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Development of Rehabilitation Services for People with Disabilities in Guyana

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Rehabilitation services in Guyana have evolved significantly over the past several decades, shaped by community leadership, international partnerships, and policy change. Yet, despite its crucial role in improving quality of life for individuals with disabilities, the history of rehabilitation remains largely undocumented in academic literature. Drawing on interviews and document analysis, this paper traces the development of rehabilitation services in Guyana, from the introduction of physiotherapy in 1949 to more recent efforts in community-based and specialized care. The COVID-19 pandemic disrupted services but also accelerated policy conversations around health equity, emergency preparedness and tele-rehabilitation. We argue that Guyana's experience offers valuable lessons for advancing inclusive, locally grounded rehabilitation planning in the Caribbean and the Global South.

Keywords: rehabilitation, Guyana, accessibility, Caribbean disability studies, historical development

Introduction

Rehabilitation services are essential for enhancing the quality of life (QOL) of individuals recovering from injuries, surgeries, chronic illnesses, and/or living with disabilities (World Bank, 2023). These services support functional independence, improve mobility, and facilitate social and economic participation.

Globally, rehabilitation has been recognized by the World Health Organization (WHO) as a key component of universal health coverage (UHC) and an essential service within health systems (WHO, 2017; WHO, 2023). Yet access to these services remains deeply uneven, especially in low- and middle-income countries and postcolonial contexts where health infrastructure has been under-resourced and disability has often been marginalized in both policy and practice.

Guyana is a country on the northern coast of South America with a population of approximately

800,000 people. Guyana has a rich and complex history. It was colonized by the Dutch in the 17th century and became a British colony in 1814. It gained independence in 1966 and became a republic in 1970. Its diverse, multicultural population includes people of Indo-Guyanese, Afro-Guyanese, Indigenous, and mixed heritage. Due to newly found offshore oil reserves, Guyana has emerged as one of the fastest-growing economies worldwide.

Despite recent economic growth, Guyana's health system development continues to reflect deep structural inequities rooted in its colonial past. These include regional disparities in service access, underinvestment in disability services, and a persistent reliance on international aid (Ministry of Health, 2021; Deepak, 2006; World Bank, 2020). Both document and interview data suggest that workforce development, rural outreach, and infrastructure improvements have often depended on donor-supported initiatives and international collaborations.

Within this context, the rehabilitation services sector in Guyana has evolved through a combination of local leadership, external partnerships, and shifting health policy priorities. Early services were limited in scope and focused primarily on basic physiotherapy for postsurgical and injury recovery (Kaietuer News, 2020). Since the introduction of physiotherapy in 1949, the sector has expanded to include a broader range of specialties, including occupational therapy (OT), speech and language therapy (SLT), audiology, and prosthetics.

However, this development has not been widely documented in scholarly literature, and there is a notable gap in research that traces the historical and political evolution of rehabilitation services in Guyana. This paper seeks to address that gap by offering a sector-level narrative co-authored with rehabilitation professionals who have helped lead and shape the field from within. Drawing on document analysis and interviews with two senior rehabilitation providers, both of whom played key roles in the sector's development, this paper explores the evolution of rehabilitation services in Guyana, with attention to policy shifts, training initiatives, and ongoing challenges related to equity, infrastructure, and inclusion. Our analysis is informed by critical disability studies and postcolonial approaches to health systems, which foreground structural inequities and the importance of locally grounded knowledge. We position Guyana as a case study for understanding how rehabilitation systems can evolve in resource-constrained contexts, and what lessons it offers for other small countries and Global South settings. The remainder of the paper is organized as follows: we first describe the methodological approach, followed by a historical and thematic analysis of rehabilitation service development in Guyana. We then reflect on lessons learned, including the impact of the COVID-19 pandemic, and conclude with implications for future planning, policy, and equity in rehabilitation.

Methods

This paper is part of a broader qualitative study on rehabilitation in Guyana, approved by the University of Toronto Research Ethics Board. The study was supported by a Pre-Partnership Grant from the Temerty Faculty of Medicine at the University of Toronto. It included interviews with rehabilitation service providers and users in January 2024, as well as document analysis.

Findings related to disabled people's perspectives on rehabilitation access and advocacy are presented in a separate article (under review Niles, Colantonio, Al Awamry), while a forthcoming manuscript will explore frontline providers' experiences providing rehabilitation services in under-resourced settings.

This paper focuses specifically on the development of the rehabilitation sector, drawing on interviews with two senior providers who played foundational roles in shaping policy and service delivery, alongside analysis of key documents. These two participants are also co-authors, and their contributions reflect both lived expertise and collaborative knowledge production. Their involvement as co-authors also provided contextual grounding and helped ensure the accuracy and relevance of the analysis, particularly for historical details and institutional developments.

This study employs a qualitative research approach based on two primary methods: semi structured interviews with key stakeholders and document analysis of publicly available sources. Semi structured interviews were conducted with rehabilitation professionals involved in disability services. Six interviews were conducted with rehabilitation providers currently working in Guyana. Two of these participants were instrumental in developing rehabilitation services in the country, and data from their interviews were used to inform this paper. Interviews were conducted in January 2024 via purposive sampling to identify individuals with experience in developing and implementing rehabilitation services. The interviews covered the following topics:

1. Evolution of rehabilitation services in Guyana
2. Impact of international collaboration and local capacity-building efforts
3. Funding structures and accessibility of rehabilitation services
4. Previous and current challenges and opportunities in expanding rehabilitation care

The interviews were recorded (with participant consent), transcribed verbatim, and analyzed via thematic analysis to identify common patterns and insights. Thematic analysis was conducted manually, using an inductive approach. After multiple close readings of each transcript, the first author conducted open coding by hand to identify initial ideas. These were then clustered into broader categories based on recurring concepts and refined into overarching themes through an iterative process.

Recurring topics included historical challenges, accessibility, funding, and the impact of international collaborations. Data from the two key informants, who played a foundational role in developing rehabilitation services in Guyana, were given analytical attention to trace historical narratives and sectoral transformations. Themes were reviewed with co-authors for feedback and validation, particularly when interpreting events, policy shifts, and institutional structures.

Document Analysis

In addition to interviews, archival research was conducted using newspaper articles, government reports, and international health organization publications. Sources were selected based on their relevance to the history, policy, and practice of rehabilitation services in Guyana. Articles from Kaieteur News, Stabroek News, the Guyana Chronicle, and reports from organizations such as the Pan American Health Organization (PAHO), Voluntary Services Overseas (VSO), and the National Commission on Disability (NCD) Guyana were examined within the last 20 years. The content was systematically reviewed to identify recurring themes, key historical milestones, and policy shifts. Due to limited academic literature, these sources were critical in constructing a historical and policy-based understanding of rehabilitation services in Guyana. Limited availability of peer-reviewed studies highlights the need for further research in this field to document best practices, outcomes, and challenges in rehabilitation services (Garnett, 2020; News, 2020). This study fills essential gaps by synthesizing information from a range of nonacademic yet authoritative sources to provide a comprehensive overview of rehabilitation development in Guyana.

Researcher Positionality

The lead author is a Critical Disability Studies scholar based in Canada, born in Guyana, with strong familial and cultural ties to the country. Although she has lived outside of Guyana for a few decades, these ties and early lived experiences shape a relational and accountable approach to research. Recognizing her temporal and geographic distance from day-to-day service provision, the author worked closely with co-authors born and raised in Guyana to review and interpret findings. This approach ensured that analysis remained grounded in local realities while also allowing for broader reflection.

Limitations

This study has limitations, including potential recall bias in interviews, the availability of historical records, and the limited number of local academic publications on rehabilitation in Guyana. There are also limits to what a small sample of providers can tell us about the full range of institutional experiences. Future research could benefit from a larger sample of

interview participants and expanded access to archival records.

Results

This section draws on both the interviews and the document analysis to trace how rehabilitation services have developed in Guyana. Interviews with two senior providers offer insight into what has changed, what has endured, and how people on the ground made things work. Their reflections are supported by analysis of government reports, news articles, and policy documents, which provide additional context and help trace key milestones. The findings are organized into themes that emerged during analysis, reflecting recurring patterns across both interviews and documents. Together, these accounts highlight the gradual and locally driven growth of rehabilitation in Guyana, as well as ongoing tensions around access, recognition, and support.

Theme 1: "We Had to Build It Ourselves": Foundations of Rehabilitation in Guyana

This theme presents the foundational efforts of early rehabilitation workers who developed services in the absence of formal systems. Their narratives, alongside historical documents and grey literature, describe how rehabilitation in Guyana emerged through improvisation, collective labour, and persistent advocacy. Participants described a time when there were no formal job descriptions, no national rehabilitation plan, no designated spaces, and minimal institutional understanding of their roles. Despite this, they built the infrastructure, relationships, and recognition that laid the groundwork for Guyana's current rehabilitation system.

Historical reports suggest that rehabilitation services in Guyana began more than 70 years ago in a small room under the X-ray department at Georgetown Public Hospital, with early contributions from professionals like Janice Simmons and Jackie Fung-Thompson (Stabroek News, 2020). During the 1970s and 1980s, services gradually expanded, including ultraviolet therapy, prenatal classes, and outreach to children and youth. These early steps laid the foundation for institutions like the Polio Centre (now Ptolemy Reid Rehabilitation Centre) and Cheshire Home.

In interviews, participants repeatedly returned to the absence of any structured system in the early years. Beverly recalled, *"We didn't have anything. No space, no equipment. We just knew people needed help and figured out how to provide it."* This sentiment was echoed across the interviews and aligned with historical records. Articles from *Stabroek News* and *Kaieteur News* described the early 2000s as a time when a single therapist might cover multiple regions, traveling with limited support or resources. One feature in 2002 noted that therapists often worked out of temporary locations, sometimes inside schools or shared hospital spaces, with no permanent placement or equipment (Kaieteur News, n.d.).

The lack of training infrastructure was another major barrier. As Barbara explained, *"We had to send our staff overseas or rely on volunteer therapists coming from abroad. That was the only way we could get people trained."* The absence of local education programs meant that staffing relied on international partnerships. Documents confirm that the early workforce was heavily supported by organizations like Voluntary Services Overseas (VSO International, n.d.) and PAHO (World Health Organization, 2021). These partnerships helped deliver services and informal training, but sustainability was a constant concern.

Even when policy recognition began to emerge, it was largely driven by the persistent efforts of providers themselves. Beverly shared, *"We had to prove ourselves before they took us seriously. We had to show that rehab wasn't a luxury."* Her comment reflects a pattern in Ministry of Health documents from the mid-2000s, which began recognizing rehabilitation not through top-down planning, but in response to local lobbying, staff advocacy, and direct service gaps. Rehabilitation providers were often tasked with justifying their own positions, drafting their own job descriptions, and shaping service delivery models.

The historical invisibility of rehabilitation also shaped how it was represented publicly. Document analysis of press coverage between 2000 and 2015 revealed that rehabilitation was rarely featured on its own. Articles typically bundled it with broader medical outreach, disability awareness, or youth development programs. For instance, a 2010 article in the *Guyana Chronicle* profiled a hospital upgrade but mentioned physiotherapy only in passing, describing it as 'available upon request' and not as part of core services (Guyana Chronicle, 2010).

Despite this limited visibility, international organizations played a critical role in both service delivery and early system-building. Organizations such as VSO, PAHO, and AIFO supported both frontline work and on-the-job training for staff. Some initiatives were also supported through the Indian Technical and Economic Cooperation Program (B. Nelson, personal communication, March 31, 2025). These partnerships were vital to filling immediate service gaps, but they also embedded a model of volunteer-dependent staffing that took decades to shift.

Participants emphasized how these constraints became the conditions under which rehabilitation was born. Barbara reflected, *"We weren't just helping patients. We were building a profession, building a system. We knew it had to last beyond us."* Her words convey how rehabilitation was always conceptualized as more than healthcare, it was a commitment to infrastructure, to visibility, and to the future.

As participants reflected, the goal was not just to help patients, it was to build something enduring. Their advocacy helped secure government commitment to more sustainable forms of

training and service planning. Eventually, these efforts led to the creation of Guyana's first local rehabilitation education programs and the release of national strategies, as outlined in the timeline below.

These early efforts shaped professional roles and recruitment pathways. While private physiotherapy clinics and NGOs emerged later in urban areas, public providers in the early stages were often hired without formal qualifications, trained on the job, and expected to lead department formation. Documents from the Ministry of Health (2021) confirm that until the late 2000s, there was no structured human resource plan for rehabilitation. Instead, service expansion occurred piecemeal, contingent on who was available, what space could be borrowed, and what partnerships could be leveraged.

The Ministry of Health also began training Rehabilitation Assistants to fill service gaps, and later supported the launch of the Medical Rehabilitation Degree Program at the University of Guyana. These developments are explored more deeply in Theme 2, but they began through relationships, improvisation, and international support.

The result was a system slowly stitched together by people who saw the need and filled it even without approval, funding, or recognition. Their reflections underscore the relational and emotional labour embedded in health system development that did not yet understand why rehabilitation mattered.

These layered efforts are visualized in the timeline below, which draws together participant recollections, press reports, and policy documents.

Table 1: Milestones in the Development of Rehabilitation Services in Guyana (1979–2025)

Year	Milestone	Details
1950s	First public rehabilitation services	Rehabilitation begins at Georgetown Public Hospital in a small room under the X-ray department, with early leadership from local pioneers including Janice Simmons and Jackie Fung-Thompson (Stabroek News, 2020).
1970s–1980s	Growth of foundational infrastructure	Launch of the Polio Centre (now Ptolemy Reid Rehabilitation Centre) and Cheshire Home. Services expanded to include ultraviolet therapy, prenatal classes, and basic mobility support in hospital and community settings (Stabroek News, 2020).
1985	First workforce figures reported	The Ministry of Health documents 16 practicing physiotherapists working across Guyana, with no formal training pipeline or licensing system in place (Stabroek News, 2020).

1990s	Increased international partnerships	VSO, PAHO, and Canadian volunteers begin providing services and informal mentorship in urban and remote regions (WHO, 2021; VSO International, n.d.).
2000	First full-time therapist in public system	One therapist is assigned to cover multiple coastal and interior regions, often working from borrowed or temporary spaces (Kaieteur News, n.d.).
2006	National Disability Strategy drafted	Strategy includes initial recognition of rehabilitation needs, but lacks clear funding, regulatory direction, or implementation plan (Ministry of Health, 2021).
2010	Public recognition begins	Guyana Chronicle and Stabroek News begin reporting on rehabilitation in broader coverage of education, youth, and hospital upgrades. Services are often mentioned in passing, not featured (Guyana Chronicle, 2010).
2010	University of Guyana launches physiotherapy degree	University of Guyana introduces the country's first in-country formal training program in physiotherapy, aiming to reduce dependence on overseas training (Guyana Chronicle, 2024).
2012	Policy brief labels sector as "emerging"	Ministry documents acknowledge the need for regulation and training, but no licensure or oversight system is developed (Ministry of Health, 2012).
2010	The Allied Health Professions Act was enacted by the Parliament of Guyana	Established a formal system for the registration, regulation of members of allied health professions supplementary to the medical profession, and associated health services. This helped provide for maintenance of professional standards and to make provisions for training of members of those professions, services, and related purposes (cite)
2020	Sector history publicly profiled	Stabroek News publishes a reflective history of rehabilitation in Guyana, featuring interviews with key sector leaders and highlighting workforce shortages and training gaps (Stabroek News, 2020).
2021	National Rehabilitation Strategy released	The Ministry of Health releases a formal rehabilitation strategy with WHO support, aiming to standardize services and address workforce planning (Ministry of Health, 2021).
2024	Free technical and vocational education	Government announces policy to make all technical/vocational education free, potentially strengthening future rehabilitation pipelines (Department of Public Information, 2024).
2025	Persons with Disability Act	Ongoing policy review may formalize sector mandates (NCD Guyana, 2025).

	revision in progress	

Theme 2: "We Had to Train Our Own People": Local Knowledge, International Partnerships, and the Slow Growth of Capacity

This theme explores how rehabilitation providers in Guyana navigated workforce shortages and education gaps by cultivating informal teaching, partnering with international actors, and gradually advocating for formal recognition. Their reflections challenge assumptions that capacity-building follows a linear path highlighting instead the labour of improvising, mentoring, and adapting in the absence of structural support.

For much of their careers, Barbara and Beverly worked without access to formal rehabilitation education in-country. "*We had to send people abroad*," Barbara recalled. "*That was the only way. And when they came back, there wasn't always a job for them.*" This absence of domestic training programs constrained capacity development and forced reliance on scholarships and visiting therapists. Yet those pathways were rarely sustainable (Stabroek News, 2020).

Throughout the 1980s and 1990s, the Ministry of Health relied on scholarships to Cuba, the UK, and Canada to train physiotherapists and occupational therapists (PAHO/WHO, 2017). But the lack of planning for post-training integration led to persistent gaps. Providers returning from training were often met with clinics that had no designated space or staff to support their work, creating cycles of frustration and attrition (Stabroek News, 2020). More recently, the 2013–2020 Health Vision Strategy named rehabilitation as a workforce need but included no operational plan or sustained funding for in-country training (Ministry of Health, 2013).

In the absence of structured systems, local practitioners became educators by necessity. "*I trained the next generation while I was still figuring it out myself*," Beverly reflected. Peer mentorship became the default model. "*There was no school, no board. Just us, and whoever was willing to teach*," Barbara explained. This kind of informal knowledge-sharing was especially critical in remote regions, where turnover was high and resources were minimal.

Visiting physiotherapists often through PAHO, VSO, or government-to-government aid programs provided short-term support by delivering direct services and introducing new clinical practices. "*They were helpful, absolutely," Beverly said. "But they would leave. And then we had to do it alone again*." Media coverage from this period often celebrated the arrival of international professionals as signs of development, while failing to name the fragility of systems that relied on their temporary presence (Kaieteur News, 2020).

A 2012 policy brief referred to the sector as "emerging" and noted regulatory gaps, but offered no concrete framework for professional licensure or validation. Practitioners were left to piece

together standards from international programs, often without formal recognition in local systems. As Barbara explained, "*We'd see rehab in the report, but no money, no school, no follow-up*". And yet, these efforts were not just reactive. Participants emphasized the intentionality of their work despite lacking authority, they were building foundations. "*We weren't just filling holes*," Barbara said. "*We were setting things in motion, even if it was slow*."

A major milestone came in 2010, when the University of Guyana launched the country's first Bachelor of Science in Physiotherapy program (Stabroek News, 2020). While still in early stages, the program represented a turning point in acknowledging rehabilitation as a legitimate and essential component of health system infrastructure. Moreover, the Ministry of Health has been training rehabilitation assistants locally since 2009, expanding the local pipeline of entry-level staff (Kaieteur News, 2020; B. Nelson, personal communication, July 31, 2025).

Providers in Guyana worked at the intersections of local mentorship, international cooperation, and absent policy often without formal authority, but with a deep sense of purpose. Their efforts show that building capacity in under-resourced health systems is not just about training more professionals. It is also about cultivating professional identity, fostering peer learning, and demanding recognition in systems that continue to underinvest in rehabilitation.

Theme 3: "Sometimes We Were at the Table, but Not Really Seen": Exclusion, Fragmentation, and the Margins of Health Planning

This theme explores how rehabilitation providers navigated ongoing exclusion from national health planning in Guyana, despite incremental gains in visibility. While the profession has advanced since its informal beginnings, providers described persistent marginalization in how services are funded, distributed, and prioritized. Across interviews and document analysis, a clear pattern emerged: rehabilitation was often named, but rarely resourced.

Barbara explained, "*They would say the right things in the reports, but we never saw the resources. Sometimes we were at the table, but not really seen*." This quote captures how rehabilitation was acknowledged in policy rhetoric but excluded from operational planning. Ministry of Health reports from the 2000s and 2010s reinforce this experience. Rehabilitation is frequently listed as a "supportive service" or placed within appendices, rather than integrated into strategic frameworks. Even where rehabilitation is mentioned, these documents provide little detail on infrastructure, workforce targets, or funding mechanisms. In several annual health plans, rehabilitation is noted only in the context of donor-funded projects or as an aspirational goal, without corresponding implementation strategies. One report refers to "uneven distribution" of rehabilitation services across the country, acknowledging that some regions had no consistent access to physiotherapy at all. Yet the documents stop short of addressing why such disparities persist or how they might be rectified (Ministry of Health, 2008; Ministry of Health, 2012).

Beverly recalled working in borrowed rooms and makeshift spaces: "*We shared with other departments. Sometimes a storeroom, sometimes a hallway. There wasn't even running water some days.*" This was echoed in a 2008 Kaieteur News article describing physiotherapy services in Region 2 being delivered from temporary, poorly resourced settings (Kaieteur News, 2008). Other media coverage from Stabroek News and the Guyana Chronicle between 2002 and 2012 similarly framed rehabilitation as a peripheral service. These articles tended to spotlight individual practitioners or international donations, rarely naming local expertise or system-level gaps. "*We weren't seen as part of the system*," Barbara said. "*We were treated like an afterthought*." Her statement reflects deeper tension rehabilitation providers were often tasked with responding to the effects of system failures (injury, trauma, chronic conditions) without being integrated into the system itself. While they delivered healthcare, trained others, and developed informal standards, they remained excluded from key planning spaces.

The initial growth of the sector was catalyzed by urgent public health needs. In particular, the polio outbreak of the 1980s created demand for long-term rehabilitation, leading to the establishment of dedicated facilities such as the Polio Centre and Cheshire Home. These were among the first services that formalized disability support outside of acute hospital care. Their existence reflected the shift from episodic to ongoing rehabilitation, a shift that occurred despite a lack of policy. These early institutions filled critical gaps in care and marked a turning point in the visibility of long-term rehabilitation (Stabroek News, 2020).

A 2012 policy brief acknowledged that the absence of licensure, defined scopes of practice, and standard job descriptions for rehabilitation professionals contributed to fragmentation. Providers often created their own protocols based on international models or personal experience, with no institutional recognition. "*We made our own policies because we had to," Beverly recalled. "No one else was doing it*." The Ministry of Health policy brief noted similar challenges, emphasizing that regulation had not kept pace with workforce growth, contributing to service inconsistencies (Ministry of Health, 2012).

The WHO's Rehabilitation in Health Systems report (2017) situates this local reality within a broader global pattern. It notes that in many low- and middle-income countries, rehabilitation is treated as an optional or secondary service, with little structural support. The report calls attention to the dangers of excluding rehabilitation from primary health care, a critique that aligns directly with the experiences described in Guyana.

Even in more recent years, public recognition remains uneven. Articles from 2023 and 2024 that mention the Ptolemy Reid Centre highlight foreign donations or short-term collaborations, rather than sustained local investment. These include features on vehicle donations and supply drives, but rarely include commentary on systems-level investment or budgetary support (Stabroek News, 2024; DPI, 2024). This echoes Barbara's concern that rehabilitation is "*still*

not funded the way it should be. Still not seen." Notably, however, the 2021–2030 National Rehabilitation Strategy marks the first comprehensive effort to centralize rehabilitation in national health planning. While its existence signals growing recognition, implementation remains a challenge, and the strategy has not yet shifted entrenched funding or infrastructure gaps (Ministry of Health, 2021).

Despite these systemic barriers, providers resisted the idea that their work was invisible. "*We were there, every day*," Beverly said. "*Even if they didn't see us, the patients did*." The providers' stories, and the documents that surround them, reveal a health system where rehabilitation has been shaped from the margins. Taken together, these accounts trace how exclusion itself became part of the labour of building rehabilitation in Guyana. Providers did not wait for the system to include them. They built around it and alongside it.

Theme 4: Ongoing Gaps in Access, Resourcing, and System Integration

Despite decades of advocacy, Guyana's rehabilitation sector remains characterized by chronic underfunding, service gaps, and uneven integration into the national health system. This theme brings forward participants' observations on the fragility of existing services, the limited role of private provision, and the disconnect between policy recognition and material investment.

While rehabilitation is formally situated under the Ministry of Health, participants emphasized that it continues to operate on the margins of health planning and delivery. "*Even though it's under the Ministry, we never have enough to do what we really need*," said Barbara. "*The funding looks bigger on paper than it is. Most of it gets absorbed elsewhere, and we have to make do with very little*." Beverly echoed this, describing rehabilitation as "*still a stepchild of the system*" present but neglected, and rarely prioritized in budget allocations or strategic planning.

Document analysis of health sector reports and media coverage supports these accounts. National plans often mention rehabilitation in passing, but few include concrete strategies for sustained investment or staffing. For example, a 2010 article in Kaieteur News described rehabilitation services as "gaining momentum," yet follow-up coverage and government reports reveal little structural change in the years that followed. Reports from the (WHO and PAHO, 2017) similarly note that rehabilitation remains fragmented and underdeveloped across the Caribbean, with Guyana named among countries facing serious infrastructure and workforce limitations.

Participants also described persistent access inequities between coastal and interior regions. Beverly shared, "*It's not that services don't exist — they do. But how do people get to them? Especially from remote areas? We've had people come all the way from the interior only to find out the therapist wasn't even there that week.*" The costs of transportation, inconsistent service

availability, and workforce turnover all contribute to these access gaps. A 2011 Stabroek News feature (unpublished) profiled a single rehabilitation assistant traveling between remote villages without basic equipment, a story participants described as "still true today."

Some participants discussed the role of private rehabilitation services but framed them as inaccessible to most Guyanese. Barbara noted how "*The private system is really for the few who can afford it. But most of our patients can't. They either wait, or they give up*." While private clinics have grown modestly in urban areas, especially Georgetown, their reach remains limited, and they are often unregulated. Government reports make little reference to this sector, indicating limited integration or oversight.

Participants also reflected on the limits of donor-funded and short-term projects. While partnerships with PAHO, VSO, and other organizations brought critical training and equipment, they were rarely sustained. "*Without the donors, I'm not sure what we'd have," said Barbara. "But we can't plan long-term that way. Projects come and go*." This observation aligns with WHO's 2017 call for countries to shift from project-based models to system-wide rehabilitation integration (WHO, 2017).

The collapse of Community-Based Rehabilitation (CBR) efforts in some regions was also named as a key gap. "*CBR worked, but we lost momentum*," explained Beverly. "*People leave, and there's no one to replace them. Volunteers can only take it so far*." This was especially evident in Indigenous and hinterland communities, where CBR had initially improved local access. However, without formal integration into health systems and no clear pathway for continuity, many CBR initiatives dissolved once external support ended.

Taken together, these reflections illustrate a tension between visibility and viability. Rehabilitation is more visible in policy discourse than ever before mentioned in strategic plans, acknowledged in public ceremonies yet remains structurally fragile. Institutionalization has not translated into equity or consistency. Providers continue to shoulder the burden of unmet needs, working within systems that often fail to invest in their capacity or recognize their expertise.

Reframing the Margins: The Politics of Exclusion in Rehabilitation Planning

Taken together, the themes in this study challenge the idea that rehabilitation in Guyana developed through formal health policy or government planning. Instead, what emerges is a portrait of a sector shaped from the margins where frontline providers built services around the state, not within it. These gaps were not incidental. They were structural, enduring, and often accepted as normative. Missing licensure systems, undefined job descriptions, limited training pathways, and a lack of dedicated infrastructure were not oversights, they reflected broader patterns of exclusion in health planning. Despite this, providers forged ways to deliver support, drawing on relationships, community trust, and informal mentorship. These efforts were

strategic responses to being repeatedly left out of decision-making spaces. Rehabilitation developed not because the system was ready to support it, but because communities and providers made it necessary and possible. Providers created informal systems, trained each other, formed communities of practice, and met needs the system had not planned for. Over time, their collective efforts became a kind of relational infrastructure deeply practical, grounded in care, but largely unacknowledged by formal governance structures.

This kind of infrastructure is not neutral. It is shaped by and simultaneously reveals the deeper contradictions in Guyana's health planning. Ministries of Health reports from the 2000s and 2010s frequently mentioned rehabilitation as a "supportive service" or in appendices, but offered little detail on funding, workforce targets, or implementation plans (Ministry of Health, 2008; Ministry of Health, 2012). When providers were invited into policy spaces, their presence often did not translate into influence. National documents celebrated the idea of rehabilitation but rarely operationalized it.

That pattern persisted even as demand for rehabilitation increased, especially after the 1980s polio outbreak catalyzed the creation of facilities like the Polio Centre and Cheshire Home. These services formalized long-term disability support in Guyana before any national rehabilitation strategy existed. The urgency of need built the sector faster than the state's ability or willingness to plan for it (Stabroek News, 2020).

And yet, Guyana may be positioned to break this cycle. Unlike many countries, it now has a National Rehabilitation Strategy (2021–2030) a document that recognizes the sector's value, names equity as a core principle, and outlines steps for integration across primary care, education, and workforce development (Ministry of Health, 2021). This moment presents both an opportunity and a test. Will policy shift from aspirational rhetoric to meaningful implementation? Will the informal systems built from the margins finally be recognized, resourced, and sustained?

Rehabilitation in Guyana emerged in response to what planning failed to do. The people who kept showing up did not wait for inclusion. They built networks of trust, systems of care, and ways of working that carried the sector through. The question now is not whether rehabilitation belongs in national health systems, it is whether the system will catch up to what already exists.

Discussion

Guyana as a Postcolonial Case Study in Health System Development

Guyana presents a compelling case study for understanding the development of rehabilitation services in a postcolonial, resource-constrained setting. As of 2002, an estimated 6.4% of its population living with disabilities (Beaie and Phil, 2007), the country faces considerable

challenges in delivering equitable and sustainable rehabilitation services. This study traced the evolution of rehabilitation in Guyana by drawing on the narratives of long-standing providers and triangulating these accounts with policy and media documents. In Guyana, rehabilitation services did not emerge through a top-down plan or structured investment. Instead, they were built over time by providers who trained each other, adapted in real time, and filled systemic gaps with the tools they had. What often gets framed as a lack of capacity is a lack of recognition for the relational and informal systems already in place. These providers developed a functioning, responsive system under conditions of scarcity, without waiting for official approval or funding. Their work challenges dominant ideas of what "capacity" looks like and where it comes from.

Disrupting Linear Models of Capacity-Building

The findings challenge dominant models of health system strengthening that assume services are built through top-down investment, standardized training, and formalized policy implementation. In many global health frameworks, particularly those rooted in Global North assumptions, the emergence of rehabilitation is linked to institutional development and technical capacity-building (World Health Organization, 2017). However, in Guyana, rehabilitation took shape in the absence of such systems. It was held together through improvisation, horizontal mentorship, and the everyday work of navigating professional invisibility. These practices are often omitted from policy discourse, yet they are central to how services function on the ground. As Grech (2015) argues, postcolonial health systems cannot be understood without attention to the histories of marginalization, aid dependency, and political neglect that structure what is visible, valued, and supported.

Relational Labour and the Architecture of a Profession

The providers in this study described building services in real time, often without designated funding, formal authority, or written protocols. Their labour included clinical work, advocacy, policy negotiation, and informal training. They mentored new colleagues, lobbied ministries, and coordinated care in settings where infrastructure was limited, and turnover was high. These forms of labour are rarely recognized in workforce planning, yet they are foundational to how systems endure in contexts of scarcity. Drawing from Meekosha and Soldatic (2011), we can understand these providers as actors who resist erasure and challenge the marginal status of disability in health systems.

Reframing What Counts as Capacity

Rehabilitation in Guyana was not merely delivered; it was imagined, constructed, and sustained through relationships. It emerged through persistence, negotiation, and refusal to disappear. This reframing invites a different understanding of capacity—one that centers relational

knowledge, lived experience, and the politics of professional recognition. These insights contribute to scholarship on health systems in the Global South by showing how the invisibilized labour of rehabilitation providers becomes a site of both survival and resistance in the absence of structural investment.

Valuing Invisible Labour in Marginalized Health Systems

The narratives of rehabilitation providers in Guyana reveal how health systems are held together by forms of labour that are often undervalued, feminized, and rendered invisible in dominant health discourses. Participants in this study were not passive recipients of international aid or national health directives. They acted as system builders, crafting roles, advocating for recognition, and mentoring others, all while navigating the chronic underfunding and marginalization of rehabilitation services. Their accounts align with a growing body of CDS and postcolonial health scholarship that critiques how dominant models of professionalism privilege credentialed knowledge and technocratic solutions while ignoring the political and emotional labour required to sustain care in contexts shaped by colonial histories and ongoing inequities (Meekosha & Soldatic, 2011; Grech, 2015).

In Guyana, the invisibility of rehabilitation labour is compounded by its position outside the central priorities of the national health agenda. As in many postcolonial states, disability services are often seen as peripheral or secondary, rather than integral to public health. Providers described having to justify their roles, create unofficial job descriptions, and fight for resources, often without assurance that their efforts would be formally recognized. This kind of advocacy work, while essential, is rarely captured in workforce metrics or policy evaluations. It reflects a broader pattern, identified in the work of Whalley Hammell (2019), where rehabilitation professionals in under-resourced settings are forced to perform a dual labour: providing direct services while simultaneously legitimizing the very existence of their profession.

The Emotional Endurance of Working in Neglected Systems

The emotional toll of working in an under-resourced, often overlooked sector emerged as a consistent theme across interviews. Participants described feelings of exhaustion, frustration, and isolation, but also spoke about purpose, community, and pride. These complex emotional responses mirror what Yeung et al. (2020) refer to as the emotional endurance required of health workers operating under conditions of structural neglect. This labour is central to the sustainability of rehabilitation in Guyana. Emotional endurance is what enabled providers to stay when others left, to build programs from scratch, and to hold space for hope even when policy and funding support were lacking.

By centering these experiences, our study contributes to literature that examines health systems

as lived structures, not just organizational frameworks. It also affirms the importance of integrating emotional and relational labour into how we define and support capacity in the rehabilitation workforce. As CDS scholars have emphasized, systems are not just built through planning or investment. They are maintained through relationships, emotion, and resistance in the face of persistent structural barriers (Puar, 2017; Soldatic & Grech, 2014).

Implications for Policy and Research in Postcolonial Contexts

The findings from this study challenge dominant approaches to health systems strengthening, particularly those that assume policy frameworks and formalized education must precede the development of services. In Guyana, rehabilitation emerged from relational labour, informal mentorship, and the strategic navigation of neglect. This disrupts global health narratives that prioritize scalability, standardization, and evidence-based planning as the primary markers of progress (Storeng & Behague, 2016). Instead, our findings reveal a slower, more contingent form of system-building that demands a different kind of policy imagination.

Policymakers and international partners often treat low- and middle-income countries as blank slates onto which models of care can be exported. But in postcolonial settings like Guyana, the health system is already being built often in fragmented, precarious, and relational ways by people whose work remains unrecognized. Acknowledging this means shifting our metrics of success. It means valuing the invisible scaffolding that holds health systems together in the absence of infrastructure, funding, or formal training.

This has clear implications for both national policy and international support. National rehabilitation strategies must account for the histories and relationships that have made current service delivery possible. Investments in training, regulation, and infrastructure should be grounded in the lived expertise of those who have kept services going, rather than displacing them. From a research perspective, studies on workforce development and capacity-building must go beyond counting providers or measuring skillsets. They must explore the textures of improvisation, mentorship, and collective survival that characterize rehabilitation systems in contexts of scarcity. Rather than framing Guyana as a place in need of rehabilitation reform, our findings position it as a site of innovation, adaptation, and relational expertise making it a critical voice in reimagining what rehabilitation can look like in the Global South.

Conclusion

This study documents the development of rehabilitation services in Guyana as told by the people who built them. It highlights a system shaped by relational work, persistence, and local ingenuity. In a context of limited recognition, resources, and regulation, rehabilitation providers carved out a path for the profession to exist, often relying on each other, improvising protocols, and mentoring the next generation with little institutional support.

These findings challenge dominant narratives that frame low-resource settings as lacking capacity. As this study shows, capacity often exists outside formal systems and metrics. It is found in relationships, refusal, and the everyday actions of people who refuse to let a system disappear. The experiences shared here push us to rethink how capacity-building is defined and by whom, and to recognize the critical contributions of those whose work is often unacknowledged.

At the same time, this research points to the urgent need for health policy to catch up with the realities on the ground. Recognition, resourcing, and regulatory support remain uneven. National plans continue to name rehabilitation without embedding it fully into budgets, workforce pipelines, or professional infrastructure. The persistence of providers cannot replace the need for structural investment.

As Guyana moves forward, the legacy of this labour offers a powerful foundation. It is a reminder that systems are not only built through formal strategies, but also through care, collaboration, and courage. Rehabilitation in Guyana is a story of what becomes possible when people build.

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