



**World Health
Organization**

**TERMS OF REFERENCE
OF
WORLD REHABILITATION ALLIANCE**

1.0 Mission

To support the implementation of the Rehabilitation 2030 initiative through advocacy for strengthening the health system to provide rehabilitation, as an integral part of Universal Health Coverage.

2.0 Preamble

2.1 Global challenges and increasing need for rehabilitation

Current health and demographic trends indicate a growing need for rehabilitation worldwide. As populations continue to age, the prevalence of noncommunicable diseases increase, and the consequences of conflict and injury persist, health systems are forced to look beyond preventive and curative measures to address functioning limitations of the population. Rehabilitation plays a central role in optimizing functioning of individuals with a broad range of acute and chronic health conditions, promoting independence and participation in education, work, and meaningful life roles. Rehabilitation is therefore well placed to contribute to the 2030 Agenda for Sustainable Development in the pledge to leave no one behind, particularly Sustainable Development Goal (SDG) 3, to “Ensure healthy lives and promote well-being for all at all ages”.

In many parts of the world, however, countries do not have the capacity to address the increasing rehabilitation needs of the population. In some low- and middle-income countries more than 50% of people do not receive the rehabilitation services they require. Where rehabilitation is available, major barriers often persist including lack of trained workforce and resources. These challenges have only been further compounded by the COVID-19 pandemic. Rehabilitation services are consistently amongst the health services most severely disrupted by the pandemic, which is concerning not only for the many individuals who now face long-term functioning limitations as a result of severe COVID-19, but also for those with other health conditions who can no longer access their usual services.

In the global health context, rehabilitation is often underprioritized, when compared to other health agendas that attract substantially more political attention and investment. The lack of attention from donors, policy- and decision-makers appears

to be due to a number of factors. Firstly, while rehabilitation is well positioned within the broader health and development agenda, being an integral part of Universal Health Coverage, political windows of opportunity need to be better leveraged. For example, there is currently no global target or indicator, such as those in the SDGs, the WHO 13th General Programme of Work (GPW)¹ or WHA Resolution indicators, that can be used to monitor the progress of rehabilitation. Without a global target or indicator, political prioritization and advocacy for rehabilitation will remain disadvantaged. Secondly, while rehabilitation needs are increasing, consumer demand remains surprisingly low, in part due to prevailing misconceptions and limited awareness about the benefits of rehabilitation. And finally, rehabilitation requires increased actor power. Rehabilitation is diverse, spanning different settings, life stages, health conditions, and health professions, often resulting in fragmented governance and diluted advocacy efforts. A culture of cohesion and a common narrative amongst advocacy groups is needed, to increase consumer demand and gain the attention of policy-makers.

2.2 Rehabilitation 2030 initiative

In 2017, WHO launched the Rehabilitation 2030: call for action to highlight the increasing unmet needs for rehabilitation and the importance of strengthening health systems to better provide rehabilitation. The initiative called for coordinated global action amongst all stakeholders on several fronts, including: improving leadership and governance, expanding rehabilitation workforce, and improving rehabilitation data collection in countries (See Annex 1 for all 10 action points). The Rehabilitation 2030 initiative has created substantial momentum and commitment amongst rehabilitation stakeholders, including representatives of Ministries of Health, rehabilitation experts, researchers, development partners, professional associations, and rehabilitation service users.

2.3 Rationale for a WHO-hosted World Rehabilitation Alliance

Despite the substantial progress that has been achieved in recent years, there is still much work to be done to realize the goals set out in the Rehabilitation 2030 initiative. Now is the time for WHO to leverage its strong convening power to further strengthen advocacy efforts and awareness raising in the rehabilitation sector. Having a WHO-hosted World Rehabilitation Alliance enables inclusive participation, building cohesion amongst rehabilitation stakeholder groups, from non-State actors, to intergovernmental organisations to Member States. Recognizing the current level of maturity of the rehabilitation sector, organizational support of a WHO-hosted Alliance also facilitates conceptual clarity and a common understanding on rehabilitation as a health strategy, increases alignment with other WHO activities, and strengthens the

¹ The GPW 13 is based on the Sustainable Development Goals (SDGs) and is structured around three interconnected strategic priorities to ensure healthy lives and well-being for all at all ages: achieving universal health coverage, addressing health emergencies and promoting healthier populations. The 44 GPW 13 Impact Framework Targets and Indicators are aligned with SDGs and/or World Health Assembly (WHA) approved resolutions or action plans. Link: <http://www.who.int/about/what-we-do/gpw-thirteen-consultation/en/>

coordination, reach and impact of collective actions amongst stakeholders in addressing the global rehabilitation challenges of today.

3.0 Status

The World Rehabilitation Alliance (WRA) is a WHO informal network for stakeholders to promote rehabilitation, expand their professional network and share experiences. The WRA is not a separate legal entity and derives its legal status from WHO. Thus, it shall be administered and housed in WHO. The operations of the WRA shall in all respects be administered in accordance with the WHO Constitution and General Programme of Work, WHO's Financial and Staff Regulations and Rules, WHO's manual provisions, and applicable WHO rules, policies, procedures and practices including the WHO Framework of Engagement with Non-State Actors (FENSA)².

4.0 Vision and Goal

The WRA envisions a world in which everyone who needs rehabilitation receives quality and timely services to optimize and maintain their functioning in everyday life.

The goal of the WRA is to raise the profile of rehabilitation at a global, regional, national and local level and to support WHO in its efforts to strengthen rehabilitation in health systems through advocacy actions.

To achieve this goal, the WRA will drive a global advocacy initiative that has time-limited goals, a well-defined mandate and indicators.

5.0 Core Principles of the Alliance

The WRA is governed by the following principles:

- To be inclusive and diverse in membership and structure, ensuring adequate representation from different stakeholder groups, geographical regions and income settings;
- To be transparent in all processes, including the operational strategy and WRA activities;
- To ensure all activities align with the WHO Rehabilitation 2030 initiative, including its narrative and action areas;
- To facilitate coordination among interested parties to advance WHO's priorities on rehabilitation.

² FENSA resolution A69/A/CONF./ strengthens WHO's engagement with non-State actors in favour of public health objectives and especially in the SDG context while at the same time reinforcing WHO's protection from any undue influence in order to preserve the integrity, independence and reputation of the Organization. This is accomplished through procedures implemented by the WHO secretariat that ensure management of conflicts of interest, transparency, accountability, due diligence and risk assessment with respect to engagements with non-State actors.

6.0 Objectives

6.1 Objective 1

Conduct evidence-based advocacy activities that increase support and raise awareness on rehabilitation. To achieve this, the WRA will:

- Develop a global advocacy strategy for rehabilitation;
- Encourage political commitment with Member States and non-State actors;
- Promote and disseminate information and resources aligned with Rehabilitation 2030, including WHO resources;
- Promote and support, when and where relevant, WHO Rehabilitation 2030 events at global and regional level.

6.2 Objective 2

Strengthen networking and knowledge sharing within the rehabilitation sector. To achieve this, the WRA will:

- Facilitate communication between stakeholder groups of the rehabilitation sector through a common understanding and narrative of rehabilitation;
- Strengthen and increase communication amongst WRA members, with policy- and decision-makers and other stakeholders.

7.0 Governance and structure

The WRA comprises of a Secretariat, a Steering Committee, and members. The governance and structure of the WRA is designed to facilitate coordination of activities, to ensure activities align with the WRA overall mission and objectives, and to preclude influences of individual or organization-specific agendas. The WRA is not a decision-making body, nor does it have any bearing over the work and activities of its members that occur outside the WRA.

7.1 The Secretariat

WHO serves as the Secretariat of the WRA. The role of the Secretariat is to oversee the day-to-day management of the WRA's work, including coordination of discussions across stakeholders on priorities and gaps, preparation of draft work plans for consideration by the Steering Committee and/or the workstreams along with administration and budget management.

More specifically, key responsibilities of the Secretariat are as follows:

- Serve as the interface between the WRA and its members;
- Select and manage the WRA's membership in line with WHO rules and policies;
- Coordinate the development, implementation and maintenance of the WRA work plans in consultation with the Steering Committee;
- Chair the Steering Committee meetings;

- Monitor and evaluate activities and processes of the WRA, making amendments as necessary, in consultation with the Steering Committee, to optimize overall WRA functioning and impact;
- Coordinate correspondence with WRA members, as required, to facilitate participation and collaboration of all members;
- Coordinate the biennial members meeting of the WRA, in collaboration with the Steering Committee, including development of relevant documentation (e.g. agenda) and logistical support;
- Develop a central repository for the WRA, to house all relevant documents and resources;
- Develop and regularly update the WRA website (hosted by WHO).

Subject to the availability of sufficient human and financial resources for this purpose, Secretariat support and coordination for the WRA will be provided by WHO. Secretariat support will be provided in accordance with WHO's rules, regulations, policies and procedures.

The Secretariat reserves the right not to implement any WRA recommendation or activity which it determines gives rise to undue financial, legal or reputational liability or is contrary to WHO policies, regulations and procedures.

WHO may terminate its role as Secretariat of the WRA or withdraw from the WRA at any time, with the provision of three months written notice to the Steering Committee and members.

7.2 Steering Committee

The Steering Committee comprises of 10 members, who are appointed by WHO. These members consist of two co-Chairs from each of the WRA's five workstreams. The selection process will strive for balanced representation of the WRA members, with respect to gender, age, geographical area and organization type. Steering Committee decisions will be made through consensus of committee members. With the exception of the Secretariat, the duration of the term of appointment of the Steering Committee members shall be for an initial term of 2 years, with the possibility of renewal once. The Steering Committee is chaired by the Secretariat, who may appoint one member of the Steering Committee as the Vice-Chair for a two-year term.

Key responsibilities of the Steering Committee are as follows:

- Provide overall strategic direction, for the operative work of the WRA. This includes supporting development of the overall WRA work plans and strategies;
- Jointly coordinate with the Secretariat the biennial members meeting of the WRA, including development of relevant documentation and logistical support;
- Approve membership applications;
- Coordinate the establishment of workstreams, approve their work plans, and oversee all workstream activities;

- Monitor and evaluate activities and processes of the WRA, proposing amendments as necessary to WHO, to optimize WRA functioning and impact.

7.3 Workstreams

Five workstreams will be initially established, with the possibility of additional workstreams being established subject to Secretariat and Steering Committee approval. The area of focus of the five workstreams will be decided jointly by the Secretariat and Steering Committee, following expert consultation. The terms of reference for each workstream is approved by the Secretariat and is of a 2-year tenure, with possibility of extension subject to approval by the Steering Committee.

All members of the WRA participate in 1 or more workstream. The purpose of the workstreams is to bring together members with similar interests, to share information and collectively work on specific activities that align with the WRA's overall mission and objectives. Each workstream will have an area of focus with corresponding work plan, that is approved by the Steering Committee, which outlines its objectives, key outputs, priorities and methodology.

Two co-Chairs will be appointed in each workstream by the Secretariat. They are responsible for:

- Coordinating workstream meetings and activities;
- Facilitating communication within the group, ensuring balanced participation of its group members;
- Providing verbal and written reports of workstream progress to the Secretariat and the Steering Committee.

The two co-Chairs of each workstream are part of the WRA Steering Committee and will therefore report on their progress at the biennial members meeting, and through an annual report to the Steering Committee.

8.0 Membership

The WRA membership³ consists of representatives from:

- Member States and State bodies;
- Intergovernmental organizations;
- Nongovernmental organizations (such as professional, condition-specific and development organizations);
- Private sector including international business associations (comprising of 1 representative entity per sector);
- Philanthropic foundations;
- Academic institutions.

³ Individuals are not eligible for the Alliance membership

The private sector including international business associations will be represented by constituencies, such that there will be one representative per sector (for example, one representative for the insurance sector, and one for assistive technology).

All entities seeking to apply for the WRA membership must meet the following criteria:

- The aims and purposes of the applicant entity should be consistent with the WHO Constitution and conform with WHO's policies;
- The entity should contribute significantly to the advancement of rehabilitation and public health and to the objectives, vision and goal of the WRA, and demonstrate support for the WHO Rehabilitation 2030 initiative;
- The entity should respect the intergovernmental nature of WHO and the decision-making authority of Member States as set out in the WHO Constitution;
- The entity should be actively and internationally working in the field of rehabilitation with proven experience and expertise in the subject matter for at least 3 years;
- The entity should have an established structure, constitutive act, and accountability mechanism;
- The entity, if a membership organization, should have the authority to speak for its members and have a representative structure;
- If a non-State actor applying, the entity is required to provide the following information and documents: name, objectives and mission of the entity, copy of the legal status (such as bylaws, constitution), governance structure, names and affiliations of the members of main decision-making bodies (such as Board, Executive Board), the assets, annual income and funding sources (list of donors and sponsors), main relevant affiliations and website address. The entity will also sign the tobacco-arms disclosure statement without alteration.

Each member of the WRA must:

- Adhere to the Terms of Reference of the WRA;
- Actively participate in and support the WRA, its purpose, goals, objectives, guiding principles, work and activities;
- Attend and actively participate at the WRA's various annual and ad hoc meetings;
- Take responsibility according to the division of labor, and make meaningful contributions, in connection with the work and activities of the various WRA workstreams;
- Share knowledge and information with other members (such as resources, data, case studies, experience etc.);
- Act in the best interest of public health in alignment with WHO policies; and
- Ensure effective communication with Secretariat and with the Steering Committee related to activities relevant to the WRA's mission and vision.

Members shall not make public statements about WRA activities or on behalf of the Secretariat without the prior written consent of the Secretariat acting in consultation with the Steering Committee.

8.1 Membership applications

A standardized form and online application process will be developed by the Secretariat. Membership approval will be based on an assessment, due diligence process, and review of submitted documents, in accordance with the eligibility criteria and in accordance with WHO's rules and policies. All membership applications will be assessed by the Secretariat and approved by Steering Committee. Following this, membership applicants will be notified of their membership approval (or otherwise) by the Secretariat. The membership status of successful applicants will be reviewed every 2 years.

9.0 Meetings

The WRA convenes a biennial members meeting, however additional meetings may be scheduled as necessary. The working language of the WRA is English. The biennial members meeting is open to all WRA members. Each member will be able to nominate a maximum of 2 delegates to attend.

The aim of the biennial members meeting will be to:

- Review the WRA work plans;
- Serve as a platform for knowledge sharing amongst members;
- Discuss issues put forward by the Steering Committee.

The Steering Committee will meet every 1-2 months, to report on progress of the workstreams, discuss issues and revise the WRA work plans.

The Steering Committee makes recommendations to the Secretariat. In the event that a consensus is not reached, the Secretariat takes a decision in consultation with the WRA Vice-Chair. The Secretariat reserves the right not to implement any recommendation or activity which gives rise to undue financial, legal or reputational liability or is contrary to WHO policies, regulations and procedures.

Steering Committee members are accountable for informing their respective organizations on decisions, commitments and plans of the WRA.

Each workstream will have meetings, attended by workstream members. The frequency of workstream meetings will be determined by the co-Chairs of the respective workstream.

The Secretariat may, at its sole discretion, invite external individuals to attend biennial members meetings or workstream meetings as an observer. Observers may be invited either as an individual expert or as a representative of an organization. The Secretariat may request invited observers to complete a confidentiality undertaking and a declaration of interests form prior to attending the meeting. Invitations to observers

attending as representatives from non-State actors will be subject to internal due diligence and conflict of interest considerations in accordance with FENSA.

10.0 Termination and withdrawal

Each member has the right to withdraw from participation in the WRA, at any time, subject to providing one month written notice to the Secretariat and to the orderly conclusion of any ongoing activities.

If a member does not attend two successive biennial members meetings, without appropriate written explanation to the Steering Committee, or does not attend at least 60% of the WRA workstream meetings, the member will be deemed to have withdrawn from the WRA.

The Secretariat also has the right to terminate the membership of any member at any time, upon providing written notice thereof to such member. Without limiting the foregoing, the participation of any member in the WRA shall terminate if and when such member: (a) no longer subscribes or adheres to the goals, objectives and/or guiding principles of the WRA, as described in these Terms of Reference; (b) engages in activities that are not compatible with WHO Policies, and/or (c) ceases to meet the membership criteria for the WRA, as set forth in these Terms of Reference. In such instances, the decision to terminate involvement of a member will be made by the Secretariat, in consultation with the Steering Committee.

WHO reserves the right to withdraw from administration of the WRA at any time, subject to providing the WRA members with at least 3 months' prior written notice and to the orderly conclusion of any ongoing activities. WHO also has the right, exercisable in its sole discretion, to close the WRA, to terminate any membership, its Steering Committee and/or to terminate any Vice-Chairmanship, in each case, at any time upon providing written notice thereof to the member(s) concerned.

11.0 Alliance evaluation

The WRA Secretariat, in consultation with the Steering Committee, will evaluate the overall processes and outcomes of the WRA on a biennial basis, with the aim of assessing whether WHO should continue to host the WRA.

12.0 Communications

12.1 Visual Identity

To ensure that the WRA is deliberately communicating with one voice to external parties on topics of substance (principles, priorities, target product profiles, standards, plans and actions, funding, and all confidential information, etc.) any communication in the name of the WRA will take place through the Secretariat.

The WRA may develop a visual identifier such as a logo which will help identify the network to its audience. The visual identifier will be accompanied by the statement "WHO hosted Network". The right to use the logo, including on publications, may be granted to members on a case-by-case basis with prior written approval of the Secretariat. Members shall not use WHO's name, acronym and emblem. This includes, inter alia, the display of the WHO logo and name on any premises, equipment, as well as on any communication and/or training materials, training certificates, social media tools or publications.

12.2 Publications

The WRA shall not produce publications, unless exceptional approval is given by the Secretariat. Any publication by a member, other than WHO, referring to WRA activities shall contain appropriate disclaimers as decided by WHO, including that the content does not reflect the views or stated policy of the members.

The members must ensure that the work of the WRA is not misrepresented, and appropriate disclaimers are included where necessary. WRA activities shall not include the development of technical materials (that aim to provide technical guidance to Member States), normative documents or policy papers.

12.3 Alliance website

The WRA has a webpage that is housed within WHO's domain. The webpage includes a list of member organizations, subject to their consent.

13.0 Finance

Members will be responsible for their own expenses in relation to all WRA activities (including participation at meetings), unless agreed otherwise by the Secretariat. If members receive third party funding to support participation in WRA meetings and activities, this must be disclosed to the Secretariat.

The Secretariat support and related day to day operations of the WRA will be financed by voluntary contributions from the members. The Secretariat may also raise funds from other sources to support the work of the WRA, in accordance WHO rules and procedures, as appropriate. All Secretariat funds shall be received, administered and acknowledged in accordance with WHO's policies including its financial regulations, rules, and practices. However, grant applications made by the members for raising funds in the name of the WRA require consultation with and endorsement by the Secretariat to ensure alignment with the goals and principles of the network. The Secretariat reserves the right to require that the WRA name not be used in such grant applications. Contributions by members including donations (in cash or in kind), will be acknowledged by the Secretariat in accordance with WHO's applicable rules, policies and practices.

14.0 Confidentiality

All participants in the WRA must declare potential conflicts of interest before participating in meeting discussions.

Depending on the agenda item being discussed, each participant in the WRA may be required to abide by confidentiality obligation and sign a standard confidentiality undertaking using the form provided by WHO for this purpose.

15.0 Amendments

These Terms of Reference may be amended from time to time by WHO in consultation with the Steering Committee.

ANNEX 1. REHABILITATION 2030 CALL FOR ACTION

The participants of the meeting Rehabilitation 2030 acknowledge the following:

- A. The unmet rehabilitation need around the world, and especially in low- and middle-income countries, is profound.
- B. Demand for rehabilitation services will continue to increase in light of global health and demographic trends, including population ageing and the increasing number of people living with the consequences of disease and injury.
- C. Greater access to rehabilitation services is required to “Ensure healthy lives and promote well- being for all at all ages” (Sustainable Development Goal [SDG] 3) and to reach SDG Target 3.8 “Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”.
- D. Rehabilitation is an essential part of the continuum of care, along with prevention, promotion, treatment and palliation, and should therefore be considered an essential component of integrated health services.
- E. Rehabilitation is relevant to the needs of people with many health conditions and those experiencing disability across the lifespan and across all levels of health care. Thus, rehabilitation partnerships should accordingly engage all types of rehabilitation users, including persons with disability.
- F. Rehabilitation is an investment in human capital that contributes to health, economic and social development.
- G. The role of rehabilitation is instrumental for effective implementation of the Global strategy and action plan on ageing and health (2016–2020), the Mental health action plan (2013–2020) and the Framework on integrated people-centred health services, and as a contribution to the efforts of the Global Cooperation on Assistive Technology (GATE) initiative.
- H. Current barriers to strengthen and extend rehabilitation in countries include: i. under-prioritization by government amongst competing priorities; ii. absence of rehabilitation policies and planning at national and sub-national levels; iii. limited coordination between ministries of health and social affairs where both are involved in rehabilitation governance; iv. non-existent or inadequate funding; v. a dearth of evidence of met and unmet rehabilitation needs; vi. insufficient numbers and skills of rehabilitation professionals; vii. absence of rehabilitation facilities and equipment; and viii. lack of integration into health systems.
- I. There is an urgent need for concerted global action by all relevant stakeholders, including WHO Member States and Secretariat, other UN agencies, rehabilitation user groups and service providers, funding bodies,

professional organizations, research organizations, and nongovernmental and international organizations to scale up quality rehabilitation.

In light of the above, the participants commit to working towards the following ten areas for action:

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