THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

Training Guide

No. 19

Professional Training Series

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FOREWORD

The Convention on the Rights of Persons with Disabilities and its Optional Protocol were adopted on 13 December 2006 and entered into force on 3 May 2008. They came into existence through a forceful call from persons with disabilities around the world to have their human rights respected, protected and fulfilled on an equal basis with others.

The Convention celebrates human diversity and human dignity. Its main message is that persons with disabilities are entitled to the full spectrum of human rights and fundamental freedoms without discrimination. This is reflected in the Convention's preamble and throughout its articles. In prohibiting discrimination on the basis of disability and establishing that reasonable accommodation shall be provided to persons with disabilities with a view to ensuring equality, the Convention promotes the full participation of persons with disabilities in all spheres of life. In establishing the obligation to promote positive perceptions and greater social awareness towards persons with disabilities, it challenges customs and behaviour based on stereotypes, prejudices, harmful practices and stigma relating to persons with disabilities. In establishing a mechanism for complaints, the Convention's Optional Protocol ensures that persons with disabilities have an equal right to redress for violations of the rights enshrined in the Convention.

Importantly, the Convention and its Optional Protocol challenge previous perceptions of disability—as a medical problem or a generator of pity or charitable approaches—and establish an empowering human rights-based approach to disability.

Through this historic paradigm shift, the Convention forges new ground and requires new thinking. Its implementation demands innovative solutions. To get it right from the start, the Convention's aims, concepts and provisions must be well understood by all stakeholders: from government officials to parliamentarians and judges; from representatives of United Nations specialized agencies, funds and programmes to professionals in areas such as education, health and support services; from civil society organizations to staff of national human rights institutions; from employers to those representing the media; and from persons with disabilities and their representative organizations to the general public.

While the ratification of the Convention and its Optional Protocol has proceeded rapidly, knowledge on how to implement and monitor them has not kept pace. Conscious of this challenge, my Office has developed this *Training Guide* on the Convention and its Optional Protocol. It is complemented by eight training modules, designed to inform and empower those who are involved in ratifying, implementing and monitoring the two

instruments. While the *Training Guide* is mainly targeted at facilitators of training courses on the Convention and its Optional Protocol, it acknowledges that each and every one of us has a role to play. I recommend wide dissemination of the training package, and its use by all those who want to embark upon the essential journey towards greater awareness and effective implementation of the rights of persons with disabilities and, ultimately, the building of an inclusive society for all.

Navanethem Pillay
United Nations High Commissioner for Human Rights

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ABOUT THE TRAINING GUIDE

Background

The United Nations General Assembly adopted the Convention on the Rights of Persons with Disabilities and its Optional Protocol in 2006 as a means of improving respect for the rights of persons with disabilities, who, according to the latest figures, comprise some 15 per cent of the world's population. Since 2006, ratification of the Convention and Optional Protocol has proceeded at a rapid pace. However, knowledge about the Convention and how to implement and monitor it has not necessarily kept up. This in turn has led to an increase in requests for training courses to build capacities of national stakeholders—representatives of Government, civil society, national human rights institutions (NHRIs) and others.

The Office of the United Nations High Commissioner for Human Rights (OHCHR) has developed this *Training Guide* in response. It seeks to provide basic information on a rights-based approach to disability, on the fundamental elements of the Convention and its Optional Protocol, and on the processes and issues underlying their ratification, implementation and monitoring. Consequently, the materials are particularly appropriate for introductory courses on the Convention.

The materials were first prepared in 2010 and revised over 2011. In August 2011, OHCHR held a validation course comprising participants from United Nations human rights presences, the United Nations Department of Economic and Social Affairs and representatives of the International Disability Alliance. On this basis, the *Guide* was finalized and published.

Overview of the Training Guide

What is this Training Guide?

The *Training Guide* is for facilitators of training courses on the Convention on the Rights of Persons with Disabilities and its Optional Protocol. It can be used to develop a training course on the Convention and/or the Optional Protocol, but is also helpful as a general information resource on these instruments. The *Training Guide* promotes interactive training sessions, intended ideally for relatively small groups of maximum 20 participants, and comprises a mix of computer slide presentations and group activities intended to encourage dialogue and exchange between facilitators and participants and among the participants themselves.

Whom is the Training Guide for?

The *Training Guide* is primarily for training facilitators and others who already have knowledge of the international human rights system and are called upon to provide training on the Convention on the Rights of Persons with Disabilities. In other words, the *Guide* assumes some knowledge of human rights standards, terminology and mechanisms but

not necessarily knowledge of the Convention itself. The *Training Guide* assumes that any training course will be undertaken by a lead facilitator, who would ideally be assisted.

Who is the target audience of the training modules?

The target audience of the training modules is broad. It could be any individual or representative of an organization or institution that is involved in promoting, implementing and monitoring the Convention. The principal beneficiaries of the training courses are therefore:

- Government representatives, particularly focal points and coordination mechanisms related to the Convention

- Parliamentarians

- Judges

- Representatives of United Nations specialized agencies, funds and programmes

- Representatives of national human rights institutions

- Persons with disabilities and their representative organizations

- Civil society organizations

- Media representatives

- Professionals in related areas such as health, education, support services and so on.

How to use the Training Guide [1]

The sessions are based on the training methodology adopted by the OHCHR Methodology, Education and Training Section.

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[1] The notes for the facilitator, the computer slide presentations and the group activity notes are available from www.ohchr.org.

Each module comprises three principal documents:

- *The note for the facilitator* explains the sequence of the training session, the documents required, background reading as well as tips for the presentation of the computer slides;

- *The computer slide presentation* provides a series of slides to help the facilitator present the various concepts in the module;

- *The group activity note* provides explanations of the group activity as well as the particular requirements for the activity, such as venue and materials.

The sessions generally follow a sequence of computer slide presentation incorporating questions and answers, followed by a group activity.

The methodology underlying the *Training Guide* is interactive and promotes a participatory approach. It is important to respect this approach throughout. Facilitators should use the computer slide presentation to encourage a discussion and exchange of information and experience with and among participants. The facilitator should avoid a one-way monologue presentation style where the facilitator imparts information and the participants take note.

The *Training Guide* seeks to fill in any knowledge gaps facilitators might face and in this sense is a support for facilitators before the session. However, facilitators should avoid using the *Training Guide* as a prop during the sessions to ensure that the presentation does not turn into a lecture rather than a discussion with the participants.

Facilitators should adapt the materials in the *Training Guide* to suit each specific audience. Not every training course needs to cover all eight modules, nor do the modules need to be presented in a particular order or all aspects of each module covered. The important issue to bear in mind is that the facilitator provides a training course that meets the needs of the participants.

Similarly, the facilitator should prepare the course in advance with examples and materials which are relevant to the country and region where the course takes place. The facilitator therefore needs to learn about the region, identify the main advances and challenges facing the Convention's ratification, implementation and monitoring, and find locally relevant cases and situations. Sometimes materials and group activities may have to be changed completely to suit the context.

Planning your course

Carry out a training needs assessment to find out what participants need from the course[2]

A training needs assessment enables the facilitator to fully understand the needs of potential learners and the context in which they work, in order to make informed decisions related to the design of the training course. A training needs assessment will also help inform decisions about the most appropriate content, methods, techniques and time frame of the planned training course.

It should enable the facilitator to gather the necessary information to build an adequate picture of the context of disability rights; develop a profile of potential learners; and identify capacity gaps or needs of learners in relation to promoting a rights-based approach to disability.

A pre-course questionnaire should ideally be sent to the participants one month before the course. This information can help design and fine tune the course plan/agenda. The pre-course questionnaire serves multiple purposes. It:

- Informs course design and informs facilitators of their audience

- Encourages participants to engage with the course before their arrival and to do some preparatory homework

- Provides a baseline of participants' capacities, which will enable their increase in knowledge, experience and confidence to be tracked

- Contributes to the sharing of experience throughout the training course.

The pre-course questionnaire should include questions such as:

- What do participants know about disability rights and the move to a rights-based approach to disability?

- What do participants know about the Convention on the Rights of Persons with Disabilities and its Optional Protocol?

- Find out how much experience the participants have, how confident they are and how comfortable they are with the subject matter.

- How do they expect to increase their knowledge and understanding of disability rights?

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[2] For more information on training needs assessment, see Equitas – International Centre for Human Rights Education and OHCHR, *Evaluating Human Rights Training Activities: A Handbook for Human Rights Educators*, Professional Training Series No. 18 (HR/P/PT/18).

- What practical skills do they want to develop?

- What have they already done, what do they want to focus on now when it comes to disability rights?

- What outputs—plans and analysis—do participants need from the course? What level of detail is required and what is achievable?

- Who will be responsible for taking the outputs forward and what is their capacity?

Select the right sessions

A training course will always comprise an opening and closing session, but the rest of the agenda should reflect the participants' specific needs.

Which modules to focus on will depend on the participants' level of understanding of disability rights and the extent to which they have already developed their strategies to ratify, implement and/or monitor the Convention. There will generally not be sufficient time to cover all eight modules so some will have to be left out. At the same time, particular aspects of some modules might be left out (if participants are already aware of the information), while in other situations, additional slides and materials might be necessary or activities adapted. The facilitator should read through all the materials first to decide what to use and what to amend or tailor, depending on the participants' needs.

Draw up a course agenda

Once the facilitator has selected the modules relevant to the participants' needs, he or she should develop the agenda. The notes for the facilitators in the *Guide* can help. They provide indicative times for the computer slide presentations and for the group activities, which the facilitator should adapt in the light of the participants' capacities as gleaned from their responses to the questionnaire. If the facilitator is working with interpreters, around 30 per cent of extra time will be necessary and should be reflected in the agenda.

Select the training team

The selection of trainers and resource persons should be based on the following criteria:

- Expertise in the subject matter and experience with the target audience

- Ability to apply the interactive training methodology of the training package

- Professional credibility and appropriate reputation among other practitioners.

In choosing the training team, consideration should be given to gender balance and to the participation of persons with different types of disability. In addition, when training a particular target audience, it is very helpful to include in the training team one of its members who is in a position to establish a good rapport with the learners. Finally, the training team should be complemented by experts in human rights and/or disability rights.

Gather additional information

The facilitator should ensure he or she has:

- Sufficient background information about specific targets, policy processes and power structures (which might include the use of local resource persons)

- Information on the status of ratification, implementation and monitoring of the Convention in the country and region

- Information on challenges and opportunities facing the rights of persons with disabilities in the country and region

- Information on domestic case law, legislation and media stories where relevant

- Information on the institutional context in which the participants work.

Specific language preparation

If the course is taking place with interpretation, the facilitator should be sure to consult people who know the local terminology related to disability and how to translate some key terms from English into local languages, as there is always a direct translation.

Context-specific preparation

This *Guide* should be adapted to different socio-political contexts, including the most pressing developmental and human rights challenges. Where possible, local resource persons who are well prepared and briefed should be integrated in the course planning process and the agenda.

Accessibility

Think about accessibility issues prior to the course. Is the venue accessible? Is the lunch area accessible? Are there accessible toilets? Are course materials accessible? And so on. When thinking about accessibility, remember to think of different disabilities so that, for example, the course is accessible not only to persons with physical disabilities, but also those with visual or hearing impairments.

Evaluation[3]

Evaluation provides the training team with information about the impact of the training in relation to the goals that the team set out to achieve. Evaluation should be incorporated throughout the training course, including during planning, design, delivery and follow-up. Evaluation can help facilitators answer some important questions about the results of their training activities, for example: Why are we offering this training? Does the content of the training respond to the needs of the learners? What did the learners learn? What actions will the learners take as a result? Will the learners apply what they have learned in their work? How will their work contribute to change in the broader community/society?

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[3] For detailed practical guidance on evaluating human rights training activities, see *Evaluating Human Rights Training Activities: A Handbook for Human Rights Educators*.

MODULE 1 – WHAT IS DISABILITY?

Introduction

Module 1 explains the concept of disability, a fundamental step in understanding why the Convention on the Rights of Persons with Disabilities was necessary. The module identifies the modern concept of "how disability works" and then places this in the historical context of various approaches to disability based on charity or on the medical diagnosis of impairments. The module examines some of the latter's consequences and then introduces the human rights approach, which paves the way for module 2. There is some duplication of slides in modules 1 and 2, because module 1 could potentially be presented independently of module 2 or similar concepts could be raised in both modules to reinforce them, depending on the training course and the participants. The facilitator can always pick the slides that fit the presentation.

A. How disability works

Many people see disability as a condition that is inherent in the person—for example, a medical condition that requires the person to be in a wheelchair or to take medication. However, as becomes clear in this module, the modern concept of disability perceives disability as an interaction between an individual's personal condition (such as being in a wheelchair or having a visual impairment) and environmental factors (such as negative attitudes or inaccessible buildings) which together lead to disability and affect an individual's participation in society. For example:

- Being in a wheelchair (personal factor) combined with living in a city with accessible buildings (environmental factor) leads to participation in the community on the same terms as someone who is not in a wheelchair: there is little or no disability.

- Having an intellectual impairment (personal factor) combined with a belief in the community that persons with intellectual disabilities lack the capacity to vote (negative environmental factor) leads to exclusion from society and denial of the right to vote: there is a disability.

Personal factors are multilayered and can be both physical and socioeconomic. For example:

- *Physical factors:* gender, ethnicity, impairment (physical, visual, hearing, intellectual, mental), size and weight, and so on;

- *Socioeconomic factors:* wealth, class, inclusion in society, education level and so on.

Personal factors can interact to exacerbate disability or alleviate it. For example, someone with a physical disability who is wealthy might be able to access tertiary education and so find a job. This might increase participation in society and alleviate disability to an extent.

Environmental factors can relate to at least four sub-factors as follows:

- *Accessibility*: hilly or flat cities, accessibility of buildings (ramps, toilets, braille signs etc.), accessible information (websites, documents in easy-to-read formats), accessible public transport, etc.

- *Legal/policy*: existence of protection from discrimination compared with denial of rights on the basis of disability, pro-poor policies, policies that refer explicitly to disability rights compared to policies that ignore persons with disabilities, etc.

- *Socioeconomic*: rural/urban (present different accessibility issues), rich/poor, positive community awareness of disability, openness of society to change, etc.

- *Services*: inclusive services or segregated services (health, education, youth centres), community-based rehabilitation (CBR) services, social support services, affordability of services, etc.

Environmental factors can also combine to exacerbate or alleviate disability. With the increasing awareness of disability, there is often a mix of both positive and negative environmental factors. For example, a school might be made accessible by including ramp access. However, public transport is still not accessible, which means that a child with a physical impairment cannot make it to school, in spite of the openness of the school environment.

All these factors combine to determine the extent to which an individual can participate in society and, as a result, the extent to which disability exists.

B. Different approaches to disability

Different approaches to disability exist in the world, some being more dominant in some parts of the world than in others.

The charity approach

The charity approach treats persons with disabilities as passive objects of kind acts or of welfare payments rather than as empowered individuals with rights to participate in political and cultural life and in their development. What characterizes this approach is that persons with disabilities are not considered able to provide for themselves because of their impairment. Consequently, society provides for them. No environmental conditions are considered under this approach; disability is an individual problem. From this perspective, persons with disabilities are the target of pity and they depend on the goodwill of society. In addition, persons with disabilities depend on duty bearers: charity houses, homes, foundations, churches, to which society delegates policies on disability and responsibility towards persons with disabilities. Under this model, persons with disabilities are disempowered, not in control of their lives and have little or no participation. They are considered a burden on society. Because charity comes from goodwill, the quality of "care" is not necessarily consistent or even important.

- If society's responses to disability are limited to care and assistance for persons with disabilities through charity and welfare programmes, opportunities for advancement are very limited. The risk—as with the medical approach—is that persons with disabilities will remain at the margins of society. This approach does not support their participation.

- If persons with disabilities continue to be considered as "unfortunate", requiring compassion, depending on contributions and assistance and on the goodwill of others, their opportunities for empowerment become very limited.

The *charity* approach increases the distance between persons with disabilities and society rather than promoting equality and inclusion.

The medical approach

In the medical model, the focus is very much on the person's impairment, which is represented as the source of inequality. The needs and rights of the person are absorbed or identified with the medical treatment provided to (or imposed on) the patient. In the medical model, individuals can be "fixed" through medicine or rehabilitation to get back to society. Particularly for persons with mental impairments, the medical treatment can be an opportunity for a "bad" patient (persons with mental disabilities are often considered dangerous) to become a "good" patient. To be considered able to provide for themselves, persons with disabilities have to be "cured" of the impairment or at least the impairment has to be reduced as much as possible. No environmental conditions are considered under this approach and disability is an individual problem. Persons with disabilities are sick and have to be fixed to reach normality.

If disability is handled primarily as a medical problem, experts such as doctors, psychiatrists and nurses have extensive power over persons with impairments; the institution's staff take decisions for the patients, whose aspirations will be dealt with within a medical framework. If complete rehabilitation is not possible, persons with disabilities will not be able to go back to society and will remain in institutions. Achievements and failures experienced within the walls of the institution will be understood as related to the impairment and, as a result, justified. In the worst cases, such an approach can legitimate exploitation, violence and abuse.

This model is often mixed with the charity approach. For example, charities raise funds for and run rehabilitation facilities. The duty bearers in this model are the medical industry and the State. When combined with a charity approach, charity houses, homes, foundations and religious institutions also play an important role. Under this model, persons with disabilities are disempowered, not in control of their lives and have little or no participation. The medical industry, professionals and charities usually represent the interests of persons with disabilities as they are seen as possessing the knowledge of what is in the best interests of their patients.

The social approach

The social approach introduces a very different thinking: disability is recognized as the consequence of the interaction of the individual with an environment that does not accommodate that individual's differences. This lack of accommodation impedes the individual's participation in society. Inequality is not due to the impairment, but to the inability of society to eliminate barriers challenging persons with disabilities. This model puts *the person* at the centre, not his/her impairment, recognizing the values and rights of persons with disabilities as part of society.

Moving from the medical to the social model does not in any way deny the importance of care, advice and assistance, sometimes prolonged, provided by medical experts

and medical institutions. In many cases persons with disabilities require medical treatment and care, exams, constant monitoring and medicines. In the social model, they continue going to hospitals and centres providing specific treatment if required. What is different is the overall approach to treatment: it responds to the expectations of the patient, not those of the institution. The social model attributes to nurses, doctors, psychiatrics and administrators new roles and identities. Their relation with persons with disabilities will be based on a dialogue. The doctor will not be on a pedestal, but on the side of the person with disabilities. Equality starts in the hospital, not outside. Freedom, dignity, trust, evaluation and self-evaluation are all features of the social model.

With the social model, disability is not a "mistake" of society but an element of its diversity. Disability is a social construct—the result of the interaction in society between personal factors and environmental factors. Disability is not an individual problem but the outcome of a wrong organization of society. As a consequence, society should restructure policies, practices, attitudes, environmental accessibility, legal provisions and political organizations and therefore dismantle the social and economic barriers that prevent full participation of persons with disabilities. It opposes the charity and medical approach by establishing that all policies and laws should be designed with the involvement of persons with disabilities. The duty bearers under this model are the State—involving all ministries and branches of Government—as well as society. Under this model, persons with disabilities are empowered, in control of their lives and enjoy full participation on an equal basis with others. The burden of disability is not on them but on society.

The human rights approach

The human rights approach to disability builds on the social approach by acknowledging persons with disabilities as subjects of rights and the State and others as having responsibilities to respect these persons. It treats the barriers in society as discriminatory and provides avenues for persons with disabilities to complain when they are faced with such barriers. Consider the right to vote. A person who is blind has the right to vote just as anyone else in society. Yet, if voting material is not in accessible formats such as Braille and the person cannot take a trusted individual into the voting booth to help indicate her preferred candidate, the person who is blind cannot vote. A human rights approach to disability recognizes the lack of voting material and the inability to have assistance in voting as discriminatory, and places a responsibility on the State to ensure that such discriminatory barriers are removed. If not, the person should be able to make an official complaint.

A rights-based approach to disability is not driven by compassion, but by dignity and freedom. It seeks ways to respect, support and celebrate human diversity by creating the conditions that allow meaningful participation by a wide range of persons, including persons with disabilities. Instead of focusing on persons with disabilities as passive objects of charitable acts, it seeks to assist people to help themselves so that they can participate in society, in education, at the workplace, in political and cultural life, and defend their rights through accessing justice.

The human rights approach is an agreement and a commitment by persons

with disabilities, States and the international human rights system to put into practice some primary aspects of the social approach. This approach is binding on all States that have ratified the Convention on the Rights of Persons with Disabilities. States must eliminate and prevent discriminatory actions. The human rights approach establishes that all policies and laws should be designed with the involvement of persons with disability, mainstreaming disability in all aspects of political action. Following this model, no "special" policies should be designed for persons with disabilities, notwithstanding the particularities needed to comply with the principle of full participation.

The main duty bearer under this model, in which society delegates the policies on disability, is the State—involving all of its ministries and branches. There are certain provisions that involve the private sector and there is a specific role for civil society, in particular persons with disability and the organizations that represent them. Under this model, persons with disabilities have rights and instruments that can empower them to claim their rights. They have the tools to be in control of their lives and fully participate on equal terms with others. The human rights approach provides that persons with disabilities are closely involved in policymaking by law.

Which approach is dominant today?

The charity approach is the oldest of the four, followed by the medical approach. The social and human rights approaches are more recent. Yet, all continue till today. In spite of the adoption of the Convention, the charity and medical models are still very prevalent—even among the human rights community.

C. The consequences of the charity and medical approaches to disability

By approaching persons with disabilities as "objects of pity" or "problems to be fixed", the burden of disability falls on the individual and, as a result, social transformation is virtually impossible. Moreover, it can give rise to certain social norms which can make it even more difficult for persons with disabilities to participate in society and enjoy their rights.

Perception that persons with disabilities are "special"

The main difference between the medical/charity approach on the one hand and the social/human rights approach to disability on the other is reflected in the difference between "special" and "inclusive" treatment. The term "special" often arises in connection with persons with disabilities: children with special needs, special schools, special services, special institutions. Yet, "specialty" is exactly what the Convention distances itself from. Being special in the context of disability is not necessarily rewarding; it may lead to marginalization.

Take special schools for example: special schools enable persons with disabilities to interact only with other persons with disabilities or with certain "professionals". This forces them to live a situation which is not realistic since it does not reflect the diversity of society. Whom does this benefit then? Persons with disabilities? Persons without disabilities? It is difficult to see the benefits of actions/decisions aimed at keeping human beings separate. Human beings are social beings, and children have the right to study and play together. Diversity and inclusion must be the norm.