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# Catalysts Of Inclusion: The Contribution Of CBID-Trained Workers To Disability Inclusion In Rural Karnataka

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## ABSTRACT

Community-based inclusive development (CBID) is the rights-based strategy for persons with disabilities (PWDs) to promote inclusion and empowerment at the local level. The University of Melbourne and the Rehabilitation Council of India collaborated to design this curriculum. Notably, several people in India are persons with disabilities, particularly those living in rural regions, and face several obstacles and challenges. In rural Karnataka, the CBID program trains field-level staff, namely Village, Urban, and Municipality Rehabilitation Workers, to enhance inclusive practices in various fields like livelihood, health, and education. This study will evaluate the contribution of CBID workers advancing disability inclusion in rural Karnataka. The study used quantitative questionnaires to gather data on CBID workers' knowledge of the practical implementation of training efficiently, implementation strategies, encountering barriers, and tracking improvements. The study used a quantitative approach, a non-probability purposive sampling technique, and a descriptive Research design. 100 CBID workers from the rural part of Karnataka participated in this research.The result revealed that CBID workers have a solid understanding of disabilities, awareness, and promote community mobilisation and access. However, intersectoral coordination, accessibility, and ongoing community participation are still lacking. The study emphasizes that CBID implementations are potentially as well as difficult. Additionally, it ends with suggestions for improving infrastructure, expanding training support, and advancing monitoring mechanisms to strengthen the CBID interventions.

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Community–Based Inclusive Development, Rehabilitation workers, Disability Rights, Inclusive Practices, Empowerment, Persons with Disabilities.

## I. Introduction

Community-based inclusive development (CBID) is a rights-based, community-driven approach that builds on the foundation of community-based rehabilitation (CBR) to promote the full inclusion and participation of persons with disabilities in social, educational, health, and livelihood opportunities. Developed collaboratively by the Rehabilitation Council of India (RCI) and the University of Melbourne. CBID, which is based on Convention on the Rights of Persons with Disabilities (CRPD) (United Nations 2006) principles and the Sustainable Development Goals, emphasizes community engagement, self-advocacy, and strengthening disability organisations (World Health Organisation 2010) (Bachifischer, Escobar, and Cortes 2023). CBID workers are mostly volunteers and members of the disability communities who identify needs, facilitate referral, provide basic rehabilitation support, raise community awareness, and support advice and data collection to guide inclusive policies and practices. (Shakespeare et al. 2024).

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Social inclusion refers to the process of enabling all individuals to participate fully in social, economic, cultural, and political Life by addressing inequalities and removing barriers (Silver, 2015). In the context, persons with disabilities mean addressing physical, institutional, and attitudinal barriers that hinder access to education, healthcare, employment, and governance while performing dignity and active citizenship (Shakespeare 2018). Community-based inclusive development (CBID) is a structured framework to advance this goal by empowering persons with disabilities and their representative organisations, promoting community awareness, and making standard services and process decision-making more accessible (WHO 2010) (Bachifischer, Escobar, and Cortes 2023). Community-based inclusive development CBID plays an ideal role by supporting persons with disabilities to overcome the challenges in rural Karnataka. These challenges include poverty, inadequate infrastructure, and restricted access to services like health, education, and employment opportunities. By directing persons with disabilities to services boosting inclusive behaviours and advocating for them in local government, trained CBID workers play a critical role as facilitators, improving social inclusion at the grassroots level of society.

This study argues that while CBID training significantly strengthens grassroots disability facilitation, structural and institutional barriers continue to limit its transformative impact in rural governance systems.

## II. Literature Review

### Community-based inclusive development CBID as a strategy

Community-based inclusive development as a tool. A widely recognised approach to localised disability inclusion is community-based inclusive development. According to the CBR matrix, the CBID program in India was created by the Rehabilitation Council of India and Melbourne University. It places a significant value on community capacity building, multisectoral integration, and rights-based service delivery (World Health Organisation 2010). According to Shakespeare, Ndagire, and Seketi (2024), CBID-trained field workers are essential in analysing needs, eliminating barriers, and connecting people with disabilities to services and benefits. Additionally, according to Bachifischer, Escobar, and Cortes (2023), CBID-trained staff members promote sustained inclusion and community ownership at the grassroots level.

### Barriers to inclusion: Policy - Practice gap

Infrastructure constraints, attitude barriers, and a lack of disability sensitization remain obstacles to inclusion despite growing identification and strategy implementation. Praveen (2022) noted through an accessibility audit in Indian universities that these issues are increased in rural settings where CBID workers frequently serve as a primary support system for persons with disabilities. Hartley et al. (2009) additionally verify that inadequate resources and methodical oversight erode the viability of grassroots disability initiatives.

### Impact of CBID-trained personnel

In order to guarantee empowerment, Bhavan and Varghese 2020 emphasize that disability inclusion must go beyond service delivery. According to their research, having trained CBID workers is associated with greater disability awareness, better community involvement, and more access to social and educational services. According to Grills et al. (2021), sensitivity to contexts and interactive training boost people's competency, and self-assurance empowers them to successfully handle challenging local problems. In the study of rural Karnataka, Rao (2019) also discovered that CBID workers greatly lower barriers to government programmes and help people with disability especially in poverty alleviation.

### Persistent challenges in CBID implementation.

Procedural and social barriers continue to hamper the success of CBID. Punani et al. (2019) highlighted recurring challenges, including limited financial resources, limited assistive equipment, weak intersectoral coordination, and institutional opposition. Mitra (2018) reported a similar conclusion, noting that the resilience of local groups and the backing of external donors play a major role in the durability of the inclusion programme in rural areas. Collectively, these studies demonstrate the necessity of increasing institutional support, financial investment, and policy reinforcement for CBID's long-term effectiveness.

### Related studies

Particularly in rural setting community based inclusive development is becoming more widely acknowledged as a crucial strategy for increasing inclusion of persons with disabilities. In Karnataka, Kadekodi (2018) shifted from the conventional growth-oriented framework for development to an inclusive development approach, emphasizing the significance of integrating social economics and policy activities to meet the needs of marginalised communities. This paper offers a theoretical framework for analysing the CBID programme in rural areas and a conceptual knowledge of how inclusive policies might be operationalised within particular regional and socio-economic situations.
The practical results of CBID intervention have been studied empirically. The CDM India trust's experimental competency-based training programmes showed quantifiable gains in CBID-trained workers' abilities and expertise, highlighting the vital role that organised capacity development programmes play in raising field-level efficacy. Similar studies on community-based rehabilitation for persons with various mental illnesses in rural Karnataka demonstrate the beneficial effects of locally driven programmes, especially when combined with already existing community-level organisations like Accredited Social Health Activists (ASHAs). These studies highlight how crucial it is to provide field-level staff with both technical and participatory skills in order to guarantee the durability and dependability of CBID interventions.

Additionally, the rise of Community-Based Rehabilitation programmes throughout India demonstrates how the CBID programme adjusts to two regional issues, including resource limitation, social stigma, and inadequate infrastructure. The effectiveness of inclusive initiatives in enhancing accessibility, encouraging a social environment, and empowering people with disabilities through community funding approaches is documented in reports by organisations such as CBM Global 2024 and Mobility India. These initiative reflects the combined focus of CBID on strengthening individual capacities while increasing systematic change at the community level. CBID is a key model for promoting disability inclusion and rural settings because the literature as a whole highlights that its efficacy depends on a mix of piping core strategy, participatory engagement, and contact sensitivity implementation techniques.

## III. Methodology

The study took up a descriptive research design with a quantitative approach, non-probability purposive sampling technique, to examine the knowledge, strategy, and training efficiency, and the barriers of Community-Based Inclusive Development (CBID) in enhancing social inclusion for persons with disabilities in rural Karnataka. In order to capture the current practice and field-level reality among trained CBID-workers, the descriptive approach was appropriate. 100 CBID-trained workers who meet the inclusion criteria are engaged in this study. Voluntary participation and informed consent of participation were included in the study. A structured questionnaire was used to collect data. The tool included closed-ended questions that focused on four main categories, which were aligned with the objectives of the study. The tool was verified by subject experts for the questions' conceptual clarity and content dependability. Descriptive statistics, particularly frequency and percentage distribution, were used to evaluate the data to find trends and patterns of the respondents.

**Inclusion criteria:**

1. The respondent must be a CBID-trained worker
2. Working primarily in rural settings within Karnataka
3. Willing to provide informed concerns and participate in the study.

**Objectives:**

- To assess the knowledge and understanding of social inclusion among CBID-trained workers.
- To examine the strategies employed by CBID-trained workers to promote inclusion in education, health, and livelihood sectors.
- To evaluate the effectiveness of the CBID training in enhancing professional confidence and performance.
- To identify the challenges encountered by CBID-trained workers in implementing inclusive practices.
- To recommend improvements to the CBID training programme based on field insights and outcomes.

## IV. Analytical Discussion

The demographic profile of the respondents (N = 100) is presented in Table 4.1, demonstrating the varied representation across each gender, designation, and work experience. 51% of them are between the ages of 36 and 45; 26.5% are between the ages of 26 and 35; 16.3% are between the ages of 46 and 55; 6.2% are between the ages of 18 and 25; none are older than 56. This suggests that the majority of the respondents are professionals in mid of their careers who are actively involved in inclusive services and rehabilitation. There was a significant gender disparity in the rehabilitation workforce, with 75.6% of the participants being men and 24.4% being women. Village rehabilitation workers make up the majority 71.6% followed by urban rehabilitation workers, 14.4%, municipality rehabilitation workers, 10%, and teachers and special educators, 2% each. In terms of experience, 45.8% had worked for 4 to 6 years, 25% have worked for one to two three years, and 4.2% have worked for one year. Overall, the finding shows that the sample is mostly made up of season rehabilitation specialists, emphasizing a workforce with significant hands-on expertise in Community-Based Disability Inclusion.

**Table 4.1: Demographic details**

| Category | Subcategory | Frequency | Percentage |
|---|---|---|---|
| Age Group | 18–25 years | 6 | 6.20% |
| | 26–35 years | 27 | 26.50% |
| | 36–45 years | 51 | 51% |
| | 46-55 years | 16 | 16.30% |
| | 56 + years | 0 | 0% |
| **Total** | | **100** | **100** |

| | | | |
|---|---|---|---|
| Gender | Male | 76 | 75.60% |
| | Female | 24 | 24.40% |
| **Total** | | **100** | **100** |
| Designation | Village Rehabilitation Workers (VRW) | 72 | 71.60% |
| | Urban Rehabilitation Workers (URW) | 14 | 14.40% |
| | Municipality Rehabilitation Workers (MRW) | 10 | 10% |
| | Teacher | 2 | 2% |
| | Special Education | 2 | 2% |
| **Total** | | **100** | **100** |
| Years of Experience | one Year | 4 | 4.20% |
| | one–3 Years | 25 | 25% |
| | 4–6 Years | 46 | 45.80% |
| | 6 years and above | 25 | 25% |
| **Total** | | **100** | **100** |

*Source: Field Data (2025)*

**Table 4.2: Awareness and understanding of social inclusion among CBID workers**

| S. No. | Variables | Response Category | Frequency (f) | Percentage (%) |
|---|---|---|---|---|
| **1** | I can clearly define "social inclusion" in the context of disability. | Strongly Agree | 71 | 71% |
| | | Agree | 20 | 20% |
| | | Neutral | 5 | 5% |
| | | Disagree | 3 | 3% |

| | | | | |
|---|---|---|---|---|
| **2** | I am aware of inclusive education policies and provisions. | Strongly Agree | 63 | 63% |
| | | Agree | 20 | 20% |
| | | Neutral | 7 | 7% |
| | | Disagree | 8 | 8% |
| | | Strongly Disagree | 2 | 2% |
| **3** | I know how to identify physical, attitudinal, and systemic barriers for Persons with Disabilities. | Strongly Agree | 75 | 75% |
| | | Agree | 10 | 10% |
| | | Neutral | 5 | 5% |
| | | Disagree | 7 | 7% |
| | | Strongly Disagree | 3 | 3% |
| **4** | I am trained in rights-based approaches and advocacy for Persons with Disabilities. | Strongly Agree | 74 | 74% |
| | | Agree | 15 | 15% |
| | | Neutral | 4 | 4% |
| | | Disagree | 5 | 5% |
| | | Strongly Disagree | 2 | 2% |

Source: Field Data (2025)

The level of awareness and understanding of social intuitions among CBID-trained workers is displayed in Table 4.2. The result shows that a sizable majority of respondents 71% strongly agree that they can identify social inclusion in contexts with disabilities, demonstrating a solid conceptual understanding of inclusion. In a similar vein, 75% believe that they are able to recognise the systematic obstacles and physical attitude that people with disabilities encounter, demonstrating the successful application of knowledge gained from CBID training. Additionally, 74% of respondents strongly believed that they had received sufficient training in a rights-based approach and advocate for persons with disabilities, underscoring the programme's focus on legal awareness and empowerment. With 63% strongly agreeing, 20% agreeing, an understanding of inclusive education policies and provisions was somewhat lower, indicating that policy-specific sensitization has to be strengthened even further.

Overall. The result showed that although there are gaps in policy awareness and advertising implementation, CBID-trained workers have a high degree of awareness and comprehension of disability inclusion ideas. This suggests that in order to provide a thorough understanding and consistent field application, ongoing personal development and new training are necessary.

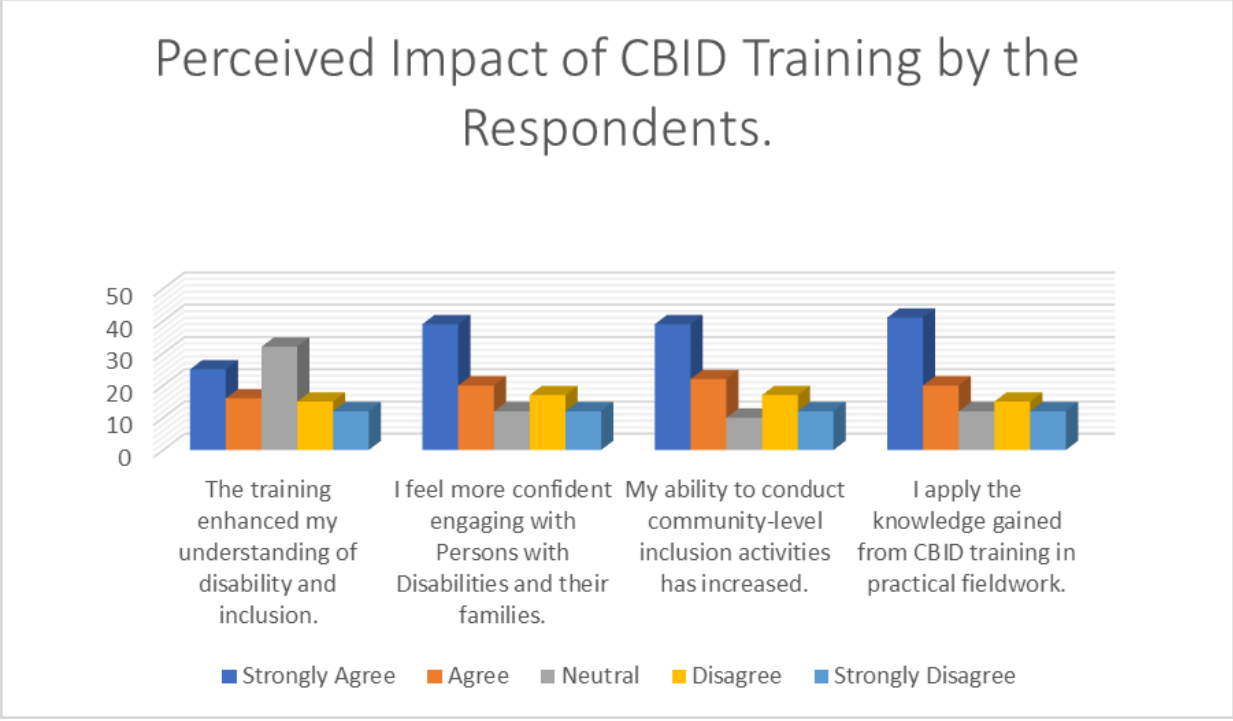
**Table 4.3: Implementation of inclusive strategies.**

| S. No. | Statements / Variables | Response Category | Frequency (f) | Percentage (%) |
|---|---|---|---|---|
| 1 | I have conducted awareness camps on disability rights. | Always | 67 | 67% |
| | | Often | 15 | 15% |
| | | Sometimes | 10 | 10% |
| | | Rarely | 6 | 6% |
| | | Never | 2 | 2% |
| 2 | I have supported school enrolment and retention of children with disabilities. | Always | 80 | 80% |
| | | Often | 10 | 10% |
| | | Sometimes | 6 | 6% |
| | | Rarely | 3 | 3% |
| | | Never | 1 | 1% |
| 3 | I have helped Persons with Disabilities access government schemes and ID cards. | Always | 92 | 92% |
| | | Often | 5 | 5% |
| | | Sometimes | 2 | 2% |
| | | Rarely | 1 | 1% |
| | | Never | 0 | 0% |

| S. No. | Statements / Variables | Response Category | Frequency (f) | Percentage (%) |
|---|---|---|---|---|
| 4 | I have referred Persons with Disabilities for medical/rehabilitation services. | Always | 71 | 71% |
| | | Often | 16 | 16% |
| | | Sometimes | 0 | 0% |
| | | Rarely | 0 | 0% |
| | | Never | 13 | 13% |
| 5 | I have facilitated inclusive livelihood training or employment linkage for Persons with Disabilities. | Strongly Agree | 67 | 67% |
| | | Agree | 14 | 14% |
| | | Neutral | 6 | 6% |
| | | Disagree | 0 | 0% |
| | | Strongly Disagree | 13 | 13% |

An examination of implementation strategies is presented in Table 4.3, which shows that CBID workers participate in promoting disability inclusion at the community level. 92% of respondents regularly help persons with disabilities with government programmes and ID cards, demonstrating their efficacy in enabling the delivery of entitlements. In a similar vein, 80% of respondents consistently support the enrolment and retention of children with disabilities in schools, indicating a strong commitment to inclusive education. Approximately 67% regularly plan disability rights awareness campaigns, demonstrating proactive communities and sensitization initiatives. Regular referrals of persons with disabilities to medical and Rehabilitation services, guarantee access to important health care support, were recorded by the majority, 71%. Only 67% of respondents correctly acknowledge that they have helped create inclusive livelihood or employment connections, indicating a relative lack of economic inclusion programmes. Overall, the findings show that workers with CBID training are successfully putting awareness, education, and service facilitation techniques into practice; nevertheless, livelihood inclusion still has to be strengthened through training, including mobilisation and intersectoral cooperation.

**Figure 4.1**




*Source: Field Data (2025)*

The perceived impact of CBID training across important domains is shown in Figure 4.1. 40.8% strongly agree or agree that the training has improved their comprehension of inclusion and disability. By contrast, 26.5% disagree or strongly disagree. In a similar vein, while 28.5% disagreed, 13.7% strongly agreed that they felt more comfortable interacting with persons with disabilities and their families. 38.7% of respondents strongly agreed with the statement on the capacity to carry out community-level inclusion efforts, while 28.5% once more expressed opposing views. In terms of using the knowledge obtained in real contexts, 40.8% firmly agreed, at 26.5% indicated dissatisfaction. Language challenges, educational background, or their capacity to internalize the material could all be contributing factors to this discrepancy. The absence of organised follow-up support to apply the training in real life might also be the reason for low impact.

## V. Key Findings

### 1.Strong role in Accessing Schemes and documentation

Notably, 91.8 % of respondents said they had assisted people with disabilities in accessing social welfare programme government-issued certificates, and Unique Disability IDs (UDID). In rural areas, where access entitlement is sometimes limited by administrative barriers and technological limitations, the position was particularly crucial. CBID workers act as mediators, helping to obtain these advantages and privileges. This result is consistent with Punani et al. (2019), highlighting that CBID workers frequently act as a system navigator for underprivileged groups.

**2. Inclusion in Gram Sabha and Social Participation**

The social participation of persons with disabilities has significantly increased, according to about 69.4% of respondents, especially in local forums like Grama Sabha meetings and large community-based activities. This demonstrates the process made in promoting active citizenship and creating the visibility and voice of persons with disabilities on public decision-making platforms. According to Bhavan and Varghese (2020), anyone's intuition requires not analyzing people to actively participate in civic and political processes, rather than only receiving services. This demonstrated how inclusion in a process has been successfully operationalised, supporting the more general objectives of equal representation, self-advocacy, and empowerment within the rural governance system.

**3. Strong Conceptual Understanding of Social Inclusion**

The majority of respondents with CBID training 70.9% demonstrated a precise and comprehensive grasp of the idea of social inclusion, especially in relation to disability. These responses clearly demonstrate the influence of successful training. This result is in line with Grills et al. (2021), highlighting the importance of interactive training in boosting confidence and competency.

**4.Engagement and disability rights advocate seat through awareness camps**

Around 67.3% of respondents with CBID training status reported that their communities actively post disability awareness campaigns. This reflex is a positive trend towards public sensitization, and vacancy at grassroot level, both of which are essential for destroying stigma, advancing rights-based viewpoints, and cultivating an inclusive attitude in society. Furthermore, Bhavan and Varghese (2020) stress that genuine inclusion necessitates not only service access but also active engagement and civic life and policy discourse.

**5.High referral to medical and rehabilitation services**

A higher proportion of respondents with CBID training 87.7% state that they have referred persons with disabilities to proper medical or rehabilitation services. Such involvement demonstrates the trainee's understanding of the availability of the service structure as well as the ability to serve as a successful liaison between the formal healthcare system and the community. The health component of the WHO Community Based Rehabilitation Matrix, which identifies important categories of inclusive development - health education, livelihood, social, environment, and empowerment -is supported by this finding (WHO, 2010). The finding also supports the findings of Grills et al. (2017) and Mitra et al. (2013), who highlighted the importance of community-based workers in promoting health access and decreasing systematic exclusion.

**6. Persistent barriers to implementation**

CBID-trained respondents reported many barriers that limit the effective implementation of inclusive development practices.

- Lack of community awareness 61.2 percent
- Insufficient funding and financial support mechanism 59.2%
- Inaccessible public infrastructure is 55.1%
- Shortage of assistive devices and Technology 44.9%
- Limited accessible transport facility 42.9%

These results are in line with Punani et al. (2019), who claim that CBID intervention runs the danger of becoming unsustainable if basic conceptual constraints are not addressed, particularly in rural and disadvantaged areas. As noted by Mitra et al. (2013), inadequate finance further restricts the community's intervention's scalability and continuity. Budget resources for localised disability initiatives are inconsistent or insufficient.

### 7.Active environment in school enrolment of students with disability

One of the encouraging outcomes is the active involvement of CBID-trained field workers in promoting inclusive education. Two-thirds of them responded that they have taken steps to support the enrolment and retention of children with disabilities in mainstream schools.

## VI. Scope Of The Study

The scope of this research income passes the assessment of community-based inclusive development CBID interventions, which aim at enhancing the social inclusion of a person with disabilities in rural Karnataka. It covers the practical application of inclusive development principles of village, urban, and municipality rehabilitation workers across key sectors including education, health, livelihood, and community participation. It extends to evaluate the capacity of field-level personnel to identify and address structural, social, and attitudinal issues and promote accessibility and implement the rights-based approach at the community level. The study also examines the operational effectiveness of CBID models, interesting intersectoral coordination, ensuring problem sustainability, and achieving measurable outcomes for persons with disabilities. By focusing on these aspects of the study, it is a framework for analysing the effectiveness gap and scale-up ability of CBID interventions, offering insights relevant to policymakers, practitioners, and training institutions. It also emphasizes the enhancement of inclusion, equity, and empowerment of persons with disabilities through evidence informed community level initiative by contributing to the broader objectives of sustainable and participatory development.

## VII. Limitations of the Study

Even though research alone offers valuable insights into the operation and effects of community-based inclusive development projects in rural Karnataka, it has major drawbacks. Its narrow focus on rural areas restricts applicability to other areas with diverse infrastructure or socio-cultural conditions. Second, the accuracy of stated practices and results may be impacted by subjective and possible responses by us if self-reported data from CBIB workers is relied upon. Third, additional aspects of disability inclusion, such as political engagement or cutting-edge treatment techniques, are not included because the scope is limited to particular sectors such as education, health, livelihood, and community participation. For the sample size and coverage potential were constrained by logistical and resource issues, which impacted the thoroughness of findings across all rural communities.

Variation and referred maybe introduced by training quality, individual experience, and local administrative support at the field levels of CBID workers, which limits the capacity to evaluate sustainability over a lengthy time frame. Despite these drawbacks, the study offers insightful information for programme enhancement and policy development about operational difficulties and field-level procedures. and conceptual obstacles in rural CBID implementations.

## VIII. Suggestions

The government can enhance the execution process of welfare schemes by creating local nodal officials for CBID workers and expediting entitlement access. Further, research into structures should include a blueprint that requires an accessibility audit in public institutions such as schools, Panchayat buildings, and Health Care centres. Integrated inclusive education must be built into the policy framework by requiring disability inclusion training for all government school teachers, assuring the availability of special educators, and providing accessible reading materials in regional languages. In addition to these initiatives, NGOs and civil society organisations can play an important role by developing rights-based community awareness campaigns using the local media, such as community radios, street banners, and posters, to reach the illiterate and rural people. On the other hand, these organisations can assist CBID employees by providing technical support, refresher training, and guidance in areas such as capacity building, policy advocacy, inclusive education approaches, and reference systems.

## IX. Conclusion

The study emphasizes the importance of CBID-trained workers in promoting the rights and inclusion of persons with disabilities by improving access to programmes, enhancing civic involvement, and supporting inclusive education and health activities. However, structural barriers such as a lack of awareness and financial constraints in service delivery continue to impair long-term success, particularly in rural communities. To solve the issues, coordinated efforts by the government, non-government organisations (NGOs), civil society, and DPOs are required, with a focus on disability inclusive planning, accessibility, infrastructure, and intersectoral collaboration. CBID, which is based on rights-based and participatory structure, has the potential to significantly increase the social, economic, and civic engagement of persons with disabilities, thereby contributing to a more equitable society.

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