


## Beyond Disability: An Intersectional Process for Promoting Community-Based Inclusive Development in Kenya

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2026: Vol 1(1), pp. 42-66

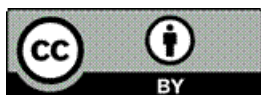
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*Received: 18/12/2025, Revised: 12/03/2026, Accepted: 01/04/2026*



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# **Beyond Disability: An Intersectional Process for Promoting Community-Based Inclusive Development in Kenya**

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## **ABSTRACT**

The aim of Community-Based Inclusive Development (CBID) is to empower marginalized people to be fully engaged in the local, social and economic life especially those with a disability. Nevertheless, the conventional CBID methods may pose the threat of homogenization; they cannot respond to the intersection of disability with gender, ethnicity, poverty and age that produce compound exclusion. This paper includes the conceptual framework of intersectional advocacy that connects the theory of intersectionality and the community-based action. Using a literature review on social justice, community psychology, and human rights-based practices to examine how advocacy, through an intersectional lens, can reconstruct structural power imbalances at the local level, the paper demonstrates the effectiveness of advocacy as a tool to build a community-focused intervention. The results indicate that intersectional advocacy is more than mere inclusion of the marginalized groups; it involves a transition to more transformative and bottom-up approaches that consider the particular, interdependent needs of those who are most behind. This paper suggests the use of a three-fold framework, which includes intersectional awareness, coalition solidarity, and localized praxis, to inform practitioners on how to apply an inclusive development especially responsive to the complexity of the human identity. This strategy is crucial towards the development of truly equal communities where CBID is not a one-fits-all model, but a more precise, justice-based system.

**Keywords:** Intersectionality; Community-Based Inclusive Development (CBID); Advocacy; Social Justice; Marginalization; Empowerment

## **INTRODUCTION**

### **Background**

Community-Based Inclusive Development (CBID), is a community-based approach to empowering persons with disabilities (PWDs) take active part in every aspect of local life (Aldersey et al., 2023; Ahmed et al., 2024). As an outcome of the conceived guidelines by the World Health Organization (WHO), the International Labour Organization (ILO), and UNESCO, in the year 2010, CBID has become a rights-based framework that focuses on the community

ownership, multi-sectoral work and integration of PWDs into health, education, livelihoods, social and empowerment sectors (Sserunkuma, Locoro, & Ddamulira, 2023; Okello, 2024). CBID functions in both rural and urban settings in Kenya, using the available resources in the area to overcome obstacles to inclusion and foster sustainable change by involving people in participatory activities.

This approach aligns with the greater post-Convention on the Rights of Persons with Disabilities (CRPD) paradigm. Kenya, being among the early ratifiers of the CRPD in May 2008, used its principles via domestic legislature in Article 2(6) of the 2010 Constitution which also incorporated the treaties that had been ratified as Kenyan law (Owiti, 2024; Ali, 2023). The CRPD also changes the paradigm of disability to human rights-based model that requires the state to remove any form of discrimination, maintain good accessibility, and facilitate full participation of individuals in the society (Articles 5, 9, 19, 24-28) (Thukia, 2025). This is embodied in the policies in Kenya, including the National Policy on Persons with Disabilities (revised versions since 2015) and county-level ones, where CBID is a feasible tool to implement CRPD requirements (Okello, 2024; Ali, 2023). Focusing on making decisions around PWDs and their organizations (OPDs) helps the CRPD focus on dignity, autonomy, and non-discrimination, helping Kenya meet its Vision 2030 and Sustainable Development Goals commitments to leave no one behind.

### **Problem Statement**

Despite its advantages, the traditional CBID implementation in Kenya often adopts a homogenized approach to disability, the PWDs being treated as a homogenous group and the interventions based on impairment as the priority rather than the interplay of overlapping identities (Thukia, 2025). This omission does not recognize disability as intersecting with gender, ethnicity, poverty, age among other signifiers to provide an add-on of exclusion and unique marginalization experiences. To illustrate, rural Kenyan societies that have women with disabilities are likely to have magnified barriers due to patriarchal norms, low rates of economic activity, and caregiving academic burden, and individuals in ethnic minority or living in abject poverty face additional degrees of stigmatisation and resource pain.

This division has resulted in advocacy that remains a silo advocacy, only paying attention to the disability rights and not other forms of oppression, which leads to a partial inclusion. The number of layers of marginalization experienced by women, indigenous people or poor households are so

many that most of them are under served and the poverty, violence and marginalization cycles are perpetuated (Aldersey et al., 2023). Research in Kenya and the Global South underscores the failure of traditional CBR/CBID practices to break down structural power structures that exacerbate existing disparities in educational, livelihood, and justice access (Okello, 2024; Thukia, 2025). The possibility of transforming CBID with this model that suits all is debilitating and leaving the most marginalized even more marginalized is further complicating the development of better communities with no chance of equality.

### **Purpose**

This paper argues that there should be the use of an intersectional lens when advocating CBID so that it can be more effective, responsive, and transformative. This intervention aims to re-direct the advocacy towards generic inclusion to context-specific advocacy that responds to compounded realities of multiple-marginalized PWDs in Kenya, by integrating intersectionality, or how different, overlapping systems of power produce experiences of disadvantage. Finally, it will attempt to promote more inclusive, equitable, and justice-based community-based development.

### **Research Question/Argument**

The primary question in this query is: How can the intersectional advocacy frameworks be made to empower Community-Based Inclusive Development (CBID) to more effectively address persons with disabilities (PWDs) and other marginalized community members in Kenya?

The main argument is that introducing intersectionality into the advocacy of CBID creates the opportunity to transform the surface involvement into the structural change. Intersectional advocacy methodically charts intersecting oppressions (disability coupled with gender, ethnicity, and poverty), focuses lived experiences of the most excluded, and puts into practice the theory of equity, power analysis, and multiplicity of knowledge systems in daily practice. In Kenyan contexts, it will be the challenge of top-down models, coalition-building across OPDs, women and anti-poverty efforts and intersectional audit inclusion in CBID elements (health, education, livelihoods).

By doing so, advocacy will be more inclusive and effective, breaking the barriers that the traditional approach does not pay attention to and such bottom-up empowerment is encouraged. This does not only promote CRPD implementation but also helps towards strong and balanced

communities where no one will be left behind as required by the constitutional imperatives in Kenya and the global justice agendas. The suggested framework provides viable ways through which practitioners, policymakers, and OPDs can pursue truly inclusive development.

## **THEORETICAL FRAMEWORK AND LITERATURE REVIEW**

### **Conceptualizing Intersectional Advocacy**

Conceptualized forms of oppression can be analyzed through the critical lens of intersectionality, which Crenshaw (1989) offers in her analysis as the shortcomings of anti-discrimination law in addressing the issues of Black women, who are regarded as the mutually exclusive categories (Razia & Chhimwal, 2022; Altındış, 2025). Crenshaw showed that single-axis models are not effective to understand the experiences of single individuals in the middle of two or more marginalized identities. This notion was further developed as the matrix of domination by Patricia Hill Collins (1990, 2000) when it is seen that interlocking systems of power, which include race, class, gender, sexuality and ability, exist at structural, disciplinary, hegemonic and interpersonal tiers to form lived realities (Collins, 1990; Altındış, 2025).

Intersectional advocacy as a concept has been used in disability advocacy to describe the very conscious practices adopted by persons with disabilities organizations (OPDs) and other civil society participants to intertwine policies, programs and issues in a manner that directly reflects and addresses PWDs with multiple identities (Aldersey et al., 2023; Brinkman et al., 2022). Instead of looking at disability as a unitary classification, intersectional advocacy charts the dynamics of disability and gender, ethnicity, poverty, age, and geographic location to generate varying access points and obstacles (Kabia et al., 2019). For example, a physically challenged woman in a marginalized ethnic group in rural Kenya does not just have to face ableism, but also gendered work-related caregiving burdens, ethnic discrimination in resource distribution, and poverty-induced marginalization in decision-making areas (Michael, 2025). Organizations thus use an intersectional coalition-building model to form their alliances based on disability, gender, and anti-poverty movements to demand comprehensive policy responses.

Crenshaw and Collins are transposed by African disability scholars and practitioners to the realities of post-colonial societies, where neoliberal development and the legacies of colonialism alongside customary law contribute to the intensification of intersecting exclusions (Collins, 1990;

Crenshaw, 1989; Ned, 2022; Michael, 2025). In Kenya, intersectional advocacy is becoming more common among OPDs, including the Association for the Physically Disabled of Kenya (APDK) and women-with-disabilities networks, which do power analyses each time a policy is being formulated, focus on the narratives of lived experience of multiple-marginalized groups, and insist on disaggregated data to represent the intersections of identities, not aggregate disability statistics (Michael, 2025; Kabia et al., 2019). This strategy changes advocacy as a silo advocacy, impairment-specific campaign to transformative praxis, which disrupts structural power hierarchies (Brinkman et al., 2022; Ned, 2022). Intersectional advocacy by connecting national policies (CRPD domestication) and local realities makes sure that the advocacy structures do not simply append the voices of the marginalized but radically restructure who is represented and how power is redistributed in the community-based development processes.

### **The Evolution of CBID**

Community-Based Rehabilitation (CBR) started in the late 1970s under WHO as a way of offering basic rehabilitation services meant to reach populations in low-resource environments that were underserved, which was largely based on the medical model of disability (Ayalew et al., 2020). Early CBR was interested in impairment reduction by community-based health workers, typically in a charity or welfare paradigm. This narrow approach was constrained, however, by the 1980s and 1990s a gradual transition was brought about by the inability of this approach to deal with social obstacles, poverty, and rights. The CBR multi-sectoral approach to equalization of opportunities and social inclusion was proposed in the 2004 joint position paper by ILO, UNESCO, and WHO redefined the term CBR (International Labour Office, United Nations Educational, Scientific and Cultural Organization, & World Health Organization, 2004).

The pivotal transformation was the implementation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2006 and the introduction of CBR Guidelines in 2010 (ILO, UNESCO, & WHO, 2004.; Ayalew et al., 2020). These principles brought in the CBR matrix, which consists of five interlinked pillars, such as Health, Education, Livelihood, Social, and Empowerment, clearly placing the strategy within a human rights-based paradigm. This development developed the name Community-Based Inclusive Development (CBID) to highlight this change, in which community ownership, removal of barriers, and full involvement of PWDs as rights-givers and not recipients is emphasized (Michael, 2025). CBID is, therefore, a rights-

based, multi-sectoral and transformative approach in line with the twin-track approach of CRPD: mainstreaming disability and empowering OPDs.

In Kenya, CBR was first implemented in the 1980s by the Ministry of Health to supplement institutional services and create an attitude change in the community (National Policy for Persons with Disabilities, 2016 draft). The National Council of Persons with Disabilities (NCPWD) was founded by the Persons with Disabilities Act No. 14 of 2003, and offered a legal basis regarding interventions at the level of community (ILO, UNESCO, & WHO, 2004). In 2016, the revision of the National Policy on Persons with Disabilities (based on the 2006 original) was explicitly a deliberate abandonment of the charity ethos in favour of the human rights and development approach with reference to Kenya having ratified the CRPD, the adoption of the Constitution of Kenya 2010 (Articles 27, 54, 260), and the social pillar flagship on disability mainstreaming in Vision 2030 (Michael, 2025). Vision 2030 also incorporated the disability aspect with the inclusion of disability with the National Development Fund, cash transfers to severe disabilities and employment quota of 5%.

Future developments such as county-level implementation frameworks and the National Plan of Action (2015-2022) formalized the ideas of CBID through encouragement of community-based habilitation, inclusive education and participatory planning. This trend indicates Kenya keeping pace with global trends: initially, a medically and top-down-focused rehabilitation to the rights-based and community-owned inclusive development that puts PWDs in the forefront of the local governance and sustainability development.

### **Intersectionality in Development**

A growing body of literature describes the convergence of disability, gender, ethnicity, poverty, and age in the context of community development and especially in the Global South. Intersectional analyses have shown that these identities are not additive but multiplicative in that they have distinctly different ways of reducing exclusion and improving resilience of marginalized people (Crenshaw, 1989; Collins, 2000). In African contexts, scholarship identifies the way in which disability exacerbates gendered traps of poverty and cultural stigmas and violence of structures.

In Kenya, Kabia et al. (2018) conduct an exemplary intersectional study of pro-poor health financing policy and show that poor women with disabilities experience compounding barriers: restrictions on mobility and decision-making due to gendered norms and costs and stigma due to disability hinder service access, even in the context of schemes such as the National Hospital Insurance Fund. Their qualitative analysis of urban and rural counties demonstrated the intersectional positioning that creates the triple jeopardy, namely poor, female, and disabled means worse enrollment, increasing spending out-of-pocket, and worse health outcomes. Likewise, the research on gender-based violence (Making it Work, 2018) reports women and girls with disabilities in Kenya and in general Africa being especially vulnerable to sexual abuse, economic exploitation, and neglect due to a combination of disability and patriarchal control, as well as, dependency caused by poverty (ILO, UNESCO, & WHO, 2004; Michael, 2025).

These tendencies are supported by wider African scholarship. In their multi-country research in Africa, Eide and Ingstad (2011) reveal a vicious cycle of poverty and disability and how ethnic marginalization in pastoralism societies and vulnerabilities of older people with disabilities compound each other. Intersecting identities in communities include lack of access to livelihood programmes (women with disabilities excluded in microfinance as risky), education (girls with disabilities being singly stigmatised in rural schools), and on-the-basis (elderly PWDs being isolated because of ageism and ableism) (Ingstad & Eide, 2011; Kabia et al., 2018). Kenyan and East African studies also point out contextual influences: customary law of certain ethnic groups that undervalues disabled female bodies, scarcity of resources caused by climate which disproportionately affects disabled pastoralists, and it is the migration to the city that disintegrates traditional support systems (Kabia et al., 2018; Making it Work, 2018).

These studies highlight the fact that any community development efforts that overlook intersections are likely to reproduce inequality. Where intersectionality is used, such as in a selection of OPD-led initiatives aimed at women with disabilities in SRHR or economic empowerment, the results are better due to the ability to offer a context-sensitive intervention that encompasses the power dynamics on household, community, and policy (Making it Work, 2018; Bunning, Gona, Newton, & Hartley, 2022). The literature therefore forms a strong theoretical and empirical basis of why disability-inclusive development should be intersectional in order to ensure equitable achievements within Kenyan community contexts.

## **Gaps in Current Literature**

While the intersectionality literature and the CBID/CBR literature are both broad and comprehensive, there are serious gaps in their understanding in application within the practical operational advocacy models concerning community-based applications (Bunning, Gona, Newton, & Hartley, 2022). The two terms are typically considered on a parallel basis instead of synthesis in the majority of studies: disability scholarship tends to use intersectionality to examine experiences, statement gaps in policy (Kabia et al., 2018), whereas CBID literature concentrates on the implementation of matrices, scale, and rights-based surveillance without including the systematic analysis of intersectional power structures (ILO, UNESCO, & WHO, 2004).

Few research provides practical and testable models integrating intersectional concepts, including equity audit, lived-experience centering, and multi-axis power mapping, into the commonly used CBID matrix elements (Health, Education, Livelihoods, Social, Empowerment) (Bachfischer et al., 2023; Richard, 2024). Empirical literature in the Kenyan and African context in general is still mostly descriptive or appraisal of individual-issue intervention, and little has been done to understand how OPDs and community actors can operationalize intersectionality to practice advocacy in daily life (International Labour Organization, 2025). The current Kenyan policy resources (National Policy for Persons with Disabilities, 2016; Vision 2030) recognize several vulnerabilities without going further to give actionable intersectional tools to the CBID practitioners.

This fragmentation creates an advocacy that is siloed in its approach with disability programs failing to acknowledge gendered or ethnic aspects and gender or poverty programs failing to acknowledge disability. As a result, multiple-marginalized PWDs such as rural women with disabilities of ethnic minorities, etc. still remain programmatic fallouts (Bunning, Gona, Newton, & Hartley, 2022; Richard, 2024). The literature thus does not provide rigorous, context-sensitive models that would change the intersectional theory into quantifiable CBID indicators, coalition strategies, and bottom-up monitoring systems that can be applied to Kenyan counties (Bachfischer et al., 2023; Richard, 2024). It is important to fill this gap to realize the transition between conceptual recognition and transformative and sustainable inclusive development.

## **ANALYSIS: INTERSECTIONAL ADVOCACY IN CBID**

### **Mapping Marginalization in Communities**

Kenyan communities are founded on patriarchal hierarchies, ethnic hierarchies, and ableist ideologies, as well as socioeconomic stratifications, which systematically create overlapping stigmatizations of persons with disabilities (PWDs) (Musyoka, 2024; Rotich, Funder, & Marani, 2023). Such structures do not exist independently, but instead, they intersect to create a compounding effect through the matrix of domination in which disability overlaps with gender, ethnicity, poverty, and urban-rural residence to create distinct experiences of exclusion. Cultural conceptualizations of disability as a curse or divine punishment are still widespread in rural settings (although they are less common in urban ones), especially among pastoralist ethnic groups in Turkana, Maasai, or Samburu (Rotich, Funder, & Marani, 2023; van Koppen, Mweemba, Amarnath, & Schreiner, 2024). The physical impairment of a rural female who belongs to a marginalized ethnic group, therefore, presents both ableist rejection of her body as a non-productive entity, gender expectations of an individual confined to the unpaid labor of the household (four hours a day compared to 1.5 by men), and ethnic discrimination in resource distribution during droughts or more community-based decision-making (van Koppen, Mweemba, Amarnath, & Schreiner, 2024). The outcome of this triple jeopardy is an increased social isolation among rural PWDs, who more than 60% indicated that they are excluded by their respective community centers and civic life (Kabia et al., 2018; Ackerman et al., 2025).

Ethical structures in urban settings are equally challenging. The urban refugee women and girls with disabilities who constitute a large percentage of the urban population of 65,100 registered urban refugees (79 percent women and children, 2017) are particularly vulnerable to sexual and gender-based violence (SGBV) because of the combination of refugee status, disability, and gender. They are considered low down in the society, and vulnerable conditions are increased by the obstacles to emergency services, SRHR, and communication (Making It Work, 2018; ILO, UNESCO, & WHO, 2004). COVAW baseline (cited in Making It Work, 2018) estimates that 57% of women/girls with intellectual disabilities in Nairobi and Kiambu counties report sexual abuse, 83% of all women and girls with disabilities experience domestic violence in the country in lifetime, and 2 times that of non-disabled women. These stigmas are amplified by poverty. PWDs are 38% poor (5.7% less than in 2019 but still 8 points above the 30% national level) and twice as

many women with disabilities have no jobs and are in low-value informal jobs (United Nations Development Programme, 2025; International Labour Organization, 2025).

In both contexts, ethnicity intersects. In rural Luo or Luhya societies, the traditional law can devalue the disabled women, limiting their chances of inheriting or being married, whereas in urban ethnic enclaves, the minority PWDs are excluded xenophobically by their local savings groups or petty trade (UNDP, 2025; Thukia, 2025). These power systems perpetuate the cycles of exclusion: physical marginalization is supported by inaccessible infrastructure, and self-oppression and a lack of help-seeking are caused by internalized stigma. By ignoring these intersections, however, traditional CBID approaches would not map the intersection of disability, leading to programs to ignore, say, the livelihood needs of older ethnic-minority women with disabilities or the justice barriers of deaf refugee girls (May, 2024). Intersectional advocacy starts, then, with stringent community-based mapping - participatory power analysis and disaggregated data - to understand how the active production of compounded stigma occurs at the local governance, kinship, and economic relations spectrum (ILO, UNESCO, & WHO, 2004; UNDP, 2025). It is only through naming such structures that CBID will be able to go beyond the superficial inclusion to disassembling the processes that have ensured the multi-marginalization of PWDs remain at the periphery.

### **Voices of the Marginalized**

Centering on the lived experiences of multiply-marginalized PWDs is not only an ethical but also an epistemological necessity of transformative CBID (Ingstad & Eide, 2011). The conventional strategies tend to follow a curing mannerism- healing people by means of medical or charity treatment but without alteration of oppressive systems. Intersectional advocacy will require a paradigmatic change, namely, using PWDs not as passive beneficiaries but as knowledge producers and agents of structural change. It is in line with emancipatory and participatory research approaches which reposition disabled individuals as co-researchers and co-designers, repatriating power and coming up with contextually-specific solutions (Ingstad & Eide, 2011; May, 2024).

Participatory methodologies have proved to be potent in the Kenyan practice. Wickenden et al. (2024) state that nine peer researchers with disabilities in Kenya engaged in the work facilitated focus groups and interviews about inclusive pre-school education, so that the children with disabilities, parents, and teachers formed the agenda and analysis. Similarly, Karuga (2023) used

community-based participatory research (CBPR) in the Korogocho and Viwandani informal settlements in Nairobi, where the community groups specifically targeted PWDs as one of the priority vulnerable populations alongside child headed households and the aged and mapped their health, education, and WASH needs through social mapping exercises and ripple-effect exercises (Musyoka, 2024; Karuga et al., 2023).

This is further promoted through emancipatory research with the express purpose of breaking down oppression. Brinkman et al. (2022) and Okello (2024) demonstrate how Kenyan and East African projects that involved children and adults with disabilities used reflexive and community-led processes to co-create interventions to address communication disabilities and inclusive education instead of reliant on data extraction, leading to capacity-building and ownership of advocacy (Ayalew et al., 2020). In such approaches, the PWDs who hold multiple identities (women living in rural areas and having albinism or youth who live in urban areas and are members of ethnic minorities) are the ones who define the problem, gather and share data (Ned, 2022). This centering breaks the expert-subject dichotomy, legitimizes various knowledges, such as indigenous and experiential knowledge that is not considered in the Western disability paradigm, and builds up collective conscientization (Karuga et al., 2023; Ayalew et al., 2020).

The consequences on the CBID are profound. In a situation where advocacy arenas are occupied by non-disabled or single-axis leaders with disabilities, the voice of multiply-marginalized groups is muted, and still divided responses take place. The mechanisms of centering lived experience include: OPD-led community dialogue using safe spaces and interpreters, peer researcher training based on underrepresented groups, and incorporating the use of narrative and storytelling techniques into CBID monitoring (Ayalew et al., 2020). These praxis changes do not involve the corrective mode of therapy to the disabled body, but instead the modification of structures to low-level, left-wing structures, patriarchal decision-making, ethnic gatekeeping, ableist service design, which create exclusion. When used in Kenya, where 80 percent of PWDs already indicate that they feel excluded in civic activity (UNDP, 2025), this voice-based model creates ownership, increases the relevance of the program or program, and creates long-term demand to change the policy. Finally, it turns CBID into a liberatory process as it makes the most marginalized be the designers of their own inclusion and, subsequently, more equal communities.

### **Operationalizing Intersectionality**

Operationalizing intersectionality into action as it pertains to grassroots CBID-related advocacy will involve operationalizing the concepts of equity, power analysis and knowledge diversity into tangible, community-based practice that breaks down silos and serves lived complexities (Ayalew et al., 2020). Equity, however, requires fair distribution of needs, not equality, power analysis involves explicit mapping the control of resources and decisions and diversity of experiences demands that lived experience will supersede external expertise (Crenshaw, 1989; Collins, 2000). The Kenyan community contexts achieve these principles by using structured but adaptive instruments that are directly incorporated into the CBID matrix (Health, Education, Livelihoods, Social, Empowerment).

Intersectional advocacy on the community level will start with compulsory quarterly cross-sectional audits by OPDs and community committees. On a case-by-case basis, each CBID component has facilitators using a basic matrix: barriers to intersections to specific interventions (rural ethnic-minority women in livelihoods programs), the location of power holders (chiefs, men groups, NGO), and occupationally specific adjustments based on disaggregated data. This is in practice in the CBID guidance (2024) and Making It Work good practices (2018) of CBM: in Bungoma and Nairobi, women-with-disabilities self-advocacy groups hold power-mapping workshops to see how the police and the elders prevent the reporting of GBV by girls with intellectual disabilities, which results in trained intermediaries and MoUs with the justice actors.

Power analysis is operationalized by participatory strategies, like the power flower exercises or the river of life exercises, which are modified to the features of low-literacy settings, i.e. the community members, including multiple-marginalized PWDs, map the intersections of privileges and oppressions using a visual tool (Ackerman et al., 2025). Knowledge diversity is secured through the privilege of community mobilization whereby women, youth and ethnic-minority PWDs are trained to be community mobilizers who facilitate discussions, gather stories and translate the findings into local action plans (Ayalew et al., 2020; Musyoka, 2024). In Kenya, such instances are Rural Women Peace Link training women on integrating disability in women peace forums and working with KAIH to offer psychosocial-legal support with reasonable accommodations (Making It Work, 2018). These methods take consultation further than token consultation to the process of co-creation.

These principles are also embedded in everyday advocacy routines. CBID meetings start with intersectionality check-ins in which the participants identify themselves by listing their multiple identities and how they influence their involvement (Karuga et al., 2023). Indicators monitored are updated to incorporate intersectional measures like the proportion of livelihood beneficiaries who are women with disabilities belonging to pastoralist groups or decrease in the number of GBV reported against deaf refugee girls (Musyoka, 2024). Formal connection between OPDs, women's groups, and anti-poverty networks promotes coalitions to advocate jointly to the county budgets allocating special lines to intersectional CBID (recommended 3 to 7 per cent disability-inclusive by UNICEF). Intersectional CBID training modules, through community radio and peer networks, have capacity building effects on the frontline workers.

Issues like resource limitations are met in a pragmatic way: visual tools that are cheap, capitalizing on already existing OPD frameworks, and fitting into the current county planning cycles (Karuga et al., 2023; Musyoka, 2024). Operationalizing intersectionality in this manner causes CBID advocacy to move towards disjointed, top-down inclusion into more transformative, bottom-up praxis that is responsive to human experience specificity and yet challenges the structures that create marginalization (Ackerman et al., 2025; Sserunkuma, Locoro, & Ddamulira, 2023). This is not only a way of enhancing service delivery, but it helps in Kenya to create resilient communities that are guided by justice in which equity would be followed, and not proclaimed.

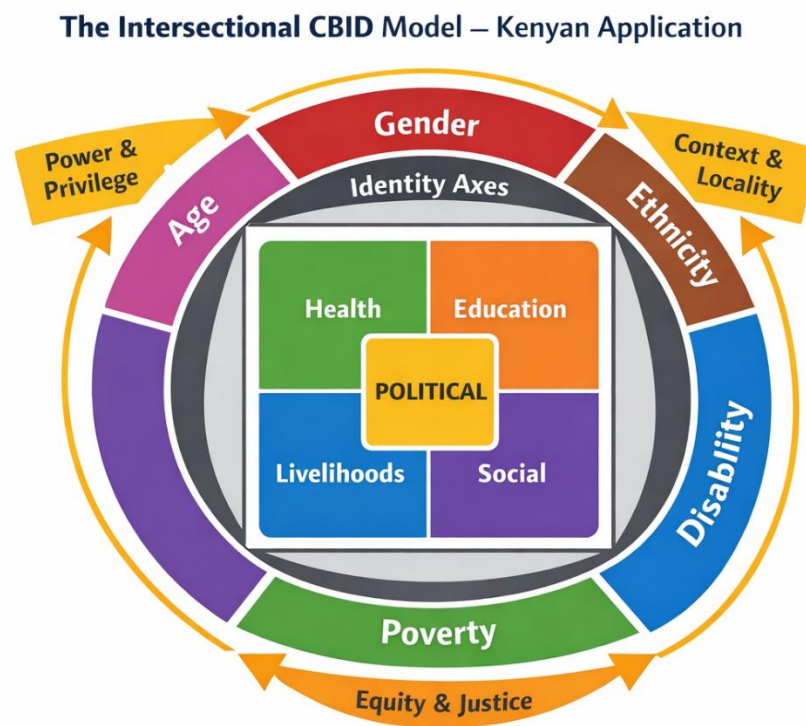
## **DISCUSSION AND PROPOSED FRAMEWORK**

### **The “Intersectional CBID” Model**

The paper proposes the Intersectional CBID Model as an idea and a practical framework, the one that incorporates the concept of intersectionality right into the regular CBID model (Razia & Chhimwal, 2022). The traditional CBID matrix, a system of five interdependent elements, including Health, Education, Livelihoods, Social, and Political (transforming the traditional pillar of Empowerment under the new label of Rights-based political participation and power-shifting) serves as the paradigm of structure (Sserunkuma, Locoro, & Ddamulira, 2023). The Intersectional CBID Model refines this matrix with three transversal principles being overlaid, i.e. intersectional awareness, coalition solidarity, and localized praxis, and by requiring an Intersectional Audit of each component.

The model is a dynamic and iterative cycle as opposed to a check list. Intersectional awareness demands that practitioners acknowledge at the beginning of any intervention how disability is influenced by gender, ethnicity, poverty, age, and any other axis (Thukia, 2025). Coalition solidarity creates alliances among OPDs, women groups, ethnic minority associations as well as anti-poverty networks in order to co-design response mechanisms (Razia & Chhimwal, 2022). Localized praxis puts these lessons into practice in context-based action featuring multiply-marginalized PWDs taking the lead themselves.

To operationalize this, every one of the five CBID elements is given explicit Intersectional Audit layer comprising four obligatory steps: (1) the disaggregated data mapping of the intersecting identities; (2) participatory power analysis; (3) the co-creation of customized indicators; and (4) quarterly circulation back with the feedback loops to OPDs.



*Figure 1: The Intersectional Community-Based Inclusive Development (CBID) Model – Kenyan Application Framework*

Figure 1 places intersectionality at the center of the lens with a matrix enclosed in the middle, with the arrows being two-way showing a continuous feedback. The Kenyan adaptation of the model involves devolved governance: county CBID committees (headed by OPDs) perform annual audits with low-cost tools (power flowers, story circles, and mobile data collection) in accordance with County Integrated Development Plans (CIDPs) and the National Policy for Persons with Disabilities (Thukia, 2025). The implementation will take a one day community validation workshop and then 12 months cycles of action reflection adjustment (Razia & Chhimwal, 2022). The model, therefore, turns the usual matrix into a transformative justice model, which guarantees that CBID no longer homogenizes PWDs but answers to the farthest behind first.

### **Challenging Traditional Power Structures**

Intersectional CBID Model is an inherently disruptive approach to top-down power relations, which has been historically a defining feature of disability programming in Kenya (Thukia, 2025). Traditional CBID and previous CBR models tended to put the government ministries, international NGOs, and non-disabled experts as the main decision-makers, leaving the OPDs to the consultative or implementation stages (United Nations Development Programme, 2025). This paternalist hierarchy recreates the hierarchies of ableism, patriarchy, ethnic gatekeeping, which marginalise multiply-disabled persons.

The model, on the other hand, requires the bottom-up governance. The leadership of intersectional audits and coalitions platforms is taken by OPDs, especially women, youth, ethnic minorities, and poor differently rural PWDs (Brinkman et al., 2022). This restructures power in three vital directions. To begin with, there is a change in the production of knowledge: the stories of lived experiences of the most excluded are becoming the primary source of evidence, replacing external evaluations (Brinkman et al., 2022). Second, the control of resources is democratised; county budgets and donor funds have to pass through intersectional CBID committees with multiply-marginalised representatives possessing a veto in the design of projects (International Labour Organization, 2025; May, 2024). Third, the responsibility mechanisms are inverted, where the government and nongovernmental organizations are held accountable to forums of community actors and not the other way around.

In practice, this is implemented in the form of the Kenyan counties with the help of power-rebalancing protocols (Ayalew et al., 2020). For example, when considering reviews of CIDP,

OPD-led coalitions can provide intersectional information, which compels ministries to reallocate resources such as the growing funding to accessible maternal health, in arid counties following audit findings that showed ethnic and gender differences (United Nations Development Programme, 2025; Owiti, 2024). NGOs accustomed to the isolated work have to now co-sign work plans with various OPDs with the same budget and credit (May, 2024; Bunning, Gona, Newton, & Hartley, 2022). The outcome is reconfiguration of power, i.e., a shift of power to village-level disability committees as compared to Nairobi boardrooms and county headquarters.

This shift aligns with CRPD Article 4(3) and Article 33(3) of close consultation with persons with disabilities, but it goes the extra mile of institutionalising intersectional representation (Richard, 2024; Owiti, 2024). It puts institutional stasis on the wrong foot by making being left out visible and expensive: any failure to hear multiply-marginalized voices now brings up formal complaints via the National Gender and Equality Commission and NCPWD. In the long run, the model develops new leadership pipelines, which involves training young women with disabilities in the pastoralist communities to become county CBID coordinators, hence maintaining the redistribution of power beyond individual projects (Bachfischer et al., 2023; Bunning, Gona, Newton, & Hartley, 2022). Finally, Intersectional CBID does not speak on behalf of people, but is guided by them in a way that allows them to be freed through their structures, which results in authentic community ownership and structural change.

### **Overcoming Challenges**

The implementation of the Intersectional CBID Model can only be met with resistance, but the three most prevalent barriers, including resource constraints, siloed advocacy, and institutional inertia, can be addressed using pragmatic approaches (Bachfischer et al., 2023; Richard, 2024). Resource limitations especially in the underfunded counties are solved by tapping into the existing structures and not by building parallel systems (Owiti, 2024; Rotich, Funder, & Marani, 2023). Audits make use of free/low-cost participatory techniques (story circles, power-making posters, and open-source mobile applications like KoBoToolbox) already in possession of OPDs and community health volunteers. CBID budgets can be ring-fenced on donor partnerships (CBM, UNICEF, and the disability-inclusive projects of the World Bank) 5-10 per cent of the CBID budgets to intersectional elements but the county governments can incorporate audits within regular CIDP monitoring with minimal additional expense (Kabia et al., 2019; Bachfischer et al.,

2023). The innovation window of the National Disability Fund is available to pilot counties to obtain seed funding.

Coupled advocacy is opposed by compulsory coalition protocols. The model will dictate that CBID funding cannot be published without a formal Memoranda of Understanding between the disability, gender, and poverty-focused organisations (Kabia et al., 2019). Quarterly meetings of Intersectional Convergence Forums in sub-counties, which are jointly topped by a variety of OPD representatives, come up with joint proposals. The experience of successful examples of Making It Work (2018) and CBM Kenya programmes shows that these coalitions lead to higher access to funds (40%), which comes as a result of joint advocacy.

The obstacles of institutional inertia, namely the willingness of government actors who have become accustomed to top-down planning, are defeated with the help of specific capacity-building and evidence-based persuasion. The Intersectional CBID Model is included in the mandatory training modules in NCPWD and county public service inductions, and real Kenyan case studies are used to demonstrate the presence of improvements (increased retention rates in livelihoods programmes) (Razia & Chhimwal, 2022). Top leaders in the ministry of labour and social protection and the council of governors can be nurtured through study tours to the successful pilot sites. Lastly, introducing the intersectional indicators on national monitoring systems (Kenya National Bureau of statistics disability disaggregation and SDG reporting) provides an external source of accountability that slowly changes the organisational culture (Rotich, Funder, & Marani, 2023). Through these mitigation measures: low-cost tools, coalition directives, capacity building, policy imbuing, the Intersectional CBID Model switches its hypothetical goodwill into a viable practice, transforming any possible opposition into collective force of fair development.

## **CONCLUSION AND RECOMMENDATIONS**

### **Summary**

Community-Based Inclusive Development (CBID) as practised traditionally in Kenya, although contributing to the inclusion of persons with disabilities (PWDs) through rights-based approaches, has its limitations in its disaggregating nature of the experiences of persons with disabilities and the complexity of exclusion intersecting on gender, ethnicity, poverty, age, and geographic

location. The analysis relied on intersectionality theory (Crenshaw, 1989; Collins, 2000), and the application of intersectionality theory to Global South situations to map the relationship between patriarchal, ethnic, and ableist power structures to create particular marginalisation of multiply-marginalised PWDs (rural women with disabilities of ethnic minorities, deaf refugee girls, older pastoralists with impairments, etc.).

The proposed Intersectional CBID Model attempts to incorporate intersectional thinking on the standard CBID matrix by introducing intersectional awareness, coalition solidarity, and localised praxis principles into the standard CBID model compulsory via regular intersectional audits of its Health, Education, Livelihoods, social, and Political constituents. This strategy is a change in advocacy towards bottom up, transformative praxis that places lived experiences at centre and distributes power to OPDs and coalitions led by communities and translatability of equity on all levels. The model tackles the issue of implementation barriers in a pragmatic manner to the effect that CBID addresses its traditional structures with an eye to the complexity of human identity instead of a one-size-fits-all approach.

A more intersectional advocacy is thus not a desirable augmentation but a vital prerequisite of sustainable equitable CBID in Kenya. In absence of it, the multiple-marginalised PWDs still become victims of programmatic loopholes, which results in poverty-violence-exclusion cycles. Through it, CBID will be an authentic driver of structural change, the progress of CRPD requirements, constitutional guarantees (Articles 27, 54), the commitments of the Social Pillar of Vision 2030, and the motto of leaving no one behind. It is only by cross-cutting lenses that the Kenyan societies can develop resilient development that is justice-based, where dignity, participation and equity is realised by all.

### **Policy Implications**

In order to operationalize the Intersectional CBID Model, national, county, and community policymakers and practitioners should incorporate intersectional indicators into the current monitoring and evaluation (M&E) models. The National Policy on Persons with Disabilities and related M&E tools should be adjusted by the National Council of the Persons with Disabilities in co-operation with the Ministry of Labour and Social Protection, and must incorporate compulsory intersectional disaggregation. This involves the gathering and reporting of data by disability type but intersecting axes i.e. gender, ethnicity, age, poverty status (when using proxy measures such

as household asset indices) and geographic location (rural/urban, arid/semi-arid). The key performance indicators should encompass:

- Percentage of beneficiaries of the CBID programme using women with disabilities in the ethnic minority communities;
- Less reported cases of gender-based violence against girls with disabilities in specific counties;
- Share of counties disability funding distributed by intersectional CBID committees, veto power on multiply-marginalised representatives;
- Count of livelihood intervention programmes with better results with the rural poor PWDs than the non-intersectional cohorts.

These indicators ought to be incorporated in County Integrated Development Plans (CIDP) as well as annual performance contracts by county governments guided by the Council of Governors and devolved disability units. OPDs will need to be co-leads in M&E recurrence where they will carry out community-based audits and feed results directly into county assemblies and national reporting (SDG Voluntary National Reviews). Certain M&E aspects used in sectors such as Health, Education, Interior should be reconciled with those of intersectionality: e.g., health facilities ought to monitor maternal health outcomes in women with disabilities disaggregated by ethnicity and poverty.

These indicators must be adopted under the conditions of donor partners (UNICEF, CBM, World Bank, USAID), who would offer technical help to build the capacity in the low-resource counties. Institutionalising intersectional M&E will see Kenya shift to an evidence-based policymaking process which addresses the furthest behind, holds accountable, and speeds up the pace of inclusive equitable development as promised in the Constitution and international commitments.

### **Future Research**

Although conceptual Model of Intersectional CBID is rather robust, its effectiveness and flexibility should be tested with hard empirical data. Mixed-method research that is conducted in a variety of counties in Kenya should be prioritized in future research to provide context-specific evidence on the implementation processes, results, and scalability. Designs suggested are longitudinal case studies in at least 4 contrast settings namely; (1) a rural arid/semi-arid county (Turkana or

Samburu) with high ethnic diversity as well as pastoralist populations; (2) an urban informal settlement county (Nairobi or Kisumu); (3) a coastal county with refugee-hosting dynamics (Garissa or Mombasa); and (4) an agriculturally intensive rural county (Bungoma or Kisii). At every location, participatory action research is supposed to pilot the model during 2436 months, entailing OPD-based intersectional audits, coalition organizing, and bottom-up surveillance.

Quantitative components are to be employed using quasi-experimental or difference-in-differences, in order to contrast intersectional CBID interventions with the standard CBID programmes in relation to the following main outcomes, disaggregated by the intersecting identities: access to services, rates of livelihood participation, violence reduction as reported, civic engagement, and household poverty measures. The qualitative strands should investigate the power shifts, change in coalitions, resistance experienced and perceived equity gains using in-depth interviews, focus group discussion and narrative analysis with the multiply-marginalised PWDs. The methodology must be based on emancipatory principles, and peer researchers selected should be co-designers of tools, interpreters of findings, and belong to the target group(s).

Additional lines of inquiry will be cost-effectiveness analysis to determine the implications of the resources in the low-budget counties and comparative analysis with non-pilot sites to isolate the model influences. Longitudinal leadership emergence (women with disabilities ascending to county CBID coordinator positions) tracking would shed on sustainability. Results must be translated into policy improvement, and this can be shared in national conferences, OPD networks and published materials. This kind of empirical validation will enhance the legitimacy of the model, feed into any scalable changes, as well as add to the expanding Global South scholarship on intersectional disability-inclusive development.

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