Conclusions: Survivors emphasized immediate emergency response that address primary needs. Communities showed resilience that can be bolstered by working through local structures. Early adjustment of key survivor-helpers can facilitate societal recovery. The role of organizations (school) and faith in adjustment should be recognized.

Keywords: cohesion; earthquake; qualitative; resilience; spirituality; survivor
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(H66) Capacity Building in Emergency Medicine—An Initiative following the Tsunami in Sri Lanka

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The 2004 tsunami devastated 15 districts in Sri Lanka. Nearly 50,000 lives were lost and about 10,000 are missing. More than two million people were displaced. Many survivors of the tsunami suffered serious mental and physical damages, and lost their hope for the future.

In this context, the Institute of Human Development and Training (IHDT) started a pilot project called the Public Health Education and Emergency Preparedness Initiative in Kahawa. Kahawa is below sea level, and the major source of income for the community was coral mining. The project covers all the stakeholders in the community including the local authority, schools, beach hotels, community-based organizations (CBOs), etc. A lecture series was held to educate the community on how to cope with disasters and manage the responses. Workshops on disaster management and first aid also were held for community leaders. Participants were trained on how to use emergency medical facilities during a disaster. The community is better prepared in emergency health care to face future disasters.

This paper analyzes the post-tsunami scenario in southern Sri Lanka and the initiative taken to prepare vulnerable communities. It describes the challenges of extending this project to a national level and provides conclusions and recommendations based on the experience.

Keywords: capacity building; community; disaster; education; preparedness; response
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(H67) Emergency Response Plan for a Teaching Hospital in Sri Lanka

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Introduction: From a medical point of view, *disasters* can be defined as incidents that generate a large number of casualties that exceeds the medical response capacity. Emergency response planning is a key element in disaster preparedness and mitigation.

The teaching hospital (Anuradhapura) manages a large number of external emergencies. It is one of the hospitalsin Sri Lanka that receives the highest number of patients per unit time. From December 2006 to November 2007, there were 16 occasions during which clusters of >15 patients were admitted to the emergency surgical unit. The Working Emergency Response Plan (WERP) of the hospital was initiated in early 2006.

Objective: The objective of this project was to evaluate the existing plan and design a more efficient and flexible working plan by analyzing the responses of emergency team members and studying other emergency plans currently in practice.

Methods: A total of 45 members using the current emergency plan were asked to complete a questionnaire, and two other emergency response plans currently in place were reviewed.

Results: The existing WERP is not adequate to maintain communication and coordination or to use human resources and infrastructure optimally during the management of a mass-casualty incident.

Conclusions: Considering the weaknesses of the existing plan and using the essentials from the other plans reviewed, a new, flexible, revisable plan was designed. The new plan is in the process of implementation. A second study is needed once the new WERP is established to assess its effectiveness.

Keywords: emergency plan; emergency response; hospital; plan; preparedness
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(H68) "We Don't Have a Backup Plan": An Exploration of Family Emergency Preparedness Plans following Stroke

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Introduction: Family preparedness planning is one strategy to mitigate the negative impact of disasters. High-risk populations, such as families coping with debilitating illness, require special consideration depending on the functional limitations imposed by the illness.

Methods: In a qualitative study of family caregiving experiences following a stroke, family caregivers were recruited through rehabilitation centers at the point of patient discharge. Within the first month after the stroke survivor was discharged from hospital/rehabilitation center, family caregivers were asked about their "back-up plan", should they become unable to provide care for the family member who is ill, or in the event of a natural disaster.

Results: Using grounded theory, with the family as the unit of analysis, the findings from these semi-structured interviews with family caregivers (n = 12) showed that the majority of these families did not have a back-up plan in the event the primary caregiver was unable to provide care. Most families would have to rely on the city's emergency respite care programs, because there is no one else to provide the care, or other family members are unable to provide respite. For natural disasters, rural families reported having more supplies, such as generators, extra water, and food.

Conclusions: Families providing daily care for a family member recovering from stroke are at high-risk of being caught off-guard