Critical disability studies have shown that disability has been geographically and culturally defined and regulated by Western Governments. Thus, disability has history and context (Campbell 2008; Thomson 1997). This paper focuses on the impact these processes may have on people with disability in Sri Lanka.

An underlying dilemma presented here concerns the relationship between philosophy and action. A critique of the universalist approach to disability governance could occur through a critical appraisal of globalisation. However, some writers would argue that a focus on globalisation is a distraction from a more pressing concern; the continued Eurocentrism of knowledge and the domination of the Global North in social policy, law reform and research (Alatas 2006; Connell 2007). I argue that the United Nations delimits and denotes the kinds of bodies known as ‘disabled’ and this culture of knowledge production controls notions of difference.

**Governmentality, geopolitics and geosurveillance**

Foucault’s early work (1977:195) on the panopticon gaze whereby ‘inspection functions ceaselessly [and …] the gaze is alert everywhere’ is invoked in nodes of geodisability structures of systemisation and measurement. Though not reviewing extensive studies of panopticism, it is important to summarise its key features.

For Foucault, the panopticon became a motif and template for ordering socio-material realities. The panopticon ‘is a diagram of a mechanism of power reduced to its ideal form … it is in fact a figure of political technology that may and must be detached from any specific use’ (ibid:205). The panopticon exposes the ‘disability’ as visible ‘otherness’. Consequently, defining and socialising disability becomes about creating a physical/mental norm and where technologically not possible, a moral or social ‘norm’ that can be categorised, catalogued and thus regulated.

The rendering of kinds of humans is produced by space. For instance, the stranger crossing territorial borders without permission or correct papers becomes an ‘illegal alien’. A more obtuse example is the French conceptualisation of disability as ‘situation of disability’ (handicap de situation). This idea bears witness to certain aspects of impairment that arise and then decline relationally and contextually (Winance, Ville and Ravaud 2007).

The institutional strategic gaze situated in the UN is able to examine, normalise and condition nation states. International disability norm standard setting is represented as a system formulated by consensus, is transcultural and objective. Knowledge formation by international consensus is not a level playing field. Connell (2007) argues non-Western approaches are not taken seriously enough to rupture the colonial experience.

An alternate reading is to see geodisability knowledge as naturalising dominant ways of seeing (knowing), citing (summoning and hailing) and situating (localising) disability. Of course increased geosurveillance can be associated with global concerns about risk and dangerousness. The enemy can be transfigured from the commonly known ‘unruly potential terrorist’ to another kind; (those sick and/or disabled) who are represented as a global, ethical and economic burden, contributing to nationalist ‘degeneration’.

Governing from a distance operates through two discursive modalities. The first is *denotative* — a cartographical description of a particular spatial zone (our interest is in the mapping of zones of ‘health’ and ‘not-health’). The second, founded on the denotative, forms an *authoritative atonement*, a discursive canon (such as international disability norms) which constructs foundational and thus sayable ‘statements’ (for example, ‘who’ is legally a ‘disabled person’) guiding policy formulation.

The impact of *authoritative atonements* on the Global South can be even more devastating given the tendency of the colonised to have a ‘captive mind’ — ‘ … the inability to be creative and raise original problems, the inability to devise original analytical methods, and alienation from the main issues of indigenous culture’ (Alatas 1974, cited in Alatas 2006:47).

The erasures of ‘place’ and localised particularities have been the foundation of Western philosophy and thought. Consequently space ‘had to be dissociated from the bodies that occupy it and from the particularities that these bodies lent to the places they inhabit’ (Escobar 2001:143). Enacting universalised geodisability knowledge production is a major modality for governing disability, placing disability out of space, or in outer space, despite the implicit materiality of the creation and living of impairment.

The *outer* space often has a similar aesthetic irrespective of geography — for example, all hospital and care homes look alike — in other words they could be any *place*, any where. The invention of disability occurs in the local and embodied notion...
of ‘place’, in distinctions made between health, not-health, disability, demonisation and so on. The stories of disability and the handling of anomaly are grounded in the local (village) contemporaneity, and based on Eurocentric notions derived from colonial ideologies.

**Intercourses of colonialism: Rattling the can**

Law’s (1999) study of the management of Portuguese imperialism identified three key technologies necessary to govern, namely, **documents** (policies and regulations), **devices** (technologies of things, instruments and resources) and **drilled people** (the docile civil servant or administrator who knows what and how to do it, and performs the task).

By shifting our gaze towards the ways Western eyes represent non-Western others, this new way of *seeing* prompts questions such as: ‘what is development? Who says that is what it is? Who aims to direct it and for whom?’ These questions can be solicited from key policy and legislative documents which act as *sites of enunciation*. It is possible then, to ask:

- Who are the agents of knowledge (international bodies, overseas universities, INGOs/NGOs, DPOs, local governments, indigenous universities)?
- How do they conceptualise disability and health; where are the analytical silences?
- Who is being empowered and who is being marginalised?
- What are the implications of states (and individuals) rejecting the trend towards adopting UN norms?

Non-Western countries are perceived as deficient or in a state of arrested development. Countries like Sri Lanka are viewed *ontologically as disabled*, therefore in need of rehabilitation and ethical guidance. Global South countries have cultural approaches to disability that are viewed as bereft, with no original research contributions to global knowledges and have schemas of disability with arcane approaches to service delivery.

Contrary to the view that globalisation increases access to knowledge it can by default, induce a sense of *ignorance* (that is, of what we know we do not know, and what we do not have in terms of resources and technologies) on the part of the Global South. This ignorance effect is not mutually shared by the Global North and South as it can be argued that the Global North often assumes they don’t need to know about the Global South.

Hellinger (1987) warned of the danger that increasing overseas aid would have on civic values and diversification of human services practices. NGOs are conceptually grounded in a charity ethos inhibiting the development of a realigned focus that promotes citizenship and rights-based social movements. The ‘reprivileging’ of indigenous responses to social concerns remains difficult as the locus of power is still retained by externally funded NGOs.

Transnational actors/networks are made up of a composite of ideas, resources and activities circulating through a range of fora playing an active part in encouraging states to embrace international norms, not just through the usual channels of political and economic persuasion, but through domestic socialisation. Regulation and prescriptiveness at an international level produces a homogenisation in reforms. The place of ‘home grown’ indigenous distinctiveness in terms of needs, processes and service delivery outcomes appears ambivalent or at best uncertain.

Agreement with dominant agendas is more probable if exposure to alternative conceptual and planning frameworks is absent. A question emerges: where do sociologists, policy makers and researchers access counter theories, methodologies and scholarship *developed independently* of aid agencies and overseas stakeholders? Investment in a particular social and economic sector by many NGOs and multilateral financial institutions means the site of interest convergence occurs in the developmental activities of donor agencies and overseas-funded research centres that, by default, create parallel institutions potentially weakening the capacity and ‘responsibility’ of the state and academy.

The Sri Lankan Government experiences increased pressure from the UN and international financial donors to conform to the universal project of disability standards, definitions of disablement and externally imposed models of service delivery, legal and policy frameworks. Concepts such as ‘health’ and its opposition, ‘disability’ are assumed to have universal and unchanging import, erasing much of the different and contrary terrains to which these concepts might apply. Interest convergence can then result in the imposition of fixed prescriptive disability *definitions* developed externally and imposed upon aid practices. A decolonised project therefore needs to highlight the importance of both conceptual and praxiological distinctiveness.

**Imported responses: Geodisability knowledge**

In the West, until recently, the dominant paradigm for understanding disability has been the ‘medical model’ where disability is assumed to have an existence altogether autonomous from any social context. The pre-eminent apparatus controlling the delimitation of disability originates with the UN. Consensual international disability norms makes possible the disclosure and visibility of disability dynamics at a country level and for the World Health Organization (WHO) to map disability globally.
A number of salient definitional instruments exist and are mandated for use by UN member nations, of which Sri Lanka is one, for the purposes of enumeration and programme development. The Human Development Index, a comparative measure of poverty, life expectancy and education, has been used by the United Nations Development Programme since 1993 as a tool to apportion funds. Sri Lanka is ranked 99 and has a medium human development ranking. UN formations of disability are deeply embedded with a broader classification of disease, which delimits disability in relation to a so-called ‘objective’ comparator referred to as health status (a person without a health condition). This is an instance of colonial ‘objective’ comparator referred to as health status (a person without a health condition). This is an instance of colonial enframing where partitioning of ‘disability’ and ‘not-disability’ obscures cultural differences.

Classifying disability
In January 2001 the 54th World Health Assembly adopted the International Classification of Functioning, Disability and Health (ICF). The new system inaugurated four dimensions related to disability: impairment, activity, participation and context. Its authors argue that the aim of the ICF was to develop a common language for speaking of ‘health’ and by default ‘disability’. Moreover, the new ICF provides the tool to implement various UN instruments and enact coherent national legislation. Without the ICF, the networked nodes of UN governance would have difficulty border crossing. Advocates of global geodisability templates argue that universal systems can be used to bring ‘into line’ renegade nation states that do not appropriately plan for the needs of people with disability.

The WHO disability framework is premised on disability being objectively and universally known, mapped and treated. Furthermore, the new ICF formulation while cognisant of the ‘participatory’ and ‘contextual’ dimensions of ‘disability’, continues to be constitutionally aligned with and thus becomes a sub-directory of the International Classification of Diseases ICD-10. This narrow framing within a disease paradigm will most likely ensure that etiological factors remain pre-eminent and the social context eclipsed.

In Sri Lanka the usage of the comparator of a person without a health condition can obscure rather than clarify service delivery needs, especially if deliberations do not factor in socio-economic considerations, access to resources and consequential social exclusion. Mental health is described by WHO (2006) along the lines of coping with the normal stresses of life. But as Fernandopulle et al (2002) points out, the notion of normalcy explodes given the almost normalised extra stress of living with inter-ethnic conflict and war.

Different cultural locations within the country would have a different threshold as to what counts as disabled or not: for example, children without birth certificates and with cognitive impairment may have no real sense of actual age, hence communities have no real sense of developmental milestones or delay, therefore individuals are not seen as impaired. A more recent tool of governance is the 2006 Convention on the Rights of Persons with Disabilities (CRPD). The Convention’s strength is its formulation of disability that transcends functional and medical orientations of traditional disability models. The Preamble at [e] states (UN nd):

disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others (emphasis added).

Article 1 of the Convention lists the more usual type of functional and classificatory approaches to disability, yet there is room to even interpret these categories through the lens of an intercultural understanding as made possible through the emphasis of the Convention’s Preamble. The impact on Sri Lankan disability affairs is uncertain. Possibly the Convention will stimulate debate and change around disability or alternatively impose little understood legal standards and obligations.

However, the issue of UN norm standard setting is deeply problematical; so little research exists to examine the processes of developing these standards and the role of cultural norms. The work of Lord (2004) documents the tensions and deals made between NGOs regarding access to planning forums and exposes the less known fact that internationally, only seven organisations have UN Economic and Social Council status, each based in the developed world with limited regional representation.

What we can conclude is that even before exploring disability policy in the Sri Lankan context, the international system of knowledge articulation is highly regulated and prescriptive. Europeanised regulatory regimes often resulting in non-Western countries with few resources feeling somewhat overwhelmed by the pressure to conform to (alien) global rules.

Sri Lankan disability scenes
Sri Lanka lies on the far southern edge of the Indian subcontinent. It has a population of around 20.9 million and is a country that has been in the grip of a terrorist crisis for 25 years, resulting in large portions of the Government budget being spent on defence and a high prevalence of war-induced physical, cognitive and psychological disableness.

The contemporary situation of people with impairments in Sri Lanka is essentially a biopolitical question. The counting of disabled Sri Lankans is a vexed question. Social planning is made difficult by a shortage of information about the scope
and needs of Sri Lanka’s disabled constituency. In Sri Lanka, disability is mainly produced through war, natural disasters, ageing populations and large numbers of people undertaking high-risk work.

Despite challenges, a specific Sri Lankan pattern of impairment can be described: there is an estimated population of 900,000 people with disability (Wijewardene and Spohr 2000). Although the incidence of physical disability produced by war has not been enumerated, the Asian Development Bank estimates (2005) are in the vicinity of 100,000 persons. The high levels of mental illness indicates the requirement for a far reaching approach to mental health taking into account the consequences of living with years of civil and military conflict.

The suicide rate ranks seventh in global statistics, with a ratio of 31:100,000. Deaths due to suicide are estimated to be 106,000, twice the number due to war (WHO 2006). The 25-year war has produced significant levels of disablement of between 10,000-15,000 soldiers (Wickramasinghe 2006). It is uncertain what impact such high levels of disability have had on transforming attitudes towards bodily or mental differences by non-disabled members of the community.

With the exception of work by Uragoda (1977, 1987, 2008) on health systems, Obeyesekere (1969, 1976) on indigenous psychiatry and Silva (1991, 1994, 1997) on the sociology of colonial epidemics, there is almost no contemporary cultural and historical research on disability in Sri Lanka. Existing research has been dominated by medico-clinical studies of mental health issues around suicide, rehabilitation of soldiers with disability, agency projects and children with communication disorders. Inputs from medical anthropology, political science, sociology, Sinhala/Tamil linguistics and women’s studies have been glaringly absent. A characteristic of research is the adoption of Western approaches to research methodology and the transmission of Western modalities to interpret indigenous situations.

The major impetus for law and policy reform has been from forces external to the country and to a lesser extent, advocacy from the local disability rights movement. Policy development and legal reforms related to disability have been slow. In 1996 the Sri Lankan Parliament passed three significant pieces of legislation: the Human Rights Commission Act (No.21 of 1996), the Protection of the Rights of Persons with Disabilities (No.28 of 1996) and the Social Security Board Act (No.17 of 1996). These changes in the legal framework are part of the country’s ongoing alignment with the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993).

Most disability legislation, however, lacks specific mechanisms for the implementation and enforcement of the rights ascribed in the legislations, especially a process for the bringing of individual or group complaints. In 2003, the Sri Lankan Government introduced The National Policy for Disability, a social framework to accompany the 1996 legislation. Increased international communication has facilitated the development of the Sri Lankan disability rights movement led by and for people with disability. Still, the dominant image of Sri Lanka is of a small island crowded in by a cacophony of NGOs, externally-based donors operating within neo-colonial nodes and a web of internationalised regulation.

Indigenising disability studies and research

For critical disability studies to grow within Sri Lanka, a vibrant training, research infrastructure and agenda is needed. Greater challenges exist at the institutional level beyond the specificity of teaching and researching disability studies. Sri Lankan social science scholars experience a restricted flow of information, resources and exposure to international debates. The degradation of the teaching and research enterprise is heightened by the peripheral role that Sri Lankan universities and ‘native scholars’ [sic] command from the broader academic community, NGOs and overseas funding bodies.

Accentuating these concerns is the conundrum where home-grown scholars still look to the West as the ‘gold standard’, and are required to engage in Western knowledge-talk in order to be heard (Chakrabarty 2000). A primary task then is to broadcast the parochialism of health and welfare scholarship. There is a need to promote indigenised scholarship that builds up epistemologies and service practices. Where there is overseas funding, programme and course development, it is guided by off-shore accreditation principles and institutions. A vacuum exists of non-clinical social science, disability studies-orientated research conducted by both universities and peak NGOs.

The first challenge is to engage in education for capacity building, and for the disability rights movement to negotiate complex debates over concepts of diverse disability formations. This is not unreasonable given the rich multivariate cultures within Sri Lanka and the range of experiences with colonialism. In contrast to homogenising global discourses of disability norms and practice, localised politics and tensions infuse translocal discourses of disability, illness and health. Global South scholars, already working at the periphery of the Western academy are accustomed to negotiating (Western) theory across space in a profoundly different place.

This process of ‘translation’, the notion that Sri Lankan history and cultures contain ‘original possibilities’, should act as a beacon illuminating the darkness of postcolonial uncertainties and unknown futures. Legal developments cannot be effective in terms of emancipation until education for justice occurs with teachers, practitioners, people with disability and human services personnel. Only limited training and development
activities have addressed recent shifts in the reconceptualisation of disablement and the public law interest implications with legal mobilisation and reform agencies. While legislative reforms create legal interests, statutes do not create institutional resources to activate those rights.

We know that Sri Lankans with disability have limited knowledge about the existence of services and law. Although recent disability legal and social policy reforms suggest an adoption of a liberal rights framework, this shift needs to be reflected in training and pedagogical strategies to negotiate existing service provision structures and attitudinal responses in fields still informed by the notion of disability as tragedy requiring charity and asylum.

Without a critical appraisal of liberal rights and Eurocentric frameworks, there is a danger of entrenching an unquestioning conformity to externally imposed regulatory standards, leading to a reliance on the ‘expertise’ of foreign advisers who may have ‘different’ interests in Sri Lanka, whilst diminishing the wisdom of Sri Lankan perspectives. It is imperative that critical disability studies education be embedded within the Sri Lankan environment. Instead of putting money primarily into supporting NGOs, overseas donors and universities need to be encouraged to develop partnerships with Sri Lankan universities through cooperative curriculum development, publications assistance, scholarly exchanges and research funding.

Conclusion
This paper attempts to make connections between the development and advancement of disability conceptualisations and service delivery models, and the continued impact of neo-colonial governance. What becomes clear is that capacity building pedagogy is fundamental to resisting the imposition of culturally eugenicist norms in the form of international disability norm standard setting that may result in the disappearance of particular Sri Lankan formations of disablement. The CRPD may facilitate debate around cultural approaches to impairment and difference. Yet there are no certainties.

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