Relevance of disability models from the perspective of a developing country: An analysis

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Abstract

This article is based on an ongoing research work in Ghana, a developing country. It examines various models of disability based on the works of scholars such as Branson, J and Miller, D (1989); Higgins, P (1992); and Barton, L (1996); and explains the diverse perspectives from which the phenomenon is perceived, embraced, analysed and understood. The paper takes a general view of disability from different viewpoints or perspectives known as models of disability. It, however, focuses on the issue of disability from the general direction of developing countries with special emphasis on Ghana. It brings out various dimensions of the disability challenge in society, discussing possible ways of overcoming these challenges.

Introduction

People with disabilities remain largely invisible in their communities and largely overlooked in efforts by the global development community to improve the human welfare and living standards of millions of the world's poor people. It is important that policy makers and development practitioners alike acknowledge that with roughly ten percent of the world's population living with some form of disability (WHO, 1996), disability components must be built into all development projects.

As a country, Ghana recognises the need to deal with and address issues relating to disability in the country. According to WHO, there are more than 600 million disabled persons in the world, of which approximately eighty percent live in low-income countries. In most developing countries, including Ghana, disabled persons constitute an impoverished marginalised group, charaterised by lack of access to public health, education, and other social services that would ideally support and protect people with disabilities. Economically as well as in social terms, disabled persons in developing countries are classified among the poorest of the poor. As is the case in many developing countries, people with disabilities in Ghana are often regarded as unproductive and incapable of contributing in a positive way to society, and rather seen as constituting an economic burden on the family and the society at large, which leaves them in a vicious cycle of poverty.

Approach

The theoretical framework of the ongoing study is *marginalisation, suppression* and *repression* concepts as well as *"Ladder of Participation"* in *"Children's Participation: from Tokenism to Citizenship"* by Roger Hart, UNICEF, 1992. Hart used "Ladder of Participation" to achieve two things: first, he sought to illustrate the concept of inclusiveness in relation to vulnerable individuals. By this, he looked at the issue of inclusiveness in its entirety, pointing out that it is not everyone or group that may be included in certain processes particularly when the individuals or groups are vulnerable. Second, he used the concept to demonstrate a process that any vulnerable adult might experience. Here also, he showed how vulnerable groups or individuals might be involved in various degrees of inclusiveness, an indication that some people may be more involved or included than others which goes to show that the perceived inclusiveness of others may be merely cosmetic or not real.

Literature Review

An extensive review and discussion of related studies on disability was done. Among others, the study examined various works on attitudes towards disability in countries such as Ireland, Australia, England, Scotland, Canada, United States and other parts of the world. Issues reviewed include stereotyping and lack of visibility of disabled people in society, health indicators for people with intellectual disability, employment rate of disabled people and their education, the social construction of disability, that is, how society perceives disability as well as interventions to improve attitudes to disability, among others.

Reviewed works show that attitudes towards disability differ from one "group" to the other. For example, the attitudes of disabled people toward people with disabilities tend to be more favourable compared to the attitude of non-disabled people towards people with disabilities. All in all, society needs to create better opportunities to make the inclusion of the disabled in social development meaningful.

Models of disability

In fact, in this article the issue of disability has been examined from different perspectives referred to as Models of Disability. There are various kinds of models of disability. These are belief systems that portray disability in a certain way and show how it can be dealt with in society. In other words, models of disability are tools for defining impairment and, ultimately, for providing a basis upon which society can devise strategies for meeting the needs of disabled people (ie the disabled), providing an insight into the attitudes, conceptions and prejudices of the former and how they impact on the latter. They help to reveal the ways in which society provides or limits access to work, goods and services, economic influence as well as political power for people with disabilities. The perspective from which one sees a problem determines what one does to resolve it. The perspective from which the problem is seen, or an approach to the problem, is what may be called a model.

The models of disability are numerous. They are:
- Medical model
- Charity/tragedy model
- Social model
- Expert/professional model
- Right-based model
- Religious/moral model
- Economic model
- Customer/empowering model
- Rehabilitation model

These models are influenced by two fundamental philosophies. The first sees disabled people as dependent upon society. This can result in paternalism, segregation and discrimination. The second perceives disabled people as customers of what society has to offer. This leads to choice, employment, quality of human rights and integration. As these different kinds of models are examined the degree to which each philosophy has been applied will be seen. Again, these models of disability should not be seen as service of exclusion options with one being superior to or replacing previous sets. The development, relevance popularity or otherwise of the models provide society with a continuous process of changing social attitudes to disability and also indicate the nature and positions of these attitudes at any point.

Nature and relevance of the models

Medical Model

The medical model holds that disability results from an individual person's physical or mental limitations and is largely unconnected to the social or geographical environments. It is sometimes referred to as the biological-inferiority or functional limitation model. It is illustrated by the world Health Organization's (WHO's) definitions which significantly were devised by doctors:
- Impairment: any loss of abnormality of psychological or anatomical structure of function.
- Disability: any restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being.
- Handicap: any disadvantage for a given the fulfillment of a role that is normal for that individual"

The model places the source of the problem with the individual who is disabled and concludes that solutions can be found by focusing on the individual. According to the model, the main need of persons with disability is medical services in form of hospitals, specialist doctors, nurses, therapists etc. Here, medical staff focuses on the thing thin that people with disability cannot be exemplified by one's inability to talk, see, walk or work for oneself. If cure is not possible, then the individual concerned will need to be cared for. The core is provided by a range of specialist professionals, counselors, social workers, psychologists and therapists who will work to reduce the "problem".
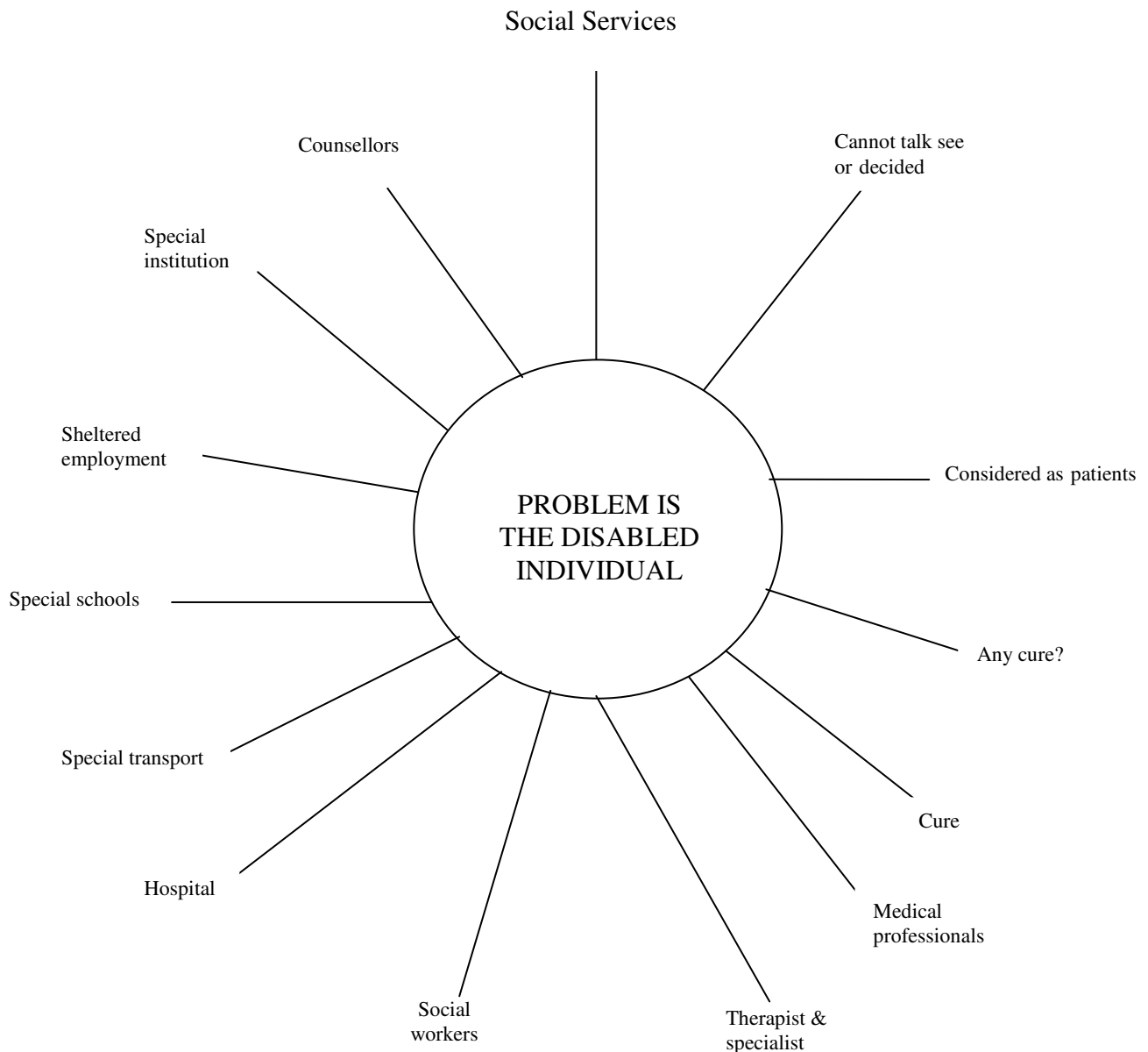
Social Services

Counsellors

Cannot talk see
or decided

Special
institution

Sheltered
employment

Considered as patients

PROBLEM IS
THE DISABLED
INDIVIDUAL

Special schools

Any cure?

Special transport

Cure

Hospital

Medical
professionals

Social
workers

Therapist &
specialist

Figure 1: The medical model of disability

There is no doubt that the medical model, as illustrated above, has dominated the formulation of disability policy for many years. Indeed, its therapeutic aspects which may cure or alleviate the physical and mental condition of many disabled people cannot be rejected outright. Seen in this light, the Medical Model is useful to some extent. However, it does not offer realistic perspective from the viewpoint of disabled people themselves. Many disabled persons share the view that the Medical Model restricts the role that can be played by the disabled is society. In the first place, the concept of 'abnormal" used to describe the disabled is considered unacceptable by critics. Secondly, the model imposes a paternalistic approach to problem which, although well-intentioned, concentrates on "care' and ultimately provides justification for institutionalization and segregation. This restricts the opportunities of disabled people to make choices, develop their potential and gain control over their own lives. Thirdly, the model fosters prejudice or bias in the minds of employers who may consider disabled people to be less productive because of their "medical" conditions. Such prejudice prevents the disabled to play a role in society.

Tragedy/Charity Model

The tragedy/charity model depicts disabled people as victims of circumstances who deserve to be pitied. Probably, the tragedy/charity model and medical model are the most commonly used models by non-disabled people to define and explain disability. The tragedy/charity model agrees with the medical model that disability is a problem that is inherited in the person who has fallen victim to it. The disabled person must, therefore, be cared for because such a person may not be able to walk without crutches, hear without a hearing aid and may not be able to think or decide for themselves. For all these reasons and many more, someone will have to come in to do things for them. The tragedy/charity model sees the individual disabled person in three ways and these are: (a) As sad, tragic and passive; (b) As bitter, twisted and aggressive; or (c) As brave, courageous and inspirational. This model has been depicted below:
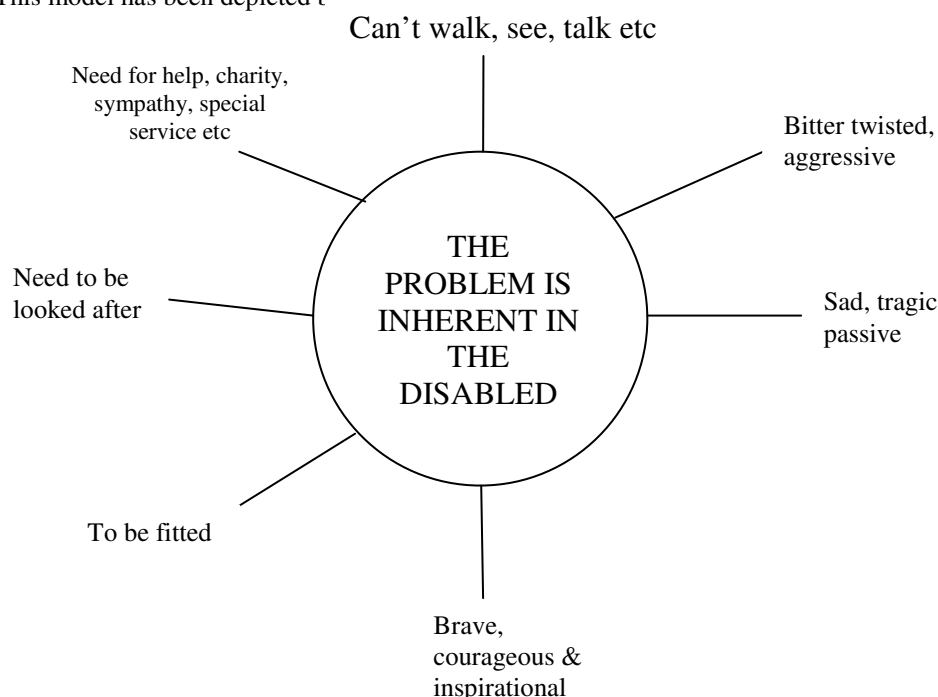

Figure 2: The tragedy/charity model of disability

Traditionally, this model has been applied in the business of fundraising for disabled persons. Although praiseworthy in many respects, critics are of the view that it poses certain dangers. From tragedy and pity stems a culture "care". When concern and care are welcome for the disabled, critics think that the model is dis-enabling and causes much discrimination. Numerous charities exist to support and care for people with a particular type of disability, thereby, medically classifying, segregation and often – as with the medical model – institutionalising many disabled people. In Britain and other parts of Europe, several thousands of adults are affected by institutionalisation. Given the choice, many, if not all of them, would opt for community life with adequate support. In fact, the idea of being recipients of charity lowers the self-esteem of people with disabilities. From donors who think they are having pity on the disabled, charitable carries with it an expectation of gratitude and a set of terms imposed on the beneficiary. The first set of terms is patronising what is provided by the donor. The second is the placement of a limit upon the choices open to the disabled. The third is that employers will view will view issues relating to disabled people as charitable cases. What this means is that rather than addressing the real issues of creating a workplace that is conducive to the employment of people with disabilities, employers may conclude that making charitable donations meets social and economic obligations.

The Charity/Tragedy Model, therefore, does not address the real problem issues of ensuring the employment of disabled people. The point here is not to call for the dismantling of charities and, thereby, kick against acts of care and charity which enrich society through soliciting badly needed or urgently required funds for a good cause. Critics of the model have called for the need to educate managers of charity organizations and other professionals to review the way they operate. By reviewing the way they operate they could ensure that funds are channeled to promote the empowerment of disabled people and their full integration into society as equal citizens who require respect but not pity.

Social Model

The Social Model views disability as a consequence of environmental, social and attitudinal barriers that prevent people with impairments from maximum participation in society. This model is best summarised in the definition of disability from the Disabled Peoples International as follows: *"the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical or social barriers."*

The Social Model is also known as the Minority-Group Model of Disability. It argues from a socio-political viewpoint that disability stems from the failure of society to adjust to meet the needs and aspirations of a disabled minority. According to the model, if the problem lies with society and the environment, then it is society and the environment that must change. If for example, a wheelchair user cannot use a bus then the bus must be redesigned.

To put the argument more forcefully, if *Society A* comes out with visual aid for people who are short-sighted and these visual aids are easily affordable of freely available, it would mean that what may be described as an impairment uniform of short-sightedness would not prevent them from participating fully in the life of the community. In such a case, there would be no disability. If, however, the short-sighted people live in *Society B* where such visual aids are not available they would be severely disabled. This means that the inability to read and subsequently learn and gather information would be counted as a severe impairment in the society.

The social model implies that the removal of attitudinal, physical and institutional barriers will not only improve the lives of disabled people but give them the same opportunity as others on an equitable basis. Taken to its logical conclusion, there would be no disability in a fully developed society.
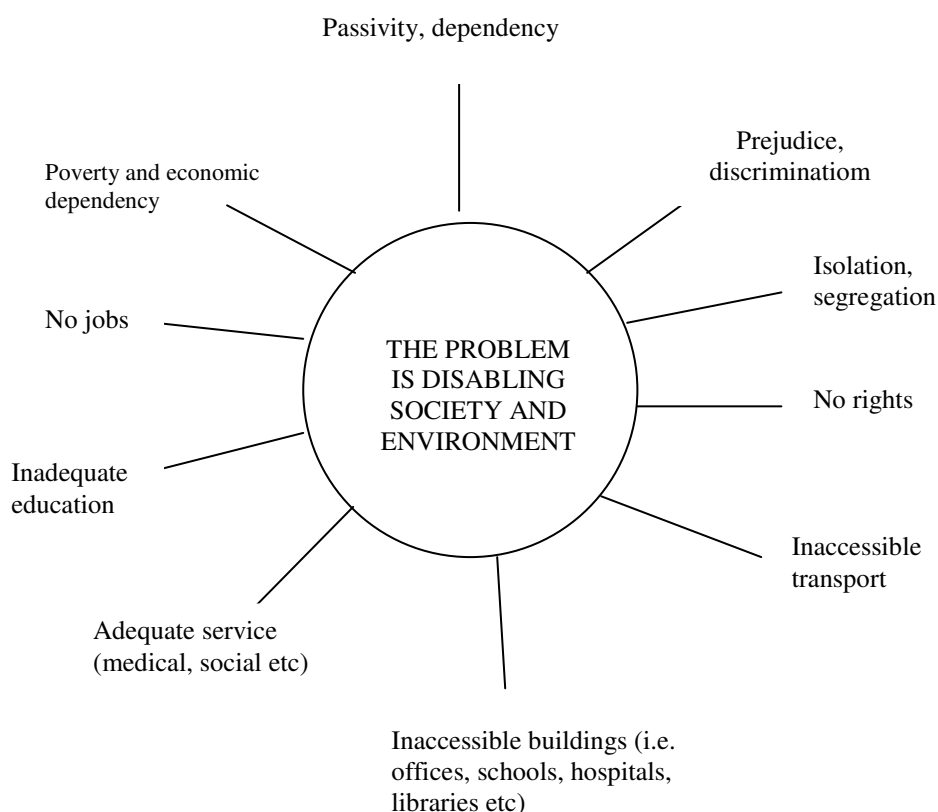

Figure 3: Social Model of Disability

The merit of the social model lies in placing the onus on the society but not the individual. At the same time it places emphasis on the need of the individual, arguing that society must create a conclusive environment for the

disabled to play a role. This is in sharp contrast with the medical model which uses diagnosis to produce categories of disability and assumes that people with the same impairment have identical needs and abilities. Again, it offers positive solutions that can work in conclusive environments as can be seen in places like Canada, Australia, United States and the United Kingdom. The social model does not exist without challenges. One challenge is that, as the population gets older the number of people with impairments will rise, thereby making it harder for society to adjust. Again, persuading committed charity or organizations and dedicated professionals to change their roles from "cure or care" to making disabled people take control of their lives will not be easy. The social model is used by organizations of persons with disabilities that have decided that the other two models-Medical and Tragedy/charity- severely and unnecessarily restrict the roles that disabled people can play in life as the models make them dependent.

Expert/Professional Model of Disability

The expert/professional model has provided a traditional response to disability issues and can be seen as an offshoot of the Medical Model. Within its framework, professionals follow a process of identifying the impairment and its limitations (using the Medical Model), and to produce a system in which an authoritarian, over-active service provider prescribes and acts for a passive client.
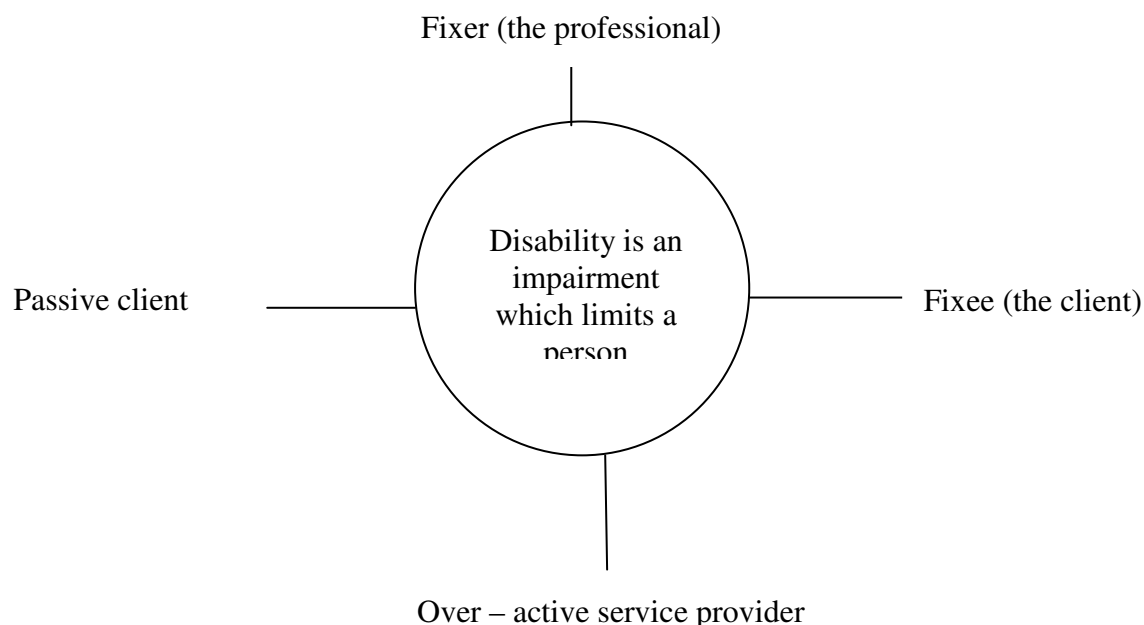

Figure 4: Expert/Professional model

This relationship has been described as that of fixer (the professional) and fixee (the client), and clearly contains an inequality that limits collaboration. Although a professional may be caring, the impositions of solutions can be less than benevolent. If the decisions are made by the "expert", the client has no choice and is unable to exercise the basic human right of freedom over his or her own actions. In the extreme, it determines the client's dignity by removing the ability to participate in the simplest, everyday decision affecting his or her life e.g. when underwear needs to be changed or how vegetables are to be cooked.

Rights-Based Model of Disability

In more recent times, however, the notions of 'disability' have come to be conceptualized as a socio-political construct within a rights-based discourse. The emphasis has shifted from dependence to independence as people with disability have sought a political voice and become politically active against social forces of able-ism. Disability activists, in engaging in identity politics, have adopted the strategies used by other social movements commanding human and civil rights, against such phenomena as sexism and racism.
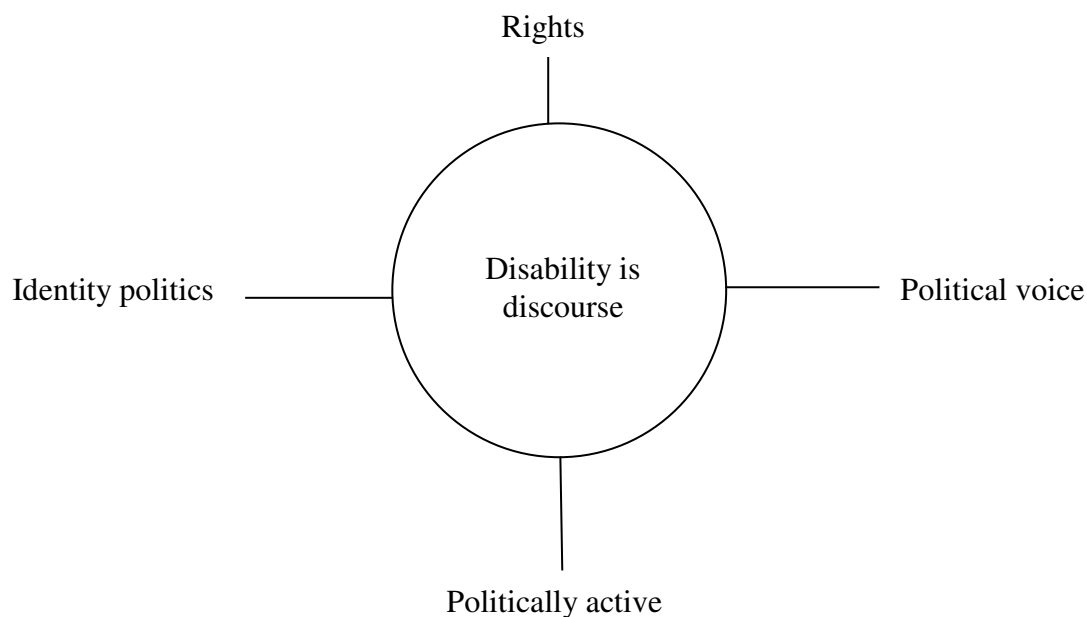
Rights

Identity politics — Disability is
discourse — Political voice

Politically active

Figure 5: Rights-based model

If all people are born equal and have the same rights, then people with disability need a strong, common voice in society to ensure that they are not discriminated against. Their wishes and rights ought to be respected.

Religious/Moral Model of Disability

The Religious Model views disability as a punishment inflicted upon on individual or family by an external force. It can be due to misdemeanors by the disabled person, someone in the family or community group, or forebears. Birth conditions can be due to actions committed in a previous reincarnation. Sometimes the presence of "evil spirits" is used to explain differences in behavior, especially in conditions such as schizophrenia. Acts of exorcism or sacrifice may be

performed to expel or placate the negative influence or recourse made to persecution or even death of the individual who is "different".

Stigmatisation of a family

Misdemeanors by a
person or family — Lowering of social status

Misdemeanors by a — Disability is a — Lowering of social status
person or family — punishment

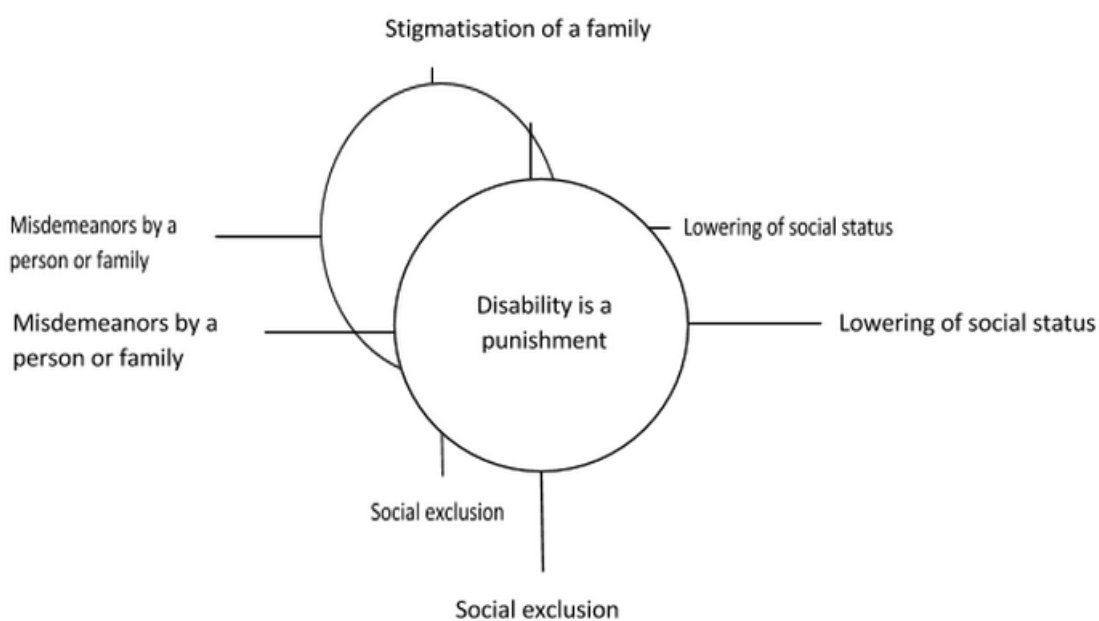Social exclusion

Social exclusion

Figure 6: Religious/moral model

In some cases, the disability stigmatises a whole family, lowering their status or even leading to total social exclusion. Or, it can be interpreted as an individual's inability to conform within a family structure. Conversely, it can be seen as necessary afflictions to be suffered before some future spiritual reward.

Economic Model

Under this model, disability is defined by a person's inability to participate in work. It also assesses the degree to which impairment affects an individual's productivity and the economic consequences for the individual, employer and the state. Such consequences include loss of earnings for and payment for assistance by the individual; lower profit margins for the employer; and state welfare payments. The economic model is used primarily by policy makers to access distribution of benefits to those who are unable participate fully in work. In recent years, however, the preoccupation with productivity has conflicted with the application of the medical model to classify disability to counter fraudulent benefit claims, leading to confusion and a lack of co-ordination in disablement policy.
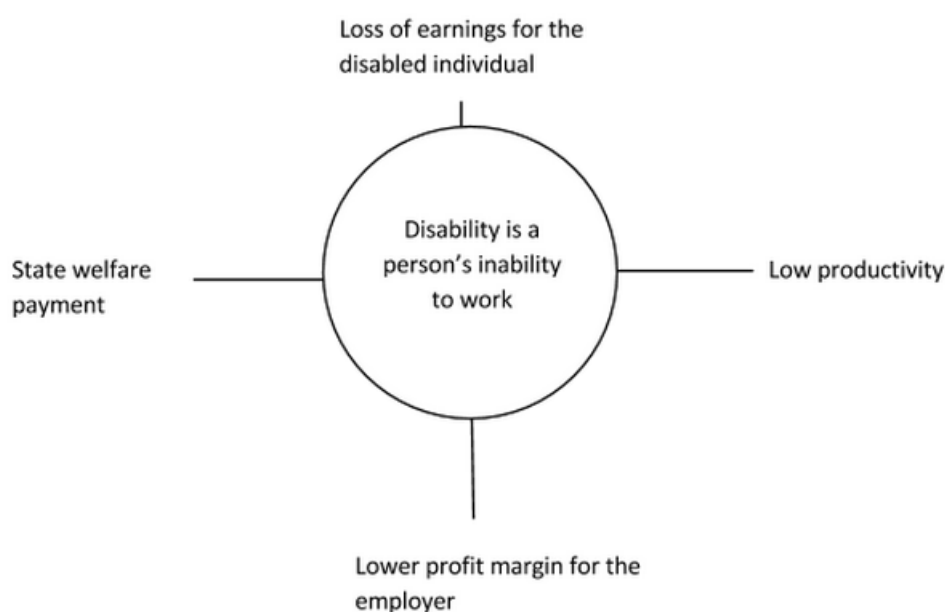

Figure 7: Economic model

The challenge facing the economic model is how to justify and support, in purely economic terms, a socially desirable of increasing participation in employment. Classical economic laws supply and demand stipulate that an increase in the labour market results in decreased wages. Arguably, extending access to work through equal opportunities reduces an employer's labour cost, but other factors come into play. The value of labour is based upon its contributions marginal cost, ie the cost of producing the last unit of production. This only works when employees make an equal contribution to marginal cost. However, evidence suggest that disabled employees make a lower contribution than their work colleagues do, resulting in losses in production and lower profits for the employer.

Social security benefits are not designed to remove disabled people from poverty. The policy maker needs to balance equity (the right of the individual to self-fulfilment and social participation through work) and efficiency. The true value of the economic model is maintaining this balance in the macro-economic context of trade cycles, inflation, globalization and extraordinary events such as wars.

Customer/Empowering Model

This is the opposite of the Expert Model. Here, the professional is viewed as a service provider to the disabled client and his or her family. The client decides and selects what services they believe are appropriate whist the service provider acts as consultant, coach and resource provider. Recent operations of this model have placed financial resources into the control of the client who may choose to purchase state or private care or both.
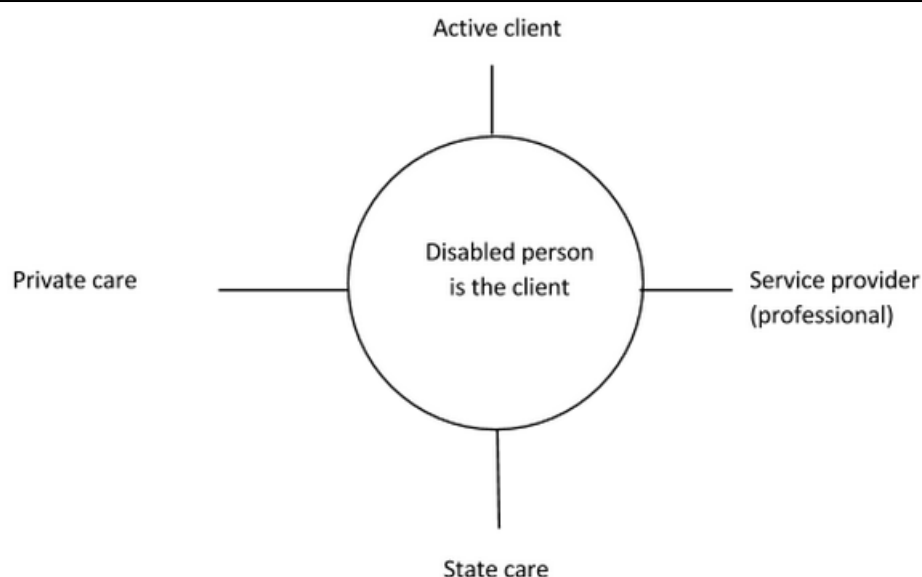
Active client

Private care — Disabled person is the client — Service provider (professional)

State care

Figure 8: Customer empowering model

Rehabilitation Model

This is an offshoot of the Medical Model which regards disability as a deficiency that must be fixed by rehabilitation professional or other helping professional. It is similar to the Medical Model in that it regards the person with a disability as in need of services to make up for the deficiency caused by the disability. Historically, it gained acceptance after the World War II when many disabled veterans needed to be re-introduced into the society. The current vocational rehabilitation system is designed according to this model.
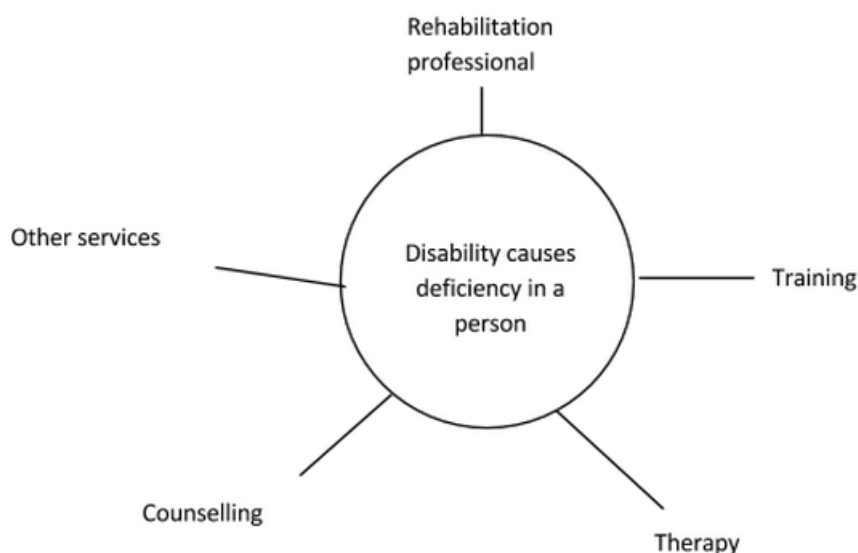
Rehabilitation professional

Other services — Disability causes deficiency in a person — Training

Counselling

Therapy

Figure 9: Rehabilitation model

Persons with disabilities have been very critical of both the medical model and the rehabilitation model. While medical intervention can be required by the individual at times, it is naïve and simplistic to regard the medical system as appropriate locus for disability related policy matters. Many disabilities and chronic medical condition will never be cured. Persons with disabilities, according to critics, are quite capable of participating in society, and the practices of confinement and institutionalization that accompany the sick role are simply not acceptable.

Relevant research questions posed by this work such as what people with disabilities think about their plight, how their expectations can be met and also how they can be brought into the mainstream of national development have not been fully answered by past research works. Past research works have come out with the neglect of the disabled and the fact that they are invisible in society. What they failed to do, however, was identifying their entrepreneurial skills as well as other talents, hidden and manifest, and then following up with training.

Practical implications

In developing countries, there are rarely strong disability movements actively working to improve the living conditions for people living with disabilities. Disabled persons are part of a lager vulnerable group weakly represented in civil society and Ghana is no exception. According to Ghana's National Disability Policy Document, *"…..People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness. Such impairment, conditions or illness may be permanent or transitory in nature."*

Some studies such as Barnes, 1991 have revealed that certain people with disabilities run small and medium scale businesses. This means that self-employment in form of entrepreneurship for some disabled people is already in operation, yet still in a very limited scale. This ongoing research-based paper is meant to improve the current situation through identifying entrepreneurial talents of the disabled and supporting them with training to make them financially independent. The general assumption is that entrepreneurs are people who are able-bodied. However, the study seeks to show that it is relevant skills and training that matter here. There is also the belief that certain skills development models are what are needed by the disabled. This work seeks to explore the field to find out the need for identifying entrepreneurial talents followed by the requisite training.

The United Nations *Convention on the Rights of Persons with Disabilities* (CRPD), adopted in 2006, aims to *"promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity"*. It reflects the major shift in global understanding and responses towards disability. Everyone needs to understand the best available information on disability so as to understand, appreciate and help improve the lives of people with disabilities and facilitate the implementation of the CRPD.

The outcome of this ongoing research has revealed serious *theoretical* and *policy implications* for the country. The concepts of *marginalisation*, *suppression* and *repression*, which form part of the theoretical basis of the study, are still prevalent as far as the needs of persons with disability are concerned. The inability of the state to adequately address the problem has resulted in a situation where persons with disability are still seen as an underprivileged group whose deserving place of abode, though incorrect as it is, is confined to the fringes of society where they continue to exist as social parasites and dependants.

Towards this end, a number of recommendations have been put forward here which, when carefully implemented with zeal and passion, will help to reverse this unfortunate, avoidable situation. To begin with, persons with disability deserve thorough recognition by society at all times. This recognition is also dependent on disability issues. Mutual respect and understanding contribute to an inclusive society. Thus, it is vital to improve public understanding of disability, confront negative perceptions and represent disability fairly. For example, education authorities should ensure that schools are inclusive and have an ethos of valuing diversity. Employers should also be encouraged to accept their responsibilities towards staff with disabilities.

Collecting information on knowledge, beliefs and attitudes about disability can help identify gaps in public understanding that can be bridged through education and public information. Governments, voluntary organisations and professional associations should consider running social marketing campaigns that change attitudes on stigmatised issues such as mental illness and other forms of disability. Involving the media is vital to the success of these campaigns and to ensuring the dissemination of positive stories about persons with disabilities and their families.

The expected recognition by society is necessary to ensure that this group of people is properly positioned in society to have their concerns appropriately addressed. Even though the responsibility falls on the shoulders of everyone, in Ghana, one public institution that needs to play a crucial role here is the National Council on Persons with Disability. The crucial role of this organisation must come in form of advocacy to raise public awareness on the rights of the disabled and also register all categories of persons with disability as well as all

institutions concerned with managing the affairs of such people in line with the Persons with Disability Act (Act715). Similarly, all individuals and organisations involved in development work must see the great link of disabilities and development. Many a time this link is overlooked.

Another recommendation is the pursuance of relevant education for persons with disability. Educational programmes must be geared towards the development of latent or hidden talent with the individual, whether able-bodied or not. In addition, adequate facilities and professional teachers ought to be made available for effective special education in the country. Where necessary and appropriate, all-inclusiveness education must be encouraged. Apart from education, the human resource capacity in all the sectors charged with managing persons with disability ought to be regularly upgraded. The attitudes and knowledge of people working in, for example, education, health care, rehabilitation, social protection, labour, law enforcement and the media are particularly important for ensuring non-discrimination and participation.

Human resource capacity can be improved through effective education, training, and recruitment. A review of the knowledge and competencies of staff in relevant areas can provide a starting point for developing appropriate measures to improve them. Relevant training on disability, which incorporates human rights principles, should be integrated into current curricula and accreditation programmes. In-service training should be provided to current practitioners providing and managing services. For example, strengthening the capacity of primary health care workers and ensuring availability of specialist staff where required, contribute to effective and affordable health care for people with disabilities. Many countries have too few staff working in fields such as rehabilitation and special education. Developing standards in training for different types and levels of rehabilitation personnel can assist in addressing resource gaps. There are also shortages of care workers and sign language interpreters. Measures to improve staff retention may be relevant in some settings and sectors.

Conclusion

Overlooking the development needs of people with disabilities or disinvesting in programmes that directly benefit them can be one of the most dramatic forms of exclusion people with disabilities can face. Underpinning the academic and practical demands of researching disabled people and their organisations is a socio-political re-interpretation of disability widely referred to as the *'Social model of disability'*. Originally devised by disabled activists in Britain this approach derives from disabled people's direct experiences of living with impairment in Western society. Since its development in the 1970s the social model has been increasingly accepted and adapted by disability groups throughout the world and now underpins, either implicitly or explicitly, their thinking and policies in countries as diverse as Britain, Japan, South Africa and the USA (WHO 2001).

This is mainly because the social model of disability is nothing more complicated than an emphasis on the economic, environmental and cultural barriers encountered by people viewed by others as having some form of impairment. These barriers include inaccessible education, information and communication systems, working environments, inadequate disability benefits, discriminatory health and social support services, inaccessible transport, housing and public buildings and amenities and the devaluing of people labelled 'disabled' by negative imagery and representation in the media – films, television and newspapers. From this perspective, people with designated impairments are disabled by society's failure to accommodate their individual and collective needs within the mainstream of economic and cultural life (Barnes 1991).

Apart from the Social Model, the other various models of disability discussed in this article do not offer any relevance to the research problem of this study. They all state that disabled persons need to be cared for, assisted or given support. While these are true, society needs to remove all barriers of accessibility to social life, as claimed by the Social Model, to ensure a meaningful, economically productive life for all persons with disability.

Also, there is, therefore, the need to identify the special entrepreneurial needs as well as other productive potentials and needs of persons with disability and help them to develop their talents to make them financially independent. Again, by ensuring a productive life for the disabled, they would be inclusive in social development. All this is meant to help provide the physically challenged with an appropriate entrepreneurial training and other forms of skills-development training, based on their own support, willingness and co-operation, to create successful business ventures.

References

1. Branson, J. and Miller, D., (1989), "Beyond Integration Policy - The Deconstruction of Disability," in Barton, L., ed., *Integration: Myth or Reality?* London: Falmer Press.
2. Barton, L. (1996), Disability and Society: Emerging issues and insights, Longman, London.
3. Funk, R, (1987) "Disability Rights: From Castle to Class in the Context of Context Rights," in Gartner, A and Joe, T., eds., *Images of the Disabled, Disabling Images*, New York: Praegar.
4. Higgins, P., (1992), Making Disability: Exploring the Social Transformation of Human Variation, Springfield, Illinois: Charles C. Thomas Publisher.

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