Rehabilitation and Inclusion as Human Rights: Disability, Access, and Equity in Belize

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Abstract

Disabled populations are among the most marginalized globally, facing long-entrenched, persistent barriers to accessing healthcare, rehabilitation services, and full societal inclusion. These disparities have led disabled populations to face increased risk of adverse outcomes, including chronic health conditions, financial instability, diminished quality of life, and even shortened life expectancy. Such outcomes are highly prevalent in low- and middle-income (LMIC) countries, whereas few as 5-15% of disabled people may have access to rehabilitation services or assistive technologies and rehabilitation is often considered a secondary, optional service. In the Latin American and Caribbean regions—including Belize—persistent rehabilitative access gaps, lack of local specialist providers, limited inclusive infrastructure, under-resourced health systems, and incomplete commitment to inclusive policies all negatively impact outcomes for disability-affected populations. Rights-based frameworks, such as the United Nations Sustainable Development Goals (SDG) and Convention on the Rights of Persons with Disabilities (CRPD), as well as programs emerging in other LMICs, show promising examples of ways by which Belize may move away from inconsistent, charity-based models and embrace holistic methods grounded in human rights and a commitment to participatory, inclusive approaches for meeting the needs of disability-affected Belizeans. This conceptual paper aims to highlight the interconnected relationship between disability, rehabilitation access, and human rights by examining the scope and impacts of disability in Belize, identifying gaps in health and rehabilitative services and their rights-related implications, reviewing rights-based frameworks from other LMICs that may be relevant to Belize, and outlining opportunities for strategic planning and policy improvements at both community and governmental levels.

Keywords: Disability, Rehabilitation, Inclusion, Justice, Equity, Human Rights, Belize

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Introduction

Belize faces persistent and systemic challenges in ensuring equitable access to healthcare and rehabilitation services for persons with disabilities (PWD), (Hartman et al., 2021). Despite growing global recognition of disability inclusion as a public health and human rights priority, rehabilitation in Belize remains limited in availability, unevenly distributed, and insufficiently integrated into the national health system (Hartman et al., 2021; Garcia Mora et al., 2023). These gaps have profound implications for the health, functional independence, and social participation of Belizeans living with disability and reflect broader patterns of underinvestment in disability-responsive health policy within the country.

Disability in Belize, as elsewhere, is not solely a medical condition but arises from the interaction between health conditions and social, environmental, and structural barriers. The World Health Organization defines disability as the result of this interaction, shaped by factors such as inaccessible infrastructure, negative societal attitudes, and limited social supports (World Health Organization [WHO], 2025). In the Belizean context, these barriers are compounded by limited rehabilitation infrastructure, shortages of trained providers, and weak policy enforcement mechanisms, resulting in the systematic marginalization of PWD from healthcare, education, employment, and broader social life (Garcia Mora et al., 2023; Gréaux et al., 2023; Hartman et al., 2021).

Globally, an estimated 1.3 billion people—approximately 16% of the world's population—live with significant long-term disabilities (WHO, 2022). Persons with disabilities experience disproportionate health inequities, including higher rates of chronic conditions, greater exposure to catastrophic health expenditures, and, in some contexts, substantially reduced life expectancy (WHO, 2022). These inequities are not incidental; rather, they stem from structural neglect within health systems that routinely deprioritize disability-inclusive care and rehabilitation in policy and financing decisions (Ferrari & Santomauro, 2024). Belize reflects these global trends, but with heightened consequences due to its small health workforce, constrained fiscal space, and limited rehabilitation capacity.

The burden of unmet rehabilitation needs is particularly acute in low- and middle-income countries (LMICs), where access to essential services remains severely constrained (Khan et al., 2018). Globally, more than 2.4 billion people could benefit from rehabilitation, yet in many LMIC settings only 5–15% of those in need have access to appropriate rehabilitation or assistive technologies (Cieza et al., 2021; Khan et al., 2018; WHO, 2022). In Belize, the shortage of disability-specific specialists and rehabilitation professionals significantly limits the health system's ability to address complex functional needs (Hartman et al., 2021). Consequently, some individuals are compelled to seek care outside the country, most commonly in Mexico or Guatemala (United Nations, 2017). Such options, however, are financially and logistically inaccessible to most Belizeans, reinforcing inequities within an already marginalized population.

The absence of accessible rehabilitation services in Belize has implications that extend beyond health outcomes alone. Rehabilitation is critical to the realization of fundamental human rights, including the rights to health, dignity, autonomy, equality, education, and work. When rehabilitation services are unavailable or inaccessible, individuals face preventable disability, increased dependency, and exclusion from social and economic participation (WHO, 2011). These dynamics contribute to the "disability–poverty cycle," in which functional limitations, lack of services, and socioeconomic exclusion mutually reinforce one another (Gréaux et al., 2023;). See Figure 1. While these patterns are observed across the Latin American and Caribbean region, Belize's limited rehabilitation infrastructure and policy gaps render PWD particularly vulnerable.

Figure 1. *Disability and* Poverty *Cycle*

Reference: (modified from) Department for International Development (DFID). (2000) Disability, poverty, and development. London: DFID

Across Latin America and the Caribbean, PWD are consistently more likely to report unmet health needs and are up to twice as likely to forgo care due to financial, geographic, or infrastructural barriers compared with persons without disabilities (Jones & Serieux-Lubin, 2018; WHO, 2022). Health systems in Central America and the Caribbean remain under-resourced with respect to rehabilitation, and Belize is no exception (Cieza et al., 2021). However, Belize's small population and centralized health governance also present opportunities for targeted, rights-based reform if rehabilitation is explicitly prioritized within national policy and planning frameworks.

This conceptual paper examines the intersection of disability, rehabilitation, and human rights within the Belizean context. It argues that access to rehabilitation in Belize must be recognized not as a discretionary or auxiliary service, but as a core component of the right to health and a critical driver of social and economic inclusion. This framing aligns with the World Health Organization's 'Rehabilitation 2030 Call to Action', which emphasizes the integration of rehabilitation into health systems as essential to achieving universal health coverage and the Sustainable Development Goals (WHO, 2020).

This paper aims to briefly summarize the interconnected nature of disability, rehabilitation access, and human rights in a broad sense, and then to more closely examine the scale and impacts of disability in Belize at individual and community levels. Existing gaps in access to health and rehabilitative services for disability-affected Belizeans will be demonstrated—including related human rights implications—and a

summary of existing rights-based frameworks and programming underway in other countries which may be applicable to the Belizean context will be provided. Finally, the authors will identify potential areas for strategic planning and positive changes in Belize's disability policy at community and governmental levels.

Disability, Rehabilitation, and Human Rights

From a public health perspective, the scale and impacts of disability are impossible to overlook (Lancet Public Health, 2021). Disability is widely recognized as both a global public health priority and a pressing human rights concern (Kuper & Heydt, 2019; McDonald & Raymaker, 2013). Prevalence of disability continues to rise, driven by factors such as aging populations, chronic disease burden, injuries, and the long-term effects of medical conditions such as COVID-19 (Ferrari & Santomauro, 2024; Stucki et al., 2018). As a central determinant and driver of health system demand, resource allocation, and workforce planning, disability is by no means an issue of marginal importance. Appropriately addressing disability within health systems requires consistent access to rehabilitation services, assistive technologies, programs which promote inclusion, and preventive measures to reduce avoidable impairments.

Rehabilitation is a comprehensive set of specialized interventions including physiotherapy, occupational therapy, speech and language therapy, prosthetics and orthotics, and physiatry. The WHO defines rehabilitation as "a set of interventions needed when a person is experiencing or is likely to experience limitations in everyday functioning due to aging or a health condition, including chronic diseases or disorders, injuries or traumas" (WHO, 2019). Like the barriers facing effective implementation of disability policy, challenges to effective rehabilitation delivery are especially acute in LMICs—where services are concentrated in urban centers, often provided privately, and largely inaccessible to rural, Indigenous, and/or otherwise marginalized populations (Cieza et al., 2021; Kamenov et al., 2019).

Alongside the aforementioned barriers to rehabilitation services, the experience of disability is itself a fundamental matter of human rights. People with disabilities have historically been largely excluded from access to education, employment, healthcare, political participation, and meaningful participation in community life—not solely because of their impairments, but also due to systemic discrimination, outdated stereotypes, and inaccessible (physically or otherwise) environments (WHO, 2011). In 2006, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) reframed disability through a rights-based lens, shifting away from biomedical models that define disability as solely attributable to individual pathology (United Nations, 2006). Instead, the CRPD emphasizes the interaction between impairments and societal barriers, mandating state action to guarantee equality, participation, and dignity. Articles 25 (Health) and 26 (Habilitation and Rehabilitation) explicitly affirm the right to timely, affordable, and high-quality rehabilitation services (United Nations, 2006).

In the years since its inception, the CRPD has spurred legal and policy reforms worldwide. Kenya's 2010 constitution, for example, enshrined protections for persons with disabilities (The Government of Kenya, 2010), while countries such as Colombia and Peru have restructured guardianship systems toward supported decision-making (Center for Public Representation, 2020). National development plans increasingly seek to integrate disability inclusion across health, education, and labor sectors. Courts throughout several African countries (International Commission of Jurists, 2025), India (Atrey, 2018), and Argentina (Aiello, 2018) have invoked the CRPD in efforts to strengthen rights PWD to inclusive education, accessibility, and participation. Despite this promising momentum, implementation gaps remain significant—particularly in LMICs, where efforts toward reform are often constrained by factors such as persistent structural inequities, resource limitations, and other internal executive structures (Gréaux et al., 2023; WHO, 2022). Belize is no different.

Recognizing the reality of these inequities, the WHO's World Report on Disability (WHO, 2011) and the Rehabilitation 2030 initiative (WHO, 2020) emphasize rehabilitation as essential for promoting universal health coverage, social inclusion, and economic development. Scholars argue that rehabilitation must be understood not only as a means of improving individual functioning, but also as a prerequisite for equality and participation (Gutenbrunner et al., 2020; Stucki et al., 2018).

As crucial as both rehabilitation and human rights protections are, the needs of those living with disability cannot be fully addressed by access to only one or the other. A comprehensive approach must integrate public health systems with human rights commitments—ensuring that rehabilitation services are available, affordable, and inclusive, while also dismantling the structural barriers that perpetuate exclusion. This dual framing has shaped international development agendas, most notably the Sustainable Development Goals (SDGs), which link universal health coverage with the more holistic principles of "leaving no one behind" and which "endeavor to reach the furthest behind first" (United Nations Department of Economic and Social Affairs, 2024).

Impacts and Realities of Disability in Belize

Belize presents a case study of global disability and rehabilitation trends at a national level. As far back as 2004, the International Disability Rights Monitor's regional report of the Americas concluded that Belize was one of the least inclusive nations in the Americas with regard to disability, lacking the basic elements necessary for the social inclusion of people with disabilities (International Disability Network, 2004). This was partly due to the divestment of funding for disability services which was enacted by the Belizean Government from the late 1990's into the early 2000's (Skeen & Cowo, 2010), as well as the exclusion of accessible rehabilitation from Belize's 2001 launch of its National Health Insurance (NHI) program (Saunders, 2012). As of 2021, rehabilitation was still listed as an excluded service under the NHI (National Health Insurance Committee, 2021) and no uniform definition or classification of disability currently exists in Belize (United States Department of State, 2024). High-quality statistics related to disability and rehabilitation-specific human resources also continue to be lacking (Abualghaib et al., 2019). Incomplete census data, as well as disruptions in data collection due to the COVID-19 pandemic, present significant barriers to accurately quantifying the proportion of Belizeans living with disability. However, it is known that the challenges of disability inclusion in Belize are intensified by factors including structural inequities, limited healthcare infrastructure, and persistent social stigma. Although the government ratified the CRPD in 2011 (UN, 2020) and more recently enacted national legislation, including the Disability Bill of 2024 (Government of Belize, 2024), substantial gaps in implementation continue to undermine progress. Moreover, the legislative landscape contains outdated conceptualizations of disability that are misaligned with contemporary human rights norms. The Unsoundness of Mind Act, which regulates the treatment and detention of individuals deemed to have mental impairments, exemplifies a custodial and protectionist framework that prioritizes control over autonomy, rehabilitation, and community-based inclusion. The Act, admittedly outdated by the Belize Ministry of Health and Wellness leadership (Diaz-Musa, 2025), contains no explicit provisions for rights-based mental health care, supported decision-making, or access to rehabilitation and psychosocial supports, thereby perpetuating stigma and structural exclusion of persons with psychosocial and intellectual disabilities. Its continued coexistence with more recent disability legislation underscores the fragmented and internally inconsistent nature of Belize's disability policy and regulatory environment.

Rehabilitation remains one of the most underdeveloped areas of the Belizean healthcare sector (Hartman et al., 2021; Trejo et al., 2021), despite the central role these services play in restoring function, fostering independence, and supporting social participation for those affected by disability (Stucki et al., 2018). A 2020 workforce analysis revealed that Belize had only 0.44 physiotherapists per 10,000 people—an alarmingly low ratio (Hartman et al., 2021). Regional comparisons highlight Belize's high level of disparity: St. Lucia, with a population numbering less than half of Belize's, boasted nearly the same number of physiotherapists (World Physiotherapy, 2020); while Bermuda, with just 63,968 residents, employed 54 physiotherapists (~8.5 per 10,000 people) (Department of Statistics, Bermuda, 2020). The Pan American Health Organization (PAHO) lists a regional median number of rehabilitation professionals per 10,000 population at 2.7 (mean=8.6) (Pan American Health Organization, 2022). Within Belize, there are no in-country educational programs for training therapists—and physiotherapy remains markedly underrepresented (18 physiotherapists) compared to other healthcare professions (Hartman et al., 2021). In contrast, in 2020 there were 412 medical doctors (10.4 per 10,000 people) and 797 registered nurses (20 per 10,000 people) practicing in Belize (Statistical Institute of Belize, 2020). When physiotherapy services are available, they are predominantly provided by the private sector in highly populated regions. Only 2 of the 18 physiotherapists work in government-operated hospitals, rendering services largely inaccessible for rural and Indigenous populations and for those with limited incomes (Hartman et al., 2021). These

imbalances echo the conclusions of Belize's 2014–2024 National Health Sector Strategic Plan (Government of Belize, Ministry of Health, 2014), which identifies the shortage of physiotherapists as a serious constraint on both the quality and availability of rehabilitation services.

Concerningly, the aforementioned workforce analysis found a complete absence of in-country licensed professionals practicing in the other rehabilitation disciplines (such as occupational therapy or speech-and-language pathology), leaving Belizeans heavily reliant upon short-term, foreign volunteers for any such services (Hartman et al., 2021). While such volunteerism is not inherently negative, it does raise significant ethical concerns which have been extensively documented in the literature (Bauer, 2017; Berry, 2014; Crump & Sugarman, 2008; DeCamp, 2007; Hartman & Dholakia, 2023; Langowski & Iltis, 2011; Lasker, 2016). Such risks may include inconsistent service delivery, lack of continuity of care, and (in some cases) volunteers practicing outside their scope of practice due to inconsistent oversight (Doobay-Persaud et al., 2019a, 2019b; Hartman & Dholakia, 2023). The lack of such rehabilitation services can lead to adverse outcomes such as (in the case of occupational therapy) a lack of early childhood intervention, which can hinder children from enrolling into school and accessing an education (Barillier & Jaegers, 2020).

National initiatives have sought to address these challenges. Belizean efforts at the governmental level have included establishment of the National Resource Center for Inclusive Education (NaRCIE), the Special Education Unit within the Ministry of Education, development of a National Disability Policy, and support for The Inspiration Center (TIC)—an outpatient rehabilitation center for children with disabilities headquartered in Belize City. In addition, there have been recent statements made by Belize Ministry of Health and Wellness leadership about efforts to update the national mental health policy and legislation related to the delivery of services to people with mental health concerns (Diaz-Musa, 2025). However, these initiatives remain either in the early stages of discussion or at most, limited in scope and sustainability due to funding constraints, a persistent shortage of trained professionals, and incomplete integration into national health systems (Trejo et al., 2021). As seen in other small states, national commitments often lack the ongoing monitoring, financing, and institutional support required for sustained success (Cieza et al., 2021; Gréaux et al., 2023). Despite ratifying international treaties and passing national laws, Belize continues to struggle with effective implementation. The absence of comprehensive rehabilitation policies, fragile data systems, and underinvestment perpetuate gaps in service delivery (Mora & Carrasco, 2023). Hartman et al. also highlight a considerable reliance on national and international NGOs and charity-based donor funding to provide rehabilitation services, which—while helping to fill critical gaps—often creates fragmented and unsustainable systems (Hartman et al., 2021). Furthermore, limited awareness and stigma surrounding disability reinforce barriers to both demand and supply of rehabilitation services (Gréaux et al., 2023).

Although Belize has made notable progress over the past 20 years, PWD continue to face structural and systemic barriers which undermine equal societal participation. Stigma and discrimination further exacerbate these barriers. Despite growing recognition of rehabilitation as a core component of health systems, (Cieza, 2019; Stucki et al., 2018) access in Belize remains constrained. These barriers are interconnected and reinforce inequities, particularly for rural, Indigenous, and low-income populations.

Four persistent, key limitations include:

1. **Workforce Shortages:** Belize faces an acute shortage of rehabilitation professionals, reflecting broader global patterns in LMICs where workforce density falls far below WHO-recommended thresholds. Rehabilitation specialists are few, largely concentrated in Belize City and/or in private practice. This creates inequitable access, with rural and Indigenous communities structurally excluded.

2. **Financial and Systemic Constraints**: Rehabilitation financing in Belize is limited, dependent upon donor contributions and private-sector engagement. Government allocations remain minimal- only those with permanent work-related disabilities assessed at 25% or higher qualify for a Disablement Pension, with a minimum weekly payment of $47 (Belize Government, Social

Security Board, 2025). This reality mirrors trends in other LMICs where rehabilitation is considered peripheral to universal health coverage. High out-of-pocket costs compound exclusion, as families must often pay privately, travel extensively, and absorb indirect expenses such as lost income. These financial burdens disproportionately affect low-income households.

3. **Fragmented Government and Implementation Gaps:** The absence of a comprehensive rehabilitation strategy within the national health system contributes to fragmentation and incomplete integration of services. Rehabilitation support in Belize remains a legal blind spot not due to policy neglect but to structural omission. While the country's legislative instruments acknowledge disability rights in principle, they fail to translate those commitments into enforceable entitlements. The continued validity of the Unsoundness of Mind Act and the aspirational nature of the Disability Act together produce a regime of partial recognition and systemic exclusion. Bridging this gap requires a paradigmatic shift toward a rights-based rehabilitation model grounded in equality, autonomy, and participation—principles already embedded within the CRPD yet unrealized in Belizean law.

4. **Cultural and Attitudinal Barriers:** Significant and persistent stigma against Belizeans with disabilities undermines both social inclusion and policy prioritization. Cultural perceptions often associate disability with dependency, pity, or even shame (Gréaux et al., 2023; Rohwerder, 2018). These attitudes not only hinder social inclusion but also impede political will to prioritize investment in rehabilitation by viewing disability as a private burden rather than a shared societal responsibility. Addressing stigma requires embedding disability inclusion within education, community engagement, and policymaking. In Belize, limited awareness campaigns and inconsistent enforcement of anti-discrimination measures allow negative stereotypes to persist, further hindering the integration of rehabilitation into broader health and development agendas (Trejo et al., 2021). Framing disability as a matter of charity rather than rights results perpetuates a cycle where PWD are simultaneously underserved by the state and socially marginalized within their communities

These realities position Belize at a critical juncture: while inclusive policy frameworks do exist, meaningful implementation requires moving from aspirational rhetoric to implementation of systemic reform. By intentionally situating rehabilitation within a human rights framework, Belize has the potential to build a more equitable and disability-inclusive health system.

Right-Based Frameworks and Inclusive Programming Examples

The conceptualization of rehabilitation as a right, rather than a privilege, is increasingly emphasized in both academic and policy discourse (Gréaux et al., 2023; Jesus et al., 2017; United Nations, 2006; WHO, 2022). The CRPD, alongside instruments such as the SDGs, affirms that health and disability inclusion are integral to achieving equity and development. Some argue that rights-based health frameworks compel states to adopt participatory, transparent, and accountable approaches to service delivery (WHO, 2019). By contrast, charity-based models—still prevalent in Belize—position rehabilitation as an optional, benevolent service, reinforcing dependency and stigma (Dholakia et al., 2024; Dholakia et al., 2021).

The rights-based approach to health integrates international human rights law with public health practice, establishing that access to health services is grounded in principles of dignity, equality, and accountability rather than mere policy preference (Gréaux et al., 2023; London, 2008; United Nations, 2006; UN, 1966) It draws heavily on instruments such as the International Covenant on Economic, Social and Cultural Rights (UN, 1966) and the CRPD, both of which enshrine the right to the "highest attainable standard of physical and mental health." Importantly, the CRPD extends this commitment by explicitly recognizing rehabilitation as integral to realizing this right.

Operationalizing a rights-based approach to health requires adherence to the AAAQ principles, developed by the United Nations Committee on Economic, Social and Cultural Rights (Campbell et al., 2013; Jesus et al., 2017). Grounded in the International Covenant on Economic, Social and Cultural Rights, this framework defines the right to health through four interrelated dimensions: availability, accessibility, acceptability, and quality. "Availability" requires that health services, facilities, essential medicines, and trained personnel exist in sufficient quantity to meet population needs. "Accessibility" ensures that these services can be reached by all people without discrimination—physically, financially, and through access to reliable health information. "Acceptability" demands that care be delivered in ways that respect cultural values, uphold dignity, and follow medical ethics. Finally, "quality" requires that services be scientifically and medically appropriate, safe, and effective. Together, these dimensions clarify that the right to health encompasses far more than the mere presence of services; it requires that care be equitably reachable, culturally respectful, and of consistently high quality for all.

On an implementation level, the literature would suggest that shifting toward a rights-based framework requires significant structural reforms: scaling rehabilitation workforce training, decentralizing services, and embedding disability inclusion into health and social systems (Hartman et al., 2021; Kamenov et al., 2019). Evidence from Latin America highlights how integrating rehabilitation into national health agendas can improve access and equity, particularly when supported by professional associations and participatory governance structures (Mactaggart et al., 2016; Hickey et al., 2019). In Chile, the government has advanced rehabilitation through the 'RehabPHC' program, launched in 2007, which expands access via community-based rehabilitation rooms and rural teams. Centered within primary care and backed by Ministry of Health leadership and funding, the program delivers timely, equitable services across the disease continuum (Seijas et al., 2023). Similarly, Brazil has promoted inclusive rehabilitation through its Unified Health System, strengthened by the Living Without Limits plan. This initiative expanded rehabilitation centers and improved access to assistive technologies for low-income populations, illustrating how national policy and targeted investment can enhance equity and social inclusion (Lyra et al., 2022).

Other regions also provide instructive examples. Uganda has strengthened its rehabilitation workforce and established a national strategy with dedicated Ministry of Health structures (Neill et al., 2024), Thailand has included rehabilitation services such as physiotherapy and assistive devices within its universal health coverage scheme (Kuper & Heydt, 2019), and India has recently emphasized the integration of Physical Medicine and Rehabilitation into national health policy through awareness campaigns and workforce initiatives (Swarnakar, 2025).

Collectively, these examples show that, when rehabilitation is integrated into universal health coverage benefit packages and delivered across levels of care, significant positive impacts--including financial protection, improved service availability, and advanced equity for persons with disabilities and chronic health conditions—may result.

When applied to the Belizean context, the rights-based approach exposes existing implementation gaps between formal ratification of human rights treaties and the lived experiences of persons with disabilities. Despite the Disability Bill and CRPD ratification, limited rehabilitation infrastructure, urban concentration of available services, and persistent financial barriers continue to undermine AAAQ standards (Hartman et al., 2021). In this sense, the rights-based approach is not merely normative but provides a potential diagnostic tool to measure state accountability.

The social model of disability, developed in the 1970s and widely adopted in disability studies, shifts the primary focus away from individual impairments toward the barriers created by society for those with disabilities (Goering, 2015; Oliver, 2013). Disability is thus not simply a medical condition but, rather, the result of inaccessible environments, discriminatory policies, and social stigma. In contrast to the pathology-focused medical model (Hogan, 2019), the social model underscores systemic responsibility—both in producing exclusion and in effectively addressing it (See Table 1). This concept is particularly relevant in Belize, where physical geography (e.g., remote rural and island communities), underfunded healthcare, and cultural stigmas collectively "disable" individuals by curtailing access to rehabilitation services and societal participation.

	Table 1. Medical vs Social Model of Disability	
	Models of Disability	
	Medical Model	**Social Model**
Core view	Disability is a problem within the individual, caused by disease, injury, or impairment	Disability arises from barriers in society (physical, social, attitudinal) that prevent full participation
Focus	Focus is on the diagnosis, treatment/cure/rehabilitation of impairments identified through examination	Focus is on removing societal barriers and promoting accessibility, inclusion, and rights
Responsibility for change	The individual must adapt, recover, or be "fixed" by healthcare providers and/or healthcare systems.	Society must adapt by removing barriers and ensuring equality of opportunity, regardless of ability
Outcome/goals	To 'normalize' the individual to a societal norm and minimize physical/functional limitations	To enable full participation, autonomy, and inclusion
Role of Professionals	Physicians, therapists, and other specialists contribute expertise in clinical assessment and treatment.	Persons with disabilities contribute expertise through lived experience to drive advocacy, policy, and community change.
Risks	Can be paternalistic, reductionist, and/or stigmatizing	May ignore the role of the medical situation and personal needs of individuals
Example	A person using a wheelchair is disabled because they cannot walk	A person using a wheelchair is disabled because buildings lack ramps/elevators

The rights-based approach and the social model are mutually reinforcing frameworks (Lawson & Beckett, 2021). The rights-based approach provides legal and normative grounding, mandating that governments fulfill obligations to provide rehabilitation. The social model offers a sociological critique, exposing the ways systems and environments disable individuals. For example, the lack of trained physiotherapists or speech therapists in Belize does not merely reflect a shortage of professionals but also perpetuates structural exclusion by denying persons with disabilities equal participation in education, employment, and community life.

Applied together, the rights-based framework lens demands accountability for the state's commitments under the CRPD, and the social model lens reveals that barriers are overwhelmingly rooted in structural inequities rather than individual deficits (Lawson & Beckett, 2021). For example, the disproportionate concentration of rehabilitation services in Belize's urban centers can effectively be critiqued both under the AAAQ framework (accessibility and availability failures) and through the social model (systemic exclusion of rural/Indigenous communities).

In addition to the previously discussed health systems, other LMIC's have drawn explicitly upon both a rights-based approach and the social model of disability to guide reforms, demonstrating that these

principles are not solely confined to high-income settings. For example, Nepal's Rights of Persons with Disabilities Act (2017) recognizes disability as shaped by social barriers, with reforms decentralizing rehabilitation services through primary care and CBR networks (Dahal et al., 2025). In the Philippines, the Magna Carta for Persons with Disabilities, strengthened after CRPD ratification, established disability as a matter of rights and social inclusion, with rehabilitation and assistive device provision integrated into national health programs (Republic Act No. 9442, 2006). Costa Rica's Equal Opportunities Law for People with Disabilities, enacted in May 1996, is grounded in international human rights frameworks. It emphasizes non-discrimination and equal opportunities, aiming to adapt environments, services, information, activities, and societal attitudes to meet the needs of all people (Montero, 1998).

Some countries with similar resource constraints have addressed service gaps through task-shifting and community-based rehabilitation programming (Gilmore et al., 2017; Jesus et al., 2016; MacLachlan et al., 2011). In Belize, such approaches are currently being implemented by several non-profit organizations, including Hillside Healthcare International and the Inspiration Center. Expanded efforts on a governmental level could be considered in Belize, where higher education for rehabilitation training is non-existent and the non-urban population is highly geographically dispersed.

The aforementioned examples demonstrate that grounding rehabilitation in human rights and the social model has practical implications across diverse contexts. Grounding the Belizean case within these frameworks allows the potential for commentary to move beyond surface-level critiques of "lack of services." Instead, it situates rehabilitation as a crucial matter of justice—and emphasizes the urgency of fulfilling international obligations and dismantling socially-constructed barriers. With commitment and consistency, this analytical foundation has the potential to develop actionable recommendations that are legally mandated, socially necessary, ethically urgent, and highly beneficial to disability-affected Belizeans.

Potential Pathways for Positive Change in Belize

International frameworks such as the CRPD and SDGs provide a normative foundation for strengthening Belize's rehabilitation infrastructure across multiple fronts. The CRPD explicitly calls upon states to ensure access to rehabilitation (Article 26), while the SDGs emphasize universal health coverage, equity, and the principle of "leaving no one behind."

By aligning national policies with these human rights-based frameworks, Belize has the potential to transform rehabilitation from a discretionary service into a state-level priority and obligation. This alignment requires moving beyond mere ratification and into full-scale implementation of CRPD commitments and AAAQ standards, with robust monitoring mechanisms installed to promote government-level accountability and the progressive realization of rights.

WHO's Rehabilitation 2030*:* A Call for Action provides further guidance, emphasizing the integration of rehabilitation into primary healthcare. Their 'Guide for Action' offers actionable means for governments to strengthen their health systems to provide rehabilitation resources. This four-phase process begins with a formal Systematic Assessment of Rehabilitation Situation (STARS) and progresses through the development of a formal rehabilitation strategic plan, via implementation, monitoring and evaluation of said plan. The purpose of tools like the STARS assessment is to help strengthen rehabilitation leadership, planning, and integration and directly supports the government in meeting AAAQ aligned obligations (Figure 2).

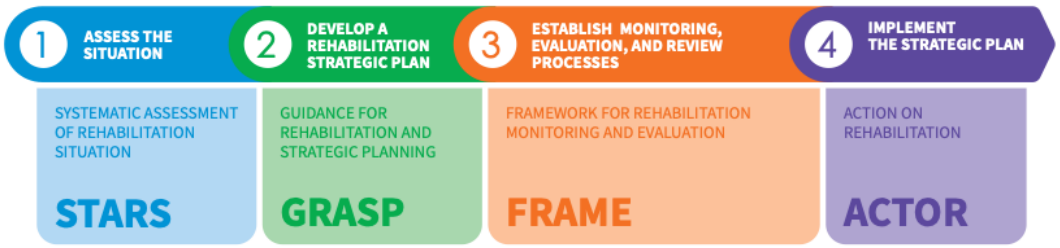

Figure 2. WHO Guide for Action

Reference: World Health Organization, (2019). Rehabilitation in health systems: A guide for Action. WHO Kobe Centre.

Adopting these tools could potentially guide Belize's efforts to map current capacities and plan strategically for expansion.

Based upon existing rights-based and social model frameworks, several emergent key recommendations are offered to help improve rehabilitation and disability inclusion in Belize:

1. Workforce Development and Training

Strengthening in-country capacity could be significantly enhanced through the development of training programs for rehabilitation professionals such as physiotherapists and occupational therapist, led in collaboration with the University of Belize School of Medicine and other academic programs in-country. Academic institutions play a pivotal role not only in expanding the availability and quality of rehabilitation professionals but also in fostering research, raising social awareness about disability and inclusion, and informing evidence-based health and social policy. By integrating education, clinical training, and policy engagement, universities can help address chronic workforce shortages while simultaneously creating career pathways for Belizeans and promoting a culture of inclusive, rights-based healthcare. The feasibility of task-shifting strategies, whereby community health workers or other medical professionals receive training in the delivery of basic rehabilitation services to rural areas (increasing geographic accessibility), may also offer potential bolstering at the local capacity level. At the organizational level, fostering of professional associations that advocate for rehabilitation disciplines may promote ongoing visibility and representation of disability-specific issues in national health dialogues.

2. Financial and Government Investment

Improving financial accessibility is critical. Integration of rehabilitation-related services into Belize's universal health coverage package and/or specific allocation of a dedicated budget line for rehabilitation within the Ministry of Health and Wellness could directly help reduce out-of-pocket patient expenses for Belizeans who experience disability. In order to supplement potential funding limitations at the governmental level, there is need for exploration of additional innovative financing mechanisms, such as international development partnerships or social impact bonds, could also be mobilized to facilitate sustained investment in services for disability-affected Belizeans.

3. Governance and Policy Integration

Policy coherence is essential for ensuring quality, acceptability, and equitable accessibility of services. Integration efforts could be strengthened by the incorporation of rehabilitation explicitly into Belize's National Health Plan and alignment of efforts with the Disability Bill and CRPD commitments, while the

World Health Organization's STARS tool could potentially be useful in assessing current rehabilitation gaps and longer-term development of evidence-based policy responses. Strengthening of cross-sectoral coordination between health, education, and social protection systems could also help to promote holistic support for persons with disabilities.

4. Community Engagement and Anti-Stigma Campaigns

Promoting social acceptability of rehabilitation involves transforming attitudes towards disability. Initiation of nationwide awareness campaigns to challenge disability stigma and promote inclusion could potentially promote incremental change at the community level. Support for community-based rehabilitation programs that empower individuals, families, and communities to participate actively in rehabilitation processes can promote shared decision-making for local-level stakeholders. Most importantly, ensuring that persons with disabilities and their representative organizations are meaningfully included in decision-making processes at all levels may promote inclusion, agency, and self-determination for Belizeans with disabilities.

Adopting such strategies in the Belizean context requires contextual sensitivity—acknowledging the nation's small population size, geographic dispersion, and limited tertiary education infrastructure. Those challenges notwithstanding, the previously discussed examples illustrate ways in which even resource-constrained countries may make significant progress when rehabilitation is prioritized as a rights-based obligation grounded in the AAAQ framework.

Ultimately, framing rehabilitation as a human right serves to transform the conversation surrounding disability—from one of charity to one of justice. It reframes access not as optional—but, rather, as a human right mandated by Belize's commitments under the CRPD and broader international law. The social model of disability further highlights that many barriers faced by PWD are not inherent to impairments, but to social systems that fail to provide them with available, accessible, acceptable, and high-quality services.

As with many other countries, Belize's path forward involves not only expanding services but also transforming attitudes, governance, and financing structures. This requires deliberately and meaningfully embedding rehabilitation into the core of health and development policy and ensuring that every citizen has the opportunity for full, thriving participation—both within their individual communities and within society.

Conclusion

Persons with disabilities in Belize live at the intersection of health inequities, social stigma, and structural exclusion. While international human rights frameworks such as the CRPD and the SDGs provide powerful commitments to inclusion, the translation of these obligations into everyday practice remains incomplete. Rehabilitation must be recognized as more than a clinical intervention: it is a human right central to dignity, autonomy, and participation in society.

This paper has attempted to lay out how rehabilitation in Belize is constrained by multiple, overlapping barriers. These include the shortage of rehabilitation professionals, insufficient government financing, geographic inequities that exclude rural and Indigenous populations, and persistent stigma that frames disability as a matter of charity rather than justice. Such barriers are not unique to Belize, but their persistence underscores the urgency of reframing disability policy through a rights-based lens. Without intentional reform, rehabilitation will remain fragmented and inequitable, perpetuating cycles of exclusion for persons with disabilities.

Despite persistent challenges, Belize has important foundations upon which to build. Ratification of the CRPD, the recent Disability Bill, a proposed update of the National Mental Health Policy (Mental Health Act), a new medical school, and support for initiatives such as the Inspiration Center and the National Resource Center for Inclusive Education demonstrate political will and recognition of the need for reform.

However, without robust implementation mechanisms, these initiatives risk becoming symbolic rather than transformative. To move beyond rhetoric and positive aspirations, Belize must institutionalize rehabilitation as a core component of its health and academic systems, integrating it into national strategic planning and universal health coverage frameworks.

International guidance offers valuable pathways forward. WHO's Rehabilitation 2030: A Call for Action and the Guide to Action provide technical tools for governments to identify gaps and set priorities. By adopting tools such as the Systematic Assessment of Rehabilitation Situation (STARS*)*, Belize could systematically assess its rehabilitation infrastructure, workforce needs, education capacity, and financing mechanisms. This process would not only generate evidence for reform but also establish a vision and allow transparency and accountability signaling a concrete commitment to fulfilling obligations mandated under international law.

The comparative experiences of other LMICs offer valuable lessons. Belize could potentially adapt some of these approaches, emphasizing community-based strategies, professional training pipelines, and cross-sectoral collaboration. The key lies in tailoring such models to Belize's unique demographic, geographic, and institutional contexts.

Ultimately, the challenge is not only technical but also normative. Reframing rehabilitation as a right rather than a privilege requires shifting mindsets across government institutions, health professionals, academic institutions, and society as a whole. It requires dismantling stigma, amplifying the voices of persons with disabilities, and ensuring their participation in decision-making processes. A rights-based and social model perspective demands that rehabilitation be embedded in national development agendas, not merely relegated to the margins.

The recommendations proposed are not aspirational ideals but actionable strategies—aligning with Belize's existing policy commitments and international obligations and offering a clear roadmap for reform. If pursued with sustained political will and inclusive partnerships, these actions can transform rehabilitation services from fragmented and underfunded programs into a robust, equitable, and rights-based system.

Belize is at a crossroads. The country can continue with piecemeal, charity-based approaches that leave persons with disabilities underserved and the government disincentivized. Or it can seize the opportunity to lead by embedding rehabilitation as a pillar of health, development, and human rights. The path forward requires courage, innovation, and investment at all levels of society, but the potential is profound: a Belize where every person, regardless of disability, has the opportunity to thrive, contribute to their community, and live with dignity. By answering the WHO's Rehabilitation 2030 call to action and harnessing international frameworks, Belize can transform rehabilitation from a peripheral concern into a central expression of its commitment to justice and inclusion.

Such a transformation would not only fulfill global obligations but also affirm a simple, yet powerful truth: rehabilitation is not charity, it is justice; it is not optional, it is essential; and in Belize, it must become a reality for all. And when this happens, everyone wins.

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