to a lack of clear guidelines and prior preparedness. Learning from these experiences, a contingency plan was prepared after consultation with all stakeholders. It was implemented during 2009 influenza pandemic. The contingency plan identifies: (1) area responsibilities; (2) disaster and screening areas for the handling of patients; (3) isolation and critical care facilities; (4) deployment of manpower; (5) allocation of drugs, consumables, equipment, and sterile supplies; (6) communication and reporting system; (7) awareness, education, and training; and (8) decision-making hierarchy and effective inter-sectoral collaboration. Also, a disaster plan has been prepared that includes standard operating procedures (SOPs) to be followed during infectious PHEs. A hospital infection control manual also has been prepared to address the issue of hospital acquired infections. The contingency plan and SOPs were effective during recent 2009 influenza pandemic in streamlining the response.

Conclusion: A well-documented contingency plan prepared in consultation with concerned stakeholders and implemented by a motivated and committed administration is essential in ensuring uninterrupted services during PHEs. It emphasizes that sound PHE plan is never an accident; it is always a result of high intentions, sincere efforts, intelligent direction, and skillful execution.

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(P1-81) Differences between Radiation Dosages to Which the Radiology Department Staff and the Public were Exposed

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Introduction: In this study, the mean daily and annual radiation exposure of the radiology department staff, other hospital health staff, and public volunteers was compared at Maresal Cakmak Military Hospital in Erzurum, Turkey.

Methods: The NEB.211 Dose–Rate Meter with a Gaiger–Müller counter was used to measure the amount of radiation. Six radiology department health staff carried the NEB.211 device during seven working hours. At the end of the day, total absorbed dosages were noted. The same measurements were also done for the six health staff of the other departments and six non-hospital volunteers. Seventeen additional hours were noted for the non-hospital volunteers. The mean value of 17 hours of daily measurements (3.31 mSv) was added to the both group's working hours measurements and the total daily radiation amounts were calculated.

Results: There was no statistical difference between each three groups in working hours ($p = 0.087$), daily and annual equivalent dosages (for both $p = 0.099$).

Discussion: The radiology department health staff was exposed to radiation under the border of equivalent dosage which is determined by Turkish Automic Energy Authority. Public volunteers were seen as they were exposed the radiation over the determined border of equivalent dosage. Nonetheless, with changes depending on living standards, the physical properties of living spaces and geographical circumstances per capita exposed annual dosage is about 2.4–2.8 mSv throughout the world. There was no significant statistical difference between the amounts of equivalent dosage which were exposed to the radiology department health staff, the other hospital staff and public members.

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(P1-82) Implementation of an Active Vaccination Strategy Increased the Pandemic Influenza A (H1N1) 2009 Vaccine Coverage among Swedish Children

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Introduction: The European Center for Disease Control and Prevention (ECDC) identified young children as a group at higher risk of developing severe pandemic influenza A (H1N1) 2009 infection compared with the general population. Since children have high attack rates and seem essential in augmenting local outbreaks of influenza, vaccination of children was an important objective in the Swedish pandemic influenza A (H1N1) 2009 vaccination campaign. Children < 13 years of age were recommended to take two doses of the pandemic vaccine (Pandemrix®).

Objective: The objective of this study was to compare the vaccination coverage among children 1–12 years of age in different councils in the County of Jämtland, Sweden that either implemented an active advocating or a passive vaccination strategy. The active strategy included direct information to parents promoting vaccination, individual appointments, collaboration between different care providers, and visits of vaccination teams to day care centers and schools, whereas no specific measures, except general information in press and media, were undertaken in councils using a passive approach.

Methods: All pandemic vaccinations in the County of Jämtland were registered in a Web-based registration software system. Vaccine coverage was determined by comparing the actual number of children residing in different councils with the number of vaccinated children.

Results: A total of 4,162 of 6,000 children (69.3%) residing in councils using an active vaccination strategy were vaccinated compared with 5,059 of 9,373 children (53.9%) living in councils using a passive vaccination strategy ($p < 0.0001$)

Conclusions: Implementation of an active advocating vaccination strategy during the Swedish pandemic influenza A (H1N1) 2009 vaccination campaign resulted in a significantly higher vaccination coverage rate compared with a passive vaccination strategy.

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(P1-83) Infectious Diseases Following Natural Disasters: Prevention and Control Measures

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Communicable diseases represent a public health problem in developing countries, especially in those affected by disasters, and necessitate an appropriate and coordinated response from national and international partners. The importance of rapid epidemiological assessment for public health planning and resources allocation is critical. This review assesses infectious disease