

EXTRACTS FROM ‘PRACTICAL LESSONS FROM FOUR PROJECTS ON DISABILITY-INCLUSIVE DEVELOPMENT PROGRAMMING’

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This article looks at early lessons learnt from inclusion of disabled people, based on socially inclusive principles, in World Vision programming work in Angola, Armenia, Cambodia and Senegal. Externally-led reviews and evaluations conducted between July 2007 and April 2008 drew out 7 common key lessons. In summary: the substantial effect of stakeholders’ attitudinal issues on practical implementation; the importance of authentic consultation with a range of disabled people; appropriate budgeting considerations; and a need for caution regarding livelihoods work.

World Vision UK has had a DFID Programme Partnership Arrangement (PPA) since 2006 which includes an objective to mainstream disability in its work. This does not mean World Vision is increasing its disability specific projects, it means World Vision is actively trying to find ways to ensure all of its work brings benefits to disabled children and adults living in focus communities.

This practice note has been written to share World Vision’s experiences so far on introducing new approaches to including disabled children and adults, based on reviews and evaluations from early projects in four countries on three continents.

EXTERNALLY-LED REVIEWS ON DISABILITY INCLUSION WORK TO-DATE IN ARMENIA, ANGOLA, CAMBODIA AND SENEGAL - SEVEN KEY LESSONS EMERGED

In recent years, World Vision has started to examine what a socially inclusive view of disability means for its work. It is a mammoth change, and one which has no established precedent in programming work, either its own or those of other comparable international NGOs. One of the first tasks undertaken as part of World Vision/DFID’s PPA was to commission externally-led reviews and evaluations to honestly critique early initiatives in 4 countries:-

- **Armenia** – support inclusive education approaches in mainstream state primary schools and kindergartens, including advocacy work with the national education ministry.¹
- **Angola** – project to support and empower Disabled People’s Organisations (DPOs) to improve their integration into Angolan society using a rights-based framework.²
- **Cambodia** – work to include disabled people in three mainstream Area Development Programmes; plus review and alter practices/policies at the central offices of World Vision in Phnom Penh.³

- **Senegal** – project in the rural Kolda district to identify and address the barriers facing disabled people locally in order to increase access to mainstream services.⁴

The reviews and evaluations took place between November 2007 and April 2008. Even though these projects were different in nature and conducted in diverse geographical and cultural situations, **seven key lessons emerged** from them, briefly outlined below.

1. Challenging staff and community attitudes is THE key ‘first step’ to seeing positive change towards the inclusion of disabled people in development work – early effective training on social model principles is crucial

All four reviews resoundingly demonstrated the impact that staff and stakeholder attitudes had on project activities and progress towards effective inclusive practices. People’s perceptions of what disability represents (the model they use), cultural beliefs and practices (such as what causes impairments) and a deep-rooted fear of how to interact with disabled people all contribute to holding back progress on inclusion.

Project staff were largely unaware of the social model concepts – partly because effective training and clear direction were not provided early enough. This led to project staff continuing to view disabled people as a separate group in receipt of specialist support. Therefore there was little or no impact on how work was implemented and disabled people were still not routinely consulted as key stakeholders. A key recommendation from the Cambodia evaluation was that staff and communities in which they

worked needed to have a clearer understanding of the social model approach. In Armenia whilst there were improvements in general attitudes towards the inclusion of disabled children in mainstream classes it was still seen largely within the context of how medical interventions could be used to enable that to happen. In Angola, training on social model inclusion happened in the latter half of the project, so had limited impact as the foundations of work were well-established by then.

Cultural beliefs and practices often precluded people from understanding disability inclusion. For example, one review discovered a pregnant staff member refused to sit in the same room as a disabled colleague for fear the impairment would be passed on to her unborn child. Progress on inclusion cannot be made until underlying beliefs and prejudices are identified, openly acknowledged, explained and challenged.

It is still rare to find disabled people in full-time employment in developing countries so many staff had barely any professional contact with disabled people. Many non-disabled staff interviewed in all reviews spoke about the fear of doing or saying the wrong thing. In Armenia that fear led to reluctance by teachers and parents to move forward themselves on ideas for inclusive lessons before ‘professionals’ could be consulted. Overcoming that fear by focusing on ‘system level’ changes rather than on the child’s impairment has since produced very positive progress.

2. Old habits ‘die hard’ – there is a tendency to drift from socially inclusive principles back towards medical/charity model approaches when implementation starts unless vigilant

All projects had a tendency to 'drift' to medical/charity approaches, even if disability awareness training had happened. A number of key project staff continued fundamentally to view disability as a medical/charity issue and couldn't acknowledge work was drifting away from its socially-inclusive intentions. In one case this resulted in project money designated for empowering DPOs actually going to NGOs clearly still focusing on service delivery for disabled people.

A range of reasons were identified accounting for this tendency, with some variation between projects:

- Project staff didn't consciously adopt social model inclusive principles at the outset, therefore personal attitudes/practices more aligned with medical/charity model thinking prevailed;
- Staff were not equipped early enough through appropriate attitudinal training to adopt social model approaches;
- Much NGO work can naturally be medical/charity model in nature so socially inclusive approaches were new thinking to some staff.

3. Beware of the power of medical professionals!

Medical model thinking has long been predominant in work with disabled people. Medical intervention has an important place for disabled people – as it does for everyone – but often disabled people are subject to the views of medical professionals who hold great power and make assumptions about what is best for them. Disability inclusion work can easily become focused solely around outputs like rehabilitation even when there is explicit desire from disabled people not to do so.

For example, World Vision Armenia attempted to break with this assumption and integrate medical efforts within an inclusive education project to ensure children had access to medical interventions if they were deemed necessary. However in practice the medical professionals became the dominant force in a project which was originally designed as a tripartite relationship between specialists, teachers and parents.

'...there still appears to be a strong emphasis, however, on achieving improved social acceptance and integration through approaches that rehabilitate or "fix" the individual disabled child, rather than through approaches that comprehensively change the way society thinks and works so that it welcomes anyone who is "different". That is, attitude change appears to have been built around a medical rather than social model approach to disability.'
Armenia review

The teachers and parents deferred to the specialists which delayed progress as there were not enough specialists to cope with the demand. Rather than the teachers and parents working to find solutions to access issues they tended to wait for professional advice and assume that their adaptations would not be as good. In effect it disempowered parents and children.

4. Consultation with disabled people (rather than making assumptions) is critical; 'disabled people' are not a homogeneous group – consultation processes should reflect this

Many non-disabled people tend to think of disabled people in homogenous terms. Too often assumptions

are made in assessments and reviews about them, rather than undertaking authentic consultation processes involving disabled people.

Further, the label of 'disabled people' covers a broad range of impairment groups (physical, sensory, intellectual, psycho-social) and socio-economic status. As with any cross-section of society there are also gender, age, ethnic and a multitude of other power dynamics.

The projects reviewed tended to only receive inputs from a limited range and representation of disabled people – typically, urban-based men with physical impairments. For example, in Angola and Senegal too much emphasis was placed on a small selection of the most articulate and geographically close disabled people with the result that the impact of the projects was substantially minimised. In Senegal the review found an absence of any representation from people with psycho-social impairments and in Angola the lack of consultation with deaf people and those with learning impairments resulted in these groups being excluded from work.

Another general concern was the lack of participation by disabled women who are widely recognised as facing double discrimination of gender and disability. The Senegal review noted that:

'Disabled women suffer double marginalisation. They are rejected by men who refuse to get married with them and by their families-in-law who are against their marriage... As a result of these barriers, they remain single or widows, bringing up their children lonely and in extreme poverty.'

5. 'Practice what you preach' – disability inclusive environments are essential

Perhaps one of the most surprising results to emerge from the reviews was the lack of attention paid to ensuring that the project environments were as accessible as possible. We came across many instances where project delivery work was not accessible to many disabled adults or children. For example, the Armenia inclusive education project was being run from a national office that does not have a meeting room accessible to wheelchair users. In Senegal the reviewers held a stakeholder focus group discussion with disabled people where it quickly became apparent to them that no Sign Language interpretation was being provided for Deaf participants in the group, until the reviewers specifically requested it. In Angola no provisions were made for producing any of the project documentation and training materials in large font or Braille formats.

Projects which aim to empower disabled people and increase their inclusion in development work should pay particular attention to access issues. For example, if training is to be provided consideration needs to go into where this will take place (e.g. wheelchair access to venue and washrooms, local transport links), how the training will be delivered (e.g. disability awareness of trainers, alternative formats for printed materials, sign language interpretation, regular breaks/variation in activities in the schedule) and how the participants are selected and informed (e.g. over reliance on one or two DPO's can exclude many disabled people as noted above). Project briefings, meetings and monitoring visits should all be accessible – the best

way to ensure they are is to have a small focus group (or steering committee) made up of representatives from across the disability community (think not only about impairment but also gender, age, ethnicity etc.). Test out ideas on this group first before attempting to engage with the wider disability community.

6. Budget for inclusion – it need not cost much

One of the main findings from the evaluation of the Angola DPO empowerment project was that insufficient funds were allocated for access – for example to hire accessible venues, and paying for interpreters, advocates and personal assistants. This applied to the other projects too.

One of the most common reasons projects cite for not including disabled people is perceived heavy cost – this essentially stems from medical model thinking and is not true. For the majority of disabled people small adjustments to the way project activities are carried out is all that is needed to secure their involvement – for example informing participants in good time ahead of meetings, taking a bit of extra time at meetings to allow for more breaks, producing information in simplified language forms, checking for venue accessibility – these will not incur significant budget costs. However reprinting information in large font or Braille, hiring sign language interpreters or advocates (for those who are deaf-blind or have moderate/severe learning impairments), covering the costs of personal assistants and guides (for mobility and visually impaired people), helping parents cover the cost of childcare etc. will have budget implications and will need provision. The key issue is that these

should be included at **design** stage of the project, not once the project is underway when it is then regarded as 'additional' cost. Evaluations in Cambodia and Angola recommended in future funds should be specifically set aside for mainstreaming across the organisation so the necessary adjustments could be made.

7. Livelihoods work - include in mainstream programmes rather than establishing separate initiatives; analyse barriers and plan very carefully before starting

Three of the evaluations had livelihood components (in the case of Cambodia a 'sister' project specifically placing young disabled people into work placements). Without exception the projects significantly struggled with this component. It has proved a complex issue requiring more research, but indications from these evaluations generally showed progress would probably be best achieved through mainstream livelihoods programmes specifically examining the barriers to disabled people in being included in them. The main points emerging from the evaluations to highlight here are that this area if not handled well may lead to the increased exclusion of disabled people; and that doubling up DPOs as income-generating entities confuses the purpose of the DPO, and can cause serious long-term problems in the internal accountabilities of the DPO. As the Angola evaluation pointed out:

'The income generating components of this project led to confusion over the project intent and did nothing to ease the tensions, conflict and rivalry caused by competing over resources... It changes the nature of the organisation from being a focal point for lobbying to one providing services.'

CONCLUSION

Disabled people are often the most excluded and subject to the deepest poverty of any community group. By recognising the explicit need to include disabled people benefits will also be gained by a range of other 'hard to reach' socially excluded groups – for example children, older people, pregnant woman, ethnic minorities. By uncovering the mechanisms which exclude disabled people and applying these lessons above, mechanisms which are excluding many others in communities should also be found.

NOTES

1. Lewis, Ingrid (2007) *Review of World Vision Armenia's Inclusive Education Programme*
2. Wapling, Lorraine; Paxe, Nsimba; Parkinson, John (2008) *Empowerment of Disabled People's Organisations – World Vision Angola – Final Evaluation Report*
3. Vanthon, Srey; Viriya, Yit; Socheat, Cheng; Kim Lay, Ong; Sopho, Prak; Moth, Trok; Phally, Ith; Sarin, Sok (2007) *Report on the Evaluation of World Vision Cambodia's Disability Mainstreaming Project*
4. Sanon, Emilienne; Cumberland, Judi; Weston, Peter; Coe, Sue (2008) *Rapport de la Revue a Mi Parcours du Project de Promotion de L'Egalite de Chances pour les Personnes en Situation de Handicap dans la Region de Kolda au Senegal*

This paper is from an article published in **Development In Practice: Volume 20, Number 7, September 2010, pp 879-886**. Development in Practice is available online at:
<http://www.informaworld.com/DIP>