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 if 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.

Conclusion: 90% of labour inclusion among unemployed people. Acknowledge from the participants of their working abilities. To generate hope in uncertainty diminishing violence. Generate space to diminish stress with impact in cardiology matters, addictions and pathologies. The disruptive effects of financial crisis are diminished considerably in these groups.
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(P1-90) Guidelines for Psychosocial Support for Uniformed Services

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In the Netherlands in 2010, the multidisciplinary guidelines for the psychosocial support of uniformed services organizations (USOs) were developed. These guidelines are accepted as a national standard for psychosocial support for police, firebrigade, ambulance services, the Ministry of Defence, and coast guard. This presentation will focus on the backgrounds, development, and status of these guidelines, and an outline of the contents will be given. Members of USOs consistently are exposed to potentially shocking events. It was recognized that there is a need in the field for clarity and unambiguity about the organization of psychosocial care to this group. The goal of the guidelines is to guarantee optimal psychosocial support and care after experiencing disasters and shocking events, so that stress-related health problems among members of the emergency services are prevented. The guidelines are evidence-based, i.e., they are based on the results of the latest scientific studies, knowledge from experience (best practices), and other considerations. Consensus was reached that the promotion of the existing means of recovery of the USO member, and the facilitation of these means by peer support structures, are the key to a successful psychosocial support system. The peer support system has an important role in recognizing those affected with psychological and/or serious clinical symptoms that require diagnosis and/or treatment. Diagnosis and treatment should be exercised by mental health professionals. Therefore, they must be readily available, but should only be deployed when necessary. Three phases in the psychosocial support for USO members are discerned: (1) preparation (selection, information and training); (2) peer support and monitoring, (3) and referral for professional care (if necessary). The guidelines provide recommendations for the USO for each of these phases. National guidelines such as these should be discussed internationally to see whether they can provide a basis for further (international) implementation and use.
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(P1-91) Beyond Emergency Care and Compensation: A Study on the Long Term Implications of Firearm Injuries for Psychosocial Well Being

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The field 'Public Health in Disasters and Complex Emergencies' is replete with either epidemiological studies or studies in the area of hospital preparedness and emergency care. The field is dominated by hospital based or emergency phase related literature. The social science perspective to public health is largely missing. It is in this context that the study of 26/11 Mumbai Terror Attack Survivors, was carried out. The study is an outcome of the ongoing work with the survivors over a period of two years following the attack. The qualitative study uses a case study approach and focuses on lived experiences of the 26/11 Mumbai Terror Attack Survivors who had firearm injuries. The paper highlights the special health issues faced by the survivors, issues of professional competence, hospital preparedness as perceived by the survivors, issues with disability assessments and issues of ill informed care and compensation policies. The paper also explores the interface between health and psychosocial well being two years after the attack and proposes a conceptual framework for understanding psychosocial well being of survivors within a public health perspective.
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(P1-92) Safety Function Action: Current and Future Directions

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Introduction: SAFETY FUNCTION ACTION for Disaster Responders (SFA) trains a framework for achieving and maintaining a high level of disaster health. Within SFA, disaster health is defined as, "maximal safety, optimal function, and effective action in preparedness for, and response to, emergencies, disasters, and extreme events." A set of six strategies forms the backbone of the framework with two strategies each for SAFETY (safeguard and sustain), FUNCTION (comfort and connect), and ACTION (advise and activate).
Methods: During 2008, a total of 2,553 participants were trained throughout the State of Florida. Participants were drawn from public health, healthcare, mental health, and professional/volunteer emergency responder workforces. During 2009, an additional 861 participants were trained as "SFA facilitators." Facilitators were provided with guidance and training materials to return to their worksites and train peers on the SFA modules. Facilitators were in direct contact with a team of 5 DEEP Center "coaches" who supported their training efforts. To assess the training's effectiveness, pre/post-assessment data on the 2,533 SFA participants and 861 SFA facilitators were collected.
Results: Live-training evaluation data showed highly favorable quality ratings for the course, materials, presenters, and all individual course components. Pre/post comparisons of the data indicated consistent gains in self-reported confidence ratings for all 7 "facilitator skills" (recruiting, motivating, training colleagues; teaching SFA skills, working with coaches) and 15 SFA "strategies and response skills" (applying the six SFA strategies to responders (self, family, team) and disaster survivors). Consistent gains were evident for 12 scales asking facilitators to self-report their comfort in dealing with disaster survivors exhibiting distress or suffering trauma and loss.