

Baba Amte and the Evolution of Rehabilitation in Leprosy Care: Historical Context, Model Analysis and Contemporary Relevance

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Received: 30.10.2025

Revised: 23.03.2026

Accepted: 24.06.2026

Leprosy has historically represented not only an infectious disease but also a social condition marked by stigma, exclusion, and disability. During the mid-20th century, when Baba Amte initiated his work, leprosy control in India was dominated by segregation, custodial care and limited therapeutic options. The later introduction of multidrug therapy transformed medical management but did not automatically eliminate social consequences of the disease. This review analyses the rehabilitation model developed by Baba Amte at Anandwan within the historical evolution of leprosy care in India. Using published literature, programmatic reports and historical sources, the paper examines prevailing medical and social responses to leprosy before and after MDT, compares Anandwan's community-based, dignity-centred approach with other rehabilitation models, and discusses its relevance in the present era of disability prevention, stigma reduction and inclusive public health. The analysis shows that Baba Amte's work anticipated modern community-based rehabilitation principles and remains relevant for managing other chronic disabling and stigmatizing conditions.

Keywords: Leprosy, Rehabilitation, Stigma, Baba Amte, Anandwan, Community-based Rehabilitation, Disability, Social Medicine

Introduction

Leprosy has historically been more than an infectious disease; it has been a social condition associated with exclusion, stigma, and lifelong disability. In India, during the mid-20th century — the period when Baba Amte began his

work — leprosy control strategies were largely custodial rather than rehabilitative (Government of India 1898). Patients were often segregated into colonies under social and legal pressures, including the Lepers Act of 1898, which reinforced isolation rather than integration.

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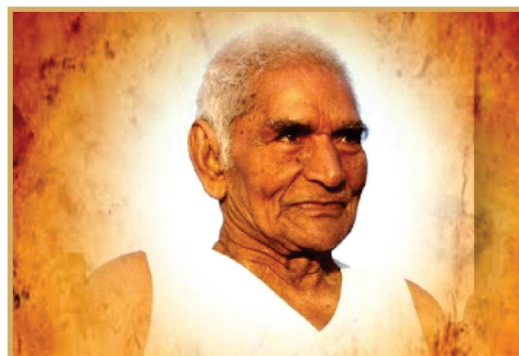
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At that time, effective curative therapy was limited to dapsone monotherapy, which required prolonged treatment and frequently resulted in disability due to delayed diagnosis and nerve damage (Bryceson & Pfaltzgraff 1990).

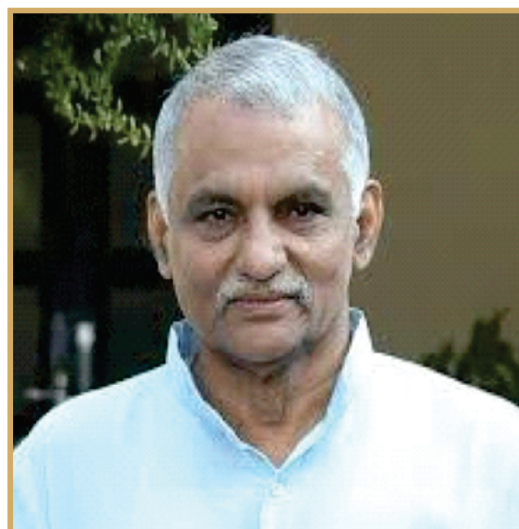
The introduction of multidrug therapy (MDT) in 1982 marked a major biomedical breakthrough, transforming leprosy into a curable disease (WHO 1982). However, the social consequences of leprosy — stigma, unemployment, family separation and psychological trauma — continued even after bacteriological cure (Lockwood & Suneetha 2005). Thus, while medical science addressed infection, the social model of rehabilitation lagged behind.

It was within this historical context that Baba Amte established Anandwan in 1949 in Maharashtra (Staffner 2000). His approach differed fundamentally from prevailing charity-based or custodial systems. Instead of viewing persons affected by leprosy as passive recipients of aid, he emphasized dignity through work, self-reliance, family life and social integration. His model represented an early form of community-based rehabilitation, decades before the term became established in public health discourse (Deepak 2003). This model has evolved from his period to Dr Prakash Amte.

Today, as India moves toward the goals of “zero leprosy” and “zero discrimination,” revisiting such historically rooted rehabilitation models is important. Understanding how Baba Amte’s work aligned with — and often preceded — developments in medical and social thinking provides insights into sustainable, humane approaches to chronic diseases associated with disability and stigma (Lockwood & Suneetha 2005, Deepak 2003).



Baba Amte



Dr Prakash Amte

Aim of the Review

This review aims to analyse the rehabilitation model developed by Baba Amte at Anandwan in the context of the historical evolution of leprosy care in India, compare it with other approaches to leprosy rehabilitation, and examine its relevance in the modern era of MDT, disability prevention and social inclusion (WHO 2021, Deepak 2003).

Literature Search Strategy

A narrative review methodology was adopted.

Literature was searched using PubMed, Google Scholar, archives of the Indian Journal of Leprosy, WHO technical reports, National Leprosy Eradication Programme documents, books and biographies on Baba Amte, and publications related to community-based rehabilitation and stigma (WHO 2010, Staffner 2000). Keywords included “leprosy rehabilitation,” “Baba Amte,” “Anandwan,” “leprosy stigma,” “community-based rehabilitation,” and “history of leprosy control in India.” Articles covering medical, social, historical and rehabilitation aspects from the mid-20th century onward were reviewed to contextualize Baba Amte’s work within broader developments in leprosy care (Lockwood & Suneetha 2005, Sermrittirong & Van Brakel 2014).

Historical Evolution of Leprosy Care in India

Leprosy care in India has passed through distinct historical phases shaped by prevailing medical knowledge, social attitudes and policy approaches. In ancient Indian medical literature, conditions resembling leprosy were described under the term *kushtharoga*, reflecting early clinical recognition but limited therapeutic understanding (Banerjee 1997). However, over centuries, the disease became associated with ritual impurity and social exclusion, reinforcing stigma and marginalization.

The discovery of the leprosy bacillus by Gerhard Armauer Hansen in 1873 established the microbial basis of the disease, shifting medical thought away from supernatural explanations, although social attitudes changed more slowly.

During the colonial period, leprosy control policies shifted toward institutional segregation. The Lepers Act of 1898 provided legal sanction for isolation of persons affected by leprosy, emphasizing containment rather than treatment or rehabilitation (Government of India 1898). Missionary-run leprosy homes and asylums



Gerhard Armauer Hansen

emerged across India, offering shelter and basic care but often reinforcing lifelong separation from family and community (Bryceson & Pfaltzgraff 1990).

By the early to mid-20th century, dapsone monotherapy became the mainstay of treatment. While it reduced bacterial load, treatment required prolonged administration and drug resistance later emerged. Disability due to nerve damage remained common because diagnosis was often delayed and disability prevention strategies were underdeveloped (Bryceson & Pfaltzgraff 1990, WHO 1982, Nicholls et al 2003). During this period, the dominant approach remained medical containment combined with social segregation rather than reintegration.

A major shift occurred with the introduction of multidrug therapy (MDT) in the early 1980s, which transformed leprosy into a curable disease (WHO 1982). National programmes, including India’s National Leprosy Eradication Programme (NLEP), gradually integrated leprosy services into general health care. However, despite biomedical advances, stigma and social consequences

persisted, and rehabilitation remained inadequately addressed in many settings (Lockwood & Suneetha 2005, Sermrittirong & Van Brakel 2014).

It was against this background — when segregation, disability and stigma dominated the lived experience of persons affected by leprosy — that Baba Amte's work emerged. His approach departed from institutional custodial models and instead emphasized productive work, community living and restoration of dignity, anticipating later concepts of community-based rehabilitation and social inclusion (Deepak 2003, Deepak 2011, Ebenso & Ayuba 2010, WHO 2010). As this model has evolved from Baba Amte to Dr Prakash Amte, the Anandwan model must be understood as part of a broader historical transition from isolation and charity to empowerment and participation.

Medical vs Social Models of Rehabilitation in Leprosy

Leprosy management has historically been dominated by a **medical model**, in which the primary objective was control of infection and prevention of transmission. Under this model, persons affected by leprosy were viewed mainly as patients requiring diagnosis, chemotherapy and management of complications (Bryceson & Pfaltzgraff 1990, WHO 1982, Britton & Lockwood 2004). Rehabilitation, when considered, focused largely on surgical correction of deformities, physiotherapy and assistive devices, often delivered in institutional settings separate from the community.

While biomedical advances, particularly the introduction of multidrug therapy, significantly reduced disease burden, the medical model alone proved insufficient in addressing the broader consequences of leprosy. Disability resulting from nerve damage frequently led to loss of employment, family disruption and social

marginalization, issues that medical treatment could not resolve (Lockwood & Suneetha 2005). Studies have shown that stigma and discrimination persisted even after bacteriological cure, limiting the effectiveness of purely clinical approaches (Sermrittirong & Van Brakel 2014).

In response to these limitations, a **social model of rehabilitation** gradually emerged. This model recognizes disability not solely as a medical impairment but as an interaction between health conditions and social, environmental and attitudinal barriers (WHO 2010). Within leprosy care, this translated into emphasis on social inclusion, livelihood support, education, community participation and reduction of stigma. Community-based rehabilitation (CBR), promoted internationally from the late 20th century, integrated health, education, livelihood and social components to enable persons with disabilities to participate fully in society (WHO 2010, Deepak 2003).

The contrast between these two models is significant. The medical model emphasizes cure and clinical management, often within health facilities, whereas the social model emphasizes participation, empowerment and integration within the community. In the context of leprosy, this shift represented a movement from viewing individuals as "cases" to recognizing them as persons with rights, capacities and social roles (Lockwood & Suneetha 2005, Sermrittirong & Van Brakel 2014).

Baba Amte's work at Anandwan exemplified this social rehabilitation perspective decades before it became widely articulated in international public health discourse. By focusing on productive work, collective living, education and dignity, his approach addressed the social determinants of disability and stigma, not merely the disease itself (Staffner 2000, Deepak 2003). Thus, the Anandwan model can be interpreted as an early,

contextually adapted form of community-based rehabilitation in leprosy care.

The Anandwan Rehabilitation Model – Structure, Philosophy and Functioning

The establishment of Anandwan (“Forest of Joy”) in 1949 by Baba Amte marked a significant departure from prevailing custodial and charity-oriented approaches to leprosy care in India. At a time when persons affected by leprosy were largely segregated and dependent on institutional support, Anandwan was conceived as a self-sustaining community emphasizing dignity, productivity and social integration (Staffner 2000).

(i) Philosophical Foundations of Anandwan Model

Baba Amte’s philosophy was influenced by Gandhian principles of self-reliance, dignity of labour and social justice. He rejected the notion that persons affected by leprosy should be passive recipients of charity. Instead, he promoted the

idea that meaningful work restores self-respect and social identity (Staffner 2000, Deepak 2003). His often-quoted belief that “work builds, charity destroys” reflected a shift from welfare to empowerment. This approach aligned with later formulations of the social model of disability, which emphasize capability and participation rather than limitation (WHO 2010). Anandwan thus anticipated the principles later embedded in community-based rehabilitation strategies.

(ii) Organisational Structure and Self-Sufficiency

Unlike traditional leprosy colonies, Anandwan functioned as a **productive settlement**. Residents engaged in agriculture, dairy farming, handicrafts, carpentry, weaving and small-scale industries, contributing to the economic sustainability of the community (Staffner 2000). Income-generating activities were integrated with rehabilitation, allowing individuals with varying degrees of disability to participate according to their abilities.



Residents and community members at Anandwan, Maharashtra, reflecting the community-based rehabilitation model. Source: Maharogi Sewa Samiti (used with permission).

दिनांक	पान नं.	वर्ग	विवरण	रक्कम	मार्ग	मार्ग नं.	मार्ग व.	दिनांक	पान नं.	विवरण
१६/११/९१	४	नाई	सी.के. परांजपे कोठे येथी	१३०००	२०			१६/११/९१	४३	नाई - जेव्हा मंडळाला पातळी मिळाली
१७/११/९१	५	जमा	आनंदवन येथील आवासीय	१४०००				१७/११/९१	४४	नाई - जेव्हा मंडळाला पातळी मिळाली
१८/११/९१	५	जमा	जमावळ कोठार येथी जमा	१५०००				१८/११/९१	४५	जमा - जेव्हा मंडळाला पातळी मिळाली
२०/११/९१	५	जमा	आनंदवन येथील आवासीय	१६०००				२०/११/९१	४६	जमा - जेव्हा मंडळाला पातळी मिळाली
२१/११/९१	५	जमा	आनंदवन येथील आवासीय	१७०००				२१/११/९१	४७	जमा - जेव्हा मंडळाला पातळी मिळाली
२२/११/९१	५	जमा	आनंदवन येथील आवासीय	१८०००				२२/११/९१	४८	जमा - जेव्हा मंडळाला पातळी मिळाली
२३/११/९१	५	जमा	आनंदवन येथील आवासीय	१९०००				२३/११/९१	४९	जमा - जेव्हा मंडळाला पातळी मिळाली
२४/११/९१	५	जमा	आनंदवन येथील आवासीय	२००००				२४/११/९१	५०	जमा - जेव्हा मंडळाला पातळी मिळाली
२५/११/९१	५	जमा	आनंदवन येथील आवासीय	२१०००				२५/११/९१	५१	जमा - जेव्हा मंडळाला पातळी मिळाली
२६/११/९१	५	जमा	आनंदवन येथील आवासीय	२२०००				२६/११/९१	५२	जमा - जेव्हा मंडळाला पातळी मिळाली
२७/११/९१	५	जमा	आनंदवन येथील आवासीय	२३०००				२७/११/९१	५३	जमा - जेव्हा मंडळाला पातळी मिळाली
२८/११/९१	५	जमा	आनंदवन येथील आवासीय	२४०००				२८/११/९१	५४	जमा - जेव्हा मंडळाला पातळी मिळाली
२९/११/९१	५	जमा	आनंदवन येथील आवासीय	२५०००				२९/११/९१	५५	जमा - जेव्हा मंडळाला पातळी मिळाली
३०/११/९१	५	जमा	आनंदवन येथील आवासीय	२६०००				३०/११/९१	५६	जमा - जेव्हा मंडळाला पातळी मिळाली
३१/११/९१	५	जमा	आनंदवन येथील आवासीय	२७०००				३१/११/९१	५७	जमा - जेव्हा मंडळाला पातळी मिळाली
३२/११/९१	५	जमा	आनंदवन येथील आवासीय	२८०००				३२/११/९१	५८	जमा - जेव्हा मंडळाला पातळी मिळाली
३३/११/९१	५	जमा	आनंदवन येथील आवासीय	२९०००				३३/११/९१	५९	जमा - जेव्हा मंडळाला पातळी मिळाली
३४/११/९१	५	जमा	आनंदवन येथील आवासीय	३००००				३४/११/९१	६०	जमा - जेव्हा मंडळाला पातळी मिळाली

Community record-keeping and administrative documentation at Anandwan demonstrating structured self-reliance. Source: Maharogi Sewa Samiti (used with permission).

Educational institutions, vocational training centres and healthcare facilities were established within the campus, enabling access to services without social exclusion. Families of affected persons were encouraged to live together, countering the pattern of isolation common in institutional settings (Deepak 2003).

(iii) Medical Care Integrated with Social Rehabilitation

Medical services at Anandwan included diagnosis, MDT administration and disability care, but these were embedded within a broader social framework. Rehabilitation was not limited to surgical or physical correction but extended to restoring roles in family and community life. This integrated approach contrasted with the

narrow clinical focus prevalent in many leprosy institutions of the period (Byceson & Pfaltzgraff 1990, Lockwood & Suneetha 2005).

(iv) Education and Social Inclusion

Education played a central role in Anandwan. Schools and training centres provided opportunities not only for persons affected by leprosy but also for their children and surrounding communities. Cultural activities, collective decision-making and shared living spaces reduced social distance between “patients” and caregivers, promoting inclusion rather than segregation (Staffner 2000).

(v) Environmental and Community Dimensions

Anandwan also incorporated environmental regeneration, transforming barren land into

productive farmland. This integration of ecological restoration with social rehabilitation reinforced community ownership and sustainability. The model demonstrated that persons affected by leprosy could contribute meaningfully to both economy and environment (Deepak 2003).

Comparison of Anandwan with Other Rehabilitation Models in India

Rehabilitation approaches for persons affected by leprosy in India have historically varied across institutional, government-led and community-based models. A comparison of these approaches highlights the distinctive features of the Anandwan model.

(a) Institutional and Custodial Colony Model

During the pre-MDT era, many persons affected by leprosy resided in segregated colonies or asylums, often established by missionary or charitable organizations. These institutions provided shelter and basic care but were largely custodial, with limited opportunities for economic independence or community integration (Kakar 1996, Buckingham 2002). While such settings reduced visible homelessness and suffering, they inadvertently reinforced lifelong dependency and social separation.

(b) Government-led Medical Rehabilitation Approach

With the development of national control programmes, rehabilitation efforts began to include reconstructive surgery, physiotherapy and provision of assistive devices. The focus remained largely on physical correction of deformities rather than social reintegration (Saunderson 2008, WHO 1998). Though medically valuable, this approach did not systematically address employment, education or stigma reduction.

(c) NGO-based Community Rehabilitation Initiatives

Several non-governmental organizations

introduced livelihood training, microcredit and social support initiatives. The Leprosy Mission and similar organisations emphasized vocational rehabilitation and community awareness, representing a shift toward social inclusion (The Leprosy Mission 2015, Cross 2006). These programmes demonstrated that economic empowerment reduces stigma and enhances quality of life.

(d) Community-Based Rehabilitation (CBR) Framework

The WHO CBR strategy integrated health, education, livelihood, social and empowerment components within community settings (ILO-UNESCO-WHO 2004). This framework recognized disability as a socio-environmental issue rather than purely medical, aligning closely with modern disability rights perspectives and emphasizing participation as an important outcome of rehabilitation (United Nations 2006, Van Brakel et al 2006). Such a comprehensive approach is also consistent with the broader recognition that health should include psychological and social dimensions and not be understood solely in terms of physical disease (Prince et al 2007, WHO 2015).

(e) Distinctiveness of the Anandwan Model

Anandwan differed from other models in several key respects. Unlike custodial colonies, it emphasized **productive work and self-sufficiency**. Unlike purely medical rehabilitation, it integrated healthcare with livelihood, education and social life. Unlike externally supported NGO projects, Anandwan evolved as a **self-sustaining community**, where residents actively shaped their environment and social structures (Staffner 2000, Maharogi Sewa Samiti 2018).

Thus, Anandwan can be interpreted as a **precursor to modern CBR**, combining medical care with socio-economic rehabilitation and dignity-

centred inclusion. Its long-term sustainability and community ownership distinguish it from short-term project-based interventions.

Impact and Outcomes of the Anandwan Model

The long-term functioning of Anandwan provides an opportunity to examine the practical outcomes of a rehabilitation model grounded in dignity, work and community participation. Unlike short-term project interventions, Anandwan evolved over decades into a stable socio-economic ecosystem, offering insights into sustainable rehabilitation.

(A) Livelihood and Economic Rehabilitation

One of the most visible outcomes of the Anandwan model has been the restoration of livelihood among persons affected by leprosy. Engagement in agriculture, crafts, dairy production and small industries enabled individuals with disabilities to become economically productive rather than dependent on charity. Studies in disability rehabilitation indicate that participation in income-generating activities is strongly associated with improved self-esteem and reduced stigma (Kuipers et al 2001). The integration of livelihood into rehabilitation aligns with evidence that economic empowerment is central to social reintegration.

(B) Social Reintegration and Reduction of Stigma

Community living at Anandwan, where residents share work, decision-making and cultural life, contrasts sharply with segregated colony systems. Research shows that contact-based social integration and visible productivity of persons with disabilities reduce community-level stigma (Heijnders & Van Der Meij 2006). Models that promote interaction rather than isolation contribute to normalization and acceptance.

(C) Psychological Well-being and Dignity

Rehabilitation approaches emphasizing meaningful roles have demonstrated positive effects on mental health outcomes in chronic disabling conditions. Participation, autonomy and social recognition are protective factors against depression and social withdrawal (WHO 2011, Prince et al 2007). The Anandwan model's focus on dignity through work and collective identity reflects these principles.

(D) Intergenerational and Educational Impact

Access to education within Anandwan reduced the intergenerational cycle of exclusion often seen in families affected by leprosy. Evidence from disability-inclusive education research suggests that educational inclusion improves long-term socio-economic mobility and social participation (UNESCO 2017). By integrating education with rehabilitation, Anandwan addressed structural determinants of marginalization.

(E) Sustainability of the Model

Unlike many externally funded rehabilitation projects, Anandwan developed internal economic systems that reduced reliance on external aid. Sustainability has been recognized as a critical factor in community-based rehabilitation success (Mannan et al 2012). Community ownership and locally adapted solutions are key determinants of long-term impact.

Relevance of the Anandwan Model in the MDT and Post-Elimination Era

The introduction of multidrug therapy (MDT) transformed leprosy into a curable disease, and many countries, including India, achieved elimination as a public health problem. However, elimination did not equate to the disappearance of disability, stigma, or social exclusion among persons affected by leprosy (WHO 2021, WHO 2024). In this context, the principles underlying the Anandwan model remain highly relevant.

(I) Persistent Disability after Bacteriological Cure

Even in the MDT era, new cases continue to present with Grade 2 disability, indicating delayed detection and ongoing nerve damage (Saunderson 2008). Persons cured of infection may live with lifelong impairments requiring social and economic rehabilitation. Anandwan's emphasis on vocational training and adaptation of work roles illustrates an approach aligned with long-term disability management rather than short-term medical care.

(II) Stigma in the Post-Elimination Context

Studies show that stigma often persists even when disease prevalence declines, because social attitudes change more slowly than epidemiological indicators (Sermrittirong & Van Brakel 2014, Cross 2006, Rafferty 2005, Tsutsumi et al 2007, Van Brakel 2006). Community-based living and visible productivity of persons affected by leprosy, as practiced at Anandwan, counteract stereotypes of incapacity and contagion, contributing to normalization and acceptance.

(III) Integration with Primary Health and Community Systems

Modern leprosy strategies emphasize integration of services into general health systems and community participation (WHO 2021). Anandwan's model, where healthcare, livelihood and social life coexist within a community setting, reflects this integrated approach. Rather than isolating leprosy care, it situates rehabilitation within broader social and developmental contexts.

(IV) Rights-Based and Inclusive Public Health

Contemporary disability discourse stresses rights, inclusion and participation (WHO 2011). Anandwan anticipated these principles by recognizing residents not as beneficiaries but as active contributors. Such rights-based

perspectives are increasingly recognized as essential for achieving "zero discrimination" goals in global leprosy strategies.

(V) Lessons for Sustainability

Many modern rehabilitation projects struggle with sustainability once external funding ends. Anandwan's self-sustaining economic structure, developed through agriculture and small-scale industries, provides a model of locally grounded resilience (Mannan et al 2012). This is particularly relevant for resource-limited settings where long-term institutional support may be uncertain.

Applicability of the Anandwan Model to Other Stigmatizing Conditions

The principles underlying the Anandwan rehabilitation model—dignity through work, community integration, and socio-economic empowerment—are not limited to leprosy. They offer important lessons for other chronic, disabling, and stigmatizing conditions where biomedical treatment alone does not ensure social inclusion.

Tuberculosis and Post-TB Disability

Tuberculosis (TB), like leprosy, carries stigma and can lead to long-term physical and socio-economic consequences even after microbiological cure. Studies highlight the need for rehabilitation addressing functional limitations, livelihood loss and social exclusion among TB survivors (Allwood et al 2020, Datta & Evans 2019). The Anandwan model's integration of medical care with vocational and community rehabilitation parallels emerging calls for post-TB care models that extend beyond treatment completion.

HIV and Chronic Disease Stigma

HIV has similarly evolved from a fatal infection to a chronic condition, yet stigma persists in many settings. Community-based empowerment, peer participation and livelihood interventions have shown effectiveness in reducing HIV-

related stigma and improving psychosocial outcomes (Mahajan et al 2008, Stangl et al 2013). Anandwan's emphasis on collective identity and productive participation mirrors these approaches.

Disability from Non-Communicable Diseases (NCDs)

With the global rise of non-communicable diseases, many individuals live with long-term disabilities requiring social and vocational adaptation. Rehabilitation frameworks stress community inclusion, accessibility and participation as essential components of care (Cieza et al 2020). Anandwan's model demonstrates how local economic and social structures can be adapted to accommodate varying functional abilities.

Mental Health and Social Participation

Mental health conditions are strongly associated with stigma and social exclusion. Recovery-oriented approaches emphasize meaningful roles, community engagement and autonomy (Davidson et al 2005). The psychosocial environment of Anandwan, where work and community life foster identity and belonging, reflects principles now recognized as central to mental health rehabilitation.

Cross-Cutting Lessons

Across these conditions, several common elements emerge: the need to move beyond clinical cure, address social determinants of disability, foster economic independence, and build inclusive communities. The Anandwan experience illustrates that locally grounded, dignity-centred models can address these dimensions simultaneously. Its relevance thus extends to a wide spectrum of health conditions characterized by chronicity, disability and stigma.

Conclusion

The evolution of leprosy care reflects a transition from segregation and custodial management to medical cure and, more recently, to social inclusion and rights-based rehabilitation. While multidrug therapy has addressed the infectious dimension of the disease, the persistence of disability, stigma and socio-economic exclusion demonstrates that biomedical advances alone are insufficient. Historical experience shows that the social consequences of leprosy often outlast bacteriological cure.

Within this trajectory, the rehabilitation model developed by Baba Amte at Anandwan represents a significant milestone. Emerging during an era dominated by isolation and charity, it introduced principles that anticipated modern community-based rehabilitation: dignity through productive work, self-reliance, family and community integration, and recognition of persons affected by leprosy as active social contributors rather than passive recipients of care. Its sustained functioning over decades illustrates the feasibility of locally rooted, economically productive and socially inclusive rehabilitation systems.

Comparison with other institutional, medical and project-based models highlights Anandwan's distinct emphasis on community ownership, livelihood integration and long-term sustainability. These features align closely with contemporary frameworks emphasizing participation, disability inclusion and people-centred health systems. The model's relevance extends beyond leprosy to other chronic and stigmatizing conditions such as tuberculosis, HIV, mental illness and non-communicable disease-related disability, where clinical management must be complemented by social rehabilitation.

In the post-elimination era, as global strategies move toward goals of zero discrimination and

full inclusion, the Anandwan experience provides practical and ethical guidance. It underscores that the ultimate objective of disease control is not merely cure, but restoration of dignity, opportunity and social belonging. Revisiting and adapting such historically grounded models may help bridge the gap between medical success and social justice in public health.

Acknowledgments

The authors gratefully acknowledge Maharogi Sewa Samiti, Warora, for granting permission to reproduce selected photographs from the Maharogi Sewa Samiti, Warora for academic publication. We sincerely thank Mr. Kaustubh Amte, Mr. Aniket Amte, and Dr. Pallavi Amte for their kind support and encouragement.

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How to cite this article : Laware SG, Gorde PL, Pawar SS et al (2026). *Baba Amte and the Evolution of Rehabilitation in Leprosy Care: Historical Context, Model Analysis and Contemporary Relevance.* *Indian J Lepr.* **98**: 283-294.