

Teachers' Perceptions and Acceptance of Children with Disabilities in the Disability-inclusive Setting in Pre-primary Education in Tanzania

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Abstract

This study addressed the teachers' perceptions and acceptance of children with disabilities and barriers in providing a disability-inclusive setting in pre-primary education in Tanzania. It was a qualitative multiple case study. The sample for this study included 26 teachers who teach children with disabilities. Data were collected through face-to-face and focus group interviews and analysed thematically. The findings showed that the teachers' perceptions and acceptance of children with disabilities were considered in light of the contrasting dominant deficit discourse involved in the medical model of children labelled with impairments, and the social model positioning disability as obstacles within the society with little attachments to spiritual model. In the views of teachers, the provision of inclusive education in pre-primary education was hurdled by a number of factors including insufficient resources, inappropriate school infrastructure, negative attitudes, and discriminatory behaviours on the part of teachers and community members towards individuals with disabilities. Thus, there is a need for combined effort of various stakeholders to disestablish thinking in the medical model among teachers and promote social thinking as well as remove barriers to the provision of inclusive education in pre-primary education.

Keywords: disability, education, inclusion, pre-primary

1.0 Introduction

Disability is a major factor that causes marginalization, discrimination and exclusion of children with disabilities from education (World Health organisation (United Nations Educational, Scientific and Cultural Organisation [UNESCO], 2010, 2015; World Health Organisation & World Bank, 2011). Globally, an analysis of 15 lower-income countries in Asia, Latin America and Africa indicate that disability is significantly associated with lack of primary education completion (UNESCO, 2006). For example, in 2014, few people who experience disabilities in Bangladesh (30%), and in Thailand one-third (34%) of people had completed primary school (UNESCO, 2014). In Nepal, it was estimated that 85% of all out-of-school children have a disability, whereas 34% of children with physical disabilities had never attended school in Thailand (UNESCO, 2014). In Iraq, 19% of children who are deaf or hard-of-hearing and 51% of children who experience psychosocial or developmental disabilities had never been in school (UNESCO, 2014).

In some countries, having a disability can double the chance of children who experience disabilities not being in school, compared to their peers without disabilities. For example, in Malawi and Tanzania, disability doubles the chances of children who are not attending school, and it puts children at risk of being out of education system by two and a half times in Bukina Faso (UNESCO, 2010, 2014). Children with disabilities do not have access to basic reading, writing or counting competencies. For example, UNESCO (2014) notes that in Uganda in 2011, around 60% of young people with no identified impairments were literate compared to 7% of those with physical or hearing impairments and 38% of those with

mental impairments. According to UNESCO (2014), the literacy rate for people who experience disabilities was 52% compared to 75% for people without disabilities in Tanzania.

1.1 Models of Disability

Disability studies offer different models or perspectives of conceptualizing impairments and disability, including medical, social, religious or African beliefs models. For this study, these three models are essential in understanding, defining and conceptualizing disability among teachers concerning education for and acceptance of children who experience disabilities.

On one hand, the medical model presents a person with disability as being broken and locates the problem within the individual. This model constructs disability as the direct result of body impairments due to damage or disease, which requires medication or rehabilitation to make a person normal or healthy (Berghs *et al.*, 2016; Jackson, 2018). In essence, medical model conceptualizes disability as “a consequence of some ‘deviation’ from ‘normal’ body functioning... an underlying physical abnormality (pathology)... and medical treatment should be directed at the underlying pathology in an attempt to correct (or prevent) the abnormality” (Berghs *et al.*, 2016, p. 26).

Based on the medical model, disability is heavily rooted in the normality/deviance discourse; that is, the relation to ability, deviance through the relation to normality (Solvang, 2000). In the normality/deviance discourse, there is “the rehabilitation side of medicine, which tries to adjust the disabling defect, for example, through surgery, orthopaedics or hearing aids” (Solvang, 2000, p. 5). The medical model can trigger ableism thinking which involves discriminatory attitudes and practices

arising from the perception that a person with disability is in some sense inferior to a person without disability (Cologon, 2013). In the educational context, this medical model-based perspective can influence some practices and use the language of deficit or abnormal, and emphasise special needs and special education approaches which may result in the exclusion of children with disabilities from mainstream education system.

On the other hand, the social model reacts against the medical model that locates disability within individual pathology and sees disability as a personal tragedy (Berghs *et al.*, 2016). At the centre of the social model is to distinguish between disability as the experience of society's oppression and disadvantage, on the one hand, and impairment as a physical, sensory, cognitive or mental health condition, on the other hand (Berghs *et al.*, 2016; Lawson & Beckett, 2020). The supporters of the social model argue that the term a 'person with disability' is directly associated to the philosophy underlying the medical model; therefore, they insist that the term 'disabled person' better reflects the societal barriers (Rerief & Letšosa, 2018). This is based on the assumption that individuals are disabled by society's structures, attitudes, and obstacles to opportunities to quality life arising out of such social processes (Purtell, 2013).

The social model of disability has been subjected to a number of critics that it ignores the often painful realities of impairment; and the model's distinction between impairment and disability is artificial because it is difficult to distinguish the end of the impairment and start of the disability (Rerief & Letšosa, 2018). However, it is important to note that the social model neither deny that some forms of illness may have disabling consequences nor deny the role of medical professionals in treating various diseases (Rerief & Letšosa,

2018). For the social model, the problem is that “medical professionals fail to distinguish between a person’s illness and their disability” (Rerief & Letšosa, 2018, p. 5). The social model advocates rights to healthcare for all – including medicines and diagnoses and other social services such as education for supporting and improving the quality of life for all.

Drawing largely on indigenous African beliefs from African cultures, on one hand, “some African beliefs promote the stigmatization and marginalization of people with disabilities through exclusion and depiction of them as objects of pity or ridicule and as victims of evil forces...” (Ndlovu, 2016, p. 29). In this context, indigenous African beliefs portray disability as an abnormality. This has implications for practitioners or teachers working in this context are likely to be negatively influenced in their daily teaching activities.

On the other hand, in Ojok and Musenze (2019) view, African spiritualism glorifies or supports disability and a person with disability is accepted as normal and given a visible role in society while their disability is believed to be a blessing from the gods. This implies that on another argument, traditional African beliefs impress and instil “empathetic moral and ethical teaching aimed at protecting and empowering those living with disabilities by depicting them as full human beings who have same rights, obligations, and responsibilities as normal persons” (Ndlovu, 2016, p. 29). The implication is that the positive aspects of African spiritualism can positively influence people’s perceptions, including teachers on disability in their daily practices.

1.2 Segregation, Integration and Inclusion

In the segregation approach, education of children with disabilities is provided in separate environments labelled 'special school' or units designed to respond to a particular impairment or various impairments in isolation from children without disabilities (Cologon, 2013, 2019). In contrast, integration means children with disabilities attend in existing mainstream educational settings to understand that they can adjust to the standardized requirements of such settings (Cologon, 2013, 2019).

Both segregation and integration are constructed on the deficit-based assumption that there is a 'problem' within a child that prevents inclusion and that it is ultimately a child who needs to change, rather than the environment or pedagogy (Cologon, 2019). They are based on an ableist assumption, which entails "the perception that being able-bodied is superior to being disabled, the latter being associated with ill health, incapacity, and dependence" (Cologon, 2013, p. 6). On this basis in educational context, children can be categorized as 'normal' or 'impaired'. In turn, the belief in the superiority of children who do not experience disabilities results in discrimination, abusive behaviour and devaluing children who experience disabilities in mainstream education.

More importantly, integration should not be misunderstood as being inclusion in the field of inclusivity. For integration, minor adjustments are made to enable children who experience disabilities are perceived as 'close enough' to 'fit' within an existing mainstream setting. On the other hand, the inclusion approach focuses on changing settings to enable all children to flourish, and it acknowledges that differences are a normal part of life (Cologon, 2013, 2019). Similarly, the inclusion approach

should not be misunderstood as being assimilation. As Cologon (2019) claimed, assimilation is about making everyone 'the same' while inclusion is about celebrating and embracing diversity and 'difference'. When inclusion is misconstrued as assimilation (as is the case with integration), it becomes about changing or 'fixing' children to 'fit' within existing structures, systems and practices. Inclusion, instead, can be understood as 'fitting' educational opportunities, settings, experiences and systems to the full diversity of children and embracing and celebrating diversity as a positive and rich learning resource (Cologon, 2013, 2019).

Segregation, integration and ableist assumptions may lead to macro-exclusion and micro-exclusion. Macro-exclusion is experienced when "a child is excluded from mainstream education and segregated into a 'special' school or a 'special' class/unit" (Cologon, 2013, p. 14). More blatant segregation occurs in macro-exclusion whereby children are educated in segregated 'special' schools or 'special' classes or units, rather than alongside all peers in mainstream settings (Cologon, 2013; 2019). This results in an emphasis on special education which suggests exclusion rather than equal participation. For micro-exclusion, Cologon and D'Alessio (2015) cited in Cologon (2019) have clarified that micro-exclusion occurs when children are placed into a mainstream education context but are segregated or excluded within the classroom/school activities or community.

As to other children, education equips children who experience disabilities with the competencies resulting in confidence, self-reliance and breaking barriers to living (Cologon, 2019; Tesni & Keenon, 2014). In this study, disability-inclusive education is understood as the inclusion of children with disabilities in pre-

primary education in regular school or classroom. It is viewed as an approach to combat all forms of exclusion and marginalisation in access and participation in learning (Cologon, 2013, 2019; UNESCO, 2017). It is the approach that can help break the discrimination or segregation that reinforces stereotypes of disability at early ages.

The barriers to disability-inclusion in general education are often mentioned in the literature. Ndlovu (2016) observed that the real barriers faced by people who experience disabilities do not necessarily emanate from their different forms of impairment – physical, mental, intellectual, or sensory. On the contrary, the main challenges are a number of environmental or societal barriers that prevent people who experience disabilities from full inclusion in different services. This study investigated the issues related to teachers' perceptions and acceptance of children who experience disabilities and barriers in providing education for children who experience disabilities in implementing disability-inclusive pre-primary education.

1.3 Purpose of the Study

The main purpose of this study was to issues in the implementation of disability-inclusive pre-primary education in rural schools as perceived by teachers.

1.3.1 Specific objectives

Specifically, it addressed: i) teachers' perception and acceptance of children with disabilities, and ii) barriers that impede teachers in implementating disability-inclusive education.

2.0 Materials and Methods

As a qualitative inquiry, the study assumes personal constructs and interpretation of the phenomena under investigation (Alvesson & Sandberg, 2013; Yin, 2011), which led to exploring the participants' experiences, perspectives and views in their natural contexts (Silverman, 2013). Furthermore, the approach enabled the researcher to get in-depth first-hand information characterised by diversity of information about disability-inclusive education in pre-primary education. On top of that, the study employed the multiple cases study design (Creswell, 2007), which involved three cases (schools), which were purposively selected within a bounded context because they enrolled children with disabilities.

The study took place in three primary schools, which were purposively involved on the basis of education services for children who experience disabilities in the integration approach in Biharamulo District in Kagera Region, Tanzania. The sample for this study included 26 teachers who teach children with disabilities. The teachers were named as T1 to T26. The sample size was guided by the saturation strategy often used in qualitative studies to determine sample size. The sample involved both sexes. 11 of the 26 teachers were women, and 15 were men whose ages ranged between 35 and 57 years respectively.

Additionally, fifteen (15) semi-structured interviews and two (2) focus group discussions were conducted with primary schools teachers to obtain the teacher perspectives and acceptance in providing pre-primary education for children with disabilities. This is because children who experience disabilities were best positioned to provide situations and experiences in educating children with disabilities.

Nevertheless, during the interviews and focus group discussions, interviewees directed the discussion to what they found important and expressed the meaning they attached to concepts (Taylor *et al.*, 2016). Information collected through was recorded with note-taking. All the interviews and focus group discussions were conducted in Kiswahili language and direct quotations were translated into English by the researcher. Average time for individual interviews and focus group discussion 30 minutes and 40 minutes respectively. All teachers who participated in the study gave informed consent and agreed to be interviewed and be involved in focus group discussions.

More importantly, the criteria for examining the rigour in the study have traditionally been internal and external validity, reliability and objectivity (Creswell, 2007; Golafshani, 2003). Gall *et al.* (2007) pose out that the term trustworthiness is appropriate for judging the quality of study in qualitative paradigms. The elements of the criteria in trustworthiness include: credibility, dependability (consistency), transferability (applicability) and conformability (neutrality). These elements were employed alongside with other strategies to ensure the quality of this particular study. Credibility is parallel to internal validity (Cohen *et al.*, 2000; Creswell, 2007). This was achieved, first, through the use multiple methods (individual in-depth interviews, focus group discussions and observations) to collect data. Second, peer reviews were used to ensure credibility, where fellow researchers were given the tentative data and findings for their reviews and comments.

Dependability corresponds to the reliability of the findings in quantitative study (Cohen *et al.*, 2000; Creswell, 2007). Dependability of the conclusions was guaranteed by asking clear questions, triangulating the data, reducing biasness and

subjectivity during the data collection, peer reviews, audit trail, and reporting the study process and the findings transparently. In conformability, parallel to objectivity criteria in the quantitative approach (Cohen *et al.*, 2000), the researcher confirmed the study's findings and grounded them in raw data evidence. The integrity of raw data was maintained by using teachers' words, including quotes, liberally.

Transferability of the findings is equivalent to generalization of the findings in the quantitative study (Cohen *et al.*, 2000; Creswell, 2007). Although the location of the study might be similar to other places in Tanzania, the researcher's aim was not to generalize the findings of the study; instead, it was to explore the acceptance and understanding and barriers of disability-inclusion in pre-primary education in the location of the study only. However, if readers would find sufficient similarities between their contexts and the context of the study, then it would be reasonable for them to transfer the findings to their individual contexts.

Data are analysed using the principles of thematic analysis. The approach involves six steps: familiarisation with the data, generation of tentative codes, elucidation of themes, review of themes, delineation of themes and production of the written report (Bricki & Green, 2007). From interviews, focus group discussion and systematic observation two themes are deductively developed as per study objectives: i) Understanding and acceptance of children who experience disabilities, and ii) barriers to pre-primary education for children who experience disabilities.

On top of that, the researcher observed the clearance logistics of the research. The researcher requested the participants' study

consent to participate in the study. All participants gave informed consent and agreed to be interviewed and be involved in focus group discussions. Prior to each interview or focus group discussion session, the researcher described the purpose and benefits of the study and steps to be taken to maintain confidentiality and anonymity. In addition, the researcher assured that the information collected were for research purpose only. Moreover, the names of the participants and school names did not feature in the report.

3.0 Findings

This study centred on the teachers' perceptions and acceptance of children with disability in the disability-inclusive setting in pre-primary education. The study addressed: i) teachers' perceptions and acceptance of children with disabilities, and ii) barriers to disability-inclusive education in pre-primary education.

3.1 Perceptions and Acceptance of Children with Disabilities

The findings indicated that some teachers positioned disability in tragedy assuming that disability is the result of impairments reflecting ableism and medical approaches to disability. Those teachers labelled children with disabilities as not able, sick all the time, impaired or abnormal and dependent on others. Teachers gave their views regarding children with disability. For instance, one T4 said, "*A child with disability lacks one or more body organs like hand(s), limb(s), does not speak or hear.*" Similarly, T2 added, "*What I believe is that a child with a disability is not as capable as a normal child.*" These views were observed to be similar with T5, 14 and 16 whose views are: "*A child with a disability is dependent on other normal*

person(s) (T14)”, “A child with disability is sick at all time; s/he needs medication for their survival (T16)”, and “A child with disability suffers from diseases in all his/her life (T5).” It implies that teachers saw disability as individual problem or deficit and medical one which needed medication and cure practices.

More importantly, some teachers recognized disability as a social issue positioning disability in the social model of disability. Those teachers argued that children who experience disabilities could perform well in education activities if the environment could be supportive with trained teachers, appropriate learning materials and devices. They said, *“Disability is not inability; a child can participate in school activities provided the learning environment is supportive to impairments (T6).”* Similarly, another teacher opined that, *“A child is disabled when the school environment does not accommodate the child’s impairment(s) (T8).”*

Those statements from teachers showed that that the teachers were in the views that children with disabilities could learn in inclusive settings provided that the structural and process components of the learning environment were supportive. The teachers with social thinking when addressing disability, felt comfortable to help children who experience disabilities. The following are statements from the teachers that showed their positions in regard to supporting children who experience disabilities. T17 said, *“It is rewarding to include children with disabilities in my class7 (T7),* whereas T24 commented, *“I feel comfortable to help and include children with disabilities as I can help them (T24).”* Similarly, T1 and T22 had these views: *“I don’t worry to include children with disabilities in my class*

because I believe they can learn something in their life (T22)” and *“It harms nothing to include children with disabilities in my class with others (T1).”* Those teachers strongly insisted that it was pained to see children who experience disabilities segregated and ending without learning anything.

Additionally, some teachers had positive attitudes and accepted the children with disabilities as gifts from and will of God. The teachers argued that the children with disabilities needed care as other children without disabilities. Those teachers mentioned that God is everything and that anyone cannot question His plans. For instance, T3 said, *“These children were not expected to be born, but this was God’s wants. We accept them as they came in as the will of the God (T3).”* The same idea was given by T5, who opined that, *“We have to love them and care for them; the God created them as He did to us (T5).”*

Although one teacher talked about the past traditional beliefs on the cause of disability, such as curses from God and hungry of ancestors for wrongdoings in families, the researcher heard little about curses or witchcraft concerning disability.

3.2 Barriers in Providing Education for Children with Disabilities

All teachers in this study perceived the widespread poverty amongst parents as a barrier for their children with disabilities to access pre-primary education. They associated poverty with a lack of work and financial capacity. As per participants, parents could not afford aids such as wheelchairs and walkers and rehabilitation services. The teachers felt sad about parents not picking their children up to comfort life and education because of poverty. T11 believed that *“Because of poverty, parents*

were not able to meet other physiological needs, such as nutrition (food) and clothes (T11).” The same argument was given by T20 as follows:

Parents do not have money to afford the cost of wheelchairs for their children. Many parents in this district are poor to support their children with disabilities in education and medical services (T20).

All teachers in this study perceived that they supported the children with disabilities in a risk society. Even though, they decreased significantly, negative attitudes, stigma, and discriminatory behaviours towards individuals with disabilities persisted in society. The teachers said the following:

When children with disabilities move around, they are teased by peers without disabilities or adults; and we always stand to make sure nobody tease them or bother them (T3).

Some people see children with disabilities as abnormal and strange to live with others; they think of isolating them from society to somewhere else (T4).

Some people in this area call children with disability names which disvalue them; they call them disabled (T8).

Those statements suggested that people in society had negative practices towards individuals with disabilities. In this situation, according to teachers, the parents of children with disabilities struggled uncomfortably to support and educate their children.

Insufficient resources represented the major constraint to disability-inclusion in education. The teachers' concern was

that there were no financial and material resources available to support disability-inclusive education. It was the concern of the teachers that there was acute inadequacy of instructional facilities for all children. For children with disabilities, the inadequacy was in Braille books, teaching aids such as chart, maps, hearing aids, pictures for deaf learners, Braille machines, Sign Language dictionaries, Sign Language alphabet, to mention a few.

Furthermore, teachers disclosed that the school's infrastructure was not conducive to supporting children who experience disabilities. It was informed that there was inadequate basic learning/teaching furniture such as classroom desks, tables and chairs suitable for children who experience and those with disabilities. In this situation, as the teachers described, it was challenging to address the needs and challenges of children with disabilities in the general classroom. Teachers felt grateful that they did not have such children in their general classes.

On teachers' competencies, the teachers informed that many teachers were not equipped with competencies to support children with disabilities. It was informed that teachers lacked knowledge and skills to guide and support such children. One teacher said the following:

Listen, my friend, untrained teachers in inclusive education do not have the appropriate knowledge and skills to support children with disabilities, even if they teach them. For example, lack of knowledge and skills such as Sign Language and Braille appears to be a serious concern for teachers in this school (T6).

In supporting the idea of the lack of competencies among the teachers, another teacher had the following to say:

We are incompetent in Sign Language and Braille, which limit us from offering appropriate services to deaf children and children with visual impairment (T4).

It was clear that teachers' daily practices in school affected the children with disabilities negatively. It was informed that teachers were reluctant to include the children with disabilities in regular classes because of their beliefs. On this, the following were said:

I can assure you that, for children with disabilities, learning in an inclusive-classroom is a challenge because sometimes, teachers tend to concentrate on those without disabilities (T9).

Some teachers dump children with disabilities in the classes, and they do not teach them. Sometimes, some teachers shout at the children with disabilities during lessons, so they learn in fear (T15).

Some teachers believe that children with disabilities and those who do not experience disabilities are like two parallel lines which can never meet (T1).

4.0 Discussion

The findings of this study indicated that the teachers positioned their perspective of disability to medical and social models and to spiritual causes. On one hand, some teachers constructed disability based on the medical model of disability. They

viewed disability as the direct result of impairment(s) due to damage or disease. Those teachers thought of disability regarding diseases or illness, cure, rehabilitation and abnormality. On this basis, the children with disabilities were viewed as broken and problematic and required correction or rehabilitation (Solvang, 2000). Those teachers failed to distinguish between impairments from disability and see disability as deviations from normal body functioning, and equated disability to abnormality (Solvang, 2000).

The medical model of understanding disability has been reported elsewhere in Tanzania. For example, according to Stone-MacDonald (2012a), “Most people understand the role of medical and health issues in the cause of disabilities, but people also believe that there is a God or another force that influences the medical problems (p. 261).” Similarly, Stone-MacDonald (2015) argued that in Tanzania, the medical model is apparent in the beliefs of local people as the cause of an individual’s disability and that disability hinders an individual’s ability to participate in education or school activities. As it is known that the medical model centres on malfunction with emphasis on the clinical diagnosis and therapists to care (Berghs *et al.*, 2016; Jackson, 2018; Solvang, 2000), the persons with disabilities are seen as incapable of performing any activity. Therefore, with this perception of disability as medical, teachers are unlikely to teach and support such children in schools.

On the other hand, some teachers better-understood disability in social model thinking. Those teachers viewed the society as being broken and that the society’s structures, attitudes, and other obstacles hurdled children who experience disabilities to access quality service (Purtell, 2013). Such teachers distinguished between an individual’s illness and their disability

(Lawson & Beckett, 2020; O'Connell *et al.*, 2008; Rerief & Letšosa, 2018; Solvang, 2000). Importantly, those teachers who conceptualized disability in social model thinking neither denied that some forms of illness might have disabling consequences nor rejected the role of medical professionals in treating various illnesses (Rerief & Letšosa, 2018).

Conversely, some teachers conceptualized disability in the spiritual model and accepted all children as gifts from God. Those teachers argued that the children with disabilities needed care as peers without disabilities. The acceptance of such children has attached to Christian religious beliefs that all children are gifts from God. Stone-MacDonald (2012b) indicated that, based on both Muslim and Christian religious beliefs and values about disability, people saw children with disabilities as a reward from God; therefore, parents of children with disabilities should feel blessed. In this study, those teachers who thought in the spiritual model were all Christians, so their Christianity beliefs on the will and plans of God on human beings determined their beliefs on children with disabilities.

Based on the African beliefs model, little was heard about curses or witchcraft related to disability. According to Stone-MacDonald (2012a, 2012b), Christian and Muslim beliefs lead people to talk little about curses or witchcraft and see these beliefs as part of their past. However, some local people still turn to traditional healers and medical doctors to treat the symptoms of a child's disability. Although little was heard about curses or witchcraft concerning disability, in this study, according to Cosmas (2018), in other parts of Tanzania, some people believed that giving birth to a child with impairment(s) was associated with witchcraft. Additionally, disabilities were

attributed to 'juju' business (ritual business) children who experience disabilities were believed to boost some other people's businesses (Cosmas, 2018).

While it is established in the literature that all children have the right to inclusive education and that when inclusive education occurs, the outcomes are positive for everyone involved, there remained extreme micro or macro-exclusion of the children with disabilities in the school labelled inclusive (Cologon, 2014; Mackenzie *et al.*, 2016). In this study, teachers argued that the current efforts of providing pre-primary education in the inclusive setting are hurdled by a misconception of disability and inclusive education. The common misconceptions of inclusion related to considering integration and inclusion to be synonym; viewing inclusion as simply the presence of a child who is labelled disabled or different in a mainstream setting; thinking that inclusion is only about some children (instead of about everyone); and viewing inclusion as a process of assimilation (Cologon, 2014).

These misconceptions of inclusion lead to macro or micro exclusion, which is sometimes misappropriated as inclusion. According to Cologon (2014), micro-exclusion is experienced when the children are enrolled in a mainstream setting, but is segregated into a separate area of the classroom or school for all or part of the day; where a child is only permitted to attend for part of the day; present but not participating in the activities along with the other children in the setting; or present but viewed as a burden and not an equally valued member of the class or setting. Macro exclusion is where a child is segregated into a separate classroom, unit, or school (Cologon, 2014).

Drawing on Thomas' social relational understanding of disability which extends on the social model of disability (Cologon & Thomas, 2014; Thomas, 2010), it was apparent in this study that children with disabilities experienced micro-exclusion because of barriers to doing and barriers to being. Barriers to doing and being are concepts that form critical components of Thomas' social relational understanding of disability (Cologon & Thomas, 2014; Thomas, 2010). Barriers to doing are obstacles that impose participation restrictions to limit access, such as building access, access to the curriculum, or shared communication strategies (Cologon & Thomas, 2014). In this study, the teachers indicated that the children with disabilities could not access to inclusive pre-primary education because of the inadequate furniture and instructional facilities, and appropriate classrooms and toilets.

Barriers to being relate to inappropriate, hurtful or hostile behaviours that can occur in individual interactions and at systemic or institutional levels (Cologon & Thomas, 2014). It was noted in this study that barriers to being, including negative and discriminatory attitudes and practices towards children with disabilities, ableism thinking, and the lack of clear and genuine support to facilitate inclusive education hurdled the disability-inclusion in pre-primary education. This implies that disability-inclusive pre-primary education cannot be attained if schools are not free from discriminatory beliefs, attitudes and practices or ableism thinking (Cologon, 2013). Those findings also aligned with the social model view, which is concerned with addressing the barriers to participation experienced by children with disabilities as a result of various factors within the social structure (O'Connell *et al.*, 2008; Runswick-Cole, 2008).

It was also found that insufficient teachers trained in inclusive education, teachers' attitudes and daily practices impeded the implementation of disability-inclusive at the pre-primary education level. In this situation, children who experience disabilities are taught by unspecialized and unprofessional teachers (Mapunda *et al.*, 2017) who are likely to exclude the children with disabilities. The teachers with negative attitudes towards disability do segregate and discriminate against children with disabilities (Disabled People Organisation, 2013; Mapunda *et al.*, 2017). According to Thomas (2007), barriers to hurt an individual's sense of self, thus affecting who or what an individual feels they can be. Thomas (2007) has referred to this process as 'psycho-emotional disablism'. Psycho-emotional disablism impacts negatively on a person's self-esteem, confidence, sense of belonging, and positive sense of self and may also negatively impact impairment's experience (Cologon & Thomas, 2014).

While the children with disabilities may be present within a school setting, unless barriers to being and doing are addressed, the children will not be included. Such children with disabilities will experience macro- or micro-exclusion in education context, labelled inclusive. Runswick-Cole (2008) portrayed that the presence of the social barriers in mainstream schools results into parents to give up on their hopes for a mainstream education for their children because of the exclusion their children experience within mainstream settings.

Removing barriers to doing and remaining potential in facilitating inclusive practice (Mackenzie *et al.*, 2016). It is crucial to disestablish ableism thinking, which entails discriminatory attitudes and practices arising from the perception that a child with disability is in some sense inferior

to a person without disability. As Cologon (2019) put clear, “to be inclusive requires directly and actively rejecting common myths of ‘normal’ or ‘typical’ ways of thinking, being and doing, and recognising that education needs to be open and responsive to the vast range of ‘differences’ among humans” (p. 3). It is essential to take the approach of universal design for learning. The needs of all are incorporated into educational practices, rather than learning strategies that exclude children who experience disability (Spratt & Florian, 2015).

5.0 Conclusion and Recommendations

Disability-inclusive education is the current movement to enable children with disabilities to acquire education at various levels of education. This movement originated from the Salamanca Statement (UNESCO, 1994) which stipulated all children in the general school or classroom. According to the Statement, the school with disability-inclusive practices combats discrimination or segregation, creates open communities and helps to develop a disability-inclusive society. In the statement, the differences among children are recognized as normal, and each person has specific physical and socio-emotional characteristics as well as learning needs. Therefore, it is encouraged to emphasize on child’s strengths rather than deficits. This means that teaching/learning should focus on the specific learning needs of an individual child rather than the child’s deficit.

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