Webinar: Rehabilitation and Universal Health Coverage
February 2, 2022
Welcome!
Please introduce yourself in the chat box by sharing your name, position, and country.
Zoom functions

1. Please **turn off** your video if you have low bandwidth and to improve your connection.

2. Please be sure to **connect your audio** either by **phone** or directly **through your computer**.

3. All participants will be **muted** for the duration of the webinar.
4. Please submit all questions and comments using the group chat box.

5. The webinar will be recorded and a link to the recording will be shared afterwards.
Zoom functions (cont.)

6. When the host of the meeting shares a poll, a new icon “Polling” appears. If the polling window does not open automatically or if you close it by mistake, click on the “Polling” button to open the window.

When the polling window is open, select your answer(s) and click **submit**.
# Webinar agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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</thead>
</table>
| 15 mins | **Welcome**  
| • Overview of agenda and objectives  
| • Opening remarks  
| • Icebreaker |
| 15 mins | **WHO Presentation:** Rehabilitation as an essential part of UHC |
| 55 mins | **Facilitated expert panel and Q&A:** Country experiences with rehabilitation and UHC |
| 5 mins  | **Closing**  
| • Explore interest for continued learning |
Webinar objectives

Respond to country demand on the need to prioritize rehabilitation services in countries health systems and UHC strategies by responding to three learning objectives:

1. Learn about the importance of rehabilitation services and why are they an essential part of UHC
2. Share countries’ experience with rehabilitation, including how its currently integrated in health systems and UHC strategies
3. Assess country demand for continued joint learning around rehabilitation and UHC
Who is in the room?

- Representatives from Ministries of Health, private sector, civil society, development partners and practitioners
- 49 countries
Opening remarks

With Kirsten Lentz, USAID and Kamiar Khajavi, JLN
Icebreaker

Please submit your answers to the polls once the window appears on your screen.

Polls:
1. Have you or someone you know experienced a need for rehabilitation? (Y/N)
2. Was the need for rehabilitation met? (Y/N)
3. Rehabilitation in my country is easily accessible for most people (Agree/Disagree)
Rehabilitation as an Essential Part of UHC

Alarcos Cieza, MSc, MPH, PhD
Vision // Hearing // Rehabilitation // Disability
Department of Noncommunicable Diseases

World Health Organization

ciezaa@who.int | Twitter:@AlarcosC
A challenge in the changing world …

The number of people with limitations in functioning in everyday life
Number of people with limitations in functioning associated to Covid-19 still to be seen
<table>
<thead>
<tr>
<th>Rehabilitation Category</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>2,366,148,316</td>
</tr>
<tr>
<td>Musculoskeletal disorders</td>
<td>1,596,649,206</td>
</tr>
<tr>
<td>Sensory impairments</td>
<td>649,151,912</td>
</tr>
<tr>
<td>Neurological disorders</td>
<td>296,277,078</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>181,442,646</td>
</tr>
<tr>
<td>Chronic respiratory diseases</td>
<td>155,073,573</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>42,787,394</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>14,383,164</td>
</tr>
</tbody>
</table>

WHO REHABILITATION NEEDS ESTIMATOR
https://vizhub.healthdata.org/rehabilitation/
Rehabilitation Optimizes Functioning

- Communication
- Mobility
- Self-care
- Ingestion
Functioning

Sleeping
Breathing
Managing stress
Communicating

Relationships
Seeing
Dressing

Working
Moving around
Hearing
Playing

Dressing
Hearing
Playing
2.4 Billion people experience health conditions that could benefit from rehabilitation.
In many countries <50% receive the rehabilitation services they require.
Call to action
Equity
Equity

Everyone who needs rehabilitation receives quality services to optimize and maintain their functioning in everyday life
Universal Health Coverage

- Provision of **high-quality**, essential services for
  - Health promotion,
  - Prevention,
  - Treatment,
  - **Rehabilitation** and
  - palliation

  according to need

- Protection from **financial hardship**
SPECIALIZED, HIGH-INTENSITY REHABILITATION
Predominantly tertiary care for people with complex rehabilitation needs during the acute and sub-acute phase of care. Commonly occurs in longer-stay rehabilitation hospitals, centres, units and departments.

REHABILITATION INTEGRATED INTO MEDICAL SPECIALTIES IN TERTIARY AND SECONDARY HEALTH CARE
For people with less complex needs & often for a short period during the acute & sub-acute phase of care. Commonly occurs in tertiary and secondary level hospitals & clinics.

REHABILITATION INTEGRATED INTO PRIMARY CARE
Delivered within the context of primary health care, which includes the services and professionals that act as a first point of contact into the health system. Commonly occurs in primary health care centres, practices and may include community settings.

COMMUNITY-DELIVERED REHABILITATION
Predominantly secondary care delivered in community settings during the sub-acute and long-term phases of care. Commonly by means of multiple programmes that provide care in homes, schools, workplaces and other community settings.

INFORMAL AND SELF-DIRECTED REHABILITATION
This form of rehabilitation occurs where no rehabilitation or health personnel are present. Commonly occurs in homes, schools, parks, health club or resorts, community centres and long-term care facilities.
Strengthening the Health System

- Governance and leadership
- Essential medicines and technologies incl. AT
- Health workforce
- Financing
- Health information system

Integrated rehabilitation as part of UHC
Strengthening the Health System

The **systematic process** that Ministry of Health and relevant partners engage in to **build up** and **integrate** the six building blogs
WHO technical tools to strengthen each building block

Leadership and governance
- DHIS2- REHAB MODULE

Information systems
- Rehabilitation in health financing technical resource

Financing
- Rehabilitation in health financing technical resource

Workforce
- GATE Global Cooperation on Assistive Technology

Assistive Technology

Service delivery
- Package of interventions for rehabilitation

Assistive Technology
WHO technical products and tools

- Emergencies
  - Emergency Preparedness Toolkit
  - COVID-19 Products
- Information systems
  - DHIS2-REHAB MODULE
  - Global Indicators
  - Functioning measure
- Workforce
  - Rehab in Health Financing
  - Rehab Expenditure Tracking and Reporting
  - Rehab Return on Investment Case
- Financing
  - PHC: Practical Guidance on Rehabilitation
  - Basic Rehab Package
- Service delivery
  - Access to rehabilitation
  - PHC: Primary Health Care
- Assistive Technology
  - Package of Interventions for Rehabilitation
- Leadership and governance
To provide information to MoHs for

- service planning
- budgeting
- implementation

Package of Rehabilitation Interventions
- Interventions
- Resources (APs)
- Equipment, Consumables
- Service delivery platforms
- Rehabilitation Workforce
- Time

$
Health Financing as part of UHC

1. Desk Review
   - 138 Documents

2. Key Informant Interviews
   - 25+ interviews

3. Input from Countries
   - 12 webinars
   - 40 countries
   - 160 participants

4. Analysis and framing

5. Finalization and launch
   - WHO-HSSA Ongoing
   - Mid 2022

Coming soon...
• To strengthen the rehabilitation workforce
• through supporting competency-based education, regulation, recruitment and other quality building initiatives
Country Health Information System (HIS)

Population-based data
- Population-based surveys
- Surveillance systems
- Census

Birth and death data
- Birth and death registration
- Causes of death

Health Service Data
- Routine Health Information Systems (RHIS)
  - Health facility assessments
- Health service resource data

District Health Information System Module
Four-phase process

1. Prepare for situation assessment
2. Collect data and information
3. Conduct assessment in the country
4. Write, revise and finalize report, disseminate and communicate findings
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 and review processes
11. Establish a recurring implementation “plan, do, evaluate” cycle
12. Increase capacity of rehabilitation leadership and governance

Phase 4. ACTOR

Phase 3. FRAME

Phase 2. GRASP

Phase 1. STARS

PHASE 12 MONTHS

Prepare for strategic planning
Identify priorities and produce first draft of plan
Consult, revise, finalize and complete costing of plan
Endorse and disseminate the strategic plan
Develop monitoring framework with indicators, baselines and targets
Establish evaluation and review processes
Establish a recurring implementation “plan, do, evaluate” cycle
Increase capacity of rehabilitation leadership and governance

World Health Organization
The challenge

The number of people with limitations in functioning in everyday life…

… is waiting for all of us to continue working together to strengthen rehabilitation
Thank you
Panel Session: Country experiences with rehabilitation and UHC

Maryke Bezuidenhout
Rural Physiotherapist, South Africa

Dr. Akanle Olufunke
Registrar/CEO at the Medical Rehabilitation Therapists Regional Board of Nigeria (MRTB)

Dr. Adolfo Martinez Valle
Steering Group Convener at JLN; Researcher and Professor of Policy, Population, and Health at Universidad Autonoma de Mexico
1. What does coverage for rehabilitation look like in your country and how has the COVID-19 pandemic affected this?

Maryke Bezuidenhout, South Africa
Highly unequal society
Upper middle-income; GDP = $351 B
Gini coefficient = 0.63 (high)
Human Capital index = 0.41 (low)
Large informal sector; Tax base: 2.6 M

Inequality & fragmentation in health system
84% population access public sector; but 49% THE (salary)
16% private sector; but 51% THE4 (FFS)
Access, quality, retention in care, FRP

Total Health Expenditure
8.7% GDP spending for poor health outcomes

Significant spending on welfare
R1.827 B on social spending5
DG, CSG, OAP

Road Accident Fund
- Fuel levy
- Governance issues

Workman's Compensation Fund
- Annual employer contributions
- Informal sector & enforcement of labor law

Social determinants of health:
Historical inequalities and current challenges around governance / implementation

1 Statistics South Africa, 2019 2 World Bank, 2019 3 National Treasury, South African Revenue Services, 2018
4 NhI White Paper, 2017 5 National Treasury, 2019
Shifted all moderate and severe disability services to home level

- Address governance issues
- Explicit priority setting
- Amalgamation of separate patient databases
- Development of electronic patient management system
- Task sharing, role release
- Strengthened end user involvement in service delivery
### Indicators: Cerebral palsy program 0-18 years

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</tr>
</thead>
<tbody>
<tr>
<td>Number children: CP 0-18y</td>
<td>136</td>
<td>133</td>
<td>53</td>
<td>46</td>
<td>51</td>
<td>43</td>
<td>33</td>
<td>30</td>
</tr>
</tbody>
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### General rehabilitation program statistics: Cerebral Palsy services

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</thead>
<tbody>
<tr>
<td>Seen for follow up rehab in last 6 months</td>
<td>61</td>
<td>113</td>
<td>31</td>
<td>36</td>
<td>22</td>
<td>40</td>
<td>7</td>
<td>26</td>
</tr>
<tr>
<td>Coverage rate: received at least one session in the last 6 months</td>
<td>45%</td>
<td>85%</td>
<td>58%</td>
<td>78%</td>
<td>43%</td>
<td>93%</td>
<td>21%</td>
<td>87%</td>
</tr>
<tr>
<td>Average number of rehab sessions received in last 6 months</td>
<td>2</td>
<td>4</td>
<td>1.3</td>
<td>6</td>
<td>0.7</td>
<td>4</td>
<td>0.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Total number OPD/clinic sessions in 6 months</td>
<td>116</td>
<td>145</td>
<td>68</td>
<td>76</td>
<td>35</td>
<td>26</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>Total number home visit sessions in 6 months</td>
<td>14</td>
<td>518</td>
<td>No data</td>
<td>141</td>
<td>No data</td>
<td>161</td>
<td>No data</td>
<td>96</td>
</tr>
<tr>
<td>Average number rehabilitation home visits offered per month for cohort</td>
<td>2</td>
<td>86</td>
<td>No data</td>
<td>24</td>
<td>No data</td>
<td>27</td>
<td>No data</td>
<td>16</td>
</tr>
</tbody>
</table>

### Wheelchair and seating services: Cerebral Palsy

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Total eligible for seating device</td>
<td>104</td>
<td>141</td>
<td>34</td>
<td>35</td>
<td>30</td>
<td>38</td>
<td>21</td>
<td>26</td>
</tr>
<tr>
<td>Total received seating device</td>
<td>70</td>
<td>131</td>
<td>11</td>
<td>29</td>
<td>22</td>
<td>36</td>
<td>19</td>
<td>26</td>
</tr>
<tr>
<td>Seating coverage rate</td>
<td>67%</td>
<td>93%</td>
<td>32%</td>
<td>83%</td>
<td>73%</td>
<td>95%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Seating review rate: one follow up review in last year</td>
<td>33%</td>
<td>81%</td>
<td>0%</td>
<td>80%</td>
<td>17%</td>
<td>84%</td>
<td>50%</td>
<td>88%</td>
</tr>
<tr>
<td>Seating review rate: 2 follow ups reviews in last year</td>
<td>10%</td>
<td>65%</td>
<td>0%</td>
<td>64%</td>
<td>0%</td>
<td>76%</td>
<td>17%</td>
<td>60%</td>
</tr>
<tr>
<td>Average age at receiving first seating</td>
<td>12</td>
<td>10</td>
<td>4.4</td>
<td>2.1</td>
<td>7.5</td>
<td>6.5</td>
<td>11.5</td>
<td>10.6</td>
</tr>
</tbody>
</table>
Supporting factors

- Improvements in data management
- Improvements in coordination of care
- Strengthening end-user involvement in service delivery
- Decentralizing care to community level
1. What does coverage for rehabilitation look like in your country and how has the COVID-19 pandemic affected this?

Dr. Akanle Olufunke, Nigeria
Rehabilitation in Nigeria

- As of 2020, there are reportedly **over 27 million Nigerians** living with some form of disabilities.

- The five most common types of disabilities in Nigeria are, **visual impairment, hearing impairment, physical impairment, intellectual impairment, and communication impairment**.

- It is urgent to support Nigeria to address the growth in demand for rehabilitation services that is
  - increasing with ageing populations,
  - the rising prevalence of non communicable diseases and
  - the increasing numbers of people living with the consequences of injury sustained as a result of high prevalence of insurgencies, terrorism and incessant road traffic accidents in Nigeria.
Coverage for Rehabilitation in Nigeria

• Rehabilitation can be provided in many different settings—public or private—from inpatient or outpatient hospital settings, to private clinics and NGOs, community settings such as an individual's home and industries.

• The available rehabilitation services are in secondary and tertiary health facilities in urban areas, rarely rehabilitation services in the rural areas.

• Rehabilitation needs a multi-professional workforce and inter-disciplinary collaboration between these professionals. There are very few facilities that can adequately meet multi-professional rehabilitation needs.

• Currently in Nigeria there are about 6000 registered rehabilitation personnel for over 200 million population.

• Data that directly informs the unmet need of rehabilitation in Nigeria is not available.
How COVID-19 has affected rehabilitation in Nigeria

Globally, many people are living with mid- and long-term consequences of COVID-19 and may be in need of rehabilitation to support their recovery from the disease. In Nigeria,

• There was finance priority given to COVID-19 related budget especially in 2020-2022 budgeting.

• The number of outpatients seen in a day was scaled down in order to avoid congestion and to give room for physical distancing.

• The prognosis of patients with disabling conditions were greatly affected, especially in physiotherapy and rehabilitation services

• Rehabilitation personnel are in highest risk of contracting the virus, therefore the mental state of healthcare providers including therapists is also affected. This is because their services require manual contact with patients.

• The isolation centers were not designed with infrastructure to meet the accessibility needs of patients with underlying disabling conditions

• Very few rehabilitation personnel were deployed/engaged in the isolation centers despite the critical roles some rehabilitation personnel played in cardiopulmonary management of patients with covid.

• Majorities of patients with underlying disabling conditions have no access to rehabilitation services, hence developed complication, some lead to death.

• There was patient’s fear of contracting the virus, further exacerbated by widespread misinformation, misconception, and attitudes toward COVID-19 in the hospital
1. What does coverage for rehabilitation look like in your country and how has the COVID-19 pandemic affected this?

Dr. Adolfo Martinez Valle, Mexico
Who needs rehabilitation in Mexico?

Population with disability (in thousands)

<table>
<thead>
<tr>
<th></th>
<th>With disability</th>
<th>With mental condition (mc)</th>
<th>With limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only disability</td>
<td>6 179 890</td>
<td>1 590 583</td>
<td>13 934 448</td>
</tr>
<tr>
<td>Disability &amp; mc</td>
<td>5 577 595</td>
<td>723 770</td>
<td>264 518</td>
</tr>
<tr>
<td>Only mc</td>
<td>602 295</td>
<td>6.0%</td>
<td>13 669 930</td>
</tr>
<tr>
<td>Limitation &amp; mc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only limitations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: INEGI, Census 2020
Difficulty of activities associated with disability

- Walking, going up & down: 48%
- Seeing, even when using eyeglasses: 44%
- Hearing, even when using hearing aids: 22%
- Bathing, dressing or eating: 19%
- Remembering or concentrating: 19%
- Speaking or communicating: 15%

Source: INEGI, Census 2020
Causes of disability & limitations (%), 2020

- Illness: 41%
- Old age: 27%
- Birth: 13%
- Injuries: 7%
- Other: 12%

Source: INEGI, Census 2020
Fragmented coverage for rehabilitation

**Without social security**
- No affiliation
- **INSABI**

**With social security**
- Private employees
- Government employees
  - **IMSS**
  - **ISSSTE**

**Private insurance**
- Capacity to pay

**Population**
- Federal government

**Stewardship**
- **31 DIF CRIS**
  - 1,400 PC
- **4 NHI**
  - 32 state level
  - 7 HRAES

**Financing**
- **23 HS**
  - 112 hospitals
  - 49 PC
- **2 HS**

**Health care delivery**
- **112 hospitals**
- **49 PC**
- **2 HS**

**Affiliated population (%)**
- 25
- 32
- 35
- 6
- 2

**Source:** INEGI, 2020

**CRIS:** Integral Rehab Centers; **PC:** Primary Care Centers; **NHI:** National Institutes of Health; **HRAES:** Regional High Specialty Care; **HS:** Specialty Care
Impact of COVID-19 on rehabilitation

- Cancelled or delayed surgeries may have worsened health conditions
- Limited access to physiotherapy services during quarantine
- Delayed seeking of needed rehabilitation care due to fear of getting infected by COVID-19
- Cancelled regular rehabilitation services due to them not being considered essential
- Loss of mobility or functionality for people who had to stay home due to COVID-19
- Rehabilitation services needed for COVID-19 patients

Hard to measure, but given that it has not been a priority so far, it can be estimated that...
2. What are the major challenges in ensuring service coverage?

Dr. Akanle Olufunke, Nigeria
Major challenges in ensuring rehabilitation service coverage in Nigeria

- Limited knowledge and understanding of rehabilitation by policy-makers
- Limited finances available to invest in rehabilitation
- Insufficient number of rehabilitation professionals
- Lack of state of arts equipped rehabilitation centers in Nigeria
- Undervalue, underemployment and underutilization of rehabilitation services at all levels of health care in Nigeria.
- Non integration of rehabilitation services into the primary health care.
- Poor referral system (Non referral or delay referral) due to poor or limited knowledge of some consultant health workers on the relevant of rehabilitation services as components of health service delivery.
- Inadequate coverage of rehabilitation services by National health Insurance Scheme (NHIS). Just few sessions (max 5) of physiotherapy services which is not adequate for long term rehabilitation conditions.
- Limited training institutions for rehabilitation professionals in Nigeria.
- Poor infrastructures especially in rural areas to introduce tele-rehabilitation into the rehabilitation services in Nigeria.
- Socio-cultural and socio-economic factors among the patients that need rehabilitation services
- Poor level of awareness among the patient with disabling conditions on the relevance of rehabilitation services to their recovery.
Way forward

• Many training institutions in Nigeria need to be aided by the development partners and international funding to strengthen the training institutions in providing standard rehabilitation training facilities, robust curriculum and employment of lecturers for the training of rehabilitation professions and carry out research of international standard to meet accreditation standards as set up by the regulatory board.

• “Brain drain” among the medical Rehabilitation professionals due to unemployment, unsatisfactory remuneration, poor recognition and engagement, lack of conducive working environment, financial support and infrastructure to carry out research on Rehabilitation in Nigeria.
  • Priority should be given to employment of rehabilitation professionals at all levels of health care including primary health care.
  • Increase the remunerations and allowances of rehabilitation professionals
  • Provide incentives for rural posting and provide enabling environment for their practice
  • Established a state of arts rehabilitation facilities that encourage multi-disciplinary approach to patient rehabilitation
  • Provide grants and funds for research and data collection to help evidence-based practice.
  • Provision should be made for exchanged programme in rehabilitation
  • Sponsorship and scholarship for continuing professional development in rehabilitation.
3. What are the major barriers for patients to receive care?

Maryke Bezuidenhout, South Africa
Barriers to uptake and retention in care

Demand side barriers:
• Financial: including TRANSPORT
• Environmental
• Attitudinal
• Acceptability of care
• Quality of care
• Consistency of care
• Appropriateness of intervention
• Beliefs

Supply side barriers:
• HR (incl mix), HRD.
• Budget & Supply chain
• Information management
• Governance and leadership
• SERVICE DESIGN
Universal Health Care

• Service coverage
• Financial risk protection
• Equity
<table>
<thead>
<tr>
<th>Data gap/assumption</th>
<th>Impact on % cohort experiencing CHE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welfare grant income used as total household income</td>
<td><strong>Over-estimation</strong> (subsistence farming, piece jobs, actual employment may incr. income- why consumption is usually used but no data)</td>
</tr>
<tr>
<td>Welfare grants shared equally amongst household</td>
<td><strong>Underestimation</strong> (not all family members contribute equally to the ‘pot’)</td>
</tr>
<tr>
<td>Unable to estimate food expenditure or consumption</td>
<td><strong>Under-estimation</strong> (this would reduce total amount available for additional things like transport)</td>
</tr>
<tr>
<td>Used transport cost as a major contributor towards healthcare expenditure, as all healthcare for PwD is free at point of care if they meet the means test- yet despite this, the level of centralization of a rehab service appears to have huge impact on uptake and retention in care.</td>
<td><strong>Over-estimation</strong>, if using traditional definitions which exclude transport as part of healthcare expenditure</td>
</tr>
<tr>
<td>Additional costs such as productivity time lost/ loss of earnings/ additional costs of hiring a caregiver/task shifting not taken into account- no data</td>
<td><strong>Under-estimation</strong> (this would increase cost of accessing healthcare)</td>
</tr>
<tr>
<td>Assumption that each clinical visit was effective and needed and of sufficient quality</td>
<td>May change if the onus is on the family to seek healthcare, even if all financial outlays equal (acceptability of care, perceived need)</td>
</tr>
<tr>
<td>Absence/infrequency of certain services (orthopedics, plastics, orthotics) reduce referrals and utilization rates</td>
<td><strong>Under-estimation</strong> of need. If need realized, this would lead to increased OOPE.</td>
</tr>
<tr>
<td>Small sample size (80 households)</td>
<td><strong>Under or Over estimation</strong></td>
</tr>
<tr>
<td>Model only runs for 8 months</td>
<td><strong>Under-estimation</strong>, as clients allocated to monthly, three monthly or six monthly visits according to severity of CP and age, as per Manguzi package of care</td>
</tr>
<tr>
<td>Lack of stratification of results (geographical location, quintiles etc)</td>
<td>Less insight into factors affecting equity in access</td>
</tr>
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## Impact (UHC)

<table>
<thead>
<tr>
<th>Threshold for CHE</th>
<th>5%</th>
<th>10%</th>
<th>15%</th>
<th>20%</th>
<th>25%</th>
<th>30%</th>
<th>35%</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current model</td>
<td>8%</td>
<td>8%</td>
<td>6%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Clinic model</td>
<td>38%</td>
<td>18%</td>
<td>14%</td>
<td>10%</td>
<td>9%</td>
<td>6%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Centralized hospital model</td>
<td>65%</td>
<td>49%</td>
<td>40%</td>
<td>26%</td>
<td>16%</td>
<td>14%</td>
<td>11%</td>
<td>8%</td>
</tr>
</tbody>
</table>

South Africa’s CHE is estimated at a mere 1.4% at a 10% threshold
Design the service to fit the patient. Don’t make the patient fit the service

- (Maryke ‘because I say so’ ™)
4. We often hear that rehabilitation is underprioritized by policymakers and in UHC strategies. What has your experience been with this and how can it be overcome?

Dr. Adolfo Martinez Valle, Mexico
Challenges for implementing a comprehensive rehabilitation agenda

- **Political will**
  - Needed to raise it in the public health agenda
  - The 1st national plan established in 2007, but since 2015 has lost momentum

- **Multisectorial approach**
  - Address disability through a systemic lens

- **Integrated & comprehensive coverage**
  - Address the fragmented financing and provision of rehabilitation services

- **Professional training**
  - Addressing all rehab needs
  - More equitable allocation
5. How can rehabilitation services be incorporated as part of primary health care?

Maryke Bezuidenhout, South Africa
Integrating rehabilitation into primary health care

- Two-pronged approach
- Policy is often weak
- Bureaucratic cultures limit access and innovation
- Innovation vs piloting for scalability
- Governance, leadership, financing limited
- Convincing arguments with relevant data
Policy and practice: PHC-R

PHC Re-engineering strategy supporting NHI

- Little mention of rehab at community level
- Nurse-led outreach team decentralized
- Bottom-up solutions and implementation
- Sharing scarce resources
- Increased visibility of rehab clients: advocacy and accountability
- Both sides and the patients gain
Policy and practice: FSDR

Framework & Strategy for Disability and Rehabilitation: Peer support

- FSDR: part of rehab team
- No current training, regulating body, posts
- Local donor funded NPOs step in
- ++ by therapists to strengthen PS NPO and integrate their services
- Support from DoH for wheelchair repairer
- Cost saving strategy yet not formally implemented or scaled
Why integrate?

- Improves coverage of care
- Improves equity
- Improves financial risk protection for some of the most vulnerable
5. How can rehabilitation services be incorporated as part of primary health care?

Dr. Akanle Olufunke, Nigeria
How rehabilitation can be a part of PHC in Nigeria

• Workforce:

  • Increase the number of rehabilitation personnel in PHC through greater investment in education and training programs, and incentives for practice in the community
  • Increase the capacity and training of general practitioners in the early identification of functioning decline, referral to rehabilitation and follow up.
  • Optimize rehabilitation workforce performance, retention, and distribution through investing in sound supervisory structures, professional development opportunities, accredited training institutions, and professional associations
  • Build effective rehabilitation referral processes, increasing opportunities for collaboration between rehabilitation providers and other primary health care workers
  • Introduce tele-rehabilitation to support general practitioners in the PHC context
  • Create and strengthen leadership and political support for the provision of assistive products in PHC
  • Ensure that information on rehabilitation access, needs, and effectiveness is integrated into PHC information management systems
  • Expand the National Health Insurance scheme to cover rehabilitation services
5. How can rehabilitation services be incorporated as part of primary health care?

Dr. Adolfo Martinez Valle, Mexico
How rehabilitation can be incorporated as part of PHC in Mexico

49 primary care centers

31 comprehensive centers & nearly 2,000 basic units

Designed a new PHC model, which in theory will cover rehab through a communitarian approach, but it has not estimated the financial, material and human resources needed to meet the demand.
Questions from our audience
If you had to prioritize one thing over the next year to improve rehabilitation in your country, what would you focus on?
Closing
What questions/topics would you like to explore further in a future learning exchange on rehabilitation and UHC?

Please type your answers in the chat.
Next steps

• Webinar slides and recording will be shared
• Reach out to HSSA4Integration@r4d.org to learn more about rehabilitation and UHC