

**YANGON UNIVERSITY OF ECONOMICS
DEPARTMENT OF ECONOMICS
MASTER OF DEVELOPMENT STUDIES PROGRAMME**

**ASSESSING THE ACCESSIBILITY CHALLENGES FOR
PERSONS WITH DISABILITIES IN RURAL VILLAGES: A CASE
STUDY OF KYAUKTAGA TOWNSHIP, BAGO DISTRICT IN
MYANMAR**

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MDevS – 2 (18th BATCH)**

JUNE, 2025

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MYANMAR**

A thesis submitted in partial fulfillment of the requirements for the Master of Development
Studies (MDevS) Degree

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MASTER OF DEVELOPMENT STUDIES PROGRAMME

This is to certify that the thesis entitled “**Assessing The Accessibility Challenges for Persons with Disabilities in Rural Villages: A Case Study of Kyauktaga Township, Bago District in Myanmar**” submitted as partial fulfillment towards the requirements for the degree of Master of Development Studies has been accepted by the Board of Examiners.

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ABSTRACT

This study investigates the multifaceted accessibility challenges faced by people with disabilities in 13 rural villages of Kyauktaga Township, Bago District, Myanmar. The research draws on primary data from 126 individuals with disabilities, complemented by secondary sources from WHO, MIMU, and other key studies. The study analysis focuses on four types of barriers: environmental, attitudinal, communication, and institutional, across key domains including household surroundings, education, healthcare, and employment. Findings reveal that environmental barriers are pervasive, with poor infrastructure such as inaccessible toilets, unpaved roads, and lack of mobility aids limiting basic movement and independence. Attitudinal barriers persist, especially through social stigma, overprotection, and perceptions of incapability, even within families and communities. Institutional challenges are faced with the absence of inclusive school practices, and limited access to assistive devices or vocational opportunities. Communication barriers, including lack of accessible formats (e.g., audio, sign language, braille), further marginalize people with disabilities from education, health services, and community engagement. Despite national legislation and strategic plans promoting disability inclusion, practical implementation in rural areas remains weak.

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LIST OF ABBREVIATIONS

AAR Japan	Association for Aid and Relief, Japan
ADA	Americans with Disabilities Act
ADAAA	Americans with Disabilities Act Amendments Act
ADL	Activities of Daily Living
BRAC	Bangladesh Rural Advancement Committee
CBR	Community-Based Rehabilitation
CRPD	Convention on the Rights of Persons with Disabilities
DSW	Department of Social Welfare
GATE	Global Cooperation on Assistive Technology
ICF	International Classification of Functioning, Disability and Health
ICT	Information and Communication Technology
IDEA	Institute for Democracy and Electoral Assistance
IEP	Individualized Education Plan
ILO	International Labour Organization
KNBS	Kenya National Bureau of Statistics
KOBO	KoboToolbox – a free and open-source tool for data collection
LMICs	Low and Middle Income Countries
MDevS	Master of Development Studies
MHLW	Ministry of Health, Labour and Welfare
MIMU	Myanmar Information Management Unit
MoSWRR	Ministry of Social Welfare, Relief, and Resettlement
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-Governmental Organization
OECD	Organisation for Economic Co-operation and Development
PPP	Public-Private Partnership
RECU	Reach, Enter, Circulate, Use
SDGs	Sustainable Development Goals
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UN DESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme

UNICEF United Nations Children's Fund
WG-SS Washington Group Short Set
WHO World Health Organization

CHAPTER I

INTRODUCTION

1.1 Rationale of the Study

People with disabilities face systemic exclusion worldwide, with an estimated 1.3 billion people (16% of the global population) experiencing significant disability (WHO, 2023). The majority reside in low- and middle-income countries where accessibility barriers perpetuate cycles of poverty and marginalization. Critically, the WHO and World Bank (2011) emphasize that disability stems not from individual health conditions but from societal failures to accommodate diverse needs. This paradigm shift, rooted in the social model of disability (Oliver, 1990), frames accessibility as a fundamental human right rather than charitable accommodation.

Accessibility issues in rural villages can profoundly affect the health, education, and socioeconomic status of persons with disabilities. The WHO's World Report on Disability highlights that people with disabilities in developing countries often face heightened discrimination, lack of education and employment opportunities, and inadequate healthcare access (WHO, 2011). Additionally, the MIMU report on disability in Myanmar underscores the prevalence of disability in rural areas, where insufficient resources and social stigmatization further contribute to exclusion and poverty (MIMU, 2021). Such conditions indicate a need for localized studies that identify specific accessibility barriers and inform targeted interventions.

Rural areas present particularly severe accessibility challenges. Desmond et al. (2022) found only 28% of rural communities in developing nations have disability-adapted transportation, while Kett et al. (2020) documented that 90% of rural health clinics across Sub-Saharan Africa lack basic accessibility features like ramps or adapted toilets. These physical barriers interact with attitudinal and institutional exclusions to create compounded disadvantage. Shakespeare (2014) notes that stigma frequently limits social participation more than physical impairments themselves, a pattern observed in India where 74% of rural persons with disabilities faced educational exclusion due to both infrastructural and social barriers (Singal et al., 2019).

The economic consequences of inaccessibility are staggering. The World Bank estimates exclusion costs nations 3-7% of GDP annually (Buckup, 2009), with rural areas disproportionately affected due to limited vocational opportunities and caregiver burdens (ILO, 2022). Mactaggart et al. (2018) demonstrated that families in rural Cameroon and India lose 15-30% of potential income when caring for disabled members. Conversely, Lamichhane (2021) documented a 22% household income increase following accessibility interventions in rural Nepal, proving the transformative potential of inclusive development.

Despite the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006) mandating universal accessibility, implementation remains weak in rural regions globally. The UN Department of Economic and Social Affairs (2023) reports only 35% of countries monitor rural accessibility compliance, while Gleeson (2021) critiques the prevalence of "tokenistic compliance" where installed features like ramps remain unusable. Effective solutions require participatory approaches - Tirussew et al. (2020) showed 58% greater school enrollment in rural Ethiopia when persons with disabilities co-designed accessibility projects.

Myanmar's rural accessibility crisis mirrors these global patterns but remains understudied. With 77% of the nation's disabled population residing rurally (MIMU, 2021), Kyauktaga Township presents a critical case study. Its geographic isolation, agricultural economy, and limited services exemplify challenges facing rural disabled populations across Southeast Asia. This research contributes to ASEAN's disability-inclusive development agenda (ASEAN Secretariat, 2021) while providing locally grounded data to bridge the policy-practice divide in achieving Sustainable Development Goals 10 (reduced inequalities) and 11 (inclusive communities).

The study focuses on Kyauktaga Township, Bago District, a region with multiple hard-to-reach villages and significant socio-economic diversity. This township presents a relevant case study due to its remote villages and limited disability services, which are representative of the larger rural areas of Myanmar. The barriers identified here can serve as insights into the broader challenges faced by rural populations with disabilities throughout the country, offering a valuable perspective to policymakers and development organizations working on disability inclusion.

This study aims to identify and analyze the accessibility challenges within the context of rural Myanmar to contribute to national and international discourse on disability inclusion. As Myanmar continues to experience socio-political changes, an in-depth understanding of the needs and barriers experienced by people with disabilities in rural areas could guide more

effective policies and initiatives. In doing so, this research supports Myanmar's commitment to achieving Sustainable Development Goal (SDG) 10, which emphasizes reduced inequalities, and SDG 11, which advocates for inclusive and sustainable rural and urban areas (WHO, 2011; MIMU, 2021).

1.2 Objective of the Study

The objectives of this study are

- (1) to explore accessibility challenges and barriers faced by people with disabilities in Kyauktaga Township, Bago District.
- (2) to access the accessibility barriers on the livelihood and employment of people with disabilities who work as the income owners in Kyauktaga Township, Bago District.

1.3 Method of the Study

This study employs a descriptive analysis approach, using both primary and secondary data to understand accessibility challenges in rural Kyauktaga. Primary data was collected through surveys, interviews, and field observations within the selected villages, involving individuals with disabilities, and their families. Secondary data include reports from sources such as WHO and Myanmar Information Management Unit (MIMU), which provide context on the prevalence and nature of disability in Myanmar. This approach allow for a comprehensive view of both individual experiences and broader contextual factors influencing accessibility in the area.

1.4 Scope and Limitation of the Study

This study focuses on identifying general accessibility barriers across four domains (household, education, healthcare, and employment) in 13 hard-to-reach villages of Kyauktaga Township. While the research provides a comprehensive overview of challenges faced by people with disabilities collectively, it has two key methodological limitations. First, the survey analysis does not disaggregate barriers by specific disability types (e.g., mobility vs. visual impairments). Although the Washington Group Short Set identified functional limitations (seeing, hearing, walking, etc.), the findings present aggregated data, which may obscure how different impairments interact with distinct barriers. For instance, individuals with congenital visual impairments may navigate household environments more adeptly than those with acquired vision loss due to long-term adaptation (WHO, 2023), but this nuance is not captured in the generalized results.

Second, the study does not examine how the cause of impairment (congenital, injury, illness, or age-related) influences barrier experiences. Research suggests that individuals with acquired disabilities often face unique psychosocial and practical challenges compared to those born with impairments (Shakespeare, 2014). For example, a person who loses mobility later in life may struggle more with attitudinal barriers in employment due to societal perceptions of “sudden incapacity,” whereas someone with lifelong mobility impairments might have developed compensatory strategies (Kett et al., 2020). The survey’s broad categorization of barriers, while useful for identifying systemic issues, cannot reveal these critical differences.

1.5 Organization of the Study

There are five chapters in this study. Chapter one presents the introduction, the rationale, objectives, method, scope, limitations, and organization of the study. Chapter two is the literature review. Chapter three states an overview of disability status in Myanmar. Chapter four examines survey analysis, and Chapter five is the conclusion.

CHAPTER II

LITERATURE REVIEW

2.1 Definations and Concepts of Disability

Disability has been conceptualized differently across historical, cultural, and academic contexts. The medical model, dominant until the late 20th century, framed disability as an individual pathology requiring correction (Oliver, 1990). This perspective, rooted in biomedical paradigms, emphasized impairments: physical, sensory, or cognitive deviations from normative functioning (WHO, 1980). However, the 1970s saw the emergence of the social model, pioneered by disability activists and scholars like Mike Oliver and Vic Finkelstein, which redefined disability as a product of societal barriers rather than personal deficits (Barnes, 2012). This shift laid the groundwork for contemporary human rights-based approaches, culminating in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006), which defines disability as an evolving concept resulting from interactions between impairments and attitudinal/environmental obstacles.

2.1.1 Key Theoretical Frameworks

The study of disability has been shaped by several key theoretical frameworks, each offering distinct perspectives on the nature of disability, its causes, and societal responses. These models, ranging from the medical to the human rights approach, reflect evolving understandings of disability across academic, policy, and activist spheres.

1. Medical Model of Disability

The medical model, dominant until the late 20th century, conceptualizes disability as an individual pathology requiring diagnosis, treatment, and rehabilitation (Shakespeare, 2014). Rooted in biomedical paradigms, this model focuses on impairments: physical, sensory, or cognitive deviations from normative functioning, and seeks to "fix" or normalize the individual (Oliver, 1990). Critics argue that this approach fosters dependency, reduces disability to a medical issue, and neglects societal accountability (Linton, 1998). For example, a person using a wheelchair might be prescribed physical therapy to improve mobility rather than provided with accessible infrastructure (Barnes, 2012). While the medical model remains influential in

clinical settings, its limitations in addressing systemic exclusion led to the development of alternative frameworks.

2. Social Model of Disability

Emerging from disability rights movements in the 1970s, the social model radically redefined disability as a socially constructed phenomenon (Oliver, 1990). Pioneered by scholars like Mike Oliver and Vic Finkelstein, this model distinguishes between impairment (a biological condition, such as paralysis) and disability (the exclusion resulting from societal barriers, such as lack of ramps) (Barnes, 2012). For instance, a deaf person's limitation stems not from hearing loss but from the absence of sign language interpreters in public spaces (Ladd, 2003). The social model shifts responsibility from individuals to society, advocating for structural changes like universal design and anti-discrimination laws (Imrie, 2014). However, critics note its tendency to overlook the lived experiences of impairment, such as chronic pain or mental health conditions (Shakespeare, 2014).

3. Biopsychosocial Model (ICF Framework)

The biopsychosocial model, formalized in the WHO's International Classification of Functioning, Disability and Health (ICF, 2001), integrates medical and social perspectives (WHO, 2001). It frames disability as a dynamic interaction between:

- Health conditions (e.g., spinal cord injury),
- Body functions/structures (e.g., mobility limitations),
- Activities (e.g., difficulty walking),
- Participation (e.g., exclusion from employment), and
- Environmental/personal factors (e.g., stigma or inaccessible transport).

This model is widely used in rehabilitation and policy for its holistic approach, though some argue it medicalizes disability by retaining health-focused language (Bickenbach, 2012).

4. Human Rights Model

The human rights model, codified in the UN Convention on the Rights of Persons with Disabilities (UNCRPD, 2006), positions disability as an equality issue (Degener, 2016). It mandates reasonable accommodations (e.g., workplace adaptations) and universal design (e.g., accessible buildings) to ensure full participation. Unlike the social model, which focuses on barrier removal, the rights model legally enforces inclusion through anti-discrimination laws (Kayess & French, 2008). For example, the Americans with Disabilities Act (ADA, 1990) requires employers to provide accommodations, framing accessibility as a civil right (Heyer, 2015).

2.1.2 Critical Debates in Disability Studies

Disability studies has evolved into a vibrant interdisciplinary field marked by several ongoing theoretical and practical debates that challenge conventional understandings of impairment, exclusion, and empowerment. These critical discussions reflect tensions between academic perspectives and lived experiences of disability across global contexts.

1. Impairment vs. Disability: The Materialist Debate

A central controversy surrounds the social model's distinction between impairment (biological condition) and disability (social exclusion). While pioneers like Oliver (1990) argued this separation was necessary to highlight societal barriers, critics contend it neglects the material realities of bodily pain and chronic illness (Shakespeare, 2014). Feminist disability scholars particularly emphasize how this dichotomy marginalizes experiences like chronic fatigue or mental health conditions that involve both biological and social dimensions (Wendell, 1996). The "impairment effects" concept (Thomas, 2007) attempts to bridge this gap by acknowledging that some limitations stem intrinsically from bodily conditions rather than solely from social structures.

2. Global North-South Tensions in Knowledge Production

Disability models developed in Western contexts, particularly the social model rooted in UK/US activism, often fail to account for alternative understandings prevalent in the Global South (Grech, 2015). Many African and Asian communities interpret disability through spiritual, familial, or communal lenses rather than through rights-based frameworks. For example, in some Ugandan communities, disability is viewed as a sign of ancestral blessing rather than a medical or social issue (Ndlovu, 2020). Similarly, Hindu and Buddhist traditions frequently associate impairment with karma, framing disability as part of a moral or cosmic order (Ghai, 2015). These cultural differences challenge the universal application of Western disability frameworks, raising critical questions about epistemic justice in disability research (Meekosha & Soldatic, 2011). The dominance of Global North perspectives in policy and academia risks marginalizing indigenous knowledge systems, necessitating more inclusive, context-sensitive approaches to disability studies and advocacy.

3. The Neurodiversity Paradox

The neurodiversity movement, which reconceptualizes conditions like autism as natural human variations rather than pathologies, has sparked significant debate (Singer, 1999). Proponents argue for acceptance and accommodation, while critics highlight tensions around medical intervention, particularly for those with high support needs (Ortega, 2009). Divisions

also exist between self-advocates, who emphasize autonomy, and parent-led organizations, which often prioritize therapeutic or curative approaches (Runswick-Cole, 2014). In capitalist economies, workplace accommodations for neurodivergent individuals remain contentious, with some employers resisting structural changes despite legal mandates (Harpur, 2019). Critics caution that the neurodiversity movement's celebration of difference may inadvertently minimize the needs of those with significant cognitive impairments, potentially exacerbating inequalities (Jaarsma & Welin, 2012). This paradox underscores the need for balanced policies that recognize both the value of neurodiversity and the realities of disability-related challenges.

4. Aging and Disability: Blurred Boundaries

Traditional disability frameworks often exclude age-related impairments, despite their functional and social similarities to other forms of disability (Jeppsson Grassman, 2013). Scholars debate whether aging inherently constitutes disability, with some arguing that age-related decline should be framed within disability rights movements (Zola, 1989). Long-term care systems frequently segregate individuals based on age rather than impairment type, creating artificial divisions between "elderly" and "disabled" populations (Putnam, 2007). This segregation reflects broader societal biases, where ageism and ableism intersect to limit access to healthcare and social services (Calasanti, 2020). For instance, older adults with mobility impairments may face rationing of assistive technologies due to assumptions about their "declining utility." Addressing these blurred boundaries requires integrated policies that recognize the shared structural barriers faced by aging and disabled populations.

2.1.3 Contemporary Definitions in Policy

Disability definitions in contemporary policy frameworks reflect an evolving understanding that combines rights-based approaches with practical implementation guidelines. These definitions serve as critical foundations for legislation, service provision, and international development agendas, shaping how societies conceptualize and address disability inclusion.

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006) represents the most influential contemporary definition, characterizing persons with disabilities as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (Article 1). This definition's innovation lies in its emphasis on the interaction between impairments and societal barriers, rather than locating disability solely within the individual (Degener, 2016). The UNCRPD's definition has been

adopted by 185 ratifying countries as the standard for disability-inclusive policy development, though national implementations vary significantly (Lord et al., 2022).

Regional policy instruments have adapted the UNCRPD framework to local contexts. The European Disability Strategy 2021-2030 defines disability through an explicitly social lens as "the outcome of the interaction between a person's impairment and the attitudinal/environmental barriers that hinder participation" (European Commission, 2021). This operationalization requires member states to address both physical accessibility and discriminatory attitudes through measurable indicators. Similarly, the Americans with Disabilities Act Amendments Act (ADAAA, 2008) expanded protections by defining disability as "a physical or mental impairment that substantially limits one or more major life activities," with "major life activities" including reading, concentrating, and bodily functions (EEOC, 2011). The ADAAA's broad interpretation has significantly increased workplace accommodations in the United States (Harpur, 2019).

International development agencies have developed complementary definitions to guide programming. The World Health Organization's International Classification of Functioning, Disability and Health (ICF, 2001) provides a biopsychosocial framework that classifies disability across three dimensions: body functions/structures, activities/participation, and environmental factors (WHO, 2001). This taxonomy enables standardized disability data collection across 194 member states, though critics note its clinical orientation may medicalize disability (Bickenbach, 2012). The World Bank's Environmental Barriers Framework (2018) quantifies disability prevalence through functional limitations (e.g., difficulty seeing, walking) while accounting for contextual factors like poverty and rurality (Morgon Banks & Polack, 2021).

Emerging policy definitions increasingly recognize intersectional disadvantages. Canada's Accessible Canada Act (2019) explicitly addresses how disability compounds with gender, Indigenous status, and racialization (Rioux & Viera, 2020). New Zealand's Disability Strategy 2016-2026 incorporates Māori concepts of wellbeing (Whānau Ora) alongside UNCRPD principles (New Zealand Government, 2016). These culturally responsive approaches challenge universal disability models while meeting international obligations.

Critical debates persist regarding policy definitions' practical impacts. Some scholars argue narrow definitions (e.g., South Africa's Employment Equity Act's "medical diagnosis" requirement) exclude those with episodic or invisible disabilities (Watermeyer et al., 2021). Others note that expansive definitions in high-income countries may not account for resource constraints in low-income settings (Grech & Soldatic, 2016). Ongoing revisions to the UN

Statistical Commission's Washington Group questions reflect efforts to balance global comparability with local relevance (Madans et al., 2022).

2.2 World Disability Population

2.2.1 Worldwide Prevalence of Disabilities by Types

Globally, an estimated 1.3 billion people (16% of the population) experience significant disabilities, according to standardized measurements by the Washington Group Short Set (WG-SS) and the World Health Organization (WHO, 2023). The WG-SS assesses disability across six functional domains, revealing distinct prevalence patterns for each impairment type. However, these percentages cannot be simply summed (totaling ~21%) because many individuals experience multiple overlapping disabilities, meaning the same person may be counted across different categories. Table (2.1) presents the prevalence rate of types of disabilities worldwide.

Table (2.1) Worldwide Prevalence of Disabilities by Types

Types of Disabilities	Population in Million (Estimate)	Percentage (Estimate)
Seeing	253	3.2%
Hearing	446	5.5%
Walking and Climbing	650	8.2%
Remembering/ Concentrating	154	1.9%
Self-care	100	1.3%
Communication	72	0.9%

Source: WHO (2023)

Below is a detailed breakdown of global disability distribution, accounting for these complexities.

1. Seeing Disabilities

Approximately 253 million people (3.2% of the global population) live with moderate to severe vision impairments, including 36 million who completely lost seeing (WHO, 2023). The burden is disproportionately higher in low- and middle-income countries (LMICs), where 90% of blindness cases result from preventable or treatable conditions like cataracts and trachoma (WHO, 2021). In contrast, high-income nations report more age-related vision loss (e.g., macular degeneration, glaucoma), accounting for 55% of cases (WHO Global Eye Health

Report, 2022). Many individuals with vision disabilities also experience mobility or self-care limitations, contributing to overlap in WG-SS reporting.

2. Hearing Disabilities

466 million people (5.5% of the global population) have disabling hearing loss, a figure expected to rise to 700 million by 2050 due to aging populations and noise pollution (WHO, 2021). Access to hearing aids remains highly unequal: only 17% of affected individuals in LMICs use them, compared to 45% in high-income countries (WHO World Report on Hearing, 2021). Childhood hearing loss is often linked to congenital infections (e.g., rubella), while adults face risks from ototoxic medications and occupational noise exposure (WHO, 2023). Many people with hearing impairments also report communication or cognitive challenges, leading to potential double-counting in WG-SS data.

2. Mobility Disabilities

Mobility impairments are the most prevalent disability type, affecting 650 million people (8.2% of the global population) (WHO, 2023). Major causes include arthritis (350 million cases), spinal injuries, and lower-limb amputations (1.5 million annually) (WHO, 2022). Rural populations face three times higher rates than urban residents due to occupational hazards, limited healthcare, and poor infrastructure (WHO Rehabilitation Needs Report, 2021). Mobility disabilities frequently co-occur with impairment in self-care, meaning individuals may be counted in multiple WG-SS categories.

4. Remembering/Concentration (Cognitive) Disabilities

An estimated 154 million people (1.9%) live with intellectual disabilities or dementia, including 55 million Alzheimer's cases (WHO, 2023). High-income countries report 2.5 times higher prevalence due to aging demographics and better diagnostic systems (WHO Mental Health Atlas, 2022). However, only 10% of LMICs have structured support programs (WHO, 2021). Cognitive impairments often overlap with communication or self-care disabilities, further complicating prevalence estimates.

5. Self-Care Disabilities

About 100 million people (1.3%) require assistance with daily activities like bathing, dressing, or eating (WHO, 2023). Leading causes include stroke (15 million annual survivors) and cerebral palsy (17 million cases) (WHO Noncommunicable Diseases Report, 2022). Gender disparities persist, with 65% of caregivers being women (WHO Gender and Disability Brief, 2021). Many individuals with self-care needs also have mobility or cognitive impairments, reinforcing the challenge of avoiding duplicate counts.

6. Communication Disabilities

72 million people (0.9%) experience speech or comprehension difficulties (WHO, 2023). Autism spectrum disorders (affecting 1 in 100 children) and post-stroke aphasia (30% of survivors) are key contributors (WHO Developmental Disabilities Report, 2022). Access to speech therapy is severely limited in LMICs, with less than 5% of affected individuals receiving support (WHO, 2021). Communication disabilities often co-occur with cognitive or hearing impairments, leading to potential overlaps in WG-SS reporting.

2.2.2 Disability Population by Country

The data from Table (2.2) are extracted from the United Nations Statistics Division (2015) and it provides a comprehensive overview of disability prevalence rates across various countries, highlighting significant disparities. The data includes the total population, the population with disabilities, and the prevalence rate expressed as a percentage of the total population for each country. The reference years for the data range from 2001 to 2018, with most data points collected around 2015. This variability in reference years and methodologies, particularly the adoption of the Washington Group Questions, may influence the reported prevalence rates. The Washington Group Questions are designed to standardize disability measurement, but differences in implementation; such as whether countries include "some difficulties" or only "a lot of difficulties and cannot do it at all" in their definitions; can lead to inconsistencies (United Nations, 2015).

Table (2.2) Disability Population by Country

Country	Total Population (Numbers in 1000)	Population with Disability (Numbers in 1000)	Prevalence Rate (% of Total Population)	Reference year
Sweden	8,011	2,819	35.2%	2014-2015
Luxembourg	467	126	27.0%	2016
United Kingdom of Great Britain and Northern Ireland	65,744	13,608	20.7%	2015
Georgia	3,714	680	18.5%	2014
Austria	7,304	1,340	18.4%	2015
Portugal	10,080	1,793	17.8%	2011
Croatia	4,285	760	17.7%	2011

Source: United Nations Statistics Division (2015)

Table (2.2) Disability Population by Country (Continued)

Country	Total Population (Numbers in 1000)	Population with Disability (Numbers in 1000)	Prevalence Rate (% of Total Population)	Reference year
Uruguay	3,066	515	17.4%	2011
Chile	16,991	2,837	16.7%	2015
Norway	4,242	637	15.0%	2015
Belize	322	46	14.3%	2010
Uruguay	3,066	515	17.4%	2011
Israel	5,376	751	14.0%	2016
Canada	27,516	3,776	13.7%	2012
Poland	38,045	4,737	13.4%	2011
Suriname	542	68	13.3%	2012
Argentina	39,671	5,114	12.9%	2010
Finland	3,506	449	12.8%	2011 & 2017
United States of America	318,176	40,747	12.8%	2016
Netherlands	14,539	1,787	12.3%	2016
Montenegro	620	68	11.1%	2011
Costa Rica	4,302	453	10.5%	2011
Czechia	10,512	1,078	10.3%	2013
Bulgaria	7,365	474	9.4%	2011
Latvia	1,950	182	9.3%	2016
United Republic of Tanzania	44,050	4,029	9.1%	2012
Zimbabwe	13,573	1,233	9.1%	2017
Spain	42,223	3,797	9.0%	2008
Bosnia and Herzegovina	3,531	294	8.5%	2013
Serbia	7,187	572	8.1%	2011
Lithuania	3,484	263	7.8%	2001
South Africa	49,677	3,843	7.7%	2016
Republic of Korea	47,188	3,395	7.2%	2015
Saudi Arabia	20,408	1,446	7.1%	2017
Turkey	68,340	4,809	7.0%	2011
Colombia	41,468	2,625	6.4%	2005
Albania	2,222	137	6.2%	2011
Ecuador	14,483	816	6.1%	2010
Senegal	13,165	755	5.7%	2013
Venezuela (Bolivarian Republic of)	27,020	1,455	5.4%	2011

Source: United Nations Statistics Division (2015)

Table (2.2) Disability Population by Country (Continued)

Country	Total Population (Numbers in 1000)	Population with Disability (Numbers in 1000)	Prevalence Rate (% of Total Population)	Reference year
Peru	30,275	1,575	5.2%	2012
Morocco	33,610	1,703	5.1%	2014
Rwanda	8,976	446	5.0%	2012
Mauritius	1,237	60	4.9%	2011
Romania	18,863	906	4.8%	2011
Myanmar	50,280	2,311	4.6%	2014
Hungary	9,804	408	4.3%	2016
Trinidad and Tobago	1,323	52	4.3%	2011
Maxico	112,337	4,528	4.1%	2010
Mongolia	2,648	108	4.1%	2010
Kazakhstan	18,157	665	3.7%	2018
Bolivia	10,060	343	3.4%	2012
Afghanistan	29,113	294	3.2%	2016-2017
Cuba	11,221	362	3.2%	2017
Oman	1,957	63	3.2%	2010
Burundi	9,251	266	2.9%	2014
Angola	25,789	656	2.5%	2014
India	1,210,855	26,815	2.2%	2011
Thailand	68,007	1,479	2.2%	2012
Yemen	25,993	565	2.2%	2014
Indonesia	246,636	5,255	2.1%	2015
Nepal	26,495	513	1.9%	2011
Philippines	92,335	1,453	1.6%	2010
Cameroon	17,464	262	1.5%	2005
Guinea	10,503	156	1.5%	2014
Iran	75,150	1,018	1.4%	2011
Malaysia	31,634	409	1.3%	2016
Qatar	1,699	8	0.4%	2010

Source: United Nations Statistics Division (2015)

Disability prevalence rates vary widely, with Sweden reporting the highest rate at 35.2%, followed by Luxembourg (27.0%) and the United Kingdom (20.7%). These high rates may reflect broader definitions of disability, inclusive social policies, and better data collection systems. Conversely, Qatar reports the lowest prevalence rate at 0.4%, with other countries like

Malaysia (1.3%) and Iran (1.4%) also showing notably low figures. These differences may stem from stricter definitions of disability, cultural stigmas leading to underreporting, or limited access to diagnostic services (World Health Organization, 2011).

It is important to note that the data may not fully reflect the current global situation, as it is nearly a decade old. Socioeconomic changes, conflicts, and health crises like the COVID-19 pandemic have likely altered disability prevalence rates since 2015. Additionally, the lack of recent data for some countries limits the ability to draw accurate contemporary comparisons.

2.2.3 Global Social Welfare Programs for People with Disabilities

Social welfare programs for people with disabilities vary significantly across nations, reflecting differences in economic capacity, policy priorities, and cultural values. In high-income countries, comprehensive social protection systems are well-established.

Nordic nations like Sweden and Norway exemplify this approach, offering universal disability allowances (€1,200/month in Sweden) and mandating employment quotas (5% of jobs reserved for people with disabilities in Norway) (OECD, 2023). These programs are supported by strong taxation systems and prioritize rights-based inclusion, providing free assistive devices and wage subsidies to employers (ILO, 2022). Similarly, Australia's National Disability Insurance Scheme (NDIS) represents one of the world's most ambitious person-centered systems, allocating AU\$34 billion annually for individualized support packages (NDIA, 2023). The scheme covers everything from home modifications to therapeutic supports, though recent critiques highlight bureaucratic delays in implementation (Productivity Commission, 2023).

Middle-income nations often implement conditional cash transfer programs alongside developing inclusive services. Brazil's *Benefício de Prestação Continuada* provides a minimum wage equivalent (R\$1,320/month) to low-income people with disabilities, lifting millions out of extreme poverty (World Bank, 2021). However, coverage gaps persist in rural areas due to complex eligibility verification. South Africa's disability grant (ZAR 2,080/month) reaches 1.2 million recipients but faces challenges like lengthy application processes and limited vocational rehabilitation (African Disability Alliance, 2022). These programs demonstrate how middle-income countries balance fiscal constraints with growing disability rights awareness, often relying on civil society partnerships to extend services.

Fragile states and low-income countries typically depend on international aid and NGO-led initiatives. In Bangladesh, community-based rehabilitation (CBR) programs run by BRAC and other NGOs provide assistive devices and skills training to 30% of rural PWDs

(WHO, 2020). Haiti's fragmented state system leaves 90% of people with disabilities reliant on charities like Humanity & Inclusion for basic mobility aids (Human Rights Watch, 2021). These contexts reveal acute service gaps: only 0.5% of global humanitarian aid specifically targets disability inclusion (UNPRPD, 2023), leaving many conflict-affected people with disabilities without support.

2.2.3 Vision and Mission of Disability Programs Worldwide

Contemporary disability programs increasingly align with the UN Convention on the Rights of Persons with Disabilities (CRPD), adopting twin goals of inclusion and empowerment. The European Disability Strategy 2021-2030 embodies this through its vision of "a Union of equality" where people with disabilities enjoy equal rights in all life areas (European Commission, 2021). Its mission focuses on removing barriers through legislation like the European Accessibility Act, which mandates accessible products and services across member states. Similarly, Japan's Basic Program for people with disabilities emphasizes employment equity via corporate tax incentives, aiming to double the disability employment rate by 2030 (MHLW, 2022). These programs reflect a shift from welfare-based to rights-based models, though critics note persistent gaps in rural implementation (Grech, 2015).

Poverty alleviation remains central to programs in developing economies. Kenya's National Disability Fund provides entrepreneurship grants but reaches only 15% of eligible people with disabilities due to funding shortages (KNBS, 2023). India's Accessible India Campaign combines infrastructure upgrades with skills training, yet faces challenges in monitoring outcomes (Social Justice Ministry, 2022). These missions often struggle to balance ambitious inclusion targets with resource limitations, sometimes leading to tokenistic compliance, for instance, building ramps without maintaining them (Gleeson, 2021).

Health and rehabilitation form another critical pillar. The WHO's Global Cooperation on Assistive Technology (GATE) initiative aims to provide 500 million people with affordable devices by 2030 (WHO, 2022). Partnering with 70+ countries, GATE supports local production of wheelchairs and hearing aids, particularly in Africa and South Asia. Meanwhile, Canada's Accessible Canada Act (2019) integrates Indigenous concepts of wellbeing with CRPD principles, requiring federally regulated organizations to develop accessibility plans (Rioux & Viera, 2020). This culturally responsive approach addresses intersectional disadvantages faced by Indigenous people with disabilities, who experience 50% higher poverty rates than non-Indigenous peers (StatsCan, 2023).

Emerging priorities include climate resilience and digital inclusion. The UN Disability-Inclusive Climate Action Framework (2023) guides nations in protecting people with disabilities during disasters, while South Korea's Digital New Deal ensures 100% accessibility in government online services by 2025 (MSIT, 2023). These innovations highlight how disability programs are evolving beyond traditional welfare to address 21st-century challenges, though consistent funding and disability participation in governance remain hurdles globally (UN DESA, 2023).

2.3 Types of Barriers faced by People with Disabilities

People with disabilities face four primary types of barriers: environmental, attitudinal, communication, and institutional (WHO, 2011). Each type significantly affects accessibility and inclusion in various aspects of daily life.

- i. **Environmental Barriers:** These include physical obstacles such as inaccessible buildings, lack of transportation, and poor infrastructure, which prevent individuals from participating fully in society. The theory of universal design, which advocates for making spaces accessible to everyone regardless of ability, is a crucial concept here (Bickenbach, 2012).
- ii. **Attitudinal Barriers:** Negative societal perceptions and stereotypes about disability can lead to discrimination and exclusion. The stigma theory suggests that people with disabilities are often perceived as different or incapable, which influences their social interactions and opportunities (Goffman, 1963).
- iii. **Communication barriers:** Communication barriers are challenges that hinder people with disabilities from understanding or being understood in various settings, from social interactions to accessing essential services. These barriers may include the lack of accessible formats, such as braille, sign language, and closed captioning, and can affect individuals with hearing, speech, or cognitive impairments (WHO, 2011).
- iv. **Institutional Barriers:** Institutional barriers involve policies and regulations that do not accommodate the needs of people with disabilities. This can range from discriminatory laws to the absence of disability-inclusive policies. The concept of "reasonable accommodation" under the CRPD highlights the need for modifications to support individuals with disabilities (WHO, 2011).

2.4 RECU Principles for Accessibility

The RECU principle: Reach, Enter, Circulate, and Use, guides the design of accessible environments that enable people with disabilities to navigate spaces independently and comfortably (WHO, 2011). Each component of RECU corresponds to a specific aspect of accessibility that impacts daily activities and participation.

- i. **Reach:** This aspect emphasizes the importance of providing accessible routes and pathways for individuals to reach a given destination. In rural areas, this often involves considerations of natural terrain and transportation (Bickenbach, 2012). Studies on accessibility indicate that providing safe and direct pathways for people with disabilities is foundational to achieving inclusion (Fernando et al., 2023).
- ii. **Enter:** Accessibility is compromised if individuals with disabilities cannot enter buildings or spaces independently. This requires ramps, elevators, and entrance designs that accommodate wheelchairs and other mobility aids.
- iii. **Circulate:** Once inside a building, individuals need accessible routes to move around freely. This includes the layout of hallways, doorways, and restrooms. Ensuring circulation within spaces is crucial in both public and private settings to support inclusion (WHO, 2011).
- iv. **Use:** The final component emphasizes the functionality of facilities, such as accessible restrooms, seating, and other amenities that allow individuals to use the space independently. The RECU principle underscores the need for holistic design that considers all aspects of accessibility, aligning with the goals of universal design.

2.5 Review of Previous Studies

The World Report on Disability by WHO (2011) provides a comprehensive overview of the challenges faced by over one billion people with disabilities globally. It highlights barriers in healthcare, education, employment, and transportation, emphasizing the intersection of disability, poverty, and exclusion. The report advocates for adopting the International Classification of Functioning, Disability, and Health (ICF) to address disability holistically, combining medical and social perspectives. It recommends inclusive policies, community-based rehabilitation, universal design, and investment in assistive technologies to improve participation and quality of life. The report serves as a critical guide for implementing the UNCRPD and promoting disability inclusion worldwide.

Lang and Upah's (2008) study examines the barriers faced by persons with disabilities in Nigeria, focusing on challenges in education, employment, healthcare, and social inclusion.

The study highlights the lack of disability-specific policies, inadequate implementation of existing frameworks, and the absence of accessible infrastructure. It emphasizes the role of stigma and traditional beliefs in perpetuating exclusion and poverty.

Shakespeare (2014) critically examines the evolution of disability studies, exploring the interplay between the medical and social models of disability. The book argues for a balanced "bio-psycho-social" approach, emphasizing that both individual impairments and societal barriers shape the lived experiences of persons with disabilities. Shakespeare challenges the oversimplifications of the social model while advocating for disability rights, inclusion, and the importance of personal agency.

The Disability in Myanmar: Analytical Brief by MIMU (2021) examines the prevalence and distribution of disabilities across Myanmar, highlighting disparities in education, healthcare, and employment. It emphasizes the challenges faced by persons with disabilities in rural areas due to limited infrastructure, accessibility barriers, and social stigma. The brief underscores the intersection of disability and poverty, noting that households with disabled members often experience greater economic hardship. It advocates for inclusive policies, improved data collection, and targeted interventions to address these barriers. The report provides valuable insights into the need for disability-inclusive development in Myanmar, especially in underserved regions.

Fernando et al. (2023) explore the experiences of persons with disabilities across urban and rural areas in four regions of Myanmar, highlighting significant accessibility and inequality challenges. The study identifies barriers in education, healthcare, and public spaces, emphasizing how geographic isolation and poverty exacerbate exclusion in rural areas. It also highlights the role of societal stigma and limited infrastructure in restricting participation for people with disabilities.

Bawi (2022) examines the challenges and opportunities for persons with disabilities in Myanmar's labor market, highlighting systemic barriers such as discrimination, lack of accessible workplaces, and limited vocational training. The study emphasizes that unemployment among persons with disabilities is significantly higher due to inadequate enforcement of inclusive labor policies and societal stigma.

Each of these studies emphasizes the importance of policy reform and community-based approaches to improve accessibility and promote the rights of people with disabilities. In the context of Myanmar, previous research indicates that increased government intervention, funding, and community engagement are essential to achieve meaningful progress in disability inclusion.

CHAPTER III

OVERVIEW OF DISABILITY STATUS IN MYANAMR

3.1 Disability Demographics in Myanmar

According to the 2014 Myanmar Population and Housing Census, approximately 2.3 million people, or 4.6% of the total population were reported to have some form of disability. This figure is based on four core functional domains: seeing, hearing, walking, and remembering/concentrating, using the Washington Group Short Set of Questions. Among them, 559,000 individuals experienced severe forms of disability, including those who had lost seeing, hearing, or are unable to walk. Table (2.2) shows the disability population and prevalence rate of Myanmar.

Table (3.1) Disability Population in Myanmar

Types of Disabilities	Population with Disability	Prevalence Rate (% of Total Population)
Any form of Disability	2,311,250	4.6%
Seeing	1,249,737	2.5%
Hearing	673,126	1.3%
Walking and Climbing	957,736	1.9%
Remembering/ Concentrating	835,598	1.7%

Source: Myanmar Population and Housing Census (2014)

The most common type of disability was difficulty seeing (2.5% of total population), followed by difficulty walking (1.9%), and remembering & concentrating (1.7), and hearing (1.3%). It is important to note that these figures may be underestimates, as they exclude children under 10 and do not account for difficulties in self-care or communication: two additional domains recommended internationally.

The data reveal significant gender and age disparities. Women (4.8% of total population) were slightly more likely to report disabilities than men (4.4% of total population).

Furthermore, disability prevalence increased sharply with age, with older persons (60 years and above) being far more likely to experience multiple functional difficulties.

A striking urban-rural divide exists in disability distribution. Approximately 77% of people with disabilities live in rural areas, where access to healthcare, education, assistive devices, and infrastructure is more limited. In contrast, urban areas, though better resourced, still face challenges in ensuring inclusive services.

Regional variation was also evident. Ayeyawady Region, Chin State, and Bago Region recorded higher disability prevalence rates, highlighting geographic inequalities in health outcomes and accessibility.

The data underscore the need for targeted policies, especially in rural and underserved regions, to promote disability inclusion and ensure that people with disabilities are not left behind in Myanmar's development process.

3.2 Legal and Policy Framework for Disability Inclusion in Myanmar

Myanmar has taken several legislative steps to promote disability rights, particularly since ratifying the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in December 2011. This ratification signifies a commitment to protect and ensure the full and equal enjoyment of all human rights by people with disabilities.

Following this, Myanmar enacted the Law on the Rights of Persons with Disabilities in 2015, replacing the outdated 1958 Disabled Persons Employment Law. The 2015 law provides a framework to promote equality, protect against discrimination, and facilitate access to education, employment, and public services for people with disabilities. It also mandates the establishment of the National Committee on the Rights of Persons with Disabilities, a body tasked with coordinating disability-related policies and programs across sectors (International IDEA, 2024).

To operationalize this law, the National Strategic Plan on the Rights of Persons with Disabilities (2020–2025) was introduced. This strategy aims to align with the CRPD and Sustainable Development Goals (SDGs), focusing on inclusive education, universal accessibility, livelihoods, and participation in public life.

Despite these efforts, major gaps remain between policy and implementation. Reports highlight a lack of enforcement mechanisms, limited budget allocation, and weak coordination among ministries. Many people with disabilities, especially in rural areas, are unaware of their rights or unable to access services due to infrastructural and attitudinal barriers (MIMU, 2021; Fernando et al., 2023). Furthermore, political instability since 2021 has disrupted the continuity

of disability governance, limiting progress in institutionalizing inclusive reforms (International IDEA, 2024).

Overall, while Myanmar has made progress in legal commitments, practical implementation remains uneven and requires stronger accountability, community engagement, and localized action.

3.3 Institutional Support and Disability Services in Myanmar

The Ministry of Social Welfare, Relief, and Resettlement (MoSWRR) serves as the principal government body responsible for disability-related welfare in Myanmar. The Department of Social Welfare (DSW) provides social services, including prevention, protection, and rehabilitation for persons with disabilities (PWDs) through community outreach and institutional programs. In 2018, a Department of Rehabilitation was established within the ministry, alongside disaster management and social welfare departments, to coordinate rehabilitation and social support.

The Department of Social Welfare and Ministry of Health together lead community-based rehabilitation (CBR) initiatives. The Ministry of Health piloted these interventions, producing assistive devices in hospitals and distributing them through CBR projects, supported by NGOs and UN agencies. These programs, present since the 1980s and strengthened after Cyclone Nargis, focus on low-cost assistive devices (e.g., white canes, wheelchairs) and volunteer training, especially in rural areas.

National and local disability organizations, such as the Myanmar Christian Fellowship of the Blind and The Leprosy Mission Myanmar, partner with DSW and the Ministry of Health to deliver CBR services, vocational training, and inclusive education. Several NGOs have played key roles in CBR since the 1980s, collaborating on home-based care, rehabilitation, and assistive device manufacture.

Myanmar has made efforts to enhance assistive device accessibility: hospital workshops under the Ministry of Health manufacture mobility aids, while CBR services distribute them in communities. Low-vision and hearing aids are distributed with support from World Vision International. Yet, data on service coverage and device need remain limited.

Healthcare infrastructure, inclusive of social assistance and assistive device production, is guided by national health policy and disability legislation. However, challenges persist in the scale and reach of services: production remains centralized, coverage is uneven, and rural implementation is constrained by limited funding and coordination.

Table (3.2) shows a brief overview of social welfare services for people with disabilities in Myanmar.

Table (3.2) Social Welfare Services for People with Disabilities in Myanmar

Type of Service	Service Provider	Location	Services Provided
Institutional Care	Department of Social Welfare (DSW)	Yangon, Sagaing, Mandalay	Residential care for orphans/unaccompanied children with disabilities; ADL training
Special Education Schools	Department of Social Welfare (DSW)	Yangon, Mandalay	Schools for the Blind (Braille education)
			Schools for the Deaf (sign language)
			Schools for intellectual disabilities (special education)
Vocational Training	DSW + NIPPON Foundation (PPP)	Yangon	Computer skills, tailoring, handicrafts for adults with physical/sensory disabilities
Community-Based Rehabilitation	DSW + NGOs (e.g., AAR Japan)	Nationwide	Mobile clinics, assistive device provision, home-based rehabilitation therapy
Sign Language Training	DSW + UNDP	Yangon, Mandalay	Sign language interpreter training; curriculum development
ICT Accessibility Programs	DSW + NIPPON Foundation	Yangon	Adaptive technology training (e.g., screen readers for visually impaired)
Awareness Campaigns	DSW + UNICEF	Nationwide	Disability rights advocacy, inclusive education promotion

Sources: Department of Social Welfare Annual Reports (2019–2023)

3.4 Overview of Bago Region and Kyauktaga Township

Located in central Myanmar, Bago Region spans approximately 39,405 km² and borders Yangon, Ayeyarwady, Rakhine, Magway, Naypyidaw, Kayin, and Mon states. The region’s terrain includes lowlands in the south and east, while the north comprises the Bago Yoma hills and forests, including teak and hardwood reserves . With a population of 4.86

million as per the 2014 Census, Bago is Myanmar’s fifth most populous region, exhibiting a 17% urban and 83% rural split. The Bamar form the majority ethnic group, with significant Karen and Mon communities, supplemented by Chin, Shan, Rakhine, and others. Religious demographics are predominantly Buddhist (93.5%), with Muslim, Christian, Hindu, and animist minorities. Literacy is comparatively high, though rural–urban disparities in educational access persist. Disability prevalence rate in Bago region was 4.2%. Among these, 2.3% reported difficulty seeing and 1.7% difficulty walking. Table (3.3) shows the disability population and its prevalence rate in Bago region.

Table (3.3) Disability Population in Bago Region

Types of Disabilities	Population with Disability	Prevalence Rate (% of Total Population)
Any form of Disability	202,431	4.2%
Seeing	109,734	2.3%
Hearing	60,786	1.2%
Walking and Climbing	82,627	1.7%
Remembering/ Concentrating	69,004	1.4%

Source: Myanmar Population and Housing Census (2014)

Economically, Bago Region is mainly agrarian, with rice occupying two-thirds of cultivated land. Other crops include pulses, sugarcane, jute, rubber, and horticulture. The region also supports industries like timber, ceramics, fish farms, and small-scale manufacturing. Notably, the Shwegyin Dam, built in 2009–2011, contributes to flood control, irrigation, and hydropower. Infrastructure investments in recent years include asphalt and concrete roads, rural electrification, water projects, and vocational training programs funded through regional government budgets. However, landmine contamination in eastern townships adds complexity to development efforts.

Kyauktaga Township is part of Nyaunglebin District in Bago Region, covering 2,831 km², with 13 urban wards and 47 village tracts, comprising 283 villages. It includes the townships of Kyauktaga and Penwegon, both situated along the Yangon–Mandalay Highway and railway line. Kyauktaga’s strategic significance is underlined by its connectivity on Myanmar’s central transport axis. The 2014 Census recorded 251,212 residents in Kyauktaga Township, up from 168,597 in 1983, indicating rapid population growth. The township displayed an average household size of approximately 4.4 and a median age near 26 years.

Disability prevalence rate in Kyauktaga was 3.0%, representing 7,441 persons, which is slightly lower than the national average of 4.6% . Among these, 1.4% reported difficulty seeing and 1.3% difficulty walking. Table (3.4) shows the disability population and it’s prevalence rate in Kyauktaga township.

Table (3.4) Disability Population in Kyauktaga Township

Types of Disabilities	Population with Disability	Prevalence Rate (% of Total Population)
Any form of Disability	7,441	3.0%
Seeing	3,442	1.4%
Hearing	2,192	0.9%
Walking and Climbing	3,376	1.3%
Remembering/ Concentrating	2,717	1.1%

Source: Myanmar Population and Housing Census (2014)

Kyauktaga benefits from key transport infrastructure: the Yangon–Mandalay highway and rail line traverse the township. Nevertheless, secondary and village roads remain largely unpaved, posing seasonal accessibility challenges. Rural electrification has progressed but remained uneven; many villages depended on generators or solar mini-grids . Water and sanitation infrastructure is limited. While village water supplies and tube wells are available, piped water access is rare. Poor sanitation facilities and unlit roads compound health and safety risks, especially for people with disabilities . Healthcare is administered through township and rural health centers; however, these facilities typically lack disability-friendly features, such as ramps, accessible toilets, or specialized equipment. Education infrastructure includes basic education schools, but inclusive education efforts are limited by lack of adapted materials, teacher training, and physical access.

The Department of Social Welfare (DSW) under the Ministry of Social Welfare leads disability services at the township level, including Community–Based Rehabilitation (CBR), social protection, and welfare. The Department of Health and NGOs jointly run CBR initiatives, offering training, medical assessments, and assistive device production/distribution.

Local NGOs and community groups such as village development committees under Bago Region’s government facilitate inclusive programs and vocational training (e.g., bamboo

handicrafts, sewing). While contributions from organizations like World Vision have introduced mobility aids and visual support services, these remain limited in scale.

Bago Region and Kyauktaga Township demonstrate considerable diversity in terms of demographics, infrastructure, and economic activity. Although connectivity improvements and agricultural productivity contribute to regional development, accessibility remains uneven, especially for people with disabilities. Rural infrastructure deficiencies, limited inclusive services, and weak data on disability prevalence emphasize the need for targeted interventions. The presence of government CBR programs and NGO-led initiatives provides a foundation, but their reach remains fragmented.

By combining demographic data, infrastructure analysis, and insight into support services, this chapter contextualizes the field research that follows, highlighting both systemic challenges and existing capacities for disability inclusion in rural Myanmar.

3.5 Issues of People with Disabilities in Kyauktaga Township

Kyauktaga Township faces a multidimensional accessibility crisis affecting people with disabilities. Environmental barriers are evident in the township's infrastructure: unpaved secondary roads, damaged bridges (e.g. Warnatyoe Creek Bridge), and limited public transport, impeding access to education, healthcare, and markets, especially during the rainy season. Although major routes like the Yangon–Mandalay highway and railway traverse Kyauktaga, last-mile connectivity to villages remains poor, reducing mobility for wheelchair users and others with mobility impairments. Attitudinal barriers also limit inclusion. Rural communities often lack awareness about disability rights, normalizing exclusion and leading to social stigma. Regions outside Yangon report that people with disabilities are often viewed as unable to participate in social and economic life. This stigma discourages people with disabilities from utilizing available services and participating in public life. Institutional barriers are pronounced at the township level. Although the Ministry of Social Welfare, Relief and Resettlement has begun registration and assessment of people with disabilities, local institutions still suffer from limited capacity and under-resourced disability services. CBR programs exist, but they are uneven in coverage and reporting suggests limited awareness and coordination, with accessible infrastructures still largely absent. Communication barriers persist in local services. Public notices, healthcare guidance, and disaster warnings often lack accessible formats such as sign language, braille, or visual aids. People with disabilities report difficulty obtaining essential information, contributing to their marginalization.

Myanmar's legal and policy framework, most notably the 2015 Disability Rights Law, the ratified CRPD, and the National Strategic Plan (2020–2025), provides a strong foundation. The Department of Social Welfare and the Department of Health have established CBR mechanisms, assistive device production, and registration systems. However, at the local level, Kyauktaga's institutions struggle with practical implementation.

Despite national commitments to universal accessibility under Myanmar's Disability Rights Law (2015) and UNCRPD ratification, significant implementation gaps persist in rural areas like Kyauktaga Township. Infrastructure remains largely inaccessible, with only 7% of rural roads nationwide meeting basic accessibility standards, and public transport systems rarely accommodating wheelchairs or mobility aids (Department of Rehabilitation, 2022). Field assessments reveal that even newly constructed buildings often lack ramps or tactile pathways, violating Section 28(a) of Myanmar's disability law (DSW, 2021).

Service provision is heavily urban-centric. While Yangon and Mandalay host 80% of Community-Based Rehabilitation (CBR) centers and assistive device distribution points, rural townships like Kyauktaga have just 1–2 trained rehabilitation workers per 10,000 people with disabilities (WHO Myanmar, 2023). The 2021 Myanmar Analytical Brief on Disability noted that only 12% of rural people with disabilities received assistive devices, compared to 43% in urban areas (MIMU, 2021).

Funding and coordination challenges exacerbate these disparities. Although the Ministry of Social Welfare allocated K3 billion for disability loans in 2020–2022, audits revealed that 67% of funds were unused due to bureaucratic delays and lack of inter-ministerial collaboration (Auditor General's Report, 2022). For instance, education and health ministries operated parallel (and often conflicting) disability registries until 2021 (UNICEF, 2022).

At the community level, stigma and weak advocacy undermine participation. A 2022 survey found that 78% of rural respondents believed disability resulted from "karma," discouraging demands for inclusive services (ARK Foundation, 2022). National awareness campaigns rarely reach villages, leaving 62% of rural PWDs unaware of their legal rights (DSW & ILO, 2020).

CHAPTER IV

SURVEY ANALYSIS

4.1 Survey Profile

The survey was conducted in 13 selected villages of Kyauktaga Township, Bago Region, which is predominantly rural and agriculturally based. These villages were chosen due to their relative isolation, limited infrastructure, and known prevalence of accessibility challenges for people with disabilities.

The total sample size for the study was 126 individuals with self-reported or caregiver-reported disabilities. The gender distribution was relatively balanced, with 62 male and 64 female respondents. A wide age range was represented, from early childhood to the elderly, ensuring a broad understanding of disability experiences across the life cycle. The sample was proportionally distributed across the selected villages based on their population size and accessibility.

Survey participants included individuals with various types of impairments: mobility, vision, hearing, self-care, cognitive, and communication, capturing the diversity of disability in rural Myanmar. Local field enumerators trained in disability-sensitive interviewing techniques conducted face-to-face interviews using structured questionnaires translated into the Myanmar language.

Ethical considerations, including informed consent, privacy, and confidentiality, were strictly followed during the data collection process. The findings from this survey provide a strong empirical foundation for understanding the accessibility challenges faced by people with disabilities in the region.

4.2 Survey Design

The survey was designed using a descriptive, cross-sectional methodology and employed both quantitative and qualitative approaches to assess accessibility barriers. The core research tool was a structured questionnaire composed of five sections, including demographic data, disability identification using the Washington Group Short Set, types and causes of impairments, and assessments of four key barrier types (environmental, attitudinal, communication, and institutional) across four major domains: household and surroundings, education, healthcare, and employment.

Data collection was carried out during April to May 2025 using KOBO Toolbox, which enabled efficient, real-time mobile data entry, even in low-connectivity areas. The collected data were exported to Microsoft Excel for analysis and tabulation. Village-level data disaggregation allowed insights into localized differences in barriers and service access.

Table (4.1) Sample of Study from Kyauktaga Township

No.	Village Name	Male	Female	Total	Percentage
1	Ah Lel Myaung	5	2	7	6%
2	Aung Myin Kone	4	6	10	8%
3	Chaung Zauk	9	12	21	17%
4	Hman Chaung (Ah Shey Su)	5	4	9	7%
5	Hpawt Hto Gi	0	3	3	2%
6	Inn Hpyawt	10	11	21	17%
7	Ka Nyin Myaung	2	2	4	3%
8	Kyar Kaik Myaung	2	1	3	2%
9	Myet Ni Kwin	4	7	11	9%
10	Pay Kone	1	4	5	4%
11	Shwe Gyoet Pin	11	3	14	11%
12	Si Son Kone	9	7	16	13%
13	Ywar Thit	0	2	2	2%
Total		62	64	126	100%

Source: Survey data, 2025

According to the Table (4.1), Sample size is 126 and it was calculated by using sample size calculation for random sampling design. The level of precision, sometimes called sampling error is ± 5 percent. The confidence level of this study is 95%, 95 out of 100 samples will have

the true population value within the range of precision. The survey data were collected by the structured questionnaire and individual one on one interview was held with the respondents.

4.3 Survey Results

The survey finding is divided by four parts: (i) Characteristics of respondents, (ii) Barriers assessment in Household and Surroundings, (iii) Barriers assessment in Education (iv) Barriers assessment in Healthcare, and (v) Barriers assessment in Livelihood/Employment.

(i) Characteristics of Respondents

Table (4.2) General Characteristics of Respondents

General Characteristics	No. of Respondents			Percentage in Total
	Male	Female	Total	
Age Group				
0 - 5 year	2	5	7	5.5%
6 - 17 year	8	9	17	13.5%
18 - 60 year	31	32	63	50%
Above 60 year	21	18	39	31%
Total	62	64	126	100%
Marital Status				
Single	29	28	57	45%
Married	25	20	45	36%
Widow	8	16	24	19%
Total	62	64	126	100%
Highest education level				
No Literacy	34	31	65	52%
Basic Literacy	0	5	5	4%
Basic Education (Primary)	20	21	41	33%
Basic Education (Middle School)	7	4	11	9%
Basic Education (High School)	0	1	1	1%
Not applicable (under 5)	1	2	3	2%
Total	62	64	126	100%

Source: Survey data, 2025

Table (4.2) shows the general characteristics of respondents in the survey area such as age, education level and marital status. The demographic profile of the respondents indicates that 49% were between 19 and 60 years, the economically active population group, and 31%

were over 60 years old, reflecting the strong link between aging and disability. Only 14% were children (6–18 years), and 6% were under 5 years old.

Regarding marital status, 45% were single, 36% married, and 19% widowed highlighting the social vulnerability of widowed PWDs, especially women.

In terms of education, the findings show that 52% of respondents were illiterate, while 33% had primary-level education. Only 1% reached high school, indicating a significant gap in educational attainment among PWDs, which may limit future employment opportunities.

Table (4.3) Disability Status of Respondents

Disability status	Male	Female	Total	Percentage (%) in Total
Seeing	14	12	26	21%
Hearing	6	17	23	18%
Walking and climbing	27	24	51	40%
Remembering/ Concentrating	9	7	16	13%
Self-care	4	2	6	5%
Communication	2	2	4	3%
Total	62	64	126	100%
Cause of impairment				
Congenital	26	33	59	47%
Illness or disease	12	17	29	23%
Accident or injury	19	6	25	20%
Age-related	5	8	13	10%
Total	62	64	126	100%

Source: Survey data, 2025

Table (4.3) shows disability prevalence rate according to Washington Group Questions (Short Set).

The most prevalent types of disability were:

- Walking and climbing difficulties (40%)
- Seeing impairments (21%)
- Hearing impairments (18%)

- Cognitive/remembering issues (13%)

Other impairments included self-care (5%) and communication difficulties (3%), confirming the diversity of functional limitations in the sample.

As for the cause of impairment, nearly half (47%) of the respondents reported congenital conditions, followed by impairments caused by illness (23%), injury or accident (20%), and age-related factors (10%).

This respondent profile reveals important socio-demographic patterns, suggesting that disability in Kyauktaga Township is widespread across age groups and types of impairments, with an educational and economic disadvantage. This further reinforces the need for targeted interventions in health, education, and employment sectors.

(ii) Barriers Assessment in Household and Surroundings

(a) Environmental Barriers Assessment in Household and Surroundings

Table (4.4) Environmental Barriers Faced in Household and Surroundings

Accessibility		Yes	No	Total Respondents
Access to Accessible stairs (with handrails, wide and deep steps)	Percentage	6%	94%	126
	Frequency	8	118	
Access to wide enough doorways	Percentage	14%	86%	126
	Frequency	18	108	
Access to accessible ramps	Percentage	7%	93%	126
	Frequency	9	117	
Access to grab bars inside the house	Percentage	4%	96%	126
	Frequency	5	121	
Access to grab bars inside the toilet/bathroom	Percentage	3%	97%	126
	Frequency	4	122	
Access to adequate lighting inside and around the house	Percentage	77%	23%	126
	Frequency	97	29	
Access to paved or smooth pathway around the house	Percentage	20%	80%	126
	Frequency	25	101	

Source: Survey data, 2025

According to Table (4.4), only 6% of respondents have access to accessible stairs. 7% have accessible ramps, and a mere 4% and 3% reported having grab bars inside the house and bathroom, respectively. This highlights significant mobility barriers within domestic spaces and inadequate accessible Infrastructure. Only 14% of respondents said their doorways were wide enough to accommodate mobility aids, 20% had paved or smooth pathways around the house. This limits safe navigation for individuals with physical impairments. 77% reported having sufficient lighting inside and around the house as a positive exception: an area where many homes are relatively well-equipped. Most respondents lack the basic physical modifications that support independent living, confirming the presence of significant environmental barriers in the home environment.

Table (4.5) Types of Toilets Used at Home

Toilet used at home	Frequency	Percentage
Traditional	124	98%
Modern	1	1%
Both	1	1%
Total	126	100%

Source: Survey data, 2025

Table (4.5) categorizes the kind of sanitation facilities used by people with disabilities. A striking 98% use traditional toilets, which typically require squatting and may lack supportive structures. Only 1% reported using modern toilets, and another 1% had access to both. The overwhelming reliance on traditional toilets points to a critical accessibility challenge, as such facilities are not disability-friendly, especially for those with mobility, balance, or joint issues.

(b) Attitudinal Barriers Assessment in Household and Surroundings

Table (4.6) Family Members' Understanding on the Needs of People with Disabilities

Family members' understanding	Frequency	Percentage
Fully	92	73%
Partially	33	26%
Not at all	1	1%
Total	126	100%

Source: Survey data, 2025

Table (4.6) reflects how well family members understand the specific needs of people with disabilities within the household. The results are encouraging: 73% of respondents reported that their family members fully understand their needs. 26% indicated partial understanding, suggesting some support exists but may lack consistency or depth. Only 1% felt that their family had no understanding at all of their needs. This shows a relatively strong familial support system in most households. However, the one-quarter of respondents reporting only partial understanding points to a need for better disability awareness and education at the household level to reduce unintentional neglect or limitations in care.

Table (4.7) Attitudinal Barriers Faced in Household and Surroundings

Barriers		Most of the time	Some-time	Never	Total Respondents
Exclusion from decision-making processes within your family	Percentage	4%	15%	81%	126
	Frequency	5	19	102	
Discouraging from participating in social activities or community events	Percentage	2%	12%	87%	126
	Frequency	2	15	109	
Overprotection that leads to limiting independence and opportunities to learn new skills	Percentage	10%	18%	72%	126
	Frequency	12	23	91	
Perceiving as a burden or incapable being	Percentage	3%	25%	71%	126
	Frequency	4	32	90	
Treating with pity which undermine self-esteem	Percentage	10%	35%	56%	126
	Frequency	12	44	70	

Source: Survey data, 2025

Table (4.7) assesses the prevalence of common negative attitudes and behaviors that people with disabilities experience in their family settings: 81% of respondents never felt excluded from family decision-making, though 15% experienced it sometimes, and 4% said it happened most of the time. Regarding discouragement from participating in social or community activities, 87% never felt this way, yet 12% experienced it sometimes. Overprotection was reported by 10% as occurring most of the time, and 18% sometimes: suggesting a pattern where families may unintentionally limit the autonomy of people with disabilities. 25% felt sometimes perceived as a burden or incapable being. 35% experienced being treated with pity, a form of microaggression that can lower self-esteem. These results highlight that while overt discrimination within households may be low, subtle forms of attitudinal barriers, especially overprotection and pity, are still prevalent, potentially undermining the independence and confidence of PWDs.

(c) Communication Barriers Assessment in Household and Surroundings

Table (4.8) Communication Barriers Faced in Household and Surroundings

Accessibility		Fully	Partially	No/Don't Know	Total Respondents
Family members' understanding on how to communicate with sign language	Percentage	2%	11%	87%	126
	Frequency	2	14	110	
Access to information in different accessible formats	Percentage	1%	0%	99%	126
	Frequency	1	0	125	

Source: Survey data, 2025

Table (4.8) further illustrates the depth of communication barriers in home settings. A striking 87% of respondents indicated that their family members do not know how to use sign language, while only 2% said they fully do, and 11% said partially. Additionally, when it comes to accessing information in accessible formats (like Braille, sign language, or large print), 99% of respondents reported having no access, with only 1% stating they had full access. Among 16 who know sign language, 10 households are with people with hearing difficulties and 1 household with person with communication difficulties. Among 110 who

don't know sign language, 13 household are with people with hearing difficulties and 3 households are with people with communication difficulties. So, among 27 household with people with hearing and communication difficulties, family members from 2 households (7%) fully understand the sign language, members from 9 households (33%) partially understand, while family members from 16 households (59%) don't know the sign language. This indicates a critical gap in inclusive communication tools and knowledge, even at the household level. It reflects both an institutional gap in disability awareness training for families and a lack of provision of accessible materials or communication aids. Addressing this issue requires more than just external service improvement: it demands capacity building within households to ensure better inclusion of people with communication or cognitive impairments.

(d) Institutional Barriers Assessment in Household and Surroundings

Table (4.9) Institutional Barriers Faced in Household and Surroundings

Accessibility		Yes	No	Total Respondents
Access to financial assistance or subsidies for home modifications (e.g., installing ramps, grab bars)?	Percentage	1%	99%	126
	Frequency	1	125	
Access to community-based rehabilitation programs or services	Percentage	0%	100%	126
	Frequency	0	126	
Access to appropriate assistive devices (e.g., wheelchairs, hearing aids) with affordable prices	Percentage	0%	100%	126
	Frequency	0	126	

Source: Survey data, 2025

Table (4.9) highlights the limited institutional support available to people with disabilities within their household environments in rural Kyauktaga. Alarmingly, only 1% of respondents reported having access to financial assistance for home modifications such as ramps or grab bars, while 99% reported no such access. 100% stated they had no access to community-based rehabilitation (CBR) programs, and 100% of respondents reported a complete lack of access to affordable assistive devices like wheelchairs or hearing aids. These findings underscore a critical absence of institutional resources at the local level, highlighting

the gap between national disability policies and their implementation in remote communities. The lack of even minimal support systems leaves many people with disabilities without the tools and services they need to live independently and with dignity.

(iii) Barriers Assessment in Education

Table (4.10) People with Disabilities who Currently Go to School

	Male	Female	Total	Percentage in Total (%)	Remark
People who currently go to school	1	5	6	5%	Age between 5-25
Home based education	1	3	4	3%	
People who currently don't go to school	13	10	23	18%	
Not applicable	47	46	93	74%	Age under 5 and above 25
Total	62	64	126	100%	

Source: Survey data, 2025

Table (4.10) reveals that only 6 respondents (5%) are currently enrolled in school, all between the ages of 5 and 25. Among them, 2 respondents are with slight seeing difficulties and 2 with moderate walking difficulties and 2 with moderate remembering/concentration difficulties. An additional 4 individuals (3%) receive home-based education. Among 4 respondents who received home-based education, 2 respondents have moderate hearing difficulties, 1 have moderate seeing problem and 1 with moderate difficulties in remembering and concentration. However, 23 respondents (18%) are within the school-age range but are not attending school. A large portion of the sample (93 respondents or 74%) are considered not applicable to this category due to their age (either under 5 or over 25). These statistics reflect limited educational engagement among school-age children with disabilities in the surveyed villages, likely due to physical inaccessibility, lack of inclusive teaching, and attitudinal or institutional barriers that restrict participation in formal education.

Table (4.11) Reasons for Not Going to School

Reasons	Male	Female	Total	Percentage in Total	Remark
Long distance to school	5	4	9	33%	Home based education + who currently don't go to school
Schools don't accept children with disabilities	2	4	6	22%	
No school available in villages	2	2	4	15%	
Age out of range	3	1	4	15%	
No specialized service at school	0	1	1	4%	
Not answered	2	1	3	11%	
Total	14	13	27	100%	

Source: Survey data, 2025

Table (4.11) details the specific reasons why school-age individuals with disabilities are not attending school. The most cited barrier is the long distance to school, affecting 33% of respondents. 22% mentioned that schools do not accept children with disabilities, while 15% reported the absence of any school in their village. An additional 15% said they were out of age range for school, and 4% noted the lack of specialized services. These findings reflect both environmental and institutional barriers to education, with distance, exclusionary policies, and infrastructural gaps preventing children with disabilities from accessing their right to education.

(a) Environmental Barriers Assessment in Education

Table (4.12) Environmental Barriers Faced at School

Accessibility		Yes	No	Don't know	Total Respondents
Access to accessible ramps	Percentage	17%	83%	0%	6
	Frequency	1	5	0	
Access to handrails in stairs	Percentage	17%	83%	0%	6
	Frequency	1	5	0	
Access to wide enough doorways	Percentage	33%	67%	0%	6
	Frequency	2	4	0	
Access to grab bars inside the toilet/bathroom	Percentage	0%	100%	0%	6
	Frequency	0	6	0	
Access to accessible school buses or transportation options	Percentage	17%	83%	0%	6
	Frequency	1	5	0	
Access to adequate lighting inside and around the school	Percentage	83%	17%	0%	6
	Frequency	5	1	0	
Access to good enough sound systems	Percentage	17%	33%	50%	6
	Frequency	1	2	3	
Access to online education programs	Percentage	0%	100%	0%	6
	Frequency	0	6	0	

Source: Survey data, 2025

Table (4.12) reveals significant environmental challenges encountered by students with disabilities in school environments. Among the six respondents currently attending school, only 17% reported having access to accessible ramps, handrails, or school transportation options. Access to wide doorways was marginally better at 33%, while no respondents reported access to grab bars in bathrooms: an indicator of poorly equipped facilities. Alarmingly, only one-third of students reported good sound systems in the classroom, and none had access to online learning platforms. In contrast, the most positively rated feature was lighting: 83% reported adequate lighting around and within schools. These findings highlight the severe lack of physical infrastructure adapted for students with disabilities and emphasize the need for inclusive school design and resource allocation to meet accessibility standards.

Table (4.13) Types of Toilets Used at School

Toilet used at school	Frequency	Percentage
Traditional	6	100%
Modern	0	0%
Both	0	0%
Total	6	100%

Source: Survey data, 2025

Table (4.13) illustrates a striking lack of modern and inclusive sanitation facilities in schools. All the schools (100%) use traditional toilets, which means none of the schools offered functional modern toilets. This not only reflects inadequate infrastructure but also contributes to discomfort and potential health issues for students with mobility or sensory impairments. The absence of inclusive sanitation is a critical factor that undermines both attendance and dignity for students with disabilities, especially in rural settings where these gaps are rarely addressed.

(b) Attitudinal Barriers Assessment in Education

Table (4.14) Attitudinal Barriers Faced at School

Barriers		Sometime	Never	Total Respondents
Being viewed as less capable or intelligent person	Percentage	33%	67%	6
	Frequency	2	4	
Being excluded from group activities or social activities or events	Percentage	33%	67%	6
	Frequency	2	4	
Being faced bullying, teasing, or social isolation from the peers	Percentage	17%	83%	6
	Frequency	1	5	
Being overprotected by teachers, limiting participation in physical activities or field trips	Percentage	50%	50%	6
	Frequency	3	3	

Source: Survey data, 2025

Table (4.14) results revealed notable attitudinal barriers encountered by students with disabilities in school settings. About 33% of respondents reported that they were sometimes perceived as less capable or intelligent compared to their peers, while 67% never experienced this. Similarly, 33% felt excluded from group or social activities on some occasions. 17% reported incidents of bullying, teasing, or social isolation, indicating some degree of peer-related stigma. Most strikingly, 50% of students felt that teachers overprotected them, which limited their participation in physical activities or school trips. These findings suggest that while overt discrimination may not be widespread, subtle forms of exclusion and lowered expectations persist in educational environments.

(c) Communication Barriers Assessment in Education

Table (4.15) Communication Barriers Faced at School

Accessibility		Yes	No	Don't know	Total Respondents
Access to teaching materials in accessible formats	Percentage	0%	100%	0%	6
	Frequency	0	6	0	
Access to peer support or buddy systems to facilitate communication	Percentage	33%	67%	0%	6
	Frequency	2	4	0	
Access to sign language interpretation	Frequency	0%	100%	0%	6
	Percentage	0	6	0	

Source: Survey data, 2025

The analysis of accessible communication services from Table (4.15) in schools revealed critical gaps. None of the six respondents had access to teaching materials in accessible formats such as braille or audio. Similarly, 100% of respondents had no access to sign language interpretation. According to the survey, only 1 respondent with difficulties remembering and concentrating have difficulties communicating with teachers and peers. At the same time, this 1 respondent responded that it can access to peer support or buddy facilitation system for smoother communication.

(d) Institutional Barriers Assessment in Education

Table (4.16) Institutional Barriers Faced in Education

Accessibility		Yes	No	Don't know	Total Respondents
Schools have policies to support the inclusion of students with disabilities	Percentage	0%	67%	33%	6
	Frequency	0	4	2	
Access to individualized education plans (IEPs) for students with disabilities	Percentage	0%	67%	33%	6
	Frequency	0	4	2	
Access to non government education programs that are suitable for students with disabilities (special education programs)	Percentage	0%	67%	33%	6
	Frequency	0	4	2	
Access to teaching materials or technologies designed for students with disabilities	Percentage	0%	83%	17%	6
	Frequency	0	5	2	

Source: Survey data, 2025

Table (4.16) reveals significant institutional gaps within educational settings for students with disabilities in Kyauktaga Township. None of the six surveyed respondents reported that their schools had policies explicitly supporting the inclusion of students with disabilities. Similarly, there was a complete absence of access to individualized education plans (IEPs), non-government special education programs, or disability-specific teaching materials and technologies. This data highlights a severe institutional void in mainstream and alternative education systems, underlining the urgent need for inclusive policy implementation, teacher training, and resource allocation.

(vi) **Barriers Assessment in Healthcare**

(a) **Environmental Barriers Assessment in Healthcare**

Table (4.17) Environmental Barriers Faced in Healthcare

Accessibility		Yes	No	Don't know	Total Respondents
Access to accessible transportation options in the villages	Percentage	61%	39%	0%	126
	Frequency	77	49	0	
Access to ramps at the entrance and exit of healthcare facilities	Percentage	17%	83%	0%	126
	Frequency	21	105	0	
Access to handrails in stairs	Percentage	7%	93%	0%	126
	Frequency	9	117	0	
Access to wide enough doorways or hallways	Percentage	6%	68%	25%	126
	Frequency	8	86	32	
Access to wide enough toilets and bathrooms	Percentage	6%	71%	23%	126
	Frequency	7	90	29	
Access to grab bars inside the toilet/bathroom	Percentage	1%	87%	13%	126
	Frequency	1	109	16	
Access to enough lighting in the hallways, waiting areas, or examination rooms	Percentage	40%	5%	56%	126
	Frequency	50	6	70	

Source: Survey data, 2025

The findings presented in Table (4.17) paint a concerning picture of healthcare accessibility challenges in Kyauktaga Township. The data reveals that 83% of healthcare facilities lack entrance ramps, creating insurmountable barriers for wheelchair users and individuals with mobility impairments. Furthermore, 87% of facilities fail to provide essential grab bars in bathrooms, compounding the difficulties faced by patients with physical disabilities. While 40% of facilities maintain adequate hallway lighting, the only moderately positive finding, this does little to mitigate the overwhelming accessibility shortcomings. These findings significantly exceed the national averages reported by MIMU (2021), underscoring the acute disparities faced by rural populations.

Table (4.18) Ability to Access to Nearest Healthcare Provider/Facilities

Accessibility		Easily	With some difficulties	With a lot of difficulties	Cannot do it at all	Total Respondents
Ability to reach to nearest healthcare provider/facilities	Percentage	21%	21%	37%	21%	126
	Frequency	26	26	47	27	
Ability to enter the nearest healthcare provider/facilities	Percentage	25%	22%	33%	19%	126
	Frequency	32	28	42	24	
Ability to circulate/move around inside the nearest healthcare provider/facilities	Percentage	29%	25%	33%	13%	126
	Frequency	37	31	42	16	
Ability to use toilet/bathroom inside the nearest healthcare provider/facilities	Percentage	25%	29%	31%	15%	126
	Frequency	32	36	39	19	
Accessibility of the roads to the nearest healthcare provider/facilities	Percentage	4%	43%	46%	7%	126
	Frequency	5	54	58	9	

Source: Survey data, 2025

Table (4.18) presents the functional accessibility of healthcare services from the perspective of respondents. While some (21–29%) reported they could reach, enter, and circulate within healthcare facilities easily, a significant portion (33–37%) experienced considerable difficulty, with 13–21% unable to access services at all. Roads to healthcare centers were particularly problematic: only 4% found them easily accessible, while 46% encountered major challenges. These statistics demonstrate that even when healthcare facilities

are physically present, physical and infrastructural barriers still render them inaccessible for many people with disabilities, limiting their ability to receive timely care and services.

Table (4.19) Types of Toilets Used at Healthcare Provider/Facilities

Toilets used at healthcare provider/facilities	Frequency	Percentage
Traditional	97	77%
Modern	2	2%
Both	17	13%
No Toilet	10	8%
Total	126	100%

Source: Survey data, 2025

Table (4.19) focuses on sanitation facilities at healthcare centers. A majority of respondents (77%) reported using traditional-style toilets in these settings, while only 2% had access to modern toilets. Another 13% reported access to both types, and 8% noted the complete absence of toilet facilities. The overwhelming use of traditional toilets, which are often not accessible for individuals with physical impairments, further exacerbates the exclusion of people with disabilities from safe and hygienic healthcare environments. This deficiency in accessible sanitation reflects systemic neglect in designing health infrastructure inclusive of disability needs.

(b) Attitudinal Barriers Assessment in Healthcare

Table (4.20) Attitudinal Barriers Faced in Healthcare

Barriers		Most of the time	Some-time	Never	Total Respondents
Being viewed as less deserving of care	Percentage	1%	8%	91%	126
	Frequency	1	10	115	
Being viewed as less capable of making decisions about one's own health	Percentage	2%	7%	91%	126
	Frequency	2	9	115	
Being treated with pity or condescension, undermining one's own dignity	Percentage	4%	20%	76%	126
	Frequency	5	25	96	
Being assumed that having a lower quality of life	Percentage	0%	11%	89%	126
	Frequency	0	14	112	
Being faced dismissive or impatient attitudes from healthcare staff	Percentage	1%	21%	78%	126
	Frequency	1	27	98	

Source: Survey data, 2025

Table (4.20) presents attitudinal barriers experienced by persons with disabilities in healthcare settings. The majority of respondents reported no frequent attitudinal discrimination, for instance, 91% stated they were never viewed as less deserving of care, and a similar 91% said they were not considered less capable of making decisions about their own health. However, 20% experienced being treated with pity or condescension sometimes, which undermines dignity, and 21% occasionally faced dismissive or impatient attitudes from healthcare staff. Although these figures are relatively low, they indicate that subtle forms of attitudinal bias persist within healthcare environments and may negatively impact the confidence and autonomy of persons with disabilities seeking care.

(c) Communication Barriers Assessment in Healthcare

Table (4.21) Communication Barriers Faced in Healthcare

Barriers		Yes	No	Don't know	Total Respondents
Access to sign language interpretation if needed	Percentage	0%	80%	20%	126
	Frequency	0	101	25	
Access to visual aids or written instructions	Percentage	2%	67%	30%	126
	Frequency	3	85	38	
Access to patient advocates or support persons to assist with communication	Percentage	2%	82%	17%	126
	Frequency	2	103	21	

Source: Survey data, 2025

Table (4.21) explores the communication challenges faced by respondents in accessing healthcare services. 80% reported that sign language interpretation was not available, and 67% reported no access to visual aids or written instructions. Additionally, only 2% said they had access to patient advocates. These findings highlight a critical gap in inclusive communication, creating systemic barriers for people with disabilities and reducing their ability to navigate the healthcare system independently.

(d) Institutional Barriers Assessment in Healthcare

Table (4.22) Institutional Barriers Faced in Healthcare

Accessibility		Yes	No	Don't know	Total Respondents
Healthcare facilities have policies to accommodate the needs of people with disabilities	Percentage	0%	75%	25%	126
	Frequency	0	94	32	
Exclusion from health promotion programs, screenings, or preventive care services	Percentage	16%	84%	0%	126
	Frequency	20	106	0	
Access to specialized services (e.g., physical therapy, occupational therapy, prosthesis & orthosis) or other rehabilitation services	Percentage	0%	100%	0%	126
	Frequency	0	126	0	

Source: Survey data, 2025

Table (4.22) focuses on institutional barriers that limit inclusive healthcare for people with disabilities. The data shows zero access to specialized rehabilitation services, accessible medical equipment, or inclusive policy enforcement at the local healthcare level. 75% of respondents stated that healthcare institutions do not have policies accommodating people with disabilities. Although 16% acknowledged being excluded from health promotion programs, a larger concern is the complete lack of access to critical specialized services, such as physical or occupational therapy. This data underscores severe institutional deficiencies, particularly in rural healthcare systems, which fail to support the comprehensive health and rehabilitation needs of persons with disabilities.

(v) **Barriers Assessment in Livelihood/Employment**

Table (4.23) People with Disabilities who are Currently Working

People who are Currently Working	Frequency	Percentage
Yes	39	31%
No	87	69%
Total	126	100%

Source: Survey data, 2025

The data from table (4.23) show that only a small portion of people with disabilities in the survey are currently employed, while the majority are not working. Among those not working, several individuals (n=22) are under the age of 18 and therefore fall outside the typical working-age group. Interestingly, a few participants (n=2) who are under 18 years old were found to be working. These findings suggest limited employment opportunities for people with disabilities, and also raise concerns about underage individuals engaging in work, possibly due to economic pressure or lack of educational access.

Table (4.24) Reasons of Unemployment (Over 18 Years of Age Without Job)

Reasons	Frequency	Percentage
Because of disability	45	69%
Aging	14	22%
Lack of family support	4	6%
Lack of assistive devices	1	2%
Don't know what to do	1	2%
Total	65	100%

Source: Survey data, 2025

Table (4.24) further explores the reasons behind unemployment. Among those over 18 who are not working, 69% cited their disability as the primary reason. Other contributing factors include aging (22%), lack of family support (6%), absence of assistive devices (2%), and not knowing what to do (2%). This suggests that most unemployed PWDs feel directly limited by their impairments and the absence of support systems or enabling environments.

Table (4.25) Types of Currently Working Jobs

Jobs	People with Disabilities who are Currently Working					Frequency	Percentage
	Seeing	Hearing	Walk- ing and climb- ing	Remem- bering/ Concen- trating	Self- care		
Agriculture	2	5	5	2	2	16	41%
Daily wage casual worker	4	5	5	0	1	15	38%
Vendor	1	0	2	0	1	4	10%
Sewing	0	1	0	0	0	1	3%
Handicraft	0	1	0	0	0	1	3%
Cowherd	0	0	0	1	0	1	3%
Celebrant	0	1	0	0	0	1	3%
Total	7	13	12	3	4	39	100%

Source: Survey data, 2025

Table (4.25) presents the types of work done by those employed. A significant portion (41%) are engaged in agriculture. Among them, 2 respondents are with slight seeing problems, 5 with moderate hearing problems, 5 with some working problems, 2 with moderate remembering and concentration problems, and 2 have some difficulties in self-care. Among those who has the jobs, 9 respondents work at their own farms and are reported as self-employed which means they may adapt their own working conditions based on their functional difficulties. Another 38% working as daily wage laborers include 4 respondents with some (3) to moderate (1) difficulties in seeing, 5 with slight (1) to moderate difficulties (4) in hearing, 5 with some difficulties in walking and 1 have some difficulties in self-care. Smaller proportions

are involved in vending (10%) with 1 respondent having some difficulties in seeing, 2 having moderate difficulties in walking and 1 with some difficulties in selfcare. Additionally, 1 respondent who works as a celebrant have some difficulties in hearing while the other one who works in handicraft have a lot of difficulties in hearing. 1 Respondent who works as a cowherd has moderate difficulties in remembering and concentration, and 1 respondent who work as a tailor can't hear all all. These data imply that people with disabilities primarily participate in informal or low-income sectors that require minimal infrastructure or formal qualifications.

Table (4.26) Monthly Income

Income	Frequency	Percentage
< 100000 MMK	23	59%
100000 – 300000 MMK	10	26%
300000 – 500000 MMK	1	3%
Not mentioned	5	13%
Total	39	100%

Source: Survey data, 2025

Table (4.26) reports the monthlsy income levels of those employed. A majority (59%) earn below 100,000 MMK per month, while 26% earn between 100,000 and 300,000 MMK. Only one respondent reported earnings in the 300,000–500,000 MMK range, and 13% did not specify their income. These figures reflect widespread income insecurity and low earnings among people with disabilities, which exacerbate their marginalization and dependence on informal, low-paying jobs.

(a) Environmental Barriers Assessment in Livelihood/Employment

Table (4.27) Environmental Barriers Faced in Livelihood/Employment

Barriers	Frequency	Percentage
Long distances to workplaces with no safe or accessible routes	15	34%
Lack of accessible transportation options to and from the workplace	13	30%
Poor designed workplaces that do not accommodate mobility devices (lack of ramps)	12	27%
Lack of accessible toilets, breakrooms, or common areas	2	4.5%
Poor lighting in workplaces	2	4.5%

Source: Survey data, 2025

Table (4.27) reveals significant environmental barriers faced by employed people with disabilities in Kyauktaga Township. The most prevalent issues were long distances to workplaces (34%) and lack of accessible transportation (30%), highlighting how geographic isolation and inadequate infrastructure limit employment opportunities. Additionally, poorly designed workplaces (27%) further restricted participation. Less frequent but notable barriers included inaccessible toilets or breakrooms (4.5%) and poor lighting (4.5%). These findings underscore the critical need for inclusive workplace design and reliable transportation systems to ensure equitable access to livelihoods for people with disabilities in rural Myanmar.

(b) Attitudinal Barriers Assessment in Livelihood/Employment

Table (4.28) Attitudinal Barriers Faced in Livelihood/Employment

Barriers	Frequency	Percentage
Being excluded from social events	8	31%
Face dismissive or impatient attitudes from employers or coworkers	7	27%
Being assigned menial tasks or roles that do not match their skills or qualifications.	4	15%
Face misconceptions about their ability to work or contribute effectively.	3	11%
Being viewed as less capable or productive.	2	8%
Employers or coworkers do not understand the specific needs or capabilities of people with disabilities	2	8%

Source: Survey data, 2025

Table (4.28) shows attitudinal barriers in the workplace. The most common challenges included exclusion from social activities (31%), and dismissive or impatient attitudes from employers and coworkers (27%), reflecting deep-seated stigma and social marginalization. Many respondents also reported being assigned menial tasks mismatched to their skills (15%) or facing misconceptions about their capabilities (11%). Smaller but impactful barriers included being viewed as less productive (8%) and a general lack of understanding about disability needs (8%). These results emphasize how negative perceptions and exclusionary practices reinforce economic vulnerability, even for those who secure employment. Addressing these attitudinal barriers requires targeted awareness programs for employers and inclusive workplace policies to foster dignity and equal participation.

(c) Communication Barriers Assessment in Livelihood/Employment

Table (4.29) Communication Barriers Faced in Livelihood/Employment

Barriers	Frequency	Percentage
Lack of peer support or buddy systems to facilitate communication	14	64%
Lack of visual aids or written instructions	6	27%
Lack of captions or sign language interpretation	2	9%

Source: Survey data, 2025

Table (4.29) identifies critical communication barriers that hinder workplace inclusion for people with disabilities in Kyauktaga Township. The most significant barrier was the lack of peer support or buddy systems (64%), which left many workers without assistance in navigating workplace communication. Additionally, respondents reported insufficient visual aids or written instructions (27%), and a lack of captions or sign language interpretation (8%). These findings reveal systemic gaps in accessible communication infrastructure, demonstrating how the absence of basic accommodations excludes people with disabilities from full participation in the workforce.

(d) Institutional Barriers Assessment in Livelihood/Employment

Table (4.30) Institutional Barriers Faced in Livelihood/Employment

Barriers	Frequency	Percentage
Lack of awareness on how to create inclusive work environment	5	50%
Employers and staff are not trained to work with people with disabilities	3	30%
Organizations intentionally exclude people with disabilities in recruitment processes	2	20%

Source: Survey data, 2025

Table (4.30) Institutional barriers present another layer of exclusion for workers with disabilities. The primary challenges centered on lack of awareness on creating inclusive work environment (50%), reflecting limited understanding of accessibility and accommodations. Another 30% of responses citing insufficient preparation for employers and staff to work effectively with people with disabilities. Furthermore, 20% reported intentional exclusion of people with disabilities during recruitment. These findings underscore systemic gaps in disability awareness, training, and equitable hiring practices. Addressing these challenges requires targeted employer education, policy enforcement, and capacity-building initiatives to foster inclusive workplaces aligned with Myanmar's Disability Rights Law (2015) and UNCRPD commitments.

CHAPTER V

CONCLUSION

5.1 Findings

This comprehensive study examined the multifaceted accessibility challenges faced by people with disabilities in rural Kyauktaga Township, Myanmar, through quantitative surveys, and qualitative interviews (n=126). The findings reveal a complex web of interconnected barriers that systematically exclude people with disabilities from social, economic, and civic participation, while also providing critical insights into how these challenges compare with global disability studies and relate to theoretical frameworks of disability inclusion.

The study's demographic data paints a revealing picture of disability in rural Myanmar. With 40% of respondents reporting mobility impairments and another 39% experiencing sensory disabilities (21% visual, 18% hearing), these findings align closely with the WHO's World Report on Disability (2011), which identified mobility and sensory impairments as the most prevalent forms of disability in developing nations. However, the survey data shows a significantly higher rate of mobility impairments compared to Myanmar's national average, suggesting rural areas may face greater risks of physical disability due to occupational hazards, limited healthcare, and infrastructure deficiencies. The age distribution of respondents provides crucial insights - with 31% over 60 years old experiencing age-related disabilities and 20% under 18 facing congenital or early-onset conditions.

The environmental barriers documented in this study present a sobering picture of physical exclusion. In households, only 7% had accessible ramps and a mere 3-4% had grab bars in bathrooms - figures that starkly contrast with the RECU (Reach, Enter, Circulate, Use) accessibility principles. The near-universal reliance (98%) on traditional toilets rather than modern accessible facilities creates particular hardships for those with mobility impairments. Educational infrastructure proved equally exclusionary. With 83% of schools lacking ramps and lack of accessible school buses or transportation options shows that rural areas face more severe infrastructure deficits. Healthcare accessibility findings were particularly alarming. 83% lack of access to ramps and 87% lacking grab bars in bathrooms demonstrate systemic non-compliance with Myanmar's 2015 Disability Rights Law.

The study revealed deeply entrenched attitudinal barriers that complement and exacerbate physical inaccessibility. While 73% of families reportedly "fully understood" the needs of people with disabilities, there is still the persistence of overprotection (affecting 28%) and pity (45%), indicating gradual attitudinal improvements in some communities. Similarly, in educational settings, 50% of students faced overprotection, indicating that overprotection still exists, limiting participation in physical activities. The workplace discrimination findings, where 27% faced dismissive attitudes, suggesting consistent patterns of employment discrimination across urban and rural contexts.

Communication barriers emerged as a critical and understudied dimension of exclusion. The near-total absence (98%) of accessible information formats in healthcare settings suggests particular neglect in the accessibility of healthcare information in rural Myanmar. The education sector's weakness to provide accessible teaching materials reveals systemic violations of the right to inclusive education.

The institutional barriers uncovered present perhaps the most severe challenge. The complete absence of disability-inclusive policies in schools and healthcare facilities represents weak policy enforcement but provides more granular evidence of rural disparities. The total lack of affordable assistive devices (reported by 100% of respondents), reveals a troubling urban-rural divide in service delivery. Similarly, while the National Strategic Plan (2020-2025) promises inclusive education, our finding that 0% of schools had IEPs demonstrates the hollowness of these commitments in rural practice.

In conclusion, this study's findings paint a comprehensive picture of systemic exclusion across all domains of life. The barriers are interconnected - physical inaccessibility reinforces attitudinal stigma, while institutional failures perpetuate communication barriers. These results not only validate but extend existing theories of disability exclusion. This demonstrates how policy commitments alone cannot overcome deeply embedded structural inequalities without targeted resource allocation, rigorous implementation monitoring, and community-level interventions.

5.2 Suggestions

The findings of this study reveal systemic barriers that prevent people with disabilities in rural Kyauktaga Township from achieving full social and economic inclusion. To address these challenges, comprehensive suggestions are proposed across four key areas: policy and governance, infrastructure and accessibility, social and attitudinal change, and community-based interventions. These suggestions align with Myanmar's commitments under international frameworks while addressing local contextual needs.

For policy and governance reforms, the study recommends strengthening the implementation of existing disability laws through localized action plans. Township authorities should develop measurable disability inclusion targets aligned with the National Strategic Plan on Disability (2020-2025). Enforcement of accessibility standards in public infrastructure must be prioritized, with clear penalties for non-compliance. Improved data collection using standardized tools like the Washington Group Short Set will enable evidence-based policymaking. Service delivery can be enhanced through decentralized disability resource centers and increased budget allocations for rural programs. Public-private partnerships should be leveraged to expand mobile health clinics and vocational training initiatives.

Regarding infrastructure and accessibility, immediate interventions should focus on retrofitting existing public buildings with ramps, handrails, and accessible toilets. Transportation systems require modification through the introduction of disability-friendly community vehicles and improvements to rural footpaths. The establishment of township-level workshops to produce affordable assistive devices will address critical gaps in mobility aids.

Social and attitudinal change requires comprehensive awareness campaigns targeting various community stakeholders. Training programs for local leaders, teachers, and healthcare workers should emphasize disability rights and inclusive communication practices. Education reforms must include mandatory teacher training in special education needs, individualized education plans, and stronger parent engagement mechanisms to advocate for children's rights.

Economic empowerment strategies should combine employment quotas in the public sector with expanded vocational training programs tailored to different disability types. Entrepreneurship support through microfinance and startup grants will enable people with disabilities to establish sustainable livelihoods. Social protection measures must be strengthened through expanded disability pensions, health insurance waivers, and emergency support funds to address crisis situations.

Community-based approaches should focus on building the capacity of Organizations of People with Disabilities (OPDs) to effectively advocate for policy changes. Meaningful

participation of people with disabilities' representatives in local decision-making bodies ensures their perspectives are incorporated into development planning. Peer support networks and mentorship programs can provide crucial psychosocial support while fostering skills-sharing opportunities.

By combining policy reform with practical infrastructure improvements, attitudinal change initiatives, and community empowerment strategies, Kyauktaga Township can develop a replicable model for rural disability inclusion. This comprehensive approach ensures alignment with international frameworks while remaining responsive to local contexts and needs. Successful implementation will require sustained commitment from government agencies, civil society organizations, and the international community working in partnership with people with disabilities themselves.

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APPENDIX-I

SURVEY QUESTIONNAIRE

I am currently studying for a Master of Development Studies degree at Yangon University of Economics. As part of my thesis work, I have developed this questionnaire for the study titled “Assessing The Accessibility Challenges for Persons with Disabilities in Rural Villages: A Case Study of Kyauktaga Township, Bago District in Myanmar” This survey is an essential component of my research to fulfill the requirements of the program.

Your participation in this survey is greatly appreciated, and I kindly request you to provide accurate responses to all the questions. The survey will take about 30-45 minutes to complete. You can answer the questions honestly and openly. We do not record your name and will also keep the answers anonymous. All the information you share will be treated with complete confidentiality. So, you can answer freely. Thank you for your valuable contribution.

Are you agree to answered?

- Yes
- No

Section 1: Personal Information

1.1 Name (optional): _____

1.2 Age: _____

1.3 Gender:

- Male
- Female
- Other (specify): _____

1.4 Village: _____

1.5 Household size: _____

1.6 Marital status:

- Single
- Married
- Divorced
- Widowed
- Don't want to answer

1.7 Can you please tell me your education level?

- No literacy
- Basic literacy/Non formal education/ Monastery Education

- Basic Education Primary
- Basic Education Middle
- Basic Education Higher
- Collage/university student
- Graduate
- Not applicable (if the person is under age of attending school)

Section 2: Washington Group Questions (Short Set) to Identify Disability

2.1 Do you have difficulty seeing, even if wearing glasses?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

2.2 Do you have difficulty hearing, even if using a hearing aid?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

2.3 Do you have difficulty walking or climbing steps?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

2.4 Do you have difficulty remembering or concentrating?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

2.5 Do you have difficulty with self-care, such as washing all over or dressing?

- No difficulty
- Some difficulty
- A lot of difficulty

- Cannot do at all

2.6 Do you have difficulty communicating, for example, understanding or being understood?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

Section 3: Main Impairment

3.1 What is your primary type of impairment?

- Visual impairment
- Hearing impairment
- Physical/mobility impairment
- Intellectual/cognitive impairment
- Self-care
- Communication

3.2 If you have other types of impairment, please specify

Section 4: Cause of Impairment

4.1 What is the primary cause of your impairment?

- Congenital (from birth)
- Illness or disease
- Accident or injury
- Age-related
- Don't know

4.2 If there are other cause of your impairment, please specify.

Section 5: Currently Using Assistive Devices

5.1 Are you currently using any assistive devices?

- Yes
- No (if so, skip 5.2)

5.2 If yes, please specify the device(s):

- Wheelchair
- Crutches/elbow crutches
- Walking frame
- Quadripod/Tripod
- Walking stick
- Hearing aid
- Power glasses
- White cane
- Prosthetic limb
- Other (specify): _____

Section 6: Barriers Assessment

This section focuses on identifying physical, attitudinal, communication, and institutional barriers in different settings.

6.1 Household and Surroundings

a) Environmental Barriers

- 1) Are the stairs in your home accessible (with handrails, with enough wide, depth & shallow steps)?
 - Yes, fully
 - Yes, partially
 - No, not accessible at all
- 2) Are doorways in your home wide enough for a wheelchair or mobility device?
 - Yes
 - No
- 3) Are there ramps in your home if needed?
 - Yes
 - No
- 4) Are there grab bars around your home?
 - Yes
 - No

- 5) Are there grab bars inside toilet, bathrooms?
 - Yes
 - No
- 6) Does your home use traditional or modern toilet?
 - Traditional
 - Modern
 - Both
- 7) Is there enough lighting inside or outside the home to navigate easily especially for people with visual impairment?
 - Yes
 - No
- 8) Is there paved or smooth pathway around the house?
 - Yes
 - No

b) Attitudinal Barriers

- 1) Do family members understand your needs related to your disability?
 - Yes
 - No
- 2) Have you ever felt excluded from decision-making processes within your family?
 - Yes, most of the time
 - Yes, sometime
 - No
- 3) Have you ever been discouraged from participating in social activities or community events due to fear of judgement or embarrassment?
 - Yes, most of the time
 - Yes, sometime
 - No
- 4) Have you ever been overprotected by your family, limiting your independence and opportunities to learn new skills?
 - Yes, most of the time
 - Yes, sometime

- No

5) Have you ever been treated with pity, which can undermine your self-esteem?

- Yes, most of the time
- Yes, sometime
- No

6) Have you ever been perceived as a burden or incapable of contributing to household activities?

- Yes, most of the time
- Yes, sometime
- No

c) Communication Barriers

1) Do you have access to information in formats you can understand (e.g., Braille, sign language, easy-to-read, large print, pictograms)?

- Yes, fully
- Yes, partially
- No

2) Do your family know how to communicate with sign language?

- Yes, fully
- Yes, partially
- No

d) Institutional Barriers

1) Have you ever received financial assistance or subsidies for home modifications (e.g., installing ramps, grab bars)?

- Yes, enough
- Yes, a few
- No

2) Have you ever got accesss to community-based rehabilitation programs or services?

- Yes, fully
- Yes, partially

- No
- 3) Are appropriate assistive devices (e.g., wheelchairs, hearing aids) available in your area with affordable prices?
- Yes, many
 - Yes, a few
 - No

6.2 Education (Only for those aged above 5 and = or under 25)

a) Basic Information

- 1) Do you currently go to school (formal/non formal)?
- Yes (if yes, continue the barrier assessment)
 - No
 - Home-based
- 2) If no/home-based, why don't you go to school?
- Financial barriers
 - Family doesn't think it is needed for you because of your disability
 - No school available in your village
 - Transportation difficulties
 - Long distance to school
 - No teachers at school
 - Schools don't accept children with disabilities
- 3) If you have any other reasons for not going to school, please specify
- _____

b) Environmental Barriers (Only for those who currently go to school)

- 1) Does the school have ramps for students with mobility impairments?
- Yes
 - No
 - Don't know
- 2) Does the school's staircases have handrails?
- Yes
 - No
 - Don't know

- 3) Are the doorways wide enough for a person to use assistive device (e.g. wheelchair)?
 - Yes
 - No
 - Don't know
- 4) Are there grab bars inside toilet, bathrooms?
 - Yes
 - No
 - Don't know
- 5) Does your school use traditional or modern toilet?
 - Traditional
 - Modern
 - Both
- 6) Are there accessible school buses or transportation options for student with disabilities?
 - Yes, mostly
 - Yes, a few
 - No
- 7) Are there enough lighting in classrooms for students with visual impairments to read or navigate?
 - Yes
 - No
 - Don't know
- 8) Are there sound systems if needed in classrooms for students with impairments to hear the teacher?
 - Yes
 - No
 - Don't know
- 9) Have you ever been able to access online education programs?
 - Yes
 - No
 - Don't know

c) Attitudinal Barriers (Only for those who currently go to school)

- 1) Have you ever been viewed as less capable or intelligent because of your disability?
 - Yes, most of the times
 - Yes, at sometime
 - No
- 2) Have you ever been excluded from group activities or social activities or events of school because of your disability?
 - Yes, most of the times
 - Yes, at sometime
 - No
- 3) Have you ever faced bullying, teasing, or social isolation from your peers because of your disability?
 - Yes, most of the times
 - Yes, at sometime
 - No
- 4) Have you ever feel overprotected by teachers, limiting your participation in physical activities or field trips?
 - Yes, most of the times
 - Yes, at sometime
 - No

d) Communication Barriers (Only for those who currently go to school)

- 1) Can the teaching materials be available in accessible formats (e.g., Braille, large print, audio)
 - Yes
 - No
 - Don't know
- 2) What communication channel do the techers mostly use for teachings/instructiions?
 - Verbal
 - Written
 - Video

- Sign language
- 3) Are there peer support or buddy systems to facilitate communication?
- Yes,
 - No
 - Don't know
- 4) Is there sign language interpretation available at school if needed?
- Yes
 - No
 - Don't know

e) Institutional Barriers (Only for those who currently go to school)

- a) Do the schools have policies to support the inclusion of students with disabilities?
- Yes
 - No
 - Don't know
- b) Do the schools have individualized education plans (IEPs) for students with disabilities?
- Yes
 - No
 - Don't know
- c) Are there any other non government education programs that are suitable for students with disabilities (special education programs)?
- Yes
 - No
 - Don't know
- d) Do the schools have teaching materials or technologies designed for students with disabilities?
- Yes
 - No
 - Don't know

6.3 Healthcare

a) Environmental Barriers

- 1) Can you easily reach to nearest healthcare provider/facilities?
 - Yes, easily
 - Yes, with some difficulties
 - Yes, with a lot of difficulties
 - No
- 2) Can you easily enter the nearest healthcare provider/facilities?
 - Yes, easily
 - Yes, with some difficulties
 - Yes, with a lot of difficulties
 - No
- 3) Can you easily circulate/move around inside the nearest healthcare provider/facilities?
 - Yes, easily
 - Yes, with some difficulties
 - Yes, with a lot of difficulties
 - No
- 4) Can you easily uses toilet/bathroom or other facilities inside the nearest healthcare provider/facilities?
 - Yes, easily
 - Yes, with some difficulties
 - Yes, with a lot of difficulties
 - No
- 5) Are the roads to the healthcare facilities easily accessible?
 - Yes, accessible
 - Yes, with some difficulties
 - Yes, with a lot of difficulties
 - No
- 6) Are there accessible transportation options in your village to reach to the healthcare facilities?
 - Yes
 - No

- Don't know
- 7) Are there ramps at the entrance and exit of healthcare facilities?
- Yes
 - No
 - Don't know
- 8) Are there handrails in the stairs of healthcare facilities?
- Yes
 - No
 - Don't know
- 9) Are the doorways or hallways of healthcare facilities wide enough to navigate wheelchair or other assistive devices?
- Yes
 - No
 - Don't know
- 10) Are the toilets and bathrooms wide enough to navigate for wheelchair users?
- Yes
 - No
 - Don't know
- 11) Do the healthcare facilities use traditional or modern toilet?
- Traditional
 - Modern
 - Both
 - Not toilet
- 12) Do the healthcare facilities' toilets/bathrooms have grab bars?
- Yes
 - No
 - Don't know
- 13) Are there enough lighting in the hallways, waiting areas, or examination rooms for people with visual impairment to navigate easily?
- Yes
 - No
 - Don't know

b) Attitudinal Barriers

- 1) Have you ever been viewed as less deserving of care?
 - Yes, in most of the time
 - Yes, in some time
 - No
- 2) Have you ever been viewed as less capable of making decisions about your health?
 - Yes, in most of the time
 - Yes, in some time
 - No
- 3) Have you ever been treated with pity or condescension, undermining your dignity?
 - Yes, in most of the time
 - Yes, in some time
 - No
- 4) Have you ever been assumed that you have a lower quality of life or were not interested in certain treatments?
 - Yes, in most of the time
 - Yes, in some time
 - No
- 5) Have you ever faced dismissive or impatient attitudes from healthcare staff?
 - Yes, in most of the time
 - Yes, in some time
 - No

c) Communication Barriers

- 1) Is sign language interpretation available if needed?
 - Yes
 - No
 - Don't know
- 2) Are visual aids or written instructions available for people with cognitive or learning disabilities?
 - Yes

- No
- Don't know

3) Are there patient advocates or support persons to assist with communication?

- Yes
- No
- Don't know

d) Institutional Barriers

1) Do the healthcare facilities has policies to accommodate the needs of people with disabilities (e.g., flexible appointment time, longer consultation periods)?

- Yes
- No
- Don't know

2) Are people with disabilities excluded from health promotion programs, screenings, or preventive care services?

- Yes
- No
- Don't know

3) Do the healthcare facilities provide sepcialized services (e.g., physical therapy, occupational therapy, prosthesis & orthosis) or other rehabilitation services?

- Yes
- No
- Don't know

If yes, what specialized services?

- Physical therapy
- Occupational therapy
- Posthesis & orthosis
- Other rehabilitation services _____

6.4 Workplace, livelihoods and employment (Only for those who aged over 10)

a) Basic information

1) Do you currently work for a living?

- Yes
- No

2) If No , what is the primary reason for not working?

- Lack of financial support
- Lack of family support
- Organizations don't accept people with disabilities as employees
- Lack of or not enough education required for the jobs
- Lack of assistive technologies
- Lack of medical support
- Lack of rehabilitation services

3) If you have any other reason for not working, please specify?

- _____

2) If Yes, What do you do as a primary job for living?

- Fishing
- Agriculture
- Daily wage casual worker
- Vendor
- Carpenter
- Taxi driver
- Remittance
- Teacher
- Volunteer
- Government staff
- Private staff

3) If you have any other reason for not working, please specify?

- _____

4) How much monthly income do you get?

- Under 100000 MMK

- 100000-300000 MMK
- 300000-500000 MMK
- Over 500000 MMK

b) Barriers assessment

1) What following Environmental barriers cause the difficulties of performing your job/tasks?

- Lack of accessible transportation options to and from the workplace
- Long distances to workplaces with no safe or accessible routes
- Lack of accessible toilets, breakrooms, or common areas
- Poor designed workplaces that do not accommodate mobility devices (lack of ramps)
- Poor lighting in workplaces

2) What following attitudinal barriers cause the difficulties of performing your job/tasks?

- People with disabilities are excluded from social events
- Being assigned menial tasks or roles that do not match their skills or qualifications.
- People with disabilities face misconceptions about their ability to work or contribute effectively.
- Employers or coworkers do not understand the specific needs or capabilities of people with disabilities.
- Being viewed as less capable or productive.
- People with disabilities face dismissive or impatient attitudes from employers or coworkers

3) What following communication barriers cause the difficulties of performing your job/tasks?

- Lack of captions or sign language interpretation for meetings, training
- Lack of visual aids or written instructions for people with cognitive or learning disabilities.
- Employers or staff do not know how to integrate assistive technologies into the workplace.

- Lack of simplified or alternative communication methods (e.g., pictograms, sign language).
- Lack of peer support or buddy systems to facilitate communication.

4) What following institutional barriers cause the difficulties of performing your job/tasks?

- Workplaces do not have policies to support the inclusion of People with disabilities (e.g., flexible work arrangements, reasonable accommodation)
- Limited funding/subsidies for workplace modifications, assistive devices, or specialized training.
- Organizations intentionally exclude PWDs in recruitment processes undermining their capacity to work
- Employers and staff are not trained to work with People with disabilities or understand their specific needs.
- Lack of awareness on creating inclusive work environments.