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The 3rd Global Rehabilitation 2030 meeting took place on 10 and 11 July, organized by the World Health Organization (WHO).

WHO would like to sincerely thank all those who supported the meeting preparations, and those who participated at the event, including: representatives from Member States, rehabilitation service user groups, nongovernmental organizations and civil society, funding bodies, international professional associations, research institutions, United Nations agencies and other multilateral organizations, as well as WHO colleagues.

Moderators and speakers
The knowledge, expertise and experiences shared by the meeting moderators and speakers was greatly appreciated. Please refer to Annex 2 for the full list of moderators and speakers of the meeting.

WHO Secretariat
The following WHO Secretariat supported the meeting preparation, logistics and coordination: Mr Abey Bekele Abebe, Ms Carolina Belinchon, Mr Francois Borrel, Mr Sandy Burtin, Dr Shelly Chadha, Ms Jiemei Chan, Mr Robin Chasserot, Dr Alarcos Cieza, Ms Nicoletta De Lissandri, Mr Zelalem Dessalgn Demeke, Ms Patricia Durand Stimpson, Dr Antony Duttine, Mr Chadi Fayad, Mr Luke Fountain, Dr Wouter de Groote, Dr Yasaman Etemadi, Ms Hayatee Hasan, Dr Pauline Kleinitz, Ms Elanie Marks, Dr Bente Mikkelson, Dr Jody-Anne Mills, Dr Pallavi Mishra, Mr Jose-luis Perez Garcia, Mr Jan Pohancanik, Dr Alexandra Rauch, Mr Peter Skelton, Ms Arveen Sodhi, Ms Susan Spackman, Mr Carlos Johan Streijffert, and Dr Abena Tannor.
The 3rd Global Rehabilitation 2030 meeting marked the 6th anniversary of the Rehabilitation 2030: Call for action, an initiative launched in 2017 in response to the estimated 2.4 billion people (1 in 3) in need of rehabilitation. Rehabilitation 2030 envisions a world in which everyone who needs rehabilitation receives quality, timely and affordable services. To achieve this, it calls for coordinated action from all stakeholders to bolster rehabilitation within broader health system strengthening efforts, as an integral component of universal health coverage.

Significant strides have been made in the rehabilitation sector in recent years, encompassing evidence generation, capacity building and country support. During the meeting, representatives from over 21 countries shared their experiences and lessons learned in this journey. Notably, the strong and united global effort across stakeholder groups, sectors, and rehabilitation professions has culminated in the historic adoption of the resolution ‘Strengthening rehabilitation in health systems’ (WHA76.6) at the Seventy-sixth World Health Assembly in Geneva in May 2023. The landmark resolution recognizes rehabilitation as a core global public health priority and outlines priority actions to be taken by Member States, civil society and WHO Secretariat moving forward.

The objectives of the meeting were to:

1. Acknowledge the resolution on ‘Strengthening Rehabilitation in Health Systems’ that was approved at the Seventy sixth World Health Assembly
2. Understand the approaches to driving the actions requested in the resolution, and introduce the new WHO tools that will facilitate the implementation of the resolution in countries
3. Identify strategic opportunities to accelerate the Rehabilitation 2030: Call for action
4. Launch the World Rehabilitation Alliance

During the meeting, WHO colleagues from all regions introduced 5 new technical tools aimed at supporting efforts to strengthen health systems and implement the WHA76.6 resolution:

1. **Package of interventions for rehabilitation (PIR):** a resource that outlines essential evidence-based interventions and related information to facilitate the planning, budgeting, and integration of rehabilitation at all service delivery levels in health systems.
2. **Guide for rehabilitation workforce evaluation (GROWE):** provides a method and tools for collecting, analyzing, and interpreting key rehabilitation workforce data. It uses labor market and competency analyses, engaging stakeholders across sectors and fostering their ongoing coordination and collaboration.
3. **Routine health information systems - rehabilitation toolkit:** supports the integration of rehabilitation into routine health facility reporting and the analysis of collected data through a standard set of indicators and considerations for their interpretation and use.
4. **Strengthening rehabilitation in health emergency preparedness, response, and resilience: a policy brief**: outlines the evidence for rehabilitation in emergencies and the need for greater preparedness of rehabilitation services. It shows how existing guidelines support the integration of rehabilitation in emergencies and sets out the steps that decision makers can take to better integrate rehabilitation into health emergency preparedness and response.

5. **Rehabilitation in health financing - opportunities on the way to universal health coverage**: presents an overview of financing practices for rehabilitation services around the world, with a focus on low- and middle-income countries, and outlines key considerations and ways forward for policymakers to optimize financing arrangements for rehabilitation in their countries.

Additionally, the meeting marked the official launch of the World Rehabilitation Alliance (WRA), a global network hosted by WHO. The WRA’s mission is to support the implementation of Rehabilitation 2030 through advocacy activities.

The meeting’s discussions underscored the importance of shifting focus towards greater country-level action and amplified advocacy efforts. This strategic shift is necessary for shaping policy, fostering increased demand for rehabilitation services, and ultimately ensuring that the priority actions of the WHA76.6 resolution are implemented.

**Content of this report**

The report contains a summary of key messages and discussions from the meeting, organized chronologically by session. The meeting agenda and list of participants can be found in the Annexes.
The meeting began with Ms Madeline Niebanck (Founder, Maddi Stroke of Luck), a 28-year old stroke survivor, author and advocate for rehabilitation sharing insights from her own rehabilitation journey. Ms Niebanck’s experiences set the stage for the meeting discussions, and illustrated the lifechanging impact that rehabilitation can have on an individual’s life.

Ms Niebanck:
“What I realize now is that surviving the brain hemorrhage was not the finish line, it was just the beginning of a very long rehabilitation journey….I firmly believe that rehabilitation has the power to help people with various conditions like myself to find a new way forward and get access to the recovery that they need.”

Dr Jérôme Salomon (Assistant Director-General for Universal Health Coverage/Communicable and Non Communicable Diseases, WHO) emphasized the importance of ensuring that everyone has access to timely, affordable and quality rehabilitation services as part of universal health coverage (UHC). He acknowledged recent world events that have profoundly increased the need for rehabilitation globally, and that have shifted health and economic priorities.

Dr Salomon:
“As experienced during COVID-19 and as we are witnessing in current conflicts, health emergencies and humanitarian crises, enormous surges in rehabilitation needs are revealing... Rehabilitation has increasingly become an integral part of WHO emergency responses, whether during the COVID-19 outbreak, the earthquake in Türkiye and Syria, or the conflicts in Sudan and Ukraine.”

Dr Salomon:
Maddi’s story reminds us that the core of rehabilitation is winning the fight to restore health, functioning and dignity. It also underlines that winning this fight is as critical as winning the fight to survive.
Today, an estimated 2.4 billion people (1 in 3 people globally) have a health condition that would benefit from rehabilitation. Dr Salomon reflected on the Rehabilitation 2030: Call for Action that was launched in 2017 to address this rehabilitation need, and the progress that has since been achieved through joint efforts of the global rehabilitation community. This progress includes technical support to Member States and the development of a range of normative resources that focus on strengthening rehabilitation in health systems. Notably, the strong and united global effort across stakeholder groups, sectors, and rehabilitation professions culminated in the historic adoption of the resolution ‘Strengthening rehabilitation in health systems’ (WHA76.6) at the Seventy-sixth World Health Assembly (WHA) in Geneva in May 2023. This significant milestone reflects the growing political prioritization of rehabilitation among Member States, and provides a clear roadmap of priority actions to move the sector forward.

Dr Salomon:
“The rehabilitation resolution is not just about improving health systems. It is about improving lives, and giving people the chance to be the best they can be. It is about creating a world where everyone has the opportunity to thrive.”

Opening remarks

Four Member State representatives provided opening remarks to the meeting, reflecting on the current challenges and opportunities in the rehabilitation sector and sharing experiences from their respective countries:

Dr Pilar Aparicio
(Director General of Public Health, Spain)

The COVID-19 pandemic disrupted Spain’s health system, including rehabilitation services. Spain responded by enhancing its health system’s resilience. This entailed integrating rehabilitation throughout all levels of the health system, extensive consultation with regions and stakeholders, bolstering the rehabilitation workforce, improving data collection, and enhancing access to assistive technologies and medical products in primary care and hospitals.

Mr Shodikhon Jamshed
(Deputy Minister, Ministry of Health and Social Protection of Population of Tajikistan)

25% of Tajikistan’s population are estimated to need rehabilitation. To address this, the country has conducted a national situation assessment, invested in rehabilitation facilities, equipment, and workforce training, and is set to implement a national strategic plan on rehabilitation and assistive technology by late 2023.
Dr Daniel Kyabayinze  
(Director Public Health, Ministry of Health, Uganda)

Uganda has taken considerable steps to strengthen rehabilitation, including its inaugural national strategic plan on rehabilitation and assistive technology. This plan is now in the endorsement and implementation phase. The country has also expanded primary health care rehabilitation services through task sharing, conducted rehabilitation research, and integrated rehabilitation into district health information systems to regularly monitor and report on progress.

Ms Pascale Delcomminette  
(Administratrice générale de Wallonie-Bruxelles Internationale, Belgium)

The government of Wallonia, Belgium, has recently established an agreement with WHO to support two countries in the African region in their efforts to strengthen rehabilitation. Over the coming years this support will see the implementation of several WHO tools aimed at strengthening rehabilitation governance, data collection and workforce.

Through a recorded video, Dr Tedros Ghebreyesus (Director-General, WHO) commended the global rehabilitation community on progress made since the Rehabilitation 2030: Call for action. He also acknowledged the significance of the landmark WHA 76.6 resolution on rehabilitation.

Dr Tedros:  
“The resolution emphasises the importance of rehabilitation in primary care and as part of emergency preparedness and response. Now is the time to translate these objectives into action. WHO is working to develop visible targets and indicators alongside technical guidance and resources to support the ongoing implementation of Rehabilitation 2030. Working together, we can address the unmet needs in rehabilitation services worldwide and support more people to live longer healthier lives.”
1.1 Rehabilitation 2030 in the context of the resolution on “Strengthening rehabilitation in health systems” endorsed at the 76th World Health Assembly

Speaker: Dr Alarcos Cieza (Unit Head, Sensory Functions, Disability and Rehabilitation, WHO)

Dr Alarcos Cieza laid the foundation for the 2-day meeting, providing an overview of Rehabilitation 2030, taking stock of progress achieved in the rehabilitation sector to date, explaining the significance of the WHA76.6 resolution on “Strengthening rehabilitation in health systems” as well as the actions requested in it, and briefly introducing the new WHO tools that will facilitate the implementation of the resolution in countries.

Rehabilitation 2030’s core principles

The Rehabilitation 2030: Call for action was launched in 2017, rallying stakeholders towards concerted and coordinated global action to scale up rehabilitation. The initiative identified 10 priority areas for action, and was based on 3 foundational principles that guide our collective efforts:

1. Functioning
Rehabilitation optimizes everyday life, encompassing communication, mobility, self-care, relationships, sensory functions, and more. It is the primary strategy for enhancing functioning and overall well-being by working with individuals and their environment.

Dr Cieza:
“The challenge and the tragedy, as all of you know, is when rehabilitation services are not available and are not provided. This does not only have consequences for the individual, in terms of their limitations in functioning, but also for their families and the economy.”
2. **Equity**

Quality rehabilitation services should be accessible to anyone in need. Rehabilitation is an important service for the whole population, for anyone with a health condition, across the life course. Achieving equity involves:

- Inclusion of rehabilitation as part of UHC, ensuring that the services are provided based on need without financial hardship.
- Strengthening the health system as a whole, and integrating rehabilitation into all health system components (see Fig. 1 below).

![Fig. 1 Health system building blocks](image)

3. **Integration**

Rehabilitation must be integrated at all levels of the health system, particularly at primary care level. Without this, we will not adequately address the rehabilitation needs of the population.

**Progress achieved**

Significant strides have been made in the global rehabilitation community in recent years. Key achievements include:

**Evidence production**

- WHO Bulletin theme issue on *Advancing health policy and systems research for rehabilitation* (2022)
Capacity development

- Numerous technical tools\(^1\) have been developed to support countries in strengthening rehabilitation leadership and governance, workforce, assistive technology, service delivery and the integration of rehabilitation in emergency contexts.

- During the two-day meeting, 5 new WHO resources were launched which will further guide countries in health system strengthening efforts (see sections 2.2, 3.2, 3.3, 4.2, 5.2 below).

Countries supported

- WHO, together with key partners, currently support 37 Member States in strengthening their health systems for better rehabilitation provision. Notably, 25 low- and middle-countries have now developed a national strategic plan for rehabilitation.

The rehabilitation resolution

The recent WHA resolution on “Strengthening rehabilitation in health systems” (WHA 76.6) is a historic milestone, marking the first time in 75 years that rehabilitation has been recognized as a core global public health priority. The resolution outlines priority actions for Member States, civil society and WHO Secretariat, aligning directly with the Rehabilitation 2030 action areas and foundational principles.

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\(^1\) Rehabilitation in health systems; Rehabilitation in Health Systems: Guide for Action; Rehabilitation Competency Framework; Minimum technical standards and recommendations for rehabilitation in emergency medical teams; Priority Assistive Products List
Implementing the resolution

The real challenge now lies in implementing the resolution’s priority actions. This demands renewed commitment and coordinated efforts from all stakeholders. The collective actions taken in the coming years will ultimately define the status of the rehabilitation sector in 2030 and beyond.

Rehabilitation 2030 and World Rehabilitation Alliance (WRA)

Dr Cieza explained the complementary nature of Rehabilitation 2030 and the World Rehabilitation Alliance (WRA), launched at the meeting’s close. These initiatives are described as two sides of the same coin:

- **Rehabilitation 2030**: focuses on capacity building in countries, providing evidence, technical tools and support.
- **WRA**: is a WHO-hosted network dedicated to advocacy, raising awareness, driving demand and creating political will.

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<td>Focuses on</td>
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<tr>
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<td>• Creating capacity</td>
<td>• Creating demand</td>
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<td>• Supporting countries</td>
<td>• Mobilizing political will</td>
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Together, they propel the rehabilitation sector towards its goals, ensuring that rehabilitation remains central to global health priorities. (For more information on the World Rehabilitation Alliance, see section 7.3).
1.2 Change where it matters most; Progress and lessons for strengthening rehabilitation in countries

Since the Rehabilitation 2030: Call for action launch in 2017, considerable progress and work has occurred at global, regional and country level. Having now arrived at the half-way period between 2017 and 2030, it is important to reflect on the lessons learned so far and how these lessons could be used to further accelerate action in countries. To do this, Dr Pilar Aparicio spoke with four Member State representatives who shared their own country’s experiences and approaches to health system strengthening. The four speakers highlighted the factors that have contributed to their progress and lessons learned along the way.

**Dr Sangeeta Kaushal Mishra**
(*Additional Health Secretary, Ministry of Health and Population, Nepal*):

“The response and recovery during and after the earthquake led to an understanding and increased commitment in the sector of rehabilitation.”

“One of the concerns is that we had the same focal unit [within Ministry of Health] which was overseeing leprosy and rehabilitation… but we now have a rehabilitation expert there, so now it has become much easier for us to lead this agenda further.”

**Ms Heather Hanlan**
(*Director of Rehabilitation Services, Public Hospitals Authority, Ministry of Health and Wellness, Bahamas*):

“I am pleased that, after years of advocating, networking and pushing the rehabilitation needs in our country, in June 2022 the director of rehabilitation and the deputy director of rehabilitation posts aligned where they are now included in decision making processes that occur within the public health care system of the Bahamas. This recognition of our health leaders of the importance of rehabilitation to be included in the level of strategic planning is a great breakthrough for leadership and governance in the Bahamas.”
Dr Khamsay Detleuxay  
(Director General of Department of Health Care and Rehabilitation, Ministry of Health, Lao People’s Democratic Republic):

“The Ministry of Health had to increase its capacity and engagement to step up and adequately lead rehabilitation strengthening."

“Training doctors and nurses in rehabilitation has increased demand for rehabilitation, as now they understand what rehabilitation is, who needs it and what can be done for people.”

Ms Celestine Akua Numatsi Esse  
(Project Officer, International Committee of the Red Cross, Togo):

“We think it’s important to promote and share experiences between countries because problems within the 3 countries [Benin, Côte d’Ivoire and Togo] are similar and countries want to learn from each other.”

Key themes that emerged from the panel discussion:

- Country-tailored and diverse approaches to health system strengthening are crucial.
- Ministry of Health leadership and capacity are vital for driving change.
- Inclusion of rehabilitation professionals in decision-making within the Ministry is essential.
- Advocacy by rehabilitation focal points during Ministry decisions is necessary.
- While strategic planning is important, emphasis on annual operational planning is even more vital.
- Collaboration among sectors and stakeholders prevents fragmentation and inefficiency.
- Development partners’ support in implementing existing tools and guidance is crucial, focusing on local capacity building.
- A functional rehabilitation workforce is foundational for progress in other areas.
2. Emergencies
(Preparedness, response and recovery)

Moderator: Dr Nedret Emiroglu (Country Readiness Strengthening, Health Emergencies Programme, WHO)

2.1 Lessons from the field: How prepared are we to respond to rehabilitation needs in emergencies?

The global impact of emergencies, and the role of rehabilitation

Each year, over 170 million people are affected by conflict, and an estimated 190 million by disasters globally. The world continues to witness conflicts, infectious disease outbreaks and various hazards that result in a devastating number of critical injuries and illnesses. Unfortunately, no country is exempt from such emergencies.

Dr Nedret Emiroglu explained that emergencies create an enormous surge in rehabilitation needs while at the same time disrupting essential rehabilitation services. Rehabilitation plays a vital role in emergency response efforts, enabling those affected by emergencies to achieve the best possible recovery in terms of health and functioning. In recent years, we have seen the importance of rehabilitation following the earthquake in Türkiye and North-West Syria, in conflicts, including the war in Ukraine, and during the COVID-19 pandemic.

Current challenges in emergency response

Unfortunately, most countries today are not equipped to respond to the sudden increase in rehabilitation needs following a health emergency. According to Dr Emiroglu, rehabilitation is rarely considered as part of emergency preparedness, and often remains an afterthought in early response efforts. During the COVID-19 pandemic, for example, rehabilitation was amongst the essential health services most disrupted by the pandemic.
Call for change

The WHA76.6 resolution on ‘Strengthening rehabilitation in health systems’ urges Member States to ensure timely integration of rehabilitation and assistive technology into emergency preparedness and response, including Emergency Medical Teams. This includes building capacity and competency of rehabilitation professionals and health emergency workforce to respond to both the acute and long-term rehabilitation needs of those affected by emergencies, to ensure a deployable rehabilitation workforce in emergency contexts, and to promote learning across countries.

Dr Emiroglu:
“We have witnessed many emergencies recently where rehabilitation services were delivered from the very start at the preparedness and readiness phase, and it has been critical in saving many lives in the emergency response.”

As we take steps towards strengthening rehabilitation within emergency preparedness, response and recovery efforts, it is important to reflect on lessons learned from past events. Dr Emiroglu spoke with three panelists, representing vastly different emergency and country contexts, who shared their experiences of rehabilitation responses following an emergency in their country:

Rehabilitation in disaster
Mr Ismaila Kebbie (Manager, National Physical Rehabilitation Program, Ministry of Health and Sanitation, Sierra Leone):
“For us as a Ministry, we were able to sit down with the rehabilitation professionals and identify the needs assessment at that moment... we were able to actually know our needs and what to ask for.”

Rehabilitation in conflict
Ms Mariia Karchevych (Deputy Minister of Health, Ukraine):
“In the midst of the war, rehabilitation emergency response in Ukraine has been based on three pillars. First, legislation and regulation. The most important here is intersectoral collaboration. The second is service delivery... also ensuring capacities and building professions. The third is assistive technology.”

Rehabilitation in an outbreak
Dr Rachael Moses (Consultant Physiotherapist and National Clinical Advisor Respiratory, National Health Service, England):
“The most valuable resource in a pandemic is people. People with the right skills being deployed in the right places at the right time.”
Collectively, the speakers highlighted the importance of all-hazard preparedness, adequate human resource capacity, ongoing advocacy for rehabilitation in emergency preparedness, timely identification and response to long-term consequences of the emergency context, and the need to protect existing rehabilitation services. They also emphasized the invaluable role of regional collaboration for filling service gaps and preparing for a surge in rehabilitation needs, the importance of intersectoral collaboration, and the benefit of having rehabilitation professionals in key leadership positions. These insights illustrate how rehabilitation services, regardless of context, can be better prepared for emergencies, and better integrated into preparedness efforts.

2.2 Launch of the WHO policy brief: *Strengthening rehabilitation in health emergency preparedness, readiness, response and resilience*

Speakers: Dr Hala Sakr (WHO Regional Office for the Eastern Mediterranean), Mr Pete Skelton (Emergency Medical Teams and Rehabilitation Programme, WHO)

Rationale and challenges in integrating rehabilitation in emergencies

Mr Peter Skelton provided background and insights into the newly published WHO policy brief: *Strengthening rehabilitation in health emergency preparedness, readiness, response and resilience*. He highlighted that many rehabilitation organizations and professions have their origins in emergencies, however despite this the role of rehabilitation in health emergencies is often not well recognized and understood. Rehabilitation is frequently considered in the late response and early recovery phase, missing the chance for timely integration into health emergency responses.

Mr Skelton:

“The reality is that emergencies are often a catalyst to strengthen the rehabilitation services in countries, but we wait for the emergency to hit before we realize this, and there is actually a huge amount that we can do now.”

Rehabilitation integration into preparedness efforts remains limited. WHO data across 19 low- and middle-income countries found that only 1 country had integrated rehabilitation into their national preparedness planning processes. Only 17% of countries, as per a World Physiotherapy survey, integrated physiotherapy. Where rehabilitation is integrated, it often focuses solely on trauma surge.
Dr Hala Sakr emphasized challenges from the Eastern Mediterranean Region, sharing examples of the region’s struggles in recognizing and integrating rehabilitation. During the COVID-19 pandemic, a 2020–21 rapid assessment of 18 Eastern Mediterranean countries found that only 50% of countries included rehabilitation in their health system response plans. The earthquake in Türkiye and North-West Syria exposed financing and supply chain issues as well as a fragmented response stemming from the absence of rehabilitation in preparedness plans.

Dr Sakr:
“In emergencies we face limited resources and compromised infrastructure, for all health services but more for rehabilitation. Health systems are disrupted, and workforce is inadequate or not qualified. Simultaneously, there is the increased [rehabilitation] need as well as the need to maintain the services for those who have the need prior to the crisis. Accessibility barriers and displacement are additional challenges and sometimes there is insufficient coordination and collaboration among humanitarian actors.”

Overview of the WHO policy brief

The WHO policy brief: *Strengthening rehabilitation in health emergency preparedness, readiness, response and resilience* outlines the evidence for rehabilitation in emergencies and the need for greater preparedness of rehabilitation services. It shows how existing guidelines support the integration of rehabilitation in emergencies and sets out the steps that decision makers can take to better integrate rehabilitation into health emergency preparedness and response.

The development of the policy brief involved extensive contributions from rehabilitation individuals and organizations, ensuring that it adequately met the needs of countries. This resource is part of a broader project, including the development of a practical toolkit and checklist to further support Member States and other leaders in integrating rehabilitation into preparedness. This forthcoming toolkit will be piloted in 2024.

For more information on the WHO Policy brief: *Strengthening rehabilitation in health emergency preparedness, readiness, response and resilience*, please refer to Section 6.3 Technical breakout session on Emergencies.

For additional information on WHO’s work on rehabilitation in emergencies, visit: [https://www.who.int/activities/strengthening-rehabilitation-in-emergencies](https://www.who.int/activities/strengthening-rehabilitation-in-emergencies)
Ms Kenza Zerrou began by sharing her personal experience of accessing rehabilitation after a stroke in 2021. In her country, rehabilitation was covered by health benefits, but this is not the case globally. In many places, individuals pay out-of-pocket for rehabilitation, risking financial strain. Ms Zerrou’s story highlights the importance of rehabilitation financing for quality care and financial security. Subsequent speakers provided an overview to health financing and shared current practices in financing of rehabilitation services.
3.1 Including rehabilitation in health financing to expand access to rehabilitation services

Overview to rehabilitation in health financing and ways forward

Speaker: Ms Tamara Chikhradze (Results for Development, Health Systems Strengthening Accelerator)

Ms Tamara Chikhradze highlighted the financing functions encompassing revenue raising, pooling and purchasing. To incorporate rehabilitation in health financing mechanisms, she emphasized the need for comprehensive information gathering, assessing the political economy and resource distribution before implementation. She highlighted 4 key policy considerations: promote integration of rehabilitation into health financing mechanisms; ensure there is coverage and financial protection for the population; prioritize financing of evidence-based interventions for rehabilitation; and the role of financing mechanisms in promoting quality services. Ms Chikhradze underscored 3 overarching principles for success: adopting a systems approach, ensuring strong governance led by Ministry of Health, and data- and evidence-driven decision making.

Ms Chikhradze:
“By integrating rehabilitation into health financing, we are not just reshaping the landscape for rehabilitation, we are reshaping the landscape for health care in general, moving it towards the type of care that looks at the quality of life it saves, and not just the quantity.”

Using evidence to inform policy and action on rehabilitation in Scotland, United Kingdom of Great Britain and Northern Ireland

Speaker: Professor Carolyn McDonald (Chief Allied Health Professions Officer, the Scottish Government)

Professor Carolyn McDonald provided insights into how Scotland shapes and delivers rehabilitation in the country, and the common sources of evidence that are used to influence health policy and financing decisions.

The importance of clinical practice guidelines for evidence-informed decision-making was highlighted. Alongside this, qualitative information, including the service user perspective, can be very powerful. In recent years, Scotland has also drawn on audits of rehabilitation services, good practice examples and an allied health professions education and workforce policy review.
in these processes. Professor McDonald emphasized the importance of ensuring alignment of rehabilitation with other policy areas within the government, promoting rehabilitation as a core part of all healthcare.

**Professor McDonald:**
“Providing evidence to support what we do is essential in modern care. Clinical practice guidelines are key to ensuring that we can present our case for rehabilitation effectively to influence health financing and subsequent service delivery.”

In order to expand the evidence-base in Scotland, research competency and capacity needs to be further strengthened. Scotland will continue to evaluate rehabilitation service delivery in order to respond to the growing need for rehabilitation.

**Defining a health benefit package inclusive of rehabilitation in Georgia**

**Speaker: Dr Akaki Zoidze (Curatio International Foundation, Health Systems Strengthening Accelerator)**

Dr Akaki Zoidze shared methods and experiences from integrating rehabilitation into the national health system in Georgia. Specifically, he reported on using a draft version of the *Package of interventions for rehabilitation* to develop health benefit packages inclusive of rehabilitation.

Dr Zoidze introduced the steps involved in the process. These included: Advocacy to sensitize policy makers; the prioritization of rehabilitation interventions and services; costing and budgeting of the selected services; ensuring that the financing for priority services were included in the State budget; developing standards, protocols, care guidelines and a national competency framework, and establishing a vision for a future model of care for rehabilitation in Georgia. Dr Zoidze went on to explain how the draft version of the *Package of interventions for rehabilitation* supported the process.

**Dr Zoidze:**
“In Georgia, we cannot cover everything from the beginning, not just because of not enough budget but also because of the shortage of human resources. The prioritization of rehabilitation services was the key to start with. It was based on considering the existing population needs, evidence and cost effectiveness of interventions, and current availability of services. The draft version of the Package of interventions for rehabilitation helped not only to identify the interventions that are evidence-based, and thus to define the minimum standard for funded programmes, but also to advocate for those services. For the future, we also plan to use the Package of interventions for rehabilitation for the development of national guidelines and protocols for patient services.”
3.2 Launch of the WHO Rehabilitation in health financing: Opportunities on the way to universal health coverage

**Speakers:** Dr Jody-Anne Mills *(WHO Regional Office for Western Pacific)*, Dr Pauline Kleinitz *(Rehabilitation Programme, WHO)*

The *Rehabilitation in health financing: Opportunities on the way to universal health coverage* was launched, a new WHO resource that recognizes the crucial role health financing plays in achieving UHC and in ensuring access to rehabilitation services without financial hardship. The resource fills a knowledge gap on how health financing practices can be harnessed to promote the delivery of rehabilitation services. This resource is broken into four parts and provides insights into current practices, framing major challenges and opportunities, and offering guidance to decision-makers engaged in strengthening rehabilitation within health systems. The resource was developed through a strong partnership between the WHO Health financing and Rehabilitation teams, and the Health System Strengthening Accelerator, funded by the United States Agency for International Development (USAID).

**Dr Mills:**
“This resource provides guidance for rehabilitation and financing stakeholders alike, so that both groups can inform decisions around rehabilitation in health financing. It really puts us all on the same page about the challenges that exist and ways forward”.

For more information on the WHO *Rehabilitation in health financing: Opportunities on the way to universal health coverage*, please refer to Section 6.5 Technical breakout session on Rehabilitation in health financing.
3.3 Launch of the Package of interventions for rehabilitation

Speakers: Dr Binta Sako (WHO Regional Office for Africa), Dr Alexandra Rauch (Rehabilitation Programme, WHO)

The *Package of interventions for rehabilitation* (PIR) was then launched in the meeting, after more than four years of development. The PIR provides information on evidence-based interventions for rehabilitation and required human and material resources that are needed to deliver the interventions. The specific focus for the development of the PIR has been low- and middle-resource contexts. It is now available for twenty health conditions.

**Dr Sako:**
"The Package of interventions for rehabilitation provides a lot of information on the type of evidence-based interventions that are needed and what is required to make the services available in terms of material and human resources. It comes at a critical and timely moment for countries. While there are countries that already have strategic plans, I think, this was the element that was missing to help them to translate the strategies into actual service delivery."

The PIR has been primarily developed to support countries in planning, budgeting and integrating interventions for rehabilitation into all service delivery levels and along the continuum of care. However, the information is also useful to service providers, academics and researchers to plan evidence-based service delivery, education and training of the rehabilitation workforce, or research activities.

More than 700 rehabilitation experts and consumer representatives, representing nearly 100 countries from all world regions have contributed to the development of the PIR.

For more information on the *Package of interventions for rehabilitation*, please refer to Section 6.1 Technical breakout session on Package of Interventions for Rehabilitation.
3.4 Enablers and drivers of expanded financing for evidence-based services

Moderators: Ms Kenza Zerrou (Engagement Funds, Banks, Multilaterals, WHO), Dr Bruno Meessen (Senior Health Financing Advisor, Department of Health Financing and Economics, WHO)

Representatives from different rehabilitation stakeholder groups came together to discuss the enablers and drivers for expanded rehabilitation financing, taking into account the different roles their respective agencies can play.

A number of key points emerged during the discussion:

1. **Consumer engagement:** Inclusive consultation with consumer groups, including rehabilitation consumers and people with disabilities, is important for effective advocacy and decision-making in rehabilitation financing.

2. **Role of personal testimonies:** Data is important, but listening to the experiences of those who have undergone rehabilitation is even more impactful for advocacy and decision-making.

3. **Academic contributions:** Researchers can help in improving the measurement and understanding of rehabilitation services, making it easier for health financing stakeholders to comprehend and cost.

4. **Rehabilitation stakeholder involvement:** Rehabilitation stakeholders should acquaint themselves with health financing concepts, and participate in decisions affecting rehabilitation service funding in their countries.

5. **Multi-agency funding:** Ministries of Health are key in rehabilitation expansion but should collaborate with other government agencies like Ministries of Social Affairs, Education, and Defense for additional funding and efficiency.

6. **Development partner role:** Development partners can work with governments to support information generation and research on rehabilitation, cross country learning, piloting and demonstration projects, and ensuring adequate evaluation and learning in the process.

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2 Round table participants: Dr Ola Abualghaib (Manager, Technical Secretariat UN PRPD, UN Multi-Partner Trust Fund), Ms Tamara Chikhradze (Results for Development, Health Systems Strengthening Accelerator), Prof Emerita Gwynnypth Llewellyn (Head, WHO Collaborating Centre for Strengthening, Rehabilitation Capacity in Health Systems, The University of Sydney), Prof Carolyn McDonald (Chief Allied Health Professions Officer, the Scottish Government), and Dr Akaki Zoidze (Curatio International Foundation, Health Systems Strengthening Accelerator).
7. **Ministry of Health financing implementation**: Ministries of Health are crucial during the implementation of financing arrangements, particularly after defining a health benefit package inclusive of rehabilitation. Informed by Georgia’s experience, successful implementation requires considerable guidance and extensive stakeholder engagement, resulting in better outcomes through greater ownership.

8. **Ministry of Health rehabilitation focal point**: The rehabilitation focal persons within the Ministries of Health also have a role in advocacy and in building awareness about rehabilitation across health, not just within their ministries but at the level of districts, heads of hospitals and other departments.

For additional information on WHO’s work on rehabilitation financing and service delivery, visit: [https://www.who.int/activities/integrating-rehabilitation-into-health-systems](https://www.who.int/activities/integrating-rehabilitation-into-health-systems)
4. Workforce

4.1 Information driven advocacy and action to strengthen the rehabilitation workforce

Moderator: Dr Khassoum Diallo (Unit Head, Data, Evidence and Knowledge Management, Health Workforce Department, WHO)

Dr Khassoum Diallo opened the discussion by highlighting the critical role of the workforce in healthcare systems, emphasizing lessons learned from the COVID-19 pandemic where workforce issues disrupted essential health services.

The development of rehabilitation workforce in many countries lags behind other health-related occupational groups due to limited awareness of their contribution and inadequate data. The rehabilitation workforce faces an array of challenges, including shortages, migration, an imbalanced distribution between private and public sectors, inadequate salaries, and poor regulation of education leading to quality concerns and unemployment.

Addressing these challenges demands comprehensive information that goes beyond mere workforce numbers. Dr Diallo stressed the importance of accurate data and robust evidence for decision-making, advocacy, resource mobilization, and country-level implementation. He highlighted the need for strong national data systems to guide policy development and monitor progress during implementation.

Dr Diallo spoke with three experts to discuss the different types of information that can support advocacy and guide country action to strengthen the rehabilitation workforce.
The need for, and use of, rehabilitation workforce availability and accessibility data

Speaker: Mr Ritchard Ledgerd (Executive Director, World Federation of Occupational Therapists)

Mr Ledgerd highlighted the need for availability and accessibility data beyond supply figures. Understanding demand, including factors like job availability and absorption, is essential. Disparities between urban and rural areas, diverse practice areas, and workforce attrition are also critical considerations. The lack of prioritization, inadequate understanding of rehabilitation’s value, and insufficient infrastructure hinder workforce data collection efforts, affecting policy-making.

Mr Ledgerd:
“There is an urgency for us to get better at capturing and using data to improve the situation of rehabilitation workforce in countries, and to remember that behind each number is a person.”

The need for, and application of, information on the competence of the rehabilitation workforce

Speaker: Dr Nassib Tawa (Centre for Research in Spinal Health and Rehabilitation Medicine, Kenya)

Dr Tawa emphasized the importance of analyzing workforce competence beyond supply-demand metrics. Deeper analysis of workforce competency delves into not only quantitative statistics but also qualitative aspects such as professional training levels, proficiency, performance, and alignment with population needs. Rehabilitation competency analysis offers a comprehensive view of the workforce, allowing countries to assess gaps and enhance workforce quality and service delivery.

Dr Tawa:
“It goes beyond the quantitative numbers by painting a holistic picture of the state of the rehabilitation workforce and making a determination as to whether the available, existing workforce and the services which are offered are best matched to the level of need within a country.”
The need for, and application of, information in the performance of the rehabilitation workforce

Speaker: Dr Ferdiliza Garcia (Committee on Professional Standards and Ethics, Philippine Association of Speech and Language Pathologists)

Dr Garcia shed light on the crucial role of a worker’s environment in influencing their performance. Physical aspects such as space allocation, equipment availability, and access to assistive technology influence workforce practices. Social factors like the perception of rehabilitation services and workforce within the broader health system context is essential. Dr Garcia provided examples from the Philippines, highlighting geographical challenges, resources disparities and disaster exposure. Dr Garcia emphasized the importance of collecting workforce data to inform planning, collaboration with institutions to establish competency standards, and advocating for health needs.

While discussing the rehabilitation workforce challenges and potential solutions, the three experts stressed the significance of accurate data and comprehensive analysis. Availability, accessibility, competence and environmental factors play vital roles in strengthening the workforce and ensuring quality service delivery.

4.2 Launch of the Guide for rehabilitation workforce evaluation

Speakers: Dr Jody-Anne Mills (Rehabilitation Programme, WHO), Dr Cathal Morgan (WHO Regional Office for Europe)

The launch of the Guide for rehabilitation workforce evaluation (GROWE) marked a significant step in addressing healthcare workforce challenges. Dr Mills emphasized GROWE’s significance as more than a data collection tool – it recognizes the rehabilitation workforce’s importance and provides an opportunity for rehabilitation professionals from a range of occupations to come together to voice their situation. GROWE aims to uncover the “why” behind workforce data, enabling more effective responses to challenges.

Dr Cathal Morgan explained that GROWE builds upon the health labor market analysis guidebook, providing a deeper analysis of the rehabilitation workforce. It encompasses quantitative and qualitative data, encouraging interdepartmental collaboration and stakeholder engagement for evidence-based decisions.

3 Please note: Dr Jody-Anne Mills participated in the meeting as WHO Regional advisor for Disability, Rehabilitation, and Long-Term Care, WHO Western Pacific Regional Office. However, in her former role at WHO headquarters, she led the development of the Guide for rehabilitation workforce evaluation.
Dr Morgan:
“GROWE works best when it is fundamentally inter-departmental, inter-ministerial, inter-organizational and inter-professional, as a basis on which you can bring all of the key stakeholders together to do the analysis and look at what the findings are telling us in order to develop a plan, to develop the workforce.”

Workforce data is often misunderstood as merely focusing on numbers. However, rehabilitation workforce challenges are multifaceted and complex (see Fig. 2 below for examples of workforce challenges). GROWE offers a comprehensive tool to navigate these complexities, offering a holistic view that supports decision-making.

Fig. 2 Examples of rehabilitation workforce challenges suggested by meeting participants

Beyond labor analysis, the tool also incorporates competency analysis and needs analysis, supporting the evaluation, planning, and advocating for a robust rehabilitation workforce. GROWE is adaptable to country contexts, allowing the evaluation to be tailored to a country’s unique rehabilitation workforce compositions and needs. The resource will also dispel misconceptions about workforce issues being purely a matter of supply or shortages. By involving various stakeholders, GROWE initiates an ongoing journey of development and planning within Member States, aligned with the goal of improving individuals’ quality of life through skilled rehabilitation professionals.

The development of GROWE was a collective effort, involving the WHO Rehabilitation programme, the WHO Health workforce department, and a large pool of peer reviewers and experts.

For more information on the Guide for rehabilitation workforce evaluation, please refer to Section 6.2 Technical breakout session on Guide for rehabilitation workforce evaluation.

For additional information on WHO’s work on rehabilitation workforce, visit: https://www.who.int/activities/integrating-rehabilitation-into-health-systems/workforce
5. Health information systems

5.1 Interactive panel: Bridging the knowledge gap – Evidence generation for decision-making and action for rehabilitation

**Moderator: Dr Leanne Riley** *(Unit Head, Surveillance, Monitoring and Reporting, Department of Noncommunicable Diseases, WHO)*

This interactive session involved 4 experts, each providing insights on the different types of evidence that are needed for effective decision-making for rehabilitation and country action.

**Routine data collection from facilities for policy and service delivery decisions**

**Speaker: Mr Mesoud Mohammed Ahmed** *(Deputy to the Executive Officer of Strategic Affairs, Ministry of Health, Ethiopia)*

Mr Ahmed discussed Ethiopia’s principles of standardization, simplification, integration, and institutionalization of their routine health information system. Six rehabilitation facility indicators were piloted in five centers, showcasing government commitment through alignment with the country strategic plan, resource allocation, and designated focal points who lead on data collection. Real-time data improves service capacity, quality, and accessibility. Early analysis in Ethiopia revealed variations among centers, in terms of waiting times and service volumes, informing health planning. Data supports performance monitoring, action planning, prioritization, budget allocation, and development of national dashboards and annual statistical reports.
Clinical evidence for service delivery decisions

Speaker: Dr Chester Ho (Professor of Physical Medicine and Rehabilitation, Alberta Health Services, Canada)

Dr Ho introduced Alberta’s health system context and the role of the strategic clinical network in implementing evidence-based practices. The network uses both quantitative data (such as surveys, literature and administrative health data) and qualitative data (such as experiences of patients and providers). Dr Ho cited examples of evidence use, such as creating a post COVID-19 rehabilitation framework through literature reviews and stakeholder collaboration. He also mentioned developing key quality indicators for inpatient rehabilitation programs based on equity concerns. Dr Ho discussed differences among program adoptions of the rehabilitation framework and identified the need for additional training, understanding workforce readiness levels, addressing staffing challenges, and ensuring alignment of key quality indicators with the broader healthcare system. Emphasis was placed on robust data infrastructure to make clinical evidence accessible to decision-makers and frontline workers.

Health policy and systems research for policy decisions

Speaker: Dr Kaori Yamaguchi (Senior researcher, Department of Health and Welfare Services, National Institute of Public Health, Japan)

The insurance systems in Japan maintain information systems with reimbursement claims data, offering comprehensive insight into rehabilitation services for the entire population. The system includes data on rehabilitation programs and patient assessment results. Dr Yamaguchi emphasized collaboration with central and local government officials through committees and grants, facilitating knowledge sharing with policymakers. Health policy and systems research based on medical claims data identified disparities for service utilization among districts in Japan, with up to a 1.6 times gap between areas. Future rehabilitation needs were estimated based on projections of demographic changes, revealing varying trends. It was concluded that local findings inform health sector plans, addressing disparities and resource allocation.
Rehabilitation data on the World Health Data Hub

Speaker: Mr Philippe Boucher (Unit head, Data Exchange team, Department of Data and Analytics, WHO)

Mr Boucher explained the World Health Data Hub’s role in collecting high-level indicators and data sets, supporting advocacy, priority setting, and funding efforts. The hub modernizes data processes, centralizing dissemination and ensuring accessibility. Global-, regional- and country-level data on the estimated need for rehabilitation will be integrated into the hub in 2024. This data will be taken from the existing WHO Rehabilitation Needs Estimator, and will be routinely updated as new data becomes available. The comprehensive approach provides contextual content, such as health workforce and financial planning data, for informed decision-making. This comprehensive approach allows users to not only address immediate needs but also identify trends and estimate future scenarios.

5.2 Launch of the Routine health information systems – rehabilitation toolkit

Speakers: Dr Wouter De Groote (Rehabilitation Programme, WHO), Mr Ameel Mohammad (WHO Regional Office for South-East Asia)

Dr Wouter De Groote reiterated the vital role of Routine Health Information Systems (RHIS) in enhancing decision-making for rehabilitation at both the facility and (sub)national level. This aligns with the recent WHA76.6 resolution on rehabilitation, which highlighted the need for strengthening health information systems for rehabilitation.

RHIS overview

RHIS forms a cornerstone of health service data collection within national health information systems. Data is sourced from health services provision and based on predefined indicators for which data are collected regularly. This data is then aggregated, analyzed and utilized at various health system levels, guiding decisions from the facility to the national level. Standard facility indicators are pivotal for RHIS, enhancing data quality, harmonizing data collection efforts, and aiding decision-making.
Dr De Groote:
“The routine health information system is one of the major sources for data and decision making.”

RHIS rehabilitation toolkit
The Routine health information systems – rehabilitation toolkit was launched during the session. The toolkit includes:


2. Digital package: Configured with DHIS2, it offers pre-developed data entry forms and dashboards, as well as installation and design guides.

3. Training materials: Targeted at rehabilitation service providers and data analysts across healthcare levels.

RHIS status in South-East Asia
Mr Mohammed Ameel outlined the varying maturity levels of RHIS for rehabilitation across South-East Asian countries. Notably, Nepal shows promising progress in data collection and reporting. The WHO South-East Asian Regional Office supports countries in strengthening RHIS through implementation of WHO toolkits, data quality assessments, and capacity-building workshops.

The launch of the Routine health information systems – rehabilitation toolkit marks a significant step toward strengthening health information systems for rehabilitation globally, with a focus on indicator standardization, improved data quality, and enhanced data analysis. The toolkit has the potential to improve the rehabilitation sector’s capacity and performance while integrating rehabilitation data into broader health services analysis.

For more information on the Routine health information systems – rehabilitation toolkit, please refer to Section 6.4 Technical breakout session on Collection and analysis of routine data for rehabilitation.

For additional information on WHO’s work on rehabilitation and health information systems, visit: https://www.who.int/activities/integrating-rehabilitation-into-health-systems/information
The breakout session aimed to i) provide more in-depth information on the development and the content of the *Package of interventions for rehabilitation* (PIR), to ii) present how the information from the PIR is currently being integrated into WHO’s *Universal health coverage compendium* and how countries can use this tool for the planning of rehabilitation services, and finally, to iii) present and discuss other areas of use of the PIR.

Participants of this breakout session had the opportunity to ask questions to the presenters and to suggest additional areas of use of the PIR.
A snapshot of the Q&A discussion

• **Question:** Does the PIR consider those with long-term rehabilitation needs?
  • **Answer:** Yes, the PIR covers the entire continuum of care, including long-term rehabilitation. It extends beyond acute care, ensuring ongoing rehabilitation as needed.

• **Question:** How does the PIR address co-morbidities and mental health?
  • **Answer:** For multiple conditions we advise users to go to different packages to find all the information needed. Mental health is addressed in all the documents. Interventions addressing mental health, particularly depression and anxiety, are also available in the section titled “Prevention of secondary conditions”.

• **Question:** Does the PIR still include information on service delivery platforms?
  • **Answer:** No, service delivery information was removed. Interventions were initially linked to levels of care, but variability in workforce and intervention availability between countries led to its exclusion. Countries now determine intervention availability at the different service delivery levels based on context.

• **Questions:** Will the PIR be available in multiple languages?
  • **Answer:** Yes, the PIR will be translated into the six official UN languages: Arabic, Chinese, English, French, Russian, and Spanish.

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Other uses of the PIR, suggested by meeting participants

- Education and the development of curricula
- Capacity audits at different levels to assess the readiness of the workforce
- Development of minimum standards for the rehabilitation equipment lists
- Advocacy at different levels
- Informing the development of clinical practice guidelines
- Assessing available evidence on interventions for rehabilitation and to inform the search for new evidence
- Assessing existing rehabilitation protocols (comparing with the interventions included in the PIR)
- Scaling up community based rehabilitation
- Individual patient management in clinical practice
The session aimed to foster a comprehensive understanding of the rehabilitation workforce, exploring the intricacies of health workforce dimensions and variables, with a focus on operational aspects of the *Guide for rehabilitation workforce evaluation* (GROWE) and data collection.

The session involved group activities, aimed at collectively mapping rehabilitation workforce variables, encompassing availability, accessibility, acceptability, and quality.

**GROWE implementation**

Ms Weronika Krzepkowska (WHO Regional Office for Europe) shared her experience implementing GROWE in Poland. Various rehabilitation workers participated in the workforce evaluation process, including physiotherapists, occupational therapists, speech and language therapists, clinical psychologists, and physical medicine rehabilitation doctors. While data existed for the regulated workforce, most specialized rehabilitation workers were not officially registered. GROWE encouraged their recognition within the rehabilitation workforce.

**Dr Mills:**

“Defining the rehabilitation workforce is something we do with a lot of caution because it is not our intention to put very thick borders around who is and is not part of the rehabilitation workforce; instead, we want the rehabilitation workforce to be contextualized around those who deliver rehabilitation.”

**A snapshot of the Q&A discussion**

- **Question:** Can data collection extend to sub-national levels within a country?
- **Answer:** In Pakistan, the need for sub-national assessments arose. The tool is designed for national use, because the need analysis calculates the incidence and prevalence of various health conditions nationally and considers population size and trends at the national level. However, it can be adapted for sub-national use with adjustments for local contexts.

- **Question:** Will WHO use a top-down or country-initiated approach for GROWE implementation?
- **Answer:** WHO’s approach varies. Countries can proactively approach WHO, or WHO identifies opportunities for specific Member States. Discussions with stakeholders determine tool relevance and priority.
**Key themes that emerged during discussion**

1. Enabling technologies’ impact on workforce optimization
2. Quality of services and contextual realities
3. Making rehabilitation engaging for both the workforce and patients
4. Making the case for investment in rehabilitation is essential
5. Addressing equity in rehabilitation discussions
6. Promoting cross-country learning
7. The significance of inter-ministerial, interdisciplinary discussions, and multi-sectoral collaborations in rehabilitation

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### 6.3 Emergencies

**Moderator: Mr Peter Skelton**  
(Emergency Medical Teams and Rehabilitation Programme, WHO)

The session aimed to familiarize participants with the WHO Policy brief *Strengthening rehabilitation in health emergency preparedness, readiness, response and resilience*. Through a series of group activities, participants had the opportunity to discuss different hazards faced in their country, to consider the rehabilitation consequences at an individual and service level, and to use the policy brief to identify priority preparedness actions.
Key themes that emerged during discussion

Rehabilitation consequences of emergencies

- **Individual level:** Surge in rehabilitation needs (injuries or illnesses); loss of assistive products; displacement.
- **Service level:** Existing rehabilitation services damaged or disrupted; overwhelming number of patients; lack of resources (workforce, equipment, assistive products); lack of continuity of care (unclear referral pathways, addressing secondary complications).

Priority preparedness activities

- **Planning and coordination:** Mapping of existing services, stakeholders, and referral pathways; identifying key coordinators and team leaders involved; sub-national, national and regional collaboration to address gaps.
- **Human resources:** Appoint a rehabilitation national focal point for emergency response, embedded into the health emergency operations centre; training of non-rehabilitation workforce (task shifting).
- **Risk communication:** Effective communication that involves rehabilitation stakeholders at both community level and among policy- and decision-makers.
- **Community capacity:** Involving rehabilitation consumers and professionals at grassroots level, particularly where there is decentralized governance.

A snapshot of the Q&A discussion

- **Question:** What constitutes a health emergency?
  - **Answer:** An emergency is defined as “A situation impacting the lives and well-being of a large number of people or a significant percentage of a population and requiring substantial multisectoral assistance”. A health emergency would therefore impact a large number of people, and result in significant health consequences.

- **Question:** How does the policy brief and forthcoming toolkit address the needs of vulnerable populations during emergency preparedness?
  - **Answer:** The policy brief and forthcoming toolkit provide guidance on the role of rehabilitation professionals in reducing the vulnerability of populations that they work with. However, it is important to note that inclusive humanitarian response is a much broader issue that goes beyond health, and requires cross-sectoral collaboration. There are many initiatives and resources available globally that provide guidance on the latter.
6.4 Collection and analysis of routine data for rehabilitation

Moderator: Dr Wouter De Groote
(Rehabilitation Programme, WHO)

Dr Wouter De Groote set the session’s objectives, aiming to provide a comprehensive understanding of the *Routine health information system (RHIS) – rehabilitation toolkit*. Participants were encouraged to explore the toolkit’s intricacies and share their questions and concerns. The session also facilitated discussions on the toolkit’s utility at the country level.

**Routine health information systems at country level**

Dr Anh Chu (Unit Head, Department of Data Analytics and Delivery for Impact, WHO) introduced the WHO toolkits for RHIS, emphasizing their role in connecting facility-level data and survey data within the broader framework of national health sector monitoring. This integration supports progress tracking towards UHC and the Sustainable Development Goals.

**Dr De Groote:**
“*When we work with countries to strengthen the Routine Health Information System for rehabilitation, we are not working in isolation because we are working in a system that is also used by other health programmes.*"
Dr Fitsume Kibret Getachew (Senior Program Officer, Results for Development) presented Ethiopia’s experience implementing RHIS for rehabilitation in five districts. The presentation covered the country’s rehabilitation needs, available services, challenges, and how the RHIS status contributes to making decisions for the improvement of the situation. The process of developing indicators and their prioritization, data collection, and reporting was discussed.

Dr Khadija Abu Khader (Public Health Officer, WHO-OPT) shared the journey of adopting the RHIS-rehabilitation toolkit in the occupied Palestinian territory. The presentation highlighted the burden of noncommunicable diseases and the growing demand for rehabilitation services locally. Insights into the Palestinian National Health Strategy and the toolkit’s role in strengthening rehabilitation were provided. The experiences gained from pilot testing, stakeholder engagement, facility identification, adaptation of the DHIS2 module, workforce training, and data collection challenges were also shared.

A snapshot of the Q&A discussion

- **Question:** How long does it take to train service providers for data entry?
  - **Answer:** Typically, it requires three to four days.

- **Question:** How can the interoperability challenge with software like DHIS2 and the double data collection burden be addressed?
  - **Answer:** This is a complex issue as countries often have various data collection systems in place. Addressing it involves early stakeholder engagement, defining consensus-based indicators, and creating a data collection governance framework at the country level.

- **Question:** How important is collaboration between academic institutions, nongovernmental organizations, health sector organizations, and implementers in using RHIS data?
  - **Answer:** Collaboration is crucial for research and implementation. RHIS provides valuable data for research, including accessibility to rehabilitation and utilization, making it useful in implementation science protocols. Collaborative efforts can enhance data analysis and understanding.
• **Question**: How does the guidance document address the challenge of a common vocabulary and benchmarking data across different countries?

• **Answer**: The guidance document offers standardized definitions for variables and data elements, but countries may still adapt these definitions to their operational processes. While this flexibility is essential for country-specific use, it can create difficulties when comparing data across countries, especially in international benchmarking.

### 6.5 Rehabilitation in health financing

**Moderator: Dr Pauline Kleinitz**  
(Rehabilitation Programme, WHO)

The breakout session aimed to introduce the aims, methods and content of the *WHO Rehabilitation in health financing: Opportunities on the way to universal health coverage on the way to UHC*, discussing key opportunities and common challenges in health financing for rehabilitation.

Mr Adeel Ishtiaq (Program Director, Results for Development, Health Systems Strengthening Accelerator) outlined the three related functions of health financing: revenue raising, pooling and purchasing. He also emphasized the critical role of governance components within the realm of financing.

**Key findings from the resource**

1. **Revenue sources and out-of-pocket expenditure**: Rehabilitation funding is derived from various sources and often falls short, leading to a substantial out-of-pocket (OOP) burden on individuals. High transportation costs, mainly due to the unavailability of services in proximity to people’s residences, contribute significantly to OOP expenses. Additionally, in low- and middle-income countries, development partners play a substantial role in financing.

2. **Fragmented financing and coordination**: Financing for rehabilitation services tends to be fragmented across different agencies, and coordination is often inadequate. Some mechanisms targeting specific population groups raise concerns about uneven coverage, although they also help ensure equitable access.

3. **Exclusion from health benefit packages**: Rehabilitation services are frequently excluded from health benefit packages, and the utilization of contracting is limited in low- and middle-income contexts.
The strategies for moving forward were categorized into two main areas:

**A. Creating an enabling environment to enhance rehabilitation in health financing**
1. Document and understand the existing situation for financing rehabilitation;
2. Strengthen Ministry of Health leadership, capacity and planning for rehabilitation;
3. Foster multi-agency coordination for improved financing of rehabilitation services;
4. Invest in health information systems and research;
5. Undertake evidence-based advocacy.

**B. Leveraging health financing opportunities and practices for rehabilitation**
1. Increase the proportion of rehabilitation funding from public health revenues;
2. Ensure effective pooling of risk and financial resources across larger population groups;
3. Identify and prioritize evidence-based rehabilitation benefits within health benefit packages;
4. Harness opportunities to reduce OOP costs, particularly for vulnerable populations;
5. Utilize additional revenue sources and mechanisms to expand rehabilitation service coverage for specific population groups;
6. Employ more strategic purchasing practices for rehabilitation, to incentivize more efficient, higher-quality and effective services given resource constraints;
7. Ensure funding from development partners is transparent, complements public health financing, and is channeled through sector-wide mechanisms to play a catalytic role.

**Key implementation challenges that emerged during discussion**

- A lack of shared understanding and definition regarding rehabilitation in countries
- Limited integration of rehabilitation in the clinical care which can see it under-represented in the health benefit packages
- Not having the services available at primary care level to begin with, so not supported in financing, and not including assistive products in the financing
- Limited investment and capacity to collect data, no routine collection of service outcome measures, and lack of information from national health accounts

The session concluded by highlighting how this resource can be instrumental in informing decision-making processes related to rehabilitation in health financing at the country level, emphasizing the importance of translating insights into actionable policies and practices.
7. Advocating for rehabilitation

7.1 The need for rehabilitation advocacy

Moderator: Ms Aleksandra Kuzmanovic (Social Media Manager, Leadership Unit, Department of Communications, WHO)

The session brought together 3 experts, who delved into the critical aspects of advocacy for rehabilitation, emphasizing the need for clear objectives and well-defined target audiences.

Advocacy theory and communication strategies

Speaker: Professor Sara Rubinelli (WHO Collaborating Center for Rehabilitation in Global Health Systems, University of Lucerne)
Professor Sara Rubinelli highlighted the multidimensional nature of advocacy, emphasizing its role in not just raising awareness but compelling individuals to take action. She introduced the concept of advocacy being content-dependent, involving various factors such as the communicator, the message, the medium, the audience, and the desired effects. The importance of effectively targeting stakeholders was underlined, navigating the “infodemic,” and maintaining coherence and consistency in advocacy. The “7 Cs” of a good message – clear, correct, complete, concrete, concise, courteous, and coherent – were discussed as fundamental principles.

**Professor Rubinelli:**
“Advocacy is not just awareness raising. ... Making a change from a communication perspective is not just knowing something is important but it is actually to convince people to act because otherwise advocacy would not go anywhere.”

**User stories: a powerful advocacy tool**

**Speaker: Mrs Jenny Clarke** *(Co-founder and CEO, SameYou)*

Mrs Jenny Clarke shared her personal journey advocating for rehabilitation, particularly focusing on young adults with brain injuries. She recounted her daughter Emilia Clarke’s story, known for her role in Game of Thrones, who experienced a brain injury. The overwhelming response to Emilia’s story led to the creation of SameYou. Jenny stressed the importance of collecting evidence and grassroots stories to drive effective change through advocacy. She emphasized the need for enhanced understanding, empathy, and information about individuals with brain injuries, highlighting the imperative of increased access to rehabilitation services.

**Mrs Clarke:**
“What we are trying to do is to gather evidence from the ground, from the grass roots, from people who really matter the most – people who have actually lived through brain injury... and come together with one voice.”
Ms Elanie Marks underscored the significance of advocacy in shaping policy and driving demand for rehabilitation. Despite the availability of technical tools and evidence, rehabilitation often remains underprioritized and underfunded. It was emphasized that advocacy can change the perception of rehabilitation from an optional service to a fundamental one that benefits the entire population. The WHA 76.6 resolution on rehabilitation was cited as a testament to advocacy’s impact but it was highlighted that collective efforts are now needed to ensure its implementation.

Connecting advocacy efforts

The panelists collectively discussed how WHO could connect advocacy efforts and engage service users in the Rehabilitation 2030 agenda. The World Rehabilitation Alliance (WRA) was highlighted as a pivotal initiative hosted by WHO, uniting stakeholders globally and focusing on rehabilitation advocacy across four key areas: primary care, research, workforce and emergencies. Interested stakeholders were encouraged to join the WRA. It was noted that WHO will additionally be scaling up communication efforts for rehabilitation in the coming months. The importance of appointing advocates within organizations was emphasized, to champion the cause and create a unified voice. The significance of consistency and coherence in advocacy was stressed, encouraging knowledge sharing among countries and the creation of a repository of advocacy practices.

Ms Marks:

"The World Rehabilitation Alliance has the potential to be a real game changer for our sector. It is a platform where we can all come together, to have a unified voice and to advocate for rehabilitation."

Sustainability in advocacy

During the Q&A session and closing remarks, sustainability in advocacy was a central topic. Panelists emphasized making advocacy relevant to key stakeholders, tailoring arguments, building advocacy communities, and identifying rehabilitation champions. They also highlighted the power of human stories in advocacy.
The session emphasized the importance of clear messaging, unity among advocates, and coordinated efforts to drive policy action and raise awareness about rehabilitation. It served as a reminder that advocacy is not merely about creating noise but about creating meaningful change in the realm of rehabilitation.

7.2 Closing remarks

Dr Bente Mikkelsen
(Director, Noncommunicable Diseases, WHO):
“As this meeting draws to a close, it is evident that the commitment to strengthening rehabilitation is stronger than ever. Now is the opportunity to follow up on the actions outlined in the historic resolution on rehabilitation that happened earlier this year. The moment is right for rehabilitation to be valued and given higher priority in countries. However, achieving this will require collective effort from all of us.”
7.3 Launch of the World Rehabilitation Alliance

The 3rd Global Rehabilitation 2030 meeting was followed by a concert by 3x Grammy award winner Ricky Kej, and an evening reception to mark the launch of the World Rehabilitation Alliance (WRA).

The significant occasion was acknowledged with key video remarks from Dr Tedros Ghebreyesus (Director-General, WHO), and Ms Emilia Clarke (British Actress and Co-founder, SameYou).

Dr Tedros:
“This new alliance is a powerful demonstration of the collaborative spirit of the rehabilitation community. By uniting our voices across sectors, we can raise the profile of rehabilitation and support its integration in the continuity of care across all countries.”

Ms Emilia Clarke:
“I have suffered two brain haemorrhages. So I know first-hand just how vital rehabilitation was to my recovery. And it is something that matters to millions and millions of people all around the world. And yet still, so many people do not get the access to it that they need. It is my absolute joy that my organization SameYou…but one of the inaugural members of the World Rehabilitation Alliance.”

The WRA launch and Ricky Kej’s concert was livestreamed on YouTube on 11 July, with 1,886 views to date.
What is the WRA?

The WRA is a WHO-hosted global network of stakeholders focused on undertaking rehabilitation advocacy activities to support implementation of the Rehabilitation 2030 initiative. The WRA aims to raise the profile of rehabilitation at a global, regional, national and local level and to support efforts to strengthen rehabilitation in health systems through advocacy actions. To do this, the WRA has two objectives:

1. Conduct evidence-informed advocacy activities
2. Strengthen networking and knowledge sharing within the rehabilitation sector

Who is involved?

The WRA is made up of 10 Steering Committee members, WHO Secretariat, and WRA member organizations. The organizations represent various stakeholder groups, including Member State and State bodies, intergovernmental organizations, nongovernmental organizations, private sector, philanthropic foundations, and academic institutions.

How does WRA operate?

All members participate in one or more of the WRA workstreams: primary care, research, workforce, emergencies and external relations. Each workstream has a corresponding 2-year workplan, which outlines their advocacy objectives, target audience and activities.

How do I find out more?

Visit https://www.who.int/initiatives/world-rehabilitation-alliance
8. Important links and related resources

3rd Global Rehabilitation 2030 meeting event page
https://www.who.int/news-room/events/detail/2023/07/10/default-calendar/3rd-global-rehabilitation-2030-meeting

Guide for rehabilitation workforce evaluation

Package of interventions for rehabilitation
https://www.who.int/activities/integrating-rehabilitation-into-health-systems/service-delivery/package-of-interventions-for-rehabilitation

Rehabilitation in health financing – opportunities on the way to universal health coverage
https://www.who.int/publications/i/item/9789240081826

Routine health information systems – rehabilitation toolkit
https://www.who.int/tools/routine-health-information-systems---rehabilitation-toolkit

Strengthening rehabilitation in health emergency preparedness, response and resilience: A policy brief
https://www.who.int/activities/strengthening-rehabilitation-in-emergencies

WHA 76.6 Resolution on “Strengthening rehabilitation in health systems”
https://apps.who.int/gb/ebwha/pdf_files/WHA76/A76_R6-en.pdf

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

World Rehabilitation Alliance webpage
https://www.who.int/initiatives/world-rehabilitation-alliance
## LIST OF PARTICIPANTS

Please note, the following list contains in-person participants only

### Member States

<table>
<thead>
<tr>
<th>Country</th>
<th>Name and Position</th>
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<tbody>
<tr>
<td>Australia</td>
<td>Ms Erica Bleakley</td>
</tr>
<tr>
<td></td>
<td>Allied Health and Rehabilitation Coordinator, National Critical Care and Trauma Response Centre</td>
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<tr>
<td>Azerbaijan</td>
<td>Mr Rovshan Safarov</td>
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<td></td>
<td>First Secretary, Permanent Mission of the Republic of Azerbaijan to the United Nations Office and other International Organizations in Geneva</td>
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<tr>
<td>Bahamas</td>
<td>Ms Heather Hanlan</td>
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<td></td>
<td>Director of Rehabilitative Services, Public Hospital Authority, Ministry of Health and Wellness</td>
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<tr>
<td>Belgium</td>
<td>Ms Pascale Delcomminette</td>
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<td>Administratice générale Wallonie-Bruxelles International</td>
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<tr>
<td>Burundi</td>
<td>Dr Jean de Dieu Havyarimana</td>
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<tr>
<td></td>
<td>Directeur du programme national intégré de lutte contre les maladies chroniques non transmissibles</td>
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<tr>
<td>Croatia</td>
<td>Dr Nikica Daraboš</td>
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<td>Minister Plenipotentiary, Permanent Mission of the Republic of Croatia to the UN Office and WHO in Geneva</td>
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<td>Ms Monica Stanovic</td>
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<td>Permanent Mission of the Republic of Croatia to the UN and WHO, Geneve, Switzerland</td>
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<tr>
<td>El Salvador</td>
<td>Mr Josue Henoch Cruz Garcia</td>
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<td></td>
<td>Especialista en Inclusión de la Oficina del Proyecto Creciendo Saludables</td>
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<tr>
<td>Ethiopia</td>
<td>Mr Mesoud Mohammed Ahmed</td>
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<td></td>
<td>Deputy Executive Officer, Strategic Affairs, Ministry of Health</td>
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<td></td>
<td>Mr Ameya Ermiyas Mulatu</td>
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<td>Team lead, Rehabilitation Desk, Ministry of Health</td>
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<td>Georgia</td>
<td>Dr Tamar Kurtanidze</td>
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<td>Head of the department of social protection, Ministry of Internally Displaced Persons, Labor, Health and Social Affairs</td>
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<td>India</td>
<td>Ms Noorin Bux</td>
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<td>Dr Neha Garg</td>
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<td>Israel</td>
<td>Mr Nitzan Arny</td>
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<td>Ms Meirav Eilon Shahar</td>
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<td>Mr Siba Khateeb</td>
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<td>Kenya</td>
<td>Dr Peace Mutuma</td>
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<td>Lao People’s Democratic Republic</td>
<td>Dr Khamsay Detleuxay</td>
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<td>Nepal</td>
<td>Dr Sangeeta Kaushal Mishra</td>
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<td>Mr Bisho Rup Khadka</td>
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<td>Pakistan</td>
<td>Mr Kamran Rehman Khan</td>
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<td>Russian Federation</td>
<td>Ms Anastasiia Bagdateva</td>
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<td>Mr Eduard Salakhov</td>
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<td>Sierra Leone</td>
<td>Mr Ismaila Kebbie</td>
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<td>Solomon Islands</td>
<td>Mrs Elsie Hilda Ningalo Taloafiri</td>
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<td>South Sudan</td>
<td>Mr Dominic Mading</td>
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<td>Spain</td>
<td>Dr Pilar Aparicio</td>
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<td>Ms Maria Ramiro Gonzalez</td>
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<td>Sweden</td>
<td>Mr Thomas Linden</td>
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<td>Syrian Arab Republic</td>
<td>Dr Rafif Dahieh</td>
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<td>Tajikistan</td>
<td>Mr Shodikhon Jamshed</td>
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<td>Uganda</td>
<td>Dr Daniel Kyabayinze</td>
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<td>Ukraine</td>
<td>Mr Oleksandr Kapustin</td>
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<td>Dr Mariia Karchevych</td>
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<td>Mr Vasyl Strilka</td>
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<td>Mr Valentyn Zhakun</td>
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<td>United Kingdom of Great Britain and Northern Ireland</td>
<td>Prof Carolyn McDonald</td>
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<td>Ms Anne Wallace</td>
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<td>United Republic of Tanzania</td>
<td>Dr James C. Kiologwe</td>
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<td>United States of America</td>
<td>Dr Theresa Cruz</td>
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<td></td>
<td>Ms Kirsten (Kiki) Lentz</td>
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<td>Dr Lana Shekim</td>
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<td>Ms Linda Thumba</td>
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</table>
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Mr Zelalem Dessalegn Demek
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Dr Antony Duttine
Rehabilitation Programme

Ms Sue Eitel
WHO Regional Office for Europe

Dr Nedret Emiroglu
Country Readiness Strengthening, Health Emergencies Programme

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Ms Nathalie Maggay  
WHO Regional Office for the Western Pacific

Ms Elanie Marks  
Rehabilitation Programme

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Director, Department of Noncommunicable Diseases

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Sensory Functions, Disability and Rehabilitation unit

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Dr Alexandra Rauch  
Rehabilitation Programme

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WHO Regional Office for Africa

Dr Hala Sakr  
WHO Regional Office for the Eastern Mediterranean

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Ms. Arveen Sodhi  
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Ms. Emma Tebbutt  
Access to Assistive Technology, Department of Health Product Policy and Standards

Ms. Kenza Zerrou  
Engagement Funds, Banks, Multilaterals

**Key**

* = WRA focal point  
** = WRA workstream co-chair
Annex 2: Agenda

PROVISIONAL AGENDA

DAY 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>8:00</td>
<td>Registration</td>
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<tr>
<td>9:00</td>
<td>Welcome and moderation</td>
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<tr>
<td></td>
<td>Dr Jérôme Salomon, Assistant Director-General, Universal Health Coverage/</td>
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<td>Communicable and Non Communicable Diseases, WHO</td>
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<td>Testimony</td>
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<td>Ms Madeline Niebanck, Stroke Survivor, Author, Advocate</td>
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<td>Opening remarks</td>
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<tr>
<td></td>
<td>• Dr Jérôme Salomon, Assistant Director-General, Universal Health Coverage/</td>
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<td>Communicable and Non Communicable Diseases, WHO</td>
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<td>• Dr Pilar Aparicio, Director General of Public Health, Spain</td>
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<td>• Deputy Minister Shodikhon Jamshed, Ministry of Health and Social Protection of</td>
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<td>Population of the Republic of Tajikistan</td>
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<td>• Dr Daniel Kyabayinze, Director Public Health, Republic of Uganda</td>
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<td>• Ms Pascale Delcomminette, Administratrice générale de Wallonie-Bruxelles</td>
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<td>• Dr Tedros Ghebreyesus, Director General, WHO (video message)</td>
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<tr>
<td>10:00</td>
<td>Rehabilitation 2030 in the context of the resolution on ‘Strengthening rehabilitation in health systems’ endorsed at the 176 World Health Assembly</td>
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<td>Dr Alarcos Cieza, Unit Head, Sensory Functions, Disability and Rehabilitation, WHO</td>
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<td>10:30</td>
<td>Morning tea</td>
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</table>
11:00 Change where it matters most; Progress and lessons for strengthening rehabilitation in countries

Moderator: Dr Pilar Aparicio, Director General of Public Health, Spain

Speakers:

- Multipronged approaches to strengthen rehabilitation in Nepal: Dr Sangeeta Kaushal Mishra, Additional Health Secretary, Ministry of Health and Population, Nepal
- Supporting leadership and planning in countries: Ms Heather Hanlan, Director of Rehabilitation Services, Public Hospitals Authority, Ministry of Health and Wellness, Bahamas
- Collaboration to develop and implement national rehabilitation plans in West Africa: Ms Celestine Akua Numatsi Esse, Project Officer, International Committee of the Red Cross, Togo
- Progress in expanding and strengthening rehabilitation services in Laos PDR: Dr Khamsay Detleuxay, Director General of Department of Health Care and Rehabilitation, Ministry of Health, Laos PDR

12:00 Lunch

EMERGENCIES (PREPAREDNESS, RESPONSE AND RECOVERY)

13:00 Lessons from the field: How prepared are we to respond to rehabilitation needs in emergencies?

Moderator: Dr Nedret Emiroglu, Country Readiness Strengthening, Health Emergencies Programme, WHO

Stories from:

- Conflict: Ms Mariia Karchevych, Deputy Minister of Health, Ukraine
- Disaster: Mr Ismaila Kebbie, Manager, National Physical Rehabilitation Program, Ministry of Health and Sanitation, Sierra Leone
- Outbreak: Dr Rachael Moses, National Clinical Advisor Respiratory, NHS England

14:00 Launch of the WHO policy brief: Strengthening rehabilitation in health emergency preparedness, readiness, response and resilience

Dr Hala Sakr, Regional Adviser, Violence, injuries and disabilities; and UAE Desk Officer, WHO Regional Office for the Eastern Mediterranean

Mr Peter Skelton, Emergency Medical Teams and Rehabilitation Programme, WHO

14:20 Afternoon tea
<table>
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<th>Time</th>
<th>Event</th>
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<tr>
<td>14:50</td>
<td><strong>Including rehabilitation in health financing to expand access to rehabilitation services</strong></td>
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<tr>
<td></td>
<td><strong>Moderator:</strong> Ms Kenza Zerrou, Engagement Funds, Banks, Multilaterals, WHO &amp; Dr Bruno Meessen, Senior Health Financing Advisor, Department of Health Financing and Economics, WHO</td>
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<td><strong>Presentations and panel discussion</strong></td>
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<td><strong>Overview to rehabilitation in health financing and ways forward.</strong> Ms Tamara Chikhradze, Results for Development, Health Systems Strengthening Accelerator</td>
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<td><strong>Using evidence to inform policy and action on rehabilitation in Scotland.</strong> Prof Carolyn McDonald, Chief Allied Health Professions Officer, The Scottish Government</td>
</tr>
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<td><strong>Defining a health benefit package inclusive of rehabilitation in Georgia,</strong> Dr Akaki Zoidze, Curatio International Foundation, Health Systems Strengthening Accelerator</td>
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<tr>
<td>15:45</td>
<td><strong>Launch of the WHO Rehabilitation in health financing: Opportunities on the way to universal health coverage</strong></td>
</tr>
<tr>
<td></td>
<td>Dr Pauline Kleinitz, Rehabilitation Programme, WHO</td>
</tr>
<tr>
<td></td>
<td>Dr Jody-Anne Mills, Disability, Rehabilitation, and Long-Term Care, WHO Western Pacific Regional Office</td>
</tr>
<tr>
<td>16:00</td>
<td><strong>Launch of the Package of Interventions for Rehabilitation</strong></td>
</tr>
<tr>
<td></td>
<td>Dr Binta Sako, Technical Officer, Universal health Coverage/Healthier Populations, WHO African Regional Office</td>
</tr>
<tr>
<td></td>
<td>Dr Alexandra Rauch, Rehabilitation Programme, WHO</td>
</tr>
<tr>
<td>16:20</td>
<td><strong>Enablers and drivers of expanded financing for evidence-based services</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Moderator:</strong> Ms Kenza Zerrou, Engagement Funds, Banks, Multilaterals, WHO &amp; Dr Bruno Meessen, Senior Health Financing Advisor, Department of Health Financing and Economics, WHO</td>
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<td><strong>Roundtable:</strong></td>
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<tr>
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<td>• Dr Ola Abualghaib, Manager, Technical Secretariat UN PRPD, UN Multi-Partner Trust Fund</td>
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<td>• Ms Tamara Chikhradze, Results for Development, Health Systems Strengthening Accelerator</td>
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<td>• Prof Emerita Gwynnyth Llewellyn, Head, WHO Collaborating Centre for Strengthening, Rehabilitation Capacity in Health Systems, The University of Sydney</td>
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<td>• Prof Carolyn McDonald, Chief Allied Health Professions Officer, The Scottish Government</td>
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<td>• Dr Akaki Zoidze, Curatio International Foundation, Health Systems Strengthening Accelerator</td>
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<td>Dr Alarcos Cieza, Unit Head, Sensory Functions, Disability and Rehabilitation, WHO</td>
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## DAY 2

### 9:00 Welcome to Day 2

**Recap:** Dr Alarcos Cieza, Unit Head, Sensory Functions, Disability and Rehabilitation, WHO

### WORKFORCE

**9:10** Information driven advocacy and action to strengthen the rehabilitation workforce

**Moderator:** Dr Khassoum Diallo, Unit Head, Data, Evidence and Knowledge Management, Health Workforce Department, WHO

**Stakeholders:**
- Dr Nassib Tawa, Centre for Research in Spinal Health and Rehabilitation Medicine, Kenya
- Dr Ferdiliza Garcia, Chair, Committee on Professional Standards and Ethics, Philippine Association of Speech Language Pathologists
- Mr Ritchard Ledgerd, Executive Director, World Federation of Occupational Therapists

**10:10** Launch of the Guide for Rehabilitation Workforce Evaluation

Dr Jody-Anne Mills, Rehabilitation Programme, WHO

Dr Cathal Morgan - Disability, Rehabilitation, Palliative and Long-Term Care, WHO

### EURO

**10:30** Morning tea

### HEALTH INFORMATION SYSTEMS

**11:10** Interactive panel: Bridging the knowledge gap - Evidence generation for decision-making and action for rehabilitation

**Moderator:** Dr Leanne Riley, Unit Head, Surveillance, Monitoring and Reporting, Department of Noncommunicable Diseases, WHO

**Panellists:**
- **Moving step by step towards using routine information for service delivery decisions,**
  - Mr Mesoud Mohammed Ahmed, Deputy to the Executive Officer of Strategic Affairs, Ministry of Health, Ethiopia
- **Clinical evidence for policy and service delivery decisions,** Dr Chester Ho, professor of Physical Medicine and Rehabilitation, Alberta Health Services, Canada
- **Health policy and systems research for policy decisions,** Dr Kaori Yamaguchi, Senior researcher, Department of Health and Welfare Services, National Institute of Public Health, Japan
- **Rehabilitation Data on the World Health Data Hub,** Mr Philippe Boucher, Unit head, Data Exchange team, Department of Data and Analytics, WHO

**12:10** Launch of the Routine Health Information Systems - Rehabilitation Toolkit

Dr Wouter De Groote, Rehabilitation Programme, WHO

Mr Ameel Mohammad, Technical Officer (Assistive Technology), WHO Regional Office for South-East Asia

**12:30** Lunch
13:30  Technical breakout rooms
   In-depth exploration of new WHO products
   
   **Room 1: Package of Interventions for Rehabilitation**, led by Dr Alexandra Rauch
   
   **Room 2: Guide for Rehabilitation Workforce Evaluation**, led by Dr Jody-Anne Mills
   
   **Room 3: Emergencies**, led by Mr Peter Skelton
   
   **Room 4: Collection and analysis of routine data for rehabilitation**, led by Dr Wouter De Groote
   
   **Room 5: Rehabilitation in health financing**, led by Dr Pauline Kleinitz

15:30  Afternoon tea

16:00  The need for rehabilitation advocacy
   
   **Moderator:** Ms Aleksandra Kuzmanovic, Social Media Manager, Leadership Unit, Department of Communications, WHO
   
   • **The power of advocacy**, Professor Sara Rubinelli, WHO Collaborating Center for Rehabilitation in Global Health Systems
   
   • **The importance of user driven advocacy**, Ms Jenny Clarke, Co-founder and CEO, SameYou
   
   • **WHO’s work on advocacy for rehabilitation**, Ms Elanie Marks, Rehabilitation Programme, WHO

16:45  Putting the resolution into action to strengthen rehabilitation in health systems: What’s next?
   
   Dr Antony Duttine, Technical Lead, Rehabilitation, WHO

17:00  Closing
   
   Dr Bente Mikkelsen, Director, Noncommunicable Diseases, WHO

17:30  Concert on the occasion of the launch of the World Rehabilitation Alliance
   
   Ricky Kej, 3x Grammy Award Winner

18:30  Reception