

## Constructing 'disability' in Myanmar

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## POINTS OF INTEREST

### **Constructing ‘disability’ in Myanmar: Teachers, community stakeholders, and the complexity of disability models**

- Myanmar is a country where scant educational research has taken place. This article is one of the first pieces of qualitative academic research on constructions and understandings of disability in Myanmar.
- This paper explores, in detail, a group of Myanmar teachers’ and community stakeholders’ understanding of disability and the ways in which this connects to their socio-religious beliefs. The research involves teachers who are Buddhist (the dominant religion), Christian, Muslim and Hindu.
- Our findings show a medicalised understanding of disability was dominant in the teachers’ discourses in terms of defining disability, but a complex variety of conceptualisations of disability were found when discussing other aspects of disability.
- Teachers’ and community stakeholders’ spoke about people with disabilities as being ‘different’ and *other*. This is likely to be a barrier to inclusion both in education and wider society.
- We argue that the conventional ‘disability models’ of the social and medical type may be limiting and problematic in understanding disability construction and conceptualisation, as a result of our findings in Myanmar.

## Constructing ‘disability’ in Myanmar: Teachers, community stakeholders, and the complexity of disability models

This paper explores Myanmar teachers’ and community stakeholders’ constructions of disability. We examine how various religious perspectives – particularly Buddhism – inform and shape understandings of impairment and how these beliefs intersect with a strongly medicalised construction of disability. However, in our discussion and exploration of the responses, we also found that the notion of two primary disability ‘models’ – namely the Medical Model and the Social Model – ~~are outdated and~~ lack nuance, complexity, and ~~cultural appropriateness~~ socio-cultural consideration. Through examining teachers’ and community members’ perspectives of disability in Myanmar, we highlight the importance of socio-cultural variance in understanding local constructions of disability.

Keywords: Myanmar; disability; teachers; medical model; Buddhism; Global South

### Introduction

Myanmar is a country going through significant social and political changes. In 2011, a new civilian government took power after decades of military rule and subsequently, in 2015, the National League for Democracy (NLD) was democratically elected. These recent democratic political overtures have also been accompanied by a renewed focus on social institutions such as education and disability rights, seemingly influenced by global agendas and discourses. Nevertheless, there is still grave concern over the systemic persecution of Muslim ethnic minorities in the country, particularly Rohingya.

Whilst significant social changes are underway in Myanmar, there is still concern over human rights and social marginalisation, particularly for those from minority ethnic groups such as disabled people. In 2011, Myanmar ratified the United Nations Convention for the Rights of People with Disabilities (CRPD). In the context of disability, whilst initiatives are beginning to further inclusive education, primarily

headed by Disabled People's Organisations (DPOs) in Yangon and supported by Non-Governmental Organisations (NGOs), there are still strong feelings of exclusion felt by many persons with disabilities in Myanmar.

This article will explore the ways in which a small group of Myanmar<sup>1</sup> teachers and other community members, including Disabled People's Organisations (DPOs), conceptualise and discuss disability, and is the result of a research project undertaken ~~over the course of two weeks~~ a few months before the NLD was elected in 2015, and also building upon Ware's experiences living and teaching in Myanmar from 2013-2014. In this article, we will first provide a background on the Myanmar political and social context as related to disability. Next, we will explore and explain our theoretical framework related to the socio-cultural and religious construction of disability. Following a brief explanation of our methodology, we will spend the remainder of the article exploring various themes related to the socio-cultural and religious construction of disability by Myanmar teachers and community stakeholders. Specifically, the themes we explore are the construction of 'normal' and 'different' in conceptualising and defining disability, and socio-cultural and religious conceptualisations of the causes of, and responses to, disability in Myanmar.

In our discussion below, key points on religion, culture, and Myanmar society will be discussed as these became important themes to emerge from our data. Because disability is theorised to be a socially constructed phenomenon, it is likely that there is substantial cross-cultural variance (Underwood, 2008; Grech, 2009). In Myanmar, whilst there is a strong Buddhist cultural and religious tradition, there are also many people of other faiths, primarily Christian, Hindu, and Muslim, and this diversity is reflected in the research participants. Due to an almost complete absence of academic

literature on disability and education in Myanmar, specific cultural contexts will be elucidated where possible.

### **A Brief Introduction to Myanmar and Relevant Disability Policy Discourse**

Myanmar is ~~a~~ located in South East Asia and bordered by India, Bangladesh, China, Laos, and Thailand. According to the World Bank (2015), Myanmar is identified as a Low-Income Country and the United Nations Development Programme (2014) ~~classify~~ classifies it as having low human development. The 2014 census, the first undertaken in 30 years, estimates the population to be 51.5m (females 51.8%) (MIP, 2015). Not all persons were enumerated in the census, including over 1 million people living in Rakhine state when the census was conducted (MIP, 2016), predominantly those belonging to the Rohingya ethnic group. There are 15 regions, with the most densely populated being Yangon. However, it is thought that 70% of the population live in rural areas (MIP, 2015). National literacy is officially reported at 89.5% nationally, yet there are large variations when looking at regional data; for example, Yangon reports a 96.6% literacy rate, whilst in Shan State it is estimated that 64.6% of the population are literate (MIP, 2015). Overall, the literacy for males is marginally higher than for females (MIP, 2015).

Within the 2014 census, the majority of people (87.9%) identified as Buddhist. However, there are significant numbers of Christians, Muslims, and Hindus (MIP, 2016). In Myanmar, Animist cultural beliefs have fused with Theravada Buddhist doctrine to form a complex, syncretic, and multi-faceted religious culture. Spiro (1978) highlights the complexity of the relationship between Animist beliefs in Myanmar and Theravada Buddhism, and argues that they should be viewed as separate religious systems. However, he also acknowledges the potential to read these systems as being

mutually sustaining. Spiro (1978) argues that in Myanmar (then Burma) there is a strong belief in 'ghosts, demons, witches, and those spirits whom the Burmese call nats' (p.3). However, it is pertinent to question the reliability of this ethnography due to it being published over thirty years ago, and also Spiro's own acknowledgement that his research was undertaken during a particularly unstable time. Nevertheless, in the 2014 census 0.2% of people identified explicitly as Animist (MIP, 2016).

The official language spoken in Myanmar is 'Myanmar'. However, it is estimated that there are 116 minority ethnic languages and 135 different ethnic groups including Shan, Kachin, Chin, Karen, and Mon. The Myanmar Government's Department of Social Welfare, Relief and Resettlement (DSW), in dialogue with the Japanese International Cooperation Agency (JICA), recently standardized Mandalay Sign Language and Yangon Sign Language, creating one official national sign language (JICA, 2014). It should be noted that the DSW oversees special schools for children with disabilities; whilst the MoE administrates state, monastic, and private schools in Myanmar.

Myanmar ratified the United Nations Conventions for the Rights of Persons with Disabilities (CRPD), without the optional protocol, in 2011. However, it wasn't until 2015 that Myanmar legislated the Law on the Rights of Persons with Disabilities (LRPD), and work is still continuing on implementing a national plan for the CRPD (UNICEF, 2016). The current English translation of the LRPD shows that it is not in full compliance with the mandates set out in the CRPD. For example, the definition of disability in the LRPD presents a conceptualisation of disability that pathologically situates disability within the person. This is not in line with the CRPD, which explicitly states that disability stems from attitudinal and social barriers (UNICEF, 2016). Moreover, rather than committing the government to protecting the rights of persons

with disabilities, the new LRPD sets out the establishment of a National Committee on the Rights of Persons with Disabilities (UNICEF, 2016).

Two notable situational analyses of persons with disabilities have been undertaken in Myanmar: one undertaken by the Leprosy Mission and DSW (2010) that focuses on all persons with disabilities, and one undertaken by UNICEF (2016) explicitly focussing on children with disabilities. The first countrywide quantitative research was undertaken on disability in 2008-2009 and published in 2010 as the National Disability Report (The Leprosy Mission and DSW, 2010). The Leprosy Mission and DSW (2010) developed a working definition of disability through a randomly selected 200-person survey and defined a person with a disability as ‘An individual who is limited in function and/or ability to conduct activities in daily living to participate in society due to physical, seeing, hearing and intellectual or learning impairment’ (p.9). This suggests an understanding of disability as relating to a medical model worldview of individual deficit and impairment and it should be noted that this definition is closer to the medicalised understanding present in the Myanmar LRPD, rather than the definition found in the CRPD.

The National Disability Survey states a disability prevalence rate of 2.3% of the population (The Leprosy Mission and DSW, 2010). Of this figure, 68.2% have physical impairments, 13.3% have visual impairments, 10.4% have hearing impairments, and 8.1% have intellectual impairment (The Leprosy Mission and DSW, 2010). The overall figure of 2.3% is very low in comparison with the global estimation for people with disabilities, which is 15% (WHO, 2011). This could be in part to due to the inclusion of chronic illness including HIV/AIDS and age-related disability in the international classification of disability used in the World Report on Disability (WHO, 2011). Nevertheless, it is also likely that the stigmatization of disability plays a part in the low

prevalence recorded in Myanmar, as in other countries (Bawi, 2012; Singal, 2010). Lastly, this survey took the form of a binary survey which likely limited the way in which people self-identified as having disabilities rather than a functional limitation survey which may have found a much higher prevalence rate (Mont, 2007). The census undertaken in 2014 highlights an increased prevalence in contrast to the 2010 report, suggesting that 4.6% of the population have disabilities (MIP, 2015). The data also suggest a rise in the prevalence of disability after the age of 40, further rising dramatically after the age of 65 (MIP, 2015). The census itself identifies the challenges faced in collecting data on disability suggesting that, still, the prevalence is likely to be under-reported (MIP, 2015). It should be noted specifically that the categorization of disability for the census included only four categories: visual impairment, hearing impairment, intellectual impairment, and physical impairment. Therefore, it is possible that some persons who identified as having cross-category impairments were excluded from identifying as such and therefore the results may be further skewed. Nevertheless, the census data identified persons with visual impairments as being the most prevalent (MIP, 2015).

Before we progress to the findings from our research in relation to the socio-cultural and religious construction of disability by Myanmar teachers and community stakeholders, we will briefly explain below our theoretical framework and analytical lens.

### **Understanding Constructions of Disability**

Disability has often been conceptualised in modern society through the lens of a medical or charity model. The medical model places disability on the individual, arising from a medical diagnosis of impairment, and this model has been closely linked with a



medical focus on curing or reducing the impairment (Shakespeare, 1996). Furthermore, a medical model worldview has been used as a rationale for segregating people with disabilities 'for their own good' (Barnes and Mercer, 2003, p.3). The charity model constructs people with disabilities as suffering from an affliction and needing help, and this model has been reinforced in many countries, particularly in majority world contexts, through charitable practices including alms giving (Ingstad, 2001). This charitable giving is a practice that occurs in Myanmar as part of its strong Buddhist heritage and culture.

Another, more recent, conceptualisation of disability is the social model, which theorises that it is the barriers constructed by society that cause disablement rather than impairment (Oliver, 1990; Shakespeare and Watson, 2002). Here, the understanding and cause of disability is clearly placed on society, rather than on the individual. This understanding has been influential worldwide, particularly with the formation of Disabled Peoples Organisations (DPOs), and informs global disability rights policy including the UN CRPD (Lang, 2001), which has been ratified by Myanmar. However, it has been argued that this understanding of disability, whilst prevalent in Euro-North American contexts, may not be as relevant in majority world contexts (Miles, 2000; Singal, 2010). In support of this view, Grech (2009) argues that the social model fails to take account of different cultural contexts or world-views and articulates only the needs of 'white, middle class, educated, western, disabled academics' (p.772). The challenges levelled at the social model of disability, particularly in majority world contexts, highlights the need to understand the construction of disability as being specific to socio-cultural, religious, and political contexts.

In acknowledging criticism of the social model and alternative models with which

to consider constructions of disability, this research is focusing primarily on exploring a socio-cultural construction of disability. In understanding the construction of disability within a particular context, Leicester and Lovell (1997) suggest that it is important to understand the 'social restrictions' that are created within a society (p.116). This will be particularly relevant with regard to analysing alms giving in Myanmar and whether it propagates an understanding of people with disabilities as suffering and in need of charity. Furthermore, it is important in this article to understand teachers' and community stakeholders' perceptions of persons with disabilities within society and whether they understand 'normal' society as having been constructed for non-disabled people (Leicester and Lovell, 1997; Davis, 1995). This is a particularly important aspect in understanding reasons for the low access to education for children with disabilities, as found in Myanmar's 2010 National Report and whether teachers consider themselves to be accepting of children with disabilities (The Leprosy Mission and DSW, 2010).

In considering different 'social restrictions' (Leicester and Lovell, 1997, p.17) and societal systems that create power structures (Foucault, 1977), religion should be thoroughly investigated as it is an important factor in analysing Myanmar society. Theravada Buddhism, as the major religion in Myanmar, may impact the understanding of disability. Schuelka (2013; 2015) and Miles (2000; 2002) find, through an examination of the literature and fieldwork in other Buddhist-majority countries in Asia, that the Buddhist teaching of *karma* is likely to influence the construction of disability in socio-cultural contexts with a traditionally Buddhist heritage. It is suggested that there may be *karmic* beliefs that impairment is caused through sins in a past life. However, in opposition, Bejoian (2006) has argued that this linear understanding of *karma* is limited and does not allow for the mysticism of all previous lives manifesting into the current one. Yet, it has been suggested through research in Thailand that many

Thai people, also coming from a tradition of Theravada Buddhism, believe impairments are caused through 'negative merit' and therefore disability can be seen as being 'constructed as negative' (Naemiratch and Manderson, 2009, p.479).

A negative construction of disability in Theravada Buddhism may also come from an emphasis on perfect bodies. Naemiratch and Manderson (2009) highlight that this emphasis on perfect bodies stems from the five aggregates – *rupa* [self], *vinnana* [consciousness], *vedana* [sensation], *sanna* [perception], and *sankhara* [mental formation]. Therefore, impairment may be understood as the 'incompleteness of the elements' and thus a negative construction of disability (p.480-482). This research may have particular relevance to Myanmar as both Thailand and Myanmar share a border and both countries share a similar and strong Theravada Buddhist heritage. In undertaking this research, it is particularly important to explore if religious constructions of disability are present in any teachers' and community stakeholders' understandings.

## Methodology

In order to explore how Myanmar teachers and community stakeholders construct and conceptualise disability, focus groups and semi-structured interviews were undertaken in Yangon, Myanmar by Ware ~~over a two-week period in May~~ 2015. Participants were located in two private schools, as well as from Non-Governmental Organisations (NGOs), Disabled Peoples Organisations (DPOs), Special Schools, and religious institutions. In reporting our findings below, it is important to recognise that this is not a representative sample of all Myanmar teachers and other professionals but, rather, an illustrative case study. The research was undertaken primarily in English and conducted by a white-British female (Ware) who was able to also speak some Myanmar language,

having previously lived and worked in Yangon. When necessary, some Myanmar language was used to convey thoughts. English was chosen as the medium of research as all the teachers participating in this research worked in schools where English was the medium of instruction for all subjects, moreover, this also avoided the use of a translator. There is the possibility of bias based on convenience sampling, but all attempts were made at data triangulation between participants from different organisations, limited existing research literature, and policy documents. All ethical procedures were followed through the research process; ethical approval was sought and granted both in the UK and in Myanmar. Consent for the research was given at multiple levels – principal of the chain of school; individual school head teacher; teacher. An overview of the participants is detailed below.

Thirteen teachers from two private primary schools (kindergarten to grade 6) participated in focus groups and semi-structured interviews. The primary schools were part of a chain of private schools across Myanmar and both were based in the centre of Yangon, the commercial capital of Myanmar. The schools used English as the medium of instruction and followed an international curriculum. English is a common feature of schools in Myanmar as the education system has been heavily influenced by British colonial rule; in government schools English is taught as a second language as well as being the medium of instruction for some subjects in secondary schools.

Ware, previously employed by the school the year prior to the research taking place, ran training sessions on working with children with learning disabilities for this particular chain of private schools. Therefore, some of the participants had previously attended sessions on raising awareness of disability and working with different behaviour in the classroom. Characteristics of these teachers that are important for consideration include: all were female (13) and working in either of the two urban

private primary schools. Most of the teachers were Buddhist (8), but some were also Muslim (2) and Christian (3). All had a bachelor's degree (13); only 2 had undertaken the government teacher training course; none had taught in a government school; and most (10) had not considered themselves to have had a child with a disability in their class before.

At each school five teachers took part in two focus groups one week apart. Two semi-structured interviews were also conducted with three teachers (two from one school and one from the other). The semi-structured interviews were carried out to stream line the topic guide for the focus groups as well as enabling validity checks to be carried out. A call was put out through the school to full time teachers who might be interested in participating in a research project on disability – the teachers who took part in the research were those who volunteered. In addition to the thirteen teacher participants described above, 9 others were interviewed once using semi-structured interview schedules. These participants included a *Bhone Gyi* [elder monk] from a monastery; the director of a special school; the general secretary of a special school for children with visual impairment; a member of a DPO; 2 officers of an NGO; the director of a research-focused NGO; and a director and teacher from a Montessori school. All the participants were located in Yangon.

The first pass of thematic qualitative data analysis was undertaken simultaneously with the research (Merriam, 2009). This was primarily due to Ware being a key part of the research process and allowed her immediately to identify themes as they were narrated. The method of constant validity checking (Bernard, 2011) was used to help draw out some of the nuanced constructions of disability and ensure that every participant's voice was validated in the post-research analysis phase. Thorough and detailed validity checking was particularly important due to the tensions of cross-

cultural research. Second pass and final thematic analysis of data (Saldaña, 2009) was conducted by both Ware and Schuelka. The quotes are taken directly from the transcriptions; they have not been edited for fluency to ensure the authenticity of the teachers' voices has been preserved. Square brackets have been used when necessary to aid the reader's understanding or to add contextual information.

### **'They Cannot Do': Defining Disability**

In discussing the Myanmar teachers' understanding of disability, the overwhelming response from our participants was to compare persons with disabilities to persons perceived as 'normal'. One teacher explained disability in terms of weakness saying, *'Disability means, I think, the person who is weak in something, maybe in the leg area or his brain is not normal'* (Focus Group, 7 May 2015). This understanding was echoed by other teachers in other focus groups and also in single interviews. Particularly, one teacher explained that disability was something that is *'wrong, for example no arm, no leg, their brain is not normal'* (Focus Group, 8 May 2015). These definitions point towards a construction of impairment as being the main factor of disability. Furthermore, these narratives also centre disability on the individual, promoting a medicalised, or pathological, understanding of disability.

Teachers from our research predominantly juxtaposed words such as 'different' and 'normal' to construct narratives of difference and disability, i.e. *'Physically and mentally they [children with disabilities] are different with a normal child'* (Focus Group, 7 May 2015). One teacher narrated disability as meaning *'people can't do anything,'* however, it was unlikely that she meant this in the completely literal sense of 'anything' as she later went on to clarify, *'so some might be like doesn't walk on his body [can't walk], or it might be hand broken or leg broken,'* suggesting that she also

understood disability as being synonymous with physical impairment (6 May 2015). These narratives constructing disability in relation to 'normal' link with the work of Davis (1995), who highlights the concept of *othering*, through the construction of disability as something 'other' than normal. Here, the participants are also creating a narrative of *othering* through the differentiation of persons with disabilities as 'not normal' (Focus Group, 7 May 2015). Davis' (1995) comment that 'normality has to protect itself by looking into the maw of disability and then recovering from that glance' (p.48) suggests that persons with disabilities are given a lower value judgment than those perceived as 'normal'. This may not be the case in the context of Myanmar as the culture is very different to Davis', which may infer a different value on 'normal'. Nevertheless, the notion of *othering* has the potential to be a strong socio-cultural factor which may impede social inclusion, and be a barrier to inclusive education through the theoretical and possibly literal separation.

Some of the teachers' construction of disability, as medicalised and impairment focused, strongly links with the definition used in Myanmar's first National Report on Disability, which stated a person with a disability as being 'an individual who is limited in function and/or ability to conduct activities in daily living to participate in society due to physical, seeing, hearing and intellectual or learning impairment' (The Leprosy Mission and DSW, 2010, p.9). Towards the end of the research process, the teachers had opportunities to look at, and discuss, the definition from the National Report. Most of the teachers highlighted that the definition was not easy to understand, and in one focus group all the teachers agreed when one teacher explained that '*we have never seen that kind of definition before*' (Focus Group, 13 May 2015). Here, it is interesting to note that whilst the majority of teachers had never seen this – or a similar – definition, they identified very similar narratives within their own definitions of disability. In

discussing the definition, one teacher felt that the use of the word 'limited' was positive, arguing that rather than identifying persons with disabilities as being completely unable to function, the definition positions their ability as 'limited' (Focus Group, 12 May 2015). In contrast, another teacher reported that the definition was very negative, and this was echoed by another teacher in the same focus group who said the definition implies that persons with disabilities *'They cannot do, in every function they are the limited one'* (Focus Group, 12 May 2015). She did not feel this was an accurate representation of persons with disabilities. In the focus group where the teachers felt the definition from the National Report was negative, suggestions were made that definitions should be more positive because *'we need to educate our society'* (Focus Group, 12 May 2015).

The National Report on Disability (The Leprosy Mission and DSW, 2010) was also discussed with the director of a research-focused NGO who had helped to determine the definition used and had also supported the national survey. He acknowledged the limitations of the definition, particularly in relation to the WHO's International Classification of Functioning, Disability and Health (ICF) framework used for measuring disability worldwide (WHO, 2011) (Interview, 7 May 2015). The key difference between ICF and the National Report is the ICF's construction of a 'bio-psycho-social' model of disability (WHO, 2011, p.4), combining both the social model of disability and also the experience of impairment in order to provide a holistic framework within which to consider and measure disability. In contrast, the National Report is based on a medical model conceptualisation of disability and only identifying impairments as factors for disability; this focus solely on impairment and function may change the way in which people relate and self-identify as disabled. Specifically, the director highlighted the exclusion of epilepsy, chronic Human Immunodeficiency Virus



(HIV), and age-related disability as contributing to the low prevalence rate of 2.32% found for persons with disabilities in Myanmar (Interview, 7 May 2015). In discussing the low prevalence rate, he noted that DPOs in Myanmar, whilst wanting the prevalence rates to be in line with the international measurement of 10-15%, did not want to broaden the membership of their DPOs – particularly in relation to those with chronic HIV and age-related disability (Interview, 7 May 2015).

Whilst the National Report (The Leprosy Mission and DSW, 2010) was now over five years old at the time of data collection, there continues to be uncertainty over who is considered disabled in Myanmar. During an interview with a member of a DPO for people with visual impairments, he explained that currently the government has four categories of disability: hearing, visual, physical and intellectual (Interview, 15 May 2015). He highlighted that having only four delineations of disability made it difficult for people to identify as having more than one disability or having cross-category disabilities. However, he was hopeful that the government would add a fifth category of 'multiple disabilities' (Interview, 15 May 2015).

In contrast to the medicalised and impairment narratives of disability, some teachers also expressed definitions offering a wider understanding of disability. One teacher explained disability through ability, rather than physical impairment, suggesting that disability is akin to not knowing how to do something, for example, painting (Interview, 7 May 2015). Another teacher highlighted environmental factors, saying:

*One person saw the good teacher, it become, it become, become a famous [one person had a good teacher and became successful]. One person saw a bad parents or don't care about him, or he live alone with the nurse, it cannot be [in contrast another person received a bad education and this changed his prospects], these two are same diseases or these two are same disability person,*

*one might be grow with their, his life, his or her life very, very successfully, but one so I mean different kinds of situation that person might be change their life.*

(Focus Group, 8 May 2015)

Here the teacher can be interpreted as showing a more nuanced view of how a child with disabilities may be more affected by the environment they are in, as opposed to by their impairment. This could be interpreted as suggesting that the experience of disability is not universally the same and it is the context or 'situation' that can 'change' the experience of disability (Focus Group, 8 May 2015). The emphasis on the development of the child with disabilities has been positioned on the adults surrounding the child with disabilities rather than the individual, highlighting environmental factors as potential barriers rather than impairments. One teacher, who herself had a family member with a disability, said of children with disabilities, '*Actually they will have their own ability but we cannot see easily behind that [impairment]*' (Interview, 6 May 2015). This teacher begins to question disabling barriers being constructed by society through the suggestion that 'we [society]' see impairments rather than ability. She goes on to say that as teachers '*we need to find the good ability from them, and if we can create like a bigger one, so they will get success, like a Helen Keller*'<sup>2</sup> (Interview, 6 May 2015). In this instance, she puts the role of removing barriers on the teacher, whose job it is to 'find the good ability', as opposed to the child conforming to the teacher's expectation (Interview, 6 May 2015). These teachers' narratives, in opposition to the majority who put forward medicalised definitions of disability, begin to place the construction of disability outside the realm of individualised impairment and, tentatively, place them on society.

In interviewing a director of an NGO school for children with disabilities, he explicitly identified himself as an advocate of the social model of disability, explaining

that, *'The impairment is not the problem, it is the system'* (Interview, 12 May 2015). He refuted the idea that the social model was not relevant to the culture of Myanmar and said that, in fact, it had worth and relevance in 'every situation'. He further explained that the social model did not *'deny people helping each other'*, rather it was integral in helping persons with disabilities access *'their fundamental human rights'* (Interview, 12 May 2015). In relating the construction of the social model of disability to the teachers, one teacher felt it was an accurate way to conceive disability, particularly highlighting how living in more developed countries could change the experience of disability, particularly with regard to accessibility (Interview, 14 May 2015). Furthermore, she highlighted the inequality persons with disabilities face due to society having been constructed by persons without disabilities who she suggested, *'think for themselves only'* (Interview, 14 May 2015).

The teacher's narrative could be understood as suggesting the idea of mainstreaming disability, as she suggests that it is important to think about other people's needs. In addition, she specifically highlights that if those in authority were persons with disabilities it is likely that persons with disabilities would have a significantly different experience. In contrast, not all the teachers found the social model of disability relevant to their own understandings of Myanmar culture. One teacher expressed *'feeling a little bit sorry'* for those who thought disability was *'because of society'* (Focus Group, 12 May 2015). She went on to explain that teaching this idea to children with disabilities was, *'Giving a way for the children to blame on somebody, 'because of society we become like this''* (Focus Group, 12 May 2015). Another teacher in the focus group, who agreed, suggested that Myanmar, due to being a 'developing' country, *'cannot think all the time for all the people'* (Focus Group, 12 May 2015). These teachers explained that rather than placing the blame on society,

persons with disabilities should be more self-sufficient, and should instead think, *'We can survive, and we can find a way to survive on our own'* (Focus Group, 12 May 2015). She continued by highlighting the power of rhetoric in talking about disability and explained that the language used when talking about persons with disabilities *'is very important'* (Focus Group, 12 May 2015).

**'Wut mar amyel nga ye mar apa' [if you do bad things you need to pay for it]:**

### **Understanding Causes of Impairment**

In discussing various conditions, the level of medical knowledge varied between teachers. Some teachers offered general reasons for impairments occurring, including accidents, complications during birth, environmental factors, and diseases (Interview, 6 May 2015). Other teachers suggested that disability occurred due to *'lack of vitamins or, because when she was in her mummy womb, so there is not vitamin'* (Focus Group, 8 May 2015). There was a general consensus throughout all focus groups in Yangon that people in rural areas were unable to take care of themselves as well as those in the city due to perceived lower education and higher poverty, thus the teachers argued there was likely to be a higher prevalence of persons with disabilities in rural areas (Interview, 6 May 2015). Reporting on their knowledge of specific syndromes and disorders one teacher said:

*Physically Down's Syndromes are very easy to differentiate each other but Attention Deficit Disorder means that we cannot see clearly those children. We cannot say, 'He or she has Attention Deficit Disorder.' After talking and after taking some time with him or her then we can know it because they cannot pay attention and they just focus on what they would like to do. (Focus Group, 7 May 2015)*

Some teachers reported that children with Down's Syndrome all had the '*same face*' (Focus Group, 8 May 2015), whilst another teacher said that Down's Syndrome was a 'disorder with the chromosomes' (Interview, 7 May 2015).

Narrating the causes of impairment through religious perspectives, teachers who identified as being either Muslim or Christian were clear that their faiths did not include the concept of multiple lives and they surmised that impairments occurred generally either due to '*Concern about the God*' (Focus Group, 8 May 2015), '*Just also accident*' or '*Inside our mummy's womb*' (Focus Group, 8 May 2015). These teachers, in discussing Islam and Christianity, struggled to identify parables or stories from their religion involving persons with disabilities. In contrast, the notion of *karma*, or 'cause and effect', was frequently drawn upon in order to explain the occurrence of disability, both by Buddhist teachers explaining their own understanding and also teachers of other faiths who chose to comment on Buddhist beliefs.

Many teachers who identified as being Buddhist explained the cause of impairment as a very linear construct of cause and effect. One teacher illustrated this by saying, '*What we give is what we get. If you do good thing you will get good thing. If you do bad thing you will get bad thing. That's it for us*' (Focus Group, 8 May 2015). Similar linear constructions of cause and effect were presented by all teachers who spoke about *karma* and impairment. Moreover, it was also suggested that the effect of *karma* could occur in the same life:

*I have a friend, his friend has leg is not good when he grew up. At the childhood his leg is very nice but when he grow and grow his leg is not good because, when since his childhood he played, how can I say, bird leg to broken [as a*

*child he broke a bird's leg] and that's why his leg is not good. (Focus Group, 7 May 2015)*

In this instance, the teacher is evidencing the effect of *karma* occurring in the same lifetime through the example that as a child a boy broke a bird's leg and therefore, as an adult, he was affected by having a physical impairment in his leg. In relation to this, one teacher explained the phrase her mother often said was, *wut mar amyet nga ye mar apa* meaning 'if you do bad things you need to pay for it', she explained this in the context of *samsara*, the continuing cycle of life that is central to Buddhism. For example, she suggested that committing suicide would result in having to suffer for another five-hundred lives (Interview, 14 May 2015). Furthermore, in discussions with the *bhone gyi* [Elder Monk], he also clearly cited *karma* as the cause of impairment, explaining that it was a process of 'cause and effect' where 'bad merit' was the cause and impairment the effect (Interview, 10 May 2015). In addition, he reported that drinking too much alcohol in a previous life could be the cause of cognitive impairment in this life (Interview, 10 May 2015). This warning of the effects of excessive alcohol consumption could be interpreted as a process of social norming – compounding in society the dangers of alcoholism. Another possibility is that this narrative may have some root in the incidence of foetal alcohol syndrome.

In discussing whether the effect of *karma* resulting in a disability could be interpreted as a punishment, one teacher contrasted the notion of *karma* in Buddhism with 'forgiveness' in other religions. This led her to question why people of other faiths also had impairments considering they had prayed for forgiveness:

*For other religions, so they think if they pray the [to] God if they apologised to the God so they can forgive for everything, so for that one also, but not only Buddhisms, that disabilities person can be from other religions as well right, is*

*it so? Yes, if they forgive to everyone, why didn't they forgive to them [persons with disabilities].* (Interview, 12 May 2015)

This reasoning about the prevalence of impairment led the teacher to suggest that, in terms of religion, '*Disability is a negative things*' (Interview, 12 May 2015). In continuing her reflection, she recounted a Buddhist story set during the time of Gautama Buddha illustrating impairment as a curse. In contrast, many of the teachers argued that whilst impairment was the effect of previous bad actions, these rules of cause and effect could be applied without putting a negative value judgment on persons with impairment in their current lives today. One teacher explained, with others' agreement, that whilst you understand the rules of cause and effect you 'don't see' the past life of a person with disabilities, and therefore you are not making a negative value judgment about them (Focus Group, 8 May 2015). This is similar to Miles' (2000) argument that the notion of *karma* in relation to impairment can be educational, rather than negatively judgmental.

Some of the teachers went on to suggest that having this rationale for impairment can help people accept their life, with one teacher explaining:

*If, in this life she can't understand this is because of the causes that she did in the past life, now in this life she has this, this effect, she can, how can I say, she can feel a little bit, she will not blame to other, 'Oh because of myself I have to suffer like this. I have to be like this' so she will not blame and she will not have any, any misunderstanding on others and might blame to others. So, I think it is a good, good things for her. If she blame to others there might be another cause and she has to suffer for the next life.* (Focus Group, 12 May 2015)

This teacher may be suggesting that if one does not accept that their impairment is caused by their actions in their previous life, then consequently in the next life one may continue to feel the effect of *karma*. In another focus group, the teachers referenced

the phrase '*tayer nae pheyl pr tel*', meaning 'calming mind', suggesting that the understanding of cause and effect – and therefore the causal explanation of an impairment– allows that you '*will feel peace*' (Focus Group, 8 May 2015). Whilst there is a strong narrative placing the cause of impairment on the individual and their actions in the previous life, the *bhone gyi* [Edler Monk] was clear that even though impairment is the effect of having made 'bad actions' in one's previous life, persons with disabilities should not be treated badly for it in their current life. He went on to explain that Gautama Buddha helped a man who had diseases when no one else would; he ended by explaining that it is our 'heart' and intention that is important saying, '*So it is up to you how you treat these people, if you do good, you will get good*' (Interview, 10 May 2015).

#### **‘I feel sorry for you is better’: Narratives of Pity, Shame, and Suffering**

In discussing the words used to speak about persons with disabilities and reflecting on how people with disabilities are treated by society – narratives of pity, shame, and suffering were frequently referenced. Many teachers, reflecting on how society perceived persons with disabilities, suggested that people felt pity. One teacher said:

*Some people [with disabilities] I saw on the road, so for me at that time I very pity on them [I feel pity for them]. I sometimes, they, they cannot run I hold their hands and I walk with them, I let them ehhe, how to say, let them go with me and this, so, so I, when I see these people I pity on them, I give something that I have.*

(Focus Group, 8 May 2015)

Others suggested that persons with disabilities are stigmatised by society and '*Some [people] avoid*' them (Focus Group, 8 May 2015). The different attitudes between pity and avoidance became a topic of heated discussion during this particular focus group,



with many teachers arguing that the majority of people felt pity towards persons with disabilities and only a small minority avoided them. In refuting the idea that only a minority of people avoided persons with disabilities one teacher, who had extensive experience travelling around small remote villages in Myanmar, argued that due to her experience she had seen more avoidance and stigmatisation of persons with disabilities as opposed to the other teachers in the group whom she felt had had limited experience residing only in the city (Focus Group, 8 May 2015).

In questioning how the narrative of pity is constructed, the teachers explained that pity was akin to feeling sorry for someone who you perceived to be lower, or have less, than you do (Focus Group, 8 May 2015). One teacher explained that people might feel pity due to comparing another with themselves and deciding the other has less than they do (Focus Group, 8 May 2015). Another teacher, on reflection, questioned whether feeling pity was a positive emotion saying, *'So pity, I pity on you. But actually, pity, so ahhh I pity on you is not good, I am really sorry for you, I'm sorry for you, I feel sorry for you is better'* (Interview, 14 May 2015). The widespread use of pity during the research with the teachers, particularly those identifying as Buddhist, was surprising due to discourse in the literature surrounding Buddhism and pity. Naemiratch and Manderson (2009), in their research in Northern Thailand suggest that there is difficulty in separating compassion from pity. However, Bejoian (2006) suggests that pity is not in Buddhist discourse; rather it is compassion that is the cure for suffering. In addition, Bejoian (2006) asserts that linking pity and compassion suggests a sense of hierarchy – the antithesis of Buddhist principles. On the one hand, our research finds a strong similarity with Naemiratch and Manderson (2009), suggesting that pity is a more prevalent and common notion than compassion. Yet, some of the teachers' perception of pity, which can be understood as akin to feeling sorry for someone who has less than

you, does suggest a sense of hierarchy, linking to Bejoian's (2006) writing. Furthermore, it could be argued that the idea of feeling pity and making donations to persons with disabilities could promote a construction of the charity model of disability. Promoting charity and the idea of pity towards persons with disabilities could lead to persons with disabilities being thought of as 'in need' and therefore having a lower status.

Linked with pity was some teachers' understanding of suffering in connection to Buddhism. One teacher explained that suffering was a part of life and starts at birth, only ending if one reaches enlightenment and thus the cessation of rebirth:

*So, do you know why, when I born so the nurse hand like that [indicates upside down] and hit. 'Yyayayhhhhh'. So, this not good for us. And then, in my mother inside also I need to stay nine months, very tight isn't it, so it's not also okay, that's why most of the monk and the Buddha they really hate that one. They don't want to be reborn as an animal also as a human also that's why they want to ends their life. (Interview, 6 May 2015)*

Other teachers referenced past lives – in the *karmic* sense as discussed above – as the cause of suffering, particularly with the lived experience of disability in the current life saying, '*She feel suffering [/disability] in this life, because, because last life*' (Focus Group, 8 May 2015). The occurrence of disability can be interpreted as intrinsically linked with the idea that living is suffering. Therefore, it may be possible to understand suffering as being linked to disability without the imperative of a negative moral judgment.

Another emotion that came out in the research in connection with persons with disabilities was the feeling of shame. However, shame was mentioned far less frequently than pity. Some teachers suggested that parents of children with disabilities would feel shame and cited this as a reason children may be kept at home. Another

teacher highlighted HIV and AIDS as *'mean[ing] it is very shameful for them...they feel shame and they don't want to go to school as well'* (Interview, 6 May 2015). One teacher felt that shame was not a good emotion to feel about disability and that the reason for feeling shame was *'Because they are not knowledgeable and they are not educated so the way they think is wrong, totally wrong'* (Focus Group, 7 May 2015). As a solution, she suggested that *'one kind of answer to educate the parents also. This is not a shameful thing'* (Focus Group, 7 May 2015).

### **Discussion and Conclusion: Problematising Disability Models, Advancing Socio-Cultural Construction**

~~In summary of the above findings, the dominant socio-cultural construction of disability in Myanmar that we found through an analysis of the focus groups and interviews conducted was that of an individual 'impairment' conceptualisation linked strongly to the medical model of disability. Our findings relate directly to the initial qualitative surveys undertaken in Myanmar (The Leprosy Mission and DSW, 2010; UNICEF, 2016). This construction of disability as 'different' and other is likely to be a barrier to both social inclusion of persons with disabilities and inclusion in education. Buddhist participants expressed a *karmic* understanding of the occurrence of disability, suggesting that one's actions in a previous life are the cause. In discussing disability as the effect of *karma*, often, this did not seem to be said as a value judgment. Pity was a common theme that arose when participants explained how they felt society perceived persons with disabilities. Feelings of pity, suggest aspects of the charity model of disability. The promotion of pity and charity towards persons with disabilities is likely to exacerbate the subjugation of persons with disabilities, with them being seen as 'in need'.~~

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~~Both ideas of *karma* and pity are strongly resonant in the language that is used to speak about persons with disabilities and disability in general. However, due to linguistic developments, there are now more enabling words for persons with disabilities including words that translate as being 'differently abled'. However, these words have not yet fully penetrated Myanmar society, meaning that the use of disabling language is likely to be still more common. Overall, complex and interrelating constructions of disability were found in this research, much of which has a strong connection to the country's Buddhist heritage. This presented a dichotomy for those of other faiths, particularly in their use of the Myanmar language without identifying with the Buddhist subtext of the language. The findings of our research, as presented above, lead us to several theoretical considerations.~~

First, our research in Myanmar suggests that whilst in many instances a medical or social model presents itself clearly, socio-cultural realities are not so dichotomous in totality. In relation to previous conceptualisations of disability – specifically, the medical and social models – ~~our research in Myanmar suggests that whilst in many instances a medical or social model presents itself clearly, socio-cultural realities are not so dichotomous in totality.~~ Our findings further support Miles' (2000) view that a binary disability model ~~understanding~~ is problematic in Asia or, generally, in other socio-cultural contexts beyond Euro-American. Similarly, Schuelka (2015) found that in Bhutan – another country with a strong Buddhist heritage relatively near Myanmar with similar religious syncretisation – ~~that~~ world-views such as the social model or medical model are complexly enmeshed within exogenous global flows and brought into Bhutan by foreigners and the Bhutanese themselves. These exogenous and dichotomous conceptualisations of disability are further complicated by already-existing socio-cultural constructions of disability, and narratives of disability become employed by

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specific individuals for specific personal or professional purposes. In other words, societal members can pick and choose from a variety of disability narratives and conceptualisations to suit the needs of the moment. They might just as easily move between narratives or merge conceptualisations together.

Second, similar to Schuelka's (2015) findings in Bhutan, our findings in Myanmar present suggests a similar phenomenon in documenting the shifting conceptualisations of disability as definitions and attitudes become influenced and affected by greater global engagement. Certainly, the participants in these focus groups and interviews represented a multitude of perspectives themselves, and each individual had their own attitudes and disability narratives that were not neatly fitted into a dichotomous disability model perspective. The incorporation of the CRPD into Myanmar's policy and practice thinking – albeit disjointed – also co-exists with the Myanmar LRPD. Whilst it is true that certain aspects of Myanmar society traditionally may have exclusionary features such as *karma* and an attenuation to human difference, it may also be true that exogenous discourses of disability carried with them new elements of exclusion in the guise of the paradox of highlighting human difference in order to then work towards inclusion.

Third, our findings in Myanmar suggest that it is not the *attitudes* of people themselves that conceptualise disability in a society, but it is the socio-cultural nature of the structures, systems, and institutions in which they inhabit. A socio-cultural perspective on disability advances that societal structures themselves construct disability and shape participants (McDermott and Varenne, 1995; Schuelka, 2018). Teachers in Myanmar interviewed for this study expressed hesitation as to the abilities of persons with disabilities to 'cope' in school. Rather than stop with the teachers with our analysis, we advocate that research needs to progress to how the institution of

schooling itself creates disability conceptualisation (see also, Slee, 2011) – as well as other societal institutions. There is a subtle difference here between the socio-cultural perspective and the social model of disability, in that the social model's focus is on overcoming societal barriers that dwell primarily on materiality and attitude. A socio-cultural perspective acknowledges that disability conceptualisation is a reflexive and situational phenomenon. Both the medical and social models represent a certain amount of objectiveness and functionality when it comes to conceptualising disability in that there are persons with and without disabilities in society and the solution to that heterogeneity go in divergent directions.

Fourth, our findings in Myanmar suggest not only the limits of the medical model in understanding disability conceptualisation within a socio-cultural framework, but the social model as well.

The open questioning of the limits of the social model is nothing new, and has been a feature in *Disability and Society* for at least the last 20 years. This discourse continues today, for example when Shakespeare (2014) opines that perhaps the social model has seen its day, and has served its political purpose. Whilst we may not go so far as to dismiss the usefulness of the social model philosophy in the present moment, we believe that 'model' is a problematic and inflexible term. Llewellyn and Hogan (2000), for example, offer much the same criticism. One particularly promising discussion on disability paradigms, theories, and models can be found in Gabel and Peters (2004). They suggest four paradigmatic domains in disability theory rather than 'models': postmodernism, historical-materialism, interpretivism, and functionalism. To this, Gabel and Peters advocate for an attention toward resistance theories. However, we advance that an interpretivist paradigm and grounded approach is crucial for understanding 'disability' in a diverse set of contexts, such as in the Global South, in

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order to stave off the neo-colonial application of disability models and objective disability thinking (Grech, 2011).

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~~Therefore, w~~We believe that there is cross-cultural promise within this reassessment of disability theory, particularly when ~~also~~ considering the work of Ingstad and Whyte (2007): ~~when they advance~~ ‘We are interested in people’s own experiences of what is disabling in their world rather than in some universal definition. These experiences must be connected to (contextualized, woven together with) the process of defining disability and the shared criteria brought into play in particular settings’ (p. 11). It is not that medical models and social models – and other models, such as “charity” – do not exist and inform people’s world-views. Rather, we argue that “models” of disability are not mutually-exclusive or zero-sum. ~~They ,and~~ complexly co-exist and co-mingle in people’s thoughts and actions. A community member may believe that ‘disability’ is akin to pathological abnormality, but may also see no issue in acknowledging the equal humanity and participation of those with ‘disabilities’. This was indeed the case in Schuelka’s (2015) study in Bhutan.

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## Conclusion

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In summary of the ~~above~~research findings, the dominant socio-cultural construction of disability in Myanmar that we found through an analysis of the focus groups and interviews conducted was that of an individual ‘impairment’ conceptualisation linked strongly to the medical model of disability. Our findings relate directly to the initial qualitative surveys undertaken in Myanmar (The Leprosy Mission and DSW, 2010; UNICEF, 2016). This construction of disability as ‘different’ and *other* is likely to be a

barrier to both social inclusion of persons with disabilities and inclusion in education. Buddhist participants expressed a *karmic* understanding of the occurrence of disability, suggesting that one's actions in a previous life are the cause. In discussing disability as the effect of *karma*, often, this did not seem to be said as a value judgment. Pity was a common theme that arose when participants explained how they felt society perceived persons with disabilities. Feelings of pity, suggest aspects of the charity model of disability. The promotion of pity and charity towards persons with disabilities is likely to exacerbate the subjugation of persons with disabilities, with them being seen as 'in need'.

Both ideas of *karma* and pity are strongly resonant in the language that is used to speak about persons with disabilities and disability in general. However, due to linguistic developments ~~and exogenous discourses being carried into Myanmar~~, there are now more enabling words for persons with disabilities including words that translate as being 'differently abled'. However, these words have not yet fully penetrated Myanmar society, meaning that the use of disabling language is likely to be still more common. Overall, complex and interrelating constructions of disability were found in this research, much of which has a strong connection to the country's Buddhist heritage. This presented a dichotomy for those of other faiths, particularly in their use of the Myanmar language without identifying with the Buddhist subtext of the language.

~~We would suggest, based~~Based on our findings in Myanmar ~~and the ensuing discussion~~  
be foregrounded in disability research and more effort be put into understanding the complex socio-cultural realities of communities rather than superimposing disability theory crafted from elsewhere. With our case in Myanmar, we found that participants represented multiple disability narratives and oft-contradictory or cognitively-dissonant disability discourses. To them, notions of *karma*, pity, compassion, shame, and

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suffering are built by competing narratives, personal experiences, religious discourse, stories from childhood, exogenous discourses, government policy, and an interminable number of other experiences and social constructions that shape our world-views and explanations.

1. In this paper we use the term Myanmar to refer to the nationality of the participants in this study. Through this, we want to acknowledge the ethnic heterogeneity of the participants coming from groups such as Mon and Kayin as well as Bamar. Whilst the majority of the research was undertaken in English, we use the term Myanmar in relation to the language spoken within this study. In translating the Myanmar language, we use phonetic translation. There is not a fully standardized way of writing Myanmar script phonetically and so one of the participants checked our English phonetic translation.
2. The teacher explained that during her secondary education (at government school) she had been set a comprehension task in English class English about Helen Keller. Helen Keller was also mentioned by other teachers as an example that persons with disabilities could be successful; they also cited their knowledge of her from an English comprehension at secondary school.

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