PERCEPTIONS OF SOCIAL STIGMA ON THE PROVISION OF INCLUSIVE EDUCATION IN RWANDA.
A CASE OF SELECTED SECTORS IN MUHANGA DISTRICT

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DECLARATION

I hereby declare that this project is my original work except for citations and quotations which have been duly acknowledged. I also declare that it has not been submitted for any other degree or award in any other institution.

Student’s Name: **Theophile NTIGURIRWA**

Signature………………………………. Date……………….

DECLARATION BY THE SUPERVISOR

This project has been submitted with my approval as the University of Rwanda supervisor.

Name: **Dr. Patrick SUUBI**

Signature…………………………………Date…………………

DEDICATION

I hereby dedicate this work to all people who contributed towards the completion of my degree course in one way or another.

ACKNOWLEDGEMENTS

I would like to acknowledge the contribution made by many people and institutions towards the completion of this research project. My deepest and sincere gratitude goes to my supervisor, Dr. Suubi Patrick, for his guidance, insightful comments, and determined facilitation extended to me throughout the writing. His friendly encouragement has been greatly appreciated.

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ABSTRACT

The concern of this study is to explore Effect of social stigma on the provision of inclusive education in Rwanda. A case of selected sectors in Muhanga district. The specific objectives include to assess the causes of social stigma, to examine the role of teachers in stigma reduction and to establish the relationship between social stigma and the provision of inclusive education. The study adopted descriptive research design using quantitative approach. Social exclusion theory was used in this study. The population involved on 188 persons including people with disabilities, teachers, head teachers, parents, and local authority leaders. Purposive sampling technique was used to sample 92 respondents taken from 188 persons as total population. Descriptive statistics were used to analyze the quantitative data. The data collected from the questionnaires were coded and presented as frequency distribution, percentages and tables. Data were gathered with the help of a self-administered questionnaire (SAQ) and analyzed using Statistical Package for Social Sciences (SPSS) and then presented in form of tables. The MS Excel and SPSS was used to calculate percentages and frequencies and to establish the correction between variables. The study will be a great important to the existing knowledge in special needs and inclusive education, to policy makers and future researchers and even the management and to the management of schools. Findings indicated that the majority (89%) agreed and strongly agreed, this implies that lack of education greatly contributes to social stigma. Besides, the study revealed that the majority of the responses (59%) being on disagree and strongly disagree implies that teachers do not apply inclusive teaching methods in schools. Finally, the findings indicated that majority of the respondents having agreed and strongly agreed (62%) is an implication that social stigma indeed adversely affects the ability to socialize. As the majority of the respondents disagreed and strongly disagreed with the statement (61%), this implies that social stigma does not adversely affect the ability to obtain housing. Pearson Correlation Coefficient results indicated a positive relationship between the two variables at $r=0.832$and $p=0.000$ It was concluded that there is a strong positive relationship between social stigma and provision of inclusive education. The study recommended that the awareness campaigns organized should be organized on the role that social stigma plays in hindering inclusive education so that all children including those with disabilities and/or special educational needs can easily access quality education.

LIST OF ACRONYMS/ABBREVIATIONS

CBC	Competence Based Curriculum
CBR	Community-based rehabilitation
CWDs	Children with disabilities
GDP	Gross Domestic Product
GoR	Government of Rwanda
IMF	International Monetary Fund
EFA	Education for All
ESSP	Education Sector Strategic Plan
MINEDUC	Ministry of Education
SAQ	Self-Administered Questionnaire
SDGs	Sustainable Development Goals
SE	Special Education
SEN	Special Educational Needs
SNE	Special Needs Education
SN&IE	Special Needs and Inclusive Education
SPSS	Statistical Package for Social Sciences
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Education Fund

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CHAPTER ONE: INTRODUCTION

1.0 Introduction

This chapter comprises the background to the study, problem statement, general and specific objectives, significance, scope, limitations and organization of the study.

1.1. Background of the study

Education is the fundamental right of all children, whatever their nature and structure, are contained in numerous declarations (Like: Education for All, 1990; UNESCO Salamanca Declaration and Framework for Action, 1994; Dakar Framework for Action, 2000; Development Goals, 2000). The International Conference on Fundamental Rights is not only about the provision and access to education, but also about its role in supporting the development of every student, including those with mental and physical disabilities (Abosi, 2007).

In many cases, children with disabilities (CWD) are among the most vulnerable in any society and constitute one of the most vulnerable groups, subject to extreme violations of their rights. They are highly dependent on the love and care of their parents, family, and the wider community. When children with physical or mental disabilities face discrimination, lack of adequate policies and limited or no access to education, education is the root cause of social change that often leads to social upheaval (Quennerstedt & Quennerstedt, 2014).

Agran et al (2020) identified six factors that determine the distribution of students with LD across grades. Perceptions of competence lead to problems with placement policies. The implication is that students with LD need specialized environments and teachers to succeed. This results in "*students being treated not as individuals, but as members of a general category"*. This is consistent with what is known from labelling theory, "that labels produce stigma by changing perceptions of others and legitimizing stratification" (Shifrer, 2013). In other words, labelling causes people to perceive learners with LD solely as their learning disability, which means that they are no longer seen as part of the general population, but as a group apart and therefore to be kept separate. Thus, separate classes reinforce the erroneous

assumption that a learning disability is a negative attribute that requires separation from the general population.

Even in regular classes, students with LD suffer from the way they are labelled. Parents' and teachers' prejudices shape perceptions and labels of students with LD. In fact, some educators fear the need to teach and accommodate students with LD, believing that these students are not capable of academic achievement (Downing, 2008). Once a child is labelled as disabled, they are treated differently from their non-disabled peers. Parents and teachers have lower academic expectations for students with LD than for their peers who are similarly academically successful (Shifrer, 2013). When comparing goals for higher education, 82% of teachers had lower expectations for students with LD, predicting that they would not receive higher education, while parents' expectations were 43% lower (Ferrari, 2017).

Because learning disabilities remain stigmatized, the mental-emotional health of students with learning disabilities is worse than that of students without learning disabilities at the same level of academic achievement, even in mainstream classrooms (Lackaye and Margalit, 2006). Students with intellectual disabilities reported significantly lower levels of hope, self-efficacy and less positive mood compared to their peers. How students with LD are treated in schools and the stigma that exists affects not only academic abilities but also emotional health. Wellers (2006) found that social-emotional profiles, including self-efficacy, are important predictors of effort investments that are related to the academic performance of students with LD. This suggests that self-efficacy is related to effort investment; that is, when students with learning disabilities perceive themselves as inadequate, students with learning disabilities invest less effort in the task, resulting in lower academic performance. The stigma surrounding learning disabilities affects these students' perceptions of themselves and can be detrimental to mental health and self-efficacy. When parents and teachers are not aware of the stigma affecting students with learning difficulties, this prevents them from facilitating a truly inclusive classroom environment in which students with learning difficulties can thrive. The essence of inclusive education (IE) is that:

"All children learn together where possible, and educational units identify and accommodate learner diversity, provide ongoing support and services to meet those needs, and reinforce

solidarity between CWD and its peers. Countries must commit to creating inclusive schools, not private schools. Children with disabilities are largely victims of deeply rooted traditional/cultural beliefs about disability that exclude them from the mainstream social community and deny them the opportunity to explore their talents and potential in inclusive educational settings" (Goffman, 2003).

According to Grima-Farrell, Bain & McDonagh (2011), every child has the right to education as stipulated in the Convention on the Rights of the Child. This universal principle applies to children with disabilities. The Convention on the Rights of Persons with Disabilities affirms the right to education of persons with disabilities and specifically states that persons with disabilities should not be excluded from mainstream education because of their disability. UNICEF (2020) pointed out:

"Children with disabilities and their families constantly face social, and economic barriers that adversely affect their development and prevent them from being included in society and enjoying their basic human rights to the fullest."

Despite the government's strong commitment to inclusive education, some school administrators, teachers and support staff have limited knowledge of the concept of inclusive education, creating a negative attitude towards students with disabilities and other students with special educational needs. This includes outdated infrastructure (classroom, blackboard, toilets, path, playgrounds, etc.) inaccessible to students with disabilities in some schools, poorly adapted teaching and learning materials, a limited number of schools administrators and teachers trained in inclusive education, teachers additional support for students with disabilities or special needs school authorities – nevertheless, inclusive education, families and schools have a common goal, etc

In Rwanda, as in most African countries, there is a strong social stigma that must be removed to ensure that students with SEN can study as easily as others. In most parts of Rwanda, children with disabilities are largely victims of entrenched traditional/cultural beliefs about disabilities that exclude them from the mainstream social community and deprive them of the opportunity to discover their talents and potential in an inclusive educational environment.

This study aims to investigate the impact of social stigma on inclusive education in Rwanda using the Muhanga district as a case study.

1.2 Problem Statement

Education is a right that belongs to all children, including those with disabilities and/or special educational needs. A child's development is based on education, as it affects his or her whole life. Access to quality education has enormous potential to increase social and economic security and reduce poverty. It ensures self-confidence and literacy and full participation in society. In addition to being a right in itself, education protects the child from harms such as child marriage, violence, child labor and trafficking for exploitation.

Inclusion is a phenomenon which is mostly discussed nowadays. Children with disabilities face many problems while attending mainstream schools. One of these is stigmatization. Regular education is an important policy in promoting social inclusion. Stigma is a complex term defined as a visible or invisible, deeply discrediting trait that deprives the wearer of complete social acceptance and often results in various forms of discrimination (Goffman, 2003). There is some evidence that different educational contexts can expose children to different levels of stigmatized treatment. Due to their cognitive impairment, the social identity of children with intellectual disabilities can be devalued and desensitized to stereotypical cartoons (Crocker et al., 2008).

The government of Rwanda (GoR) sees education as the gateway to full participation in society. In this context, it has shown its commitment to supporting students with special educational needs (SEN) and people with disabilities. This commitment is contained in the Ministry of Education (MINEDUC) Strategic Priority Number 7 of the Education Sector Primary Education Strategic Plan Framework (ESSP) 2018/19-2023/24, and specifically to promote the participation and success at all levels of children with disabilities and special educational needs." In addition, the 2016 Competency-Based Curriculum (CBC) is designed to be accessible to all students, including those with special educational needs. However, there are still social stigma that needs to be eradicated to ensure that learners with SEN can be

easily given education like others as children with disabilities are largely victims of deep rooted traditional and cultural belief on disability that exclude them from the mainstream social community and deny them to explore their abilities and potential within inclusive educational setting. It is against that background that this study was carried out in order to investigate perceptions of social stigma on the provision of inclusive education in Rwanda by using Muhanga District as a case study.

1.3 General Objective

The general objective of this study was to examine the perceptions of social stigma on the provision of inclusive education in Muhanga District.

1.3.1 Specific Objectives

i. To assess the causes of social stigma in Muhanga District;

ii. To examine the role of teachers in stigma reduction in Muhanga District;

iii. To establish the relationship between social stigma and the provision of inclusive education in Muhanga District.

1.3.2 Research Questions

i. What causes social stigma in Muhanga District?

ii. What role do teachers play in stigma reduction in Muhanga District?

iii. What is the relationship between social stigma and the provision of inclusive education in Muhanga District?

1.4 Scope of the Study

This study on perceptions of social stigma on the provision of inclusive education is delimited in content, in space and in time.

In content scope, covered the content related to social stigma on the provision of inclusive education. Regarding, geographical scope, the present research study was based on the information collected from different respondents of selected sectors which are Nyamabuye and Shyogwe in Muhanga District. Concerning time scope, the study covered a duration of three years; starting from 2017 to 2019. This interval was crucial because it helped the researcher to

collect data and analyze on the provision of inclusive education as delimited in content, in space and in time.

1.5. Significance of the Study

This research will allow the researcher to acquire in-depth knowledge on special needs and inclusive education. Future researchers will be interested in the same field of study; they will use this research project as a reference. The study hopes to provide valuable information to students and researchers interested in the field of special needs and inclusive education.

Furthermore, when formulating or revising existing policies, especially for students with special educational needs in inclusive education setting, this research will contribute to the management of special and inclusive schools in Rwanda by guiding policy makers on the critical issues to consider when expanding to more schools, while ensuring that early special and inclusive schools do not reinvent the wheel.

1.6. Limitations of the Study

Despite the current study's substantive contribution to the discussion on perceptions of social stigma on the provision of inclusive education, caution should be exercised in the interpretation of the findings due to the following limitations. The first limitation of this study was that the respondents were selected from people with obvious disabilities and those who have been diagnosed with a disability. In doing so, people with severe activity limitations but no visible disabilities or diagnosis maybe have been overlooked. Also, persons with severe dementia and psychosis were not included in this study. Secondly, findings were based on self-report measures, therefore no observational or interview data was gathered and responses might thus be socially desirable. The study conducted in only two sectors of Muhanga District and also adopted a non-probability method of sampling, this should, therefore, be considered in interpreting the results. Moreover, the sample size for this study is rather moderate hence the generalizability of these findings is quite limited.

1.7. Organization of the Study

The study was organized into five chapters. Chapter one is the general introduction. It contains background to the study, problem statement, research purpose, research objectives, research questions, significance of the study, scope of the study, definition of key concepts and structure of the study. Chapter two deals with literature review, whereby theoretical orientation, related literature and conceptual framework were developed. Chapter three consists of the research methodology adopted for the study. It also encompasses research design, target population, sampling size and sampling techniques/procedure, research instruments, data collection, data analysis and ethical consideration. Chapter four dealt with data presentation, analysis and interpretation. Finally, chapter five was dedicated to the discussion, conclusion and recommendations.

1.8. Definitions of terms

Inclusion: It is adequate support offered, which does not take disability categories into account. It also means finding different ways of teaching so that all children in the class actively participate (Agbenyega, 2003)

Inclusive education: It means examining how our schools, classrooms, programs, and courses are designed so that all children can participate and learn. It is the process of meeting the educational needs of all students in a general education setting. It is based on the principle that all students are different and can learn and develop in different ways, so the educational system is expected to adapt flexibly to the needs of each student (Van der Meij & Heijnders, 2004).

Social stigma: Social stigma is the disapproval of, or discrimination against, a person based on perceivable social characteristics that serve to distinguish them from other members of a society. Social stigma is commonly related to culture, gender, race, intelligence, and health (Wang, 2011).

Special Educational Needs (SEN): These are the non-typical needs that a student may have in education due to inherent or external limitations/barriers. A student with SEN requires additional attention/help from the teacher and/or the use of different teaching methods and/or resources (Adnan & Hafiz, 2001).

Special Educational Needs (SEN): It is the education that aims to school all children who, for whatever reason, have a temporary or permanent need for adapted education in addition to ordinary education (Abosi, 2007).

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter deals with the introduction, theoretical review, empirical review, theoretical framework, conceptual framework and summary.

2.1. Theoretical Review

Education is the ability of all people to learn what they need and want throughout their lives according to their potentials. It is the gateway to full participation in society, to earn a living and to take advantage of all the opportunities society has to offer. Therefore, education is a human right. But it is more than that: it also serves as a fundamental component of economic and social development. For these reasons, Universal Primary Education (UPE) is at the center of both human rights declarations and economic development frameworks. Providing education for all children is important for children with disabilities who are often stigmatized or excluded. Indeed, school attendance is an important way for children with disabilities to break down misconceptions that hinder their inclusion elsewhere (Groce, 2004).

Special needs and inclusive education is an important component of the Education Sector Strategic Plan (ESSP) and the overall vision for improving access and quality of education in Rwanda. One of the key tenets of the curriculum framework is that schools have a responsibility to ensure that learning is organized so that it is inclusive and every child is valued (SN&IE Policy, 2019). Inclusivity is a more discussed phenomenon in our society. Disabled children face many problems when they attend regular schools. One of them is stigma. General education is a key policy in promoting social inclusion (Quennerstedt, 2014).

There is evidence that different educational settings may expose children to different levels of stigmatized treatment. Due to their cognitive impairments, the social identities of intellectually disabled children can be devalued and depersonalized into stereotypic caricatures (Crocker *et al 1998*). This may lead to the stigmatized individual experiencing differential treatment and being systematically avoided, derided and marginalized (Dovidio *et al* 2000). It has been found that young people with IDs educated in integrated schooling often believe that their

social identity is devalued (Szivos-Bach 1993). Sensing that others do not like, value or respect one represents a major threat to self-esteem (Baumeister & Leary 1995). Meanwhile, there is evidence that those educated in segregated settings may be protected from an insight into the devalued status that people with IDs can hold in society (Todd, 2000).

In the educational field, a 2004 study carried out by Special Olympics12 of 4000 middle school students from across Japan examined their beliefs and attitudes towards student peers with intellectual disabilities. Overall the students underestimated the capabilities of students with intellectual disabilities and were hesitant to interact with them. On the other hand, they were willing to include students with intellectual disabilities in their schools and classrooms. In the 2004 Canada Benchmarking Attitudes to Disability Survey, 55% of the Canadian thought that children with physical disabilities would best be taught alongside other children but there were only 33% of the people for children with mental illness.

The term stigma goes back to the Greeks who cut or burned marks on the skins of criminals, slaves, and traitors, describing them as imperfect or immoral people to be avoided (Goffman, 2003). Stigma is a complex term defined as a visible or invisible quality that deprives its bearer of full social acceptance, deeply discrediting, often resulting in various forms of discrimination (Goffman, 2003). Most definitions of stigma consist of two basic components: recognition of difference and devaluation (Rutman, 2004). They also emphasize that stigma occurs in social interactions. In this respect, stigma is thought to take place in the social context, not in the individual (Peters, 2004). What is stigmatizing in one social context may not be so in another (Groce, 2004). Being a victim of stigma has many negative consequences, including poor mental health, physical illness, poor academic performance, infant mortality, low social status, poverty and reduced access to housing, education and work (Coser, 2006; Duffield, 2010).

Also, when a person is labeled as stigmatized, it is considered a deviation from others. Being labeled as deviant can lead to rejection by the normal population, isolation, restriction of social opportunities, and lowered self-esteem (Goffman, 2001). Today, stigma is defined as severe social disapproval due to individual characteristics, beliefs or behaviors that are

believed or real, contrary to economic, political, cultural or social norms (Lauber, 2008). It is characterized by a lack of knowledge about disability, fear, prejudice and discrimination. In its most developed forms, stigma leads to exclusion from various areas of social functioning and provokes guilt, shame, inferiority and a desire to hide (Stuart, 2004).

Stigma students with special needs is a complex issue with the capacity to affect all facets of a person's life, such as the opportunity to find housing and employment, enter higher education, obtain insurance, and get fair treatment in the criminal justice or children welfare systems (Everett, 2006; Charbonneau, 2007).

Therefore, stigma deprives students with special needs of particularly important life opportunities that are vital to achieving life goals, gaining competitive employment, and living independently in a safe and comfortable home (Corrigan & Kleinlein, 2005). Stigma affects people's quality of life, social and psychological well-being. It causes stress, anxiety and more stigma. Less acceptance in the public sphere can result in disapproval, discrimination, rejection and social exclusion. As a result, people with disabilities are deprived of employment opportunities and forced to rely on social security. Some people with mental illness refused to seek help for their ailment, which would have prevented them from receiving the necessary treatment

The literature identifies three general approaches for countering stigmatizing attitudes and discriminating behavior associated with children with disabilities. These are education, contact, and protest (Corrigan & O'Shaughnessy, 2007). Although each of these stigma reducing approaches has some degree of validity on the surface, they are not uniformly effective (Wang, 2011).

The first strategy to fight stigma originates from the belief that stigma is related to poor factual knowledge about mental illness and disability, and seeks to inform the general public and health professionals by replacing inaccurate stereotypes and false assumptions of mental illness, and disable children with facts and accurate conceptions about the illness (Rusch, Angermeyer, Corrigan, 2005). The limitations of this kind of intervention are that many

stereotypes are resilient to change (Corrigan & Penn, 1999), and it has been argued that education modifies literacy and, sometimes, attitudes, but rarely behavior (Stuart, 2005).

The second strategy aims to change negative attitudes toward the mentally ill through direct interactions with affected persons. Direct and face-to-face interactions are examples of contact interventions (Van der Meij & Heijnders, 2004). Contact appears to be the most promising strategy for reducing stigma (Corrigan & Penn, 1999), especially when contact is one-on-one: when people are seen as having equal status and when people are working together in a cooperative rather than competitive manner (Islam, & Hewstone, 1993). This is showed better by the inclusion policy.

The third strategy works on conveying messages to report and to believe reported negative and inaccurate representations of mental illness and children with disabilities. Advocacy activities, educational support groups, and patient empowerment groups are examples of interventions within the protest strategy. This kind of strategy is usually effective in diminishing negative attitudes about mental illness but it fails to promote more positive attitudes supported by facts. Also, a rebound effect may occur and can be observed in the stigmatizing beliefs of the public (Corrigan & Penn, 1999), meaning that protest does not necessarily change people's prejudice about mental illness.

The challenge of combating stigma is still prominent in the mental health field and much more needs are to be done. The fight against stigma is a complex endeavor, with multifaceted implications, and must be examined from multiple perspectives (e.g., mentally ill individuals, their families, and healthcare professionals) to increase knowledge and experience about the best strategies for ant stigma campaigns. Until now, few studies focusing on the perspective of those having mental illness, relatives or mental health practitioners, have been published and there is a paucity of research using everyday life settings for examining strategies to fight stigma.

Most efforts have focused on directly improving community attitudes even though it seems relevant that ant stigma programs would also address patients and their relatives. Studies conducted in this manner reported few suggestions, which were mainly concerned with

improving information on mental health issues for the public (Gaebel, Bauman, & Zaske, 2005).

2.1.1. Causes of social stigma in inclusive school

Disability awareness, education and training are basic requirements for all professionals. Instructors must have a complete understanding of the specific learning experience impairments when working with particular students. As Lauber (2008) noted, education providers often fail to identify, recognize or understand a child's disability. Globally, recent research has made significant efforts by teachers, the public, and communities to express positive attitudes toward children affected by various disorders. However, upon closer examination, some behaviors can be negative if investigated (Peters et al., 2005). For example, while teachers theoretically agree with the inclusion projects for this group, in practice they have very little decision and are kept in the classroom (Peters, 2004). The position of teachers towards children with disabilities has a major impact on the overall educational experience (Saend, 2010; Stuart, 2004).

Although legal provisions establish that CWDs may attend regular classes, they do not guarantee acceptance or fear of treatment by instructors or peers (Coser, 2006). Therefore, schools must eliminate the general attitudes of social rejection and discrimination towards these vulnerable groups. The literature highlights that inclusivity may not achieve the expected results for special students due to persistence of bias (Corrigan and Mathews, 2003). Stereotypical beliefs about CWD can hinder the development of children who come into contact with explicit and subtle conversations that affect their identity as learners (Corrigan & O'Shaughnessy, 2007).

According to Sailor (2002), many will never reach their full potential because of discrimination and marginalization. The mentor's self-esteem is an important factor in their perception of self-efficacy; In other words, if the instructor has a high / low sense of worth, it can affect other teachers and ultimately the quality of inclusive education. Thus, if educators' positive attitude drives the success of the EI experience, among others, a negative attitude becomes an unsuccessful use of EI and exacerbates the position of children with disabilities at school. This

is supported by the findings of Charbonneau (2007), who examined the link between psychological problems and teachers' approach to disability and demonstrated that attitudes to disability affect the overall learning environment of students with disabilities, reiterating that children achieve higher learning outcomes. An educational environment free from discrimination, exclusion and negativity. Furthermore, the teacher is accepted as a role model who embraces the true values of education; Therefore, students imitate this behavior. Furthermore, mentors have a vital role to play in managing the education of children with disabilities.

Donald et al (2001) argued that home-based events and peer relationships can influence student responses in schools, with a significant impact on teaching practices. Similarly, Berk (2001) argued that CWD self-efficacy and educational performance are primarily driven by the family environment, because beliefs and attitudes within the family environment have an important direct impact on the development of children with disabilities. Children are more likely to enjoy EI if the mentor understands its important role in managing and supporting the education of people with disabilities. Therefore, the success of EI depends on the interaction between teachers and school administrators and adjusting the curriculum to include the student. Despite the benefits of inclusion, some studies highlight the difficulty of secondary education institutions in meeting the needs of special students in a normal classroom (Bayene & Tizazu, 2011; Berit, H. & Miriam, 2001).

One reason is that staff believe they do not have the skills or time to adapt the curriculum to meet the needs of children with SEN. Other authors (e.g. Charlton, 2000; Davis, 2003) found that general education had no significant effect on the performance of children with disabilities. The positive effects of inclusion mainly include improved social interaction, peer role models, improved academic outcomes, higher expectations, tighter cooperation among school staff, and greater integration of families with children with disabilities into the local community (Bayene & Tizazu, 2011; Charlton, 2000).

A Special Olympics (2004) study of 4000 Japanese middle school students investigated their thoughts and behavior towards their peers affected by mental disorder, highlighting the latter's

general underestimation of their abilities and delayed interaction. However, they were willing to accept students with intellectual disabilities as their colleagues.

Wang (2011) presented a complementary analysis to identify differences in attitudes between US and Japanese students and documented that American students are more willing to interact with their peers affected by disabilities than their Japanese counterparts. In addition, the authors demonstrated that North American youth have better perceptions of CWD abilities as a result of their greater exposure to students with various disorders. Despite major missteps in both states, all participants were open to involving more students with special needs.

The findings were in stark contrast to the survey of Saperstein et al. (2003) of adult perceptions of people with intellectual disabilities in 10 provinces (Japan, Republic of Ireland, Northern Ireland, United States, Brazil, China, Egypt, Germany, Nigeria and Russia). It was discovered that adults have more false beliefs about these groups; for example, 60% of Japanese adults argued that such communities should be taught separately to students without disabilities. The fact that young people in both states value their peers and are more receptive to participation reflects an opportunity to change attitudes.

Rao (2004) provides an interesting review of the available literature that investigates the behavior of university teachers and staff toward students with intellectual or physical disabilities. At the time, the literature on the link between staff attitudes and their willingness to meet the needs of special students did not find a clear link between the two, which merits further investigation. Rao's (2004) findings showed that educators need to know more about students with disabilities in order to change their attitudes, which may be a critical factor for this particular group for the success of the failure of the educational experience.

In examining and measuring teachers 'and teachers' attitudes toward students with disabilities, there is more evidence to support the existence of social bias. The negative attitudes of educators are reflected in the study of Kavale and Fornes (2005, 2006); In this study, it was revealed that when teachers were aware of the existence of students with disabilities, these teachers distinguished nearly 80% of students with disabilities from their peers who did not

have students with disabilities. experience distraction, hyperactivity and adjustment problems (Bayene & Tizazu, 2011). Throughout the literature, there is a common theme of negative attitudes that arises in response to students with disabilities. For example, one study found that instructors often say that they feel sorry for students with disabilities (Berit and Miriam, 2001) and that they find them not only harder to teach but also less intelligent (Bayene & Tizazu, 2011; Berit & Miriam, 2001; Charlton). Some of these negative aspects may be due to the negotiation process required in deciding how to meet student-teacher harmony. Understandably, this is a difficult and stressful process for the teacher as well as the student, and educators often seem reluctant to facilitate students or suspect their invisible barriers (Lukas, 2013).

Another common negative aspect reported by teachers is that students with disabilities are lazy or struggling. This finding is confirmed by a study by Lock & Layton (2001), which shows that some teachers believe that students use learning problems as an excuse to leave work. This negative conclusion is sad, given the large number of reports in the literature on students labeled as students with disabilities who put themselves in a state of fatigue (Lewis, 2009; Lukas, 2013; Martha et al., 2011) and even on the duration of headache and physical illness. from the load. It is used to compensate for the difficulties caused by students with disabilities (Bayene & Tizazu, 2011).

2.1.2. Role played by teacher in stigma reduction

Stigma critically influences well-being and recovery for people with mental illnesses, affecting employment, income, social ties, quality of life, mastery, self-esteem, depressive symptoms, and access to medical and mental health services (Link, 1999). In recognition of this problem, there has been a sustained effort to reduce stigma by educating the public about neurobiological bases of mental illnesses and available treatments, with the assumption that framing mental disorders as medically treatable “illnesses like any other” would reduce stigma.

There is clear evidence that the public has adopted this understanding and that mental health treatment is increasingly viewed as beneficial (Mackenzie, 2014) and sought by the public.

Nevertheless, these changes have not been accompanied by stigma reduction. Core aspects of stigma emotional reactions, stereotypes, and social distance remain unchanged or have worsened. What can explain this discrepancy? Research now shows that biological explanations tend to increase rather than decrease stigma (Phelan, 2014).

To develop a stigma intervention that can be broadly disseminated, the study evaluated a classroom-based curriculum, which was designed to appeal to teachers and students and easy for teachers to implement without specialized training. It also evaluated the effectiveness of a contact intervention and of saturating classrooms with anti-stigma materials. Several aspects of social and psychological development led to target sixth-graders rather than younger children. Preadolescents begin to understand that others have thoughts and feelings different from their own, include interpersonal and psychological features in their understanding of themselves and others, and experience heightened social comparison (Ian, 2010).

Beyond augmenting a very small body of research, several strengths of the study allow it to meaningfully extend what can be concluded from the existing literature. Previous studies, like ours, employ a teacher-administered curriculum that does not entail extensive teacher training, suggesting that a relatively easily disseminated curriculum can reduce stigma. However, most of the previous studies rely on samples that involved teacher self-selection, allowing the possibility that effects will only be found when teachers favor an anti-stigma agenda.

Stigma associated with mental illness hurts social lives, lowers self-esteem and can even prevent people from seeking the care they need. Stigma is especially harmful to adolescents and young adults with mental illness, many of whom are not receiving treatment. Research has found that attitudes towards mental illness and stigmatizing behavior typically develop at a young age. Thus, efforts to fight stigma in schools by improving knowledge, attitudes and behaviors about mental illness are vital. Many studies have addressed different strategies to address stigma including curriculums, printed materials and presentations by people living with a mental illness (Farey, 2013).

Strategies based on curriculum changes were discussed in three articles. Strategies based on curriculum are defined as teaching staffs and students with and without mental disorders. mental health-related facts as part of the school's curriculum. According to Angermeyer (2003), reported that teaching a mental health class for a semester was effective to reduce stigma for students with schizophrenia. The project was designed to promote the knowledge of mental health for young people age between 14 and 18 and to reduce stigma toward people with schizophrenia. The study had 90 students in a secondary school setting who took the class for 3 months. The class included activities to interact with people with schizophrenia. The participated students' attitudes and behavior toward people with schizophrenia were measured through pre-test and post-test by asking the changes in stereotypes of people with schizophrenia and social distance, while a control group of students were asked the questions without taking classes. As a result, the students who took the class showed a significant decrease of negative stereotyping, and the changes maintained at the follow-up in a month later. The result of stigma reduction projects at the school showed a possible effective approach to increase acceptance of students with mental disorders and reduced negative stereotypes (Shulze et al., 2003).

2.1.3. Relationship between social stigma and the provision of inclusive education

Social stigma is defined by scientists as the disapproval of, or discontent with a person on the basis of characteristics that distinguish him or her from other members of society (Nobullying, 2015). Goffman (1963) defines social stigma as "the process by which the reaction of others spoils (blemishes) normal identity". Boundless (2015) sees social stigma as severe social disapproval of a person because of a particular trait that indicates his or her deviance from social norms. Without a society, one cannot have social stigma.

To have social stigma, one must have a social stigmatizer and someone who is socially stigmatized. Given that social stigma is a social relationship, the phenomenon (incident) places emphasis not on the existence of deviant traits, but on the perception and marking of certain traits as deviant by a second party. For example, theorists of stigma care little about whether someone has a stigmatizing attribute, but rather how others perceive the condition and subsequently treat the person differently. Social stigma is so profound that it overpowers

positive social feedback regarding the way in which the same individual adheres (abides) to other social norms (Boundless, 2015).

Children with disabilities face widespread stigma and discrimination based on deeply rooted negative perceptions about disability. These attitudes and beliefs reflect what is known as "ableism"; a value system that discriminates against people with disabilities based on the idea that certain ways of appearance, functioning and behavior are essential for living a life of value.

For too long, practitioners developing interventions to reduce stigma and discrimination against children with disabilities have been working in the dark. When it comes to changing behaviors, attitudes and social norms to make families, communities, schools, health care and social services truly inclusive of children with disabilities, there isn't much evidence of what works and what does not. As we especially don't know what leads to long term change, we risk wasting time and resources on programs that will not deliver sustainable results.

At the level of institutions like schools, a holistic approach is key to reducing stigma and discrimination and supporting real inclusion. Effective interventions create a shared vision and shared responsibility for inclusion among the entire school, as well as an institutional scaffolding to support changes in attitudes and behaviors. They address both supply and demand, helping to ensure that schools provide inclusive education, through everything from policies, regulations and budgets to curricula, teaching and facilities – while also supporting students, families and communities to abandon stigma and embrace inclusive education.

2.2. Empirical Review

A report by UNESCO (2008) states that the prices of IE and special education are the same, but the results at each institution were good. Inclusion allows CWD to grow in their families and livelihoods rather than in remote areas. Education is based on the principle of acceptance of all children, whatever their circumstances. Having a child with a disability at school without first giving him or her what he or she needs is far from a complete, balanced and

fulfilling task. IE means playing an active role in transforming traditional politics, culture and school performance. According to Seinfeld (2005), CWD students and their peers are more likely to be productive adults and to be included in their families. Research on human investment shows a significant loss of GDP in developing countries due to lack of education for people with disabilities and unemployment. The United Nations Department of Health (2011) estimates that the revenue loss to Bangladesh is estimated at $ 1.2 billion a year or 1.7% of the country's gross domestic product.

A study of 750 teachers and 400 parents from 75 provinces by Laurin-Bowie (2009) found that Education for All (EFA) is not a good option for CWD, especially for children with mental disabilities. The author described education as a process that requires a positive attitude and leads to good behavior, special teacher training, a simple curriculum and assessment methods, and a school environment.

The results of 20 studies by Laurin-Bowie (2009) showed poor development of all these factors, and the results were rooted in education. A global assessment of the quality of education. A study by Rieser (2012) found that despite good practice, there has been a failure to include CWD in EFA programs and a general belief that such efforts have been prevented by silencing international unrest. New ideas, such as thinking about education products on the global market, are becoming more popular, while those supporting collaboration and care are becoming more popular. Forlin's (2012) work confirms this view, although the author has been instrumental in the Hong Kong government's integration process, and has highlighted the development of independent education in Asia.

Just as the existence of education providers is based on economic activity, and their role is to make them more educated, there is no reason to seek out the aspirations of students who have a particular problem, which can be expensive and expensive. the Exam, along with the results. Similarly, Slee's (2011) study highlights the relationship between the World Bank (WB) economy and the IMF, as well as the growth of neo-conservatism and consumerism, and the barriers to education development that include everyone. However, the author stated that it is not uncommon for this behavior to be tolerated and overturned. An analysis by UNESCO

Bangkok (2009) of the four Asia-Pacific countries highlighted differences in interpretation and understanding of IE. In 2000, the government of Samoa conducted a survey to identify all outstanding students and to include SEN syllabuses at the National University of Samoa so that primary school teachers with SEN grades — the effort that followed was to establish six SEN departments in primary schools. the nature of education.

Numerous studies on Inclusive Education highlight that social cognitions and constructions underpin the stigmatization of learners with SEN (see Crocker, Major, and Steele 1998; Humphrey 2008). Humphrey (2008) uncovers the different negative and false constructions around autism. Consistent with Humphrey (2008), Salmon's (2013) study highlights how children with special needs stick together as a means of coping with the social exclusion that follows necessarily from being stigmatized. The awareness of being stigmatized and the stress of perceiving oneself as stigmatized may lead to low self-esteem and, ultimately, results in self-exclusion (O'Brien, 2000). Furthermore, studies highlight that the perceptions of those who stigmatize often translate to discriminatory behaviours which hinders the inclusion of the stigmatized learner (Hornby, 1999). Stigma is re-enforced by the individual's perceptions of self. Should the individual have low sense of self, they are not likely to participate actively in communal learning (Corbett, 2001). The implication is that learners with SEN are likely to be less productive if they perceive themselves or are perceived as being able to make little contribution to the wider society. Unfortunately, this has often been the case when it comes to how learners with SEN are perceived by others and by themselves in societies of both developing and developed countries (Miller, 2004).

The studies described so far measured the effect of several labels—mentally retarded, emotional/behavioral disability (or its earlier designation, emotionally disturbed), and learning disabled. In a more nuanced study by Levin, Arluke, and Smith (1982), 75 high school teachers were asked to evaluate a ninth grade student as described in a school psychologist's report. To vary the diagnostic labeling, a quarter of the teachers were told that the student was dyslexic, a quarter that he was emotionally disturbed, a quarter that he was mentally retarded, and a quarter that he had no disorder. In addition to the labeling information, half of the teachers were given a writing sample that was at grade level, and half were given a sample at

below grade level. To add another dimension, teachers were asked questions not only about their optimism regarding the student's academic success, but also about their willingness to offer services to help the student succeed (e.g., create special lessons, stay after school), as a measure of their expectations for their own behavior.

They found that only the emotionally disturbed label was significantly more negative regarding optimism for student success compared with the no label condition. In contrast with the findings about the labels, the student writing samples had a much greater impact on teachers' expectations for the student's success, with the below-grade-level sample adversely affecting expectations. Lastly, the study failed to uncover any significant main effects of labeling or student behavior (in the form of the writing sample) on teachers' estimation of their willingness to provide extra help. The researchers thus concluded that (a) not all labels have the same impact on teacher expectations; (b) student behavior may have a greater impact on teachers' expectations than do many labels; and (c) teachers' expectations can be adversely affected, while their classroom behavior may not be.

2.4. Theoretical Framework

This study is guided by the theory of social exclusion. The following gives details

2.4.1. Social exclusion theory

This study is based on the theory of social exclusion. According to Bayene & Tizazu (2011), it is a multidimensional process of strengthening social dislocation, separating groups and individuals from social contacts and institutions, and preventing them from participating fully in the normal, normative activities of social society. live in it. Therefore, this theory is useful to know whether it is possible to integrate students with disabilities, including VI students, into special schools. It becomes a barrier in special schools for VI students

Social exclusion is about the inability of our society to keep all groups and individuals within reach of what we expect as a society to realize their full potential (Berit & Miriam, 2001). To be excluded from society can take various relative senses but social exclusion is usually defined as more than a simple economic phenomenon: it also has consequences on the social, symbolic field. Social exclusion could be in the form of excluding from education, where a

central issue in placing a learner with a visual impairment is whether the necessary specialized training is best delivered in a special school. Students with visual impairments often need to learn special skills such as how to use special computer applications and any other materials to improve learners' academic performance.

Social isolation is the inability of our society to keep all groups and individuals within reach of what we expect as a society to reach its full potential (Berit & Miriam, 2001). Alienation from society can take on different relative meanings, but social alienation is usually defined as something more than just an economic phenomenon: it also has consequences for the social, symbolic sphere. Social exclusion can take the form of exclusion from education, where the central issue in finding a visually impaired student is whether it is best to provide the necessary special training in a special school. Visually impaired students often need to master special skills, such as using special computer programs and any other materials to improve students' academic performance.

Most theorists argue that social exclusion is a process, not just a condition that reflects the outcome of such treatment. However, only a few non-specialists, if any, reach the end of the expected trajectory. There are no formal "exclusion thresholds" that need to be crossed, for example, for low quality. Rather, while citizens are in a multidimensional range and can move to a detachment in one sense or another, or to a state of all-encompassing, collective social disintegration. This process, among other terms, is referred to as "social exclusion" or "disenfranchisement" and encompasses degradation as well as social isolation (Charlton, 2000).

Social isolation is a structural process, the removal of many dimensions of social participation. If such a shutdown were voluntary, again, it would be difficult to call it a "refusal." Instead, it requires vigorous coordination between the banned and the excluded. Inhibitors are agents that use specific mechanisms to push others out and deny access to resources and relationships. While it may seem that the excluded want to leave the community, they may do so in response to ill-treatment. Exceptions include loss of status, lack of recognition and often

humiliation. The shame of the socially alienated is crucial in the reports of those who go down (Davis, 2003).

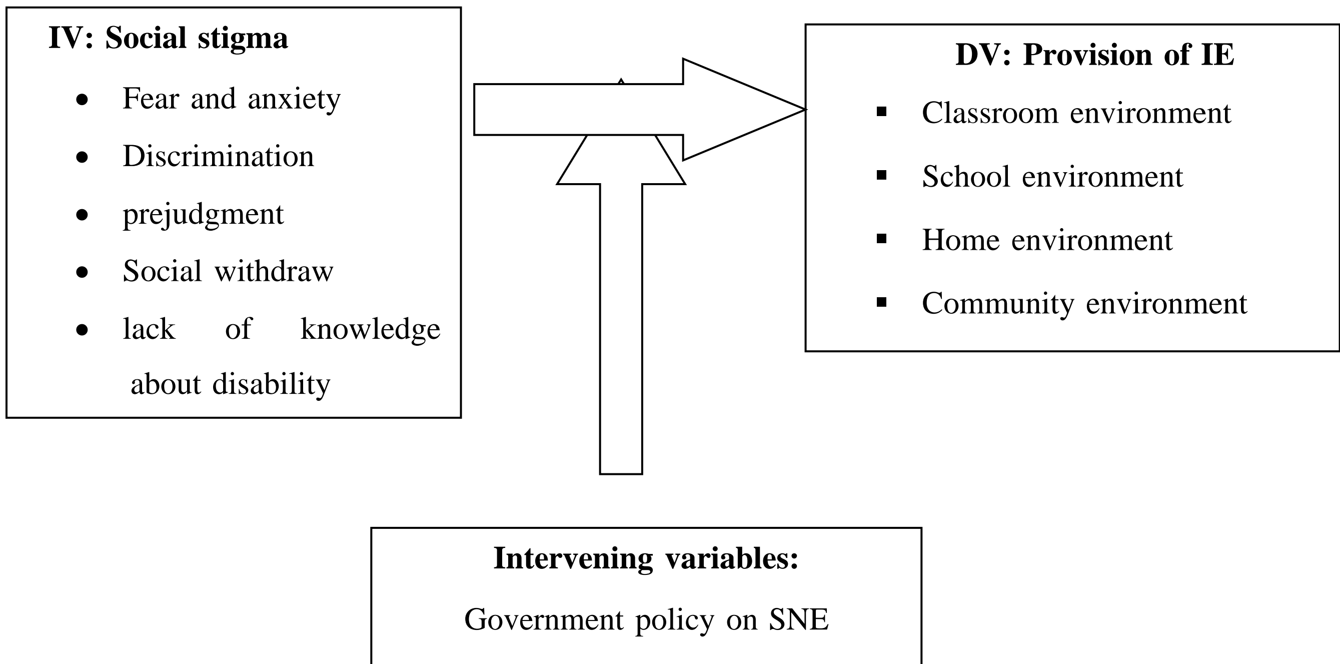
Therefore, this study will apply this theory, as it supports the idea of inclusion for students with disabilities and encourages the removal of barriers that prevent them from accessing quality education. Barriers to the theory of social exclusion have a strong impact on the academic performance of students with disabilities, and if these barriers are not removed, inclusion will never be realized.

2.4. Conceptual Framework

Inclusion is a most discussed phenomenon at our society. Children with disable needs, when they go to mainstream schools, face a lot of problems. One of them is stigma. Mainstream education is a key policy in the promotion of social inclusion (Scottish Executive, 2000; Department of Health 2002). Stigma is a complex term defined as a visible or invisible attribute, deeply discrediting, that disqualifies its bearer from full social acceptance, often resulting in several forms of discrimination (Goffman, 1963). There is evidence that different educational settings may expose children to different levels of stigmatized treatment. Due to their cognitive impairments, the social identities of intellectually disabled children can be devalued and depersonalized into stereotypic caricatures (Crocker et al 1998).

Stigma students with special needs is a complex issue with the capacity to affect all facets of a person's life, such as the opportunity to find housing and employment, enter higher education, obtain insurance, and get fair treatment in the criminal justice or children welfare systems (Everett, 2006; Charbonneau, 2007). Thus, stigma robs students with special needs of particularly important life opportunities vital to achieving life goals, obtaining competitive employment, and living independently in a safe and comfortable home (Corrigan and Kleinlein, 2005). The following conceptual framework gives details on how variables of this study are interacted between them.

Figure 2.1: Conceptual Framework



Source: Researcher, 2022

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CHAPTER THREE
RESEARCH METHODOLOGY

3.0. Introduction

This chapter describes the methodology used in this study, starting with the study design, the sample and the sampling techniques. It discusses the instruments used for data collection. It explains how the instruments are tested. This chapter deals with the study procedures, the way the data will be collected and analyzed, and ensuring the ethics of the study.

3.1. Research Design

According to Grinnell and Williams (2000), a research design is a plan used to answer research questions. A descriptive research plan was adopted in this study. A descriptive survey plan is a method of gathering information by surveying or completing a sample of individuals (Bryman & Bell, 2003). Descriptive research design was used to analyze data collected from a sample of questionnaires and interviews. This is due to the fact that both approaches are complementary, as qualitative methods provide detailed explanations, and quantitative - accurate data needed to achieve the desired goals.

3.2. Target Population

Each study has a target group from which information is collected about the phenomena being studied. Creswell (2003) refers to a population as an aggregate or unit of all objects, subjects, or members that meet certain definitions. This study was conducted on 184 persons, including people with disabilities, teachers, headteachers and parents.

Table 1. Table representing Target population

Categories	Population
Learners with disabilities	110
Teachers	76
Headteachers	2
Total	184

Source: Researcher, 2022

3.3. Sampling technique and sample size

3.3.1. Sampling Strategies

A purposive sample of 92 participants was selected based on some selected criteria, such as knowledge about the social stigmatization on provision of inclusive education. In addition, the researcher also used personal judgement to select those respondents (see Table 3.2 below).

Nyamabuye and Shyogwe sectors were purposively selected because those are sectors which have inclusive schools. Teachers and school administrators were also purposively selected because they were expected to be knowledgeable about social stigmatization and its impact on inclusive education. In this survey, a convenience sampling technique was used to obtain the right sample of respondents.

3.3.2. Sample size

In simple words, sampling technique or procedure the researcher would adopt in selecting items or individual for the sample; and due to resources constraints (time and money), the whole population cannot be covered consequently; sample size was chosen using the Taro Yamane formula:

$$nc = \frac{n}{1+\frac{n}{N}} = \frac{n}{\frac{N+n}{N}} = \frac{N.n}{N+n}$$

where nc $\frac{184 \times 96}{184+96} =$ 92

Where:

Nc is the adjusted minimum sample size

n is the minimum sample size =96

N is the total population = 184

A sample of 92 respondents was targeted to participate in this study. This formula was used to estimate a representative sample.

A total number of 92 respondents was taken as simple size.

Table 2. Table representing the sample size

Categories	Sample size
Learners with disabilities	52
Teachers	38
Headteachers	2
Total	92

Source: Researcher, 2022

3.4 Data Collection Methods

Data collection methods was done from Nyamabuye and Shyogwe sectors. Data were collected through data collection form and with an opened and closed questions by the use of an administered questionnaire. The sample size was 92. After the necessary data being collected and entering into a computer, they were running through Excel for analytical purpose.

The collection form clearly focused on the point of interests. In order to construct the theoretical part, a number of books and online resources were consulted and referred to. With the use of data questionnaire, data were taken from Nyamabuye and Shyogwe sectors and were filled by the researcher.

3.5.Data Collection Instruments

These are methods that are utilized to get the data needed on the topic (Roger, 2003). In order to find effective information that was eventually led to suitable answers, the following methods were used.

3.5.1. Interview guide

Unstructured interview was used in order to enrich data from questionnaire. Thus, respondents were asked questions about perceptions on social stigma on the provision of inclusive

education at the selected schools in Nyamabuye and Shyogwe sectors in Muhanga District. The researcher scheduled an interview with the head teachers of the two selected schools in Nyamabuye and Shyogwe sectors in Muhanga District.

3.5.2. Administered Questionnaire

Questionnaires were also being used purposely to elicit relevant information. In this technique, the researcher used a series of questionnaires used in Likert scale. All questions set were administered to the learners and teachers of two selected schools in Nyamabuye and Shyogwe sectors in Muhanga District.

3.6.Administration of Data Collection Instruments

The data collection form and administered questionnaire were given to each learners with disabilities and teachers from two selected schools in Nyamabuye and Shyogwe sectors in Muhanga District taken as our sample size. The data collection form was filled by the researcher.

In the interview guide, the researcher ensured that the same general areas of information were collected from each interviewee; this provides more focus than the conversational approach, but still allowed a degree of freedom and adaptability in getting information from the interviewee. Qualitative interview was given to the head teachers of two selected school one in Nyamabuye and another one in Shyogwe sectors in Muhanga District.

Qualitative and quantitative data were obtained, descriptive analysis like frequencies, tables, graphs, and percentage were used in data presentation; content analysis , Excel was used to analyse data. After data manipulation, the researcher analysed data following objective per objective.

3.7. Data Analysis Procedures

Without proper analysis of the data collected, the entire research process would have been wasted (Bryman & Bell, 2003). Data analysis as a process of inspecting, refining, modifying and modeling data with the aim of finding useful information, proposing conclusions and supporting decision-making (Creswel, 2003).

At every stage of analysis, data cleaning, computations, coding and analyses were done by the use of statistical methods. The data from questionnaire were analysed in order to get information on quantitative data and were focused mostly on perceptions of social stigma on the provision of inclusive education in two selected schools in Muhanga District. It is during the quantitative data analysis that the researcher was inevitably attempt to test the research questions which were formulated for the researcher study. This was done by the first defining research questions and setting the parameters for the study. The researcher selected an appropriate test based on the variables defined in the study and on whether the distribution was normal or not.

3.8. Validity and Reliability

According to Byne (2002), validity and reliability are very important for all meaningful scientific research. This is because they help to ensure the reliability and validity of the research results themselves. The validity of a measurement tool is considered to be the extent to which the tool measures what it claims to measure; while reliability refers to the extent to which an assessment tool produces stable and consistent results (Creswell, 2003). To ensure that the tools used were valid and reliable, a few respondents underwent pre-testing and the tools were validated accordingly.

3.9. Ethical Considerations

Ethical issues were addressed by obtaining research approval from the University of Rwanda. This letter was submitted to various authorities (institutions) to allow me access to the data required for this study. This study should not conflict with ethical principles, including the obligation to avoid harming or embarrassing participants and to respect their privacy. The researcher should ask himself/herself whether the study is ethically appropriate in terms of values and the steps to be taken to achieve these values. To this end, the researcher takes a number of measures to comply with ethical standards throughout the research process. While the benefits are related to the finalist student's compliance with the university requirements to conduct the research, the challenges of participating in this research are related to the time frame and the difficulty of obtaining the necessary information to achieve the goal.

The dean of the faculty provided the researcher with a letter of recommendation explaining the rationale for conducting the study in order to obtain the information needed by the organisation being studied; formal permission was required from each interviewee before interviewing them or starting any discussion; participants were informed that they had the right to refuse to participate in the study; Participants signed informed consent forms; participants guaranteed the confidentiality of any information provided and that it would only be used for research purposes; we utilised participants' anonymity by coding them rather than naming them; we protected their privacy by meeting them at a location of their choice. Before interacting with the employees, I obtained permission in the form of a written request from the relevant authorities of the surveyed schools.

CHAPTER FOUR
RESEARCH FINDINGS AND DISCUSSIONS

4.0 Introduction

This chapter presents, analyses and discusses the results collected in the field. The purpose of the study was to analyze the perceptions of social stigma on the provision of inclusive education in Rwanda. A case of selected sectors in Muhanga district. This study was guided by three research objectives, namely: to assess the causes of social stigma in Muhanga District; to examine the role of teachers in stigma reduction in Muhanga District and to establish the relationship between social stigma and the provision of inclusive education in Muhanga District.

Findings were collected using questionnaire and interview. Those instruments were important to provide a wealth of information for the analysis of perceptions of social stigma on the provision of inclusive education in Rwanda. To present the findings, respondents were supposed to respond on questionnaire in order to preserve the originality of the data collected. The results are presented in accordance with the objectives of the study. In each section, the data were first presented and then the findings were discussed in relation to the theoretical approach and literature reviewed

4.1. Demographic characteristics of respondents

The research established the gender, age of the respondents, education levels; terms of areas of employment and the results were combined in one table 3 as shown of respondents

In this section, respondents provided the socio-demographic information including gender, age, marital status, year experience in teaching of the participants.

Table 3 Demographic Characteristics of the Sample

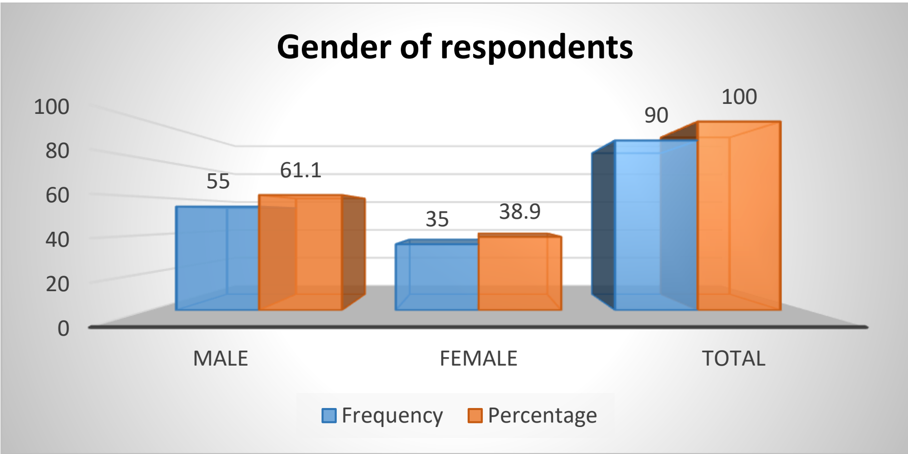
Section	Category	Frequency	Percentage
Gender	Male	55	61.1
	Female	35	38.9
	Total	**90**	**100.0**
Age of respondents	Below 11 years	0	0
	12-16 years	10	11.1

	17-21 years	40	44.4
	22-26 years	19	21.1
	27-31 years	14	15.5
	32 Above	7	7.8
	Total	**90**	**100.0**
Year of study			
	LFK	3	5.7
	EKK	3	5.7
	Senior 4 HEG	5	9.6
	Senior 5 HEG	9	17.3
	Senior 6 HEG	32	61.5
	Total	**52**	**100**
Teaching experience	Below 3 years	5	9.6
	4-6 years	8	15.3
	7-9 years	36	69.2
	10 years above	3	5.7
	Total	**52**	**100**

Source: Researcher, 2022

Table 4.3 indicated that the gender composition of the respondents, 61.1% of them were males and 38.9% of them were females. The number of males is slightly greater than number of females. However, the difference in number does not affect the reliability of the data. The following figure indicates the gender of respondents.

Figure 1: Gender of respondents

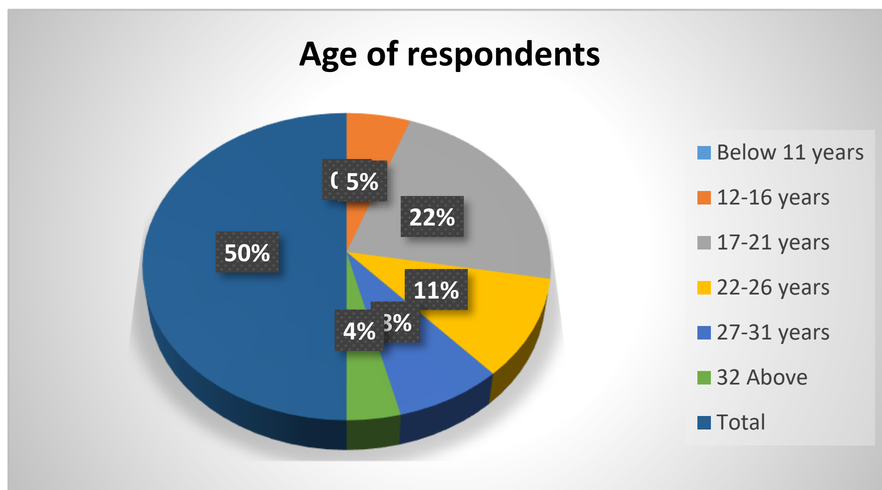


Source: Primary data, 2022

Moreover, on the table 3, the study revealed that the majority of the respondents i.e., 44.4% were between 17 to 21 years old and 11.1% were between the age group of 12 and 16

whereas 21.1% were between 22 to 26. Besides, 15.5% were between 27 and 31. Finally, there was a small portion of 7.8% who were above 32 years old. The following figures highlights age of respondents:

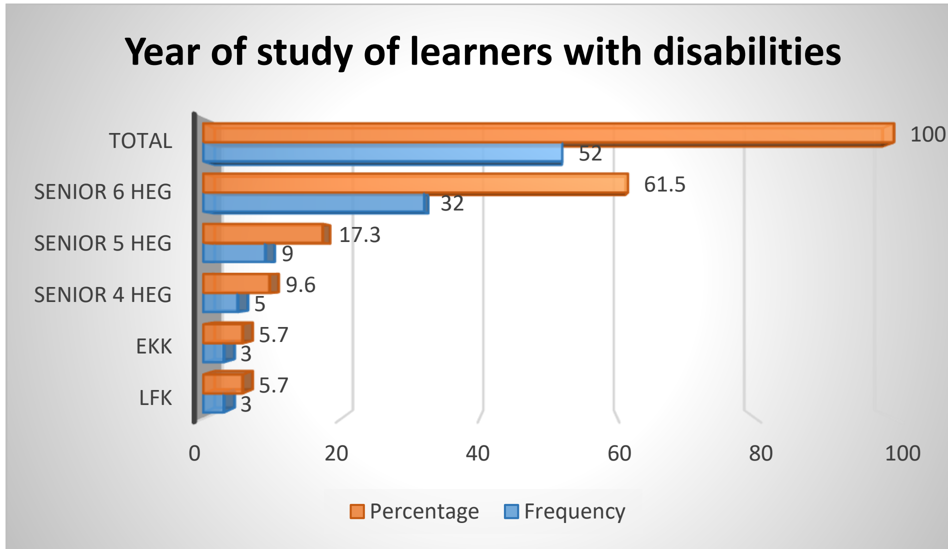
Figure 2: Age of respondents



Source: Primary data, 2022

Furthermore, the table 3 above also indicates the year of study of learners. The majority of them are in Senior 6 HEG with 61.5% of respondents, respectively 17.3% are in Senior 5HEG, 9.6% were in LFK, 5.7% were in EKK and lastly 5.7% are senior 4 HEG. The following is the figure which indicates. The figure below gives a clear picture of year of study for students with disabilities in two selected schools from Nyamabuye and Shyogwe sectors.

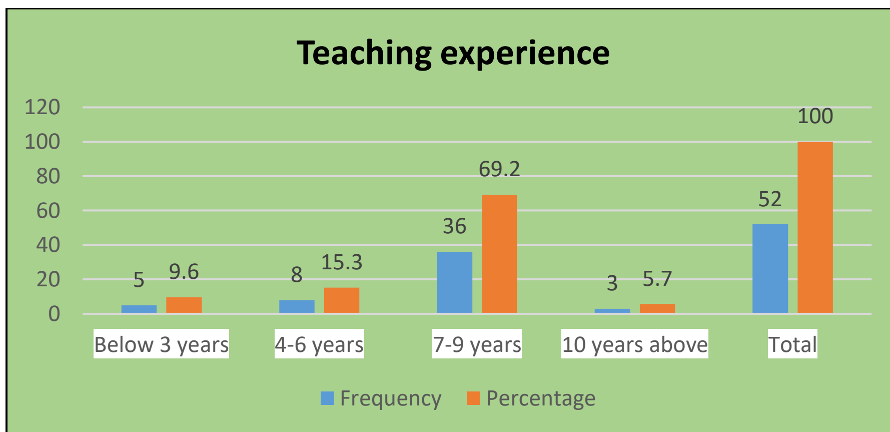
Figure 3: Year of study



Source: Primary data, 2022

Besides, Table 3 also highlights the teaching experience of respondents. The researcher found that the majority of them (69.2%) have an experience between 4 to 6 years, 15.3% rated with experience between 4 to 6 years, 5.7% of respondents have an experience of more than 10 years in teaching inclusive school and only 5 respondent represented by 9.6% have an experience in teaching special school which is under 3 years. The figure below gives also details.

Figure 4. Teaching experience of learners with disabilities



Source: Primary data, 2022

4.2 Presentation of the Findings

The research work was conducted on the perceptions of social stigma on the provision of inclusive education in Muhanga District. This section deals with the presentation and analysis of the research data and discussion of findings. These are presented in tables following the sequence of the specific research problem.

4.2.1. Causes of social stigma in Nyamabuye and Shyogwe sectors

Stigma is often due to lack of understanding or fear. Both factors are due to the media presenting a false or misleading picture of mental illness. The following tables provide details:

Table 4: Level of agreement on the causes of social stigma

Statements	**SA**	**A**	**N**	**D**	**SD**
	Freq (%)	Freq (%)	Freq (%)	Freq (%)	Freq (%)
Lack of awareness	36 (39)	30 (32)	9 (5)	10 (11)	11 (13)
Lack of education	46 (49)	38 (40)	1 (1)	5 (7)	0 (0)
Lack of perception	44 (47)	27 (28)	8 (9)	6 (6)	8 (10)
Nature and complications of the mental illness	29 (31)	42 (45)	7 (8)	6 (7)	8 (9)

Source: Researcher, 2021

The results in Table 4 shows that 39% (36) of the participants strongly agreed, 32% (30) agreed, 5% (5) were not sure, 11% (10) disagreed and 13% (12) strongly disagreed. Besides, 11% of respondents disagreed and 13% strongly agreed indicate that lack of awareness is one of the major causes of social stigma. Several studies show that stigma usually arises from lack of awareness, lack of education, lack of perception, and the nature and complications of the mental illness, for example odd behaviors and violence.

Besides, the results in Table 4 also show that 49% participants strongly agreed, 40% agreed, 1% were unsure, 7% disagreed and 3% strongly agreed with the statement that lack of

education also causes social stigma. As the majority (89%) agreed and strongly agreed, this means that lack of education contributes significantly to social stigma. Moreover, lack of perception as indicates in table 4 is another cause of social stigma as highlighted by the results. A number of 44 (47%) strongly agreed, 28% agreed, 9% were not sure, 6% disagreed and 10% strongly disagreed with the statement that social stigma is caused by a lack of perception. Given that the majority of respondents (47%) strongly agreed or agreed with the statement, this implies that lack of perception is an important factor contributing to social stigma.

Lastly Table 4 shows that nature and complications of the mental illness is also a cause of social stigma. The majority of respondents strongly agreed (31%) and agreed (45%) that statement but 8% were undecided, respectively 7% disagreed and 9% strongly disagreed that statement.

During the interview done with the headteacher A, on that point he stated:

"Social stigmatization is the extreme disapproval of a person or group in terms of various characteristics that distinguish an individual from other members of a community. Social stigma can be based on the perception of mental illness as well as various other characteristics such as skin color, ethnicity and sexual orientation."

Another headteacher B asserted:

"Social stigma is the extreme disapproval of a person or group regarding various characteristics that distinguish an individual from other members of a society. Social stigma can result from the perception of mental illness, as well as various other characteristics, such as skin color, ethnicity, and sexual orientation"

From the findings of Table 4, the results revealed that the causes of social stigma in Nyamabuye and Shyogwe sectors are associated with lack of awareness, lack of education, lack of perception and nature and complications of the mental illness.

Peters (2005) fully supports this in his study on stigma and integration. The main contributor to stigma is the lack of education about mental illness. Often there are no physiological signs to explain the condition, leading to the individual and/or family being blamed for their problems. These findings are in line with Gander (2011) who argues that education is uniquely and significantly associated with both physical and mental health, meaning that lower levels of education are associated with poorer health outcomes. Individuals with low levels of education are more likely to be depressed and smokers.

These findings are in line with (Dan) who pointed out that the causes and consequences of stigmatisation are often indistinguishable and lead to prejudices that influence attitudes, which in turn perpetuate prejudice. In this context, both self-stigmatization and perceived stigmatisation contribute significantly to outcomes that include changes in family and community attitudes. Much of the impact of stigma can be explained by the concepts of self-stigma and perceived stigma, which are defined as domains of stigma that can be categorized as personal, social, familial, medical and treatment of illness. Perceived stigma refers to how individuals perceive stigmatisation, which in turn affects their coping styles (Byrne, 2001). This is probably the reason why the consequences of stigmatisation are individualized.

This is also consistent with Thera et al. (2005) who point out that stigma associated with schizophrenia is particularly high in India. Schizophrenia-related stigma and discrimination was found to have a significant impact on the lives of these individuals in a study examining patients' perceptions of stigma. In terms of perceived causes of stigmatisation, it was reported that a strikingly high proportion of participants (97%) believed that stigmatisation was due to lack of knowledge about schizophrenia, followed by the nature of the illness (73%). Behavioural symptoms associated with schizophrenia are also thought to cause stigma, while medication-related complications are thought to play a less influential role in stigmatisation. 69% of patients think that stigmatisation is caused by attitudes from the general community, 46% from co-workers and 42% from family members (Srivastava et al., 2011).

4.2.3. Role of teachers in reducing stigma in Nyamabuye and Shyogwe sectors

Reducing the stigma surrounding mental health in schools is important to both the students in the classroom, but also, the wider school community. The following tables gives details on how teachers plays big role in reducing stigma at school:

Table 5: Level of agreement on role of teachers in reducing stigma

Statements	SA	A	N	D	SD
	Freq (%)	Freq (%)	Freq (%)	Freq (%)	Freq (%)
Advocating for social inclusion	9 (10)	18 (19)	10 (11)	31 (34)	22 (23)
Awareness raising	8 (9)	20 (22)	8 (9)	28 (30)	27 (28)
Application of inclusive teaching methods	9 (10)	9 (10)	19 (21)	18 (20)	36 (37)
Identification of learners with disabilities	10 (11)	21 (23)	7 (8)	23 (25)	29 (32)

Source: Researcher, 2021

Table 4. shows the level of agreement on role of teachers in reducing stigma. As indicated by the table above 10% strongly agree, 19% agree, 11% are unsure, 34% disagree and 26% strongly disagree that one of the roles of teachers is to promote social inclusion in schools. The majority of respondents disagreed and strongly disagreed (57%), suggesting that teachers in Nyamabuye and Shyogwe sectors in Muhanga District are not promoting social inclusion in their schools.

Furthermore, the table also show that 9% of participants strongly agreed, 22% agreed, 8% were unsure, 30% disagreed, and 31% strongly disagreed with the statement that teachers conduct awareness activities. The fact that the majority of respondents (58%) disagreed and strongly disagreed is an indication that teachers in Nyamabuye and Shyogwe sectors do not have awareness. This implies that teachers across the district need to become aware of their role in creating awareness among the public.

The survey results presented in Table 4. shows that 10% of the participants strongly agreed, 10% agreed, 8% were unsure, 30% disagreed and 31% strongly disagreed that teachers do not

apply inclusive teaching methods for those learners who have stigma. With the majority of participants disagreeing or strongly disagreeing (61%), this indicates that teachers are not applied any teaching methods to help them in studying. This implies that there is a need to sensitize all teachers in the district to take up their role in educating learners with disability especially those with stigma.

Further, on the statement regarding identification of learners with disabilities, the table 4 highlights
that 11% of the participants strongly agree, 23% agree, 8% are undecided, 25% disagree and 32% This means that a big percentage of 57% strongly agreed and agreed that the teachers always not identified easily the students with disabilities suffering from stigma in the classroom.

During the interview done with the headteacher A from Nyamabuye sector on role of teachers in reducing stigma, he argued:
"A few teachers were aware of the presence of students with disabilities and/or special educational needs and how to provide appropriate education. Moreover, ignoring or not taking into account learning difficulties contributes to students' needs not being met in schools. Consequently, this hinders the realization of universal primary education and equal educational opportunities"

Another headteacher B from Shyogwe sector asserted:
"Creating opportunities to talk about mental health is an important part of raising awareness and improving knowledge, as is combating stigma. It could be a quick referral to encourage people to attend a stress management session on offer, or it could be a deliberate organized staff wellbeing initiative that runs for a whole week"
From the findings above, the study revealed that the teachers do not play well the role in reducing stigma in Nyamabuye and Shyogwe sectors in Muhanga District as he does not advocate for social inclusion and all the teachers in Muhanga Disctrict but especially in Nyamabuye and Shyogwe sectors should sensibilize to embrace their role of carrying out awareness raising among population. Furthermore, teachers do not also apply even teaching

methods for learners with disabilities as it is sometimes difficult for them to identify learners with disabilities.

Corrigan and O'Shaughnessy (2007) echo the same sentiment in their findings. These findings are in line with an international study conducted in 2008 with almost 1 200 head teachers from 27 countries, including Canada, which confirmed the important role that schools can play in supporting pupils with mental health problems. Most of the principals surveyed consider emotional/mental health and well-being to be "very important" for academic success and, consistent with other international research in this area, estimate that about one-fifth of their students need prevention or intervention services (Rowling et al., 2012).

4.2.4. Relationship between social stigma and provision of IE

Mainstream education is an important policy for promoting social inclusion (Scottish Executive, 2000; Department of Health 2002). However, few studies have compared the perceptions of young people with intellectual disabilities (ID) when they leave mainstream school with segregated education. There is evidence that different educational settings may expose children to different levels of stigmatization. Because of their cognitive disabilities, the social identities of children with ID may be devalued and depersonalized into stereotypical caricatures (Crocker et al. 1998). This can lead to the stigmatized individual being treated differently and systematically excluded, ridiculed and marginalized. The following tables and correlation analyses provide details on the relationship between social stigma and provision of IE.

Table 6: Level of agreement on relationship between social stigma and inclusive education

Statements	SA	A	N	D	SD
	Freq (%)	Freq (%)	Freq (%)	Freq (%)	Freq (%)
Social stigma lowers self-esteem	16 (18)	15 (16)	15 (16)	25 (27)	25 (27)
Social stigma affects ability of inclusive education	13 (14)	13 (14)	11 (12)	31 (30)	23 (24)

Source: Researcher, 2021

The results in Table 4.12 show that 18% of the participants strongly agreed, 16% agreed, 16% were not sure, 27% disagreed and 27% strongly disagreed with the statement that social stigma decreases self-esteem. The majority of respondents (54%) disagreed and strongly disagreed that social stigma does not decrease self-esteem, as previously assumed. Furthermore, Table 6 shows that 14% of respondents strongly agree, 14% agree, 12% are note sure, 30% disagree and 27% strongly disagree that social stigma has a negative impact on the ability of inclusive education. As the majority of respondents (54%) disagree or strongly disagree this implies that social stigma does not have a positive impact on the ability on inclusive education.

During the interview done with the headteacher A from Nyamabuye sector, he stated:

"In general, the population of students identified with LD tends to meet these stigmatising conditions; however, the experience of stigma is not uniform within a stereotypical group). Rather, "individuals' perceptions of the likelihood of being stereotyped, their awareness of stigma, vary and this variation is associated with differences in the degree of negative impact of stigma and stereotyping". Just as emphasis has been placed on understanding the heterogeneity of the nature of learning and social-emotional challenges within the population with intellectual disabilities, experiences of stigmatisation are also not uniform".

These findings concur with Pascoe (2004) who conducted a study and came out with the same findings and stated that there is strong empirical evidence that inclusive classrooms are more conducive to the social, behavioural and academic success of students with disabilities. A study that examined eight pairs of students with disabilities in general and special education classes found that students observed in general education classes showed significantly higher levels of communicative interaction than their peers in special education classes (Foreman, Arthur-Kelly & Pascoe, 2004). Furthermore, communication with class assistants and peers increased, facilitating positive interactions and the development of social skills. These findings are confirmed by the two-year longitudinal study conducted by Fisher and Meyer in 2002 on 40 students with LD. According to this evidence, inclusive classes are more conducive to the social-emotional learning of students with disabilities than special education classes.

Table 7: Relationship between social stigma and Inclusive Education

Correlations			
		Social stigma	Inclusive education
Social stigma	Pearson Correlation	1	.823**
	Sig. (2-tailed)		0.000
	N	90	12
Inclusive education	Pearson Correlation	.823**	1
	Sig. (2-tailed)	0.000	0
	N	90	90
**. Correlation is significant at the 0.01 level (2-tailed).			

The results presented in Table 7 show the correlation between the variables. There is a significant, strong and positive correlation between social stigma and inclusive education ($r = 0.823$ and $p = 0.000$ respectively). This means that social stigma affects the provision of inclusive education by 82.3%.

This is in line with Patrick (2016) who stated that stigma against persons with disabilities leads to exclusion from society and as a result, persons with disabilities are excluded from development programs that are intended to improve a person's quality of life and future. "Inequality not only leads to exclusion and discrimination, but combined with the widespread lack of social protection measures, it almost inevitably leads to people with disabilities (and

their families) ending up in life-threatening situations of poverty and extreme poverty". This leads to continued exclusion and lack of access to essential services for development, increasing vulnerability and reinforcing the cycle of poverty.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter includes: Summary of the findings, conclusions, recommendations and the area of further study. It provides a summary of the study findings on the following three study objectives: (i) to assess the causes of social stigma in Muhanga District; (ii) to examine the role of teachers in stigma reduction in Muhanga District; and (iii) to establish the relationship between social stigma and the provision of inclusive education in Muhanga District. It also gives conclusions and recommendations.

5.1 Summary of the Findings

5.1.1 Causes of social stigma in Nyamabuye and Shyogwe sectors in Muhanga District

From the findings, the study revealed the level of agreement by indicating that 49% participants strongly agreed, 40% agreed, 1% were unsure, 7% disagreed and 3% strongly disagreed with the statement that lack of education also causes social stigma. As the majority (89%) agreed and strongly agreed, this means that lack of education contributes significantly to social stigma. Moreover, lack of perception as indicated in table 4 is another cause of social stigma as highlighted by the results. A number of 44 (47%) strongly agreed, 28% agreed, 9% were not sure, 6% disagreed and 10% strongly disagreed with the statement that social stigma is caused by a lack of perception. Given that the majority of respondents (75%) strongly agreed or agreed with the statement, this implies that lack of perception is an important factor contributing to social stigma.

Lastly the study also indicates that nature and complications of the mental illness is also a cause of social stigma. The majority of respondents strongly agreed (31%) and agreed (45%) that statement but 8% were undecided, respectively 7% disagreed and 9% strongly disagreed that statement. These findings are in line with (Dan) who pointed out that the causes and consequences of stigmatization are often indistinguishable and lead to prejudices that influence attitudes, which in turn perpetuate prejudice. In this context, both self-stigmatization and perceived stigmatization contribute significantly to outcomes that include changes in family and community attitudes. Much of the impact of stigma can be explained by the concepts of

self-stigma and perceived stigma, which are defined as domains of stigma that can be categorized as personal, social, familial, medical and treatment of illness. Perceived stigma refers to how individuals perceive stigmatization, which in turn affects their coping styles (Byrne, 2001). This is probably the reason why the consequences of stigmatization are individualized.

5.1.2. Role of teachers in stigma reduction in Nyamabuye and Shyogwe sectors in Muhanga District

Findings from the study revealed the level of agreement on role of teachers in reducing stigma. As indicated by the findings 10% strongly agree, 19% agree, 11% are unsure, 34% disagree and 26% strongly disagree that one of the roles of teachers is to promote social inclusion in schools. The majority of respondents disagreed and strongly disagreed (60%), suggesting that teachers in Nyamabuye and Shyogwe sectors in Muhanga District are not promoting social inclusion in their schools.

Furthermore, the table also show that 9% of participants strongly agreed, 22% agreed, 8% were unsure, 30% disagreed, and 31% strongly disagreed with the statement that teachers conduct awareness activities. The fact that the majority of respondents (58%) disagreed and strongly disagreed is an indication that teachers in Nyamabuye and Shyogwe sectors do not have awareness. This implies that teachers across the district need to become aware of their role in creating awareness among the public. The survey results presented in Table 4. shows that 10% of the participants strongly agreed, 10% agreed, 8% were unsure, 30% disagreed and 31% strongly disagreed that teachers do not apply inclusive teaching methods for those learners who have stigma. With the majority of participants disagreeing or strongly disagreeing (61%), this indicates that teachers are not applied any teaching methods to help them in studying. This implies that there is a need to sensitize all teachers in the district to take up their role in educating learners with disability especially those with stigma.

Furthermore, on the statement regarding identification of learners with disabilities, the table 4 highlights that 11% of the participants strongly agree, 23% agree, 8% are undecided, 25% disagree and 32% strongly disagree, this means that a big percentage of 57% strongly

disagreed and disagreed that the teachers always do not identify easily the students with disabilities suffering from stigma in the classroom. These findings are in agreement with Corrigan and O'Shaughnessy (2007) echo the same sentiment in their findings. These findings are in line with an international study conducted in 2008 with almost 1200 head teachers from 27 countries, including Canada, which confirmed the important role that schools can play in supporting pupils with mental health problems. In addition, the results also show that 18% of the participants strongly agreed, 16% agreed, 16% were not sure, 27% disagreed and 27% strongly disagreed with the statement that social stigma decreases self-esteem.

5.3. The relationship between social stigma and the provision of inclusive education in Muhanga District

From the findings, the study revealed that the majority of respondents (54%) disagreed and strongly disagreed that social stigma does not decrease self-esteem, as previously assumed. Furthermore, the findings revealed that 14% of respondents strongly agree, 14% agree, 12% are note sure, 30% disagree and 27% strongly disagree that social stigma has a negative impact on the ability of inclusive education.

As the majority of respondents (54%) disagree or strongly disagree this implies that social stigma does not have a positive impact on the ability on inclusive education. Besides, the findings also revealed the correlation between two variables which are social sigma and inclusive education. The study revealed that there is a significant, strong and positive correlation between social stigma and inclusive education ($r = 0.823$ and $p = 0.000$ respectively). This means that social stigma affects the provision of inclusive education by 82.3%.

These findings concur with Patrick (2016) who stated that stigma against persons with disabilities leads to exclusion from society and as a result, persons with disabilities are excluded from development programs that are intended to improve a person's quality of life and future. "Inequality not only leads to exclusion and discrimination, but combined with the widespread lack of social protection measures, it almost inevitably leads to people with disabilities (and their families) ending up in life-threatening situations of poverty and extreme

poverty". This leads to continued exclusion and lack of access to essential services for development, increasing vulnerability and reinforcing the cycle of poverty.

5.2 Conclusion

The research finding revealed that the cause of sigma in Muhanga District is linked with lack of awareness, lack of education and lack of perception and nature and complications of the mental illness. Secondly from the findings, the study concluded that the teachers have different role in reducing social stigma such as advocating for social inclusion, awareness raising which was not done properly in Muhanga District. Besides, another role is application of inclusive teaching methods and identification of learners with disabilities. Lastly, the study also concluded that There is a significant, strong and positive correlation between social stigma and inclusive education. This means that social stigma significantly impacts on inclusive education. The findings of the study show that there is a strong positive relationship between social stigma and the provision of inclusive education in Muhanga district.

5.3 Recommendations

Based on the findings, the following recommendations are suggested:

- The teachers from Muhanga District should be sensitized and awareness campaigns organized on the role that social stigma plays in hindering inclusive education so that all children including those with disabilities and/or special educational needs can easily access quality education.

- The teachers should be aware of how to identify learners with social stigma so that they can be helped before starting and till the end of the lesson

- To know the cause of social stigma of a student should help the teacher to follow him in every day’s teaching and learning activities

- As it has been highlighted by the findings, social sigma affects inclusive education, thus the government after knowing that problem, should try to look for solutions

especially for Muhanga District teachers by giving them training which would help them in changing attitudes toward social stigma of learners with disabilities

5.4 Suggestions for Further Studies

There is a need for a nationwide survey with a larger sample size to help understand the real scope of the phenomenon of social stigma on the provision of inclusive education.

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APPENDICES

APPENDIX 1: QUESTIONNAIRE FOR TEACHERS AND LEARNERS WITH DISABILITIES

Please complete the questionnaire by responding to all questions. Information that you give will be kept confidential and will be used for the purpose of this study to improve education of students with disabilities in Rwanda.

Section A (Personal information):

Please tick where appropriate

1. Age:

16 years - 20years ☐

21yrs - 30years ☐

31 years - 35 years ☐

36years and above ☐

2. Gender: Female ☐ Male ☐

3. Teaching experience Below 3 years ☐

4-6 years ☐

7-9 years ☐

Over 10 years ☐

4. Academic qualifications:

a) A1
b) A2
c) A0

Section B

1) How would you promote inclusive practices in your school?

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2) Do you think that your school level educational program prepared you to implement inclusion in the general education classroom?

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3) How teachers can make their classrooms more accessible for students with disabilities

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4) Do you think training teachers on inclusion should better prepare them to manage inclusion in the general education classroom?

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5) What specific kinds of resources do you think might be helpful for teachers and paraprofessionals in the efforts to implement inclusion in the general education classroom?

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SECTION B: CAUSES OF SOCIAL STIGMA IN MUHANGA DISTRICT

*N.B: Tick (√) the right statement using **1**=Strongly Agree; **2**=Agree; **3**=Not sure; **4**=Disagree; **5**=Strongly disagree*

S/N	Statements	1	2	3	4	5
1	Lack of awareness					
2	Lack of education					
3	Lack of perception					
4	Nature and complications of the mental illness					

SECTION C: ROLE OF TEACHERS IN STIGMA REDUCTION IN MUHANGA DISTRICT

*N.B: Tick (√) the right statement using **1**=Strongly Agree; **2**=Agree; **3**=Not sure; **4**=Disagree; **5**=Strongly disagree*

S/N	Statements	1	2	3	4	5
1	Advocating for social inclusion					
2	Awareness raising					
3	Application of inclusive teaching methods					
4	Identification of learners with disabilities					

SECTION D: RELATIONSHIP BETWEEN SOCIAL STIGMA AND PROVISION OF IE IN MUHANGA DISTRICT

*N.B: Tick (√) the right statement using **1**=Strongly Agree; **2**=Agree; **3**=Not sure; **4**=Disagree; **5**=Strongly disagree*

S/N	**Statements**	**1**	**2**	**3**	**4**	**5**
1	It lowers self-esteem					
2	It contributes to disrupted family relationships					
3	It adversely affects the ability to socialize, obtain housing, and become employed.					
4	It adversely affects the ability to socialize,					
5	It adversely affects the ability to obtain housing					
6	It adversely affects the ability to become employed					

Thank you

INTERVIEW GUIDE FOR TEACHERS

1) How would you promote inclusive practices in your school?

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…………………………………………………………………………………………………
…………………………………………………………………………………………………

2) Do you think that your school level educational program prepared you to implement inclusion in the general education classroom?

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3) What causes social stigma in Muhanga District?

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…………………………………………………………………………………………………
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4) What role do teachers play in stigma reduction in Muhanga District?

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5) What is the relationship between social stigma and the provision of inclusive education in Muhanga District?

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6) Do you make follow up on the ways the teachers are teaching the students suffering from stigma within your institution?

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………………………………………………………………………………………………
………………………………………………………………………………………………

7) What do the teachers do in order to help them?

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………………………………………………………………………………………………
………………………………………………………………………………………………

UNIVERSITY of RWANDA

COLLEGE OF EDUCATION

School of Inclusive and Special Needs Education

OFFICE OF THE DEAN

TO WHOM IT MAY CONCERN

Dear Sir/Madam

Re: Ethical clearance for Mr NTIRENTIRWA Theophile

The School of Inclusive and Special Needs Education offers Masters in Special Needs Education, and as part of the academic requirements, students are expected to conduct field studies and write a dissertations on topics of their choice.

The purpose of present letter therefore, is to seek your cooperation in allowing the above named student to conduct his/her research, and/or facilitate his/her data collection in your Institution/Organization:

"Effect of social stigma on the provision of inclusive education ..."

In case you require any other information regarding this exercise, you are welcome to contact the School of Inclusive and Special Needs Education on the address below.

Thank you for your cooperation

Sincerely yours

Done at UR-CE on 18th /03/2021

Signed

Dr. Evariste Karangwa
Dean School of Inclusive and Special Needs Education
Email: mugorehy1@yahoo.com, **habinshutihgo@gmail.com**
Tel :(+250) 788755285, 0785489767, **0788809234**