

**Reducing Barriers and Increasing Inclusion of Persons with Disabilities:
A Comparative Case Study of Two Post-Conflict Nations, Cambodia and
Sierra Leone**

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In memory of my father

Abstract

Disability in developing and post-conflict nations is an understudied and often overlooked area of development. However, literature indicates that persons with disabilities in developing and post-conflict nations are among the most impoverished, and are a sizable, vulnerable social group facing immense social, political, economic, cultural, and environmental barriers. The aims of this study are:

- to understand disability in a country specific context
- to examine societal barriers faced by persons with disabilities
- to examine the extent to which existing policies and practices support persons with disabilities
- to identify local and global strategies to increase inclusion in Cambodia and Sierra Leone, with recommendations potentially applicable to other developing or post-conflict nations

The social model of disability serves as a conceptual framework for this research, as it explores and addresses larger societal contexts in order to dismantle barriers to inclusion. This desk based study adopts a comparative case study research design to examine disability in Cambodia and Sierra Leone, two countries sharing similar recent histories and living conditions for persons with disabilities.

Qualitative research methods were used to collect primary data from local and international organisations working with persons with disabilities in Cambodia and Sierra Leone. Secondary data, drawn from existing reports and research, are included to strengthen the study. Study findings reveal a tendency for the general populations and local governments of both countries to understand disability through the individual models (medical, religious, and charity), as opposed to the social model or International Classification of Functioning, Disability and Health (ICF) perspectives which are commonly adopted by academia, and national and international organisations. This disconnect may be amplifying challenges for persons with disabilities. Furthermore, findings highlight a range of social, political, economic, cultural, and environmental barriers to the inclusion of persons with disabilities in both countries. These barriers demonstrate the multidimensional aspects of poverty, and support a connection between disability, poverty, and conflict. Findings also show that certain social groups with disabilities face multiple barriers, making them further susceptible to marginalisation. Furthermore, the majority of services for persons with disabilities focus on physical impairments, excluding a significant segment of the disabled population and reinforcing a narrow, individual model perception of disability.

While secondary sources indicate that some organisations and programs geared to support persons with disabilities in fact perpetuate barriers and discrimination, primary sources show that organisations face significant challenges which impede their ability to effectively support those with disabilities. Finally, despite existing policies geared to strengthen and protect the rights of persons with disabilities in both countries (UNCRPD and some disability laws), they have been largely ineffective due to poor implementation and a reliance on non-governmental organisations (NGOs) with limited capacity to deliver services. This research suggests key strategies to reduce barriers and increase inclusion: improve disability data, coordinate disability stakeholders, educate at all levels, target social groups who face multiple barriers, implement legal obligations and evaluate progress, increase the capacity of NGOs and disabled people's organisations (DPOs), and mainstream disability. While data did not directly recommend that the governments of Cambodia and Sierra Leone adopt a broader definition of disability in their laws and policies, this step may promote inclusion among local populations and improve alignment with national and international organisations. Overall, findings from this study highlight the potential for governments and organisations to lead by example in breaking down societal barriers through creating and implementing inclusive policies and practices, ultimately fostering inclusion at local, national, and international levels.

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Abbreviations and Acronyms

CDMD	Cambodian Development Mission for Disability
CDPO	Cambodian Disabled People's Organization
CSES	Cambodian Socio-Economic Survey
CSO	Civil Society Organisation
DAAG	Disability Awareness Action Group
DAC	Disability Action Council
DFID	Department for International Development
DPO	Disabled People's Organisations
ERW	Explosive Remnants of War
ESRC	Economic and Social Research Council
HDI	Human Development Index
ICF	International Classification of Functioning, Disability and Health
MDG	Millennium Development Goals
MOSALVY	Ministry of Social Affairs, Labor and Vocational Training and Youth Rehabilitation
NGO	Non-Governmental Organisation
PRSP	Poverty Reduction Strategy Paper
RGC	Royal Government of Cambodia
SNAP	Strategic National Action Plan for Disaster Risk Reduction
TRC	Truth and Reconciliation Commission
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UPE	Universal Primary Education
UPIAS	The Union of the Physically Impaired Against Segregation
WHO	World Health Organisation

Chapter 1

Introduction

“... a lack of disability inclusion represents a missed opportunity”
(Trani, Browne, and Kett *et al.*, 2011, p. 1201).

1.1 Background

Research indicates that persons with disabilities in developing and post-conflict nations are invariably among the most poor (DFID, 2000; Yeo, 2001). Despite existing data demonstrating that this sizable social group faces incredible societal barriers, little research has been done to understand the situation of persons with disabilities in developing and post-conflict nations, and they are excluded from many development policies and practices (WHO, 2011; Yeo, 2001; Grech, 2009; Mitra *et al.*, 2013). Until societal barriers are examined and strategies to increase inclusion are implemented in developing and post-conflict nations, global and national poverty reduction and human rights goals will not be met.

My passion for researching disability in developing and post-conflict nations originates from a trip to Cambodia in the late 1990s. I was shocked to see the number of people with missing arms, legs, or eyes, not to mention the widespread poverty. I was even more surprised when, a few weeks later, in a marketplace in northern Thailand, community members advised me to ignore a man with leprosy begging for money, they explained that he was disabled because of sins from his past life and deserved his fate. These moments sparked my interest in this field of development and have shaped the direction of my life. This dissertation has been an opportunity to increase my knowledge on this topic, to contribute toward an understudied area of development, and to collaborate with others who share similar interests.

1.2 Research Questions, Research Strategy, Limitations, and Terminology

As this research aims to uncover barriers and identify strategies for increasing the inclusion of persons with disabilities in Cambodia and Sierra Leone, the research questions, derived from themes that emerged from literature examined in chapter 2, are directly related to the aims of, and provide a structure for, the entire study. The subsidiary research questions build upon one another to answer the primary research question.

Primary Research Question:

- How can barriers be reduced and inclusion increased for persons with disabilities in Cambodia and Sierra Leone?

Subsidiary Questions:

- How is disability understood and defined in Cambodia and Sierra Leone?
- What barriers to inclusion do persons with disabilities face in Cambodia and Sierra Leone?
- To what extent do development policies and practices support persons with disabilities in Cambodia and Sierra Leone?
- How can barriers to the inclusion of persons with disabilities in Cambodia and Sierra Leone be addressed on local and global development levels?
- To what extent can findings from Cambodia and Sierra Leone be applied to development policies and practices in other developing and post-conflict nations?

This study examines disability through the social model lens, as:

“This model has huge implications for poverty reduction work and has relevance for all manner of marginalised groups. If the problem emanates from society itself then what is needed is to change society not the individual. If society were constructed in a more egalitarian, inclusive manner then both poverty and the exclusion of disabled people could be addressed” (Yeo, 2005, p. 6).

The research is guided by the interpretive social science approach, as this methodology seeks to understand people's experiences and interpretations of reality, and it naturally aligns with the social model of disability. In order to examine disability in Cambodia and Sierra Leone, a comparative case study research design was selected. Case studies investigate contemporary phenomena in their real life contexts, and by comparing and contrasting data from multiple countries, the value of a case study can be strengthened (Yin, 2003; Baxter and Jack, 2008). The two countries chosen, Cambodia and Sierra Leone, are both recovering from civil war, and share similar recent histories and living conditions for persons with disabilities. Data was collected and analysed through qualitative research methods, as

these methods help to explore intangible elements of society and can provide an opportunity for participants to share their experiences and knowledge, both important aspects of this study. Secondary findings, including quantitative data, drawn from existing research and reports are further used to strengthen the study. The University of Birmingham's Code of Practice for Research informed and guided all aspects of this research.

Limitations envisioned at the outset of the study include: minimal existing data and literature on persons with disabilities in developing nations (post-conflict in particular), inconsistent interpretations of disability, inability to conduct in person interviews due to time and resource constraints, and possible language barriers. Furthermore, this author recognises the implications of language and supports the social model usage of the term 'disabled people' (Oliver, 1990); however, for the purposes of this dissertation, the term 'persons with disabilities' is adopted as it is internationally recognised and consistent with language used by United Nations (UN) documents on disability as well as the *World report on disability* (2011), which was a joint collaboration between the World Health Organisation (WHO) and the World Bank.

1.3 Structural Overview

This dissertation is divided into six chapters. Chapter 1, Introduction, provides a brief background of the study, listing the research questions and discussing the research strategy, limitations, terminology, and the overall structure of the dissertation. Chapter 2, A Review of the Literature on Disability in Developing and Post-Conflict Nations, serves as a foundation for the rest of the dissertation. It explores various models of disability, the prevalence of disability in developing nations, and the connection between disability, poverty, and conflict; it ultimately argues that persons with disabilities in developing and post-conflict nations are a sizable, vulnerable social group that encounters significant barriers. Chapter 3, Researching Inclusion: Methodology, Research Design, and Methods, explains the interpretive social science research methodology, the comparative case study research design, and the qualitative research methods adopted for this study. It also discusses the role of the researcher, sampling and finding participants, challenges to the study, and ethical considerations. Chapter 4, Case Profiles of Cambodia and Sierra Leone, briefly details recent history and the similar current situations for persons with disabilities in each country. Chapter 5, Study Findings, discusses data analysis and presents the findings made through primary and secondary research. Chapter 6, Conclusion, highlights

the significance of this study's findings, and details implications for future policy and practice, limitations to the study, and suggestions for further research.

Chapter 2

A Review of the Literature on Disability in Developing and Post-Conflict Nations

Introduction

This chapter will review literature on disability in developing and post-conflict nations. It will examine core models used to understand disability, discuss the prevalence of disability in developing nations, and highlight the connection between disability, poverty, and conflict in post-conflict developing nations. According to Hart (1998, pp. 1-2) the literature review is intended to make “use of the ideas in the literature to justify the particular approach to the topic, the selection of methods, and [to demonstrate] that this research contributes to something new.” Included literature was derived from extensive electronic database searches (the University of Birmingham library, Leeds Disability Archive), from publications and reports of key organisations (Leonard Cheshire International, UN, WHO), and from resources that resulted from snowball searching (reference lists and author searches). Consequently, sources referenced in this chapter include: journal articles, books, grey literature, and work by key authors in the field.

This chapter is comprised of three main sections. Each section builds on the previous to argue that persons with disabilities in post-conflict nations are a sizable, vulnerable social group that faces considerable social, political, cultural, economic, and environmental barriers. This will provide the foundation for the rest of the dissertation, which aims to identify barriers for persons with disabilities and strategies to increase inclusion in the post-conflict nations of Cambodia and Sierra Leone. The first section, 2.1, looks at core models of disability, such as the individual models, the social model, and the International Classification of Functioning, Disability and Health (ICF), as they provide a base for defining and understanding disability. This section concludes by explaining that the social model of disability is adopted in this study as it uncovers societal barriers contributing to the marginalisation of persons with disabilities. The second section, 2.2, discusses the prevalence of disability, as the *World report on disability* (WHO, 2011) estimates approximately 15% of the world's population has a disability, with the vast majority living in developing nations (UN Enable, 2008-2012). Due to inconsistent definitions of disability, differing methodologies, inadequate research and data, and marginalisation of persons with disabilities, these figures may actually understate the true prevalence of disability. Furthermore, partly due to these challenges, persons with disabilities are often overlooked in

development, yet this group may be among the most susceptible to poverty. The third section, 2.3, examines the connection between disability, poverty, and conflict in developing nations as this link has emerged as a pressing development issue and is a cornerstone to this dissertation.

2.1 Models of Disability

2.1.1 The Individual Models

Key individual models of disability include: the medical model, the religious model, and the charity model. The medical model, which was the original model of disability, originated in response to the 'war maimed' and is grounded in a medical perspective with disability seen and treated as a disease (Toboso, 2010). According to Mitra (2006, p. 237), the medical model “considers disability a problem of the individual that is directly caused by a disease, an injury, or some other health condition and requires medical care in the form of treatment and rehabilitation.” It views disability as a personal tragedy and any negative social, economic, or political implications are simply natural extensions of limited bodily function (Oliver, 1990). This model predominated into the 1970s and continues to influence many developing nations today. The religious model attributes disability to external forces such as spirits, karma, and sins. According to Gartrell's (2010a, p. 7) research in Cambodia,

“Karma guarantees retribution in the current life for unwholesome actions and thoughts in previous incarnations. From this perspective, disability is a form of repayment: the embodiment of de-meritous deeds performed in past lives.”

While the religious model is less used than the medical or social models, it is culturally relevant in many countries and will be discussed again in chapter 5, Study Findings. Finally, the charity model assumes that an individual or family is burdened by disability and is unable to lead a full, active life. Consequently, persons with disabilities require assistance or are dependent on others. Coleridge (1999, p. 158) argues that development is about change, and “charity, despite its good intentions, is counter-development because it does not promote change; it perpetuates the status quo of inequality.” The individual models have been critiqued for neglecting human rights, for reinforcing non-disabled western theorists' perspectives on disability, for assuming that persons with disabilities are a homogenous group, and for ignoring social, economic, environmental, and political marginalisation.

The social model of disability arose as a consequence of dissatisfaction with the individual models.

2.1.2 The Social Model

The social model emerged in the 1960s and 1970s as a shift away from the predominant individual models, as activists in the United Kingdom aimed to define disability as a socio-cultural construct rather than a biological construct (Lang, 2007; Thomas, 2010). The origin of the social model is attributed to Oliver (1983) as well as the 1976 document, *Fundamental Principles of Disability*, produced by The Union of the Physically Impaired Against Segregation (UPIAS). Oliver (1990) criticises the medical model for failing to account for broader elements of disability such as social, economic, political, cultural, and environmental barriers. Lang (2007, p. 3) explains that the “social model shifts away from consideration of the deficits of the functional, physiological and cognitive abilities of the impaired individual, to the ability of society to systemically oppress and discriminate against disabled people, and the negative social attitudes encountered by disabled people throughout their everyday lives.” As a result, society becomes an agent of change through the associated barriers or supports built into the larger social, economic, political, cultural, and environmental structures impacting persons with disabilities. This perspective is linked to the materialist understanding of disability whereby key influencing factors behind disability lie within historical and cultural contexts and within dominant ideological hegemony (Finkelstein, 1980; Lang, 2007; Thomas, 2010; Shakespeare and Watson, 2002). In particular, Oliver (1990) argues that industrialisation led to the isolation and exclusion of persons with disabilities as they were deemed unfit to participate in the labour market, and therefore a hindrance to the capitalist economy.

An important component arising from the materialist perspective is the differentiation between impairment and disability. Culture, Lang (2007, p. 22) argues, can play a role in understanding and differentiating between impairment and disability: “what [it] means to have an 'impairment' and experience 'disability' is therefore, by implication, culturally defined and will vary between societies.” Like Lang (2007), Coleridge (2000, p. 23) argues that “disability is defined by culture” and that the term itself is subject to various meanings and interpretations. In the 1970s, UPIAS (1976) defined *impairment* as “lacking part or all of a limb, or having a defective limb, organism or mechanism of the body” while *disability* was defined as “the disadvantage or restriction of activity caused by contemporary organisation which takes little or no account of people who have physical impairments

and thus excludes them from the mainstream of social activities” (Lang, 2007, p. 7).

In 2006, the Convention on the Rights of Persons with Disabilities (UNCRPD) was a milestone in the disability rights movement.

“The CRPD provides the most detailed set of international standards pertaining to the rights of people with disabilities in international law. It is a comprehensive convention consisting of 50 articles, which provide coverage of a full range of civil, political, economic, social, and cultural rights applicable to people with disabilities. It also establishes a mechanism to monitor treaty compliance at the international level” (Ovadiya and Zampaglione, 2009, p. 18).

The convention implicitly pushed for disability to be viewed through the social model lens and to have disability integrated into the mainstream development agenda. The social model has radically changed the way disability is perceived. Yeo (2005) argues that disability has become a human rights issue, and the social model has contributed toward a shift away from charity to a 'rights-based approach' that is a common stance for many international organisations. However, Grech (2009) contends that the social model has been derived primarily from a white, academic setting and connotes a universal understanding of disability that may not be applicable and relevant in all contexts and cultures. Furthermore, Grech (2009, p. 776) states: “the social model has also been heavily criticised on the basis of impairment/disability dichotomy, a process sidelining the phenomenological aspects of functional limitations and pain and abandoning the theorisation of impairment.” Shakespeare and Watson (2002, p. 5) highlight this dichotomy, arguing that while the social model has been a powerful tool in the disability rights movement, “the very success of the social model is now its main weakness. Because it is such a powerful tool, and because it was so central to the disability movement, it became a sacred cow, an ideology which could not easily be challenged.” These authors call for an approach that accounts for impairments while eliminating disabling environments and practices.

2.1.3 International Classification of Functioning, Disability and Health

The 2011 *World report on disability*, commissioned by the WHO and The World Bank, adopted a definition of disability that fused elements of the medical and social models of disability. The WHO advocates that disability is not simply aligned with either the medical or social model, but argues it is

both. The ICF, originally adopted by the WHO in 2001, is a conceptual framework incorporating elements of both models, to reflect a “bio-psycho-social model” of disability (WHO, 2001; WHO, 2011). According to the ICF:

“Disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors)” (WHO, 2011, p 4).

The strengths of the ICF are its balance of the medical and social model approaches to disability, as well as its capacity to measure disability. Mitra (2006, p. 238) states: “the ICF is the only conceptual model of disability that also comes close to offering a concrete classification system of individuals.” The ICF can assess individuals through a *capacity qualifier* and a *performance qualifier* that can create standardised assessments for individuals that can be cross culturally compared (Mitra, 2006). For example, in an in-depth multidimensional study of disability in 15 developing countries, Mitra *et al.* (2013) adopt an ICF definition of disability to measure the prevalence of disability and the connection to poverty. Despite its assets, the ICF can be overly complex, and can fail to draw attention to the larger socio-economic, political, cultural, and environmental barriers of disability. Pfieffer (2000) argues that the ICF remains grounded in a western, able-bodied, male, medicalised perspective of disability as medical professionals often hold the power to judge the quality of life of persons with disabilities. Pfieffer (2000, p. 1079) states:

“... a person's impairment is not the cause of the restriction of activity which is imposed upon people who are labelled disabled. It is the organisation of society which presumes that people labelled disabled can do little or nothing of value.”

Furthermore, Barnes and Mercer (2004) critique the ICF for creating a classification system rooted in western scientific concepts, placing the individual at the front-line of body function and activity analysis, labelling 'participation' as individual circumstance rather than social and political inclusion, and finally, while the ICF suggests examination of environmental factors, it does not suggest methods for assessing larger social, economic, cultural, and political disabling policies and practices.

2.1.4 Adopting a Conceptual Framework

Given the limitations of both the individual models and the ICF approach to disability, this dissertation reflects a social model perspective as the conceptual framework to guide and inform the research questions, methodology, and interpretation of results. The social model examines and addresses the larger socio-economic, cultural, political, and environmental barriers that marginalise persons with disabilities; it promotes a rights based approach to disability, and can contribute toward strategies to overcome exclusion (Guernsey *et al.*, 2006). Guernsey *et al.* (2006, p. 4) state:

“This way of understanding disability is important because it shows the need to identify, remove and prevent the creation of societal barriers. It also promotes an enabling environment that facilitates the inclusion of people with disabilities.”

Furthermore, this research project aligns with a working definition of disability as adopted by the UNCRPD (2006):

“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.”

2.2 The Prevalence of Disability in Developing Nations

2.2.1 Measuring Disability: Statistics

The *World report on disability* (WHO, 2011), and Ovadiya and Zampaglione (2009) explain that the measured prevalence of disability can vary greatly depending on methodologies used for data collection, on how disability is conceptualised and defined, and on underlying factors leading to disability unique to a region or country. In attempt to capture global statistics on the prevalence of disability, the WHO conducted a *World Health Survey* in 2002-2004 of 70 countries, of which 59 held 64% of the world's population (WHO, 2011, p. 27). The results presented in the *World report on disability* indicate that 15.6% or 650 million people aged 18 and older have a disability or experience significant challenges functioning in their daily lives. The *World report on disability* (WHO, 2011, p.

5) explains data accuracy remains challenging to determine as interpretations of disability differ greatly, surveys and censuses yield inconsistent results, and “most developing countries report disability prevalence below those reported in many developed countries, because they collect data on a narrow set of impairments, which yield lower disability prevalence estimates.” Ovadiya and Zampaglione, in the 2009 World Bank Working Paper entitled *Escaping Stigma and Neglect: People with Disabilities in Sierra Leone*, indicate that “the data instruments in developing countries tend to only identify the most severely disabled people, and not even all of them” (2009, p. 8). The authors (2009, p. 7) give a case example of Sierra Leone's 2004 census:

“The census estimates... are likely to be limited to people with certain types of disabilities, especially those with severe ones. For example, the census reported only 3,300 cases of mental retardation, while a 2003 study estimated that Sierra Leone was likely to have almost 219,000 children with mild to medium forms of mental retardation in addition to 33,000 children with severe forms of mental retardation....”

The statistics derived from this census along with the Sierra Leone Integrated Household Survey indicate that disability prevalence in Sierra Leone is low, at about 2.4% of the population. However, in neighbouring Liberia, the authors estimate the disability rate to be 17% (based on a statement made by the 2003 Sierra Leonean Minister of Health and Social Welfare); this is congruent with the 16% disability rate derived from Liberia's 2008 Housing and Population Census (LISGIS, 2009). Ovadiya and Zampaglione (2009) argue that the 2.4% figure is not a true reflection of disability in Sierra Leone. Grech (2008) argues that minimal qualitative research, and a lack of disability indicators and dimensions in censuses, in poverty assessments, in household surveys, and in measurements of well being, have contributed to voids in accurate data and in inclusive development policies and practices.

2.2.2 Disability in Developing Nations: Numbers are Modest

As detailed above, due to a lack of quality data and difficulty researching this population, UN Enable's (2008-2012) estimation that 80% of the world's disabled population live in low-income or developing nations, may understate the actual situation. Yeo (2001), Yeo and Moore (2003), and Mitra *et al.* (2013) advocate not only that statistics are likely modest, but that marginalisation in society has caused persons with disabilities to be excluded from research.

“Traditional development research often involves non-poor, non-disabled outsiders questioning people about their lives. The very marginalization that disabled people face can make it difficult and time-consuming for outside researchers to find and communicate with them.... In areas where stigma is attached to having a disabled person in the family, other members of the family may deny the existence of their relative. Disabled people may not physically be able to get to community-meeting places. They may also be socially excluded from these places” (Yeo and Moore, 2003, p. 577).

Historically, persons with disabilities have been overlooked in research and in development policy - perhaps because they have little representation in social, economic, and political spheres (Yeo, 2001). The absence of persons with disabilities from development policy is exemplified by the Millennium Development Goals (MDGs), a set of eight core development strategies for the global community to tackle by 2015. The Report of the Secretary General at the sixty-fourth session of the General Assembly of the UN (2009, p. 4) states:

“... disability is largely invisible in the implementation, monitoring, and evaluation of the MDG efforts. 'Disability' and 'persons with disabilities' are not mentioned in the MDGs nor in the targets and indicators that operationalize MDG efforts. They are also missing from the accompanying guidelines, policies, programmes, and conferences that are a part of on-going MDG efforts. ”

Furthermore, Grech (2009, p. 775) argues:

“The MDGs also retain a top-down orientation, and political pressure to reduce poverty head counts quickly and to document these in statistics means the exclusive focus remains on those easier to lift out of poverty.... Again, this means that disabled people and those living in chronic poverty are often bypassed because these require extended time, resources and fundamental organizational changes and are, hence, less politically attractive targets.”

Moreover, Mitra *et al.* (2013, p. 1) detail that persons with disabilities have not only received little

attention in development, but that they have also “been assumed to be a very small group, reserved for the specialist attention of health or rehabilitation professionals and beyond the scope of development studies.” Research in 15 developing nations by Mitra *et al.* (2013) demonstrates through an in-depth multidimensional poverty analysis that persons with disabilities are, in fact, a sizable group ranging from 5-15% per country, and particularly vulnerable to poverty. Their research reinforces the 15% global disability estimate reported in the 2011 *World report on disability* (WHO, 2011). It is evident that, overall, further in-depth qualitative and quantitative research is required to foster inclusive development policies and practices. Limited data and minimal extensive qualitative studies to draw upon have posed challenges for this dissertation; however, at the same time, this void in research provides a knowledge gap that this dissertation can contribute toward filling. The following section draws on research demonstrating the connection among disability, poverty, and conflict, as it provides a foundation for this research project.

2.3 Poverty, Disability, and Conflict

2.3.1 Poverty

“Poverty is a multifaceted reality. It is not simply a lack of adequate income; it is a cruel mix of human deprivation in knowledge, health, dignity and rights, obstacles to participation and lack of voice” (UNDP, 2013).

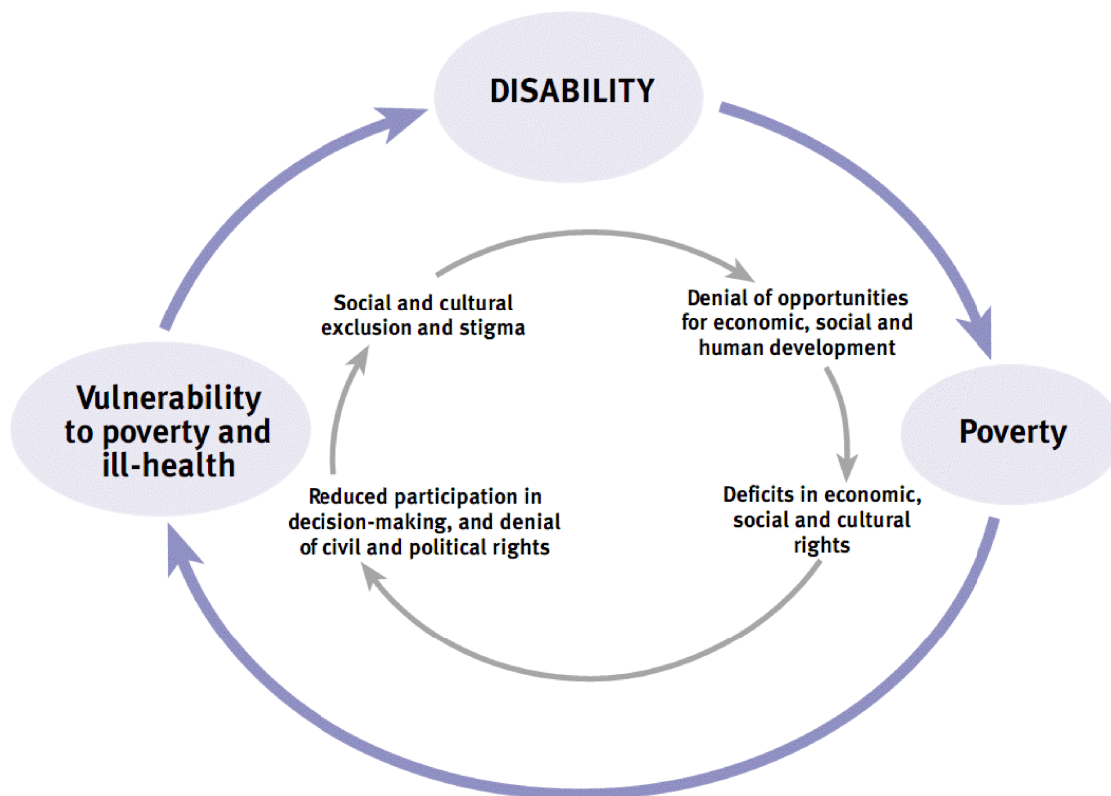
Similar to disability, poverty is challenging to define and lacks a universal definition. There are four key approaches commonly adopted when examining poverty: the monetary approach, the capability approach, social exclusion, and the participatory approach. The monetary approach, most utilised to quantify poverty, measures “income, consumption, or a range of other social indicators to classify poor groups against a common index of material welfare” (Wratten, 1995, p. 12). While it effectively generates statistics or terms of reference (\$1 a day poverty line), it is very narrow in scope, and fails to capture the causes and experiences of poverty. Sen's capability approach to poverty addresses poverty and development not in terms of income or material resources, but in terms of capacity to fulfil one's activities or desires (ODI, 2001). Mitra (2006, pp. 236-237) states:

“Under Sen's approach, capability does not constitute the presence of a physical or mental ability; rather it is understood as a *practical opportunity*. *Functioning* is the actual achievement of the individual, what he or she actually achieves through being or doing.”

Mitra (2006) explains that disability can be interpreted as a deprivation of capabilities or functioning from the combination of an individual's social location (age, gender, impairment), assets or income, and larger social, economic, political, and cultural factors. The remaining approaches - social exclusion, and the participatory approach - while different from one another, are broad in scope and more subjective in nature, incorporating elements such as the process by which people are marginalised from society, and how the poor self-define and derive strategies to overcome poverty. While all approaches are helpful in examining poverty, poverty has become well recognized as multidimensional, significantly more diverse than simple economic deprivation.

2.3.2 The Disability-Poverty Connection

Figure 1: Poverty and disability – a vicious cycle



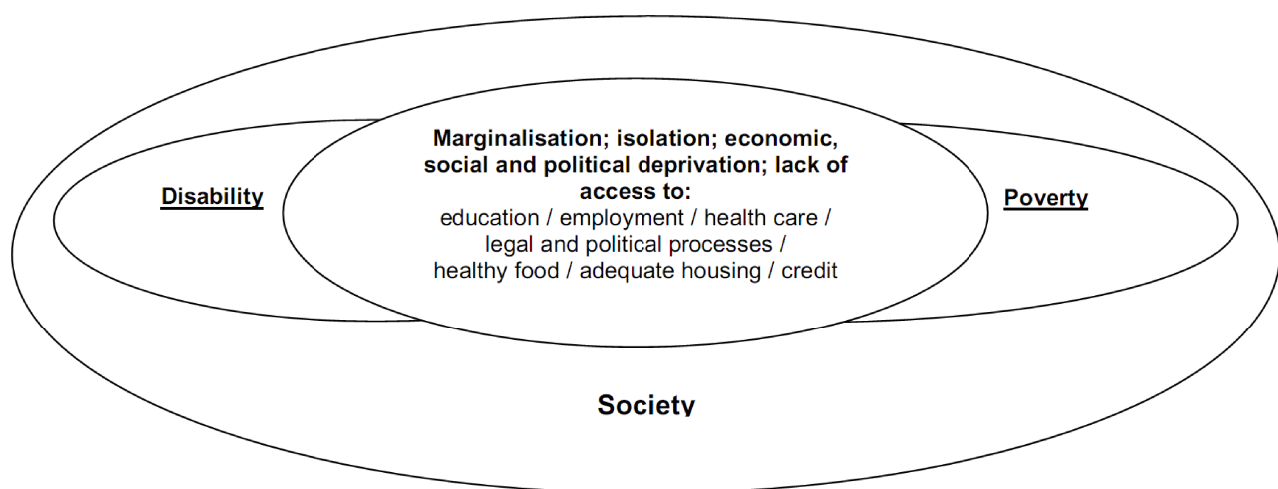
Source: DFID, 2000, p. 4

The report, *Disability, poverty and development*, by the British Department for International Development (DFID, 2000, p. 2) states: “poverty is both a cause and consequence of disability. Poverty and disability reinforce each other, contributing to increased vulnerability and exclusion.” The DFID adheres to the social model understanding that institutional, environmental, and attitudinal discrimination is what creates disability, not necessarily an individual's impairment.

“Institutional discrimination exists, for example where no legal or other provision is made to ensure that children with a disability can attend school. Environmental discrimination is where a person with a disability is unable to participate due to a physical barrier, such as inaccessible public transport or inappropriately designed buildings. Attitudinal discrimination is often expressed through fear and embarrassment on the part of a non-disabled person when confronted with a person with a disability” (DFID, 2000, p. 8).

The connection between disability and poverty has often been described as a 'vicious cycle', see figure 1, whereby poverty increases the likelihood of disability, and similarly, exclusion faced by persons with disabilities is a precursor to poverty (DFID, 2000; Yeo and Moore, 2003). Yeo (2005) argues that while the vicious cycle demonstrates the causal relationship between disability and poverty, it overlooks commonalities. Yeo (2005, p. 19) suggests a framework based on interlocking circles, see figure 2, that describes “both disability and poverty [as] symptoms of the way that society is organised;

Figure 2: Relationship between the characteristics of poverty and disability



Source: Yeo, 2005, p. 21

marginalising and isolating certain people.”

Grech (2008) and Trani and Loeb (2012) question the relationship between disability and poverty. While Grech (2008, p. 1) acknowledges a disability-poverty connection in his qualitative research in Guatemala, he states: “the relationship between poverty and disability [overall]... has not been systematically examined, and the evidence base remains anecdotal.” Similarly, Trani and Loeb's (2012) household survey in Afghanistan and Zambia derived mixed results regarding the interdependency of disability and poverty. The researchers acknowledge some limitations to their study due to viewing disability as activity limitation; surveying households, excluding institutions, care facilities, and the homeless; as well as having a restricted assets index. Their results indicate that poverty affects non-disabled and disabled individuals and families similarly, and at the same time, do not show those in low economic groups to be more susceptible to disability. Conversely, their research indicates that other dimensions of poverty (asset ownership, access to education and employment) are important determinants of susceptibility to disability. While the nature of the relationship between poverty and disability may be debatable, further research is needed as the above evidence is not adequate to discredit a cyclical relationship.

2.3.3 Disability Reinforces Poverty

Persons with disabilities are vulnerable to poverty largely due to lifelong social, economic, and political marginalisation they face on a daily basis. Children born with disabilities are often considered burdens to their families for a number of reasons: the extra time required to care for them; the stigma associated with disability; associated costs of medication, assistance devices, and transportation; and lost working time (Yeo and Moore, 2003). Yeo and Moore (2003, p. 573) state:

“Thus, disabled children often get last access to food and other basic resources. When disabled children become ill they are often not given any treatment. In households or communities already living in poverty, this exclusion is frequently a life or death situation.”

Ovadiya and Zampaglione (2009, p. 5) argue that “children with disabilities are more likely to die young, to be neglected, malnourished, uneducated, and poor.” Yeo (2001, p. 15) states that “where the main breadwinner of the family becomes disabled it often has a devastating effect on the whole family.

The whole household may slide deeper into poverty.” The editors of *Poverty and Disability* (2010), Barron and Manombe Ncube, attest that a key factor contributing to the poverty of persons with disabilities is limited access to education:

“Such exclusion often results from negative attitudes concerning their perceived human worth. These attitudes exist in families and they influence the kind of decisions made about the welfare of the disabled members of households” (2010, p. 12).

Yeo and Moore (2003) describe that when children with disabilities do in fact attend school, they often lack the necessary supplies and may be excluded from classroom activities.

“In Tanzania, recent work suggests that less than 10% of disabled children are enrolled in schools. But with twice as many disabled boys as girls enrolled, it is likely that the proportion of disabled girls enrolled is less than 5%” (Yeo and Moore, 2003, p. 574).

Navigating life with little to no education exposes persons with disabilities to disabling attitudes, isolation, illiteracy, limited resources, reduced earnings, low self-confidence, and increased potential of dependency on others. An in-depth qualitative study by Lwanga-Ntale (2003) in Uganda suggests that the link between poverty and disability is reinforcing, and persons with disabilities are often excluded through economic, social, and political marginalisation. Discrimination manifests as barriers to childhood schooling (lack of transportation and mobility assistance, high fees, stigmatisation), little specialised healthcare support, lack of political opportunity, social exclusion, and stigmatisation of families and women with children with disabilities or with disabilities themselves (Lwanga-Ntale, 2003). These findings are concerning as Uganda is considered fairly progressive in the disability field for numerous reasons: ratifying the UNCRPD in 2008, prioritising children with disabilities in the Universal Primary Education Policy (UPE), and for an active disabled people's organisation (DPO) lobbying and succeeding to achieve fair representation at various levels of government since 2001 (DFID, 2000; Mwendwa *et al.*, 2009). Mitra *et al.* (2013), in their study of 15 developing countries previously mentioned in section 2.2.2, advocate that certain social groups (age, gender) experiencing disabilities are especially vulnerable to poverty. Overall, Mitra *et al.*'s (2013, p. 11) research concludes that “persons with disabilities, on average, experience multiple deprivations at higher rates and in

higher breadth, depth, and severity than persons without disabilities.” Lifelong social, economic and political exclusion combined with other axes of social difference such as age, gender, and ethnicity, push persons with disabilities further into poverty, with minimal opportunity to escape.

2.3.4 Poverty Reinforces Disability

UN Enable (2003-04) states: “poverty can greatly increase the chance of a person becoming disabled and a person with disabilities has a greater chance of experiencing poverty.” Poverty contributes to disability through poor nutrition; limited access to healthcare, land, and shelter; minimal maternal care; poor sanitation and hygiene; reduced employment opportunities; poor working conditions; and limited to non-existent economic and political safety nets (UN Enable, 2003-2004; DFID, 2000; Yeo and Moore, 2003; Yeo, 2001). Yeo (2001, p. 15-16) argues that:

“Not only do disabled people experience disproportionate high rates of poverty, but being poor dramatically increases the likelihood of getting an impairment.... The impairment can then lead to more marginalisation and exclusion, resulting in disability, more exclusion, loss of income and further poverty.... However impairment does not inevitably lead to discrimination and disability. It is at this point that the cycle could be broken.”

The work of Thomas (2005) in Cambodia illustrates that malnourishment, iron deficiency, and vitamin A deficiency have been associated with stunted growth in children, developmental delay, and long-term intellectual disability. Furthermore, Thomas argues that poverty can lead to mental health concerns such as depression and anxiety, which can be very disabling, especially for women. Thomas' study echoes the findings of Mitra *et al.* (2013), that certain social groups are susceptible to disability and poverty, yet she also argues that many of the conditions that generate disability are preventable. Evidently, in developing nations a strong connection between disability and poverty can be seen; however, this link is further accentuated in times of conflict where the combination of poverty, disability, and violence becomes even more debilitating. While limited studies exist on persons with disabilities in post-conflict nations, the available literature clearly demonstrates that disability increases in prevalence due to conflict and natural disasters (World Disasters Report, 2007).

“While anyone can be born with or acquire a disability, poor people are significantly

more likely to become disabled and once disabled, are more likely to fall to the very bottom of the economic ladder. This is because poor people have less access to safe maternal and child health practices; to clean water and food; healthcare; education and adequate living conditions. Poor people also have limited representation and political participation, such as voting rights. All of these factors can contribute to circumstances which lead to the systemic, entrenched social exclusion and marginalization of persons with disabilities. In many developing countries across the globe, these factors are also accentuated by conditions of conflict and other humanitarian emergencies” (Kett *et al.*, 2009, p. 650).

To provide a background context for the case studies of this research project, the next section will examine literature on persons with disabilities in disaster, conflict, and post-conflict zones.

2.3.5 Conflict and Persons with Disabilities

“Conflict, like disability, is both a *cause* and a *consequence* of poverty” (Kett, 2010, p. 342). It debilitates resources, and reinforces both poverty and disability; alternately, poverty is a key precursor to violence when resources are scarce and opportunities unequal (Kett, 2010; Kett *et al.*, 2009). Conflict destroys the social, economic, and political fabric of a region and for those who survive, available resources are virtually non-existent.

“As a result of conflict, health systems and services are often disrupted and dilapidated, if not entirely destroyed. Further, essential services, supplies, and logistics are damaged including the provision of clean water and sanitation, food, key infrastructure, as well as networks of communication. Essential preventive services such as disease control, immunization and supplementation programs, and campaign activities are thwarted” (Ovadiya and Zampaglione, 2009, p. 10).

Contemporary conflicts are increasingly complex, and more often than not, fought internally by groups and alliances with shifting borders, that do not abide by conventional rules of war (Elwan, 1999; Kett 2007). Civilians are increasingly involved in war, and as Kett (2007, p. 156) argues:

“... are now the most common casualties of conflict (9:1).... In Rwanda, over 500 000 people have missing limbs and over 300 000 people have impairments from wounds sustained during the genocide. Advances in medical technology have led to people surviving injuries they previously would have not. However survival may mean lifelong impairment and subsequent disability.”

Many of the numerous challenges persons with disabilities experience before, during, and after emergencies or disasters are not necessarily connected to an impairment, but are more related to inadequate societal structures and disaster risk reduction and response. As society adopts a survivalist mentality during times of conflict, those with disabilities may become further ostracised (Santos-Zingale and McColl, 2006; World Disasters Report, 2007). Case study research conducted by Priestley and Hemingway (2007) examined recovery for persons with disabilities in the 2004 Asian tsunami and the 2005 hurricane Katrina and found that “scarcity of resources after a disaster can intensify discriminatory attitudes and behaviour within families and communities, leading to further exclusion.” Persons with disabilities may be seen as a burden when families are seeking refuge; other family members may be prioritised to receive food, healthcare, or education; and those with disabilities, especially girls, are particularly susceptible to violence and abuse (Priestley and Hemingway, 2007). The *World Disasters Report* (2007, p. 91) states:

“Persons with disabilities, especially women and children, are particularly vulnerable to violence, exploitation and sexual abuse in such situations. Anyone affected by disasters or conflict is more vulnerable to mental health and psychological problems – which may result in misunderstandings and further isolation and social exclusion for families and communities.”

In times of conflict, communities are fragmented and DPO and institutional assistance is often non-existent. Individuals already disabled, or who become disabled as the result of conflict are vulnerable to further violence, disease, poverty, and marginalisation. The *World Disasters Report* (2007, p. 89) states:

“Despite the obvious direct correlation between disability, disasters and conflicts through injuries or accidents, there are also more indirect effects such as inadequate health care, poverty,

and malnutrition, loss of support structures and change of environment. If the health care system is disrupted, as it often is in such situations, and relief organizations have limited capacity to follow up or include people with chronic illnesses, then there is a risk of further disability.”

The *World Disasters Report* (2007) examines Liberia's and Sierra Leone's youth, many of whom are former soldiers from violent conflicts suffered in both countries during the 1990s, to illustrate how discriminatory policies and practices have led to this group being marginalised from society. In Liberia, youth with visible impairments assumed to be from combat are not included in rehabilitation programs, leaving them ostracised from the community and subject to further poverty and marginalisation. While policies in Sierra Leone have more inclusively embraced war-wounded youth, many housing and skill training programs were established outside of urban areas and are unsustainable for many youth. In-depth qualitative research in Sierra Leone by Santos-Zingale and McColl (2006) calls for further research and documentation of the experiences of persons with disabilities in conflict and post-conflict developing nations, ultimately aiming to shape progressive policies and practices. Post-conflict, Kett (2007, p. 159) argues that “despite the prevalence of conflict-related impairments, it is not physical impairments that hamper reconstruction and development, but how people are excluded from these processes.” It is the aim of this dissertation to uncover barriers to the inclusion of persons with disabilities in the post-conflict nations of Cambodia and Sierra Leone in order to address the knowledge gap, and ultimately increase awareness and inclusion of this social group.

Conclusion

The first section of this literature review, 2.1, discussed key models of disability, and explained that the social model is adopted as a conceptual framework for this study because it highlights the need to eliminate societal barriers. The second section, 2.2, examined the prevalence of disability in developing nations, and concluded that due to different interpretations of disability, inconsistent measurements of disability, marginalisation of persons with disabilities, and a lack of research in the field, disability figures are likely modest and those with disabilities, while particularly susceptible to poverty, are often overlooked. The third section, 2.3, examined the relationship among poverty, disability, and conflict, ultimately suggesting that persons with disabilities face dire challenges in post-conflict developing nations. The research questions guiding this dissertation, outlined in chapter 1,

emerged as the literature review was conducted. The questions seek to establish barriers that have contributed to the marginalisation of persons with disabilities in Cambodia and Sierra Leone, and to identify strategies to reduce those barriers and increase inclusion. This study can contribute towards research in an understudied area of development, offer insights into some of the challenges faced by one of the most marginalised social groups, provide country specific strategies to reduce marginalisation and increase inclusion, and contribute to broader disability and development knowledge that may be applicable to other post-conflict or developing nations. The following chapter will discuss the methodology, research design, and research methods of this project.

Chapter 3

Researching Inclusion: Methodology, Research Design, and Methods

Introduction

This desk based study includes primary research collected electronically, and secondary research drawn from key journal articles and reports. The current chapter will examine the methodology, research design, and methods adopted to conduct the primary research. The first section, 3.1, discusses methodology, explains why an interpretive research philosophy was chosen, and locates the researcher. The second section, 3.2, examines research design and the rationale behind conducting a comparative case study. The final section, 3.3, reviews the qualitative methods used in this study to generate, analyse and interpret data, strategies used for finding participants, challenges encountered in the research process, and ethical considerations.

3.1 Methodology

3.1.1 Understanding the Social World

The methodology, or philosophical worldview, adopted for this dissertation has shaped the research design, the methods for generating data, and the interpretation of the study findings. Neuman (1994) describes three primary approaches to social research: positivism, interpretive social science, and critical social science. Positivism refers to empirical research that quantifies reality through objective observation and experimental methods; interpretive social science is concerned with how people perceive and experience their social world, and favours in-depth qualitative research methods; critical social science measures aspects of social reality in order to fuel social change and action (Neuman, 1994). As this research project aims to understand and interpret people's experiences, "to determine the meaning of the experiences", and gain an insider's perspective, it adopts an interpretive social science, or interpretive approach (Tuohy *et al.*, 2012, p. 20; Schwandt, 2000). Neuman (1994, p. 63) states:

“The interpretive approach holds that social life is based on social interactions and socially constructed meaning systems. People possess an internally experienced sense of reality. This subjective sense of reality is crucial for explaining social life. External human behaviour is an indirect and often obscure indicator of true social meaning.... For interpretive researchers,

social reality is based on people's definitions of it.”

Furthermore, the interpretive approach naturally aligns with the social model (see section 2.1.2) understanding that disability is socially constructed. The social model of disability reveals “the ability of society to systemically oppress and discriminate against disabled people, and the negative social attitudes encountered by disabled people throughout their everyday lives” (Lang, 2007, p. 3); while the interpretive approach “describes the informal norms, rules, or conventions used by people in everyday life” (Neuman, 1994, p. 64).

3.1.2 The Role of the Researcher

Creswell (2007, p. 18) argues that:

“All researchers bring values to a study, but qualitative researchers like to make explicit those values.... In a qualitative study, the inquirers admit the value-laden nature of the study and actively report their values and biases as well as the value-laden nature of information gathered from the field. We say that they 'position themselves' in a study.”

As an able bodied woman from a western country, my perspective has been shaped by my social location, my profession, my experiences travelling and volunteering overseas, my personal friendships, and my academic learning. Undertaking this research as an outsider holds both the advantage of allowing an objective or neutral perspective, as well as the disadvantage of being viewed as unable to understand the daily reality of persons with disabilities. My view of disability aligns with the social model, as discussed in sections 2.1.2 and 2.1.4. As a researcher, I value that persons with disabilities living in developing and post-conflict nations, and those directly involved with them, are the experts and I am in the position of learning - gathering, analysing, and interpreting data in the most accurate, respectful way possible. While my position may impose limitations, I approach this research with a positive attitude of collaboration.

3.2 Research Design

3.2.1 Comparative Case Study

According to de Vaus (2001), research design, not to be confused with research methods, is more than a strategy or plan for collecting data, it is a logical structure. Its aim is to “ensure that the evidence obtained enables us to answer the initial question as unambiguously as possible” (de Vaus, 2001, p. 9). Despite other designs, such as experiments, longitudinal design, and cross sectional design, this project's research design is based on a comparative case study of the countries of Cambodia and Sierra Leone. According to Yin (2003, p. 18), case studies investigate “a contemporary phenomenon in depth and within its real life context, especially when the boundaries between phenomenon and context are not clearly evident.” They can be “used in many situations, to contribute to our knowledge of individual, group, organizational, social, political and related phenomena” (Yin, 2003, p. 4). Moreover, Yin (2003, p. 9) states:

“... 'how' and 'why' questions are more explanatory and likely to lead to the use of case studies, histories, and experiments as the preferred research [design]. This is because such questions deal with operational links needing to be traced over time, rather than mere frequencies or incidence.”

Alternately, experiments separate the phenomenon from its context, and while histories do not separate the two, they do not usually deal with contemporary events (Yin, 2003).

The validity of case study research has been debated. Toma (2006, p. 412) states that internal validity refers to “meaningful inferences from instruments that measure what they intend to measure” and external validity means findings that are generalisable and can be applied to “individuals and settings beyond those immediately studied.” According to Verschuren (2003), and Yin (2003), case study research has been criticised for poor scientific rigour, for being a slow cumbersome research process, and for lacking validity as it is unable to highlight a causal relationship and provides minimal basis for scientific generalisation. Challenging these criticisms, Yin (2003, p. 15) states: “case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes.” Similarly, Verschuren (2003, p. 137) argues:

“... the criticisms of controllability and researcher independence [lose] much of their weight once it is realized that... research strategies only differ as to the technical research design, and

not the conceptual design. The criticisms of internal and external validity... appear not to hold true for holistic case study aimed at in-depth knowledge of patterns, structures, and processes.”

The value of case studies can be strengthened by utilising a comparative, or multiple, case study design in order to compare similarities and differences, and draw conclusions based on comparative data (Baxter and Jack, 2008).

3.3 Research Methods

Research methods are the ways in which data are collected and analysed. Qualitative research methods were used in this dissertation, as they are “effective in identifying intangible factors, such as social norms, socioeconomic status, gender roles, ethnicity, and religion, whose role in the research may not readily be apparent” (Mack *et al.*, 2005, p. 1). Key attributes of qualitative methods include: focusing on humanistic elements through personal, subjective knowledge and experiences; a holistic approach examining the meanings behind behaviours in a particular context; an interpretive approach to explain, not merely describe the phenomenon; researchers being reflexive about their role in and influence on the research; methods are often open-ended, in-depth and naturalistic, aiming to study people, events and things in a natural environment; and finally, qualitative research is flexible as it is able to work in conjunction with other research methods (triangulation) (Kielman *et al.*, 2011). Many of the foregoing points are in alignment with the interpretive approach, as Creswell (2007, p. 3) states: “the focus of all qualitative research needs to be on understanding the phenomenon being explored rather than solely on the reader, the researcher, or the participants being studied.”

Qualitative research methods are important to this dissertation as they enable data collection on variables that are difficult or impossible to quantify. Nonetheless, quantitative methods, such as surveys and questionnaires, are essential for generating statistics and data sets on pre-selected variables, information that is lacking in this field, and that is essential for informing policies and practices, as discussed in section 2.2 (Sandelowski, 2000; Mack *et al.*, 2005). Quantitative data relevant to this dissertation has been included in chapters 2 and 4, to compliment and strengthen the study through triangulation.

3.3.1 Sampling and Finding Participants

Qualitative research for this dissertation was conducted through open ended, semi-structured interview questions in questionnaire format aimed to attain a broad understanding of the participants' opinions and perspectives on deep social issues (DiCicco-Bloom and Crabtree, 2006). Other interview techniques, such as unstructured or structured interviews, were not as relevant to this study as unstructured interviews are often based on participant observation with interviews of key informants, and structured interviews, being more rigid, often result in 'yes' or 'no' responses.

The first task was to select a method for obtaining a sample population to interview. Sampling, according to Singh (2007, p. 102), is “the process or technique of selecting a suitable sample, representative of the population from which it is taken, for the purpose of determining parameters or characteristics of the whole population.” The two common sampling methods are random or probability sampling and purposive or theoretical sampling. Random sampling often requires accurate census data in order to capture a sample that best represents the entire population (Woodhouse, 2007). Purposive sampling, according to Singh (2007, p. 108), is “done with a purpose, which means that selection of sampling units is purposive in nature.” While it is susceptible to bias and produces a sample that is not necessarily reflective of the larger population, it “can be very useful for situations where you need to reach a target sample quickly and where a random process of selection or proportionality is not the primary concern” (Singh, 2007, p. 108). Purposive sampling was selected for this research as neither random selection nor proportionality were primary concerns, and under the parameters of time and resource constraints it would be possible to examine a specific social group.

The second phase of this research entailed in-depth searches of the internet and resource lists in order to find and contact international agencies (such as: Leonard Cheshire Disability, Handicap International, Liliane Fonds, Aria International, and the Australian Red Cross) as well as local DPOs and non-governmental organisations (NGOs) that work directly with persons with disabilities in either Cambodia or Sierra Leone. Organisations were strategically selected, as their direct experience and knowledge would provide better information than a random sample of the population. A letter (Appendix A and B) inviting participation in the research and outlining the researcher's role, the intent of the research, ethical parameters, a copy of the dissertation proposal, and contact information of the researcher and her dissertation supervisor, was sent via email to stakeholders at potential agencies. Reminder emails were sent two weeks after the initial email. Some agencies responded with further

questions, some suggested other organisations to contact, and some simply requested the interview questions be sent to them. Participants were requested to complete and return their responses within a six week time period. Two participants involved in the research referred the researcher to other organisations that were interested in participating. This snowball sampling resulted in one of the final four responses. According to Mack *et al.* (2005, p. 6), snowball sampling is a form of purposive sampling and can be very useful for reaching “hidden populations” that are not generally captured by other sampling strategies. Several participants expressed interest in participating, but did not have time available to do so.

The third phase of this study consisted of sending the interview questions (Appendix C and D) to interested agencies and collecting their responses. The interview questions were directly related to the research questions and themes identified from literature in chapter 2 (Blaikie, 2000). In total, nine organisations were contacted in Cambodia and eight in Sierra Leone. In Cambodia, four agencies expressed interest in participating and requested the interview questions, while two of the four agencies completed and returned the form. Similarly, in Sierra Leone two of four agencies that requested the interview questions completed and returned the form. Hence, these four qualitative interviews, two from each country, will be drawn on for primary data. Of the four responses, one is from an international NGO and three are from local NGOs. All employ local staff who may or may not be persons with disabilities. One response gathered is based on data compiled from local DPOs.

3.3.2 Challenges

Limitations to this study include: a lack of direct participation from DPOs, use of the English language for communication, electronic communication, and attrition of participants. All correspondence was in English via email due to time and resource constraints. Conducting the interviews electronically allowed the researcher to connect with a range of organisations and for agencies to respond at their convenience. However, this method did not allow for connecting face-to-face with individuals, or provide the opportunity to work with individuals who could not write in English. While there did not appear to be a language barrier, the researcher appreciates the participants' willingness to be flexible and acknowledges that meaning and interpretation can get lost in translation (Santos-Zingale and McColl, 2006).

3.3.3 Ethical Considerations

Ethical considerations were guided by the University of Birmingham's Code of Practice for Research. This includes adhering to guidelines for integrity and accountability; proper collection and storage of research data; following appropriate publication protocol; and awareness of intellectual property rights, conflicts of interest, and ethical reviews (Code of Practice for Research, 2014-15). This project also aligns with the Economic and Social Research Council's (ESRC) six principles for ethical research, which closely echo the above Code of Practice, it includes: ethical research design of a high standard, full disclosure to participants about the intent and possible risks of the project, confidentiality and anonymity of participants, voluntary participation, avoidance of harm for all participants, and addressing any potential conflicts of interest (ESRC, 2012, pp. 2-3). A few considerations emerged in the process of conducting research for this project. First, while all participants were offered the option that their responses and identities could remain anonymous, one organisation specifically accepted the offer, hence their identity will not be disclosed. Second, as research participation was voluntary, agencies that did not respond after the reminder email was sent were not contacted again. Third, as this topic could be emotionally challenging for some participants, the interview questions were not person specific, but allowed for responses that reflect larger issues applicable to individuals as well as groups. Finally, an able-bodied western researcher could conceivably have been seen as an outsider with little contextual understanding; however, from the participants that responded, this did not appear to be an issue.

Conclusion

This chapter examined the structural decisions made in order to gather, analyse, and interpret data applicable to this research. It has explained the rationale behind adopting the interpretive approach as the guiding methodology; it has also located the researcher, discussed selection of the comparative case study research design and qualitative research methods, and illustrated challenges and ethical considerations that influenced this study. The following chapter will outline the two countries included in the comparative case study, Cambodia and Sierra Leone.

Chapter 4

Case Profiles of Cambodia and Sierra Leone

Introduction

This chapter provides brief background history of Cambodia and Sierra Leone since the mid 20th century, as well as a discussion of the current knowledge on disability in each country. Despite obvious geographic and cultural differences, Cambodia and Sierra Leone share numerous similarities which serve as the grounds for their selection in this comparative case study. Both have histories of colonisation and civil war; they also rank low on the 2014 Human Development Index (HDI), continue to grapple with poverty, have questionably low documented rates of disability, and despite progressive policies and laws, persons with disabilities in both Cambodia and Sierra Leone continue to encounter obstacles to inclusion.

4.1 Cambodia

Figure 3: Map of Cambodia



Source: Encyclopædia Britannica, Inc., 2007

Cambodia, located in Southeast Asia, has a 2013 population estimate of 15.14 million (World Bank, 2014). The vast majority of the population lives rurally as rice production and fishing form “the backbone of Cambodian economy and society” (Gartrell and Hoban, 2013, pp. 198-199; World Bank, 2014). The HDI “is a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and [having] a decent standard of living” (UNDP, 2013a). Cambodia is ranked 136th out of 187 countries on the 2014 HDI, and according to the UNDP (2013b), the poverty rate in 2011 was 19.8%. While significant strides in poverty reduction have been made since the 1990s, Cambodia remains one of the poorest countries in the world (UNDP 2013b; Gartrell, 2010b; UNICEF, 2014).

Historical events in Cambodia have created immense social, economic, and political upheaval. Following independence from France in 1953, Cambodia emerged as self-sufficient and stable. It was not until the late 1960s that Cambodia entered a 30 year period of conflict. First, the 1968-1975 Indochina War when over 500 000 American bombs were dropped on Cambodia, followed by the 1974-1979 Khmer Rouge Regime, responsible for between 1.5 and 2 million deaths, and finally two decades of civil war that lasted into the 1990s (Durham and Hoy, 2013; Trani and VanLeit, 2010; Gartrell, 2010a). Trani and VanLeit (2010, p. 8) state: “all of these events severely weakened the basic infrastructure, educational and health systems, and the economy, which have only begun to stabilize and grow again in the last 10 years.” According to Durham and Hoy (2013), over 648.8 km² of Cambodia were desecrated with anti-personnel mines and cluster munitions leaving communities vulnerable to injury for years to come. Gartrell (2010a, p. 49) describes the lasting legacy of landmines:

“... Cambodia has the highest number of physically disabled inhabitants due to mine accidents in the world. From 1979 to September 2000, a total of 45,000 casualties were recorded, the majority civilians who stepped on mines whilst engaging in livelihood activities. The indiscriminate use of mines as an offensive weapon in the prolonged civil war has left a legacy of an estimated 4 to 7 million dormant mines in rice paddies, along foot paths, riverbeds and around villages.”

There are no conclusive statistics in reports or publications on the prevalence of disability in Cambodia.

Cambodia's 2008 General Population Census estimates that disability affects 192 538 people, or 1.44% of the population, with disability rates higher in rural areas than urban, and the aged 15-29 years cohort having the highest proportion of disability, likely resulting from birth during the civil war years of 1979 to 1993. The census's low disability rate is unaligned with the *World report on disability's* global estimate of 15%; and as discussed in section 2.2.1, is likely due to data collection on a narrow set of impairment indicators, to the definition of disability, to methodologies used to gather and analyse data, and to limited access to persons with disabilities. Other sources, such as the 2009 Cambodian Socio-Economic Survey (CSES), have reported disability rates to be at least 6% (UNICEF, 2014). According to UNICEF Cambodia (2004), children are particularly vulnerable to landmine accidents, making up half of all casualties. Likewise, Trani and VanLeit (2010, p. 8) argue that children are the most susceptible to disability in Cambodia:

“Factors placing children at high risk for disability include lack of antenatal care or skilled delivery assistance for pregnant women, serious childhood diseases (e.g. acute respiratory conditions or chronic diarrhoea) that go untreated, low vaccination rates (especially in rural areas), and high rates of children whose growth is stunted or who are underweight.”

The most common types of disability detailed in the 2008 census are moving, or mobility challenges, followed by seeing, mental, speech, and hearing difficulties. Thomas (2005) and Gartrell (2010b) explain that mobility challenges are not necessarily due to conflict or the legacy of landmines; illness and disease, followed by congenital causes and traffic accidents are more likely to result in disability than conflict related actions in Cambodia. Many of these causes are preventable consequences of poverty (Thomas, 2005; Gartrell, 2010b).

4.2 Sierra Leone

Located in West Africa, Sierra Leone has a 2013 population estimate of 6.092 million, is ranked 183rd out of 187 countries on the 2014 HDI, and has a 2012 estimated poverty rate of 60% (World Bank, 2014; UNDP, 2012). Ovadiya and Zampaglione (2009, p.1) state: “though extremely rich in natural resources (diamonds, gold, and other minerals) and with considerable agricultural potential, Sierra Leone remains among the poorest countries in the world.” After 65 years of British colonisation, Sierra Leone gained independence in 1961, and the following thirty years were relatively stable and

prosperous (Santos-Zingale and McColl, 2006). However, between 1991 and 2002, warlords subjected the country to violence and terror during 11 years of civil war (Santos-Zingale and McColl, 2006). The civil war in Sierra Leone is an example of Kett's (2007) sentiment, discussed in section 2.3.5, that civilians have become instruments of war. Berghs (2011, p. 1399) illustrates:

“The conflict affected thousands of people, irrespective of religion or ethnicity, and was marked by massive displacement and atrocities which included murder, sexual violence against women and girls, forced conscription of children, and mutilation of civilians, inclusive of amputation.”

The 2004 Housing and Population Census of Sierra Leone estimates the nation's disability rate to be low, at 2.4% (Housing and Population Census of Sierra Leone, 2004; Ovadiya and Zampaglione, 2009; Kett, 2010). Similar to Cambodia, and as discussed in section 2.2.1, the data gathered to generate these statistics was based on a narrow set of impairments and presumably led to under reporting. Ovadiya

Figure 4: Map of Sierra Leone



Source: Encyclopædia Britannica, Inc., 1998

and Zampaglione (2009) state that the disability rate in Sierra Leone is likely at least four times greater than the estimated 2.4%. 2004 census data indicates that the leading impairments are limited leg functioning, followed by visual challenges, and blindness (Trani, Browne, and Kett *et al.*, 2011). However, like Cambodia, statistics reveal that only 10 percent of those with a physical disability in Sierra Leone acquired it from conflict, as long-term disability is more likely to result from factors associated with conflict and poverty, such as disease, injury, lack of access to healthcare, and destroyed social networks (Ovadiya and Zampaglione, 2009; Kett, 2010).

Post-conflict, both Cambodia and Sierra Leone have made social, economic, and political progress including ratifying the UNCRPD and adopting specific strategies to support and protect the rights of persons with disabilities (UNDP 2012; UNDP 2013b). For example, the Royal Government of Cambodia (RGC), in 1997, established the Disability Action Council (DAC), which co-ordinates all disability programs and advises NGOs and government on all disability issues. Moreover, in 2009 the RGC created the Law on the Protection and the Promotion of the Rights of Persons with Disabilities. Similarly, Sierra Leone included persons with disabilities in the mandates of the 2005-07 Poverty Reduction Strategy Paper (PRSP) and formed The Persons with Disability Act in 2011 (Ovadiya and Zampaglione, 2009). Nevertheless, implementation has proven challenging in both countries, and persons with disabilities continue to face widespread discrimination. Further discussion of current policies and practices in each country will be presented in chapter 5, Study Findings.

Conclusion

This chapter has provided a brief background history and a discussion of the current knowledge on disability in Cambodia and Sierra Leone. These countries were selected for this comparative case study due to their similar histories and related social, economic, and political environments in which persons with disabilities must live. The following chapter will present the study findings of this dissertation.

Chapter 5

Study Findings

Introduction

This chapter presents data gathered through primary and secondary research for this comparative case study of Cambodia and Sierra Leone. All data collected was directly applicable to the research questions stated in chapter 1. The first section, 5.1, briefly details the process that was adopted for analysing the primary data derived from responses to the semi-structured interview questions (explained in 3.3.1). To provide a logical structure, presentation and discussion of the study findings will be guided by the research questions (that were derived from literature in chapter 2). The final research question will be discussed in the following chapter, in section 6.1. Section 5.2 presents findings regarding how disability is understood in Cambodia and Sierra Leone, and identifies barriers to inclusion faced by persons with disabilities in each country. The final section, 5.3, reveals findings surrounding existing supports, and ultimately recommends strategies to increase inclusion of persons with disabilities in Cambodia and Sierra Leone.

5.1 Data Analysis

Qualitative data analysis is a process grounded in inductive strategy (Lichtman, 2013). According to Mason (2002, p. 180), inductive strategy is “where the researcher will develop theoretical propositions or explanations out of the data, in a process which is commonly seen as moving from the particular to the general.” In order to derive meaning from this study, themes and sub-themes were identified within the interview responses. This was followed by secondary research conducted in order to add depth to the primary data (Lichtman, 2013). Ultimately, as Lichtman (2013, p. 255) states, “making meaning from qualitative data is a process that moves between questions, data, and meaning.” The process of memoing, by which “the researcher creates, defines, and refines conceptual categories,” was adopted in order to interpret the data from a social model perspective, and link findings to the research questions (Bailey, 2007, p. 133).

5.2 Understanding Disability and Barriers to Inclusion

5.2.1 How is disability understood and defined in Cambodia and Sierra Leone?

Cambodia

Cambodian research participants indicate that disability is viewed by the general population largely through medical, religious, and charity lenses. The anonymous organisation reports information gathered from DPOs: “disability is seen as needing medical treatment, charity... people see people with disabilities as 'beggars.' ” The independent Cambodian NGO, Cambodian Development Mission for Disability (CDMD), explains:

“Cambodian society defines disability as a barrier to perform daily activities such as studying, working, communicating and so forth. When people see persons with disabilities, they feel pity and offer helping, and keen to donate some money in case those persons with disabilities are poor.”

Both agencies shared that persons with disabilities are believed to have negative karma or to have sinned in past lives. CDMD states:

“Many people, especially the elders, believe that disability is a sin committed in the previous life such as corruption, killing people, harming other people...etc. Traditionally, most people console persons with disabilities that it is their sin; therefore, they should feel sad about life and there's nothing they can do.”

Furthermore, the anonymous organisation contributes:

“Karma bad deed from past life, people with disabilities will bring bad luck to a couple in the wedding, people believe in bad omens believing that people with disabilities cannot do a good job, also believe that if one persons with an impairment marries another, their child will also have an impairment.”

Secondary data, drawn from Cambodia's Law on the Protection and the Promotion of the Rights of Persons with Disabilities (2009, p. 5), reveals a medical model definition of disability at the government level:

“Persons with disabilities refers to any persons who lack, lose, or damage any physical or mental functions, which result in a disturbance to their daily life or activities, such as physical, visual, hearing, intellectual impairments, mental disorders and any other types of disabilities toward the insurmountable end of the scale.”

Further data, gathered from Gartrell's (2010b) ethnographic study explains that Theravada Buddhism, with the concept of karma, is the dominant religion in rural Cambodia. Gartrell (2010b, p. 294) argues that according to karma, disability, poverty, and suffering result from “bad actions and poor character in past lives.” Interestingly, a disability survey of 1000 households in Cambodia conducted by Trani and VanLeit (2010) found that karma was a perceived cause of disability, yet it was not mentioned as a reason for differential treatment of persons with disabilities. Indicating a negative perception of disability, Thomas' (2005) Executive Summary for DFID, entitled *Poverty reduction and development in Cambodia: Enabling disabled people to play a role*, draws on anecdotal evidence that many children with disabilities are teased or name-called, are not given names, or are referred to by their disability name.

Sierra Leone

Primary data gathered from participants in Sierra Leone indicates that disability is generally understood according to the medical and religious models. Disability Awareness Action Group (DAAG), a national organisation based in Freetown and Makeni, references The Persons with Disability Act (2011) to define disability: “in Sierra Leone, disability means a physical, sensory, mental or other impairments which has a substantial long-term adverse effect on a persons ability to carry out normal day-to-day activities.” Moreover, One Family People, a local human rights organisation, shares that disability is understood as a physical condition with spiritual origins:

“Sierra Leonean society still believe that disability is cause by witch craft, voodoo, demon possessed or curse from the gods. Don't believe in any scientific definition of disability.... Their understanding is based on physical disability.... Due to lack of scientific data on disability in the country, it's not all forms of disability that are recognised....”

Secondary research indicates that, following the civil war, disability became highly medicalised and charity focused. Berghs (2011) argues that adopted terminology (amputee, war wounded), segregated camps for displaced persons injured during the war, and a focus on rehabilitative services all contributed to a medicalised mentality. Berghs (2011, p. 1402) illustrates this point:

“Medical relief was a priority in the immediate post-conflict environment but this had the unintended consequence that Western medical models of disability, health and illness became 'transnational idioms' of understanding daily life, as did militarised and donor language.”

Focus groups interviewed for the report entitled *The Rights of Persons with Disabilities in Sierra Leone* reveal that persons with disabilities in Sierra Leone are name-called, much like in Cambodia. “In *Krio*, persons with physical disabilities are generally called cripple or *die fut, die ahn* (dead feet, dead hands), [and] children with severe disabilities are known as *debul pikin* (devil or demon child) (UNHCR, 2011, p. 19).” Persons with disabilities who had lived in camps revealed, through qualitative interviews conducted by Berghs (2011), that they became spectacles for visiting journalists, NGOs, and missionaries. Consequently, according to Berghs (2011) and *The Rights of Persons with Disabilities in Sierra Leone* (UNHCR, 2011), the charity model emerged in Sierra Leone, with disability becoming a commodity, and begging and NGO assistance becoming essential income streams.

Overall, these findings demonstrate that disability is understood among the general populations and local governments of Cambodia and Sierra Leone according to the individual models, placing the problem of disability on the person, as opposed to society, as outlined in section 2.1. More so than in Cambodia, the way disability is understood in Sierra Leone, predominately through medical and charity model perspectives, appears to be largely linked with the recent civil war. Neither the social model nor ICF is a dominant perspective on disability in either country, yet organisations interviewed in this study appear to reflect those frameworks. These study findings suggest that perceptions of disability in Cambodia and Sierra Leone are shaped by culture and society, as discussed in section 2.1.2, reinforcing the use of the social model for examining marginalisation and strategies to break down disabling barriers: “basic attitudes and perceptions have an impact on all aspects of involvement in society, and are critical to understanding how to address barriers to access and participation” (Trani and VanLeit, 2010, p. 10).

5.2.2 What barriers to inclusion do persons with disabilities face in Cambodia and Sierra Leone?

Cambodia

Primary research reveals a range of societal barriers that persons with disabilities encounter in Cambodia. CDMD describes:

“... people with disabilities are still discriminated on job placement, especially in private sectors to which they usually get teasing and stigma... people with disabilities are not given opportunities to participate in community activities such as studying in schools, attending vocational training skills, community meetings... most people with disabilities in Cambodia live in poverty and lack of financial supports to run small businesses or do farming... most public and private buildings lack of in-and-out accessibilities and other assistive devices... we have policy to support people with disabilities such as disability law, employment quota for people with disabilities, ...etc., but in reality, it is still far beyond the needs of people with disabilities in Cambodia.”

Secondary research, through semi-structured interviews and focus groups conducted by Thomas (2005, p. 5), provides further evidence that persons with disabilities in Cambodia face “direct discrimination and stigma” in social, economic, political, and environmental realms. In particular, certain social groups with disabilities, such as women and children, are further susceptible to marginalisation. Women who give birth to children with disabilities are often abandoned by their husbands; women with disabilities find it challenging to find a marriage partner and unmarried women face further social stigmatisation (Thomas, 2005). Furthermore, evidence gathered from Trani and VanLeit's (2010) aforementioned survey and Mak and Nordtviet's (2011) qualitative research indicates significant barriers to children with disabilities accessing education: transportation, unsupportive teachers, poor physical accessibility, lack of equipment, expenses, discrimination, and overall concern that the RGC has not been implementing policies to support children with disabilities. These findings all exemplify the multidimensional aspects of poverty, and demonstrate the disability-poverty connection, as discussed in section 2.3.

Secondary research revealed unexpected findings that persons with disabilities encounter barriers not only from their local communities and governments, but also from NGOs and programs that are intended to provide support (Thomas; 2005, Zook; 2010; Gartrell and Hoban; 2013). Individuals interviewed by Thomas (2005) described exclusion from development initiatives such as community meetings, micro-credit programs run by NGOs, and local food-for-work initiatives. Thomas (2005, p. 6) elaborates:

“... many development initiatives require potential members to have some resources to join micro-credit schemes. The very poorest - and disabled people are often in this category - literally do not have the time or assets to take part because they are continually on survival mode. The disabled informants said that non-disabled people see them as weak and unable to work like their able-bodied peers or to contribute to the household and community economy.”

Qualitative interviews from Gartrell and Hoban's (2013) research in Cambodia show that some NGOs perpetuate discrimination against persons with disabilities through: selectively sharing information about services, persons with disabilities having to incur costs applying for or accessing services, staff behaviour reinforcing power imbalances and dependency, inappropriate vocational training, and having to adhere to the rules and norms of the NGO in order to access assistance. Furthermore, Zook's (2010) research demonstrates that there are insufficient numbers of NGOs working to support individuals with intellectual disabilities, reinforcing the misconception that disability is primarily a physical impairment. By providing insight into the ingrained discrimination faced by persons with disabilities, these findings add a further dimension to this study that could not have been captured by only interviewing NGOs.

Sierra Leone

Primary research participants from Sierra Leone detail barriers encountered by persons with disabilities, many of which are similar to the barriers in Cambodia. DAAG lists numerous challenges: “unemployment, homelessness, lacks medical facilities, inaccessibility to public buildings, educational challenge, negative perception of the public towards disability.” One Family People also describes barriers:

“Persons with disabilities are exclusion in decision making processes, laid down policies are not

implemented to be tailored to meet their needs, inadequate, ineffective and non-disable friendly protection mechanisms. For example Sierra Leone has ratified the UNCRPD and passed laws that protect children with disabilities yet abuse and violation continues to happen at all levels. Children with disabilities especially girls are highly vulnerable to physical, emotion and sexual as well as neglect. There is a lack of recognition of the extent of these abuses. They are denied access to protection services as well as other rights enjoined by able children. Adolescent and adults with disabilities are more likely excluded from sex education programmes.”

Furthermore, One Family People cites barriers to formal education for children with disabilities: poor teaching and learning environment, a lack of physical structures and facilities, minimal spaces for children with disabilities in special education schools, discriminatory attitudes from teachers, and parents preferring to have their children beg for income.

Secondary data, via a report produced by Leonard Cheshire Disability entitled *Disability in and Around Urban Areas of Sierra Leone* by Trani, Bah, Bailey *et al.* (2010), provides evidence that persons with disabilities living in urban or semi-urban areas of Sierra Leone face significant barriers: high unemployment, limited social engagement, challenges accessing healthcare, seeing little value in education for persons with severe disabilities, and high levels of violence and abuse. *The Rights of Persons with Disabilities in Sierra Leone* (UNHCR, 2011) provides further evidence of ongoing social, economic, political, and environmental barriers. For example, focus groups indicated that accessing employment or micro-credit loans is difficult, and many are forced to beg or live off of donations; skill training is mostly in urban areas; many children experience name-calling and discrimination at school; healthcare and transportation are unaffordable; and specialised services and equipment are lacking (one psychiatrist in Sierra Leone). Despite physical barriers to accessing voting stations, many persons with disabilities register to vote and do vote. Yet engagement in political activities appears to be inadequate, as persons with disabilities lack fair representation in government and are often not involved in local level decision making. Much like Cambodia, secondary evidence indicates that post-conflict, some NGOs exacerbated challenges for persons with disabilities. Berghs (2011, p. 1407) illustrates:

“... NGOs created divisions, with categories of 'victims' and hierarchies of injuries as amputees were given precedence over the war-wounded, for example in skills-training projects or

housing. This caused problems and in the Freetown region resulted in a split between 'amputee' and 'war-wounded' people.”

Qualitative interviews conducted by Santos-Zingale and McColl (2006) reveal that some of the barriers faced by persons with disabilities are directly linked with poverty, such as losing employment income or property following the war, prohibitive costs for assistive devices, and discrimination when accessing community services.

Overall, research findings show that persons with disabilities in Cambodia and Sierra Leone face significant societal barriers, strengthening the social model argument that disability is a social construct. Furthermore, the relationship between disability and poverty, as discussed in section 2.3, has been demonstrated in both countries by the primary and secondary data collected. In particular, secondary evidence from Cambodia and primary evidence from Sierra Leone aligns with literature from chapter 2 stating that certain social groups with disabilities, such as women and children, are most vulnerable to marginalisation and exclusion. Finally, secondary research shows that some NGOs and associated programs (vocational, micro-credit) intended to support persons with disabilities in fact perpetuate discrimination and exclusion.

5.3 Existing Supports and Recommendations for Increasing Inclusion

5.3.1 To what extent do development policies and practices support persons with disabilities in Cambodia and Sierra Leone?

Secondary research indicates three primary actors working in the disability field in both Cambodia and Sierra Leone: the state, service providers (NGOs), and DPOs.

Cambodia

As discussed in chapter 4, the RGC has signed (2007) and ratified (2012) the UNCRPD; has adopted the Law on the Protection and the Promotion of the Rights of Persons with Disabilities (2009), which addresses discrimination in the workforce, employment quotas, accessibility, inclusive education, and the right to vote; and through the Ministry of Social Affairs, Labor and Vocational Training and Youth Rehabilitation (MOSALVY), created the DAC in 1997. Other key policies that the RGC has adopted

include:

- numerous UN human rights treaties
- the Constitution of 1993, amended in 1999, whereby fundamental human rights are recognised for all citizens
- National Plan of Action for Persons with Disabilities in 2008-2012, which contributed to the rights of individuals and family members of persons with disabilities, including landmine and Explosive Remnants of War (ERW) survivors
- National Education Law of 2008, promoting fundamental rights of students with disabilities
- ratification of the Anti-Personnel Mine Ban treaty in 1999
- support for the Biwako Millennium Framework for Action for Persons with Disabilities in Asia and the Pacific 2003-2012 (International Labour Organisation/Irish Aid Partnership Programme, 2009; Zook, 2010; Thomas, 2005; CDPO, 2013a)

Direct state support for persons with disabilities is minimal and is funnelled into office rental for DAC, to patients in some rehabilitation centres (US \$0.25/day), and to veteran and civil servant pensions (Thomas, 2005).

According to Thomas (2005), DPO presence in Cambodia is minimal, yet DPOs are essential in advocating for rights, promoting inclusion, and advising organisations and governments. A notable DPO in Cambodia is the Cambodian Disabled People's Organization (CDPO), which focuses on advocacy and rights monitoring, awareness raising and communication, and DPO development (CDPO, 2013b). In 2013, CDPO organised DPO meetings and compiled *A Stakeholders report prepared by Disabled People Organizations (DPOs) in Cambodia*, which highlighted concern over the RGC's commitment and implementation of laws, policies, and action plans. This stakeholder group critiqued the 2009 law, detailed earlier in this section, for focusing on impairment as opposed to barriers to equality and inclusion; for nominally implementing the UNCRPD guidelines regarding the rights of persons with disabilities; and for limited application and enforcement of the law itself. Furthermore, this report cites that persons with disabilities have been excluded from the Strategic National Action Plan for Disaster Risk Reduction (SNAP), and Cambodian laws and policies have failed to reach law enforcement agencies, public servants, and persons with disabilities, who are often unaware of their

rights (CDPO, 2013a).

Services in Cambodia are delivered almost exclusively by NGOs:

“The RGC is able to offer limited material assistance to people with disability without the support of international organizations and NGOs. MOSALVY depends on NGOs and international organizations to finance the majority, if not all activities in the disability sector” (Gartrell and Hoban, 2013, p. 198).

Thomas (2005, p. 8) argues that despite the plethora of NGOs in Cambodia, services are lacking for the following reasons: long term funding is insecure, they “have largely focused on the needs of those disabled by war, mines and polio, to the exclusion of other types of impairments”, rural areas are undersupported, and many services have been labelled as ineffective by those who Thomas interviewed.

Primary data from CDMD indicates that while the foregoing policies and efforts are important, organisations still experience a range of challenges:

“... local authorities and communities still neglect and discriminate towards persons with disabilities. Therefore, disability issues were not broadly included in their development plans... most buildings don't have accessibilities because the expenses on them are expensive, access to information for persons with disabilities is still limited... many disability policies and sub-degrees were already developed, but still not broadly implemented and it is still far beyond the real needs... other government ministries are still not aware about disability rights and employment opportunities for persons with disabilities are yet to be given in their institutions, [and] budget allocation to support disability sector from government is still less priority.”

The anonymous organisation cites a lack of coordination and poorly understood laws as key challenges to NGOs, yet it is hopeful that, with the recent ratification of the UNCRPD, “action for change” may occur. Also according to this agency, DPOs are challenged by a lack of the following factors: leadership, good governance, funding, inclusive skills, small enterprise, mobilisation skills, network

leverage, capacity building, material support, technical support, strong commitment to promote the rights of persons with disabilities, and networking with other NGOs, institutes, and government.

Sierra Leone

Key policies supporting the inclusion of persons with disabilities in Sierra Leone include:

- the 1991 Constitution
- the 2002 Truth and Reconciliation Commission (TRC) to address war crimes
- the 2004 Human Rights Commission of Sierra Leone Act
- inclusion of persons with disabilities in the 2005-07 Poverty Reduction Strategy Paper (PRSP)
- inclusion of persons with disabilities under the Ministry of Welfare, Gender and Children's Affairs
- creation of The Persons with Disability Act in 2011, which calls for a National Commission for Persons with Disabilities, a National Development Fund, and addresses the rights of persons with disabilities
- signatory to six of the seven human international human rights conventions, including ratification of the UNCRPD in 2009 (Santos-Zingale and McColl, 2006; Kett, 2007; The Persons with Disability Act, 2011; Ovadiya and Zampaglione, 2009)

Similar to Cambodia, the government of Sierra Leone provides very few direct services to persons with disabilities, despite mandates under several ministries to do so. According to Ovadiya and Zampaglione (2009, p. 23), the reasons for this are a “lack of resources, capacity constraints, inadequate intersectoral coordination, and insufficient awareness of service providers with respect to the rights and entitlements of the people with disabilities.”

Before the civil war, charities, associations of disabled people, and national NGOs provided some services to persons with disabilities; during the civil war, there was a void in services; and following the war, support groups were created that later became DPOs (Trani, Bah, and Bailey *et al.*, 2010). Additionally, a surge of national and international NGOs, charities, and religious organisations emerged soon after the war to provide relief and rebuilding. A number of donors specifically assisted those disabled due to conflict (Berghs, 2011); however, as Ovadiya and Zampaglione (2009, p. 23) note, and

as discussed in chapter 4, “people whose disabilities are not a direct result of conflict have received very limited donor support, although their number is by far greater than those with war related disabilities.” According to Ovadiya and Zampaglione (2009), NGOs are now challenged by: funding constraints, as the war ended in 2002 and donors are gradually pulling out of Sierra Leone; and by a lack of capacity among civil society organisations (CSOs), DPOs, and NGOs.

In addition to the foregoing key policies adopted in Sierra Leone, primary data from One Family People reveals other actions taken to support persons with disabilities in Sierra Leone:

“One Family People has simplified the Disability Act 2011 and is supporting the use of sign [language] in the national TV news... One Family People has also established a cottage industry for skilled, talented and committed persons with disabilities called 'Dignity Market Center'; and a formidable disable musical group called 'Wapoleans' that uses music and drama to break barriers and change mindset on disability... Handicap International is providing rehabilitation and lively hood programs... Liliane Fonds is providing direct support to children and youngsters with disabilities in the areas of education, health and livelihood.”

However, similar to Cambodia, primary research compiled from DAAG and One Family People cites that funding, lack of data on disability, constant eviction of persons with disabilities, the public perception of disability, and the government failing to ratify the optional UNCRPD protocol on disability, all impact organisations' capacity to support persons with disabilities.

Research findings from Cambodia and Sierra Leone indicate that despite important policies and laws intending to support persons with disabilities, there is a void in implementation and monitoring, contributing to discrimination and marginalisation. While NGOs and DPOs are responsible for service delivery and for representing persons with disabilities, they have limited capacity due to unpredictable funding, poor disability data, negative public perception of persons with disabilities, a focus on physical disability, and poor support and government guidance.

5.3.2 How can barriers to the inclusion of persons with disabilities in Cambodia and Sierra Leone be addressed on local and global development levels?

Cambodia

Primary data drawn from the anonymous Cambodian organisation details strategies to increase inclusion on a local level:

“Increased coordination of disability focused stakeholders; increased socialization and implementation of the law related to disability; informal education awareness raising, and communication at all levels provisional and national.”

CDMD shares that national and sub-national levels of government in Cambodia should: “develop and strengthen disability... legislation and regulation,” create sectoral support programs, increase advocacy and promote awareness of the rights of persons with disabilities, promote barrier free environments and social protection policies, and support education and vocational training at local and national levels.

CDMD and the anonymous organisation identify global level strategies that could help minimise barriers for persons with disabilities in Cambodia: strengthen international laws, such as the UNCRPD, and Incheon Strategy; improve disability data and statistics; include persons with disabilities in decision-making processes at international and regional levels; promote capacity building, international cooperation, and idea exchange regarding best practices in the disability sector among countries; enhance gender equality; increase attention to those facing multiple forms of discrimination; strengthen civil society organisations and DPOs; implement early inclusive education; increase involvement of the private sectors; and create awareness raising campaigns.

Secondary research, from *A Stakeholders report prepared by Disabled People Organizations (DPOs) in Cambodia* (CDPO, 2013a), identifies recommendations to minimise barriers and increase inclusion:

- amend the 2009 disability law, including making provisions for the UNCRPD, to ensure full participation of persons with disabilities in all facets of life
- reflect the needs of persons with disabilities in the SNAP
- include persons with disabilities in all national policies and plans, with strategies to monitor progress

- the government must actively consult with DPOs and families to develop laws and policies
- strengthen dissemination of information regarding the rights of persons with disabilities to reach the public through media, and in formats accessible to persons with disabilities
- improve design and accessibility of buildings, transportation, and informational and educational materials
- properly train teachers to teach all children with disabilities
- amend policy on education to include students with intellectual and sensory impairments
- ensure voter registration and polling stations are accessible
- amend the Election Laws that discriminate against persons with intellectual and psycho-social disabilities
- collect data of voters with disabilities on a voluntary basis
- build more healthcare centres in remote areas and provide incentives for doctors to work in those areas
- train doctors and nurses to communicate with and better serve persons with disabilities

Furthermore, Thomas (2005) advocates improving data on disability, providing programs that prevent disability, improving awareness and understanding of disability among donors and donor staff, and mainstreaming disability in all aspects of development as the RGC can not rely on civil society to address disability issues.

Sierra Leone

Primary data gathered from DAAG specifies steps to increase inclusion on a local level in Sierra Leone: robust advocacy and lobbying, increased project funding, and intensive engagement and mainstreaming of disability in all private and public enterprises. Similarly, One Family People recommends the government implements their legal commitments, particularly the UNCRPD and the 2011 Disability Act. Moreover, NGOs, development agencies, and donors must consult with DPOs to mainstream disability across all programs; and an inclusive education system is crucial and requires attention. Furthermore, One Family People states:

“Measures to reduce and eliminate stigma and discrimination must be prioritized to address the root cause of exclusion from education and protection. Change must occur within society and

in the way it views disability rather than [persons with disabilities] having to change to fit society, society must make room for them and uphold their rights.”

One Family People also identifies efforts that the global community can make to support inclusion in Sierra Leone:

“Provide technical and financial support to government to implement their commitment on disability; facilitate the visit of the UN Special Repertoire on disability in Sierra Leone to guide government in the implementation of the UNCRPD; all global development action plans should mainstream disability especially the UN millennium development goal. There should be specific goal and indicators targeting disability.”

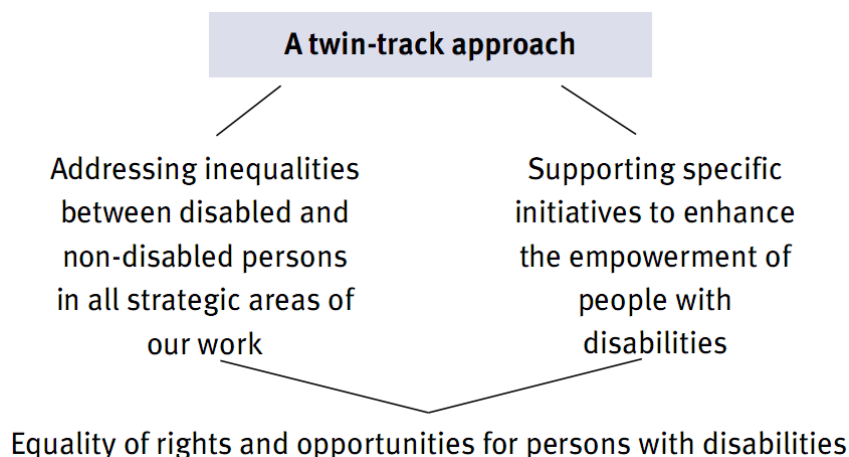
DAAG suggests that media engagement, information sharing, and linked funding of projects on the global level could also contribute toward increasing inclusion.

A secondary source, the UNHCR report entitled *The Rights of Persons with Disabilities in Sierra Leone* (2011), recommends the government, independent national institutions, DPOs, and the international community take specific action to increase inclusion of persons with disabilities. These recommendations include: prohibiting discrimination based on disability in the Constitution, making the election process more accessible and inclusive, creating the National Commission for Persons with Disabilities, and mainstreaming the rights of persons with disabilities in the next PRSP and in all international projects and programs, inclusive of United Nations policies.

Overall, this research in Cambodia and Sierra Leone reveals a range of strategies to increase inclusion and minimise barriers on local, national, and international levels. Most notable are the recommendations to improve disability data, coordinate disability stakeholders, educate at all levels, target social groups who face multiple barriers, implement legal obligations and evaluate progress, increase the capacity of NGOs and DPOs, and mainstream disability. Many of the suggestions align with a twin-track approach, see figure 5, to mainstream disability in development (figure 5, left column) and create specific initiatives to target the unique needs and rights of persons with disabilities (figure 5, right column). According to Gartrell and Hoban (2013, p. 208), mainstreaming “aims to

achieve disability equality by adopting disability-inclusive policies and strategies both in general programs and those designed specifically for people with disability.” Research findings suggest that governments and national and international organisations have the potential to lead through role modelling inclusive strategies and behaviours, in turn breaking down individual models of understanding disability, and influencing local populations to become more inclusive.

Figure 5: A twin-track approach to disability and development



Source: DFID, 2000, p.11

Conclusion

This chapter began by outlining the process adopted for analysing the primary data, then, guided by the research questions outlined in chapter 1, presented and discussed the data generated from the comparative case study of Cambodia and Sierra Leone. Many of the findings echo previous research identified in chapter 2, as well as highlight key issues. The significance of these findings, with implications for future policy and practice, limitations, and suggestions for further research, will be explained in the following chapter.

Chapter 6

Conclusion

Introduction

This chapter will outline the significance of this study's findings, as well as discuss implications for future policy and practice, identify limitations to the study, and finally suggest topics for further research. Overall, this study has strengthened previous research (discussed in chapter 2) on persons with disabilities in developing and post-conflict nations, and it has also illuminated key issues specific to persons with disabilities in Cambodia and Sierra Leone.

6.1 Significance of the Study

Data gathered to address the first research question provides evidence that among the general populations and local governments of Cambodia and Sierra Leone, disability is largely understood according to the individual models (medical, religious, and charity), and not through the social model or ICF perspectives, which are generally adopted by academics, and national and international organisations, as described in sections 2.1 and 2.3.2. The disconnect between how these governments define disability (medical model, discussed in section 5.2.1) and the way many national and international organisations (NGOs, UN) define or view disability (broader scope) seems to contribute to: inconsistent measurements of disability, insufficient and inaccurate disability data, limited disability services, limited success meeting poverty reduction goals, discrimination of persons with disabilities accessing services, and challenges for organisations delivering services. Furthermore, these findings reinforce Coleridge's (2000) argument discussed in section 2.1.2 that culture shapes the understanding of disability, and confirms the observation made by Grech (2009) that the social model is not universally accepted across all cultures and contexts.

Data pertaining to the second research question reveals that persons with disabilities in Cambodia and Sierra Leone experience barriers on multiple levels, including social, economic, political, cultural, and environmental. These barriers are examples of the multidimensional aspects of poverty, and confirm a connection between poverty, disability, and conflict, as discussed in section 2.3. Furthermore, primary and secondary evidence indicate that particular social groups, such as women and children, are especially vulnerable to exclusion and discrimination, facing multiple societal barriers, also discussed

in section 2.3. Secondary research highlights that there is a tendency for both countries to focus services on those with physical impairments, consequently excluding the sizable segment of the disabled population with intellectual, cognitive, sensory, or psycho-social disabilities, and reinforcing a narrow understanding of disability. Additionally, secondary research indicates that some organisations and associated vocational and micro-finance programs from both countries that intend to support persons with disabilities in fact perpetuate barriers and discrimination. This could be due to a plethora of possible reasons such as: employees reverting to cultural norms, employees untrained in inclusive strategies, donor mandates restricting NGOs from serving all persons with disabilities, narrow government definition of disability, poor disability statistics, limited scope of impairment focused diagnoses, and capacity being limited by a number of factors shown in section 5.3.1.

Study findings corresponding to the third research question indicate that while Cambodia and Sierra Leone have made significant progress by adopting laws and policies to support the rights of persons with disabilities, poor implementation and monitoring seriously undermine their efficacy. Additionally, disability laws in both countries reflect an individual model definition of disability, as discussed in sections 5.2.1 and 2.1.1, which likely reinforces barriers to those with disabilities and to the organisations designed to support them. Furthermore, as previously discussed, persons with disabilities have encountered barriers accessing some NGO services and assistance, yet data collected indicates that NGO capacity is significantly constrained by: a lack of legal authority, limited resources, minimal support from government, unpredictable funding, and a negative public perception of persons with disabilities. Despite best intentions, these limits impact organisations' ability to effectively foster inclusive communities.

Research findings addressing the fourth research question describe a range of local and global strategies to reduce barriers and promote inclusion in Cambodia and Sierra Leone. Key recommendations, some of which parallel literature discussed in chapter 2, include: improve disability data, coordinate disability stakeholders, educate at all levels, target vulnerable social groups who face multiple barriers, implement legal obligations and monitor progress, increase the capacity of NGOs and DPOs, and mainstream disability. In addition to, and to facilitate these recommendations, the governments of Cambodia and Sierra Leone must become more social model or ICF oriented in order to help shift cultural understandings of disability away from the limiting individual models, and to align

better with national and international organisations. Overall, governments and organisations play an important role in creating and implementing inclusive policies and practices, which in turn may foster inclusion at local, national, and international levels.

While these findings may be specific to Cambodia and Sierra Leone, some could pertain to other nations and can assist in answering the final research question: to what extent can findings from Cambodia and Sierra Leone be applied to development policies and practices in other developing and post-conflict nations? As the social model is based on the understanding that disability is a social construct, this model would be appropriate for identifying barriers and guiding inclusive policy and practices of organisations and governments not only in Cambodia and Sierra Leone, but in any other developing or post-conflict nation. This study indicates that a narrow perception and definition of disability in Cambodia and Sierra Leone negatively impacts disability data and scope of services, and excludes those with some types of disability (Ovadiya and Zampaglione, 2009). Other countries that exhibit narrow understandings of disability may conceivably experience similar challenges.

6.2 Implications for Future Policy and Practice

While findings from this research did not explicitly recommend the governments of Cambodia or Sierra Leone adopt broader definitions of disability, the data implies that this step could influence policies and practices to become more inclusive. Moreover, future policy and practices in Cambodia and Sierra Leone, and possibly other developing nations, must reflect the relationship between poverty, disability, and conflict, focus attention on marginalised social groups experiencing disability, include persons with disabilities in disaster risk reduction plans, and prioritise strategies to support NGO capacity and inclusivity. The importance of DPOs in all developing and post-conflict countries can not be overstated. They are essential for guiding governments and national and international organisations toward effective strategies for inclusion. Finally, while Cambodia and Sierra Leone have adopted progressive policies and laws, such as ratifying the UNCRPD, they have also demonstrated that without careful implementation and monitoring, these laws have little effect.

6.3 Limitations

As this study focuses on Cambodia and Sierra Leone, it is difficult to generalise about other post-conflict nations, although the findings and suggestions may be applicable. Additionally, as this study is

based on a small purposive sample, the data does not necessarily represent the entire disabled population of either country. A greater number of participants, and the participation of DPOs would have strengthened the research. Other challenges to this study included: minimal literature and in-depth qualitative research to draw upon, a general void in accurate disability statistics, and inconsistent interpretations of disability. Time and resource limitations impacted the duration of the study and negated the option of engaging directly with a wider range of stakeholders.

6.4 Suggestions for Further Research

While this study reveals a discrepancy between how disability is understood among general populations and the governments of Cambodia and Sierra Leone on one hand, and academia and national and international organisations on the other, further research is needed to identify strategies to minimise this gap. Secondly, as highlighted in chapter 2, disability data in developing and post-conflict nations is critical for influencing inclusive policies and practices. Further research is needed in Cambodia and Sierra Leone and in other developing and post-conflict nations in the following areas: the disability-poverty-conflict connection, the causes and prevalence of disability, needs of especially marginalised social groups such as women, children, and individuals with intellectual, cognitive, sensory, and psycho-social disabilities, and strategies to increase the capacity of organisations supporting persons with disabilities. Furthermore, monitoring the effectiveness of organisations delivering services to persons with disabilities may contribute to strategies to improve service delivery, and reduce barriers persons with disabilities encounter accessing some NGOs and affiliated programs.

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Appendix A

Participant Request Letter: Cambodia

Dear,

I am a graduate student in the International Development Department at the University of Birmingham, England, writing a dissertation on overcoming barriers to inclusion for persons with disabilities in post-conflict nations, specifically looking at Cambodia. I am seeking to gather information from five to seven local and international organisations that work with people with disabilities or are operated by persons with disabilities. I am looking for key staff from each organisation to complete a written email questionnaire of 7 questions that would require approximately 30 minutes. The questions are related to challenges being faced by persons with disabilities in Cambodia and strategies to overcome these barriers. I would be very grateful for your participation.

Participation in the questionnaire is voluntary, and any requests for anonymity will certainly be respected. Participants are free to withdraw at any time during the research with no repercussions. If requested, I would be more than willing to share my research findings and dissertation with you or your organisation.

The purpose of this research is to contribute toward a knowledge gap in the development field and question the barriers and challenges preventing full inclusion of persons with disabilities on local and global levels in post-conflict nations. I have attached a summary of my dissertation proposal for reference, and if requested I would be happy to send along the full dissertation proposal. Additionally, if you would like verification of my student status, please feel free to contact my dissertation supervisor, Dr. David Cobley, at d.s.cobley@bham.ac.uk.

If your organisation is willing to participate in this research please respond to this email (NXC169@bham.ac.uk) and I will forward the questions to you via email. I hope to have all responses back from participants by mid-April 2014. Thank you for your time and consideration.

Sincerely,

Natalie Cherchas
NXC169@bham.ac.uk
MSc candidate International Development (Poverty, Inequality and Development)
International Development Department, University of Birmingham

Appendix B

Participant Request Letter: Sierra Leone

Dear,

I am a graduate student in the International Development Department at the University of Birmingham, England, writing a dissertation on overcoming barriers to inclusion for persons with disabilities in post-conflict nations, specifically looking at Sierra Leone. I am seeking to gather information from five to seven local and international organisations that work with people with disabilities or are operated by persons with disabilities. I am looking for key staff from each organisation to complete a written email questionnaire of 7 questions that would require approximately 30 minutes. The questions are related to challenges being faced by persons with disabilities in Sierra Leone and strategies to overcome these barriers. I would be very grateful for your participation.

Participation in the questionnaire is voluntary, and any requests for anonymity will certainly be respected. Participants are free to withdraw at any time during the research with no repercussions. If requested, I would be more than willing to share my research findings and dissertation with you or your organisation.

The purpose of this research is to contribute toward a knowledge gap in the development field and question the barriers and challenges preventing full inclusion of persons with disabilities on local and global levels in post-conflict nations. I have attached a summary of my dissertation proposal for reference, and if requested I would be happy to send along the full dissertation proposal. Additionally, if you would like verification of my student status, please feel free to contact my dissertation supervisor, Dr. David Cobley, at d.s.cobley@bham.ac.uk.

If your organisation is willing to participate in this research please respond to this email (NXC169@bham.ac.uk) and I will forward the questions to you via email. I hope to have all responses back from participants by mid-April 2014. Thank you for your time and consideration.

Sincerely,

Natalie Cherchas
NXC169@bham.ac.uk
MSc candidate International Development (Poverty, Inequality and Development)
International Development Department, University of Birmingham

Appendix C

Emailed Interview Questions: Cambodia

Dissertation Research Project

Overcoming barriers to inclusion for person with disabilities in post-conflict nations

Please read and respond to the questions via email to the best of your ability. If there is a question that you are not able to answer, please leave it blank. Please note that participation is voluntary, and anonymity will be respected if requested. Thank you very much for your participation.

- How does Cambodian society define and understand disability?
- What are some key challenges or barriers that persons with disabilities face on a daily basis in Cambodia?
- What strategies do you believe would reduce challenges or barriers to inclusion for persons with disabilities in Cambodia?
- What supports to promote the inclusion of persons with disabilities exist in Cambodia?
- What are some of the challenges or barriers faced by organisations supporting persons with disabilities in Cambodia?
- How can barriers to the inclusion of persons with disabilities in Cambodia be addressed locally?
- How can barriers to the inclusion of persons with disabilities in Cambodia be addressed on the global development level?

Appendix D

Emailed Interview Questions: Sierra Leone

Dissertation Research Project

Overcoming barriers to inclusion for person with disabilities in post-conflict nations

Please read and respond to the questions via email to the best of your ability. If there is a question that you are not able to answer, please leave it blank. Please note that participation is voluntary, and anonymity will be respected if requested. Thank you very much for your participation.

- How does Sierra Leonean society define and understand disability?
- What are some key challenges or barriers that persons with disabilities face on a daily basis in Sierra Leone?
- What strategies do you believe would reduce challenges or barriers to inclusion for persons with disabilities in Sierra Leone?
- What supports to promote the inclusion of persons with disabilities exist in Sierra Leone?
- What are some of the challenges or barriers faced by organisations supporting persons with disabilities in Sierra Leone?
- How can barriers to the inclusion of persons with disabilities in Sierra Leone be addressed locally?
- How can barriers to the inclusion of persons with disabilities in Sierra Leone be addressed on the global development level?

