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To cite this article: Hannah Ware & Matthew J. Schuelka (2019) Constructing 'disability' in Myanmar: teachers, community stakeholders, and the complexity of disability models, *Disability & Society*, 34:6, 863-884, DOI: [10.1080/09687599.2019.1580186](https://doi.org/10.1080/09687599.2019.1580186)

To link to this article: <https://doi.org/10.1080/09687599.2019.1580186>



Published online: 25 Mar 2019.



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# Constructing 'disability' in Myanmar: teachers, community stakeholders, and the complexity of disability models

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## ABSTRACT

This article 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 – lack nuance, complexity, and 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.

## ARTICLE HISTORY


Received 5 December 2017  
Accepted 5 February 2019

## KEYWORDS

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

## Points of interest

- 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 article 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 that a medicalised understanding of disability was dominant in the teachers' discourses in terms of defining disability, but a complex variety of conceptualisations of disability was found when discussing other aspects of disability.

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This article has been republished with minor changes. These changes do not impact the academic content of the article.

- 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.

## 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 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. In 2011, Myanmar ratified the United Nations Convention on the Rights of Persons 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 DPOs, conceptualise and discuss disability, and is the result of a research project undertaken a few months before the National League for Democracy was elected in 2015, and also building upon the Ware's experiences living and teaching in Myanmar from 2013 to 2014. In this article, we will first provide 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, 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 located in South East Asia and bordered by India, Bangladesh, China, Laos, and Thailand, and is identified as a low-income country (World Bank 2015) with low human development (United Nations Development Programme 2014). The 2014 census, the first undertaken in 30 years, estimates the population to be 51.5 million (females 51.8%) (Ministry of Immigration and Population [MIP] 2015). Not all persons were enumerated in the census, including over one million people living in Rakhine state at the time of the census (MIP 2016), who were predominantly from 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 also significant numbers of Christians, Muslims, and Hindus (MIP 2016). In Myanmar, Animist cultural beliefs have fused with the Theravada Buddhist doctrine to form a complex, syncretic, and multi-faceted religious culture (Spiro 1978).

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 standardised 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 Ministry of Education administrates state, monastic, and private schools in Myanmar.

Myanmar ratified the CRPD, without the optional protocol, in 2011. However, it was not 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 (United Nations Children's Fund [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 focusing on children with disabilities. The first countrywide quantitative research was undertaken on disability in 2008/09 and published in 2010 as the National Report on Disability (The Leprosy Mission and DSW 2010). The Leprosy Mission and DSW 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' (2010, 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 Report on Disability 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% (World Health Organization [WHO] and World Bank 2011). This could be in part 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 and World Bank 2011). Nevertheless, it is also likely that the stigmatisation 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 years, further rising dramatically after the age of 65 years (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 categorisation 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 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 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, 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 conceptualisation of disability is the social model which became prominent in the latter half of the twenty-first century. This model theorises that it is the barriers constructed by society that cause disablement rather than the 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 DPOs, and informs global disability rights policy including the 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, 772) argues that the social model fails to take account of different cultural contexts or worldviews and articulates only the needs of 'white, middle class, educated, western, disabled academics'. The challenges levelled at the social model of disability, particularly in majority world contexts, highlight 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, 116) suggest it is important to understand the 'social restrictions' that are created within a society. This will be particularly relevant with regard to analysing alms giving in Myanmar and whether this 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, 117) 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, 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 (2009, 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 whether 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 in 2015. Participants were located in two private schools, as well as from NGOs, DPOs, special schools, and religious institutions. 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, Myanmar language was used to convey thoughts and simultaneous translations were made in situ. English was chosen as the medium of research as all of 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 (BERA 2014); ethical approval was sought and granted both in the United Kingdom and in Myanmar. Consent for the research was given at multiple levels: principal of the chain of school; individual school head teacher; and teacher.

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 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 in 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 ( $n = 13$ ) were female and working in either of the two urban private primary schools. Most of the teachers were Buddhist ( $n = 8$ ), but some were Muslim ( $n = 2$ ) and Christian ( $n = 3$ ). All teachers had a bachelor's degree ( $n = 13$ ); only two had undertaken the government teacher training course; none had taught in a government school; and most ( $n = 10$ ) 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 streamline 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 13 teacher participants already described, nine others were interviewed once using semi-structured interview schedules. These participants were: 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; two officers from an NGO; the director of a research-focused NGO; and a director and teacher from a Montessori school. All of the participants were located in Yangon.

The first pass of thematic qualitative data analysis was undertaken simultaneously with the research (Sharan 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 authors. The quotes are taken directly from the transcriptions. In order to preserve the authenticity of the teachers' voices, the quotes have been only minimally edited for fluency. To minimise the editing of the

teachers' quotes we augment their voices with square brackets to aid the reader's understanding or to add contextual information.

### **'Not normal': Myanmar teachers' descriptions of disability**

In discussing the Myanmar teachers' understanding of disability, the overwhelming response from 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, with teachers using words such as 'wrong' and '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; that is, 'Physically and mentally they [children with disabilities] are different with a normal child' (focus group, 7 May 2015). Moreover, teachers also spoke about disabled people being unable to do daily activities such as walking or moving, suggesting an understanding of disability as being synonymous with physical impairment. 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). Whilst the value judgement placed on the concept of 'normal' by the teachers is unclear, the othering of people considered disabled has the potential to be a strong socio-cultural factor which may impede social inclusion and to be a barrier to inclusive education through theoretical and possibly literal separation.

### ***Reflections on formal definitions***

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, 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 of 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 '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 and World Bank 2011) (interview, 7 May 2015). The key difference between the ICF and the National Report is the ICF's construction of a 'bio-psycho-social' model of disability (WHO and World Bank 2011, 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, 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 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).

### ***Socio-environmental constructions of disability***

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 [had] the good teacher and become famous. One person saw [had] bad parents or [that] don't care about him, or he live alone with the nurse. These two are same diseases or these two are same disability person, one might be grow with their life very, very successfully; but one ... so I mean different kinds of situation might 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; rather, it is the context or 'situation' that can change the experience of disability (focus group, 8 May 2015). Here, 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' (interview, 6 May 2015). Hence, some teacher teachers' narratives begin to place the construction of disability outside the realm of individualised impairment and 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', but 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 physical accessibility and access to assistive devices (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).

In contrast, not all of 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 rationalised 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 positioning disability 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).

### **'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 a '*lack of vitamins or, because when she was in her mummy womb, there is not vitamin*' (focus group, 8 May 2015). There was a general consensus throughout all focus groups in Yangon (the urban centre

of Myanmar) 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). Many of the teachers indicated their knowledge of specific conditions and impairments; Down syndrome was the most frequently mentioned condition. Some teachers reported that children with Down syndrome all had the 'same face' (focus group, 8 May 2015), whilst another teacher said that Down syndrome was a 'disorder with the chromosomes' (interview, 7 May 2015).

### **Religious narratives of disability**

Reflecting on 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 accident', or 'inside our mummy's womb' (focus group, 8 May 2015). 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' (focus group, 8 May 2015). Similar linear descriptions of cause and effect were presented by all teachers who spoke about karma and impairment. Moreover, one teacher also suggested that the effect of karma could occur in the same life through describing a friend of a friend who broke a bird's leg as a child and as an adult now has a physical impairment:

I have a friend, his friend has leg is not good. At the childhood his leg is very nice but when he grow and grow his leg is not good. Since his childhood he played 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 relation to this, one teacher explained that 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' (interview, 14 May 2015). She spoke about *samsara*, the continuing cycle of life central to Buddhism, suggesting that committing suicide would result in having to suffer for another 500 lives (interview, 14 May 2015). Furthermore, the *Bhone Gyi* also 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. 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 explanation 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 God so they can forgive for everything. Not only Buddhism, disabilities person can be from other religions as well [disabled people are of all religion]. If the God forgive to everyone, why didn’t they forgive 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 thing’ (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 judgement on persons with impairment in their current lives today. One teacher explained 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 judgement about the person themselves (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 judgemental.

Some of the teachers went on to suggest that having this rationale for impairment can help people accept their life. One teacher explained:

If, in this life she can understand this is because of the causes that she did in the past life, she will not blame to other – ‘oh, because of myself I have to suffer like this. I have to be like this’. So, I think it is a good thing for her. If she blame others there might be another cause and she has to suffer for the next life. (Focus group, 12 May 2015)

This teacher is 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, teachers referenced the phrase ‘*tayer nae pheh pr te*’, meaning ‘calming mind’ (focus group, 8 May 2015). They explained that understanding cause and effect 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* 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. The *Bhone Gyi* ended by explaining that it is our 'heart' and intention that is important: 'so it is up to you how you treat these people [persons with disabilities], if you do good, you will get good' (interview, 10 May 2015).

### **'When I see these people I pity them, I give something that I have': narratives of 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 them. They cannot run I hold their hands and I walk with them. When I see these people I pity 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 and suggestions were made that in rural areas stigmatisation and isolation of persons with disabilities was more likely than in urban areas.

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 in society, or to have less (focus group, 8 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 social hierarchy, linking to Bejoian's (2006) writing. Furthermore, the idea of feeling sorry for a person and hence making donations to persons with disabilities could promote a construction of the charity model of disability. Consequently, 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. Other teachers referenced past lives – in the karmic sense as discussed earlier – as the cause of suffering, particularly with the lived experience of disability in the current life: '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 judgement.

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 or suffering. Some teachers suggested that parents of children with disabilities would feel shame and hence may be kept at home. Another teacher highlighted that people with HIV and AIDS would 'feel shame and 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 sensitisation: 'one kind of answer is to educate the parents: this is not a shameful thing' (focus group, 7 May 2015).

### **Problematizing disability models: advancing a socio-cultural construction**

The findings of our research, as already presented, 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 findings further support Miles' (2000) view that a binary disability model is problematic in Asia or, generally, in other socio-cultural contexts beyond the Euro-American. Similarly, Schuelka (2015) found that in Bhutan – another country with a strong Buddhist heritage with similar religious syncretisation – worldviews 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 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 suggest a shifting conceptualisation 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 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 regards 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 of 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 attention towards 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 order to stave off the neocolonial application of disability models and objective disability thinking (Grech 2011).

Therefore, we believe that there is cross-cultural promise within this reassessment of disability theory, particularly when considering the work of Ingstad and Whyte:

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 (contextualised, woven together with) the process of defining disability and the shared criteria brought into play in particular settings. (2007, 11)

It is not that medical models and social models – and other models, such as ‘charity’ – do not exist and inform people’s worldviews. Rather, we argue that ‘models’ of disability are not mutually exclusive or zero sum. They 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’.

## Conclusion

In summary of the research findings, the dominant socio-cultural construction of disability in Myanmar which we found through an analysis of the focus groups and interviews conducted was that of an individual ‘impairment’ conceptualisation. 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, this often did not seem to be said as a value judgement. 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'.

Ideas of both 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 sub-text of the language.

Based on our findings in Myanmar and the ensuing discussion, we conclude that community participant perspectives should be foregrounded in disability research and more effort should 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 often contradictory or cognitively dissonant disability discourses. To them, notions of karma, pity, compassion, shame, and 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 worldviews and explanations.

## Notes

1. In this article we use the term Myanmar to refer to the nationality of the participants in the study. Through this, we want to acknowledge the ethnic heterogeneity of the participants coming from groups such as Mon and Kayin as well as Barmar. 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

standardised 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 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 English comprehension at secondary school.

## Disclosure statement

No potential conflict of interest was reported by the author.

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