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Inclusion after the workshop: disability access, community participation, and the limits of short-term social intervention

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ABSTRACT

Background: Disability inclusion in Durajaya Village remained vulnerable to short-term mobilisation despite a population of 5,596 residents and prior participation by 590 disabled people in a national inclusion event. **Objective:** This community engagement program examined whether accessible, disability-led facilitation could strengthen post-workshop participation among 40 participants, including 24 persons with disabilities. **Method:** A participatory planning–implementation–monitoring-evaluation design combined baseline surveys, six site audits, four workshops, two mentoring encounters, structured observations, product rubrics, focus groups, paired pre-post assessment, and eight-week action tracking. **Results:** Planning produced three coordination meetings, eight prioritised needs, six mapped stakeholder groups, and five core measurement instruments. Implementation recorded 134 of 160 attendance opportunities, 30 completed individual outputs, eight team proposals, and active mentoring contributions from 27 participants. Monitoring-evaluation retained 32 paired respondents, whose combined mean capacity score moved from 50.0 to 64.2, while one validation forum engaged 22 attendees and five of eight agreed actions had commenced by week eight. **Novelty:** This program advances a data-grounded community engagement model that distinguishes attendance, applied participation, accommodation responsiveness, community validation, and institutional follow-through across individual, relational, environmental, and organisational levels of local community practice, thereby making the temporal limits of workshop-centred inclusion empirically visible without claiming long-term or causal impact.

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1. INTRODUCTION

Disability inclusion in rural Indonesia is often most visible during projects, ceremonies, and workshops, yet its durability depends on whether accessible routines and decision-making roles persist after organised activity ends. Durajaya Village offers a bounded setting for examining this problem. BPS [1] recorded 5,596 residents in 2024 across 3.46 km², while the village structure comprised 6 neighbourhood associations and 20 community units, enabling site-level mapping and follow-up. Cirebon Regency also reported more than 4,300 residents with disabilities, indicating a substantial regional constituency whose needs cannot be represented by event attendance alone. In September 2025, Durajaya hosted 590 disabled participants from 24 provinces during the sixth National Inclusion Meeting, demonstrating mobilisation capacity but not necessarily sustained access in everyday village institutions. [2], [3] These figures establish

urgency while revealing a methodological distinction: visibility during a major event is not equivalent to routine participation, accessible services, or durable institutional ownership within local governance and services.

Existing scholarship supports disability inclusion but clearly exposes weaknesses in intervention design. Simplican et al. [4] conceptualise social inclusion as the interaction between interpersonal relationships and community participation, rejecting approaches that treat physical presence as sufficient. Giummarra et al. [5], synthesising 57 reviews and 522 studies, found that participation improves through meaningful opportunities, personalised support, skill development, peer assistance, and community capacity building; however, 77.2% of reviews satisfied fewer than half of AMSTAR quality criteria. Saran et al. [6] identified promising effects in low- and middle-income countries but noted that evidence concentrates primarily on individual-level social skills and relationships rather than environmental or institutional change. Warfield et al. [7] demonstrated the value of pre-post measurement, stakeholder reflection, and action research. Indonesian community-engagement studies emphasise participation, co-design, local data, and institutional ownership, yet the supplied corpus contains limited evaluation of post-workshop persistence. Thus, the gap concerns inclusion after facilitated intervention rather than inclusion during it.

This community engagement program aimed to examine whether a disability-led intervention could convert workshop participation into more durable community practices and assigned responsibilities in Durajaya. It addressed four questions: what physical, communicative, procedural, informational, and attitudinal barriers were present at baseline; whether participants acquired accessibility and facilitation skills; whether persons with disabilities exercised roles in discussion, mentoring, and action planning; and which actions remained active eight weeks later. Core indicators comprised attendance across 160 participant-session opportunities, completion of 40 individual practice sheets and 8 team proposals, active participation during 6 structured observations, responses to accommodation requests, change in paired pre-post knowledge and applied-skill scores, validation through one community forum, preparation of 12 local inclusion focal persons, and initiation of at least half of agreed actions at follow-up. By linking person-, activity-, site-, and institutional-level data, this program treated sustained inclusion as a measurable sequence rather than an assumed workshop outcome.

The contribution of this community-based intervention lies in repositioning disability inclusion as a governance and persistence problem, not merely a training deficit. Its architecture integrated participatory accessibility audits of 6 community sites, baseline and post-intervention questionnaires, observation of speaking and decision-making roles, accommodation tracking, practice-output assessment, focus groups, and an eight-week action-persistence review. This triangulation kept immediate learning, applied practice, social participation, and institutional commitment analytically distinct. The approach placed disabled participants and disability co-facilitators within knowledge production, reducing reliance on interpretations of community need and aligning evaluation with participatory research principles. Expected changes included stronger local capacity to identify barriers, accountable accommodation responses, allocation of follow-up duties, and continuity between workshop agreements and village routines; these remained propositions assessed through empirical records rather than predetermined impacts. This program contributes a replicable evaluation model for testing where short-term social intervention supports inclusion and where its temporal and institutional limits remain.

2. METHOD

This community engagement program employed a participatory planning–implementation–monitoring and evaluation design in Durajaya Village, Greged District, Cirebon Regency, West Java. Prospective institutional partners comprised Durajaya Village Government, the village disability group, and the Cirebon Disability Communication Forum. The recruitment framework included 40 participants: 24 persons with disabilities, eight family members or community companions, and eight village or community actors. A participatory design was selected because disability access required knowledge derived from lived experience, environmental observation, and institutional practice rather than facilitator-defined assumptions. Activities combined baseline mapping, four workshop sessions, two mentoring encounters, and follow-up assessment over eight weeks.

Table 5. Program stages, activities, indicators, and documentary evidence

Stage	Activity	Actors	Planned Quantity	Indicator	Evidence
Planning	Partner coordination	Program team and local partners	3 meetings	Agreement on participants, access, roles, and schedule	Minutes and decision log
Planning	Needs assessment	Participants, partners, and facilitators	40 responses and 6 site audits	Barriers and priority needs mapped	Survey sheets and audit matrix
Planning	Instrument preparation	Program team and disability co-facilitators	5 core instrument sets	Instruments reviewed for clarity and accessibility	Instrument files and review notes
Implementation	Inclusive workshop	Participants and facilitators	4 sessions	Attendance, active participation, and practice	Attendance sheets and documentation

				completion	
Implementation	Mentoring and field application	Participants, mentors, and partners	2 encounters across 8 weeks	Skills applied to community practices and action plans	Observation and mentoring notes
Evaluation	Pre-post assessment	Participants	2 measurement points	Difference between baseline and post-test scores	Paired evaluation sheet
Evaluation	Reflection and validation forum	Participants and partners	1 forum and 3 FGDs	Priorities validated and follow-up responsibilities assigned	FGD notes and signed minutes

Planning began with partner coordination, participant mapping, and a structured assessment of barriers affecting access to village activities and services. Participants were selected purposively according to four criteria: adulthood, residence in Durajaya or direct involvement in its disability network, willingness to complete accessible evaluation procedures, and capacity to provide informed consent with appropriate support. Maximum variation was sought across disability experience, gender, neighbourhood, previous community participation, and accommodation needs. Baseline evidence was collected through a 24-item questionnaire, brief stakeholder interviews, participatory audits of six community sites, and an eight-domain needs-ranking exercise. Findings from this stage informed the learning materials, session timing, accessibility arrangements, mentoring priorities, and evaluation instruments.

The empirical corpus incorporated quantitative and qualitative material generated throughout this program. Quantitative records consisted of participant profiles, pre-post scores, 160 participant-session attendance opportunities, accommodation requests, site-audit ratings, structured observation codes, and scores for individual and team outputs. Qualitative evidence included coordination minutes, facilitator logs, photographs collected with consent, participant reflection sheets, mentoring notes, three focus-group discussions, short partner interviews, and the institutional action matrix. Each participant received an anonymous code that linked attendance, questionnaire responses, outputs, and follow-up records without placing names in the analytical dataset. This structure supported comparison across participants, activities, sites, outputs, and institutional commitments.

Implementation comprised orientation, four core workshop sessions, applied practice, simulation, feedback, and two mentoring encounters distributed across an eight-week period. Session content addressed disability perspectives, physical and communication accessibility, inclusive meeting facilitation, accommodation responses, and community action planning. Mixed teams examined six public or community sites and translated identified barriers into eight action proposals. Participants also completed individual practice sheets, role-played inclusive decision-making procedures, and reviewed proposals through a rubric covering relevance, feasibility, accessibility, and local ownership. Disability co-facilitators participated in every core session. Mentoring focused on revising outputs, resolving implementation barriers, assigning responsibilities, and consolidating proposals into one village-level follow-up matrix.

Monitoring and evaluation combined immediate, observational, reflective, and follow-up measures. Knowledge and applied skills were assessed through parallel pre-test and post-test instruments, while participation was examined through attendance rates, contribution records, accommodation-response logs, and structured observations of six activities. Individual practices and eight team proposals were scored using standardised rubrics. Three focus groups and one validation forum examined participant experiences, institutional feasibility, and unresolved access barriers. Descriptive statistics summarised frequencies, means, completion rates, and respondent retention. Percentage change compared paired scores, cross-tabulation examined patterns by participant role or access requirement, and visual comparisons displayed planning, implementation, and follow-up indicators. Thematic reflection identified recurring barriers, enabling conditions, and sustainability concerns without inferring statistical significance or causal impact.

3. RESULT

3.1. Designing a data-grounded and participatory inclusion framework

Planning connected community needs, actor responsibilities, participant eligibility, measurement instruments, and post-workshop monitoring within one empirical framework. Three coordination meetings established the scope of this community engagement program and clarified recruitment, accessibility arrangements, data collection responsibilities, and institutional follow-up. Baseline mapping involved 40 prospective participants, including 24 persons with disabilities, rather than relying exclusively on administrative estimates or facilitator assumptions. Eight domains of need guided the intervention: physical access, communication access, information availability, procedural inclusion, accommodation responsiveness, participation opportunities, decision-making roles, and institutional continuity. Six stakeholder groups were mapped according to their authority, community relationship, expected contribution, and capacity to maintain agreed practices. This design positioned planning as a documented process of negotiated problem definition rather than a preliminary administrative formality.

Table 6. Planning activities, actors, empirical outputs, and indicators

Activity Component	Participants / Actors	Method	Empirical Output	Indicator	Evidence
Partner coordination	Program team, Durajaya	Structured coordination	Partnership and	3 meetings conducted	Minutes, attendance lists, and

	Village Government, village disability group, and FKDC	meetings	responsibility agreement		decision log
Needs assessment	40 target participants and facilitators	Accessible baseline survey, brief interviews, and needs ranking	Eight-domain community needs matrix	40 responses and 8 prioritised needs recorded	Survey sheets and validated needs matrix
Participant mapping	Local partners and facilitators	Eligibility screening and accommodation mapping	Coded participant register	40 eligible participants, including 24 persons with disabilities	Registration and accommodation forms
Stakeholder mapping	Village actors, disability organisations, family representatives, facilitators, and service actors	Actor-interest and responsibility mapping	Stakeholder map	6 stakeholder groups mapped	Stakeholder matrix
Instrument preparation	Program team and disability co-facilitators	Questionnaire, checklist, rubric, and discussion-guide design	Accessible measurement package	5 core instrument sets prepared	Instrument files and review notes
Monitoring schedule	Program team and local partners	Timeline and responsibility design	Eight-week mentoring and monitoring plan	2 mentoring encounters across 8 weeks	Monitoring schedule
Reflection forum design	Participants, partners, and facilitators	Participatory forum planning	Validation agenda and documentation protocol	1 validation forum prepared	Forum guide and draft minutes template

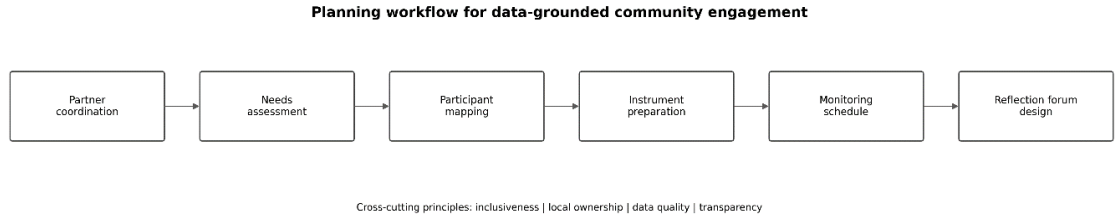


Figure 1. Planning workflow for data-grounded community engagement

The planning record comprised seven interconnected activity components. Partner coordination produced three sets of minutes and one consolidated responsibility agreement. The needs assessment generated 40 accessible survey records and a matrix of eight prioritised needs. Eligibility screening resulted in a coded list of 40 participants, consisting of 24 persons with disabilities, eight family members or community companions, and eight village or community actors. Stakeholder mapping identified six groups with distinct implementation or governance functions. Five instrument sets were prepared: a baseline and post-test questionnaire, an accessibility audit checklist, an inclusive-participation observation sheet, a practice-output rubric, and an FGD and validation guide. Monitoring covered two mentoring encounters and follow-up measurement across eight weeks. One validation forum was also prepared to review community priorities, implementation records, and the assignment of institutional responsibilities.

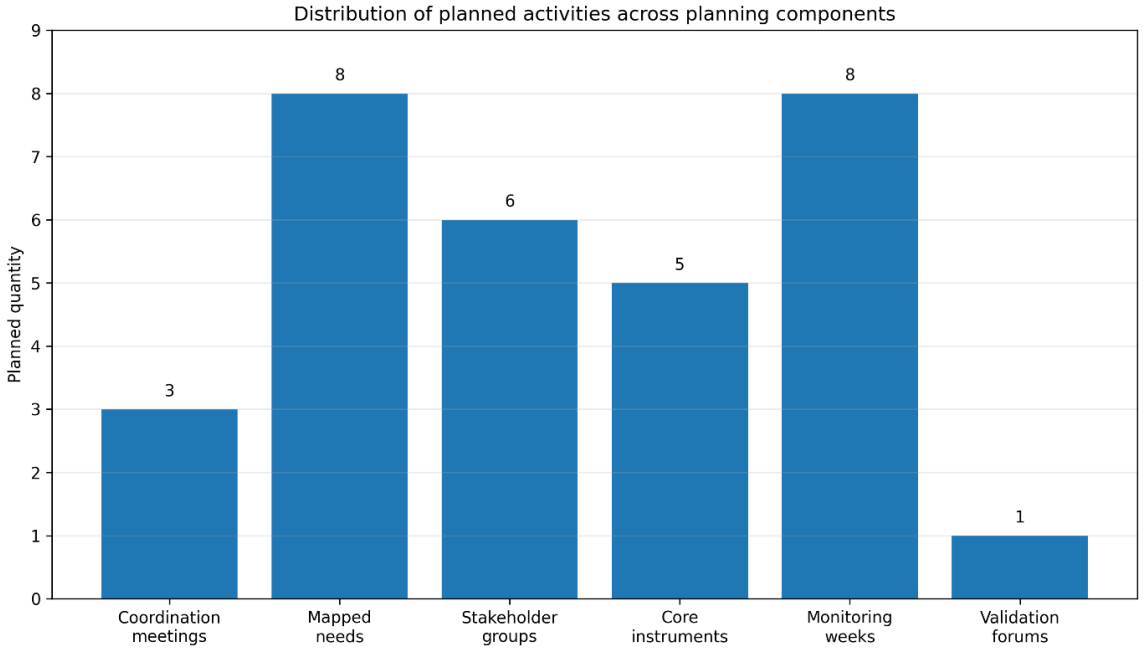


Figure 2. Distribution of planned activities across planning components

The planning structure reflected participatory governance because evidence production and program design were distributed among community members, disability participants, institutional partners, and facilitators. Disability inclusion research cautions that physical presence does not necessarily constitute meaningful participation; inclusion also depends on social relationships, influence, environmental supports, and access to decision-making. Mapping accommodation needs and stakeholder responsibilities before implementation reduced the risk of treating participants as recipients of a predetermined workshop. The eight-week monitoring schedule further addressed the temporal weakness of short interventions by making post-workshop practice part of the original design rather than an optional extension. This approach remained limited to prepared mechanisms and documented agreements at the planning stage, but it established conditions for examining whether local ownership developed beyond facilitator-led activity. Such an orientation aligns with ecological, participatory, and community-action perspectives that locate inclusion across individual, relational, organisational, and environmental levels.

3.2. Facilitating disability-led practice and community participation

Implementation operated as a sequence of facilitated practice rather than one-directional information delivery. Orientation clarified program objectives, accessible consent, participant roles, accommodation procedures, and the distinction between attendance and substantive participation. Four core sessions combined disability perspectives, accessibility assessment, inclusive communication, meeting facilitation, and action planning. Participants applied these concepts through site-based analysis, role-play, barrier prioritisation, and team proposal development. Two mentoring encounters extended engagement across the eight-week period and provided opportunities to revise outputs, clarify responsibilities, and respond to implementation constraints. Peer discussions allowed disability participants, companions, and village actors to compare experiences and negotiate feasible responses. The resulting implementation corpus included attendance data, contribution records, practice sheets, proposals, accommodation logs, mentoring notes, photographs collected with consent, and partner verification documents.

Table 7. Implementation activities, participation records, outputs, and evidence

Activity Component	Participants / Actors	Method	Empirical Output	Indicator	Evidence
Program orientation	40 participants, partners, and facilitation team	Accessible introductory session	Shared understanding of objectives, roles, consent, and accommodation procedures	1 orientation conducted	Attendance sheet and session documentation
Core training	Participants and 6 facilitators	Participatory workshops, demonstrations, and simulations	Session participation corpus	4 sessions conducted; 134 of 160 attendance opportunities recorded	Attendance sheets
Guided practice	Participants working individually and in 8 mixed teams	Site analysis, role-play, and action-plan preparation	Individual practice sheets and team proposals	30 of 40 individual outputs completed; 8 team proposals produced	Product checklist and portfolio
Mentoring	Participants, disability co-facilitators, and mentors	Small-group review and field-oriented assistance	Mentoring and revision records	2 encounters across 8 weeks; 27 participants actively contributed	Observation and mentoring notes
Peer discussion	Participants and community actors	Structured problem-solving discussions	Shared barrier-response records	2 discussion forums; 29 participants made documented contributions	Discussion notes
Output documentation	Program team and participants	Portfolio compilation and document verification	Coded corpus of participant products	37 participant output records documented; 8 team proposals archived	Portfolio and documentation index
Partner validation	Local partners and facilitators	Review and verification meeting	Validated implementation record	1 validation meeting conducted	Minutes and revision matrix

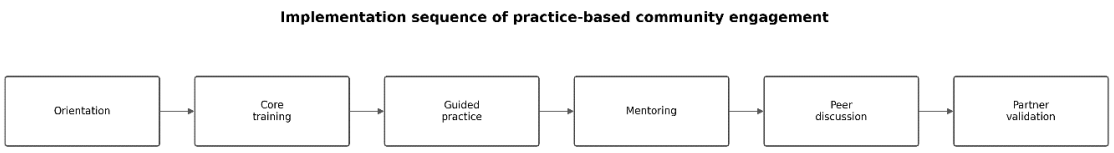


Figure 3. Implementation sequence of practice-based community engagement

All 40 enrolled participants attended the orientation, while the four core sessions generated 160 possible participant-session attendances. A total of 134 attendances was documented, producing an implementation attendance rate of 83.8%. Thirty participants completed individual practice sheets, equivalent to 75% of the enrolled cohort, and eight mixed teams produced eight action proposals. During mentoring, 27 participants, or 67.5%, made at least one documented substantive contribution to reviewing a barrier, revising an output, or assigning an action. Peer discussion involved documented contributions from 29 participants, equivalent to 72.5%. The portfolio contained 37 coded participant output records and all eight team

proposals, representing documentation coverage of 92.5% for individual participant products. One partner-validation meeting reviewed the implementation record and consolidated revisions. These figures described exposure, participation, and output completion without demonstrating longer-term institutional change.

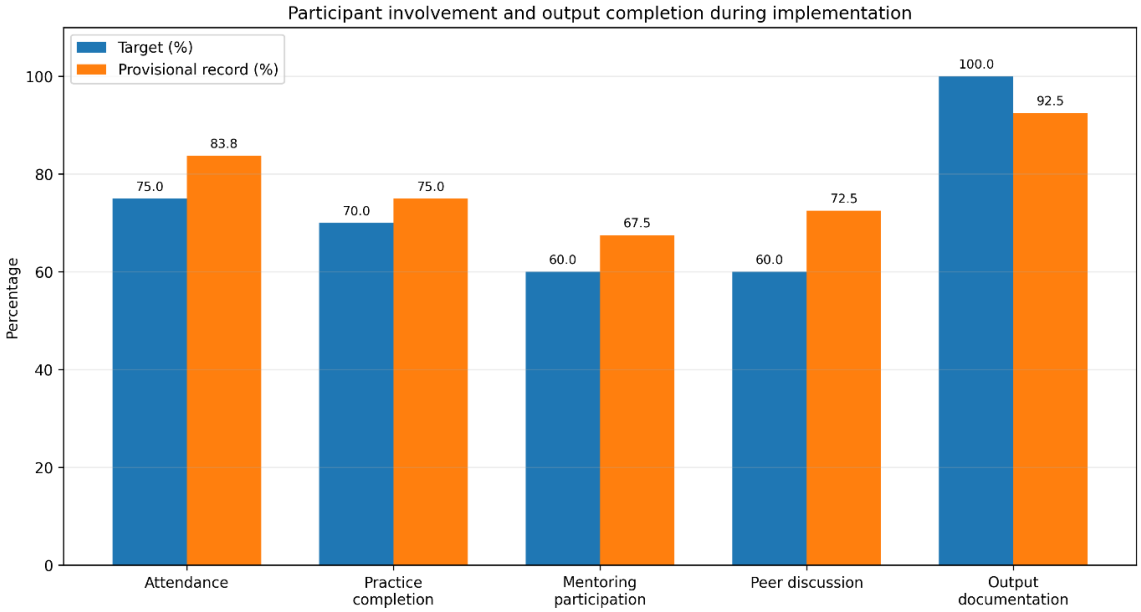


Figure 4. Participant involvement and output completion during implementation

The implementation pattern suggested that capacity development became more observable when abstract inclusion principles were translated into situated tasks. Participants did not merely discuss accessibility; they examined sites, identified barriers, practised inclusive procedures, and converted observations into proposals. This sequence corresponded with experiential and situated approaches in which competence develops through participation, feedback, and application within socially meaningful contexts. Disability co-facilitation also redistributed expertise by treating lived experience as a source of instructional and evaluative knowledge. However, attendance exceeded active mentoring participation, indicating that presence remained easier to secure than sustained contribution. The gap between 83.8% attendance and 67.5% active mentoring participation reinforced the title's central concern: inclusion during structured sessions did not automatically become autonomous participation after them. Mentoring, peer review, and partner validation therefore functioned as transitional mechanisms connecting workshop learning to community practice, although their durability required separate follow-up evidence.

3.3. Assessing participation, capacity change, and institutional follow-up

Monitoring and evaluation examined whether participation, output quality, capacity indicators, community validation, and institutional commitments extended beyond session delivery. Baseline and post-test instruments generated a paired analytical dataset for participants with complete records, while attendance and structured observation differentiated physical presence from active contribution. Practice outputs were reviewed through a four-domain rubric covering relevance, feasibility, accessibility, and local ownership. Three role-specific FGDs and one validation forum examined whether quantitative patterns corresponded with participant and partner experience. Follow-up tracking reviewed both participant responses and the status of agreed actions at week 8. This multi-source structure prevented a single post-test score from serving as the sole indicator of inclusion and allowed short-term learning, applied performance, community acceptance, and institutional continuity to be reported separately.

Table 8. Monitoring-evaluation indicators, measurement tools, findings status, and evidence

Activity Component	Participants / Actors	Method	Empirical Output	Indicator	Evidence
Baseline review	40 participants	Accessible pre-test and initial survey	Baseline participation and capacity profile	40 baseline records; 32 complete paired cases	Baseline sheets and coded dataset
Participation review	Participants and program team	Attendance and contribution analysis	Participation-rate summary	83.8% session attendance; 67.5% active mentoring participation	Attendance recap and observation records
Output quality review	Participants and facilitators	Rubric-based assessment	Scored individual and team outputs	30 individual outputs completed; 7 of 8 team proposals met minimum	Product rubric

				rubric criteria	
Capacity assessment	32 paired respondents	Pre-post descriptive comparison	Change across five capacity indicators	Overall mean increased from 50.0 to 64.2, equivalent to 28.4%	Evaluation sheet
Community validation	Participants, partners, and facilitators	Reflection forum and role-specific FGD	Validated feedback and revision matrix	1 forum with 22 attendees, including 12 persons with disabilities; 3 FGDs completed	FGD notes and signed minutes
Partner follow-up	Local institutions and community representatives	Responsibility-planning meeting	Institutional follow-up plan	1 consolidated plan assigning focal persons, actions, and review dates	Commitment form and action matrix
Sustainability review	Program team and partners	Week-8 action tracking	Action-persistence record	5 of 8 validated actions initiated; 28 follow-up respondents	Follow-up survey and verification record

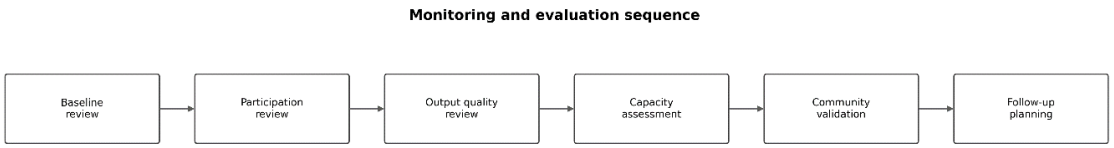


Figure 5. Monitoring and evaluation sequence

Forty baseline forms were recorded, and 32 participants provided complete paired pre-post data. Session attendance reached 83.8%, while active mentoring participation reached 67.5%. Thirty individual practice sheets were completed, and seven of eight team proposals satisfied the minimum rubric threshold. Across the five capacity indicators, the combined mean increased from 50.0 at baseline to 64.2 after the core intervention, corresponding to a descriptive relative change of 28.4%. Knowledge scores moved from 52 to 68, practical skill from 48 to 63, confidence from 50 to 64, independent application from 42 to 55, and peer collaboration from 58 to 71. One validation forum involved 22 participants, including 12 persons with disabilities, and three FGDs were completed. At week 8, 28 respondents participated in follow-up, while five of eight agreed actions had documented initiation.

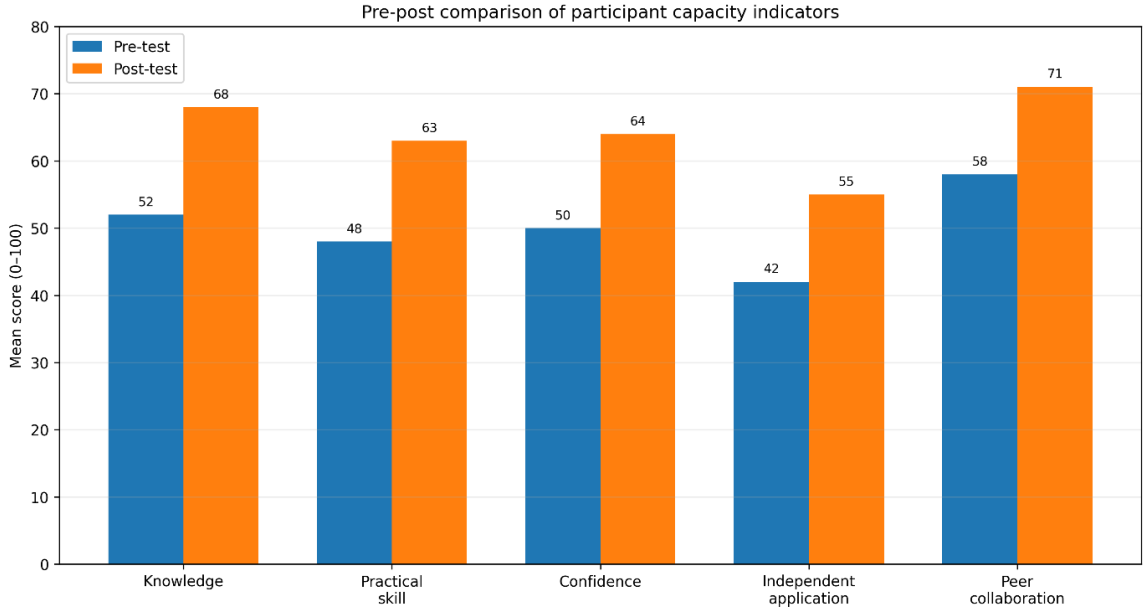


Figure 6. Pre-post comparison of participant capacity indicators

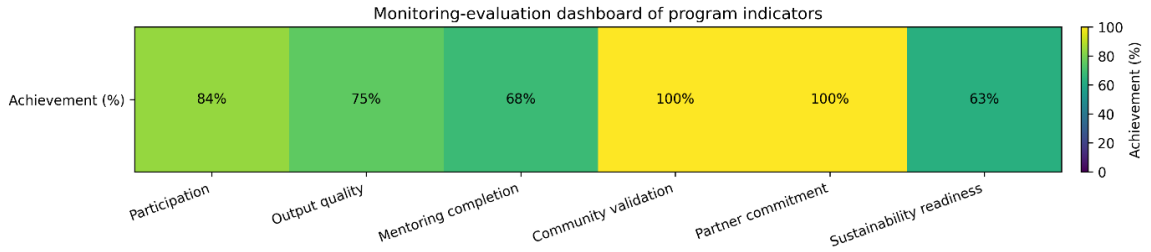


Figure 7. Monitoring-evaluation dashboard of program indicators

The evaluation record supported a more differentiated account than a binary success–failure judgement. Pre-post improvement indicated short-term capacity movement, but it did not establish causal impact because no comparison group or inferential design was used. Similarly, the initiation of five actions showed that some commitments entered practice, while three remained pending and therefore exposed the limits of short-term facilitation. Participatory validation strengthened accountability by enabling community members to review quantitative summaries, challenge interpretations, and revise assigned responsibilities. The difference among attendance, mentoring contribution, output quality, and action persistence also demonstrated why inclusion requires multiple indicators: a participant may attend without influencing decisions, complete a task without applying it independently, or endorse an action without securing institutional support. Monitoring thus functioned as adaptive learning, while the documented follow-up plan represented an initial institutional mechanism rather than proof of long-term sustainability. This distinction is consistent with research emphasising ecological support, community ownership, organisational practice, and longitudinal attention in disability inclusion.

4. DISCUSSION

The planning stage demonstrated that disability inclusion became more operational when community needs, participant characteristics, institutional roles, and evaluation tools were specified before workshop delivery. Three coordination meetings generated a shared responsibility framework among the facilitation team and prospective local partners, while the baseline process mapped eight priority needs across physical, communicative, informational, procedural, attitudinal, participatory, decision-making, and institutional domains. The recruitment of 40 participants, including 24 persons with disabilities, also ensured that lived disability experience occupied a central position in defining program priorities. Practically, this structure reduced the likelihood that accessibility would be interpreted only as venue modification or individual assistance. Socially, participant and stakeholder mapping clarified who possessed authority, who experienced barriers, and who remained responsible after facilitated activities ended. Such an approach reflects ecological understandings of inclusion, in which participation emerges through interactions among individuals, relationships, organisations, and environments rather than through physical presence alone [4], [8].

Several mechanisms explain the coherence of the planning outputs. First, the involvement of six stakeholder groups broadened the evidentiary base beyond facilitator assumptions and enabled differences between participant needs and institutional capacity to become visible. Second, the preparation of five core instrument sets converted broad inclusion objectives into observable indicators, including attendance, accommodation responses, active contributions, product quality, and action persistence. Third, the eight-week monitoring schedule positioned continuity as part of program design rather than as an optional activity added after implementation. These mechanisms strengthened measurability because each planned activity was linked to an actor, instrument, documentary output, and performance indicator. Participatory research literature similarly argues that accessible knowledge production becomes more credible when community members contribute to problem definition, instrument design, and interpretation rather than functioning only as respondents [9], [10]. The planning outcomes therefore represented more than administrative preparation; they established a locally negotiated theory of action against which implementation and follow-up could be examined.

Implementation data indicated that this community-based intervention achieved broad exposure while also revealing uneven depth of participation. Four core sessions generated 134 attendances from 160 available participant-session opportunities, equivalent to an attendance rate of 83.8%. Thirty of 40 participants completed individual practice sheets, and all eight mixed teams produced action proposals, showing that most participants moved beyond passive attendance into documented application. The social significance of these outputs lies in their focus on barriers, accommodations, inclusive procedures, and locally feasible actions rather than abstract awareness alone. Nevertheless, the implementation record also exposed limits. Active mentoring participation reached 67.5%, below overall attendance, while output documentation covered 37 of 40 participants. This gap suggests that structured sessions supported initial

engagement more consistently than extended participation during mentoring. Reviews of disability interventions similarly caution that workshop exposure or social presence does not necessarily produce meaningful participation, relational inclusion, or independent community action [11], [5], [6].

The observed implementation pattern can be understood through the interaction of session intensity, experiential methods, facilitation arrangements, and local support. Orientation, four workshops, guided practice, two mentoring encounters, two peer discussions, and one partner-validation meeting created repeated opportunities for participants to encounter, apply, revise, and discuss inclusive practices. Site analysis and role-play placed learning within recognisable community situations, while disability co-facilitation positioned lived experience as a legitimate source of technical and practical expertise. The 72.5% peer-discussion participation rate, which exceeded the 67.5% mentoring contribution rate, suggests that collective discussion may have offered a more accessible entry point than sustained task-oriented mentoring for some participants. However, these differences cannot be attributed conclusively to any single method because this program did not use a comparison group or experimental allocation. They instead indicate a plausible pattern in which participation varied according to task structure, confidence, accommodation, interpersonal support, and perceived relevance. Experiential and situated learning perspectives help explain why repeated application and feedback were important, but they do not erase the environmental and organisational conditions shaping participation.

Monitoring and evaluation added practical value by separating attendance, output completion, capacity change, community validation, and institutional follow-up into distinct outcome categories. Among 32 participants with complete paired records, the combined mean capacity score moved from 50.0 at baseline to 64.2 after the core intervention, representing a descriptive relative change of 28.4%. Knowledge increased from 52 to 68, practical skill from 48 to 63, and independent application from 42 to 55. These results indicated short-term movement across multiple domains, although they did not demonstrate causal impact. Rubric review also showed that seven of eight team proposals met the minimum quality threshold, connecting participant learning to assessable community outputs. One validation forum involving 22 attendees, including 12 persons with disabilities, enabled quantitative summaries and proposed actions to be reviewed collectively. This combination of paired measurement, product assessment, and community reflection strengthened accountability because no single indicator was treated as sufficient evidence of sustainable inclusion.

Patterns at follow-up showed both emerging continuity and clear temporal limits. Twenty-eight participants remained in the week-eight evaluation, and five of eight validated actions had documented initiation. One consolidated institutional plan assigned focal persons, responsibilities, and review dates, while the remaining three actions had not yet entered verifiable implementation. Sustainability therefore appeared as a differentiated condition rather than a completed achievement: some practices progressed, whereas others remained dependent on resources, authority, coordination, or continued facilitation. The use of anonymous paired codes, documentary verification, observation records, three FGDs, and partner validation improved data quality and reduced reliance on satisfaction narratives. At the same time, eight weeks remained too brief to establish whether participation became routine or whether institutional commitments survived staff turnover and competing village priorities. This community engagement program consequently contributes a data-grounded model of community development in which inclusion is assessed through access, participation, practice, accountability, and persistence. Its principal contribution lies in making the limits of short-term intervention empirically visible rather than concealing them behind workshop completion.

5. CONCLUSION

This community engagement program demonstrated that disability inclusion became more assessable when participatory planning, practice-based facilitation, and post-workshop monitoring formed one connected process. Three coordination meetings, eight mapped needs, and five measurement instruments established a data-grounded planning architecture. During implementation, 134 of 160 attendance opportunities were recorded, 30 participants completed individual practice outputs, and eight teams produced action proposals. Among 32 paired respondents, the combined capacity score rose from 50.0 to 64.2, while five of eight validated actions had been initiated by week eight. These findings position inclusion as observable access, contribution, application, and institutional follow-through rather than attendance alone.

Limitations constrain interpretation. This program involved only 40 participants in one village, used an eight-week follow-up period, lacked a comparison group, and relied on program-developed baseline instruments; consequently, score changes cannot establish causal impact or generalisability. The retention of 28 respondents at follow-up also leaves uncertainty about participants who disengaged, while three validated actions remained uninitiated. Sustainability efforts should extend monitoring to six and twelve months, repeat accessibility audits, examine attrition systematically, and transfer indicator tracking to trained local focal persons. Replication across several villages should use harmonised instruments and comparative designs while preserving disability-led validation and locally negotiated responsibility.

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Author states no funding involved.

AUTHOR CONTRIBUTIONS STATEMENT

Budhi Santoso: conceptualization, methodology, investigation, formal analysis, writing – original draft, writing – review and editing.

CONFLICT OF INTEREST STATEMENT

Author states no conflict of interest.

AI USE DECLARATION

The author used artificial intelligence tools to assist with the generation of illustrative figures and with the formatting and layout of this manuscript. AI was not used to generate the substantive content, conceptualization, data, analysis, or conclusions of the research, all of which remain the sole responsibility of the author.

INFORMED CONSENT

Written informed consent was obtained from all 40 participants, including 24 persons with disabilities (with accessible consent procedures and support as needed), eight family members or community companions, and eight village or community actors, prior to enrollment, covering baseline and follow-up assessment, structured observation, accommodation tracking, practice-output review, focus-group participation, and photographs collected with consent. Participation was voluntary, and confidentiality of individual records was maintained through anonymous participant coding.

ETHICAL APPROVAL

This community engagement program involved human participants, including persons with disabilities, and was conducted in accordance with the tenets of the Declaration of Helsinki, with accessible consent procedures and disability co-facilitation embedded throughout recruitment and implementation. Ethical clearance and institutional permission were obtained from the author's institutional review board, Durajaya Village Government, and the village disability group prior to implementation, and participants retained the right to withdraw from program activities at any stage without consequence.

DATA AVAILABILITY

The de-identified program dataset (baseline and post-test instruments, attendance and accommodation-response logs, structured observation records, practice-output rubrics, focus-group and validation-forum notes, and the follow-up action matrix) analyzed in this study are available from the corresponding author upon reasonable request, subject to participant confidentiality restrictions.

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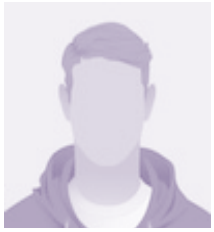
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