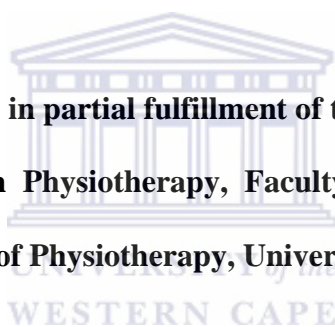


**BARRIERS TO SCHOOL ATTENDANCE AMONG CHILDREN WITH
DISABILITIES IN RWANDA**

JEAN BAPTISTE SAGAHUTU

**Mini-Thesis submitted in partial fulfilment of the requirements of degree of
Masters of Science in Physiotherapy, Faculty of Community and Health
Sciences, Department of Physiotherapy, University of the Western Cape**



Supervisor: Prof. Patricia Struthers

November 2008

ABSTRACT

The number of children with disabilities under the age of 18 years around the world varies from 120 to 150 million. In many countries, throughout the world, the majority of children with disabilities either do not receive any form of education or, if they receive any, it is often inappropriate. UNESCO estimates that more than 90% of children with disabilities in developing countries do not attend schools. Rwanda has recently started inclusive education in a number of schools around the country for ensuring that children with disabilities have access to education. Despite this, in Rwanda, many children with disabilities do not attend school and this number is not known. This study aimed to identify the barriers to school attendance by children with disabilities in Rwanda. A quantitative, cross-sectional, descriptive study was carried out by use of a time limited sample of 94 parents/caregivers of children with disabilities who were not attending school and attending Inkurunziza or Gahini Community Based Rehabilitation programmes. A structured questionnaire with closed-ended questions was used to investigate the barriers to school attendance. Data analysis was done using Statistical Package for Social Sciences (SPSS) and Microsoft Excel. Descriptive statistics using frequencies, percentages, means, and standard deviations and inferential statistics using Chi-square test were calculated. The data have been presented in forms of tables, graphs, and pie charts. Ethical issues included the permission for conducting the study, informed consent, assured anonymity, confidentiality, voluntary participation, and the right to withdraw from the study. The findings indicate that the parents/caregivers of children with disabilities in Rwanda are very poor especially in the rural area where most of them are not employed and their level of education is very low. In Rwanda, many roads are not

well maintained, public transport are not conducive for children with disabilities, and the school environment also is not accessible for a number of children with mobility difficulties. There is a negative attitude among parents/caregivers and the community towards children with disabilities. Awareness raising and attitudinal change about disability issues is needed in Rwandese society to promote schooling for children with disabilities. The removal of all barriers which can hinder the education process of children with disabilities should be promoted for the successful Education for All goals. Recommendations are proposed for facilitating the removal of barriers to school attendance by children with disabilities in Rwanda.



DECLARATION

I hereby declare that “**barriers to school attendance among children with disabilities in Rwanda**” is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources used or quoted have been indicated and acknowledged by complete references.

Jean Baptiste Sagahutu



Signature.....

November 2008

Witness: **Prof. Patricia Struthers**

.....

DEDICATION

I dedicate this mini thesis to the Lord God Almighty. I also dedicate this work to my family especially to my lovely fiancée, M. Louise Bajeneza for the love, patience and support that you have shown me.



ACKNOWLEDGEMENTS

I would like to acknowledge and extend my gratitude to the following who contributed to this study:

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I extend special thank to all my classmates who assisted me in one way or the other. I am grateful to the parents/caregivers of children with disabilities who accepted to participate in this study.

I sincerely thank the Inkurunziza and Gahini CBR programmes and all community-based rehabilitation workers who participated and assisted me during research field work.

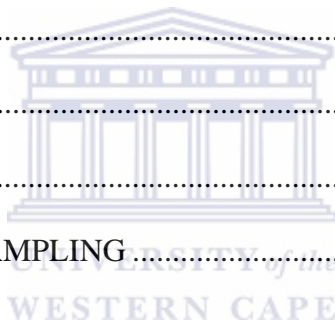
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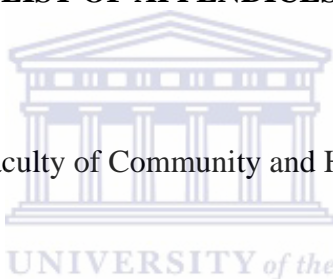
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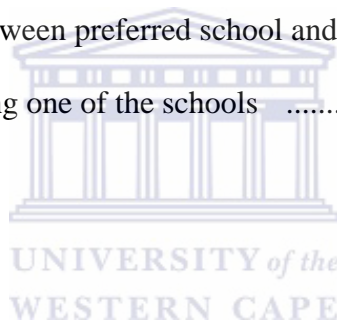
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ABBREVIATIONS

BCDP	British Council of Disabled People
DCDD	Dutch Coalition on Disability and Development
DFID	Department for International Development
EENET	Enabling Education Network
EFA	Education for All
FIDIDA	Finishing Disabled People's International Development Association
ICDIH	International Classification of Impairment, Disability and Handicap
ICF	International Classification of Functioning, Disability and Health
IE	Inclusive education
LSEN	Learners with special education needs
MBLN	Meeting Basic Learning Needs
MINALOC	Ministry of Local Government, Information and Social Affairs
MINEDUC	Ministry of Education
MINISANTE	Ministère de la Santé
SPSS	Statistical Package for Social Science
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
WCED	Western Cape Education Department
WHO	World Health Organisation

KEYWORDS

Barrier

Children

Disability

Education for All

Learner with Special Education Needs

Parents/caregivers

Rwanda

School attendance

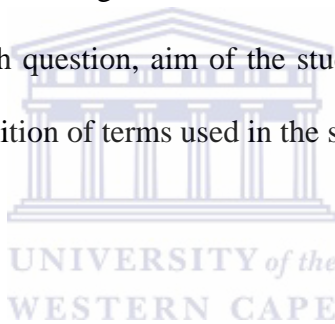


CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

This chapter consists of background information on disability issues worldwide, in developing countries, and in Rwanda where a large number of children with disabilities do not attend school. In this chapter, different declarations, conferences, and statements to adopt the Education for All declarations are highlighted. The education policy for children with disabilities in Rwanda is given. It also includes the motivation of this study, the problem statement, research question, aim of the study, and objectives of the study. The chapter ends with the definition of terms used in the study.



1.2 BACKGROUND

Worldwide disability prevalence increases as war, conflict, and poverty increase. However, the need of children with disabilities in developing countries is not well recognised (Shawky, Abalkhail & Soliman, 2002). The World Health Organisation (WHO) has estimated that between 7% and 10% of the world population have some type of disability and that 80% of these people live in developing countries (WHO, 2002; Richler, 2004; UNESCO, 2006). UNESCO and others estimate that the number of children with disabilities under the age of 18 years around the world varies from 120 to 150 million (World Bank, 2007). Many children with disabilities including those who have difficulties with learning, speech, cognitive, hearing, seeing, mobility and emotional, are likely to have never attended school (World Bank, 2008). In developing

countries, fewer than 5% of children with disabilities reach the Education for All (EFA) goal of primary school completion (Richler, 2004). Meijer and Hegarty (1994) further say that the majority of those children with disabilities, in many countries throughout the world, either do not receive any form of education, or if they receive any, it is often inappropriate. This number may be growing due to global conditions of increasing poverty, armed conflict, child labor practice, violence and abuse, and HIV/AIDS (World Bank, 2008).

Working to increase the number of children attending school thus has become the objective of most governments in their effort to attain equity and harmony in their societies (Asprey & Nach, 2006). Different international declarations and conferences have been held to adopt the goal of EFA with initiative of inclusion of learners with special education needs (LSEN) and removal of all barriers which can hinder the education of children with disabilities (P. Engelbrecht, Green, Naicker, & L. Engelbrecht, 1999).

The worldwide commitment to education for children with disabilities has been growing since 1975 (Smith-Davis, 2002). The world conference on Education for All: Meeting Basic Learning Needs (MBLN), held in Thailand 1990 was aimed at bringing the benefits of education to every citizen in every society. It comprised a broad coalition of national governments, civil society groups, and development agencies such as UNESCO and the World Bank (UNESCO, 1990). The World Summit for the children with disabilities, held in New York 1990, adopted the goal of Education for All by the year 2000 including

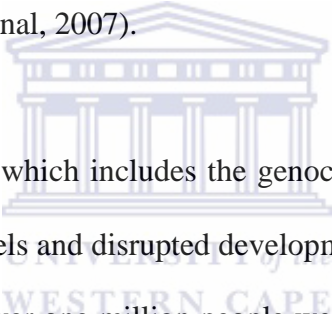
LSEN (UNESCO, 1994).

Furthermore, the Salamanca Statement was produced in Salamanca (Spain) in 1994, where 92 governments and 25 international organisations met at the world conference on Special Needs Education. They agreed to a new statement on the Education of All children with disabilities, which called for inclusion to be the norm (UNESCO, 1994). The Salamanca Conference adopted a new framework that ordinary schools should accommodate all children with disabilities, regardless of their physical, intellectual, social, emotional, linguistic or other conditions. Children with disabilities should attend the usual neighbourhood school that would be attended if the child did not have a disability (UNESCO, 1994). The Salamanca Statement also stipulates that every child has the fundamental right to education. He/she must be given the opportunity to achieve and maintain an acceptable level of learning, and that every child has unique characteristics, interests, abilities and learning needs (UNESCO, 2000). In addition, the second goal of UN Millennium Development Goals (UN, 2007) aims at ensuring that all boys and girls, including those with disabilities, complete a full course of primary schooling.

Despite these policy declarations and statements, UNESCO (2004) and Richler (2004) estimate that 98% of children with disabilities in developing countries do not attend school and 99% of girls with disabilities are illiterate. UNESCO (2004) states that youth with disabilities run a great risk of remaining illiterate, which leads to restricted opportunities to further education, employment, and income. In developing countries, many families do not feel that children with disabilities should receive any education, and

other families believe that children with disabilities are incapable of learning (Groce, 2004).

Rwanda, a developing country located in central Africa, faces the same problem. The population was 8.1 million in the 2002 population census (Republic of Rwanda-Ministry of Finance and Economic Planning, 2002). Handicap International (2007), states that 84% of Rwandan population lives on less than \$2 per day. Life expectancy is low and infant mortality high (Ministry of Local Government, Information and Social Affairs (MINALOC), 2003). In Rwanda, 29% of children with disabilities are orphans and/or vulnerable (Handicap International, 2007).



The recent history of Rwanda, which includes the genocide and an ensuing civil war in 1994, increased the poverty levels and disrupted development efforts (MINALOC, 2003). During the genocide and war over one million people were killed, many became widows and orphans, and a very large number become disabled. The national census in 2002 estimated the prevalence of all disabilities in Rwanda at 4.8% (Thomas, 2005). However, globally, the World Health Organization (WHO) estimates that 10% of any population is disabled, and this is the figure used by the Ministry of Health (Ministère de la Santé (MINISANTE), 2005). The Rwandan census 2002 did not indicate the percentage of children with disabilities in and out of schools, but the Ministry of Education (MINEDUC) has planned a survey of children with disabilities to develop a comprehensive policy on education of disabled children with disabilities (MINEDUC, 2003). Article 40 of Rwanda's Constitution affirms the right of every citizen to

education. It is also states that “...the state has the duty to facilitate the education of disabled people” (Republic of Rwanda, 2003, p. 72).

In Rwanda the educational opportunities for disabled children lie within segregated schools and centres. There are a limited number of government special schools which are almost exclusively for children with visual and hearing difficulties (Handicap International, 2007). For the most part, educational provision for children with disabilities is organised outside of the national system by private and religious organisations (Handicap International, 2007). At the moment, the Rwanda has seven centres for children with disabilities with hearing, visual, speaking, mobility and learning disabilities, known as special schools which are operated by faith-based groups (Thomas, 2005). Most of them are located in urban areas far from most children with disabilities’ homes, and their limited capacity cannot solve the needs of large numbers of children with disabilities. Very recently the policy of inclusive education has been implemented in a number of schools around the country (Karangwa & Kobusingye, 2008).

1.3 PROBLEM STATEMENT

Primary school is compulsory and the Government of Rwanda is implementing the policy of fee-free education to ensure attainment of the policy of universal primary education by 2010 and Education for All by 2015. However, after working in Community Based Rehabilitation (CBR) for about four years in the eastern province of Rwanda, the researcher found that the majority of children with disabilities had never attended schools and others had dropped out school. However, no study on barriers to school attendance

by children with disabilities had been conducted in Rwanda. It was therefore important to find out what are the barriers to school attendance by children with disabilities.

1.4 RESEARCH QUESTION

Why do children with disabilities not attend school in Rwanda?

1.5 AIM OF THE STUDY

The overall aim of this study was to identify the barriers to school attendance by children with disabilities in Rwanda.

1.6 OBJECTIVES OF THE STUDY

In order to achieve the aim of this study, the following objectives were identified:

1. To determine the socio-economic status of parents/caregivers of children with disabilities who do not attend schools.
2. To identify the types of disabilities of children who do not attend schools
3. To determine the physical environmental barriers to school attendance by children with disabilities.
4. To determine the psychosocial environmental barriers to school attendance by children with disabilities.
 - 4.1. To determine the attitude of parents/caregivers of children with disabilities towards their children with disabilities' attendance at schools.
 - 4.2. To determine the parent's/caregiver's perception of members of community's attitude to children with disabilities' attendance at schools.

5. To determine the knowledge of parents/caregivers of children with disabilities about schools their children with disabilities could attend in their community.

1.7 DEFINITION OF TERMS

Parent/caregiver: In this study, the term “parent” refers to the child’s biological parent who is the father or mother, whereas “caregiver” refers to other carers such as grandmother, grandfather, brother or sister, stepparent, and other relatives or supporters. These two terms are used because the child may not have the biological parents. This is also because the biological parents may not be the prime caregiver of the child or the person who brings the child to the organised day centre.

Special Needs Education: Special Needs Education refers to needs or priorities which the individual person or the system may have which must be addressed to ensure effective learning. The child has Special Needs Education when he/she experiences difficulties in learning for different reasons and might need particular special support in order to learn successfully in the mainstream schools (P. Engelbrecht, Green, Naicker, & L. Engelbrecht, 1999).

Inclusive education: Inclusive education (IE) is defined as a process of addressing the diverse needs of all learners by reducing barriers to, and within the learning environment.

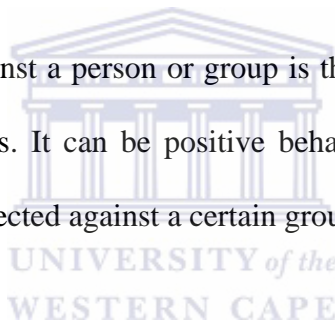
Disability: In the International Classification of Functioning, Disability and Health (ICF), the term disability is defined as an umbrella term for impairment, activity limitation and participation restriction (WHO, 2001).

Children with disabilities: Children with disabilities are defined as people under the age of 18 years who have a physical or intellectual impairment which may limit social interaction, mobility, education, health and well-being and future employment potential (Republic of Rwanda, 2003).

Barrier: Anything that causes you to slip up in your goal or anything that makes it difficult or not possible to make progress (Tank, 2008).

Attitude: The attitude is a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor (Eagly & Chaiken, 1993).

Discrimination toward or against a person or group is the prejudicial treatment of them based on certain characteristics. It can be positive behavior directed towards a certain group, or negative behavior directed against a certain group (Wikimedia Project, 2008).

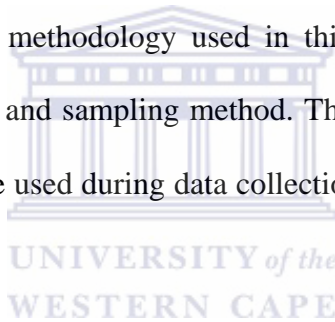


1.8 SUMMARY OF CHAPTERS

Chapter One describes the background of the study.

Chapter Two presents a review of the relevant literature. This chapter discusses the definition of disability, models of disabilities, international rights of children with disabilities to education, and school attendance by children with disabilities in developing countries. Information on schools for children with disabilities, disability in Rwanda, education policy related to children with disabilities in Rwanda, and barriers to learning by children with disabilities are also presented.

Chapter Three describes the methodology used in this study. The research settings, study design, study population and sampling method. The chapter gives the information about instrument and procedure used during data collection. Finally, analysis and ethical considerations are described.



Chapter Four presents the results of the study. The results are presented in tables and graphs comprising both descriptive findings and associations to give the comprehensive picture.

Chapter Five discusses the findings in relation to the available literature to interpret the findings. The limitations that were encountered in the current study are also given.

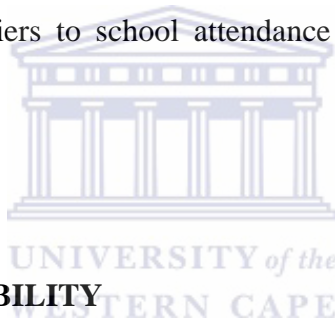
Chapter Six includes the summary of the study and the conclusion. Finally the recommendations related to the findings of this study are presented.

CHAPTER TWO

LITERATURE REVIEW

2.1. INTRODUCTION

This chapter gives an overview of the definitions of disability. The common models of disability used are outlined. The international right of children with disabilities to education and schools that children with disabilities could attend are also described. A general overview of disability in Rwanda is included. Prevalence and types of disabilities, people with disabilities, and education policy for children with disabilities in Rwanda are is described. Finally, the barriers to school attendance and learning by children with disabilities are described.

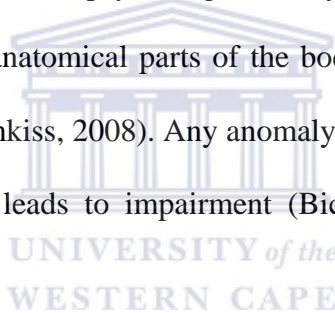


2.2. DEFINITION OF DISABILITY

The definition of disability was revised by the World Health Organisation (WHO) from the International Classification of Impairment, Disability and Handicap (ICIDH) to the International Classification of Functioning, Disability and Health (ICF) (Lang, 1998; WHO, 2001). The ICIDH used the terms impairment, disability and handicap while the ICF uses the terms impairment and disability. The ICF has moved away from understanding disability to be a consequence of disease which was the form of classification (1980 version) to become a component of health (WHO, 2001). For further understanding of disability, the International Classification of Functioning, Disability and Health (ICF), uses body functions and body structures, activity and participation, and environmental factors (Keaney & Pryor, 2004).

Impairment is the functional limitation, or any problem in body function or structure as deviation or loss caused by physical, mental or sensory loss (Bickenbach, Chatterji, Badley, & Ustun, 1999; WHO, 2001). Disability is defined as an umbrella term of impairment, activity limitation together with participation restriction or loss of opportunities to take part in the normal life of the community on equal level (WHO, 2001). According to Schriener, 2003; DFID (2000) disability can be defined as a long term impairment leading to social and economic disadvantages, denial of rights, and limited opportunities to play and equal role in the society.

Body functions are physiological or psychological body systems, e.g. vision or seeing function. Body structures are anatomical parts of the body such as organs, e.g. the eye, limb and related structures (Simkiss, 2008). Any anomaly, defect, loss or other significant deviations in body structures leads to impairment (Bickenbach, Chatterji, Badley, & Ustun, 1999).



Activity is the execution of a task or action by an individual, hence activity limitations are difficulties an individual may have in executing activities (Keaney & Pryor, 2004). Participation is involvement in life situation; hence participation restrictions are problems an individual may experience in involvement in life situations (Stucki, Boonena, Tugiwel, Cieza, & Boers 2007).

Contextual factors include environmental and personal factors. Environmental factors are physical, social and attitudinal environment in which people live and conduct their life. The negative attitude towards people with disabilities is common. The physical

environment barriers are the biggest problem especially for people with physical disabilities (Pfeiffer, 1999). Personal factors are the particular background of an individual's life and living (Rusch et al 2004).

A full understanding of disability recognises that it has a powerful human rights dimension and is often associated with social exclusion, and increased vulnerability to poverty (DFID, 2000). It denotes the negative aspects of interaction between an individual with a health condition, and that individual's contextual factors, which are environmental and personal factors (Schriner, 2003).

2.3. MODELS OF DISABILITY

Models of disability provide conceptual frameworks for understanding disability and facilitate the decision-making process of parents, social workers, and policy makers (Bricout, Porterfield, Tracey, & Howard, 2004).

2.3.1 The medical model

The medical model views disability as a problem within the person, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals (Brisenden, 1994). The medical model, which is the best-known model, with the rehabilitation model, focuses on the impairment (Fallon, 2007). This approach to management of the disability is aimed at a cure or the individual's adjustment and behaviour change (Shakespeare, 2006). The medical model is

sometimes known as the individual model because it promotes the notion that it is the individual person with disability who must adapt to the way in which society is organised (Fallon, 2007, Thomas, 2008).

2.3.2 The social model

This social model of disability, on the other hand, sees the issue mainly as a socially created problem, and basically as a matter of the full integration of individuals into society (Thomas, 2008). The social model does not blame the disabled person for the problems they have (Bricout, Porterfield, Tracey, & Howard, 2004). Disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment (Fallon, 2007). Hence the management of the problem requires social action, and it is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life (Goodley, 1997). The issue is therefore an attitudinal or ideological one requiring social change, which at the political level becomes a question of human rights (Fallon, 2007).

Disabled people may have medical conditions which hamper them or which may or may not need medical treatment, human knowledge, technology and collective resources (Stevens, 2008). Their physical or mental impairments may not prevent them from being able to live perfectly good lives (Stevens, 2008). This model has been developed by

disabled people themselves to help them describe and take action against discrimination (Campbell, 2006).

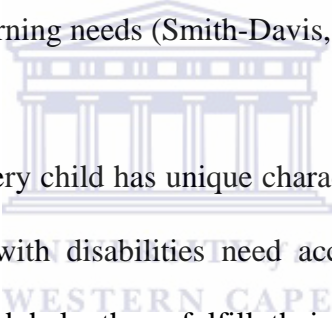
The social model of disability is the preferred model used in the United Kingdom (UK) because other models of disability arguably oppress disabled people (Pearson & Watson, 2007). Other models include the administrative model, which looks at disability and doing an assessment process and the charity model which looks at disability as a personal tragedy.

2.3.3 The biopsychosocial model

The biopsychosocial model is considered a comprehensive model that allows people to address all major areas of the presenting issue across three spheres: physical, psychological, and sociocultural (Zittell, Lawrence, & Wodarski, 2002). This model came as the link between medical and social models. The medical model of disability implies that the cause of disability is the impairment that a person experiences, and its management involves helping the individual reduce that the impairment. The social model sees the issue mainly as a socially created problem (Thomas, 2008; Fallon, 2007). The biopsychosocial model of disability indicates that both impairments and the environment can contribute to disability (Stevens & Smith, 2005). It is an approach that states that biological, psychological (which includes thoughts, emotions, and behaviors), and social factors play a significant role in human functioning in the context of disease or illness (Zittell, Lawrence, & Wodarski, 2002).

2.4 RIGHTS OF CHILDREN WITH DISABILITIES TO EDUCATION

In 1994, more than 300 participants representing 92 governments and 25 international organisations met in Salamanca, Spain, at the World Conference on Special Needs Education (SNE) (Engelbrecht et al., 1999). The conference concluded with the Salamanca Statement. The Salamanca Statement has the principle of inclusion that ordinary schools should accommodate all children, regardless of their physical, intellectual, emotional, social, linguistic or other conditions (UNESCO, 1999). In 2000, the World Education Forum in Dakar, Senegal, adopted the Dakar Framework for Action. This Framework highlighted that Education for All includes the most disadvantaged, including those with special learning needs (Smith-Davis, 2002).



UNESCO (2000) states that every child has unique characteristics, interests, abilities and learning needs, and children with disabilities need access to regular schools, which should accommodate them and help them fulfill their needs. In addition, UNESCO (2004) stipulates that every child has a fundamental right to education, and he/she must be given the opportunity to achieve and to maintain an acceptable level of learning and be included in educational policy at all levels. UNESCO (2004) continues that children with disabilities should attend their neighborhood schools. The Article 2 of the Salamanca Statement says that regular schools with this inclusion orientation are the most effective way of combating discriminatory attitudes, creating welcoming communities, building an inclusive society and achieving Education for All (UNESCO, 2000). Universal primary education by the year 2015 is one of the Millennium Development Goals. However, universal primary education cannot be obtained without including children with

disabilities (UN Enable, 2006).

The article 24 of UN Enable (2006, p.16-17), entitled Convention on the Rights of Person with Disabilities, highlights the right to education of people with disabilities. The convention states that:

States Parties recognize the right of persons with disabilities to education. In realising this right, the states parties shall ensure that the person with disabilities are not excluded from general education and children with disabilities are not excluded from free and compulsory primary education. The person with disabilities can access an inclusive, quality, free primary and secondary education on an equal basis with others in the communities in which they live.

2.5 EDUCATION FOR CHILDREN WITH DISABILITIES

2.5.1 Inclusive education

Inclusive education is defined as a learning environment that promotes the full personal, academic and professional development of all students irrespective of race, class, gender, disability, religion, culture, sexual preference, language and learning styles (WCED, 2002). Inclusive education has become central in the education policies of large numbers of counties in developed and developing counties around the world (Pijl, Meijer, & Hegarty, 1997). The inclusive education philosophy grew from Salamanca Statement UNESCO (1994).

According to South Africa Department of Education (2001, P.6-7), inclusive education is about:

- Acknowledging that all children and youth can learn and that all children and youth need support
- Accepting and respecting that all learners are different in some way and have different learning needs which are equally valued and an ordinary part of our human experience.
- Enabling education structures, systems and learning methodologies to meet the needs of all learners.
- Acknowledging and respecting differences in learners whether due to age, gender, ethnicity, language, class, disability or HIV status.
- Changing attitudes, behaviour, teaching methodologies, curricula and the environment to meet the needs of all learners.
- Maximising the participation of all learners in the culture and the curricula of educational institutions and uncovering and minimising barriers to learning.
- Empowering learners by developing their individual strengths and enabling them to participate critically in the process of learning.
- Acknowledging that learning also occurs in the home and community, and within formal and informal modes and structures.



According to UNESCO (2000) Inclusive education is concerned with removing all barriers to learning, and with the participation of all learners vulnerable to exclusion and marginalisation. It is a strategic approach designed to facilitate learning success for all children. It addresses the common goals of decreasing and overcoming all exclusion from the human right to education, and enhances participation and learning success in quality basic Education for All (Villa & Richard, 1995).

2.5.2 Special schools

Special schools make special educational provision for children with special needs educational whose needs cannot be fully met within mainstream provision (Every Child Matters, 2005). The most common type of special educational needs for which special schools are approved are: severe learning difficulties, moderate learning difficulties,

behaviour, emotional and social difficulties, and autistic spectrum disorders (Baker & Bovair, 1998). According to Thomas (2005), the special schools accommodate a small number of children with disabilities compared to ordinary schools and they can not be found in every child's community. Baker and Bovair (1998) concludes that these kinds of schools can, however, benefit the children with severe disabilities who can not attend the ordinary school.

2.5.3 Ordinary schools

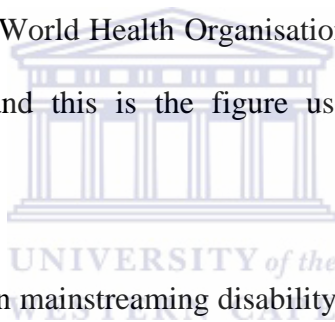
These are the nearest schools that accommodate children with and without disabilities. According to UNESCO (2002), the learners with special education needs must enroll their district schools in the same way the learners without disabilities do. The ordinary schools can include a great diversity of children with the principle of ensuring that the learner with disability is a valued and needed member of the community in every respect (Western Cape Education Department (WCED), 2002). The ordinary schools meet the international policy of Education for All by accommodating learners with and without disabilities.

2.6 DISABILITY IN RWANDA

2.6.1 Prevalence of disability in Rwanda

Every country calculates the number of people with disabilities in different ways depending on the cultural differences, different disability definitions and different methods of data collection (American National Council on Disability, 2008). There is no

clear definition of disability in Rwanda; therefore, there are inaccurate data on prevalence of disability (Thomas, 2005). In 1995, Handicap International together with the former Ministry of Rehabilitation and Social Integration carried out an all-age national survey and estimated the disability prevalence of 0.58% which was probably underestimated and physical deformities were the main cause (Atijosan, 2007). This was directly after the war and this result was thought to be the result of selection bias due to inaccessibility of the population so soon after war. According to the Community Based Rehabilitation survey in 1997, the prevalence of all disabilities was 1.8% (MINISANTE, 2005). In contrast the National Census in 2002 estimated the prevalence of all disabilities at 4.8% (Thomas, 2005). Globally, the World Health Organisation (WHO) estimates that 10% of any population is disabled, and this is the figure used by the Ministry of Health (MINISANTE, 2005).



According to Thomas (2005), in mainstreaming disability development (Rwanda Country Report), there is no data on the prevalence of different types of disabilities, but, according to the 2002 census, mobility difficulties are the most common, followed by hearing difficulties, intellectual difficulties, seeing difficulties and psychological difficulties. There is no data on prevalence according to the moderate and severe disabilities, age group and gender.

2.6.2 Types of disabilities in Rwanda

According to Thomas (2005, p.69) using IFC classification of disability, the table below summarises the type of disabilities people have in Rwanda.

Type of disability	Definition	Disabilities
Seeing difficulties	Person who is short sighted, low vision or could not see any objects	Blind one eye/both eye, optic nerve damage, dislocated eyes (could not see), ptosis (eyes with weak muscles), corneal scar, trichinosis, hypohema, retinitis, retinitipigmentosa
Hearing difficulties	Person who has a hearing impairment (at birth or due to injury or disease) or due to the ageing process	Deaf, earless person, ear without ear drum(s), perforation of ear drum(s)
Speaking difficulties	Person who has difficulty in saying words and can not say clearly enough or at all, or not enough to be understood by other people	Speaking impaired person, cleft lip and cleft palate, big tongue, mute, slurred (speech not clear), stick teeth
Moving difficulties	Person who has physical difficulty in moving from one place to another or in moving a part of his/her body, or who cannot move at all	Amputee arm(s)/leg(s), polio, muscular dystrophy, contracture, tight muscles, cerebral palsy, club foot/feet, bowed legs, congenital defect, paraplegia, hemiplegia, quadriplegia, paralysis, spinal cord curve (kyphosis/ lordosis), dislocated hip, broken bone (fracture), juvenile arthritis, osteoarthritis, tuberculosis bone deformity, osteoporosis, scoliosis
Feeling difficulties	Person who has lost sensation or does not feel anything while touching objects	Third degree of leprosy (Hansen's disease), person who has severe beriberi (numbness) of the hands or legs, parahemiplegia, kwashiorkor
Psychological difficulties (strange behaviour)	Person who changed behaviour so much that now he/she behaves like a different person, it happens regularly and they have difficulty in	Schizophrenia, paranoia, neurosis, mania, stress, anxiety, depression, psychosis

	feeling, thinking and/or behaviour	
Learning difficulties	Person who has low memory, could not remember or do things like other people of the same age	Intellectual disability, Down's syndrome, slow learner, cerebral palsy, autism
People who have fits	Person who often has convulsions and foams at the mouth	Epilepsy, hypoglycaemia, hyperglycaemia
Other	Person who has restrictions in physical and social functioning	Disfigurement/deformity, chronic illness, dwarfs, midgets, hydrocephalus, HIV/AIDS-related conditions, severe keloid

2.6.3 Disability and discrimination in Rwanda

In Rwanda, people with disabilities are over-represented among the poor and often among the very poorest (Thomas, 2005; McClain-Nhlapo, 2007). People with disabilities, usually, are identified as among the most vulnerable groups, along with widows and orphans (Thomas, 2005). According to the Rwandese National Employment Policy, there is a stigma attached to having a disability. When a person becomes disabled or a disabled child is born, the family enters into a new world about which they know next to nothing and about which they have a lot of stereotyped notions (Republic of Rwanda, 2005). "Social exclusion" is not a concept that is widely practiced in Rwanda, but it often takes place with people with disabilities who are both actively and passively excluded in Rwandan society (Thomas, 2005). Thomas (2005) argues that children with disabilities are often hidden away and disabled women find it difficult to get married.

The needs of people with disabilities have been marginalised by being categorised as 'special' or 'different' from those of population at large. This approach brings difference

rather than promoting inclusion. In Rwanda DFID (2000) describes three major types of discrimination that are common towards people with disabilities: Institutional discrimination, environmental discrimination, and attitudinal discrimination.

-Institutional discrimination: According to the Rwandan Ministry of Education (2006), many of those children with disabilities do not attend schools. The reality in much of Africa is that people with disabilities are often excluded from education and employment (Republic of Rwanda, 2005).

-Environmental discrimination: In Rwanda, people with disabilities cannot participate in different activities due to physical barriers such as inaccessibility to public transport, buildings, etc (Republic of Rwanda, 2005).

-Attitudinal discrimination: The attitude of Rwandese society suggests that disability is a source of shame in a family, underestimated, being-seen as useless, meaningless, and in their assumption “when you are disabled person, you live with your disabilities and wait for what God will do for you” (Thomas, 2005, p.21). According to MINALOC (2003), negative attitudes are particularly strong towards those with severe disabilities, people with intellectual and learning disabilities, and people with seeing and speaking difficulties. People with disabilities themselves do not understand their role in society. They often do nothing and are used as instrument of begging or stretching their hand for help (MINALOC, 2003).

2.7 EDUCATION POLICY RELATED TO CHILDREN WITH DISABILITIES IN RWANDA

The educational rights and needs of children with disabilities are recognised in the Rwandan Educational Sector Strategic Plan 2004-2008. One of the seven goals of the plan is to eliminate all the causes and obstacles, which can lead to disparity in education, be it by gender, disability, geographical or social group (MINEDUC, 2003). “In line with the Millennium Development Goals, to attain Education for All by 2015, the Government of Rwanda recognises that special needs education is now a priority ... The policy will focus on ‘Inclusive Education’ as an ideal educational model” (Karangwa & Kobusingye, 2008, p.2). The article 40 of Rwanda’s Constitution states that “....the state has the duty to facilitate the education of disabled people” (Republic of Rwanda, 2003, p. 72). The Government of Rwanda emphasises that children with special educational needs will be supported to attend their local school in the community, where possible, rather than a special school away from home (Karangwa & Kobusingye, 2008). The Government of Rwanda also recognises the need to provide education to LSEN, as both a national obligation and a commitment to international frameworks (Republic of Rwanda, Ministry of Education, 2006).

The report by the Ministry of Education on the national policy for LSEN highlights the promotion of a quality education for all children in Rwanda through the eradication of barriers that result in inequity in schooling (MINEDUC, 2007). The Ministry of Education continues to argue that barriers that exclude children from entering school are a violation of a child’s right to education. Through the implementation of the special

needs education policy, the Government of Rwanda is demonstrating its commitment to the rights of children with disabilities (MINEDUC, 2007). According to Karangwa and Kobusingye (2008), Handicap International (Rwanda) in conjunction with the Rwandan Ministry of Education have started inclusive education in a number of schools around the country to ensure that children with disabilities have access to education.

2.8 BARRIERS TO LEARNING EXPERIENCED BY CHILDREN WITH DISABILITIES

“Barriers can be located within the learner, within the centre of learning, within the education system and within the broader socio- economic and political context” (South Africa Department of Education, 1997, p.12). Children with disabilities have been found to be at increased risk for limited participation in many activities including schooling due to different barriers in their society (Heah, Case, McGuire, & Law, 2007). According to South Africa Department of Education, (1997) and EENET (2000), barriers to learning experienced by children with disabilities include: socio economic barriers; lack of access to basic services; poverty and underdevelopment; factors that place the learners at risk; attitudes; inaccessible and unsafe built environment; inflexible curriculum; language and communication; inappropriate and inadequate provision of support services; lack of parental recognition and involvement; lack of human resource development strategies; lack of enabling and protective legislation and policy; and severity of disability. These barriers can prevent the child with disabilities from going to school or can lead to drop-out if he/she attended school.

2.8.1 Socio economic barriers

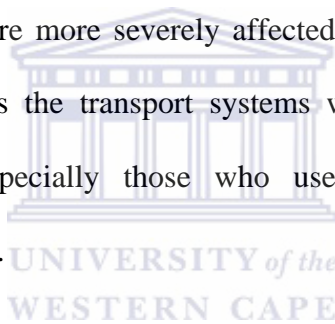
There is a relationship between education provision and socio-economic conditions in any society. Effective learning is influenced by the availability of education resources to meet the needs of any learner in society (Department of Education, South Africa, 1997). There are inadequate facilities to meet the education needs of the population especially in poorer countries. Rwanda is among the very poorest county in the world with a high level of unemployment and 84% of Rwandan population lives on less than \$2 per day (Republic of Rwanda-Ministry of Finance and Economic Planning, 2002).

2.8.1.1 Lack of access to basic services

People with disabilities have a greater needs for health and educational services than other people, but they face more challenges in accessing the basic services due to physical and social barriers (UN Millennium Development Goals, 2007). The inability to access the educational provision that exists and the inability to access other services which contribute to the learning process is the most significant barrier to learning by children with disabilities (Department of Education, South Africa, 1997). In South Africa it has been found that in most cases, the inability to access education provision is the result of inadequate or non-existent services and facilities which are the key to participation in the learning process of children with disabilities.

In South Africa in many poor communities, especially in rural areas, children with disabilities are unable to reach their centre of learning because there are no transport facilities available to them or the roads are not conducive and well maintained so that the

centres can be reached by children with disabilities (Department of Education, South Africa, 1997). In South Africa education for children with disabilities is concentrated in urban areas, while a number of people with disabilities live in rural areas where those services are often unavailable. In developing countries most of those children do not have equipment to assist them in going to school or coping with the school environment (Price, 2003). According to UN Millennium Development Goals (2007), fewer than 10% of children with disabilities in the Asia-Pacific region have access to any form of education compared to 70% of non-disabled who have access to the education system. Because such barriers affect all children in poor communities, it is very important to highlight that particular groups of learners are more severely affected by barriers (Price, 2003). It is known that in many countries the transport systems which exist are inaccessible to learners with disabilities, especially those who use wheelchairs (Department of Education, South Africa, 1997).



Lack of access to clinics is also a barrier to school attendance by children with disabilities. For example, if a child has a chronic illness and needs regular medical treatment this may result in a long period of absence from the class to receive the treatment, if the school does not have those facilities (Jones, 2000). This leads to the learner dropping out or not attending schools (Price, 2003).

2.8.1.2 Lack of human resource development

The lack of trained teachers, for example sign language interpreters and teachers for children with seeing difficulties means that these children will not participate in the

education process. Hence many of the parents prefer their children to attend the special schools where they think the schools have trained teachers and appropriate equipment (EENET, 2000).

2.8.1.3 Poverty and underdevelopment

Worldwide people with disabilities make up approximately 10% of any population and a large number of them live in extreme poverty especially in developing countries where 82 % of people with disabilities live below the poverty line (British Council of Disabled People (BCDP), 2005). These figures can be higher in countries devastated by civil war and/or natural disaster. The children with disabilities from families where one or more of breadwinners are unemployed or poorly paid are mostly the children who do not attend or drop-out of school (Jonsson & Wiman, 2001). This brings about limited skills with fewer work opportunities, increased likelihood of unemployment or poorly paid work and leads to ongoing poverty and exclusion (Department of Education, South Africa, 1997).

The link between poverty and disability is known as a cause and consequence of one another and their association has been widely recognised (Halender, 1993). People with disabilities are often those who are excluded from the education system as consequence of poverty (DFID, 2000). In many poor families, the child with a disability is kept at home and others go to school because the perception of the parents is that the child with a disability is unlikely to be employed or to be in position to contribute to the family income (World Bank, 2008). In some countries, like Hungary, where education of children with disabilities is based on special schools, the poor families can not afford the

cost of those schools or centres and schooling largely remains for non disabled children (Jonsson & Wiman, 2001).

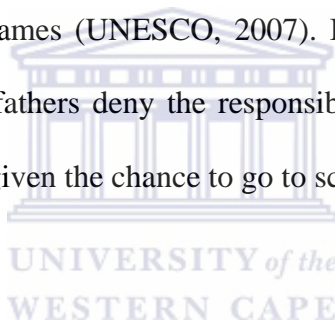
2.8.2 Attitudes

The greatest barriers to school attendance by children with disabilities are caused by society, not by particular medical impairments. The negative attitude towards disability remains a critical barrier to learning and development in our society (Wolfensohn, 2004). Discrimination resulting from prejudice against people based on gender, race, religion, disability or other characteristics or differences manifest as the barriers to learning when such attitudes are directed to the learners in education system (Department of Education, South Africa, 1997; UNESCO, 2007). According to UN Millennium Development Goals (2007), girls with disabilities are the most marginalised, as they have double disadvantages as a result of their gender and disability.

The lack of awareness and knowledge about disability among some parents and teachers remains a significant barrier to their school attendance (Arbeiter & Hartley, 2002). According to EENET (2000), there is a negative attitude of teachers, parents, and other children who incorrectly think that children with disabilities need the specialised professionals to teach them; they can fall down; they need special care; they are very slow; they are often in hospital; they can not attend school every day (Department of Education, South Africa, 1997).

The marginalisation and isolation of the children with disabilities may be exacerbated when children are able to go into the education system. Often the lack of trained teachers leads to many children with disabilities dropping out of school because teachers fear to accommodate them in their class and respond negatively to their attendance (UNESCO, 2007).

The negative attitudes to school attendance by children with disabilities extend to the relatives, the community, and finally to the other children who give children with disabilities different abusive names (UNESCO, 2007). In some cultures, the mother is blamed for the disability and fathers deny the responsibility for the child and later the child with the disability is not given the chance to go to school (Department of Education, South Africa, 1997).



These negative attitudes towards schooling for children with disabilities frequently result from religious tradition and beliefs which denigrate disability (Ahuja, 2000). In many societies, disability is often perceived very negatively due to cultural factors, ignorance, and fear. Sometimes, disability is seen as a curse or punishment from God (Finishing Disabled people's International Development Association (FIDIDA), 2008). Many families find it a burden to have children with disabilities and tend to hide them and to not offer them any opportunity for development as they are ashamed of them. Others think that educating children with disabilities is a waste of money or that they are not capable of learning (Wolfensohn, 2004). Hence, children with disabilities have restricted

education opportunities (FIDIDA, 2008).

2.8.3 Inaccessible and unsafe built environment

In many countries the majority of schools are physically inaccessible to a large number of learners with disabilities. In South Africa, it has been found that learners with disabilities who should be attending or who wish to attend school are unable to even reach the school because the available public transport is either physically inaccessible or does not want to transport them. Because they are not able to walk to school or classes, they are totally excluded from the education system (Department of Education, South Africa, 1997). The poor accessibility of schools (most are only accessible on foot) means that for most students with physical disabilities, attendance at school is impossible (Robertson, 2000). Distances or apparent isolation, from the schools, or from the nearest town where mostly found the schools, are two of the main barriers commonly identified in rural areas (Soboh & Mass, 1997). The inaccessibility is particularly evident where the schools are physically inaccessible to learners with disabilities who use wheelchairs or other mobility devices. However, inaccessibility also makes the schools unsafe for children with seeing and hearing difficulties (FIDIDA, 2008).

According to Enabling Education Network (EENET) (2000) and Hollar (2005), in developing countries the schools and classroom are often not accessible due to physical environmental barriers like stairs, toilets, chairs, classroom designs, tables, and playgrounds. The way schools are built could be a barrier to learners using wheelchairs when there are no ramps leading to classes and when the doors are no wide enough for

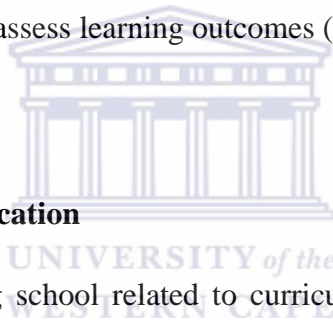
the wheelchair to pass through (P. Engelbrecht et al., 1999). The data from three representative studies on the living conditions of people with disabilities in Namibia (2002), Zimbabwe (2003), and Malawi (2004), show that children with disabilities have less access to services than those without disabilities (Dutch Coalition on Disability and Development (DCDD), 2005). The study showed that 35% of children with disabilities had never attended school. There was also a lack of assistive devices. Only 36% of those in need of assistive devices had received the support (DCDD, 2005).

2.8.4 Inflexible curriculum as the cause of dropping-out

An inflexible curriculum is the one of the most serious barriers to learning for children with disabilities. When the learners with disabilities are not able to access the curriculum, learning breakdown or drop-out occurs (Wolfensohn, 2004). “The key components of curriculum include the style and tempo of teaching and learning, what is taught, the way the classroom is managed and organised, as well as materials and equipment which are used in the learning and teaching process” (Department of Education, South Africa, 1997, p.16). Often, the curriculum is centrally designed and rigid, leaving little flexibility for local adaptations or for teachers to experiment and try out new approaches (UNESCO, 2007).

Most of the time the teachers, because of their lack of or inadequate training, utilise the teaching styles which may not meet the needs of the learners. The teacher may use a way of teaching which only accommodates the learners who learn very quickly (Department of Education, South Africa, 1997; Wolfensohn, 2004). There are some children with

disabilities who are excluded from certain aspects of curriculum as a result of ignorance or prejudice. Children with physical disabilities are often prevented from playing sport or are not given the opportunity to play (Department of Education, South Africa, 1997). The barriers also can be manifested in the learners with disabilities who do not receive the necessary assistive devices or equipment which could help them to participate in the learning process (EENET, 2000). Children with seeing difficulties cannot access the curriculum effectively if the Braille facilities and equipment are not available in education system or if teachers are not trained for using Braille (Department of Education, South Africa, 1997). Learning breakdown or drop-out also occurs through the mechanisms which are used to assess learning outcomes (Ahuja, 2000)



2.8.5 Language and communication

The other barriers to attending school related to curriculum that may lead to drop-out result from the medium of learning and teaching. Some children learn in a language which is not their first language (UNESCO, 2007). This leads to linguistic difficulties and contributes to learning breakdown especially in learners with hearing difficulties (Department of Education, South Africa, 1997). For learners with speaking difficulties, their first language is usually Sign Language. Their learning process requires this specialised teaching method. Learners with speaking difficulties due to the severe physical, intellectual, and/or mental disability experience enormous barriers to learning (Department of Education, South Africa 1997).

2.8.6 Inappropriate and inadequate provision of support services

In some countries, there may be inadequate or even no provision of support services for learning for children with disabilities (EENET, 2000). According to Queensland Department of Education, Training and the Arts (2006), the support services can be: the education adjustment program, the school transport assistance for students with disabilities, the adjustment information management system, the disability services support unit, and early childhood intervention services. According to Struthers (2000), in South Africa, there is a great role of physiotherapists, occupational therapists and speech therapists working with learners at school to provide more appropriate support for teachers to promote the inclusion. The therapists who work with children with disabilities need to empower the parents and promote the inclusion in school and the broader society. Their advocacy role can challenge the barriers children with disabilities experience in inclusion and participation in the education system and their own communities (Struthers, 2000). Successful inclusive education requires effective education support services in providing both direct support for the learner and indirect support for the teachers, the school, the parents and others in the community. This support service should focus on overcoming barriers in the education system (Struthers, 2005).

Inadequate and inappropriate support services may contribute to the exclusion of children with disabilities in the education system or may contribute to the learning breakdown. Where there is no provision for minimising, removing and preventing barriers to learning, barriers cannot be overcome and needs cannot be met (Ahuja, 2000). The barriers can arise where, for example, the nature of the service is focused on the problems in the

learner rather than in the system where the barriers may be found. The basic services that can support the learners and the system to minimise, remove or prevent barriers are often limited or lacking especially in poorer communities. This is true in rural areas where there is limited amount of professional assistance or it may even not exist. According to Ahuja (2000) and South Africa Department of Education (1997), the inability of learners to access the educational provision and other services affects their learning process and breakdown occurs.

2.8.7 Lack of parental recognition and involvement

The parents of children with disabilities and the community at large have to be actively involved in the attendance and learning process of their children (Department of Education, South Africa, 1997). This is central to effective learning and development. Where this recognition is not appropriate or where there is no active participation of parents, the effective participation of children with disabilities in education is hindered (EENET, 2000). In poor communities parents do not get as involved in the learning process of their children with disabilities as they do for the other children without disabilities and do not know which school could be attended by their children, either special or ordinary school (Ahuja, 2000). In developing countries, parents prefer their children with disabilities to be in special school because they think these special school take can more care of them than other schools in their communities (EENET, 2000). Some parents are uneducated and feel they have nothing to contribute to the schooling process and prefer their children without disabilities to go to school rather than those with disabilities. In many families, women are responsible for care of their children when the

men are not very involved, especially for children with disabilities (Ahuja, 2000).

All these barriers manifest themselves in different ways and only become obvious when learning breakdown occurs, when learners drop out of the system or when the excluded children become visible (Department of Education, South Africa, 1997).

2.9 SUMMARY OF THE CHAPTER

The literature described the definition of disabilities by WHO (2001) and described the models of disability. The right of children with disabilities to education was described in this chapter by giving the different policies, declarations and statements for ensuring the education of children with disabilities. Disability in Rwanda is described in this chapter by indicating the prevalence of disability and types of disability people have in Rwanda. Disability and discrimination in Rwandan society was also discussed. The education policy related to children with disabilities in Rwanda was highlighted in this chapter. Finally barriers to school attendance by children with disabilities were discussed in depth. These barriers include socio economic barriers; lack of access to basic services; poverty and underdevelopment; attitudes; inaccessible and unsafe built environment; inflexible curriculum; language and communication; inappropriate and inadequate provision of support services; lack of parental recognition and involvement; and lack of human resource development strategies. These barriers can prevent the child with disabilities from going to school or can lead to drop-out if he/she attended school. In the next chapter the methodology is presented.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

In this chapter, the research method used in the present study is described. This includes the research setting, study design, study population and sampling, instrument used in the study, reliability and validity of the instrument, translation, procedure, and data analysis. The ethical considerations are also stated.

3.2 RESEARCH SETTING

The study was carried out in the day centres of two Community Based Rehabilitation (CBR) projects in Rwanda: Inkurunziza CBR and Gahini CBR programmes. The Inkurunziza CBR and Gahini CBR programmes are sponsored by the Christian Blind Mission (CBM), which is a German based organization. The Inkurunziza CBR programme is currently managed by the Inkurunziza Church and Gahini CBR programme is managed by the Anglican Church. The choice of these two settings was based on the large number of parents of children with disabilities in the two research areas, because these are only two CBR projects operating in the country that could be identified.

The Inkurunziza CBR project is situated in Kigali, the capital city of Rwanda, an urban area, and most of the clients are from this urban area. Twelve community-based rehabilitation workers visit their clients at home and at ten day centres. Children with

disabilities and parents/caregivers meet at these day centres weekly. The Gahini CBR programme is located in the rural area, in the Eastern Province of Rwanda. Most of the clients are from that rural area. Five physiotherapists and three assistant physiotherapists visit the eleven day centres where they meet with children with disabilities and their parents/caregivers, and those who need physiotherapy treatment are referred to Gahini Rehabilitation Centre.

3.3 STUDY DESIGN

A quantitative, cross-sectional, descriptive study design was used in the study. A descriptive study is used to gain information about characteristics within a particular field of study. Bowling (1997, p. 173) says that “Quantitative research is appropriate in situations in which there is pre-existing knowledge, which will permit the use of standardised data collection methods”. Sarantakos (2000) argues that the quantitative study design is known to explain the social life of the participants, to test theories, to be objective, to take measurements, and to enable generalisability of findings. The quantitative cross-sectional descriptive study design was chosen because it is an appropriate approach to meet the aim of the study, which was to identify the barriers to school attendance by children with disabilities in Rwanda.

3.4 POPULATION AND SAMPLING

All parents/caregivers who had children with disabilities that were not attending schools, and who attended Inkurunziza and Gahini research settings during the period of data

collection were included in the study. The total population of children with disabilities attending these centres was not known by the health workers. Accurate records are not kept because some parents attend with their children with disabilities only once and records are not kept.

A time limited sample of 94 parents/caregivers of children with disabilities who were not attending school and attended these two settings was therefore recruited to participate in the study. Data collection was done over 6 weeks. This period did not allow the researcher to reach a larger number of parents of children with disabilities.



3.4.1 Inclusion criteria

- Male and female parent/caregiver of a child with any disability.
- The parent/caregiver of a child aged between 7-18 years.
- The parent/caregiver of a child who either never attended school or who dropped-out of school.

3.4.2 Exclusion criteria

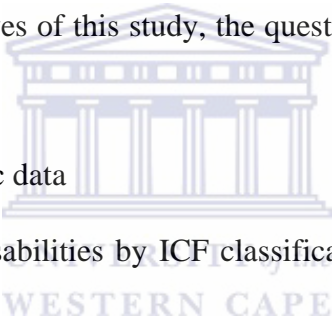
- The parent/caregiver of a child with a disability attending school or who had finished primary school.

3.5 STUDY INSTRUMENT

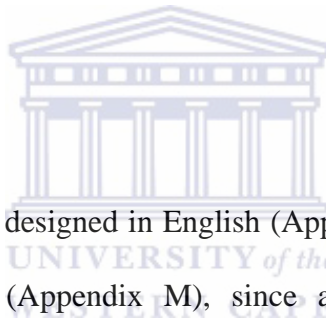
A structured questionnaire, developed by the researcher, based on literature and

researcher's experience was used to collect data. The literature used to formulate the questionnaire is included below according to the questionnaire sections. The questionnaire had closed-ended questions. Close-ended questions offer anonymity and avoid bias (De Vos & Delpont, 2002). According to Babbie and Mouton (2006), closed-ended questions are easily processed, transferred directly into computer format, and fall in the researcher's structuring of responses. The questionnaire was a non-standardised instrument because no standardised questionnaire that met the specific needs of this study could be found.

To answer the aim and objectives of this study, the questionnaire was divided into seven sections accordingly:

- 
- Section A: Demographic data
 - Section B: Types of disabilities by ICF classification: Thomas (2005), EENET (2000).
 - Section C: Socio-economic status of parents/caregivers of children with disabilities: Department of Education, South Africa, (1997), UN Millennium Development Goals (2007), Price (2003), Jones (2000), WHO (2004), FIDIDA (2000), DFID (2000), (Thomas, 2005; McClain-Nhlapo, 2007), (Jonsson & Wiman, 2001), (P. Engelbrecht et al., 1999).
 - Section D: Physical environmental factors: Dutch Coalition on Disability and Development (DCDD) (2005), Robertson (2000), Soboh and Mass (1997), FIDIDA (2008), Department of Education, South Africa, (1997), (EENET) (2000), Hollar (2005).

- Section E: Attitude of parents/caregivers towards attendance of their children with disabilities in schools: Wolfensohn (2004), UNESCO (2007), Department of Education, South Africa, (1997), Arbeiter and Hartley (2002), EENET (2000), Ahuja (2000), FIDIDA (2008).
- Section F: Parent's/caregiver's perception of members of community's attitude to attendance of children with disabilities in schools: Wolfensohn (2004), Ahuja (2000).
- Section G: The knowledge of parents/caregivers about schools their children with disabilities could attend in their community: Ahuja (2000), EENET, (2000).



3.6 TRANSLATION

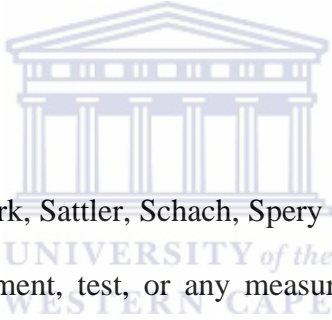
The original questionnaire was designed in English (Appendix L) and translated into the local Kinyarwanda language (Appendix M), since all of parents/caregivers spoke Kinyarwanda and did not understand English. Kinyarwanda is the language most commonly used in the Rwanda society, so it was most suitable for parents/caregivers. The translation of the questionnaire from Kinyarwanda back to English by an independent translator was not done due to the researcher's limited time. The researcher speaks and writes Kinyarwanda fluently.

3.7 VALIDITY

According to Sirard & Russell (2000), validity determines the extend to which an instrument measures what it supposes to measure. The construct validity was used. The

construct validity refers to the extent to which a measurement corresponds to the theoretical concepts (constructs) or determines if the results obtained using measurements concur with the results predicted from underlying theoretical models (US National Library of Medicine, 2007). During the pilot study (described in section 3.9), four parents/caregivers of children with different disabilities were selected to complete the questionnaire; two of them were invited to a discussion for possible changes about the clarity and understanding of the questionnaire. The discussion was in Kinyarwanda. After a discussion, the questionnaire was found to be clear and meaningful to the parents/caregivers.

3.8 RELIABILITY



According to Hawel, Miller, Park, Sattler, Schach, Sperry et al. (2005), reliability refers to the extent to which an experiment, test, or any measuring procedure yields the same result on repeated trials. The test-retest method was used after the pilot study to ensure reliability of the instrument. The test retest method is used to make the same measurement more than once, and the same response should be expected both time (Babbie & Mouton, 2006). Four parents/caregivers of children invited during pilot study and used to test validity of the questionnaire were also tested for the second time using the same Kinyarwanda questionnaire to ensure that the same results will be found. After the test-retest the same responses were obtained from participants.

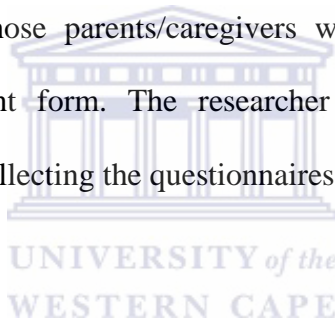
3.9 PILOT STUDY

A pilot study was carried out using the Kinyarwandan questionnaire at Gahini CBR programme with male and female parents/caregivers of children with different types of disabilities. The four parents/caregivers involved in the pilot study were not included in the main study. The pilot study took one day, and researcher completed questionnaires on behalf of the parents/caregivers. The aim was to determine how well respondents understood the questionnaire and how long it took to answer. The parents/caregivers were allowed to ask questions to clarify the questionnaire. After the pilot study, the questionnaire was modified using the information collected from the parents/caregivers. This included making changes in Section D where it was found that this section was applicable to only those who have mobility difficulties, and not all children with disabilities because it encompasses the questions about physical environmental barriers. Hence, this section was only used with children with mobility difficulties. The Question 8 Section B, which asked how much money do they got per day: The range of income was asked in US Dollar and converted into Rwandese francs for understanding purpose. One US dollars was equivalent of 545 Rwandese Francs at the time of conversion. Ethical procedures were followed during the pilot study and the parents/caregivers were informed that their responses would be used to make revisions to the questionnaire that would be used in the main study.

3.10 PROCEDURE

After obtaining the permission to conduct the study as described in the section on ethical considerations (Section 3.12), the questionnaire translated in Kinyarwanda was used to

collect data over a period of six weeks. Eight community based rehabilitation workers at Inkurunziza, who were not among population under study, were trained as research assistants. The purpose of training was to explain their role in the study to them, the aim of the study, how to complete the questionnaires, and the ethical behaviour they needed to follow. At Inkurunziza, data collection was carried out at each day centre linked to Inkurunziza where research assistants selected the participants who matched the inclusion criteria. At Gahini, data collection was done by the researcher himself. Each day centre was visited only once during the period of data collection. Because of distances to the different day centres, it was not possible to visit more frequently within the time available. At any setting, those parents/caregivers who agreed to participate were requested to sign the consent form. The researcher and research assistants were responsible for filling in and collecting the questionnaires from each participant.



3.11 DATA ANALYSIS

The analysis was made possible by means of the Statistical Package for the Social Sciences (SPSS) (15.0 version) and the Microsoft Excel Package. Based on the descriptive nature of the study, the data analysis included descriptive statistics as frequency distributions and percentages. The means and standard deviation were used for the age of children and parents/caregivers. The data was presented in the form of normal tables and cross-tables, graphs, and pie charts. CHI-Square was used to determine the association between variables. The level of significance (alpha) was set at 0.05.

Data analysis was made under the headings: demographic characteristics of children with

disabilities, socio-economic status of parents/caregivers of child with disability, type of disability, physical environmental factors, attitude of parents/caregivers towards attendance of their children in schools, parents'/caregivers' perception of member of community's attitude to attendance of children with disabilities in schools, and finally knowledge of parents/caregivers about schools their children could attend.

3.12 ETHICAL CONSIDERATION

The permission to conduct the study was obtained from all the institutions involved. The first institution included permission from the Higher Degrees Committee of the University of the Western Cape (Appendix A), and ethical clearance from the Research and Study Grant Committee. Secondly, the permission was obtained from Ministry of Education of Rwanda (Appendix C). Finally, permission was obtained from the Directors of Community Based Rehabilitation programme of Inkurunziza (Appendix E) and the Director of Community Based Rehabilitation programme of Gahini (Appendix G). A participant information sheet (in Kinyarwanda) was given to all participants for them to read or to be read to them because some were illiterate (Appendix I). Finally, signed informed written consent (in Kinyarwanda) (Appendix K) was requested from each participant and they were assured of respect, confidentiality and anonymity.

Participation in the study was voluntary, and the participants were free to withdraw from the study at any time. The parents/caregivers were told that if anything happened to upset them, a counsellor was available for them to speak to. During the study, no participant needed a counsellor.

3.13 SUMMARY OF THE CHAPTER

This chapter described the methodology used in this study. It explained the research setting, study design, study population, and the procedure of data collection and data analysis. Finally the chapter described the ethical considerations used in this study. In the next chapter the findings are presented.

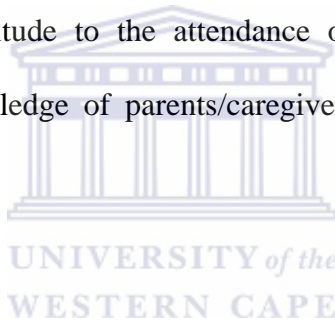


CHAPTER FOUR

RESULTS

4.1 INTRODUCTION

The results of the study are presented in this chapter under the sections demographic characteristics of children with disabilities, socio-economic status of the parents/caregivers of children with disabilities, type of disability, and physical environmental factors. The sections also include the attitude of the parents/caregivers towards the attendance of their children at schools, parents'/caregivers' perception of members of community's attitude to the attendance of children with disabilities at schools, and finally the knowledge of parents/caregivers about schools their children could attend.



4.2 DEMOGRAPHIC CHARACTERISTICS OF CHILDREN WITH DISABILITIES

4.2.1 Age, gender, and education level of children with disabilities

A total of 94 parents/caregivers of children with disabilities participated in the study. Sixty-six percent (n=62) were mothers, 15.9% (n=15) were fathers, and the rest (18.1%; n=17) were caregivers who included grandmothers, brothers, and sisters. The mean age of the children with disabilities was 11.73 years and the standard deviation was 3.36. The youngest child was 7 years and the oldest was 18 years. Table 4.1 indicates the age group, gender and education level of the children with disabilities. The education level

indicates the number of years a child attended school. The results indicate that 57.1% (n=28) of male and 57.8% (n=26) of female children had never attended school while 42.9% (n=21) of male and 42.2% (n=19) of female children dropped out of school.

Table 4.1 Age group, gender and education level of children with disabilities (N=94)

Gender	Age group			Total
	7-10 years	11-14 years	15-18 years	
	n (%)	n (%)	n (%)	n (%)
Male	16 (17.1)	20 (21.3)	13 (13.8)	49 (52.1)
Female	19 (20.2)	18 (19.1)	8 (8.5)	45 (47.9)
Total	35 (37.3)	38 (40.4)	21 (22.3)	94 (100)
Education level				
Never	30 (31.9)	20 (21.3)	4 (9.2)	54 (57.4)
1 year	6 (6.4)	12 (12.8)	3 (3.2)	21 (22.4)
2 years	1 (1.1)	3 (3.2)	4 (4.2)	8 (8.5)
3 years	0	2 (2.1)	5 (5.3)	7 (7.4)
4 years	0	1 (1.1)	1 (1.1)	2 (2.1)
5 Years	0	0	2 (4.2)	2 (2.1)
Total	35 (37.2)	38 (40.4)	21 (22.3)	94 (100)

4.2.2 Number of children in one family

Table 4.2 indicates the number of children in one family. This number includes children with disabilities and children without disabilities.

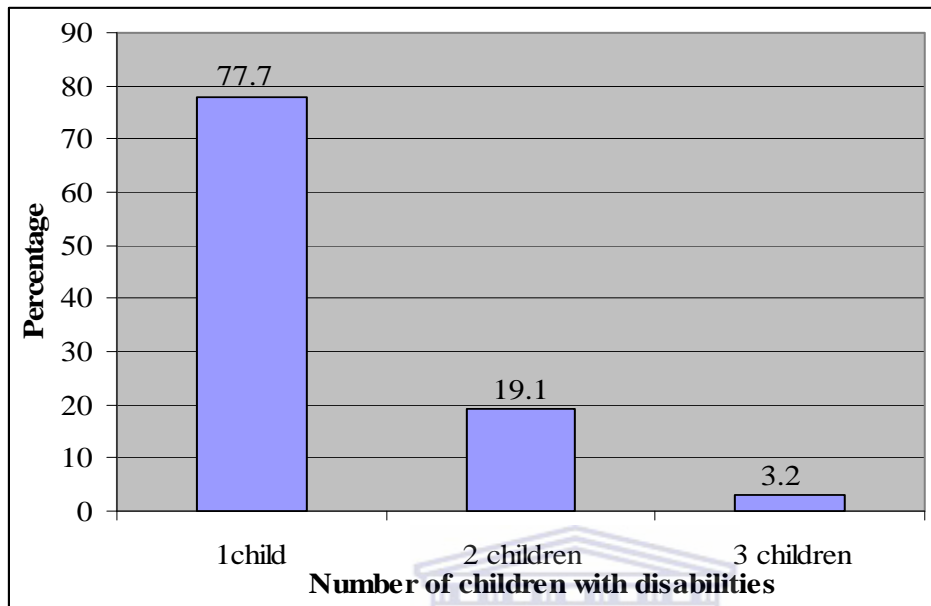
Table 4.2 Number of children in the family (N=94)

Number of children	Family	
	n	%
1 child	8	8.5
2 children	5	5.3
3 children	13	13.8
4 children	13	13.8
5 children	13	13.8
6 children	9	9.6
7 children	13	13.8
8 children	13	13.8
9 children	5	5.3
13 children	2	2.1
Total	94	100

4.2.3 Number of children with disabilities in one family

Figure 4.1 illustrates the number of children with disabilities in one family. One child in the family (n=73), two children in the family (n=18), and three children in the family (n=3).

Figure 4.1 Number of children with disabilities in the family (N=94)



4.3. SOCIO-ECONOMIC STATUS OF PARENTS/CAREGIVERS OF CHILDREN WITH DISABILITIES



4.3.1 Socio-demographic characteristic of the parents/caregivers of the children with disabilities

Table 4.3 indicates the socio-economic characteristics of the parents/caregivers of the children with disabilities. The mean age of the parents/caregivers was 42.57 years and the standard deviation was 11.202. The youngest parent/caregiver was 18 years and the oldest was 83 years.

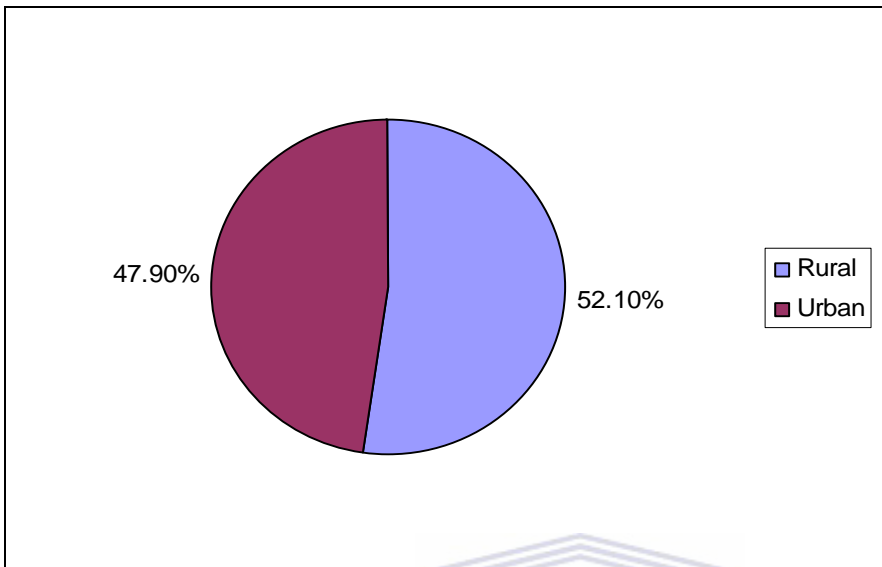
Table 4.3 Socio-demographic characteristics of parents/caregivers (N=94)

Age group	n	%
<20	3	3.2
21-30	7	7.4
31-40	32	34
41-50	35	37.2
51-60	14	14.9
>60	3	3.2
Gender		
Male	22	23.4
Female	72	76.6
Relationship		
Mother	62	66
Father	15	15.9
Grandmother	6	6.4
Brother	7	7.4
Sister	4	4.3
Marital status		
Single	5	5.3
Married	47	50
Widow	29	30.9
Separate	6	6.4
Divorced	7	7.4

4.3.2 Residence of parents/caregivers of children with disabilities

Figure 4.2 illustrates the residence of the parents/caregivers of the children with disabilities. These were the two settings used in the study: Gahini setting represents the rural area (n=49) and Inkurunziza setting represents the urban area (n=45).

**Figure 4.2 Residence of parents/caregivers
(N=94)**



4.3.3 Socio-economic characteristics of parents/caregivers

Table 4.4 indicates the socio-economic characteristics of the parents/caregivers including their level of education, employment status, and daily wage in relation to their residence.

Table 4.4 Socio-economic characteristics (N=94)

	n=49		n=45		N=94	
Education	Rural	n (%)	Urban	n (%)	Total	n (%)
None		21 (42.9)		12 (26.7)		33 (35.1)
Primary		27 (55.1)		30 (66.7)		57 (60.6)
Secondary		1 (2)		3 (6.7)		4 (4.3)
Tertiary		0		0		0
Employment						
Employed		2 (4.1)		3 (6.7)		5 (5.3)
Unemployed		47 (95.9)		42 (93.3)		89 (94.7)
Daily wage						
Nothing per day		10 (20.4)		5 (11.1)		15 (15.9)
Below 545 Fr		37 (75.5)		35 (77.8)		72 (76.6)
Between 545 and 1090 Fr		1 (2)		2 (4.4)		3 (3.2)
Above 1090 Fr		1 (2)		3 (6.7)		4 (4.3)

The CHI-Square test was not significant (P-value<0.05), which means that there is no significant difference in socio-economic characteristics among parents/caregivers from rural and urban areas.

4.4 TYPE OF DISABILITY

The types of disabilities parents/caregivers could identify included difficulties with seeing, hearing, speaking, mobility, feeling, learning, behaviour, and convulsion.

4.4.1 Number of disabilities per child

Table 4.5 indicates the number of the types of disabilities experienced by one child. The results show that one child could have 1, 2, 3, 4, and even 5 types of disabilities. This means that more than one types of disability could be found on one child. Example: a

child might have difficulty with seeing, hearing, learning and mobility.

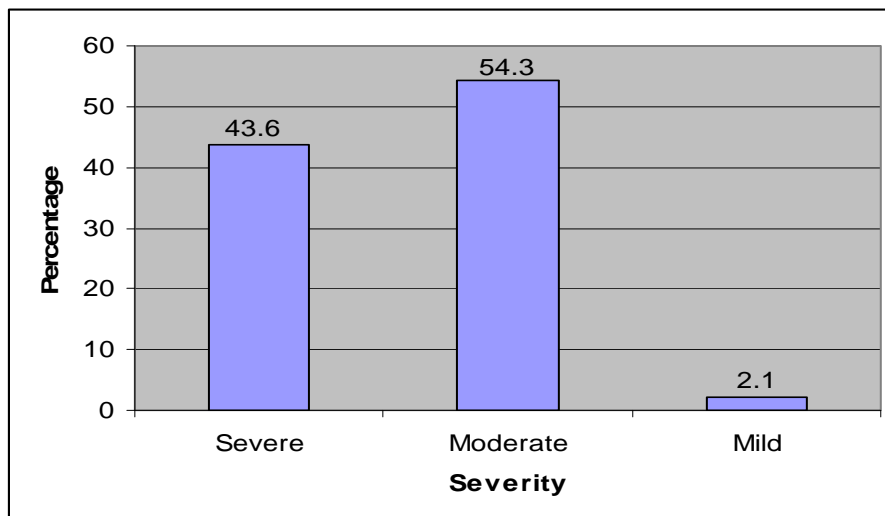
Table 4.5 Number of disabilities (N=94)

Number of disabilities	n	%
1 disability	51	54.3
2 disabilities	29	30.8
3 disabilities	7	7.4
4 disabilities	3	3.2
5 disabilities	4	4.3
Total	94	100

4.4. 2 Severity of disability among children who do not attend school

Figure 4.3 below illustrates parents'/caregivers' perception of the severity of the disability. Severe disabilities (n=41), moderate (n=51), and mild (n=2).

Figure 4.3 Perceived severity of disability (N=94)



4.4. 3 Types of disabilities and their severity

The results in table 4.6 show the severity of each type of disability as perceived by the parents/caregivers. One child could have more than one disability, hence number of disabilities is higher than number of children.

Table 4.6 Perceived severity of the different disabilities (N=94)

Difficulty	n=41	n=51	n=2	N=94
	Severe n (%)	Moderate n (%)	Mild n (%)	Total n (%)
Seeing	4 (9.8)	6 (11.8)	0	10 (10.6)
Hearing	6 (14.6)	3 (5.9)	1 (50)	10 (10.6)
Speaking	15 (36.6)	12 (23.5)	1 (50)	28 (29.8)
Mobility	21 (51.2)	29 (56.9)	0	50 (53.2)
Feeling	0	1 (1.9)	0	1 (1.1)
Learning	10 (24.4)	11 (21.6)	0	21 (22.3)
Behaviour	6 (14.6)	5 (9.8)	0	11 (11.7)
Convulsions	11 (26.8)	16 (31.4)	1 (50)	28 (29.8)

4.4.4 The relationship between type of disability and school attendance

Table 4.7 indicates the type of disabilities and school attendance by children with disabilities. The CHI-Square test found a significant association between speaking difficulties and children who never attended school (P-value=0.001).

Table 4.7 A comparison between types of the disabilities and school attendance (N=94)

	n=54	n=30	n=10	N=94
	Never attended school	Started school with disability	Dropped out after acquiring disability	Total
Difficulties	n (%)	n (%)	n (%)	n (%)
Seeing	5 (9.3)	4 (13.3)	1 (10)	10 (10.6)
Hearing	6 (11.1)	1 (3.3)	3 (30)	10 (10.6)
Speaking	24 (44.4)*	2 (6.7)	2 (20)	28 (29.8)
Mobility	27 (50)	17 (56.7)	6 (60)	50 (53.2)
Feeling	1 (1.9)	0	0	1 (1.1)
Learning	12 (12.8)	9 (30)	0	21 (22.3)
Behaviour	7 (13)	2 (6.7)	2 (20)	11 (11.7)
Convulsion	20 (37)	7 (13)	1 (10)	28 (29.8)

4.4.5 Severity of disabilities versus school attendance by children with disabilities

Table 4.8 indicates the severity of disabilities in relation to school attendance by children with disabilities.

**Table 4.8 A comparison between severity of the disabilities and school attendance
(N=94)**

	n=54	n= 30	n=10	N=94
	Never attended school	Started school with disability	Dropped out after acquiring disability	Total
Severity	n (%)	n (%)	n (%)	n (%)
Severe	27 (50)	10 (33.3)	4 (40)	41 (43.6)
Moderate	26 (48.1)	19 (63.3)	6 (60)	51 (54.3)
Mild	1 (1.9)	1 (3.3)	0	2 (2.1)
Total	54 (57.4)	30 (31.9)	10 (10.6)	94 (100)

4.4. 6 Number of children with disabilities who dropped out of school

Figure 4.4 illustrates the number of children who dropped out of school which includes those who started school with disabilities (n=30) and those who developed disabilities while at school (n=10).

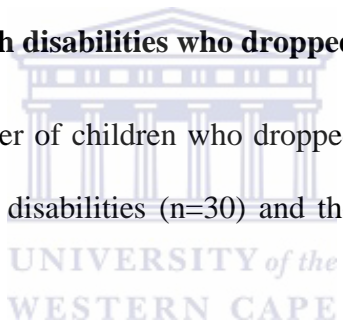
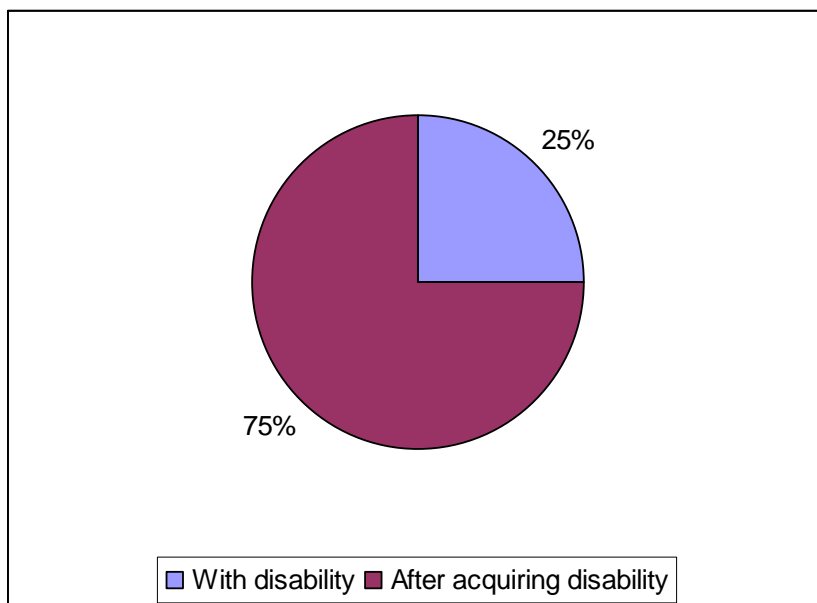


Figure 4.4 Children who dropped out (N=40)



4.4. 7 Proportion of children who need assistive devices

The study determined the number of children who needed assistive devices according to the types of disabilities. The findings of this study indicated that 60% of children (n=54) needed assistive devices for helping them in their disabilities. The majority of children with mobility difficulties (78%; n=39) needed assistive devices like a standing frame, wheelchair, crutches, stick, walking frame or any other kind of walking aid, a leg or arm prosthesis, and leg or arm orthosis. The majority of children with hearing difficulties (90%; n=9) needed assistive devices like hearing aid. Children with seeing difficulties (60%; n=6) reported a need for assistive devices like glasses.

4.4. 8 Reasons for not having assistive devices

Table 4.9 indicates the different reasons given by parents/caregivers for why the children with disabilities did not have assistive devices they needed. The reasons are broken down according to the residence of the children.

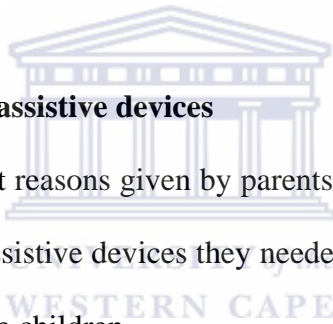


Table 4.9 A comparison between the reasons for not having assistive devices and residential area (N=54)

	n=29	n=25	N=54
Reason	Rural	Urban	Total
	n (%)	n (%)	n (%)
Assistive devices is not available	5 (17.2)	8 (32)	13 (24.1)
I do not know where to get it	12 (41.4)	5 (20)	17 (31.5)
I cannot afford it	23 (79.3)	16 (64)	39 (72.2)
Only needed occasionally	0	0	0
The condition is not serious	0	0	0

4.5 PHYSICAL ENVIRONMENTAL FACTORS

This section was only for parents/caregivers of children with mobility difficulties (N=50).

4.5.1 Time taken to walk from home to the nearest school by children without disabilities versus residence

Table 4.10 indicates the time it would take others (without physical difficulties) in community to walk to the nearest school. This is indicated according to the residence of the children.

Table 4.10 A comparison on time taken to walk to school and area of residence (N=50)

	n=27	n=23	N=50
	Rural	Urban	Total
Time in minutes	n (%)	n (%)	n (%)
<20	3 (11.1)	1 (4.3)	4 (8)
20-40	14 (51.9)	8 (34.8)	22 (44)
41-60	6 (22.2)	8 (34.8)	14 (28)
>60	4 (14.8)	6 (26.1)	10 (20)
Total	27 (100)	23 (100)	50 (100)

4.5.2 Time from home to the nearest school by children without disabilities versus school attendance

Table 4.11 compares the time taken by others in the community to reach the nearest school with the school attendance by children with disabilities.

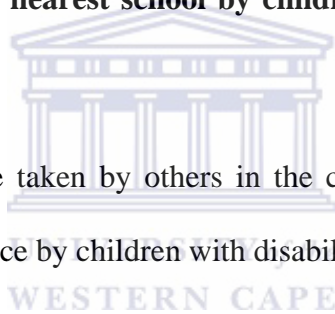


Table 4.11 A comparison of time to walk to school and school attendance

	n=26	n= 18	n=6	N=50
Time in minutes	Never attended school	Started with disability	school Dropped out after acquiring disability	Total
	n (%)	n (%)	n (%)	n (%)
<20	3 (11.5)	1 (5.6)	0	4 (8)
20-40	11 (42.3)	8 (44.4)	3 (50)	22 (44)
41-60	5 (19.2)	6 (33.3)	3 (50)	14 (28)
>60	7 (26.9)	3 (16.7)	0	10 (20)
Total	26 (100)	18 (100)	6 (100)	50 (100)

4.5.3 Reasons for difficulty walking to school

Table 4.12 indicates reasons why children had difficulties walking to school and compares this with residential area.

Table 4.12 Comparing difficulties with walking to the nearest school to school attendance (N=50)

Response	n=26	n=18	n=6
	Never attended school n (%)	Started school with disability n (%)	Dropped out after acquiring disability n (%)
The road is not well maintained	23 (88.5)*	11 (61.1)	3 (50)
It is not safe to walk	22 (84.6)	14 (77.8)	4 (66.7)
Disabled child cannot walk that distance	20 (76.9)	12 (66.7)	5 (83.3)

The CHI-Square test found a significant association between the difficulties of walking to the nearest school because the road is not well maintained and children who never attended school (P-value=0.002).

4.5.4 Methods used by other children in the community to go to school

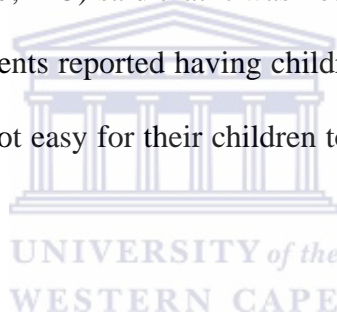
Table 4.13 compares the transport method used by other children in the community to go to school and their residence to determine the most commonly used means of transport.

Table 4.13 Means other children use to go to school versus residence (N=50)

Means	n=27			n=23			N=50
	Rural			Urban			
	Always n (%)	Sometimes n (%)	Never n (%)	Always n (%)	Sometimes n (%)	Never n (%)	Total n (%)
Walk	26(96.3)	1 (3.7)	0	19(82.6)	3 (13)	1(4.3)	50(100)
Taxi/cars	0	1 (3.7)	26(96.3)	1(4.3)	3 (13)	19(82.6)	50(100)
Bicycles	0	1 (3.7)	26(96.3)	0	0	23(100)	50(100)

4.5.5 The ability of children with disabilities to get in and out of cars

Of the seven (100%) parents/caregivers who reported using a taxi/bus/others always or sometimes, the majority (71.4%; n=5) said that it was not easy for their children to get in and out of those cars. Four parents reported having children who use wheelchairs. All of them (100%) said that it was not easy for their children to get in and out of cars with the wheelchairs.



4.5.6 Reasons why children with mobility difficulties dropped out of school

Table 4.14 indicates reasons why children with mobility difficulties dropped out of school and compares this with whether the child developed the disability before school or after starting school. Four parents who had children who used wheelchairs reported that it was not possible for their children to move around the school.

Table 4.14 Reasons for dropping out of school (N=24)

Reason	n=18	n=6
	Started school with disability n (%)	Dropped out after acquiring disability n (%)
There were stairs at school	15 (83.3)	4 (66.7)
The child was unable to play in the playground	13 (72.2)	5 (83.3)
No toilet that my child could use	12 (66.7)	3 (50)
No special seat at school	13 (72.2)	3 (50)
The doors were a problem for my child	6 (33.3)	0

4.6 ATTITUDE OF PARENTS/CAREGIVERS TOWARDS ATTENDANCE OF THEIR CHILDREN AT SCHOOL

4.6.1 Attitude of parents/caregivers towards having a child with a disability

Table 4.15 compares the attitudes of parents/caregivers in rural and urban areas to having a child with a disability in their families. The CHI-Square test was not significant, which means that there is no significant difference in attitudes among parents/caregivers from rural and urban areas.

Table 4.15 Comparison of attitude of parents/caregivers in rural and urban areas to having a child with a disability (N=94)

Attitude	n=49	n=45	N=94
	Rural n (%)	Urban n (%)	Total n (%)
It is a shame to the family	27 (55.1)	30 (66.7)	57 (60.6)
I am proud of the child with disabilities	8 (16.3)	7 (15.6)	15 (16)
Having a child with a disability is a burden	41 (83.7)	31 (68.9)	72 (76.6)
I do not know why God gave me this child	17 (34.7)	16 (35.6)	33 (35.1)
I do not like to expose my child in public	14 (28.6)	9 (20)	23 (24.5)

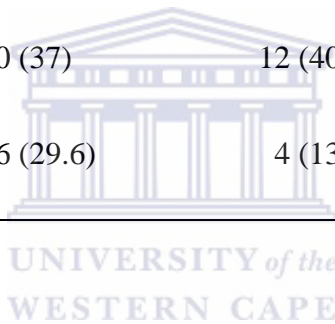


Table 4.16 compares the attitudes to having a child with a disability with school attendance. The CHI-Square test was not significant, which means that there is no significant difference in the attitudes of those whose children had attended school and those who never attended school.

Table 4.16 Attitude to having a child with a disability versus school attendance

(N=94)

	n=54	n=30	n=10
	Never attended school	Started school with disability	Dropped out after acquiring disability
Attitude to having a child with a disability	n (%)	n (%)	n (%)
It is a shame to the family	36 (66.7)	16 (53.3)	5 (50)
I am proud of the child with a disability	8 (14.8)	5 (16.7)	2 (20)
Having a child with disability is a burden	43 (79.6)	21 (70)	8 (80)
I do not know why God gave me this child	20 (37)	12 (40)	1 (10)
I do not like to expose my child in public	16 (29.6)	4 (13.3)	3 (30)



4.6.2 Prioritising education for disabled or nondisabled children

Figure 4.5 illustrates the attitude of parents/caregivers to determine if they prioritised the child with the disability or the child without the disability. Most parents/caregivers (n=57) indicated they would choose to send the child without the disability to school.

Figure 4.5 Prioritising which child to attend school (N= 90) (Missing=4)

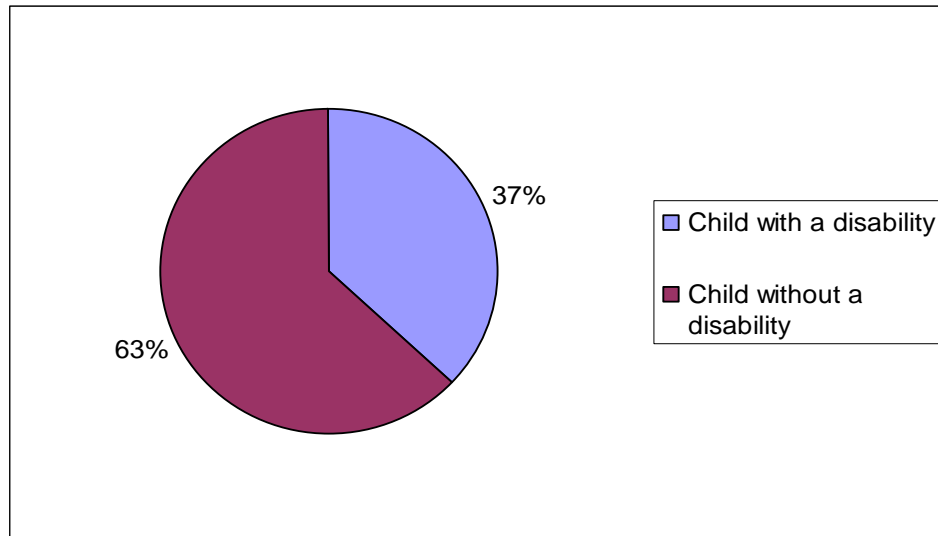


Table 4.17 shows the attitude of parents/caregivers to whether the disabled child or non disabled child is given priority to school according to school attendance and residence.

Table 4.17 Child who has priority to go to school compared to school attendance and residence (N=94)

	n=54	n=30	n=10
Response	Never attended school	Started school with disability	Dropped out after acquiring disability
	n (%)	n (%)	n (%)
Child with a disability	15 (27.8)	13 (43.3)	6 (60)
Child without a disability	39 (72.2)	17 (56.7)	4 (40)
	Rural (n=49)	Urban (n=45)	
Child with a disability	23 (46.9)	10 (22.2)	
Child without a disability	26 (53.1)	35 (77.8)	

4.6.3 Reasons of parents/caregivers for why their children with disabilities cannot attend schools versus residence

The majority of parents/caregivers (62.8%; n=59) reported that their children can attend school and the rest (37.2%; n=35) reported that their children cannot attend school. Table 4.18 outlines the reasons given by parents/caregivers for why their children cannot go to school in relation to their residence.

Table 4.18 Reasons why children with disabilities cannot attend school versus their residence (N=35)

Reason	n=14	n=21	N=35
	Rural n (%)	Urban n (%)	Total n (%)
I fear about his/her safety	7 (50)	10 (47.6)	17 (48.6)
Should not receive any education	4 (28.6)	7 (33.3)	11 (31.4)
Incapable of learning	10 (71.4)	11 (52.4)	21 (60)
He/she is always sick	3 (21.4)	9 (42.9)	12 (34.3)
It will be a waste of money	1 (7.1)	8 (38.1)	9 (25.7)
No school near me he/she could attend	11 (78.6)	14 (66.7)	25 (71.4)
He/she needs a special school	9 (64.3)	11 (52.4)	20 (57.1)
I want to be with him/her all the time	4 (28.6)	7 (33.3)	11 (31.4)

Table 4.19 compares the reasons given by parents/caregivers for why children with disabilities cannot attend school with their school attendance history.

Table 4.19 Reasons why a child with a disability cannot attend school versus school attendance history (N=35)

Reason	n= 26	n=7	n=2
	Never school n (%)	attended Started school with disability n (%)	Dropped out after acquiring disability (%)
I fear about his safety	13 (50)	2 (28.6)	2 (100)
Should not receive any education	9 (34.6)	2 (28.6)	0
Incapable of learning	15 (57.7)	4 (57.1)	2 (100)
He/she is always sick	10 (38.5)	2 (28.6)	0
It will be a waste of money	7 (26.9)	1 (14.3)	1 (50)
No school near me he/she could attend	18 (69.2)	5 (71.4)	2 (100)
He/she need a special school	15 (57.7)	3 (42.9)	2 (100)
I want to be with him/her all the time	9 (34.6)	0	2 (100)

4.7 PARENT’S/CAREGIVER’S PERCEPTION OF MEMBERS OF COMMUNITY’S ATTITUDE TO CHILDREN WITH DISABILITIES ATTENDANCE IN SCHOOLS

4.7.1 The relationship between parents’/caregivers’ perceptions of the community’s attitude to disability versus school attendance of the child.

Table 4.20 compares the perception of the parents/caregivers of the community’s attitudes to their children and people with disabilities with school attendance.

Table 4.20 The relationship between the perception of the parents/caregivers of the community's attitudes to disability versus children's school attendance (N=90)

(Missing=4)

Perception	n=53	n=28	n=9	N=90
	Never attended school	Started school with disability	Dropped out after acquiring disability	Total
	n (%)	n (%)	n (%)	n (%)
The Department of Education has not made it possible for my child to go to school because he/she has a disability	38 (71.7)	19 (67.9)	6 (66.7)	63 (70)
Other children in my community don't want to play with my child	25 (47.2)	11 (39.3)	2 (22.2)	38 (42.2)
The community considers my child as a shame in my family	30 (56.6)	14 (50)	6 (66.7)	50 (55.6)
They call my child different names because of his/her disability	40 (75.5)	18 (64.3)	7 (77.8)	65 (72.2)
My child is hidden because people laugh to him/her	10 (18.7)	4 (14.3)	0	14 (15.6)
Other people do not want my child to attend church because he/she is disabled	14 (26.4)	6 (21.4)	4 (44.4)	24 (26.7)
It is difficult for disabled girls to get married	39 (73.6)	23 (82.1)	7 (77.8)	69 (76.7)
It is difficult for disabled people to get a job	36 (67.9)	19 (67.9)	5 (55.6)	60 (66.7)

4.7.2 The relationship between the perceptions about teachers’ attitude to school attendance of the children with disabilities and school attendance

Table 4.21 indicates the perception of parents/caregivers about teachers’ attitude to school attendance by children with disabilities in relation to their school attendance. This only includes parents/caregivers of children who attended school for a period of time (n=40).

Table 4.21 Perceptions of parents/caregivers of teachers’ attitudes (N=40)

	n=30	n=10	N=40
	Started school with disability	Dropped out after acquiring disability	Total
My child does not go to school because	n (%)	n (%)	n (%)
The teachers do not want to teach my child	11 (36.7)	3 (30)	14 (35)
The teachers said that teaching my child is a burden	14 (46.7)	3 (30)	17 (42.5)
The teachers teach very quickly. My child needs the teacher to teach more slowly	9 (30)	6 (60)	15 (37.5)
The teachers only help the non disabled children with school work	11 (36.7)	2 (20)	13 (32.5)
The teachers told me that my child has to go to school with other disabled children	17 (56.7)	5 (50)	22 (55)

4.8 KNOWLEDGE OF PARENTS/CAREGIVERS ABOUT SCHOOLS THEIR CHILDREN COULD ATTEND

4.8.1 The parents/caregivers' preferred school for their children with disabilities versus school attendance

Table 4.22 shows the kind of school reported by parents/caregivers to be their choice for their children with disabilities. The CHI-Square test found a significant association between the preferred special school and never attended school. It means that the parents/caregivers of children who never attended school preferred the special school.

Table 4.22 The relationship between preferred school and school attendance (N=94)

Preferred school	n=54		n=30		n=10		
	Never attend school	n (%)	Started with disability	n (%)	Dropped out after acquiring disability	n (%)	Total
Special school	49 (90.7)*		22 (73.3)		8 (80)		79 (84)
Ordinary school	5 (9.3)		8 (26.7)		2 (20)		15 (16)
Total		54 (100)		30 (100)		10 (100)	94 (100)

Table 4.23 indicates the school by parents/caregivers preferred that their children could attend in relation to their residence.

Table 4.23 The relationship between preferred school and residence (N=94)

Preferred school	n=49		n=45		N=94	
	Rural	n (%)	Urban	n (%)	Total	n (%)
Special school	42 (85.7)		37 (82.2)		79 (84)	
Ordinary school	7 (14.3)		8 (17.8)		15 (16)	
Total		49 (100)		45 (100)		94 (100)

4.8.2 The reasons for school preference

Table 4.24 shows the relationship between the reasons of parents/caregivers for preferring the ordinary or special school for their children and the residence.

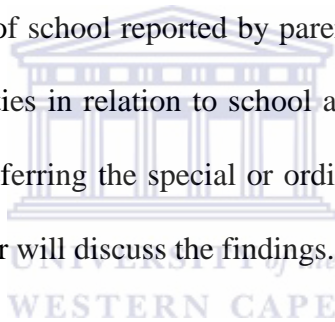
Table 4.24 Reasons for choosing one of the schools (N=91) (Missing=3)

	n=42	n=37	n=79
	Rural	Urban	Total
Special school n=79	n (%)	n (%)	n (%)
No discrimination	38 (90.5)	25 (67.6)	63 (79.7)
It is only that school I know my child could attend	32 (76.2)	23 (62.2)	55 (69.2)
They can take care of my child	37 (88.1)	30 (81.1)	67 (84.8)
They have special teachers	38 (90.5)	25 (67.6)	63 (79.7)
They have assistive devices	32 (76.2)	9 (24.3)	41 (51.9)
Ordinary school n=15	n=7	n=8	n=15
It is the nearest school	6 (85.7)	4 (50)	10 (66.7)
It is only one I know	0	3 (37.5)	3 (20)
I do not have money for a special school	4 (57.1)	5 (62.5)	9 (60)
I do not want my child to be away from me	4 (57.1)	2 (25)	6 (40)

4.9 SUMMARY OF THE CHAPTER

In this chapter the results were presented according to objectives of the study. The demographic characteristics of children with disabilities were described. Socio-demographic characteristics of parents/caregivers were summarised. Cross tabulations were done between level of education, employment, daily wage and residence of parents/caregivers. The results indicated that a large number of parents/caregivers were unemployed. The types of disability most often identified among children who did not attend school were mobility difficulties. Physical environmental factors were also

identified by determining the time taken from home to the nearest school, difficulties with walking that distance by children with disabilities, and reasons of dropping out of school. The attitudes of parents/caregivers towards attendance of their children at school were summarised in this chapter. A comparison of attitudes of parents/caregivers in relation to the residence and school attendance was described. This chapter also identified the parent's/caregiver's perception of members of community's attitude to children with disabilities. It determined the relationship between perceptions about community's, teacher's attitude and school attendance by children with disabilities. Finally, this chapter identified the knowledge of parents/caregivers about schools their children could attend. The results indicated the kind of school reported by parents/caregivers to be their choice for their children with disabilities in relation to school attendance and in relation to the residence. The reasons for preferring the special or ordinary school were also indicated in this chapter. The next chapter will discuss the findings.



CHAPTER FIVE

DISCUSSION

5.1 INTRODUCTION

The purpose of this study was to identify the barriers to school attendance by children with disabilities in Rwanda. In this chapter the results of the study are discussed with reference to the aim and objectives, and relevant literature. This chapter is divided into six sections according to the objectives of the study. The sections are, firstly, socio-economic barriers to school attendance by children with disabilities; secondly, type of disability among children who do not attend school; thirdly, environmental barriers to school attendance; fourthly, attitudes of parents/caregivers towards children with disabilities; fifthly, the parent's/caregiver's perception of members of community's attitude to children with disabilities; and sixthly, the schools parents/caregivers would prefer their children to attend.

5.2 SOCIO-ECONOMIC BARRIERS TO SCHOOL ATTENDANCE BY CHILDREN WITH DISABILITIES

The results indicate that the highest percentage of parents/caregivers (37.2%) who participated in this study were between 41 and 50 years old. The majority of parents of children with special needs who participated in the study done by Al-Shammari and Yawkey (2008) on extent of parental involvement in improving the students' levels in special education program in Kuwait were between 41-50 years. The majority of

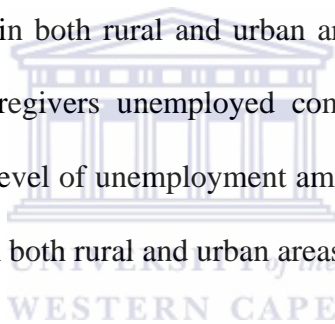
parents/caregivers were females (76.6%), 66% of whom were mothers. This is not unexpected because in Rwanda the women are usually the parents/caregivers who accompany their children (Remera, 2004). This is supported by Ahuja (2000) who states that in many families, women are responsible for care of their children while men are not generally involved especially with children with disabilities.

Another reason is that, in Rwanda, many mothers are single parents as a high percentage of women are widows due to the 1994 genocide (Ministry of Gender and Women Promotion, 2004). According to MINALOC (2003), during the genocide and war in 1994 over one million people were killed, many became widows and orphans. The findings of the study indicate that 50% of parents/caregivers were married while 30.9% were widows who live with their children without any assistance. In Rwanda, 29% of children with disabilities are orphans (Handicap International, 2007). Widows who are mothers are among the poorest people in the country. As a result if they have children with disabilities they may not attend school if their parents/caregivers do not have any help.

This study was carried out in two settings: Gahini CBR programme which is a rural area and Inkurunziza CBR programme which is in the urban area. The majority (52.1%) of parents/caregivers were from the rural area. This study indicated that the majority of parents/caregivers (60.6%) had only primary education level and (35.1%) of parents/caregivers did not even have primary school education. This indicates that the education level of the parents/caregivers was very low and can lead to unemployment and poverty as stated by Wolbers (2000). The low level of education also affects their

involvement in the education of their children with disabilities and can influence parents to keep their children at home as their parents did. It is not easy for the parents who have never attended school to send their children with disabilities at school or to be actively involved in their education process. South African policy (Department of Education, South Africa, 1997) encourages the parents of children with disabilities and the community at large to be actively involved in the attendance and learning process of their children. This active involvement may be easier if the parents are educated because if the parents are not educated they feel they have nothing to contribute to schooling process and prefer their children without disabilities to go to school rather than those with disabilities (Ahuja, 2000). It is important for the Rwandan Department of Education, in its policy, to encourage all parents, even illiterate parents, to send their children with disabilities to school. Forty-two point nine per cent of parents/caregivers in the rural area did not even have primary education compared to the 26.7% in the urban area who did not have primary education level. At primary level, 66.7% in the urban area had primary education level compared to the rural area where 55.1% had only primary level. Very few had secondary education level. These numbers indicate that the level of education of parents/caregivers was even lower in the rural than the urban area. Similar results in Rwanda have been found by American Population Council (2003) in results from the Rwandan Demographic and Health Survey where the level of education was very low in the rural area compared to the urban area. As it has been discussed before, the illiteracy leads to unemployment and poverty (Wolbers, 2000). It is important for the Department of Education in Rwanda to pay particular attention to the rural areas.

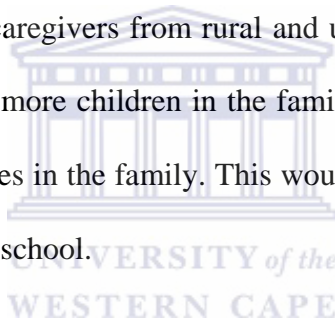
The study found a high level of unemployment among parents/caregivers of children with disabilities with 94.7% unemployed. In Rwanda, over 90% of people are engaged in substance agriculture and only 6% are salaried workers. More females (97.18%) are engaged in agriculture than males (90.19%) (Republic of Rwanda, 2005). In the Rwandan context, people who are engaged in substance agriculture are considered to be unemployed as they do not save money from their harvest and if they receive any it does not help much. Other studies have found that the children with disabilities from families where one or more of breadwinners are unemployed or poorly paid frequently do not attend or drop-out of school (Jonsson & Wiman, 2001). Although the level of unemployment was very high in both rural and urban areas, the rural area was slightly higher with 95.9% parents/caregivers unemployed compared to the urban area with 93.3% unemployed. The high level of unemployment among parents/caregivers might be due to low level of education in both rural and urban areas.



A very large number of parents/caregivers (92.5%) were earning below 545 Frs per day (US \$1.00). The British Council of Disabled People (BCDP) (2005) states that the majority of the population lives in extreme poverty especially in developing countries where 82 % of people with disabilities live below the poverty line. According to World Bank Group (2008), in 2005 was estimated 1.4 billion people lived below the line of poverty which was US \$1.25 per day. In many poor families, the child with a disability is kept at home and while others go to school because of the perception that the child with a disability is unlikely to be employed or to be in position to contribute to the family income (World Bank, 2008). These figures can be higher in countries devastated by civil

war and/or natural disaster (Jonsson & Wiman, 2001). This is in line with Rwanda where people with disabilities are over-represented among the poor and often among the very poorest (Thomas, 2005; McClain-Nhlapo, 2007).

A larger proportion of parents/caregivers from the rural area (95.9%) had a daily wage below US \$1.00 than the urban area where this percentage was 88.9%. This includes 20.4% of parents/caregivers who received nothing per day in the rural area while in the urban area 11.1% of parents/caregivers received nothing per day. However, the CHI-Square test showed that there is no significant difference in socio-economic characteristics among parents/caregivers from rural and urban areas. Most families were large with 58% having five or more children in the family. Additionally 22.3% had two or more children with disabilities in the family. This would have made it difficult to send the children with disabilities to school.



As it has been discussed before, the major cause of poverty is that over 90% of Rwandese population depends on the land for their livelihoods sometimes with a very poor harvest (Ministry of Finance and Economic Planning, 2005). The shortage of land is a cause of poverty and conflict. According to Republic of Rwanda (2005), in the National Employees Policy, there is a policy established by the Constitution of the Republic of Rwanda and the Universal Declaration of Human Rights to increase the chance of employment and poverty eradication. The Government is trying put in place a favorable environment for the development of employment everywhere and for all, as stipulated in ILO Convention 122 regarding employment policy (Republic of Rwanda, 2005).

However, in Rwanda there is no known policy of funding parents of children with disabilities or people with disability in general. A few parents of children with disabilities find some help from faith based organisations/and or non governmental organisations.

5.3 TYPE OF DISABILITY OF CHILDREN WHO DO NOT ATTEND SCHOOL

The type of disabilities found among the children who did not attend school was classified according to the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001a). According to Thomas (2005), using the ICF, the types of difficulties found in Rwanda include the following: seeing, hearing, speaking, mobility, feeling, learning, behaviour, and fits or convulsions.

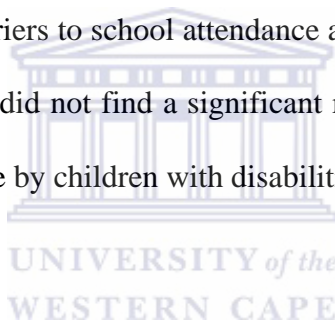
The predominant type of disability was mobility difficulties (53.2%). The reason why mobility difficulties could have dominated was because the day centers where the research was undertaken were visited by physiotherapists who usually work with people with mobility difficulties. However, Helander (1999), states that mobility difficulties are more common in countries which continue to have poliomyelitis and poor perinatal care; or in countries with a recent history of civil or liberation wars. This could be another reason for the high percentage of mobility disabilities in Rwanda which is recovering from the 1994 genocide. The lack of treatment facilities during the genocide, poor pre and perinatal care resulted in a high number of cases of cerebral palsy which results in mobility difficulties (Morris, 2002). This might also be the cause of high number of people with epilepsy (29.8%) reported by parents/caregivers.

Rwanda has had many meningitis epidemics which have affected a large number of people (Ministry of Health, 1997). Helander, (1999) stated that speaking, learning, and hearing difficulties are more common when meningitis is common. The study showed mobility, speaking, learning, and epilepsy were the most common difficulties. The CHI-Square test found a strong association between speaking difficulties and children who never attended school. In Rwanda, there is a strong negative attitude towards people with speaking difficulties (MINALOC, 2003). In addition, in Rwanda, there are no trained teachers for children with speaking difficulties in ordinary school, hence those children find more barriers to attending school than others.

According to the severity of the disabilities, the study found that many children had moderate difficulties (54.3%) and severe difficulties (43.6%). This is in contrast to Canada's National Statistical Agency (2001) where it has been found that severe difficulties were more common than moderate difficulties. In this study the interviewer described what is severe, moderate, or mild to the parents/caregivers. They then decided on the severity of their children's disability. This may be more accurate if the children were diagnosed by physiotherapists who can classify the severity of disabilities so there is more consistency from one child to the next. It would also be more accurate if there were more specific criteria for measuring mild, moderate, and severe.

When comparing severity of disability and school attendance, the study indicates that many children who never attended school (50%) had severe difficulties and 48.1 % had moderate difficulties. The percentage of children with severe difficulties was lower in

those who attended school compared to those who never attended school. The children who attended school included those who started school with a disability (33.3%) and those who later acquired a disability (40%). On the other hand there was a higher percentage of children with only moderate difficulties who attended school. This included 63.3% of children who started going to school with a disability and 60% of those who dropped out after having acquired a disability. This indicates that many children with severe disabilities never got the opportunity to go to school, whereas a higher proportion of children with moderate difficulties went to school. This is supported by the South Africa Department of Education (1997) and EENET (2000) who state that severity of disability can be one of the barriers to school attendance among children with disabilities. However, the CHI-Square test did not find a significant relationship between severity of disability and school attendance by children with disabilities.

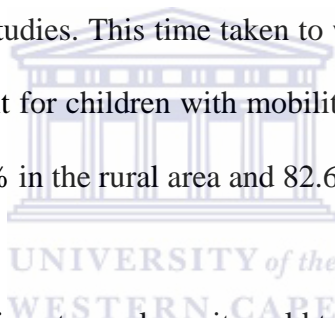


5.4 ENVIRONMENTAL BARRIERS TO SCHOOL ATTENDANCE

5.4.1 Geographical environment

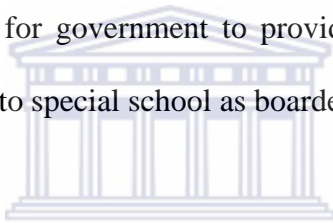
This section was only for children with mobility difficulties because it encompassed mainly the physical environmental factors which can be barriers to children with mobility difficulties. Robertson (2000) states that physical environmental factors mainly affect children with mobility difficulties. The results of the time taken from home to the nearest school by children without disabilities indicate that it took 44% of the children without disabilities between 20 and 40 minutes to walk from home to the nearest school. This proportion was higher in the rural area (51.9%) compared to the urban area (34.8%).

A further (28%) of the parents/caregivers reported it took 41 to 60 minutes to walk to the nearest school, 34.8% in the urban and 22.2% in the rural area. Twenty percent reported it took more than 60 minutes for children without disabilities to walk to school (14.8% in the rural area and 26.1% in the urban area). This study suggests that many children from the urban areas walk a greater distance to reach the nearest school than those from the rural areas. These were not the same findings as stated by Soboh & Mass (1997), who argues that distances and isolation from schools are the main barriers more commonly identified in rural than urban areas. The reason for this difference is that the parents/caregivers might not estimate the time accurately which could result in the difference between these two studies. This time taken to walk to school is important as it will be that much more difficult for children with mobility difficulties to get to school as the majority would walk (96.3% in the rural area and 82.6% in the urban area).



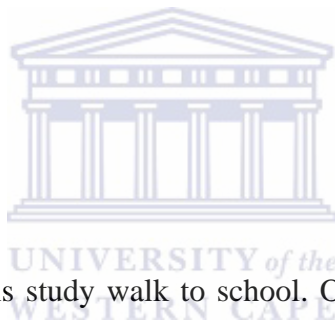
However, even if that distance is not very long, it could take a long time for children with mobility difficulties. This distance also could be the reason for dropping out of school for those who started going to school with disabilities who stopped after some years of attending and those who stopped going to school after acquiring disabilities. EENET (2000) has reported that distance can be one of the barriers to learning by children with disabilities. However, no statistical association was found by the CHI-Square test between time taken from home to the nearest school and school attendance. The CHI-Square test showed that never attending school, going to school with a disability and later stopping or dropping out after acquiring a disability were not associated significantly with the time taken from home to the nearest school. Robertson (2000) argues that the

poor accessibility of schools (most are only accessible on foot) means that for most students with physical disabilities, attendance at school is impossible. Many parents/caregivers who never attended school (88.5%) reported that the roads were not well maintained for their children to walk on. This could be also a problem for many of children with disabilities to reach the schools as many of them must walk. In many poor communities, especially in rural areas, children with disabilities are unable to reach their centre of learning because there are no transport facilities available to them or the roads are not conducive and well maintained so that the centres can be reached by children with disabilities (Department of Education, South Africa, 1997). The only possibility for education of these children is for government to provide transport for the children to school or for the children to go to special school as boarders.



The majority of parents/caregivers whose children started going to school with a disability (71.4%) and 69.2% of those who never attended school reported that no school was near them that their children could attend. Here they were referring to school for children with disabilities or special school which they could not find in their community. Most parents/caregivers (62.2% urban, 76.2% rural) indicated that a special school was the only school their children could attend. It seems that many parents/caregivers did not know that their children could attend an ordinary school. In poor communities, the parents do not get involved in learning process of their children with disabilities as they do for other children without disabilities and do not know which school could be attended by their children, either special or ordinary school (Ahuja, 2000). The parents/caregivers from the rural area (78.6%) and 66.7% of those from the urban area reported not having a

school near them that could be attended by their children with disabilities. The fact that many parents/caregivers reported not having a school for their children near them might be a barrier for not attending school among children with disabilities if parents/caregivers think that their children must only attend special schools. No information informing parents/caregivers of children with disabilities about their right to education for their children and at which school their children could attend is available in Rwanda. But, Handicap International (Rwanda) in conjunction with the Rwandan Ministry of Education have started inclusive education in a number of ordinary schools around the country to ensure that children with disabilities have access to education (Karangwa & Kobusingye, 2008).

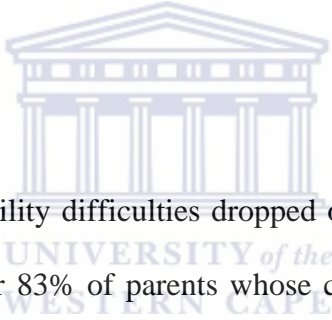


5.4.2 Transport

The majority of children in this study walk to school. Only one parent/caregiver in the urban area reported that children in the area always use taxi/cars to go to school. However, it was possible to get a taxi. Five out of seven parents/caregivers reported that it was not easy for their children to get in and out of taxi/bus/others cars. In this study four parents/caregivers reported having children who use wheelchairs. All of them said that it was difficult for their children to get in and out of taxi/bus/others cars with the wheelchairs. The public transport in Rwanda is not conducive to people with disabilities. It is known that in many countries the transport systems which exist are inaccessible to learners with disabilities, especially those who use wheelchairs (Department of Education, South Africa, 1997). In developing countries people with disabilities cannot easily go in and out most of, if not all public transport or it is not easy for them to find an

appropriate seat. Sometimes drivers of public transport do not like to put people with disabilities in their cars because it takes a long time for the person to get in and out and they find it difficult to help them to sit. This affects the children with mobility difficulties who must use the cars to reach their schools. The findings are line with the South Africa Department of Education (1997) which states that learners with disabilities who should be attending or who wish to attend school are unable to even reach the school because the available public transport is physically inaccessible. If there is no accessible transport, and children with disabilities are not able to walk to school, they are totally excluded from the education system (Department of Education, South Africa, 1997).

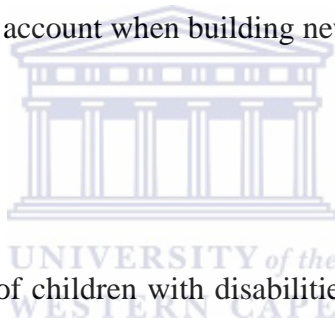
5.4.3 School environment



The reasons children with mobility difficulties dropped out of school were presented in the findings (Table 4.15). Over 83% of parents whose children started going to school with disabilities and dropped after attending some years reported that there were stairs at school. The stairs are a big challenge to children with mobility difficulties especially those who use the wheelchairs and other assistive devices. Four parents who had children who use wheelchairs reported that it was not possible for their children to move around the school. According to FIDIDA (2008), the inaccessibility becomes evident where the schools are physically inaccessible to learners with disabilities who use wheelchairs or other mobility devices. The majority (83.3%) of parents/caregivers whose children dropped out of school after developing disabilities reported the inability of their children to play on the playground like others. If they are no longer playing like before they acquired the disability or if the playground does not allow them to play it can lead to

them dropping out.

A number of parents/caregivers also reported toilets, seats or chairs, doors or class designs to be the barriers. Enabling Education Network (EENET) (2000) and Hollar (2005) indicate that in developing countries the schools and classroom are often not accessible due to physical environmental barriers like stairs, toilet, chairs, classroom designs, tables, and the playground. The way schools are built could be a barrier to learners using wheelchairs when there are no ramps leading to classes and when the doors are not wide enough for the wheelchair to pass through (P. Engelbrecht et al., 1999). It is important that this is taken into account when building new schools in Rwanda.



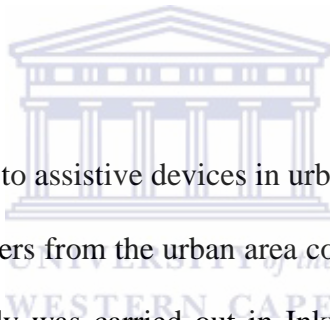
5.4.4 Assistive devices

This study indicates that 60% of children with disabilities needed assistive devices. The majority were children with mobility difficulties (78%) who needed assistive devices like a standing frame, wheelchair, crutches, stick, walking frame or any other kind of walking aid, a leg or arm prosthesis, and leg or arm orthosis. The findings also indicated that many children with hearing difficulties (90%) needed assistive devices like hearing aids, and majority of children with seeing difficulties (60%) reported a need for assistive devices like glasses.

If a child does not have an assistive device to help him cope with his/her disability or with the school environment, this child can either not attend school or learning break down may occur. According to EENET (2000), the barriers to school attendance can be

manifest in the learners with disabilities who do not receive the necessary assistive devices which could help them to participate in the learning process.

The reason for not having these assistive devices was poverty. Most parents (72.2%) could not afford them because they were expensive. As discussed the majority of parents/caregivers were not employed, most of them were poor and did not have any aid either from the Government, NGOs, or from religious organisations. Over 79% of parents/caregivers from the rural area could not afford the assistive devices for their children compared to 64% of parents/caregivers from the urban area who could not afford assistive devices.



This difference between access to assistive devices in urban and rural areas may be due to the fact that the parents/caregivers from the urban area could have more help from NGOs than the rural area as this study was carried out in Inkurunziza (urban) CBR which is sponsored by Christian Blind Mission (CBM). CBR and Handicap International are major NGOs operating in Rwanda which help people with disabilities in terms of assistive devices. These NGOs are based in Kigali city of Rwanda and cannot reach a large part of the rural area. Price (2003) argues that in developing countries most of children with disabilities in rural areas do not have assistive devices to help them going to school or coping with the school environment.

5.5 ATTITUDES OF PARENTS/CAREGIVERS TOWARDS CHILDREN WITH DISABILITIES

The greatest barriers to school attendance by children with disabilities are caused by society, not by particular medical impairments (Wolfensohn, 2004). Wolfensohn (2004) argues that the negative attitude towards disability remains a critical barrier to learning and development in our society.

5.5.1 Shame

In Rwanda, when a person becomes disabled or a disabled child is born, the family enters into a new world about which they know next to nothing and about which they have a lot of stereotyped notions (Republic of Rwanda, 2005). The findings of this study indicate that the negative attitude towards children with disabilities was very pronounced among parents/caregivers. According to the comparison of the attitudes of parents/caregivers in rural and urban areas to having a child with a disability in their families, 76.6% of parents/caregivers found having a child with a disability a burden. This included both rural and urban areas. However, the percentage was higher in the rural area (83.7%) than the urban area (68.9%). This might be the result of lower level of education and high level of poverty in the rural area.

Wolfensohn (2004) states that many families find it a burden to have a child with disability and tend to hide them and not to offer them any opportunity for development due to both fear for and being ashamed of them. Other families find that educating a child with disabilities is a waste of money and provide no education for children with

disabilities because they say they are not capable of learning (Wolfensohn, 2004). The second most common negative statement about having a child with a disability was that the child was considered to be a shame in the family (60.6%). In Rwanda, children with disabilities are considered as a source of shame in a family, underestimated, being-seen as useless, meaningless, and there is an assumption “when you are a disabled person, you live with your disabilities and wait for what God will do for you” (Thomas, 2005, p.21). This concept of shame for the family was higher in the urban area (66.7%) than the rural area (55.1%). It was also higher where the children had never attended school (66.7%) (compared to 50-53.3% for those who had attended school). This suggests that shame was a barrier to attending school for children with disabilities. A small percentage of parents/caregivers in both rural (16.3%) and urban (15.6%) areas reported being proud of having a child with a disability. Thomas (2005) argues that in Rwanda people with disabilities are usually identified as among the most vulnerable groups and sometimes, disability is seen as a curse or punishment from God (FIDIDA, 2008). This results in not being proud of having children with disabilities and leading to shame in the family. Hence, children with disabilities have restricted education opportunities (FIDIDA, 2008).

To change the parent’s self esteem so that they do not feel shame to having a child with a disability, the CBR programmes should help the community to raise their awareness of having a child with a disability. This may be done by education and empowering the parents/caregivers of children with disabilities.

5.5.2 Incapable of learning

According to Wolfensohn (2004), many parents consider that educating a child with a disability is a waste of money and do not support education for children with disabilities because they think they are not capable of learning. In contrast, the idea of education of children with disabilities as a waste of money was infrequently reported (7.1% in rural, 38.1% in urban). However, the reason that children with disabilities are incapable of learning was a common reason given for not attending school (71.4% in rural, 52.4% in urban). This is not surprising because in Rwanda people with disabilities are often considered as people without intelligence and not able to be educated. The findings of this study indicate that the majority of parents/caregivers (63%) supported the idea of children without disabilities attending school rather than those with disabilities. This would be a barrier to school attendance for children with disabilities. The majority of parents/caregivers who preferred the children without disabilities to have a priority to go to school were those whose children never attended school (72.2%). Many parents/caregivers in poor communities prefer their children without disabilities to go to school rather than those with disabilities (Ahuja, 2000). The highest percentage (77.8%) of parents/caregivers who prioritised the children without disabilities to attend school was parents/caregivers in the urban area and only 53.1% of parents/caregivers in the rural area. This might be related to the proportion of parents/caregivers who considered the child with a child with a disability as a shame in their family which was also higher in the urban area. They may not want to prioritise their education saying that the children are incapable of learning, and will not contribute to the society.

5.6 PARENT'S/CAREGIVER'S PERCEPTION OF MEMBERS OF COMMUNITY'S ATTITUDE TO CHILDREN WITH DISABILITIES

5.6.1 Community

The findings of this study (Table 4.21) indicate that the majority of parents/caregivers (76.7%) believe that the community thinks it is difficult for disabled girls to get married. This proportion was very high (82.1%) among parents/caregivers whose children started going to school with a disability. This could restrict the school attendance of children with disabilities, especially girls, for the reason that they will not play a role in family in terms of love and getting married. According to UN Millennium Development Goals (2007), the girls with disabilities are the most marginalised and least likely to be educated, as they have double disadvantages compared to boys including their gender and disability, and Thomas (2005) argues that, in Rwanda, disabled women find it difficult to get married. The Ministry of Gender and Family Promotion must play a greatest role in raising awareness in Rwandan community towards girls with disabilities and in empowering their families.

Calling children with disabilities abusive names demonstrates a common negative attitude towards children with disabilities in the community (72.2%). The negative attitudes to school attendance by children with disabilities extend to the relatives and community in large, and finally to the other children who abuse children with disabilities by giving them different unkind names (UNESCO, 2007). Children in Rwanda are given different abusive names relating to their impairment or their difficulties. Some of those names indicate that they are useless, different from normal people, etc. Among those

abusive names in Kinyarwanda include “karema” or “kajoliti” (casualty). This might contribute to the decision not to send the child to school because many parents/caregivers (75.5%) whose children were given abusive names did not send their children to school. This kind of bullying needs to be stopped in the Rwandan community because it negatively affects children with disabilities participating in different activities as well as education.

5.6.2 Teachers

These findings include the perception of parents/caregivers of teachers’ attitude to school attendance by children with disabilities in relation to their school attendance. These findings only include the information from parents/caregivers of children who attended school for a period of time and then dropped after. Many parents/caregivers (55%) reported that the teachers told them that their children had to go to a school for children with disabilities. Here they were talking about the special school. According to EENET (2000) and South Africa Department of Education (1997) there is often a negative attitude of teachers that suggests that children with disabilities need the specialised professionals to teach them. It is possible that the teachers did not feel qualified to teach the children with disabilities. Forty-two point five percent of parents/caregivers said that the teachers told them that teaching their children was a burden. This might be due to lack of trained teachers or the lack special education materials which causes the teachers to become tired and find difficulty to teaching the children with disabilities. According to Arbeiter and Hartley (2002), the lack of awareness and knowledge about disability among some parents and teachers remains a significant barrier to their school attendance.

The lack of trained teachers can lead to children with disabilities dropping out of school because teachers are afraid to accommodate them in their class and respond negatively to their attendance (UNESCO, 2007). The Rwandan Educational Sector Strategic Plan 2004-2008 includes the training of special education teachers for implementation of the policy on inclusive education (MINEDUC, 2003). However, in Rwanda, many primary school teachers are not trained for special education. For successful Education for All, the Rwandan Department of Education should train the primary school teachers in order to accommodate children with disabilities in ordinary schools.

5. 7 SCHOOLS PARENTS/CAREGIVERS WOULD PREFER THEIR CHILDREN ATTEND

There two types of schools which can accommodate children with disabilities: ordinary schools and special schools. According to Every Child Matters (2005), special schools make special educational provision for children with special educational needs (SEN) whose needs cannot be fully met within mainstream provision. Ordinary schools are the nearest schools that accommodate children with and without disabilities (UNESCO, 2002).

This study indicates the kind of school reported by parents/caregivers to be their choice for their children with disabilities. The majority of parents/caregivers (84%) reported the special school to be their first choice for their children with disabilities. This shows that many parents prefer their children to be in a special school rather than in the ordinary schools. According to Karangwa and Kobusingye (2008), Handicap International

(Rwanda) in conjunction with the Rwandan Ministry of Education have started inclusive education in a number of ordinary schools around the country for ensuring that children with disabilities have access to education. This is a new policy in Rwanda, but many parents are not yet aware they can send their children with disabilities to ordinary schools. Instead they still prefer their children to be isolated in special schools. According to EENET (2000), in developing countries, parents prefer their children with disabilities to be isolated in special school instead of ordinary school because they think this school can take care of the children.

The goal of Education for All cannot be met if parents/caregivers want their children to attend the special school. According to Thomas (2005), the special schools accommodate only a small number of children with disabilities compared to ordinary schools and they can not be found in every child's community. This might be a barrier to school attendance by a large number of children with disabilities as almost all of those who never attended school (90.7%) preferred the special school to be their choice. The CHI-Square test found a significant association between preferring special school and never attending school. The study further indicated that the highest number of those who preferred ordinary school (26.7%) were those whose children started school with disabilities and stopped after some years. This suggests that the parents/caregivers wanted their children to study in ordinary school with other children without disabilities and then they met some barriers and stopped going to school. South Africa Department of Education (1997) states that these barriers manifest themselves when learning breakdown occurs, when learners drop out of the system or when the excluded becomes visible.

The reasons for choosing either special or ordinary school were given by parents/caregivers. The reason most frequently selected for choosing the special school was that at special school they can take care of their children with disabilities (84.8%). This is not surprising because in Rwanda many parents think that the special school is the only one which can take care of their children with disabilities. Other reasons most frequently given were that there is no discrimination at special school (79.7%), they have special teachers (79.7%), and it was the only school the parents/caregivers knew their child could attend (69.2%). According to the residence the majority (90.5%) of parents/caregivers from the rural area preferred the special schools because they have special teachers. According to EENET (2000), there is negative attitude of some parents/caregivers to their children attending ordinary schools as they incorrectly believe that the children with disabilities need the specialised professionals to teach them or they need special care. In the rural area in Rwanda, there are sometimes non qualified teachers. This is more common in the rural area in than in the urban area. As a consequence parents may not have confidence in them. On the other hand, the predominant reason for choosing the ordinary school was that it was their nearest school (66.7% who reported). As stated by UNESCO (2002), ordinary schools are the nearest schools that accommodate children with and without disabilities. Many parents/caregivers (85.7%) from the rural area chose the ordinary school because it was the nearest school compared to 50 % from the urban area. This is because in Rwanda there are few special schools and most of them are located in urban areas far from most children with disabilities' homes (Thomas, 2005).

5.8 SUMMARY OF THE CHAPTER

The discussion dealt with major findings of the study and relevant literature. The summary of the study, conclusion and recommendations based on the findings will be presented in the next chapter.



CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter consists of summary of the study, limitations of the study, the major findings of the study are given in the conclusion, significance of the study, and the recommendations are proposed at the end of the chapter.

6.2 SUMMARY

The study was undertaken to answer the research question: why children with disabilities do not attend school in Rwanda. The aim of this study was to identify the barriers to school attendance by children with disabilities in Rwanda. The objectives of this study were to determine the socio-economic status of parents/caregivers of children with disabilities who do not attend schools, the types of disabilities of children with disabilities who do not attend schools, and the physical environmental barriers to school attendance by children with disabilities. The study also determined the psychosocial environmental barriers to school attendance by children with disabilities, the attitude of parents/caregivers of children with disabilities towards their children with disabilities attendance in schools. Finally, this study determined the parent's/caregiver's perception of members of community's attitude to children with disabilities attendance in schools, and the knowledge of parents/caregivers of children with disabilities about schools their children with disabilities could attend in their community.

The findings of this study indicated that a large number of children with disabilities have never attended school (57.4%) and others have dropped out after attending for some years (42.6%). Most parents/caregivers had only primary school level of education (60.6%) or no education (35.1%). A large number of them were not employed and their daily wage was very low in both rural and urban areas. The CHI-Square test showed that there was no significant difference in socio-economic characteristics among parents/caregivers from rural and urban areas.

The predominant type of disability was mobility difficulties (53.2%). In this study, 54.3% of children had moderate difficulties and 43.6% severe difficulties. Many children who never attended school (50%) had severe difficulties. However, the CHI-Square test did not find a significant relationship between severity of disability and school attendance by children with disabilities. The study found that many children needed some assistive device to help them, but because their parents/caregivers were poor they could not afford those assistive devices. The majority of parents/caregivers whose children had never attended school (88.5%) reported that the roads were not well maintained for their children to walk. The CHI-Square test found a significant association between the inability to walk the distance from home to the nearest school and children who never attended school (P-value=0.002). For the children from the areas where normally they use the taxi/bus/other cars to go to school, it was not easy for the children with disabilities to get in and out of those taxi/bus/other cars especially those who used the wheelchairs. Some reasons for dropping out were given by a number of parents/caregivers who reported that the stairs at school to be their problems. Other

problems met in school environment by children with disabilities were toilets, seat or chairs, doors or class designs.

The study also determined the attitudes of the parents/caregivers and the community. Many parents reported that having a child with a disability is burden, and few were proud of having child with a disability. The majority of parents/caregivers preferred the children without disabilities to attend school rather than children with disabilities. The study indicated that many parents/caregivers thought that their children could not go to school because there was no school near them the children could attend. Many parents/caregivers reported that the community gives their children different abusive names. About the teachers' attitude, a high proportion of parents/caregivers said that the teachers told them that their children had to go to the schools for other children with disabilities. Many parents/caregivers in this study, reported preferring the special schools for their children because they can take care of their children, that there is no discrimination at special school and they have special teachers.

6.3 LIMITATIONS OF THE STUDY

The following are limitations of this study:

- There was not enough time to have a bigger sample of parents/caregivers of children with disabilities in the two research settings during a period of data collection.

- Parents/caregivers may have incorrectly reported the types and severity of disabilities. It would be better if the physiotherapists were to identify types and severity of the disabilities.
- There was no standardised instrument (questionnaire) to use for data collection as there have been few studies about barriers to school attendance among children with disabilities. Many more studies have been about the barriers children meet in the school environment, while my research question was why do children with disabilities not attend school in Rwanda.
- As this study was quantitative parents/caregivers did not have chance to provide their own experience. This would have been possible if the study had combined both qualitative and quantitative designs.

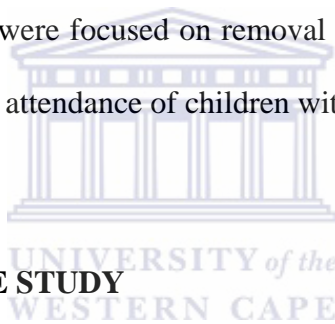
6.4 CONCLUSION

Few studies have been done on barriers to school attendance by children with disabilities. Many studies have been done to identify the barriers met by children with disabilities mainly in school environment but not in the communities. This study is the first to identify the barriers to school attendance by children with disabilities in Rwanda.

Economically, the parents/caregivers of children with disabilities in Rwanda are very poor, amongst the poorest in the country especially in the rural areas where most of them

are unemployed. In Rwanda, many roads are not well maintained, public transport is not conducive for children with disabilities, and the school environment also is not accessible for a number of children with mobility difficulties. The attitude among parents/caregivers and the community at large is negative towards children with disabilities. Awareness raising and attitudinal change about disability issue among Rwandese society is needed to promote schooling for children with disabilities.

Although the international policy of inclusive education is being implemented in Rwanda, many children with disabilities are still out of school. A successful Education for All would be possible if it were focused on removal of all barriers which can hinder the education process or school attendance of children with disabilities.



6.5 SIGNIFICANCE OF THE STUDY

As stated by Van, Emerson and Ichikawa (2002), the parents of children with disabilities have a vital role and key role to play in education process of their children with disabilities. According to the Ministry of Local Government, Information and Social affairs (MINALOC) (2003), negative attitudes are particularly strong towards people with disability in Rwanda.

This study will help Ministry of Local Government, Good Governance, Rural Development and Social Affaires to help the parents and community to consider their children with disabilities as human beings who have the ability to learn like other children without disabilities. As a comprehensive policy of Special Needs Education

which will outline the philosophy, goals and objectives of Education for All is currently being developed in Rwanda (MINEDUC, 2007), the result of this study will help the Ministry of Education in strategic plans of the policy development Education for All towards inclusive education.

Most Community Based Rehabilitation programmes (CBR) aim to integrate children with disabilities into their local school. Their integration in the local school is therefore linked to a wider movement to promote an inclusive society (EENET, 2000). This study will assist physiotherapists, as CBR workers, in overcoming the barriers to school attendance experienced by children with disabilities as they work with the community, and to help in implementation of inclusive education.



6.4 RECOMMENDATIONS

On the basis of the findings of this study this study, the following recommendations are proposed:

1. Further studies about teachers'/community's attitude towards education for children with disabilities in Rwanda.
2. The Community Based Rehabilitation (CBR) must play a great role in identifying children with disabilities and in awareness raising in the community about disability. This might help in removal of some barriers like the negative attitudes towards children with disabilities in the community.

3. The role of physiotherapy in working with learners with disabilities should be expanded in School of Physiotherapy in Rwanda.
4. The Ministry of Education must encourage the removal of physical environmental barriers at school and in the community to facilitating the implementation of inclusive education in Rwanda.
5. For a successful implementation of inclusive education in Rwanda, the Ministry of Education should organise the training of the primary school teachers for special education.
6. Also for a successful implementation of inclusive education in Rwanda, the Ministry of Education in collaboration with the Ministry of Health should employ physiotherapists to play a role in terms of direct and indirect support for the learners with disabilities.
7. The Rwandan Ministry of Public Service, Skills Development, Vocational Training and Labor should develop accessible public transport for people with disabilities in general.

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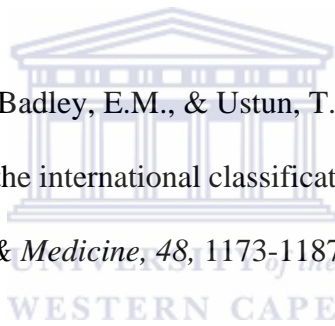
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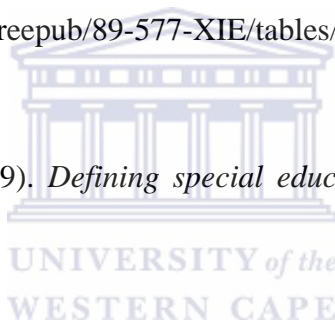
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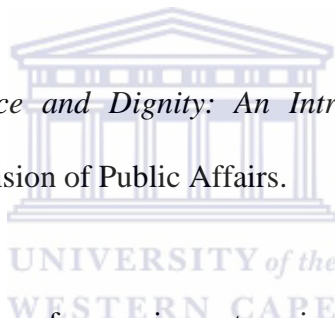
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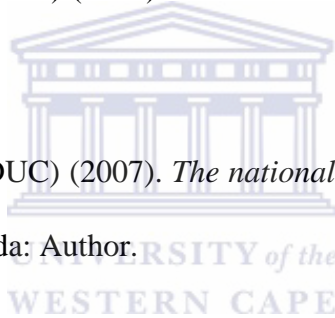
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