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The elections of the Junior Deputies who will sit in the Children's Parliament of Congo

MODULE 0

Foundation Module

Addressing stigma and discrimination toward children and youth with disabilities through social and behaviour change (SBC).

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FOREWORD

Fifteen per cent of the world's population – at least one billion people – have some form of disability, whether present at birth or acquired later in life. Nearly 240 million of them are children. One in every 10 children globally has a disability.

Inclusion starts with the understanding that disability is the result of interactions between inaccessible environments and a person who has long-term impairments. Inclusion can be achieved when people work to break down physical barriers, when services are accessible to everyone, when policies equally benefit all individuals, when communications reach every person, regardless of if they are blind, deaf or have low literacy. But acting to move the world further in this direction requires an inclusive mindset as foundation.

Unfortunately, many people in most societies across the world still have negative, pitying, patronizing attitudes toward people with disabilities. As a result, over one billion people continue to experience stigma and discrimination. This sometimes manifests in violence, institutionalization or exclusion from society, and sometimes in silence or overprotection. Breaking the stigma will require multilevel strategies co-developed with children and adults with disabilities. Governments and partners need to invest in integrated, evidence-based social and behaviour change (SBC) interventions to address the negative attitudes, beliefs and norms that fuel stigma and discrimination against children with disabilities, and to make services more accessible and inclusive. Service providers and communities need to be empowered to support the inclusion of children and adults with disabilities and to enable their access to services. Policies that address stigma and discrimination against children with disabilities and their families need to be put in place, with enough resources allocated to implement them. Drawing on various disciplines – sociology, psychology, communication and behavioural economics – SBC encompasses a broad set of strategies and interventions that influence drivers of change and support local action towards better societies. In every sector, UNICEF's SBC programmes bring together local knowledge with scientific insights to support the most vulnerable. Based on the reports, In 2023, over 100 UNICEF country offices are already implementing SBC interventions to promote disability inclusion. This toolkit will support them, and contribute to rallying additional country offices to further advance inclusive SBC interventions so that all children have equal opportunities.

This toolkit was developed through extensive consultation with UNICEF employees, organizations of persons with disabilities, SBC experts, government partners, academics, and youth with disabilities. It provides insights, tools and resources to help users understand barriers to the inclusion of children with disabilities. It offers practical support to help design and implement SBC programmes that engage and empower children with disabilities and their families to be agents of change in their communities, and to enjoy the same opportunities as their peers.

We hope you will enjoy diving into this toolkit as much as we enjoyed developing it with many of you.



Vincent Petit
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Addressing stigma and discrimination toward children and youth with disabilities through social and behaviour change (SBC).

The students of the Junior Secondary school sit in the Children's Parliament of Congo

MODULE 0
Foundation Module

Danielle Muehls and Adelle Zullo, Attorneys at Law, are smiling and sharing during the closing ceremony and presentation of certificates of the 'Inclusion' program, Honduras, 2021

MODULE 1
Inclusive Evidence Generation for SBC

Children at an inclusive education activity promote children's rights of the benefit of newly identified and protection, water, hygiene, and sanitation, Venezuela, 2022

MODULE 2
Empowering Children and Families

Children with autism from Jharkhand are engaged in the event of the Blue Connect program, organized by UNICEF Bangladesh to mark the World Children's Day

MODULE 3
Understanding and engaging communities

Mangesh, a community health worker and president of the independence committee, is active in raising awareness during polio vaccination campaign

MODULE 4
Disability-inclusive services

The students of the Junior Secondary school sit in the Children's Parliament of Congo

MODULE 5
Strengthening partnerships for advocacy

The damaged house of Mr. Dong Van Ngan, 40 years old and his wife, Mrs. Thi Thanh, collapsed during the flood. The couple have three children: the eldest daughter is 7 years old and the 2nd and 3rd children were born with visual impairment, Viet Nam

MODULE 6
Disability-inclusive SBC in humanitarian settings

Bethan, 7 years old has received an eye cancer treatment during the lesson at school with his teacher Bethan

MODULE 7
Monitoring, evaluating and measuring

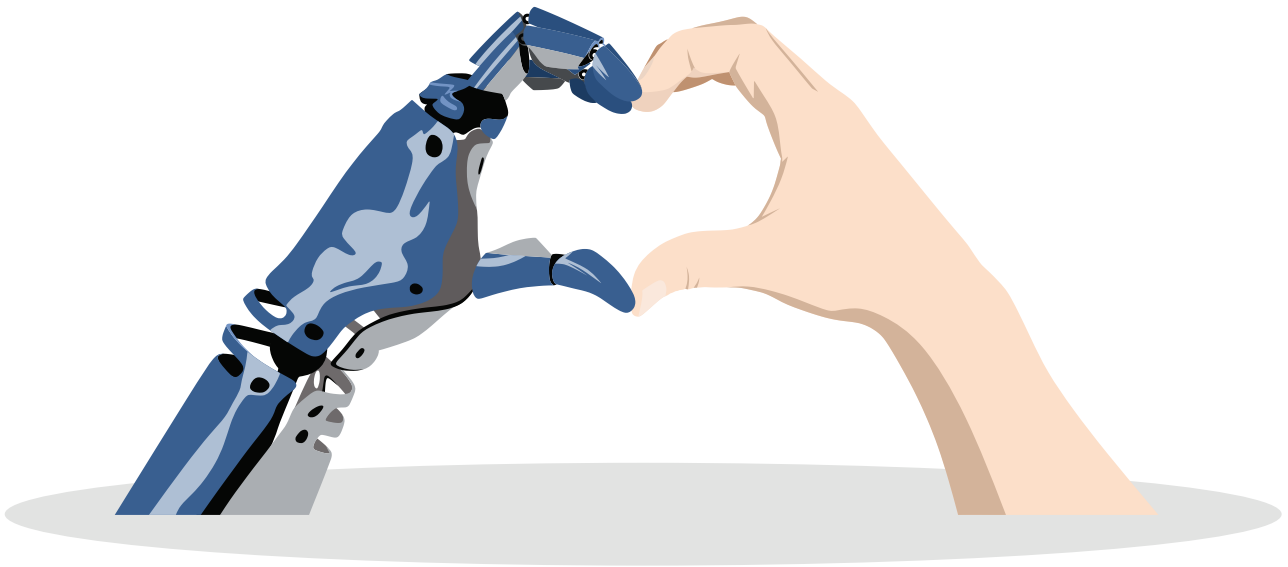
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Sarah's story, part 0

Hi, my name is Sarah. I am a girl, a sister, daughter, friend, student. I'm passionate about music. And I have a disability. I was born with cerebral palsy. It is a motor disability that causes changes in the use of muscles. I limp when I walk, and I have difficulty speaking clearly. So I have many identities, and being a person with a disability is one of them. However, people often prefer to focus on this one. I was born in a loving family in city X, where I lived with my two siblings, and my mom and dad.



INTRODUCTION



About this toolkit

This toolkit was developed to help achieve a world where “all children, including those with disabilities, live in barrier free and inclusive communities, where persons with disabilities are embraced and supported, across the life cycle, to realise and defend their rights, and to achieve full and effective participation” (UNICEF Disability Inclusion Policy and Strategy, 2022-2030).

SBC programming has a critically important and urgent role to play in identifying and implementing solutions that empower children with disabilities and their families and support their social inclusion. We are therefore pleased to share this practical guide to understanding and tackling the social norms and behaviours that limit the inclusion of children with disabilities in their communities.

This toolkit aims to provide insights, tools and resources to help you understand the barriers to the inclusion of children with disabilities, with a focus on stigma and discrimination, and to offer practical support for designing, implementing, monitoring and evaluating social and behaviour change (SBC) interventions that include children with disabilities and their families and empower them to be included in their communities and enjoy the same opportunities as their peers.

A range of users can benefit from this toolkit – including SBC specialists, organizations of people with disabilities (OPDs), education specialists. Whatever your specialization, you are encouraged to approach this toolkit with your specific priority interventions in mind.

This toolkit is built to be both comprehensive and flexible, to accommodate a range of needs and circumstances. Its primary approach is to promote multi-layered interventions that comprehensively target disability stigma. Because resource constraints may not allow such multi-layered interventions in some cases, this toolkit offers a spectrum of options for you to choose from. Whether you are guiding practitioners through complete programme cycles or assisting in the thoughtful design of a specific, targeted intervention, you will find guidance here.

This toolkit comprises an introduction, a foundational module, seven thematic modules, a user guide and a PowerPoint presentation. The modules are as follows:

- Module 0: Foundation
- Module 1: Inclusive evidence generation
- Module 2: Empowering children and youth with disabilities and their families
- Module 3: Understanding and engaging communities
- Module 4: Building disability-inclusive services
- Module 5: Strengthening partnerships for advocacy
- Module 6: SBC for disability inclusion in humanitarian action
- Module 7: Monitoring, Evaluating and Measuring

Taken together, the modules describe the key elements of achieving sustainable social and behaviour change.

Sustainable social and behaviour change starts with a clear understanding of the stigma and barriers to inclusion experienced by children with disabilities and their families in a particular context (Module 0). Participatory research informs all interventions, so that they support an in-depth understanding of the communities they serve (Module 1).

The keys to effecting behaviour change are programmes that sustainably empower children with disabilities and their families (Module 2), create space for thoughtful community engagement (Module 3), design and implement inclusive services that are available to everyone in the community (Module 4), forge strong partnerships for advocacy (Module 5), respond to the needs of children with disabilities in humanitarian contexts (Module 6) and measure progress in clear and objective ways (Module 7).



“It’s not our differences that divide us. It is our inability to recognize, Accept and celebrate those differences”

Audre Lorde

Each module begins by explaining how its particular focus area contributes to the broader goals of improving SBC practice for children with disabilities. We have organized each module according to a simple framework that reflects the project cycle: **Ready?, Steady..., Set., Go!**. The intention is to provide you, the user, with the opportunity to engage with the content, wherever you are in your project or programming journey.

Whether you are an expert in disability inclusion or SBC, or if you're new to both fields, start with Module 0, which covers fundamental concepts related to disability and SBC. It's essential that you start with a solid grasp of the basics of these concepts. If you feel the need to delve deeper, you can explore additional resources in the 'Tools' section.

This toolkit is aligned with [UNICEF's SBC Programme Guidance](#) and [UNICEF's minimum quality standards and indicators for community engagement](#). It is intended as a tool for the implementation of the [UNICEF Disability Inclusion Policy and Strategy, 2022-2030 \(DIPAS\)](#).

● Children with disabilities and key barriers to inclusion

Fifteen per cent of the world's population – at least 1 billion people – have some form of disability, whether present at birth or acquired later in life. Nearly 240 million of them are children. Each has the right to be nurtured and supported through responsive care and education, to receive adequate nutrition and social protection, and to enjoy play and leisure time.

Too often, however, these rights are denied. The reasons vary: stigma, lack of accessible services, lack of access to assistive devices, physical barriers. When children with disabilities are excluded from society, their chances to survive and thrive are diminished, as are their prospects for a bright future. But this can and must change.

The Convention on the Rights of Persons with Disabilities defines disability as a long-term physical, mental, intellectual or sensory impairment that – in interaction with the environment – hinders one's participation in society on an equal basis with others. This means that as societies remove barriers, people experience fewer functional limitations.

impairment + barrier = disability
impairment + accessible environment = inclusion



On their own, impairments are not disabilities. Understanding the difference is the key to addressing barriers to inclusion.

Children and adolescents with disabilities are a highly diverse group with wide-ranging life experiences. They live in every community, and are born with or acquire distinct impairments that, in relation to their surroundings, lead to difficulties in functions like seeing, walking, communicating, caring for themselves or making friends. But the extent to which children with disabilities are able to function, participate and lead fulfilling lives depends on the extent to which society is inclusive.

Example: If a young girl from a village has low vision, but no access to glasses – an assistive device that is often taken for granted – we would say that her environment does not allow her to exercise the same rights as other children: to receive education, to learn and go to school. Unable to view learning materials in the classroom and to fully participate, she may not be able to keep up with other students, and may eventually drop out of school.

Children with disabilities face a range of barriers that limit their ability to function in daily life, access social services like education and health care, and engage in their communities. These include:

- **Physical barriers**, for example, buildings, transportation, toilets and playgrounds that cannot be accessed by wheelchair users.
- **Communication and information barriers**, such as textbooks unavailable in Braille, or public health announcements delivered without sign language interpretation.

- **Attitudinal and behavioural barriers** like stereotyping, low expectations, pity, condescension, harassment and bullying.
- **Policy barriers**, such as policies and laws that discriminate against people with disabilities, or the lack of legal frameworks for the fulfilment of equal rights.

Each of these barriers is rooted in stigma and discrimination that reflect negative perceptions associated with **ableism** – a system of beliefs, norms and practices that devalues people with disabilities. Because of ableism and the barriers that stem from it, children with disabilities are among the most marginalized people in every society.



UNDERSTANDING STIGMA

Stigma is one of biggest barrier to inclusion. There are two types of stigma: public stigma and self-stigma.

- **Public stigma** is a social process that contains three interdependent components: stereotypes, prejudice and discrimination.¹
- **Stereotypes** are collectively held beliefs that allow people to quickly generate impressions and expectations of individuals who belong to a particular social group – often at the price of distorting reality. One common stereotype is that people with disabilities are incompetent, unable to live and work successfully.²
- **Prejudices** are negative attitudes towards a group of people,³ resulting from endorsement of stereotypes that generate negative emotional reactions. An example of a negative attitude is that people with disabilities can't and shouldn't be included in society and services. When measuring attitudes, it is very important to measure implicit (unconscious) biases as well as explicit (conscious) ones, as they can significantly differ. See module 4 for more information on implicit biases.
- **Discrimination** is a behavioural response based on prejudice towards a group, which may result in harm towards members of that group.⁴ Examples of discriminatory behaviours include avoidance and segregation.
- **Self-stigma** – also referred to as internalized, experienced or anticipated stigma – occurs when people apply stereotypes to themselves, develop prejudices that are harmful to themselves and engage in self-discrimination.⁵ For

example, someone may hold the self-stereotyping belief, “I am incapable,” which evokes a negative attitude – “I can't and shouldn't be included in society” – leading them to self-isolate.

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Children who acquire disabilities early in life often contend with stigma throughout childhood. It is embedded in caregivers' paternalistic attitudes, overprotective parenting, low expectations, ableism in schools and the widespread neglect of the voices, needs and capacities of children with disabilities. Stigma is the root of such as school segregation, institutionalization and forced sterilization of children with disabilities.⁷ Due to ableist assumptions, children with disabilities are frequently seen as in need of ‘fixing’ and help, less able to contribute and participate, less worthy of attention and having less inherent value than others.

Addressing stigma and discrimination against children, adolescents and adults with disabilities require systematic, multi-level approaches. It entails addressing negative attitudes, harmful beliefs and norms, misconceptions and ableism in society – and empowering children and adults with disabilities, their families and OPDs to demand their rights and participate in processes aiming to make policies, services and communities more inclusive.

1 Corrigan, 2000. For full references, see the reference list in module 0.
 2 Pescosolido et al., 1999; Cohen and Struening, 1962; Kermode et al., 2009; Kobau et al., 2010; Pescosolido et al., 1996; Van 't Veer et al., 2006.
 3 Corrigan, 2000.

4 Crocker et al., 1998
 5 Corrigan et al., 2006.
 6 Corrigan et al., 2006.
 7 UNICEF, n.d.

PROPOSED THEORY OF CHANGE

Understanding and addressing social issues requires a thorough diagnosis, and effective Social and Behavior Change (SBC) strategies are grounded in a proper understanding of the problem. To design impactful programs, it is crucial to answer the fundamental question: "Why are people doing what they are doing?". In this case, the question is "why are people excluding people with disabilities?". Unraveling the 'why' is essential to inform the 'how'.

A theory of change (ToC) is the cornerstone of any evidence-based programme which answers this "why", serving as the blueprint for understanding and addressing the issue. Hence, this global toolkit features a thorough ToC that was carefully crafted through extensive research and insights from practice. It serves as a universal reference point for practitioners, offering a solid foundation to adapt and personalize their own strategies. Packed with comprehensive insights, it is an invaluable resource that includes everything practitioners need to contextualize their approaches effectively. It consists of two integral parts: a problem analysis and a solution analysis. The problem analysis identifies the drivers of stigma, while the solution analysis specifies the outputs and outcomes required to achieve the goal of reducing stigma.

The journey begins by defining stigma, particularly ableism, directed at people with disabilities. Stigma is dual-natured, divided into public stigma—a social process involving stereotypes, prejudice, and discrimination—and self-stigma, an internalized or anticipated form that varies among individuals within a stigmatized group.


When exploring the reasons behind disability stigma, the TOC points to three main drivers: psychological, sociological, and environmental. Within the psychological drivers, three crucial elements stand out—attitudes, self-efficacy, and interest. Sociological drivers cover social learning, social norms, and the impact of social movements. Environmental drivers include inclusive spaces, the communication environment, and moral development in schools. To provide practitioners with a thorough understanding, each of these drivers is further unpacked to reveal second and third-layer drivers. This detailed breakdown aims to offer practitioners a comprehensive insight into the root causes of each of the driver.


This ToC is both research-based and practice-oriented, functioning as a comprehensive global reference that blends practicality with evidence. It serves as a versatile guide for practitioners, designed to be adaptable to specific contexts. Practitioners from any country can refer to and customize it based on their contexts. Please see the [PowerPoint Presentation of proposed detailed TOC](#). The short version is available in Module 0.


THE PERSON-FIRST APPROACH


The toolkit introduces the person-first approach, which is not the same thing as person-first language. A person-first approach starts with the recognition that everyone is a person first. Everyone has multiple dimensions to their identity, and their impairment is only one component. A person-first approach hinges on a change in mindset, confronting the unconscious biases and legacies of ableist thinking that may influence individual decision-making and, ultimately, social and behaviour change.

The responsibility to take a person-first approach lies with each of us. To take a person-first approach means to internalize these changes and champion person-first ways of working. The shift in mindset facilitates a shift in the way programmes and services are delivered to children and youth with disabilities and their families, towards a focus on person-led or human-centred approaches. Programmes and services that take a person-first approach are:

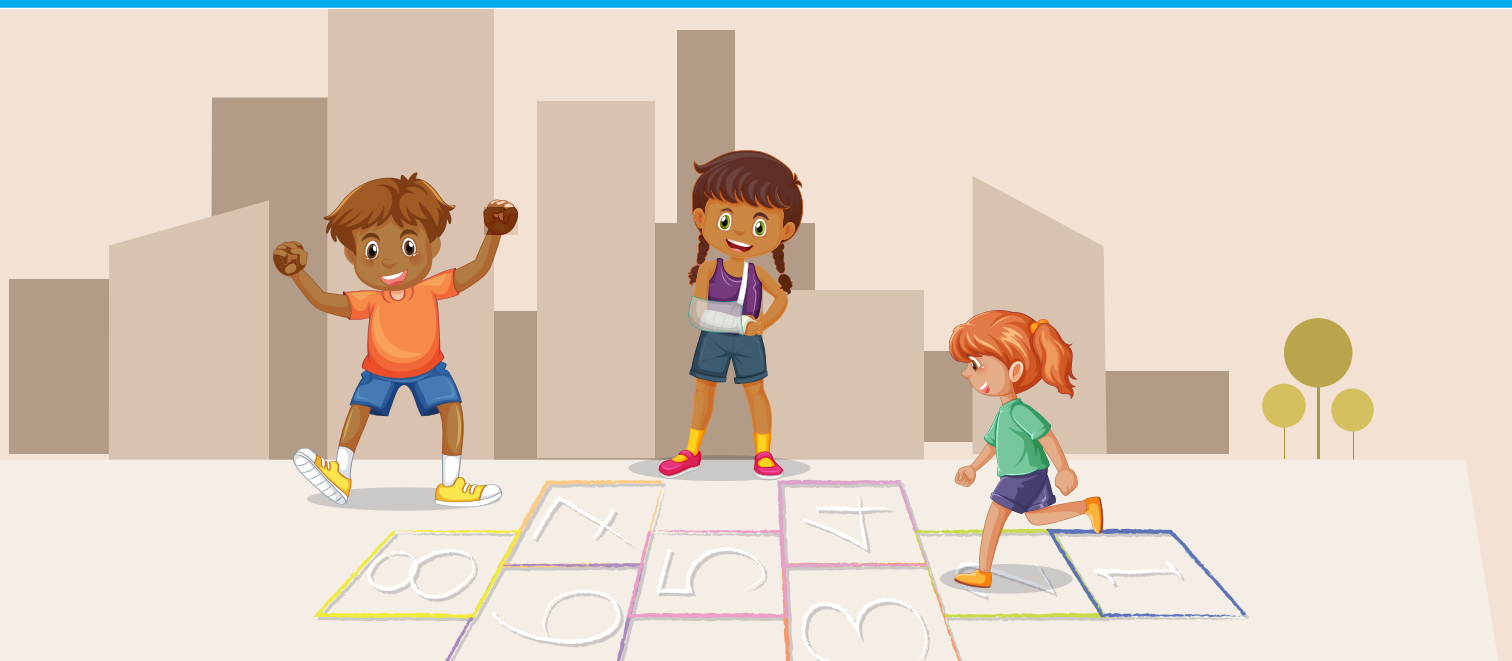
 **Intersectional** – recognizing the compounding impact of multiple marginalizing barriers. People may experience marginalization on account of disability, gender, race, sexual identity, ethnicity, culture, rurality and other factors relating to identity – and multiple forms of marginalization intersect to multiply the challenges they experience. For instance, the experiences of a girl from a rural community are profoundly different from those of an adult man from a city, even if they have the same impairments.

 **Empathy-led** – understanding stakeholders' pain points, emotions and motivations enables us to build empathy. We avoid blaming or finger-pointing, and invite all stakeholders to embrace a new way of working that's premised on empathy and person-first thinking. This, in turn, is key to sustainability.

 **Trans-sectoral** (multidisciplinary) – every sector is responsible for ensuring inclusive services, instead of shifting the responsibility to disability services or experts. For instance, policymakers from the education, health and social sectors need to work together to enable children with disabilities to be able to access education.

 Based on a **twin-track approach** – recognizing that general interventions may need to be complemented with specific interventions to address current inequalities. For example, the success of an SBC strategy to decrease stigma experienced by youth with disabilities seeking sexual and reproductive health services may require programmes to empower youth as advocates for inclusion.

Participatory and representative – ensuring that initiatives engage children and youth with disabilities and their families, and are planned with representation in mind – especially representation of the people who are the focus of the initiatives. For instance, a programme seeking to tackle stigma and discrimination against children with disabilities is not participatory if it engages only parents of children with disabilities, or only people of one gender or with one type of impairment.



WHO ARE CHILDREN WITH DISABILITIES?

This is the foundational module of this toolkit. It provides a basic understanding of disability, explains the concept of stigma and gives a rationale for our approach to this topic.

FACTS AND FIGURES

Fifteen per cent of the world's population – at least 1 billion people – have some form of disability, whether present at birth or acquired later in life. Nearly 240 million of them are children. Each has the right to be nurtured and supported through responsive care and education, to receive adequate nutrition and social protection, and to enjoy play and leisure time.

Too often, however, these rights are denied. The reasons vary: stigma, lack of accessible services, lack of access to assistive devices, physical barriers. When children with

disabilities are excluded from society, their chances to survive and thrive are diminished, as are their prospects for a bright future. But this can and must change.

Everyone with a disability is a person first. Children and adolescents with disabilities are a diverse group with wide-ranging life experiences. They live in every community, and are born with or acquire impairments that, in relation to their surroundings, lead to difficulties in functions like seeing, walking, communicating, caring for themselves or making friends.

The extent to which children with disabilities are able to function, participate and lead fulfilling lives depends on the extent to which the societies they live in are inclusive. The [Convention on the Rights of Persons with Disabilities](#) defines disability as a long-term physical, mental, intellectual or sensory impairment that – in interaction with the environment – hinders one’s participation in society on an equal basis with others.

This means that as societies remove barriers, people experience fewer functional limitations.

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- **Attitudinal barriers**, like stereotyping, low expectations, pity, condescension, harassment and bullying.
- **Policy barriers**, such as policies and laws that discriminate against people with disabilities, or the lack of legal frameworks for the fulfilment of equal rights.

Each of these barriers is rooted in stigma and discrimination that reflect negative perceptions associated with **ableism – a system of beliefs, norms and practices that devalues people with disabilities**. Because of ableism and the barriers that stem from it, children with disabilities are among the most marginalized people in every society.

In many parts of the world, we don’t consider low vision (near- or farsightedness) to be a disability. But imagine a young girl with low vision, but no access to eyeglasses – a vital assistive device, often taken for granted. At school, she has a hard time seeing the blackboard, or maybe she can’t read the text in books or on screens – and so she can’t keep up with the other students. She may drop out of school, because her environment does not enable her to exercise the same rights as other children.



A local stuttering myth exists in my community, and particularly in my family, that if a baby’s hair is cut too early after childbirth, that child will stutter...Others believed that I was tickled too much under my feet, resulting in my stutter. Throughout my childhood these myths were what I accepted as the cause of my stutter...

Yaaseen S. South Africa Youth Month: ‘My world in words’ | UCT News

KEY FRAMEWORKS RELATED TO THE RIGHTS OF CHILDREN WITH DISABILITIES

The three key treaties relevant to the rights of children with disabilities are:

- The Convention on the Rights of the Child (CRC), 1989.
- The Convention on the Rights of Persons with Disabilities (CRPD), 2006.
- The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), 1979.

Each treaty dovetails with, reinforces and elaborates on the others, and contributes to the goals of equality and inclusive development. Their interrelated nature was acknowledged in the Secretary General's Status Report and Omnibus Resolution on children with disabilities, adopted by the UN General Assembly in 2011. Together, they embody four core values of human rights law that are particularly important in the context of disability¹:

- The **dignity** of each individual. All people are of inestimable value because of their inherent self worth, not because they are economically or otherwise 'useful'.
- **Autonomy** or **self-determination**, based on the presumption of a capacity for self-directed action and behaviour, requiring that people be placed at the centre of all decisions affecting them.
- The inherent **equality** of all, regardless of difference.
- The principle of **solidarity**, which requires society to sustain the freedom of the person with appropriate social support.

Two articles of the CRC render children with disabilities visible and place explicit obligations on States to introduce measures to promote inclusion and freedom from discrimination.

- **Article 2** states that no child should encounter discrimination on the grounds of "race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status" The CRC was the first human rights treaty to include disability as a ground for protection from discrimination. It broke new ground in establishing the right to protection and obliging States to take all necessary measures to ensure that right for all children with disabilities.
- **Article 23** is dedicated to children with disabilities and emphasizes their right to a "full and decent life in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community." It obliges States to provide special care and assistance to enable the child to achieve the "fullest possible social integration and individual development, including his or her spiritual or cultural development."

The preamble of the CRPD recognizes that children with disabilities should have full enjoyment of all human rights on an equal basis with others. **Article 5** obliges States parties to prohibit all discrimination on the basis of disability and guarantee to people with disabilities equal and effective legal protection against discrimination on all grounds.

While many countries have registered progress in realizing the rights of people with disabilities, and 177 have ratified the CRPD, most children and adolescents with disabilities still experience stigma and ableism, along with their inevitable consequences – including a lack of access to services, a self-perceived inferiority and a lack of confidence that reinforces isolation and exclusion.

¹ UNICEF, 2019a.

UNDERSTANDING THE TRANSITION TO THE SOCIAL AND HUMAN RIGHTS MODELS OF DISABILITY

To understand the concept of stigma and the relevant social and behaviour change (SBC) approaches to combat it, it's important to grasp how disability models have evolved, and why some should not be used anymore.

Models of disability can be categorized into two main approaches: **individual approaches**, which see the person as having a problem, and **social approaches**, which see society as having a problem – that is, being unable to accommodate all people.

The four main models of disability are the **charity model**, the **medical model**, the **social model** and the **human rights model**. The first two are individual approaches. The other two are social approaches, focusing on external factors that need to be changed or adapted to create an enabling environment for people with disabilities.²

- The **charity model** views people with disabilities as victims of circumstances who deserve pity. This culture of 'care' can jeopardize the rights of people with disabilities, as it leads to medically classifying, segregating and institutionalizing them.
- The **medical model** sees disability as a health condition, an impairment located in the individual. It assumes that addressing the medical ailment will resolve the problem.

This model ignores the full spectrum of issues related to living with a disability, and sees people with disabilities as tragic.³

- The **social model** focuses on society as the source of the problem. Barriers – whether social, institutional, economic or political – exclude people with disabilities from full participation in society. The solution entails reforming society, removing barriers to participation, raising awareness and changing attitudes, practices and policies.
- The **rights-based model** is based on the social model and shares the premise that it is society that needs to change. This approach focuses on equity and rights, and looks to include all people equally within society – regardless of gender, age, background or any other characteristic. It sees people with disabilities as central actors in their own lives, as decision-makers, citizens and rights-holders. Like the social model, it seeks to transform unjust systems and practices.

While the charity and medical models are still used in some contexts, they are outdated and should no longer be applied, as they are not compliant with the CRPD. They have been superseded by the **social model** and the **rights-based model**, which aim to fulfill the rights of all people to participate in society.

² CBM, n.d.

³ Disabled World, 2023.

“ Before starting my university journey of self-discovery and advocacy, I struggled to accept and adapt to my disability and as a result I was bullied and mocked by classmates, and worst of all, by family members...Stuttering is an invisible disability. Unfortunately, this results in a generalization of disability, where unnoticeable disabilities like stuttering get isolated and ‘interiorized’, to the extent that one’s lived experiences are relegated in comparison to more noticeable disabilities

Yaaseen S. South Africa Youth Month: ‘My world in words’ | UCT News

STIGMA AND DISCRIMINATION AS KEY BARRIERS TO INCLUSION

Stigma and discrimination are some of the strongest determinants of children’s and adolescents’ development (WHO/UNICEF, 2012). Due to ableist assumptions, children with disabilities are often considered to be in need of ‘fixing’ and help, seen as less able to contribute and participate, less worthy of attention and having less inherent value than others.

Both children and adults with disabilities face discrimination based on multiple identities – not only disability, but also age, gender and other identities. Discrimination can occur within their communities, in families, and in services and systems. People with disabilities experience structural discrimination in areas including education, social protection and health.

Children who acquire disabilities early in life often contend with stigma throughout childhood. It is embedded in caregivers’ paternalistic attitudes, overprotective parenting, low expectations, ableism in schools and the widespread neglect of the

voices, needs and capacities of children with disabilities. It is the root of discriminatory and harmful practices such as school segregation, institutionalization and forced sterilization of children with disabilities.⁴

Addressing stigma and discrimination against children, adolescents and adults with disabilities require systematic, multi-level approaches. It entails addressing negative attitudes, harmful beliefs and norms, misconceptions and ableism in society – and empowering children and adults with disabilities, their families and organizations of persons with disabilities (OPDs) to demand their rights and participate in processes aiming to make policies, services and communities more inclusive.

SBC programming has a critically important and urgent role to play in identifying and implementing solutions that empower children with disabilities and their families, and support their social inclusion.

⁴ CBM, n.d. 2

DEFINING DISABILITY STIGMA

Ableism is stigma applied to people with disabilities. Broadly speaking, there are two types of stigma: **public stigma** and **self-stigma**.

Public stigma

Public stigma is a social process with three components: **stereotypes**, **prejudice** and **discrimination**.⁵

1. Stereotypes

Stereotypes are collectively held beliefs about members of a social group. They serve as efficient means of categorizing information, allowing people to quickly generate impressions and expectations of individuals who belong to a particular social group⁶. But these shortcuts can distort reality. Around the world, the most common stereotypes applied to people with disabilities are that they are **dangerous**⁷, **unpredictable** and **difficult**⁸, and **incompetent** (that is, unable to live their lives or work successfully).⁹

The literature on mental illness notes other common beliefs that stereotype people with disabilities – **blame**, **shame** and **curability**:

- In some cases, people are blamed for their own disabilities. People with mental illnesses are more likely to be blamed for their illness than those with physical

illnesses. There is a common belief that someone with a mental illness can ‘snap out of it’, or recover on their own, without treatment.

- Some people feel that a person with a mental illness should be ashamed.¹⁰
- A person with a mental illness may be seen as likely to recover – or not. Beliefs about curability relate to the perceived efficacy of the treatment someone receives, or the prognosis they can expect.¹¹

Stereotypical beliefs are linked to emotional reactions by the people who hold the stereotypes. With regard to people with mental illness, three types of emotional reactions to have been well studied: **fear**, **anger** and **pity**.¹²

- Someone who thinks that people with disabilities are dangerous and unpredictable is likely to feel fear.¹³
- Someone who thinks that people with disabilities are to blame for their disability is likely to feel like anger.¹⁴

Someone who thinks that people with disabilities are incompetent, shameful, blameless and not curable is likely to feel pity.¹⁵ While pity can lead to helping, which is a positive behaviour, it is still considered a negative emotion, because it stems from negative stereotypes.

⁵ Corrigan, 2000.

⁶ Augoustinos et al., 1994; Esses et al., 1994; Hamilton & Sherman, 1994; Hilton & von Hippel, 1996; Judd & Park, 1993; Krueger, 1996; Mullen et al., 1996.

⁷ Bos et al., 2013; Corrigan et al., 2003; Kobau et al., 2010; Angermeyer & Matschinger, 2003a, b; Van't Veer et al., 2006; Kermodé et al., 2009; Griffiths et al., 2006.

⁸ Angermeyer & Matschinger, 2003a, b; Crisp et al., 2000; Griffiths et al., 2006; Kermodé et al., 2009; Kobau et al., 2010; Krueger, 1996; Mullen et al., 1996.

⁹ Pescosolido et al., 1999; Cohen & Struening, 1962; Kermodé et al., 2009; Kobau et al., 2010; Pescosolido et al., 1996; Van't Veer et al., 2006.

¹⁰ Griffiths et al., 2006.

¹¹ Angermeyer & Matschinger, 2003a, b; Crisp et al., 2000; Kobau et al., 2010; Pescosolido et al., 1996, 2007.

¹² Angermeyer & Matschinger, 1997, 2003a, b; Corrigan, et al., 2003.

¹³ Angermeyer & Matschinger, 2003a, b; Martin et al., 2000; Pescosolido et al., 2007.

¹⁴ Angermeyer & Dietrich, 2006; Angermeyer & Matschinger, 2003a, b.

¹⁵ Bos et al., 2013; Yeh et al., 2017.

Disability is in the eyes of society. It is not in our eyes. If provided with opportunities, we can prove our worth.”

(Quotes from child with disability in Nepal)¹

2. Prejudice

Prejudice is a negative attitude towards a group of people.¹⁶ For example, some people believe that people with disabilities can't and shouldn't be included in society and services.

Prejudice results from endorsement of stereotypes, which generate negative emotional reactions. It can be implicit (unconscious) or explicit (conscious). When measuring attitudes, it is important to measure implicit ones, as they can significantly differ from explicit attitudes. For more information, see **Module 7: Monitoring, evaluating and measuring.**

3. Discrimination

Discrimination is a behavioural response towards a group, based on prejudice, that may result in harm towards members of that group.¹⁷ The main discriminatory behaviours towards people with disabilities are avoidance, coercion, segregation, hostile behaviors (e.g., physical harm or threats of harm) and withholding help.

To bring it all together, public stigma is a social process whereby people endorse a negative stereotype about other people, evoking a negative emotion and leading to prejudiced attitudes and discriminatory behaviours. There is a two-way relationship between these attitudes and behaviours – they reinforce each other. This process is visualized in Figure 1.

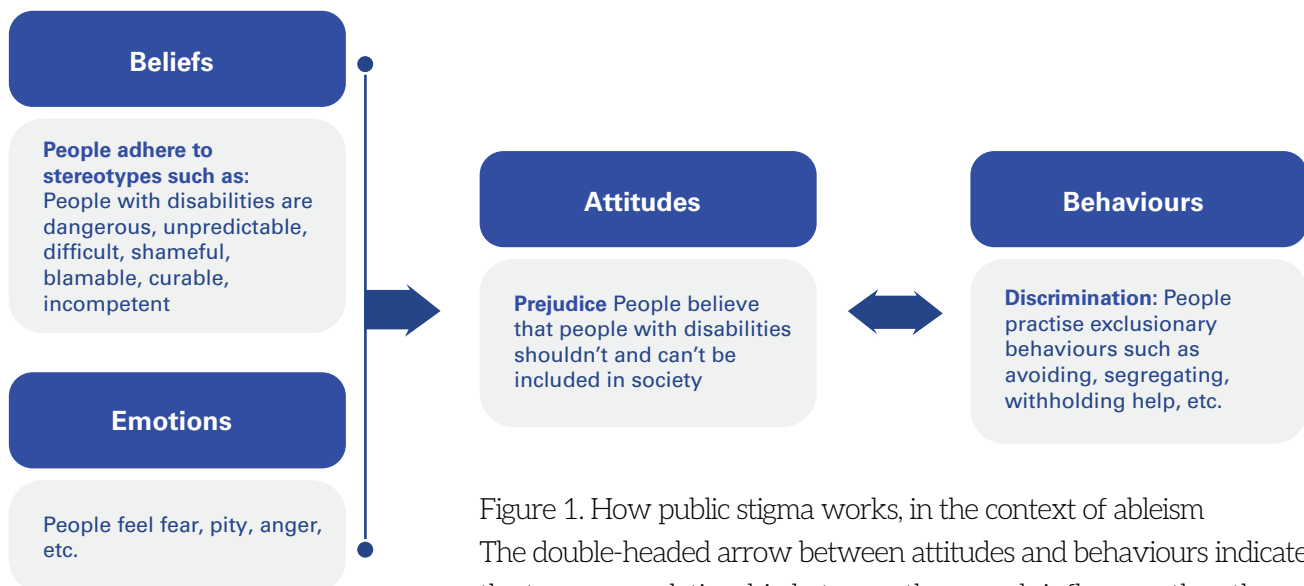


Figure 1. How public stigma works, in the context of ableism
The double-headed arrow between attitudes and behaviours indicates the two-way relationship between them: each influences the other.

Attribution theory, an important framework in psychology, notes that when people make attributions about the cause and controllability of a person's conditions, they make inferences about responsibility – which then can evoke emotional reactions that can translate into discriminatory behaviours.

¹⁶ Corrigan, 2000.

¹⁷ Crocker et al., 1998.

4. Self-stigma

Self-stigma is also referred to as internalized, experienced or anticipated stigma. Not all people in a stigmatized group develop self-stigma.¹⁸ **Module 2** provides insights and tools on how to prevent and decrease it.

Self-stigma occurs when people apply stereotypes to themselves, develop prejudices that are harmful to themselves and engage in self-discrimination.¹⁹ For example, someone may hold the self-stereotyping belief, “I am dangerous,” which evokes the emotion, “I am afraid of myself,” and leads them to self-isolate.

Self-stigma involves an interplay of stereotypes and emotions. When people internalize ableist stereotypes, they may feel negative emotions such as sadness, embarrassment or humiliation.²⁰ Low self-esteem, low self-efficacy and low self-worth are proven negative effects of internalizing stigma.²¹

People with disabilities may self-discriminate through secrecy or hiding – for instance, by concealing their disability from others.²² Another form of self-discrimination is self-imposed social isolation – avoiding interactions with other people.²³ Self-stigma is visualized in Figure 2.

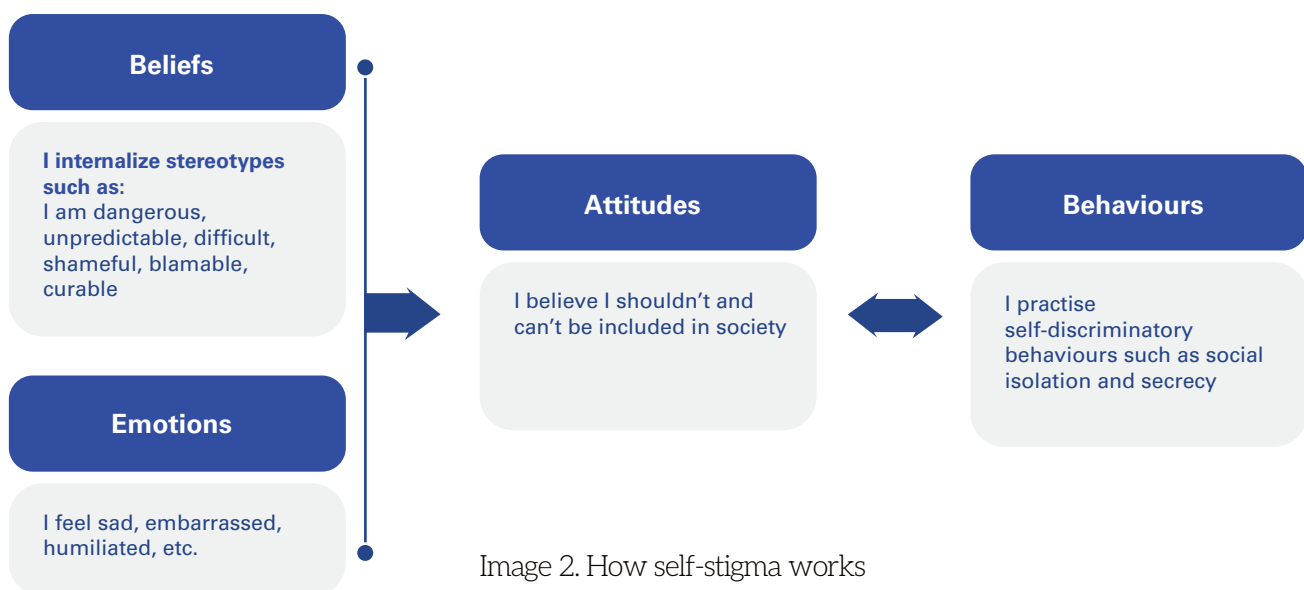


Image 2. How self-stigma works

¹⁸ Corrigan & Rao, 2012.

¹⁹ Corrigan et al., 2006.

²⁰ Griffiths et al., 2006; Parcesepe and Cabassa, 2013; Walker, et al., 2008.

²¹ Watson et al., 2007.

²² Link et al., 1997.

²³ Corrigan & Rao, 2012.



Regardless of our recommendation if the people don't understand, it will not get anywhere. Therefore, I recommend awareness, awareness to our public, our education system, our traditional leaders, and our churches. Awareness is the key to getting people to understand the situation and act for its improvement in society.

Rosalyn A, Ghana

THE ROLE OF SBC IN ADDRESSING DISABILITY STIGMA

SBC approaches aims to empower individuals and communities, and to lower structural barriers that hinder people from adopting positive practices and prevent societies from becoming more equitable, inclusive, cohesive and peaceful.

Drawing on disciplines including sociology, psychology, communication and behavioural economics, SBC encompasses strategies and interventions that influence drivers of individual and social change and support local action towards better societies. It helps development practitioners and policymakers design more effective programmes for reducing poverty and inequity. And it blends scientific knowledge with community insights – its most important element – to expand people's control over the decisions that affect their lives. SBC is a key component of UNICEF's work towards the Sustainable Development Goals.

SBC practitioners use research and evidence to design programmes that can respond to pressing issues in the places UNICEF works, including to reduce stigma and discrimination and promote the inclusion of children with disabilities. This toolkit

introduces tools, approaches and methods that SBC practitioners can apply to influence people and societies toward greater inclusion.

WHY DOES STIGMA EXIST? DEVELOPING A THEORY OF CHANGE

A theory of change (TOC) is the cornerstone of any evidence-based programme to target stigma. It has two parts: a **problem analysis** and a **solution analysis**. The first identifies the drivers of the problem, while the second proposes solutions through which the programme will address each of these drivers. Practitioners can refer to the example TOC below when building TOCs tailored to their own contexts.

Problem analysis for stigma

In the case of disability stigma, the behavioural problem is that **people discriminate against people with disabilities**. According to the [UNICEF Behavioural Drivers Model](#), every behavioural problem has three main categories of drivers: **psychological**, **sociological** and **environmental**.²⁴

24 Petit, 2019.



Figure 3. Psychological, sociological and environmental drivers of disability stigma

► **PSYCHOLOGICAL DRIVERS**

Psychological drivers involve the cognitions and emotions of individuals.²⁵ Disability stigma has three main psychological drivers: **attitudes, self-efficacy and interest.**

But why do people adhere to negative stereotypes and have the negative emotions associated with them? And what other drivers might affect attitudes? Research has shown that **intergroup contact** and **knowledge**, among other factors, can influence stereotypes and associated emotions, while **values** also affect attitudes.

● **Attitudes**

People discriminate because they hold prejudicial attitudes (as seen in Figure 1). They have prejudicial attitudes because they adhere to negative stereotypes that are associated with negative emotions.



25 Petit, 2019.

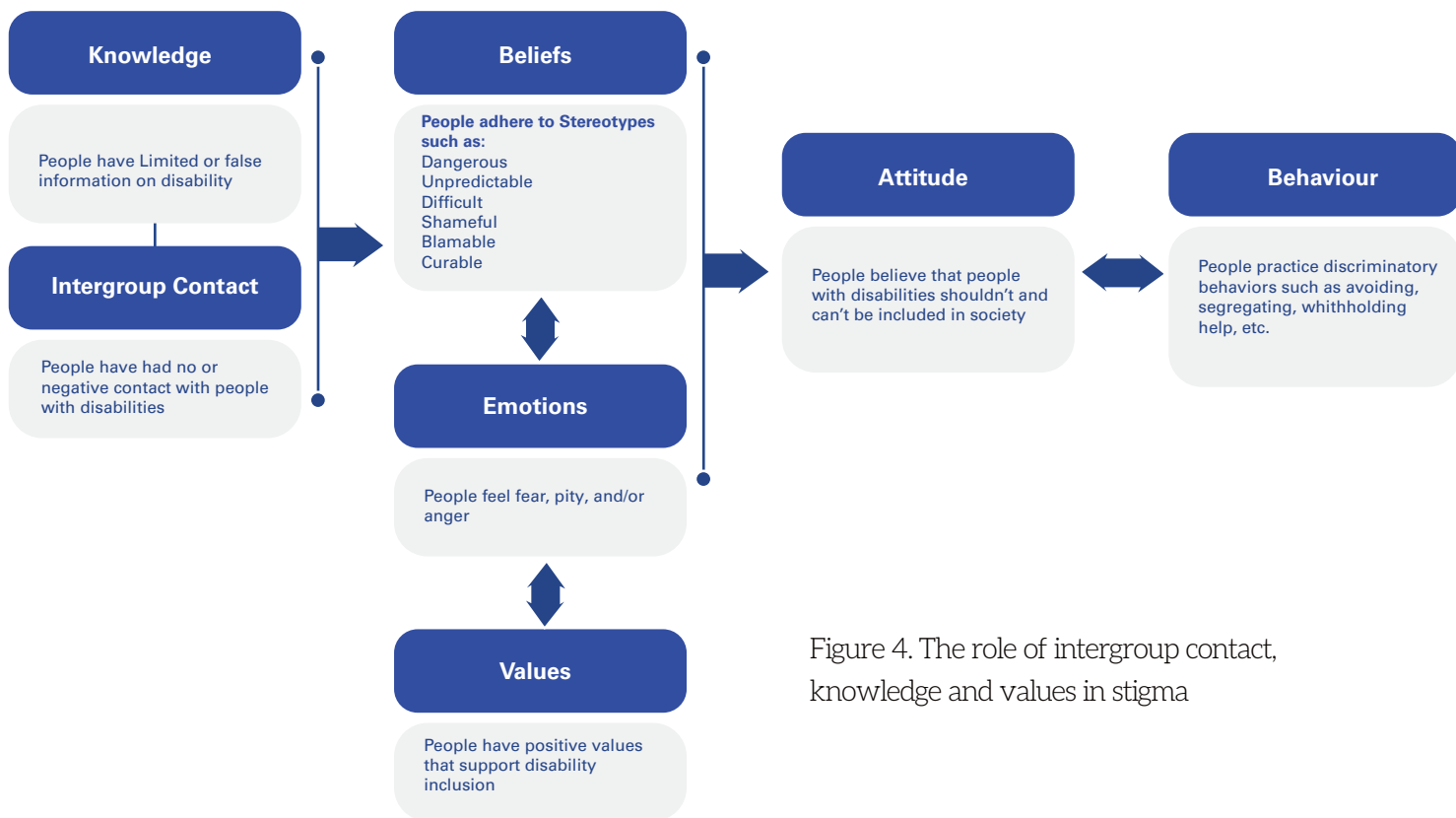


Figure 4. The role of intergroup contact, knowledge and values in stigma

● Intergroup contact

There is evidence that interventions involving contact between people with and without disabilities can have an impact on stigma.²⁶ This is in line with the intergroup contact hypothesis, initially proposed by G. W. Allport.²⁷

For contact to reduce stigma, however, certain criteria need to be met – otherwise, contact can have a negative effect on attitudes. The criteria are:

- Equal status
- Intergroup cooperation
- Common goals
- Support by social and institutional authorities.



²⁶ Armorer Wason, et al., 2020.

²⁷ Allport, 1954.

Among children, there are additional conditions for intergroup contact to have a positive impact. According to UNICEF's *Towards a Child-Led Definition of Social Cohesion*, these include the following:²⁸

- They feel consulted, listened to and understood.
- They have good relationships with adults.
- They are treated equally.
- Friends are present.
- Trust is present both between children and adults, and among the children.
- They have and understand clear structures of help.
- They have freedom of expression and participation.
- Everyone is included in activities.
- There is no violence or bullying, either by adults or by other children.
- Where there is no contact or negative contact between people with and without disabilities, people are more likely to have negative emotions and adhere to stereotypes.

● Knowledge

Providing accurate information can help break down stereotypes on disability – but by themselves, educational programmes aren't sufficient.²⁹

● Values

Values are enduring beliefs about what is desirable, important and morally right.³⁰

Examples of values that support disability inclusion include inclusivity, fairness, respect and social responsibility.

Values serve as guiding principles for evaluating and forming attitudes.³¹ To understand why people hold particular values – and may not hold the inclusion-supporting values enumerated above – we need to consider sociological and environmental drivers, because personal values are shaped by moral norms, and moral development is also shaped by education. These will be discussed below.

● Self-efficacy

Self-efficacy is an individual's belief in their own capabilities to successfully perform specific tasks or accomplish goals.³² If someone doesn't believe in their own capacity to include people with disabilities, they won't practice inclusion.

Two main factors contribute to a lack of self-efficacy. First, people may not have the skills for disability inclusion. Second, developing skills takes rehearsal and practice – and often, people have neither rehearsed nor put into practice their skills for disability inclusion.³³

● Interest

Lack of interest in disability inclusion is another psychological driver of prejudicial attitudes. When people become engaged and invested in a topic, their acquired knowledge, experience and exposure to it can shape their attitudes.³⁴

Why aren't people interested in disability inclusion? The **effort** needed and the **perceived gains and avoided losses** of practising disability-inclusive behaviours play a role.

²⁸ UNICEF, 2019b.

²⁹ Corrigan, P.W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, 1(1), 16–20.

³⁰ Fishbein & Ajzen, 1975; Rokeach, 1973.

³¹ Schwartz, 1992, 1994.

³² Bandura, 1977a.

³³ Fazio & Olsen, 2007; Fazio et al., 1982.

³⁴ Hidi & Renninger, 2006.

● Effort

When the effort required to learn something or practise a new behaviour is perceived as excessive, people may experience a decline in interest.³⁵ People may perceive that being inclusive requires too much effort, especially if they believe that people with disabilities are difficult.

● Perceived gains and avoided losses

Interest and willingness to engage in a behaviour depends on what people think they will get out of it – whether it is a potential gain or an avoided loss.³⁶ Potential gains and avoided losses perceived by people who discriminate include **enjoyment**,³⁷ **perceived risk**³⁸ and **reinforcement** (seeking a reward).³⁹ People may perceive that engaging with people with disabilities isn't enjoyable, especially if they believe that people with disabilities are dangerous or difficult. Someone who views people with disabilities as dangerous would probably avoid engaging with them. It is also possible that people don't act inclusively because they aren't rewarded for it.

▶ SOCIOLOGICAL DRIVERS

Sociological drivers are determinants related to interactions within families, communities, groups and society at large.⁴⁰ Three main sociological drivers are involved in disability stigma: **social learning**, **social norms** and **demand through social movements**.

● Social learning

People acquire new behaviours and beliefs by observing and imitating others within their social environment.⁴¹ We learn discriminatory behaviours by seeing others discriminate.

³⁵ Fredricks et al., 2011.

³⁶ Ames & Archer, 1988; Wigfield & Eccles, 2000; Kahneman & Tversky, 1979; Linnenbrink-Garcia et al., 2010.

³⁷ Harackiewicz et al., 2008.

³⁸ Elliot & Church, 1997.

In communities where established social norms support discriminatory behaviours, these norms may be challenged by identifying and promoting **positive deviants** – people who do practise inclusive behaviours.

In this problem analysis, we assume that there are not enough visible positive deviants who display inclusive behaviours that others can learn from.

● Social norms

Negative social norms that contribute to the exclusion of people with disabilities also drive discriminatory behaviours.

One reason negative norms exist is the lack of positive deviants. People tend not to go against negative norms that prevail in their communities, because they fear negative social consequences. **Outcome expectancies** play a central role in whether someone is willing to violate what they perceive as an established norm.

● Demand through social movements

One of the reasons an inclusive environment does not exist is that there is not enough demand for it.

Social movements provide an organized, collective platform through which individuals can effectively and persistently voice their demands. According to the evidence-based Contentious Politics framework, social movements are organized efforts by groups of individuals who come together to pursue common goals, challenge existing power structures and engage in sustained interactions with authorities.⁴²

³⁹ Eccles & Wigfield, 2002.

⁴⁰ Petit, 2019.

⁴¹ Bandura, 1977b; Bandura & NIMH, 1986.

⁴² Tilly, 2004.

Charles Tilly proposed four concepts to explain the dynamics that drive people’s involvement in collective action: **worthiness**, **unity**, **numbers** and **commitment** (WUNC).

- **Worthiness** refers to the perception that a cause is morally just and deserves support. It helps individuals connect their personal beliefs to a broader collective effort. People are more likely to get involved in a movement when they believe that its goals align with their own values and principles.
- **Unity** refers to the sense of belonging and solidarity that individuals experience when they join a social movement. The social ties formed within the movement create a supportive environment and encourage sustained involvement.

- Collective action is more effective when there is a critical mass of participants. When people see that significant **numbers** of people are participating in a movement, it signals to them that the cause has widespread support and can achieve impact – and this can motivate them to join.
- **Commitment** denotes dedication and sustained engagement in work towards the movement’s goals. High levels of commitment are often associated with increased willingness to invest time, effort and resources, even in the face of challenges.

Social movements have played a key role in advancing disability rights, and these movements need to be strengthened in different country contexts.

In this problem analysis, we assume that the social movement in a specific country context is weak, as illustrated in Figure 5.

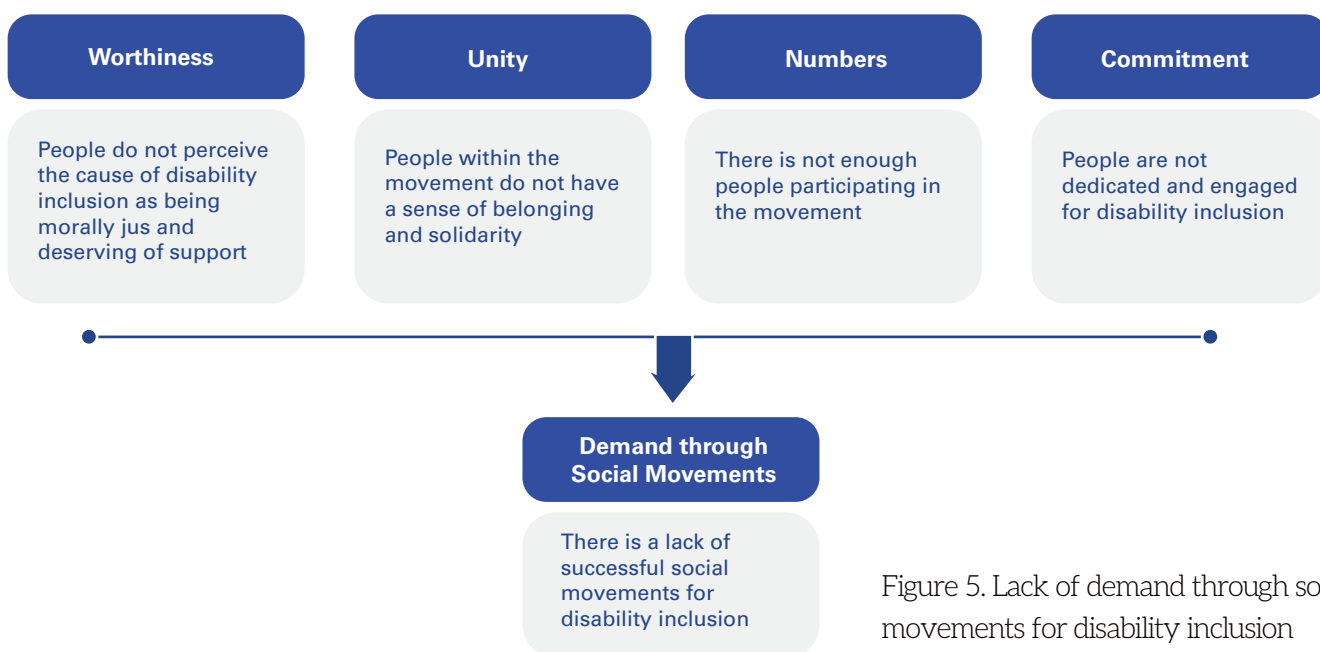


Figure 5. Lack of demand through social movements for disability inclusion

▶ ENVIRONMENTAL DRIVERS

Environmental drivers pertain to elements such as institutions, policies, systems and services, infrastructure and information.⁴³ Three elements play a critical role in determining the extent to which environments are inclusive of people with disabilities: the **structural environment**, the **communication environment** and **moral development in schools**.

When practitioners develop their context-specific ToCs, they must specify the spaces they are focusing on – for instance, schools, public gardens or community health centres.

● Structural environment

The structural environment includes organizations, institutions, facilities and other spaces. The lack of inclusive spaces influences how people behave, limiting positive intergroup contact between people and decreasing social learning.

When an environment is not disability-inclusive, it is usually because of four main factors:

- **Accessibility:** The environment is not physically accessible for all people.
- **Self-efficacy:** The staff do not have the self-efficacy to provide disability-inclusive services.
- **Human resources:** There are not enough staff to provide an inclusive, safe space.
- **Institutional policies and procedures:** Well thought-out disability-inclusive policies and procedures are not in place.

There are two environmental reasons why these elements may not be in place:

- **National policies and procedures:** National disability policies and procedures do not enforce disability-inclusive standards and requirements.
- **Funding:** Lack of financial resources is a barrier for an inclusive structural environment.

Psychological, sociological and environmental drivers are very intertwined – so in addition to these environmental drivers, other drivers may play a role in determining the degree to which the structural environment is inclusive of people with disabilities. These may include psychological drivers – the attitudes, self-efficacy and interest of institutional staff, policymakers and other stakeholders – as well as sociological drivers like demand.

● Communication environment

The communication environment comprises the information, opinions, arguments and stories we are exposed to, which play a significant role in shaping our attitudes, interests and behaviours. Multiple channels and sources shape this environment – not only mass and social media, but also sources like the movies we watch, the songs we listen to and the word on the street.⁴⁴

⁴³ Petit, 2019.

⁴⁴ Petit, 2019.

The communication environment can play a critical role in reducing stigma associated with disabilities by:

- Facilitating the dissemination of accurate information,⁴⁵ especially because in many countries, people rely on media to obtain information on disability.
- Promoting virtual intergroup contact, through online platforms or social media.⁴⁶
- Fostering social learning.⁴⁷

The availability of disability-inclusive communication materials influences the inclusiveness of the communication environment. There are many reasons why disability-inclusive communication materials may not be produced, depending on the country context. Practitioners are encouraged to specify these in their TOCs.

● Moral development in schools

Formal education plays a crucial role in the moral development of individuals.⁴⁸ Two main factors contribute to the failure to impart inclusive values:

- School **curricula** do not teach students about disability inclusion.
- Teachers do not have the **self-efficacy** to teach and practice inclusive behaviours and values.

● Solution analysis for stigma

The solution analysis articulates the results your programme aims to achieve and the changes it aims to contribute to – formulated as **outputs** and **outcomes**.

To develop the solution analysis, simply flip all the drivers from the problem analysis from negative to positive. For example:

Problem statement (behaviours) : **People discriminate against people with disabilities.**

becomes

Solution statement (behaviour): **People practise inclusive behaviours towards people with disabilities.**

Negative driver (attitude): **People believe that people with disabilities shouldn't and can't be included in society and services.**

becomes

Positive driver (attitude): **People believe that people with disabilities should and can be included in society and services.**

The solution analysis of the TOC forms the basis for developing a monitoring framework, using the defined outputs and outcomes. Module 7 provides guidance for creating a monitoring framework, and provides the monitoring framework for this example TOC.

The full solution analysis can be found on page 14.

⁴⁵ Corrigan & Watson, 2007

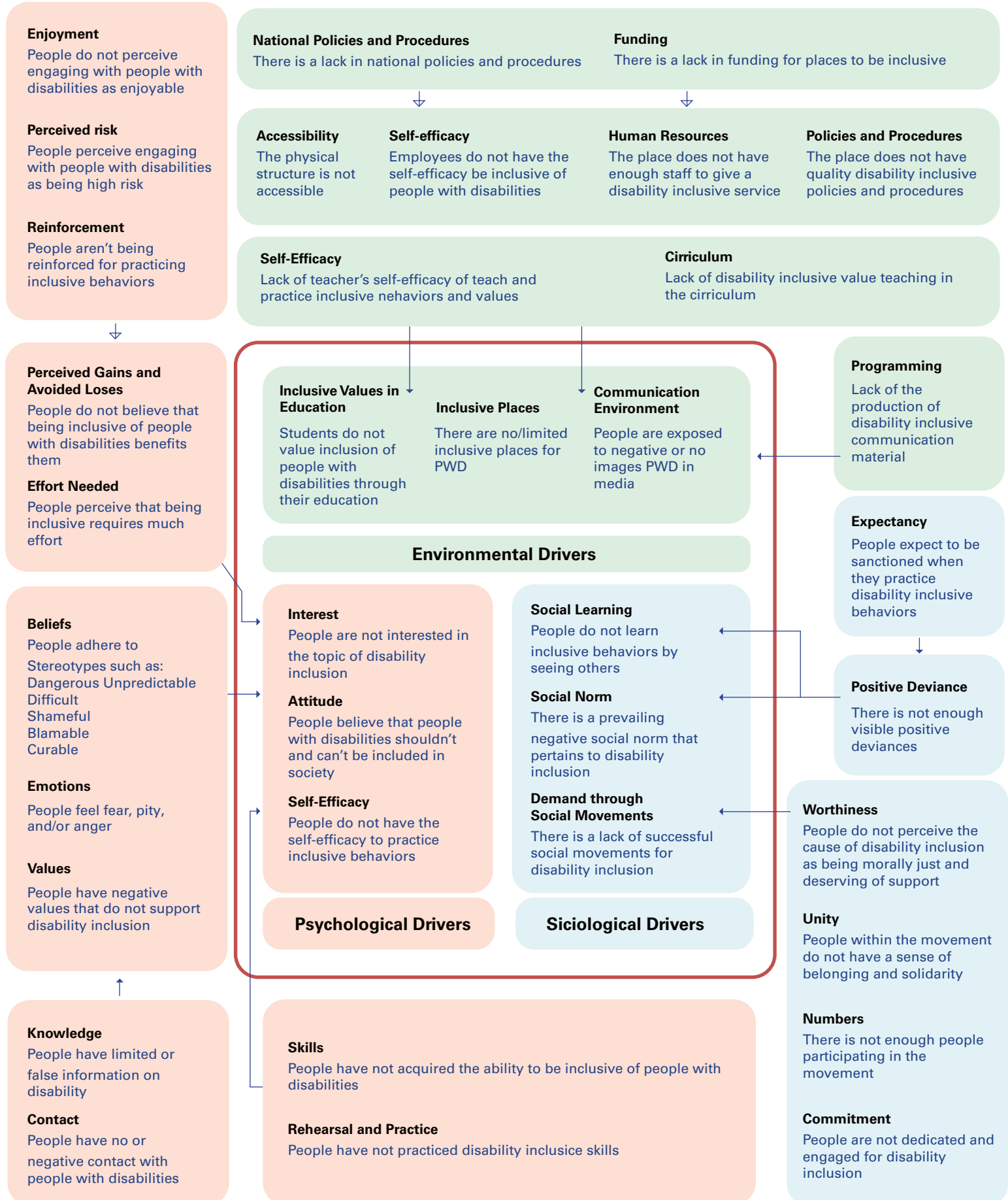
⁴⁶ Paolini et al., 2010.

⁴⁷ Gibson & Pettigrew, 2012.

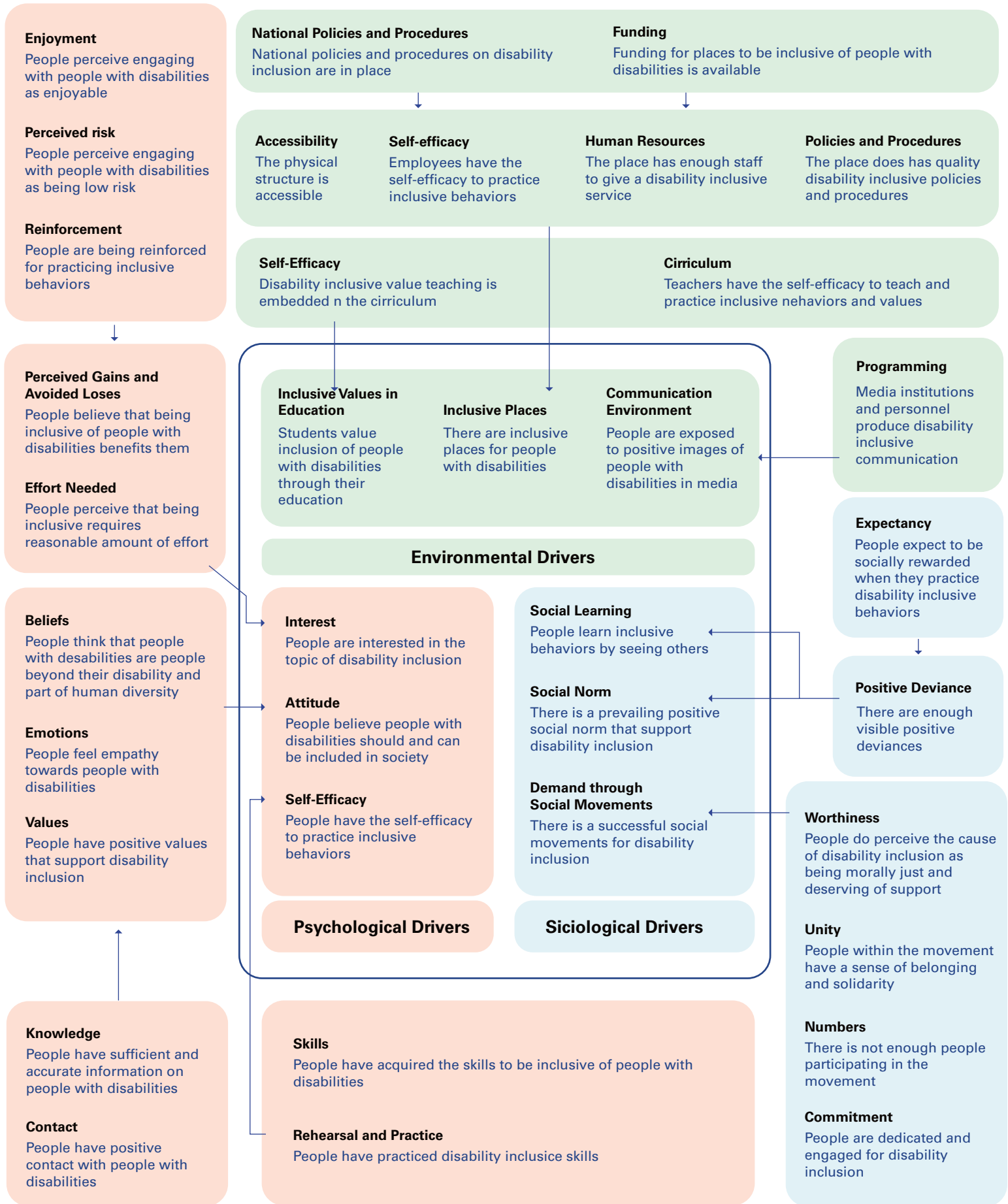
⁴⁸ Berkowitz and Bier, 2004; Nucci, 2001.

THEORY OF CHANGE

PEOPLE PRACTICE DISCRIMINATORY BEHAVIORS TOWARDS PEOPLE WITH DISABILITIES



PEOPLE PRACTICE DISABILITY INCLUSIVE BEHAVIORS



TOOLS

- [Terminology Cheat Sheet](#) covers concepts including the person-first approach, meaningful participation, intersectionality, the twin-track approach, trans-sectoral and empathy-led approach.
- [Intersectionality Resource Guide and Kit: An intersectional approach to Leave No One Behind](#) offers a starting point for those wishing to deepen their understanding of intersectionality and apply an intersectional approach to their work. It aims to provide conceptual clarity, a practical framework and tools for reducing compounded and intersecting inequalities faced by people experiencing diverse and compounded forms of discrimination.
- [Tips on Communicating with Children and Adolescents with Disabilities](#), and [Dos and Don'ts: Disability etiquette](#) also offers important notes, while [Communicating with Children with Disability](#) includes a practice example.
- [Person-First Approach Checklist](#) is a tool to help practitioners apply the four basic steps to applying the person-first approach in all programme design, delivery, monitoring and evaluation activities, whether disability-specific or not.
- [Mythbuster Activity: Tackling ableism](#) can help individuals and organizations reflect on common beliefs and myths, exploring the extent to which they exist within their work, strategic or cultural contexts. Mythbusting encourages introspection and critical thinking, to challenge myths in a thoughtful and responsible way.
- [Check Yourself: What would you do?](#) helps any practitioner who is starting to work on disability inclusion to check their implicit biases. It is designed as a self-assessment followed by a plenary discussion, and can be used in group sessions for frontline workers in the field. It walks participants through scenario-based worksheets, and helps identify responses influenced by stereotypes and biases about people with disabilities – versus objective facts, evidence and actual experience.
- [Toolkit on Disability for Africa: Culture, beliefs and disability](#), developed by the UN Division for Social Policy Development, examines different stereotypes of disability held in different African countries.

REFERENCES

Ajzen, I. (2005). Attitudes, personality, and behavior. McGraw-Hill Education

Allport, G. W. (1954). The nature of prejudice. Reading, MA: Addison-Wesley.

Ames, C., & Archer, J. (1988). Achievement goals in the classroom: Students' learning strategies and motivation processes. *Journal of Educational Psychology*, 80(3), 260–267.

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: A review of population studies. *Acta Psychiatr Scand*, 113(3), 163-179.
doi.org/10.1111/j.1600-0447.2005.00699.x

- Angermeyer, M. C., & Matschinger, H. (1997). Social distance towards the mentally ill: Results of representative surveys in the Federal Republic of Germany. *Psychological Medicine*, 27(1), 131–141. doi.org/10.1017/S0033291796004205
- Angermeyer, M. C., & Matschinger, H. (2003a), Public beliefs about schizophrenia and depression: Similarities and differences, *Social Psychiatry and Psychiatric Epidemiology*, 38 (9), 526-34.
- Angermeyer, M. C., & Matschinger, H. (2003b), The stigma of mental illness: Effects of labelling on public attitudes towards people with mental disorder, *Acta Psychiatrica Scandinavica*, 108 (4), 304-09.
- Armorer Wason, A., et al. (2020). Social and behavioural change interventions to strengthen disability-inclusive programming: A synthesis of the evidence. UNICEF.
- Augoustinos, M., et al. (1994). Stereotypes and prejudice: The Australian experience. *British Journal of Social Psychology*, 33(1), 125.
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84(2), 191-215. doi: 10.1037/0033-295X.84.2.191
- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. Freeman.
- Bandura, A., & National Institute of Mental Health. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice-Hall, Inc.
- Baumeister, R. F., et al. (2007). *Losing control: How and why people fail at self-regulation*. Academic Press.
- Becker, L. J., & Seligman, C. (1981). Fears and losses that motivate behavior. *Motivation and Emotion*, 5(3), 231–240.
- Berkowitz, M. W., & Bier, M. C. (2004). *What works in character education: A research-driven guide for educators*. Character Education Partnership.
- Bos, Aijan E. R., et al. (2013). Stigma: Advances in theory and research, *Basic and Applied Social Psychology*, 35 (1), 1-9.
- Carver, C. S., & Scheier, M. F. (1998). *On the self-regulation of behavior*. Cambridge University Press.
- CBM (n.d.). What are models of disability?. <https://participation.cbm.org/why/disability-participation/models-of-disability>
- Charlesworth, T. E., & Banaji, M. R. (2019). Patterns of implicit and explicit attitudes: Long-term change and stability from 2007 to 2016. *Psychological Science*, 30(2), 174–192. doi.org/10.1177/0956797618813087

- Cohen, J., & Struening, E. L. (1962), Opinions about mental illness in the personnel of two large mental hospitals. *Journal of Abnormal and Social Psychology*, 64 (5), 349-60.
- Corrigan, P.W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice*, 7(1), 48–67.
doi.org/10.1093/clipsy.7.1.48
- Corrigan, P.W., et al. (2003), An attribution model of public discrimination towards persons with mental illness, *Journal of Health and Social Behavior*, 44 (2), 162-79.
- Corrigan, P.W., et al. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social & Clinical Psychology*, 25(9), 875–884. Retrieved from Google Scholar.
- Corrigan, P.W., et al. (2009), The public stigma of mental illness and drug addiction, *Journal of Social Work*, 9 (2), 139-47.
- Corrigan, P.W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, 54, 765-776.
- Corrigan, P.W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *The Canadian Journal of Psychiatry*, 57(8), 464–469.
doi.org/10.1177/070674371205700804
- Corrigan, P.W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, 9(1), 35–53. doi.org/10.1093/clipsy.9.1.35
- Corrigan, P.W., & Watson, A. C. (2007). The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver. *Community Mental Health Journal*, 43(5), 439-458.
- Crisp, A. H., et al. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, 177 (1), 4-7.
- Crocker, J., et al. (1998). Social stigma. In D.T. Gilbert, S.T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., Vol. 2, pp. 504–553). McGraw-Hill.
- Csikszentmihalyi, M. (1990). *Flow: The psychology of optimal experience*. Harper & Row.
- Deci, E. L., & Ryan, R. M. (1985). *Autonomy and control: Intrinsic motivation and self-determination in human behavior*. Plenum Press.
- Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. Springer.
- Deci, E. L., & Ryan, R. M. (2000). The ‘what’ and ‘why’ of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*, 11(4), 227–268.
- Diani, M. (2017). *Social movements: An introduction* (3rd ed.). Wiley.

Disabled World (2023). Models of disability: Types and definitions.
<https://www.disabled-world.com/definitions/disability-models.php>

Eagly, A. H., & Chaiken, S. (1993). *The psychology of attitudes*. Harcourt Brace Jovanovich College Publishers.

Eccles, J. S., et al. (1983). Expectancies, values, and academic behaviors. In J.T. Spence (Ed.), *Achievement and achievement motives: Psychological and sociological approaches* (pp. 75–146). W.H. Freeman.

Eccles, J. S., & Wigfield, A. (2002). Motivational beliefs, values, and goals. *Annual Review of Psychology*, 53(1), 109–132. doi.org/10.1146/annurev.psych.53.100901.135153

Elliot, A. J., & Church, M. A. (1997). A hierarchical model of approach and avoidance achievement motivation. *Journal of Personality and Social Psychology*, 72(1), 218–232.

Elliot, A. J., & Harackiewicz, J. M. (1996). Approach and avoidance achievement goals and intrinsic motivation: A mediational analysis. *Journal of Personality and Social Psychology*, 70(3), 461–475.

Esses, V. M., et al. (1994). The role of mood in the expression of intergroup stereotypes. In M. P. Zanna & J. M. Olson (Eds.), *The psychology of prejudice: The Ontario symposium, Vol. 7* (pp. 77-101). Hillsdale, NJ: Lawrence Erlbaum Associates.

Evans-Lacko, S., et al. (2013). Public knowledge, attitudes, and behaviour regarding people with mental illness in England 2009-2012. *British Journal of Psychiatry*, 202 (S55), S51-57.

Fazio, R. H., et al. (1982). The feature-positive effect in the self-perception process: Does not doing matter as much as doing? *Journal of Personality and Social Psychology*, 42(3), 404–411. doi.org/10.1037/0022-3514.42.3.404

Fazio, R. H., & Olson, A. (2007). Attitudes. In M. A. Hogg & J. Cooper (Eds.), *The Sage handbook of social psychology (concise 2nd ed.)*. Sage.

Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research*. Addison-Wesley.

Fredricks, J. A., et al. (2011). School engagement: Potential of the concept, state of the evidence. *Review of Educational Research*, 74(1), 59–109.

Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist*, 56(3), 218–226.

Gibson, B., & Pettigrew, T. F. (2012). Longitudinal effects of protracted contact: A 12-month intervention with people with intellectual disabilities. *Journal of Applied Social Psychology*, 42(12), 2981-2998.

Griffiths, K. M., et al. (2006). Stigma in response to mental disorders: A Comparison of Australia and Japan. *BMC Psychiatry*, 6 (1), 1-10.

Hamilton, D. L., & Sherman, J. W. (1994). Stereotypes. In R. S. Wyer, Jr., & T. K. Srull (Eds.), *Handbook of social cognition: Basic processes; Applications* (1–68). Lawrence Erlbaum Associates, Inc.

Harackiewicz, J. M., et al. (2008). Short-term and long-term consequences of achievement goals: Predicting interest and performance over time. *Journal of Educational Psychology*, 100(2), 361–378.

Harackiewicz, J. M., & Sansone, C. (1991). Goals and intrinsic motivation: You can get there from here. In M. L. Maehr & P. R. Pintrich (Eds.), *Advances in motivation and achievement* (Vol. 7, pp. 21–49). JAI Press.

Hidi, S., & Renninger, K. A. (2006). The four-phase model of interest development. *Educational Psychologist*, 41(2), 111–127.

Higgins, E. T. (1997). Beyond pleasure and pain. *American Psychologist*, 52(12), 1280–1300.

Hilton, J. L., & von Hippel, W. (1996). Stereotypes. *Annual Review of Psychology*, 47, 237–271.

Hollenbeck, J. R., et al. (2002). An empirical examination of the antecedents of commitment to difficult goals. *Journal of Applied Psychology*, 87(4), 687–696.

Judd, C. M., & Park, B. (1993). Definition and assessment of accuracy in stereotypes. *Psychological Review*, 100, 109–128.

Kahneman, D., & Tversky, A. (1979). Prospect theory: An analysis of decision under risk. *Econometrica*, 47(2), 263–291.

Kermode, M., et al. (2009). Attitudes to people with mental disorders: A mental health literacy survey in a rural area of Maharashtra, India. *Social Psychiatry and Psychiatric Epidemiology*, 44 (12), 1087–96.

Kobau, R., et al. (2010). Attitudes about mental illness and its treatment: Validation of a generic scale for public health surveillance of mental illness associated stigma. *Community Mental Health Journal*, 46 (2), 164–76.

Krueger, J. (1996). Personal beliefs and cultural stereotypes about racial characteristics. *Journal of Personality & Social Psychology*, 71, 536–548.

Levine, M. (2016). *Positive deviance: How to ignite and sustain positive deviant performance*. Routledge.

Link, B. G., et al. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior*, 38(2), 177–190.

Link, B. G., et al. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin*, 30 (3), 511–41.

Linnenbrink-Garcia, L., et al. (2010). Adaptive motivation and emotion in education: Research and principles for instructional design. *Review of Research in Education*, 34(1), 297–326.

Locke, E. A., & Latham, G. P. (2006). New directions in goal-setting theory. *Current Directions in Psychological Science*, 15(5), 265–268.

Loewenstein, G. (1994). The psychology of curiosity: A review and reinterpretation. *Psychological Bulletin*, 116(1), 75–98.

Martin, J. K., et al. (2000). Of fear and loathing: The role of “disturbing behavior,” labels, and causal attributions in shaping public attitudes toward people with mental illness. *Journal of Health and Social Behavior*, 41(2), 208–223. doi.org/10.2307/2676306

McAdam, D., et al. (2018). *Dynamics of contention*. Cambridge University Press.

Mullen, B., et al. (1996). The phenomenology of being in a group: Complexity approaches to operationalizing cognitive representation. In J. Nye & A. M. Brower (Eds.), *What’s social about social cognition? Research on socially shared cognition in small groups* (pp. 205-229). Sage Publications.

Nucci, L. P. (2001). *Education in the moral domain*. Cambridge University Press.

Oxford University Press. Skill. (2021). In *Oxford English Dictionary*.

Paolini, S., et al. (2010). Negative intergroup contact makes group memberships salient: Explaining why intergroup conflict endures. *Personality and Social Psychology Bulletin*, 36(12), 1723-1738.

Parcesepe, A. M., & Cabassa, L. J. (2013), Public stigma of mental illness in the United States: A systematic literature review, *Administration and Policy in Mental Health*, 40 (5), 384-99.

Pescosolido, B. A., et al. (1996), *Americans’ view of mental health and illness at century’s end: Continuity and change*. Bloomington: Indiana University.

Pescosolido, B. A., et al. (1999), The public’s view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *American Journal of Public Health*, 89 (9), 1339-45.

Pescosolido, B. A., et al. (2007), Perceived dangerousness of children with mental health problems and support for coerced treatment. *Psychiatric Services*, 58 (5), 619-25.

Petit, V. (2019). *The behavioural drivers model: A conceptual framework for social and behaviour change programming*. UNICEF.

Polletta, F., & Jasper, J. M. (2001). Collective identity and social movements. *Annual Review of Sociology*, 27, 283-305.

Rao, D., et al. (2019). From advocates to activists: Strategies for engaging psychiatrists in social change. *Psychiatric Services*, 70(10), 899-901. doi:10.1176/appi.ps.201900170

Renninger, K. A., et al. (2004). *The role of interest in learning and development*. Lawrence Erlbaum Associates.

Rokeach, M. (1973). *The nature of human values*. The Free Press.

Ryan, R. M., & Deci, E. L. (2000). Intrinsic and extrinsic motivations: Classic definitions and new directions. *Contemporary Educational Psychology*, 25(1), 54–67.

Schwartz, S. H. (1992). Universals in the content and structure of values: Theoretical advances and empirical tests in 20 countries. *Advances in Experimental Social Psychology*, 25, 1-65.
[doi.org/10.1016/S0065-2601\(08\)60281-6](https://doi.org/10.1016/S0065-2601(08)60281-6)

Schwartz, S. H. (1994). Are there universal aspects in the structure and contents of human values? *Journal of Social Issues*, 50(4), 19-45. doi.org/10.1111/j.1540-4560.1994.tb01196.x

Sheldon, K. M., & Elliot, A. J. (1999). Goal striving, need satisfaction, and longitudinal well-being: The self-concordance model. *Journal of Personality and Social Psychology*, 76(3), 482–497.

Sivacek, J., & Crano, W. D. (1982). Vested interest as a moderator of attitude-behavior consistency. *Journal of Personality and Social Psychology*, 43(2), 210-221.
doi.org/10.1037/0022-3514.43.2.210

Tilly, C. (2004). *Social movements, 1768-2004*. Cambridge University Press.

UNICEF (2019a). *A rights-based approach to disability in the context of mental health*. UNICEF.

UNICEF (2019b). *Towards a child-led definition of social cohesion*. UNICEF.

UNICEF (n.d.), *Case studies on disability and inclusion*.
<https://www.unicef.org/eca/case-studies-disability-and-inclusion/>

Van't Veer, J. T., et al. (2006), *Determinants that shape public attitudes towards the mentally ill*. *Social Psychiatry and Psychiatric Epidemiology*, 41 (4), 310

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Harvard University Press.

Walker, J. S., et al. (2008), *Children's stigmatization of childhood depression and ADHD: Magnitude and demographic variation in a national sample*. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47 (8), 912-20.

Watson, A. C., et al. (2007). Self-stigma in people with mental illness. *Schizophrenia Bulletin*, 33, 1312–1318.

Weiner, B., et al. (1988), *An attributional analysis of reactions to stigmas*. *Journal of Personality and Social Psychology*, 55 (November), 738-48.

Wigfield, A., & Eccles, J. S. (2000). Expectancy–value theory of achievement motivation. *Contemporary Educational Psychology*, 25(1), 68–81.

Yeh, M. A., et al. (2017). The stigma of mental illness: Using segmentation for social change. *Journal of Public Policy & Marketing*, 36(1), 97-116. doi.org/10.1509/jppm.13.125

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