Include us!

A study of disability among Plan International's sponsored children

FULL REPORT

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

International Centre for Evidence in Disability

Plan

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A large print summary report is available on: www.plan-international.org
Individual country reports are available upon request.

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We would like to thank all the Plan Key Informants who agreed to be interviewed and provided useful information on Plan's work on disability.

Thanks to: the Plan Disability Inclusion Working Group, Victor Ochieng, Julio Garcia, Isobel Taylor, Lynda Taylor and all the Plan sponsorship staff for collaborating on the research.

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List of acronyms explained

CBR	Community Based Rehabilitation
CCCD	Child Centred Community Development
CO	Country Office
CPO	County Programmes Outlines
CRC	Convention on the Rights of the Child
CSP	Country Strategic Plan
DPOs	Disabled People's Organisation
ECCD	Early Childhood Care and Development
EDPRS	Economic Development and Poverty Reduction Strategy
GDcwd	Global Partnership on Children with Disabilities
ICED	International Centre for Evidence in Disability
INAM	National Institute of Women in Honduras
INEC	Estadístico Instituto Nacional de Estadística y Censos
LMICs	Low and Middle Income Countries
LSHTM	London School of Hygiene and Tropical Medicine
MDGs	Millennium Development Goals
NO	National Organisation
NORAD	Norwegian Agency for Develop Cooperation
OR	Odds Ratio
PALS	Programme Accountability and Learning Cycle
PE	Physical Education
POLT	Programme Operations Leadership Team
PU	Programme Unit
RO	Regional Office
UNCRC	United Nations Convention on the Rights of the Child
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNICEF	United Nations Children's and Emergency Fund
WHO	World Health Organisation

Executive summary

Within the international community, there is a growing awareness of the problems caused by the lack of data on children with disabilities. There are around 150 million children with disabilities in the world today. They face many barriers to their inclusion and participation in everyday activities (WHO, 2011).

UNICEF argues that for these children, 'many of their deprivations stem from and are perpetuated by their invisibility' and the report calls for ways in which they 'can be rendered visible through sound data collection and analysis' (UNICEF, 2013).

Presented here is latest research on children with disabilities from Plan International, in collaboration with the London School of Hygiene and Tropical Medicine. Its basis is Plan's powerful dataset of 1.4 million sponsored children, used here for the first time to explore more fully the challenges faced by children with disabilities. The compelling findings, based on Plan's sponsored children, will help Plan – and other researchers and organisations – to improve responses to the needs of children with disabilities, particularly with respect to their health and education.

Research scope and objectives

As part of its sponsorship role, Plan has for several years collected a wealth of data on the lives of its sponsored children in developing countries. Now Plan has taken that dataset a step further in a wide-reaching study with two overarching objectives. The first was to understand better the challenges faced by sponsored children with a disability to improve Plan's programmatic response and to help fill existing knowledge gaps on children with disabilities. The second was to gauge the usefulness of the dataset for research purposes by using it for quantitative analysis. This would help improve Plan programming as well as identify areas for improving the collection and processing of data for future use.
What makes this dataset unique derives from the cumulative effect of its main characteristics:

- it is extremely large and includes children with disabilities in each country's sponsorship programme
- it spans a large number of countries
- it asks comparable questions across all those countries
- the questions are comprehensive in assessing multiple domains of inclusion.

The findings – missing out on schooling and health

The key findings from analyses of the dataset were the following:

*Children with disabilities are **substantially less likely to attend school than children without disabilities**. In fact, the likelihood that a child with a disability did not attend school was often more than ten times greater than for a child without a disability.*

*When children with disabilities do attend school, **their level of schooling is below that of their peers**.*

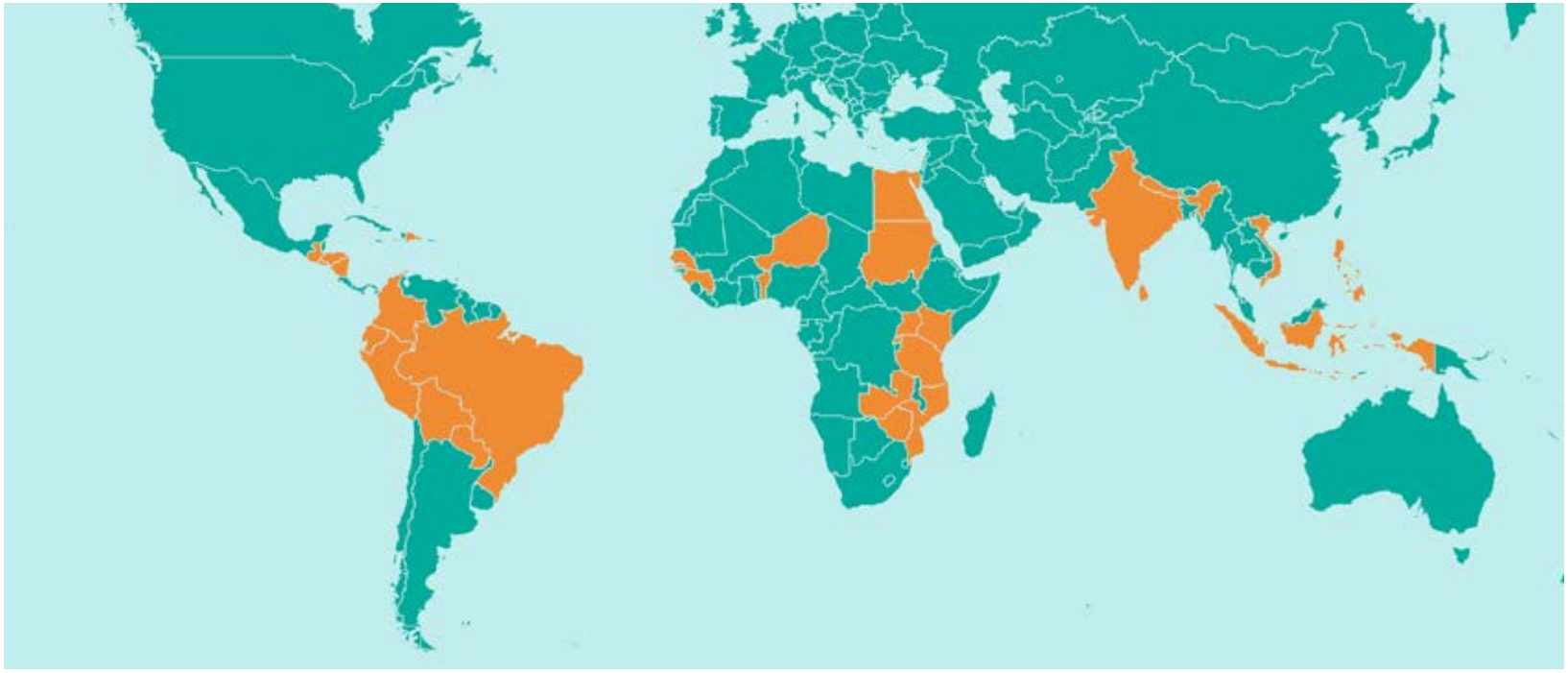
*Children with disabilities are much **more likely to have had a serious illness in the last 12 months**, including malnutrition, than children without disabilities*

Within most countries, inclusion levels for children with disabilities in schooling were highest for those with vision or hearing impairments and lowest for those with learning, physical or communication impairments. This indicates that the level of exclusion can be linked to the type of impairment. This area is ripe for more research to determine why, for example, some children with certain impairments are more able to access school than children with other types.
Poor health and lack of school attendance are likely to have a long-lasting impact on the life of the child. These factors may influence future employment opportunities, social opportunities, and their overall quality of life, including the likelihood of experiencing poverty.

Implications – furthering our understanding of children with disabilities

For Plan, the findings of this study have three sets of implications. First, programmatically they show that more efforts are needed to promote the inclusion of sponsored children with disabilities in education, and to meet their health needs. Second, the study shows areas needing further research: to determine why children with disabilities are not attending formal education and why they report higher rates of illness. Once this research is completed, Plan can develop targeted interventions alongside with mainstreaming disability inclusion, and advocate more broadly for change within those countries. Third, the study has demonstrated that the sponsorship dataset is a valuable and usable resource that can inform Plan programming, particularly on inclusion.

This report considers the international framework on children with disabilities; describes the methodology of the analyses; presents the main findings and country level findings; and outlines the implications for Plan and other development actors.



The countries in orange are where the data has been collected among Plan sponsored children in 2012.

1. Introduction

'The child sponsorship dataset is a unique and fantastic resource. It provides internationally comparable data of more than a million children across 49 countries, and includes detailed information about their lives. This information can be used to fill many existing knowledge gaps and help Plan and other organisations to better target the needs of children in resource-poor settings in order to improve their lives and their futures.'

Dr Hannah Kuper, Director at the International Centre for Evidence in Disability at the London School of Hygiene and Tropical Medicine

Plan International is one of the oldest and largest children's rights and development organisations in the world, working in 50 developing countries across Africa, Asia and Latin America. For several years, Plan has collected a wealth of data annually on more than 1.4 million of the children who are sponsored through Plan. Now Plan has taken that powerful dataset a step further, using it for the first time to explore more fully the challenges faced by sponsored children with disabilities. The compelling results will help Plan – and other researchers and organisations – to improve their responses to the needs of children with disabilities.

At the heart of these responses must be inclusion. There are 150 million children with disabilities who face many barriers to their inclusion and participation in everyday activities according to the 2011 World Report on Disability by the World Bank and the World Health Organisation (WHO). Enabling these children to overcome such barriers is part of Plan's commitment to the principles of inclusion and non-discrimination. It is central to Plan's child-centred community development (CCCD) approach that underscores all its work. It can be seen in Plan's Global Strategy for 2011 to 2015, One Plan, One Goal, with its strategic pledge to work with excluded and marginalised children – which includes children with disabilities – and towards 'better mainstreaming of inclusion' (Plan International, 2011). Plan's continuing commitment to inclusion was further highlighted in the 2012 Strategic Inclusion Review, (Plan International, 2012) which was part of the organisational process to enhance performance on inclusion.

This commitment to inclusion was a key driver behind the research presented here. It is part of a study begun in 2013, in collaboration with the International Centre for Evidence in Disability at the London School of Hygiene and Tropical Medicine (LSHTM), to explore the

feasibility of Plan's sponsorship dataset for research. As will be illustrated in Chapter 4 and 5 of this report the sponsorship dataset presents a range of different variables based on the comprehensive information collected on sponsored children. The reason that this first study was on children with disabilities was based on Plan's commitment to the principle of inclusion and the fact that the dataset would allow an inquiry into two important aspects of inclusion: disability and gender. This study is therefore the first part of this exercise, as it was expected that the findings of this quantitative study would require qualitative follow up research to understand the findings in more depth and within its context with a particular focus on what this means for Plan's programming.

The primary objective of the project was to understand better the challenges faced by sponsored children with a disability in order to improve Plan's programmatic response and to help fill existing knowledge gaps on children with disabilities. The second objective was to gauge the usefulness of the dataset for research purposes by using it for quantitative analysis; this also would help improve Plan's programming, as well as identify areas for improving the collection and processing of data for future use.

What makes this dataset unique derives from the cumulative effect of several of its characteristics:

- it is extremely large and has children with disabilities in each country's sponsorship programme
- it spans a large number of countries
- it asks comparable questions across all those countries
- the questions are comprehensive in assessing multiple domains of inclusion.

The dataset originates from Plan's sponsorship role: children in developing countries are sponsored by donors who live in countries where Plan has national offices, such as the United States, Canada, Japan, the United Kingdom, Germany, and the Netherlands among many other places. Plan annually collects data on the progress of each sponsored child in order to update the sponsors about the child's life and living conditions, and how the donated funds are spent in the community. It includes variables relating to: location, gender, health, education, disability, birth registration, water and sanitation, and housing to name a few. Currently the dataset holds information on more than 1.4 million children with data for the last six years.

As well as updating sponsors, the dataset represents an extremely useful source of information to help Plan in evidence-based decision-making. It has already been used in a number of ways, primarily for reporting and for monitoring and evaluation initiatives. But the full potential of the dataset as a source for quantitative research to establish trends and generate knowledge had not been fully realised – until now.

Chapter 2 of this report provides a brief review of the relevant international framework and selected literature as well as some perspective from Plan's work on disability through a review of documents and discussions with Key Informants from Plan.

Chapter 3 describes the project's methodology from the collection data from Plan's sponsored children, through to the statistical analysis undertaken, including issues of data protection and limitations of the study.

Chapters 4 and 5 present the main findings first on a global and regional level, followed by the findings for each of the 30 countries that were the focus of the analysis.

Finally chapters 6 and 7 outline the implications of the findings for Plan's work with children with disabilities and for future research, recommending certain key actions that would further enhance Plan's commitment to inclusion.

2. Setting the scene

This chapter '*setting the scene'* serves two purposes. It summarises key recent international conventions, guidelines, policies, and research, which relate to children with disabilities, with a focus on low and middle income countries. This aims to embed the analysis of the sponsorship data within a wider framework of current international work on disability, and provide a useful benchmark against which to understand and interpret Plan's sponsorship data.

Secondly, it provides a brief summary of key global documents within Plan which relate to disability, so that the sponsorship data can be better understood within the wider context of Plan's work. In this section we also document key issues identified by interviews with a range of Plan key informants, in order to help enrich the understanding of the findings of the sponsorship data, and how this relates to programmes.

It is beyond the scope of this report to provide a comprehensive literature review of research on all issues related to children with disabilities. A detailed review of the literature, with a focus on education and protection, was recently conducted for the Plan West Africa's Regional Office (International Centre for Disability and Rehabilitation, 2013) and this is an extremely useful reference document for Plan.

2.1 A global overview

Two key recent influential resource documents on disability have been the first ever WHO and World Bank World Report on Disability (2011), and UNICEF's State of the World's Children report on children with disabilities (2013).

The World Report on Disability is a comprehensive document which illustrates the great need for improved data, policies and programmes to address disability. A recurrent theme in the report is the connection between disability and poverty. Sub-groups that are identified as particularly vulnerable include: women, older people, children, and persons with mental health disabilities. The report concludes: *'People with disabilities have generally poorer health, lower education achievements, fewer economic opportunities and higher rates of poverty than people without disabilities. This is largely due to the lack of services available to them and the many obstacles they face in their everyday lives'* (World Health Organisation, 2011).

The recent 2013 UNICEF State of the World's Children report focuses on the experiences of children with disabilities and their families. It highlights that children who live in poverty *and* have a disability are even less likely to attend the local school or health service, are likely to be vulnerable to violence, and their families more likely to be poorer. One of the key recommendations is to promote approaches which remove the physical, cultural, economic, communication, mobility and attitudinal barriers that impede the realisation of the child's rights. This very much ties in with Plans' own right's based approach to working with children.

2.2 Guiding international conventions

Children with disabilities are arguably doubly disadvantaged, being marginalised and discriminated against both because of their age and their disability. The two key conventions which detail guiding principles for work with children with disabilities are the United Nations Convention on the Rights of the Child (UNCRC) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). Within the UNCRC specific reference to disability includes art.19 on children with disability, and art 2 on non-discrimination, which is one of the important principles of the UNCRC. All countries that have ratified the UNCRC therefore have a responsibility to be inclusive of children with disabilities.

The UNCRPD more recently came into force in 2008, and to date 158 States have signed the Convention and 138 States have ratified the Convention. It sets out clearly the obligations on States to promote, protect and ensure the rights of persons with disabilities. Most of the 50 articles are of relevance to children with disabilities, and specifically art. 7 articulates the responsibility of the governments to children with disabilities; *'That they agree to take every possible action so that children with disabilities can enjoy all human rights and freedoms equally with other children. They also agree to make sure that children with disabilities can express their views freely on all things that affect them. What is best for each child should always be considered first.'*

The Convention incorporates a social development perspective, and emphasises the need to ensure that international development programmes are inclusive of and accessible to persons with disabilities. Article 32 specifically commits development actors to mainstream disability rights. This Convention is gradually influencing donor priorities and requirements, and increasingly placing demands upon organisations to evidence that programmes are inclusive of persons with disabilities.

The impact of this Convention on donors is becoming more apparent. For example, since Norway's ratification in June 2013, there is now a requirement for organisations that are funded from the Norwegian Agency for Development Cooperation (NORAD) to report on how persons with disabilities have been included in their programmes. This will have implications for Plan's reporting to NORAD, and data on sponsored children with disabilities will be valuable.[1]

2.3 Data on children with disabilities

The World Report on Disability estimates that there are more than one billion people living with disabilities (World Health Organisation, 2011). Prevalence is believed to be highest in the poorest parts of the world, and among the poorer sectors of society (Kuper et al, 2008 and Rischewski et al, 2008). UNICEF estimated in 2005 that 150 million children globally live with a disability, and that the majority of these are in low or middle income countries (LMICs.); estimates of childhood disability prevalence varying from 0.4-12.7% (UNICEF, 2005).

There is an increasing demand for reliable statistics on the magnitude of disability and quality research, seen as critical for planning programmes and services and for advocacy to raise awareness of the importance of disability as a global issue. UNICEF highlights that for children with disabilities *'many of their deprivations stem from and are perpetuated by their invisibility, and that there is a need for research to render more children visible by improving data collection and analysis'* (UNICEF, 2013).

At the same time there is general agreement about the challenges of generating statistics on disability, the wide discrepancies in the data, and the limited knowledge available about the implications for children with disabilities. The challenges in data collection are due to lack of consensus around definitions of disability and approaches to measuring disability (World Health Organisation, 2011 and Nanoo, 2011). These issues are being tackled by initiatives from UNICEF and the World Bank to reach consensus on the measurement of disability in children. Other important issues still remain, however, such as the lack of internationally comparable data or that the sample sizes of studies are often too small to make robust inferences about the impact of disability on the lives of children, as well as a lack of investment in research.

The use of the Plan sponsorship data to better understand the lives of children with disabilities is therefore responding to this need to render children with disabilities more visible and generate much needed data.

[1] Information provided through key informant interview, Plan Norway.

2.4 Poverty and disability

The review of the Millennium Development Goals (MDGs) proposes the adoption of a zero extreme poverty target for 2030. This ambitious target is unlikely to be reached without focused attention on the relationship between global poverty and disability (Groce and Trani, 2009). Poverty and disability can be considered as overlapping dimensions of disadvantage (Wolff and De-Shalit, 2007), and *'disability is both a cause and consequence of poverty';* they reinforce each other and contribute to increased exclusion (DFID, 2000).

Although the evidence base is still relatively limited, an increasing body of research highlights that disabled people, and their households, are more likely to experience poverty (Kuper et al, 2008; Rischewski et al, 2008; Braithwaite and Mont, 2009; and Groce, 2011). Data from high income countries such as the United Kingdom also show higher levels of poverty and disadvantage in families with a child with a disability (Blackburn et al, 2010). Estimates of the additional costs of disability borne by families range from 9 per cent of income in Vietnam to 11–69 per cent in the United Kingdom (UNICEF, 2013).

A combination of factors has been documented to explain the higher levels of poverty which includes: a higher level of unemployment as a result of the opportunity cost of a parent or other family member taking on a caring role, lower average working hours and pay, the additional costs of transport and paying for adaptations to the home, and the medical treatment and rehabilitation costs (UNICEF, 2013). This relationship may also arise because the children of poorer families are more vulnerable to disability or have their impairment alleviated through medical care and rehabilitation, particularly in low and middle income countries. A recent Africa multi-country study highlighted that '*Poverty remains a major problem in safeguarding the wellbeing of children with disabilities: with up to 88% of caregivers unable to meet the basic needs of their children with disabilities'* (Nanoo, 2011). Again, the data on the relationship between poverty and disability is currently too sparse and inadequate, particularly in low and middle income countries.

2.5 Disability and health

The right to health is a fundamental basic right, and is central to poverty reduction and individual well-being. Article 25 of the UNCRPD reinforces the right of persons with disabilities to attain the highest standard of health care, without discrimination. All adults and children with disabilities have the same general health care needs as everyone else, and therefore need access to mainstream health care services. In fact, people with disabilities may be more vulnerable to common health concerns, such as malnutrition (Groce et al, 2013), thus requiring additional health care utilisation. Additionally, some impairments require access to rehabilitation services and /or have associated health conditions which need treatment and care.

Yet studies have highlighted the low uptake of health and rehabilitation services by disabled people in low income settings (Atijosan et al, 2008; Syed et al, 2013 and Trani, 2011). Specifically in terms of uptake of services in children, a variety of barriers can explain low uptake including: costs, attitudes of the family and community, distances and transport, administrative hurdles for referrals, stigma, and the need for additional support (Nanoo, 2011; Nesbitt et al, 2012). Barriers to access to health care in a recent World Health Organisation factsheet on disability and health also highlighted prohibitive costs, the lack of appropriate services, poorly skilled health workers, and physical barriers to access (WHO, 2013). More data is needed to understand the health needs of people with disabilities in order to better bridge the health care gap.

2.6. Water and sanitation

It is increasingly well documented that exclusion is one of the main barriers to improving hygiene, which in turn is inextricably linked to health outcomes (WHO, 2004). In low and middle income countries (LMICs) different categories of people who are socially and economically marginalised are still not able to access and use safe sanitation facilities. People with disabilities, as well as children, are two groups which often remain excluded from water and sanitation programmes and may need specially adapted services. People with disabilities are excluded both because they suffer from asset poverty, but also potentially for social reasons (Gosling and Patkar, 2011).

In terms of *children* with disabilities, there remains a gap in the research. However it is important to understand how the families manage and care for children with disabilities, and what their priorities for support are. Recent research conducted in Bangladesh and Kenya highlighted that difficulties with toileting and hygiene were identified as real challenges in caring for a child with chronic disability, exacerbated by the lack of inclusive facilities (Zuurmond and Alam, 2011 and Zuurmond and Nyapera, 2013).

2.7 Education

All children regardless of ability level have the same right to develop their potential and access education; this is clearly outlined in both the UNCRPD (Article 7, 24) and the UNCRC(Article 2, 23) [4, 6]. A recent monitoring report on the Convention on the Rights of the Child acknowledged that '*the challenges faced by children with disabilities in realizing their right to education remain profound*' and that they are '*one of the most marginalized and excluded groups in respect of education*' (United Nations, 2011).

Children with disabilities are less likely to start school, have lower rates of school attendance and lower transition rates to higher levels of education (WHO, 2011). A gap for school attendance at primary level between children with disabilities and their non-disabled peers exists, and this gap widens for attendance at secondary level (UNICEF, 2013 and Filmer, 2008).

Additionally, while enrolment may have increased for some types of impairment groups in a few LMICs, and some progress has been made with building the capacity of teachers on inclusive teaching practice, the overall quality of educational experiences for disabled children remain rather poor and exclusionary (Singal and Jeffrey, 2011).

A comprehensive literature review of inclusive education and child protection issues, focussing on West Africa, was recently conducted by Plan (International Centre for Disability and Rehabilitation, 2013a.). In-depth country case studies in Togo, Guinea, Niger and Sierra Leone also detailed the range of actors, relevant policy and legislation and programmes (International Centre for Disability and Rehabilitation, 2013b-2013e.). The review concluded that '*Even though on the right track, a lot remains to be done in order to protect the rights of the children with disabilities and to achieve their inclusion in educational programmes and full participation in the community. In order for change to occur governments must work together with stakeholders at different levels through a rights based and child-centred approach to implementation of the laws and establish mechanisms to ensure accountability*' (Plan International, 2013).

2.8 Child protection

Studies have shown that children with disabilities are disproportionately vulnerable to violence, neglect and abuse, as a result of exclusion and discrimination. A recent systematic review of the evidence conducted in 2012 demonstrated that children with disabilities

are three to four times more likely to be victims of violence. Their increased vulnerability can be due a variety of factors including; the additional strain on carers, significant numbers of disabled children still placed in residential care which is a major risk factor for sexual and physical abuse, and impairments affecting communication which may render some children particularly vulnerable as they may not be able to disclose abusive experiences (Jones et al, 2012). Plan recently commissioned a comprehensive literature on child protection issues for children with disabilities, with a focus on West Africa, and this is a useful reference document.

The UNCRPD obligates States to guarantee effective legal protection for children with disabilities. The UNCRC also includes a broad range of provisions that seek to protect all children, including children with disabilities. However, an increasing body of evidence shows that many children with disabilities lack access to protection, medical, psychosocial, and legal services (UNICEF, 2005). These children are often more isolated, and may have little possibility for reporting or receiving support (Handicap International and Save the Children, 2011).

Key recommendations to improve protection for this vulnerable group include: (1) the need to tackle social and structural discrimination which affects children with disabilities (2) greater investment in high-quality, free services that prevent and respond to sexual violence against children and young people with disabilities (3) support greater participation of children with disabilities by rendering them more visible, for example conducting more research on issues that affect them, and (4) increase in advocacy activities (Handicap International and Save the Children, 2011).

2.9 Plan's work with children with disabilities

Plan is a rights-based organisation. The Child-Centred Community Development (CCCD) approach commits Plan to an inclusive approach, which promotes participation as a central tenant. The new strategy One Goal, One Plan provides a very strong justification for work with children with disabilities, as it calls to 'maximize our reach and impact on children's lives, particularly those from excluded or marginalized groups.' Plan's Programme Guide highlights 'Inclusion and Non Discrimination' as an area where programmes will be intensified, and that understanding and tackling exclusion is essential for achieving Plan's vision of tackling child poverty (Plan International, 2010). These commitments tie in with the core principles of the UNCRC and the UNCRPD.

Within Plan's work, children with disabilities are included under a variety of categories; 'marginalised, 'excluded' 'vulnerable groups' and 'children in especially difficult circumstances'. A Plan discussion paper, 'Each and Every Child' (Ray and Carter, 2007), focuses on work with children in the poorest and most difficult situations, which includes children with disabilities. It highlights the need to recognise the common causes and experiences of these different groups[2], and for programmes to provide an integrated response. The report highlights how many of the immediate and root causes that precipitate children into very difficult situations are similar and include: (1) relationships of violence, neglect, abuse and exploitation, (2) exclusion from their societies, and (3) the deprivation of basic needs and essential services. The paper argues that common principles should be applied in working with specific groups of children, including children with disabilities, applying a rights-based framework.

An internal mapping of work on disability was conducted within Plan in 2011, at Country office (CO), National Organisation (NO) and Regional office (RO) level (Plan Norway, 2011 and Plan Australia, 2011). This mapping was based on an email questionnaire, which not all offices responded to; neither could the information be verified on the ground. However, this exercise highlighted pockets of good practice around disability-focussed work and inclusive practice, whilst at the same time highlighting that some of the work was quite piecemeal and/or small-scale. The mapping review highlighted that at a strategic level many country strategic plans (CSPs) do not analyse or refer to children with disabilities, although there is a recognition that these children may be included if programmes are inclusive, and are considered under the general banner of 'marginalised' children. At the national office level, a small but significant number of national offices do have a policy/are putting in a policy to mainstream disability across their work.

Some of the challenges for addressing disability, highlighted by staff at CO, NO and RO level include:

- the lack of reliable data on children with disabilities which makes it very hard to Plan services
- the need for more staff expertise on disability at all levels within Plan,
- the wider country policy environment which may not support a focus on disability,
- the need for increased global commitment/leadership on the issue of disability from Plan
- the perception that work on disability can be more resource intensive (Plan Norway, 2011 and Plan Australia, 2011).

[2] Other groups of children living in difficult circumstances include: children in the worst forms of child labour, street and working children, children in conflict with the law, children affected by conflict and disaster, children affected by HIV/AIDS, children affected by violence, exploitation, neglect and abuse, and children from discriminated castes and ethnic minorities.

These findings also mirrored the emerging issues highlighted in the Key Informant Interviews also undertaken for this review.[3] A key recommendation from the mapping exercise was that disability needs to be addressed in a more holistic way across all areas of Plan's work, including within the sponsorship programme (Plan International, 2011).

Following on from the mapping exercise, a comprehensive strategic review of inclusive practice within Plan's programmes was conducted in 2012 (Chapman et al, 2012), and Plan's work with children and youth with disabilities was one of a number of groups explored, although there was no significant reference to children with disabilities. Many of the findings and recommendations mirrored those in the disability mapping review. Key programmatic findings included:

- the need to strengthen the linkages between child rights and poverty analysis and strategic planning/programme design
- the need for all programmes to be inclusive and not focus on projects for specific excluded groups as this 'reduces the likelihood of effectiveness and sustainability and increases the risks that specific groups, such as out of school youth or children with disabilities, are forgotten'
- challenges in moving to a rights-based approach which requires programmes to address underlying causes
- the need to build staff capacity on issues of exclusion.

Although the review focussed on programmes, it also recognised that wider organisational issues needed to be addressed, and that Plan systems and processes require adaptation to support work on exclusion.

In the last 2 years Plan has been a member of the Global Partnership on Children with disabilities established through an initiative of UNICEF. The Global Partnership on Children with Disabilities (GPcwd) is a network of more than 240 organisations, including international NGOs, national and local NGOs, Disabled People's Organizations (DPOs), governments, academia and the private sector, working to advance the rights of children with disabilities at the global, regional and country levels. With a rights-based approach the GPcwd provides a platform for advocacy and collective action to ensure the rights of children with disabilities are included and prioritised by both the disability and child rights movement. The partnership has four established task forces, namely Education, Nutrition, Humanitarian Action, Assistive Technology and two newly emerged Early Childhood Development and Physical Activity.

[3] A small number of Key Informant Interviews with Plan Staff were undertaken to support this review process and to guide the selection and interpretation of Plan documentation.

2.10 Disability Conference

The first Plan International Disability Conference was organised under the auspices of the Disability-Inclusion Working Group[4] in Egypt in October 2012. This was considered a landmark conference for Plan as the first global conference on disability. Key recommendations from this conference built on the earlier review on inclusion and disability mapping and highlighted the need to develop awareness of disability rights as well as build staff capacity to ensure programmes are inclusive of children with disabilities, address organisational barriers to inclusion, address disability under one common agenda of tacking exclusion, and build on Plan's strategic focus on inclusion to strengthen advocacy work on disability.

It is therefore very timely that this analysis of Plan's sponsorship data on children with disabilities responds to these various recommendations. It will provide a global overview of disability in sponsorship, contribute to a better understanding of how children with disabilities compare to children without disabilities, and will help render children with disability more visible within the organisation. It can also provide useful data in relation to Plan's progress on inclusion.

[4] The Disability Inclusion Working Group is a Country Office, Regional Office and National Office initiative which aims to strengthen Plan's disability inclusion work.

3. Methodology

3.1 Collection of data

Plan's sponsorship data is collected in the local language through Plan front line staff and volunteers using paper questionnaires. The interview takes place with the caretaker of the sponsored child. Before the start of the interview consent is sought in order to use this data to inform programming and for sponsorship and fundraising activities. The questionnaire covers the following areas: age, gender, birth registration, family situation, health, education, the use of bed nets, type of house and assets, water and sanitation facilities, amongst others. The volunteers and front line staff are trained in data collection methods and provided with guidelines set out in what Plan terms the *Sponsorship Booklet*. Once collected, the data is entered into a dataset called ChildData, which is purpose built for Plan and operates on a code system. There are restrictions on which staff may access ChildData and they are specifically cleared for their tasks for child protection reasons.

The data is subsequently transferred to another dataset called BI Online (Cognos), where it can be used for management purposes, analysis and research. Each child is assigned a unique sponsorship number, which ensures the anonymity of the child and his/her family. Currently the dataset holds data starting from 2008, however for this research only the 2012 data was analysed. This is because in 2011 the questionnaire was updated. In particular the questions around impairment leading to disability were changed into the following questions:

- *Does the sponsored child have an impairment/ a medical condition that can lead to disability?*
- *If Yes, What type of impairment?*
- *Since what age has the SC had the impairment/ medical condition that can lead to disability?*

The *Sponsorship Booklet,* which provides guidance to the volunteers and front line staff who collect the data, includes the following information on these questions:

'This question is about whether the sponsored child has any impairment/medical condition that the caregiver feels can lead to them being excluded /discriminated against. The question has been designed based on guidelines available on the WHO website which states: 'Impairment: A characteristic and condition of an individuals' body or mind which unsupported has limited, does limit or will limit that individual's personal or social functioning in comparison with someone who has not got that characteristic or condition. Impairment relates to a physical, intellectual, psychosocial or sensory condition; as such it is largely an individual issue. Accordingly, disability is the way(s) in which people with impairments are excluded or discriminated against; as such, it is largely a social and development issue.'

> **Disability** is the umbrella term for impairments, activity limitations and participation restrictions and refers to difficulties encountered in any or all three areas of functioning.
>
> **Impairments** are problems in body function or alterations in body structure – for example, paralysis or blindness
>
> **Activity limitations** are difficulties in executing activities – for example, walking or eating
>
> **Participation restrictions** are problems with involvement in any area of life – for example, facing discrimination in employment or transportation
>
> *The World Report on Disability (2011)*

3.2 Data Analysis

As part of the analysis the questions relating to impairments were cross analysed with other variables, such as education and health. The questions relating to these other variables will be described in the relevant sections of this report. For the statistical analysis the data was entered into the statistical programme Stata.[5] Children within the dataset were categorised as 'children with disabilities' or 'children without disabilities' based on a self-report. For children with disabilities, they were classed by type of impairment. Children

[5] Stata is a statistical software package that provides data analysis, data management, and graphical representation of data.

with disabilities were compared to those without (as a comparison group) for a number of variables including: birth registration, health, education and poverty variables.

The poverty variables were scored through a principle component analysis,[6] where distance to water, family assets and the type of house were combined to provide a score which served as an economic proxy. The mean values and the proportion of children in different categories, such as those attending school or not, were calculated in relation to children with disabilities and those without. The difference between the children with and without disabilities was tested for statistical significance[7] for these key variables in order to identify whether there was a relationship between disability and the key variables (eg. poverty, school attendance).

The children with disabilities were generally older than those without, therefore the analyses had to be adjusted for age in order to make meaningful comparisons. Otherwise, the difference between the children with disabilities and those without may not be an account of the disabilities, but due to differences in age. A multiple logistic regression model was created to make these comparisons, using the Stata statistical package.[8] Through Stata the odds ratios and 95% confidence intervals were generated,[9] which allowed the assessment of age-adjusted relationship between disability and the key variables. Most of the analyses were conducted separately for boys and for girls. For the education variables the analysis was restricted to only include children aged five years and older. Given the small number of young people aged 18 years and above in the sponsorship programme, they were excluded from all the country analyses.

The study analysed 30 of Plan's programme countries, whereas Plan works in 50 programme countries. There are two reasons for this. First, Myanmar, does not have a sponsorship programme, as operations only started there after Cyclone Nargis hit the country. Second, the other 19 countries did not have a high enough number of children with disabilities included in their sponsorship programmes. The threshold number of children with a disability that would allow for a statistical analysis was set at 100. So for example, Togo, which has 98 children with a disability in their sponsorship programme, was not part of the analysis. Yet, it is important to note that all countries include children with disabilities in the sponsorship programme.

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[6] Principal component analysis is a statistical procedure that allows for the conversion of a set of observations into a single score. In this case, a large number of observations related to poverty (eg. household assets and sanitation) were converted into a single poverty score.
[7] Statistical significance is when a test rejects the null hypothesis. This is usually determined by the p-value calculated by the statistical test being less than 0.05.
[8] A multiple logistic regression model is a statistical model whereby the difference between two groups is assessed (eg. between children with and without disabilities in school attendance), while keeping other differences between the groups constant (eg. age).
[9] 95 per cent confidence intervals show the range for which there is a 95% confidence that it includes the true value of the parameter.

3.3 Limitations

As with every dataset there are a number of limitations that should be noted. Firstly, the data reflects the status of sponsored children only. In some communities the sponsored children can be representative for all children in the communities in which Plan works; however, this will not apply to all communities where Plan operates. As the data only represents sponsored children, no general statement about children with disabilities can made at a national level.

Plan's sponsorship programmes are located in economically disadvantaged areas and sponsored children and their families are amongst the poorest or most marginalised within their communities. Children are selected into Plan's sponsorship programme using the guidelines set out in the Sponsorship book, however, local Plan offices develop criteria for enrolment of families considering wealth, willingness to participate in community development activities etc. Nevertheless, there are a number of criteria that apply across all countries, such as: one sponsored child per family, the sponsored child must live with his/her parent(s), or a responsible relative or guardian, and the designated Plan field staff/community volunteer must ensure that the family is not receiving significant benefits from another organisation. The guidelines specifically mention that 'special needs children' are eligible for sponsorship. Yet, this is not formulated according to inclusive language.

Secondly, Plan has over 1.4 million sponsored children but traditionally, due to different data collection cycles, the data is not always updated annually. Sometimes this happens once every 18 months, or more likely, twice within the same year (at the beginning or end of the year), which means the following year is missing. Where this occurs, the most recent sponsorship questionnaire update is used. The sponsorship team in Plan have recently adapted the data collection cycles and this will ensure that future collection takes place annually. Although the quality of the data was generally very high, for some variables, there were issues with miscoded or missing data (eg. duration of disability, vaccination status). Problems with data quality are unlikely to be different depending on disability status, and consequently any bias in the results would have been towards the null,[10] thus underestimating any potential associations.

[10] The null is also called 'non differential misclassification bias' in technical jargon. It means that if there is a poor measure of the variable (eg. illness in last month) then two groups that are actually different in terms of that variable will appear more similar. In other words, some children who were ill were classed as not ill, and vice versa, in both groups. This means that differences are concealed, and that the association that is being reported is biased towards the null, where null is no difference between the two groups.

3.4 Contextualising the data

The sponsorship data analysis provides Plan with a fantastic resource for quantitative analysis, but to create a full picture the data should be understood in its (local) context. To ensure this, the following information was included as part of the analysis .For each country their five year country strategic plans were consulted to specify the programmatic focus areas and whether particular programmes for children with disabilities exist. In addition, it was reported whether the country signed up and ratified the 2006 UN Convention on Persons with Disabilities and/or whether specific national laws exist that afford children with disabilities their rights. The population statistics and the percentages of children aged 0-14 were sourced from the World Bank.

In addition, a scoping exercise was undertaken to provide an overview of the recent documentation related to the disability and rights agenda, and of disability inclusion within Plan. This included:

- A Literature review of key recent documents on disability and of key Plan documentation. The decision was taken not to undertake a comprehensive literature review given the recent work on disability commissioned by the Plan WARO office.
- Key informant interviews were undertaken to both guide and facilitate interpretation of key emerging issues in the data. A total of six in-depth interviews were conducted, which included representatives of the Plan Disability Inclusion Working Group. This was a small number of interviews due to the limited availability of staff,[11] but the data helped guide the research process including the identification of key documentation, supported the interpretation of statistical data, and ensured that the research findings were placed within the wider context of Plan's work.

Sponsorship data explained

In 2012, there were 1,431,075 children in 49 countries who took part in Plan's sponsorship programme (Myanmar does not yet have a sponsorship programme). Sponsored children have sponsors in 20 different countries.

Plan's sponsorship dataset holds data from the last six years, starting in 2008. Sponsorship donations benefit the entire community and not only the sponsored child.

[11] A total of 10 intervie

4. Global and regional analysis

They key findings from the analyses of the dataset were the following:

*Children with disabilities are **substantially less likely to attend school than children without disabilities**. In fact, a child with a disability did not attend was often ten times less likely to attend school compared to a child without a disability.*

*When children with disabilities do attend school, **their level of schooling is below that of their peers**.*

*Children with disabilities are much **more likely to have had a serious illness in the last 12 months**, including malnutrition, than children without disabilities*

Within most countries, inclusion levels for children with disabilities in schooling were highest for those with vision or hearing impairments and lowest for those with learning, physical or communication impairments. This indicates that the level of exclusion can be linked to the type of impairment, rather than the absolute availability of schooling. This area is ripe for more research to determine why, for example, some children with certain impairments are more able to access school than children with other types and how this can be overcome. Poor health and lack of school attendance are likely to have a long-lasting impact on the life of the child. These factors may influence future employment opportunities, social opportunities, and their overall quality of life, including the likelihood of experiencing poverty.

These are some of the most important, consistent findings relating to inclusion in education and to health among sponsored children with disabilities, arising from the dataset analyses. As highlighted in Chapter 2 it is known that children with disabilities are less likely to

attend school. Yet, for Plan's sponsored children this analysis now demonstrates how much less likely children with disabilities are not able to attend school, for which reasons, or how much more likely that they have experienced health problems.

For any statistical analysis, it is important to set out the demographic characteristics in order to understand the population to which the analyses relate. Tables 1 to 8 present the total number of sponsored children with and without a disability in the thirty countries, and the distribution by age and gender, the prevalence and type of impairment.

4.1 Demographics

The age and gender distribution was similar across all countries (Tables 1-3), with a few exceptions, such as Benin where the focus of the programme was on girls.
The children with disabilities were generally older than those without (Tables 4-6). This is consistent with disabilities becoming manifest during the development of the child, rather than always being evident, or present, from birth.

Table 1: Demographic characteristics of sponsored children in Latin America

Country	Number of sponsored children	Of which number of children with a disability	Average age (SD)	% male	% female
Bolivia	41,979	372	9.5 (4.2)	41%	
Brazil	12,993	143	6.9 (4.0)	44%	
Colombia	22,020	235	8.8 (4.3)	42%	
Dominican Republic	26,560	178	8.7 (4.7)	41%	
Ecuador	47,070	793	9.7 (4.2)	46%	
El Salvador	34,814	646	10.1 (4.0)	45%	
Guatemala	38,797	432	9.9 (3.9)	44%	
Honduras	34,040	551	9.3 (4.2)	44%	
Nicaragua	27,793	459	9.5 (4.3)	46%	
Paraguay	7,813	114	9.0 (4.1)	46%	
Peru	25,364	195	8.9 (4.5)	42%	

Table 2: Demographic characteristics of sponsored children in Africa

Country	Number of	Of which number	Average age	% male	% female

	sponsored children	of children with a disability	(SD)		
Benin	24,547	108	10.5 (3.2)	6%	
Egypt	33,871	452	9.9 (4.0)	44%	
Guinea	28,208	146	9.9 (3.9)	30%	
Kenya	60,139	258	10.1 (3.9)	42%	
Mozambique	6,782	119	6.2 (2.3)	44%	
Niger	19,103	185	7.7 (4.3)	33%	
Rwanda	6,443	214	7.2 (3.3)	29%	
Senegal	32,738	155	9.1 (4.2)	36%	
Sudan	27,225	131	9.8 (4.0)	37%	
Tanzania	24,303	105	9.8 (3.9)	41%	
Uganda	35,466	268	9.6 (4.1)	39%	
Zambia	16,725	113	10.2 (3.8)	47%	
Zimbabwe	33,346	200	10.5 (3.9)	34%	

Table 3: Demographic characteristics of sponsored children in Asia

Country	Number of sponsored children	Of which number of children with a disability	Average age (SD)	% male	% female
India	65,360	522	8.0 (4.1)	35%	
Indonesia	45,860	376	9.4 (4.0)	45%	
Nepal	38,450	259	9.6 (3.9)	26%	
Philippines	33,543	397	9.6 (4.3)	39%	
Sri Lanka	21,743	166	9.6 (4.3)	45%	
Vietnam	34,639	608	8.5 (3.9)	34%	

Table 4: Age and disabilities amongst sponsored children in Latin America

Mean age	MALES			FEMALES		
	Disabled	Non disabled	p-value	Disabled	Non disabled	p-value
Bolivia	10.5 (4.0)	10.1 (3.9)	0.19	10.1 (3.7)	9.1 (4.3)	0.001
Brazil	8.2 (3.8)	6.9 (4.0)	0.003	8.1 (4.3)	6.9 (3.9)	0.02
Colombia	10.1 (3.8)	9.4 (4.1)	0.05	9.8 (4.0)	8.4 (4.4)	0.001

Dominican Rep	11.2 (4.6)	9.5 (4.8)	0.002	9.7 (4.2)	8.1 (4.6)	0.001
Ecuador	10.5 (3.8)	10.0 (4.1)	0.004	9.9 (4.1)	9.4 (4.2)	0.01
El Salvador	11.3 (3.6)	10.3 (3.9)	0.001	10.8 (3.7)	9.8 (4.1)	0.001
Guatemala	10.9 (3.5)	10.5 (3.6)	0.08	10.0 (3.9)	9.4 (4.1)	0.04
Honduras	10.5 (3.4)	9.8 (4.1)	0.005	9.9 (3.9)	9.0 (4.2)	<0.001
Nicaragua	10.4 (3.9)	9.5 (4.2)	0.002	10.1 (3.9)	9.4 (4.4)	0.03
Paraguay	10.3 (3.7)	9.4 (4.1)	0.06	9.8 (4.1)	8.8 (4.1)	0.09
Peru	10.3 (3.7)	9.6 (4.3)	0.12	9.3 (4.5)	8.4 (4.6)	0.07

Table 5: Age and disabilities amongst sponsored children in Africa

Mean age	MALES			FEMALES		
	Disabled	Non disabled	p-value	Disabled	Non disabled	p-value
Benin	14.0 (2.0)	13.3 (3.7)	0.68	10.0 (2.8)	10.3 (3.1)	0.23
Egypt	10.4 (3.8)	10.5 (3.8)	0.88	9.9 (3.8)	9.5 (4.1)	0.16
Guinea	10.4 (3.7)	8.3 (3.7)	0.0001	11.9 (3.5)	10.5 (3.8)	0.0001
Kenya	11.2 (3.1)	10.6 (3.8)	0.08	10.3 (4.1)	9.8 (4.0)	0.21
Mozambique	7.2 (2.5)	6.2 (2.2)	0.001	7.3 (2.3)	6.2 (2.4)	<0.001
Niger	10.6 (3.6)	8.5 (4.0)	<0.001	9.5 (4.0)	7.3 (4.4)	<0.001
Rwanda	7.9 (3.4)	7.6 (3.4)	0.46	7.3 (3.3)	7.0 (3.3)	0.20
Senegal	11.8 (3.7)	10.1 (3.9)	0.0001	9.5 (4.0)	8.5 (4.3)	0.06
Sudan	12.7 (3.6)	10.4 (4.0)	<0.001	12.2 (3.9)	9.4 (4.0)	<0.001
Tanzania	10.9 (3.8)	10.3 (3.9)	0.24	10.8 (4.1)	9.4 (3.8)	0.007
Uganda	10.1 (4.0)	10.3 (3.9)	0.61	9.4 (3.9)	9.1 (4.2)	0.33
Zambia	12.0 (3.3)	10.4 (3.8)	0.002	11.7 (2.7)	10.0 (3.8)	0.001
Zimbabwe	11.6 (3.5)	11.6 (3.7)	0.88	9.9 (3.6)	9.9 (3.9)	0.88

Table 6: Age and disabilities amongst sponsored children in Asia

Mean age	MALES	FEMALES				
	Disabled	Non disabled	p-value	Disabled	Non disabled	p-value
India	9.9 (3.8)	8.9 (4.0)	0.001	9.2 (4.1)	7.6 (4.1)	0.001
Indonesia	10.3 (3.8)	9.7 (3.9)	0.02	10.5 (3.8)	9.2 (4.0)	<0.0001
Nepal	9.1 (3.9)	9.3 (4.1)	0.61	9.7 (4.1)	9.7 (3.9)	0.88

Philippines	11.0 (3.7)	10.5 (3.9)	0.11	9.8 (4.3)	9.0 (4.4)	0.007
Sri Lanka	10.1 (4.4)	9.7 (4.3)	0.44	10.6 (4.3)	9.4 (4.4)	0.01
Vietnam	10.3 (3.5)	9.4 (3.7)	<0.0001	9.0 (3.8)	8.0 (3.9)	<0.0001

The questions relating to impairment are the following:

- Does the sponsored child have an impairment/ a medical condition that can lead to disability? *Yes/No*
- What type of impairment?
- Since what age has the sponsored child had the impairment/medical condition that can lead to disability?

The last question, however, had too many missing values in order to do a proper analysis.

Despite the large numbers of children enrolled in the sponsorship programme, the number of children who reported having a disability was relatively small, ranging from 0.4 to 3.3 per cent of the children included (Tables 7-9). The prevalence of disability was almost higher in boys than in girls. Possible explanations for this pattern include the greater vulnerability of boys to development of disability (eg. due to injuries, generic conditions), greater awareness of the occurrence of disability in boys, or lower survival among children with disabilities.

Although this data is useful for estimating the prevalence of self-reported disability among the sponsored children, it cannot be extrapolated to the general population and so do not show the national level prevalence. These estimates are also likely to underestimate the true prevalence among the sponsored children: few caregivers perceive their child as having a disability, even though the child would potentially be classed as 'having a disability' through more comprehensive assessments or questionnaires, or caregivers may be more likely not to report on a child's disability for a number of reasons. For example, a 2013 Plan study in Niger on children with disabilities reported that 'A disabled child is most often considered a burden on the family, and they are considered to be a non-productive member of society. Children with disabilities are frequently kept hidden by their families.' (Keachi, 2013) Last, it should be taken into account that this study looks at sponsored children only and that as part of Plan's selection process into the sponsorship programme there can only be one sponsored child per family. However, the sponsorship questionnaire does not cover whether a sibling of the sponsored child has a disability or not.

Table 7: Prevalence of disabilities of sponsored children by gender in Latin America

Country	No. children with disabilities	Overall prevalence (95% CI)	Prevalence Males (95% CI)	Prevalence females (95% CI)	OR for Males vs Females and Disability (95% CI)
Latin America					
Bolivia	372	0.9% (0.8-1.0%)	1.0% (0.9-1.2%)	0.8% (0.7-0.9%)	1.2 (1.0-1.5)
Brazil	143	1.1% (0.9-1.3%)	1.4% (1.1-1.7%)	0.8% (0.6-1.1%)	1.6 (1.2-2.2)
Colombia	235	1.0% (0.9-1.2%)	1.3% (1.0-1.6%)	0.9% (0.7-1.0%)	1.4 (1.1-1.9)
Dominican Rep	178	0.7% (0.6-0.8%)	0.8% (0.6-0.9%)	0.6% (0.5-0.7%)	1.2 (0.9-1.6)
Ecuador	793	1.7% (1.6-1.8%)	1.9% (1.8-2.1%)	1.7% (1.6-1.8%)	1.3 (1.1-1.5)
El Salvador	646	1.9% (1.7-2.0%)	2.2% (2.0-2.4%)	1.6% (1.4-1.7%)	1.4 (1.2-1.6)
Guatemala	432	1.1% (1.0-1.2%)	1.3% (1.1-1.5%)	1.1% (0.8-1.1%)	1.3 (1.1-1.6)
Honduras	551	1.6% (1.5-1.8%)	2.0% (1.8-2.2%)	1.3% (1.1-1.5%)	1.5 (1.2-1.7)
Nicaragua	459	1.7% (1.5-1.8%)	1.9% (1.7-2.1%)	1.4% (1.2-1.6%)	1.3 (1.1-1.6)
Paraguay	114	1.5% (1.2-1.7%)	1.9% (1.4-2.3%)	1.1% (0.7-1.4%)	1.7 (1.1-2.4)
Peru	195	0.8% (0.7-0.9%)	0.9% (0.7-1.1%)	0.7% (0.5-0.8%)	1.3 (1.0-1.8)

Table 8: Prevalence of disabilities of sponsored children by gender in Africa

Country	No. children with disabilities	Overall prevalence (95% CI)	Prevalence Males (95% CI)	Prevalence females (95% CI)	OR for Males vs Females and Disability (95% CI)
Benin	108	0.4% (0.4-0.5%)	0.3% (0.04-0.6%)	0.4% (0.4-0.5%)	1.0 (0.9-1.0)
Egypt	452	1.3% (1.2-1.5%)	1.6% (1.4-1.8%)	1.2% (1.0-1.3%)	1.4 (1.1-1.6)
Guinea	146	0.5% (0.4-0.6%)	0.5% (0.4-0.7%)	0.5% (0.4-0.6%)	1.3 (0.9-1.8)
Kenya	258	0.4% (0.4-0.5%)	0.5% (0.4-0.6%)	0.4% (0.3-0.4%)	1.3 (1.0-1.6)
Mozambique	119	1.8% (1.4-2.1%)	1.8% (1.3-2.3%)	1.7% (1.3-2.1%)	1.1 (0.7-1.5)
Niger	185	1.0% (0.8-1.1%)	1.4% (1.1-1.7%)	0.8% (0.6-0.9%)	1.6 (1.2-2.1)
Rwanda	214	3.3% (2.8-3.8%)	3.8% (2.9-4.7%)	3.1% (2.6-3.6%)	1.2 (0.9-1.6)
Senegal	155	0.5% (0.4-0.5%)	0.7% (0.6-0.9%)	0.3% (0.3-0.4%)	1.9 (1.3-2.6)
Sudan	131	0.5% (0.4-0.6%)	0.7% (0.5-0.8%)	0.4% (0.3-0.5%)	1.6 (1.1-2.2)
Tanzania	105	0.4% (0.3-0.4%)	0.5% (0.4-0.6%)	0.4% (0.3-0.5%)	1.2 (0.8-1.7)
Uganda	268	0.8% (0.7-0.8%)	0.8% (0.7-1.0%)	0.7% (0.6-0.8%)	1.2 (0.9-1.5)
Zambia	113	0.7% (0.6-0.8%)	0.8% (0.6-0.9%)	0.6% (0.4-0.8%)	1.4 (1.0-1.8)
Zimbabwe	200	0.6% (0.5-0.7%)	0.7% (0.6-0.9%)	0.5% (0.4-0.6%)	1.4 (1.0-1.8)

Table 9: Prevalence of disabilities of sponsored children by gender in Asia

Country	No. children with disabilities	Overall prevalence (95% CI)	Prevalence Males (95% CI)	Prevalence females (95% CI)	OR for Males vs Females and Disability (95% CI)
India	522	0.8% (0.7-0.9%)	1.0% (0.9-1.1%)	0.7% (0.6-0.8%)	1.3 (1.1-1.5)
Indonesia	376	0.8% (0.7-0.9%)	1.0% (0.8-1.1%)	0.7% (0.6-0.8%)	1.4 (1.1-1.7)
Nepal	259	0.7% (0.6-0.8%)	1.0% (0.8-1.2%)	0.5% (0.5-0.6%)	1.9 (1.5-2.4)
Philippines	397	1.2% (1.1-1.3%)	1.4% (1.2-1.6%)	1.0% (0.9-1.2%)	1.3 (1.1-1.6)
Sri Lanka	166	0.8% (0.6-0.9%)	0.8% (0.6-0.9%)	0.8% (0.6-0.9%)	1.0 (0.7-1.3)
Vietnam	608	1.8% (1.6-2.0%)	2.5% (2.2-2.8%)	1.3% (1.2-1.5%)	1.7 (1.5-2.0)

Tables 10-12 indicate types of underlying impairment that cause the disability, categorised as: learning, physical, communication, vision and hearing. These overarching categories consist of more detailed description, which can be found in the country reports. The questionnaire allows the recording of only a single type of impairment, and it can therefore be presumed that if a sponsored child has multiple impairments that the most serious type was recorded.

Among the children with disabilities, the least common types of impairment were vision or hearing; the most common were communication and physical impairments, with the latter marginally more prevalent. Reports of learning impairments were very low in Africa, potentially indicating under-reporting of this condition due to stigma or lack of awareness, rather than a lack of occurrence of learning impairment.

Table 10: Type of impairment amongst sponsored children in Latin America

Country	Learning	Physical	Communication	Vision	Hearing
Bolivia	20%	19%	33%	20%	8%
Brazil	27%	43%	12%	13%	6%
Colombia	29%	21%	26%	19%	6%
Dominican Republic	16%	32%	20%	28%	4%
Ecuador	21%	22%	25%	25%	6%
El Salvador	10%	36%	33%	15%	7%
Guatemala	11%	24%	31%	27%	7%
Honduras	26%	21%	19%	28%	7%
Nicaragua	21%	22%	28%	23%	6%

Paraguay	20%	28%	23%	25%	4%
Peru	26%	22%	24%	25%	4%

Table 11: Type of impairment amongst sponsored children in Africa

Country	Learning	Physical	Communication	Vision	Hearing
Benin	1%	31%	5%	46%	17%
Egypt	26%	31%	26%	13%	4%
Guinea	3%	43%	32%	13%	8%
Kenya	6%	25%	28%	15%	27%
Mozambique	2%	23%	30%	17%	29%
Niger	1%	48%	27%	14%	10%
Rwanda	3%	45%	9%	22%	21%
Senegal	6%	27%	45%	17%	5%
Sudan	6%	38%	24%	21%	10%
Tanzania	3%	57%	18%	10%	11%
Uganda	1%	36%	26%	15%	22%
Zambia	6%	32%	22%	20%	19%
Zimbabwe	11%	37%	23%	15%	16%

Table 12: Type of impairment amongst sponsored children in Asia

Country	Learning	Physical	Communication	Vision	Hearing
India	4%	45%	24%	23%	5%
Indonesia	9%	32%	39%	12%	7%
Nepal	3%	53%	22%	20%	3%
Philippines	10%	36%	31%	17%	6%
Sri Lanka	10%	24%	33%	22%	12%
Vietnam	20%	33%	18%	22%	7%

4.2 Education

The education analysis included assessment of formal education attendance, reasons for non-attendance and level of schooling, among children aged five years and older. The questions on education in the sponsorship questionnaire are the following:

- Does the sponsored child regularly attend formal education?
- If yes, which level of formal education does the sponsored child attend?
- If no, why is the sponsored child not attending formal education?

Attendance

Levels of school attendance among children without disabilities were generally very high – above 90 per cent for most countries (Tables 13-15). However, what appears clearly from the analysis is that sponsored children with a disability are substantially less likely to attend formal education. For example, in Brazil 98 per cent of sponsored boys and girls without a disability go to school, compared to 72 per cent of girls with a disability and 77 per cent of boys with a disability. After adjusting for age, Tables 13, 14 and 15 indicate how many times less likely a child with a disability is to attend school compared to a child without a disability (the odds ratio). Alarmingly, the likelihood that a child with a disability did not attend school was often ten times greater than that for a child without a disability. Although the magnitude of the relationship varied between countries, this was generally similar for boys and girls within each country.

Non-attendance

The most commonly reported reason for sponsored children with a disability not attending school was because of impairment or illness. In contrast, the main reason for children without a disability not attending formal education was being too young. The reasons for not attending formal education are described in each country section and report that for example in Egypt, 80 per cent of children with a disability say that they do not go to school 'because they have an impairment', whereas 75 per cent of children without a disability say that they are 'too young'. When a child with a disability says that the impairment was the main reason for not attending school, it strongly indicates that the barrier stopping the child from realising his or her right to education relates to exclusion due to disability – not a lack of access to education in general. Further research is required into the underlying reasons for non-attendance.

Table 13: Education and disabilities amongst sponsored children in Latin America

	MALES	FEMALES

Attend formal education (age 5+)		Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
Bolivia	Yes	110 (69%)	14488 (94%)	Baseline	118 (63%)	19224 (93%)	Baseline
	No	50 (31%)	851 (6%)	7.8 (5.5 - 10.9)	70 (37%)	1348 (7%)	8.5 (6.3 - 11.5)
Brazil	Yes	49 (77%)	3847 (98%)	Baseline	36 (73%)	4870 (98%)	Baseline
	No	15 (23%)	90 (2%)	15.1 (8.0 - 28.3)	13 (27%)	91 (2%)	25.2 (12.5-50.5)
Colombia	Yes	78 (67%)	7900 (98%)	Baseline	71 (74%)	9779 (98%)	Baseline
	No	38 (33%)	147 (2%)	30.0 (19.2 - 46.8)	25 (26%)	169 (2%)	21.5 (12.6 - 36.5)
Dominican Rep	Yes	50 (66%)	8481 (95%)	Baseline	43 (54%)	10956 (95%)	Baseline
	No	26 (34%)	458 (5%)	16.3 (9.7 - 27.5)	37 (46%)	592 (5%)	31.0 (18.8 - 51.1)
Ecuador	Yes	269 (69%)	17910 (95%)	Baseline	237 (71%)	20220 (95%)	Baseline
	No	120 (31%)	883 (5%)	11.3 (8.8-14.6)	97 (29%)	1167 (5%)	9.1 (6.9-11.9)
El Salvador	Yes	210 (63%)	12888 (91%)	Baseline	192 (69%)	15053 (92%)	Baseline
	No	122 (37%)	1214 (9%)	6.3 (5.0 - 7.9)	88 (31%)	1397 (8%)	5.0 (3.9 - 6.5)
Guatemala	Yes	127 (59%)	14358 (89%)	Baseline	115 (59%)	15906 (85%)	Baseline
	No	88 (41%)	1854 (11%)	5.3 (4.0 - 7.0)	79 (41%)	2842 (15%)	4.0 (3.0 - 5.3)
Honduras	Yes	179 (63%)	10728 (83%)	Baseline	140 (61%)	13500 (86%)	Baseline
	No	103 (37%)	2206 (17%)	3.2 (2.4 - 4.1)	89 (39%)	2229 (14%)	4.1 (3.1 - 5.5)
Nicaragua	Yes	126 (56%)	10155 (92%)	Baseline	117 (59%)	11635 (93%)	Baseline
	No	99 (44%)	925 (8%)	9.1 (6.9 - 12.2)	81 (41%)	911 (7%)	10.0 (7.4 - 13.6)
Paraguay	Yes	33 (53%)	2925 (96%)	Baseline	23 (56%)	3408 (96%)	Baseline
	No	29 (47%)	118 (4%)	21.9 (12.8 - 37.3)	18 (44%)	132 (4%)	21.3 (11.2 - 40.5)
Peru	No	62 (67%)	8684 (97%)	Baseline	54 (67%)	10908 (96%)	Baseline
	Yes	30 (33%)	300 (3%)	15.6 (9.8 - 24.8)	27 (33%)	428 (4%)	13.9 (8.5 - 22.8)

Table 14: Education and disabilities amongst sponsored children in Africa

		MALES			FEMALES		
Attend formal education (age 5+)		Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
Benin	Yes	3 (60%)	1331 (87%)	Baseline	81 (79%)	20505 (92%)	Baseline
	No	2 (40%)	196 (13%)	4.5 (0.7 - 28.9)	21 (21%)	1900 (8%)	3.2 (2.0 - 5.3)
Egypt	Yes	79 (37%)	12741 (94%)	Baseline	67 (35%)	14589 (91%)	Baseline
	No	136 (63%)	870 (6%)	25.4 (19.1-33.8)	122 (65%)	1398 (9%)	19.5 (14.4-26.4)

Guinea	Yes	15 (35%)	5460 (75%)	Baseline	17 (17%)	12733 (69%)	Baseline
	No	28 (65%)	1790 (25%)	8.1 (4.2 - 15.4)	83 (83%)	5655 (31%)	10.9 (6.5 - 18.4)
Kenya	Yes	94 (79%)	22910 (99%)	Baseline	83 (70%)	30482 (99%)	Baseline
	No	25 (21%)	147 (1%)	52.2 (31.8 - 85.7)	36 (30%)	307 (1%)	60.2 (39.1 - 92.8)
Mozambique	Yes	37 (82%)	1838 (83%)	Baseline	38 (68%)	2352 (85%)	Baseline
	No	8 (18%)	370 (17%)	2.0 (0.8 - 4.6)	18 (32%)	400 (15%)	5.4 (2.8 - 10.4)
Niger	Yes	34 (41%)	3483 (68%)	Baseline	23 (26%)	5908 (67%)	Baseline
	No	49 (59%)	1627 (32%)	2.8 (1.8 - 4.4)	67 (74%)	2854 (33%)	6.0 (3.7 - 9.7)
Rwanda	Yes	42 (69%)	1241 (88%)	Baseline	86 (77%)	2799 (85%)	Baseline
	No	19 (31%)	162 (12%)	4.3 (2.2 - 8.1)	25 (23%)	497 (15%)	2.1 (1.3 - 3.6)
Senegal	Yes	19 (23%)	6878 (64%)	Baseline	22 (33%)	10670 (64%)	Baseline
	No	64 (77%)	3889 (36%)	6.6 (4.0 - 11.1)	44 (67%)	6086 (36%)	3.7 (2.2 - 6.1)
Sudan	Yes	38 (56%)	8614 (92%)	Baseline	32 (53%)	13624 (91%)	Baseline
	No	30 (44%)	718 (8%)	20.7 (12.3 - 34.9)	28 (47%)	1376 (9%)	14.1 (8.4 - 23.7)
Tanzania	Yes	37 (77%)	8499 (93%)	Baseline	39 (71%)	11842 (92%)	Baseline
	No	11 (23%)	689 (8%)	3.9 (2.0 - 7.7)	16 (29%)	978 (8%)	5.5 (3.1 - 9.9)
Uganda	Yes	69 (66%)	12177 (97%)	Baseline	90 (67%)	17104 (95%)	Baseline
	No	36 (34%)	411 (3%)	18.8 (12.1 - 29.1)	45 (33%)	963 (5%)	10.2 (7.0 - 14.9)
Zambia	Yes	35 (60%)	6500 (90%)	Baseline	34 (63%)	7350 (90%)	Baseline
	No	23 (40%)	699 (10%)	8.2 (4.7 – 14.1)	20 (37%)	858 (10%)	5.7 (3.3 - 10.1)
Zimbabwe	Yes	63 (78%)	10230 (96%)	Baseline	95 (87%)	19223 (96%)	Baseline
	No	18 (22%)	422 (4%)	7.2 (4.2 - 12.4)	14 (13%)	703 (4%)	4.1 (2.3 - 7.3)

Table 15: Education and disabilities amongst sponsored children in Asia

		MALES			**FEMALES**		
Attend formal education (age 5+)		**Disabled**	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
India	Yes	130 (63%)	17831 (93%)	Baseline	186 (72%)	29204 (92%)	Baseline
	No	75 (37%)	1322 (7%)	8.6 (6.3 - 11.8)	74 (28%)	2691 (8%)	4.0 (3.0 - 5.4)
Indonesia	Yes	115 (61%)	17196 (94%)	Baseline	77 (48%)	20690 (95%)	Baseline
	No	73 (39%)	1088 (6%)	10.0 (7.4 - 13.5)	84 (52%)	1061 (5%)	20.8 (15.1 - 28.5)
Nepal	Yes	66 (73%)	8302 (97%)	Baseline	103 (74%)	23961 (94%)	Baseline
	No	24 (27%)	286 (3%)	13.4 (8.1 - 22.2)	36 (26%)	1434 (6%)	6.3 (4.2 - 9.4)

Philippines	Yes	104 (60%)	1022 (93%)	Baseline	127 (69%)	15973 (96%)	Baseline
	No	70 (40%)	884 (7%)	13.9 (9.5 - 20.4)	58 (31%)	662 (4%)	13.1 (9.2 - 18.7)
Sri Lanka	Yes	45 (67%)	8294 (98%)	Baseline	56 (67%)	9838 (99%)	Baseline
	No	22 (33%)	172 (2%)	38.7 (20.8 - 72.2)	27 (33%)	147 (1%)	36.1 (21.1 - 61.5)
Vietnam	Yes	200 (73%)	9813 (96%)	Baseline	206 (74%)	17461 (97%)	Baseline
	No	74 (27%)	393 (4%)	10.8 (7.7 - 15.2)	72 (26%)	457 (3%)	17.5 (12.5 - 24.3)

Levels of schooling

Children with disabilities who do attend school are generally at a lower level of schooling than their non-disabled peers of the same age. For example, in Guatemala, children with disabilities are 7.8 times more likely (odds ratio) to be in nursery or pre-school and three times more likely to be in primary rather than secondary school, compared to non-disabled peers. Lack of progression within the school system will have important future implications for children with disabilities in terms of employment and other opportunities.

Table 16: Education level amongst sponsored children in Latin America

		MALES			**FEMALES**		
	Of those at school, school level	**Disabled**	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Bolivia	Secondary or above	23 (21%)	4152 (28%)	Baseline	18 (15%)	4961 (25%)	Baseline
	Primary	77 (69%)	9698 (66%)	2.2 (1.2 - 3.9)	91 (77%)	13257 (67%)	2.8 (1.5 - 5.3)
	Nursery/pre-school	12 (11%)	949 (6%)	5.4 (1.8 - 15.7)	9 (8%)	1673 (8%)	3.2 (1.1 - 9.9)
Brazil	Secondary or above	2 (4%)	488 (11%)	Baseline	4 (11%)	716 (13%)	Baseline
	Primary	42 (82%)	2707 (62%)	10.8 (2.4 - 47.6)	26 (70%)	3438 (62%)	4.3 (1.3 - 13.6)
	Nursery/pre-school	7 (14%)	1192 (27%)	12.5 (2.0 - 80.4)	7 (19%)	1376 (25%)	9.8 (1.9 - 50.5)
Colombia	Secondary or above	19 (23%)	3052 (35%)	Baseline	22 (28%)	3684 (32%)	Baseline
	Primary	48 (59%)	4294 (49%)	7.7 (3.4 - 17.1)	44 (56%)	5311 (46%)	10.0 (4.3 - 23.5)
	Nursery/pre-school	15 (18%)	1430 (16%)	25.4 (6.6 - 98.2)	13 (16%)	2551 (22%)	30.9 (7.3 - 131.4)
Dom Rep	Secondary or	5 (10%)	942 (11%)	Baseline	2 (4%)	1230 (11%)	Baseline

	above						
	Primary	42 (82%)	7157 (82%)	1.6 (0.6 - 4.3)	42 (93%)	9172 (81%)	3.4 (0.7 - 15.3)
	Nursery/pre-school	4 (8%)	578 (7%)	3.0 (0.6 - 15.0)	1 (2%)	940 (8%)	0.9 (0.1 - 12.1)
Ecuador	Secondary or above	60 (21%)	6137 (32%)	Baseline	53 (21%)	6377 (29%)	Baseline
	Primary	197 (70%)	11533 (60%)	3.4 (2.3-5.0)	180 (70%)	13570 (62%)	2.4 (1.6-3.6)
	Nursery/pre-school	26 (9%)	1459 (8%)	6.9 (3.4-14.1)	25 (10%)	2070 (9%)	3.3 (1.5-6.9)
El Salvador	Secondary or above	36 (17%)	2786 (21%)	Baseline	44 (23%)	3566 (23%)	Baseline
	Primary	160 (76%)	8804 (68%)	2.6 (1.7 - 4.1)	134 (69%)	9898 (65%)	2.0 (1.3 - 3.2)
	Nursery/pre-school	15 (7%)	1393 (11%)	3.3 (1.4 - 7.6)	16 (8%)	1777 (12%)	2.7 (1.1 - 6.4)
Guatemala	Secondary or above	14 (11%)	2314 (16%)	Baseline	11 (9%)	2006 (12%)	Baseline
	Primary	102 (80%)	11062 (77%)	3.0 (1.6 - 5.8)	88 (75%)	12481 (77%)	1.8 (0.9 - 3.8)
	Nursery/pre-school	11 (9%)	1067 (7%)	7.8 (2.7 - 22.6)	19 (16%)	1644 (10%)	4.2 (1.4 - 12.3)
Honduras	Secondary or above	23 (13%)	2041 (19%)	Baseline	21 (15%)	2533 (18%)	Baseline
	Primary	140 (78%)	7966 (72%)	2.6 (1.5 - 4.4)	107 (75%)	9939 (71%)	2.7 (1.5 - 4.9)
	Nursery/pre-school	16 (9%)	1001 (9%)	3.9 (1.6 - 9.3)	14 (10%)	1574 (11%)	4.5 (1.7 - 12.1)
Nicaragua	Secondary or above	19 (15%)	2608 (24%)	Baseline	22 (18%)	3568 (29%)	Baseline
	Primary	95 (73%)	6811 (63%)	5.0 (2.7 - 9.1)	82 (69%)	7243 (58%)	5.9 (3.3 - 10.8)
	Nursery/pre-school	17 (13%)	1423 (13%)	11.8 (4.3 - 32.5)	15 (13%)	1638 (13%)	15.5 (5.5 - 43.5)
Peru	Secondary or above	12 (19%)	3151 (34%)	Baseline	12 (20%)	3368 (28%)	Baseline
	Primary	43 (67%)	4939 (53%)	3.3 (1.3 - 8.0)	36 (61%)	6622 (55%)	2.3 (0.9 - 5.8)
	Nursery/pre-school	9 (14%)	1214 (13%)	3.8 (0.9 - 16.1)	11 (19%)	2089 (17%)	3.2 (0.7 - 13.8)

Table 17: Education level amongst sponsored children in Africa

		MALES			**FEMALES**		
	Of those at school, school level	**Disabled**	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Egypt	Secondary or above	20 (25%)	3986 (31%)	Baseline	14 (20%)	4082 (27%)	Baseline

	Primary	56 (69%)	8413 (65%)	1.7 (0.9-3.4)	52 (75%)	9882 (65%)	2.4 (1.1-5.2)
	Nursery/pre-school	5 (6%)	601 (5%)	2.9 (0.7-11.7)	3 (4%)	1175 (8%)	1.8 (0.3-9.5)
Rwanda	Secondary or above	3 (7%)	24 (2%)	Baseline	3 (3%)	54 (2%)	Baseline
	Primary	37 (88%)	1147 (89%)	0.3 (0.1 - 1.1)	77 (86%)	2524 (83%)	0.6 (0.2 - 2.1)
	Nursery/pre-school	2 (5%)	120 (9%)	0.2 (0.01 - 1.3)	10 (11%)	453 (15%)	0.4 (0.1 - 2.0)
Senegal	Secondary or above	4 (21%)	1383 (20%)	Baseline	3 (13%)	1809 (16%)	Baseline
	Primary	15 (79%)	5359 (77%)	1.5 (0.4 - 5.7)	17 (74%)	8538 (77%)	1.1 (0.3 - 5.0)
	Nursery/pre-school	0 (0%)	248 (4%)	-	3 (13%)	736 (7%)	2.1 (0.2 - 23.4)
Sudan	Secondary or above	3 (8%)	702 (8%)	Baseline	3 (9%)	789 (6%)	Baseline
	Primary	33 (87%)	7476 (86%)	2.5 (0.7 - 8.5)	29 (91%)	11838 (85%)	1.4 (0.4 - 5.0)
	Nursery/pre-school	2 (5%)	563 (6%)	8.3 (1.0 - 70.4)	0 (0%)	1330 (10%)	-
Tanzania	Secondary or above	1 (3%)	770 (9%)	Baseline	3 (8%)	877 (7%)	Baseline
	Primary	33 (89%)	6752 (77%)	4.5 (0.6 - 35.3)	32 (82%)	9216 (75%)	1.8 (0.5 - 6.6)
	Nursery/pre-school	3 (8%)	1255 (14%)	2.8 (0.2 - 34.4)	4 (10%)	2228 (18%)	1.7 (0.3 - 11.1)
Uganda	Secondary or above	3 (4%)	782 (6%)	Baseline	0 (0%)	1089 (6%)	Baseline
	Primary	62 (86%)	10884 (88%)	2.0 (0.6 - 6.6)	84 (93%)	14925 (83%)	-
	Nursery/pre-school	7 (10%)	744 (6%)	4.7 (1.0 - 22.8)	6 (7%)	1863 (10%)	-
Zambia	Secondary or above	2 (6%)	486 (7%)	Baseline	3 (9%)	541 (7%)	Baseline
	Primary	32 (91%)	5524 (82%)	2.1 (0.5 - 9.2)	29 (85%)	6165 (80%)	1.3 (0.4 - 4.5)
	Nursery/pre-school	1 (3%)	738 (11%)	0.9 (0.1 - 12.7)	2 (6%)	968 (13%)	1.0 (0.1 - 8.5)
Zimbabwe	Secondary or above	13 (21%)	3040 (29%)	Baseline	10 (10%)	3814 (19%)	Baseline
	Primary	49 (78%)	6984 (67%)	1.8 (0.9 - 3.8)	78 (81%)	14693 (74%)	2.6 (1.2 - 5.8)
	Nursery/pre-school	1 (2%)	369 (4%)	0.8 (0.1 - 7.7)	8 (8%)	1464 (7%)	3.5 (1.0 - 12.4)

Table 18: Education level amongst sponsored children in Asia

		MALES			**FEMALES**		
	Of those at	**Disabled**	**Non disabled**	**Age adjusted**	**Disabled**	**Non disabled**	**Age adjusted**

	school, school level			OR			OR
India	Secondary or above	31 (22%)	4624 (24%)	Baseline	39 (19%)	5688 (16%)	Baseline
	Primary	88 (63%)	11809 (60%)	1.8 (1.0 - 3.1)	124 (61%)	19971 (57%)	2.4 (1.4 - 3.8)
	Nursery/pre-school	20 (14%)	3138 (16%)	2.3 (0.9 - 5.6)	40 (20%)	9156 (26%)	3.5 (1.6 - 7.3)
Indonesia	Secondary or above	18 (16%)	4262 (24%)	Baseline	13 (16%)	5332 (25%)	Baseline
	Primary	93 (80%)	11893 (67%)	2.5 (1.4 - 4.7)	57 (72%)	13983 (65%)	3.8 (1.8 - 7.8)
	Nursery/pre-school	5 (4%)	1498 (8%)	1.5 (0.4 - 5.3)	9 (11%)	2251 (10%)	9.0 (2.6 - 31.4)
Nepal	Secondary or above	8 (12%)	2020 (23%)	Baseline	19 (17%)	5965 (24%)	Baseline
	Primary	50 (74%)	5881 (66%)	3.7 (1.5 - 9.0)	77 (71%)	17069 (68%)	2.2 (1.2 - 4.1)
	Nursery/pre-school	10 (15%)	1015 (11%)	6.8 (1.8 - 25.4)	13 (12%)	2238 (9%)	4.5 (1.6 - 12.6)
Philippines	Secondary or above	21 (19%)	3391 (29%)	Baseline	26 (19%)	4666 (27%)	Baseline
	Primary	77 (71%)	7109 (61%)	2.4 (1.3 - 4.5)	92 (68%)	10327 (59%)	3.7 (2.1 - 6.7)
	Nursery/pre-school	10 (9%)	1105 (10%)	2.8 (0.9 - 8.9)	17 (13%)	2513 (14%)	6.7 (2.4 - 18.9)
Sri Lanka	Secondary or above	23 (50%)	5199 (60%)	Baseline	35 (63%)	5931 (57%)	Baseline
	Primary	19 (41%)	2790 (32%)	2.2 (1.0 - 4.8)	17 (30%)	3469 (33%)	1.4 (0.7 - 2.9)
	Nursery/pre-school	4 (9%)	659 (8%)	2.9 (0.7 - 12.5)	4 (7%)	960 (9%)	2.0 (0.5 - 7.7)
Vietnam	Secondary or above	78 (36%)	4142 (39%)	Baseline	55 (25%)	5764 (28%)	Baseline
	Primary	110 (51%)	5014 (47%)	2.9 (1.8 - 4.7)	129 (58%)	9951 (48%)	2.3 (1.4 - 3.8)
	Nursery/pre-school	26 (12%)	1561 (15%)	4.7 (2.0 - 11.2)	39 (17%)	4968 (24%)	2.3 (1.0 - 5.3)

Education by type of impairment

Within most countries, inclusion rates for children with disabilities are highest for those with vision or hearing impairments and lowest for those with learning, physical or communication impairments (Tables 19-21). This indicates that the level of exclusion can be linked to the type of impairment. This area is ripe for more research to determine why, for example, some children with certain types of impairment are more able to access school than children with other types and how these barriers can be overcome. Such research would allow Plan to identify targets to promote inclusion.

Table 19: Education and type of impairment among those aged 5+ attending formal education in Latin America

	No disability	Learning	Physical	Communication	Vision	Hearing
Bolivia	Baseline	11.6 (7.3 - 18.6)	4.9 (2.7 - 8.7)	15.6 (10.7 - 22.8)	2.5 (1.3 - 5.0)	5.7 (2.5 - 12.8)
Brazil	Baseline	20.6 (8.7 - 48.9)	29.8 (14.3 – 62.0)	24.6 (8.5 - 71.0)	-	29.5 (5.0 – 173.4)
Colombia	Baseline	32.6 (18.0 - 59.1)	30.0 (15.1 - 59.7)	69.7 (37.2 - 130.4)	5.9 (1.7 - 20.3)	-
Dominican Rep	Baseline	51.3 (19.8 - 132.5)	104.7 (51.0 - 215.3)	185.1 (74.5 - 460.1)	2.7 (0.9 - 8.2)	18.8 (3.2 - 111.8)
Ecuador	Baseline	17.4 (11.9-25.4)	18.3 (12.4-26.9)	23.3 (16.4-33.2)	2.2 (1.3-3.7)	1.7 (0.6-4.9)
El Salvador	Baseline	13.9 (8.3 - 23.4)	4.8 (3.6 - 6.4)	9.1 (6.9 - 12.1)	2.2 (1.2 - 3.8)	1.6 (0.6 - 4.0)
Guatemala	Baseline	18.3 (9.4 - 35.6)	5.8 (3.8 - 8.7)	6.6 (4.6 - 9.5)	1.3 (0.8 - 2.2)	2.4 (1.0 - 5.6)
Honduras	Baseline	5.0 (3.5 - 7.3)	8.3 (5.3 - 13.0)	7.6 (4.9 - 11.8)	0.9 (0.6 - 1.4)	2.4 (1.1 - 5.1)
Nicaragua	Baseline	12.4 (8.0 - 19.1)	23.3 (14.9 - 36.6)	15.4 (10.4 - 22.8)	2.5 (1.5 - 4.3)	1.5 (0.4 - 5.1)
Paraguay	Baseline	38.2 (16.1 - 90.7)	34.6 (16.5 - 72.3)	40.5 (17.8 - 91.8)	1.3 (0.2 - 10.0)	6.7 (0.7 - 60.6)
Peru	Baseline	27.1 (14.1 - 51.9)	17.5 (8.4 - 36.7)	20.6 (10.9 - 39.2)	6.1 (2.5 - 15.2)	-

Table 20: Education and type of impairment among those aged 5+ attending formal education in Africa

	No disability	Learning	Physical	Communication	Vision	Hearing
Benin	Baseline	-	1.8 (0.7 – 4.6)	22.9 (3.4 – 156.9)	2.5 (1.1 – 5.5)	11.7 (4.1 – 33.0)
Egypt	Baseline	39.5 (25.0-62.3)	23.1 (16.1-33.3)	44.3 (27.8-70.7)	2.7 (1.3-5.6)	7.7 (2.8-21.3)
Guinea	Baseline	-	5.2 (3.1 - 8.8)	39.7 (12.3 - 128.2)	4.7 (1.8 - 12.1)	28.8 (3.7 - 227.3)
Kenya	Baseline	59.8 (14.9 – 240.2)	132.3 (70.1 – 249.7)	142.3 (78.1 – 259.5)	9.4 (2.7 – 32.3)	61.2 (30.8 – 124.3)
Mozambique	Baseline	-	3.6 (1.2 - 10.4)	14.9 (5.7 - 38.6)	4.7 (1.0 - 23.3)	0.8 (0.2 - 3.7)
Niger	Baseline	-	3.2 (2.0 - 5.1)	7.8 (3.8 - 15.7)	1.3 (0.6 - 3.2)	11.1 (3.2 - 39.0)
Rwanda	Baseline	26.8 (3.0 - 236.6)	4.2 (2.2 - 8.1)	13.4 (3.6 - 49.1)	0.8 (0.3 - 2.2)	2.9 (1.1 - 8.0)
Senegal	Baseline	-	3.2 (1.7 - 6.1)	11.1 (5.6 - 21.9)	1.8 (0.8 - 4.0)	6.5 (1.2 - 34.0)
Sudan	Baseline	48.6 (9.3 - 253.5)	68.0 (34.9 - 132.3)	54.0 (24.1 - 120.9)	2.5 (0.7 - 9.3)	36.8 (9.5 - 141.9)
Tanzania	Baseline	48.0 (4.1 – 561.6)	3.6 (1.9 - 6.9)	7.5 (2.9 - 19.8)	2.4 (0.5 - 11.5)	8.9 (2.6 - 30.5)
Uganda	Baseline	51.9 (4.4-606.1)	17.6 (10.8-28.8)	35.4 (20.6-60.7)	3.9 (1.3-11.9)	4.8 (2.3-10.1)
Zambia	Baseline	33.7 (6.3 - 179.1)	6.3 (3.1 – 13.0)	20.8 (9.1 – 47.6)	3.5 (1.3 - 9.1)	3.8 (1.4 - 10.5)

Zimbabwe	Baseline	25.1 (10.2 - 61.8)	3.9 (1.8 - 8.2)	10.3 (5.2 - 20.4)	0.9 (0.1 - 6.9)	0.9 (0.1 - 6.6)

Table 21: Education and type of impairment among those aged 5+ attending formal education in Asia

	No disability	Learning	Physical	Communication	Vision	Hearing
India	Baseline	16.5 (6.2 – 44.1)	5.4 (3.9 – 7.5)	10.9 (7.2 – 16.5)	2.4 (1.4 – 4.0)	2.7 (0.8 – 8.8)
Indonesia	Baseline	4.3 (1.9 - 10.0)	13.0 (8.8 - 19.2)	30.8 (21.8 - 43.6)	4.5 (2.2 - 9.4)	4.6 (1.9 - 11.4)
Nepal	Baseline	-	6.0 (3.8 - 9.6)	28.0 (15.9 - 49.4)	3.6 (1.4 - 9.7)	-
Philippines	Baseline	32.5 (15.0 - 70.3)	13.9 (9.0 - 21.7)	29.5 (18.0 - 48.3)	2.8 (1.2 - 6.6)	11.2 (3.6 - 34.8)
Sri Lanka	Baseline	-	1.8 (0.7 - 4.6)	23.0 (3.4 - 157.2)	2.5 (1.1 - 5.5)	11.7 (4.1 - 33.1)
Vietnam	Baseline	26.0 (16.0 - 42.2)	10.8 (7.0 - 16.8)	61.9 (36.3 - 105.4)	3.8 (2.0 - 7.5)	10.6 (4.8 - 23.6)

4.3 Health

The health analysis included the assessment of a range of variables related to health, which are collected through the following questions:

- Has the sponsored child had any serious health problems during the last twelve months?
- If yes, what type of serious health event(s) or problem(s) did the sponsored child experience during this period?
- Where did you seek advice or treatment?
- If you did not seek advice or treatment what was the reason?
- Did/does the health problem(s) prevent the sponsored child from attending education?

The analysis showed consistent findings across the countries; that children with a disability are much more likely to have had serious health problems in the last 12 months than children without disabilities (see Tables 22-24). In all likelihood, the serious illness may be

related both to the disability (eg. children with hearing impairment with ongoing ear problems), as well as to the higher vulnerability of children with a disability to serious illness (eg. children with disabilities may be more likely to experience malnutrition because of difficulties in feeding). The findings related to the other health variables vary per country and are therefore described in the country sections.

Table 22: Health and disability amongst sponsored children in Latin America

		MALES			FEMALES		
	Serious illness	**Disabled**	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Bolivia	No	128 (75%)	15668 (93%)	Baseline	142 (71%)	22904 (93%)	Baseline
	Yes	43 (25%)	1194 (7%)	4.6 (3.2 - 6.5)	59 (29%)	1841 (7%)	5.3 (3.9 - 7.3)
Brazil	No	71 (89%)	5556 (98%)	Baseline	57 (90%)	7003 (98%)	Baseline
	Yes	9 (11%)	136 (2%)	5.4 (2.6 - 11.0)	6 (10%)	155 (2%)	5.1 (2.2 - 12.1)
Colombia	No	103 (84%)	8993 (98%)	Baseline	101 (90%)	12404 (98%)	Baseline
	Yes	20 (16%)	190 (2%)	9.7 (5.9 - 16.1)	11 (10%)	198 (2%)	7.1 (3.7 - 13.4)
Dominican Rep	No	79 (94%)	10709 (99%)	Baseline	84 (89%)	15342 (99%)	Baseline
	Yes	5 (6%)	129 (1%)	5.9 (2.3 - 15.0)	10 (11%)	202 (1%)	9.3 (4.7 - 18.2)
Ecuador	No	323 (77%)	19997 (95%)	Baseline	286 (76%)	23831 (95%)	Baseline
	Yes	96 (23%)	1158 (5%)	5.3 (4.2-6.7)	88 (24%)	1291 (5%)	5.8 (4.6-7.5)
El Salvador	No	281 (81%)	14042 (91%)	Baseline	242 (81%)	17349 (92%)	Baseline
	Yes	65 (19%)	1354 (9%)	2.5 (1.9 - 3.4)	58 (19%)	1423 (8%)	3.0 (2.3 - 4.1)
Guatemala	No	189 (84%)	16209 (96%)	Baseline	176 (85%)	20508 (96%)	Baseline
	Yes	36 (16%)	684 (4%)	4.7 (3.3 - 6.8)	31 (15%)	964 (4%)	3.9 (2.7 - 5.8)
Honduras	No	212 (71%)	12805 (88%)	Baseline	186 (73%)	16537 (87%)	Baseline
	Yes	85 (29%)	1734 (12%)	3.1 (2.4 - 4.0)	68 (27%)	2413 (13%)	2.7 (2.0 - 3.5)
Nicaragua	No	177 (72%)	10952 (87%)	Baseline	162 (75%)	12683 (86%)	Baseline
	Yes	68 (28%)	1672 (13%)	2.7 (2.0 - 3.6)	52 (25%)	2027 (14%)	2.1 (1.5 - 2.8)
Paraguay	No	52 (78%)	3212 (92%)	Baseline	35 (74%)	3880 (92%)	Baseline
	Yes	15 (22%)	276 (8%)	3.6 (2.0 - 6.5)	12 (26%)	331 (8%)	4.2 (2.2 - 8.2)
Peru	No	84 (87%)	10059 (96%)	Baseline	78 (80%)	14127 (96%)	Baseline

	Yes	13 (13%)	385 (4%)	4.2 (2.3 - 7.6)	20 (20%)	598 (4%)	6.3 (3.8 - 10.4)

Table 23: Health and disability amongst sponsored children in Africa

		MALES			FEMALES		
	Serious illness	**Disabled**	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Benin	No	5 (100%)	1569 (100%)	Baseline	103 (100%)	22866 (100%)	Baseline
	Yes	0 (0%)	1 (0%)	-	0 (0%)	3 (0%)	-
Egypt	No	226 (97%)	14764 (99.6%)	Baseline	207 (95%)	18532 (99.6%)	Baseline
	Yes	8 (3%)	55 (0.4%)	9.5 (4.5-20.3)	11 (5%)	68 (0.4%)	14.8 (7.7-28.3)
Guinea	No	26 (59%)	8174 (96%)	Baseline	73 (72%)	18960 (97%)	Baseline
	Yes	18 (41%)	322 (4%)	17.7 (9.5 - 32.7)	29 (28%)	606 (3%)	12.9 (8.3 - 20.0)
Kenya	No	86 (69%)	22547 (90%)	Baseline	97 (72%)	31737 (91%)	Baseline
	Yes	38 (31%)	2479 (10%)	4.1 (2.8 - 6.1)	37 (28%)	3118 (9%)	3.9 (2.7 - 5.8)
Mozambique	No	20 (37%)	2136 (72%)	Baseline	35 (54%)	2670 (72%)	Baseline
	Yes	34 (63%)	815 (28%)	4.7 (2.7 - 8.3)	30 (46%)	1042 (28%)	2.4 (1.5 - 3.9)
Niger	No	55 (64%)	4058 (66%)	Baseline	54 (55%)	7863 (62%)	Baseline
	Yes	31 (36%)	2135 (34%)	1.1 (0.7 - 1.7)	45 (45%)	4863 (38%)	1.3 (0.9 - 2.0)
Rwanda	No	32 (46%)	1382 (78%)	Baseline	35 (24%)	3342 (75%)	Baseline
	Yes	38 (54%)	387 (22%)	5.1 (3.1 - 8.5)	109 (76%)	1118 (25%)	10.8 (7.3 - 16.0)
Senegal	No	69 (83%)	11291 (97%)	Baseline	57 (79%)	20437 (97%)	Baseline
	Yes	14 (17%)	323 (3%)	7.0 (3.9 - 12.6)	15 (21%)	532 (3%)	10.4 (5.8 - 18.4)
Sudan	No	63 (91%)	9798 (97%)	Baseline	50 (81%)	16562 (97%)	Baseline
	Yes	6 (9%)	302 (3%)	3.8 (1.6 - 9.0)	12 (19%)	432 (3%)	10.4 (5.5 - 19.8)
Tanzania	No	41 (84%)	9671 (97%)	Baseline	49 (88%)	13857 (97%)	Baseline
	Yes	8 (16%)	273 (3%)	6.9 (3.2 - 14.8)	7 (13%)	397 (3%)	4.7 (2.1 - 10.6)
Uganda	No	72 (62%)	11282 (82%)	Baseline	94 (62%)	17424 (81%)	Baseline
	Yes	45 (38%)	2463 (18%)	3.6 (2.3 - 5.5)	57 (38%)	4029 (19%)	3.4 (2.4 - 5.0)
Zambia	No	32 (54%)	5878 (76%)	Baseline	35 (65%)	6486 (73%)	Baseline
	Yes	27 (46%)	1856 (24%)	3.0 (1.8 - 5.0)	19 (35%)	2392 (27%)	1.6 (0.9 - 2.8)
Zimbabwe	No	65 (78%)	10710 (96%)	Baseline	90 (77%)	21047 (96%)	Baseline
	Yes	18 (22%)	472 (4%)	6.3 (3.7 - 10.7)	27 (23%)	917 (4%)	6.9 (4.5 - 10.6)

Table 24: Health and disability amongst sponsored children in Asia

		MALES			FEMALES		
	Serious illness	**Disabled**	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
India	No	213 (95%)	22085 (98%)	Baseline	282 (95%)	41376 (98%)	Baseline
	Yes	12 (5%)	400 (2%)	3.6 (2.0 - 6.6)	15 (5%)	977 (2%)	2.9 (1.7 - 4.9)
Indonesia	No	159 (80%)	19167 (94%)	Baseline	151 (86%)	23860 (95%)	Baseline
	Yes	41 (21%)	1155 (6%)	4.3 (3.1 - 6.1)	25 (14%)	1302 (5%)	3.0 (2.0 - 4.7)
Nepal	No	92 (89%)	9580 (97%)	Baseline	135 (87%)	27508 (97%)	Baseline
	Yes	11 (11%)	300 (3%)	3.8 (2.0 - 7.2)	21 (13%)	803 (3%)	5.4 (3.4 - 8.7)
Philippines	No	29 (16%)	547 (4%)	4.4 (2.9 - 6.7)	29 (14%)	981 (5%)	3.2 (2.2 - 4.8)
	Yes	155 (84%)	12340 (96%)	Baseline	184 (86%)	19278 (95%)	Baseline
Sri Lanka	No	64 (85%)	9615 (99%)	Baseline	69 (76%)	11677 (99%)	Baseline
	Yes	11 (15%)	138 (1%)	12.4 (6.4 - 24.2)	22 (24%)	147 (1%)	26.1 (15.7 - 43.5)
Vietnam	Yes	70 (24%)	1110 (10%)	3.4 (2.5 - 4.5)	78 (25%)	2554 (11%)	3.0 (2.3 - 3.9)
	No	223 (76%)	10231 (90%)	Baseline	237 (75%)	20136 (89%)	Baseline

Plan's sponsorship questionnaire covers a range of variables about the lives of sponsored children. As part of this analysis all available variables were explored, however, not all were fit for analysis. For example, the data on birth registration, vaccinations and from what age the sponsored child has had a disability had too many missing values and are therefore not part of this report. On the other hand, the data on distance to school and whether the child attends non-formal education didn't show any significant findings across all countries, but have been included in the following Chapter under each country analysis for information purposes. The sponsorship questionnaire also covers a range of questions on type of housing and asset scores, which were used to create a poverty score for the sponsored children and allow us to assess whether there was an association between poverty and children disabilities. As the data showed that nearly all children were poor, there were no significant differences in poverty between children with disabilities compared to those without, by and large. Apart from that it shows Plan that the families who take part in Plan's sponsorship programme are indeed economically disadvantaged for the most part. The tables on poverty and disability can be found in the appendix to the report.

5. Country analyses

At the heart of this study are the 30 country analyses which will be described in more details in this chapter. Plan believes that the value of the sponsorship data is greatest at a local level, because the information can be understood in its context.

In order to provide a brief overview of the national context of Plan's sponsorship data, each country section will start with a brief description of the country and highlighting what Plan's goals are in that country. Plan's programmes operate through a Plan specific programme cycle - Programme Accountability and Learning System (PALS) – which is a five year cycle where the programme focus for the following five year period is decided through an extensive process of evaluation, consultation with stakeholders and a detailed situation analysis. This process results in the development of a five year Country Strategic Plan (CSP). The CSP sets the strategic goal for the country as well as describing the country programmes that will be implemented in that country. These are high level strategic programmes which will, for the duration of the CSP, encompass specific projects and other initiatives.

In addition, to add to the local context, it is noted whether the country signed up and ratified the 2006 UN Convention on Persons with Disabilities and/or whether specific national laws exist that afford children with disabilities their rights. The population statistics and percentage of children aged 0-14 years, sourced from the Wold Bank, are also provided.

All country statistical analyses that follow in this Chapter were stratified by gender, meaning that they were conducted separately for males and females to see whether there were differences in the relationship of disability with other variables. For the analyses the demographic data is presented first in order to explain the general characteristics of the sponsored children and to set the scene for the more in-depth analysis that follows. The data for the relationship of disability with educational characteristics is provided, including the main reasons for not attending formal education. This is followed by an examination of the relationship between disability and health-related variables. Finally, the relationship between disability and poverty is also explored. The detailed analysis of the relationship between disability and poverty is not set out herein, but can be found in the separate country reports, which are available on request.

Plan in Asia

5.1 India

The country population of India is 1,236,686,732 and the percentage of the population that constitutes children between the ages of 0-14 is 29% (World Bank Population Data, 2013). India ranks 136 out of 187 countries in the 2013 Human Development Report, ranking it close to the bottom of medium human development (UNDP International Human Development Indicators , 2013). India was amongst the 80 countries that signed the UNCRPD on the first day of opening for signatures. India ratified the UNCRPD the same year as signing the Convention (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status , 2013). In addition, India has a Disability Act 1995 and several laws in relation to children, which specifically address the protection and wellbeing of children with disabilities; National charter for Children 2004, National Plan of Action for Children 2005, the Commissions for the Protection of Child Rights Act 2005 (Plan India, 2011).

Plan India works in 8 out of 28 states, namely the states of Bihar, Rajasthan, Orissa, Uttar Pradesh, Jharkhand and Andhra Pradesh and is exploring to expand their work into the states of Madhya Pradesh and Chhattisgarh. In addition, Plan India works to overcome urban poverty in the metropolitan areas of Delhi, Hyderabad and Mumbai. The Plan India office is both a Country Office, as well as a National Organisation, given the fact that it also does fundraising activities. Plan India's situation analysis, undertaken to inform the drafting of the Country Strategic Plan (CSP), clearly notes how children with disabilities are affected in India in relation to Education. It says 'A specially deprived group identified by the survey is the physically or mentally challenged children who formed 0.8% of the sample. Of these 39% had orthopaedic disability, 12-15% had mental, visual, speech or multiple disabilities. Of the total number of children with disabilities 9% have hearing impairment. Of the total challenged children in the survey 38% were out of school; those with multiple disability comprised 61%, with mental disability 47%, speech disability 42% and visual disability 29%' (Plan India, 2013).

The goal of the current CSP is to create a partnership between children, communities, civil society and corporates to promote child rights and participation in the most marginalised communities of India to end child poverty and injustice.

To address the root causes of child poverty, three levels of mutually interrelated principles are required, namely:

- To ensure children are protected from abuse and exploitation;
- To ensure children have access to basic services (e.g. nutrition, education, health, sanitation, household economic security);
- To ensure children's voices are heard and they are participating in decisions affecting their lives.

In India, the 2012 sponsorship dataset included 65,360 sponsored children, ranging in age from 0-17. The average age was 8.0 (standard deviation=4.1),[12] and 35% were male. Among the children, 522 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.8% (95% confidence interval 0.7 – 0.9 %). The prevalence of disability was slightly higher in males (1.0 %, 95% CI 0.9 – 1.1 %) than in females (0.7 %, 95% CI 0.6 – 0.8 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.3 95% CI 1.1 – 1.5).

The most common types of impairment was physical, while learning and hearing were least common, as can be seen in Table 25.

Table 25: Type of impairment by gender in India

	Male	**Female**
Learning	6 (3%)	14 (5%)
Physical	102 (45%)	132 (44%)
Communication	55 (24%)	70 (24%)
Vision	55 (24%)	64 (22%)
Hearing	7 (3%)	17 (6%)
Total	225 (100%)	297 (100%)

Educational and disability

As in line with the overall findings children with disabilities were much less likely to attend formal education, compared children without disability; after adjusting for age boys with disabilities were 8.6 times less likely to attend school and girls with disabilities were 4.0 times less likely to attend school.

[12] Standard deviation is a statistical measure which shows how much variation from the average exists in the group studied.

Table 26: Educational variables in relation to disability in India

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	139 (62%)	19571 (87%)	Baseline	203 (68%)	34815 (82%)	Baseline
- No	86 (38%)	2914 (13%)	4.6 (3.5 - 6.0)	94 (32%)	7538 (18%)	2.5 (2.0 - 3.2)
Age 5+: Attend formal education						
- Yes	130 (63%)	17831 (93%)	Baseline	186 (72%)	29204 (92%)	Baseline
- No	75 (37%)	1322 (7%)	8.6 (6.3 - 11.8)	74 (28%)	2691 (8%)	4.0 (3.0 - 5.4)
Of those at school, school level						
- Secondary/University/College	31 (22%)	4624 (24%)	Baseline	39 (19%)	5688 (16%)	Baseline
- Primary	88 (63%)	11809 (60%)	1.8 (1.0 - 3.1)	124 (61%)	19971 (57%)	2.4 (1.4 - 3.8)
- Nursery/pre-school	20 (14%)	3138 (16%)	2.3 (0.9 - 5.6)	40 (20%)	9156 (26%)	3.5 (1.6 - 7.3)
Time taken to school						
- <30 minutes	99 (71%)	13757 (70%)	Baseline	161 (79%)	26578 (76%)	Baseline
- 30 minutes-1 hour	40 (29%)	5519 (28%)	0.9 (0.6 - 1.3)	39 (19%)	7925 (23%)	0.6 (0.4 - 0.9)
- >1 hour	0 (0%)	295 (2%)	-	3 (1%)	312 (1%)	1.0 (0.3 - 3.2)
Attending non formal education						
- No	222 (99%)	22237 (99%)	Baseline	291 (98%)	41884 (99%)	Baseline
- Yes	3 (1%)	248 (1%)	1.1 (0.4 - 3.6)	6 (2%)	469 (1%)	1.6 (0.7 - 3.5)

Children with disabilities were more likely to be at a lower school level compared to children without disability, after accounting for age differences, particularly among girls. Increased time taken to school may have been related to less disability in girls.

Table 27: Attendance of formal education by impairment type in India

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	54,386 (84%)	10,452 (16%)	47,035 (92%)	4013 (8%)	Baseline	Baseline	Baseline
Learning	7 (35%)	13 (65%)	7 (37%)	12 (63%)	-	20.3 (5.9 – 70.0)	16.5 (6.2 – 44.1)
Physical	145 (62%)	89 (38%)	141 (67%)	68 (33%)	-	4.1 (2.6 – 6.3)	5.4 (3.9 – 7.5)
Communication	76 (61%)	49 (39%)	62 (58%)	45 (42%)	-	7.5 (4.2 – 13.4)	10.9 (7.2 – 16.5)
Vision	96 (81%)	23 (19%)	90 (82%)	20 (18%)	-	1.2 (0.6 – 2.7)	2.4 (1.4 – 4.0)
Hearing	18 (75%)	6 (25%)	16 (80%)	4 (20%)	-	1.8 (0.4 – 8.7)	2.7 (0.8 – 8.8))

Considering the data by type of impairment, learning and communication impairment had the greatest effect on school attendance, followed by physical and vision impairment. There were insufficient numbers of disabled children in the disability categories (particularly learning and hearing) to perform the analysis for boys alone.

Having an impairment was cited as the major reason for not attending formal education among children with disabilities (73%) while being too young was the most common reason among children without disability (60%), as can be seen in Table 28.

Table 28: Reason for not attending formal education by disability status in India

	Disabled	**Not disabled**
Is pregnant or gave birth	0 (0%)	0 (0%)
Is attending a non-formal edu program	0 (0%)	1 (0%)
Has completed primary education	0 (0%)	1 (0%)
Too young	18 (10%)	6257 (60%)
Too old	0 (0%)	55 (1%)
Economic problems	1 (1%)	81 (1%)
Closest school too far	4 (2%)	635 (6%)
Has been ill	5 (3%)	6 (0%)
Is married	0 (0%)	84 (1%)
Needed to help family	6 (3%)	1547 (15%)
Has an impairment	132 (73%)	0 (0%)

	Disabled	Not disabled
Is working outside family	0 (0%)	85 (1%)
Was expelled for class repetition	1 (1%)	310 (3%)
Primary not considered important by family	8 (4%)	973 (9%)
Secondary not considered important by family	4 (2%)	330 (3%)
Expelled	0 (0%)	23 (0%)
Fears violence at school	0 (0%)	5 (0%)
Fears violence on way to school	0 (0%)	3 (0%)
Do not have required document	0 (0%)	12 (0%)
Plays truant	1 (1%)	43 (0%)

Health and disability

Children with disabilities were more likely to have had a serious illness in the last 12 months than children without disability; boys with disabilities were 3.6 times more likely to have had a serious illness in the last 12 months and for girls with disabilities this was 2.9. In India the hospital was the most likely location for treatment when sponsored children reported to be ill.

Table 29: Association between health and health seeking behaviour and disability in India

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
Serious illness						
- No	213 (95%)	22085 (98%)	Baseline	282 (95%)	41376 (98%)	Baseline
- Yes	12 (5%)	400 (2%)	3.6 (2.0 - 6.6)	15 (5%)	977 (2%)	2.9 (1.7 - 4.9)
Malnutrition						
- No	224 (99.6%)	22479 (99.97%)	Baseline	296 (99.7%)	42341 (99.97%)	Baseline
- Yes	1 (0.4%)	6 (0.03%)	22.4 (2.7 - 188.6)	1 (0.03%)	12 (0.03%)	17.4 (2.2 - 135.3)
Where sought treatment						
- Other	2 (17%)	35 (9%)	Baseline	3 (20%)	119 (12%)	Baseline
- Hospital	9 (75%)	271 (68%)	0.6 (0.1 - 2.8)	9 (60%)	633 (65%)	0.6 (0.1 - 2.1)

- Health clinic	0 (0%)	16 (4%)	-	1 (7%)	30 (3%)	1.3 (0.1 - 13.3)
- Private	1 (8%)	69 (17%)	0.2 (0.0 - 2.7)	2 (13%)	176 (18%)	0.4 (0.1 - 2.7)
- Did not seek	0 (0%)	9 (2%)	-	0 (0%)	19 (2%)	-
Illness prevent school						
- No	2 (29%)	63 (24%)	Baseline	3 (38%)	101 (15%)	Baseline
- Yes	5 (71%)	205 (76%)	0.8 (0.1 - 4.2)	5 (63%)	553 (85%)	0.3 (0.1 - 1.3)
Time taken to nearest health facility						
- <30 minutes	77 (34%)	9578 (43%)	Baseline	131 (44%)	18333 (43%)	Baseline
- 30 minutes-1 hour	111 (49%)	9315 (41%)	1.4 (1.1 - 1.9)	108 (36%)	17194 (41%)	0.8 (0.7 - 1.1)
- 1 – 2 hours	34 (15%)	2809 (12%)	1.5 (1.0 - 2.3)	56 (19%)	5726 (14%)	1.3 (1.0 - 1.8)
- >2 hours	3 (1%)	783 (3%)	0.5 (0.1 - 1.5)	2 (1%)	1100 (3%)	0.3 (0.1 - 1.0)
Slept under bednet last night						
- No malaria in area	30 (14%)	4022 (19%)	Baseline	32 (11%)	5524 (13%)	Baseline
- Yes	64 (30%)	4703 (22%)	1.9 (1.2 - 2.9)	95 (34%)	11042 (27%)	1.5 (1.0 - 2.3)
- No	122 (56%)	12959 (60%)	1.3 (0.9 - 2.0)	155 (55%)	24717 (60%)	1.2 (0.8 - 1.7)

Children with a disability were more likely to have had a serious illness in the last twelve months than children without disability. This pattern was observed most strongly for those with hearing and learning impairment, as can be found in the country report. The most common types of illness among the children with disabilities were malaria, acute respiratory tract infection, ear infection, eye problems, severe diarrhoea and malnutrition. Being malnourished was strongly associated with disabilities. The majority of sponsored children sought treatment from hospitals.

Other findings

Within the India dataset there were some findings that were not common in other countries. First, boys living in rural areas and girls living in mixed urban rural areas were more likely to be disabled than boys or girls living in urban areas. Second, the least poor children were least likely to be disabled. Third, having an unofficial toilet was associated with increased disability, as was having any other source of water than water piped into dwelling. Last, Children with a disability may have preferred art and disliked physical education (PE).

Overall the relationship between disability and indicators of inclusion between boys and girls was similar, in other words, the gender differences were minimal.

5.2 Indonesia

The country population of Indonesia is 246,864,191 and the percentage of children aged 0-14 is 29% (World Bank Population Data, 2013). Indonesia ranks 121 out of 187 countries in the 2013 Human Development Report, making it a country with medium human development (UNDP International Human Development Indicators, 2013). The Government of Indonesia has ratified the Convention of the Rights of Persons with Disabilities (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status 2013) and three national Plans of actions for children have been formulated. In addition, there are five laws for the interest of the child: Law on Child Protection, Law on Protection of Witness and Victim, Law on Eliminating of Domestic Violence, Law on Elimination of Trafficking in Persons, Law on Anti Pornography (Plan Indonesia, 2011).

Plan Indonesia works in 9 Programme Units (PUs) and the main geographical area of work is Eastern Indonesia, due to the recent economic progress which has mainly taken place in Western Indonesia. Plan Indonesia, in their strategic planning, identifies children with disabilities as some of the most marginalised. The Indonesian Directorate of Special Education and Services estimated in 2010 that over two million children with disabilities of a school going age are not attending school. Plan Indonesia therefore has a specific focus on children with disabilities in relation to early childhood care and development. The goal of the current Country Strategic Plan is: 'All children in Plan Indonesia's impact areas enjoy the rights to early childhood care and development, water sanitation, economic security, sexual and reproductive health and protection from all forms of violence, abuse and exploitation as well as from disasters.' And Plan's Indonesia main programme focus areas are:

- Water and Sanitation
- Early Childhood Care and Development
- Disaster Risk Management
- Protection

- Economic Security

In Indonesia, the 2012 dataset included 45,860 sponsored children, ranging in age from 0-17. The average age was 9.4 (standard deviation= 4.0), and 45 % were male. Among the children, 376 had had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.8 % (95% confidence interval 0.7 – 0.9 %). The prevalence of disability was slightly higher in males (1.0%, 95% CI 0.8 – 1.1 %) than in females (0.7 %, 95% CI 0.6 – 0.8 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.4, 95% CI 1.1 – 1.7%).

As can be seen in Table 30, the most common types of impairment were communication and physical, while learning, vision and hearing were less common.

Table 30: Type of impairment by gender in Indonesia

	MALES	FEMALES
Learning	24 (12%)	10 (6%)
Physical	76 (38%)	45 (26%)
Communication	62 (31%)	86 (49%)
Vision	24 (12%)	21 (12%)
Hearing	14 (7%)	14 (8%)
Total	200 (100%)	176 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. As illustrated in Table 31 boys with disabilities were 10 times less likely to attend school and girls were 20.8 times less likely to attend school. In addition, after accounting for age differences, children with disabilities were more likely to be at a lower school level compared to children without disability, particularly for girls. Increased time taken to school did not seem to be related to disability, although the greater than one hour category analysis was underpowered. Whether the child attended non-formal education was also not related to disability, although again there were insufficient numbers of children attending non-formal education for this analysis to be precise.

Table 31: Educational variables in relation to disability in Indonesia

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	116 (58%)	17653 (87%)	Baseline	79 (45%)	21566 (86%)	Baseline
- No	84 (42%)	2669 (13%)	6.5 (4.8 - 8.7)	97 (55%)	3596 (14%)	13.6 (10.0 - 18.5)
Age 5+: Attend formal education						
- Yes	115 (61%)	17196 (94%)	Baseline	77 (48%)	20690 (95%)	Baseline
- No	73 (39%)	1088 (6%)	10.0 (7.4 - 13.5)	84 (52%)	1061 (5%)	20.8 (15.1 - 28.5)
Of those at school, school level						
- Secondary/University/College	18 (16%)	4262 (24%)	Baseline	13 (16%)	5332 (25%)	Baseline
- Primary	93 (80%)	11893 (67%)	2.5 (1.4 - 4.7)	57 (72%)	13983 (65%)	3.8 (1.8 - 7.8)
- Nursery/pre-school	5 (4%)	1498 (8%)	1.5 (0.4 - 5.3)	9 (11%)	2251 (10%)	9.0 (2.6 - 31.4)
Time taken to school						
- <30 minutes	77 (66%)	10783 (61%)	Baseline	61 (77%)	13178 (61%)	Baseline
- 30 minutes-1 hour	34 (29%)	6137 (35%)	0.8 (0.5 - 1.1)	15 (19%)	7471 (35%)	0.4 (0.2 - 0.7)
- >1 hour	5 (4%)	733 (4%)	0.9 (0.4 - 2.3)	3 (4%)	917 (4%)	0.6 (0.2 - 2.0)
Attending non formal education						
- No	196 (98%)	19987 (98%)	Baseline	171 (97%)	24727 (98%)	Baseline
- Yes	4 (2%)	335 (2%)	1.1 (0.4 - 3.1)	5 (3%)	435 (2%)	1.5 (0.6 - 3.7)

As seen in Table 32, considering the data by type of impairment, physical and communication impairment had the strongest association with school attendance. This overall pattern was also apparent within boys and girls, although of note was that all impairments seems to have a much stronger relationship with non-attendance in girls than boys.

Table 32: Attendance of formal education by impairment type in Indonesia

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	39219 (86%)	6265 (14%)	37886 (95%)	2149 (5%)	Baseline	Baseline	Baseline
Learning	26 (76%)	8 (24%)	26 (79%)	7 (21%)	3.8 (1.4 - 10.4)	5.5 (1.1 - 26.7)	4.3 (1.9 - 10.0)
Physical	61 (50%)	60 (50%)	59 (57%)	45 (43%)	11.7 (7.2 - 19.1)	16.3 (8.3 - 31.7)	13.0 (8.8 - 19.2)
Communication	52 (35%)	96 (65%)	51 (36%)	90 (64%)	19.9 (11.7 - 33.6)	44.4 (27.7 - 71.3)	30.8 (21.8 - 43.6)
Vision	34 (76%)	11 (24%)	34 (79%)	9 (21%)	4.4 (1.6 - 11.8)	4.8 (1.6 - 14.4)	4.5 (2.2 - 9.4)
Hearing	22 (79%)	6 (21%)	22 (79%)	6 (21%)	2.3 (0.5 - 10.6)	7.8 (2.4 - 24.9)	4.6 (1.9 - 11.4)

As shown in Table 33, having an impairment was cited as the major reason for not attending formal education among children with disabilities (73%) while being too young was the most common reason among children without disability (79%).

Table 33: Reason for not attending formal education by disability status in Indonesia

	Disabled	**Not disabled**
Too young	27 (15%)	4977 (79%)
Too old	0 (0%)	76 (1%)
Did not pass secondary school exam	0 (0%)	2 (0%)
Is needed to work	0 (0%)	0 (0%)
Economic problems	7 (4%)	502 (8%)
Closest school too far	0 (0%)	86 (1%)
Has been ill	10 (6%)	7 (0%)
Is married	0 (0%)	23 (0%)
Needed to help family	0 (0%)	315 (5%)
Has an impairment	133 (73%)	14 (0%)

	Disabled	Not disabled
Is working outside family	0 (0%)	37 (1%)
Was expelled for class repetition	1 (1%)	31 (0%)
Primary not considered important by family	0 (0%)	47 (1%)
Secondary not considered important by family	0 (0%)	81 (1%)
Expelled	1 (1%)	26 (0%)
Fears violence at school	1 (1%)	1 (0%)
Do not have required document	0 (0%)	10 (0%)
Plays truant	1 (1%)	30 (0%)

Health and disability

As illustrated in Table 34, children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with physical and hearing impairment. Boys with disabilities were 4.3 times more likely to have had a serious illness in the last twelve months and for girls with disabilities this was 3.0 The most common type of illness among the children with disabilities was malaria, followed by severe diarrhoea, acute respiratory tract infection, malnutrition and vaccine preventable diseases. Malnutrition was strongly related to having a disability, particularly for girls, although the numbers were very small. Not seeking treatment was related to having a disability, although whether illness prevented school was not. Among the children with disabilities who had not sought treatment, the reasons given were either 'too expensive' or 'no transport'. Attending a hospital treatment for the illness was associated with disabilities among boys but not among girls. The analyses for time taken to nearest health facility or slept under a bed net loss nine did not indicate that these variables were related to having a disability.

Table 34: Association between health and health seeking behaviour and disability in Indonesia

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
Serious illness						
- No	159 (80%)	19167 (94%)	Baseline	151 (86%)	23860 (95%)	Baseline
- Yes	41 (21%)	1155 (6%)	4.3 (3.1 - 6.1)	25 (14%)	1302 (5%)	3.0 (2.0 - 4.7)

Malnutrition						
- No	198 (99%)	20303 (99.9%)	Baseline	173 (98%)	25138 (99.9%)	Baseline
- Yes	2 (1%)	19 (0.1%)	12.4 (2.9 - 54.2)	3 (2%)	25 (0.1%)	26.3 (7.7 - 89.8)
Where sought treatment						
- Other	11 (27%)	524 (45%)	Baseline	16 (64%)	556 (43%)	Baseline
- Hospital	20 (49%)	364 (32%)	2.6 (1.2 - 5.5)	5 (20%)	440 (34%)	0.4 (0.2 - 1.2)
- Health clinic	7 (17%)	240 (21%)	1.4 (0.5 - 3.8)	2 (8%)	275 (21%)	0.3 (0.1 - 1.2)
- Private	1 (2%)	13 (1%)	3.8 (0.5 - 32.1)	0 (0%)	10 (1%)	-
- Did not seek	2 (5%)	14 (1%)	6.8 (1.4 - 33.7)	2 (8%)	21 (2%)	3.2 (0.7 - 15.1)
Illness prevent school						
- No	6 (27%)	187 (25%)	Baseline	4 (40%)	203 (23%)	Baseline
- Yes	16 (73%)	573 (75%)	0.8 (0.3 - 2.0)	6 (60%)	677 (77%)	0.4 (0.1 - 1.4)
Time taken to nearest health facility						
- <30 minutes	122 (61%)	11151 (55%)	Baseline	104 (59%)	13825 (55%)	Baseline
- 30 minutes-1 hour	67 (34%)	7435 (37%)	0.8 (0.6 - 1.1)	64 (36%)	9264 (37%)	0.9 (0.7 - 1.2)
- 1 – 2 hours	7 (4%)	1261 (6%)	0.5 (0.2 - 1.1)	6 (3%)	1483 (6%)	0.5 (0.2 - 1.2)
- >2 hours	4 (2%)	475 (2%)	0.8 (0.3 - 2.1)	2 (1%)	590 (2%)	0.5 (0.1 - 1.9)
Slept under bednet last night						
- No malaria in area	5 (3%)	918 (5%)	Baseline	5 (3%)	902 (4%)	Baseline
- Yes	110 (67%)	12177 (68%)	1.9 (0.8 - 4.6)	124 (77%)	15742 (71%)	1.8 (0.7 - 4.5)
- No	49 (30%)	4800 (27%)	2.0 (0.8 - 5.1)	33 (20%)	5413 (25%)	1.3 (0.5 - 3.4)

Other Findings

Overall, the children with disabilities were older than the children without disability, in particular girls. The poverty score and other poverty variables did not seem to show strong relationships with disabilities. In addition, using an unofficial toilet was related to having a disability for boys. Finally, in relation to gender differences, although the prevalence of disability was higher in boys, a number of variables were more strongly associated with disabilities for girls than for boys (e.g. school level, school non-attendance, malnutrition).

5.3 Nepal

The total population of Nepal is 27,474,377 and the percentage of children aged 0-14 is 36% (World Bank Population Data, 2013). Nepal is ranked 157 out of 187 in the 2013 Human Development Index, making it a country with low human development (UNDP International Human Development Indicators, 2013). The Government of Nepal has ratified the Convention of the Rights of Persons with Disabilities (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status , 2013) and in addition to the country's constitution, which grants children a number of rights, Nepal has a Plan of Action for Children (2004-2014) and the Children's Act of 1992, the Child Labour Act of 1992 and the Juvenile Justice Rules of 2006, which safeguard children's rights. Nepal has an interim constitution since 2007, following the Comprehensive Peace Agreement in 2006, which ended ten years of conflict. The interim constitution outlaws discrimination based on gender, caste, religion and disability.

Nepal's 2010-2015 Country Strategic Plan (CSP) mentions that Nepal is one of the poorest countries in Asia; it is estimated that 31% of the population subsists on less than 1$ a day. The divide between rural and urban populations is particularly striking, as 'the disparity between urban and rural poverty rates 10% and 35%.' Therefore Plan Nepal works in seven Programme Units which are mainly in a rural context. Plan Nepal's situation analysis undertaken to inform the drafting of the Country Strategic Plan clearly identifies children with disabilities as a marginalised group; 'in the bottom strata fall women, children, Dalits (the so-called untouchables of the Hindu cast system), religious and ethnic minorities, and the disabled.' As a result children with a disability are an important focus in the CSP and it describes the link between health and children with disabilities and how Plan Nepal will promote the screening, prevention and treatment of disabilities in children; pay for treatment of selected children with disabilities; provide rehabilitative supports; and increase awareness. It also mentions disabled-friendly features in its infrastructure projects, particularly in relation to water and sanitation. In its effort to address the most pressing violations of the rights of Nepali children, Plan Nepal has formulated the following five goals for their CSP:

- Girls, children with disabilities, children of Dalit families, and children belonging to the most marginalised ethnic groups will have improved health status and grow up in an environment conducive to good health.
- Girls, children with disabilities, children of Dalit families, and children belonging to the most marginalised ethnic groups will have access to and complete their basic education in a child-friendly, good-quality learning environment in which they have a voice.

- The very poorest and most marginalised families will achieve sufficient economic security to ensure that children's rights to education, health, and protection are fulfilled.
- All children in Plan working areas, but particularly children at risk, will be protected from exploitative working conditions, trafficking and gender-based violence, and will exercise their rights to identity and participation.
- Children and youths will live in an environment that is resilient to disaster and be able to secure their rights to education, health and protection even during disasters and conflict-induced emergencies (Plan Nepal, 2010).

In Nepal, the 2012 dataset included 38,450 sponsored children, ranging in age from 0-17. The average age was 9.6 (standard deviation= 3.9), and 26% were male. Among the children, 259 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.7 % (95% confidence interval 0.6 - 0.8 %). The prevalence of disability was higher in males (1.0%, 95% CI 0.8 - 1.2%) than in females (0.5%, 95% CI 0.5 - 0.6%). After adjustment for age, males had significantly higher odds of disability compared to females (1.9, 95% CI 1.5 - 2.4).

As shown in Table 35, the most common types of impairment were physical, communication and vision, while learning and hearing impairments were the least common.

Table 35: Type of impairment by gender in Nepal

	MALES	FEMALES
Learning	5 (5%)	3 (2%)
Physical	54 (52%)	82 (53%)
Communication	29 (28%)	35 (22%)
Vision	10 (10%)	31 (20%)
Hearing	5 (5%)	5 (3%)
Total	103 (100%)	156 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. As illustrated in Table 36 boys with disabilities are 13.4 times less likely to attend school and girls with disabilities are 6.3 times less likely to attend school then children without disabilities. Children with disabilities were much more likely to be at a lower school level compared to children without disability, after accounting for age differences (particularly boys). Increased time taken to school did not seem to be related to increased disability, and there was no evidence that children with a disability were more likely to attend non-formal education than those without disability.

Table 36: Educational variables in relation to disability in Nepal

	MALES			**FEMALES**		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	68 (66%)	8914 (90%)	Baseline	109 (70%)	25272 (89%)	Baseline
- No	35 (34%)	966 (10%)	5.5 (3.6 - 8.5)	47 (30%)	3039 (11%)	3.9 (2.7 - 5.5)
Age 5+: Attend formal education						
- Yes	66 (73%)	8302 (97%)	Baseline	103 (74%)	23961 (94%)	Baseline
- No	24 (27%)	286 (3%)	13.4 (8.1 - 22.2)	36 (26%)	1434 (6%)	6.3 (4.2 - 9.4)
Of those at school, school level						
- Secondary/University/College	8 (12%)	2020 (23%)	Baseline	19 (17%)	5965 (24%)	Baseline
- Primary	50 (74%)	5881 (66%)	3.7 (1.5 - 9.0)	77 (71%)	17069 (68%)	2.2 (1.2 - 4.1)
- Nursery/pre-school	10 (15%)	1015 (11%)	6.8 (1.8 - 25.4)	13 (12%)	2238 (9%)	4.5 (1.6 - 12.6)
Time taken to school						
- <30 minutes	49 (72%)	6068 (68%)	Baseline	77 (71%)	17580 (70%)	Baseline
- 30 minutes-1 hour	17 (25%)	2652 (30%)	0.8 (0.5 - 1.4)	30 (28%)	7077 (28%)	1.0 (0.6 - 1.5)

- >1 hour	2 (3%)	196 (2%)	1.3 (0.3 - 5.2)	2 (2%)	615 (2%)	0.7 (0.2 - 3.0)
Attending non formal education						
- No	103 (100%)	9814 (99%)	Baseline	153 (98%)	27873 (98%)	Baseline
- Yes	0 (0%)	68 (1%)	-	3 (2%)	438 (2%)	1.2 (0.4 - 3.9)

As can be seen in Table 37, considering the data by type of impairment, communication impairment had by far the greatest effect on school attendance, followed by physical and vision impairment. All of the children with learning or hearing impairment attended formal education. This overall pattern was apparent in relation to boys and girls.

Table 37: Attendance of formal education by impairment type in Nepal

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	34186 (90%)	4005 (10%)	32263 (95%)	1720 (5%)	Baseline	Baseline	Baseline
Learning	8 (100%)	0 (0%)	8 (100%)	0 (0%)	-	-	-
Physical	96 (71%)	40 (29%)	92 (77%)	27 (23%)	10.9 (5.0 - 23.7)	4.7 (2.6 - 8.3)	6.0 (3.8 - 9.6)
Communication	32 (50%)	32 (50%)	29 (51%)	28 (49%)	56.8 (23.2 - 139.0)	18.4 (8.8 - 38.6)	28.0 (15.9 - 49.4)
Vision	33 (80%)	8 (20%)	32 (86%)	5 (14%)	3.5 (0.4 - 29.6)	3.7 (1.2 - 11.0)	3.6 (1.4 - 9.7)
Hearing	8 (80%)	2 (20%)	8 (100%)	0 (0%)	-	-	-

As shown in Table 38, having an impairment was cited as the major reason for not attending formal education among children with disabilities (73 %) while being too young was the most common reason among children without disability (61%).

Table 38: Reason for not attending formal education by disability status in Nepal

	Disabled	Non disabled
Too young	17 (21%)	2439 (61%)
Too old	0 (0%)	227 (6%)

	Disabled	Non disabled
Did not pass secondary school exam	0 (0%)	2 (0%)
Economic problems	3 (4%)	240 (6%)
Closest school too far	0 (0%)	29 (1%)
Has been ill	1 (1%)	3 (0%)
Is married	0 (0%)	102 (3%)
Needed to help family	0 (0%)	570 (14%)
Has an impairment	60 (73%)	1 (0%)
Is working outside family	0 (0%)	3 (0%)
Was expelled for class repetition	0 (0%)	21 (1%)
Primary not considered important by family	1 (1%)	275 (7%)
Secondary not considered important by family	0 (0%)	92 (2%)
Plays truant	0 (0%)	1 (0%)

Health and disability

As can be seen in Table 39, children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with learning and physical impairment. Boys with disabilities were 3.8 times more likely to have had a serious illness in the last twelve months and girls with disabilities were 5.4 more likely. The most common types of illness among the children with disabilities were eye problems, acute respiratory tract infection, mental health problems and typhoid. Hospital was the most commonly cited places where treatment was sought and time taken to nearest health facility did not seem to be related to disability. Whether illness prevented the child from attending school was not related to disability, although this analysis was underpowered. For girls, there was a suggestion that being in an area with malaria was related to reduced disability.

Table 39: Association between health and health seeking behaviour and disability in Nepal

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
Serious illness						
- No	92 (89%)	9580 (97%)	Baseline	135 (87%)	27508 (97%)	Baseline

- Yes	11 (11%)	300 (3%)	3.8 (2.0 - 7.2)	21 (13%)	803 (3%)	5.4 (3.4 - 8.7)
Malnutrition						
- No	103 (100%)	9880 (100%)	Baseline	154 (99%)	28307 (100%)	Baseline
- Yes	0 (0%)	0 (0%)	-	2 (1%)	4 (0%)	95.9 (17.2 - 535.2)
Where sought treatment						
- Other	0 (0%)	25 (8%)	Baseline	2 (10%)	81 (10%)	Baseline
- Hospital	6 (55%)	138 (46%)	-	11 (52%)	241 (30%)	1.9 (0.4 - 8.6)
- Health clinic	1 (9%)	56 (19%)	-	6 (29%)	200 (25%)	1.3 (0.2 - 6.3)
- Private	4 (36%)	80 (27%)	-	2 (10%)	277 (34%)	0.3 (0.0 - 2.1)
- Did not seek	0 (0%)	1 (0.3%)	-	0 (0%)	4 (0.5%)	-
Illness prevent school						
- No	2 (29%)	63 (23%)	Baseline	4 (25%)	123 (17%)	Baseline
- Yes	5 (71%)	208 (77%)	0.8 (0.1 - 4.2)	12 (75%)	609 (83%)	0.6 (0.2 - 2.0)
Time taken to nearest health facility						
- <30 minutes	48 (47%)	4519 (46%)	Baseline	72 (46%)	13805 (49%)	Baseline
- 30 minutes-1 hour	43 (42%)	3929 (40%)	1.0 (0.7 - 1.5)	63 (40%)	10757 (38%)	1.1 (0.8 - 1.6)
- 1 – 2 hours	10 (10%)	1172 (12%)	0.8 (0.4 - 1.6)	14 (9%)	3071 (11%)	0.9 (0.5 - 1.6)
- >2 hours	2 (2%)	260 (3%)	0.7 (0.2 - 2.9)	7 (4%)	678 (2%)	2.0 (0.9 - 4.3)
Slept under bednet last night						
- No malaria in area	14 (15%)	641 (7%)	Baseline	14 (10%)	1426 (6%)	Baseline
- Yes	58 (61%)	6521 (74%)	0.4 (0.2 - 0.7)	104 (72%)	19132 (75%)	0.6 (0.3 - 1.0)
- No	23 (24%)	1696 (19%)	0.6 (0.3 - 1.2)	27 (19%)	5029 (20%)	0.5 (0.3 - 1.0)

Other Findings

Overall, the children with disabilities were similar in age than the children without disability and the relationship between disability and indicators of inclusion/exclusion was similar between boys and girls. The poverty variables were not related to disabilities, although the analyses lacked power.

5.4 Philippines

The country population of the Philippines is 96,706,764 and the percentage of the population that constitutes children between the ages of 0-14 year is 35% (World Bank Population Data 2013). The Philippines ranks 114 out of 187 countries in the 2013 Human Development Report, making it a country with medium human development (UNDP International Human Development Indicators, 2013). The Government of the Philippines ratified the UN Convention on the Rights of Persons with Disabilities in 2008 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013). In addition, the Government of the Philippines enacted many laws to protect Filipino children from various forms of abuse, exploitation and violence, such as Republic Act 7610 against child abuse, exploitation and discrimination; Republic Act 9231 eliminates worst forms of child labour and affords stronger protection for the working child; Republic Act 9208 provides stronger mechanisms to protect children from trafficking, while Republic Act 9263 eliminates violence against women and children.

Plan Philippines works in seven Programme Units, located in West Mindoro, North Samar, East Samar, West Samar, Southern Leyte, Camotes and Masbate and they run two programmes managed from the national office, namely Luzon and Visayas. Plan Philippines situation analysis' undertaken to inform the drafting of the Country Strategic Plan describes that there are an estimated 8 million persons with disabilities in the Philippines and that children with disabilities face particular difficulties in education with the lack of trained teachers. Children with disabilities are also specifically mentioned in relation to their right to protection, it says 'children with disabilities and children in conflict with the law are vulnerable to exploitation and abuse by the very nature of their exclusion'. Children with disabilities are therefore described as a group amongst whom exclusion and rights violations are more prevalent. Plan Philippines country goal is 'for every child within our sphere of influence to enjoy his or her right to education' and their programmatic goals are the following:

- all children complete quality basic education
- all children are healthy and well-nourished to be able to attend and learn in school
- all children are protected from abuse, exploitation, violence, and harm from disasters that interfere with their right to education
- all children, based on their evolving capacities, participate in advancing their education and other rights (Plan Philippines, 2010).

In the Philippines, the 2012 dataset included 33,543 sponsored children, ranging in age from 0-17. The average age was 9.6 (standard deviation=4.26), and 39% were male. Among the children, 397 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.2% (95% confidence interval 1.1 – 1.3 %). The prevalence of disability was slightly higher in males (1.4%, 95% CI 1.2 – 1.6%) than in females (1.0%, 95% CI 0.9 – 1.2%). After adjustment for age, boys were significantly more likely to be disabled compared to girls (odds ratio = 1.3, 95% CI 1.1-1.6).

As illustrated in Table 40, the most common types of impairment were physical, communication and vision, while hearing and learning impairments were the least common.

Table 40: Type of impairment by gender in the Philippines

	MALES	FEMALES
Learning	20 (11%)	19 (9%)
Physical	74 (40%)	70 (33%)
Communication	44 (24%)	80 (38%)
Vision	31 (17%)	37 (17%)
Hearing	15 (8%)	7 (3%)
Total	184 (100%)	213 (100%)

Education and disability

As can be seen in Table 41, children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. Boys with disabilities were 13.9 less likely to attend school and girls with disabilities were 13.1 times less likely to attend school. And of those at school, the children with disabilities were much more likely to be at a lower school level compared to children without disability, after accounting for age differences, with the difference particularly marked for girls. There was minimal difference in the time taken to get to school for those with disabilities compared to those without disability.

Table 41: Educational variables in relation to disability in the Philippines

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	108 (59%)	11605 (90%)	Baseline	135 (63%)	17506 (86%)	Baseline
- No	76 (41%)	1282 (10%)	6.3 (4.7 - 8.5)	78 (37%)	2753 (14%)	5.1 (3.8 - 6.8)
Age 5+: Attend formal education						
- Yes	104 (60%)	11022 (93%)	Baseline	127 (69%)	15973 (96%)	Baseline
- No	70 (40%)	884 (7%)	13.9 (9.5 - 20.4)	58 (31%)	662 (4%)	13.1 (9.2 - 18.7)
Of those at school, school level						
- Secondary/University/ College	21 (19%)	3391 (29%)	Baseline	26 (19%)	4666 (27%)	Baseline
- Primary	77 (71%)	7109 (61%)	2.4 (1.3 - 4.5)	92 (68%)	10327 (59%)	3.7 (2.1 - 6.7)
- Nursery/pre-school	10 (9%)	1105 (10%)	2.8 (0.9 - 8.9)	17 (13%)	2513 (14%)	6.7 (2.4 - 18.9)
Time taken to school						
- <30 minutes	85 (79%)	8835 (76%)	Baseline	105 (78%)	13339 (76%)	Baseline
- 30 minutes-1 hour	21 (19%)	2454 (21%)	0.9 (0.6 - 1.5)	28 (21%)	3652 (21%)	0.9 (0.6 - 1.4)
- >1 hour	2 (2%)	316 (3%)	0.7 (0.2 - 2.8)	2 (1%)	515 (3%)	0.4 (0.1 - 1.8)
Attending non formal education						
- No	184 (100%)	12856 (99.8%)	Baseline	212 (100%)	20235 (99.9%)	Baseline
- Yes	0 (0%)	31 (0.2%)	-	1 (0%)	24 (0.1%)	-

As can be seen in Table 42, considering the data by type of disability, learning and communication impairment had the greatest effect on school attendance, followed by physical and hearing impairment. The effect of vision impairment was much less, although still apparent. This overall pattern was also apparent within boys and girls, although for boys vision impairment did not seem to impact school attendance, and the learning and communication effects were more marked.

Table 42: Attendance of formal education by impairment type in the Philippines

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	29111 (88%)	4035 (12%)	26995 (95%)	1546 (5%)	Baseline	Baseline	Baseline
Learning	17 (44%)	22 (56%)	17 (44%)	22 (56%)	48.3 (14.9 - 156.9)	24.3 (8.6 - 68.6)	32.5 (15.0 - 70.3)
Physical	86 (60%)	58 (40%)	80 (63%)	47 (37%)	14.4 (7.8 - 26.8)	14.6 (7.8 - 27.5)	13.9 (9.0 - 21.7)
Communication	67 (54%)	57 (46%)	65 (59%)	46 (41%)	48.6 (21.1 - 112.2)	21.5 (11.7 - 39.5)	29.5 (18.0 - 48.3)
Vision	57 (84%)	11 (16%)	53 (88%)	7 (12%)	1.8 (0.5 - 6.7)	4.4 (1.4 - 14.0)	2.8 (1.2 - 6.6)
Hearing	16 (73%)	6 (27%)	16 (73%)	6 (27%)	25.7 (6.7 - 99.0)	-	11.2 (3.6 - 34.8)

In line with the overall findings and as indicated in Table 43, having an impairment was cited as the major reason for not attending formal education among children with disabilities (74%) while being too young was the most common reason among children without disability (63%).

Table 43: Reason for not attending formal education by disability status in the Philippines

	Disabled	Not disabled
Is pregnant or gave birth	1 (1%)	2 (0%)
Too young	22 (14%)	2537 (63%)
Too old	1 (1%)	32 (1%)
Economic problems	2 (1%)	518 (13%)
Closest school too far	1 (1%)	48 (1%)
Has been ill	0 (0%)	11 (0%)
Is married	0 (0%)	60 (1%)
Needed to help family	5 (3%)	340 (8%)
Has an impairment	114 (74%)	8 (0%)
Is working outside family	0 (0%)	88 (2%)
Was expelled for class repetition	1 (1%)	11 (0%)
Primary not considered important by family	2 (1%)	81 (2%)
Secondary not considered important by family	3 (2%)	135 (3%)
Expelled	0 (0%)	16 (0%)
Fears violence at school	0 (0%)	16 (0%)
Fears violence on way to school	0 (0%)	10 (0%)
Do not have required document	2 (1%)	27 (1%)
Plays truant	0 (0%)	94 (2%)

Health and disability

As evidenced in Table 44, children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with hearing impairment. Boys with disabilities were 4.4 times more likely to have had a serious illness in the last twelve months and girls were 3.2 times more likely. The most common types of illness among the children with disabilities were epilepsy, eye problems, ear infection, mental health problems, influenza and severe diarrhea. There was insufficient data on malnutrition to assess whether this was more common in those with disabilities than those without, although this was suggested for boys. The majority of children with a serious illness (96% for both children with and without a

disability had sought treatment. Among the few who had not sought treatment, the most commonly cited reasons were ‘advised treatment unnecessary’ and ‘too expensive’.

Hospital or private treatment were the most commonly cited places where treatment was sought. There was little difference between the children with and without a disability in terms of whether the illness prevented school attendance, similarly in relation to distance to the nearest health facility. Finally, children with disabilities were no more likely or unlikely to have slept under a bednet the previous night than children without a disability.

Table 44: Association between health and health seeking behaviour and disability in the Philippines

	MALES			**FEMALES**		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	29 (16%)	547 (4%)	4.4 (2.9 - 6.7)	29 (14%)	981 (5%)	3.2 (2.2 - 4.8)
- Yes	155 (84%)	12340 (96%)	Baseline	184 (86%)	19278 (95%)	Baseline
Malnutrition						
- No	1 (1%)	21 (0.2%)	3.7 (0.5 - 27.7)	0 (0%)	26 (0.1%)	-
- Yes	183 (99%)	12866 (99.8%)	Baseline	213 (100%)	20233 (99.9%)	Baseline
Where sought treatment						
- Other	17 (59%)	155 (28%)	4.1 (1.6 - 10.6)	12 (41%)	279 (28%)	3.3 (1.1 - 9.5)
- Hospital	3 (10%)	125 (23%)	0.9 (0.2 - 3.6)	6 (21%)	240 (24%)	1.9 (0.6 - 6.2)
- Health clinic	3 (10%)	31 (6%)	3.7 (0.9 - 15.9)	4 (14%)	58 (6%)	5.3 (1.4 - 20.4)
- Private	0 (0%)	25 (5%)	-	2 (7%)	36 (4%)	4.1 (0.8 - 22.0)
- Did not seek	6 (21%)	211 (39%)	Baseline	5 (17%)	368 (38%)	Baseline
Illness prevent school						
- No	6 (33%)	150 (34%)	Baseline	8 (44%)	267 (38%)	Baseline
- Yes	12 (67%)	296 (66%)	1.0 (0.4 - 2.7)	10 (56%)	445 (63%)	0.7 (0.3 - 1.8)

Time taken to nearest health facility						
- <30 minutes	130 (71%)	8804 (68%)	Baseline	157 (74%)	13795 (68%)	Baseline
- 30 minutes-1 hour	44 (24%)	3379 (26%)	0.9 (0.6 - 1.2)	47 (22%)	5256 (26%)	0.8 (0.6 - 1.1)
- 1 – 2 hours	9 (5%)	444 (3%)	1.4 (0.7 - 2.7)	6 (3%)	775 (4%)	0.7 (0.3 - 1.5)
- >2 hours	1 (1%)	260 (2%)	0.3 (0.0 - 1.9)	3 (1%)	433 (2%)	0.6 (0.2 - 1.9)
Slept under bednet last night						
- No malaria in area	118 (72%)	8033 (70%)	Baseline	135 (71%)	11353 (66%)	Baseline
- Yes	38 (23%)	2977 (26%)	0.9 (0.6 - 1.3)	40 (21%)	5202 (30%)	0.7 (0.5 - 1.0)
- No	9 (5%)	452 (4%)	1.4 (0.7 - 2.7)	14 (7%)	747 (4%)	1.6 (0.9 - 2.9)

Other Findings

Overall, the children with disabilities were older than the children without disability. In relation to gender differences, it appeared that the relationship between disability and indicators of inclusion/exclusion were generally similar between boys and girls, although the poverty variables seemed to be more strongly associated with disabilities in boys. In addition, impaired vision seemed to be more strongly associated with girls not attending education than boys, while learning or communication impairment may have been more strongly associated with non-attendance in boys than girls. Finally, the poverty variables showed some relationship with disabilities, particularly for boys

5.5 Sri Lanka

Sri Lanka has a population of 20,328,000 of which 25 % are children aged 0-14 (World Bank Population Data, 2013). Sri Lanka ranks 92 out of 187 in the 2013 Human Development Report, placing it at the bottom of the countries categorised as having high human development (UNDP International Human Development Indicators, 2013). The Sri Lankan Government signed the UNCRPD in March 2007, but it has not yet been ratified (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013). In addition, the Disability Rights Bill has been pending for the last 7 years.

Plan Sri Lanka's situation analysis undertaken to inform the drafting of the Country Strategic Plan (CSP) reports that the rights of children with disabilities fall under the Ministry of Social Services and Social Welfare, whose policy says that 'a disabled child should be integrated into society and should be provided with facilities, skills and competencies to have an independent life.' It also describes the government's efforts on inclusive education, which are set out in National Policy on Disability (2003) by developing and modifying where necessary the work which is currently being done in inclusive education.

Plan Sri Lanka works in 3 Programme Units, which are located in the North and Central province. Because despite the increase in GDP, the economic growth has been unequal, with the Western Province growing far more rapidly than the other provinces, particularly as the Northern areas were affected by civil strife. Children with disabilities are part of the focus of Plan Sri Lanka's CSP. The CSP mentions the relationship between malnutrition and disability; it also describes double discrimination within the education system, particularly for girls with disabilities. In terms of education the CSP says: 'Children with disabilities are among the least likely to participate', it goes on to say 'Conditions in formal schools tend to discriminate de facto and discourage disabled children from joining, although the de jure policy is inclusive education. Families with disabled children are stigmatised by the community and tend to hide their children' (Plan Sri Lanka, 2012). Plan Sri Lanka's overall goal in the CSP is to ensure that all children, particularly those who live in remote rural areas and are conflict-affected, get adequate nutrition, care, and a wide range of early stimuli so that they can achieve their full growth and development potential, realise their right to good quality education at the pre primary and primary levels, and grow up in safe environments protected from all forms of violence. Plan Sri Lanka's programme focus is the following:

- Survival
- Development
- Protection
- Participation

In Sri Lanka, the 2012 dataset included 21,743 sponsored children, ranging in age from 0-17. The average age was 9.6 (standard deviation= 4.3), and 45% were male. Among the children, 166 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.8 % (95% confidence interval 0.6 - 0.9 %). The prevalence of disability was the same for males and females (odds ratio for the association = 1.0, 95% CI = 0.7-1.3).

As can be seen in Table 45, the most common types of impairment were communication, physical and vision, while hearing and learning were less common.

Table 45: Type of impairment by gender in Sri Lanka

	Male	Female
Learning	9 (12%)	7 (8%)
Physical	20 (27%)	20 (22%)
Communication	24 (32%)	30 (33%)
Vision	13 (17%)	23 (25%)
Hearing	9 (12%)	11 (12%)
Total	75 (100%)	91 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. As can be seen in Table 46 boys with disabilities are 38.7 times less likely to attend school and girls are 36.1 times less likely. Increased time taken to school seemed to be related to increased disability for boys but not for girls.

Table 46: Educational variables in relation to disability in Sri Lanka

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
SCHOOL						
All ages: Attend formal education						
- Yes	46 (61%)	8648 (89%)	Baseline	56 (62%)	10360 (88%)	Baseline
- No	29 (39%)	1105 (11%)	8.2 (5.0 - 13.6)	35 (38%)	1464 (12%)	10.7 (6.7 - 17.1)
Age 5+: Attend formal						

education						
- Yes	45 (67%)	8294 (98%)	Baseline	56 (67%)	9838 (99%)	Baseline
- No	22 (33%)	172 (2%)	38.7 (20.8 - 72.2)	27 (33%)	147 (1%)	36.1 (21.1 - 61.5)
Of those at school, school level						
- Secondary/University/ College	23 (50%)	5199 (60%)	Baseline	35 (63%)	5931 (57%)	Baseline
- Primary	19 (41%)	2790 (32%)	2.2 (1.0 - 4.8)	17 (30%)	3469 (33%)	1.4 (0.7 - 2.9)
- Nursery/pre-school	4 (9%)	659 (8%)	2.9 (0.7 - 12.5)	4 (7%)	960 (9%)	2.0 (0.5 - 7.7)
Time taken to school						
- <30 minutes	15 (33%)	4093 (47%)	Baseline	24 (43%)	4919 (47%)	Baseline
- 30 minutes-1 hour	28 (61%)	4197 (49%)	1.8 (1.0 - 3.5)	30 (54%)	4995 (48%)	1.1 (0.6 - 1.9)
- >1 hour	3 (7%)	358 (4%)	2.3 (0.7 - 8.1)	2 (4%)	446 (4%)	0.8 (0.2 - 3.3)
Attending non formal education						
- No	75 (100%)	9744 (99.9%)	Baseline	91 (100%)	11816 (99.9%)	Baseline
- Yes	0 (0%)	9 (0.1%)	-	0 (0%)	8 (0.1%)	-

As shown in Table 47, considering the data by type of impairment, communication impairments had the greatest effect on school attendance, followed by hearing and vision impairments. There was insufficient data to perform this analysis for the learning category and for any category within males.

Table 47: Attendance of formal education by impairment type in Sri Lanka

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	22233 (91%)	2212 (9%)	21838 (91%)	2100 (9%)	Baseline	Baseline	Baseline
Learning	0 (0%)	1 (100%)	0 (0%)	1 (100%)	-	-	-
Physical	29 (85%)	5 (15%)	29 (85%)	5 (15%)	-	1.1 (0.3 - 3.7)	1.8 (0.7 - 4.6)
Communication	2 (40%)	3 (60%)	2 (40%)	3 (60%)	-	23.1 (3.4 - 159.1)	23.0 (3.4 - 157.2)
Vision	42 (84%)	8 (16%)	42 (84%)	8 (16%)	-	2.8 (1.3 - 6.2)	2.5 (1.1 - 5.5)
Hearing	12 (67%)	6 (33%)	11 (65%)	6 (35%)	-	11.8 (4.2 - 33.6)	11.7 (4.1 - 33.1)

In line with the overall findings and as evidenced in Table 48, having been ill or having an impairment were cited as the major reason for not attending formal education among children with disabilities (72%) while being too young was the most common reason among children without disability (88 %).

Table 48: Reason for not attending formal education by disability status in Sri Lanka

	Disabled	**Not disabled**
Lack of primary schools in community	0 (0%)	1 (0%)
Is working outside family	0 (0%)	3 (0%)
Was expelled for class repetition	0 (0%)	6 (0%)
Primary not considered important by family	0 (0%)	7 (0%)
Secondary not considered important by	0 (0%)	39 (2%)

	Disabled	Not disabled
family		
Expelled	1 (2%)	25 (1%)
Fears violence on way to school	0 (0%)	1 (0%)
Do not have required document	0 (0%)	2 (0%)
Plays truant	0 (0%)	10 (0%)
Too young	14 (22%)	2260 (88%)
Too old	2 (3%)	141 (5%)
Did not pass secondary school exam	1 (2%)	5 (0%)
Economic problems	0 (0%)	17 (1%)
Closest school too far	0 (0%)	2 (0%)
Has been ill	26 (41%)	10 (0%)
Is married	0 (0%)	11 (0%)
Needed to help family	0 (0%)	21 (1%)
Has an impairment	20 (31%)	8 (0%)

Health and disability

As illustrated in Table 49, children with a disability were much more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with learning and physical impairment. Boys with disabilities were 12.4 times more likely to have had a serious illness in the last twelve months and girls were 26.1 time more likely. The most common types of illness among the children with disabilities were chronic illness, eye problems, ear infections and acute respiratory tract infections. Only two children did not seek treatment and nearly all children who did sought treatment from a hospital. Time taken to the nearest health facility seemed to be associated with disabilities amongst boys but not girls, while living in an area with malaria was associated with increased disability amongst girls but not boys.

Table 49: Association between health and health seeking behaviour and disability in Sri Lanka

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
Serious illness						

- No	64 (85%)	9615 (99%)	Baseline	69 (76%)	11677 (99%)	Baseline
- Yes	11 (15%)	138 (1%)	12.4 (6.4 - 24.2)	22 (24%)	147 (1%)	26.1 (15.7 - 43.5)
Malnutrition						
- No	75 (100%)	9751 (99.9%)	Baseline	91 (100%)	11824 (100%)	Baseline
- Yes	0 (0%)	2 (0.1%)	-	0 (0%)	0 (0%)	-
Where sought treatment						
- Other	0 (0%)	1 (1%)	Baseline	0 (0%)	4 (3%)	Baseline
- Hospital	11 (100%)	132 (96%)	-	20 (91%)	138 (94%)	-
- Health clinic	0 (0%)	0 (0%)	-	0 (0%)	3 (2%)	-
- Private	0 (0%)	4 (3%)	-	2 (9%)	1 (1%)	-
- Did not seek	0 (0%)	1 (1%)	-	0 (0%)	1 (1%)	-
Illness prevent school						
- No	4 (67%)	37 (40%)	Baseline	5 (42%)	62 (64%)	Baseline
- Yes	2 (33%)	55 (60%)	0.3 (0.1 - 1.9)	7 (58%)	35 (36%)	2.3 (0.7 - 8.0)
Time taken to nearest health facility						
- <30 minutes	13 (17%)	2523 (26%)	Baseline	19 (21%)	3126 (26%)	Baseline
- 30 minutes-1 hour	36 (48%)	5268 (54%)	1.3 (0.7 - 2.5)	50 (55%)	6432 (54%)	1.3 (0.7 - 2.2)
- 1 – 2 hours	24 (32%)	1627 (17%)	2.8 (1.4 - 5.6)	18 (20%)	1867 (16%)	1.5 (0.8 - 2.9)
- >2 hours	2 (3%)	335 (3%)	1.1 (0.3 - 5.0)	4 (4%)	399 (3%)	1.5 (0.5 - 4.5)
Slept under bednet last night						
- No malaria in area	15 (24%)	2605 (32%)	Baseline	11 (14%)	2901 (29%)	Baseline
- Yes	31 (50%)	3641 (44%)	1.5 (0.8 - 2.8)	47 (60%)	4741 (48%)	2.7 (1.4 - 5.3)
- No	16 (26%)	1969 (24%)	1.4 (0.7 - 2.8)	20 (26%)	2278 (23%)	2.1 (1.0 - 4.5)

Other Findings

Overall, girls with disabilities were slightly older than girls without disability and there were gender differences observed for some of the variables (eg. poverty, time taken to school and time taken to nearest health facility). The poverty score was not related to disability, but other poverty variables showed some relationship with disability. Among the girls, poorer wall quality was associated with disabilities

whereas among boys, poorer floor quality was associated with disabilities. Finally, increased house quality score and increased distance and water source were related to less disability in girls

5.5 Vietnam

The country population of Vietnam is 88,775,500 and the percentage of the population that constitutes children between the ages of 0-14 is 23% (World Bank Population Data, 2013). Vietnam ranks 127 out of 187 in the 2013 Human Development Report, making it a country with medium human development (UNDP International Human Development Indicators, 2013). The Vietnamese government signed the UNCRPD, but it has not yet been ratified (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan Vietnam has 8 programme units in the central and northern parts of the country, predominantly in hard-to-reach areas where many of the most marginalised groups live. As part of Plan Vietnam's situation analysis undertaken to inform the drafting of the Country Strategic Plan, the situation of children with disabilities was described in relation to education and protection; 'Disadvantaged and vulnerable children, including ethnic minority children, migrant children, children with disabilities, and others, experience significant barriers to pre-primary and basic education. [..] Children with disabilities are also vulnerable to harm and neglect.'
Plan Vietnam's Country Strategic Goal is that children in Vietnam – especially the most vulnerable and marginalised – live in communities that increasingly respect and promote their rights, enabling them to actively and meaningfully participate in society. The goal will be achieved through the following three Country Programmes:

- Early Childhood Care and Development in Ethnic Minority Areas: Focusing on the right to survival and development of ethnic minority children;
- Child Protection for All: Ensuring the right to protection from harm and violence of all children, with a special focus on children in special circumstances;
- Child Centred Disaster Risk Management and Climate Change Adaptation: Promoting the right to protection and assistance in emergencies and building the resilience of children, families and communities to better cope with the impact of disasters and climate change (Plan Vietnam, 2013).

In Vietnam, the 2012 dataset included 34,639 sponsored children, ranging in age from 0-17. The average age was 8.5 (standard deviation=3.9), and 34% were male. Among the children, 608 had 'an impairment/a medical condition that can lead to disability.' This

gives a prevalence of disability of 1.8% (95% confidence interval 1.6 – 2.0 %). The prevalence of disability was slightly higher in males (2.5 %, 95% CI 2.2 – 2.8 %) than in females (1.3 %, 95% CI 1.2 – 1.5 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.7, 95% CI 1.5 – 2.0).

As evidenced in Table 50 the most common type of impairment was physical, learning, communication and vision were less common, while hearing was the least common.

Table 50: Type of impairment by gender in Vietnam

	MALES	FEMALES
Learning	55 (19%)	64 (20%)
Physical	98 (33%)	103 (33%)
Communication	50 (17%)	60 (19%)
Vision	66 (23%)	68 (22%)
Hearing	24 (8%)	20 (6%)
Total	293 (100%)	315 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. As shown in Table 51 boys with disabilities were 10.8 times less likely to attend school and girls with disabilities were 17.5 times less likely to attend school. And of those at school, the children with disabilities were much more likely to be at a lower school level compared to children without disability, after accounting for age differences, with the difference particularly marked for boys. There was minimal difference in the time taken to get to school for those with disabilities compared to those without disabilities.

Table 51: Educational variables in relation to disability in Vietnam

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	214 (73%)	10717 (94%)	Baseline	223 (71%)	20683 (91%)	Baseline
- No	79 (27%)	624 (6%)	6.1 (4.6 - 8.0)	92 (29%)	2007 (9%)	5.6 (4.3 - 7.2)
Age 5+: Attend formal education						
- Yes	200 (73%)	9813 (96%)	Baseline	206 (74%)	17461 (97%)	Baseline
- No	74 (27%)	393 (4%)	10.8 (7.7 - 15.2)	72 (26%)	457 (3%)	17.5 (12.5 - 24.3)
Of those at school, school level						
- Secondary/University/ College	78 (36%)	4142 (39%)	Baseline	55 (25%)	5764 (28%)	Baseline
- Primary	110 (51%)	5014 (47%)	2.9 (1.8 - 4.7)	129 (58%)	9951 (48%)	2.3 (1.4 - 3.8)
- Nursery/pre-school	26 (12%)	1561 (15%)	4.7 (2.0 - 11.2)	39 (17%)	4968 (24%)	2.3 (1.0 - 5.3)
Time taken to school						
- <30 minutes	95 (44%)	5338 (50%)	Baseline	125 (56%)	11290 (55%)	Baseline
- 30 minutes-1 hour	101 (47%)	4432 (41%)	1.2 (0.9 - 1.6)	85 (38%)	8031 (39%)	0.9 (0.7 - 1.2)
- >1 hour	18 (8%)	947 (9%)	1.0 (0.6 - 1.6)	13 (6%)	1362 (7%)	0.8 (0.4 - 1.4)
Attending non formal education						
- No	293 (100%)	11324 (100%)	Baseline	315 (100%)	22681 (100%)	Baseline
- Yes	0 (0%)	17 (0.2%)	-	0 (0%)	9 (0.04%)	-

As illustrated in Table 52, considering the data by type of disability, learning and communication impairment had the greatest effect on school attendance, followed by physical and hearing impairment. The effect of vision impairment was much less, although still apparent. This overall pattern was also apparent within boys and girls, although for boys vision impairment did not seem to impact school attendance, and the effect of hearing impairment was more marked in girls.

Table 52: Attendance of formal education by impairment type in Vietnam

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
Learning	79 (66%)	40 (34%)	75 (66%)	39 (34%)	28.6 (14.3 - 57.0)	25.3 (12.8 - 49.9)	26.0 (16.0 - 42.2)
Physical	153 (76%)	48 (24%)	142 (79%)	38 (21%)	12.7 (7.0 - 23.3)	9.5 (4.8 - 18.5)	10.8 (7.0 - 16.8)
Communication	57 (52%)	53 (48%)	51 (53%)	45 (47%)	52.7 (23.7 - 117.3)	77.0 (37.6 - 157.7)	61.9 (36.3 - 105.4)
Vision	117 (87%)	17 (13%)	110 (91%)	11 (9%)	2.5 (0.9 - 6.7)	6.4 (2.6 - 15.7)	3.8 (2.0 - 7.5)
Hearing	31 (70%)	13 (30%)	28 (68%)	13 (32%)	5.0 (1.5 - 16.8)	23.0 (7.4 - 71.2)	10.6 (4.8 - 23.6)
No disability	31400 (92%)	2631 (8%)	27274 (97%)	850 (3%)	Baseline	Baseline	Baseline

In line with the overall findings and as shown in Table 53, having an impairment was cited as the major reason for not attending formal education among children with disabilities (81%) while being too young was the most common reason among children without disability (68%).

Table 53: Reason for not attending formal education by disability status in Vietnam

	Disabled	Not disabled
Too young	14 (8%)	1788 (68%)
Too old	0 (0%)	16 (1%)
Did not pass secondary school exam	1 (1%)	96 (4%)
Economic problems	1 (1%)	52 (2%)
Closest school too far	1 (1%)	19 (1%)
Has been ill	2 (1%)	9 (0%)
Is married	0 (0%)	2 (0%)
Needed to help family	2 (1%)	134 (5%)
Has an impairment	139 (81%)	0 (0%)
Is working outside family	1 (1%)	117 (4%)
Was expelled for class repetition	1 (1%)	4 (0%)
Primary not considered important by family	0 (0%)	6 (0%)
Secondary not considered important by family	0 (0%)	4 (0%)
Expelled	0 (0%)	1 (0%)
Fears violence at school	0 (0%)	2 (0%)
Do not have required document	0 (0%)	21 (1%)
Plays truant	9 (5%)	359 (14%)

Health and disability

As illustrated in Table 54, children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with hearing impairment. Boys with disabilities were 3.4 time more likely to have had a serious illness in the last twelve months and girls were 3.0 times more likely. The most common types of illness among the children with disabilities were acute respiratory tract infection, influenza, malaria, eye problems, ear infection and malnutrition. Malnutrition was related to increased disability in both girls and boys. The majority of children with a serious illness had sought treatment (97%). Among the few who had not sought treatment, the most commonly cited reasons were ‘advised treatment unnecessary’ and ‘no transport’. Hospital or private treatment were the most commonly cited places where treatment was sought. Illness was less likely to prevent school attendance in disabled boys than in boys without a disability, while there was little difference for

girls. There was little difference between the children with and without disability in terms of distance to the nearest health facility, and the number of children who did not sleep under a bednet was insufficient to allow the relationship of this with disabilities to be assessed.

Table 54: Association between health and health seeking behaviour and disability in Vietnam

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- Yes	70 (24%)	1110 (10%)	3.4 (2.5 - 4.5)	78 (25%)	2554 (11%)	3.0 (2.3 - 3.9)
- No	223 (76%)	10231 (90%)	Baseline	237 (75%)	20136 (89%)	Baseline
Malnutrition						
- Yes	4 (1%)	29 (0.3%)	6.4 (2.2 - 18.3)	5 (2%)	77 (0.3%)	6.1 (2.4 - 15.4)
- No	289 (99%)	11312 (99.7%)	Baseline	310 (98%)	22613 (99.7%)	Baseline
Where sought treatment						
- Hospital	33 (47%)	243 (22%)	2.8 (1.4 - 5.7)	25 (32%)	563 (22%)	2.0 (1.0 - 4.0)
- Health clinic	25 (36%)	581 (52%)	0.9 (0.4 - 1.8)	35 (45%)	1399 (55%)	1.1 (0.6 - 2.1)
- Private	0 (0%)	16 (1%)	-	4 (5%)	37 (1%)	4.4 (1.3 - 14.3)
- Other	11 (16%)	213 (19%)	Baseline	12 (15%)	496 (19%)	Baseline
- Did not seek	1 (1%)	57 (5%)	0.4 (0.1 - 3.2)	2 (3%)	59 (2%)	1.5 (0.3 - 6.9)
Illness prevent school						
- Yes	25 (53%)	727 (75%)	0.4 (0.2 - 0.7)	35 (66%)	1470 (71%)	0.8 (0.4 - 1.4)
- No	22 (47%)	244 (25%)	Baseline	18 (34%)	604 (29%)	Baseline
Time taken to nearest health facility						
- <30 minutes	118 (40%)	4932 (43%)	Baseline	144 (46%)	9689 (43%)	Baseline
- 30 minutes-1	131 (45%)	4354 (38%)	1.3 (1.0 - 1.7)	125 (40%)	8742 (39%)	1.0 (0.8 - 1.2)

hour						
- 1 – 2 hours	34 (12%)	1571 (14%)	1.0 (0.7 - 1.4)	35 (11%)	3270 (14%)	0.7 (0.5 - 1.1)
- >2 hours	10 (3%)	484 (4%)	1.0 (0.5 - 1.8)	11 (3%)	989 (4%)	0.8 (0.4 - 1.5)
Slept under bednet last night						
- No malaria in area	0 (0%)	2 (0.02%)	Baseline	2 (1%)	5 (0.02%)	Baseline
- Yes	269 (99%)	10491 (98%)	2.1 (0.7 - 6.5)	293 (97%)	20683 (97%)	0.04 (0.01 - 0.2)
- No	3 (1%)	262 (2%)	-	8 (3%)	716 (3%)	0.03 (0.01 - 0.2)

Other Findings

Overall the children with disabilities were on average one year older than the children without disability. Among girls, those who were least poor were most likely to be disabled. Finally, in relation to gender differences, the relationship between disability and indicators of inclusion/exclusion was similar between boys and girls, although there were some differences in relationship to the markers for poverty. In addition, girls' non-attendance at school seems to be more affected by vision and hearing impairment than boys' non-attendance.

Plan in Africa

5.7 Benin

The country population of Benin is 10,050,702 and the percentage of the population that constitutes children between the ages of 0-14 years is 43% (World Bank Population Data, 2013). Benin is still one of the poorest countries in the world according to the UNDP 2013 Human Development Index, which ranked the country 166 out of 187 countries (UNDP International Human Development Indicators, 2013). According to Plan Benin's Country Strategic Plan 2011 – 2015 (Plan Benin, 2011), economic growth has stabilized at 3.9%, which is slightly above the population growth rate.

Plan Benin operates in the programme areas of Atacora, Bohicon, and Couffo. In its Country Strategic Plan from 2011-2015, Plan Benin's country goal is to contribute to an environment where the duty bearers better assume their responsibilities and children are more capable of claiming and realizing their recognized rights to survival, development, participation, and protection.

To achieve this goal, Plan Benin has adopted three country programmes:

- Governance and child rights: By 2015, state institutions, civil society actors, private sector, and local councils will have improved governance for the effective realisation of child rights, including in emergency situations
- Youth leadership for responsible citizenship: By 2015, young girls and boys in Benin will develop leadership competencies and life skills to positively influence policies on the realisation of their rights in an organized manner
- Empowered Women for Child Rights: By 2015, women from the most vulnerable households are empowered to influence policies and development agendas to ensure more equitable and sustainable access to quality basic services for their children.

Benin signed the UN Convention on the Rights of Persons with Disabilities in 2008 and ratified it in 2012 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013). Thus the Convention only became binding on the country after the adoption of Plan Benin's most recent CSP. Despite this the situation of children with disabilities is dealt with in the situational analysis of the CSP where it is noted that opportunities for children with special needs (including children with disabilities) to receive an education are virtually non-existent. In addition, the vulnerabilities of children with disabilities predisposes them to be victims of violence and are compounded by poverty and traditions that are unsupportive of child rights. In analysing the gaps in the State response to its duty to realise children's rights it is also observed that the protection of children with disabilities is largely overlooked. The analysis also points out that children with disabilities are not provided with the opportunity to exercise free play opportunities.

However, despite this analysis, no mention is made of programming in relation to children with disabilities under the three country programmes.

The 2012 dataset included 24,547 sponsored children, ranging in age from 0-17. The average age was 10.5 (standard deviation= 3.2), and 6% were male. Among the children, 108 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.4% (95% confidence interval 0.4 – 0.5%). The prevalence of disability was slightly higher in females (0.4%, 95% CI 0.4 – 0.5 %) than in males (0.3 %, 95% CI 0.04 – 0.6 %). After adjustment for age, there was no significant difference in the odds of disability between boys and girls.

The most common type of impairment was vision, while learning and communication were the least common, as can be seen in Table 55.

Table 55: Type of impairment by gender in Benin

	MALES	FEMALES
Learning	0 (0%)	1 (1%)
Physical	2 (40%)	32 (31%)
Communication	0 (0%)	5 (5%)
Vision	3 (60%)	47 (46%)
Hearing	0 (0%)	18 (17%)
Total	5 (100%)	103 (100%)

Education and disability

In line with the overall findings, children with disabilities were less likely to attend formal education, compared to children without disability, although this analysis was underpowered for boys. After adjusting for age boys with disabilities were 4.5 times less likely to attend school and girls with disabilities were 3.2 times less likely to attend school.

Table 56: Educational variables in relation to disability in Benin

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	3 (60%)	1367 (87%)	Baseline	82 (80%)	20864 (91%)	Baseline
- No	2 (40%)	203 (13%)	4.3 (0.7 - 26.9)	21 (20%)	2005 (9%)	2.9 (1.8 - 4.7)
Age 5+: Attend formal education						
- Yes	3 (60%)	1331 (87%)	Baseline	81 (79%)	20505 (92%)	Baseline
- No	2 (40%)	196 (13%)	4.5 (0.7 - 28.9)	21 (21%)	1900 (8%)	3.2 (2.0 - 5.3)
Of those at school, school level						
- Secondary/University/ College	0 (0%)	651 (48%)	Baseline	3 (4%)	2998 (14%)	Baseline
- Primary	3 (100%)	698 (51%)	-	79 (96%)	17660 (85%)	3.8 (1.1 - 12.6)
- Nursery/pre-school	0 (0%)	18 (1%)	-	0 (0%)	206 (1%)	-
Time taken to school						
- <30 minutes	2 (67%)	653 (48%)	Baseline	53 (65%)	13710 (66%)	Baseline
- 30 minutes-1 hour	1 (33%)	635 (46%)	0.5 (0.04 - 5.6)	27 (33%)	6481 (31%)	1.1 (0.7 - 1.8)
- >1 hour	0 (0%)	79 (6%)	-	2 (2%)	673 (3%)	0.9 (0.2 - 3.6)
Attending non formal education						
- No	5 (100%)	1499 (95%)	Baseline	97 (94%)	22187 (97%)	Baseline
- Yes	0 (0%)	71 (5%)	-	6 (6%)	682 (3%)	2.4 (1.0 - 5.7)

Girls with disability were more likely to be at a lower school level compared to girls without disability, after accounting for age differences, and were more likely to be attending non-formal education. Children who had communication impairment were far less likely to attend formal education compared to those children without disability. The difference in school attendance was smaller comparing children with vision impairment compared to those with no disability, and physical impairment did not seem to be associated with school attendance. There was insufficient numbers of those with learning or hearing impairment in the sample to assess the effect of these impairments, and insufficient numbers of disabled boys to perform any analysis of which impairment type affected school attendance.

Table 57: Attendance of formal education by impairment type in Benin

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	22231 (91%)	2208 (9%)	21836 (91%)	2096 (9%)	Baseline	Baseline	Baseline
Learning	0 (0%)	1 (100%)	0 (0%)	1 (100%)	-	-	-
Physical	29 (85%)	5 (15%)	29 (85%)	5 (15%)	-	1.1 (0.3 – 3.7)	1.8 (0.7 – 4.6)
Communication	2 (40%)	3 (60%)	2 (40%)	3 (60%)	-	23.1 (3.4 – 158.8)	22.9 (3.4 – 156.9)
Vision	42 (84%)	8 (16%)	42 (84%)	8 (16%)	-	2.8 (1.3 – 6.2)	2.5 (1.1 – 5.5)
Hearing	12 (67%)	6 (33%)	11 (65%)	6 (35%)	-	11.8 (4.2 – 33.5)	11.7 (4.1 – 33.0)

As seen in Table 58, having an illness or impairment was cited as the major reason for not attending formal education among children with disabilities (57%) while the most common reason among children without disability was needed to help family (27%) or being expelled for class repetition (25%).

Table 58: Reason for not attending formal education by disability status in Benin

	Disabled	**Not disabled**
Too young	1 (4%)	291 (13%)
Too old	0 (0%)	132 (6%)

	Disabled	Not disabled
Did not pass secondary school exam	0 (0%)	1 (0%)
Economic problems	0 (0%)	16 (1%)
Lessons were repetitive	0 (0%)	1 (0%)
Closest school too far	0 (0%)	12 (1%)
Has been ill	11 (48%)	31 (1%)
Is married	0 (0%)	68 (3%)
Needed to help family	5 (22%)	605 (27%)
Has an impairment	2 (9%)	1 (0%)
Is working outside family	0 (0%)	16 (1%)
Was expelled for class repetition	1 (4%)	563 (25%)
Primary not considered important by family	0 (0%)	226 (10%)
Secondary not considered important by family	0 (0%)	22 (1%)
Expelled	0 (0%)	35 (2%)
Fears violence at school	0 (0%)	1 (0%)
Do not have required document	0 (0%)	2 (0%)
Plays truant	3 (13%)	189 (9%)

Health and disability

As Illustrated in Table 59, girls with a disability were 4.7 times more likely to have had a serious illness in the last twelve months than girls without disability, a pattern that was observed most strongly for those with hearing and communication impairment. The most common types of illness among the children with disabilities were malaria, eye problems and acute respiratory tract infection. There was insufficient data on malnutrition to assess whether this was more common in those with disability than those without. Only 2 children did not seek treatment, and the most common location that treatment was sought was hospital, health clinic or other. There were insufficient numbers of children not sleeping under a bed net or living in an area without malaria to assess the role of bed nets and living in a malarial area.

Table 59: Association between health and health seeking behaviour and disability in Benin

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	5 (100%)	1555 (99%)	Baseline	84 (82%)	21842 (96%)	Baseline
- Yes	0 (0%)	15 (1%)	-	19 (18%)	1027 (4%)	4.7 (2.8 - 7.8)
Malnutrition						
- No	5 (100%)	1569 (100%)	Baseline	103 (100%)	22866 (100%)	Baseline
- Yes	0 (0%)	1 (0%)	-	0 (0%)	3 (0%)	-
Where sought treatment						
- Other	5 (33%)	5 (33%)	Baseline	6 (32%)	331 (32%)	Baseline
- Hospital	8 (53%)	8 (53%)	-	7 (37%)	378 (37%)	1.0 (0.3 – 3.0)
- Health clinic	2 (13%)	2 (13%)	-	5 (26%)	294 (29%)	0.9 (0.3 – 3.0)
- Private	-	-	-	0 (0%)	23 (2%)	-
- Did not seek	-	-	-	1 (5%)	1 (0.1%)	56.4 (3.1 – 1013.6)
Illness prevent school						
- No	-	8 (62%)	Baseline	10 (59%)	395 (41%)	Baseline
- Yes	-	5 (39%)	-	7 (41%)	568 (59%)	0.5 (0.2 – 1.4)
Time taken to nearest health facility						
- <30 minutes	2 (40%)	460 (29%)	Baseline	38 (37%)	7907 (35%)	Baseline
- 30 minutes-1 hour	2 (40%)	743 (47%)	0.6 (0.1 - 4.5)	47 (46%)	10015 (44%)	1.0 (0.6 - 1.5)
- 1 – 2 hours	0 (0%)	306 (19%)	-	16 (16%)	3837 (17%)	0.9 (0.5 - 1.6)
- >2 hours	1 (20%)	61 (4%)	3.7 (0.3 - 41.3)	2 (2%)	1110 (5%)	0.4 (0.1 - 1.6)

Slept under bednet last night						
- No malaria in area	0 (0%)	0 (0%)	Baseline	1 (1%)	8 (0.04%)	Baseline
- Yes	5 (100%)	1538 (100%)	-	100 (98%)	22367 (99%)	0.04 (0.004-0.29)
- No	0 (0%)	7 (0%)	-	1 (1%)	273 (1%)	0.03 (0.002-0.51)

Other findings

Overall it was found that in Benin the children with disabilities were similar in age to the children without disability and there were insufficient numbers of disabled boys in the survey to assess any gender differences. When applying the poverty variables to the analysis it was found that they were related to disability. Girls in the least poor quartile of poverty or with higher asset or house quality scores were significantly less likely to have a disability compared to girls in the poorest quartile of poverty. Girls who lived in houses with rudimentary walls had increased disability, while for boys living in houses with natural roof material was associated with disability. In addition, girls who used a latrine or composting toilet or unofficial toilet were less likely to be disabled than girls using a flushed toilet. All of the children in the sample had their birth registered

5.8 Egypt

The country population of Egypt is 80,271,874 and the percentage of the population that constitutes children between the ages of 0-14 years is 31% (World Bank Population Data, 2013). Egypt ranks 112 out of 187 countries in the 2012 Human Development Index, making it a country with medium human development (UNDP International Human Development Indicators, 2013). Egypt was one of the first states to ratify the UN Convention on Persons with Disabilities, having signed it in 2007 and ratified it in 2008 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013). In addition the country's Child Law (126 of 2008) was amended in 2008 to strengthen a number of children's rights including those pertaining to children with disabilities.

Plan Egypt works in 6 of the 27 Governates in which Egypt is divided, namely Cairo, Giza, Kalyoubia, Alexandria, Beheira and Assiut. Plan Egypt's situation analysis undertaken to inform the drafting of the Country Strategic Plan clearly notes how children with disabilities are affected in Egypt (Plan Egypt, 2012). It notes how violence is perpetrated against children with disabilities, how children

with disabilities get less access to rehabilitative services than adults with disabilities and how cultures of silence and denial regarding disability often result in neglect, where children are often hidden from view and denied their rights to go to school.

The goal of the current Country Strategic Plan is 'transformed and empowered communities and institutions that fulfil the rights of children'.
In order to achieve this overall goal, Plan Egypt has four Country Programme Goals:

- Increased effectiveness of child protection mechanisms at family, community and government levels.
- Increased opportunities for girls and women to engage in public decision making and household economic security.
- Enhanced capacity for youth employability and participation in governance.
- Increased participation of children, youth and communities in civic engagement and public accountability processes for the rights of children.

Disability features strongly in these country programmes and many interventions can be interlinked and all are coordinated in the planning and implementation process. For example, the intervention of Community Based Rehabilitation is shown under the Country Programme of Protection and Participation of Children, targeting children and families with disabilities, the strategies and approach also includes a strong focus on addressing gender discrimination, youth participation and local organization strengthening.

Mothers of children with disabilities are supported through integrating Village Savings and Loan Associations (under Girls' and Women's Empowerment). Under the Country Programme of Youth Development and Leadership, children with disabilities are included in youth groups of Child Media or access the Youth Employability Program. Under Country Programme of Active Citizenship and Civil Society Alliances, local organizations are established as resource centres for Community Based Rehabilitation and then joined into networks to advocate and promote children's rights, including organizations of people with disabilities.

Alongside strategic partners, Plan is also very active in all the issues related to the government's work on disability, facilitating the participation of persons with disability, their parents, activists, NGOs involved in disability, and disability experts in improving the legislative and policy environment.

In Egypt, the 2012 dataset included 33,871 sponsored children aged 0-17, of whom 452 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.3% (95% confidence interval 1.2-1.5%). The prevalence of disability was

slightly higher in males (1.6%, 95% CI 1.4-1.8%) than in females (1.2%, 95% CI 1.0-1.3%). After adjustment for age, males had significantly higher odds of disability compared to females (1.4, 95% CI 1.1-1.6).

The most common type of impairment was physical, while vision and hearing were the least common types of impairment as can be seen in Table 60.

Table 60: Type of impairment by gender in Egypt

	MALES	FEMALES
Learning	60 (26%)	56 (26%)
Physical	72 (31%)	68 (31%)
Communication	60 (26%)	58 (27%)
Vision	30 (13%)	29 (13%)
Hearing	12 (5%)	7 (3%)
Total	234	218

Education and disability

In Egypt, children with a disability were substantially less likely not to attend formal education, compared to age-matched children without disability. As shown in Table 61 boys with disabilities were 25.4 times less likely to attend school and girls with disabilities were 19.5 times less likely to attend school. Among children with disability attending school, more than one third (38%) attended 'special' schools, while 62% attended 'regular' schools, which was very similar among boys and girls.

Table 61: Educational variables in relation to disability in Egypt

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
SCHOOL						
All ages: Attend formal education						

- Yes	81 (35%)	13000 (88%)	Baseline	69 (32%)	15139 (81%)	Baseline
- No	153 (65%)	1819 (12%)	17.5 (13.2-23.2)	149 (68%)	3461 (19%)	15.3 (11.3-20.6)
Age 5+: Attend formal education						
- Yes	79 (37%)	12741 (94%)	Baseline	67 (35%)	14589 (91%)	Baseline
- No	136 (63%)	870 (6%)	25.4 (19.1-33.8)	122 (65%)	1398 (9%)	19.5 (14.4-26.4)
Of those at school, school level Nursery/pre-school Primary Secondary/University/College	 5 (6%) 56 (69%) 20 (25%)	 601 (5%) 8413 (65%) 3986 (31%)	 2.9 (0.7-11.7) 1.7 (0.9-3.4) Baseline	 3 (4%) 52 (75%) 14 (20%)	 1175 (8%) 9882 (65%) 4082 (27%)	 1.8 (0.3-9.5) 2.4 (1.1-5.2) Baseline
Time taken to school <30 minutes 30 minutes-1 hour >1 hour	 58 (72%) 21 (26%) 2 (2%)	 10612 (82%) 2316 (18%) 72 (1%)	 Baseline 1.7 (1.0-2.8) 5.1 (1.2-21.3)	 55 (80%) 13 (19%) 1 (1%)	 12432 (82%) 2615 (17%) 92 (1%)	 Baseline 1.1 (0.6-2.0) 2.4 (0.3-17.7)
Attending non formal education Yes No	 9 (4%) 225 (96%)	 24 (0.2%) 14795 (99.8%)	 25.3 (11.6-55.4) Baseline	 12 (6%) 206 (95%)	 49 (0.3%) 18551 (99.7%)	 21.1 (10.9-40.6) Baseline

Among those at school the boys with disability were somewhat more likely to be at a lower school level compared to the boys without disability, after matching for age. This pattern was not evident among the girls. The children with disability were more than 20 times more likely to attend non-formal education compared to the children without disability, and this was clear in both boys and girls. There was little difference between children with and without disability in distance to school.

Table 62: Attendance of formal education by impairment type in Egypt

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
Learning	26 (22%)	90 (78%)	25 (25%)	77 (75%)	35.1 (20.0-63.3)	45.6 (21.9-94.7)	39.5 (25.0-62.3)
Physical	46 (33%)	94 (67%)	46 (35%)	85 (65%)	35.6 (21.2-60.0)	15.9 (9.5-26.7)	23.1 (16.1-33.3)
Communication	23 (19%)	95 (81%)	23 (22%)	81 (78%)	46.9 (25.0-88.2)	48.0 (23.9-96.4)	44.3 (27.8-70.7)
Vision	44 (75%)	15 (25%)	42 (82%)	9 (18%)	3.1 (1.2-8.3)	2.3 (0.8-6.7)	2.7 (1.3-5.6)
Hearing	11 (58%)	8 (42%)	10 (63%)	6 (38%)	7.2 (1.8-28.8)	8.3 (1.8-37.5)	7.7 (2.8-21.3)
No disability	28139 (84%)	5280 (16%)	27330 (92%)	2268 (8%)	Baseline	Baseline	Baseline

When the data was disaggregated by type of disability, it was found that children who had learning, physical or communication impairment were far less likely to attend formal education compared to those children without disability, as seen in Table 62. In contrast, there was little difference between the children with vision impairment compared to those with no disability in terms of attendance of formal education, and limited difference for the children with hearing impairment. These patterns were similar in boys and girls.

Table 63: Reason for not attending formal education by disability status in Egypt

	Disabled	**Non disabled**
Too young	37 (12.3%)	4008 (75.4%)
Too old	1 (0.3%)	36 (0.7%)

Is needed to work	0	1 (0.02%)
Economic problems	6 (2.0%)	664 (12.5%)
Lessons were repetitive	0	5 (0.1%)
Closest school too far	1 (0.3%)	15 (0.3%)
Has been ill	7 (2.3%)	1 (0.02%)
Lack of interest in school attendance	0	5 (0.1%)
Is married	0	16 (0.3%)
Needed to help family	0	29 (0.6%)
Has an impairment	242 (80.1%)	3 (0.1%)
Is working outside family	1 (0.3%)	70 (1.3%)
Was expelled for class repetition	6 (2.0%)	404 (7.6%)
Primary not considered important by family	0	8 (0.2%)
Secondary not considered important by family	0	8 (0.2%)
Expelled	1 (0.3%)	33 (0.6%)
Fears violence at school	0	8 (0.2%)
Fears violence on way to school	0	4 (0.1%)
Plays truant	0	1 (0.2%)

As can be seen in Table 63, impairment or illness was cited as major reason for not attending formal education among children with disability (80%), while being too young was the most common reason among children without disability (75%), while this was rarely cited as a reason among children with disability (12%).

Health and disability

Very few children reported experiencing a serious illness in the last twelve months – 19 children with disability and 434 children without disability, limiting the ability to detect statistical patterns for this variable. Children with disability were significantly more likely to have had a serious illness in the last twelve months than children without disability. Boys with disabilities were 9.5 times more likely to have had a serious illness in the last twelve months and girls were 14.8 times more likely. All children with a serious illness had sought treatment. Unfortunately, there was too much missing data to be able to assess the relationship between vaccination history and disability.

Table 64: Association between health and health seeking behaviour and disability in Egypt

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- Yes	8 (3%)	55 (0.4%)	9.5 (4.5-20.3)	11 (5%)	68 (0.4%)	14.8 (7.7-28.3)
- No	226 (97%)	14764 (99.6%)	Baseline	207 (95%)	18532 (99.6%)	Baseline
Malnutrition						
- Yes	0	2 (0.01%)	Not applicable	1 (0.5%)	7 (0.04%)	Not applicable
- No	234 (100%)	14817 (99.99%)		217 (99.5%)	18593 (99.96%)	
Where sought treatment						
- Hospital	8 (100%)	55 (100%)	Not applicable	11 (100%)	67 (99%)	Not applicable
- Other	0	0		0	1 (1%)	
Illness prevent school						
- Yes	2 (67%)	10 (29%)	5.3 (0.4-66.3)	2 (29%)	13 (28%)	1.0 (0.2-5.9)
- No	1 (33%)	25 (71%)	Baseline	5 (71%)	33 (72%)	Baseline
Time taken to nearest health facility						
<30 minutes	165 (71%)	10604 (72%)	Baseline	165 (76%)	13158 (71%)	Baseline
30 minutes-1 hour	61 (26%)	3874 (26%)	1.0 (0.8-1.4)	48 (22%)	4953 (27%)	0.8 (0.6-1.1)
>1 hour	8 (3%)	341 (2%)	1.5 (0.7-3.1)	5 (2%)	489 (2%)	0.8 (0.3-1.9)

Other findings

First, the children with disability were not different in age compared to the children without disability and overall the relationship between disability and indicators of inclusion/exclusion were remarkably similar between boys and girls.

In relation to poverty and disability, the poverty variables showed some relationship with disability: there was weak evidence that poorer household quality was related to disability. Access to good water and sanitation facilities was associated with disability and children with disability were more likely to live in urban areas

5.9 Guinea

The population of Guinea is 11,451,273 with 42% of the population being between 0 and 14 years of age (World Bank Population Data, 2013). Guinea is still one of the poorest countries in the world according to the 2013 Human Development Index, which ranked the country 178 out of 187 countries (UNDP International Human Development Indicators, 2013).

Plan's target population is all Guinean children aged 0-18 years living in communities in the Forest Region. The families of these children are also target beneficiaries for Plan Guinea together with over 300 communities ('Districts' or 'Quartiers') of which these children are members. Plan's initial programme area (Gueckedou, 1989) was chosen on the basis of need and opportunity. It was a disadvantaged and remote area with one of the highest population densities in the country. The programme area then expanded into two neighbouring prefectures, namely, Kissidougou (1994) and Macenta (1994). Further expansion into the Forest Region was initiated in 1997 with families being enrolled in N'Zerekore (1998) and Yomou (1998) (Plan Guinea, 2012).

Guinea signed the UN Convention on Persons with Disabilities in 2007 and formally ratified it in 2008 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013). In the situational analysis to the 2012 Country Strategic Plan mention is made of the issue of persons with disabilities in the context of the right to development and education. It notes that Guinea exhibits 'unacceptable disparities'. In addition to gender disparities, there are the rural/urban disparities: the Gross Enrolment rate in urban areas may be as high as 97% while it is only 24% in some rural areas. Worse, children with physical/mental disabilities and children with broken family ties seldom attend school. The Country Strategic Plan notes that the immediate causes are multiple but fall within two main categories: insufficient offer of facilities and services and low effective demand from families and communities. It also notes that de facto discrimination against specific groups or categories is evident, including against children with physical or mental handicap or children of handicapped parents.

Plan Guinea has 3 overarching country goals which inform the programming that the country undertakes. These goals target education, health and child protection:

- Equal access to sustainable quality basic education services for all girls and boys including the most marginalised and vulnerable children, in order to increase basic school enrolment and completion rates.
- Equal access to sustainable quality basic health, water and sanitation services for all in order to decrease child and maternal mortality and morbidity.
- Safe, Secure and Empowering environment for all children, including in emergency situations whether caused by disasters or conflicts.

Although no direct mention is made of programming on children with disabilities, the emphasis in the overall goals to equal access means that the Plan programmes are inclusive of all children. In addition, the Country Strategic Plan does make mention that children particularly difficult in circumstances, including disabled children and children with disabled parents, will benefit from the services of adequate institutions specialising in their cases.

The wording used in the Country Strategic Plan to discuss children and persons with disabilities is at times unfortunate, particularly given the use of the word 'handicapped'. However, this may be due to translation issues from French to English.

In Guinea the 2012 dataset included 28,208 sponsored children, ranging in age from 0-17. The average age was 9.9 (standard deviation=3.9), and 30% were male. Among the children, 146 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.5% (95% confidence interval 0.4-0.6 %). The prevalence of disability was similar in males (0.5%, 95% CI 0.4-0.7 %) compared to females (0.5%, 95% CI 0.4-0.6 %). After adjustment for age, males had slightly higher odds of disability compared to females (1.3, 95% CI 0.9-1.8).

The most common type of impairment was physical, while the least common were learning and hearing, as indicated in Table 65.

Table 65: Type of impairment by gender in Guinea

	MALES	FEMALES
Learning	1 (2%)	4 (4%)
Physical	15 (34%)	48 (47%)
Communication	15 (34%)	32 (31%)
Vision	9 (20%)	10 (10%)

Hearing	4 (9%)	8 (8%)
Total	44 (100%)	102 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. As shown in Table 66 boys with disabilities were 8.1 times less likely to attend school and girls with disabilities were 10.9 times less likely to attend school. Given the very small number of children with disabilities who attended school, it was difficult to assess the relationship between disability and school level or time taken to school. Very few children attended non- formal education.

Table 66: Educational variables in relation to disability in Guinea

	MALES			**FEMALES**		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	15 (34%)	5553 (65%)	Baseline	17 (17%)	12846 (66%)	Baseline
- No	29 (66%)	2943 (35%)	7.5 (3.9 - 14.4)	85 (83%)	6720 (34%)	10.3 (6.1 - 17.3)
Age 5+: Attend formal education						
- Yes	15 (35%)	5460 (75%)	Baseline	17 (17%)	12733 (69%)	Baseline
- No	28 (65%)	1790 (25%)	8.1 (4.2 - 15.4)	83 (83%)	5655 (31%)	10.9 (6.5 - 18.4)
Of those at school, school level						
- Secondary/University/College	0 (0%)	286 (5%)	Baseline	1 (6%)	731 (6%)	Baseline
- Primary	14 (93%)	4903 (88%)	-	16 (94%)	11608 (90%)	0.8 (0.1 - 7.3)

- Nursery/pre-school	1 (7%)	364 (7%)	-	0 (0%)	507 (4%)	-
Time taken to school						
- <30 minutes	11 (73%)	4346 (78%)	Baseline	15 (88%)	10156 (79%)	Baseline
- 30 minutes-1 hour	4 (27%)	1104 (20%)	1.3 (0.4 - 4.3)	2 (12%)	2515 (20%)	0.5 (0.1 - 2.4)
- >1 hour	0 (0%)	103 (2%)	-	0 (0%)	175 (1%)	-
Attending non formal education						
- No	43 (98%)	8425 (99%)	Baseline	101 (99%)	19274 (99%)	Baseline
- Yes	1 (2%)	71 (1%)	1.9 (0.3 - 14.5)	1 (1%)	292 (1%)	0.5 (0.1 - 3.6)

The numbers of children with disabilities was too small to reasonably consider the data by type of impairment, but the data (as shown in Table 67) does indicate that children who had communication or hearing impairments were far less likely to attend formal education compared to those children without disability.

Table 67: Attendance of formal education by impairment type in Guinea

	All ages		Age 5+				
	Attend formal education	Do not attend formal education	Attend formal education	Do not attend formal education	Males: Age adjusted OR	Females: Age adjusted OR	Total group: Age and sex adjusted OR
No disability	18399 (66%)	9663 (34%)	18193 (71%)	7445 (29%)	Baseline	Baseline	Baseline
Learning	0 (0%)	5 (100%)	0 (0%)	5 (100%)	-	-	-
Physical	21 (33%)	42 (67%)	21 (34%)	41 (66%)	5.7 (1.9 - 17.2)	5.4 (2.9 - 10.1)	5.2 (3.1 - 8.8)
Communication	3 (6%)	44 (94%)	3 (7%)	43 (93%)	22.7 (5.7 - 90.3)	-	39.7 (12.3 - 128.2)
Vision	7 (37%)	12 (63%)	7 (37%)	12 (63%)	4.1 (0.9 - 18.3)	9.0 (1.9 - 42.4)	4.7 (1.8 - 12.1)
Hearing	1 (8%)	11 (92%)	1 (9%)	10 (91%)	-	15.9 (2.0 - 129.4)	28.8 (3.7 - 227.3)

As seen in Table 68, and in line with the overall findings, having an impairment or being ill were cited as the major reason for not attending formal education among children with disabilities (77%) while being too young was the most common reason among children without disability (46%).

Table 68: Reason for not attending formal education by disability status in Guinea

	Disabled	Not disabled
Too young	8 (7%)	4484 (46%)
Too old	12 (11%)	1559 (16%)
Did not pass secondary school exam	0 (0%)	3 (0%)
Economic problems	0 (0%)	76 (1%)
Closest school too far	0 (0%)	535 (6%)
Has been ill	16 (14%)	29 (0%)
Is married	1 (1%)	286 (3%)
Needed to help family	3 (3%)	1748 (18%)
Has an impairment	72 (63%)	2 (0%)
Is working outside family	0 (0%)	49 (1%)
Was expelled for class repetition	1 (1%)	374 (4%)
Primary not considered important by family	0 (0%)	113 (1%)
Secondary not considered important by family	0 (0%)	24 (0%)
Expelled	1 (1%)	132 (1%)
Fears violence at school	0 (0%)	21 (0%)
Do not have required document	0 (0%)	4 (0%)
Plays truant	0 (0%)	8 (0%)

Health and disability

As seen in Table 69, it was found that children with a disability were substantially more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed across all impairment types, but most strongly for children with hearing impairment. Boys with disabilities were 17.7 times more likely to have had a serious illness in the last twelve months and girls were 12.9 times more likely. The most common types of illness among the children with disabilities were malaria (21%), eye or ear problem (26%) or epilepsy (15%), while malaria was most common among the children without disabilities (60%). None of the children with disabilities reported illness due to malnutrition in the last twelve months. Only one child reported not seeking treatment.

As to where treatment was sought, 'other' facilities were the most commonly cited places. Boys with disabilities were far more likely to report attending 'other' facilities compared with boys without disabilities, while there was no such relationship among girls. It was also found that the time taken to the nearest health facility and bed net use were not related to disability.

Table 69: Association between health and health seeking behaviour and disability in Guinea

	MALES			**FEMALES**		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
Serious illness						
- No	26 (59%)	8174 (96%)	Baseline	73 (72%)	18960 (97%)	Baseline
- Yes	18 (41%)	322 (4%)	17.7 (9.5 - 32.7)	29 (28%)	606 (3%)	12.9 (8.3 - 20.0)
Malnutrition						
- No	44 (100%)	8488 (99.9%)	Baseline	102 (100%)	19542 (99.9%)	Baseline
- Yes	0 (0%)	8 (0.1%)	-	0 (0%)	24 (0.1%)	-
Where sought treatment						
- Other	14 (78%)	98 (30%)	Baseline	11 (38%)	272 (45%)	Baseline
- Hospital	2 (11%)	95 (30%)	0.2 (0.01 - 1.0)	10 (34%)	126 (21%)	2.0 (0.8 - 4.9)
- Health clinic	2 (11%)	98 (30%)	0.2 (0.01 - 0.9)	8 (28%)	137 (23%)	1.5 (0.6 - 3.8)
- Private	0 (0%)	31 (10%)	-	0 (0%)	69 (11%)	-
- Did not	0 (0%)	0 (0%)	-	0 (0%)	1 (0.2%)	-

seek						
Illness prevent school						
- No	3 (33%)	107 (57%)	Baseline	3 (50%)	185 (56%)	Baseline
- Yes	6 (67%)	80 (43%)	3.2 (0.7 - 13.6)	3 (50%)	143 (44%)	1.3 (0.3 - 6.6)
Time taken to nearest health facility						
- <30 minutes	36 (82%)	6744 (79%)	Baseline	75 (74%)	14749 (75%)	Baseline
- 30 minutes-1 hour	7 (16%)	1212 (14%)	1.0 (0.4 - 2.2)	16 (16%)	3342 (17%)	0.9 (0.5 - 1.5)
- 1 – 2 hours	0 (0%)	477 (6%)	-	9 (9%)	1210 (6%)	1.4 (0.7 - 2.7)
- >2 hours	1 (2%)	63 (1%)	2.2 (0.3 - 16.7)	2 (2%)	265 (1%)	1.3 (0.3 - 5.5)
Slept under bednet last night						
- No malaria in area	0 (0%)	9 (0%)	Baseline	0 (0%)	48 (0%)	Baseline
- Yes	34 (79%)	7190 (88%)	-	82 (83%)	16912 (89%)	-
- No	9 (21%)	1000 (12%)	-	17 (17%)	2076 (11%)	-

Other findings

Overall, the children with disabilities were older than the children without disability and the relationship between disability and indicators of inclusion/exclusion was very similar between boys and girls. To be expected, the poverty score showed an inverse relationship with disabilities, so that the least poor children were least likely to be disabled.

5.10 Kenya

The population of Kenya is 39,824,734 of which 42% of the population is between the ages of 0 and 14 years (World Bank Population Data, 2013). Kenya is classified as a country with low human development, ranked 145 out of 186, according to the 2013 Human Development Index (UNDP International Human Development Indicators, 2013). Kenya signed the UN Convention on the Rights of Persons with Disabilities in 2007 and ratified it in 2008 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan Kenya is currently working in eight programme units, of which seven are rural and one is urban. These are Kwale and Kilifi in Coast Province, Tharaka and Machakos in Eastern Province, Kisumu, Homa Bay and Bondo in Nyanza Province, and Nairobi in Nairobi Province.

A number of key issues were identified, through a situation analysis, to be the focus of the current Country Strategic Plan (Plan Kenya, 2011). One of these is that in Kenya there is limited participation and exclusion of groups such as children with disability, orphans, women and girls. The analysis also indicated that child abuse cases, including neglect, are also on the increase and that the most affected groups are children with disabilities and those with special needs such as orphans.

Plan Kenya's country goal is 'transformed institutions and societies that respect and fulfil rights of all children in Kenya.' To achieve this goal, Plan Kenya has developed 5 country programmes with corresponding sub-goals:

- Right to health: Goal - enhanced capacities of children, parents and communities to progressively realise their right to the highest attainable standard of health.
- Right to quality education: Goal - increased access to quality education especially for vulnerable groups of children.
- Right to sustainable and dignified livelihood: Goal - increased opportunities for households and groups to engage in sustainable means of livelihoods for dignified standards of living.
- Right to inclusion and protection: Goal - increased effectiveness of child protection mechanisms at family, community and all government levels.
- Right to just and democratic governance: Goal - increased participation by children, youth and communities in public decision making and accountability processes for improved service delivery.

The country programmes make some reference to children with disabilities. The Right to Quality Education Country Programme specifically includes children with disabilities as a vulnerable group which is targeted in the country programme. So too, in the Right to Inclusion and Protection Country Programme, the structural causes of child discrimination, violence, abuse and exploitation will be addressed at local and national levels. It will focus on influencing formulation and implementation of policies and laws such as Children's Act and child labour laws; and supporting research and documentation on issues affecting children with disabilities and child headed households. It will also contribute to changing the attitudes of communities on children with disability and children affected and infected by HIV and AIDS. This programme will also draw on the work under the Right to Just and Democratic Governance Country Programme to support capacity building of children, youth, communities, Plan staff and partners on participatory budgeting processes to ensure child protection issues are prioritised and adequately budgeted allocated for, particularly for excluded and marginalised groups such as children with disability.

For Kenya, the 2012 dataset included 60,139 sponsored children, ranging in age from 0-17. The average age was 10.1 (standard deviation=3.9), and 42% were male. Among the children, 258 had had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.4% (95% confidence interval 0.4 – 0.5 %). The prevalence of disability was slightly higher in males (0.5 %, 95% CI 0.4 – 0.6 %) than in females (0.4 %, 95% CI 0.3 – 0.4 %). After adjustment for age, there was evidence that males had higher odds of disability compared to females (1.3, 95% CI 1.0 – 1.6).

As seen in Table 70, and in line with the overall findings, the most common types of impairment were physical, communication and hearing, while learning and vision impairments were less common.

Table 70: Type of impairment by gender in Kenya

	MALES	FEMALES
Learning	4 (3%)	11 (8%)
Physical	32 (26%)	33 (25%)
Communication	39 (31%)	32 (24%)
Vision	18 (15%)	20 (15%)
Hearing	31 (25%)	38 (28%)
Total	124 (100%)	134 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. As shown in Table 71 boys with disabilities were 52.2 times less likely to attend school and girls with disabilities were 60.2 times less likely to attend school.

Children with disabilities did not seem to be at a lower school level compared children without disability, after accounting for age differences, although the analysis was underpowered and a strong association cannot be discounted. Increased time taken to school was not related to increased disability.

Table 71: Educational variables in relation to disability in Kenya

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	95 (77%)	23733 (95%)	Baseline	89 (66%)	32076 (92%)	Baseline
- No	29 (23%)	1293 (5%)	23.2 (13.3 - 40.7)	45 (34%)	2779 (8%)	26.2 (16.1 - 42.4)
Age 5+: Attend formal education						
- Yes	94 (79%)	22910 (99%)	Baseline	83 (70%)	30482 (99%)	Baseline
- No	25 (21%)	147 (1%)	52.2 (31.8 - 85.7)	36 (30%)	307 (1%)	60.2 (39.1 - 92.8)
Of those at school, school level						
- Secondary/University/ College	1 (1%)	310 (1%)	Baseline	0 (0%)	483 (2%)	Baseline
- Primary	88 (93%)	21091 (89%)	1.4 (0.2 - 10.5)	77 (87%)	27669 (86%)	-

- Nursery/pre-school	6 (6%)	2332 (10%)	1.0 (0.1 - 9.7)	12 (13%)	3924 (12%)	-
Time taken to school						
- <30 minutes	42 (44%)	7606 (32%)	Baseline	26 (29%)	9986 (31%)	Baseline
- 30 minutes-1 hour	50 (53%)	14874 (63%)	0.6 (0.4 - 0.9)	58 (65%)	20138 (63%)	1.1 (0.7 - 1.8)
- >1 hour	3 (3%)	1253 (5%)	0.4 (0.1 - 1.4)	5 (6%)	1952 (6%)	1.0 (0.4 - 2.5)
Attending non formal education						
- No	123 (99%)	24919 (100%)	Baseline	134 (100%)	34717 (100%)	Baseline
- Yes	1 (1%)	107 (0%)	1.7 (0.2 - 12.3)	0 (0%)	138 (0%)	-

Considering the data by type of impairment, physical and communication impairment had the greatest effect on school attendance, followed by learning and hearing impairment, as can be seen in Table 72. However, there were insufficient numbers of disabled children over the age of four in the sample to assess the association between formal education attendance and impairment type for boys.

Table 72: Attendance of formal education by impairment type in Kenya

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	55809 (93%)	4072 (7%)	53392 (99%)	454 (1%)	Baseline	Baseline	Baseline
Learning	11 (73%)	4 (27%)	10 (77%)	3 (23%)	-	21.2 (2.3 – 197.4)	59.8 (14.9 – 240.2)
Physical	41 (63%)	24 (37%)	40 (66%)	21 (34%)	-	177.1 (72.7 – 431.5)	132.3 (70.1 – 249.7)
Communication	44 (62%)	27 (38%)	44 (66%)	23 (34%)	-	112.0 (46.5 – 269.6)	142.3 (78.1 – 259.5)

Vision	34 (89%)	4 (11%)	32 (91%)	3 (9%)	-	13.6 (2.8 – 65.7)	9.4 (2.7 – 32.3)
Hearing	54 (78%)	15 (22%)	51 (82%)	11 (18%)	-	87.4 (36.6 – 208.4)	61.2 (30.8 – 124.3)

As illustrated in Table 73, and in line with the overall findings, having an impairment was cited as the major reason for not attending formal education among children with disabilities (70 %) while being too young was the most common reason among children without disability (97 %).

Table 73: Reason for not attending formal education by disability status in Kenya

	Disabled	Not disabled
Too young	12 (16%)	3964 (97%)
Too old	0 (0%)	7 (0%)
Economic problems	0 (0%)	24 (1%)
Closest school too far	0 (0%)	7 (0%)
Has been ill	4 (5%)	1 (0%)
Is married	0 (0%)	9 (0%)
Needed to help family	0 (0%)	6 (0%)
Has an impairment	58 (78%)	2 (0%)
Is working outside family	0 (0%)	10 (0%)
Was expelled for class repetition	0 (0%)	8 (0%)
Is pregnant or gave birth	0 (0%)	3 (0%)
Primary not considered important by family	0 (0%)	2 (0%)
Secondary not considered important by family	0 (0%)	16 (0%)
Expelled	0 (0%)	8 (0%)
Do not have required document	0 (0%)	1 (0%)
Plays truant	0 (0%)	2 (0%)

Health and disability

Children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with learning and vision impairment. As shown in Table 74 boys with disabilities were 4.1 times more likely to have had a serious illness in the last twelve months and girls were 3.9 times more likely.
The most common types of illness among the children with disabilities were malaria, eye problems and ear infections. There was insufficient data on malnutrition to assess whether this was more common in those with disabilities than those without. Not seeking treatment was strongly related to disability among girls, and possibly among boys. Among those who had not sought treatment, the most commonly cited reason was 'too expensive'. Where treatment was sought, Hospital was the most commonly cited place where this occurred.

Table 74: Association between health and health seeking behaviour and disability in Kenya

	MALES			**FEMALES**		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	86 (69%)	22547 (90%)	Baseline	97 (72%)	31737 (91%)	Baseline
- Yes	38 (31%)	2479 (10%)	4.1 (2.8 - 6.1)	37 (28%)	3118 (9%)	3.9 (2.7 - 5.8)
Malnutrition						
- No	124 (100%)	24981 (99.8%)	Baseline	133 (99%)	34809 (99.9%)	Baseline
- Yes	0 (0%)	45 (0.2%)	-	1 (1%)	46 (0.1%)	5.7 (0.8 - 41.5)
Where sought treatment						
- Other	3 (8%)	190 (8%)	Baseline	3 (8%)	224 (7%)	Baseline
- Hospital	18 (47%)	1470 (59%)	0.8 (0.2 - 2.7)	24 (65%)	1818 (58%)	1.0 (0.3 - 3.2)
- Health clinic	15 (39%)	792 (32%)	1.2 (0.3 - 4.2)	8 (22%)	1047 (34%)	0.5 (0.1 - 2.1)
- Private	1 (3%)	16 (1%)	4.0 (0.4 - 40.7)	0 (0%)	21 (1%)	-
- Did not seek	1 (3%)	11 (0%)	5.6 (0.5 - 59.0)	2 (5%)	8 (0%)	19.6 (2.8 - 135.1)
Illness prevent school						
- No	15 (48%)	861 (39%)	Baseline	10 (37%)	1096 (41%)	Baseline
- Yes	16 (52%)	1336 (61%)	0.7 (0.3 - 1.4)	17 (63%)	1605 (59%)	1.2 (0.5 - 2.5)

Time taken to nearest health facility						
- <30 minutes	17 (14%)	2389 (10%)	Baseline	16 (12%)	3154 (9%)	Baseline
- 30 minutes-1 hour	46 (37%)	11240 (45%)	0.6 (0.3 - 1.0)	59 (44%)	15620 (45%)	0.7 (0.4 - 1.3)
- 1 – 2 hours	48 (39%)	8294 (33%)	0.8 (0.5 - 1.4)	47 (35%)	11552 (33%)	0.8 (0.5 - 1.4)
- >2 hours	13 (10%)	3102 (12%)	0.6 (0.3 - 1.2)	12 (9%)	4529 (13%)	0.5 (0.2 - 1.1)
Slept under bednet last night						
- No malaria in area	0 (0%)	669 (3%)	Baseline	5 (4%)	1097 (4%)	Baseline
- Yes	85 (73%)	15787 (71%)	-	94 (78%)	22026 (71%)	1.0 (0.4 - 2.4)
- No	31 (27%)	5703 (26%)	-	22 (18%)	7936 (26%)	0.6 (0.2 - 1.6)

Other findings

Overall, the children with disabilities were similar in age to the children without disabilities and the relationship between disability and indicators of inclusion/exclusion was similar between boys and girls. As far as the poverty index was concerned, the poverty variables showed little relationship with disabilities. Finally, children with disabilities were more likely to live in mixed urban rural areas than in rural areas.

5.11 Mozambique

The population of Mozambique is 23,361,025 of which 45% of the population is between the ages of 0 and 14 years (World Bank Population Data, 2013). Mozambique is classified as a country with low human development, ranked 185 out of 186, according to the UNDP Human Development Index 2013 (UNDP International Human Development Indicators, 2013). Mozambique signed the UN Convention on the Rights of Persons with Disabilities in 2007 and ratified it in 2012 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

The overall goal of the Plan Mozambique Country Strategic Plan is 'the improved well-being of all children in Mozambique' (Plan Mozambique, 2010). To achieve the goal, Plan has developed four country programmes:

- Maternal and Child Health,
- ECCD and Primary Education,
- Child Protection,
- Social and Economic Capacity Building

Disability does not feature particularly strongly in the Country Strategic Plan; however there are some areas which include a focus on persons with disability. Under the Child Protection Country Programme, there is a commitment to raising awareness among the government partners, legal authorities and partners on child protection and the importance of inclusion of all marginalised groups of children (including children living with disabilities). Under the Social and Economic Capacity Building Country Programme Plan Mozambique will work with NGOs and community based organizations to improve access to and support for credit institutions that support farmers, youth and women's associations as well as other marginalized groups such as persons with disabilities.

In Mozambique, the 2012 dataset included 6,782 sponsored children, ranging in age from 0-13. The average age was 6.2 (standard deviation=2.3), and 44% were male. Among the children, 119 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.8% (95% confidence interval 1.4 – 2.1 %). The prevalence of disability was slightly higher in males (1.8 %, 95% CI 1.3 – 2.3 %) than in females (1.7 %, 95% CI 1.3 – 2.1 %), although after adjustment for age, there was not difference in the odds of disability between males and females (OR=1.1, 95% CI 0.7-1.5).

As shown in Table 75, the most common type of impairment in boys was hearing impairment, while in girls it was communication impairments. Learning impairments were very rare.

Table 75: Type of impairment by gender in Mozambique

	MALES	FEMALES
Learning	1 (2%)	1 (2%)
Physical	14 (26%)	13 (20%)
Communication	14 (26%)	22 (34%)
Vision	7 (13%)	13 (20%)
Hearing	18 (33%)	16 (25%)

Total	54 (100%)	65 (100%)

Education and disability

Children with disabilities were less likely to attend formal education than those without a disability, after taking account of age. As shown in Table 76 boys with disabilities were 2.0 times less likely to attend school and girls with disabilities were 5.4 times less likely to attend school. For the remainder of the analyses, there were insufficient numbers to allow precise estimates of association to be obtained.

Table 76: Educational variables in relation to disability in Mozambique

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	38 (70%)	1994 (68%)	Baseline	38 (58%)	2559 (69%)	Baseline
- No	16 (30%)	957 (32%)	2.1 (1.0 - 4.4)	27 (42%)	1153 (31%)	5.5 (2.8 - 10.5)
Age 5+: Attend formal education						
- Yes	37 (82%)	1838 (83%)	Baseline	38 (68%)	2352 (85%)	Baseline
- No	8 (18%)	370 (17%)	2.0 (0.8 - 4.6)	18 (32%)	400 (15%)	5.4 (2.8 - 10.4)
Of those at school, school level						
- Secondary/University/ College	0 (0%)	5 (0.3%)	Baseline	0 (0%)	6 (0.2%)	Baseline
- Primary	35 (92%)	1866 (94%)	-	38 (100%)	2369 (93%)	-
- Nursery/pre-school	3 (8%)	123 (6%)	-	0 (0%)	184 (7%)	-
Time taken to school						

- <30 minutes	7 (18%)	376 (19%)	Baseline	7 (18%)	535 (21%)	Baseline
- 30 minutes-1 hour	25 (66%)	1070 (54%)	1.2 (0.5 - 2.7)	18 (47%)	1337 (52%)	1.0 (0.4 - 2.4)
- >1 hour	6 (16%)	548 (27%)	0.6 (0.2 - 1.7)	13 (34%)	687 (27%)	1.3 (0.5 - 3.4)
Attending non formal education						
- No	54 (100%)	2946 (99.8%)	Baseline	65 (100%)	3703 (99.8%)	Baseline
- Yes	0 (0%)	5 (0.2%)	-	0 (0%)	9 (0.2%)	-

Considering the data by type of impairment for boys and girls combined, communication impairment had the greatest effect on school attendance, followed by physical and vision impairment, after adjusting for age and gender, as can be seen in Table 77. There was insufficient numbers of those with learning or hearing impairment in the sample to assess the effect of these impairments, but of note was that none of the children with learning impairments attended formal education. The effect of impairment type on school attendance differed by gender, with boys very strongly affected by having hearing impairments.

Table 77: Attendance of formal education by impairment type in Mozambique

	All ages		**Age 5+**				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	4553 (68%)	2110 (32%)	4190 (84%)	770 (16%)	Baseline	Baseline	Baseline
Learning	0 (0%)	2 (100%)	0 (0%)	1 (100%)	3.4 (0.8 - 14.9)	-	-
Physical	17 (63%)	10 (37%)	16 (70%)	7 (30%)	2.7 (0.5 - 14.9)	3.9 (0.8 - 18.5)	3.6 (1.2 - 10.4)
Communication	18 (50%)	18 (50%)	18 (56%)	14 (44%)	13.6 (1.9 - 98.6)	31.5 (10.0 - 98.8)	14.9 (5.7 - 38.6)
Vision	13 (65%)	7 (35%)	13 (87%)	2 (13%)	-	-	4.7 (1.0 - 23.3)
Hearing	28 (82%)	6 (18%)	28 (93%)	2 (7%)	110.4 (52.8 - 230.7)	2.1 (0.4 - 11.3)	0.8 (0.2 - 3.7)

Table 78 illustrates that being too young was cited as the major reason for not attending formal education among children with disabilities (63%) and without disability (95%).

Table 78: Reason for not attending formal education by disability status in Mozambique

	Disabled	Not disabled
Too young	27 (63%)	2010 (95%)
Too old	1 (2%)	3 (0%)
Did not pass secondary school exam	0 (0%)	0 (0%)
Is needed to work	0 (0%)	0 (0%)
Economic problems	0 (0%)	23 (1%)
Closest school too far	1 (2%)	35 (2%)
Has been ill	1 (2%)	6 (0%)
Needed to help family	0 (0%)	8 (0%)
Has an impairment	13 (30%)	0 (0%)
Is working outside family	0 (0%)	1 (0%)
Was expelled for class repetition	0 (0%)	1 (0%)
Primary not considered important by family	0 (0%)	4 (0%)
Expelled	0 (0%)	1 (0%)
Fears violence at school	0 (0%)	2 (0%)
Fears violence on way to school	0 (0%)	6 (0%)
Do not have required document	0 (0%)	6 (0%)
Plays truant	0 (0%)	3 (0%)

Health and disability

As shown in Table 79, children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with hearing impairments. Boys with disabilities were 4.7 times more likely to have had a serious illness in the last twelve months and girls were 2.4 times more likely. The most common types of illness among the children with disabilities were malaria, ear infections, and eye problems. There was insufficient data on malnutrition to assess whether this was more common in those with disabilities than those without.

In relation to where treatment was sought, hospital was the most commonly cited place. Neither time taken to the nearest health facility nor sleeping under a bednet seemed to be related to disability, although both analyses were underpowered.

Table 79: Association between health and health seeking behaviour and disability in Mozambique

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	20 (37%)	2136 (72%)	Baseline	35 (54%)	2670 (72%)	Baseline
- Yes	34 (63%)	815 (28%)	4.7 (2.7 - 8.3)	30 (46%)	1042 (28%)	2.4 (1.5 - 3.9)
Malnutrition						
- No	54 (100%)	2946 (99.8%)	Baseline	65 (100%)	3702 (99.7%)	Baseline
- Yes	0 (0%)	5 (0.2%)	-	0 (0%)	10 (0.3%)	-
Where sought treatment						
- Other	12 (35%)	168 (21%)	Baseline	7 (23%)	178 (17%)	Baseline
- Hospital	20 (59%)	637 (78%)	0.5 (0.2 - 1.0)	22 (73%)	849 (81%)	0.7 (0.3 - 1.6)
- Health clinic	0 (0%)	3 (0.4%)	-	1 (3%)	8 (1%)	3.7 (0.4 - 34.8)
- Private	0 (0%)	1 (0.1%)	-	0 (0%)	3 (0.3%)	-
- Did not seek	2 (6%)	6 (1%)	4.8 (0.8 - 27.3)	0 (0%)	4 (0.4%)	-
Illness prevent school						
- No	13 (54%)	217 (41%)	Baseline	10 (42%)	304 (45%)	Baseline
- Yes	11 (46%)	317 (59%)	0.5 (0.2 - 1.2)	14 (58%)	372 (55%)	1.1 (0.5 - 2.4)
Time taken to nearest health facility						

- <30 minutes	2 (4%)	142 (5%)	Baseline	5 (8%)	194 (5%)	Baseline
- 30 minutes-1 hour	16 (30%)	494 (17%)	2.3 (0.5 - 10.2)	18 (28%)	658 (18%)	1.1 (0.4 - 3.1)
- 1 – 2 hours	11 (20%)	844 (29%)	1.0 (0.2 - 4.6)	19 (29%)	1075 (29%)	0.8 (0.3 - 2.1)
- >2 hours	25 (46%)	1471 (50%)	1.3 (0.3 - 5.6)	23 (35%)	1785 (48%)	0.6 (0.2 - 1.5)
Slept under bednet last night						
- No malaria in area	1 (2%)	112 (4%)	Baseline	2 (3%)	157 (4%)	Baseline
- Yes	24 (48%)	1131 (41%)	2.6 (0.3 - 19.2)	24 (39%)	1379 (39%)	1.3 (0.3 - 5.6)
- No	25 (50%)	1547 (55%)	1.8 (0.2 - 13.6)	35 (57%)	1976 (56%)	1.2 (0.3 - 5.3)

Other findings

The children with disabilities were slightly older in age than the children without disability. The most pronounced gender difference was the type of impairment and school attendance. Finally, in relation to the poverty index, the poverty variables showed minimal relationship with disabilities, although many of the analyses were underpowered.

5.12 Niger

The population of Niger is 17,157,042 with 50% of the population aged 0-14 years (World Bank Population Data, 2013). Niger is still one of the poorest countries in the world according to the 2013 Human Development Index, which ranked the country last, at 186, in its list of countries alongside Democratic Republic of Congo (UNDP International Human Development Indicators, 2013). Niger signed the UN Convention on the Rights of Persons with Disabilities in 2007and ratified it in 2008 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan started working in Niger in 1998 and is currently intervening in 76 villages, covering a total population of approximately 600,000 people from two Programme Units (Dosso and Tillabéri). According to Plan Niger's Country Strategic Plan the right to development of children living with disabilities is unfulfilled due to lack of appropriate structures to ensure their inclusion in the education system (Plan

Niger, 2009). The Country Strategic Plan states that Plan Niger's principal weaknesses include a lack of experience in working with children living with disabilities.

The Country Strategic Plan identifies 2 country goals. The first is to ensure that children are better able to claim and enjoy their rights to protection, survival, development and participation, in communities which are more respectful of these rights, so that they realise their full potential. The second is that households in Plan partner communities are better able to prevent and manage risks and emergency situations and to mitigate economic shocks, leading to a less risky and more stable community environment in which children's rights can be fulfilled in a more sustainable manner. Plan Niger has defined four country programmes to work towards the achievement of these goals until June 2014:

- Realisation of the right to survival for all children
- Realisation of the right to access to quality education for all children
- Quality protection for all children
- Prevention and management of emergency situations and reduction of household vulnerability

The only mention of children with disabilities in Plan Niger's country programme strategy is in the Monitoring, Evaluation and Research framework, where one of the questions asked to measure gaps and evaluate changes brought about by programme implementation is 'Do all children have access to school (boys, girls, children living with disabilities, minorities etc)?' in the context of the country goal that children are better able to claim and enjoy their rights to protection, survival, development and participation, in communities which are more respectful of these rights, so that they realize their full potential.

In Niger, the 2012 dataset included 19,103 sponsored children, ranging in age from 0-17. The average age was 7.7 (standard deviation=4.30), and 33% were male. Among the children, 185 had had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.0% (95% confidence interval 0.8 – 1.1 %). The prevalence of disability was slightly higher in males (1.4 %, 95% CI 1.1 – 1.7 %) than in females (0.8 %, 95% CI 0.6 – 0.9 %). After adjustment for age, males had a significantly higher odds of disability compared to females (1.6, 95% CI 1.2-2.1). As illustrated in Table 80, the most common types of impairment were physical and communication, while vision, learning and hearing impairments were less common.

Table 80: Type of impairment by gender in Niger

	MALES	FEMALES
Learning	0 (0%)	1 (1%)

Physical	45 (52%)	44 (44%)
Communication	21 (24%)	29 (29%)
Vision	10 (12%)	16 (16%)
Hearing	10 (12%)	9 (9%)
Total	86 (100%)	99 (100%)

Education and disability

As seen in Table 81, children with a disability were much less likely to attend formal education than those without a disability, after taking account of age. Boys with disabilities were 2.8 times less likely to attend school and girls with disabilities were 6.0 times less likely to attend school. Of those in school, female children with a disability were much more likely to be at a lower level compared to children without a disability. Interestingly, a higher percentage of males with a disability were likely to be at secondary/university or college level compared to males without a disability and females. There were slight differences in the time taken to get to school, with both males and females with a disability taking between 30 minutes to one hour to get to school compared to children of the same gender without a disability. However, the numbers in these categories were small.

Table 81: Educational variables in relation to disability in Niger

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	34 (40%)	3639 (59%)	Baseline	23 (23%)	6319 (50%)	Baseline
- No	52 (60%)	2554 (41%)	2.2 (1.4 - 3.4)	76 (77%)	6406 (50%)	3.8 (2.4 - 6.1)
Age 5+: Attend formal education						
- Yes	34 (41%)	3483 (68%)	Baseline	23 (26%)	5908 (67%)	Baseline
- No	49 (59%)	1627 (32%)	2.8 (1.8 - 4.4)	67 (74%)	2854 (33%)	6.0 (3.7 - 9.7)
Of those at school, school level						
- Secondary/University/College	6 (18%)	147 (4%)	Baseline	1 (4%)	232 (4%)	Baseline
- Primary	27 (79%)	3183 (87%)	0.4 (0.1 - 1.2)	20 (87%)	5341 (85%)	1.3 (0.1 - 11.5)

- Nursery/pre-school	1 (3%)	309 (8%)	0.2 (0.0 - 2.7)	2 (9%)	746 (12%)	1.3 (0.1 - 22.8)
Time taken to school						
- <30 minutes	31 (91%)	3561 (98%)	Baseline	22 (96%)	6206 (98%)	Baseline
- 30 minutes-1 hour	3 (9%)	58 (2%)	3.1 (0.8 - 11.5)	1 (4%)	99 (2%)	2.4 (0.3 - 18.9)
- >1 hour	0 (0%)	20 (1%)	-	0 (0%)	14 (0%)	-
Attending non formal education						
- Yes	78 (91%)	5933 (96%)	Baseline	98 (99%)	12397 (97%)	Baseline
- No	8 (9%)	260 (4%)	1.4 (0.7-3.1)	1 (1%)	328 (3%)	0.3 (0.03-1.6)

Considering the data by type of disability, hearing and communication impairment had the strongest association with school attendance, followed by physical and vision, as shown in Table 82.

Table 82: Attendance of formal education by impairment type in Niger

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
Learning	0 (0%)	1 (100%)	0 (0%)	1 (100%)	2.1 (1.1 - 3.9)	-	-
Physical	31 (35%)	58 (65%)	31 (38%)	51 (62%)	4.5 (1.7 - 11.9)	5.4 (2.6 - 11.0)	3.2 (2.0 - 5.1)
Communication	10 (20%)	40 (80%)	10 (20%)	39 (80%)	1.2 (0.3 - 4.4)	12.9 (4.4 - 37.6)	7.8 (3.8 - 15.7)
Vision	13 (50%)	13 (50%)	13 (59%)	9 (41%)	10.0 (2.1 - 48.1)	1.5 (0.5 - 4.9)	1.3 (0.6 - 3.2)
Hearing	3 (16%)	16 (84%)	3 (16%)	16 (84%)	0.1 (0.1 - 0.2)	12.5 (1.5 - 103.0)	11.1 (3.2 - 39.0)
No disability	9958 (53%)	8960 (47%)	9391 (68%)	4481 (32%)	Baseline	Baseline	Baseline

The analysis found, as indicated in Table 83, that having an impairment was cited as the major reason for not attending formal education among children with a disability (41%) while also being too old was also a common reason (29%) and also being too young (24%).

Table 83: Reason for not attending formal education by disability status in Niger

	Disabled (n=128)	Not disabled (n=8961)
lack of primary schools in community	0 (0%)	1 (0%)
Too young	24 (19%)	5839 (65%)
Too old	37 (29%)	1662 (19%)
Did not pass secondary school exam	0 (0%)	2 (0%)
Economic problems	2 (2%)	139 (2%)
Closest school too far	0 (0%)	35 (0%)
Has been ill	7 (5%)	10 (0%)
Lack of interest in school attendance	0 (0%)	1 (0%)
Is married	0 (0%)	1 (0%)
Needed to help family	2 (2%)	303 (3%)
Has an impairment	52 (41%)	0 (0%)
Is working outside family	0 (0%)	6 (0%)
Was expelled for class repetition	3 (2%)	485 (5%)
Primary not considered important by family	1 (1%)	292 (3%)
Secondary not considered important by family	0 (0%)	6 (0%)
Expelled	0 (0%)	68 (1%)
Fears violence at school	0 (0%)	1 (0%)
Do not have required document	0 (0%)	2 (0%)
Plays truant	0 (0%)	108 (1%)

Health and disability

There was no real difference observed for both females (1.3) and males (1.1) with a disability and those without in terms of serious illness, as seen in Table 84. All children regardless of disability status had high malnutrition levels. However among females without a disability, a higher percentage were identified to have had a serious illness (62% vs 55%)

The most common types of illness among children with disabilities were malaria (74%), eye problems (5%) and ear infections (4%). The most common types of disabilities among males and females were physical disabilities including cleft lip 31% and 27%), physical impairment (20% and 15%), orthopaedically disabled (16% and 14%) and mute (12% and 16%). These were also the most common illnesses among children without a disability, as well as influenza (6%).

Children with a disability appeared to be less likely to sleep under a mosquito net compared to children without a disability for both genders.

The place where treatment was sought for serious illness by children with disabilities was often at a health centre, however the majority of children both with and without a disability had sought treatment (approximately 55%) at another facility which was not specified. The most commonly cited reasons as to why treatment was not sought among those with a disability were 'advised treatment unnecessary' and 'no transport'.

Table 84: Association between health and health seeking behaviour and disability in Niger

	MALES			**FEMALES**		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- Yes	55 (64%)	4058 (66%)	Baseline	54 (55%)	7863 (62%)	Baseline
- No	31 (36%)	2135 (34%)	1.1 (0.7 - 1.7)	45 (45%)	4863 (38%)	1.3 (0.9 - 2.0)
Malnutrition						
- Yes	86 (100%)	6192 (99.98%)	Baseline	99 (100%)	12714 (99.9%)	Baseline
- No	0 (0%)	1 (0.02%)	-	0 (0%)	12 (0.1%)	-
Where sought treatment						
- Other	17 (55%)	1172 (55%)	Baseline	25 (56%)	2650 (54%)	Baseline
- Hospital	2 (6%)	28 (1%)	6.6 (1.4 - 31.2)	2 (4%)	41 (1%)	5.2 (1.2 - 22.9)

- Health clinic	12 (39%)	928 (43%)	0.9 (0.4 - 1.9)	17 (38%)	2157 (44%)	0.9 (0.5 - 1.6)
- Private	0 (0%)	0 (0%)	-	0 (0%)	0 (0%)	-
- Did not seek	0 (0%)	7 (0.3%)	-	1 (2%)	15 (0.3%)	-
Illness prevent school						
- Yes	5 (33%)	347 (27%)	Baseline	1 (14%)	729 (30%)	Baseline
- No	10 (67%)	913 (73%)	-	6 (86%)	1698 (70%)	0.4 (0.05-3.3)
Time taken to nearest health facility						
- <30 minutes	81 (94%)	5618 (91%)	Baseline	84 (85%)	11596 (91%)	Baseline
- 30 minutes-1 hour	5 (6%)	513 (8%)	0.6 (0.2 - 1.4)	14 (14%)	1026 (8%)	1.7 (1.0 - 3.1)
- 1 – 2 hours	0 (0%)	49 (1%)	-	1 (1%)	97 (1%)	1.4 (0.2 - 9.8)
- >2 hours	0 (0%)	13 (0.2%)	-	0 (0%)	7 (0.1%)	-
Slept under bednet last night						
- No malaria in area	0 (0%)	3 (0.1%)	Baseline	0 (0%)	4 (0.03%)	Baseline
- Yes	64 (74%)	5196 (84%)	-	68 (69%)	10246 (81%)	-
- No	22 (26%)	963 (16%)	-	30 (31%)	2386 (19%)	-

Other findings

Overall, the children with disabilities were older than the children without a disability and relationship between disability and indicators of inclusion/exclusion were generally similar between boys and girls. In relation to the poverty index, the poverty variables showed a weak relationship with children with disabilities.

5.13 Rwanda

The country population of Rwanda is 11,457,801 and the percentage of the population that constitutes children between the ages of 0-14 years is 44% (World Bank Population Data, 2013). Rwanda ranks 167 out of 187 countries in the 2013 Human Development Index,

making it a country with low human development (UNDP International Human Development Indicators, 2013). Rwanda acceded to the UN Convention on Persons with Disabilities in 2008 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan Rwanda currently operates in two districts in the Eastern Province (Bugesera and Gatsibo) and one district in the Southern province (Nyaruguru). A new country strategic plan from 2013 – 2018 has just been adopted in August 2013 (Plan Rwanda, 2013), and so the previous Country Strategic Plan (2009 – 2013) will also be discussed (Plan.

From 2009 – 2013 the programme approach centred on supporting and upholding Rwanda Vision 2020 and the Rwandan Economic Development and Poverty Reduction Strategy (EDPRS 1) and accordingly had 4 country goals (Plan Rwanda, 2009):

- Create opportunities for retention, improved performance and completion of primary and secondary education among girls
- Children less than six years of age have improved developmental status and realize their rights to survival, care, protection and development
- Improve access to livelihood opportunities and effective participation among the youth in their own development
- Empower children and youths to exercise their citizenship and enable communities to lead their own development

These country goals translated into 4 country programmes:

- Girls Education Programme
- Early Childhood Care for Development Programme
- Youth empowerment Programme
- Child Rights and Building Partnerships Programme

The Country Strategic Plan however makes no mention of children with disabilities either in its situational analysis or in its planned programmes. But this can be contrasted to the new one. In the situation analysis it clearly notes that despite government interventions that have successfully addressed child rights issues (including the establishment of Children's Committees, Children's Forums), most key children's rights continue to be violated and the UN Committee of Experts on the Rights of the Child emphasized the following groups as the most vulnerable in Rwanda: girls from poor background, children born out of rape during genocide, children with disabilities, child-headed households and children from the historically marginalized groups. It is against this backdrop that Plan

Rwanda states that it will target the most excluded and vulnerable groups in relation to the rights which are generally not upheld in Rwanda (e.g., right to quality and inclusive education, right to protection).

Under the 2013 – 2018 Country Strategic Plan the programme commitment is to maximise Plan's reach and impact on children's lives, particularly those from excluded or marginalised groups. To achieve this there are 4 country programmes, not unlike the previous 4 country programmes:

- Right to access quality and inclusive education
- Right to early childhood care and development through united communities
- Right to youth economic security through active citizenship
- Right to protection

In relation to the right to access quality and inclusive education programme, the Country Strategic Plan notes the difficulties facing children with disabilities in accessing quality education. Accordingly one of the components of the programme is supporting inclusive education for children from the most vulnerable and marginalised groups, particularly girls, by providing multi-year educational support including mentoring and remedial classes.

In discussing challenges facing youth the Country Strategic Plan notes that rural girls, girls with disabilities and out-of-school girls tend to experience a higher rate of sexual and gender-based violence and that there is limited access to adolescent friendly health services in rural areas. This analysis indicates a sensitivity to the intersecting vulnerabilities of children with disabilities. As part of the right to youth economic security programme Plan Rwanda will scale up the Village Savings and Loan Association (VSLA) methodology and will reinforce equal economic opportunities and financial inclusion whereby young people with disabilities will be given the opportunity to join VSLAs and participation of young women will be ensured. However the programme doesn't specifically set out how this will necessarily address the challenges facing young persons with disabilities as noted in the situation analysis.

Finally, the situation analysis conducted as part of the development of the child protection programme notes that children/youth in emergencies, girls, children living in child-headed households, children with disabilities, working children and children living or working in the street are at particular risk of experiencing child abuse and neglect in Rwanda. In addition, the situation of gender-based violence and violence against children is worsened because of multiple factors including ccultural beliefs and practices. There are deep-rooted, traditional gender norms that result in power imbalances between men and women, as well as discrimination against groups who are particularly vulnerable including children with disabilities, children from the historically marginalized groups, and girls. Although children

with disabilities do not feature specifically in the child protection programme, one of its components is to support the capacity building of rights holders and duty bearers (e.g. through improved knowledge, skills and behaviour change) on gender-based violence, strengthening community led child protection systems, and children and youth involvement in claiming and defending their rights. Given the identification of children with disabilities as a vulnerable group, the work should be inclusive of them.

For Rwanda, the 2012 dataset included 6,443 sponsored children, ranging in age from 0-16. The average age was 7.2 (standard deviation= 3.3), and 29 % were male. Among the children, 214 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 3.3 % (95% confidence interval 2.8 - 3.8 %). The prevalence of disability was slightly higher in males (3.8 %, 95% CI 2.9 – 4.7 %) than in females (3.1 %, 95% CI 2.6 – 3.6 %). After adjustment for age, the odds of disability was similar when comparing males to females (1.2, 95% CI 0.9 - 1.6).

As illustrated in table 85, the most common type of impairment was physical, while learning and communication were the least common types of impairment.

Table 85: Type of impairment by gender in Rwanda

	MALES	FEMALES
Learning	1 (1%)	5 (3%)
Physical	33 (47%)	64 (44%)
Communication	5 (7%)	15 (10%)
Vision	18 (26%)	29 (20%)
Hearing	13 (19%)	31 (22%)
Total	70 (100%)	144 (100%)

Education and disability

Children with disabilities were less likely to attend formal education than those without a disability, after taking account of age, as can be seen in Table 86. Boys with disabilities were 4.3 times less likely to attend school and girls with disabilities were 1.9 times less likely to attend school. Increased time taken to school did seem to be related to disability in girls although in boys this analysis was imprecise (wide confidence intervals).

Table 86: Educational variables in relation to disability in Rwanda

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	42 (60%)	1291 (73%)	Baseline	90 (63%)	3031 (68%)	Baseline
- No	28 (40%)	478 (27%)	3.4 (1.8 - 6.6)	54 (38%)	1429 (32%)	1.9 (1.2 - 3.0)
Age 5+: Attend formal education						
- Yes	42 (69%)	1241 (88%)	Baseline	86 (77%)	2799 (85%)	Baseline
- No	19 (31%)	162 (12%)	4.3 (2.2 - 8.1)	25 (23%)	497 (15%)	2.1 (1.3 - 3.6)
Of those at school, school level						
- Secondary/University/College	3 (7%)	24 (2%)	Baseline	3 (3%)	54 (2%)	Baseline
- Primary	37 (88%)	1147 (89%)	0.3 (0.1 - 1.1)	77 (86%)	2524 (83%)	0.6 (0.2 - 2.1)
- Nursery/pre-school	2 (5%)	120 (9%)	0.2 (0.0 - 1.3)	10 (11%)	453 (15%)	0.4 (0.1 - 2.0)
Time taken to school						
- <30 minutes	15 (36%)	440 (34%)	Baseline	23 (26%)	987 (33%)	Baseline
- 30 minutes-1 hour	20 (48%)	703 (54%)	0.8 (0.4 - 1.6)	47 (52%)	1612 (53%)	1.2 (0.7 - 2.0)
- >1 hour	7 (17%)	148 (11%)	1.4 (0.6 - 3.5)	20 (22%)	432 (14%)	2.0 (1.1 - 3.6)
Attending non formal education						
- No	70 (100%)	1767 (100%)	Baseline	144 (100%)	4434 (99%)	Baseline
- Yes	0 (0%)	2 (0%)	-	0 (0%)	26 (1%)	-

As can be seen in Table 87, considering the data by type of impairment, learning and communication impairment had the strongest association with school non-attendance, followed by physical and hearing impairment, as shown in Table 87. Vision impairment did not seem to be related to attendance of formal education. However, the pattern varied by gender: physical impairment was the most strongly associated with non-attendance in boys, while for girls learning impairment was the most strongly related. For boys the analyses of communication, vision and hearing impairment were imprecise due to a small sample size, while similarly for girls the physical and vision impairment analyses were imprecise.

Table 87: Attendance of formal education by impairment type in Rwanda

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	4322 (69%)	1907 (31%)	4040 (86%)	659 (14%)	Baseline	Baseline	Baseline
Learning	3 (50%)	3 (50%)	3 (50%)	3 (50%)	-	89.8 (6.8 - 1193.4)	26.8 (3.0 - 236.6)
Physical	56 (58%)	41 (42%)	54 (73%)	20 (27%)	10.4 (3.8 - 28.3)	2.3 (0.9 - 5.5)	4.2 (2.2 - 8.1)
Communication	8 (40%)	12 (60%)	8 (50%)	8 (50%)	2.7 (0.3 - 23.0)	28.2 (6.1 - 130.3)	13.4 (3.6 - 49.1)
Vision	36 (77%)	11 (23%)	35 (88%)	5 (13%)	1.7 (0.5 - 6.1)	0.3 (0.0 - 2.1)	0.8 (0.3 - 2.2)
Hearing	29 (66%)	15 (34%)	28 (78%)	8 (22%)	3.8 (0.5 - 27.3)	2.7 (0.8 - 8.7)	2.9 (1.1 - 8.0)

Finally, as illustrated in Table 88, being too young was cited as the major reason for not attending formal education among children with disabilities (74 %) and those without disability (97%).

Table 88: Reason for not attending formal education by disability status in Rwanda

	Disabled	Not disabled
Too young	61 (74%)	1844 (97%)
Too old	1 (1%)	2 (0%)
Economic problems	1 (1%)	30 (2%)
Closest school too far	1 (1%)	10 (1%)
Needed to help family	0 (0%)	7 (0%)
Has an impairment	17 (21%)	2 (0%)
Is working outside family	0 (0%)	2 (0%)
Primary not considered important by family	1 (1%)	5 (0%)
Do not have required document	0 (0%)	2 (0%)
Plays truant	0 (0%)	3 (0%)

Health and disability

As can be seen in Table 89, children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, particularly girls. This pattern was observed most strongly for those with vision and hearing impairment. Boys with disabilities were 5.1 times more likely to have had a serious illness in the last twelve months and girls were 10.8 times more likely. The most common types of illness among the children with disabilities were malaria, eye problems, ear infections and acute respiratory tract infections. Malnutrition was related to the presence of disability in girls and possibly in boys, although this analysis was underpowered. Not seeking treatment was strongly associated with disabilities amongst both boys and girls. Among those disabled children who had not sought treatment, the most commonly cited reason was 'no documents'. Seeking treatment in a hospital was related to the presence of disability, when compared to seeking treatment in the 'other' category. Finally, time taken to nearest health facility and slept under bednet last night did not seem to be related to disability, although all estimates had wide confidence intervals.

Table 89: Association between health and health seeking behaviour and disability in Rwanda

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
Serious illness						
- No	32 (46%)	1382 (78%)	Baseline	35 (24%)	3342 (75%)	Baseline

- Yes	38 (54%)	387 (22%)	5.1 (3.1 - 8.5)	109 (76%)	1118 (25%)	10.8 (7.3 - 16.0)
Malnutrition						
- No	69 (99%)	1755 (99%)	Baseline	139 (97%)	4396 (99%)	Baseline
- Yes	1 (1%)	14 (1%)	2.0 (0.3 - 16.0)	5 (3%)	64 (1%)	2.7 (1.1 - 7.0)
Where sought treatment						
- Other	11 (29%)	164 (42%)	Baseline	45 (41%)	551 (49%)	Baseline
- Hospital	13 (34%)	73 (19%)	2.2 (0.9 - 5.2)	31 (28%)	180 (16%)	1.8 (1.1 - 3.0)
- Health clinic	10 (26%)	135 (35%)	1.1 (0.4 - 2.6)	23 (21%)	357 (32%)	0.8 (0.5 - 1.3)
- Private	0 (0%)	8 (2%)	-	3 (3%)	15 (1%)	2.5 (0.7 - 9.1)
- Did not seek	4 (11%)	7 (2%)	6.4 (1.6 - 26.4)	7 (6%)	15 (1%)	5.1 (2.0 - 13.4)
Illness prevent school						
- No	18 (86%)	124 (68%)	Baseline	48 (71%)	425 (75%)	Baseline
- Yes	3 (14%)	59 (32%)	0.3 (0.1 - 1.2)	20 (29%)	139 (25%)	1.2 (0.7 - 2.1)
Time taken to nearest health facility						
- <30 minutes	13 (19%)	264 (15%)	Baseline	15 (10%)	553 (12%)	Baseline
- 30 minutes-1 hour	18 (26%)	597 (34%)	0.6 (0.3 – 1.2)	42 (29%)	1403 (31%)	1.1 (0.6 – 1.9)
- 1 – 2 hours	23 (33%)	602 (34%)	0.8 (0.4 – 1.6)	58 (40%)	1751 (39%)	1.2 (0.7 – 2.2)
- >2 hours	16 (23%)	305 (17%)	1.1 (0.5 – 2.3)	29 (20%)	753 (17%)	1.4 (0.7 – 2.7)
Slept under bednet last night						
- No malaria in area	0 (0%)	9 (1%)	Baseline	0 (0%)	43 (1%)	Baseline
- Yes	55 (93%)	1430 (91%)	1.3 (0.5 - 3.6)	121 (94%)	3649 (91%)	1.4 (0.7 - 2.8)

- No	4 (7%)	135 (9%)	-	8 (6%)	331 (8%)	-

Other findings

Overall, the children with disabilities were similar in age to the children without disability and while there may have been some gender differences, although as the analyses generally lacked power, determining this from the results obtained is difficult. The poverty score showed a relationship between poverty and disability in boys, but not girls, while the other poverty variables did not seem to show a relationship to disability

5.14 Senegal

The country population of Senegal in 2012 was 13,726,021 of which 44% are children aged between 0 and 14years (World Bank Population Data, 2013). Senegal is one of the poorest countries in the world according to the 2013 Human Development Index, which ranked the country 154 out of 187 countries, only marginally better than some of its neighbours in the West Africa region (UNDP International Human Development Indicators, 2013). Senegal signed the UN Convention on Persons with Disabilities in 2007 and formally ratified it in 2010 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan Senegal works in 5 separate Programme areas - Thies, Kaolack, Louga, St Louis (rural) and Dakar (suburban). Plan Senegal's Country Strategic Plan for 2012 – 2016 sets the country goal as ensuring that girls, boys and youth, especially the most vulnerable, live as active citizens for the fulfilment of their rights with reliable access to basic services in a safe environment (Plan Senegal, 2012). To achieve this goal Plan Senegal has developed four country programmes, namely:

- Quality Learning for children and youth
- Child Protection
- A safe and healthy environment for children and youth
- Social and economic leadership for youth and women

Despite having no programmes directed solely at helping children with disabilities, they are referenced, as a group, twice during the Country Strategic Plan. First, Plan Senegal discusses future plans to 'seek new partnership to work with specific population groups that require expertise such as children with disabilities.' Second, children with disabilities have also been identified as a vulnerable group and within the social and economic leadership for youth and women programme, Plan Senegal aims to: 'promote the social and economic empowerment for youth, including the most vulnerable and women.' It must be noted that within the Monitoring, Evaluation and Research section of the Country Strategic Plan, the need to address discrimination against vulnerable groups is included, but no specific issues are identified in relation to children with disabilities.

In Senegal, the 2012 dataset included 32,738 sponsored children, ranging in age from 0-17. The average age was 9.1 (standard deviation=4.2), and 36% were male. Among the children, 155 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.5% (95% confidence interval 0.4 – 0.5 %). The prevalence of disability was slightly higher in males (0.7 %, 95% CI 0.6 – 0.9%) than in females (0.3 %, 95% CI 0.3 – 0.4 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.9, 95% CI 1.3 – 2.6%).

As can be seen in Table 90, the most common types of impairment were physical and communication, while vision and learning impairments were less common.

Table 90: Type of impairment by gender in Senegal

	MALES	FEMALES
Learning	5 (6%)	5 (7%)
Physical	18 (22%)	24 (33%)
Communication	42 (51%)	27 (38%)
Vision	12 (14%)	15 (21%)
Hearing	6 (7%)	1 (1%)
Total	83 (100%)	72 (100%)

Education and disability

As illustrated in Table 91, children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. Boys with disabilities were 6.6 times less likely to attend school and girls with disabilities were 3.7 times less likely to attend school. Unfortunately, the sample size was too small to determine if the children with disabilities were more or less likely to be at a lower school level compared to children without disability, after accounting for age differences. Increased time taken to school may have been related to increased disability, although again the sample size was insufficient. In addition, children with a disability were less likely to be attending non-formal education than those with a disability for both boys and girls.

Table 91: Educational variables in relation to disability in Senegal

	MALES			**FEMALES**		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	19 (23%)	6990 (60%)	Baseline	23 (32%)	11083 (53%)	Baseline
- No	64 (77%)	4624 (40%)	6.4 (3.8 - 10.8)	49 (68%)	9886 (47%)	3.2 (1.9 - 5.3)
Age 5+: Attend formal education						
- Yes	19 (23%)	6878 (64%)	Baseline	22 (33%)	10670 (64%)	Baseline
- No	64 (77%)	3889 (36%)	6.6 (4.0 - 11.1)	44 (67%)	6086 (36%)	3.7 (2.2 - 6.1)
Of those at school, school level						
- Secondary/University/College	4 (21%)	1383 (20%)	Baseline	3 (13%)	1809 (16%)	Baseline
- Primary	15 (79%)	5359 (77%)	1.5 (0.4 - 5.7)	17 (74%)	8538 (77%)	1.1 (0.3 - 5.0)
- Nursery/pre-school	0 (0%)	248 (4%)	-	3 (13%)	736 (7%)	2.1 (0.2 - 23.4)
Time taken to school						
- <30 minutes	16 (84%)	6157 (88%)	Baseline	18 (78%)	9770 (88%)	Baseline
- 30 minutes-1 hour	2 (11%)	752 (11%)	0.9 (0.2 - 3.9)	4 (17%)	1221 (11%)	2.0 (0.7 - 6.1)
- >1 hour	1 (5%)	81 (1%)	3.7 (0.5 - 29.7)	1 (4%)	92 (1%)	7.5 (0.9 -

						59.1)
Attending non formal education						
- No	68 (82%)	6511 (56%)	Baseline	61 (85%)	13375 (64%)	Baseline
- Yes	15 (18%)	5103 (44%)	0.3 (0.2 – 0.5)	11 (15%)	7594 (36%)	0.3 (0.2 – 0.6)

Considering the data by type of impairment, communication and hearing impairment had the greatest effect on school attendance, followed by physical and vision impairment, as can be seen in Table 92. There were insufficient numbers of those with learning impairment in the sample to assess the effect of this impairment, but of note was that this was due to the fact that none of the 19 children with a hearing impairment attended formal education. This overall pattern was also apparent within boys and girls, although for boys hearing impairment had a strong effect on attendance, while for girls there was insufficient data to analyse the effect of this impairment. The difference in school attendance was smaller comparing children with physical and vision impairment compared to those with no disability. Significantly, no child with a learning disability attended school.

Table 92: Attendance of formal education by impairment type in Senegal

	All ages		**Age 5+**				
	Attend formal education	**Males: attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	18073 (55%)	14510 (45%)	17548 (64%)	9975 (36%)	Baseline	Baseline	Baseline
Learning	0 (0%)	10 (100%)	0 (0%)	9 (100%)	-	-	-
Physical	15 (36%)	27 (64%)	15 (38%)	25 (63%)	2.5 (1.0 - 6.3)	4.0 (1.6 - 10.0)	3.2 (1.7 - 6.1)
Communication	10 (14%)	59 (86%)	10 (15%)	57 (85%)	14.7 (5.7 - 37.7)	7.4 (2.7 - 20.1)	11.1 (5.6 - 21.9)
Vision	15 (56%)	12 (44%)	14 (54%)	12 (46%)	3.3 (1.0 - 10.5)	1.1 (0.4 - 3.4)	1.8 (0.8 - 4.0)
Hearing	2 (29%)	5 (71%)	2 (29%)	5 (71%)	12.9 (1.5 - 112.1)	-	6.5 (1.2 - 34.0)

Having an impairment or illness were cited as the major reason for not attending formal education among children with disabilities (82%) while being too young was the most common reason among children without disability (53%), as shown in Table 93 .

Table 93: Reason for not attending formal education by disability status in Senegal

	Disabled	Not disabled
Too young	15 (13%)	7656 (53%)
Parents apparent lack of interest	0 (0%)	3 (0%)
Is attending a non-formal edu program	0 (0%)	3 (0%)
Too old	6 (5%)	1396 (10%)
Did not pass secondary school exam	0 (0%)	13 (0%)
Economic problems	0 (0%)	192 (1%)
Lessons were repetitive	0 (0%)	1 (0%)
Closest school too far	0 (0%)	231 (2%)
Girls education not considered important	0 (0%)	2 (0%)
Has been ill	39 (35%)	18 (0%)
Lack of interest in school attendance	0 (0%)	0 (0%)
Is married	0 (0%)	14 (0%)
Needed to help family	0 (0%)	689 (5%)
Has an impairment	47 (42%)	4 (0%)
Is working outside family	0 (0%)	24 (0%)
Was expelled for class repetition	1 (1%)	350 (2%)
Primary not considered important by family	4 (4%)	3755 (26%)
Secondary not considered important by family	1 (1%)	56 (0%)
Expelled	0 (0%)	31 (0%)
Do not have required document	0 (0%)	45 (0%)
Plays truant	0 (0%)	28 (0%)

Health and disability

As seen in Table 94, children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with physical and vision impairment. Boys with disabilities were 7.0 times more likely to have had a serious illness in the last twelve months and girls were 10.4 times more likely. The most common types of illness among the children with disabilities were mental health problems, eye problems, ear infections, accidents and epilepsy. There was insufficient data on malnutrition to assess whether this was more common in those with disabilities than those without. Not seeking treatment was very strongly related to disability, particularly amongst boys. Among those who had not sought treatment, the most commonly cited reason was 'advised treatment unnecessary'. Hospital was the most commonly cited place where treatment was sought by children with a disability, while those without a disability predominantly sought treatment from health clinics. There was a suggestion that illness preventing school was more likely amongst those who were disabled, although the analysis lacked power. Time taken to the nearest health facility did seem to be related to increased disability, particularly in girls.

Table 94: Association between health and health seeking behaviour and disability in Senegal

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	69 (83%)	11291 (97%)	Baseline	57 (79%)	20437 (97%)	Baseline
- Yes	14 (17%)	323 (3%)	7.0 (3.9 - 12.6)	15 (21%)	532 (3%)	10.4 (5.8 - 18.4)
Malnutrition						
- No	83 (100%)	11612 (99.98%)	Baseline	72 (100%)	20958 (99.95%)	Baseline
- Yes	0 (0%)	2 (0.02%)	-	0 (0%)	11 (0.05%)	-
Where sought treatment						
- Other	1 (7%)	94 (29%)	Baseline	1 (7%)	133 (25%)	Baseline
- Hospital	9 (64%)	76 (24%)	10.7 (1.3 - 86.4)	12 (80%)	96 (18%)	17.4 (2.2 - 136.9)
- Health clinic	0 (0%)	135 (42%)	-	1 (7%)	257 (48%)	0.6 (0.0 - 9.0)
- Private	0 (0%)	10 (3%)	-	0 (0%)	25 (5%)	-

- Did not seek	4 (29%)	8 (2%)	36.9 (3.6 - 380.7)	1 (7%)	21 (4%)	5.9 (0.4 - 98.3)
Illness prevent school						
- No	2 (33%)	186 (71%)	Baseline	5 (63%)	315 (77%)	Baseline
- Yes	4 (67%)	77 (29%)	4.1 (0.7 - 23.1)	3 (38%)	95 (23%)	1.6 (0.4 - 7.1)
Time taken to nearest health facility						
- <30 minutes	44 (53%)	6576 (57%)	Baseline	40 (56%)	11896 (57%)	Baseline
- 30 minutes-1 hour	26 (31%)	4055 (35%)	0.9 (0.6 - 1.5)	26 (36%)	7555 (36%)	1.0 (0.6 - 1.7)
- 1 – 2 hours	13 (16%)	917 (8%)	2.0 (1.1 - 3.7)	4 (6%)	1397 (7%)	0.8 (0.3 - 2.3)
- >2 hours	0 (0%)	66 (1%)	-	2 (3%)	121 (1%)	4.6 (1.1 - 19.4)
Slept under bednet last night						
- No malaria in area	0 (0%)	34 (0%)	Baseline	0 (0%)	74 (0%)	Baseline
- Yes	68 (83%)	8900 (77%)	-	61 (85%)	16325 (79%)	-
- No	14 (17%)	2566 (22%)	-	11 (15%)	4289 (21%)	-

Other findings

Overall, the children with disabilities were slightly older than those without disability, particularly for boys and the relationship between disability and indicators of inclusion/exclusion were generally similar between boys and girls. The poverty variables were not associated with disabilities, nor were the hygiene and sanitation measures

5.15 Sudan

The population of Sudan (excluding South Sudan) is 34,853,178 of which 41% of the population is between the ages of 0 and 14 years (World Bank Population Data, 2013). Sudan is classified as a country with low human development, ranked 171 out of 186, according to the UNDP Human Development Index 2013 report (UNDP International Human Development Indicators, 2013). Sudan signed the UN Convention on the Rights of Persons with Disabilities in 2007 and ratified it in 2009 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan Sudan developed a Country Strategic Plan for the period 2007 to 2016 (Plan Sudan, 2007). However in 2008, the country programmes were revised and now cover the period 2009 to 2013.

Plan Sudan's overall goal is for all children to enjoy their rights and realise their full potential in a safe and protective environment. This goal is supported through 4 country programmes:

- Quality Education
- Working Together for Children's Health
- Pleasing Environment for Children
- Economic Security

Plan Sudan has not prioritised children with disabilities in its programming work, but discussions on the drafting of an new Country Strategic Plan are underway.

In Sudan, the 2012 dataset included 27,225 sponsored children, ranging in age from 0-17. The average age was 9.8 (standard deviation=4.0), and 37% were male. Among the children, 131 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.5% (95% confidence interval 0.4-0.6 %). The prevalence of disability was higher in males (0.7%, 95% CI 0.5-0.8 %) than in females (0.4%, 95% CI 0.3-0.5%). After adjustment for age, males had significantly higher odds of disability compared to females (1.6, 95% CI 1.1-2.2).

As shown in Table 95, the most common type of impairment was physical, while learning and hearing impairments were least common.

Table 95: Type of impairment by gender in Sudan

	MALES	FEMALES
Learning	4 (6%)	4 (6%)
Physical	30 (43%)	20 (32%)
Communication	18 (26%)	14 (23%)
Vision	14 (20%)	14 (23%)
Hearing	3 (4%)	10 (16%)
Total	69 (100%)	62 (100%)

Education and disability

As illustrated in Table 96, children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. Boys with disabilities were 20.7 times less likely to attend school and girls with disabilities were 14.1 times less likely to attend school. Boys with disabilities were more likely to be at a lower school level compared to children without disability, after accounting for age differences, but there were not enough girls with disabilities at school to be able to detect this relationship. Increased time taken to school was not related to increased disability and very few children attended non formal education.

Table 96: Educational variables in relation to disability in Sudan

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	38 (55%)	8741 (87%)	Baseline	32 (52%)	13957 (82%)	Baseline
- No	31 (45%)	1359 (13%)	19.8 (11.6 - 33.5)	30 (48%)	3037 (18%)	13.0 (7.7 - 21.9)
Age 5+: Attend formal education						
- Yes	38 (56%)	8614 (92%)	Baseline	32 (53%)	13624 (91%)	Baseline
- No	30 (44%)	718 (8%)	20.7 (12.3 - 34.9)	28 (47%)	1376 (9%)	14.1 (8.4 - 23.7)
Of those at school, school level						
- Secondary/University/College	3 (8%)	702 (8%)	Baseline	3 (9%)	789 (6%)	Baseline

- Primary	33 (87%)	7476 (86%)	2.5 (0.7 - 8.5)	29 (91%)	11838 (85%)	1.4 (0.4 - 5.0)
- Nursery/pre-school	2 (5%)	563 (6%)	8.3 (1.0 - 70.4)	0 (0%)	1330 (10%)	-
Time taken to school						
- <30 minutes	37 (97%)	8375 (96%)	Baseline	31 (97%)	13520 (97%)	Baseline
- 30 minutes-1 hour	1 (3%)	337 (4%)	0.5 (0.1 - 4.0)	1 (3%)	389 (3%)	0.9 (0.1 - 6.7)
- >1 hour	0 (0%)	30 (0.3%)	-	0 (0%)	49 (0.4%)	-
Attending non formal education						
- No	69 (100%)	9917 (98%)	Baseline	61 (98%)	16744 (99%)	Baseline
- Yes	0 (0%)	183 (2%)	-	1 (2%)	250 (1%)	0.8 (0.1 - 6.1)

Considering the data by type of impairment, children with vision impairment were most likely to attend school, while school attendance was low in the other impairment groups, as shown in Table 97. These patterns were similar between boys and girls, given the small numbers available.

Table 97: Attendance of formal education by impairment type in Sudan

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	22798 (84%)	4396 (16%)	22238 (91%)	2094 (9%)	Baseline	Baseline	Baseline
Learning	3 (38%)	5 (63%)	3 (38%)	5 (63%)	232.2 (18.6 - 2902.1)	13.7 (1.5 - 126.9)	48.6 (9.3 - 253.5)
Physical	21 (42%)	29 (58%)	21 (44%)	27 (56%)	96.0 (38.8 - 237.6)	61.4 (21.8 - 172.8)	68.0 (34.9 - 132.3)
Communication	16 (50%)	16 (50%)	16 (50%)	16 (50%)	37.8 (11.6 - 122.9)	101.4 (30.4 - 338.5)	54.0 (24.1 - 120.9)
Vision	24 (86%)	4 (14%)	24 (89%)	3 (11%)	4.2 (0.7 - 26.9)	1.4 (0.2 - 11.9)	2.5 (0.7 - 9.3)

Hearing	6 (46%)	7 (54%)	6 (46%)	7 (54%)	173.0 (10.5 - 2852.5)	23.4 (5.4 - 101.1)	36.8 (9.5 - 141.9)

As seen in Table, 98 and in line with the overall findings, having an impairment or illness was cited as the major reason for not attending formal education among children with disabilities (84%) while being too young was the most common reason among children without disability (90%).

Table 98: Reason for not attending formal education by disability status in Sudan

	Disabled	Not disabled
Too young	6 (10%)	3954 (90%)
Too old	0 (0%)	44 (1%)
Did not pass secondary school exam	0 (0%)	1 (0%)
Economic problems	2 (3%)	173 (4%)
Closest school too far	0 (0%)	14 (0%)
Has been ill	10 (16%)	6 (0%)
Is married	0 (0%)	48 (1%)
Needed to help family	1 (2%)	10 (0%)
Has an impairment	42 (69%)	1 (0%)
Is working outside family	0 (0%)	1 (0%)
Was expelled for class repetition	0 (0%)	4 (0%)
Primary not considered important by family	0 (0%)	80 (2%)
Secondary not considered important by family	0 (0%)	20 (0%)
Expelled	0 (0%)	39 (1%)
Plays truant	0 (0%)	1 (0%)

Health and disability

As illustrated in Table 99, children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with hearing impairment. Boys with disabilities were 3.8 times

more likely to have had a serious illness in the last twelve months and girls were 10.4 times more likely. The most common type of illness among the children was malaria, both among the children with disabilities (50%) and those without (66%).None of the children with disabilities reported being ill due to malnutrition in the last twelve months. All the children with disabilities sought treatment when seriously ill and hospital was the most commonly cited place where treatment was sought. Furthermore, time taken to the nearest health facility was not related to disability.

Table 99: Association between health and health seeking behaviour and disability in Sudan

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	63 (91%)	9798 (97%)	Baseline	50 (81%)	16562 (97%)	Baseline
- Yes	6 (9%)	302 (3%)	3.8 (1.6 - 9.0)	12 (19%)	432 (3%)	10.4 (5.5 - 19.8)
Malnutrition						
- No	69 (100%)	10098 (99.98%)	Baseline	62 (100%)	16988 (99.96%)	Baseline
- Yes	0 (0%)	2 (0.02%)	-	0 (0%)	6 (0.04%)	-
Where sought treatment						
- Other	0 (0%)	14 (5%)	Baseline	1 (8%)	8 (2%)	Baseline
- Hospital	5 (83%)	197 (65%)	-	10 (83%)	282 (65%)	0.3 (0.0 - 2.5)
- Health clinic	1 (17%)	89 (29%)	-	1 (8%)	140 (32%)	0.1 (0.0 - 1.0)
- Private	0 (0%)	0 (0%)	-	0 (0%)	0 (0%)	-
- Did not seek	0 (0%)	2 (1%)	-	0 (0%)	2 (0.5%)	-
Illness prevent school						
- No	1 (25%)	69 (30%)	Baseline	4 (67%)	77 (27%)	Baseline
- Yes	3 (75%)	159 (70%)	1.1 (0.1 - 10.6)	2 (33%)	213 (73%)	0.2 (0.0 - 1.0)

Time taken to nearest health facility						
- <30 minutes	60 (87%)	8589 (85%)	Baseline	55 (89%)	15021 (88%)	Baseline
- 30 minutes-1 hour	5 (7%)	1194 (12%)	0.5 (0.2 - 1.4)	6 (10%)	1617 (10%)	0.8 (0.4 - 2.0)
- 1 – 2 hours	3 (4%)	282 (3%)	1.3 (0.4 - 4.1)	1 (2%)	329 (2%)	0.6 (0.1 - 4.6)
- >2 hours	1 (1%)	36 (0%)	4.2 (0.6 - 31.5)	0 (0%)	28 (0.2%)	-
Slept under bednet last night						
- No malaria in area	0 (0%)	42 (1%)	Baseline	1 (3%)	69 (1%)	Baseline
- Yes	26 (58%)	2933 (42%)	-	18 (46%)	4961 (43%)	0.2 (0.0 - 1.8)
- No	19 (42%)	4024 (57%)	-	20 (51%)	6593 (57%)	0.2 (0.0 - 1.4)

Other findings

Overall, the children with disabilities were older than the children without disability, among both girls and boys and the relationship between disability and indicators of inclusion/exclusion were similar between boys and girls. The type of area that the children lived was not related to having a disability. Finally, the poverty variables showed no relationship with disabilities, nor did the sanitation and hygiene variables.

5.16 Tanzania

The population of Tanzania is 43,639,752 of which 49% of the population is between the ages of 0 and 14 years (World Bank Population Data, 2013). Tanzania is classified as a country with low human development, ranked 152 out of 186, according to the UNDP Human Development Index 2013 (UNDP International Human Development Indicators, 2013). Tanzania has not signed or

ratified the UN Convention on the Rights of Persons with Disabilities (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status).

The Tanzania government has consolidated its obligations under the UNCRC into a National Plan of Action (NPA), which has subsequently been integrated into the National Strategy for Growth and Reduction of Poverty (MKUKUTA) in 2005 (Plan Tanzania, 2011). Specific to children, a comprehensive Child Law was enacted and came into effect in 2009. This law has domesticated the provisions of the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child and gives a legal enjoyment of rights to all children.

Plan works in seven districts in Tanzania: namely, Illala district in Dar es Salaam city, Kibaha and Kisarawe districts in Coastal Region, Nyamagana, Ilemela in Mwanza Region and Kilombelo (Ifakara) in Morogoro Region.

In drafting the Country Strategic Plan for Tanzania, a comprehensive situation analysis was undertaken which highlighted one issue issue relating to children with disabilities. The right of children to be heard and to participate in political and social processes is recognized in the Constitution of Tanzania and their participation has increased after the initiation of the MKUKUTA, but in practice the recommendations and decisions made by the youth platforms are neither known nor incorporated by duty bearers into policy formulation, planning or budgeting at national and local levels. This is particularly the case for children having various forms of disabilities or circumstances that are negatively perceived like AIDS orphan, street child, albino, children from poor background.

The overall goal of the Country Strategic Plan that is children and youths are empowered, respected and are responsible. In order to achieve this goal, Plan has developed five country programmes:

- Safe Environment for Children and Youth
- Fair Start in Early Childhood, Care and Development (ECCD)
- Healthy Life
- Children and Youth Voice
- Household Economic Security

However, disability only features under the ECCD country programme. In this respect there are two specific focuses. First, at the family and community level, Plan will focus on the role of ECCD centres in creating life-long learning interest and in the early identification of and attention to children with disabilities. Second, in relation to capacity building Plan will target ECCD and pre-primary education care-takers to strengthen their skills on best practices, early identification of children disability and their capacity to provide necessary support.

In Tanzania, the 2012 dataset included 24,303 sponsored children, ranging in age from 0-17. The average age was 9.8 (standard deviation=3.9), and 41% were male. Among the children, 105 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.4% (95% confidence interval 0.3-0.5%). The prevalence of disability was slightly higher in males (0.5%, 95% CI 0.4-0.6%) than in females (0.4 %, 95% CI 0.3-0.5%). After adjustment for age, males had slightly higher odds of disability compared to females (1.2, 95% CI 0.8-1.7).

As seen in Table 100, the most common type of impairment is physical, while learning impairments are very uncommon.

Table 100: Type of impairment by gender in Tanzania

	MALES	FEMALES
Learning	1 (2%)	2 (4%)
Physical	28 (57%)	32 (57%)
Communication	11 (22%)	8 (14%)
Vision	5 (10%)	6 (11%)
Hearing	4 (8%)	8 (14%)
Total	49 (100%)	56 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age, as illustrated in Table 101. Boys with disabilities were 3.9 times less likely to attend school and girls with disabilities were 5.5 times less likely to attend school. The numbers were too small to be able to assess the relationship between disability and school level. Increased time taken to school was not related to increased disability, and none of the children with disabilities attended non formal education.

Table 101: Educational variables in relation to disability in Tanzania

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	37 (76%)	8777 (88%)	Baseline	39 (70%)	12321 (86%)	Baseline
- No	12 (24%)	1167 (12%)	3.1 (1.6 - 6.2)	17 (30%)	1933 (14%)	4.3 (2.4 - 7.7)
Age 5+: Attend formal education						
- Yes	37 (77%)	8499 (93%)	Baseline	39 (71%)	11842 (92%)	Baseline
- No	11 (23%)	689 (8%)	3.9 (2.0 - 7.7)	16 (29%)	978 (8%)	5.5 (3.1 - 9.9)
Of those at school, school level						
- Secondary/University/ College	1 (3%)	770 (9%)	Baseline	3 (8%)	877 (7%)	Baseline
- Primary	33 (89%)	6752 (77%)	4.5 (0.6 - 35.3)	32 (82%)	9216 (75%)	1.8 (0.5 - 6.6)
- Nursery/pre-school	3 (8%)	1255 (14%)	2.8 (0.2 - 34.4)	4 (10%)	2228 (18%)	1.7 (0.3 - 11.1)
Time taken to school						
- <30 minutes	25 (68%)	4612 (53%)	Baseline	25 (64%)	6627 (54%)	Baseline
- 30 minutes-1 hour	12 (32%)	3854 (44%)	0.6 (0.3 - 1.1)	13 (33%)	5253 (43%)	0.6 (0.3 - 1.2)
- >1 hour	0 (0%)	311 (4%)	-	1 (3%)	441 (4%)	0.5 (0.1 - 3.5)
Attending non formal						

education						
- No	49 (100%)	9855 (99%)	Baseline	56 (100%)	14163 (99%)	Baseline
- Yes	0 (0%)	89 (1%)	-	0 (0%)	91 (1%)	-

As seen in Table 102, considering the data by type of impairment, learning impairment had the greatest effect on school attendance, although the numbers were very small. This was followed by communication and hearing impairments.

Table 102: Attendance of formal education by impairment type in Tanzania

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	21098 (87%)	3100 (13%)	20341 (92%)	1667 (8%)	Baseline	Baseline	Baseline
Learning	1 (33%)	2 (67%)	1 (33%)	2 (67%)	-	20.2 (1.1 - 362.1)	48.0 (4.1 – 561.6)
Physical	46 (77%)	14 (23%)	46 (79%)	12 (21%)	2.9 (1.1 - 7.9)	4.3 (1.8 - 10.3)	3.6 (1.9 - 6.9)
Communication	12 (63%)	7 (37%)	12 (63%)	7 (37%)	7.1 (2.0 - 25.4)	8.1 (1.8 - 35.4)	7.5 (2.9 - 19.8)
Vision	9 (82%)	2 (18%)	9 (82%)	2 (18%)	-	4.9 (0.9 - 28.1)	2.4 (0.5 - 11.5)
Hearing	8 (67%)	4 (33%)	8 (67%)	4 (33%)	6.4 (0.6 – 63.2)	10.3 (2.3 - 45.8)	8.9 (2.6 - 30.5)

In line with the overall findings, and as shown in Table 103, being ill/impaired was cited as the major reason for not attending formal education among children with disabilities (54%) while being too young was the most common reason among children without disability (84%).

Table 103: Reason for not attending formal education by disability status in Tanzania

	Disabled	**Not disabled**
Too young	9 (31%)	2608 (84%)
Too old	2 (7%)	132 (4%)

	Disabled	Not disabled
Economic problems	0 (0%)	33 (1%)
Closest school too far	0 (0%)	6 (0%)
Has been ill	7 (24%)	5 (0%)
Is married	0 (0%)	6 (0%)
Needed to help family	0 (0%)	11 (0%)
Has an impairment	9 (31%)	0 (0%)
Is working outside family	0 (0%)	2 (0%)
Was expelled for class repetition	0 (0%)	5 (0%)
Primary not considered important by family	0 (0%)	3 (0%)
Secondary not considered important by family	2 (7%)	229 (7%)
Expelled	0 (0%)	2 (0%)
Fears violence at school	0 (0%)	1 (0%)
Do not have required document	0 (0%)	3 (0%)
Plays truant	0 (0%)	5 (0%)

Health and disability

As illustrated in Table 104, children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with learning and hearing impairment. Boys with disabilities were 6.9 times more likely to have had a serious illness in the last twelve months and girls were 4.7 times more likely. The most common types of illness among the children with disabilities was malaria (53%). There was insufficient data on malnutrition to assess whether this was more common in those with disabilities than those without. Almost all children sought treatment when seriously ill and a hospital was the most commonly cited place where treatment was sought. However, location of treatment was not related to disability, nor was distance to health facility or sleeping under a bednet.

Table 104: Association between health and health seeking behaviour and disability in Tanzania

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR

Serious illness						
- No	41 (84%)	9671 (97%)	Baseline	49 (88%)	13857 (97%)	Baseline
- Yes	8 (16%)	273 (3%)	6.9 (3.2 - 14.8)	7 (13%)	397 (3%)	4.7 (2.1 - 10.6)
Malnutrition						
- No	49 (100%)	9943 (100%)	Baseline	56 (100%)	14253 (100%)	Baseline
- Yes	0 (0%)	1 (0%)	-	0 (0%)	1 (0%)	-
Where sought treatment						
- Other	0 (0%)	46 (17%)	Baseline	2 (29%)	62 (16%)	Baseline
- Hospital	6 (75%)	144 (53%)	-	5 (71%)	224 (56%)	0.7 (0.1 - 3.7)
- Health clinic	1 (13%)	76 (28%)	-	0 (0%)	105 (26%)	-
- Private	0 (0%)	7 (3%)	-	0 (0%)	6 (2%)	-
- Did not seek	1 (13%)	0 (0%)	-	0 (0%)	0 (0%)	-
Illness prevent school						
- No	6 (75%)	91 (36%)	Baseline	4 (57%)	182 (50%)	Baseline
- Yes	2 (25%)	161 (64%)	0.2 (0.04 - 1.0)	3 (43%)	183 (50%)	0.8 (0.2 - 3.9)
Time taken to nearest health facility						
- <30 minutes	24 (49%)	3231 (32%)	Baseline	24 (43%)	4465 (31%)	Baseline
- 30 minutes-1 hour	12 (24%)	4445 (45%)	0.4 (0.2 - 0.7)	23 (41%)	6731 (47%)	0.6 (0.4 - 1.1)
- 1 – 2 hours	12 (24%)	1816 (18%)	0.9 (0.4 - 1.7)	5 (9%)	2451 (17%)	0.3 (0.1 - 0.9)
- >2 hours	1 (2%)	452 (5%)	0.3 (0.0 - 2.2)	4 (7%)	607 (4%)	1.1 (0.4 - 3.3)
Slept under bednet last night						
- No malaria in area	2 (4%)	43 (0%)	Baseline	2 (4%)	74 (1%)	Baseline
- Yes	43 (93%)	8948 (97%)	0.1 (0.02 - 0.4)	47 (96%)	129881 (98%)	0.1 (0.03 - 0.6)
- No	1 (2%)	199 (2%)	0.1 (0.01 - 1.3)	0 (0%)	221 (2%)	-

Other Findings

Overall, the girls with disabilities were older than the girls without disabilities, but this pattern was not apparent among the boys and the relationship between disability and indicators of inclusion/exclusion was very similar between boys and girls. The poverty variables were not related to disability, nor were hygiene and sanitation variables.

5.17 Uganda

The population of Uganda is 32,864,273 of which 49% of the population is between the ages of 0 and 14 years (World Bank Population Data, 2013). Uganda is classified as a country with low human development, ranked 161 out of 186, according to the UNDP Human Development Index 2013 report (UNDP International Human Development Indicators, 2013). Uganda signed the UN Convention on the Rights of Persons with Disabilities in 2007 and ratified it in 2008 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan Uganda presently works in five districts, namely Kampala, Kamuli, Lira, Luwero, Tororo. While Kampala is an urban area, the other four locations are predominantly rural and cover areas of eastern, north-central and central regions of the country. In the coming years, Plan will initiate a gradual phase-out of Luwero District, which is where Plan first began its operations in 1992. In the other four districts, the existing programme areas will be extended into neighbouring locations. The child sponsorship caseload from the Luwero programme area will progressively be relocated to Lira District, which has had no child sponsorship to date.

In developing the Country Strategic Plan for 2010 to 2015 (Plan Uganda, 2010), Plan Uganda undertook a situation analysis in which it was estimated that some 50% of children in Uganda are vulnerable and living in difficult circumstances. Some categories of these children are more vulnerable than others, including orphans (well over two million in total, of which over one million orphaned by AIDS) and children with disabilities (over one million). In addition the analysis noted that less than 20% of children with disabilities attend primary school. One reason is continued stigmatisation of disability, but also the failure of schools to provide an educational environment hospitable to children with disabilities.

Plan Uganda's country programme goal for the period 2010 – 2015 is: the rights of children in Uganda to survival, protection, development, and participation are better respected, protected, and fulfilled. To fulfil this goal a strategic framework embodying a life cycle approach to programming has been adopted encompassing three country programmes:

- A Good Start in Life: Early Childhood (under 6 years)
- The Next Steps: Primary School Years (6-12 years)
- Ready for the Future – Now: Adolescence (13 – 24 years)

Working with children with disabilities features across all three country programmes. One of the early childhood programme areas of focus is improved access by orphans and vulnerable children, including those with disabilities, to special needs care and support. The next steps country programme, focusing on the primary school years makes mention of children with disabilities in that the programme seeks to ensure that children's rights are respected, protected, and fulfilled at home, in primary schools, and in the community, thereby ensuring that children, including those with disabilities or otherwise vulnerable, are safe from all forms of neglect and abuse and have improved access to essential social services. In addition, there is a focus on Improved access to quality primary school or training (formal or non-formal) by children with special needs / disabilities. Finally, one of the focussed interventions of the adolescence country programme is increased access by adolescents with special needs, vulnerabilities and/or disabilities to appropriate care and health services

In Uganda, the 2012 dataset included 35,466 sponsored children, ranging in age from 0-17. The average age was 9.6 (standard deviation=4.1), and 39% were male. Among the children, 268 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.8% (95% confidence interval 0.7-0.8 %). The prevalence of disability was slightly higher in males (0.8%, 95% CI 0.7-1.0 %) than in females (0.7%, 95% CI 0.6-0.8%). After adjustment for age, males had slightly higher odds of disability compared to females (1.2, 95% CI 0.9-1.5).

As seen in Table 105, the most common types of impairment were physical, communication and hearing. Reports of learning impairments were very rare.

Table 105: Type of impairment by gender by Uganda

	MALES	FEMALES
Learning	3 (3%)	1 (1%)
Physical	39 (33%)	58 (38%)
Communication	29 (25%)	40 (26%)
Vision	14 (12%)	26 (17%)
Hearing	32 (27%)	26 (17%)
Total	117 (100%)	151 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age, as illustrated in Table 106. Boys with disabilities were 18.8 times less likely to attend school and girls with disabilities were 10.2 times less likely to attend school. Children with disabilities were somewhat more likely to be at a lower school level compared to children without disability, after accounting for age differences, although the numbers were small. There was no relationship between disability and time taken to school. None of the disabled children attended non formal education.

Table 106: Educational variables in relation to disability by Uganda

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	72 (62%)	12410 (90%)	Baseline	90 (60%)	17877 (83%)	Baseline
- No	45 (38%)	1335 (10%)	12.2 (7.7 - 19.3)	61 (40%)	3576 (17%)	7.0 (4.8 - 10.4)
Age 5+: Attend formal education						
- Yes	69 (66%)	12177 (97%)	Baseline	90 (67%)	17104 (95%)	Baseline
- No	36 (34%)	411 (3%)	18.8 (12.1 - 29.1)	45 (33%)	963 (5%)	10.2 (7.0 - 14.9)
Of those at school, school level						
- Secondary/University/College	3 (4%)	782 (6%)	Baseline	0 (0%)	1089 (6%)	Baseline
- Primary	62 (86%)	10884 (88%)	2.0 (0.6 - 6.6)	84 (93%)	14925 (83%)	-
- Nursery/pre-school	7 (10%)	744 (6%)	4.7 (1.0 - 22.8)	6 (7%)	1863 (10%)	-
Time taken to school						
- <30 minutes	17 (24%)	2818 (23%)	Baseline	21 (23%)	4239 (24%)	Baseline

- 30 minutes-1 hour	46 (64%)	8418 (68%)	0.9 (0.5 - 1.6)	54 (60%)	11971 (67%)	0.9 (0.5 - 1.5)
- >1 hour	9 (13%)	1174 (9%)	1.3 (0.6 - 2.9)	15 (17%)	1667 (9%)	1.8 (0.9 - 3.5)
Attending non formal education						
- No	117 (100%)	13733 (99.9%)	Baseline	151 (100%)	21434 (99.9%)	Baseline
- Yes	0 (0%)	12 (0.1%)	-	0 (0%)	19 (0.1%)	-

As seen in Table 107, considering the data by type of impairment, learning and communication impairment had the greatest effect on school attendance, followed by physical impairment. The difference in school attendance was smaller comparing children with vision and hearing impairment compared to those with no disability.

Table 107: Attendance of formal education by impairment type by Uganda

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age adjusted OR**
No disability	30287 (86%)	4911 (14%)	29281 (96%)	1374 (5%)	Baseline	Baseline	Baseline
Learning	2 (50%)	2 (50%)	2 (50%)	2 (50%)	14 .7 (0.98 – 219.8)	-	51.9 (4.4-606.1)
Physical	55 (57%)	42 (43%)	53 (62%)	33 (38%)	31.3 (13.8 – 70.9)	12.7 (6.8 – 23.7)	17.6 (10.8-28.8)
Communication	33 (48%)	36 (52%)	32 (50%)	32 (50%)	41.7 (18.1 – 95.9)	32.6 (16.0 – 66.4)	35.4 (20.6-60.7)
Vision	27 (68%)	13 (32%)	27 (87%)	4 (13%)	44.8 (11.4 – 176.6)	-	3.9 (1.3-11.9)
Hearing	45 (78%)	13 (22%)	45 (82%)	10 (18%)	4.24 (1.3 – 13.3)	5.7 (2.2 – 15.3)	4.8 (2.3-10.1)

In line with the overall findings, and as seen in Table 108, having an impairment was cited as the major reason for not attending formal education among children with disabilities (62%) while being too young was the most common reason for not attending school among children without a disability (94%).

Table 108: Reason for not attending formal education by disability status by Uganda

	Disabled	Not disabled
Too young	31 (29%)	4617 (94%)
Too old	0 (0%)	23 (0%)
Economic problems	0 (0%)	94 (2%)
Closest school too far	1 (1%)	9 (0%)
Has been ill	7 (7%)	13 (0%)
Is married	0 (0%)	97 (2%)
Needed to help family	0 (0%)	11 (0%)
Has an impairment	66 (62%)	5 (0%)
Is working outside family	0 (0%)	4 (0%)
Was expelled for class repetition	0 (0%)	19 (0%)
Primary not considered important by family	0 (0%)	2 (0%)
Secondary not considered important by family	0 (0%)	1 (0%)
Expelled	1 (1%)	9 (0%)
Fears violence on way to school	0 (0%)	1 (0%)
Do not have required document	0 (0%)	1 (0%)
Plays truant	0 (0%)	6 (0%)

Health and disability

Children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with learning impairment, which can be seen in Table 109. Boys with disabilities were 3.6 times more likely to have had a serious illness in the last twelve months and girls were 3.4 times more likely. The most common types of illness among the children with disabilities was malaria (68%). There was insufficient data on malnutrition to assess whether this was more common in those with disabilities than those without. The vast majority of children sought treatment when ill.

Health clinics were the most commonly cited places where treatment was sought, but place of treatment was not related to disability. In addition, time taken to the nearest health facility was weakly related to disability and there was no relationship between bednet access/use and disability.

Table 109: Association between health and health seeking behaviour and disability by Uganda

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	72 (62%)	11282 (82%)	Baseline	94 (62%)	17424 (81%)	Baseline
- Yes	45 (38%)	2463 (18%)	3.6 (2.3 - 5.5)	57 (38%)	4029 (19%)	3.4 (2.4 - 5.0)
Malnutrition						
- No	116 (99%)	13739 (99.96%)	Baseline	151 (100%)	21446 (99.97%)	Baseline
- Yes	1 (1%)	6 (0.04%)	19.3 (2.3 - 162.1)	0 (0%)	7 (0.03%)	-
Where sought treatment						
- Other	4 (9%)	300 (12%)	Baseline	7 (12%)	392 (10%)	Baseline
- Hospital	15 (33%)	593 (24%)	1.7 (0.6 - 5.2)	16 (28%)	955 (24%)	0.9 (0.4 - 2.1)
- Health clinic	25 (56%)	1557 (63%)	1.4 (0.5 - 4.0)	33 (58%)	2651 (66%)	0.8 (0.3 - 1.8)
- Private	1 (2%)	10 (0.4%)	6.1 (0.6 - 60.9)	0 (0%)	28 (1%)	-
- Did not seek	0 (0%)	3 (0.1%)	-	1 (2%)	3 (0.1%)	23.0 (2.1 - 252.7)
Illness prevent school						
- No	18 (67%)	1011 (68%)	Baseline	16 (64%)	1502 (68%)	Baseline
- Yes	9 (33%)	466 (32%)	1.0 (0.4 - 2.3)	9 (36%)	715 (32%)	1.0 (0.4 - 2.3)
Time taken to nearest health facility						
- <30 minutes	11 (9%)	1711 (12%)	Baseline	17 (11%)	2844 (13%)	Baseline

- 30 minutes-1 hour	70 (60%)	8476 (62%)	1.3 (0.7 - 2.4)	88 (58%)	13497 (63%)	1.1 (0.6 - 1.8)
- 1 – 2 hours	27 (23%)	2880 (21%)	1.5 (0.7 - 2.9)	35 (23%)	4075 (19%)	1.4 (0.8 - 2.6)
- >2 hours	9 (8%)	678 (5%)	2.0 (0.8 - 5.0)	11 (7%)	1037 (5%)	1.8 (0.9 - 3.9)
Slept under bednet last night						
- No malaria in area	1 (1%)	97 (1%)	Baseline	4 (3%)	115 (1%)	Baseline
- Yes	75 (71%)	8212 (68%)	0.9 (0.1 - 6.5)	74 (61%)	12729 (69%)	0.2 (0.1 - 0.5)
- No	29 (28%)	3812 (31%)	0.8 (0.1 - 5.7)	43 (36%)	5698 (31%)	0.2 (0.1 - 0.6)

Other findings

Overall, the children with disabilities were older than the children without disability and the relationship between disability and indicators of inclusion/exclusion was similar between boys and girls. The least poor children were less likely to have disabilities compared to those in the poorest group, particularly among the girls. Finally, there was little variation in sanitation variables among the children

5.18 Zambia

The population of Zambia is 14,075,099 with children aged between 0 and 14 years constituting 47% of the population (World Bank Population Data, 2013). Zambia is ranked 163 out of 186 countries according to the UNDP Human Development Index 2013 report (UNDP International Human Development Indicators, 2013). Zambia signed the UN Convention on Persons with Disabilities in 2008 and ratified it in 2010 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

In drafting the new Country Strategic Plan for Zambia, Plan undertook a comprehensive situation analysis (Plan Zambia, 2011). This indicated that since the signing and ratification of the United Nations Convention on the Rights of the Child (UNCRC) 20 years ago, the government has adopted several policies and programmes to promote the rights of children and full equality of women in reproductive health, legal and social protection issues. In addition, the Constitution encompasses a Bill of Rights that protects a number of

fundamental rights and freedoms of the individual. Furthermore, in 2005, Zambia began a legal reform exercise to harmonize child related legislation with a view to bring national laws in conformity with international conventions, norms and standards. This has encompassed a legislative audit, which has been completed, and a National Plan of Action for Children.
In the situation analysis, a number of broad issues were identified which require attention in the realisation of the rights of children to survival, health, protection and participation and education, among others. Accordingly Plan Zambia developed two country goals for the period 2011 – 2015:

- Zambian children, families and their communities have the skills, knowledge and opportunities to make meaningful choices over their own lives; and
- The human rights of children, as outlined by the UN, CRC and other relevant instruments, are recognised and claimed.

Given the plethora of issues identified in the situation analysis, Plan Zambia deemed it appropriate and expedient to concentrate on a limited number of key responses across three growth stages of children and young people. These are; 0-5 years, 6-14 years and 15-24 years and in each age cohort, one clear priority will be the primary focus area for the organisation's work over the next five years. The key responses / primary focus areas identified are:

- Heath
- Education
- Child Protection and participation
- Economic empowerment

Disability does not feature very predominantly in the Country Strategic Plan. In the situation analysis it is noted that child abuse and violence is endemic in Zambia and takes many forms including discrimination based on gender or disabilities. In addition, the analysis noted that many children in Zambia are deprived of opportunities to be heard, consulted with, or participate in forums where issues affecting them are decided. Children who are very young, poor, live in remote areas or are disabled, are less likely to be a 'participant' in school and unlikely to participate in other children's associations.

In response, to some of the issues identified in the situation analysis, the country programmes do make some mention of the inclusion of children with disabilities in their scope of action. So for instance, in relation to education Plan Zambia will make deliberate effort to

identify and design appropriate ways of engaging the marginalised children who include the out of school children, the disabled, and the sick. These will be identified through the community based groups and the community leaders. In addition,
In relation to economic empowerment the most disadvantaged and marginalised youth, particularly females and those who are disabled, will be targeted.

In Zambia, the 2012 dataset included 16,725 sponsored children, ranging in age from 0-17. The average age was 10.2 (standard deviation=3.8), and 47% were male. Among the children, 113 had 'an impairment/a medical condition that can lead to disability'. This gives a prevalence of disability of 0.7% (95% confidence interval 0.6-0.8%). The prevalence of disability was slightly higher in males (0.8 %, 95% CI 0.6-0.9 %) than in females (0.6 %, 95% CI 0.4-0.8 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.4, 95% CI 1.0 – 1.8).

As illustrated in Table 110, the most common types of impairment were physical, communication and vision. Learning impairments were very rarely reported.

Table 110: Type of impairment by gender in Zambia

	MALES	FEMALES
Learning	2 (3%)	5 (9%)
Physical	21 (36%)	15 (28%)
Communication	16 (27%)	9 (17%)
Vision	9 (15%)	14 (26%)
Hearing	11 (19%)	11 (20%)
Total	59 (100%)	54 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age, as can be seen in Table 111. Boys with disabilities were 8.2 times less likely to attend school and girls with disabilities were 5.7 times less likely to attend school. There was little difference in school level or distance to school between children with or without disabilities. None of the children with disabilities attended non formal education.

Table 111: Educational variables in relation to disability in Zambia

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	35 (59%)	6748 (87%)	Baseline	34 (63%)	7674 (86%)	Baseline
- No	24 (41%)	986 (13%)	7.9 (4.6 - 13.7)	20 (37%)	1204 (14%)	5.2 (3.0-9.2)
Age 5+: Attend formal education						
- Yes	35 (60%)	6500 (90%)	Baseline	34 (63%)	7350 (90%)	Baseline
- No	23 (40%)	699 (10%)	8.2 (4.7 – 14.1)	20 (37%)	858 (10%)	5.7 (3.3 - 10.1)
Of those at school, school level						
- Secondary/University/College	2 (6%)	486 (7%)	Baseline	3 (9%)	541 (7%)	Baseline
- Primary	32 (91%)	5524 (82%)	2.1 (0.5 - 9.2)	29 (85%)	6165 (80%)	1.3 (0.4 - 4.5)
- Nursery/pre-school	1 (3%)	738 (11%)	0.9 (0.1 - 12.7)	2 (6%)	968 (13%)	1.0 (0.1 - 8.5)
Time taken to school						
- <30 minutes	8 (23%)	1693 (25%)	Baseline	10 (29%)	2163 (28%)	Baseline
- 30 minutes-1 hour	12 (34%)	3353 (50%)	0.7 (0.3 - 1.7)	12 (35%)	3890 (51%)	0.6 (0.3 - 1.4)
- >1 hour	15 (43%)	1702 (25%)	1.6 (0.7 - 3.9)	12 (35%)	1621 (21%)	1.4 (0.6 - 3.2)
Attending non formal education						
- No	59 (100%)	7686 (99%)	Baseline	54 (100%)	8795 (99%)	Baseline
- Yes	0 (0%)	48 (1%)	-	0 (0%)	83 (1%)	-

As shown in Table 112, considering the data by type of impairment, learning and communication impairment had the greatest effect on school attendance. This overall pattern was also apparent within boys and girls.

Table 112: Attendance of formal education by impairment type in Zambia

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	14422 (87%)	2190 (13%)	13850 (90%)	1557 (10%)	Baseline	Baseline	Baseline
Learning	2 (29%)	5 (71%)	2 (29%)	5 (71%)	8.4 (0.5 – 134.2)	57.7 (6.3 - 525.9)	33.7 (6.3 - 179.1)
Physical	23 (64%)	13 (36%)	23 (66%)	12 (34%)	10.0 (3.9 - 25.4)	3.7 (1.2 - 11.8)	6.3 (3.1 – 13.0)
Communication	10 (40%)	15 (60%)	10 (40%)	15 (60%)	19.3 (6.8 – 53.3)	25.9 (6.4 - 105.6)	20.8 (9.1 – 47.6)
Vision	17 (74%)	6 (26%)	17 (74%)	6 (26%)	2.7 (0.5 - 14.2)	3.9 (1.2 - 12.7)	3.5 (1.3 - 9.1)
Hearing	17 (77%)	5 (23%)	17 (77%)	5 (23%)	6.4 (1.7 – 25.2)	2.3 (0.5 - 10.9)	3.8 (1.4 - 10.5)

In line with the overall findings, and as illustrated in Table 113, being impaired or ill was cited as the major reason for not attending formal education among children with disabilities (70%) while being too young was the most common reason among children without disability (64%).

Table 113: Reason for not attending formal education by disability status in Zambia

	Disabled	**Not disabled**
Too young	4 (9%)	1400 (64%)
Parents apparent lack of interest	0 (0%)	2 (0%)
Too old	1 (2%)	31 (1%)
Did not pass secondary school exam	1 (2%)	6 (0%)
Economic problems	4 (9%)	246 (11%)
Closest school too far	0 (0%)	115 (5%)
Has been ill	4 (9%)	4 (0%)

	Disabled	Not disabled
Is married	0 (0%)	103 (5%)
Needed to help family	1 (2%)	101 (5%)
Has an impairment	27 (61%)	4 (0%)
Is working outside family	2 (5%)	49 (2%)
Was expelled for class repetition	0 (0%)	13 (1%)
Primary not considered important by family	0 (0%)	41 (2%)
Secondary not considered important by family	0 (0%)	3 (0%)
Expelled	0 (0%)	15 (1%)
Fears violence at school	0 (0%)	2 (0%)
Do not have required document	0 (0%)	2 (0%)
Plays truant	0 (0%)	51 (2%)

Health and disability

As can be seen in Table 114, boys with disabilities were more likely to have had a serious illness in the last twelve months than boys without a disability, but this was less apparent among girls. Boys with disabilities were 3.0 times more likely to have had a serious illness in the last twelve months and girls were 1.6 times more likely. There was little variation in illness occurrence by type of impairment. The most common types of illness among the children with disabilities was malaria (63%) and there were no children with disabilities who reported malnutrition. Almost all children sought treatment, but disability was significantly related to not seeking treatment. Among those who had not sought treatment, the most commonly cited reason was ‘advised treatment not necessary’ (39%) or ‘no transport’ (39%). Where treatment was sought, health clinics were the most commonly cited places where it was sought. There was no variation in place of treatment sought by disability status, nor was there a relationship with distance to health facility.

Table 114: Association between health and health seeking behaviour and disability in Zambia

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	32 (54%)	5878 (76%)	Baseline	35 (65%)	6486 (73%)	Baseline
- Yes	27 (46%)	1856 (24%)	3.0 (1.8 - 5.0)	19 (35%)	2392 (27%)	1.6 (0.9 - 2.8)
Malnutrition						
- No	59 (100%)	7732 (99.7%)	Baseline	54 (100%)	8871 (99.9%)	Baseline
- Yes	0 (0%)	2 (0.3%)	-	0 (0%)	7 (0.1%)	-
Where sought treatment						
- Other	5 (19%)	290 (16%)	Baseline	3 (16%)	396 (17%)	Baseline
- Hospital	4 (15%)	160 (9%)	1.5 (0.4 - 5.7)	2 (11%)	196 (8%)	1.3 (0.2 - 7.9)
- Health clinic	14 (52%)	1258 (68%)	0.7 (0.2 - 1.8)	13 (68%)	1614 (67%)	1.1 (0.3 - 3.8)
- Private	2 (7%)	138 (7%)	0.8 (0.2 - 4.4)	0 (0%)	179 (7%)	-
- Did not seek	2 (7%)	10 (1%)	12.4 (2.1 - 72.9)	1 (5%)	8 (0.1%)	11.4 (1.0 – 124.7)
Illness prevent school						
- No	9 (60%)	681 (46%)	Baseline	8 (57%)	909 (47%)	Baseline
- Yes	6 (40%)	792 (54%)	0.6 (0.2 - 1.6)	6 (43%)	1036 (53%)	0.6 (0.2 - 1.8)
Time taken to nearest health facility						
- <30 minutes	4 (7%)	617 (8%)	Baseline	4 (7%)	772 (9%)	Baseline
- 30 minutes-1 hour	15 (25%)	2360 (31%)	1.0 (0.3 - 3.1)	11 (20%)	2774 (31%)	0.8 (0.2 - 2.4)
- 1 – 2 hours	18 (31%)	2307 (30%)	1.3 (0.4 - 3.9)	16 (30%)	2698 (30%)	1.2 (0.4 - 3.5)
- >2 hours	22 (37%)	2450 (32%)	1.5 (0.5 - 4.3)	23 (43%)	2634 (30%)	1.7 (0.6 - 4.9)
Slept under bednet last night						
- No malaria in	0 (0%)	25 (0.3%)	Baseline	2 (4%)	54 (1%)	Baseline

	area						
-	Yes	34 (64%)	5293 (72%)	-	33 (63%)	6421 (76%)	0.1 (0.01 - 0.5)
-	No	19 (36%)	2028 (28%)	-	17 (33%)	1987 (23%)	0.2 (0.01 - 0.9)

Other findings

Overall, the children with disabilities were older than the children without disability, among both males and female and. the relationship between disability and indicators of inclusion/exclusion was similar between boys and girls, excepting the stronger relationship between disability and serious illness among the boys. The poverty variables were not related to disability, nor were the hygiene and sanitation variables.

5.19 Zimbabwe

The population of Zimbabwe is 13,724,317 with children aged between 0 and 14 years constituting 40% of the population (World Bank Population Data, 2013). Zimbabwe is still one of the poorest countries in the world according to the 2013 Human Development Index, which ranked the country 172 out of 186 countries (UNDP International Human Development Indicators, 2013). Zimbabwe only recently acceded to the UN Convention on Persons with Disabilities on 23 September 2013 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan Zimbabwe works in 10 districts in Zimbabwe, of which two are peri-urban settings, Epworth near Harare and Pumula near Bulawayo. In drafting its new Country Strategic Plan, Plan Zimbabwe undertook a situation analysis in 2012 to identify gaps in the realization of the rights of children .Findings indicated that major issues affecting children and youths in the country relate to: poor access, retention and completion at ECCD, primary and secondary education levels, poor quality of learning in schools, high prevalence of child and maternal diseases and mortality, increasing incidences of child abuse and violation of children's rights and limited opportunities for children to participate in issues affecting their lives, high levels of unemployment and limited opportunities for youths. Chief among the causes for these gaps affecting the realization of children's rights are grouped into the following categories (Plan Zimbabwe, 2013):

- Harmful traditional, cultural and religious practices (e.g. in relation to child pledging and marriages and low societal value attached to the girl child)
- Food, economic and poverty issues at the household level (e.g. leading to school drop-out)
- Legal pluralism where there are contradictions between statutory and customary laws (e.g. on child marriages and child labour)
- Policy inadequacy and poor implementation (e.g. delivery of justice where the laws are adequate or relating to sexual violence)
- Inadequate service delivery by Government and other duty bearers, including parents and guardians.
- Ineffective social protection mechanisms which are not able to provide safety nets for vulnerable and marginalised families

As the situation analysis indicated, the capacity of the Zimbabwean Government and parents to play their role as duty bearers has been severely eroded by the socio economic realities in the country. As a result a number of children are facing particular vulnerabilities. In view of this, Plan Zimbabwe has decided, in the new Country Strategic Plan, to deliberately target marginalized groups of children, including children living with disabilities.

The overall Country Strategic Plan's country goal is therefore: 'children in Zimbabwe have secured rights and access quality services'. In order to achieve this, four country programmes, with attendant sub-goals, were formulated:

- Right to basic education: Goal - increased access to quality basic education particularly of marginalized children.
- Right to Protection: Goal - increased effectiveness of child protection mechanisms at family, community and national levels to protect children from all forms of abuse and neglect and increase children and youth participation.
- Right to survival and development for children and their mothers: Goal - enhanced capacities of communities to attain improved health status especially for children and women.
- Building households resilience and protection of children for sustainable livelihoods. Goal - improved resilience and sustainable livelihoods for protection of children and families.

The above four thematic areas addressed in the country programmes will be strengthened through the integration of the cross-cutting issues of gender, disability and disaster risk reduction.

To illustrate how this integration will happen, in the case of the country programme on the right to education, Plan Zimbabwe will, in order to promote inclusion of disabled and other excluded children, work with the relevant ministries and disabled people's

organizations to ensure that children living with disabilities are accorded equal chances to learn. Special education teachers and resource units for disabled children will receive support. Plan will lobby for the inclusion of special education training (e.g. sign language and Braille) for all teacher trainees, including supporting in-service training for those who have already qualified. In addition Plan will work with responsible authorities and communities to ensure that school infrastructure and facilities are sensitive to disability issues.

In Zimbabwe, the 2012 dataset included 33,346 sponsored children, ranging in age from 0-17. The average age was 10.5 (standard deviation=3.9), and 34% were male. Among the children, 200 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.6% (95% confidence interval 0.5-0.7 %). The prevalence of disability was slightly higher in males (0.7 %, 95% CI 0.6-0.9 %) than in females (0.5 %, 95% CI 0.4-0.6 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.4, 95% CI 1.0-1.8).

As seen in Table 115, the most common type of impairment was physical, while learning impairments were the least common.

Table 115: Type of impairment by gender in Zimbabwe

	MALES	FEMALES
Learning	11 (13%)	10 (9%)
Physical	24 (29%)	49 (42%)
Communication	20 (24%)	25 (21%)
Vision	14 (17%)	16 (14%)
Hearing	14 (17%)	17 (15%)
Total	83 (100%)	117 (100%)

Education and disability

As illustrated in Table 116, children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. Boys with disabilities were 7.2 times less likely to attend school and girls with disabilities were 4.1 times less likely to attend school. The numbers were too small to assess and impact of disability on school level. In addition, increased time taken to school was weakly related to increased disability. Only one child with a disability reported attending non-formal education.

Table 116: Educational variables in relation to disability in Zimbabwe

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	63 (76%)	10393 (93%)	Baseline	96 (82%)	19971 (91%)	Baseline
- No	20 (24%)	789 (7%)	4.7 (2.8 - 7.9)	21 (18%)	1993 (9%)	2.5 (1.5 - 4.1)
Age 5+: Attend formal education						
- Yes	63 (78%)	10230 (96%)	Baseline	95 (87%)	19223 (96%)	Baseline
- No	18 (22%)	422 (4%)	7.2 (4.2 - 12.4)	14 (13%)	703 (4%)	4.1 (2.3 - 7.3)
Of those at school, school level						
- Secondary/University/College	13 (21%)	3040 (29%)	Baseline	10 (10%)	3814 (19%)	Baseline
- Primary	49 (78%)	6984 (67%)	1.8 (0.9 - 3.8)	78 (81%)	14693 (74%)	2.6 (1.2 - 5.8)
- Nursery/pre-school	1 (2%)	369 (4%)	0.8 (0.1 - 7.7)	8 (8%)	1464 (7%)	3.5 (1.0 - 12.4)
Time taken to school						
- <30 minutes	13 (21%)	2653 (26%)	Baseline	24 (25%)	5333 (27%)	Baseline
- 30 minutes-1 hour	39 (62%)	6316 (61%)	1.3 (0.7 - 2.4)	53 (55%)	12227 (61%)	1.0 (0.6 - 1.6)
- >1 hour	11 (17%)	1424 (14%)	1.6 (0.7 - 3.6)	19 (20%)	2411 (12%)	1.8 (1.0 - 3.3)
Attending non formal education						
- No	82 (99%)	11174 (99.9%)	Baseline	117 (100%)	21949 (99.9%)	Baseline
- Yes	1 (1%)	8 (0.1%)	16.9 (2.1 - 137.6)	0 (0%)	15 (0.1%)	-

Considering the data by type of impairment, learning and communication impairment had the greatest effect on school attendance, followed by physical impairment, as can be seen in table 117. There was no reduction in school attendance among children with hearing or vision impairment compared to those children without disabilities

Table 117: Attendance of formal education by impairment type in Zimbabwe

	All ages		Age 5+				
	Attend formal education	Do not attend formal education	Attend formal education	Do not attend formal education	Males: Age adjusted OR	Females: Age adjusted OR	Total group: Age and sex adjusted OR
No disability	30364 (92%)	2782 (8%)	29453 (96%)	1125 (4%)	Baseline	Baseline	Baseline
Learning	10 (48%)	11 (52%)	10 (50%)	10 (50%)	18.4 (5.5 - 61.6)	37.0 (9.5 - 144.3)	25.1 (10.2 - 61.8)
Physical	59 (81%)	14 (19%)	59 (88%)	8 (12%)	5.8 (1.9 - 17.5)	2.9 (1.0 - 8.3)	3.9 (1.8 - 8.2)
Communication	32 (71%)	13 (29%)	31 (72%)	12 (28%)	14.9 (5.8 - 38.3)	7.3 (2.7 - 20.1)	10.3 (5.2 - 20.4)
Vision	29 (97%)	1 (3%)	29 (97%)	1 (3%)	2.0 (0.3 - 15.4)	-	0.9 (0.1 - 6.9)
Hearing	29 (94%)	2 (6%)	29 (97%)	1 (3%)	1.9 (0.2 - 14.7)	-	0.9 (0.1 - 6.6)

As shown in Table 118, being ill or impaired was cited as the major reason for not attending formal education among children with disabilities (62%) while being too young was the most common reason among children without disability (72%).

Table 118: Reason for not attending formal education by disability type in Zimbabwe

	Disabled	Not disabled
Too young	13 (32%)	2004 (72%)
Lack of primary schools in community	0 (0%)	1 (0%)
Parents apparent lack of interest	0 (0%)	10 (0%)
Too old	0 (0%)	103 (4%)
Did not pass secondary school exam	0 (0%)	4 (0%)
Is needed to work	0 (0%)	1 (0%)
Economic problems	0 (0%)	214 (8%)
Lessons were repetitive	0 (0%)	1 (0%)

	Disabled	Not disabled
Closest school too far	0 (0%)	3 (0%)
Has been ill	2 (5%)	4 (0%)
Is married	0 (0%)	152 (5%)
Needed to help family	0 (0%)	80 (3%)
Has an impairment	25 (61%)	3 (0%)
Is working outside family	0 (0%)	48 (2%)
Was expelled for class repetition	0 (0%)	23 (1%)
Is pregnant or gave birth	0 (0%)	3 (0%)
Primary not considered important by family	0 (0%)	6 (0%)
Secondary not considered important by family	0 (0%)	4 (0%)
Expelled	0 (0%)	45 (2%)
Fears violence at school	0 (0%)	1 (0%)
Fears violence on way to school	0 (0%)	0 (0%)
Do not have required document	0 (0%)	8 (0%)
Plays truant	1 (2%)	64 (2%)

Health and disability

As seen in Table 119, children with disabilities were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed across impairment types. Boys with disabilities were 6.3 times more likely to have had a serious illness in the last twelve months and girls were 6.9 times more likely. The most common types of illness among the children with disabilities were malaria (31%) and eye problems (20%). There was insufficient data on malnutrition to assess whether this was more common in those with disability than those without. Almost all children who had a serious illness sought treatment, and there was no clear difference in places where treatment was sought or time to facility between children with disabilities and those without.

Table 119: Association between health and health seeking behaviour and disability in Zimbabwe

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted	Disabled	Non disabled	Age adjusted OR

			OR			
Serious illness						
- No	65 (78%)	10710 (96%)	Baseline	90 (77%)	21047 (96%)	Baseline
- Yes	18 (22%)	472 (4%)	6.3 (3.7 - 10.7)	27 (23%)	917 (4%)	6.9 (4.5 - 10.6)
Malnutrition						
- No	83 (100%)	11179 (99.97%)	Baseline	116 (99%)	21962 (99.99%)	Baseline
- Yes	0 (0%)	3 (0.03%)	-	1 (1%)	2 (0.01%)	94.4 (8.5- 1048.8)
Where sought treatment						
- Other	3 (17%)	81 (17%)	Baseline	3 (11%)	127 (14%)	Baseline
- Hospital	7 (39%)	254 (54%)	0.8 (0.2 - 3.1)	17 (63%)	503 (55%)	1.4 (0.4 - 4.9)
- Health clinic	5 (28%)	121 (26%)	1.1 (0.3 - 4.8)	5 (19%)	248 (27%)	0.8 (0.2 - 3.5)
- Private	2 (11%)	5 (1%)	12.0 (1.6 - 91.2)	0 (0%)	11 (1%)	-
- Did not seek	1 (6%)	11 (2%)	2.4 (0.2 - 25.3)	2 (7%)	28 (3%)	3.0 (0.5 - 18.9)
Illness prevent school						
- No	4 (27%)	152 (39%)	Baseline	8 (36%)	296 (39%)	Baseline
- Yes	11 (73%)	233 (61%)	1.8 (0.6 - 5.7)	14 (64%)	462 (61%)	1.1 (0.5 - 2.7)
Time taken to nearest health facility						
- <30 minutes	7 (8%)	1335 (12%)	Baseline	17 (15%)	2450 (11%)	Baseline
- 30 minutes-1 hour	36 (43%)	4724 (42%)	1.5 (0.6 - 3.3)	59 (50%)	9665 (44%)	0.9 (0.5 - 1.5)
- 1 – 2 hours	21 (25%)	3398 (30%)	1.2 (0.5 - 2.8)	26 (22%)	6443 (29%)	0.6 (0.3 - 1.1)
- >2 hours	19 (23%)	1725 (15%)	2.1 (0.9 - 5.0)	15 (13%)	3406 (16%)	0.6 (0.3 - 1.3)
Slept under bednet last night						
- No malaria in area	5 (6%)	888 (8%)	Baseline	6 (5%)	1936 (9%)	Baseline
- Yes	28 (36%)	3832 (36%)	1.3 (0.5 - 3.4)	43 (39%)	7531 (36%)	1.8 (0.8 - 4.3)
- No	45 (58%)	5817 (55%)	1.4 (0.5 - 3.5)	62 (56%)	11367 (55%)	1.8 (0.8 - 4.1)

Other findings

Overall, the children with disabilities were similar in age to the children without disability and the relationship between disability and indicators of inclusion/exclusion was very similar between boys and girls. The poverty variables were not related to disability, nor were the hygiene and sanitation variables.

Credit: Plan / Martin Acevedo

Plan in Latin America

5.20 Bolivia

The country population of Bolivia is 10,496,285 and the percentage of the population that constitutes children between the ages of 0-14 year is 35% (World Bank Population Data, 2013). Bolivia ranks 108 out of 187 countries in the 2013 Human Development Index, making it a country with medium human development (UNDP International Human Development Indicators, 2013). The government of Bolivia has ratified the UN Convention on the Rights of Persons with Disabilities (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

As part of Plan Bolivia's situational analysis, the legal framework for overall inclusion, with a specific mention of children with disabilities, is described. It reports that prior to ratifying the UNCRPD, the Supreme Decree 28521 was established, creating the National Disabled Person's Registry System and Supreme Decree 28671: National Plan for Equality and Equal Opportunity for Persons with Disabilities (2006). With the new State Constitution of the Republic of Bolivia (2008) it was further recognised that rights are inviolable, universal, inter-dependent, indivisible and progressive and that the State has the duty of promoting, protecting and respecting them, and that every human being possesses these rights. Furthermore, it includes the principle of inclusion and recognises fundamental rights for all people, especially for children, adolescents and youths, as well as for traditionally excluded groups, such as indigenous peoples (Plan Bolivia, 2009). Bolivia sets out in their National Development Plan to reduce social-economic, policy and cultural gaps regarding gender, generation and disability. However, the final observations of the international Child Rights Committee (October 2009) show that despite progress, there are still gaps in the fulfilment of CRC principles. They Child Rights Committee concluded:

- 'disabled children continue to experience discrimination'
- 'Establish systems for early identification and intervention (of disabilities) as part of your healthcare services'
- 'Expand community-based rehabilitation programmes …parental support groups'

Prior to this the Committee for the Elimination of Discrimination against Women (February 2008) concluded that 'persistently high levels of poverty and social exclusion among women… rural… indigenous … elderly… disabled' exist (Plan Bolivia, 2009). Therefore the situational analysis mentions in relation to protection and education 'Inclusive initial special education orientation and referral support for rehabilitation programmes.'

Plan Bolivia works in four Programme Units, namely: Altiplano, Santa Cruz, Sucre and Tarija. As part of Plan Bolivia's Country Strategic Plan, they enshrined a set of organisational principles and values**,** one of those specifically refers to children with disabilities:

‘Respect child and human rights based on the innate and inalienable dignity of all human beings regardless of age, gender, race, ethnic background, religion, class or disability’. As part of Plan Bolivia’s programmes focussing on children with disabilities, they say the following:

- Promote community-based alliances to detect, prevent, rehabilitate and reintegrate children with special educational needs or disabilities.
- Promote networks and alliances to detect, prevent, rehabilitate and reintegrate children with special educational needs or disabilities.
- Special protection programming, with variable terms and locations; this will facilitate partnership with children, youth and women living in special circumstances (orphaned or abandoned children and adolescents, disabled, street children, those involved in the worst forms of child labour and at risk of being victims of illegal trafficking of minors, among other things).
- Facilitate integrated care for children, pregnant mothers, breastfeeding mothers, people over 65 and the disabled living in adverse or disaster situations; this takes place within safe and protective environments in families, camps and communities, promoting commitment from parents, main caregivers, leaders, community authorities and municipal authorities.

The overall goal of the current Country Strategic Plan is: ‘Contribute to creating an environment that is favourable to the exercise of human rights, thus achieving lasting changes in the quality of life and fulfilment of child, adolescent and women’s rights within the most excluded populations of the country.’ In order to achieve this overall goal, Plan Bolivia the three central programmes and four cross cutting programmes. The three central programmes are:

- Integrated early childhood development (prenatal to 5 years)
- Integrated child and adolescent development (6 to 14 years)
- Integrated adolescents and youths development (15 to 24 years)

And the four crosscutting programmes are:

- Pro-child, adolescent and youth governance
- Protection, gender and intercultural issues
- Communication and education for development
- Risk reduction, management and adaptation to climate change

In Bolivia, the 2012 dataset included 41,979 sponsored children, ranging in age from 0-17. The average age was 9.5 (standard deviation=4.2), and 41% were male. Among the children, 372 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 0.9% (95% confidence interval 0.8-1.0%). The prevalence of disability was slightly higher in males (1.0%, 95% CI 0.9-1.2%) than in females (0.8%, 95% CI 0.7-0.9%). After adjustment for age, males had significantly higher odds of disability compared to females (1.2, 95% CI 1.0-1.5).

As shown in Table 120, the most common type of impairment was communication impairment, while hearing impairment was the least common.

Table 120: Type of impairment by gender in Bolivia

	MALES	FEMALES
Learning	29 (17%)	46 (23%)
Physical	32 (19%)	39 (19%)
Communication	64 (37%)	57 (28%)
Vision	29 (17%)	46 (23%)
Hearing	17 (10%)	13 (6%)
Total	171 (100%)	201 (100%)

Education and disability

As illustrated in Table 121, children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. Boys with disabilities were 7.8 times less likely to attend school and girls with disabilities were 8.5 times less likely to attend school. Children with disabilities were significantly more likely to be at a lower school level compared to children without disability, after accounting for age differences. The analysis indicated that increased time taken to school was not related to increased disability. Children with a disability were also more likely to be attending non-formal education than those with a disability for both boys and girls, although the numbers were very small.

Table 121: Educational variables in relation to disability in Bolivia

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	112 (65%)	14799 (88%)	Baseline	118 (59%)	19891 (80%)	Baseline
- No	59 (35%)	2063 (12%)	4.8 (3.5 - 6.7)	83 (41%)	4854 (20%)	4.7 (3.5 - 6.4)
Age 5+: Attend formal education						
- Yes	110 (69%)	14488 (94%)	Baseline	118 (63%)	19224 (93%)	Baseline
- No	50 (31%)	851 (6%)	7.8 (5.5 - 10.9)	70 (37%)	1348 (7%)	8.5 (6.3 - 11.5)
Of those at school, school level						
- Secondary/University/College	23 (21%)	4152 (28%)	Baseline	18 (15%)	4961 (25%)	Baseline
- Primary	77 (69%)	9698 (66%)	2.2 (1.2 - 3.9)	91 (77%)	13257 (67%)	2.8 (1.5 - 5.3)
- Nursery/pre-school	12 (11%)	949 (6%)	5.4 (1.8 - 15.7)	9 (8%)	1673 (8%)	3.2 (1.1 - 9.9)
Time taken to school						
- <30 minutes	88 (79%)	10774 (73%)	Baseline	78 (66%)	14798 (74%)	Baseline
- 30 minutes-1 hour	19 (17%)	3206 (22%)	0.7 (0.4 - 1.2)	34 (29%)	4026 (20%)	1.6 (1.1 - 2.4)
- >1 hour	5 (4%)	819 (6%)	0.8 (0.3 - 1.9)	6 (5%)	1067 (5%)	1.1 (0.5 - 2.5)
Attending non formal education						
- No	168 (98%)	16857 (99.97%)	Baseline	200 (99.5%)	24729 (99.9%)	Baseline
- Yes	3 (2%)	5 (0.03%)	56.8 (13.4 - 240.5)	1 (0.5%)	16 (0.1%)	6.1 (0.8 – 46.6)

As evidenced in Table 122, considering the data by type of impairment, learning and communication impairment had the greatest effect on school attendance, while the impact of physical, visual or hearing impairment on school attendance was less marked through remained significant. This overall pattern was apparent for both boys and girls.

Table 122: Attendance of formal education by impairment type in Bolivia

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	34690 (83%)	6917 (17%)	33712 (94%)	2199 (6%)	Baseline	Baseline	Baseline
Learning	40 (53%)	35 (47%)	40 (56%)	32 (44%)	9.5 (4.3 - 21.1)	13.0 (7.2 - 23.5)	11.6 (7.3 - 18.6)
Physical	50 (70%)	21 (30%)	50 (77%)	15 (23%)	4.6 (1.9 - 11.3)	5.1 (2.4 - 10.9)	4.9 (2.7 - 8.7)
Communication	57 (47%)	64 (53%)	56 (50%)	55 (50%)	12.2 (7.2 - 20.8)	20.4 (11.8 - 35.4)	15.6 (10.7 - 22.8)
Vision	61 (81%)	14 (19%)	60 (86%)	10 (14%)	2.8 (1.0 - 8.0)	2.4 (1.0 - 5.7)	2.5 (1.3 - 5.0)
Hearing	22 (73%)	8 (27%)	22 (73%)	8 (27%)	8.9 (3.3 - 24.3)	2.6 (0.6 – 12.0)	5.7 (2.5 - 12.8)

In line with the overall findings and as indicated in Table 123, the presence of illness or impairment were was cited as the major reason for not attending formal education among children with disabilities (75%) while being too young was the most common reason among children without disability (79%).

Table 123: Reason for not attending formal education by disability status in Bolivia

	Disabled	**Not disabled**
Too young	28 (20%)	5480 (79%)
Lack of primary schools in community	0 (0%)	2 (0%)
Too old	0 (0%)	112 (2%)
Economic problems	1 (1%)	239 (3%)
Closest school too far	1 (1%)	196 (3%)
Has been ill	25 (18%)	36 (1%)

	Disabled	Not disabled
Is married	0 (0%)	58 (1%)
Needed to help family	6 (4%)	575 (8%)
Has an impairment	81 (57%)	14 (0%)
Is working outside family	0 (0%)	103 (1%)
Was expelled for class repetition	0 (0%)	16 (0%)
Primary not considered important by family	0 (0%)	31 (0%)
Secondary not considered important by family	0 (0%)	23 (0%)
Expelled	0 (0%)	3 (0%)
Fears violence at school	0 (0%)	6 (0%)
Fears violence on way to school	0 (0%)	1 (0%)
Do not have required document	0 (0%)	7 (0%)
Plays truant	0 (0%)	21 (0%)

Health and disability

As evidenced in Table 124, children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with visual impairment. Boys with disabilities were 4.6 times more likely to have had a serious illness in the last twelve months and girls were 5.3 times more likely. The most common types of illness among the children with disabilities were acute respiratory tract infection (20%), eye problems (14%), severe diarrhoea (10%) and influenza (9%). There was insufficient data on malnutrition to assess whether this was more common in those with a disability than those without. Not seeking treatment was not related to disability and among those who had not sought treatment, the most commonly cited reason was ‘Advised treatment unnecessary.’ Where treatment was sought out, hospital was the most commonly cited place where this occurred. There was no relationship found between disability and place of seeking treatment, time taken to nearest health facility or sleeping under a bednet.

Table 124: Association between health and health seeking behaviour and disability in Bolivia

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	128 (75%)	15668 (93%)	Baseline	142 (71%)	22904 (93%)	Baseline
- Yes	43 (25%)	1194 (7%)	4.6 (3.2 - 6.5)	59 (29%)	1841 (7%)	5.3 (3.9 - 7.3)
Malnutrition						
- No	171 (100%)	16853 (99.95%)	Baseline	198 (99%)	24722 (99.9%)	Baseline
- Yes	0 (0%)	9 (0.05%)	-	3 (1%)	23 (0.1%)	18.6 (5.5 - 62.8)
Where sought treatment						
- Other	3 (7%)	165 (14%)	Baseline	7 (12%)	242 (13%)	Baseline
- Hospital	20 (47%)	477 (40%)	2.4 (0.7 - 8.1)	25 (42%)	750 (41%)	1.2 (0.5 - 2.7)
- Health clinic	11 (26%)	351 (29%)	1.8 (0.5 - 6.5)	14 (24%)	532 (29%)	0.9 (0.4 - 2.3)
- Private	1 (2%)	12 (1%)	4.8 (0.5 - 50.4)	2 (3%)	28 (2%)	2.4 (0.5 - 12.2)
- Did not seek	8 (19%)	189 (16%)	2.3 (0.6 - 9.0)	11 (19%)	289 (16%)	1.3 (0.5 - 3.4)
Illness prevent school						
- No	19 (66%)	627 (62%)	Baseline	24 (57%)	899 (61%)	Baseline
- Yes	10 (34%)	381 (38%)	0.9 (0.4 - 1.9)	18 (43%)	569 (39%)	1.2 (0.6 - 2.2)
Time taken to nearest health facility						
- <30 minutes	97 (57%)	8840 (52%)	Baseline	96 (48%)	13266 (54%)	Baseline
- 30 minutes-1 hour	39 (23%)	4712 (28%)	0.7 (0.5 - 1.1)	49 (24%)	6665 (27%)	1.0 (0.7 - 1.4)
- 1 – 2 hours	14 (8%)	1875 (11%)	0.7 (0.4 - 1.2)	31 (15%)	2667 (11%)	1.6 (1.1 - 2.4)

- >2 hours	21 (12%)	1435 (9%)	1.3 (0.8 - 2.2)	25 (12%)	2147 (9%)	1.7 (1.1 - 2.6)
Slept under bednet last night						
- No malaria in area	124 (77%)	12363 (80%)	Baseline	150 (78%)	17867 (78%)	Baseline
- Yes	24 (15%)	1778 (11%)	1.4 (0.9 - 2.1)	29 (15%)	3112 (14%)	1.1 (0.8 - 1.7)
- No	13 (8%)	1332 (9%)	1.0 (0.5 - 1.7)	14 (7%)	1980 (9%)	0.8 (0.5 - 1.5)

Other Findings

Overall, the children with disabilities were older than the children without disabilities and the relationship between disability and indicators of inclusion/exclusion was similar between boys and girls. The poverty variables showed no relationship with disability, nor did the hygiene and sanitation measures.

5.21 Brazil

The country population of Brazil is 198,656,019 and the percentage of the population that constitutes children between the ages of 0-14 year is 25% (World Bank Population Data, 2013). Brazil ranks 85 out of 187 countries in the 2013 Human Development Index, making it a country with high human development (UNDP International Human Development Indicators, 2013). In 2008 the Government of Brazil ratified the UN Convention on the Rights of Persons with Disabilities (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan Brazil works in rural areas and the peripheral urban areas of smaller municipalities in the state of Maranhão and will establish Plan in the neighbouring state of Piauí. In Plan's Brazil Country Strategic Plan it states that 'all Plan´s programming will focus on addressing the discrimination and exclusion of the most marginalized groups, particularly girls and Afro-Brazilian and indigenous populations.' Therefore disability is only mentioned as part of Plan's overall commitment to Child Centred Community Development (CCCD) approach in relation to Inclusion and non-discrimination: 'Plan believes in the innate and inalienable dignity of all human beings - irrespective of age, sex, race, ethnicity, religion, class or disability - and in the right of all citizens to equal access to public

services. Plan Brazil will continue its efforts, at all operational levels, to combat discrimination and the exclusion of the less privileged groups and populations.'

The overall country goal of Brazil's Country Strategic Plan is: 'In the next five years, Plan Brazil will contribute through the implementation of the CCCD approach, that Brazilian children, adolescents and youth - in particular those living within Plan Brazil intervention areas – enjoy a sustainable improvement in their quality of life and are able to fully exercise their rights' (Plan Brazil, 2013). Plan Brazil's strategic response will be implemented through four programmes:

- Healthy Childhood (0 to 6 years)
- Learning and Life Skills for girls, Boys and Adolescents (7-17 years of age)
- Economic empowerment of youth and women
- Children's rights to Protection from Violence and Disaster Risks

In Brazil, the 2012 dataset included 12,993 sponsored children, ranging in age from 0-17. The average age was 6.9 (standard deviation= 4.0), and 44% were male. Among the children, 143 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.1 % (95% confidence interval 0.9 - 1.3 %). The prevalence of disability was slightly higher in males (1.4 %, 95% CI 1.1 - 1.7 %) than in females (0.8 %, 95% CI 0.6 - 1.1 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.6, 95% CI 1.2 - 2.2).

As can be seen in Table 125, the most common type of impairment was physical. Learning impairment was almost as common as physical impairment in boys, while vision impairment was the next most common impairment in girls. Finally, as regards the least common impairments - communication impairment was uncommon in girls, while there were no boys with hearing impairment.

Table 125: Type of impairment by gender in Brazil

	MALES	FEMALES
Learning	30 (38%)	9 (14%)
Physical	32 (40%)	29 (46%)
Communication	11 (14%)	6 (10%)
Vision	7 (9%)	11 (17%)
Hearing	0 (0%)	8 (13%)

Total	80 (100%)	63 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age (particularly girls), as illustrated in Table 126. Boys with disabilities were 15.1 times less likely to attend school and girls with disabilities were 25.2 times less likely to attend school. Children with disabilities were much more likely to be at a lower school level compared to children without disability, after accounting for age differences (particularly marked for boys). There was a trend of increased time taken to school related to increased disability in boys.

Table 126: Educational variables in relation to disability in Brazil

	MALES			**FEMALES**		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	51 (64%)	4387 (77%)	Baseline	37 (59%)	5530 (77%)	Baseline
- No	29 (36%)	1305 (23%)	6.9 (3.7 - 12.8)	26 (41%)	1628 (23%)	11.4 (5.6-23.3)
Age 5+: Attend formal education						
- Yes	49 (77%)	3847 (98%)	Baseline	36 (73%)	4870 (98%)	Baseline
- No	15 (23%)	90 (2%)	15.1 (8.0 - 28.3)	13 (27%)	91 (2%)	25.2 (12.5-50.5)
Of those at school, school level						
- Secondary/University/College	2 (4%)	488 (11%)	Baseline	4 (11%)	716 (13%)	Baseline
- Primary	42 (82%)	2707 (62%)	10.8 (2.4 - 47.6)	26 (70%)	3438 (62%)	4.3 (1.3 - 13.6)
- Nursery/pre-school	7 (14%)	1192 (27%)	12.5 (2.0 - 80.4)	7 (19%)	1376 (25%)	9.8 (1.9 - 50.5)

Time taken to school						
- <30 minutes	37 (73%)	3805 (87%)	Baseline	29 (78%)	4824 (87%)	Baseline
- 30 minutes-1 hour	13 (25%)	559 (13%)	2.2 (1.2 - 4.2)	8 (22%)	670 (12%)	1.8 (0.8 - 4.0)
- >1 hour	1 (2%)	23 (1%)	3.2 (0.4 - 24.9)	0 (0%)	36 (1%)	-
Attending non formal education						
- No	77 (96%)	5584 (98%)	Baseline	63 (100%)	7042 (98%)	Baseline
- Yes	3 (4%)	108 (2%)	1.6 (0.5 - 5.2)	0 (0%)	116 (2%)	-

As can be seen in table 127, considering the data by type of impairment, communication, physical and hearing impairment had the greatest impact on school attendance. Learning impairment was also strongly related to not attending school, while there was insufficient data for the vision impairment analysis (although of note was that all children with visual impairment over the age of five attended formal education). Communication impairment had the greatest impact on boys school attendance followed by learning impairment. In contrast physical impairment had the greatest impact on girls, followed by learning impairment. Hearing impairment was also strongly related to non-attendance for girls but seemed to be associated with increased attendance for boys, when compared to boys with no disability.

Table 127: Attendance of formal education by impairment type in Brazil

	All ages		**Age 5+**				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	9917 (77%)	2933 (23%)	8717 (98%)	181 (2%)	Baseline	Baseline	Baseline
Learning	27 (69%)	12 (31%)	26 (76%)	8 (24%)	16.2 (6.1 - 42.8)	41.6 (7.1 – 243.0)	20.6 (8.7 - 48.9)
Physical	30 (49%)	31 (51%)	29 (71%)	12 (29%)	13.9 (4.5 - 43.2)	63.4 (21.9 – 183.4)	29.8 (14.3 – 62.0)
Communication	10 (59%)	7 (41%)	10 (62%)	6 (38%)	36.0 (9.9 - 131.0)	10.5 (1.2-95.5)	24.6 (8.5 - 71.0)
Vision	15 (83%)	3 (17%)	14 (100%)	0 (0%)	-	-	-

Hearing	6 (75%)	2 (25%)	6 (75%)	2 (25%)	-	33.7 (5.3 – 213.3)	29.5 (5.0 – 173.4)

In line with the overall findings and as shown in Table 128, having an impairment was cited as the major reason for not attending formal education among children with disabilities (50%) while being too young was the most common reason among children without disability (97 %).

Table 128: Reason for not attending formal education by disability status in Brazil

	Disabled	Non disabled
Too young	26 (46%)	2857 (97%)
Economic problems	0 (0%)	4 (0%)
Closest school too far	0 (0%)	14 (0%)
Has been ill	2 (4%)	2 (0%)
Is married	0 (0%)	2 (0%)
Needed to help family	0 (0%)	5 (0%)
Has an impairment	28 (50%)	9 (0%)
Primary not considered important by family	0 (0%)	13 (0%)
Secondary not considered important by family	0 (0%)	2 (0%)
Expelled	0 (0%)	1 (0%)
Fears violence on way to school	0 (0%)	6 (0%)
Do not have required document	0 (0%)	10 (0%)
Plays truant	0 (0%)	2 (0%)

Health and disability

As seen in Table 129, children with a disability were much more likely to have had a serious illness in the last twelve months than children without a disability, a pattern that was observed for all types of impairment with the exception of communication (for which there were wide confidence intervals). Boys with disabilities were 5.4 times more likely to have had a serious illness in the last twelve months and girls were 5.1 times more likely. The most common types of illness among the children with disabilities were accident, malnutrition and acute respiratory tract infection. It was found that suffering from malnutrition was very strongly related to disability.

The main treatment location was hospital for both disabled and non-disabled children, and the treatment location did not seem to be associated with disability status.

Whether illness prevented school did not seem to be related to the presence of disability. Increasing time taken to the nearest health facility may have been related to disability in boys, although the analysis that indicated this was underpowered. In malarial areas, children with disabilities were more likely to use a bednet than children without disabilities.

Table 129: Association between health and health seeking behaviour and disability in Brazil

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	71 (89%)	5556 (98%)	Baseline	57 (90%)	7003 (98%)	Baseline
- Yes	9 (11%)	136 (2%)	5.4 (2.6 - 11.0)	6 (10%)	155 (2%)	5.1 (2.2 - 12.1)
Malnutrition						
- No	79 (99%)	5689 (99.95%)	Baseline	62 (98%)	7156 (99.97%)	Baseline
- Yes	1 (1%)	3 (0.05%)	28.8 (2.9 - 283.3)	1 (2%)	2 (0.03%)	75.2 (6.6 – 854.6)
Where sought treatment						
- Other	0 (0%)	11 (8%)	Baseline	0 (0%)	17 (11%)	Baseline
- Hospital	7 (78%)	111 (82%)	-	5 (83%)	124 (80%)	-
- Health clinic	1 (11%)	8 (6%)	-	0 (0%)	9 (6%)	-
- Private	0 (0%)	3 (2%)	-	0 (0%)	1 (1%)	-
- Did not seek	1 (11%)	3 (2%)	-	1 (17%)	4 (3%)	-
Illness prevent school						
- No	4 (57%)	60 (56%)	Baseline	2 (50%)	61 (55%)	Baseline
- Yes	3 (43%)	47 (44%)	0.8 (0.2 - 3.8)	2 (50%)	49 (45%)	0.8 (0.1 - 6.6)
Time taken to nearest health facility						
- <30 minutes	61 (76%)	4567 (80%)	Baseline	57 (90%)	5836 (82%)	Baseline
- 30 minutes-1	15 (19%)	991 (17%)	1.1 (0.6 - 2.0)	5 (8%)	1149 (16%)	0.4 (0.2 - 1.1)

hour						
- 1 – 2 hours	3 (4%)	120 (2%)	1.9 (0.6 - 6.0)	1 (2%)	155 (2%)	0.7 (0.1 - 4.9)
- >2 hours	1 (1%)	14 (0%)	5.1 (0.6 - 39.3)	0 (0%)	18 (0.3%)	-
Slept under bednet last night						
- No malaria in area	35 (95%)	2689 (99%)	Baseline	23 (92%)	3114 (99%)	Baseline
- Yes	1 (3%)	3 (0.1%)	22.2 (2.2 - 219.7)	1 (4%)	4 (0.1%)	34.2 (3.7 – 318.9)
- No	1 (3%)	25 (1%)	3.7 (0.5 - 28.6)	1 (4%)	15 (0.5%)	9.2 (1.2 – 72.4)

Other Findings

Overall, the children with disabilities were slightly older than the children without disability and with regard to gender differences, differences between girls and boys were observed in relation to which impairment type affected school attendance the most. The poverty variables showed little relationship with disability, nor did the hygiene and sanitation measures.

5.22 Colombia

The country population of Colombia is 47,704,427 and the percentage of the population that constitutes children between the ages of 0-14 year is 28% (World Bank Population Data, 2013). Colombia ranks 91 out of 187 countries in the 2013 Human Development Index, making it a country with high human development (UNDP International Human Development Indicators, 2013). The Government of Colombia ratified the UN Convention on the Rights of Persons with Disabilities in 2011 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013). Yet, Plan Colombia's situational analysis, undertaken to inform the drafting of the Country Strategic Plan (Plan Columbia, 2013), highlights specific issues affecting children with disabilities. Firstly, it reports on the recommendations of the Committee on the Rights of the Child which according to the Alternative Report on the Implementation of the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography (2010) notes that Colombia has not adopted the protocol in practice, as either a legal and policy framework, or a methodological framework. According to the report, the plans, programs and strategies developed have made children, indigenous people, Afro-Colombians, peasant farmers and disabled people invisible, and have aggravated their discrimination and marginalization in public policies.

Furthermore, violence in schools is mentioned as affecting the lives of children in Colombia and particularly children with disabilities. Second, the situational analysis refers to an investigation conducted by Plan Colombia in 2010, which revealed that social discrimination is common in schools, with skin colour being the most common basis of discrimination against boys (14%), and disability the most common for girls (15.7%). It reported that 29 % of disabled children between the ages of 3 and 4, 65.1% of disabled children between the ages of 5 and 9, and 68.6% of disabled children between the ages of 10 and 14 attend school. Twenty-four percent of disabled people over the age of 5 cannot read or write. Third, it highlighted that for some groups, participation is difficult, for example, 'in the design of programs that do not include tools or mechanisms of participation, which hinders the participation of disabled or displaced children or children who are the victims of ethnic discrimination or who live in rural sectors (access to information, costs of displacement, inclusive language, significant and relevant activities), by limited opportunities for expression, by the armed conflict, and by the lack of sustainability and continuity of development opportunities'.

Plan Colombia is both a Country Office, as well as a National Organisation, given the fact that it also does fundraising activities. Plan Colombia works along the Atlantic and Pacific coasts, as these are the regions where there is a high incidence of violations of children's rights, and where there is greater inequity and inequality. They operate in Nariño (especially the town of Tumaco), Chocó, Valle del Cauca (mainly in Jamundí and Cauca), the Atlantic Coast (mainly Cartagena in the Department of Bolivar and Sincelejo in the Department of Sucre). In their Country Strategic Planning they state that 'the effort of Plan Colombia will be addressed towards children, adolescents and young people whose fundamental rights are denied and violated in a systematic way, especially Afro-Colombians, women and girls, and victims of the armed conflict, with an emphasis on population displacement. Similarly, Plan Colombia will include the disabled in all its programmatic efforts to enable them to participate in the programs, thus ensuring the removal of barriers to their inclusion' (Plan Columbia, 2013). Plan Colombia further mentions disability in relation to their human management resources and specifically states for selection processes to include people with disabilities and ethnic, gender, age and other differences.

The overall goal of the current CSP of Plan Colombia is: 'Contribute to the construction of inclusive and peacefully coexisting communities that promote the enjoyment of rights for every girl, boy and youth with environmental sustainability.' The Strategic Plan comprises the following four programmes:

- Strengthen and support the creation of safe, inclusive and protective environments so that children, adolescents and young people, with equality of opportunity, may enjoy the rights to a decent, healthy and violence-free life.
- Contribute to the strengthening of the life projects and affective ties of children, adolescents and young people through the development of meaningful learning in environments of peaceful coexistence.

- Promote the recognition and participation of children, adolescents and young people in the different social environments for the exercise of their rights, the transformation of their reality and the construction of learning networks.
- Develop better socio-economic conditions and implement safer and more resilient practices for confronting emergencies for children, adolescents and young people and their families.

Interestingly, Plan Colombia also mentions disability in relation to monitoring and evaluation of its work and states the impact should be measured by disaggregated variables, which will enable Plan Colombia to verify whether they are complying with the principle of social inclusion: gender, life cycle, displaced persons and disabled persons, among others (Plan Colombia, 2013).

In Colombia, the 2012 dataset included 22,020 sponsored children, ranging in age from 0-17. The average age was 8.8 (standard deviation=4.3), and 42% were male. Among the children, 235 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.0% (95% confidence interval 0.9 – 1.2 %). The prevalence of disability was slightly higher in males (1.3 %, 95% CI 1.0 – 1.6 %) than in females (0.9%, 95% CI 0.7 – 1.0 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.4, 95% CI 1.1 – 1.9).

As can be seen in Table 130, the most common types of impairment were physical, communication and learning, while hearing impairment was the least common.

Table 130: Type of impairment by gender in Colombia

	MALES	FEMALES
Learning	31 (25%)	37 (33%)
Physical	32 (26%)	18 (16%)
Communication	31 (25%)	29 (26%)
Vision	22 (18%)	22 (20%)
Hearing	7 (6%)	6 (5%)
Total	123 (100%)	112 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. Boys with disabilities were 30.0 times less likely to attend school and girls with disabilities were 21.5 times less likely to attend school. Children with disabilities were much more likely to be at a lower school level compared to children without disability, after accounting for age differences. Increased time taken to school was related to increased disability in boys but not girls (for which there was a lack of data to perform this analysis).

Table 131: Educational variables in relation to disability in Colombia

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	82 (67%)	8776 (96%)	Baseline	79 (71%)	11546 (92%)	Baseline
- No	41 (33%)	407 (4%)	13.2 (8.9 - 19.7)	33 (29%)	1056 (8%)	7.3 (4.8 - 11.3)
Age 5+: Attend formal education						
- Yes	78 (67%)	7900 (98%)	Baseline	71 (74%)	9779 (98%)	Baseline
- No	38 (33%)	147 (2%)	30.0 (19.2 - 46.8)	25 (26%)	169 (2%)	21.5 (12.6 - 36.5)
Of those at school, school level						
- Secondary/University/College	19 (23%)	3052 (35%)	Baseline	22 (28%)	3684 (32%)	Baseline
- Primary	48 (59%)	4294 (49%)	7.7 (3.4 - 17.1)	44 (56%)	5311 (46%)	10.0 (4.3 - 23.5)
- Nursery/pre-school	15 (18%)	1430 (16%)	25.4 (6.6 - 98.2)	13 (16%)	2551 (22%)	30.9 (7.3 - 131.4)
Time taken to school						

- <30 minutes	74 (90%)	7859 (90%)	Baseline	67 (85%)	10515 (91%)	Baseline
- 30 minutes-1 hour	6 (7%)	872 (10%)	0.7 (0.3 - 1.7)	12 (15%)	968 (8%)	1.8 (0.9 - 3.3)
- >1 hour	2 (2%)	45 (1%)	4.5 (1.1 - 19.1)	0 (0%)	63 (1%)	-
Attending non formal education						
- No	123 (100%)	9169 (100%)	Baseline	112 (100%)	12586 (100%)	Baseline
- Yes	0 (0%)	14 (0%)	-	0 (0%)	16 (0%)	-

As illustrated in Table 132, considering the data by type of impairment, communication impairment had the greatest effect on school attendance, followed by learning and physical impairment. There were insufficient numbers of those with hearing impairment in the sample to assess the effect of this impairment, but of note was that this was due to the fact that all of the children with a hearing impairment attended formal education. This overall pattern was also apparent within boys and girls.

Table 132: Attendance of formal education by impairment type in Colombia

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	20322 (93%)	1463 (7%)	17679 (98%)	316 (2%)	Baseline	Baseline	Baseline
Learning	45 (66%)	23 (34%)	42 (67%)	21 (33%)	33.7 (15.1 - 75.2)	33.6 (14.0 - 80.7)	32.6 (18.0 - 59.1)
Physical	33 (66%)	17 (34%)	31 (69%)	14 (31%)	30.8 (13.2 - 71.8)	24.9 (7.9 - 78.9)	30.0 (15.1 - 59.7)
Communication	33 (55%)	27 (45%)	29 (54%)	25 (46%)	70.1 (31.8 - 154.5)	62.7 (22.4 - 175.7)	69.7 (37.2 - 130.4)
Vision	37 (84%)	7 (16%)	35 (92%)	3 (8%)	8.0 (1.7 - 36.7)	3.8 (0.5 - 31.3)	5.9 (1.7 - 20.3)
Hearing	13 (100%)	0 (0%)	12 (100%)	0 (0%)	-	-	-

In line with the overall findings and as shown in Table 133, having an impairment or illness was cited as the major reason for not attending formal education among children with disabilities (89%) while being too young was the most common reason among children without disability (79%).

Table 133: Reason for not attending formal education by disability status in Colombia

	Disabled	Non disabled
Too young	6 (8%)	1163 (79%)
Economic problems	1 (1%)	62 (4%)
Closest school too far	0 (0%)	9 (1%)
Has been ill	29 (39%)	9 (1%)
Lack of interest in school attendance	0 (0%)	0 (0%)
Is married	0 (0%)	49 (3%)
Needed to help family	0 (0%)	39 (3%)
Has an impairment	37 (50%)	8 (1%)
Is working outside family	0 (0%)	3 (0%)
Was expelled for class repetition	0 (0%)	9 (1%)
Primary not considered important by family	0 (0%)	23 (2%)
Secondary not considered important by family	1 (1%)	74 (5%)
Expelled	0 (0%)	1 (0%)
Do not have required document	0 (0%)	6 (0%)
Plays truant	0 (0%)	5 (0%)

Health and disability

As evidenced in Table 134, children with a disability were more likely to have had a serious illness in the last twelve months than children without a disability, a pattern that was observed most strongly for those with vision impairment. Boys with disabilities were 9.7 times more likely to have had a serious illness in the last twelve months and girls were 7.1 times more likely. The most common types of illness among the children with disabilities were eye problems, epilepsy and acute respiratory tract infection. Children with malnutrition were much more likely to be disabled than those without, although the numbers affected were very small. Hospital was the

most commonly cited place where treatment was sought. There was a suggestion of a trend in increasing time to nearest health facility being related to disability.

Table 134: Association between health and health seeking behaviour and disability in Colombia

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	103 (84%)	8993 (98%)	Baseline	101 (90%)	12404 (98%)	Baseline
- Yes	20 (16%)	190 (2%)	9.7 (5.9 - 16.1)	11 (10%)	198 (2%)	7.1 (3.7 - 13.4)
Malnutrition						
- No	122 (99%)	9178 (99.9%)	Baseline	111 (99%)	12595 (99.9%)	Baseline
- Yes	1 (1%)	5 (0.1%)	15.3 (1.8 - 132.7)	1 (1%)	7 (0.1%)	20.1 (2.4 - 166.5)
Where sought treatment						
- Other	0 (0%)	1 (1%)	Baseline	0 (0%)	4 (2%)	Baseline
- Hospital	15 (75%)	130 (68%)	-	8 (73%)	129 (65%)	-
- Health clinic	5 (25%)	47 (25%)	-	3 (27%)	51 (26%)	-
- Private	0 (0%)	3 (2%)	-	0 (0%)	4 (2%)	-
- Did not seek	0 (0%)	9 (5%)	-	0 (0%)	10 (5%)	-
Illness prevent school						
- No	5 (36%)	65 (39%)	Baseline	4 (57%)	70 (41%)	Baseline
- Yes	9 (64%)	101 (61%)	1.2 (0.4 - 3.7)	3 (43%)	101 (59%)	0.4 (0.1 - 2.1)
Time taken to nearest health facility						
- <30 minutes	104 (85%)	7320 (80%)	Baseline	86 (77%)	10477 (83%)	Baseline
- 30 minutes-1 hour	14 (11%)	1641 (18%)	0.6 (0.3 - 1.0)	21 (19%)	1895 (15%)	1.3 (0.8 - 2.1)
- 1 – 2 hours	4 (3%)	190 (2%)	1.4 (0.5 - 3.9)	5 (4%)	198 (2%)	2.8 (1.1 - 7.1)

- >2 hours	1 (1%)	32 (0%)	2.2 (0.3 - 16.4)	0 (0%)	32 (0%)	-
Slept under bednet last night						
- No malaria in area	44 (45%)	3381 (43%)	Baseline	44 (50%)	4625 (46%)	Baseline
- Yes	25 (26%)	2053 (26%)	1.0 (0.6 - 1.6)	19 (22%)	2629 (26%)	0.8 (0.5 - 1.4)
- No	29 (30%)	2405 (31%)	0.9 (0.6 - 1.5)	25 (28%)	2830 (28%)	0.9 (0.5 - 1.5)

Other Findings

It was found that the children with disabilities were slightly older than the children without disability, and overall the relationship between disability and indicators of inclusion/exclusion were similar between boys and girls. The poverty variables were not related to disability, nor were the hygiene and sanitation variables.

5.23 Dominican Republic

The country population of the Dominican Republic is 10,276,621 and the percentage of the population that constitutes children between the ages of 0-14 year is 31% (World Bank Population Data, 2013). The Dominican Republic ranks 96 out of 187 countries in the 2013 Human Development Index, making it a country with medium human development (UNDP International Human Development Indicators, 2013). The Government of the Dominican Republic ratified the UN Convention on the Rights of Persons with Disabilities in 2009 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013). Yet, Plan Dominican Republic's situational analysis, undertaken to inform the drafting of the Country Strategic Plan (Plan Dominican Republic, 2013), highlights specific issues affecting children with disabilities. Firstly, it reports that children and young people from excluded groups, such as 'children of Haitian descent, children who live with a disability or on the streets has even lesser opportunities to participate, for reasons that include the limited use of the Creole language, existing prejudices and the lack of understanding of the Haitian culture by those who facilitate children's participation; attitudes in families and rural communities towards disability as an invalidity, and the fact that meeting spaces, methodologies and timetables make it difficult for them to access and attend.' Second, it identifies children and young people with disabilities in relation to natural and man-made hazards and climate change. It states that the case of the populations that have been identified as the most excluded, vulnerability is more acute due to social and institutional invisibility (children and young people of Haitian descent and/or who live with some type of disability); also because of the limited conditions for

accessing basic services and protection mechanisms (children and young people of Haitian descent or living on the streets and lacking documentation); as well as the lack of knowledge of the language needed to receive warnings and advice.

Plan Dominican Republic works in the south western regions, namely Valdesia; specifically in the province of Azua, El Valle; provinces of San Juan de la Maguana and Elías Piña and Enriquillo; specifically in the provinces of Barahona, Independencia and Pedernales. It will also expand its work into the border provinces of Elías Piña (the poorest in the country) and Pedernales. Work will takes place in both urban and rural contexts in the south western provinces. Plan Dominican Republic reports in its Country Strategic Plan (2014-2018) that 'it will work on sensitisation, training and accompaniment of children and young people, tailored to their age and understanding of the topic of disaster risk adaptation, mitigation and preparedness, and with a differentiated approach for children and young people of Haitian descent and other marginalised children (e.g. those living with a disability), via workshops, innovative initiatives and/or micro projects.' In addition, it will place special emphasis on inclusion and non-discrimination against children and young people in situations of extreme poverty and social exclusion and will ensure that all its programmes ensure active participation of all groups, irrespective of age, sex, culture, condition (e.g. disabled).' Plan Dominican Republic will specifically focus its efforts on one excluded group, namely children and young people of Haitian descent.

Plan Dominican Republican have described an overall vision as part of their 2014-2018 Country Strategic Plan: a Dominican Republic in which all children and young people can fully develop their capacities, in a society that respects and guarantees the fulfilment of people's rights and dignity. In order to achieve this vision, they will focus on:

- Children aged 0-5 to develop their full physical, cognitive and socio-emotional potential in safe and protected
- environments;
- Children and young people to develop in safe and protected environments, free from violence and in relationships based
- on love, respect and equality;
- Children and young people to develop in resilient communities that are adaptive to climate change, and their rights are
- protected in the face of natural and man-made hazards;
- Children and young people to complete quality education and acquire knowledge and life skills;
- Young people to develop their autonomy, economic empowerment and an adequate standard of living.

In the Dominican Republic, the 2012 dataset included 26,560 sponsored children, ranging in age from 0-17. The average age was 8.7 (standard deviation=4.7), and 41% were male. Among the children, 178 had 'an impairment/a medical condition that can lead to disability'.This gives a prevalence of disability of 0.7% (95% confidence interval 0.6-0.8%). The prevalence of disability was slightly higher in males (0.8%, 0.6-0.9%) than in females (0.6%, 0.5-0.7%). After adjustment for age, males had slightly higher odds of disability compared to females (1.2, 95% CI 0.9-1.6).

As can be seen in Table 135, the most common types of impairment were physical and vision, while hearing impairments were the least common.

Table 135: Type of impairment by gender in Dominican Republic

	MALES	FEMALES
Learning	14 (17%)	15 (16%)
Physical	30 (36%)	27 (29%)
Communication	18 (21%)	17 (18%)
Vision	17 (20%)	32 (34%)
Hearing	5 (6%)	3 (3%)
Total	84 (100%)	94 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age, as shown in table 136. Boys with disabilities were 16.3 times less likely to attend school and girls with disabilities were 31.0 times less likely to attend school. Children with disabilities were not at a different school level compared to children without disability, although the numbers were too small to make meaningful comparisons. Increased time taken to school was not related to increased disability. Boys with a disability were more likely to be attending non-formal education than those with a disability, but none of the girls attended non-formal education.

Table 136: Educational variables in relation to disability in Dominican Republic

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	51 (61%)	8677 (80%)	Baseline	45 (48%)	11342 (73%)	Baseline
- No	33 (39%)	2161 (20%)	12.1 (6.9 - 21.0)	49 (52%)	4202 (27%)	21.6 (12.6 - 37.2)
Age 5+: Attend formal education						
- Yes	50 (66%)	8481 (95%)	Baseline	43 (54%)	10956 (95%)	Baseline
- No	26 (34%)	458 (5%)	16.3 (9.7 - 27.5)	37 (46%)	592 (5%)	31.0 (18.8 - 51.1)
Of those at school, school level						
- Secondary/University/ College	5 (10%)	942 (11%)	Baseline	2 (4%)	1230 (11%)	Baseline
- Primary	42 (82%)	7157 (82%)	1.6 (0.6 - 4.3)	42 (93%)	9172 (81%)	3.4 (0.7 - 15.3)
- Nursery/pre-school	4 (8%)	578 (7%)	3.0 (0.6 - 15.0)	1 (2%)	940 (8%)	0.9 (0.1 - 12.1)
Time taken to school						
- <30 minutes	46 (90%)	7917 (91%)	Baseline	39 (87%)	10200 (90%)	Baseline
- 30 minutes-1 hour	4 (8%)	709 (8%)	1.0 (0.4 - 2.7)	6 (13%)	1078 (10%)	1.5 (0.6 - 3.5)
- >1 hour	1 (2%)	51 (1%)	3.0 (0.4 - 22.7)	0 (0%)	64 (1%)	-
Attending non formal education						
- No	82 (98%)	10800 (100%)	Baseline	94 (100%)	15505 (100%)	Baseline
- Yes	2 (2%)	38 (0%)	5.9 (1.4 - 24.9)	0 (0%)	39 (0%)	-

As illustrated in Table 137, considering the data by type of impairment, physical and communication impairment had the greatest effect on school attendance, followed by hearing and learning impairment. This overall pattern was apparent within boys and girls, although exclusion among girls with communication impairment was particularly noted.

Table 137: Attendance of formal education by impairment type in Dominican Republic

	All ages		Age 5+				
	Attend formal education	Do not attend formal education	Attend formal education	Do not attend formal education	Males: Age adjusted OR	Females: Age adjusted OR	Total group: Age and sex adjusted OR
No disability	20019 (76%)	6363 (24%)	19437 (95%)	1050 (5%)	Baseline	Baseline	Baseline
Learning	18 (62%)	11 (38%)	18 (64%)	10 (36%)	17.5 (4.1 - 75.0)	156.7 (38.7 - 634.9)	51.3 (19.8 - 132.5)
Physical	22 (39%)	35 (61%)	22 (44%)	28 (56%)	86.4 (32.4 - 230.5)	119.6 (43.2 - 330.7)	104.7 (51.0 - 215.3)
Communication	14 (40%)	21 (60%)	13 (42%)	18 (58%)	52.3 (15.8 - 172.6)	1208.2 (251.8 - 5796.9)	185.1 (74.5 - 460.1)
Vision	37 (76%)	12 (24%)	35 (90%)	4 (10%)	-	6.8 (2.1 - 22.8)	2.7 (0.9 - 8.2)
Hearing	5 (63%)	3 (38%)	5 (63%)	3 (38%)	29.0 (3.3 - 250.9)	7.8 (0.5 - 135.0)	18.8 (3.2 - 111.8)

In line with the overall findings and as seen in Table 138, being ill/having an impairment was cited as the major reason for not attending formal education among children with disabilities (68%) while being too young was the most common reason among children without disability (98%).

Table 138: Reason for not attending formal education by disability status in Dominican Republic

	Disabled	Non disabled
Too young	20 (24%)	6235 (98%)
Too old	1 (1%)	9 (0%)
Economic problems	2 (2%)	6 (0%)

	Disabled	Non disabled
Closest school too far	0 (0%)	6 (0%)
Has been ill	43 (52%)	5 (0%)
Is married	0 (0%)	19 (0%)
Needed to help family	0 (0%)	3 (0%)
Has an impairment	14 (17%)	2 (0%)
Is working outside family	0 (0%)	6 (0%)
Was expelled for class repetition	0 (0%)	2 (0%)
Primary not considered important by family	1 (1%)	21 (0%)
Secondary not considered important by family	0 (0%)	10 (0%)
Expelled	0 (0%)	7 (0%)
Fears violence at school	0 (0%)	1 (0%)
Fears violence on way to school	0 (0%)	1 (0%)
Do not have required document	1 (1%)	15 (0%)
Plays truant	0 (0%)	15 (0%)

Health and disability

The occurrence of a serious illness was low in both children with disabilities and those without, which limited the ability to detect statistical differences. As can be seen in Table 139, children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed most strongly for those with physical impairment. Boys with disabilities were 5.9 times more likely to have had a serious illness in the last twelve months and girls were 9.3 times more likely. The most common types of illness among the children with disabilities were eye (20%) and ear (13%) problems. There was insufficient data on malnutrition to assess whether this was more common in those with disability than those without. Only one child with disability did not seek treatment for the illness. When seeking treatment, a hospital was the most commonly cited place where treatment was sought, but the numbers were too small to make meaningful comparisons. Finally, time taken to the nearest health facility was not related to increased disability.

Table 139: Association between health and health seeking behaviour and disability in Dominican Republic

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	79 (94%)	10709 (99%)	Baseline	84 (89%)	15342 (99%)	Baseline
- Yes	5 (6%)	129 (1%)	5.9 (2.3 - 15.0)	10 (11%)	202 (1%)	9.3 (4.7 - 18.2)
Malnutrition						
- No	84 (100%)	10835 (100%)	Baseline	93 (99%)	15539 (99.97%)	Baseline
- Yes	0 (0%)	3 (0%)	-	1 (1%)	5 (0.03%)	39.6 (4.5 - 349.8)
Where sought treatment						
- Other	1 (20%)	6 (5%)	Baseline	1 (10%)	13 (6%)	Baseline
- Hospital	3 (60%)	104 (81%)	0.2 (0.0 - 2.3)	7 (70%)	144 (71%)	0.8 (0.1 - 6.9)
- Health clinic	1 (20%)	12 (9%)	0.5 (0.0 - 9.5)	1 (10%)	30 (15%)	0.6 (0.0 - 10.3)
- Private	0 (0%)	1 (1%)	-	0 (0%)	3 (1%)	-
- Did not seek	0 (0%)	6 (5%)	-	1 (10%)	12 (6%)	1.8 (0.1 - 37.4)
Illness prevent school						
- No	4 (100%)	63 (72%)	Baseline	5 (71%)	70 (49%)	Baseline
- Yes	0 (0%)	25 (28%)	-	2 (29%)	72 (51%)	0.4 (0.1 - 2.4)
Time taken to nearest health facility						
- <30 minutes	73 (87%)	9388 (87%)	Baseline	80 (85%)	13470 (87%)	Baseline
- 30 minutes-1 hour	10 (12%)	1324 (12%)	1.0 (0.5 - 1.9)	12 (13%)	1897 (12%)	1.0 (0.6 - 1.9)
- 1 – 2 hours	1 (1%)	109 (1%)	1.1 (0.1 - 7.8)	1 (1%)	137 (1%)	1.2 (0.2 - 8.4)
- >2 hours	0 (0%)	17 (0.2%)	-	1 (1%)	40 (0.3%)	4.2 (0.6 - 31.1)
Slept under bednet last night						
- No malaria in	0 (0%)	78 (1%)	Baseline	3 (3%)	87 (1%)	Baseline

	area					
-	Yes	39 (51%)	4417 (45%)	-	43 (50%)	6659 (47%)	0.2 (0.1 - 0.7)
-	No	38 (49%)	5351 (54%)	-	40 (47%)	7502 (53%)	0.2 (0.0 - 0.5)

Other Findings

Overall, the children with disabilities were older than the children without disability and the relationship between disability and indicators of inclusion/exclusion was very similar between boys and girls. The poverty, hygiene and sanitation variables were not related to disability.

5.24 Ecuador

The country population of Ecuador is 15,492,264 and the percentage of the population that constitutes children between the ages of 0-14 year is 30% (World Bank Population Data, 2013). Ecuador ranks 89 out of 187 countries in the 2013 Human Development Index, making it a country with high human development (UNDP International Human Development Indicators, 2013). The Government of Ecuador ratified the UN Convention on the Rights of Persons with Disabilities in 2008 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013). According to Plan Ecuador's situational analysis, undertaken to inform the drafting of the new Country Strategic Plan (2013-2018), nearly 1,608,000 people with disabilities live in Ecuador (Plan Ecuador, 2012). This group is severely marginalised by families, communities and society, as they are systematically excluded from exercising their rights to opportunities and resources normally available to rest of the citizens. INEC (Estadístico Instituto Nacional de Estadística y Censos) data indicates that 2.8% of children and adolescents 0 to 17 (149,832) have had some kind of permanent disability for more than 1 year. In 2007 it was reported that 1.2% of all children under 5 had some kind of disability and between 20% and 25% of newborns have psycho-neurosensory handicaps, while the most frequent functional deficiencies of children under 5 years are standing, walking alone and communicating, (72.5%). In the situation analysis it was noted that according to the National Survey on Employment, Unemployment and Sub-employment of 2010, 11.2% of children between the ages of 5 and 14 who are out of school, are not enrolled due to a disability or illness.

Plan Ecuador operates in 11 of the country's 24 provinces, mainly the Sierra and Coastal Regions, but also extends to cover marginalised urban areas (approx 20% of Plan Ecuador's projects). Plan Ecuador defined a vision for its programmatic response, which was to ensure**:** 'An Ecuador in which all children and adolescents develop their skills for empowerment to live healthy and safe lives in a society committed to protection of children and adolescents, human rights, and equality'. In order to achieve this vision Plan Ecuador has following country development objectives:

- Enable children and adolescents to access quality education in settings that are democratic, safe, and inclusive and with equal opportunity for all.
- Help children and adolescents exercise their right to protection in family and community settings that are safe and free of physical and psychological violence, including that which occurs in emergency situations.
- Contribute to the empowerment of children and adolescents so that they can make healthy, safe and informed choices for the progressive and safe exercise of their sexual and reproductive rights.

In Ecuador, the 2012 dataset included 47,070 sponsored children, ranging in age from 0-17. The average age was 9.7 (standard deviation=4.2), and 46% were male. Among the children, 793 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.7% (95% confidence interval 1.6-1.8%). The prevalence of disability was slightly higher in males (1.9%, 95% CI1.8-2.1%) than in females (1.5%, 95% CI 1.3-1.6%). After adjustment for age, males had a significantly higher odds of disability compared to females (OR=1.3, 95% CI=1.1-1.5).

As can be seen in Table 140, learning, communication, physical and vision impairments were approximately equally common, while hearing impairments were less frequent.

Table 140: Type of impairment by gender in Ecuador

	MALES	FEMALES
Learning	88 (21%)	81 (22%)
Communication	96 (23%)	81 (22%)
Physical	106 (25%)	95 (25%)

Vision	100 (24%)	99 (26%)
Hearing	29 (7%)	18 (5%)
Total	419	374

Education and disability

Children with disabilities were substantially less likely not to attend formal education, compared to age-matched children without disability, as can be seen in Table 141. Boys with disabilities were 11.3 times less likely to attend school and girls with disabilities were 9.1 times less likely to attend school. Furthermore, of those at school the children with disabilities were much more likely to be at a lower school level compared to the children with disabilities, after matching for age. There was little difference between children with and without disability in distance to school or attendance of non-formal education.

Table 141: Educational variables in relation to disability in Ecuador

	MALES			**FEMALES**		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education Yes No	283 (68%) 136 (32%)	19129 (90%) 2026 (10%)	Baseline 5.0 (4.0-6.2)	258 (69%) 116 (31%)	22017 (88%) 3105 (12%)	Baseline 3.6 (2.9-4.5)
Age 5+: Attend formal education Yes No	269 (69%) 120 (31%)	17910 (95%) 883 (5%)	Baseline 11.3 (8.8-14.6)	237 (71%) 97 (29%)	20220 (95%) 1167 (5%)	Baseline 9.1 (6.9-11.9)
Of those at school, school level Nursery/pre-school Primary Secondary/University/College	26 (9%) 197 (70%) 60 (21%)	1459 (8%) 11533 (60%) 6137 (32%)	6.9 (3.4-14.1) 3.4 (2.3-5.0) Baseline	25 (10%) 180 (70%) 53 (21%)	2070 (9%) 13570 (62%) 6377 (29%)	3.3 (1.5-6.9) 2.4 (1.6-3.6) Baseline

Time taken to school <30 minutes 30 minutes-1 hour >1 hour	227 (80%) 47 (17%) 9 (3%)	14669 (77%) 3934 (21%) 526 (3%)	Baseline 0.8 (0.6-1.1) 1.1 (0.6-2.2)	211 (82%) 42 (16%) 5 (2%)	16896 (77%) 4565 (21%) 556 (3%)	Baseline 0.7 (0.5-1.0) 0.7 (0.3-1.8)
Attending non formal education Yes No	40 (10%) 379 (90%)	1707 (8%) 19448 (92%)	1.1 (0.8-1.6) Baseline	41 (11%) 333 (89%)	1960 (8%) 23162 (92%)	1.4 (1.0-1.9) Baseline

As illustrated in Table 142, when the data was disaggregated by type of disability, it was found that children who had learning, physical or communication impairment were far less likely to attend formal education compared to those children without disability. In contrast, there was no difference between the children with vision or hearing impairment compared to those with no disability in terms of attendance of formal education. These patterns were similar in boys and girls.

Table 142: Attendance of formal education by impairment type in Ecuador

	All ages		**Age 5+**				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
Learning	106 (63%)	63 (37%)	101 (64%)	58 (36%)	19.3 (11.6-32.1)	15.3 (8.7-26.8)	17.4 (11.9-25.4)
Physical	97 (55%)	80 (45%)	89 (58%)	64 (42%)	25.3 (15.2-42.3)	11.9 (6.6-21.5)	18.3 (12.4-26.9)
Communication	120 (60%)	81 (40%)	104 (59%)	73 (41%)	23.8 (14.8-38.5)	22.7 (13.4-38.5)	23.3 (16.4-33.2)
Vision	176 (88%)	23 (12%)	172 (91%)	18 (9%)	1.9 (0.9-4.1)	2.5 (1.2-5.1)	2.2 (1.3-3.7)
Hearing	42 (89%)	5 (11%)	40 (91%)	4 (9%)	2.0 (0.6-7.4)	1.1 (0.1-8.9)	1.7 (0.6-4.9)

No disability	41146 (89%)	5131 (11%)	35130 (95%)	2050 (5%)	Baseline	Baseline	Baseline

In line with the overall findings, impairment or illness was cited as major reason for not attending formal education among children with disabilities (84%), while being too young was the most common reason among children without a disability (62%).

Table 143: Reason for not attending formal education by disability status in Ecuador

	Disabled	Not disabled
Too young	24 (10%)	3200 (62%)
Too old	0	43 (1%)
Did not pass secondary school exam	0	4
Economic problems	6 (2%)	420 (8%)
Closest school too far	0	64
Has been ill	28 (11%)	5 (0.1%)
Is married	1 (0.4%)	229 (4%)
Needed to help family	2 (0.8%)	712 (14%)
Has an impairment	183 (73%)	7 (0.1%)
Is working outside family	1 (0.4%)	57 (1%)
Was expelled for class repetition	0	17 (0.3%)
Primary not considered important by family	1 (0.4%)	96 (2%)
Secondary not considered important by family	2 (0.8%)	162 (3%)
Expelled	0	3
Fears violence at school	0	6
Fears violence on way to school	0	3
Do not have required document	1	31
Plays truant	3 (1%)	93 (2%)

Health and disability

Children with disabilities were significantly more likely to have had a serious illness in the last twelve months than children without disability, as can be seen in Table 144. This pattern was observed for children of all disability types. Boys with disabilities were 5.3 times more likely to have had a serious illness in the last twelve months and girls were 5.8 times more likely. The most common types of illness among the children with disabilities were acute respiratory tract infection, eye problems, ear infection, mental health problem, and influenza. In addition, malnutrition was significantly more common among children with disabilities compared to those without. Almost all children with a serious illness had sought treatment (98% of children with disabilities and 98% of children without disability). Among the few who had not sought treatment, the most commonly cited reasons were 'treatment not needed' (44%), 'too expensive' (31%) or 'no time' (19%).

The boys with disabilities were less likely to seek treatment from mainstream health services than the boys without disability, but this difference was not observed for the girls. There was little difference between the children with and without disability in terms of whether the illness prevented school attendance, or in relation to distance to the nearest health facility. Children with disabilities were more likely to have slept under a bednet the previous night than children without disability. Finally, there was too much missing data to be able to assess the relationship between vaccination history and disability.

Table 144: Association between health and health seeking behaviour and disability in Ecuador

	MALES			**FEMALES**		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- Yes	96 (23%)	1158 (5%)	5.3 (4.2-6.7)	88 (24%)	1291 (5%)	5.8 (4.6-7.5)
- No	323 (77%)	19997 (95%)	Baseline	286 (76%)	23831 (95%)	Baseline
Malnutrition						
- Yes	3 (0.7%)	21 (0.1%)	7.5 (2.2-25.3)	4 (1%)	23 (0.1%)	12.6 (4.3-36.7)
- No	416 (99.3%)	21134 (99.9%)	Baseline	370 (99%)	25099 (99.9%)	Baseline
Where sought treatment	39 (41%)	380 (33%)	2.0 (0.8-4.9)	44 (50%)	414 (32%)	1.6 (0.8-3.4)
- Hospital	41 (43%)	524 (45%)	1.6 (0.6-3.7)	26 (30%)	602 (47%)	0.7 (0.3-1.4)
- Health clinic	10 (10%)	102 (9%)	2.1 (0.7-5.9)	6 (7%)	112 (9%)	0.8 (0.3-2.4)

- Private - Other - Did not seek	6 (6%) 0	117 (10%) 0	Baseline -	9 (10%) 3 (3%)	137 (11%) 26 (2%)	Baseline 1.7 (0.4-6.8)
Illness prevent school Yes No	 36 (49%) 37 (51%)	 415 (44%) 537 (56%)	 1.3 (0.8-2.0) Baseline	 32 (48%) 35 (52%)	 420 (41%) 606 (59%)	 1.3 (0.8-2.2) Baseline
Time taken to nearest health facility <30 minutes 30 minutes-1 hour 1-2 hours >2 hours	 322 (77%) 73 (17%) 23 (5%) 1 (0.2%)	 15408 (73%) 4694 (22%) 932 (4%) 121 (0.6%)	 Baseline 0.67 (0.6-1.0) 1.2 (0.8-1.8) 0.4 (0.1-2.8)	 269 (72%) 87 (23%) 14 (4%) 4 (1%)	 18174 (72%) 5594 (22%) 1175 (5%) 179 (0.7%)	 Baseline 1.0 (0.8-1.3) 0.8 (0.5-1.4) 1.5 (0.6-4.1)
Slept under bednet last night No malaria in area Yes No	 131 (33%) 232 (58%) 37 (9%)	 8259 (41%) 9472 (47%) 2484 (12%)	 Baseline 1.6 (1.3-2.0) 1.0 (0.7-1.4)	 119 (34%) 203 (58%) 31 (9%)	 9789 (41%) 11203 (47%) 2987 (12%)	 Baseline 1.5 (1.2-1.9) 0.9 (0.6-1.3)

Other Findings

Overall, the children with disabilities were significantly older than the children without disability and the relationship between disability and indicators of inclusion/exclusion were remarkably similar between boys and girls. The poverty variables showed some relationship with disabilities, particularly among the girls and among the girls a low asset score was related to the presence of disability, though not among the boys. Finally, children with a disability had poorer access to water, both in terms of accessing unofficial sources rather than piped water, and in terms of distance to water.

5.25 El Salvador

The country population of El Salvador is 6,297,394 and the percentage of the population that constitutes children between the ages of 0-14 year is 31% (World Bank Population Data, 2013). El Salvador ranks 107 out of 187 countries in the 2013 Human Development Index, making it a country with medium human development (UNDP International Human Development Indicators, 2013). The government of El Salvador ratified the UN Convention on the Rights of Persons with Disabilities in 2007 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan El Salvador's situation analysis undertaken to inform the drafting of the Country Strategic Plan mentions disability in relation to education and health. 'The average health service coverage during the first month of life is 57%, which delays the vaccination plan, nutrition vigilance actions, and early diagnosis of disabilities.' It also refers to recommendations of the Child Rights Committee, who recommend to: i)provide equal access to health services without discriminating any child, ii) urgently resolve the problem of excessive cost of medicines, and iii) implement the Basic Integrated Health Systems Law. In terms of education, the recent improvements are mentioned, nonetheless 'the education system in general still has deficient coverage and excludes girls, poor boys and children with disabilities. 64% do not complete sixth grade, less than 15% graduate from high school, and less than 9% have access to higher education. That exclusion perpetuates and deepens structural poverty that seriously limits people's access to the opportunities they need to improve their life conditions' (Plan El Salvador, 2011).

Plan El Salvador works in predominantly rural communities in 60 municipalities located in the five departments of Cabañas, Cuscatlán, Chalatenango, San Salvador and La Libertad. As part of their CSP process Plan El Salvador included a youth representative with a physical disability (blindness). In the CSP (2011-2016) they say 'Youth representative participation has not only enriched the CSP, but has also served as a valuable learning and growth experience for them, as acknowledged by the youths themselves.' The overall goal of the current Country Strategic Plan is to help create the conditions for acknowledgement and guarantee of social citizenship for children, adolescents and youths, by promoting the full exercise of their rights. In order to achieve this goal, Plan El Salvador has the following programmes:

- Right to a healthy start in life
- Right to protection against all forms of violence

- Right to economic security, sexual and reproductive health and education
- Right to participate as citizens
- Right to protection in emergencies and to live in resilient communities

In El Salvador, the 2012 dataset included 34,814 sponsored children, ranging in age from 0-17. The average age was 10.1 (standard deviation=4.0), and 45% were male. Among the children, 646 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.9% (95% confidence interval 1.7- 2.0 %). The prevalence of disability was higher in males (2.2 %, 95% CI 2.0 – 2.4 %) than in females (1.6 %, 95% CI 1.4 – 1.7 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.4, 95% CI 1.2 – 1.6).

As can be seen in Table 145, the most common types of impairment were physical and communication, whereas learning, vision and hearing impairments were less common.

Table 145: Type of impairment by gender in El Salvador

	MALES	FEMALES
Learning	35 (10%)	27 (9%)
Physical	124 (36%)	108 (36%)
Communication	116 (34%)	99 (33%)
Vision	50 (14%)	45 (15%)
Hearing	21 (6%)	21 (7%)
Total	346 (100%)	300 (100%)

Education and disability

As indicated in Table 146, children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. Boys with disabilities were 6.3 times less likely to attend school and girls with disabilities were 5.0 times less likely to attend school. Of those at school, the children with disabilities were more likely to be at a lower school level compared to children without disability, after accounting for age differences, with the difference particularly marked for boys. There was minimal difference in the time taken to get to school for those with disabilities compared to those without disability.

Table 146: Educational variables in relation to disability in El Salvador

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	211 (61%)	12983 (84%)	Baseline	194 (65%)	15241 (81%)	Baseline
- No	135 (39%)	2413 (16%)	4.8 (3.9 - 6.1)	106 (35%)	3531 (19%)	3.6 (2.8 - 4.7)
Age 5+: Attend formal education						
- Yes	210 (63%)	12888 (91%)	Baseline	192 (69%)	15053 (92%)	Baseline
- No	122 (37%)	1214 (9%)	6.3 (5.0 - 7.9)	88 (31%)	1397 (8%)	5.0 (3.9 - 6.5)
Of those at school, school level						
- Secondary/University/College	36 (17%)	2786 (21%)	Baseline	44 (23%)	3566 (23%)	Baseline
- Primary	160 (76%)	8804 (68%)	2.6 (1.7 - 4.1)	134 (69%)	9898 (65%)	2.0 (1.3 - 3.2)
- Nursery/pre-school	15 (7%)	1393 (11%)	3.3 (1.4 - 7.6)	16 (8%)	1777 (12%)	2.7 (1.1 - 6.4)
Time taken to school						
- <30 minutes	177 (84%)	10986 (85%)	Baseline	169 (87%)	12768 (84%)	Baseline
- 30 minutes-1 hour	32 (15%)	1887 (15%)	1.0 (0.7 - 1.5)	24 (12%)	2335 (15%)	0.7 (0.5 - 1.1)
- >1 hour	2 (1%)	110 (1%)	1.1 (0.3 - 4.3)	1 (1%)	138 (1%)	0.5 (0.1 - 3.5)
Attending non formal education						
- No	345 (99.7%)	15348 (99.7%)	Baseline	296 (99%)	18731	Baseline

					(99.8%)	
- Yes	1 (0.3%)	48 (0.3%)	0.7 (0.1-5.2)	4 (1%)	41 (0.2%)	5.0 (1.8-14.1)

As shown in Table 147, considering the data by type of disability, learning and communication impairment had the strongest association with school attendance, followed by physical and vision impairment. There was no observed association between having a hearing impairment and not attending school, but the sample lacked power for this analysis. This overall pattern was apparent within boys and girls.

Table 147: Attendance of formal education by impairment type in El Salvador

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
Learning	26 (42%)	36 (58%)	26 (45%)	32 (55%)	19.3 (9.5 - 39.5)	9.2 (4.2 - 20.3)	13.9 (8.3 - 23.4)
Physical	151 (65%)	81 (35%)	149 (70%)	65 (30%)	5.1 (3.5 - 7.6)	4.3 (2.8 - 6.8)	4.8 (3.6 - 6.4)
Communication	115 (53%)	100 (47%)	115 (55%)	93 (45%)	9.8 (6.7 - 14.3)	8.5 (5.6 - 12.7)	9.1 (6.9 - 12.1)
Vision	76 (80%)	19 (20%)	75 (83%)	15 (17%)	2.5 (1.2 - 5.1)	1.9 (0.8 - 4.4)	2.2 (1.2 - 3.8)
Hearing	37 (88%)	5 (12%)	37 (88%)	5 (12%)	1.9 (0.6 - 6.5)	1.3 (0.3 - 5.4)	1.6 (0.6 - 4.0)
No disability	28224 (83%)	5944 (17%)	27941 (91%)	2611 (9%)	Baseline	Baseline	Baseline

In line with the overall findings and as illustrated in table 148, having an impairment was cited as the major reason for not attending formal education among children with disabilities (63%) while being too young was the most common reason among children without disability (76%).

Table 148: Reason for not attending formal education by disability status in El Salvador

	Disabled	Not disabled
Too young	55 (23%)	4518 (76%)
Too old	0 (0%)	11 (0%)
Did not pass secondary school exam	0 (0%)	3 (0%)

	Disabled	Not disabled
Economic problems	9 (4%)	303 (5%)
Closest school too far	1 (0%)	103 (2%)
Has been ill	9 (4%)	35 (1%)
Is married	0 (0%)	57 (1%)
Needed to help family	0 (0%)	22 (0%)
Has an impairment	151 (63%)	2 (0%)
Is working outside family	1 (0%)	102 (2%)
Was expelled for class repetition	0 (0%)	41 (1%)
Primary not considered important by family	4 (2%)	226 (4%)
Secondary not considered important by family	11 (5%)	464 (8%)
Expelled	0 (0%)	5 (0%)
Fears violence at school	0 (0%)	14 (0%)
Fears violence on way to school	0 (0%)	6 (0%)
Do not have required document	0 (0%)	7 (0%)
Plays truant	0 (0%)	25 (0%)

Health and disability

Children with a disability were more likely to have had a serious illness in the last twelve months than children without disability, a pattern that was observed across all types of impairment. Boys with disabilities were 2.5 times more likely to have had a serious illness in the last twelve months and girls were 3.0 times more likely. The most common types of illness among the children with disabilities were epilepsy, mental health problems, acute respiratory tract infection and eye problems. There was insufficient data on malnutrition in boys to assess whether this was more common in those with disabilities than those without, but a strong association was observed for girls. The majority of children with a serious illness had sought treatment (93% in those with a disability and 94% in those without). Among the few who had not sought treatment, the most commonly cited reason amongst disabled children was ‘no time’ (89%) while non-disabled children cited ‘not available’ (69%).

Hospital or health clinics were the most commonly cited places where treatment was sought. There was little difference between the children with and without disability in terms of whether the illness prevented school attendance or distance to the nearest health facility. Children with a disability were more likely to have slept without a bednet the previous night than children without a disability.

Table 149: Association between health and health seeking behaviour and disability in El Salvador

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	281 (81%)	14042 (91%)	Baseline	242 (81%)	17349 (92%)	Baseline
- Yes	65 (19%)	1354 (9%)	2.5 (1.9 - 3.4)	58 (19%)	1423 (8%)	3.0 (2.3 - 4.1)
Malnutrition						
- No	346 (100%)	15373 (99.8%)	Baseline	298 (99%)	18754 (99.9%)	Baseline
- Yes	0 (0%)	23 (0.2%)	-	2 (1%)	18 (0.1%)	7.7 (1.8 - 33.7)
Where sought treatment						
- Other	4 (6%)	90 (7%)	Baseline	0 (0%)	112 (8%)	Baseline
- Hospital	36 (55%)	383 (28%)	2.0 (0.7 - 5.8)	29 (50%)	344 (24%)	-
- Health clinic	20 (31%)	783 (58%)	0.5 (0.2 - 1.6)	25 (43%)	860 (60%)	-
- Private	0 (0%)	22 (2%)	-	0 (0%)	17 (1%)	-
- Did not seek	5 (8%)	76 (6%)	1.3 (0.3 - 5.1)	4 (7%)	90 (6%)	-
Illness prevent school						
- Yes	25 (66%)	572 (53%)	Baseline	19 (58%)	588 (54%)	Baseline
- No	13 (34%)	503 (47%)	0.6 (0.3 - 1.2)	14 (42%)	499 (46%)	0.9 (0.4 - 1.8)
Time taken to nearest health facility						
- <30 minutes	171 (49%)	7090 (46%)	Baseline	147 (49%)	8723 (46%)	Baseline
- 30 minutes-1 hour	135 (39%)	6062 (39%)	0.9 (0.7 - 1.2)	118 (39%)	7493 (40%)	0.9 (0.7 - 1.2)
- 1 – 2 hours	36 (10%)	1884 (12%)	0.8 (0.5 - 1.1)	27 (9%)	2142 (11%)	0.8 (0.5 - 1.1)
- >2 hours	4 (1%)	360 (2%)	0.4 (0.2 - 1.2)	8 (3%)	414 (2%)	1.2 (0.6 - 2.4)
Slept under bednet last night						

- No malaria in area	325 (99%)	14448 (99.6%)	Baseline	283 (99%)	17636 (99%)	Baseline
- Yes	0 (0%)	1 (0%)	-	0 (0%)	1 (0.01%)	-
- No	4 (1%)	61 (0.4%)	3.3 (1.2 - 9.3)	4 (1%)	139 (1%)	2.3 (0.8 - 6.4)

Other Findings

Overall the children with disabilities were slightly older than the children without disability and the relationship between disability and indicators of inclusion/exclusion were similar between boys and girls. The poverty score was not related to disabilities, nor for the most part were the hygiene or sanitation variables.

5.26 Guatemala

The country population of Guatemala is 15,082,831 and the percentage of the population that constitutes children between the ages of 0-14 year is 41% (World Bank Population Data, 2013). Guatemala ranks 133 out of 187 countries in the 2013 Human Development Report, making it a country with medium human development (UNDP International Human Development Indicators, 2013). The Government of Guatemala ratified the UN Convention on the Rights of Persons with Disabilities in 2009 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan Guatemala's situation analysis undertaken to inform the drafting of the Country Strategic Plan (CSP 2012-2016) refers to 'the National Survey on Disability (ENDIS), conducted in Guatemala in 2004, this shows that 2% of children are affected by some disability, with the leading causes being birth defects (64.4%)' and problems and/or complications with pregnancy and delivery (7.5%) (Plan Guatemala, 2012). The situational analysis describes how children with disabilities are at high risk of suffering human rights violations due to actions or the neglect of people around them 'they are also easy targets for physical, emotional and sexual aggression.'

Plan Guatemala works in rural, indigenous communities in 636 communities in 15 municipalities, namely Polochic, Carcha, Salama, Rabinal, Jalapa, Gualan and the Country Office – and will increase programme efforts in the Polochic area, one of the poorest and most excluded areas of country, with a high percentage of Maya population.

In the CSP it is reported that a key aspect of Plan's work will be to combat exclusion and discrimination and to reduce the inequities faced by vulnerable groups, particularly girls, indigenous children and children with disability. Plan Guatemala will work towards greater respect, protection and fulfilment of child and adolescent rights by the Duty Bearer and Co-responsible parties. In order to achieve this, Plan Guatemala has following five programmes:

- Early Childhood Care and Development
- Inclusive Schools
- Skills for Life
- Citizenship for Development
- Protecting Children from Disasters

In Guatemala, the 2012 dataset included 38,797 sponsored children, ranging in age from 0-17. The average age was 9.9 (standard deviation=3.9), and 44% were male. Among the children, 432 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.1% (95% confidence interval 1.0-1.2%). The prevalence of disability was slightly higher in males (1.3%, 95% CI 1.1-1.5%) than in females (1.0%, 95% CI 0.8-1.1%). After adjustment for age, males had significantly higher odds of disability compared to females (1.3, 95% CI 1.1-1.6).

As can be seen in Table 150, the most common types of impairment were communication, physical and vision impairment, while hearing and learning impairments were less common.

Table 150: Type of impairment by gender in Guatemala

	MALES	FEMALES
Learning	24 (11%)	24 (12%)
Physical	57 (25%)	48 (23%)
Communication	75 (33%)	57 (28%)
Vision	53 (24%)	65 (31%)
Hearing	16 (7%)	13 (6%)

Total	225 (100%)	207 (100%)

Education and disability

As can be seen in Table 151, children with a disability were much less likely to attend formal education than those without a disability, after taking account of age. Boys with disabilities were 5.3 times less likely to attend school and girls with disabilities were 4.0 times less likely to attend school. Children with a disability were also more likely to be at a lower school level compared to children without a disability, after accounting for age differences. Increased time taken to school was not related to increased disability. There were also very low levels of attendance at non-formal education among all children.

Table 151: Educational variables in relation to disability in Guatemala

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	127 (56%)	14443 (85%)	Baseline	118 (57%)	16131 (75%)	Baseline
- No	98 (44%)	2450 (15%)	4.6 (3.5 - 6.0)	89 (43%)	5341 (25%)	2.5 (1.9 - 3.3)
Age 5+: Attend formal education						
- Yes	127 (59%)	14358 (89%)	Baseline	115 (59%)	15906 (85%)	Baseline
- No	88 (41%)	1854 (11%)	5.3 (4.0 - 7.0)	79 (41%)	2842 (15%)	4.0 (3.0 - 5.3)
Of those at school, school level						
- Secondary/University/College	14 (11%)	2314 (16%)	Baseline	11 (9%)	2006 (12%)	Baseline
- Primary	102 (80%)	11062 (77%)	3.0 (1.6 - 5.8)	88 (75%)	12481 (77%)	1.8 (0.9 - 3.8)
- Nursery/pre-school	11 (9%)	1067 (7%)	7.8 (2.7 - 22.6)	19 (16%)	1644 (10%)	4.2 (1.4 - 12.3)
Time taken to school						
- <30 minutes	108 (85%)	12306 (85%)	Baseline	103 (87%)	13759 (85%)	Baseline
- 30 minutes-1 hour	17 (13%)	1922 (13%)	1.0 (0.6 - 1.6)	13 (11%)	2183 (14%)	0.8 (0.4 - 1.4)
- >1 hour	2 (2%)	215 (1%)	0.9 (0.2 - 3.6)	2 (2%)	189 (1%)	1.4 (0.4 - 5.9)

Attending non formal education						
- No	225 (100%)	16868 (99.8%)	Baseline	206 (100%)	21446 (99.9%)	Baseline
- Yes	0 (0%)	25 (0.2%)	-	1 (0%)	26 (0.1%)	3.3 (0.4 - 24.7)

As evidenced in Table 152, considering the data by type of impairment, learning impairments had the greatest effect on school attendance, followed by physical and communication impairment. There was little impact on vision or hearing impairment on school attendance. This overall pattern was apparent within boys and girls.

Table 152: Attendance of formal education by impairment type in Guatemala

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	30574 (80%)	7791 (20%)	30264 (87%)	4696 (13%)	Baseline	Baseline	Baseline
Learning	12 (25%)	36 (75%)	12 (25%)	36 (75%)	24.4 (9.0 - 66.1)	14.4 (5.8 - 35.6)	18.3 (9.4 - 35.6)
Physical	57 (54%)	48 (46%)	55 (56%)	43 (44%)	4.9 (2.8 - 8.5)	7.0 (3.8 - 13.0)	5.8 (3.8 - 8.7)
Communication	65 (49%)	67 (51%)	64 (51%)	61 (49%)	8.1 (5.0 - 12.9)	5.1 (2.9 - 8.8)	6.6 (4.6 - 9.5)
Vision	91 (77%)	27 (23%)	91 (83%)	19 (17%)	1.5 (0.7 - 3.3)	1.2 (0.6 - 2.3)	1.3 (0.8 - 2.2)
Hearing	20 (69%)	9 (31%)	20 (71%)	8 (29%)	2.4 (0.8 - 7.7)	2.4 (0.7 - 8.1)	2.4 (1.0 - 5.6)

In line with the overall findings and as seen in table 153, illness or impairment were cited as the major reason for not attending formal education among children with disability (71%) while being too young was the most common reason among children without disability (71%).

Table 153: Reason for not attending formal education by disability status in Guatemala

	Disabled	**Not disabled**
Too young	38 (20%)	4525 (58%)

	Disabled	Not disabled
Too old	1 (1%)	183 (2%)
Economic problems	2 (1%)	263 (3%)
Closest school too far	1 (1%)	145 (2%)
Has been ill	18 (10%)	48 (1%)
Is married	0 (0%)	188 (2%)
Needed to help family	8 (4%)	1571 (20%)
Has an impairment	115 (61%)	2 (0%)
Is working outside family	0 (0%)	195 (3%)
Was expelled for class repetition	0 (0%)	3 (0%)
Primary not considered important by family	2 (1%)	348 (4%)
Secondary not considered important by family	2 (1%)	205 (3%)
Expelled	0 (0%)	5 (0%)
Fears violence at school	0 (0%)	16 (0%)
Fears violence on way to school	0 (0%)	23 (0%)
Do not have required document	0 (0%)	12 (0%)
Plays truant	0 (0%)	59 (1%)

Health and disability

As shown in Table 154, children with a disability were more likely to have had a serious illness in the last twelve months than children without a disability, a pattern that was observed consistently across all impairment types. Boys with disabilities were 4.7 times more likely to have had a serious illness in the last twelve months and girls were 3.9 times more likely. The most common types of illness among the children with disability were acute respiratory tract infection (19%) and eye (10%) or ear (9%) problems. There was insufficient data on malnutrition to assess whether this was more common in those with a disability than those without. Not seeking treatment was rare among children. Among those who had not sought treatment, the most commonly cited reason was ‘advised not needed’.

The health clinic was the most commonly cited place where treatment was sought. There was a suggestion that children with disabilities were more likely to seek care at hospitals than those without disabilities, although the analysis lacked power. Time taken to the nearest health facility was not related to increased disability.

Table 154: Association between health and health seeking behaviour and disability in Guatemala

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	189 (84%)	16209 (96%)	Baseline	176 (85%)	20508 (96%)	Baseline
- Yes	36 (16%)	684 (4%)	4.7 (3.3 - 6.8)	31 (15%)	964 (4%)	3.9 (2.7 - 5.8)
Malnutrition						
- No	224 (99.6%)	16886 (99.96%)	Baseline	205 (99%)	21462 (99.95%)	Baseline
- Yes	1 (0.4%)	7 (0.04%)	11.9 (1.5 - 97.5)	2 (1%)	10 (0.05%)	25.2 (5.4 - 116.9)
Where sought treatment						
- Other	5 (14%)	156 (23%)	Baseline	3 (10%)	206 (21%)	Baseline
- Hospital	14 (39%)	131 (19%)	3.1 (1.1 - 8.8)	5 (16%)	138 (14%)	2.2 (0.5 - 9.5)
- Health clinic	16 (44%)	302 (44%)	1.6 (0.6 - 4.4)	20 (65%)	472 (49%)	2.9 (0.8 - 9.9)
- Private	1 (3%)	73 (11%)	0.4 (0.0 - 3.4)	1 (3%)	118 (12%)	0.5 (0.1 - 5.1)
- Did not seek	0 (0%)	22 (3%)	-	2 (6%)	30 (3%)	4.3 (0.7 - 26.7)
Illness prevent school						
- No	24 (100%)	423 (73%)	Baseline	16 (84%)	524 (73%)	Baseline
- Yes	0 (0%)	158 (27%)	-	3 (16%)	198 (27%)	0.5 (0.1 - 1.7)
Time taken to nearest health facility						
- <30 minutes	149 (66%)	11142 (66%)	Baseline	129 (62%)	14121 (66%)	Baseline

- 30 minutes-1 hour	48 (21%)	3796 (22%)	0.9 (0.7 - 1.3)	55 (27%)	4900 (23%)	1.2 (0.9 - 1.7)
- 1 – 2 hours	21 (9%)	1462 (9%)	1.1 (0.7 - 1.7)	18 (9%)	1895 (9%)	1.0 (0.6 - 1.7)
- >2 hours	7 (3%)	493 (3%)	1.1 (0.5 - 2.3)	5 (2%)	556 (3%)	1.0 (0.4 - 2.4)
Slept under bednet last night						
- No malaria in area	100 (48%)	9644 (60%)	Baseline	106 (54%)	11413 (56%)	Baseline
- Yes	29 (14%)	1802 (11%)	1.6 (1.0 - 2.4)	29 (15%)	2913 (14%)	1.1 (0.8 - 1.7)
- No	81 (39%)	4736 (29%)	1.7 (1.2 - 2.2)	62 (31%)	6210 (30%)	1.1 (0.8 - 1.5)

Other Findings

Overall, the children with disability were older than the children without disability and the relationship between disability and indicators of inclusion/exclusion was similar between boys and girls. The poverty variables showed no relationship with disability, nor was there a relationship with water and sanitation variables.

5.27 Honduras

The country population of Honduras is 7,935,846 and the percentage of the population that constitutes children between the ages of 0-14 year is 36% (World Bank Population Data, 2013). Honduras ranks 120 out of 187 countries in the 2013 Human Development Index, making it a country with medium human development (UNDP International Human Development Indicators, 2013). The Government of Honduras ratified the UN Convention on the Rights of Persons with Disabilities in 2008 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

Plan Honduras works in six Programme Units, namely Lempira, Intibucá, Copan, Santa Barbara, La Paz and Ocotepeque. According to Plan Honduras' situational analysis, undertaken as part of the drafting of the Country Strategic Plan 2009-2014 (Plan Honduras, 2009), broad sectors of Honduran children suffer discrimination within and outside of their homes. A survey carried out by Plan Honduras confirmed that being discriminated against was one of the common complaints cited by children in terms of the violation of their rights; one of areas and types of discrimination identified was: discrimination against the disabled. Also, during consultations with

children it was said that the rights of children are not only found in the Convention on the Rights of the Child, but that there are other specific rights that may apply to children with special identities. For Plan Honduras this emphasised the importance of having a focus on gender and disability that promotes respect for the rights of women and the disabled. The Country Strategic Plan says: 'It is no less true that, although our work is centred on the rights of children, its implementation has to respect and promote the human rights of the entire population, and particularly of groups with special needs' (Plan Honduras, 2009). It subsequently describes that it will develop methodologies which facilitate community organisation that includes the most marginalised and ignored members of the community, such as women, poor families, indigenous peoples and those of African descent, the disabled, senior citizens and working children.

The vision of Plan Honduras' current Country Strategic Plan is that Child-Centred Community Development is a rights-based approach in which girls and boys, families and communities are the principal and active agents of their own development. It optimizes their abilities and opportunities to work together or with other social actors to address the structural causes and consequences of child poverty at all levels. To achieve this vision, Plan Honduras has the following intervention strategies:

- Methodologies for the implementation of Child Centred Community Development that identify patterns of discrimination in the community and actively combat them.
- The design, implementation and monitoring of Country Programme Outlines (CPOs) and Plan projects that incorporate the principle of non-discrimination.
- Awareness raising, training, social organisation and mobilisation in favour of the rights of children that clearly incorporates the principle of non-discrimination.
- Lobbying the State on the behalf of discriminated children.

In Honduras, the 2012 dataset included 34,040 sponsored children, ranging in age from 0-17. The average age was 9.3 (standard deviation=4.2), and 44% were male. Among the children, 551 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.6% (95% confidence interval 1.5-1.8%). The prevalence of disability was slightly higher in males (2.0%, 95% CI 1.8-2.2%) than in females (1.3%, 95% CI 1.1-1.5%). After adjustment for age, males had significantly higher odds of disability compared to females (1.5, 95% CI 1.2-1.7).

As can be seen in Table 155, the most common types of impairment were vision and learning, while a hearing impairment was the least common.

Table 155: Type of impairment by gender in Honduras

	MALES	FEMALES
Learning	73 (25%)	69 (27%)
Physical	66 (22%)	49 (19%)
Communication	58 (20%)	45 (18%)
Vision	82 (28%)	73 (29%)
Hearing	18 (6%)	18 (7%)
Total	297 (100%)	254 (100%)

Education and disability

As evidenced in Table 156, children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. Boys with disabilities were 3.2 times less likely to attend school and girls with disabilities were 4.1 times less likely to attend school. Children with disabilities were more likely to be at a lower school level compared to children without disability, after accounting for age differences. Increased time taken to school was not related to increased disability, nor was there a relationship between attendance at non-formal education and disability.

Table 156: Educational variables in relation to disability in Honduras

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
SCHOOL						
All ages: Attend formal education						
- Yes	179 (60%)	11008 (76%)	Baseline	142 (56%)	14046 (74%)	Baseline
- No	118 (40%)	3531 (24%)	2.1 (1.6 - 2.6)	112 (44%)	4904 (26%)	2.5 (2.0 - 3.2)
Age 5+: Attend formal education						
- Yes	179 (63%)	10728 (83%)	Baseline	140 (61%)	13500 (86%)	Baseline

- No	103 (37%)	2206 (17%)	3.2 (2.4 - 4.1)	89 (39%)	2229 (14%)	4.1 (3.1 - 5.5)
Of those at school, school level						
- Secondary/University/College	23 (13%)	2041 (19%)	Baseline	21 (15%)	2533 (18%)	Baseline
- Primary	140 (78%)	7966 (72%)	2.6 (1.5 - 4.4)	107 (75%)	9939 (71%)	2.7 (1.5 - 4.9)
- Nursery/pre-school	16 (9%)	1001 (9%)	3.9 (1.6 - 9.3)	14 (10%)	1574 (11%)	4.5 (1.7 - 12.1)
Time taken to school						
- <30 minutes	153 (85%)	9485 (86%)	Baseline	123 (87%)	12145 (86%)	Baseline
- 30 minutes-1 hour	23 (13%)	1360 (12%)	1.0 (0.7 - 1.6)	18 (13%)	1677 (12%)	1.0 (0.6 - 1.6)
- >1 hour	3 (2%)	163 (1%)	1.1 (0.3 - 3.4)	1 (1%)	224 (2%)	0.4 (0.0 - 2.6)
Attending non formal education						
- No	295 (99%)	14443 (99%)	Baseline	250 (98%)	18840 (99%)	Baseline
- Yes	2 (1%)	96 (1%)	0.9 (0.2 - 3.6)	4 (2%)	110 (1%)	2.2 (0.8 - 6.1)

As can be seen in Table 157, considering the data by type of impairment, physical and communication impairment had the greatest effect on school attendance, followed by learning impairment. Vision impairment did not appear to be related to lack of attendance of education. This overall pattern was very similar in boys and girls.

Table 157: Attendance of formal education by impairment type in Honduras

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	25054 (75%)	8435 (25%)	24228 (85%)	4435 (15%)	Baseline	Baseline	Baseline
Learning	74 (52%)	68 (48%)	73 (53%)	64 (47%)	3.8 (2.3 - 6.4)	6.8 (4.0 - 11.5)	5.0 (3.5 - 7.3)
Physical	49 (43%)	66 (57%)	49 (51%)	47 (49%)	8.1 (4.5 - 14.7)	8.7 (4.3 - 17.5)	8.3 (5.3 - 13.0)
Communication	46 (45%)	57 (55%)	46 (49%)	47 (51%)	7.3 (4.1 - 13.1)	8.0 (4.1 - 15.9)	7.6 (4.9 - 11.8)
Vision	127 (82%)	28 (18%)	126 (85%)	23 (15%)	0.8 (0.4 - 1.4)	1.1 (0.6 - 2.2)	0.9 (0.6 - 1.4)
Hearing	25 (69%)	11 (31%)	25 (69%)	11 (31%)	2.5 (0.9 - 7.4)	2.2 (0.7 - 6.6)	2.4 (1.1 - 5.1)

As illustrated in table 158, illness or impairment were cited as the major reason for not attending formal education among children with disabilities (69%) while being too young (54%) or economic problems (22%) were the most common reason among children without a disability.

Table 158: Reason for not attending formal education by disability status in Honduras

	Disabled	Not disabled
Too young	40 (17%)	4595 (54%)
Too old	2 (1%)	394 (5%)
Did not pass secondary school exam	0 (0%)	25 (0%)
Economic problems	14 (6%)	1825 (22%)
Closest school too far	2 (1%)	60 (1%)
Has been ill	29 (13%)	33 (0%)
Is married	1 (0%)	148 (2%)
Needed to help family	4 (2%)	339 (4%)
Has an impairment	128 (56%)	11 (0%)
Is working outside family	4 (2%)	313 (4%)
Was expelled for class repetition	0 (0%)	1 (0%)
Primary not considered important by family	1 (0%)	193 (2%)
Secondary not considered important by family	5 (2%)	462 (5%)
Expelled	0 (0%)	1 (0%)
Fears violence at school	0 (0%)	7 (0%)
Fears violence on way to school	0 (0%)	4 (0%)
Do not have required document	0 (0%)	2 (0%)
Plays truant	0 (0%)	22 (0%)

Health and disability

As can be seen in Table 159, children with a disability were more likely to have had a serious illness in the last twelve months than children without a disability, a pattern that was observed for all types of impairment. Boys with disabilities were 3.1 times more likely to have had a serious illness in the last twelve months and girls were 2.7 times more likely. The most common types of illness among the

children with disabilities were acute respiratory tract infection (28%) and eye problems (18%). Malnutrition was more common in children with disabilities compared to those without. Very few children did not seek treatment, and this was not related to disability. Among those who had not sought treatment, the most commonly cited reason was 'treatment not needed' (50%) or 'too expensive' (43%).

A health clinic was the most commonly cited place where treatment was sought. There was a weak suggestion that among boys those seeking care at health centres were less likely to be disabled. Time taken to the nearest health facility was not related to increased disability.

Table 159: Association between health and health seeking behaviour and disability in Honduras

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	212 (71%)	12805 (88%)	Baseline	186 (73%)	16537 (87%)	Baseline
- Yes	85 (29%)	1734 (12%)	3.1 (2.4 - 4.0)	68 (27%)	2413 (13%)	2.7 (2.0 - 3.5)
Malnutrition						
- No	293 (99%)	14519 (100%)	Baseline	250 (98%)	18926 (100%)	Baseline
- Yes	4 (1%)	20 (0%)	11.4 (3.8 - 33.6)	4 (2%)	24 (0%)	14.5 (5.0 - 42.4)
Where sought treatment						
- Other	12 (14%)	156 (9%)	Baseline	8 (12%)	230 (10%)	Baseline
- Hospital	21 (25%)	317 (18%)	0.9 (0.4 - 1.8)	21 (31%)	382 (16%)	1.7 (0.7 - 3.9)
- Health clinic	38 (45%)	1028 (59%)	0.5 (0.3 - 1.0)	30 (44%)	1485 (62%)	0.6 (0.3 - 1.4)
- Private	6 (7%)	56 (3%)	1.5 (0.5 - 4.1)	3 (4%)	76 (3%)	1.2 (0.3 - 4.8)
- Did not seek	8 (9%)	177 (10%)	0.6 (0.2 - 1.5)	6 (9%)	240 (10%)	0.7 (0.2 - 2.1)
Illness prevent school						
- No	25 (47%)	644 (54%)	Baseline	22 (47%)	895 (54%)	Baseline
- Yes	28 (53%)	557 (46%)	1.3 (0.8 - 2.3)	25 (53%)	763 (46%)	1.3 (0.7 - 2.4)

Time taken to nearest health facility						
- <30 minutes	178 (60%)	8219 (57%)	Baseline	142 (56%)	10612 (56%)	Baseline
- 30 minutes-1 hour	87 (29%)	4481 (31%)	0.9 (0.7 - 1.2)	74 (29%)	5993 (32%)	0.9 (0.7 - 1.2)
- 1 – 2 hours	23 (8%)	1454 (10%)	0.7 (0.5 - 1.2)	31 (12%)	1836 (10%)	1.3 (0.9 - 1.9)
- >2 hours	9 (3%)	385 (3%)	1.1 (0.6 - 2.2)	7 (3%)	509 (3%)	1.1 (0.5 - 2.3)
Slept under bednet last night						
- No malaria in area	218 (79%)	9533 (72%)	Baseline	182 (76%)	12176 (70%)	Baseline
- Yes	3 (1%)	294 (2%)	0.5 (0.2 - 1.5)	6 (2%)	515 (3%)	0.9 (0.4 - 2.0)
- No	54 (20%)	3488 (26%)	0.7 (0.5 - 0.9)	53 (22%)	4689 (27%)	0.8 (0.6 - 1.0)

Other Findings

Overall the children with disabilities were older than the children without a disability and the relationship between disability and indicators of inclusion/exclusion was very similar between boys and girls. The poverty variables did not show a relationship with disabilities, nor was there a relationship with hygiene or sanitation variables.

5.28 Nicaragua

The country population of Nicaragua is 5,991,733 and the percentage of the population that constitutes children between the ages of 0-14 year is 33% (World Bank Population Data, 2013). Nicaragua ranks 129 out of 187 countries in the 2013 Human Development Index, making it a country with medium human development (UNDP International Human Development Indicators, 2013). The Government of Nicaragua ratified the UN Convention on the Rights of Persons with Disabilities in 2007 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013). However, Plan Nicaragua's situational analysis, undertaken to inform the drafting of the Country Strategic Plan 2012-2016 mentions that 'in 1995, Nicaragua adopted the Law of Protection, Rehabilitation, and Equal Opportunities for Persons with Disabilities, but little effort has been made to enforce it. Comprehensive programmes are needed

to address the situation of children with disabilities. The poverty, low educational level, discrimination, and limited recognition and acceptance of disabilities are basic factors that persons with disabilities must face' (Plan Nicaragua, 2012).

Plan Nicaragua mainly works in rural areas, namely in the provinces of Chontales, Boaco, Chinandega, Madriz, partially in Managua and in the North Atlantic Autonomous Region. Plan Nicaragua's CSP has children with disabilities as one of their focus groups and specific actions are mentioned in the areas of early childhood, protection, sexual and reproductive rights and civil society organisations, which are urged to incorporate child agendas that include children with disabilities. In relation to early childhood it says: 'it will optimise and implement the Community-based Rehabilitation (CBR) methodology as a development strategy for the prevention of disabilities, including actions for early stimulation. It will facilitate the development of capacities in parents' networks to enable them to support the self-esteem of the children and to offer social support in emergency educational actions and in the management of psychological problems resulting from disasters.'

The Strategic Objective in Plan Nicaragua's current CSP is to apply the Child-centred Community Development (CCCD) approach to help children, adolescents, and youth from Plan Nicaragua's impact area to exercise their rights fully and sustainably. In order to achieve this objective Plan Nicaragua has the following five programmes:

- Early Childhood Development, to help children from zero to five years of age grow up healthy in protective, stimulating and caring environments, developing cognitive, motor, psycho-social, affective and language abilities and skills appropriate to that stage.
- Right to Education, to attain the effective exercise of the right to inclusive and quality education for children, adolescents, and young people, with gender equality, in formal, non-formal, and informal modalities.
- Right to Protection, to contribute to the fulfilment of the right to protection of children and adolescents in the face of risks of violence, by empowering them, their families, their communities, partners, and authorities with practices to promote a protective culture and environment.
- Sexual and Reproductive Rights, to help adolescents and youth exercise their sexual and reproductive rights at the individual, family and community levels, in a protective environment and prioritizing vulnerable and excluded groups.
- Family Economic Well-being, to help children, adolescents, youth and their families to improve their family well-being, by strengthening the human, social and financial capital of the family, sustainably contributing to human development in gender equality.

In Nicaragua, the 2012 dataset included 27,793 sponsored children, ranging in age from 0-17. The average age was 9.5 (standard deviation=4.3), and 46% were male. Among the children, 459 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.7% (95% confidence interval 1.5-1.8%). The prevalence of disability was slightly higher in males (1.9 %, 95% CI 1.7-2.1 %) than in females (1.4 %, 95% CI 1.2-1.6 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.3, 95% CI 1.1-1.6).

As can be seen in Table 160, learning, physical, communication and visual impairments were approximately equally common, while hearing impairments were less common.

Table 160: Type of impairment by gender in Nicaragua

	MALES	FEMALES
Learning	57 (23%)	38 (18%)
Physical	56 (23%)	46 (22%)
Communication	65 (27%)	63 (29%)
Vision	50 (20%)	55 (26%)
Hearing	17 (7%)	12 (6%)
Total	245 (100%)	214 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age, as illustrated in Table 161. Boys with disabilities were 5.7 times less likely to attend school and girls with disabilities were 5.2 times less likely to attend school. Children with disabilities were also more likely to be at a lower school level compared to children without a disability, after accounting for age differences. Increased time taken to school was related to increased disability among the girls. Children with a disability were not more likely to be attending non-formal education than those without a disability for both boys and girls, although the numbers attending non formal education were too small to make clear inferences.

Table 161: Educational variables in relation to disability in Nicaragua

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	131 (53%)	10842 (86%)	Baseline	119 (56%)	12449 (85%)	Baseline
- No	114 (47%)	1782 (14%)	5.7 (4.4 - 7.4)	95 (44%)	2261 (15%)	5.2 (3.9-6.9)
Age 5+: Attend formal education						
- Yes	126 (56%)	10155 (92%)	Baseline	117 (59%)	11635 (93%)	Baseline
- No	99 (44%)	925 (8%)	9.1 (6.9 - 12.2)	81 (41%)	911 (7%)	10.0 (7.4 - 13.6)
Of those at school, school level						
- Secondary/University/College	19 (15%)	2608 (24%)	Baseline	22 (18%)	3568 (29%)	Baseline
- Primary	95 (73%)	6811 (63%)	5.0 (2.7 - 9.1)	82 (69%)	7243 (58%)	5.9 (3.3 - 10.8)
- Nursery/pre-school	17 (13%)	1423 (13%)	11.8 (4.3 - 32.5)	15 (13%)	1638 (13%)	15.5 (5.5 - 43.5)
Time taken to school						
- <30 minutes	106 (81%)	9222 (85%)	Baseline	97 (82%)	10570 (85%)	Baseline
- 30 minutes-1 hour	22 (17%)	1451 (13%)	1.3 (0.8 - 2.0)	17 (14%)	1679 (13%)	1.0 (0.6 - 1.8)
- >1 hour	3 (2%)	169 (2%)	1.4 (0.4 - 4.5)	5 (4%)	200 (2%)	2.5 (1.0 - 6.2)
Attending non formal education						
- No	244 (99.6%)	12602 (99.8%)	Baseline	213 (99.5%)	14677 (99.8%)	Baseline
- Yes	1 (0.4%)	22 (0.2%)	1.8 (0.2 - 13.8)	1 (0.5%)	33 (0.2%)	1.7 (0.2 - 12.7)

As seen in Table 162, considering the data by type of impairment, physical impairment had the greatest effect on school attendance, followed by learning and communication impairment. Vision and hearing impairment had little impact on school attendance. These patterns were similar between boys and girls.

Table 162: Attendance of formal education by impairment type in Nicaragua

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	23291 (85%)	4043 (15%)	21790 (92%)	1836 (8%)	Baseline	Baseline	Baseline
Learning	47 (49%)	48 (51%)	47 (50%)	47 (50%)	12.2 (7.0 - 21.4)	12.5 (6.3 - 24.9)	12.4 (8.0 - 19.1)
Physical	38 (37%)	64 (63%)	37 (41%)	53 (59%)	18.5 (10.1 - 33.9)	30.4 (15.7 - 58.8)	23.3 (14.9 - 36.6)
Communication	60 (47%)	68 (53%)	57 (49%)	60 (51%)	12.7 (7.4 - 22.0)	18.8 (10.7 – 32.7)	15.4 (10.4 - 22.8)
Vision	81 (77%)	24 (23%)	79 (82%)	17 (18%)	3.7 (1.8 - 7.6)	1.6 (0.7 - 3.8)	2.5 (1.5 - 4.3)
Hearing	24 (83%)	5 (17%)	23 (88%)	3 (12%)	-	4.9 (1.2 - 19.1)	1.5 (0.4 - 5.1)

In line with the overall findings and as evidenced in Table 163, having an impairment was cited as the major reason for not attending formal education among children with disabilities (82%) while being too young was the most common reason among children without disability (58%).

Table 163: Reason for not attending formal education by disability status in Nicaragua

	Disabled	**Not disabled**
Is pregnant or gave birth	0 (0%)	1 (0%)
Too young	17 (8%)	2348 (58%)
Too old	1 (0%)	105 (3%)
Did not pass secondary school exam	0 (0%)	1 (0%)

	Disabled	Not disabled
Economic problems	3 (1%)	568 (14%)
Closest school too far	4 (2%)	185 (5%)
Has been ill	7 (3%)	56 (1%)
Is married	1 (0%)	196 (5%)
Needed to help family	1 (0%)	205 (5%)
Has an impairment	172 (82%)	0 (0%)
Is working outside family	0 (0%)	13 (0%)
Was expelled for class repetition	0 (0%)	8 (0%)
Primary not considered important by family	1 (0%)	139 (3%)
Secondary not considered important by family	0 (0%)	106 (3%)
Expelled	1 (0%)	6 (0%)
Fears violence at school	1 (0%)	12 (0%)
Fears violence on way to school	0 (0%)	2 (0%)
Plays truant	1 (0%)	94 (2%)

Health and disability

As can be seen in Table 164, children with a disability were more likely to have had a serious illness in the last twelve months than children without a disability, a pattern that was very similar across the impairment types. Boys with disabilities were 2.7 times more likely to have had a serious illness in the last twelve months and girls were 2.1 times more likely. The most common types of illness were acute respiratory tract infection. There were very few children who reported illness due to malnutrition, but this may have been more common among the children with disabilities. Not seeking treatment was unrelated to disability. Among those who had not sought treatment, the most commonly cited reason was being advised that treatment was not necessary.

A health clinic was the most commonly cited place where treatment was sought. Time taken to the nearest health facility was not related to disability.

Table 164: Association between health and health seeking behaviour and disability in Nicaragua

	MALES	FEMALES

	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
Serious illness						
- No	177 (72%)	10952 (87%)	Baseline	162 (75%)	12683 (86%)	Baseline
- Yes	68 (28%)	1672 (13%)	2.7 (2.0 - 3.6)	52 (25%)	2027 (14%)	2.1 (1.5 - 2.8)
Malnutrition						
- No	244 (99.6%)	12613 (99.9%)	Baseline	213 (99.5%)	14703 (99.95%)	Baseline
- Yes	1 (0.4%)	11 (0.1%)	5.5 (0.7 - 42.8)	1 (0.5%)	7 (0.05%)	10.9 (1.3 – 89.8)
Where sought treatment						
- Other	10 (15%)	252 (15%)	Baseline	2 (4%)	274 (14%)	Baseline
- Hospital	17 (25%)	354 (21%)	1.2 (0.6 - 2.8)	16 (30%)	465 (23%)	4.8 (1.1 - 21.0)
- Health clinic	38 (56%)	977 (58%)	1.0 (0.5 - 1.9)	30 (58%)	1174 (58%)	3.6 (0.8 – 14.5)
- Private	0 (0%)	14 (1%)	-	1 (2%)	13 (1%)	9.4 (0.8 – 110.9)
- Did not seek	3 (4%)	75 (4%)	0.9 (0.2 - 3.4)	3 (6%)	101 (5%)	3.9 (0.6 - 23.6)
Illness prevent school						
- No	26 (62%)	696 (56%)	Baseline	14 (44%)	903 (56%)	Baseline
- Yes	16 (38%)	557 (44%)	0.8 (0.4 - 1.5)	18 (56%)	700 (44%)	1.7 (0.8 - 3.4)
Time taken to nearest health facility						
- <30 minutes	168 (69%)	9035 (72%)	Baseline	141 (66%)	10606 (72%)	Baseline
- 30 minutes-1 hour	57 (23%)	2883 (23%)	1.0 (0.8 - 1.4)	56 (26%)	3328 (23%)	1.2 (0.9 - 1.7)
- 1 – 2 hours	16 (7%)	561 (4%)	1.7 (1.0 - 2.8)	18 (8%)	615 (4%)	2.3 (1.4 - 3.8)
- >2 hours	4 (2%)	145 (1%)	1.6 (0.6 - 4.4)	0 (0%)	161 (1%)	-
Slept under bednet last night						

- No malaria in area	190 (86%)	10338 (90%)	Baseline	175 (90%)	12062 (90%)	Baseline
- Yes	21 (9%)	676 (6%)	1.8 (1.2 - 2.9)	15 (8%)	840 (6%)	1.3 (0.8 - 2.2)
- No	11 (5%)	445 (4%)	1.3 (0.7 - 2.4)	4 (2%)	494 (4%)	0.5 (0.2 - 1.4)

Other Findings

Overall, the children with disabilities were older than the children without disability, among both males and females and the type of area that the children lived was not related to having a disability. In addition, the relationship between disability and indicators of inclusion/exclusion was similar between boys and girls. The poverty variables did not show a relationship with disabilities, nor did the hygiene and sanitation variables.

5.29 Paraguay

The country population of Paraguay is 6,687,361and the percentage of the population that constitutes children between the ages of 0-14 year is 33% (World Bank Population Data, 2013). Paraguay ranks 111 out of 187 countries in the 2013 Human Development Index, making it a country with high human development (UNDP International Human Development Indicators, 2013). The Government of Paraguay ratified the UN Convention on the Rights of Persons with Disabilities in 2008 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

The Country Office of Plan Paraguay is located in the capital Asuncion and programme implementation and operations are coordinated from four Programme Units (PUs) which cover a total of 21 municipalities and are located in four different departments of the country, namely San Pedro, Caaguazú, Guairá and Paraguarí. According to Plan Paraguay Country Strategic Plan 2014-2018 they will focus on four particularly excluded groups: 'girls, indigenous children, families living in extreme poverty and youth - while upholding its commitment to ensure the participation of all the excluded groups in its programs and in society at large' (Plan Paraguay, 2013). However, Plan Paraguay has decided not to prioritize children with a disability, as information regarding these children is absent in Paraguay and Plan Paraguay has no expertise in this area. Yet, they do say 'they may represent a group with whom we will work at a later point in the CSP' (Plan Paraguay, 2013).

The vision of the current CSP is 'Boys, girls and adolescents enjoy their rights, develop to their full potential and, together with their families, are the protagonists in advancing an inclusive Paraguay.' In order to achieve this vision, Plan Paraguay has the following programme goals:

- Boys, girls, adolescents live free of violence within family and school settings, in relationships based on respect and equity, including in emergency situations.
- Boys and girls aged 0 – 8 are registered at birth and grow up healthy and well nourished, developing to their full potential in safe and caring settings.
- Children, adolescents and youth receive and complete quality primary and secondary education and acquire essential knowledge and for their individual, social and economic empowerment.

In Paraguay, the 2012 dataset included 7,813 sponsored children, ranging in age from 0-17. The average age was 9.0 (standard deviation=4.1), and 46% were male. Among the children, 114 had 'an impairment/a medical condition that can lead to disability.' This gives a prevalence of disability of 1.5% (95% confidence interval 1.2 – 1.7%). The prevalence of disability was slightly higher in males (1.9 %, 95% CI 1.4 – 2.3%) than in females (1.1 %, 95% CI 0.7 – 1.4 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.7, 95% CI 1.1 – 2.4).

As can be seen in Table 165, the most common types of impairment were communication, physical and vision for boys, while physical was the most common for girls, followed by learning and vision. Overall, hearing impairments were the least common.

Table 165: Type of impairment by gender in Paraguay

	MALES	FEMALES
Learning	12 (18%)	11 (23%)
Physical	18 (27%)	14 (30%)
Communication	19 (28%)	7 (15%)
Vision	17 (25%)	11 (23%)
Hearing	1 (1%)	4 (9%)
Total	67 (100%)	47 (100%)

Education and disability

As shown in Table 166, children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age. Boys with disabilities were 21.9 times less likely to attend school and girls with disabilities were 21.3 times less likely to attend school. Children with disabilities were also more likely to be at a lower school level compared to children without disability, after accounting for age differences. Increased time taken to school may have been related to increased disability in girls.

Table 166: Educational variables in relation to disability in Paraguay

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
SCHOOL						
All ages: Attend formal education						
- Yes	34 (51%)	2979 (85%)	Baseline	24 (51%)	3481 (83%)	Baseline
- No	33 (49%)	509 (15%)	12.3 (7.1 - 21.0)	23 (49%)	730 (17%)	12.0 (6.3 - 23.0)
Age 5+: Attend formal education						
- Yes	33 (53%)	2925 (96%)	Baseline	23 (56%)	3408 (96%)	Baseline
- No	29 (47%)	118 (4%)	21.9 (12.8 - 37.3)	18 (44%)	132 (4%)	21.3 (11.2 - 40.5)
Of those at school, school level						
- Secondary/University/ College	2 (6%)	218 (7%)	Baseline	0 (0%)	252 (7%)	Baseline
- Primary	28 (82%)	2469 (83%)	2.2 (0.5 - 10.0)	23 (96%)	2884 (83%)	-
- Nursery/pre-school	4 (12%)	292 (10%)	5.1 (0.6 - 43.4)	1 (4%)	345 (10%)	-

Time taken to school						
- <30 minutes	20 (59%)	1470 (49%)	Baseline	12 (50%)	1859 (53%)	Baseline
- 30 minutes-1 hour	13 (38%)	1440 (48%)	0.6 (0.3 - 1.3)	11 (46%)	1547 (44%)	1.1 (0.5 - 2.5)
- >1 hour	1 (3%)	69 (2%)	1.0 (0.1 - 7.7)	1 (4%)	75 (2%)	2.1 (0.3 - 16.2)
Attending non formal education						
- No	67 (100%)	3452 (99%)	Baseline	46 (98%)	4163 (99%)	Baseline
- Yes	0 (0%)	36 (1%)	-	1 (2%)	48 (1%)	1.7 (0.2 - 12.5)

As can be seen in table 167, considering the data by type of impairment, communication impairments had the greatest effect on school attendance, followed by learning and physical impairments. Hearing impairments had less impact (although had very wide confidence intervals), while vision did not seem to have an effect (although again having wide confidence intervals). The pattern differed somewhat by gender, with learning impairments affecting boys the most, and communication impairments affecting girls.

Table 167: Attendance of formal education by impairment type in Paraguay

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	6460 (84%)	1239 (16%)	6333 (96%)	250 (4%)	Baseline	Baseline	Baseline
Learning	9 (39%)	14 (61%)	9 (41%)	13 (59%)	49.7 (14.8 - 167.5)	29.7 (8.3 - 106.5)	38.2 (16.1 - 90.7)
Physical	13 (41%)	19 (59%)	13 (43%)	17 (57%)	39.6 (15.1 - 104.2)	27.1 (8.4 - 86.8)	34.6 (16.5 - 72.3)
Communication	10 (38%)	16 (62%)	10 (40%)	15 (60%)	31.0 (12.0 - 80.1)	94.0 (17.6 - 502.9)	40.5 (17.8 - 91.8)
Vision	22 (79%)	6 (21%)	20 (95%)	1 (5%)	-	4.0 (0.5 - 33.0)	1.3 (0.2 - 10.0)
Hearing	4 (80%)	1 (20%)	4 (80%)	1 (20%)	-	9.1 (0.9 - 90.8)	6.7 (0.7 - 60.6)

As indicated in Table 168, having an impairment was cited as the major reason for not attending formal education among children with disabilities 68%) while being too young was the most common reason among children without a disability (91**%).**

Table 168: Reason for not attending formal education by disability status in Paraguay

	Disabled	Not disabled
Too young	14 (25%)	1124 (91%)
Too old	1 (2%)	3 (0%)
Is needed to work	0 (0%)	1 (0%)
Economic problems	1 (2%)	19 (2%)
Closest school too far	0 (0%)	15 (1%)
Has been ill	2 (4%)	2 (0%)
Is married	0 (0%)	2 (0%)
Needed to help family	0 (0%)	11 (1%)
Has an impairment	38 (68%)	1 (0%)
Is working outside family	0 (0%)	19 (2%)
Was expelled for class repetition	0 (0%)	1 (0%)
Primary not considered important by family	0 (0%)	26 (2%)
Secondary not considered important by family	0 (0%)	12 (1%)
Fears violence on way to school	0 (0%)	1 (0%)
Do not have required document	0 (0%)	1 (0%)
Plays truant	0 (0%)	1 (0%)

Health and disability

Children with a disability were more likely to have had a serious illness in the last twelve months than children without a disability, a pattern that was observed most strongly for those with physical and communication impairments. Boys with disabilities were 3.6 times more likely to have had a serious illness in the last twelve months and girls were 4.2 times more likely. The most common type of illness among the children with disabilities was influenza. There was insufficient data on malnutrition to assess whether this was more common in those with disabilities than those without. A health clinic or hospital was the most commonly cited place where treatment

was sought. Among those who had not sought treatment, the most commonly cited reason was ‘advised treatment unnecessary’ or ‘too expensive.’

Table 169: Association between health and health seeking behaviour and disability in Paraguay

	MALES			FEMALES		
	Disabled	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Serious illness						
- No	52 (78%)	3212 (92%)	Baseline	35 (74%)	3880 (92%)	Baseline
- Yes	15 (22%)	276 (8%)	3.6 (2.0 - 6.5)	12 (26%)	331 (8%)	4.2 (2.2 - 8.2)
Malnutrition						
- No	67 (100%)	3488 (100%)	Baseline	47 (100%)	4209 (99.9%)	Baseline
- Yes	0 (0%)	0 (0%)	-	0 (0%)	2 (0.1%)	-
Where sought treatment						
- Other	1 (7%)	25 (9%)	Baseline	0 (0%)	32 (10%)	Baseline
- Hospital	5 (33%)	72 (26%)	1.6 (0.2 - 15.0)	5 (42%)	116 (35%)	0.6 (0.1 - 2.7)
- Health clinic	8 (53%)	139 (50%)	1.4 (0.2 - 12.0)	4 (33%)	140 (42%)	0.4 (0.1 - 1.9)
- Private	0 (0%)	2 (1%)	-	0 (0%)	3 (1%)	-
- Did not seek	1 (7%)	38 (14%)	0.6 (0.0 - 9.5)	3 (25%)	40 (12%)	-
Illness prevent school						
- No	4 (80%)	114 (75%)	Baseline	2 (50%)	131 (74%)	Baseline
- Yes	1 (20%)	39 (25%)	0.6 (0.1 - 5.7)	2 (50%)	47 (26%)	2.8 (0.4 - 21.4)
Time taken to nearest health facility						
- <30 minutes	14 (21%)	851 (24%)	Baseline	10 (21%)	1068 (25%)	Baseline

- 30 minutes-1 hour	41 (61%)	1716 (49%)	1.4 (0.8 - 2.6)	21 (45%)	2031 (48%)	1.1 (0.5 - 2.3)
- 1 – 2 hours	10 (15%)	776 (22%)	0.7 (0.3 - 1.7)	15 (32%)	924 (22%)	1.7 (0.7 - 3.7)
- >2 hours	2 (3%)	145 (4%)	0.8 (0.2 - 3.6)	1 (2%)	188 (4%)	0.6 (0.1 - 4.5)
Slept under bednet last night						
- No malaria in area	13 (25%)	529 (22%)	Baseline	6 (17%)	712 (25%)	Baseline
- Yes	2 (4%)	74 (3%)	1.0 (0.2 - 4.6)	2 (6%)	123 (4%)	1.7 (0.3 - 8.6)
- No	38 (72%)	1753 (74%)	0.7 (0.4 - 1.4)	28 (78%)	2004 (71%)	1.4 (0.5 - 3.4)

Other Findings

Overall the children with disabilities were similar in age to the children without disabilities, among both males and females and the relationship between disability and indicators of inclusion/exclusion was similar between boys and girls. Children from the least poor households were most likely to have disabilities.

5.30 Peru

The country population of Peru is 29,987,800 and the percentage of the population that constitutes children between the ages of 0-14 year is 29% (World Bank Population Data, 2013). Peru ranks 77 out of 187 countries in the 2013 Human Development Index, making it a country with high human development (UNDP International Human Development Indicators, 2013). The Government of Peru ratified the UN Convention on the Rights of Persons with Disabilities in 2008 (United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities Status, 2013).

The Peruvian government also has a National Plan of Action for Children 2002–2010, which sets the actions, programs and strategies to be adopted and implemented by the various sectors, government institutions and civil society in order to ensure that the rights of children and adolescents are respected and delivered according to international agreements and conventions. One of the areas that received little attention is the special protection mechanisms for under-served groups such as children with disabilities and others, as described in Plan Peru's Country Strategic Plan (Plan Peru, 2011). However, the CSP has no further mention of children with

disabilities, but it says that ‘interventions will be increasingly focused on reaching a great number of the poorest of the poor and the most excluded Peruvian children. It also describes how it will operate according to Plan’s CCCD principle of non-discrimination.

The Country Office of Plan Peru is in the capital Lima and field operations take place in the following four Program Units (PUs) and regions; Piura with mixed urban–rural interventions; Cusco in remote Andean rural highlands and in communities as high as 4800 metres above sea level; Lima in urban slum areas on the outskirts of the capital; and Crisnejas in the rural highland communities.

The vision in the current CSP is one in which girls, boys, adolescents and youth of Peru fully exercise their rights in a democratic society and with a State effectively fulfilling its role as duty bearer. In order to achieve this vision, Plan Peru has the following four strategic country objectives:

- Girls, boys, adolescents and youth, especially those living in extreme poverty and exclusion, exercise their right to participate as active citizens, contributing to a governance that is democratic.
- Girls, boys, adolescents and women live violence free and in relationships based on respect and equity, and are treated well, including in situations of emergency.
- Girls and boys under 5 years of age, especially those living in extreme poverty and exclusion, enjoy integrated care and development with affection, are treated well, and are protected from violence.
- Girls, boys, adolescents and youth, especially those living in extreme poverty and exclusion, achieve significant learning and life skills.

In Peru, the 2012 dataset included 25,364 sponsored children, ranging in age from 0-17. The average age was 8.9 (standard deviation= 4.5), and 42 % were male. Among the children, 195 had ‘an impairment/a medical condition that can lead to disability.’ This gives a prevalence of disability of 0.8 % (95% confidence interval 0.7 - 0.9 %). The prevalence of disability was slightly higher in males 0.9 %, 95% CI 0.7 – 1.1 %) than in females (0.7 %, 95% CI 0.5 – 0.8 %). After adjustment for age, males had significantly higher odds of disability compared to females (1.3, 95% CI 1.0 – 1.8).

As can be seen in Table 170, the most common types of impairments were learning, physical, communication and vision, whereas hearing impairments were least common. Communication and vision impairments were the most common types of impairment amongst boys, whilst learning and physical impairments were the most common for girls.

Table 170: Type of impairment by gender in Peru

	MALES	FEMALES
Learning	22 (23%)	28 (29%)
Physical	17 (18%)	25 (26%)
Communication	28 (29%)	19 (19%)
Vision	25 (26%)	23 (23%)
Hearing	5 (5%)	3 (3%)
Total	97 (100%)	98 (100%)

Education and disability

Children with disabilities were much less likely to attend formal education than those without a disability, after taking account of age, as can be seen in Table 171. Boys with disabilities were 15.6 times less likely to attend school and girls with disabilities were 13.9 times less likely to attend school. Disabled boys at school were more likely to be at a lower level than non-disabled boys, and a similar trend was observed for girls, although the analysis did lack power. Increased time taken to school did not seem to be related to increased disability, although the analysis had wide confidence intervals. Children with a disability were much more likely to be attending non-formal education than those without a disability for both boys and girls.

Table 171: Educational variables in relation to disability in Peru

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
SCHOOL						
All ages: Attend formal education						
- Yes	64 (66%)	9304 (89%)	Baseline	59 (60%)	12079 (82%)	Baseline
- No	33 (34%)	1140 (11%)	6.1 (3.9 - 9.5)	39 (40%)	2646 (18%)	5.0 (3.2 - 7.8)

Age 5+: Attend formal education						
- Yes	62 (67%)	8684 (97%)	Baseline	54 (67%)	10908 (96%)	Baseline
- No	30 (33%)	300 (3%)	15.6 (9.8 - 24.8)	27 (33%)	428 (4%)	13.9 (8.5 - 22.8)
Of those at school, school level						
- Secondary/University/College	12 (19%)	3151 (34%)	Baseline	12 (20%)	3368 (28%)	Baseline
- Primary	43 (67%)	4939 (53%)	3.3 (1.3 - 8.0)	36 (61%)	6622 (55%)	2.3 (0.9 - 5.8)
- Nursery/pre-school	9 (14%)	1214 (13%)	3.8 (0.9 - 16.1)	11 (19%)	2089 (17%)	3.2 (0.7 - 13.8)
Time taken to school						
- <30 minutes	56 (88%)	8320 (89%)	Baseline	51 (86%)	10738 (89%)	Baseline
- 30 minutes-1 hour	8 (13%)	905 (10%)	1.3 (0.6 - 2.8)	8 (14%)	1238 (10%)	1.4 (0.6 - 2.9)
- >1 hour	0 (0%)	79 (1%)	-	0 (0%)	103 (1%)	-
Attending non formal education						
- No	93 (96%)	10438 99.9%)	Baseline	97 (99%)	14717 (99.9%)	Baseline
- Yes	4 (4%)	6 (0.1%)	64.8 (17.5 - 240.4)	1 (1%)	8 (0.1%)	15.7 (1.9 - 128.1)

As shown in Table 172, considering the data by type of impairment, learning and communication impairment had the strongest association with non-attendance of school, followed by physical impairment. Vision impairment was less strongly related, whilst there was insufficient numbers of those with hearing impairments in the sample to assess the effect of this impairment, but of note was that this was due to the fact that all of the children with hearing impairments attended formal education. This overall pattern applied to girls, whilst for boys physical impairments were more common than communication impairments.

Table 172: Attendance of formal education by impairment type in Peru

	All ages		Age 5+				
	Attend formal education	**Do not attend formal education**	**Attend formal education**	**Do not attend formal education**	**Males: Age adjusted OR**	**Females: Age adjusted OR**	**Total group: Age and sex adjusted OR**
No disability	21383 (85%)	3786 (15%)	19592 (96%)	728 (4%)	Baseline	Baseline	Baseline
Learning	24 (48%)	26 (52%)	23 (52%)	21 (48%)	36.5 (14.4 - 92.2)	20.1 (8.1 - 50.1)	27.1 (14.1 - 51.9)
Physical	25 (60%)	17 (40%)	24 (67%)	12 (33%)	26.5 (8.9 - 78.6)	12.5 (4.5 - 34.8)	17.5 (8.4 - 36.7)
Communication	28 (60%)	19 (40%)	27 (60%)	18 (40%)	17.7 (7.8 - 40.2)	26.0 (9.2 - 73.4)	20.6 (10.9 - 39.2)
Vision	38 (79%)	10 (21%)	34 (85%)	6 (15%)	6.2 (1.8 - 21.6)	5.8 (1.5 - 21.6)	6.1 (2.5 - 15.2)
Hearing	8 (100%)	0 (0%)	8 (100%)	0 (0%)	-	-	-

In line with the overall findings and as illustrated in Table 173, having an impairment was cited as the major reason for not attending formal education among children with disabilities (56 %) while being too young was the most common reason among children without a disability (84 %).

Table 173: Reason for not attending formal education by disability status in Peru

	Disabled	**Not disabled**
Too young	9 (13%)	3185 (84%)
Too old	0 (0%)	61 (2%)
Economic problems	3 (4%)	309 (8%)
Closest school too far	0 (0%)	9 (0%)
Has been ill	20 (28%)	6 (0%)
Is married	0 (0%)	36 (1%)

	Disabled	Not disabled
Needed to help family	0 (0%)	85 (2%)
Has an impairment	40 (56%)	13 (0%)
Is working outside family	0 (0%)	46 (1%)
Was expelled for class repetition	0 (0%)	9 (0%)
Primary not considered important by family	0 (0%)	6 (0%)
Fears violence on way to school	0 (0%)	1 (0%)
Do not have required document	0 (0%)	1 (0%)

Health and disability

As can be seen in Table 174, children with a disability were more likely to have had a serious illness in the last twelve months than children without a disability, a pattern that was observed most strongly for those with physical and communication impairments. Boys with disabilities were 4.2 times more likely to have had a serious illness in the last twelve months and girls were 6.3 times more likely. The most common types of illness among the children with disabilities were acute respiratory tract infection, influenza, chronic illness and eye problems. Malnutrition was strongly associated with disabilities in boys. Among those who had not sought treatment, the most commonly cited reason among disabled children was 'too expensive.' A health clinic was the most commonly cited place where treatment was sought for both disabled and non-disabled children and treatment location did not seem to be related to disability. Similarly, time taken to nearest health facility did not seem to be related to disability, nor did whether the child slept under a bednet the previous night.

Table 174: Association between health and health seeking behaviour and disability in Peru

	MALES			FEMALES		
	Disabled	Non disabled	Age adjusted OR	Disabled	Non disabled	Age adjusted OR
Serious illness						
- No	84 (87%)	10059 (96%)	Baseline	78 (80%)	14127 (96%)	Baseline
- Yes	13 (13%)	385 (4%)	4.2 (2.3 - 7.6)	20 (20%)	598 (4%)	6.3 (3.8 - 10.4)

Malnutrition						
- No	96 (99%)	10440 (99.96%)	Baseline	98 (100%)	14715 (99.9%)	Baseline
- Yes	1 (1%)	4 (0.04%)	29.8 (3.3 - 271.1)	0 (0%)	10 (0.01%)	-
Where sought treatment						
- Other	1 (8%)	32 (8%)	Baseline	5 (25%)	47 (8%)	Baseline
- Hospital	3 (23%)	46 (12%)	2.1 (0.2 - 21.0)	3 (15%)	61 (10%)	0.5 (0.1 - 2.1)
- Health clinic	8 (62%)	264 (69%)	1.0 (0.1 - 8.0)	10 (50%)	429 (72%)	0.3 (0.1 - 0.8)
- Private	0 (0%)	15 (4%)	-	0 (0%)	17 (3%)	-
- Did not seek	1 (8%)	28 (7%)	1.1 (0.1 - 19.1)	2 (10%)	44 (7%)	0.4 (0.1 - 2.3)
Illness prevent school						
- No	4 (40%)	203 (67%)	Baseline	9 (60%)	302 (69%)	Baseline
- Yes	6 (60%)	102 (33%)	3.0 (0.8 - 10.8)	6 (40%)	138 (31%)	1.5 (0.5 - 4.2)
Time taken to nearest health facility						
- <30 minutes	85 (88%)	8335 (80%)	Baseline	83 (85%)	11582 (79%)	Baseline
- 30 minutes-1 hour	8 (8%)	1463 (14%)	0.6 (0.3 - 1.2)	11 (11%)	2161 (15%)	0.7 (0.4 - 1.4)
- 1 – 2 hours	4 (4%)	420 (4%)	1.0 (0.4 - 2.7)	2 (2%)	662 (4%)	0.4 (0.1 - 1.8)
- >2 hours	0 (0%)	226 (2%)	-	2 (2%)	320 (2%)	0.9 (0.2 - 3.7)
Slept under bednet last night						
- No malaria in area	65 (70%)	6253 (62%)	Baseline	62 (68%)	9059 (64%)	Baseline
- Yes	10 (11%)	1346 (13%)	0.7 (0.4 -	12 (13%)	1946 (14%)	0.9 (0.5 - 1.7)

			1.4)			
- No	18 (19%)	2524 (25%)	0.7 (0.4 - 1.1)	17 (19%)	3206 (23%)	0.7 (0.4 - 1.3)

Other Findings

Overall, the children with disabilities were similar in age to the children without disability. Children who were least poor were most likely to be disabled and children with disabilities were less likely to live in houses with natural floor material or houses that used coal or locally sourced fuel for cooking. In addition, children who used latrine or composting toilet were less likely to be disabled than those who used a flushed toilet. As far as gender differences are concerned, the association between disability and at least one of each type of variable, such as health or education, varied by gender.

6. Conclusion

The findings of this study have three main sets of implications that align with the objectives of the study. These objectives were to gain a better understanding of the challenges faced by sponsored children with disabilities; to fill existing knowledge gaps in this domain; and to gauge the usefulness of the Plan sponsorship dataset for improved programming and wider research.

First, these analyses from the dataset show that children with disabilities are much less likely to attend formal education compared to their peers without disabilities. Children with disabilities are also significantly more likely to experience serious illness in the last 12 months. These two findings have important implications for the child's participation in his/ her community and for the child's family. They may need to care for the sick child or the child not attending school, or pay for their treatment. This all places further strain on already impoverished households. In the long term, poor health and lack of school attendance are likely to have lasting impacts on the life of the child. They may influence future employment opportunities, social opportunities, and the overall quality of life, including the likelihood of experiencing poverty later on.

Second, in order to establish how Plan addresses these challenges within programme work, further research is needed to determine why children with disabilities are not attending formal education and why they are reporting high rates of illness. There also needs to be investigation into how these illnesses can be prevented or ameliorated for children with disabilities. Once this research is done, Plan can develop targeted interventions, alongside with mainstreaming disability inclusion, in order to improve the lives of children with disabilities in the programme areas, and also advocate more broadly for change within the countries concerned.

Third, the research has demonstrated that the Plan sponsorship dataset is a valuable and useable resource that can inform Plan programming. The analysis has shown that there are questions relating to other aspects of inclusion that should be explored within the dataset, for example, in relation to gender and inclusion. It would also be extremely beneficial for Plan to consider how the dataset could be explored to monitor children over time, enabling valuable longitudinal studies into the life trajectories of the sponsored children. Specifically, the longitudinal follow-up of children with disabilities would be useful to compare their long-term future inclusion,

in terms of livelihood and social participation, to that of children without disabilities. This has not yet been explored by other organisations.

The benefits of this study are twofold. Not only has the research identified issues that Plan needs to address in its programmatic work – it has also contributed important information to understanding the current situation for children with disabilities. Plan can use this to improve its work within the communities it serves, while the information captured by the sponsorship dataset can add value to the general body of knowledge and learning in relation to children with disabilities.

7. Recommendations

Building on the above conclusions, what follows are some recommendations which are based on the three sets of implications for Plan: programming, research and the use of the sponsorship dataset.

7.1 Recommendations for programme

First, in line with Plan's practice, a management response will be prepared for Plan's Programme Leadership Team (POLT) sought by Plan's global leadership team to ensure appropriate steps are taken as a result of the research findings.

Second, the analysis which forms the basis for this research generated thirty separate country reports. These reports will be shared with the countries in question. It is recommended that the senior management in each country (specifically programme and sponsorship) review the findings of the research and identify opportunities in their existing programmes or projects to mainstream disability inclusion. This should include the identification of knowledge gaps, where these findings can be used to inform further research with a view to improve the way in which the issue of children with disabilities is addressed by Plan's work (discussed below under section 7.2). Obviously, there is no imperative to start work on children with disabilities where this is not a focus area for the work that is done on inclusion in the country's strategic plan. However, in the latter instance, when planning new programme strategies or project activities, it is recommended that the issue of children with disabilities be considered and included where appropriate and indicated. This must be done in accordance with the Approach to Tackling Exclusion and Standards in developing the approval and assessment process for Country Strategic Plans and Programme Units Long Term Plans, which emerged in the management response to the Inclusion Review in 2012.

It is also recommended, in light of the findings and Plan's overall commitment to inclusion that the country senior management teams, as well as all other Plan offices, discuss how inclusive our offices are for persons with disabilities as employees. In addition, it is recommended that competencies for working with children with disabilities be developed among Plan staff to improve our ability to programme for disabilities, and in this regard it is recommended that the results of the research be incorporated in the development of the disability modules for the Plan Academy.

Third, the findings of this research will be furnished to the Global Gender and Inclusion Advisor for further action according to the recommendations in the management response to the Inclusion Review. This would include, informing the review, development and piloting of the Approach to Tackling Exclusion Standards; guidance on decision making on tackling exclusion at country and programme level and integrating the approach to tackling exclusion into all key steps of the Programme Accountability and Learning System (PALS), among others.

Third, given the important findings regarding access to schooling by sponsored children with disabilities, it is recommended that the Global Education Advisor address inclusive education in the new education strategy that is currently under discussion.

Finally, one of the initial findings of the analysis highlights that Plan does not have a significant number of sponsored children with disabilities, especially given that 19 countries did not pass the threshold of 100 or more sponsored children with disabilities required for this analysis. As noted in Chapter 2 there is little direction around the enrolment of children with disabilities into Plan's sponsorship programme. Given Plan's clear commitment to inclusion and the fact that the sponsorship team at the International Headquarters manage the total number of sponsored children and related policies and guidelines, it is recommended that the International Headquarters sponsorship team investigate ways of ensuring that children with disabilities are not excluded from the sponsorship programme in anyway. This would include guidelines in the new sponsorship manual, currently under development. But could also include mechanisms to ensure children with disabilities are more readily assigned to sponsors. However, more importantly it is also recommended that at the country level, a more active outreach approach is adopted with communities to ensure that children with disabilities are identified and considered for sponsorship.

7.2 Recommendations for research to inform future programmes and projects

These research findings, while illustrative of the situation of sponsored children with disabilities, cannot alone inform programming. The findings require further qualitative research at a local level to investigate the causes of the quantitative findings and explore ways of addressing the challenges faced by children with disabilities. In each case, there needs to be a careful consideration of what specific research is needed to address knowledge gaps, both at the national level and specific to Plan's programme areas. Nevertheless, based on the overarching findings of this study, qualitative research is necessary to investigate why children with disabilities are not attending formal education and why they are reporting high rates of illness. So for instance, the recent research undertaken by Plan in

Western Africa, mentioned in Chapter 2, on access to education and protection of girls and boys with disabilities in Sierra Leone, Togo, Guinea and Niger to improve programming is an excellent example of what is needed.

In addition, given some of the literature on the challenges facing children with disabilities in relation to child protection issues, it is recommended that, through research, Plan develops effective child protection mechanisms both to support prevention and to support children with disabilities access child protection services.

With reference to the recommendations in section 7.1 above, where countries decide to include children with disabilities in their programming or to design a specific project on issues of disability, qualitative research will be key in being able to design and develop targeted interventions, alongside with mainstreaming disability inclusion, that respond to the challenges faced by children with disabilities in the communities in which Plan operates. Therefore it is recommended that countries undertake locally specific research to complement the findings from this study when embarking on the development of programmes on disability. It is recommended that countries seek the guidance from both the Disability Inclusion Reference Group within Plan, the Global Gender and Inclusion Advisor and, where required by the Research Policy and Standards, the Research and Knowledge Management Team at the International Headquarters to ensure maximum learning and sharing of best practice and knowledge across the organisation.

In addition, linked to section 7.3 below, it would also be extremely beneficial for Plan to consider how the dataset could be explored to monitor children over time, enabling valuable longitudinal studies into the life trajectories of the sponsored children. However, this would be resource dependant.

Finally, given Plan's commitment to inclusion it is recommended that when doing quantitative research, all such research should be gender disaggregated and preferably disaggregated for type of impairment.

7.3 Recommendations for the use of the sponsorship dataset

As noted in chapter 1, one of the objectives of this study was to gauge the usefulness of the sponsorship dataset for research purposes as this had not yet been done at this scale within Plan. Having now undertaken the study it is clear that the dataset is indeed useful, unique and can contribute a considerable wealth of knowledge to improve understanding on a range of issues based on the information it holds. This has implications for the various uses of the dataset.

Of particular relevance, it is recommended that countries make use of the sponsorship dataset, where possible and bearing in mind its limitations, when undertaking monitoring and evaluation activities. In addition, as mentioned in section 7.1, because it is a source specific on children we work with and areas we work in, the dataset should be one of the sources of information when countries embark on situation analyses for the development of country strategic plans or other strategic planning processes.

Second, even though the sponsorship data is already very useful in its current form, there were certain variables which had a high number of missing values (eg. vaccination, birth registration) it is recommended that these will be looked into and the data collection and entry processes amended appropriately.

Last, with specific reference to children with disabilities, and linked to section 7.2, it is recommended that should Plan centrally, or in specific countries which have the resources available, to undertake a longitudinal follow-up study of children with disabilities. Such a study would be useful to compare children's long-term future inclusion, in terms of livelihood and social participation, to that of children without disabilities.

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Appendix

Poverty and disabilities

		MALES			FEMALES		
	Poverty score	**Disabled**	**Non disabled**	**Age adjusted OR**	**Disabled**	**Non disabled**	**Age adjusted OR**
Latin America							
Bolivia	1 (poorest)	44 (26%)	4273 (25%)	Baseline	54 (27%)	6124 (25%)	Baseline
	2	40 (23%)	4251 (25%)	0.9 (0.6-1.4)	54 (27%)	6162 (25%)	1.0 (0.7-1.4)
	3	38 (22%)	4183 (25%)	0.9 (0.6-1.3)	48 (24%)	6230 (25%)	0.8 (0.6-1.2)
	4 (least poor)	49 (29%)	4155 (25%)	1.1 (0.7-1.7)	45 (22%)	6229 (25%)	0.8 (0.5-1.2)
Brazil	1 (poorest)	20 (25%)	1435 (25%)	Baseline	17 (27%)	1783 (25%)	Baseline
	2	17 (21%)	1435 (25%)	0.8 (0.4-1.5)	16 (25%)	1781 (25%)	0.9 (0.4-1.8)
	3	20 (25%)	1449 (25%)	0.9 (0.5-1.7)	16 (25%)	1764 (25%)	0.9 (0.4-1.7)
	4 (least poor)	23 (29%)	1373 (24%)	1.0 (0.5-1.9)	14 (22%)	1830 (26%)	0.7 (0.3-1.5)
Colombia	1 (poorest)	29 (24%)	2009 (22%)	Baseline	31 (28%)	3436 (27%)	Baseline
	2	28 (23%)	2329 (25%)	0.8 (0.5-1.4)	25 (22%)	3124 (25%)	0.8 (0.5-1.4)
	3	34 (28%)	2407 (26%)	1.0 (0.6-1.6)	29 (26%)	3036 (24%)	1.0 (0.6-1.6)
	4 (least poor)	32 (26%)	2438 (27%)	0.9 (0.5-1.5)	27 (24%)	3006 (24%)	0.9 (0.5-1.5)
Dominican Republic	1 (poorest)	21 (25%)	3023 (28%)	Baseline	24 (26%)	4263 (27%)	Baseline
	2	23 (27%)	2448 (23%)	1.4 (0.8-2.5)	25 (27%)	3453 (22%)	1.3 (0.7-2.3)
	3	24 (29%)	2633 (24%)	1.3 (0.7-2.3)	18 (19%)	3967 (26%)	0.8 (0.4-1.5)
	4 (least poor)	16 (19%)	2734 (25%)	0.8 (0.4-1.5)	27 (29%)	3861 (25%)	1.2 (0.7-2.0)
Ecuador	1 (poorest)	96 (23%)	5130 (24%)	Baseline	110 (29%)	6463 (26%)	Baseline
	2	126 (30%)	5318 (25%)	1.3 (1.0-1.7)	102 (27%)	6352 (25%)	0.9 (0.7-1.2)
	3	98 (23%)	5249 (25%)	1.0 (0.7-1.3)	85 (23%)	6231 (25%)	0.8 (0.6-1.1)

	4 (least poor)	99 (24%)	5458 (26%)	1.0 (0.7-1.3)	77 (21%)	6076 (24%)	0.7 (0.5-1.0)
El Salvador	1 (poorest)	81 (23%)	3833 (25%)	Baseline	73 (24%)	4718 (25%)	Baseline
	2	88 (25%)	3819 (25%)	1.1 (0.8-1.5)	71 (24%)	4749 (25%)	1.0 (0.7-1.3)
	3	90 (26%)	3894 (25%)	1.1 (0.8-1.5)	88 (29%)	4609 (25%)	1.2 (0.9-1.6)
	4 (least poor)	87 (25%)	3850 (25%)	1.0 (0.8-1.4)	68 (23%)	4697 (25%)	0.9 (0.6-1.3)
Guatemala	1 (poorest)	38 (17%)	4418 (26%)	Baseline	44 (21%)	5338 (25%)	Baseline
	2	65 (29%)	4026 (24%)	1.9 (1.3-2.8)	46 (22%)	5484 (26%)	1.2 (0.7-1.6)
	3	59 (26%)	4104 (24%)	1.6 (1.1-2.5)	68 (33%)	5409 (25%)	1.5 (1.1-2.3)
	4 (least poor)	63 (28%)	4345 (26%)	1.6 (1.1-2.4)	49 (24%)	5241 (24%)	1.1 (0.7-1.7)
Honduras	1 (poorest)	78 (26%)	3507 (24%)	Baseline	69 (27%)	4856 (26%)	Baseline
	2	75 (25%)	3632 (25%)	0.9 (0.7-1.3)	62 (24%)	4741 (25%)	0.9 (0.6-1.3)
	3	78 (26%)	4032 (28%)	0.8 (0.6-1.2)	72 (28%)	5196 (27%)	0.9 (0.7-1.3)
	4 (least poor)	66 (22%)	3368 (23%)	0.8 (0.6-1.2)	51 (20%)	4157 (22%)	0.8 (0.5-1.1)
Nicaragua	1 (poorest)	62 (25%)	3140 (25%)	Baseline	52 (24%)	3731 (25%)	Baseline
	2	59 (24%)	3193 (25%)	0.9 (0.6-1.3)	47 (22%)	3662 (25%)	0.9 (0.6-1.3)
	3	64 (26%)	3157 (25%)	0.9 (0.6-1.3)	72 (34%)	3606 (25%)	1.3 (0.9-1.9)
	4 (least poor)	60 (24%)	3134 (25%)	0.8 (0.6-1.2)	43 (20%)	3711 (25%)	0.7 (0.5-1.1)
Paraguay	1 (poorest)	10 (15%)	951 (27%)	Baseline	8 (17%)	1147 (27%)	Baseline
	2	18 (27%)	767 (22%)	2.3 (1.1-5.1)	16 (34%)	994 (24%)	2.4 (1.0-5.7)
	3	20 (30%)	891 (26%)	2.2 (1.0-4.8)	8 (17%)	1031 (24%)	1.2 (0.4-3.1)
	4 (least poor)	19 (28%)	879 (25%)	2.1 (1.0-4.6)	15 (32%)	1039 (25%)	2.2 (0.9-5.1)
Peru	1 (poorest)	24 (25%)	2812 (27%)	Baseline	18 (18%)	3632 (25%)	Baseline
	2	16 (16%)	2539 (24%)	0.7 (0.4-1.3)	12 (12%)	3641 (25%)	0.7 (0.3-1.4)
	3	22 (23%)	2507 (24%)	1.0 (0.5-1.7)	36 (37%)	3769 (26%)	1.9 (1.1-3.3)
	4 (least poor)	35 (36%)	2589 (25%)	1.5 (0.9-2.5)	32 (33%)	3683 (25%)	1.7 (1.0-3.0)
Africa							
Benin	1 (poorest)						
	2	0 (0%)	199 (13%)	Baseline	37 (36%)	5901 (26%)	Baseline
	3	2 (40%)	338 (22%)	-	27 (26%)	5993 (26%)	0.7 (0.4-1.2)
	4 (least poor)	2 (40%)	485 (31%)	-	26 (25%)	5428 (24%)	0.8 (0.5-1.3)
		1 (20%)	548 (35%)	-	13 (13%)	5547 (24%)	0.4 (0.2-0.7)

Egypt	1 (poorest)	54 (23%)	3642 (25%)	Baseline	49 (22%)	4723 (25%)	Baseline
	2	59 (25%)	4079 (28%)	1.0 (0.7-1.4)	43 (20%)	5158 (28%)	0.8 (0.5-1.2)
	3	51 (22%)	3369 (23%)	1.0 (0.7-1.5)	50 (23%)	4325 (23%)	1.1 (0.7-1.6)
	4 (least poor)	70 (30%)	3729 (25%)	1.3 (0.9-1.8)	76 (35%)	4394 (24%)	1.6 (1.1-2.4)
Guinea	1 (poorest)	18 (41%)	2566 (30%)	Baseline	39 (38%)	5643 (29%)	Baseline
	2	12 (27%)	1885 (22%)	0.9 (0.4-1.9)	19 (19%)	4490 (23%)	0.6 (0.3-1.0)
	3	8 (18%)	2475 (29%)	0.5 (0.2-1.1)	29 (28%)	6126 (31%)	0.7 (0.4-1.1)
	4 (least poor)	6 (14%)	1570 (18%)	0.5 (0.2-1.4)	15 (15%)	3307 (17%)	0.6 (0.4-1.2)
Kenya	1 (poorest)	29 (24%)	6661 (27%)	Baseline	28 (21%)	8540 (25%)	Baseline
	2	41 (33%)	6700 (27%)	1.4 (0.9-2.2)	35 (16%)	9031 (26%)	1.2 (0.7-1.9)
	3	30 (24%)	6313 (25%)	1.1 (0.6-1.8)	29 (29%)	9401 (27%)	1.3 (0.8-2.1)
	4 (least poor)	24 (19%)	5352 (21%)	1.0 (0.6-1.7)	32 (24%)	7883 (23%)	1.2 (0.7-2.0)
Mozambique	1 (poorest)	12 (22%)	808 (27%)	Baseline	19 (29%)	1042 (28%)	Baseline
	2	13 (24%)	706 (24%)	1.3 (0.6-2.8)	11 (17%)	873 (24%)	0.7 (0.3-1.4)
	3	20 (37%)	685 (23%)	2.0 (1.0-4.1)	18 (28%)	894 (24%)	1.1 (0.6-2.1)
	4 (least poor)	9 (17%)	752 (25%)	0.8 (0.3-1.9)	17 (26%)	903 (24%)	1.0 (0.5-2.0)
Niger	1 (poorest)	24 (28%)	1556 (25%)	Baseline	35 (35%)	3265 (26%)	Baseline
	2	23 (27%)	1598 (26%)	1.0 (0.5-1.7)	25 (25%)	3258 (26%)	0.7 (0.4-1.2)
	3	22 (26%)	1488 (24%)	0.9 (0.5-1.7)	19 (19%)	3032 (24%)	0.6 (0.3-1.1)
	4 (least poor)	17 (20%)	1551 (25%)	0.7 (0.4-1.3)	20 (20%)	3170 (25%)	0.6 (0.4-1.1)
Rwanda	1 (poorest)	24 (34%)	514 (29%)	Baseline	55 (38%)	1417 (32%)	Baseline
	2	26 (37%)	352 (20%)	1.6 (0.9-2.9)	29 (20%)	875 (20%)	0.9 (0.6-1.4)
	3	8 (11%)	381 (22%)	0.5 (0.2-1.0)	25 (17%)	1139 (26%)	0.6 (0.4-0.9)
	4 (least poor)	12 (17%)	522 (30%)	0.5 (0.2-1.0)	35 (24%)	1029 (23%)	0.9 (0.6-1.3)
Senegal	1 (poorest)	25 (30%)	3017 (26%)	Baseline	18 (25%)	5139 (25%)	Baseline
	2	18 (22%)	2894 (25%)	0.7 (0.4-1.3)	17 (24%)	5317 (255)	0.9 (0.5-1.7)
	3	22 (27%)	2870 (25%)	0.9 (0.5-1.7)	14 (19%)	5206 (25%)	0.8 (0.4-1.5)
	4 (least poor)	18 (22%)	2833 (24%)	0.8 (0.4-1.5)	23 (32%)	5307 (25%)	1.2 (0.7-2.3)
Sudan	1 (poorest)	16 (23%)	2597 (26%)	Baseline	17 (27%)	4516 (27%)	Baseline
	2	21 (30%)	2666 (26%)	1.5 (0.8-2.8)	16 (26%)	4325 (25%)	1.1 (0.6-2.2)
	3	14 (20%)	2291 (23%)	1.1 (0.5-2.2)	17 (27%)	3930 (23%)	1.3 (0.6-2.5)
	4 (least poor)	18 (26%)	2546 (25%)	1.3 (0.6-2.5)	12 (19%)	4223 (25%)	0.8 (0.4-1.6)

Tanzania	1 (poorest)	8 (16%)	2568 (26%)	Baseline	13 (23%)	3497 (25%)	Baseline
	2	21 (43%)	2583 (26%)	2.6 (1.1-5.9)	18 (32%)	3463 (24%)	1.4 (0.7-2.8)
	3	11 (22%)	2530 (25%)	1.4 (0.6-3.4)	15 (27%)	3559 (25%)	1.1 (0.5-2.3)
	4 (least poor)	9 (18%)	2263 (23%)	1.3 (0.5-3.4)	10 (18%)	3735 (26%)	0.7 (0.3-1.7)
Uganda	1 (poorest)	31 (26%)	3284 (24%)	Baseline	56 (37%)	5959 (28%)	Baseline
	2	32 (27%)	3209 (23%)	1.1 (0.6-1.8)	40 (26%)	5196 (24%)	0.8 (0.5-1.1)
	3	33 (28%)	4117 (30%)	0.9 (0.5-1.4)	33 (22%)	5903 (28%)	0.5 (0.3-0.8)
	4 (least poor)	21 (18%)	3135 (23%)	0.7 (0.4-1.3)	22 (15%)	4395 (20%)	0.5 (0.3-0.8)
Zambia	1 (poorest)	16 (27%)	1993 (26%)	Baseline	19 (35%)	2357 (27%)	Baseline
	2	13 (22%)	1792 (23%)	0.9 (0.4-1.8)	11 (20%)	2174 (24%)	0.6 (0.3-1.3)
	3	16 (27%)	1990 (26%)	0.9 (0.5-1.9)	10 (19%)	2215 (25%)	0.5 (0.2-1.2)
	4 (least poor)	14 (24%)	1959 (25%)	0.8 (0.4-1.7)	14 (26%)	2132 (24%)	0.7 (0.4-1.5)
Zimbabwe	1 (poorest)	24 (29%)	3880 (35%)	Baseline	41 (35%)	8244 (38%)	Baseline
	2	15 (18%)	1518 (14%)	1.6 (0.8-3.1)	13 (11%)	2938 (13%)	0.9 (0.5-1.7)
	3	25 (30%)	3258 (29%)	1.2 (0.7-2.2)	33 (28%)	6197 (28%)	1.1 (0.7-1.7)
	4 (least poor)	19 (23%)	2526 (23%)	1.2 (0.7-2.2)	30 (26%)	4585 (21%)	1.3 (0.8-2.1)
Asia							
India	1 (poorest)	80 (36%)	5253 (23%)	Baseline	91 (31%)	10938 (26%)	Baseline
	2	44 (20%)	5100 (23%)	0.6 (0.4 - 0.8)	69 (23%)	11168 (26%)	0.7 (0.5 - 1.0)
	3	57 (25%)	6429 (29%)	0.5 (0.4 - 0.7)	81 (27%)	9710 (23%)	0.8 (0.6 - 1.1)
	4 (least poor)	44 (20%)	5703 (25%)	0.5 (0.3 - 0.7)	56 (19%)	10537 (25%)	0.6 (0.4 - 0.8)
Indonesia	1 (poorest)	41 (21%)	5189 (26%)	Baseline	29 (16%)	6237 (25%)	Baseline
	2	65 (33%)	5152 (25%)	1.6 (1.1-2.3)	56 (32%)	6282 (25%)	1.9 (1.2-2.9)
	3	43 (22%)	4966 (24%)	1.1 (0.7-1.6)	53 (30%)	6286 (25%)	1.8 (1.1-2.8)
	4 (least poor)	51 (26%)	5016 (25%)	1.2 (0.8-1.8)	38 (22%)	6358 (25%)	1.2 (0.7-2.0)
Nepal	1 (poorest)	35 (34%)	2772 (28%)	Baseline	33 (21%)	6781 (24%)	Baseline
	2	32 (31%)	2659 (27%)	1.0 (0.6-1.5)	48 (31%)	6963 (25%)	1.4 (0.9-2.2)
	3	14 (14%)	2303 (23%)	0.5 (0.3-0.9)	38 (24%)	7164 (25%)	1.1 (0.7-1.7)
	4 (least poor)	22 (21%)	2149 (22%)	0.8 (0.5-1.4)	37 (24%)	7403 (26%)	1.0 (0.6-1.6)
Philippines	1 (poorest)	53 (29%)	3011 (23%)	Baseline	71 (33%)	5270 (26%)	Baseline
	2	49 (27%)	3077 (24%)	0.9 (0.6-1.3)	44 (21%)	5197 (26%)	0.6 (0.4-0.9)

	3	46 (25%)	3279 (25%)	0.8 (0.5-1.1)	54 (25%)	5010 (25%)	0.7 (0.5-1.1)
	4 (least poor)	36 (20%)	3520 (27%)	0.5 (0.4-0.8)	44 (21%)	4782 (24%)	0.6 (0.4-0.9)
Sri Lanka	1 (poorest)	20 (27%)	2389 (24%)	Baseline	26 (29%)	3001 (25%)	Baseline
	2	18 (24%)	2391 (25%)	0.9 (0.5 - 1.7)	25 (27%)	3002 (25%)	0.9 (0.5 - 1.6)
	3	18 (24%)	2454 (25%)	0.9 (0.5 - 1.6)	19 (21%)	2982 (25%)	0.7 (0.4 - 1.2)
	4 (least poor)	19 (25%)	2519 (26%)	0.9 (0.5 - 1.6)	21 (23%)	2839 (24%)	0.8 (0.4 - 1.4)
Vietnam	1 (poorest)	56 (19%)	2587 (23%)	Baseline	52 (17%)	5994 (26%)	Baseline
	2	65 (22%)	2535 (22%)	1.1 (0.8-1.6)	71 (23%)	5973 (26%)	1.3 (0.9-1.9)
	3	105 (36%)	3648 (32%)	1.2 (0.8-1.6)	128 (41%)	6952 (31%)	1.9 (1.4-2.7)
	4 (least poor)	67 (23%)	2571 (23%)	1.0 (0.7-1.5)	64 (20%)	3771 (17%)	1.7 (1.1-2.4)

Publishing information

Published by Plan Limited
Block A, Dukes Court
Duke Street
Woking
Surrey GU21 5BH
United Kingdom

Plan Limited is a wholly owned subsidiary of Plan International, Inc. (a not-for-profit corporation registered in New York State, USA) and a Limited Company registered in England, registration number 03001663.

British Library Cataloguing in Public Data: A catalogue record for this publication is available from the British Library. ISBN: 978-1-906273-50-7

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