MEETING ON REHABILITATION IN UNIVERSAL HEALTH COVERAGE

29–31 August 2017
Manila, Philippines
WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

MEETING REPORT
MEETING ON REHABILITATION IN UNIVERSAL HEALTH COVERAGE

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NOTE

The views expressed in this report are those of the participants of the Meeting on Rehabilitation in Universal Health Coverage 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 on Rehabilitation in Universal Health Coverage in Manila, Philippines, from 29 to 31 August 2017.
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Key words:

Continuity of patient care / Disability / Health priorities / Health systems plan / Rehabilitation /
Universal coverage
SUMMARY

The availability of quality 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”. However, health interventions in the Western Pacific Region have not sufficiently included support for strengthening of rehabilitation services and affordable access to quality assistive technology. Many countries in the Region do not have rehabilitation services that address ongoing health priorities.

In line with the objectives set out by the WHO Global Disability Action Plan 2014–2021: Better Health for All People with Disability, Universal Health Coverage: Moving Towards Better Health – Action Framework for the Western Pacific Region and the new WHO guidance on Rehabilitation in Health Systems, WHO organized a regional meeting on 29–31 August 2017. The meeting provided the opportunity for Member States from the Western Pacific Region to discuss issues and prioritize actions to strengthen rehabilitation in universal health coverage (UHC) in their countries.

Objectives

The objectives of the meeting were:

(1) to share experiences and good practices on strengthening rehabilitation in the Western Pacific Region;
(2) to discuss and prioritize how to strengthen rehabilitation as part of UHC development; and
(3) to identify ways for rehabilitation services to reach disadvantaged groups in accordance with UHC.

Conclusions

(1) Despite the importance of rehabilitation, its resonance thus far has been limited to the disability and rehabilitation communities; however, with the rise of noncommunicable diseases (NCDs) and the ageing population, it is increasingly clear that all individuals will need rehabilitation services at some point in their lives.

(2) UHC for effective and affordable rehabilitation services and assistive technology (AT) should be considered in the context of the Sustainable Development Goals (SDGs).

(3) Provision and financing of rehabilitation services require intersectoral coordination and cooperation among ministries of health, social welfare, finance and others.

(4) An appropriate rehabilitation financing mechanism should support the integration of rehabilitation into people-centred care throughout the health-care continuum.

(5) Lack of human resources is a challenge for many countries, including the dearth of rehabilitation professionals and facilities in rural or geographically remote areas.

(6) The need for AT is growing globally but challenged by issues of accessibility, affordability and quality; the Global Cooperation Assistive Technology (GATE) aims to help countries in addressing these needs.

(7) Data collection for monitoring of rehabilitation services is vital for evaluating the success of any rehabilitation plan.
Recommendations for Member States

Member States are encouraged to:

(1) Engage in multisectoral collaboration and partnerships with other ministries, nongovernmental organizations (NGOs), disabled persons’ organizations (DPOs), international development agencies and civil society in providing affordable, effective and timely rehabilitation services.

(2) Explore different financing mechanisms for rehabilitation in UHC, taking into account the five principles of UHC: quality, efficiency, equity, accountability, and sustainability and resilience. Reduction of out-of-pocket costs should be a key goal.

(3) Develop a national rehabilitation strategic plan that includes serving the needs of different populations and communities in different care settings throughout the continuum of care.

(4) Learn about GATE and sign up to be on the email list (gate@mednet-communities.net) to become part of the network.

(5) Conduct data gathering on rehabilitation services for monitoring and evaluation to be reviewed at least every two years.

(6) Build training capacity for rehabilitation workforce.

(7) Include evidence-based research on the effects and consequences of rehabilitation when approaching policy-makers and decision-makers.

(8) Understand and communicate that rehabilitation is a health service for all people in society and not only for people with disability.

During the group work activity, representatives of Member States identified country-specific actions they intend to undertake at the conclusion of the meeting:

**Cambodia:** Establish a Rehabilitation Technical Task Force; develop a rehabilitation curriculum and training modules; strengthen and expand rehabilitation services in hospitals; conduct a gap assessment on the rehabilitation workforce and AT; and integrate rehabilitation intervention into NCD and disability-related action plans.

**China:** Develop cross-regional support (e.g. centre to remote areas, city to countryside); develop outreach rehabilitation medical services; centralize information and resources for disability prevention and rehabilitation of people with disability; establish a central IT system for rehabilitation; and expand medical coverage of rehabilitation.

**Fiji:** Endorse the *Disability-Inclusive and Rehabilitation Action Plan 2014–2022*; create an allied health position at the National Rehabilitation Medicine Hospital; build a rehabilitation system in the western and northern divisions; provide budget allocation for rehabilitation and AT; and specify simple useful data about rehabilitation service outputs.

**Lao People's Democratic Republic:** Create a rehabilitation division within the Ministry of Health; endorse and implement the *National Rehabilitation Strategy and Action Plan*; provide scholarships for new rehabilitation specialists; decentralize rehabilitation services and AT at provincial and district levels.
Malaysia: Improve data collection based on functional outcomes in different care settings; give feedback to service providers; evaluate the current standard of care in rehabilitation services; mobilize workforce and resources by creating a prosthetics and orthotics (P&O) position and contract/part-time positions; work towards health insurance coverage of rehabilitation services and AT; and revamp rehabilitation plan and components of the plan.

Federated States of Micronesia: Educate and engage government leaders at all levels of rehabilitation services; finalize the Rehabilitation and AT Strategic Plan; develop funding mechanisms for rehabilitation and AT services; improve and increase rehabilitation workforce; and improve data collection on persons accessing rehabilitation services.

Mongolia: Develop standards for rehabilitation centres and departments; develop rehabilitation guidelines for children, older people, people with disability, and persons with NCDs; establish rehabilitation centre under the Ministry of Health; solicit funds from international organizations and international investors; and develop an action plan for trauma and NCD patients in the inpatient setting.

Philippines: Develop a roadmap for incorporating rehabilitation into the health system; conduct a situational analysis of the national to local conditions in the country; engage with various stakeholders/partner groups (NGOs, consumer groups, DPOs, academe, etc.); gather evidence-based examples of rehabilitation; and develop relevant policies/legislation to support and fund rehabilitation services at the provincial/community levels.

Samoa: Strengthen rehabilitation in the health system; strengthen the rehabilitation workforce; create positions and relevant employment opportunities; build capacity of the existing workforce; and improve information collection and recording mechanisms.

Solomon Islands: Develop policies and guidelines for rehabilitation services; adopt and incorporate priority AT products list; strengthen P&O services; establish stakeholder’s committee throughout the provinces; and improve and strengthen referral processes at the national, provincial and community levels.

Tonga: Include rehabilitation in primary and secondary health-care levels and activities; strengthen and grow rehabilitation workforce; strengthen staff capacity, resources and procurement for diabetes foot clinic; begin providing community-based rehabilitation; and coordinate efforts with the Ministry of Health to expand rehabilitation services.

Vanuatu: Lead the development of rehabilitation and AT strategy; establish a rehabilitation advisory group; identify a champion/focal point for rehabilitation; identify and select field officers and physiotherapists for training; and establish a physical space for a rehabilitation centre.

Viet Nam: Increase community-based rehabilitation services; develop a rehabilitation network; develop and revise a curriculum for graduate and postgraduate rehabilitation training; upgrade rehabilitation facilities; conduct a national survey on use of AT in rehabilitation facilities; and complete policies and guidelines for rehabilitation.

Recommendations for WHO

WHO is requested to:

(1) Continue supporting Member States in strengthening rehabilitation services in their countries by developing relevant guidelines, training materials and assessment tools, and providing technical support and guidance as needed.
(2) Further support Member States in advocating for rehabilitation as part of UHC in their countries.

(3) Provide opportunities for Member States to learn best practices from one another, such as through regional meetings, workshops and consultations.

(4) Hold a meeting on NCDs that includes rehabilitation (a special request was made for WHO to hold such a meeting).

(5) Encourage and facilitate partnerships between Member States, NGOs and international development agencies to increase accessibility and affordability of rehabilitation services and AT.
1. INTRODUCTION

1.1 Meeting organization

A Meeting on Rehabilitation in Universal Health Coverage was organized by the World Health Organization (WHO) Regional Office for the Western Pacific. Presentations, plenary discussions and interactive activities were held from 29 to 31 August 2017 at the WHO Regional Office in Manila, Philippines. Country representatives shared their experiences through discussions and group work. Based on a review of progress and challenges, countries identified opportunities and developed specific action plans.

1.2 Meeting objectives

The objectives of the meeting were:

1. to share experiences and good practices on strengthening rehabilitation in the Western Pacific Region;

2. to discuss and prioritize how to strengthen rehabilitation as part of universal health coverage (UHC) development; and

3. to identify ways for rehabilitation services to reach disadvantaged groups in accordance with UHC.

2. PROCEEDINGS

2.1 Opening session

Dr Hai-Rim Shin, Acting Director, Division of NCD and Health through the Life-Course, welcomed participants to the meeting and delivered the opening remarks on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific. Dr Shin reiterated the importance of rehabilitation services in the face of increases in noncommunicable diseases (NCDs), ageing populations and more and more people living longer with impairments that contribute to disability. WHO defines health as a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”. Therefore, it is impossible to have a healthy population without including rehabilitation as a priority in our health systems. Investing in rehabilitation saves money and produces better health-related outcomes because it restores health and real well-being. She called on Member States in the Region to work with WHO to increase understanding of how it can help prioritize, resource and sustain quality rehabilitation services for all.

Mr Darryl Barrett opened the session and went over the three objectives of the meeting. Participants were then invited to introduce themselves. A list of participants is in Annex 1.

Ms Anjana Bhushan began her presentation by showing a video created by WHO about UHC in the 21st century. She gave an overview of how rehabilitation services can be successfully delivered within the framework of UHC. SDG 3.8, “to ensure healthy lives and promote well-being for all at all ages”, should be viewed not just as a target, but also as a platform from which to deliver health and health-related goals as health is also central to other SDGs. A well-performing health system encompassing the five attributes – quality, efficiency, equity, accountability, and sustainability and resilience – enables rapid achievement of UHC, as outlined in the regional action framework, Universal Health Coverage: Moving Towards Better Health. Ms Bhushan outlined how each of these attributes could be applied to the strengthening of rehabilitation services, including within the health system building blocks of leadership/governance, health-care financing, medicines and health
technologies, information and research, workforce and service delivery. While each country has its own unique challenges, they all face a few common challenges, such as gaps in service coverage and access between advantaged and disadvantaged populations. “Leaving no one behind” is an important goal for SDGs; therefore, progress has to be made not just at the aggregate level, but such that the most vulnerable populations receive quality and timely care without suffering financial hardship.

In her presentation on rehabilitation in the 21st century, Dr Alarcos Cieza began by challenging participants to think about a mystery – why is it that while rehabilitation is a key health strategy for the 21st century, nobody knows this beyond the disability and rehabilitation communities? Given the population trends, the number of people living with disability will only increase in the future, and treatment prevention and promotion strategies are no longer enough. Yet despite knowing how important rehabilitation is, rehabilitation services are not part of the axis of health services offered in many countries. To help countries understand the linkages between SDGs, UHC and rehabilitation, WHO developed a document, *Rehabilitation in Health Systems*, which addresses the integration of rehabilitation into health systems, at different levels and sites of care, beyond the health sector and throughout the life-course. In February 2017, a meeting convened in Geneva for rehabilitation experts and policy-makers was attended by 208 participants from 46 different countries. “Rehabilitation 2030: a call for action” launched a new definition of rehabilitation as “a set of interventions designed to reduce disability and optimize functioning in individuals with health conditions in interaction with their environment”. The meeting identified 10 different actions stakeholders can take to scale up quality rehabilitation services around the world. While rehabilitation needs to be strengthened in the health sector because it should be provided within a continuum of care, Dr Cieza emphasized that it is a multidisciplinary and multisectoral effort involving both health and non-health interventions, as well as other sectors, such as finance, social, education and labour. The health system can play a stewardship role while working with other sectors to strengthen rehabilitation as a whole.

### 2.2 Country presentations

Mr Setareki Macanawai opened this session with a personal testimonial on the importance of rehabilitation and its impact on people with disability, especially in the Pacific. Like everyone, persons with disability do not just want to survive, but to enjoy quality of life. Early identification and intervention are critical to minimizing and preventing further disability. Health programmes should be inclusive, non-discriminatory and able to reach populations in hard-to-reach areas. The availability, affordability and quality of AT should also be addressed, as they tend to be very expensive and of poor quality in the Pacific. The families of persons with disability should be included in discussions as they are their advocates. And finally, networking and collaboration are essential for working across different domains to ensure health programme coverage that is inclusive and leaves no one behind.

Mr Barrett invited representatives to present on the status of rehabilitation in their countries. Some key points from each presenter are listed below.

**Cambodia (Dr Kol Hero):** Cambodia has implemented Objective 2 of the *WHO Global Disability Action Plan* – strengthening rehabilitation, AT, support services and community-based rehabilitation. Some achievements include the development of national strategic plans and guidelines on rehabilitation, the upgrading of a physical therapy curriculum, and basic rehabilitation interventions being included in a minimum package of activities for health centres. However, challenges remain such as rehabilitation services being split among several agencies, continued reliance on external funding, limited workforce, and services mostly provided at the primary health care level.

**Solomon Islands (Ms Elsie Taloaffiri and Mr Ernest Mae):** A big achievement in Solomon Islands has been the drafting of a corporate plan for the Rehabilitation Division. A role delineation policy has been implemented and will be used as a platform for implementing the *National Health Strategic Plan* to the different zones. The community-based rehabilitation (CBR) programme is well established, and the Government subsidizes all costs of AT. Geographical issues such as limited and costly transportation to the islands, and lack of human resources continue to pose challenges.
Federated States of Micronesia (Mr Johnny Hadley Jr): Currently there are no rehabilitation services available for persons with disabilities in the four island states, Pohnpei, Kosrae, Chuuk and Yap. The Government is now reviewing its implementation plan for the Convention on the Rights of Persons with Disabilities (CRPD) with a goal of completing it for all four states by the end of the year. One of Mr Hadley’s purposes in attending the meeting was to seek assistance and advocate for mental health patients and those families underrepresented in the mental health care plan.

Philippines (Ms Maria Cristina Raymundo): The Philippines passed a Magna Carta for Disabled Persons that provides a 20% discount and VAT exemption for persons with disabilities in all settings (e.g. transportation, hospital and medical costs). A Revised National Policy on Strengthening the Health and Wellness Program for Persons with Disabilities envisions that all persons with disability, including children and their families, have full access to inclusive health and rehabilitation services. The “Z Benefits Package” and “Z-MORPH Package” cover costs of mobility devices for children and adults with disabilities, respectively. Some ongoing challenges include development of a mandatory national health insurance programme (PhilHealth) coverage for all persons with disability; need to establish medical rehabilitation centres at all levels, such as at provincial hospitals and municipal health centres; and strengthening of the health information system.

Vanuatu (Dr Willie Tokon): Vanuatu works closely with international development partners, civil society organizations (CSOs), faith-based organizations (FBOs) and other NGOs to provide services to persons with disability. With 83 islands, one major challenge is geographical. There is no specific budget allocation for rehabilitation and AT from the Ministry of Health, but the Nakato Society (Vanuatu Society for People with Disability) and other NGOs, CSOs and development partners do have funding support from their own organizations to support rehabilitation activities. Many challenges remain, such as the development of a national policy on rehabilitation and AT, limited workforce capacity and capacity-building of persons with disabilities and their family members for independent living.

Fiji (Dr Pratima Gajraj-Singh): Fiji is currently waiting for Parliament to endorse a Disability Bill (No. 12 of 2016). The Rehabilitation Action Plan has not yet been endorsed. Funding for outreach programmes has been available from the Government and from WHO; however, one challenge is the long delay in the process of releasing funds. To address the gap in rehabilitation services in the workforce, new positions have been created for the first time this year. Zone nurses visit homes to provide services, but a big challenge remains transportation to hard-to-reach areas. A mobile outreach service is being supported by WHO and will be presented in greater detail during the meeting. Some other successes are that families caring for persons with disability are now eligible for a monthly subsidy, and older people and those with disability now have a social welfare card that grants them free transportation.

Samoa (Dr Robert Thomsen): Samoa’s Disability Program was established in 2013 with the financial assistance of the Government of Australia and has 11 main objectives, including accessible quality and affordable services for persons with disability and their families. The Ministry of Health is currently separate from National Health Services (NHS), with the former responsible for planning, legislation and financing, and the latter providing public health services. However, per a directive from the Government, the Ministry of Health and NHS are to be combined in the coming fiscal year. The Ministry of Health also works through service agreements with NGOs and other partners, such as Motivation Australia, which funded a new state-of-the-art prosthetic workshop for mobility devices to be locally made. One challenge is sourcing materials, which might have to come from Australia, New Zealand, Europe or the United States of America. Workforce capacity is another challenge; four people were recently sent to Cambodia to receive training on rehabilitation care.

Tonga (Dr Veisinia Matoto): Rehabilitation in Tonga became prominent in the government agenda due to political efforts, the help of Motivation Australia, and people like Mr Macanawai increasing its visibility. The Government has established a policy entitling people with disability to benefits, and it
is gaining ground as a political movement. The next steps would be for the Ministry of Health to form a working committee on disability so that activities can be coordinated, for NCD nurses to be trained in rehabilitation and to increase CBR awareness.

Participants engaged in a lively dialogue with one another covering questions and issues such as the role of traditional medical practitioners in providing rehabilitation services, discrimination against persons with disability, and stigma some families feel towards mental health and disability.

Mr Barrett pointed participants to the WHO QualityRights training package, which focuses on the implementation of a human rights and recovery approach in mental health.

2.3 Rehabilitation considerations for specific health conditions

Mr Martin Vandendyck introduced the speakers for the session on rehabilitation considerations for health conditions that are a priority in this Region, namely ageing, mental health and NCDs. The proportion of the world’s population over age 60 will double from 11% to 22% by 2030, which makes “healthy ageing” a public health priority. Professor Gwynyth Llewellyn spoke on how rehabilitation efforts can help optimize people’s abilities and functional capacities, and enable well-being, which is the main goal for healthy ageing. WHO published a World Report on Ageing and Health in 2015 that addresses these concerns. Some fundamental steps to take are to combat ageism, invest in older people, support their psychosocial health and build their resilience, and develop age-friendly environments. There are many barriers to accessibility for older people, but an age-friendly environment can enable rather than hinder the ability to age healthily. Rehabilitation is a set of interventions to optimize functioning, increase participation and allow older people to remain longer in their homes. Research has shown that rehabilitation measures are effective. For instance, falls in older people can be prevented by rehabilitation programmes that teach simple techniques for safe mobility. A comprehensive and effective programme takes into account how older people live their lives in the community. Professor Llewellyn was heartened to see older people doing tai chi in the park, as this kind of activity has positive impacts both physically and socially.

Next, Dr Felicitas Artiaga-Soriano presented on psychosocial rehabilitation (PSR), which focuses on whole functioning, treating the patient and not just their illness per se. No treatment can be considered complete or adequate without giving due consideration to rehabilitation or aftercare services. PSR provides people with not only counselling and psychotherapy, but also financial and workplace support so they can develop self-confidence and independence. Patients with mental health issues often face stigma and rejection in their communities and even families. However, with proper treatment, they can lead productive lives. There is strong evidence that some forms of PSR are effective, such as work rehabilitation, family interventions, psychoeducation and assertive community treatment. She shared some inspirational stories of individuals with mental illness who were able to lead productive lives after receiving PSR.

In his presentation on NCDs and rehabilitation, Dr Warrick Kim asked participants for their input on how to collaborate between these two programmes. NCDs are now a major cause of deaths; at the same time, better technologies and treatments mean more and more people survive NCDs and live a long time with complications. Both microvascular and macrovascular complications cause impairment, affect a person’s quality of life and increase medical costs for both the individual and the country. However, NCDs are preventable. The WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 offers recommended cost-effective interventions, but there is not much guidance on how these can be applied to rehabilitation, and the Global Monitoring Framework for nine global NCD targets do not have any targets or indicators for rehabilitation. The 2030 Sustainable Development Agenda includes SDG 3.4 on the reduction of mortality from NCDs by 2030, so there is now a push to align this goal with other SDGs. Dr Kim mentioned several related efforts, including the Regional Action Plan on Health Promotion in the SDGs 2018–2030 slated for endorsement by Member States during the Regional Committee meeting in October, an open webinar on 5–6 September 2017 on a global action plan for physical activity, and
the WHO Package of Essential NCD Interventions (PEN) and global HEARTS initiative. He requested that participants share how WHO can help countries in implementing rehabilitation services in NCDs.

For the World Café activity, participants were divided into groups to discuss questions, key points, challenges and opportunities related to rehabilitation within each of the three topics. Groups were rotated every 10 minutes and a volunteer summarized the discussion of each topic. Some highlights from the group work were as follows:

**NCDs:**
- NCD is very broad so it is difficult to integrate rehabilitation into NCDs.
- A major challenge, especially in Asia and the Pacific, is the low level of awareness about rehabilitation.
- Cost–benefit analyses are needed to identify what kinds of rehabilitation services countries need to prioritize.
- In Hong Kong SAR (China), there has been a shift from a medical focus to a social focus that engages the family/community; care should not end after people are discharged.
- There is a need to restructure existing NCD services so they can address rehabilitation needs and everyday practices.

**Ageing:**
- Some countries, such as Cambodia, are engaged in high-level policy development on ageing, which represents an opportunity to think about actions and action plans related to rehabilitation.
- One opportunity to consider is to link with existing community programmes, such as going into people’s homes to discuss family health or to see people with diabetes.
- Family structures are changing in the Region, with older people becoming more socially isolated, which can have an impact on their health.
- Accessibility issues are challenging if health facilities are not easy to access, whether physically or due to cost.

**Mental health:**
- Stigmatization of people with mental health conditions remains a big problem, with many people being placed in jails or locked up in institutions.
- There is a lack of human resources to provide mental health care.
- While there may be laws protecting the rights of people with mental health conditions, implementation of these laws is poor.

### 2.4 Country presentations (continued)

**Mongolia** (Dr Amarjargal Yadam): In Mongolia, rehabilitation was developed as exercise therapy from 1972 to 2000. In 2005 rehabilitation departments were established in universities, and in 2011 the Mongolian *National Rehabilitation Strategy 2011–2015* was approved by the Ministry of Health. While many policy documents have been written covering services for people with disability or mental health conditions, action plans have to be improved and implemented. There is currently a National Rehabilitation and Development Centre that functions under the Ministry of Social Welfare; ideally Dr Amarjargal is interested in exploring having the functionality fall under MoH. There is a need to establish guidelines and standards for treatment and rehabilitation for NCDs and training programmes for CBR services. As a young developing country, Mongolia needs to establish good-quality programmes now that will benefit the health of the population in 10 to 15 years’ time. Major
challenges are related to budget, mobilization and lack of human resources at the primary and secondary care levels.

**China (Dr Zhang Meng):** Rehabilitation involves many ministries in China, including the medical, educational, employment, psychological and community services sectors; therefore, multisectoral collaboration is very important. Government policies have been published on rehabilitation and disability, and China’s Healthy China 2030 programme outlines several objectives, such as provision of long-term care, building talent and improving affordability. The Government pays for basic health services, including free examinations, follow-ups, medications and health education for individuals with hypertension, diabetes and stroke. Almost 28 million people with disabilities received basic rehabilitation services last year and financial support and insurance provide almost full coverage for 29 different services. Other government-provided services include a living allowance for poor persons with disability and nursing care allowance for persons with severe disability. More professionals are now doing rehabilitation work, and efforts are being made to promote social work and improve medical services for persons with disability. China wishes to strengthen cooperation with WHO and other countries in the Region.

**Viet Nam (Dr Phan Hong Van):** Dr Phan gave an overview of rehabilitation services available for persons with disability in Viet Nam, which number 7 million (7.8% of the population). For those from poor households, who have severe or very severe disability, who are ethnic minorities or who live in remote areas, the state health insurance fund covers 100% of 284 rehabilitation techniques and services and 20 types of medical supplies. However, some equipment, such as braces and prosthetics, are not covered and are beyond the reach of many people. Persons with severe mental illness receive living expenses and support for travel and treatment. A CBR programme is being implemented in most of the country, with a focus on early detection, early intervention, and screening and early intervention for children. However, funding is limited and there is a shortage of human resources. There are many policies to support independent living and full inclusion for persons with disability in their communities. The production and supply of AT in Viet Nam are limited and receive no government funding, but there is ongoing collaboration with the International Red Cross for the provision of appropriate AT.

**Lao People’s Democratic Republic (Mr Khamko Chomlath):** A National Rehabilitation Taskforce has been proposed as well as the development of a draft Rehabilitation Strategy and Action Plan for 2016–2025, but implementation of these is currently still at the macro level, awaiting final approval by the Ministry of Health. There has also been a delay in creating and staffing a Rehabilitation Department. Building and sustaining a rehabilitation workforce is difficult due to limited subsidies from the Ministry of Health, but more than 400 rehabilitation personnel have been trained with the help of partner NGOs. Lack of funding for rehabilitation services is similarly a challenge and provision is therefore heavily reliant on international donors. The equity fund supports some costs for the poorest populations, but rehabilitation services are not yet included in basic health-care package to advance UHC. People with disability in remote areas do not have access to health services and rehabilitation, and AT are rarely available at the community level. Local authorities and service providers are often not aware of the unmet needs of persons with disability.

**Malaysia (Dr Yusniza Mohd Yusof):** Malaysia has an online registration system (SMOKU) for persons with disability; currently 1.42% of the population are registered as persons with disability, but this is likely a low number. The Ministry of Health and the Ministry of Women, Family and Community Development are the guardians of disability work in the country, with most work done under the Ministry of Health, but also involving the ministries of education, defence, human resources (vocational centre) and finance. Rehabilitation is provided through CBR, specialist services in hospitals, and stand-alone medical and vocational and rehabilitation centres. The current rehabilitation strategy and plan is to expand services. UHC has been advanced and funding is mainly from the MoH through taxation. However, AT costs are not taken into consideration in terms of costs of medical services, and insurance companies do not usually cover these devices. There is now ongoing discussion with the insurance industry regarding coverage for rehabilitation services.
Device Act provides tax relief for medical devices for use by persons with disability; challenges include appropriateness, funding resources and mechanism, as well as logistics and equity issues. Malaysia’s first gold medal from the Paralympics was a turning point for raising the awareness and status of persons with disability.

Following the country presentations, participants were encouraged to ask questions and give feedback to one another. Some topics discussed included the advantages and disadvantages of nursing homes and programmes such as Australia’s Ageing in Place approach, which supports older people living in their homes as long as they can; the assimilation of traditional medical practices into medical care; tax-based versus insurance schemes; and out-of-pocket (OOP) costs.

**DAY 2**

**2.5 Universal health coverage and rehabilitation financing**

To begin the second day of the meeting, Mr Barrett invited Mr Soarith Ngin to give a personal testimonial and offer his reflections on the previous day’s activities. Mr Ngin appreciated the linkage being made between disability and health as research shows that people with disability require three times the amount of health care compared to most people. This meeting is a good platform from which to learn from one another about how to include disability in health care. He encouraged people with disability to advocate for themselves and tell the Government what they need.

Ms Pauline Kleinitz introduced the speakers for the next session on UHC and rehabilitation financing. Ms Bhushan began her presentation on rehabilitation services as part of basic health packages by showing a video on people-centred care. This framework of people-centred integrated health service delivery is a service design principle that can help to support and improve strategies that enhance access and encourage UHC and primary and community-based care. Ms Bhushan emphasized that there is no “one size fits all” strategy because it depends on each country’s context and needs. The key is to balance the trade-offs between access, costs and quality of services. In terms of rehabilitation, the services required by three overlapping populations – older people, persons with disability and individuals with NCDs – are distinct, and focus should be on closing the gap between loss of capacity in these groups and their ability to function. Strategies also have to be adjusted in line with shifting demography and epidemiology. The whole health system has to be aligned to support rehabilitation, workforces should be reoriented to meet increasing demands, barriers to access (geographical, economic, sociocultural and so on) need to be addressed and costs reduced. Ms Bhushan encouraged participants to think of new ways to work across disciplines and not in vertical silos. WHO advocates the integration of rehabilitation into all levels of health-care services as it is more efficient and more desirable from a patient-centred care perspective.

In her presentation on financing considerations for rehabilitation services, Dr Annie Chu pointed out that rehabilitation is unique in that it is not limited to the health sector, so multisectoral coordination is needed between the Ministry of Health and ministries of finance and social welfare. The three main functions of financing are efficient and equitable collections of sufficient revenue, pooling risks such that funds are appropriately channelled, and purchase of resources that maximize their benefits. There are many ways to finance health services, including general tax, payroll tax, various types of prepayment and direct payment (OOP). A key aspect of UHC is financial protection; while there is no perfect way to finance health services, OOP should be avoided as it causes financial hardship to people at a time when they are most vulnerable. Dr Chu showed a graph of the sources of financing in many countries in the Region, indicating a range of systems in place. One important piece of evidence that is often lacking is the tracking of health expenditure, especially for rehabilitation. Answers to the questions “are we spending enough?” and “are we spending it on the right things?” can be used as an evidence-based approach to advocate for decision- and policy-makers. Certain rehabilitation services, such as transportation funding for persons with disability, are not traditionally considered in terms of health, but in terms of social services; however, the health sector can take the lead in coordinating such services across sectors.
Next, Dr Wesley Pryor presented on a disability-inclusive health toolkit currently under development by the WHO Western Pacific Region and the University of Melbourne Nossal Institute and Centre for Health Equity. The purpose of the toolkit is to be a practical resource for countries to move from assessment to intervention that addresses access to health care for persons with disability. The toolkit consists of nine modules covering topics ranging from barriers (attitudinal, physical, communication) to referral pathways and planning. Each module contains a fact sheet with key messages, a narrative, a case study or best practice from the Region, suggested activities for implementation and links to existing tools and resources. The first three modules have been drafted, and finalization of the toolkit is by December 2017. Dr Pryor sought feedback from meeting participants on the list of topics, the quality and length of the modules, and whether countries would find the toolkit useful. He appealed to them to approach him if they are interested in commenting on the draft of the first three modules.

Participants engaged in an animated discussion after the presentations; some comments relevant to country-specific concerns were:

- Funding in the Federated States of Micronesia is mostly from the United States, but there is a need for a sustainable plan as the Compact of Free Association with the United States will end in 2023.
- In Cambodia, rehabilitation has historically been financed by NGOs, but as these move out there is now a gap. This presents an opportunity for a detailed report on rehabilitation needs in the country to be undertaken.
- Where two separate ministries might be providing the same services, deciding whether or how to consolidate these should start with a report on the cost-effectiveness of the services. While data may not be easily collected, they are helpful for planning and to increase efficiency.
- In many small Pacific island countries, tertiary care is only accessible outside the country; however, there may be cost-effective regional solutions to this problem. There will be a special side event at the WHO Regional Committee meeting to discuss this issue.

### 2.6 Rehabilitation models

Professor Llewellyn introduced the next two speakers for the session on rehabilitation models.

Dr Kathy Eagar was struck by the diversity of models for developing rehabilitation care. She emphasized that rehabilitation should be an essential part of the health continuum. “Rehabilitation does not save lives, but makes the saved life worth living” is an idea that needs to be promoted. An effective message to bring to governments is that rehabilitation is a good investment because it saves money in the long run. Dr Eagar identified four groups that can benefit from rehabilitation services – patients requiring hospital-based rehabilitation, those requiring community rehabilitation after discharge from hospital, people living with disability, and people who are ageing and experiencing functional losses due to chronic disease. Each country should start with what it already has and build on it, working out which models are best for each group. Developing a comprehensive rehabilitation system takes years, but it can be begun by taking one step at a time. Dr Eagar shared the example of a mature system in New South Wales, Australia, which provides service at six different care settings. The first two settings are in-reach to acute and rehabilitation inpatient; the other four are community rehabilitation settings for patients in day hospitals, hospital outpatients, and patients in community-based and home-based settings. Care settings are not just places where care is delivered, but also where rehabilitation services can grow in terms of national leadership, workforce development and planning standards. Countries may not have service at all six care settings, but they can begin by setting priorities on where to start. Some of the suggestions she made include:
• Identify rehabilitation champions and high-profile advocates at the policy, clinical and consumer levels.
• Develop workforce standards based on country-specific needs.
• Service planning standards (e.g. knowing how many beds are needed and how many beds there are) can be used as lobbying tool; many countries may not even have that information.
• Gather national data on rehabilitation and clinical benchmarking.
• Figure out what resources are needed and how to harness these.
• Have short-, medium- and long-term plans.
• Formulate a way to evaluate the plans.

Dr Eagar shared links to the Australian Health Services Research Institute and the Australian Rehabilitation Outcome Centre, which are ready to be of assistance to Member States.

Next, Dr Gajraj-Singh presented on Fiji’s mobile rehabilitation outreach programme, which brings P&O and mobility aids out to the community. The programme was started by Dr Singh after she attended a CBR forum in 2012 and the services and coverage areas have gradually expanded. The rehabilitation team conducts case assessments of patients, offering nursing care and advice, and referrals or hospital admission as needed. Also provided are medicines and medical supplies, P&O fittings and repairs, as well as patient and family education and counselling in the home environment, which have been found to be effective. The team may also make recommendations that enhance social welfare: for example, in one village a wheelchair path was made to enhance mobility. By doing home visits, the mobile outreach programme eliminates the time and cost required for patients to travel to a hospital or clinic; some can even return to school or work on the same day. Challenges include: inadequate staffing needs as often the same staff provide the care in hospitals and in the mobile outreach programme; funding, which comes from WHO and the MoH; and a paper-based data collection system, which is tedious, time-consuming and prone to error.

Dr Llewellyn commented that Fiji’s mobile outreach programme was an excellent example of working one step at a time towards building a rehabilitation system. Seeing people in their homes and environments also drives home the importance of having a life worth living. In the discussion that followed, participants were encouraged to become advocates for change to their governments. Rehabilitation not only results in positive health outcomes for individuals, but also increases productivity of the patient and their family members and saves money in other parts of the system. When asked what role WHO can play in influencing the uptake of rehabilitation concerns, Mr Barrett answered that one way is to continue having these meetings and for Member State representatives to continue to convey what they need from WHO to their governments.

2.7 Rehabilitation and assistive technology

Dr Cieza next introduced the Global Cooperation Assistive Technology, or GATE. The disability and health system scenarios in the 21st century are changing; therefore, the conversation around disability needs to change, to push the agenda that rehabilitation and AT must be coordinated across different levels and sites of care within and beyond the health sector, according to needs throughout the life-course. Dr Cieza argued that with the rise of NCDs and ageing populations, we need to embrace the concept that disability is a continuum that all of us are on – it is a matter of degree and not a matter of duality. One billion people in the world need AT, but only one in 10 people have access to what they need, with one of the major barriers being cost. There are good-quality products available that only the rich can afford. WHO wants to close this gap between need and access. GATE is a community of game changers who are working to promote international cooperation at all different levels, including with governments, both as producers and developers. Similar to when it developed the Essential Medicines List, WHO has now developed a Priority Assistive Products List, which will be presented at the World Health Assembly. If endorsed, it will be a powerful advocacy tool for everyone to take to their home countries. Dr Cieza urged participants to express their support to their governments to
include this important topic on the agenda at the Assembly. She then invited Ms Kylie Mines to share the GATE approach.

Ms Mines outlined the four key elements of the GATE approach: Products, Personnel, Provision and Policy. Tasks under Products include developing standards for 25 highest-priority assistive products and a practical procurement manual. Personnel refers to the development of workforce capacity and includes training packages targeting people working at the community level, with programmes being piloted in Rwanda and two other countries. Provision of an integrated AT service delivery mechanism builds on successful models from different countries, with the idea to provide a blueprint that people can use in their countries. And finally, under Policy, the goal is to develop a national AT policy framework that governments can use. Ms Mines described the high level of energy and commitment going into these key initiatives and encouraged participants to sign up to be on the GATE email list (gate@mednet-communities.net).

Mr Hadley from the Federated States of Micronesia presented on the experiences from a pilot implementation of the Rehabilitation Resources Project in Pohnpei. There are very limited rehabilitation services in the country and AT, such as wheelchairs, have only been available from external donors. The WHO Regional Office for the Western Pacific contracted Motivation Australia and the University of Sydney to provide rehabilitation training and materials and technical support on AT and rehabilitation. The project will be rolled out in phases and requires coordination to evaluate what aspects have to be improved. The major challenge is sustainability, including finding long-term funding options, alignment with existing health system finance models, provision and maintenance of country-appropriate AT and the need to invest in personnel to build capacity. Mr Stuard Penias added that, being a small nation with limited resources, the Federated States of Micronesia needs the support of all the countries in the room, and the learnings from this meeting will make a difference to his country.

Following the country presentation, participants were divided into groups to discuss at least one example of an AT service or initiative from each country. They were asked to think about two questions:

1. Is AT service integrated and coordinated within rehabilitation and health systems?
2. Is AT service designed to align with principles of UHC? And, if so, how?

Each of the teams reported a key conclusion from their discussion:
Solomon Islands, Vanuatu, Viet Nam – Social mapping of rehabilitation needs has started in Solomon Islands. All field officers have gone out to allocated zones to raise awareness and identify people needing rehabilitation or AT. AT provision is well integrated with the health and rehabilitation system.

Cambodia, Federated States of Micronesia, Philippines – Participants discussed the treatment of club foot, which requires linkages between midwives (early identification), orthopaedic and pediatric surgeons and a social welfare system that can provide assistance after surgery. The example illustrates how rehabilitation and AT cannot happen in isolation.

China, Lao People’s Democratic Republic, Malaysia, Tonga – Discussants drew the conclusion that there is a need for the Ministry of Health to build capacity to be a gatekeeper for AT entering the country so that quality standards of AT can be upheld. The group also discussed what services were to be provided to meet the needs of users and follow-up when a country receives AT donations. A regulatory body at Ministry of Health can prevent miscoordination between the Ministry of Health and other ministries such as social welfare. A scenario was brought up in which the Ministry of Health might reject wheelchairs that are substandard, but another ministry accepts them, being unaware of the standards. The Lao People’s Democratic Republic could pilot a regulatory mechanism for AT in coordination with the Ministry of Social Welfare.
Fiji, Mongolia, Samoa – Discussants agreed that countries have mechanisms in place for the provision of hearing aids and crutches, but the challenge is being able to sustain the supply and ensure technical support is available. Equity in financing is another issue that was brought up, with the example of Mongolia’s social insurance covering 100% of hearing aid costs for persons over 55 but only 50% for others.

2.8 Rehabilitation services planning

Dr Vivath Chou moderated this session and introduced Ms Pauline Kleinitz, who presented on a WHO rehabilitation toolkit for strengthening rehabilitation services at the country level. Ms Kleinitz described the status of rehabilitation systems assessment, planning and monitoring in the Region as extremely important but unfortunately often neglected. Many countries lack the data to conduct analyses and a regional survey found that only five countries out of 27 had done strategic planning for rehabilitation; monitoring and reporting processes are rare. She gave an overview of the many barriers and challenges to rehabilitation, including lack of knowledge at the Ministry of Health, lack of coordination among different sectors, large unmet needs yet coupled with low consumer demand, and silo thinking within the rehabilitation sector such that there is not one voice speaking for rehabilitation. However, she pointed out that sometimes all it takes are some strong advocates and champions to motivate decision-makers to take action.

The WHO rehabilitation toolkit is meant to be a tool for governments to use to catalyse change and take action with the help of WHO and other development partners and external advisers who can assist with assessment and planning. Ms Kleinitz emphasized that governments – ideally through the Ministry of Health – must be on board or else implementation would be too difficult. The rehabilitation strengthening approach should take twin-track actions targeting rehabilitation strengthening and at the same time integration of rehabilitation into other health systems. The toolkit is based on a conceptual framework that is a log frame with items under input, output, outcome and impact, with the ultimate impact being good population health and functioning with financial protection. Rehabilitation strengthening encompasses determining the situation; facilitating capacity, commitment and planning; developing a rehabilitation strategic plan and monitoring framework; and regular review and implementation of the plan. Constant monitoring is crucial for ensuring that the implementation is taking place, so while review every two years is acceptable, the ideal would be to do so annually. WHO is aiming for 12 countries to be committed by the end of 2018, with two from each region.

In the discussion that followed, participants made many comments about the concept of “rehabilitation for all”, which shifts the issue of access to rehabilitation from the smaller niche population of persons with disability to the entire population, making it an explicit part of the health agenda and UHC. Not all people who need rehabilitation may identify themselves as having disability, yet advocating for them will also lead to more support for the needs of persons with disability. This broadening of the conversation needs to be taken to the disabled community so all sectors can work together for a common goal.

In the group work activity, participants were asked to reflect on the current rehabilitation system in their country and to identify actions that can be taken. Mr Barrett reminded everyone that the tools presented in this session would be ready by mid-2018; he hoped these would be helpful to countries, which can ask WHO for assistance.

2.9 Country planning

During this session, participants worked within their country groups to identify five priority actions their countries can take and to list down corresponding roles for government, WHO and civil society/international aid partners. Each country then selected one action to present to the group. The country-specific actions are available in Annex 3.
Some highlights from the discussion that occurred during the presentations include:

- A starting point for opening dialogue with decision-makers is to use the power of stories and make the issue personal. Civil society can collect data and stories about the consequences arising from lack of rehabilitation care and bring these to the MoH.
- Resource distribution within the same country is a problem even for those that have rehabilitation policies in place. Participants are requested to share good practice examples from the Region. The review of Fiji’s mobile outreach programme would be shared with everyone.
- Linkages can be formed with the academic sector to mobilize research on cost-effectiveness and sustainability of programmes.
- When planning budgets, consider how costs might be shared with other sectors and other health-care units.
- Children are another vulnerable population, and screening and early detection/intervention for children who need rehabilitation should be included in the plans. Screening tools are in use in Cambodia and the Lao People’s Democratic Republic, which can be shared with participants.
- NCD units are focused on prevention and treatment but usually consider rehabilitation a low priority. Therefore, participants made a special request for WHO to organize a meeting on NCD that includes rehabilitation.
- Currently the best option for P&O training in the Pacific is for health professionals to go to Cambodia or India. A regional training institute may be something to reach for. WHO is also looking into structured mentoring and follow-up after training to provide more support to newly trained practitioners.

Mr Barrett reminded everyone that there is a lot of information in their WHO meeting packages, including a brochure on rehabilitation developed by WHO headquarters that can be shared with their governments. They were also encouraged to share videos that were viewed during the meeting and to use their country presentation posters and PowerPoint presentations as advocacy tools.

### 2.10 Meeting summary, reflections and next steps

Mr Macanawai was invited to be the moderator during the meeting summary session. He reflected that “after all is said and done, there is usually more said than done”. He urged the meeting participants to prove this wrong and to take action and move forward. He then asked Dr Pryor, Mr Ngin and Dr Cieza to share some thoughts on the meeting.

Dr Pryor likened the rehabilitation sector to the national bird of the host country, the Philippine eagle, as it is fast and agile (responding quickly to change), playful and curious (engaged in the process of discovery and finding out what others are doing), independent and cooperative (willing to collaborate with many different sectors and organizations).

Mr Ngin expressed the sentiment that everyone needs the support of WHO as their knowledge, human resources and funding are limited. Practitioners should listen to the voices of people with disability and work side by side with them and not from the top down. He hopes to see action taken, especially cooperation between governments and NGOs to make sure benefits can extend to everyone. Lastly, he appreciated the networking opportunity during this meeting to get to know people from different regions.

Dr Cieza characterized the meeting as a journey with a clear vision – that anyone around the world who needs rehabilitation care will receive quality and timely rehabilitation services. Acceleration, but also patience, are required for this journey. She emphasized that the fundamental message about the importance of rehabilitation needs to be communicated beyond the rehabilitation sector. In this, DPOs are allies and a potential strong voice fighting for inclusion of everyone’s rights to rehabilitation. She
believes this Region is rich in terms of experiences and can lead and be an example for the rest of the world.

2.11 Closing

In his closing remarks, Mr Barrett thanked all the participants for the spirit of excitement and questioning they brought to the meeting. While there is much work yet to be done, the energy expressed in the room was encouraging and tangible. He also expressed thanks to the Government of Australia for their strong and ongoing support in the Region, as well as to the WHO collaborating centres, observers and technical advisers.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

(1) Despite the importance of rehabilitation, its resonance thus far has been limited to the disability community; however, with the rise of NCDs and the ageing population, it is increasingly clear that all individuals will need rehabilitation services at some point in their lives.
(2) UHC for effective and affordable rehabilitation services and AT should be considered in the context of the SDGs.
(3) Provision and financing of rehabilitation services require intersectoral coordination and cooperation between ministries of health, social welfare, finance and others.
(4) An appropriate rehabilitation financing mechanism should support the integration of rehabilitation into people-centred care throughout the health-care continuum.
(5) Lack of human resources is a challenge for many countries, including the dearth of rehabilitation professionals and facilities in rural or geographically remote areas.
(6) The need for AT is growing globally but is challenged by issues of accessibility, affordability and quality; the GATE programme aims to help countries in addressing these needs.
(7) Data collection for monitoring of rehabilitation services is vital for evaluating the success of any rehabilitation plan.

3.2 Recommendations

3.2.1 Recommendations for Member States

Member States are encouraged to:

(1) Engage in multisectoral collaboration and partnerships with other ministries, NGOs, DPOs, international development agencies and civil society in providing affordable, effective and timely rehabilitation services.
(2) Explore different financing mechanisms for rehabilitation in UHC, taking into account the five principles of UHC: quality, efficiency, equity, accountability, and sustainability and resilience. Reduction of OOP costs should be a key goal.
(3) Develop a national rehabilitation strategic plan that includes serving the needs of different populations and communities in different care settings throughout the continuum of care.
(4) Learn about GATE and sign up to be on the email list (gate@mednet-communities.net) to become part of the network.
(5) Conduct data gathering on rehabilitation services for monitoring and evaluation to be reviewed at least every two years.
(6) Build training capacity for rehabilitation workforce.
(7) Include evidence-based research on the effects and consequences of rehabilitation when approaching policy- and decision-makers.
(8) Understand and communicate that rehabilitation affects everybody in society and not only people with disability.

During the group work activity, representatives of Member States identified country-specific actions they intend to undertake at the conclusion of the meeting.

**Cambodia:** Establish a Rehabilitation Technical Task Force; develop a rehabilitation curriculum and training modules; strengthen and expand rehabilitation services in hospitals; conduct a gap assessment of the rehabilitation workforce and AT; and integrate rehabilitation intervention into NCD and disability-related action plans.

**China:** Develop cross-regional support (e.g. centre to remote areas, city to the countryside); develop outreach rehabilitation medical service; centralize information and resources for disability prevention and rehabilitation of people with disability; and establish a central IT system for rehabilitation; expand medical coverage of rehabilitation.

**Fiji:** Endorse the *Disability-Inclusive and Rehabilitation Action Plan 2014–2022*; create an allied health position at the National Rehabilitation Medicine Hospital; build a rehabilitation system in the western and northern divisions; provide budget allocation for rehabilitation and AT; and specify simple useful data about rehabilitation service outputs.

**Lao People's Democratic Republic:** Create a rehabilitation division within the MoH; endorse and implement the National Rehabilitation Strategy and Action Plan; provide scholarships for new rehabilitation specialists; and decentralize rehabilitation services and AT at provincial and district levels.

**Malaysia:** Improve data collection based on functional outcomes in different care settings; give feedback to service providers; evaluate current standard of care in rehabilitation services; mobilize workforce and resources by creating a P&O position and contract/part-time positions; work towards health insurance coverage of rehabilitation services and AT; and revamp rehabilitation plan and components of the plan.

**Micronesia (Federated States of):** Educate and engage government leaders at all levels on rehabilitation services; finalize Rehabilitation and AT Strategic Plan; develop funding mechanisms for rehabilitation and AT services; improve and increase rehabilitation workforce; and improve data collection on persons accessing rehabilitation service outputs.

**Mongolia:** Develop standards for rehabilitation centres and departments; develop rehabilitation guidelines for children, older people, people with disability and persons with NCDs; establish a rehabilitation centre under the MoH; solicit funds from international organizations and international investors; and develop an action plan for trauma and NCD patients in the inpatient setting.

**Philippines:** Develop a roadmap for incorporating rehabilitation into the health system; conduct a situational analysis of the national to local conditions in the country; engage with various stakeholder/partner groups (NGOs, consumer groups, DPOs, academe, etc.); gather evidence-based examples of rehabilitation; and develop relevant policies/legislation to support and fund rehabilitation services at the provincial/community levels.

**Samoa:** Strengthen rehabilitation in the health system; strengthen the rehabilitation workforce; create positions and relevant employment opportunities; build capacity of existing workforce; and improve information collection and recording mechanisms.
**Solomon Islands:** Develop policies and guidelines for rehabilitation services; adopt and incorporate priority AT products list; strengthen P&O services; establish stakeholder’s committees throughout the provinces; and improve and strengthen referral processes at the national, provincial and community levels.

**Tonga:** Include rehabilitation in primary and secondary health-care levels and activities; strengthen and grow rehabilitation workforce; strengthen staff capacity, resources and procurement for diabetes foot clinic; begin providing CBR; and coordinate efforts with the Ministry of Health to expand rehabilitation services.

**Vanuatu:** Lead the development of rehabilitation and AT strategy; establish a rehabilitation advisory group; identify a champion/focal point for rehabilitation; identify and select field officers and physiotherapists for training; and establish a physical space for a rehabilitation centre.

**Viet Nam:** Increase CBR services; develop a rehabilitation network; develop and revise curriculum for graduate and postgraduate rehabilitation training; upgrade rehabilitation facilities; conduct a national survey on the use of AT in rehabilitation facilities; and complete policies and guidelines for rehabilitation.

### 3.2.2 Recommendations for WHO

WHO is requested to:

1. Continue supporting Member States in strengthening rehabilitation services in their countries by developing relevant guidelines, training materials and assessment tools, and providing technical support and guidance as needed.

2. Further support Member States in advocating for rehabilitation as part of UHC in their countries.

3. Provide opportunities for Member States to learn best practices from one another, such as through regional meetings, workshops and consultations.

4. Hold a meeting on NCDs that includes rehabilitation (a special request was made for WHO to hold such a meeting).

5. Encourage and facilitate partnerships between Member States, NGOs and international development agencies to increase accessibility and affordability of rehabilitation services and AT.
ANNEX 1. PROGRAMME OF ACTIVITIES

Day 1: Tuesday, 29 August 2017

08:30–09:00 Registration

09:00–10:00 (1) Opening ceremony

Opening remarks Dr Hai-Rim Shin
Acting Director
Division of NCD and Health through the Life-Course (DNH)
WHO Regional Office for the Western Pacific

Meeting objectives and introduction of participants Mr Darryl Barrett
Technical Lead
Disabilities and Rehabilitation
WHO

Overview of universal health coverage in the Western Pacific Region Ms Anjana Bhushan
Acting Coordinator
Integrated Service Delivery
Division of Health Systems (DHS)
WHO

Rehabilitation in the 21st century Dr Alarcos Cieza
Coordinator
Blindness and Deafness Prevention
Disability and Rehabilitation
WHO/Headquarters

Administrative announcement Mr Darryl Barrett

Group photo

10:00–10:30 Coffee/Tea break

10:30–12:30 (2) Country presentations

Introduction and testimonial from Pacific representative of persons with disabilities Mr Setareki Macanawai
Chief Executive Officer
Pacific Disability Forum (PDF)

Country updates/poster presentations Member States

Discussion

12:30–13:30 Lunch break
(3) Rehabilitation considerations for specific health conditions

Mr Martin Vandendyck
Technical Lead
Mental Health and Substance Abuse
WHO

Age-related health conditions

Professor Gwynnyth Llewellyn
Professor
Family and Disability Studies
Faculty of Health Sciences
University of Sydney

Mental health conditions

Dr Felicitas Artiaga-Soriano
Acting Assistant Chief Professional Medical Staff
Veterans Memorial Medical Center

Diabetes and other high-priority noncommunicable diseases (NCD)

Dr Warrick Junsuk Kim
Medical Officer
Noncommunicable Diseases and Health Promotion Unit
WHO

World Café activity

Discussion

Coffee/Tea break

(4) Country presentations continued

Mr Saorath Ngin
Chair, ASEAN Disability Forum
Executive Director
Cambodian Disabled People’s Organization (CDPO)

Testimonial from Asia representative of persons with disabilities

Country updates/poster presentations

Discussion

Reception (Al Fresco, WPRO)

Day 2: Wednesday, 30 August 2017

08:45–09:00 Reflections from Day 1

Mr Darryl Barrett
09:00–10:30  (5) Universal health coverage and rehabilitation financing

Rehabilitation services as part of basic health packages

Financing considerations for rehabilitation services

Disability-inclusive health toolkit

Discussion

10:30–11:00  Coffee/Tea break

11:00–12:30  (6) Rehabilitation models

Models and approaches to rehabilitation services

Member State presentation

Discussion

Group activity

12:30–13:30  Lunch break

13:30–15:00  (7) Rehabilitation and assistive technology

Overview of the Global Assistive Technology Initiative (GATE)

Member State presentation

Discussion

15:00–15:30  Coffee/Tea break
15:30–17:00  (8) Rehabilitation services planning  Dr Vivath Chuo  
Technical Officer  
Disability and Rehabilitation  
WHO Country Office  
Cambodia  
Presentation of Rehabilitation Toolkit  Ms Pauline Kleinitz  
Discussion

**Day 3: Thursday, 31 August 2017**

08:45–09:00  Reflections of Day 2  Mr Darryl Barrett
09:00–10:00  (9) Country planning  Mr Darryl Barrett
10:00–10:30  Country presentation and discussions  Dr Alarcos Cieza
10:30–11:00  Coffee/tea break
11:00–12:30  Country presentation and discussions continued  Dr Alarcos Cieza
12:30–12:45  Meeting summary, reflections and next steps  Mr Setareki Macanawai
12:45–13:00  (10) Closing statement  Mr Darryl Barrett
13:00  Closing
ANNEX 2. LIST OF PARTICIPANTS, TEMPORARY ADVISERS, RESOURCE PERSON, OBSERVERS AND SECRETARIAT

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