrive among international medical aid agencies on December 30th. Moved quickly to Kalmunai in Ampara Province and opened the clinic in a camp for displaced people two medical teams successively saw 2,251 patients and handed over the clinic to an American NGO, named North West Medical International and a Japanese NGO, named Humanitarian Medical Assistance.

In Thailand, the JDR medical team treated 1,050 patients in clinics located in a school and a camp for displaced people in Takuapa district in Phang-nga Province from December 31st to January 9th.

In Indonesia, we set up an outpatient clinic at the KDC playground in Banda Aceh from January 1st through January 21th. Three teams were dispatched successively and total number of patients treated was 3,658. The Japan self defense force medical team took over our clinic.

The JDR team to the Maldives provided medical services at the Muli Regional Hospital and at health posts of other seven islands in the Meemu Atoll during 1-5 January and treated 229 patients.
Discussion:
1. Characteristics of JDR medical team

1) The framework of the Japan international disaster relief organization.

The Ministry of Foreign Affairs manages the overseas disaster assistance division which provides emergency relief to affected countries. Disaster relief consists of three types: the financial assistance, deployment of personnel and provision of emergency relief supplies to the affected country. The deployment of personnel and provision of relief goods are implemented by the Japan International Cooperation Agency, JICA. There are three different types of personnel deployments: a rescue team, a medical team, and an expert team.

2) The outline of JDR medical team.

According to the Japanese law, JDR team generally responds to natural disaster. JDR medical team consists of doctors, nurses, pharmacists and paramedics who are registered voluntary. A standard medical team consists of 21 members. Team leader is a staff of the ministry of the foreign affairs charged with affected area or countries. Medical division consist four doctor (one is sub-leader), seven nurses (one is chief), one pharmacist, 3 clerks. Logistic division consists of 5 members.
Duration of dispatch is generally two weeks and average duration of practicing medical care is nine or ten days. Level of medical service is treating acute and chronic ill patients in the temporary outpatient clinic. Sometimes we work with local medical staff in the hospital in affected area. Other medical activities are a tentative survey of epidemic spread of infections disease and technical advice and the education of health hygiene to affected people. Maximum capacity of JDR medical team is expected to treat two hundred patients per day for ten days by using coded prescriptions and disposable medical materials. The operations are independent (self-sufficient) and conducted along the strategy and coordination of UN. After the end of the operation we definitely submit a brief report about our activities and problems and suggestions for future medical managements to the government and the local authorities.

3) A standard list of our luggage.

Medical equipments and supplies and groceries are well arranged packed in same-sized duralumin boxes. We also bring along two big air tents for the clinic. Total weight is almost 2.5 tons.
2. Needs assessment of the place for the medical services

Making the decision of the place of the clinic is one of the important issues to provide medical services effectively. We generally follow the request of the disaster management center but in Indonesia, JICA also sent assessments team in advance to find the appropriate place of our clinic before the arrival of the main team. After opening the clinic, we regularly check the medical needs of other place according to the information of other donors and the disaster management center.

3. Coordination: connectedness

Another important issue of medical services for disaster relief is coordination for connectedness. In Tsunami disaster three JDR clinic activities were respectively handed over to NGOs and Japanese GO and a UN branch.

4. Gap fillings in provision of available services

The general medical services by activities in clinic is not sufficient to meet the gap in require of victims. These gaps can be identified at the disaster management center meeting and /or the donors’ meeting through activities of regularly survey of medical needs or tentative assessment. JDR also conducts tentative assessments of infectious disease or water and sanitation then the results are submitted to those meetings.

In Indonesia, JDR medical team realized the gap in the sector of public health, so JDR started to collaborate with students of hygiene and public health of Muhamadia University on the education of public hygiene to displaced people.

5. Capacity building for future disasters
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In preparing for future disasters, the first step is undoubtedly the training of triage strategies and first aid. The next step is the establishment of transportation for evacuation from affected area. The third step is quick response from international assistance. Unfortunately, there is no inter-governmental network to coordinate the provision of primary care services in Asia. In urban search and rescue assistance, INSARAG initiates the international cooperation and coordination in the earthquake response.

The first meeting was held between the Japanese and Indonesian medical teams at Jakarta on October 12. Dr Hsujudi, Ministry of Health and Iijima, Ambassador of Japan attended this meeting. At the meeting, several issues were discussed and some proposals were recommended. After the meeting, a TV conference of experts of mass casualty in four Asia countries (Indonesia, Philippine, Malaysia and Japan) was held on Oct 17th supported by JICA and WHO. It was about one month before the Tsunami. These meetings were very fruitful and it was good timing that it helped us to facilitate medical services smoothly and effectively in for the tsunami relief of Indonesia.

**In conclusion and proposal:**
1. We provided primary care services in Sri Lanka, Thailand, Indonesia and Maldives simultaneously within the first month after the tsunami disaster in Asia.
2. Needs assessments, Coordination and Gap fillings in our operations are relatively acceptable
3. Capacity buildings are still to be established.
4. It is necessary to make inter-governmental network and coordination of primary care services in Asia like INSARAG in urban search and rescue as soon as possible.