

Rehabilitation
IN HEALTH SYSTEMS
GUIDE FOR ACTION



World Health
Organization



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Rehabilitation in health systems: guide for action

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Acronyms

ACTOR	Action on Rehabilitation
AT	Assistive technology
FRAME	Framework for Rehabilitation Monitoring and Evaluation
GRASP	Guidance for Rehabilitation Strategic Planning
NCD	Noncommunicable disease
NGO	Nongovernmental organization
OT	Occupational therapy
PMR	Physical rehabilitation medicine
PT	Physiotherapy
RIM	Rehabilitation Indicator Menu
RMM	Rehabilitation Maturity Model
SDG	Sustainable Development Goal
STARS	Systematic Assessment of Rehabilitation Situation
SWOT	Strengths, Weaknesses, Opportunities and Threats
TRIC	Template for Rehabilitation Information Collection
UHC	Universal health coverage
WHO	World Health Organization



Introduction

Background

Rehabilitation and universal health coverage

Rehabilitation is a fundamental health service for people with a wide range of health conditions, throughout all stages of the life-course, and during all phases of acute, sub-acute and long-term care. Rehabilitation addresses the impact of a health condition on the person's life by focusing primarily on improving their functioning and reducing the experience of disability. Rehabilitation focuses on the functioning of an individual and not the disease. It does this through a strong emphasis on educating and empowering people to manage their health conditions, adapt to their situation and remain as independent and active as possible. By doing this, rehabilitation enables greater participation in education, employment and community life, with far-reaching health, social and economic benefits.

Rehabilitation is an increasingly important health service in light of ageing populations and the rising prevalence of noncommunicable diseases (NCDs).¹ Furthermore, as access to health care interventions expands, rehabilitation is needed to maximize their effectiveness and impact. Currently, however, the need for rehabilitation greatly exceeds its availability.²

Substantial unmet need for rehabilitation compromises the social and economic outcomes of health care and hinders realization of the Sustainable Development Goals (SDGs) (see Box 1). Achievement of SDG 3, “Ensure healthy lives and promote well-being for all across all ages”, can only be possible through universal health coverage (UHC). UHC necessitates that health services address the full range of health needs of the population, including the availability of health promotion, prevention, treatment, rehabilitation and palliative care.³

There is already substantial unmet need for rehabilitation in many low- and middle-income countries and, due to current health trends and the widespread under-prioritization of rehabilitation by ministries of health, these unmet needs are likely to increase. Further prioritization of rehabilitation within health is urgently needed to meet the needs of millions of people around the world.

Box 1: The Sustainable Development Goals and rehabilitation

SDG 3: Ensure healthy lives and promote well-being for all at all ages

To achieve Sustainable Development Goal 3, there must be universal health coverage.

To attain universal health coverage, health services must address the full scope of health needs of the population.

Therefore, universal health coverage requires provision of health promotion, prevention, treatment, rehabilitation and palliative care.

Health system strengthening is the key strategy for achieving universal health coverage.

This resource provides a guide to health system strengthening practices with a focus on rehabilitation.

Responding to the Rehabilitation 2030 Call for action

In February 2017, in response to the urgent need to strengthen rehabilitation worldwide, WHO launched the Rehabilitation 2030 initiative, and raised a “Call for action”. This call identified 10 areas for concerted attention to reduce unmet needs for rehabilitation. Among these is the need to strengthen rehabilitation leadership, planning and integration across health care, incorporating rehabilitation into UHC and integrating rehabilitation data across health information systems. The 10 Areas for Action are outlined in Box 2.

To assist countries in strengthening rehabilitation, the World Health Organization (WHO) has developed this guide, the *Rehabilitation in health systems: guide for action* (henceforth “the Guide”). This resource leads governments through health system strengthening practices with a focus on rehabilitation. It facilitates leadership and planning for rehabilitation through a situation assessment and strategic planning process, and it strengthens rehabilitation information and accountability through the development of systems that support rehabilitation monitoring and evaluation.

1 Rehabilitation in health systems. Geneva: World Health Organization; 2017.

2 Rehabilitation 2030 – a call for action. Background paper: The need to scale up rehabilitation. Geneva: World Health Organization; 2017.

3 Rehabilitation 2030 – a call for action. Background paper: Rehabilitation: Key for health in the 21st century. Geneva: World Health Organization; 2017.

Box 2: Rehabilitation 2030 – Call for action

The World Health Organization's Rehabilitation 2030 Call for action sets out 10 key activities:

1. Creating strong leadership and political support for rehabilitation at subnational, national and global levels.
2. Strengthening rehabilitation planning and implementation at national and subnational levels, including within emergency preparedness and response.
3. Improving integration of rehabilitation into the health sector and strengthening intersectoral links to effectively and efficiently meet population needs.
4. Incorporating rehabilitation into universal health coverage.
5. Building comprehensive rehabilitation service delivery models to progressively achieve equitable access to quality services, including assistive products, for all the population, including those in rural and remote areas.
6. Developing a strong, multidisciplinary rehabilitation workforce that is suitable for each country context and ensuring rehabilitation as a topic is included in all health workforce education efforts.
7. Expanding financing for rehabilitation through appropriate mechanisms.
8. Collecting information relevant to rehabilitation to enhance health information systems, including system-level rehabilitation data and information on functioning using the International Classification of Functioning, Disability and Health (ICF).
9. Building research capacity and expanding the availability of quality evidence for rehabilitation.
10. Establishing and strengthening networks and partnerships in rehabilitation, particularly between low-middle- and high-income countries.

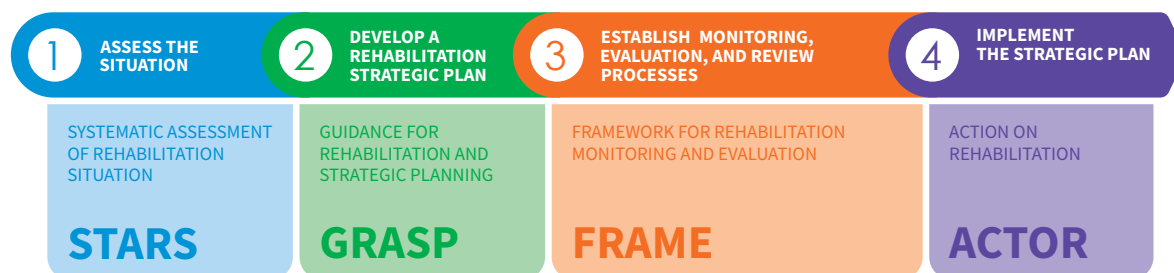
What this guide covers, and who it is for

This practical guide aims to strengthen rehabilitation within countries and is organized around four key phases, for each of which guidance is available (see Table 1):

1. Assess the situation
2. Develop a rehabilitation strategic plan
3. Establish monitoring, evaluation, and review processes
4. Implement the strategic plan

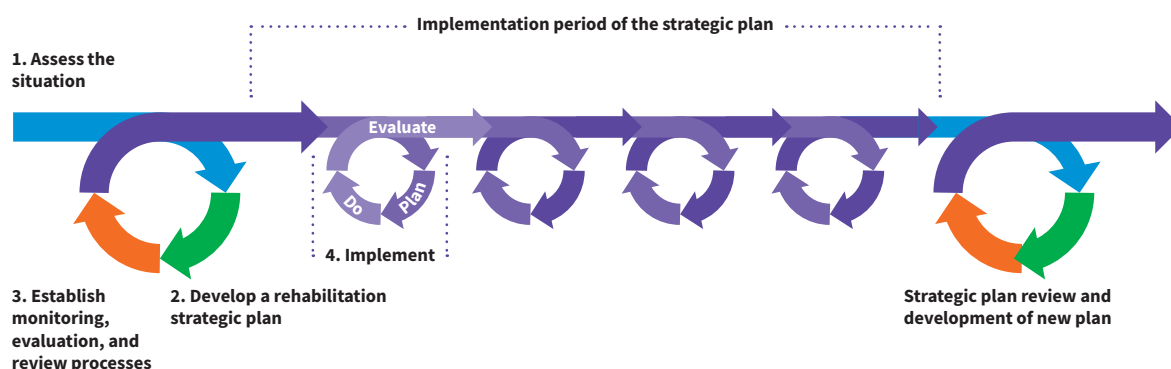
The guide's primary audiences are governments of low- and middle-income countries and the agencies with whom they partner. It is designed for use at national level but can also be used at subnational level. Although it is recommended that the four phases be undertaken in the sequence proposed, the guide should be used flexibly and tailored to the country situation. Success in strengthening rehabilitation with the help of the four-phase process requires government leadership, readiness, and commitment. Completion of the four-phases takes approximately 12 months, with phase four – the implementation of the strategic plan – being an ongoing process.

Table 1: The Four-Phase Process and Accompanying Guidance



The cyclical nature of the process and how that process evolves over multiple years is represented in Figure 1. Phases one to three are carried out periodically, for example once every 5 years, whereas phase four – 'implement' – is ongoing and includes an annual "plan, do and evaluate" cycle that is conducted repeatedly over multiple years.

Figure 1: Four-Phase Process



Using health system strengthening for rehabilitation

This guide uses common health system strengthening practices, such as strategies that improve health system functions that lead to better health through improvements in access, coverage, quality or efficiency.⁴ WHO's health system building blocks are an important framework for understanding health systems and efforts to strengthen them. The different components of rehabilitation within the health system can be grouped under the six building blocks as indicated in Table 2. The structure of the health system building blocks are reflected in the STARS and FRAME guidance.

Table 2: Health System Building Blocks and Rehabilitation

THE SIX BUILDING BLOCKS OF THE HEALTH SYSTEM		REHABILITATION COMPONENT
	LEADERSHIP AND GOVERNANCE	- Laws, policies, plans and strategies that address rehabilitation. - Governance structures, regulatory mechanisms and accountability processes that address rehabilitation. - Planning, collaboration and coordination processes for rehabilitation.
	FINANCING	- Health expenditure for rehabilitation. - Health financing and payment structures that include rehabilitation.
	HEALTH WORKFORCE	Health workforce that can deliver rehabilitation interventions – including rehabilitation medicine, rehabilitation-therapy personnel, and rehabilitation nursing.
	SERVICE DELIVERY	Health services that deliver rehabilitation interventions, including in specialized rehabilitation hospitals, centres, wards and units; in tertiary and secondary hospitals and clinics; in primary health care facilities and in community settings.
	MEDICINES AND TECHNOLOGY	Medicines and technology commonly used by people accessing rehabilitation, particularly assistive products.
	HEALTH INFORMATION SYSTEMS	- Data relevant to rehabilitation in the health information systems, such as population functioning data, rehabilitation availability and use data, and rehabilitation outcomes data. - Research relevant to rehabilitation policy and programmes.

⁴ WHO Health Systems Strengthening glossary [website] (https://www.who.int/healthsystems/hss_glossary/en/).

Planning as a focus of health system strengthening efforts

This guide focuses on strengthening national planning for rehabilitation, both longer-term strategic planning and shorter-term operational planning. Strategic planning in health is a form of medium- to long-term planning and aims to identify, sequence and time actions for the health sector in a comprehensive way. Operational planning specifies the different activities required to implement the strategic plan. It focuses on shorter time segments such as annual or quarterly intervals.

Table 3, from the *WHO Strategizing Health in the 21st Century* resource, outlines the differences between strategic planning and operational planning in the health system context.⁵ This guide addresses both types of planning. Guidance on strategic planning is included in GRASP which accompanies phase 2. Guidance on operational planning is included in ACTOR which accompanies phase 4.

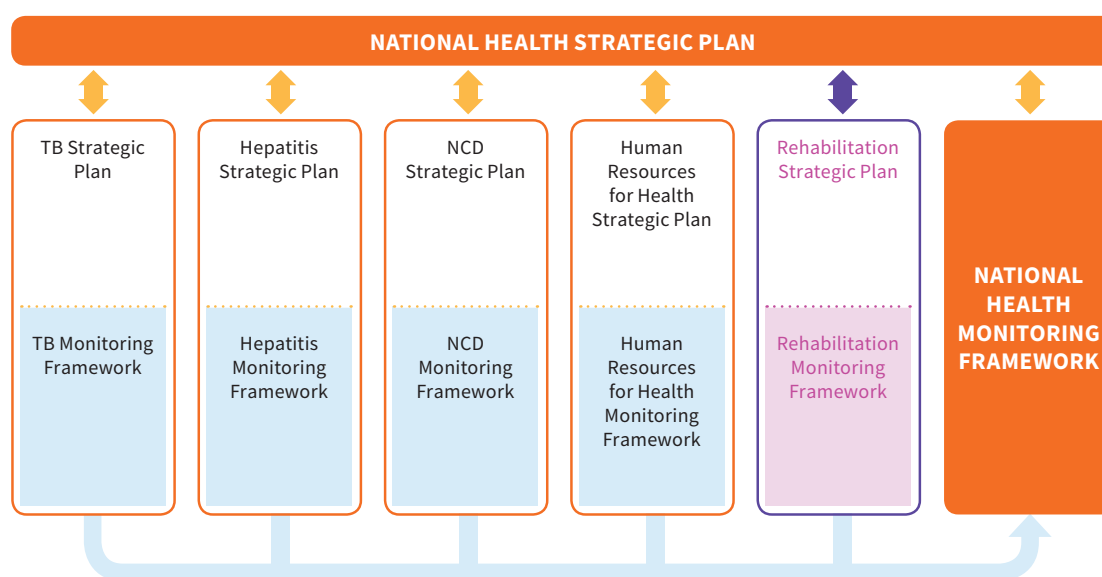
Table 3: Key Characteristics of Strategic and Operational Planning

	STRATEGIC PLANNING	OPERATIONAL PLANNING
PERSPECTIVE	Medium- to long-term development	Shorter-term development
FOCUS	Strategic direction for the health sector	Concrete implementation of activities
TIMEFRAME	3–5 -year document	1 year or less timeframe
FLEXIBILITY	Unlikely to change during its term	Can be adapted and modified according to changing circumstances

Most governments have a national health strategic plan to direct their medium- to long-term operations and sectoral plans that reflect priority areas for health. These sectoral plans may focus on a disease, life-course stage or on a health system building block. Linked to both the national strategic plan and sectoral plans are monitoring frameworks that enable governments to track progress against health goals.

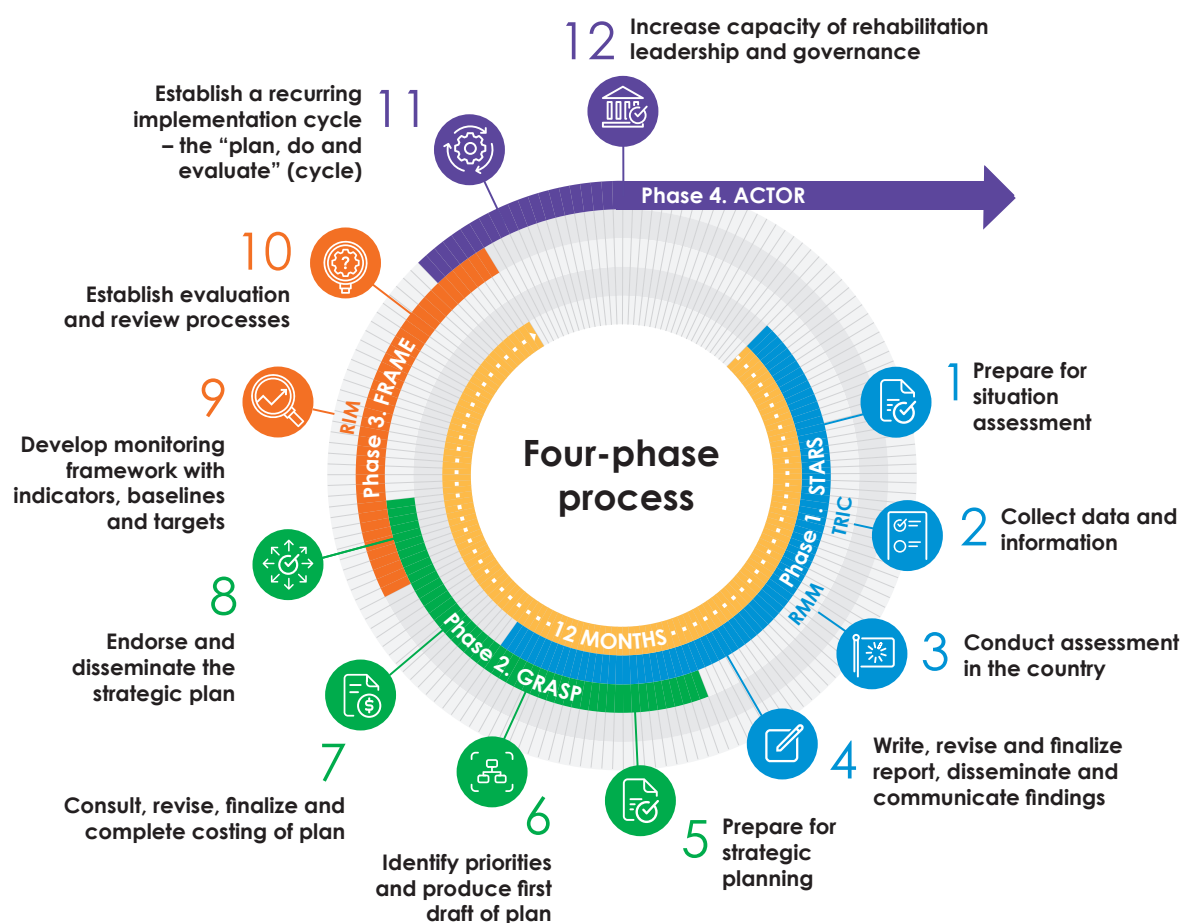
This guide leads readers in taking a stepwise approach to developing a rehabilitation strategic plan and an associated monitoring framework. The rehabilitation strategic plan and its monitoring framework should be aligned with the national health strategic plan and its own monitoring framework – as illustrated in Figure 2. Figure 3 provides an overview of all components of this guide.

Figure 2: National Strategic Plan and Monitoring Framework



⁵ WHO Strategizing national health in the 21st century: A handbook. Geneva: World Health Organization; 2016

Figure 3: Overview of this resource



Phase 1. STARS

ASSESS THE SITUATION

- Follow the four steps of the **Systematic Assessment of Rehabilitation Situation (STARS)** to undertake a comprehensive situation assessment
- Use the **Template for Rehabilitation Information Collection (TRIC)** within STARS to direct collection of data and information
- Use the **Rehabilitation Maturity Model (RMM)** within STARS to structure the assessment and its findings
- Produce a high-quality situation assessment report

Phase 2. GRASP

DEVELOP A REHABILITATION STRATEGIC PLAN

- Follow the four steps of the **Guidance for Rehabilitation Strategic Planning (GRASP)** to undertake a strategic planning process
- Produce a high-quality strategic plan

Phase 3. FRAME

ESTABLISH MONITORING, EVALUATION, AND REVIEW PROCESSES

- Follow the two steps of the **Framework for Rehabilitation Monitoring and Evaluation (FRAME)** to establish a monitoring framework for the strategic plan and an evaluation and review process
- Use the **Rehabilitation Indicator Menu (RIM)** to guide selection of indicators, then identify baselines and targets

Phase 4. ACTOR

IMPLEMENT THE STRATEGIC PLAN

- Follow the two steps of the **Action on Rehabilitation (ACTOR)** guidance to establish the recurring implementation cycle
- Build capacity of rehabilitation governance and leadership to improve implementation of the rehabilitation strategic plan over time

REHABILITATION GUIDE FOR ACTION: QUICK START

We have broken down the complex task of strengthening rehabilitation into:

- **4 phases**, each with accompanying guidance
- **12 steps**
- a series of **substeps**, some with associated **tools**

The **tools** are indicated by this icon: 

Each tool is located in one of three places:

- In the **text** (e.g. boxes or tables)
- In an **appendix** at the end of this guide (e.g. “Sample time frame for four-phase process”)
- On the **WHO website** (e.g. “Template for information collection – TRIC”)

We recommend that you **start** by reading the **summary** that starts on the next page.

Next, familiarize yourself with the **navigation pane** on page 12 that provides a detailed overview of the four phases and accompanying guidance; the 12 steps, and their substeps and associated tools.

You should also consider reading the **Frequently asked questions** in Appendix 1 before you start.

You can then move on to the more detailed guidance for each of the four phases – **STARS, GRASP, FRAME, and ACTOR**.

If you require more information about the process, online tools, or sample situation report and strategic plans, then please contact the **WHO Rehabilitation Programme** at rehabilitation@who.int

This is recommended reading for all stakeholders wishing to use this guide for any of the four phases.

Before governments start strategic planning for rehabilitation, they should have a thorough understanding of the status of rehabilitation in their country or area. The STARS guidance ensures that a high-quality, evidence-based and standardized situation assessment and report is completed. The report will provide governments with information on the strengths and weaknesses of rehabilitation in the country, priority areas for action, and make recommendations for moving forward.

1

Phase 1. Assess the situation

Guidance: Systematic Assessment of Rehabilitation Situation (STARS)

The process of assessing the situation using STARS is divided into four steps:



Step 1. Prepare for situation assessment



Step 2. Collect data and information



Step 3. Conduct assessment in the country



Step 4. Write, revise and finalize report, disseminate and communicate findings

Step 1: Prepare for situation assessment

Preparation allows for the assessment to be properly planned and organized. It includes developing a planning document or concept note, ensuring the government is on board, defining the scope of the assessment, identifying stakeholders, confirming timelines and availability of resources, and establishing a working group.

Step 2: Collect data and information

The Template for Rehabilitation Information Collection (TRIC) guides the collection of data by governments. TRIC is structured according to the health system building blocks and generates information for the situation assessment. Collecting data in a standardized way using TRIC allows comparison over time and across countries.

Step 3: Conduct assessment in the country

The in-country assessment involves assessors, either international and/or national, visiting sites and services and interviewing stakeholders. The STARS guidance provides detailed information for performing the in-country assessment and includes the Rehabilitation Maturity Model (RMM) that evaluates rehabilitation along a continuum of development.

Step 4: Write, revise and finalize report, disseminate and communicate findings

The report should include a description and analysis of the rehabilitation situation and a set of feasible recommendations. The STARS guidance provides a template for reports to enhance their quality and comparability. A dissemination plan should be developed and tailored to the country's circumstances.

2

Phase 2. Develop a rehabilitation strategic plan

Guidance: Guidance for Rehabilitation Strategic Planning (GRASP)

The process of strategic planning establishes a vision and direction for rehabilitation in the country. It draws on findings from the situation assessment, identifies priorities and actions needed to advance rehabilitation and outlines how they will be achieved.

The GRASP tool guides this process and is structured according to four steps:**Step 5.** Prepare for strategic planning**Step 6.** Identify priorities and produce first draft of plan**Step 7.** Consult, revise, finalize and complete costing of plan**Step 8.** Endorse and disseminate the strategic plan**Step 5: Prepare for strategic planning**

This step focuses on organizing the strategic planning process. It is important at this stage that all parties agree on the scope of the plan, how priorities will be identified, who will undertake the drafting, available budget and timelines, how the costing exercise will be carried out, how consultation processes will be conducted, and the process by which the plan will be finalized and endorsed by government.

Step 6: Identify priorities and produce first draft of plan

As many actions are potentially needed for rehabilitation strengthening, prioritizing among them is a crucial step. The findings of the situation assessment should be used to help set priorities. Taking time to discuss these findings and identify priorities with the aim of reaching consensus is critical. The planning process involves translating the priorities into objectives and then identifying and organizing actions to achieve objectives. Drafting of the strategic planning document occurs in tandem with the planning process.

Step 7: Consult, revise, finalize and complete costing of plan

Consultations on the draft strategic plan involve presenting it to relevant stakeholders to obtain feedback – and then making appropriate changes. It is important that stakeholders have the opportunity to express their views. This step will also build support and buy-in for implementation. The costing of the strategic plan requires that the resources to undertake the actions are identified and ascribed a monetary value. A costing exercise identifies all the actions within the plan that require a budget to implement. Costing allows for more effective future budgeting and increases the plan's political acceptability. GRASP provides further guidance on costing.

Step 8: Endorse and disseminate the strategic plan

Endorsement involves the government approving the plan. Governments and ministries have their own processes for endorsement which should be identified early in the planning process. Often, various briefing materials and meetings are required by senior personnel in the Ministry of Health for the strategic plan to be finalized and endorsed. This step is critical for future support and resourcing of the strategic plan. Without final endorsement, achieving a commitment to implement the plan's activities will be difficult. Disseminating and communicating the strategic plan for rehabilitation involves making stakeholders aware of the plan and ensuring they understand its content and relevance. Guidance on dissemination is included in GRASP.

3

Phase 3. Establish monitoring, evaluation, and review processes

Guidance: Framework for Rehabilitation Monitoring and Evaluation (FRAME)

Monitoring, evaluation and review ensure that the strategic plan is implemented as intended and achieves its objectives. Monitoring, evaluation and review allow progress to be tracked and are essential for informed decision-making and accountability. All three processes should be planned by government.

FRAME provides guidance on establishing the monitoring framework and the evaluation and review processes for the strategic plan.

Phase 3 is divided into two steps:



Step 9. Develop monitoring framework with indicators, baselines and targets



Step 10. Establish evaluation and review processes

Step 9: Develop monitoring framework with indicators, baselines and targets

A rehabilitation monitoring framework consists of a set of indicators, with baselines and targets, which provides an ongoing measure of the status of rehabilitation in the country. Indicators are selected to monitor progress towards the main objectives of the strategic plan. FRAME includes the Rehabilitation Indicator Menu (RIM), a set of core and expanded rehabilitation indicators.

Step 10: Establish evaluation and review processes

Evaluation periodically assesses progress towards the achievement of objectives. The review builds on monitoring and evaluation by identifying specific barriers to achieving objectives and makes recommendations to overcome these barriers. Evaluation and review processes are important as they inform further planning.

Evaluation of a rehabilitation strategic plan is typically linked to an annual or biennial reporting period. The evaluation may take the form of a written report that is used to inform the operational planning for the next 1–2-year period. A review may happen less frequently and be linked to broader review processes in a given country. Typically, an annual evaluation meeting takes place and a mid-term review occurs halfway through the period of the strategic plan, with an end-of term review on completion of the plan.

4

Phase 4. Implement the strategic plan

Guidance: Action on Rehabilitation (ACTOR)

This phase involves the implementation of rehabilitation strengthening efforts according to the strategic plan and building the capacity of rehabilitation governance and leadership. It is divided into two steps:



Step 11. Establish a recurring implementation cycle – the “plan, do and evaluate” (cycle)



Step 12. Increase capacity of rehabilitation leadership and governance

Step 11: Establish a recurring implementation cycle – the “plan, do and evaluate” (cycle)

In this step, a recurrent cycle of implementation is established – the “plan, do and evaluate” cycle. In this cycle, actions within the rehabilitation strategic plan are operationally planned, executed and the results evaluated. This cycle should be led and coordinated by government and bring together all stakeholders engaged in implementation. This process is commonly synchronized with planning and budgeting timelines within government.

Step 12: Increase capacity of rehabilitation leadership and governance

The capacity of stakeholders – particularly of ministries of health – to lead and govern rehabilitation has a direct impact on the implementation of the rehabilitation strategic plan. If the capacity to lead and govern remains weak over the period of the strategic plan, the results will be compromised. Good governance and leadership capacity support all four phases of the process and are essential for achieving the objectives of the strategic plan. Building the capacity to lead and govern rehabilitation should be an ongoing process over the timeframe of the strategic plan.

ACTOR provides guidance for this and includes good practice recommendations that have been used to build governance and leadership in rehabilitation and other areas of health.

Navigation pane: Four phases and accompanying

STEP	SUBSTEP
PHASE 1: ASSESS THE SITUATION – SYSTEMATIC ASSESSMENT OF REHABILITATION SITUATION	
1	PREPARE FOR SITUATION ASSESSMENT
	1. Develop planning document/concept note for phases 1 to 3, and Gantt chart 2. Ensure the government is committed and leading the assessment 3. Establish the scope of the assessment 4. Identify key stakeholders and clarify their roles and responsibilities 5. Confirm timelines and availability of resources 6. Establish Rehabilitation Technical Working Group
2	COLLECT DATA AND INFORMATION
	1. Completion of the Template for Rehabilitation Information Collection 2. Consultant prepares for the in-country assessment
3	CONDUCT ASSESSMENT IN THE COUNTRY
	1. Consultant and government conduct interviews, focus groups, and site visits in the country 2. Consultant and government complete Rehabilitation Maturity Model 3. Meetings between the consultant and Rehabilitation Technical Working Group
4	WRITE, REVISE AND FINALIZE REPORT, DISSEMINATE AND COMMUNICATE FINDINGS
	1. Write first draft of situation assessment report 2. Obtain feedback from stakeholders 3. Revise and finalize report 4. Disseminate report
PHASE 2: DEVELOP A REHABILITATION STRATEGIC PLAN – GUIDANCE FOR REHABILITATION	
5	PREPARE FOR STRATEGIC PLANNING
	1. Ensure the government is committed to development of a strategic plan 2. Confirm timelines, roles, responsibilities and availability of resources 3. Establish Rehabilitation Technical Working Group if not previously done
6	IDENTIFY PRIORITIES AND PRODUCE FIRST DRAFT OF PLAN
	1. Identify priorities 2. Plan and draft, establishing priorities, objectives and actions 3. Complete first draft
7	CONSULT, REVISE, FINALIZE AND COMPLETE COSTING OF PLAN
	1. Consult on first draft of strategic plan, revise and finalize 2. Cost the plan and mobilize resources
8	ENDORSE AND DISSEMINATE THE STRATEGIC PLAN
	1. Government endorses strategic plan 2. Disseminate the strategic plan
PHASE 3: ESTABLISH MONITORING, EVALUATION, AND REVIEW PROCESSES – FRAMEWORK FOR	
9	DEVELOP MONITORING FRAMEWORK WITH INDICATORS, BASELINES AND TARGETS
	1. Identify people to be engaged in development of monitoring framework 2. Review the rehabilitation strategic plan and identify a results chain 3. Select indicators 4. Identify and develop the data sources within the health information systems 5. Identify indicator baselines, develop time-bound targets and establish frequency of data collection
10	ESTABLISH EVALUATION AND REVIEW PROCESSES
	1. Establish the evaluation process 2. Establish the review process 3. Document and share the monitoring, evaluation and review processes
PHASE 4: IMPLEMENT THE STRATEGIC PLAN	
11	ESTABLISH A RECURRING IMPLEMENTATION CYCLE – THE “PLAN, DO AND EVALUATE” (CYCLE)
	1. Operational planning – “Plan” 2. Execute activities – “Do” 3. Monitor and evaluate – “Evaluate”
12	INCREASE CAPACITY OF REHABILITATION LEADERSHIP AND GOVERNANCE
	1. Good practice recommendations for strengthening rehabilitation leadership and governance capacity

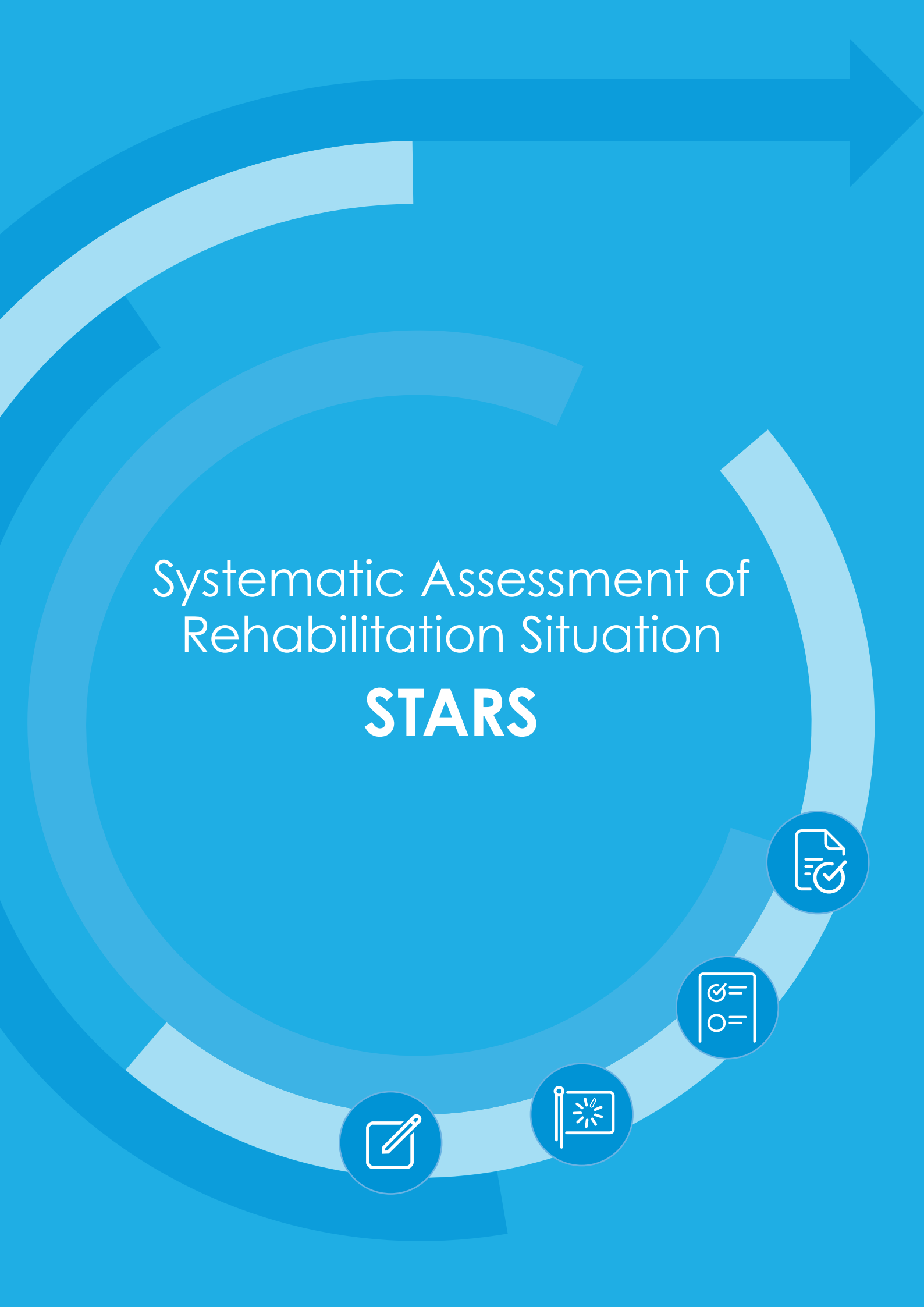
guidance, 12 steps, substeps, and associated tools

ASSOCIATED TOOLS	LOCATION OF TOOL
PHASE 1: SITUATION ASSESSMENT (STARS)	
Frequently asked questions regarding situation assessment and strategic planning	<i>Annex 1 p. 46</i>
Scope of rehabilitation situation assessment	<i>In text, Box 3 p. 17</i>
Sample terms of reference for international consultant	<i>Annex 3 p. 50</i>
Sample timeframe for four-phase process	<i>Annex 4 p. 51</i>
Sample budget for four-phase process	<i>Annex 5 p. 53</i>
Rehabilitation Technical Working Group – members and terms of reference	<i>In text, Box 4 p. 19</i>
Template for information collection – TRIC	<i>On WHO website</i>
Sample itinerary for in-country assessment	<i>Annex 6 p. 54</i>
In-country assessment period potential stakeholders to meet	<i>Annex 6 p. 54</i>
Rehabilitation components assessed during STARS assessment	<i>In text, Table 5 p. 21</i>
Rehabilitation Maturity Model	<i>WHO website</i>
STARS report template for writers	<i>Annex 7 p. 56</i>
Key questions to consider when developing a dissemination plan	<i>In text, Box 7 p. 31</i>
PHASE 2: STRATEGIC PLANNING (GRASP)	
Planning questions for rehabilitation strategic planning	<i>In text, Table 7 p. 27</i>
Frequently asked questions regarding assessment and planning	<i>Annex 1 p. 46</i>
Rehabilitation Technical Working Group – members and terms of reference	<i>In text, Box 4 p. 19</i>
Rehabilitation in health systems – key recommendations	<i>In text, Box 6 p. 28</i>
Suggested content and structure of, and common priorities addressed in, a rehabilitation strategic plan	<i>In text, Table 8 p. 29</i>
Key questions to consider when developing a dissemination plan	<i>In text, Box 7 p. 31</i>
PHASE 3: MONITORING AND EVALUATION (FRAME)	
Rehabilitation Indicator Menu	<i>On WHO website</i>
The rehabilitation results chain and monitoring framework	<i>Annex 8, p. 62</i>
Rehabilitation Indicator Menu	<i>On WHO website</i>
Rehabilitation data sources	<i>In text, Figure 5 p. 18</i>
Suggested annual evaluation process contained within FRAME	<i>In text, p. 40</i>
Six good practices	<i>In text, p. 42</i>

 Learn more

The following resources are suggested for additional learning on strengthening health systems to provide rehabilitation.

- Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016.
- Rehabilitation in health systems. Geneva: World Health Organization; 2017.
- Rehabilitation – key for health in the 21st century. Background paper for WHO Rehabilitation 2030 Meeting. Geneva: World Health Organization; 2017.
- The need to scale-up rehabilitation. Background Paper for the WHO Rehabilitation 2030 Meeting. Geneva: World Health Organization; 2017.
- Health information systems and rehabilitation. Background Paper for WHO Rehabilitation 2030 Meeting. Geneva: World Health Organization; 2017.
- World report on disability. Geneva: World Health Organization; 2011.
- Everybody's business. Strengthening health systems to improve health outcomes. Geneva: World Health Organization; 2007.
- World health report 2000. Health systems: improving performance. Geneva: World Health Organization; 2000.



Systematic Assessment of Rehabilitation Situation

STARS



STARS – Systematic Assessment of Rehabilitation Situation

Aim: to **assist governments**, and those working with government, to:

- undertake a **comprehensive situation assessment**;
- develop a high-quality **standardized report** that will inform the planning process.

Result:

- Identification of the **status of the system** (strengths and weaknesses).
- Clear **recommendations** for improvement.

4 steps: (1) prepare; (2) collect data; (3) conduct assessment; (4) produce and disseminate report.

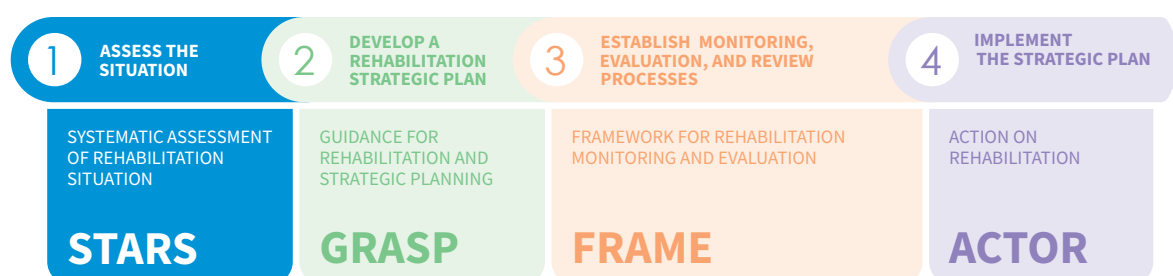
For use at national level but can also be used at **subnational level**.

Should be **adapted** to each situation.

See Table 4 for how STARS forms part of the four-phase process set out in this guide.

STARS also includes the Template for Rehabilitation Information Collection (TRIC) and the Rehabilitation Maturity Model (RMM), available on the **WHO website**.

Table 4: STARS and the Four-Phase Process



Assessment of rehabilitation

Health system assessments describe, measure and analyse the components of the system. A high-quality assessment will be comprehensive, relevant, analytical and evidence based.⁶ Situation assessments provide a “snap shot” of rehabilitation at that time and they are commonly undertaken by health programmes. These assessments are not exhaustive, and may not capture every detail of rehabilitation. They should focus on the information that is most pertinent to mid- to long-term planning.

The STARS guidance uses WHO definitions of rehabilitation and health systems to define its scope (see Box 3). By using the WHO definition of rehabilitation,⁷ STARS recognizes all aspects of rehabilitation, including rehabilitation that is typically characterized as a “rehabilitation service” (e.g. high-intensity physical rehabilitation), as well as rehabilitation that is typically integrated into a wide range of health services and not consistently referred to as a “rehabilitation service” (e.g. in the context of mental health, vision and hearing care).

⁶ Health system analysis for better health system strengthening. Peter Berman and Ricardo Bitran. HNP Discussion Paper. Washington DC: World Bank; 2011.

⁷ Rehabilitation in health systems. Geneva: World Health Organization; 2017.



Box. 3: Scope of rehabilitation situation assessment

WHO definitions of **rehabilitation** and **health system** define the scope of the rehabilitation situation assessment.

WHO defines **rehabilitation** as “a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment. Health condition refers to disease (acute or chronic), disorder, injury or trauma.

“A health condition may also include other circumstances such as pregnancy, ageing, stress, congenital anomaly, or genetic predisposition.”

WHO defines a **health system** as all the activities whose primary purpose is to promote, restore or maintain health, and the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve.

The use of WHO’s definition of a health system – with its focus on “all the activities whose primary purpose is to promote, restore or maintain health” – means that any agencies engaged in delivery of health can be included. These might include agencies under the ministries of social affairs or defence, for example, as well as the profit and not-for-profit sectors.

The use of the two definitions to determine the scope of the assessment aligns to the Rehabilitation 2030 agenda, which deliberately seeks to expand understanding of rehabilitation and to highlight its contribution towards a broader range of health outcomes.

A situation assessment is important as it forms the basis for the planning process. In the past, few governments have undertaken situation assessments of rehabilitation, and the status of rehabilitation in many low- and middle-income countries is not well understood. As well as informing planning, a situation assessment helps establish a baseline for tracking capacity and performance of rehabilitation in a given country. Using a standardized tool to conduct the assessment enables comparisons between countries, and when conducted repeatedly in multiple countries, new knowledge regarding rehabilitation systems can be generated.

The rehabilitation results chain

The “rehabilitation results chain” is based on the idea of a results chain that is widely used in programme monitoring and evaluation,⁸ and is used in the STARS and FRAME guidance.

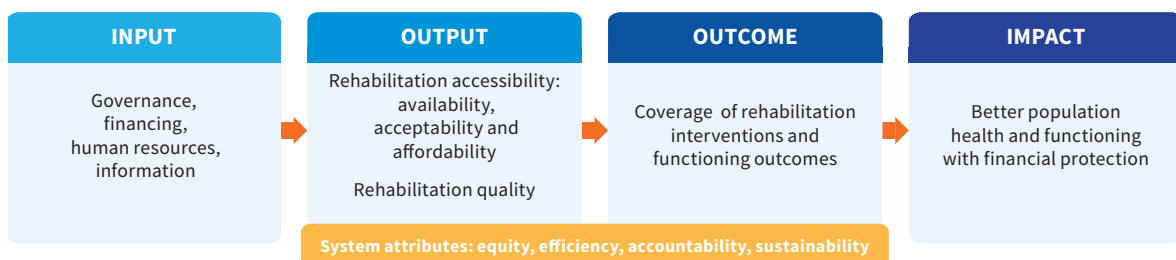
The four components of a results chain are:

- **Input:** the financial, human, material, information and other resources required by a programme.
- **Output:** short-term, direct and immediate results of a programme.
- **Outcomes:** intended medium-term effects on target groups that are clearly linked to the programme goals.

Impact: the longer term and broader improvements brought about by a programme on populations, institutions, systems, and society. The causal relationship to the programme is often more difficult to prove.

Figure 4 shows the results chain adapted to rehabilitation.

Figure 4: Rehabilitation results chain



The rehabilitation results chain supports the assessment and measurement of rehabilitation, both in its capacity and performance. Its capacity is defined as the resources available in the system, such as human, financial, and institutional resources that enable action by health system authorities. Rehabilitation capacity corresponds to “input” in the rehabilitation results chain.

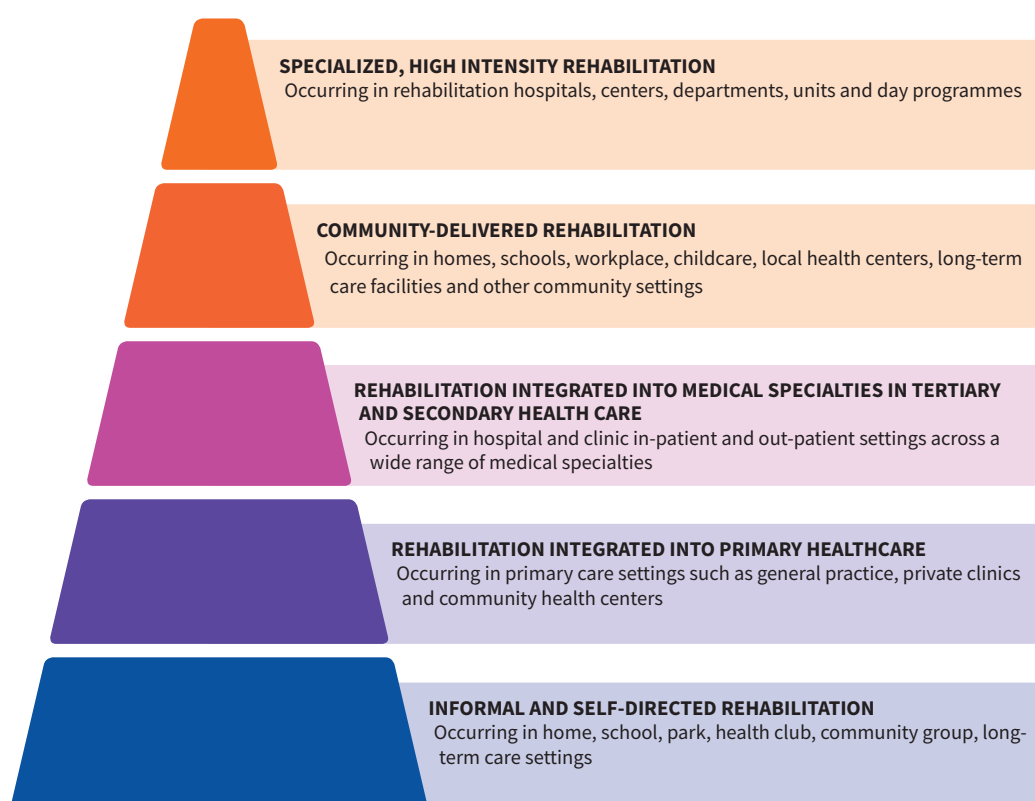
8 Global reference list of 100 core health indicators. Geneva: World Health Organization; 2015.

Its performance refers to how well it is operating and producing the desired outputs, outcomes and impact. Rehabilitation performance is measured in terms of rehabilitation accessibility and quality (“outputs”), population coverage (“outcome”) and population health and functioning (“impact”). The health system attributes of equity, efficiency, accountability and sustainability are also taken into account.

Rehabilitation in Health Framework

The Rehabilitation in Health Framework informs the STARS guidance by providing a common structure and organization of rehabilitation within health care. Across countries there is significant variation in the configuration of rehabilitation. This framework highlights common types of rehabilitation and suggests an optimal mix of rehabilitation in a country. It integrates rehabilitation into the pyramidal structure commonly used to illustrate the organization of tertiary, secondary and primary healthcare. The framework highlights the different types of rehabilitation and the settings where it commonly occurs. The types of rehabilitation are; specialized (dedicated), high-intensity rehabilitation that is commonly delivered through longer-stay facilities; community-delivered rehabilitation that may be dedicated or integrated into a range of community delivered health programmes; rehabilitation that is highly integrated across a wide range of medical specialties in tertiary and secondary health care; rehabilitation integrated into primary health care; and the informal and self-directed rehabilitation that occurs in community settings. Figure 5 illustrates this framework, while Annex 2 includes more detailed definitions for each level within it.

Figure 5: Rehabilitation in Health Framework



Steps and substeps of the situation assessment process

Step 1: Prepare for situation assessment

The preparation period allows for planning and organization of the assessment. Adequate preparation is of the utmost importance for a successful assessment. Preparation for the situation assessment consists of six substeps.

1. Develop planning document or concept note for phases 1–3, and Gantt chart

Government, along with development partners helping with the process, should develop a planning document or concept note. This document should cover phases 1–3 and include a Gantt chart or timeline that establishes the schedule of the planned actions.

2. Ensure the government is committed, and leading the assessment

A situation assessment is not advised unless the government leads the process and is committed to investing in and implementing identified actions. The engagement of senior people in the Ministry of Health should occur early in this process as building high-level commitment within the ministry is essential. Time spent during this period generating strong government commitment and building leadership will significantly benefit all four phases of the process.

3. Establish the scope of the situation assessment

Before starting the assessment, the Ministry of Health should define the scope of rehabilitation to be assessed. For example, some countries may wish to include mental health rehabilitation within the scope of the assessment, while others might prefer to do a separate situation assessment of mental health rehabilitation (see Box 3).

4. Identify key stakeholders and clarify their roles and responsibilities

The single most important stakeholder is the Ministry of Health. In some countries rehabilitation is also delivered by ministries of social affairs or labour, so it is important to agree on the roles and level of engagement in the process of these other stakeholders. Other key stakeholders are WHO and other development partners such as international nongovernmental organizations.

A key decision to be made during planning is whether an external consultant is needed to support the in-country assessment and report writing, as these activities often require more time than that available to government personnel. Commonly, governments contract either a local consultant or international consultant, or both, to assist them to undertake assessments. There are sample terms of reference for an international consultant in Annex 3.

5. Confirm timelines and availability of resources

The time required from initial agreement to undertake a situation assessment until the report is completed is likely to be 6 months or more. This varies depending on factors such as government personnel and consultant availability. The main cost of the assessment is that of the international (or national) consultant. Other small costs may include consultation meetings and transport.



Box 4: Rehabilitation Technical Working Group

Potential members:

- Ministry of Health personnel from central and provincial level
- Senior rehabilitation personnel
- Medical specialists who work closely with rehabilitation personnel
- Other relevant government agencies
- Rehabilitation user group
- Professional associations
- Academia
- Nongovernmental organizations delivering rehabilitation
- Development partners

Suggested terms of reference:

- To assist the government collate and validate information required for completion of the TRIC.
- To input into situation assessment findings and provide feedback.
- To assist the government identify priorities to be included in the rehabilitation strategic plan.
- To assist the government draft the strategic plan, its objectives and actions, and provide feedback on drafts.
- To support implementation of the strategic plan and engage in monitoring, evaluation and review processes.
- To advocate for rehabilitation and implementation of the strategic plan.

Annex 4 contains a sample timeframe for the completion of the four-phase process. Annex 5 contains a sample budget for the four-phase process using an international consultant.

6. Establish a Rehabilitation Technical Working Group

Establishment of a Rehabilitation Technical Working group is recommended to provide technical input throughout the assessment period and the other steps in the process. Such a group may already exist and function appropriately, or a new one with specific time-limited terms of reference can be created. See the suggested members and terms of reference for this group in Box 4.

Step 2: Collect data and information

Step 2, which involves collecting data and information, consists of two sub-steps.

1. Completion of the Template for Rehabilitation Information Collection (TRIC)

The **Template for Rehabilitation Information Collection (TRIC)** directs the collation of data by governments. It is structured according to health system building blocks, and the data inform assessment of capacity and performance of rehabilitation systems in the country. The TRIC provides the key information for the situation assessment.

The TRIC should be given to governments approximately 8 weeks before the in-country assessment period to allow sufficient time for data collation. The government should complete it, liaising with other rehabilitation stakeholders as required, and return a final version to the consultant. It is best not to have it completed by many different people. The government or development partners may consider contracting a local consultant to help them complete the TRIC. The TRIC is part of STARS and copies can be obtained from the **WHO website** or by emailing the WHO Rehabilitation Programme on **rehabilitation@who.int**.

2. Consultant prepares for the in-country assessment

In addition to completing the TRIC, the government and any consultants should collect other relevant information regarding health and rehabilitation in the country and the consultant should prepare for the in-country assessment. A sample itinerary for the in-country assessment period is included in Annex 6.

Step 3: Conduct assessment in the country

In Step 3, which is divided into three substeps, an international or national consultant works with the government to conduct the in-country assessment

1. Consultant and government conduct interviews, focus groups, and site-visits in the country

The consultant, along with the government, should carry out a combination of key informant interviews, focus group discussions and site visits to ascertain what the population needs and expects from rehabilitation services. It is during this process that the strengths and weaknesses of rehabilitation, and their underlying causes, are identified. The in-country assessment generates further information about the rehabilitation system which allows for interpretation and confirmation of data already collected with the TRIC.

If a national or international consultant is undertaking the assessment, it is recommended that they be accompanied by the government rehabilitation officer or focal person during much of the assessment. It is very important that government be part of the interviews, meetings and site visits so they hear and learn first-hand about the concerns regarding rehabilitation in their country. This period provides an opportunity for government to discuss rehabilitation strengthening issues with the consultant.

Suggestions for the in-country assessment, including who should be interviewed and sites to be visited are in Box 5.

2. Consultant and government complete the Rehabilitation Maturity Model

The Rehabilitation Maturity Model (RMM), available on the **WHO website**, is used for the in-country assessment. The RMM identifies 50 components of rehabilitation and describes them according to four-levels of maturity. The process for doing this should be participatory and include the consultant and government, and whenever possible WHO. This process should occur towards the end of the in-country assessment period and include a meeting between the government, the consultant and WHO. This meeting provides an important opportunity for a government to reflect on the maturity of its rehabilitation provision, and to identify what is needed to move to a higher level of maturity. As the RMM contains 50 components it is normal for only a few components to be discussed with government during this meeting. The consultant should determine in advance which components to discuss and should assess the remaining components separately. The list of RMM components assessed is in Table 5 and headings align with the

Rehabilitation Results Chain (Background and Annex 8). There is a separate RMM Excel document that can be accessed from the **WHO website**.

The RMM provides more detail about these components. The RMM is complex and in some cases a shortened version of the RMM can be used, which is also available on the **WHO website**, should be shared with governments.



Box 5: In-country assessment period

Potential stakeholders to meet:

- Ministry of Health rehabilitation officers, focal points
- Ministry of Health directors and senior personnel, central level
- Ministry of Health representatives from provincial health levels
- Ministry of Social Affairs, Ministry of Education, and any other relevant government stakeholder for rehabilitation, such as national health insurance agencies
- Agency responsible for disability coordination
- Rehabilitation personnel from across profession
- Professional associations for the rehabilitation profession
- Medical specialists working with rehabilitation, such as paediatricians, neurologists, orthopedic surgeons and general practitioners
- Academics
- Rehabilitation users and their representative groups including disabled persons' organizations
- Key nongovernmental organizations
- Development partners (bilateral/UN) active in rehabilitation

Potential sites to visit:

- Rehabilitation hospital/centre/unit
- Tertiary hospitals with rehabilitation
- Secondary hospital rehabilitation facilities, with and possibly without rehabilitation
- Primary health centre level services, with and without rehabilitation
- Community-delivered rehabilitation programmes
- NGO rehabilitation providers
- Mental health, vision, hearing rehabilitation services
- Early childhood intervention programmes, paediatric hospitals/rehabilitation services

Table 5: Rehabilitation Components Assessed During a STARS Assessment



INPUTS

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 INFORMATION

16. Information on rehabilitation needs, including population functioning and disability
17. Information on rehabilitation availability and utilization
18. Information on rehabilitation quality and outcomes
19. Rehabilitation information used during decision-making



OUTPUTS

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

REHABILITATION QUALITY

35. Extent to which evidence-based rehabilitation interventions are utilized
36. Extent to which rehabilitation interventions are of sufficient specialization and intensity to meet needs
37. Extent to which rehabilitation interventions empower, educate and motivate people
38. Extent to which rehabilitation interventions are underpinned by appropriate assessment, treatment planning, outcome measurement and note-taking practices
39. Extent to which rehabilitation is timely and delivered along a continuum, with effective referral practices
40. Extent to which rehabilitation is person-centered, flexible, and engages users, family, and carers in decision-making
41. Extent to which health personnel and community members are aware, knowledgeable and seek rehabilitation
42. Extent to which rehabilitation is safe



OUTCOMES AND IMPACT

OUTCOMES AND ATTRIBUTES OF REHABILITATION

43. Coverage of rehabilitation interventions for population groups that need rehabilitation
44. Functioning outcomes of rehabilitation for those who receive rehabilitation
45. Equity of rehabilitation coverage across disadvantaged population groups
46. Allocative and technical efficiency of rehabilitation
47. Multi-level accountability for rehabilitation performance
48. Financial and institutional sustainability of rehabilitation
49. Resilience of rehabilitation for crisis and disaster
50. The functioning of the population without financial hardship

3. Meetings between the consultant and the Rehabilitation Technical Working Group

At least two meetings between the consultant and the Rehabilitation Technical Working Group should occur during the in-country assessment period. This is because the working group can provide the consultant – who often needs to learn quickly – with important information and perspectives about the situation in the country. An in-country assessment period of 2 weeks is recommended for an international consultant. During this period a meeting with the Rehabilitation Technical Working Group should occur once during the initial days, and then again at the end of the two-week period.

The Rehabilitation Technical Working Group can undertake a SWOT analysis to identify the strengths, weaknesses, opportunities and threats to rehabilitation. Later this group can be used to help validate preliminary findings, which should be done at the end of the 2-week period.

Step 4: Write, revise and finalize report, disseminate and communicate findings

This step, which concerns the writing and disseminating of the situation assessment report, is made up of four sub-steps.

1. Write first draft of situation assessment report

The report should include description and analysis of the situation and a set of feasible recommendations. The claims made about the situation in the report should be justified and explained through, for instance, the description of the rehabilitation system. Annex 7 includes a template for the structure and content of the report. Using the template ensures alignment with the maturity model, comparability with other reports using the template, and better overall quality. The structure of the report can, however, be modified based on the situation in the county. The Ministry of Health is the key audience for the report and writers should use language appropriate for this audience.

2. Obtain feedback from stakeholders

After the government has received the first draft of the report they are responsible for providing feedback and relaying this to the consultant for incorporation. It is recommended that government use their Rehabilitation Technical Working Group for obtain feedback.

3. Revise and finalize report

After incorporation of feedback, the rehabilitation situation assessment report can be finalized.

4. Disseminate report

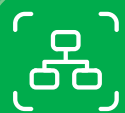
The final report should be disseminated. While the report is inherently technical, an effort should be made to translate the findings into accessible language, as the report contains information that is valuable to a large number of stakeholders. Dissemination of the written report may include distribution of hard and electronic copies, use of traditional and social media, and communicating the findings through policy dialogue events and roundtable discussions. GRASP provides further information on dissemination.

CHECKLIST FOR STARS

STEP 1. PREPARE FOR SITUATION ASSESSMENT		KEY TASKS COMPLETED
1. Develop planning document/concept note for phases 1 to 3 with Gantt chart or timeline	• Concept note agreed upon	☐
2. Ensure the government is committed and leading the assessment	• Government clear of their role • Focal person within ministry of health administration established	☐
3. Establish the scope of the assessment	• Scope of rehabilitation situation assessment confirmed	☐
4. Identify key stakeholders and clarify their roles and responsibilities	• Government, WHO, development partner(s), consultant are clear of their role	☐
5. Confirm timelines and availability of resources	• Timeframe and budget confirmed	☐
6. Establish Rehabilitation Technical Working Group	• Rehabilitation Technical Working Group formed	☐
STEP 2. COLLECT DATA AND INFORMATION		KEY TASKS COMPLETED
1. Completion of the Template for Rehabilitation Information Collection	• Template for Rehabilitation Information Collection completed	☐
2. Consultant prepares for the in-country assessment	• Itinerary for in-country assessment agreed upon • Consultation meetings and workshops confirmed	☐
STEP 3. CONDUCT ASSESSMENT IN THE COUNTRY		KEY TASKS COMPLETED
1. Consultant and government conduct interviews, focus groups, and site-visits in the country	• In-country assessment period completed, all necessary sites visited and stakeholders consulted	☐
2. Consultant and government complete Rehabilitation Maturity Model	• Rehabilitation Maturity Model discussed with government	☐
3. Meetings between the consultant and Rehabilitation Technical Working Group	• Rehabilitation Technical Working Group and consultant meetings undertaken	☐
STEP 4. WRITE, REVISE AND FINALIZE REPORT, DISSEMINATE AND COMMUNICATE FINDINGS		KEY TASKS COMPLETED
1. Write first draft of situation assessment report	• First draft sent to government	☐
2. Obtain feedback from stakeholders	• Feedback received from government	☐
3. Revise and finalize report	• Report finalized	☐
4. Disseminate report	• Report disseminated	☐



Guidance for Rehabilitation Strategic Planning **GRASP**



GRASP – Guidance for Rehabilitation Strategic Planning

Aim: to **assist governments** to develop a quality **strategic plan**.

Primary audience: **government** and those working closely with them.

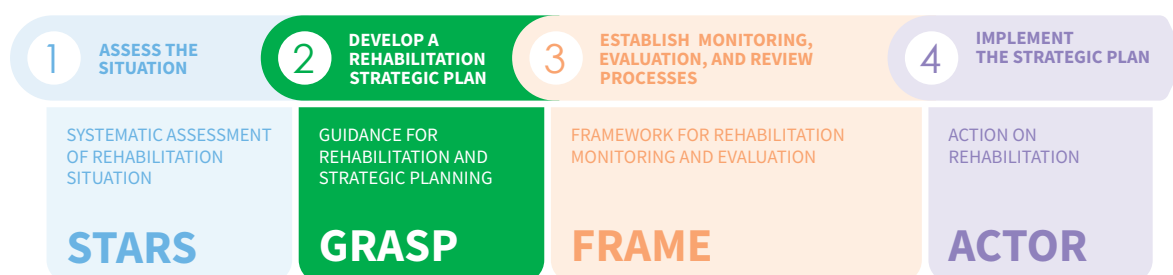
4 steps: (1) prepare, (2) produce report, (3) consult & revise, (4) endorse and disseminate report.

For national level but can also be used at the **sub-national level**.

Strategic planning **translates** long-term **vision & priorities** into **concrete actions** for implementation.

See Table 6 for how GRASP forms part of the four-phase process set out in this guide.

Table 6: GRASP and the Four-Phase Process



Strategic planning for rehabilitation

Planning ensures resources are used in the most efficient way to achieve explicit objectives.⁹ Strategic planning in health is a form of long- to medium-term planning and aims to identify, sequence and time medium-term interventions for the health sector.¹⁰ The end product is a strategic plan that guides the activities and the resourcing necessary to achieve the objectives of the plan.

In the past there has been limited rehabilitation planning undertaken by governments, and the status of rehabilitation in many low- and middle-income countries often reflects this. Development of a rehabilitation strategic plan is recommended to address this situation. Most commonly this process results in a document called a “strategic plan”, but, depending on their procedural environment, governments may prefer to call the document a policy, strategy, road map or action plan, or a combination of these. A strategic plan is an important step in strengthening rehabilitation as it identifies priorities, objectives and actions that mobilize and direct resources for rehabilitation.

Governments regularly undertake strategic planning at the national level, and commonly develop a national health strategic plan and strategic plans for other priority areas of health. The rehabilitation strategic plan sits alongside these other sectoral/programme plans, all of which need to be aligned with the national health strategic plan.

Steps and substeps in developing a Rehabilitation Strategic Plan

Step 5: Prepare for strategic planning

Preparation is important so that the process is clear and agreed to by all involved. Providing answers to the planning questions in Table 7 will help with the strategic planning process and with the following three substeps:

1. Ensure the government is committed to development of a strategic plan

It is the responsibility of government to lead the development of the strategic plan, so it is critical to first ensure that the government is committed to developing a strategic plan. It is also their responsibility to prepare adequately.

⁹ Green A. An instruction to health planning in developing countries. Oxford: Oxford University Press; 1992.

¹⁰ WHO Strategizing national health in the 21st century: A handbook. Geneva: World Health Organization; 2016.

2. Confirm timelines, roles, responsibilities and availability of resources

During the preparatory period, timelines, roles, responsibilities and availability of adequate resources for strengthening rehabilitation should all be confirmed. Similarly, if a planning document or concept note was not developed during the situation assessment phase, then it should be developed, with government, at this stage, including an outline of the steps and timeframes for the process. The planning document should address the planning questions in Table 7.

The frequently asked questions section in Annex 1 may also be useful during the preparatory step of strategic planning.

3. Establish Rehabilitation Technical Working Group if not previously done

If a Rehabilitation Technical Working Group was not established during the situation assessment phase, it should be established at this stage. Suggestions for the composition and terms of reference for working group are included in the STARS guidance (Box 4, p. 19).

Table 7: Planning Questions for Rehabilitation Strategic Planning



PLANNING QUESTIONS FOR REHABILITATION STRATEGIC PLANNING

1. Is there high-level support for a strategic plan to be developed, and has the health minister and director general for health been briefed on the rehabilitation situation assessment findings?
2. Are there any high-level ministerial planning or political processes that need to be considered? Is now the right time to develop a rehabilitation strategic plan?
3. What is the scope of the strategic plan? Does it include all areas of rehabilitation within the Ministry of Health? For example, does it include rehabilitation in the context of people with physical, mental health, hearing, and vision impairments?
4. If rehabilitation is delivered by other ministries, how will the strategic planning process and plan itself involve those ministries?
5. Is there any confusion regarding the intersections between disability policies and plans and the rehabilitation strategic plan? If so, how will this be addressed?
6. What is the typical process for developing a strategic plan? Has the ministry planning office been consulted? Are there specific requirements? What do other strategic plans in the country contain and what learnings exist regarding the process of their development?
7. What is the available budget and timeline for drafting, consulting on, costing, finalizing and disseminating the strategic plan? Are there development partners who can financially support aspects of the development of the plan?
8. Who will undertake the drafting of the plan? Is WHO engaged and will an international consultant be required? Should a drafting group be assembled and who should it include?
9. Is a costing of the strategic plan required, and who, when and how will this be undertaken?
10. What budget (and/or budget ceiling) exists for implementation of the plan that should be considered while developing the content of the plan?
11. What will the consultation process on the first draft of the plan entail? Who, when and how will consultations take place?
12. How will the rehabilitation strategic plan be finalized and endorsed by government?
13. When will the development of the monitoring framework and evaluation and review processes take place? Can it occur during development of the plan or after the plan is finalized?

Step 6: Identify priorities and produce first draft of plan

1. Identify priorities

As many actions are needed for rehabilitation strengthening, determining those to be resourced and undertaken earliest is necessary. The process of priority-setting may require time for discussion to explore options and reach consensus among key stakeholders. Prioritization is inherently a political process, so considering political factors is a necessity.

Identifying priorities should be informed by the STARS-guided situation assessment. Its “Conclusion and Recommendations” section will have already identified a number of “Priority Areas for Action” and recommendations for how to address these (see report template in Annex 7).

Priorities can be further explored using one or more of the following approaches:

- Use the rehabilitation situation assessment findings as the basis for further exploration. The Ministry of Health rehabilitation technical officer, unit or department can, for instance, do this with their senior management.
- Convene a meeting of the Rehabilitation Technical Working Group to discuss priorities and reach consensus. This may include an exercise in which a list of priority areas are ranked.
- Where there may be difficulty identifying priorities, a set of criteria can be established to help determine the level of priority for each issue.

2. Plan and draft, establishing priorities, objectives and actions

The planning process involves translating priorities into objectives and identifying actions to achieve them. Typically, the planning and drafting occur together and involve a core “drafting group”. This group may include Ministry of Health staff and senior practitioners and other stakeholders, sometimes working with a consultant who does the drafting.

Members of the drafting group should overlap with the Rehabilitation Technical Working Group. A drafting group should convene for a 2–5 day meeting, during which most of the strategic plan is organized and drafted. Some members of the group, such as representatives from health information systems or human resources, may only stay for the relevant parts of the drafting workshop. A consultant or technical WHO staff may be used to help facilitate the meeting.

The development of objectives and actions should be based on evidence about health system strengthening and rehabilitation. The WHO *Rehabilitation in Health Systems* is an important resource document for this stage of planning – see “Learn More” at the end of the overview section. Key recommendations from the document are highlighted in Box 6.

Box 6: WHO Rehabilitation in health systems – key recommendations

- Rehabilitation services should be integrated into health systems
- Rehabilitation services should be integrated into and between primary, secondary and tertiary levels of the health system
- A multi-disciplinary rehabilitation workforce should be available
- Both community and hospital rehabilitation services should be available
- Hospitals should include specialized rehabilitation units for inpatients with complex needs
- Financial resources should be allocated to rehabilitation services to implement and sustain the recommendations on service delivery
- Where health insurance exists, or is to become available, it should cover rehabilitation services
- Financing and procurement policies should be implemented to ensure that assistive products are available to everyone who needs them
- Adequate training should be offered to the user, and care provider when appropriate, when assistive products are provided

3. Complete first draft

Table 8 provides suggestions for the content and structure of a rehabilitation strategic plan and lists some of the common priorities that such a plan addresses. Some ministries of health have templates and standard approaches to strategic planning. The suggestions below should, therefore, be adapted to the country situation. Examples of rehabilitation strategic plans are available from WHO at rehabilitation@who.int.

Table 8: Content, Structure and Common Priorities Addressed in a Rehabilitation Strategic Plan



CONTENT, STRUCTURE AND COMMON PRIORITIES ADDRESSED IN A REHABILITATION STRATEGIC PLAN

CONTENT OF A REHABILITATION STRATEGIC PLAN SHOULD

- Be dictated by the specific context of the country and priorities identified
- Be coherent, with objectives flowing logically from priorities
- Reflect priorities, yet also be comprehensive enough to include all major areas impacting on the development of rehabilitation in that setting
- Be balanced, with each objective and action developed to a similar level of detail
- Describe links between the rehabilitation strategic plan and the national health strategic plan, and health reform priorities

COMMON STRUCTURE OF A REHABILITATION STRATEGIC PLAN

- Preface, letter of support from the Minister of Health and Director General for Health
- Table of contents
- Acronyms
- Background – rehabilitation concepts, the need for rehabilitation, and the value of rehabilitation
- The status of rehabilitation in the country – summary of situation assessment findings
- Priority considerations and directions for rehabilitation
- Linkages between rehabilitation strategic plan and the national health strategic plan and health other reforms
- Vision, mission, goals, principles
- Objectives and actions
- Evaluation and review process for the strategic plan
- Monitoring framework with indicators, targets and baseline (may also be a separate document)
- Annex with glossary and definitions

COMMON PRIORITIES ADDRESSED IN A REHABILITATION STRATEGIC PLAN

- Strengthening leadership, governance, planning and coordination for rehabilitation
- Building stronger integration of rehabilitation across health system planning, making rehabilitation the business of all health services.
- Strengthening the generation and use of rehabilitation data, evidence and research
- Expanding the financing to rehabilitation and reducing out-of-pocket costs
- Increasing the availability and improving rehabilitation workforce competencies
- Expanding availability of specialized, intensely delivered rehabilitation in longer-stay facilities
- Expanding delivery of rehabilitation into the community
- Expanding the integration of rehabilitation across tertiary and secondary levels of health care
- Expanding access to rehabilitation in primary health care
- Improving the quality and effectiveness of rehabilitation
- Developing early identification of, and interventions for, children with developmental delays and disabilities
- Developing rehabilitation for prioritized groups, such as older people, people with noncommunicable diseases, people with disabilities, people with mental health conditions and people with vision and hearing impairments
- Increasing access to assistive products
- Improving the rehabilitation infrastructure and equipment

Step 7: Consult, revise, finalize and complete costing of plan

1. Consult on first draft of strategic plan, revise and finalize

Consultation involves presenting the plan to stakeholders to obtain feedback and revising it accordingly. Consultation should last a few weeks to a couple of months and take place through email and face-to-face meetings. If consultations are sufficiently inclusive, they will not only improve the plan, but also generate greater support for it.

Key groups to be consulted:

- Different levels within health: central ministry, provincial health departments, hospital directors, providers, practitioners.
- Other government agencies, particularly those that are responsible for programmes that intersect with rehabilitation such as early childhood intervention services, disability coordinating agencies.
- Nongovernmental organizations who deliver rehabilitation and/or disability services.
- Professional associations for rehabilitation personnel and specialist practitioner groups.
- Academia and research groups.
- Users of rehabilitation, including specialist groups such as stroke groups and disabled persons organizations.

2. Cost the plan and mobilize resources

Costing the plan involves attributing a monetary value to the resources required to undertake the actions in the plan. Costing is important as it enables more effective future budgeting and should increase political acceptability. Usually a local consultant with experience in costing other health plans is contracted and they commonly liaise with ministries' planning departments.

Implementation of a strategic plan requires resources and mobilizing financial resources from both within and outside the government should be prioritized. In some low- and middle-income countries, development partners can help develop proposals to access donor funds that support implementation of a national strategic plan.

Step 8: Endorse and disseminate the strategic plan

1. Government endorses strategic plan

Endorsement of the strategic plan is the final step. This commonly involves the minister's final approval and may include endorsement by parliament or other legislative bodies. Governments and ministries have their own processes for endorsement, and these should be identified early on in the planning process. This step is important for future support and resourcing of the strategic plan. Various briefing materials and meetings may be required by senior Ministry of Health personnel for the plan to be endorsed.

2. Disseminate the strategic plan

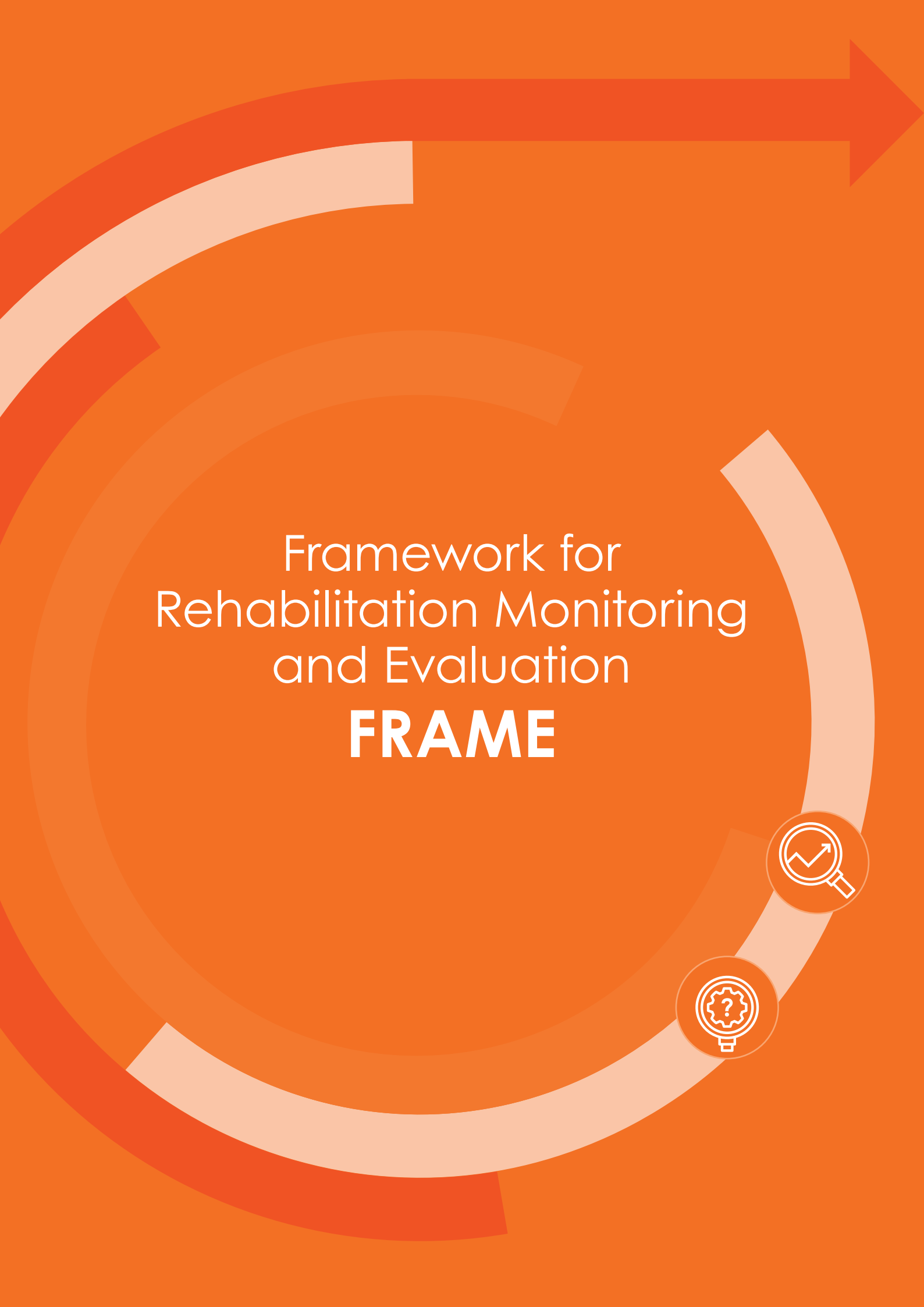
Disseminating and communicating the strategic plan involves making people aware of the plan and its content and relevance. Dissemination and communication help mobilize support for its implementation across a range of relevant stakeholders. As the strategic plan is finalized, a dissemination plan can be developed. Box 7 includes a set of questions to guide development of the dissemination plan. Remember to consider dissemination strategies used by other Ministry of Health programmes that have proved successful.

Box 7: Key questions to consider when developing a dissemination plan

1. What exactly will be disseminated? The full strategic plan, a summary with key messages, an information sheet or other products, or a combination?
2. What are the key messages? Identify key information to be conveyed and its format.
3. Who is the audience? List the people and stakeholders who should receive a copy of the rehabilitation strategic plan.
4. What is the best way to reach your audience? Consider launch events, policy dialogues and roundtables, email, post, network groups, meetings, social media etc.
5. What other networks or partners can help you disseminate the rehabilitation strategic plan? Who can help you champion the strategic plan and what will they do?
6. Roles, responsibilities and resources? Develop a summary document and ensure all people who have responsibilities are aware of these and have the resources they need.

CHECKLIST FOR GRASP

STEP 5. PREPARE FOR STRATEGIC PLANNING		KEY TASKS COMPLETED
1. Ensure the government is committed to development of a strategic plan		• Planning questions for rehabilitation strategic planning completed, including clarification of costing of the plan and final endorsement processes ☐
2. Confirm timelines, roles, responsibilities and availability of resources		• Concept note for strategic planning reviewed and confirmed ☐
3. Establish Rehabilitation Technical Working Group if not previously done		• Rehabilitation Technical Working Group Established (if not already) ☐
STEP 6. IDENTIFY PRIORITIES AND PRODUCE FIRST DRAFT OF PLAN		KEY TASKS COMPLETED
1. Identify priorities		• Priorities discussed and confirmed ☐
2. Plan and draft, establishing priorities, objectives and actions		• Country stakeholders identified objectives and actions ☐ • Opportunities for resource mobilization for strategic plan implementation identified
3. Complete first draft		• First draft completed and sent to government ☐
STEP 7. CONSULT, REVISE, FINALIZE AND COMPLETE COSTING OF PLAN		KEY TASKS COMPLETED
1. Consult on first draft of strategic plan, revise and finalize		• Strategic plan consulted on, and feedback sent back to consultant ☐
2. Cost the plan and mobilize resources		• Plan finalized and costing of the plan completed ☐
STEP 8. ENDORSE AND DISSEMINATE THE STRATEGIC PLAN		KEY TASKS COMPLETED
1. Government endorses strategic plan		• Strategic plan endorsed ☐
2. Disseminate the strategic plan		• Strategic plan disseminated ☐



Framework for Rehabilitation Monitoring and Evaluation **FRAME**



FRAME – Framework for Rehabilitation Monitoring and Evaluation

AIM: to assist government to develop:

- **A monitoring framework** that tracks progress against selected indicators
- **Evaluation** and **review** processes

Primary audience: **government** and those working closely with them.

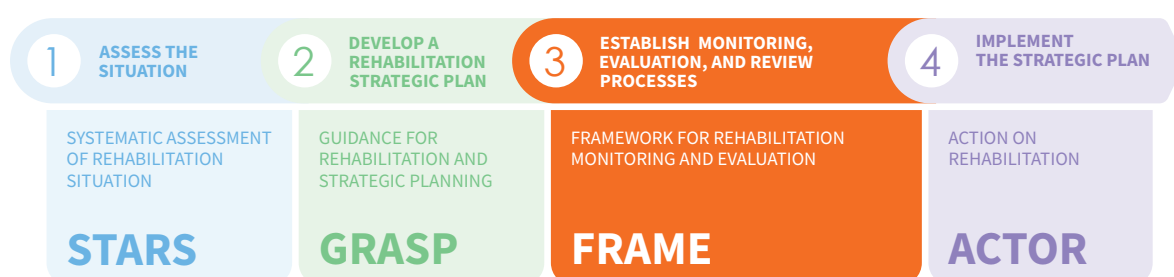
2 steps: (1) develop monitoring framework, (2) establish evaluation and review processes.

For **national levels** but can also be used at the **sub-national level**.

Strategic planning **translates** long-term **vision** and **priorities** into **concrete actions** for implementation.

See Table 9 for how FRAME forms part of the four-phase process set out in this guide.

Table 9: FRAME and the Four-Phase Process



Rehabilitation monitoring, evaluation and review

Monitoring refers to the collection and analysis of information about a project or programme – or the implementation of a plan, undertaken while it is ongoing and which provides indications of progress. Information is collected in relation to specified “indicators” that measure the extent of progress towards the achievement of objectives. A monitoring framework includes the set of indicators that measure progress towards the objectives of the plan.

Monitoring allows government to measure and report on the results of their strategic plan. The relationship between strategic plans and monitoring frameworks is illustrated in Figure 2 in the background section of this guide. Development of the monitoring framework should occur during the later stage of development of the rehabilitation strategic plan, or immediately after it is finalized, or both. Reasons to develop a monitoring framework are outlined in Box 8.



Box 8: Benefits of a monitoring framework for a rehabilitation strategic plan

- Monitors the results of the strategic plan against intended objectives
- Enables government accountability for rehabilitation
- Drives integration of rehabilitation into health information systems
- Builds technical knowledge of rehabilitation
- Identifies failures and successes of the strategic plan
- Provides data for advocacy and lobbying for further resources

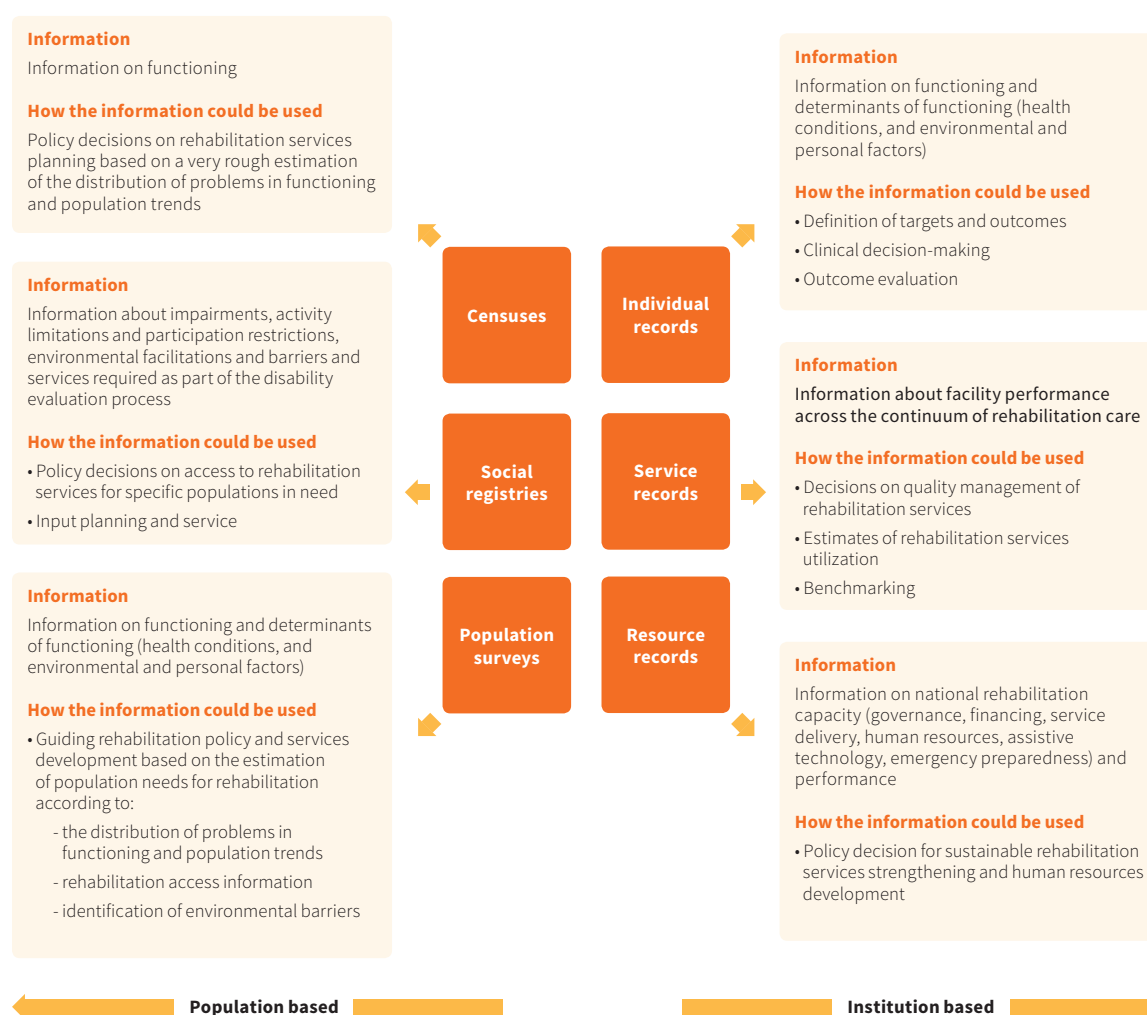
Evaluation is the periodic, retrospective assessment of an ongoing or completed project or programme – or of the implementation of a plan. The aim is to determine the relevance and fulfillment of the objective of the plan. An evaluation should provide information that is credible and useful, enabling the incorporation of lessons learned into the decision-making process of both recipients and donors. Evaluation builds on monitoring with the analysis going deeper. While monitoring tends to be a continuous process, evaluation is typically periodic, involves greater analysis and reflection, and considers the meaning of the monitoring framework results.

Reviews build on both monitoring and evaluation, and use more official processes to assess overall progress of the rehabilitation strategic plan.¹¹ The review focuses on specific barriers to achieving strategic objectives and makes recommendations to overcome these barriers. A review will provide information to enable a rehabilitation strategic plan to be adjusted, extended for a longer period or completely renewed. A review may happen less frequently and be linked to broader established review processes in that country. Conducting a review commonly requires additional financial resources.

Health information system data sources for rehabilitation monitoring

The indicators selected in a monitoring framework draw on information from a variety of data sources within the health information system, as illustrated in Figure 5. This figure outlines the different information sources, types of information and how the information can be used for rehabilitation decision-making.¹²

Figure 6: Rehabilitation Information Sources Within Health Information Systems



Different types of information will be used for the different types of indicators sitting across the input, output, outcome and impact categories (see Annex 8).

Prior to the development of a rehabilitation monitoring framework, it is worth considering developing a “rehabilitation results chain” – as introduced in the Background section. Annex 8 provides suggestions on how this can be done and on how such as chain can contribute to the development of the rehabilitation monitoring framework and help organize sources of information for the selected indicators.

¹¹ WHO Strategizing national health in the 21st century: A handbook. Geneva: World Health Organization; 2016.

¹² Further information on data sources and health information systems for rehabilitation can be found in the Rehabilitation 2030 meeting, *Background Paper on Health Information Systems and Rehabilitation*.

Indicators for rehabilitation monitoring

The FRAME guidance is accompanied by an additional tool, the Rehabilitation Indicator Menu (RIM). RIM contains a list of indicators that may be selected, adapted and used in a rehabilitation monitoring framework.

The indicators within the RIM are categorized according to the rehabilitation results chain (see Annex 8). Crucial to the selection of any indicator is that it reliably tracks change over time. To this end, a set of criteria – including reliability, validity, comparability, etc. – was developed to inform the selection of the indicators included in RIM. See Annex 8 for further details on these criteria.

The RIM includes two categories of indicator – core Indicators and expanded Indicators.

The core indicators were developed to monitor rehabilitation in general and allow comparison across countries. WHO encourages countries to adopt indicators that allow cross-country comparison. This can also ease reporting requirements from external stakeholders.

The expanded indicators were also developed to monitor of rehabilitation but are not necessarily comparable across countries. The expanded indicator set covers a wider range of rehabilitation results and some indicators include a short list of options to enable more tailoring of indicators to the specific goals, objectives and actions of the rehabilitation strategic plan.

The RIM is a separate document available on the **WHO website** and from WHO offices.

Steps and substeps of the process of establishing a rehabilitation monitoring framework and evaluation and review processes

Step 9: Develop monitoring framework with indicators, baselines and targets

1. Identify people to be engaged in development of monitoring framework

The Ministry of Health should create an informal group of people with expertise in rehabilitation, health information systems and evaluation, and reviewing health programmes to assist them in this process. The focal person or technical officer for rehabilitation within the Ministry of Health, along with the consultant, typically lead the process.

2. Review the rehabilitation strategic plan and identify a results chain

- Develop a results chain, based on the rehabilitation results chain (adapt as required), taking into account the overarching goals and objectives of the plan (see Background and Annex 8).
- Use the goals and objectives of the plan as a basis to select indicators.
- Consider other relevant Ministry of Health monitoring frameworks.

3. Select indicators

Countries should choose all of the core rehabilitation indicators from the RIM. Selection of indicators is an iterative process, with final decisions based on:

- goals and objectives of the plan;
- results chain, with balance across input, output, outcome, and impact;
- data sources identified (see substep 4 below);
- institutional capacity within country for data collection, management, analysis and use.

Consider the following when selecting indicators:

- *Is the indicator valid in our context?* Validity refers to there being sufficient evidence to link the indicator with the health objective being sought.
- *Is the indicator reliable in our context?* Reliability refers to the consistency of the indicator. A reliable indicator will produce similar results when measured repeatedly, provided there has been no change in the underlying value.
- *Is it feasible?* Feasibility refers to the data sources for the indicator being available within required timeframes and existing resources.

- *Is it relevant and does it help to achieve a good balance of indicators across the rehabilitation strategic plan?* Relevance suggests that the indicator will clearly relate to the objectives of the rehabilitation strategic plan, including priorities within the strategic plan, and that it complements other indicators selected.

4. Identify and develop data sources within the health information systems

A key issue is the extent to which data sources are available for the indicator. Consider what routine data are already collected regarding rehabilitation and how it can be adapted and expanded for the monitoring framework. As data for rehabilitation is generally restricted and inconsistently available due its limited integration into health information systems, it is very likely that some new data sources will need to be established in order to monitor indicators. Seek the expertise of health information systems personnel from the Ministry of Health to identify the possible new data sources and processes and anticipate that establishing these processes may occur over the first 2 years of the strategic plan period.

5. Identify indicator baselines, develop time-bound targets and establish frequency of data collection.

- Collect baseline information for each core indicator.
- Set time-bound targets that are realistic given resources available.
- Determine the frequency of data collection (some data sources, such as population surveys, are conducted at regular intervals).

Step 10. Establish evaluation and review processes

This step entails the working group establishing appropriate evaluation and review processes, including timeframes and the responsibilities of stakeholders. It is important that the evaluation processes are adapted to the country context – such as whether a country undertakes annual or biennial planning, and the capacity of rehabilitation stakeholders – in order to avoid onerous evaluation processes.

1. Establish the evaluation process

The evaluation reporting process should occur annually or biennially, with two steps:

- A. *Development of an annual evaluation report.*
 - B. *Conducting a joint stakeholder evaluation meeting.*
- A. *Development of a report.* The government should start the development of a short annual evaluation report 1 month before the end of the current year of planned activities. To this end, it should aggregate information from all stakeholders and complete a written report. The report may be informal and internal (i.e. not published) and primarily for participants attending the annual joint evaluation meeting.

The report should include three components

- i. *Update on progress on the implementation of the Rehabilitation Strategic Plan.* This component will help hold to account stakeholders engaged in implementation. It identifies the areas within the plan where action is being taken, where it may have been delayed, or is simply not occurring. This component can be presented in the style of either a “report card” or “traffic light” in relation to each of the plan’s actions, supplemented by a note of explanation where necessary. Information will come from government and other stakeholders engaged in implementation of the plan.
 - ii. *Numerical update on the Rehabilitation Monitoring Framework.* This can be presented as a copy of the monitoring framework, with numerical updates inserted for that year and a note of explanation where necessary.
 - iii. *A narrative report analysing and interpreting results.* Drawing on the two other components and any other relevant information, this component analyses and interprets the meaning of the results in narrative form. It considers the results in relation to each of the plan’s objectives and how and why these results are occurring. This should be succinct.
- B. *Conducting a joint stakeholder evaluation meeting.* Government should convene a joint rehabilitation stakeholder evaluation meeting, which should take place just before the planning meeting for the following year’s activities. The aim is to review the results of the evaluation report, allow stakeholders to discuss results, and to use the information to inform planning. Participants should include key stakeholders engaged in implementation of the rehabilitation strategic plan (a group very similar – or identical – to the Rehabilitation Technical Working Group created during the development of the rehabilitation strategic plan). The meeting provides a forum for all stakeholders, not just government, engaged in implementation of the plan to be held to account. This meeting could be used as a step in the finalization of the report.

2. Establish the review process

Reviews are less frequent than evaluations and may occur halfway through the strategic plan, or once it is completed. A review is a more formal process with dedicated resources allocated to it and reports made available to the public. Establishing a plan for review processes requires determining details such as when it will occur, available resources, and who is responsible for conducting the review. Enough resources should be available to support a consultant to undertake the review process and write up a report as this often requires more time than that available to government personnel.

The review should be comprehensive and systematic, and planned and resourced in a similar way to the situation assessment process outlined in STARS (consider using the STARS guidance). This allows the situations before and after the implementation of the strategic plan to be compared. However, the review is more than a second situation assessment. It should also provide an understanding of which changes have occurred as a direct result of the rehabilitation strategic plan and which aspects of the plan worked well or which did not. A review should also identify recommendations to inform development of the next rehabilitation strategic plan.

3. Document and share the monitoring, evaluation and review processes

The documentation and sharing of the monitoring, evaluation and review process are important aspects of government accountability and transparency. The evaluation and review processes can be documented within the strategic plan. The monitoring framework may also be inserted into the rehabilitation strategic plan document – though some baselines or targets may have yet to be selected.

CHECKLIST FOR FRAME

STEP 9. DEVELOP MONITORING FRAMEWORK WITH INDICATORS, BASELINES AND TARGETS		KEY TASKS COMPLETED
1. Identify people to be engaged in development of monitoring framework	• Planning for monitoring framework completed, contributors identified	☐
2. Review the rehabilitation strategic plan and identify a results chain	• Results chain identified and understood	☐
3. Select indicators	• Indicators selected	☐
4. Identify and develop data sources within the health information systems	• Data sources for indicators identified	☐
5. Identify indicator baselines, develop timebound targets and establish frequency of data collection	• Baselines, targets and frequency of data collection identified	☐
STEP 10. ESTABLISH EVALUATION AND REVIEW PROCESSES		KEY TASKS COMPLETED
1. Establish the evaluation process	• Evaluation process clarified and established	☐
2. Establish the review process	• Review process clarified and established	☐
3. Document and share the monitoring, evaluation and review processes	• Processes documented and shared	☐



Action on Rehabilitation **ACTOR**



ACTOR – Action on Rehabilitation

Aim: assist government to develop **processes** that **facilitate and coordinate** the **implementation** of the Rehabilitation Strategic Plan.

Primary audience: **government** and those working closely with them.

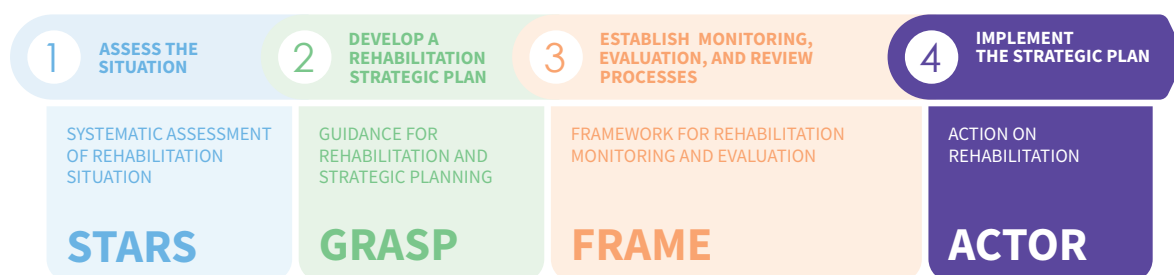
4 steps: (1) establish implementation cycle, (2) increase capacity of rehabilitation leadership and governance.

For **national level** but can also be used at the **sub-national level**.

Adapting this guidance to each situation is encouraged.

See Table 10 for how ACTOR forms part of the four-phase process set out in this guide.

Table 10: ACTOR and the Four-Phase Process



Implementing a rehabilitation strategic plan

During the implementation phase – typically a 3–5 -year period – the plan directs the actions of government and relevant stakeholders. Management processes are essential to ensure the plan actually gets implemented. A practical process to support the management is the “plan, do, and evaluate” cycle (see Figure 6). When undertaken, this cycle provides a clear mechanism for the overall management and coordination of strategic plan implementation.

The government, often through the rehabilitation officer or focal person, is responsible for establishing these processes and a high degree of participation from all stakeholders is recommended. When done well, this process will continue to build shared responsibility and investment in the rehabilitation strategic plan. Success or failure of a rehabilitation strategic plan will largely depend on the buy-in, willingness and understanding on the part of a range of health and rehabilitation stakeholders. This phase will be critical to the overall impact of the rehabilitation strategic plan.

Steps and substeps of the process of implementing the strategic plan

Step 11: Establish a recurring implementation cycle – the “plan, do and evaluate” (cycle)

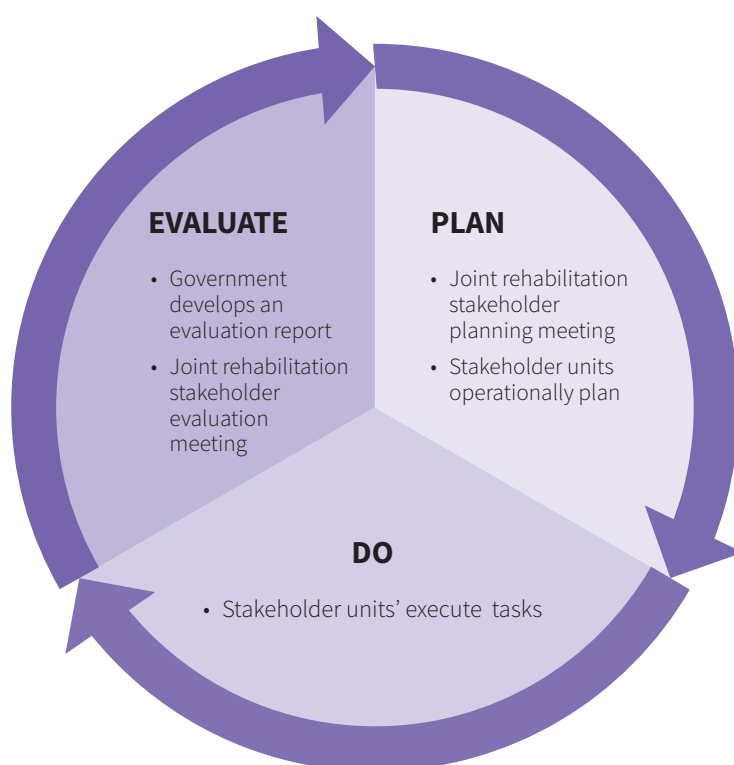
Establishing a recurring implementation cycle includes three stages (see Figure 6):

- Operational planning – “Plan”
- Execution of activities – “Do”
- Undertaking monitoring and evaluation – “Evaluate”

This should be led by government and engage implementation partners. All governments have different management structures, processes and timelines which this step needs to accommodate. Identifying successful implementation and programme management approaches used by other health programmes is helpful.

The planning is best carried out by those who will implement the actions in the plan. The group involved in this joint process will be similar, or identical, to the Rehabilitation Technical Working Group.

Figure 7: Recurring Implementation Cycle – Plan, Do and Evaluate



1. Operational planning – “Plan”

Operational planning is crucial to successful implementation of a strategic plan. During operational planning, implementation modalities are defined, financial and other resources identified, and timelines, budgets, and responsibilities agreed upon. Operational planning for implementing the rehabilitation strategic plan should be scheduled to allow time for its results to be integrated into government's larger operational planning and budgeting processes

The following suggestions are provided to support operational planning but should be adapted to the country situation.

- *Hold a joint rehabilitation stakeholder meeting to coordinate and plan:* This meeting should include all stakeholders executing tasks within the Rehabilitation Strategic Plan, and can occur alongside or immediately after the joint rehabilitation stakeholder evaluation meeting, which is linked to the annual evaluation process described below and in the FRAME guidance. During the rehabilitation stakeholder meeting the activities of the rehabilitation strategic plan scheduled for that year are clearly planned. The outcome is that all stakeholders, including those within ministries of health and those outside (e.g., professional associations or clinical specialist groups), know which tasks they are responsible for during the year ahead.
- *Operational planning at organization level:* Once activities have been planned for the following year, operational planning and budgeting should occur within the organization or unit implementing the activities. During this process, responsibilities, timelines and budgets should be made clear to all stakeholders.

2. Execute activities – “Do”

The next part of the implementation cycle is the execution and operationalization of tasks guided by the rehabilitation strategic plan. Many of the tasks within the strategic plan will be the responsibility of the Ministry of Health, and some will be the responsibility of other agencies. Each agency is accountable for their actions and results, and this accountability is reviewed when the outcomes are aggregated during the annual reporting.

3. Monitor and evaluate – “Evaluate”

The guidance for this substep is contained within the FRAME guidance, under Step 10, Evaluation process. The monitoring and evaluation processes are generally identified during finalization of the rehabilitation strategic plan, or immediately after.

Step 12: Increase capacity of rehabilitation leadership and governance

The achievement of the strategic plan's objectives depends on stakeholders' capacity – both human and financial – to lead and govern rehabilitation. Strengthening rehabilitation governance and leadership capacity should, therefore, be a priority. This is the responsibility of government, although stakeholders can also help. Some recommendations for good practice to strengthen the rehabilitation leadership and governance capacity are included below.

1. Good practices for strengthening rehabilitation leadership and governance capacity

Increasing the human and financial capacity for rehabilitation in the Ministry of Health

- Dedicated personnel with adequate financial resources are crucial for leadership and essential for successful implementation of a rehabilitation strategic plan.
- Creation of a rehabilitation unit or a dedicated rehabilitation technical officer within the Ministry of Health, which enables government to effectively govern and lead in this area, should be considered.
- This may also be an initial step leading up to development of a rehabilitation strategic plan.

Creating clear governance and accountability for rehabilitation

- The government is responsible for the overall development of rehabilitation.
- However, often the structures of governance for rehabilitation are not clear, and accountability mechanisms do not exist or do not function well. Improving these is a crucial step.
- Development of a clear governance structure, including an organogram with roles and responsibilities at different levels is a practical way to achieve this. While the basic governing frameworks and structures of the Ministry of Health will encapsulate rehabilitation, there are additional options, including creation of a high-level steering group or advisory group which has an oversight role and is in addition to the Rehabilitation Technical Working Group.

Building technical capacity and skills in leadership and rehabilitation

- The people who lead rehabilitation require both leadership skills and knowledge of rehabilitation. Frequently, personnel have skills in one area but seldom in both. Building capacity in both areas can occur through a variety of mechanisms.
- Formal training workshops, seminars and short courses may support the development of knowledge and skills in either leadership or rehabilitation.
- Supporting attendance at regional or international meetings and conferences can also contribute.

Creating rehabilitation networks, partnerships and alliances for rehabilitation

- Rehabilitation leadership is more powerful when united under a shared vision for improved rehabilitation services. Creating a united voice for rehabilitation advocacy and lobbying at the national level is crucial.
- To do this, a range of rehabilitation networks, partnerships and alliances should be developed. This will require breaking down – or preventing the formation of – rehabilitation professional silos.
- Creation of a national rehabilitation alliance is a mechanism for addressing this, and the rehabilitation technical working group may be a precursor to it.
- There may also be networks formed around particular health condition groups that drive the plan forward.

Nurturing and mentoring rehabilitation champions

- Mentoring facilitates the development of rehabilitation champions by establishing a two-way information flow between mentor and mentee. Mentoring builds deeper knowledge, skill and enthusiasm, and it provides the tailored information and encouragement that champions require.
- Connecting current and future leaders with others who can demonstrate, discuss and coach in specific areas for further development is an established method for ongoing professional development.

Facilitating country-to-country exchanges

- Country-to-country exchanges promote the transfer of knowledge and technical capacity, and enhance the local application of theory and practice.
- Study tours are one form of exchange and can facilitate deep-level experiential learning of complex systems. Leaders can observe the similarities and differences of real systems in action, recognize challenges, and gain an understanding of how to tailor systems to local needs.

CHECKLIST FOR ACTOR

STEP 11. ESTABLISH A RECURRING IMPLEMENTATION CYCLE – THE “PLAN, DO AND EVALUATE” (CYCLE)

KEY TASKS COMPLETED

- | | | |
|--------------------------------------|--|--------------------------|
| 1. Operational planning – “Plan” | <ul style="list-style-type: none"> • Government leading the coordination and operational planning of the strategic plan • Undertake operational planning | ☐ |
| 2. Execute activities – “Do” | <ul style="list-style-type: none"> • All agencies executing activities | ☐ |
| 3. Monitor and evaluate – “Evaluate” | <ul style="list-style-type: none"> • Government leading the monitoring and evaluation of the strategic plan | ☐ |

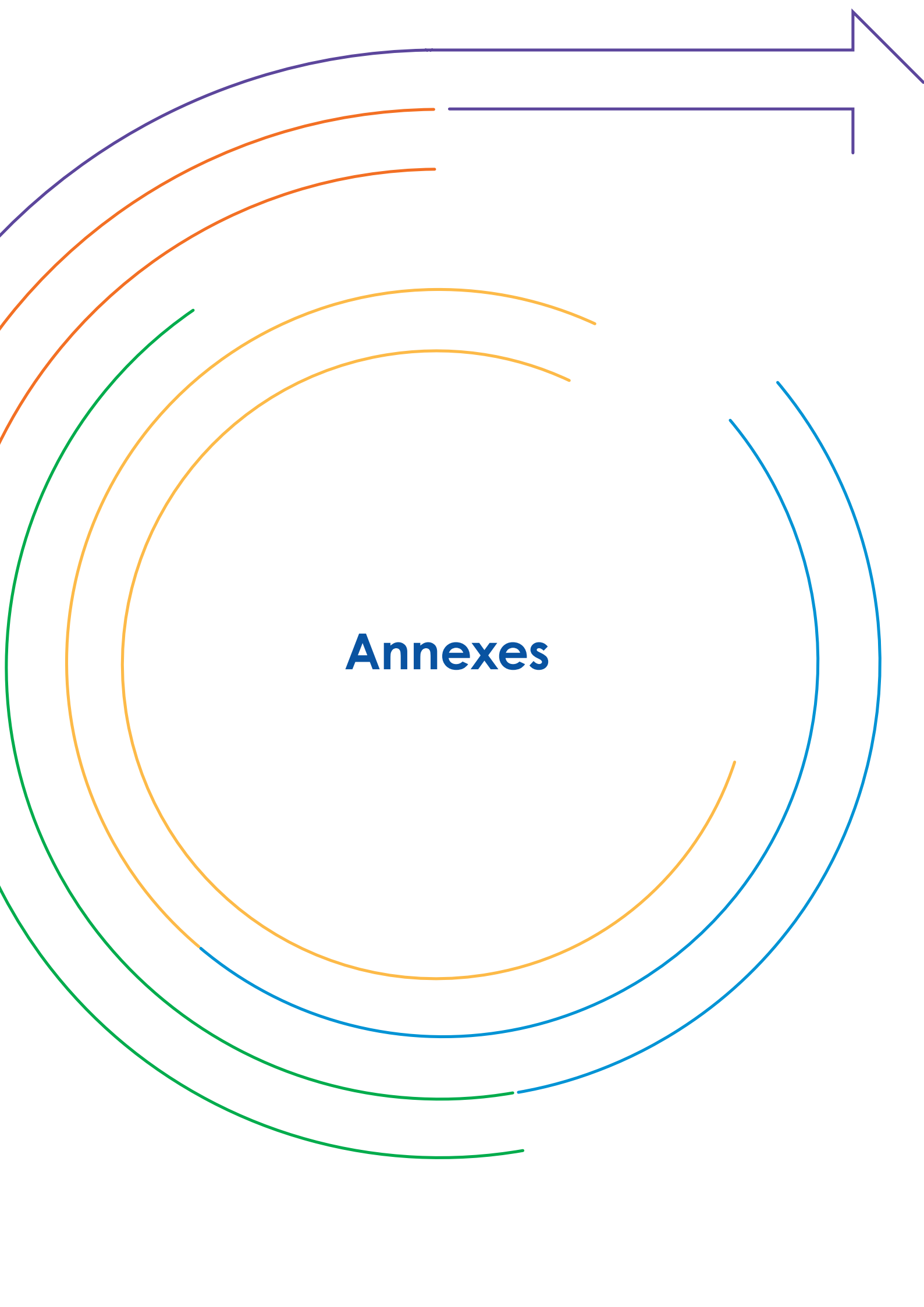
STEP 12. INCREASE CAPACITY OF REHABILITATION LEADERSHIP AND GOVERNANCE

KEY TASKS COMPLETED

- | | | |
|--|---|--------------------------|
| 1. Good practice recommendations for strengthening rehabilitation leadership and governance capacity | <ul style="list-style-type: none"> • Government, non-government and development partners building the leadership and governance for rehabilitation | ☐ |
|--|---|--------------------------|

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Annexes

Annexes

ANNEX 1. Frequently asked questions about rehabilitation assessment and planning

What aspects of rehabilitation should be in the situation assessment and the strategic plan? Should it include mental health, substance abuse, vision and hearing rehabilitation?

There is no right or wrong scope. The assessment and strategic plan should respond to the country's needs. For example, the inclusion of rehabilitation for people with mental health conditions may be unnecessary if it is already addressed in a mental health report and strategic plan. Similarly, rehabilitation for vision impairment may not be required if it is being included in an eye health situation assessment and strategic plan.

However, the rehabilitation strategic plan should identify priorities and synergies between rehabilitation and other health programmes. This will help support integration of rehabilitation into those programmes in future. Other health programmes where synergies are relevant include for older people, young children and people with long-term health conditions.

Ideally the decision regarding the scope of the strategic plan should be made prior to the situation assessment so all relevant areas are included in the situation assessment – and of this is not done it is prudent to keep it broad. In the STARS guidance, the scope of the plan is determined by the definition of rehabilitation interventions and by that of health systems, in this way all aspects of rehabilitation could be included.

Should a rehabilitation situation assessment and strategic plan include both the Ministry of Health and Ministry of Social Affairs? Should it also include other ministries who deliver rehabilitation services?

Again, there is no right or wrong answer to this question. Which ministries to include depends on what is best for stakeholders in that country at that point in time, it may also depend on the size of the country and complexity of the systems involved.

If there is agreement by the ministries that deliver rehabilitation that all rehabilitation should be assessed, then this can occur. Including all the ministries in the assessment may assist future collaboration, coordination and decision-making regarding which ministry is better placed to deliver different services. It is also appropriate to undertake an assessment of only the rehabilitation being delivered by the health ministry, if this occurs the assessment should consider how rehabilitation is intersecting with the other agencies and their services. After the assessment, a decision regarding the scope of the strategic plan is then required. If there is very good collaboration between ministries, then a joint strategic plan endorsed by both the Ministry of Health and the Ministry of Social Affairs – and other ministries, if relevant – may be a good way forward. However, if this is likely to pose many challenges, then separate planning that also addresses the coordination and collaboration between ministries is appropriate. For example, if the Ministry of Health is ready to undertake strategic planning but the Ministry of Social Affairs is not, then the Ministry of Health can move forward, making sure the plan includes coordination and collaboration mechanisms with the Ministry of Social Affairs. If both ministries are engaged, then the Ministry of Health should take the lead.

Should rehabilitation legislation and policy be developed alongside a strategic plan?

The answer depends on the country. Countries use different combinations of laws, policies, strategies and plans to govern and achieve their goals. In some countries, the development of policies and legislation may be necessary to generate the support and resources required for the successful implementation of a strategic plan. In other countries, this is not needed. Commonly, a strategic plan, led by the relevant government ministry within its current policy and legal framework, can mobilize enough support.

What evidence exists for how to optimally develop rehabilitation?

There is good evidence regarding development of rehabilitation and it should be carefully considered during the strategic planning process. The WHO *Rehabilitation in Health Systems* resource has brought together the best available

evidence on rehabilitation systems. This resource recommends the following which are relevant for rehabilitation strategic planning:

- Rehabilitation services should be integrated into health systems.
- Rehabilitation services should be integrated into and between primary, secondary and tertiary levels of the health system.
- A multi-disciplinary rehabilitation workforce should be available.
- Both community and hospital rehabilitation services should be available.
- Hospitals should include specialized rehabilitation units for inpatients with complex needs.
- Financial resources should be allocated to rehabilitation services to implement and sustain the recommendations on service delivery.
- Where health insurance exists, or is to become available, it should cover rehabilitation services.
- Financing and procurement policies should be implemented to ensure that assistive products are available to everyone who needs them.
- Adequate training should be offered to the user, and care provider when appropriate, when assistive products are provided.

How can strengthening rehabilitation and the provision of assistive products be synergized in a country?

Rehabilitation includes provision of assistive products (AP), so it is relevant to consider inclusion of AP in a rehabilitation strategic plan. However, the rehabilitation strategic plan may not necessarily address all areas related to AP, nor include all government agencies that deliver AP. Consequently there are times when more dedicated and focused strategic planning for AP is also appropriate.

AP is under-developed in many low- and middle-income countries and WHO is committed to strengthening AP in line with the WHO Global Assistive Technology Initiative. The provision of AP is embedded into the STARS Rehabilitation Maturity Model in two locations: in governance (under inputs of the rehabilitation results chain) and in rehabilitation availability (under outputs of the results chain). There are also questions related to AP financing in the Template for Rehabilitation Information Collection.

The inclusion of AP provision in a rehabilitation strategic plan should be based on the situation in the country. In many low- and middle-income countries where AP provision is limited, the inclusion of AP in a rehabilitation strategic plan may strengthen its development. In higher income countries, where rehabilitation and AP provision are more mature and services more complex, separate strategic planning may be advisable. AP, like rehabilitation, is a highly integrated service that should also be integrated into a range of health, disability, education and ageing programmes.

Should a rehabilitation strategic plan include a dedicated objective making health systems more inclusive and accessible for people with disability?

A rehabilitation strategic plan addresses rehabilitation services that must be made available to the whole population – including both people with and without disabilities. To ensure clarity about the target population of rehabilitation – the whole population – it is recommended that the strategic plan not include a dedicated objective making health systems more inclusive and accessible for people with disability.

Addressing barriers to health care and ensuring it is inclusive and accessible for people with disability is very important. Opportunities to do this need to be identified, and targeted approaches to building inclusive and accessible health care are warranted. Accessible and inclusive health care for people with disabilities is a human rights and equity issue. Undertaking separate actions to address barriers to health care for people with disability is a clear way forward. But this should occur under a strategic approach separate from the one for strengthening rehabilitation.

How do we create a long-term plan for the development of rehabilitation?

For a country to create a national rehabilitation strategic plan with a 5-year time frame, it may be helpful to create a 10+-year vision for rehabilitation. The level of detail of long-term planning (10+ years) may vary across countries. For some countries, the long-term plan could simply be that “all provinces have a specialist rehabilitation facility and that all tertiary and secondary level health care facilities have multi-disciplinary rehabilitation care with selected primary care facilities having single-professional care”. In many low and middle income countries this level of long-term planning is often adequate. However, some countries may require more detailed planning whereby the identification of which precise facilities are developed, this requires more extensive planning resources.

Into which health planning processes can rehabilitation be integrated?

Other health planning processes into which rehabilitation can be integrated include national health strategic planning, role delineation planning, defining of the packages of care, and development of service standards. Rehabilitation should also be integrated into health planning in areas such as mental health plans, eye and hearing care plans, and in health plans for older people, people with non-communicable disease and in the context of healthcare during early childhood. Other areas for integration of rehabilitation include health emergency preparedness and health workforce and infrastructure planning. Rehabilitation strategic planning should always seek to better integrate rehabilitation into other health planning processes.

How do we undertake rehabilitation planning when we have limited data on the need for rehabilitation?

It is important to make every effort to collect data on rehabilitation need to inform planning. The STARS assessment directs governments to collate information regarding incidence and/or prevalence of health conditions amenable to rehabilitation. Often these data are from population-level sources such as injury rates, or from Global Burden of Disease estimates. Efforts should also be made to collect other types of data such as through audits of patients who required rehabilitation and those who receive adequate rehabilitation and waiting lists for rehabilitation. If such data are limited or not available, then data from the Global Burden of Disease studies from the Institute of Health Metrics can provide insights.

In low- and middle-income countries, planning for rehabilitation can move forward without precise data on rehabilitation needs because the evidence clearly indicates significant unmet need and therefore significant expansion of services are necessary and should be planned.

What is an appropriate governance structure for rehabilitation?

The government agency responsible for rehabilitation should be clearly designated, this should be the ministry of health. Inside this ministry it should be clear where rehabilitation is 'housed' and a director have responsibility for rehabilitation. There may also be specialized rehabilitation committees and working groups established. For example, a high-level steering committee for rehabilitation can be created, which includes senior management from the ministry, expert practitioners, academics, and consumer representation. A Rehabilitation Technical Working Group can also be established to provide advice to government, support coordination, facilitate collaboration and contribute to advocacy.

Where there are two ministries delivering rehabilitation, it is appropriate for each to have its own internal governance structure for rehabilitation, however, effective mechanisms to coordinate their activities should be established. Governance structures for rehabilitation that have proved effective in other countries may serve as a useful model. It is not recommended that a country's only governance structure for rehabilitation sit under the auspices of a disability plan or policy.

Should the government develop a strategic plan if there is no dedicated rehabilitation officer within the Ministry of Health?

Development and implementation of a strategic plan requires capacity within the Ministry of Health – capacity to support the overall planning, implementation and reporting on the plan. If a government is committed to developing a rehabilitation strategic plan, it should therefore have a dedicated rehabilitation officer within the Ministry of Health and the resources to fund this position.

In many low- and middle-income countries there are ministries of health with no formally appointed rehabilitation officers. Instead, they have informally appointed the director of a national rehabilitation facility or a leading rehabilitation medicine practitioner as their focal point for rehabilitation. This is rarely sufficient to support the development and implementation of a strategic rehabilitation plan.

Should a national or subnational-level strategic plan be developed?

The answer depends on the country and depends on, among other factors, the degree of decentralization, the country's population and the complexity of the rehabilitation system. A country with a large population, complex and developed rehabilitation systems and a decentralized governance system will benefit from a subnational rehabilitation strategic plan.

A smaller, more centralized country with a less complex and developed rehabilitation system may be better off with a national rehabilitation strategic plan. Examining national or subnational plans for other health programmes, and the degree of their success, might help guide this decision.

ANNEX 2. Rehabilitation in Health Framework. Definitions.

The Rehabilitation in Health Framework informs the STARS guidance by providing a common structure and organization of rehabilitation. Across countries there is significant variation in the configuration of rehabilitation. This framework highlights common types of rehabilitation and suggests an optimal mix of rehabilitation in a country. It utilizes an adapted version of the commonly applied pyramidal structure of primary to tertiary health care. The following definitions accompany Figure 5 in the STARS guidance. These definitions and a glossary can also be found in the TRIC tool.

Specialized, high-intensity rehabilitation

Characteristics: This type of rehabilitation is specialized with capacity for high-intensity delivery in a longer-stay facility or programme. This rehabilitation is commonly for people with complex needs that impact on multiple domains of functioning. This rehabilitation is considered tertiary care that may start in the acute phase and continue into the sub-acute phase. Services may be highly specialised for one health condition, such as in a spinal cord injury, or provide rehabilitation for people with a range of health conditions in a dedicated rehabilitation centre. In this type of rehabilitation, the rehabilitation interventions are most commonly delivered by rehabilitation personnel but can also be delivered by other specialised health personnel.

Key user groups: People with spinal cord injury, traumatic brain injury, burns, stroke, major trauma, orthopaedic fracture and replacements, deconditioning, pain, organ transplant, amputation and a range of other cardiovascular, neurological and psychiatric conditions.

Settings: Inpatient, outpatient and day programmes in longer-stay rehabilitation hospitals, departments, programmes and centres. It may also include specialised units where rehabilitation is intensely delivered, such as a burn or stroke unit.

Community-delivered rehabilitation

Characteristics: This type of rehabilitation is delivered in community settings for people whom delivery in these settings further optimizes their functioning, and who have difficulties accessing rehabilitation outside of these settings. Community-delivered rehabilitation is a form of secondary and tertiary care occurring during the sub-acute and long-term phases of care, this distinguishes it from primary healthcare. It encompasses moderate- to low-intensity rehabilitation over a short-, intermittent- or long-term period. It may include specialised rehabilitation, such as for people transitioning into the community with ongoing rehabilitation needs or it may be integrated into a range of other health services and community programmes, such as in-home nursing care or early childhood intervention programmes. In this type of rehabilitation, the rehabilitation interventions are most commonly delivered by rehabilitation personnel but can also be delivered by other health personnel.

Key user groups: People recently discharged from a longer-stay facility with complex rehabilitation needs; people with intermittent rehabilitation needs; people with limited access to transportation; children with disabilities; older people participating in health programmes; people with vision, degenerative disease or workplace injury; and people receiving rehabilitation in nursing homes or palliative care services and programmes.

Settings: Localised health clinics, single or multi-professional practices, homes, schools, childcare settings, workplaces, leisure settings, long-term care facilities, hospices and local community centres.

Rehabilitation integrated into medical specialties in tertiary and secondary health care

Characteristics: This type of rehabilitation is less specialized and typically delivered for a short period during the acute- or sub-acute phases of care. It is integrated into health services and programmes for people with a wide range of conditions who are being treated in tertiary and secondary health care. In this type of rehabilitation, the rehabilitation interventions are most commonly delivered by rehabilitation personnel but can also be delivered by other health personnel.

Key user groups: People with a wide range of musculoskeletal, neurological, cardiovascular, respiratory, geriatric, psychiatric, internal organ, hearing, vision, gynaecological, paediatric and other health conditions.

Settings: Tertiary or secondary hospital and clinic settings. Hospitals may be general with multiple medical specialties or they may be specialised, such as an eye, ear or cancer hospital.

Rehabilitation integrated into primary health care

Characteristics: This type of rehabilitation is 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. It may be delivered during the acute-, sub-acute and long-term phases of care. In this type of rehabilitation, the rehabilitation interventions are most commonly delivered by rehabilitation personnel but can also be delivered by other primary health care personnel.

Key user groups: People with musculoskeletal, neurological, or psychiatric conditions.

Settings: Primary health care centres, clinics, single- or multi-professional practices.

Informal and self-directed rehabilitation

Characteristics: This type of rehabilitation is informal and self-directed, occurring where there may be no rehabilitation or health personnel present. It occurs during a rehabilitation process and or as part of an individual rehabilitation plan, it may also occur when people initiate their own rehabilitation to maintain or further improve their functioning, commonly over long-term period. Examples of this include carers supporting rehabilitation in long-term care settings, education workers carrying out rehabilitation with children with disability in schools, people with lower back pain undertaking yoga or tai chi classes, and coaches incorporating rehabilitation into sports training programmes. It also includes the rehabilitation exercise performed by people in their homes to maintain or improve their functioning.

Key user groups: People with a wide range of musculoskeletal, neurological, cardiovascular, respiratory, geriatric, psychiatric, gynaecological, paediatric and other health conditions.

Settings: Home, school, park, workplace, health club or resort, swimming pool, community group, long-term care facilities.

ANNEX 3. Sample terms of reference for consultants using STARS

Terms of reference for undertaking a rehabilitation situation assessment using STARS may include the following activities.

- To undertake a situation assessment of rehabilitation in NAME OF COUNTRY utilizing the WHO Systematic Assessment of Rehabilitation Situation (STARS) guidance.
- To work closely with government to assist them to plan details of the assessment process, including (but not limited to) clarification of the scope of assessment, completion of the STARS Template for Rehabilitation Information Collection (TRIC), creation of a rehabilitation technical working group, itinerary for the in-country assessment and timelines for report completion and consultation.
- To work closely with WHO and relevant development partners to ensure alignment and coordination of the support to government.
- To work closely with government to guide it through the STARS Rehabilitation Maturity Model (RMM) and ensure understanding of the assessment findings.
- While in-country, undertake site visits, key informant interviews, focus group discussions, SWOT analyses and other activities to ensure thorough consultation has taken place.
- As appropriate and as opportunities arise, to provide technical advice and capacity development to key stakeholders on the strengthening of rehabilitation systems.
- To input data from TRIC into the WHO database and return to WHO.
- To write a coherent, succinct and timely report following the WHO STARS template for writers, and incorporate feedback on subsequent drafts.

ANNEX 4. Sample timeframe for the four-phase process

TIME	TYPICAL PROCESS FOR THE FIRST 12 MONTHS	RESPONSIBLE AGENCY
1st month	SEND REQUEST: Government requests WHO for assistance	Government
	COORDINATE ACROSS THREE LEVELS OF THE ORGANIZATION: Headquarters, Regional and Country Offices	WHO
	CLARIFY ROLES: If additional development partners are engaged, clarify and document the roles of all partners	WHO, government, and development partner
	ESTABLISH COMMUNICATION: Establish group email between all partners and WHO to share information	WHO
2nd month	DETAILED PLANNING OF FOUR-PHASE PROCESS: Agreement on process, budget, timeframe, and roles.	Government & WHO combined
	COMMISSION CONSULTANT: Identification, contracting and briefing of consultant	WHO, government, and development partner.
	COMMENCE ASSESSMENT: Send STARS <i>Information and Template for Rehabilitation Information Collection (TRIC)</i> to government (8 weeks before in-country assessment period)	WHO to send template to government
3rd month	CREATE ITINERARY: For conducting in-country assessment	Government, consultant and WHO
	ESTABLISH REHABILITATION TECHNICAL WORKING GROUP: For technical guidance during four-step process	Government
4th month	CONDUCT IN-COUNTRY ASSESSMENT: Utilizing STARS , typically occurs over 2 weeks, jointly conducted by government and consultant.	Government and consultant
5th month	REPORT WRITING: First draft submitted to government within 4 weeks of completion of in-country assessment	Consultant
6th month	REPORT REVIEW: Government shares report with Rehabilitation Technical Working Group and key stakeholders to provide feedback to consultant for finalization	Government and WHO
	PREPARE FOR STRATEGIC PLAN: Government plans process and forms a Rehabilitation Strategic Plan and Monitoring Framework Drafting Group	Government
7th month	DRAFT STRATEGIC PLAN: Using GRASP guidance, a 1–2 week in-country period with a consultant is recommended. The first draft is submitted to government within 1 week of mission completion. This period may include:	Government and consultant
	A policy dialogue event during which the situation assessment findings are shared and government commitment to rehabilitation is expressed.	Government
	Costing of the rehabilitation strategic plan. If a costing is required, government must indicate this early during the planning process and provide significant input to the costing exercise and determine if another consultancy is required.	Government and consultant
	Development of the rehabilitation monitoring framework, using FRAME. This may occur during or immediately after drafting of plan. If time and funds permit, this can be supported by a consultant on a separate visit – see below.	Government and consultant

8th month	CONSULTATION ON DRAFT REHABILITATION STRATEGIC PLAN: Government facilitates consultation on draft rehabilitation strategic plan	Government and WHO
9th month	FINALIZE REHABILITATION STRATEGIC PLAN AND MONITORING FRAMEWORK: Government incorporates feedback on first draft of strategic plan Another visit from a consultant for in-country technical support to develop the rehabilitation monitoring framework using FRAME (if not undertaken earlier)	Government, WHO, and consultant
10th month	FINALIZE BOTH REHABILITATION STRATEGIC PLAN AND MONITORING FRAMEWORK: Government in final approval process of the rehabilitation strategic plan	Government
11th month	ENDORSE STRATEGIC PLAN: Government has rehabilitation strategic plan and monitoring framework endorsed/signed off by relevant minister and/or parliament. Copies are printed and disseminated	Government
12th month	IMPLEMENT: Start implementation of the rehabilitation strategic plan through coordination and development of government and rehabilitation stakeholders' work plans Use ACTOR guidance and enter cyclical process of annual or biennial planning, action and evaluation	Government, development partner, and WHO

ANNEX 5. Sample budget four-phase process

TIME	ACTIVITY	AGENCY LIKELY TO CONTRIBUTE	ESTIMATED COST
4th Month	Consultant for STARS assessment, including 2-week in-country period.	WHO or development partner *government in some cases	20 days' work plus consultant travel costs US\$ 18 000
4th Month	In-country consultation meeting(s) during assessment period	Government	US\$ 3 000
4th Month	In-country transport for consultant during assessment period	Government	US\$ 1 000
7th Month	Consultant for strategic planning using GRASP, including 2 weeks in-country period. (contracted by WHO or development partner)	WHO or development partner *government in some cases	20 days' work plus consultant travel costs US\$ 18 000
7th Month	In-country consultation and planning meetings during strategic planning period	Government	US\$ 3 000
7th Month	A costing of the strategic plan is often needed; if so, a local consultant can be hired	WHO or development partner *government in some cases	US\$ 3 000
9th Month	A separate in-country consultant period may occur for finalization of strategic plan and development of the Rehabilitation Monitoring Framework using FRAME	WHO or Development Partner *Government in some cases	10 days' work plus consultant travel costs US\$ 10 000
12th Month	Printing and distribution of, and launch event for, the Strategic Plan	Government	US\$ 2 000

ANNEX 6. Itinerary suggestions for the in-country assessment period

Overall suggestions for planning the itinerary

- Ministry of health should lead the assessment process with the consultant in a supporting role.
- The Ministry of Health rehabilitation officer and focal points should accompany the consultant during (at least parts of) the assessment.
- Advanced planning of appointments by the Ministry of Health is essential, as consultant time in the country may be relatively short.
- Government is responsible for transport, but WHO or other development partners may assist at times.
- Commence with initial Ministry of Health and WHO briefing.
- End with a final Ministry of Health and WHO debriefing.
- Meeting and briefing available senior Ministry of Health representatives should be given priority.
- Consider holding a roundtable/seminar during the second week if government identifies the need; this could include sharing initial findings and recommendations.

List of people who should be met (this will vary by country)

- Ministry of Health core rehabilitation officers, focal points, units, groups.
- Ministry of Health directors and senior personnel from other areas, e.g. director of hospitals, preventive medicine, workforce.
- Ministry of Health representatives from provincial health, e.g. director/focal person for rehabilitation.
- Ministry of Social Welfare, Ministry of Education, and any other relevant government rehabilitation stakeholders, such as national health insurance agencies.
- Ministry/agency responsible for disability coordination.
- Rehabilitation personnel from across professions, types of service, and agencies.
- Professional associations for rehabilitation professionals.
- Rehabilitation academics and teachers in rehabilitation training schools.
- Rehabilitation consumers and disabled persons' organizations.
- A range of other medical specialists who interface with rehabilitation providers, such as paediatricians, neurologists, orthopedic surgeons and general practitioners.
- Key international and national nongovernmental organizations, and development partners (bilateral/UN) active in rehabilitation.

The facilities that should be visited will vary in each country, but below is a list of suggestions. The site visits will commonly include interviews or focus group discussions with providers

- National rehabilitation centre/hospital/unit
- Tertiary hospital rehabilitation facilities
- Secondary-level hospitals, with and without rehabilitation
- Primary health care services, with and without rehabilitation
- Community-delivered rehabilitation programmes
- NGO service providers
- Mental health, vision and hearing rehabilitation services
- Early childhood intervention programmes, paediatric rehabilitation programmes

Engagement with rehabilitation users

A dedicated focus group discussion is suggested with rehabilitation users, and possibly rehabilitation providers. This focus group discussion should focus on accessibility, including whether rehabilitation is available, affordable and acceptable. This discussion should help identify barriers to accessing rehabilitation. The focus group should also explore care quality and consider how people have been respected, engaged, educated and empowered during the rehabilitation processes.

SAMPLE ITINERARY FOR IN-COUNTRY ASSESSMENT PERIOD

WEEK ONE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Initial briefing with Ministry of Health and WHO	Meeting with Rehabilitation Technical Working Group, including undertaking a SWOT analysis	Site visit to tertiary hospital and specialist rehabilitation facility. <i>All site visits include interviews and meetings with staff</i>	Site visit to primary health care/ community health programmes, including those without rehabilitation, to understand how users with rehabilitation needs are managed	Site visit to other rehabilitation facilities, such as community NGOs, or specialist hearing, vision or mental health rehabilitation programme
Meeting with Ministry of Health, including detailed preparation for upcoming meetings	Further meetings with senior Ministry of Health representatives or other key government agencies	Site visit to secondary-level health facility with rehabilitation	Meeting with other relevant programmes and service providers, including ministry of education, labour or development partners	Meeting with professional associations and academic institutions

WEEK TWO

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Visit to provincial and rural health and rehabilitation facilities/services	Continuation of visit to provincial and rural health and rehabilitation facilities/services	Meeting with users of rehabilitation services	Ministry of Health and consultant meeting to discuss findings across the Rehabilitation Maturity Model components	Full or half-day meeting with Rehabilitation Technical Working Group and potentially other stakeholders to discuss findings and situation
Provincial and rural meetings, including with NGOs/providers and rehabilitation users	Continued visit in rural areas, including meetings and travel.	Any further meetings with government agencies, development partners etc.	Further time with Ministry of Health for discussion of priorities and planning	Debriefing – Ministry of Health and WHO

ANNEX 7. Template for a STARS Report

Note. Actual examples of STARS reports can be sourced from WHO offices, through email rehabilitation@who.int

Table of Contents, including for tables or figures

Acronyms

Executive summary

A 2-page summary of the report, including:

- Key findings (e.g. strengths of the system)
- Identification of the priority areas for action
- Full set of recommendations

Background and methodology

- Explain the background and rationale for the assessment, include both the global and country perspectives
- Link with increasing need for rehabilitation and consider including the WHO Rehabilitation 2030 Initiative and Call for action
- Describe how government has expressed its commitment to strengthen rehabilitation
- Describe the methodology used for the assessment

Introduction to rehabilitation

Introduce the reader to rehabilitation and the actual report. Not everyone reading the report will be familiar with rehabilitation, so a definition and its importance should be included here. Include a standard definition of rehabilitation and its multiple benefits and explain its importance to health systems and universal health coverage.

Health trends and rehabilitation needs

- Describe health trends in the country and highlight current and potential rehabilitation needs
- Include data, and Global Burden of Disease Country Profiles on disability and morbidity
- Include other trends that impact rehabilitation needs, e.g., noncommunicable and communicable diseases, injuries, ageing, and the country's health pyramid

Overview to rehabilitation

Provide an overview of rehabilitation in the country, its relation to health and other sectors (e.g. social affairs), and its evolution.

Overview to the health system

- Provide, in one short paragraph, basic information about the country, its population, socio-economic situation and relevant features
- Outline basic structure to the health system
- Describe the key agencies engaged in rehabilitation, broadly include their governance, financing and service structures
- Include any recent reforms to and developments in the health and social system relevant to rehabilitation, and highlight their relevance and links with rehabilitation.

Outline of rehabilitation in country

- Briefly outline the rehabilitation situation in the country, including key stakeholders and the programmes and services that exist
- Describe the scope of rehabilitation within this assessment, reflecting the focus of this tool on health-related rehabilitation, including:

- all rehabilitation delivered to adults and children, including in health facilities and outside of health facilities; and
 - rehabilitation programmes for children with developmental delays and disabilities.
- Describe the evolution of rehabilitation in the country
 - Describe if conflict, disaster or disease have influenced the sector and explain the role that government and other stakeholders, such as NGOs have had on the system
 - If cultural understandings of disability and rehabilitation have significantly influenced the development of rehabilitation, explain their influence and impact

Rehabilitation intersections with other agencies/sectors

Describe how rehabilitation intersects with other sectors and include any governance linkages. This section provides an opportunity to clarify the difference between rehabilitation and disability and describe any overlaps between ministries and their programmes related to rehabilitation.

Rehabilitation governance

Describe how well rehabilitation governed (the suggested headings below align to RMM components of governance and may be altered to better suit the context). Under each of these headings describe the situation with concrete examples. The contents of the maturity model can be used as prompts for describing the situation.

At the start of this governance section a small table highlighting key information should be included, as suggested here.

KEY INFORMATION	DETAILS
REHABILITATION LEGISLATION	
REHABILITATION POLICY	
REHABILITATION STRATEGIC PLAN	
REHABILITATION COORDINATION MECHANISMS	
REHABILITATION ACCOUNTABILITY MECHANISMS	

Rehabilitation leadership, planning and coordination

Accountability, transparency and regulation for rehabilitation

Governance and procurement of assistive products

Summary of Governance

Summarize the key features of rehabilitation governance in the country, highlighting both strengths and challenges.

Rehabilitation financing

Describe how well rehabilitation is financed (the suggested headings incorporate the maturity model components of financing). These may be altered to better suit the context. Under each of these headings describe the situation with concrete examples. The contents of the maturity model can be used as prompts for describing the situation.

At the start of this financing section a small table highlighting key information should be included, as suggested here.

KEY INFORMATION	DETAILS
REHABILITATION EXPENDITURE	
REHABILITATION EXPENDITURE AS PROPORTION OF TOTAL HEALTH EXPENDITURE	
ASSISTIVE PRODUCT EXPENDITURE	
OUT-OF-POCKET COSTS FOR HEALTH AND CATASTROPHIC HEALTH EXPENDITURE LEVELS	
MECHANISMS FOR REHABILITATION FINANCING	

Financing mechanisms for rehabilitation

Out-of-pocket payments and financial protection of rehabilitation

Summary of financing

Summarize the key features of rehabilitation financing systems in the country and include their strengths and weaknesses.

Rehabilitation human resources and infrastructure

Describe the rehabilitation workforce (the suggested headings below incorporate maturity model components of workforce system). These can be altered to better suit the context. Under each of these headings describe the situation with concrete examples. The contents of the maturity model can be used as prompts for describing the situation.

At the start of this workforce section, a small table highlighting key information should be included, as suggested here.

KEY INFORMATION	DETAILS
TOTAL NUMBER OF REHABILITATION PERSONNEL	
NUMBER OF REHABILITATION PERSONNEL PER 10 000 POPULATION	
TOTAL NUMBER OF EACH REHABILITATION PROFESSIONS AVAILABLE	
DISTRIBUTION OF REHABILITATION PERSONNEL ACROSS GEOGRAPHIC AREAS	
NUMBER OF REHABILITATION COURSE GRADUATE'S PREVIOUS YEAR	

Rehabilitation personnel availability

Rehabilitation personnel training and skills

Summary of human resource

This section should summarize the key features of rehabilitation workforce in the country and include their strengths and weaknesses.

Rehabilitation information

Describe the status and uptake of rehabilitation information from across health information systems (the suggested headings below incorporate maturity model components of information systems). These may be altered to better suit the context. The contents of the maturity model can be used as prompts for describing the situation.

At the start of this rehabilitation section a small table highlighting key information should be included, as suggested here.

KEY INFORMATION	DETAILS
DATA ON DISABILITY, FUNCTIONING AND REHABILITATION NEEDS	
DATA ON AVAILABILITY OF REHABILITATION	
DATA ON UPTAKE OF REHABILITATION	
DATA ON OUTCOMES OF REHABILITATION	
GOVERNMENT FUNDING FOR REHABILITATION RESEARCH	

Rehabilitation information Generation

Rehabilitation information used to inform policy and programme decision-making

Summary of information

Summarize the key features of rehabilitation information systems in the country and include their strengths and weaknesses.

Rehabilitation accessibility and quality

Describe the rehabilitation delivered in the country (the suggested headings below incorporate the maturity model components of services). These may be altered to better suit the context. The contents of the maturity model can be used as prompts for describing the situation. This section should cover two broad components of services: the accessibility of rehabilitation and the quality of rehabilitation delivered. The accessibility of rehabilitation is broken down into availability (the largest part of the section), affordability and acceptability. The inclusion of these sections here maintains the alignment with the rehabilitation results chain.

At the start of this section a small table highlighting key information should be included, as suggested here.

KEY INFORMATION	DETAILS
Percentage of tertiary hospitals with rehabilitation services (this may be broken down into separate professional services, e.g. physiotherapy, occupational therapy, speech and language therapy, prosthetics and orthotics, physical and rehabilitation medicine services, or as multi-professional e.g. % of tertiary hospitals with 3+ professions)	
Percentage of secondary hospitals with rehabilitation (this may be broken down into separate professional services as above or as multi-professional e.g. % of secondary hospitals with 2+ professions)	
Percentage of primary care with rehabilitation. This will commonly need to specify which level of primary health care as not all primary care facilities are expected to have rehabilitation	
Percentage of districts/communities covered by rehabilitation services; this may represent nongovernmental organizations	
Number of specialist rehabilitation facilities/units	
Number of rehabilitation beds, and rate per 10,000 population	

Accessibility of rehabilitation

- Availability of specialist rehabilitation, with longer-stay, high intensity more specialized capacity
- Availability of rehabilitation in tertiary health care
- Availability of rehabilitation in secondary health care
- Availability of rehabilitation in primary health care
- Availability of rehabilitation delivered in the community
- Availability of rehabilitation across all phases of acute, sub-acute and long-term care.
- Availability of rehabilitation for children with developmental difficulties and disabilities
- Availability of rehabilitation for target population groups
- Provision of assistive products – mobility, environment, vision, hearing, cognition, communication
- Affordability of rehabilitation
- Acceptability of rehabilitation

Quality of rehabilitation

- Effectiveness of rehabilitation
- Timeliness and delivery of rehabilitation along the continuum of care
- Person-centered rehabilitation care that engages users, family, carers
- Safety of rehabilitation

Summary of services delivering rehabilitation

Summarize the key features of rehabilitation delivered in the country and include their strengths and weaknesses.

Outcomes and system attributes

Informed by the rehabilitation results chain, include the rehabilitation outcomes, coverage of rehabilitation in the population groups who need it, and functioning outcomes among population groups who receive it. Also include the four attributes of high-performing health systems – equity, efficiency, accountability and sustainability. The suggested headings below align to the maturity model components. These may be altered to better suit the context. The contents of the maturity model can be used as prompts for describing the situation.

Outcomes

- Coverage of rehabilitation in the groups who need it
- Functioning outcomes of rehabilitation in the groups who receive it, including population functioning

Attributes

- Equity
- Efficiency
- Accountability
- Sustainability

Conclusions and recommendations

Bring together the main findings of the assessment and:

- draw conclusions about the strengths of rehabilitation;
- identify remaining challenges and priority areas for action; and
- make recommendations for strengthening rehabilitation.

The three subheadings below should read as a logical progression and be comprehensive, coherent and concise.

Strengths of rehabilitation

Synthesize findings and present them as strengths and challenges. The content should reflect the strengths, weaknesses, opportunities and threats (SWOT) of rehabilitation and address both internal and external drivers of the system.

Remaining challenges and priority areas for action

Outline remaining challenges that are also clear and actionable priority areas to strengthen rehabilitation. Recommendations in the next section should flow logically from this section.

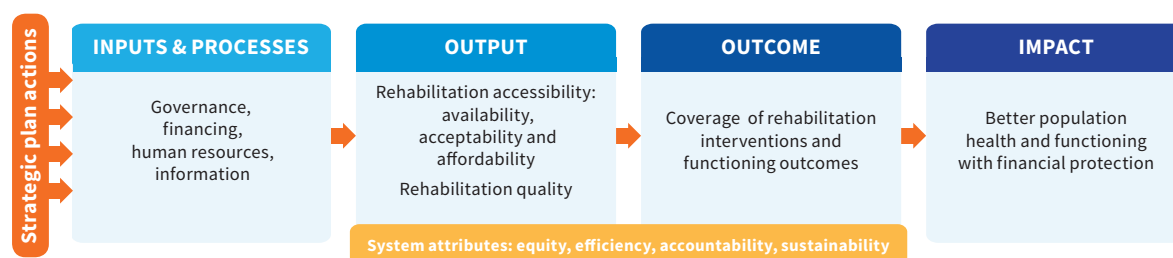
Recommendations for strengthening rehabilitation

Set out a shortlist of recommendations for strengthening the rehabilitation within the health system in the country. This section should focus on a limited number of realistic and feasible priority actions within the context of the country – both short- and longer-term.

ANNEX 8. The rehabilitation results chain and the rehabilitation monitoring framework

The rehabilitation results chain, introduced in the Background section (p. 2), depicts rehabilitation across inputs, outputs, outcomes and impact. It can be adapted to include actions from the rehabilitation strategic plan and thus provide a results chain for the strategic plan and its monitoring framework.

Figure A8.1: Rehabilitation results chain and strategic plan actions



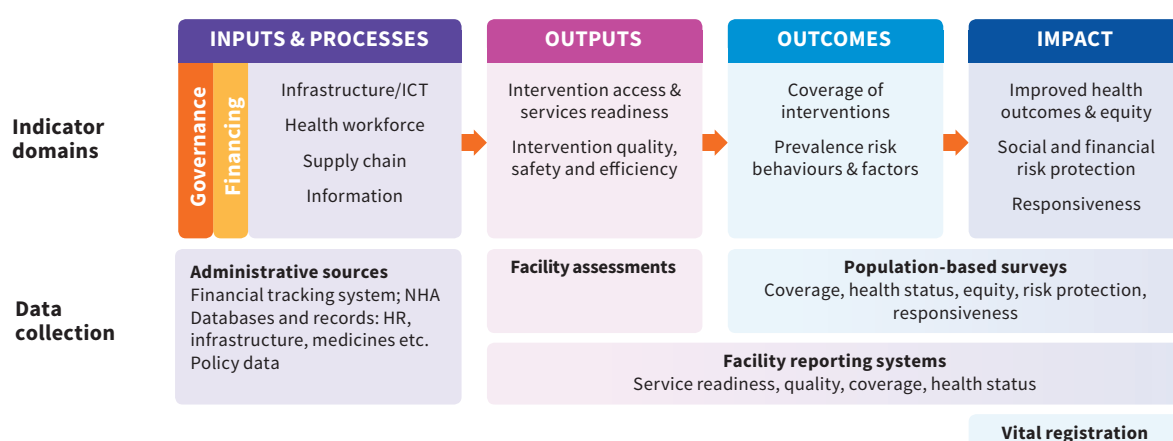
The indicators that inform the goals and objectives of the strategic plan lie at the heart of monitoring. They sit at different points along the rehabilitation results chain and can be categorized as an input, output, outcome or impact indicator.

Different sources – as shown in Figure A8.1 – provide different types of information for the different types of indicators sitting across the input, output, outcome and impact categories. This figure is from the *WHO Monitoring and Evaluation of Health System Strengthening*,¹³ and illustrates different “indicator domains” using a results chain.

WHO Common Monitoring and Evaluation Framework for a national health strategy

The selection of indicators for a monitoring framework requires understanding of the different types of indicators and what they measure. While indicators sit across the categories of input, output, outcome and impact (see Figure A8.1), the indicators can also be categorized under other headings. The *WHO Global Reference List of 100 Core Health Indicators*¹⁴ uses two categories, one aligned to the results chain and one that places indicators under; health status, risk factors, service coverage and health systems.

Figure A8.2: Common Monitoring and Evaluation Framework for a national health strategy



¹³ Monitoring and evaluation of health system strengthening. An operational framework. Geneva: World Health Organization; 2009.

¹⁴ Global reference list of 100 core health indicators. Geneva: World Health Organization; 2015.

Criteria for selection of rehabilitation indicators

What is crucial to the development and selection of any indicator is that it reliably achieves its purpose of tracking change over time. During the development of the Rehabilitation Indicator Menu a set of criteria was developed to inform the selection of indicators to be included. These criteria are listed in Table A8.1.

Table A8.1: Criteria for Selection of Rehabilitation Indicators

CRITERIA	DEFINITION
1. Valid	An indicator for which sufficient (scientific) evidence exists to support a link between the value of an indicator and one or more aspects of rehabilitation within health systems
2. Reliable	An indicator that produces similar results for repeat measurements of a stable phenomenon
3. Relevant	An indicator that measures an aspect of rehabilitation within health systems with high importance
4. Actionable	An indicator that measures an aspect of rehabilitation within health systems that is subject to control by providers and/or the health care system and may be used at a national level for policy-making or strategy development
5. Internationally feasible	An indicator that can be derived for international comparisons without substantial additional resources
6. Internationally comparable	An indicator for which any differences in values across reporting countries (those complying with the relevant data definition and where differences in the indicator values between countries reflect issues in health systems rather than differences in data collection methodologies, coding or other measurement or health system reasons



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