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Brief Report

Rehabilitation strengthens health systems in emergencies: Perspectives from the 2026 Sidney Licht Lecture

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Our specialty originated in emergencies. The rehabilitation of soldiers returning from the World Wars gave rise to modern physical medicine and rehabilitation (PMR); the polio pandemics of the mid-twentieth century accelerated its growth. Yet despite these origins, rehabilitation remains one of the most consistently neglected components of contemporary health emergency response. That paradox demands both our attention and our action.

The scale of current global humanitarian needs is staggering. According to the Global Humanitarian Overview 2026, approximately 259 million people require humanitarian assistance, driven primarily by conflict and climate-related disasters.[1] This decade has been defined as an era of conflict and violence, with civilians increasingly targeted and health infrastructure among the first casualties. The number of extreme climate- and weather-related disasters has steadily increased year over year, with the United Nations (UN) Office for Disaster Risk Reduction reporting 1.23 million lives lost between 2000 and 2019 in 7,348 major recorded disaster events. For every person who does not survive, many more do with injuries that require rehabilitation.[2] Among the nearly 118 million forcibly displaced people in 2025,[3] an estimated 11 million live with disabilities, the vast majority lacking access to the rehabilitation care they need.[2]

The challenges of providing rehabilitation in these settings are specific and predictable: destroyed medical facilities, overwhelmed systems, disrupted communications, disease outbreaks, and the breakdown of coordination mechanisms. The consequence is not only delayed care, but inappropriate care, which can lead to more complex rehabilitation needs in the immediate, short, and long term.[2,4-6] Persons with disability, older adults, and children are disproportionately affected by emergencies, not because of inherent vulnerability, but because emergency systems are often designed without them in mind. Inaccessible evacuation and shelters, assistive device damage, loss of care supports, and interrupted health services compound pre-existing inequities.[2]

These features of emergencies are amenable to planning. The evidence supporting early rehabilitation in emergencies is both compelling

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and underutilized. Early rehabilitation reduces mortality, shortens inpatient lengths of stay, prevents secondary complications, and improves long-term functioning outcomes.[2,4-6] In resource-constrained systems under emergency surges, these benefits should not be considered periphery, but essential to health system function. Preventing pressure injuries and contractures, promoting early mobilization, and helping patients regain self-care skills can reduce resource utilization, shorten hospital stays, and facilitate an earlier return to community life. Rehabilitation must not be deferred until acute care is complete; it must be integrated into bedside care from the first day of the emergency response.[5]

Yet, as the World Health Organization (WHO) has documented, rehabilitation is nearly always neglected in emergency preparedness and early response.[7] The underlying reasons are well recognized: decision makers in government ministries and disaster management agencies often lack an understanding of the role of rehabilitation and its importance in the acute phase of care. There is a pervasive and empirically refutable assumption that rehabilitation is a later-phase, optional service rather than a clinical priority. Of note, many countries have no rehabilitation component in their emergency preparedness plans. Furthermore, rehabilitation professionals themselves are often not aware of the role our specialty can and should play in emergency response.[2,7]

I have witnessed this response firsthand. Following the 2010 earthquake in Haiti, several field hospitals declined to admit patients with spinal cord injury (SCI), citing as "minimal chance of ultimate rehabilitation".[8] At that time, the average post-injury life expectancy of a person with paraplegia in a low-income country was reportedly two to three years. Through coordinated rehabilitation response, including cohorting patients in designated centers, rapidly mobilizing local and international capacity, establishing database and referral pathways, and integrating patients and families as active team members, these statistics were directly challenged. Newly injured individuals not only survived but also thrived, with Haiti represented at the 2012 London Paralympics. This illustrates what can be achieved when rehabilitation is available from the outset and delivered in a deliberate, coordinated, and prioritized manner.

More recently, the full-scale invasion of Ukraine in 2022 has generated thousands of new cases of SCI, the majority resulting from explosive ordnance, landmines, and gunshot wounds. The international community of rehabilitation organizations working alongside the WHO and WHO Country Office of Ukraine, and in-country partners has supported the acceleration of national and regional SCI care capacity, not through the imposition of external expertise, but through deliberate training models including train-the-trainer programs that transfers skills, builds institutional infrastructure, and develops local ownership. Ukrainian clinicians are currently delivering training, conducting research, and leading their national professional society. That transformation, achieved amid ongoing armed conflict, provides proof of concept for a rehabilitation response driven by local capacity-building and leadership.

Global commitments and policy mandates have never been stronger. The UN Convention on the Rights of Persons with Disabilities, Article 11 requires that all necessary measures be taken to protect persons with disability in emergencies. The landmark 2023 World Health Assembly resolution on strengthening rehabilitation explicitly calls on Member States to integrate rehabilitation into emergency preparedness and response.[9] The WHO has published policy briefs, technical guidance and minimum standards to support this integration.[2] What is needed now is translation from policy to practice, which is our professional responsibility.

Consider what each of us can do. We can engage with national preparedness planning and advocate for rehabilitation's inclusion as a core component. We can pursue the WHO Emergency Medical Team classification, enabling deployment as part of internationally coordinated responses. International collaboration does not always require presence in a crisis zone; effective remote support, as demonstrated during novel coronavirus disease 2019 (COVID-19) and in

collaborations from Morocco to Nepal,[10] is both feasible and impactful. We can prioritize capacity building over the provision of visiting expertise, recognizing that the most sustainable contributions are those that persist after we leave. We can integrate persons with lived experience as genuine team members rather than passive beneficiaries. We can measure what we do, develop functioning outcome data tools and insist that functioning be recognized as the third dimension of global health metrics, so that in emergency settings we can make our impact visible and our advocacy evidence-based.

I would like to reframe the narrative. We often speak of strengthening rehabilitation within health systems. Instead, I would rather argue that rehabilitation strengthens health systems. I did not set out to build a career in emergency response. Through my experiences in Haiti and Ukraine, and the growing body of evidence, I have come to understand that rehabilitation strengthens health systems in emergencies, not occasionally, not only at the end of acute care, but throughout the entire continuum of care.

In conclusion, members of our specialty have always responded to the needs of their time. The emergencies of the twenty-first century including conflict, climate-related disasters, and pandemics represent some of the most pressing humanitarian challenges of our era. We help bridge the gap between survival and meaningful living. The aspiration articulated by our community is unambiguous: all persons who need rehabilitation should receive timely, essential rehabilitation services in emergencies.[2] The evidence supports this aspiration, and the established frameworks mandate action. The need is urgent, and the time to act is now.

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Data Availability

The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

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AI tools were not used in the conceptualization, data interpretation, or preparation of conclusions in this manuscript. AI medical tool Scribeberry was used to transcribe the 2026 lecture audio and AI tool for grammar check was employed.

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