CHAPTER 1

Understanding Impairment and Disability: towards an international perspective

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Despite recent attempts to construct a universal language of disability (Üstün et al. 2001), to be designated 'disabled' in the wealthier 'developed' or 'minority world' nations in North America, Europe, and Australasia often carries with it a different set of meanings and experiences to those encountered by people who acquire this label in the poorer countries of the 'developing' or 'majority world' in, for example, Africa and Asia (Coleridge 1993; Ingstad and Whyte 1995; Ingstad 2001). Notwithstanding such international variation, the experience of disability is interwoven in most societies with multiple deprivations and disadvantages (WHO 2001; Barnes and Mercer 2003). Hence, the growth of political activism amongst disabled people and their organisations across the globe since the 1960s has concentrated on campaigns to overturn their social exclusion and oppression and achieve 'independent living' (Driedger 1989; Charlton 1998).

The chapters in this book explore selected aspects of these developments with particular emphasis on the contribution of the 'social model of disability' that was constructed during the 1970s by disabled activists. The social model approach shifted the attention away from the functional limitations and psychological 'loss' stressed by the dominant individual or medical approach to 'disability' or the ways in which physical and social environments excluded individuals with impairments from participation in mainstream society (UPIAS 1976; Oliver 1983). It offered a socio-political analysis of the discriminatory structures and processes that impact on the lives of people with impairments. Its early adoption in 1981, albeit in a modified form, by Disabled Peoples' International (DPI) signalled its widening significance for disabled people, not just in Europe but in majority world countries (Driedger 1989).

The contributors to this volume present detailed studies of these issues from a variety of countries and perspectives. In order to provide further context for their analyses, this introduction offers a critical overview of the global production of impairment and disability.

Impairment: prevalence and origins

In their efforts to direct attention towards the economic, political and cultural aspects of the disability experience early advocates of a social model approach highlighted a conceptual distinction between impairment and disability. Initially, social model writers accepted the contemporary medical definition of impairment, typically equating it with functional limitations. In contrast, disability refers to the social exclusion and oppression experienced by people with accredited impairments (UPIAS 1976), with a particular stress on significant historical and cross-cultural differences. Although not of the same interest to early social model advocates, the definition of impairment is also influenced by socio-cultural factors, as illustrated by changing and contested notions of 'mental illness' and 'learning difficulties'. While not denying the relevance of a medical focus on treating impairment for some disabled people, the social model emphasises the need for political action and social change to remove 'disabling' barriers (Barnes and Mercer 2003).

This conflicts with the traditional approach among health and social welfare professionals which regards impairment as the underlying cause of 'disability'. In the World Health Organization's (WHO 1980) highly influential formulation, the *International Classification of Impairments, Disabilities and Handicaps* (ICIDH), 'impairment' is defined as the biological condition, 'disability' as the ensuing functional limitation, and 'handicap' as the social consequences of impairment and disability. This approach underpinned international league tables compiled by the United Nations on the prevalence of 'disability' (UN 1990). Even then, international comparisons are made problematic because of the different meanings given to impairment and disability between societies and the sometimes stark differences in methods of data collection and processing. For instance, some nations relied on professional diagnoses and research whilst others were based on lay responses.

Setting aside these concerns, the UN figures indicate that most of the world's disabled population live in the poorer nations of the majority world, although the incidence of reported impairment (broadly functional limitations) is higher in wealthier countries. There are three major reasons

for this. First, in richer societies the longer life expectancy and much larger proportion of people over fifty years old are linked directly with higher (age-related) rates of impairment. Second, these countries have more extensive health and support services, which typically produce a higher survival rate among people born with impairments and those who acquire them later in life. Third, some conditions such as dyslexia are classified as an impairment in highly industrialised economies although in more rural majority world countries these are often not considered a 'functional limitation' and therefore not recorded as an impairment to anything like the same degree (Coleridge 1993).

There are other noteworthy patterns between majority world countries. For example, a higher level of impairment is reported in more urbanised areas. This is probably because they contain more medical rehabilitation and support services, while there is also a greater risk of injury through pollution, traffic and work accidents, and perhaps more possibilities for a person with an impairment to earn a living, including begging. Again, there is often an association with gender, 'race' and ethnicity, because of the marked differences in the geographical distribution and quality of medical services. Thus, over recent decades in South Africa, this has meant that a spinally injured white person was ten times more likely to survive into late middle age than a black person with a similar condition (Coleridge 1993).

Furthermore, the disparity in wealth between the 'developed' and 'developing' world has widened steadily. Some estimates suggest that in 1820 the gap between the world's richest and poorest nation was approximately three to one, but by 1992 this had risen to a staggering seventy-two to one (Giddens 2001: 70). Much impairment across the world is the outcome of such skewed and exploitative economic and social development. Specific diseases once common but now rarely recorded in industrialised countries remain widespread and in some cases are increasing in other parts of the world. For example, there were over 100,000 new cases of polio in 'developing' countries in 1994 (Stone 1999a: 5), and in India, the prevalence of polio and blindness is at least four times higher among people who are below the poverty line compared with those who are above it (Ghia 2001: 29). More than 30 per cent of the population in some villages in Zaire are affected by 'river blindness' (Coleridge 1993). Such experiences underpin the demand for public health and medical-related interventions to complement the struggle against social and environmental barriers by disability activists (WHO 2001). Whereas

lifestyle choices such as diet, lack of exercise, consumption of alcohol and smoking are ranked as significant causes of impairments in wealthier nations (Gray 2001), around three-quarters of India's 60 million disabled people live in areas where public amenities like clean water, electricity, sanitation, and medical services are in very short supply (Ghia 2001). Disabled women and children in majority world states are especially vulnerable and frequently experience higher levels of poverty and impairment (S. Miles 1996; UN ESCAP 2003). Some critics have calculated that as much as half the impairment in the majority world could be prevented by the introduction of effective policies to reduce poverty and malnutrition, improve sanitation, drinking water and working conditions (Charlton 1998).

The lack of funding to counter these sources of impairment is further exacerbated by the policies of international financial institutions such as the World Bank and International Monetary Fund that force governments to cut back on public services to service enormous international debts. Moreover, access to medical and rehabilitation services is often dependent on the ability to pay and this poses major problems for disabled people and their families. There is also an acute shortage of trained medical personnel that is made worse by the active 'poaching' of qualified staff by richer nations, with no financial compensation for poorer countries to educate and train new staff. As a result, only one per cent of disabled people in 'developing' nations have access to any form of rehabilitation or disability related services (WHO 2001). This contrasts starkly with the much higher proportion of financial and human resources in 'developed countries' that is channelled into medical services, including preventive medicine. However, the latter has attracted considerable criticism from disabled people where it has led to policies supporting euthanasia, selective abortion, eugenics and other attacks on their human rights.

Needless to say, poverty and the lack of an adequate health and social care infrastructure are neither peculiar to majority world states nor the only factors leading to impairment (Abberley 1987). A fuller set of 'causes' includes natural disasters (earthquakes, floods), by-products of economic development (industrial accidents and pollution), and specific cultural practices (such as female genital mutilation). Civil wars, often fanned by the international arms trade, have resulted in an unprecedented growth in civilians and military personnel with impairments. In Cambodia, an estimated 100,000 people lost limbs as a direct result of the combatants' use of landmines (UNESCO 1995). There was a similar growth in the

number of people with impairments associated with the civil war in Rwanda, with claims that a strategy of maiming rather than killing people helps undermine resistance both economically and psychologically because 'disabled people remain far more visible than the dead' (Coleridge 1993: 107).

Socio-cultural perceptions of impairment

Social research studies illustrate how perceptions of individual health, well-being, competence and ability differ conspicuously between cultures. While most include notions of what is 'normal' and or 'ideal', the body-mind split has been a particular feature of western, scientific medical thinking. What rank as acceptable individual attributes, and what 'difference' justifies an individual's social exclusion also diverge significantly (Hanks and Hanks 1980; Scheer and Groce 1988; Miles 1992, 1995; Ingstad and Whyte 1995).

These cultural differences have generated competing explanations. To understand the significance of impairment and how and why certain individuals and groups are considered 'abnormal' or 'incompetent' and how control and resistance is exercised, it is necessary to explore these issues within specific cultural contexts. According to Mary Douglas (1966), responses to perceived physical, sensory or cognitive difference involve deep-seated psychological fears of 'anomaly'. This denotes a connection between perceptions of impairment and a non-human 'liminal' status. Cultures deal with assumed ambiguity by either attempting to control it in some way or by adopting it as ritual. Examples include the Nuer practice of regarding 'monstrous' births as baby hippopotamuses accidentally born to humans. The Nuer's response is to return them to 'the river where they belong' (Douglas 1966: 39). Nevertheless, infanticide for those born with perceived impairments is far from typical of traditional cultures (Charlton 1998).

Ida Nicolaison (1995) identifies notions of 'humanity' and 'personhood' as key concepts in understanding how different cultures create their own complex hierarchies to locate individuals. She shows how, among the Punan Bah of Central Borneo, only a relatively narrow set of conditions, notably epilepsy, 'madness' and severe birth defects, denote a non-human status that warrants social exclusion. In addition, the notion of 'personhood' is used to distinguish between specific roles or rankings. This encompasses expectations of what it means to be a child or adult, man or woman. Whereas in most western societies personhood is equated with

adult employment, in China it has been traditionally linked to marriage, parenthood and lineage (Stone 1999b).

Other interpretations accord religious ideas a crucial role in determining what is considered socially acceptable, particularly in non-western cultures. However, there is no consensus among major religions such as Buddhism, Hinduism and Islam on the 'correct' way to regard impairment. In societies where these religions hold sway impairments are widely regarded as 'misfortunes, sent by deity, fate, karma; and often associated with parental sin' (Miles 1995: 52). These produce often very different social responses to the individual with an impairment and their family. However, social research in poorer societies has concentrated on responses to impairment in small-scale, rural-based groups, where religious beliefs may exert a stronger influence compared with those living in urban environments (Scheer and Groce 1988; Ingstad and Whyte 1995).

These examples illustrate the diversity of cultural responses to people with designated impairments in 'developing' societies (Kisanji 1993). Certainly, perceived impairment does not necessarily lead to social exclusion. Among the Masai people of Kenya, people with physical impairments may marry, become parents and participate in all communal activities (Talle 1995). More broadly across different cultures, the range of social statuses of people with physical impairments stretches from 'pariah', because the individual is deemed an economic or moral liability or threat, through 'limited participation', where the individual is granted selected social or other concessions, to 'laissez-faire', where some people enjoy opportunities to acquire prestige and wealth (Hanks and Hanks 1980).

Disability and globalisation in an unequal world
In order to understand this complex relationship between impairment and disability in the 21st century, comparative studies must also be located within a broader materialist analysis. Over the last few decades, the process of globalisation has intensified, with a gathering internationalisation of economic, political and cultural structures and processes, stimulated by the rapid spread of new information and communication technologies. These trends have been complemented by the dramatic growth of trans-national corporations like Coca Cola, General Motors and Exxon, which have become richer than many majority world states. This signifies a significant extension of the capitalist world order (Held et al. 1999).

This is where terms such as 'developed' and 'developing' countries tend to obscure the reasons underlying the vast inequalities of wealth between

'rich' and 'poor' nations, and the international dissemination of western institutions and practices. Most importantly, they conceal the extent to which the 'developed' world 'underdevelops' the majority world by exercising its overwhelming economic and political power (Hoogvelt 1976, 1997). Even so, the polarisation of countries into either the majority or minority world grouping is not always straightforward, just as the expansion of the European Union into eastern and southern Europe is bringing together countries at very different 'stages of development'.

Nevertheless, the spread of industrial capitalism has typically forced changes in traditional approaches to impairment and disability. For example, its impact on the Punah Bah economy and culture has been dramatic. The arrival of international logging companies has brought very different approaches to work and wage labour which conflict with established understandings of personhood and the status of people with accredited impairments. Furthermore, smaller family units have been replacing the typical extended household, leading to a reduced capacity to support dependent members. Overall, 'capitalist' values are beginning to 'imperceptibly permeate the Punan Bah view of themselves and the world' (Nicolaisen 1995: 54). In a similar fashion, the exposure of Masai society to market forces has undermined traditional support networks for people with impairments (Talle 1995). This process has been considerably heightened by the growing influence of 'scientific medicine' and the western mass media in promoting a contrary perception understanding of 'able-bodied normalcy' (Coleridge 1993; Charlton 1998).

The impact of industrial capitalism on the majority world has been particularly severe among disabled people. There is a lack of appropriate support systems ranging from technical aids and equipment such as brailling machines, wheelchairs and prostheses, as well as sign language interpreters, to an inaccessible built environment, housing and transport systems. Even where appropriate support is available it is often too expensive for most potential users. Moreover, the likelihood of early changes being introduced is remote exactly because the disabling barriers are so extensive and entrenched and there are very few resources to fund the necessary changes (Charlton 1998).

Education is widely presented as a way of addressing the problem of poverty and social exclusion. Yet in many majority world states disabled children, most often girls, are routinely denied formal schooling (UNESCO 1995; UN ESCAP 2003). Even then, western-style education may have unintended consequences for disabled children. For example, the

emphasis on literacy and numeracy for economic and social success can lead to the labelling of some children as 'educationally backward' and their marginalisation from environments even where these attributes are not vital to an individual's life chances (Kalyanpur 1996; S.Miles 1996).

The experience of social exclusion in developing countries has generated widespread political activism amongst disabled people (Jayasooria and Ooi 1994). International contacts in the 1980s had a particularly galvanising effect for many disabled activists and disability rights organisations. This was particularly evident at the inaugural meeting of Disabled Peoples' International, the world's first international organisation controlled and run exclusively by disabled people, in Singapore in 1981 (DPI 1982). As the disabled activist Joshua Malinga from Zimbabwe reported: 'When I went to Singapore I was a conservative, but when I returned I was very radical' (quoted in Charlton 1998: 133).

The growing international interest in disability issues and policy can be traced back to the 1970s and the UN's *Declaration of the Rights of Mentally Retarded Persons* (1971) and the *Declaration of the Rights of Disabled Persons* (1975). These were followed by the designation of 1981 as the 'International Year of Disabled Persons' (IYDP) and 1983–92 the 'Decade for Disabled Persons'. However, the apparent radical thrust of these initiatives has been weakened by the continuing influence of conventional individualistic notions of disability and medical rehabilitation (Barnes and Mercer 2003). Nonetheless, since the 1990s, anti-discrimination legislation for disabled people has been enacted in countries as diverse as the United States and China. Another decisive initiative was the United Nations' *Standard Rules on the Equalization of Opportunities for People with Disabilities* (UN 1993). It comprises twenty-three rules to facilitate full participation and equality for 'persons with disabilities'. These cover aspects of daily living including awareness raising, medical and support services, education, employment, leisure and cultural activities. More recently, the WHO's (1999) revised definition of disablement - the 'International Classification of Functioning, Disability and Health' – has been associated with an 'environmental turn' in international disability policy (Tøssebro 2004). However, the rhetoric from international organisations still outruns policy implementation at national levels, not least because majority world governments have insufficient resources to bring about radical changes.

Disability and the European Union

The prospect of the transfer of social model thinking into national policy practice has also been enhanced by its adoption by the Commission of the European Communities (2003). It expresses a commitment to removing 'the environmental barriers in society which prevent the full participation of people with disabilities in society' (p. 4). However, it remains to be seen how far individual Member States follow this up with specific initiatives, particularly as the widening of EU membership into eastern and southern Europe has brought together very different traditions in disability policy.

Organisations of disabled people have campaigned for the EU to take action on disability rights since the 1980s, ranging from the setting up of the European Network for Independent Living in 1989 to holding a Disabled People's Parliament in 1993. The EU has also been sensitive to international developments, particularly the UN's (1993) *Standard Rules on the Equalization of Opportunities for People with Disabilities*. Action very much followed a legal route with the representation of disability as a human rights issue, although the early EU emphasis was on measures to enable a disabled person to enter and retain employment. The inclusion of disability in the Treaty of Amsterdam in 1997 as one of the grounds for challenging discrimination proved crucial. This was reinforced by the Framework Equal Treatment Directive (FETD) in 2000 which required those states which had not already done so to introduce anti-discrimination legislation by 2006. For disabled people's organisations, the aim has been to emulate the EU's 'Race Directive' which extended beyond employment into such areas as education, housing, social protection, goods and services. However, the disability remit does now include indirect discrimination and requires 'reasonable accommodation' to be made for disabled people. It remains to be seen how the courts interpret this formulation on removing disabling barriers.

The widening of the disability remit is evident in the EU Disability Strategy with its goal of achieving a 'society open and accessible to all'. This stresses:

- co-operation between the Commission and the Member States;
- full participation of people with disabilities;
- mainstreaming disability in policy formulation.

In accordance with the principle of 'subsidiarity', the EU Commission is accorded a significant facilitative role in promoting disability awareness whilst policy responsibility is exercised at the national level. This has led to the inclusion of disability in National Action Plans, and initiatives such as

an annual 'European Day of Disabled People', National Information Days on disability issues, and the 2003 European Year of Disabled People.

The involvement of disabled people in policy making and implementation has been highlighted as part of a wider attempt to promote a more active civil society and new processes of governance across the EU. The (EU funded) European Disability Forum, was set up as an umbrella organisation with the largest (in terms of membership) 'disability' organisation 'representing' each Member State. This disregards basic questions about whether these organisations are controlled by disabled people, and whether they accept a primary focus on removing disabling social barriers rather than individual rehabilitation. Disabled people's organisations are also participants in the EQUAL initiative (2000–2006) that is charged with producing new ideas on job creation and social inclusion. This raises important questions about how far there is a 'European way' of approaching disability and the extent and direction of disabled people's influence in reforming national institutions, structures and processes so as to enhance the social inclusion of disabled people in each Member State.

Furthermore, a specific Unit for the Integration of People with Disabilities has been charged with mainstreaming disability issues into Commission activities beyond its current focus on employment and training. This is evident in a growing focus on accessibility in the built environment, with technical standards drawn up for work, leisure and educational environments, amidst a general promotion of 'universal design' or 'Accessibility for All'.

Such initiatives open the way for a policy convergence on disability across Member States. At present, the contrasting economic and socio-cultural traditions are represented in very different social policy regimes. For the majority, medical and allied health and social welfare professionals have defined the needs of disabled people in ways that have perpetuated a view of their 'personal tragedy' and social dependence (Barnes and Mercer 2003). In EU terms, achieving political agreement on the eligibility of citizens for social security and other benefits is confounded by the many different national definitions of a disabled person. In contrast, the social model literature has stressed the identification and removal of the barriers to social inclusion as opposed to defining a disabled person.

Notwithstanding the EU's endorsement of the social model, and attempts to find mechanisms to generate appropriate 'good practice', very different national practices abound, with stark contrasts in 'mainstreaming'

services as opposed to 'special provision'. The recognition of the human rights of disabled people still leaves them at the mercy of resource allocation, with states excused action on the grounds of too many demands on their scarce resources. There is, as the contributors to this collection demonstrate, a long way to go before equality of opportunity and equal treatment for people with designated impairments are the norm rather than the exception whether in the EU or the majority world.

The organisation of the chapters

This book contains contributions from academics, researchers and activists that explore the impact of social model inspired thinking in Europe and the majority world. In Chapter 2, Mark Priestley examines the various ways in which social model thinking has become more visible in policy documents produced by the European Union. He argues that despite a shift in emphasis towards explicit recognition of disabled people's rights, specific policies have yet to materialise with which to make the vision of an inclusive Europe a reality. This, he maintains, is due to the disparate histories and characteristics of Member States and their respective economic, political and welfare concerns. His analysis raises major questions about the complex interplay between EU disability policy, national interests, and disability activism within an increasingly global economy characterised by market forces and economic and social inequality.

In Chapter 3, Susanne Berg analyses how economic considerations play a crucial role in the development of personal assistance reforms in Sweden – a country renowned for its communitarian welfare policies. Employing a social model interpretation as her starting point, she shows how the Swedish 'relational' model of disability that underpins welfare policy for disabled people in general and personal assistance reforms in particular, actually re-enforces rather than challenges conventional notions of disabled people's economic and social dependence.

Sensitive to the challenges of exploring different cultural contexts Felicity Armstrong analyses education policy for children with impairments in France through both a medical and a social model lens in Chapter 4. Her overview of the historical and philosophical foundations upon which French policy rests and broad brush account of current educational practices demonstrates how social exclusion remains the norm rather than the exception. She argues that used together the medical and social models enable us to identify the distinctions and overlaps in culturally embedded systems and practices, struggle and realignment.

In a similar vein, Rachel Hurst in Chapter 5 warns against confusing the social model as an analytical tool and the actions needed for meaningful social change, and the political struggle for rights. She provides a brief sketch of the role of the social model within the British disabled people's movement and on Disabled Peoples' International, Europe. She argues that, when coupled with an approach to disability as a human rights issue, these offer a much more positive political programme than the deficit models of disability that characterise European policy statements. However, further advances are threatened by a range of factors, from bioethics and eugenics to the silencing of the voices of disabled people.

In Chapter 6, Anna Lawson and Bryan Matthews draw attention to the problem of inaccessible transport across Europe. They illustrate how, over the last decade, some progress has been made in terms of the acknowledgement of, and tentative efforts to overcome, the difficulties encountered by disabled people when using public transport systems in European states both by policy makers and the transport industry. In a critical evaluation of these measures from a social model perspective, they argue that the full force of the law is urgently needed to hasten the pace of change.

Hannah Morgan and Helen Stalford address issues pertaining to the freedom of movement within and between European states and its links to paid employment in their discussion of the barriers to disabled people's equal status as European citizens in Chapter 7. They examine the limitations of current thinking in this regard and argue for a broader rights based approach. This should extend beyond the economic imperative of the free movement of labour towards a more inclusive and positive declaration of the needs of disabled Europeans which values their direct and indirect participation in the economy.

Alison Sheldon, in Chapter 8, signals a shift in focus in this volume towards 'developing' countries or the 'majority world'. She explores a radical political economy approach that takes account of the increasing influence of globalisation on disability. This suggests a close relationship between disability and uneven economic development. When informed by a social model approach, it underscores the significance of a materialist analysis of disability in the majority world in contrast to the dominant concern with cultural factors and differences. Sheldon suggests a 'systemic solution' that will encompass both the exclusion of disabled people and the poverty of majority world people generally.

In Chapter 9, Bill Albert provides a critical evaluation of the various policy documents that have emerged from international aid agencies.

Albert's primary concern is with the complex relationship between disability and development, and he acknowledges that some limited progress has been made in recognising disability as a human rights issue in official documents. Nevertheless, policy implementation is basically locked into a traditional individualistic welfare approach that has limited relevance for furthering the demand for a wider human rights agenda.

In Chapter 10, Heba Hagrass provides a socio-political analysis of impairment and disability in Egypt. She shows how economic and cultural factors are major causes of impairment in Egypt, but argues that whereas social interaction between disabled and non-disabled people takes many forms it is often less harsh than widely imagined. Moreover, Egyptian legislation and policy are firmly grounded in an individualistic deficit model of disability, and she contends that the impetus for change must be given more support by the international community of disability activists and scholars.

A comparative analysis of the services for people with spinal cord injury in Bangladesh is provided by A. K. M. Momin in Chapter 11. His contribution provides a graphic account of provision and support for people with spinal injuries provided by the Centre for the Rehabilitation of the Paralysed (CRP) and general hospitals in Bangladesh. His study demonstrates how the combination of a medical and social model approach to rehabilitation, as provided by the CRP, the only unit of its kind in Bangladesh, offers clear benefits for spinal cord injured people, but that a chronic shortage of resources means that they are only available to a fraction of those who need them.

In Chapter 12, Tara Flood discusses some of the criticisms of social model thinking in majority world contexts. By tracing socio-political interpretations of disability within the international disabled people's movement, Flood shows how the social model/social action mantra as used by disabled activists has had a particularly meaningful impact on user-led community based rehabilitation projects in majority world states such as Mexico, South Africa, Cambodia and India.

The relationship between CBR and social model thinking is a key theme in Chapter 13 by Enrico Pupulin, based on his experience as the Chief Medical Officer of the WHO's Disability and Rehabilitation Team. Pupulin describes how the socio-political or social model approach to disability rose to prominence, albeit gradually through the 1990s, culminating in initiatives such as *Rethinking Care from the Perspective of Disabled People* (WHO 2001).

Taken together these chapters illustrate how far, and in what ways, the socio–political or social model approach to addressing and explaining the problems encountered by disabled people in both developed and developing nations is timely and appropriate. There can be little doubt that at the start of the 21st century:

> Overall, the politics of impairment is inseparable from the politics of global poverty and inequality, and the social, economic, political and cultural changes resulting from capitalist industrialisation and globalisation. It is particularly important given that these developments will almost certainly have profound implications for everyone whether a disabled person or not, and regardless of whether they live in the minority or majority world (Barnes and Mercer 2003: 149).

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