



Community-Based Rehabilitation in Developing Regions: Access, Effectiveness, and a Capability-Centred Agenda for Inclusive Practice

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ARTICLE INFO

KEYWORDS

community-based rehabilitation;
disability; developing regions; capability
approach; access to healthcare; disability
inclusion; evaluation

HOW TO CITE

Diallo, F., Pérez, A. L., & O'Reilly, K.
(2026). Community-Based Rehabilitation
in Developing Regions: Access,
Effectiveness, and a Capability-Centred
Agenda for Inclusive Practice.
International Journal of Rehabilitation &
Disability Studies, 2(1), 33-42.

<https://doi.org/10.54878/7gtfoa57>

ABSTRACT

Community-based rehabilitation (CBR) remains the principal strategy through which low- and middle-income countries attempt to close the gap between the scale of rehabilitation need and the reach of formal health systems. Yet more than four decades after its introduction, the evidence on what CBR achieves, for whom, and under what conditions is still uneven, and much of the debate proceeds without a clear normative account of what rehabilitation is ultimately for. This paper offers an interdisciplinary synthesis. Drawing on published evaluations, systematic reviews, and recent programme reports from sub-Saharan Africa, South Asia, and Latin America, we examine patterns of access, documented effectiveness, and recurring barriers to CBR in developing regions. We then propose an integrated analytical framework that joins a sociological reading of structural exclusion with the capability approach as a normative anchor, and we outline a simple composite measure, a capability-adjusted rehabilitation access index, together with a modelling strategy that programmes could adopt with routinely collected data. Three findings stand out. First, unmet need is very large and socially patterned: poverty, rurality, gender, and stigma compound one another. Second, where CBR has been evaluated with credible designs it shows meaningful effects on independence, social inclusion, and livelihoods, but evaluation practice remains weak overall. Third, emerging digital and data-driven tools could strengthen CBR monitoring, provided that questions of equity, consent, and algorithmic bias are addressed from the outset. We close with recommendations for programme design, measurement, and policy that follow from treating people with disabilities as agents whose real freedoms are the proper measure of success.



Double-blind peer review by independent reviewers.

Received: 24 Jan 2026, Accepted: 13 May 2026, Published: 14 Jun 2026

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1. Introduction

The arithmetic of rehabilitation need is stark. An estimated 2.41 billion people worldwide live with health conditions that would benefit from rehabilitation at some point in the course of their illness or injury, a figure that has grown by roughly two thirds since 1990 as populations age and non-communicable diseases spread (Cieza et al., 2020). The majority of these people live in low- and middle-income countries (LMICs), where rehabilitation professionals are scarce, services are concentrated in cities, and public budgets rarely treat rehabilitation as a priority. The World Report on Disability estimated that about fifteen per cent of the world's population lives with some form of disability, and documented that in many LMICs only five to fifteen per cent of those who need assistive devices have access to them (WHO & World Bank, 2011). Kuper and Heydt (2019) put the point bluntly: roughly a billion people are effectively missing from health systems designed without them in mind.

Community-based rehabilitation emerged in the late 1970s precisely because the institutional model of rehabilitation could not be scaled to meet need of this magnitude. What began as a strategy for delivering basic rehabilitation through trained community workers has evolved, in the formulation of the WHO guidelines, into a broad approach to community development for the equalisation of opportunities, spanning health, education, livelihood, social participation, and empowerment (WHO, 2010). The strategy has since been folded into wider policy agendas, notably the UN Convention on the Rights of Persons with Disabilities (United Nations, 2006) and the WHO Rehabilitation 2030 initiative, which calls for rehabilitation to be integrated into health systems rather than treated as a charitable annex (WHO, 2017).

And yet CBR occupies an awkward position in the literature. Practitioners describe it as indispensable; reviewers describe the evidence base as thin, methodologically fragile, and difficult to compare across settings (Iemmi et al., 2015; Grandisson, Hébert, & Thibeault, 2014). Recent programme reports presented at the World Congress on Rehabilitation, several of them from districts and countries rarely represented in indexed journals, suggest both the vitality of the field and the persistence of old problems: catastrophic gaps in access, chronic underfunding, and evaluation practices that stop at counting activities rather than measuring changed lives (Kabir, 2024; Tadyanemhandu, Shava, Chengetanai, & Mkandla, 2024).

This paper has three aims. The first is descriptive: to draw together what published evidence tells us about access to

and effectiveness of CBR in developing regions, with particular attention to sub-Saharan Africa, South Asia, and Latin America. The second is analytical: to propose a framework, and a small set of measurable quantities, that connect the sociological determinants of exclusion to the outcomes that matter. The third is normative: to argue, following the capability approach, that the proper test of a rehabilitation programme is not the volume of services delivered but the expansion of what people with disabilities are actually able to do and to be (Mitra, 2006). We write as a sociologist, a data scientist, and a philosopher, and the paper is deliberately structured so that these three registers speak to one another rather than past one another.

The remainder of the paper proceeds as follows. Section 2 sets out the conceptual foundations. Section 3 describes our review methods and analytical approach. Section 4 presents the synthesis of evidence on need, access, and effectiveness. Section 5 develops the integrated framework and its associated measures. Section 6 discusses implications, including the promise and risk of data-driven tools, and Section 7 concludes with recommendations.

2. Background and Conceptual Foundations

2.1 The evolution of community-based rehabilitation

CBR was conceived as a response to a supply problem: specialist rehabilitation could reach only a small minority of people who needed it, and almost none of those living in rural poverty. Early programmes trained local workers and family members to deliver simplified interventions at home. Over time, criticism from disabled people's organisations pushed the strategy away from a narrowly medical cast toward community development and rights. The 2010 WHO guidelines codified this shift in the CBR matrix, which organises the field into five components, health, education, livelihood, social, and empowerment, each with five elements (WHO, 2010). Table 1 reproduces the structure. The matrix matters not because every programme must do everything, but because it makes visible the claim that rehabilitation detached from schooling, work, and social participation will not, by itself, change the position of disabled people in their communities.

Table 1. The WHO community-based rehabilitation matrix: components and illustrative elements (adapted from WHO, 2010).

Component	Illustrative elements	Primary orientation
Health	Promotion; prevention; medical care; rehabilitation; assistive devices	Functioning and access to care
Education	Early childhood; primary; secondary and higher; non-formal; lifelong learning	Knowledge and skills across the life course
Livelihood	Skills development; self-employment; wage employment; financial services; social protection	Economic security and independence
Social	Personal assistance; relationships, marriage and family; culture and arts; recreation and sport; justice	Participation in community life
Empowerment	Advocacy and communication; community mobilisation; political participation; self-help groups; disabled people's organisations	Voice, agency, and collective action

2.2 Sociological perspectives: structure, stigma, and the social model

Sociology's central contribution to disability studies has been to relocate the "problem" of disability from the individual body to the organisation of society. The social model, in its classic formulation, distinguishes impairment from disability and identifies the latter with socially imposed barriers, inaccessible institutions, discriminatory labour markets, and exclusionary norms (Oliver, 2013). Thirty years of debate have complicated the picture. Shakespeare (2006) argues persuasively that a model which brackets the lived reality of impairment cannot fully account for the experience of disabled people, particularly where pain, fatigue, or degenerative conditions are involved, and that an adequate account must hold the biological and the social together. For CBR in developing regions this debate is not academic. Programmes that treat disability purely as a medical deficit tend to deliver services without touching the structures that reproduce exclusion; programmes that treat it purely as social construction risk neglecting the concrete therapeutic and assistive needs that families identify as their most urgent priorities.

The empirical sociology of disability in LMICs adds a further, well-documented regularity: disability and poverty are entangled in both directions. In their systematic review of 150 studies, Banks, Kuper, and Polack (2017) found that eighty-one per cent reported a positive association between disability and poverty, an association robust across countries, age groups, and measures. Disability raises the cost of living and depresses earnings; poverty raises the risk of impairment and

restricts access to services that might limit its consequences. Any serious analysis of CBR must therefore treat livelihood and social protection not as optional extras but as core rehabilitation.

2.3 The capability approach as a normative anchor

If the social model tells us where barriers come from, it is less explicit about what success looks like. Here the capability approach, developed by Amartya Sen and Martha Nussbaum and applied to disability most influentially by Mitra (2006), does useful work. On this view, the currency of justice is neither resources nor subjective satisfaction but capabilities: the real freedoms people have to achieve beings and doings they have reason to value. Disability is understood as a deprivation of capabilities that arises from the interaction of personal characteristics, the resources available to a person, and the environment. Two people with identical impairments may face very different capability sets depending on whether their village has an accessible school, whether local employers will hire them, and whether their family can absorb the extra costs of disability.

Three consequences follow for CBR. First, outcome measurement should reach beyond clinical function to participation, choice, and agency. Second, because capabilities depend on conversion factors that vary from person to person, equal provision is not the same as equal opportunity; programmes must attend to who can actually convert services into functionings. Third, empowerment, often the vaguest component of the CBR matrix, acquires a precise meaning: expanding people's effective power to shape their own lives and the decisions

that affect them. These consequences inform the framework we develop in Section 5.

3. Methods

This paper is an integrative review with an analytical extension. We did not undertake a new systematic review; rather, we built on the existing corpus of systematic reviews and added recent primary reports, then used the combined material to develop a framework and measurement proposals.

Our evidence base was assembled in three steps. Step one identified the major syntheses of CBR evidence in LMICs: the Campbell systematic review of CBR effectiveness (Iemmi et al., 2015), the systematic review of access to rehabilitation (Bright, Wallace, & Kuper, 2018), the review of evaluation methods in CBR (Grandisson et al., 2014), and the poverty–disability review (Banks et al., 2017), alongside the framing documents of the field (WHO, 2010; WHO & World Bank, 2011; WHO, 2017; United Nations, 2006). Step two added primary studies with credible causal or descriptive designs, notably the quasi-randomised impact evaluation of CBR in Mandya district, India (Mauro, Biggeri, Deepak, & Trani, 2014), and recent programme analyses from Bangladesh (Kabir, 2024) and Zimbabwe (Tadyanemhandu et al., 2024) published through the Emirates Scholar Center's World Congress on Rehabilitation proceedings. Step three incorporated work on emerging data-driven approaches relevant to rehabilitation monitoring and diagnosis, including a recent review in this journal of artificial intelligence in neurodevelopmental care (Alshamsi & Alhammadi, 2025).

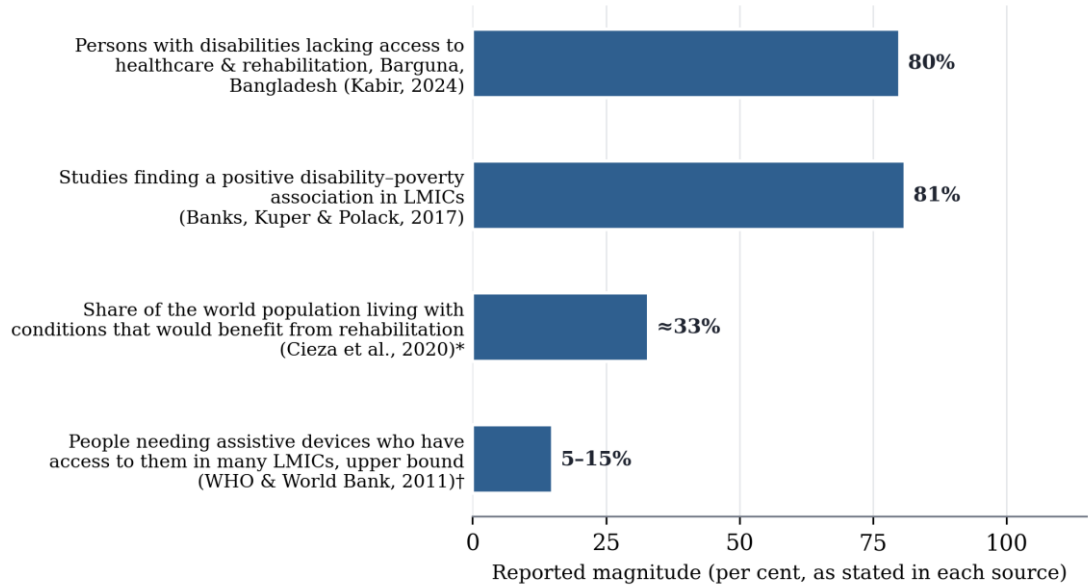
Studies were read against three questions: what do they show about the scale and social patterning of unmet

rehabilitation need; what do they show about the effectiveness of CBR; and what barriers and enabling conditions do they identify? Because the designs range from randomised comparisons to small qualitative studies, we make no attempt at meta-analysis. Instead we report findings narratively, flag the strength of the underlying design where it matters, and are explicit when a number is an estimate carried over from a single source. The analytical extension in Section 5, the index and the model specification, is a proposal for future use rather than an analysis we have performed on new data; we state its assumptions and data requirements so that programmes can judge its feasibility.

4. Findings

4.1 The scale and social patterning of unmet need

Four numbers, drawn from the sources above, frame the problem, and Figure 1 sets them side by side. Roughly one person in three worldwide lives with a condition that would benefit from rehabilitation (Cieza et al., 2020). In many LMICs, only five to fifteen per cent of people who need assistive devices have them (WHO & World Bank, 2011). In Barguna, one of the poorest and most climate-exposed districts of Bangladesh, a recent stakeholder study found that eighty per cent of persons with disabilities lacked access to adequate healthcare and rehabilitation facilities (Kabir, 2024). And across the LMIC literature as a whole, four studies in five find disability and poverty positively associated (Banks et al., 2017). None of these figures is surprising on its own; together they describe a system in which need is greatest precisely where provision is weakest.



*Cieza et al. (2020) estimate 2.41 billion people — roughly one in three — live with conditions that would benefit from rehabilitation.
†WHO & World Bank (2011) report that in many low- and middle-income countries only 5–15% of those who require assistive devices have access.

Figure 1. Reported magnitudes of rehabilitation need and access gaps in the cited literature. Each bar reproduces a figure as stated in its source; sources and qualifications are given in the notes.

The patterning matters as much as the scale. Bright, Wallace, and Kuper (2018), reviewing access studies across LMICs, found that utilisation of rehabilitation services was consistently lower among poorer households, rural residents, and, in many settings, women and girls; the most frequently reported barriers were cost, transport, and lack of information about what services existed. Kabir's (2024) respondents in coastal Bangladesh add a dimension that will become more prominent: environmental vulnerability. Cyclones and salinity intrusion undermine livelihoods, and households coping with climate shocks postpone or abandon rehabilitation expenditure first. The sociological reading is straightforward. Access is not a matter of individual health-seeking behaviour; it is stratified by the same structures, class, gender, geography, that stratify everything else.

4.2 Regional experiences

Sub-Saharan Africa. The Zimbabwean programme analysed by Tadyanemhandu and colleagues (2024) illustrates both the reach and the fragility of African CBR. Operating through village health workers and local rehabilitation technicians, the programme improved access to basic services and created channels for empowerment in communities with effectively no specialist provision. Yet the analysis also records familiar constraints: dependence on external funding, uneven training and supervision, and difficulty retaining volunteers whose own livelihoods are precarious. Similar patterns recur across the continent, where CBR often functions as the de facto rehabilitation system rather than a complement to a formal one. The policy implication

drawn in the study is one we endorse: CBR needs to be anchored in national health systems and budgets, not left to the project cycle of donors.

South Asia. South Asia contributes the strongest causal evidence in the CBR literature. Mauro, Biggeri, Deepak, and Trani (2014) evaluated a mature CBR programme in Mandya district, India, using a quasi-randomised design comparing new entrants with matched controls. They found significant positive effects on activities of daily living, social inclusion, and, for adults, work opportunities, effects that were larger for people with more severe impairments. Bangladesh presents the other face of the region: Kabir's (2024) Barguna study documents what the absence of such programmes means in a district where poverty and climate exposure compound disability. The juxtaposition is instructive. CBR can work, and work best for those who need it most; but its coverage is thin exactly where conditions are hardest.

Latin America. Latin America is comparatively under-represented in the indexed CBR literature, a gap noted by reviewers (Iemmi et al., 2015; Bright et al., 2018), though the region has a long tradition of community health work into which rehabilitation has been folded with varying success. The access studies that do exist echo the barriers found elsewhere, cost, distance, and fragmented referral systems, while adding a distinctive institutional feature: relatively strong disability rights legislation whose implementation lags far behind its text. For the data-science agenda developed below, the region's comparatively good administrative data systems make it a promising setting for the kind of routine outcome monitoring that CBR evaluation has lacked.

Table 2. Selected evidence on community-based rehabilitation and access in developing regions.

Study	Setting	Design	Key findings
Mauro et al. (2014)	Mandya district, India	Quasi-randomised impact evaluation	Significant gains in independence, social inclusion, and work opportunities; larger effects for severe impairments
Iemmi et al. (2015)	LMICs (15 studies)	Campbell systematic review	CBR may improve clinical outcomes and functioning; evidence base small, heterogeneous, and methodologically weak
Bright et al. (2018)	LMICs (77 studies)	Systematic review of access	Utilisation consistently lower for poor, rural, and female populations; cost,

			transport, and information the leading barriers
Banks et al. (2017)	LMICs (150 studies)	Systematic review	81% of studies find a positive disability–poverty association
Kabir (2024)	Barguna district, Bangladesh	Stakeholder interviews and focus groups (n = 50)	80% of persons with disabilities lack access to adequate healthcare and rehabilitation; climate shocks deepen exclusion
Tadyanemhandu et al. (2024)	Zimbabwe	Programme analysis	CBR extended basic access and empowerment where specialist services were absent; sustainability constrained by funding and workforce attrition

4.3 What the effectiveness literature shows, and what it cannot

The Campbell review remains the most careful accounting of CBR effectiveness to date. Across the fifteen studies that met inclusion criteria, Iemmi and colleagues (2015) found evidence that CBR can improve clinical outcomes, functioning, and quality of life for people with various disabilities, and can benefit carers, but they were equally clear about the limits: few controlled designs, short follow-up, outcome measures that vary from study to study, and almost no cost-effectiveness data. Grandisson, Hébert, and Thibeault (2014), reviewing how CBR evaluations are actually conducted, found a field dominated by process indicators, activities run, people reached, with participation of disabled people in evaluation design more often recommended than practised.

It is worth pausing on why this matters. Weak evaluation is not merely an academic deficiency; it has distributional consequences. Programmes that cannot demonstrate

outcomes struggle to claim public budgets, and so remain donor-dependent, and so remain short-lived, which is precisely the fate the Zimbabwean and Bangladeshi studies describe. The path from measurement to sustainability runs through the ministry of finance. This is one reason we give measurement a central place in the framework that follows, and it is also where emerging data infrastructure, including the AI-supported approaches reviewed by Alshamsi and Alhammad (2025) in the diagnostic context, may eventually lower the cost of knowing what a programme achieves.

4.4 Barriers across regions

Table 3. organises the barriers reported across the reviewed studies into five categories. The consistency across settings as different as coastal Bangladesh, rural Zimbabwe, and peri-urban Latin America is itself a finding: the obstacles to rehabilitation access are structural and predictable, which means they are also, in principle, addressable by design rather than by exhortation.

Table 3. Recurring barriers to rehabilitation access in developing regions, synthesised from the reviewed literature.

Category	Typical manifestations	Principal sources
Financial	Direct costs of care and devices; transport costs; income forgone by carers; catastrophic spending after climate or health shocks	Bright et al. (2018); Banks et al. (2017); Kabir (2024)
Geographic	Services concentrated in cities; long travel distances; inaccessible terrain and transport	WHO & World Bank (2011); Bright et al. (2018)
Informational	Families unaware services exist; low referral rates from primary care; no outreach	Bright et al. (2018); Tadyanemhandu et al. (2024)

Attitudinal	Stigma and shame; low expectations of disabled people; gendered restrictions on care-seeking	Oliver (2013); Shakespeare (2006); Banks et al. (2017)
Systemic	Rehabilitation absent from health budgets and insurance; workforce shortages; donor-dependent programmes; weak monitoring data	WHO (2017); Iemmi et al. (2015); Tadyanemhandu et al. (2024)

5. An Integrated Framework and Measurement Proposal

5.1 The framework

Figure 2. draws the threads together. Structural conditions (poverty, health-system capacity, social norms, environmental risk) and the policy environment (CRPD commitments, national strategies, financing, data systems) jointly shape what CBR

programmes can deliver across the five matrix components. Programme delivery, in turn, is assessed not by outputs but by capability outcomes: gains in functioning, yes, but also expanded real choices, economic participation, belonging, and agency. The dashed return path records the insight, sociological and philosophical at once, that participation feeds back into norms and policy: people with disabilities who are visible in schools, workplaces, and public decision-making change the conditions under which the next cohort seeks rehabilitation.

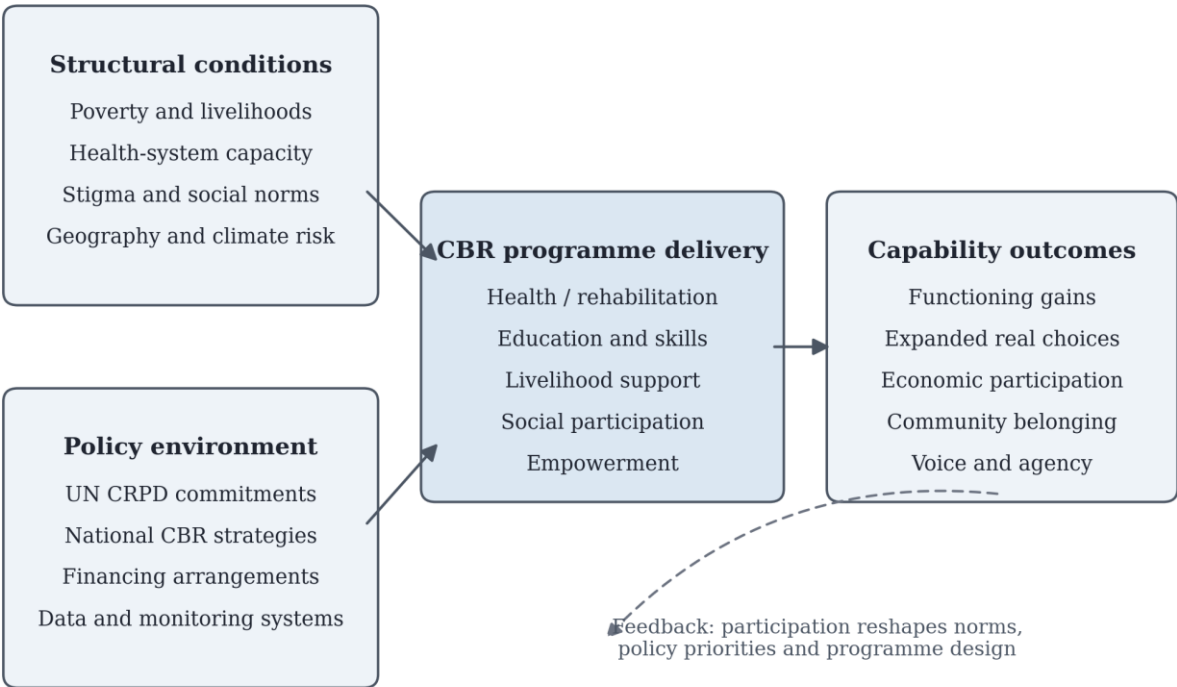


Figure 2. A capability-centred framework for analysing community-based rehabilitation in developing regions.

5.2 A capability-adjusted rehabilitation access index

Evaluation practice in CBR needs measures that are simple enough to compute from routine data yet faithful to the capability view of outcomes. We propose a composite of the following form. For individual *i*, define a capability-adjusted rehabilitation access index

$$CARAI_i = \sum_{k=1..5} w_k \cdot a_{ik} \text{ , with } \sum w_k = 1, 0 \leq a_{ik} \leq 1 \text{ (1)}$$

where *a_{ik}* measures person *i*'s effective access within CBR component *k* (health, education, livelihood, social,

empowerment), scored not by whether a service nominally exists but by whether the person could actually use it, the capability-relevant question. The weights *w_k* should be set participatorily, by disabled people's organisations in the programme area, rather than fixed by researchers; this operationalises the capability approach's insistence that people are agents in defining valuable outcomes (Mitra, 2006) and answers Grandisson et al.'s (2014) call for participatory evaluation. A programme-level index is the mean over participants, and the distribution, not only the mean, should be reported: a programme that raises the average while leaving the most excluded untouched has failed on its own terms.

To identify who remains excluded and why, we propose that programmes model effective access with routinely collected covariates. A minimal specification is the logistic model

$$\text{logit } P(A_i = 1) = \beta_0 + \beta_1 \text{Poverty}_i + \beta_2 \text{Rural}_i + \beta_3 \text{Female}_i + \beta_4 \text{Severity}_i + \beta_5 \text{Distance}_i + \epsilon_i \quad (2)$$

where A_i indicates effective access to a needed service. The purpose is diagnostic rather than academic: the fitted coefficients tell a programme which conversion factors are binding locally, whether the dominant barrier is affordability, distance, gendered norms, or severity-related need for outreach, and therefore where to spend the next unit of budget. The covariates in (2) are exactly those the access literature identifies as decisive (Bright et al., 2018; Banks et al., 2017), and all can be collected in a one-page intake form. Where programmes operate across many villages, multilevel versions of (2) separate individual from community-level variation, which speaks directly to the sociological claim that exclusion is a property of places and institutions, not only of persons.

5.3 What this asks of programmes

The data demands are deliberately modest: an intake form, a periodic follow-up of the five access scores, and participatory weight-setting workshops repeated every few years. The analytic demands, one composite index and one regression, are within reach of a district health office with basic statistical support, and are far cheaper than the external evaluations programmes currently commission at donor insistence. What the proposal mainly requires is a change of habit: from counting services delivered to asking, systematically and disaggregatedly, whether people can do more than they could before.

6. Discussion

6.1 Reading the evidence sociologically

The synthesis supports a structural reading of rehabilitation exclusion. The same variables recur in every setting: poverty, distance, gender, stigma, and the capacity of the surrounding system. This has an uncomfortable implication for programme design. CBR projects that operate as enclaves, delivering services while leaving labour markets, schools, and local politics untouched, will show modest and perishable effects, because the mechanisms that produce exclusion remain intact. The stronger results in Mandya (Mauro et al., 2014) came from a mature programme embedded in local institutions for over a decade, with self-help groups and livelihood components alongside therapy. Duration and

embeddedness are not incidental features; they are the treatment.

6.2 Measurement, data, and the uses of new technology

A recurring theme of this paper is that CBR's evaluation deficit is a policy problem. Here developments in data science bear directly on the field's future. At the diagnostic end, Alshamsi and Alhammadi (2025) review how artificial intelligence combined with multi-omics data is beginning to shift the identification of neurodevelopmental disorders from delayed behavioural assessment toward earlier, biology-informed detection, while cautioning that small cohorts, cost, privacy, and algorithmic bias currently limit clinical translation. The nearer-term opportunity for CBR is humbler and, we would argue, more consequential: mobile data collection by community workers, routine computation of indices like (1), and simple predictive models flagging participants at risk of drop-out. None of this requires frontier methods. It requires interoperable records, modest training, and a commitment to publish results, including disappointing ones.

Two cautions apply. First, digital tools inherit the access gradients documented above; if follow-up migrates to smartphones, the poorest participants become invisible to the data exactly as they are to services. Second, prediction can quietly become allocation. A model that identifies participants "unlikely to benefit" invites triage that a capability framework forbids, since the point of the enterprise is precisely to change the conditions that make benefit unlikely. Data systems for CBR should be designed with disabled people's organisations at the table, with consent processes appropriate to low-literacy settings, and with bias audits as standard practice.

6.3 The normative stakes

Philosophically, the choice of outcome measures is a choice about what rehabilitation is for. If the metric is services delivered, the implicit theory is charity. If the metric is clinical function, the implicit theory is repair. The capability approach supplies a third answer, freedom, and it is notable how closely it converges with what disabled people's movements have demanded and what the CRPD codifies: participation on an equal basis with others (United Nations, 2006; Mitra, 2006). This convergence is practically useful. It means the normative framework we propose is not an external imposition on the field but a systematisation of commitments the field has already made, and it gives evaluators a principled basis for resisting the drift back toward output counting whenever budgets tighten.

6.4 Limitations

Three limitations should be kept in view. First, this is an integrative rather than a systematic review; we prioritised the strongest available syntheses and recent primary reports, but we did not search exhaustively, and the regional balance of the literature, thin for Latin America in particular, constrains what any synthesis can say. Second, several access figures we cite, including the eighty per cent estimate for Barguna, derive from single studies with modest samples and should be treated as indicative rather than precise. Third, the index and model of Section 5 are proposals; their measurement properties, especially the behaviour of participatory weights across cultural settings, remain to be established empirically. We regard each limitation as an agenda item rather than a caveat to be filed away.

7. Conclusion and Recommendations

Community-based rehabilitation sits at the intersection of the largest unmet need in global health and the oldest demand of the disability movement: nothing about us without us. The evidence reviewed here shows that the need is vast and socially patterned, that CBR can deliver real gains in independence and participation when it is embedded and sustained, and that the field's chronic weakness in measurement undermines both its funding and its accountability to the people it serves.

Five recommendations follow. Governments should integrate CBR into national health systems and budgets, as Rehabilitation 2030 urges, rather than leaving it to donor cycles (WHO, 2017). Programmes should adopt capability-oriented measurement of the kind sketched in Section 5, with weights set by disabled people's organisations and results reported disaggregated by poverty, gender, and severity. Funders should require, and pay for, evaluation designs capable of supporting causal claims, of which Mandya remains the exemplar (Mauro et al., 2014). Researchers should direct attention to the under-studied regions, Latin America foremost, and to cost-effectiveness, the largest single gap in the literature (Iemmi et al., 2015). And those building the field's emerging data infrastructure should treat equity, consent, and bias auditing as design requirements rather than afterthoughts (Alshamsi & Alhammadi, 2025).

The deeper point is simpler. A rehabilitation programme succeeds when a girl with cerebral palsy in Barguna can go to school, when a man injured in Harare can earn again, when their families are not driven into poverty by the attempt, and when both have a say in the services meant for them. Everything else, indices included, is instrumentation in the service of that end.

Declarations

Conflict of interest. The authors declare no conflict of interest.

Funding. This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Acknowledgements. The authors thank colleagues at their respective departments for comments on an earlier draft.

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