Ministry of Health

National Rehabilitation Strategic Plan 2020-2024

Jordan

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The Ministry of Health gratefully thanks World Health Organization Country Office in Jordan, for supporting the development of "National Rehabilitation Strategic Plan in Jordan 2020-2024".

Ministry of Health

National Rehabilitation Strategic Plan

Ministry of Health
2020-2024

His Majesty King Abdullah II

His Royal Highness
Crown Prince Al Hussein bin Abdullah II

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List of Abbreviations

CBR	Community based rehabilitation
CRPD	Convention on the Rights of Persons with Disabilities
DPO	Disabled People's Organisation
EHSP	Essential Health Services Package
HCD	Higher Council for the Rights of Persons with Disabilities
HHC	High health Council
NCD	Non-communicable disease
MoE	Ministry of Education
MoH	Ministry of Health
MoSD	Ministry of Social Development
OT	Occupational Therapy
PT	Physiotherapy
P&O	Prosthetics and Orthotics
RMS	Royal Medical Services
SDG	Sustainable Development Goals
SOP	Standard Operating Procedures
UHC	Universal Health Coverage
WHO	World Health Organization

Foreword

Today, rehabilitation is considered integral in universal health coverage services, which reflects the importance of the following two aspects: the multidisciplinary approach in providing rehabilitation services which guarantees a delicate process of diagnosis, treatment plan and follow up to achieve the best outcomes in terms of quality of life. The integration between the specialty of rehabilitation and other specialties to maximize the treatment outcomes and minimize time and money loss.

The Hashemite Kingdom of Jordan was one of the first countries in the region to adopt the WHO tools to develop a national rehabilitation strategy. With the support of Humanity & Inclusion (HI), a rehabilitation platform was initiated. The process entailed situation analysis (STARS), developing GRASP and FRAME and eventually the Strategy was developed.

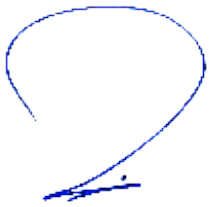
The Strategy sheds light on the role of Ministry of Health, being pivotal in providing rehabilitation services and integrating rehabilitation services into the primary, secondary and tertiary services. Another important aspect is the adoption of regulations, practices and rules to enhance the rehabilitation governance as well as regulating assistive technology to ensure the provision of high quality rehabilitation services. Moreover ; it focuses on capacity building and training of rehabilitation professionals.

We would like to thank WHO, HI and all who contributed in the development of this Strategy.

I hope that the full application of this Strategy will contribute to decrease the economic burden of non - communicable diseases, aging, road traffic accidents and neuromusculoskeletal disorders on Jordanians and non- Jordanians to ensure the provision of equitable rehabilitation services.

We ask the Almighty to guide us all to serve this Country under the Hashemite leadership of His Majesty King Abdullah II bin Al-Hussein.

Minister of Health
Dr. Saad Jaber



1. Introduction

Rehabilitation is a fundamental health service that is relevant to people with a wide range of health conditions and disabilities, throughout all stages of the life-course, and during all phases of their care[1]. Rehabilitation is an increasingly important health service considering the ageing populations and a rising prevalence of chronic and non-communicable diseases (NCD)[2]. Furthermore, as access to healthcare interventions expands, rehabilitation is needed to maximize their effectiveness and impact[3]. Currently, however, the need for rehabilitation globally greatly exceeds its availability, and this is the situation as well in Jordan. Accessible and affordable rehabilitation is necessary for achievement of Universal Health Coverage goals as well as the Sustainable Development Goal (SDG) 3, 'Ensure healthy lives and promote well-being for all at all ages. Jordan is committed to achieve Universal health Coverage by 2030.

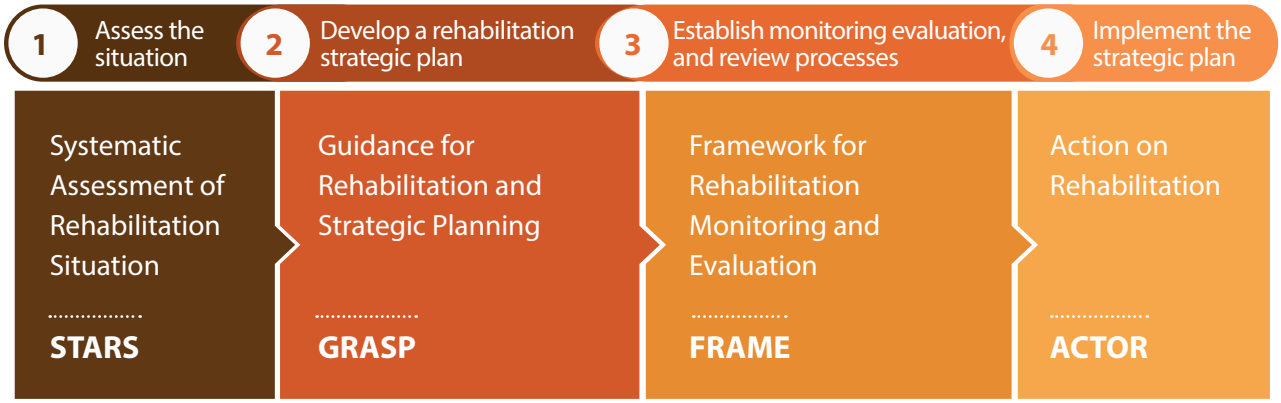
The Ministry of Health, Jordan, has led the development of rehabilitation for more than 35 years and the country has quite a diverse and established workforce. Together, with the Royal Medical Services and the private sector, they deliver most of the rehabilitation in Jordan. Two University hospitals also provide rehabilitation; Jordan University Hospital and King Abdullah University Hospital. In addition to the health sector, rehabilitation is provided in disability and social care centres managed by the Ministry of Social Development and to a small extent in the educational system under the Ministry of Education's supervision. Furthermore, the non-governmental sector is providing rehabilitation and assistive products, emphasizing on filling the gap at community level, including 10 community-based rehabilitation centres[4] across the Palestinian refugee camps in Jordan.

In 2018, after concerted actions of key actors working in the rehabilitation sector in Jordan, the Ministry of Health agreed to conduct a comprehensive assessment of rehabilitation in the health sector. WHO and Humanity & Inclusion assisted this process which coincided with WHO's development of the 'Rehabilitation in Health Systems – Guide for Action' package[5]. Jordan thus became one among the first countries to implement the Guide for action – systematic assessment of rehabilitation situation (STARS) between May and September 2018, followed by a report that was approved by the Ministry of Health beginning of 2019[6]. In July 2019, a strategic planning workshop was successfully conducted, and the first draft strategic plan was developed. The draft plan underwent consultation and during a consensus workshop in November 2019, the strategic plan and its monitoring and evaluation framework was discussed and finalised.

[1] *WHO (2017). "Rehabilitation in Health Systems". World Health Organization, Geneva, Switzerland.*
[2] *WHO (2017). "Rehabilitation: key for health in the 21st century". Background Paper for the WHO Rehabilitation 2030 Meeting. World Health Organization. 2017.*
[3] *WHO (2017). Rehabilitation in Health Systems. World Health Organization, Geneva, Switzerland.*
[4] *These centres were previously run by UNRWA but are now managed as civil society run centres, supported partially by UNRWA.*
[5] *WHO (2019). Rehabilitation in health systems: guide for action, Geneva, World Health Organization, Switzerland.*
[6] *Ministry of Health Jordan, WHO and Humanity and Inclusion (2018). A Situation Assessment of Rehabilitation in Jordan.*

Table 1: Rehabilitation in health systems - A guide for action.

WHO Call for action in 2017 to promote the increase of rehabilitation in health systems brought forward the development of a guide to assist countries in strengthening their rehabilitation systems. The 'Rehabilitation in health systems: guide for action' leads governments to strengthen rehabilitation within its health systems. The development of Jordan Rehabilitation Strategy used this guide and methodology, which started in 2018 with a situation assessment (STARS) and a strategic planning process in 2019, including wide consultation, technical workshops and a final validation workshop at the end of 2019, agreeing on the implementation framework with key indicators and monitoring system. The WHO guide for action is suggesting a methodology organised around four key phases, and can be adapted and used flexibly to each country situation.



The Rehabilitation Strategic Plan is a Ministry of Health responsibility and aims to strengthen leadership and governance of rehabilitation and increase access to rehabilitation for people who need it in Jordan. Other public health systems, such as Royal Medical Services and University Hospitals, as well as the private sector are encouraged to support the strategy, and coordination will take place concerning key interventions that have a national impact such as data collection, training of professionals, treatment protocols, assistive devices production, provision and purchase among others.

2. Rehabilitation

2.1 Rehabilitation concepts that inform Jordan rehabilitation strategic plan

The concepts are aligned with the WHO recommendations on rehabilitation in health systems[7].

Rehabilitation is about functioning.

Rehabilitation addresses the impact of a health condition on the person's life by improving and maintaining functioning and reducing the experience of disability. It does this through a strong emphasis on educating and empowering people to manage their health conditions, adapt to their situation and remain active. Rehabilitation improves people's quality of life.

During rehabilitation, the person identifies his/her needs and goals and the rehabilitation interventions are then tailored considering the individual and the environment.

Rehabilitation is for all the population.

There is an extensive array of health conditions that benefit from rehabilitation, almost all health conditions. It is relevant during all phases of care and treatment, during the acute, sub-acute and long-term phases. It is for all the population regardless of their age; from babies through to elderly people. Rehabilitation benefits many persons with disabilities and persons with long-term chronic health conditions.

Rehabilitation is highly person-centred, individualised, and strongly involves the user.

Rehabilitation is tailored to individual needs of the person; it is goal orientated, time-bound and outcome focused. Rehabilitation is required for people with complex, intense rehabilitation needs as well as for persons with other temporary or permanent functional limitations. Rehabilitation engages the person in the treatment process and, where appropriate, the family, and carers.

Rehabilitation needs a multi-professional workforce.

There are many different rehabilitation professions. The most common are specialists in Physical Medicine and Rehabilitation (physiatrists), physiotherapists, occupational therapists, speech and language therapists, prosthetists and orthotists, psychologists and rehabilitation nurses, as well as others including counsellors or social workers. Delivery of effective rehabilitation very often requires inter-disciplinary collaboration between these professionals.

Rehabilitation is part of the universal health coverage

and expands the focus of health beyond preventive and curative care. Universal health coverage is defined as "ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship" [8]. The need for rehabilitation is large and growing. Health trends that keep people living longer with chronic communicable and non-communicable disease (NCD), increasing incidence of injuries and survival of people living with the consequences of injuries, and ageing populations, all result in a growing need for rehabilitation. Rehabilitation should be integrated into a wide range of other health services, such as neurological, orthopaedic, cardio-respiratory, paediatric, mental health and women's health, among others.

[7] *https://www.who.int/rehabilitation/rehabilitation_health_systems/en/*
[8] *https://www.who.int/healthsystems/universal_health_coverage/en/*

Rehabilitation may be integrated into services outside of typical health services.

Around the world much of the rehabilitation delivered sits within health services. However, rehabilitation also occurs outside of the context of a 'typical health service'. Rehabilitation is delivered in schools, in early childhood intervention programmes and in daily activities centres or community-based living facilities, correction and rehabilitation facilities, and centres for rehabilitation of drug addiction and substance abuse, and thus may be funded by different ministries. The precise configuration of these services can vary between countries.

2.2 Rehabilitation needs

The need for rehabilitation is large and growing.

The demographic picture is changing, and it is expected that Jordan, as many countries today, will face an increased number of elderly people[9].

Data on the top causes of Disability-Adjusted Life Years shows that

NCDs and injuries are on the rise

while communicable diseases, maternal, neonatal, and nutritional causes are generally on the decline in Jordan[10].

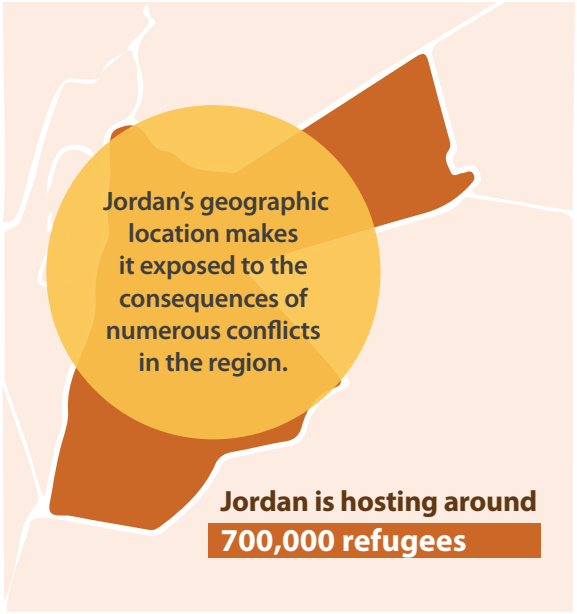
The proportion of those in the age group of 65 and above will rise from:

3.3 in 2012 to
4.9 in 2020[11].

Therefore, it is necessary to take this demographic shift into account when planning for health and rehabilitation.

While traffic road accidents in Jordan are showing a decreasing trend, they are still an important public health issue. WHO data shows that 13.5% of all injuries lead to permanent disabilities[12]. Many of these persons injured will have high support needs and require longer-term rehabilitation as well as assistive products.

Disability prevalence among the Jordanian population aged five years and above is estimated to 11.2%[13]. While the census in 2015, where the data is extracted, does not look at needs for rehabilitation. It is widely known that persons with vision, hearing and mobility difficulties may require at some point in their lifetime rehabilitation and/or assistive products.



(an estimated 1,5 million including non-registered refugees) from Iraq, Yemen, and Syria, which has affected and stretched the public health sector and impacted the social and economic development.

[9] *High Health Council. "The National Strategy for Health Sector 2016-2020." The Hashemite Kingdom of Jordan.*
[10] *Global Burden of Disease profile Jordan 2010. http://www.healthmetricsandevaluation.org*
[11] *WHO (2017). "Health profile 2015. Jordan." WHO Regional Office for the Eastern Mediterranean.*
[12] *WHO (2015). "Global Status report on Road Safety 2015. Jordan country profile." http://www.who.int/violence_injury_prevention/road_safety_status/2015/country_profiles/Jordan.pdf*
[13] *Jordan Department of Statistics (2017). "Disability Situation in Jordan Based on Data of Population and Housing Census 2015." Hashemite Kingdom of Jordan.*

The current rehabilitation needs are largely unmet. Data that directly informs the unmet need of rehabilitation in Jordan is not available. However, by considering the Global Burden of Disease data, along with ratio of rehabilitation personnel to population data, as well as reports and experiences from practitioners, organisations of persons with disabilities (DPOs) and user groups suggest that there is a significant unmet need for rehabilitation[14]. Also of consideration, when combining the current unmet need for rehabilitation with current health trends, there is potential for unmet needs to actually increase unless significant investment in these services occurs.

2.3 The value of rehabilitation

Rehabilitation delivers better health outcomes.

The goals of rehabilitation move beyond diagnosis and acute medical care. Rehabilitation is designed to maximise and restore function to enable people to have better health, functioning and well-being. Rehabilitation has the potential to make significant cost savings across the health system by supporting timely discharge, prevention of complications and decreasing re-admission rates. Rehabilitation also makes an essential contribution to the outcomes of medical and surgical interventions.

Rehabilitation realises the rights of persons with disabilities.

Access to rehabilitation supports the realization of the right to health and specifically contributes to the rights of people with disabilities. As many people with disabilities experience limitations in functioning, rehabilitation and assistive products are particularly important health services that often enable them to achieve further rights.

Rehabilitation delivers better health and social outcomes and it is an integral aspect of the right to health.

It has the potential to make significant costs savings for wider government services as it commonly enables people to return to work, access and graduate from education, have a livelihood and contribute to community life. It also benefits everyone around them. The family, the community and society, and can decrease care requirement. Rehabilitation is an investment in human and social capital that contributes to health, economic and social development.

3. Rehabilitation situation in Jordan

The situation assessment of rehabilitation in Jordan occurred in 2018 and revealed different information about the strengths and weaknesses of rehabilitation across the main building blocks of the health system. This being a strategy for Ministry of Health, the summary of the rehabilitation situation assessment here is focusing on the Ministry of Health rehabilitation sector, while acknowledging that the Royal Medical Services, the University hospital system and the private sector substantially contribute to the rehabilitation sector in Jordan.

3.1 Rehabilitation in Jordan

Jordan has made important advancement in terms of health during the past decades and considerably reduced infant and maternal mortality rate. Communicable diseases and nutritional causes to Disability- Adjusted Life Years (DALYs) are also decreasing[15].

[14] *Ministry of Health, HI and WHO. A Situation Assessment of Rehabilitation in Jordan, 2018.*
[15] *Global Burden of Disease profile Jordan 2010. http://www.healthmetricsandevaluation.org*

The Ministry of Health and the Royal Medical Services' hospitals deliver most of the rehabilitation in Jordan at hospital level. Jordan University Hospital and King Abdullah University Hospital also provide rehabilitation. In addition to the health sector, rehabilitation is provided in disability and social care centres managed by the Ministry of Social Development and to a small extent in the educational system under the Ministry of Education's supervision. Furthermore, the non-governmental sector is providing rehabilitation and assistive products, emphasizing on filling the gaps at community level, but their services remain limited in scope and coverage.

Whereas Jordan has a long tradition of providing rehabilitation services, the 2018 assessment indicated that there is a significant unmet need for rehabilitation in Jordan and that due to health trends and demographic changes these needs are increasing.

Leadership and governance structures on rehabilitation

are still to be defined and require additional resources. The Ministry of Health and the Higher Health Council have the overall responsibility to formulate policies and ensure that rehabilitation is integrated in relevant health policies. This however, has not yet been fully developed and rehabilitation is not clearly defined in the health legislation and national health strategies, and there has been little strategic planning of the rehabilitation service system. There is limited inter-sectoral and inter-ministerial coordination on rehabilitation and a need to reinforce the capacity with both financial and human resources.

Article 24 of the Law no 20 (2017) on the Rights of Persons with Disabilities entrusts the Ministry of Health the responsibility to ensure rehabilitation and provision of assistive products to registered persons with disabilities.

There is a computerized health record system available in the majority of Ministry of Health and Royal Medical Services' facilities, Hakeem, which provides an opportunity for rehabilitation information to be collected at facility level, and potentially collated at governorate and central level. This will contribute to improving the systems on rehabilitation, case management, and coordination. There is only partial **data collection and monitoring of rehabilitation sector performance,** including on the provision of assistive products.

There is a good level of technical capacity in rehabilitation in Jordan through a **rehabilitation workforce that is degree-level trained** across five universities offering most rehabilitation disciplines. Recently, Master programmes are available for several rehabilitation professions. **Clinical academic research is established in physiotherapy, occupational therapy and speech and language pathology** and a number of university faculty members have a PhD level from abroad. But additional investment and open dissemination channels are needed to promote evidence-based practice.

Nevertheless, the current workforce in the Ministry of Health rehabilitation services is mainly comprised of physiotherapists and physiatrists (including those in residency programmes) while there are limited job openings and adequate conditions for occupational therapists and speech and language therapists in both Ministry of Health and Royal Medical Services' hospitals. Rehabilitation nurses are not yet trained in Jordan. There are also very few rehabilitation personnel trained in mental health rehabilitation.

Furthermore, there are **concerns about motivation and retention among the rehabilitation workforce** that have to be addressed. In the Ministry of Health, degree-level trained physiotherapists, occupational

therapists, and speech and language therapists are allotted 'technician' as professional status with correspondingly lower remuneration. This undervalues and demotivates the workforce. The status of psychologist remains also to be clarified and upgraded. There can also be improvements in hospital workplace practices to increase the engagement of therapy personnel in assessment, diagnosis, and treatment planning which would improve workforce motivation and the quality of rehabilitation delivered.

All rehabilitation professionals are represented by a professional society, which could build a critical unified voice to improve rehabilitation in the national health planning and decision-making.

Rehabilitation is available at more than half of the Ministry of Health and Royal Medical Services' hospitals. This demonstrates reasonable access and coverage of rehabilitation at urban levels. Nevertheless, rehabilitation is not integrated into primary healthcare, which significantly restricts equitable access to rehabilitation. Primary healthcare personnel (doctors and nurses) have limited awareness and knowledge on early identification and referral on basic rehabilitation interventions. Some rehabilitation is made available at the community level through NGOs and community-based rehabilitation services. However, there is limited referral and coordination that could expand access and many providers lack sustainable funding to increase and sustain coverage.

Private health insurances are increasingly being introduced in Jordan, but rehabilitation is not comprehensively covered. So far, only limited numbers of physiotherapy sessions are offered in these insurance schemes.

Rehabilitation personnel cover all governorates, and thus is a good foundation to build upon. There is a need for improving the equal distribution of professionals across the country. More personnel are working in Amman and the north. Moreover, **the absence of rehabilitation wards and beds** prevents provision of rehabilitation for people with complex needs, children with multiple disabilities, and those who need interventions in a sub-acute care. Effective follow-up and referral mechanisms after discharge need to be addressed.

The provision of assistive products in Jordan is limited and not well coordinated. While a number of assistive products are covered within the health insurance system, they are not always available in the government sector. There is no clear division of role and responsibilities regarding the provision of assistive products and their maintenance, and so far, there **is no recognized list of essential assistive products.** There are strengths to build upon though, with three public hospitals producing prosthetic and orthotic (P&O) devices and medical boots: Ministry of Health Al Basheer hospital in Amman, Princess Basma hospital in Irbid, and the Royal Medical Services Royal Rehabilitation Centre in Amman. Other assistive products are mainly provided via donations, either through the Ministry of Social Development and Ministry of Education, or the NGO sector. Many persons in need of assistive products, particularly those residing in southern and western Jordan have to purchase items from the private market, often at high and unaffordable costs and with the risk of not being well fitted. Assistive products linked to cognitive rehabilitation are rarely available.

Jordan is committed to Universal Health Coverage and the civil health insurance has recently been extended to additional groups of the population such as children below the age of six, persons above 60 years of age and persons with disabilities. **Concerns exist regarding the equitable access and coverage of rehabilitation** because of the social stratifies present in Jordan (such as gender, age, disability, rural/urban). The cost on households of traveling to and from health services prohibit many from accessing rehabilitation and assistive products they or their family members need.

> **'Jordan 2025: A National Vision and Strategy' reiterates the government's commitment to Universal Health Coverage and the aim is to reach 100% coverage in 2030.**

3.2 Linkages between the rehabilitation strategic plan and other policies

Jordan rehabilitation strategic plan 2020-2024 has been developed in the context of the final years of implementing the 'National Strategy for Health Sector in Jordan' (2016-2020). The health strategy has four main strategic objectives:

1. Support the policy environment and good governance in the health system.
2. Provide individual-centred integrated health services and respond to the growing needs.
3. Provide health, financial and social protection to the entire population on a fair basis.
4. Promote investment in the health sector to support the national economy.

The rehabilitation strategic plan emphasizes rehabilitation as a core health service to be available at all levels of health care, and therefore its integration in health systems is necessary to achieve Universal Health Coverage. Another important aspect of Jordan 2025 is that it aims to ensure citizens are active and healthy. Rehabilitation is a key health discipline that aims to restore and maintain optimal functioning, which is fundamental for being an active citizen.

It is important that the rehabilitation strategic plan is aligned with these strategies and supports their implementation. Furthermore, rehabilitation was poorly reflected in the national strategy for health sector and there is an opportunity to advocate for priority areas in rehabilitation to be better integrated in the next national health strategic planning.

Other legislation, policies and strategies that the rehabilitation strategic plan is aligning with and will support implementation of are:

- The Law no 20 (2017) on the Rights of Persons with Disabilities, particularly Article 24.
- Convention on the Rights of Persons with Disabilities general principles and relevant articles.

- The de-institutionalization strategy and CBR programme of the Higher Council for the rights of persons with disabilities and the Ministry of Social Development.
- The National Mental Health and Substance Abuse action plan of the Ministry of Health.
- The National Social Protection Strategy 2019-2025 of the Ministry of Social Development.

3.3 Priorities for strengthening rehabilitation

The following priorities were identified during the systematic assessment of the rehabilitation situation in Jordan (STARS)[16]. These priorities, among several, were determined as those requiring most attention for ensuring more people access quality rehabilitation in future and have shaped the objectives within the rehabilitation strategic plan.

1. Establish stronger rehabilitation leadership and planning at the national level.

Leadership and well-informed planning are crucial for the successful strengthening of the sector and the effective and efficient use of resources. Rehabilitation is a multi-disciplinary health sector, which necessitates a multi-disciplinary leadership structure. For many years, the Ministry of Health has had limited resources, capacity and information in order to fulfil its leadership role in rehabilitation. The rehabilitation sector also includes international development partners, national NGOs and importantly organisations of persons with disabilities and other rehabilitation user groups. Therefore, the leadership structure on rehabilitation should reflect such multi-stakeholder and multi-professional collaborative planning processes.

2. Expand the availability of rehabilitation.

Rehabilitation is an essential health service that should be available at all levels of health services, from primary to tertiary care. In Jordan, there are gaps in the rehabilitation available in general hospitals, especially in the area of occupational therapy, speech language therapy and counselling and psychosocial support. Moreover, the lack of rehabilitation wards and beds prevents provision of rehabilitation for people with complex needs or who need rehabilitation in sub-acute care. Effective follow-up and referral mechanisms after discharge need to be addressed.

There is limited rehabilitation provided at primary health care and delivered in community settings. Rehabilitation must be part of any essential package of health services, in the Universal health coverage that Jordan has committed to implement.

Additionally, greater capacity for rehabilitation outreach into people's homes and local community settings is required to further optimize health outcomes for people. Better and more formal cooperation with NGOs that are delivering rehabilitation at community level could be explored.

3. Increase the government's support for assistive products and establish cross-ministerial coordination.

Many people, and particularly many persons with disabilities, need quality assistive products as part of their rehabilitation, to reach optimal functioning and independence. Today, many people have to purchase their assistive products from the private market, which is an equity

[16] *Ministry of Health Jordan, WHO and Humanity and Inclusion (2018). A Situation Assessment of Rehabilitation in Jordan.*

problem as well as a quality problem, as they will not always get tailored and advice fitting their needs. Therefore, it is a must to develop an assistive product plan that defines the roles and responsibilities across ministries, including planning for improved procurement system and provision mechanisms, resulting in a priority assistive products list. Information about access and eligibility criteria needs to be developed in accessible formats (electronic, Braille, audio, easy-to-read etc.) for the population.

4. Expand the workforce and strengthen rehabilitation professionals' status.

A well-trained and supported multi-discipline rehabilitation workforce is necessary for effective rehabilitation. Jordan has a good supply of rehabilitation professionals through well-established university programmes, and a long tradition of residency specialisation in physical medicine and rehabilitation. Nevertheless, the rehabilitation workforce is under-valued across healthcare. It is important to increase the status of all rehabilitation professions in order to retain staff. Job descriptions and requirements should be revised so that the position and salaries correspond to the competencies acquired during the university and increase autonomy of practice. Ministry of Health should also create more positions for particularly speech and language therapists and occupational therapists for expanding multi-professional teams' availability in more hospitals. Universities could also consider establishing residency programmes for specialisation in physical medicine and rehabilitation. The recent update for re-licensing health professionals each five years is a good opportunity to develop programmes of continuous education for all rehabilitation staff, in collaboration with universities and professional societies.

5. Improve the quality of rehabilitation and use of evidence-based practice.

There are limited standardised treatment protocols and clinical practice guidelines in Ministry of Health. Such protocols, or Standard Operating Procedures (SOP) for rehabilitation across facilities in-line with on-going quality improvements in the overall health system, could be considered to ensure quality treatment and safety for the patients. Furthermore, a person-centred and comprehensive, multidisciplinary rehabilitation approach remains to be fully implemented. Increased financial support for clinical research as well as improving research conditions and proactive dissemination of research through open web portals and organisations of events, conferences, webinars, or other means should be encouraged for improving evidence-based practice.

6. Expand and strengthen specialised rehabilitation, including in mental health.

Rehabilitation programmes that are developed specifically for children with disabilities and people with mental health conditions will provide more specialised and effective care. There are significant shortages in specialised rehabilitation for children, particularly children with disabilities. There is also limited rehabilitation for people with complex injuries and health conditions. Inadequate harmonisation between programmes across the ministries of health, education, and social development contributes to these shortages. Early identification and intervention programmes should be reinforced and developed, particularly for children with developmental difficulties by creating cross-ministerial coordination and cooperation with NGOs.

It is recommended to look into possibilities of strengthening hospitals by establishing short-term stay rehabilitation wards and/or beds as well as on a longer term, develop national centre(s) of excellence where multi-disciplinary assessment and specialist treatment can be applied. In the field of rehabilitation in mental health, there is also a scarcity of services available with a centralisation of tertiary services in Amman. A reform has started, introducing a community based mental health system though much remains to be done and rehabilitation within this model require creating positions and building capacity of professionals. Rehabilitation professionals also have limited knowledge on effective rehabilitation interventions in the field of mental health and rely on a bio-medical model focusing on tertiary care.

7. Increase rehabilitation information and generation of data.

Routine rehabilitation information collection and reporting is necessary for informed decision making. Information and data about rehabilitation in Jordan is very limited and there is a need to strengthen the generation of rehabilitation data and information within health information systems. Furthermore, the Ministry of Health should consider to improve and standardise the use of Hakeem patient information system and to increase the regularity of monitoring and evaluation of rehabilitation in order to better inform decision making and hold government to account regarding the performance of rehabilitation.

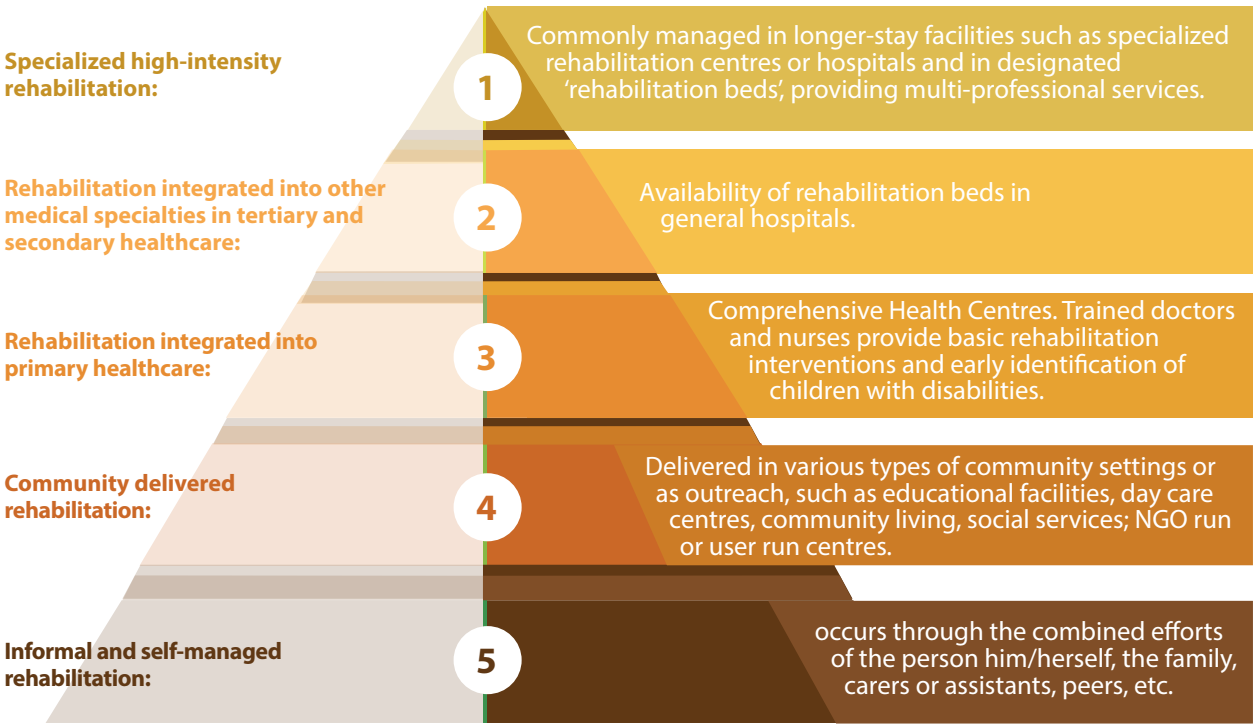


Figure 1: Rehabilitation in Jordan framework.

3.4 A framework for the future development of rehabilitation in Jordan

During the implementation of the rehabilitation strategic plan, further projections and decisions will have to be taken regarding the structure and organisation of rehabilitation in Jordan. In all countries, the population requires access to a range of rehabilitation; these are characterized broadly as different 'types of rehabilitation'. A framework for rehabilitation in Jordan building on WHO reference in its Rehabilitation in health Systems – Guide for Action has been developed, which suggest types of rehabilitation to be available on a longer term (Figure 1). As the strategic vision and objectives in next chapter show, the current strategy in Jordan aims to focus on improving quality and availability at secondary health care and initiate rehabilitation into primary health care and strengthen referral mechanisms. Some actions will start to address specialised rehabilitation.

Specialised high-intensity rehabilitation:
This rehabilitation is required for people with complex needs who require higher dosage and intensity of rehabilitation at in-patient stay facilities; they are commonly managed in rehabilitation centres or hospitals and in designated 'rehabilitation beds' accessing multi-disciplinary services.

Rehabilitation integrated into other medical specialties in tertiary and secondary healthcare:
This rehabilitation is characterized by its highly integrated nature across a range of medical specialties (such as orthopaedics, cardio-respiratory, neurology, trauma and emergency care, psychiatry and mental health, paediatrics and geriatrics) in tertiary and secondary healthcare (general hospitals).

Rehabilitation integrated into primary healthcare:
Rehabilitation interventions in primary health care will be delivered in the first phase in Comprehensive Health Centres, primarily by physiotherapists and occupational therapists and a consulting physiatrist. Furthermore, trained general doctors and nurses will provide basic rehabilitation interventions (to be defined) and early identification of children with disabilities.

Community delivered rehabilitation:
This is defined through its delivery in community settings of various types, such as educational facilities, day care centres, social services, NGO-run or user-run centres. It is often a form of secondary rehabilitation interventions but may incorporate some components of primary and tertiary care.

Informal and self-directed care:
This is the rehabilitation, which occurs through the combined efforts of the person him/herself, the family, carers or assistants, peers, etc. This type of rehabilitation is not a formal service but recognizes that self-directed rehabilitation is very important and strongly contributes to the goals of rehabilitation.

4. Strategic Plan 2020-2024

Vision All people in Jordan enjoy quality of life and function to their fullest and effectively participate to the sustainable development of Jordan.

Goal To increase access for all Jordanians to equitable and quality rehabilitation services, delivered by qualified multi-disciplinary professional teams

Strategic objectives and areas of interventions

1 Enhance leadership and effective governance for rehabilitation.

- Enhance leadership and accountability for rehabilitation.
- Increase planning of rehabilitation, including integration across health planning.
- Increase rehabilitation awareness and knowledge across all health sectors.
- Expand rehabilitation financing models and opportunities.

2 Increase the availability of reliable data on rehabilitation at national and governorate levels

- Develop routine rehabilitation monitoring and reporting for integration of rehabilitation into health information systems.
- Increase quantity and use of rehabilitation research.

3 Integrate quality rehabilitation services in all health care levels and in the community.

- Integrate rehabilitation within primary healthcare.
- Expand access to rehabilitation in secondary hospitals (including mental health).
- Develop referral systems and a range of quality improvement initiatives for key areas of rehabilitation.

4 Expand the development of specialized rehabilitation.

- Expand specialized rehabilitation through strengthening multi-professional rehabilitation across tertiary and secondary level hospitals.
- Develop rehabilitation in mental health services for children and youth to reduce hospitalization and institutionalization.

5 Expand and strengthen a comprehensive rehabilitation workforce.

- Develop a detailed rehabilitation workforce plan based on current and projected need.
- Develop regulatory mechanisms and competency framework for all rehabilitation professions in line with their educational qualifications.

- Identify and address challenges regarding the attraction and retention of rehabilitation personnel.
- Promote and provide opportunities for continuous education for rehabilitation professionals for more evidence-based practice.

6 Increased availability and quality of assistive products with appropriate provision at an affordable cost.

- Create a mechanism for improved coordination and collaboration for assistive products, with MoH, MoSD, MoE and HCD.
- Increase provision of prosthetic and orthotic products through expanding and establishments of prosthetic and orthotic departments and clinics.
- Define a priority list of assistive products in coordination with relevant actors.
- Address gaps in effective and adequate provision of assistive products.

5. Implementation framework

Table 2: Legend on Acronyms.

DPO	Organisation of persons with disabilities
EHS	Electronic Health Solutions, responsible for Hakeem
HCD	Higher Council for the Rights of Persons with Disabilities
HHC	High Health Council
INGO	International Non-Governmental Organisations
HI	Humanity & Inclusion
JFDA	Jordan Food and Drug Administration
MoE	Ministry of Education
MoH	Ministry of Health
MoHE	Ministry of Higher Education and Scientific research
MoP	Ministry of Planning
MoSD	Ministry of Social Development
NGO	Non-Governmental Organisation
OT	Occupational Therapist
P&O	Prosthetic and Orthotic technician
PRM	Physical and Rehabilitation Medicine
PT	Physiotherapists
RMS	Royal Medical Services
SLT	Speech and Language Therapist
WHO	World Health Organization

Universities	Jordan University, Jordan University of Science and Technology, Hashemite university, Mutah University
University hospitals	King Abdullah University hospital, Jordan University hospital
Professional Associations	Jordanian Association of Physical Medicine, Arthritis and Rehabilitation, Prosthetics and Orthotics Society, Jordanian Physiotherapy society, Jordanian Society for Occupational Therapy, Arab Union of Psychological Science

Key strategic objective 1		**Enhanced leadership and effective governance for rehabilitation**			
Areas of actions/ intervention		**Actions**	**R: Responsible C: Contributing**	**Estimated resources**	**Time frame**
1.1	Enhance leadership and accountability for rehabilitation	1.1.1 Ministry of Health defines rehabilitation leadership and governance structure, appoint a rehabilitation focal person or unit	R: MoH C: HHC, HCD MoSD, MoE, WHO	Meeting costs Consultancy costs	Year 1
		1.1.2 Create a technical advisory group (TAG) with clear terms of reference, representing all rehabilitation disciplines, relevant ministries, RMS and University hospitals, Universities and user associations, to support and advise on the implementation of the strategy			Year 1
		1.1.3 Build effective rehabilitation governance and strengthened leadership through technical assistance and support to the focal person/unit and TAG			Year 2-4
		1.1.4 Define and support inter-ministerial coordination mechanisms	R: MoH, MoE, MoSD, HCD, HHC	Meeting costs	Year 1-2
		1.1.5 Establish monitoring framework of the national strategy with indicators, baselines and targets and report on these annually	R: MoH C: MoSD, MoE, HHC, HCP D,	To be estimated	Year 1 and on-going
		1.1.6 Undertake annual operational planning and review of the strategic plan and other relevant plans to rehabilitation	R: MoH C: TAG	Meeting costs	Annually

Areas of actions/ intervention		Actions	R: Responsible C: Contributing	Estimated resources	Time frame
1.2	Increase planning of rehabilitation, including integration across health planning	1.2.1 Integrate rehabilitation within national and sectoral health strategies, policies, and plans, and to other relevant social and educational policies in coordination with other ministries	R: MoH C: Universities, RMS, NGOs, MoSD, MoE		Year 1 and on-going
		1.2.2. Map current rehabilitation capacity and service utilization across MoH (and potentially University hospitals, RMS and non-governmental sectors)	R: MoH C: University hospitals, RMS, NGOs and INGOs	Consultancy costs and meeting costs	Year 1-2
		1.2.3 Develop a master plan, including cost-estimates, to strengthen and expand rehabilitation across tertiary, secondary and primary health care level aligned to the Jordan Rehabilitation Framework	R: MoH (HHC) C: RMS, University hospitals, NGOs, professional associations		Year 2
1.3	Increase rehabilitation awareness and knowledge across all health sectors	1.3.1 Identify gaps in the knowledge on rehabilitation and the role of rehabilitation professional across other health specialties	R: MoH C: RMS, Universities	Consultancy costs	Year 2
		1.3.2 Address the gaps by developing and disseminate material and host workshops, sensitization events, meetings with other health specialties and ministerial directorates on rehabilitation		Workshop costs Material	Year 2-5
		1.3.3 Integrate rehabilitation science into all undergraduate and post-graduate curricula of nursing and medical degrees	R: MoH, Jordan medical council, MoHE, Universities C: Professional associations		Year 3-5
		1.3.4 Develop fully accessible national awareness campaign on rehabilitation and benefits of rehabilitation (media, social media, MoH website etc.) for the general public	R: MoH C: RMS, HCD, Universities, INGOs, NGOs,		Year 1 and on-going

Areas of actions/ intervention		Actions	R: Responsible C: Contributing	Estimated resources	Time frame
1.4	Expand rehabilitation financing models and opportunities	1.4.1 Undertake resource mobilization by identifying innovative strategies to ensure long-term financial and technical sustainability and quality of rehabilitation that can be: a) proposed to bilateral donors, international NGOs etc. b) through national health insurance programs	R: MoH C: WHO, INGOs, ICRC, donors	Consultant cost	Year 1 and on-going
		1.4.2. Promote and advocate for the inclusion of rehabilitation in Universal Health Care coverage and any essential health care package being developed at primary, secondary and tertiary levels	R: MoH C: Donors	Meeting costs Campaign costs	Year 1-2

Strategic objective 2		Increase the availability of reliable data on rehabilitation at national and governorate levels			
Areas of actions/ interventions		Actions	Responsible Contributor	Estimated resources	Time frame
2.1	Develop routine rehabilitation monitoring and reporting for integration of rehabilitation into health information systems	2.1.1 Identify key indicators on rehabilitation to be included in the national health monitoring system	R: MoH C: HHC, MoP	Human resource time needed, but no real costs	Year 2
		2.1.2 Establish the data sources and data collation processes in order to annually report on the strategic plan indicators	R: MoH C: HHC		Year 2
		2.1.3. Create template and guidance for rehabilitation data collection and collation at health facilities and provide training to all facilities on its use	R: MoH C: EHS		Year 2/3
		2.1.4. Analyse current use of Hakeem medical records in rehabilitation across MoH to identify areas of improvement, inconsistencies and training needs	R: MoH C: EHS	Consultancy costs	Year 1-2

Areas of actions/ interventions		Actions	Responsible Contributor	Estimated resources	Time frame
		2.1.5. Develop capacity on the use of Hakeem (consistent use of diagnosis in line with international classification systems, treatment sessions, functional assessment, discharge etc.) across all rehabilitation professionals	R: MoH, C: EHS, RMS, university hospitals	Consultancy costs	Year 2-3
		2.1.6. Create a template and guidance for rehabilitation data collection and collation for rehabilitation provided by accredited rehabilitation outside of the MoH	R: MoH C: MoSD, MoE, RMS, University hospitals, NGOs	No costs needed	Year 2-3
2.2	Increase quantity and use of rehabilitation research	2.2.1 Increase and encourage rehabilitation research that is policy relevant for MoH in coordination with Universities, RMS and University hospitals	R: MoH, Universities, RMS C: MoHE, Professional associations, INGOs, donors	Costs f	On-going On-going
		2.2.2 Build rehabilitation research capacity		To be defined	

Strategic objective 3		Integrate quality rehabilitation services in all health care levels and in the community			
Areas of actions/ interventions		Actions	Responsible Contributor		Time frame
3.1	Integrate rehabilitation within primary healthcare	3.1.1 Develop a pilot project of establishing rehabilitation at five Comprehensive Health Care centres aiming to have at minima 2 PTs (male/female) or PTs and OTs and 1 consulting rehabilitation doctor, based on a needs assessment and feasibility study (that will identify the 5 pilot locations)	R: MoH, MoP C: WHO, INGOs, MoSD, HCD, donors, INGOs, WHO, professional associations	Consultancy costs	Year 3-5
		3.1.2 Develop training materials and guidance for delivery of rehabilitation at comprehensive health care centres, including identification of rehabilitation needs, set of rehabilitation interventions to be provided at CHC level, referral processes and follow-up		Human resource costs Meeting costs	

Areas of actions/ interventions		Actions	Responsible Contributor		Time frame
		3.1.3 Train family doctors, general practitioners, and nurses at primary health care levels on: a) identification of rehabilitation needs, including for persons with disabilities, b) early identification of children with development delays, disabilities, or mental health conditions, c) provision of a basic set of rehabilitation interventions, including early childhood intervention for children with development challenges or disabilities d) referral to rehabilitation services as needed	R: MoH, MoP C: WHO, INGOs, MoSD, HCD, donors, INGOs, WHO, professional associations	Cost of trainers	
		3.1.4 Develop patient and carer/ family education materials to support rehabilitation for priority health conditions – in particular for stroke, cerebral palsy, spinal cord injuries, and intellectual disabilities	R: MoH, MoSD C: Professional associations, DPOs, university hospitals, RMS, INGOs, NGOs	Meeting costs	Year 2-3
		3.1.5 Coordinate with the HCD and MoSD to promote and develop rehabilitation within the de-institutionalization strategy, including formalising coordination mechanisms across health (rehabilitation and community social and educational services)	R: MoH, HCD, MoSD C: NGOs, INGOs	Meeting costs	Year 1-3
3.2	Expand access to rehabilitation in secondary hospitals (including mental health)	3.2.1 Increase rehabilitation personnel in general hospitals, work towards having physiatrists, PTs, OTs and SLTs and mental health counsellors in all general hospitals, with adequate gender balance	R: MoH C: Universities, professional societies, donors, INGOs, WHO	To be defined	Year 2-4
		3.2.2 Establish one equipped and staffed P&O centre in the south of Jordan	R: MoH C: RMS, donors, INGOs, ICRC	To be defined	

Areas of actions/ interventions		Actions	Responsible Contributor		Time frame
		3.2.3 Develop and improve rehabilitation infrastructure within general hospitals with adequate and accessible rehabilitation treatment rooms and space, offices and storage and a standard list of equipment	R: MoH C: INGOs, ICRC, donors	To be defined	Year 2-4
		3.2.4 Further develop rehabilitation services in the area of mental health care at secondary health care level, in line with the National Mental Health and Substance Abuse Action Plan	R: MoH, Mental Health and Disability directorate C: WHO, INGOs, DPOs	To be defined	Year 3
3.3	Develop referral systems and a range of quality improvement initiatives for key areas of rehabilitation	3.3.1 Strengthen referral processes within health care levels: a) Develop Standard Operating Procedures (SOP) that support patient referral to and from rehabilitation within the health sector and where relevant with RMS and University hospitals b) Develop guidance for the referral system, including for patients, and disseminate widely	R: MoH C: NGOs, DPOs, RMS	Time of MoH staff Consultancy costs	Year 3
		3.3.2 Create multi-professional working groups that will develop rehabilitation management guidelines/clinical practice guidelines/ protocols and outcome measurements for priority health condition groups in Jordan	R: MoH, professional associations, university hospitals C: WHO, HI, ICRC, NGO	Meeting costs	Year 3
		3.3.3 Develop a standardized accessible (Braille, audio, or mobile format) user satisfaction survey and conduct routine user satisfaction surveys of rehabilitation and develop an accessible complaint mechanism in line with MoH procedures	R: MoH	To be defined	Year 3 and 5

Strategic objective 4		Expand the scope of specialized rehabilitation			
Areas of actions/ interventions		**Actions**	**Responsible Contributor**	**Estimated resources**	**Time frame**
4.1	Expand specialized rehabilitation, including through strengthening multi-professional rehabilitation across tertiary and secondary level hospitals	4.1.1 Develop a plan for the creation of a national rehabilitation centre of excellence for providing specialized care for complex rehabilitation needs (for adults and children)	R: MoH, MoP, HHC C: WHO, donors, HCD, DPOs	Consultancy costs Time of MoH staff	Year 3-5
		4.1.2 Progressively introduce rehabilitation beds / wards at major general hospitals across Jordan for improving rehabilitation outcomes for priority health conditions such as stroke, spinal cord injuries, trauma injuries, cerebral palsy and other complex paediatric conditions, among others		To be defined	
		4.1.3 Progressively staff all general hospitals in Jordan with multi-professional rehabilitation teams, ensuring at least one in each governorate capital city by end of the strategy		To be defined	
		4.1.4 Strengthen rehabilitation interventions for children with disabilities, including early identification, intervention and referral		Time of MoH staff Training costs	
4.2	Develop rehabilitation in mental health services to reduce hospitalization and institutionalization	4.2.1 Develop a plan for enhancing a multidisciplinary rehabilitation approach in the national centre for mental health and other mental health care services in line with the mental health and substance abuse action plan	R: MoH, national centre for mental health C: HCD, MoSD, RMS, NGOs, WHO, DPOs and user associations	To be defined	Year 2-4
		4.2.2 Progressively implement the plan on enhancing quality rehabilitation in mental health care services, including adequate rehabilitation staffing			
		4.2.3 Develop coordination and referral mechanisms with community-based rehabilitation organisations and self-help groups or user associations supporting persons with mental health conditions, to improve follow-up and reduce readmission to hospitalisation	R: MoH, National mental health centre C: WHO, NGOs, DPOs and user associations	Time of MoH staff	Year 3-4

Strategic objective 5		Expand and strengthen a comprehensive rehabilitation workforce			
Areas of actions/ interventions		**Actions**	**Responsible Contributor**	**Estimated resources**	**Time frame**
5.1	Develop a detailed rehabilitation workforce plan based on current and projected needs	5.1.1 Assess the current rehabilitation workforce coverage, qualifications and identify gaps and needs for expansion and upgrading of qualifications in Ministry of Health (include RMS and University hospitals, as well as NGO run rehabilitation, where possible)	R: MoH C: RMS, University hospitals, Professional associations, donors, WHO, INGOs	Time of MoH staff Meeting costs	Year 1-5
		5.1.2 Develop and implement a detailed rehabilitation workforce plan (5 years), particularly to create positions for professions that currently are not much available in MoH, such as occupational therapists, speech and language therapists		To be defined	
5.2	Develop regulatory mechanisms and competency framework, for all rehabilitation professions in line with their educational qualifications	5.2.1 Develop a competency framework for all type of rehabilitation professionals and revise job descriptions and titles to correspond with academic studies and competence	R: MoH, C: professional associations, RMS and Universities, INGOs, WHO	Meeting costs	Year 2-3
		5.2.2 Ensure that regulatory and licensing bodies in MoH have good understanding of rehabilitation and competency framework required for each profession		Meeting costs	
5.3	Identify and address challenges regarding the attraction and retention of rehabilitation personnel	5.3.1 Undertake further assessments of workforce concerns regarding attraction and retention; and identify feasible actions	R: MoH C: Professional associations	Consultancy costs	Year 2
		5.3.2 Undertake actions that improve the attraction and retention of the rehabilitation personnel			

Areas of actions/ interventions		Actions	Responsible Contributor	Estimated resources	Time frame
5.4	Promote and provide opportunities for continuous education for rehabilitation professionals for more evidence-based practice	5.4.1 Ensure that recent mechanisms on continuous education for re-licensing as defined by MoH are implemented	R: MoH C: professional associations	No costs	Year 1
		5.4.2 Identify priority areas for training across all rehabilitation professionals in MoH, including those in mental health services	R: MoH, MoHE, professional associations, universities C: INGOs, WHO,	Meeting costs	Year 1
		5.4.3 Enhance and support opportunities for continuous education, including for sub-specialization and clinical research, Masters and PhD degrees (including through grants and scholarships), and ensure all rehabilitation personnel across Jordan have access		To be defined	Year 2-5
		5.4.4 Provide opportunities for rehabilitation workforce to access national and international conferences or other learning and exchange events		Travel costs	On-going
		5.4.5 Establish a medical residency program at university level for PMR doctors and enhance or establish inter-entity residency training	R: MoH, MoHE, Jordan Medical Council C: Universities, RMS	To be defined	Year 3-4

Strategic objective 6		Increased availability and quality of assistive products with appropriate provision at an affordable cost			
Areas of actions/ interventions		Actions	Responsible Contributor	Estimated resources	Time frame
6.1	Create a mechanism for improved coordination and collaboration for assistive products, with MoH, MoSD, MoE and HCD	6.1.1 Establish a multi-stakeholder cross-ministerial working group or committee to lead on improving the coordination and provision of assistive products, identify its members, terms of reference and resources	R: MoH, MoSD, HCD, MoE, NGOs, INGOs C: RMS, DPOs, UNRWA	Meeting costs	Year 2 on-going
		6.1.2 Coordinate with NGOs that provide assistive products for more effective service delivery and reduce duplication			
		6.1.3 The working group meet biannually for planning and coordination to strengthen the agenda and advocate the government for increased resources (including tax exemptions for assistive products)			

Areas of actions/ interventions		Actions	Responsible Contributor	Estimated resources	Time frame
6.2	Increase provision of prosthetic and orthotic products through expanding and establishments of prosthetic and orthotic departments and clinics	6.2.1 Prioritize capital investment into the infrastructure and equipment needed for one new prosthetic and orthotic departments/clinics in south of Jordan	R: MoH C: RMS, INGOs, WHO, donors	To be defined	Year 3-5
		6.2.2 Establish 1 additional prosthetic and orthotic workshop in rehabilitation department in southern Jordan, exploring collaboration with RMS		To be defined	
		6.2.3. Identify and address factors that will contribute to enhance and sustain Prosthetic and Orthotic Education Programme in Jordan (e.g. improve education quality, continuous education in new technologies and practices of existing staff to improve mentoring, etc.)		Consultancy costs Training costs	
6.3	Define a priority list of assistive products in coordination with relevant sectors	6.3.1 Develop a priority list of assistive products in coordination with other actors	R: MoH, HCD, MoSD, MoE C: INGO UNRWA, RMS, professional associations, WHO, ICRC, INGOs, NGOs, DPOs, procurement department, donors	Meeting costs	Year 2-4
		6.3.2 Develop a national registry on assistive products with careful attention to security and safety of personal data		Consultancy support	
		6.3.3 Undertake an analysis of needs and costing of the implementation of assistive products priority list (including training of staff, procurement costs, safety and security etc.)		Consultant cost	
		6.3.4 Raise awareness and disseminate the assistive products priority list to increase funding across ministries.		No cost	
6.4	Address gaps in effective and adequate provision of assistive products	6.4.1 Conduct a needs assessment on assistive products in Jordan to have an accurate picture of needs and gaps at national level	R: MoH, MoSD, HCD, MoE C: UNRWA, RMS, WHO, INGOs	Consultant cost Time of MoH staff	Year 2-3
		6.4.2 Review current procurement system with the aim to streamline and make more efficient future procurement	R: MoH, RMS, MoSD, HCD, DPOs, UNRWA, NGOs, ICRC and INGOs, WHO, donors	Consultant cost	Year 3-5
		6.4.3 Develop national guidelines for assistive products provision, follow-up, and maintenance to ensure safe and effective customized provision		Consultant cost Meeting costs	
		6.4.4 Provide training on the guidelines to all concerned actors procuring, delivering, and maintaining assistive products		Consultancy costs Training costs	

5.1 Monitoring, evaluation, and review of the strategic plan

The Ministry of Health recognises the need for this strategic plan to be monitored, evaluated, and reviewed in order to track progress towards the plan's objectives and goals. To do this, a monitoring framework with selected outcome indicators for the plan has been developed. The selection of indicators for the monitoring framework is balanced across the 6 objectives of the plan and aligned to its results chain and are selected among the indicators recommended by WHO[17]. It includes WHO's six core indicators to allow for international comparability.

Ministry of Health stresses the importance and responsibility of stewardship for the oversight of public health initiatives.

Monitoring and evaluation of the rehabilitation strategy should:

- Monitor and evaluate rehabilitation services and their impact on the population, including men, women and children with disabilities.
- Provide the best available information on priority indicators.
- Provide relevant, high quality data and information on health system performance.
- Coordinate the design and use of monitoring and evaluation plans and systems with the overall health information system at the Ministry of Health.

The implementation framework, defining roles and responsibilities, timelines and budget implications will be broken down in annual operational action plans to guide the implementation where clearly defined expected results and measurable indicators will be followed-up with.

The information and data needed for each indicator will be collected at appropriate regular intervals and reported on. Some indicators will require new data sources to be created. Within this plan, are actions to further integrate rehabilitation into the health information systems, which will provide some of the data sources for future monitoring.

The monitoring, evaluation and review process will include:

- An annual evaluation meeting in which the annual operational plan and activities of the previous year will be assessed.
- The Steering Committee, the Technical Advisory Group, and members of working groups that were involved in implementing specific activities during the year will attend the meeting.
- The Ministry of Health will share the results and updates with all other key stakeholders engaged in implementation of activities of the strategic plan.
- At these annual meetings, there will be review and reflection of the progress, including what has and has not been achieved and why. These meetings will align with the annual planning processes and support the coordination and planning of actions for the following year of activities.
- Finally, the Ministry of Health commits to undertaking a mid-term review after 3 years of implementation and a final, external larger

[17] *WHO (2019). Rehabilitation indicator menu. A tool accompanying the Framework f or Rehabilitation Monitoring and Evaluation (FRAME). Geneva.*

review, of the results of the action plan at its completion. The final evaluation will include a review of the situation of rehabilitation (potentially using the STARS methodology comparing with the situation in 2018) and the progress made towards the strategic plan's goals and objectives.

5.2 Rehabilitation strategic plan monitoring framework

STRATEGIC OBJECTIVE 1: Enhanced leadership and effective governance for rehabilitation				
Indicator		**Baseline**	**Target for 2024**	**Reporting frequency**
1	Ministry of Health rehabilitation expenditure	TBD	TBD	Every 2 years
2	Rehabilitation integrated into health plans	1	5	Every 2 years
3	Number of meetings of the rehabilitation steering committee (or similar structure at MoH)	2	2 per year/10 meetings	Annually
4	Annual rehabilitation operational plan and report based on the rehabilitation strategic plan	0	100% annual reporting	Annually
5	Number of rehabilitation awareness raising and promotional activities across health sector levels	0	2 per year/total 5	Annually
STRATEGIC OBJECTIVE 2: Increase the availability of reliable data on rehabilitation at national and governorate levels				
Indicator		**Baseline**	**Target**	**Reporting Frequency**
6	Rehabilitation information - Quarterly rehabilitation reporting on rehabilitation from MoH hospitals	5%	80% of hospitals report on rehabilitation	Starting year 2 and annually
7	Total number of rehabilitation research projects implemented and published annually	0	5 (1 per year)	
8	Report on rehabilitation user experience of services, undertaken through a questionnaire across more than 10% of facilities where rehabilitation is provided (self-reporting)	0	2 (year 2 and 5)	Twice per 5 years
9	Percentage of rehabilitation users who report having received comprehensive education and information for self-management (or their caregivers where relevant)	0%	30%	Based on frequency of rehab user report

OBJECTIVE 3: Integrate quality rehabilitation services in all health care levels in the community				
Indicator		**Baseline**	**Target**	**Reporting Frequency**
10	Number of rehabilitation beds in Ministry of Health	0	10-12 beds	Every 2 years
11	Percentage of general hospitals with rehabilitation: (Defined as the presence of 2 or more rehabilitation professions)	47%	70%	Every 2 years
12	Number of Comprehensive Health Centres with PTs and/or OTs and consulting physiatrist	0	5	Every 2 years
13	Number of Comprehensive Health Centres trained in a set of priority rehabilitation interventions	0	20	Annually
14	Number of new clients of rehabilitation across rehabilitation departments in secondary hospitals	TBD	TBD	Quarterly
15	Number of rehabilitation related protocols, management guidelines.	0	6	Annually
STRATEGIC OBJECTIVE 4: Expand the development of specialized rehabilitation				
Indicator		**Baseline**	**Target**	**Reporting frequency**
16	Number of tertiary hospitals with 3+ rehabilitation professions	0	1	Every 2 years
17	Coverage of people with major injury/trauma (SCI/TBI) receiving comprehensive multi-disciplinary care	TBD	TBD	Annually
OBJECTIVE 5: Expand and strengthen a comprehensive rehabilitation workforce				
Indicator		**Baseline**	**Target**	**Reporting Frequency**
18	Number of rehabilitation personnel in MoH (disaggregated by sex, profession, geography)	TBD	Increase with 10 personnel annually	Annually
19	Number of annual graduates from rehabilitation courses (disaggregated by sex, profession, location)	TBD	TBD	Annually
20	Number of annual residents in physical medicine and rehabilitation specialty	30	Increase by 7 annually	Annually

STRATEGIC OBJECTIVE 6: Increased availability and quality of assistive products with appropriate provision at an affordable cost				
Indicator		**Baseline**	**Target**	**Reporting Frequency**
21	Number of meetings of multi-stakeholder cross-ministerial working group on Assistive products	0	2 per year / total 8	Annually (starting year 2)
22	Number of national guidelines for assistive products provision	0	TBD	Annually
23	Number and type of assistive products provided, reported quarterly	TBD	TBD	Annually
24	Rehabilitation waiting time for prosthetic and orthotic:	2-4 months	50% decrease in waiting time	Annually

5.3 Implementation and evaluation of the strategic plan

The implementation period of the Rehabilitation Strategic Plan is the point in which the plan directs the actions of government and relevant stakeholders. This will happen over the 5-year period of the strategic plan, from 2020-2024.

To support the implementation of the plan; the Ministry of Health commits, along with the Rehabilitation Steering Committee, and supported by the members in the Technical Advisory Group, to convene a joint annual planning meeting that corresponds to the annual evaluation meeting previously mentioned. The annual 'operational' planning meeting will entail coordination and planning between stakeholders engaged in activities within the plan. Operational planning occurs both between stakeholders at the meeting and then within each agency's own planning processes. Attempts will be made to ensure that the timing of the annual rehabilitation strategic planning meeting complements the planning processes and timeframes most commonly used by the Ministry of Health.

The implementation of the strategic plan can be characterized as a 'plan, do, evaluate' process. This process should occur each year and it is recommended that the annual evaluation and planning meeting occur on the same day with appropriate stakeholders. Figure 2 illustrates the 'plan, do, evaluate' process.

Implementation of the strategic plan will occur through the guidance and hard work of the:

1. Rehabilitation Focal Point (unit), Rehabilitation Steering Committee, Technical Advisory group, and the High Health Council.

2 Various working groups that will be formed based on the annual planning process, **for example:**

- Rehabilitation information and integration.
- Rehabilitation workforce and continuous education.
- Defining priority list of health conditions for protocols, develop patient education material, etc.
- Assistive Products and the development of a priority list, guidelines and procurement.

Figure 2: Annual cyclical planning and evaluation process.

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