MEETING ON PLANNING AND MONITORING THE IMPLEMENTATION OF THE REGIONAL FRAMEWORK ON REHABILITATION

18–20 June 2019
Manila, Philippines
WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

MEETING REPORT

MEETING ON PLANNING AND MONITORING THE IMPLEMENTATION
OF THE REGIONAL FRAMEWORK ON REHABILITATION

Convened by:

WORLD HEALTH ORGANIZATION
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NOTE

The views expressed in this report are those of the participants of the Meeting on Planning and Monitoring the Implementation of the Regional Framework on Rehabilitation 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 Planning and Monitoring the Implementation of the Regional Framework on Rehabilitation in Manila, Philippines from 18 to 20 June 2019.
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**Keywords**

Disability / Primary health care / Health systems plan / Rehabilitation / Regional health planning
SUMMARY

Across the World Health Organization (WHO) Western Pacific Region, noncommunicable diseases such as cardiovascular disease, stroke and diabetes are on the rise, despite prevention efforts. Similarly, populations in many countries are ageing. More and more people in the Region are living with limitations in functioning. To “ensure healthy lives and promote well-being for all at all ages” (Sustainable Development Goal 3), there needs to be a cultural shift in addressing the issue of health that goes beyond prevention and cure of diseases. With a core goal of WHO being the attainment by all people of the highest attainable standard of health, indicators such as mortality, morbidity, functioning and well-being are important. However, the third health indicator (functioning) is often not measured with regard to people’s health. Functioning is the core business of rehabilitation.

Rehabilitation and functioning were discussed on the first day of the meeting, as a strategy to assist governments to understand the instrumental value of health interventions. When people experience a health condition, their functioning can be affected, and this impacts their ability to move around, communicate, manage self-care, study, work or join their communities. The participants were introduced to the concept of functioning in relation to rehabilitation, and the importance of measuring functioning as part of how health systems consider people’s health. This is important because, to date, this has not been given a priority by WHO or many Member States. Countries (Australia, New Zealand, Philippines and Singapore) gave examples of how they measure functioning in their own contexts.

Rehabilitation as a public health strategy can be achieved by integrating it into the health system. WHO has developed toolkits that provide guidance to Member States to facilitate policy dialogues and health system planning to strengthen rehabilitation as part of universal health coverage (UHC), and these tools were also discussed during the meeting.

Over the second and third days of the meeting, the focus shifted from measurement of functioning to discussion of national-level data and indicators. Data tell us a story so we can make evidenced-based decisions. Currently, health information systems (HIS) are very weak at telling the story of rehabilitation. Member States were introduced to HIS aspects and how systems need to better integrate and consider rehabilitation. In particular, countries were encouraged to consider gaps in their current HIS which could be bridged to better address rehabilitation data needs. Countries shared experiences of monitoring rehabilitation. In particular, Mongolia, Solomon Islands and Viet Nam shared their experiences in plenary, followed by other country examples from participants. After discussions on measuring rehabilitation and monitoring progress within the context of HIS, countries were presented with proposed indicators to consider at the national level linked to the Western Pacific Regional Framework on Rehabilitation.

At the conclusion of the meeting, the Member States chose 10 indicators to monitor the development of rehabilitation at the national level:

1. Percent of rehabilitation expenditure in total health expenditure
2. Number of health plans that include rehabilitation
3. Number of rehabilitation personnel working in the country
4. Number of tertiary hospitals in the country with three or more rehabilitation professions
5. Number of rehabilitation beds in the hospital
6. Number of primary health-care facilities with rehabilitation
7. Number of rehabilitation facilities in the country where clinical standards are met
(8)  Number of people with complex needs because of injury who access multidisciplinary rehabilitation
(9)  Average change in people’s functioning from initial rehabilitation assessment to discharge
(10) Level of functioning of people in the population.
1. INTRODUCTION

1.1 Meeting organization

The Meeting on Planning and Monitoring the Implementation of the Regional Framework on Rehabilitation, organized by the World Health Organization (WHO) Regional Office for the Western Pacific, was held on 18–20 June 2019 in Manila, Philippines. Presentations, plenary discussion and interactive activities facilitated the sharing among Member States of their experiences relating to the implementation of the Western Pacific Regional Framework on Rehabilitation. At the conclusion of the meeting, the Member States as a group recommended additional indicators that will be used to monitor the Region’s progress towards the implementation of the Regional Framework.

1.2 Meeting objectives

The objectives of the meeting were to provide an opportunity for Member States:

1. to further understand and explore actions to implement the Regional Framework in their own contexts;
2. to identify and share opportunities for collaboration among Member States on strengthening rehabilitation in line with the Regional Framework; and
3. to discuss a draft monitoring and evaluation framework, including indicators, to obtain a baseline of rehabilitation and monitor progress at the national level.

2. PROCEEDINGS

2.1 Opening session

Dr Hai-rim Shin, Director of the Division of NCD and Health through the Life-Course, WHO Regional Office for the Western Pacific, welcomed participants to the meeting and delivered the opening remarks. Dr Shin stated that across the Region, noncommunicable diseases (NCDs) such as cardiovascular disease and diabetes are on the rise, despite prevention efforts. Similarly, many countries’ populations are growing older. Despite this increasing need, there is sporadic coverage and inconsistent quality of rehabilitation services in the region. In 2018, the WHO Regional Committee for the Western Pacific endorsed the Western Pacific Regional Framework on Rehabilitation. Guided by this Framework, WHO supports Member States to strengthen health systems to provide rehabilitation services as part of universal health coverage (UHC) and deliver it across the continuum of care. This meeting is an opportunity for countries, WHO and key stakeholders to come together to support the strengthening of rehabilitation services for all people who need it across the continuum of care.

Mr Darryl Barrett, Technical Lead of the Disability, Rehabilitation and Blindness Prevention Unit from the Division of NCD and Health through the Life-Course, WHO Regional Office for the Western Pacific, said that the meeting is part of a “cultural shift” of addressing global challenges, particularly on health. The focus of WHO’s work is Goal 3 of the United Nations Sustainable Development Goals (SDGs): Ensure healthy lives and promote well-being for all at all ages. Health as defined by WHO is the “state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity”. The integration of rehabilitation into health systems ensures that mechanisms to support people’s health go beyond prevention and cure of diseases and helps to ensure that no one is left behind. He also provided an update on the Region’s achievements on rehabilitation.
2.2 Regional achievements on rehabilitation

**Service availability and quality examples from countries.** Tonga has a new rehabilitation department. Prosthetists and orthotists have been added to their rehabilitation team; physiotherapy graduates are expected to join the services by December 2019. Cambodia has implemented a plan to integrate rehabilitation at the primary health care level through the training of rehabilitation professionals and primary care workers using the WHO Basic Stroke Rehabilitation Toolkit.

**Governance and financing examples from countries.** Solomon Islands is the first country in the Region to conduct a rehabilitation situation analysis using a new tool developed by WHO. It informed the development of the country’s first strategic plan for rehabilitation, with a focus on governance and implementation of community-based rehabilitation services. Similarly, Mongolia and Viet Nam are scheduled to develop rehabilitation strategic plans using the WHO developed tool commencing in July and August of 2019, respectively.

Since 2014, Fiji has been implementing their community outreach rehabilitation service outside of Suva. The multidisciplinary team of rehabilitation professionals composed of a rehabilitation doctor, physical therapists, prosthetists and orthotists, and nurses follow up with patients (amputees and stroke survivors) in the community after they are discharged from the hospital. Initially, a significant amount of the funding for the outreach services was provided by WHO. Currently, the Ministry of Health has increased its budget allocation for the outreach services, and WHO has reduced its contribution.

**Workforce.** Viet Nam is working on improving the country’s rehabilitation workforce in the rural and remote areas. Australia has implemented a rural generalist programme in Queensland and telerehabilitation in South Australia.

**Data and research.** The Philippines and the Lao People’s Democratic Republic have carried out the Model Disability Survey with significant findings related to disability prevalence and barriers in the community that limit people with disability from participating on an equal basis as others. Motivation Australia is undertaking a feasibility study of accessing assistive devices in the Pacific with funding support from the Government of Australia.

**Western Pacific Regional Framework on Rehabilitation.** The endorsement of the Framework during the 2018 session of the WHO Regional Committee is the Region’s most significant achievement. It defines rehabilitation as a set of interventions designed to reduce disability and optimize functioning in individuals with health conditions in interaction with their environment. The Framework will serve as a menu of actions through which countries can address issues in the integration of rehabilitation in the health system as part of UHC.

**Package of Priority Rehabilitation Interventions and rehabilitation support package toolkit.** WHO is currently working on the Package of Priority Rehabilitation Interventions which will be an important resource to facilitate policy dialogues and health system planning for countries to strengthen the inclusion of rehabilitation in UHC. The other tool being developed is a strategic planning toolkit: Rehabilitation in Health Systems: Guide for Action. This is a four-part tool, which includes: (1) the Systematic Assessment of Rehabilitation Situation (STARS); (2) Guidance for Rehabilitation Strategic Planning (GRASP); (3) Framework for Rehabilitation Monitoring and Evaluation (FRAME); and (4) Action on Rehabilitation (ACTOR). This toolkit guides countries to identify gaps, prioritize needs and tailor their own strategic plan. A profession-neutral framework called the WHO Rehabilitation Competency Framework is also being developed to capture the values, knowledge, skills and behaviours required to deliver rehabilitation interventions.
2.3 Opportunities for rehabilitation data: why functioning matters

Dr Alarcos Cieza, Coordinator for Blindness and Deafness Prevention, Disability and Rehabilitation, WHO headquarters, started her presentation with the word potential. It sums up the possibilities for rehabilitation: not only as a clinical management strategy but as a public health strategy integrated across all levels of health care. WHO’s goal is the attainment by all people of the highest attainable standard of health. The mechanism to monitor the attainment of this goal is through four indicators: mortality, morbidity, functioning and well-being. The third indicator, functioning, which is often forgotten, refers to areas in our lives that we realize are important only when we start having difficulties in performing them (i.e. hearing, seeing, thinking, communicating, remembering, moving around, self-care, relationships, working and other activities). With the increasing ageing population and incidence of NCDs, more and more people are living with limitations in functioning. Rehabilitation is a strategy that a health ministry can use to optimize the functioning of the population.

For rehabilitation to have an impact at the population level, we have to make sure that rehabilitation is completely integrated at all levels of health care and especially strengthened at the primary health care level. To date, this has not been given a priority. Rehabilitation as a public health strategy can be achieved by integrating it into the health system.

At the conclusion of the presentation, Dr Cieza answered questions relating to: differentiating treatment and rehabilitation (in rehabilitation the focus is to optimize functioning and not the treatment of disease); how to measure functioning at the population level (the Model Disability Survey can be used to measure this); how rehabilitation relates to palliative care (rehabilitation plays a role in supporting someone to die with dignity); and how functioning findings translate into policies (results of surveys can be used as an advocacy tool and as a basis for strategic planning and policy dialogues).

2.4 Country reflections on experiences in measuring functioning

Professor Gwynnyth Llewelyn, professor of family and disability studies, Faculty of Health Sciences of the University of Sydney facilitated the first panel discussion. The panel’s task was to answer the following questions:

(1) How do you measure people/patient functioning in the health sector?
(2) How do you use information about people/patient functioning in health system planning?
(3) What could you recommend to countries to start or develop the measurement of functioning in health?

New Zealand (Mr Christopher Carroll)

Rehabilitation is seen as important in keeping individuals and families well and in helping to prevent increasing costs on government by limiting the impact of impairment, unnecessary loss of function and dependency. Rehabilitation is for all, operates a mix model and with responsibility shared across different sectors and agencies (health, education, injury and social). Functioning is measured at various levels (individual, family, community, services, systems and societal). In the Ministry of Health, examples of measures of functioning are embedded in: the New Zealand Health Survey; Global Burden of Disease study; programme evaluations; service review; clinical measures of disease and physical, biological, mental and other functions; and individual self-reports of health status (functioning) and well-being. The information gathered about people’s functioning is applied in the different aspects of health system planning (resourcing; governance, legislation & policy-making; district population funding & planning; service delivery; data & information; and research).
In relation to developing measurement of functioning in health, Mr Carroll recommends that countries: (1) take stock and think about their data and measurement needs; (2) take time to understand their own country situation, considering what matters most to their people about rehabilitation; and (3) keep it simple – get basic data about health and social functioning and use it well.

**Australia** (Ms Rosalind Knox)

Rehabilitation is embedded in the complex health system with both public and private sectors. Rehabilitation is part of the health system. Australia mainly focuses on the patient’s journey driven by the individual needs and goals. Information in functioning is used in three levels of planning: in state and federal government for the highest level of planning, in primary health networks for the local population level and in local hospital networks for the provision of services.

Australia shared their experience with the Telehealth programme, which is designed to improve their service provision and to reach more people in remote areas. This is available in a region in South Australia and for patients upon discharge. The programme provides appointments, consultations and home assessments through the use of an iPad lent to the patient. The challenges faced by the programme include patient preference to meet a health provider in person or difficulty in access when a patient has cognitive or speech limitations.

**Singapore** (Ms Susan Niam)

In Singapore, functioning is measured to help decide the workforce size, capability, capacity and availability of rehabilitation services, and necessary resources. Functioning is measured at different levels (functioning, patient reported and impairment level). Tools used include the Modified Barthel Index (MBI) and length of stay. These data are useful to estimate clinical outcome over costs to demonstrate the value of rehabilitation. Ms Niam also presented an example of an early mobilization programme in the intensive care unit (ICU) involving a multidisciplinary team that reduced length of stay.

**Philippines** (Dr Terence John Antonio)

In the Philippines, measurement is still in the context of disability and a population-based survey based on the Model Disability Survey was conducted in 2016. The 2016 National Disability Prevalence Survey showed the stratification of disability of the population aged 15 years and older. The results revealed that 23% reported mild disability, 47% moderate disability and 12% reported severe disability. Another source of data is the Disability Registry that collects information from persons with disability. Data are collected to map out the demand for the rehabilitation services in the context of implementing UHC: the kind of rehabilitation services needed and rehabilitation workforce required throughout the continuum of care.

**Member State responses to pre-meeting questions**

Prior to the meeting, Member States were asked to reflect on the following:

1. Which pillar or pillars from the Western Pacific Regional Framework on Rehabilitation are the most relevant to your country and why?
2. Indicate if your country has a national rehabilitation strategic plan, and if it does, list the top three challenges with implementation of the plan.
3. If your country does not have a rehabilitation strategic plan, are there steps being taken to develop one, and if so, what are your top three challenges to developing such a plan?
(4) If your country’s health services and facilities measure people’s functioning (e.g. someone’s ability to communicate, move around, think, manage their self-care, etc.), please explain how they do this as part of the health sector.

(5) If your country’s health services and facilities do not measure people’s functioning, please explain the top three barriers to doing this as part of the health sector.

(6) What information does your country collect on rehabilitation at the health service or facility level?

(7) What information systems currently exist in your country which could be used to improve rehabilitation-related data collection?

(8) How does your country collect information about people’s functioning at the population level (e.g. in a Model Disability Survey)?

During the meeting, the Member States were asked to review the summary of their responses (see Annex 3). The activity involved Member States removing or placing additional (country) flags on the tally sheet posted on the wall of the venue. This activity provided an overall visual representation of the Member State responses in the Region.

The open dialogue after the review of the summary board gave Member States the opportunity to expound on their answers. The Lao People’s Democratic Republic, Viet Nam and Cambodia have disability data in the national survey, but there is disparity in the percentages which can be attributed to the difference in culture, tool used and even the question asked in the national survey. Brunei Darussalam has no disability survey due to lack of human resources funding and technical expertise. Moreover, Brunei Darussalam similar to the Philippines has data on functioning in the clinical setting but no standardized institutional data. China has a very limited workforce relative to its large population. Cook Islands has not yet recognized rehabilitation fully. For most countries, physiotherapists assess functioning of patients at the health facility level. Guam’s data are mostly insurance-driven outcome measure. Australia, New Zealand and Singapore collect a lot of data, but these are not consistent across public and private sectors.

2.5 Understanding and analysis of functioning

At the start of her presentation, Dr Alarcos Cieza invited everyone to assess their own level of functioning using the web-based self-administered questionnaire, the WHO Disability Assessment Schedule or WHODAS. Participants were asked to answer the 12 questions on functioning experienced in the past 30 days. The domains included cognition, mobility, self-care, getting along, life activities and participation. The result is a score indicating the level of limitation in functioning from 0 (no limitation) to 100 (unable to do so). The activity highlighted the benefits of using WHODAS as a tool to measure functioning.

After the presentation, participants engaged in a table discussion to share their perspective on (1) the potential facilitators and barriers to include the 12 items of WHODAS in routine data collection on rehabilitation in their own country and (2) concrete steps that need to happen in their own country/context to include an instrument like the 12-item WHODAS in routine data collection on rehabilitation.

During the open discussion, participants shared the following as facilitators to implementation of the 12-item WHODAS: actual good practices seen in other countries (effective referral system); actual training on how to use the 12-item WHODAS; notable cost–benefit analysis; and the current direction towards UHC. Barriers to implementation included identification of limitation in awareness, leadership, financing, policy, technology, training and workforce.
Concrete steps identified for inclusion of WHODAS in routine data collection in rehabilitation included: educating and convincing all stakeholders to ensure buy-in to the importance of rehabilitation and measuring functioning; conducting a pilot study in own department/facility as an initial step; including measurement of functioning questions in established surveys/data collection currently implemented, in census and in insurance reporting; and training data collectors. Countries with established rehabilitation in their health system may wish to develop a standard tool that is free of charge and measures functioning in different points of the patient’s journey which is validated and linked to return on investment.

Key messages during the day’s presentations and discussions revolved around: (1) rehabilitation as a public health strategy should be integrated at all levels of health care and in the health system; (2) linked to rehabilitation is optimizing functioning, which is the third health indicator; and (3) data on functioning tells the story of rehabilitation and will help promote policy change.

2.6 Strategic planning on rehabilitation

On the second day of the meeting, Mr Darryl Barrett presented more details on Rehabilitation in Health Systems: Guide for Action, a strategic planning tool that is being developed by WHO and has been trialed in countries. He explained that only upon request from the health ministry can WHO provide technical assistance to help countries navigate the process of planning for the integration of rehabilitation in the health systems using the tools developed. The involvement of a rehabilitation technical working group organized by the country’s health ministry from the start of the process will help ensure that all stakeholders are involved from the assessment up until the implementation of the strategic plan.

Specific to planning for rehabilitation in relation to the health systems building blocks:

- **workforce** – does not only refer to rehabilitation professionals, but health workers in general;
- **service delivery** – needs to be strengthened at all levels, but it does not mean having a multidisciplinary team at each level, but rather having systems to allow referral to the next level of care;
- **medicines and technology (assistive products)** – these may be available outside of the health sector (for example, social affairs); and
- **health information system** – rehabilitation needs to be seen inside the story of health.

Mr Barrett also explained that Viet Nam and Mongolia will undergo country assessments in July and August. This meeting is timely for the Ministry of Health in Papua New Guinea as they are currently working on a country situational analysis to inform their strategic plan for 2021–2030. Although there is no specific plan for rehabilitation, they will include rehabilitation in their strategic planning.

2.7 Strengthening health information systems to include information on rehabilitation

Professor Yeoh Eng Kiong, Head of the Division of Health System Policy and Management of the Chinese University of Hong Kong, led the second panel discussion on country experiences on rehabilitation data collection in response to the following questions:

1. What data on rehabilitation do you collect at the rehabilitation facilities?
2. What rehabilitation-related data are collected as part of the health system data collection process?
3. How are rehabilitation data used to support national health strategic planning or policies?
Viet Nam (Mr Tran Ngoc Nghi)

They collect data from all four levels of the rehabilitation system (Level 1: Central, Level 2: Province, Level 3: District and Level 4: Commune) and from different agencies and organizations (Ministry of Health, Medical Service Administration, General Statistics Office, rehabilitation professional associations, training institutions, nongovernmental organizations and international organizations) engaged in rehabilitation services. Data collected are general country information that includes information regarding population demographics and data reflecting rehabilitation needs (trauma and stroke cases per year, prevalence of NCDs and communicable diseases). Recently, they have started collecting so-called rehabilitation capacity data as part of the STARS (Systematic Assessment of Rehabilitation Situation) phase in the WHO *Rehabilitation in Health System: Guide for Action* toolkit. This is expected to be completed in August 2019, with the aim to develop a rehabilitation strategic plan by October 2019.

Mongolia (Dr Barkhas Azar)

In 2018, a situation analysis was carried out. A rehabilitation technical working group was formed in April 2019 which is led by the Ministry of Health Insurance and General Secretary. Mongolia collects data from different sources and is currently working on validating the accuracy of the data collected and developing a strategic plan.

Solomon Islands (Ms Elsie Taloafiri)

Rehabilitation has been present in Solomon Islands for four decades and is now slowly being recognized. Data collection on rehabilitation only started in 2005. Rehabilitation services are spread out in the nine provinces across 43 offices. Thirty-two field officers in the communities collect data on rehabilitation services. The information collected is demographic information, referral sources, condition, impairments and data on assistive devices. WHODAS questions are also being used. The data collected provide the basis for decision-making, budget allocation and workforce recruitment. The plan is to integrate the rehabilitation database into the health system database by September 2019. A lesson from the data collection at hospital services is the importance of capturing the bed occupancy rate as a core indicator aside from the percentage of patients receiving rehabilitation.

In summary, Professor Yeoh stated that there are different ways of collecting data made easier with the use of technology: in Hong Kong SAR (China), data are captured routinely through electronic health records; smartphones are being used in China for appointments, and special televisions are used to communicate with doctors; in Macao SAR (China), artificial intelligence is used to get information and conduct metadata analysis to include health indicators. Data must be collected efficiently and be structured to avoid duplication to save time. Though data on rehabilitation are available from different sources and areas, it is important to know how to collect the correct data and how these will be used.

2.8 Development and finalization of the national monitoring and health information systems

Dr Linh-Vi Le, Epidemiologist of HIV, Hepatitis and STI in the Division of Communicable Diseases, WHO Regional Office for the Western Pacific, started her presentation with an overview of global health monitoring, linking the SDGs and UHC within the health system. There are 230 SDG indicators, of which 27 are health indicators for SDG 3 and 20 are health-related indicators for other SDGs. For SDG indicator 3.8.1 (coverage of essential health services), the 16 tracer indicators do not include rehabilitation. However, under the SDG and UHC Regional Monitoring Framework in the Western Pacific, rehabilitation is included in the 88 indicators. This specifically relates to the rate of use of assistive devices among people with disabilities and the proportion of the population utilizing
the rehabilitation services they require. These rehabilitation indicators are to be updated based on the results of this regional meeting.

Dr Le also provided examples of monitoring and evaluation frameworks on HIV and NCD. She discussed: the 10 progress monitoring indicators used by WHO to report progress to the United Nations General Assembly in 2017; essential components of monitoring and evaluation; attributes of an effective health information system; sources of information in the health sector; and examples of health data sources in Cambodia and Vanuatu. Dr Le concluded with considerations for developing the indicators of the Rehabilitation Monitoring and Evaluation Framework for the Western Pacific Region.

During the open forum, questions/comments from the country representatives included: why process indicators are excluded; countries need to take ownership of the rehabilitation monitoring and evaluation framework and think how this can work within their own context; how to get all stakeholders involved and be accountable; there is a big challenge in collecting data – how do we collect data at the personal level for a country with a very big population; and inclusion of health economics as part of monitoring and evaluation.

Dr Alarcos Cieza gave a presentation on strengthening health information systems to include information on rehabilitation. Dr Cieza clarified that it is about strengthening the existing health information systems in the country to include rehabilitation and not about creating separate building blocks for rehabilitation. The data tell a story to help make evidence-based, informed decisions: for policy-makers to identify and respond to problems and allocate resources effectively; for planners and managers to design more effective services and monitor and evaluate them; and for clinicians to assess the quality and evidence base of services. Health information systems are needed to inform the different types of indicators: determinants of health, health systems and health status (mortality, morbidity, functioning and well-being). Data can be collected from population- and institution-based sources.

Currently, rehabilitation is not yet integrated within health information systems. As a consequence, there is no information that will help decision-makers at all levels make informed decisions. This knowledge gap hinders the path towards strengthening health systems to deliver rehabilitation. It is thus necessary to: create a monitoring framework for rehabilitation that can serve as guidance for countries; define the data sources that need to be part of health information systems; and define what instruments to use. The objective is to strengthen the existing health information system to include data on rehabilitation.

As a starting point, six core global indicators are identified in the Rehabilitation Monitoring Framework. The task required of the country representatives was to discuss the additional four indicators from a list of 34 expanded indicators to add to the six core indicators and form the 10 indicators for countries in the Region.

Comments and questions after the presentation included: why organization and management is not included as part of the input indicator – it affects the outcome of rehabilitation; safety as part of indicators; the need to have the right balance between input, output, outcomes and impact indicators; and who constituted the panel of experts consulted in the selection of indicators – there needs to be a representation of client experience of care versus indicators selected by experts.

After Dr Cieza’s presentation, country representatives reviewed each of the 34 indicators and identified four additional indicators. Each country individually prioritized the four indicators that best fit their own context/requirement for data collection. The results of the prioritization of the indicators were then presented to the group by Dr Le on the third day of the meeting. The next task was for the whole group to discuss the four additional indicators that will form the Region’s 10 core indicators.
2.9 Creating a set of rehabilitation indicators for the Western Pacific

Starting from the afternoon session of the second day until the morning session of the third day, Member States had the opportunity to review the proposed indicators in groups, and they provided comments on the clarity of the indicator definitions and suggested improvements.

Member States were also asked to review proposed indicators and to select indicators that will form part of the set of rehabilitation indicators for the Western Pacific Region. Dr Le facilitated the group’s task by first reminding them of the four pillars (service availability and quality; governance and financing; workforce; and data and research) and three principles of rehabilitation (access, person centred and for all at all ages) stated in the Regional Rehabilitation Framework. She also reminded Member States to ensure that the selected indicators reflect a good balance of input, output, outcome and impact indicators of a strengthened health system that delivers rehabilitation.

As a starting point, Member States discussed the six core global indicators:

1. Number of new rehabilitation status and monitoring reports
2. Percent of rehabilitation expenditure in total health expenditure
3. Number of rehabilitation personnel working in the country
4. Number of tertiary hospitals in the country with three or more rehabilitation professions
5. Number of rehabilitation beds in the hospital
6. Number of people with complex needs because of injury who accessed multidisciplinary rehabilitation.

Member States were then tasked to review the set of expanded indicators and identify four indicators that they prioritize based on their country context. They rated their four selected indicators on a scale of 1–4 (4 highest priority, 1 least priority). The plan was to add these four indicators to the six core global indicators above. These 10 indicators would then become the set of regional indicators to monitor the implementation of the Western Pacific Regional Framework on Rehabilitation.

On the third day of the meeting, Dr Le tallied the results of the Member State ratings and presented the top six indicators to the group. These indicators were:

1. Level of functioning of people in the population
2. Number of health plans that include rehabilitation
3. Number of primary health care facilities with rehabilitation
4. Number of districts which delivers rehabilitation in the community
5. Average change in people’s functioning from initial rehabilitation assessment to discharge
6. Number of rehabilitation facilities in the country where clinical standards are met.

The group deliberated between “rehabilitation integrated in primary health care” and “rehabilitation in the community”. It was reasoned that rehabilitation in primary health care is limited to facility-level interventions and that rehabilitation needs to reach the communities, involving families in the provision of rehabilitation. On the other hand, it was important to anchor to the primary health care agenda, which WHO has highlighted to achieve UHC. Rehabilitation integrated into primary health care will tell the story of a strengthened health system in line with UHC.

In relation to the importance of anchoring rehabilitation to the primary health care agenda, Dr Cieza agreed to consider this indicator as one of the six core global indicators. The indicator on rehabilitation in primary health care replaced the global core indicator on routine rehabilitation reporting, which looks at the number of new rehabilitation status and monitoring reports every two years.
Another clarification on the indicators related to “functioning change” versus “client experience”. A few participants proposed client experience as a measure of the quality of life based on receiving rehabilitation interventions. However, during group discussions it was decided against introducing quality of life as a dimension of this indicator for rehabilitation. Achieving quality of life is not solely covered by rehabilitation interventions; it cuts across other interventions such as education, labour and employment, and other social determinants of life.

2.10 Closing

In his closing remarks, Mr Darryl Barrett reminded the participants that this is the first time in the meetings of the Western Pacific Region that functioning has been discussed so extensively. He thanked all the participants and WHO staff for their professionalism in their participation and active engagement in the discussions.

Dr Hai-rim Shin in her closing remarks reiterated the importance of rehabilitation to support people to be active, healthy and participate in their communities. Rehabilitation is a health strategy for the whole population to improve functioning. In the Region, rehabilitation is important considering the prevalence of NCDs and impact on an ageing population. The Western Pacific Regional Framework on Rehabilitation provides guidance to countries to strengthen the health system to deliver rehabilitation. Functioning, the core business of rehabilitation, is the third health indicator. The regional indicators discussed in the meeting will help tell the story of rehabilitation. Data gathered about rehabilitation in the health systems will help countries to prioritize actions to support rehabilitation as part of UHC. WHO is always ready to provide technical support.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

As an outcome of the participatory approach to developing the regional monitoring and evaluation of rehabilitation, involving Western Pacific Member States, observers from implementing partner organizations, academic institutions, and WHO staff from headquarters and the Regional Office, the group supported the choice of the following 10 indicators:

(1) Percent of rehabilitation expenditure in total health expenditure
(2) Number of health plans that include rehabilitation
(3) Number of rehabilitation personnel working in the country
(4) Number of tertiary hospitals in the country with three or more rehabilitation professions
(5) Number of rehabilitation beds in the hospital
(6) Number of primary health care facilities with rehabilitation
(7) Number of rehabilitation facilities in the country where clinical standards are met
(8) Number of people with complex needs because of injury who access multidisciplinary rehabilitation
(9) Average change in people’s functioning from initial rehabilitation assessment to discharge
(10) Level of functioning of people in the population

Member States recognized that rehabilitation is a public health strategy and assessing functioning is as crucial as measuring mortality and morbidity. They also are aware of the importance of developing a rehabilitation strategic plan that aligns with their country context and priorities.
3.2 Recommendations

3.2.1 Recommendations and next steps for Member States

Member States are encouraged to consider the following:

(1) Continue their work on integration of rehabilitation in the health system and in UHC by utilizing the menu of actions and recommendations from the *Western Pacific Regional Framework on Rehabilitation*.

(2) Refer to *Rehabilitation in Health Systems: Guide for Action*. The preliminary step is to undertake a systematic assessment of the rehabilitation situation in their country. Subsequent to this is to develop the country’s rehabilitation strategic plan. Setting up a rehabilitation technical working group in the country is encouraged to provide support on developing strategic plans and rehabilitation guidelines.

(3) Having agreed to the 10 indicators identified at the conclusion of the meeting, continue to work with WHO to finalize definitions and parameters for the use of these indicators.

(4) Include additional indicators as they need for monitoring rehabilitation in their country according to their own country context.

(5) Identify sources of information or incorporate indicators in established health surveys, censuses or insurance reports.

3.2.1 Recommendations for WHO

WHO is requested to consider the following:

(1) Continue to provide support and technical assistance in the implementation of the *Western Pacific Regional Framework on Rehabilitation* recognizing that Member States are at different levels of maturity in rehabilitation.

(2) Continue supporting Member States by providing technical support in integrating rehabilitation within the health systems using the steps outlined in *Rehabilitation in Health Systems: Guide for Action*.

(3) Continue to raise awareness and promote buy-in among various stakeholders about rehabilitation as a health strategy across the continuum of care linked to UHC.

(4) Clarify, resolve and provide clear guidance and definitions of the indicators for the Region.

(5) Provide opportunities for Member States to learn best practices and training on gathering data on rehabilitation integrated into existing health information systems.
ANNEXES

Annex 1. Programme of activities

Day 1: Tuesday, 18 June 2019

08:30–09:00 Registration

09:00–09:10 Welcome remarks

Dr Hai-rim Shin
Director, Division of NCD and Health through the Life-Course
WHO WPRO

09:10–09:30 Introductions and objectives of the meeting

Mr Darryl Barrett
Technical Lead, Disabilities and Rehabilitation, Division of NCD and Health through the Life-Course
WHO WPRO

09:30–09:50 Regional achievements in rehabilitation

Mr Darryl Barrett

09:50–10:00 Administrative announcements and group photo

Ms Lenny Fernandez
Assistant, Disabilities and Rehabilitation Division of NCD and Health through the Life-Course
WHO WPRO

10:00–10:30 Coffee/Tea break

10:30–11:10 Opportunities for rehabilitation data: why functioning matters?

Dr Alarcos Cieza
Coordinator, Blindness Deafness Prevention, Disability and Rehabilitation WHO, Geneva

11:10–11:25 Discussion

Mr Darryl Barrett

11:25–12:10 Country reflections on experiences in measuring functioning – Panel 1

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

12:10–12:30 Discussion

12:30–13:30 Lunch break

13:30–15:00 Group work 1: understanding and analysis of functioning

15:00–15:30 Coffee/Tea break

15:30–16:30 Group work 1 continued, including feedback

17:30–19:00 Reception

Day 2: Wednesday, 19 June 2019

08:30–08:40 Review of Day 1

Mr Darryl Barrett

08:40–08:55 Strategic planning in rehabilitation

Mr Darryl Barrett
08:55–09:05 Discussion

09:05–09:45 Rehabilitation data collection – Panel 2

**Professor Yeoh Eng Kiong**
Director and Professor of Public Health
Jockey Club School of Public Health and Primary Care; Head, Division of Health System Policy and Management
The Chinese University of Hong Kong

09:45 –10:00 Discussion

10:00–10:30 Coffee/Tea break

10:30–11:00 National response data collection and health information system overview

**Dr Linh–Vi Le**
Epidemiologist HIV, Hepatitis and STI
Division of Communicable Diseases
WHO WPRO

11:00–11:15 Discussion

11:15–12:15 Monitoring of rehabilitation data. How can countries monitor rehabilitation development?

**Dr Alarcos Cieza**

12:15–12:30 Discussion

12:30–13:30 Lunch break

13:30–15:00 Group work 2: Development and finalization of the national M& E tool for rehabilitation

15:00–15:30 Coffee/Tea break

15:30–16:30 Group work 2 (continued)

**Day 3: Thursday, 20 June 2019**

08:30–08:40 Review of Day 2

**Professor Gwynnyth Llewellyn**

08:40–10:00 Group work 2 (continued)

10:00–10:30 Coffee/Tea break

10:30–12:30 Group work 2 (continued)

12:30–13:30 Lunch break

13:30–15:00 Discussion on final monitoring tool (indicators) including monitoring process

**Dr Linh-Vi Le**

15:00–15:30 Coffee/Tea break

15:30–16:10 Country issues – review of meeting and additional questions on rehabilitation issues for Member States

**Mr Darryl Barrett**

16:10–16:20 Next steps

**Mr Darryl Barrett**

16:20–1630 Closing

**Dr Hai-rim Shin**
Annex 2. List of participants, temporary advisers, observers and Secretariat

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Annex 3. Summary of country answers to pre-meeting questions

In preparation for the meeting, Member States were asked to provide information in advance by answering the eight questions below:

1. Which pillar or pillars, from the Western Pacific Regional Framework on Rehabilitation are most relevant to your country and why?

2. Indicate if your country has a national rehabilitation strategic plan, and if it does, list the top three (3) challenges with implementation of the plan.

3. If your country does not have a rehabilitation strategic plan, are there steps being taken to develop one, and if so, what are your top three challenges to developing such a plan?

4. If your country’s health services and facilities measure people’s functioning (e.g. someone’s ability to communicate, move around, think, manage their self-care, etc.), please explain how they do this as part of the health sector?

5. If your country’s health services and facilities do not measure people’s functioning (e.g. someone’s ability to communicate, move around, think, manage their self-care etc), please explain the top three (3) barriers to doing this as part of the health sector.

6. What information does your country collect on rehabilitation at the health service or facility level?

7. What information systems currently exist in your country which could be used to improve rehabilitation-related data collection?

8. How does your country collect information about people’s functioning at the population level (e.g. in a Model Disability Survey)?

The summary of the Member States responses to these questions are presented in the following pages.
### Most relevant pillars of the Western Pacific Regional Framework on Rehabilitation

| Country | AUS | BRN | KHM | CHN | COK | FJI | GUM | KIR | LAO | MAC | MYS | MHL | FSM | MNG | NZL | PLW | PNG | PHL | SGP | SLB | TON | VUT | VNM |
|---------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Pillar 1: Service availability and quality | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Pillar 2: Governance and financing | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Pillar 3: Workforce | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Pillar 4: Data and research | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

### Countries with a National Rehabilitation Strategic Plan

- ✓

### Common challenges with the implementation of a national rehabilitation strategic plan:

- Integration of rehabilitation into the health system ✓
- Limited scope of rehabilitation services ✓
- Budget availability; funding mechanisms and service delivery models ✓
- Workforce capacity and development ✓ ✓ ✓ ✓
- Rehabilitation data collection ✓
- Infrastructure ✓ ✓
- Disability-focused policy agenda ✓
- Understanding of what rehabilitation is ✓
- IT system ✓
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<thead>
<tr>
<th>Countries that DO NOT HAVE a National Rehabilitation Strategic Plan</th>
<th>AUS</th>
<th>BRN</th>
<th>KHM</th>
<th>CHN</th>
<th>COK</th>
<th>FJI</th>
<th>GUM</th>
<th>KIR</th>
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<th>MHL</th>
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<th>PLW</th>
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<th>SLB</th>
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<tr>
<td>Common challenges with the development of a national rehabilitation strategic plan:</td>
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<td>• Policy expertise, including understanding what rehabilitation is</td>
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<td>• Leadership, prioritization and coordination</td>
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<td>• Workforce capacity</td>
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Common barriers to measuring functioning as part of the health sector:

- Understanding of what rehabilitation is
- Lack of awareness of the importance of measuring functioning
- Lack of tools for measuring functioning
- Budget
- Workforce to deliver rehabilitation
- Transportation
- Poor data collection systems in the health systems
- Governmental oversight and coordination

Rehabilitation information collected at the health service level:

- A number of rehabilitation doctors
- Number of clients attending physiotherapy
- Assistive technology requirements
- Rehabilitation services provided
- Inpatient/outpatient rehabilitation requirements
- Condition-specific indicators
- Functional outcome measures (inpatient)
- Type of disability

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### Rehabilitation information collected at the health service level

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### Information systems that could improve rehabilitation-related data collection:

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### How functioning is measured at the population level

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