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Strengthening Social Rehabilitation Policies for Persons with Disabilities through Inclusive and Equitable Services

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ABSTRACT

This study examines how social rehabilitation policy for persons with disabilities can be strengthened through inclusive and equitable services. A qualitative approach with an embedded case study design was adopted to capture policy-to-practice dynamics, as inclusion and equity are shaped by institutional routines, service interactions, and interagency coordination. The research was conducted in the Bandung Metropolitan Area, Indonesia, selected for its diverse service capacity and dense network of governmental and non-governmental providers, enabling analysis of territorial variation and coordination challenges. Data were generated through semi-structured interviews, limited non-participant observations, and document analysis, involving 28 purposively selected informants representing policymakers, frontline workers, disability organizations, persons with disabilities, and caregivers. Findings show that inclusion is frequently treated administratively as coverage, while service users experience exclusion through inaccessible information, inconsistent communication accommodations, and high administrative burdens. Equity is weakened when uniform eligibility rules ignore unequal conversion factors such as poverty, stigma, transport, and navigation capacity. Fragmented referrals and person-dependent coordination further undermine service continuity. The study recommends institutionalizing accessibility standards, reducing administrative burdens, implementing integrated case management and referral tracking, and adopting equity-sensitive resourcing and monitoring focused on participation outcomes.

INTRODUCTION

Social rehabilitation has re-emerged as a strategic policy domain as governments and service systems confront the persistent exclusion of persons with disabilities from education, employment, health care, social protection, and civic participation. Despite normative advances in disability rights and the growing adoption of inclusive development agendas, many rehabilitation programs still operate within residual welfare logics that prioritize short-term assistance over long-term capability expansion and social participation (Lamprinidis, 2025). This tension becomes especially visible when services are delivered through fragmented institutions, uneven local capacities, and eligibility rules that inadvertently reproduce inequities among disability groups and across geographic, socioeconomic, and gender lines. In this context, strengthening social rehabilitation policy through inclusive and equitable services is not merely a technical exercise in program improvement, but a governance challenge that requires aligning rights-based commitments with implementation realities, resource allocation, and accountability for outcomes (Watharow & Wayland, 2022).

The state of the art in disability policy and rehabilitation research increasingly emphasizes a shift from charity-oriented approaches toward rights-based and social models of disability, which highlight how barriers in the environment, institutions, and attitudes disable individuals more than impairments themselves (Kluknavská, 2024). Contemporary scholarship also advances the capability approach and person-centered practice as complementary lenses, arguing that effective rehabilitation should expand real freedoms such as the freedom to access services, move safely, communicate, work, learn, and participate in community life rather than only restoring bodily functions or providing episodic support. Parallel developments in public policy and public administration underscore that inclusion and equity require more than universal coverage; they demand targeted strategies to address structural disadvantage, intersectionality, and territorial disparities. Yet, while the literature offers robust conceptual tools, empirical evidence and policy design guidance remain uneven, especially regarding how social rehabilitation can be operationalized as an inclusive and equitable service system across multiple sectors and levels of government (Haid et al., 2025).

A key problem is that "rehabilitation" is often treated as a bounded program rather than a coordinated service ecosystem. In many settings, social rehabilitation is administered separately from health rehabilitation, inclusive education, labor market activation, and community-based support, producing discontinuities across the life course and across service touchpoints. Individuals may face repeated assessments, inconsistent definitions of disability, variable eligibility thresholds, and competing case-management approaches (Maulani et al., 2024). Service providers, in turn, work under divergent mandates, data systems, and funding streams that limit referrals and continuity of care. The consequences are not trivial: fragmented governance tends to amplify inequalities, because the people most in need those with complex support requirements, those living in poverty, those in remote areas, and those facing stigma are least able to navigate administrative complexity and least likely to access coordinated services(Ven et al., 2025).

The main research problem addressed in this study is the limited effectiveness of existing social rehabilitation policies in ensuring that persons with disabilities receive services that are simultaneously inclusive (accessible, participatory, responsive to diverse needs) and equitable (fairly distributed, sensitive to structural disadvantage, and capable of reducing outcome gaps) (Chakravarty et al., 2025). Policy reforms frequently emphasize expanding program coverage or increasing the number of beneficiaries, but coverage metrics can conceal inequities in service quality, intensity, timeliness, and appropriateness. Moreover, inclusion is sometimes interpreted narrowly as the physical availability of facilities or the formal presence of disability programs, while equity is assumed to follow automatically from uniform rules. In practice, uniformity can reproduce injustice when groups start from unequal positions and when service environments are not designed for diversity (Özden, 2025).

The research gap emerges at the intersection of three strands of scholarship. First, rights-based disability studies provide a normative and conceptual foundation for inclusion, but they often offer limited operational guidance for restructuring rehabilitation services within real-world constraints such as budget ceilings, administrative fragmentation, and uneven local capacity. Second, rehabilitation and social work literature offers practice-level insights into person-centered interventions, yet it may undertheorize the policy architecture and governance mechanisms needed to scale inclusive practice system-wide (Rabinovich et al., 2025). Third, public policy studies supply tools to analyze policy implementation, interorganizational coordination, and distributive effects, but they frequently treat disability as one vulnerability category among many, without deeply engaging disability-specific accessibility requirements, communication needs, support services, or the heterogeneity of impairments and lived experiences. Consequently, there is insufficient integrated analysis that connects policy design and governance arrangements to measurable inclusiveness and equity outcomes in social rehabilitation (Yu et al., 2025).

Within this gap, the novelty of the present research lies in its integrative approach to strengthening social rehabilitation policy by explicitly linking inclusive service principles to an equity-oriented governance framework. Rather than positioning inclusion and equity as aspirational values, this study treats them as operational criteria that can be translated into policy instruments, service standards, coordination mechanisms, and accountability indicators (Sodhi & Singla, 2025). Conceptually, the research advances a structured synthesis that bridges (a) disability rights and social model commitments, (b) person-centered and life-course service delivery, and (c) policy implementation and multi-level governance analysis. Empirically, the study is designed to generate actionable insights into where and why service systems fail to deliver inclusive and equitable rehabilitation, and which policy levers such as eligibility reform, integrated case management, accessible information systems, capacity building, and equitable financing are most consequential for improving outcomes (Boyd et al., 2024).

Guided by these concerns, the study is organized around research questions that focus on the policy-to-practice pathway. It asks how current social rehabilitation policies define inclusion and equity, and how these definitions are translated into service design, targeting, and delivery processes. It examines what barriers and enabling factors shape inclusive and equitable access across different disability groups and across territories with varying service capacity. It investigates how coordination among agencies and service providers affects continuity of support, including referrals, assessment processes, and follow-up. It further asks which policy instruments and governance arrangements are most effective for strengthening inclusiveness and equity, and what implementation trade-offs or risks accompany different reform options. These questions collectively position social rehabilitation not as an isolated program but as a system whose performance depends on both design coherence and implementation fidelity.

Accordingly, the purpose of this research is to propose and validate a policy strengthening agenda for social rehabilitation services that is grounded in inclusive and equitable principles and informed by implementation realities (Hu et al., 2023). The study aims to develop an analytical framework that can assess inclusiveness and equity across key dimensions of service delivery, including accessibility (physical, informational, and communicational), availability and adequacy (service presence, intensity, and quality), affordability and administrative burden (direct and indirect costs, complexity of procedures), acceptability (stigma-free and culturally responsive practice), and accountability (complaints mechanisms, participation, and performance monitoring) (Karnaji et al., 2024). In addition, the research seeks to identify leverage points for policy reform, such as harmonizing definitions and eligibility rules, establishing interoperable data and referral systems, strengthening community-based rehabilitation and outreach, ensuring meaningful participation of persons with disabilities in policy processes, and implementing equity-sensitive financing to reduce territorial disparities.

The expected benefits of this study are threefold. Theoretically, it contributes to the refinement of inclusion and equity as operational constructs in disability-related social policy by clarifying their dimensions, interdependencies, and measurable implications within social rehabilitation systems. Academically, it enriches interdisciplinary dialogue by connecting disability studies, social work, and public policy scholarship, offering a framework that can guide future empirical research and comparative analysis across contexts (Tamwifi & Akbar, 2024). Practically, the study is intended to support policymakers, administrators, and service providers by offering evidence-informed recommendations for redesigning programs, reducing fragmentation, and improving service experiences and outcomes for persons with disabilities. These practical implications include guidance on setting service standards, designing integrated case management, building workforce competencies for inclusive practice, and establishing monitoring systems that capture equity-sensitive performance metrics rather than relying solely on aggregate coverage (Lallement, 2025).

Tabel 1. Key Data

Data	Show
1.3 billion people (16%) experience significant disability (global estimate)	Disability is common and directly linked to equity in access to services.
~2.4 billion people could benefit from rehabilitation (global estimate)	Rehabilitation need is very large and increasing.
~240 million children have disabilities (global estimate)	Inclusion affects life-course outcomes (education, participation, future work).

Sources: WHO Global report on disability equity.

At the same time, the study acknowledges important limitations. Social rehabilitation systems are embedded in broader socioeconomic structures and intersect with health, education, and labor markets; therefore, policy strengthening in rehabilitation alone cannot fully resolve exclusion without complementary reforms in related sectors. Data limitations may constrain the measurement of inclusiveness and equity, especially where disability data are incomplete, inconsistent, or not disaggregated by relevant characteristics. Implementation findings may also be context-dependent, shaped by institutional mandates, decentralization arrangements, fiscal capacity, and sociocultural attitudes toward disability. In addition, capturing lived experiences across diverse impairment types and intersectional identities requires careful methodological design; any single study may face constraints in representing all groups equally, particularly those with high support needs or those who are socially isolated.

These limitations point to directions for subsequent research. Future studies could undertake longitudinal analysis to assess whether policy reforms produce sustained improvements in participation outcomes, not only immediate service utilization. Comparative research across regions or countries could clarify which governance arrangements best support inclusive and equitable rehabilitation under different administrative and fiscal conditions. Deeper investigation into intersectionality such as how disability interacts with gender, age, ethnicity, poverty, and rurality would strengthen equity diagnostics and policy targeting. Additional work is also needed to develop and validate equity-sensitive indicators for rehabilitation performance, including measures of administrative burden, service quality, user experience, and functional participation in community life. Finally, research that centers participatory and co-production approaches where persons with disabilities and their representative organizations are involved throughout the research and policy cycle can help ensure that inclusion is not only a policy outcome but also a policy-making process.

By situating social rehabilitation within an integrated inclusion–equity framework and foregrounding the governance mechanisms that translate policy into practice, this study responds to a pressing policy challenge: building service systems that do not merely reach persons with disabilities, but do so fairly, respectfully, and effectively. Strengthening policy in this domain requires moving beyond fragmented interventions toward coordinated, person-centered, and equity-oriented services capable of reducing persistent gaps in access and outcomes.

LITERATURE REVIEW

The literature on disability and social rehabilitation has increasingly moved from viewing disability as an individual deficit toward understanding it as a relational condition shaped by social, institutional, and environmental barriers. Within this shift, “inclusive and equitable services” have become central policy aspirations, yet their translation into social rehabilitation systems remains uneven. Scholars generally agree that social rehabilitation is not only a set of interventions aimed at improving individual functioning, but also a policy arena where rights, public service governance, resource allocation, and social participation intersect. Consequently, strengthening social rehabilitation policy requires a theoretical foundation that can explain why exclusion persists, how services can be redesigned to enable participation, and how policy intentions are transformed sometimes distorted during implementation (Bonilla-Quijada et al., 2025).

Contemporary state-of-the-art research highlights three recurring themes relevant to the title “Strengthening Social Rehabilitation Policy for Persons with Disabilities through Inclusive and Equitable Services (Cabradilla & Lipa, 2025).” First, inclusion is increasingly defined as meaningful access and participation rather than mere service availability. This includes accessibility of information and communication, reasonable accommodation, continuity of support, and respectful interactions that reduce stigma. Second, equity is treated as fairness in both distribution and outcomes, implying that uniform service rules are insufficient when individuals and regions start from unequal positions. Equity-oriented policy therefore requires attention to social determinants (poverty, education, geography), intersectionality (gender, age, ethnicity), and differential support needs (Wulung et al., 2024). Third, rehabilitation outcomes are most sustainable when services are coordinated across sectors and delivered through person-centered, community-based ecosystems rather than fragmented programs. This body of research suggests that policy strengthening must address governance and delivery architecture how agencies coordinate, how eligibility is determined, how discretion is exercised, and how accountability is enforced because these features often determine whether inclusion and equity are realized in practice.

To ground this study's literature review, three theories are especially relevant: the Social Model of Disability, the Capability Approach, and Street-Level Bureaucracy. Each theory illuminates a different mechanism that produces (or can reduce) exclusion within social rehabilitation systems: structural barriers, real freedoms to achieve valued life outcomes, and implementation dynamics at the frontline (Cheah & Koay, 2022).

The Social Model of Disability was popularized by Michael James Hoiles Oliver in 1983, associated with academic work in the United Kingdom and later strongly linked to his role at the University of Greenwich (England, UK). Oliver's formulation distinguishes impairment (a bodily or cognitive condition) from disability (social restrictions created by barriers) (Pant, 2025). This conceptual move redirected policy attention from "fixing individuals" toward reforming disabling environments physical spaces, institutions, professional practices, and discriminatory attitudes. In rehabilitation policy, the Social Model challenges service designs that narrowly emphasize clinical or remedial outcomes while neglecting participation and accessibility (Cooper, 2025). It also reframes "inclusion" as barrier removal and rights-based access, implying that inclusive rehabilitation services must prioritize universal design, reasonable accommodation, and anti-discrimination safeguards, not merely increased program coverage.

Oliver's conceptual framework is especially influential for diagnosing why rehabilitation services can remain exclusionary even when they are well-funded. If assessment processes are built around deficit-oriented criteria, if service pathways require complex administrative navigation, or if services are delivered in inaccessible facilities without communication supports, then disability is reproduced by policy design itself (Zacharias et al., 2024). Under the Social Model, strengthening social rehabilitation policy becomes a matter of redesigning systems so that the default environment enables participation. The theory's development has also progressed beyond early dichotomies (medical vs. social) toward more nuanced accounts acknowledging embodied experience while still emphasizing structural barriers. This evolution supports current "rights-based and person-centered" rehabilitation paradigms: the individual's lived experience and support needs matter, but they are shaped often amplified by social arrangements. In contemporary policy debates, the Social Model is frequently used to justify participatory governance, where persons with disabilities and their representative organizations are involved in standard-setting, monitoring, and evaluation, thereby aligning inclusion with procedural justice rather than treating it as a technical add-on (Ota et al., 2025).

The Capability Approach was pioneered and articulated in the 1980s by Amartya Kumar Sen, with early formalization appearing in works such as "Commodities and Capabilities" (1985). Sen's academic affiliations during the development of these ideas include the University of Oxford (Oxford, UK), where he served as Drummond Professor of Political Economy, and later Harvard University (Cambridge, United States), where he held the Thomas W. Lamont University Professorship. The core claim is that welfare and justice should be evaluated in terms of people's real opportunities (capabilities) to achieve valued "beings and doings" (functionings), rather than resources alone (income, benefits) or subjective satisfaction (Sarker et al., 2024). For social rehabilitation, this is crucial: two individuals can receive the same service package but convert it into different outcomes due to conversion factors such as stigma, inaccessible transport, lack of assistive technology, communication barriers, or family and community support.

Sen's framework strengthens the concept of equity in rehabilitation policy by shifting attention from nominal entitlements to realized opportunities. Equity, from a capability perspective, means ensuring that persons with disabilities can genuinely pursue education, employment, independent living, and community participation outcomes that matter for dignity and social inclusion. This has direct implications for service standards: inclusive rehabilitation services should be evaluated not only by outputs (number served, sessions delivered) but by capability-relevant outcomes (improved access to schooling, increased job retention, reduced dependency created by environmental barriers, enhanced mobility and communication in daily life). The Capability Approach has also evolved through extensive contemporary scholarship, including methodological work on operationalizing capabilities and developing multidimensional measures of deprivation and well-being. This development is highly relevant for policy strengthening because it offers a structured way to define what "inclusive and equitable" should mean in measurable terms, while recognizing heterogeneity across disability groups and life stages.

Street-Level Bureaucracy, popularized by Michael Lipsky in 1980, provides a complementary lens that explains why policy intentions often diverge from service realities. Lipsky's formulation emerged from public administration research in the United States and is strongly associated with his earlier academic career as a professor of political science at the Massachusetts Institute of Technology (MIT, United States) (Ven et al., 2025). The theory argues that frontline workers such as social workers, case managers, and local service officers effectively "make policy" through discretionary decisions under conditions of limited resources, ambiguous rules, and high caseloads. In social rehabilitation, these conditions are common: assessments require judgment, eligibility rules may be interpreted differently across locations, and resource constraints can lead to rationing, informal gatekeeping, or prioritization of "easier-to-serve" clients. This helps explain why inclusion and equity can fail even when formal policies appear progressive (Rakkarn et al., 2023).

Lipsky's conceptual framework is especially useful for analyzing implementation gaps in inclusive rehabilitation services. Inclusion requires consistent accessibility accommodations, respectful communication, and coordinated referrals; equity requires fair prioritization and needs-based allocation. Yet street-level settings are often shaped by time pressure, incomplete information, and performance metrics focused on throughput rather than quality. Under such constraints, frontline discretion can inadvertently produce inequities: for example, individuals with complex support needs may be deemed "too difficult," rural clients may be deprioritized due to travel burdens, or those lacking documentation may be excluded. Recent developments in street-level research extend Lipsky's insights into networked governance and contemporary administrative environments, including contracting-out, performance management, and the increasing role of digital systems in shaping discretion (Rabinovich et al., 2025). These developments are directly relevant to policy strengthening because many rehabilitation systems now rely on interagency networks and data systems that can either coordinate services or create new bureaucratic barriers.

Bringing these three theories together offers a coherent conceptual basis for the present study. The Social Model of Disability explains the structural production of exclusion and provides normative direction for barrier removal and rights-based inclusion (Jung et al., 2024). The Capability Approach provides an evaluative framework that translates inclusion and equity into real freedoms and participation outcomes, clarifying what "service success" should mean beyond coverage statistics. Street-Level Bureaucracy explains implementation dynamics and why inclusive-equitable intentions may be diluted through discretion, resource constraints, and fragmented governance. Integrated, these theories suggest that strengthening social rehabilitation policy requires simultaneous attention to barrier-sensitive design (Social Model), capability-expanding outcomes and equity metrics (Capability Approach), and implementable governance instruments that shape frontline behavior and accountability (Street-Level Bureaucracy).

This theoretical synthesis directly addresses the main research problem: why social rehabilitation services for persons with disabilities frequently remain fragmented, uneven in quality, and inequitable in access and outcomes (Yu et al., 2025). The Social Model frames fragmented services and inaccessible procedures as disabling barriers produced by institutions rather than by individuals' impairments. The Capability Approach clarifies that fragmented services undermine the conversion of resources into meaningful life opportunities, making "equal service provision" insufficient for equity. Street-Level Bureaucracy explains how fragmentation and ambiguity amplify discretionary variation across regions and providers, widening territorial and group-based disparities (Pickvance, 2024).

The same synthesis also clarifies the research gap. Much disability scholarship is strong in normative claims (rights, non-discrimination, accessibility) but often less explicit about how to redesign policy instruments and governance arrangements to deliver inclusion at scale. Capability-oriented work provides sophisticated evaluative tools but can be underapplied in rehabilitation governance, where output-focused monitoring dominates (Ven et al., 2025). Street-level research explains implementation variation but does not always integrate disability-specific accessibility requirements or the lived realities of diverse impairment groups. This study's novelty lies in using the three theories together to build an integrated analytical framework that links policy design features (eligibility rules, coordination mechanisms, service standards, financing) to implementation dynamics (frontline discretion, administrative burden, capacity constraints) and to equity-relevant outcomes (capability expansion and participation) (Jung et al., 2024).

In relation to the study's research questions, each theory contributes a distinct set of analytical prompts. The Social Model informs questions about which environmental, institutional, and attitudinal barriers are embedded in current rehabilitation policies and service pathways, and how inclusive design can be strengthened. The Capability Approach informs questions about which capabilities social rehabilitation should prioritize, how services translate into real opportunities, and which outcome indicators best capture inclusion and equity. Street-Level Bureaucracy informs questions about how discretion, workload, and resource limitations shape actual access, service continuity, and fairness, and which governance reforms can reduce arbitrary variation without eliminating professional judgment that is necessary for person-centered practice (Agudelo-Hernández et al., 2024).

The theories also align with the study's objectives and benefits. Theoretically and academically, the synthesis advances a clearer operationalization of "inclusive and equitable services" by connecting barrier removal (Social Model), opportunity-realization (Capability Approach), and implementation governance (Street-Level Bureaucracy). Practically, it supports policy recommendations that are not only normatively desirable but implementable: for example, simplifying administrative procedures to reduce burdens, standardizing accessibility accommodations, strengthening integrated case management and referral pathways, designing equity-sensitive financing to reduce territorial gaps, and developing monitoring indicators that reflect participation outcomes rather than solely outputs. In this way, the conceptual framework supports both scholarly contribution and policy usability (Wang et al., 2024).

A brief acknowledgement of limitations is important even at the literature review stage. The three-theory framework may not fully capture all dimensions of disability experience, particularly the embodied and emotional aspects that some scholars argue are underemphasized by purely structural accounts. In addition, capability measurement can be methodologically demanding and data-intensive, and street-level analyses can risk overgeneralizing frontline behavior if not grounded in careful empirical observation across varied settings. Finally, because social rehabilitation sits at the intersection of health, education, employment, and social protection, theory-driven analysis may still be constrained by sectoral silos and data fragmentation that limit cross-system evaluation.

Future research building on this review can deepen the framework in several directions. Empirical studies can test which combinations of barrier removal, capability-oriented service packages, and governance reforms most effectively improve participation outcomes for different disability groups and territories. Comparative research across regions can clarify how decentralization and local capacity influence equity, and whether certain institutional designs better protect inclusion under resource constraints. Research can also examine how digitalization affects accessibility and discretion, including whether algorithmic eligibility tools reduce arbitrariness or introduce new forms of exclusion. Finally, participatory and co-produced research where persons with disabilities shape research questions, indicators, and interpretation can strengthen both validity and ethical alignment with inclusion goals (Silva & Brisola, 2025).

In conclusion, the literature indicates that strengthening social rehabilitation policy through inclusive and equitable services requires more than expanding coverage or adding programs. It demands barrier-sensitive policy design rooted in the Social Model of Disability, outcome-oriented evaluation of real opportunities grounded in Sen's Capability Approach, and implementable governance reforms informed by Lipsky's Street-Level Bureaucracy. Together, these theories and their contemporary developments provide a rigorous conceptual foundation for addressing the main problem, articulating the gap, justifying the study's novelty, and aligning the research questions, objectives, and intended theoretical, academic, and practical contributions with the title "Strengthening Social Rehabilitation Policy for Persons with Disabilities through Inclusive and Equitable Services."

RESEARCH METHODS

This study employs a qualitative approach to examine how social rehabilitation policy for persons with disabilities can be strengthened through inclusive and equitable services. A qualitative method is appropriate because the research problem concerns policy meaning, implementation processes, service experiences, and governance dynamics that cannot be adequately captured through numerical indicators alone. Inclusion and equity are enacted through everyday interactions assessment procedures, case-management decisions, referral pathways, accessibility accommodations, budgeting priorities, and accountability practices where context, interpretation, and discretion shape outcomes. Qualitative inquiry therefore enables an in-depth understanding of how policy intentions are translated into service delivery, why gaps persist between formal commitments and lived realities, and which policy levers are most feasible for system strengthening.

The study is designed as an embedded qualitative case study. The case study design is selected because it allows the researcher to investigate a contemporary phenomenon social rehabilitation governance and service delivery within its real-life institutional setting, where boundaries between “policy” and “practice” are intertwined. The “embedded” structure reflects the inclusion of multiple units of analysis within one overarching case: policy and administrative structures, service-provider practices, and user experiences of persons with disabilities and their families. This design is particularly aligned with the study’s analytical intent to connect policy design features (standards, eligibility, financing, coordination) to implementation dynamics (frontline discretion, organizational capacity, interagency collaboration) and to inclusion–equity outcomes (accessibility, fairness, continuity, and participation). The case study also supports theory-informed analysis by enabling systematic comparison between what policies prescribe and what occurs at service interfaces (Millett et al., 2024).

The research is conducted in the Bandung Metropolitan Area, West Java, Indonesia, which provides a strategically relevant context for examining inclusive and equitable social rehabilitation services. Bandung is selected for three reasons. First, as an urban–peri-urban metropolitan area, it contains marked diversity in service capacity, infrastructure, and socioeconomic conditions, enabling the study to observe equity-related differences within one policy environment. Second, the area hosts a relatively dense network of public and non-governmental service providers, including social rehabilitation units, community-based organizations, disability-focused NGOs, and referral links to health and education services, which is essential for analyzing cross-sector coordination. Third, metropolitan settings often become policy implementation “testing grounds,” where administrative innovations coexist with persistent access barriers; this combination makes Bandung suitable for identifying both enabling practices and systemic bottlenecks relevant to policy strengthening.

Data are collected through semi-structured in-depth interviews, limited non-participant observations, and document analysis. Semi-structured interviews are used to capture stakeholder perspectives while maintaining a consistent focus on core themes: definitions of inclusion and equity, eligibility and assessment practices, accessibility accommodations, continuity and referral, coordination mechanisms, budgeting and resource constraints, and accountability pathways including complaint handling. Observations are conducted at selected service touchpoints such as intake desks, waiting areas, and information counters to document accessibility features and interaction patterns (for example, signage clarity, communication supports, and privacy in assessment processes). Document analysis covers policy guidelines, local technical instructions, service standard operating procedures, program reports, budgeting and planning documents (where accessible), and anonymized administrative forms used in eligibility screening and case management. Using these three sources supports triangulation by comparing formal policy claims, implementation routines, and user experiences (Gao & Wang, 2025).

The study uses purposive sampling with maximum variation, complemented by criterion-based selection. Purposive sampling is justified because the research seeks information-rich cases that illuminate policy–practice links, rather than statistical representativeness. Maximum variation is applied to ensure that inclusion and equity are examined across different impairment types, gender, age groups, and socioeconomic and geographic contexts. Criterion-based selection ensures that informants have direct involvement with social rehabilitation services either as policymakers, implementers, or service users within the study location. Sampling continues iteratively until thematic saturation is achieved, understood as the point where additional data no longer generate substantively new insights about the main analytical categories.

A total of 28 informants participate in the study. From the government and administrative side, interviews include "Mr. Arif," a provincial social rehabilitation policy coordinator; "Ms. Rina," head of a municipal social rehabilitation unit; "Mr. Dimas," a district-level planner involved in social budgeting; and "Ms. Sari," an officer responsible for disability data and registration. These informants are selected because they shape policy translation into procedures, budgets, performance indicators, and coordination routines. From frontline service delivery, interviews include "Ms. Maya," a senior social worker; "Mr. Bima," a case manager responsible for intake and referral; "Ms. Lia," a community outreach worker; and "Mr. Yusuf," a service desk administrator who manages documentation and eligibility screening. They are chosen because they operationalize inclusion and equity through discretionary decisions, service interactions, and practical accommodations in resource-constrained environments. From non-governmental and community sectors, interviews include "Ms. Nadia," director of a disability-focused NGO; "Mr. Hendra," a leader of a disabled persons' organization; and "Ms. Putri," coordinator of a community-based rehabilitation initiative. These informants are included to capture advocacy perspectives, community-level service realities, and accountability concerns external to government systems (Mansoor & Gilani, 2023).

Service-user perspectives are captured through interviews with persons with disabilities and family caregivers who have engaged with social rehabilitation services within the past 12 months. Participants include "Tono," a wheelchair user who has sought mobility-related supports; "Ayu," a woman with low vision navigating information access and referrals; "Rafi," a young adult with psychosocial disability who has experienced administrative screening; "Dewi," a caregiver of a child with autism who has interacted with multiple agencies; "Nina," a deaf participant who requires communication accommodations; and "Pak Jaya," a father supporting an adult child with intellectual disability. These participants are selected to represent heterogeneous support needs and to illuminate how inclusion and equity are experienced in practice, including barriers related to transportation, cost, documentation, stigma, and communication access. Pseudonyms are used to protect privacy, and identifying institutional details are generalized in transcripts and reporting.

To ensure accessibility and ethical inclusion, interviews are conducted in locations chosen by participants (for example, NGO offices, community centers, or quiet spaces near service sites) and, where necessary, through remote modalities. Communication accommodations are provided as required, including the option to involve a sign language interpreter for deaf participants, the use of plain-language interview prompts, flexible pacing, and the option for a trusted support person to accompany participants when appropriate. Informed consent is obtained in accessible formats, emphasizing voluntariness, confidentiality, and the right to withdraw. The study adopts a harm-minimization approach, particularly for participants who may have experienced stigma or distress in service encounters; interview protocols include pause/stop options and referral information to relevant support services if needed (Shanti & Putri, 2025).

Data analysis follows a hybrid thematic and framework analysis approach. The process begins with familiarization through repeated reading of transcripts, observation notes, and documents, followed by initial open coding to capture emergent meanings. A structured analytical framework is then developed that aligns with the study's focus on inclusion and equity in social rehabilitation policy: accessibility (physical, informational, and communicational), adequacy and continuity (service quality, intensity, follow-up), fairness (distributional equity, needs-based prioritization, reduction of administrative burdens), coordination (referral pathways, interagency roles, data interoperability), and accountability (complaints mechanisms, user participation, monitoring indicators). Codes are iteratively refined through constant comparison across stakeholder groups, enabling the analysis to identify convergences and contradictions for example, differences between policy officials' assumptions about "coverage" and service users' accounts of procedural barriers. Documents are analyzed both for stated commitments (what should happen) and for operational mechanisms (how it is supposed to happen), then compared with interview and observation findings to map implementation gaps.

The technique for drawing conclusions is an iterative, evidence-weighted synthesis that combines triangulation, explanation building, and analytic generalization. Triangulation is applied across sources and informant categories to test the consistency of findings and to identify where discrepancies signal governance problems (such as ambiguous eligibility rules or inconsistent accommodation practices). Explanation building is used to articulate causal pathways linking policy features to inclusion–equity outcomes, for instance how fragmented referral systems and non-interoperable data can produce repeated assessments and delay supports, disproportionately affecting those with limited resources. Analytic generalization is employed to connect empirical patterns in the case to broader theoretical expectations about barrier production, capability constraints, and frontline discretion, while carefully delimiting claims to contexts with similar administrative and service characteristics.

Trustworthiness is strengthened through multiple strategies. Credibility is supported by triangulation and member checking, where selected informants review summarized interpretations for accuracy without exposing confidential details. Dependability is enhanced through an audit trail that documents sampling decisions, interview guides, coding revisions, and analytic memos. Confirmability is strengthened through reflexive journaling that records the researcher's assumptions and potential biases, particularly regarding normative commitments to inclusion and equity. Transferability is supported through thick description of policy and service contexts, enabling readers to judge relevance to other settings. These procedures collectively increase confidence that conclusions reflect the data and are not merely interpretive preference (Guo et al., 2024).

While the study is qualitative and does not seek statistical generalization, it is designed to produce robust, actionable insights for strengthening social rehabilitation policy through inclusive and equitable services. By systematically connecting institutional arrangements, frontline practices, and lived experiences within one metropolitan policy environment, the methodology enables the study to identify leverage points for reform that are both normatively aligned with inclusion and equity and practically grounded in implementation realities.

RESULTS AND DISCUSSION

The findings indicate that the central obstacle to strengthening social rehabilitation for persons with disabilities is not the absence of policy intent, but the weak translation of inclusive and equitable principles into operational rules, service pathways, and accountability routines. Across interviews, observations, and document review in the Bandung Metropolitan Area, inclusion was frequently articulated by administrators as "service availability" or "program reach," while equity was commonly interpreted as "uniform treatment" through standardized eligibility criteria. However, service users and frontline workers described inclusion as the practical ability to enter, understand, and navigate services without stigma and without repeated procedural hurdles, and they understood equity as needs-sensitive support that accounts for unequal starting points across disability groups and territories. This mismatch clarifies the main research problem: formal commitments to disability inclusion do not automatically produce inclusive and equitable service experiences because the service ecosystem remains fragmented, administratively burdensome, and heavily dependent on discretionary practices at the frontline.

A first core result concerns the persistence of institutional barriers embedded in intake and assessment procedures. Service users and caregivers repeatedly described barriers related to physical accessibility, information and communication access, and administrative complexity. "Ayu" (low vision) explained that information about available services existed, but was not accessible in formats she could use independently, forcing reliance on family members and informal networks. "Nina" (deaf participant) reported that communication support depended on whether a staff member felt confident enough to improvise solutions; formal interpreter arrangements were not routine. Observational notes in service sites showed that signage, forms, and queue instructions were predominantly text-heavy and rarely designed in plain language, which disproportionately affected clients with intellectual disabilities or those with low literacy. These barriers align strongly with the Social Model of Disability: disability was produced not by impairment alone, but by service environments that were designed around an assumed "standard client." In implementation terms, inclusiveness was undermined at the first point of contact, even before service content could be evaluated (Sebaeng et al., 2023).

A second result highlights the inequitable distribution of service quality and continuity, despite formally similar eligibility rules. Many participants reported that the same "entitlement" led to different outcomes depending on where a person lived, the staff capacity at the local unit, and the presence of NGO intermediaries who could assist with referrals. "Pak Jaya," supporting an adult child with intellectual disability, described being bounced across offices with repeated documentation requests, whereas "Tono," a wheelchair user connected to a strong community organization, described faster referral routing and clearer guidance. This pattern illustrates a capability-oriented problem: resources and nominal access did not reliably convert into real opportunities for participation. The capability lens clarifies why equity cannot be inferred from equal rules; conversion factors transport availability, family support, administrative literacy, stigma exposure, and service coordination shape whether rehabilitation services expand real freedoms. In practice, the system tended to reward those with stronger navigation capacity and penalize those with complex needs, fewer resources, or limited social capital.

A third result concerns fragmentation and "coordination gaps" across agencies and providers. Policy documents reviewed by the research team emphasized intersectoral collaboration, but interview data suggested that coordination was largely informal and person-dependent. "Ms. Rina," head of a municipal social rehabilitation unit, described coordination as "good when relationships are good," indicating reliance on interpersonal networks rather than standardized pathways. "Mr. Bima," a case manager, noted that referrals often lacked feedback loops; once a client was referred to a health or education provider, rehabilitation staff frequently had no structured mechanism to track whether services were received or whether accommodations were implemented. This produced discontinuities that were especially harmful for participants who required multi-step support, such as assistive devices combined with skills training and workplace linkage. From the Social Model perspective, fragmentation functioned as an institutional barrier; from the Capability Approach, it constrained the capability set by making pathways unreliable; and from Street-Level Bureaucracy, it increased discretionary decision-making under ambiguity, amplifying variation across locations and workers (IONCE & BREABAN, 2025).

A fourth result directly addresses the implementation dynamics shaping inclusion and equity: frontline discretion operated as a de facto policy instrument. "Ms. Maya," a senior social worker, described making judgment calls when formal criteria did not fit the client's lived reality, especially for psychosocial disabilities where functional impacts fluctuated. "Rafi," a young adult with psychosocial disability, explained that his eligibility experience depended on whether a staff member interpreted his needs as legitimate or saw him as "not disabled enough." These accounts reveal classic street-level conditions: ambiguous categories, limited resources, and pressure to manage caseloads. Under such conditions, staff often used informal heuristics prioritizing clients who could provide complete documentation, who were accompanied by caregivers, or who had "clear" impairment markers. While discretion sometimes enabled compassionate problem-solving, it also created inequity by allowing implicit bias and administrative convenience to shape access. This finding is crucial for the main problem because it shows that equity failures are not only structural but also procedural, occurring through routine decisions about who is served first, who is referred, and who is asked to return later.

A fifth result concerns the role of administrative burden as an equity amplifier. Several participants described repeated requests for documents, frequent re-verification, and unclear instructions, which increased costs and time burdens. "Dewi," caregiver of a child with autism, reported that repeated visits were required to "complete" paperwork, leading to missed workdays and additional transport expenses. This burden disproportionately affected low-income families and those living farther from service points. From a capability perspective, administrative burden reduces real opportunities by consuming time and resources that could otherwise support participation. From a street-level perspective, administrative burden is also a coping mechanism for overworked offices: requirements serve as rationing devices when demand exceeds capacity. In equity terms, burdens function as invisible exclusion mechanisms, particularly for those with limited documentation access or those who cannot afford repeated visits.

In relation to the study's research questions, the findings provide clear answers. Regarding how inclusion and equity are defined and operationalized, the system largely operationalized inclusion as coverage and equity as uniform rule application, while service users experienced inclusion as practical accessibility and equity as needs-responsiveness. Regarding barriers and enablers, barriers included inaccessible information, limited communication accommodations, fragmented coordination, administrative burden, and discretionary gatekeeping; enabling factors included NGO-mediated navigation support, proactive outreach workers, and occasional innovations in case management where local leadership prioritized continuity. Regarding coordination, interagency collaboration was fragile and person-dependent, with limited data interoperability and weak follow-up mechanisms. Regarding effective policy instruments, participants consistently pointed to the need for harmonized eligibility interpretation, integrated referral and tracking systems, standardized accessibility accommodations, and equity-sensitive resource allocation that reduces territorial disparities.

The findings also speak directly to the study's objectives: to propose and validate a policy strengthening agenda grounded in inclusive and equitable principles and informed by implementation realities. The data suggest that strengthening cannot rely solely on expanding programs. It requires redesigning the policy-to-service chain so that inclusion is built into procedures and environments, and equity is protected through governance mechanisms that reduce arbitrary variation and address unequal conversion factors. In practical terms, informants emphasized the importance of integrated case management that follows clients across agencies, simplified and accessible administrative processes, routine provision of communication supports, and training that equips frontline staff to implement rights-based accommodations consistently. "Mr. Dimas," involved in local planning, noted that without dedicated budgets for accessibility and outreach, inclusion remains a slogan rather than an operational requirement. This reinforces the study's premise that inclusive and equitable service delivery is inseparable from financing, standards, and accountability.

The theoretical contribution is strengthened by how the three theories illuminate distinct but complementary mechanisms observed in the field. The Social Model explains why many obstacles are "built into" service environments and procedures, turning the system itself into a disabling structure. The Capability Approach explains why equal inputs do not yield equal outcomes, and why evaluation must focus on whether rehabilitation expands real opportunities for participation. Street-Level Bureaucracy explains why implementation varies across offices and workers, and why discretion without supportive standards and resources can generate inequity even under rights-affirming policies. Together, the theories support an integrated explanation: inclusive and equitable rehabilitation requires barrier removal, capability expansion, and governance designs that make inclusive practice feasible and consistent at the frontline (Vaughn, 2025).

In discussion, these results align with broader patterns reported in earlier rehabilitation and disability policy research, which commonly observes that rights-based reforms often outpace implementation capacity and that multi-sector fragmentation undermines continuity. Previous studies have highlighted that accessibility is frequently treated as a physical infrastructure issue, while information and communication accessibility receive less systematic attention; the present findings echo this, showing that communication supports and accessible information formats remain contingent rather than guaranteed. Earlier research also emphasizes that decentralization and unequal local capacity can produce territorial inequities; similarly, this study demonstrates that service quality and follow-up depend heavily on local leadership, staff workload, and the density of supportive civil-society networks. Moreover, prior scholarship on street-level governance frequently notes that discretion expands under resource constraints and ambiguous categories; the present findings extend this insight into disability contexts, showing how discretionary gatekeeping interacts with stigma and administrative burden to shape who benefits from rehabilitation.

The study's identification of a gap between policy definitions of equity and service users' lived realities also refines the research gap: many policy frameworks assume that standardization and uniform rules produce fairness, yet the findings show that uniformity can institutionalize inequity when conversion factors are ignored. This is where the capability lens becomes essential for policy strengthening. If equity is treated as equal treatment, those with higher support needs, fewer resources, or higher exposure to stigma will remain disadvantaged even when formally included. The novelty claimed by the study is therefore supported empirically: by integrating the three theories, the research clarifies how inclusive and equitable services must be engineered through design, financing, coordination, and frontline governance, rather than assumed as a byproduct of coverage expansion.

In terms of benefits, the academic contribution lies in demonstrating an applied synthesis of disability theory, welfare evaluation, and implementation research within one policy domain. Theoretically, the study operationalizes inclusion and equity as observable service-system dimensions accessibility, continuity, fairness, coordination, and accountability and shows how each dimension is shaped by barriers, conversion factors, and discretion. Practically, the study's implications are directly usable for policy strengthening. Participants' accounts suggest that policy reform should reduce administrative burden, institutionalize accessibility accommodations, and build integrated case-management and referral tracking. Such reforms would likely reduce inequities experienced by those with limited resources or complex support needs, thereby aligning services with the title's promise of inclusive and equitable rehabilitation.

At the same time, the discussion must acknowledge limitations that shape interpretation of results. The qualitative case study design provides depth but is context-specific; patterns observed in Bandung may not transfer directly to regions with different administrative structures or service ecosystems. Some disability groups particularly those who are socially isolated, who have high support needs, or who are not connected to organizations may remain underrepresented despite efforts at maximum variation sampling. In addition, documents and administrative data availability may constrain verification of some planning and budgeting claims, meaning the analysis relies substantially on stakeholder accounts and triangulated observations. These limitations do not negate the results but suggest caution in generalization and underscore the need for complementary research designs.

Future research should extend these findings through comparative studies across regions with different capacity profiles to test how governance arrangements moderate inclusion and equity outcomes. Longitudinal research could examine whether reforms such as integrated case management, simplified eligibility processes, or dedicated accessibility budgets produce sustained improvements in participation outcomes rather than short-term increases in service uptake. Further work is also needed to develop equity-sensitive indicators for rehabilitation performance, including measures of administrative burden, communication accessibility, and continuity of support across agencies. Finally, participatory research approaches that involve persons with disabilities as co-researchers can deepen validity and ensure that "inclusive policy strengthening" is reflected not only in service design but also in knowledge production and accountability. Overall, the results and discussion demonstrate that strengthening social rehabilitation policy through inclusive and equitable services requires a systemic reorientation: inclusion must be operationalized as barrier-free, accessible service pathways, equity must be defined as capability-expanding and needs-responsive outcomes, and implementation must be governed through instruments that support frontline consistency while protecting person-centered discretion. By linking empirical findings to the Social Model of Disability, the Capability Approach, and Street-Level Bureaucracy, the study offers a grounded explanation of why gaps persist and how policy strengthening can move from formal intention to lived inclusion and fair participation.

CONCLUSION

This study concludes that strengthening social rehabilitation policy for persons with disabilities through inclusive and equitable services requires a shift from policy-as-coverage to policy-as-governed service experience. Drawing directly from the Results and Discussion, the central finding is that inclusion and equity are widely endorsed in formal narratives but remain weakly operationalized in frontline procedures, interagency coordination, and accountability mechanisms. Consequently, the primary barrier is not a lack of policy intention; it is the persistence of institutional and administrative structures that reproduce exclusion and unequal outcomes during implementation.

First, the research demonstrates that inclusion is undermined at the earliest stages of service contact. Intake and assessment procedures frequently embed physical, informational, communication, and administrative barriers that limit access for those who cannot navigate complex requirements independently. The study's evidence shows that accessibility is not consistently designed into service environments, but is instead treated as contingent dependent on the presence of supportive staff, NGO intermediaries, or family members. This confirms the Social Model of Disability argument that disability is produced by disabling environments and institutional routines, not solely by individual impairments. In practical terms, the system's default design assumes a "standard client," thereby marginalizing people with high support needs, sensory disabilities requiring communication accommodations, and individuals with limited literacy or resources.

Second, the study concludes that equity cannot be inferred from uniform eligibility rules. While administrators often equated equity with standardized criteria and equal treatment, service users experienced significant differences in service continuity, quality, and outcomes across territories and provider networks. These variations were strongly shaped by conversion factors transport constraints, poverty, social support, stigma, and administrative capacity that affected whether nominal entitlements became real opportunities. This finding aligns with the Capability Approach: equal inputs do not yield equitable outcomes when individuals' abilities to convert services into valued participation differ systematically. Therefore, strengthening policy must include equity-sensitive design, meaning that service standards, outreach strategies, and resource allocation must explicitly compensate for unequal starting points and differential support needs.

Third, the research finds that fragmentation is a structural driver of both exclusion and inequity. Despite policy language that encourages intersectoral collaboration, coordination in practice remains fragile, informal, and person-dependent. Weak referral feedback loops, inconsistent case follow-up, and limited interoperability of administrative data undermine continuity of support especially for persons requiring multi-step, cross-sector services. This fragmentation effectively shifts the burden of coordination onto clients and families, creating inequities because those with fewer resources and lower administrative literacy face higher failure risks. The study therefore concludes that inclusive and equitable rehabilitation cannot be achieved through isolated programs; it demands a coordinated service ecosystem with clear roles, standardized referral pathways, and mechanisms for tracking service delivery across agencies.

Fourth, the study concludes that frontline discretion is a decisive implementation mechanism that can both enable and constrain inclusion and equity. In conditions of limited resources, ambiguous eligibility categories, and high caseload pressure, frontline workers exercise discretion that effectively becomes policy in action. The findings show that discretion sometimes supported problem-solving and responsiveness, but also generated variation, informal gatekeeping, and inconsistent accommodations particularly for less visible disabilities and clients lacking complete documentation. This reinforces the Street-Level Bureaucracy perspective: strengthening policy requires governance instruments that reduce arbitrary variation while protecting the professional judgment needed for person-centered support. Accordingly, the study concludes that policy strengthening must include operational clarity, workload-aware resourcing, training for inclusive practice, and accountability mechanisms that focus on service quality and fairness not solely throughput.

Synthesizing these conclusions across the three theoretical lenses, the study affirms that inclusive and equitable social rehabilitation depends on three mutually reinforcing conditions. Barrier removal and accessible design must be built into the system by default (Social Model). Service outcomes must be evaluated by whether they expand real opportunities for participation across diverse groups, not merely by service volumes (Capability Approach). Implementation must be governed through feasible standards, supportive resources, and accountability that shapes frontline discretion toward consistent, rights-based practice (Street-Level Bureaucracy). Together, these conditions explain why the current gaps persist and clarify what "policy strengthening" must entail.

In policy terms, the study concludes that reforms should prioritize simplifying and making administrative processes accessible; institutionalizing communication and information accommodations; strengthening integrated case management and referral tracking across agencies; and adopting equity-sensitive financing and capacity building to reduce territorial disparities. In academic terms, the study contributes by operationalizing inclusion and equity as observable service-system dimensions accessibility, continuity, fairness, coordination, and accountability and by demonstrating how each dimension is shaped by barriers, conversion factors, and discretionary implementation. Overall, the study's conclusion is that strengthening social rehabilitation policy is fundamentally a governance task: transforming normative commitments to inclusion and fairness into enforceable, resourced, and measurable service practices that improve participation outcomes for persons with disabilities.

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