

outreach activities, which interface directly with federal/state/tribe/territory animal health stakeholders. NVS team members work hand-in-hand with these leaders to help develop written NVS-specific plans for their jurisdictions, provide logistics training, and sponsor discussion-based and operations-based exercises in accordance with the Homeland Security Exercise and Evaluation Program.

Conclusion: The USDA NVS exists to provide states/tribes/territories the countermeasures they need to respond to catastrophic animal disease outbreaks created by either terrorists or nature. As logistical experts, the NVS team develops plans for logistical emergency response, manages their supply chain of countermeasures, and helps stakeholders improve logistical response capabilities.

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(A169) Strategic National Stockpile: American Preparedness to a Domestic Biological Attack

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This session offers an overview of the Strategic National Stockpile (SNS) and the Cities Readiness Initiative (CRI), including CHEM PACK. Managed by the US Department of Health and Human Services Centers for Disease Control and Prevention (CDC), “push-packs” of this critical federal cache of pharmaceuticals and medical materiel are at sites located throughout the country. The CDC’s CRI is a federally funded program designed to compliment the SNS and enhance preparedness in the nation’s largest cities and Metropolitan Statistical Areas (MSA) where more than 50% of the US population resides. Through CRI, state and large metropolitan public health departments continue refining plans to respond to a large-scale bioterrorism attack by dispensing antibiotics to the entire population of an identified MSA with 48 hours. The SNS Technical Assistance Review (TAR) will be reviewed, as well as best practices and lessons learned from successful public health emergency preparedness and response programs throughout the US.

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(A170) Health Sector Coordination Following Civil Conflict in Sri Lanka, 2009

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Background: Three decades of internal conflict, displacing 300,000 civilians, in the Northern and Eastern Provinces of Sri Lanka ended in May 2009. Civilians affected by the fierce fighting in the proceeding months were ushered by the military into internally displaced persons (IDP) camps in an area called “Manik Farm” in Vavuniya District until they could be resettled. The Ministry of Health led the provision of health services to the displaced in coordination with the humanitarian

health cluster at the national and field level immediately after of the war.

Methods: The Ministry of Health plans and reports were reviewed, along with reports from health sector partners and national and international guidelines on coordination in humanitarian relief operations. The way the Ministry of Health coordinated with health sector partners via the health cluster was different from other coordination models where military and civil administration were involved in providing humanitarian relief also was compared.

Conclusions: The review shows that the health sector coordination mechanism adapted in Sri Lanka had a clear leadership and guidance for health sector partners according to national plans and frameworks. It was indicated by better health outcomes like mortality and morbidity among displaced population in IDP camps in Manik Farm.

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(A171) Daily Crude Mortality Rate (DCMR) as an Indicator to Measure the Success of Provision of Services to Internally Displaced Population (IDP) in Sri Lanka

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Background: Sri Lanka’s 28 year protracted civil conflict between the government forces and Liberation Tigers of Tamil Eelam (LTTE) in the North of country saw dramatic end by May 2009 when the military forces succeeded in crushing the LTTE. Around 300,000 people were displaced due to the conflict and they were settled in welfare villages established in the North.

Discussion: The Government of Sri Lanka working in partnership with all other actors mounted a major humanitarian response to address the needs of the war displaced population. The Ministry of Health took a leading role in coordinating the health care programs for the Internally Displaced Population (IDP).

Observations: Higher morbidity and mortality observed during early phase of settlement of IDPs was due to the results of two scenarios, one being the conflict situation and its direct consequences that have caused injuries, disabilities and mental trauma among the population. The second being the result of the collapse of the health system in conflict affected areas, long period of displacement of people and the disruption of social structures that have led to the indirect consequences of increase of infectious diseases and worsening of chronic diseases. Ministry of Health used Daily Crude Mortality Rate (DCMR) to measure the success of the response. According to the Sphere Project guidelines that developed a set of minimum standards in a disaster situation, the DCMR should be 0.25 per 10 000 population for South East Asia. The emergency threshold level is 0.5 per 10 000 per day for this region.

Conclusions: Of the number of people reaching the IDP welfare villages in early stages of emergency phase in May, DCMR averaged to 0.7. The figure settled to less than 0.5 per 10000 in June 2009. Thereafter daily DCMR remained less than 0.5 indicating success of the provision of care for IDPs.

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