WHO Emergency Medical Team Initiative &
‘WHO Minimum Technical Standards and
Recommendations for Rehabilitation for EMTs'

James Gosney MD MPH
Focal Point, WHO Emergency Medical Teams Initiative (ISPRM)
Immediate Past-Chair- Committee on Rehabilitation Disaster Relief (CRDR)
International Society of Physical and Rehabilitation Medicine (ISPRM)

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Speaker’s Note

This presentation was prepared in consultation with WHO. The speaker does not represent WHO.

Nothing to declare.
Severity of SOD impact on health service
## Expected effects of Natural disaster


<table>
<thead>
<tr>
<th>Effect</th>
<th>Earthquakes</th>
<th>Strong Winds</th>
<th>Tsunamis and Flash floods</th>
<th>Ordinary Floods</th>
<th>Landslides</th>
<th>Volcanic and Lava Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of lives</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Severe injuries requiring complex treatment</td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Major risk of communicable diseases</td>
<td></td>
<td></td>
<td>Potential risk following all significant phenomena</td>
<td>(Likelihood increases with crowding and the degradation of sanitary conditions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Damage to health facilities</td>
<td>Severe (structure and equipment)</td>
<td>Severe</td>
<td>Severe but localized</td>
<td>Severe (equipment only)</td>
<td>Severe but localized</td>
<td>Severe (structure and equipment)</td>
</tr>
<tr>
<td>Damage to water supply systems</td>
<td>Severe</td>
<td>Light</td>
<td>Severe</td>
<td>Light</td>
<td>Severe but localized</td>
<td>Severe</td>
</tr>
<tr>
<td>Food scarcity</td>
<td>Infrequent (generally caused by economic or logistical factors)</td>
<td>Common</td>
<td>Common</td>
<td>Infrequent</td>
<td>Infrequent</td>
<td></td>
</tr>
<tr>
<td>Large migrations</td>
<td>Infrequent (common in severely affected urban areas)</td>
<td></td>
<td>Common</td>
<td>(Generally limited)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Vision

Preserving Health

Protecting Dignity

Saving Lives

Mission

Reducing the loss of lives and prevention of long-term disabilities in sudden onset disasters and outbreaks through the rapid deployment and coordination of quality assured Emergency Medical Teams.

https://extranet.who.int/fmt/page/home
Who Are EMTs?

The term EMT refers to groups of health professionals providing direct clinical care to populations affected by disasters or outbreaks and emergencies as surge capacity to support the local health system.

They include governmental (both civilian and military) and non-governmental teams and can include both national and international EMTs.
Key Activities

- Expand Global/Regional Coordination and Partnerships
- Set Standards, Collect Best Practices and SOPs and Create Knowledge Hub
- Implement Capacity Building and Training
- Provide Quality Assurance and Classification
- Deliver Response Coordination and in field Quality Assurance

https://extranet.who.int/fmt/page/home
Benefits of Emergency Medical Teams Initiative

Benefits of a global EMT Initiative include:

1. Governments and people affected by emergencies and outbreaks can be assured of a predictable and timely response by well-trained and self-sufficient medical teams.

2. Medical teams that reach the minimum standard and are quality assured in a peer review process will be more likely to be requested to respond by affected member states and have a streamlined arrival process. Donors including the general public can be assured that the teams they support have reached an international minimum standard and work within a globally coordinated response system.

3. The development of an EMT Community of Practice and the creation of a knowledge hub will allow EMTs to share SOPs and best practice. Operational research and development by WHO partners will improve EMT performance.

4. National & Regional EMTs will be capacitated to prepare & respond to domestic, sub-regional & regional events. This will ensure an even more timely and appropriate response to health emergencies in the future.
All health systems are comprised of a series of escalating levels of care from basic primary health to district hospitals to regional referral centres, and it is common practice for patients to move between all levels of care. EMTs in an SOD support the surge in demand at each of these various levels or temporarily replace damaged facilities.

This conceptual model also shows the value of:

- a pre-existing knowledge of context and capacity
- rapid assessment of facilities and surge in demand can be used to calculate estimated needs for EMT surge capacities
- similar calculations are possible for an outbreak, but likely to be over a slightly longer timeframe, whereas a “no regrets” approval will be needed for trauma-related events

this model also shows the importance of Ministries of Health leadership in distribution or tasking of EMTs to cover the needs based on an initial impact assessment.

https://extranet.who.int/fmt/page/home
## WHO EMT Classification

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Mobile</strong></td>
<td>Mobile outpatient teams: teams to access the smallest communities in remote areas.</td>
<td>&gt;50 outpatients a day</td>
</tr>
<tr>
<td><strong>1 Fixed</strong></td>
<td>Outpatient facilities +/- tented structure</td>
<td>&gt;100 outpatients a day</td>
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<td><strong>2</strong></td>
<td>Inpatient facilities with surgery</td>
<td>&gt;100 outpatients and 20 inpatients 7 major or 15 minor operations a day</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Referral level care, inpatient facilities, surgery and high dependency</td>
<td>&gt;100 outpatients and 40 inpatients, including 4-6 intensive care beds; 15 major and 30 minor operations a day</td>
</tr>
<tr>
<td>Specialized care team (eg rehab, surgical, paediatric, infectious disease)</td>
<td>Teams that can join local facilities or EMTs to provide supplementary specialist care</td>
<td>Variable</td>
</tr>
</tbody>
</table>

Adapted from ‘Minimum technical standards and recommendations for rehabilitation for EMTs’. WHO (forthcoming).
Global Classification & Verification

“Strengthen National capacity”

“Ready for International deployment”
Haiti

- **300** Teams deployed

Philippines

- **83** Total number of EMTs registered on arrival
- **151** Total number of EMTs deployed, and actively engaged in coordination
- A total of **193,647** consultations were recorded by the **83** reporting teams

Vanuatu

- **28** Total number of medical teams deployed
- **169** Total number of international medical staff

Ebola Outbreak

- The Ebola response was the largest deployment of EMTs for an outbreak
- **58** teams and over **4,000** staff

https://extranet.who.int/fmt/page/home
China and Russia teams join WHO's Emergency Medical Team Initiative

24 MAY 2016 - GENEVA - The Director-General of the World Health Organization has presented letters of certification to Emergency Medical Teams (EMTs) from China and Russia confirming that they are capable of providing mobile emergency field hospitals and staff members in response to natural disasters and disease outbreaks.

“I would like to thank both countries for their participation in this process and congratulate them on this worthy achievement,” said Dr Margaret Chan.

The Emergency Medical Teams (EMTs), 1 from China and 2 from Russia, completed WHO’s rigorous certification process. “This means that, when a disaster strikes and an affected country requests help, we can quickly deploy medical teams that we know meet our high standards,” added Dr Chan.

Today, Dr Chan will meet with the Head of EMERCOM (Emergency Ministry of the Russian Federation) field hospital, Dr Igor Yalovnevich, and the Head of Zasoria field hospital, Dr Valery Shaburov, to present certification letters to the respective EMTs.

On Sunday, 22 May, Dr Chan met with EMT Lead Dr Zhongmin Liu to present the certificate to China’s National Emergency Rescue Team Shanghai.

China and Russia were among the first countries to sign up for the certification process. China’s and Russia’s teams demonstrated commitment to the WHO’s guiding principles for patient care and met the standards outlined in the document.

Classification and minimum standards for Foreign Medical Teams in sudden onset disasters

“The classification process follows months of engagement with WHO through a peer-to-peer mentoring programme, which provides support from committed experts,” said Dr Ian Norton, who leads WHO’s work on EMTs.

More than 80 EMTs from more than 25 countries are committed to meeting minimum standards required by WHO. That number is expected to rise as many as 200 teams. WHO works with governments and organizations to register medical teams from around the world.

Dring emergencies, EMTs offer a critical role in providing care support to national...
Rehabilitation burden in emergency

ICRC War Surgery

The outcome of surgery is determined by the quality of hospital treatment (resuscitation, surgery, post-operative care, physical therapy and rehabilitation).

Sphere Humanitarian Standards

Surgery provided without any immediate rehabilitation can result in a complete failure in restoring functional capacities of the patient.

Early rehabilitation can greatly increase survival and enhance the quality of life for injured survivors.
WHO Trauma Guidelines

Much of the disability from extremity injuries in developing countries should be eminently preventable through inexpensive improvements in orthopaedic care and rehabilitation.

The consequences to the individual of injuries that result in physical impairment are minimized by appropriate rehabilitative services.

Basic physiotherapy/occupational therapy for those recovering from extremity injuries (especially fractures and burns) is deemed essential at all hospital levels.
FMT Minimum Standards (‘blue book’)

Rehabilitation is one of the core functions of trauma care systems in regular health care and as such FMTs should have specific plans for the provision of rehabilitation services to their patients post sudden onset disaster.

Rehabilitation is included as a core component (either integral or via referral) of any inpatient surgical team while specialist rehabilitation teams may be deployed to provide support to FMTs and hospitals unable to provide rehab services.
CLASSIFICATION AND MINIMUM STANDARDS FOR FOREIGN MEDICAL TEAMS IN SUDDEN ONSET DISASTERS
Why?

- Integration of rehabilitation into early response is not a consideration of many surgical teams
- A more effective EMT response is likely to result in increased impairment and rehabilitation need - not a decrease
- Rehabilitation services are poorly developed in most LMIC
- Identified as a priority area by WHO
How?

- Literature review
- Emphasis on SOD with major trauma
- Highly consultative inter-disciplinary process
- WHO working group including OT, PT, P&O, PRM, and Rehab Nursing
- Contributing organisations including CBM, HI, ICRC, MSF, and WHO
- Reviewed by WHO, EMT leaders, and global professional bodies (ISCOS, ISPO, ISPRM, RI, WFOT, WCPT)
Key Standards

• One rehabilitation professional per 20 beds at deployment with further recruitment depending on case-load and local rehabilitation capacity

• Allocation of a purpose-specific rehabilitation space of at least 12 m² for deployments exceeding 3 weeks

• Deployment of EMTs with at least the essential rehabilitation equipment and consumables

• Reporting of patients with notifiable injuries (spinal cord injury, lower limb amputation, or complex fracture) to the MoH of the host country/WHO coordination cell at stipulated intervals
3.5 Considerations for patient management

3.5.1 Rehabilitation considerations by type of injury

Table 6 lists common traumatic injuries managed by EMTs and the presentation of people with pre-existing disability. Rehabilitation for specific injuries by EMT type is described in Annex 2.

Table 6. Considerations for rehabilitation after common severe traumatic injuries and pre-existing disability in emergencies

<table>
<thead>
<tr>
<th>Patients with spinal cord injury</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimum standards</strong></td>
<td></td>
</tr>
<tr>
<td>1. The host ministry of health/coordination cell should be informed of all patients with suspected spinal cord injury via the established reporting system.</td>
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<tr>
<td>2. People with a long-term wheelchair requirement should be referred rapidly to local providers.</td>
<td></td>
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<tr>
<td><strong>Recommendations</strong></td>
<td></td>
</tr>
<tr>
<td>1. EMTs are encouraged to identify safe transfer options early for patients who have sustained spinal cord injuries, so that they are managed at a specialized centre with experienced rehabilitation staff.</td>
<td></td>
</tr>
<tr>
<td>2. Support from peers with spinal cord injuries can be beneficial; therefore, links should be established with local disabled people's organizations and any community-based rehabilitation programmes after the acute phase.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patients with amputation</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimum standards</strong></td>
<td></td>
</tr>
<tr>
<td>1. Rehabilitation input should commence from the pre-operative stage of care to advise on what level would be best in light of prosthetic availability and functional outcome.</td>
<td></td>
</tr>
<tr>
<td>2. Links with local prosthetic providers and prescription of appropriate assistive devices should be established as early as possible.</td>
<td></td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
<td></td>
</tr>
<tr>
<td>1. Support from peers with amputations can be beneficial; therefore, links should be established with local disabled people's organizations and any community-based rehabilitation programmes after the acute phase.</td>
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</tbody>
</table>
### Patients with traumatic brain injury

**Minimum standards**

1. If long-term mobility deficits are anticipated, a local provider of appropriate wheelchairs and mobility aids should be identified early.
2. The patient should be referred to local providers and peer support groups before discharge.

**Rationale**

In emergencies, mild traumatic brain injuries are often missed, as attention is paid to more visible injuries. Severe traumatic brain injuries are often rare, because of low survival rates. In settings where ventilation equipment is readily available, however, people with severe brain injuries may survive. They will require extensive rehabilitation throughout the continuum of care and perhaps for months or years. A plan for continuing care and links with local service providers are therefore necessary.

**Recommendations**

1. Depending on the anticipated duration of inpatient stay and rehabilitation needs, plans for referral to a step-down facility should be made early and local rehabilitation providers and support networks identified.
2. Cognitive and neurological changes should be monitored with regular, documented assessments.
3. EMTs should establish links with local disabled people's organizations and any community-based rehabilitation programmes.

### Patients with peripheral nerve injury

**Minimum standards**

1. EMTs should identify referral pathways for microsurgery for patients for whom this is considered beneficial.
2. Patients with long-term or permanent nerve injury should be considered for provision of an orthotic device, which should be sought from a local provider to replace any temporary device provided by the EMT.

**Rationale**

Orthotic devices can require continuing maintenance or renewal during the patient's life and in many cases have to be custom-made. Devices should therefore be obtained from a local provider (27, 28).

### Patients with fracture

**Minimum standards**

1. When an inpatient is discharged, restrictions such as weight bearing and follow-up plans such as for removal of a cast or an external fixator should be clearly documented and communicated to the patient, and a telephone number should be obtained for further communication.

**Rationale**

In previous emergency responses, many patients have been lost to follow-up after discharge into the community. Patients immobilized for long periods can develop significant complications, such as contractures or joint ossification. Patients should therefore be given clear information about plans for follow-up and the implications of not receiving timely care (1, 23).
### Patients with burns

**Minimum standards**

1. Rehabilitation should be started in the most acute phase of care. For inhalation burns, respiratory care, such as chest physiotherapy, should be started from day 1 of patient care.
2. When long-term functional implications are suspected, the patient should be referred to appropriate specialist care.

**Recommendations**

1. EMTs should identify local services that can provide long-term follow-up (≤ 18 months) for patients who have severe (second- or third-degree) burns, especially when they cross-joints, are on the face or on any part of the hand.
2. A rehabilitation specialist competent in splinting and scar management, including compression bandaging, should treat patients with severe burns, if possible.

### People with pre-existing disability

**Minimum standards**

1. EMTs should ensure that people with a pre-existing disability have equal access to services by referring to them to appropriate providers when indicated.

**Recommendations**

1. EMTs should incorporate capacity-building into their services and leave local staff with formal training in rehabilitation so that they can manage disability when necessary.
Benefits of integrating rehabilitation

1. Better continuity of care
2. Improved functional outcome
3. Improved quality of life
4. Decreased length of stay
5. More efficient hospital services
Key Standard: Discharge/Referral

- To ensure rehabilitation referrals are managed effectively, the patient & referring EMT should keep a copy of the referral, including at a minimum:
  - functional status, including mobility and precautions
  - assistive devices provided
  - follow-up requirements with the referral team (e.g. repeat x-ray, surgical review, external fixator removal)

- EMTs should keep a current list of all patients who require rehabilitation follow-up post-discharge or after the departure of the EMT and communicate the list to the host MOH/coordinating cell as requested.
Figure 2. EMT rehabilitation referral pathway

* Such as a prosthetic, orthotic or wheelchair
** National facility, IO or NGO

Present to EMT

Triage

Outpatient

Ongoing rehabilitation or support needed beyond the stay of the EMT?

Yes: Referral form

No: Refer to local service provider**

Discharge home

Follow-up rehabilitation required?

Yes

No

Discharge destination
- Safe?
- Accessible?
- Adequate support?

Yes

No

Delay discharge or refer to step-down facility.

Inpatient

Conservative management

Surgical management

Rehabilitation as indicated

Medically stable

Patients with spinal cord injury

Spinal cord injury Specialist centre

Long-term assistive device* required?

Yes

No

Identify & refer to a local provider early
### WHO EMT Classification

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</tr>
</tbody>
</table>

Adapted from ‘Minimum technical standards and recommendations for rehabilitation for EMTs’. WHO (forthcoming).
3.1.1 Skill requirements

Minimum standards

1. Rehabilitation professionals with an arriving team should be experienced in trauma and medical rehabilitation with experience and/or training to work in austere environments.

2. Rehabilitation professionals should comply with the same requirements for practice as in their home country (such as professional registration and licensing) and should work within their scope of practice. Those from countries in which there is no professional certification may practice under the direction and authority of their EMT clinical lead with approval of the ministry of health of the host country.

Type 1: Type 1 EMTs should be able to provide basic rehabilitation care or refer patients to an appropriate EMT or existing local facility.

Types 2 and 3: Types 2 and 3 EMTs, with one or numerous rehabilitation professionals, should be able to autonomously to provide rehabilitation for patients with:
- fracture, including those with external fixation or traction;
- amputation;
- peripheral nerve injury or
- burns, grafts or flaps.

Type 2 and 3 EMTs should be able to provide early rehabilitation to patients with acquired brain injury and spinal cord injury while they await specialist rehabilitation.
## Annex 2. Overview of rehabilitation input by EMT type, and specific discharge considerations

<table>
<thead>
<tr>
<th>Basic fracture (conservative management)</th>
<th>Type 1</th>
<th>Type 2</th>
<th>Type 3</th>
<th>Referral and discharge considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic fracture (conservative management)</td>
<td>• Provide clear guidance on weight-bearing status</td>
<td>• As type 1</td>
<td>• As type 1</td>
<td>• Rehabilitation follow-up</td>
</tr>
</tbody>
</table>
|  | • Provide assistive devices  
  |  | • Advise on range of motion (ROM) and functional use | | |
| Complex fracture | • Provide assistive devices  
  |  | • Advise on ROM and precautions  
  |  | • Functional retraining  
  |  | • External-fixator care  
  |  | • Pain management  
  |  | • Patient and care provider education | • Provide assistive devices  
  |  | • Advise on ROM precautions  
  |  | • Functional retraining  
  |  | • External-fixator care  
  |  | • Pain management  
  |  | • Patient and care provider education | • Clarify time for removal of external fixator  
  |  | • Progression of weight-bearing status  
  |  | • Education about possible complications  
  |  | • Rehabilitation follow-up |
| Spinal cord injury | • Neurological assessment  
  |  | • Refer according to national protocol or specialized care team | • Neurological assessment  
  |  | • Pain management  
  |  | • Functional retraining  
  |  | • Provide temporary wheelchair  
  |  | • Refer according to national protocol or specialized care team  
  |  | • Patient and care provider education | • Neurological assessment  
  |  | • Pain management  
  |  | • Functional retraining  
  |  | • Provide temporary wheelchair  
  |  | • Refer according to national protocol or specialized care team  
  |  | • Patient and care provider education | • Provide temporary assistive devices, including pressure-relieving equipment  
  |  | • Educated on self-care, including bladder and bowel management, and precautions  
  |  | • Referral to local provider for long-term assistive devices  
  |  | • Rehabilitation follow-up |
| Burns | • Advise on appropriate dressing  
  |  | • Positioning, including splinting if indicated  
  |  | • ROM, strength and functional retraining  
  |  | • Refer to burns/plastics specialized care team if indicated  
  |  | • Patient and care provider education | • Advise on appropriate dressing  
  |  | • Positioning, including splinting if indicated  
  |  | • ROM, strength and functional retraining  
  |  | • Refer to burns/plastics specialized care team if indicated  
  |  | • Patient and care provider education | • Identify step-down facility if required  
<p>|  | • Identify providers of local burns/plastics care and/or specialized burns care team for scar management, including compression garments. Long-term rehabilitation follow up required for scar maturation and risk for contracture |</p>
<table>
<thead>
<tr>
<th>Condition</th>
<th>Type 1</th>
<th>Type 2</th>
<th>Type 3</th>
<th>Referral and discharge considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral nerve injury</td>
<td>- Positioning, including splinting if indicated</td>
<td>- Positioning, including splinting if indicated</td>
<td>- Positioning, including splinting if indicated</td>
<td>- Identify microsurgery specialist care early if surgical intervention anticipated</td>
</tr>
<tr>
<td></td>
<td>- Patient and care provider education</td>
<td>- Patient and care provider education</td>
<td>- Patient and care provider education</td>
<td>- Referral to local provider for long-term assistive devices (such as orthotics)</td>
</tr>
<tr>
<td></td>
<td>- ROM, strength and functional retraining</td>
<td>- ROM, strength and functional retraining</td>
<td>- ROM, strength and functional retraining</td>
<td>- Education about possible complications, such as contracture</td>
</tr>
<tr>
<td></td>
<td>- Pain management</td>
<td>- Pain management</td>
<td>- Pain management</td>
<td>- Rehabilitation follow-up</td>
</tr>
<tr>
<td></td>
<td>- Refer to microsurgery specialized care team if indicated</td>
<td>- Refer to microsurgery specialized care team if indicated</td>
<td>- Refer to microsurgery specialized care team if indicated</td>
<td></td>
</tr>
<tr>
<td>Traumatic brain injury</td>
<td>- Basic neurological and cognitive assessment</td>
<td>- Neurological and cognitive assessments</td>
<td>- Neurological and cognitive assessments</td>
<td>- Identify step-down facility if required</td>
</tr>
<tr>
<td></td>
<td>- Refer as indicated</td>
<td>- Positioning, including splinting if indicated</td>
<td>- Positioning, including splinting if indicated</td>
<td>- Identify local providers of neurological rehabilitation. Provide long-term follow up throughout neurological recovery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- ROM, strength and functional retraining</td>
<td>- ROM, strength and functional retraining</td>
<td>- Referral to local provider for long-term assistive devices if indicated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient and care provider education</td>
<td>- Patient and care provider education</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Refer to neurological specialized care team if indicated</td>
<td>- Refer to neurological specialized care team if indicated</td>
<td></td>
</tr>
<tr>
<td>Wounds</td>
<td>- Advise on appropriate dressing, and refer as indicated</td>
<td>- Advise on appropriate dressing</td>
<td>- Advise on appropriate dressing</td>
<td>- Identify plastics specialized care team early</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provide assistive devices</td>
<td>- Provide assistive devices</td>
<td>- Progression of weight-bearing status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- ROM, strength and functional retraining</td>
<td>- ROM, strength and functional retraining</td>
<td>- Education about possible complications, such as infection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient and care provider education</td>
<td>- Patient and care provider education</td>
<td>- Rehabilitation follow-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Refer to plastics specialized care team if indicated</td>
<td>- Refer to plastics specialized care team if indicated</td>
<td></td>
</tr>
<tr>
<td>Amputation</td>
<td>- Basic wound management</td>
<td>- Preoperative advice according to prosthetic availability and functional outcomes</td>
<td>- Preoperative advice according to prosthetic availability and functional outcomes</td>
<td>- Referral to local provider for long-term assistive devices, such as prosthetic and/or wheelchair if indicated</td>
</tr>
<tr>
<td></td>
<td>- Refer to type 2 or 3 or national facility</td>
<td>- Stump management</td>
<td>- Stump management</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provide temporary assistive devices</td>
<td>- Provide temporary assistive devices</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Pain management</td>
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Rehabilitation Specialized Care Team

- Embedded into an EMT or a local facility
- LOS 1 month minimum or same as host team
- Brings its equipment or contracts for its provision
- Aligns services with local infrastructure & practice
- Considers service provision after its departure
Nepal Earthquake (2015) [IASC Level 3]

- Majority of EMTs had no rehab with limited referral

- Limited early data dependent on individual reporting with no EMT injury tracking system

- Creation of an injury rehabilitation sub-cluster (IRSC) at the request of MoHP and WHO for data management, service mapping, referral mechanism implementation and coordination of incoming rehab specialized care teams
Nepal Earthquake, 2015: Health Facility Damage/FMT* Deployment

* Foreign Medical Team Deployment

Health Emergency Operations Center
Ministry of Health and Population
Map Produced: 19 May 2015
HF damage data as of: 18 May 2015
FMT data as of: 20 May 2015 (13:00 hrs)

Note: Location of FMTs are randomly assigned to VDCs. FMT with unknown location is assigned to a district headquarter.
Role of ISPRM CRDR: Nepal response

CRDR leadership

- **Confirmed** FMT policy with WHO Coordination Cell & monitored disaster developments
- **Advised** rehab ISPRM national society-linked teams on FMT registration/reporting procedures & developments
- **Liased** with WHO/MoHP IRSC on response issues including referral of FMTs

CRDR members

- **Coordinated** Australia & Bangladesh FMTs
- **Implemented** earthquake relief funds for local rehab NGO (SIRC)
- **Participated** in SIRC online tele-rehabilitation
Role of ISPRM CRDR: WHO EMTI

- Consulted on development of ‘WHO Minimum Technical Standards and Recommendations for Rehabilitation for EMTs’ (forthcoming) as a reviewing organization and as individual WG members
- Will support ISPRM National Societies in helping individuals and teams meet minimum technical standards & recommendations
  - inform of WHO EMTI and global EMT Classification Process
  - disseminate the rehab standards and recommendations
  - provide relevant humanitarian education/training
  - fill other team needs (logistics, equipment) via financial project support
Annex 3. Resources

Emergency response standards

Physical accessibility

Disability in emergency response

Mental health and psychosocial support

Mobility devices

Spinal cord injury
Acknowledgement

WHO Emergency Medical Teams Initiative
WHO Rehabilitation Minimum Standards Working Group
Terima kasih