

Multistakeholder meeting on the development of the rehabilitation workforce in central Asia and eastern Europe

7-8 June 2022

Copenhagen, Denmark



European Region

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List of abbreviations

ADL	activities of daily living
COVID-19	novel coronavirus disease (SARS-CoV-2)
IALP	International Association of Communication Sciences and Disorders
ICF	International Classification of Functioning, Disability and Health
ICP	interprofessional collaborative practice
ICRC	International Committee for the Red Cross
ISPO	International Society for Prosthetics and Orthotics
P&Os	prosthetists and orthotists
PRM	physical and rehabilitation medicine
Q&A	question and answer
RCF	Rehabilitation Competency Framework
SDG	Sustainable Development Goal
SLTs	speech and language therapists
STARS	Systematic Assessment of Rehabilitation Situation
TAP	Training in Assistive Products
TRIC	Template for rehabilitation information collection
UHC	universal health coverage
USET	Ukrainian Society of Ergotherapists
WFOT	World Federation of Occupational Therapists

Introduction

The aim of this hybrid meeting was to initiate a high-level discussion among decision-makers and rehabilitation stakeholders to support the development of competency-based rehabilitation education in central Asian and eastern European countries. Participants worked towards producing a roadmap for developing rehabilitation education in the nine attending countries (Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan).

Objectives and concept

The objectives of the meeting were to:

1. identify strategies to build political support and leadership for educating rehabilitation professionals in the targeted countries;
2. establish a roadmap for competency-based education for rehabilitation professionals, harnessing regional partnership and drawing on lessons learned from shared experiences to date;
3. identify next steps for strengthening education of rehabilitation professionals in the countries of the region.

The meeting served to provide insights into various aspects of the rehabilitation workforce, introducing each of the professions, as well as the need for interprofessional practice and collaboration among the disciplines. The attending representatives of the various global professional associations outlined their organizations and functions. Relevant tools and frameworks were also presented and their practical application explained. This formed the basis of in-depth discussion as to how participants could move forward with strengthening rehabilitation workforce education in their countries.

Rehabilitation 2030

WHO's core mandate is universal health coverage (UHC), which means that all people should have access to the full range of essential health services, when and where they need them, without financial hardship. This includes health promotion, prevention, treatment, rehabilitation and palliative care. UHC cannot be achieved without the provision of rehabilitation services, and rehabilitation is therefore also key to achieving Sustainable Development Goal (SDG) 3 – “Ensure healthy lives and promote well-being for all at all ages”.¹ Good health and functioning promote inclusion and support participation, allowing children to learn and adults to earn. UHC also provides an escape from poverty and the basis for long-term, sustainable economic development. Rehabilitation is thus an important investment in human capital, contributing to health, economic and social development, and progressing towards the attainment of the SDGs.

Difficulties in functioning occur as a result of impairments in body function and environmental barriers. Such impairments cause limitations in activities of daily living (ADL) and restrictions in participation, for example in work and community life. Rehabilitation is defined by WHO as “a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment”.² It is carried out by addressing limitations in everyday physical, mental and social functioning due to ageing or a health condition, including chronic diseases or disorders, injury or trauma. Rehabilitation might be needed by anyone, regardless of age, gender, or socioeconomic status. Access to rehabilitation services and assistive products has multiple impacts on individuals, with far-reaching economic and social benefits.

¹ Goals. 3. Ensure healthy lives and promote well-being for all at all ages [website]. New York (NY): United Nations Department of Economic and Social Affairs; 2022 (<https://sdgs.un.org/goals/goal3>, accessed 20 December 2022).

² Rehabilitation [website]. Geneva: World Health Organization; 2022 (<https://www.who.int/news-room/fact-sheets/detail/rehabilitation#:~:text=>, accessed 20 December 2022).

Improved medical care, population ageing, and the ongoing demographic, epidemiological and nutrition transitions all mean that the need for rehabilitation is great and growing; 2 in 5 inhabitants have diseases or impairments amenable to rehabilitation in 2019.³ Among the nine countries involved in the stakeholder meeting, over 47 million people had at least one condition that would benefit from rehabilitation. As people live longer, the impetus to ensure quality of life is maintained as long as possible is growing.

Barriers to accessing rehabilitation include the lack of prioritization and allocation of resources to the sector by decision-makers, largely due to a lack of understanding of and political interest in the benefits of rehabilitation. Many countries therefore lack rehabilitation services, particularly at primary health care level. In some countries, over 50% of people who need rehabilitation services do not receive them. Rural areas are noticeably underserved, as rehabilitation is provided largely in urban settings and/or in secondary- or tertiary-level facilities.

Rehabilitation 2030 – a Call for Action⁴ appeals to countries to strengthen their health systems to enable greater provision of quality rehabilitation services. *Rehabilitation in health systems: guide for action*⁵ is a practical guide for governments on how to achieve this and the tool is being implemented in over 50 countries worldwide and in over 10 countries in the central Asian and eastern European region.

Developing the rehabilitation health workforce is foundational. Rehabilitation 2030 and the SDG 3(c) call for a substantial increase in health financing and recruitment, development, training and retention of the health workforce. The WHO European Region is below the global average for the number of health professionals delivering rehabilitation services. Numbers of occupational therapists, physiotherapists, prosthetists and orthotists (P&Os) and physical and rehabilitation medicine (PRM) practitioners in low- and middle-income countries are falling well below the levels seen in high-income countries in the Region.

Most countries in central Asia and eastern Europe are yet to fully develop the roles and importance of rehabilitation professionals in the health care system or to integrate these professions into the country's health professional classifications. In most countries of this region, entry-level **education programmes** for occupational therapy, physiotherapy, prosthetics and orthotics, and speech and language therapy are non-existent. Moreover, where they do exist, they are not consistent with **competency-based or contemporary international professional standards**.

Workforce strengthening is required to increase rehabilitation services as part of committing to achieving UHC and optimizing individuals' functioning in order to support inclusivity, economic prosperity and independence among individuals, communities and society as a whole.

³ Cieza A, Causey K, Kamenov K, Handon SW, Chatterji S, Vos T. Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: A systematic analysis for the Global Burden of Disease Study 2019. *Lancet* 2020;396(10267):2006–2017 ([https://doi.org/10.1016/S0140-6736\(20\)32340-0](https://doi.org/10.1016/S0140-6736(20)32340-0), accessed 20 December 2022).

⁴ Rehabilitation 2030 initiative [website]. Geneva: World Health Organization; 2017 (<https://www.who.int/initiatives/rehabilitation-2030>, accessed 20 December 2022).

⁵ Rehabilitation in health systems: guide for action [website]. Geneva: World Health Organization; 2019 (<https://www.who.int/publications/i/item/9789241515986>, accessed 20 December 2022).

Human resources for health

Tomas Zapata (*WHO Regional Office for Europe Regional Adviser, Health Workforce and Service Delivery*) presented on the principles and methods of developing and sustaining a health care workforce.

The health workforce is critical, forming a cornerstone or key pillar of health systems. To achieve UHC, it is essential to strengthen the workforce, in turn strengthening whole health systems. Strong evidence exists that improving and expanding the health workforce, including increasing access to health care professionals and by rethinking service provision priorities and approaches, in turn increases service coverage and thus improves health outcomes.

The established dimensions of the health and care workforce are availability, accessibility, acceptability, and quality – all feeding into the idea of effective health service coverage through health workforce planning.⁶ **Availability** can be understood in terms of whether supply meets population needs (that is, whether there are enough health care workers). The focus of health workforce strengthening efforts would usually be on increasing the workforce by attracting and retaining more health professionals into certain roles. Establishing this picture is difficult in many countries of the region in the rehabilitation field, owing to extensive gaps in data collection and reporting. **Accessibility** can be understood in terms of distribution of health care workers; that is, whether the populations that need to access care are able to do so (e.g., geographical, socioeconomic, public–private divide, and so on). The focus for the countries of the subregion specifically is on improving the urban–rural health workforce distribution. The **acceptability** dimension relates to the aforementioned rethinking and reorganization of rehabilitation services and the workforce, in terms of ensuring the appropriate skill mix is represented. The focus here is on task optimization and whether there are enough of the right type of health care professionals working together in multidisciplinary teams to meet current and future population needs. **Quality** can be thought of in terms of how to increase efficiency and performance of the workforce, for example by adopting digital health or telemedicine initiatives.

Dr Zapata highlighted the need for countries of the subregion to consistently **collect and analyse high-quality evidence-based data** on the numbers, skill mix and distribution of health professionals. As much **granularity** in this information as possible is needed in terms of age and gender profiles, education streams and structures, focusing specifically on representing each of the rehabilitation professions in the analysis. This requires **political leadership and commitment to advocacy at country level** to ensure the national strategies move beyond classic administrative recruit-and-deploy approaches. In this way they can be used to influence policy changes, with a view to: increasing or improving workforce **production** (education, selection and enrolment); encouraging workforce **retention, productivity and performance**; achieving the **right skill mix in the right places**; and underpinning the system with appropriate **regulation** to support the provision of high-quality rehabilitation health services that meet population needs.

⁶ Global strategy on human resources for health: workforce 2030. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/250368>, accessed 20 December 2022).

Introduction to the rehabilitation workforce

Jody-Anne Mills (*Sensory Functions, Disability and Rehabilitation, WHO Headquarters*)

The ideal approach is for a strong multidisciplinary rehabilitation workforce to work as part of the broader health workforce. Rehabilitation is not exclusively the domain of the rehabilitation workforce but should be promoted by and integrated within the care provided by all health workers at all levels of the health system. Rehabilitation care is often best delivered through an interprofessional collaborative practice (ICP) approach, whereby multiple professions work together around a patient's goals.

To achieve this integrated ICP approach across care settings and health care system levels, **communication** is key among the health care team, along with an increase in **investment** in the rehabilitation workforce. This in turn requires changing perspectives to ensure rehabilitation workers are seen as an **asset** to the health system and to the individuals in need of care, rather than a cost. ICP produces multiple benefits in the health care sector, by maximizing efficient use of resources, reducing disability, and ensuring health systems meet population needs appropriately. In this way, the highest possible quality of care can be delivered across settings and throughout care pathways.

Physiotherapy

Jonathon Kruger (*Chief Executive Officer of World Physiotherapy*) highlighted that people's understanding of physiotherapy can vary, even within the rehabilitation field. The World Physiotherapy definition of physiotherapy is "services provided by [physiotherapists] to individuals and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan".⁷ One of the principal aims of the meeting was to understand the landscape for physiotherapy and other health professions in the countries represented. Another was to explain how the professional associations and organizations present **could work together with country representatives to help develop a contemporary rehabilitation workforce**.

World Physiotherapy represented 685 000 physiotherapists globally in 2022. There remains a significant lack of data about actual numbers of physiotherapists in some areas of the world, but an estimated 2 million physiotherapists are currently practising globally and the profession is known to be predominantly female.

In most countries, physiotherapists are **autonomous practitioners**, prepared for their role through professional entry-level physiotherapy education. A referral is not needed from a medical doctor for a patient to access physiotherapy. World Physiotherapy advocates for the right of those seeking physiotherapy services to self-refer, including in both community and medical settings. Physiotherapists will work in consultation with all other health care professionals, but can begin treating patients from the outset in an efficient and timely manner.

Occupational therapy

Samantha Shann (*President of the World Federation of Occupational Therapy (WFOT)*) defined occupational therapy as a client-centred health profession that promotes health and well-being by working with individuals and communities, through occupation, enabling them to participate in the activities of everyday life. Such occupations include but are not restricted to work activities. She explained that in some countries, including in central Asia and eastern Europe, the term **ergotherapy** is often used. The WFOT uses both terms – occupational therapy and ergotherapy – interchangeably. Occupational therapy addresses occupations that bring meaning/purpose

⁷ World Physiotherapy. Description of physical therapy. Policy statement. London: World Confederation of Physiotherapy, 2019 (<https://world.physio/sites/default/files/2020-07/PS-2019-Description-of-physical-therapy.pdf>, accessed 20 December 2022).

to people's lives. Occupational therapists optimize individual capacity, adapting the activity, and modifying the environment to ensure people can achieve what they need, want or are expected to do in their daily lives.

Occupational therapy is an autonomous profession that is occupation based, person centred and evidence informed, with occupational therapists working as **equal members of interdisciplinary teams (ICP)** comprising health, social and rehabilitation professions. As autonomous health professionals, occupational therapists do not require referral, approval or supervision by other professions. They conduct individualized assessments to identify people's needs, strengths and barriers, then develop occupation, performance and participation-based goals. Reassessment or evaluation of the outcomes of the intervention is undertaken following participation in occupational therapy.

Data on the global workforce of occupational therapists is regularly collected by WFOT from member organizations. Reliable data are often lacking in some jurisdictions, particularly in the countries of central Asia and eastern Europe. A priority is contributing to **robust and complete data collection** to allow tracking of workforce development and trends. The WFOT represents just over 600 000 occupational therapists globally, with 1141 education programmes meeting WFOT minimum international standards for the education of occupational therapists. The profession is 94% female, with employment of occupational therapists predominantly in public or government-funded positions, but with an increasing number moving to private practice and the social sector.

Prosthetics and orthotics

Claude Tardif (*President of the International Society for Prosthetics and Orthotics (ISPO)*) presented an overview of the prosthetics and orthotics field. He defined prosthetics and orthotics as the umbrella term for the science, technology, education and application of prostheses and orthoses (among other mobility products and devices), intended to restore individuals' independent functioning and mobility, optimize health and well-being, and increase participation. A prosthesis is an externally applied device used to **replace** wholly or partly absent or deficient limb segment. An orthosis is an externally applied device used to **support** or modify the structural and functional characteristics of the neuromuscular and skeletal systems.

He referred to prosthetics and orthotics as a "ghost profession" owing to its underrepresentation generally and the severe **lack of data available on the profession and professionals** providing these services. It is widely understood that there is huge unmet need for P&Os, with none of the countries around the world meeting the defined international standards for the number of personnel required, even in high-income countries.

Training programmes for prosthetics and orthotics exist and are audited according to the ISPO standards, to ensure professionals enter the field at the required competency levels for their occupational classification. Accreditations are subsequently issued if the required standards are met. However, numbers are low; 45 recognized programmes exist worldwide, but none exist in the central Asia and eastern European region and programmes that do exist further afield do not meet international standards.

Speech and language therapy and audiology

Jytte Isaksen (*Speech and Language Therapist (SLT) at the International Association of Communication Sciences and Disorders (IALP)*) conveyed the regards of the Association's president Professor Emerita Pamela Enderby. She introduced the IALP as a long-standing, non-profit-making, global organization of professionals and scientists in communication, voice, speech language pathology, audiology, and swallowing.

Professionals working in this field assess and treat speech, language and communication problems in people of all ages to help them communicate better, as well as support people with eating and swallowing problems. SLTs and audiologists work with clients and carers to provide tailored support, alongside and **in collaboration with other health professionals** (including physiotherapists and occupational therapists) and teachers (ICP). Their work is person centred, evidence based, and the WHO International Classification of Functioning, Disability and Health (ICF) model resonates with the way they approach the profession.

The speech and language therapy profession is autonomous, recognized as such, and practitioners can work independently. The IALP represents associations from around 60 countries, along with individual members. The association is eager to support emerging collaborative speech and language therapy and audiology work among rehabilitation professions and the wider health care professions (e.g. continuing with their collaborative mentorship programmes).

PRM

Volodymyr Golyk (*National Professional Officer, WHO Country Office Ukraine*) explained that from a PRM perspective, diagnosis and treatment plans take place as a result of the interaction between medical diagnosis and functional assessment (based on the WHO ICF conceptual framework). In many cases, interventions are determined and carried out by PRM practitioners or within the PRM team, taking a transversal role in their collaboration with multi-professional teams (ICP), and using a patient-centred approach to meet patients' rehabilitation needs. Interventions include (among many others) medicines, physiotherapy, exercise-based treatment, and education, with standardized PRM programmes available for many diseases and functional problems. Outcomes of this **multidisciplinary approach** through PRM programmes and interventions show improvements in functioning and participation and a reduction in mortality among certain groups of patients, along with cost savings for the health system.

Numbers of PRM physicians vary across Europe, with a particular lack of these professionals in the region represented at the meeting. Various challenges exist all areas, in terms of governance, legislation, classification and standards.

Rehabilitation workforce

In the countries of the targeted subregion:

- numbers of rehabilitation personnel and rehabilitation specialists are low;
- resources and impetus are lacking to implement training programmes from scratch (ensuring they are accredited to ensure recognition) to increase the rehabilitation workforce;
- it is common to see medical doctors transferring to the rehabilitation field.
 - » To increase numbers of competent, trained professionals graduating as quickly as possible into the professions in which they are most needed, it is **inefficient and costly** to convert trained medical doctors to rehabilitation practitioners.
 - » Training undergraduates would be more effective, with specific, internationally recognized education programmes designed to meet population rehabilitation needs (including placements or fieldwork).
 - » It is necessary to build a suitable workforce with a strong professional identity; this would also be more cost-effective for health systems.
- It is important that the approach is clear at the policy-making level regarding definitions, terminology, roles and supervision within the rehabilitation professions.

Membership of global professional associations

Advantages of membership of global professional associations included advocacy, and varied support for the development of both the profession itself and of national associations, in both the short and longer term.

Accreditation processes and education programmes

Each of the international professional organizations support universities and national professional associations to develop culturally relevant education programmes.⁸

- For the IALP, Ms Isaksen explained that accreditation or approval processes for education programmes delivered by education or training institutions were country specific, rather than global. In some countries, institutions are (usually) required legislatively to meet minimum national education standards, but in other countries it can fall to the education institution themselves to work with the clinics/practice settings at national level to implement the required standards.
- From a WFOT perspective, approval of occupational therapy education/training institutions occurs at a national level using WFOT global minimum education standards. The national association works alongside university and national accreditation processes, underpinned by rigorous, international, peer-reviewed standards that form the basis of WFOT approval over a 5-year or 7-year time frame. Elements of the global minimum education standards are non-negotiable, such as the number of assessed clinical/fieldwork hours and requirements for occupational therapists teaching occupational therapy subjects. The standards also stipulate that the education programme must be consistent with the cultural context, allowing for country-specific service delivery settings. The WFOT works with education providers globally to achieve these standards.
- It was reiterated how important **communication** is to the process of bringing everyone involved in the rehabilitation workforce together, including the communities where the services are needed.
- In the eastern European context, defining terminology and roles was clearly important and there was work to be done to establish a standardized, common understanding of (a) physiotherapy itself and (b) the various professions, to assist with accreditation and regulation of education and training standards between countries and internationally.
- The regional context of common post-Soviet tradition should be acknowledged and worked with, in terms of structure, training approaches, hierarchy of professions, and so on, while seeking to align the professional standards internationally.
 - » Communication with the local population is also important: in some countries (e.g. Georgia) **service users themselves do not have enough information** about how the rehabilitation health care system works, how to access services, the reality of waiting times, and so on.
 - Improving awareness regarding the provision of rehabilitation is considered essential to improving rehabilitation health service quality overall in these countries.

⁸ Further information was provided on the frameworks and minimum standards available from each of the professional organizations and can be found in the later subsection on [Tools and support available](#).

Introduction to interprofessional practice

Delegates watched a short video on ICP in health, recorded by Margot Skinner (Immediate Past Vice President of World Physiotherapy).

Important concepts underpinning ICP include:

- a patient-centred focus for care, also including families, carers and communities
 - » everyone is equal in this relationship;
- multiple health workers from different professional backgrounds work together, with a strong, collaborative team culture, to deliver high-quality care across health care settings
 - » each health professional brings a unique perspective, notices different things (symptoms, effects) and considers different possibilities, resulting in a more holistic view, together – of the patient – which can only benefit health outcomes.

Outcomes from effective ICP include:

- active participation of each discipline in patient care, with professionals fully engaged and working together;
- interprofessional team leadership adapting according to the care setting, so that patient needs remain at the centre of care considerations;
- respect among all professionals, with a sense of community and increased morale;
- evidence-based improvements in quality of care (in particular for noncommunicable diseases) – not only for patients but also for rural/remote and global populations;
- risk reduction, in terms of reduced likelihood of missed symptoms, misdiagnoses, and medication errors;
- earlier treatment interventions, improving patient outcomes;
- improvements in communication by using modern digital/information communication technology, to enable remote or distanced professional collaboration; and
- cost savings, in terms of interprofessional overlap resulting in reduced inefficiencies, fewer problems, and reduced length of inpatient stay.

Discussion

Each of the rehabilitation professionals emphasized the importance of **early intervention** to reduce complications and ultimately decrease costs, ensuring the highest potential for full recovery and resumption of participation. They also highlighted the need for **ICP** with all members of the health care team, as well as communication with the patient and their family at the centre of the process.

In the initial phase of acute care, all the professions would prioritize **communication** with the acute-care medical personnel in the hospital to ensure patient needs were met and all professionals involved were aware of the necessary considerations.

The steps involved in the rehabilitation pathway for all of the rehabilitation professionals included assessment, establishing priorities, setting goals and liaising with various acute-care team members (nurses, specialists, and other rehabilitation professionals). This was to ensure continuity of patient care at the right stage of the care pathway, aiming to progress from intensive care to sub-acute care in a rehabilitation setting, then eventually to discharge from hospital, recovery at home and return to work.

Key takeaways from the discussion included **the need for:**

- **patient-centred care**, in terms of establishing the patient's priorities and capacity, considering the care setting, and so on, with a focus on patient needs;
- **ICP**, including **respect** for differing knowledge perspectives and an understanding of (and willingness towards) the need to lead or allow others to lead, as appropriate at different points in the care pathway
 - » regular **nurse interaction** with patients, for example, provided an ideal opportunity for feedback to rehabilitation professionals throughout the care pathway;
- an **adaptive approach**, as the patient progresses with rehabilitation – this should encompass not only acute care and physical considerations, but a holistic approach throughout the care plan, including mental health, and aiming to achieve independence and return to work;
- acknowledgment and respect for traditional, post-Soviet models of care – whereby postoperative strategy and rehabilitation were the responsibility of physicians and specialists – while working at a health care system level to implement the required changes towards modernizing thinking on rehabilitation and the various professions, and how they interact; and
- due consideration of socioeconomic and/or cultural factors, where necessary, in the context of how rehabilitation is viewed, framed, prioritized and funded in some countries of the region.

Role of global organizations and professional associations

This session focused on the role of global professional organizations, presented an overview of the functions and benefits of national member organizations for rehabilitation professions, and considered the advantages at a global level. Each of the professional associations set out their missions and provided some information about membership and its advantages at national and global levels.

Functions and benefits of national member organizations include:

- leadership and a national voice for members of a profession (e.g. physiotherapists advocating for physiotherapists) – leading to the best possible outcomes for those receiving care;
- training and education – the national member organization is often the focal point (subsequent to entry-level education at university level) for ongoing professional development;
- developing and disseminating standards;
- opportunities for networking and communication;
- research initiation, leading to better care;
- input into national policy and practice – for example, for ministries, having a strong professional voice at national level can facilitate decision-making;
- collaboration with other organizations in the rehabilitation field, including involvement in assistive technology.

This positive picture is essentially replicated at the level of **global** member organizations, with the functions and benefits of membership having a broader basis for effect. For example, global membership allows for: a **global** voice for the profession, **wider** dissemination of standards and education, networking **between countries and regions**, inputs into **international** policy and practice, and global collaboration among countries and regions as well as in official capacity with international organizations (e.g. WHO). In this way, professional associations work together to amplify their impact in influencing national health policy to ensure rehabilitation is prioritized both within health care systems and globally. They also aim to ensure countries align with international standards in order to improve health outcomes at a population-wide level.

The Rehabilitation Competency Framework (RCF)

Jody-Anne Mills presented WHO's RCF,⁹ explaining to delegates that it is available online at the WHO website along with more information and webinars¹⁰ for those who might wish to explore it further.

The RCF – which is essentially a description of rehabilitation workers' behaviour (collectively described as **competencies**), **activities** (what they do), their **knowledge and skills**, and their **core values and beliefs** – was developed in conjunction with the various rehabilitation professions. The purpose of this was to:

- fill an obvious need, where previously no rehabilitation-specific competency framework existed;
- make the process of developing a contextualized competency framework more accessible for countries;
- make available one shared framework to be applied to the whole rehabilitation workforce (models and standards already exist for specific, separate professions but the RCF allows workforce-wide, national-level evaluation, interdisciplinary practice evaluation and workforce planning through a **competency lens**);
- harmonize language and concepts around describing rehabilitation workforce and roles – essentially to improve communication and remove barriers to collaboration through shared terminology.

The RCF is relevant to and can apply for **all** rehabilitation workers across any of the professions or occupations. It is designed to complement, rather than supersede other competence frameworks or standards, as an alternative lens through which to view the rehabilitation workforce and to assist in its development for improved rehabilitation care within health systems. It allows analysis of what care the workforce is required to provide in a given scenario, and what that service provision means for the population requiring that care (i.e. the outcome). While the focus for the RCF is rehabilitation workers, they do not exist in a vacuum, and as such the framework does not stand alone. Other important considerations include infrastructure and equipment, and an enabling, supportive professional environment.

The framework is designed to be adapted by users to their context, according to the requirements of their workforce analysis, whether by country, workforce occupation or specialization (for example). They can use it as a launch pad for work on rehabilitation workforce competency. Stepwise guidance is available on the RCF website to (a) help users adapt the RCF to build a context-specific competency framework;¹¹ and then (b) use the adapted framework. It can be applied in a variety of ways,¹² such as for regulation and accreditation purposes, performance appraisal, to feed into competency-based education or workforce planning activities, and so on.

Ms Mills explained that the RCF's purpose is to capture and describe the shared competencies and behaviours of rehabilitation workers, representing the aggregate of the different activities that they perform across all the professions. For example, competencies such as **communication, collaboration, problem-solving, and critical thinking** are all needed to provide high-quality patient-centred care.

The RCF can also be used to analyse the workforce on a more granular level, as specific activities (and within them, even more specific tasks, interventions and assessments) will differ between occupational groups, across a **spectrum of performance**. Rehabilitation workers do not just operate at one level – their input into the health system varies or evolves according to working practices, levels of guidance, specialization, autonomy and

⁹ Rehabilitation competency framework. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/338782>, accessed 20 December 2022).

¹⁰ <https://www.who.int/news-room/events/detail/2021/03/11/default-calendar/rehabilitation-competency-framework-in-action-training-webinar-1-adapting-the-who-rehabilitation-competency-framework-to-a-specific-context>, accessed 20 December 2022.

¹¹ Adapting the WHO Rehabilitation Competency Framework to a specific context. A stepwise guide for competency framework developers. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/i/item/9789240015333>, accessed 20 December 2022).

¹² Using a contextualized competency framework to develop rehabilitation programmes and their curricula. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240016576>, accessed 20 December 2022).

leadership, and so on. This is described through four stages, or **proficiency levels**, within the RCF. A birds-eye view or snapshot of the RCF can be seen in Fig. 1, which shows the key **domains** of rehabilitation professions (defining **competencies and activities** under five headings) centring around the **core values and beliefs** of rehabilitation professionals (**compassion and empathy, sensitivity and respect for diversity, dignity and human rights, and self-determination**). These values are underpinned by concepts that are well understood in the rehabilitation context: functioning as a central pillar of health and well-being; the importance of person- or family-centred care; the need for collaboration and for rehabilitation to be available to everyone who needs it.

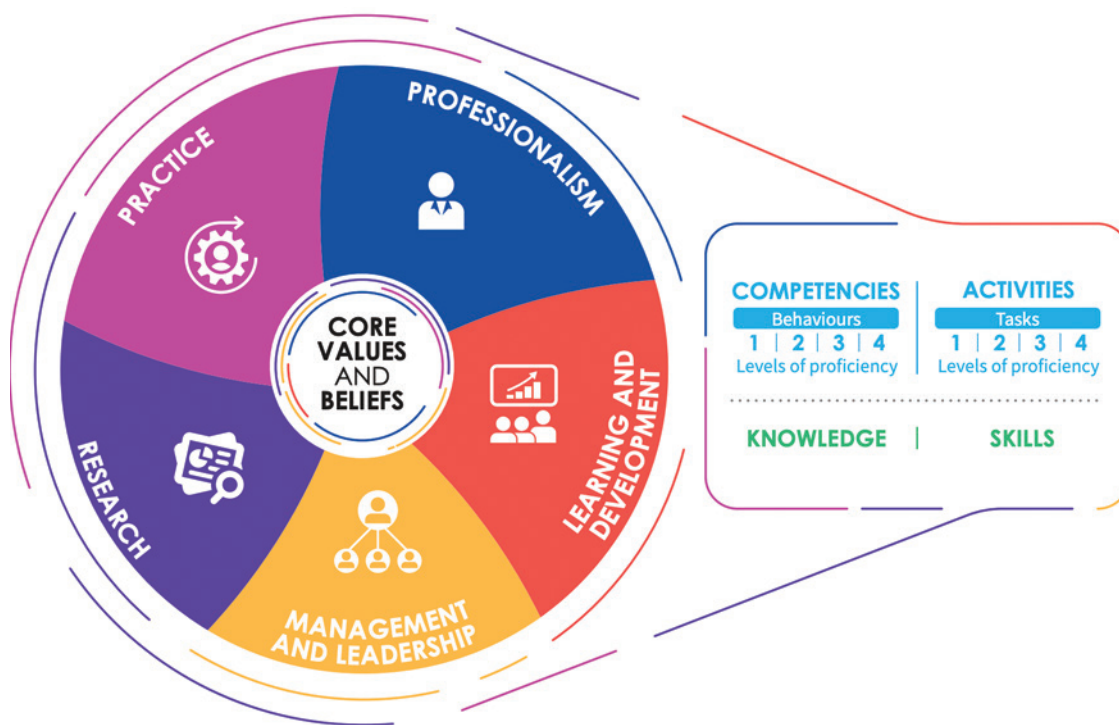


Fig. 1. A snapshot of the workings of the RCF

The **knowledge and skills** identified by the RCF underpin the competencies and activities of the workforce. Knowledge forms the informational basis required for competencies and activities, while skills are a specific cognitive or motor ability that is typically developed through training and practice (enabling a required/desired behaviour or activity/task performance). The RCF includes **core**, cross-cutting knowledge and skills, as well as **activity-specific** knowledge and skills. Contrary to the approach to the competencies/behaviours analysed, the RCF does not break down these knowledge and skills into proficiency levels, leaving this instead to the context-specific needs of the user.

This approach allows the RCF to be used for a detailed analysis of the composition of a workforce, both within and across professions. More specifically, it enables a description of what a rehabilitation worker at each of the proficiency levels might look like (their competencies and activities). The framework also allows scope for capturing change within the workforce – people develop within their career, in terms of knowledge, specialization and experience, and the proficiency mix shifts accordingly.

One of the most common applications of the RCF is in designing or developing **curricula for competency-based education** of the rehabilitation workforce (or parts thereof). The focus in this case is on **outcome-oriented** education; for example, what competencies learners need to develop and what activities they need to be able to perform (and to what level) as a result of the education programme. The resulting competency framework will then break this down into combinations of **targeted, theoretical, integrated** and **applied learning experiences** in order to achieve the desired learning objectives.

Feedback and impressions on Day 1 from delegates

The impressions session raised several points from the point of view of the delegates from the countries of the subregion, including that more specific, targeted **information and assistance** would be welcome from both WHO and the professional associations present on:

- **developing human resources** for rehabilitation through analysis of the current in-country education programmes to understand what elements need developing, how to find or encourage higher numbers of rehabilitation professionals to enter the workforce, what **competencies** are needed and approaches to ensure they are included;
- the specifics of **training programmes** for people to become rehabilitation professionals, **developing educational curricula** and **ensuring they are aligned with international standards**;
- how to provide recognition to the professions through **certification/accreditation**;
- establishing a supervision framework at a high (government/ministry) level to **manage governance** of the rehabilitation workforce, to increase understanding of the stakeholder balance, and ensure efficiency in the division of functions to avoid unnecessary duplication of work;
- **legislative reforms** to ensure the desired changes can be effective at country level (e.g., state legislation relating to NGO/professional association influence and involvement);
- the practicalities of distinguishing between medical and paramedical personnel – not to create silos, but to **clarify terminology and definitions** of the separate professions and their scope(s) of practice in order to have more effective **multidisciplinary teamworking** and move away from a medical-only perspective on rehabilitation;
- financing and strengthening of international and national associations in terms of **scientific research relating to rehabilitation** – good evidence is needed to underpin developments being implemented;
- help for governments to become aware of and to access **financing** for rehabilitation professional development;
- further **shared experiences**, or examples of success stories, which could serve as a basis and inspiration for other countries in the region – e.g. strengthening rehabilitation education and recognition for professionals in record time (Ukraine), making good use of international associations or technical tools (Ukraine, Tajikistan), or establishing multidisciplinary rehabilitation programmes in alternative (nongovernmental) settings, with positive results from **interprofessional, patient-centred collaboration** being introduced into education programmes at an early stage (Ukraine)
 - » [NB. communicating about shared **negative** experiences or **common challenges and barriers** can also be important in terms of learning from each other, in particular in the context of post-Soviet countries];
- opportunities to collaborate with European countries (as well as with WHO, other United Nations agencies, and the international professional associations) – evidence has shown that developing rehabilitation professions has a very real, positive impact on health care delivery and outcomes, improving health system response and ultimately overall population health;
- switching to a long-term rehabilitation strategy that considers rehabilitation is important for the whole population (i.e. not just for people with disabilities), and ensures that the **approach to training is more systematic and diverse** (not just for medical doctors or professionals already trained in medicine – working towards **parity of esteem** for the professions, a **balance of responsibility** for the oversight of rehabilitation services, providing a more integrated health service response for improved, patient-centred care);
- extending the concept of **multidisciplinary working across rehabilitation professions in rural settings**, working to overcome human resources distribution and planning problems, whereby a physical lack of professionals can negatively influence patient outcomes in remote areas – for example, telemedicine approaches could be used to enhance ICP and ensure a range of inputs to the patient pathway (e.g. not just medical doctors responding postoperatively to physical needs).

Regional workforce situation assessment

Sidy Dieye (*Head of Programme, World Physiotherapy*) presented the results of a situation analysis of the rehabilitation workforce carried out in central Asia, Caucasus and Ukraine by the WFOT and World Physiotherapy, in collaboration with WHO and with input from the ISPO.

The overarching conclusion from the detailed data presented was that the professional definitions and required education for physiotherapy or occupational therapy in most of the countries **do not meet World Physiotherapy or WFOT international standards**. People are being counted as rehabilitation professionals with no formal or recognized/accredited training in the profession, in particular in the prosthetics and orthotics field, but also across all rehabilitation professions. There remain significant difficulties in accessing the exact number of physiotherapists, occupational therapists and prosthetics/orthotics professionals in each country. Large discrepancies exist between the WHO global statistics, numbers from ministries, World Physiotherapy data, and numbers cited in previously published work. Workforce data are not routinely collected at any level of the health system, meaning the overall picture remains very unclear.

In central Asia, physiotherapy services are provided by either medical doctors or nurses who have had training in rehabilitation or physiotherapy. Owing to the lack of shared terminology and definitions, there is no common understanding of the roles of health professionals; their titles vary markedly, including examples such as Doctor Physiotherapist, Physiotherapist, Rehabilitologist and Rehabilitation Therapist. Only certain few countries of the region have occupational therapy or physiotherapy listed and/or licensed as recognized professions, and numbers vary widely in those countries that do recognize the professions in some capacity (albeit rarely in line with international standards).

In terms of education, only two of the countries in the region have WFOT-approved education programmes in occupational therapy (Georgia – BSc; Ukraine – MSc, including fieldwork). Armenia has a postgraduate MSc programme in occupational therapy but it is not WFOT approved. Similarly, only two countries in the region have World Physiotherapy-approved education programmes for physiotherapist training (Georgia and Ukraine – both at BSc and MSc levels). Tajikistan has a diploma in physiotherapy in progress. In the prosthetics and orthotics profession, entry-level education is sorely lacking: no accredited training programme exists for P&Os in the region. However, some pilot training programmes – provided by organizations such as the International Committee of the Red Cross (ICRC) or Human Study, and accredited by the ISPO – have been provided in certain countries (Azerbaijan, Georgia, Tajikistan and Ukraine). Ukraine had made significant headway in terms of designing a curriculum with help from accredited educational institutions, intending to build and convert teacher and trainer capacities from among 24 trained P&Os. These professionals had been trained at associate level with a blended learning model, allowing them to stay in place, providing needed rehabilitation services. This conversion would allow future accreditation of prosthetics and orthotics professionals with higher-education certificates (BSc) from a recognized university programme. Unfortunately, the current context of conflict in Ukraine had put a stop to these plans at the time of the meeting.

There is no regulation of scope of practice for people providing physiotherapy or occupational therapy services within health systems in the central Asia region, and no educational institutions nor corresponding ministries of education have instituted examinations or licensing requirements to practice.

Membership of professional associations is also sparse: only two countries of the region enjoy full WFOT membership with approved education programmes (Georgia and Ukraine), while a further two are associate members (Armenia and Kazakhstan), and Kyrgyzstan is in the process of developing an association. Georgia and Ukraine also have professional associations for physiotherapists, and enjoy World Physiotherapy membership, while Armenia and Azerbaijan have professional associations but their educational institutions do not meet World Physiotherapy international standards for physiotherapy education and the profession is not recognized at national level.

Volodymyr Golyk commented that it must be a country-level responsibility to implement international standards via national regulatory mechanisms in order to achieve certification of educational institutions or programmes. International standards are available, and assessment by and assistance from international professional associations is important and can be useful in terms of establishing the necessary criteria for individual rehabilitation professions. However, the impetus must come from the country level and real changes made locally, including ensuring specific content is translated into the local language and that the programmes meet the international standards on a profession-by-profession basis.

In summary, the **common problems** that exist in the region revolve around the lack of:

- workforce data
- common terminology/definitions of professionals
- recognition and/or regulation of professions
- educational standards (content and delivery of programmes)
- professional association membership
 - » where they do exist, support is needed with leadership and advocacy.

Broad recommendations to start to remedy these shortfalls and make progress on developing the rehabilitation workforce in the region include:

- updating the **common understanding** of rehabilitation and specific professions, and what it means to meet international standards, through national campaigns both within the health sector and at community level; and
- providing **technical support** for creating and/or increasing the roles of **national professional associations** for the rehabilitation professions, to assist with community-building, awareness-raising, knowledge-sharing and continuing education activities. These associations can also, crucially, help with promoting and supporting
 - » the creation of **profession-specific entry-level education programmes** (minimum BSc) that **meet international standards** (developing curricula, training academic faculties, etc.);
 - » the **recognition** of specific rehabilitation professions, ensuring they are added to the national recognized list of professions.

Country perspectives on rehabilitation

In this session, moderated by **Sue Eitel** (*WHO Regional Office for Europe*), three participants presented detailed information about the rehabilitation workforce situation in their country context, providing insights into the workforce, services and some of the barriers or facilitators to strengthening rehabilitation.

Armenia

Liana Aghajanyan (*Child Rehabilitation Consultant, Ministry of Health of the Republic of Armenia*) gave details of the situation in the rehabilitation field in Armenia – a country with a population of 3 million in 2021. The development of rehabilitation professions in Armenia has its roots in disaster and conflict, driven by need during the recovery from the Spitak earthquake in 1988 and hostilities in the country around the Nagorno-Karabakh conflict. Project HOPE was started in 1989 for child rehabilitation, for which local specialists were trained. Since 1996 a Swiss Foundations organization has cooperated with paediatric rehabilitation centres, implementing training programmes and producing joint conferences and seminars.

Specialist rehabilitation training has been supported by the ICRC in Armenia through the creation in the early 1990s of the first rehabilitation centre for adults with post-traumatic spinal cord injuries. Education departments have subsequently been introduced, training rehabilitation doctors, nurses, physiotherapists, occupational therapists and orthotists, and the first orthopaedic laboratories were also created.

Armenia works with WHO, using tools and algorithms (TRIC, STARS)¹³ to collect data on rehabilitation, and a specific rapid needs assessment survey was carried out in 2021 (albeit hampered by conflict and the novel coronavirus disease (COVID-19) pandemic; an update is forthcoming during 2022). Recognition of the rehabilitation specializations providing paramedical services began in 2021 but remains unclear. Rehabilitation doctors are the main subspecialty in the rehabilitation field (with clinical residency possible since 1996, taking place through higher education setting and with a 2-year residency requirement).

Physiotherapy in Armenia has traditional roots, mainly carried out by doctors having started their career during the Soviet era and dedicated to electrotherapy techniques. In relation to this strong history and tradition, terminology and definition of professions remain problematic and an ingrained tendency towards prioritizing medical over paramedical persists. There remains a strong belief that medical specialists should coordinate and be responsible for the rehabilitation process.

Occupational therapy is predominately within the special education field although the professional association has close links with the WHO Country Office. There is a need to reinstate the BSc Occupational Therapy programme alongside the present postgraduate MSc.

Alongside rehabilitation medical doctors (PRMs) and physiotherapists, the country also has occupational therapists, SLTs, P&Os, psychologists, social workers, and pedagogic specialists, all working in the rehabilitation field and collaborating with highly skilled medical staff (particularly nurses). Interprofessional collaboration exists in the rehabilitation field in Armenia between health care professionals working within the inpatient (hospital-based, clinical care) setting and also between rehabilitation centres (e.g. the Arabkir Medical Center) and counterparts in other countries (e.g. University Hospital Zürich), sharing experiences to improve patient care.

¹³ Template for rehabilitation information collection (TRIC): a tool accompanying the Systematic Assessment of Rehabilitation Situation (STARS). Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/330956>, accessed 20 December 2022)

Ms Aghajanyan described in detail the education programmes for each of the rehabilitation professions, highlighting their strengths and weaknesses. Strengths include: higher-education programmes in place for several of the professions (albeit not accredited or meeting international standards); some good examples of international collaboration and knowledge-sharing; and the existence of various professional associations or bodies in the country. However, for several of the professions, entry requirements for educational programmes are not set. Accredited postgraduate courses do not exist and there is confusion and lack of recognition at all levels of the health care system about roles and titles of professionals. Specialties are not recognized at all in the country – neither at population nor policy-making levels.

Barriers to rehabilitation workforce development include the lack of:

- compliance of curricula with international standards;
- clarity around titles/subspecialties, or differentiation of the status of various professions – stemming from a broader lack of clarity in terminology existing since the Soviet era;
- postgraduate qualification-enhancing opportunities across the board;
- motivation of doctors to choose rehabilitation specialties;
- awareness of the benefits of rehabilitation, including in the medical community;
- regulatory mechanisms for specialisms;
- basic applied medical education – paramedical personnel do not have enough hands-on skills and knowledge to start rehabilitation roles without further education and training.

The following improvements and contextual amendments would be needed to help with rehabilitation workforce development:

- reforms of the existing educational programmes (with the existing study system at the centre);
- establishment of a qualification-enhancing postgraduate centre;
- awareness-raising about the various professions and specialisms;
- increased focus on accreditation of existing and new paramedical rehabilitation personnel, to ensure they are able to work autonomously in acute-care settings.

Azerbaijan

Nigar Nazarli (*Senior Advisor to the Healthcare Administration Department of the Ministry of Health of Azerbaijan*) presented on the current state and future prospects of rehabilitation in Azerbaijan – the largest country in the Caucasus region, with a population of just over 10 million. She provided detailed information about percentages of the population living with disability resulting from various diseases and conditions, as well as breaking down by specialism the different types of rehabilitation personnel working in the country.

Azerbaijan has a few institutions for the education and training of rehabilitation specialists, with education delivered at various levels, including (from 2020/2021) a 4-year bachelor's degree in physiotherapy and rehabilitation, as well as master's degree and doctoral opportunities in various (mostly physical education/sports-related) rehabilitation specialisms. The country produces physiotherapists, therapeutic physical exercise physicians, psychiatric rehabilitation physicians and nurse instructors in therapeutic physical exercise. Some courses have residency training elements and require specialists to work towards certification every five years. Interprofessional collaboration with the wider health care system and medical teams is common, and international collaboration takes place with educational institutions in other countries (such as University College London).

The focus in Azerbaijan remains divided between rehabilitation services in state-funded urban centres on the one side (providing post-operative, traumatology-based acute-care rehabilitation to test and restore functioning) and sanatorium-resort treatment prophylactic facilities on the other (known as SRRCs). These latter facilities use natural resources and balneological treatments for chronic diseases, post-clinical treatment, rehabilitation and prevention, along with recreational approaches to improving health. Both types of rehabilitation care are used to prevent and treat a wide range of conditions and diseases.

Barriers to rehabilitation workforce development in Azerbaijan include the lack of:

- professionals in this branch of medicine (labour shortage)
 - » because it is not popular among students and graduates seeking to specialize;
- understanding of the need for, as well as appreciation of the rehabilitation professions at society level;
- a competitive approach by educational institutions/faculties, reflected in fewer enrolments.

Prospects for rehabilitation in Azerbaijan currently include the following positive points.

- **Government attention** to the importance of rehabilitation is increasing, along with **political will** to discuss and implement major changes in the classification and structuring of the rehabilitation system.
- **State funding** for rehabilitation assistance is being increased (as a result of the above attention), with the expansion of education and training through the introduction of new education programmes for rehabilitation professions at all higher education levels – this should help to encourage more professionals into the workforce.

Ms Eitel emphasized the importance of data in establishing evidence-based need for rehabilitation, including numbers and types of professionals. She also mentioned the obvious division of professionals among the settings in which they deliver care, and in which fields, in terms of the urban versus rural context and the medical versus paramedical focus, according to the country context. This would also influence rehabilitation workforce needs and planning in many countries, just as in Azerbaijan.

Tajikistan

Professor **Yusufi Salomudin** (*Head of Department of Medical Pharmaceutical Education, Human Resources, Policy and Science at the Ministry of Health and Social Protection, Republic of Tajikistan*) presented the current situation and perspectives on rehabilitation services development in Tajikistan. It is in the central Asia region and has a population of approximately 9.5 million, 74% of whom live in rural areas. Prof. Yusufi gave details of the requirement for rehabilitation in the country, outlining the types of rehabilitation professionals/specialists and at what level they were trained. These included college/mid-level for certificated specialists (including various nursing specialisms), and higher education diplomas for medical doctor education, including specialist training in a wide variety of rehabilitation-focused areas (speech and language therapy, occupational therapy, physiotherapy, physiotherapy, psychology, etc.).

There is significant historical and functional overlap between the medicine, pedagogy and rehabilitation fields in Tajikistan. Specialists with higher education include physiotherapists (trained abroad to international standards), physiochemists, physical medicine doctors, and traumatologist-orthopaedists (these latter professionals being the highest in number). Nurses and other rehabilitation personnel are trained through mid-level (college) education programmes and training, including physiotherapy models at dedicated faculties, with varying lengths of study.

Prof. Yusufi explained the funding mechanism for what is known as the state social order, whereby social services are procured from local nongovernmental organizations, provided in social service centres for children with disabilities and other vulnerable population groups. Provision has increased from over 13 years from 3 centres to 53, with a funding increase of 6% from 2021 to 2022. Other types of rehabilitation care setting include various state organizations, day-care centres, sanatoria, and national orthopaedic centres. For the provision of prosthetics and orthotics products, 25 devices are produced locally within Tajikistan, while 13 are purchased from abroad (with plans in place to start producing these locally).

Actions aiming to expand and improve rehabilitation personnel include:

- plans to integrate rehabilitation services at all levels of the health care system, improving access to and quality of rehabilitation services, involving
 - » development of targeted programmes for a specific list of conditions;
 - » access to assistive products for people with disabilities;

- an increase in dissemination of information and specialist knowledge (most health workers have only limited understanding of the role of rehabilitation and, in particular, technical assistive products), involving
 - » development of educational and training programmes for new rehabilitation professions and skills (encompassing technical training and meeting international standards);
- a strategy for protecting the health of the population for the period up to 2030;
- a draft strategy for the development of social protection of the population for the period up to 2035 (in process, awaiting approval).

In terms of physiotherapy, a project is underway in Tajikistan, in collaboration with several international organizations. The project aims to: improve qualification levels of teachers providing physiotherapy education and revise curricula and training programmes for medical rehabilitation and physiotherapy, ensuring they are moving towards aligning with international standards and guidelines (introducing a new physiotherapy curriculum during 2022/2023, working towards meeting international standards and adapted to the local context). It will also create a basis for the creation of a national professional association of physiotherapists in the country and cooperate with international organizations to improve the material and technical foundations of the Republican Medical Colleges.

A number of therapists were educated in occupational therapy in India and Iran and have now returned to Tajikistan to practice.

The main **barriers to rehabilitation development in Tajikistan** include the lack of:

- material resources (funding);
- professionals working in the rehabilitation field;
- modern curricula that meet international standards, with a systematic approach to workforce training;
- professionals able to train the incoming workforce to international standards (existing teachers were trained according to outdated curricula and knowledge);
- understanding among the health care workforce of the rehabilitation specialties (e.g. physiotherapy);
- limited use of sign language in rehabilitation and social services.

Opportunities and factors to help ensure rehabilitation workforce development include:

- allocating more funding to rehabilitation education;
- creating a working group to focus on improving rehabilitation in Tajikistan, involving all relevant stakeholders – ministries across all sectors, medical and educational institutions (with both treatment and prophylactic foci), and civil society representatives of population groups with particular rehabilitation needs;
- creating or updating modern educational departments at medical universities, focusing on revising both undergraduate and postgraduate curricula in line with evidence-based medicine principles, involving
 - » training qualified staff in the rehabilitation field (across all professions);
 - » attracting specialists to the sector and motivating them;
 - » providing remote support for newly trained teachers and specialists, such as through mobile communication centres in the regions;
 - » developing education programmes for specific professions that meet international standards.
- harmonizing definitions and terminology to avoid conflict between the roles and responsibilities of rehabilitation health professionals;
- revising the role of the Institute of Medical and Social Expertise and Rehabilitation of the Disabled, creating a resource centre to improve and continue to develop rehabilitation professionals' skills and knowledge;
- creating professional associations at national level for the rehabilitation professions;
- introducing translation services in the rehabilitation and social services field through sign language.

Discussion – regional perspectives

In discussion the point was raised that it is important to acknowledge the commonalities and differences across the countries of the region, in particular differences in how countries approach definitions and terminology (both for the professions/professionals and in terms of defining disability). It is important to understand and consistently apply definitions in the country context to ensure fidelity of data collection, reporting and international comparison, as well as to underpin local context assessment.

Separation of health and social sectors can be problematic, in terms of defining where the responsibility lies for services, both legislatively and operationally. Close cooperation and communication would go a long way towards removing this barrier, but in practice this can be difficult, depending on the country context and the specifics of the legislative landscape.

Ms Eitel asked the **professional associations to outline their journeys within the countries of the subregion** in terms of developing the rehabilitation workforce in their specialist fields.

Occupational therapy in the subregion

Samantha Shann of the WFOT advised countries of the region to seek advice from professional associations and WHO, and to learn from other countries' previous experiences, rather than attempting to implement curricula developments and administrative changes without guidance. This had proven for some countries to be costly in terms of time and effort. Working with international experts would lead to quicker and more effective development of the rehabilitation workforce in various aspects, applying the appropriate methodologies to build a strong professional identity.

The WFOT's journey with Ukraine had been exemplary (albeit with some challenges and opportunities remaining) in terms of the speed and clarity with which occupational therapy had been established as a profession within the country and the level of professional identity already developed. The Federation had carried out an in-country visit, working with the newly established national professional association (Ukrainian Society of Ergotherapists; USET) to facilitate agreement at ministerial level over classification of the profession. Initial discussions had involved three distinct ministries (not only the Ministry of Health), to ensure discussion of education programmes was carried out with all the relevant stakeholders and a collective understanding of the international standards required.

The progress made, with a signed Memorandum of Understanding and subsequent associate membership of the WFOT was a direct example of a country working with professional associations to influence policy-making. This advanced the development of occupational therapy as a recognized rehabilitation profession. Assistance had also been provided to establish a train-the-trainer faculty development programme, securing approval for the first curriculum that met WFOT requirements and leading to full WFOT membership in 2021.

Physiotherapy in the subregion

On behalf of **World Physiotherapy**, **Jonathon Kruger** reiterated the importance of in-country visits to establish a particular country's needs and carry out a gap analysis of the reality of the situation. In Tajikistan, for example, this enabled a refined, targeted approach to helping develop physiotherapy, writing a concept note for a project that ultimately led to a physiotherapy course being implemented, in partnership with Momentum Wheels for Humanity and with funding from the United States Government.

Underrepresentation of prosthetics and orthotics in the subregion

From an **ISPO point of view**, **Claude Tardif** raised concerns about the lack of representation and recognition of the prosthetics and orthotics profession in the countries of the region, reiterating that the ISPO was available and indeed keen to help develop P&Os (but also to strengthen services provision, more generally, throughout the rehabilitation sector) in the region. Nonetheless, he recognized that collaboration with other organizations (such as the ICRC) had led to ISPO-approved training programmes in certain countries (Azerbaijan, Georgia), resulting in certification for professionals trained at institutions that met the required educational standards, and recognition of the professional title.

The professional associations were recognized as an essential source of knowledge and support, providing the impetus for helping countries to encourage people to enter the rehabilitation professions. Communication within the region would be vital for countries to not reinvent the wheel but to learn from their shared experiences and differences.

Rehabilitation Workforce Progression Model

In the afternoon of Day 2 of the meeting, Jody-Anne Mills reflected on the starting points and opportunities for collaboration already identified, noting the impressive amount of political will that had been demonstrated to progress with rehabilitation workforce development. The countries began drafting an initial roadmap, which set out the key objectives for that progress. Preliminary discussions would form the basis for a more complex, lengthy task that would continue after the meeting.

To provide a framework for drafting the roadmap, Ms Mills presented a progression model that defined four key areas for action in planning and developing the workforce, across three phases of workforce development (see Fig. 2). The descriptions shown in the figure are snapshots of what a country might (or should aim to) be doing within any of those action areas and in any of the development phases.

EDUCATION & TRAINING	Harness regional and international partnerships to establish and accredit education programmes, address competency gaps through interprofessional education, and meet immediate needs through sponsoring study abroad.	Enhance institutional capacity through building more permanent faculty, expanding learning experiences, and equipping facilities with infrastructure and equipment to bolster the quality of education and training.	Expand access to postgraduate education and opportunities for specialization, and invest in research.
RECOGNITION & REGULATION	Formally recognize rehabilitation occupations within legal frameworks and integrate them within national health workforce regulatory systems.	Establish competency standards and institutional capacity for their attainment and enforcement.	Strengthen monitoring and assessment of the rehabilitation workforce against competency standards.
DATA & MONITORING	Gather and report data on rehabilitation workforce supply and employment in National Health Workforce Accounts (NHWAs).	Gather and report data on rehabilitation workforce education, distribution, and demographics in NHWAs.	Gather and report data on rehabilitation workforce labour market flows, employment characteristics, and working conditions, spending and remuneration in NHWAs.
ASSOCIATIONS & NETWORKS	Harness regional and international partnerships to establish national professional associations, and develop their relationships with relevant stakeholders.	Build the capacity of professional associations to offer training, promote the profession, and collect and manage workforce information.	Expand the availability of special interest networks and communities of practice to advance knowledge and support sub-specialization.

Fig. 2. A Workforce Progression Model

Note. The action areas appear in an arbitrary order in the model – no one element is more important than another and this does not represent an exhaustive list of areas for action.

The model represents an oversimplification of reality, in the sense that it does not capture dynamics and interactions between action areas, but the structure is useful when considering objectives for planning workforce development. It demonstrates an evolution or progression of steps through the workforce development process, from the very initial set-up (**emerging**) phase through to **building** the workforce and then eventually to **strengthening** workforce development once in a more established position.

The afternoon's group work centred around two documents provided to participants: (1) an expanded version of the Workforce Progression Model, with example activities that could serve as pathways itemizing granular, specific activities within each action area; and (2) a Roadmap Template for each country to define three (or more) objectives for each of the action areas for workforce development, using the expanded progression model

for inspiration. These objectives should be outlined according to the country context, considering country-specific resources, opportunities and barriers, objectives and time frames. They were not a strict protocol but a springboard for countries to start to define steps that needed to be taken to progress workforce development through the phases – they could all be revised and adapted in due course, as the roadmaps were refined.

Time frame was important, and opportunities for international collaboration should also be defined alongside each objective (i.e., key stakeholders to work with, such as associations, neighbouring countries, international organizations, etc.). The objectives were not intended to define **how**, but **what** needed to be achieved, and it was important to be specific about which rehabilitation occupations/professions were involved in the objectives being set. As a secondary task, actions could also be added under each objective (and these would outline **how** the objectives could be achieved).

WHO National Professional Officers were present in each working group to guide and engage with the teams, as well as helping with notetaking to report back to the plenary.

Roadmaps for the way forward

On returning to the plenary after the group work, the groups fed back on the draft roadmap objectives, focusing in particular on potential regional or international collaboration requirements or opportunities to pursue. Country representatives were requested to share their draft country roadmaps after the meeting, to enable further support to be provided by WHO in building on and implementing the roadmaps. These can be made available on request.

Cathal Morgan moderated the session, summarizing the **country-specific takeaways relating to the roadmap development objectives**.

For **Armenia**, it was clear that the country had strong NGO partners and was looking to use those relationships to good effect, seeking to connect with the international professional associations through those partnerships to develop rehabilitation education and the workforce. There was a clear impetus for classification and clarity of professional titles and role specifications for each of the professions, and continued collaboration with the United Nations agencies was also a priority.

For **Azerbaijan**, three solid areas of work had emerged from the exercise. (1) Legislative developments were needed, ensuring a structure was in place by means of an interagency task force, as well as involving all the key ministries to ensure their support at a high level for workforce development planning. (2) Capacity-building was also key, with education for rehabilitation professions being “renewed” or refreshed to ensure a good basis for workforce development, as well as working alongside and with the support of a wide range of international associations and partners. (3) Collaboration and linkages with the global international professional associations would also be important – they were willing to work together on developing curricula and ensuring developments in the country meet international standards.

For **Georgia**, the emerging prosthetics and orthotics field was clearly a focus, requiring lots of collaboration and input from professional associations and international organizations to develop curricula. The country was able to draw on country assessments already carried out and was using strategic planning tools to establish a strong evidence base for actual rehabilitation workforce needs at present and in the future. The WHO pilot project for training in assistive products (TAP) in the country was an impressive initiative, and an example of interagency collaboration to improve provision of assistive technology in the rehabilitation care field. Georgia was also intending to concentrate on education and training for rehabilitation professionals more widely, and had identified the need for collaborative help to implement a system to register lists of professionals and regulate their practices after graduation. Mr Morgan commented that the building blocks were stacking up in the right direction in Georgia for developing and progressing the rehabilitation workforce.

For **Tajikistan**, the strong links with international partners was important (in particular assistance from Momentum Wheels for Humanity), including carrying out assessments in the country, which would be a good opportunity to work together on refining the details of the roadmap. There was a clear emphasis on prioritizing physiotherapy curricula, and a drive in the country to support further education and training for existing PRM doctors. The meeting – and the roadmap session in particular – represented an opportunity to identify specific areas for future collaboration with the global professional bodies, on which WHO would follow up to support all countries in achieving this.

For **Turkmenistan**, key areas of focus included the development of educational programmes for rehabilitation professionals across various education levels, ensuring compatibility with international standards and that the capacity-building was underpinned by regulation. Strong links were mentioned with leading global centres and global professional bodies to develop curricula and establish faculty, as well as working to raise awareness of and recognition for the rehabilitation professions at all levels. Collaboration with United Nations agencies and global professional bodies would be important and an intersectoral, multidisciplinary working group would be established, intending to develop indicators against which to measure performance, assess quality, and compare findings. This was an approach that could apply to all countries in the region and represented a strong way to stimulate change, signalling positive progress towards developing Turkmenistan’s roadmap for rehabilitation workforce development.

For **Ukraine**, the focus in the across the board was building and strengthening all the rehabilitation professions. Having already established good relationships with the global professional associations, developing separate educational and professional standards for the individual professions would represent a big step forward, along with reflecting these in the legislation and regulation underpinning the professions. The WHO RCF can be used to support the development of professional standards. The juxtaposition of introducing licensing at the same time as exploring a self-governance model would be interesting and WHO would be keen to see how that develops in due course.

For **Uzbekistan** the priorities were to establish an interprofessional working group and carry out an extensive situational assessment of the rehabilitation professions in the country, to establish a baseline from which to develop. WHO Regional Office and Country Office colleagues would help with this. Education and training standards were to be updated to align with international standards, with legislative changes and regulation to underpin these developments. Building the recognition of the various professions was a priority, along with collaboration with international partners and global professional associations, to ensure an interprofessional, multidisciplinary approach to developing the rehabilitation workforce in the country.

For **Kazakhstan**, there were lots of similarities with other countries of the region around professional training, capacity development, standards, regulation, and designing curricula that meet international standards. Important points to note included the lack of Russian-language resources which were a significant barrier to developing rehabilitation in the country.¹⁴ In addition, there was a need for advocacy support to establish interministerial roles and leadership responsibilities among the various ministries. This would help strengthen the legislative framework around education and training for the rehabilitation professions, and raise the profile of rehabilitation at all levels. It was important to redirect the focus away from emphasizing only the medical aspects of rehabilitation, encompassing the other professions to move to a more integrated health and social care system. WHO and the global professional associations were on hand to help with this.

Mr Morgan highlighted the similarities across countries of the central Asian and eastern European region in terms of challenges they face in developing the rehabilitation education workforce. He reiterated that there are also common solutions available. WHO and other United Nations agencies are available to support countries to focus on the key roadmap areas, encouraging collaboration among countries of the region to enable progress without reinventing the wheel.

Common challenges faced in the subregion

In summary, **common challenges** identified for the countries of the subregion in developing the rehabilitation workforce include:

- definitions and terminology
 - » modernization and standardization needed;
- lack of professionals
 - » supply and demand issues to be resolved according to specific country, health system and educational contexts;
- lack of education programmes
 - » curricula and training approaches need to align with international standards;
- regulation and recognition of the rehabilitation professions
 - » at government and population levels as well as within the wider health care workforce; and
- legislative changes
 - » required in many countries to understand and influence stakeholder roles and responsibilities.

¹⁴ It was noted elsewhere by Human Study that international educational programme materials had recently been translated from English language to Russian, which was good news for some countries hampered by English-only certification mechanisms.

Tools and support available

Tools and support available to countries to help with these issues include:

- contacts, networking opportunities and country-specific help from the relevant global professional associations
 - » this includes various **education frameworks** and **minimum standards** provided by those associations, to assist with planning and updating (listed below);
- Country Office (and wider) support from WHO to signpost on these issues, and to refine and implement roadmaps;
- tools such as the **WHO RCF** and various workforce planning models that can be adapted to country and health system-specific contexts, with support from WHO and international partners as needed
 - » underpinning these are initiatives such as **Rehabilitation 2030 – a Call for Action**, and guidance such as WHO's *Rehabilitation in health systems: guide for action*.

The minimum standards and education frameworks available from the international professional associations include those listed here.

- **Physiotherapist education framework**. London: World Physiotherapy; 2021.
- **Minimum standards for the education of occupational therapists**. Revised 2016. London: World Federation of Occupational Therapists; 2016.
- **ISPO standards for prosthetic/orthotic occupations**. Brussels: International Society for Prosthetics and Orthotics; 2018.
- **WHO standards for prosthetics and orthotics**. Part 1: standards. Geneva: World Health Organization; 2017.
- **Postgraduate training**. Brussels: European Union of Medical Specialists; 2022.

Wrap-up and meeting close

In closing, Satish Mishra described the meeting as a “conversation starter”, gathering specialists and stakeholders in the rehabilitation field to identify some of the key issues and opportunities around rehabilitation workforce development for the central Asian and eastern European region. He and colleagues had been impressed with the commitment, contributions and high-level engagement from all nine countries represented and felt that a constructive exchange had been achieved, paving the way for real future development. There was still work to be done, and in future it would be useful to engage with more professionals across the interdisciplinary team to expand the depth of engagement and work towards removing some of the barriers to the rehabilitation workforce development that was much needed in the region.

Annexes

Annex 1. List of participants

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE



ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Multistakeholder meeting on the development
of rehabilitation education in central Asia and
eastern Europe

/5

Hybrid Meeting
7-8 June 2022
Copenhagen, Denmark

[issue date]
Original: English

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Annex 2. Provisional programme

WORLD HEALTH ORGANIZATION
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ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

WELTGESUNDHEITSORGANISATION
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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Multistakeholder meeting on the development
of rehabilitation education in central Asia and
eastern Europe

7–8 June 2022
Copenhagen, Denmark

2 June 2022
Original: English

Provisional programme

Tuesday, 7 June 2022	
08:30–09:00	Registration and welcome coffee
09:00–09:15	Welcome and introductions Satish Mishra, Technical Officer, Disability, Rehabilitation, Palliative and Long-term Care, WHO Regional Office for Europe
09:15–09:30	Aims, objectives and agenda Satish Mishra, WHO Regional Office for Europe
09:30–09:50	Human resources for health Tomas Zapata, Regional Adviser, Health Workforce and Service Delivery, WHO Regional Office for Europe
09:50–10:10	Rehabilitation 2030 and overview Satish Mishra, WHO Regional Office for Europe
10:10–10:30	Introduction to the rehabilitation workforce Jody-Anne Mills, Sensory Functions, Disability and Rehabilitation, WHO headquarters
10:30–11:00	Coffee break
11:00–11:05	Introduction to rehabilitation professions Satish Mishra, WHO Regional Office for Europe
11:05–11:15	Physiotherapy Jonathon Kruger, World Physiotherapy
11:15–11:25	Occupational therapy Samantha Shann, World Federation of Occupational Therapists (WFOT)
11:25–11:35	Prosthetics and orthotics Claude Tardif, International Society for Prosthetics and Orthotics (ISPO)
11:35–11:45	Other key rehabilitation personnel Jytte Isaksen, International Association of Communication Sciences and Disorders Volodymyr Golyk, WHO Country Office, Ukraine

(Continued)

(Continued)

11:45–11:50	Summary of key messages for rehabilitation professions Satish Mishra, WHO Regional Office for Europe
11:50–12:00	Q&A on rehabilitation professions Moderator: Sidy Dieye, World Physiotherapy
12:00–13:00	Lunch
13:30–13:15	Introduction to interprofessional practice Moderator: Justine Gosling, WHO Regional Office for Europe
13:15–14:00	Interprofessional practice: a patient journey Moderator: Justine Gosling, WHO Regional Office for Europe
14:00–14:15	Professional identity and collaboration Olga Mangusheva, Ukrainian Society of Ergotherapists
14:15–14:45	Role of global organizations and professional associations Moderator: Sidy Dieye, World Physiotherapy
14:45–15:15	Coffee break
15:15–16:00	Rehabilitation Competency Framework Jody-Anne Mills, WHO headquarters
16:00–16:30	Impressions Day 1: Q&A for delegates Moderator: Cathal Morgan, Technical Officer, Disability and Rehabilitation, WHO Regional Office for Europe
16:30–17:00	Wrap up and Day 1 close Satish Mishra, WHO Regional Office for Europe
17:00–19:00	Reception
Wednesday 8 June 2022	
08:30–09:00	Welcome coffee
09:00–09:15	Welcome and recap of Day 1 Satish Mishra, WHO Regional Office for Europe
09:15–09:45	Regional workforce situation assessment Sidy Dieye, World Physiotherapy
09:45–10:30	Country perspectives on rehabilitation: Armenia Azerbaijan Tajikistan Moderator: Sue Eitel, WHO Regional Office for Europe
10:30–11:00	Coffee break
11:00–11:30	Health workforce planning and rehabilitation Cris Scotter, Technical Officer, Human Resources for Health, WHO Regional Office for Europe
11:30–12:15	Rehabilitation workforce regional discussion: challenges, opportunities and questions Moderator: Sue Eitel, WHO Regional Office for Europe
12:15–13:15	Lunch
13:15–13:30	Rehabilitation Workforce Progression Model Jody-Anne Mills, WHO headquarters

(Continued)

13:30–15:00	Roadmap for the way forward: <ul style="list-style-type: none">• Education and training• Recognition and regulation• Data and monitoring• Associations and networks
15:00–15:30	Coffee break
15:30–16:30	Roadmap presentations Moderator: Cathal Morgan, WHO Regional Office for Europe
16:30–17:00	Summary and meeting close Satish Mishra, WHO Regional Office for Europe

Annex 3. FAQs

How can occupational therapists support independence?

Occupational therapy is a client-centred profession concerned with promoting health and well-being through occupation. Occupations include everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life, including those involved in taking care of oneself and others, participating in paid and unpaid work and enjoying leisure time. The primary goal of occupational therapy is to enable people to participate in the occupations they want, need, or are expected to do.

Do physiotherapists only work with people with musculoskeletal disorders?

No. Physiotherapists work with people with many different types of conditions or diseases affecting the body, including cancers and occupational health injuries, as well as chronic health conditions, such as neurological and cardiorespiratory diseases.

Do physiotherapists only work in hospitals?

No. Physiotherapy is delivered in a variety of settings (as well as hospitals), such as primary health care centres, individual homes, education settings and workplaces.

Do physiotherapists need to work under the direction / supervision of doctors?

No. Physiotherapists are university-educated professionals, who operate as independent practitioners as well as members of multi-professional health care teams. They can:

- undertake a comprehensive assessment of an individual's needs; and
- formulate a diagnosis, prognosis, and care plan.

In most countries in the world physiotherapists can act as first-contact practitioners, and patients may seek direct care without referral from another health care professional.

Do speech and language pathologists/therapists (SLTs) just teach people to speak?

No. Speech and language therapy is about more than just helping people to articulate clearly. It is important for people to learn to communicate effectively and this includes understanding language, developing a vocabulary, learning about meaning and grammatical structure, intonation, tone of voice as well as non-verbal expression. All these communication skills support literacy, social interaction, academic achievement and employment. SLPs/SLTs also help people with difficulties in swallowing food and drink. They are licensed and/or certified, autonomous practitioners in most countries.

Do SLPs/SLTs only work with children?

No, they work with all ages from 0 to 100+.

What is a prosthetist and orthotist (P&O)?

A P&O is a practitioner who has completed an approved course of education and training and is authorized by an appropriate national authority to design, measure and fit prostheses and orthoses. Prostheses and orthoses are externally applied devices and products used to assist people with physical impairments or functional limitations, in order to improve their functioning. **A prosthesis** is an externally applied device used to replace wholly or partly an absent or deficient limb segment (arm or leg). Common examples are artificial legs and arms. **An orthosis** is an externally applied device used to support or modify the structural and functional characteristics of the neuromuscular and skeletal systems (such as arms, legs and the spine). Common examples are braces, splints and supports.

What is a physical and rehabilitation medicine (PRM) physician?

PRM physicians are medical doctors who treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PRM doctors evaluate and treat injuries, illnesses and disability, and are experts in designing comprehensive, patient-centred treatment plans alongside other rehabilitation professionals.

THE WHO REGIONAL OFFICE FOR EUROPE

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