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Changing THE WAY WE care SM

Social Cohesion for Disability Inclusion in Kenya

Binding, bonding and bridging to support children with disabilities to thrive in family care

April 2025

GHR FOUNDATION® UBS Optimus Foundation UBS YOU SHALL BE MY WITNESSES K.C.C.B Changing THE WAY WE care CRS CATHOLIC RELIEF SERVICES Maestral.

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Need to know more? Contact *Changing the Way We Care* at **info@ctwwc.org** or visit **changingthewaywecare.org.**

Changing The Way We Care℠ (CTWWC) is implemented by Catholic Relief Services and Maestral International, along with other global, national, and local partners working together to change the way we care for children around the world. Our principal global partners are the Better Care Network and Faith to Action. CTWWC is currently funded in part by Catholic Relief Services and the GHR Foundation.

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Executive Summary

Introduction

Changing the Way We Care (CTWWC) is a global initiative that promotes family care for children by strengthening national care systems. The Social Cohesion for Disability Inclusion Approach, implemented in Kenya, aims to prevent child-family separation due to stigma and discrimination against children with disabilities. The approach uses Catholic Relief Services' (CRS) 3B/4D methodology, combining Appreciative Inquiry with **binding, bonding** and **bridging** techniques to transform relationships and promote disability inclusion. This approach fosters acceptance, support and improved community-based services for children with disabilities and their caregivers.

The Social Cohesion for Disability Inclusion Approach was implemented by CTWWC and the Kenya Council of Catholic Bishops in Kisumu and Mombasa. The project began in September 2023 and included three phases: training of trainers (TOT), community sessions and connector activities. The TOT ensured that future facilitators understood the approach and were capable of mobilizing community members and caregivers. Community sessions engaged over 370 community members and caregivers of children with disabilities through separate workshops focused on disability perspectives, self-care and community inclusion. Connector activities included interactions to raise awareness, build empathy and provide support.

The project piloted the social cohesion approach within a care reform agenda, aiming to explore its potential to support families through Catholic dioceses, parishes and small Christian communities. The learning agenda focused on three areas: the extent of curriculum implementation; changes in knowledge, attitudes, and behaviors among community members; and changes among caregivers of children with disabilities.

Methodology

Monitoring the pilot involved various data collection methods, including pre/post-tests, supervisor checklists, facilitator after-action reviews, participant feedback forms, post-session interviews for TOTs and community sessions, and reflections and interviews for connector activities. The data collection sought to understand session implementation, participant engagement, and changes in knowledge, attitudes and behaviors. Despite some limitations (e.g., delays in implementation and literacy challenges), the data provided valuable insights into the effectiveness of the intervention and its impact on the community.

Findings

Learning Question 1: To what extent is the social cohesion content/curriculum implemented as designed?

The **TOT** was well received, with participants feeling equipped with new insights and a clear understanding of the social cohesion approach. They expressed confidence in leading the approach and requested more time for deeper exploration of subjects. Participants were excited about the training and felt the need to practice what they had learned; however, holding one central training with over 50 participants, and then dispersing the training within two separate archdioceses, made ongoing support difficult. Ongoing support was deemed critical to ensure knowledge translated into practice.

Community sessions received positive feedback from mentors, facilitators and participants. The timing and duration of sessions were generally welcomed, though some sessions were longer than intended

when participants had much to share. The facilitation style was learner-centered, participatory and inclusive. Facilitators, some with disabilities, created a safe space for honest conversations, shifting attitudes and providing encouragement. The curriculum was largely followed, with adjustments for clarity and relevance, including translation into local languages. Participation was high, with attendees actively engaging in discussions and sharing experiences. Despite some challenges (e.g., late starts and translation difficulties), participants reported high satisfaction with the sessions.

Recommendations for improvement included adding content on government disability policies, mental health challenges and inclusive caregiving strategies. Improving translation quality and simplifying feedback forms were also suggested. Ensuring sessions accommodated persons with disabilities by providing assistive devices and supporting childcare and transportation needs was recommended. Participants expressed a desire for broader disability awareness campaigns in schools, churches, community forums and radio stations.

Overall, the sessions fostered a positive and inclusive environment, promoting respectful and inclusive communication and ensuring caregivers of children with disabilities felt valued and heard.

Learning question 2: To what extent do select knowledge, attitudes and behaviors change among community members over the duration of the social cohesion intervention?

The community sessions and connector activities led to significant changes in knowledge, attitudes and practices among community members regarding disability inclusion. Participants learned about the rights of children with disabilities and the challenges faced by their caregivers. This new knowledge translated into a shift in attitudes, with community members embracing and supporting children with disabilities rather than stigmatizing them. Community members and caregivers formed support groups and engaged in economic-strengthening activities. Churches made physical improvements to enhance accessibility, and community members began playing a vital role as ambassadors for disability inclusion.

Community members are now more connected with families of people with disabilities and are better placed to support and engage them. Community members are actively supporting caregivers to enroll their children in schools and technical schools, to be assessed and registered with the National Council of Persons with Disabilities (NCPwD) (at least 300 assessments and over 40 registrations were recorded), and to help families with their agricultural and economic initiatives. Together, community members and caregivers in Mombasa have started three self-help groups and other economic-strengthening activities including small businesses and shared agricultural projects. Churches have undertaken physical improvements to improve accessibility (e.g., ramps installed and toilets modified), and as a result of training for church leaders, there has been some improvement in including children and adults with disabilities. This means that children who were previously left at home are now being taken to Mass and Sunday school and are being included in social events.

"Personally, the training has completely changed how I view disability. I used to believe the harmful myths—that children with disabilities were the result of sacrifices for wealth. But now, I see things differently." – community member, Mombasa

"During the training, I met many community members who I already knew, but I did not know they had children with disabilities. I was surprised to learn they had such children. Now, I bring these families closer, encourage them to register with NCPwD, and support them." – community member, Mombasa

"Before, neighbors' children never visited my home. Now, they come and play with my child. The community has started accepting my child as a creation of God, just like any other child." – caregiver, Kisumu

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Learning question 3: To what extent do select knowledge, attitudes and behaviors change among caregivers over the duration of the social cohesion intervention?

The community sessions and connector activities led to shifts in caregiver understanding and knowledge of disability inclusion. Participants learned the importance of self-care for reducing stress and maintaining mental health. They gained awareness of available community support, such as government programs, churches and nongovernmental organizations (NGO). Caregivers reported changes in their attitudes, viewing children with disabilities as blessings rather than burdens. They gained confidence in caring for their children and felt empowered to advocate for their rights. Support groups and financial self-help groups were formed, fostering new connections and reducing feelings of isolation. Caregivers began seeking assessments, therapy and school enrollment for their children, leading to a more inclusive community.

"I've changed since the training. Even when people speak to me harshly, I don't take it personally—I've become more resilient." – caregiver, Kisumu

"I'm proud that people now call me Mama [Jonathan] instead of using hurtful names. [He] is my firstborn, and I'm proud of him. We are now invited to community events, and I feel confident speaking about disability. Our [savings] group helps us share bills and support each other. Members even help me take care of [my son] for short errands, though not for long periods." – caregiver, Mombasa

"I finally enrolled my child in school. I used to pity him and worry that he wouldn't benefit or might get hurt because of his cerebral palsy. But once I took that step, I realized that there are other children with even more severe disabilities who are thriving. That gave me hope." – caregiver, Mombasa

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Conclusion

The pilot project demonstrated the effectiveness of the Social Cohesion for Disability Inclusion Approach in supporting and promoting the inclusion of children with disabilities. Community sessions and connector activities led to significant positive outcomes for children, caregivers and the wider community. Caregivers felt more supported and able to access services, while both community members and caregivers gained new insights and shifted their attitudes to be more positive. Although direct connections to reintegration or foster care placements were not established, the approach showed potential for future care reform efforts.

Recommendations

The aim of this pilot project was to test the Social Cohesion for Disability Inclusion Approach within the context of Kenya's care reform journey with the support of the Catholic Church and to generate lessons to inform future use.

For the Catholic Church in Kenya, it is recommended to:

- Present key learnings at the Bishops' Plenary Meeting along with practical suggestions for scaling the social cohesion approach.
- Scale across existing archdioceses by developing a roadmap for spreading the Social Cohesion for Disability Inclusion Approach through existing systems.
- Adapt Social Cohesion for Disability Inclusion materials to better suit participants' language and literacy, and incorporate local examples and faith-based references.
- Leverage Catholic radio and social media platforms, and design flyers and posters to share disability inclusion messages.
- Utilize chiefs' barazas, churches, community groups and market centers as effective platforms to share disability inclusion messages.
- Support role modeling and leadership amongst caregivers and persons with disabilities, showing inclusion is possible and breaking down barriers and misconceptions.
- Strengthen or introduce diocesan disability policies in light of social cohesion learnings, highlighting successful outcomes and practices that can be scaled.
- In addition, within the wider care reform efforts in Kenya and beyond, it is recommended to:
- Use the social cohesion approach alongside the reintegration of children from residential care and the development of family-based alternative care to support inclusion of children with disabilities and their caregivers.
- Consider the social cohesion approach when planning future service models for the transition of residential care facilities.

Introduction

Changing the Way We Care

Changing the Way We Care (CTWWC) is a global initiative designed to promote safe, nurturing family care for children. The initiative seeks to support the strengthening of national care systems for children, so that the systems can prioritize family care through supporting family strengthening, promoting family reintegration and family-based alternative care, and transforming residential care into family and community services. CTWWC is implemented by Catholic Relief Services (CRS) and Maestral International through a Global Development Alliance (GDA), which previously included USAID and still includes GHR Foundation and partners in national governments and national and local civil society and faith-based organizations, including Lumos Foundation, Better Care Network, Faith to Action and many others.

Social Cohesion for Disability Inclusion Approach

Children with disabilities must be central to any care reform approach as they are at increased risk of experiencing violence, abuse and neglect, including stigma and discrimination, all of which act as barriers to accessing services and push them into alternative care, often leaving them behind in reintegration processes. This vulnerability stems from societal misconceptions and limited understanding of, and stigma around, disability and inaccessible environments. To address this challenge, CTWWC Kenya and partners within the Catholic Church have implemented the Social Cohesion for Disability Inclusion Approach. The approach aims to promote disability inclusion to prevent child-family separation driven by violence, specifically stigma and discrimination perpetuated by families, service providers and community members. Further, the approach aims to contribute greater acceptance of, and support for, children with disabilities and their caregivers as well as improved community-based services for children with disabilities and their caregivers.

The Social Cohesion for Disability Inclusion Approach builds on CRS' signature social cohesion 3B/4D methodology,[1] which combines Appreciative Inquiry with the 3Bs peacebuilding methodology: binding, bonding and bridging. The 3Bs methodology guides the process of transforming relationships. **Binding** focuses on personal reflection and healing, fostering self-awareness and transformation. **Bonding** encourages building connections within groups through shared experiences and commonalities. **Bridging** aims to bridge divides between different groups through dialogue, collaboration and joint action. Appreciative Inquiry is a strengths-based approach that focuses on “finding the gold within” by building upon strengths and positive attributes that exist in each situation rather than framing the situation as a problem to be fixed. This approach is particularly relevant for disability inclusion, as it promotes understanding and appreciation of individual capabilities beyond perceived limitations.

Process

CTWWC implemented the Social Cohesion for Disability Inclusion Approach in conjunction with the Kenya Conference of Catholic Bishops (KCCB) in two archdioceses: Kisumu and Mombasa. The project began in September 2023 with the adaptation of the 3B/4D training manual to make it more specific to the context, needs and expected outcomes of the project. This was followed by three phases of intervention:

[1] CRS (2022) The Ties that Bind: Building Social Cohesion in Divided Communities https://ics.crs.org/resource/ties-bind-building-social-cohesion-divided-communities

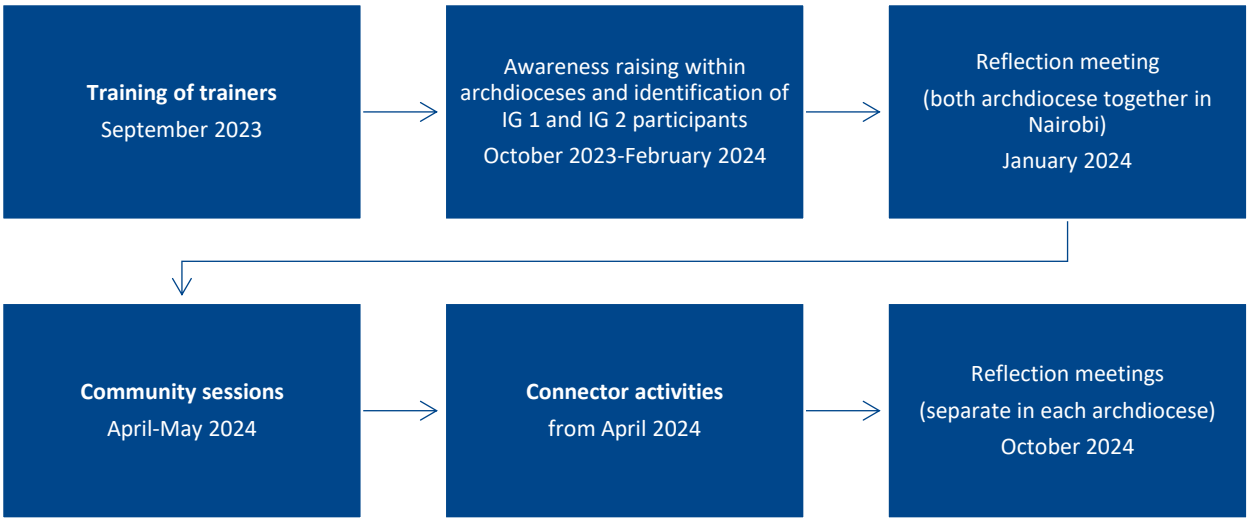
- **Training of trainers (TOT) and mobilization**: A four-day training aimed at ensuring participants understood the 3B/4D approach and disability inclusion principles and had the capacity to mobilize and facilitate community members and caregivers.
- **Community sessions**: A series of workshops structured around the 3Bs and Appreciative Inquiry (see Table 1) that engaged two identity groups: (1) community members, including potential foster parents, relatives, neighbors and local leaders and (2) caregivers of children with disabilities, including families at risk of separation.
- **Connector activities**: Iterative interactions to normalize inclusive behaviors, raise awareness and build empathy that included: one-on-one interactions between community leaders and caregivers of children with disabilities to raise and address issues for support, child sitting by neighbors and awareness sessions during community gatherings. Importantly, the form of each connector activity was determined by individual caregivers to meet their needs and preferences.

Separate workshops were held for each group to reflect on their experiences of, and perspectives about, disability. Caregivers focused on developing self-care skills, mapping community resources and envisioning a more inclusive future for their children with disabilities. Community members engaged in activities to understand and address stigma and discrimination, map community barriers and envision an inclusive community. Both groups continued to meet separately to deepen their understanding of disability rights, barriers and strategies for promoting inclusion. The two groups came together to share their visions, insights and experiences. Connector activities were planned and implemented collaboratively.

Table 1: Outline of community sessions (from the Training of Trainers handbook)

Community members (IG1)	**Caregivers of children with disabilities (IG2)**
• Focus is on sparking empathy for children with disabilities, raising awareness on disability and its impact, and reflecting on the value and feasibility of alternative family care for children with disabilities. • Sessions should be scheduled close to each other in a compressed timeframe (e.g., full-day or half-day sessions on sequential days or as close as possible).	• Focus is on self-care practices, reflection on experience of disability and realizing others have similar experiences. • Two-hour sessions; childcare needs to be available. Sessions can be scheduled according to people's availability over a few days or a few weeks; the goal is iterative sessions to give caregivers time and space for reflection, practicing self-care methods and strengthening bonds among themselves.
Binding Module 1: Reflecting on disability (attitudes)	**Binding**: Module 1: Reflecting on disability (experience)
Bonding Module 2: Models of disability	**Binding**: Module 2: Self-care exercises
Bonding/Bridging: Module 3: Disability etiquette	**Binding /Bonding:** Module 3: Reflecting on caregiving
Binding/Bonding: Module 4: Strengths-based approach	**Binding**: Module 4: Stress management
Bonding: Module 5: Disability rights	**Bonding**: Module 5: Providing mutual support
Bonding: Module 6: Social model: Barriers	**Bonding**: Module 6: Models of disability
Bonding: Module 7: Community barrier map	**Bonding**: Module 7: Disability rights
Bonding/Bridging: Module 8: Disability inclusion	**Bonding**: Module 8: Navigating barriers
Bonding: Module 9: Understanding stigma	**Bonding**: Module 9: Stigma & discrimination
Bonding: Module 10: Stigma reduction	**Bonding**: Module 10: Community Barrier Map
Bonding: Module 11: Community Resource Map	**Bonding**: Module 11: Community Resource Map
Bonding/Bridging: Module 12: Visioning	**Bonding /Bridging**: Module 12: Visioning

Figure 1: Timeline of key activities in the social cohesion process



Participants

In both Kisumu and Mombasa Archdioceses, the training and community rollout involved government officers from the National Council of Persons with Disabilities (NCPwD), representatives of organizations of persons with disabilities and other related resources, such as community health promoters, nurses, teachers, sign language interpreters and community leaders, all of whom are pivotal members of the community when it comes to embracing disability inclusion. Although the intervention was led by teams from the archdioceses, the community sessions targeted participants from various denominations of the Christian and Muslim faiths and prospective foster parents. In total, 373 people participated, which included 170 community members and 203 caregivers of children with disabilities (see Table 2).

Table 2: Number of participants

		Number of community members (IG1)			Number of caregivers (IG2)		
Archdiocese	**County**	**M**	**F**	**Total**	**M**	**F**	**Total**
Kisumu	Siaya	24	23	47	21	34	55
	Kisumu	13	9	21	7	19	26
	Total	**37**	**32**	**69**	**28**	**53**	**81**
Mombasa	Mombasa	14	30	44	14	50	64
	Taita Taveta	16	14	30	7	25	32
	Giriama	8	19	27	6	20	26
	Total	**38**	**63**	**101**	**27**	**95**	**122**

Learning agenda

This project was a pilot of the social cohesion approach within the context of care reform. Given that, there is a desire to learn about its implementation and the outcomes generated. Therefore, a learning agenda was developed with the overarching question of, "To what extent do Catholic dioceses, parishes and other small Christian communities' knowledge, attitudes and behavior change because of social cohesion intervention training?" Specifically, the learning agenda aims to answer three questions:

- **Learning Question 1**: To what extent is the social cohesion content/curriculum implemented as designed?
- **Learning Question 2**: To what extent do select knowledge, attitudes and behaviors change among community members (IG1 participants) over the duration of social cohesion interventions? In this case, "community members" refers to those in small Christian communities under the Catholic Church, relatives and neighbors of children with disabilities, local leaders and other influential figures.

- **Learning Question 3**: To what extent do select caregivers' knowledge, attitude and behaviors (IG2) change over the duration of the intervention? In this case, "caregivers" refers to parents, kinship caregivers and foster parents of children with disabilities who are part of small Christian communities under the Catholic Church.

These questions will structure the findings of this report.

Methodology

Across the three stages of the intervention (TOTs, community sessions and connector activities), various data collection methods were used to help generate insights to answer the learning questions. These were:

- **TOTs**: Pre/post-tests.
- **Community sessions**: Supervisor checklists, facilitator after-action reviews, participant feedback forms and participant post-session interviews.
- **Connector activities**: Reflections and interviews.

Table 3: Community Session Data Collection Methods and Sample Size

Method	Sample size in each location
Supervisor checklists	Mombasa: 11 sessions
Facilitator after-action review	Mombasa: 16 sessions
Participant feedback forms	Mombasa: 39 participants
Participant pre/post-tests	Mombasa: 18 community members, 16 caregivers Kisumu: 30 community members, 37 caregivers
Participant post-session interviews	Mombasa: 22 community members, 44 caregivers Kisumu: 9 community members, 12 caregivers

Community session checklists, after-action reviews and feedback forms sought to understand how the sessions were implemented and what did or did not go well from the point of view of the supervisors, facilitators and participants. Trainers used supervisor checklists to guide mentors in evaluating session facilitators. The checklists included 10 questions to help supervisors reflect on how the session was conducted, the facilitator's style and participant engagement. Alongside this tool was an after-action review completed by the supervisor and facilitator together at the end of a session. It guided a short discussion around what had or had not gone well, any changes that were made and a thought exercise to suggest improvements for following sessions. Participant feedback forms were completed by all participants at the end of sessions to gather insights about the session timing, facilitation, content and any recommendations or requests they had.

Community session pre/post-tests were different for caregivers and community members. They involved 10–12 short statements about disability rated on a 5-point scale that ranged from "strongly agree" to "strongly disagree." The statements included perceptions and knowledge of disability, the way caregivers look after their children and seek support, and how communities and local leaders can support families. Session participants were asked to complete the same set of questions at the start and end of the sessions to see if their responses changed.

Post-session interviews were held once all sessions were completed and were designed to gather feedback on session content and to go deeper into what participants learned and how they felt their

attitudes and behaviors had changed. These interviews were different for each identity group with the focus of the questions reflecting the content of the sessions.

Once connector activities began, reflections were held with participants in the community. An after-action review was also held with participation from CTWWC, KCCB and trainers and facilitators drawn from within relevant Church structures (e.g., Family Life Desks [the structures within the Church that provide leadership for work with families] and Charitable Children's Institutions [CCIs—residential care providers for children]). The reflections and reviews sought to understand the initial impact of the connector activities. Specifically, they provided an opportunity to reflect on activity implementation and changes observed in the communities due to working through the social cohesion process.

Due to disruption to project implementation (following termination of a USAID award for the wider work of CTWWC), the final stage of data collection involving interviews with community members and caregivers did not take place until August 2025, over a year after connector activities began. These interviews were an opportunity to hear from participants about changes they experienced or observed in their community over the previous year. Given the delay, a second round of reflection workshops was also held with facilitators to share the initial findings from the earlier data collection for their review and input, and to learn about the sustainability of outcomes.

Limitations

The social cohesion intervention and its linked data collection, especially given that it was a pilot, faced some limitations that should be noted as the report is read. The partnership approach meant that some delays in implementation occurred. As a result the linkage between implementation of the planned approach and the data collected timeline were not concurrent. Some data collection was not possible in Kisumu, some data collection tools were not used at the intended time and some participants struggled with completing the tools due to literacy levels and the length of the tools. These limitations were taken into consideration during analysis and in the results presented in this report.

Findings

Learning Question 1: To what extent is the social cohesion content/curriculum implemented as designed?

Training of Trainers

The TOT was well received by participants. They felt well equipped with new insights and a clear understanding and expressed confidence in the social cohesion approach they were to lead (see Figure 2). They found the content and training approach to be very positive (see Figure 3), with the only request being to have more time to allow them to go into greater depth on some subjects. In addition, participants felt excited about the training and felt the need to practice what they had learned. They also felt they would like to meet again to reflect on experiences and have a refresher (this eventually happened). However, it was also noted that holding one central training with over 50 people, and then having the facilitators return to two separate archdioceses and disperse the training further within those archdioceses, made ongoing support difficult. To this point, ongoing support was also felt to be critical to ensuring that knowledge gained translated into practice.

Figure 2: Percentage of Trainers Responding Positively to Pre- and Post-Test Questions (pre n=51, post n=41)

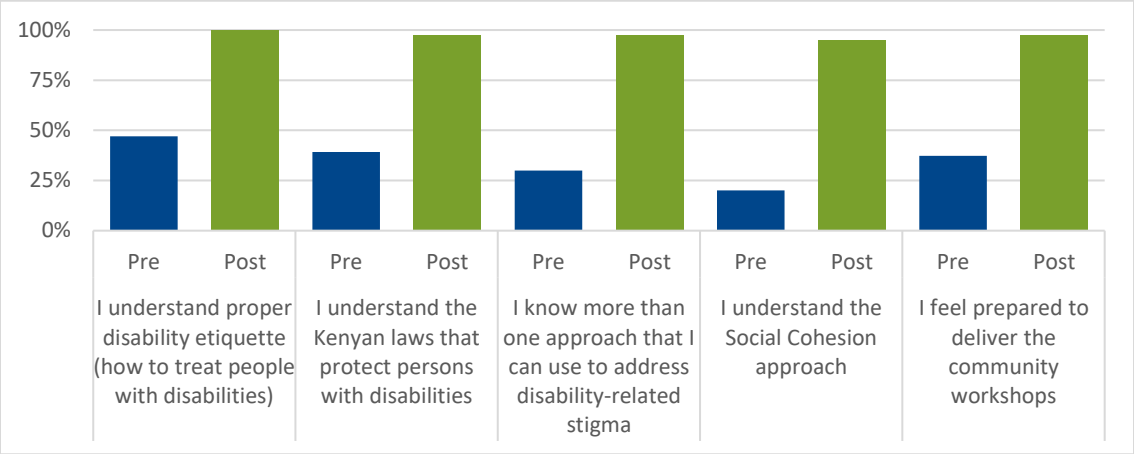
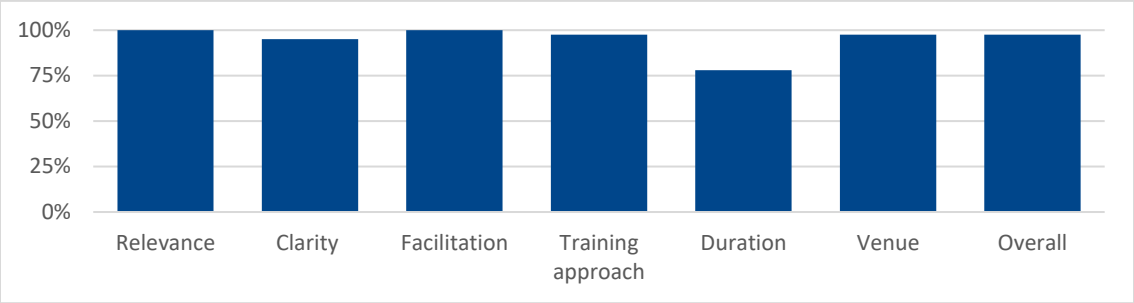


Figure 3: Percentage of trainers responding positively to session format at end of workshop (n=41)



Community Sessions

The feedback from mentors, facilitators/trainers and participants on how community sessions were implemented was largely positive.

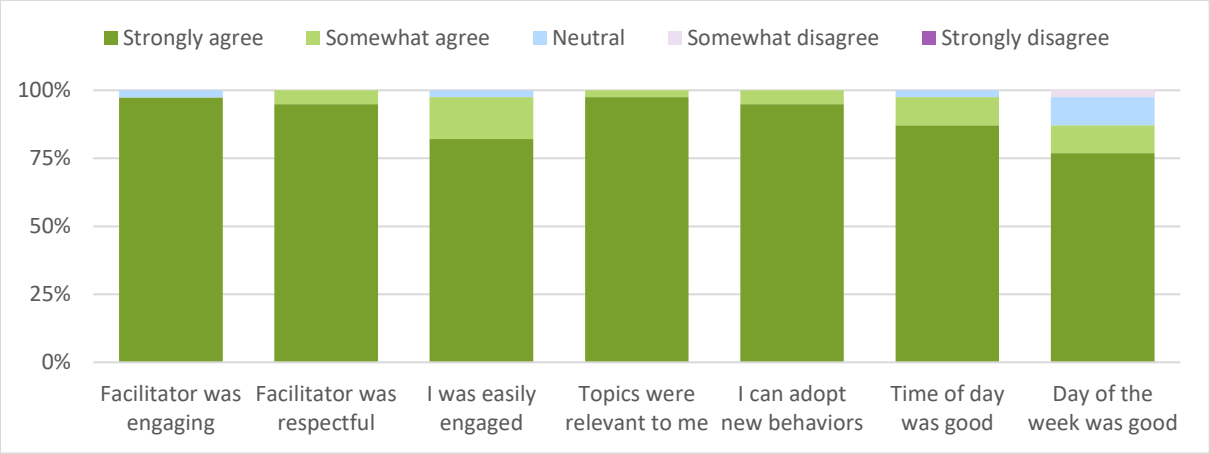
The timing and duration of the sessions were welcomed by participants. Most sessions were completed within the designed 30–60 minute duration, however, some extended to two hours when participants had a lot to share. Still other participants felt the sessions could have been longer to allow for deeper discussion of the material. Mentors and participants felt that the facilitation style was learner-centered, highly participatory and fostered an inclusive and engaging environment. Facilitators were approachable, empathetic and adaptable, adjusting their delivery to meet the diverse needs of participants. Some facilitators were themselves people with disabilities and their involvement made a significant impact. It was observed that participants were able to relate to these facilitators, they were able to create a safe space for honest conversations, and their presence shifted attitudes and provided encouragement. In some locations, where there was no facilitator with a disability, participants questioned the lack of representation. All facilitators encouraged active participation, creating spaces where individuals felt comfortable sharing their experiences. Humor and real-life examples were skillfully used to ease discussions on sensitive topics, while faith-based messages helped strengthen connections with participants. Facilitators also ensured the use of appropriate disability etiquette, promoting respectful and inclusive communication throughout the sessions. This approach was pivotal in maintaining high levels of engagement and ensuring that caregivers of children with disabilities felt valued and heard.

The curriculum was largely followed as designed, with only a few small adjustments to ensure clarity and relevance for all participants, particularly to address challenges posed by low literacy levels. Facilitators translated materials into local languages (e.g., Giriama, Dholuo, Kiswahili and Kikamba) to bridge literacy gaps and enhance comprehension. Facilitators and participants with disabilities were able to help with

translation and adaptation of content, especially around key terminologies and etiquette. This was seen to motivate others and reinforce respectful and inclusive communication. Some sessions were delivered with a sign language interpreter, but not all participants with hearing impairment were able to communicate in this way. Real-life examples and local and faith-based references were incorporated to make the material more accessible and applicable to participants' daily lives. As some groups were a mix of Christian and Muslim participants (in Mombasa), when Biblical references were used, similar verses from the Qur'an were also provided by participants. This highlighted the shared values between the faiths and was a unifying factor in the groups. This approach of including local examples and faith references ensured that the content was not only relevant, but also resonated deeply with participants, enhancing their understanding and participation.

Participation was consistently high throughout the sessions, with attendees actively engaging in discussions and sharing personal experiences. Despite some participants arriving late, they remained committed and fully involved in the sessions. The flexible session structure allowed those who arrived late to catch up, maintaining full participation. Participants reported a high level of satisfaction with the sessions (see Figure 4), finding the content relevant, easy to understand, engaging and informative. They felt strongly that the knowledge gained could be actioned and turned into new behaviors (as shown in the findings under the learning questions in the next sections). It was clear that participants felt eager to do more and embrace their newfound insights. They appreciated the facilitators' respectful and knowledgeable approach, their ability to adapt to ensure that everyone understood the materials and the creation of a safe environment where everyone felt encouraged to share and discuss.

Figure 4: Participant Feedback on Community Sessions, Percentage of Each Response Option (n=39)



While the sessions were generally successful, a few challenges emerged. Some sessions started late due to participants' long travel distances or need to arrange childcare. These delays occasionally resulted in extended session times. Additionally, certain technical terms and legal concepts were difficult to translate into local languages, creating comprehension challenges for some participants. Minor adjustments to feedback forms and a need for more in-depth exploration of specific topics were also highlighted as areas for improvement.

Recommendations for improvements include:

- **Content:** Include more content on government disability policies, mental health challenges, autism and non-speaking disabilities, inclusive caregiving strategies and the social model of disability.
- **Language:** Improve translation quality, particularly Kiswahili, and simplify feedback forms to match participants' literacy levels for better comprehension.

- **Inclusivity:** Ensure sessions accommodate persons with disabilities by providing assistive devices, such as Braille and sign language interpreters, and support the provision of childcare arrangements and transport when needed.

Feedback for future steps from participants also included requests to hold additional and more frequent sessions with wider engagements to foster societal change. While community outreach for greater disability inclusion began during the pilot project (see the sections below), at the close of the community sessions the participants expressed a desire to see broader disability awareness campaigns in schools, churches, community-based forums and radio stations.

Learning question 2: To what extent do select knowledge, attitudes and behaviors change among the community members over the duration of the social cohesion intervention?

The community sessions and connector activities led to many community members gaining new knowledge in relation to disability inclusion. The interviews and reflection sessions showed that community members found the sessions educational and thought-provoking. They recognized that children with disabilities have a right to equal opportunities and learned about the struggles that caregivers and their children with disabilities face in their day-to-day lives to access these opportunities. Participants reported that they now understand the need for extensive support for parents and caregivers, including counseling, proper equipment to assist their children and the importance of treating them with patience and respect. There was a noticeable shift toward a "person-first" approach when addressing individuals with disabilities, recognizing their humanity and individuality beyond their condition. Community members were keen to receive more learning opportunities and extend these opportunities to more participants in their community.

This knowledge translated into changes in attitudes amongst community members. It was reported that there was an evident shift in community mindsets toward persons with disabilities, with community members embracing children with disabilities rather than stigmatizing them. Community members reported having an increased appreciation for the talents and capabilities of children with disabilities, reinforcing the attitude that impairment does not automatically equate to inability. Participants adopted a more inclusive mindset, emphasizing the importance of not separating children with disabilities from the rest of the community and expressed a stronger commitment to being positive and supportive toward them.

> *"Personally, the training has completely changed how I view disability. I used to believe the harmful myths—that children with disabilities were the result of sacrifices for wealth. But now, I see things differently." – community member, Mombasa*

The interviews and reflections contained evidence of emerging practices amongst community members and leaders within the church. Community members are now more connected with families of people with disabilities and are better placed to support and engage them.

> *"During the training, I met many community members who I already knew, but I did not know they had children with disabilities. I was surprised to learn they had such children. Now, I bring these families closer, encourage them to register with NCPwD, and support them." – community member, Mombasa*

"Hearing directly from parents who are raising children with disabilities gave me a new perspective and strengthened my courage to engage more openly with the parents I work with. Following the training, I also took the initiative to speak with children and teachers in regular schools about how to treat persons with disabilities with respect and dignity." – community member, Mombasa

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It was reported that community members were actively supporting caregivers to enroll their children in schools and technical schools, to be assessed and registered with the NCPwD (at least 300 assessments and over 40 registrations were recorded), and to help families with their agricultural and economic initiatives. Together, community members and caregivers in Mombasa have started three self-help groups and other economic-strengthening activities like small businesses and shared agricultural projects. Churches undertook physical improvements to improve accessibility (e.g., ramps installed and toilets modified), and as a result of training for church leaders, there has been some improvement in including children and adults with disabilities. This means that children who were previously left at home are now being taken to Mass and Sunday school and being included in social events.

"We formed a support group and received special recognition in church. The church community has become more aware of how to support persons with disabilities—for example, by providing designated seating areas to accommodate their needs." – community member, Mombasa

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Community members began playing a vital role as ambassadors by sharing the knowledge they gained with others. As a result, facilitators received invitations to provide further sensitization sessions at churches and schools.

"We actively engage communities by sharing information in churches, market centers and through local groups. In the past, children with disabilities were often abandoned at rehabilitation centers, but through continuous sensitization we've empowered persons with disabilities." – community member, Kisumu

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Caregivers commented that they felt community members had become more accepting of them and their children. They mentioned how their neighbors, both adults and children, would more readily visit and engage with them, and even provide care for children to allow the caregiver to work or travel.

"Before, neighbors' children never visited my home. Now, they come and play with my child. The community has started accepting my child as a creation of God, just like any other child." – caregiver, Kisumu

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"We also shared lessons on self-care practices, and to my surprise, my neighbors even helped care for my child for a whole week when I needed to travel up country. I used to be afraid to leave him alone, but now I feel confident knowing others can step in when needed." – caregiver, Mombasa

"There's been a big change. Before, people used to hide children with disabilities and didn't want them to mix with others. Now, I can put my child in a wheelchair and other children come to play with her. They even share their food with us. People no longer see us just through the fence—they interact and include us." – caregiver, Mombasa

These insights are reflected in the survey results, which community members responded to at the beginning and end of the community sessions. The results are mixed, but there are some positive shifts in the knowledge, attitudes and practices of community members (full results visuals in Annex A). Responses that show the biggest changes were in response to statements about:

- Knowing that children with disabilities have a right to education and health care and that beating is not effective in improving a child's behavior (knowledge).
- Believing local leaders should educate their communities about disabilities, hiding children with disabilities does not protect them and children with disabilities should be invited to community events (attitudes).

In addition, responses to certain statements under the learning question 2 saw a reduction in the most positive response option (Strongly Agree) in favor of the second most positive option (Somewhat Agree) (see figure 4), whilst the total of the two positive response options (Strongly Agree and Somewhat Agree) did not change significantly. This slight shift indicated that participants were not as well informed as they believed or that there was more they could be doing.

Learning question 3: To what extent do select knowledge, attitudes and behaviors change among caregivers over the duration of the social cohesion intervention?

The community sessions and connector activities led to shifts in caregivers' understanding and knowledge of disability inclusion. In the feedback forms, interviews and reflection sessions, participants reported recognizing the importance of prioritizing their own well-being, learning that self-care is essential for reducing stress, maintaining mental health and being effective caregivers. They shared that practices such as exercise, social activities, prayer and self-love are ways to take care of themselves. Caregivers reported gaining awareness of the support available in their communities, such as government programs, churches and nongovernmental organizations (NGO), which provide financial assistance, counseling and advocacy. They understood that support is available to those who seek it. They learned about the concept of disability inclusion, that children with disabilities should not be hidden, that disability can affect anyone at any time in life, and the importance of patiently explaining the needs of their children to overcome barriers to services. They mentioned learning to think more positively and finding a balance between seeking help and fostering independence.

The feedback from caregivers and observations from facilitators also revealed shifts in their attitudes towards disability inclusion. Caregivers who arrived weighed down by their struggles underwent a visible transformation, becoming more engaged and gaining a more positive outlook. Caregivers reported changes in their beliefs and feelings toward their children. They mentioned coming to believe that children with disabilities are not a burden, but a blessing and that all children should be treated with dignity and all have been created for a purpose. One caregiver, who had been in deep denial, confessed that she had once considered poisoning her child. However, after attending the sessions, she embraced and accepted her child, developing a newfound love and appreciation for her. Another participant shared that, during her school days, she had mistreated children with disabilities—ignoring, pushing and

abusing them. After attending the training, she came to understand the importance of treating children with disabilities with the same dignity and respect as other children.

"I've changed since the training. Even when people speak to me harshly, I don't take it personally—I've become more resilient." – caregiver, Kisumu

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Caregivers also reported gaining confidence in caring for their children because of sharing experiences and practical insights, which validated their efforts and helped them build new relationships with other caregivers, diminishing feelings of isolation and inadequacy. They gained a sense of empowerment in caring for their children, a greater openness to reaching out for assistance and a firm belief in their capacity to inform their communities about the rights and needs of children with disabilities, empowering them to become advocates for greater understanding and inclusivity.

"I'm proud that people now call me Mama [Jonathan] instead of using hurtful names. [He] is my firstborn, and I'm proud of him. We are now invited to community events, and I feel confident speaking about disability. Our [savings] group helps us share bills and support each other. Members even help me take care of [my son] for short errands, though not for long periods." – caregiver, Mombasa

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Finally, the interviews and feedback from caregivers and reflections from facilitators highlighted some initial ways in which caregivers' practices were shifting. It was reported that caregivers were more willing to walk confidently with their children, no longer feeling ashamed. They reported having greater patience with their children and noted a strengthened bond between themselves and their children. Caregivers began coming forward for assessments, therapy and rehabilitation for their children, and began seeking other services such as birth registration and even enrollment at school.

"I finally enrolled my child in school. I used to pity him and worry that he wouldn't benefit or might get hurt because of his cerebral palsy. But once I took that step, I realized that there are other children with even more severe disabilities who are thriving. That gave me hope." – caregiver, Mombasa

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Support groups were formed as safe spaces to share experiences and advice, and financial self-help groups were also created and registered under the Directorate of Social Development. The new connections built between caregivers and with the wider community are allowing for more people to come forward and seek support.

"I feel the community is becoming more accepting of children with disabilities. Recently, someone called me for advice after their child was born with hydrocephalus, just like mine. It felt good to help." – caregiver, Mombasa

"I'm no longer embarrassed to take my child to school. I've met other caregivers I knew before, but didn't realize they had children with disabilities. Now we call and support each other when one of us is struggling." – caregiver, Mombasa

These insights are backed up in the quantitative results from caregiver surveys undertaken at the beginning and end of the community sessions. Overall, the results show a positive shift across all caregivers in knowledge, attitudes and practices (full results visuals in Annex A). Responses that show the biggest changes were in response to statements about:

- Knowing their child had a right to education and where to get help (knowledge).
- Feeling isolated (attitudes).
- Being included by their community, being able to ask for help, and loving and accepting their child (practices).

Conclusion

Overall, this pilot project has shown that the Social Cohesion for Disability Inclusion Approach is useful in providing support for, and promoting inclusion of, children with disabilities. Community sessions with community members and caregivers of children with disabilities, followed by connector activities, have led to significant outcomes for children, caregivers and their wider community, including mobilizing community members to continue advancing disability inclusion beyond the project intervention. The pilot project successfully helped caregivers feel more supported and able to access services, whilst both community members and caregivers gained new insights and began to shift their attitudes to be more positive.

"There has been a noticeable shift in how people perceive and treat us. Where we were once labeled as witches, we are now recognized and accepted by the church and the wider community. This recognition has brought a sense of dignity and belonging. Personally, I've grown in self-acceptance and now take better care of myself. The training provided to community members has helped bridge gaps; they are now more supportive and understanding. In the past, disability was seen as a curse. Today, people understand that disability is not a result of bad luck, but a part of life." – caregiver, Mombasa

Although it was not possible to directly connect this pilot project to the reintegration of children from residential care or the placement of children into foster care, there is potential to make this connection, especially where it is church-affiliated residential care providers that are transitioning their service model to provide alternative family-based care or family-strengthening support. The Social Cohesion for Disability Inclusion Approach will be a useful tool in ensuring that children with disabilities are not left behind by care reform efforts but are placed at the center and fully included.

Recommendations for the Future

The aim of this pilot project was to test the Social Cohesion for Disability Inclusion Approach within the context of Kenya's care reform journey with the support of the Catholic Church. It is hoped that the lessons learned from this pilot will inform future use of the approach in support of disability inclusive care reform in Kenya and beyond.

For the Catholic Church in Kenya , the participants in the pilot made the following recommendations:

- **Present key learnings at the Bishops' Plenary Meeting** along with practical suggestions, such as scaling the social cohesion approach, inclusive catechism, sacrament access and infrastructure improvements.
- **Scale across existing archdioceses** by developing a roadmap for spreading the Social Cohesion for Disability Inclusion Approach through existing systems (priests' Annual General Meeting [AGM], deanery, Caritas meetings) and providing logistical support for social cohesion ambassadors to reach more communities across the two archdioceses, including equipping them with printed and digital materials for effective message-sharing.
- **Adapt Social Cohesion for Disability Inclusion materials** to better suit participants' language and literacy and incorporate local examples and faith-based references suitable for the context (e.g., Biblical references for use with Christian communities).
- **Leverage Catholic radio and social media platforms** and design flyers and posters to share disability inclusion messages, stories and educational content across parish and youth audiences.
- **Utilize chiefs' barazas, churches, community groups and market centers** as effective platforms to share disability inclusion messages and stories, with active involvement of both caregivers and children during awareness sessions.
- **Support role modeling and leadership amongst** caregivers and persons with disabilities, showing inclusion is possible and breaking down barriers and misconceptions.
- **Strengthen or introduce diocesan disability policies** in light of social cohesion learnings, highlighting successful outcomes and practices that can be scaled.

In addition, within the wider care reform efforts in Kenya and beyond, it is recommended to explore:

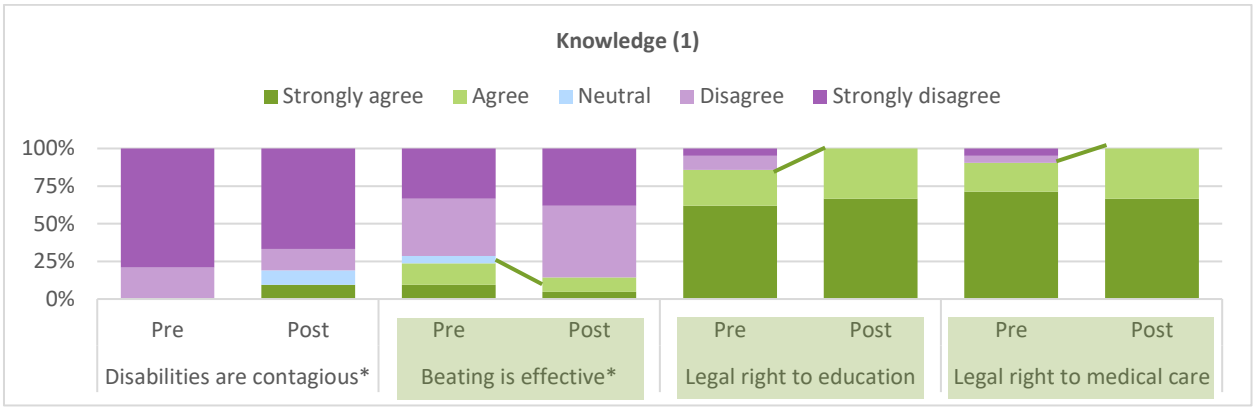
- Implementation of the social cohesion approach alongside the reintegration of children from residential care into their families and the development of foster care or other family-based alternative care to ensure that these forms of care are open to children with disabilities and that their caregivers receive the support they need. This could include further exploring the use of this approach within Muslim communities where Kafaalah is being promoted.
- Undertaking the social cohesion approach alongside the transitioning of residential care facilities and incorporating the approach into new family-based and community-facing service models that may result from the transition process. This could be specific to the Catholic Church, as in this pilot, which is affiliated with many residential care facilities in Kenya and around the world, but also with non-faith-based care facilities.

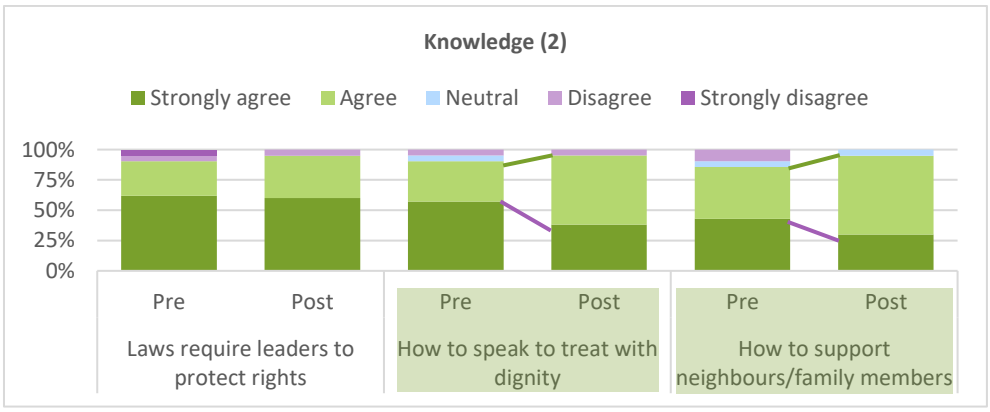
Annex A: Pre/Post-Knowledge, Attitudes and Practices Survey Results Visuals

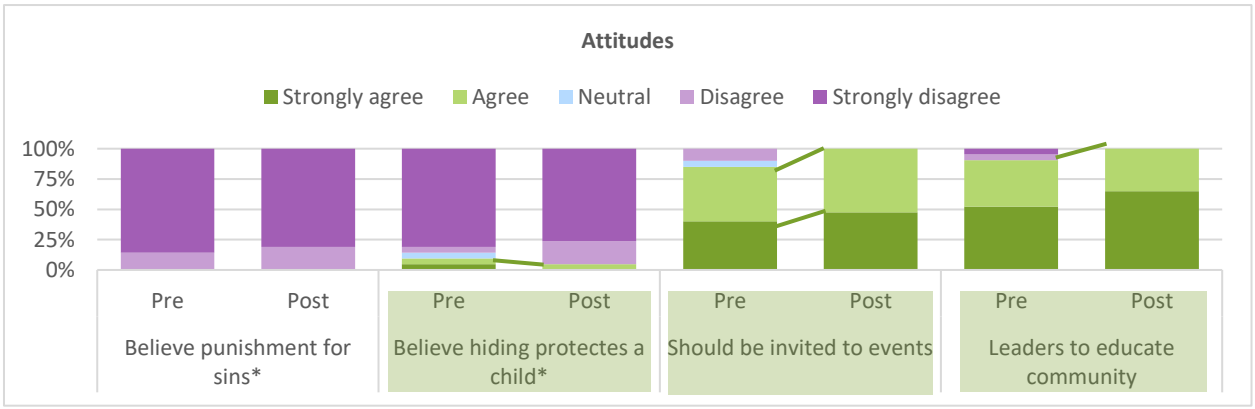
Community members

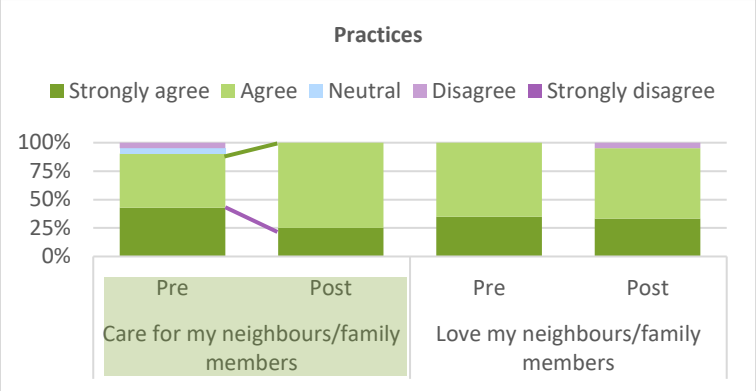
Each graph shows the percentage of community members (n=21) who responded to each category with statements ranging from "strongly agree" to "strongly disagree" for each statement in either their pre- or post-test. Some statements (indicated with *) were phrased in the negative so that "strongly disagree" is the most positive answer, and a positive shift is an increase in disagreement with the statement.

Green highlights and lines show statements where the responses had a +9% positive shift between pre- and post-tests. Purple lines show statements where the responses had a significant negative shift in the most positive category, signifying that respondents realized they were not as well informed as they thought and still had more to learn, or that they were not doing as much as they could.









Caregivers

Each graph shows the percentage of caregivers (n=25) who responded to each category with statements ranging from "strongly agree" to "strongly disagree" for each statement in either their pre- or post-test. Some statements (indicated with *) were phrased in the negative so that "strongly disagree" is the most positive answer, and a positive shift is an increase in disagreement with the statement. Green highlights and lines show statements where the responses had a +9% positive shift between pre- and post-tests.