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Brief Communication

Community, health and rehabilitation

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Abstract

The problems of guaranteeing the best possible social and health services in every part of the world to combat any form of disability and limitation of participation for all, as indicated by international ethical-political documents, are still very great. A critical point that could favour this progress is to enhance the integration between the growing potential of rehabilitation science (medical and clinical evidence, technologies, and training of numerous operators..) and the ability of communities as a whole to stimulate, support and qualify these interventions with the participation of citizens (families, neighbours and associations) who can voluntarily actively carry out important synergistic actions in many fields. This could develop in any socio-economic condition; in developed ones supporting and finalizing any treatment in common life and in developing countries offering competencies and knowledge to the strong funding actions of community projects aimed at populations with disabilities in this part of the World. The community of rehabilitation professionals, national governments and rulers, and international institutions (UN, WHO..) must well understand this aspect and make it their own in training, in the definition of care protocols, in the definition of the organization of socio-health and rehabilitation systems in each country in relation to the different local economic and cultural conditions.

More Information

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For years now, numerous documents from international organizations (UN, WHO ..) have defined the basic needs and rights of people with disabilities and described the conditions for the availability of economic, health, welfare, and community services and services that must make these rights concrete. Scientific documents have been produced that guide what must be the behaviours of Governments, non-governmental organizations, associations, volunteers, foundations and the many professionals who are involved in these actions in every part of the world.

However, the reality is still very varied in the different countries, naturally first of all in relation to the economic conditions of each country, in relation to the conditions of the social and health systems for the protection of citizens, and also sometimes in relation to the local cultural and religious conditions [1]. Which often implies a differentiated perception with respect to disability and social and individual commitment to contrast it.

Can be generally said that in the most economically advanced countries on the various continents, the development of social, economic, health, and cultural safeguards has evolved positively, often generating situations of effective prevention and contrast of discrimination and even conditions of social inclusion [2]. In these countries, however, the evolution of organizations, general and individual costs portend future difficulties in sustaining and continuously implementing these actions and also about the life expectancy indicators of the population as a whole [3,4].

Conversely, there are very many countries in which the situation of life, assistance and care for people with disabilities and limited functioning remain very negative. An important initiative in relation to this situation has been for many years to create Community-Based Rehabilitation to carry out international intervention programs in these countries: programs with socio-health potential even if related to the often minimal government organizations operating in these territories; programs that have their fundamental positive value precisely on the non-professional but voluntary and direct commitment of the Community in all its articulations (starting from the family to the neighbors).

Alongside this positive value, however, there are often inadequacies of the interventions and activities carried out by the "community" with the aim of rehabilitation, in relation to the optimal appropriateness and effectiveness to be achieved in the interest of the people at the center of these interventions [5,6]. It, therefore, appears necessary, also so that the often important funds that are mobilized are not lost, the progressive development, within these community programs, of networks of structures that correlate the needs and community interventions with more structured

programs, effective from a perspective of life, autonomy, and inclusion of these subjects. Progressive integration between community and non-professional activities in the territories with educational and school structures, with the possibility of assistance, work, mobility, and residential care, and undoubtedly health and rehabilitation structures. Therefore a progressive integration that enriches and finalizes community rehabilitation with the professional one and its potential that research is rapidly developing in richness and effectiveness.

Moreover, this validity and importance of the synergy between community and professional activity appear very important also for countries where the evolution of the professional component is already important but where very often the community component has not been adequately involved: just think of generalized awareness. Around the rights of persons with limited participation and functioning, to the active and dutiful ability of each to commit themselves so that they are really payable. We know how conscious and active motivation can be a condition of effectiveness for each individual rehabilitation project [7-9]. We know that the conditions of inclusion for all are realized only when all are aware of the real equality and equality of opportunity for everyone in the community.

They are symmetrical and synergistic issues that must be explored in the community of experts and professionals in rehabilitation and social integration, including by the stakeholders and in international organizations for an increasingly organic and positive development of programs to combat disability at every level.

Main health and rehabilitation international documents

WHO Declaration of Alma-Ata (1978) - *Resolution WHA58.23 on Disability* (2005) of the World Health Assembly - *United Nations Convention on the Rights of Persons with Disabilities* (2006-)- *Declaration of Astana* (2018), in which global leaders and Governments reaffirmed the commitments expressed in the 2030 Agenda for Sustainable Development, in pursuit of Health for All including prevention, management and rehabilitation and urges countries to promote and strengthen community-based rehabilitation (CBR) programs

There is growing interest in task-shifting approaches to healthcare with evidence of success. Driven by shortages of physicians, unbalanced workforce distribution in rural versus urban areas, and financial constraints, disruptive, low-cost healthcare delivery models are emerging and improving access to care. There is substantial evidence of the need for cooperation between specialized services and competencies with the community and primary health interventions [10,11].

World Bank endorses community-driven development programs as important elements of an effective poverty-reduction and sustainable development strategy. International Federation of the Red Cross/Red Crescent successfully uses approaches centered on community volunteers to address healthcare challenges.

Currently (2019) *WHO Rehabilitation 2030 Call for Action* sets out key activities described in detail in Rehabilitation in Health Services a Guide for Action and these are:

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 intersectoral links to effectively and efficiently meet population needs.
4. Incorporating rehabilitation into universal health coverage.
5. Building comprehensive rehabilitation service delivery models to progressively achieve equitable and affordable 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 each country's context and ensures rehabilitation, is a topic to be included in all health workforce education efforts.
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 using the International Classification of Functioning, Disability and Health (ICF).
9. Building research capacity and expanding the availability of quality evidence for rehabilitation.
10. Establishing and strengthening networks and partnerships in rehabilitation, particularly between low - middle - and high-income countries.

Suggestions for health systems in developing countries and not only, strengthening community power and roles

Contents and Aims of Community Based Rehabilitation can be easily connected: Community Based means that all actions and interventions listed in CBR Matrix are evaluated, realized, and managed in the Community (school, village, communication, funds, overcoming barriers....) and in the same time can be also delivered technical Aids, education and training for maintenance, to improve Functioning after or

instead of specialized interventions and all these are Based (and integrated) on Community, mainly by not-professional subjects (family, voluntaries, associations, caregivers, assistants, neighbors....). Actually, there is accepted awareness of the synergy between professional interventions (at any level of complexity, duration, and existing local health Service standards) and all Community-Based rehabilitation interventions.

By these points all participants in Rehabilitation activities (professional and non-professional) understand and accept that Community is for All the "place for functioning, health and inclusion", and they all are able to work, applying different responsibilities and duties, in this perspective, in any different socio-economical condition in any Country. Even today, the majority of persons with disabilities are victims of stigma and prejudice - society's attitude towards persons with disabilities. Besides rehabilitation and health care services, CBR plays a catalyst role in terms of changing mentalities and fighting prejudice and exclusion in every place and country.

It is therefore essential that:

- A) In countries with advanced socio-health and rehabilitation systems, enrich the synergy between all these potentialities of service to the citizen and guarantee their continuation and completion in the Community, underlining their relevance in the organization and management of the offer to the whole population and also in the training of health professionals at all levels. This need was made very evident during the phase of the Covid19 Pandemic but its importance clearly goes far beyond this particular contingency to strengthen, articulate and expand the distribution and effectiveness of enabling and rehabilitative interventions toward concrete inclusion for all.

- B) In developing countries the concept is completely similar but with specific attention to Community aspects. In fact, CBR programs, very widespread in these countries, are mainly active towards aspects of economic support and the supply of aid to people with disabilities and functional limitations as if this alone were able to achieve Inclusion. These projects involve local communities and organizations, families, non-professional operators, and volunteers who carry out great and meritorious work but are often not adequately correlated with scientific evidence with respect to the expectation of rehabilitation efficacy for many important problems of disability and functional limitations taken into account consideration. Obviously, voluntary and non-professional commitment cannot and must not be thwarted or transformed, but better integration must be built to expand the results that these CBR Programs can produce. Elements of this integration to create a sort of "Primary rehabilitation care" could be:

- The search for the coherence of those Community activities with elementary bases of scientific evidence in the various possible rehabilitation actions,

- The construction of minimal information training in this sense for non-professional people (mostly family members) who will be able to carry out such Community activities,

- When possible, the creation of a network linking the professional rehabilitation activities even existing in those countries to the Community ones (remote communication technologies? mobile services?).

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