Editorial

Beyond the Clinic: The Community, Household, and Digital Frontiers of Modern Rehabilitation

Solomon Mekonnen Abebe

1 Editor-in-chief, Disability, CBR & Inclusive Development Journal, University of Gondar, Ethiopia
* Corrospondance: solomon.mekonnen@uog.edu.et

Editor:: Solomon Mekonnen
Article History:
Received: September 2, 2026
Accepted: September 2, 2026
Published: September 7, 2026

Citation: Solomon Mekonnen Abebe, Beyond the Clinic: The Community, Household, and Digital Frontiers of Modern Rehabilitation. DCIDJ. 2026, 37:3. doi.org/10.20372/dcidj.1108

INTRODUCTION

For much of the twentieth century, the medical model of disability framed impairment as an individual deficit to be corrected within clinical walls, leaving social and environmental barriers largely unaddressed (1). However, a profound paradigm shift since the 1970s has reshaped the rehabilitation landscape. Grounded in Community-Based Rehabilitation (CBR) (2) and inclusive development frameworks (3), contemporary research conceptualizes disability as dynamic outcomes of ongoing interactions between physical health, immediate environments, and social networks (4).

This movement toward embedding care within communities is a matter of practical necessity. Traditional clinic-bound therapies frequently impose geographic, financial, and transportation barriers, restricting access for vulnerable populations (4). Consequently, rehabilitation is expanding into three major spheres: the physical household, the digital landscape, and the social community. Within these frontiers, telehealth, virtual reality (VR), and play-based therapies offer scalable alternatives, though their reach is bounded by digital equity and socioeconomic constraints.

The articles in this issue exemplify this transformation, offering evidence from diverse contexts that together illuminate the contours of modern rehabilitation. They demonstrate how interventions rooted in everyday environments – whether mediated through digital technologies, embedded in family routines, or supported by community networks – can expand access, enhance participation, and challenge systemic inequities.

In Yucatan, Mexico, Widman-Valencia and colleagues explore the potential of telehealth to empower caregivers of children with feeding disorders. Their Oral-Motor Therapy Online Program (OMOP) illustrates both the promise and the limitations of digital interventions. While the program provided low-cost, scalable training, its implementation was hindered by internet failures, time, poverty, and family health crises. The authors' adaptive strategies, including aligning schedules with the school calendar, utilizing WhatsApp for reminders, and sharing videos directly to mobile phones, underscore the importance of context-sensitive design. Their work underlines that digital innovation must be accompanied by deliberate efforts to confront stark digital equity issues and linguistic barriers if it is to achieve meaningful impact.

Kumar and colleagues reported on a systematic review of randomized controlled trials (RCTs) across multiple VRT delivery modalities. The study confirms the effectiveness of VRT in reducing dizziness and improving balance. Particularly striking is the finding that reality-augmented VRT produced superior outcomes in older adults, demonstrating how immersive technologies can enrich therapeutic experiences. Equally important, the review highlights the scalability of home-based and internet-based models, which offer programmatic alternatives to clinic-bound care. Here, digital rehabilitation emerges not

as a supplement but as a viable, non-inferior mode of delivery that can extend reach and reduce barriers.

From India, Srivastava and Begum's cross-sectional study of parental awareness of children's psychosocial needs situates rehabilitation within the household sphere. The findings reveal diagnostic hierarchies shaped by visibility and stigma: awareness is highest in autism spectrum disorder, where regression is most apparent, and lowest in intellectual disability, were stigma delays acceptance and intervention. Gendered differences are also evident, with mothers demonstrating greater awareness than fathers, while household socioeconomic status strongly correlates with access to therapy and digital literacy. These results highlight the relational and cultural dimensions of rehabilitation, reminding us that family context, social acceptance, and resource distribution are as critical as clinical expertise in shaping outcomes.

In Indonesia, Subasno's Pastoral Accompaniment in Leisure (PAiL) model offers a vivid illustration of how leisure-based, relational interventions can foster expressive communication among individuals with severe cerebral palsy. By embedding therapy in leisure activities that utilize visual cards, music, and screen-based stimuli, the study demonstrates that communication is not a static competence but a relational process. Improvements emerged through supported participation rather than formal instruction alone, consistent with Vygotsky's socio-cultural learning theory (5), but declined when support was withdrawn. This underscores the necessity of ongoing scaffolding, responsive partners, and caregiver capacity building. Rehabilitation here is not about isolated skills but about sustained relational engagement with everyday environments.

At a global level, Camacho and colleagues' bibliometric analysis of disability and well-being research reveals both rapid growth and stark inequalities. The field expanded significantly between 2020 and 2025, yet scholarship remains concentrated in the Global North, leaving low- and middle-income countries peripheral. Conceptually, the analysis maps a transition from biomedical deficit models toward structural analysis of ableism, health equity, and participation. This shift reflects a growing recognition that disability is produced not only by bodies but by institutions and power structures. The findings underline the urgent need to elevate local voices and diversify authorship, ensuring the global scholarship reflects the realities of marginalized communities rather than reproducing existing hierarchies.

Fatehi's article highlights employment as a vital dimension of rehabilitation. Effective programs, such as Project SEARCH with outcomes above 70%, succeed through personalized assessments, hands-on learning, and strong partnerships. Natural support systems play a crucial role, though barriers of stigma, funding, and accessibility persist, especially in low- and middle-income countries. The authors argue that vocational training must be embedded within rights-based frameworks like the CRPD and CBR guidelines, ensuring ongoing support. By aligning employment pathways with household, digital, and community spheres, vocational training emerges as a critical extension of modern rehabilitation.

Finally, Kumar and colleagues' systematic scoping review of Faith-based Organizations (FBOs) highlights their role as trusted actors in rehabilitation and community reintegration. While their moral leadership, volunteer networks, and cultural responsiveness provide valuable support, the lack of technical rehabilitation expertise and systematic research coverage, especially in low- and middle-income countries, underscores the need for capacity building. FBOs often serve as the sole service providers in underserved regions, yet their contributions remain rarely documented and supported. Intentionally engaging these networks could strengthen CBR and bridge gaps between formal healthcare services and local realities.

Taken together, these contributions point toward a multidimensional model of modern rehabilitation. In the physical and leisure sphere, therapy embedded in home routines and play environments transforms exercises into relational, motivating interactions. In the digital sphere, telehealth, scalable digital VRT, and remote coaching models expand reach, but their success depends on addressing digital equity and linguistic diversity. In the social sphere, caregivers and community networks, including FBOs, emerge as vital therapeutic agents, bridging formal and informal systems of support.

Ultimately, the articles remind us that rehabilitation cannot be achieved in isolation. A sustainable, inclusive framework must actively dismantle systemic ableism, elevate local voices, build caregiver capacity, and design context-sensitive community-based interventions that respond to the realities of low- and middle-income countries. By situating rehabilitation within households, communities, and digital frontiers, the studies in this issue collectively chart a path toward equity, participation, and global responsiveness. We hope this issue inspires scholars, practitioners, and policymakers to rethink the boundaries of rehabilitation and to advance community-based inclusive development in ways that are equitable, participatory, and globally responsive.

REFERENCE

Campbell FK. Contours of ableism: The production of disability and abledness. Palgrave Macmillan; 2009.

World Health Organization, UNESCO, ILO, IDDC. Community-Based Rehabilitation: CBR Guidelines. Geneva: World Health Organization; 2010.

Sen A. Development as freedom. Oxford University Press; 1999.

World Health Organization. Global report on health equity for persons with disabilities. Geneva: World Health Organization; 2022.

Vygotsky LS. Mind in society: The development of higher psychological processes. Harvard University Press; 1978.