

Introduction

Disability and Culture: An Overview

Susan Reynolds Whyte and Benedicte Ingstad

A preliminary common-sense definition of disability might be that it is a lack or limitation of competence. We usually think of disability in contrast to an ideal of normal capacity to perform particular activities and to play one's role in social life. Sickness also inhibits ability, but we distinguish between sickness, which is temporary (whether ended by healing or death), and disability, which is chronic. In principle, disabled people cannot be cured; they may be rehabilitated. Disability is used to refer to limitations resulting from dysfunction in individual bodies and minds. By metaphoric extension, we may speak of social disabilities such as poverty or race. But the core meaning of disability for most of us is a biopsychological one. Blindness, lameness, mental deficiency, chronic incapacitating illness—these are prototypical disabilities.

The International Year of Disabled Persons in 1981, followed by the United Nations Decade for Disabled Persons declared by the United Nations in 1983, put disability into a global context and posed the question of how it may be understood in a multicultural world. How are deficits of the body and mind understood and dealt with in different societies? How is an individual's culturally defined identity as a person affected by disability? What processes of cultural change shape local perceptions of disability? Through a series of case studies, this book provides some preliminary answers to these questions.

A great deal of work has been carried out by psychologists and sociologists on disability and rehabilitation in Northern (European and North American) societies. A rich literature and several journals attest to the empirical and theoretical development of the field. Rather belatedly, anthropologists are now beginning to write about disability as well. In the introduction to a recent special issue of *Social Science and Medicine* devoted

to cross-cultural perspectives on disability, Nora Groce and Jessica Scheer (1990) point to the slow emergence of anthropological research in this field and the need for holistic conceptualizations of persons in their cultural contexts. Yet the articles in that issue are based on research in North America, as are most of the earlier anthropological contributions (Ablon 1984; Edgerton 1967; Estroff 1981; Groce 1985; Murphy 1987). Work on disability in Southern countries (we use "Southern" to mean non-European and non-North American countries) has been mostly in the area of mental health; chronic mental illness, epilepsy, and mental retardation have attracted more attention than sensory or motor disabilities. Robert Edgerton was a pioneer here, not only through his East African research but in his attempts to formulate general cross-cultural questions about disability and deviance (Edgerton 1970, 1985). He showed that attitudes toward people with impairments of their mental facilities varied greatly in non-Western cultures, from negative discrimination, to acceptance, and even to the positive attribution of supernatural powers.

Much research in medical anthropology has a "therapeutic theme." It has concentrated on conceptions of illness and disease, on modes of healing, and on the interaction between patient and practitioner. Studies of disability require us to move away from the clinic toward the community, where individuals and families live with deficits. Cultural assumptions about the body and personhood must be seen in the context of ordinary social interaction. We are less concerned with disease than with its long-term consequences and more concerned with adjustment than with therapy. Impairment raises moral and metaphysical problems about personhood, responsibility, and the meaning of differences. Questions about autonomy and dependence, capacity and identity, and the meaning of loss are central.

There is a growing consciousness in Europe and North America of disablement as a human and social issue that touches us all, the disabled and the "temporarily abled" as well. Powerful popular accounts by and about persons with disabilities articulate the experience of impairment (e.g., Sacks 1985, 1989). Political activism by interest groups has created awareness of how society handicaps people with disabilities. Moreover, the transition from acute to chronic morbidity and the perceived failure of biomedicine to cure other conditions as effectively as it does infectious diseases means that disablement poses an ideological challenge, indeed a crisis, for health care in industrialized society (Williams 1991). It is timely and instructive to examine some of these issues in a cross-cultural perspective.

The method of cultural juxtaposition (Marcus and Fischer 1986:157ff.) is well established in anthropology as a way of providing perspective on our own situation. In assembling articles about disability in very different cultural contexts, we follow the tradition of juxtaposition, and we hope that these accounts will be useful for those primarily interested in disability in

Northern countries. But we want to be wary of a pitfall of cultural juxtaposition: our tendency to look at other cultures in terms of our own problems and thus to fail to grasp the premises upon which other people are operating. We have tried to be sensitive to this danger, in part through awareness of the assumptions about disability we bring to the study of other cultures. This is particularly necessary as rehabilitation programs are established in Southern countries; we hope that people working with health development in those settings will find the juxtapositions illuminating as well.

A UNIVERSAL DEFINITION?

Attempts to universalize the category "disabled" ran into conceptual problems of the most fundamental sort. Differing definitions made it difficult to document the extent of the problem. The first estimates by the World Health Organization were that 10 percent of any population was disabled. Later these figures were modified to 6 or 7 percent, giving a global figure of 245 million disabled people (E. Helander 1993). Estimates depend on what counts as disability (the first figures included malnutrition), on how severe an impairment must be before it is considered disabling, and on how categories are implemented in actually gathering data. Although a number of surveys have been carried out in developing countries, we can still make only a qualified guess about statistics (Renker 1982). Any epidemiological study involves cultural factors (Johansson 1991), and cultural factors are especially involved in attempts to count cases of disability.

The World Health Organization definition of disability is logically stringent and designed for universal application. The *International Classification of Impairments, Disabilities, and Handicaps* (WHO 1980) is based on the model of the International Classification of Diseases, but because it attempts to categorize the consequences of disease, it includes a consideration of social contexts.

An impairment is defined as "any loss or abnormality of psychological, physiological, or anatomical structure or function" (WHO 1980:27). The concept bears close resemblance to Arthur Kleinman's definition of disease as "a malfunctioning of biological and/or psychological processes" (Kleinman 1980:72). Like disease, impairment is defined "primarily by those qualified to judge physical and mental functioning according to generally accepted standards" (WHO 1980:27).

While impairment relates to constituents of the body (the "organ" level), disability has to do with "compound or integrated activities expected of the person or of the body as a whole, such as are represented by tasks, skills and behaviour." It is defined as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (WHO 1980:28). Handicap relates

to the social consequences of deficiencies in organs and activity performance. It is defined as “a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual” (29). Handicap depends on valuations and expectations that put the disabled person at a disadvantage. The WHO manual states explicitly that valuation depends on cultural norms.

The formulation of these concepts represents a valuable attempt to move beyond the restrictions of straight biomedical classifications. Nevertheless, the taxonomy is based on a biomedical concept, that of impairment; disability and handicap are consequences of impairment (itself a consequence of disease or trauma). It is on the basis of the biomedical definition of impairment that the classification is proposed as a universal tool. The primacy of the biomedical concern is reflected in the fact that the list of impairments is far more extensive and detailed than that of disabilities, which is again more elaborated than that of handicaps.¹ Most anthropologists would prefer a cultural relativist position rather than the universalizing approach proposed by the WHO (and this is reflected in the fact that few of them have chosen to use the WHO definitions systematically).

An example may illustrate the problem. A Malian and a Norwegian researcher set out to describe those qualities of an individual which might inhibit the ability to play normal roles among the Kel Tamasheq (Tuareg). They explain the Tamasheq notion of fault, or “default,” and exemplify it by citing old age and immaturity (making one physically dependent), illegitimate birth (making one socially anomalous), and ugliness (rendering it difficult to marry). They list Tamasheq terms for a variety of faults, including deafness, excessive freckles, protruding naval, absentmindedness, and flabby or small buttocks (Halatine and Berge 1990:58–59). Most of these impairments are not on the WHO list and several, like illegitimate birth, are social and not “organic” problems. Others are organic but would never be seen as impairments by biomedical authorities. But the point they want to make does not have to do with identification and classification, but with the very notion of “fault” itself and the Tamasheq view of personhood.

Cultural relativism, the idea that phenomena must be understood within their relevant cultural contexts, takes two forms. Within discussions of disability, a “weak relativist” position is common. The point here is that the disadvantage posed by a disability depends on the capacities most prized or needed in a particular context. One of us remembers visiting the Alhambra many years ago—the lovely view over the town with the Sierra Nevada rising magnificently above, and the plea chalked on a wall of the fortress: “Give alms, woman, for there is nothing worse in all the world than to be blind in Grenada.” The idea that it is worse to be blind in the midst of beauty, or mentally retarded in a setting that values educational achievement, or

crippled where all earn their living by hard physical labor, is commonly accepted. However, few anthropologists would be satisfied with this form of relativism, because it remains at the level of specific functions and tasks and ignores the way in which culture structures whole life worlds, imbuing individual variations of the human condition with significance more far-reaching than the simple ability to perform a given activity.

“Radical relativism” seeks to reveal basic assumptions about what it is to be a person, and what kinds of identities and values exist in given social contexts. How important is individual ability as a source of social identity? What is it people are trying to achieve? The strong version of relativism questions the terms of analysis and attempts to uncover the categories implicit in other worldviews. The concept of disability itself must not be taken for granted. In many cultures, one cannot be “disabled” for the simple reason that “disability” as a recognized category does not exist. There are blind people and lame people and “slow” people, but “the disabled” as a general term does not translate easily into many languages. In this volume, Aud Talle (chap. 3) explains that the Maasai term used to translate the English word *disabled* actually refers to a lizard that walks in an awkward way. The emphasis is on physical movement, so conditions like mental retardation or chronic mental illness are not included. The concepts of disability, handicap, and rehabilitation emerged in particular historical circumstances in Europe.² As a social identity, “disabled” is only now being created in most Southern countries—through surveys, research projects, rehabilitation programs, and government policy.³

EURO-AMERICAN DISABILITY

Cross-cultural studies of disability must involve consideration of its cultural construction in Western society. We need this clarification not only in order to understand case studies from Europe and North America but also because Western (or Northern) concepts, organizations, and practices are carried over to other contexts and because culturally specific assumptions are often implicit in our analyses.

A fundamental theme in the contemporary Western discourse on disability is the assumption of the desirability of equality—understood as sameness or similarity. The terms *handicap*, *disability*, and *rehabilitation* themselves provide clues to this supposition. Etymologically, *handicap* was originally a game, a kind of lottery, in which the winner paid a forfeit; the umpire held the money in his hand in a cap. Later, the term came to be used in relation to competitions in which unequal competitors were weighted so as to make the match more equal. Thus the word has connotations of competition and efforts to create equality. *Disability* implies a deprivation or loss of a needed competency or qualification, in contrast to *inability*, which suggests an in-

herent lack of power to perform a thing. This notion of loss is underlined by the response to disability, *rehabilitation*, which implies restoration to a previous condition. There is an underlying ideal of equality lost and restored, and of the *right* to be able to participate equally.

Western concepts of equality and individual rights are central to a notion of person that Louis Dumont has called “Homo aequalis.” Dumont traces a distinction between a notion of equality as a political ideal that recognizes innate differences (the kind of equality of which Rousseau wrote), and the nineteenth-century American concept of equality, which tended toward an ideal of innate similarity. In discussing Tocqueville, Dumont writes:

If equality is conceived as rooted in man’s very nature and denied only by an evil society, then, as there are no longer any rightful differences in condition or estate, or different sorts of men, they are all alike and even identical, as well as equal. This is what Tocqueville says: where inequality reigns, there are as many distinct humanities as there are social categories, the reverse being true in egalitarian society. (Dumont 1980:16)

It is this theme of similarity and difference which Henri-Jacques Stiker (1982) follows in tracing the history of impairment in Western society. While neither he nor Dumont is interested in a cynical deconstruction of the idea of equality, both draw attention to possible consequences of the pursuit of equality: intolerance of innate diversity and individualism which denies the social nature of persons. This concern is so fundamental for Stiker that he begins his history by declaring his own position—that the love of difference leads to humane social life, while the passion for similarity brings repression and rejection.

Western conceptions of disability are formed in the context of a centralist state that imposes a universal code through legislation. Stiker argues that legislation gives to infirmity an existence and a consistency it never had before—definition, criteria, and degrees of severity. People with infirmities become a marked group; they are given a social identity, as citizens who have the same rights as others and should be integrated like ordinary people. They have a double self-image: as injured beings and as citizens/workers like everyone else. “Paradoxically, they are designated so as to disappear, they are named so as to go unmentioned” (Stiker 1982:149; our translation).

Stiker draws attention to the contradictions of this situation; the culture of “as if” would negate handicap, but in pretending that everyone is identical, it does not make them equal. In fact, this may be seen as a kind of confinement—of the different in the common and familiar. It is this contradictory situation that Robert Murphy and his coauthors call “liminal.” The word may be misleading, in that it suggests the possibility of transition to another state. But the point they make fits well with Stiker’s assessment of the paradoxical position of people with impairments. In American

middle-class culture, disability is treated as unspeakable and invisible. Children are taught not to point, stare, or mention the impairments of people they meet. "And so we are treated to the paradox of nobody 'seeing' the one person in the room of whom they are most acutely, and uncomfortably aware" (Murphy et al. 1988:239). Such differences are painfully embarrassing in a society where differences are supposed to be compensated so that the ideal of equality cum similarity may be maintained.

Euro-American assumptions about disability are not only based in a particular political philosophy but are elaborated through a set of laws, administrative procedures, medical diagnoses, welfare institutions, professional specializations, and business interests. In Europe and North America, disability is a political privilege entitling one to financial support and a series of services. The state assigns to physicians the task of determining who is entitled to these rights. In this way, the political issue of redistribution, which involves separating the deserving from the undeserving, becomes a clinical problem (Sundby 1990). In the Scandinavian countries, doctors must decide at what point alcoholism is severe enough to entitle one to an "invalid pension." In the United States, Social Security benefits can be awarded only to sufferers of persistent pain, "when medical signs and findings show a medical condition that could be expected to produce the pain" (Osterweis et al. 1987:51). In her analysis of the history of disability as an administrative classification, Deborah Stone (1984) examines the tendencies toward expansion of the category. Various interests are served by maintaining flexibility in definitions and by continually incorporating new conditions (chronic fatigue syndrome, fibromyalgia) as disabling. Although cast in biomedical terms, the determination of disability involves political decisions about the distribution of social goods. "Instead of seeing disability as a set of objective characteristics that render people needy, we can define it in terms of ideas and values about redistribution" (ibid.:172). Nevertheless, the ongoing discussion *is* about objective criteria and measurements of incapacity, precisely because the state must be seen to be distributing (increasingly) scarce goods in a (seemingly) fair and systematic way.

The development of disability as a concern of the state was accompanied by the emergence of rehabilitation as a medical and paramedical specialization, beginning in the struggle for professional control over the damaged bodies of the First World War (Gritzer and Arluke 1985). In the United States, as the population aged and suffered more chronic diseases, as federal legislation on disability expanded, and as the health insurance industry developed, disability became big business. In a political-economic approach to rehabilitation in America, Gary Albrecht (1992) argues that disability has been institutionalized and reified, and that rehabilitation goods and services have become commodities with an ever-increasing market. A consequence of this trend is that people with disabilities become consumers; they

develop an identity and form groups as users of the services available to them. The disability rights movement is still young and involves only the most active consumers. But it demands a part in shaping the rehabilitation marketplace to reflect the needs and values of the consumers themselves (ibid.:285ff.).

Thus disability in Europe and North America exists within—and is created by—a framework of state, legal, economic, and biomedical institutions. Concepts of personhood, identity, and value, while not reducible to institutions, are nevertheless shaped by them. Notions of citizenship, compensation, and value lost through impairment and added through rehabilitation are institutionally reinforced constituents of disability as a cultural construct. So is the idea that disability is a medical condition for which technical expertise (educational, psychological, social) is the answer. In countries of the South, where this kind of institutional infrastructure exists only to a very limited degree, disability as a concept and an identity is not an explicit cultural construct. The meaning of impairment must be understood in terms of cosmology and values and purposes of social life.

DIFFERENCE AND PERSONHOOD

One of the basic questions for cross-cultural research on disability is that of how biological impairments relate to personhood and to culturally defined differences among persons. Are people with impairments impaired people? Are they valued differently than other members of society? Irving Zola speaks of the invalidation and infantilization of disabled people; one's validity as a full person is denied. Being different means being less (Zola 1982:235–237). Murphy uses concepts of liminality and impurity to characterize this state of ambiguous personhood. The Norwegian author Finn Carling captured his sense of being not only devalued but dehumanized, in the title of his book *And Yet We Are Human* (1962).

In order to begin to deal with such issues, it may be useful to distinguish between humanity and personhood. Accounts from some societies suggest that individuals with certain kinds of impairments or biological characteristics may not be considered human. Or rather, there may be a point at which such an individual's humanity is in doubt. In many Northern countries, the abortion of a defective fetus is considered more acceptable than that of a "normal" one, suggesting that the "human" status of an impaired individual is more negotiable. The debate about whether severely impaired infants or even adults should be kept alive also involves the attribution of humanity, as the revealing term "human vegetable" implies. In many societies, birth defects are more likely to be seen as inhuman than defects acquired later in life, when humanity and personhood are already established. The ethnographic literature contains many reports of infants who are not anthropo-

morphized and are expected to die. Nancy Scheper-Hughes describes how impoverished women in northeast Brazil neglect these "poor little critters" and compares them to Nuer "crocodile infants" and Irish "changelings," all excluded from the realm of humanity. "The sickly, wasted, or congenitally deformed infant challenges the tentative and fragile symbolic boundaries between human and nonhuman, natural and supernatural, normal and abominable" (Scheper-Hughes 1992:375). What is significant for our purposes at the moment is that the cultural conceptualization of humanity is variable; the anomalies that may be seen as inhuman differ greatly from one society to another, and they do not correspond directly to biomedical definitions of impairment. Twins are not considered human by the Punan Bah (chap. 2) nor are children born with teeth by the Bariba (Sargent 1982).

Such examples may easily become stereotype generalizations about the cultural construction of disability; in fact they are only a simple beginning to an investigation of disability and personhood. If personhood is seen as being not simply human but human in a way that is valued and meaningful, then individuals can be persons to a greater or lesser extent. There may be kinds and degrees of personhood, and the qualities of a person are evolved and confirmed throughout life. (Personhood refers to the evaluation of others in contrast to the reflexive sense of self.) So what are the significant characteristics of a person? Individual ability? Community membership? Family? There is no single answer for any culture, nor is there a universal set of priorities. For several of the societies described in this book, being a member of a family and having children are far more important to being a person than work capacity or appearance. The contrast between egocentric and sociocentric concepts of personhood (Geertz 1973; Schweder and Bourne 1982) provides one kind of comparative framework here. Where a person's worth is conceived in terms of individual abilities and achievements, we would expect impairment to diminish personhood. But where persons are primarily considered in terms of relations to others, this would not necessarily be the case. Such a dichotomy must be used with care, however, for both kinds of qualities are recognized everywhere. The real challenge lies in understanding the way particular characteristics, be they impairments or gifts, inhibit or facilitate individual achievements and relational integration in a given cultural world.⁴

One of the recurring themes in the American (and European) conceptualization of disability is that of autonomy and dependence. In fact, Murphy asserts that they are universal aspects of all social relationships and that dependency is a problem that all disabled people must confront (Murphy 1987:156). But he also shows how reliance upon another person may be encompassed by love and a feeling of mutuality. That is to say, dependency may have different values and implications. We have already suggested that in some cultures, sociality (family and community membership) may out-

weigh individual ability as a value. Ann Goerdts's study of physical disability in Barbados makes an interesting comparison because it falls somewhere between the egocentric concern with independence and the sociocentric one with community. The Barbadian conception of personhood emphasizes a balance between autonomy and connectedness. "At the same time that one should demonstrate autonomy, one must not be too independent of others. . . . for the unity of the group depends not only on the contribution of each member, but also on each member's willingness to accept help from others" (Goerdts 1984:88). Thus Barbadians conceptualize disability not just in terms of helplessness, dependence, and infantilization (failure of autonomy) but also in terms of limitations on social interaction (failure of connectedness), which they sometimes describe as "hiding."

SOCIAL ORGANIZATION AND DISABILITY

Cultural conceptualizations of difference must be seen in relation to social contexts. Cross-cultural literature on disability employs two general ways of doing this: examining overall features of social organization, and focusing on the implications of specific social characteristics (gender, age, class) within a society. The first concern has been the most common, because of the interest in juxtaposition and comparison of whole societies, indeed of whole kinds of societies.

A broad social structural hypothesis has been proposed by Scheer and Groce to explain the differing situations of disabled people in small-scale and complex societies. They suggest that where face-to-face contact between individuals is frequent, and people have multistranded and diffuse relations with one another, social identity is based on a variety of family and other characteristics.

In such situations, a single personal characteristic, such as a physical impairment, does not generalize to define one's total social identity. In complex societies, however, social relationships and contexts are more impersonal and task specific, and individuals are not related to each other in varied contexts. Accordingly, visible physical characteristics are commonly used to classify and socially notate the individual's identity. (Scheer and Groce 1988:31-32)

The distinction made here between traditional, small-scale societies and complex societies involves a contrast not only in types of social identity but also in social participation and support of disabled individuals. From several studies, a picture emerges of a kind of "natural integration" of disabled people as members of families and communities in simpler societies.⁵ Perhaps the best-known example is Groce's own ethnohistorical study of deafness on Martha's Vineyard, in which she describes a society where everyone, hearing and deaf, spoke sign language, and where deaf people farmed and

ished, married and had children, participated in town meetings and ordinary social interaction. They were remembered as unique individuals, never as "the deaf" (Groce 1985:4).

Of the contributions to this volume, both Ida Nicolaisen's article on Punan Bah of Sarawak (chap. 2) and Aud Talle's on the Maasai of Kenya (chap. 3) describe situations where disabled individuals are integrated and accepted. Kinship identity, residence in a longhouse or large compound, and rank or membership of an age-set are more important factors in social identity than impairment. One is truly handicapped when unable to marry or participate in the community, and it is up to the family to insure that this does not happen.

However, we will argue that as an analytical tool, the dichotomy between traditional/small-scale and complex societies has significant limitations. Not all relationships in complex societies are impersonal and task specific; in many situations, identity is based on criteria other than physical characteristics. And even in small-scale societies, there are kinds of impairments that may dominate social identity; inability to have children limits the strands in relationships. Not all relationships are multistranded, unless one never leaves one's own village; while people may not attribute a primary identity as impaired to their own neighbors, they are likely to do so in relation to people they know less well (see Goerdt 1984:26-27 on madness, and Whyte, chap. 12, on epilepsy). Furthermore, very few societies in the world today are small-scale in the sense of being untouched by national institutions and the global economy. Nicolaisen suggests that wage labor and the timber industry impinge upon the possibilities for disabled Punan Bah individuals to be economically integrated. Talle shows how Maasai families may use national institutions such as schools and the home for disabled children.

The point that identity does not generally derive from impairment in small-scale societies should not distract us from recognizing that there may well be roles and activities where impairment is the central criterion for recruitment. All deaf children from Martha's Vineyard were sent to the American Asylum for the Deaf and Dumb in Hartford from the time of its founding in 1817 and at state expense; in the nineteenth century, they were better educated than other islanders (Groce 1985:77-78). In this respect, the island was not small-scale, and the identification of individuals by their impairment supported their participation in island life.

The other example that Scheer and Groce use as an illustration of a simple society with diffuse social roles is the community of San Pedro Yolox in southern Mexico, studied by John Gwaltney. Many adults, especially older ones, had been blinded by onchocerciasis, and Gwaltney shows how deeply embedded they were in village life through ties of real and fictive kinship. He also writes about the importance of begging expeditions, from which

blind people “derive a great sense of approved, purposeful participation in the life of their pueblo” (Gwaltney 1970:112). People were supposed to beg in other villages, but some also did so in their own. Clearly, begging requires identifying oneself as disabled,⁶ and begging in other villages is a task-specific social relationship requiring a particular physical characteristic. In ordinary social interaction as well, blindness is an important part of identity, to judge from Gwaltney’s account of how individuals expound upon their misfortune and receive commiseration (114). While Scheer and Groce point to an important dimension in relating role structures to social identity, the problem is that the polarity of two ideal type societies is too simple for the analysis of real cases.

In examining the characteristics of social organization relevant to disability, there are three important questions. First, what is the ability of the family to care for an infirm member? Demographic factors such as family size as well as the organization of the economy and social activities are important here. It has been claimed that the “phenomenon of the handicapped” emerges in European society in part as a function of the difficulties of the nuclear family in bearing the burden of care. Sociality (work, leisure, education) is disaggregated in space and time; the technical constraints of special care and training may require removing the person from the home, at least part of the time. This, together with the normative demands for conformity and achievement, places an enormous practical and psychological burden on a family, often on a mother (Stiker 1982:175).

Research in Africa has examined the way that households cope with caregiving in contemporary circumstances there. In Tanzania, Susan Whyte (1991) found that people with mental illness, retardation, and epilepsy were almost always cared for by their families and care was regarded as a family, not a community, responsibility. Because families were large, the burden of care could be shared. However, labor migration and poverty transform family situations. Sidsel Saugestad (1990) describes how in Zimbabwean villages it is often grandmothers who care for disabled children because parents (or unmarried mothers) are working in town. From Botswana, Benedicte Ingstad and coauthors (1992) describe a similar pattern. Labor migration takes away the healthy and able household members, leaving the old, the very young, and the infirm to survive on subsistence farming and often irregular remittances. Loyal and affectionate care may well mark the relations among these “weaker” members of a family. But that does not eliminate the need for cash and other assistance from the most “able” relatives. Coping with care is a matter of the disposition of family resources (Walman 1984) and also of the willingness to give such care priority over other needs and goals. Increasing pressures on families in developing countries may be instrumental in creating a demand for programs for the disabled, and thus a social category of “the disabled.”

The second question in examining social organization and disability is, How does the occupational structure of the society incorporate people with impairments? The organization of production, the degree of specialization, and the nature of the work affect the degree to which people with impairments are able to participate. Where the family is the basic unit of production, it seems easier for people with disabilities to make a contribution. Working conditions are flexible, tasks are varied so there is almost always something they can do, and there is support from other family members and neighbors. Impairment does not usually disqualify people for work in subsistence production, domestic tasks, or even home-based handicraft production for the market. When labor is a commodity sold on a competitive market in fixed time and skill units, the participation of people with disabilities is more problematic.

We can take this question a step farther by asking whether impairments actually qualify people for certain occupations or whether some jobs are thought specially suitable. (For the moment we leave aside national vocational training programs for the handicapped.) The information on this point in historical and ethnographic literature is limited. In some places, blind people were more likely to become singers, storytellers, or learned religious men. M. C. Narasimhan and A. K. Mukherjee (1986:2) mention the *Surdasi*, blind singers of India, called after a famous blind vocalist. In many countries, impairment is a valuable qualification for the occupation of begging. Studies from India describe the techniques of beggars displaying their defects: "arousing . . . compassion by skilfully exhibiting their physical disabilities and diseased condition" (Chaudhuri 1987:33); "Some sat silently . . . exposing their diseased part or physical handicap and thereby they tried to bang on the emotion of the passersby" (Misra and Mohanty 1963:40). In premodern Taiwan, beggars who lacked a suitably "pitiful image" might fake disability or exploit an impaired person as "a begging implement" (Schak 1988:47). Yet even though mendicancy is the most widely mentioned special occupation for people with impairments, probably no more than a fraction actually engage in it in societies where it is an option.

A final question concerns the existence of special programs, institutions, and organizations for disabled people. These may comprise laws and welfare benefits for the disabled as a generic category, as well as institutions and interest groups for people with specific kinds of impairment. Some excellent fieldwork accounts are based on participant observation in such institutions (Zola 1982) and with people defined in relation to an institution (Edgerton 1967; Estroff 1981) or organization (Ablon 1981; May and Hill 1984). By contrast, many disabled people in developing countries are not (yet) touched by any kind of special program; where deafness and blindness are not as common as they were on Martha's Vineyard and in San Pedro