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ATTITUDE OF FAMILIES OF PERSONS WITH DISABILITIES TOWARDS COMMUNITY-BASED REHABILITATION (CBR) PROGRAMME: A CROSS-SECTIONAL STUDY FROM NORTHERN INDIA

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ABSTRACT

Background: Community-Based Rehabilitation (CBR) identifies the family as the primary source of support and social inclusion for individuals with disabilities. The degree to which the programme can be effective relies heavily on caregivers' attitudes and perceived competencies. However, little empirical research has been conducted in urban India regarding caregivers' perceptions and attitudes toward caring for individuals with disabilities.

Objectives: The objective of this study was to assess the attitudes of family caregivers regarding CBR in a metropolitan area of Northern India and to determine whether there were significant differences in caregivers' attitudes based on gender, age, or type(s) of disabilities.

Methods: The study used a cross-sectional survey that included 120 primary caregivers selected through purposive sampling from 12 Non-Governmental Organizations (NGOs) providing CBR services. The data were collected using a psychometrically validated self-constructed 30-item Attitude Scale (Cronbach's $\alpha = 0.72$) and were analyzed using Descriptive Statistics, an Independent-samples t-test, one-way ANOVA with Tukey HSD post-hoc comparison, and Chi-square testing.

Results: The overall mean attitude toward CBR was 103.33 (SD = 6.72). A majority of families (55.0%) exhibiteda negative attitude toward the CBR programme, while 40.8% showeda neutralattitude, and only 4.2% hada positive attitude. The gender and age of the caregivers had no significant impact on the overall attitudes ($p = 0.19$; $p = 0.59$, respectively). The type of disability had a highly significant effect on overall attitudes toward CBR (F(4,

115) = 8.83, $p < 0.001$, $\eta^2 = 0.24$). Families of children with ASD (M = 97.33) and Down Syndrome (M= 94.00) had significantly lower mean attitude scores towards CBR than families of children with locomotor or sensory disabilities.

Conclusion: The predominance of negative and neutral attitudes reveals a critical implementation gap in urban CBR. The findings highlight the need for several strategies to enhance the overall acceptance of Urban-based CBR and improve the sustainability of CBR programmes. These strategies may include a specific focus on capacity-building for developmental disabilities, the development of a structured engagement process through which families can support one another, and the establishment of an ongoingdiagnosis-specific peer support model.

KEYWORDS: Community-Based Rehabilitation, caregiver attitude, disability, persons with disabilities, social inclusion.

1. INTRODUCTION

1.1 Background and Context

Rehabilitation services for Persons with Disabilities (PWDs) in India have traditionally been structured around an institution-based model focused on providing medical assistance and treatment, primarily located in large urban areas. Although specialist hospitals, rehabilitation centres, and segregated special schools provide valuable support in terms of expert interventions, assistive technology, and therapeutic services, their reach remains structurally limited due to geographic barriers, cost, and the lack of availability of specialist staff members (Mitra, et al., 2013). As per the Census of India (2011), around 26.8 million individuals (2.21% of the national population) live with some form of disability. However, this figure iswidely regarded as an underestimation due to definitional ambiguities, the prevalence of societal stigma against persons with disabilities, and the persistent under-reporting of disabilities among marginalized and rural populations (World Bank, 2019). If India's true disability burden aligns with the WHO estimates, the absolute number of people with disabilities would jump from 26.8 million to roughly 200 million, a projection widely accepted by public health experts and advocacy groups in India.Although the need for rehabilitation services for PWDs is significant, estimates indicate that less than 3% of individuals with disabilities who require support have accessed rehabilitation services through institutions (WHO, 2010; Raza, M. M., & Begum, S., 2022). Therefore, a significant gap in equity and access exists in institute-based rehabilitation services.

Due to the limitations of the traditional institution-based model, such as high operational costs, limited scalability, and limited community involvement, national policymakers and international organizations began to explore decentralized, participatory models for service delivery. The primary strategy that emerged from this shift is Community-Based Rehabilitation (CBR), which has received joint endorsement by the World Health Organization (WHO), International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO), and United Nations Children's Fund (UNICEF) (WHO, 2010; Raza, Md & Begum, Sara., 2022). CBR includes five interdependent domains: health, education, livelihood, social participation, and empowerment. It aims to develop a decentralized network for rehabilitation service delivery by mobilizing local resources, promoting intersectoral collaboration, and adopting a rights-based approach to inclusion. In low- and middle-income countries, CBR is widely regarded asa cost-effective and scalable method for addressing a significant proportion of rehabilitation needs, particularly when supported by meaningful community engagement and robust policy frameworks (Helander, 1993; WHO, 2010). In India, CBR also aligns with the Rights of Persons with Disabilities Act (RPwD Act 2016) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), both of which emphasize tenets of inclusion, participation, and equal opportunity.

Within the CBR framework, the family is placed at its core. In contrast to institute-based models, where rehabilitation is primarily delivered through professionals, CBR assumes that family caregivers will work in partnership with professionals to ensure the continuity of therapeutic gains achieved through the rehabilitation process, provide support in daily living and community participation, and act as advocates for the PWDs (WHO, 2010). This approach places significant responsibilities on family members, as caregiver attitudes towards CBR are considered fundamental determinants of programme uptake, fidelity, and long-term effectiveness (Scorgie et al., 2004).

1.2 Theoretical Framework

The social model of disability forms the foundation for this study, as it views disability with an emphasis on societal, environmental, and attitudinalbarriers rather than solely on impairment (Oliver, 1996; Shakespeare, 2014). The social model conceptualizes disability as both a relational and contextual phenomenon, withthe family serving asthe closest micro-community for the individual with disability. Therefore, the attitudes of family members influence how effectively the individual with disability interacts with their social environment on a day-to-day basis.

Ajzen's (1991) Theory of Planned Behaviour and the Social Model of Disability complement each other by providing insight into how attitude, social norms, and perceived behavioral control influence the likelihood of a particular behavior. The Theory of Planned Behavior posits that individuals are more likely to demonstrate high levels of active participation in community-based rehabilitation (CBR) when they hold positive attitudes towards rehabilitation, perceive supportive attitudes from family members and friends, and feel a sense of control over rehabilitation-related activities. For example, caregivers who demonstrate positive attitudes toward rehabilitation will be more likely to actively participate in the programme's activities, continuously implement home-based interventions, and encourage their family members and friends to participate socially with PWDs. In contrast, negative or ambivalent attitudes may lead to passive involvement, inconsistent participation, or withdrawal from the programme. Therefore, measuring and understanding family attitudes toward CBR are critical not only for predictions of participation but also for informing effective programme design and implementation.

1.3 CBR in India: Policy Context and Urban Challenges

India has a long history of implementing Community-Based Rehabilitation (CBR), beginning in 1980 through pilot projects supported by the World Health Organization. Since then, CBR has been incorporated into various national and state-level disability welfare programmes. The Rights of Persons with Disabilities Act (RPwD Act) established a legal framework for providing CBR as one of the approaches to ensuring the rights of people with disabilities at the community level. Although government commitment is evident through policy and legislation, considerable variability exists in the actual delivery of CBR services. There are greater numbers of CBR programmes in rural and tribal areas than in urban areas; most CBR programmes in these regions are facilitated by international non-governmental organizations (NGOs). At the same time, many urban areas have witnessed an increase in private specialist service providers, often competing with community-based organizations (CBOs) for the same clients and, in some cases, replacing them (Sharma & Lakshminarayanan, 2019). The presence of diverseservice optionsin metropolitan areas has created a unique context that influencescaregivers' attitudestowards CBR,shaped by their experiences with both community-based and institutional or private rehabilitation services.

1.4 Research Gap and Objectives

The majority of existing literature in India related to the rehabilitation of individuals with disabilities has typically addressed issues around rural delivery of services, workforce development, and the overall coverage of rehabilitation programmes (Dalal, 2006; Murthy,

2016). In contrast, the attitudes of caregivers towards community-based rehabilitation (CBR) have received much less systematic empirical attention, particularly in urban areas. This information is important for managers of rehabilitation programmes because attitudes areconsidered modifiable determinants of behavior. Understanding the distribution and correlates of caregiver attitudes toward CBR can help managersdevelop interventions tailored to specific groups of caregivers. Therefore, the objectives of this study were to determine: (a) the overall attitude of family caregivers towards CBR in the metropolitan area of a northern Indian city; (b) whether the caregiver's gender and age group influence their attitude; and (c) whether attitude varyaccording to the type of disability, thereby identifying groups of caregivers who may require targeted intervention related to their attitude towards CBR.

2. METHODOLOGY

2.1 Research Design

A cross-sectional descriptive survey design was used for this quantitative prevalence research. This type of design allows researchers to quantify attitudes towards a particular variable within a target population by measuring attitudes at a single point in time, and it can also help identify correlations among the variables being studied (Kelley et al., 2003). While this design is efficient and appropriate for the exploratory and policy-oriented objectives of thepresent study, it does not permitthe establishmentof causal relationships between the survey findings and the variables under investigation. However, the cross-sectional exploratory study design provides a foundation for future intervention studies and longitudinal assessmentsaimed at measuring changes in attitudes following interventions among the same or similar populations (Kumar, 2011).

2.2 Population and Sample

The study population comprised primary caregivers of PWDs enrolled on CBR programmes operated by NGOs of Delhi-NCR. A two-phase sampling procedure was used. In phase 1, 12 NGOs actively involved in implementing CBR programmes were identified and selected through the snowball sampling technique, as no central CBR register was available for the region. Phase 2 involved the use of purposive sampling techniques to recruit 120 primary caregivers who had been actively involved with one of the selected CBR programmes for at least six months, as this duration was considered sufficient for the development of relatively stable attitudes towards caregiving. As a result, 10 caregivers were recruited from each of the twelve participating NGOs to ensure representation from organizations with different models of organization, service delivery approaches and target populations. The sample size of 120

was consideredadequateto achieve sufficient statistical power ($1 - \beta > 0.80$, $\alpha=0.05$) for conducting the intended ANOVA comparisons, based on the guidelines proposed by Cohen (1988).

2.3 Inclusion and Exclusion Criteria

Participants were included if they were: (a) the primary family caregiver of a PWD enrolled in a Community Rehabilitation (CBR) programme, and (b) associated with the CBR programme for at least six months or longer. Families of PWDs who had enrolled within the preceding six months were excluded.

2.4 Tool used in the study

Data were collected using a self-constructed Attitude Scale (Attitude Scale for Families of PWDs towards CBR Programme), designed in accordance with current guidelines for the development of attitudinal instruments outlined by Devellis (2016). An initial pool of 45 items was generated through a review of literature related to CBR and disability attitudes, focus group discussions with caregivers, and consulting with rehabilitation professionals. The items were categorized into five thematic domains. These included (1) perceived benefits of participation in CBR for PWDs, (2) clarity of family roles in CBR participation, (3) perceptions regarding the competency of personnel working in CBR programmes, (4) perceptions of community acceptance and integration, and (5) preference for community-based versus institutional care.To finalize the scale, an expert panel comprising five professionals reviewed the items and provided feedback on all 45 items. Based on their recommendation, 15 items were eliminateddue to redundancy, lack of clarity, or limited relevance to the constructs being measured. The final version of the scale consistedof 30 Likert-type items, including 25positively worded items and 5 negatively worded items. Each item was rated on a five-point continuum ranging from Strongly Disagree (1) to Strongly Agree (5). Negatively worded items (items 3, 4, 5, 14 and 17) were reverse-coded prior to scoring the total score. Scores for the scale range from 30 to 150, with higher scores indicating more positive attitudes toward CBR. In order to interpret the results, three operational categories of attitudes were developed: negative (≤104), neutral (105–114), and positive (≥115). A pilot study was conducted with 60 caregivers; however, these data were not included in the final analysis. The pilot testing yielded a Cronbach's alpha coefficient of 0.72, indicating acceptable internal consistency for use in exploratory research (Nunnally, 1978; Devellis, 2016).

2.5 Ethical Considerations

The study was carried out after obtaining ethical approval through a formal institutional process. All voluntary participants were providedwith detailed information about the study and were asked to give written informed consent prior to participation. Participation in the study was entirely voluntary, and complete anonymity of both participants and orzanizations was maintained, as no identifying information was included in the report.

2.6 Data Analysis

IBM SPSS Statistics software (Version 25) was used to perform data analysis and generate descriptive statistics (e.g., frequencies, percentages, means, and standard deviations) for the sample characteristics and distribution of attitude scores across demographic variables (i.e., sex). An independent-samples t-test was conducted to examinedifferences in caregiver attitude scores based on sex. A one-way ANOVA was used to test differences in caregiver attitudes according to age group and types of disability. Whenever a significant difference was identified, Tukey's DSD post hoc test was applied to determine the specific group differences.

The normality of the data was assessedusing the Shapiro-Wilk test, while homogeneity of variance was examined using Levene's test. The results indicated thatthe assumptions of normality and homogeneity of variance were satisfied. Effect sizes were calculated for both t-tests (Cohen's d) and ANOVA (partial $\eta 2$) using conventional benchmarks proposed byCohen (1988): Cohen's d = 0.20 (small), 0.50 (medium), and 0.80 (large); and $\eta 2$ = 0.01 (small), 0.06 (medium), and 0.14 (large).

3. RESULTS

3.1 Socio-demographic Profile

The Socio-Demographic characteristics of the Sample populations are presented in the summary table (Table 1). The mean (M) age of the participants was found to be 39.7 years (SD=4.7), with ages ranging from 29 to 57 years. Females constituted a larger portion (61.7%) of the caregiver population compared to males (38.3%). This distribution reflects the culturally gendered nature of caregiving responsibilities commonly observed in many Indian households.

The majority of the participants (67.5%) belonged to the 36-45 years age group. Locomotor disabilities represented the most common category of disability among the participants (46.7%), followed by intellectual disabilities (21.7%). In comparison, the other disability

categories were significantly less prevalent, including Sensory Disabilities (17.5%), Autism Spectrum Disorder (7.5%) and Down Syndrome (6.7%), respectively.

Table 1: ***Socio-demographic Characteristics of the Sample. (N = 120)***

Variable	Category	N	%
Gender	Female	74	61.7
	Male	46	38.3
Age Group (years)	≤ 35	31	25.8
	36–45	81	67.5
	>45	8	6.7
Disability Category	Locomotor/Physical	56	46.7
	Intellectual Disability	26	21.7
	Sensory Disability	21	17.5
	Autism Spectrum Disorder	9	7.5
	Down Syndrome	8	6.7

3.2 Overall Attitude toward CBR

The mean attitude of the participants was 103.33 (SD = 6.72), with scores ranging from 84 to 122. This indicates that, on average, participants demonstrated attitudes that fell within the negative to neutral range and remained below the defined neutral category (105-114). The data were found to be normally distributed (as indicated by the Shapiro-Wilk test of normality, W=0.98, p=0.22). As presented in Table 2, 55% of caregivers demonstrated a negative attitude (scores ≤ 104), 40.8%demonstrated a neutralattitude (scores between 105 and 114), and only 4.2%demonstrate positive attitude (scores ≥ 115).

Table 2: ***Distribution of Caregiver Attitude Levels towards CBR. (N = 120)***

Attitude Category	Score Range	Frequency (n)	Percentage (%)
Positive	≥ 115	5	4.2
Neutral	105–114	49	40.8
Negative	≤ 104	66	55.0
Total		**120**	**100.0**

3.3 Gender and Age Differences

Based on the total attitude score towards caregiving, female caregivers (M = 103.91, SD = 6.73, n = 74) and male caregivers (M = 102.24, SD = 6.63, n = 46) did not demonstrate a statistically significant difference in attitudes based on gender t(117) = 1.31, p = 0.19, Cohen's d = 0.25), indicating a small and statistically non-significant effect size. Equality of variances between the two gender groups was confirmed using Levene's Test (F = 0.07, p = 0.79).

Furthermore, a one-way ANOVA revealed no statistically significant differences among the age groups with respect to their overall attitudes towards caregiving. The analysis included three age groups: Group 1: (≤35 years; M = 102.87, SD = 6.55); Group 2: (36-45 years; M = 103.28, SD = 6.98), Group 3: >45 years; M = 105.62, SD = 4.27). The results indicated no statistically significant difference among the three age groups, F (2, 117) = 0.54, p = 0.59, η^2 = 0.01. Although Group 3 (>45 years) showed a comparatively higher mean score than Groups 1 and 2,this difference was not statistically significant, possibly due to the small sample size of Group 3 (n = 8).

3.4 Influence of Disability Type

The result of one-way ANOVA indicated a statistically significant and large effect of disability category on the caregiver attitude scores. Caregivers of children with Autism Spectrum Disorder (ASD) (M = 97.33, SD = 6.46) and Down syndrome (M = 94.00, SD = 4.50) demonstrated significantly lower attitude scores compared to caregivers of children with locomotor/physical disabilities (M = 104.93, SD = 6.20) and sensory disabilities (M = 105.48, SD = 5.59); with all pairwise comparisons showing statistical significance($p < .05$). Caregivers of individuals with intellectual disabilities (M = 103.12, SD = 5.98) demonstrated attitude scores that fell in the middle range and were not significantly different from either the locomotor/sensory disability group or the developmental disability groups.

Table 3: ***Attitude Scores by Disability Category. (N = 120)***

Disability Category	N	M	SD	Post-hoc (Tukey HSD)
Locomotor/Physical	56	104.93	6.20	Higher than ASD, DS*
Sensory	21	105.48	5.59	Higher than ASD, DS*
Intellectual Disability	26	103.12	5.98	No significant difference
Autism Spectrum Disorder	9	97.33	6.46	Lower than Locomotor, Sensory*
Down Syndrome	8	94.00	4.50	Lower than Locomotor, Sensory*

Note. ASD = Autism Spectrum Disorder; DS = Down Syndrome. F(4, 115) = 8.83, p < .001, , η^2 = 24. * p < .05.

4. DISCUSSION

4.1 Predominance of Negative Attitude: Interpreting the Findings

The striking finding that 55.0% of the caregivers in the present study demonstrated negative attitudes towards the CBR programme, while only 4.2% exhibited positive attitudes, is significant in relation to the ongoing policy direction of CBR. This finding differs considerably from earlier rural Indian studies in which CBR was often perceived more positively, largely becausecommunity-based services were among the few accessible

rehabilitation options available in rural settings (Dalal, 2006; Sharma & Lakshminarayanan, 2019). In contrast, families living in urban areas have access to a wider range of rehabilitation services, including private physiotherapists, special schools, hospital outpatient departments, and NGO- operated special centres. The availability of multiple serviceoptions in urban settings may encourage families to compare CBR unfavorably with alternative services, often with lower service intensity and fewer specialized personnel. Wirz and Thomas (2002) observed that caregivers who previously experienced intensive service through institutional settings tended to evaluate community-based alternatives against comparatively higher standards.

The high percentage of neutral responses (40.8%) is also noteworthy. It is likely that neutrality represents ambivalence, or that caregivers are engaged with CBR primarily for practical reasons such as affordability and accessibility rather than the strong belief that CBR is an effective service delivery model. In this context, such ambivalence may represent a form of "reluctant participation," as described in the CBR literature from sub-Saharan Africa (Hartley et al., 2009; Finkenflügel et al., 2005). From a sustainability perspective, ambivalent attitudes may represent an unstable condition. Unless deliberate and targeted efforts are put in place to change the ambivalence to positive engagement, there is a possibility that such attitudes may graduallyshift towards negative participation, particularly as children grow older and their rehabilitation needs become more complex.

4.2 Gender and Age as Non-predictors: Implications for Outreach

The absence of significant gender differences in caregiver attitudes reinforces the view that caregiving attitudes in South Asian cultures may no longer be shaped solely by the traditionally higher caregiving burden experienced by female caregivers, which was often associated with a more negative attitude toward caregiving (McConachie, 1994). This finding may also reflect changing family structures in urban metropolitan areas, where fathers are increasingly participating in rehabilitation-related decision-making, attending therapy sessions, and becoming more actively involved in rehabilitation programmes. Consequently, CBR programmes may not focus extensively on gender-specific attitudinalinterventions, but rather on developing interventions that address factors related to disability.

Similarly, the non-significance of age is in agreement with the findings of Srinivasan and Bhatt (2018) and supports the argument that caregiving attitude is primarily based on a person's experience with the individual with the disability and the quality of the CBR experience and not dependent on the caregiver's age or years of experience caring for a person with a disability. This makes it easier for programmes to target their outreach efforts;

therefore, universal outreach methods should be used to engage potential users of CBR programme resources while developing disability-specific materials for additional support.

4.3 Disability-Specific Disparities: A Critical Programme Gap

The major conclusion of this study was that the type of disability significantly influences caregivers' attitudes towards the support provided for their children ($\eta 2 = 0.24$).The comparatively lower scores among caregivers of children with ASD and Down syndrome highlight the additional challenges and support requirements associated with these specific developmental conditions. In the case of locomotor and sensory impairments,the strategies, mobility aids, and supportsystems used by CBR workers are relatively well established and can often be implemented effectively with appropriately trained community personnel. However, in comparison, supporting children with developmental disabilities frequently requires highly individualized, intensive, and specialized interventions, such as Applied Behavioural Analysis for children with ASD, speech and language therapy, structured educational programming, and long-term transitional support (Guralnick, 2019; Lord et al, 2020).

Consequently, when CBR workers do not possess the specific skill required to address the complex needs associated with developmental disabilities, caregivers (families) may perceive that CBR programmes lack the capacity to provide adequate support for their children. This often contributes to reduced confidence and trust in the effectiveness of CBR services.

These findings are consistent with evidence from other regions of the world, which suggests that CBR programmes tend to perform more effectively in addressing physical and sensory disabilities than developmental or intellectual disabilities Hartley, 2002; WHO, 2010). The relatively moderate position of disability group indicated that although certain community-based supports, such as daily living skills training and social inclusion activities, may be beneficial across developmental disability categories, additional specialist support is often necessary to address more complex presentations effectively. As mandated by the Rehabilitation Council of India, rehabilitation professionals are expected to possess specific competencies are not consistently incorporated into the training of CBR workers at the community level, thereby creating a significant service gap that must be addressed in order to build caregiver trust and confidence in CBR programmes.

4.4 Limitations

This study has several limitations. First, a casual interpretation cannot be made because the cross-sectional design does not allow the establishment of cause-and-effect relationships, thereby limiting the understanding of whether attitudes influence participation in the CBR

programme or whether participation itself shapes caregiver attitudes. Second, although participants were purposively sampled from 12 different NGOs and therefore had varying degrees of exposure to CBR programming, the findings may not be generalizable to all caregivers of PWDs within the same region. Third, the relatively small number of participants in the Autism Spectrum Disorder (n = 9) and Down syndrome (n = 8) group limits the strength of statistical comparisons involving these categories, making future replication studies with larger samples necessary. Finally, it is acknowledged that the nature of the data collection process, particularly the use of face-to-face interviews, may have introduced social desirability bias, potentially leading participants to report a slightly more positive attitude than they may actually hold.

5. CONCLUSION AND RECOMMENDATIONS

This study provides evidence to support the argument that community-based rehabilitation (CBR) in an urban north Indian setting is experiencing a relatively low level of acceptance among families receiving its services. The high prevalence of negative and neutral attitudes, particularly among families of children with autism spectrum disorder and Down syndrome, suggests concern regarding service quality as well as limited family engagement CBR process. These findings are not merely descriptive in nature; rather. They highlight important areas where CBR programme can be strengthened and improved. The findings suggest several important areas for improvement in CBR programmes. First,

Disability-specific Capacity Building: There is a need to strengthen disability-specific capacity building by increasing the availability of trained professionals for developmental disabilities, particularly ASD and Down syndrome. Such professionals should receive formal, structured, and competency-based training aligned with standards established by the Rehabilitation Council of India and should be equipped to deliver interventions appropriate to the needs of the clients.

Structures Family Engagement: The next priority area isthat CBR programmes should incorporate regular family training initiatives through counselling services, transparent and continuous evaluation of children's progress within CBR programmes, and community-level awareness campaigns highlighting the effectiveness and success of CBR, particularly those based on evidence-based practices. Such activities may help caregivers transition from attitude of neutrality or negativity towards more active engagement and informed commitment to the rehabilitation process.

Diagnosis-specific Peer Support Networks: The third recommendation is to establish diagnosis-specific peer support networks for caregivers. Support groups areorganiszed based on the specific type of disability diagnosed in their children and help reduce feelings of isolation, promote peer learning, establish community-level normalization of rehabilitation services, and foster collective advocacy efforts to improve the quality of CBR programmes (Gupta & Singhal, 2005). Studies have shown that these types of networks can help caregivers reduce the burden they are placed under, as well as increase their participation in CBR programs globally.

To better understand the long-term impact of CBR on caregiver attitudes, future research should adopt longitudinal study designsand incorporate mixed-methodapproaches combining qualitative and quantitative methods. Such approaches would provide deeper insight into how caregivers perceive changes brought about through CBR and how they interpret and construct their attitudes towards rehabilitation services.Furthermore, to determine whether these findings can be generalized across different regions of India and todevelop a more comprehensive understanding of CBR policy implementation at the national level, future studies should include larger samples drawn from multiple metropolitan areas across the country.

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