WORLD HEALTH ORGANIZATION

منظمة الصحة العالمية

ORGANISATION MONDIALE DE LA SANTÉ

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

EM/RC30/10
June 1980

Thirtieth Session
Agenda item 11

ORIGINAL: ENGLISH

REHABILITATION

TABLE OF CONTENTS

	Page
Definition	1
Rehabilitation: A Team Responsibility	1
The Team Approach	1
Early Intervention	2
Emotional and Social Impact	2
Traditional Social Practice	3
Dependence on Institutions	3
Economic Rehabilitation	4
Increasing Demand	4
1981 - International Year of the Disabled	5
WHO - UNICEF Interest	5
WHO/EMRO Activity	6
Conclusion	7

Definition

The word rehabilitation originates, according to Webster's Dictionary, from the Latin word "*rehabilitare*" meaning "to restore". The word is a composite of the Latin prefix "*re*" meaning "again" and "*habilitare*" meaning "to make suitable". In other words "*to rehabilitate*" means to restore a person to a former capacity. The dictionary definition is important as it indicates the necessity of considering rehabilitation as involving the "whole" person. It implies not only the restoration of physical deficiencies, but also the retraining of handicapped persons and the provision of the appropriate psychological and social support to repair traumatized mental states.

Rehabilitation: A Team Responsibility

Formal interest in rehabilitation is a comparatively modern phenomenon. In the past, it mainly concerned the problems of veterans returning from wars; this has led to the present tremendous interest.

However, the importance of rehabilitation to industrial development is obvious, when the heavy price in taxes and insurance for failure to absorb disabled persons into the economy is considered. Cost/benefit studies have shown that significant savings can be achieved by returning handicapped persons to sheltered or suitable jobs in industry.

The Team Approach

The full concept of rehabilitation immediately makes us aware that it is not a task for a single individual. It is very much a team responsibility and involves cooperation between many skills, such as physiotherapy, orthotic technology, occupational therapy, rehabilitation nursing, recreational services, speech therapy, psychological services, medical social work, vocational counselling and job-placement assistance. Obviously each individual case does not require the services of all of these disciplines, but there are few, if any cases, which do not require the services of some of the group mentioned.

A great deal can be learnt from rehabilitation in industry, where re-training and the use of sheltered workshops has been common for some time. These techniques may be used for a wide variety of disabilities, including those resulting from cardiac disease, arthritis, rheumatic disease, neuro-muscular diseases such as poliomyelitis, cerebral palsy, paraplegia, and a wide range of traumatic and orthopaedic conditions.

Early Intervention

Rehabilitation is more successful when it commences immediately at the onset of the disease or injury. This is a process of adjustment for the patient, supplying a number of services which operate not singly nor sequentially but together and concurrently. Thus, physical rehabilitation should be started almost as soon as the patient is admitted to hospital. The immediate task is the control of the disease or injury by surgery, drugs, nursing and whatever else is appropriate. The outcome in terms of recovery, length of convalescence, residual disability and limitation of capacity for physical work should be estimated as soon as possible.

During convalescence, the first objective of the programme is preventing or minimizing physical deterioration; the second is re-building strength and the third is restoring physical function as far as possible.

The rehabilitation programme begun in hospital is then transferred appropriately to other agencies. Medical supervision may be progressively reduced, although it should continue at a suitable level, until the full return of the patient to society.

Emotional and Social Impact

The emotional disturbance which accompanies serious illness and accidents must always by considered. Initial efforts of physicians, nurses and other counsellors must be directed towards boosting the morale of the patient from the very beginning of the traumatic episode. Thus, the application of physical therapy, occupational therapy, education, recreation, visiting by friends and relatives, entertainment and education by the mass media may all contribute to boost morale and maintain emotional stability.

Traditional Social Practice

Rehabilitation in this Region must also take note of significant cultural characteristics which differ so markedly in many ways from those of "the West". Traditionally, the people of the East have accepted a responsibility at a community and family level, for both physically and mentally handicapped persons and for the deaf and the blind.

This reliance on community acceptance has, to a large extent, to date, reduced the necessity of governments' acceptance of responsibility for the care of the handicapped and the aged. However, increased urbanization, with its accompaniment of reduced living space, is increasingly thrusting responsibility on governments for the care of the handicapped. This is one of the prices to be paid for "progress".

Yet there is a lesson to be learned by all of us, which is the necessity of enhancing the capability of the community for caring for the dependent. Rather than scrapping the wealth of the traditional approach, governments in our Region can support, foster, and develop the traditional, rather than rushing helter-skelter into elaborate and expensive programmes of institutionalization of the handicapped as a solution.

The importance of religion cannot be underestimated. The comfort and aid which seriously ill and injured patients can derive from their own beliefs, and from their spiritual advisers, can be a powerful aid in rehabilitation programmes. Courage may be restored, and the ability to face a long and perhaps tedious road back to society may be obtained more from spiritual sources then from the scientific disciplines.

Dependence on Institutions

Long residence in hospitals produces an excess of dependency on the hospital services. However, early discharge to the home environment may prove a formidable experience for a disabled person. He may suffer from an acute sense of inferiority,

because of the realization of his limitations. In addition, his family may feel disgusted or discontented with the return of a disabled family member to their care, and find the additional responsibility and strain on the family resources unacceptable. Thus an important factor in successful rehabilitation is counselling, both for the patient and his family. Both the family and the patient must be prepared for the return home.

Economic Rehabilitation

Particularly in urban centres, severe illness or accident may well be an economic catastrophe for the individual. Thus, it is often essential for the State to assume some responsibility to reduce the disastrous economic impact on the victim, until such time as he is again securely established as a wage-earner. The national economy will benefit from the restoration of the injured and the handicapped to a productive life as quickly as possible, rather than permitting them to continue as charges on the community.

Because of the vast implications of establishing a comprehensive rehabilitation programme, due note should be taken of the importance of Voluntary Organizations. Voluntary Organizations have played a most important role in this particular field in many countries. It is a very appropriate role for Voluntary Organizations who, with the availability of scientific support, can make economically feasible what would otherwise be impossibly expensive.

Increasing Demand

In our Region we face a diminishment of family responsibility, which is accompanying increasing industrial development, the augmentation of the numbers of vehicles in the countries and the unfortunate continuation of strife in many parts of the Region. These factors all produce an aftermath in the form of an increased demand for all types of rehabilitation services. Many of our urban developments include large numbers of exceedingly small dwellings, with overcrowding presenting an increasing problem, and resulting in a very high number of domiciliary accident cases, particularly burns from inadequate cooking facilities.

1981 - International Year of the Disabled

The United Nations is taking an increased interest in rehabilitation and at its very first session in 1976, the General Assembly proclaimed the year 1981 as the "International Year of the Disabled". The theme for the year is "Full Participation and Equality".

WHO - UNICEF Interest

For the first time in its history, UNICEF at the 1980 Session of its Executive Board, considered a general policy on disabled children as a separate agenda item. It received for discussion a special report by Rehabilitation International (E/ICEF/L.1410) which gives an excellent general review of the situation in so far as it concerns children. This study reviewed relevant literature and reported on a series of field observations of children with disabilities, in a global variety of countries which included from this Region Jordan and Saudi Arabia. Their report states at the beginning of the presentation, that one in every ten children is born with or acquires a physical, mental or sensory impairment and that little is done to prevent the occurrence of such impairments or their damaging consequences.

To quote from the report: "Throughout the world, the problems of disabled children are, in part, the product of centuries of ignorance, superstition and fear. In the developing countries the problems are combined with the inevitable limitations that accompany poverty and under-development. To improve the situation will require time, the change of human attitudes and behaviour, the integration of new concepts into human service programmes, and the modification of development strategies".

On a more optimistic note, the report continues: "A modest enrichment of training programmes for basic health, welfare, education and vocational services can expand their coverage to include children with disabilities. In fact, it is only through such improved application of existing human resources that there can be any hope of giving effective help to the millions of children affected, or in danger of being affected, by disability".

It is unfortunate, but we must recognize the fact, and realize that only a small percentage of the disabled, especially in the developing countries, have any access to the rehabilitation services they need.

WHO agrees with UNICEF in recognizing that the resources available may never be adequate. Both Organizations are committed to the principles of primary health care, and are at present actively supporting programmes for developing self-care techniques and training manuals for the family and the community.

WHO/EMRO Activity

WHO has been actively engaged in cooperation with the Governments in developing rehabilitation programmes for many years. In Jordan, we have supplied consulting services on the rehabilitation of handicapped children. In Syria, two full-time staff members are currently cooperating in developing physiotherapy and orthotics.

In Saudi Arabia, we also have two full-time staff members, and are now recruiting a third, a medical specialist in rehabilitation, for the programme there. So far, cooperation appears to be achieving excellent results, with for example a reduction of length of stay in hospital (four weeks for fractured femurs) and of the development in Riyad of a special unit for the care of spinal injuries.

Our cooperative programme in Iran, with the Regional Rehabilitation Centre, resulted in the training of over 150 orthopaedic technicians over the course of a very few years.

However, we face a world-wide shortage of specialist staff, and thus find it difficult to recruit the specialists most appropriate for assisting in developing national programmes. This is compelling us to focus our activity even more intensely on the prevention of disability. Many of our programmes are already directed towards this objective.

The Expanded Programme of Immunization will, through controlling poliomyelitis and measles, make a major contribution to reducing the neuro-muscular disability of poliomyelitis and the deafness, eye problems and chronic chest conditions often following measles. Our Prevention of Blindness programmes should have enormous effects in the area of the Upper Volta. In Pakistan and Sudan, we are helping to develop a programme for the provision of low-cost spectacles, which will assist in preventing blindness and also improve the capacity of many thousands to absorb education. We hope in the near future to intensify the road traffic accident prevention programme and note with great pleasure the leadership which Kuwait is giving in this field and their intention of convening a workshop/seminar on this subject early in 1981. We also have an industrial accident prevention programme in our Occupational Health Division which is well received.

Plans are also underway to enhance activities for the appropriate rehabilitation of psychosocially disabled persons. A regional meeting is scheduled to take place in 1981 and it is hoped that the exchange of information and sharing of experience will further strengthen the evolving activities in this field.

Conclusion

Because of the economic factors involved, we shall be forced to emphasize the principles of self-help, and to continue training of parents of handicapped children in home treatment techniques. We stand willing and ready to intensify our programme in rehabilitation and look forward to hearing the comments of and discussion by the participating countries.