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Impact of Categorisation of Persons with Disability on Their Participation in Government Development Programmes in Rwanda

Mukazayire Christine
Student, Department of Business Administration, School of Human Resource Development,
Jomo Kenyatta University of Agriculture and Technology, Kigali Campus, Kenya
Mbabazi Mbabazize
Lecturer, Department of Agricultural Science, School of Agriculture and Applied Economics
Jomo Kenyatta University of Agriculture and Technology, Kigali Campus, Kenya
Jaya Shukla
Lecturer, Department of Agricultural Science, School of Agriculture and Applied Economics
Jomo Kenyatta University of Agriculture and Technology, Kigali Campus, Kenya

Abstract:
The study was particularly assessed the impact of categorisation of PWD on their participation in government development projects in Rwanda with General goal of examining the impact of deemed categorisation with specific objectives to examine how categorisation of disability impacts participation of PWDs in Government development programmes, to investigate how intensity of disability impacts participation of PWDs in Government development programmes, to identify the development services received by the PWDs from the Government of Rwanda and to examine challenges the PWDs face in accessing Government programmes in Rwanda. The study will help individuals appreciate the impact of categorisation of PWDs in their participation in Government development programmes, respond to the academic requirement in order to obtain a Master's Degree in Project Management and contribution to the existing theories related to impact of categorisation of persons with disabilities in their participation in Government development programmes scientifically. The research methodology during the study was involved the Research design, study population, sample size and selection, sampling techniques, data collection methods, Data collection instruments, procedure of data collection and data analysis techniques. Primary data has been collected by use of questionnaires, while Secondary data was employed the use of desk research, library research on journals, text books and report publications. The target population was included categorised PWDs as well as the Employees of National Council of Persons with Disabilities in Rwanda with a sample size of 399. Purposive and simple random sampling techniques have been employed to sample the participants for the study and Data analysis was involved the use of both qualitative and quantitative methodologies using descriptive statistics. Data presentation has been in the form of tables and figures to help interpret findings and generate conclusions that would aid recommendations to the identified problems.

Keywords: *Categorisation, persons with disability and participation*

1. Introduction

1.1. Background

According to the World Health Organization disability is defined as an umbrella term of impairment, activity limitation together with participation restriction or loss of opportunities to take part in the normal life of the community on equal level. More than one billion persons in the world live with some form of disability. Of this number, nearly 200 million experience considerable difficulties in functioning. The prevalence of disability increases as war, conflict, and poverty increase. In the years ahead, disability will be an even greater concern because its prevalence is on the rise WHO (2001).

A new report at the global prevalence of disabilities showed that about 15% of the world's populations have some form of disabilities. About 80 percent of those disabilities live in low income countries WHO (2014)

In 2006, the UN adopted the International Convention on the Rights of PWDs, and many governments and international development agencies are turning their attention to the goal of including PWDs in socio-economic development initiatives Mont, (2007). Rwanda ratified the UN Convention on the Rights of PWDs in 2008. UN Enable (2008). In addition, there is a growing acknowledgement that

unless PWDs are included in social and economic development programmes, realization of the Millennium Development Goals (MDGs) will remain elusive.

Rwanda as a country has achieved the classification and categorisation of PWDs process. PWD classification is done for many reasons; a primary reason is to establish protocols for the distribution of benefits and services. Categorizing disabilities helps the government identify needs and allocate necessary resources to various populations of persons with similar disabilities CDC (2013).

The Ministry of Local Government, Republic of Rwanda and African Decade of PWDs identified 522,856 PWDs in the Country in 2010 (Republic of Rwanda, 2010).The national census conducted in 2012 by the National Institute of Statistics of Rwanda reported an estimate of 446,456 PWDs, a prevalence of 5% of the population (Republic of Rwanda, 2012). This census excludes children under five years.

Ministry of Health (MOH) in collaboration with Ministry of Local Government (MINALOC) under National Council of Persons with Disabilities (NCPD) has been working hard towards achieving ambitious goals in terms of categorization of those PWDs to give effect to the Ministerial Orders on Categorization; to ensure the implementation of Article 31 of the UN Convention on the Rights of Person with Disabilities; to enable the Government Ministries, Districts and District Hospitals to assess the unmet needs of those PWDs in their area and subsequently formulate policies and programs based on correct data collected. It is against this background and based on article 3 of the ministerial order n° 20/18 of 27/7/2009 determining the modalities of classifying Persons with Disabilities into basic categories based on the degree of disability that this exercise was conducted.

It is hoped that the classification activities may be of use to the government of Rwanda, development partners, international and local nongovernmental organizations (NGOs) and Organization of Persons with Disabilities, to take forward the work of rehabilitation of PWDs in Rwanda.

1.2. Statement of the Problem

The government of Rwanda recognised the plight of the persons with disabilities thus enacting a law no 01/2007 of 20/01/2007 relating to protection and promotion of persons with disabilities in general and contains the legal measures to protect their rights. The Law emphasizes that notwithstanding the benefits to this effect a person with disability has equal right and obligations before the law like any other citizens and is protected like others without discrimination.

Therefore, the strategy stated by the Government of Rwanda in order to minimize ineffectiveness is implementing some legal measures that promote the rights of persons with disabilities and make them participate in development government programs offered to other citizens such as access to inclusive schools , access to health services, infrastructure, housing, food security, sport, framework communication, justice etc. Categorization of persons with disabilities project was one of the strategies.

However, Despite the Ministry of Health (MOH) in collaboration with Ministry of Local Government (MINALOC) under National Council of Persons with Disabilities (NCPD) working hard towards achieving ambitious goal of categorization of those PWDs, Many people with disabilities do not have equal access to health care, education, and employment opportunities, do not receive the disability-related services that they require, and experience exclusion from everyday life activities.

Much as categorisation is of PWD is said to be a success, huge gaps still remain, for example, there has still not been a proper categorisation of those with disabilities or even an assessment of their needs.

1.3. Objectives of the Study

1.3.1. General Objective

This study was examined how categorisation of PWDs by the Government of Rwanda with regards to intensity and type of disability impacts on the participation of the PWDs in government development programmes in Rwanda.

1.3.2. Specific Objectives

i. To examine how categorisation of disability impacts participation of PWDs in Government development programmes.
ii. To investigate how intensity of disability impacts participation of PWDs in Government development programmes.
iii. To identify the development services received by the PWDs from the Government of Rwanda.
iv. To examine challenges the PWDs face in accessing Government programmes in Rwanda.

1.4. Research Questions

i. How does categorisation of disability impacts participation of PWDs in Government development programmes.
ii. How do intensity of disability impacts participation of PWDs in Government development programmes.
iii. What development services do PWDs received from the Government of Rwanda?
iv. What challenges do PWDs face in accessing Government programmes in Rwanda?

1.5. Importance and Justification of the Study

To the individuals that work with PWDs, the study will help them appreciate the impact of categorisation of PWDs in their participation in Government development programmes. This will further lead to an increased knowledge base. We hope that the result of our research will help the readers of the work and future researchers.

Academic significance: Traditionally, at the end of university studies, a student has to carry out a research project to complete his or her studies and be awarded a degree. This research will respond to this academic requirement in order to obtain a Master's Degree in Project Management.

As far as scientific work is concerned, the study aimed at bringing a contribution to the existing theories related to impact of categorisation of persons with disabilities in their participation in Government development programmes. The research in this domain will bring relevant development services to the PWDs in Rwanda.

The recommendations of this study will further enhance Governmental Decision makers, persons with disabilities, Partners and Researchers about services received, challenges faced Persons with disabilities and proposed measures for establishing standards that will help on their life condition improvement in Rwanda.

As Future manager we are fascinated by social-economic participation of persons with disabilities which may be considered as strategy of the Government to improve functional status and quality of life such as advocacy group, Employment accessibility, sport participation and recreation, health care services, housing, assistive technology, participation and safety and so forth.

There is need to know more about the social economic participation received by person with disabilities during the government development programmes implementation and challenges facing.

2. Literature Review

2.1. Introduction

This chapter was a survey of literature regarding PWDs categorisation and their participation in government development programmes in developed and developing worlds. The chapter began with a theoretical review of the concepts and basic operational aspects of PWDs, touches on the aspect of participation of PWDs in government development programmes. The chapter also considered empirical literature, hypothesized variables, conceptual framework, and critique of the literature, research gaps and summary.

2.2. Theoretical Framework

Since the 1970s, with the rise of the independent living movement, initially in California, Texas, and Massachusetts; Boschen (1998), new approaches, including self-help and peer support, led to new processes of service delivery. Professionals recognized the importance of working together in collaboration with persons with disabilities towards their goals. This interaction is now termed "inter-professionalism." By far, most studies have focused on the Spinal Cord Injury (SCI) population. Historically, the independent living movement led to increased awareness of the physical and social barriers in the environment, and encouraged new research directions; Dunn (1990).

One term frequently used in the literature is 'community integration.' This term refers to aspects of being part of mainstream community and family life, living independently, assuming age-, gender-, and culturally -appropriate roles and responsibilities, and contributing to society as a whole; Dijkers (1998); it is a correlate of community participation.

In recent years, two prominent models have emerged to describe the interactions between personal and environmental factors, and the effects of these factors on activities of people, within the home or in the community. The International Classification of Functioning, Disability and Health; ICF, WHO (2001) and the Disability Creation Process; Fougeyrollas et al. (2002) both stress the importance of interaction between personal and environmental factors on activities. This interaction has become so recognized that even the American Psychological Association website, which provides guidelines recommended by The Qualitative Report, states: 'the environment is frequently overlooked as a major source of limitation, even when it is far more limiting than the disability' APA (2007).

Several theories and models have been created to help understand disability as well as their participation in society. This thesis brings out four major models of disability and their relevant concepts and meanings have also been examined.

2.2.1. The Medical Model

The medical (or biomedical) model considers disability as problem of the individual that is directly caused by a disease, an injury, or some other health condition and requires medical care in the form of treatment and rehabilitation. The medical model attributes the problem to the individual, who has a condition that is unwanted and that places him or her in the "sick role" Parsons, (1975). As explained by Pfeiffer (2001), "if a person has a permanent impairment which results in using a wheelchair to move around, that person will never get 'well.

With this model people are considered disabled on the basis of being unable to function as a "normal" person does.

Rehabilitation has an important role to play in bringing the person back or close to the norm. The major concern of the medical model at the political level is to provide health-care and rehabilitation services. This model has been criticized on different grounds, including its normative strength; Amundson, (2000).

2.2.2. The Social Model

The social model of disability has been called 'the big idea' of the British disability movement Hasler, (1993). Developed in the 1970s by activists in the Union of the Physically Impaired against Segregation (UPIAS), it was given academic credibility via the work of Vic Finkelstein (1980, 1981), Colin Barnes (1991) and particularly Mike Oliver (1990, 1996). The social model has now become the ideological litmus test of disability politics in Britain, used by the disabled people's movement to distinguish between organisations, policies, laws and ideas which are progressive and those which are inadequate.

The British social model generally contains several key elements. It claims that disabled people are an oppressed social group. It distinguishes between the impairments that people have, and the oppression which they experience. And most importantly, it defines 'disability' as the social oppression, not the form of impairment. Oliver,(1996).

North American theorists and activists have also developed a social approach to defining disability, which includes the first two of these elements. However, as is illustrated by the US term 'people with disabilities', these perspectives have not gone as far in redefining 'disability' as social oppression as the British social model. Instead, the North American approach has mainly developed the notion of people with disabilities as a minority group, within the tradition of US political thought. The work of Hahn (1985, 1988), Albrecht (1992), Amundsen (1992), Rioux et al (1994), Davis (1995), and Wendell (1996) explores important social, cultural and political dimensions of disability.

The medical model is often referred to as the old paradigm and stands in contrast to the social model of disability. The latter has at least nine different versions, which are listed and summarized in Pfeiffer (2001): (a) the social model of the United Kingdom, (b) the oppressed minority model, (c) the social constructionist version of the United States, (d) the impairment version, (e) the independent living version, (f) the postmodern version, (g) the continuum version, (h) the human variation version, and (i) the discrimination version. The first two versions are briefly reviewed here.

In general, the social model sees disability as a social construct. Disability is not the attribute of the individual; instead, it is created by the social environment and requires social change. Disability activists in the Union of the Physically Impaired against Segregation (UPIAS) developed the U.K. social model, at the heart of which lies societal oppression (Oliver, 1990). The core definition of the British social model comes in the UPIAS document Fundamental Principles of Disability, an edited version of which is reprinted by Oliver (1996): this model implies that it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society Oliver (1996):" (p. 22). As noted by Pfeiffer (2001), the U.K. social model is quite marxist in its view of disability, a view not often found in the United States.

The second version of the social model reviewed here, that of the oppressed minority, says that persons with disabilities face discrimination and segregation through sensory, attitudinal, cognitive, physical, and economic barriers, and their experiences are therefore perceived as similar to those of an oppressed minority group. Hahn (2002), among others in the United States, supports this view: Social inequalities encountered by persons with disabilities are considered as similar to those encountered by other minorities such as "extraordinarily high rates of unemployment, poverty and welfare dependency; school segregation; inadequate housing and transportation; and exclusion from many public facilities. Hahn, (2002).

Drawing the overall picture of disability models is not as simple as presenting a dichotomy between a medical model and a social model. There are other models that have developed on their own, as extensions of the medical or the social model or as integrations of the two. In the following section, two of these models are discussed: (a) the Nagi model, which has wielded substantial influence for the last three decades at the policymaking level in the United States and in the economics of disability in general, and (b) the recent International Classification of Functioning, Disability and Health of the WHO, the worldwide scope of which gives this model a strong potential role in data collection efforts and policy development in the years ahead.

2.2.3. The Nagi Model

Pathology is the starting point of Nagi's (1965) model, also called the functional limitation paradigm. Pathology refers to an interruption of normal body processes. An active pathology or residuals of pathology may lead to impairments, which are anatomical or physiological abnormalities or losses. Nagi identifies functional limitations as the restrictions that impairments impose on the individual's ability to perform the tasks of his or her roles and normal daily activities. These roles include family roles (e.g., looking after a child), work roles (having a job), community roles, and other interactional roles as well as self-care activities. Nagi (1991) has defined functional limitation as "an inability or limitation in performing socially defined roles and tasks expected of an individual within a socio-cultural and physical environment.

Here, impairment is at the source of a causal chain leading to disability, which eventually becomes a social construct. For instance, say a 12-year-old girl with mental retardation does not attend school but stays home with her parents helping with household chores. If she lives in a society where young girls are not expected to go to school, but to stay at home, then she does not have a disability under the Nagi model. In contrast, if she lives in a society where girls her age attend school, then she does not perform this socially expected role and is therefore considered disabled. The Nagi model therefore promotes a social and cultural relativistic view of disability.

2.2.4. The International Classification of Functioning

The WHO developed the International Classification of Impairments, Disabilities and Handicaps (ICIDH) in the early 1980s. It was recently revised and renamed the International Classification of Functioning, Disability and Health (ICF). Conceptually, the ICF is presented as an integration of the medical and the social models: "ICF attempts to achieve a synthesis, in order to provide a coherent view of different perspectives of health from a biological, individual and social perspective" (World Health Organization, 2001, p. 20). The ICF model is sometimes termed the bio-psychosocial model of disability (Bickensack, Chatterji, Badley, & Ustun, (1999).

The ICF model posits that disability has its genesis in a health condition that gives rise to impairments, and then to activity limitations and participation restrictions within contextual factors. Impairments are problems in body function or structure causing a significant deviation or loss. An activity is the execution of a task or action by an individual, and participation is the "lived experience" of people in the actual context in which they live. Participation is not understood in terms of a role to play but in terms of an involvement in a life situation that can mean "being included or engaged in an area or being accepted or having access to needed resources" Altman,

(2001). Contextual factors refer to the entire background of an individual's life, including personal factors, the environment (home, school, and work), services available in the community (e.g., transportation, health care, social services), and cultural factors (laws and attitudes). Activity and participation domains include, among others, learning and applying knowledge, mobility self-care, education, remunerative employment, and economic self-sufficiency. These individual domains can come into play within different roles, but they are not organized as a set of tasks geared toward performing a particular role. Functioning and disability are two umbrella terms, one being the mirror image of the other. Functioning covers body functions and structures, activities, and participation, whereas disability includes impairments, activity limitations, and participation restrictions. Interactions between the different components of the ICF are shown in Figure 1 below. The ICF is the only conceptual model of disability that also comes close to offering a concrete classification system of individuals. It gives two scales of 0–9 for assessing individuals.

A capacity qualifier measures an individual's ability to execute tasks or actions in a standardized environment to neutralize the impact of different environments on the abilities of the individual. A performance qualifier measures the actual lived experience of people in the actual context in which they live.

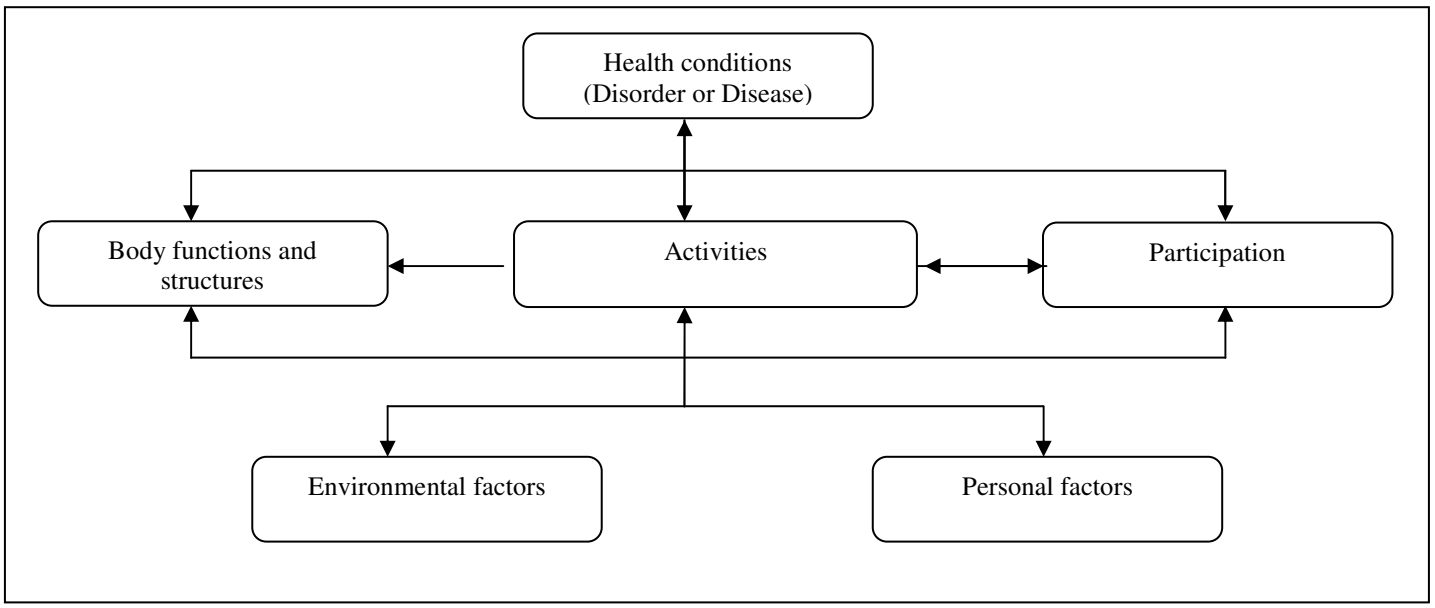

Figure 1: The International Classification of Functioning, Disability and Health.
Source: World Health Organization (2001).

Barnes (1992) and Klepper (1996) state that 'the history of the portrayal of disabled people is the history of oppressive and negative representation. This has meant that people with disabilities (PWD, hence forth) have been presented as socially flawed able bodied people, not as disabled people with their own identities'.

According to Barnes (1992), the link between impairment and all that is socially unacceptable was first established in classical Greek Theatre. Today there are a number of cultural stereotypes which perpetuate this linkage. However, these depictions are not mutually exclusive; frequently one will be linked to another. This is particularly the case with fictional characterization. The disabled person as evil, for example, is often combined with the disabled person as sexually degenerate. The point is that the overall view of disabled people is decidedly negative and a threat to the well- being of the non-disabled community.

Media images and stories influence thinking and establish social norms. People with disabilities have endured misrepresentation, defamation, and lack of representation in the media news and entertainment. While the disability rights movement has made enormous strides in the past 30 *years using law and policy development and civil rights advocacy, this movement has not yet* altered the hearts and minds of many people who do not have personal experience with disability. Many still do not understand disability issues as rights issues Barnes, (1995).This lack of awareness is a problem in the sense that the wider society may not have a positive attitude towards PWDs and this may slow down the process of mainstreaming and their being included in the normal daily activities. Catlet (1993) asserts that policy issues that a country has put in place to address the plight of people with disabilities affects the attitudes that the wider society may have towards them. In some countries of the world today, measures have been put in place to ensure some form of parity for PWD in the sense that persons with disability are portrayed as being able to do what everyone else can do including owning businesses and running media stations, for instance, ILO (2010) states that in Beijing, the 'One Plus One' Cultural Exchange Centre is a media operation run entirely by disabled journalists. In 2008, two of the company's staff became the first fully-accredited, disabled Chinese journalists in the history of the Olympics. Their radio shows now reach most parts of China.

In some countries of the world, policies have been put in place to ensure that PWDs are 'not discriminated against. Byers (2004) states that in America, The American with disabilities act (ADA) was introduced and put in effect as well as Rwanda's laws. The ADA has profoundly changed how society views and accommodates its citizens with disabilities. Universal design -- the practice of designing products, buildings and public spaces and programs to be usable by the greatest number of people -- has helped create a society where curb cuts, ramps, lifts on buses, and other access designs are increasingly common. Curb cuts designed for wheelchair users are also

used by people with baby carriages, delivery people, and people on skateboards and roller blades. The ADA has created a more inclusive climate where companies, institutions, and organizations are reaching out far more often to people with disabilities. Colleges and universities, for example, now accommodate more people with disabilities than they did before ADA, even though they have been obligated by law for nearly 25 years to make their campus and classrooms accessible.

In understanding disability, Hurst (1995) goes beyond generalized statistics of PWD and provides a more intricate statistical representation that, there are 500 million disabled people worldwide. Of these, 55 million are blind (11%), 70 million are deaf (14%),130 million have a severe intellectual impairment (26%), 20 million have epilepsy (4%) and 160 million have some sort of mobility impairment (32%).The incidence of impairment varies according to age, geographical and economic conditions.

2.3. Literature Review

This research proposal was considered a person with restrictions or lack of abilities to perform an activity in the manner or within the range considered normal for a human being as having disability. It excluded illness/injury of recent origin (morbidity) resulting into temporary loss of ability to see, hear, speak or move.

The United Kingdom Equality Act (2010) considers a person to be disabled under the Equality Act 2010 if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities.

The Australian Disability Services Act (1993) considers a disability to mean any continuing condition that restricts everyday activities.

Rwanda's' Law No. 01/2007 of 20/01/2007 defines disability as "the condition of a person's impairment of health ability that he or she should have been in possession of, and consequently leading to deficiency compared to others".

The main categories of disability are physical, sensory, psychiatric, neurological, cognitive and intellectual. Many people with disability have multiple disabilities. A physical disability is the most common type of disability, followed by intellectual and sensory disability. Physical disability generally relates to disorders of the musculoskeletal, circulatory, respiratory and nervous systems.

2.3.1. Categorization of PWD and How This Affects Their Participation

2.3.1.1. International Classification of Functioning, Disability and Health

The World Health Organization (WHO) published the International Classification of Functioning, Disability and Health (ICF); WHO (2001). The ICF provides a standard language for classifying changes in body function and structure, activity, participation levels, and environmental factors that influence health. This helps to assess the health, functioning, activities, and factors in the environment that either help or create barriers for people to fully participate in society. The classification by WHOM (2001) are:

- Health Conditions: This term refers to illness, disease, disorder, injury or trauma. The condition is usually a diagnosis. For example, autism spectrum disorders, spina bifida, and traumatic brain injury are health conditions.
- Body Structures: Body structures are physical parts of the body. For example, heart, legs, and eyes are body structures.
- Body Functions: Body functions describe how body parts and systems work. For example, thinking, hearing, and digesting food are body functions.
- Functional Limitations**:** Functional limitations are difficulties completing a variety of basic or complex activities that are associated with a health problem. For example, vision loss, hearing loss, and inability to move one's legs are functional limitations.
- Activity: Activity means doing a task or action. For example, eating, writing, and walking are activities
- Activity Limitations: Activity limitations are difficulties a person may have in doing activities. For example, not being able to brush one's teeth or open a medicine bottle are activity limit q342`11`ations.
- Participation: Participation means being involved in a life situation and fully participating in society. For example, attending school and playing sports. This also means including people with disabilities in all aspects of a communities' political, social, economic and cultural life.
- Participation Restrictions: Participation restrictions are problems a person may have in life situations.
- Environmental Factors: Environmental factors are things in the environment that affect a person's life. For example, technology, support and relationships, services, policies, and the beliefs of others are environmental factors.
- Personal Factors: Personal factors relate to the person, such as age, gender, social status, and life experiences.

2.3.2. Categorization of Disability – Rwanda's Case

Based on the International Classification of Functioning, Disability and Health (ICF) of WHO (2001), the Government of Rwanda has also documented its country specific categorisation of disability. The Rwanda National Institute of Statistics ultimately instituted a Census that aided the categorisation of disability. NISR (2012). The categorisation of persons with disabilities thus resulted into five categories based on percentages of their ability and identity: 1st: Between 90 and 100%, 2nd: between 70 and 89%, 3rd between 50 and 69% , 4th: between 30 and 49% , 5th: Under 30 and Five Types of Disability based on the their kind of Disability: Physical disability, mental disability, Hearing impairment, visual impairment and multiple disabilities called other categories . Rwanda National classification of Persons with disabilities Report, (2014). Rwanda ultimately adopted fives types of disability and five Degree of disability. The categorisation is aimed at increasing the participation of PWDs in government development programmes.

The Australian Institute of Health and Welfare, (2006).further asserts that Disabled people are not a homogeneous group. Like all people, their identities, personal situations and needs are shaped by a multiplicity of factors including their gender, age, personality, location, education, ethnicity, colour, class, family, religion and sexual orientation. Disability is simply another dimension of human

diversity. It is a normal part of human experience and anyone in society may experience disability at some time in life. Australian Institute of Health and Welfare (2006)

Disabilities are themselves also diverse in nature. The main types include sensory disabilities, such as visual and hearing impairments; physical disabilities, such as mobility and orthopaedic impairments; intellectual disabilities, such as impairments in learning, understanding and concentrating; and psychosocial disabilities, such as impairments brought about by mood disorders, maladaptive behaviours and mental illnesses. For each of these disability types, there is a range of associated, specific needs that might need to be met to ensure that the productivity of individuals is maximized. For example, people who are deaf or hard of hearing might require their supervisors and co-workers to use alternative communication methods, such as sign language. People with mobility impairments might need additional attention given to the physical layout and accessibility of the workplace. People with intellectual disabilities might need job tasks analysed and broken down into a sequence of more easily understood steps. People with psychosocial disabilities might need to take more frequent breaks if their concentration is impaired. The specific circumstances of disabilities also vary and can therefore affect individuals' development as potential workers and their ability to be productive. Australian Institute of Health and Welfare (2006)

For example in Rwanda: Law No. 01/2007 of 20/01/2007 defines disability as "the condition of a person's impairment of health ability that he or she should have been in possession of, and consequently leading to deficiency compared to others" Article 2 of the law No. (01/2007) It defines a disabled person as any individual who was born without congenital abilities like those of others; or a person who was deprived of such abilities due to disease, accident, conflict or any other reason which may cause disability.

Out of this definition one can say that the causes of disability in Rwanda are: Disease, Conflict/war, Accidents, Congenital, and Other.

According to the study by Philippa Thomas (2005) there are also other causes. For example, poverty can lead to malnutrition and the lack of adequate medical care, which because of ignorance can lead people to seek recourse to traditional healers and to have poor access to care during pregnancy.

In Rwanda, 5% of the population have a serious disability MINECOFIN, (2005). This sector of the population share the characteristics mentioned below.

- Nine per cent of persons with disabilities are in old age.
- A few people are within the age range of 0–4 or above the age of 80.
- In terms of gender, the proportions of disabled people are the same for men and women because disability is linked to age range rather than sex.
- Many persons with disabilities live in towns than in rural areas. This is because there are more facilities for disabled people in urban areas than in rural areas, for example, there are education facilities and health care facilities. Consequently, more people with disabilities survive in towns than in rural places.
- In terms of matrimony, many persons with disabilities are single as they have but a small chance of marrying a spouse due to the community's negative attitude towards disability. MINECOFIN census, (2005).

2.3.3. How Intensity of Disability Affects Participation

In looking at intensity of disability and how it affects participation in development, Rabiee, Moran, & Glendinning, (2009) noted that the more able service users and those with strong support networks are most likely to benefit from individualised funding than the least able bodied of the PWDs. Laragy (2009) raises concerns expressed in the literature that the most vulnerable may be left unsupported in a market economy, marginalised even further because they are not the route to a profit and, lacking a case manager, without an effective advocate to challenge inadequate resources and support.

It is troubling that a government programme designed to bring dignity, autonomy, and choice, and to recognise the equal citizenship of people including those with disabilities, could contribute to further inequity by disadvantaging the most profoundly disabled, the socially isolated, and the poorly-educated (Rummery, 2009). However, Laragy (2009) concluded from her global PWD investigations that it is not the case that people with an intellectual disability will be disadvantaged in a market economy. She suggests an important safeguard against risk: the involvement of a broad range of people in the planning and oversight of service delivery, with specific attention paid to the vulnerabilities of each person concerned.

There are some who argue that categorisation rather than individualisation will best protect people with the most severe disabilities. For example, one US examination of the market approach to the provision of disability services concluded that other mechanisms for service distribution should be considered; Swenson, (2008). Swenson's main suggestion is more specific categorisation of people by needs and type of service required, to enable targeted planning, delivery, and evaluation.

As an example of new problems that can arise from attempting to solve an old one, people with the most severe disabilities are at risk of being marginalised by the otherwise laudable goal of categorising as work the tasks performed by users of individualised funding schemes, such as recruitment, management, accounting, supervision, and interpersonal negotiation (e.g., Prideaux et al., 2009). The aim of such categorisation is to contribute to reconstructing the provision of disability services and the meaning of "work" (consistent with a feminist assessment that does not include only paid employment as work). However, it seems to exclude those people whose disability is so severe as to limit or prevent active participation in the management of services. Are there to be two or more categorisations of disability such that some are left behind in "welfare" and only some are understood to be full citizens? When implementing person-centred approaches in a market economy, a conscious effort will need to be made to ensure that all kinds and degrees of disability are included.

2.3.4. Participation of PWDs in Government Programmes and the Services Received

According to the Productivity Commission (2010) of Australia, the types of services required by people with a disability as part of an adequate care and support system are usually grouped into personal care services, respite and accommodation services, community access, community support, income support, employment, transport, aids and appliances, and home modification, as well as a range. The closest to participation of PWD in government programmes is the person-cantered approaches based on individualised funding ideas of Laragy, (2004), Lord & Hutchison, (2003). This thesis will analyse participation based on the Person-Centred Approaches and Individualised Funding.

2.3.4.1. Person-Centred Approaches and Individualised Funding

Person-centred approaches to the care of people with a disability are designed to ensure self-determination and community participation. Individualised funding is one mechanism for enabling such flexibility; it means that money to support a person is allocated directly to the person instead of to a service agency (e.g., Laragy, 2004; Lord & Hutchison, 2003). This process is also called direct funding, self-directed support, consumer-directed support, and cash-for-care (e.g. Cumella, 2008; Laragy, 2004; Rummery, 2009). The goal of providing funds directly to the person who needs services is to enable them to determine what services they need; their needs will thus shape the service system (Laragy, 2002). Worldwide, person-centred approaches and the associated individualised funding model still constitute a minority of methods for providing care to people with a disability (Fisher et al., 2010).

2.3.4.2. History of Person-Centred Approaches

Among the most useful documents for summarising the history of person-centred approaches, especially those that use individualised funding, are Cumella (2008), Lord and Hutchison (2003), Rummery (2009), and papers by authors whose work is particularly relevant to Australia (DiRita et al., 2008; Laragy, 2004, 2009).

Laragy (2002, 2004) draws on other authors to summarise the background to person-centred approaches to disability and individualised funding over the last five or six decades. After the Second World War, people with disabilities were treated as victims. Until the 1960s the medical model of disability dominated; decisions were made by doctors on behalf of patients, many of whom lived in institutions. The movement to deinstitutionalisation dominated the 1960s; independent living was the goal, but various professions retained the power to make decisions for people with disabilities. In the 1970s, 'normalisation' was the buzzword, with an emphasis on assisting people with disabilities to live as members of the community through 'individualised planning', but professionals still tended to make most of the decisions. It was criticised as emphasising quality program delivery rather than quality of life. Person-centred planning emerged at around same time; the focus was on the individual but it was still a professional who was focusing on and making decisions for the person with a disability. The most recent person-centred approach (often called 'self-determination') is that which gave rise to individualised funding, with the goal of enabling the person with a disability to determine what she or he needs rather than accepting what professionals think is required.

Behind most of the changes in approaches to the care and support of people with disabilities is an increased awareness of the rights of the person with a disability (e.g., Bigby, 2007; Ellis, 2005; Laragy, 2002). The United Nations Declaration of Rights of Disabled Persons (1975) is the foundation document which has guided legislation around the world. People with disabilities and their advocates constitute a disability movement that campaigned for an end to segregation as essential to the rights of people with a disability (e.g., Clapton, 2009). As institutions closed in Western countries and community living became the ideal, the campaign extended to advocating control over personal assistance, identified as fundamental to independent living (e.g., Boyle, 2008; Burchardt, 2004). Momentum increased after the International Year for Disabled Persons in 1981 (Clapton, 2009). Since then, there has been the 2006 United Nations Convention on the Rights of Persons with Disabilities which, among other things, requires governments to provide services that enable people with disabilities to exercise their rights (see Cumella, 2008).

2.3.4.3. Person-Centred Approaches Internationally

Over the past decade, person-centred approaches to disability service delivery have gained momentum internationally, particularly in Canada and the UK. A detailed history of programs is beyond the scope of this report. There are informative documents for Canada (Lord & Hutchison, 2003), the UK (Carmichael & Brown, 2002; Hudson & Henwood, 2008; Laragy, 2009; D. Leece & Leece, 2006; J. Leece, 2004; Priestley et al., 2007), Netherlands (Buntinx, 2008; J. Leece, 2004; Rummery, 2009), Sweden (Laragy, 2009) and other Scandinavian countries (Fisher et al., 2010), the US (Cloutier, Hagner, Malloy, & Cotton, 2006; Lord & Hutchison, 2003; Rummery, 2009), and New Zealand (Fisher et al., 2010, Appendix D). According to the Australian Productivity Commission (2010), some of the most advanced models of person-centred funding are to be found in the UK and Germany, and person-centred funding is an important aspect of disability services in many states in the US. Hatton and co-authors (2008) give information about the background and context of In Control, the UK charity founded in 2003 specifically to promote personal budgets for people with learning difficulties, which was set up by a group including the Department of Health (see Hudson & Henwood, 2008, for a less partial perspective). Organisations to support the use of person-centred approaches have also been established in Europe, Canada, and the US (Laragy, 2002).

In Ontario, Canada, individualised funding for people with developmental disabilities began in 1982 in a program called Special Services at Home (SSAH), which gave families the option of administering their own disability supports (Lord & Hutchison, 2008).

In the UK, the Community Care (Direct Payments) Act (1996) gave people with all types of disabilities the right to direct payments depending on a needs assessment; direct payments have existed in the UK since April 1997 (Hudson & Henwood, 2008). Local authorities were enabled to make cash payments to disabled people aged 18 to 64 instead of directly providing services (Blyth &

Gardner, 2007; Priestley et al., 2007). Because the scheme was designed to replace formal rather than informal care and support (Rummery, 2009), it was not permitted to use the direct payments to pay family members. Initially, direct payments could be used only to employ support workers, but greater flexibility has subsequently been introduced. Payments can now also be made to people over 65, to carers of disabled children under 18, and to young people in transition (aged 16-17) (Blyth & Gardner, 2007; Hudson & Henwood, 2008). More recently, there has been legislative commitment to extending the scope of direct payments to people "without capacity" who had been excluded (Hudson & Henwood, 2008). Legislative change means that direct payments are no longer available only at the discretion of the local authority but are a mandated responsibility that local authorities must offer to eligible service users (Blyth & Gardner, 2007). Nevertheless, there have been slower implementation and acceptance of direct payments than desired or expected by government and organisations advocating for people with disabilities (Blyth & Gardner, 2007; Hudson & Henwood, 2008). According to Priestley and co-authors (2007) among others, not all disabled people were aware of direct payments; furthermore, professionals tended to have limited views of capacity and entitlement, especially as they concerned people with intellectual disabilities. Local welfare politics also played a role in restricting implementation (Priestley et al., 2007). In particular, Hudson and Henwood (2008) associate the local variation in take-up of direct payments with the early activism of user-led advocacy groups, especially for those with physical disabilities, so that areas in which there was activism and early implementation have continued to attract support and encourage usage. The take-up continues to be largely by people with physical rather than intellectual disabilities.

Among other countries with varieties of person-centred approaches in the disability field are the Netherlands (from the 1990s), Italy (in limited form, over the last 10 years), and Austria (limited, from the 1990s) (Rummery, 2009). Most developing countries have not much adopted the approach.

2.3.5. Challenges PWDs Face in Trying to Participate in Government Development Programs

2.3.5.1. The Isolated Individual

Participatory or person-centred approaches and individualised funding are understood as means by which people with disabilities can be helped to achieve more meaningful and fulfilling lives, preferably on their own terms. However, Harvey and co-authors (2008) point out that the concept of the individual in social policy discourse is likely to entail an atomistic, rational thinker. At the same time, by definition, the individual model of care or service delivery does not embrace a collective model of responsibility or support (Spall et al., 2005). It could be understood as parallel to the individual workplace agreement model of employment contrasting with unionised collective bargaining. It is possible, therefore, for individuals to be isolated under this system, especially if group programs are rejected as not fitting the individualised model. Each person, regardless of disability, needs to be part of a community. To ensure that people are not isolated, the concept of "individualised" should position the person with a disability in a web of supportive relationships designed to support his or her unique needs and abilities (Harvey et al., 2008). Support can come from the community at large, but there is also benefit in having a web of people with disabilities, where possible and appropriate, to share knowledge and experiences and to provide peer support.

2.3.5.2. Dependence, Independence, Autonomy

In considering individualised funding as an aspect of person-centred approaches, the Productivity Commission (2010) includes on its list of risks that of "dependency":

"Individualised funding arrangements in which families effectively pay them for attendant care or use the money to purchase ordinary goods and services would mean that funding would become like ordinary income. That might create dependency by carers on the support system and undermine the goal of achieving independence for the person with a disability." (Productivity Commission, 2010, p. 23-24)

Whether it is undesirable or not for people with disabilities and their carers to depend on an income like the majority of the community is a moot point. One may ask, on what else should they depend?

Independence is not advisable, probably not even possible, for many people with disabilities. If they are to include people with the widest possible range of disabilities and severity, person-centred approaches, it is argued, need to emphasise autonomy rather than aim for independence (Ellis, 2005). Individuals may need to have a proxy appointed to help with or undertake decision-making. A system can be truly person-centred only if it enables the widest possible choice. It was recently found that, in Sweden, only 3% of people with a disability chose to manage their own funding when other options were available (Laragy, 2009). Dependence, independence, and autonomy are complex notions for everyone, not just for people with a disability. An important implication for people with a disability of the discursive threads underpinning person-centred approaches is how to enable autonomy while accepting various degrees of dependence and support.

2.3.5.3. Choices and Decisions

Choice, a central component of person-centred approaches, is limited by capacity and availability of options. The Productivity Commission (2010, p. 23) includes as a risk "whether all people with disabilities or carers have the capability of making well-based choices". The Commission's concern is that people might not make the kind of choice that others consider to be in their best interests. The broader implication is whose decisions should be given priority.

2.3.5.4. Interpersonal Relationships

Interpersonal relationships, already challenged by the effects of a disability, may be put under further strain by some of the demands of a person-centred approach to disability services. The Productivity Commission (2010, p. 23), for example, identifies as a risk that "tensions over the use of individualised funding may sometimes arise between informal carers and people with disabilities (for example, over the need for respite services for the carer)". There are further concerns that people with disabilities may be more subject to the preferences of their parents or carers once they are no longer protected by a professional such as a case manager (Laragy, 2002).

2.3.5.5. People in Rural and Remote Areas

Ensuring appropriate person-centred care in rural and remote areas is extremely difficult when there are so few options available. Indigenous people living in rural and remote areas are especially vulnerable, but they are likely also to be at a disadvantage in urban areas. The Productivity Commission (2010). Said that, in assessing eligibility for the proposed new national scheme, factors taken into account will need to include places where "local support and resources are low (some country areas) or where general disadvantage is combined with disability (some Indigenous communities)"

2.4. Conceptual Framework

In this study, categorisation of persons with disability based on categories: 1st: Between 90 and 100% , 2nd: between 70 and 89% , 3rd between 50 and 69% , 4th: between 30 and 49% , 5th: Under 30: have been conceptualised to impact the participation of persons with disabilities in government development programmes in Rwanda and they are postulated to be independent variables, while participation of people with disabilities in government development programmes in Rwanda are conceptualised as the dependent variable that are influenced by categorisation.

This study was find out whether categorisation increases participation or reduces participation or leads to no participation of PWDs in development programmes.

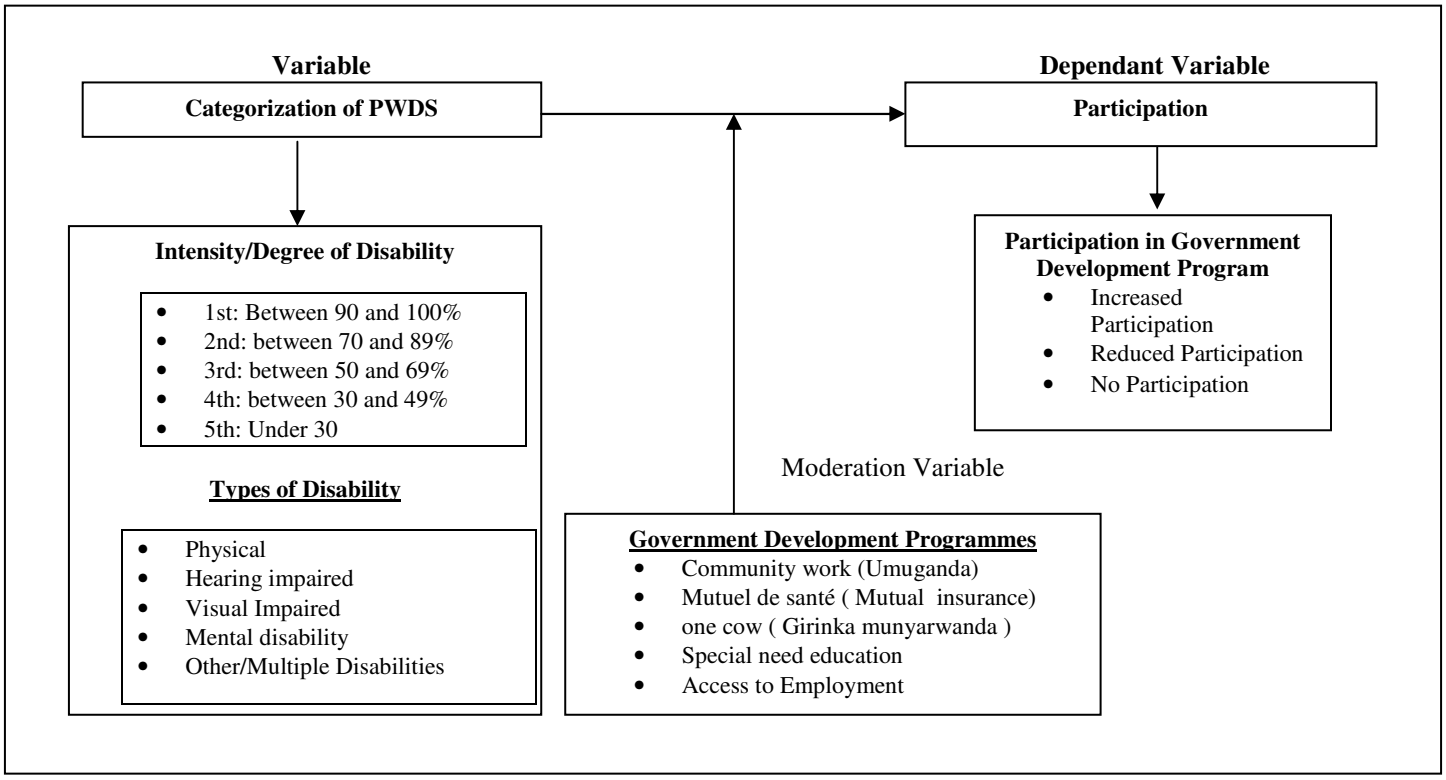

Figure 2: Conceptual Framework
Source: Researchers Conceptualisation.

2.5. Empirical Literature of Variables

One study done on disability in Rwanda that carries some significance for this study is the one by the Secretariat of the African Decade of Persons with Disabilities (2008)

The baseline survey on the status of disability mainstreaming in Rwanda aimed at analysing the situation of persons with disability in Rwanda through a thorough research with regards to existing policies and laws and the status of their implementation..

The objective was to study the extent to which these policies have an impact on the daily lives of the disabled and at what level they took into consideration decisions related to disability as well as analysing the extent to which the African Decade and the Continental Plan of Action have changed the situation for people with disabilities in Rwanda.

The survey repost gathered evidence of disability mainstreaming six key ministries whose responsibility it is to assist, protect or promote activities of disabled persons according to law of Rwanda: No. 01/2007 of 20 (2007). These ministries are: The Ministry of Local Government which is the leading ministry in matters of disability mainstreaming, Ministry of Health, Ministry of Education, Ministry of Infrastructure, Ministry of Labour, Ministry of Culture and Sports.

The report also took into consideration inputs by Disability Service Provider Organisations that are composed of local NGOs and international NGOs. It takes into account information gathered from organisations of disabled persons.

The baseline survey in question adopted a Methodology that included: First of all, laws and regulations, as well as policy documents were analysed in order to know what is provided for at a strategic and policy level, Secondly, HVP Gatagara (a centre offering rehabilitation and educational services to persons with disabilities) and the Physiotherapy Department of Byumba District Hospital were visited. The aim was to know how these services serve persons with disabilities and the appreciation levels of these services by the disabled persons. At each occasion questions about knowledge of the African Decade and Continental Action Plan were asked.

In order to gather information, an interview with the Director of the Protection of Special and Vulnerable groups in MINALOC was carried out. This interview was semi-structured with open questions about where the mainstreaming of disability in Rwanda is being done; who is co-ordinating the activities of mainstreaming disability in Rwanda; and collaboration between the Ministry and RNDSC and FENAPH. The purpose of the interview was to understand the National Policy on Disability and to ascertain the progress of its implementation, MINALOC (20011)

A questionnaire was distributed randomly to nine organisations working with disabilities via RNDSC. These organisations are: RNDSC, FENAPH, HI, Tubakunde, ANFSMR UMUCYO, UAHLS, ASFH and AGHR. The questionnaire was distributed and was to be filled in at the discretion of the organisation. All of them completed the questionnaire and returned it.

Three persons with disabilities were visited and informal discussions were held with them. The information collected was mainly to find out if they are aware of the African Decade of Persons with Disabilities and the Continental Plan of Action. These individual persons with disabilities included a businessman, a laboratory specialist and a farmer. All of them are adults.

The study findings revealed that:

There was a legal framework in place to handle disability issues. For example: The Rwandan Constitution has four articles about the rights of persons with disability. Article 11 proscribes and punishes discrimination of whatever kind based, amongst others, on physical or mental disability. The Rwandan Constitution in article 14 takes this a step further by pledging assistance to the disabled and other vulnerable groups within the scope of its capacity. In article 40 the Constitution reaffirms the freedom of learning and emphasises the duty of the state to take special measures to facilitate the education of disabled people. In article 76, modified by Amendment 2, the Constitution provides for a representative of persons with disability in the Rwandan Parliament, Chamber of Deputies. Even if the Member of Parliament is according to constitutional principle a representative of all Rwandans, the fact that he/she is elected in an indirect way by the associations of persons with disability stresses that he/she has the mission to represent the interests of persons with disabilities. Report Census of Persons with disabilities MINALOC (2011)

In the execution of Constitutional provisions, Rwanda has mainstreamed the disabled by putting in place laws and policies. This is the case of law No. 01/2007 of 20/01/2007 which is related to the protection of persons with disability in general, hereinafter, law No. 01/2007 or the Disability Law and law No. 02/2007 of 20/01/2007 related to the protection of persons with disability who are former combatants, hereinafter law No. 02/2007. The Ministerial Order No. 010/07.01 of 12/10/2007 provides for the regulation of the federations, associations and centres responsible for the welfare of disabled persons.

Policies are still lacking in some ministries:

The study discovered that only four ministries have policies in place that take into consideration the needs of persons with disabilities. These are the Ministry of Local Government, Good Governance, Community Development and Social Affairs, the Ministry of Education, the Ministry of Labour and the Ministry of Health. The Ministry of Local Government, Good Governance, Community Development and Social Affairs has set up the National Policy on Disability. The Ministry of Education has some disability components in its Education Policy. Besides, there is also Special Needs Education Policy in favour of people with disabilities lately adopted by the Cabinet meeting. The Ministry of Education has a specific department and a task force in charge of special education within the Ministry. The Ministry of Labour also supports work by persons with disability although not in an exhaustive manner. Finally, the Ministry of Health has a Five-year Strategic Plan on Disability. Other Ministries, such as the Ministry of Sports and Culture, have activities that mainstream disability but have not yet put in place a policy on disability in their area of intervention. The Ministry of Sports and Culture works closely with the National Paralympics Committee to promote sports amongst the disabled people.

The Education Policy for the Disabled Persons:

The National Education Policy rests on five pillars that enhance the education of the child with disability. These are:

1) Equal access for boys and girls into integrated education at all levels. Here the emphasis is on the rural child. This pillar allows all children, including the disabled, to access education. The didactic materials used are intended to accommodate the needs of children with disabilities.

2) The availability of special education for children with disabilities when inclusive education is not possible The Ministry of education applies a global strategy of inclusive education whereby non-disabled children study in the same classroom and under the same conditions as disabled children with equipment adapted to children with special needs. Inclusive education protects the right of the child with disability to attend school and not to be discriminated against. The Rwandan Ministry of Education has a department in charge of special education that is mandated with the inclusion of children with disabilities from their nursery school days until university. However, the number of children enrolled in inclusive education is not known.

3) The inclusion of modules about the education of children with special needs in the teacher training programmes of colleges. The policy about special education is still under consultation. The inclusion of these modules at teacher training colleges has not yet started.
4) Training teachers at ordinary schools to incorporate the educational needs of children with disabilities Because of the geo-demography of Rwanda, it is not easy to integrate all children with disabilities in ordinary schools because the existing schools are not adapted to deal with all kinds of disabilities. Furthermore, the training of teachers at these ordinary schools has not yet started so that the admission of disabled children in ordinary schools can be accelerated.
5) Partnership between schools, families and other sectors that assist persons with disabilities in education The National Education Policy includes and strongly advises the development of partnerships between schools and other role players in the education system. In ordinary schools, this partnership is effective. In some vocational training centres, the partnership is still embryonic. In the special education of disabled persons, the partnership is not yet in place due to factors such as the prevalence of social discrimination, lack of revenue, the availability and location of centres that are often far away from the villages of disabled children.
The general situation with the Education system in Rwanda.
The Research carried out by the Ministry of Finance and Economic Planning (MINECOFIN) in 2005 revealed illiteracy amongst more than of half the persons with disabilities. Many persons with disabilities do not know how to read or write. Of those who have not gone to school at all, 50.1% of them are persons with disabilities. In the remaining portion, 84.3 % have reached the primary level; whereas vocational training is preferred rather than a technical education amongst the disabled population.

2.5.1. Vocational Training
Disabled youth, women and men are trained in specific jobs needed in the job market, and if possible, are integrated in the ordinary education system. In collaboration with different partners, special schools take care of the education of the disabled.

2.5.2. Health Policies
Health policies: Rehabilitation Plan 2008–2012:
The Ministry of Health has put in place a five-year plan for the rehabilitation of persons with disabilities. This plan aims at increasing by 20% the level of prevention, care, rehabilitation and the promotion of persons with physical disabilities.
The specific objectives of the plan are: Putting in place pilot committees at national and district levels; Carrying out investigations at community level about the causes of disability, its prevention and the care of persons with disabilities; Improving access by persons with disabilities to rehabilitation services; and Insuring the early and correct intervention for the causes of disabilities. Rehabilitation Plan 2008–2012 is comprehensive and ambitious because it requires collaboration with different ministries as well as with different stakeholders who sometimes have other priorities.

2.5.3. National Employment Policy
The 1990–1994 civil war and the 1994 genocide attacks exacerbated unemployment and underemployment in Rwanda. In a bid to find solutions, Rwanda has adopted an employment priority-based strategic plan with the view to achieve the targets of Vision 2020. In implementing Vision 2020, Rwanda has adopted the Poverty Reduction Strategic Paper (PRSP) that was pitched to, amongst other pillars, the creation of employment. After five years of PRSP, the Economic Development and Poverty Reduction Strategy (EDPRS) was adopted for five years and is an improvement on the first PRSP since it takes into consideration the lessons learnt from the failures of the latter.

2.5.4. Disabled Persons Organisations
All associations of disabled persons questioned are aware of the African Decade of Persons with Disability and are members of the Rwanda National Decade Steering Committee (RNDSC). These associations participate in the activities of the Committee and some of them have members who sit on the Board of the Committee.
The study made a number of Recommendations including:
The need for the government to:
Speed up the implementation of the Ministerial Orders for implementing law No. 01/2007 and law No. 02/2007 in order to give policy makers a strong basis for their policies.
The Ministry of Health should keep advocating for the disabled in order to fully implement its Strategic Plan 2008–2012.
The Ministry of Infrastructure should consider a special policy to facilitate access for disabled people to public buildings and services.
The Ministry of Research and Technology should develop means of communication adapted to different forms of disability.
The Ministry of Education should insist on the inclusion of children with disabilities by training a good number of teachers and by availing adequate equipment to enable disabled children to study together with non-disabled children.
The Ministry of Local Government, the Ministry of Sports and Culture and the Ministry of Gender and Family Promotion should combine their energy to fight social discrimination against of persons with disabilities.
The Ministry of Labour should set up a clear policy for employing persons with disability.

2.6. Critical Review

Most studies on disability focus on health related disability and consider the health related deficits that come along as well as how the health situation affects the participation of PWDs in development. For example Boschen (1998) particularly looked at health and injury and how it affects development.

There is also no literature that specifically focuses on categorisation and how this affects participation of PWDs in government development programmes. Let alone with special consideration on Rwanda or any other developing country.

The understating of disability categorisation by Hurst (1995) is based only on manifestation of the disability. For example Hurst (1995) considers PWD in categories of: blindness, deafness, intellectual impairment, epilepsy, mobility impairment, and then notes that the incidence of impairment varies according to age, geographical and economic conditions. This is totally different from the Rwanda categorisation in NISR (2012) which is in percentages of severity rating from 1st to 5th categories. For example: 1st: Between 90 and 100%, 2nd: between 70 and 89% , 3rd between 50 and 69% , 4th: between 30 and 49% , 5th: Under 30

The Productivity Commission (2010) of Australia, clearly elaborates the kind of services needed by PWDs but does not indicate how categorisation and these services are related or in what ways are these services impacted by categorisation.

The closest literature to participation of PWD in government programmes is the person-cantered approaches based on individualised funding ideas of Laragy, (2004), Lord & Hutchison, (2003). There is no clear literature indicating what participation of PWDs in development means.

2.7. Research Gaps

This study was filled the gap of analysing the impact of categorisation of PWDs on participation in government development programmes. There is generally no literature that specifically focuses on categorisation and how this affects participation of PWDs in government development programmes. Let alone with special consideration on Rwanda or any other developing country.

There is also no literature explaining what categorisation of PWDs using the Rwanda categorisation approach in NISR (2012) as follows: 1st: Between 90 and 100%, 2nd: between 70 and 89%, 3rd between 50 and 69%, 4th: between 30 and 49%, 5th: Under 30. Specifically what does this mean to participation by category? As noted this is missing in literature and needs to be analysed.

What exactly does participation mean in the Rwanda PWD perspective? What are the services that PWDs are engaged in? What are the challenges specific to Rwanda in as far as participation of PWDs are concerned? These are also gaps that existing literature does not address and needs to be considered in this study.

2.8. Summary

This chapter presented previous works in the field of PWD study. The chapter specifically looked at literature on PWD including; theories in understanding disability, categorisation and types of PWDs, how intensity of disability affects participation, services received by PWDs and the challenges among other vital literature.

The chapter looks at empirical literature, theoretical literature and the conceptual framework.

3. Research Methodology

3.1. Introduction

This chapter presents the methodologies that have been used during the study. It involved the Research design, study population, sample size and selection, sampling techniques, data collection methods, Data collection instruments, procedure of data collection and data analysis techniques.

3.2. Research Design

According to Kombo (2006) research design is an outline or plan that is used to generate answers to research problems/questions. A research design is an arrangement of conditions of data collection and analysis.

For this study researcher was embraced descriptive survey methodology designed to assess the impact of categorisation of PWDs on their participation in development programmes. The design was employed self-administration of questionnaires to a sample of individuals. The questionnaires have been aimed at finding peoples' attitudes, and opinion about PWD categorisation and participation in Rwanda. The researcher has used both primary and secondary data. Primary data was obtained using questionnaires while secondary data was gathered from the documents available at the washing stations and journals.

3.3. Target Population

Mugenda and Mugenda (2003) define the population as a complete set of individuals, cases or objects with some common observable characteristics. The target population for this study were PWDs and employees of National council of persons with disability (NCPD). The Total Population is 1699 where sample size for the study was 399. The Research has been fully conducted at the city of Kigali.

3.4. Sample and Sampling Technique.

The researcher adopted the sampling techniques by RAOSOFT (2014)-

Margin of error at 5%	5 %	The margin of error is the amount of error the researcher will tolerate.
Confidence level 95%	95 %	The confidence level is the amount of uncertainty the researcher will tolerate. Higher confidence level requires a larger sample size.
Total population size?=1699	1699	This is the number of people the researcher will choose from, it's the total number of employees at NCPD
Response distribution =50%	50 %	This is the researchers expectation of response for each question
Resultant sample size is 399	**399**	This is the minimum recommended size for the study

Table 1

Source: Mugenda and Mugenda (2003).

$$n=\frac{N}{1+N\,(E)_2}$$

Where n= Desired sample size.
E=Probability of Error, i.e. the desired precision, e.g, 0.05 for 95% confidence level
N= the estimate of the population size, the target population of 1699 PWDs categorized by NCPD and its employees.

Application of Formula: $n=\frac{1699}{1+1699*(0.05)_2 = \textbf{399 Participants}}$

Based on the sample size calculated above, only 399 respondents has been targeted for the study and the researcher was used simple random sampling methodology to identify the 399 respondents out of the 1699.

3.5. Procedures for Data Collection

An introductory letter has been collected from the JKUAT offices authorising the researcher to go for data collection. Self-administered questionnaires have been delivered to the selected respondents for completion. Available documents and journals have also been reviewed.

3.6. Source of Data

Data have been collected from primary and secondary sources. Primary data have been derived from the questionnaires while secondary data have been derived from available literature. The literature was included policies, reports, journals found online and newspaper publications.

3.7. Data Collection Methods

Data for the research has been collected using two methods. These include self-administered questionnaires and document review. Self-administered questionnaires have been used since they would enable the researcher obtain first-hand information from the field. Data has been obtained from respondent categories indicated under 3.3 target populations above. The type of data was included: social demographic characteristics of respondents (age, gender, level of education etc), perceptions about the study variable etc. Document reviewing was enabled the researcher to obtain information on already existing literature on the study variables.

3.7.1. Questionnaire Survey

A self-administered questionnaire has been used in the study targeting all respondents. Mugenda and Mugenda (2003) states that questionnaires are used to obtain vital information about the population and ensure a wide coverage of the population in a short time. In addition Sekaran (2003) states that questionnaires are an efficient data collection mechanisms where the researcher knows exactly what is required and how to measure the variables of interest. He further asserts that administering questionnaires to number of interest simultaneously is less expensive and time consuming and does not require much skill to administer as compared to conducting interviews. Closed ended question has been used with detailed guiding instructions as regards the manner in which respondents are required to fill them independently with minimal supervision. This has been made possible due to the fact that majority of the respondents are able to read and write and in instances where the respondents are illiterate, a research assist was trained by the researcher to translate questionnaire into the local language and fill them according to the responses provided by the respondents. Closed ended questionnaire have had pre-coded answers according to themes from which respondents have been asked to choose the appropriate responses. Respondents was given ample time to fill and return questionnaires later when they were through.

3.7.2. Document Reviews

The study involved carrying out library and office research where a secondary source about the research questions has been considered.

Documentary review checklist containing a list of documents to be reviewed has been used to provide necessary data for the study. The documents for review was obtained from offices, libraries, organisations involved in the PWDs work, reports, newspapers, policies and regulations guidelines, annual reports and online journals.

This information has been useful for cross validating primary data and provide basis for explaining certain concepts.

3.8. Data Collection Instruments

The data collection instruments were included structured questionnaires and document review check list.

3.8.1. Structured Questionnaire

The researcher has used close ended questionnaire for all respondents. The use of questionnaire was enabled the collection of data from respondents and also enable respondents give sensitive information without fear as their personal identity has not been needed on the questionnaires. This supports Amin, 2005 (P.270)'s contention that questionnaires Offer greater assurance of anonymity thus enabling the respondents to give sensitive information without fear. Rensis Likert's scale statement having five category response continuum of 5 – 1 has been used where I would mean "strongly disagree", 2 "Disagree; 3 "No comment" 4 "Agree" and 5 "strongly agree" with the assertion in question. This has been designed to establish the extent to which respondents are in agreement with statements and it will be used to measure the variables under study. In using this, each respondent was selected a response most suitable to them in describing each statement and the response categories which are weighed from 5 – 1 and average for all items has been computed accordingly.

3.8.2. Document Review

List of documents has also been developed and reviewed to provide necessary data for the study. The documents for review has been obtained from offices, libraries, organisations involved with PWD word, reports, newspapers, policies and regulations guidelines, annual reports and online journals. These documents were provided relevant qualitative information that was supported the quantitative analysis of the data.

4. Research Results and Discussion

4.1. Introduction

This chapter brings out the research results and discussions. Data is hereby presented in line with the methodology of the study described in chapter three above while the discussions are guided by the results of the study in line with the study questions.

4.2. Presentation and Discussion of the Data

4.2.1. Demographic Characteristics of Respondents

4.2.1.1. Gender of Respondents

The study considered both the male and female respondents. Males made up 74% while females made up 26%. The Table.1 below shows percentage distribution of respondents by sex.

Sex of respondents helps us to appreciate the gender component of the study and the involvement of all gender dimensions in the study. We also appreciated that the recommendations have the gender perspective inbuilt.

Gender	Number (no)	Percentage (%)
Male	294	74
Female	105	26
Total	399	100

Table 2: Sex of respondents

4.2.1.2 .Age Group of Respondents

In analysing the age of respondents, the researcher categorised age of respondents in groups as follows. 20 years and below, 21 – 29, 30 – 39, 40 – 49, and 60 years and above. Findings reveal that 36 percent of the respondents were aged between 30 and 39 while only 8 percent of respondents were aged 60 years and above.

This helped us to appreciate that opinions were sought from all age groups and thus the recommendations are not age specific and possible interventions will not be age specific.

This information has also been elaborated below in table 3.

Age group (years)	Number (no)	Percentage (%)
20 years and below	59	14
21 – 29	61	15
30 – 39	126	36
40 – 49	121	30
60 years and above	32	8
Total	399	100

Table 3: Age of Respondents

4.2.1.3. Level of Education of Respondents

The level of education of respondents was also analysed. The researcher considered primary, secondary, college and university education level.

Findings of the study show that 33 percent of respondents had attained secondary education, 31% attained primary education, and 25% attained college education.

Table 3 below shows the percentage distribution of respondents by education level.

Level of Education	Number (no)	Percentage (%)
Primary	124	31
Secondary	130	33
College	99	25
University	46	46
Total	399	100

Table 4: Level of Education

4.2.1.4. Marital Status of Respondents'

The researcher further considered the marital status of the respondents. With regard to marital status, the researcher considered four options which are: single, married, divorced, and widowed. Analysis shows that 58% of the respondents were married while 41.5% were single. There were no respondents that were neither divorced nor widowed.

Table 5 below illustrated the percentage distribution of respondents by the period of service in the respective work places.

Level of Education	Number (no)	Percentage (%)
Single	163	41.5
Married	234	58
Divorced	0	0
Widowed	2	0.5
Total	399	100

Table 5: Marital status of respondents

4.2.2. Categorization of Disability and How It Impacts Participation of PWDs in Government Development Programmes

Under Categorization of disability and how it impacts participation of PWDs in Government development programmes, the researcher investigated whether all PWDs in Rwanda have been categorised, whether categorisation has increased participation in government programs, and whether categorisation has had an impact on PWDs among others. Findings show the following: On whether all PWDs in Rwanda have been categorised, 43% strongly agree, on whether most PWDs are not categorised 40% disagree, on whether categorisation has increased participation in government programs 48% agree, on whether categorisation has reduced participation in government programs 39% strongly disagree and on whether categorisation has had no effect on participation of PWDs 31% were not sure.

Table 6 below gives a full analysis of the percentage distribution of responses.

	Percentage distribution of responses									
	Strongly agree		Agree		Not sure		disagree		Strongly disagree	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
All PWDs in Rwanda have been categorised	53	43	22	19	16	21	11	8	7	12
Most PWDs are not categorised	7	6	12	11	6	7	57	40	7	12
Categorisation has increased participation in government programmes	17	14	48	42	13	16	10	7	9	15
Categorisation has reduced participation in government programmes	39	31	13	12	20	25	33	23	23	39
Categorisation has had no effect on participation of PWDs	8	6	18	16	24	31	32	22	13	22

Table 6: categorization of PWDs and how it impacts participation of PWDs in government development programmes

The analysis showed that the Specific way has categorisation impacted participation of PWDs in government development programmes mentioned by respondents are: PWDs are considered by Decision makers, authorities and leaders, PWDs are known as

persons like others, PWDs are happy to meet with authorities and Doctors living together in the District and sectors, PWDs discovered that are known by government, PWDs are respected in the country, PWDS known that are responsible to work with others in society. In other hand on the way can participation of PWDs in Rwanda be increased, respondents point different Government programmes participated in such as participating in umuganda, creation of association and cooperatives, PWDs are received cows and domestic animals, identification of Children with disabilities dropout, Participation in ubudehe program where PWDs are employed, Participation in schools, in election and PWDs received Mutuel de santé and Poor PWDs are benefiting the social protections actions.

- Test of Correlation for the relationship between categorisation and participation in government Development programs

The analysis points to a significant relationship between categorisation of PWDs and participation in government programs. This is mainly with regard to the fact that when PWDs are categorised, they can be able to participate in programs that meet their specific needs. It is also true that extension workers visit the PWDs that have been categorised and support them to participate in programs of the government.

		Participation in government programs
Categorization of PWDs	Pearson Correlation	0.224*
	Sig. (2-tailed)	0.001
	N	86
*Correlation is significant at the 0.01 level (2-tailed).		

Table 7

4.2.3. How Severity of Disability Impacts Participation of PWDs in Government Development Programs

In looking at how severity of disability impacts participation of PWDs in Government development programs, the researcher considered whether severity of disability has a direct impact on participation of PWD in government programs, whether People with severe disability are normally neglected in development work by the government, whether Severity of disability is responsible for the low participation of PWDs in development and whether Government has special plans for the PWDs with severe/intense disabilities

Findings show the following:

With regard to whether severity of disability has a direct impact on participation of PWD in development programmes 24% agree, on whether severity of disability has no impact on participation as all PWDs are engaged by government in development 25% strongly disagree yet 24% strongly agree, on whether People with severe disability are normally neglected in development 24% disagree, on whether severity of disability is responsible for the low participation of PWDs in development programs, 27% disagree, And whether Government has special plans for the PWDs with severe/intense disabilities 49%strongly agree.

Table 8 below illustrates the percentage distribution of how severity of disability affects participation in government programs

	Percentage distribution of responses									
	Strongly agree		Agree		Not sure		disagree		Strongly disagree	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Severity of disability has a direct impact on participation of PWD in development programmes	13	8	29	24	28	22	7	6	18	32
Severity of disability has no impact on participation as all PWDs are engaged by government in development	39	24	22	19	24	20	25	22	14	25
People with severe disability are normally neglected in development	12	8	15	13	28	22	27	24	9	16
Severity of disability is responsible for the low participation of PWDs in development	17	11	25	22	29	23	30	27	6	11
Government has special plans for the PWDs with severe/intense disabilities	79	49	25	22	16	13	23	21	9	16

Table 8: How severity of disability impacts participation of PWDs in Government development programs

The respondents point also the way has severity/ intensity of disability impacted participation of PWDs in development: providing support designed by government through social protection program, accessible houses and schools, provision of support of wheelchairs, orthotics and prosthesis to PWDs, building houses for PWDs, training PWDs to TVET activities, benefiting to Girinka , making of different hand craft activity, driving licence for PWDs in transportation and Provision of adapted vehicles for PWDs.

The analysis on how can involve PWDs with severe/intense disability in development, respondents raise the issue of mainstream PWDs by providing the mutual insurance, sensitisation to authorities, families and Teachers in schools, mobilising Partners to plan actions related to their needs, help PWDs to find job, involving PWDs to have access to business and reduce Taxes, build accessible houses for PWDs, provide training to community on how to take care persons with disabilities especially in market, hospital, banks, restaurants, officers and build roads accessible to PWDs.

- Test of Correlation for the relationship between severity of disability impacts participation of PWDs in Government development programs

The analysis points to a significant relationship between severity of disability and participation in government programs. This is mainly with regard to the fact that people with severe disability call for specialised services which are sometimes limited.

		Participation in government programs
Severity of disability	Pearson Correlation	0.377**
	Sig. (2-tailed)	0.001
	N	88
**. Correlation is significant at the 0.01 level (2-tailed).		

Table 9

It was noted by the respondents that severity of disability affected participation by generally weakening the body to get active.

4.2.4. How type/Category of Disability Impacts Participation of PWDs in Government Development Programs

Under how type/category of disability impacts participation of PWDs in Government development programs the researcher considered whether Type/category of disability has a direct impact on participation of PWD in development programs, whether Type/category of disability is responsible for the low participation of PWDs in development, and whether Government has special plans for all PWDs with different types/categories of disabilities among others.

Findings reveal the following:

With regard to whether type/category of disability has a direct impact on participation of PWD in development programmes 17% strongly agree, with regard to whether type/category of disability has no impact on participation as all PWDs are engaged by government in development 12% strongly disagree, with regard to people with certain types of disability are normally neglected in development 15% strongly disagree, with regard to type/category of disability is responsible for the low participation of PWDs in development 23% strongly disagree, with the view on Government has special plans for all PWDs with different types/categories of disabilities 13% were not sure while only 9% disagree, with regards to people with physical disability actively engage in development programmes 16% strongly disagree while only 9% agree, with regard to people with mental disability actively engage in development programmes 13% strongly disagree while only 8% agree, with regard to people with hearing impairment actively engage in development programmes 12% agree while 11% were not sure, with regard to People with visual impairment actively engage in development programmes 13% agree while 7% were not sure, and with regard to people with visual impairment actively engage in development programmes 21% strongly disagree while 8% strongly agree.

Table 10 below illustrates the detailed percentage distribution with regard to type of disability.

	Percentage distribution of responses									
	Strongly agree		Agree		Not sure		disagree		Strongly disagree	
	No	%	No	%	No	%	No	%	No	%
Type/category of disability has a direct impact on participation of PWD in development programmes	29	17	31	11	24	9	16	8		
Type/category of disability has no impact on participation as all PWDs are engaged by government in development	13	7	25	10	29	11	22	11	9	12
People with certain types of disability are normally neglected in development	7	4	31	11	24	9	25	12	11	15
Type/category of disability is responsible for the low participation of PWDs in development	18	10	23	8	24	9	17	8	17	23
Government has special plans for all PWDs with different types/categories of disabilities	19	11	29	11	32	13	19	9		
People with physical disability actively engage in development programmes	15	9	25	9	23	8	22	10	12	16
People with mental disability actively engage in development programmes	16	10	22	8	27	10	24	12	10	13
People with hearing impairment actively engage in development programmes	21	12	27	10	28	10	23	11		
People with visual impairment actively engage in development programmes	21	12	33	13	32	12	14	7		
People with visual impairment actively engage in development programmes	14	8	22	9	25	9	24	12	16	21

Table 10: How type/category of disability impacts participation of PWDs in Government development programs.

In the way has types/categories of disability impacts participation of PWDs in development, respondents said that Persons with Physical disability has opportunity to participate more than other persons with disabilities, other persons with disabilities are also

participating but require some specific needs related to their disabilities like white cane Guide, specific training and education methods, sign language interpreters for hearing impairment, will charge users, and special needs equipment's and materials.

To how can PWDs be involved regardless of the type of disability in the development, respondents has mentioned an issue of providing specific needs such as access to schools, get employment, materials and equipment, separate the needs for each categories, Thinks about Visual impaired and mental disability, Partner with PWDs, increase the capacities of PWDs, consider PWDs in all programmes, avoid isolation and discrimination, make in place specific programmes to severe disability and mental disability, conduct Public and private dialogues between decision makers and PWDs, organize campaign on issues affecting PWDs.

- Test of Correlation for the relationship between type of disability and participation of PWDs in Government development programs

The analysis points to a significant relationship between type of disability and participation in government programs. This is mainly with regard to the fact that specific types of disabilities call for specific actions. These actions are sometimes not available.

		Participation in government programs
Type of disability	Pearson Correlation	0.467***
	Sig. (2-tailed)	0.000
	N	89
*** Correlation is significant at the 0.01 level (2-tailed).		

Table 11

4.2.5. Development services received by the PWDs from the Government of Rwanda

Here the researcher considered whether People with disability in Rwanda participate in Ubudehe, Girinka munyarwanda, Mutuel insurence/mutuelle de santé, special needs education, Employment, and Umuganda.

As can be noted in table 12 below findings show that:

On whether People with disability in Rwanda participate in Ubudehe, 19% agree while only 5% disagree. This signifies the fact that respondents felt PWDs participate in ubudehe. With regard to Girinka munyarwanda, 17% strongly agree while only 6% disagree. This also seems to point out that respondents agree with the assertion that PWDs benefit from Girinka munyarwanda. As for whether PWDs benefit from Mutuel insurence/mutuelle de santé, 15% strongly agree while 12% strongly disagree. We note here that PWDs highly benefit from the Mutuel insurence/mutuelle de santé. Also looking at whether special needs education was utilised by PWDs, 26% strongly disagree while another 21% were not sure, Talking about Umuganda, 32% disagree while only 15% agree. Further analysis is as illustrated in table 12 below.

	Percentage distribution of responses									
	Strongly agree		Agree		Not sure		disagree		Strongly disagree	
	No	%	No	%	No	%	No	%	No	%
People with disability in Rwanda participate in Ubudehe	27	17	39	19	33	18	7	5	5	5
People with disability in Rwanda participate in Girinka munyarwanda	27	17	37	13	25	13	10	6	8	9
People with disability in Rwanda participate in Mutuel insurence/mutuelle de santé	24	15	40	14	25	13	10	6	11	12
People with disability in Rwanda participate in special needs education	18	12	27	10	39	21	15	9	23	26
People with disability in Rwanda participate in Employment	25	16	54	20	22	12	33	22	9	10
People with disability in Rwanda participate in Umuganda	13	9	43	15	11	6	48	32	14	15
PWDs highly participate in these above development programmes	22	14	26	9	32	17	30	20	21	23

Table 12: Development services received by the PWDs from the Government of Rwanda

The Researcher identified other programmes PWDs participated in as follow:

Breeding, sewing, plumbing, firming vegetables, carpentry, canton making and massage, small business.

The Respondents rise that there is non-development programme which is not involved in by PWDs in Rwanda, it depend on the preference and the choice of every disability persons, its ability to do something and the capital to start.

4.3. Challenges the PWDs face in Accessing Government Programs in Rwanda

Here the researcher considered two issues; one is whether PWDs face challenges in participating in development programmes and the other is whether Government has already addressed all the challenges of PWDs. With the analysis on whether PWDs face challenges in participating in development programs, 55% strongly agree and with regard to whether government has already addressed all challenges addressed by PWDs in accessing services 69% disagree while 45% agree.

	Percentage Distribution of Responses									
	Strongly agree		Agree		Not sure		disagree		Strongly disagree	
	No	%	No	%	No	%	No	%	No	%
PWDs face challenges in participating in development programmes	24	55	56	48	17	47	5	31	4	32
Government has already addressed all the challenges of PWDs	20	45	61	52	19	53	11	69	2	23

Table 13: challenges faced by PWDs in accessing services

4.3.1. Challenges Highlighted by Respondents

Some of the challenges respondents noted included: the general body weakness of the PWDs to participate, other respondents mentioned illiteracy, law level of education, Lack of Information Communication Technology Skills of some PWDs, others mentioned segregation, ignorance by the virtue of being disabled while another respondents mentioned lack of awareness about existing opportunities, others also mentioned lack of means : Finance mean related to starting a small business, lack of place, lack of Firms for production.

4.3.2. Solutions Fronted by Respondents

Respondents mentioned the need for awareness and sensitisation of the masses about disability issues, awareness among the PWDs about the opportunities within the government structures, as well as building the capacity of PWDs to participate in programs.

Respondent mentioned again the lack of specific appropriate programmes that can empower them in term of Business promotion, employment, access schools and provision of special need education.

5. Summary, Conclusions & Recommendations

5.1. Introduction

This chapter brings out the research results and discussions. Data is hereby presented in line with the methodology of the study described in chapter three above while the discussions are guided by the study questions.

5.2. Summary

5.2.1. Categorization of Disability and How it Impacts Participation of PWDs in Government Development Programs

Most PWDs in Rwanda have been categorised. With regards to whether categorisation has increased participation in government programs, it can be reliably said that PWDs are active in government programs as a result of categorisation.

There is generally a positive relationship between categorisation and participation in Government programs. Categorisation generally strengthens participation of PWDs in government programs.

5.2.2. How Intensity/Severity of Disability Impacts Participation of PWDs in Government Development Programs

Intensity of disability indeed affects participation in government programs. People with severe/intense disabilities are normally neglected in development work by the government.

Severity/intensity of disability is also responsible for the low participation of PWDs in development programs.

The Government unfortunately has no special plans and for the PWDs with severe/intense disabilities.

There is also a significant relationship between severity of disability and participation in government programs. This is mainly with regard to the fact that people with severe disability call for specialised services which are sometimes limited.

5.2.3. How Type/Category of Disability Impacts Participation of PWDs in Government Development Programs

Type/category of disability has a direct impact on participation of PWD in development programs

More to this is the fact that type/category of disability is responsible for the low participation of PWDs in development.

The Government of Rwanda also does not have any specific plans for all PWDs with different types/categories of disabilities.

There is further s significant relationship between type of disability and participation in government programs. This is mainly with regard to the fact that specific types of disabilities call for specific actions.

5.2.4. Development Services Received by PWDs from the Government of Rwanda

All PWDs In Rwanda Does Not Actively Participate In Ubudehe, Girinka And Umuganda Programmes. Only Physical Disabilities Are participated more.

PWDs mainly benefit from Mutuel insurence/mutuelle de santé.

In Rwanda, PWDs still do not take advantage of the special education. It was still revealed that PWDs do not actively participate in education and are also less engaged in employment.

5.2.5. Challenges the PWDs Face in Accessing Government Programs in Rwanda

PWDs face a number of challenges in accessing government programs; however, the government has tried to address the challenges faced by PWDs.

5.3. Conclusions

Although most PWDs in Rwanda have been categorised some are still not categorised.

Those PWDs that have been categorised actively participate in government programs, while those that are not categorised do not tend to have access to government programs.

- When PWDs are categorised, they easily access government programs. But when they are not categorised they do not participate in the government programs.

Intensity of disability affects participation of PWDs in government programs. People with severe/intense disabilities are normally neglected in development work by the government.

Severity/intensity of disability is one of the factors responsible for the low participation of PWDs in development programs.

The Government of Rwanda has no special plans for the PWDs with severe/intense disabilities.

There is also a significant relationship between severity of disability and participation in government programs. This is mainly with regard to the fact that people with severe disability call for specialised services which are sometimes limited.

Type/category of disability has a direct impact on participation of PWD in development programs

Type/category of disability is also another factor responsible for the low participation of PWDs in development programs in Rwanda.

The Government of Rwanda also does not have any specific plans for all PWDs with different types/categories of disabilities.

- There is a significant relationship between type of disability and participation in government programs.

PWDs in Rwanda do not actively participate in Ubudehe, Girinka munyarwanda and Umuganda.

PWDs mainly benefit from Mutuel insurence/mutuelle de santé.

In Rwanda, PWDs still do not take advantage of the special education. It was still revealed that PWDs do not actively participate in education and are also less engaged in employment.

Although PWDs face a number of challenges in accessing government programs; the government has tried to address the challenges faced by PWDs.

5.4. Recommendations

The government needs to roll out another program for the categorisation of all other PWDs that have not been categorised. This will ensure an increase in the number of PWDs participating in government programs.

Since intensity of disability affects participation of PWDs in government programs. There is a deliberate need to tailor specific programs for the different people with varying severities of disability.

The Government of Rwanda needs to also develop specific special plans for the PWDs with severe/intense disabilities.

We also note that the type/category of disability has a direct impact on participation of PWD in development programs. This calls for special programs tailored towards people with different disabilities.

In Rwanda, PWDs need to be encouraged to actively participate in Ubudehe, Girinka munyarwanda and Umuganda, education and employment.

A policy needs to be put in place for the employment of PWDs and their education. This will increase their participation in education and taking up employment opportunities.

PWDs also need to be given the right skills which will enable them to acquire jobs, and thus earn incomes to sustain their own live.

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