

Global Community-Based Rehabilitation Practices for Persons with Disabilities: A Systematic Review

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ABSTRACT

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Community-Based Rehabilitation (CBR) serves as a significant effort of global disability-inclusive development and access to rehabilitation services for persons with disabilities (PWDs). Despite this programme being recognised as effective and emphasising a community-driven model, CBR implementation and practices vary across regions due to contextual, structural, and policy-related disparities. This systematic review rigorously assesses global evidence on CBR implementation practices. A comprehensive search was conducted across major scientific databases in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. 29 eligible studies between 2022 and 2025, and indexed up to 21 April 2026. The studies were appraised using the Mixed Methods Appraisal Tool (MMAT) for checklist-based quality criteria. Data were synthesised thematically. Collectively, the six main implementation practices underscore the complexity of translating the CBR principles into effective practice: (1) Community Participation and Empowerment; (2) Standardisation vs Flexibility; (3) Capacity Building; (4) Multidisciplinary Approaches and Intersectoral Coordination; (5) Sustainability and System Capacity; and (6) Monitoring, Evaluation and Learning. Integrated policy frameworks, consistent resource mobilisation, workforce development, and stronger community partnerships are required to strengthen the CBR implementation. The review provides valuable insights for policymakers, practitioners, and researchers seeking to enhance CBR effectiveness and to uplift disability inclusion globally.

Contribution/Originality: This study contributes to the existing literature by providing a comprehensive synthesis of global CBR implementation practices across 29 empirical studies. It develops a six-theme implementation framework that highlights

key practices that support sustainable, inclusive, and community-based rehabilitation. This offers practical guidance for policymakers, practitioners, and future researchers.

1. Introduction

Community-based rehabilitation (CBR) has been widely implemented, particularly in low- and middle-income countries, to address the challenges faced by persons with disabilities (PWDs) (Blose et al., 2024), where access to specialised services is usually limited (Beckerlegge & Asthana, preprint, 2025). CBR has long been reported as being implemented in over 90 countries, aiming to enhance access to rehabilitation services for persons with disabilities, initially in rural areas and later extended to urban populations (Iemmi et al., 2017; Shumba et al., 2021). The programme is designed based on a multisectoral approach to foster an inclusive environment in which persons with disabilities can enjoy equal access to rights and opportunities within their communities (Tofani et al., 2021). It is part of the development strategy, which aims to promote rehabilitation services, equal opportunity, and social inclusion of PWDs by offering rehabilitation services, education, and training not only for PWDs but also for their families and local community members (Besoain-Saldaña et al., 2020). It has progressed beyond its primary focus of providing access to health and rehabilitation services for PWDs.

In modern society, the CBR has evolved into a comprehensive strategy that encompasses a wide range of implementation approaches and practices. It includes education, livelihood development, social participation, and empowerment (Blose et al., 2021). A variety of models and strategies are used to meet the diverse needs of individuals and local communities. Despite the widespread adoption of CBR as a strategy for poverty alleviation, social inclusion, and the equalisation of opportunities, persons with disabilities continue to face significant infringements of their human rights and limited access to basic services, particularly in low- and middle-income nations (Blose et al., 2021).

Empirical studies show gaps in CBR implementation, with programmes in parts of Asia and Africa still heavily focusing on health components. Meanwhile, other components, such as social, livelihood, and empowerment, remain underdeveloped (Asres, 2025; Wolderufael, 2022; Cutamora et al., 2025). Workforce-related gaps are also prominent, including insufficient training, limited conceptual understanding of CBR, and weak supervision systems, mainly in low-resource settings, while emerging task-sharing models lack sufficient evidence on scalability (Ayalew et al., 2020; Weber et al., 2021). Furthermore, weak intersectoral coordination and fragmented service delivery are consistently reported in Latin America and Asia, in contrast to more integrated yet context-specific models in higher-income settings (Agudelo-Hernández et al., 2025; Zhu et al., 2025; Thilarajah et al., 2025). In the African continent, sustainability challenges remain pervasive. Insufficient funding, limited innovative financing models, weak governance, and socio-economic challenges affect long-term implementation (Vaughan & Thapa, 2023; Pasara, 2022; Al Imam et al., 2022). In addition, the monitoring and evaluation process and systems are indicated as underdeveloped globally. Limited use of standard and contextually validated indicators, especially in low- and middle-income countries, highlights a significant gap between programme learning and evidence-based implementation (Goto et al., 2025; Asres, 2025).

The primary objective of the systematic review is to study and synthesise CBR implementation practices across diverse global contexts. By mapping regional approaches and experiences, this study emphasises a deep understanding of the evolving landscape of CBR and highlights the strategies that effectively address the needs of PWDs. It aims to generate significant insights to guide policymakers, practitioners, and researchers in enhancing CBR implementation and practices. Ultimately, this review aims to advance social work and disability-inclusive development by advocating for equitable access to rehabilitation services and promoting greater social inclusion for the global PWDs community.

1.1. Research Question and Research Objective

This study aims to investigate this research question and objective as follows:

- i. Research Question:
What are the key implementation practices of Community-Based Rehabilitation (CBR) programmes for persons with disabilities across different global contexts?
- ii. Research Objective:
To systematically review and synthesise global evidence on the implementation practices of Community-Based Rehabilitation (CBR) programmes for persons with disabilities.

2. Research Methods

The systematic review utilised the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) methodology. The main purpose was to bring together the scattered knowledge on the topic into a more consistent understanding.

Table 1 presents the database-specific search strings used to identify studies related to CBR implementation practices. The search strategy was adapted according to the indexing requirements of each database while maintaining consistent core concepts across all searches. The search combined CBR terms, disability terms, and implementation-related terms, including implementation, practice, approach, and strategies. Although these database searches yielded numerous publications, the most suitable were carefully selected based on the study's objectives. Duplicate records were removed, and the remaining articles were narrowed down by reading each article's title and abstract.

Table 1: Keywords used in Article Searching for each Database

Databases	Keywords used
Scopus	TITLE-ABS-KEY ("community-based rehabilitation" AND ("person* with disabilit*" OR "people with disabilit*" OR PWD*) AND (implementation OR practice* OR approach* OR strateg*))
Emerald	"community-based rehabilitation" AND ("persons with disabilities" OR "people with disabilities") AND (implementation OR practice OR approach OR strategies).
Springer Nature Link	"community-based rehabilitation" AND (implementation OR practice OR approach* OR strategy* OR framework* OR model* OR "service delivery" OR intervention)

Science Direct	"community-based rehabilitation" AND (implementation OR practice OR approach* OR strateg* OR framework* OR model* OR "service delivery" OR intervention)
Web of Science	TS=("community-based rehabilitation" AND (implementation OR practice OR approach* OR strateg* OR framework* OR model* OR "service delivery" OR intervention))
Google Scholar	"community-based rehabilitation" implementation OR practice OR approach OR strategies

A thorough search across several databases, including Scopus, Emerald, Springer Nature Link, ScienceDirect, Web of Science, and Google Scholar, was part of the review process. Reviewing literature from various databases is highly significant, offering a wide range of sources across many fields, such as the social sciences, the arts, and the humanities. The study guarantees a comprehensive examination of the literature by sweeping across several databases, recording, analysing and understanding the challenges of CBR implementation from a range of ideas and perspectives.

The predefined inclusion and exclusion criteria applied during study selection are summarised in Table 2. To ensure the analysis is based on empirical evidence, only research articles are selected. Non-research articles, systematic literature review journals, book chapters, and conference proceedings were excluded. To ensure the analysis and discussion reflect the current implementation and development of CBR, the selected English articles are limited to publications from 2020 to 2026, and indexed up to 21 April 2026. Studies published before 2020 were excluded to maintain the relevance of the findings, and non-English publications were excluded to avoid potential translation bias and ensure consistency in the analysis. Only studies related to Social Science and Health were included, as these fields directly contribute to understanding CBR implementation for persons with disabilities.

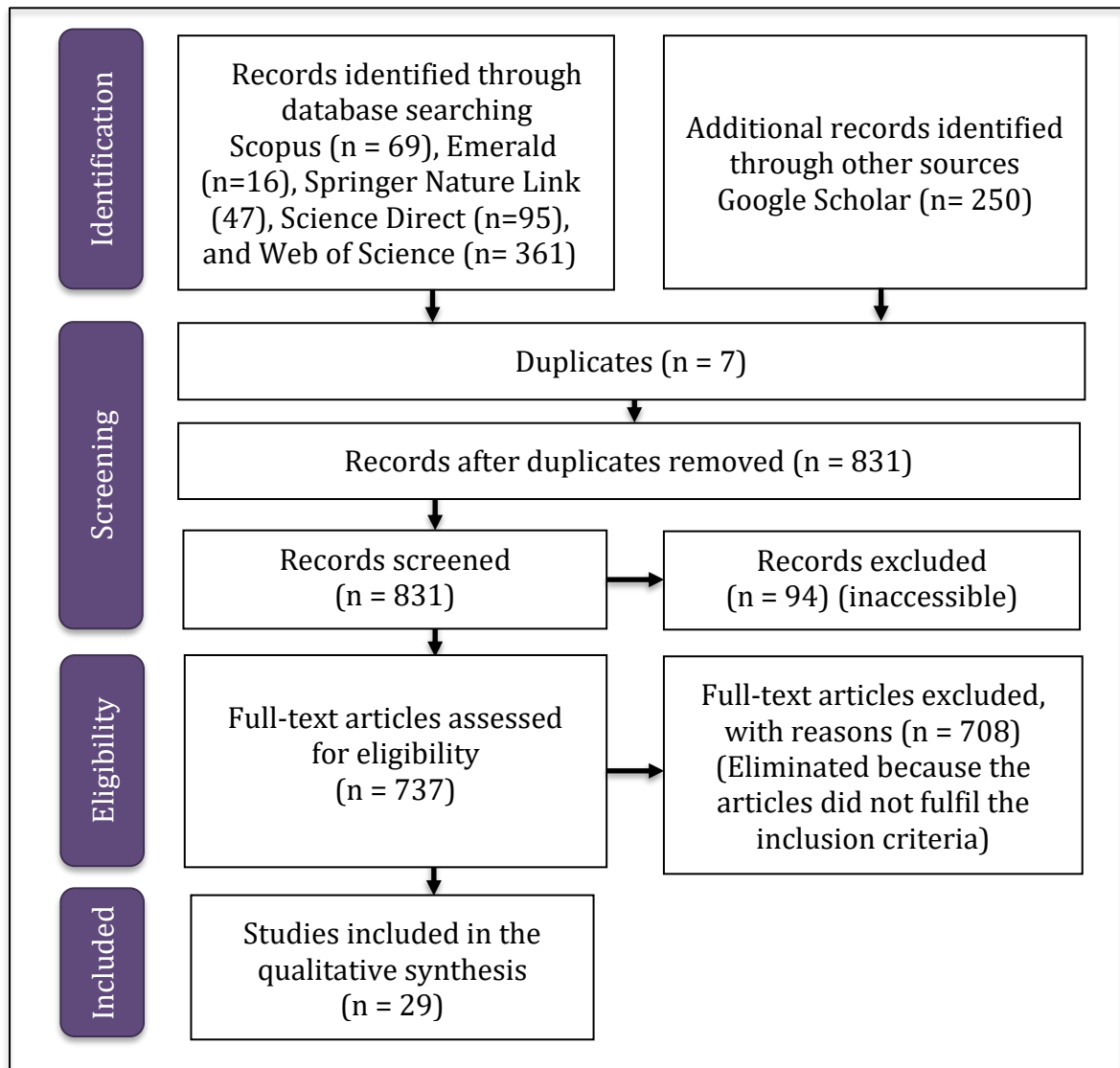
Table 2: Inclusion and Exclusion Criteria for Article Selection

Criterion	Inclusion	Exclusion
Document type	Peer-reviewed Journal Articles	Non-research articles, chapters in books, conference proceedings, grey literature, NGO reports, and technical reports
Language	English	Non-English
Year of publication	Between 2020 and 2026	Below 2020
Topical Relevance	Community-based rehabilitation (CBR) or a similar programme	Irrelevant to Community-based rehabilitation (CBR) or a similar programme
Thematic Relevance	CBR Implementation Practices	Not related to the CBR Implementation Practices

Figure 1 illustrates the PRISMA screening process used to identify eligible studies. A thorough search was conducted across the main academic databases with comprehensive coverage of the social sciences, health and rehabilitation, and disability studies to identify relevant literature. From the search, a total of 838 records were identified through database searching and other sources. The specific contributions are from Scopus (n=69), Emerald (n=16), Springer Nature Link (n=47), ScienceDirect (n=95), WoS (n=361), and Google Scholar (n=250). These were potentially relevant records, particularly the CBR studies. After that, the screening process was conducted by reviewing the articles' titles, abstracts, and relevant keywords to assess the suitability of the studies towards this

study. After duplicate removal, 831 records were screened; 94 records were excluded because full text could not be retrieved, leaving 737 full-text reports assessed for eligibility. Each article was carefully evaluated against predefined inclusion and exclusion criteria. Further analysis excluded studies that were not directly focused on CBR investigations or that did not provide empirical data. Only those articles that satisfied the strict selection criteria remained after 708 articles were eliminated.

Figure 1: PRISMA flow diagram for systematic review of CBR implementation practices



The last stage of the methodology involved choosing studies for qualitative synthesis. A total of 29 studies were identified as suitable and fit for analysis. The quality of the included studies was also assessed by using the Mixed Methods Appraisal Tool (MMAT), version 2018 (Hong et al., 2018). The MMAT was selected because the review included qualitative, quantitative, and mixed-methods studies. It allows consistent appraisal across multiple research designs using a single validated instrument. Thematic analysis was then applied to identify recurring themes and patterns. All selected studies provide valuable insights into CBR implementation practices. By using this systematic approach, the study's results were based on studies that met the predefined inclusion criteria and were appraised for methodological quality. The PRISMA framework enhances the transparency and replicability of the review process and supports the study's credibility.

3. Results

A thematic analysis approach was employed to synthesise findings across studies (Braun & Clarke, 2006). Table 3 summarises the six major themes and 15 sub-themes generated from the thematic analysis synthesis with the number of studies contributing to each theme. Six themes were generated from the thematic synthesis of the 29 included studies. Because individual studies could contribute to more than one theme, theme counts are not mutually exclusive. The themes are (1) Community Participation and Empowerment (16 articles); (2) Standardisation vs Flexibility (21 articles); (3) Capacity Building (12 articles); (4) Multidisciplinary Approaches and Intersectoral Coordination (26 articles); (5) Sustainability and System Capacity (21 articles); and (6) Monitoring, Evaluation and Learning (25 articles). Relevant findings from each study were coded and mapped into these themes and sub-themes.

Table 3: The themes, sub-themes and the number of articles that contribute to each theme for the analysis

Theme		Sub-themes	Total articles
1	Community Participation and Empowerment	1.1 Meaningful Participation and Co-Production	16
		1.2 Community Empowerment and Livelihood Integration	
2	Standardisation vs Flexibility	2.1 Application of Global Frameworks and Standards	21
		2.2 Localisation and Contextual Adaptation	
3	Capacity Building	3.1 Expanded Capacity Building Beyond Professionals	12
		3.2 Continuous Training and Capacity Development Systems	
4	Multidisciplinary Approaches and Intersectoral Coordination	4.1 Intersectoral Collaboration and Partnership	26
		4.2 Integrated and Interdisciplinary Service Delivery	
		4.3 Supportive Governance and Policy Environment	
5	Sustainability and System Capacity	5.1 Adequate Funding and Resource Infrastructure	21
		5.2 Human Resource Sustainability	
		5.3 Scalable and Sustainable Implementation Models	
6	Monitoring, Evaluation and Learning	6.1 Structured Evaluation and Measurement Approaches	25
		6.2 Contextualisation and Validation of Measurement Tools	
		6.3 Participatory and User-Centred Evaluation	

Figure 2 indicates that the 29 selected studies span 2020 to 2025, with the highest number of articles in 2022 (9), followed by 2025 (8), 2020 (5), 2021 (3), 2024 (3), and 2023 (1).

Figure 2: Number of Selected Studies by Publication Year

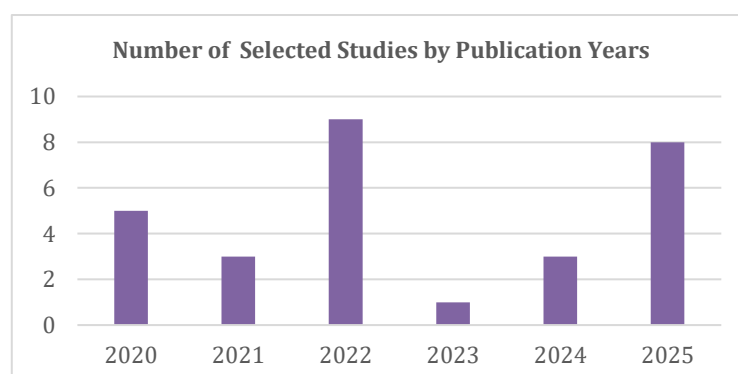


Table 4 maps each included study to the identified themes and sub-themes, illustrating how individual studies contributed to the overall thematic framework.

Table 4: The Author(s), Themes and Sub-Themes of the CBR Implementation

No.	Author/s & Year	Themes and Sub-Themes														
		1		2		3		4			5			6		
		Community Participation and Empowerment		Standardisation vs Flexibility		Capacity Building		Multidisciplinary Approaches and Intersectoral Coordination			Sustainability and System Capacity			Monitoring, Evaluation and Learning		
		1.1	1.2	2.1	2.2	3.1	3.2	4.1	4.2	4.3	5.1	5.2	5.3	6.1	6.2	6.3
1	Abdul Latif et al. (2020)				/				/						/	
2	Agudelo-Hernández et al. (2024)	/			/			/		/	/		/			/
3	Agudelo-Hernández et al. (2025)			/	/					/			/			
4	Asher et al. (2022)					/	/		/				/	/	/	
5	Asres (2025)	/	/			/		/		/	/	/		/		
6	Ayalew et al. (2020)	/	/		/	/	/	/		/	/	/	/	/		
7	Besoain-Saldaña et al. (2020)			/				/	/					/		
8	Blose et al. (2024)					/		/		/	/	/		/		
9	Bunning et al. (2022)	/	/		/	/	/	/					/			/
10	Chen et al. (2020)								/					/		
11	Chompoonimit et al. (2024)	/	/		/	/	/	/		/	/	/	/	/		
12	Cutamora et al. (2025)			/						/	/			/		/
13	Das et al. (2025)		/						/				/	/		
14	Gale et al. (2022)			/		/	/					/			/	
15	Goto et al. (2025)													/	/	
16	Hashemi et al. (2025)	/			/	/		/	/		/					/
17	Jose et al. (2023)	/	/					/		/	/		/			
18	Koly et al. (2022)	/							/	/						/
19	Malik & Nadeem (2022)								/					/		
20	Nazeer et al. (2020)	/	/		/			/	/	/	/		/	/		

21	Nugraha et al. (2021)			/			/		/		/	/				
22	Pasara (2022)		/	/	/		/	/	/		/	/				
23	Rebolledo-Sanhueza et al. (2021)	/	/		/		/	/						/		
24	Sagun et al. (2025)				/		/		/	/						
25	Shumba et al. (2021)	/	/		/	/			/		/			/		
26	Thilarajah et al. (2025)	/			/	/	/	/	/		/			/		
27	Tofani et al. (2022)				/		/		/		/					
28	Tongsiri (2022)	/			/	/	/			/	/	/				
29	Wolderufael (2022)	/		/		/	/	/	/	/	/	/				
Total Articles / Sub-themes		14	10	7	16	11	7	14	14	13	11	8	13	16	4	8
Total Articles/ Theme		16		21		12		26		21		25				

RESEARCH ARTICLE

Table 5 further illustrates the geographical distribution, research design, and study settings of all included studies, demonstrating the global diversity of the evidence base. Selected studies on CBR were conducted across five continents, particularly Asia, Africa, Europe, North America, and South America, indicating the significance of CBR implementation for the inclusion of persons with disabilities. Across all 29 selected studies, Asia has the highest number (15), followed by Africa (8), South America (4), Europe (1), and North America (1), reflecting greater attention to developing countries, where community-based approaches are widely utilised. The studies employed qualitative, quantitative and mixed-methods designs, with qualitative approaches being dominant (15 studies).

Table 5: Distribution of Selected Studies by Continents, Countries, Author(s) & Year, and Study Design

Continent	Country	Author(s) & Year	Study Design
Asia (15)	Bangladesh (2)	Das et al. (2025)	Quantitative
		Koly et al. (2022)	Qualitative
	China (1)	Chen et al. (2020)	Quantitative
	India (3)	Gale et al. (2022)	Mixed methods
		Jose et al. (2023)	Qualitative
		Nazeer et al. (2020)	Qualitative
	Indonesia (1)	Nugraha et al. (2021)	Qualitative
	Japan (1)	Goto et al. (2025)	Quantitative
	Thailand (2)	Chompoonimit et al. (2024)	Qualitative
		Tongsiri (2022)	Mixed methods
	Pakistan (1)	Malik & Nadeem (2022)	Quantitative
	Philippines (2)	Cutamora et al. (2025)	Mixed methods
		Sagun et al. (2025)	Qualitative
	Malaysia (1)	Abdul Latif et al. (2020)	Qualitative
	Singapore (1)	Thilarajah et al. (2025)	Mixed methods
Africa (8)	Ethiopia (4)	Asres (2025)	Mixed methods
		Asher et al. (2022)	Quantitative
		Wolderufael (2022)	Qualitative
		Ayalew et al. (2020)	Mixed methods
	Kenya (1)	Bunning et al. (2022)	Mixed methods
	Namibia (1)	Shumba et al. (2021)	Qualitative
	South Africa (1)	Blose et al. (2024)	Qualitative
	Zimbabwe (1)	Pasara (2022)	Mixed methods
South America (4)	Chile (2)	Besoain-Saldaña et al. (2020)	Quantitative
		Rebolledo-Sanhueza et al. (2021)	Qualitative
	Colombia (2)	Agudelo-Hernández et al. (2024)	Qualitative
		Agudelo-Hernández et al. (2025)	Qualitative
Europe (1)	Italy (1)	Tofani et al. (2022)	Qualitative
North America (1)	Guatemala (1)	Hashemi et al. (2025)	Qualitative

4. Discussion

4.1. Community Participation and Empowerment

The reviewed studies highlighted that community participation and empowerment are essential in the CBR implementation. It is achieved through the active participation of persons with disabilities, caregivers, families, the community, and local stakeholders. Participatory approaches, co-production practices, and livelihood integration were among the elements found to improve community ownership, social inclusion, empowerment, and the long-term sustainability of CBR implementation (Agudelo-Hernández et al., 2024; Chompoonimit et al., 2024; Pasara, 2022; Thilarajah et al., 2025).

4.1.1. Meaningful Participation and Co-Production

Across the reviewed studies, meaningful participation emerged as the most significant factor, with persons with disabilities, caregivers, families, and frontline staff positioned as active contributors to programme planning, feedback, and redesign rather than passive recipients of services. In Singapore, CBR was implemented most explicitly through experience-based co-design, in which clients, caregivers, and staff collaboratively identified priorities, validated a trigger film, and contributed to the development of clinical practice guidelines and community rehabilitation recommendations (Thilarajah et al., 2025). Similarly, the study in Colombia highlights that effective CBR implementation relies on strong stakeholder networks, active family involvement, community-based leadership, and clearly defined goals to guide support processes (Agudelo-Hernández et al., 2024). Evidence from the CBR implementation in Chile shows a similar situation. 74.4% of participatory diagnosis activities and 62.8% of community organisation activities are conducted. Even so, activities are limited to the rehabilitation centre rather than to mass, community-led initiatives (Besoain-Saldaña et al., 2020).

In Guatemala, efforts to improve access to healthcare services through a pilot CBR-linked primary healthcare access initiative demonstrated the value of engaging PWDs, community health workers, local organisations, and Ministry of Health personnel (Hashemi et al., 2025). In Thailand, Chompoonimit et al. (2024) reported that effective CBR services for persons with disabilities resulted from the active involvement of these individuals and community representatives in organisational structures and related activities. A study by Nazeer et al. (2020) within the Suraksha Community-Based Rehabilitation programme for persons with mental illness in India indicates that the CBR programme was implemented through active stakeholder engagement. It is done by establishing self-help associations that involve patients and caregivers, focusing on reducing stigma, enhancing community involvement, and representing collective needs. The programme also included capacity-building initiatives that equipped caregivers with essential knowledge and skills for home-based care and for involvement in the collaborative programme. Collectively, these studies indicate that while co-production may not be the ideal approach for implementing CBR, it is a practical prerequisite for ensuring ongoing community sensitivity, legitimacy, and acceptance (Hashemi et al., 2025; Chompoonimit et al., 2024; Thilarajah et al., 2025).

4.1.2. Community Empowerment and Livelihood Integration

In Zimbabwe, it is reported that even with limited direct funding, the PWD group receives training in disability management, income-generating projects, and internal savings and

lending. However, it is suggested that empowerment efforts often progressed further in training and mobilisation than in capital support (Pasara, 2022). Ayalew et al. (2020) and Wolderufael (2022) emphasised that vocational training, start-up financing, and livelihood-related support are significant components of CBR practice in Ethiopia, despite limited-service coverage. On the other hand, in Bangladesh, education, social support, and opportunities for social participation are valued by participants in the mental health CBR programme. In addition, family narratives about rehabilitation services are often associated with hopes for employment and better household futures (Koly et al., 2022). Thus, the livelihood element integrated with CBR services appears to serve as an empowerment pathway in PWDs' lives. However, success will depend on several factors, including material, organisational, and follow-up support (Ayalew et al., 2020; Wolderufael, 2022; Pasara, 2022; Koly et al., 2022).

The reviewed studies demonstrate that community empowerment extends beyond livelihood assistance to strengthen participation and local ownership of the programmes. In Bangladesh, integrating livelihood support with rehabilitation services enhances caregivers' social capital and community integration (Das et al., 2025). In line with that, studies from Thailand and India also show that active participation of local organisations, community members, and governance structures has resulted in better sustainable and responsive CBR implementation (Chompoonimit et al., 2024; Jose et al., 2023; Nazeer et al., 2020). These findings suggest that livelihood initiatives are most effective when community participation and collaborative support systems are visible in the CBR implementation.

4.2. Standardisation vs Flexibility

The CBR implementation operates within a dynamic tension between following the global standard and being flexible to the local capacity. Global frameworks provide structured guidance. However, the effectiveness of CBR implementation depends on how they are adapted and enacted within local contexts. Evidence shows that international standards such as the WHO CBR Matrix, the International Classification of Functioning, Disability and Health (ICF), and right-based instruments like the CRPD are widely referred to guide programme design, workforce competencies, and service delivery (Tongsiri, 2022; Besoain-Saldaña et al., 2020; Gale et al., 2022). However, their adaptation varies across contexts. It must be matched to the local socio-economic, cultural and institutional conditions.

4.2.1. Application of Global Frameworks and Standards

CBR implementation globally shows widespread reliance on and reference to global frameworks, including the WHO CBR Matrix, the International Classification of Functioning, Disability and Health (ICF), and related rights-based disability instruments. In Thailand's capacity-building strategy, the WHO/ExpandNet Scaling-up Framework and the ICF are explicitly integrated. The programme planning and monitoring are guided by ICF-based data collection (Tongsiri, 2022). In Chile, the CBR is implemented based on the five components of the WHO CBR Matrix, with health being the most highly emphasised, social, livelihood, and empowerment at a moderate level, and education being the least developed (Besoain-Saldaña et al., 2020). The structured and standardised competency framework for Indian CBR personnel is designed and guided by the WHO CBR Guidelines, the UN Convention on the Rights of Persons with Disabilities (CRPD), and the ICF. It identifies their job functions, competency stages, and minimum practice standard (Gale et

al., 2022). These studies suggest that global guidelines and standards are frequently referenced when defining the operations of the CBR, especially regarding the inclusion of PWDs, interdisciplinarity, and rights. Their operational value depends heavily on how effectively they are translated into local tools, competencies, and workflows (Tongsiri, 2022; Gale et al., 2022; Besoain-Saldaña et al., 2020; Hashemi et al., 2025).

4.2.2. Localisation and Contextual Adaptation

Localisation and contextual adaptation are central to the effectiveness of CBR implementation, especially in diverse and resource-constrained environments. Several studies consistently highlight that CBR strategies must be adapted to and aligned with the local socio-cultural, economic, and institutional contexts, rather than implemented as uniform models. For example, the priority element for the successful implementation of CBR in Colombia is identified as contextual to local governance structures, community dynamics, and available resources (Agudelo-Hernández et al., 2024). Correspondingly, a study from Thailand shows that adapting interventions to specific community contexts, including the effective use of local resources and active community involvement, is an important evidence-based factor for the success of CBR implementation (Chompoonimit et al., 2024). These findings underscore that localisation is not merely a contextual adjustment but a significant mechanism for ensuring the programme's sustainability, relevance, and ownership.

Furthermore, the programme's contextual adaptation is operationalised through integration with local systems and cultural practices, as well as context-sensitive delivery approaches. For instance, the Indian Suraksha initiative has shown that sustainability and responsiveness to rural needs result from integrating CBR into self-government frameworks (Nazeer et al., 2020). Meanwhile, in Kenya, engagement and social engagement outcomes are enhanced by low-cost, culturally home-based interventions adapted to caregivers lived realities (Bunning et al., 2022). In addition, innovative approaches such as telerehabilitation in the Philippines and adaptive programme designs in Malaysia demonstrate the importance of flexibility in CBR service delivery that is responsive to technological accessibility, socioeconomic limits, and users' needs (Sagun et al., 2025; Abdul Latif et al., 2020). Overall, these studies demonstrate that effective CBR implementation requires context-driven, adaptable methods that utilise local knowledge and resources, as well as governance institutions that reduce the gaps between global frameworks and local realities.

4.3. Capacity Building

Another fundamental component of sustainable CBR implementation is capacity building, which involves not only professionals but also caregivers, families, volunteers, communities, and local institutions. Across different cases, the effectiveness of CBR is supported by continuous training, participatory learning approaches, interdisciplinary collaboration, and community empowerment. It collectively improves workforce capability, service quality, and the sustainability of CBR implementation (Asher et al., 2022; Bunning et al., 2022; Chompoonimit et al., 2024; Tongsiri, 2022).

4.3.1. Expanded Capacity Building Beyond Professionals

The literature shows that capacity building in the implementation of CBR goes beyond formal professionals to include various stakeholders, such as carers, families, local

communities, volunteers, and local institutions. This situation reflects a participatory and inclusive atmosphere fostered by the community's togetherness. Correspondingly, in the Philippines, family-centred approaches in telerehabilitation emphasise that parents and caregivers are key implementers of interventions and require training and support to deliver care effectively within the home environment (Sagun et al., 2025). Evidence from Kenya shows that carers are not just recipients of services but are trained as active agents of change through home-based interventions and participation in self-support groups, leading to better caregiving practices, enhanced social support, and increased personal agency (Bunning et al., 2022).

Additionally, several studies emphasise the importance of mobilising community actors and non-professional stakeholders as part of a broader capacity-building system. Programs in Thailand, for example, encourage the involvement of community representatives, local organisations, and the participants themselves in the delivery and management of services, promote the development of local skills, and emphasise shared responsibility to achieve effective recovery outcomes (Chompoonimit et al., 2024). In Ethiopia, the involvement of volunteer workers in providing psychosocial support and rehabilitation has proven effective in addressing workforce shortages, without compromising positive outcomes (Asher et al., 2022). Similarly, participatory approaches, such as those in Namibia, empower CBR volunteers and persons with disabilities to contribute to programme evaluation and advocacy, and to strengthen community ownership and capacity (Shumba et al., 2021). Collectively, the evidence shows that expanding capacity building beyond the professional group not only serves as a pragmatic response to limited resources but also functions as a fundamental mechanism for fostering community ownership, empowerment, and the sustainability of these programmes.

4.3.2. Continuous Training and Capacity Development Systems

Selected studies indicate that continuous training and structured capacity development systems are essential to improving and ensuring the sustainable implementation of CBR. However, it remains underdeveloped across contexts. Several studies highlight the significance of ongoing training, knowledge transfer, and a structured learning system in sustaining CBR effectiveness. For instance, a structured capacity-building model incorporating multi-stage training (e.g. team-building, data collection, care planning, and evaluation) in Thailand has successfully improved staff competencies and supported interdisciplinary collaboration (Tongsiri, 2022). Similar results were also seen in the case of CBR in South Africa, where initiatives such as training, awareness, and resource-sharing among stakeholders were identified as important elements that positively improve the programme implementation, highlighting the need for continuous learning and coordination mechanisms (Bloose et al., 2024). In Kenya, improvements in knowledge, attitudes, and involvement result from integrated training for caregivers and community groups. It indicates that capacity development must extend beyond professionals to include families and communities (Bunning et al., 2022).

The literature, however, also highlights systematic gaps in formalised training structures and long-term capacity initiatives. In India, effective CBR delivery is hampered by the absence of clear competency frameworks and a structured training system, resulting in limited development of higher-order skills (Gale et al., 2022). Likewise, findings from CBR highlight the need for workplace learning frameworks and continuous professional development systems to address gaps in guideline adherence and improve service quality

(Thilarajah et al., 2025). More generally, CBR implementation needs ongoing coordination, knowledge sharing, and skills development across sectors and care levels. Even so, these systems are frequently underdeveloped and fragmented (Tongsiri, 2022; Hashemi et al., 2025). Overall, the data indicate that establishing integrated, ongoing training and capacity-building mechanisms that support workforce capabilities, community participation, and long-term programme efficacy is essential for the sustainable implementation of CBR.

4.4. Multidisciplinary Approaches and Intersectoral Coordination

CBR implementation typically involves collaboration among multiple parties, including health services, government agencies, NGOs, communities, families, and multidisciplinary teams, to support integrated rehabilitation services, coordinated governance, and person-centred care. These collaborative efforts improve service accessibility, continuity of care, and encourage a community-based support system for persons with disabilities (Agudelo-Hernández et al., 2024; Asher et al., 2022; Chompoonimit et al., 2024; Thilarajah et al., 2025).

4.4.1. Intersectoral Collaboration and Partnership

CBR is inherently a programme implemented through a multi-sectoral strategy that requires coordination among health services, the social sector, government and non-government agencies, local communities, persons with disabilities, carers, and their families (Bloese et al., 2024). However, several studies highlight some challenges that must be faced in implementing this programme. For example, in Colombia, the fragmented health system and lack of inter-sectoral coordination significantly limit the effectiveness of recovery efforts for the target groups (Agudelo-Hernández et al., 2025). It is supported by studies conducted in Ethiopia and Guatemala, where limited stakeholder involvement and weak coordination mechanisms resulted in restricted programme reach and sustainability despite the implementation of collaborative approaches (Wolderufael, 2022; Hashemi et al., 2025).

The literature also shows that strong partnerships and coordinated networks can yield significant outcomes in implementing CBR. Collaboration involving local government, local communities, networks, and coordinated programme management in Thailand makes the delivery of CBR services more effective and sustainable (Chompoonimit et al., 2024). Similarly, the coordinated governance structure in India and community-based initiatives, such as the Suraksha programme, serve as catalysts for effective service delivery and programme sustainability by involving local government, the health system, and the local community (Jose et al., 2023; Nazeer et al., 2020). Additionally, participatory approaches and co-design, as implemented in Singapore, emphasise the involvement of various stakeholders in planning and improving programmes. The involvement of customers, carers, and multidisciplinary teams can create a more responsive and person-centred care environment for persons with disabilities (Thilarajah et al., 2025). Collectively, the results of the involved studies highlighted that although inter-sectoral cooperation is seen as very important, the effectiveness of services in particular and the implementation of programmes in general still depend on the clearly defined roles of each stakeholder, robust coordination mechanisms, and continuous and comprehensive government partnerships at various levels, sectors, and communities.

4.4.2. Integrated and Interdisciplinary Service Delivery

An effective CBR model emphasises an integrated approach by combining health, social, and livelihood interventions into a cohesive framework. For example, the integrated Micro Finance and rehabilitation model in Bangladesh has shown positive results in encouraging the participation of persons with disabilities and their caregivers. This situation illustrates how the combination of rehabilitation activities and socioeconomic interventions yields overall programme outcomes and strong community integration (Das et al., 2025). Correspondingly, integrating mental health services into CBR programmes in Bangladesh shows that placing specialised care within community-based systems can increase access to services, especially when formal mental health infrastructure is limited (Koly et al., 2022). In Ethiopia, integrated service delivery that combines facility-based care with community-based psychosocial interventions delivered by lay workers has demonstrated improved functional outcomes for individuals with schizophrenia. It demonstrates the effectiveness of blended clinical and community rehabilitation models (Asher et al., 2022).

Interdisciplinary coordination in CBR implementation relies on how well the systems support collaboration across sectors and service levels. Evidence from Thailand and Singapore illustrates that structured teamwork and tools such as ICF and co-design can enhance the care and rehabilitation service delivery (Tongsiri, 2022; Thilarajah et al., 2025). Nevertheless, fragmentation remains evident in the Malaysian and Chilean contexts, where limited integration can lead to discontinuity of care (Besoain-Saldaña et al., 2020; Abdul Latif et al., 2020). Similarly, limited stakeholder participation and weak coordination in Ethiopia and Indonesia make effective integration challenging despite the diversity of services (Wolderufael, 2022; Nugraha et al., 2021).

4.4.3. Supportive Governance and Policy Environment

Supportive governance and positive policy environment emerged as central mechanisms for sustaining CBR implementation. It has been realised through decentralised leadership, intersectoral collaboration, formal coordination structures, and rights-based policy alignment. Several pieces of evidence, such as from Colombia, Chile and Singapore, highlighted that CBR is implemented through national or health-system policy frameworks that include mental health policy, primary care system, and national rehabilitation initiatives (Agudelo-Hernández et al., 2024; Agudelo-Hernández et al., 2025; Besoain-Saldaña et al., 2020; Thilarajah et al., 2025).

In India, Kerala's BUDS and Suraksha models demonstrated how local self-governments and panchayat-based structures effectively support infrastructure development, service coordination, financial aid, and community-level rehabilitation (Jose et al., 2023; Nazeer et al., 2020). Likewise, in the case of South Africa, Bangladesh, Ethiopia, and Zimbabwe, the effective CBR governance needs clear roles, stakeholder participation, monitoring and evaluation, community ownership, NGO government collaboration, and alignment with disability rights and inclusive development goals (Ayalew et al., 2020; Blose et al., 2024; Koly et al., 2022; Pasara, 2022).

4.4. Sustainability and System Capacity

A strong system capacity supports sustainable CBR. It includes adequate funding, supportive resource infrastructure, workforce sustainability and adaptable

implementation models. Across different contexts, sustainable CBR practices are regularly supported through intersectoral collaboration, community involvement, continuous human resource development, and locally integrated service models that enable long-term service delivery and responsiveness to the local needs (Asher et al., 2022; Besoain-Saldaña et al., 2020; Jose et al., 2023; Thilarajah et al., 2025; Tongsiri, 2022).

4.4.1. Adequate Funding and Resource Infrastructure

Another important factor of sustainable CBR implementation across different contexts is financial and resource support. Several studies showed that CBR implementation was commonly supported through collaborations from governments, NGOs, universities, local organisations, and communities. Collaborations are significant in supporting funding, infrastructure, training, transportation, assistive devices, and livelihood support for persons with disabilities (Agudelo-Hernández et al., 2024; Asres, 2025; Jose et al., 2023). To strengthen the programme's sustainability and efficient service delivery, several programmes are also integrated, including income-generating activities, community resource mobilisation, and local administrative support (Chompoonimit et al., 2024; Pasara, 2022). Furthermore, coordination in resource sharing and intersectoral collaboration were identified as important elements in CBR implementation practices, enabling the continuity and effectiveness of the CBR programme within community settings (Bloese et al., 2024; Cutamora et al., 2025).

4.4.2. Human Resource Sustainability

The reviewed studies show that human resource sustainability in CBR implementation depends on a skilled, community-based workforce, multidisciplinary collaboration, and continuous workforce support. In Ethiopia, the CBR was effectively implemented through lay workers, rehabilitation professionals, the government, NGOs, and community stakeholders, with a focus on workforce support and competitive wages to maintain the service delivery (Asher et al., 2022; Asres, 2025; Ayalew et al., 2020). Other than that, coordination and active involvement among project managers, professionals, the community, and persons with disabilities are also identified as significant factors for sustaining disability service centres in Thailand (Chompoonimit et al., 2024). Furthermore, in Chile and Singapore, workforce sustainability was supported through professional development, staff engagement, and a workplace learning system to sustain long-term CBR implementation (Besoain-Saldaña et al., 2020; Thilarajah et al., 2025).

4.4.3. Scalable and Sustainable Implementation Models

Rather than top-down strategies, scalable and sustainable CBR implementation relies on several factors. It requires locally integrated, community-driven, and context-adaptable models. In India, locally embedded programmes such as the Suraksha model have been successfully sustained through decentralised governance and integration with the main healthcare systems (Nazeer et al., 2020). In the case of Kerala, integration with local governance structures led to more responsive and scalable rehabilitation services (Jose et al., 2023). Meanwhile, in Thailand, the WHO/ExpandNet framework highlights the importance of structural capacity building, multi-stakeholder collaboration, and adaptable implementation in local contexts (Tongsiri, 2022).

At the same time, the key to sustainable CBR is participatory and adaptive approaches. In Singapore, co-design involving clients, caregivers, and professionals encourages the development of scalable and individual-centred service models (Thilarajah et al., 2025). In Namibia, a participatory approach such as photovoice improves community ownership and programme growth (Shumba et al., 2021). Generally, locally grounded, participatory, and system-integrated models of CBR, supported by strong policy, community involvement, and adaptive capacity-building strategies, are essential to ensure CBR's sustainability.

4.5. Monitoring, Evaluation and Learning

Several indicators and frameworks are commonly used to evaluate the CBR outcomes related to quality of life, disability, service capacity, and social inclusion of PWDs. In addition to standardised measurement tools, the CBR evaluation increasingly incorporates mixed methods, stakeholder feedback, and continuous monitoring. It supports evidence-based learning, programme improvement, and accountability (Besoain-Saldaña et al., 2020; Chen et al., 2020; Nazeer et al., 2020).

4.5.1. Structured Evaluation and Measurement Approaches

The reviewed studies used several tools, including WHO CBR indicators, WHOQoL-BREF, WHODAS, ICF Frameworks, and the International Classification of Service Organisations in Rehabilitation (ICSO-R) 2.0 to measure CBR outcomes on quality of life, disability, service capacity, and social inclusion of PWDs (Goto et al., 2025; Malik & Nadeem, 2022; Asher et al., 2022; Tongsiri, 2022; Nugraha et al., 2021). For example, WHODAS has been used to track disability outcomes over time (Asher et al., 2022), while the ICF supports profiling of individual functioning (Tongsiri, 2022). The validated Japanese CBR Indicators (J-CBR-Is) further underscore the significance of culturally appropriate, reliable instruments for cross-contextual comparisons (Goto et al., 2025). The gaps between expected standards and actual execution, especially in areas such as livelihood and empowerment, are identified by utilising the Provus Discrepancy Evaluation Model (Cutamora et al., 2025).

Nevertheless, structured evaluation extends beyond quantitative measurement. Multi-method approaches, such as surveys, interviews, document reviews, and observations, strengthen it. The methods help capture programme implementation and sustainability (Nazeer et al., 2020; Chen et al., 2020; Besoain-Saldaña et al., 2020). Stakeholders' involvement and feedback, along with iterative evaluation processes, are typically incorporated into these methodologies to facilitate programme enhancement. Overall, CBR evaluation is evolving towards integrated systems. It involves standardised tools, a variety of data sources, and continuous feedback. These strategies can enhance evidence-based learning, monitoring, and accountability.

4.5.2. Contextualisation and Validation of Measurement Tools

Global instruments are adapted through translation, cultural alignment, and psychometric testing. The Japanese version of the CBR Indicators (J-CBR-Is) was validated for reliability and cultural relevance (Goto et al., 2025). In Bangladesh, the SASCAT tool was utilised to assess caregivers' social capital in the local context (Das et al., 2025). In Thailand, the ICF framework required trained fieldworkers to ensure appropriate data collection (Tongsiri, 2022), and in Indonesia, ICSO-R 2.0 demonstrated feasibility in

community-based settings (Nugraha et al., 2021). Similarly, competency tools in India were identified through Delphi processes and field settings to ensure they are suitable for the local practice needs (Gale et al., 2022). Overall, the studies indicate that effective and meaningful CBR evaluation depends not only on the use of standard tools but also on adapting and validating the process within local and institutional contexts.

4.5.3. Participatory and User-Centred Evaluation

Across studies, the evaluation process needs participation from multiple stakeholders. It involves service users, caregivers, local communities, practitioners, and policymakers. Their active involvement is significant to ensure that the findings are reflected in lived experiences and inform decision-making. For instance, in Colombia, a participatory approach is used to support the co-development and implementation efforts (Agudelo-Hernández et al., 2024). A study in Bangladesh gathered user-driven insights into service access and programme gaps through interviews (Koly et al., 2022). Experience-based co-design (EBCD) is utilised in Singapore to enable stakeholders to jointly analyse data and develop improvements (Thilarajah et al., 2025). On the other hand, the photovoice approach empowered communities to share their experiences and influence the policy development in Namibia (Shumba et al., 2021). Similarly, in the study conducted in India and Guatemala, stakeholders are engaged in the evaluation process to assess the programme's impact and sustainability (Nazeer et al., 2020; Hashemi et al., 2025).

5. Limitations of the Study

The review is limited by the number of included studies (n=29). Non-research articles, chapters in books, conference proceedings, grey literature, NGO reports, and technical reports that contain potentially valuable ground-level findings on CBR implementation are also excluded from the review selection. In addition, the inclusion criteria for published English-language articles from 2020 to 2026 may exclude relevant evidence in other languages, from earlier years, and across other disciplines. This limitation implies that important insights from pre-2020 studies, which could highlight historical context and evidence of long-term progress in CBR, may not have been captured. Hence, all of the elements may be considered for future review.

6. Conclusion

CBR is conceptually robust and widely adopted globally. However, the implementation remains highly variable and strongly shaped by context. Several variables shape the effectiveness of its implementation: community participation, capacity development, intersectoral coordination, and a supportive policy environment, all of which should be aligned to translate theoretical frameworks into locally practical results. Positive practices are emerging, with a particular focus on stakeholder participation, continuous capacity building, and integrated service delivery. Therefore, to ensure the sustainability of CBR, a shift from policy commitment to implementation alignment is required. This is to ensure that the global framework can be adapted to the local context and supported by a robust, sustainable system that promotes the social inclusion of persons with disabilities and delivers long-term impact.

Ethics Approval and Consent to Participate

Ethics approval was not applicable because this study is a systematic literature review based exclusively on published studies. It did not involve human participants or identifiable personal data.

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Conflict of Interest

The authors declare no conflict of interest regarding the publication of the study.

AI Declaration

Artificial Intelligence (AI) tools, namely, Grammarly and ChatGPT (OpenAI), were used during the preparation of this manuscript for language editing, fact-checking, and reorganisation of ideas. AI scientific interpretation, data analysis, and conclusions were critically reviewed and verified by the authors, who accept full responsibility for the content of this manuscript.

References

- Abdul Latif, R., Ismail, R., & Mohd Mahidin, E. M. (2020). Game-Based Rehabilitation Program for Community-Based Centers in Malaysia. *International Journal on Advanced Science, Engineering and Information Technology*, 10(2), 640–646. <https://doi.org/10.18517/ijaseit.10.2.10228>
- Agudelo-Hernández, F., Cuadrado, L., & Delgado-Reyes, A. C. (2025). 'The policies say something else': Psychiatric rehabilitation in Colombia, a necessity amid contradictory public policies. *Global Public Health*, 20(1). <https://doi.org/10.1080/17441692.2025.2541233>
- Agudelo-Hernández, F., Rojas-Andrade, R., & Giraldo Alvarez, A. B. (2024). Building an implementation strategy for community-based rehabilitation for mental health in Colombia. *JBI Evidence Implementation*, 22(3), 303–315. <https://doi.org/10.1097/XEB.0000000000000431>
- Al Imam, M. H., Das, M. C., Jahan, I., Muhit, M., Akbar, D., Badawi, N., & Khandaker, G. (2022). A Social Business Model of early intervention and rehabilitation for people with disability in rural Bangladesh. *Brain Sciences*, 12(2), 264. <https://doi.org/10.3390/brainsci12020264>
- Asher, L., Birhane, R., Weiss, H. A., Medhin, G., Selamu, M., Patel, V., De Silva, M., Hanlon, C., & Fekadu, A. (2022). Community-based rehabilitation intervention for people with schizophrenia in Ethiopia (RISE): Results of a 12-month cluster-randomised controlled trial. *The Lancet Global Health*, 10(4), e530–e542. [https://doi.org/10.1016/S2214-109X\(22\)00027-4](https://doi.org/10.1016/S2214-109X(22)00027-4)

- Asres, G.W. (2025). The practices of community-based rehabilitation programs for persons with disabilities for inclusive development in Ethiopia. *Discovery Social Science Health* (5), 141. <https://doi.org/10.1007/s44155-025-00277-3>
- Ather Malik, Areeba, & Nadeem Masood. (2022). Community-Based Rehabilitation (CBR) and its impact on Quality of Life (QoL) of disabled children. *Review of Education, Administration & Law* (5), 519–532. <https://doi.org/10.47067/real.v5i4.267>
- Ayalew, A.T., Adane, D.T., Obolla, S.S., Ludago, T.B., Sona, B. & Biewer, G. (2020). From Community-Based Rehabilitation (CBR) Services to inclusive development. A study on practice, challenges, and future prospects of CBR in Gedeo Zone (Southern Ethiopia). *Frontiers in Education* (5), 23 October 2020. <https://doi.org/10.3389/feduc.2020.506050>
- Beckerlegge, F., & Asthana, S. (2025). Exploring the opportunities for improving the accessibility of rehabilitation services in rural communities in Uganda through the inclusion of CBR graduates at the primary health care level. [Preprint]. *medRxiv*. <https://doi.org/10.1101/2025.02.27.25322759>
- Besoain-Saldaña, Álvaro, Sanhueza, J. R., Hizaut, M. M., Rojas, V. C., Ortega, G. H., & Aliaga-Castillo, V. (2020). Community-Based Rehabilitation (CBR) in primary care centers in Chile. *Revista De Saúde Pública*, 54, 38. <https://doi.org/10.11606/s1518-8787.2020054001999>
- Blose, S., Chetty, V., Cobbing, S. & Chemane, N. (2024). ‘Managers’ perceptions on the implementation of community-based rehabilitation in KwaZulu- Natal’. *South African Journal of Physiotherapy*, 80(1), a1965. <https://doi.org/10.4102/sajp.v80i1.1965>
- Blose, S., Cobbing, S., & Chetty, V. (2021). Community-Based Rehabilitation implementation for persons with disabilities in South Africa: A protocol for a scoping review. *Systematic Reviews*, 10(1). <https://doi.org/10.1186/s13643-021-01839-7>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Bunning, K., Gona, J.K., Newton, C.R., Hartley, S. (2022). Empowering caregivers of children with learning and developmental disabilities: from situation analysis to community-based inclusive development in Kilifi, Kenya. *Tizard Learning Disability Review*, 27(1), 1–10, <https://doi.org/10.1108/TLDR-08-2021-0023>
- Chen, S., Lei, Y., Dai, H., Wu, J., Yang, Z., & Liao, X. (2020). Community-based rehabilitation service in Chengdu, Southwest China: a cross-sectional general survey. *BMC Health Services Research*, 20(1), 625. <https://doi.org/10.1186/s12913-020-05480-3>
- Chompoonimit, A., Nakham, M., & Nualnetr, N. (2024). Community-Based Rehabilitation enhances the functioning of general disability service centres in Khon Kaen Province, Thailand. *Disability, CBR & Inclusive Development*, 35(1), 61–83. <https://doi.org/10.20372/dcidj.758>
- Cutamora, U., Leonardo, G., & Lagria, M. M. (2025). Evaluating a Community-Based Rehabilitation Program using the Provus Discrepancy Evaluation Model. *Recoletos Multidisciplinary Research Journal*, (1), 1–19. <https://doi.org/10.32871/rmrj25sit2416>
- Das, M. C., Jahan, I., Al Imam, M. H., Akbar, D., Islam, S., Khan, N., Muhit, M., Badawi, N., & Khandaker, G. (2025). Effectiveness of an integrated community-based livelihood and rehabilitation intervention on the social capital of caregivers of children with cerebral palsy: Secondary analysis of an existing cluster randomized controlled trial in rural Bangladesh. *Children*, 12(12), 1687. <https://doi.org/10.3390/children12121687>

- Ding, R., Zhao, M., Wang, Y., Wang, M., Guo, D., Liu, X., Wang, L., Wei, W., Zhang, W., & He, P. (2023). Community-based rehabilitation interventions on quality of care for people with schizophrenia in China (CRISC): study protocol for a cluster-randomized controlled trial. *BMC Psychiatry*, 23(1), 339. <https://doi.org/10.1186/s12888-023-04774-0>
- Gale, L., Gillis, S., & Grills, N. (2022). Determining the vocational competencies required to deliver community-based rehabilitation and inclusive development services in India. *Disability and Rehabilitation*, 44(17), 4929–4943. <https://doi.org/10.1080/09638288.2021.1907622>
- Goto, R., Yazawa, A., & Mitsuyama, T. (2026). Development and validation of the Japanese version of Community-Based Rehabilitation Indicators. *Disability and rehabilitation*, 48(13), 4233–4241. <https://doi.org/10.1080/09638288.2025.2588062>
- Hashemi, G., Wickenden, M., Santos, A. L., & Hameed, S. (2025). Stakeholders' perspectives on a pilot project focusing on improving access to primary healthcare for adults with disability in Santiago Atitlán, Guatemala. *Disability, CBR & Inclusive Development*, 36(2), 28–39. <https://doi.org/10.20372/dcidj.763>
- Iemmi, V., Kumar, K. S., Blanchet, K., Gibson, L., Hartley, S., Murthy, G. V. S., Patel, V., Weber, J., & Kuper, H. (2017). Community-based rehabilitation for people with physical and mental disabilities in low- and middle-income countries. *The Cochrane Database of Systematic Reviews*, 2017(3), CD010617. <https://doi.org/10.1002/14651858.CD010617.pub2>
- Jose, P., Kumar, S. S., Chandru, B. A., Sundaram, S., Vijayanand, S. M., Kutty, V. R., & Varma, R. P. (2023). Local governments and community-based rehabilitation for developmental disabilities: leaving no one behind. *Public Health Action*, 13(1), 37–43. <https://doi.org/10.5588/pha.22.0027>
- Koly, K. N., Abdullah, R., Shammi, F. A., Akter, T., Hasan, M. T., Eaton, J., & Ryan, G. K. (2022). Mental Health and Community-Based Rehabilitation: A qualitative description of the experiences and perspectives of service users and carers in Bangladesh. *Community Mental Health Journal*, 58(1), 52–66. <https://doi.org/10.1007/s10597-021-00790-0>
- Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., . . . Pluye, P. (2018). The mixed methods appraisal tool (MMAT) version 2018 for information professionals and researchers. *Education for Information*, 34(4), 285–291. <https://doi.org/10.3233/EFI-180221>
- Melak, M., Mekonnen, S., Fakolade, A., Batorowicz, B. (2026) "It Feels Like My Spine is About to Break": Experience and support needs of family caregivers of children with cerebral palsy in Ethiopia. *PLoS One* 21(4): e0346049. <https://doi.org/10.1371/journal.pone.0346049>
- Nazeer, E., Prabhakaran, A., & Jayaprakashan, K.P. (2020). Retrospective analysis of the program Suraksha Community Based Rehabilitation of person with mental illness and empowering the affected families' Social Justice-Psychiatry MC.TVM pilot project at a rural block Panchayat in Kerala, S. India 2019. *IOSR Journal of Humanities and Social Science (IOSR-JHSS)*, 25 (9), Series 4 (September. 2020) 45-55. [https://www.iosrjournals.org/iosr-jhss/pages/25\(9\)Series-4.html](https://www.iosrjournals.org/iosr-jhss/pages/25(9)Series-4.html)
- Nugraha, B., Ruslina Defi, I., Prima Yolanda, R., Warliani, M., Biben, V., Jennie, J., Mubarak, H., Mayasari, N., & Gutenbrunner, C. (2021). Describing community-based rehabilitation services in Indonesia by using the International Classification of Service Organization in Rehabilitation 2.0. *Journal of Rehabilitation Medicine*, 53(3), jrm00166. <https://doi.org/10.2340/16501977-2804>

- Pasara, M.T. (2022). Impact of community-based rehabilitation on attainment of sustainable development goals: The case of selected districts in Zimbabwe. *Frontiers in Communication*, (7) – 2022. 7:935097. <https://doi.org/10.3389/fcomm.2022.935097>
- Rebolledo-Sanhueza, J., Besoain-Saldaña, A., Manríquez-Hizaut, M., Huepe-Ortega, G., & Aliaga-Castillo (2021). Experiences and perceptions on disability and social participation in community rehabilitation centers in Chile. *Journal Saúde e Sociedade*, 30 (2), e200858, 2021. <https://doi.org/10.1590/S0104-12902021200858>
- Sagun, K. S., Alava, R. N. H., Cablay, K. T. S., Dagdag, K. A., Lagman, F. R. P., Nocos, K. E. S., Quidilla, J. Y., & Tan, N. M. M. (2025). Exploring the Accessibility of Community-Based Telerehabilitation for children with disabilities from low-income households. *International Journal of Telerehabilitation*, 16(2). <https://doi.org/10.5195/ijt.2024.6625>
- Shumba TW, Haufiku D, Amukugo H (2021). The use of photovoice in evaluating a community-based rehabilitation (CBR) program: experiences from CBR volunteers in Namibia. *Journal of Health Research*, 35(3), 249–264, doi: <https://doi.org/10.1108/JHR-10-2019-0224>
- Thilarajah, S., Dancza, K., Chen, Z.Z., Wong, C.X.Q., Yan, C.C., Niam, S., Ng, Y.S., Lynch, E., Churilov, L., Tan, W.K., Tan, E. & Kwah, L.K. (2025). Transforming Community-Based Rehabilitation services: A National Redesign Using Experience-Based Co-Design. *Health Expectations*, (28): e70330. <https://doi.org/10.1111/hex.70330>
- Tofani, M., Berardi, A., Iorio, S., Galeoto, G., & Marceca, M. (2022). Exploring global needs of migrants with disability within a community-based inclusive development perspective. *Annali dell'Istituto Superiore di Sanità*, 58(2), 124–130. https://doi.org/10.4415/ANN_22_02_08
- Tofani, M., Esposito, G., Berardi, A., Galeoto, G., Iorio, S., & Marceca, M. (2021). Community-Based Rehabilitation indicators: validation and preliminary evidence for disability in Italy. *International Journal of Environmental Research and Public Health*, 18(21), 11256. <https://doi.org/10.3390/ijerph182111256>
- Tongsiri, S. Scaling-up community-based rehabilitation programs in rural Thailand: the development of a capacity building program. *BMC Health Service Research* 22, 1070 (2022). <https://doi.org/10.1186/s12913-022-08458-5>
- Vaughan, K. R., & Thapa, R. K. (2023). Affordability of an NGO-government partnership for community-based disability rehabilitation. *African Journal of Disability* (12), a1283. <https://doi.org/10.4102/ajod.v12i0.1283>
- Wolderufael, W. (2022). Assessing practice and challenges of University of Gondar Community Based Rehabilitation Program to provide services for persons with disabilities. *European Online Journal of Natural and Social Sciences*, 11(3), pp. 743-759. Retrieved from <https://www.european-science.com/eojnss/article/view/6524>