

Responding internationally to disasters



A do's and don'ts guide for rehabilitation professionals



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International Society for Prosthetics and Orthotics (ISPO)

<http://www.ispoint.org/>

International Society of Physical and Rehabilitation Medicine (ISPRM)

<http://www.isprm.org/>

International Spinal Cord Society (ISCoS)

<http://www.iscos.org.uk/>

World Confederation for Physical Therapists (WCPT)

<http://www.wcpt.org/>

World Federation of Occupational Therapists (WFOT)

<http://www.wfot.org/>

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OVERVIEW

When disasters strike, there is always a huge amount of goodwill from rehabilitation professionals around the world who wish to use their skills to support those affected. This brief guidance informs those who are considering responding internationally to a disaster either as individuals or as part of a team. It highlights key questions to consider before departing, whilst working in the disaster area, and on returning home. Responses to these questions considered are presented as "Do's and Don'ts" which are exemplified by recommended practices and those to avoid in the real case studies below. The guidance note is not intended to be a step-by-step or technical guide, nor is it exhaustive, and does not supersede any specific guidance provided by your own global professional body.

SUMMARY

- Individuals should only travel to disaster zones as part of an established international organisation or as a member of an Emergency Medical Team (EMT).
- Emergency Medical Teams include any dedicated rehabilitation teams. They are identified in the **WHO classification and minimum standards** as specialised teams, and must register in advance with the **WHO EMT Initiative** (see page 5).
- Those interested in responding to disasters must access appropriate clinical and humanitarian training, normally as part of their team, before a disaster strikes.
- International disaster responders should support not undermine local professionals, who are the experts in their local context.
- Home and host country standards of clinical governance, scope of practice and research ethics continue to apply to international responders in disasters.
- Responders must be accountable to the people they are trying to help, the hosting organization, their team members and those they have accepted resources from.
- Responders must always consider the long term needs of those they work with.

Questions to consider before leaving home, whilst working in the disaster area, and on returning home: Do's and Don'ts

BEFORE LEAVING HOME

1: I am thinking of helping, what should I do to get involved?

DO

- ✓ Consider ways to help without travelling to the disaster area e.g. making donations and supporting disaster relief organisations.
- ✓ Consider your desire to respond **before** any disaster hits and develop your skills and experience appropriately.

DON'T

- ✗ Depart in haste assuming your help is needed (*Chaudry and Beasley, 2013*).

2: Do I have the appropriate skill, knowledge and experience to work in a humanitarian environment?

DO

- ✓ Have an understanding of the **Humanitarian Code of Conduct** and Humanitarian Principles (See page 13) and working cross-culturally.
- ✓ Have specific clinical skills in the management of conditions in resource-constrained environments through either training or working internationally in non-emergency settings.
- ✓ Assess that you have the clinical skills needed for your role – normally at least 2 years of experience in the clinical area you will be working in.
- ✓ Assess if you have the language skills needed, and an understanding of the local context.

DON'T

- ✗ Go without experience or training in humanitarian or resource-constrained environments, having inappropriate clinical skills or without the knowledge or skills to adapt to an emergency environment.

Case Study: Most of the volunteers who came were there for two weeks, so by the time they adapted to the environment, it was time for them to go. Patients as well as the staff had to adjust to a lot of changes due to this practice. Not all the volunteers were experts in emergency management and hence took time to adapt to the new situation in emergency. Psychologically, the staff and patients had to suffer due to this constant adaptation and turn over.

3: Do I have the personal attributes to work in a disaster area?

DO

- ✓ Recognise your own capacity to adapt to an emergency environment.
- ✓ Critically examine your own ability to cope with sustained stress and challenging living conditions without the comforts of home.

DON'T

- ✗ Travel if you are unsure that you are in the right frame of mind to work under sustained stress.

Case Study: When we asked people who had deployed what interpersonal skills they thought were most important, they mentioned things like team work, adaptability, communication, having a good sense of humour and being calm under

pressure. Having experience and the ability to work across cultures was valued, while having previous international experience was also seen as important.

4: How can I personally prepare to work in a disaster area?

DO

- ✓ Discuss your decision with family and friends.
- ✓ Organize emergency contact details.
- ✓ Make a will.
- ✓ Ensure you have all the vaccinations and personal medication you require for the duration of your assignment.
- ✓ Ensure you or your organisation has the personal, medical and professional insurance that is valid in a disaster area (many are not).
- ✓ Be prepared to live in a challenging environment without any of the comforts of home.

DON'T

- ✗ Go without considering the impact on your health, personal life, employer, family and friends and financial circumstances.
- ✗ Travel as an escape from personal difficulties at home.
- ✗ Travel and work as a healthcare provider without the appropriate vaccinations, medications, health insurance, and professional registration and insurance.

Case Study: We found it helpful that our team had trained together before we deployed, including adapted clinical training and humanitarian training, covering everything from humanitarian principles to safety and security to our own health and wellbeing. We also had a large trained group to draw on, so we could match their skills more effectively to the needs in the disaster area.

5: Who should I go with?

DO

- ✓ **If going as an individual:**
Pre-register with international non-governmental organisations (INGO) or with international medical teams who have registered in advance with the EMT coordinating body.
- ✓ **If going as a group of two or more to provide rehabilitation:**
You must be prepared and registered as a specialised cell EMT in advance of any disaster.
- ✓ Go with a team led by an experienced humanitarian.
- ✓ Know your team mates, with prior interprofessional collaborative training and agreed standards of governance.

DON'T

- ✗ Go on your own without support of a local or international organization.
- ✗ Form a team based on perceived need or convenience rather than a local request.
- ✗ Travel without an invitation.
- ✗ Join an organisation or team that has been newly set up to respond to the specific disaster without past experience of the country or context.

Case Study: During a sudden-onset disaster, a volunteer arrived from their holiday to work in a hospital for a few days but started work without checking with the hospital manager. As they were not part of the system, they duplicated work that was already done such as opening fresh dressings and provided contradictory advice to patients already seen by an existing team. They did not keep notes or attend meetings, so it was not possible to know what had been done.

INGOs and other international organisations involved in rehabilitation in emergencies include:

- CBM
- Handicap International (HI)
- International Committee of the Red Cross and Red Crescent (ICRC)
- International Federation of the Red Cross and Red Crescent (IFRC)
- International Medical Corps (IMC)
- Malteser International
- Medecins Sans Frontieres (doctors without borders) (MSF)
- Medecins Du Monde (doctors of the world) (MDM)
- Motivation
- Rehabilitation International (RI)

The WHO Emergency Medical Teams (EMT) Initiative

EMTs are any groups of health professionals (including dedicated rehabilitation teams) providing direct clinical care to populations affected by disasters or outbreaks as surge capacity in support of the local health system.

Uncoordinated medical team deployment during a sudden onset disaster (SOD) or disease outbreak can significantly disrupt national emergency coordination plans. Teams that deploy without first understanding the national or international emergency response systems may not only deplete a country's resources if not self-sufficient, but also may not recognize the receiving country's needs. By categorizing teams according to their capacity, assessing their compliance with defined standards, and supporting governments to coordinate them in the event of an emergency, the Emergency Medical Team Initiative helps ensure that the response is needs-based and does not place additional strain on the affected country.

Any team (i.e more than 1 person) specifically providing rehabilitation would be classed by the Minimum Standards as an Emergency Medical Team "Specialized Cell". To be placed on the Global Classification List of quality assured teams groups need to register and be assessed against the minimum standards developed by WHO in advance of any emergency event.

The EMT Minimum Standards recommends that all medical teams providing inpatient care include rehabilitation. Therefore it is advised that rehabilitation personnel wanting to respond to emergencies should first seek out and join existing multi-disciplinary EMTs in their home country, rather than seeking to form new teams.

Teams on 'the list' may be called forward by the affected ministry of health to provide assistance during an emergency. Teams that are not listed and not requested by the ministry of health should NOT travel to disaster areas.

6: How much funding do I need?**DO**

- ✓ Ensure that you can be financially independent.
- ✓ Make sure you have adequate funds in place to achieve aims with a view to long term impact.

DON'T

- ✗ Travel without the funding in place to secure aims.
- ✗ Expect to be provided with accommodation, food and supplies or to be able to use existing local medical resources.

7: I am a student or recently qualified professional, should I travel to help?**DO**

- ✓ Start by gaining clinical skills and experience relevant to a resource-constrained environment in your home country.
- ✓ Support colleagues who are in disaster areas by covering their usual work duties, raising awareness, fundraising and being a distant clinical resource.

DON'T

- ✗ Travel as a student or newly qualified professional, unless at a later stage in a response and with an organisation prepared to offer appropriate supervision, training and support in an emergency setting.

8: What personal equipment do I need to bring?**DO**

- ✓ Come with life support equipment appropriate to the crisis. Needs vary depending on the situation, but basics may include tents, rations and water purification equipment.
- ✓ Arrive with sufficient essential personal clinical equipment for patient safety in your role (including basics such as gloves and hand sanitiser).

DON'T

- ✗ Be unprepared for emergency environments expecting to be able to source equipment on arrival.
- ✗ Drain local resources like food, water, fuel and medication.
- ✗ Be a liability in the event of a second emergency.

9: How long should I be prepared to stay for?

DO

- ✓ If you are joining a local organisation, the longer you can stay the better. Many will ask for minimum commitment of 1 month.
- ✓ If coming as part of an EMT, the team must commit to a minimum period of between 3 weeks and 2 months depending on the type of EMT they will register as (**WHO Minimum Standards for Rehabilitation in Emergency Medical Teams, in print**).
- ✓ If travelling as a dedicated rehabilitation team, the proposed minimum length of stay for the team is 1 month (WHO, in print).
- ✓ Allow time for handover if individual team members rotate.

DON'T

- ✗ Come only for a few days to weeks risking little or no continuity for the local services.

Case Study: After the earthquake, the high turnover rate of volunteers and lack of continuity of practices between the different organisations meant there was little uptake of new skills or techniques. Consequently, local staff resorted to what they already knew to avoid confusion between the disparate approaches of transient volunteer teams. As one professional reported The (country) staff just switch off because they know that the team are going to be there for 5, 6, days and then... the next team's going to come with a whole different way of doing things... It's disastrous. (Tataryn and Blanchet, 2012)

WHILST WORKING IN THE DISASTER AREA

10: Who should I register with on arrival?

DO

- ✓ Ensure your team is registered locally with the humanitarian response coordinating body and with the relevant professional association in country.
- ✓ Make arrangements for the above as a matter of priority if not already done so.

DON'T

- ✗ Turn up unannounced.
- ✗ Practice without registering as a health professional with the relevant professional or regulatory association in country.
- ✗ Work without registering with a local or international coordinating body, risking duplication or ineffectiveness due to the lack of coordination.

Case Study: During the response phase of the disaster, multiple international aid organizations established rehabilitation "tents" operating on grounds of local and field hospitals. While many of these participated in the Health Cluster meetings ensuring collaboration among providers and with local health meetings,

others operated independently. As a result, it was not unusual to find more than one rehabilitation provider organization in the same location, working completely independently, using their own methods of record keeping and treating patients with their own protocols, human resources and equipment.



11: Where should we work when we get there?

DO



Work at a location based on need as tasked by the humanitarian response coordinating body, ideally with pre-existing relationships with your host.

DON'T



Work independently, not integrating into a team and the overall response.



Choose a place of work based on convenience or personal relationships rather than need.

12: Can I work outside my scope of practice given the scarcity of health professionals?

DO



Work within your scope of practice, applying strong clinical governance.



Ensure your practice meets host, home country and international standards.



Refer cases you are not able to manage appropriately on to appropriate services with the relevant expertise by working closely with the local coordinating body.

DON'T



Work outside of your scope of practice, either in host country or home country.



Fail to comply with national and international standards of clinical governance.



Work alone, not using established emergency coordination and referral systems, making the assumption 'if we don't do it, no one will'.

13: What should my role be?

DO



Be part of an integrated, collaborative team, supporting and empowering local services with a long term view (WHPA, 2013).



Work only in response to a locally identified need.



Recognise that achieving meaningful change takes time and a disaster setting is not the time to try to change local practice fundamentally.



Remember that if you are delivering general aid such as water or shelter, rather than health care, you are classed as a general aid worker not as a clinician, and should follow the appropriate guidance for your role.

DON'T



Assume the role of "expert" with a focus on your own impact or leadership.



Try to immediately implement changes in local practice or service provision mechanisms without understanding local constraints.



Take on a role a local provider could have performed, thereby taking a job from a disaster affected person or disempowering a local responder.



14: How should I work in collaboration with local staff?

DO

- ✓ Respect the authority of local professionals, and work alongside local staff as equals, responding to their requests and local needs in a supportive manner.
- ✓ Acknowledge that local health personnel are the experts in their own context.
- ✓ Build capacity and implement training jointly that has been requested by the local staff around needs that have been identified.
- ✓ Consider the level of training of local health personnel and provide support appropriately and sensitively.
- ✓ Coordinate and work in collaboration with local and international organisations.
- ✓ Consider the disaster context and the likely stress that local health personnel are under at all times, and acknowledge that they were there before the disaster and during the disaster, and will remain after international teams leave.

DON'T

- ✗ Treat staff as subservient, ignoring their expertise in the local context.
- ✗ Assume that there is a "quick fix" for identified problems without understanding local constraints.
- ✗ If recruiting local staff, offer inflated salaries without considering national pay scales, undermining local employers.

Case Study: A multi-disciplinary team was deployed to a facility to provide rehabilitation for two weeks. On arrival, a team member wanted to make changes to the way patients were being clinically managed and became angry when the local staff explained that the current local management was meeting the patients' needs. This was not useful as the planned focus of care had already been discussed and agreed. This scenario created bad feeling between the team member and the local staff, which had to be endured for two weeks.

15: What are the standards for documentation and data collection?

DO

- ✓ Follow national or global standards of governance in the local or accepted international language without abbreviations.
- ✓ Ensure a summary record stays with the patient. Where working in a local facility, notes should be integrated into the local record system as much possible.
- ✓ Collect data in a way that is integrated into local health information systems with national or international agreed data sets, where agreed. Share or use data only with the consent of the individual subject of data and permission of the host organisation and in accordance with their data protection rules if applicable.

DON'T

- ✗ Fail to keep records.
- ✗ Use language or abbreviations not understood locally.
- ✗ Hold records within the team instead of with the patient.
- ✗ Keep separate records that are not shared with local stakeholders without consent.
- ✗ Use data without the consent of the patient or of host organisations for your own research purposes or for self-promotion.

Case Study: At the end of their week despite being asked to update the multidisciplinary team handover daily, (the therapists) had not done this. Instead they designed new handovers, stating they were an improvement on the established system. This cost the (existing) therapist's valuable time transferring data back onto the main handover system on their departure, ready for the new teams arriving the next day.



16: Should I bring donated equipment or prosthetics with me?

DO

- ✓ Bring clinical equipment required for your immediate role with you so as not to drain local resources.
- ✓ Source local equipment where appropriate, strengthening local manufacture with training if indicated.
- ✓ Strengthen existing local provision of assistive devices through training and equipment, if required.
- ✓ Where international equipment is donated ensure it is appropriate and done so in a sustainable manner, and accompanied by training, if required. (*WHO, 2000*)
- ✓ Adhere to international standards for items such as wheelchair provision (*WHO, 2008*).
- ✓ If importing equipment or medications make sure you have all the right paperwork in place before you leave.

Case Study: A volunteer physiotherapist worked with a team to identify wheelchair users and prepared photo guidelines on how to assess and fit them safely, providing training to the rest of the team.

DON'T

- ✗ Donate equipment without checking needs or quality.
- ✗ Assume that customs procedures and import duties will be waived in a disaster.
- ✗ Provide equipment not suited to the post disaster environment.
- ✗ Give out equipment that cannot be maintained or replaced locally without sustainable options e.g. high specification wheelchairs or prosthetics.
- ✗ Set up short term prosthetics or other equipment workshops not integrated into local provision.

Case Study: A volunteer in a field hospital fitted a donated prosthetic limb to a patient. When observed to be poorly fitting and posing a safety risk, it was removed by concerned staff which caused the patient more emotional trauma.

Case Study: Many patients living in far flung mountainous areas spent most of their time confined to their homes as the fancy donated wheel chairs could not be manoeuvred in the hilly terrain. (Rathore, 2015)

17: Who should I be accountable to in my work?

DO

- ✓ Be accountable to the people you are trying to help, the hosting organization, your team members and to those you have accepted resources from (*ICRC, 1994*).
- ✓ Apply a high standard of clinical governance.
- ✓ Reporting should be collaborative and shared with local partners. Any recommendations made should be done so jointly, and with sound understanding of local challenges and how recommendations might be implemented.
- ✓ Report through established reporting mechanisms such as the EMT coordination cell or health cluster and via channels within the country, via an identified team lead within the country.
- ✓ Openly share both positive and negative aspects of your own deployment and lessons learned.
- ✓ Report any near misses or clinical errors to the relevant authority.

DON'T

- ✗ Assume that lower standards of clinical governance apply in a humanitarian setting.
- ✗ Report only on positive aspects, limiting the ability of others to learn from negative experiences.
- ✗ Evaluate accountability from your own perspective, ignoring the disaster or local context.
- ✗ Fail to report, or report based on assumptions without fact checking or local input.
- ✗ Report via intermediaries, sharing information without consent.

Case Study: We received so many patients from departed international teams with no notes whatsoever. We had no way of knowing what procedures had been performed, if there were any precautions to follow, what rehabilitation they had had, and what their follow up plans were. This made providing ongoing care incredibly challenging.



18: What should I do if I encounter people with increased vulnerability in my work?

DO

- ✓ Recognise that humanitarian environments place people at increased risk of discrimination and/ or abuse e.g. children, women, the elderly and those with existing disability or chronic conditions (WHO, 2013).
- ✓ Protect vulnerable people and engage with the humanitarian protection mechanisms in place to raise any concerns.
- ✓ Have team members trained in humanitarian protection issues, with a focal point identified where possible.

DON'T

- ✗ Be unaware of common humanitarian challenges.
- ✗ Assume that social services and other support systems you may be used to at home will be in place.
- ✗ Not act on situations leaving an adult or child in a vulnerable position.
- ✗ Travel with teams that are not appropriately vetted to work with vulnerable people.

19: Are there rules on the use of social media?

DO

- ✓ Ensure patient and organisation information is only ever used with their informed consent.
- ✓ Obtain locally appropriate informed consent for pictures, and protect patients' identity.
- ✓ If working in a team, have written policies in place.
- ✓ Ensure that all team members are briefed regarding confidentiality and social media use in a way that does not undermine local responders or portrays them as victims or passive recipients of aid.

DON'T

- ✗ Share information (written/photos/film) about organisations and/or patients inappropriately (ie; via email, Facebook, blogs, published articles, interviews or presentations).
- ✗ Assume patient confidentiality guidelines that you would normally adhere to at home do not apply in the disaster context.
- ✗ Present inaccurate representations of the need or response to further own (or organisation's) aims.
- ✗ Present yourself as the lead or hero of a response at the expense of local providers.

Case Study: A rehabilitation team on deployment to a local rehabilitation centre were all asked to sign a volunteer agreement to protect patient confidentiality and asked not to take photos without permission.

Case Study: Whilst working unsupervised, the students would take photos of themselves treating children without asking parents and post them to Facebook accounts. At the end of their stay, they also wrote a harmful open access blog about perceived mismanagement of the organisation.

20: If conducting research, are there principles I need to follow?

DO

- ✓ Ensure that the research is locally relevant.
- ✓ Use established data sets in accordance with global standards.
- ✓ Include all relevant local stakeholders when defining research questions, designing research, interpreting and presenting results.
- ✓ Use trained data collectors, working in collaboration with local service providers, to conduct action orientated research that will aid the local response and future responses.
- ✓ If data is used for research purposes informed written consent from patients is needed in addition to consent from host organisations.
- ✓ Ensure that research meets accepted ethical standards of your home country and the local setting, including ethics committee approval.

DON'T

- ✗ Conduct research without consent of individuals, host organisations or compliance with local and international ethical standards. (*WHO, 2011; WMA, 2013*)
- ✗ Keep inappropriate records.
- ✗ Fail to train data collectors.
- ✗ Prioritise research over clinical need.

Case Study: A team came to assist with training at a rehabilitation centre but collected data for their own research without the centre's knowledge or consent. On leaving, they produced an evaluation of the facility based on their short stay which was submitted to the Ministry of Health.

21: Do I need to handover on leaving?

DO

- ✓ Consider your departure prior to your deployment.
- ✓ Consider the long term needs of patients and local staff and plan the transition period with them in line with their service needs.
- ✓ Conduct training with the relevant staff, who will be carrying on with the work after you leave, in a culturally appropriate manner.

DON'T

- ✗ Leave without plan for who will take over your patients and role.
- ✗ Not engage with local providers.
- ✗ Not consider the impact of your departure on the local capacity.

Case Study: After the initial funding phase, a major challenge remained the transition and ownership of services to local providers, who could not fund the transport and assistive devices provision on their own. The sustainability of the services was therefore questionable, and solutions needed to be identified by the teams constituted from local and foreign service providers. This solution should have been identified at the project's start.

Case Study: Following an earthquake, spinal injury patients were discharged without any long term follow-up plans, rehabilitation protocols, advice for community re-integration and home modifications. Many were re-admitted later with pressure ulcers and severe urinary tract infections. (Rathore, 2015)



ON RETURNING HOME

22: How do I accurately communicate on the work I have done?

DO

- ✓ Share open and honest lessons by reflecting on your own response team's strengths and weaknesses.
- ✓ Consider above interconnected agencies and get support to develop a robust monitoring, evaluation and learning framework to support this.
- ✓ Understand how evaluation can serve a range of purposes including reshaping policy and practice, and provide a means by which different "voices" can be heard.
- ✓ Always recognise the role that local responders have played in any response.

DON'T

- ✗ Ignore interconnected levels of learning – individual, organisational, inter-organisational and learning by beneficiaries.
- ✗ Evaluate based on your own countries' model of health service delivery or your own expectations of health service delivery.
- ✗ Share experiences without an awareness and consideration of your own strengths and weaknesses, and without a full understanding of host organization or other organizations.
- ✗ Be quick to criticise the practices of local organisations or staff.

23: What support is needed on returning home?

DO

- ✓ Ensure that you have access to appropriate support on your return home, including psychological support, and an opportunity to debrief.
- ✓ Be aware of the need for rest and reflection.
- ✓ Be aware of negative coping mechanisms, including drug and alcohol use.

DON'T

- ✗ Have no support mechanisms or follow up available for returning volunteers.
- ✗ Assume that your friends, family and colleagues will find it easy to relate to your experiences.

Case Study: After an international team returned from a disaster, one to one debriefs were held with each team member, and all members were offered access to a specialist counselling service. A follow up meeting with a strong social element was held to bring the team together, and many of the team members continued to meet away from work.



Humanitarian Principles

Humanity	Neutrality	Impartiality	Independence
Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings.	Humanitarian actors must not take sides in hostilities or engage in controversies of a political, radical, religious or ideological nature.	Humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religious belief, class or political opinions.	Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented.

(OCHA, 2012)

Principles of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Response Programmes (IFRC and ICRC, 2012)

1. The humanitarian imperative comes first.
2. Aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone.
3. Aid will not be used to further a particular political or religious standpoint.
4. We shall endeavour not to act as instruments of government foreign policy.
5. We shall respect culture and custom.
6. We shall attempt to build disaster response on local capacities.
7. Ways shall be found to involve programme beneficiaries in the management of relief aid.
8. Relief aid must strive to reduce future vulnerabilities to disaster as well as meeting basic needs.
9. We hold ourselves accountable to both those we seek to assist and those from whom we accept resources.
10. In our information, publicity and advertising activities, we shall recognize disaster victims as dignified human beings, not hopeless objects.

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