



TRAVELLING TOGETHER

Introductory disability inclusion training course

A one-day course, delivered in two half-day sessions



World Vision is a Christian relief, development and advocacy organisation dedicated to working with children, families, and their communities to reach their full potential by tackling the root causes of poverty and injustice. World Vision serves all people, regardless of religion, race, ethnicity, or gender.

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INTRODUCTION

Including children with disabilities in World Vision's programming is central to Our Promise to reach the most vulnerable children and a key component of our overall [Gender Equality and Social Inclusion Approach](#). Disability is one of the factors used to identify serious discrimination within World Vision's mapping of the most vulnerable children. It is likely training on gender equality and social inclusion will identify disability as one of several intersectional vulnerabilities alongside gender, age, refugee or migration status, ethnicity, religion, caste, poverty, etc.

The Travelling Together disability training goes into more detail on disability inclusion to address some of the beliefs among staff and partners that unintentionally impose barriers to the full participation of children with disabilities in our programming, and that prevent these children from enjoying fullness of life. At the end of the training, staff and partners should be able to better understand how they can assist children with disabilities. Additional support and training will then be made available to support staff to make technical programs and projects inclusive of children with disabilities.

Considerations for training

One of the best ways to conduct this training is with persons with disabilities. Ideally, this training should be led by, or at least conducted with, people with disabilities. If you're not well connected to local disability groups (OPDs – Organisations of Persons with Disabilities), it's still possible to run the training program yourselves. However, OPDs are organisations that are primarily managed and staffed by persons with disabilities and can provide important understanding of realities faced by persons with disabilities in your context. You can use this training as a way to start making links with persons with disabilities and OPDs and finding out what the situation is like for them. Invite them to come and take part in the Travelling Together workshops. Having trainees interact with persons with different disabilities during meals and other informal settings is one of the best ways to facilitate deeper personal connections.

Facilitating attitudinal change in a training room environment is demanding. The course materials, when well facilitated, should enable this to happen. It is critical that all facilitators are confident and comfortable with the [rights-based approach to disability inclusion](#) in the concepts presented. More importantly, you need to agree with them – if you do not, then we suggest you do not deliver this course.

Goals for Training: What do we want participants to do after completing this training?

- Demonstrate understanding of social model/ Convention on the Rights of Persons with Disabilities (CRPD) rights-based approaches to disability inclusion.
- Express appropriate personal attitudes towards disability inclusion – these are the foundations of delivering disability-inclusive approaches in World Vision.
- Feel confident to onward-deliver the course's activities to colleagues in World Vision. Participants should be encouraged to share the learning from this course with colleagues and partners – having done the training they will become a good source of information on disability rights for colleagues in World Vision.

This course is primarily aimed at program staff in Field Offices in World Vision. Experience has shown it can be used with a much broader range of staff and tends to be easy to adapt.

Training Room Selection and Layout: How to create an inclusive training room environment for people with disabilities.

As you organise your course on inclusion, ensure persons with disabilities can participate. Here are a few key principles to bear in mind:

- Be prepared for persons with disabilities even if you haven't specifically invited them.
- Try to know your audience in advance by asking all participants if they have any access needs in the invitation. That way you can prepare your venue and materials to take account of their impairments.
- Think about access at an early stage so you have sufficient funds set aside to cover adjustment costs.

We recommend you think about disability access to your training room even if you think no one who has an impairment is planning to attend as there can often be unanticipated changes of plan, sometimes on the day itself. Check access issues before starting the day. The simplest way is to ensure everyone is greeted on arrival, either by the facilitator or their assistants.

Mobility – think about any activities you're planning to use that rely on moving around quickly and/or a lot. Consider how someone with a physical or visual impairment might be excluded from this activity.

Usually, you'll be able to find ways of adjusting activities with a little creativity. If you have time during your preparations, consider asking people with mobility impairments how they could participate in your planned activity. If this isn't possible, be prepared to change the activity for something less physical. The important thing is to ensure everyone is included and can participate.

Sight – if people with visual impairments are attending, there are several protocols to follow. Take them around the workshop venue and facilities (including the toilets) at the beginning of the day, to familiarise them with the layout.

Ask people to state their names before talking in any discussion so everyone knows who is speaking. At the beginning of any session when people may have changed places, going around the group and asking people to give their name helps visually impaired people to know who is present and where they are located.

Remember to describe any visual aids used during the workshop such as PowerPoint presentations, drawings, posters, flipcharts, handouts, etc. Read out loud what is written. This also helps people with limited literacy skills.

If there are any practical exercises, ensure anyone with a visual impairment is able to feel and touch the exhibits. Simple charts, diagrams, drawings and maps can be made tactile by gluing string around the outlines (in advance!). For people with low vision, large print versions of handouts are helpful as is making sure the room is well lit.

Hearing – if there are people with hearing impairments attending, find out their preferred form of communication – for example, sign language or lip-reading?

For communicating with people who lip-read, ensure the speaker's face is well lit, and can be clearly seen by the lip-reader, and that they speak clearly without exaggeration. If the person uses sign language find out which interpreters are appropriate. There are often regional variations, or

the person may rely more on 'home signs' rather than a standardised form of sign language. Professional interpreters or communication support can be arranged through local deaf associations or in consultation with the deaf person and their family.

Frequent use of drawings and the written word are often helpful in supporting the inclusion of deaf participants but do not assume they can read well or fast enough.

Understanding – it's important to ensure that people with mild to moderate intellectual impairments are also included in community programs. Their ability to understand information will vary according to the degree of impairment. The key is simple language, short messages, patience, and repetition as necessary.

The selection of the training room and its layout is important. There needs to be suitable space for group work and displaying materials.

Place participants in a 'horseshoe' shape where possible, rather than having formal rows and lots of tables. A light and bright environment is helpful. It doesn't send out the right messages if you choose a room which participants who are persons with disabilities cannot access, and/or which does not have suitable toilet facilities.

Throughout the training there is a range of group work. Think about how you want the groups to be divided. If randomly, then try using wrapped sweets or candy (chocolate, toffees, etc.) making sure that each type has a different style/colour of wrapper. You'll need the same number of types of sweets or candy as you want groups, and the same number of each type of sweet as the number of people in each group. Mix all the sweets up, then hand around the group, asking them to take a sweet from the bag(s). Their group is everyone with the same type of sweet as them. People often appreciate sweets during training – and for you, as facilitator, the 'sugar rush' from the sweets can help lift the energy in the room!



Example course timetable (two half-day sessions)

SESSION 1: Summary: What is disability inclusion? Why is it important?

TIME	ACTIVITY
8.30 – 9.00am	Welcome participants to the training session; health and safety briefings, etc.; participants to self-introduce
9.00 – 9.20am	Devotions: Jesus and the people – value and inclusion
9.20 – 9.50am	Activity 1: Guessing Game Assumptions we make about disability
9.50 – 10.45am	Activity 2: What is disability? Three models of disability explained, including an introduction to the inclusion barriers children/young people with disabilities experience in development and humanitarian work
10.45 – 11.05am	Tea break
11.05am – 12.05pm	Activity 3: The Chances of Childhood Why is disability an important development issue for World Vision? How opportunities in childhood affect life's outcomes for children and young people
12.05 – 12.45pm	Activity 4: International obligations on disability inclusion; "Nothing About Us Without Us" Key global conventions/frameworks on disability rights An introduction to the disability rights movement and different types of disability organisations
12.45 – 1pm	Conclude: Opportunity for questions and feedback from participants

SESSION 2: Summary: Starting the "how" on disability inclusion programming

TIME	ACTIVITY
9.00 – 9.20am	Devotions: God removes barriers for people with disabilities
9.20 – 9.30am	Recap the key learning points from Day 1 (assumptions, 3 models/barriers/disability definition, why disability is important for World Vision's work, key conventions)
9.30 – 10.00am	Activity 5: The Wall Identifying barriers that block inclusion for children with disabilities
10.00 – 10.30am	Activity 6: Myths About Disability Uncovering and addressing discrimination experienced by children with disabilities
10.30 – 11.00am	Tea break
11.00am – 12.30pm	Activity 7: Introduction to Programming Approaches How your perspective of disability impacts the life outcomes for children with disabilities; Disability programming and World Vision's GESI continuum
12.30 – 1.15pm	Activity 8: Excuses, excuses Why don't development agencies include disability as a programming issue?
1.15 – 2.00pm	Conclude: Final questions and comments. Personal action planning.

OPTIONAL SESSION

Introductory Devotions for Christian Populations¹

Jesus and the people – value and inclusion

Time: 20 minutes

Introduction:

We are going to spend two half-day sessions together thinking about children/young people with disabilities in World Vision's programming work. Let's start by looking to Jesus, and what He did in this famous passage at the start of his final week before death and resurrection in Jerusalem.

Read:

Matthew 21:12-15:

Jesus went straight to the Temple and threw out everyone who had set up shop, buying and selling. He kicked over the tables of loan sharks and the stalls of dove merchants. He quoted this text: "My house was designated a house of prayer; You have made it a hangout for thieves."

Now there was room for the blind people and the physically impaired to get in. They came to Jesus and he healed them. When the religious leaders saw the outrageous things he was doing, and heard all the children running and shouting through the Temple, "Hosanna to David's Son!" they were up in arms and took him to task. "Do you hear what these children are saying?" Jesus said, "Yes, I hear them. And haven't you read in God's Word, 'From the mouths of children and babies I'll furnish a place of praise?'"

Questions to discuss and consider:

This passage is much more radical than it appears to our 21st century reading of it. In Jesus's time, only selected people were allowed in the central sections of the Temple. Many people were excluded and kept out – people who were not deemed acceptable. Children were not allowed. And definitely not people with disabilities.

Discuss how Jesus's actions created space for the socially excluded people to come into the temple.

Consider Jesus's life; whom did He choose to spend his time with? Why do you think He went against the Jewish culture of the day to spend time with these people?

What is Jesus bringing to the people? Healing for the short term or wholeness – especially acceptance – for the long term?

Input:

Jesus strongly demonstrated inclusive values through his actions – very forcefully in the Temple during his final week of Crucifixion and Resurrection. Paul carried on this theme in his writings. Consider these verses from his letter to the Galatians:

Galatians 3:26-28:

For you are all sons of God through faith in Christ Jesus. For as many as were baptised into Christ have put on Christ. There is neither Jew nor Greek, there is neither slave nor free, there is neither male nor female; for you are all one in Christ Jesus.

Questions:

Do you think Paul would add to this list that there is also neither people with disabilities nor people without disabilities? What can we learn about how Jesus demonstrates God's value of people to those he meets?

Input:

From the writer Louise Gosbell:

By touching those considered 'unclean' and by being willing to spend time with those whom society has rejected, Jesus brings them back to their families and communities. But more than this, Jesus offered them a greater restoration. Jesus offers them, as with everyone, the opportunity to be spiritually healed – and the opportunity to be restored in their relationship with God. The results of the miracles are temporary but the spiritual restoration is eternal.

Conclusion:

Jesus broke down barriers – literally – to allow both children and people with disabilities into the inner sanctuary of the Temple. Places where society had banned them from. We should take our example from Jesus. What barriers in society can we work to remove in our programming work at World Vision, to allow children/young people/adults with disabilities access and inclusion to our work?

Prayer:

Dear Lord

As we come together today and tomorrow in this course on disability inclusion, help us to see persons with disabilities as you see and value them. Reveal to us your purposes. Help us to bring our hearts and minds into this room as we learn more about persons with disabilities in our discussions together this week. Help us to be open with each other, and open to greater inclusion of all of your children on earth to your work – especially those who are most vulnerable. Amen

¹ This activity should only be conducted with Christian participants. If the workshop is being conducted with Muslim, Buddhist or Hindu participants, facilitators could prepare a session that is appropriate for these participants.



Session 1

Session 1: Activity 1: Guessing Game

Uncovering our assumptions about disability



Time: 15-30 minutes



Materials:

- Participants to have pen and paper (or a good memory!).
- Flipchart with pre-prepared questions written up (reveal in step 1).

Introduction for trainer:

Assumptions can be stubborn roadblocks on our journey towards inclusion. This initial activity challenges those, and helps set the framework for the rest of the discussions throughout the two half-day training course sessions.

Without exception, this session has proved to be an effective icebreaker, something tangible that people remember long after the training has happened. It gives a quick insight into a core issue – the assumptions people make about children and adults with disabilities and whether these are appropriate – and helps to quickly settle participants into the topic and what the rest of the training activities might bring.

Method:

1. Ask participants to get into pairs, preferably with someone they don't know well.
2. Without talking, pairs have up to three minutes to look at their partner and guess five things about them. Reveal the flipchart with your pre-prepared list.

The list below is suggested. Others could be used, depending on the training context.

- Favourite food
 - Favourite childhood game
 - A favourite book/TV program/radio program/movie from your youth
 - Best place/country ever visited
 - An unfulfilled life ambition.
3. Pairs to share their answers with each other first and check how accurate they were (probably not very accurate!).
 4. Gather back as a group. Invite people to share some of their answers – start with guesses that were right, then move to guesses that were inaccurate.

Ask people what they based their guesses on (both right and wrong). This can cause a lot of humour! Please be sensitive not to cause embarrassment for anyone in the training group through their sharing of answers.

5. Ask for general feedback. How accurate were they? What made it hard/easy to guess? How did people feel when their partner revealed their answers? Why?

Generally, people will make guesses based on clues such as gender, age, physical appearance, and nationality/ethnic group. People often express a mixture of surprise, pleasure and discomfort in having guesses made about them! It can make people feel a little uncomfortable that a colleague has 'judged' something about them on little information. People can also feel awkward making guesses – how could they possibly know the answers to some of these questions when they don't know anything about them?

6. Once you feel you've covered all their ideas, start to talk about disability, concluding with bringing focus onto children/young people with disabilities and their families.

Provide this introduction: This activity gets everyone to make guesses about someone they don't know. Another word for these guesses is **assumptions**.

We all make assumptions about people we do not know (and some about those we do!) based on many factors acquired over our lifetimes from a combination of sources/experiences/values/culture. They are our way of coping with life in a complex social environment. Factors such as age, gender, ethnicity and physical appearance can all have an influence – often without us consciously being aware – on the way we assess people when we first meet them, before we've even spoken to them.

Assumptions can sometimes be useful. But assumptions also create barriers. They can prevent us from engaging with people we think have little in common with us.

*The reason for starting this course on disability with this activity is to bring into focus the central part **assumptions** play in disability inclusion programming work.*

*Many of the things that stop children/young people with disabilities progressing in their lives start as a result of the **assumptions** others make about them – what they need, what they are capable of, what they want to achieve. Children/young people with disabilities are largely*

observed, then other people decide what to implement for them, based on what they think children/young people with disabilities need. This happens before they even get to know them. If children/young people with disabilities are noticed at all – they are often ignored or overlooked in programming design.

People with disabilities commonly report their daily 'lived' experience is that many assumptions are made about them before they are even spoken to or engaged with. This applies to children/young people with disabilities and their families – the focus of World Vision's programming work. Most assumptions about disability are generally based on stereotypes – often stemming from prejudice and discrimination. Some examples:

- People without disabilities often assume a pre-school child with a disability can't join in with nursery class activities because they don't have capacity to participate in activities. One of your guesses was about your favourite childhood game – many may assume children with disabilities aren't able to join in and play games.
- Girls and women with disabilities, for example, are often wrongly assumed to be uninterested in or unable to have children and are therefore not targeted by sexual/reproductive health awareness programs.
- In school, children with various disabilities are often excluded from taking part in sports or music activities by teachers who make assumptions that they would not be able to participate or enjoy the activities.

These assumptions are usually false. But without taking time to engage children with disabilities and their families/caregivers, it will be difficult to know. There's a big danger you'll continue to exclude them because of what you think they cannot do.

We all carry personal assumptions about children/young people with disabilities. These are based on our experiences, values and cultural 'lenses' acquired throughout our lives. Being self-aware of these assumptions is a key part of our journey as staff in World Vision as we strive for greater inclusion of children and adults with disabilities in our work.

Disability is one of the six criteria in World Vision's Most Vulnerable Child (MVC) assessment framework. Many of the other criteria in the MVC framework will also apply to children with disabilities in all the contexts where we work (in abusive, violent or exploitative relationships; in extreme poverty and deprivation; with serious discrimination that prevents them from accessing services/opportunities; with the most vulnerability to negative impacts of catastrophes or disasters; lacking in adequate care and protection).²

This training will get you to consider what having a disability means for a child and their family. It will also look at what it means for World Vision's programming work to fully include children/young people with disabilities and their families.

Motive:

This activity should start discussions on the **assumptions** we all make without knowing each other. It is based on non-verbal communication. Assumptions are our way of coping with life in a complex social environment. It can be very useful. However, it can also be a huge barrier when assumptions prevent others from succeeding.

Many people without disabilities in the world have negative assumptions about children/young people with disabilities. Some of these will be explored in this training course. Many families who have children with disabilities experience huge assumptions (and judgements) about them. These are based on appearance – or on a surface understanding of their situation. No real progress will be made if these assumptions aren't raised and challenged.

This activity can help start to open up important discussions in later activities. It's very important for people to start this discussion and consider how they personally regard children/young people with disabilities. Everyone involved in planning and implementing programming work brings their beliefs, experiences and values on disability into what they do. These have been gained over a lifetime of experiences – personal networks, society, media messaging, etc. – which pre-date being a World Vision staff member! Many will not have consciously thought about disability before. Most people are not fully self-aware what their beliefs and values are about children/young people with disabilities – they have probably absorbed views and approaches "fed" to them in the societies in which they have lived over the course of their lifetimes.

Experience in World Vision has shown that the values and beliefs held by each and every person involved in programming planning and delivery, strongly influences how disability-inclusive programming is delivered – and how successful it is.

All the communities in which World Vision works will have their own beliefs and assumptions about children/young people with disabilities. Our work to encourage communities to include children/young people with disabilities begins with what we think about them ourselves.

² A Toolkit for Integrating Gender and Social Inclusion in Design, Monitoring and Evaluation, April 2020, p. 6

Session 1: Activity 2: Defining Disability

What does disability mean to you?



Time: 60 minutes



Materials:

- [Handout 1: Models of Disability, Barriers to Inclusion, Disability Definitions](#)
 - Prepared diagrams of the models. These should be displayed when you talk the group through their differences in step 4 of this activity
 - A5-sized cards or large post-it notes and marker pens for each group
 - Pen and paper for individual participant list-writing in step 1

Introduction for trainer:

Development programs often ignore children and adults with disabilities – or treat them as a special case. **This activity deals with different models of understanding of disability, and is central to the whole training.** As trainer, you need to be comfortable with the differences in approaches before you lead the training, because participants will probably want to challenge many aspects before accepting them.

Both the medical and charity approaches (known as the ‘individual’ models as they focus on the person with disability as the ‘problem’) have targeted children and adults with disabilities as a separate group – needing only specialist or dedicated services, chosen on their behalf by ‘experts’.

By contrast, the social model assumes children and adults with disabilities should participate in all development activities. But it also assumes those actions may need to be adapted for accessibility and inclusion, removing barriers that prevent children and adults with disabilities being equal participants. This means World Vision needs to take responsibility for understanding how to include children and adults with disabilities as stakeholders in all our mainstream work – and to look for ways to support their participation in community life.

You may also encounter models related to different religions and religious norms that assume disabilities are caused by the sins of an individual or their parents. It is very important to understand that faith traditions may have contradictory messaging on disability. World Vision will be developing additional resources to support work with faith leaders and faith communities to address

messages which don’t support a social or human rights model of disability.

Method:

1. Ask participants – **‘What words or images come to mind when you say or think about the terms “disability” or “child/children with disabilities”?’** Give them two or three minutes to consider everything that comes to mind. Participants may want to write personal lists – these lists can be quite long.
2. Divide participants into small groups of between four and six (see ‘trainer tips’ for a fun idea how to do this).
3. 10-15 minutes: Ask groups to share their lists with each other. Encourage them to talk about words and phrases they chose – what was in their mind as they thought about them? Each group should write all their words/phrases onto the cards provided – **only one word/phrase per card** (on one side only). Where more than one group member has written down the same word/phrase, only one card needs to be written for it. Once finished, each group needs to keep their cards safe, ready to share with the others later. **Check in with each group after 5-10 minutes to ensure they understand the task** – some may have questions. Each group will typically produce 10-25 cards between them.
4. Bring the whole group back together. Ask groups to keep hold of their cards for now – they will be used later.

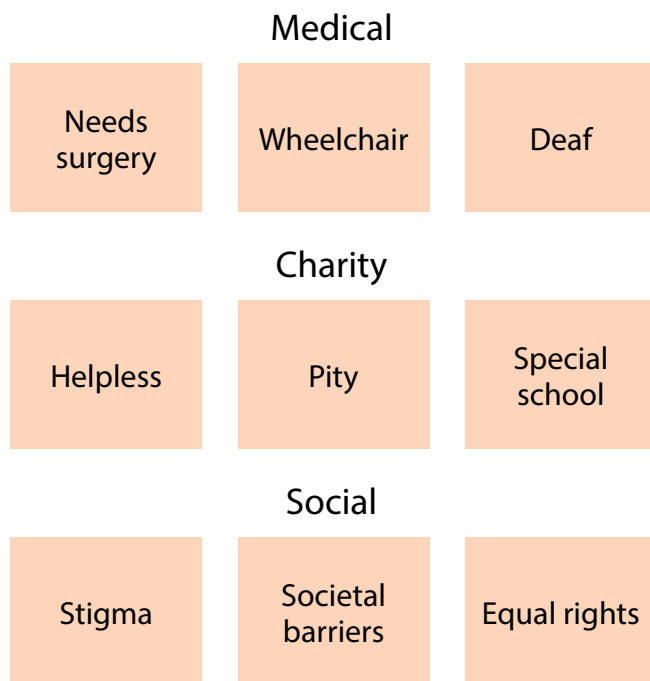
Using the prepared diagrams (see ‘trainer tips’ on how to easily produce them) explain the concepts of medical, charity (individual) and social models of disability. Explain to participants they will be given a handout afterwards so they don’t need to take notes. Use the information in Handout 1 to describe each model. You can summarise the models at the end by saying that the first two models (medical and charity approaches) focus on barriers to participation being with the child with an impairment who needs to be ‘fixed’ or will be long-term dependent. The third model, known as the ‘social’ or ‘human rights’ model, focuses on barriers being with society’s view of children with disabilities and how this leads to the exclusion of the child with an impairment.

5. Ask if there are any initial clarification questions on the descriptions of the models. Discuss and share. See the ‘Critical Points for Trainers’ for some advice and inputs

on commonly asked questions and comments that participants make, especially if they have never been introduced to social-model thinking before.

- Having carefully explained each of the three models/approaches, ask each small group to lay out their cards of collective words/phrases under the headings of 'medical', 'charity' or 'social' model on your pre-prepared models flipcharts laid side-by-side on the floor. They should place each card on the model they think best fits their understanding of the word/phrase according to the descriptions you have presented.

Example words that may be placed onto models in step 6 exercise:



- Invite all participants to look at the models and where all the words/phrases have been placed. Facilitate a full group discussion on the following:
 - What do participants see – are there duplicates? Are there the same words/phrases placed under different model headings?
 - Are any words/phrases placed onto a model they would like to make an observation about, or ask a question about?
 - Ask participants to explain why they placed words under particular headings – facilitate their discussions. Encourage people to question whether they think the words are under the most appropriate headings. This works well if the same word/phrase is placed on two different models – what was the thinking behind the placement of the word/phrase?

Discussions should happen as participants try to explain why they placed words under particular headings. Further clarification will probably need to be provided by you, to ensure people have understood the differences between the different approaches to disability inclusion within each model. Use the information in the 'Critical Points and Training Tips' section to help inform your responses and clarifications.

- Conclude the session by distributing Handout 1 on models, barriers and the definition of disability. Write up the following on a flipchart as a summary definition of disability:

'Impairment + Barriers = Disability'

Emphasise the difference between the terms 'impairment' and 'disability' (see Handout 1 for information).

Emphasise that this definition fits World Vision's approach to disability inclusion, and the UN Convention on the Rights of Persons with Disabilities (CRPD). The CRPD will be introduced to participants in a later activity in this session (Activity 4).

Motive:

This activity is central to the whole training. Of bigger importance, it is central to what will happen as a result of the training. It is very important that participants understand the differences between the individual (medical and charity) and social models of disability, as it affects how they will view disability inclusion in programming work. In the past, nearly all international NGO programming work has been based on the individual models of disability.

The way forward is to implement social model principle work – that is, disability inclusion work. The principles of the social model are those of the UN Convention on the Rights of Persons with Disabilities – it obligates all mainstream organisations to include children/young people/adults with disabilities in their work.

It is strongly recommended you take time to ensure at the end of the activity that participants understand the differences between individual and social models of disability. Other training activities that follow will give you opportunities to check if participants have understood the key differences or are still confused. If they are, take all opportunities to re-clarify the core differences between the individual and social model approaches. Each opportunity should bring greater clarity for participants.

Ensuring you – as the trainer – are comfortable (and more importantly – agree) with the concepts communicated in this activity is very important. Participants often have

questions about the models and the differences between them. Each model represents a different perspective on what 'disability' is – and influences what actions are implemented in relation to children/young people/adults with disabilities. As trainer, you need to be comfortable with the differences in approaches before you lead the training, because participants will possibly want to challenge many aspects before accepting them.

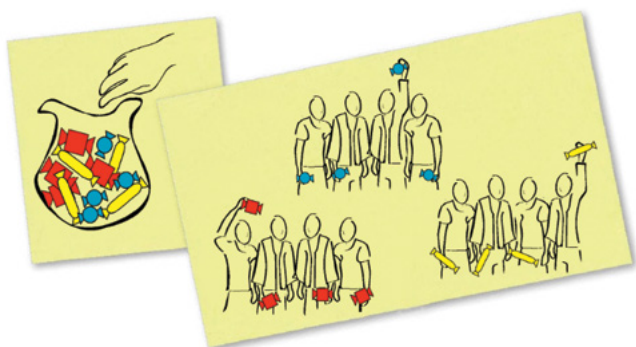
Trainer tips and critical points:

For an interesting discussion on the development and impact of the models of disability, see this academic article:

Anna Lawson & Angharad E. Beckett. (2021), 'The social and human rights models of disability: towards a complementarity thesis', *The International Journal of Human Rights*, 25:2, 348-379, [DOI: 10.1080/13642987.2020.1783533](https://doi.org/10.1080/13642987.2020.1783533)

How to create discussion groups – use of sweets/candy and random selection

Think about how you want the groups to be divided. If randomly, then try using wrapped sweets/candy (chocolate, toffees, boiled sweets, etc.) making sure that each type has a different style/colour of wrapper. You'll need the same number of types of sweets as you want groups, and the same number of each type of sweet as the number of people in each group. Mix all the sweets up, then hand around the group, asking them to take a sweet from the bag(s). Their group is everyone with the same type of sweet as them. People appreciate sweets – and from the trainer's perspective the 'sugar rush' from the sweets can help lift the energy in the room!



How to produce models on flipcharts

The diagrams of the three models are best prepared in advance of the workshop. It's easy to do, even if you're not an artist. You need two different sized round objects to draw around and something with a straight edge like a ruler to draw the arrows (or a steady hand). We've used a whole variety of different round objects from dinner and tea plates to upturned wastebaskets and cups! Please stick masking tape around the edge of crockery before drawing around them to protect it from getting covered in marker pen!

Questions of clarification on the explanations of the three models and barriers to inclusion

Try to avoid saying that medical and charity approaches are 'bad' and the social model is 'good'. Not only is this too simplistic, but it may also provoke strong reactions from people who have followed the individual approach to disability throughout their career. It's especially difficult for medical and welfare personnel.

However, it is important to finish this activity (step 8) by stating what World Vision's approach is (social model) – and that this aligns completely with the UN Convention on the Rights of Persons with Disabilities, which will be introduced in Activity 4 at the end of this first session.

Plenary discussion on placement of groupwork phrases according to the 3 models

It is common to see the same phrases placed under different models – for example, 'wheelchair' can be placed under the 'medical' model, or the 'social' model.

Where the same words/phrases appear on different models, ask people to share their reasoning behind putting the word/phrase on the model they chose. The key point is as much about the thinking behind where it is placed as the placement choice itself. Giving this context is very important and will enable you to find out if it is a misunderstanding of the model description that needs re-explanation, or key context information.

The participants' discussion is important. The rationale they describe behind the placement of phrases on the models will demonstrate their understanding of the conceptual models of disability. As trainer, you will need to listen very carefully to help discern what the participants' rationale behind their choice is. Sometimes, it may lead to long debates about differences in approach. In reality, it's difficult to completely separate out words in this way. There are some words or phrases that don't seem to fit anywhere. Encourage participants to think about meanings behind the words. But don't get too drawn into arguments around specific words if the discussion is not especially productive.

Tip: where learners are already familiar with rights-based approaches, it is useful to directly compare the rights of children/young people with disabilities with other rights work they will be familiar with. In this case, children/young people with disabilities have rights that they are prevented from fulfilling due to the barriers placed on them by society (attitudinal, environmental and institutional).

Commonly asked questions about the models and the barriers

For most participants, the conceptualisation of 'social model' will be totally new thinking. It is likely they will only have thought about disability from an 'individual model'

perspective (medical or charity). There are likely to be a lot of questions posed to you which may challenge these conceptualisations. As you deliver more of these courses you will gain experience in anticipating and responding to likely questions. Here is a list of questions that have been frequently asked in previous training courses, with some suggested responses:

Question: Does the social model of disability mean that medical interventions for children/young people with disabilities shouldn't be carried out?

Answer: No, absolutely not. It does not deny the need for medical intervention or support – good health is an important need (and right) for everyone. Health work is definitely part of social model approaches. But it does emphasise that medical interventions **on their own** will not lead to inclusion. The social model provides a perspective on **how** children/young people with disabilities should access health support. Children/young people with disabilities have the same rights to health as those without disabilities and should be able to seek medical treatment that is applicable to them. However, their choice to decide on important health issues is often denied – either because appropriate treatment, rehabilitation or assistive technology is not available, or because health facilities themselves are inaccessible (due to physical and attitudinal barriers). A social model perspective can help identify where the barriers are to accessing healthcare. *Remember, the medical model is not the same as medical treatment.*

Question: We need a bit of all three models (medical model, charity model, social model) to achieve a comprehensive disability inclusive approach.

Answer: This comment is often made in training. If this comment is made it demonstrates the learner has not quite grasped the models as concepts yet – specifically that the three models represent alternative **perspectives** on what disability is conceptually, and therefore what practical approaches need to be taken to achieve disability inclusion.

If this comment is made, emphasise that each model represents a different **perspective** on what 'disability' is conceptually, and therefore what approaches/actions flow from beliefs about what challenges should be addressed to achieve the inclusion of children/young people with disabilities in society. If helpful, it is fine to acknowledge there are some similarities between the two individual models: 'medical' and 'charity' (i.e., that the 'problem' is defined as starting with the child with the impairment), but there are fundamental – and incompatible – differences between the individual models and the social/human rights model.

Question: When describing the social model your focus is on removing the barriers that society places on children/young people/adults with disabilities. Isn't the answer to empower them to advocate and sort out their own issues?

Answer: The most effective approach is to work on **both** removing barriers **and** empowering children/young people with disabilities. Empowering individual children/young people/adults with disabilities and their representative organisations is an important aspect to inclusive development. The social/human rights model does not prevent this – in fact, it encourages work on both empowerment and inclusion.

Many children/young people/adults with disabilities face such high levels of exclusion and marginalisation throughout their lives that participating in mainstream programming activities is difficult unless they receive direct capacity-building support. Children/young people with disabilities are often so isolated that even within the family unit they may never have been consulted over a decision or even permitted to join the rest of the family at mealtimes or for other social occasions. For girls, youth and women with disabilities, their chances for participation, even within the household are reduced by both their disability and their gender status. As a result, they are likely to be very unfamiliar with being asked to make contributions and may believe themselves to be worthless with no opinions to offer. Also remember, many children/young people with disabilities (especially girls) will not have been to school which will leave them very unsure of what the social norms are around participation.

This is why many children/young people with disabilities will go on to adopt 'individual' model thinking as 'fact' without realising that the discrimination and challenges they face are the result of attitudinal, environmental, and institutional barriers. This 'internalised oppression' (i.e., adopting the oppressive and discriminatory views as personal belief) is the result of having had years of people telling them it is their 'fault' they have an impairment and that they are not capable of being independent or able to make any meaningful contributions.

The social model emphasises society's disabling barriers. Interventions built on social/human rights-based approaches seek to identify and remove those barriers so that children/young people with disabilities have the opportunity to participate. But sometimes children/young people with disabilities will have been so excluded that they require additional assistance to build their confidence and skills to enable them to take up those opportunities.

Question: Shouldn't disability come under health programming?



Answer: Traditionally, disability has been seen only as a health issue. This stems from medical-model thinking – that health interventions are the sole response to achieve disability inclusion. This ignores the systemic exclusion that people with disabilities face in all other areas of life – education, child protection, employment, community participation, etc. Health interventions are part of what children/young people with disabilities might require (in the same way that everyone has rights to good health). But it is not the whole story.

All children/young people with disabilities have the right to participate in society alongside those without disabilities. All programming areas that World Vision supports such as agricultural production, water and sanitation, education, economic development, disaster mitigation and emergency relief are just as important and relevant to children/young people with disabilities. These sectors have often ignored and excluded children/young people with disabilities because of a lack of understanding that disability is a human rights issue rather than a health issue. Including children/young people with disabilities alongside those without disabilities will help promote the participation of children/young people with disabilities as equal citizens. The social/human rights model explicitly recognises barriers in different sector program areas.

If it is a helpful comparison that learners will relate to, you may wish to use the example of HIV and AIDS responses by NGOs and how they changed over time. In the early response phases in the 1980s/1990s, HIV and AIDS was seen as a purely medical issue requiring a medical response. But people with HIV and AIDS faced multiple

barriers and exclusion as a result of their condition. The NGO sector then shifted its approach to broad-based inclusion, across the breadth of its programming and advocacy work.

Question: We work in emergency contexts where it's not possible for us to identify the individual needs of everyone. How is it possible for us to use the social model approach?

Answer: Taking an individual model approach to disability will tend to result in relief agencies thinking they do not have the skills or time to work with children/young people with disabilities. That's because they are focusing on the impairments rather than on the potential barriers that might prevent children/young people with disabilities from access to relief services. In this scenario, relief agencies tend to rely on disability-specific organisations to work with children/young people with disabilities, but these organisations are often very small, not used to working directly with children, and lack the kinds of resources needed to reach everyone. The key to ensuring a social model approach that can be adopted even in emergency situations, is in the preparation. We already know that there will be children/young people with disabilities caught up in emergency situations, so we can take measures to ensure our aid delivery systems are as barrier free as possible. Disaster Risk Reduction work for example should always ensure children/young persons with disabilities are included and that discussions around preparedness focus on what communities and supporting agencies will do to ensure all children/young people with disabilities are protected during a crisis.

Session 1: Activity 3: The Chances of Childhood

Opportunities for children and young people and how discrimination affects them



Time: 60 minutes



Materials:

No specific materials but setting up the room is important. You may need to spend time reorganising the chairs. You'll need enough space for four people to stand side-by-side, with the other participants seated around the edges of the room, facing towards the volunteers. Creating a 'corridor' in the middle of the room, enabling you to use the full length of the room for the exercise, is ideal.

Introduction for trainer:

Story is a powerful means of conveying your message. And it is used to great effect in this visual representation of discrimination and how this impacts the opportunities and outcomes for children all living in poverty situations together. It helps to reinforce concepts raised.

When the story begins and participants start to think about whether an infant with disability would be as welcome as an infant without disability, you can talk about some of the prejudices surrounding disability – and some of the causes of this stigma. Throughout the story there are many opportunities for raising issues of concern, so it's helpful if you prepare well by researching local attitudes, beliefs and challenges.

This is the activity where the main point of the training course usually 'hits home'. People have been transformed by this activity. Participants often wish to discuss and reflect on the issues raised between each other here – so a little time is often needed for everyone to absorb the message. Having some time together after the session finishes – to take tea or have lunch perhaps – can make the second half-day session especially productive.

As trainer, you will need to take a sensitive and non-judgemental approach to handling discussions that arise from this activity. Be mindful of the fact that people will be engaging and reflecting on their own attitudes and approaches in relation to the different childhood life stages discussed. Facilitating to enable this reflection to happen is important.

Please note this activity has some similarities to the 'Power Walk' activity you may have used elsewhere in your work at World Vision. Participants who have attended that training therefore have an opportunity to build on their learning from that course in relation to disability inclusion. The key difference, however, is that this activity incorporates more space for learner reflection and critical self-analysis by focusing on fewer characters in a single community with just two primary individual inequality factors – disability and gender – operating within World Vision's critical individual inequality factor of childhood. You have the opportunity therefore to explore these intersecting issues in greater depth.

To many, this session will reveal things about the communities where World Vision works which they may never have considered before. It can be fun. Humour can take the edge off some hard facts exposed during the activity. But some participants can find it distressing, because it focuses on some painful, personal truths.

In groups that include participants with disabilities and participants without disabilities, this activity can have additional sensitivities. It is very important that participants feel comfortable enough with each other to honestly explore the situation from their perspectives.

Method:

1. **Ask for four volunteers** from among the group (ideally, two men and two women), willing to stand for about 40-45 minutes to represent the following:
 - male without disability
 - male with disability
 - female without disability
 - female with disability

Stress that this is NOT a role-play exercise, the volunteers will be representing a character from within a village. Many people do not like role-play, hence the need for reassurance!

2. **Assign each volunteer one of the four roles.** Explain how you'll be telling a story of childhood and youth, taking the characters on a journey from birth to being a young adult. As you reach each significant life event, you'll ask them to respond as they think their character (or their family) would react. They'll need to take:

- **two steps forward** for a very positive, very likely opportunity or very successful experience;
- **one step forward** for a positive, likely opportunity or successful experience;
- **one step back** for a not-so-positive, no-so-likely opportunity or not-so-successful experience;
- **two steps back** for a negative, very unlikely opportunity or unsuccessful experience.

Once your volunteers understand what they'll be required to do, reinforce that they are representing a character type and should respond accordingly. Their response should be based on what they think is currently accurate for their culture and situation, not what it ought to be. Encourage them to avoid thinking about specific impairments or basing decisions on their own life experiences. They should represent what they think would typically happen in a community for their character.

3. **Explain to the whole group that after each life stage** is given and the volunteers respond with their moves, **they will be given time and opportunity to react and comment.** If there is disagreement, the group should decide by consensus and the volunteer may be asked to alter their move. As trainer, you have ultimate say over whether or not the response seems fair. If there is no consensus or if you believe the response has been too positive/negative (i.e., more based on what ought to happen rather than what is likely to happen) then you can ask the volunteer to alter their move accordingly (you can say that you are taking ownership of the role of 'God', 'judge' or 'the hand of fate!').
4. **Set the scene for the story.** As you want to emphasise links between disability and poverty, place the story in a rural village where World Vision works. Describe it in as much detail as you can, explaining that income poverty levels are generally quite high, although most families have land and access to safe water. For entrepreneurs, opportunities exist in the nearby town where there are also health and educational facilities. You may wish to choose a geographical location to help people imagine the village (for example, an East African or South Asian village).

You can choose any place for this situation, so alter the place if a rural village is not the most appropriate setting to consider for your participants.
5. Start with the first life event, as if telling a story...

Life Chance 1

"One fine day, after a long wait of nine months, your character is born. You are the first-born child in your family.

How does your family feel and react when they see who you are? Make your moves."

Say to the rest of the group that these four babies are all first-born children, all born in the same village, and all born on the same day.

Note what might happen, for example:

- Family is very happy (boy without disability born) – two steps forward
 - Family is quite happy (boy with disability/girl without disability) – one step forward
 - Family is not happy (boy with disability) – one step back
 - Family is very unhappy (girl with disability) – two steps back
6. Once the 4 volunteers have made their moves, ask one of them for the reasons behind their choice of the number of steps forward/back.
 7. Then invite all observing for comments and suggestions. *"Do you agree with the selection? Disagree? Why?"* Encourage observers to give reasons why they agree/disagree. You don't need everyone in the room to share every time, just a selection for each stage – people will usually speak up! Ask the whole group to confirm the number of steps forward/backward for that character. The group should decide by consensus. If their view is different to the volunteer, then the volunteer may be asked to alter their move. If they cannot agree as a group, then you as trainer make the final decision!
 8. Repeat steps 6 and 7 for each of the other 3 volunteers.

A number of key issues about family and community attitudes towards disability and gender should start to emerge. Typical points that might be made (or you may wish to draw out if participants have not made them) are:

- Culture affects whether girls or boys are more valued when they are born. First-born males are more likely to be embraced by their families than girls, as boys are viewed as productive members of society.
- Families may be very shocked if they discover their child has a disability – whether that's a girl or a boy, although due to gender norms in the culture, boys with disabilities are usually better placed than girls with disabilities to be accepted within the family.
- The mother's male partner or father of the child may be inclined to abandon the family altogether if a child with a disability is born – blaming the woman

for the child's disability and leaving her to struggle on as best she can. If lucky, she may return to her own parents but it will put added strain on the *whole household*.

- Parents (especially the mother) may be subject to stigma from their wider families and communities leading them to hide/deny their child's impairment (for as long as possible) or even to hide the child itself. Witchcraft or divine 'punishment' are often cited as reasons for impairments – these beliefs lead to stigmatisation of the girls and boys with disabilities and their families.

Your role as the trainer is to assess when to intervene and comment to clarify reasons for decisions and to bring out and discuss any prejudicial points. The specific impairment is not relevant to the main point of this exercise, so try not to focus on this too much. It won't alter the essence of the activity.

As trainer, you can supplement points made by participants with other examples. You may want to introduce some issues they have not raised (from the list above), which are important in your operational context.

9. Having completed the first childhood life/chance stage, repeat the same process in steps 5-8 for the following 5 'chances'. Key trainer information points are given for each one that you can use with your training group.

Life Chance 2

"World Vision has established a nutrition and immunisation program for under 5s in your village. How likely is it that your character will be included in it?"

Typical points that might be made (or you may wish to draw out if participants have not made them) in this stage are:

- Children with disabilities may be left at home because the families do not want the community to know about their child. This could be compounded for girl children.
- It may become increasingly difficult for caregivers (usually women) to bring their child with an impairment to a clinic that is relatively far from home. Children with behavioural or mobility difficulties, could find the journey difficult, especially where public transport is overcrowded and inaccessible.
- In some cases, the birth of children with disabilities are not officially registered due to stigma or negative assumptions about their future. This could

mean they are not called for vaccination or feeding programs because they are not known about.

- Beliefs by family/community that the child with disabilities is 'not worth' feeding or getting immunised – can lead to further impairments, compounding issues. In worst case scenarios this can lead to extreme neglect – and potentially even infanticide.

Life Chance 3

"You are now about 5-6 years old, and it's time to start thinking about school. How likely is it that you will be able to start at primary school? Make your moves."

Typical points that might be made (or you may wish to draw out if participants have not made them) in this stage are:

- Access to primary education is the basic right of every child. The SDGs acknowledge the important role education plays in Goal 4 which says that by 2030 the world should have inclusive and equitable quality education for all. A lot of progress has been made toward Universal Primary Education – globally net attendance reached 87% in 2019 with around four in five children attending primary school reaching completion. But 58 million children remain out of school, over half of whom are girls (54%) and only about 10% of children with disabilities in low-income countries attend school. There has been little improvement in out of school rates since 2007.³
- Boys with disabilities may start school – especially if they are first-born children. However, they are likely to face some barriers such as: distance to school; physical access; attitudes of teachers, other students, the families of other students not wanting their children to be taught (or make friends with) the boys or girls with disabilities.
- Girls with disabilities are least likely to be sent to school. Even with universal primary education families incur costs to send their children to school – for example, school uniforms, transport, and books. For girls and boys with disabilities these opportunity costs are often higher because of the need to accompany children to school, to pay for adapted teaching and learning materials or assistive technology. Families can often feel 'there is no point' in making the financial investment needed to send girls with disabilities to school because they are unlikely to achieve very much. But families may also be more protective over girls with disabilities and unwilling to send them into an environment which could be difficult for them.

³ This data comes from <https://data.unicef.org/topic/education/primary-education/> (2021)

- Fears around violence against girls and boys with disabilities is another reason why they may be reluctant to go to school. Girls and boys with disabilities are **3.7 times** more likely than children without disabilities to be victims of any sort of violence, **3.6 times** more likely to be victims of physical violence, and **2.9 times** more likely to be victims of sexual violence. Girls and boys with mental or intellectual impairments appear to be among the most vulnerable, with **4.6 times** the risk of sexual violence than girls and boys without disabilities.

Life Chance 4

“Your character is now about 12-13 years old. How likely is it that you have completed primary school education and entered secondary school education? Make your moves.”

Typical points that might be made (or you may wish to draw out if participants have not made them) in this stage are:

- Even if children with disabilities start education, the chances of them staying in schools and learning to a decent standard is not high. There are multiple, compounding barriers they face. Some of them are environmental barriers – the school itself might have some accessible features but not all (e.g., toilets and hand-washing facilities, school meal areas – it is not just steps and classrooms). Environmental barriers exist that are linked to school attendance but often not thought about (e.g., roads and pathways to the school, transport to/from school). Many of them are attitudinal barriers from multiple sources – teachers and school management (who may lack training or believe children with disabilities should be educated in special schools), parents of children without disabilities who don’t want their children educated or associating with children with disabilities (due to cultural myths and beliefs around contamination). Families may feel they don’t have, or cannot justify, the resources to continue taking their child to school each day – especially when their child is not learning and experiencing horrific exclusion and discrimination within the boundaries of a place that should be safe for them. Plan West Africa researched the experience of children with disabilities in 6 countries in West Africa in their 2013 Outside the Circle report and identified some shocking findings.⁴
- Gender issues will emerge quite strongly at this stage. The difference between girls and boys without disabilities succeeding in education should be clear in the choices made, for example, boys

without disabilities are more likely to go on to complete secondary school education than girls without disabilities. Gender disparity remains a considerable challenge at secondary education level with girls in sub-Saharan Africa and South and West Asia continuing to experience considerable disadvantages in terms of secondary enrolment compared to boys.

- It is not just the physical accessibility of schools that determines if girls and boys with disabilities succeed in education. Teaching methodologies that are inclusive are needed. Family willingness to continue supporting girls and boys with disabilities in education is also important (see above). If a family is in poverty, they may not feel they can/want to continue to support their child who is living with a disability through education unless there are clear benefits.
- Most importantly, the attitudes of everyone in the education system towards girls and boys with disabilities will determine if going to school will enable them to learn. Research studies have found negative and discriminatory attitudes towards girls and boys with disabilities from many different stakeholder groups – teachers, school management, Ministry of Education, parents of children without disabilities in the school (which impacted the attitudes of children without disabilities towards their classmates with disabilities). Discrimination is multi-layered and reinforcing. With that level of stigma and discrimination, would families continue to push their child to a place where they experience so much exclusion and don’t learn?

Life Chance 5

“You are now about 18 years old, like to keep busy and want to make some money. You try to get a job. How easy will it be for you to find one?”

Typical points that might be made (or you may wish to draw out if participants have not made them) in this stage are:

- The impact of opportunities in your life to-date now starts making a big difference. If you have no education or qualifications, it will be harder to get work. The work available to you is likely to be unskilled manual work and because of your disability, employers may simply assume you cannot do it.
- Employers often have false negative views of what young people with disabilities can do and achieve

⁴ <https://plan-international.org/publications/outside-circle>

in the workplace, so they don't offer opportunities – even if they are qualified.

- Many young persons with disabilities will look to establish their own businesses. However, discriminatory attitudes may affect how well they succeed. For example, banks may refuse to offer loans to young persons with disabilities, or the banks themselves may be inaccessible. Communities may hold such negative beliefs about disability that people refuse to buy from them. For example, people may believe having their clothes made by a person with a disability will bring 'bad luck'.
- Overall, opportunities for young women with disabilities will be significantly less even than for young men with disabilities because of the combined impact of gender and disability discrimination. Young women with disabilities are much less likely even than young men with disabilities to be hired for formal employment, to be given promotions, equal pay, or access to training opportunities. They are less likely to be given access to credit and they will find it difficult to participate in economic decision making.

Life Chance 6 (final chance of childhood/youth)

"You have reached late adolescence/young adulthood. You are starting to think about whether you may like to marry and have children. How possible do you think it will be to have a relationship with someone you are content with? Make your moves."

Check if the young woman with an impairment takes two steps back or is instructed to do so by the group. Why did this happen? They may say it's because most women with disabilities are physically unable to have children, a common myth. Two steps back may well be an accurate response for a different reason – women with disabilities often don't have children because society thinks they can't or shouldn't.

Typical points that might be made (or you may wish to draw out if participants have not made them) in this stage are:

Relationships and marriage

- Depending on culture, men may have more freedom to marry or form relationships than women.
 - The pressure to marry will be felt by all our characters so it is likely that everyone will be in some form of relationship. However, young women with disabilities may be much more likely to be in a relationship that is exploitative and potentially abusive.
- Young women and girls with disabilities are at much greater risk than their peers without disabilities of physical, psychological, sexual or financial violence, neglect, social isolation, entrapment, degradation, detention, denial of health care, forced sterilisation, and psychiatric treatment. They are twice as likely as young women without disabilities to experience domestic violence along with other forms of gender-based violence and the abuse they experience tends to be for longer and result in more severe injuries.
 - Young men with disabilities may also be victims of abuse – especially those that rely on personal support to carry out daily living activities.
 - It should also be noted that children who live with adults with disabilities and are expected to fulfil a 'caring' role may also be at risk of abuse.

Having children

- Many people falsely assume that young people with disabilities do not (or cannot) have sex.
 - There are false beliefs stemming from this that lead to abusive and exploitative practices against young women with disabilities in particular – e.g., that HIV-positive men can be 'cured' by having sex with someone who is a virgin – thereby increasing the risk that young women with disabilities will be raped because men assume they will not have had sex.
 - In some countries, it is still common practice to forcibly sterilise women of reproductive age with cognitive or mental health impairments without their consent; or to force them to have abortions if they become pregnant.
 - Most young women with disabilities will go on to have children and build families in similar ways to young women without disabilities.
 - Unfortunately, young women with disabilities often cannot get access to pre-natal care from health clinics due to barriers (environmental and attitudinal). Sexual and reproductive health services and campaigns are rarely designed with young persons with disabilities in mind and tend to be inaccessible, leaving them at increased risk of disease. A lack of access to maternal health programs may also mean young women and men with disabilities lack information about vaccinations, nutrition and hygiene measures, leaving their children at increased risk of disease.
10. Ask the group to reflect on the final positions of everyone in the group – all young adults still only in their early 20s. Remind everyone that these four

characters were all born on the same day in the same village.

- Who is in the best position now? Who is in the worst place?
- Ask each volunteer – what do you think your character has been feeling through this journey? How does that make you feel?
- Ask everyone – does any of this surprise anyone? How and why?
- The young man without disability at the front of the exercise is still regarded as living in poverty – this is a poor community which World Vision is working in. What does this imply for the young man and young woman with disabilities in this exercise?

Highlight the point that each stage/chance represents the **opportunities** that each character has at key points in their life. World Vision's work is focused on increasing opportunities at key points for people living in poverty.

11. The most powerful way to end this session is to ask the group to *look once again at where the characters are standing in relation to each other*. The lack of opportunities in life for the characters with disabilities have compounded through their young lives. Recall that this is happening in a rural location where general levels of poverty are quite high. Each 'chance' represents the opportunities each character has – or does not have – throughout their childhood and youth. Even though the characters without disabilities are well ahead of the characters with disabilities, they are by no means wealthy.

Ask the group, *who does World Vision currently focus its programming efforts on in a village like this?* In most groups, they will probably answer "the ones at the front".

The final question to then ask the group is "so if you focus on the ones at the front, without thinking much about the two characters with disabilities further back, what is your programming work at World Vision in practice doing?" If an answer is not volunteered, then – in a gentle way – point out that World Vision is making **the gap bigger** between boys and girls with disabilities and those without in this village – which participants can see physically in front of them according to where the four characters are standing.

12. Ensure you thank all the volunteers for their participation in the activity, and thank everyone for sharing their views.

Motive:

Including children/young people with disabilities is an important issue for poverty reduction – and a very important part of World Vision's mission to improve the

lives of the world's most vulnerable children. This session should help show in a powerful way why children/young people with disabilities are especially vulnerable to chronic poverty. It also provides you as trainer with a good opportunity to talk about many different development issues that affect girls and boys with disabilities, but which rarely get discussed.

Trainer tips and critical points:

It is important that people volunteer for their roles.

In some situations, religious or traditional beliefs may preclude some from participating. Be aware and respect that. In some cultures, even to imagine being a person with disability can be seen as 'tempting fate'.

In groups with participants with and without disabilities, this activity can have additional sensitivities. It's therefore really important that participants feel comfortable enough with each other to honestly explore the situation from their perspectives. Be aware of this if you are a person without disability and it's the first time you've worked with people with disabilities.

Key:

1. Girl without disability.
2. Boy without disability.
3. Girl with disability.
4. Boy with disability.



This activity can be used as a 'stand-alone' activity for groups if time is very limited. There's no need to prepare any materials, and it can be run in as little as 30 minutes (ideally, one hour). It has a strong impact on people and always provokes many discussions. So, it's ideal if you have limited time to get your message across.

Session 1: Activity 4: International disability inclusion obligations and an introduction to disability organisations – ‘Nothing About Us Without Us’

Why disability inclusion is not ‘an optional extra’ in World Vision’s work; the importance of working with the disability movement



Time: 45-60 minutes



Materials:

- Document ‘Supplementary guidance for trainer - Session 1 Activity 4: International Obligations on Disability Inclusion; “Nothing About Us Without Us” – an Introduction to disability rights movement’
- [Handout 2: Key Global Conventions and Frameworks on Disability Rights](#)
- [Handout 3: A Guide to Disability Organisations](#)
- *For Route A:* PowerPoint presentation – ‘Conventions, frameworks and the disability movement’
- *For Route B:* Pre-prepared A5 different-coloured cards with Convention articles and key SDG disability references written on them – 1 per card (NB: you will have a pile of lots of different cards!)

List of other resources (one copy of each to be available to the trainer) for reference purposes:

- Understanding the human rights framework to promote the rights of children with disabilities (UNICEF)
- The 2030 Agenda: The Inclusion of Persons with Disabilities (International Disability and Development Consortium (IDDC) and International Disability Alliance (IDA), 2016)
- <https://www.un.org/development/desa/disabilities/about-us/sustainable-development-goals-sdgs-and-disability.html>
- [Our Promise, Going Further mentions disability and broader gender equality and social inclusion are key drivers of child well-being.](#)
- **GESI Policy:** ‘The Sustainable Development Goals (SDGs) and our Ministry Goal (sustained child well-being within families and communities, especially for the most vulnerable) can only be achieved when opportunities, resources and choices are available to women and men, girls and boys and marginalised and excluded groups, **especially children living with disabilities.**’

Introduction for trainer:

Children, young people, and their caregivers have rights that need to be protected. In most countries in which World Vision operates children/young people with disabilities are protected by legislation that has been developed in response to the country’s ratification of the UN Convention on the Rights of Persons with Disabilities (CRPD) and to a lesser extent other rights frameworks such as the Commission on the Rights of the Child (CRC). This activity focuses on the obligations World Vision needs to fulfil to comply with core UN Conventions and international rights-based frameworks. Many people do not realise these legal obligations exist – it often is a surprise when they realise it! The session briefly introduces participants to the disability movement, Organisations of Persons with Disabilities (OPDs) and the critically important principle of ‘Nothing About Us Without Us’ – the long-held motto of disability movements around the world.

Method:

You can choose one of two routes to present this material, depending on your training style and whether you have reliable electricity and technology available.

Route A

1. Lead a presentation on key conventions and commitments relating to disability using PowerPoint presentation file ‘Conventions and Frameworks’. Use the document ‘Supplementary guidance for Session 1 Activity 4 - International Obligations on Disability Inclusion: “Nothing About Us Without Us” – an introduction to the disability rights movement’ for your personal reference.
2. Start by introducing the two key UN Conventions and the key framework (PowerPoint presentation, [slide 2](#)) discussed in this session, which are:
 - United Nations Convention on the Rights of Persons with Disabilities (CRPD)

- Explicit disability commitments in the Sustainable Development Goals (SDGs)
 - References to disability in the United Nations Convention on the Rights of the Child (CRC)
3. Present key points relating to disability rights within these conventions and frameworks using the participant Handout 2 on 'Key Global Conventions and Frameworks on Disability Rights' for guidance. Tell participants they will receive a copy of this handout at the end of the session. Supplement from personal observations where possible.
- UN CRPD – [slides 3-7](#)
 - The 2030 Agenda and the SDGs – [slides 8-11](#)
 - UN CRC – [slides 12-15](#)

A critical point to draw out on the CRPD is Article 32 – international development cooperation. This is generally the most surprising – and shocking – article to most people, especially anyone who may be familiar with other UN Conventions. This is because if programming work is funded by a grant from a State which has ratified the CRPD (which most have), then the CRPD equally applies to all that programming work – i.e., activities should all be inclusive of, and accessible to, children/young people/adults with disabilities. This is a unique article.

4. Allow for any questions, observations, or clarifications before moving on to the next part of your presentation.
5. Present key points on the history of the disability movement ([slides 16-17](#)) and points to consider when engaging representative OPDs ([slides 18-20](#)). Again, if you have personal experience of engaging OPDs, it would be good to supplement the information provided with examples.
6. Be aware that there might be significant participant fatigue by this part of the session – and at the end of a long half-day of training. If you observe participants are no longer engaging with the materials presented, then just strongly focus on one key point on engaging with persons with disabilities – the critical importance of the slogan **'Nothing About Us Without Us'**. Participants can read the handout later. It is important that they leave the session remembering and understanding this slogan. Persons with disabilities have been excluded from decision making about their lives throughout time, this was the origins of why the CRPD came into force.
7. Ask if there are any questions, observations, or clarifications before finishing the session. Conclude by distributing Handouts 2 and 3 on global frameworks,

commitments and laws relating to disability rights, and 'A Guide to Disability Organisations'.

Route B

1. Talk through some of the main points of each Convention – and their importance – using your pre-prepared cards. As you talk about each individual card, place it on the floor, or encourage participants to share the cards around the room. Use your supplementary guidance document – 'International Obligations on Disability Inclusion: "Nothing About Us Without Us" – an introduction to the disability rights movement' and participant Handout 2 to help make points. Use examples from your own experience to highlight important points on some of the articles and points, if you have them.
2. Invite a speaker from an OPD to address the group on key points about 'Nothing About Us Without Us' (see Training Tips and Critical Points for some key preparation information). Have a question-and-answer session for the group with the speaker.
3. Distribute Handout 3: A Guide to Disability Organisations to participants for future reference.

Motive:

Children/young people/adults with disabilities in communities where World Vision works are systemically excluded from decision making and advocacy efforts. They are stigmatised in most countries, even if they are wealthy. This means that their requirements are often ignored in the development of legislation, policy, budgets and in the provision of services. Even services for children and adults with disabilities are often designed without their engagement. Citizen Voice and Action (CVA), World Vision's proven approach to social accountability, provides a structure to support the engagement of young people and adults with disabilities to take a leadership role. CVA also provides a way to collect data on access to rights and services that isn't typically available from government. This data can then inform better decision making. Knowing how to engage representative organisations is important so a key part of this session is ensuring participants understand how to identify OPDs and where they may need support.

Training tips and critical points:

Terminology and language

The way we talk about children, young people and adults with disabilities and the language we use around disability is important because it reflects the way disability is approached. We need to ensure our language is inclusive and respects the integrity and dignity of children and young people with disabilities. The use of

'people/persons (children/child) with disabilities' is the preferred terminology in North America and much of the developing world, as well as being used in the CRPD. It is based around the concept of putting 'people first', thereby affirming the person before their impairment.

Be aware that the widely recognised term DPO – Disabled Peoples' Organisations – is being replaced by OPDs – Organisations of Persons with Disabilities.

As course developers, we strongly recommend you do NOT use the acronyms 'PWD' or 'CWD' for persons with disabilities or children with disabilities *at any point in time*, and make sure that participants do not get into the habit of using these shortcuts. Acronyms dehumanise people and do not fit the spirit of the CRPD or acknowledge the value inherent in each child and young person.

See Annex 2 of World Vision's Guidance for Disability Inclusion for more information on appropriate terminology when speaking about disability: [Guidance for Disability Inclusion in WV Programs.pdf \(wvcentral.org\)](https://www.wvcentral.org/Guidance%20for%20Disability%20Inclusion%20in%20WV%20Programs.pdf)

Inviting a speaker from an OPD to brief the group

Key points to note include:

1. Meet and get to know the OPD representative/speaker beforehand. If possible, engage speakers who are known disability rights activists. You will need to make sure you have undertaken all the appropriate **due diligence and safeguarding procedures** before confirming your speaker. OPDs should be subject to the same safeguarding standards as any other community partner.
2. Be aware that not all OPD members are familiar with – or yet adopt – CRPD approaches. Persons with disabilities who have not had exposure to these life-changing principles may continue to follow individual models of disability in their own lives (medical and charity), perhaps believing it is the only way to receive support from large NGOs like World Vision. There have been many reports over the past 10 years of the delivery of Travelling Together training which have helped to transform the attitudes and approaches of persons with disabilities themselves, and how they advocate for their rights going forward.
3. The speaker you invite may not be used to giving talks and presentations and they may not be used to limiting themselves to a strict time limit. Help them prepare – perhaps even providing an opportunity for a 'practice run' so they feel comfortable addressing the training group.

4. Be mindful to ensure all access requirements are met – check the speakers' requirements beforehand and use the introductory notes from this guide to make sure you set up the room appropriately.
5. Avoid asking intrusive personal questions of the speakers – apply the Luke 6:31 principle of **'Do to others as you would have them do to you'**. If they volunteer information on their personal situation and impairment that is fine, but steer away from intrusive personal questions. Encourage respect and dignity for all in the training room.

Critical points to highlight

There are some key points that will need to be clearly communicated to participants so be sure that you are familiar with the conventions and frameworks. These key points are:

- **World Vision has legal obligations** to fulfil that require the inclusion of children and young people with disabilities in its work because of the UN CRPD throughout its 50 articles. **Article 32 is especially important.**
- There are also key commitments and obligations towards disability inclusion in the UN CRC – specifically Article 23 of the CRC.
- The 2030 Agenda and associated SDGs contain obligations too – both specific references to persons with disabilities and the overarching 'Leave No One Behind' principle.
- There are also likely to be laws and policies in place promoting the inclusion of persons with disabilities in many countries in which World Vision works and organisations working to promote and improve them. You may want to make sure your participants – and other World Vision staff – are aware of them.
- Disability Inclusion is integral to Our Promise and to implement the 2021 GESI policy.



International obligations on disability inclusion: ‘Nothing About Us Without Us’ – an introduction to the disability rights movement

Introduction

The information provided here gives you some reasons why disability is an important development issue that is core to all of World Vision’s work. In summary, there are **obligations** – including legal ones – that World Vision **needs** to fulfil to comply with core UN Conventions and international rights-based frameworks. Many people do not realise these legal obligations exist.

Below are some of the major international frameworks and conventions relating to the inclusion of children and adults with disabilities in World Vision’s work. In addition, there are likely to be laws and policies in place in the countries where your World Vision program is working. You should become familiar with these before you begin this presentation.

To build successful inclusive programs, World Vision needs to engage directly with children and adults with disabilities and their caregivers. This can either be achieved through direct consultation, that is making sure all consultation processes are accessible and inclusive of children and adults with disabilities and their caregivers or through engaging representative organisations. The most appropriate organisations are those that are set up and managed by people with disabilities. These are Organisations of Persons with Disabilities (OPDs) and are present in most countries where World Vision operates. The second part of this session will outline what to look for when engaging an OPD.

Overview of the Conventions and Frameworks covered in Activity 4

(PowerPoint presentation [Slide 2](#))

The three conventions and frameworks we will cover in this activity are

- United Nations CRPD
- Explicit disability commitments in the SDGs
- References to disability in the United Nations CRC

Key points for each convention and framework you will present are provided below. As well as the information below, there is a handout with more information, which we suggest you hand out to participants at the end of the activity for their reference and information.

United Nations Convention on the Rights of Persons with Disabilities (CRPD)

(PowerPoint presentation [slides 3-7](#))

Full information on the CRPD and text of the Convention in several languages can be found at:

<https://www.un.org/development/desa/disabilities/>

In December 2006, the General Assembly of the United Nations adopted the CRPD. It was the first human rights treaty of the 21st century and the first to focus explicitly on disability. By 2008 it had officially come into force, marking a significant milestone in the history of disability rights.

It was also unique in the speed of its development (just 5 years) and the unprecedented level of involvement from the civil society sector, especially from people with disabilities. As of 2021, it has been ratified by 182 countries and is already starting to influence the development of national disability rights legislation and disability inclusive development.

The CRPD is the most detailed of all the UN human rights treaties with 50 articles and a preamble. Its main purpose is to ‘promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities...’ (Article 1). Hence it doesn’t create any new rights but reaffirms those that exist within the context of disability.

The CRPD articulates, supports, and promotes the social/ human rights model of disability marking a major shift in approaching disability from one that has been dominated by medical and welfarist concerns to one based on disability as a human rights issue which acknowledges the disabling effects of societal barriers and prejudices.

The CRPD and International Development:

The CRPD acts as both a development and a human rights tool: it is the only human rights framework currently that includes a specific article on international cooperation (Article 32). All States Parties are obliged to ensure that all development aid is ‘...inclusive of and accessible to, persons with disabilities’ (CRPD Article 32).

This has important implications for development agencies, bilateral and multilateral donors, development studies and research. **For the first time, there is now a binding commitment to ensure equality and inclusion not only domestically but also through development aid.**

For example, since the UK has ratified the CRPD it is now under obligation to work towards ensuring the countries to which it supplies aid also develop and implement anti-discrimination legislation. It must also ensure that whatever development activities it funds are inclusive of persons with disabilities.

As a direct result of the CRPD, increasing numbers of governments around the world are passing or amending pro-disability legislation, more international agencies are specifically including persons with disabilities and there are now more opportunities for research.

Donors are also increasingly developing strategies, plans and position papers on disability-inclusive development. The UN recently produced its first Disability Inclusion Strategy (2020) which is stimulating greater moves towards inclusion across the UN system with UNICEF and WHO now increasing their focus.

Australia, Austria, Finland, Germany, Ireland, Italy, Japan, New Zealand, Norway, Sweden, and the US all have varying levels of stated commitment to disability inclusion. The FCDO has committed to focusing on the poorest and most marginalised with women and girls and persons with disabilities highlighted for attention, whilst the UK government is finalising a new UK National Disability Strategy which should include an international section, due to be launched in early 2022.

Implementation of the CRPD

Implementation of the CRPD, even with accompanying domestic legislation is still a work in progress. The concepts of disability rights, and the social/human rights model are still new in most low- and middle-income countries and will take time to become embedded in legislation, policies and practices.

The lack of dialogue between persons with disabilities and policymakers means that there is still a critical lack of progress. Politically it remains a low priority, so the financial and human resources needed to fund inclusive development remain far too low for what is needed. Continued lack of robust statistical data and research on the lives of children and adults with disabilities also hinders progress. Whilst this is starting to improve in places, it is still hard to provide the evidence base needed for governments to allocate more time and resources to disability-inclusive development. And, as mentioned previously, OPDs are still struggling to engage with the wider development and human rights discourse.

The 2030 Agenda and the Sustainable Development Goals (SDGs)

(PowerPoint presentation [slides 8-11](#))

Full information on the 2030 Agenda and the SDGs can be found in:

- this toolkit jointly produced by the International Disability Alliance (IDA) and the International Disability and Development Consortium (IDDC) <http://www.iddconsortium.net/resources-tools/2030-agenda-inclusion-persons-disabilities>
- this UN information page <https://www.un.org/development/desa/disabilities/about-us/sustainable-development-goals-sdgs-and-disability.html>

The overarching principle of the 2030 Agenda is: **Leave No One Behind**. This means to ensure its success the Agenda must include children, young people and adults with disabilities. This is reflected in many of the statements of both the 2030 Agenda and the 17 SDGs.

The 2030 Agenda, which includes the SDGs includes persons with disabilities with **11 specific references**. Governments of all 193 Member States of the UN have made a political commitment to them.

Persons with disabilities are referenced directly 11 times in the 2030 Agenda. These are in paragraphs on human rights, vulnerable groups, and education. There are also **direct references in 5 SDGs**:

- Goal 4: Education
- Goal 8: Employment
- Goal 10: Reduce inequality
- Goal 11: Inclusive cities
- Goal 17: Means of implementation (data)

However, the phrasing of all 17 SDGs and the **'Leave No One Behind'** principle means that including children, young people and adults with disabilities is core to the successful implementation of all the SDGs. Further, disaggregation of data by disability is a core principle to implement in follow-up and review processes of both the 2030 agenda and the SDGs.

Where are children and young persons with disabilities in the 2030 Agenda?

Paragraph 23 of the 2030 Agenda states **'People who are vulnerable must be empowered. Those whose needs are reflected in the Agenda include all children, youth, persons with disabilities (of whom more than 80 percent live in poverty)'**. This paragraph places children and adults with disabilities at the centre of poverty eradication throughout the entire Agenda.

The 2030 Agenda and the SDGs is influencing the direction of global and national policies relating to sustainable development for the next 10 years. If the

2030 Agenda is going to be successful, all of the UN Member States – **193 countries – must include children and adults with disabilities** in their national plans for implementation and monitoring.

What links disability, human rights, and the SDGs?

The CRPD provides a direct link between the SDGs and human rights. **All countries who have ratified the CRPD are legally bound to implement the core articles** and must report on their progress in writing to the United Nations on a periodic basis.

At the same time, the 2030 Agenda and SDGs have been adopted by all 193 countries and will influence the direction of global and national policies until 2030. If the 2030 Agenda is going to be successful all the UN Member States must include persons with disabilities in their national plans for implementation and monitoring, according to commitments they have agreed to.

(PowerPoint presentation [slides 12-15](#))

Fuller information on the CRC and children with disabilities can be found at:

http://www.un.org/esa/socdev/unyin/documents/children_disability_rights.pdf

The Convention on the Rights of the Child (CRC) comprises 54 Articles. It was adopted by the UN General Assembly in 1989 and came into force in November 1990. Prior to its adoption, there was no legally binding international treaty addressing the specific situation of children. The CRC rapidly achieved near universal ratification.

All the provisions of the CRC apply on an equal basis to children with disabilities. It also includes two specific provisions for children with disabilities:

- **Article 2** states that no child should encounter discrimination on the grounds of *'race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status'*. The CRC was the first human rights treaty to include disability as grounds for protection from discrimination. It broke new ground, establishing the right to protection, and imposing obligations on States to take all necessary measures to ensure that protection for all children with disabilities.
- **Article 23** is specifically focused on children with disabilities and emphasises their right to a ***'full and decent life in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community'***. In its 4 sub-clauses it imposes obligations on

States to provide special care and assistance to enable the child to achieve the ***'fullest possible social integration and individual development, including his or her spiritual or cultural development'***.

Drafted during the 1980s, Article 23 reflects earlier thinking of disability as a 'problem' located within the individual, needing targeted or special services, rather than the current understanding which locates the multiple barriers in society as the disabling factors impeding the realisation of rights. However, the CRC did explicitly place the issue of both children and disability in the arena of international human rights law, and in the context of a comprehensive treaty spanning the full range of human rights.

One reason why the Convention of Rights for Persons with Disabilities (CRPD) came into existence is that mentions of disability inclusion in other Conventions – including the CRC – weren't bringing practical implementation and change. A separate Convention to draw everything together was considered important by the disability movement, hence the first UN Convention of the 21st century, the CRPD.

Overview of the disability movement

(PowerPoint presentation [slides 16-20](#))

During the 1970's, as the social model of disability was beginning to be defined, people with disabilities began to understand that it was not their impairments that were the cause of their disadvantage but the systematic discrimination and oppression of society. A new concept of disability was being created which associated the challenges of disability with those of the civil rights movement.

People with disabilities were now challenging the fact that their voice was largely absent from decision making, even when it involved them. Power over their lives most often resided with the medical profession and social workers who were taking decisions and allocating resources based on the individual's impairment and perceived future rather than in consultation with them.

One of the defining features of the disability movement is the coming together of people with disabilities to advocate for rights. Over the past 50 years, this has led to significant changes in national and international legislation which are progressively improving the opportunities adults and children with disabilities have to participate. Important for this debate is the role OPDs and disability advocates have played in raising the issue of the participation of children and adults with disabilities in development.

Organisations of Persons with Disabilities (OPDs)

(Also known as Disabled Persons' Organisations [DPOs])

Whilst there is no universal definition, OPDs are mainly defined by being led by people with disabilities and are made up of members who are mainly people with disabilities. Sometimes they also include 'concerned' people such as parents of children with intellectual impairments. They are the organisations which represent and voice concerns and rights of children and adults with disabilities, and have an important role to play at local, national, and international levels, engaging with governments, service providers and communities.

Key characteristics:

- Membership organisations
- Led and managed by persons with disabilities/ caregivers
- Majority of members are people with disabilities
- Represent the voice and interests of people with disabilities

Whilst actual structures vary, what they all have in common is that they are membership organisations. Most members (especially the leadership) will be persons with disabilities, although sometimes people without disabilities also join – perhaps as advocates, guides, interpreters or involved individuals such as caregivers.

If they are formally registered, they will have a constitution, a governing board (consisting of a majority of people with disabilities), and a General Assembly. Accountability and decision making are therefore carried out by people with disabilities, making these organisations strongly representative of their ideas and concerns.

There are many different types of OPD, ranging from 'impairment specific' groups, whose members share (or are concerned by) a specific impairment, to cross-disability organisations with members with a wide variety of impairments. They can exist at different levels, from grassroots to global, and can sometimes be concerned with specific issues such as gender, youth, sport, entrepreneurship, or HIV and AIDS.

Many OPDs will operate like NGOs with a varied program of activities (often articulated in a strategic plan) managed either by an elected voluntary Secretariat, or if they have funding, by hired project management teams.

Federations or National Unions are networks of impairment specific OPDs positioned to be able to lobby and influence government services and legislation. These networks focus much more on removing barriers, improving access,

and challenging discriminatory beliefs and practices rather than representing single impairment issues. There is also representation at international level with regional bodies such as the Southern Africa Federation of the Disabled (SAFOD) and the Pacific Disability Forum (PDF) which try to support the implementation of international frameworks like the SDGs and the CRPD. Internationally, the [International Disability Alliance](#) is an umbrella of global organisations of persons with disabilities.

OPDs will engage in a wide range of different activities many of which bring direct benefits to their members (or impairment groups). The methods they use however tend to be similar.

Core activities include:

- Psycho-social support to members and their families (providing a sense of identity and a space in which key problems can be talked about);
- Impairment based support – ranging from sign language and mobility training to provision of sunscreen and access to information on potential medical interventions;
- Awareness raising and sensitisation – with families, communities, leaders and service providers (especially education and health) on the need to respect people with disability;
- Mobilisation – with people with disability themselves, enabling them to understand they are members of communities with rights (CRPD is providing a natural focal point for this);
- Organisational development – training in basic leadership, financial stewardship, planning, reporting and fundraising;
- Annual events across the country in support of specific issues like International Day of Disabled Persons (December 3rd).

As there are OPDs in most countries around the world, there is an opportunity for development agencies to seek out the voice of people with disabilities when planning and implementing activities. In some contexts (such as Uganda, or the Philippines for example), there are relatively well-developed OPDs that are used to working with government and development agencies.

However, in many cases OPDs are quite weak and chronically underfunded, even in comparison to other civil society organisations and may require a more targeted approach to help bring them into development discussions. The benefits are considerable, because once an agency establishes a trusting relationship with OPDs they will open the possibilities for connections to people with disabilities across a broad range of sectors.

Disability NGOs

These are organisations (both national and international) that work to support children and adults with disabilities. They can be impairment focused, supporting people with autism or Down Syndrome for example, or more thematic based such as those that support inclusive education or provide legal advice and services. They often provide essential, impairment-based assistance which complement or take the place of government services where these are not available. They may be faith-based charities supporting special needs schools, vocational training centres or working to help produce orthotics/prosthetics. They may hire persons with disabilities as staff, advisers, or volunteers but they are not membership organisations so persons with disabilities may or may not play significant decision-making roles. This is what makes them different to OPDs. Many are transitioning towards rights-based approaches. Policy work and advocacy campaigns are often more advanced than the programming operations of the larger disability NGOs, mainly due to the historical journeys of each organisation and the composition of their supporter base.

Key characteristics:

- Work for children and adults with disabilities
- Provide services to children and adults with disabilities

International disability NGOs include [Handicap International - Humanity & Inclusion | HI](#), [CBM-Christian Blind Mission \(cbm.org\)](#), [Sightsavers | Protecting sight and fighting for disability rights](#) and [Global Alliance | and Leonard Cheshire](#).

Self-help groups

Self-help groups exist at community level and represent groups of persons with disabilities and/or caregivers that are not yet registered as OPDs. They are much more common in rural or semi-urban contexts where OPDs haven't yet established a presence. Despite their limited size they play an important role at community level primarily by connecting people with disabilities and/or caregivers with each other. Self-help groups offer social support and can be mobilised to provide assistance during emergencies, especially if they are connected to local government. They can be an important link between persons with disabilities and/or caregivers and community development or disaster resilience programs and they should be sought out when carrying out mapping activities.

Key characteristics:

- Groups of persons with disabilities and/or caregivers not yet registered as OPDs
- Based at community level





Session 2

INTRODUCTORY DEVOTIONS⁵

God removes barriers for people with disabilities

Introduction:

Yesterday we learnt about how Jesus – literally – smashed barriers in the temple to allow children and people with disabilities to access holy ground they were previously excluded from. In our training we were introduced to the fact that a series of barriers – environmental (physical and communication), attitudes, laws and policies – prevent children/young people/adults with disabilities from being included in their societies – and often in World Vision’s practical programming work.

Today in training we will consider how to start practical inclusion of children with disabilities in World Vision’s programming work on social model principles. So, let’s start with this Devotion by looking at some situations in the Bible where the Lord addressed specific barriers faced by two people with disabilities.

Note for trainer – if you are time limited (there is a lot of training content to cover in today’s session!) you may wish to choose just one of these examples for the Devotion.

First – someone who is a biblical giant, but most people do not realise had an impairment – Moses.

Read:

Exodus 4:10-17 (The Message)

When God encountered Moses from the burning bush and called him to lead the Israelites out of Egypt:

Moses raised another objection to GOD: “Master, please, I don’t talk well. I’ve never been good with words, neither before nor after you spoke to me. I stutter and stammer.” GOD said, “And who do you think made the human mouth? And who makes some mute, some deaf, some sighted, some blind? Isn’t it I, GOD? So, get going. I’ll be right there with you—with your mouth! I’ll be right there to teach you what to say.” He said, “Oh, Master, please! Send somebody else!” GOD got angry with Moses: “Don’t you have a brother, Aaron the Levite? He’s good with words, I know he is. He speaks very well. In fact, at this very moment he’s on his way to meet you. When he sees you he’s going to be glad. You’ll speak to him and tell him what to say. I’ll be right there with you as you speak and with him as he speaks, teaching you step by step. He will speak to the people for you. He’ll act as your mouth, but you’ll decide what comes out of it. Now take this staff in your hand; you’ll use it to do the signs.”

Question to discuss:

What did God see in Moses: potential because of who he was and where he was brought up; or obstacles because of his stutter? Why?

Input:

Moses had a speech impairment. This was no barrier to God. He gave him Aaron, his brother, in order that Moses would still speak to the tens of thousands of people who he would lead out of Egypt, and on the long journey to the Promised Land.

Secondly – a man born blind who Jesus met. The story is recorded by John in his Gospel.

Read:

John 9:1-2 (The Message)

Walking down the street, Jesus saw a man blind from birth. His disciples asked “Rabbi, who sinned: this man or his parents, causing him to be born blind?” Jesus answered “You’re asking the wrong question. You’re looking for someone to blame. There is no such cause-effect here. Look instead for what God can do. We need to be energetically at work for the One who sent me here.”

Question to discuss:

The disciples assumed that the man’s blindness was because of sin – either the sin of the man, or his parents. This was a common belief. What did Jesus clearly answer?

Input:

The clear answer to the question is “neither”. The man had not sinned. His parents had not sinned. It was not sin that caused his blindness.

Jesus then decided to give sight to the man born blind – on the Sabbath!! Afterwards, the Pharisees decided to investigate this healing, upset at what had happened. They stated Jesus was not from God because he did not keep the Sabbath. They refused to believe the man born blind’s account of what happened. They intimidated the parents of the man born blind – who were too scared to tell the truth of what happened. When the man born blind was interrogated again, with boldness he continued to tell the truth of what had happened. He even cheekily suggested perhaps the Pharisees wanted to become disciples of Jesus, which was why they kept asking him the same questions! The Pharisees replied to him v. 31

⁵ This session is for Christian populations. Staff will need to adapt (or omit) these sessions for Muslim, Buddhist, or Hindu populations.

“You were steeped in sin at birth, how dare you lecture us!” and they threw him out.

The Pharisees were stubborn and refused to see the discrimination they showed towards this man. They did not want to believe who Jesus was. The Pharisees believed that disability was caused by sin. Jesus said it was not.

This man had gone through his whole childhood with his society believing he or his parents had sinned, and that is why he was blind. Jesus clearly said this was not true.

Conclusion:

Moses had an environmental barrier (speech communication issues). The man born blind – and his parents – had faced a lifelong attitudinal barrier (discrimination – that sin caused his blindness). In both cases, God and Jesus directly answered that these were no barriers to Him. So, they should not be barriers for us either as we seek to include all children – with and without disabilities – in our programming work at World Vision.

Remember from yesterday the verses we shared from Paul’s letter to the Galatians (3:26-28)

“You are all sons of God through faith to Christ Jesus for all of you who were baptised into Christ have clothed yourselves with Christ. There is neither Jew nor Greek, slave nor free, male nor female, for you are all one in Christ Jesus.”

Paul was clear – we are all equal before God. This applies to children/young people/adults with and without disabilities too. What barriers are we placing on them that don’t allow this to happen?

Prayer:

GOD of all

We thank you that there are no barriers with you. We thank you for what you did through Jesus to break down the barriers for people with disabilities.

As we seek to serve your Kingdom through our work at World Vision, help us to understand where we are placing barriers between us and children, young people and adults with disabilities. Reveal to us where they need to be removed. Teach us how to find more and better ways to include all your children in our work – especially children with disabilities. Amen



Session 2: Activity 5: The Wall

Identifying barriers that block inclusion for children with disabilities



Time: 60 minutes
(Steps 1-4: 50 mins, Step 5: 10 mins)



Materials:

- Prepare 3 flipcharts (see Figure 1 below) on different forms of exclusion to look like a blank wall of bricks – environmental barriers, institutional barriers, attitudinal barriers
- [Handout 1: Models of Disability, Barriers to Inclusion, Disability Definitions](#) NB: This handout also used in Session 1 Activity 2 (Defining Disability) and Session 2 Activity 6 (Myths About Disability)
- A5 cards, or large post-it notes, and marker pens for each group

Information for trainers:

Describing exclusion as a series of barriers can help participants to feel what it is like for children and young people with disabilities to miss out on activities going on around them. Each barrier is like an individual 'brick'. When combined they create a wall. But once identified they can be challenged and eliminated – breaking down the wall, bit by bit, and allowing more and more children and young people with disabilities to be included in activities and programs.

You will be tackling exclusion by breaking it down into three key barriers – **attitudinal**, **environmental**, and **institutional** (or policy/laws). This makes exclusion as a topic more manageable and highlights areas where direct project interventions can make a difference.

Ensure you're familiar with the different barriers before leading this session. Environmental barriers are often easiest to identify. But don't let the group get too focused only on **physical access** – steps, narrow pathways, uneven surfaces for example. **Communication** access issues are just as significant for those with sensory or communication impairments where information isn't available in formats they can interact with.

Institutional barriers (policies and laws) are some of the most difficult to identify. Without a proactive search for them, they won't be as immediately evident. That's because they are often linked to social and cultural norms and written into policies and legislation. The way to start identifying them is to focus on sectors in which you work, and try to map the legal, cultural, and social practices that might need addressing. Consulting with local persons

with disabilities will be an essential part of helping to identify these barriers.

Underpinning both institutional and environmental barriers are those associated with attitudes.

Attitudinal barriers are the most important to identify

– time and again they are the main reason prohibiting progress on disability inclusion. Negative attitudes and assumptions have led to many children and young people with disabilities believing themselves to be worthless, dependent and in need of support. This cycle of charity and dependency can be difficult to break.

You need to draw out all these issues – and more – as you talk through barriers with the group. It's worth trying to identify some local examples in advance.

Method:

1. Begin by talking through the **Barriers scenario** (see **Box 1** below) which describes a typical school water and sanitation project. Ask everyone to take a few moments to think through where children and young people with disabilities might be excluded from activities if their requirements have not been considered. Think as widely as possible – don't just focus on physical things. Ask each participant to write a list of areas where children and young people with disabilities might be excluded.

Box 1: Barriers scenario

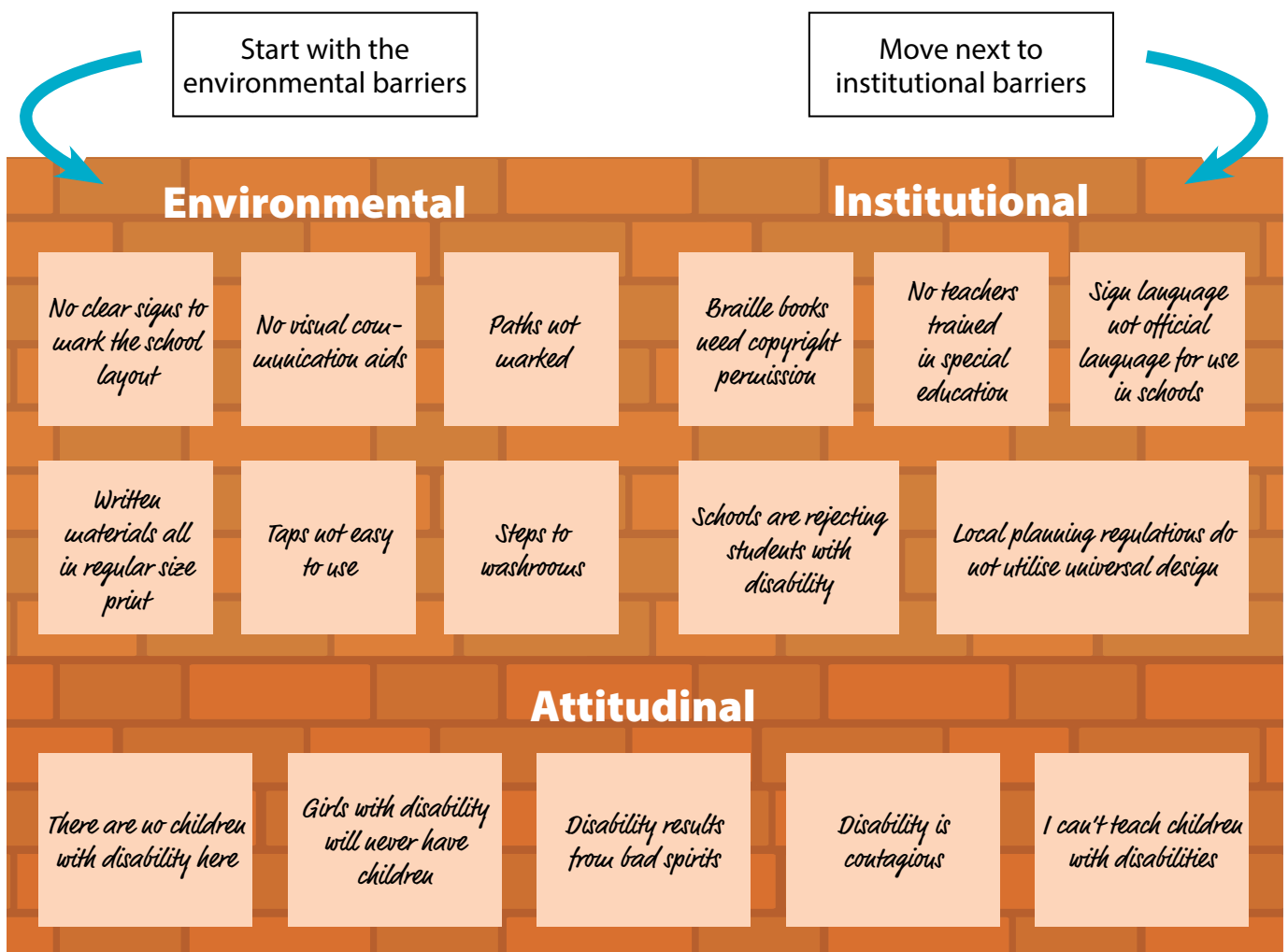
You have recently taken over a new school-focused Water and Sanitation project that is in its early stages of implementation. The aim of the project is to provide local primary schools with new washroom facilities, clean drinking water, and handwashing stations to ensure children can wash their hands before entering their classes. In addition, the project is providing ideas to teachers on how to include hygiene in the curriculum. Girls' clubs are being established, which amongst other things, will focus on menstrual health hygiene.

2. Divide into mixed groups of four to six. Give each group post-it notes (or A5 pieces of paper, with tape to attach to flipcharts). Ask the groups to combine their individual observations and write down one idea per post-it note or piece of paper.
3. After 15 minutes, bring the whole group together and display the prepared flipchart sheets to form a

wall (see **Figure 1** below for an example of how your wall will look). Note that the 'attitudinal' bricks should go at the bottom of the wall, underpinning both the 'environmental' and 'institutional' bricks. Explain the 'bricks' represent the exclusion faced by children and young people with disabilities, and are grouped into three main barriers – environmental, institutional (policy), and attitudinal. Explain these three forms of exclusion to the group. Use Handout 1 to help your descriptions. Remind the group that Handout 1 distributed in Session 1 during the session defining disability has these descriptions for them to refer to.

4. Ask one person from each group, in turn, to place their post-it notes/pieces of paper onto the 'wall' – thinking about the best heading (attitude, environment, institutional) for each idea. Discussions should flow as people try to decide where to place their observations and why. If people aren't talking, and you can see ideas going into barriers that are not appropriate, lead a discussion on it. Use this to help people understand the reasons behind the barriers.
5. Invite people to discuss their experiences of identifying barriers and what they've learned. Use the lessons learned to make key points (based on the 'Motive' section).

Figure 1: How to construct your wall



Motive:

This is a good exercise for groups who haven't thought about different forms of exclusion that exist for children and young people with disabilities – in other words, discrimination. The activity flows well from the session on models in Session 1. It will help explain the barriers you introduced in the description of the social model in Activity 2.

This activity is done in a systematic way, breaking down different forms of exclusion into three main barriers – environmental (both physical access and communication), institutional (or policy) and attitudinal. This makes the issues more manageable and highlights areas where direct intervention can make a difference.

From the perspective of program design, environmental barriers can be dealt with as you plan project activities

and inputs, making provisions for appropriate access requirements. In this sense, you need to make sure that any construction that happens (such as in the case of new classrooms or WASH facilities) is done using universal design principles and that communications always consider access for those with sensory or neurological impairments (such as ensuring online study sessions include appropriate captions/signed content and audio-description). Once identified, institutional barriers can form the basis of an advocacy campaign or strategy targeting specific policies or laws. Attitudinal barriers can be reduced through awareness-raising events, campaigns, or training, especially when it is targeted at children and young people without disabilities.

Trainer tips:

A good way of using this tool is with groups of adults and young people with disabilities – or even better with community groups that include adults and young people with disabilities. Prepare the wall statements with some of your ideas about barriers, then compare them to the ones local young people and adults with disabilities have identified. This can bring up issues that are missed when adults and young people with disabilities aren't included in consultations.

In the training room, display the barriers in the order shown. Most people tend to think of environmental barriers, and it will probably be the fullest flipchart, many are often surprised that attitude is the biggest barrier!

Critical points:

The most significant form of exclusion comes from attitudinal barriers which is why these 'bricks' have been placed at the foundations of the wall. Often, some of the more obvious forms of exclusion exist in the environment so these 'bricks' should be relatively easy to identify and address, although be sure to steer people away from focusing only on physical access. Even institutional barriers, once identified, can be tackled through the development of inclusive policies and directives. But exclusion related to negative attitudes may remain long after other forms of exclusion have been addressed. Ignoring these attitude barriers will probably result in little overall progress towards inclusion so it is important that negative attitudes are identified and addressed as early as possible in any disability-inclusive intervention. Starting with World Vision staff and key partners in communities will be critical.



Session 2: Activity 6: Myths About Disability

Uncovering and addressing discrimination experienced by children with disabilities



Time: 30 minutes



Materials:

Page 8 of [Handout 1: Models of Disability, Barriers to Inclusion, Disability Definitions](#) – information on different types of impairment.

NB: Handout 1 is also used in Session 1 Activity 2 (Defining Disability) and Session 2 Activity 5 (The Wall)

Introduction for trainers:

Myths have emerged across all cultures and religions around why children and young people are born with or acquire impairments. They are a major cause of discrimination for children, young people and their families – especially mothers. This activity is designed to help participants appreciate some of those. Project staff going into communities with the intention of including adults or young people with disabilities and their caregivers should have an awareness of local beliefs and superstitions.

There are many examples of myths, ranging from ‘bad spirits’ and punishment for sins to fear of seeing or touching a person with a disability while pregnant. Where factual knowledge on the causes of impairments is limited, these beliefs can be powerful and pervasive. They will profoundly affect the way children and adults with disabilities – and often their families too – are treated and view themselves.

A session like this, held in the community, could be a useful starting point for introducing disability-inclusive activities. Unless some of the myths are answered and refuted, the discrimination against children with disabilities will probably remain. It will be very difficult for disability-inclusive programming work to succeed.

Method:

1. Talk through some of the most common forms of impairments and their typical causes. It is useful to help participants understand the language associated with different disabilities. Refer participants to p.8 of Handout 1, listing the different impairment groups.
2. Ask participants to describe some common reasons given locally for the causes of impairments, and

some common reactions to children and adults with disabilities. List the most popular myths about disability onto flipchart paper which can then be displayed (see Figure 2 below for examples).

3. Tell the group the true-life story using Box 2 below (or you can develop your own based on local myths that you have encountered). Are there local cultural beliefs like the one from Kenya? Lead a discussion. Help the group understand how local people perceive disability. Some myths of impairments are contributing to negative, sometimes hostile, attitudes towards children and adults with disabilities.

Motive:

The session should focus on process rather than outcome. It allows participants to voice the superstitions. The facilitator can help clarify the more likely causes of impairment. The outcome is that people have a chance to talk about superstitions, so participants can understand these are myths, not facts.

Trainer tips and critical points:

Program staff need to be aware of what people they work with believe causes impairments. It will have a huge impact on how well children/young people/adults with disabilities and their caregivers are accepted into project activities by the community. If you are bringing caregivers of children with disabilities or young people with disabilities themselves into a CVA process, then you need to understand what the underlying community attitudes and beliefs are surrounding disability that might lead to their exclusion. Without careful preparation there is a risk the experience could be harmful, reinforcing cultural stereotypes and segregation.

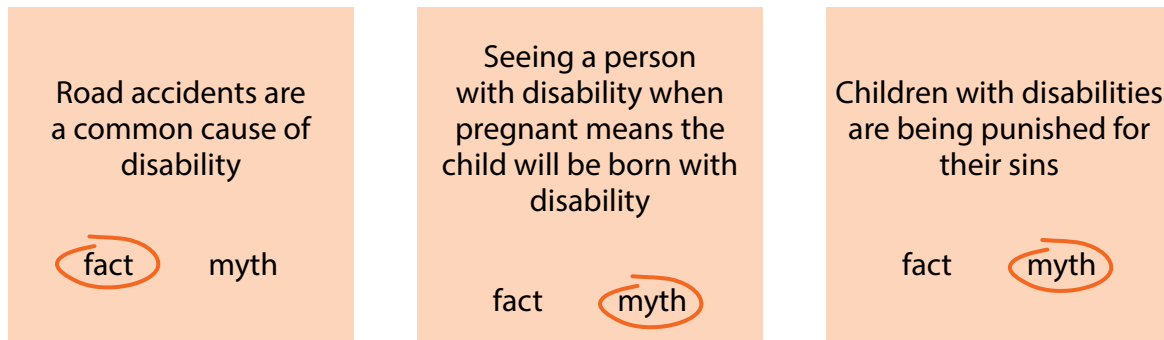
Our experience of delivering training over 15 years has shown that these myths can also be believed by NGO staff, partners, government officials, academics, etc. Don't assume these myths only exist in the communities you work in. You may need to address them amongst your colleagues and key partners first.

We have observed that myths can be more prominent in fragile, conflict and post-conflict situations. Perhaps because it is human nature to want to make sense of things we do not understand, and there is so much about fragile, conflict and post-conflict situations that it is difficult to make sense of.

Unfortunately, all major world religions have traditionally held beliefs that have led to discrimination against children, young people and adults with disabilities. Engaging with faith leaders in the communities you work with on these topics, to help share the actual situation on why people are born with or acquire impairments, may make a big difference in dispelling the myths that hold back children and adults with disabilities from being included in their communities.

This paper⁶ (from 2018) collects a range of research findings together about disability stigma from which you can draw many examples on common discriminatory beliefs. These may be useful if you are not sure of any such beliefs held locally where you are training, and/or participants say they don't know what people believe locally about the causes of impairments for children and adults with disabilities.

Figure 2: Examples of facts and myths



Box 2: Tell a story

In Kenya, the Samburu people held the belief that having a child with albinism is extremely unlucky. They didn't understand how two black people could produce a white child. So, the father was allowed to question the paternity. He did this by leaving the infant across the gate of the cattle boma (compound) as the cattle were released. If the child wasn't trampled by the cattle and survived, it was assumed the child was his.

There are other hazards an albino child might have endured. Mothers believed if they left the child in the sun, the burns the child receives would settle and cause the skin to darken. This caused much suffering to the child and would likely shorten life expectancy. There were very few albinos in Maasai culture.



6 Rohwerder, B. (2018). Disability stigma in developing countries. K4D Helpdesk Report. Brighton, UK: Institute of Development Studies. https://assets.publishing.service.gov.uk/media/5b18fe3240f0b634aec30791/Disability_stigma_in_developing_countries.pdf

Session 2: Activity 7: Introduction to Programming Approaches

How your perspective on disability impacts the life outcomes for children with disabilities; Disability programming and World Vision's GESI continuum



Time: total of up to 90 minutes (including tea-break)

- 30 minutes small group work
- 30 minutes presentations and discussion

NB: Incorporate a 20-30 minute tea-break within this session: use your judgement for the best moment to do this – it will probably be during the group work time. If this happens, offer groups the option to grab their refreshments and continue working on their group plans if they wish.



Materials:

- [Handout 5: The Twin-Track Approach](#)
- [Handout 6: Group Task for Activity 7: Development Planning Scenario for the 3 Groups](#)
- Flipchart paper and marker pens
- [Handout 7: GESI Continuum with a Disability Focus](#)

Introduction for trainer:

Whilst this is a light-hearted activity, its purpose is a serious one because it demonstrates how the perspectives programming staff have on disability impact the way projects or programs are designed and implemented. This has real, life-changing consequences for children and young people with disabilities and their caregivers.

Method:

1. Split participants into 3 groups and give each a specific development planning scenario listed in Handout 6: Group Task for Activity 7. Each group will address the same scenario using different approaches to disability – one medical, one charity, and one social. They will have 30 minutes to develop their plans for presentation back to the full group – using flipcharts. Encourage creativity – 'rich' pictures are often the best received! **NB: this handout has pre-prepared sheets you can distribute to each group.**
2. During the group work time, circulate around the groups regularly, supporting and encouraging discussions. Be especially careful in your conversations with the two groups working on the charity and medical model approaches, because they aren't working on social model approach themselves – which is the approach World Vision wants them to apply in their programming work. As facilitator, you

can check if every group **practically** understands the difference between the approaches in the 3 models, and what their work is trying to demonstrate. It is an opportunity as trainer for further, more informal discussions with participants where you can check they have absorbed the course's key learning concepts of understanding the key differences between the 'individual' models and the social model.

3. Bring groups back together and ask a representative from each to report back on how they would address the scenario using their given model.
4. As facilitator, lead a discussion on the differences in methodologies, strategies, plans – and from that, the likely outcomes of each model. Reinforce through this discussion the importance of the social model as the best approach for creating long-term sustainable change that will have the greatest chance of making a difference to the lives of children and young people with disabilities and their families.
5. Distribute Handout 7: GESI Continuum with a Disability Focus to participants. Make the link between the 3 models of disability and the extent to which their activities **reinforce** (charity model), **accommodate** (medical model), or **transform** (social model) power relationships which fit within World Vision's existing Gender and Social Inclusion (GESI) Continuum approach. Using the GESI continuum, it is possible to see how the models align from interventions which are not GESI responsive (reinforcing) through to those that are GESI responsive (accommodating and transformative). Handout 7 outlines the GESI Continuum. If there is time, ask participants to consider where on this scale some of their current projects and programs might sit.
6. Conclude that World Vision has adopted the social model approach – and remind participants it also fits with the CRPD principles and goals.

Motive:

The session is intended to refresh and stimulate thinking on the three models of disability, helping to clarify understanding on the differences between the medical, charity and social model approaches. The outcomes of the three project plans are likely to be very different. It should effectively show the difference World Vision makes to the outcomes for children with disabilities according

to the approach they are applying. Requiring participants to think and plan within a specific framework not only reminds them of the models that were described in Session 1 Activity 2, but also highlights key differences in terms of methodologies, strategies and plans between the approaches. It should also provoke fun and humour, especially if they come up with more extreme medical/charity focused projects! Participants may well recognise initiatives from the medical and charity approaches in their area of work which can lead to some stimulating discussions.

The 'wrapping up' discussion of this activity on the likely outcomes of each approach should further emphasise the value and sustainability of the social model approach that World Vision adopts towards more general inclusion of a wide range of marginalised populations. It can examine how good transformational programming addresses all five of the GESI domains, as shown in Figure 3.

Figure 3: World Vision's GESI Theory of Change



This means it is not enough to provide better access to services or resources or enhance their well-being in the short term. Children with disabilities need to be able to participate fully in the educational, social and cultural lives of their communities and make decisions. Our programs and projects also need to challenge institutional barriers including inequitable formal systems (processes, laws) and informal systems (social norms) that limit opportunities for children with disabilities. If we do this, children with



disabilities will be empowered, have greater agency and live in a transformed environment.

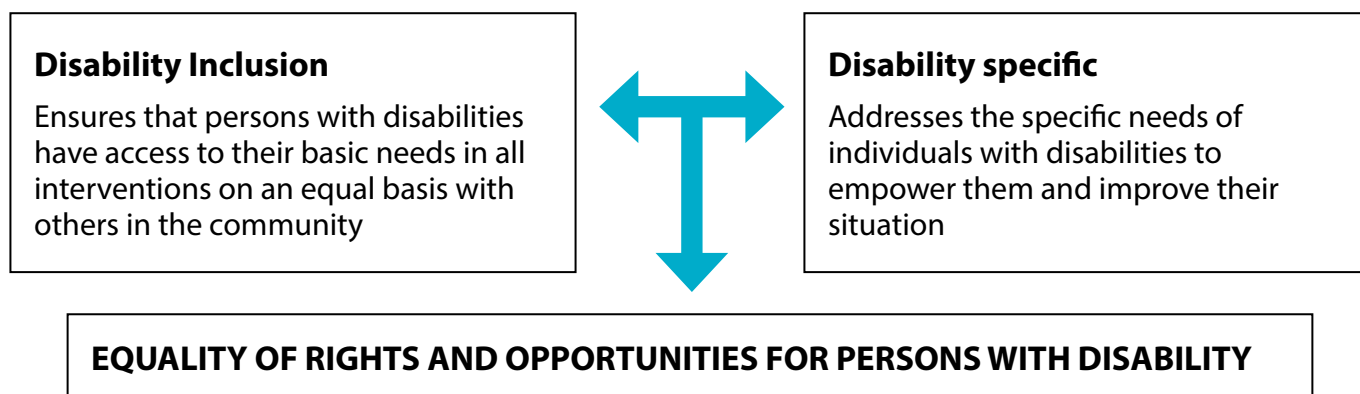
It is also important to talk through the twin-track approach so participants understand that program design needs to incorporate both disability inclusion and disability-specific interventions. Distribute Handout 5: The Twin-Track Approach which contains the information and Figure 4 below.

The Twin-Track Approach

To address the needs of persons with disabilities, we use a twin-track approach and World Vision's GESI approach and Theory of Change to make sure that our programming is transformative for persons with disabilities.

Within the twin-track approach for disability inclusion, we take both disability inclusive actions and disability specific actions – both actions are necessary to support equality of rights and opportunities for persons with disabilities. Disability specific interventions lift persons with disabilities up to a position where they can take advantage of a more inclusive environment around them.

Figure 4: The Twin-Track Approach to Disability Inclusion



It is very important that you ensure participants who have worked on the medical and charity model approaches appreciate and understand the difference between their plans and the social model plan, and why World Vision wants to use the social model approach.

Trainer tips and critical points:

This session needs extremely careful facilitation. **You do NOT want to see an outcome where participants fail to understand the clear positive difference the social model approach makes to children and adults with disabilities.** As two-thirds of the group will be working on medical and charity model approaches, as trainer you have a responsibility to ensure everyone in the room understands the points and differences at the end of the activity.

Humour can often feature in this exercise for participants in the medical and charity model groups. Partly it is a realisation of what the activities they have seen in the past mean in practice, and how people in the disability

movement may view them. It can be awkward, but being able to express these feelings through laughing about them can also 'drive the point home' quite powerfully. People are not laughing at children with disabilities (that should **never** be tolerated) – they are laughing at some of the development sector's past attempts (some of them very clumsy) to include children with disabilities in their work. It gives participants a fresh perspective on how these projects can be viewed through the 'lens' of the social model approach now that they know about it. It can drive home the point that children with disabilities have needs and wants that all children have – for good education, good access to WASH, safe play, a loving and protective family, etc.

This activity is an opportunity to help participants make the link between the models of disability and the extent to which activities **transform** power relationships around disability – linking it with the broader approach to GESI that World Vision is promoting. This activity aligns with the broader GESI Continuum approach.



Session 2: Activity 8: Excuses, Excuses

Why don't development agencies include disability as a programming issue? What would you say in response to them?



Time: 60 minutes.



Materials:

- [Handout 4: The Global Truth About Disability – some disability facts and figures](#) (also used in Session 2 Activity 6: Myths about Disability) – or make a display of disability statistics on a flipchart
- [Handout 8: Common Myths About Disability Inclusion](#)
- Prepared questions (given in step 2) written on flipchart paper
- Flipchart paper and marker pens for each group.

Introduction for trainer:

Why are children/young people with disabilities excluded from most World Vision programs? With everything that has been learnt in this course, it is a core question. And it's tackled directly in this session. This does not just happen in World Vision – it is still sadly common throughout the humanitarian and development sector.

Many of the reasons given by people for not considering the needs of children/young people with disabilities are remarkably similar. And everything that has been learnt in this training can be used as a response to these excuses.

Encourage the group to discuss these issues in as non-threatening a way as possible. Try to keep discussions as fun as you can to avoid people becoming defensive. You're not judging the work that's happened. You want to encourage change going forward. But you do want to help all participants understand why children/young people with disabilities have been excluded for so long.

Method:

1. If you have time, a good way to start this session is to talk through some of the more serious statistics relating to children/young people with disabilities where World Vision has programs. You can use Handout 4: The Global Truth About Disability to help you. Many people aren't aware how many children/young people with disabilities there are in any population – and that they make up such a significant proportion of the world's poorest people.
2. Ask the whole group the following questions (display on your pre-prepared flipchart):

“Do you actively include children and young people with disabilities and young people with disabilities in all your programs?”

- o *If yes – from what you have learnt in this training, which disability model do you think you used (medical, charity, social)?*
- o *If not, why don't you actively include children and young people with disabilities in your programs?”*

The key part of these questions is the word **'actively'**. This should be stressed when you present the questions to participants. Encourage people to be honest about their answers – this will give them the best opportunity to analyse the issue(s).

3. If any of the group answers 'yes' – briefly explore what they are doing.

Please note that work described in answer to 'yes' may be a medical or charity model in its approach. If this seems to be the case – and participants are not aware of this – you will need to carefully handle a discussion encouraging them to explore how their approach compares with what has been learnt in this training course, and if there is anything they may want to approach a little differently as a result of what has been learnt.

4. Assuming most of the group does not actively include children or young people with disabilities in their programming work – invite people to share all the different reasons why. List them on flipchart paper. Possible answers may include – it's expensive; time-consuming; we don't have the experience; we don't know how to; why should we, this is just one more marginal group amid many others; it's not practical in our type of work, etc.
5. Explain the most likely common misconceptions – and their responses. Use Handout 8: Common Myths About Disability Inclusion for information to help you explain.
 - 'We need to sort out the problems of "normal" children and young people first'
 - 'It's not cost effective'
 - 'There aren't many children and young people with disabilities here, so it's not an issue.'
 - 'We don't "do" disability'
 - 'We don't have the skills'
 - 'Let's create a special program'

Observe how all the reasons above **seem to come from a perspective that disability inclusion is based on the 'medical' or 'charity' model approaches (the 'individual' models)**. In this training we have learnt that World Vision aims to base its disability inclusion work on the social model approach. When you look at it through this 'lens', inclusion is not so daunting. It is about identifying and eliminating the different barriers that children and young people with disabilities face in their communities.

Also remind participants of what was learnt in Session 1's 'Chances of Childhood' and the 'UN Conventions' activities yesterday. There are legal obligations now to build disability inclusive programming from the start of a project. Just as important (if not more) – programs that do not plan for the inclusion of children and young people with disabilities are probably 'doing harm' by increasing the gap for children with disabilities to other children – a shocking fact that many development agencies don't realise as this is not their intention. They are also being denied their rights as stated in both the CRPD and CRC.

6. Divide participants into groups of four to six. Give each group a selection of the excuses they've come up with. Ask them to develop a reply refuting the statement, writing their key points on flipchart paper. They need to imagine they are facing people who are coming up with all these reasons why they are not going to include children with disabilities in their programming work. Their job is to reassure them that inclusion is both good development practice – and a non-negotiable obligation. Including children with disabilities will improve the effectiveness of the program as a whole.
7. Ask the groups to present a selection of their favourite responses to the rest of the participants. They can do

this in whatever format they choose. Some groups might like to illustrate their ideas with pictures, perform a short dialogue that highlights the debate, or simply describe their ideas. Or use the traditional 'flipchart' presentation!

Motive:

Uncovering barriers as to why children and young people with disabilities are not routinely included in World Vision's work is the first most important step to overcoming their exclusion. They are not included because there are different reasons preventing it. Identifying what those reasons are is central to developing a more inclusive program.

By asking people to defend excuses in a light-hearted way, you'll be providing them with insights into their own perceptions and helping prepare them for how others might react to their plans for disability inclusion.

Training tips and critical points for trainer:

This is your final opportunity to check whether your participants have absorbed the main learning points and concepts you want to communicate through the whole course. Listen carefully to the presentations to check that everyone has clearly understood the differences between the 3 models – and why implementation of the social model inclusive approach is important for them and their programming work.

Facilitate broader discussions if there still appears to be some confusion and misunderstanding about the concepts. Ensure that participants leave the training with a clear understanding of the disability inclusive approach World Vision is adopting through the social model – and why this is important for their development programming work.



Session 2: Activity 9: Our Next Steps

What can we do for disability inclusion now?



Time: 50 minutes



Materials:

- Flipchart for each group (or for each person)
- Markers, pencils or pens for groups (or for each person)

Introduction for trainer:

This activity is intended to give participants a chance to reflect on what they have learned and to make simple commitments to disability inclusion. The activity is written for group reflection and commitment, but can be done individually as well.

Method:

1. Inform participants this will be the last activity of the workshop and is intended for participants to reflect on what they can do to support persons with disabilities in their personal or work lives.
2. Split the participants into groups of 3-4 people.
3. Advise participants they will reflect on the workshop individually and will then discuss the workshop in their small group.
4. Ask them to think about the following questions

individually:

- a. 'What is one thing you learned during this workshop that impacted you the most?'

- b. 'What is one thing you can do to apply that learning in your work or personal life?'

- c. 'What would you like to learn more about?'

5. After 5 minutes (or once it seems like participants are finished reflecting individually), instruct them to share these reflections in their small groups.
6. Give groups 15 minutes to share with one another what they learned and what they think they can do to apply what they learned.
7. Once it seems like most people have shared in their small groups, give each group a flipchart and a pen/pencil/markers.
8. Ask the groups to draw a picture to depict their commitments. Tell them to be as creative as they can.
9. After 15 minutes, give each group 2-3 minutes to share their pictures.
10. Once every group has shared, thank everyone for their contributions. Highlight how our individual commitments to disability inclusion can impact the lives of children and adults with disabilities on a broad scale – especially as staff and partners make commitments to change the negative norms faced by adults and children with disabilities.
11. Explain the other [learning opportunities or resources](#) available to them on disability inclusion.
12. Close the workshop by thanking the participants for their time, contribution and experience.



HANDOUT 1: Models of Disability, Barriers to Inclusion, Disability Definitions

THE THREE MODELS OF DISABILITY

Defining disability is central to work on disability inclusion. How people conceptualise disability influences how they behave towards children and adults with disabilities, how they frame their problems and needs, and how programs are developed in response. Currently, most development programs ignore children and adults with disabilities – or treat them as a special case.

There are three predominant models of disability representing different approaches:

- The Medical model
- The Charity model
- The Social/Human-Rights model

It is the power relations regarding the role of society, professionals and children and adults with disabilities that in essence defines the difference between each of these models.

Traditionally, disability has been conceptualised using either the medical or charity models. Collectively these models are referred to as the 'individual model' because both focus on the child or adult with an impairment as being (or having) the 'problem'. These models are behind programs that target children and adults with disabilities as separate groups needing specialist or dedicated services, chosen on their behalf by 'experts'. This is characterised by the development of isolated initiatives such as the provision of prosthetics/orthotics, habilitation/rehabilitation, speech therapy programs, or the setting up of specialist income-generating projects or vocational training centres, where these are not linked to any particular mainstream program.

By contrast, the social/human rights model promotes the assumption that children and adults with disabilities should participate in all development activities since they are members of communities. But it also pays attention to the fact that those activities may need to be adapted for accessibility and inclusion. It means different social agents taking responsibility for understanding what barriers might exist and how to mitigate them so that children and adults with disabilities are included as stakeholders in all mainstream work, and looking for ways to support their participation in community life.

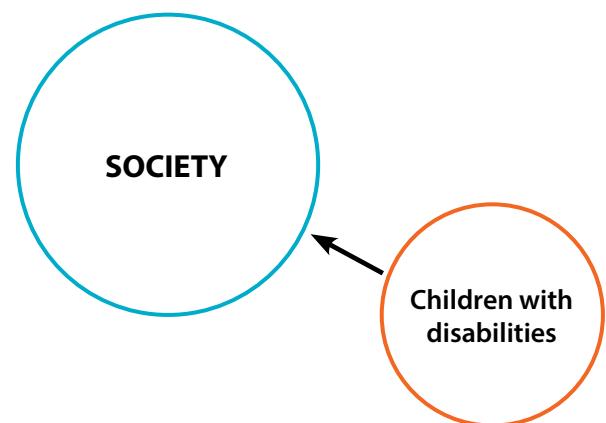
Everyone has a right to basic services such as health, education and income generation. But the needs of children and adults with disabilities have traditionally been treated as separate and specialised which has put

them outside mainstream development, with little voice or power when it comes to the design of programs or interventions. The UN Convention on the Rights of Persons with Disabilities challenges this narrow approach. The emphasis for inclusion under the social/human rights model is placed on society reducing barriers and promoting opportunities for participation rather than on expecting children and adults with disabilities to 'fit in' as best they can. Children and adults with disabilities should be seen as people with the same basic needs as others, able to choose how and when they participate and are supported to achieve that.

Each model represents a different **perspective** on what 'disability' is conceptually. This affects what staff or partners think they should do to achieve disability inclusion.

Medical Model (individual approach)

Disability is seen as 'a problem' in the person

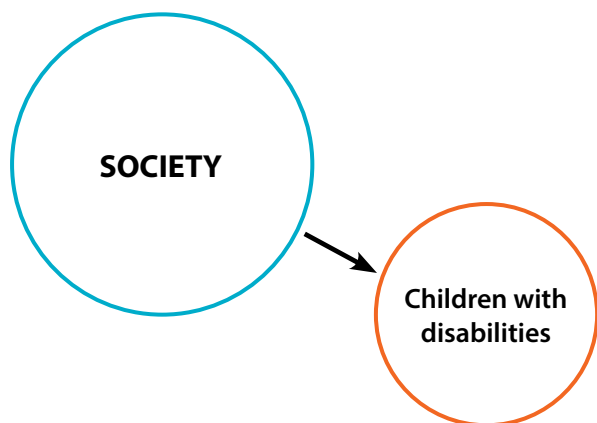


Activities focus on 'fixing' children and young people with disabilities, who are 'sick', so they can join 'normal' society.

- The focus is on a child's impairment as the obstacle.
- The motivation is to 'cure' or 'improve' individuals to 'fit' them into society.
- This leads to segregated services resulting in exclusion from the mainstream, with the rationale that this means better, specialised services can be provided.
- Decision making is placed in the hands of specialists or professionals with little or no regard to the rights of individuals.
- It is an expensive process that tends to benefit relatively few.
- Children and young people with disabilities play a passive role in the development and implementation of disability policy and practice.

Charity Model (individual approach)

Disability is seen as 'a problem' in the person



Activities are aimed at 'helping' children and young people with disabilities who are 'helpless' and outside 'normal' society.

- Children and young people with disabilities are regarded as 'unfortunate', 'dependent' or 'helpless'.
- They are seen as needing pity and charity, often with roots in traditional understandings that impairments result from sin, ill-favour, or a curse.
- It is assumed that children and young people with impairments cannot contribute to society or support themselves.
- They are provided largely with money or gifts, such as food or clothing.
- They become long-term recipients of welfare and support – through their adult lives as well.
- Aid is provided by specialist organisations, not mainstream development organisations and service providers.

Social/Human Rights Model (rights-based approach)



Disability results from barriers in society

Activities focus on inclusion, recognising explicitly that children and young people with disabilities are a normal part of all communities.

- Disability is seen as the social consequence of impairment.
- Children and young people with disabilities are regarded as part of society, rather than as separate.
- These people with impairments are disabled by society denying their rights and opportunities.
- Their rights are the same as children and young people without disabilities, e.g., education, health, the need for loving relationships, etc.
- This model leads to inclusive approaches to education, employment and other services by encouraging the participation of children and young people with disabilities in mainstream programming.
- Activities focus on identifying and removing attitudinal, environmental and institutional barriers that block inclusion.
- This approach is underpinned by national and international legislation including the UN Convention on the Rights of Persons with Disabilities (CRPD).

In summary, the first two models (the medical and charity approaches) focus on **barriers to participation being with the individual with an impairment** who needs to be 'fixed' or will be long-term dependent. The third model, known as the 'social' or 'human rights' model, focuses on **barriers being with society's view of children and young people with disabilities and how this leads to the exclusion** of the individual with an impairment.

THE THREE BARRIERS TO INCLUSION

Environmental Barriers

Children and young people with disabilities encounter barriers in areas such as:

- public transport
- hospitals and clinics
- schools and housing
- shops and marketplaces
- places of worship
- media and communications
- public information systems

There are two main categories of barriers:

1. **Physical barriers.** Most people think of the physical barriers in this category – e.g., a school classroom is inaccessible for wheelchair users if it has steps and narrow doorways. Once aware of these barriers, it is relatively easy to identify them – in consultation with persons with disabilities. It is important that toilets, handwashing facilities and refreshment areas are physically accessible to all in buildings as well.
2. **Communication barriers.** Communications can also be disabling for those with sensory impairments – e.g., for deaf people if there's no sign language or communication adaptations, for those with visual impairments if large print textbooks are not available, for people with intellectual impairments when people use language they do not understand. Poor communication can have devastating results where important school-based education campaigns happen (e.g., HIV and AIDS, COVID-19 precautions). Students with hearing, visual or intellectual impairments are unlikely to access vital information unless their access requirements have been met.

These barriers are grouped together as **environmental barriers**.

Physical barriers are often easiest to identify – for example, steps, narrow pathways, uneven surfaces, toilets with no supporting handrails. But **communication barriers** are just as significant to identify for those with sensory or communication impairments.

Institutional Barriers

Some barriers exclude or segregate children and young people with disabilities from areas such as:

- legal systems
- education policies
- employment laws
- health service provisions
- social services
- humanitarian/development agency policies
- belief systems and religion

Many of the services people take for granted are 'no-go' areas for children and young people with disabilities because of laws and policies that cause discrimination against them.

The lack of official recognition of sign language, for example, can mean that schools are unable to teach deaf children where it is their main language and there is no support for sign language interpreter training. Having to pay copyright fees to print books in braille may limit

the number of texts available to students with visual impairments who use braille.

In many countries, legislation still permits forced sterilisation or termination of pregnancies in young women with cognitive or psycho-social impairments and may continue to promote institutionalisation without consent.

If young people with disabilities make it through the education system and acquire qualifications, the lack of willingness amongst employers to implement reasonable accommodation measures may preclude them from taking up work. There are examples of physically impaired people qualifying as teachers but then being banned from getting jobs in schools because of the school's inadequate interpretation of 'fitness to work' criteria commonly written into job descriptions. There are also reports of young deaf people being unable to open bank accounts to start businesses because banks refuse to allow communication support into meetings with bank staff – saying it will break their strict confidentiality codes. Even where legislation is in place, if the terms of reasonable accommodation are not specified and not enforced, then young people with disabilities will remain excluded from the workforce.

These barriers are grouped together as **institutional barriers**.

Institutional barriers are some of the most difficult to identify. Without a proactive search for them, they won't be as immediately evident. That's because they're often linked to social and cultural norms and written into policies and legislation. The way to start identifying them is to focus on sectors in which you work, and try to map the legal, cultural, and social practices that might need addressing. Consulting with local persons with disabilities (including their representative organisations – OPDs) will be an essential part of helping to identify them.

Attitudinal Barriers

Prejudice, discrimination and stigma cause the biggest problems for people with disabilities – but it is often the least recognised barrier when considering disability inclusion. Children, young people and adults with disabilities are often assumed to be one or more of the following:

- incapable/inadequate
- of low intelligence
- in need of 'a cure'
- needing 'special' services or support
- cursed by 'bad spirits'
- inspirational/exceptional

People who make these judgments treat children and young people with disabilities as superfluous or superhuman. They either fail to respond to the individual – with all their inherent personality, strengths and weaknesses – or they assume they have ‘superhuman’ abilities to cope with their impairment.

People without disabilities can respond with fear, pity, repulsion, or a sense of superiority. These assumptions and emotions are often reinforced by the media and important cultural influencers in societies. Negative language reflects, and often reinforces, prejudices. Persons with disabilities wish to change the language people without disabilities use to describe them – especially language that is offensive and inaccurate.

These barriers are grouped together as **attitudinal barriers**.

Attitudinal barriers are the most important to identify – time and time again they are the main reason behind preventing progress on disability inclusion. Negative attitudes and assumptions have led to many children and

young people with disabilities believing themselves to be worthless, dependent and in need of support. This cycle of charity and dependency can be difficult to break.

In discussions with people with disabilities and their families, if time is taken to understand their challenges, most report the biggest barriers they face are attitudinal ones. Most people in society who don’t know them, assume the biggest barriers they face are environmental ones, especially physical access barriers. That, of course, is if they have considered at all the barriers faced by them in society.

DEFINITION OF DISABILITY

As per the UN Convention on the Rights of Persons with Disabilities (CRPD):

‘...disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.’ (Source: CRPD Preamble [e])

TALKING ABOUT DISABILITY

Impairment – characterised by:

- problems in body function or structure;
- conditions caused by disease or injury that affect a person’s functioning or appearance. e.g., lacking part of or all of a limb; or having a limb, organ or system that doesn’t fully function;
- long-term or short-term problems;
- Single or multiple problems.

Use ‘impairment’ when you want to describe what makes an individual different from others (i.e., the physical, sensory, cognitive, or mental health problem[s] they have).

Disability – characterised by:

- the results of limitations imposed on people with impairments;
- those limitations preventing their full and active participation in society;
- attitudinal, environmental and institutional barriers preventing inclusion.

Use ‘disability’ when you want to describe the impact that an impairment has on an individual’s opportunity to carry out daily tasks.

A useful summary to describe disability uses a maths equation analogy:

$$\text{Impairment} + \text{Barriers} = \text{Disability}$$

What are some of the main causes of impairments?

- Some impairments are congenital due to genetic factors.
- Other impairments can be caused by an injury or illness before birth.
- Others can be caused by injury or illness after birth.
- A child or adult can have multiple impairments from one or more causes.

How do impairments affect children and adults?

- Physical impairment affects body movement and/or appearance.
- Sensory impairment affects sight, hearing, speech, smell, taste, sensation/feeling, physical balance.
- Neurological impairment affects the nervous system, speech, motor skills, vision, memory, muscles, learning abilities.
- Intellectual impairment affects cognitive functioning and behaviour.
- Mental illness affects thinking, moods, ability to relate and capacity for coping with life.

HANDOUT 2: Key Global Conventions and Frameworks on Disability Rights

There are three key conventions and frameworks for World Vision staff to be aware of in relation to disability rights:

1. UN Convention on the Rights of Persons with Disabilities (CRPD)
2. Sustainable Development Goals (SDGs) within Agenda 2030
3. UN Convention on the Rights of the Child (CRC) – specifically Article 23

UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (CRPD)

<https://www.un.org/development/desa/disabilities/>

In December 2006, the General Assembly of the United Nations adopted the Convention on the Rights of Persons with Disabilities (CRPD). It was the first human rights treaty of the 21st century and the first to focus explicitly on disability. By 2008 it had officially come into force, marking a significant milestone in the history of disability rights.

It was also unique in the speed of its development (just 5 years) and the unprecedented level of involvement from the civil society sector, especially from people with disabilities. It has been signed and ratified by 182 countries and is already starting to influence the development of national disability rights legislation and disability inclusive development.

The CRPD is the most detailed of all the UN human rights treaties with 50 articles and a preamble. Its main purpose is to 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities...' (Article 1).

The CRPD articulates, supports and promotes the social/human rights model of disability, marking a major shift in approaching disability from one that has been dominated by medical and welfarist concerns to one based on disability as a human rights issue which acknowledges the disabling effects of societal barriers and prejudices.

The CRPD and International Development

The CRPD acts as both a development and a human rights tool: it is the only human rights framework currently that includes a specific article on international cooperation (Article 32). All States Parties are obliged to ensure that all development aid is '...inclusive of and accessible to, persons with disabilities' (CRPD Article 32).

This has important implications for development agencies, bilateral and multilateral donors, development studies and research. **For the first time, there is now a binding commitment to ensure equality and inclusion, not only domestically, but also through development aid.** For example, since the UK has ratified the CRPD it is now under obligation to work towards ensuring the countries to which it supplies aid also develop and implement anti-discrimination legislation. It must also ensure that whatever development activities it funds are inclusive of persons with disabilities.

As a direct result of the CRPD, increasing numbers of governments around the world are passing or amending pro-disability legislation, more international agencies are specifically including people with disabilities and there are now more opportunities for research.

Donors are also increasingly developing strategies, plans and position papers on disability-inclusive development. Australia, Austria, Finland, Germany, Ireland, Italy, Japan, New Zealand, Norway, Sweden, and the US all have varying levels of stated commitments to disability inclusion. In 2015, the UK's FCDO launched an updated Disability Framework setting out its commitments to disability inclusion across its aid program, and a new UK Disability Strategy is being launched in 2022 which will include a section on international cooperation. The UN launched its first UN Disability Inclusion Strategy (UNDIS) in 2020 which sets out how the whole UN system intends to become more inclusive and as a result, several agencies including WHO and UNICEF, now have their own inclusion strategies. The World Bank also launched a disability and inclusion accountability framework in 2018 which has targets around social protection and employment.

Implementation of the CRPD

Implementation of the CRPD, even with accompanying domestic legislation, is still a work in progress. The concepts of disability rights and the social/human rights model are still new in most low- and middle-income countries and will take time to become embedded in legislation, policies, and practices.

The lack of dialogue between persons with disabilities and policymakers means there is still a critical lack of progress. Politically, it remains a low priority, so financial and human resources needed to fund inclusive development remain far too low for what is needed. The continued lack of robust statistical data and research on the lives of children and adults with disabilities also hinders progress. Whilst

starting to improve, it is still hard to provide the evidence base needed for governments to allocate more time and resources to disability inclusive development. And, as mentioned elsewhere, Organisations of Persons with Disabilities (OPDs) still struggle to engage with the wider development and human rights discourse.

SUSTAINABLE DEVELOPMENT GOALS (SDGs)

The overarching principle of the 2030 Agenda is: **Leave No One Behind**. This means, to ensure its success, the Agenda must include children, young people and adults with disabilities. This is reflected in many of the statements of both the 2030 Agenda and the 17 SDGs.

The 2030 Agenda, which includes the SDGs, includes persons with disabilities with **11 specific references**. Governments of all 193 Member States of the UN have made a political commitment to them.

Persons with disabilities are referenced directly 11 times in the 2030 Agenda. These are in paragraphs on human rights, vulnerable groups, and education. There are also **direct references in 5 SDGs**:

- Goal 4: Education
- Goal 8: Employment
- Goal 10: Reduce inequality
- Goal 11: Inclusive cities
- Goal 17: Means of implementation (data)

However, the phrasing of all 17 SDGs and the 'Leave No One Behind' principle mean that including persons with disabilities is core to the successful implementation of all the SDGs. Furthermore, disaggregation of data by disability is a core principle to implement in follow-up and review processes of both the 2030 agenda and the SDGs.

Where are Persons with Disabilities in the 2030 Agenda?

Paragraph 23 of the 2030 Agenda states **'People who are vulnerable must be empowered. Those whose needs are reflected in the Agenda include all children, youth, persons with disabilities (of whom more than 80 percent live in poverty)'**. This paragraph places children and adults with disabilities at the centre of poverty eradication throughout the entire Agenda.

The 2030 Agenda and the SDGs will influence the direction of global and national policies relating to sustainable development for the next 15 years. If the 2030 Agenda is going to be successful, all of the UN Member States – **193 countries – must include children and adults with disabilities** in their national plans for implementation and monitoring.

What links disability, human rights, and the SDGs?

The CRPD, provides a direct link between the SDGs and human rights. All countries who have ratified the CRPD are legally bound to implement the core articles and must report on their progress in writing to the UN on a periodic basis.

At the same time, the 2030 Agenda and SDGs have been adopted by all 193 countries and will influence the direction of global and national policies for the next 15 years. As mentioned, if the 2030 Agenda is going to be successful, all the UN Member States must include persons with disabilities in their national plans for implementation and monitoring, according to commitments they have agreed to.

UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD (CRC)

[https://www.unicef.org/disabilities/files/Synergies_paper_V6_Web_REVISSED\(1\).pdf](https://www.unicef.org/disabilities/files/Synergies_paper_V6_Web_REVISSED(1).pdf)

The Convention on the Rights of the Child (CRC) comprises 54 Articles. It was adopted by the UN General Assembly in 1989 and came into force in November 1990. Prior to its adoption, there was no legally binding international treaty addressing the specific situation of children. The CRC rapidly achieved near universal ratification.

All the provisions of the CRC apply on an equal basis to children with disabilities. It also includes two specific provisions for children with disabilities:

- **Article 2** states that no child should encounter discrimination on the grounds of 'race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, **disability**, birth or other status'. The CRC was the first human rights treaty to include disability as a ground for protection from discrimination. It broke new ground, establishing the right to protection, and imposing obligations on States to take all necessary measures to ensure that protection for all children with disabilities.
- **Article 23** is specifically focused on children with disabilities and emphasises their right to a **'full and decent life in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community'**. In its 4 sub-clauses it imposes obligations on States to provide special care and assistance to enable the child to achieve the **'fullest possible social integration and individual development, including his or her spiritual or cultural development'**.

Drafted during the 1980s, Article 23 reflects earlier thinking of disability as 'a problem' located within the individual, needing targeted or special services, rather than the current understanding which locates the multiple barriers in society as the disabling factors impeding the realisation of rights. However, the CRC did explicitly place the issue of both children and disability in the arena of international human rights law, and in the context of a comprehensive treaty spanning the full range of human rights.

One reason why the CRPD came into existence is that the mention of disability inclusion in other Conventions – including the CRC – wasn't bringing practical implementation and change. A separate Convention to draw everything together was felt important by the disability movement, hence the first UN Convention of the 21st century, the CRPD.

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UN, (2006), Convention on the Rights of People with Disabilities, UN Department Social And Social Affairs, New York. <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>

UNICEF, (2013), The State of the World's Children 2013: Children with Disabilities, UNICEF, New York. <http://www.unicef.org.uk/Documents/Publication-pdfs/sowc-2013-children-with-disabilities.pdf>

WHO, (2011), World Report on Disability, Geneva http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf

References and information on SDGs

Full information on the 2030 Agenda and the SDGs can be found here:

- A toolkit, jointly produced by the International Disability Alliance (IDA) and the International Disability and Development Consortium (IDDC) <http://www.iddcconsortium.net/resources-tools/2030-agenda-inclusion-persons-disabilities>
- A UN information page, <https://www.un.org/development/desa/disabilities/about-us/sustainable-development-goals-sdgs-and-disability.html>

References and information on CRC

Disabled Children's Rights and the UN Convention on the Rights of the Child, Hazel Jones, 2000

<https://dsq-sds.org/article/view/266/281>

World Vision's GESI policy

The Sustainable Development Goals (SDGs) and our Ministry Goal (sustained child well-being within families and communities, especially for the most vulnerable) can only be achieved when opportunities, resources and choices are available to women and men, girls and boys, and marginalised and excluded groups, **especially children living with disabilities.**

HANDOUT 3: A Guide to Disability-focused Organisations

Children and adults with disabilities have been excluded from most decision-making processes. Families, communities – and development organisations – have tended to decide on their behalf, even when it directly affects their lives. That could be about undertaking physical therapy, having surgery, or being sent away to a ‘special needs’ school.

As a result, persons with disabilities are rarely consulted or involved in development planning, and few can take up leadership positions. In response, a disability movement has been growing around the world. Its aim is to represent the voice of children and adults with disabilities and lobby for greater inclusion. Conditions vary from country to country, but often there are national organisations for many of the main impairment groups – with branches or committees in towns and villages. If the movement has been established for a while, there may also be a federation or union representing all children and adults with disabilities in national-level policymaking.

Each organisation has a part to play, to ensure children and adults with disabilities benefit from development. All can be important resources for meeting the needs in your region. However, contacts for consultation about inclusion must be with organisations of persons with disabilities themselves – through self-help groups, OPDs or national and international bodies.

Organisations of Persons with Disabilities (OPDs)

– also known as Disabled Peoples’ Organisations (DPOs)

- OPDs are organisations made up of persons with disabilities.
- They are led and managed by persons with disabilities.
- Many represent people with a particular impairment.
- In countries where the disability movement isn’t strong, there may only be two or three impairment groups represented.
- Some national-level OPDs are known for their lobbying, such as the National Union of Disabled People Uganda (NUDIPU), and Federation of Disability Organisations in Malawi (FEDOMA).
- Some are represented at regional and international level, like the Southern Africa Federation of the Disabled (SAFOD) and International Disability Alliance (IDA).

- Many can be small and relatively weak in capacity that focus on meeting the immediate needs of their members (often linked to high-poverty levels in areas with low historic levels of support).
- The most important aspect of OPDs is their ability to understand the needs in their locality and to mobilise persons with disabilities.
- With appropriate support, OPDs can be effective partners in community development programs for mainstream initiatives.

Self-help Groups:

- are groups of persons with disabilities and/or caregivers not yet registered as OPDs;
- tend to be more common in rural or semi-urban contexts where OPDs have yet to reach, or for groups who lack the resources to formally apply for registration;
- play an important role at local level in connecting children, adults and caregivers with disabilities with each other;
- often offer social support and can be mobilised to provide assistance during emergencies;
- can be an important link between children and adults with disabilities and community development programs or disaster resilience programs, and should be sought when carrying out mapping activities.

Disability Non-Governmental Organisations (NGOs)

- These organisations work for adults and children with disabilities.
- They include large international NGOs like Sightsavers, Leonard Cheshire Disability, CBM, Humanity & Inclusion (formerly Handicap International) Deaf Child Worldwide, Sense International, Sue Ryder Care, Able Child Africa, and ADD International.
- Some specialise in particular impairments, some are more focused on building the capacity of persons with disabilities and their representative organisations.
- Numerous national NGOs target people with disabilities specifically, e.g., Uganda Foundation for the Blind, and Association for People with Leprosy in Angola.

- They include faith-based charities supporting special needs schools and classes, vocational training centres or working to help produce orthotics/prosthetics.
- In many cases, medical/rehabilitation needs may be primary support focus.
- Many are transitioning towards rights-based approaches. Policy work and advocacy campaigns are often more advanced in this journey than the programming operations of the larger disability NGOs, mainly due to the historical journeys of each organisation and the composition of their supporter base.

HANDOUT 4: The Global Truth About Disability – some disability facts and figures

Not all children and young people with disabilities have issues with their health or impairments.

But many will live in families and households that face poverty, discrimination, prejudice, and stigma. Many lack access to basic public services, health, education, clean water, sanitation, and housing. Children, young people and adults with disabilities are more vulnerable during times of conflict and humanitarian crises, violence, abuse, and neglect.

More than 600 million of the world's population have impairments, with three-quarters of them living in low- and middle-income countries (LMICs). In addition, 1 in 4 of the world's poorest people have an impairment. If you consider the exclusion and discrimination that children, young people and adults with disabilities and their families face, the impact of these figures becomes even greater.

Here is just a selection of facts and figures that paint the real picture for children, young people and adults with disabilities across the world.

General information

- 15% of the global population is estimated to have a disability.ⁱ
- Globally, there are around 100 million children with moderate to severe disabilities.ⁱⁱ
- 80% of children and adults with disabilities live in LMICs.ⁱⁱⁱ
- There is a direct link between poverty and disabling impairments.^{iv}
- Children, young people and adults with disabilities have been disproportionately affected by the COVID-19 pandemic – and studies in India and the Philippines have found that high proportions (50% and 91% respectively) of people with disabilities did not have accessible information about COVID-19.^v
- In Nepal, 32% of people with disabilities reported that services usually provided by caregivers had to stop because of lockdown, and in 50% of cases caregivers could not be replaced.^{vi}

Poverty

- Nationally representative data from Multiple Indicator Cluster Surveys (MICS) shows that children from poor households are significantly more likely to have a disability.^{vii}

- A 2017 systematic review found that 81% of included studies found an association between disability and income or asset poverty in LMICs.^{viii}
- People with disabilities in 13 out of 14 LMICs were more likely to live in poor households than those without disabilities. In Kenya, 52% of people without disabilities live in poor households compared with 67% of people with disabilities.^{ix}
- Around 30% of street children have a disability.^x

Health

- A systematic review found that people with disabilities have a higher need for general health care services, poorer coverage, and experience higher health care costs. They also have limited access to specialist health care services including rehabilitation and assistive technologies.^{xi}
- Data from several countries shows people with disabilities are at higher risk of HIV infection and poor mental health, and that children with disabilities are more likely to experience serious illnesses.^{xii}
- In Kenya, children with disabilities are up to three times as likely as those without disabilities to be malnourished. In Malawi, children with disabilities are twice as likely to die from malnourishment as those without.^{xiii}

Education

- Analysis from 51 countries using World Health Survey data showed that 48% of 18 to 49-year-olds with disabilities had completed primary school, compared to 60% without disabilities.^{xiv}
- Girls with disabilities are less likely to complete primary school than boys with disabilities, with 33% of women with disabilities aged 18 and over completing primary school compared with 46% of men with disabilities.^{xv}
- Data from the UNESCO Institute of Statistics shows 34.5% of children with disabilities are out of school compared with 14.1% children without disabilities at the primary level across six LMICs. Using data from 26 LMICs, the literacy rate for adults with disabilities is 55.6% compared with 74% of adults without disabilities.^{xvi}

Violence and Stigma

- People with disabilities are more likely to experience violence than people without disabilities, with children being 3-4 times at risk.^{xvii}

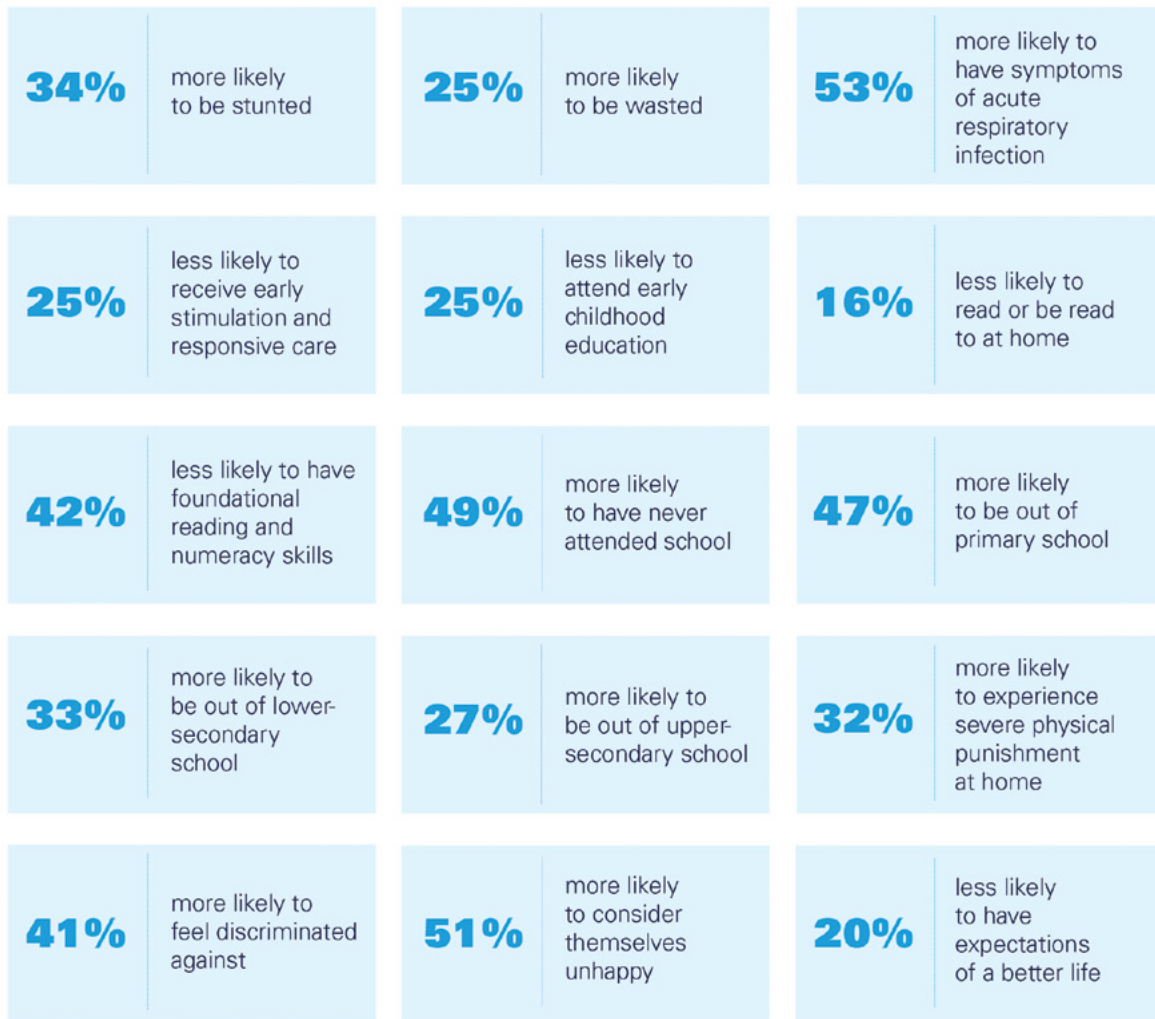
- Data from studies in six LMICs funded under the DFID-funded What Works to Prevent Violence Against Women and Girls (VAWG) program found that women with disabilities are 2-4 times more likely to experience intimate partner violence (IPV) than women without disabilities. Women with

disabilities are also more likely to experience non-partner sexual violence. ^{xviii}

- Stigma and discrimination against children with disabilities and their carers is common, and this is associated with barriers to accessing services and participation in economic and social life. ^{xix}

Key facts

Compared with children without disabilities, children with disabilities are:



United Nations Children's Fund
Data and Analytics Section
Division of Data, Analytics, Planning and Monitoring
3 United Nations Plaza
New York, NY 10017, USA

Email: data@unicef.org
Website: data.unicef.org



HANDOUT 5: The Twin-Track Approach

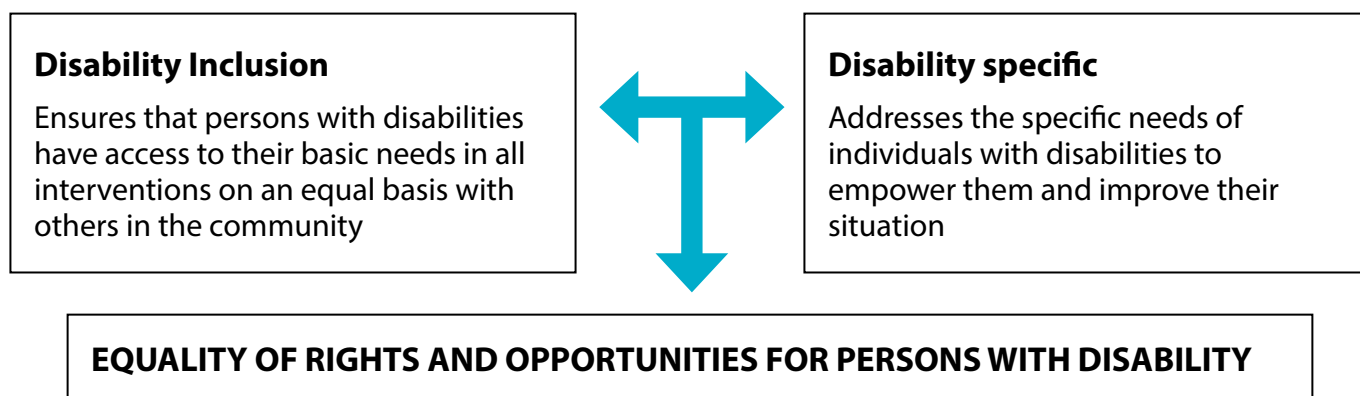
To address the needs of persons with disabilities, we use a twin-track approach and World Vision's GESI approach and Theory of Change to make sure that our programming is transformative for persons with disabilities.

Figure 3: World Vision's GESI Theory of Change



Within the twin-track approach for disability inclusion, we take both disability inclusive actions and disability specific actions – both actions are necessary to support equality of rights and opportunities for persons with disabilities. Disability specific interventions lift persons with disabilities up to a position where they can take advantage of a more inclusive environment around them.

Figure 4: The Twin-Track Approach to Disability Inclusion



HANDOUT 6: Group Task for Activity 7 – medical

Development Planning Scenario for the 3 Groups

Development planning using the disability models

World Vision has decided to implement a new project in rural Zambia. You are the team leader of this new project. It has been decided that the new project will focus on child health, and child protection. The project is about to move to the design phase.

Towards the end of the assessment phase, project staff report back that during this process they have come across at least 20 children and young people with disabilities among the 200 children identified as potential project beneficiaries. While the project team don't know much about disability, some of those identified are unable to walk by themselves or walk with difficulty, while others cannot see, hear, or talk. There are at least three individuals who people describe as 'stupid' or 'possessed'. Some parents of children who have disabilities have been present at consultative meetings held with the community, but don't appear to have anything to

say – they just sit there quietly. Furthermore, as staff have gone around the villages visiting households, people sometimes tell them that there are other children with disabilities hidden away in their neighbours' houses (never their own), but whenever project staff ask that household, this is always denied.

The project staff don't know how to help the children and young people with disabilities, or their caregivers living in the area and come to you for advice and support. You know that World Vision wants to include children and young people with disabilities and their caregivers in its work and want to ensure they are also able to benefit from the new project.

Consider how you would ensure that the children and young people with disabilities and their caregivers in this community are able to benefit from World Vision's work using the **individual (medical) approach to disability**. Think about and describe what methodologies, strategies and plans you would use/make to ensure this. You have 30 minutes for this exercise. Your group will then be asked to present your ideas back to everyone.

HANDOUT 6: Group Task for Activity 7 – charity

Development Planning Scenario for the 3 Groups

Development planning using the disability models

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Consider how you would ensure that the children and young people with disabilities and their caregivers in this community are able to benefit from World Vision's work using the **individual (charity) approach to disability**. Think about and describe what methodologies, strategies and plans you would use/make to ensure this. You have 30 minutes for this exercise. Your group will then be asked to present your ideas back to everyone.

HANDOUT 6: Group Task for Activity 7 – human rights

Development Planning Scenario for the 3 Groups

Development planning using the disability models

World Vision has decided to implement a new project in rural Zambia. You are the team leader of this new project. It has been decided that the new project will focus on child health, and child protection. The project is about to move to the design phase.

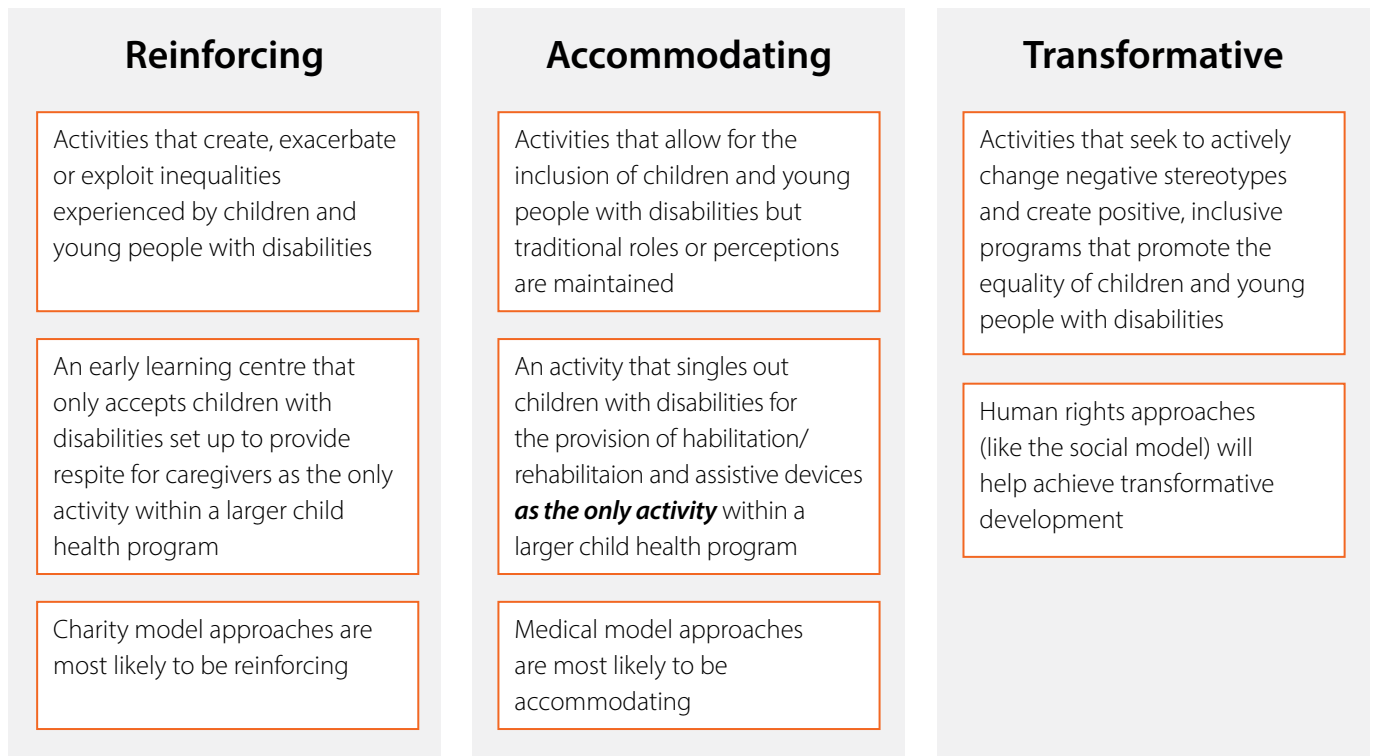
Towards the end of the assessment phase, project staff report back that during this process they have come across at least 20 children and young people with disabilities among the 200 children identified as potential project beneficiaries. While the project team don't know much about disability, some of those identified are unable to walk by themselves or walk with difficulty, while others cannot see, hear, or talk. There are at least three individuals who people describe as 'stupid' or 'possessed'. Some parents of children who have disabilities have been present at consultative meetings held with the community, but don't appear to have anything to

say – they just sit there quietly. Furthermore, as staff have gone around the villages visiting households, people sometimes tell them that there are other children with disabilities hidden away in their neighbours' houses (never their own), but whenever project staff ask that household, this is always denied.

The project staff don't know how to help the children and young people with disabilities, or their caregivers living in the area and come to you for advice and support. You know that World Vision wants to include children and young people with disabilities and their caregivers in its work and want to ensure they are also able to benefit from the new project.

Consider how you would ensure that the children and young people with disabilities and their caregivers in this community are able to benefit from World Vision's work using the **social (human-rights) approach to disability**. Think about and describe what methodologies, strategies and plans you would use/make to ensure this. You have 30 minutes for this exercise. Your group will then be asked to present your ideas back to everyone.

HANDOUT 7: Gender and Social Inclusion (GESI) Continuum with a Disability Focus



The three disability models correspond as follows:

DISABILITY MODEL

- Charitable
- Medical
- Social

TYPE OF PROGRAMMING

- Reinforcing
- Accommodating
- Transformative

GESI CONTINUUM

- Exploitative
- Accommodating/Sensitive
- Transformative

The goal is to achieve GESI transformative programming, assessing progress along the World Vision GESI continuum:



HANDOUT 8: Common Myths About Disability Inclusion

A whole range of reasons are given when you ask why children, young people and adults with disabilities are not travelling on the 'main road' of development. Here are some of the most commonly held views – along with informed common-sense responses:

'We need to sort out the problems of "normal" people first.'

Disability IS normal. People with disabilities are in every community. It's an expression of the diversity of the human race. Our perceptions are distorted by social norms which keep children and adults with disabilities out of the public arena, and by the narrow vision of 'beauty' presented in media images. Good development work challenges conditions which exclude the oppressed and the vulnerable. People with disabilities are among the most oppressed and vulnerable.

'It's not cost effective.'

Including children and adults with disabilities is often seen as an 'extra'. It happens in an ideal world. It's a luxury. Saying 'we only have enough money for the basics, so we can't afford to include them' denies the reality that people with disabilities' needs ARE the basics. It doesn't necessarily cost much more to include them in development, especially if it is planned from the outset. For example, physical accessibility is estimated to account for additional construction costs of between 0.1 and 5%. Trying to make buildings and facilities accessible retrospectively typically costs 25% of the original build cost. Many of the specific needs of children with disabilities can be met within existing programs or by referring children to services provided by OPDs or organisations that serve children with disabilities.

'There aren't many children and young people with disabilities here, so it's not an issue.'

Disability is treated as a specialist area, often because of the misconception that their number is insignificant. This myth arises for two reasons. First – many children and adults with disabilities are invisible. They may be hidden away due to stigma or are excluded from meetings because of a lack of access. If NGO workers don't see children and adults with disabilities in their work, they tend to assume they don't exist in the community. Disability affects the family as well as the individual, who may also face discrimination and increased poverty. Secondly – how disability is captured and recorded. There is a long history of disability data collection under-recording the actual incidence of impairment

and disability in populations. The movement led by the Washington Group Questions has sought to address this over the last 15 years, but change is slow. Just because you are told there are no children and adults with disabilities – or you do not see them yourself – does not mean they are not there.

'We don't "do" disability.'

Children and young people with disabilities are often regarded as a distinct target group for separate programming. So, some agencies specialise in disability and others do not, thinking their needs are already being dealt with. However, only a small number of children and young people with disabilities participate in programs of specialised agencies or targeted work. By not including children and young people with disabilities, mainstream programs fail to address the needs of a group who account for between 5 and 10% of any given population, depending on the age profile.

'We don't have the skills.'

Working with children and young people with disabilities is not significantly different from working with any other group. Many needs are the same. Sometimes the approach to meeting them is different. Children and young people with disabilities themselves are the best experts and can often suggest modifications to make things work for them. It's largely about changing attitudes. Sometimes low-tech simple solutions can have a major impact on accessibility for children and young people with disabilities. We can also partner with organisations who do have the skills to meet needs including organisations of persons with disabilities and other organisations providing assistance to children with disabilities.

'Let's create a special program.'

It's unrealistic to expect a single specialist intervention program to address all the needs and rights of all children and young people with disabilities, who are a diverse group. Many of these needs are shared by other children and young people and are not disability-specific. They are best addressed within the framework of the whole program.

Perhaps you have come across other reasons why inclusion of children and young people with disabilities isn't happening – what should a common-sense response to them be?

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Slide Presentation

Presentation Slides



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Presentation for International Obligations on Disability Inclusion and "Nothing About Us Without Us"

Global Conventions, frameworks and the disability movement

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Key international frameworks

- UN Convention on the Rights of Persons with Disabilities (CRPD)
 - Sustainable Development Goals (SDGs)
- UN Convention on the Rights of the Child (CRC)




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Key international framework

UN Convention on the Rights of Persons with Disabilities (CRPD)

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UN Convention of the Rights of Persons with Disabilities (CRPD)

'...the Convention is intended as a human rights instrument with an explicit, social development dimension; it is both a human rights treaty and a development tool.'

(UNESCO, 2008)

- adopted in 2006 and came into force in 2008.
- 50 articles.
- unprecedented levels of involvement from the civil society sector, especially people with disabilities.
- most detailed of all the UN human rights treaties.
- main purpose is to:
 - '...promote, protect and ensure the full and equal enjoyment of all human rights...by persons with disabilities...'* (Article 1)

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The CRPD and International Development

- A unique feature of the CRPD is the inclusion of an article on **international cooperation**. Member States now have an obligation to ensure that all development aid is:
 - '...inclusive of and accessible to, persons with disabilities'* (Article 32)
- For the first time, there is now a binding commitment to ensure equality and inclusion not only domestically but also through development aid.

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UN Convention of the Rights of Persons with Disabilities (CRPD)

For more information about the CRPD please visit:

<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

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Implementation of the CRPD

- Implementation of the CRPD is still a 'work in progress' especially for developing countries due to:
 - New concepts like disability rights and social / human rights model;
 - Lack of familiarity and engagement between disabled people and policy-makers;
 - Low political priority leading to shortfalls in financial and human resources;
 - Lack of robust statistical data and research on which to base policy decisions;
 - Weak OPDs who struggle to engage with the wider development and human rights discourse.

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Key international framework

The 2030 Agenda and the Sustainable Development Goals (SDGs)



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The Sustainable Development Goals and **disability inclusion**

The overarching principle of the 2030 Agenda is:

Leave No One Behind

This means to ensure its success the Agenda **must** include children and adults with disabilities.

Persons with disabilities are referenced directly 11 times in the 2030 Agenda. These are in paragraphs on human rights, vulnerable groups and education.

In the Sustainable Development Goals there are direct references in 5 of the 17 Goals.

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The Sustainable Development Goals and **disability inclusion**

Sustainable development goals (SDGs) explicitly reference persons with disabilities in targets and indicators

Highlighted Goals Reference Disability

Disaggregation of data by disability is encouraged across all SDGs (follow up and review)

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Where are Persons with Disabilities in the 2030 Agenda?

“People who are vulnerable must be empowered. Those whose needs are reflected in the Agenda include all children, youth, persons with disabilities (of whom more than 80 per cent live in poverty)”

(paragraph 23)

This paragraph calls for the empowerment of “vulnerable” people and places children and adults with disabilities at the centre of poverty eradication throughout the entire Agenda.

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Key international framework

UN Convention on the Rights of the Child (CRC)

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UN Convention on the Rights of the Child (CRC)

- The Convention on the Rights of the Child (CRC) comprises 54 articles. It came into force in 1990 – a legally binding international treaty addressing the specific situation of children. The CRC rapidly achieved near universal ratification on its adoption.
- The CRC is an important international Convention for World Vision due to its focus on children.
- All CRC provisions apply on an equal basis to children with disabilities.
- Two articles have explicit obligations on States re. children with disabilities: to introduce measures to promote inclusion and freedom from discrimination. These are articles 2 and 23.

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UN Convention on the Rights of the Child (CRC) - Article 2

Article 2 states that no child should encounter discrimination on the grounds of ‘race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status’.

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UN Convention on the Rights of the Child (CRC) – Article 23

Article 23 is specifically focused on children with disabilities. Four sub-clauses can be summarised by clause 1

- States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

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The International Disability Movement

A brief introduction

The International Disability Movement

- Arose in 1970s.
- Ideologically, its foundations can be found in the social model of disability
- Across the world from the mid-1970's onwards, people with disabilities were coming together for the first time to establish organisations that would represent their voice and interests. These are known as Organisations of Persons with Disabilities (OPDs).
- The international disability movement maintains that persons with disabilities (children and adults) have the inherent right to play a strategic and leading role in the development, management and evaluation of all policy and services that affect their lives - whether that's disability related or not. The phrase 'nothing about us, without us' captures this rallying cry.

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The International Disability Movement

Organisations of Persons with Disabilities (OPDs)

(Also known as Disabled Persons' Organisations (DPOs))

OPDs are run and managed by people with disability and are primarily concerned with promoting disability rights.

Key characteristics

- Membership organisations
- Led and managed by persons with disabilities / caregivers
- Majority of members are people with disabilities
- Represent the voice and interests of people with disabilities.

OPDs can be impairment specific, or cross-disability and can exist at different levels from grassroots to global.

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The International Disability Movement

OPDs engage in a wide range of activities but some key ones include:

- **Psycho-social support** - to members and their families;
- **Impairment based support** – ranging from sign language to mobility training;
- **Awareness raising and sensitisation** – with families, communities, leaders etc.;
- **Mobilisation** – with people with disability to enable them to understand their rights;
- **Organisational development** – training in basic leadership, planning etc.;
- Annual events across the country in support of issues like **United Nations International Day of Persons with Disabilities, 3 December.**

OPDs represent a considerable resource for development since they can mobilise persons with disabilities to take part in discussions and activities. They have been chronically underfunded and can be weak but are potentially powerful allies for everyone working on development and health issues.

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The International Disability Movement

Disability NGOs

Organisations for people with disabilities.

Disability NGOs (national and international) work to support children and adults with disabilities by providing services and supporting advocacy campaigns. Can be impairment focused, supporting people with autism for example, or thematic based such as those that support inclusive education.

Self-Help Groups

Groups of people with disabilities

Present at community level, these informal groups are usually too small to have registered as OPDs. Common in rural and semi-urban contexts they play a significant role in connecting people with disabilities and/or caregivers with each other.

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Nothing Without Us

'Nothing About Us Without Us' – the long-held motto of disability movements around the world.

It communicates the idea that no policy, program, project or decision about people with disability should be planned, implemented or monitored without the full and direct participation of members of the group(s), hence people with disability.

It means in practice that persons with disabilities and their families want to have their voices heard.

It focuses on the importance of the involvement of people with disability at all levels of decision-making.

Even more, there is a trend to move from "Nothing About Us Without Us" to "Nothing Without Us", meaning that all policies and programs should consult people with disabilities or their representative organizations, to make sure that no one's needs are left behind.

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