WHO Framework of Rehabilitation Services
Meeting Report

WHO Headquarters, Geneva Switzerland
29-30 June 2017

MEETING OUTCOMES

1. Reviewed seminal work relating to rehabilitation service and intervention classifications and frameworks and its potential contribution for the World Health Organization's (WHO) work
2. Developed a draft framework based on intervention groupings for external review and further development
3. Identified potential applications of a framework of services for health financing and workforce planning

DAY ONE

Rehabilitation in the global health agenda

Alarcos Cieza
Coordinator, Prevention of Blindness and Deafness, Disability, and Rehabilitation, WHO

Summary

While there is ample evidence suggesting rehabilitation is an important aspect of health care, this knowledge has largely failed to reach beyond the rehabilitation community. Because demand for rehabilitation is going to increase with ageing populations and rising prevalence of noncommunicable disease, health systems can no longer afford to invest only in promotion, prevention and treatment; rehabilitation needs to be integrated at all levels of the health system and available across the continuum of care.

In the era of the Sustainable Development Goals, universal health coverage (UHC) presents an opportunity to ensure that rehabilitation is integrated in health systems and that access to quality, affordable services is expanded. Currently, even where rehabilitation services are available, they are rarely integrated into UHC.

To ensure rehabilitation can be included in UHC and adequately integrated into all levels of the health system, WHO has to take a twin-track approach: work internally within key departments of WHO, such as Health Systems Governance and Financing, Health Workforce, Service Delivery and Safety, and work externally with Member States and key rehabilitation stakeholders.

Key messages

- Health and demographic trends mean that health systems need to begin strengthening rehabilitation services to address the growing needs of the population
- There is a need to move rehabilitation into the context of the Sustainable Development Agenda, promoting rehabilitation as a universal health strategy, integral to UHC
- To be effective in advancing the global rehabilitation agenda, WHO needs to work both within the organization to mainstream rehabilitation into its various areas of work, and directly with Member States and stakeholders
- Any WHO rehabilitation framework needs to be consistent with WHO's definition of rehabilitation and conceptualization of 'health condition'

Framework on integrated people-centred health services

Nuria Toro Polanco
Technical Officer, Services Organization and Clinical Interventions, WHO

Summary

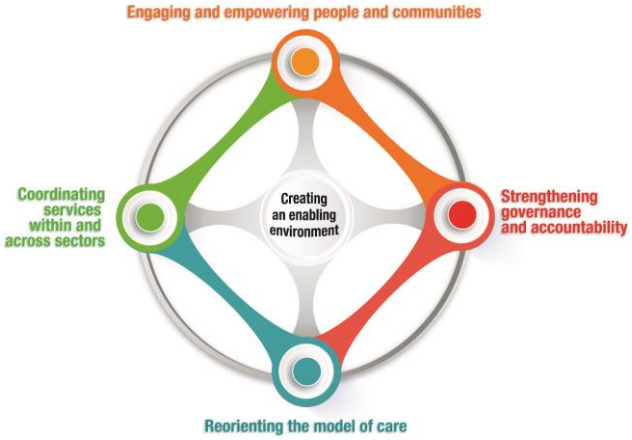
Health systems face emerging demands in the context of ageing populations, migration, climate change, and globalization, amongst others. Health systems are constrained by a lack of community empowerment and engagement, insufficient and misaligned financing, sub-optimal workforce, service fragmentation, and limited intersectoral action and are unable to effectively respond to those challenges and demands. There is clearly a need to operate under a new model of service delivery that is orientated around the needs of people and communities, rather than traditional structures.

The Framework on Integrated People-centred Health Services presents a vision of a service delivery model whereby "All people have equal access to quality health services that are co-produced in a way that meets their life course needs, are coordinated across the continuum of care and are comprehensive, safe, effective, timely, efficient and acceptable; and all carers are motivated, skilled and operate in a supportive environment". Five key strategies are proposed to advance towards this vision: 1)engaging and empowering people and communities , 2) strengthening governance and accountability, 3) reorienting the model of care. , 4) coordinating services within and across sectors, and 5) creating an enabling environment

In order for a service delivery model to effectively address the emerging and evolving demands of population, rehabilitation as part of the continuum of health care needs to be included and considered in each of the five strategies.

Key messages

- The changing global context (health and demographic trends of the 21st century) present challenges that demand a shift in how health services are delivered
- The Framework on Integrated People-centred Health Service aims to respond to the emerging demands and system constraints by promoting a model of service delivery designed around people's evolving needs
- Implementation of the Framework involves interventions focused on engaging and empowering people and communities, strengthening governance and accountability, reorienting care, and coordinating services within and across sectors
- The Framework was approved by 194 Member States in 2016



Including rehabilitation in Universal Health Coverage (UHC)

Melanie Bertran
Technical Officer, Economic Analysis and Evaluation, WHO

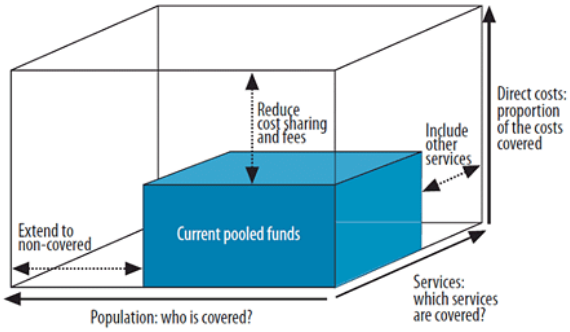
Summary
UHC is a mechanism that seeks to ensure "all people receiving quality health services that meet their needs, without being exposed to financial hardship in paying for the services". It is achieved by increasing the services covered and the population included, and reducing the costs incurred by the user. WHO supports Member States to achieve UHC by facilitating the process of priority setting, strategic planning, costing and implementing, and promoting transparent and evidence-based decision making that occurs within a clearly defined legal framework.

The OneHealth tool (http://www.who.int/choice/onehealthtool/en/), a software used to inform strategic planning for UHC in low- and middle-income countries, currently does not include rehabilitation interventions. Information on the cost-effectiveness of different rehabilitation

interventions is needed in order to effectively embed them in the software, and enable countries to factor rehabilitation into their costing.

Key messages

- The choice regarding which services are included in UHC in a country should be based on data and dialogue and consider both the country's priorities and resource availability
- Including rehabilitation in the OneHealth platform requires consideration of which delivery platforms it should be provided through (such as hospitals, health centres, outreach, and community), and whether it is considered a vertical or cross-cutting programme



Three dimensions to consider when moving towards universal coverage

Human resources: defining workforce competencies

Rania Kawar
Technical Officer, Health Workforce, WHO

Summary
The evolving health climate and shifting demands on health systems have considerable consequences for health workforce- how they are educated, distributed and retained. Each national context faces unique challenges and opportunities that determine their needs and effect how they approach health workforce development. WHO's efforts to support health workforce development therefore need to incorporate a degree of adaptability that ensures global relevance.

Many countries face a workforce crisis where need for providers far outstrips their availability. This is particularly true of specializations, and rehabilitation professionals are no exception. Rehabilitation workforce shortages are particularly profound in low- and middle-income countries, where the resources and the structures to build it are lacking. Addressing this dilemma requires careful consideration of what constitutes a rehabilitation service and what needs to be delivered at different levels in order to determine the type and specialization of workforce required across the health system. Defining the competencies of the rehabilitation workforce (the knowledge, skills, attitudes and behaviours required to deliver different interventions) is critical to identifying novel and practical approaches to addressing the rehabilitation workforce crisis encountered in many parts of the world. Issues of scope of practice and regulation of different cadres needs to occur concurrently if one is to ensure that interventions are delivered effectively and safely. In high-income countries, the same information on competencies, scope of practice and regulation can help maximize the performance of the existing rehabilitation workforce.

Key messages

- The delivery of integrated people-centred health services has an impact on health workforce; competencies need to be compatible with an integrated model of care
- There is an emerging shift towards competencies and scopes of practice, although the workforce still needs to be regulated
- The diversity of national contexts demands that rehabilitation competencies be defined (knowledge, skills, attitudes and behaviours) to facilitate health workforce planning, particularly in resource-scarce settings, and maximise workforce performance
- A global competency framework for rehabilitation workforce would need to be based on an agreed rehabilitation services framework with essential interventions across the different levels of care.

What are the needs of countries when describing rehabilitation services?

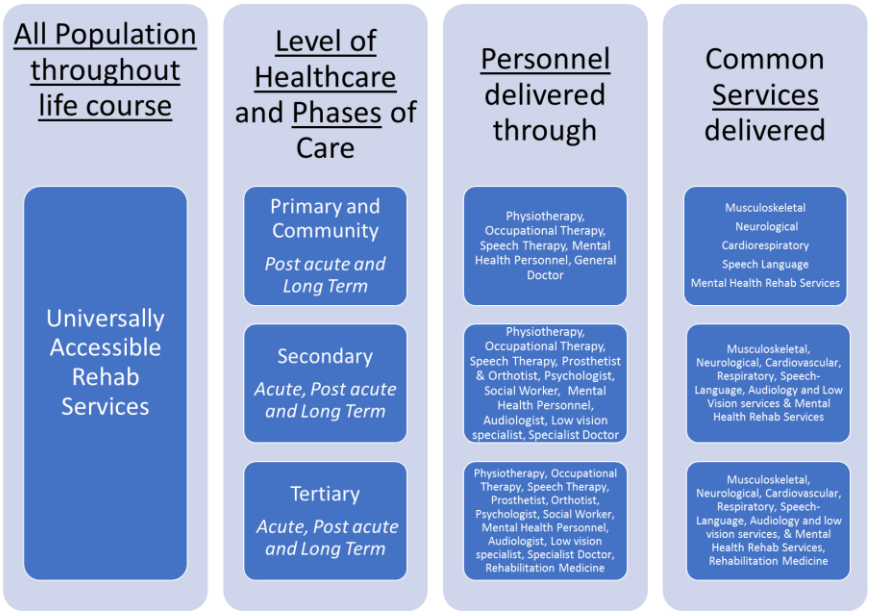
Pauline Kleinitz
Consultant, Prevention of Blindness and Deafness, Disability, and Rehabilitation, WHO

Summary
Strengthening the health system to provide rehabilitation is critical to expanding access to quality services. One of WHO's primary roles is to support system strengthening through providing technical support, tools and knowledge. While every Member State is different, there are commonalities across low- and middle-income countries (as well as some high-income countries) in the status of rehabilitation systems; many face weak leadership with poorly defined roles and responsibilities, coordination mechanisms with other sectors are lacking, and rehabilitation-related data are scarce or non-existent.

Describing the need for rehabilitation in the population and the types of services required is frequently the starting point to strengthening rehabilitation systems when working with ministries of health. This is particularly important for creating a clear vision for rehabilitation amongst policy-makers. Currently rehabilitation is described in a variety of ways:

- As a health strategy included in the definition of universal health coverage, along with prevention promotion, treatment and palliation
- According to WHO's definition: Rehabilitation is "a set of interventions designed to reduce disability and optimize functioning in individuals with health conditions in interaction with their environment"
- In relation to providers, e.g., medical doctors, therapists, nurses, and community workers
- Normative categorization of services, e.g., neurorehabiltation, cardiorespiratory rehabilitation, early childhood rehabilitation
- The principles that underlie its implementation

Offering a variety of model rehabilitation service systems that can be adapted to country contexts could further help policy-makers capture a strong vision of rehabilitation.



Example of a model of a rehabilitation service system

Key messages

- Rehabilitation system planning faces numerous challenges, including weak leadership, confusion in ministerial roles and responsibilities, and scarce data

- Educating and building the capacity of decision makers is critical to the process of strengthening the health system for rehabilitation, and requires a way of describing services and models of service delivery that can foster a strong vision for rehabilitation
- Key messages to Member States: Rehabilitation services should be available to people over the life course, across all levels of care, and across the continuum of care

Scoping review to identify services classifications: results

Kaloyan Kamenov
Consultant, Prevention of Blindness and Deafness, Disability, and Rehabilitation, WHO

Jody Mills
Technical Officer, Prevention of Blindness and Deafness, Disability, and Rehabilitation, WHO

Summary
A broad scoping review was conducted as part of an initial exploration of health-related classifications and frameworks. The aim of the scoping review was to identify and draw inspiration and lessons from existing rehabilitation service frameworks and classifications. Both peer-reviewed literature and grey literature were searched, revealing 23 relevant publications. Key findings included the variety of styles of frameworks and classifications used, and the different purposes they serve, such as describing or comparing services, monitoring services, classifying interventions or facilitating planning. Depending on the type and objective of a framework, different dimensions were captured, however the most frequently occurring included the level/setting/context, phase/continuum of care, and providers/human resources.

Key messages
- The scoping review was an initial exploration of existing health-related frameworks and classifications and was not exhaustive
- The review revealed a diverse range of frameworks and classifications, 12 of which related directly to rehabilitation, and 11 of which related to other areas of health
- Frameworks and classifications included various dimensions of a service or intervention, the most common of which were level/setting/context, phase /continuum of care, and providers/human resources

Rehabilitation treatment taxonomy

Tessa Hart
Institute Scientist, Moss Rehabilitation Research Institute

Summary
The process of developing a Rehabilitation Treatment Taxonomy (RTT) was embarked on due to the need for a precise way of characterizing and measuring treatments in rehabilitation, so that their effects could be studied and replicated. Currently, rehabilitation treatments are commonly measured and reported according to time (e.g., length of stay), discipline (e.g., x hours of physical therapy), or by the problem they are addressing (e.g., memory training), which does not specify what was done or how the problem was addressed. The RTT attempts to use treatment theory to classify rehabilitation treatments in a way that captures how and why they work. It structures rehabilitation treatments according to:
- Targets: the specific aspects of a recipient's functioning to be changed
- Ingredients: specific modalities or actions chosen to bring about the change
- Mechanism of action: how the ingredients work to change the target

The RTT further differentiates between a treatment and a treatment target, noting that a treatment may have more than one target and multiple ingredients to change the target, while a treatment component has a single target. Treatment components can be grouped according to their targets under organ functions, skills and habits, or representations (cognitive or affective changes). The RTT is also strictly reserved for treatments delivered to an individual to improve functioning, and as such is not relevant to describing a rehabilitation program, case management, or societal interventions.

Key messages

- The aim of the RTT project is to provide a standardized and disciplined way of describing, reporting and measuring rehabilitation treatments.
- The RTT structures treatments according to targets, ingredients and mechanism of action
- Treatments are differentiated from treatment components, the former having multiple targets and using different ingredients,, while the latter has a single target and uses a single ingredient
- Current approaches to reporting and measuring rehabilitation treatments fail to shed light on how and why they work
- There are three different groups of targets: organ functions, skills and habits, and representations (cognitive, affective), and treatment components can be grouped accordingly

International Classification of Health Interventions (ICHI)

Richard Madden
Director , National Centre for Classification in Health, University of Sydney

Summary
ICHI is part of the WHO family of classifications, which also includes the International Classification of Diseases (ICD), and the International Classification of Functioning, Disability and Health (ICF). Currently there many national classifications for interventions, and very limited coverage of allied health, functioning or public health. ICHI allows for international comparison of interventions, and is adaptable for national use. It is designed to cover all health strategies and interventions across phases of care, as well as public health and traditional medicine interventions.

ICHI describes a health intervention as, "an act performed for, with or on behalf of a person or a population whose purpose is to improve, assess, maintain, promote or modify health, functioning or health conditions", and breaks them down into a target (the entity on which the action is carried out), action (the deed done by an actor to a target) and means (the process and methods by which that action is carried out). There are also optional extension codes that encompass therapeutic products, assistive products, medicaments, and additional targets, amongst others. Interventions can broadly fall under one of three areas: Medical/surgical, functioning, or public health, and can be further broken down into interventions for body systems and functions, activities and participation, and environment and health-related behaviour.

ICHI does not include the reason for the intervention, nor the outcome of the intervention, both of which are covered by the ICD and ICF, and does not consider the provider of the intervention or the setting in which it occurs.

Key messages

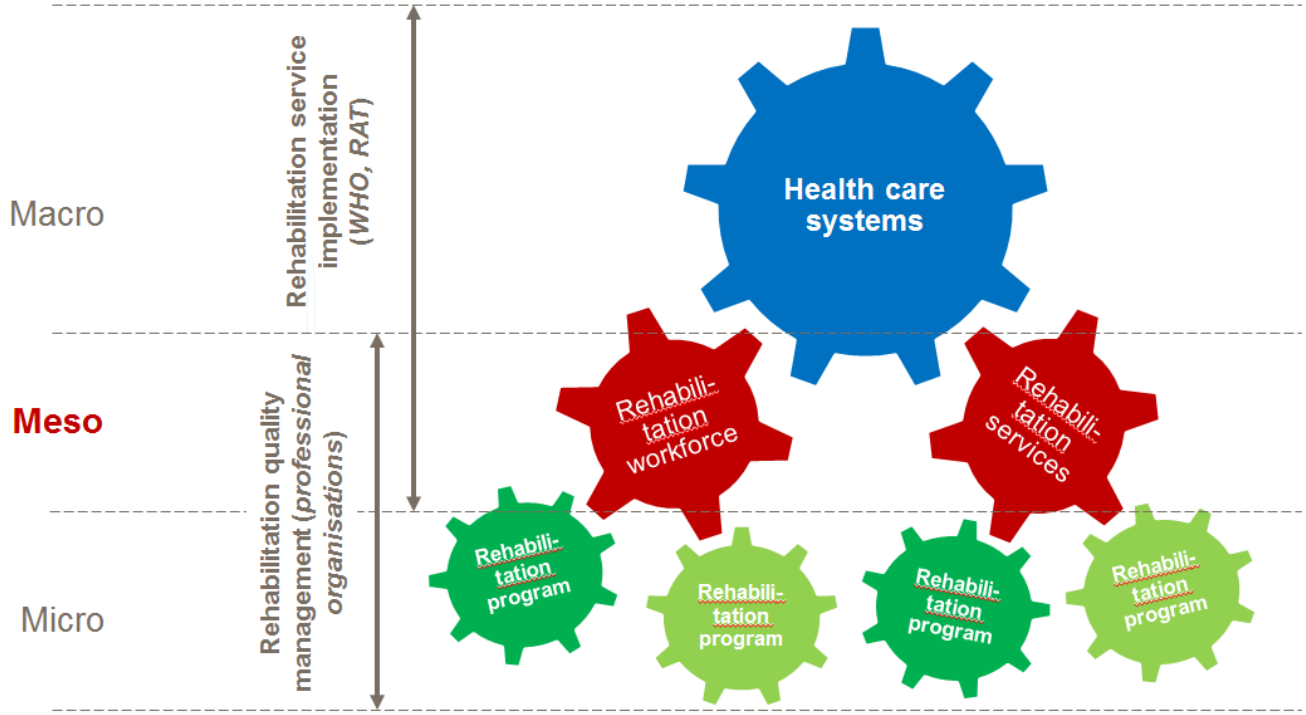
- ICHI was designed to provide a usable international classification aligned with the ICD and ICF, that covers all sectors of the health system (rather than only acute diagnostic, medical and surgical interventions provided in hospitals)
- In addition to enabling international comparisons, ICHI can be used by countries with no classification system
- Health interventions classified by ICHI have three axes: target, action, and means
- ICHI does not include the reason for an intervention, who provides it, where it is provided or the outcome

International System for Service Organization in Rehabilitation (ICSO-R)

Christoph Gutenbrunner
Director , Department of Rehabilitation, Medicine, Hannover Medical School

Summary
The ICSO-R was developed to facilitate the development of a rehabilitation situation assessment, benchmark rehabilitation services, and describe prototypes of rehabilitation services. It is based on a conceptualization of rehabilitation aligned with WHO and the ICF, and provides a description of

rehabilitation services as "personal and non-personal intangible products" at the meso level (see figure below). The aim of the ICSO-R is to develop a list of dimensions and categories to describe the



organization of rehabilitation services. To this end it has two main dimensions: 'provider' and 'service provision', under which sit numerous categories and sub-categories by which a service can be described. These categories and sub-categories include context, governance and leadership, financial budget, service goals, target group, amongst others.

The ICSO-R can be accompanied by narrative descriptions of common types of rehabilitation services, such as 'acute rehabilitation services delivered in secondary and tertiary hospitals' and post-acute rehabilitation services delivered immediately or shortly after discharge from acute care hospitals'.

Key messages

- ICSO-R is based on a meso-level conception of a 'service', with interventions and programs being at the micro level and systems at the macro
- The ICSO-R is based on 2 dimensions: Service provider, and service delivery, each with a more extensive list of categories and sub-categories
- Rehabilitation services are described against each of the categories to give a comprehensive picture of the service
- The ICSO-R can be accompanied by narrative descriptions of rehabilitation services at different settings and phases of care

DAY TWO

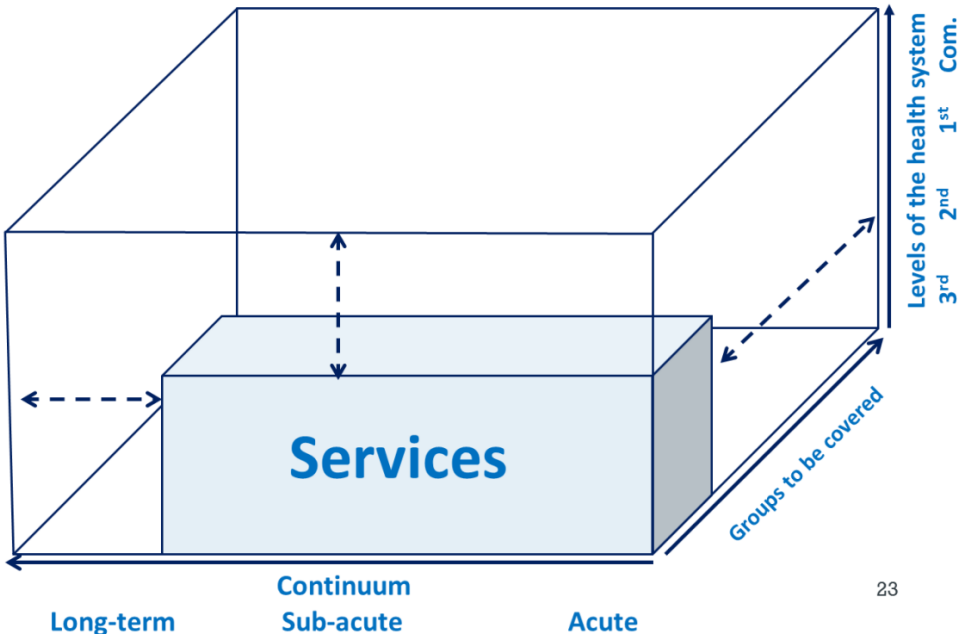
Summary and conclusions from day one

Alarcos Cieza
Coordinator , Prevention of Blindness and Deafness, Disability, and Rehabilitation, WHO

Key messages

- The frameworks and classifications presented on day one make a valuable contribution to improving the discipline with which rehabilitation interventions and services (and contexts) are reported/described
- It is essential that WHO and the rehabilitation community contribute to the Beta version of ICHI to ensure it adequately represents health interventions for rehabilitation by its completion in 2019
- The work completed to date relating to rehabilitation classifications and frameworks can help guide future work on competencies; as health conditions are dynamic, the competencies needed to address them over the continuum of care and across settings will change
- WHO will complement existing work on rehabilitation classifications and frameworks by concentrating on a framework for grouping and describing rehabilitation interventions based on continuum/phases of care, service delivery settings, and health conditions and/or functioning domains

Portraying the need for rehabilitation services across levels of the health system, population groups and the continuum of care



As per the UHC cube, this cube shows the 'gaps to be closed' to ensure rehabilitation services are universally available. Policy-makers need to ensure that rehabilitation services are delivered in such a way that interventions are available along the continuum of care, through all levels of the health system and for all groups of people who may need them.

Approaches to describing and grouping rehabilitation interventions

Condition grouping:
As per the ICF core sets but with additional for missing groups

- Musculoskeletal conditions
- Cardiovascular and respiratory conditions
- Neurological conditions
- Cancer
- Mental health
- + Developmental and congenital conditions
- + Internal medicine rehabilitation
- + Sensory conditions (vision and hearing)

Functioning and disability groupings:
As per the ICF

- Impairments of body functions and structures
- Activity limitations and participation restrictions
- Environmental factors

Strengths of this approach: Practical, likely to be understood by policy-makers unfamiliar with rehabilitation or the ICF, and captures most conditions relevant to rehabilitation

Weaknesses of this approach: Not conceptually sound, unclear where certain conditions would fall e.g. multi-trauma, multi-comorbidities.

Strengths of this approach: Conceptually sound and grounded in the ICF, comprehensive and likely to capture the full scope and breadth of rehabilitation interventions and services

Weaknesses of this approach: potentially too complex for policy-makers and overly detailed for the purposes of education and planning

Proposal for a WHO Framework of Rehabilitation Services based on intervention groupings

Setting	Continuum of Care		
	Acute	**Sub-acute**	**Long-term**
Community	*Interventions*	*Interventions*	*Interventions*
Primary	*Interventions*	*Interventions*	*Interventions*
Secondary	*Interventions*	*Interventions*	*Interventions*
Tertiary	*Interventions*	*Interventions*	*Interventions*

Example of disaggregation of interventions by condition group and/or functioning and disability

Setting	Continuum of care
	Acute
Community	Musculoskeletal rehabilitation interventions targeting mobility

Potential application of framework for countries and WHO

- Demonstrate the rehabilitation interventions requires across the continuum of care and each setting
- Identify the rehabilitation competencies requires at different settings to address the full continuum of care- informs workforce planning
- Develop packages of care, especially for low-resource settings

Setting	Continuum of care
	Acute
Community	*Interventions*

ANNEX 1. FEEDBACK SUMMARIES

Rehabilitation Treatment Taxonomy (RTT), Dr Tessa Hart

Question	Summary of responses
1. Describe what the RTT is	• The RTT is a detailed and analytical tool to describe what we do with patients • The RTT is a conceptual and theoretical basis for a very granular taxonomy and provides the basis for the classification of any rehabilitation intervention • The RTT is a structure to describe any rehabilitation treatment
2. Whose needs does the RTT address?	• Rehabilitation providers: Can help identify best practices, for specific interventions, but would need to be simplified • Researchers • May be useful for provision, payment and validation of interventions • Faces the same question as the ICF- "how can I use this?" • Not sure of useful for politicians
3. What questions do you have regarding the RTT?	• Do you want to include dosage and progression? • Where does treatment start and a program start? • How is the environment taken into account? • What lessons have been learnt along the way? • How could it be applied in daily practice?
4. How can the RTT contribute towards WHO's work?	• The RTT could help to visualize the different layers of interventions • The RTT could help to provide an evidence-base for better services and for advocacy • The RTT is too complex for low-income countries • It is unclear how the RTT could be used by WHO • The RTT could feed into the global competency framework (ingredients, mechanisms of action- target) • The RTT could provide a language for cost-effectiveness research

International Classification of Health Interventions (ICHI), Prof Richard Madden

Question	Summary of responses
1. Describe what ICHI is	• ICH is a comprehensive classification of health interventions including targets, actions and means • ICHI complements the ICF and ICD
2. Whose needs does ICHI address?	• Policy makers and health systems (because it can quantify interventions) • Insurance companies • Researchers (because it standardizes interventions)
3. What questions do you have regarding ICHI?	• How can ICHI be used for complex multidimensional interventions? • Can 'means' be elaborated? • Will ICHI serve health economic evaluation? • Can a setting, dosage and volume be added to ICHI? • Is ICHI inclusive of everything done in rehabilitation? • Will ICHI actually be used in practice? • How is ICHI useful, as interventions have different levels of granularity? • How has ICHI tested for exhaustiveness of the interventions included? • How are means and actions derived? • What has been the role of scientific evidence in selecting the interventions included in ICHI?
4. How can ICHI contribute towards WHO's work?	• ICHI can describe systems and progress of health services at the micro level • ICHI illustrates the types of interventions that can be done • ICHI is too simplistic for rehabilitation • ICH helps put rehabilitation on eye level with other health interventions

International System for Service Organization in Rehabilitation (ICSO-R), Prof Christoph Gutenbrunner

Question	Summary of responses
1. Describe what the ICSO-R is	• ICSO-R is a classification system outlining service delivery, and who is providing the service • ICSO-R shows how rehabilitation services are organized locally for international comparison • ICSO-R draws from the System of Health Accounts (SHA) • The ICSO-R is descriptive rather than evaluative
2. Whose needs does the ICSO-R address?	• Providers • Health systems and service planners/policy makers • Researchers • Funding agencies (provides examples)
3. What questions do you have regarding the ICSO-R?	• How easy is it to use the ICSO-R? • How can users access information from the ICSO-R? • Why was the environment not included? • Will the ICSO-R map the average user (complexity of cases)? • How can a micro to meso (bottom-up) feedback loop be added in? • Are social care settings relevant for ICSO-R? • What impact does funding have for the meso level? • What is the feasibility and usefulness of the ICSO-R?
4. How can the ICSO-R contribute towards WHO's work?	• The ICSO-R could facilitate health care planning • The ICSO-R could identify areas of rehabilitation and inform decision making • ICSO-R could support implementation research • The ICSO-R is a meso-level classification that provides a comprehensive look at service delivery • ICSO-R could be important for implementation research

Closing plenary session: Summary of recommendations for WHO in the context of a framework of rehabilitation services

- Be clear about who will use the framework/who it is designed for and the goals/context of its use
- One framework cannot achieve everything; establish short-, mid-, and long-term expected outcomes
- We are supportive of a framework that has the purpose of describing required competencies for rehabilitation and to plan workforce (current and future needs)
- The main priority of the framework should be that it has good uptake (is actually used) and the ability to improve rehabilitation services
- Potential threats: A framework that oversimplifies rehabilitation, that is too prescriptive and that does not celebrate the diversity of rehabilitation
- The framework should have consistencies/align with the various existing classifications systems: ICD, ICF and ICHI with service characteristics consistent with SHA
- A series of workshops could be used to construct the framework
- Continue promoting the inclusion of rehabilitation in universal health coverage
- Further develop rehabilitation service assessment methodology and implementation in the framework
- Work on completion of the Family of Classifications and develop a matrix with interfaces
- The framework should further define rehabilitation – is it medication? Is it treatment? Is prevention part of rehabilitation? Define the terms and the boundaries for the outside world
- Establish a framework that is usable and adaptable to diverse needs
- WHO can offer a comprehensive understanding of services to different countries

Day 2 Feedback

Question	Summary of responses
1. What has been you general impression of what has been presented on day 2?	• There are many challenges and questions to be answered but the philosophy and approach is appropriate • The focus on advancing UHC and workforce planning are positive • The framework would be helpful, especially for low-income countries
2. Do you believe WHO is heading in the right direction?	• Yes
3. What concerns, if any, do you have with hat has been presented on day 2?	• If there is sufficient awareness of the limitations and challenges • It is unclear what role evidence will play in any framework or classification that is developed • The framework will need to be flexible enough to account for clinical realities e.g., evolving needs of patients • The development and operationalization of the framework is not clear • Should the framework also capture social support and community integration?
4. What suggestions do you have for advancing what you have seen presented on day 2?	• Move forward with the idea of a meeting on rehabilitation workforce • WHO should provide communication resource that support stakeholders to more broadly disseminate WHO's work and vision for rehabilitation • A policy document from WHO on what community-based rehabilitation is would be useful • Any framework developed should have the input of rehabilitation professionals, who deliver the services • Include functions rather than conditions as a dimensions • To reach global competencies for rehabilitation, knowledge and skill have to be integrated

ANNEX 2. AGENDA

Day one- Thursday 29 June

9:00	Welcome and introductions	Alarcos Cieza
	Role of WHO in the global health agenda	
	Rehabilitation in the global WHO health agenda	
	Meeting objectives	
10:00-10:30	Discussion	All
10:30-11:00	Coffee break	
11:00-11:15	Framework on integrated people-centred health services	Nuria Toro Polanko
11:15-11:30	Including rehabilitation in Universal Health Coverage	Melanie Bertran
11:30-11:45	Human resources: defining workforce competencies	Rania Kawar
11:45-12:00	What are the needs of countries when describing rehabilitation services?	Pauline Kleinitz
12:00-12:30	Discussion	All
12:30-13:30	Lunch break	
13:30-13:45	Scoping review to identify services classifications: results	Kaloyan Kamenov & Jody Mills
13:45-14:00	Rehabilitation treatment taxonomy	Tessa Hart
14:00-14:15	Q & A	All
14:15-14:30	International Classification of Health Interventions (ICHI)	Richard Madden
14:30-14:45	Q & A	All
14:45-15:00	International System for Service Organization in Rehabilitation (ICSO-R)	Christoph Gutenbrunner
15:00-15:15	Q & A	All
15:15-15:45	Coffee break	
15:45-16:15	How can the treatment taxonomy, ICHI and ICSO-R be useful for a WHO framework of rehabilitation services?	All
16:15-17:00	Small groups and plenary: recommendations for WHO framework of rehabilitation services	All

Day 2- Friday 30 June

9:00-9:30	Recap and introduction to day 2	Alarcos Cieza
9:30-10:30	Small groups: defining the way forward	All
10:30-11:00	Coffee break	
11:00-12:00	Plenary: defining next steps	All
12:00-12:30	Summary and meeting close	Alarcos Cieza

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