opportunity offered to us to help a sister nation, we reiterate that we are engaged, if required again to respond with the same promptly and sense of humanity shown so far.
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(P1-19) Disaster Medical System in APEC Japan 2010

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Background and Method: The preparedness for mass casualty is needed in political event. We have the experience to build up the disaster medical system in G8 summit in Okinawa and Hokkaido. But these two areas were resort area which had little population. This time Japan hosted APEC JAPAN 2010 which held in Yokohama City. We reported disaster medical system for this event in big city.
Result: We mobilized DMAT from 21 hospitals whole Japan. We set 11 teams in Yokohama city, 10 teams in 2 Airports. DMAT inspected rerated disaster base hospitals. These hospitals made the plan for receive mass casualty included the victims by CBRNE event and had the exercise. They set up the decontamination system during APEC leader's week. We also have the contingency plan to coordinate with fire department. This contingency plan included transportation plan for hospitals and coordination plan in site. In transportation plan, sever casualty transported dispersal for hospital in Yokohama within 25. For over 25, sever casualty transported intensive for 4 hospitals in Yokohama. After stabilization treatment in these hospitals, the casualty transported dispersal from these hospitals to outside of Yokohama. In coordinate plan in site included job description in command and control, decontamination and medical relief post.
Discussion: We established disaster medical system for APEC JAPAN 2010. This event hold in Yokohama City had the big population. Compare with former G8 summit, medical system put importance in mass casualty event. As a result, non mass casualty event happened. But this preparedness will contribute not only future same kind events but also accidental mass casualty event such as train accident.
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(P1-20) Disasters and Women's Health: The 2010 Earthquake in Haiti

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Background: Recent reports have highlighted the health disparities that women and other vulnerable populations experience following disasters. Humanitarian groups have struggled to implement effective measures to mitigate such disparities during subsequent disasters.
Objectives: To analyze and provide practical solutions to mitigate barrier's to women's health encountered in Haiti following the 7.0 magnitude earthquake in January 2010.
Methods: In February 2010, a New York based team of emergency and international medicine specialists staffed the mobile emergency department in Port au Prince at L'Hôpital de l'Université d'Etat d'Haïti.
Results: Common presentations included infectious diseases, traumatic injuries, chronic disease exacerbations, and follow-up for earthquake-associated conditions. Female gender-specific problems included vaginal infections, breast pain or masses, pregnancy-related concerns, and the effects of gender-based violence. Identified barriers to effective gender-specific care included communication, camp geography, supply availability, and poor inter-organization communication.
Discussion: Recent disasters in Haiti, Pakistan, and elsewhere have challenged the international health community to provide gender-balanced healthcare in sub-optimal environments. Much room for improvement remains. Although our assessment team was gender-balanced, improved incorporation of Haitian personnel may have enhanced patient trust, and improved cultural sensitivity and communication. Camp geography should foster both patient privacy and security during sensitive examinations. This could have been improved upon by geographically separating men's and women's treatment areas and using a barrier screen to generate a more private examination environment. Women's health supplies must include an appropriate exam table, emergency obstetrical and midwifery supplies, urine dipsticks, and sanitary and reproductive health supplies. A referral system must be established for patients requiring a higher level-of-care. Lastly, improved inter-organization communication and promotion of resource pooling may improve treatment access and quality for select gender-based interventions.
Conclusion: Simple inexpensive modifications to organized post-disaster medical relief settings may dramatically reduce gender-based healthcare disparities.
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(P1-21) Medical Disaster Relief after the 2009 American Samoan Tsunami: Lessons Learned

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Background: Tsunamis most commonly occur in the "Ring of fire" in the Pacific due to frequency of earthquakes and volcanic activity. Damaging tsunamis occur 1–2 times yearly. On September 29, 2009, an earthquake on the Pacific floor caused a tsunami that struck American Samoa, Samoa and Tonga, with only 20 minutes warning.
Objective: To evaluate the disaster response in American Samoa by emergency medical services (EMS), the territorial hospital, and the Department of Health.
Methods: A retrospective review of EMS logs, public health records, hospital emergency department charts, and key-informant interviews over a 2-week period. Descriptive statistics were used to evaluate data.
Results: Three 5-meter waves struck the American Samoan islands, with land inundation as far as 700 meters. Many low-lying villages, including the capital city Pago Pago were affected.