Review Article

The Role of Faith-Based Organizations in Rehabilitation and Community Reintegration of Individuals with Physical Disabilities: A Scoping Review

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Editor: Solomon Mekonnen

Article History:
Received: May 7, 2026
Accepted: July 3, 2026
Published: September 7, 2026

Citation: Selvaraj Samuelkamaleshkumar, Judy Ann John, Arumugam Elango, Nathan Grills, Lynette Joubert, The Role of Faith-Based Organizations in Rehabilitation and Community Reintegration of Individuals with Physical Disabilities: A Scoping Review. DCIDJ. 2026, 37:3. doi.org/10.20372/dcidj.1016

ABSTRACT

Aim: To systematically map and synthesise the existing global evidence on the role of faith-based organisations (FBOs) in supporting the rehabilitation and community reintegration of individuals with physical disabilities.

Method: A scoping review was conducted following the Joanna Briggs Institute (JBI) methodology and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) guidelines. MEDLINE, CINAHL, Scopus, Web of Science, and PsycINFO were searched from January 2010 to December 2025. Studies reporting on FBO involvement in rehabilitation, health promotion, disability support, or community reintegration initiatives for individuals with physical disabilities were considered for inclusion. Two reviewers independently screened studies, extracted data, and synthesised findings using descriptive and thematic analysis.

Results: Of 1,518 records identified, four studies met the inclusion criteria. All studies were conducted in the United States and primarily employed community-based participatory or program evaluation approaches. The identified FBO initiatives focused predominantly on health promotion, community engagement, capacity building, and culturally responsive health education rather than structured rehabilitation interventions. Reported contributions included enhanced health literacy, improved psychosocial support, strengthened social support networks, increased community engagement, and facilitation of connections to available health services. Key facilitators included community trust, moral leadership, cultural relevance, and volunteer involvement, while barriers included limited funding, inconsistent training, and a lack of rehabilitation-specific expertise. No studies from low- and middle-income countries (LMICs) were identified.

Conclusion: Current evidence regarding the role of FBOs in rehabilitation and community reintegration is limited and geographically concentrated in high-income settings. The findings suggest that FBOs may indirectly contribute to rehabilitation-related goals through community engagement, psychosocial support, health education, social participation, and facilitating connections to available services. However, evidence regarding direct rehabilitation interventions, functional outcomes, and long-term community reintegration remains scarce. The absence of studies from LMICs highlights a significant geographical and contextual knowledge gap and underscores the need for context-specific

research examining the role of FBOs within rehabilitation and community reintegration efforts.

Limitations: Only four studies met the inclusion criteria, and all were conducted in the United States, limiting the transferability of findings to other geographical and sociocultural contexts. Most studies focused on health promotion, community engagement, and psychosocial support rather than structured rehabilitation interventions or measurable functional outcomes. Furthermore, the review was restricted to individuals with physical disabilities; therefore, the findings may not be generalizable to other disability groups. Restriction to English-language publications may have further limited the scope of available evidence.

Keywords: Community; Disability; Faith-based organisations; Social participation; Community Reintegration; Rehabilitation

INTRODUCTION

Integrating persons with physical disabilities into society is influenced by multiple factors, including access to employment, mobility, and overall well-being (Pasin & Karatekin, 2024). Social support networks play a pivotal role in enhancing the quality of life of individuals with disabilities by providing both emotional and practical assistance (Holanda et al., 2015). In India, where public health expenditure remains limited to approximately 1.15% of the gross domestic product (GDP) (Das & Guha, 2023), faith-based organisations (FBOs) have emerged as important community partners in addressing the needs of people with disabilities, particularly in rural and resource-constrained regions where formal healthcare and rehabilitation services are often limited or unavailable (Roșu et al., 2025).

Evidence suggests that social support networks are foundational to the well-being and community participation of individuals with disabilities. These networks facilitate access to essential resources and services, fostering independence and social inclusion. Emotional support, conveyed through empathy, encouragement, and acceptance, strengthens psychological resilience and nurtures a sense of belonging among persons with disabilities (Langford et al., 1997; Uchino, 2009). In collectivist societies such as India, families, extended kinship networks, and community structures serve as primary sources of social support (Chadda & Deb, 2013). Consequently, enhancing community-based support mechanisms becomes vital to mitigate the social and functional challenges faced by people with disabilities (Chawa et al., 2021).

FBOs have long been instrumental in delivering essential social and humanitarian services—such as food, shelter, education, and healthcare—to marginalised and underserved populations (Boro et al., 2022). Their deep community roots and moral credibility uniquely position them to address the multifaceted needs of individuals with disabilities, extending beyond medical care to encompass social, emotional, and spiritual dimensions of rehabilitation (Jahani & Parayandeh, 2024). FBOs have been described as "faith-based civil society organisations, informal faith-based programmes, initiatives and community-based organisations, larger national and international non-governmental organisations, congregations such as places of worship, religious leaders, faith-based healthcare facilities, and denominational and interdenominational health networks (Nicol et al., 2022)."

Despite their significant social presence and outreach capacity, there remains a notable gap in empirical research examining the role of FBOs in delivering rehabilitation and community reintegration services for individuals with physical disabilities. Existing literature documents the broad contributions of FBOs to health promotion and social welfare, particularly in underserved settings (Clarke, 2007; Olivier et al., 2015). However, research

explicitly evaluating their role in rehabilitation, functional independence, and social participation remains limited and fragmented (Carter, 2016; Swartz & Schneider, 2015). Studies at the intersection of faith and disability have highlighted the paucity of systematic, outcome-oriented research assessing how faith-based initiatives contribute to rehabilitation processes and long-term community inclusion (Carter, 2016; Matope et al., 2025). Furthermore, the currently available literature appears to be geographically concentrated in high-income settings, with limited evidence from low- and middle-income countries (LMICs), including India. Addressing this knowledge gap is critical to informing future research, collaborative partnerships, and policy discussions regarding the potential role of FBOs within broader community-based rehabilitation and disability support systems.

This scoping review, therefore, aims to systematically map and synthesise the existing global evidence on the role of FBOs in the rehabilitation and community reintegration of individuals with physical disabilities. Given the limited and heterogeneous evidence base, the review primarily seeks to identify conceptual roles, models of engagement, implementation approaches, and gaps in the literature rather than establish the effectiveness of FBO-led rehabilitation interventions.

The review aims to:

- Identify the types of rehabilitation and reintegration services provided by FBOs.
- Examine the models of community engagement and collaboration adopted by these organisations.
- Explore the outcomes and challenges associated with FBO-led disability interventions.

A preliminary search conducted in MEDLINE, the Cochrane Database of Systematic Reviews, and JBI Evidence Synthesis revealed no existing or ongoing systematic or scoping reviews on this topic. Therefore, this review represents a novel and timely contribution to the literature.

By synthesising current evidence, this review will elucidate how FBOs contribute to rehabilitation and community reintegration for individuals with physical disabilities and identify important gaps warranting future investigation. The findings are expected to inform policymakers, rehabilitation professionals, and faith-based institutions regarding opportunities for collaboration and to enhance community-based support initiatives. Given the limited empirical evidence currently available, particularly from LMICs, the review also highlights the need for further context-specific and outcome-oriented research in this area.

Key Research Question:

What roles have FBOs played in supporting the rehabilitation and community reintegration of individuals with physical disabilities across different community and healthcare contexts?

Sub-Questions:

1. What types of rehabilitation, health promotion, and community reintegration services are provided by FBOs for individuals with physical disabilities?
2. How do FBOs support community participation, social inclusion, and psycho-social well-being among individuals with physical disabilities?
3. What evidence exists regarding the implementation and reported outcomes of faith-based rehabilitation or community support initiatives?
4. What models of collaboration and community engagement are adopted by FBOs in rehabilitation-related initiatives?
5. What barriers and facilitators influence the ability of FBOs to contribute to rehabilitation and community reintegration efforts?

6. How do cultural, spiritual, and contextual factors shape the role of FBOs in disability rehabilitation and community support?
7. What gaps exist in the current literature regarding FBOs and rehabilitation, particularly in low- and middle-income countries?

METHODS

This scoping review systematically identified and synthesised published literature on the role of FBOs in supporting the rehabilitation and community reintegration of individuals with physical disabilities across global contexts, while acknowledging the limited availability of evidence from India and other low- and middle-income countries (LMICs). This scoping review was conducted using the Joanna Briggs Institute methodology for scoping reviews (Pollock et al., 2023) and guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). As a scoping review, the primary aim was to map the breadth and nature of the available evidence rather than evaluate intervention effectiveness. This review did not involve human subjects or primary data collection. This scoping review is registered on the Open Science Framework (osf.io/q58j2).

Inclusion criteria

Participants

This review included studies involving individuals with physical disabilities requiring rehabilitation and community reintegration. These comprised individuals with neurological conditions such as stroke, traumatic brain injury, cerebral palsy, spinal cord injury, and cancer-related physical disabilities; orthopaedic conditions such as amputations and musculoskeletal injuries; and chronic conditions resulting in physical disability, including muscular dystrophy and poliomyelitis. Studies exploring the perspectives of caregivers, family members, and rehabilitation professionals involved in the rehabilitation and community reintegration of these individuals were also included where relevant.

The review focused specifically on individuals with physical disabilities because their rehabilitation goals, intervention approaches, and community reintegration needs differ substantially from those of individuals with visual, hearing, intellectual, or developmental disabilities. Restricting the review to physical disabilities reduced clinical heterogeneity and enabled a more focused, meaningful synthesis of the available evidence on the role of FBOs in rehabilitation and community reintegration.

Concept

The review examined the role and contributions of FBOs to disability rehabilitation and community reintegration, focusing on the following areas:

1. Rehabilitation Services:

- Provision of rehabilitation programs aimed at improving physical functioning and independence.
- Support for mobility training, assistive device provision, and physical or occupational therapy.

2. Social Support Networks:

- Facilitation of inclusion by enabling individuals with disabilities to participate in meaningful social roles, including employment, family life, and leisure activities.
- Promotion of social participation and integration into community life through collaborations with other stakeholders, such as governmental agencies and non-governmental organisations (NGOs).

3. Implementation Characteristics and Reported Outcomes of FBO-Linked Initiatives:

- Description of programs utilising FBO networks to support rehabilitation and community reintegration of individuals with physical disabilities.
- Exploration of reported outcomes related to functional independence, quality of life, psychosocial well-being, social participation, and community engagement associated with FBO-linked initiatives, where available.

The scope of this review excluded studies that focused solely on emotional or spiritual care, basic needs assistance (such as food, shelter, or financial aid), or faith-based approaches (such as prayer, meditation, or pastoral counselling) without a rehabilitation or reintegration component.

Context

This review considered studies conducted in settings where FBOs operated and provided rehabilitation and community reintegration services for persons with physical disabilities.

Included contexts:

Faith-based institutions (FBOs): Churches, mosques, temples, and other religious centres that offered direct rehabilitation services or served as hubs for facilitating social inclusion.

Freestanding faith-based organisations: Independent, faith-driven charities or NGOs that provided structured, practical, and community-integrated rehabilitation programs and support services.

Geographical focus: Studies from all geographical settings were considered. Particular attention was given to studies conducted in underserved and resource-constrained settings where healthcare and rehabilitation services may be limited in availability.

Collaborations: Partnerships between FBOs and governmental or non-governmental systems aimed at improving integration, scalability, and sustainability of rehabilitation services.

Cultural and socio-economic factors: Studies addressing how local traditions, community structures, and societal attitudes toward disability shaped rehabilitation and reintegration strategies.

Excluded contexts:

- High-resource urban settings where FBO contributions significantly overlapped with robust public or private healthcare systems.
- FBOs that focused primarily on spiritual care, religious rituals, or pastoral counselling rather than structured rehabilitation.
- Programs providing only emotional, financial, or basic needs support (such as food, shelter, or clothing) without an explicit focus on community reintegration or rehabilitation.
- Non-community-based services, such as inpatient rehabilitation centres or hospital-based interventions, not linked to faith-based organisations.

Types of sources

This scoping review considered a wide range of study designs to ensure a comprehensive understanding of the role of FBOs in the rehabilitation and community reintegration of individuals with physical disabilities.

Both experimental and quasi-experimental designs were included, such as randomised controlled trials (RCTs), non-randomised controlled trials, before-and-after studies, and interrupted time-series designs.

Additionally, analytical observational studies were considered, including prospective and retrospective cohort studies, case-control studies, and analytical cross-sectional studies.

Descriptive observational studies such as case series, individual case reports, and descriptive cross-sectional studies were also eligible for inclusion to capture contextual insights and practice-based evidence relevant to FBO-led rehabilitation.

The review further included qualitative studies employing diverse methodologies, such as phenomenology, grounded theory, ethnography, qualitative description, action research, and feminist research, that explored experiences, perceptions, and contextual dynamics associated with FBOs' contributions to disability rehabilitation and community reintegration.

In addition, systematic reviews meeting the inclusion criteria were considered if they contributed relevant evidence addressing the research objectives. Text and opinion papers that provided conceptual or theoretical perspectives on the role of FBOs in disability rehabilitation were also included, recognising their potential to enrich understanding of underlying frameworks and community practices.

Given the exploratory nature of the review topic and the anticipated limited empirical evidence base, the inclusion of diverse study designs and conceptual literature was considered appropriate to comprehensively map the scope of existing knowledge.

No primary data collection or analysis of unpublished datasets was undertaken in this review. The study relied exclusively on published literature and publicly available sources, including peer-reviewed journal articles, reports, and grey literature.

To ensure objectivity and minimise bias, the following measures were undertaken:

- Access to data was limited strictly to published and publicly available sources identified through systematic search strategies.
- The research team did not access or review any unpublished results, summary statistics, or raw datasets from included studies prior to the formal screening and data extraction stages.
- All data extraction and synthesis followed a pre-specified review protocol, and reviewers remained blinded to study outcomes until inclusion decisions were finalised, thereby reducing the risk of confirmation bias.
- Only information available in the public domain was utilised; no confidential, proprietary, or restricted-access datasets were included.

These procedures ensured that the review process remained transparent, unbiased, and independent of prior knowledge of study results, thereby upholding the methodological rigour and ethical standards required for evidence synthesis.

An initial exploratory search was conducted in PubMed and the Cochrane Central Register of Controlled Trials (CENTRAL) to identify relevant literature and key terminology related to FBOs and rehabilitation. The preliminary search used the key terms ("faith-based organisations" OR "religious organisations") AND ("rehabilitation" OR "community-based rehabilitation") AND ("stroke" OR "spinal cord injury" OR "muscular dystrophy"). Following the Joanna Briggs Institute (JBI) three-step search strategy, the text words and index terms used in the titles and abstracts of relevant articles identified in this initial search were analysed to refine and expand the search vocabulary.

The finalised search strategy was then adapted and applied across multiple electronic databases, including MEDLINE (via Ovid), CINAHL (via Ovid), Scopus, Web of Science, and PsycINFO (via Ovid), to ensure comprehensive coverage of the literature relevant to the review objectives. The complete finalised search strategy, including database-specific

search strings, keywords, controlled vocabulary terms, and Boolean operators, is provided in Appendix I to enhance transparency and reproducibility of the review process.

In addition, citation searching was performed to identify further eligible studies. Only studies published in English were included to ensure interpretive accuracy and to minimise the risk of bias associated with translation. The search process was conducted iteratively, with progressive refinement to optimise both sensitivity (comprehensiveness) and specificity (relevance) in capturing evidence aligned with the review's purpose. The search included peer-reviewed studies published from January 2010 to December 2025 to comprehensively map and synthesise relevant evidence. No geographical restrictions were applied during the search process in order to capture the global scope of available literature.

Study/Source of evidence selection

Following the database search, all identified citations were collated and imported into Zotero, a reference management software, and subsequently uploaded to Covidence for screening and review management. A pilot screening was conducted to calibrate the reviewers and ensure consistent application of the inclusion criteria. Titles and abstracts were then independently screened by two reviewers (SS and EA) against the predefined eligibility criteria. The full texts of potentially relevant articles were retrieved and assessed in detail by the same reviewers (SS and EA) to determine final inclusion.

Data extraction was carried out using a predefined template developed for this review, and each article was independently reviewed by two researchers. Reasons for exclusion at the full-text stage were systematically documented and reported in the final scoping review. Any disagreements between reviewers at any stage of the screening or data extraction process were resolved through discussion and consensus.

The entire screening and selection process was managed through Covidence, which facilitated duplicate removal, independent screening, and decision tracking. The process and outcomes of study selection were reported in accordance with PRISMA-ScR guidelines, including a PRISMA flow diagram (Figure 1) illustrating the number of records identified, screened, included, and excluded, along with reasons for exclusion at each stage.

Data extraction

Data were extracted from all included studies using the Covidence software. Based on the Joanna Briggs Institute (JBI) "Source of Evidence Details, Characteristics and Results Extraction Instrument," the data extraction template within Covidence was modified to capture details specific to this review, particularly regarding the role of FBOs in disability rehabilitation and community reintegration.

The data extraction process was conducted independently by two reviewers (SS and EA) using the customised template. The extraction tool was iteratively refined to align with the objectives of the scoping review and to ensure comprehensive capture of study characteristics and findings. The final data extraction form, developed within Covidence and supported by Microsoft Word for documentation, included the following major domains:

Article details: Study ID, citation, title, author details, and country of study.

Study methods: Aim, study design (e.g., RCT, quasi-experimental, qualitative, or mixed methods), study period, and funding sources.

Participants: Description of the population, inclusion and exclusion criteria, and total number of participants.

Intervention details: Type and method of intervention (e.g., policy, programmatic, or rehabilitation service); targeted indicators (functional independence, quality of life, socio-economic participation, access to services); duration of exposure; and follow-up details.

Faith-based organisation characteristics: Type of FBO involved (e.g., church, mosque, temple, or faith-based NGO); implementation strategies (training, partnerships, community engagement); and evaluation stage (pre-, during, or post-intervention).

Results and outcomes: Key outcomes related to rehabilitation and community reintegration, including barriers, facilitators, and author recommendations.

Cultural and contextual factors: The influence of traditions, community structures, and societal attitudes on the implementation and effectiveness of FBO-led initiatives.

Exclusion details: Reasons for exclusion when studies did not meet eligibility criteria (e.g., not empirical, no FBO involvement, or absence of rehabilitation/community reintegration focus).

Any discrepancies in data extraction between the two reviewers were resolved through discussion and consensus within Covidence. This structured and transparent process ensured accuracy, completeness, and consistency in data charting. A sample of the final data extraction form is provided in Appendix II.

Data analysis and presentation

Extracted data were exported from Covidence and organised in Microsoft Excel for coding, charting, and synthesis. Consistent with the Joanna Briggs Institute (JBI) methodology for scoping reviews, data analysis and presentation followed a descriptive and narrative synthesis approach to provide a comprehensive overview of the existing evidence.

Quantitative data, such as publication years, geographical distribution of studies, study designs, participant characteristics, and types of FBOs involved, were summarised using frequencies and percentages. Qualitative data, including descriptions of FBO-led interventions, implementation strategies, community engagement approaches, and reported outcomes, were analysed descriptively to provide contextual insights into how these organisations contribute to rehabilitation and community reintegration.

The extracted information was collated and mapped to illustrate the scope and nature of the available evidence. Data were organised in a summary table to present key study characteristics (e.g., author, year, country, study design, population) and intervention features (e.g., type of FBO, nature of rehabilitation service, target outcomes, barriers and facilitators, and cultural or contextual factors).

Narrative summaries accompanied these visual representations to highlight patterns, similarities, differences, and gaps across studies. This descriptive synthesis allowed for an in-depth understanding of the diversity of FBO roles, service models, and contextual influences, without synthesising effect sizes or comparative outcomes. The approach was consistent with the purpose of scoping reviews, focusing on mapping the breadth and depth of available evidence rather than evaluating intervention effectiveness. Accordingly, the findings were interpreted descriptively and conceptually, particularly given the small number and the contextual concentration of the included studies.

RESULTS

Study Inclusion

The article identification, screening, and inclusion process is illustrated in the PRISMA-ScR flow diagram (Figure 1). A comprehensive search across multiple databases initially identified 1,518 records, including 774 from Web of Science, 681 from MEDLINE, 31 from CINAHL, 21 through citation searching, 9 from Scopus, and 2 from PsycINFO. After

duplicate removal (n = 21) using Covidence, 1,497 records remained for title and abstract screening.

During the title and abstract screening process, 1,492 records were excluded for failing to meet the inclusion criteria. The primary reasons for exclusion were that the studies did not include individuals with physical disabilities (n = 746), did not involve faith-based organisations (n = 597), or did not address rehabilitation or community reintegration (n = 149). Five full-text articles were retrieved and assessed for eligibility. Of these, four studies met the inclusion criteria and were included in the final synthesis, while one study was excluded because it was a scoping review, and the relevant primary studies identified within that review had already been screened separately. No ongoing studies or studies awaiting classification were identified.

Characteristics of Included Studies

A total of four studies met the inclusion criteria for this scoping review. All four studies were conducted in the United States and explored the role of FBOs, primarily churches and community congregations, in promoting health education, community engagement, and rehabilitation-related support initiatives (Allen et al., 2014, 2016; Leyva et al., 2017; Ravenell et al., 2015). The studies were published between 2014 and 2017 and examined community-driven and faith-based approaches to health promotion, community engagement, and support initiatives.

Many studies employed community-based participatory research and program evaluation methodologies to explore the implementation and perceived contributions of interventions conducted in partnership with FBOs. These studies emphasised the potential of faith-based networks to disseminate evidence-based health programs, promote preventive practices, and facilitate engagement with marginalised populations, including individuals at risk of chronic conditions or disability.

Allen et al. (2014) and Allen et al. (2016) examined the integration of religious belief systems into health education and behavioural interventions. Their studies reported that collaboration with churches enhanced participation in screening programs, awareness of health and rehabilitation-related services, and adherence to preventive health practices. These interventions also contributed to local capacity building within congregations to support ongoing community health engagement.

Ravenell et al. (2015) investigated the role of faith-based outreach in stroke health education, focusing on culturally tailored strategies within African American church communities. Their findings highlighted that leveraging trusted community leaders and peer networks within faith-based settings improved stroke awareness, risk factor management, and linkage to available healthcare services, which, in turn, may support rehabilitation-related outcomes.

Leyva et al. (2017) focused on capacity building among FBOs, describing how training and partnership initiatives enhanced organisational competencies to support community-based health programs. The study emphasised the role of education, partnership models, and sustainability planning in strengthening the implementation of faith-based interventions targeting chronic illness management and health promotion.

Across studies, FBOs served as culturally relevant and trusted community platforms that facilitated the implementation of health promotion and rehabilitation-related initiatives. Common facilitators included strong community trust, cultural alignment, and organisational commitment to service, while barriers involved limited financial resources, inconsistent training, and varying levels of health literacy among faith leaders.

Collectively, the included studies suggest that FBOs may have potential value as community partners in rehabilitation and reintegration efforts. However, the available evidence remains limited to high-income contexts, and there is a notable absence of studies from low- and middle-income countries (LMICs), particularly those examining structured

rehabilitation and long-term community reintegration outcomes for persons with disabilities. The findings should therefore be interpreted as exploratory and descriptive, reflecting the limited and geographically concentrated evidence base currently available (Table 1).

Summary of Findings / Thematic Overview

Analysis of the included studies revealed that faith-based organisations (FBOs) may play several interconnected roles in supporting health promotion, rehabilitation-related activities, and community reintegration among individuals with physical disabilities. Although the evidence base was limited and focused primarily on health promotion initiatives, the findings collectively suggest that FBOs serve as trusted community platforms that facilitate engagement, provide social support, strengthen local capacity, and promote culturally relevant approaches to health and well-being.

Across all included studies, FBOs served as important entry points for community engagement. Churches and other religious congregations provided familiar, trusted environments for disseminating health information and rehabilitation initiatives. Integrating health education into faith settings increased participation in screening activities, enhanced awareness of health and rehabilitation services, and encouraged the adoption of preventive behaviours (Allen et al., 2014, 2016). Similarly, peer-led and pastor-supported stroke education programmes improved health literacy and awareness of stroke prevention strategies among African American congregations (Ravenell et al., 2015). These findings suggest that FBOs may help bridge communication and engagement gaps between healthcare providers and marginalised populations by leveraging existing social trust and community networks.

A second interconnected theme was the role of FBOs in building community capacity. Several studies highlighted how training clergy, lay health leaders, and volunteers enhanced organisational readiness to support and sustain health-related initiatives (Allen et al., 2016; Leyva et al., 2017). Developing competencies in programme management, partnership development, and culturally sensitive care strengthened FBOs' ability to function as community partners. However, the sustainability of these initiatives depended on ongoing resources, technical support, and collaboration with healthcare institutions and government agencies.

Although the included studies did not directly evaluate structured rehabilitation interventions, they highlighted several pathways through which FBOs may contribute to rehabilitation-related goals. Enhanced health literacy, psychosocial support, social participation, and improved connections to available healthcare services may indirectly support rehabilitation and community reintegration. Health messages delivered through sermons and congregational activities also appeared to reduce stigma and promote social inclusion among individuals living with chronic illness or disability. Nevertheless, direct evidence regarding measurable functional rehabilitation outcomes, functional independence, or long-term community reintegration remains limited.

The cultural and spiritual relevance of faith-based settings emerged as another important finding. Shared beliefs, trust, and culturally familiar narratives appeared to increase the acceptability of health-related interventions and facilitate community participation. The incorporation of spiritual values and religious messaging often enhanced engagement and message resonance, suggesting that FBOs may be particularly well positioned to deliver culturally responsive community support initiatives.

Despite these strengths, several barriers limited the implementation and scalability of FBO-led initiatives. Common challenges included limited financial and technical resources, inconsistent training of faith leaders, and the absence of standardised monitoring

and evaluation frameworks. These constraints may hinder the integration of FBO-led initiatives into broader public health and rehabilitation systems, underscoring the need to strengthen partnerships between faith communities and formal healthcare services.
Finally, the review identified important research and practice gaps. The available evidence was geographically concentrated in the United States, with no eligible studies identified from low- and middle-income countries despite the potentially important role of FBOs in these settings. Furthermore, there was limited documentation of structured rehabilitation programmes, measurable functional outcomes, or long-term community reintegration initiatives for individuals with physical disabilities. These findings highlight the need for context-sensitive and methodologically robust research examining how FBOs may contribute to rehabilitation and community reintegration across diverse healthcare and cultural contexts.

DISCUSSION

This scoping review mapped the existing global evidence on the role of FBOs in the rehabilitation and community reintegration of individuals with physical disabilities. Despite a comprehensive search strategy, only four studies met the inclusion criteria, all conducted in the United States. Although none of the included studies directly evaluated structured rehabilitation interventions, the findings suggest that FBOs may contribute to rehabilitation-related goals by supporting health literacy, psychosocial well-being, social participation, and community engagement. Given the small number of studies and their concentration in a single high-income setting, these findings should be interpreted as exploratory and conceptual rather than as evidence of rehabilitation effectiveness.

A prominent finding of this review was the role of FBOs as trusted community institutions that facilitate health promotion and engagement with health-related initiatives. Across the included studies, FBOs leveraged their cultural relevance, moral authority, and established social networks to disseminate health information and encourage participation in preventive programmes. These findings are consistent with broader literature demonstrating that churches, mosques, temples, and other faith-based institutions can effectively address stigma, promote social inclusion, and influence health-related behaviours (Duff & Buckingham, 2015; Levin, 2014). Such characteristics are particularly important in rehabilitation, where long-term participation and social support are fundamental determinants of successful community reintegration.

The findings also highlight the potential role of FBOs within the World Health Organisation's Community-Based Rehabilitation (CBR) framework. The social participation and empowerment domains of the CBR matrix emphasise community engagement, inclusion, and locally available support systems (Khasnabis et al., 2010). The community embeddedness and value-based motivation of FBOs may therefore position them as important partners in supporting participation and inclusion, particularly in contexts where rehabilitation services are limited in availability or where individuals experience barriers to engaging with existing services.

Another important finding was the contribution of FBOs to community capacity building. Training clergy, volunteers, and lay leaders appeared to strengthen organisational readiness and improve the sustainability of health-related initiatives. These observations align with the broader community-based rehabilitation literature, which emphasises the importance of community ownership, local leadership, and capacity building in sustaining rehabilitation and disability programmes (Hartley et al., 2009; Khasnabis et al., 2010). However, the reviewed studies did not demonstrate direct delivery of rehabilitation interventions or measurable functional rehabilitation outcomes. Rather, the evidence

suggests that FBOs may strengthen local support systems through education, community mobilisation, leadership development, and facilitation of referral pathways.

The findings further suggest that FBOs may indirectly contribute to rehabilitation and community reintegration through psychosocial support and social participation. Faith-based spaces provided opportunities for peer interaction, emotional support, and community inclusion, which may help mitigate social isolation and stigma experienced by individuals living with physical disabilities. These observations are supported by previous research demonstrating that faith-based initiatives can positively influence emotional well-being, resilience, and social participation among individuals living with chronic health conditions and disabilities (Kruk et al., 2024). Spiritual communities often address emotional, social, and spiritual dimensions of recovery that may receive comparatively less emphasis within biomedical rehabilitation models.

Nevertheless, the available evidence did not demonstrate direct improvements in functional independence, rehabilitation outcomes, or long-term community reintegration. Consequently, FBOs should be viewed as potential community partners within rehabilitation ecosystems rather than as proven providers of rehabilitation interventions. Their primary contribution, based on the currently available evidence, appears to lie in strengthening community engagement, psychosocial support, social participation, and connections to available health and rehabilitation services.

Several barriers to the implementation of FBO-led initiatives were also identified, including limited technical expertise in rehabilitation sciences, insufficient funding, inconsistent training among faith leaders, and the absence of standardised monitoring and evaluation systems. Similar challenges have been reported in broader global health literature, which emphasises that while FBOs possess strong community legitimacy and extensive social networks, they frequently require partnerships with healthcare institutions and technical support to deliver evidence-informed interventions effectively (Olivier et al., 2015).

Finally, one of the most important findings of this review was the absence of eligible studies from low- and middle-income countries (LMICs), including India. This finding is noteworthy because faith-based institutions and mission hospitals have historically played important roles in healthcare delivery, rehabilitation, and community support in many regions of Africa and Asia (Adu-Gyamfi et al., 2020; Michael Kpughe, 2017; *World Bank*, n.d.). The absence of empirical evidence from these settings therefore represents a significant geographical and contextual knowledge gap rather than evidence of limited FBO involvement in rehabilitation. Consequently, caution is warranted when extrapolating findings from the United States to LMIC contexts, where healthcare systems, sociocultural factors, and the roles of faith-based institutions may differ substantially.

CONCLUSION

This bibliometric study provides an updated overview of the scientific development of research on disability, discrimination, and psychological well-being between 2020 and 2025. The findings demonstrate sustained growth in scientific production, increasing citation impact, and progressive thematic diversification. Although mental health, stigma, and discrimination remain the dominant focus of the literature, the increasing visibility of ableism, intersectionality, equity, and rights-based approaches suggests that the field is gradually broadening its conceptual scope.

The results indicate that contemporary disability research is characterised by the coexistence of established psychosocial perspectives and increasingly articulated structural, social, and contextual approaches to well-being. Rather than reflecting a uniform shift between paradigms, the thematic structure reveals uneven conceptual development. Mental

health, stigma, and discrimination remain central, while ableism, intersectionality, equity, and rights-based perspectives form a more structurally developed research agenda.

The study also highlights important research gaps. Scientific production and international collaboration remain concentrated in countries of the Global North, whereas evidence from Latin America and other low- and middle-income regions continues to be comparatively limited. Likewise, some disability groups, particularly people with physical, sensory, and intellectual disabilities, remain underrepresented within the thematic structure of the literature. Addressing these gaps will require greater geographical diversity, stronger international collaboration, and the expansion of longitudinal, intervention-based, participatory, and mixed-methods research.

Overall, this study contributes to a more comprehensive understanding of the evolution of research on disability, discrimination, and psychological well-being by identifying emerging themes, collaboration patterns, and current knowledge gaps. These findings provide evidence that can inform future research priorities, disability policy, Community-Based Rehabilitation (CBR), and inclusive development strategies aimed at reducing discrimination, promoting equitable participation, and improving the well-being of persons with disabilities This bibliometric study provides an updated overview of the scientific development of research on disability, discrimination, and psychological well-being between 2020 and 2025. The findings demonstrate sustained growth in scientific production, increasing citation impact, and progressive thematic diversification. Although mental health, stigma, and discrimination remain the dominant focus of the literature, the increasing visibility of ableism, intersectionality, equity, and rights-based approaches suggests that the field is gradually broadening its conceptual scope.

The results indicate that contemporary disability research is characterised by the coexistence of established psychosocial perspectives and increasingly articulated structural, social, and contextual approaches to well-being. Rather than reflecting a uniform shift between paradigms, the thematic structure reveals uneven conceptual development. Mental health, stigma, and discrimination remain central, while ableism, intersectionality, equity, and rights-based perspectives form a more structurally developed research agenda.

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Data Availability Statement: This work was supported by the Melbourne Research Scholarship (Fee Offset only).

REFERENCES

Adu-Gyamfi, S., Kuusaana, M., Darkwa, B., & Tomdi, L. (2020). The changing landscape of mission medicine and hospitals in Sub-Saharan Africa. *Christian Journal for Global Health*, *7*, 65–81. https://doi.org/10.15566/cjgh.v7i5.417

Allen, J. D., Leyva, B., Torres, A. I., Ospino, H., Tom, L., Rustan, S., & Bartholomew, A. (2014). Religious beliefs and cancer screening behaviors among Catholic Latinos: Implications for faith-based interventions. *Journal of Health Care for the Poor and Underserved*, *25*(2), 503–526. https://doi.org/10.1353/hpu.2014.0080

Allen, J. D., Torres, M. I., Tom, L. S., Leyva, B., Galeas, A. V., & Ospino, H. (2016). Dissemination of evidence-based cancer control interventions among Catholic faith-based organizations: Results from the CRUZA randomized trial. *Implementation Science: IS*, *11*(1), 74. https://doi.org/10.1186/s13012-016-0430-6

Boro, E., Sapra, T., Lavison, J.-F., Dalabona, C., Ariyaratne, V., & Samsudin, A. (2022). The Role and Impact of Faith-Based Organisations in the Management of and Response to COVID-19 in Low-Resource Settings. *Religion and Development*, *1*, 132–146. https://doi.org/10.30965/27507955-20220008

Carter, E. W. (2016). A place of belonging: Research at the intersection of faith and disability. *Review & Expositor*, *113*(2), 167–180. https://doi.org/10.1177/0034637316637861

Chadda, R. K., & Deb, K. S. (2013). Indian family systems, collectivistic society and psychotherapy. *Indian Journal of Psychiatry*, *55*(Suppl 2), S299–S309. https://doi.org/10.4103/0019-5545.105555

Chawa, A., Putra, M., & Purba, D. (2021). Community-based Approach to Empower People with Disabilities. *IJDS: Indonesian Journal of Disability Studies*, *8*, 467–480. https://doi.org/10.21776/ub.ijds.2021.008.02.13

Clarke, G. (2007). Agents of transformation? Donors, faith-based organisations and international development. *Third World Quarterly*, *28*(1), 77–96. https://doi.org/10.1080/01436590601081880

Das, T., & Guha, P. (2023). Pattern of Public Healthcare Expenditure and Preparedness for COVID-19 in India: An Interstate Analysis. *Journal of Health Management*, *25*(4), 903–917. https://doi.org/10.1177/09720634231215390

Duff, J. F., & Buckingham, W. W. (2015). Strengthening of partnerships between the public sector and faith-based groups. *Lancet (London, England)*, *386*(10005), 1786–1794. https://doi.org/10.1016/S0140-6736(15)60250-1

Hartley, S., Finkenflugel, H., Kuipers, P., & Thomas, M. (2009). Community-based rehabilitation: Opportunity and challenge. *Lancet (London, England)*, *374*(9704), 1803–1804. https://doi.org/10.1016/S0140-6736(09)62036-5

Holanda, C., Andrade, F., Bezerra, M., Nascimento, J., Neves, R., Bezerra, S., & Ribeiro, K. (2015). Support networks and people with physical disabilities: Social inclusion and access to health services. *Ciência & Saúde Coletiva*, *20*, 175–184. https://doi.org/10.1590/1413-81232014201.19012013

Jahani, R., & Parayandeh, M. Y. (2024). The Role of Faith-Based Organizations in Social Service Provision. *Interdisciplinary Studies in Society, Law, and Politics*, *3*(3), 12–19. https://doi.org/10.61838/kman.isslp.3.3.3

Khasnabis, C., Heinicke Motsch, K., Achu, K., Al Jubah, K., Brodtkorb, S., Chervin, P., Coleridge, P., Davies, M., Deepak, S., Eklindh, K., Goerdt, A., Greer, C., Heinicke-Motsch, K., Hooper, D., Ilagan, V. B., Jessup, N., Khasnabis, C., Mulligan, D., Murray, B., … Lander, T. (Eds.). (2010). *Community-Based Rehabilitation: CBR Guidelines*. World Health Organization. http://www.ncbi.nlm.nih.gov/books/NBK310940/

Kruk, J., Aboul-Enein, B. H., Kruk, J., & Aboul-Enein, B. H. (2024). Religion- and Spirituality-Based Effects on Health-Related Components with Special Reference to Physical Activity: A Systematic Review. *Religions*, *15*(7). https://doi.org/10.3390/rel15070835

Langford, C. P. H., Bowsher, J., Maloney, J. P., & Lillis, P. P. (1997). Social support: A conceptual analysis. *Journal of Advanced Nursing*, *25*(1), 95–100. https://doi.org/10.1046/j.1365-2648.1997.1997025095.x

Levin, J. (2014). Faith-based partnerships for population health: Challenges, initiatives, and prospects. *Public Health Reports (Washington, D.C.: 1974)*, *129*(2), 127–131. https://doi.org/10.1177/003335491412900205

Leyva, B., Allen, J. D., Ospino, H., Tom, L. S., Negron, R., Buesa, R., & Torres, M. I. (2017). Enhancing capacity among faith-based organizations to implement evidence-based cancer control programs: A community-engaged approach. *Translational Behavioral Medicine*, *7*(3), 517–528.

Matope, K., Mitumbu, D., Lucio, T., Kambalame, H., Porinsky, R., & Hatzfeld, J. (2025). Church-Based Ministry to People with Disabilities in Malawi: A Case Study and Program Evaluation. *Christian Journal for Global Health*, *12*(1). https://doi.org/10.15566/cjgh.v12i1.331

Michael Kpughe, L. (2017). Scholars Journal of Arts, Humanities and Social Sciences ISSN 2347-5374 (Online) Christian Churches and Leprosy Control in Anglophone Cameroon: The Case of the Manyemen Leprosarium, 1954-1992. *Scholars Journal of Arts, Humanities and Social Sciences*, *5*, 540–549. https://doi.org/10.21276/sjahss

Nicol, J. U., Iwu-Jaja, C. J., Hendricks, L., Nyasulu, P., & Young, T. (2022). The impact of faith-based organizations on maternal and child health care outcomes in Africa: Taking stock of research evidence. *The Pan African Medical Journal*, *43*, 168. https://doi.org/10.11604/pamj.2022.43.168.32983

Olivier, J., Tsimpo, C., Gemignani, R., Shojo, M., Coulombe, H., Dimmock, F., Nguyen, M. C., Hines, H., Mills, E. J., Dieleman, J. L., Haakenstad, A., & Wodon, Q. (2015). Understanding the roles of faith-based health-care providers in Africa: Review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *Lancet (London, England)*, *386*(10005), 1765–1775. https://doi.org/10.1016/S0140-6736(15)60251-3

Pasin, T., & Karatekin, B. D. (2024). Determinants of social participation in people with disability. *PLOS ONE*, *19*(5), e0303911. https://doi.org/10.1371/journal.pone.0303911

Pollock, D., Peters, M. D. J., Khalil, H., McInerney, P., Alexander, L., Tricco, A. C., Evans, C., de Moraes, É. B., Godfrey, C. M., Pieper, D., Saran, A., Stern, C., & Munn, Z. (2023). Recommendations for the extraction, analysis, and presentation of results in scoping reviews. *JBI Evidence Synthesis*, *21*(3), 520–532. https://doi.org/10.11124/JBIES-22-00123

Ravenell, J., Leighton-Herrmann, E., Abel-Bey, A., DeSorbo, A., Teresi, J., Valdez, L., Gordillo, M., Gerin, W., Hecht, M., Ramirez, M., Noble, J., Cohn, E., Jean-Louis, G., Spruill, T., Waddy, S., Ogedegbe, G., & Williams, O. (2015). Tailored approaches to stroke health education (TASHE): Study protocol for a randomized controlled trial. *Trials*, *16*, 176. https://doi.org/10.1186/s13063-015-0703-4

Roșu, E.-R., Gherguț, A., & Cobzeanu, A. (2025). The Intersection of Faith and Disability: Theological Perspectives from Catholic, Orthodox, and Reformed Representatives. *Journal of Disability & Religion*, 1–26. https://doi.org/10.1080/23312521.2025.2531806

Swartz, L. P., & Schneider, M. (2015). *Tough choices: Disability and social security in South Africa*. https://doi.org/10/6118

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M. D. J., Horsley, T., Weeks, L., Hempel, S., Akl, E. A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M. G., Garritty, C., … Straus, S. E. (2018). PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Annals of Internal Medicine*, *169*(7), 467–473. https://doi.org/10.7326/M18-0850

Uchino, B. N. (2009). Understanding the Links Between Social Support and Physical Health: A Life-Span Perspective With Emphasis on the Separability of Perceived and Received Support. *Perspectives on Psychological Science: A Journal of the Association for Psychological Science*, *4*(3), 236–255. https://doi.org/10.1111/j.1745-6924.2009.01122.x

World BankDocument.(n.d.). Retrieved January 6, 2026, from https://documents1.worldbank.org/crated/en/739091468010198457/pdf/762230v20WP0Fa0Box374365B000PUBLIC0.pdf