REHABILITATION 2030
a call for action

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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 of Great Britain and Northern Ireland), 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), Gerald 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 Khasnabish (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, the United Kingdom), Joel Block (Osteoarthritis and Cartilage journal, United States of America), Laragh Gollogly (Bulletin of the World Health Organization), John Beard (Department of A1eage 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 Sminkew, Tamitza Toroyan and Judith van der Veen.

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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 21st century, can be found online (https://www.who.int/news-room/events/detail/2017/02/06/default-calendar/rehabilitation-2030-a-call-for-action).
REHABILITATION 2030 PARTICIPANTS IN NUMBERS

Total participants

208

Participations from around the world

Representation across WHO regions

Representation by stakeholder type
1. INTRODUCTION

Dramatic shifts in the health and demographic profiles of populations are characterizing the 21st 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.

"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

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

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.
“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

“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

“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
2. REHABILITATION: TESTIMONIALS

2.1 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.

“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 50th 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 7th 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.

“Take it from me, rehabilitation gave me a second life, a second life definitely worth living.”

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2.2 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.

“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.

“Rehabilitation is crucial. It’s a life changer, and it needs to be beefed up all over the world… Rehabilitation is crucial if we really want to make sure that no one is left behind…”

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.
2.3 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.

“Rehabilitation taught me to see my future and made me a different person. In rehabilitation I learnt that people with SCI could actually work.”

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.

“When I go out in the rural community I meet people who did not get rehabilitation. They suffer and live with complications... Their families tell me later that he or she has died, mostly because of pressure sores... 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\(^1\), 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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\(^1\) Convention on the Rights of Persons with Disabilities
3. REHABILITATION IN THE 21ST CENTURY

3.1 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 21st century and the sustainable development agenda. The Rehabilitation 2030 background paper, Rehabilitation: key for health in the 21st 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.”
3.2 The Need to Scale Up Rehabilitation

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


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 ([1](#)) (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.

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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.
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.
3.3 The Cost of Failing to Provide Rehabilitation Services

Dr David McDaid, London School of Economics, the 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:

- 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
3.4 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 https://www.who.int/news-room/events/detail/2017/02/06/default-calendar/rehabilitation-2030-a-call-for-action.

**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.
“Global trends in health and ageing require a major scaling up of rehabilitation services in countries around the world.”

-Rehabilitation in health systems

“In many parts of the world, rehabilitation services are often provided only at selected levels of the health system.”

-Rehabilitation in health systems
4. IMPLEMENTING REHABILITATION IN HEALTH SYSTEMS: KEY LESSONS FROM MEMBER STATES

The meeting, Rehabilitation 2030, provided an opportunity to launch Rehabilitation in health systems (https://www.who.int/publications/i/item/978241549974). 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
- conducting provincial workshops on assistive technology.

“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

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

5.1 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.

5.2 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.

5.3 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
https://www.who.int/health-topics/assistive-technology#tab=tab_1
“Very few people really know about rehabilitation and it is our obligation to make sure that everyone is aware of its importance.”

-Jan Monsbakken, President of Rehabilitation International
6. 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 policymakers, 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 (https://www.who.int/news-room/events/detail/2017/02/06/default-calendar/rehabilitation-2030-a-call-for-action).

### 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.

### Condition specific organizations

- Rehabilitation professional organizations
- International and nongovernmental organizations
- Rehabilitation professionals working in medical faculties
- Researchers and professionals working in public health
- Editors of journals

### 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 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 policymakers, 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
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.
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.

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.
ANNEX A. LIST OF PARTICIPANTS

Dr Roberto Aguilar Tassara, Direccion de Servicios Medicos e Apoyo Tecnico, Centro Nacional de Rehabilitacion (CENARE), Caja Costarricense de Seguro Social, Costa Rica

Dr Michael Angastiniotis, Medical Advisor, Thalassaemia International Federation, Cyprus

H.E. Mr Ravinatha Aryasinha, Permanent Representative of Sri Lanka to the United Nations Office in Geneva, Geneva

Mr Srinivasan Balasubramanian, Chief Executive, Enhance Head Neck Rehabilitation, India

Professor Moon Suk Bang, Editor-In-Chief, Annals of Rehabilitation Medicine and Seoul National University, Republic of Korea (the)

Professor Linamara Rizzo Battistella, University of São Paulo Medical School and São Paulo State Secretary for the Rights of the Person with Disability, São Paulo, Brazil

Dr Mauri Beeri, Director General, ALYN Hospital Pediatric Rehabilitation Center, Israel

Professor Jerome Bickenbach, Disability Policy Unit Head, Swiss Paraplegic Research (SPF), Switzerland

Professor Anita Björkland, Editor-In-Chief, Scandinavian Journal of Occupational Therapy, Sweden

Professor Joel Block, Editor-In-Chief, Osteoarthritis and Cartilage Journal and Osteoarthritis Research Society International (OARSI), the United States

Dr Oksana Bochkarova, Chief Doctor, Khmelnytsky Regional Hospital for Veterans of War, Ukraine

Ms Marieke Boersma, Senior Consultant, Community Based Rehabilitation, Light for the World, Austria

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Mr Geoff Bowen, Counsellor, DFAT Permanent Mission, Geneva

Ms Laurence Boymond, Institutional Partnership Officer, Handicap International Federation, Switzerland

Dr Joachim Breuer, Director General, German Social Accident Insurance (DGUV) and President of ISSA, Germany

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Ms Beth Capper, Director of Operations, Global Clubfoot Initiative, the United Kingdom

Dr Alain Chatelin, Member of the Executive Committee, International Cerebral Palsy Society, France

Mr Matthieu Chatelin, Patient representative and member of the board, Les Amis de La Fondation Motrice, La Fondation Motrice, France

Professor Jackie Clark, Co-Founder, Coalition for Global Hearing Health, University of Texas, the United States

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Professor Richard Madden, Director, National Centre for Classification in Health, University of Sydney, Australia
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Mr Gopal Mitra, Programme Specialist, Children with Disabilities, UN International Children’s Emergency Fund (UNICEF), the United States

Mr Jan Monsbakken, Immediate Past President, Rehabilitation International, Norway

Mrs Rebecca Morton Doherty, Senior Advocacy Manager, Union for International Cancer Control (UICC), Switzerland

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Honorable Dr Phouthone Muongpak, Deputy Minister of Health, Ministry of Public Health, Lao People’s Democratic Republic (the)

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Ms Francesca Ortali, Head of Project Office, Italian Association Amici di Raoul Follereau (AIFO), Italy

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Ms Marilyn Pattison, President, World Federation of Occupational Therapists (WFOT), Australia

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Professor Jon Pearlman, Director, International Society of Wheelchair Professionals (ISWP), the United States

Assoc. Professor Dr Bouathep Phoumin, Vice-Dean, Faculty of Medical technology, University of Health Science, Ministry of Public Health, Lao People’s Democratic Republic (the)

Mr Carlos Pinto, Deputy National Director, Servicio Nacional de la Discapacidad (SENADIS), Gobierno de Chile

Dr Wesley Pryor, Senior Technical Advisor, Nossal Institute of Global Health, Australia

Dr Darshan Punchi, Parliamentary Secretary of Health, Ministry of National Health Services, Pakistan

Professor Zhuoying Qiu, Co-chair, WHO Family International Classification Collaborating Center China and Director, China Key Laboratory of Classification, Evaluation and Rehabilitation (Sport) of Intellectual and Developmental Disability, Zhengzhou University, China

Mr. Kurbanov Qudratullo, Head of the Department of Social Protection, Ministry of Health and Social Protection of the Republic of Tajikistan, Republic of Tajikistan (the)
Ms Gaboelwe Rammekwa, Head of the Rehabilitation and Mental health Division, Ministry of Health, Botswana

Mr Vinicius Ramos, International Cooperation and Research Support Officer, Physical and Rehabilitation Medicine Institute, University of Sao Paulo Medical School General Hospital (IMREA HCFMUSP), Brazil

Ms Zahra Aly Rashid, Low Vision Consultant, Kenya

Mr Thierry Regenass, Executive Director, the ICRC MoveAbility Foundation, Switzerland

Mr Martín Remón Miranzo, Consejero (asuntos de sanidad y trabajo), Representación Permanente de España ante la Oficina de Naciones Unidas en Ginebra, Ministerio de Asuntos Exteriores y de Cooperacion, Spain

Assoc. Professor Lorie Richards, Editor-In-Chief, The American Journal of Occupational Therapy and Chair of the Department of Occupational Therapy, The University of Utah, the United States

Professor Leocadio Rodríguez Mañas, Geriatrician, Jefe de Servicio de Geriatría, Geriatrics Service, Hospital Universitario De Getafe, Servicio Madrileño De Salud (SERMAS), Spain

Dr Belkis Romeu, Health Attaché, Permanent Mission of Cuba, Geneva

Ms Gundula Roßbach, Direktorin bei der Deutschen, Deutsche Rentenversicherung Bund, Germany

Professor Paula Rushton, School of Rehabilitation, University of Montreal, Canada

Dr Carla Sabariego, Chair for Public Health and Health Services Research, Institute for Public Health and Health Services Research, Ludwig-Maximilians-University (LMU), Germany

Dr Shaukat Sadikot, President, International Diabetes Federation, India

Dr Daniel Nyamongo Sagwe, Head of Physiotherapy and Rehabilitation, Rehabilitative Sciences Department, Jomo Kenyatta University of Agriculture and Technology (JKUAT), Kenya

Dr. Yamilé Sánchez, Teaching Vice-Director of the “Julio Diaz” Hospital, National Rehabilitation Center of Cuba

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

Dr Sujatha Senarathne, Private Secretary to the Hon. Minister of Health, Nutrition and Indigenous Medicine, Sri Lanka

Mr Mostafa Seraj, Director of Social Welfare, Ministry of Health and Medical Education, Iran (the Islamic Republic of)

Ms Nicky Seymour, Service Development Manager, Motivation Charitable Trust, the United Kingdom

Professor Raad Shakir, President, World Federation of Neurology, the United Kingdom
Professor Shajila Singh, Director and Head of Department, Department of Health and Rehabilitation Sciences, University of Cape Town, South Africa

Ms Cheat Sokha, Executive Director, Spinal Cord Injury Association of Cambodia (SCIAC), Cambodia

Professor Katharina Stibrant Sunnerhagen, Professor of Rehabilitation Medicine, World Stroke Organisation, Sweden

Dr Emma Stokes, President, World Confederation for Physical Therapy (WCPT), Ireland

Dr Vasyl Strilka, Chief Specialist, Division of Medical Rehabilitation, Palliative and Hospice care, Medical Department, Ministry of Health of Ukraine, Ukraine

Professor Gerold Stucki, Director, Swiss Paraplegic Research (SPF), Chair and Professor of Department of Health Sciences and Health Policy, University of Lucerne, Switzerland

Dr S. Subasinghe, Advisor to the Hon. Minister of Health, Nutrition and Indigenous Medicine, Sri Lanka

Ms Kate Swaffer, Founder, Chair and CEO, Dementia Alliance International, Australia

Professor George Tavartkiladze, General Secretary, International Society of Audiology (ISA) and the National Research Centre for Audiology and Hearing Rehabilitation, Russian Federation (the)

Dr Safietou Thiam, Secrétaire Exécutif du Conseil National de Lutte contre le SIDA Ministère de la Santé et de l’Action sociale, Senegal

Dr Maya Thomas, Editor-In-Chief, Disability, CBR and Inclusive Development Journal, India

Professor Dr Murali Thyloth, Bangalore President Elect, World Association for Psychosocial Rehabilitation and Head of the Department of Psychiatry, Ramaiah Medical College, India

Dr Jose Tormos, Research Director, Institut Guttman, Spain

Mr Johannes Trimmel, Director of Advocacy, The International Agency for the Prevention of Blindness (IAPB), the United Kingdom

Mr Stefan Trömel, Senior Disability Specialist, Gender, Equality and Diversity Branch, International Labor Organization (ILO), Geneva

Ms Isabelle Urseau, Technical Resources Division, Head of the Rehabilitation Technical Unit, Handicap International Federation, France

Dr Herminigildo Valle, Undersecretary of Health, Department of Health, Philippines (the)

Professor J. M. van Laar, Editor-In-Chief, Rheumatology (Oxford, England) Journal, Netherlands (the)
Professor Dr Geert Verheyden, Editor, Physiotherapy Research International Journal and Research Lead, KU Leuven, Belgium

Mr Lindsley Jeremiah Villarante, Senior Health Program Officer, Health Policy Development and Planning Bureau, Department of Health, Philippines (the)

Ms Laura Vicente de Torres, Observer, Fondazione IRCCS Istituto Neurologico Carlo Besta, Italy

Dr Sandra Willis, Policy Advisor, United Arab Emirates

Dr Jill Winegardner, Lead Psychologist, Oliver Zangwill Centre, the United Kingdom

Ms Christiane Wiskow, Health Services Sector Specialist, UN International Labor Organization (ILO), Geneva

Professor David Wood, President, the World Heart Federation, the United Kingdom

Mr Marc Wortmann, Executive Director, Alzheimer's Disease International, the United Kingdom

Dr Sam Wu, Treasurer, International Society of Physical and Rehabilitation Medicine (ISPRM), the United States/Switzerland

Professor Jean Jacques Wyndaele, President, International Spinal Cord Society (ISCoS), Belgium

Mr Marc Zlot, Physical Rehabilitation Program Coordinator, International Committee of the Red Cross (ICRC), Switzerland

WHO SECRETARIAT

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

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Dr Shelly Chadha, Technical Officer, Blindness Deafness Prevention, Disability and Rehabilitation Department

Dr Somnath Chatterji, Scientist, Information, Evidence and Research Department

Dr Oleg Chestnov, Assistant Director-General, World Health Organization

Dr Dan Chisholm, Health Systems Advisor, Department of Mental Health and Substance Abuse

Dr Alarcos Cieza, Coordinator, Blindness Deafness Prevention, Disability and Rehabilitation Department

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Dr Paloma Cuchi, Representative, Office of the WHO Representative in Chile
Dr Juliet Fleischl, Representative, Office of the WHO Representative in Lao People's Democratic Republic

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Ms Judith van der Veen, Technical Officer, Blindness Deafness Prevention, Disability and Rehabilitation Department

Ms Marieke van Regteren Altena, Consultant, Blindness Deafness Prevention, Disability and Rehabilitation Department
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 21st 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, the 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 Necnulhueque 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 Joachim 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, the 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
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

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.
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.
Recommendations for strengthening rehabilitation in health systems

- **Ministry of Health**
  - Integrate rehabilitation into the health system
- **Primary, Secondary, Tertiary**
  - Integrate rehabilitation services into and between primary, secondary and tertiary levels of health systems
- **World Health Organization**
  - Ensure the availability of a multi-disciplinary rehabilitation workforce
- **Implementing on the ground**
  - Ensuring both community and hospital rehabilitation services are available
  - Implementing financing and procurement policies that ensure assistive products are available to everyone who needs them
- **Ensure financial resources are allocated to rehabilitation services**
  - Where health insurance exists or is to become available, ensure rehabilitation services are covered

Infographic available via: [http://www.who.int/disabilities/Banner.pdf?ua=1](http://www.who.int/disabilities/Banner.pdf?ua=1)
ANNEX E. IMPORTANT LINKS AND RELATED RESOURCES

WHO Rehabilitation webpage
https://www.who.int/health-topics/rehabilitation#tab=tab_1

Rehabilitation 2030: A Call for Action webpage
https://www.who.int/news-room/events/detail/2017/02/06/default-calendar/rehabilitation-2030-a-call-for-action

Rehabilitation in health systems webpage
https://www.who.int/publications/i/item/9789241549974

Rehabilitation in the 21st century video
https://www.youtube.com/watch?v=a8ugRziXruc

Global Cooperation on Assistive Technology (GATE)
https://www.who.int/health-topics/assistive-technology#tab=tab_1

WHO Rehabilitation email: rehabilitation@who.int

Key WHO action plans relevant to rehabilitation

WHO global disability action plan 2014-2021

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/