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 Results of a Foresight Exercise: Future Threats and Trends in Crisis Management

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Introduction: The challenges that the health systems face in the last years increased exponentially. No matter if we are talking about the impact of the COVID-19 pandemic or the Russian military action in Ukraine, the European health ecosystem is facing new problems. In the light of these uncertainties, we assessed which could be the next trends that can impact the healthcare systems, in order to better prepare and adapt to the new contexts.
Method: Using two foresights exercises (FSE), one in 2018 and the second one in 2022, we identified the most important trends in the political, economic, social, technological, security, environmental and medical sectors that could have an impact on health.
Results: 53 people participated in the first FSE and 40 in the second one. The respondents identified cyber security, an increased reliance on digital technologies for communications, CBRNE management of the patients, centrally coordinated attacks, demographic aging, reduced economic resources, violence against emergency medical staff and the increased need and demand for psychosocial support as the most important trends. Moreover, they considered that wars, hybrid threats, the fake news, pandemics and the influence of artificial intelligence could impact the healthcare systems.
Conclusion: Many of the trends identified in 2018 as having a possible impact on the health system proved to be relevant four years later. Therefore, we consider the FSE a relevant tool in foreseeing the main areas that could have an impact on health and its results could guide the preparedness for the future.

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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

project, creating a community capable of acting at the intersection of policymaker, companies and citizens.
Conclusion: The case of NOFEAR demonstrates how, thanks to a European project, created a network of individuals and businesses that interact and or collaborate with each other can accelerate knowledge driven and sustainable growth of multidisciplinary ecosystems able to mitigate the fragmentation of the emergency medical systems.
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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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