**Introduction:** Sri Lanka has been divided into 26 districts. These 26 districts are Colombo, Gampaha, Kalutara, Galle, Matara, Hambanthota, Trincomalee, Batticaloa, Ampara, Jaffna, Mullaitivu, Kilinochchi, Mannar, Vavuniya, Kandy, Matale, Nuwara Eliya, Anuradhapura, Polonnaruwa, Rathnapura, Kegalle, Badulla, Monaragala, Puttalam and Kurunegala. Ten key natural disasters have been identified in Sri Lanka as important to develop response capacity. These natural disasters are coastal erosion, cyclones, droughts, earthquakes, epidemics, floods, forest fires, landslides, lightning and tsunamis. Five battalions of the Sri Lanka Army Medical Corps (SLAMC) have been established in various parts of Sri Lanka. These battalions are named 1 SLAMC, 2(V) SLAMC, 3 SLAMC, 4 SLAMC and 5 SLAMC. The Army Hospital, Army Base Hospitals (ABH), and Medical Reception Stations have been located in various parts of Sri Lanka.

**Method:** Each battalion and hospital have Emergency Medical Teams (EMTs) for response to disasters. An EMT consists of: one medical officer, two nurses, two nursing assistants and one ambulance with a driver. There are two EMTs in each battalion and each ABH. The Army hospital has three EMTs.

**Results:** 1 SLAMC is responsible for responding to disasters in Colombo, Gampaha, Kalutara, Galle, Matara, Rathnapura, Kegalle, Kurunegala and Puttalam. 2(V) SLAMC is responsible for responding to disasters in Hambanthota, Kandy, Matale, Nuwara Eliya, Badulla and Monaragala. 3 SLAMC will respond to disasters in Anuradhapura, Vavuniya, Mannar and Mullaitivu. 4 SLAMC will respond to disasters in Jaffna and Kilinochchi dis. 5 SLAMC is responsible for disasters arising in Polonnaruwa, Trincomalee, Batticaloa and Ampara. When disasters happen in adjacent districts, hospitals will respond to those disasters.

**Conclusion:** EMTs will be deployed to the disaster site as soon as possible and do treatments for casualties by staying seven days. The number of EMTs depends on the magnitude of the disaster.

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The Network of Practitioners For Emergency medicAl systems and cRitical care project - A Case Study for Innovative Approach of Cooperation Between End-Users, Policy Makers, and Businesses

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**Introduction:** The Network Of practitioners For Emergency medicAl systems and cRitical care project (NO-FEAR) was funded through an innovative call from the European Commission contained in the Horizon 2020 2016-2017 work program dedicated to Safe Societies - Protecting the freedom and security of Europe and its citizens.

The call assumed that professionals from many different sectors, including medical emergency teams, had little means and time to monitor innovation and research that could be useful to them. Moreover they have little opportunity to interact with academia or industry on these issues.

The project, funded in 2018 under a Coordination and Support Action Call, brings together practitioners, academia, policymakers and the industry involved in the response to medical emergencies, crises and health threats.

Since the very beginning, NO-FEAR has mobilized the vast network created during the project, to share real-time knowledge, experiences, lessons observed and challenges.

**Method:** Qualitative methodology

**Results:** This article intends to present the stages of the project during its journey where the creation of a network of practitioners dedicated to medical emergency services according to the three pillars methodology set in the project and which took place during the Covid 19 pandemic constituted a space to test innovative approaches in the relationship between end user and industry, in the identification of gaps and needs in the field and in responding to them, often going beyond the mandate of the
Implementing Crisis Standards of Care in the Intensive Care Unit: A Scoping Review

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Introduction: Disasters have the potential to cause a surge of patients, some of which may require admission to an intensive care unit (ICU). Due to the high resource requirements of ICUs, normal standards of care may need to be altered to treat more people with limited resources, a care model referred to as crisis standards of care (CSC). The pragmatic implementation of CSC in ICUs due to patient surges from disasters has not been well explored in the literature.

Method: This scoping review guided by the Joanna Briggs Institute methodology for scoping reviews searched medical databases including CINHAL, PubMed, ProQuest and SCOPUS. Articles were included if they reflected on the actual implementation of CSC delivered in ICU as a result of a patient surge from a disaster. Quantitative data was extracted into tables and qualitative content was thematically analyzed.

Results: A total of 17 papers were included in the review. The disaster event that dominated the results was COVID-19. Most papers relayed subjective accounts of how care models were impacted by patient surges. Common themes included the repurposing of other clinical areas to accommodate ICU patients, resource shortages (particularly ventilators) and staff shortages. Moral strain was felt when processes such as palliation and treatment modality were altered due to resource restrictions.

Conclusion: This review highlights the dearth of high-quality research in implementing CSC in ICUs. Understanding the pragmatic experiences of CSC shows not only the logistical insufficiencies that have been experienced, but the moral and clinical repercussions that these insufficiencies have caused. Inadequate preparation for future disasters, particularly short notice disasters, may lead to further implementation of CSC resulting in poorer outcomes for patients and detrimental impacts on healthcare workers. More research into the practical application of CSC in ICU may help mitigate the impact of patient surges from disasters.

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Women are More Infected and Seek Care Faster but are Less Severely Ill: Gender Gaps in Covid-19 Morbidity and Mortality During Two Years of a Pandemic in Israel

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Introduction: In the context of COVID-19 outcomes, global data has deduced a gender bias towards severe disease among males. The aim of this study is to compare morbidity and mortality during two years of the COVID-19 pandemic in female and male patients with COVID-19, as well as to assess length of stay, health seeking behavior time after positive diagnosis, and vaccination differences.

Method: A retrospective-archive study was conducted in Israel from March 1st (patient zero cases) to March 1st, 2022 (two consecutive years). Data were obtained from the Israeli Ministry of Health’s (MOH) open COVID-19 database.

Results: The findings indicate female infections are 1.12 times more likely, across almost all age groups, apart from the youngest (0-19) age groups. Despite this, the relative risk of severe illness, intubation and mortality is higher among men. In addition, our findings indicate that the mean number of days taken by unvaccinated men from positive diagnosis to hospital admission was greater than among unvaccinated women among the deceased population.

Conclusion: Targeted approaches including risk communication which take into consideration sex and gender and the intersecting factors are necessary to engage in the fight against COVID-19 for ensuring the most effective and equitable pandemic response.

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Emergency Healthcare Providers’ Perceptions of Preparedness and Willingness to Work during Disasters and Public Health Emergencies

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Introduction: COVID-19 for ensuring the most effective and equitable pandemic response.

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