Session: Introduction to the main Models of Disability

Learning Objectives	Participants should be able to: ● Acknowledge the importance of identifying their current personal **assumptions** about disability ● Describe three key alternative models of what “disability” is (medical, charity, social/human rights) ● Understand how programming approaches that results from each model leads to significantly different inclusion experiences for persons with disabilities
Key Messages	● **Personal assumptions about disability are important to self-identify** when starting to consider disability inclusion in programming work – we all carry them. For most people when starting to actively consider disability-inclusive programming, they are unconsciously based on the two individual models of disability. Evidence shows acknowledging personal assumptions are an important starting point to effective disability inclusive programming. ● **There are three main models of disability** to be aware of in two categories – “individual” models (medical approach, charity approach) and social/human rights ● The definition of disability is **impairment + barriers = disability**. Contrasting the individual model definitions of “impairment = disability” ● **Inclusive programming is based on the social/human rights model**. Identifying and eliminating access, institutional and attitudinal barriers is the basis of taking a disability-inclusive programming approach.
Facilitator’s Notes	● **The messages in this activity are central to the whole course**. Of bigger importance, it is central to what will happen in programming work as a result of the course. It is very important that participants understand the differences between the individual (medical and charity) and social/human rights models of disability, as it affects how they will view disability inclusion in programming work. ● Being clear about the differences between the models is critical. Make sure you have a good understanding. In essence, there are just 2 models – individual models (medical and charity) and social/human rights.

	- Be prepared to ask clarifying questions and re-explain the different perspectives each model offers – they lead to very different programme approaches. In turn this leads to very different programming outcomes for persons with disabilities - Make sure you have examples to share as you explain each model – it helps understanding. For many, this could be the first time thinking about disability in anything other than an “individual” model way
Duration	45min
Activity	1. Individual activity: write down list of all words and ideas associated with terms “disability” and “persons with disabilities” (5 mins) 2. Assumptions – presentation from Powerpoint slides (5 mins) 3. Disability models – Explanation of the models: powerpoint presentation (15 mins) and taking questions comments in plenary (up to 10 mins) – Return to the individual activity lists – self-reflection (up to 5 mins) – Further questions and discussions on the sessions (5 mins)
Resources	Powerpoint presentation (facilitator); Paper/pen or technology (participants to write lists); Participant handout
Technology	PowerPoint presentation

Activity 1: Words and ideas associated with disability

Information:

This first exercise provides a baseline of information for each participant’s starting point on their disability awareness journey as they start the training. Everyone will be in a different place. If participants have not engaged with CRPD-based disability inclusion before they will probably understand disability according to the individual models.

Process:

1. Ask everyone to write down all the words and phrases and images they think of when they hear the terms ‘**disability**’ and ‘**people with disabilities**’. What images come to their minds? Give a few minutes for individuals to complete their personal lists.

2. Ask everyone to put their lists to one side.

Activity 2: Assumptions

Information:

The reason for starting with this activity is to bring into focus the central part **assumptions** play in disability inclusion programming work. Many of the things that stop persons 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. It is important, as programming staff, to start the process by becoming self-aware of our own existing assumptions about persons with disabilities.

Process:

Present Powerpoint slides that contain this information:

- We all make assumptions about people we do not know (and some about those we do) based on many factors we have 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. Markers such as age, gender, ethnicity and physical appearance can all have a subtle, unintended influence on the way we assess people when we first meet them, before we’ve even had time to talk.

- Assumptions can be very useful, enabling us to filter out information and focus on details that are important to us. However, sometimes assumptions create barriers, when they falsely prevent us from seeking to engage with people we might believe have little in common with us. You can probably appreciate that we will be making quick assumptions about people based on very general observations around gender, age, or ethnicity for example which are often exacerbated when we understand the person has a disability. These assumptions can impact peoples' opportunities for participation because we may simply disregard them, assuming they will have nothing to contribute. Our assumptions are generally a mixture of accuracy and stereotypes.

- People with disabilities commonly report their daily ‘lived’ experience is that many assumptions are made about them before they are ever spoken to or engaged with. Most of these assumptions are generally based on stereotypes, often driven by underlying prejudice and discrimination. Girls, youth 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 programmes.

- We all carry personal assumptions about 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 the journey as programming practitioners consider greater inclusion of persons with disabilities in our work.

Activity 3: Disability models

Information:

This activity is critical to the whole course. Ensuring you are comfortable with the concepts communicated in this activity is very important. Learners 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 persons with disabilities. Below are some background notes for you to be familiar with before you lead this session. As facilitator 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.

Defining disability is central to work on disability inclusion. How people conceptualise disability influences how they behave towards persons with disabilities; how they frame their problems and needs; and ultimately how programmes are developed in response. At this point as a facilitator, it is important you understand the difference between ‘impairment’ and ‘disability’ because these two concepts lie at the centre of the difference in how disability is approached. You will need to ensure participants are comfortable describing the difference by the end of this activity.

In reality most development programmes often ignore people with disabilities - or treat them as a special case. This activity deals with the different ways in which disability is conceptualised and understood (referred to here as ‘models’). There are three predominant models of disability representing different approaches. The three models are:

- **The medical model** (“individual” model)
- **The charity model** (“individual” model)
- **The social/human rights and empowerment model**

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

Process:

1. Present the 3 main models of disability and disability definitions using the Powerpoint presentation and handout information
2. Take clarification questions, and general comments and questions
3. Ask participants to re-read their lists from activity 1 and self-reflect on where they would place them – against which model?
4. Take questions and comments in plenary.

Supplementary materials for Activity 3

Adapted from: ***“Travelling Together – Commonly Asked Questions about the Models and Barriers”****; Coe, S. and Wapling, L, World Vision, 2022*

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 courses on this information 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 medical interventions for persons 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 part of social model programming approaches. But it does emphasise that medical interventions on their own will not lead to inclusion. The social model provides a perspective on how people with disabilities should access health support. Persons 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: **Don’t 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 made, it usually 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 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 persons 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 persons with disabilities.

Empowering individuals 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 persons 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. Persons 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 persons with disabilities have the opportunity to participate. But sometimes persons 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. Women with disabilities often are excluded from reproductive health service provision. Health interventions are part of people with disabilities might require (in the same way that everyone has rights to good health). But it is not the whole story. All persons with disabilities have the right to participate in society alongside those without disabilities. Other sectors have often ignored and excluded persons with disabilities because of a lack of understanding that disability is a human rights issue rather than a health issue. The social/human rights model explicitly recognises barriers in different sector program areas. It is important to identify and work to reduce/eliminate the range of access, attitudinal and institutional barriers in all program sectors.

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 persons with disabilities. That’s because they are focusing on the impairments rather than on the potential barriers that might prevent people with disabilities from access to relief services. In this scenario, relief agencies tend to rely on disability-specific organisations to work with persons with disabilities, but these organisations are often very small 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 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 persons with disabilities are included and that discussions around preparedness focus on what communities and supporting agencies will do to ensure all people with disabilities are protected during an emergency crisis.