

# **Rehabilitation 2030: A Call for Action**

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Executive Boardroom, WHO Headquarters

Meeting Report

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## **ACKNOWLEDGEMENTS**

This report follows the meeting, Rehabilitation 2030: A Call for Action, organized by the World Health Organization (WHO).

WHO would like to express its sincere thanks to those who participated in the meeting: representatives from Member States, UN agencies, governmental and nongovernmental organizations, editors of journals, academia, institutions and WHO collaborating centres.

### **SPEAKERS AND MODERATORS**

Speakers, panellists and moderators contributed their expertise and insights throughout the meeting. In order of presentation: Etienne Krug (Department for the Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention, WHO), Oleg Chestnov (Cluster for Noncommunicable Diseases and Mental Health, WHO), Dorcus Makgato (Minister of Health and Wellness, Botswana), Rajitha Senaratne (Minister of Health and Indigenous Medicine, Sri Lanka), Phouthone Moungpak (Deputy Minister of Health, Lao People's Democratic Republic), Ritu Sadana, Gopal Mitra, Cheat Sokha, Alarcos Cieza (Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention, WHO), Somnath Chatterji (Department for Information, Evidence and Research, WHO), David McDaid (London School of Economics, United Kingdom), Anneke Schmider (Department for Information, Evidence and Research, WHO), Linamara Battistella (University of São Paulo Medical School, Brazil), Gwynnyth Llewellyn (University of Sydney, Australia), Ximena Neculhueque Zapata (Director of Rehabilitation, Ministry of Health, Chile), Carlos Pinto (Deputy National Director, SENADIS, Ministry of Social Development, Chile), Gundula Rossbach (President, German Statutory Pension Insurance Scheme), Joachin Breuer (Director General, German Social Accident Insurance), Darshan Punchi (Parliamentary Secretary of

Health, Pakistan), Herminigildo Valle (Undersecretary of Health, Department of Health, Philippines), Gerold Stucki (University of Lucerne, Switzerland), Nhan Tran (Alliance for Health Policy and Systems Research, WHO), Dan Chisholm (Department of Mental Health and Substance Abuse, WHO), Chapal Khasnabis (Global Cooperation on Assistive Technology, WHO), Jan Monsbakken (Rehabilitation International), Karsten Dreinhöfer (Chair, Global Alliance for Musculoskeletal Health), Emma Stokes (World Confederation of Physical Therapy), Karen Heinicke-Motsch (CBM), Christoph Gutenbrunner (Department of Rehabilitation Medicine, University of Hannover, Germany), Allen Foster (London School of Hygiene and Tropical Medicine, United Kingdom), Joel Block (Osteoarthritis and Cartilage journal, United States of America), Laragh Gollogly (Bulletin of the World Health Organization), John Beard (Department of Ageing and Life Course, WHO), Jan Ties Boerma (Department of Health Statistics and Informatics, WHO), Ed Kelley (Department of Service Delivery and Safety, WHO), and Shekhar Saxena (Department of Mental Health and Substance Abuse, WHO).

## **WHO SECRETARIAT**

The following members of the WHO Secretariat supported the organization and coordination of the meeting: Chris Black, Laure Cartillier, Helene Dufays, Louisa Djerroud, Kaloyan Kamenov, Lindsay Lee, Elanie Marks, Jody-Anne Mills, Marieke van Regteren, Altena, Laura Sminkey, Tamitza Toroyan and Judith van der Veen.

## **FINANCIAL SUPPORT**

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## **EXECUTIVE SUMMARY**

With the rising prevalence of noncommunicable diseases and injuries and the ageing population, there is a substantial and ever-increasing unmet need for rehabilitation. In many parts of the world, however, the capacity to provide rehabilitation is limited or non-existent and fails to adequately address the needs of the population.

With its objective of optimizing functioning, rehabilitation supports those with health conditions to remain as independent as possible, to participate in education, to be economically productive, and fulfil meaningful life roles. As such, the availability of accessible and affordable rehabilitation plays a fundamental role in achieving Sustainable Development Goal (SDG) 3, “Ensure healthy lives and promote well-being for all at all ages”.

The barriers to scaling up rehabilitation indicate a need for greater awareness and advocacy, increased investment into rehabilitation workforce and infrastructure, and improved leadership and governance structures. The magnitude and scope of these unmet needs signals an urgent need for concerted and coordinated global action by all stakeholders.

### **OBJECTIVES**

1. To draw attention to the increasing needs for rehabilitation.
2. To highlight the role of rehabilitation in achieving the SDGs.
3. To call for coordinated and concerted global action towards strengthening rehabilitation in health systems.

### **OUTCOMES**

Rehabilitation 2030: A Call For Action,

**FOSTERED AWARENESS** of the need to strengthen rehabilitation in health systems to meet the existing and future needs of populations.

**HIGHLIGHTED THE ROLE** of different stakeholder groups in contributing to the rehabilitation agenda.

**DEMONSTRATED THE IMPORTANCE** of rehabilitation across WHO strategies and in the achievement of Sustainable Development Goal 3.

**SHED LIGHT ON** the approaches to implementing rehabilitation services in countries, using examples from Chile, Germany, Pakistan and the Philippines.

## **CONTENTS OF THIS REPORT**

This report summarizes the key messages of the various sessions in chronological order. The Call for Action, translated into French, Spanish and Russian, the agenda, participant list and infographic of Rehabilitation in health systems can be found in the annexes. Background papers and the concept note, as well as the video, Rehabilitation in the 21<sup>st</sup> century, can be found online (<http://www.who.int/disabilities/care/rehab-2030/en/>).

# REHABILITATION 2030 PARTICIPANTS IN NUMBERS

Total participants: 208

## **Representation across WHO regions**

Europe: 46%

Eastern Mediterranean: 4%

South-East Asia: 9%

The Americas: 19%

Western Pacific: 15%

Africa: 7%

## **Representation by stakeholder type**

Government representatives: 27%

WHO: 15%

Rehabilitation professional organizations: 9%

Academia: 25%

Condition-specific organizations: 14%

Other: 10%

# 1. Call for Action

**The participants of the meeting *Rehabilitation 2030* acknowledge the following:**

- A. The unmet rehabilitation need around the world, and especially in low- and middle-income countries, is profound.
- B. Demand for rehabilitation services will continue to increase in light of global health and demographic trends, including population ageing and the increasing number of people living with the consequences of disease and injury.
- C. Greater access to rehabilitation services is required to “Ensure healthy lives and promote well-being for all at all ages” (Sustainable Development Goal [SDG] 3) and to reach SDG Target 3.8 “Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”.
- D. Rehabilitation is an essential part of the continuum of care, along with prevention, promotion, treatment and palliation, and should therefore be considered an essential component of integrated health services.
- E. Rehabilitation is relevant to the needs of people with many health conditions and those experiencing disability across the lifespan and across all levels of health care. Thus, rehabilitation partnerships should accordingly engage all types of rehabilitation users, including persons with disability.
- F. Rehabilitation is an investment in human capital that contributes to health, economic and social development.
- G. The role of rehabilitation is instrumental for effective implementation of the *Global strategy and action plan on ageing and health (2016–2020)*, the *Mental health action plan (2013–2020)* and the *Framework on integrated people-centred health services*, and as a contribution to the efforts of the Global Cooperation on Assistive Technology (GATE) initiative.
- H. Current barriers to strengthen and extend rehabilitation in countries include:



- i. under-prioritization by government amongst competing priorities;
  - ii. absence of rehabilitation policies and planning at national and sub-national levels;
  - iii. limited coordination between ministries of health and social affairs where both are involved in rehabilitation governance;
  - iv. non-existent or inadequate funding;
  - v. a dearth of evidence of met and unmet rehabilitation needs;
  - vi. insufficient numbers and skills of rehabilitation professionals;
  - vii. absence of rehabilitation facilities and equipment; and
  - viii. lack of integration into health systems.
- I. There is an urgent need for concerted global action by all relevant stakeholders, including WHO Member States and Secretariat, other UN agencies, rehabilitation user groups and service providers, funding bodies, professional organizations, research organizations, and nongovernmental and international organizations to scale up quality rehabilitation.

**In light of the above, the participants commit to working towards the following ten areas for action:**

1. Creating strong leadership and political support for rehabilitation at sub-national, national and global levels.
2. Strengthening rehabilitation planning and implementation at national and sub-national levels, including within emergency preparedness and response.
3. Improving integration of rehabilitation into the health sector and strengthening inter-sectoral links to effectively and efficiently meet population needs.
4. Incorporating rehabilitation in Universal Health Coverage.
5. Building comprehensive rehabilitation service delivery models to progressively achieve equitable access to quality services, including assistive products, for all the population, including those in rural and remote areas.
6. Developing a strong multidisciplinary rehabilitation workforce that is suitable for country context, and promoting rehabilitation concepts across all health workforce education.

7. Expanding financing for rehabilitation through appropriate mechanisms.
8. Collecting information relevant to rehabilitation to enhance health information systems including system level rehabilitation data and information on functioning utilizing the International Classification of Functioning, Disability and Health (ICF).
9. Building research capacity and expanding the availability of robust evidence for rehabilitation.
10. Establishing and strengthening networks and partnerships in rehabilitation, particularly between low-, middle- and high-income countries.

## 2. INTRODUCTION

Dramatic shifts in the health and demographic profiles of populations are characterizing the 21<sup>st</sup> century. People are living longer and with disabling chronic conditions that impact on their functioning and well-being. The population aged over 60 is predicted to double by 2050 while the prevalence of noncommunicable diseases has already increased by 18% in the last 10 years. Health systems are confronted with the responsibility of responding to these emerging challenges and health policies are placing increased emphasis on services targeted at increasing functioning, in addition to those that reduce mortality. Sustainable Development Goal 3 – Ensure healthy lives and promote well-being for all at all ages – articulates the importance of promoting healthy life expectancy, i.e. both living longer and living better.

Rehabilitation is a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment. Health condition refers to disease (acute or chronic), disorder, injury or trauma. A health condition may also include other circumstances such as pregnancy, ageing, stress, congenital anomaly, or genetic predisposition.

The Rehabilitation 2030 meeting, bringing together rehabilitation stakeholders from health policy, clinical practice, users, funders, academia and development, was an invaluable opportunity to establish joint commitments for action towards scaling up rehabilitation services, and address the profound unmet needs that exist.

Rehabilitation 2030 presented an ideal platform to launch the newly published *Rehabilitation in health systems*, which provides recommendations for the expansion and extension of rehabilitation in countries. Dr Oleg Chestnov (Cluster for Noncommunicable

Diseases and Mental Health, WHO) presented the document at the introduction of the meeting and examples of the implementation of the recommendations were provided by countries from different WHO regions during the course of the meeting (see section 5).

In their opening remarks to the participants, Dr Etienne Krug (Department for the Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention, WHO) and Dr Chestnov noted that the meeting was long overdue.

Dr Chestnov emphasized that rehabilitation is a multisectoral strategy and that scaling up services is necessary not only to respond to the growing demand arising from health and demographic trends, but to maximize the benefits of advances in medicine and assistive technology. He also highlighted the substantial need for rehabilitation within emergency contexts. Importantly, Dr Chestnov acknowledged that the sustainable development agenda cannot be effectively achieved without addressing the unmet needs for rehabilitation services.

Keynote addresses from ministries, (including Honorable Ms Dorcas Makgato, Minister of Health and Wellness, Botswana, Honorable Dr Rajitha Senaratne, Minister of Health and Indigenous Medicine, Sri Lanka, and Honorable Dr Phouthone Moungpak, Deputy Minister of Health, Lao People's Democratic Republic) further highlighted the importance of integrating rehabilitation into health systems. Together they highlighted some of the challenges faced, and how this is being addressed in accordance with the needs and priorities of each country.

**“Our hope is that this meeting will accelerate action in countries to ensure rehabilitation services are available for all who need them. We rely on the support of all of you to achieve this ambitious goal.”**

- Dr Etienne Krug

**“The issue of rehabilitation is today one of the main strategic aims for our organization...the Sustainable Development Goals cannot be effectively achieved unless we address [it].”**

- Dr Oleg Chestnov

**“Even though I am saying that [rehabilitation] services are available, the question is are they adequate where they are available, and the answer is no. This provided a necessity for us to infuse rehabilitation into national development planning.”**

- Honorable Ms Dorcas Makgato

**“Efficient rehabilitation requires proper planning. To do this we need health information systems to collect, process and manage relevant [rehabilitation] information.”**

- Honorable Dr Rajitha Senaratne

**“The Ministry of Health knows that there is a long way to go to [address] the unmet needs of people living with functional limitations in our country... The Lao PDR recognize the need to fully integrate and strengthen rehabilitation in the system.”**

- Honorable Dr Phouthone Moungpak

## 3. REHABILITATION: TESTIMONIALS

### 3.1 Rehabilitation is a Package

- Dr Ritu Sadana

One of my passions is cycling. As a teenager in California, I loved road races and of course, the Tour de France. Over the years, cycling also brought my husband, Jacques and I together in Denmark, and then later, family fun with our kids. I'm showing here some photos from the summer of 2013 - my favourite one is with my son, Jacques-Kabir - especially his grin when we got to the top of Crestet, a little village in Provence. That was late August 2013: I was 49, and he, 14.

So imagine that a few weeks later, on a Saturday afternoon I went for a bike ride alone, just near our home. I remember blue sky and lots of sun. And then a black hole.

Imagine, that I woke up 2 weeks later completely immobile with neck and leg braces, tubes all over. It was real -- this photo is from October 2013. I was told the good news, that I've survived being hit by a car at 90 km an hour. But that I had serious injuries, including a broken neck, crushed lower back, blocked arteries, and despite a helmet, part of my scalp was gone. I already had many surgeries, including putting in 2 cages along my unstable spine. But I could still be paralyzed and will need to have another surgery to replace the L1 vertebra, and ongoing monitoring in case of cognitive decline. And when my husband told me that my mom was flying over from California, I realized, wow, it must be serious.

But now, three years later, I've been reconstructed, and with ongoing rehabilitation, I'm doing a lot of things I really like to do, including being back at work.

But to this day many people, even within WHO, tell me, "Ritu, you're a miracle." Honestly, I survived because of excellent emergency and trauma care. But being me again, this is all about rehabilitation.

My first message is that rehabilitation is not a miracle, but it is a PACKAGE. Rehabilitation professionals were my first contact. Their encouragement, skills and ability to build up a trusting relationship, pushed me to go beyond what I thought was possible. Mrs Nathalie Jaros, Physiotherapist, from Clinique La Lignière, is here today - her warm water and massage therapy has helped me manage pain and contributes to my overall well-being. I also benefit from a range of services promoting alignment, mobility, strength and balance. I've used different equipment, some low tech, like elastic exercise stretch bands, big red balance ball and lots of uneven surfaces.

Financial coverage is also essential, otherwise I wouldn't be able to afford it. I also need time to do physio, and my home and work place has been adapted, for example, WHO has given me a movable desk, so I can work sitting or standing. Clearly there needs to be policies: But it is people who make sure that these are put in place. WHO's Director of Staff Health and Wellbeing Services, Dr Caroline Cross, discussed with my husband early on options for rehabilitation hospitals, and along with my boss, Dr John Beard, made sure I got a formal agreement allowing me to go to physiotherapy during working hours. I still benefit from this today.

I wish I could tell you many more examples of crucial support from family, friends and colleagues.

There are two more parts in this package that I have control over – that's to celebrate every success, and to stay motivated and not give up. I followed the advice of a dear friend, “do one more repetition” and then you're already 10% further along, ahead of the curve. My second message is that the result was a new me. Of course at first it was basic, so that I could go home for a day visit; and then increase autonomy and confidence so I could go home for good. But always with support from people around me, like when my sister flew here from the USA, to help out the first week I came home – and celebrate my 50<sup>th</sup> birthday. These photos show my trajectory over the past few years.

If I had stopped rehabilitation after one year, I would probably still move like a robot and be uncomfortable in a crowd, and not come back to work. I still have limitations: I can't run, jump or pick up anything heavy; and my neck and back have limited rotation.

Now, ongoing rehabilitation allows me to focus and optimize what I can do, maintain the gains I've made, and manage chronic pain. I know that some people end up using opiates or other drugs for chronic neck and back pain, and a growing number become dependent. I chose another path and am grateful that I am supported.

My third message is that rehabilitation is a part of my daily life, and those around me. I see a strong connection between rehabilitation and health promotion. There are some things I do alone, like ride a stationary bike – I started as soon as I was released from the hospital. But with my family, we go on walks. After the first six months, I was encouraged to snowshoe – I cried after doing 100 metres. Now I snowshoe with a passion – it builds up core back muscles and fits in with local culture. My husband “shoes” with me and as the photos show, my 83 year old father came from California to try it out.

My fourth and final message is that rehabilitation has had a huge impact, with immense value. Let me go back to December 2013: I had just come home from the hospital, wearing the hard neck brace, really thin and weak. I want to share with you the Christmas card my daughter, Gitanjali, made. She was 12 at that time and wrote “Merry Christmas mom, Santa Claus will give you the gift of rehabilitation, and it will arrive on the 7<sup>th</sup> of January, stay strong until then” ... indeed, that was when a CT scan showed enough consolidation so the hard neck brace could be removed and I could start more active physiotherapy. Since then, it's been a long journey, and it's very meaningful that my husband and children, and many others who have supported me, are also here today.



And I hope I've convinced you it's been a worthwhile investment with a huge return. Take it from me, rehabilitation gave me a second life, a second life definitely worth living.

### 3.2 Overcoming Misconceptions

- Mr Gopal Mitra

I became blind nearly 20 years back when I was in my late 20s. If you look at the definition of rehabilitation as a set of services that enable people with disability or at risk of disability to attain optimal functioning, and as instrumental to participating in education, employment and the community, it is clear that I am well rehabilitated, and that's a fact. But the journey has been fought with lots of ups and downs, as the journey of life always is. I became blind very suddenly due to an explosion. I woke up in an intensive care unit two weeks later with 200 stitches all over my body and I was told that the chances I would see again were small.

I come from a lower middle class family from a small town in India, and when my family learnt of my injuries, they were shattered. While I was lucky to have survived the explosion, I struggled to find the psychosocial counselling and support that myself and my family needed. I was lucky, more lucky than many of my fellow Indians, to get rehabilitation. But I had to arrange most of it myself. I found that there is a gross lack of awareness about rehabilitation; even medical doctors and eye doctors do not know what services are available for people whose sight cannot be restored. When I was injured, the internet and google were not available. I found what I needed in the way of services and support through trial and error, through friends, and through persons with disabilities. I was initially sent back to my town where there were no services. I discovered that services were completely urban-centric. This is something I feel has to change. You see, a large number of people (if not most) that need rehabilitation services live in rural settings. Rehabilitation services need to be available everywhere – in the community where real people live.

The second point I want to raise is about the quality of rehabilitation services. I was sent to an institute that had responsibility for rehabilitating the blind and visually impaired. After the second week of my mobility

and orientation training, I developed severe backache. I had been given a shorter cane, because the one for my size was not available, and I was told to make do with it. In the same institute, I asked what vocational options I had since I had to leave the army. The person asked me, what did you do? I told him I was a major in the army, and I have organized complex operations, logistics, and so on. He told me to forget everything – he said “You are blind now. I have two rehabilitation vocational courses short listed for you: basket weaving and telephone operator”. I was so angry, I wanted to weave a basket and put him in it so that he cannot give such advice to any other blind people! Rehabilitation services have not been updated since the 1950s in many cases, which is when basket weaving and candle making were prevalent. So, it is not only about making services available, they have to be quality services.

I also encountered some major institutional barriers. I went to the district rehabilitation centre and was told that I need a disability certificate in order to get assistive devices, which were crucial for me. Yet when I went to the hospital to get my certificate, they told me I had to wait five years to get a disability certificate because they needed to be sure I had a long-term impairment. My right eye is a prosthetic, so I took it out and gave it to him and said, “Can this grow back?” What happens to people with temporary functional limitations? Do they not also deserve rehabilitation? We have policies that prevent people from accessing the rehabilitation they need. This has to change.

I was lucky to have received proper rehabilitation. Whatever I received, whether computer training, orientation or mobility, associations of the blind and visually impaired people and organizations of persons with disabilities played a major role. As part of the overall rehabilitation architecture, we have to ensure that such institutions are supported by the government and by the overall system.

Finally, we need to address the issue of out-of pocket expenses. Most people with disability live in poverty. I was able to get rehabilitation paid partly by my organization and partly by myself, but a lot of people will not be able to afford it. We see this in the course of work at UNICEF every day. Systems and structures need to be set up to minimize out-of-pocket expenses, because these are so prohibitory.

I would like to congratulate WHO for undertaking this initiative. Rehabilitation is crucial. It's a life changer, and it needs to be beefed up all over the world. The Sustainable Development Goals talk about leaving no one behind. They do not say, "leave almost no one behind". Rehabilitation is crucial if we really want to make sure that no one is left behind, and quality rehabilitation has to be available to each and every person with disability, as well as those that have temporary functional limitations.

### **3.3 Challenges in Accessing Life-changing Rehabilitation Services**

- Ms Cheat Sokha

I am Cheat Sokha from Cambodia, and I have been a paraplegic since I was 14 years old.

At the time of my injury my family and I lived in a small village near the border of Thailand. Cambodia had been experiencing civil war for more than a decade.

One evening in 1985, I heard shooting from the next village. One shot fell in the premises of my house. I suddenly fell down and I noticed that I could not feel from my waist down. Shrapnel had hit my backbone and I had a spinal cord injury (SCI).

There was no treatment, rehabilitation, or awareness of SCI in Cambodia at that time and initially, I had no treatment at all. Very quickly I developed a pressure sore and my condition worsened. My family tried to seek treatment for me, carrying me to the refugee camp across the border to Thailand. This was both illegal and hazardous, with landmines and military deployed along the border.

It was at the refugee camp that I first received rehabilitation, and indeed, knew what it was. It was the NGOs, Handicap International and the International Committee of the Red Cross (ICRC), who provided this.

During rehabilitation, my situation improved; my initial pressure sore healed and I learnt how to prevent them. I also learnt how to mobilize, to dress myself, move from bed to wheelchair and how to get around in my wheelchair.

SCI is a big challenge for anyone, especially in a poor country like Cambodia.

Before rehabilitation I couldn't see my future; I was always in despair, depressed, and never believed that I could do anything such as study or work. I always felt my life would be difficult.

Rehabilitation taught me to see my future and made me a different person. In rehabilitation I learnt that people with SCI could actually work. At the rehabilitation centre I witnessed people with SCI and amputations working in the workshop.

In 2012 I had the opportunity to establish the SCI Association of Cambodia, which offers peer support. Since then I have been working with many Cambodian people with SCI.

The family of someone with a SCI often seek treatment and rehabilitation for their loved one to enable them to walk. Through this experience, many learn that they cannot walk again and believe they will be a burden to the family. The family must keep working hard to make money to pay for treatment from the medical services or drug shop.

In Cambodia, most people with SCI live at home, they don't go out, they don't work, and they seem isolated by community and society.

When I go out in rural community I meet people who did not get rehabilitation. They suffer and live with SCI complications such as pressure sores, urinary problems, fever, contracture of stiff joints, and not being independent. Their families tell me later that he or she has died, mostly because of pressure sores. But they also die because of depression; they give up, they don't care about their situation. Many die within two years of their injury.

But good quality rehab makes a difference, and I have seen this. With good quality rehabilitation, they understand, they know how to take care of themselves, and how to be independent and how to adjust to life after SCI. They can re-integrate, they get vocational training, a job, get money and then are appreciated in the family and community. They survive longer.

In Cambodia, how people manage after SCI depends on the individual family – If they support the person enough and if they have money. It shouldn't be about this.

Article 26 of the CRPD<sup>1</sup>, says that rehabilitation is a human right and that State Parties have to take measures to protect, promote and ensure that persons can access quality rehabilitation. So far, this is not always the reality. By 2030, I hope that nobody needing rehabilitation is left behind.

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<sup>1</sup> Convention on the Rights of Persons with Disabilities

## 4. REHABILITATION IN THE 21<sup>ST</sup> CENTURY

### 4.1 Rehabilitation in the Context of the Global Agenda

- Dr Alarcos Cieza, Department for the Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention, WHO

Dr Cieza provided a summary of why rehabilitation is particularly relevant in the context of the 21<sup>st</sup> century and the sustainable development agenda. The Rehabilitation 2030 background paper, *Rehabilitation: key for health in the 21<sup>st</sup> century*, on which her presentation is based, can be accessed at (<http://www.who.int/disabilities/care/rehab-2030/en/>).

#### **What is rehabilitation?**

Rehabilitation is a set of interventions designed to reduce disability and optimize functioning in individuals with health conditions in interaction with their environment.

'Health condition' refers to disease (acute or chronic), disorder, injury or trauma. A health condition may also include other circumstances such as pregnancy, ageing, stress, congenital anomaly, or genetic predisposition.

#### **Who are rehabilitation services for?**

Rehabilitation services may be used by people living with health conditions (all types) and are not only for persons with disabilities, seen from a minority point of view.

#### **Why 'Rehabilitation 2030'?**

Rehabilitation is a key objective in the WHO Global Disability Action Plan 2014–2021, yet now, in the era of the sustainable development agenda, it needs to be brought into a broader context. Rehabilitation services are necessary for the achievement of SDG goal 3 – Ensure healthy lives and promote well-being for all at all ages. Rehabilitation



2030 is a call for action to scale up rehabilitation so that countries can be prepared to address the evolving needs of populations up to 2030.

### **Why the health system?**

Rehabilitation is multidisciplinary and uses professionals that are from both health and other sectors (education and labour, for example). For rehabilitation services to be effectively scaled up, there needs to be strong collaboration across these sectors. Health systems, however, should play a stewardship role in strengthening rehabilitation services, because rehabilitation is a health strategy that is needed by people with health conditions, at all levels (primary, secondary, and tertiary), across the continuum of care and across the lifespan.

### **How does rehabilitation fit within Universal Health Coverage?**

According to WHO's definition, rehabilitation is one of the quality health services that should be included in Universal Health Coverage. This means that all individuals should be able to access quality rehabilitation services without fear of financial hardship.

“Universal Health Coverage means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, REHABILITATION, and palliative care.”

## 4.2 The Need to Scale Up Rehabilitation

- Dr Somnath Chatterji, from the Department for Information, Evidence and Research, WHO

Dr Chatterji explained the findings detailed in the Rehabilitation 2030 background paper, *The need to scale up rehabilitation* (accessed at <http://www.who.int/disabilities/care/rehab-2030/en/>) and explained the challenges associated with creating estimations of rehabilitation need.

### **What do the data show about the global need for rehabilitation?**

There is a clear mismatch between the global need for rehabilitation and the availability of services. However, the data are very limited; conclusions regarding the extent of the gap in rehabilitation services are drawn from what data are available on the number of people who have needs for services or the number of specialized rehabilitation professionals available in countries. Nonetheless, the data available are likely an underestimation of the true gap; data collected from facilities or population surveys would show that the unmet need is greater than what is indicated with the limited sources available.

### **What are the current approaches to estimate the global need for rehabilitation?**

There are two approaches to estimating the global need for rehabilitation. The analysis used in the background paper, *The need to scale up rehabilitation*, provides an estimate of need based on the epidemiology of diseases, their prevalence and the distribution of severity across the population. This approach is referred to as a top-down approach, and has several limitations. The alternative, more ideal approach, is a bottom-up approach that estimates rehabilitation need based on the capacity of individuals in the general population independent of the underlying health condition(s); this information is collected through population-based surveys and administrative data. Population surveys, such as the Model Disability Survey, that estimate

performance<sup>[1]</sup> (based on the environments in which people live) are capable of a more accurate estimation of rehabilitation need than epidemiological data.

### **What are the challenges in the measurement of the need for rehabilitation?**

One of the key challenges for estimating rehabilitation need is the variability in what is being measured. Many of the data collected measure impairment; however this does not fully capture rehabilitation need, as rehabilitation aims to improve performance (target a person's environment as well as impairment). A consensus on what data are used to estimate rehabilitation need is thus needed to ensure that estimates of need are based on accurate and comparable data.

### **What are the future directions in terms of strengthening rehabilitation within the health system?**

An important step for strengthening rehabilitation in health systems is to begin including rehabilitation information within the health information system. Data are needed both from health facilities (including long-term care facilities) and from the general population. This can be achieved when a common set of data collection items is used across long-term care, patient-reported outcomes in clinical practice and in general population surveys. Such information would provide the true need for rehabilitation in different settings. The availability of information and communications technology has the potential to facilitate more efficient and effective data collection (that will allow people to report their experience in their real life environment). Yet integration of information within the health system is possible only when the health system delivers rehabilitation interventions and has the responsibility for stewarding non-health interventions that are delivered outside the health sector.

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[1] Performance, according to the International Classification of Functioning, Disability and Health (ICF), describes what people do in their current environment, and so brings in aspect of a person's involvement in life situations.

### **4.3 The Cost of Failing to Provide Rehabilitation Services**

- Dr David McDaid, London School of Economics, United Kingdom

Dr McDaid provided an overview of the availability of evidence for the cost-effectiveness of rehabilitation and highlighted several of the challenges in ascertaining the cost of failing to provide rehabilitation.

#### **Is there an economic case for investing in rehabilitation?**

There is an evidence base demonstrating a return on investment for different types of rehabilitation, for different health conditions and in different contexts. The methodology used is different, however, and studies are mainly from high-income countries. Understanding the system context is particularly important when making an economic case for investment in rehabilitation.

#### **How are returns on investment in rehabilitation quantified?**

Returns from investment are not only quantified in monetary terms; returns may also be realized in improved quality of life and increased participation in education and employment, for example.

Policy-makers are usually most interested in direct costs (such as savings associated with medical management) but the cost-benefits of rehabilitation can also be indirect (such as reduced need for long-term care).

#### **Who benefits from investment in rehabilitation?**

Rehabilitation impacts not only the health system, but also other sectors, such as education and labour. Therefore, the case for investment in rehabilitation also needs to be made for these sectors. The individual and their family also benefit through improved health and social outcomes.

#### **What are the challenges for establishing the cost of not providing rehabilitation?**

In order to establish the cost of not providing rehabilitation, a comparator is needed i.e. no rehabilitation, a poorer quality of

rehabilitation, or a different duration or particular starting point of intervention. Currently this varies between studies.

Duration and outcomes also have an important impact on how costs are measured. Costs associated with failing to provide rehabilitation may be incurred over weeks, months or years, and by different sectors, the individual and their family.

Another challenge is that the parameters of rehabilitation (or how it is defined) are not always clear. Some cost–effectiveness studies that explore rehabilitation interventions do not identify them as rehabilitation.

### **Examples of cost–effectiveness studies on rehabilitation:**

- Howard-Wilsher S, Irvine L, Fan H, Shakespeare T, Suhrck M, Horton S, et al. Systematic overview of economic evaluations of health-related rehabilitation. *Disabil Health J* 2016;9:11–25
- Oldridge NB, Pakosh, MT, Thomas, RJ. Cardiac rehabilitation in low- and middle-income countries: a review on cost and cost-effectiveness. *Int Health* 2016;8:77–82
- Lewin GF, Alfonso HS, Alan JJ. Evidence for the long term cost effectiveness of home care reablement programs. *Clinical Interventions in Ageing*; 1 Oct 2013
- Farag et al. Economic evaluation of a falls prevention exercise program among people with Parkinson's disease. *Movement Disorders*; 23 Sept 2015
- Turner-Stokes L, Williams H, Bill A, Bassett P, Sephton K. Cost–efficiency of specialist inpatient rehabilitation for working-aged adults with complex neurological disabilities. A multicentre cohort analysis of a national clinical dataset. *BMJ Open* 2016;6:e010238.

#### **4.4 Improving Data for Rehabilitation in Health Information Systems**

- Ms Anneke Schmider, Department for Information, Evidence and Research, WHO

Ms Schmider discussed the necessity of including rehabilitation and functioning information into health information systems and what is involved with its successful integration. The Rehabilitation 2030 background paper, *Health information systems and rehabilitation*, on which this presentation is based, can be accessed at <http://www.who.int/disabilities/care/rehab-2030/en/>.

#### **Why is it important to include information about rehabilitation and functioning in health information systems?**

Data in health information systems underpin decisions in health policy, management and clinical care. It is important to include information about rehabilitation and functioning in order to raise revenue for rehabilitation services and make decisions about resource allocation, amongst other strategic financing decisions. Importantly, such information is needed to make the economic case for investment in rehabilitation services.

Successfully achieving the first five points in the call for action (see section 8) will require health systems to have access to robust information on rehabilitation and functioning, particularly as the health and demographic profiles of countries shift.

#### **What information should be collected?**

In order to capture the necessary breadth and depth of information on rehabilitation and functioning, health information systems should include individual data, programme and facilities data, and population data from surveys and censuses.

#### **How can countries integrate information on rehabilitation and functioning efficiently?**

Where possible, information on rehabilitation and functioning should be integrated into existing broader health information systems. Modern

data systems that are multi-source, multi-method, multi-purpose and technology enabled will better ensure efficient collection, management and use of data. Efficiency of data integration will be greatly facilitated by improved individual records (better standards of record keeping, content and use), data sharing, management and linkages

Rehabilitation and functioning information can be drawn from different sources at the level of the individual, programme and population. Together, this information provides the full picture of rehabilitation needed within the health information system to guide policy and financial decision-making.

## 5. IMPLEMENTING REHABILITATION IN HEALTH SYSTEMS: KEY LESSONS FROM MEMBER STATES

The meeting, Rehabilitation 2030, provided an opportunity to launch *Rehabilitation in health systems* ([http://www.who.int/disabilities/rehabilitation\\_health\\_systems/en/](http://www.who.int/disabilities/rehabilitation_health_systems/en/)).

This document contains key recommendations towards strengthening rehabilitation services in countries that are underdeveloped and under resourced. Representatives from Chile, Germany, the Philippines and Pakistan presented examples of how rehabilitation is being integrated and strengthened in the health system of their country.

### Chile

-Dr Ximena Neculhueque Zapata, Director of Rehabilitation, Ministry of Health

- Mr Carlos Pinto, Deputy National Director, SENADIS, Ministry of Social Development

Dr Zapata and Mr Pinto spoke to the implementation of recommendation B, “Integrate rehabilitation into and between primary, secondary and tertiary levels of health systems”, and recommendation D, “Ensure both community and hospital rehabilitation services are available”, within the context of Chile.

Rehabilitation is needed in both community and hospital settings, and across all levels of care.

**“The aim is to implement rehabilitation across the continuum of care, regardless of the health condition.”**

- Dr Ximena Neculhueque Zapata

In Chile, to achieve this aim, attention needs to be given to:

- training rehabilitation professionals, including those in vision and hearing;



- improving rehabilitation information collection and management; and
- optimizing multisectoral relationships.

## **Germany**

-Ms Gundula Rossbach, President, German Statutory Pension Insurance Scheme

-Dr Joachin Breuer, Director General, German Social Accident Insurance

Ms Rossbach and Dr Breuer spoke to the implementation of recommendation F, “Ensure financial resources are allocated to rehabilitation services”, and recommendation G, “Where health insurance exists or is to become available, ensure rehabilitation is included”, within the context of Germany.

The cost–benefits of rehabilitation have been found to be substantial in the context of return to work in Germany, and these benefits are anticipated to increase in the coming years.

**“Rehabilitation is an investment, but it takes time.”**

- Dr Joachin Breuer

To ensure access to rehabilitation (return to work rehabilitation specifically), Germany is:

- recognizing rehabilitation as a key part of recovery and integrating it into health accordingly;
- funding rehabilitation as an investment; and
- ensuring return to work rehabilitation is covered by insurance, and that employers contribute.

## **Pakistan**

- Dr Darshan Punchi, Parliamentary Secretary of Health

Dr Punchi spoke to recommendation C, “Ensure the availability of a multi-disciplinary rehabilitation workforce”, and the good practice

statements of assistive technology, “Implement financing and procurement policies that ensure assistive products are available to everyone who needs them”, and “Ensure adequate training is offered to users to whom assistive products are provided”, within the context of Pakistan.

Rehabilitation is multidisciplinary (the workforce is constituted of more than physiotherapy). To expand the number and types of rehabilitation professionals, Pakistan is:

- creating more rehabilitation positions at the district level;
- increasing the university affiliations for various rehabilitation disciplines; and
- using both the private and public sectors to train rehabilitation professionals.

Accessing appropriate assistive products can be critical to optimizing functioning, and Pakistan is working both at the international political level and locally to improve the availability of assistive products. For example, Pakistan has:

- strongly promoted the inclusion of assistive technology on WHO’s agenda;
- developed a framework for ensuring access to assistive products across the country; and is
- conducting provincial workshops on assistive technology.

**“There is a clear lack of understanding that rehabilitation is an integral component of health services”**

- Dr Darshun Punchi

## **Philippines**

- Dr Herminigildo Valle, Undersecretary of Health, Department of Health

Dr Valle spoke to recommendation A, “Integrate rehabilitation into the health system”, and recommendation E, “Ensure hospitals include

specialized rehabilitation units for inpatients with complex needs”, within the context of the Philippines.

Rehabilitation is included in the Philippine Health Agenda and a portion of the budget for health care has been allocated to expanding rehabilitation services, which are currently concentrated around urban facilities. Priorities include:

- ensuring rehabilitation units are included in secondary and tertiary health facilities; and
- setting a standard of integrating rehabilitation services in primary health care packages.

**“We have included in our national development plan, the upgrading of physical and psychosocial rehabilitation services after a national capacity assessment that is to be conducted.”**

-Dr Herminigildo Valle

## **6. STRENGTHENING REHABILITATION IN HEALTH SYSTEMS: LEARNING FROM CURRENT INITIATIVES IN WHO**

### **6.1 Alliance for Health Policy and Systems Research (AHPSR)**

-Dr Nhan Tran, Alliance for Health Policy and Systems Research, WHO

#### **What is the AHPSR?**

AHPSR is an alliance to promote the generation, dissemination and use of knowledge for enhancing health systems. It focuses on ensuring integration of interventions through applying policy and systems research.

#### **Key messages from the AHPSR**

There is often an incorrect assumption that outcomes and impact can be predicted based on inputs and outputs. In reality, factors such as systems readiness, opportunities for change, political will, competing interests and country context all determine the impact research has. Consequently, there are rarely single solutions to complex problems. This does not discredit the fundamental importance of evidence, but rather means that it inform policy within the context of the system.

A learning health system is one that captures insights, evidence and experience through leadership, incentives and a culture that facilitates its uptake to improve patient experience. This can best occur when research is embedded within the health system (research institutes linked with government bodies). In such a way, health decision-makers guide the research to ensure it is relevant to their needs.

#### **Conclusion for rehabilitation**

Ensuring rehabilitation is successfully integrated in health systems requires not only the generation of key knowledge (such as the cost-effectiveness of rehabilitation) but strong links with the implementing ministry to ensure the findings have maximum impact.

## **6.2 Programme for Improving Mental Health Care (PRIME):**

- Dr Dan Chisholm, Department for Mental Health and Substance Abuse, WHO

### **What is PRIME?**

PRIME is a research consortium focused on scaling up mental health services in low resource settings. It has used research to develop packages of mental health interventions that can be integrated into primary health care. The field of mental health faces very similar challenges to that of rehabilitation (e.g. under-funded, under-resourced, weak governance, and fragmented inefficient service delivery), making it a valuable field to draw lessons from.

### **Key messages from PRIME**

PRIME packages of care are based on available cost-effectiveness research, implementation science and partnerships with local governments and community partners that direct where to concentrate attention and how to apply it in different contexts. Successful implementation of a package of care is ensured through a three phase approach that includes: 1) a formative phase involving a situation analysis, focus groups, theory of change workshops, service planning and costing, 2) implementation phase, and 3) a scaling-up phase. Resource planning has been found to be critical for PRIME; human resources needs and health services costs of scale up need to be considered in order to ensure that implementation and scale up are feasible and sustainable.

Fundamental to the PRIME approach is engagement at all levels; health care organization, facilities and community. The packages include interventions for each of these levels. For example, capacity building and health information systems at the health care organization level, diagnosis and delivery at the facility level, and family support and livelihood support at the community level. Furthermore, as well as

treatment, the package spans awareness, detection, recovery and enablement.

### **Conclusion for rehabilitation**

Cost-effectiveness research for rehabilitation needs to be strengthened and existing research utilized to inform scale up. Packages of interventions for rehabilitation may be an effective mechanism to extend the access and quality of services, but need to be implemented based on comprehensive situation analysis.

### **6.3 Global Cooperation on Assistive Technology (GATE):**

- Mr Chapal Khasnabis, Global Cooperation on Assistive Technology, WHO

#### **What is GATE?**

A global alliance to increase access to high quality affordable assistive technology through addressing policy and service delivery models, defining priority products and developing training packages for personnel.

#### **Key messages from GATE**

The GATE initiative is founded on the belief that health care interventions should be rehabilitative and assistive, as well as preventative, promotive and curative. The importance of strengthening these components of health care is evermore paramount in the context of ageing populations (nearly 75% of assistive technology users are 60+) and rising prevalence of noncommunicable disease. Assistive technology is not only for persons with disability, but for anyone with limitations in functioning.

For low- and middle-income countries, current procurement processes inflate costs to the extent that assistive products are not affordable for the end user. Addressing this barrier means shifting assistive technology out of the sphere of 'medical devices' and using mutually beneficial partnerships between designers, manufacturers and distributors.

## **Conclusions for rehabilitation**

Access to quality assistive technology is fundamental to improving the functioning of populations, and rehabilitation providers have a role in ensuring the appropriate provision and use of such products.

For information on GATE, visit

[http://www.who.int/phi/implementation/assistive\\_technology/phi\\_gate/en/](http://www.who.int/phi/implementation/assistive_technology/phi_gate/en/).

## 7. RAISING AWARENESS FOR REHABILITATION

Different groups of rehabilitation stakeholders came together to determine how best they could use their position and strengths to raise awareness for rehabilitation amongst policy-makers, civil society and in the private sector. The full statements and/or presentation of each group of stakeholders can be found on the Rehabilitation 2030 meeting website (<http://www.who.int/disabilities/care/rehab-2030/en/>).

23 Condition specific organization

9 rehabilitation professional organizations

17 International and nongovernmental organizations

12 Rehabilitation professionals working in medical faculties

11 researchers and professionals working in public health

16 Editors of journals

### **Key themes for raising awareness from all stakeholder groups:**

- The importance of cooperative action between and within stakeholder groups.
- The necessity to demonstrate the need for rehabilitation through the generation and use of evidence (especially the efficacy of rehabilitation interventions and the cost of failing to provide rehabilitation).
- The need to engage with user groups (including persons with disabilities).
- Promoting the contribution of rehabilitation towards the achievement of the Sustainable Development Goals (SDGs).
- The value of being unified in approach, language and policy.



**Increase the awareness of the medical community by educating physicians (both specialists and those in primary care) and other health professionals, promoting integrated people-centered care and integrating rehabilitation into medical guidelines.**

- Professor Karsten Dreinhofer representing condition-specific organizations

**Collaboration between health professionals and consumer/patient/client may be achieved through the development of a global rehabilitation consortium with stakeholders from a range of backgrounds as part of a collaborative model of engagement.**

- Dr Emma Stokes representing rehabilitation professional organizations

**To raise awareness on global priorities in rehabilitation, it is necessary to highlight critical gaps and make the link between rehabilitation, assistive technology, accessibility, universal health coverage, and the global frameworks of the Convention on the Rights of Persons with Disabilities (CRPD) and the SDGs.**

- Ms Karen Heinicke-Motsch representing international and nongovernmental organizations

**It is not enough to provide the evidence and write papers. These have to be translated into clear messages for different audiences, including policy-makers and implementers.**

- Prof Allen Foster representing researchers and professionals working in public health

**In order to raise awareness amongst policy-makers, information on functioning needs to be mainstreamed into data collection mechanisms within the health system. This will help guide payment and funding schemes.**

- Dr Christoph Gutenbrunner representing rehabilitation professionals working in medical faculties

**As the world moves to evidence-based decision-making, it is important to acknowledge that randomized-control trials are not always the most appropriate form of research. Journals can look more broadly to other forms of evidence. Translating content into lay summaries and into different languages will further ensure information is accessible more globally to a wider audience.**

- Prof Joel Bock representing editors of journals

**“Rehabilitation, above all, is a person-centered strategy to address an individual’s needs, which are beyond specific organizations, beyond specializations and beyond specific groups. The spirit of collaboration that we hear in the statements from different stakeholders needs to be maintained in our Call for Action.”**

- Dr Alarcos Cieza, Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention, WHO

## **8. REHABILITATION IN THE CONTEXT OF WHO STRATEGIES**

Rehabilitation is a cross-cutting health service and has relevance across many WHO areas of work. Directors from five different departments participated in a panel discussion, chaired by Dr Laragh Gollogly, Editor-in-chief of the Bulletin of the World Health Organization, to discuss how rehabilitation relates to their areas of work.

### **7.1 Messages from the Directors**

#### **Department of Service Delivery and Safety**

- Dr Ed Kelley, Director

One of the major roles of the department of Service Delivery and Safety is to move on issues of integration and people centeredness in health care. This involves re-orienting models of care around people's needs. If this is to be successful, and service delivery truly shaped around needs, then rehabilitation must be fully integrated into models of health care service delivery.

#### **Department of Mental Health and Substance Abuse**

- Dr Shekhar Saxena, Director

Rehabilitation can be essential in getting people with a wide range of mental health and developmental disorders functioning optimally.

However, psychosocial rehabilitation is not only needed for these disorders but for people with any impairment, including physical impairment.

The department of Mental health and Substance Abuse operates around several action plans (such as for autism, epilepsy and dementia) and all have a clear content area on rehabilitation. This department therefore has a responsibility to promote the Rehabilitation 2030 agenda.

## **Department of Ageing and Life Course**

- Dr John Beard, Director

The conceptualization of healthy ageing is about maintaining older people's ability to do the things that they value. This is achieved through both the intrinsic capacities of the person, and the environment in which they live. The department strongly promotes an integrated approach to care that focus on functioning rather than diseases, to influence the trajectory of capacity across a person's lifespan.

The aims of rehabilitation clearly align with how healthy ageing is framed in the Department of Ageing and Life Course and its strategic direction.

## **Department of Health Statistics and Informatics**

-Dr Jan Ties Boerma, Director

The Department of Health Statistics and Informatics is engaged with issues of measurement of health states, mortality monitoring in the context of the SDGs as well as the WHO family of classifications, including the International Classification Diseases (ICD) and the International Classification of Functioning, Disability and Health (ICF) and others. It is clear that there is a substantial morbidity (and functioning) information gap and inadequate data on service access and coverage. This is due in part to the lack of, and missing, comparable data.

The ICF has been in use for approximately 15 years and provided a conceptual framework that has transformed thinking around disability measurement. Its full implementation, however, still has a way to go. Today it is being integrated across WHO's departments in different

areas of work and in national surveys and studies on ageing and mental health.

## **Department for the Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention**

- Dr Etienne Krug, Director

Rehabilitation is extremely important for people with all the conditions covered in the Department, from stroke, cancer, diabetes, eye health issues, and hearing issues, to injuries and violence. The department has long focused on disability and less so on rehabilitation, however Rehabilitation 2030 demonstrates a shift in this balance. There will be strong efforts to work with Member States, development partners and other stakeholders to scale up rehabilitation services.

### **7.2 Summary of Questions and Comments from the Floor**

***Q: Several questions arose regarding WHO's approach to rehabilitation for several specific conditions such as dementia, intellectual disability and club foot.***

***A:*** Directors acknowledged that there is much to be done in better addressing the management of specific diseases but stressed an integrated approach to care. Dr Etienne Krug highlighted that due to WHO's capacity they are limited in their ability to tackle rehabilitation disease by disease, but will rather focus efforts on generating political will and developing the tools and knowledge to scale up rehabilitation as a cross-cutting health service.

***Q: How can we achieve integrated models of care that include rehabilitation?***

***A:*** Dr Ed Kelley pointed to several things that are key to including rehabilitation in integrated and people-centred care. Firstly, outcome measures need to include patient-reported outcomes that can assess the value of this approach. Secondly, there needs to be a push for

multidisciplinary teams that include not only medical professionals but also rehabilitation providers. Finally, integrated approaches rely on strong health networks and referral systems that users can easily navigate.

**Q: *Is the role of rehabilitation in the prevention of noncommunicable diseases reflected in WHO's work?***

**A:** The preventative role of rehabilitation in the context of noncommunicable diseases is currently neglected. However the work on prevention of noncommunicable diseases is being scaled up and rehabilitation will be part of the approach. Dr Ed Kelley noted that there are some powerful figures about the effectiveness of rehabilitation, for example in stroke prevention, that can be leveraged to raise awareness to the role rehabilitation plays in prevention of these conditions.

**Q: *What is being done to close the gap on comparable morbidity data, specifically in low- and middle-income countries?***

**A:** Dr Jan Ties Boerman responded that equity is central to the SDGs, and morbidity data collection should thus be core and routine in health information systems, whether through data collected surveys, administrative or clinical data. For WHO, the ICF is the backbone of capturing information on functioning in statistics. Examples of tools based on the ICF include the WHODAS 2,0 and the Model Disability Survey. Simplifying and standardizing approaches to the collecting of information on morbidity (and functioning) are key to ensuring this information is included in health statistics. The use of electronic health records will further facilitate the collection of these data, and will be particularly valuable in settings where staff have limited capacity for data collection and coding.

**Q: *How can rehabilitation be integrated into early childhood development initiatives?***

**A:** Dr John Beard responded that it is important to promote a life-course approach, and to recognize that early childhood development is

about building the capacities of a person, while geriatric care is about maintaining these capacities for as long as possible. He encouraged the participants to speak out and advocate for the inclusion of rehabilitation in early childhood development to motivate action both within WHO and externally.

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## ANNEX B. AGENDA

### WHO Executive Board Room

**DAY 1: 6 FEBRUARY 2017**

**08:00 Registration**

**09:00 Welcome**

**Moderator:** Dr Etienne Krug, Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention, WHO

**Welcome and opening remarks:** Dr Oleg Chestnov, Cluster for Noncommunicable Diseases and Mental Health, WHO

**Video:** Rehabilitation: Key for Health in the 21<sup>st</sup> Century

**09:15 Keynote addresses**

Honorable Ms Dorcas Makgato, Minister of Health and Wellness, Botswana

Honorable Dr Rajitha Senaratne, Minister of Health and Indigenous Medicine, Sri Lanka

Honorable Dr Phouthone Mouangpak, Deputy Minister of Health, Lao People's Democratic Republic

**09:40 Personal testimonies**

Dr Ritu Sadana

Mr Gopal Mitra

Ms Cheat Sokha

**10:00 Presentations - Rehabilitation: Key for Health in the 21st Century**

**Moderator:** Dr Alarcos Cieza, Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention, WHO

**Rehabilitation in the context of the global agenda:**

Dr Alarcos Cieza

**The need to scale up rehabilitation:**

Dr Somnath Chatterji, Department for Information, Evidence and Research, WHO

**The costs of failing to provide rehabilitation services:**

Dr David McDaid, London School of Economics, United Kingdom

**Improving data for rehabilitation in health information systems:**

Ms Anneke Schmider, Department for Information, Evidence and Research, WHO

**11:00 Coffee**

**11:30 Panel discussion - Rehabilitation in health systems: implementing WHO recommendations in countries**

**Moderators:** Professor Linamara Battistella, University of São Paulo Medical School, Brazil

Professor Gwynnyth Llewellyn, University of Sydney, Australia

**Government representatives Chile:**

Dr Ximena Neculhueque Zapata, Director Rehabilitation, Ministry of Health

Mr Carlos Pinto, Deputy National Director, SENADIS, Ministry of Social Development

**Government representatives Germany:**

Ms Gundula Rossbach, President, German Statutory Pension Insurance Scheme

Dr Joachin Breuer, Director General, German Social Accident Insurance

**Government representative Pakistan:**

Dr Darshan Punchi, Parliamentary Secretary of Health

**Government representative Philippines:**

Dr Herminigildo Valle, Undersecretary of Health, Department of Health

**12:30 Lunch**

**14:00 Presentations - Rehabilitation in health systems: learning from current initiatives**

**Moderator:** Professor Gerold Stucki, University of Lucerne, Switzerland

**Alliance for Health Policy and Systems Research:**

Dr Nhan Tran, Alliance for Health Policy and Systems Research, WHO

**Programme for Improving Mental Health Care (PRIME):**

Dr Dan Chisholm, Department for Mental Health and Substance Abuse, WHO

**Global Cooperation on Assistive Technology (GATE):**

Mr Chapal Khasnabis, Global Cooperation on Assistive Technology, WHO

**15:30 Coffee**

**16:00 Panel discussion - Raising awareness of the need for rehabilitation**

**Moderator:** Mr Jan Monsbakken, Rehabilitation International

Professor Karsten Dreinhofer, Chair, Global Alliance for Musculoskeletal Health, representing condition-specific organizations

Emma Stokes, World Confederation of Physical Therapy, representing rehabilitation professional organizations

Ms Karen Heinicke-Motsch, CBM, representing international and nongovernmental organizations

Professor Christoph Gutenbrunner, Department of Rehabilitation Medicine, University of Hannover, Germany, representing rehabilitation professionals working in medical faculties

Professor Allen Foster, London School of Hygiene and Tropical Medicine, United Kingdom, representing researchers and professionals working in public health

Professor Joel Block, Osteoarthritis and Cartilage, representing editors of scientific journals

**17:30 Reception at WHO Cafeteria**

**DAY 2: 7 FEBRUARY 2017****09:00 Panel discussion - Rehabilitation in the context of WHO strategies**

**Moderator:** Dr Laragh Gollogly, Bulletin of the World Health Organization

Dr John Beard, Department of Ageing and Life Course, WHO

Dr Jan Ties Boerma, Department of Health Statistics and Informatics, WHO

Dr Ed Kelley, Department Service Delivery and Safety, WHO

Dr Etienne Krug, Department for the Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention, WHO

Dr Shekhar Saxena, Department of Mental Health and Substance Abuse, WHO

**10:15 Coffee****10:45 Presentation and statements - Global leadership and call for action**

**Moderator:** Dr Etienne Krug, Department for the Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention, WHO

**WHO areas of action in rehabilitation:** Dr Alarcos Cieza, Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention, WHO  
*This session will focus on the political commitment of stakeholders to strengthen rehabilitation and includes statements from the floor.*

**12:00 Closing of Rehabilitation 2030 Meeting**

## ANNEX C. CALL FOR ACTION

### FRENCH

#### **Les participants à la réunion Réadaptation 2030 : un appel à l'action reconnaissent ce qui suit :**

- A. Les besoins non satisfaits en matière de réadaptation sont substantiels à travers le monde, en particulier dans les pays à revenu faible et intermédiaire.
- B. Compte tenu des tendances démographiques et sanitaires mondiales, telles que le vieillissement de la population et le nombre croissant de personnes vivant avec les conséquences d'une maladie ou d'un traumatisme, la demande en services de réadaptation continuera à augmenter.
- C. Un meilleur accès aux services de réadaptation est nécessaire pour « [p]ermettre à tous de vivre en bonne santé et promouvoir le bien-être de tous à tout âge » (Objectif de développement durable, ODD 3) et d'atteindre la cible 3.8 des ODD, à savoir : « *[f]aire en sorte que chacun bénéficie d'une couverture sanitaire universelle, comprenant une protection contre les risques financiers et donnant accès à des services de santé essentiels de qualité et à des médicaments et vaccins essentiels sûrs, efficaces, de qualité et d'un coût abordable* ».
- D. La réadaptation est un élément fondamental du continuum de soins, au même titre que la prévention, la promotion, le traitement et les soins palliatifs. Elle devrait par conséquent être considérée comme une composante essentielle des services de santé intégrés.
- E. La réadaptation est utile pour répondre aux besoins de personnes atteintes de divers problèmes de santé ou d'un handicap, tout au long de la vie et à tous les niveaux de soins. Ainsi, des partenariats de la réadaptation devraient engager tous les types d'utilisateurs des services de la réadaptation, y compris les personnes ayant un handicap.
- F. Elle constitue un investissement dans le capital humain qui contribue au développement sanitaire, économique et social.

- G. La réadaptation est un instrument pour la mise en oeuvre efficace de la *Stratégie et [du] plan d'action mondiaux sur le vieillissement et la santé 2016-2020*, du *Plan d'action pour la santé mentale 2013-2020* et du *Cadre pour des services de santé intégrés centrés sur la personne*, et elle contribue aux efforts de l'initiative de coopération mondiale relative aux technologies d'assistance (GATE).
- H. Parmi les obstacles actuels au renforcement et à l'extension de la réadaptation dans les pays figurent notamment :
- i. une importance insuffisante accordée par les gouvernements face à des priorités concurrentes;
  - ii. l'absence de politiques et d'une planification de la réadaptation aux niveaux national et infranational;
  - iii. lorsque le ministère de la Santé et celui des Affaires sociales sont tous deux impliqués dans la réadaptation, une coordination limitée entre ces deux entités;
  - iv. un financement inexistant ou inadéquat ;
  - v. le manque de données factuelles relatives aux besoins satisfaits et non satisfaits en matière de réadaptation;
  - vi. un nombre insuffisant de professionnels de la réadaptation et des compétences inadéquates;
  - vii. l'absence de centres et d'équipement de réadaptation; et
  - viii. le manque d'intégration dans les systèmes de santé.
- I. Il est urgent que toutes les parties intéressées, y compris les États membres et le Secrétariat de l'OMS, d'autres organismes des Nations Unies, des organisations représentant des groupes d'utilisateurs de services de réadaptation et des prestataires de services de réadaptation, des organismes de financement, les organisations professionnelles, des instituts de recherche, et les organisations internationales et non-gouvernementales, mènent une action mondiale concertée en vue de renforcer la qualité de la réadaptation.



**À la lumière de ce qui précède, les participants s'engagent à oeuvrer vers la réalisation des objectifs suivants:**

1. Créer un leadership et un soutien politique fort en faveur de la réadaptation aux niveaux mondial, national et infranational.
2. Renforcer la planification et la mise en oeuvre de la réadaptation aux niveaux national et infranational y compris dans la préparation et la riposte aux situations d'urgence.
3. Améliorer l'intégration des services de réadaptation dans le secteur de la santé, et le renforcement des liens intersectoriels, afin de répondre de manière efficace et efficiente aux besoins de la population.
4. Inclure la réadaptation dans la couverture sanitaire universelle.
5. Élaborer des modèles de prestation de services de réadaptation complets visant à parvenir progressivement à un accès équitable à des services de qualité, y compris aux produits d'assistance, pour toute la population y compris ceux des régions rurales et éloignées.
6. Constituer un effectif de professionnels de la réadaptation solide et multidisciplinaire, adapté au contexte national, et promouvoir l'inclusion des notions liées à la réadaptation dans l'ensemble de la formation des personnels de santé.
7. Étendre le financement de la réadaptation par le biais de mécanismes appropriés.
8. Collecter des informations liées à la réadaptation en vue d'améliorer les systèmes d'informations sanitaires en incluant les données relatives à la réadaptation au niveau systémique et les informations relatives au fonctionnement basées sur la Classification internationale du fonctionnement, du handicap et de la santé (CIF).
9. Développer les capacités de recherche et assurer la disponibilité à plus grande échelle de données factuelles solides en faveur de la réadaptation.

10. Créer et renforcer des réseaux et des partenariats dans le domaine de la réadaptation, en particulier entre pays à revenu faible et intermédiaire et pays à revenu élevé.

## ANNEX C. CALL FOR ACTION

### SPANISH

#### **Los participantes de la reunión Rehabilitación 2030: un llamado a la acción reconocen lo siguiente:**

- A. La cantidad de necesidades insatisfechas de rehabilitación en todo el mundo, y especialmente en países con ingresos bajos y medios, es profunda.
- B. La demanda de servicios de rehabilitación seguirá aumentando a la luz de las tendencias globales demográficas y de salud, incluida la población envejecida y la creciente cantidad de personas que viven con las consecuencias de enfermedades y lesiones.
- C. Se requiere un mayor acceso a los servicios de rehabilitación para “Garantizar vidas saludables y fomentar el bienestar para todos en todas las edades” (Objetivo de Desarrollo Sustentable (ODS) 3) y para alcanzar el Objetivo ODS 3.8 *“Lograr una cobertura universal de salud, incluida la protección de riesgos financieros, el acceso a servicios médicos básicos de calidad y el acceso a medicinas y vacunas básicas seguras, efectivas, de calidad y asequibles para todos.”*
- D. La rehabilitación es una parte fundamental del espectro de la atención, junto con prevención, promoción, tratamiento y paliación, y por lo tanto debe ser considerada un componente fundamental de los servicios de salud integrados.
- E. La rehabilitación es relevante a las necesidades de la gente con muchas afecciones de salud y las personas que experimentan discapacidad durante el transcurso de la vida y en todos los niveles de la atención médica. Por consiguiente, las asociaciones de rehabilitación deben considerar a todos los usuarios de rehabilitación, incluidas las personas con discapacidad.
- F. La rehabilitación es una inversión en capital humano que contribuye al desarrollo económico, social y de la salud.
- G. El rol de la rehabilitación es fundamental para una efectiva implementación de la *Estrategia global y plan de acción sobre*

*envejecimiento y salud (2016–2020), el Plan de acción sobre salud mental (2013–2020) y el Marco sobre servicios de salud integrados centrados en las personas, y como aporte a los esfuerzos de la iniciativa Cooperación mundial sobre tecnologías de apoyo (GATE, por sus siglas en inglés).*

- H. Los obstáculos actuales para fortalecer y ampliar la rehabilitación en los países incluyen los siguientes:
- i. escasa priorización por parte del gobierno entre las prioridades contrapuestas;
  - ii. ausencia de políticas y planificación de rehabilitación en el ámbito nacional y subnacional;
  - iii. cuando ambos ministerios de salud y asuntos sociales están implicados en la rehabilitación, existe coordinación limitada entre ellos;
  - iv. financiación inexistente o inadecuada;
  - v. escasez de evidencia de las necesidades de rehabilitación satisfechas e insatisfechas;
  - vi. cantidades y habilidades insuficientes de profesionales de rehabilitación;
  - vii. ausencia de instalaciones y equipos de rehabilitación; y
  - viii. falta de integración en los sistemas de salud.
- I. Existe una necesidad imperiosa de acción global coordinada por parte de todas las partes interesadas relevantes, incluidos los Estados Miembros y la Secretaría de la OMS, otras agencias de las Naciones Unidas, grupos de usuarios y proveedores de servicios de rehabilitación, organismos de financiación, organizaciones profesionales, organizaciones de investigación, y organizaciones internacionales y no gubernamentales para ampliar la rehabilitación de calidad.

**A la luz de lo antedicho, los participantes se comprometen a trabajar en pro de las siguientes diez áreas de acción:**

1. Crear liderazgo fuerte y apoyo político respecto de la rehabilitación en el ámbito subnacional, nacional e internacional.
2. Fortalecer la planificación e implementación de rehabilitación en el ámbito nacional y subnacional, incluso dentro de la preparación y respuesta ante emergencias.
3. Mejorar la integración de la rehabilitación en el sector de la salud y fortalecer las relaciones intersectoriales para satisfacer de forma efectiva y eficiente las necesidades de la población.
4. Incorporar la rehabilitación en la Cobertura Universal de Salud.
5. Construir modelos de prestación de servicios de rehabilitación integrales para lograr progresivamente el acceso equitativo a servicios de calidad, incluidos productos de asistencia, para toda la población, incluidos los de las zonas rurales y remotas.
6. Desarrollar una fuerte fuerza de trabajo multidisciplinaria de rehabilitación que sea adecuada para el contexto del país, y promover conceptos de rehabilitación en la educación de la fuerza de trabajo de salud.
7. Ampliar la financiación para rehabilitación a través de mecanismos adecuados.
8. Recopilar información relevante a la rehabilitación para mejorar los sistemas de información de salud, incluidos los datos de rehabilitación a nivel del sistema y la información sobre funcionamiento que utiliza la Clasificación Internacional del Funcionamiento, de la Discapacidad y de la Salud (ICF).
9. Desarrollar capacidad de investigación y ampliar la disponibilidad de evidencia sólida para rehabilitación.
10. Establecer y fortalecer redes y asociaciones en rehabilitación, especialmente en países con ingresos bajos, medios y altos.

## **ANNEX C. CALL FOR ACTION**

### **RUSSIAN**

**Участники встречи «Реабилитация 2030: призыв к действиям» признают следующее:**

- A. Масштабы неудовлетворенной потребности в реабилитационных услугах во всем мире, особенно в странах с низким и средним уровнем доходов, огромны.
- B. Вследствие глобальных тенденций в области здравоохранения и демографических изменений, таких как старение населения и увеличение числа людей, живущих с последствиями заболеваний и травм, спрос на реабилитационные услуги будет продолжать расти.
- C. Для достижения Целей в области устойчивого развития (ЦУР), а именно «обеспечения здорового образа жизни и содействия благополучию для всех в любом возрасте» (ЦУР 3) и «обеспечения всеобщего охвата услугами здравоохранения, в том числе защиты от финансовых рисков, доступ к качественным основным медико-санитарным услугам и доступа к безопасным, эффективным, качественным и недорогим основным лекарственным средствам и вакцинам для всех» (ЦУР 3.8), необходимо расширить доступ к реабилитационным услугам.
- D. Реабилитационные услуги являются неотъемлемой частью охраны здоровья наряду с профилактикой, пропагандой здорового образа жизни, лечением и паллиативной помощью и должны рассматриваться в качестве ключевого компонента комплексного медицинского обслуживания.
- E. В реабилитационных услугах нуждаются люди всех возрастов, имеющие самые различные заболевания и формы инвалидности. Потребность в таких услугах ощущается на всех уровнях системы здравоохранения. Таким образом, реабилитационные услуги должны быть доступны всем

нуждающимся, в том числе людям с ограниченными физическими возможностями.

- F. Реабилитационные услуги – это инвестиции в человеческий капитал, способствующие улучшению здоровья людей и экономическому и социальному развитию.
- G. Реабилитационные услуги очень важны для эффективного осуществления *Глобальной стратегии и плана действий по проблемам старения и здоровья на 2016–2020 гг., Плана действий в области психического здоровья на 2013-2020 гг. и Рамочной программы по комплексным социально ориентированным медицинским услугам*, а также для реализации инициативы «Глобальное сотрудничество в области ассистивных технологий» (Global Cooperation on Assistive Technology, GATE).
- H. Текущие барьеры на пути развития и расширения доступа к реабилитационным услугам, с которыми сталкиваются страны, включают:
- i. недостаточное внимание со стороны правительств, которые ставят во главу угла другие приоритеты;
  - ii. отсутствие политики и планирования в области оказания реабилитационных услуг на национальном и субнациональном уровнях;
  - iii. в странах, где сектор реабилитационных услуг регулируется как министерством здравоохранения, так и министерством социального обеспечения, – недостаточная координация между этими ведомствами;
  - iv. отсутствие или ограниченность финансирования;
  - v. недостаток данных об удовлетворенных и неудовлетворенных потребностях в реабилитации;
  - vi. недостаточное количество и ограниченность навыков специалистов в области реабилитации;
  - vii. отсутствие реабилитационных средств и оборудования; а также
  - viii. недостаточная интеграция в систему здравоохранения.
- I. Существует острая необходимость в принятии согласованных глобальных действий по расширению доступа к качественным

услугам реабилитации всеми заинтересованными сторонами, включая государства-члены и Секретариат ВОЗ, другие учреждения системы ООН, объединения потребителей и поставщиков реабилитационных услуг, финансирующие ведомства, профессиональные организации, научно-исследовательские заведения, а также неправительственные и международные организации.

**В свете вышеизложенного, участники обязуются осуществлять работу по перечисленным ниже десяти направлениям:**

1. Создание эффективных механизмов координации и поддержки усилий по расширению доступа к реабилитационным услугам на субнациональном, национальном и глобальном уровнях.
2. Совершенствование планирования в области оказания реабилитационных услуг на национальном и субнациональном уровнях, в том числе в рамках подготовки к чрезвычайным ситуациям и реагирования на них.
3. Усиление интеграции реабилитационных услуг в систему здравоохранения и укрепление межсекторных связей, чтобы эффективно удовлетворять потребности населения.
4. Обеспечение всеобщего доступа к реабилитационным услугам.
5. Построение моделей комплексной поставки реабилитационных услуг для постепенного обеспечения равного доступа к качественным услугам, в том числе ассистивным технологиям, для всех людей, в том числе проживающих в сельских и отдаленных районах.
6. Создание крупного многопрофильного контингента специалистов в области реабилитации с учетом специфики каждой страны, а также пропаганда концепции реабилитации на всех уровнях обучения работников сферы здравоохранения.
7. Расширение финансирования реабилитационных услуг через соответствующие механизмы.
8. Сбор информации, имеющей отношение к оказанию реабилитационных услуг, для совершенствования информационных систем сферы здравоохранения, включая



общие данные по реабилитации и функционированию с использованием «Международной классификации функционирования, ограничений жизнедеятельности и здоровья» (МКФ).

9. Нарращивание исследовательского потенциала и расширение доступности надежных данных по реабилитации.
10. Создание и укрепление сетей и партнерств в области оказания реабилитационных услуг, особенно между странами с низким, средним и высоким уровнем доходов.

# ANNEX D. INFOGRAPHICS

## Recommendations for strengthening **REHABILITATION** in health systems

 <p style="text-align: center;"><b>Ministry of Health</b></p> <p style="text-align: center;"><b>Integrate rehabilitation into the health system</b></p>	 <p style="text-align: center;"><b>Integrate rehabilitation services into and between primary, secondary and tertiary levels of health systems</b></p>	 <p style="text-align: center;"><b>Ensure the availability of a multi-disciplinary rehabilitation workforce</b></p>
 <p style="text-align: center;"><b>Ensure both community and hospital rehabilitation services are available</b></p>	 <p style="text-align: center;"><b>Ensure hospitals include specialized rehabilitation units for inpatients with complex needs</b></p>	 <p style="text-align: center;"><b>Implement financing and procurement policies that ensure assistive products are available to everyone who needs them</b></p>
 <p style="text-align: center;"><b>Ensure adequate training is offered to users to whom assistive products are provided</b></p>	 <p style="text-align: center;"><b>Ensure financial resources are allocated to rehabilitation services</b></p>	 <p style="text-align: center;"><b>Where health insurance exists or is to become available, ensure rehabilitation services are covered</b></p>



**World Health Organization**

Infographic available via: <http://www.who.int/disabilities/Banner.pdf?ua=1>

## ANNEX E. IMPORTANT LINKS AND RELATED RESOURCES

WHO Rehabilitation webpage

<http://www.who.int/disabilities/care/en/>

Rehabilitation 2030: A Call for Action webpage

<http://www.who.int/disabilities/care/rehab-2030/en/>

Rehabilitation in health systems webpage

[http://www.who.int/disabilities/rehabilitation\\_health\\_systems/en/](http://www.who.int/disabilities/rehabilitation_health_systems/en/)

Rehabilitation in the 21<sup>st</sup> century video

<https://www.youtube.com/watch?v=a8uaRziXruc>

Global Cooperation on Assistive Technology (GATE)

[http://www.who.int/phi/implementation/assistive\\_technology/phi\\_gate/en/](http://www.who.int/phi/implementation/assistive_technology/phi_gate/en/)

WHO Rehabilitation email: [rehabilitation@who.int](mailto:rehabilitation@who.int)

### Key WHO action plans relevant to rehabilitation

WHO global disability action plan 2014-2021

<http://www.who.int/disabilities/actionplan/en/>

WHO Framework on integrated and people-centred health services

<http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/>

Workforce 2030

<http://who.int/hrh/resources/globstrathrh-2030/en/>

Global strategy and action plan on ageing and health

<http://who.int/ageing/global-strategy/en/>