

outbreaks during and after disasters caused by natural hazards and describes comprehensive prevention and control measures. The natural hazard event that causes a disaster does not transmit infectious diseases in the immediate aftermath of the disaster, nor do dead bodies. During the impact phase, most of the deaths are associated to blunt trauma, crush-related injuries, burns, and drowning rather than from infectious diseases. Most pathogens cannot not continue to survive in a corpse. The remaining survivors are the ones from which infectious diseases can be transmitted under appropriate conditions created by the natural disasters. Among several diseases, diarrheal diseases, leptospirosis, viral hepatitis, typhoid fever, acute respiratory infections, measles, meningitides, tuberculosis, malaria, dengue fever, and West Nile Virus commonly were described days, weeks, or months after the disaster event in areas where they are endemic. Therefore, diseases can also be imported by healthy carriers among a susceptible population. The objective of the public health intervention is to prevent and control epidemics among the disaster-affected populations. The rapid implementation of control measures should be a public health priority especially in the absence of pre-disaster surveillance data, through the re-establishment and improvement of the delivery of primary health care and restoration of affected health services. Adequate shelter and sanitation, water and food safety, appropriate surveillance, immunization and management approaches, as well health education will be strongly required for the reduction of morbidity and mortality.

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(P1-84) Application of an Indian Public Health Standard for Evaluation of Community Health Centers of Rajasthan, India

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Background: Community Health Centers (CHCs) constitute the secondary level of health in India. However, these centers are fulfilling the tasks entrusted to them only to a limited extent. In order to provide quality care in these CHCs, Indian Public Health Standards (IPHS) are being prescribed to provide optimal expert care to the community and to maintain an acceptable standard of quality of care. These standards would help to monitor and improve the functioning of the CHCs.

Objectives: The aim of this study is to apply the IPHS for evaluation of the CHCs of Rajasthan.

Methods: A cross-sectional observational study was conducted during August to October 2010. Four CHCs of Rajasthan were visited and data were collected in a pre-designed Performa. The quality of services provided in the selected CHCs as per the IPHS norms was assessed.

Result: All the four CHCs were rendering the assured services of the outpatient department, 24-hour general emergency services, new born care, normal delivery, and referral (transport). All CHCs had full-time physicians, but only three (75%) had surgeons and obstetricians, two (50%) CHCs had pediatricians. One (25%) had anesthetists and one (25%) had a program manager. There was a blood storage facility at one (25%) CHC.

Nursing staff were adequate. Basic laboratory facilities were available in all CHCs.

Conclusions: The present study revealed important deficiencies as per IPHS norms in the studied CHCs so that adequate measures can be taken to improve the healthcare facility.

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(P1-85) Health Seeking Behavior Post-Unintentional Household Injury in Hong Kong

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Background: Unintentional household injuries are a major public health problem that affects large numbers of people. Various population-based surveys from the literature showed > 40% of households reporting an injury that required medical attention. However, there is a general lack in comprehensive population surveys to highlight the risk of post-injury, help-seeking behavior and its associated financial cost. This study is part of the urban, home-based injury epidemiological study series (2007–2010) in Hong Kong.

Methods: A population-based, cross-sectional, random telephone survey was conducted using the last birthday method in 2009. A study instrument was developed and validated based on the modified Chinese World Health Organization guidelines for injury and violence surveys.

Results: The study population comprised of non-institutionalized, Cantonese-speaking Hong Kong residents ($n = 6,570$). Among the 39.4% self-reported injuries within the past 12 months, only 8.6% of injured people had sought medical care. Respondents tended to seek medical care from the private setting in the first episode of post-injury treatment. Among health seekers, 70% of the injured participants reported having to seek a second treatment and the care-seeking pattern shifted from private to public medical service delivery setting. Predictors of service preferences were identified and discussed.

Conclusions: Medical care seeking patterns post-unintentional household injury was identified. Medical and emergency services providers may wish to consider health service implications.

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(P1-86) Socioeconomic Impact of Natural Disasters in China

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Introduction: China is one of the countries most affected by disasters caused by natural hazards. Disasters comprise an important restricting factor for economic and social development.

Methods: Retrospective analysis was performed based on the epidemiological data of disasters caused by natural hazards in recent two decades.

Results: The deadliest disaster that was reviewed was the Sichuan, Wenchuan earthquake on 12 May 2008 with a death toll of 88,928. Floods were the the primary natural hazard resulting in disaster in China. The economic loss caused by natural disasters

was huge, the Sichuan earthquake alone resulted in an economic loss of 845.1 billion Chinese Yuan. However, psychosocial factors did not receive attention by Chinese Government and academics. **Conclusions:** The characteristics and impact of disasters should be analyzed to scientifically provide useful information for natural disaster mitigation in China.

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(P1-87) Preparedness of Healthcare Facilities for an Influenza Pandemic - Protecting the Healthcare Workers

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Aim: To assess the preparedness of hospitals with respect to protecting health care workers (HCWs) during a pandemic.

Methods: A self-administered questionnaire was performed between November 2009 and January 2010, and a scoring system was developed to provide a quantifiable measure of preparedness.

Results: A total of 12 hospitals in NSW, Australia, were approached – six regional hospitals (RHs) and six tertiary referral centres (TRCs). The study was extended to assess three hospitals in England, allowing a limited comparison between the hospitals in Australia that had faced the initial wave of the H1N1 (“swine flu”) pandemic and the hospitals in the UK that had more time to prepare for the outbreak. Response rates were 66% from the TRCs, 33% from the RHs, and 100% from the English hospitals. The overall preparedness scores were relatively high, with a median TOTAL score (adjusted) of 50.75 out of 70. The demographic that scored the highest Total was tertiary referral centres in Sydney. All English hospitals scored below the median. However, the range of scores across hospitals was quite narrow (45.1 – 57.1 adjusted). Scores were generally high for the areas of Preparedness, Infection control, Education and Training. Scores for Vaccination were more variable. The category that consistently demonstrated the lowest scores was that of Psychosocial Welfare and Assistance, despite this being found in previous research to be an integral part of that which HCWs have identified as important.

Conclusions: Given their integral role in pandemic response, protecting HCWs must be a priority as part of any pandemic preparedness plan. This goes beyond protection from infection, extending into aspects of physical and psychological wellbeing. Identifying these issues and addressing them is the key to maximising staff support and morale, and minimising staff absenteeism at such a crucial time.

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(P1-88) Development of a First Hospital Based Trauma Registry at JPN Apex Trauma Center, India

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Although Injury is being looked into as a major public health problem in India, most of the data coming is mortality related data from the National Crime Records Bureau and projections based on that data. There is complete absence of injury

related data both surveillance data as well as outcome based data. Apex Trauma Center, All India Institute of Medical Sciences, New Delhi is one of the pioneering centers to understand the need to record the injury related data of all trauma cases which are admitted to the Apex Center, thus establishing a first of its kind hospital based Trauma Registry in India. This trauma registry will serve as a means for collating trauma data that will further help in the evaluation, prevention, and research of trauma care and can be used for quality control and planning future research and injury prevention activities, in India. Later, the center has an objective of networking all regional hospitals for data collection with an aim to establish a National Trauma Registry. Although several trauma registry software's exist from Western hemisphere but the Apex Trauma Center decided to formulate and designed its own Trauma Registry form and develop the related software which includes: Basic Identification; Demographic profile; Brought by personnel and vehicle; Condition at time of arrival; ED Interventions; Detailed Diagnosis; Definitive Procedures; Disposition/ Outcome The Trauma registry is being maintained, under the leadership of a Faculty and the data is collected and entered by the Trauma Nurse Coordinators, who follow the patient from admission to discharge. The data collection for the JPNATC Trauma Registry had started w.e.f. April 2009, but initially there were usual problems of data loss and non-availability of data. This has been overcome gradually and we hope that the registry will attain its full potential in another year or so.

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(P1-89) Psychosocial Tsunami- Financial Crisis

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Psychosocial Tsunami Financial Crisis Tragedies produced by nature have patterns similar to psychosocial emergencies. The disruptive effects impact on Public Health. Unemployment covers society and doesn't allow personal aptitudes to emerge and sinks people in hopelessness. There is a perception of constant risk. People are in alert with all the effects of sharp and chronic stress and in some occasions Post Traumatic Stress.

Objective: To get an efficient answer to reality from this impoverished group with severe effects facing working uncertainty and unsatisfied basic needs. To avoid the social tragedy to be a big wave that sinks a big part of the population very quickly. To train people on the importance of work to get a better quality life for each participant, the family and community.

Methodology and Diagnosis: 6200 people were trained in twenty months and motivated to work in a population of 95000 citizens approximately. They got a salary and social security financed by the government and articulated with the NGO. They were organized according to working experience and abilities and a supervisor was elected every ten people. Each participant had been polled to reach these conclusions. Industrial security, health care, and group work abilities were some of the syllabus topics. Some of the tasks performed were: painting, gardening, public places embellishment and fixing, administrative duties, river cleaning, etc.