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## **How the Medical Model has Influenced United Nations Policies on Refugees with Disabilities**

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### **Abstract**

*Medical model perspectives have consistently influenced United Nations policies regarding disability, particularly in terms of refugees with disabilities. Refugees with disabilities are classified in the same category as refugees with medical needs, giving them an unequal chance of being resettled into a third country. Although the United Nations has moved away from medical model rhetoric in the past 15 years, this has not yet proven to have translated into resettlement policy for refugees with disabilities. This paper analyzes how the United Nations has shifted from a medical model of disability to a social model in various declarations, resolutions, and policies, and the impact this has had on refugees with disabilities. However, it is impossible to know the full extent of this impact, given a significant gap in research on the topic of this specific population.*

### **1. Introduction**

Of the more than 25.4 million refugees in the world (UNHCR, 2018), recent reports estimate that around 9.3 million of them have a disability (Duell-Piening, 2018). This is an enormous number, yet shockingly little attention is paid to this large population of people. Individuals who identify as being a refugee as well as having a disability are doubly marginalized, yet they are consistently forgotten about, even by humanitarian organizations (Mirza, 2011). This marginalization has an impact on durable resettlement solutions available to them as refugees. Refugees with disabilities are more overlooked than other vulnerable subpopulations of refugees largely because disability is primarily viewed from the medical model perspective, which isolates them and classifies them as being a greater burden than other refugees. The United Nations has evolved its disability framework throughout the past 30 years towards policies more in line with the social model, yet it is unclear whether these are being actively implemented. As a result, refugees with disabilities are less likely to be resettled into third countries than refugees without disabilities.

*International Journal on Responsibility 3.1 Sept 2019*

## **2. Models of Disability**

Before specifically investigating why refugees with disabilities are marginalized, it is important to take a step back and discuss the three main models of disability that guide how individuals with disabilities are perceived in society: the medical model, the social model, and the biopsychosocial model. Comparing these models and how they define disability is critical for later understanding the driving forces behind the exclusion of refugees with disabilities in society.

### *2.1. Medical Model*

Definitions of disability have historically been centered around the medical model. The medical model states that disability is a medical condition or impairment which results in an individual's inability to participate fully in society. The blame for this inability is placed within the person with the disability. When blame is centered on the individual, the resulting marginalization is perceived as justified. When an individual's disability prevents them from participating in a certain activity or accessing certain services, they are seen as a burden due to the perception that society must go out of its way to conform to their needs. In reality, it is a disabling environment that causes this limited access to activities and services, not the individual's own abilities. According to the medical model, any limitations that an individual with a disability faces are a direct result of their impairment and inability to conform to what is considered "normal" for society (Wasserman, Asch, Blustein, & Putnam, 2016).

An important aspect to the medical model, besides society placing blame on the individual, is the notion that disabilities are a tragic medical condition that should be cured and prevented whenever possible. The implication of conceptualizing disability as an impairment that must always be treated is a prevalence of the view that there is something inherently wrong with the individual with the disability, and that the person needs fixing in order to live a purposeful life (Hartley, 2011).

### *2.2. Social Model*

The social model of disability doesn't define disability in terms of a medical condition, impairment, or abnormality, but rather states that disability is a relationship between an individual and their environment. According to the social model of disability, individuals with "certain physical and mental characteristics" are consciously excluded from full and active participation in all aspects of society. This exclusion occurs as a result of an inherently discriminatory social and physical environment (Wasserman et al., 2016). The ableist way in which society is structured naturally ostracizes individuals with disabilities, therefore casting the assumption that those with disabilities are less capable, less worthy, and more of a burden to society than those without.

*International Journal on Responsibility 3.1 Sept 2019*

As the disability rights movement has evolved throughout the past few decades, social scientists, politicians, and humanitarian actors have adopted the social model as the favored framework for disability studies and activism (Wasserman et al., 2016). When disability is viewed as a result of a discriminatory social environment rather than the result of an individual's perceived "abnormality," the rights and needs of individuals with disabilities are taken seriously and put on an equal level as those without disabilities.

*2.3. Biopsychosocial/Interactional Model*

The biopsychosocial model, also known as the interactional model, essentially combines aspects of both the medical and social models. It argues that disability arises from an interaction of biological, psychological and social conditions. The biopsychosocial model recognizes that disability is a relationship between an individual and their environment, but it also does not reduce or dismiss the medical, biological aspect of disability (Smeltzer, 2007). The biopsychosocial model is the model that the United Nations frequently uses to conceptualize disability in various assessment tools, which will be referenced later in more depth.

**3. United Nations and Disability**

The United Nations has evolved its conceptualization of disability throughout the past three decades. They proclaimed 1983-1992 to be the "UN Decade of Disabled Persons," with the purpose of increasing awareness of and attention to people with disabilities within their communities and their countries (United Nations Department of Economic and Social Affairs, n.d.). At the beginning of this decade, they published the *World Programme of Action Concerning Disabled Persons*, which was written with the objective to effectively prevent disability and promote rehabilitation, so that individuals with disabilities could participate in society. In this document, disability is defined as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (United Nations, 1982).

Although the United Nations can be commended for attempting to raise the visibility of the disability rights movement through the UN Decade of Disabled Persons, the way they approached the topic was incredibly flawed. The *World Programme of Action Concerning Disabled Persons*, written in December 1982, was the document that was meant to kickstart this decade of activism and awareness. However, its objective of working to essentially eliminate disability is an indisputable example of the medical model in action, making the disability the issue instead of the environment. It defines disability as the problem that needs to be solved, instead of recognizing that disabling societies are the bigger issue. Its definition of disability is also problematic, implying that individuals with

### *International Journal on Responsibility 3.1 Sept 2019*

disabilities are not normal human beings and isolating them further within society (United Nations, 1982).

#### *3.1. Paradigm Shift*

The *UN Convention on the Rights of Persons with Disabilities* (CRPD), written in 2006, demonstrates a dramatic shift away from the medical rhetoric of the '80s. It instead reflects the worldwide movement towards the social model of disability and away from the medical model, emphasizing the fact that disability is a result of disabling social environments (Smith-Khan, Crock, Saul, & McCallum, 2014). The CRPD (2006) states that “disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.” This represents a clear rhetorical shift to the social model in comparison to the definition of disability in the *World Programme* of 1982. The purpose is to promote respect for inherent dignity, full inclusion in society, and equal accessibility to individuals with disabilities around the world (Duell-Piening, 2018). This objective is a much more human-centered approach than that of the 1982 *World Programme*, which as mentioned above, aimed to eliminate disability altogether and increase rehabilitation and treatment efforts.

The World Health Organization (WHO), a special agency of the United Nations, released a 2014-2021 *Global Disability Action Plan* which was “directed at improving the health, functioning and well-being of people with disability” (World Health Organization, 2015, p. 2). It presents disability as a global public health issue, a human rights issue, and a development issue. Instead of stating that disability itself is a health issue, it argues that individuals with disabilities often face extra barriers in accessing important health services due to inherently discriminatory policies and legislation on a global level (World Health Organization, 2015). This stance aligns with the biopsychosocial model of disability, because it addresses the physical impact that a harmful sociopolitical environment can have on individuals with disabilities.

#### *3.2 Assessment Tools*

In 2001, all 191 member states of the World Health Organization endorsed the *International Classification of Functioning, Disability, and Health* (ICF) as the “international standard for measuring health and disability at both individual and population levels” (World Health Organization, 2018). The WHO describes the ICF as using the biopsychosocial model to approach disability because it includes environmental factors that interact with the physical experience of disability. As a WHO guidebook to the ICF explains, “disability is always an interaction between features of the person and features of the overall context in which the person lives, but some aspects of disability are almost entirely internal to the person, while another aspect is almost entirely external” (World Health Organization,

*International Journal on Responsibility 3.1 Sept 2019*

2013). In this sense, it is logical to categorize the ICF under the biopsychosocial model, since it combines aspects of both the medical and social models. Although it aims to measure disability in comparison to the social environment, its definition of disability itself is still extremely medical model, claiming that disability is a term that encompasses impairments, physical limitations and other types of restrictions. For this reason, it still somewhat borders with the medical model despite the fact that it also addresses environmental factors.

The ICF is a reference guide for various assessment tools that measure disability on a global level, including the *Model Disability Survey*. The *Model Disability Survey*, or MDS, was developed by the WHO and the World Bank to identify disability within populations and pinpoint societal barriers that they commonly face (World Health Organization, n.d.). The survey helps to identify specific barriers, inequalities, and unmet needs faced by individuals with disabilities in specific communities around the world. The MDS utilizes the ICF's definition of disability as its baseline understanding of disability, which demonstrates how the ways in which disability is defined is so important. Since the ICF advocates for the adoption of a biopsychosocial approach to disability in its guidebook (World Health Organization, 2013), this is the conceptualization that the MDS has also taken.

According to the MDS, disability is defined as “the outcome of an interaction between an individual's health condition(s) or impairments and the physical, human-built attitudinal and sociopolitical environment in which the person lives” (World Health Organization, n.d.). The MDS collects data on the distribution of individuals with disabilities in a community, their living conditions, employment situations, the level of functioning and participation in society of those with health conditions, quality of life, and general demographics (World Health Organization, n.d.). It then identifies barriers and needs in those communities. The MDS is, overall, a positive example of how the UN has reconceptualized disability in recent years.

#### **4. The UNHCR and Disability**

As the United Nations' conceptualization of disability has shifted over time, so has their conceptualization of refugees with disabilities. The 80-page 1982 *World Programme of Action Concerning Disabled Persons* document only included a four-sentence paragraph about refugees with disabilities. This brief mention demonstrates that the UN was aware of this population but didn't deem it worthy of significant discussion. The four sentences simply state the fact that refugees with disabilities exist, and that their impairment combined with their refugee status make them “doubly handicapped” (United Nations, 1982).

In the 1990s, the UN began the process of shifting from a rigid medical definition of disability and focused on a more comprehensive model of disability that emphasized access to community-based services for refugees with disabilities

*International Journal on Responsibility 3.1 Sept 2019*

(Mirza, 2011). They released a book of guidelines for UNHCR field officers in 1992, which addressed the protection of refugees with disabilities and called for an increase of services and community-level care. These guidelines were updated in 1996 and focused on rehabilitation and prevention of disability and called for more humanitarian intervention for disabled refugees (Mirza, 2011). The 1992 and 1996 guidelines for refugees with disabilities were an improvement from the 1982 *World Programme* in that they addressed protection and access to services, but they still should be undoubtedly categorized within the medical model of disability (Mirza, 2011).

Less than a decade later, in 2004, the UNHCR released a nearly 500-page handbook on refugee resettlement. Part of this handbook outlines how refugee resettlement should be organized and prioritized and determines how to recognize vulnerable populations of refugees that should be resettled into a third country. Chapter four of the handbook addresses refugees with disabilities in a brief paragraph, which is a subsection of the “medical needs” category for resettlement. The short paragraphs states that “disabled refugees who are well-adjusted to their disability and are functioning at a satisfactory level are generally not to be considered for resettlement” (United Nations High Commissioner for Refugees, 2004, p. 4.11)

#### *4.1 Paradigm Shift*

However, fast-forwarding just two years, there is a clear paradigm shift in how the UN talks about refugees with disabilities. The *Convention on the Rights of Persons with Disabilities* of 2006 specifically calls out the fact that refugees with disabilities are at a disadvantage compared to other refugees, and this is expanded further in the few years following. This is a welcome shift in tone, especially compared to the way that disability was mentioned in the 2004 handbook, where refugees with disabilities were essentially brushed to the side.

Improvements in how the UNHCR addresses disability really began after the 2006 CRPD mentioned above. The 2010 *Conclusion on Refugees with Disabilities and Other Persons with Disabilities Protected and Assisted by UNHCR*, written by the Executive Committee of the High Commissioner’s Programme, is a landmark document concerning refugees with disabilities. It finally moves completely away from the medical model, embracing the concept that existing discriminatory societal barriers are what prevent individuals with disabilities from fully participating in society. Instead of simply stating that refugees with disabilities are “doubly handicapped” (United Nations, 1982), it recognizes that they are typically overlooked in humanitarian interventions and are more likely to be exploited and excluded from protections that refugees without disabilities have access to. Additionally, it calls on UNHCR officials to increase disability awareness training, to ensure that any policies regarding refugees with disabilities are consistent with this social model of disability (UNHCR Executive Committee of the High Commissioner’s Programme, 2010).

*International Journal on Responsibility 3.1 Sept 2019*

The 2004 *Resettlement Handbook* mentioned earlier was updated in 2011, and this is the newest version to date. It provides a more comprehensive overview of the experiences of refugees with disabilities compared to the 2004 handbook, and instead of addressing this population in the ‘medical needs’ section, the 2011 handbook recognizes refugees with disabilities in their chapter entitled “Specific Protection Risks and Potential Vulnerabilities” (United Nations High Commissioner of Refugees, 2011, p. 172). This section emphasizes that refugees with disabilities are at a greater risk of discrimination and exploitation and often are denied access to resources that are available to able-bodied refugees. It goes on to say that refugees with disabilities should have an equal opportunity for resettlement compared to any other refugee, which is a stark contrast to the recommendation of the 2004 handbook (United Nations High Commissioner of Refugees, 2011, pp. 197-198).

Further, the UNHCR released a guidebook in 2019 entitled *Working with Persons with Disabilities in Situations of Forced Displacement*, which is meant to help UNHCR staff adopt inclusive, rights-based policies regarding refugees with disabilities. It outlines key guiding principles and identifies steps that should be taken to remove discriminatory barriers that continuously marginalize refugees with disabilities. The guide emphasizes the importance of not reinforcing a medical model of disability during awareness campaigns, stresses the importance of universal design in refugee camps, and calls out the fact that there is a lack of research into this population (United Nations High Commissioner of Refugees, 2019). It is 28 pages, which is the most in-depth document specifically regarding refugees with disabilities that the UN has released. It specifically condemns the medical model, which demonstrates how much their rhetoric has shifted.

It is apparent that the UN has evolved its disability paradigm since the 1980s, from its rigid medical model perspective towards a social model approach that calls out gaps in existing protection frameworks. In turn, this paradigm shift has drawn more attention to refugees with disabilities. However, it still remains unclear how much this increased attention has been translated to implementation on the ground, so there are still large protection gaps and issues of marginalization that exist for refugees with disabilities. There is a stunning lack of data and academic literature written about this issue, as most of it focuses on refugees who have already been resettled in third countries, and refugee health in general (Smith-Khan et al., 2014). Despite the increased attention paid to this population by the UN in the past 15 years, refugees with disabilities are still often overlooked. This is particularly manifested in durable resettlement solutions available to this population.

*4.2 Assessment Tools*

In an effort to document different groups of vulnerable populations of refugees in camps, the UNHCR developed an assessment tool in 2007 called the *Heightened Risk Identification Tool* (HRIT) (Mirza, 2011). The HRIT was designed to identify

*International Journal on Responsibility 3.1 Sept 2019*

the six subpopulations of refugees that the UNHCR perceives to be the most vulnerable. The tool categorizes them by legal and physical protection, women and girls at risk, children/adolescents at risk, older people at risk, survivors of violence or torture, and health and disability (UNHCR, 2007). Although grouping health and disability together into one category automatically creates the assumption that all disabilities are health concerns, therefore playing into the medical model, the tool does further break them both down and define them further in the assessment questions. It assesses refugees for sight impairment, hearing impairment, moderate mental disabilities, severe mental disabilities, physical disabilities, physical incapacity, and speech impairment. Each of these categories is also defined in further detail (UNHCR, 2007). The HRIT, although flawed, is noteworthy because it demonstrates that the UNHCR perceives disability amongst refugees as something worth documenting.

To improve data collection of refugees with disabilities, the 2019 UNHCR guidebook for field officers recommends the use of the *Washington Group Short Set of Questions on Disability* (United Nations High Commissioner of Refugees, 2019, p.15). While recognizing that collecting data on refugees is difficult given that they are not static, the UNHCR emphasizes that it is essential for planning and policy objectives. Additionally, they stress the importance of not assessing individuals solely based on medical diagnoses and visual cues, which is why they recommend the Washington Group assessment (United Nations High Commissioner of Refugees, 2019, p. 14). The Washington Group on Disability Statistics bases their conceptual model of disability on that of the ICF, similar to the MDS. However, the questions are used to determine an individual's personal level of function within their society, which could be considered in line with the medical model rather than the biopsychosocial model that the ICF advocates for.

### **5. Consequences on Resettlement**

The three durable solutions for refugees are resettlement in a third country, local integration into the country of asylum, and voluntary repatriation. Having a disability plays a major role in determining whether an individual is eligible for resettlement. To be considered for resettlement in a third country, refugees must fall into one of the following categories of protection needs: legal and/or physical protection needs, survivors of torture and/or violence, medical needs, women and girls at risk, family reunification, child and adolescent at risk, or lack of foreseeable alternative durable solutions (Duell-Piening, 2018).

Refugees with disabilities who are living in refugee camps are classified and registered officially as having medical needs. This label puts them into a medical model box, which can greatly impact their chances for resettlement. In its 1996 guidelines, the UNHCR made it clear that resettlement to a third country was an option of last resort for refugees with disabilities, because it is "more advisable to help the integration of the disabled into their own communities"



*International Journal on Responsibility 3.1 Sept 2019*

(United Nations High Commissioner of Refugees, 1996). Although this rhetoric has changed, refugees with disabilities continue to be placed in the ‘medical needs’ category for resettlement, which puts them at a significantly lower chance for resettlement. To qualify for resettlement under the medical needs category, the refugee must demonstrate that they meet a set of strict requirements: that the health condition or disability is life threatening or irreversible damage will occur if they are not resettled, that the environment of the country of asylum worsens their condition, that adequate treatment is either unavailable or inaccessible in the country of asylum, that the health condition or disability will prevent them from living a normal life in the country of asylum, and that no treatment or rehabilitation exists in the country of asylum that could improve their quality of life (United Nations High Commissioner of Refugees, 2011, p. 257).

These requirements contradict what was argued earlier in the same 2011 document; that refugees with disabilities should have equal access to resettlement opportunities. If a refugee is determined to have a disability, they are placed under the ‘medical needs’ special risk category, which according to the requirements listed above, makes it nearly impossible for refugees with non-life-threatening disabilities to qualify for resettlement. These requirements are inherently discriminatory towards refugees with disabilities and create unequal access to resettlement opportunities. Along these same lines, according to the 2008 Women’s Refugee Commission report on refugees with disabilities, there are 200 locations around the world that accept refugees with disabilities, but these are reserved for refugees who need urgent medical care or have a life-threatening illness or disability. An individual with a chronic or long-term disability would not be considered part of this category. Further, many resettlement countries have cost ceilings for resettling refugees with medical needs and refuse to accept refugees that they believe will require excessive medical care, which includes individuals with disabilities.

## ***6. Implications and Limitations***

Putting disability in the same category as medical issues leaves refugees in a complete protection gap. When deciding which refugees are in most critical need of being resettled into a third country, the UNHCR has made it clear throughout the years that the priority within this group will always go to those who have a life-threatening medical condition, which is inherently discriminatory against those with disabilities. This is not to say that refugees with disabilities should be resettled specifically because they have a disability, and this automatically constitutes a greater need; rather, refugees with disabilities should have an equal opportunity at resettlement as any other refugee, as the 2011 Handbook states, and putting them in the same category as those with medical needs denies them of this right.

*International Journal on Responsibility 3.1 Sept 2019*

Despite the UNHCR moving towards a social model of disability in its resettlement framework, there is a blatant lack of evidence to demonstrate whether this has been implemented in policy (Smith-Khan, et al., 2014). While there is substantial research on the other vulnerable categories of refugees indicated in the HRIT, refugees with disabilities are seldom given much thought. Further research must be done on refugees with disabilities, beyond just their medical needs and access to services after they have been resettled into a third country. This is a glaring oversight in the academic field, especially considering the enormity of the population it involves.

This lack of research and academic literature speaks volumes about how society views disability. Although policies are shifting toward the social model, it is common for society in general to hold the medical model view that disability is the impairment of an individual, therefore reducing them to little more than a burden to society. The value that individuals with disabilities bring to the community is typically overlooked, so governments see little incentive to accept refugees with disabilities to be resettled in their countries.

## **7. Conclusion**

It is clear that the rhetoric that the United Nations uses when addressing individuals with disabilities impacts policies. When the UN started shifting away from the medical model and towards the social and biopsychosocial models of disability in its conceptualization of disability, more attention was shifted to individuals with disabilities. The conversations around disability went from focusing on rehabilitation and prevention to equality and inclusion. However, although the UN has had a paradigm shift in its conceptualization of disability throughout the past few decades, it is unclear whether this paradigm shift has manifested into actual changes for refugees with disabilities. This lack of clarity is largely due to an absence of data and research into this population, and this gap must be filled. Investing additional time and research into refugees with disabilities would provide critical insight about the needs and specific societal challenges this population faces. Without open discussion and research about refugees with disabilities, they will continue to be an overlooked group whose needs are forgotten about and ignored by society.

The medical model of disability is so prevalent throughout society that it has resulted in policies which embody the assumption that individuals with disabilities are a burden and have little value. Refugee resettlement policies discussed in this paper exemplify this. When societal rhetoric surrounding disability changes, and the value and worth of individuals with disabilities is recognized and celebrated, it is likely that policies will reflect this. Refugees with disabilities are more likely to have fair access to resettlement opportunities when there is an overall shift in how society views disability, and this starts with moving away from the medical model.

*International Journal on Responsibility* 3.1 Sept 2019

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*International Journal on Responsibility 3.1 Sept 2019*

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*International Journal on Responsibility 3.1 Sept 2019*

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