PEDIATRIC EMERGENCY CARE

Diane Petrie, MSN, RN, FNP-BC,
AAHIVS, AACRN, CPN, DIMPH

DISCLOSURES

- I have no relevant financial disclosures

OBJECTIVES

- Define pediatric emergency care and acute health issues in children
- Describe and identify common pediatric emergencies, including respiratory issues, trauma, infections, and allergic reactions
- Present evidence-based protocols and guidelines for managing pediatric emergencies, emphasizing the importance of timely and appropriate interventions.
- Discuss how cultural beliefs and socioeconomic factors influence pediatric emergency care practices and access to care globally.
- Encourage discussion of innovative approaches to enhance pediatric care delivery, such as telemedicine and mobile health solutions.

INMED

GLOBAL EMERGENCY CARE

Image: University of Washington FPECC Program

INMED

PEDIATRIC CARE NEEDS

- Currently, 4 pediatric critical care- and 1 pediatric emergency medicine-trained doctors in Kenya serve a population of 17 million children under 14 years of age.
- The 2 pediatric critical care training programs in Africa are at capacity and unable to meet the region's growing needs.
- **Despite success in decreasing global child mortality, 15,000 children in resource-limited settings die each day from preventable causes.**

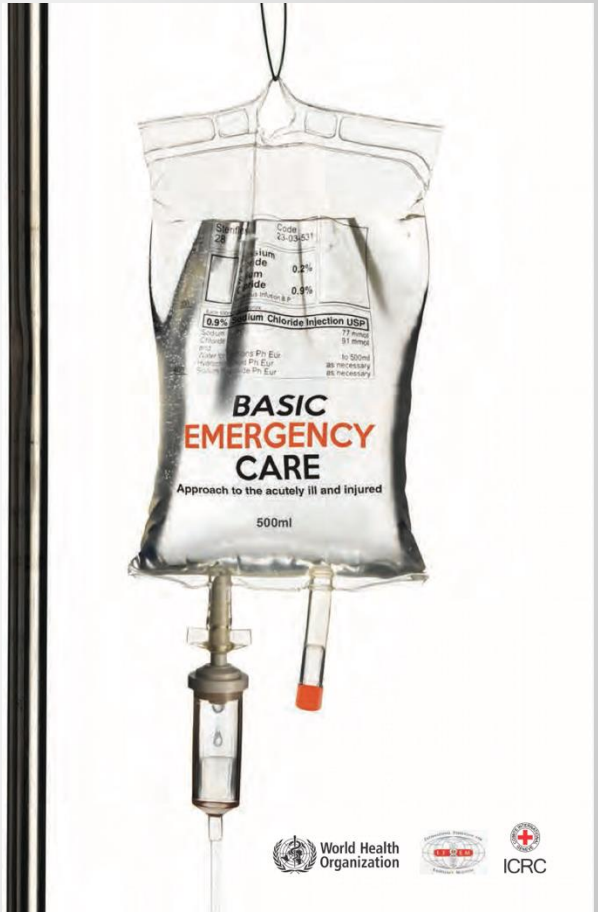
INMED

LEADING CAUSES OF DEATH

- Many leading causes of pediatric death can be prevented by simple, timely, and appropriate pediatric critical care:
  - Severe dehydration
  - Infection/sepsis (including severe Malaria)
  - Accidents and trauma
- Good and consistent trauma and critical care have been obscured by the huge burden of other medical problems, lack of access to care, and limited experience with pediatric emergency/critical care.

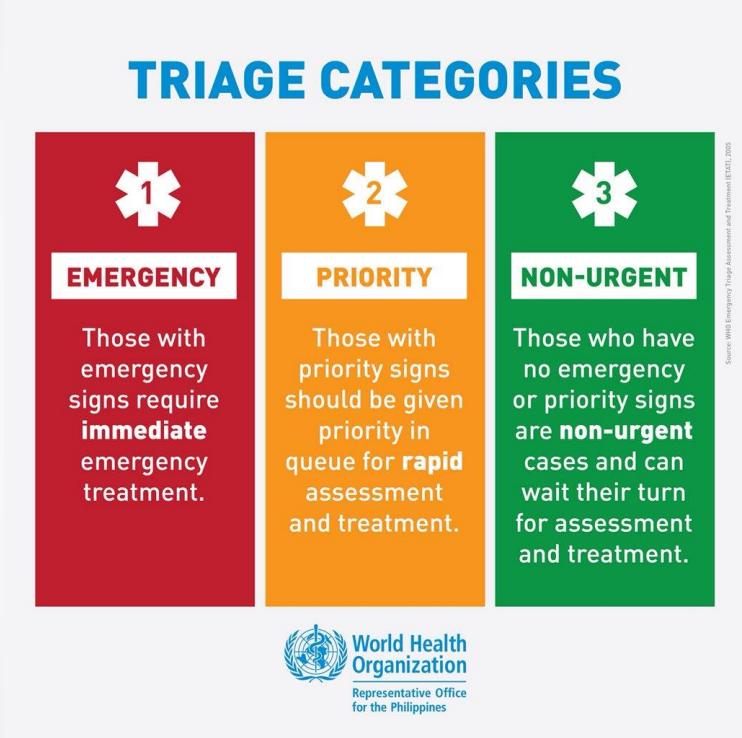
PREPARING FOR EMERGENCIES

- Having a clear plan, practicing it, and maintaining emergency resources are critical to responding quickly and appropriately.
- WHO Basic Emergency Course has created training (with many similar concepts to our AHA, ATLS, etc.) to create a clear, repeatable plan to standardize emergency care



TRIAGE

- WHO created the *Emergency Triage, Assessment and Treatment (ETAT)* system for children.
- The Integrated Management of Childhood Illness (IMCI) provides simplified guidance to improve the identification and rapid initiation of critically ill children.
- Regardless of the triage scale used all staff should be trained to the same standards.



INTERAGENCY INTEGRATED TRIAGE TOOL: Age < 12

1 CHECK FOR RED CRITERIA

- Unresponsive

AIRWAY & BREATHING
- Stridor
- Respiratory distress* or central cyanosis

CIRCULATION
- Capillary refill >3 sec
- Weak and fast pulse
- Heavy bleeding
- Cold extremities
- Any two of:
  - Lethargy
  - Sunken eyes
  - Very slow skin pinch
  - Drinks poorly

DISABILITY
- Active convulsions
- Altered mental status (confused, restless, continuously irritable or lethargic) with stiff neck, hypothermia or fever
- Hypoglycaemia (if known)

OTHER
- Any infant <8 days old
- Age <2 months and temp <36 or >39°C
- High-risk trauma*
- Threatened limb*
- Acute testicular/scrotal pain or priapism
- Snake bite
- Poisoning/ingestion or dangerous chemical exposure*
- Pregnant with adult red criteria

YES

MOVE TO HIGH ACUITY RESUSCITATION AREA IMMEDIATELY

NO

2 CHECK FOR YELLOW CRITERIA

AIRWAY & BREATHING
- Any swelling/mass of mouth, throat or neck
- Wheezing (no red criteria)

CIRCULATION
- Unable to feed or drink
- Vomits everything
- Ongoing diarrhoea
- Dehydration
- Severe pallor (no red criteria)

DISABILITY
- Restless, continuously irritable or lethargy
- Severe pain

OTHER
- Any infant 8 days to 6 months old
- Malnutrition with visible severe wasting OR oedema of both feet
- Trauma/burn (no red criteria)
- Sexual assault
- Known diagnosis requiring urgent surgical intervention
- New rash worsening over hours or peeling (no red criteria)
- Exposure requiring time-sensitive prophylaxis (e.g. animal bite)
- Pregnancy (no red criteria)
- Headache (no red criteria)

YES

MOVE TO CLINICAL TREATMENT AREA

NO

Patients with high-risk vital signs or clinical concern need up-triage or immediate review by supervising clinician

YES

3 CHECK FOR HIGH-RISK VITAL SIGNS

Temp <36° or >39°

SpO2 < 92%

AVPU other than A

RR	< 1 year	1-4 years	5-12 years
High	50	40	30
Low	25	20	10
HR	< 1 year	1-4 years	5-12 years
High	180	160	140
Low	< 90	< 80	< 70

NO

MOVE TO LOW ACUITY OR WAITING AREA

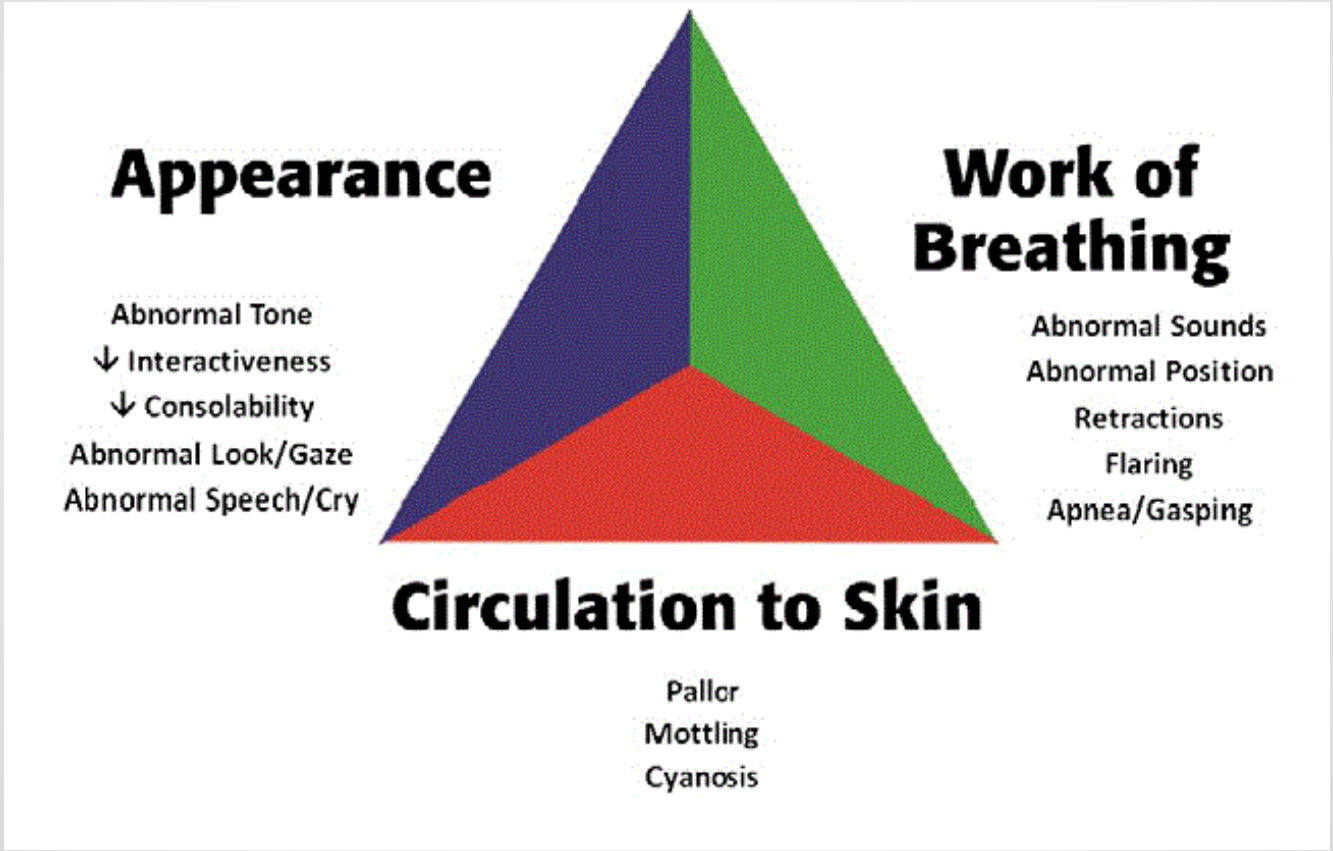
TRIAGE

INMED

*See Reference Card

Developed by World Health Organization, International Committee of the Red Cross, Médecins Sans Frontières

PEDIATRIC ABCS



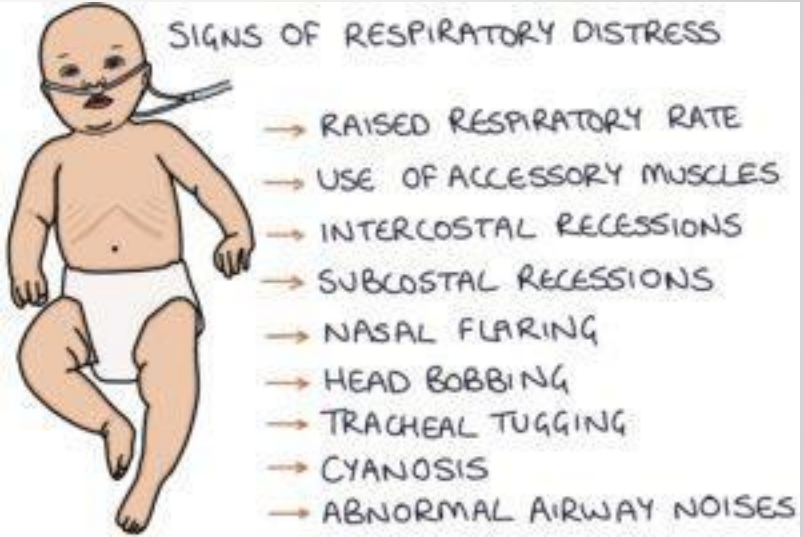
INMED

PEDIATRIC EMERGENCY PEARLS

INMED

PEDIATRIC CONSIDERATIONS AIRWAY/BREATHING

- Children are far more likely to suffer from conditions of respiratory distress/failure than cardiovascular.
- Good Airway and respiratory assessment is critical and in any critically ill child, oxygen should be applied judiciously.
- In pediatric emergencies, crying is always a good sign!



INMED

PEDIATRIC AIRWAY CONSIDERATIONS

Compared to adults, children have:

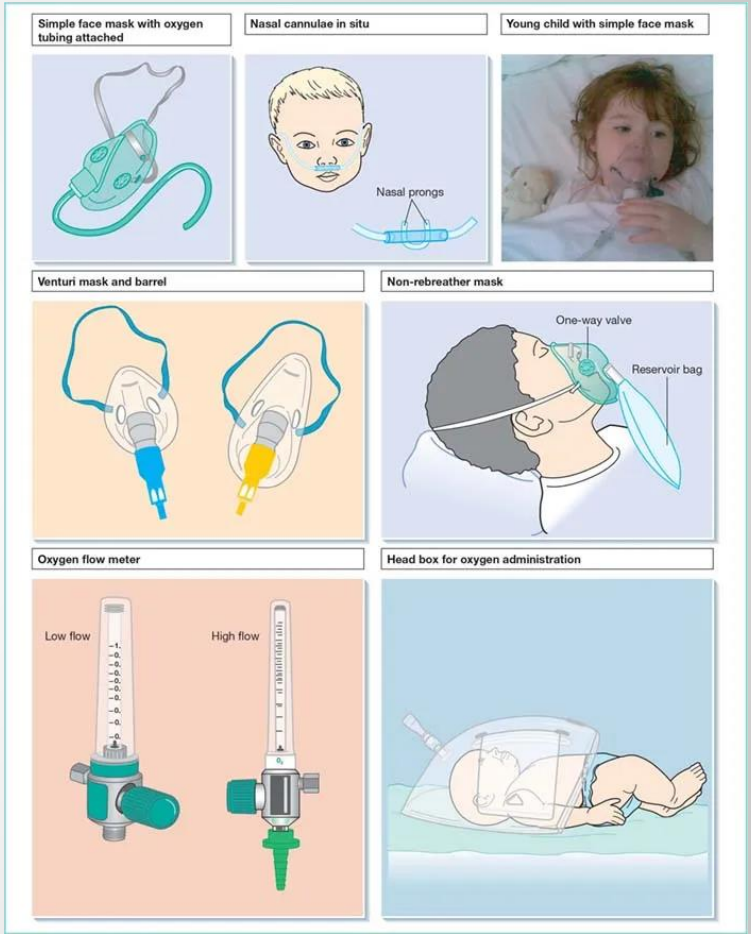
- Bigger tongues
  - Use the “sniffing” position
- Shorter necks, softer airways
  - Easier to block off
  - Avoid over-extending the neck
- A larger head compared to the body
  - Watch closely for airway obstruction
  - Use jaw thrust
  - Correct head position with padding under the shoulders to open the airway

Excessive drooling, stridor, airway swelling, unwillingness to move neck are high-risk signs in children!

INMED

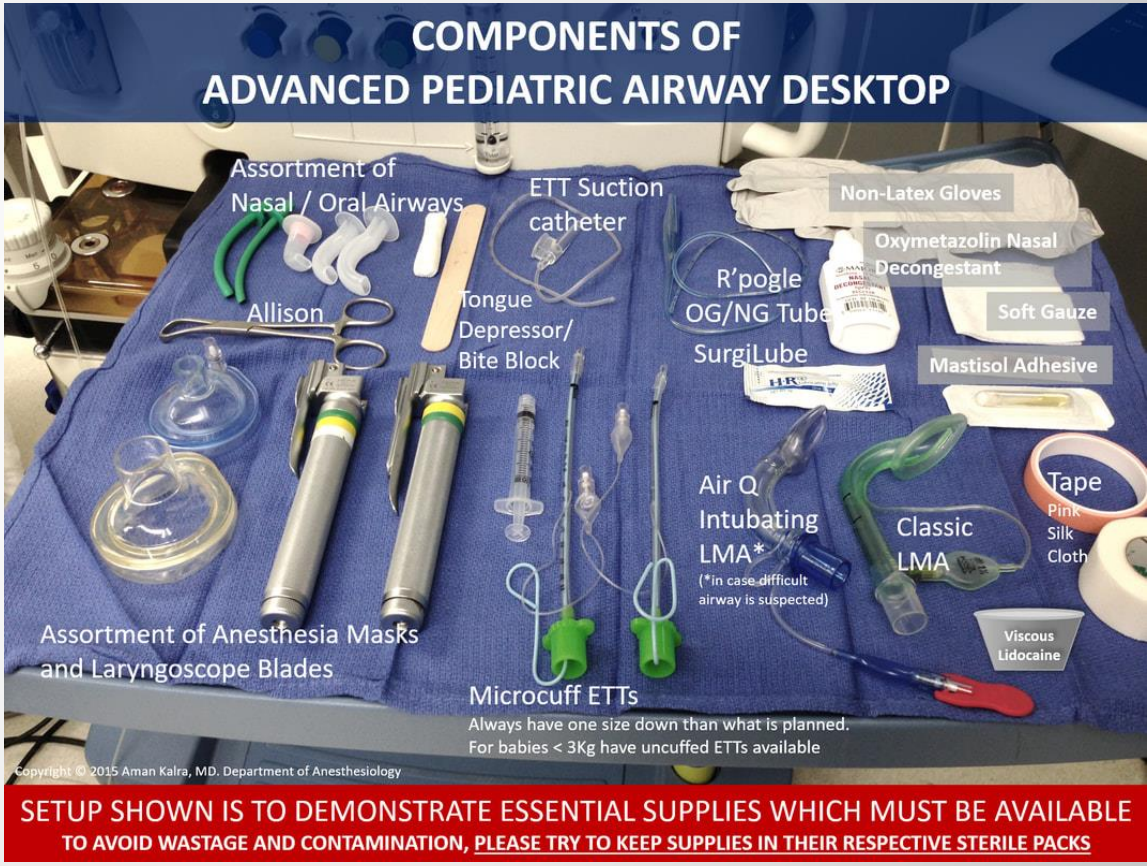
AIRWAY/BREATHING

- Always intervene before continuing your assessment!
- Always provide oxygen – preferably non-rebreather.
- Open the airway
- Remove visible foreign body
- Ventilate with bag and mask
- If prolonged bagging, consider advanced airway if qualified personnel and equipment.



AIRWAY/BREATHING

- Indications for advanced airway:
  - Prolonged bagging
  - Severe hypoxemia
  - Neurologic deficit without respiratory drive.
  - Reduce metabolic demands in severe shock.



BROSELOW TAPE

A tool utilized in pediatric emergency settings to quickly and accurately assess a child's size/weight for equipment, medication dosages, critical vital signs, etc.

INMED

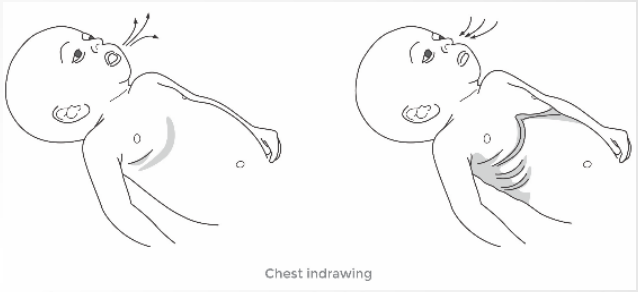
BROSELOW TAPE

INMED

BREATHING CONSIDERATIONS

Look for signs of respiratory distress :

- Nasal flaring
- Head bobbing
- Grunting
- Chest indrawing or retractions


Chest indrawing

- Cyanosis, a blue/gray discoloration around lips, mouth or fingertips, is a danger sign

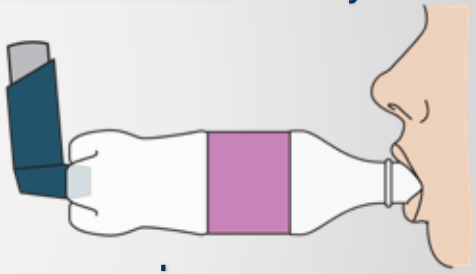
Look at the lower ribs

- Chest indrawing occurs when the lower chest wall moves inward during inspiration.
- In normal breathing, the chest and abdomen move outward as the child inhales.

BREATHING CONSIDERATIONS

Listen

- *Silent chest* is a sign of severe distress in a child
  - Severe spasms and airway narrowing cause limited airway movement, and few or no breath sounds may be heard.
  - Give Bronchodilator and OXYGEN.
  - Reassess frequently.



- *Stridor* is a sign of severe airway compromise
  - Put child in position of comfort, decrease painful stimuli
  - Plan for rapid HANDOVER/TRANSFER.
  - Give nebulized ADRENALINE/Epinephrine.
  - If unable to transfer, consider IM ADRENALINE

INMED

CIRCULATION

- For most core temp not needed in emergency.
- Give oxygen if not already applied.
- Check Cap refill (> 3 seconds)
- Check pulse
- Check for severe malnutrition.
- Check for injury or bleeding.

CIRCULATION

- Stop any bleeding
- If no malnutrition: give crystalloid IV fluids rapidly (20mg/kg bolus)
- If unable to get IV, place IJ or IO
- If malnutrition: assess if child can take oral or NGT fluids
- Check blood glucose

NORMAL VITAL SIGNS IN PEDIATRICS BY AGE

Infant
0-12 months

	Normal Range
Heart Rate	100 - 180
Blood Pressure	72 - 104 / 37 - 56
Respirations	30 - 53

Toddler
1-2 years

	Normal Range
Heart Rate	90 - 140
Blood Pressure	86 - 106 / 42 - 63
Respirations	20 - 37

Preschooler
3-5 years

	Normal Range
Heart Rate	80 - 120
Blood Pressure	89 - 112 / 46 - 72
Respirations	20 - 28

School-Age Child 6-9 years

	Normal Range
Heart Rate	75 - 118
Blood Pressure	97 - 115 / 57 - 76
Respirations	18 - 25

CIRCULATION CONSIDERATIONS

Low blood pressure in a child is a sign of severe shock

- Children maintain normal blood pressure longer than adults, but then decompensate quickly.
- Monitor other signs of poor perfusion.
  - Decreased urine output
  - Sunken fontanelle, poor skin turgor, lethargy, altered mental status

Rate, volume, and type of IV fluid depend on body weight, the cause of poor perfusion, and the child's nutritional status.

Malnourished children require careful fluid management!

INMED

COMA/CONVULSION

- Intervene rapidly for children who are not awake/alert.
- Manage airway
- If convulsing, give rectal diazepam
- Stabilize neck if trauma is suspected
- Check blood sugar

Table 1. Shock Types and Subtypes

Type of Shock	Subtypes of Shock
Distributive shock	• Septic shock • Anaphylactic shock • Neurogenic shock
Cardiogenic shock	• Heart failure • Dilated cardiomyopathy • Kawasaki disease • Multisystem inflammatory syndrome in children
Obstructive shock	• Cardiac tamponade • Constrictive pericarditis • Pulmonary embolism • Tension pneumothorax
Hypovolemic shock	• Blood loss: hemorrhagic shock • Fluid loss: vomiting/diarrhea

DEHYDRATION (DIARRHEA)

- Diarrhea plus any of the following:
  - Lethargy
  - Sunken eyes
  - Skin tenting
- Warm the child
- Treat shock if present
- Start oral fluids as soon as able

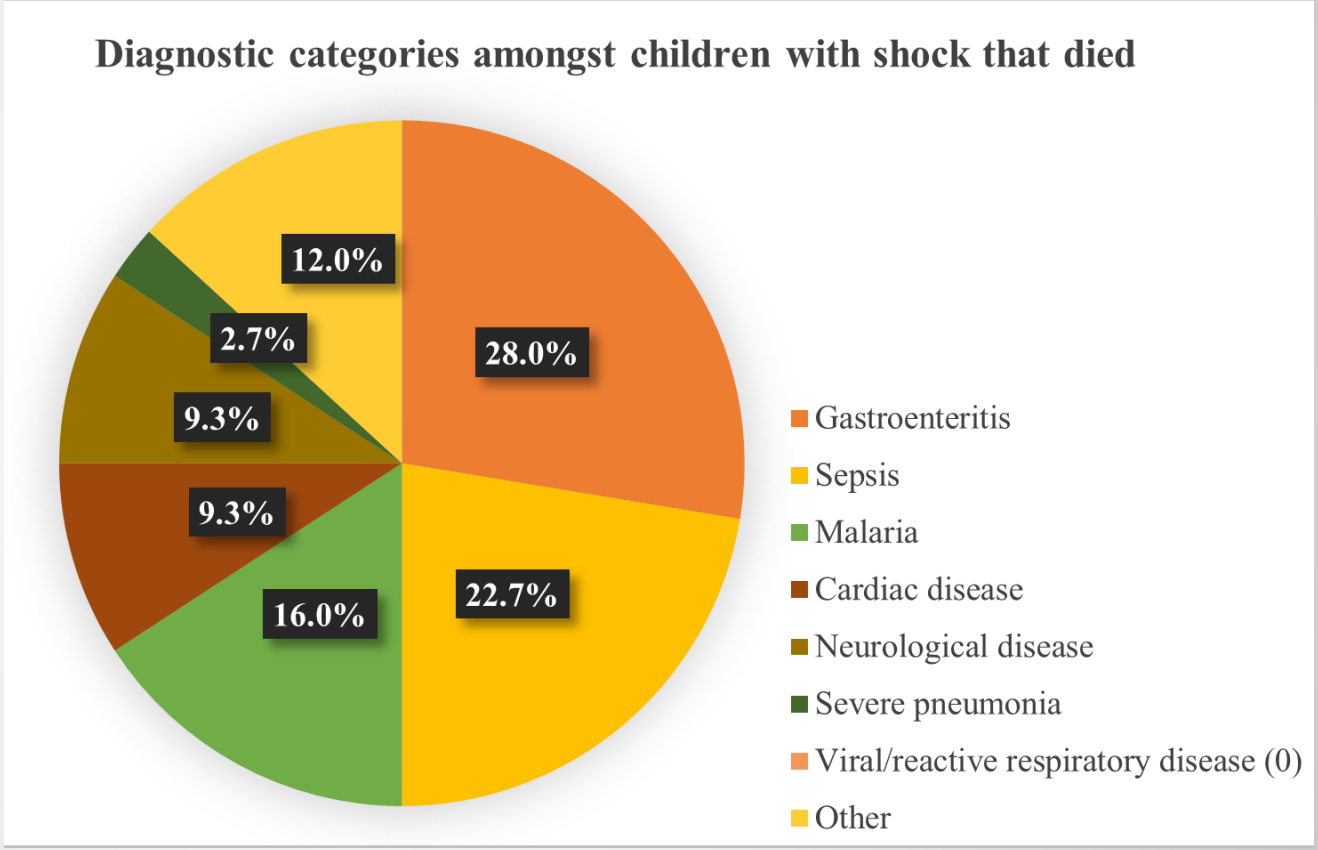


Image: Kumwanda, et al, PLOS, 2024

DISABILITY CONSIDERATIONS

Low blood glucose is a common cause of altered mental status in a sick child.

- When possible, check blood glucose.
- When not possible, give GLUCOSE .

Always check blood glucose with seizures or convulsions.

It may be difficult to determine whether a young child is behaving normally. Ask family members or friends to provide this information.

INMED

EXPOSURE CONSIDERATIONS

Infants/children have trouble maintaining temperature and can become hypothermic or hyperthermic quickly.

- Remove wet clothing and dry skin thoroughly.
- Provide skin-to-skin contact for infants.
- If concerned about hypothermia →Cover very small children's heads
- If concerned about hyperthermia →Unbundle tightly wrapped babies

INMED

CARDIOPULMONARY ARREST

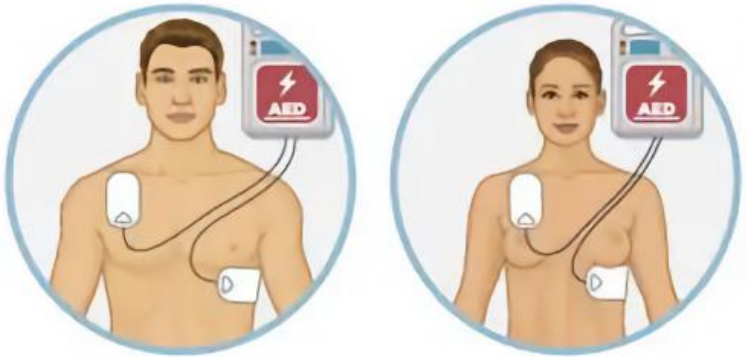
- Cardiac arrest is most commonly result of respiratory failure or shock leading to severe hypoxia.
- Pediatrics: 1-rescuer vs. 2-rescuer CPR.
- Shock if rhythm strip (or AED) indicates
- Use pediatric pads if available; otherwise, place 1 pad in front and 1 in back.
- Prompt and skillful response makes the difference between life and death.

INMED

CARDIOPULMONARY ARREST

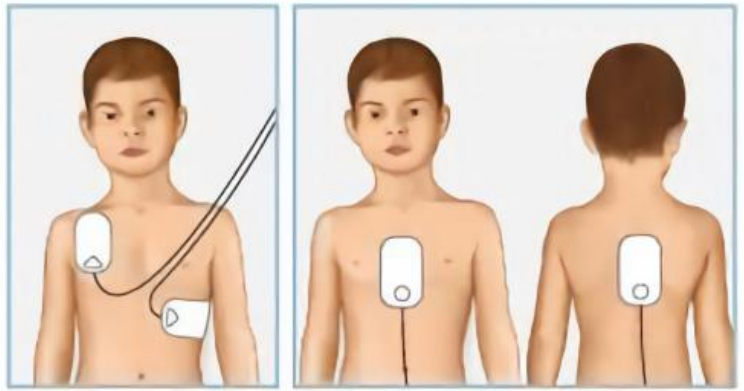
AED Pad Positions

Adult & Child > 8 years



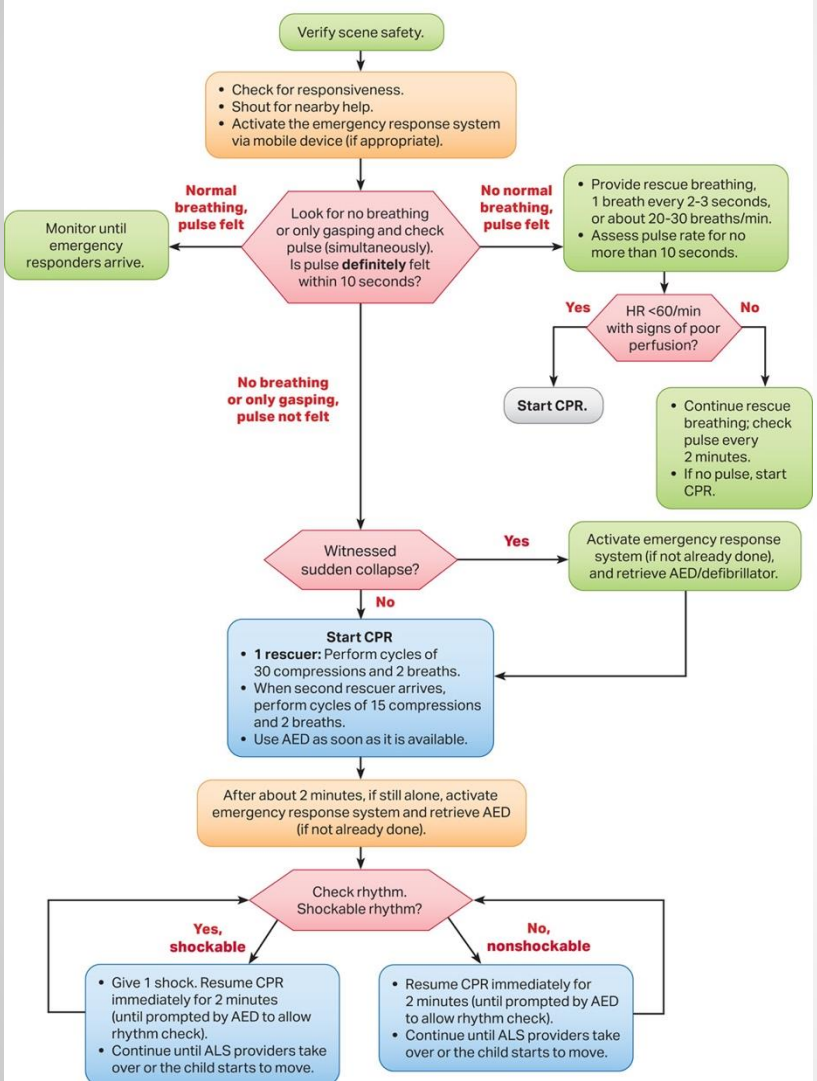
Same pad position for both male/female adult and older child

Child < 8 years



Pad position for male/female child

Alternate position for male/female child if the pads would touch



CARDIAC ARREST ALGORITHM

INMED

ASSESS ALL CHILDREN FOR THE PRESENCE OF DANGER SIGNS !

A child with danger signs needs urgent attention!

- Signs of airway obstruction
- Increased breathing effort
- Cyanosis
- Altered mental status
- Moves only when stimulated or no movement (AVPU other than "A")
- Not feeding well/ cannot drink or breastfeed
- Vomiting everything
- Seizures/convulsions
- Low body temperature (hypothermia)

INMED

PEDIATRIC DANGER SIGNS

DANGER SIGNS in CHILDREN	
• Signs of airway obstruction (unable to swallow saliva/ drooling or stridor)	• Moves only when stimulated or no movement at all (AVPU other than "A")
• Increased breathing effort (fast breathing, nasal flaring , grunting, chest indrawing or retractions)	• Not feeding well, cannot drink or breastfeed or vomiting everything
• Cyanosis (blue colour of the skin, especially at the lips and fingertips)	• Seizures/convulsions
• Altered mental status (including lethargy or unusual sleepiness, confusion, disorientation)	• Low body temperature (hypothermia)

ESTIMATED WEIGHT in KILOGRAMS for CHILDREN 1–10 YEARS OLD:

[age in years + 4] x 2

INMED

COMMON PEDIATRIC EMERGENCIES

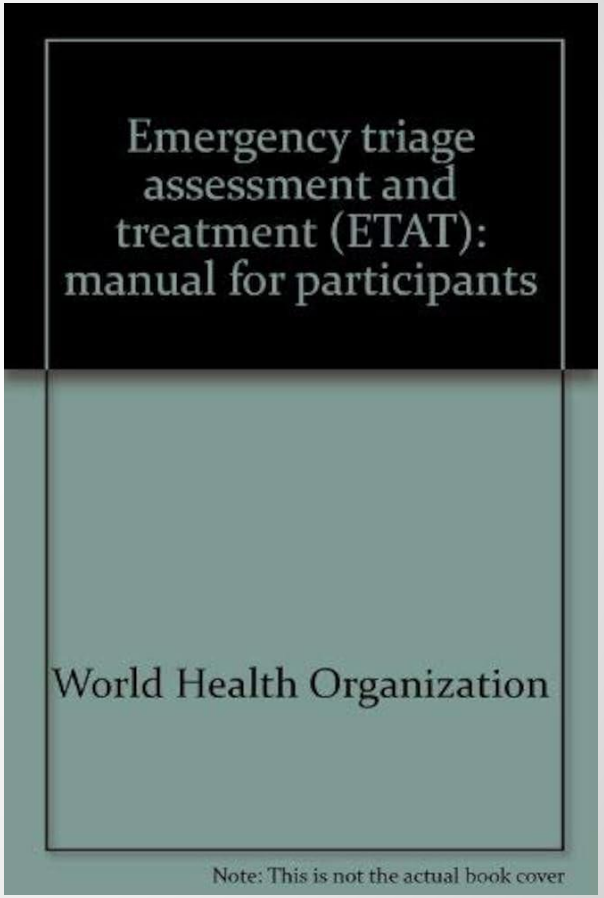
- Respiratory Distress
- Circulation/shock/dehydration
  - Injury Trauma
  - Infection/Sepsis
  - Underlying Conditions
- Seizure/Neurologic
- Allergic Reaction/Anaphylaxis
- Injury/Trauma

Image: https://www.unitekemt.com/blog/most-common-pediatric-emt-emergencies/.

INMED

COMMON PEDIATRIC EMERGENCIES

- Emergency Triage Assessment and Treatment (ETAT) guidelines were developed by the WHO to standardize and improve care for sick children.
- They can be downloaded or purchased on Amazon.



COMMON PEDIATRIC EMERGENCIES

- Standardized, systematized care leads to earlier recognition of pediatric warning signs, improved interventions, and more rapid treatment for the most common pediatric emergencies.
- Algorithms and treatment guidelines should be placed or readily available in areas where emergency care is provided.
- Care providers should practice scenarios and regularly refresh their skills with re-training or recertification.

INMED

COMMON PEDIATRIC EMERGENCIES

THEN ASK ABOUT MAIN SYMPTOMS:
Does the child have cough or difficult breathing?

If yes, ask:

- For how long?

Look, listen, feel*:

- Count the breaths in one minute.
- Look for chest indrawing.
- Look and listen for stridor.
- Look and listen for wheezing.

CHILD MUST BE CALM

If wheezing with either fast breathing or chest indrawing:

Give a trial of rapid acting inhaled bronchodilator for up to three times 15-20 minutes apart. Count the breaths and look for chest indrawing again, and then classify.

If the child is:	***Fast breathing is:***
2 months up to 12 months	**50** breaths per minute or more
12 Months up to 5 years	**40** breaths per minute or more

Classify COUGH or DIFFICULT BREATHING

• Any general danger sign or • Stridor in calm child.	***Pink:*** **SEVERE PNEUMONIA OR VERY SEVERE DISEASE**	▪ **Give first dose of an appropriate antibiotic** ▪ **Refer URGENTLY to hospital****
• Chest indrawing or • Fast breathing.	***Yellow:*** **PNEUMONIA**	▪ **Give oral Amoxicillin for 5 days***** ▪ If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days****** ▪ If chest indrawing in HIV exposed/infected child, give first dose of amoxicillin and refer. ▪ Soothe the throat and relieve the cough with a safe remedy ▪ If coughing for more than 14 days or recurrent wheeze, refer for possible TB or asthma assessment ▪ Advise mother when to return immediately ▪ Follow-up in 3 days
• No signs of pneumonia or very severe disease.	***Green:*** **COUGH OR COLD**	▪ If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days****** ▪ Soothe the throat and relieve the cough with a safe remedy ▪ If coughing for more than 14 days or recurrent wheezing, refer for possible TB or asthma assessment ▪ Advise mother when to return immediately ▪ Follow-up in 5 days if not improving

**If pulse oximeter is available, determine oxygen saturation and refer if < 90%.*

*** If referral is not possible, manage the child as described in the pneumonia section of the national referral guidelines or as in WHO Pocket Book for hospital care for children.*

****Oral Amoxicillin for 3 days could be used in patients with fast breathing but no chest indrawing in low HIV settings.*

***** In settings where inhaled bronchodilator is not available, oral salbutamol may be tried but not recommended for treatement of severe acute wheeze.*

COMMON PEDIATRIC EMERGENCIES

Does the child have diarrhoea?

If yes, ask:

- For how long?
- Is there blood in the stool?

Look and feel:

- Look at the child's general condition. Is the child:
  - Lethargic or unconscious?
  - Restless and irritable?
- Look for sunken eyes.
- Offer the child fluid. Is the child:
  - Not able to drink or drinking poorly?
  - Drinking eagerly, thirsty?
- Pinch the skin of the abdomen. Does it go back:
  - Very slowly (longer than 2 seconds)?
  - Slowly?

Classify DIARRHOEA

for DEHYDRATION	Two of the following signs: • Lethargic or unconscious • Sunken eyes • Not able to drink or drinking poorly • Skin pinch goes back very slowly.	***Pink:*** **SEVERE DEHYDRATION**	▪ If child has no other severe classification: ◦ Give fluid for severe dehydration (Plan C) OR **If child also has another severe classification:** ◦ **Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way** ◦ **Advise the mother to continue breastfeeding** ▪ **If child is 2 years or older and there is cholera in your area, give antibiotic for cholera**
	Two of the following signs: • Restless, irritable • Sunken eyes • Drinks eagerly, thirsty • Skin pinch goes back slowly.	***Yellow:*** **SOME DEHYDRATION**	▪ Give fluid, zinc supplements, and food for some dehydration (Plan B) ▪ **If child also has a severe classification:** ◦ **Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way** ◦ **Advise the mother to continue breastfeeding** ▪ Advise mother when to return immediately ▪ Follow-up in 5 days if not improving
	Not enough signs to classify as some or severe dehydration.	***Green:*** **NO DEHYDRATION**	▪ Give fluid, zinc supplements, and food to treat diarrhoea at home (Plan A) ▪ Advise mother when to return immediately ▪ Follow-up in 5 days if not improving
and if diarrhoea 14 days or more	• Dehydration present.	***Pink:*** **SEVERE PERSISTENT DIARRHOEA**	▪ Treat dehydration before referral unless the child has another severe classification ▪ Refer to hospital
	• No dehydration.	***Yellow:*** **PERSISTENT DIARRHOEA**	▪ Advise the mother on feeding a child who has PERSISTENT DIARRHOEA ▪ Give multivitamins and minerals (including zinc) for 14 days ▪ Follow-up in 5 days
and if blood in stool	• Blood in the stool.	***Yellow:*** **DYSENTERY**	▪ **Give ciprofloxacin for 3 days** ▪ Follow-up in 3 days

COMMON PEDIATRIC EMERGENCIES

Does the child have fever?

(by history or feels hot or temperature 37.5°C* or above)

If yes:

Decide Malaria Risk: high or low

Then ask:

- For how long?
- If more than 7 days, has fever been present every day?
- Has the child had measles within the last 3 months?

Look and feel:

- Look or feel for stiff neck.
- Look for runny nose.
- Look for any bacterial cause of fever**.
- Look for signs of MEASLES.
  - Generalized rash and
  - One of these: cough, runny nose, or red eyes.

Do a malaria test: If NO severe classification***

- In all fever cases if High malaria risk.
- In Low malaria risk if no obvious cause of fever present.

Classify FEVER

High or Low Malaria Risk

• Any general danger sign or • Stiff neck.	***Pink:*** **VERY SEVERE FEBRILE DISEASE**	▪ **Give first dose of artesunate or quinine for severe malaria** ▪ **Give first dose of an appropriate antibiotic** ▪ **Treat the child to prevent low blood sugar** ▪ **Give one dose of paracetamol in clinic for high fever (38.5°C or above)** ▪ **Refer URGENTLY to hospital**
• Malaria test POSITIVE.	***Yellow:*** **MALARIA**	▪ **Give recommended first line oral antimalarial** ▪ **Give one dose of paracetamol in clinic for high fever (38.5°C or above)** ▪ Give appropriate antibiotic treatment for an identified bacterial cause of fever ▪ Advise mother when to return immediately ▪ Follow-up in 3 days if fever persists ▪ If fever is present every day for more than 7 days, refer for assessment
• Malaria test NEGATIVE • Other cause of fever PRESENT.	***Green:*** **FEVER:** **NO MALARIA**	▪ **Give one dose of paracetamol in clinic for high fever (38.5°C or above)** ▪ **Give appropriate antibiotic treatment** for an identified bacterial cause of fever ▪ Advise mother when to return immediately ▪ Follow-up in 3 days if fever persists ▪ If fever is present every day for more than 7 days, refer for assessment

No Malaria Risk and No Travel to Malaria Risk Area

• Any general danger sign • Stiff neck.	***Pink:*** **VERY SEVERE FEBRILE DISEASE**	▪ **Give first dose of an appropriate antibiotic.** ▪ **Treat the child to prevent low blood sugar.** ▪ **Give one dose of paracetamol in clinic for high fever (38.5°C or above).** ▪ **Refer URGENTLY to hospital.**
• No general danger signs • No stiff neck.	***Green:*** **FEVER**	▪ **Give one dose of paracetamol in clinic for high fever (38.5°C or above)** ▪ **Give appropriate antibiotic treatment** for any identified bacterial cause of fever ▪ Advise mother when to return immediately ▪ Follow-up in 2 days if fever persists ▪ If fever is present every day for more than 7 days, refer for assessment

If the child has measles now or within the last 3 months:

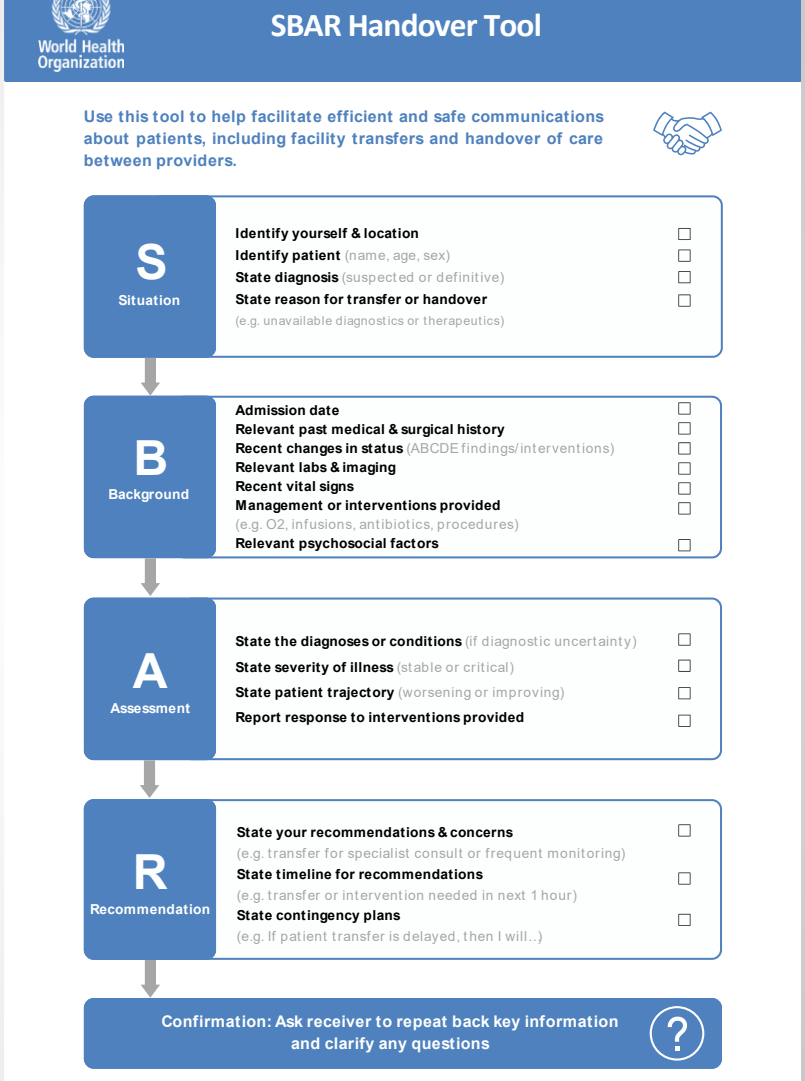
- Look for mouth ulcers. Are they deep and extensive?
- Look for pus draining from the eye.
- Look for clouding of the cornea.

If MEASLES now or within last 3 months, Classify

• Any general danger sign or • Clouding of cornea or • Deep or extensive mouth ulcers.	***Pink:*** **SEVERE COMPLICATED MEASLES****	▪ **Give Vitamin A treatment** ▪ **Give first dose of an appropriate antibiotic** ▪ **If clouding of the cornea or pus draining from the eye, apply tetracycline eye ointment** ▪ **Refer URGENTLY to hospital**
• Pus draining from the eye or • Mouth ulcers.	***Yellow:*** **MEASLES WITH EYE OR MOUTH COMPLICATIONS****	▪ **Give Vitamin A treatment** ▪ **If pus draining from the eye, treat eye infection with tetracycline eye ointment** ▪ If mouth ulcers, treat with gentian violet ▪ Follow-up in 3 days
• Measles now or within the last 3 months.	***Green:*** **MEASLES**	▪ **Give Vitamin A treatment**

PLAN FOR AND SYSTEMATIZE CARE

- Planning for transfer of care to hospital, inpatient or intensive care unit, or to higher level care (with specific surgical intervention) if available is always a consideration.
- Begin transport planning as soon as you realize need.
- Basic Emergency Course has resources for patient transfer with SBAR



World Health Organization

SBAR Handover Tool

Use this tool to help facilitate efficient and safe communications about patients, including facility transfers and handover of care between providers.

S Situation

- **Identify yourself & location** ☐
- **Identify patient** (name, age, sex) ☐
- **State diagnosis** (suspected or definitive) ☐
- **State reason for transfer or handover** ☐
  (e.g. unavailable diagnostics or therapeutics)

B Background

- **Admission date** ☐
- **Relevant past medical & surgical history** ☐
- **Recent changes in status** (ABCDE findings/interventions) ☐
- **Relevant labs & imaging** ☐
- **Recent vital signs** ☐
- **Management or interventions provided** ☐
  (e.g. O2, infusions, antibiotics, procedures)
- **Relevant psychosocial factors** ☐

A Assessment

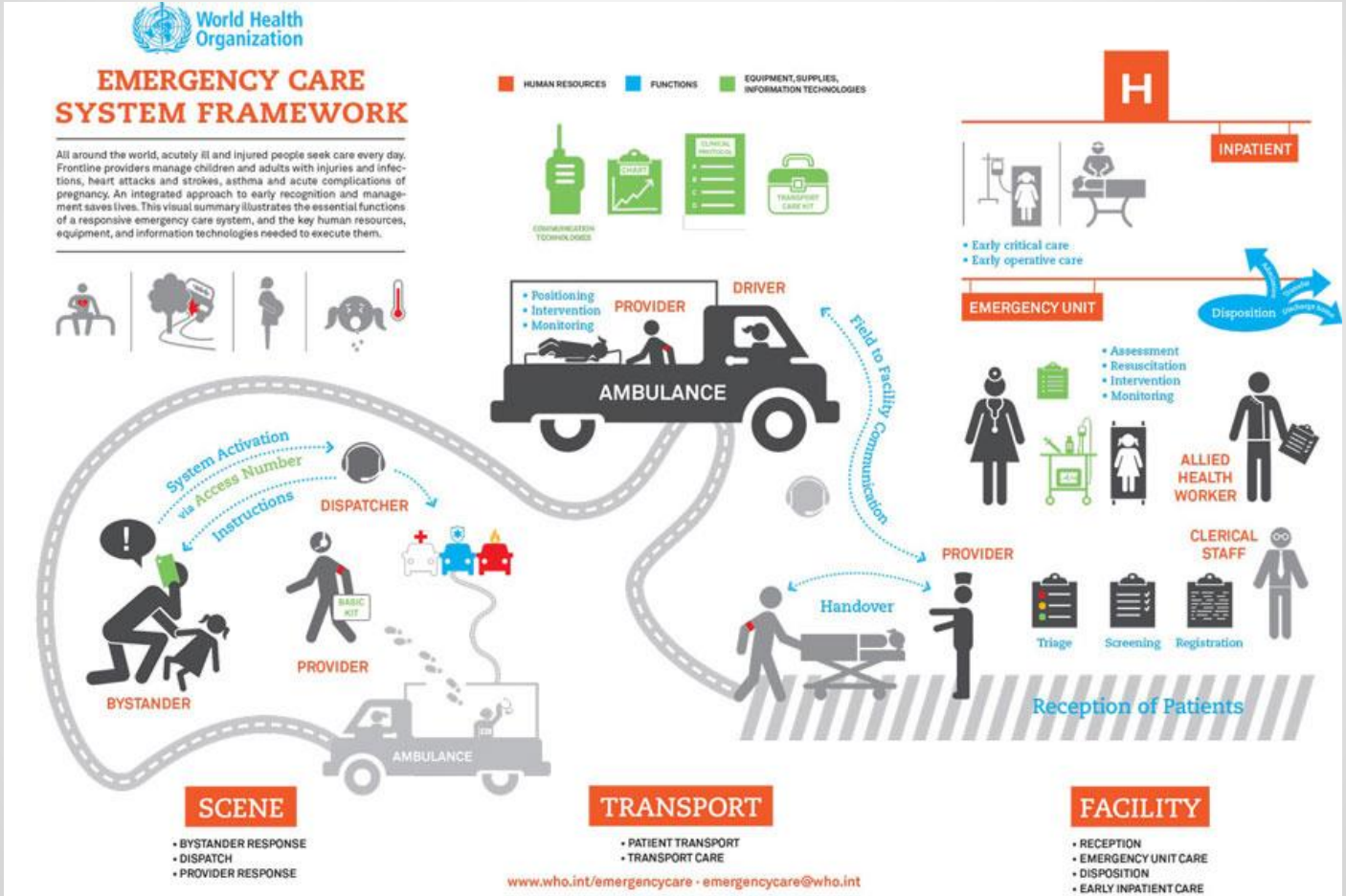
- **State the diagnoses or conditions** (if diagnostic uncertainty) ☐
- **State severity of illness** (stable or critical) ☐
- **State patient trajectory** (worsening or improving) ☐
- **Report response to interventions provided** ☐

R Recommendation

- **State your recommendations & concerns** ☐
  (e.g. transfer for specialist consult or frequent monitoring)
- **State timeline for recommendations** ☐
  (e.g. transfer or intervention needed in next 1 hour)
- **State contingency plans** ☐
  (e.g. If patient transfer is delayed, then I will...)

Confirmation: Ask receiver to repeat back key information and clarify any questions

PLAN FOR AND SYSTEMATIZE CARE



INMED

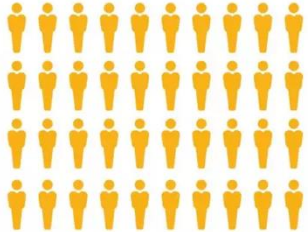
PLAN FOR AND SYSTEMATIZE CARE

- Recurring Emergency Care training and updates help to keep skills fresh and healthcare workers familiar with care processes, equipment, and resources.
- Assess the current health system to identify available assets and resources and explore how collaboration can improve emergency care for all patients.
- Resources and training for health care workers (such as the Basic Emergency Care course) can increase the number of workers prepared to care in emergencies and make a life-saving difference.

INMED

The impact of Global Emergency Care

Each Emergency Care Practitioner (ECP) trained will care for over 40,000 patients over their career.



The cost to train an ECP over 2 years is $7,000 - just $0.18 per patient treated over his/her lifetime

WHY WE NEED YOUR HELP

Sub - Saharan Africa has an estimated shortage of 420,000 physicians*

Less than 20% of the hospitals in Sub-saharan Africa have the ability to deliver emergency care.

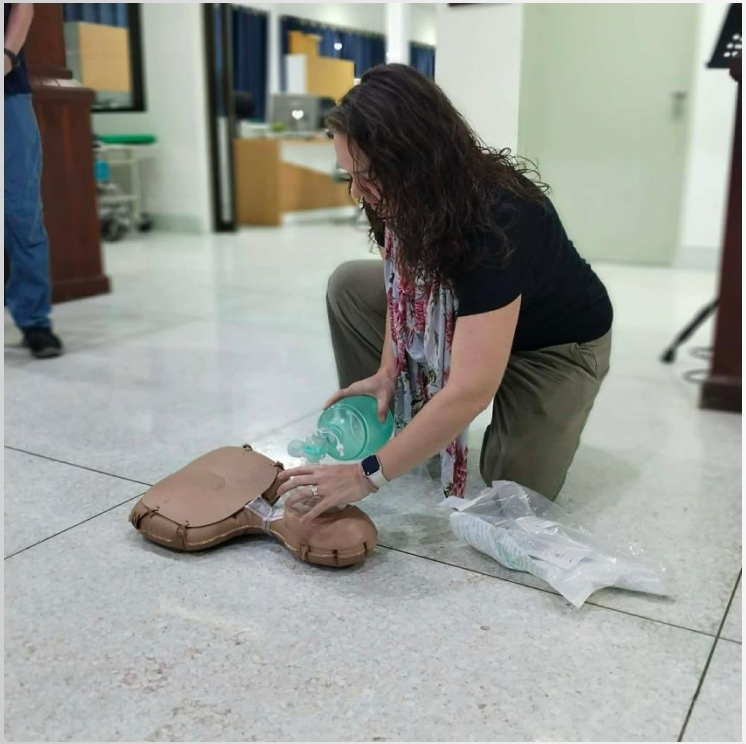
GEC ECPs are currently treating more than 4,000 children and 20,000 total patients each year for acute illness or injury

We project emergency care saves 1 additional life among every 20 children sick enough to be admitted to the hospital, based on pilot site data.

Life Saving Medical Care for all

*Based on WHO recommendation for physician to population ratio (2015)

ALL EFFORTS CAN SAVE LIVES



INMED

THANK YOU