Rehabilitation 2030

World Health Organization

GLOBAL REHABILITATION INDICATORS

Background

The Sustainable Development Goals (SDG) recognise universal health coverage (UHC) as key to achieving many health targets. SDG 3.8 target is to "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". UHC defines service coverage as a spectrum of services provided across the life cycle: promotion, prevention, treatment, rehabilitation, and palliation[1].

Rehabilitation is an essential health service that aims to optimise functioning in daily life. Despite its centrality to achieving UHC, the global need for rehabilitation remains largely unmet, driven by ageing populations, noncommunicable diseases and injuries. WHO estimates that 1 in 3 people worldwide have health conditions that could benefit from rehabilitation[2], and in many low- and middle-income countries the large majority of these needs unmet.

In response WHO launched Rehabilitation2030 in 2017 with a call for action to address the profound unmet needs for rehabilitation. This initiative identified 10 priority areas to strengthen health systems for rehabilitation[3]. It was followed by the endorsement of Resolution 76.6 "Strengthening rehabilitation in health systems"[4] at the 76th World Health Assembly in May 2023, which urges countries "to expand rehabilitation to all levels of health, from primary to tertiary care, and to ensure the availability and affordability of quality and timely rehabilitation services". The resolution also requests the Director-General of WHO to "develop, with input from Member States, a baseline report with information on the capacity of Member States to respond to existing and foreseeable rehabilitation needs, to report on progress on the implementation of the Resolution to the World Health Assembly, and to develop feasible global health system rehabilitation targets and indicators for effective coverage of rehabilitation services".

Following the endorsement of Resolution 76.6, the WHO Rehabilitation Programme, including the 3 levels of the organization, in 2024 and 2025 conducted a Member State consultation for the development of a set of rehabilitation indicators for global reporting. Data collected on the selected indicators will track progress toward implementation of Resolution 76.6 and inform a **WHO global baseline report on the capacity of Member States to respond to existing and foreseeable rehabilitation needs**.

[1] Health – United Nations Sustainable Development. Available from: https://www.un.org/sustainabledevelopment/health/

[2] Cieza A, Causey K, Kamenov K, Hanson SW, Chatterji S, Vos T. 2020. Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet. 2020;396(10267):P2006–17 (https://doi.org/10.1016/S0140-6736(20)32340-0).

[3] Rehabilitation2030 initiative. Geneva, World health Organization; 2017. Available from: https://www.who.int/initiatives/rehabilitation-2030

[4] World Health Organization. Landmark resolution on strengthening rehabilitation in health systems. Available from: https://www.who.int/news/item/27-05-2023-landmark-resolution-on-strengthening-rehabilitation-in-health-systems

Development of the global rehabilitation indicator set

- First, a draft list of 19 rehabilitation indicators for global reporting was developed and selected from the WHO Rehabilitation Indicator Menu (RIM)[5], and including some additional indicators from existing regional frameworks for rehabilitation and indicators with a track record from other health programmes (adapted for rehabilitation). Selected indicators for the draft list apply to the criteria for quality indicators[6] (Table 1).

Table 1. Criteria for selecting indicators

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

- Second, in 2024 and 2025, WHO organized a regional consultation with its Member States to select indicators from the draft list. To particate, Ministries of Health were requested to nominate a focal person with knowledge in rehabilitation and in a position to collaborate with those responsible at the monitoring and evaluation department of the Ministry. The consultation consisted of the following 2-steps:

1/ online regional meetings to introduce and discuss the process for selecting the Global Rehabilitation Indicators and outline future reporting mechanisms.

[5] World Health Organization. Rehabilitation in health systems: guide for action. Geneva: World Health Organization; 2019
[6] Adapted from: OECD Health Care Quality Experts Group. Towards actionable international comparisons of health system performance: expert revision of the OECD framework and quality indicators. Int J Qual Health Care. 2015;27(2).

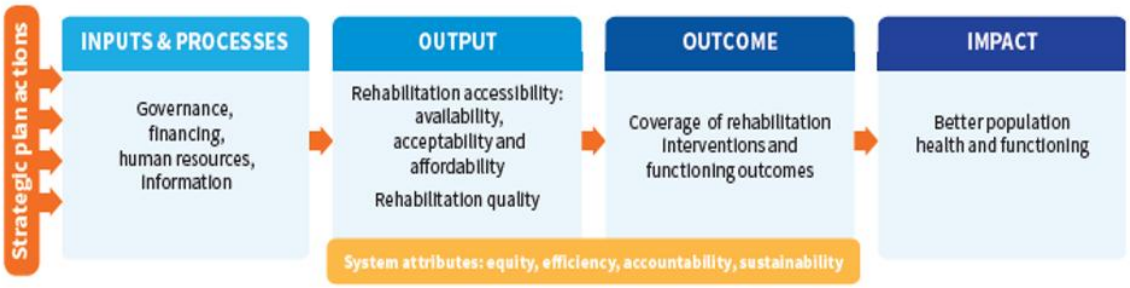
2/ online survey to identify a set of Global Rehabilitation Indicators. For this, Member States were requested to rate all indicators in the draft list from 'highly agree' to 'highly disagree' and to rank the indicators within each health system building block, ensuring a minimum of one indicator for the following building blocks: governance, information, financing, workforce, service delivery, all inclusive of assistive technology. Indicators were selected when ranked highest and not addressed with major objections from Member States.

- Third, the selection of eight indicators was concluded to inform a global survey for reporting to WHO. In addition to this set of eight indicators, two indicators were added to the set of global indicators but are not included in the global survey: 1/ the assessment of effective coverage of rehabilitation as requested by WHA Resolution 76.6 and collected in countries on a demand basis with WHO technical support, and 2/ geographic coverage for assistive technology for assessing the 'Health products' building block, identified with the WHO Global Cooperation on Assistive Technology and collected through the Member States reporting on the capacity to respond to the need for assistive products.

Global Rehabilitation Indicators overview

The Global Rehabilitation Indicators have been categorized across the domains of the rehabilitation results chain (Figure 1); inputs, output, outcome, and impact.

Figure 1. Rehabilitation results chain



The results chain domains are defined as follows:

- *Input indicators* measure the resources and activities needed (such as for rehabilitation governance, financing, workforce and health information) to undertake an action.
- *Output indicators* measure the results of the input in the form of achieved services and products.
- *Outcome indicators* measure expected or achieved short- and intermediate-term effects of the services and product outputs.
- *Impact indicators* measure at the population-level the long-term effects of the services and products that have been directly or indirectly influenced by outputs.

Table 1 presents the consolidated set of Global Rehabilitation Indicators.

Input	Output	Outcome	Impact
Rehabilitation governance • Rehabilitation integrated into national health sector plan **Rehabilitation preparedness** • Rehabilitation in health emergency preparedness **Rehabilitation financing** • Rehabilitation in largest public-sector health benefit package **Rehabilitation workforce** • Rehabilitation worker density and distribution **Health products for rehabilitation** • Geographic coverage for assistive technology **Rehabilitation information**	**Rehabilitation services** • Rehabilitation service utilization • Rehabilitation integrated into primary health care • Rehabilitation services standards	**Rehabilitation coverage** • Effective coverage of rehabilitation	-

• Rehabilitation reporting completeness			

Global Rehabilitation Indicators and metadata

1.Rehabilitation integrated into the national health sector plan

Rehabilitation results chain: Input – Rehabilitation governance

Definition: The national health sector (strategic) plan explicitly includes rehabilitation at the level of an activity. This means rehabilitation is included in the context of actions in the current national health sector plan – i.e. it is not only mentioned in the background text. This does not include internal operational plans, only the high-level overarching health plans. It excludes national plans for dedicated health programmes such as mental health, older people, vision, hearing, noncommunicable disease and early childhood/nurturing care. If the national health sector plan is under review or in the process of being updated/renewed, the most recent existing national health sector plan is assessed.

Rationale: The inclusion of rehabilitation in the national health sector plan indicates the extent of integration of rehabilitation in health planning.

Numerator: -

Denominator: -

Method of calculation: The current national health sector plan explicitly includes rehabilitation at the level of an activity - Yes/No

Preferred data sources: National and subnational health sector plans from ministry of health.

Resources: -

2.Rehabilitation in health emergency preparedness

Rehabilitation results chain: Input – Rehabilitation preparedness

Definition: The status of health emergency preparedness planning for rehabilitation defined by the ratio of key components of (sub)national health emergency preparedness planning that are in place. Eight key

components for rehabilitation that should be included when preparing for rehabilitation in a health emergency are:

- Risk assessment including consideration of surges in rehabilitation needs and threats to essential rehabilitation services.
- Designation of a rehabilitation focal person for health emergency preparedness and response.
- Description of rehabilitation stockpiles or supply chain analysis if stockpiles are not required.
- Review of key rehabilitation infrastructure, with a requirement for key facilities to have conducted risk assessments and developed evacuation plans.
- Mapping of critical rehabilitation services with the development of adapted rehabilitation referral pathways based on the risk assessment.
- Rehabilitation workforce surge plan.
- Rehabilitation services continuity plan.
- Integration of rehabilitation in national health emergency management policy or strategy document.

Rationale: Health emergencies can create enormous surges in rehabilitation needs and also disrupt essential rehabilitation services. Integrating rehabilitation into health emergency preparedness planning is the best way to systematically prepare rehabilitation services for emergencies.

Numerator: Number of key components for rehabilitation preparedness planning that are in place.

Denominator: Eight key components for rehabilitation preparedness planning that should be included in health emergency preparedness planning.

Method of calculation: Number of key components for rehabilitation preparedness planning in place/ Eight key components for rehabilitation preparedness planning

Preferred data sources: Administrative records from MoH, (sub)national health emergency preparedness plan, (sub)national dedicated rehabilitation emergency preparedness plan, preparedness plans from key facilities.

Resources:
WHO policy brief on health emergencies preparedness for rehabilitation. Geneva: World Health Organization; 2023.

3.Rehabilitation in largest public-sector health benefit package

Rehabilitation results chain: Input – Rehabilitation financing

Definition: The existence of 15 evidence informed, prioritized, quality rehabilitation interventions within the country's health benefit package linked to the largest public-sector health-financing scheme. The largest public-sector health-financing scheme is defined as that covering the greatest number of individuals in the country. The set of 15 rehabilitation interventions has been developed by WHO for it's regular global survey on Health Benefit Packages. The list of interventions does not want to comprehensively assess rehabilitation services provision and serves as a tracer for rehabilitation services only. The interventions include the provision of assistive products, rehabilitation interventions for

mobility and spasticity, after lower limb amputation, in elderly for hearing deficits, and in adults with depression[7].

Rationale: The inclusion of the rehabilitation interventions within the largest public-sector health financing scheme reflects the extent to which the government finances rehabilitation services.

Numerator: -

Denominator: -

Method of calculation: Existence of a set of 15 evidence informed, prioritized, quality rehabilitation interventions within the country's largest public-sector health-financing scheme. - Yes/No

Preferred data sources: Largest public-sector health financing scheme

Remarks: This indicator has previously been reported through a data collection mechanism established with the WHO survey on Health Technology Assessment (HTA) and Health Benefit Packages. The last and final update was in 2021 (see Resources). Reporting is done for all 15 interventions allowing in-depth analysis for included intervention types.

Resources:
WHO Rehabilitation in health financing: opportunities on the way to universal health coverage. Geneva: World Health organization; 2024

WHO survey on Health Technology Assessment (HTA) and Health Benefit Packages. Geneva: World Health organization; 2020

4.Rehabilitation worker density and distribution

Rehabilitation results chain: Input – Rehabilitation workforce

Definition: Number of rehabilitation workers per 10 000 population. Common rehabilitation personnel are physical medicine and rehabilitation doctors, rehabilitation nurses, physiotherapists, occupational therapists, speech and language therapists, prosthetists and orthotists, and clinical psychologists. Other rehabilitation occupational groups relevant to the country can also be included, for example assistants

[7]Interventions for motor functions and mobility: Supervised strengthening exercises, Provision of orthotics (splints, braces, casts, etc.) for maintaining range of movement, Botulinum toxin for spasticity management, Provision of a motorized wheelchair (also called, electric wheelchair, electric-powered wheelchair, or powerchair).
Interventions for lower limb amputation: Residual limb and stump care (including skin care, and education on positioning), Provision and training of lower limb prosthesis, Provision of basic mobility devices (e.g. crutches, wheelchair), Rehabilitation programs for amputees with prosthesis to return to sports and/or work.
Interventions for older adult health: Multimodal exercise programs including strength resistance training, aerobic training, balance training, flexibility training, Provision of assistive device, Home assessment and environmental adaptations for mobility ease and safety.
Interventions for hearing deficits: Hearing aid provision, Rehabilitative therapy (e.g. auditory-verbal therapy).
Interventions for depression in adults: full course of psychotherapy (e.g., CBT, interpersonal therapy) by a psychologist or psychiatrist, Multi-disciplinary specialist rehabilitation service for depression

(or technicians), chiropractors, audiologists, social workers and mid-level rehabilitation cadres. This includes those working in government, private practice and nongovernmental services.

Rationale: The number of rehabilitation workers per 10 000 population provides an indication of the availability of rehabilitation services. The inclusion of all rehabilitation personnel, including mid-level cadres, contributes to this information. When disaggregating further, information about personnel numbers for different rehabilitation occupational groups and density for geographic areas and facility types is important for measuring workforce composition and distribution.

Numerator: Number of health workers per rehabilitation occupational group.

Denominator: Total population.

Method of calculation: Number of health workers per rehabilitation occupational group / Total population x 10 000.

Optional disaggregation and additional dimensions: For numerator, disaggregation by geographic region, facility type (administrative level of care, public/private). For denominator, disaggregation by geographic region.

Preferred data sources: National Health Workforce Regulatory and or Licensing Agencies that include the rehabilitation workforce, National Health Workforce Accounts and MOH data bases and/or RHIS (WHO standard facility indicator "Rehabilitation personnel density"), records from Professional Associations.

Remarks:

- Preferably, this is reporting about practicing personnel (active stock), including staff in a non-clinical role. If not, it could include only those in clinical roles or at least reporting about licensed rehabilitation workers. This should be indicated. If reported through professional associations, a standardization of data collection from each professional association is needed.
- Denominator is based on estimates from the World Bank or from national office for statistics.
- Reliable rehabilitation workforce numbers outside of government services can be difficult to determine in countries without national registration data or when the private sector is not included for data collection with the health management information system (HMIS).
- Workforce density data collected with the HMIS may include rehabilitation workers that are partially employed.

Resources:

Handbook on monitoring and evaluation of human resources for health with a special focus on low- and middle-income countries. Geneva: World Health Organization; 2009 (https://apps.who.int/iris/handle/10665/44097.

Monitoring the building blocks of health systems: a handbook on indicators and their measurement strategies. Geneva: World Health Organization; 2010 (https://apps.who.int/iris/bitstream/handle/10665/258734/9789241564052-eng.pdf).

Routine Health Information Systems – rehabilitation toolkit. Geneva: World Health Organization; 2022.

WHO national health workforce accounts: a handbook. Geneva: World Health organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/259360/9789241513111-eng.pdf).

5.Geographic coverage for assistive technology

Rehabilitation results chain: Input – Health products

Definition: The percentage of districts (or similar) that have government or government-recognized assistive technology services providing assistive technology for the different functioning domains[8] (communication, cognition, hearing, mobility, self care and vision).

Rationale: Assistive technology services are often concentrated in urban centres. Limited distribution of services often prevents people from accessing assistive technology, particularly those living in rural and remote areas. Monitoring the extent to which services are available across the country and beyond tertiary level settings provides a measure of reducing inequity of access.

Numerator: Number of districts (or similar) that have government or government-recognized assistive technology services that provide assistive products.

Denominator: Number of districts (or relevant division for local governance).

Method of calculation: Number of districts (or similar) that have government or government-recognized assistive technology services that provide assistive products x100 / Total number of districts.

Optional disaggregation and additional dimensions: For numerator, disaggregation by functioning domain: communication, cognition, hearing, mobility, self care, and vision.

Preferred data sources: Assistive technology progress assessment questionnaire - tracking progress on access to assistive technology, WHO data collection 2025 (Question 5: Geographic and decentralized service coverage).

[8] WHO classifies assistive products into six domains. Some products may be relevant to more than one domain. The six functional domains used in the priority Assistive Products List are: cognition, communication, hearing, mobility, self care and vision. -Cognition products help people who have difficulties with memory, attention, planning or organization to manage daily routines and stay safe. Examples of products to help with cognition include simple memory aids, and orientation and localization systems. -Communication products support people who find it hard to understand others or express themselves to share their needs, ideas and choices. Examples of these products include non-digital communication aids, dedicated digital communication aids, and alternative input devices. -Hearing products make speech and other important sounds easier to notice and understand so people can communicate and take part in daily life. Examples of these include digital hearing aids, personal remote microphone systems, and alarm signallers with lights, sounds or vibrations. -Mobility products help people who have difficulty standing, walking or moving around to get where they need to go and join in family, work and community activities. Examples of these include walking sticks, wheelchairs, postural support systems and transfer aids. -Self care products support safety and independence in everyday activities, such as dressing, bathing, toileting, eating and managing medicines. Examples of these include toilet chairs, dressing aids, catheter systems and fall alarms. -Vision products help people who are blind or have low vision to read, move around safely and access information. Examples include spectacles for near or distance vision, magnifiers, screen readers and Braille products.

Remarks:

- Government services are those led and implemented by the Government.
- Government-recognized services may include those provided by non-government and/or private organizations through formal or informal agreement with the Government.
- District level may be district, provincial, or equivalent administrative division used for local governance.

Resources:
Assistive technology progress assessment questionnaire: tracking progress on access to assistive technology. World Health Organization, 2025.

6.Rehabilitation reporting completeness

Rehabilitation results chain: Input – Health information for rehabilitation

Definition: The percentage of health facilities designated to report on rehabilitation services that collected a minimum rehabilitation data set (defined as service utilization data), last reporting period.

Rationale: It is recommended integrating information on rehabilitation into the routine health information systems by collecting and reporting core rehabilitation data disaggregated by sex and age. The availability of information on rehabilitation service utilization at facility level describes the extent to which rehabilitation minimal information is made available. The timely availability of complete routine rehabilitation data from facilities is essential for decision-making. The indicator measures compliance with the requirements of complete reporting for a minimal data set across facilities in a specified period of time.

Numerator: Number of health facilities designated to report on rehabilitation services that collected service utilization data, last reporting period.

Denominator: Number of health facilities designated to report on rehabilitation services.

Method of calculation: Number of health facilities designated to report on rehabilitation services that collected service utilization data, last reporting period x100 / Number of health facilities designated to report on rehabilitation services.

Preferred data sources: RHIS (WHO standard facility indicator “Rehabilitation reporting completeness”).

Remarks:

- The country needs to establish a rehabilitation Master Facility List, which is a list of health facilities that are expected to report on rehabilitation, whether services are provided by rehabilitation workforce or non-rehabilitation workforce through task sharing.
- The timeliness and completeness of reporting is defined by national guidance
- If rehabilitation data on service utilization is not included in the current Health Management Information System (HMIS) of the country, or the HMIS or other reporting mechanism is not existing, the indicator would be reported as 0%.

Resources:

Routine Health Information Systems – rehabilitation toolkit. Geneva: World Health Organization; 2022

District Health Information System 2 (DHIS2) user manual [website] 2023 (https://docs.dhis2.org/2.24/en/user/html/ch01.html).

Monitoring the building blocks of health systems: a handbook on indicators and their measurement strategies. Geneva: World Health Organization; 2010 (https://apps.who.int/iris/bitstream/handle/10665/258734/9789241564052-eng.pdf).

7.Rehabilitation service utilization

Rehabilitation results chain: Output – Rehabilitation services – Utilization

Definition: The number of cases accessing rehabilitation services per 10 000 population, last year. This can be categorized by health condition group (i.e. musculoskeletal, neurological, mental health, cardiovascular and respiratory conditions, sensory impairments, cancer, and others). It includes in- and outpatients and people accessing services through telerehabilitation.

Rationale: The indicator provides information on the number of cases receiving rehabilitation services. If data are disaggregated for underlying health condition (groups), it informs the assessment of accessibility and availability of rehabilitation services for different clinical populations.

Numerator: Number of cases that has received rehabilitation services, last year.

Denominator: Total population.

Method of calculation: Number of cases that has received rehabilitation services, last year / Total population x 10 000.

Optional disaggregation and additional dimensions: For numerator: health condition group.

Preferred data sources: RHIS (WHO standard facility indicator "Rehabilitation service utilization"), rehabilitation service records, ministry of health administrative data source or national body charged with reporting on rehabilitation.

Remarks:

- Rehabilitation services are health services provided by rehabilitation professionals.
- Denominator is based on estimates from the World Bank or national office for statistics.
- When using HMIS data, it is important to distinguish between new cases and old cases utilizing rehabilitation services. Counting the latter for the numerator may result in an overestimation of service utilization. This may also happen when service utilization data for rehabilitation are calculated by adding service utilization data from the different professional groups.

Resources:
Routine Health Information Systems – rehabilitation toolkit. Geneva: World Health Organization; 2022.

8.Rehabilitation integrated into primary health care

Rehabilitation results chain: Output – Rehabilitation services – Availability

Definition: The extent to which rehabilitation services delivered by the rehabilitation workforce are available at primary care settings (public and private health sector).

Rationale: The presence of the rehabilitation workforce in primary care settings indicates the availability of rehabilitation services at primary care.

Numerator: -

Denominator: -

Method of calculation: The extent to which rehabilitation services delivered by rehabilitation professionals are available at primary care settings: poor availability, moderate availability, good availability.

Preferred data sources: Facility audits, (sub)national Essential Health Services Package.

Remarks:

- Countries may define their primary care level differently; it typically includes the service delivery level(s) below the tertiary and secondary hospitals. The assessment is for the national situation.
- Good availability means 70% or more of patients in need are reached. Moderate availability means less than 70% but more than 30 % of patients in need are reached. Poor availability means less than 30 % of patients in need are reached.
- Whether rehabilitation services are poorly or highly available at the level of primary care, countries can also report on the types of services that are available: physiotherapy, occupational therapy, prosthetic and orthotic services, psychological services, physical and rehabilitation medicine, speech and language therapy, rehabilitation nursing. Some countries may include other service types such as audiology, social services, and mid-level rehabilitation services.

Resources: -

9. Rehabilitation services standards

Rehabilitation results chain: Output – Rehabilitation services – Quality

Definition: Percentage of rehabilitation facilities meeting (inter)national endorsed rehabilitation standards through accreditation or certification. Standards provide guidance that support the provision of quality rehabilitation. These are commonly “rehabilitation service standards” that have been set at the (sub)national level for health facilities providing rehabilitation services with rehabilitation professionals and define aspects related to quality care (personnel, infrastructure, equipment, administration, management and clinical processes).

Rationale: There is evidence that the existence and implementation of rehabilitation service standards improve the quality, effectiveness and efficiency of rehabilitation care.

Numerator: Number of rehabilitation facilities meeting (inter)national endorsed rehabilitation standards.

Denominator: Total number of rehabilitation facilities.

Method of calculation: Number of rehabilitation facilities meeting (inter)national endorsed rehabilitation standards x 100/ Total number of rehabilitation facilities.

Preferred data sources: National accreditation, quality standards agencies.

Remarks:

- Facilities meet the standards through accreditation or certification. Where (sub)national service standards are not (yet) established, regional or international standard service assessments and accreditation systems can also be considered. Hence, hospitals providing rehabilitation services that have received overall accreditation including rehabilitation are also accepted.

Resources:
WHO Health systems strengthening glossary. Geneva: World Health Organization (https://cdn.who.int/media/docs/default-source/documents/health-systems-strengthening-glossary.pdf).

Harmonized Health Facility Assessment. Geneva: World Health Organization, 2022 (https://www.who.int/data/data-collection-tools/harmonized-health-facility-assessment/introduction).

10. Effective coverage of rehabilitation

Rehabilitation results chain: Outcome – Rehabilitation coverage

Definition: The percentage of adults with chronic primary low back pain and limitations in functioning that has benefited from rehabilitation.

Rationale: This WHO global tracer indicator enables monitoring of coverage of rehabilitation services at population level and the performance of the health system in terms of the quality of services that have been provided. The indicator has been developed for population-based surveys, requiring the selection of a tracer health condition based on its prevalence and evidence base for rehabilitation, namely chronic primary low back pain. The highest contribution to the need for rehabilitation comes from musculoskeletal disorders, with low back pain being the most prevalent condition in a majority of countries (568 million people in 2019[9]). There is evidence showing that many rehabilitation interventions are cost-effective in chronic low back pain.

[9] Cieza A, Causey K, Kamenov K, Wulf Hanson S, Chatterji S, Vos T. Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet. 2020;396(10267):P2006-2017.

Numerator: Number of adults with chronic primary low back pain and limitations in functioning that has benefited from rehabilitation.

Denominator: Number of adults with chronic primary low back pain and limitations in functioning.

Method of calculation: (Prevalent adults with chronic primary low back pain experiencing limitations in functioning and benefiting from rehabilitation / Identified number of adults with chronic primary low back pain experiencing limitations in functioning) x 100.

Optional disaggregation and additional dimensions: Age, gender, socioeconomic status, urban/rural and other relevant sociodemographic stratifiers where available.

Preferred data sources: Integration of the WHO questionnaire and functioning measure in a household survey.

Remarks: -

Resources:

De Groote W, Côté P, Wong J et al. Development of a World Health Organization indicator and corresponding questions to measure effective coverage of rehabilitation. eClinicalMedicine, 2025; 85