Community-Based Rehabilitation Models for Children with Disabilities: Lessons Zimbabwe for Global Application.

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Abstract- ***Worldwide, it is known that there are 240 million children with a disability, which makes up for about one in every ten children. Such children tend to have accumulated problems such as lack of access to health, education, and social systems, besides the stigma and economic instability. Such barriers are escalated further in low- and middle-income countries (LMICs) by shortages of resources and geographic isolation. Community-Based Rehabilitation (CBR) has been developed into a well-known approach to bring about inclusion, empowerment, and the rights of persons with disabilities and is informed by the World Health Organization CBR Matrix.This study is a qualitative case study that explores the CBR approach in Zimbabwe by reviewing the case study of St. Daniel's Rehabilitation and Vocational Training Centre. The Centre was established to meet the needs of children with disabilities (CWDs) and their caregivers that were unaddressed at the time, making it an all-inclusive, family-focused model comprising health, education, livelihood, and advocacy. Information was extracted on the basis of organizational records, policy documents, and secondary literature, which gave information on the strategies employed on programs, partnerships, and their results.The results present four major lessons that have global relevance: the usefulness of holistic, family-focused rehabilitation; how economic empowerment can be integrated into rehabilitation services; how the partnership can be used to make it more sustainable; and how to balance local culture with attempts to uphold principles based on rights. Such lessons provide a plan to adopt CBR models in various economic and cultural environments. The paper concludes that the experience of Zimbabwe evidences how the policies and practices can be bridged through locally situated, multi-sectoral approaches and that this contributes towards the filming of inclusive societies. Wider cross-country learning and inculcation into international global disability models are advisable to empower CBR globally.***

I. INTRODUCTION

Approximately one in ten children in the world lives with a disability, which is approximately 240 million children (World, 2023). Examples of these are in the physical (including sensory, developmental, and psychosocial) conditions, usually compounded by poverty, stigma, and inaccessibility to urgently needed services. These problems are compounded by underfunded health systems, inaccessible infrastructure, and shortages of trained personnel in low- and middle-income countries (LMICs), which require new and community-based solutions.

Provided by the World Health Organization, Community-Based Rehabilitation (CBR), introduced in the late 1970s, provides a multi-sectoral, rights-based approach to health, education, livelihoods, social participation, and empowerment (Chapal et al., 2025). As a community-based intervention, CBR uses local resources as well as cultural capabilities to enhance the quality of life of both children with disabilities (CWDs) and their families and is in line with international guidance like the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

The population in Zimbabwe has the progressive disability policy and the ratification of UNCRPD; however, economic barriers and deficiencies in the infrastructure reduce the ability to provide services. NGOs and other non-profitable voluntary organizations (PVOs) are also important in filling the gaps by means of rehabilitation, advocating, and inclusive education practices (Kabonga, 2023). This paper focuses on the experience of the CBR in Zimbabwe as the case study. The case study is St. Danilas Rehabilitation and Vocational Training Centre, an integrated approach and partnership of the center. The article summarizes the globally relevant lessons that can be applied in the strategies towards inclusive disability care that is community-focused.

II. LITERATURE REVIEW

Global CBR Frameworks: The WHO CBR Matrix

The World Health Organization (WHO) formalized the Community-Based Rehabilitation (CBR) framework in the late 1970s in reaction to the fact that few people and resources in underprivileged locations received rehabilitation services. Over the years the strategy has developed into an approach based more on a comprehensive, rights-based, and multi-sectoral approach instead of being medical in focus. The CBR Matrix is a conceptual framework developed in 2010 and included in the WHO CBR Guidelines that consists of five interdependent elements: health, education, livelihood, social participation, and empowerment (Chapal et al., 2020). These areas are meant to help and offer direction to governments, organizations, and communities to develop the development of inclusion of persons with disabilities since what was affected was the absence of programs that incorporate the functional rehabilitation requirements of persons with disabilities as well as their overall participation in socio-economic and cultural life. Interventions in the health component extend through medical rehabilitation and mental health support; in the education component, they enhance inclusive schooling; in the livelihood strategies, they train skills and employment; in the social participation, they create inclusive participation in both cultural and recreational life; and finally, in empowerment, they undertake advocacy, human rights, and the representation of themselves (Aldersey et al., 2023). The Matrix is accommodative to different contexts, and thus it serves as one of the main global references for obtaining the implementation of CBR.

Historical Evolution of CBR in Low- and Middle-Income Countries CBR also appeared as a cost-effective way of reaching the rural population with basic rehabilitation services, who relatively had limited access to professional services. Physical rehabilitation formed a large part of the intervention, in the early stages usually provided by trained community workers overseen by health professionals. But that focus on CBR in LMICs during that part of the 20th century changed by the 1990s and early 2000s when the focus moved towards the social model of disability, with CBR expanding to include social, educational, and economic aspects. Advocacy movements, policy changes, and international mechanisms such as the UNCRPD, which focused on the rights and agency of persons with disabilities, instigated this transformation. In other African nations, including Uganda, Kenya, and Zimbabwe, CBR initiatives developed to meet these poignant socio-economic circumstances, in these cases with a focus on getting people into some form of income-generating activity and vocational rehabilitation through rehabilitation plans (Lightfoot, 2024). This turn was a huge change from service delivery through charity to an individual-based approach of service delivery rooted in communities.

Evidence on CBR Outcomes for Children with Disabilities Internationally

Evidence-based practice has demonstrated repeatedly that CBR can enhance the inclusion and quality of life of children with disabilities, especially when practiced in afflicted settings. As an example, the study in rural India showed a positive effect of CBR interventions on school enrollment rates and reduced child mobility restrictions associated with physical impairments. Community-based programs have been found to lead to better access to assistive devices, increased access to education, and greater caregiver coping strategies in sub-Saharan Africa (Malik & Nadeem, 2022). Moreover, CBR programs involving the participation of families and communities have been identified to minimize stigma and stimulate inclusive attitudes. Other factors that have led to economic stability and minimized external aid dependency include the introduction of livelihood

training to caregivers, which has been witnessed in a number of LMIC situations. Notably, in WHO and UNICEF reviews, interventions based on local culture and nurtured on multi-sectoral partnerships are more likely to deliver more sustainable effects, since they are adapted to the community necessities and possibilities.

Adaptation of CBR Across Cultural and Economic Contexts

In spite of the mentioned successes, major gaps in literature remain in the area of adapting and scaling CBR models in various cultural and economic contexts. Much of the current research tends to base itself on pilot projects or small-scale project types of work, with few longitudinal studies of the areas that are long-term sustainable. Furthermore, the CBR Matrix provides a general model, but it still can take a context-specific form to be implemented properly, which is not thoroughly described in scholarly works. To give an example, the strategies that are effective in the rural context in Africa would have to be adapted significantly in the urban high-income country environment, where structures, cultural attitudes, and the policy landscape are much different. Most of the research on both CBR and children with disabilities has been held in Asia and Africa, and very little of such research has been done in Latin America, the Middle East, and post-conflict settings (Agudelo et al., 2024). The absence of comparative analysis that would check which elements of CBR can and cannot easily be implemented everywhere also exists. Such lack of knowledge highlights the necessity of cross-country learning and the adaptation of the practices in terms of systematization, especially with the growth of disability-inclusive development as a priority in the international Sustainable Development Goals (SDGs) market.

III. METHODOLOGY

This research was qualitative case study research that took a descriptive analytical approach to investigate the Community-Based Rehabilitation (CBR) model practiced by St. Daniel's Rehabilitation and Vocational Training Centre in Zimbabwe. The method of the case study was selected due to its ability to relay the detailed overview of the circumstances, procedures, and consequences of a certain intervention, which allows substantially analyzing a myriad of strategies and learning and how it can be applied in other contexts. There was the use of descriptive analysis by reporting structured narrative findings using qualitative document materials and secondary literature.

The research was dependent on the availability of (or access to) a number of data sources to provide triangulation and increase validity. These were organizational documents of St. Daniel's Centre, including records of programs, number of beneficiaries, and agreements with partners. The documents that were reviewed in relation to disability and rehabilitation in Zimbabwe were available policy documents on disability and alignment to the UNCRPD. Peer-reviewed journal articles, reports published by the WHO and UNICEF, and regional studies on CBR were searched as secondary sources to place the findings in the context of the global discussion of disability-inclusive development.

The case study of the St. Daniels Rehabilitation and Vocational Training Centre was specifically chosen because of its multi-sectoral and comprehensive CBR approach as well as its proven effectiveness in the Midlands Province of Zimbabwe. The Centre was established after the unmet needs of children with disabilities and their caretakers without any mechanisms to support children with disabilities and their caretakers psychosocially and, also, equip them with skills needed to earn a living. Its collaborations with other global organizations, including UNICEF, Save the Children, and Plan International, all underscore that it is a relevant, replicable, and scalable model. This research is limited in that secondary data and organizational records were relied on; these can be prone to reporting bias. This lack of primary interviews limits the breadth of the views of the beneficiaries. Ethical issues considered were ensuring that there was confidentiality in the management of organizational information and following the lines of keeping up with the principles of respectful and non-stigmatizing language when addressing the issues of disability.

Context of Zimbabwe's CBR Implementation

National Disability Policies and Alignment with UNCRPD Zimbabwe has shown its willingness to accept disability inclusion, as it ratified the UNCRPD in 2013, an indicator of the rights approach that pays attention to social and environmental barriers as significant factors hindering participation. Inclusive education, access to infrastructure, social protection, and livelihoods are supported by the Disabled Persons Act (1992) and the National Disability Policy (2021). Such are consistent with the principles of the UNCRPD but are challenging to implement (Ndhlovu & Nyunyutai, 2022). Contracting budgets, poor enforcement, and minimal professional training prevent any effective on-the-ground efforts, especially in rural underserved regions where resources to deliver services are already limited.

Socio-Economic Challenges Faced by CWDs and Caregivers

Children with disabilities (CWDs) in Zimbabwe usually face further stigma and deprivations through their resource deprivation, reduced services, and poverty. Several families are unable to cover assistive gadgets, healthcare needs, and transport to reach schools that are supportive to them. The economic instability also limits the household, and therefore the caregivers, mostly mothers, have to decide between employment and full-time care. Additionally, access to timely diagnosis and rehabilitation is limited by rural isolation and lack of qualified professionals with a disability (Pasara, 2022). Exclusion goes even deeper with stigma, bullying, and discrimination taking place in communities and schools. Such economic, geographic, and cultural barriers put great emotional and financial pressure on families.

Role of NGOs, Community Volunteers, and Government Agencies

In Zimbabwe, non-governmental organizations (NGOs), community groups, and private voluntary organizations (PVOs) play a crucial role in the provision of Community-Based Rehabilitation (CBR) services. They provide therapy, assistive aids, inclusive education, vocational training, and support to the caregivers. The community volunteers activate the resources, create awareness, and connect families to services. The input is offered by the government agencies, especially the Ministry of Public Service, Labour and Social Welfare, through policy-making and small financial support (McConkey et al., 2024). The partnership between these actors—which is usually facilitated by international donors—has resulted in the maintenance of culturally specific, sustainable, and CBR outcomes that had the capacity to deliver to underserved rural and marginalized populations.

Overview of St. Daniel's Rehabilitation and Vocational Training Centre

The St. Daniels Rehabilitation and Vocational Training Centre was established by Mrs. Petty Musekiwa, motivated by the need to support a child with special needs identified as having autism. The organization supports the needs of the child and provides CBR services since gaps exist in the Midlands Province of Zimbabwe. It is a registered PVO (32/2017) that consists of psychosocial counselling, physiotherapy, occupational therapy, vocational training, support of inclusive education, and advocating disability. It also has income-generating initiatives by caregivers, which strengthens the resilience of the households. It reaches out to the rural aspects where it fails to provide rehabilitation services. Its collaboration with UNICEF, Save the Children, and Plan International has helped expand its capacity, outreach, and advocacy power.

IV. THE ST. DANIELS CBR MODEL

Multi-Sectoral Approach

The St. Daniels Rehabilitation and Vocational Training Centre adopts a multi-sectoral, timely community-based rehabilitation (CBR) approach that combines health, education, livelihoods, and advocacy. The approach corresponds to the foundations of the WHO CBR Matrix so that children with disabilities (CWDs) and their caregivers are supported in a way that achieves not only the short-term rehabilitation outcomes but also the long-term social inclusion of individuals with disabilities. The center offers basic rehabilitation services, which include physiotherapy and occupational therapy in the health area, whereas the center is also engaged in providing psychosocial counselling services to address mental well-being. The education programs target inclusive schooling through helping place the

child in school, giving them remedial services, and providing teacher education on disability-sensitive pedagogy (Magnusson et al., 2016). Livelihood activities focus on the caregivers providing vocational skills that will help in increasing the incomes of the household to boost their economic independence. The creation and promotion of a stigma-free environment and empowerment of disability rights through advocacy at the community and policy level is an attempt to change service delivery models. This is a complete combination, which makes interventions interconnecting, thus solving the multi-dimensionality of challenges that CWDs and their families face.

Disability-Friendly Counselling and Vocational Training

Disability-friendly counselling and vocational training programs are some of the distinct markers of the St. Daniels model. Counselling services are aligned with individual emotional and social requirements of CWDs, and they include communication approaches acceptable to children with speech, cognitive, or sensory deficiency (Reppsi & Hanass, 2024). In the case of caregivers, counselling sessions are based on the issues of coping mechanisms, stress relief, and resilience to social stigma and the challenges of caregiving. Vocational study is also all-inclusive, in that it is developed to accommodate different capabilities or learning styles. The areas one is trained in are tailoring, carpentry, beadwork, poultry farming, and small-scale agriculture. The center prepares persons to take up available vocational opportunities by linking them with the local market demands in order to make skills gained applicable in income-generating activities. Notably, such programs promote social inclusion, giving the CWDs and their families more active participation in the economy of the community.

Community Mobilization Strategies

The St. Daniels CBR model revolves around community mobilization because the inclusion of the disabled depends on the contribution of all the stakeholders. The Centre involves traditional leaders, religious institutions, local government representatives, and school administrators in order to create supportive environments for CWDs (Chapal et al., 2025). Depending on community volunteers, who are usually the ones to organize the awareness campaigns, they are aimed at debunking myths related to disability and encouraging inclusion through education, as well as early referrals to rehabilitation services. Some services and interventions access reduces the physical barrier because therapy, counselling, and training are introduced in the rural location with outreach programs. Disability committees are also formed locally and are regarded as disability advocacy entities that observe the rights and needs of the CWDs and lead in communicating with providers. This bottom-up action does not only enhance service utilization but also creates the local ownership of disability inclusion efforts.

Partnerships with UNICEF, Save the Children, and Plan International

The defining strength in the St. Daniels model refers to the strategic partnerships. Partnerships with UNICEF have helped the Centre to improve its skills in providing child-focused rehabilitation services, especially in the area of inclusive education and child protection. Save the Children has encouraged the programs connected to protection, psychological stability, and educational inclusion of CWDs in susceptible societies. The participation of Plan International has also enabled livelihood initiatives, wherein they offer means and training to caregivers to help them in setting up small enterprises (Basha & Naseerali, 2017). Such partnerships have also brought about enhanced advocacy activities that enable the Centre to engage in the national policy discussion and contribute to the development of disability-related legislation. Through the knowledge base, capital base, and connectivity among these global organizations, St. Daniels has been able to do so much more—increase its footprint, manage the quality of its services, and be able to sustain the programs.

Qualitative Outcomes Achieved

Qualitative results of the St. Daniels CBR model can also be observed wherein the quality of life of the population is increased, the attitudes of the people within the surroundings improve, and CWDs and their families are made more empowered. The beneficiaries have noted that they have gained self-esteem, have fewer feelings of isolation, and have

become more active in participating in education and community activities. Trained caregivers in vocational skills have reported more financial freedom to afford good care for the household and the independence of the household members (Bongo et al., 2018). This involvement of teachers and community leaders via awareness programs has shown more inclusive attitudes, which has resulted in real-life changes in the CWDs' school enrollment and retention. The inclusion of advocacy has led to the changes in policy locally, including the increased accessibility of the general facilities as well as the improved coordination of the health and education services. Although the quantitative evidence on the results is poor, these qualitative signals prove the high level of social impact of the Centre, illustrating the worth of locally rooted, multi-sectoral application of CBR.

Holistic, Family-Centered Rehabilitation

One of the insights gathered under the St. Daniels model is that the needs of children with disabilities (CWDs) and their caretakers should be addressed on a holistic, family-centered basis. The rehabilitation in this context goes past medical and therapeutic rehabilitation to the psychosocial support and assistance to inclusion education and empowerment of caregivers (McConkey et al., 2024). Understanding the family unit as the basis of the development of the child, the services aim to improve the ability of the caregivers to consistently treat their children, defend the child's rights, and cope with the emotional issues of disability. This model takes into consideration that family resilience and stability are directly linked with the welfare of the child. Internationally, a more family-centered approach can be implemented in CBR to enhance outcomes because they support sustainable insurance of ensuring that the interventions are realistic and based on the day-to-day reality associated with CWDs.

Integration of Economic Empowerment with Rehabilitation

Economic vulnerability is considered a major setback to proper rehabilitation, especially when resources are low. St. Daniels Centre implemented its response to this with economic empowerment programs or activities like vocational training in skills development and providing small businesses with start-up funds as part of its CBR program. Caregivers are mostly mothers who have missed the opportunity to earn an income through strengths in tailoring, farming, production of crafts, and other jobs that match the local markets (Sunil, 2022). This integration accrues to the fact that the rehabilitation efforts are augmented by higher household income, thus limiting the financial pressure facing support and allowing the families to address the successive needs of CWDs. To be applicable in the global application, especially in the LMICs, the rehabilitation programs can and should be enhanced by livelihood aspects to ensure sustainable impact and self-reliance and alleviate aid dependency as well as boost dignity.

Leveraging Partnerships for Sustainability

The strength of the partnerships that are necessary in achieving sustainability and scalability of CBR initiatives usually dictates the partnerships. St. Daniels has managed to form partnerships with international organizations and other organizations such as UNICEF, Save the Children, and Plan International in such a way that it can expand to more people, locate sources of funds, and access technical knowledge. The alliances have also assisted the Centre in implementing superior services and policies at elevated levels and maintaining projects where other disparate resources can be procured. It points to the significance of cross-level partnerships globally since community-based players are networked with national agencies and international players (Bria et al., 2020). The alliances can provide stability, amplification of advocacy platforms, and the capacity-building services required by CBR programs to succeed. To this end, it is also possible to exchange information between countries and regions.

Adapting to Local Cultural Norms While Upholding Rights-Based Principles

CBR should be attentive to cultural values or practices without violating of the people living with disabilities. St. Daniels has addressed the stigma of the disability and the relevance of traditional beliefs in Zimbabwe through dialogue with the village leaders, faith-based organizations, and family awareness activities (Bongo et al., 2018). Such activities have resulted in reframing disability from a shameful condition to a rights and inclusion issue. Within a global context, this shows that CBR models

need to be context adjusted so as to touch local core values and belief systems while at the same time conforming to international rights-based systems as defined by the UNCRPD. This is not only a balance that will make such a community buy-in necessary to the sustainability of inclusive practices, but it also protects the dignity and autonomy of CWDs.

V. COMPARATIVE ANALYSIS

Comparison with Other CBR Initiatives

The St. Daniels model in Zimbabwe has many things in common with successful CBR initiatives throughout Africa, Asia, and Latin America, but it is also in line with idiosyncratic adaptations to the local situation. Multi-sectoral interventions involving health, education, livelihoods, and advocacy have also been implemented in programs at the national level in Uganda and Kenya in Africa (Sibindi, 2025). As such, St. Daniel's engagement with the grassroots can be compared to the National CBR Program of Uganda, as the country has placed emphasis on rural outreach and community-based disability committees. In Asia, the CBR programs of India (especially in rural Andhra Pradesh) have focused on inclusive education, vocational training, and self-help groups, which represent the model of self-help groups formed in Zimbabwe (caregiver empowerment schemes). CBR programs in Latin America, which include Colombia, have been known to be post-conflict-oriented, blending the sense of psychosocial help and community development. Although all of these models feature the community participation aspect, the St. Daniels model is of special interest due to its inclusion of the economic empowerment factor in the rehabilitation process as opposed to an additional activity.

Universally Adaptable Components vs. Context-Specific Elements

Some of the aspects of the St. Daniels model can be transferred anywhere. These are, inter alia, the fact that it uses a holistic approach that incorporates health, education, livelihoods, and advocacy; the fact that it focuses on family-centered care; and its use of community mobilization to achieve inclusion. Another strategy that has global relevance on how to scale up and maintain CBR is the integration of partnerships, which connects the local efforts with international organizations (Balestrery, 2023). Nevertheless, certain of its elements are greatly situational. When considering vocational skills available at St. Daniels, such as tailoring, poultry, and beadwork, there is the reflection of the rural setting by the economic system in Zimbabwe as a country, and thus this may have to change with the market dynamics in other areas. Equally, cultural engagement strategies like the inclusion of the traditional leaders to overcome stigma might have to change when the cultures to be interacted with are less traditional. The program also responds to the peculiarities of the Zimbabwe socio-economic issues, including hyperinflation and scanty provision of public services, which influences its operational strategies in ways that are not directly related to stable economies.

VI. RECOMMENDATIONS FOR GLOBAL ADAPTATION

Policy-Level Recommendations

Governments that intend to build up on the disability inclusion by using the Community-Based Rehabilitation (CBR) need to give special focus to capacity building, especially by making the CBR part of the national development plans in addition to the disability action plans. These are the use of specific budget lines to support CBR programs, enhanced monitoring systems to support adherence to the US convention on the rights of persons with disabilities (UNCRPD), and inter-ministerial collaboration at the health, education, and social welfare departments. There also should be policies that require the gathering of disaggregated data of children with disabilities (CWDs) to plan, monitor, and fill in the gaps in services.

Practical Steps for NGOs and Community Leaders

Community leaders and non-governmental organizations (NGOs) can modify what was done in St. Daniel's model in Zimbabwe by, first of all, carrying out a community needs assessment to come up with context-specific interventions. Special focus should be on multidimensional service provision that integrates rehabilitation and educational assistance, bolsters caregiving, and provides advocacy. To ensure continuity and local ownership, the NGOs ought to develop capacity within the volunteer

community that can act as facilitators in the process of rehabilitation and mobilizers. Leaders of the community can overcome stigma by organizing awareness campaigns, discussing the issue of disability rights, and speaking with persons with disabilities to be included in decision-making processes. In addition, connecting the livelihood training with local market needs can raise the sustainability of incomes of families of CWDs significantly.

Integration with Global Disability Frameworks

CBR programs are advised to be consistent with the known world disability frameworks, including the WHO CBR Matrix, the Child Disability Inclusion Framework by UNICEF, and the Inclusive Education Guidelines by UNESCO, to achieve the maximum impact and sustainability of the program. These frameworks provide evidence-based methods and technical guidelines that can be localized. Connection to the international networks allows exchanging knowledge as well as peer learning along with receiving access to the international funding opportunities. Also, you can attend regional and global disability forums that can intensify the advocacy as well as the formulation of inclusive country and international policy. Within such frameworks, local programs can be embedded to make sure that the activities made at local levels relate to international commitments of ensuring inclusive and equitable societies.

CONCLUSION

The experience in Zimbabwe, as seen in the case of the St. Daniels Rehabilitation and Vocational Training Centre, can contribute so much to the CBR thinking around the world. Its family-centered model with its holistic approach shows how the multi-sectoral interventions (that should include health, education, livelihoods, and advocacy) can meet the various needs of children with disabilities (CWDs) and their caregivers. Through the incorporation of economic empowerment within the rehabilitation process and the use of partnerships with international agencies, the St. Daniels approach reveals the possibility of resource-limited conditions producing sustainable and meaningful results. The same can be said about its culturally sensitive approach to community mobilization, which clearly emphasizes the significance of localizing interventions to the local context, leaving a rights-based basis intact.

The experiences of Zimbabwe suggest the need to scale up cross-country learning in which practitioners, policymakers, and researchers share their experiences and distill optimal practices as well as record innovative practices. Such platforms of collaboration with the support of agencies such as WHO, UNICEF, and UNESCO could speed up scaling of effective CBR models across regions and contexts. CBR contributes most towards the attainment of inclusive societies in a manner that removes barriers and strengthens the families, and also the persons with disabilities are able to fully take part in matters relating to their social and economic and also cultural life. This is in line with the Sustainable Development Goals as nations work to become more equitable and compassionate towards one another and will require an adaptable, community-based rehabilitation model such as the one practiced in Zimbabwe.

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