

Disability

Book or Report Section

Accepted Version

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(2014) Disability. In: Desai, V. and Potter, R. B. (eds.) The
Companion to Development Studies. Routledge, Abingdon, pp.
466-469. ISBN 9780415826655 Available at
<https://centaur.reading.ac.uk/37425/>

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Publisher: Routledge

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Chapter contribution: Disability¹

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Disability, poverty and development

The complex links between disability, poverty and development have been increasingly acknowledged within development discourses and research in recent years. Poverty is regarded as both a 'cause' and a 'consequence' of disability (DfID, 2000). Although reliable statistical data on the incidence of disability/impairment is not widely available and there is no agreed consensus on how disability should be defined, over a billion people worldwide (15% of the global population) live with disability (WHO, 2011). The majority of the global population of disabled people (80%) live in low and middle income countries, which often have limited resources available to meet their needs. Furthermore, disabled people are disproportionately represented among the numbers of people living in chronic poverty. The high rates of impairment and preventable illness in the global South are largely caused by malnutrition, poverty, lack of access to sanitation, safe drinking water, healthcare and other services, hazardous work, landmines and armed conflict (Yeo and Moore, 2003; McEwan and Butler, 2007).

Being poor also increases the likelihood of an individual experiencing ill health and becoming disabled (Yeo and Moore, 2003). Childhood impairment, for example, is often caused by preventable injuries and illnesses in homes and neighbourhoods that are related to poor living conditions, inadequate access to healthcare and sanitation and accidents among working children (McEwan and Butler, 2007). Many disabled children are denied access to education, due largely to the fact that education systems in the global South lack the resources and skills to include disabled students within mainstream educational settings and adequately meet the needs of disabled students. This in turn leads to high levels of illiteracy, reduced skills and employment opportunities for disabled people in adulthood, perpetuating the cycle of poverty from one generation to the next (Yeo and Moore, 2003). Disabled women and girls often experience multiple disadvantages, on the basis of their gender and disability, and are particularly vulnerable to abuse, chronic poverty and exclusion.

Improving health systems, infrastructure and the prevention and treatment of diseases are critically important in preventing and reducing the prevalence of disability in the global South. Fulfilling disabled people's rights and enhancing their wellbeing, however, also requires efforts to tackle poverty and the socio-cultural, political and economic inequalities and structural violence that people experience.

The 'medical' and 'social' models of disability

¹ This chapter draws on a more extensive discussion of health, disability and development in Potter et al.'s 2012 book, *Key Concepts in Development Geography*, London: Sage.

Development approaches based on multidimensional understandings of poverty that aim to enhance human capacities and wellbeing have been influenced by disability politics and social theories of the body, health and disability that developed from the 1970s onwards. Disability activists in the global North rejected medical, rehabilitative models of disability which were based on assumptions that disabled people suffer primarily from physical and/or mental abnormalities that medicine can, and should treat, cure, or at least prevent (Oliver, 1990). Within the dominant 'medical model' approach, disability is perceived as an 'individual misfortune' or 'tragedy'. The disability movement in the global North (led by mainly UK-based activists and allies) instead developed a 'social model' of disability to focus attention on the socio-cultural, economic, political and spatial barriers to participation that disabled people experience. An individual's 'impairment' was seen as separate from the social, attitudinal and environmental dimensions of 'disability' that exclude disabled people. The 'social model' thus focuses on changing society to facilitate the participation and inclusion of disabled people, rather than on efforts to 'rehabilitate' individuals and overcome biological constraints of the body.

These understandings of disability have been crucial to improving accessibility, achieving equality of opportunity and securing disabled people's rights within the public sphere in the global North, including in education, employment, health and social care. Commentators, however, have questioned the appropriateness of applying Western-centric social models of disability in the global South (McEwan and Butler, 2007). The wider macro-economic context, resource constraints and limited availability of technical solutions to make environments more accessible constrain the implementation of social model approaches to disability in many low income countries. Chronic poverty, limited income earning options and restricted access to health and education that many disabled people experience mean that access to basic services is likely to represent a higher priority for disabled people, governments and policymakers, rather than issues of accessibility or assistive technology.

Debates about the need to reconcile both medical and social models of disability in the 1980s led to the establishment of 'community-based rehabilitation' approaches in the global South. Such approaches aimed to provide rehabilitation through medical intervention and care, as well as promoting the social inclusion and participation of disabled people within their communities. Community-based rehabilitation projects have been criticised, however, for being ill-conceived and lacking sensitivity to local cultures and practices, including overlooking the existing care and support that many families and communities provide for disabled people (McEwan and Butler, 2007). Community-based rehabilitation can be seen as reinforcing medical/charitable models of disability that were introduced in the colonial era, perpetuating ideas that disabled people are dependent and need to be supported by charitable fundraising and donations (McEwan and Butler, 2007). Community-based rehabilitation projects have sought to shift towards a more community development approach in recent years and aim to empower disabled people and facilitate their participation in the development process.

Although debates about disability and chronic illness within the social sciences have been largely dominated by urban, Anglophone and Western-centric concerns to date, there has been growing recognition of the need to investigate the interconnections between socio-cultural representations of health, illness and disability and development processes at both a local and global scale (McEwan and Butler, 2007; Power, 2001). Understandings of bodies, disability and illness vary according to the economic, geopolitical, socio-cultural and spatial context. While most cultures ascribe to notions of a 'normal' or 'ideal' body or mind, the meanings attached to different illnesses and impairments and the social responses that are deemed appropriate are not universal. In many Sub-Saharan African countries, for example, disability in children is associated with maternal wrongdoing and witchcraft and in contexts of poverty, negative cultural attitudes and a lack of support, families may 'hide' or abandon disabled children who are considered 'abnormal' (Kabzems and Chimedza, 2002). However, impairment does not always lead to exclusion and many individuals are supported and included within their families and communities (Barnes and Mercer, 2003).

Research from the global South is increasingly challenging Northern framings of the disability debate (Connell, 2011). Social model approaches to disability have been criticised for failing to acknowledge the materiality of the body such as the effects of pain and impairment on people's everyday lives, and the impacts of structural violence, such as impairments resulting from processes of imperialism and colonisation. Meekosha and Soldatic (2011) argue that a politics of impairment is critical for understanding 'disability' in the global South. The authors point to the example of the Vietnamese Agent-Orange Movement's claims for redistributive justice against the US military. Such political mobilisations to achieve compensation for impairments caused by crimes committed as part of the colonisers' project draw heavily on medical science to make claims for a global resource transfer from the North to the South. Similarly, people living with HIV in Africa and others with chronic illness may identify with others on the basis of their biomedical diagnosis rather than according to a strategic notion of 'disability' and the focus of their activism may be on access to healthcare and medical treatment, which differs from the focus of the disability movement in the global North (Evans and Atim, 2011).

The separation of 'impairment' from 'disability' that underpins the social model can result in impairment being constructed as 'natural' (as opposed to disability which is viewed as 'social'). However, as Meekosha and Soldatic (2011: 1393) argue, 'impairment is not in fact always natural, but the outcome of deeply politicised processes of social dynamics *in* bodies that then become medicalised and then normalised through a raft of moral discursive and real practices'. They call for a 'politics of diversity within unity' as a central strategy of global mobilisation on disability and impairment.

Disability politics and rights

The adoption and rapid ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) by many countries from 2008 has resulted in a high level of state and civil society mobilisation around disability. This has been accompanied by a growing awareness that many Millennium Development Goals and

other international development targets are unlikely to be met unless disabled people's views, needs and priorities are taken into account within efforts to alleviate poverty. Disability issues appear to be increasingly mainstreamed within the 'rights-based development' agenda, although the legal rhetoric is often very distant from the lived reality experienced by many disabled people in the global South (Meekosha and Soldatic, 2011).

Disabled people's organisations, led by disabled people in the global South, have played an important role in collective advocacy for the representation of disabled people in all stages of the development process at the national and international levels. For example, the National Union of Disabled People of Uganda (NUDIPU) lobbied for the inclusion of disabled people at all levels of political administration. As a result, disabled people have achieved a higher level of political representation in Uganda than in any other country (McEwan and Butler, 2007). International non-governmental organisations, coalitions and networks, such as Disabled People's International (established in 1981) have helped to strengthen national disabled people's organisations and facilitate collective advocacy for disabled people's rights at the global level.

The UN Convention on the Rights of Persons with Disabilities is broadly informed by the social model of disability. Disability and impairment are not explicitly defined, but 'persons with disabilities' include: 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others' (UN, 2010). Key tenets of the Convention are disabled people's rights to participation and inclusion, non-discrimination and accessibility. While the emphasis is on mainstreaming disability into all development activities, such as Poverty Reduction Strategy Papers and the MDGs, it is recognised that disability specific measures may be necessary to 'accelerate or achieve de facto equality of persons with disabilities' (UN, 2010).

While the 'mainstreaming' of disability within rights-based approaches to development has been broadly welcomed by advocates and activists, tensions remain. Concerns focus on the dangers of token involvement of disabled people and the neglect of their self-determination and equality, in addition to the lack of attention to global structural inequalities and the role of imperialism and colonialism as root causes of violations of human rights, famines, malnutrition, ecological degradation and growing impairment in the global South (Meekosha and Soldatic, 2011).

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Further reading

Third World Quarterly (2011) 'Disability in the global South', special issue, 32(8). This collection of articles discusses recent conceptualisations of Southern bodies, disability, poverty and human rights.

Groce, N., Kembhavi, G., Wirz, S., Lang, R., Trani, J-F, Kett, M. (2011) 'Poverty and Disability - a critical review of the literature in Low and Middle Income Countries', Working Paper Series No. 16, Leonard Cheshire Disability and Inclusive Development Centre, University College London. This paper provides a useful review of the evidence regarding the links between poverty and disability in the global South.

Eide, A. and Ingstad, B. Eds. (2011) *Disability and Poverty: a Global Challenge*, Bristol: The Policy Press. This wide-ranging collection explores the social, cultural and political dimensions of disability and poverty in different contexts in the global South.

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Barron, T. and Manombe Ncube, J. Eds. (2010) *Poverty and Disability*, London: Leonard Cheshire Disability. This edited collection provides analysis of the links between poverty and disability in the global South from policy, practice and academic perspectives.

Useful website

www.un.org/disabilities