

Disaster Rehabilitation Response Plan

Now or Never

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Abstract: There is a strong consensus among humanitarian response authorities for a need for global action by professional organizations to work toward developing a structured approach to provide a coordinated international response during sudden-onset disasters. The aim of this report was to develop a Disaster Rehabilitation Response Plan to enable International Society of Physical and Rehabilitation Medicine to provide leadership and governance role in liaison/coordination with the WHO emergency medical team initiative and other relevant stakeholders to provide rehabilitation input during sudden-onset disasters. The proposed plan uses a “three-tier approach”: *tier 1*, immediate disaster response at a national/international level; *tier 2*, organization and deployment of rehabilitation personnel; and *tier 3*, rehabilitation management of disaster survivors and community reintegration. The International Society of Physical and Rehabilitation Medicine (and its subcommittee, the Disaster Rehabilitation Committee), categorized in the *tier 2*, could provide central leadership role working for the rehabilitation subcluster within the WHO emergency medical team initiative (*tier 1*) and support in coordination, preparation, and management of rehabilitation teams and/or members for deployment to sudden-onset disasters. The Disaster Rehabilitation Committee could also contribute to advocacy, training, and accreditation processes for rehabilitation professionals. The challenge ahead is commitment of countries worldwide to develop comprehensive rehabilitation-inclusive approach to ensure effective delivery of services to communities at risk.

Key Words: Disaster, Rehabilitation, Response Plan, Action Plan, World Health Organization

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The incidence of sudden-onset disasters (SODs) is escalating, with more than 700 major natural and/or technological hazards reported annually for the last decade, affecting more than 270 million people.^{1–3} Such disasters may result in complex injuries, such as traumatic brain injury (TBI), spinal cord injury, crush injury, burns, and peripheral nerve injuries.^{1–3} Furthermore, during disasters, destruction of local healthcare infrastructure and overstretched healthcare systems impact health service delivery resulting in unmet healthcare demands. Therefore, there is often need for international assistance, particularly in low- and middle-income countries (LMICs).¹ In response, the World Health Organization (WHO) and other disaster-related organizations have established various initiatives to improve disaster response/rescue and field management. One of the key programs is the emergency medical teams (EMTs) initiative, which is responsible for the EMT accreditation and registration process, coordination and deployment of EMTs to respond to SODs, integration of rehabilitation professionals into EMTs, development and implementation of the emergency response frameworks (standards and guidelines), etc.^{1,4,5}

Rehabilitation is a holistic approach to patient care delivered by an interdisciplinary team and is defined as “a set of interventions designed to optimize function and reduce disability in individuals with health conditions (disease, disorder, injury, or trauma) in interaction with their environment.”⁶ This definition applies to the disaster settings as well, which includes management of injury/trauma, prevention and management of complications and permanent disability, restoration of functional capabilities, and successful reintegration of survivors into the community.^{2,7} The WHO and other humanitarian organizations acknowledge the importance of rehabilitation-inclusive disaster management plans for continuity of sustainable and comprehensive care in both acute stages and the long term, as the number of people injured exceeds those killed in most disasters.^{1,5} Evidence suggests that provision of rehabilitation programs during the early stages of recovery can reduce disability, improve clinical outcomes, and lead to better participation and quality of life among disaster survivors.^{8–12} Survivors treated in health services with rehabilitation programs with the involvement of rehabilitation physicians have fewer complications, better clinical outcomes, reduced length of stay, and improved life satisfaction compared with patients in centers without an integrated rehabilitation service.^{7,10,11,13–15} The role and responsibility of a rehabilitation professional is multifaceted and requires a mix of skills and training.¹⁶ Their roles are more complex and challenging in disaster settings because of different factors, such as lack of skilled human resources (e.g., allied health personnel), limited access to required services, geophysical challenges,

communication, logistics, sociocultural, and others.^{2,7,8,12} Skilled and competent rehabilitation professionals are crucial to ensure effective delivery of care and empowerment of consumers within the community.¹⁷ The recommended skill requirements for optimal patient care in disaster settings are detailed in Table 1.⁵

Why Do We Need a Rehabilitation Response Plan?

There is agreement among the international medical community regarding the importance of incorporating rehabilitation in each phase of the disaster cycle, which includes preparedness, response, recovery, and mitigation phases.¹⁸ Rehabilitation is the longest and most expensive phase of disaster management and should be accessible to all disaster survivors.⁷ Despite this, rehabilitation services are considered a low priority and frequently neglected in previous disasters, where response plans emphasize saving lives and treating acute injuries. Furthermore, there are disparities between countries, whereby countries with high disaster risk have low coping capacity and limited rehabilitation resources (skilled rehabilitation professionals, infrastructure).⁸ These factors have led to mismatched resources across the entire disaster cycle, with rehabilitation services and medical rehabilitation professionals excluded in disaster response and planning.⁸ Previously, the lack of comprehensive management plans and coordination among the responsible agencies/stakeholders were reported as key barriers for comprehensive delivery of rehabilitation.^{7,19,20}

The 2010 Haiti earthquake disaster response was ad hoc without proper coordination, professional standards, and delivery of quality care, leading to unsatisfactory outcomes and

limited rehabilitation documentation.²¹ The review of EMT deployment in the Nepal earthquake (2015) indicates that although rehabilitation services and community care were prioritized (with the formation of a rehabilitation subcluster), the focus for disaster management primarily was acute medical and surgical care.²² Of the 137 EMTs (from 36 countries) deployed in Nepal, only 6 (4%) were Specialized Rehabilitation Care Teams.²² Importantly, there was poor coordination of EMT handover and/or replacement processes, which impacted the care continuum and overall longer-term survivor management.²³ The deployed rehabilitation teams struggled to coordinate with the relevant authorities for support and/or to formulate a comprehensive exit strategy.²³ The “*Emergency medical teams: minimum technical standards and recommendations for rehabilitation*”²⁴ is a collaborative effort of the WHO EMT initiative, International Society of Physical and Rehabilitation Medicine (ISPRM), and global rehabilitation experts that now sets out the core standards for rehabilitation services in SODs regarding workforce, working areas, equipment/consumables, information management, etc. It emphasizes the need for improved coordination/planning, strengthening rehabilitation capacity of local EMTs, rehabilitative care, and the continuum of care beyond the departure of international EMTs from the disaster zone.²⁴

Disaster Rehabilitation Response Plan

After SODs, the immediate emergency response and recovery efforts are undertaken by national and international responders; however, the mitigation of disaster-related disability can be significantly challenged by the relative absence of a rehabilitation-inclusive management plan. As mentioned, with

TABLE 1. Recommended skill requirements for optimal patient care⁵

1. Rehabilitation professionals 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 EMTs should be able to provide basic rehabilitation care OR refer patients to an appropriate EMT or existing local facility.
Types 2 and 3 EMTs with one or numerous rehabilitation professionals should be able to provide rehabilitation for patients (including pediatric and geriatric) with:
 - fracture, including those with external fixation or traction;
 - amputation;
 - peripheral nerve injury; and
 - 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.
 Essential clinical rehabilitation skills to be represented in the EMT:
 - basic splinting;
 - assistive device prescription, fitting and training;
 - positioning and patient mobilization, including early mobilization;
 - education and retraining of patients and care providers in daily activities;
 - provision of psychosocial support, for example, psychological first aid; and
 - respiratory care, including sputum clearance techniques.
3. Rehabilitation professionals should be deployed primarily on the basis of demonstrated essential skills; however, those deployed within the first 2 weeks of response should have at least 2 years of clinical experience and more if working in a specialized area.
4. Emergency medical teams are encouraged to prepare terms of reference for rehabilitation professionals and define team roles before deployment.
5. Rotation of rehabilitation staff is decided by the EMT; however, a minimum stay of 3 weeks is recommended to provide continuity of care, with sufficient time planned for handover.
6. Efforts should be made to maintain consistency in the treatment approaches of different rehabilitation professionals by the use of guidelines, protocols and common predeployment training.

an increasing number of natural disasters worldwide, there is a need for rehabilitation as part of disaster management.²⁵ The integral role of rehabilitation throughout the disaster cycle from the acute response phase until successful reintegration of survivors into society, based on their clinical needs, is now well recognized.² The disaster rehabilitation care continuum should include community health, with complete integration into the local health service of the affected community.⁸

This report proposes a Disaster Rehabilitation Response Plan (DRRP) to enable ISPRM to provide a crucial leadership and governance role in liaison/coordination with the WHO EMT initiative, other relevant stakeholders, and member national societies to provide rehabilitation input during SODs. The plan recommends a formal policy on rehabilitation-inclusive disaster management, coordination of rehabilitation EMTs and their requirements for deployment (including EMT selection, staffing and configuration), advocacy and training, and research and evaluation.

The key objectives of the DRRP are to:

- Outline a rehabilitation-inclusive action plan and arrangements for prevention, preparedness, response, recovery and resilience after SODs
- Define the role of the ISPRM working in liaison with the WHO in supporting the global EMT initiative in disaster management
- Define the ISPRM Disaster Rehabilitation Committee's role in current and future developments in disaster management
- Describe the roles and responsibilities of rehabilitation medical personnel to support disaster management during the acute, subacute, and long-term phases
- Build capacity of the rehabilitation workforce
- Improve awareness of the importance of rehabilitation in disaster management

Scope

This DRRP extends the minimum standards proposed in the EMT Classifications and Minimum Standards²¹ and Minimum Standards and Recommendations for Rehabilitation⁵ guidelines. The proposed plan and recommendations provided are based on published guidelines, reports, and academic articles on SODs from a rehabilitation perspective.

The "Tier Approach" of the DRRP

The DRRP can serve as a guide for decision-makers and the ISPRM for managing offers and requests for rehabilitation for a rapid and effective disaster-relief response, strengthening of rehabilitation personnel deployment and management systems. However, as disasters and their impact can vary, it is necessary to plan for the type, magnitude, and location of a disaster to ensure that best possible care is provided to those in need. Based on existing deployment and response decision-making processes, and hierarchy of leadership and operational procedures, we propose the following three major tiers for the DRRP:

1. Immediate disaster response at a national or international level
2. Deployment of rehabilitation medical personnel to the disaster setting

3. Rehabilitation management and community reintegration of disaster survivors

A detailed DRRP with its association and coordination pathways is provided in Figure 1.

Tier 1: Immediate Disaster Response at a National or International Level

Tier 1 represents the immediate disaster response at a national or international level and coordination with the WHO and other relevant international/regional organizations (Fig. 2). When a disaster strikes, the local national government and governing healthcare organization (mainly the local Ministry of Health [MOH]) is the authority in management and implementation of existing national coordination structures, mapping existing resources (human resources, infrastructure) and needs assessment, gathering and approving resources, calling for assistance from the civil defense authorities (military, police, private sector, etc.), and activating international systems of cooperation and aid as required. Depending on the scale and nature of a disaster, local governmental and nongovernmental organizations (NGOs) may respond within their own country if local demands can be met.⁴ However, when large-scale disasters occur, the demand may exceed local resources, and affected countries are dependent on global humanitarian and foreign medical assistance.⁷ The WHO is the first point of call for international medical assistance and has introduced an EMT registration process from different parts of the world, for provision of effective and coordinated medical care after SODs.⁵ Other some of the relevant organizations responding to SODs include the following: the United Nations International Strategy for Disaster Risk Reduction, United Nations Office for the Coordination of Humanitarian Affairs, and the Sphere project.²⁶ The United Nations International Strategy for Disaster Risk Reduction serves as the focal point for coordination of disaster reduction, ensuring synergies among member states and systems. The United Nations Office for the Coordination of Humanitarian Affairs coordinates humanitarian action to ensure that disaster survivors receive the assistance and protection they need. The Sphere Standards: *Humanitarian Charter and Minimum Standards in Disaster Response*, clearly outline minimum standards in key areas, such as water, nutrition, sanitation, education, and protection, to ensure that planned assistance is delivered in an accountable and consistent manner.²⁶

All these organizations have a role to play in any disaster under a coordinated mechanism, with the local MOH and the WHO taking responsibility for healthcare needs. The WHO is actively promoting standards and oversees training and accreditation of the EMTs, including rehabilitation. If required and when international health assistance is offered, the local MOH and governing healthcare organization within the affected country are key players, along with the WHO, in facilitating and coordinating EMTs deployment and management. One such example is the Rapid Disaster Response Model across East Asia Summit countries (refer to Appendix 1 in supplement of this article, Supplemental Digital Content 1, <http://links.lww.com/PHM/A873>).²⁷ Most recently, the WHO EMT initiative adopted a decentralized model of disaster management, liaising with the various healthcare organization and governments, and other relevant international NGOs and NGOs, including ISPRM (for rehabilitation needs).

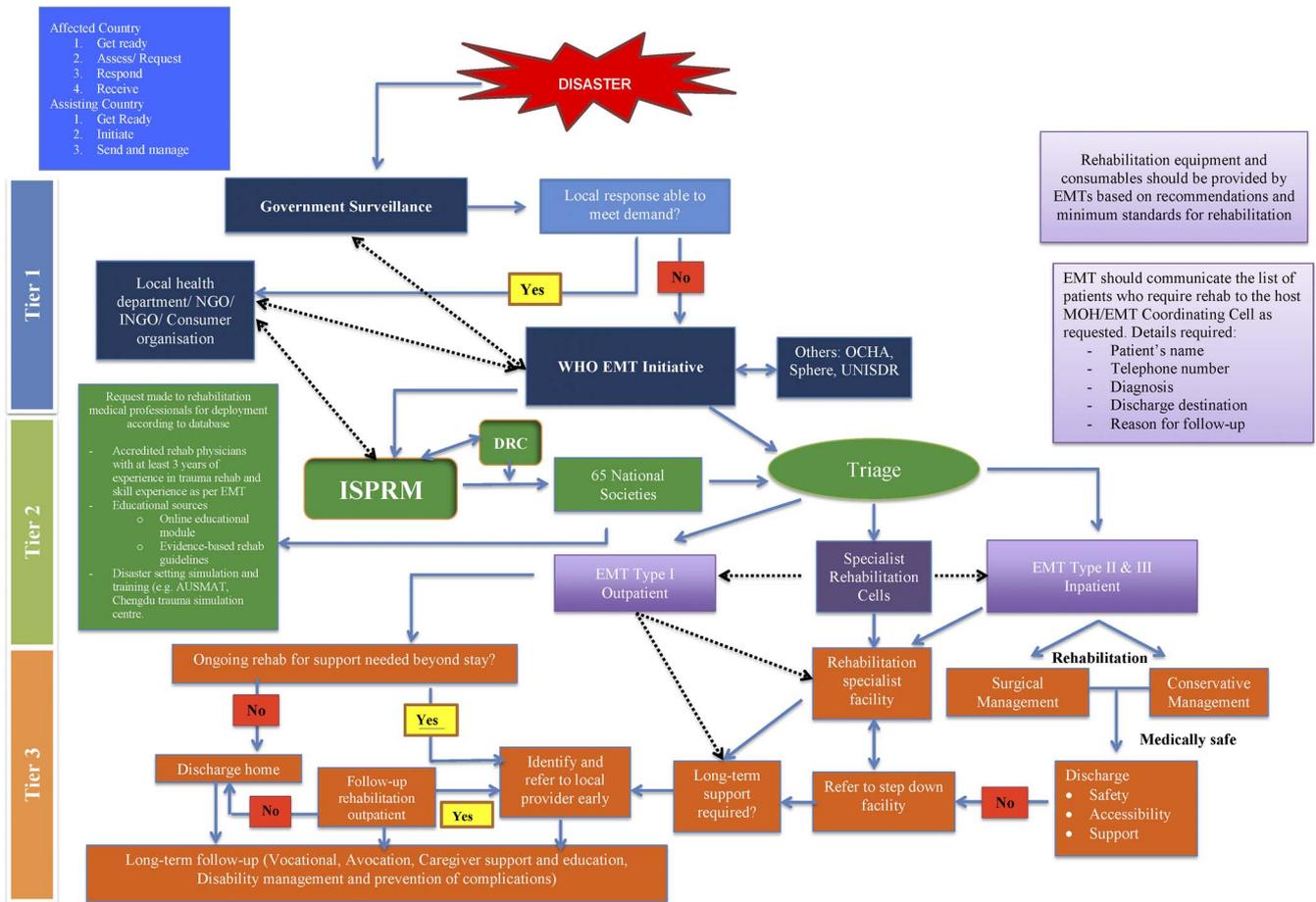


FIGURE 1. Disaster Rehabilitation Response Plan. AUSMAT, Australian Medical Assistance Team; INGO, international nongovernmental organization; OCHA, Office for the Coordination of Humanitarian Affairs (United Nations); UNISDR: United Nations International Strategy for Disaster Risk Reduction.

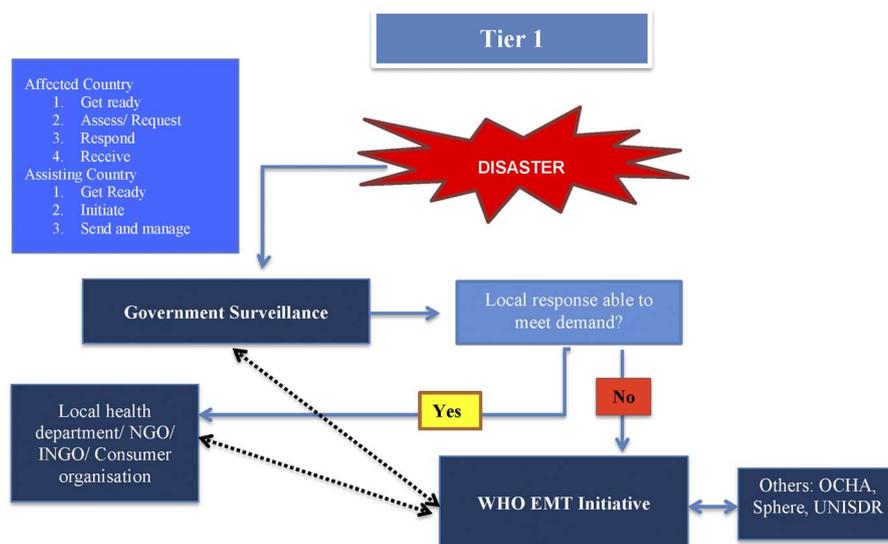


FIGURE 2. Disaster Rehabilitation Response Plan – tier 1. INGO, international nongovernmental organization; OCHA, Office for the Coordination of Humanitarian Affairs (United Nations); UNISDR: United Nations International Strategy for Disaster Risk Reduction.

Tier 2: Deployment of Rehabilitation Medical Personnel to Disaster Setting

In line with the WHO’s *Rehabilitation 2030: a call for action*,²⁸ the Disaster Rehabilitation Committee (DRC) and the ISPRM-WHO Liaison Committee both recognize that building and strengthening rehabilitation capacity through education and training, especially in LMICs, are important in expanding a skilled rehabilitation workforce, for improved service provision and governance, and awareness of rehabilitation (Fig. 3).²⁹ In response to SODs, following the guiding principles of scalability and enabling local responses to rehabilitation needs, the ISPRM and DRC could play a crucial role in organizing, managing, and coordinating both national and international rehabilitation teams (EMTs or specialized cells) to ensure a rapid, professional, and coordinated response. Ideally, the ISPRM (central) should be in contact with the WHO after any disaster alert to identify how rehabilitation resources and management structures at a high level could be used more effectively. Availability of rehabilitation physicians for deployment could be ascertained from the member database (currently in progress) and/or through the 71 National Societies affiliated with the ISPRM. Depending on need, the DRC could propose an accredited rehabilitation team or individual physicians to be integrated into different types of EMTs (refer to Appendix 2 in supplement of this article for EMT classification, Supplemental Digital Content 2, <http://links.lww.com/PHM/A874>). The DRC could have a pivotal role in coordinating with the WHO and various National Societies to ensure that all rehabilitation physicians registered in the database comply with the accreditation process and requirements before deployment. According to the minimum technical standard, rehabilitation professionals should have at least 3 years’ experience in trauma injury rehabilitation, and at least one team member should have experience in emergency response (Table 2). All team members should have undergone training in austere environments.⁵

The DRC members could also provide medical rehabilitation guidance through remote teleconferencing and on-site consultation, raising funds, collaborating with other national and international organizations for knowledge sharing/dissemination, and assistance in development of relevant guidelines and protocols.³⁰ As previously mentioned, rehabilitation guidelines for disasters

have been developed by the WHO and in collaboration with the DRC rehabilitation experts.^{4,5} More recently, various working groups within the DRC are developing injury-specific guidelines, such as *Minimum Technical Standards and Recommendations for TBI Specialist Rehabilitations Teams*, which provide an overview of rehabilitation input for TBI survivors by EMT type.²⁴

The DRC could facilitate and coordinate disaster management training and trauma simulation programs with relevant authorities in different countries, ensuring that members are trained for deployment to future disasters. In Australia, for example, the disaster preparedness and response team of the National Critical Care and Trauma Response Centre provides training for the Australian Medical Assistance Team.³¹ The well-equipped trauma simulation center at Sichuan University in Chengdu, China, could be used by rehabilitation professionals to develop relevant skills and/or upskill to strengthen rehabilitation capacity.

The DRC contributes to the humanitarian agenda by advocating for rehabilitation medicine in minimizing disability, optimizing function, and participation of persons who sustain injury during a disaster or those with preexisting disability.³⁰ It regularly hosts symposia, workshops, and special sessions in national and international scientific meetings to promote disaster rehabilitation. It comprises 10 Specific Working Groups, including *Disaster Preparedness, Response and Recovery, Education and Training, Meetings, Research, Communications, and Finances*, led by respective coordinators to oversee the DRC action plan. The DRC action plan includes the following:

1. Establishment of an ISPRM database of rehabilitation professionals who are willing to undergo disaster training and deployment to disaster settings if requested by WHO
2. Development of evidence-based clinical practice guidelines and protocols for the common disaster-related injuries
3. Development of free on-line training modules for management of common injuries in disaster/austere settings
4. Provision of disaster rehabilitation education and training to nonrehabilitation professional responders
5. Develop and/or trial standardized measurement tools for data collection in disaster setting (e.g., the International Classification of Functioning, Disability and Health Generic-7 set)^{32,33}

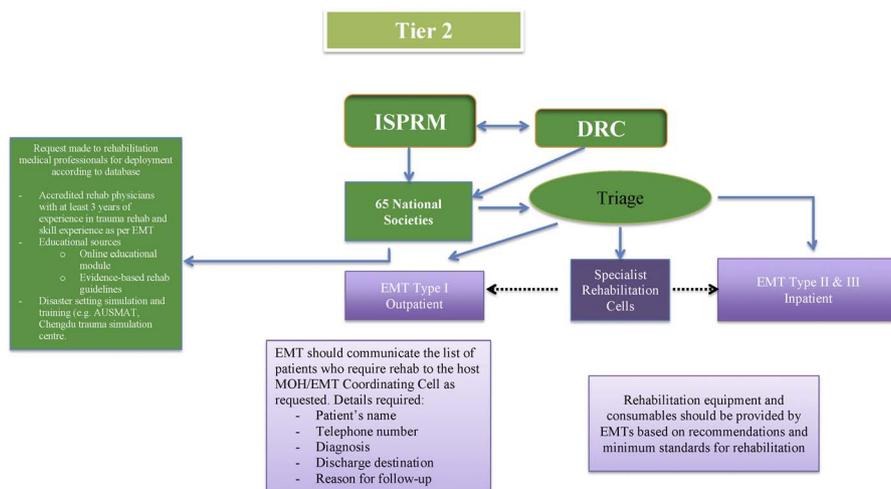


FIGURE 3. Disaster Rehabilitation Response Plan – tier 2. AUSMAT, Australian Medical Assistance Team.

TABLE 2. Minimum standards of the Specialized Rehabilitation Team⁵

1. Multidisciplinary and comprise at least three rehabilitation professionals
2. Teams embedded into a local facility must remain for at least 1 month, unless requested by the facility
3. A team embedded into an EMT should stay for the minimum length of stay of that EMT (3 weeks for a type 2; 4–6 weeks for a type 3)
4. Must either deploy with equipment and consumables required for self-sufficiency for at least 2 wks or provide a written agreement that such materials will be provided by the EMT or local facility into which they will be embedded
5. Must align their services with local practice and consider service provision after departure with mutually agreed structured support for the purposes of local capacity building

Tier 3: Rehabilitation Management and Community Reintegration of Disaster Survivors

The “third tier” DRRP encompasses actual deployment and on-ground operation of deployed teams or members (Fig. 4). After an SOD, specialized rehabilitation care teams/cells or individual members embedded within other EMTs would be deployed after a request from the host country health authorities/WHO, with assessment of needs and required services from the EMT Coordinating Cell (EMT-CC). Adequate assessment and consultation will determine the best structure/skill-mix for the team, as disaster settings vary significantly depending on the type and amplitude of disasters. The DRC with the WHO EMT-CC would ensure that team members adhere to the same guiding principles and core standards as other EMTs (Table 2). All team members will need to comply with professional credentialing and training requirements and be able to physically/mentally perform assigned tasks consistent with local practice. It is desirable that the ISPRM database (currently under development) includes members and/or teams with their availability for a rapid deployment to meet specific needs in disaster settings. Preference would be for local and/or regional teams. The rehabilitation care teams/cells need to adequately prepared to provide not only human resources but also operational and medical supplies, and meet all EMT standards for care of survivors. The rehabilitation teams would coordinate with local teams to avoid service duplication and overriding existing local services’ protocols.

Rehabilitation physicians should be involved in the early disaster response phase for management of acute primary injury, minimization of complications, and transfer for appropriate care. Acute rehabilitation should commence after surgical or medical treatment. Disaster survivors needed to be “triaged” for provision of rehabilitative treatment and management. Those medically ready and safe to return to the community should be discharged from the field hospital or local healthcare facility. Factors for consideration for discharge include the following:

medical stability, accessibility to home (building infrastructure often destroyed in disasters), and presence of support systems in the community. Disaster survivors may be referred to a “step-down” or rehabilitation facility to improve functional independence with support systems in place before they are discharged home. Disaster survivors in ambulatory settings should have a needs assessment for rehabilitation before discharged home. These should be identified early and referred to local health service providers, especially if longer-term support is required (vocational/avocational, caregiver support, disability management, and prevention of complications).⁵ Team members must respect local cultural and ethnic customs of survivors.

The rehabilitation teams should be prepared to make a rapid assessment of the local facilities (including information technology), train local health staff (survivors and family) in rehabilitation and self-care skills, consistent with local practice/culture, so that adequate care is continued after the departure of the deployed EMTs. Where feasible, teams should develop appropriate educational resources in local languages (preferably pictorial) to support patient and caregiver education. All rehabilitation teams and/or team members must communicate regularly with the DRC and EMT-CC. A team exit strategy should be formulated in coordination with the host local MOH, EMT-CC, the DRC, and local rehabilitation services. The EMT-CC/DRC should coordinate a plan for ongoing support (if required), whether departing team replacement is by a local team or another EMT. Core skills required in disaster settings for different professional groups are listed in Table 3.³⁴

DISCUSSION

We propose the DRRP *three-tier approach* as a model for ISPRM to coordinate and deliver comprehensive rehabilitation assistance with WHO and other relevant organizations (if requested) in future disasters (Fig. 1). To our knowledge, any such models are yet to be published. The DRRP emphasizes

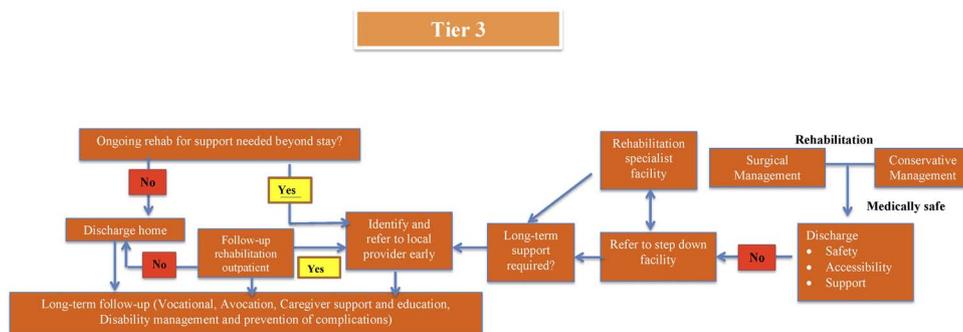


FIGURE 4. Disaster Rehabilitation Response Plan – tier 3.

TABLE 3. Core skills/treatment methods required of rehabilitation professionals in disaster settings³⁴**Rehabilitation physicians and other medical practitioners:**

- Diagnostic and clinical skills
- Prescription of medications and assistive devices
- Communication and education of patients/family
- Knowledge of rehabilitation techniques
- Leadership and managerial role

Physiotherapists:

- Physical functional activities and assessment
- Improving ADLs and patient autonomy
- Neuromuscular rehabilitation
- Patient communication/education

Occupational therapists:

- Improving ADLs and self-management skills
- Home and environmental modification
- Standardized assessment techniques
- Mobilization techniques

Speech therapists:

- Assessment and diagnosis of hearing and communication difficulties
- Speech, language and swallow rehabilitation techniques
- Patient/family communication

ADLs, activities of daily living.

“shared” responsibility of all actors in the disaster management cycle, including local healthcare authorities.²⁹ It highlights the crucial role of the WHO and the ISPRM (and DRC) in organizing, managing, and coordinating both national and international rehabilitation teams (EMTs or specialized cells) to ensure a rapid, professional, and coordinated response.

After the Haiti earthquake response, approaches to disaster management have changed, with improved processes, organization, and coordination between international humanitarian organizations and related international NGOs/NGOs for effective disaster management.^{20,35} With escalating SODs worldwide, there is an inevitable increase in survivors with complex long-term disabling injuries (brain and/or spinal cord injury, burns, trauma). Many disaster-related injuries are now considered preventable, requiring an interdisciplinary management approach, including rehabilitation.^{8,25} As most SODs occur in developing countries (with limited rehabilitation services), calls for rehabilitation assistance are anticipated, and therefore rehabilitation preparation, coordination, and planning are priorities for effective, adequate, and timely international response to SODs. The proposed plan for the establishment of the “Rehabilitation Physician Disaster Training and Deployment Registry” by the ISPRM is a step in the right direction, which will assist in selection and training of appropriately skilled rehabilitation physicians for deployment into EMTs and to exchange information with relevant organizations.

In countries with a shortage of skilled rehabilitation medicine personnel, task-shifting practices can strengthen the healthcare workforce. Skill training of nonmedical healthcare professionals can result in more efficient use of available human resources.³⁴ The authorities should focus on future planning to ensure comprehensive rehabilitation, preventative care, and community reintegration for disaster survivors. Although current developments in disaster rehabilitation are crucial and much needed, there are many challenges ahead, including (but not limited to)²³:

- Integration of rehabilitation into broader disaster management and planning systems
- Mapping the existing rehabilitation services, specifically in LMICs
- Increasing the number of qualified rehabilitation personnel
- Capacity building initiatives (such as courses, conferences, telemedicine, library, etc.)
- Development of systems and processes for organized delivery of rehabilitation care
- Expanding community-based rehabilitation for continuity and longer-term care
- Improving processes relating to clinical documentation
- Improve clinical reasoning for treatments provided
- Development of evidence-based guidelines/protocols/standards
- Development of user-friendly assessment tools, process measures, referrals, discharge forms and reporting systems
- Training of disaster survivors (and caregivers), including psychological support, peer support groups
- Increasing the use of information technology, low-cost local technology
- Provision of key performance indicators, standards of care, and accreditation criteria
- More research and better data for evidence-informed policy

The unmet need for rehabilitation has been widely reported in past disasters especially in LMICs, signifying a need for an integrated rehabilitation-inclusive plan with intersectoral and interdisciplinary partnerships among national and international organizations. The proposed DRRP provides a comprehensive rehabilitation perspective, to facilitate deployment of rehabilitation professionals in EMTs in future disasters. The challenge ahead is the commitment of countries worldwide to develop a comprehensive, targeted, and rehabilitation-inclusive approach to ensure that effective services reach vulnerable communities at risk.

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