HEALTH SYSTEMS STRENGTHENING ACCELERATOR

JOINT LEARNING NETWORK For Universal Health Coverage

Joint Learning on Strengthening Rehabilitation in Primary Health Care Virtual Roundtable Series

Technical Report

February 2023

Background and Acknowledgements

Through funding from the Leahy War Victims Fund (LWVF) and partnership with USAID's Inclusive Development Hub, the Health Systems Strengthening Accelerator (Accelerator)[1] partnered with the Joint Learning Network for Universal Health Coverage (JLN)[2] to facilitate peer learning on rehabilitation in primary health care.

As a first step to initiating cross-country dialogue, the Accelerator and the JLN co-hosted a public webinar on Rehabilitation and Universal Health Coverage in February 2022, that invited country policymakers and practitioners to learn about and discuss approaches to strengthening rehabilitation for UHC. Over 150 participants from 30 countries joined the webinar, demonstrating considerable demand for cross-country learning.

In response, the Accelerator and the JLN hosted a Virtual Roundtable Series on Integrating Rehabilitation into Primary Health Care. From November 2022 to January 2023, 53 total participants from ministries of health, service delivery settings, non-governmental organizations, and universities in 18 countries came together to share their experiences advancing rehabilitation in health systems and primary health care and to co-develop a cross-country learning agenda.

This report is a synthesis of the virtual roundtable series. It:

- Synthesizes country experiences, challenges, and needs related to strengthening rehabilitation in primary health care, including (1) planning and prioritization; (2) strengthening the health workforce; and (3) enhancing data collection, generation, and analysis.
- Identifies a short-list of cross-country needs and learning priorities.

[1] The Accelerator partners with countries to address specific health system issues while institutionalizing country-driven processes for the selection, rapid testing, and purposeful scale-up of health system strengthening interventions. The Accelerator is led by Results for Development (R4D) with support from Health Strategy and Delivery Foundation (HSDF, headquartered in Nigeria), ICF, and a growing number of global, regional, and local partner organizations.

[2] The JLN is an innovative, country-driven network of practitioners and policymakers from 34 countries who learn from one another and co-develop global knowledge that helps bridge the gap between theory and practice to achieve universal health coverage.

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Executive Summary

Expanding rehabilitation in primary health care (PHC) is an important strategy to increasing access to services across the life course. Despite growing interest in expanding rehabilitation services in PHC, there is little practical guidance on how it can be done and what support is needed.

The objective of this roundtable series was to identify cross-country challenges, experiences, and lessons learned on the integration of rehabilitation in PHC and to develop a cross-country learning agenda and future potential activities on a prioritized topic.

Prioritization of rehabilitation in PHC is a major barrier to advancing rehabilitation's integration. A lack of awareness on rehabilitation was the most prioritized challenge identified by participants. Improving prioritization requires a simultaneous top-down and bottom-up approach. Advocacy to policy makers and planning for rehabilitative care is critical to improving policy frameworks and budget allocation for rehabilitation services. However, additional evidence-based models to provide rehabilitation in PHC are required to convince policy makers that the approach is feasible, cost-effective, and valuable.

It is critical that rehabilitation services can meet population demand. **Strengthening the health workforce** was stressed by participants. First, building the capacity of rehabilitation and non-rehabilitation professionals to deliver low-complexity services in community settings. Second, improving awareness of rehabilitation among the PHC workforce can strengthen referrals and increase service coverage.

Rehabilitation data generation and analysis provides the enabling conditions for prioritizing and planning for rehabilitation services and deploying the right mix of health workers. Data is critical to 'make the case' for rehabilitation to policy makers, and it can guide quality service provision at the PHC level.

Across these topics, participants prioritized one topic most critical for cross-country learning:

> How to improve awareness of rehabilitation across stakeholders – including government agencies, non-rehabilitation health care workers, and communities – to support its prioritization?

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Background

The Challenge – how can rehabilitation be integrated into primary health care?

Rehabilitation aims to improve functioning and reduce disability. Rehabilitation services are essential to ensuring continuity of care and represent one of the core components of Universal Health Coverage (UHC).[1] One third of the world's population needs rehabilitation at some point over the course of an illness or health condition,[2] and this need will only keep growing due to aging populations, surging non-communicable diseases (NCDs), and persisting conflict-induced injuries. However, rehabilitation is often under-prioritized in countries' health systems and UHC strategies, and especially so in low- and middle-income countries (LMICs).

The World Health Organization's (WHO) Rehabilitation 2030: Call for Action (Rehab 2030) is drawing attention to this gap and advocating for countries to recognize rehabilitation as a key component of UHC alongside promotive, preventive, curative, and palliative care.[3] Key to this is expanding access to rehabilitation within primary health care (PHC). Integrating rehabilitation into PHC could increase diagnosis of conditions benefiting from rehabilitation, improve early detection, and bring services closer to communities.[4]

Challenges, experiences, and lessons learned with integrating rehabilitation in primary health care

Three topics were prioritized for the roundtable series: (1) planning and prioritization, (2) strengthening the health workforce, and (3) enhancing data collection, management, and analysis. For each topic, participants discussed and shared context-specific challenges, successful approaches, and key lessons learned.

These topics are interrelated. Increased prioritization and stronger policy and planning frameworks can elevate rehabilitation within a country's health agenda, improve awareness, and increase budgetary commitment. But, as a participant from Malawi argued, "*if we generate demand, we need personnel.*" Building capacity of the workforce at the PHC level is critical to expanding access to quality services, both to those provided at the PHC level and at higher levels of care through patient referral pathways. Data systems are also needed to plan for the appropriate health workforce based on population needs. Improving data for rehabilitation in PHC can also improve prioritization and planning by raising awareness on how many people would benefit from rehabilitation. This data is equally critical to evaluate the coverage of rehabilitation services and to evaluate the effectiveness of those services in improving population health outcomes.

Each topic is described below, from the perspective of the roundtable participants.

Planning and Prioritization of Rehabilitation in Primary Health Care

"The main thing we need right now is advocacy and budgetary provisions!"
– Roundtable Participant

Background

The first roundtable focused on planning and prioritizing rehabilitation within PHC. Prioritization is defined as: (1) continued concern for an issue, (2) advancement of policies with consensus-based solutions, and (3) regular allocation of adequate public funding.[5] This definition equally prioritizes attention and commitment to rehabilitation.[6] A consistent barrier to advancing rehabilitation is a lack of understanding of what rehabilitation means, why it is important, and the extent of the population that can benefit from rehabilitative care. Because rehabilitation is multisectoral, fragmentation across government agencies may result in competing interests[7] and a lack of inclusion of rehabilitation in health planning processes.[4] Inclusion of rehabilitation within the MOH can establish health sector plans, policies, and regulations that include rehabilitation and ensure that rehabilitation is integrated into countries' UHC strategies.[4,8]

What are the challenges?

Participants identified four major barriers to the prioritization of rehabilitation in PHC: (1) lack of policy frameworks that guide service provision, (2) gaps in the existing health system make implementation challenging, (3) existing service delivery models and evidence on their effectiveness is limited, making it challenging to present clear solutions to policymakers, and (4) awareness of rehabilitation is low.

Lack of existing policy frameworks to provide rehabilitation services in PHC was described as an overarching challenge that prevents rehabilitation services from expanding to PHC. For example, without regulatory guidance on health worker standards, rehabilitation workers cannot practice at the PHC level.

Rehabilitation is not currently well integrated into the health system. Historic exclusion of rehabilitation services in PHC, and the health system more broadly, present implementation challenges to existing policies, and they may reduce prioritization of new rehabilitation policies because of a lack of evidence. For example, government budgets for rehabilitation remain limited, and rehabilitation is often not included in existing health insurance schemes. There is an acute shortage of needed rehabilitation health workers, stemming from a lack of rehabilitation's inclusion in medical school and the migration of trained professionals. Health management information systems (HMIS) often do not include rehabilitation indicators, making it challenging to plan for needed services.

Specifically, participants described a **lack of evidence for rehabilitation service delivery models**. Country participants from Uganda, Malawi, and South Africa indicated that a lack of data on effective service delivery models prevents successful advocacy with both MOH and donors. Lack of evidence on how rehabilitation can be delivered in PHC, and which specific services should be provided by which types of health workers is a challenge.

As a result, **low awareness of rehabilitation** was described across all countries. Participants in South Africa, Kenya, and Uganda described low community demand from services due to a lack of awareness of what rehabilitation is and the benefits. There is need for both a bottom-up approach for sensitizing communities and a top-down approach for advocating to governments.

How can planning and prioritization be improved? Learning from participant experiences

Participants identified multiple strategies to support the development of rehabilitation policies and plans and build further awareness on what rehabilitation is and why it is important. Such strategies shared included more clearly defining the problem, showcasing possible solutions via successful service delivery models, and working across stakeholders. Table 1 summarizes experiences and lessons learned across participants.

Table 1. Summary of the experiences and lessons learned for prioritization and planning

What is working?	What are the lessons learned?
• Assessments and evidence generation, which help define the problem and inform plans and improve awareness. • Comprehensive stakeholder engagement • Providing solutions: Build awareness in the community through mobile service units (Nigeria); improving provision of low-complexity services in the community (Colombia) • Building awareness through policy and planning processes	The following are key to strengthening rehabilitation in PHC: • Leadership commitment and stewardship of the process • Stakeholder coordination and cohesion – "move as one" • Sustained advocacy and awareness building. • Ensuring services are participatory by working with patient and persons with disability groups. • "Never waste a good crisis"- use the opportunity to raise awareness of rehabilitation and its inclusion in PHC

In **Ethiopia**, there is increasing need for rehabilitation services; however, rehabilitation is not included in most health sector strategies, including those related to PHC. In response, the Ministry of Health has developed new strategies to promote the integration of rehabilitation in PHC: (1) a National Rehabilitation Service and Assistive Technology Strategy Plan, (2) a priority list for assistive technology (AT), and (3) a rehabilitation information system to integrate into the national HMIS. Planning for integration into PHC has begun through the development of a landscape analysis for rehabilitation service integration at the PHC level. Sustained advocacy and high-level leadership support has been critical throughout the process.

In **Malaysia**, integration of rehabilitation in PHC started with a 'children with special needs' program at PHC clinics, which led to the expansion of rehabilitation services for the elderly. The phased approach has led to the gradual expansion of the

workforce, beginning with doctors, and then adding physiotherapists and rehabilitation specialists. A cluster hospital system simplifies the planning process by combining a lead hospital (with specialty services) with other hospitals that do not have specialists. Now, Malaysia is working to strengthen its health system – including financing, human resource, and the supply chain for AT – to ensure that promised services can be reliably provided.

In **Uganda**, services are provided largely by the private sector and donor funded programs, and there was no strategic roadmap to guide rehabilitation. An interim technical working group (TWG) was established to improve rehabilitation planning. A series of national and regional stakeholder consultations and consensus workshops with were held with key stakeholders – Ministry of Health, Ministry of Gender, Labour, and Social Development, Ministry of Education, development partners, Civil society organizations, organizations of persons with disabilities, and rehabilitation and AT health workers. The WHO Strategic Systematic Assessment of the Rehabilitation Situation (STARS) was conducted to identify how rehabilitation is integrated into the health system and areas for improvement. As a result, Uganda is developing its first rehabilitation strategic plan. The comprehensive process also increased awareness of rehabilitation through extensive stakeholder consultations.

Resources on planning and prioritization

Existing resources with guidance on how to assess governance capacities and incorporate rehabilitation into planning processes are provided below.

Specific to rehabilitation, the WHO's Rehabilitation in Health Systems: Guide for Action includes the following resources:

- The Systematic Assessment of the Rehabilitation Situation (STARS): a tool to identify rehabilitation strengths and areas for improvement in the broader health system
- Guidance for Rehabilitation Strategic Planning (GRASP): a process for developing a strategic plan
- Framework for Rehabilitation Monitoring and Evaluation (FRAME): a monitoring and evaluation tool for a rehabilitation strategic plan

There are also general planning and prioritization resources available from the JLN that could be adapted for rehabilitation specific needs:

- Strategic Communications for UHC: Practical Guide: a guide that provides step-by-step insights on how to raise awareness of an issue across key stakeholders.
- Making the Case for Health: A Messaging Guide for Domestic Resource Mobilization: A guide for developing evidence-based arguments for investing in health.
- Costing of Health Services for Provider Payment: A Practical Manual: A step-by-step, practical guide to costing health services, which could be applied to rehabilitation services and inform planning and financing.

Improving Workforce Capacity for Rehabilitation in Primary Health Care

Background

The second roundtable focused on strengthening the health workforce to provide rehabilitation in PHC, including sub-topics on screening and referrals and delivering rehabilitation services in communities. Providing rehabilitation services within PHC requires innovative service delivery and workforce models to complement hospital-based care.[8,9] Building the capacity of existing health workforce cadres - including nurses, primary care officers, and community health workers (CHWs) - to provide rehabilitation through protocol-based care approaches can improve access to rehabilitation for common conditions.[4]

What are the challenges?

Participants from many countries (Uganda, Malawi, Ethiopia, India, Nigeria, Kenya) indicated that there are little to no rehabilitation services in PHC, while other participants (Malaysia, Philippines, South Africa, Colombia) suggested that limited services were provided in PHC. Two major challenges uniting these diverse contexts were (1) insufficient number of skilled rehabilitation professionals and (2) limited awareness of rehabilitation among the PHC workforce, leading to an underutilization of the referral network.

There are multiple challenges leading to an **insufficient number of rehabilitation professionals**. From the perspective of participants, rehabilitation professionals work mostly in the private sector, hospitals, or urban areas, which limits access. Additionally, there is limited inclusion of rehabilitation in pre-service training. In-service training initiatives are variable and often conducted by specific programs or districts instead of nationwide. Additionally, professionals are often 'generalists' who cannot always meet the specific needs of patients with multiple complex functioning challenges. Participants also indicated that the rehabilitation profession is often mis-interpreted as physiotherapy; however, a diversity of specialists (e.g., physiotherapy, occupational therapy, speech and language therapists, audiologists, and more) are needed as well.

Second, the **limited awareness of rehabilitation among the PHC workforce** was seen as the major barrier to expanding referrals from PHC to secondary and tertiary levels of care. Community and PHC workers often do not know how to screen or diagnosis conditions in need of rehabilitation, limiting access to services even when they are available.

How can the health workforce be strengthened? Learning from participant experiences

Table 2. Summary of the experiences and lessons learned for prioritization and planning

What is working?	What are the lessons learned?
• Network approach, tried in Nigeria: hospitals actively work with lower-level facilities in their catchment area to increase referrals and build skills of lower-level facilities • Having rehabilitation professionals train and/or share knowledge with PHC workforce • Including rehabilitation in existing pre-service and in-service training programs for non-rehabilitation specialists	• Leadership commitment at all levels – ministries of health and hospital management are critical • Increased awareness of rehabilitation among health care professionals is a barrier to improving access to care for patients • More attention is required to increasing the number of skilled rehabilitations professionals

In **India**, the Ministry of Health and Family Welfare has started a large-scale reform, Ayushman Bharat, to expand financial protection and transform existing PHC centers and sub-health centers into a comprehensive PHC model through Health and Wellness Centers. At this stage, the focus has been on using community health officers to promote referrals for rehabilitative care, which is available in tertiary health centers. Specific training models with specific rehabilitation skills need to be developed and supportive supervision provided at the community level to equip lower-level cadre workers with more rehabilitation knowledge.

The University of **Nigeria**'s Teaching Hospital Enugu is increasing screening and referrals to rehabilitation in the community by partnering with regional comprehensive health centers in their catchment area to identify patients. Approaches included establishing a physiotherapy unit in the regional health center, posting a resident to increase identification of cases, and improving the definition of cases that require referral.

In **Colombia**, previous civil conflict has led to increased need for rehabilitation. Strengthening human resource capacities is important to improving quality standards in health services. A multi-part approach has been taken to train health workers including rehabilitation in undergraduate and postgraduate training programs, working with guilds and unions, and increasing available internships and virtual courses to increase trained professionals. Tele-education is also being used to increase training opportunities. Additional sensitization has been undertaken to improve health managers' understanding of rehabilitation's ability to generate financial resources and positive health outcomes.

Resources on health workforce

- Physiopedia: an online repository of education, online courses, and other resources for rehabilitation professionals.
- OpenTeleRehab: multidisciplinary telerehabilitation software designed for limited internet connectivity and offline use. Facilitates discharge, transition of care and follow-up across a variety of clinical domains.
- Basic Rehabilitation Package: A Resource for Primary Health Care and Low-resource Settings: This resource is under development by the WHO.
- Access to Rehabilitation in Primary Health Care: An Ongoing Challenge: this resource from WHO provides high-level insights on strengthening the health workforce and emerging service delivery models.
- Designing Health Benefits Policies: A Country Assessment Guide: A practical guide to developing and implementing (non-rehabilitation specific) benefits packages. This JLN resource was developed and piloted by six countries.
- Making Explicit Choices on the Path to UHC: Guide for Health Benefits Package Revision: a guide for revising existing benefits packages, developed from the experience of 14 LMIC countries.

Enhancing rehabilitation data collection, management, and analysis capabilities

"You can't get data because there are no services, but there are no services because you don't have data."

- Roundtable participant

Background

The third and final roundtable focused on enhancing rehabilitation data collection, management, and analysis capabilities in PHC. Most contexts have limited data on rehabilitation within PHC, including information on the prevalence of specific conditions, services accessed, referrals completed, and patient outcomes.[4] This is important data to inform human resource planning and budgeting for rehabilitation within PHC. Including rehabilitation in countries' HMIS is also important to providing routine data for planning, decision making, and monitoring and evaluation efforts.[4]

What are the challenges?

Participants shared concern in ensuring the data collection and analysis translates to practical benefits for service providers and service users. However, limited investment in data for rehabilitation has led to several practical challenges.

Most participants described **limited electronic systems** for collecting and reporting data in their country. As a result, there are no large datasets available for rehabilitation-related analysis or research.

When there is data, that **data is often fragmented and incomparable**. In South Africa, for example, available data systems varied across regional, state, or district/provincial

levels, which limits a coordinated national approach. Participants from Nigeria and Malaysia described hospital-based data systems that contain different indicators based on the hospital and do not combine into a larger data set.

Finally, despite the recent development of global resources, there is a lack of clarity at the country level regarding the most **essential indicators to collect**. This is particularly true for which indicators to collect at the PHC level.

These challenges reflect the lack of prioritization of rehabilitation and the limited health workforce. Inability to capture patient needs or services provided was raised as an underlying reason behind lack of budget allocation. For example, in South Africa, the national indicator for rehabilitation contains only two indicators – the number of wheelchairs issued, and the number of hearing aids issued. This reflects a limited understanding of rehabilitation specialties and fails to account for broader services that health workers are providing.

How can the data for rehabilitation be improved? Learning from participant experiences

Dr. Wouter de Groote from the WHO shared four types of data and how it can be used to strengthen PHC (Table 3).

Table 3. Types of data and their importance in PHC

Type of data	Examples of what to collect in PHC	Examples of how the data can be used
Routine data	• Utilization and uptake of services • Availability of basic rehabilitation interventions • Geographical distribution of services • Continuum of care	• Assess rehabilitation's integration into the health system • Geographic coverage
Clinical records	• Patient needs • Clinical outcomes • Referral pathways	• Document rehabilitation needs and whether they have been met • Cost-effectiveness
Research	• Prevalence of risk factors • Effectiveness data • Rehabilitation models	• Inform effective models of care
Population-level data	• Epidemiological data • Levels of functioning • Effective coverage	• Inform rehabilitation planning • Determine level of universal coverage

Building on a top-down approach to strengthening data capacities, participants shared country experiences improving data for rehabilitation.

Rural Rehab **South Africa** has taken a bottom-up approach to strengthening data availability and use in a rural hospital. An electronic patient management system was developed to schedule community follow-ups, but expanded over time to include active case management, service user population data, services provided, service needs, wait times, and coverage. Successful implementation of the system required close engagement of service providers to improve data literacy and to ensure that the data collected was important and useful for improving their work. The data has become an important advocacy tool for rehabilitation in South Africa and the model is working on how to increase its impact.

Resources on data collection, management, and analysis

- The WHO Routine Health Information Systems - Rehabilitation Module: A guidance document on the incorporation of rehabilitation into HMIS, including a set of core indicator from the DHIS2.0 rehabilitation module and further guidance on data collection, quality, and analysis.[7]
- The WHO's Rehabilitation Indicator Menu: this resource builds on the indicators provided in DHIS2.0[8] and is available for country use.
- OpenMRS: collaborative open-source project for electronic health records

Future directions: what is needed to improve the integration of rehabilitation into PHC?

Roundtable participants prioritized the following topic where a cross-country implementation learning activity could have the greatest impact:

- **How to improve awareness of rehabilitation?** Participants expressed a strong need for awareness of what rehabilitation is, why it is important, and its benefits. Awareness raising is needed across stakeholders – including government agencies, non-rehabilitation health workers, and communities.

Additional topics of interest to country participants:

- Training resources and tools to build the capacity of the PHC workforce to deliver rehabilitation services in the community
- A benefits package or checklist of services that can be feasibility provided in PHC *(note: this is under development by the WHO)*
- Financing models for rehabilitation in primary care, including tools for costing, provider payment, and revenue raising (*note: general tools for health service costing, provider payment, and domestic resource mobilization are available from the JLN*)
- Evidence on the effectiveness and cost-effectiveness of rehabilitation service delivery models
- Prioritized set of indicators for rehabilitation data systems *(note: resources available from the WHO)*

Available resources on these topics are provided in the links above.

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Annex

Roundtable One Agenda: Planning and Prioritization of Rehabilitation in Primary Health Care

Tuesday, November 29th, 2022
6:00 to 7:30am EST

Content	Facilitator
Introduction to Participants and Joint Learning Approach • What is joint learning? • Purpose of the roundtable series • Ground rules for our sessions • Get to know participants	Daniela Gutierrez, Reva Alperson, and Rachel Neill, Health Systems Strengthening Accelerator (Accelerator)
How can rehabilitation be prioritized in PHC? • Sharing of country experience on prioritization • Small group discussion on prioritization and learning needs • Report out	Binyam Kemal, Deputy Director for Clinical Service Directorate, Ministry of Health Ethiopia Small group discussion
Planning for rehabilitation: challenges and opportunities • Sharing of country experiences on planning for rehabilitation • Small group discussion on planning and learning needs • Report out	Gerald Okello, Technical Coordinator, ReLAB-HS, Uganda Small group discussion
Closing discussion • Reactions from participants and suggestions for future joint learning • Preview of roundtable two *The virtual room will stay open for further discussion, questions, and suggestions for facilitators.*	Rachel Neill, Accelerator

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Roundtable Two Agenda: Improving Workforce Capacity for Rehabilitation in Primary Health Care

Tuesday, December 6th, 2022
6:00 to 7:30am EST

Content	Facilitator
Introduction • Introduction to the series • Get to know participants	Health Systems Strengthening Accelerator (Accelerator)
Delivering rehabilitation in the community: challenges and opportunities for learning • Spotlight on experiences from India and Colombia • Small group discussion and identification of learning needs	Dr. U Venkatesh, All India Institute of Medical Science Yenny Maritza Alvarado Rojas, Weaving Lives and Hope – USAID OIM Small group discussion
Strengthening screening and referrals in PHC to improve access to rehabilitation • Spotlight on experiences from Nigeria • Group exercise	Dr. Obiekwe Chinwe, University of Nigeria Teaching Hospital Group exercise
Closing discussion • Reactions from participants and suggestions for future joint learning • Preview of roundtable three *The virtual room will stay open for further discussion, questions, and suggestions for facilitators.*	Rachel Neill, Accelerator

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Roundtable Three Agenda: Enhancing rehabilitation data collection, management, and analysis capabilities

Thursday, January 12th, 2023
6:00 to 7:30am EST

Content	Facilitator
Introduction • Get to know participants • Recap of the previous sessions	Health Systems Strengthening Accelerator (Accelerator)
Data for rehabilitation in PHC: country experiences • Framing presentation: the importance of rehabilitation data in PHC • Country experience spotlight: South Africa • Small group discussion • Report out on learning topics	Wouter De Groote, Technical Advisor, World Health Organization Rehabilitation Programme Dr. Kate Sherry, South Africa Small group discussion and group report outs
Priorities for learning: rehabilitation in PHC • Group exercise on learning topics across the three roundtables • Reflections from participants	Group poll exercise Rachel Neill, Accelerator
Closing discussion • Summary of the series • Next steps and staying in touch *The virtual room will stay open for further discussion, questions, and suggestions for facilitators.*	Rachel Neill, Accelerator

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