Meeting to Review and Plan for Expanded Delivery of Disability Inclusive Health and Rehabilitation Services

11–13 November 2015
Manila, Philippines
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MEETING REPORT

MEETING TO REVIEW AND PLAN FOR EXPANDED DELIVERY OF DISABILITY INCLUSIVE HEALTH AND REHABILITATION SERVICES

Convened by:

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NOTE

The views expressed in this report are those of the participants of the Meeting to Review and Plan for Expanded Delivery of Disability Inclusive Health and Rehabilitation Services and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the Meeting to Review and Plan for Expanded Delivery of Disability Inclusive Health and Rehabilitation Services, held in Manila, Philippines from 11 to 13 November 2015.
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Keywords:

Disability – rehabilitation / Health services / Rehabilitation
SUMMARY

Disability is estimated to affect 15% of the global population. Prevalence in the Western Pacific Region is growing as a result of chronic disease, injuries and ageing populations. Historically, disability has been under prioritized on national agendas. Health and rehabilitation services for people with disabilities are commonly inadequate to meet needs. People with disabilities experience poorer health than their non-disabled peers and face widespread barriers to accessing services, but disability need not preclude good health. Access to health care and rehabilitation enables adults and children with disabilities to achieve better health, education, economic and social outcomes.

The WHO Regional Office for the Western Pacific, in line with the Convention on the Rights of Persons with Disabilities (CRPD) and WHO Global Disability Action Plan 2014–2021, is supporting ministries of health and lead ministries for disability to build more inclusive and accessible services. The Sustainable Development Goals (SDG) and universal health coverage (UHC) agenda reinforce and provide opportunities to deliver service improvements.

Representatives from ministries of health, ministries of social affairs, and disabled persons organizations from eight countries attended the three-day meeting in Manila, Philippines. The meeting built knowledge and provided an opportunity to share tools and experience for disability-inclusive health. Countries demonstrated progress over recent years and all attending countries are now undertaking practical initiatives to build greater access to health and rehabilitation for people with disabilities. Cooperation between ministries of health and ministries of social affairs (the lead disability ministry) is variable across countries. While ministerial cooperation has improved significantly in some countries, it has improved to a lesser extent in others. As a result, the issue remains a priority. Improving access to health requires initiatives aimed at decreasing physical, financial and communication barriers as well as improving the quality and continuum of services.

Effective steps forward by countries have included development of national disability-inclusive health and rehabilitation strategic plans; identification of a dedicated focal point within the ministry of health; provincial demonstration projects of integrated health, rehabilitation and disability services; development of disability-inclusive training curricula for health personnel; and initiatives to increase the continuum of care for clients, such as referral pathways and service directories. Disability data are increasing in countries; however, the understanding of measurement approaches to disability remains underdeveloped leading to confusion in many countries. Further training in disability must include simple and complex measurement approaches.

The objectives of the meeting were met through technical presentations, countries sharing key tools and experiences, and providing the opportunity for country representatives to jointly analyze progress and develop plans.

WHO is requested to: 1) Continue to advocate for disability-inclusive health and integrate this broadly into the UHC agenda and SDGs; 2) Support the inclusion of the health and rehabilitation needs of people with disabilities in national health strategies; 3) increase disability and rehabilitation capacity in country offices; 4) develop standardized tools for ministries of health to develop more accessible and inclusive health services; 5) build capacity in ministries of health and contribute positively to planning and coordination within and across ministries; 6) support ministries to develop demonstration projects as to “learn” how to build more inclusive and accessible services; 7) undertake training in disability
measurement and disability data collection approaches; and 8) support people-centered approaches to health as they will directly benefit people with disabilities as well.

Member States may consider: 1) increasing human resources capacity dedicated to disability within the ministry of health; 2) increasing internal ministry of health planning on disability and rehabilitation; 3) continuing to strengthen coordination between ministries of health and social affairs; 4) increasing financial investment in rehabilitation services, as an investment in human capital and important commitment towards realizing the goals of CRDP; 5) addressing disability data through greater knowledge of measurement approaches in disability and appreciation of different tools for different purposes; 6) developing demonstration projects in provinces to “learn in a hands-on manner” how to make services inclusive and accessible; 7) moving towards better information systems in the long term and taking practical steps in this direction; 8) including disability in health curricula training and ensuring it reflects a rights-based approach; and 9) progressing the “people-centered care” approach in health that encompasses many of the needs of people with disabilities.

Country specific recommendations and next steps:

**Brunei Darussalam** does not have a full-time disability and rehabilitation focal point within Ministry of Health. The focus for the next two years will be on increasing accessibility to health facilities and expanding the availability of rehabilitation services.

**Cambodia** is implementing the Provincial Disability-inclusive Health Demonstration Project, which is designed to ensure health and community partners better identify people with functioning difficulties, ensure basic services are provided, improve the continuum of care and strengthen the quality of services provided. Key plan for the next two years has three objectives: increase understanding among stakeholders to influence political will; increase service coordination; and improve data collection.

The **China** Disabled Persons’ Federation (CDPF) is a dedicated agency for disability and achieved significant progress for people with disabilities in the last couple of decades. The focus for the next two years will be on enhancing referral systems within different levels of health care to promote integrated services and the continuum of care (early detection and referral).

The **Lao People’s Democratic Republic’s** Disability-inclusive Heath and Rehabilitation Plan guides the work of Ministry of Health and ensures long-term planning for increasing provision of rehabilitation services. The plan has brought key stakeholders together and resulted in significant progress. The focus for the next two years will be on strengthening functional and effective physical rehabilitation units.

**Malaysia** included the Washington Group Questions (short set) to the National Health Survey which found a disability prevalence of 3.3%. Further analysis of the results showed disparities in accessing healthcare, between people with and without a disability. The focus for the next two years will be on equitable health services for people with disabilities and include work to create disability friendly communities.

**Mongolia** adapted the Stroke Rehabilitation Guidelines and produced online training material in open source platform to ensure that disability and rehabilitation are included in a range of health topics utilizing the platform. The focus for the next two years will be on disability data and explore the model disability survey, and build capacity for research and training.

The **Philippines’** experience of integrating disability and rehabilitation services into the post-Typhoon Haiyan work of WHO revealed opportunities seized as well as some lost during the
early response period. The focus for the next two years will be on increasing accessibility of rehabilitation services in various levels of health care and expand health insurance packages.

Viet Nam will expand the range of services available, including the hotlines for social workers and provision of counselling services for the next two years.
1. INTRODUCTION

1.1 Meeting organization

The Meeting to Review and Plan for Expanded Delivery of Disability Inclusive Health and Rehabilitation Services was held in Manila, Philippines, from 11 to 13 November 2015. Twenty-eight participants from 10 Member States, as well as three WHO temporary advisers and eight observers attended the meeting. The secretariat was comprised of seven WHO staff and consultants from WHO headquarters, the WHO Regional Office for the Western Pacific, the Western Pacific Region Division of Pacific Technical Support (DPS), and the Office of the WHO Representative in the Philippines (the country office). The list of participants is available in Annex 1.

1.2 Background

The World Health Organization (WHO) estimates that 15% of the global population experience disability and that 2–4% of the global population experience very severe difficulties in functioning. Evidence indicates that the prevalence of disability is high and growing as a result of increasing chronic disease, injuries and ageing populations.

International and national action on disability continues, with 163 countries having now ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD). In May 2014, the World Health Assembly adopted the WHO Global Disability Action Plan 2014–2021: better health for all people with disability (GDAP). GDAP aims to contribute to improving health, well-being and human rights for people with disabilities. The recently adopted Sustainable Development Goals (SDGs) include a focus disability and prioritized equity and inclusion. There are specific mention and/or targets for disability across health, gender, education, employment and urban development goals.

People with disabilities more commonly encounter discrimination and barriers to services. They are 50% more likely to experience catastrophic health expenditures and four times more likely to report being treated badly in health systems. While disability is associated with a health condition, it need not preclude good health. Rehabilitation services are often under-prioritized and neglected on the national health agenda. Significant unmet service needs exist in many countries in the Western Pacific Region.

In June 2014, a regional meeting of Asian countries focused on rehabilitation and support to countries. In early 2015, Regional Office for the Western Pacific initiated a survey on national capacity to deliver disability-inclusive health and rehabilitation services. Over the previous year, new initiatives and progress have occurred at the country level, particularly in the area of inclusive and accessible health.

The November meeting built on the previous rehabilitation meeting that brought together a similar group of countries in the Asia region. The meeting provided a detailed situation assessment utilizing findings from the regional survey and mapped current progress and plans for the key articles of the CRPD, the SDGs and the WHO global disability action plan. Actions and approaches for ministries of health to achieve targets and strengthen the provision of disability-inclusive health services were recommended. Specific linkages to how disability and rehabilitation fit with the Universal Health Coverage agenda were included. The meeting provided an opportunity to share country experiences and new tools and build on rehabilitation achievements since the previous meeting in 2014.

Representatives from both the ministry of health and the lead ministry for disability attended, as well as representatives from national disabled people’s organization (DPOs) attended.
Bringing together this mixed stakeholder group proved very successful at strengthening relationships, collaboration, and identifying and undertaking actions at country level.

1.3 Meeting objectives

1) To review the status and progress in the delivery of disability-inclusive health services in participating countries.

2) To identify the necessary actions required to deliver disability-inclusive health and implement the WHO Global Disability Action Plan 2014–2021: Better health for all people with disability (GDAP), CRDP and SDGs.

3) To prioritize and plan country and regional actions to accelerate the development of disability-inclusive health and rehabilitation services.

1.4 Opening remarks

Dr Li Ailan, Director, Division of Health Security and Emergencies, WHO Regional Office for the Western Pacific, opened the workshop and delivered the opening remarks on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific. She noted that people with disabilities experience financial, physical, social and behavioural difficulties in accessing health services, which contribute to poorer health and socioeconomic outcomes in this group.

She underscored the importance of the third goal of the recently adopted SDGs, which is to ensure healthy lives and promote well-being for all at all ages. The health needs of people with disability should be fully met by removing barriers to health service and programme access as expressed in GDAP, and by including and strengthening rehabilitation, assistive technology and community-based rehabilitation (CBR) services under universal health care (UHC) and following CRPD.

In the Western Pacific Region, governments increasingly understand that investing in rehabilitation enhances the well-being and productivity of its population. Health ministries, in coordination with other key sectors, play a crucial role in the success of disability-inclusive health and rehabilitation services.

Finally, Dr Li reiterated the United Nations General Assembly call to “leave no one behind” by moving forward with disability-inclusive health and rehabilitation services.

1.5 Appointment of Chairperson, Vice-Chairperson and Rapporteur

Dr Prak Piseth Raingsey, Director, Preventive Medicine Department, Ministry of Health, Cambodia, was appointed as Chairperson; Ms Trinh Thi Nguyet, Officer, Social Protection Department, Viet Nam, as Vice-Chairperson; and Ms Chuluundolgor Bat, Chairperson of the Mongolian National Association for Wheelchair Users, as Rapporteur.
2. PROCEEDINGS

2.1 Overview of disability-inclusive health and rehabilitation: situation and needs


Ms Pauline Kleinitz, Technical Lead, Disabilities and Rehabilitation, WHO Regional Office for the Western Pacific, provided an overview of the global disability situation citing over 1 billion people, 15% of the global population, experiencing some form of disability. Prevalence is increasing. Women, older people, poor households and residents of low-income countries are disproportionately affected.

She emphasized that people with disabilities face barriers in education, employment, community participation and health. They have the same general health-care needs as the rest of the population, but these are usually overlooked due to inadequate health-care provider skills and equipment, actual denial of care and poor treatment, and information and transport barriers. A major barrier is finance, where 50% more people with disability risk catastrophic expenditure compared to non-disabled people. To achieve disability-inclusive health, quality health services need to be accessible, affordable and available to people with disabilities.

She also described the three GDAP objectives: (1) to remove barriers and improve access to health services and programmes; (2) to strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and CBR; and (3) to strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services. She described the seven targets from the SDGs that explicitly mention disability and reviewed in depth the two key articles from the CRPD: Article 25 on Health and Article 26 on Rehabilitation and Habilitation.

2.1.2 The health of people with disabilities

Dr Zee-A Han, Director, Department of Spinal Cord and Injury and Rehabilitation Chief, Health Promotion Center for Persons with Disabilities National Rehabilitation Center, Ministry of Health and Welfare, Republic of Korea, presented various models of health and disability. She recommended the Bio-Psycho-Social Model adapted by the International Classification of Functioning, Disability and Health (ICF), which describes disability as a dynamic interaction between health conditions and contextual factors such as environmental and personal factors that contribute to difficulties in any or all three areas of functioning – impairment, limitations and restrictions.

She then gave an overview of the health status of people with disabilities, noting that disability is associated with a diverse range of primary health conditions that lead to some form of impairment, activity limitation and participation restriction. On top of this, secondary health conditions, which are mostly preventable, can further reduce functioning and lower quality of life (e.g. pressure ulcers and urinary tract infections). Co-morbidities that are independent and unrelated to the primary condition (e.g. diabetes, hypertension) may also co-exist in people with disabilities but detection and treatment are often not well managed. Moreover, people with disabilities have greater vulnerability to age-related conditions, increased rates of health risk behaviours (physical inactivity, obesity and smoking), and greater risks of being exposed to violence and premature death.

Despite existing or potential health concerns, people with disabilities have more unmet health-care needs compared with the general population. For example, women with
disabilities receive less screening for breast and cervical cancer, while men with disabilities are less likely to receive screening for prostate cancer. Based on the 2014 Korean National Disability Survey, reasons that contribute to limited health-care access include inconvenient transportation systems, finances, communication difficulties, difficulties of obtaining appointments and inaccessible health facilities.

2.2 Disability and health

2.2.1 What people with disabilities require from health services

Dr Cathy Vaughan, Lecturer, Melbourne School of Population and Global Health, University of Melbourne, Australia, described the rights to health and elaborated on the following people with disabilities rights: awareness of health services and access to the same; respectful and equitable treatment; communication, equipment and procedures that are adapted to their needs; skilled service providers; and referrals to address unmet needs.

She recommended various approaches that allow health-care providers to address the above needs. These include conducting outreach, health promotion and screening activities; providing or facilitating accessible transportation; raising awareness among health-care providers; adapting processes and developing protocols; ensuring a variety of communication strategies exist; and coordinating with other health-care providers. The inclusion of these approaches and activities in existing health policy and budgeting is necessary to ensure successful implementation.

2.2.2 What people with disabilities experience

Ms Carmen Zubiaga, Executive Director, National Council on Disability Affairs, Philippines, shared challenges commonly experienced by people with disabilities and shared personal experiences with health services. She described barriers she encountered while growing up that limited her access to quality health-care services including low awareness of her right to health and the availability of health services and rehabilitation services that did exist. She recalled the poor or inadequate medical, surgical and rehabilitation management causing pain and further physical complications, as well as no access to assistive devices. There were also financial problems arising from prolonged care and travel to specialized care.

Over the years she has observed improvements in the attitude of health providers towards people with disabilities as a result of training and advocacy programmes. She also commended more inclusion and representation of people with disabilities in policy development, such as the Reproductive Health Bill in the Philippines. However, more efforts are needed to further raise awareness among people with disabilities and caregivers on their rights to accessible health services, and to improve communication skills of health-care providers and sensitize them. She also recommended scaling up incentives for local government units to comply with accessibility guidelines for public buildings through recognitions and awards, for example, a seal of governance award.

Finally, she made a call for the realization of a responsive health delivery programme through participation and active involvement of people with disabilities at all levels of policy development and decision-making processes following the intention of Article 4.3 of the CRPD, “Nothing about Us, Without Us.”
2.2.3 How health systems need to respond

Dr Ayesha de Lorenzo, Technical Officer, Health and System Strengthening, WHO Regional Office for the Western Pacific, discussed how the changing global context and emerging demands affect existing health systems. There are more attention and demand now for people-centered integrated services, which considers individuals, families and communities as participants in addition to being beneficiaries of a health system. She presented five strategic directions as a general way forward: empowering and engaging people; strengthening governance and accountability; reorienting the model of care; coordinating services; and creating an enabling environment.

Dr de Lorenzo also presented the UHC dimensions, stages of health system development, and five health system attributes (quality, efficiency, equity, accountability, and resilience) and the corresponding action domains. For each attribute, she emphasized specific action domains that were relevant to people with disabilities. Of the five attributes, the most pertinent to people with disabilities was “equity”, however, all action domains (financial protection, service coverage, and non-discrimination) were relevant.

2.3 Measuring progress

2.3.1 Measuring the health status of people with disabilities at population level

Ms Kleinitz presented the measurement of progress in disability-inclusive health across three levels – health impact, health outputs and health system inputs – based on the UHC monitoring framework. She emphasized that the purpose of measuring people with disabilities influences the use of appropriate tools and approaches. In measuring impact or outcomes it is important to first properly identify people with disabilities and then describe their health status or outcome. Surveys used for this purpose include the Demographic and Health Survey (DHS), the National Disability Surveys (NDS) and the Health Information System (HIS). Disability was defined as the outcome of the interaction between the impairment and the environment, and measurement approaches should reflect this definition. Disability prevalence varies depending on how one measures disability along the spectrum of functioning difficulties. Prevalence in Asia is likely to be in line with global data where 15% of the population have significant functional difficulties and 2–4% have very significant difficulties. A survey that uses the Washington Group questions typically may capture disability prevalence between 5% and 10% in the population, whereas the new WHO Model Disability Survey is more sensitive to people with functioning difficulties and likely to reveal disability levels closer to 15%.

Measuring health service utilization or “outputs” is a helpful measurement as well. This information may come from HIS, especially where national health insurance schemes exist, also health-care utilization can be captured in DHS and NDS. Indicators that reflect this information may be the frequency of health visits, out-of-pocket health costs, where out-of-pocket costs are coming from, the experiences of health care utilization, such as equipment, skills, respect, good treatment, and the cost of patient transportation.

And lastly, the measurement of health “inputs” can be focused on the core areas of the health system as reflected by the six health sector building blocks. This, for example, could include the number of health personnel trained in disability-inclusive health and the number of rehabilitation personnel, or perhaps the number of rehabilitation facilities, the physical accessibility of health facilities and the money that is earmarked in the budget to address the health needs of people with disabilities.
2.3.2 Measuring the capacity to deliver disability-inclusive health and rehabilitation

Ms Cheryl Ann Xavier, Consultant, Disabilities and Rehabilitation, WHO Regional Office for the Western Pacific, presented the preliminary findings of a recent survey that collected information from the Member States on rehabilitation services, CBR and assistive technology.

Most countries have governance components in place, such as endorsed or signed international commitments, and/or national health policies, and have a national disability coordination body that allows participation of people with disability in planning activities.

Rehabilitation services were mostly available in tertiary-level facilities, such as audiology services, low-vision services, occupational therapy, physical therapy, prosthetic and orthotic services, psychiatric care, and rehabilitation medicine. These services were lacking at the primary health/community level in most upper-middle and middle- and low-income countries. At the same time, the ratio of physical therapists per 10 000 people was notably higher in high-income countries (range: 0.7–11 therapists per 10 000) versus lower- to upper-middle income countries (range: 0.1–2.37 therapists per 10,000). Rehabilitation services were mainly funded by the government although, in a few lower-income countries, nongovernmental organizations and out-of-pocket spending were the primary fund sources. The findings shared were preliminary and further data analysis is currently being undertaken.

2.4 Country updates on disability-inclusive health and rehabilitation

2.4.1 Brunei Darussalam

Brunei Darussalam’s Ministry of Health Vision 2035, “Together Towards a Healthy Nation”, highlights universal access to better health care, equity of access to comprehensive health services, intersectoral partnerships and public participation based on the concept of the co-production of efficient and effective health services for all. It launched the Health System and Infrastructure Master Plan in May 2015 and is now drafting the People with Disabilities Order, led by the Ministry of Culture, Youth and Sports (MCYS). A Special Committee on Persons with Disabilities, chaired by the MCYS, coordinates programmes and action plans of relevant agencies.

Access to health care (primary, secondary and tertiary) is free to all citizens of Brunei Darussalam. However, people with disabilities or their families/caregivers need to spend more for assistive devices and often transport. Examples of additional programmes are the ophthalmology department in government hospitals has a Low Vision Aid Loan service and the Rehabilitation Medicine Unit holds regular group education sessions for people with more complex disabilities such as Acquired Brain Injury and Spinal Cord Injury.

There are no national standards or guidelines on the physical accessibility of health-care services or health facilities. There is a plan to conduct accessibility assessments. Efforts to reach people with disabilities using different communication formats within government-led health promotion campaigns are limited. CBR programmes exist for mental health, under the Ministry of Health. MCYS is also involved in CBR, and nongovernmental organizations have their own programmes in their areas. A volunteer programme for people with disabilities and CBR and a training programme for the volunteers are now being conceptualized.

The number of health personnel with specialist skills in rehabilitation and working with people with disabilities is inadequate. The National Health Strategic Plan and Health System and Infrastructure Master Plan seek to address this. There is a plan to establish an integrated Department of Rehabilitation Medicine at the national hospital in the near future.
### 2.4.2 Cambodia

Cambodia ratified CRPD in December 2012, preceded by the Law on Protection and Promotion of the Rights of Persons with Disabilities in July 2009. Cambodia’s *Third Health Strategic Plan* (HSP3) is now being finalized. Leadership and coordination tasks for disability are lodged with multiple agencies, such as the Department of Social Welfare for Persons with Disabilities under the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY); Department of Preventive Medicine under the Ministry of Health; the Secretary General of the Disability Action Council; the Persons with Disability Foundation; and the Cambodian Disabled People's Organization. Various coordination mechanisms include the Inter-Ministerial Prakas on the establishment of the National Council on the Assessment of the Type and Level of Disability (Re-adopted in 2015), the National CBR Committee and Technical Working Group for Health (TWG-H).

There is an increasing amount of disability data, and the Cambodia Demographic Health Survey 2015 revealed that 9.5% of the total population have disabilities. In terms of rehabilitation services, there has been recent progress with the development of the stroke rehabilitation clinical guidelines. An early child detection and referral tool is being piloted and finalized. A recent workshop on strengthening the role of physiotherapy within hospitals has occurred, and training on intermediate-level wheelchair provision was organized. There are still challenges, and financing of assistive technology is an ongoing issue and a study on the cost of rehabilitation was conducted.

### 2.4.3 China

China is in the process of formulating a policy on disability prevention and rehabilitation for people with disabilities. Existing policies include a mandate on accelerating the “well-off” process for people with disability approved in 2015, a policy of progressively increasing medical rehabilitation services covered by health insurance, and a mandate on a subsidies system for poor people and people with significant disabilities that was approved in 2015 and will come into effect in 2016. It is now evaluating the 12th Five-year National Developmental Programme and Plans (2011–2015) and drawing up the succeeding one.

The Chinese Government recently approved an action plan to improve medical services provided by hospitals to people with disabilities and to enable better physical access to facilities. China recently hosted the Asia-Europe Meeting (ASEM) on Disability and the Global Conference on Assistive Devices and Technology on 29–30 October 2015, where the China Disabled Person's Federation proposed the Beijing Initiative consisting of actions for greater international cooperation, government support, social cooperation, scientific backup, and enterprise investment for assistive devices and technology.

### 2.4.4 Lao People’s Democratic Republic

Lao People’s Democratic Republic have policy instruments that refer to or include people with disabilities, the more recent are the 2013 decree on the National Committee for Disabled and Elderly (NCDE) and the 2014 decree on people with disabilities, with a chapter on prevention, treatment and rehabilitation. The disability policy is expected to be finalized in 2016. In 2015, consultations were held for the systematic review of the seven objectives of the draft *Strategic Action Plan for National Disability-inclusive Health and Rehabilitation*. Also during the year, these objectives were partially integrated into the Five-Year Plan for Health Systems Strengthening. In 2015, a health delivery services technical working group was created, with a rehabilitation task force that has under it are six sub-task forces for human resource, financing, information systems, service delivery, assistive technology and CBR. Training for further rehabilitation service personnel, doctors and nurses has started and will continue until April 2017.
Among the challenges are weak capacities for programme management and research for disability within the Ministry of Health; limited understanding of health conditions associated with disability among policy-makers; and a weak continuum of health-related rehabilitation services among hospitals, physical rehabilitation centres, CBR services and the community services. The knowledge, skills and attitude of rehabilitation personnel still need to be improved. It has been observed that there are insufficient coordination and no long-term planning on the part of international nongovernmental organizations, such that it is difficult to scale up successful practices.

2.4.5 Malaysia

Malaysia's health-care programme for people with disabilities for the period of 2011–2020 focuses on the following strategies: (i) advocacy on issues and policies related to people with disabilities; (ii) increased accessibility to facilities and services; (iii) empowering individuals, families and communities through awareness and understanding of the needs of people with disabilities and by fostering community participation; (iv) strengthening intersectoral collaboration; (v) ensuring an adequate and competent workforce; (vi) intensifying research and development; and (vii) programme development for specific disabilities. Success in these strategies will enable the country to focus on the consolidation of programmes and services for people with disabilities in the next phase (2021–2025).

A Disability-Friendly Services Training Manual was developed with nongovernmental organization partners, and it will be used for disability awareness. There is a yearly training for Ministry of Health staff and DPOs on disability awareness. Training of caregivers on Domiciliary Health Care Services and training of health staff in the management of children with disabilities was also conducted. Planning briefs for health facilities now include disability features. Rehabilitation services are now available in 685 clinics. There is a National Blue Ocean Strategy (NBOS) for the provision of rehabilitation services in older people institutions. There is an increasing placement of therapists in health clinics, and new posts had been created at the primary care level for medical social workers, speech therapists, dieticians and optometrists.

Human resources are inadequate in terms of numbers and expertise. The quality of service needs improvement and training should be developed and conducted regularly. It was noted that there is an increasing number of people with disabilities, as well as those with severe disabilities and people with multiple disabilities, and the programme has identified the need to address sexual and reproductive health issues of people with disabilities.

2.4.6 Mongolia

Mongolia ratified CRPD in May 2009 and has various legislation, policies and action plans relating to social protection, health insurance and human rights. The leadership for disability rests with the Ministry of Population Development and Social Protection. The funding mechanisms for rehabilitation include the Social Health Insurance Fund, nongovernmental organizations like AIFO (Italy) and the State Fund.

Among the disability-inclusive national health programmes are the Tegsh duuren Programme, the National Programme of Healthy Ageing and the Health of Elderly, the National Strategy on Prevention of Injury and Violence, and the National Strategy of Development of Rehabilitation Services. Everyone is also entitled to be covered under social health insurance. Assistive technology and devices are covered by the social health insurance law. National standards exist on friendly environments for people with disabilities.
The rehabilitation work force consists of 150 licensed rehabilitation doctors (with 1 doctor per 10,000 inhabitants, as of 2010) and 27 qualified physiotherapists (only in Ulaanbaatar) in 2013. In 2014, an occupational therapy course started. There are no social workers and no speech and language therapists. Aside from the need to have a larger pool of rehabilitation practitioners, improvement in the training curriculum is necessary to have well-trained rehabilitation health-care providers who focus on active, functional and evidence-based rehabilitation.

2.4.7 Philippines

The Philippines has various enabling policies and legislation for people with disabilities, which include the Magna Carta, with a chapter on National Health Program and Rehabilitation/Health Services that provides for 20% discount for purchase of medicines and other health services. There is also the National Health Insurance Act that prioritizes the health-care needs of the underprivileged, older people and people with disabilities. In 2013, PhilHealth launched the Z-MORPH (Mobility, Orthosis, Rehabilitation and Prosthesis Help) benefit package, and this is now increasing to include other assistive devices.

The quality of health services for people with disabilities is enhanced through a new training package called the “Provision of Disability Inclusive Health and Rehabilitation Services at the Primary Health Care Level”. The criteria to be used in identifying people with disabilities prior to the issuance of a “PWD ID” is now being revised so as to be based on functional ability rather than medical diagnosis. In 2016 there will be the development of a 10-Year National Plan for Upgrading of Rehabilitation Facilities and Services.

2.4.8 Viet Nam


CBR started in 1987 and is seen as a focus for future programming in Viet Nam. CBR is applied in 46 out of 63 provinces, in 24 districts and 24 communes, with very positive results: 64% of adults with disability and 71% of children with disability are provided with health care and rehabilitation services; 50% of children with disabilities are accessing education services; and 24% of adults with disabilities have a job and improved incomes.

Hospital-based rehabilitation is provided through the rehabilitation department in all provincial hospitals and medical universities. There are 42 provincial hospitals with rehabilitation departments in 39 provinces, and 15 rehabilitation centres under Ministry of Health management.

2.4.9 Summary

Ms Kleinitz commended the presentations as they showed real progress and growing momentum in the last few years in countries to address the health and rehabilitation needs of people with disabilities. She emphasized that now the challenge is to build on the accomplishments and strengths to date.

Ms Kleinitz noted that from presentations, it is clear that there are still challenges on the supply of an appropriately skilled health workforce, with the need even greater in rural and remote areas. In most middle-income countries there are no qualified physiotherapists, occupational therapists or speech therapists available to work in the communities at the primary health care level. The workforce needs will exist for decades and in some regions,
such as East Africa, they have developed a “mid-level” rehabilitation training and cadre of workers, and this was something Asian countries should seriously consider.

2.5 Good practices

Ms Kleinitz introduced the participants to World Café, which is a technique to share as much information and ensure enough time for discussion. There were six topics on the white boards (Disability-inclusive Health Services, Disability-inclusive Health Workforce, Disability-inclusive Health Surveillance, Health Promotion within Health Services, Disability-inclusive Governance, and Leadership and Disability-Inclusive Health Financing) that will be presented by six discussion leaders.

2.5.1 Sharing

The discussion leaders were then asked to share the salient points of the discussions.

1. Disability-inclusive Health Services
   - The importance of involving people with disabilities throughout the process in order to have more impact on service providers and decision-makers who provide the resources.
   - The need to address basic barriers including infrastructure, such as physical, communication practices and capabilities of health workers.
   - The importance of strong referral pathways so that health workers refer clients to other health facilities and specialists as required. This is also about building the skills of service providers to be confident to make referrals.

2. Disability-inclusive Surveillance and Information (Republic of Korea)
   - National disability surveys should be used for generating evidence, policy-making and mobilizing resources. Information on managing disability is just as important as prevalence data.
   - It is more helpful to have longitudinal (comparable over time) data and for surveys to be reliable and tailored to countries.
   - Currently, most countries have used the Washington Group questions. This is good for getting a preliminary picture of the prevalence, however, more detailed information will be gained through a national disability survey and the information is very important for more efficient and accurate policy-making.

3. Disability-inclusive Health Workforce

Brainstorming was done from a values-based perspective.

Values:
   - Person-centered care and support that is provided in a professional, ethical and safe way that is responsive and flexible.
   - Accessible for all, free from barriers (physical, informational and attitudinal).

To achieve these:
   - Health worker training, employment and opportunities for advancement are requisites. In the context of advancement, the group talked about interim-level qualification and the duality of the challenge (having interim-level workers for whom advancement would be a greater challenge, but will enable greater service coverage of population).
- Responsibility of society in having people-centered care and support, by making people health literate and knowing when and where should they access health services

4. Disability-inclusive population health services – the example of Health Promotion in Persons with Mobility Impairment (Japan)
   - The health promotion programme should cover different types of disabilities and different population segments (e.g. adults, children and older people)
   - Health promotion should be built into much of the work done by health and rehabilitation personnel when working with people with disabilities. The need for incentives and skill may need to be addressed.
   - It is important to monitor interventions and the measurement of both physical and mental outcomes should be included.

5. Disability-inclusive Health Financing (China)
   - China has a complex health financing system with various insurance programmes, and health and rehabilitation packages for people with disabilities should be built into them all and slowly expanding over time.
   - Funding is also made more complex by variations at the national and provincial level and some provinces offer more than others.
   - Funding for rehabilitation and assistive devices may also come from the China Disabled Persons Federation. The federation currently provides funding for priority areas such as cochlear implantation, fitting of hearing aids and rehabilitation for children who are deaf, rehabilitation training for children with cerebral palsy and autism, and fitting assistive devices and orthoses for and a medical and hospitalization subsidy for psychiatric patients.

6. Disability-inclusive health governance and leadership (Hong Kong SAR [China])
   - Governance is complex and must always be responsive, the example of a good hospital health-care system in Hong Kong SAR (China), which is disability friendly and affordable has resulted in over 120% occupancy and, therefore, long waiting times for admission. Responses need to carefully balance patient needs and rights and a strong focus on community-based interventions and CBR are needed to address this current challenge.
   - In Hong Kong SAR (China) disability inclusion in health has been progressed through the Equal Opportunity Commission that acts swiftly on complaints against discrimination and the strong patient grievance mechanism in hospitals where civil society organizations are actively involved.
   - Consultation and participation of people with disabilities are the best way forward in disability-inclusive health governance.

2.6 Reviewing country situations

Ms Kleinitz refreshed the participants on the six building blocks. She then discussed the monitoring framework (outcomes/impact, outputs, inputs) for tracking progress in disability inclusive health, the vision for all the joint efforts (“Better health for all people with disability”), and the actions that address each of the building blocks. She guided participants into the next activity that called for each country group to review its country against a menu of actions that has been developed to support efforts to improve the health of people with disabilities. The menu follows the six building blocks. Group members should discuss and rate in a participative manner if their country is “Beginning”, “Adequate”, or “Comprehensive” on each action in the menu.
2.7 Identifying next steps

Bottleneck analysis

Ms Kleinitz announced the remaining activity for the day, which in adjunct to another activity for Day 3, will help participants prioritize future actions for their countries. The activity was a bottleneck analysis where country groups were asked to discuss the barriers to progress – not barriers to health care. “Why are you where you are now?” “Why is it that there were many ‘beginning’ but not ‘adequate’, many ‘adequate’ but not ‘comprehensive’ ratings in the ratings made in the previous group exercise?”

Poster sharing

The following are the bottlenecks shared by the country groups:

**Brunei Darussalam**
1. Insufficient policy, legislation.
2. Limited data for decision-making.
3. Inadequately coordinated leadership among government and nongovernmental organizations.
4. No full-time disability and rehabilitation focal point within the Ministry of Health.

**Cambodia**
1. Poor political understanding and commitment, need for stronger advocacy.
2. Insufficient implementation of policies and legislation.
3. Inadequately coordinated leadership across ministries – health, social affairs, labour information, education, finance.
4. Lack of tools and systems, e.g. tool for collecting data, screening tool for service providers, and monitoring and evaluation tools.

**China**
1. Uneven development across the country, making access to services unequal.
2. Limited data.

**Lao People’s Democratic Republic**
1. No full-time focal unit in the Ministry of Health, only three people in the division responsible for the whole country: a nurse and two doctors. The additional full-time staff is needed. There is a division, standard operating procedures and terms of reference, but not adequate human resources.
2. Inadequately coordinated leadership; some mechanisms already exist but the people who are in charge need to push the system to function.
3. Lack of data for decision-making. Without focal persons in Ministry of Health, how can the needed data be collected and utilized?
4. Poor political understanding and commitment, resulting from the other weaknesses.

**Malaysia**
1. Information on the social or living conditions and environment of people with disabilities.
2. Weak political commitment from other sectors and ministries.
3. Inability to regulate and enforce services and their standards.
Mongolia
1. Political instability due to frequent change in leadership at the Ministry of Health. No full-time focal point at the Ministry of Health, while there is a Unit on Disability at the Ministry of Population, Development and Social Protection.
2. Lack of quality multisectoral collaboration, given the uncertainties in the Ministry of Health.
3. Limited evidence, data and not using International Classification of Functioning, Disability and Health concepts and tool.
4. Lack of adequately trained human resources, especially for CBR.

Philippines
1. Limited data for decision-making.
2. Poor political understanding and commitment because of lack of data.
3. Inadequately coordinated leadership, within the Ministry of Health and across levels of care and across agencies. Need to elevate disability to the highest level in the Ministry of Health and make rehabilitation a cross-cutting concern in health service delivery.

Viet Nam
1. Inadequately coordinated leadership, lacks synergy for what each ministry needs to do.
2. Insufficient policies and legislation.
3. Limited data for decision-making
4. Poor political understanding and commitment.

2.8 Country highlights

A World Café activity occurred where countries highlighted initiatives on services and programmes that promote disability-inclusive health.

Cambodia shared its Provincial Disability-inclusive Health Demonstration Project. This project is designed to ensure health and community partners better identify people with functioning difficulties, ensure basic services are provided, improve the continuum of care and strengthen the quality of services provided. By developing tools and learning “how to” in one province, they will then be scaled up to other provinces.

China explained the role of China Disabled Persons’ Federation (CDPF) in disability and health. The dedicated agency for disability, along with high-level political support, has resulted in significant progress for people with disabilities in the last couple of decades. CDPF has invested heavily in service development, for example, CBR programmes and assistive technology.

The Lao People’s Democratic Republic shared its successes and challenges in drafting the country’s Disability-inclusive Health and Rehabilitation Plan. This plan was requested by the Ministry of Health to guide its work in this area and ensure long-term planning for increasing provision of rehabilitation services. The plan has brought key stakeholders together and resulted in significant progress with final endorsement yet to come.

Malaysia featured its work on disability data and research, where the inclusion of the Washington Group Questions (short set) was included in the National Health Survey resulting in a disability prevalence of 3.3%. They shared their further analysis of the results in which they are finding disparities in accessing healthcare, between people with and without a disability.
Mongolia shared the country’s adaptation of their Stroke Rehabilitation Guidelines to produce online training material to be used on an open source platform. This training platform is being utilized for a range of health topics, and they have worked to ensure disability and rehabilitation are included.

The Philippines communicated its experience of integrating disability and rehabilitation services into post-Typhoon Haiyan work of WHO. The experience revealed opportunities seized as well as some lost during the early response period. Efforts to strengthen access to health and rehabilitation have been successful, and there is now a greater investment and more services available in the affected areas than before the typhoon.

2.9 Reviewing progress: What have we learnt?

Dr Michelle Ann Villeneuve provided an overview of the session – a focus on amplifying strengths and finding innovative ways to scale up. Vertical and horizontal communication and coordination are important to influence systems change. The activity is to focus on what works through practice-informed inquiry. This practice of reflecting on successful results is a valid approach and a form of research towards development of evidence-based policy and practice.

The countries then worked as a group to reflect on successful results achieved in the last two years – what worked well and explain what made it successful. In the afternoon, they shared their experiences on successes in disability-inclusive health-care initiatives. Common successful factors among countries are: (1) coordination; (2) additional resources and attention; (3) capacity in government in terms of financial and human resources; (4) a shared vision and understanding among stakeholders; (5) meaningful involvement of users and advocating together persistently; (6) political support and will; (7) willingness, openness and accountability; and (8) empowering all stakeholders to be committed and active. Other success factors included building on existing mechanisms, having a champion, expansive learning and positive feedback.

2.10 Country planning

In this session, Ms Kleinitz gave countries the task to identify priorities and goals to achieve in the next two years. Considering what is doable and what will have an impact and identifying actions within a specific timeline. Countries were provided with a template to fill in and submit to Ms Kleinitz at the end of the meeting. This will serve as a monitoring tool and be utilized to support planning of technical support from WHO.

Key plans identified by countries included:

Brunei Darussalam will increase accessibility to health facilities and expand the availability of rehabilitation.

Cambodia set three objectives: increase understanding among stakeholders to influence political will; increase service coordination; and improve data collection.

China will focus on enhancing referral systems within different levels of health care to promote integrated services and the continuum of care (early detection and referral).

The Lao People’s Democratic Republic will focus on strengthening functional and effective physical rehabilitation units in the country.
Malaysia will focus on equitable health services for people with disabilities and include work to create disability friendly communities.

Mongolia will work on disability data and explore the model disability survey, and build capacity for research and training.

The Philippines will work to increase accessibility of rehabilitation services in various levels of health care and expand health insurance packages.

Viet Nam will expand the range of services available, including the hotlines for social workers and provide counselling services.

3. CONCLUSION and RECOMMENDATIONS

3.1 Conclusion

The meeting provided significant opportunity to review and plan for disability-inclusive health in participating countries. The objectives of the meeting were all achieved through the combination of presentations, sharing of experiences and country-level planning. Overall there was a clear demonstration of progress made by countries in recent years.

Key conclusions are:

a. Health ministries are increasingly clear about their role in addressing the health of people with disabilities. Health ministries understand that while they are not the “national lead” ministry for disability, they play a significant role in the development of specialist services, including rehabilitation, provision of assistive technology, and early childhood identification and intervention services.

b. Health ministries are increasingly aware that many general health services are not “inclusive and accessible” for people with disabilities and that there are still many barriers for people with disabilities.

c. Health ministries noted that a dedicated focal point within the ministry of health for disability was needed to push the agenda forward and are often challenged by their own internal capacity.

d. Health ministries agreed that people-centred approaches to health reflect many of the values and practices needed to build more accessible and inclusive services for people with disabilities. Support and linkages with this agenda are an important way forward.

e. Health ministries agreed that improving the continuum of care between health and disability services is a priority. Developing mechanisms, such as referral pathways, clinical guidelines and service directories, is an effective approach being utilized.

f. Demonstration projects at provincial levels have been used to assist some health ministries to improve their practices. These projects involve tool development and experimentation and are useful for countries to learn “hands on” how to achieve inclusive services. Ministries of health and social Affairs should work together in future programmes.

g. Rehabilitation services commonly cut across both ministries of health and ministries of social affairs, and because of this, the need for strong coordination and collaboration is high between these ministries. Not collaborating is detrimental to the health of people with disabilities.

h. National health insurance programmes provide a key opportunity for service...
expansion, and packages aimed at the needs of people with disabilities are an important step forward.

i. Advocacy for disability inclusion to Ministry of Health has been modest to date and DPOs should continue to advocate for greater investment in quality health and rehabilitation service provision.

j. Service utilization data by people with disabilities and health information systems that include disability is currently limited in the middle- and low-income countries. Measuring the success of disability-inclusive health policies and programmes will remain a significant challenge for years to come. Population surveys that capture health outcomes of people with disabilities and health-care utilization are the best way for middle-income countries to measure success.

k. Disability data are a complex area to understand and the dynamic interaction of people with disabilities in their environment means complex approaches to measurement are needed. There is currently limited understanding of disability measurement in many countries, and the need to build capacity in this area is urgent. It is important that government agencies understand the complexity of disability measurement and data collection approaches so that confusion regarding tools does not continue.

3.2 Recommendations

3.2.1 Recommendations for the WHO Secretariat

WHO is requested to:

1. continue to advocate for disability-inclusive health and integrate this broadly into the UHC agenda and SDGs;
2. support the inclusion of the health and rehabilitation needs of people with disabilities in national health strategies;
3. increase disability and rehabilitation capacity in country offices;
4. develop standardized tools for ministries of health to develop more accessible and inclusive health services;
5. build capacity in ministries of health and contribute positively to planning and coordination within and across ministries;
6. support ministries to develop demonstration projects as to “learn” how to build more inclusive and accessible services;
7. undertake training in disability measurement and disability data collection approaches; and
8. support people-centered approaches to health as they will directly benefit with disabilities as well.

3.2.2 Recommendations for the Member States

The Member States may consider:

1. increasing human resources capacity dedicated to disability within the ministry of health;
2. increasing internal ministry of health planning on disability and rehabilitation;
3. continuing to strengthen coordination between ministries of health and social affairs;
4. increasing financial investment in rehabilitation services, as an investment in human capital and important commitment towards realizing the goals of CRDP;
5. addressing disability data through greater knowledge of measurement approaches in
disability and appreciation of different tools for different purposes;
6. developing demonstration projects in provinces to “learn in a hands-on manner” how to make services inclusive and accessible;
7. moving towards better information systems in the long term and taking practical steps in this direction;
8. including disability in health curricula training and ensuring it reflects a rights-based approach; and
9. progressing the “people-centered care” approach in health that encompasses many of the needs of people with disabilities.

3.3 Next steps

- WHO will disseminate the report and prompt participants to review and reflect on it again.
- WHO has collated the country work plans developed at the meeting and will use these to inform planning of WHO support to countries
- Countries should review their plans and ensure actions described at the meeting are undertaken.
ANNEX 1

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ANNEX 2

PROGRAMME OF ACTIVITIES

Day 1: Wednesday, 11 November 2015

08:00 – 08:30 Registration

08:30 – 09:15 Opening ceremony

Welcome remarks Dr Ailan Li
Director, DSE
WHO WPRO

Introduction of participants

Election of Chairpersons/Rapporteurs

Group photo

09:15 – 09:45 Coffee/tea break

09:45 – 10:00 Overview of the meeting objectives and schedule Ms Pauline Kleinitz
Technical Lead
Disability and Rehabilitation
WHO WPRO

10:00 – 12:00 Session 1 – Overview to disability inclusive health and rehabilitation: situation and needs

Overview to Disability Inclusive Health & related CRPD, SDG and WHO Global Disability Action Plan Goals Ms Pauline Kleinitz

The health of people with disabilities Dr Zee-A Han
Director, Department of Spinal Cord and Injury and Rehabilitation Chief, Health Promotion Center for Persons with Disabilities, National Rehabilitation Center Ministry of Health and Welfare

12:00 – 13:00 Lunch break
13:00 – 15:00  **Session 2 – Disability and health**

- What people with disabilities require from health services?
  **Dr Cathy Vaughan**
  Lecturer
  Melbourne School of Population and Global Health, The University of Melbourne

- What people with disabilities experience?
  **Ms Carmen Zubiaga**
  Executive Director
  National Council on Disability Affairs

- How health systems need to respond?
  **Dr Ayesha de Lorenzo**
  Technical Officer
  Health and System Strengthening
  WHO WPRO

15:00 – 15:30  **Coffee/tea break**

15:30 – 17:00  **Session 3 – Measuring progress**

- Measuring the health status of people with disabilities at population level
  **Ms Pauline Kleinitz**

- Measuring the capacity to deliver disability inclusive health and rehabilitation
  **Ms Cheryl Ann Xavier**
  Consultant

18:00 – 20:00  **Reception (Bayview Salon)**

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**Day 2: Thursday, 12 November 2015**

08:30 – 08:45  Summary of Day 1

08:45 – 10:30  **Session 4 – Country updates on disability inclusive health and rehabilitation**
  Brunei Darussalam, Cambodia, China, Laos, Malaysia, Philippines, Viet Nam

10:30 – 11:00  **Coffee/tea break**
11:00 – 12:30  **Session 5 – Good practices (World Café)**

Disability Inclusive Health financing  Dr Lu Min
Associate Professor
WHO Collaborating Centre for
Training and Research in
Rehabilitation, Tongji Hospital

Disability Inclusive Health governance and leadership  Dr Joseph Kwok
Vice-Chairman
The Hong Kong Society for Rehabilitation

Disability Inclusive Health surveillance and information  Dr Zee-A Han

Disability Inclusive Health services (facility level)  Dr Cathy Vaughan

Disability Inclusive Health services (population health)  Dr Toru Ogata
Director, Center of Sports Science and Health Promotion, National Rehabilitation Center for Persons with Disabilities

Disability Inclusive Health workforce  Dr Michelle Villeneuve
Co-Stream Leader
Center for Disability Research and Policy
The University of Sydney

12:30 – 13:30  **Lunch break**

13:30 – 15:00  **Session 6 – Reviewing country situation**
Rating country status against Menu of Actions  Country group work

15:00 – 15:30  **Coffee/tea break**

15:30 – 17:00  **Session 7 – Identifying next steps**
Identifying challenges and priorities  Country group work

**Day 3: Friday, 13 November 2015**

08:30 – 08:45  Summary of Day 2
08:45 – 10:30  **Session 8 – Country highlights (World Café)**

Cambodia – Disability Inclusive Health Demonstration Project
China – Disability and Health
Laos – Disability and Rehabilitation Action Plan Development
Malaysia – Disability Data, and Research Clearinghouse
Mongolia – Online Rehabilitation Training Materials
Philippines – Integrated Health and Rehabilitation Services Post Haiyan

10:30 – 11:00  *Coffee /tea break*

11:00 – 12:30  **Session 9 – Reviewing progress:**  Ms Pauline Kleinitz

What have we learnt?

Feature of recent progress
Challenges to current progress
Building on progress

12:30 – 13:30  *Lunch break*

13:30 – 15:00  **Session 10 – Country planning**  Country group work

15:00 – 15:30  *Coffee /tea break*

15:30 – 16:45  **Session 11 – Feedback from countries and regional steps forward**  Presentation and discussions

16:45 – 17:00  Closing