Four-phase process

1. Prepare for situation assessment
2. Collect data and information
3. Conduct assessment in the country
4. Write, revise, report, disseminate
5. Prepare for strategic planning
6. Identify priorities and produce first draft of plan
7. Consult, revise, finalize and complete costing of plan
8. Endorse and disseminate the strategic plan
9. Develop monitoring framework with indicators, baselines and targets
10. Establish evaluation review processes
11. Establish a recurring implementation cycle – the “plan, do and evaluate” (cycle)
12. Increase capacity of rehabilitation leadership and governance
GOVERNANCE, FINANCING, INFORMATION, WORKFORCE, TECHNOLOGY

1. Rehabilitation legislation, policies and plans
2. Leadership, coordination and coalition building for rehabilitation
3. Capacity and levers for rehabilitation policy and plan implementation
4. Accountability, reporting and transparency of rehabilitation
5. Regulation of rehabilitation and assistive technology
6. Assistive technology policies, plans and leadership
7. Assistive technology procurement processes

REHABILITATION FINANCING

8. Rehabilitation financing and coverage of the population
9. Scope of rehabilitation included in financing
10. Financing of rehabilitation and out-of-pocket costs

REHABILITATION HUMAN RESOURCES AND INFRASTRUCTURE

11. Rehabilitation workforce availability
12. Rehabilitation workforce training and competencies
13. Rehabilitation workforce management and planning
14. Rehabilitation workforce mobility, motivation and support
15. Rehabilitation infrastructure and equipment
REHABILITATION ACCESSIBILITY – AVAILABILITY/AFFORDABILITY/ACCEPTABILITY

20. Availability of specialized, high-intensity, longer stay rehabilitation
21. Availability of community delivered rehabilitation
22. Availability of rehabilitation in tertiary health care
23. Availability of rehabilitation in secondary health care
24. Availability of rehabilitation in primary health care
25. Occurrence of informal, self-directed rehabilitation
26. Availability of rehabilitation across the acute, sub-acute and long-term phases of care
27. Availability of rehabilitation across mental health, vision and hearing programmes
28. Availability of rehabilitation for target population groups based on country need
29. Early identification and referral to appropriate health and rehabilitation for children with developmental difficulties and disabilities
30. Availability of rehabilitation in hospital, clinical and community settings for children with developmental difficulties and disabilities
31. Availability of assistive products, including for mobility, environment, vision, hearing, communication and cognition
32. Availability of assistive products and their service delivery
33. Affordability of rehabilitation
34. Acceptability of rehabilitation
<table>
<thead>
<tr>
<th>Component</th>
<th>Definition</th>
<th>Needs no immediate action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Accountability, reporting and transparency for rehabilitation</td>
<td>Accountability for rehabilitation is the result of the process which ensures that health outcomes take responsibility of what are required to be done and are made accountable for their actions. A clear relationship between those making decisions and those affected by them. Reporting and reviewing the accountability and transparency for rehabilitation. Transparency is referring to the decision-making, stakeholder allocation, and assistance processes such as reporting.</td>
<td>Needs minor strengthening</td>
</tr>
<tr>
<td></td>
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<td>Needs major strengthening</td>
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<td></td>
<td></td>
<td>Needs establishing</td>
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<td></td>
<td>Score</td>
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<tr>
<td></td>
<td></td>
<td>Comments on maturity level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Possible actions</td>
</tr>
</tbody>
</table>

| Regulations of rehabilitation and assistive technology                  | Regulations of rehabilitation and assistive technology entails the implementation of rules and laws to ensure the provision of assistive products and services. As such, other processes and interventions by the state and in the context of client care. The aim of regulation is to ensure that the rehabilitation and assistive technology services are high-quality, efficiently, and effectively. |                                 |
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Programmes that support the provision of assistive product are good, they have moderately effective management.
<table>
<thead>
<tr>
<th>Input and processes</th>
<th>Output</th>
<th>Outcome</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rehabilitation governance</strong></td>
<td><strong>Rehabilitation services</strong></td>
<td><strong>Rehabilitation coverage</strong></td>
<td><strong>Rehabilitation impact</strong></td>
</tr>
<tr>
<td>- Rehabilitation integrated into health plans</td>
<td>- Rehabilitation in tertiary hospitals</td>
<td>- Multidisciplinary rehabilitation for people with complex needs</td>
<td>- Population functioning</td>
</tr>
<tr>
<td>- Routine rehabilitation reporting</td>
<td>- Rehabilitation bed density</td>
<td>- Rehabilitation coverage for specific population groups</td>
<td></td>
</tr>
<tr>
<td>- Rehabilitation-governing measures</td>
<td>- Rehabilitation beds and day programme places</td>
<td>- Assistive product coverage for specific population groups</td>
<td></td>
</tr>
<tr>
<td>- User engagement in governance</td>
<td>- Rehabilitation integrated into secondary care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Priority assistive product list</td>
<td>- Rehabilitation integrated into primary health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation financing</strong></td>
<td><strong>Rehabilitation delivered in the community</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Rehabilitation expenditure</td>
<td>- Assistive products in health facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Assistive product expenditure</td>
<td>- Clinical guidelines for rehabilitation</td>
<td></td>
<td></td>
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<tr>
<td><strong>Rehabilitation workforce</strong></td>
<td>- Rehabilitation standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Rehabilitation personnel density</td>
<td>- Rehabilitation timeliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- All rehabilitation personnel</td>
<td>- Rehabilitation waiting times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Rehabilitation graduates</td>
<td>- Length of rehabilitation episode</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Rehabilitation professional accreditation</td>
<td>- Episode intensity</td>
<td></td>
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</tr>
</tbody>
</table>
Core indicator 5: Rehabilitation bed density

Rehabilitation results chain: Output – Rehabilitation services

Rationale: Dedicated rehabilitation beds per capita is an indicator of the availability of specialist, high-intensity, longer stay rehabilitation services for the population.

Definition: The total number of rehabilitation beds per capita that are specifically reserved for rehabilitation clients. These are commonly in rehabilitation hospitals, centres, units and wards, and used for people requiring more intensive and specialized rehabilitation care.

Numerator: Total number of rehabilitation beds.

Denominator: Total population.

Disaggregation and additional dimensions: This can also include the number of funded places in a rehabilitation day programme. See limitations below and expanded indicator 13.

Method of measurement: Total number of rehabilitation beds/total population of country x 10 000.

Measurement frequency: Annually.

Monitoring and evaluation framework: Output and processes.

Preferred data sources: Data from Ministry of Health.

Other possible data sources and related links: /

Limitations: Intense rehabilitation day programmes, which exist in some countries, provide rehabilitation for a similar population group. While day programme places are generally not included in international comparisons, they can be included in the indicator at national level. Such beds are generally used for physical rehabilitation, but in some specialist facilities they may be used by people with mental health conditions.

References
Common experiences – Getting Started

• Both MOH or Development Partners (DPs) interested
• MOH recognise need, rehabilitation often neglected
• Long period from initial interest to commencing process, often 1-2 years
• MOH expressing initial interest yet sometimes unclear about focus of RGA
• MOH mostly requesting WHO for technical support for both situation assessment and strategic planning
• Significant preparation required
Common experiences - Utilizing RGA

- MOH commencing process without adequate capacity
- Rehabilitation leadership limited, expands during process
- Rehabilitation Technical Working Groups – formal & informal.
- Core group drives process (MOH, WHO, DP, Consultant, Practitioners). Consultants do the writing.
- Usual MOH bureaucracy and political issues
- Funding consultants - mix of WHO, USAID, HI, other DPs
- Consultant experience and capacity growing
- Increased rehabilitation knowledge, esp through workshops
- Each strategic plan specific to country but similarities emerging
Common experiences – Implementing Plans

• Limitations in MOH administrative capacity ongoing
• Leadership groups / platforms essential to ‘execute’
• Difficulty mobilizing additional MOH resources
• Additional support and time needed for creation of data sources for monitoring frameworks
• Long term commitment needed by MOH but changes due to politics and staff turnover etc
• Slow process of change, e.g. workforce development takes years
Overall benefits?

- High-level MOH attention, potentially support
- Creates leadership, widens the group/platform
- Builds understanding, creates shared vision
- Clarifies where/how to integrate rehab into health planning
- Brings MOH, WHO & DPs together
- MOH and DPs working & funding in the same direction
- Can breaks down professional silos, a united approach
- Creates data sources & integrates rehab into HIS
Experiences in:
Jordan
Myanmar
Guyana
Challenges?

• Of course!
• Let's discuss

What are the 4 key challenges and/or concerns in utilizing the RGA in your country?
Addressing Concerns and Challenges

Panel Discussion
Moving forward

• Start the conversation about rehabilitation & RGA
• Prompt senior MOH personnel
• MOH send request to WHO for technical assistance
• Reach out to WHO Regional Office and/or HQ
• Plan for process in advance – identify funds early
• Increase capacity of rehabilitation leadership
• Address any issues - disability confusion
• Learn from other countries
Who would like to undertake this process in their country?

Who can commit?
Thank you!