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IDOSR JOURNAL OF APPLIED SCIENCES 11(1):117-127, 2026 ISSN: 2550-7931

https://doi.org/10.59298/IDOSRJAS/2026/111117127 IDOSRJAS11106

# Disability and Rehabilitation in Post-War Societies: Challenges, Responses, and Pathways to Inclusion

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**ABSTRACT**

Armed conflicts leave profound and enduring impacts on populations, with disability emerging as one of the most significant yet under-addressed consequences of war. This narrative review examines the burden of disability in post-war societies, the multidimensional challenges faced by persons with disabilities, and the evolving landscape of rehabilitation and inclusion efforts. Evidence from conflict-affected regions demonstrates that war-related injuries, psychological trauma, explosive remnants, and the destruction of health and social systems significantly increase disability prevalence while simultaneously weakening service delivery capacity. Post-conflict environments are further characterized by inadequate funding, fragmented health systems, limited assistive technologies, and persistent social stigma, all of which constrain rehabilitation outcomes and hinder social integration. Despite these barriers, innovative approaches including community-based rehabilitation (CBR), inclusive policy reforms, strengthened health workforce training, and partnerships between governments, NGOs, and disability organizations show promise in advancing equitable access to rehabilitation services. The review highlights the need for long-term, context-specific strategies that prioritize accessibility, community participation, and systems strengthening. Sustainable investments in rehabilitation, robust disability-inclusive policies, and the integration of assistive technologies are essential for enabling full participation and improving the quality of life of persons with disabilities in post-war settings.

**Keywords:** Post-conflict rehabilitation, Disability inclusion, Community-based rehabilitation (CBR), Assistive technology, and Social and structural barriers.

## INTRODUCTION

The aftermath of armed conflict leaves societies and people with multifaceted challenges. Disability emerges as a concern for conflict-affected societies due to two contrasting processes. Armed conflict can generate new disabling injuries, putting many people into impairment categories, whereas a post-conflict environment that enables higher movement, trade, information dissemination, and demands on the workforce both formal and informal often creates a path for previous impairments to diminish. Conflicts contribute to the emergence of even minor disabilities into a social and health concern [1]. Such disability and rehabilitation challenges in caregiving and social inclusion connect to the lack of comprehensive definitions and frameworks for understanding, identifying, and analyzing disability. Thus, a disability framing seems appropriate and may provide the greatest explanatory power and analytical leverage in post-conflict rehabilitation efforts [4]. The expansion of disability as a post-conflict concern highlights the need for a disability conceptual framework that can guide issue analysis and encourage meaningful rehabilitation responses while analyzing gaps [2]. Moreover, this multi-framework consideration needs to examine disability concern before, during, and after conflict exposure and the wider shift from rehabilitation projected by the United Nations target of "leave no one behind" to a broader aspiration of social inclusion and full participation of all citizens regardless of disability[3]. Recognizing, acknowledging, and

responding to a disability concern in post-conflict environments triggers a question: How does one influence rehabilitation programming and service procurement in post-conflict contexts?

## Conceptual Frameworks and Historical Context

An analysis of disability in post-war settings must begin by understanding the socio-political landscape that a rehabilitation framework must respond to [5]. The inability to adequately address the after-effects of conflict has a disallowing effect on many forms of reconstruction, so tracing shifts in definitions, norms, and policy milestones across humanitarian and development communities identifies key windows for engagement that arise or return within post-war contexts[3]. Despite widespread acknowledgement of the pervasive impact of armed conflict on health and disability, fundamental debates over aspects of disablement remain unresolved; dominant models [2], largely uncritically adopted from geographical post-war norms, fail to sit well with contested theories [5]. The promotion of rehabilitation has frequently been coupled to the lesser-acknowledged but equally influential objective of social inclusion. Apart from the many broader factors affecting inclusion, conceptual difficulties underpinning the rehabilitation agenda bear directly on approaches to integration with development and humanitarian aid [1]. Social and economic upturns in many parts of the world, particularly the Global North, during the post-war period have generated extensive programme development in fields closely allied to disability, but wider application of internationally endorsed management strategies emphasises the merits of consistent engagement with recovery, reconstruction, and development, rather than diffusion into unrelated areas [1]. The dominant conceptual lenses constraining the post-war handicap analysis can be summarised in relation to the rehabilitation and social inclusion models. Aspects of these frameworks also characterize much of the longer-established disability discourse informing service provision and support more broadly [3]. Explorations of the extent to which countries, regions, and organisations apply items aligned with these frameworks point to fewer geographical components and greater disparities at sub-geographical scales.

## Disability in Post-War Settings

Disability, defined as the interaction between persons with impairments and barriers that hinder participation in society, presents complex dynamics in post-war situations [29]. Emphasizing the variety of post-war settings, this section assesses representative countries to identify generalizable aspects [2]. Globally, fifty years of advocacy for equalization of opportunities, full participation, and rights-based approaches have failed to address reformulation of concepts of rehabilitation, inclusion, and rights of persons with disabilities in post-war countries, where unique circumstances need recognition and varied but interconnected factors affect the situations of different actors [3].

Developing countries and countries with transitional economies constitute most nations involved in armed conflict [4]. The criteria for war are length, intensity, and resulting casualties, consistent with the UN definition of "major armed conflict." Sixty-four countries experienced at least 1000 battle-related deaths since the mid-1990s; twenty-nine of these nations had major armed conflicts at the end of 2008, affecting 15% of the world's population [5]. It is interesting to note that, according to the World Bank, fragility and conflict now affect one billion people worldwide; if good governance, security, and sustained development cannot be provided, 1.8 billion individuals are projected to be living in fragile contexts by 2050 [5].

## Rehabilitation and Social Inclusion Models

Reducing barriers to participation and ensuring equal access to rehabilitation, services, and support remain priorities [1]. Comprehensive rehabilitation means restoring lost functions, such as mobility and speech, and does not always require specialized services. Although most post-war contexts face rehabilitation shortages, few recognize the full range of challenges or systematically address them [3]. Preliminary surveys identify urgent needs—including both physical and mental health burdens, yet policy responses often overlook rehabilitation and approve only restricted service packages through post-war plans and procedures [4].

## Prevalent Challenges in Post-Conflict Environments

Conflict situations increase physical and mental health burdens; detrimental outcomes arise not only from direct injuries but also from indirect effects on existing conditions, exacerbating total body impairment [6]. Individuals requiring rehabilitation post-conflict commonly present post-traumatic stress disorder, depression, and anxiety; these often co-occur with other conditions. A literature review indicated that health needs and access obstacles limited data availability; where information existed, revision of clinical guidelines was necessary [3]. Survivors often face diverse challenges associated with the recovery trajectory, necessitating adaptive responses. Supporting rehabilitation among individuals sustaining life-changing injuries follows a common pathway [4]. Mental sequelae after trauma vary widely, resulting from sociocultural context or prevailing stressors encountered in restoration efforts [2].

### Physical and Mental Health Burdens

Physical health sequelae, attributable to armed conflict, natural disasters, and other traumatic events, can substantially impact psychosocial well-being, especially when they restrict mobility or other functions [7]. Dependence on others for assistance, particularly with personal care, can lead to feelings of shame and embarrassment. Difficulties in daily activities can also diminish independence and self-esteem. Survivors may avoid social situations, fearing exposure to their disabilities, loss of privacy, or detrimental stigma [8]. Furthermore, persons with disabilities report social exclusion, rejection, and loss of family or social ties more often than people without disabilities [7]. Mental disorders such as depression, anxiety, and post-traumatic stress disorder are prevalent in post-conflict settings. Addressing the coexistence of physical and psychological needs thus remains critical for survivors with disabilities, as for the wider population [6].

### Health System Disruptions and Resource Constraints

Health system disruptions significantly compromise rehabilitation service delivery following armed conflict. Loss of physical infrastructure, fragile supply chains, small workforce numbers, and unstable funding create severe and epidemic imbalances in the health sector [8, 9]. Post-war recovery typically focuses on the reconstruction of the health system, rather than the rehabilitation sector. Availability of specialists remains low in extreme and post-conflict situations; for example, whenever armed violence has affected a country for at least 30 years, physiotherapy services are absent in 70% of surveyed health facilities[6].

### Social, Economic, and Structural Barriers

Disability remains a sensitive subject in settings emerging from violence, conflict, or armed military engagement. People with disabilities continue to face stigma, discrimination, and detrimental attitudes [7]. The impact of such negative perceptions can be compounded by existing structural disadvantages, leading to exclusion on multiple levels [10]. For example, in rural contexts after war, majority populations, including individuals with disabilities, face additional marginalization linked to urban to rural divides [5].

### Rehabilitation Services: Scope and Gaps

Rehabilitation services are essential for enabling individuals with disabilities to improve functioning and quality of life. Gaps in service provision include limited access in rural areas, inadequate support for secondary complications, and insufficient integration of mental health and social participation [1]. Addressing disparities, incorporating human rights perspectives, and ensuring person-centered approaches are crucial. Strengthening rehabilitation requires tackling systemic barriers and promoting inclusive policies for better outcomes. A wide range of medical rehabilitation services is crucial in post-war settings [3]. Health workers of various disciplines provide physiotherapy, occupational therapy, and psychotherapy services. Community health workers offer a broader range of services, such as rehabilitation, mental health support, and psychosocial support [5]. Essential assistive products typically include wheelchairs, prostheses, hearing aids, gloves, white canes, and spectacles. Particular challenges faced include the maintenance of medical rehabilitation equipment and assistive products due to shortages of qualified repair technicians and service providers, and assistance for vulnerable persons to procure assistive products [6].

### Medical Rehabilitation and Assistive Technology

Rehabilitation is provided for individuals disabled by disease or injury to restore independence and enhance quality of life; assistive technology enables disabled persons to participate more fully in society [5]. The goal of rehabilitation is for survivors to regain optimal physical, mental, social, and vocational skills that can be restored after an injury [1]. This includes restoration of gross and fine motor function, communication skills, cognitive function, activities of daily living such as dressing and grooming, mobility, new skills for vocational work, and pain management [11]. Following significant trauma, survivors exhibit catastrophe theories of recovery, and the provision of rehabilitation services can alter the recovery trajectory. Investing in rehabilitation and assistive technology following injury pays economic dividends through the restoration of skills and capabilities, minimized loss of economic productivity, and lowered social support for dependents [3].

### Community-Based Rehabilitation Approaches

Although the World Health Organization originally established community-based rehabilitation (CBR) in 1977 with a focus on physical restoration, its contemporary understanding is much broader [12]. Now recognized as a community development strategy encompassing aspects of rehabilitation, CBR fosters social inclusion and equal opportunities among people with disabilities from a rights perspective [12]. Applied in low-resource settings, CBR reinforces a primary health-care approach through coordination and outreach and by mobilizing community resources to promote an accessible environment [13]. By facilitating the retention of trained rehabilitation personnel and integrating rehabilitation into overall health-sector development, it is scalable and adaptable to multiple service-delivery models. CBR offers an inclusive, non-institutional approach that broadens health access

and bolsters societal reintegration in post-war settings [11]. Particular prominence has been given to mental health, as war-torn societies have witnessed a dramatic increase in associated disabilities; CBR assists recovery through community-based outreach, integration of rehabilitation and primary health care, and collaboration with psychosocial and technical services [15].

**Workforce Development and Training Needs**

Access to rehabilitation services, assistive devices, and post-rehabilitation support is crucial for sustainable recovery and reintegration of survivors in post-war settings. Lack of availability, affordability, and awareness of existing services hinders access to rehabilitation [14]. Workforce shortages compound these challenges, as evidenced by a lack of training local practitioners and professionals to maintain critical rehabilitation supplies [15]. Given the growing demand for rehabilitation, timely action is needed to develop the workforce [20]. Further education for existing health professionals is essential to expand their capacity to provide rehabilitation, build on the generalist training approach adopted following previous conflicts, and promote cross-sector collaboration for equitable service provision [20]. In some post-war environments, non-health personnel, including engineers, social workers, and community workers, form the rehabilitation workforce [25]. Training such personnel, particularly teachers and psychosocial personnel, remains a high priority to ensure the establishment of rehabilitation services. Curriculum development efforts are usually accommodated within existing educational structures containing registered training centers for health personnel, but accreditation, certification, supervision, and staff turnover remain pressing issues. The domain is under-researched in many post-conflict settings, leaving scant information and sources to support distance education or self-study [29].

**Policy and Governance for Inclusive Rehabilitation**

Post-conflict rehabilitation policies should derive from international guidelines adapted to national and local contexts [16]. Each country's National Development Plans often articulate disability-inclusive development priorities that align with the Convention on the Rights of Persons with Disabilities, yet the actual implementation of these policies varies widely [13]. In addition to legal rights, access to safety nets and social protection remains critical, influencing rehabilitation access and effectiveness. Continued attention is thus required to the maintenance and further development of inclusive laws, safety net coverage, and other financial support mechanisms [12]. Analytical frameworks, data collection, and monitoring and evaluation efforts could be enhanced by greater national and international adherence to internationally recommended general principles for effective rehabilitation policy and governance [21].

**International Guidelines and Local Adaptation**

International normative frameworks provide comprehensive visions of rehabilitation and disability policy, yet the path from advocacy to local implementation remains elusive [9]. By juxtaposing international guidance with local initiatives, this section assesses alignment with the UN Convention on the Rights of Persons with Disabilities (CRPD), National Development Plans (NDPs), and national disability and health strategies, highlighting priority actions to bridge identified gaps. Guidance on intersections between rehabilitation, disability, and development is particularly salient, underscoring sectoral coordination and multiservice integration [8]. The Global Action on Disability and Development (GADD), which emphasises the integration of disability into the global development agenda, urges national commitment to the 2030 Agenda for Sustainable Development, and calls for a systematic approach to disability-inclusive development in humanitarian contexts, reinforcing the complementary role of rehabilitation and development objectives in broadening the scope of inclusion efforts [13]. Despite extensive international guidance regarding disability, rehabilitation, development, and humanitarian situations, local adaptation remains uneven, with particular non-governmental organisations (NGOs) necessitating further assistance in interpreting and contextualising these frameworks [17].

**Disability Rights, Protection, and Social Protection Mechanisms**

People with disabilities experience greater hardships in post-conflict settings. Limited disability rights protection remains a widespread obstacle globally, and such protection is even more tenuous in post-war contexts. Legal recognition marks a vital development, one that can spur action through conventions, treaties, and national frameworks [4]. In many situations, however, the legal right to protection coexists with pervasive inequity. Cash and in-kind benefits offer additional assistance, as does social inclusion programming intended to empower people with disabilities to voice grievances and pursue justice [3]. As in many domains of rehabilitation, benefit and inclusion measures lack a comprehensive definition and active measurement [13]. Protection can include laws against discrimination, recognition of equal rights, and guarantees of employment; offers of cash, transport, material, housing supplies, or food; and access to initiatives designed to bolster social inclusion. Alongside established civil and political rights arrangements, these sorts of measures are particularly relevant in post-conflict scenarios characterised by massive loss of life, multi-dimensional deprivation, and compromised social inclusion

[3]. Data nevertheless remains scarce in these areas [5]. Emerging frameworks that enable better monitoring, the identification of local data sources, and the determination of equitable modalities for data collection are thus imperative. Benefits and inclusion can serve as vital channels for empowerment in such environments, as outlined in case studies of Afghanistan and Zimbabwe [4].

**Data, Monitoring, and Evaluation**

The systematic collection, monitoring, and analysis of data related to rehabilitation services constitute a critical component in fostering the rights of persons with disabilities across a diverse range of post-war settings [8]. Indicators that specifically relate to the availability, accessibility, and comprehensiveness of health and rehabilitation services therefore play a key role in (a) advocating for the integration of rehabilitation needs into national health and disability agendas and (b) outlining targeted areas of action [5]. A variety of sources can provide relevant information on disaggregated health data [18]. A particular challenge remains the selection of appropriate markers and the respectful implementation of inclusive processes to ensure a consideration of the perspectives of persons with disabilities alongside established data-collection methodologies [3].

**Case Studies from Post-War Contexts**

In southern Europe, governments shifted attention away from rehabilitation services once the immediate crisis ended. Post-conflict evaluations revealed little to no recovery for survivors [7]. Long-term disability persisted due to unmet health needs. The conflict highlighted the need for inclusive rehabilitation to enhance recovery and foster participation in post-war recovery. An inclusive model of rehabilitation remains unavailable [8]. In sub-Saharan Africa, spatially structured community-based models were documented. A flexible approach addressing physical, psychosocial, and vocational needs increased access. Focus on community health and capacity-building enabled long-term sustainability [6]. Deficits emerged in non-health determinants of disability. Model elements might enhance existing strategies. Community-based rehabilitation evolved in southern Africa before the crisis. Recommendations emphasize model replication and embedding in integrated, broad-based systems [9]. In the Middle East and North Africa, initial strategies tackled common chronic conditions amid protracted conflict. Gender and multiple displacements formed a distinctive reality. Diverse transitions between conflict settings complicated response adaptation. Minimal emphasis on health-related rehabilitation persisted despite a global push toward inclusive and multisectoral approaches [10]. Systematic information on access limitations remained scarce. Strategies for inclusive rehabilitation stand apart yet align with global imperatives and relevant goals on well-being and human capital [1].

**Case Study A: Southern Europe**

In the wake of independence, Southern Europe witnessed significant armed conflicts, which affected all countries in the region: Cyprus, Greece, Italy, Portugal, and Spain [6]. The end of military dictatorship in Greece (1974), the fall of the fascist regime in Portugal (1974), and the restoration of democracy in Spain (1977) are major historical turning points that contributed to the democratization of each country and the establishment of a legal framework protecting the human rights of persons with disabilities [8]. In each case, the emergence of civil society and the establishment of rehabilitation organisations played a key role in shaping contemporary rehabilitation responses towards the inclusion of disabled persons. Rehabilitation actions are now aimed at preventing further aggravation of health conditions related to disability and at enabling persons with such conditions to live with as few restrictions as possible [15]. A large-scale study conducted between 2003 and 2010 revealed that the basic architecture of rehabilitation services and the legislative framework on disability policies were fairly comparable throughout the Southern European nations surveyed, as were the main barriers encountered in service provision [19].

**Case Study B: Sub-Saharan Africa**

Disability in Sub-Saharan Africa presents immense challenges for post-war rehabilitation. Historically excluded from national agendas, disabled people face structural barriers to achieving social and economic rights [8]. Rural populations suffer especially under the legacy of conflict. Community-based rehabilitation (CBR) is the dominant model, but nationwide implementation remains incomplete [7]. Disabled people in Sub-Saharan Africa endure extreme hardships despite marked political, civil, and social improvements. Governments generally lack adequate policies to facilitate rehabilitation and design, implement, and monitor social inclusion programmes. Limited financial and human resources undermine rehabilitation efforts [8]. Disabling conditions caused by preventable diseases, accidents, violence, or the unresolved legacy of conflict multiply in post-war upheaval. Adult and child survivors frequently encounter co-morbidities exacerbated by poverty and unmet needs [4].

**Case Study C: Middle East and North Africa**

The term "Middle East and North Africa" (MENA) includes a variable number of countries: from ten (i.e. Djibouti, Egypt, Libya, Morocco, Somalia, Sudan, Tunisia, and the Western Sahara) to 26, depending on the context

(various authors), use of the term MENA-Arab, MENA-Islam (Tlemçani, 2005), the Arab League, and other factors [6]. The 10 countries above are widely considered fragile or conflict-affected (Crisis Group, 2019) and share numerous characteristics [26]. The great majority were formerly European colonies, most achieved independence between 1945 and 1965, and invariantly independence was regarded as a transformation from the position of a subjugated nation and a component of Chad's official agenda (Akol, 2002; Cedeño, 2016; Ahamat & Schiavone, 2021), to one of the few MENA countries to emerge from six decades of war with a resilient and inclusive social contract on a strong, post-conflict, reinforced, and durable social compact [25]. Overall, inclusive rehabilitation strategies in the Middle East and North Africa are strongly influenced by national governments [4]. Inclusive Rehabilitation and Disability are significant global concerns, Amnesty and Human Rights Watch have widely reported on these issues in the region, and several international organizations support national governments in addressing them (the ability of national governments to address global concerns, while invoking methods of rapprochement, with international organizations on them, is unequal), nonetheless the present Case Study accentuates the lasting effects of multi-dimensional armed violence 20 that are specific to the region and shape further patterns of response[20].

**Community Engagement, Education, and Social Reintegration**

Acknowledging the vital role of families and caregivers in post-war rehabilitation programs, interventions for inclusion must address their specific needs [21]. Family and caregivers often facilitate access to services while also bearing the burden of meeting additional care and support needs [5]. Training for caregivers on how to support rehabilitation and improve daily functioning reduces the practical and emotional challenges of caregiving. The burden associated with caregiver roles often leaves them with little time for work, causing financial strain. The mobility of caregivers and access to information on available services are further priorities [6]. Engagement in education, employment, and economic participation, key dimensions in the broader social reintegration process, remain elusive for many persons with disabilities [11]. Attending school strengthens social skills, cognitive development, and community ties while guarding against economic disenfranchisement. Collecting data on enrollment, attendance, performance, drop-out rates, and school-based rehabilitation follow-up, as well as reviewing relevant policies that help or hinder wider access, is therefore essential in all contexts [12]. To improve educational access and outcomes, priority measures include the provision of appropriate facilities and supplies; technical aids; awareness-raising at all levels; and, where necessary, the establishment of mobile services that can support geographically dispersed groups [5]. Equally important are post-education training and employment options to broaden the range of opportunities available to persons with disabilities. Respected, accredited vocational programs can motivate participation and avoid unproductive initiatives [6]. Key measures also include the integration of disability-information dissemination and guidance into pre-employment services as well as into educational programs; capacity-building for programme delivery throughout the vocational sector; retraining offers for the current workforce; outreach to industry; and placement follow-up. Consideration must also focus on economic participation outside of formal, wage-earning employment [10].

**Family and Caregiver Roles**

Caregivers play a crucial role in the care and rehabilitation of persons with disabilities; the importance of family support and social reintegration is increasingly recognized by rehabilitation professionals and related programs [9]. Support from family caregivers increases rehabilitation outcomes, provides emotional assistance, and raises informal community awareness about rehabilitation initiatives [8]. The role of family members and other caregivers, however, is highly variable across cultural contexts and depends on social and family structures, perceptions of disability, and previous and ongoing access to support from professional networks and organizations [6]. Policies and regulations that ensure caregiver support, entitlement to time away from the caregiver role, training on rehabilitation topics, and easy access to counseling and referral services are essential complementary measures in support of the rehabilitation process [7, 8]. Such measures are particularly important in resource-poor societies where the availability of professional counselors has not yet advanced to the same level as the overall rehabilitation service. Family and community support is widely accepted and expected throughout the rehabilitation process, but adequate resources and support services for caregivers are frequently lacking [22, 23].

**Education, Employment, and Economic Participation**

Globally, significant disparities in education persist at primary, secondary, and tertiary levels for persons with disabilities [2]. Rates of illiteracy, drop-out, and non-attendance are much higher than for persons without disabilities. In addition to education, employment rates are a crucial indicator of economic participation; persons with disabilities are often unable to access the labour market, obtain employment commensurate with their qualifications, or remain in the labour market [24]. After displacement due to armed conflict, severe violence, civil

disorder, natural disaster, or other calamities, these barriers become even more prominent, and the situation deteriorates further. Disruption of the education system hampers the ability of persons with disabilities to read, write, or obtain knowledge that is normally acquired through educational channels [23]. Without the intellectual exercise and social skills gained in childhood and adolescence, many drop out of school and find it difficult to return. Interrupted education exacerbates possible illiteracy; even when a person with a disability obtains a diploma, the poor quality of the education received makes it challenging to secure a well-paying job in competitive situations [22]. Furthermore, during and in the aftermath of crises, employment opportunities become scarce, and competition for jobs intensifies even for able-bodied people; persons with disabilities remain largely excluded from economic participation, and their rate of economic activity deteriorates further [21].

**Rural and Urban Inclusion Strategies**

Post-war contexts are characterized by different degrees of urbanization, population density, and access to basic services. These factors drastically influence the scope and nature of inclusion initiatives [8]. In rural regions, challenges persist due to entrenched social, cultural, economic, and structural barriers. Stigma, isolation, distance, and a lack of qualified service providers remain prevalent [31]. Access to basic and rehabilitation services in a supportive environment, access to basic water, sanitation, health and hygiene, education, and protection from violence remains limited [5]. A disconnect between community-based rehabilitation activity and functional services hinders priorities. Rural–urban disparities are evident in distance and modes of transport to facilities [6]. Rural outreach approaches, using community health workers, offer solutions if integrated within a structured approach. Rural transition programmes bridging rehabilitation assert no-science degree and specified knowledge, overcoming the difficulty of the available workforce in the immediate post-conflict [4]. Complementing rural approaches, urban inclusion strategies address bottleneck challenges for disadvantaged groups. Low-cost technologies, digital solutions, and free or subsidized online education widen access and extend reach [3]. Local resource mapping and digital communications help match demand and supply. Strategies targeting youth skill-building, income-generating opportunities, entrepreneurship, cooperatives, and collective bargaining ease labour market insertion. Community resilience, early recovery, economic focus, and synergies with basic services and education support return to school, job readiness, and employability [14].

**Ethical Considerations in Rehabilitation Research and Practice**

A distinguishing feature of rehabilitation, especially in the post-war context, is its ethical character. Central to rehabilitation practice and research are the values promoted by the profession: respect for autonomy, justice, non-discrimination, dignity, and the rights of persons with disabilities [6]. Related ethical principles, such as beneficence, non-maleficence, autonomy, and justice, have further shaped discourses on ethics within rehabilitation [3]. Several ethical principles and guidelines inform rehabilitation procedures [30]. The World Medical Association's Declaration of Helsinki emphasizes respect for persons, highlighting autonomy and individual decision-making, but recognizing that not all individuals have equal capacity and that some are in need of additional protection [1]. Autonomy and consent must also be understood in the context of culture, legal frameworks, and social or economic conditions. Stakeholders are led by these principles to develop and adhere to ethical guidelines addressing the type of research and the methods used to collect data from vulnerable populations [9].

**Respect for Autonomy and Consent**

The human rights framework for disability emphasizes respect for autonomy and consent through positive supports, reasonable accommodations, and equal participation [8]. It shifts away from safeguarding and welfarist approaches towards a participatory ethos that recognizes the 'dignity of risk', individuals' right to make other choices even if deemed risky or imprudent, without coercive interventions [31]. This approach aligns with person-centred psychiatry, which empowers patients to take ownership of their treatment and recovery [9]. The focus moves from "fixing" individuals to providing supports within societal and environmental contexts, emphasizing the social model of disability, which attributes barriers to environmental and structural obstacles rather than impairments themselves [14]. The most fundamental shift concerns the concept of universal legal capacity, challenging traditional tests of mental competence and affirming that legal rights and capacities should not be dependent on decision-making ability, as articulated in the CRPD [25]. Respect for autonomy involves not only deference to subjective choices but also considering ways to promote autonomy. Autonomy competencies enable individuals to explore values and needs with authentic self-awareness [27]. Internal traits like self-confidence and self-trust provide a foundation but are influenced by socialization, which can either enable or hinder autonomy. In abusive contexts, these traits may be suppressed, leading to distrust and self-doubt [12]. A relational analysis emphasizes that respecting autonomy requires positive support and intervention to promote long-term agency, rather than mere acknowledgment of individual choices [26].

## Cultural Competence and Participatory Approaches

People's lives, health, and well-being are all shaped by culture. An understanding of the influence of culture and of individual histories, values, needs, and beliefs is therefore essential for engaging with those who experience disability [11]. When rehabilitation services and programmes do not consider cultural context or seek stakeholder engagement, they may fail to respect local norms, practices, and taboos. Such gaps have been widely documented [12], and continuing engagement with service users and other stakeholders across the rehabilitation process is advised [13]. The involvement of community members is critical not only to ensure culturally informed approaches but also to safeguard the establishment of resilient rehabilitation systems [7].

## Equity, Non-Discrimination, and Stigmatization

Discrimination against persons with disabilities in post-war contexts constitutes a collective tragedy of humanity, perpetuated by the need to comprehend disability and its diverse perspectives [26]. Stigmas arise from ignorance: enlightening communities about disabilities reduces societal prejudices and exclusion from assistance programs; however, merely equipping individuals with all necessary tools remains futile without fostering understanding. If certain elements are missing from policy and inclusion programs, marginalization continues [27]. Thus, another facility for assistance is urgently needed to establish the initial network for facilitating connections. Political advocacy is critical for dismantling the structures governing marginalization [23]. Language plays an indispensable role in forming opinions and ideas, contributing to the marginalization of persons with disabilities. Norms of who is addressed and who remains silent dictate how affirmative language is utilized [31]. The agency of persons with disabilities is diminished when they are framed merely as "disabilities," defined solely by unmet needs, exemplifying the objectification perpetuated by a charitable approach [25]. By interrogating predominant words, attitudes, and practices that stigmatize and exclude persons with disabilities, inclusive language imbues them with personhood.

## Future Directions: Resilience, Innovation, and Sustainable Systems

Technology-Enabled Rehabilitation. Technological innovation can enhance rehabilitation services and introduce new modalities. E-Rehabilitation, including tele-rehabilitation, telerehabilitation, and virtual rehabilitation, comprises service delivery methods employing audiovisual technology to link provider and remote client and facilitate interventions from various professional disciplines [13]. Tele-rehabilitation can address limited geographic coverage by enabling access to rehabilitation modalities when proximity precludes service delivery. Computer simulation, virtual reality, and monitoring technologies can support virtual-rehabilitation technology dietary interventions without operational curtailment [8]. Enhanced assistive devices with evidence-based platforms, multisensory feedback, and long-term management strategies improve community-based participation [27]. Integrated Service Delivery Models. Delivery models that streamline access to services across governmental sectors, professions, and organizational regions can enhance cost-effectiveness and efficacy. An integrated model proposes delivery of rehabilitation within safety nets operating multisector systems engaging the health, education, social protection, and livelihood sectors commensurate with the socioeconomic context of post-war settings [30]. At the centre lies the person, family, or community, always at the forefront [9]. Sectoral-articulated rehabilitation loops create a procedure, sequence, and coordination of delivery across preventive, curative, rehabilitative, and supportive programs to ensure continuity [28]. Investment, Financing, and Global Cooperation. Rehabilitational investment, currently not a standard criterion for national programmatic development or funding, is crucial to foster growth; further funding is essential to cater for acceleration plans [16]. Putting rehabilitation initiatives into public investment territories and maintenance of global strategic economic partnerships empowers high-priority cross-boundary activities at the country level [8]. Countries without pre-existing financing mechanisms should initiate dialogue to create or add rehabilitation to those already functional immediately and readily [15]. Recovery supplies and equipment, professional post-war development and research investigators, and advisory platforms for evaluating the feasibility of re-establishing rehabilitation-derived facilities for different times and spaces remain still demanding and feasible[11].

## Technology-Enabled Rehabilitation

Technology-enabled rehabilitation aims to offer reusable, easy-to-order tele-rehabilitation devices accessible via mobile devices, desktop computers, and social networks [26]. Durable and affordable assistive devices would assist survivors with geriatric, oral, orthotic, prosthetic, and post-operation support [24]. A regular data collection module would track activity progress and utilize artificial intelligence to generate personalised recovery programmes, adaptable for remote rehabilitation even without a clinician [23]. Furthermore, participatory design and co-design efforts address local needs while enabling a broader focus on simultaneous content development, production, and research. Incorporating data tracking aids the evidence base and the understanding of global

requirements. Accelerated technology-led rehabilitation innovation is expected to increase post-war service availability and enhance pre-existing opportunities [28].

### Integrated Service Delivery Models

Services for persons with disabilities tend to be fragmented and disjointed in post-war settings as a result of restricted or disrupted government capacities, limited investments, the absence of clear coordination mechanisms, and inadequate linkages across sectors, regions, institutions, and communities [29]. Existing services are often not fully utilized due to weak supply systems, a lack of information about available services, insufficient outreach mechanisms, and people's limited awareness of their entitlements. Barriers to social inclusion and effective service delivery arise from various factors, such as a lack of consensus about how disability is understood [30]. The nature of services used in the immediate aftermath of conflict diverges significantly from those in other contexts with limited resources. Persons with disabilities, particularly those affected by conflict, face huge difficulties [28]. Apart from the physical and psychological conditions and ailments that each treatment addresses, the wider context within which persons with disabilities interact with and rely on services for their day-to-day livelihood and survival must also be taken into consideration [28].

### Funding, Investment, and Global Cooperation

Rehabilitation funding is a challenge in many settings, especially where policy and programmatic development are nascent. Various financing mechanisms are available, but their use is rarely optimised [31-36]. The World Rehabilitation Alliance-Network has engaged prominent finance institutions to explore scalable rehabilitation financing mechanisms [37-40]. These recommendations have converged around the potential of three mechanisms warranting consideration: International Financing Institutions, Private Sector Financing, and Global Funds; diversified partnerships for joint funding would extend their reach [30]. Resilience-building efforts strive to improve rehabilitation services through rapid recovery, but optimal approaches remain underutilised. Certain pilot projects geared toward strengthening the rehabilitation sector are under consideration; however, they often lack the agency or funding to broaden their impact. A framework for participation and evaluation is needed to guide prioritisation and enhance uptake of available models [41, 42].

## CONCLUSION

Disability and rehabilitation in post-war societies remain critical yet often overlooked dimensions of recovery and peacebuilding. This review shows that the long-term impacts of conflict, including physical injuries, psychological trauma, chronic illness, and social exclusion, require sustained, coordinated responses that extend beyond emergency care. Post-war contexts frequently lack the infrastructure, funding, and trained personnel necessary to deliver comprehensive rehabilitation services, leaving many individuals without the support needed to regain functionality and independence. Social and structural barriers, including discrimination, gender inequality, and limited economic opportunities, further impede the full inclusion of persons with disabilities. While challenges persist, emerging evidence underscores that transformative progress is possible when disability is embedded within national recovery agendas. Approaches such as community-based rehabilitation, disability rights legislation, inclusive service models, and targeted investments in assistive technologies provide pathways toward equitable and effective rehabilitation systems. Strengthening data systems, expanding the rehabilitation workforce, and ensuring meaningful participation of persons with disabilities in decision-making are fundamental to achieving long-term inclusion. Ultimately, rebuilding post-war societies requires a holistic commitment to disability inclusion, one that recognizes rehabilitation not as an optional service but as a cornerstone of human rights, social justice, and sustainable development.

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**CITE AS: Nalongo Bina K. (2026). Disability and Rehabilitation in Post-War Societies: Challenges, Responses, and Pathways to Inclusion. IDOSR JOURNAL OF APPLIED SCIENCES 11(1):117-127.**
**https://doi.org/10.59298/IDOSRJAS/2026/111117127**