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Children with Disabilities in Latin America and the Caribbean:

A statistical overview of their well-being

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Foreword

An estimated 19.1 million children with disabilities live in Latin America and the Caribbean. Like all children, they have the right to be nurtured and supported through responsive care and education, to receive proper nutrition and health services, to access social protection and to play. Still, these rights are often denied. The reasons range from stigma and lack of accessible services to institutionalization and physical barriers. The consequences, however, are sadly consistent in countries across the region. Often excluded from society, these children face diminished chances to survive, thrive and build a promising future.

For years, the inclusion of children with disabilities in development efforts has been hindered by the absence of reliable, comprehensive data. New data collection tools, however, have increased both the quantity and quality of available data on children with disabilities, driving new analyses and enhancing knowledge generation. The development of the Child Functioning Module, and its roll-out as part of the Multiple Indicator Cluster Survey programme, has led to the generation of cross-nationally comparable data on children with disabilities in Latin America and the Caribbean, which are presented for the first time in this report.

This statistical overview presents data from 12 countries in the region, covering indicators of child well-being including nutrition, health, education, protection from violence and exploitation, and the right to a clean and safe environment. Each number represents a child's unique story – his or her realities and potential. The report aims to make children with disabilities more visible by deepening our understanding of their experiences and the challenges they face. Data are vital for decision-making, to fulfil our collective duty of ensuring every child has a fair chance in life.

The persistent deprivation and discrimination faced by children with disabilities reveal a profound societal failure to protect their most fundamental human rights. Yet, the barriers they encounter are shaped by societal choices and are not inevitable. This understanding holds the promise of transformative progress, where societies can work to not only accept but embrace children with disabilities in all their diversity.

The journey towards genuine inclusion begins with each of us – it is up to you, me and everyone. Join the movement and be the change every child deserves!

Karin Hulshof
Acting Director,
UNICEF Regional Office for Latin America and the Caribbean

Introduction

Over 19 million children with disabilities live in Latin America and the Caribbean. Each of them – like every child in the world – has the right to be nurtured and supported through responsive care and education, to receive adequate nutrition and social protection, and to enjoy play and leisure time. Too often, however, such rights are denied. The reasons vary: They include stigma, lack of accessible services, institutionalization and physical barriers. But the consequences are sadly consistent. When marginalized from society, the chances for these children to survive and thrive are diminished, along with their prospects for a bright future.

In 2015, the adoption of the 2030 Agenda for Sustainable Development was framed around the pledge of leaving no one behind. It calls for a commitment to ensure that all 17 Sustainable Development Goals (SDGs), comprising 169 targets, are achieved for the benefit of all members of society. It emphasizes reaching those furthest behind first, which inevitably includes children with disabilities and their families.

Monitoring the inclusion of children with disabilities in development efforts has long been held back by the lack of reliable and comprehensive data. Recent years, however, have seen renewed efforts to fill these data gaps. The development of new data collection tools has resulted in a substantial increase in the availability and quality of data on children with disabilities, fostering new analyses and contributing to increased knowledge generation. This report is a testament to these efforts. It includes internationally comparable data from 12 countries in Latin America and the Caribbean and covers more than 30 indicators of child well-being – from nutrition, health and education to protection from violence and discrimination. It also presents global and regional estimates of children with disabilities drawn from more than 1,000 data sources.

The report's objective is to promote the use of these data to make children with disabilities in the region more visible, bringing about a fuller understanding of their life experiences. It offers evidence crucial to decision-making to fulfil obligations, both moral and legal, to give every child an equal chance in life.

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Understanding disability in children

Children with disabilities are a highly diverse population group. They include children who were born with a genetic condition that affects their physical, mental or social development; who sustained a serious injury, nutritional deficiency or infection that contributed to long-term functional difficulties; or who were exposed to environmental toxins that resulted in developmental delays. Children with disabilities also include those who developed anxiety or depression as a result of stressful life events.

Disability is a complex and evolving concept, involving aspects of body function and structure (impairments), capacity (measured by the ability to carry out basic activities without the benefit of assistance in any form), and performance (measured by the individual's ability to carry out these same basic activities using available assistive technologies and assistance). As stated in the Convention on the Rights of Persons with Disabilities, disability stems from the interaction between certain conditions or impairments and an unaccommodating environment that hinders an individual's full and effective participation in society on an equal basis with others. The framework of the International Classification of Functioning, Disability and Health (ICF) relies on a three-level model to describe the concept of disability. According to the ICF, disability can occur as:

- An impairment in body function or structure (for example, a cataract or opacity of the natural lens of the eye, which prevents the passage of rays of light and impairs or destroys sight)
- A limitation in activity (for example, low vision or inability to see, read or engage in other activities)
- A restriction in participation (for example, exclusion from school or participation in other social, recreational or other events or roles).

The ICF framework defines disability within a biopsychosocial model, integrating factors pertaining to both the individual and his or her environment. In contrast, the medical model defines disability as a problem resulting from a medical condition. Awareness of the important role of the social context in defining disability led to the development of the social model of disability, which defines disability not merely as a medical condition or diagnosis but rather as a failure of the policy, cultural and physical environments to accommodate differences in function. For instance, children with myopia who do not have access to diagnostic services and glasses will have difficulty seeing, whereas those who have such access will not. Furthermore, children with similar functional difficulties may participate in society to varying degrees because of physical, communication and cultural barriers. Access to assistive devices, technology and services, as well as exposure to nurturing relationships and positive social norms and beliefs, are crucial to promoting the inclusion of all children, regardless of their impairments.

Counting children with disabilities

The availability of data on children with disabilities has been a longstanding challenge due to limitations related to the use of narrow definitions and the lack of a standardized data collection methodology. While most countries have produced estimates of the number of persons with disabilities, the use of different measurement tools limits the validity and comparability of data. The definition of disability that is used in any given data collection instrument determines who is identified as having a disability and included in the appraisal of evidence. Different conceptualizations and differences in operationalizing the concept of disability will directly impact the quality and utility of the gathered data. Historically, measures of disability have focused on domains related to physical and sensory functioning, while other domains, notably those related to psychosocial functioning, were largely overlooked. Language that was stigmatizing or judgemental was also commonly found in some of the questionnaires used to determine disability status.

An additional limitation to the production of high-quality data on children with disabilities relates to the protocols used to collect them. Non-inclusive data collection methods and analyses can lead to the generation of inaccurate, incomplete, irrelevant or misleading evidence.[1] The absence of inclusiveness may result in severe underestimations and misidentification of persons with disabilities, aggravating exclusion and preventing the implementation of efforts where they are most needed. Further to the considerations on measuring disability in general, identifying children with disabilities presents additional challenges. The domains of functioning that may indicate that a young child has a disability are different from those in older children and adults. For example, asking about difficulties related to self-care is relevant among older children

and adults but not young children. In addition, measuring functional difficulties is complex since children, especially at younger ages, develop at different rates. Therefore, the identification of functional difficulties in children needs to account for what is a typical variation in development versus a developmental delay or a consequence of a specific impairment. Measuring disability among children requires instruments that are specifically designed to reflect the breadth of functional domains that are relevant for children. During childhood, this implies accounting for all the domains of physical, psychosocial, sensory and cognitive functioning. Furthermore, a comprehensive measure of disability must include all sorts of individual and environmental factors that may prevent children from developing skills and building trustworthy relationships and that inhibit their full and effective participation in society on an equal basis with others.

A new way to identify children with disabilities in data collection efforts

To address the paucity of data on the situation of children with disabilities globally, UNICEF and the Washington Group on Disability Statistics developed the Child Functioning Module for use in censuses and surveys. The module is intended to provide a population-level estimate of the number and proportion of children with functional difficulties. The module covers children between 2 and 17 years of age and assesses difficulties in various domains of functioning.[2] It conforms to the biopsychosocial model of disability, focusing on the presence and extent of functional difficulties rather than on body structure or conditions. For example, a mobility limitation can be the result of cerebral palsy, loss of limbs, paralysis, muscular dystrophy or spinal cord injuries. Behavioural issues may result from autism, attention deficit hyperactivity disorder or a mental health condition. Basing disability statistics on questions that ask about diagnosable conditions is problematic. Many caregivers may not know their child's diagnosis, particularly if this involves mental and psychosocial conditions; and knowledge about diagnoses is often correlated with education, socioeconomic status and access to health services, all of which may bias collected data. Questions that focus on basic actions, such as those in the Child Functioning Module, serve as a better basis for identifying children with disabilities. For the purposes of social participation and equalizing opportunities, functional status – and how that impacts someone's life – is of greater interest than the cause (medical or otherwise), since children with the same conditions or impairments may have very different degrees of difficulties. For example, one child with cerebral palsy might have a slight speech impairment but can easily be understood while another child with the same condition might not be able to speak at all, making communication challenging. Some of these difficulties are traditionally seen as a 'disability', while others are not. The Child Functioning Module comprises two questionnaires, one with 16 questions for children aged 2 to 4 years and another with 24 questions for children aged 5 to 17 years. The questions are to be administered to the mother or primary caregiver of the child in question. They are designed to identify difficulties according to a range of severity. To better reflect the degree of functional difficulty, each area is assessed against a rating scale. In addition to collecting data on domains related to physical, sensory and cognitive functioning, the Child Functioning Module includes questions on difficulties in psychosocial functioning. These questions identify children having difficulties expressing and managing emotions, accepting changes, controlling behaviour and making friends. While all children may sometimes manifest worry, sadness or anxiety, these emotions may be significant and frequent enough to place certain children at higher risk of dropping out of school, withdrawing from family or community life, or harming themselves. The reporting of anxiety or depression should be interpreted as an indication of those conditions, rather than as a clinical diagnosis. Results should not be used to assess the epidemiological characteristics of any disease or impairment; rather, they provide an indication of the prevalence of moderate to severe functional difficulties that, in interaction with various barriers, can place children at increased risk for non-participation and exclusion.

While the Child Functioning Module was originally developed and tested for use on surveys and censuses, work is ongoing to test the use of the module in other data sources, including administrative records. These efforts include testing the questions in Education and Health Management Information Systems.

The Child Functioning Module was developed in consultation with organizations of persons with disabilities, among other stakeholder groups. These organizations were instrumental in the design of the module, including through their engagement during its validation in the field.[3] The module also

underwent extensive review by other experts and was tested in several countries to determine the quality of questions and how well they are understood by people in diverse cultures.[4] In March 2017, a joint statement issued by multiple UN agencies and Member States, organizations of persons with disabilities and other stakeholders recommended the module as the appropriate tool for SDG data disaggregation for children.[5]

The development of the Child Functioning Module and its roll-out as part of the Multiple Indicator Cluster Survey (MICS) programme has led to the release, for the first time, of cross-nationally comparable data on children with disabilities. In addition, many countries have also included the module as part of their nationally representative surveys.

BOX 1

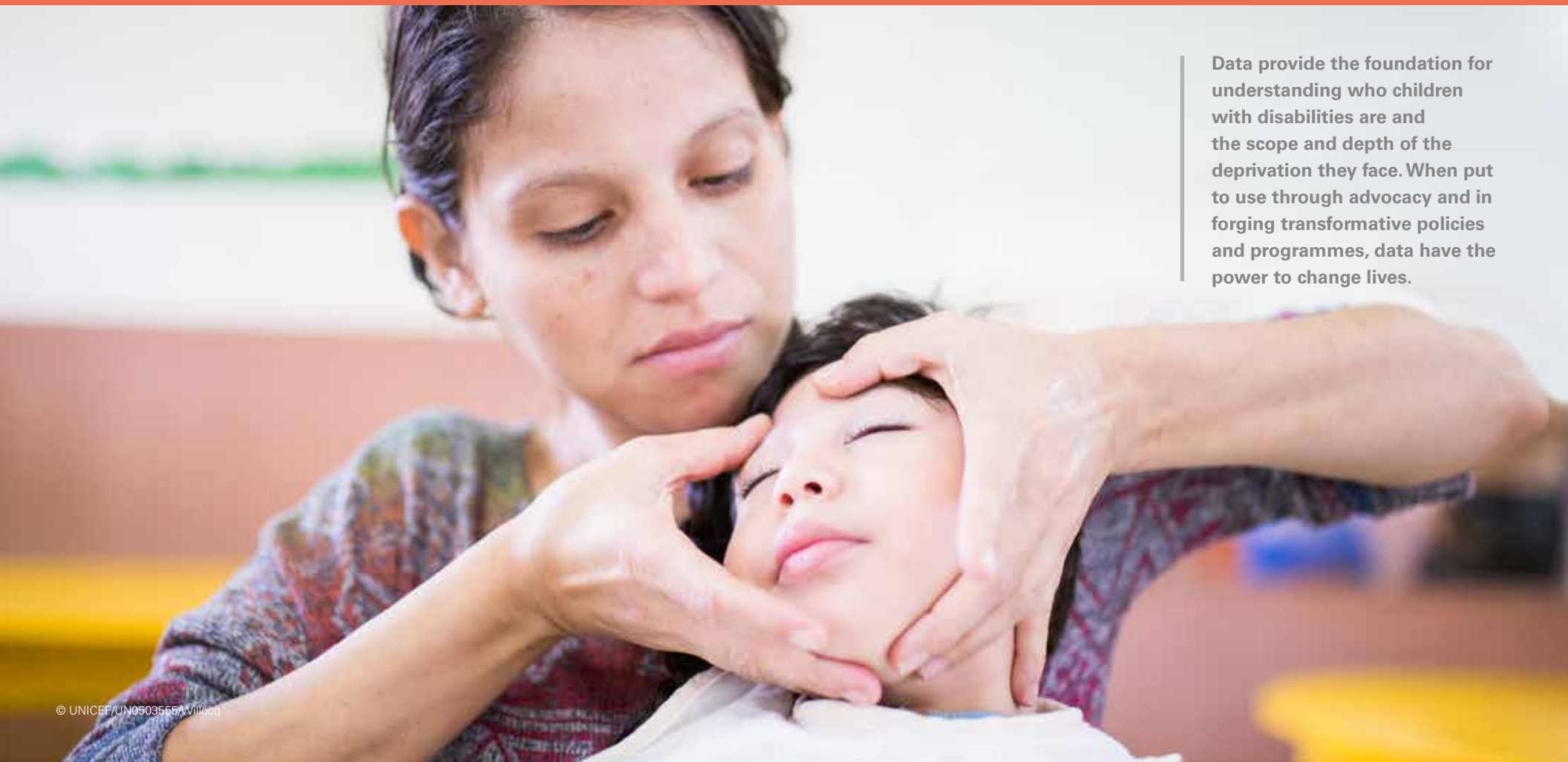
Collecting data on children with disabilities through Multiple Indicator Cluster Surveys

The MICS programme is designed to assist countries in collecting and analysing data on the situation of women and children. Since its inception in the mid-1990s, the MICS has enabled nearly 120 countries to collect nationally representative and internationally comparable data on more than 100 key indicators in areas such as nutrition, child health, mortality, education, water and sanitation, child protection, and HIV and AIDS.[6]

The MICS tools, including core questionnaires and modules on specific topics, are developed by UNICEF in consultation with relevant experts from various UN organizations and interagency monitoring groups. The surveys are designed by country teams and implemented by local agencies, typically national statistical offices. The core questionnaires are a household questionnaire, a questionnaire for individual girls and women between the ages of 15 and 49, a questionnaire for individual boys and men between the ages of 15 and 49, a questionnaire on children under age 5 (administered to mothers or primary caregivers), and a questionnaire on children aged 5 to 17 years (also administered to mothers or primary caregivers). The questionnaires are all modular in nature and can be adapted or customized to the needs of the country. In countries as diverse as Argentina, Bangladesh, Côte d'Ivoire, Fiji, Qatar, Thailand and Turkmenistan, trained fieldwork teams conduct interviews with household members on a variety of topics – focusing mainly on those issues that directly affect the lives of children and women. The MICS is an integral part of the policies and plans of many governments around the world and a major data source for more than 30 SDG indicators.

Starting in 2016, the Child Functioning Module and the Washington Group Short Set on Functioning[7] became part of the MICS and are used to collect data on children aged 2 to 17 years and on adult women and men aged 18 to 49 years, respectively. With the inclusion of these two tools, the MICS programme has become the largest source of internationally comparable data on children and adults with disabilities. When analysed in conjunction with other MICS indicators, the data can be used to document the inequities experienced by persons with disabilities at the global level.

Every child has the right to be counted



Data provide the foundation for understanding who children with disabilities are and the scope and depth of the deprivation they face. When put to use through advocacy and in forging transformative policies and programmes, data have the power to change lives.

Indicators and data sources used in this chapter

This report aims to generate evidence on children with disabilities aligned, to the greatest extent possible, with the Convention on the Rights of Persons with Disabilities and the biopsychosocial model of disability. This intent guided the production of the global and regional estimates and is reflected in country-level data collected by the Child Functioning Module. In line with this approach, the expression 'children with disabilities' used in charts and tables throughout the report refers to 'children with functional difficulties'.

The regional and global estimates presented here rely on information about functional difficulties or limitations among children gathered through more than 100 data sources with some degree of international comparability. The selection of data sources involved an extensive process of data compilation and consultations with country-level experts to overcome limitations on data availability and comparability, and to ensure their views were reflected in the data selection, harmonization and estimation process. In the case of countries in Latin America and the Caribbean, the estimates are based on data from 12 countries that used the Child Functioning Module. Detailed technical information on the estimation work and data sources is provided in the technical annex at the end of the report.

The country data presented in this chapter are drawn from MICS conducted in Argentina, Costa Rica, Cuba, Dominican Republic, Guyana, Honduras, Jamaica, Mexico, Suriname, Trinidad and Tobago, and Turks and Caicos Islands between 2015 and 2022, as well as the national health survey in El Salvador from 2021.

Children with one or more functional difficulties include the following:

Children aged 2 to 4 years who reportedly kick, bite or hit other children or adults a lot more than other children of the same age and/or who have 'a lot of difficulty' or 'cannot do at all' certain functions. These include:

- Seeing, even if using glasses
- Hearing, even if using a hearing aid
- Walking, even if using equipment or assistance
- Understanding or being understood when speaking
- Picking up small objects with their hands
- Learning things
- Playing.

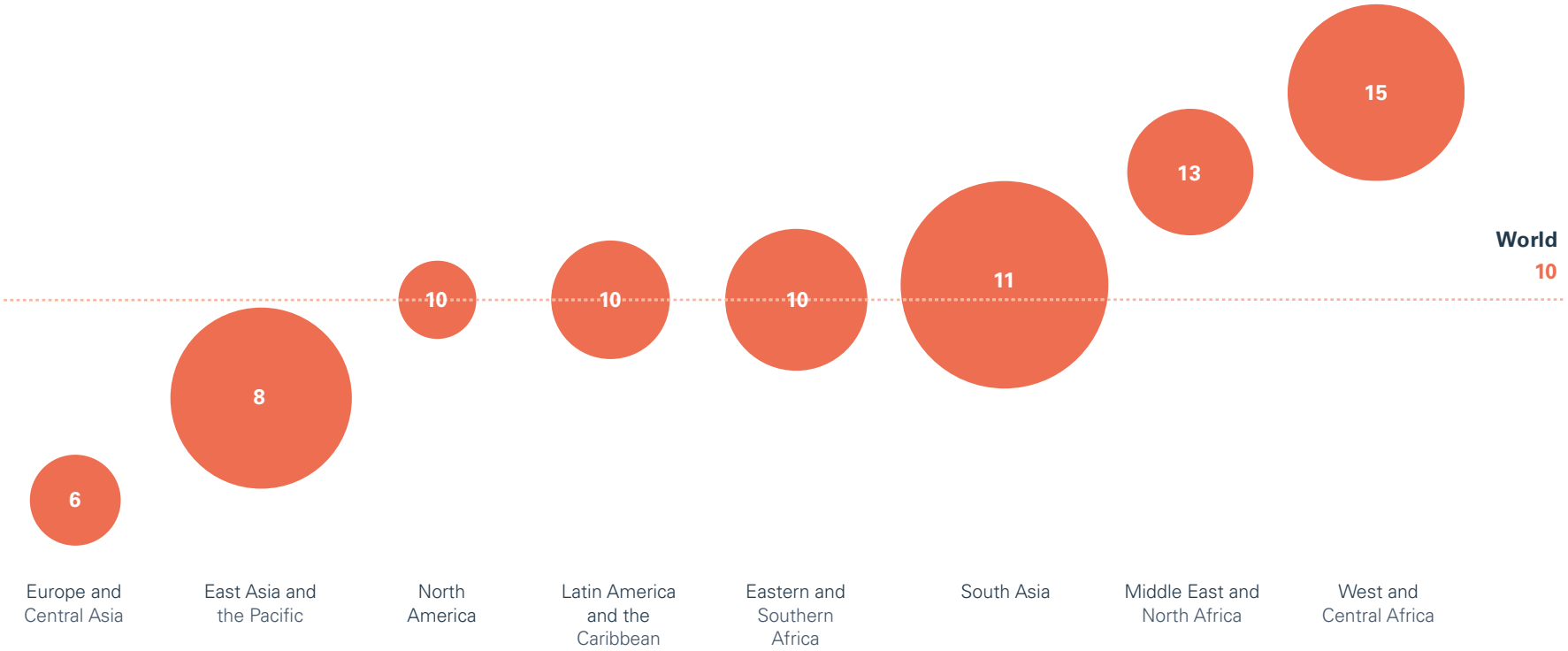
Children aged 5 to 17 years who reportedly seem very anxious, nervous or worried and/or very sad or depressed on a daily basis and/or who have 'a lot of difficulty' or 'cannot do at all' certain functions. These include:

- Seeing, even if using glasses or contact lenses
- Hearing, even if using a hearing aid
- Walking on level ground, even if using equipment or assistance
- Performing self-care activities, such as feeding or dressing themselves
- Being understood when speaking to people inside or outside their household
- Learning things
- Remembering things
- Concentrating on an activity they enjoy
- Accepting changes in their routine
- Controlling their behaviour
- Making friends.

Children with more than one functional difficulty include all children who have difficulties functioning in more than one of the domains listed above.

Ten per cent of children in Latin America and the Caribbean have disabilities

FIGURE 1 Percentage of children aged 0 to 17 years with disabilities



Note: The size of the circles reflects the number of children with disabilities in the respective regions.

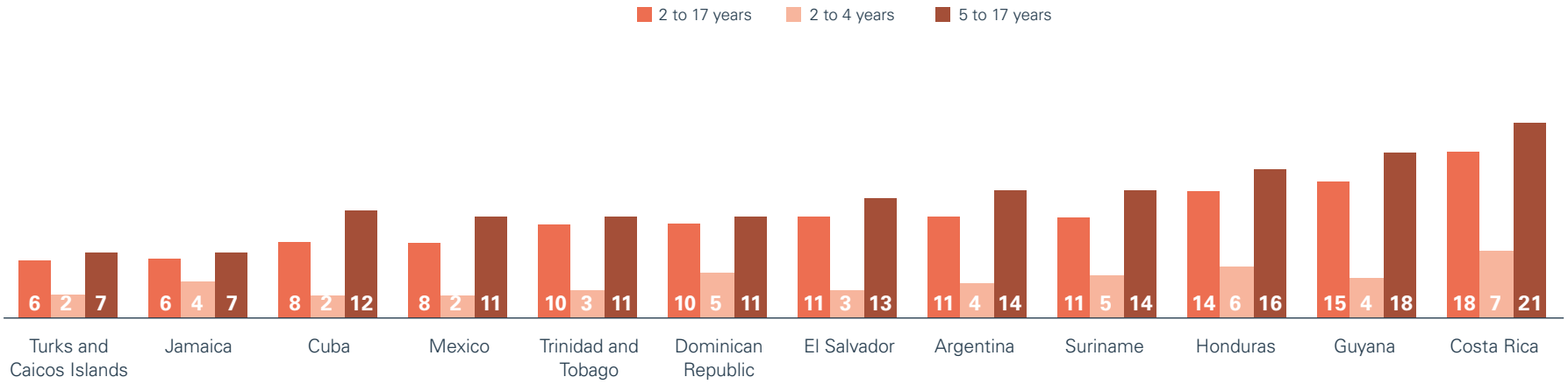
Of the 240 million children globally with disabilities, more than 19 million live in Latin America and the Caribbean

FIGURE 2 Number of children aged 0 to 17 years with disabilities

Notes: The global estimate is based on a subset of 103 countries covering 84 per cent of the global population of children aged 0 to 17 years. Regional estimates represent data covering at least 50 per cent of the regional population of children.

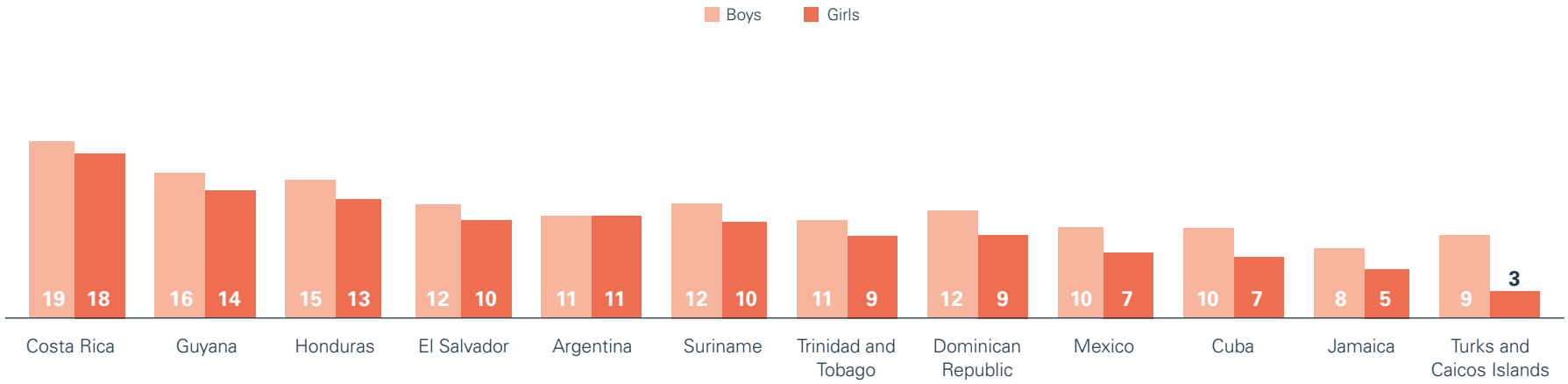
In all countries, the proportion of children with disabilities increases as children age, but overall proportions among countries vary

FIGURE 3 Percentage of children aged 2 to 17 years with one or more functional difficulties



In most countries, no statistically significant differences are found in the proportion of boys and girls with functional difficulties

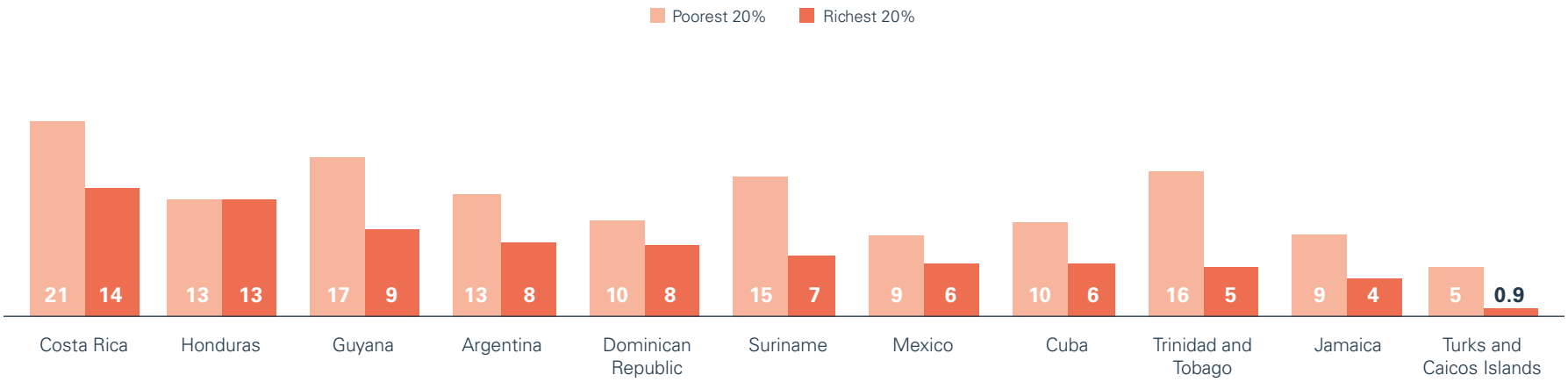
FIGURE 4 Percentage of children aged 2 to 17 years with one or more functional difficulties



Note: Differences for Argentina, Costa Rica, Cuba, El Salvador, Guyana, Honduras, Jamaica, Suriname, Trinidad and Tobago, and Turks and Caicos Islands are not statistically significant.

In one third of countries with available data, the proportion of children with disabilities is significantly higher in the poorest households

FIGURE 5 Percentage of children aged 2 to 17 years with one or more functional difficulties



Notes: Differences for Argentina, Costa Rica, Cuba, Dominican Republic, Honduras, Jamaica and Mexico are not statistically significant. Data for El Salvador were not available.

Most children with disabilities have functional difficulties in only one domain

FIGURE 6 Percentage of children aged 2 to 4 years with one or more functional difficulties

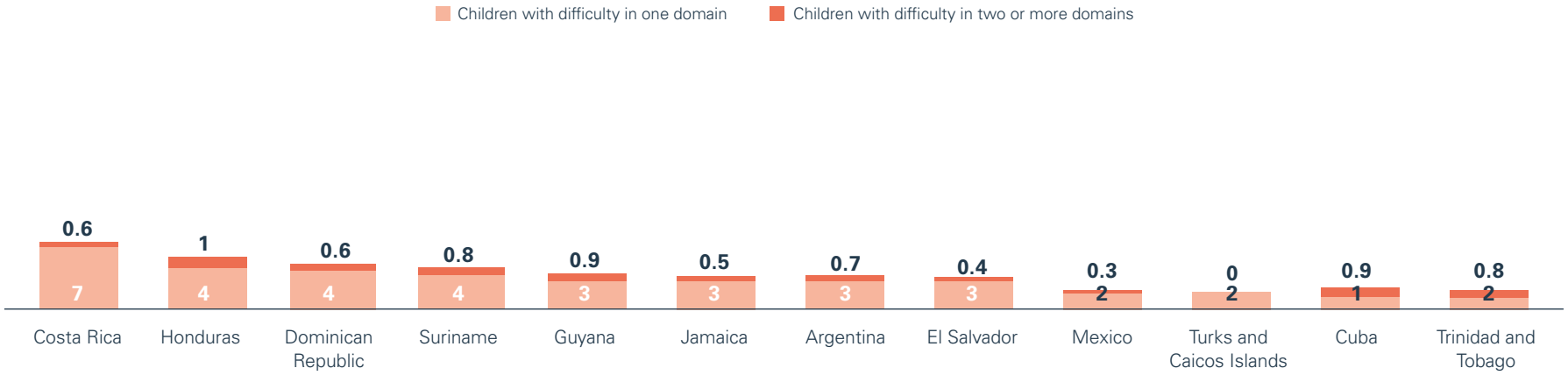
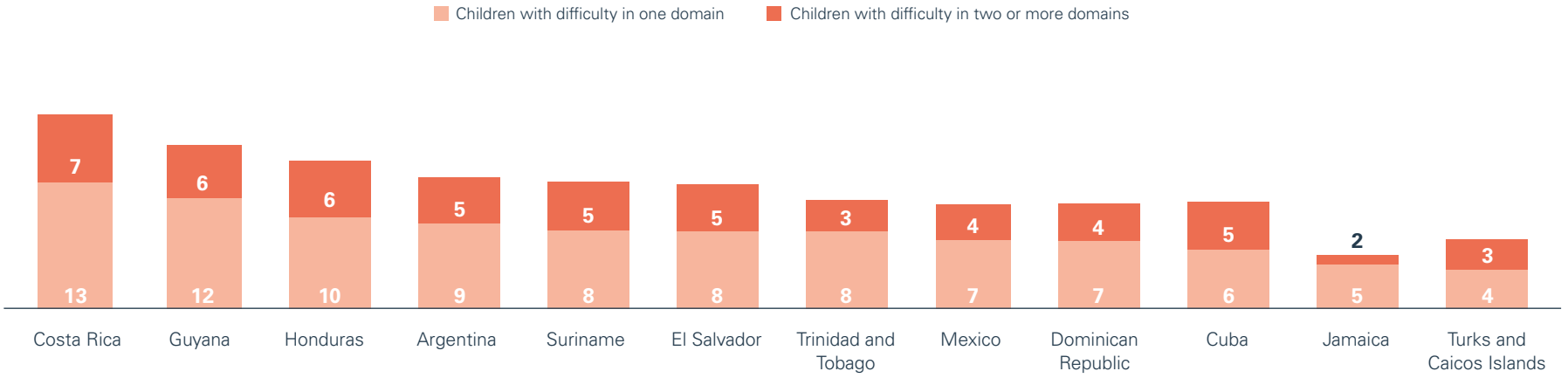


FIGURE 7 Percentage of children aged 5 to 17 years with one or more functional difficulties



The proportion of children with functional difficulties varies significantly by domain; however, psychosocial difficulties predominate across all countries

TABLE 1 Percentage of children aged 2 to 17 years with one or more functional difficulties

		Argentina	Costa Rica	Cuba	Dominican Republic	El Salvador	Guyana	Honduras	Jamaica	Mexico	Suriname	Trinidad and Tobago	Turks and Caicos Islands
2 to 17 years	Seeing	0.8	1.6	0.4	0.5	0.6	0.4	1.0	0.3	0.6	0.4	0.3	0.2
	Hearing	0.2	0.1	0.0	0.2	0.1	0.3	0.4	0.0	0.2	0.1	0.2	0.0
	Walking	0.8	0.7	0.8	0.6	0.8	1.7	1.6	1.0	0.7	1.5	1.2	0.1
	Communicating	1.4	2.2	0.6	1.2	0.9	0.8	1.5	0.6	1.1	1.1	0.9	0.3
	Learning	1.5	1.9	0.8	1.4	1.3	1.8	2.8	1.2	1.4	1.9	1.5	0.3
	Controlling behaviour	1.8	4.7	1.0	2.7	2.2	1.8	3.6	1.8	0.7	3.5	1.5	1.5
2 to 4 years	Fine motor skills	0.2	0.2	0.0	0.1	0.1	0.1	0.5	0.2	0.1	0.0	0.1	0.0
	Playing	0.3	0.3	0.1	0.2	0.2	0.2	0.5	0.3	0.2	0.4	0.4	0.0
5 to 17 years	Self-care	0.5	0.7	0.1	0.5	0.6	0.5	0.8	0.2	0.4	0.7	0.2	1.2
	Remembering	1.0	2.6	0.8	0.9	1.2	2.5	2.4	1.2	1.3	1.6	1.2	1.3
	Concentrating	1.4	2.2	0.6	0.6	1.0	0.6	1.7	0.5	1.3	0.8	1.1	0.3
	Accepting change	1.8	4.1	0.8	0.8	1.1	0.9	1.2	0.8	1.8	2.8	1.3	1.5
	Making friends	1.6	3.4	0.8	0.6	1.0	1.2	2.1	0.7	1.8	1.4	0.7	2.5
	Signs of anxiety	8.1	8.5	8.1	6.1	7.0	9.4	4.7	1.7	5.5	4.4	5.1	1.5
	Signs of depression	3.0	2.2	4.5	2.2	3.2	3.9	2.7	1.2	1.5	2.0	2.7	2.4

Every child has the right to survive and thrive

All children have the right to survive and develop, and to live a life free from disease, illness or other conditions that affect their well-being and future prospects. Access to adequate nutrition and quality health care, including immunization, is paramount in making this right a reality for every child.

Indicators and data sources used in this chapter

The country data presented in this chapter are drawn from MICS conducted in Argentina, Costa Rica, Cuba, Dominican Republic, Guyana, Honduras, Jamaica, Mexico, Suriname, Trinidad and Tobago, and Turks and Caicos Islands between 2015 and 2022, as well as the national health survey in El Salvador from 2021.

Immunization coverage for all basic vaccinations: Percentage of children aged 24 to 35 months who received all basic vaccinations at any time before the survey. Basic immunizations include one dose of BCG (the Bacillus Calmette–Guérin vaccine, primarily used against tuberculosis), three doses of vaccine for polio, three doses of vaccine for DTP (diphtheria, tetanus and pertussis, or whooping cough) and one dose of vaccine for measles.

Care-seeking for fever: Percentage of children age 24 to 59 months with a reported fever in the last two weeks for whom advice or treatment was sought from a health facility or provider.

Underweight prevalence (moderate and severe): Percentage of children aged 24 to 59 months who fall below minus two standard deviations of the median weight-for-age of the World Health Organization (WHO) Child Growth Standards.

Stunting prevalence (moderate and severe): Percentage of children aged 24 to 59 months who fall below minus two standard deviations of the median height-for-age of the WHO Child Growth Standards.

Early stimulation and responsive care: Percentage of children aged 24 to 59 months who engaged in four or more activities to provide early stimulation and responsive care in the last three days with any adult household member (mother, father, other). Activities include reading books or looking at picture books with the child; telling stories; singing songs to or with the child; taking the child outside the home; playing with the child; naming, counting or drawing things for or with the child.

Definitions and data interpretation issues

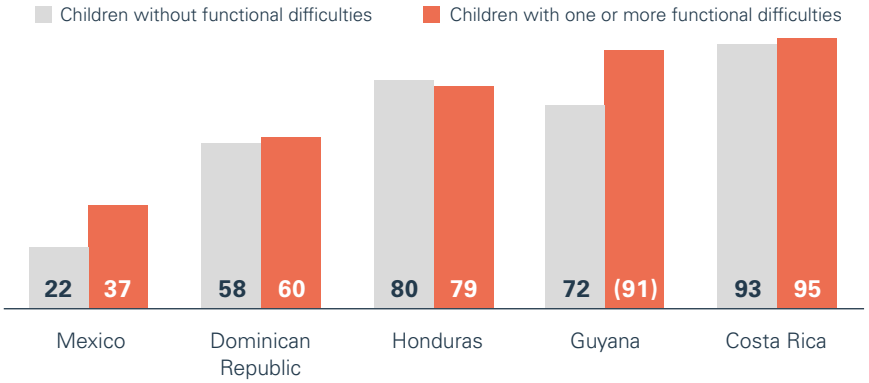
Some of the findings in this chapter present limitations. Since the Child Functioning Module only captures information on children 2 years of age and older, some health and nutrition outcomes that may affect children with disabilities before this age are not reflected in the data. This is significant since it is before age 2 that many immunizations are administered, vulnerability to infection remains high and challenges may arise in providing early nutrition (such as difficulties in breastfeeding).

Findings on nutritional status should also be interpreted with caution. Anthropometric measurements are carried out by trained measurers and under uniform conditions, which include the use of standardized digital scales and measurement boards.[8] Nevertheless, collecting data on the growth of children with disabilities presents additional challenges. Children with certain types of impairments may not grow in the same way as children who develop more typically. This may mean that their health and development cannot be properly measured by standard tools used in the context of household surveys.[9] Moreover, measuring and weighing children with specific types of impairments may lead to larger measurement errors.[10] Finally, it should be noted that the WHO Child Growth Standards were calculated based on children without physical impairments. Therefore, even when a child's height and weight can be collected, standard nutrition indicators (used to measure stunting, wasting and overweight) may be inappropriate to assess growth for certain children with disabilities,[11] making findings more difficult to interpret.

Children with disabilities are overrepresented in the number of children with missing anthropometric data. The two main reasons for missing data are that the child was not measured or that the data were collected but were implausible within the WHO growth standards reference z-scores. While the findings presented in this chapter do not specify the reason for missing data, they do provide some insights into the challenges around height and weight measurement of children with disabilities. These include: (1) difficulty measuring a child with an impairment (for example, if limbs are deformed due to polio and proper use of the measurement equipment is not possible), which may mean the measurement was not carried out at all; (2) the quality of the measurement may be poor due to the child's inability to stand upright, leading to inaccuracies; and (3) the growth standard used to generate the z-score for each child may yield an implausible value. This may be due either to the way in which children with certain impairments grow or to errors in measurement exacerbated by the child's condition, meaning that these children would not be included in the estimates at all. For all these reasons, the results presented may not accurately describe the nutritional status of all children with disabilities.

In most countries, no differences are found in the proportion of children with and without disabilities who have received basic immunization against vaccine-preventable childhood diseases

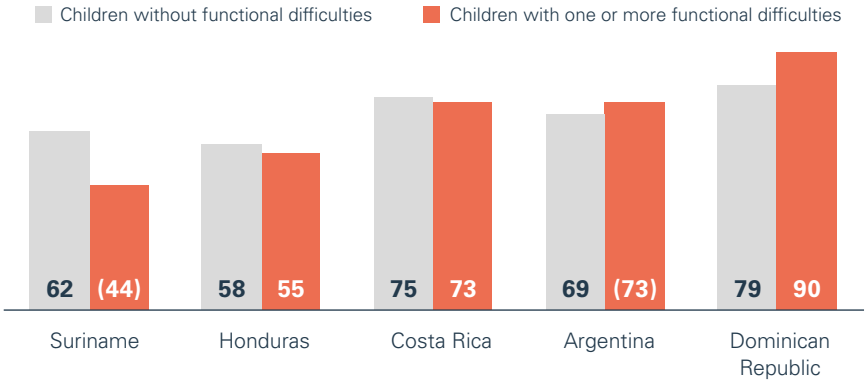
FIGURE 8 Percentage of children aged 24 to 35 months who received all basic vaccinations at any time prior to the survey



Notes: Differences for Costa Rica, Dominican Republic, Honduras and Mexico are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Values for Cuba, Jamaica, Trinidad and Tobago, and Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for Argentina, El Salvador and Suriname were not available.

When children with disabilities have a reported episode of fever, they are just as likely to be taken for treatment as children without disabilities

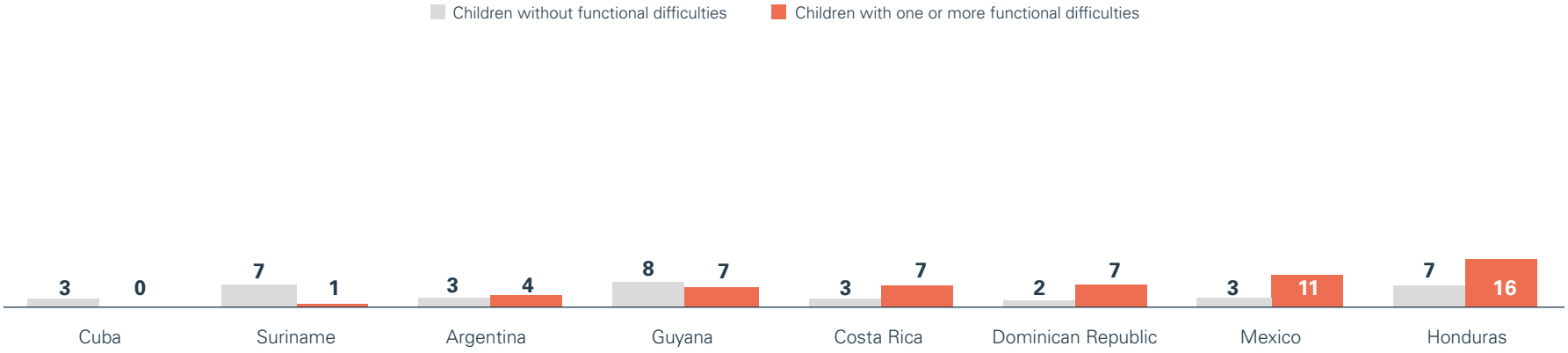
FIGURE 9 Percentage of children age 24 to 59 months with a reported fever in the last two weeks for whom advice or treatment was sought from a health facility or provider



Notes: Differences for Argentina, Costa Rica, Dominican Republic, Honduras and Suriname are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Values for Cuba, Guyana, Jamaica, Trinidad and Tobago, and Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for El Salvador and Mexico were not available.

In one third of countries in the region, children with disabilities are significantly more likely to be underweight than children without disabilities

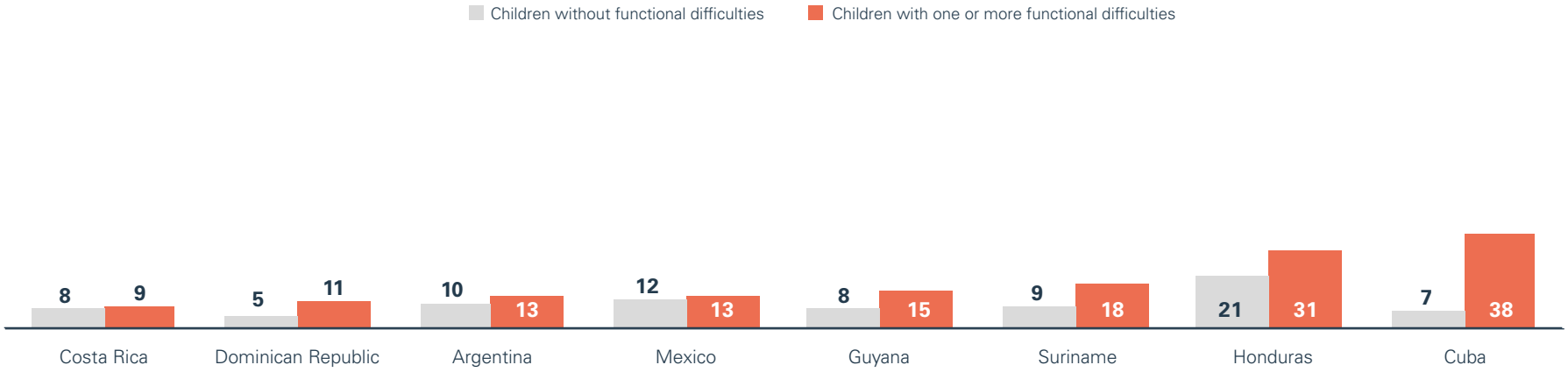
FIGURE 10 Percentage of children aged 24 to 59 months who are underweight



Notes: Differences for Argentina, Costa Rica, Cuba and Guyana are not statistically significant. Values for the Turks and Caicos Islands were suppressed as they were based on less than 25 observations. Data for El Salvador, Jamaica and Trinidad and Tobago were not available.

In half of the countries, children with disabilities are significantly more likely to be stunted than children without disabilities

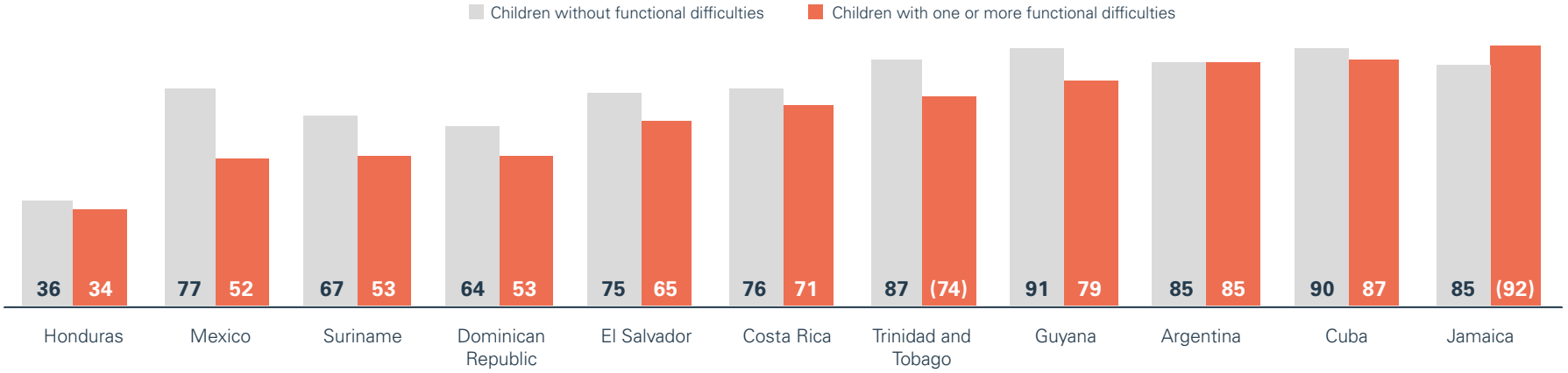
FIGURE 11 Percentage of children aged 24 to 59 months who are stunted



Notes: Differences for Argentina, Costa Rica, Guyana, Mexico and Suriname are not statistically significant. Values for the Turks and Caicos Islands were suppressed as they were based on less than 25 observations. Data for El Salvador, Jamaica and Trinidad and Tobago were not available.

In only two countries are children with disabilities significantly less likely to receive early stimulation and responsive care than children without disabilities

FIGURE 12 Percentage of children aged 24 to 59 months who engaged in four or more activities to provide early stimulation and responsive care in the last three days with any adult household member



Notes: Differences for Argentina, Costa Rica, Cuba, El Salvador, Honduras and Trinidad and Tobago are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Values for the Turks and Caicos Islands were suppressed as they were based on less than 25 observations.

Every child has the right to learn

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Education provides children with the knowledge and skills they need to grow and prosper, creating well-being, pathways to future opportunities and healthier lives. Ensuring opportunities for all children to succeed in school requires inclusion that guarantees access, participation, progress and achievement of key learning outcomes. This means addressing all aspects of a child's educational path and eliminating the disparities and barriers that begin early in life, accumulate during childhood and generate further disadvantages for the most marginalized children, including children with disabilities.

Indicators used in this chapter

The country data presented in this chapter are drawn from MICS conducted in Argentina, Costa Rica, Cuba, Dominican Republic, Guyana, Honduras, Jamaica, Mexico, Suriname, Trinidad and Tobago, and Turks and Caicos Islands between 2015 and 2022, as well as the national health survey in El Salvador from 2021.

Attendance of early childhood education: Percentage of children aged 36 to 59 months who are attending an early childhood education programme.

Out-of-school rate: Percentage of children of:

- Primary-school age who are not attending early childhood education, primary school or higher
- Lower-secondary-school age who are not attending primary, lower- or upper-secondary school or higher
- Upper-secondary-school age who are not attending primary, lower- or upper-secondary school or higher.

School completion rate: Percentage of children 3 to 5 years older than the intended age for the last grade of primary education who have completed that grade.

Never attended school: Percentage of children aged 10 to 17 years old who never attended school.

Learning outcomes:

- Foundational reading skills: Percentage of children aged 7 to 14 years who demonstrate foundational reading skills by successfully completing three foundational reading tasks:
  - Word recognition (correctly reading 90 per cent of words in a story)
  - Literal questions (correctly answering three literal questions)
  - Inferential questions (correctly answering two inferential questions).

Only by correctly reading 90 per cent of words in a story and correctly answering the questions in all three categories of the module is a child considered to have foundational reading skills.

- Foundational numeracy skills: Percentage of children aged 7 to 14 years who demonstrate foundational numeracy skills by successfully completing four foundational numeracy tasks:
  - Number reading
  - Number discrimination
  - Addition
  - Pattern recognition.

Each category has several questions, and the child must answer every question in every category correctly to be considered to have foundational numeracy skills.

Definitions and data interpretation issues

Several methodological issues need to be addressed to accurately interpret the findings in this chapter.

A relevant consideration is the limitation of the data in providing a comprehensive account of all factors affecting a child's learning experience. While the indicators used here measure education uptake and outcomes, they fall short in fully capturing the experiences of children with disabilities in obtaining an education and the barriers they face. Additional information and data sources are needed to gain such understanding.

Another data limitation is the inability to distinguish between children who are in mainstream education and those who are in disability-specific educational settings. This is significant since many countries have highly segregated school systems for children with disabilities. For example, what is considered progression in a special education school may be significantly different from that in a mainstream school, fundamentally altering responses to what is considered 'at level' for the child. If this distinction could be captured, then the reported inequities between children with and without disabilities would likely be even greater.

Results related to upper-secondary-school attendance are based on children who were less than 18 years old at the time of the survey. These results should

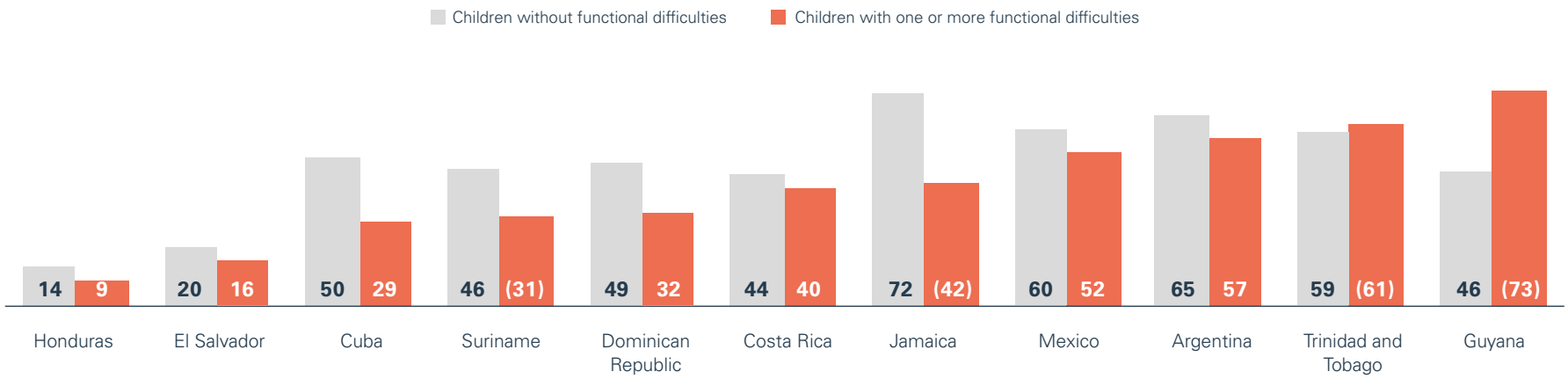
thus be interpreted carefully given that they do not include persons above the age of 18 who may still have been attending upper-secondary school.

A final consideration is the fact that the denominators used for some indicators do not capture the entire population of children represented by the sample. For example, out-of-school indicators only represent the situation of children who have ever attended school. It is well known that the most marginalized children in society, including those with disabilities, tend to be overrepresented among those who are out of school, either because they have never attended school or because they have dropped out. Therefore, the results that show disaggregated information on school progression for children with and without disabilities reflect the experiences of a subgroup of children that, in all likelihood, face lower barriers to education than those who have never been able to attend school.

A similar consideration applies to the results on foundational learning. In this case, the indicators for foundational reading and numeracy skills are only generated for children who can complete three reading tasks and four numeracy tasks. Non-completion observations include children who started but were unable to finish the assessment tasks, who refused to take the assessment (or whose mothers did not permit them to take the assessment) or who could not participate in the assessment due to illness or an impairment. Inaccessibility could thus be a barrier to participation for some children (for example, if a child is blind or requires assistive technology or reasonable accommodations to participate and these could not be provided). Therefore, the results that show differences in foundational learning skills for children with and without disabilities should be interpreted with the understanding that children with certain difficulties are less likely to have been part of such an assessment.

In almost one fourth of countries with available data, children with disabilities are significantly less likely to attend an early childhood education programme than children without disabilities

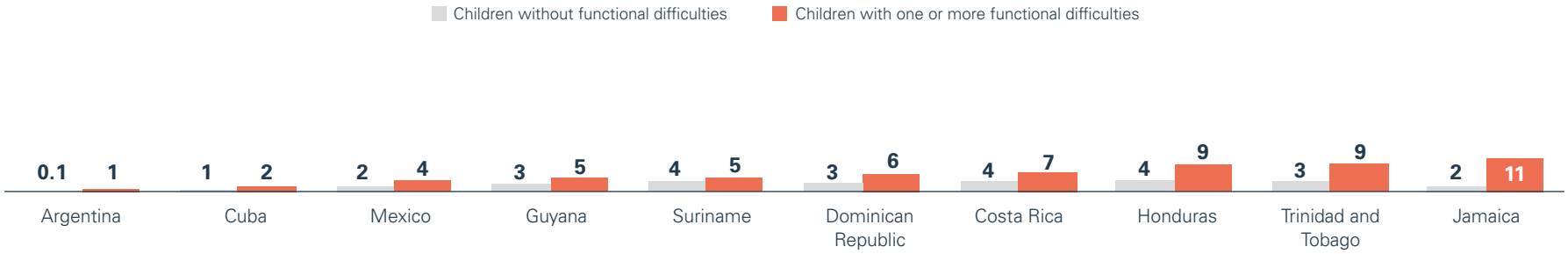
FIGURE 13 Percentage of children aged 36 to 59 months who are attending an early childhood education programme



Notes: Differences for Argentina, Costa Rica, Cuba, El Salvador, Honduras, Mexico and Trinidad and Tobago are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Values for the Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations.

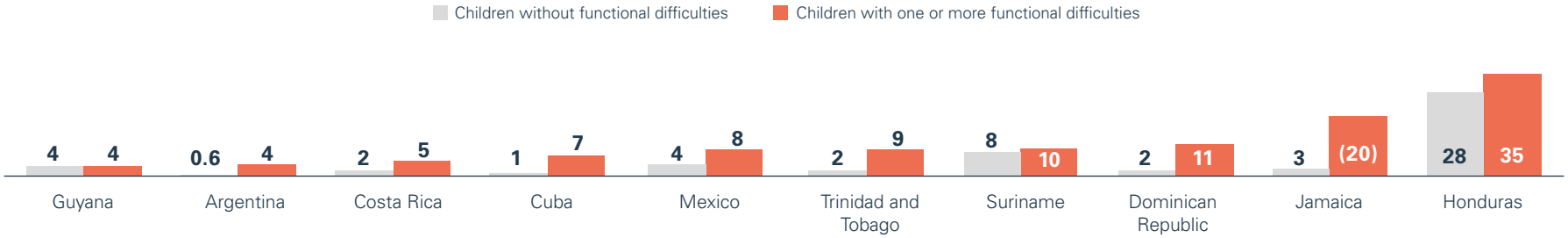
Children with disabilities are more likely to be out of school than children without disabilities, depending on the country and the level of education

FIGURE 14 Percentage of children of primary-school age who are not attending primary school or higher



Notes: Differences for Costa Rica, Cuba, Guyana and Suriname are not statistically significant. Values for the Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for El Salvador were not available.

FIGURE 15 Percentage of children of lower-secondary-school age who are not attending primary, lower- or upper-secondary school or higher



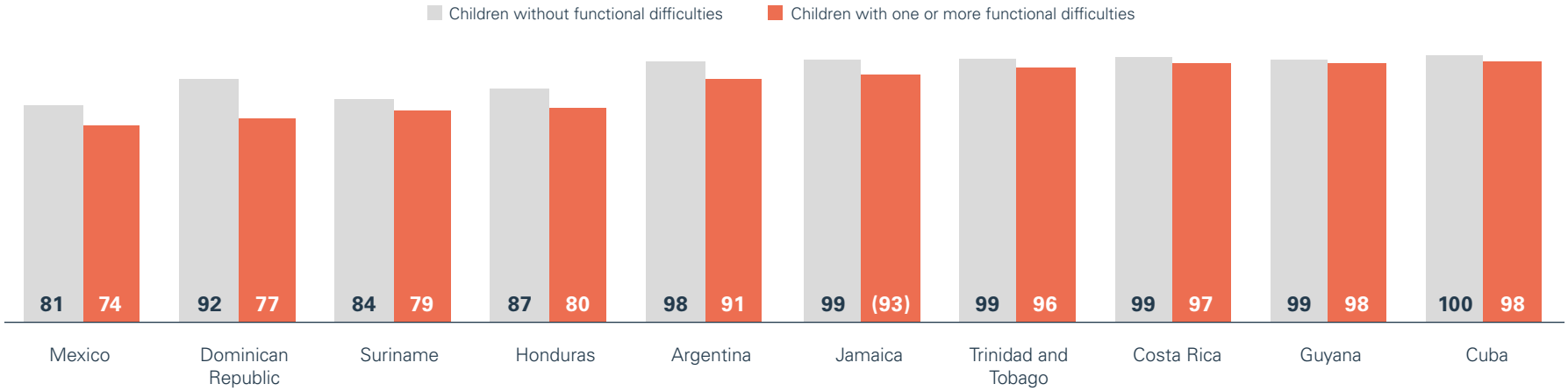
Notes: Differences for Costa Rica, Guyana, Honduras and Suriname are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Values for the Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for El Salvador were not available.

FIGURE 16 Percentage of children of upper-secondary-school age who are not attending primary, lower- or upper-secondary school or higher

Notes: Differences for Argentina, Costa Rica, Guyana, Honduras, Suriname and Trinidad and Tobago are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Values for the Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for El Salvador were not available.

In most countries, children with disabilities are significantly less likely to complete primary school than children without disabilities

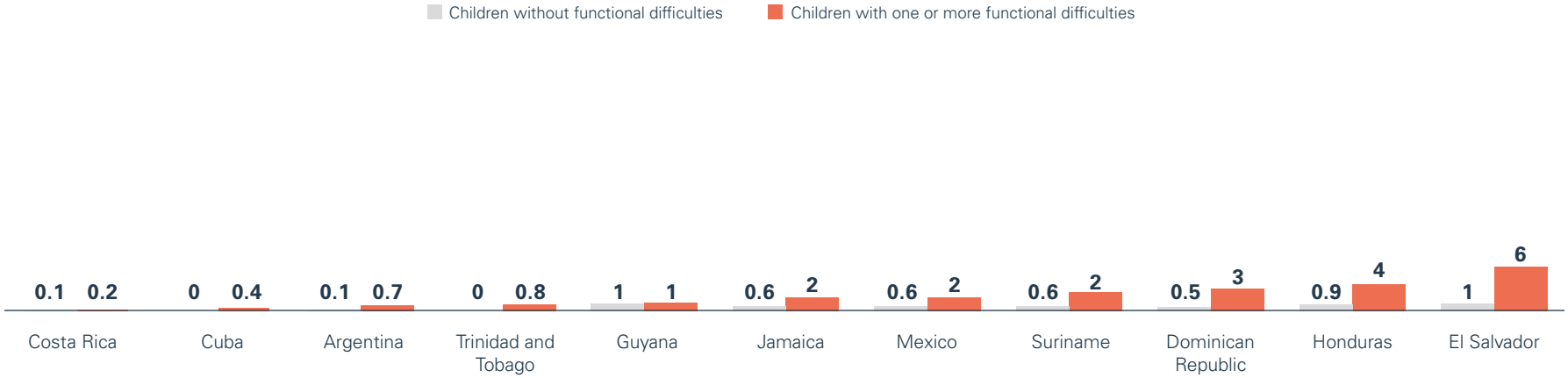
FIGURE 17 Percentage of children who are three to five years above the intended age for the last grade who have completed that grade in primary school



Notes: Differences for Guyana, Mexico and Suriname are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Values for the Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for El Salvador were not available.

In most countries, children with disabilities are significantly more likely to never attend school than children without disabilities

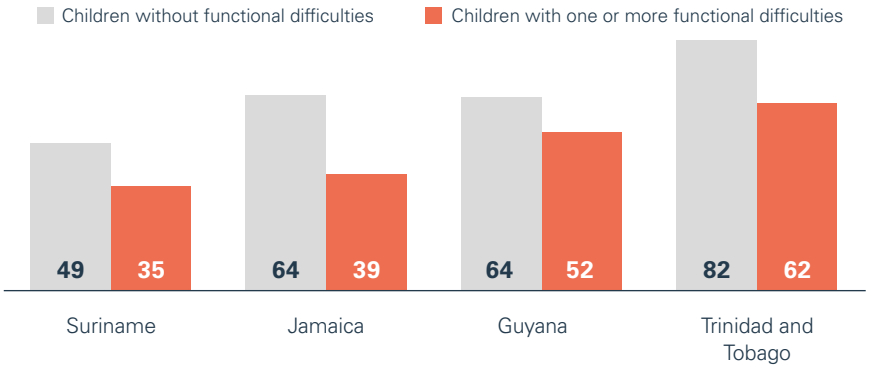
FIGURE 18 Percentage of children aged 10 to 17 years who have never attended school



Notes: Differences for Costa Rica, Guyana, Jamaica and Suriname are not statistically significant. Values for the Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations.

In all countries with available data, children with disabilities are significantly less likely to possess foundational reading skills than children without disabilities

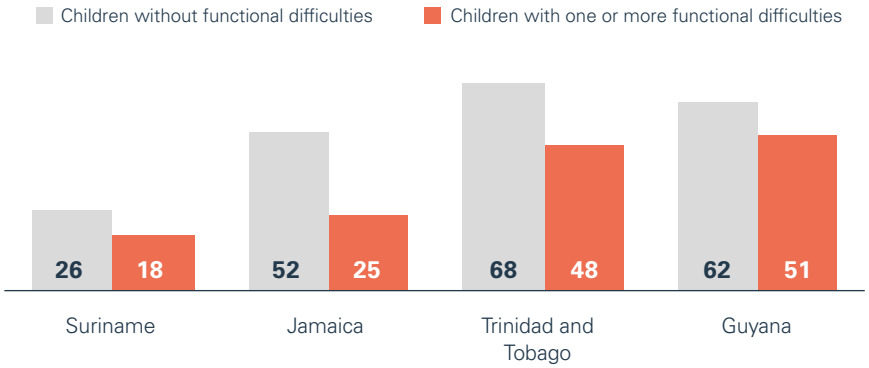
FIGURE 19 Percentage of children aged 7 to 14 years who demonstrate foundational reading skills



Notes: Values for the Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for Argentina, Costa Rica, Cuba, Dominican Republic, El Salvador, Honduras and Mexico were not available.

In all countries with available data, children with disabilities are significantly less likely to possess foundational numeracy skills than children without disabilities

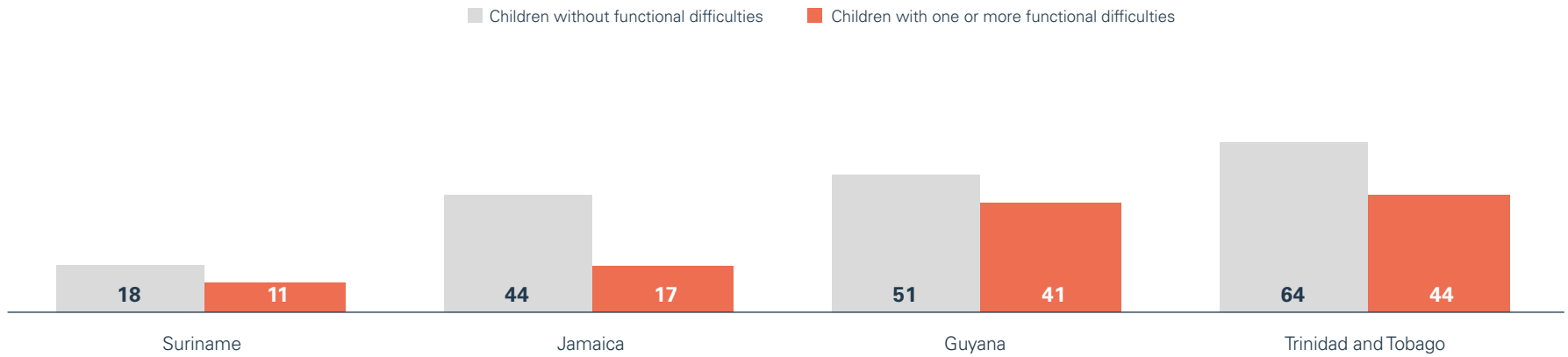
FIGURE 20 Percentage of children aged 7 to 14 years who demonstrate foundational numeracy skills



Notes: Values for the Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for Argentina, Costa Rica, Cuba, Dominican Republic, El Salvador, Honduras and Mexico were not available.

Children with disabilities are significantly less likely to possess foundational reading and numeracy skills than children without disabilities

FIGURE 21 Percentage of children aged 7 to 14 years who demonstrate foundational numeracy skills and foundational reading skills



Notes: Values for the Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for Argentina, Costa Rica, Cuba, Dominican Republic, El Salvador, Honduras and Mexico were not available.

Every child has the right to protection from violence and exploitation

The right of children to live free from violence and exploitation is enshrined in both the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities.

Indicators and data sources used in this chapter

The country data presented in this chapter are drawn from MICS conducted in Argentina, Costa Rica, Cuba, Dominican Republic, Guyana, Honduras, Jamaica, Mexico, Suriname, Trinidad and Tobago, and Turks and Caicos Islands between 2015 and 2022, as well as the national health survey in El Salvador from 2021.

Birth registration: Percentage of children aged 24 to 59 months whose births are registered with a civil authority.

Psychological aggression: Percentage of children aged 2 to 14 years who experienced any psychological aggression by caregivers in the past month.

Physical punishment: Percentage of children aged 2 to 14 years who experienced any physical punishment by caregivers in the past month.

Severe physical punishment: Percentage of children aged 2 to 14 years who experienced severe physical punishment by caregivers in the past month.

Any violent discipline: Percentage of children aged 2 to 14 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month.

Attitudes towards physical punishment: Percentage of mothers of children aged 2 to 14 years who believe that physical punishment is needed to bring up, raise or educate a child properly.

Child labour: Percentage of children aged 5 to 17 years who are involved in economic activities or household chores above age-specific thresholds.

Hazardous working conditions: Percentage of children aged 5 to 17 years who work under hazardous conditions.

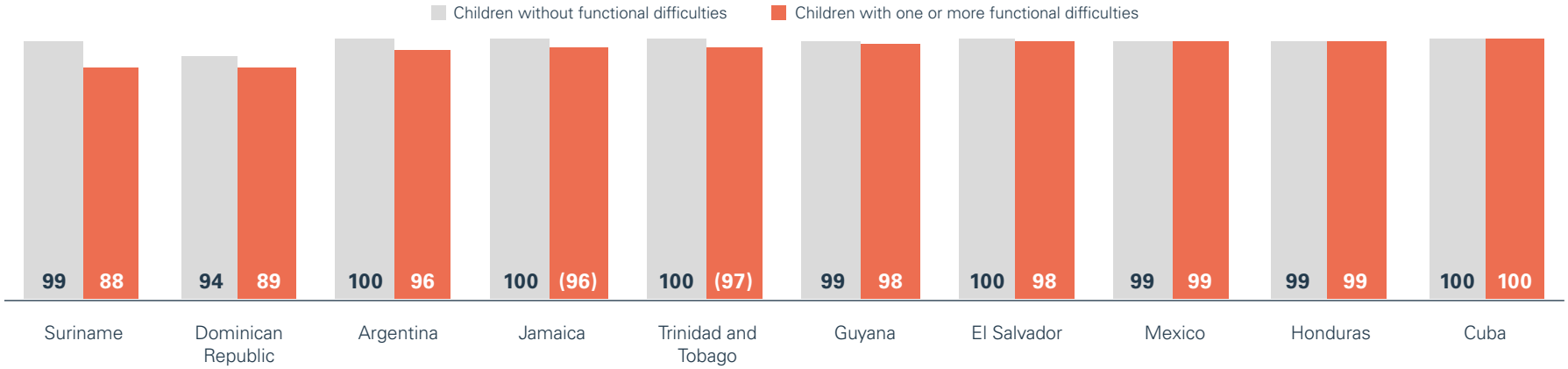
Definitions and data interpretation issues

Findings regarding violent methods of discipline should be interpreted with caution since, for a significant percentage of children with functional difficulties, no disciplinary method was reported. For children with difficulties in some domains of functioning, the finding of 'no discipline method reported' is more than five times greater than it is for children without disabilities, suggesting issues within this indicator that may have numerous explanations. Data for this indicator are collected by the interviewer asking whether a child is subjected to different disciplinary methods – both positive and negative. It is therefore possible that the methods used on children with disabilities vary significantly from those used on children without disabilities. However, as these are not mentioned in the survey, they have gone unrecorded. Alternatively, it could be indicative of parents not engaging with their children with disabilities and putting time and energy into disciplining them, either positively or negatively.

A further limitation is that the definition of child labour used for statistical purposes does not include begging because this activity does not imply an exchange of goods or services. Since children with disabilities may be forced to beg,[12] the prevalence of child labour among such children may be underestimated in certain contexts.

In half of countries, children with disabilities are significantly less likely to have their births registered than children without disabilities

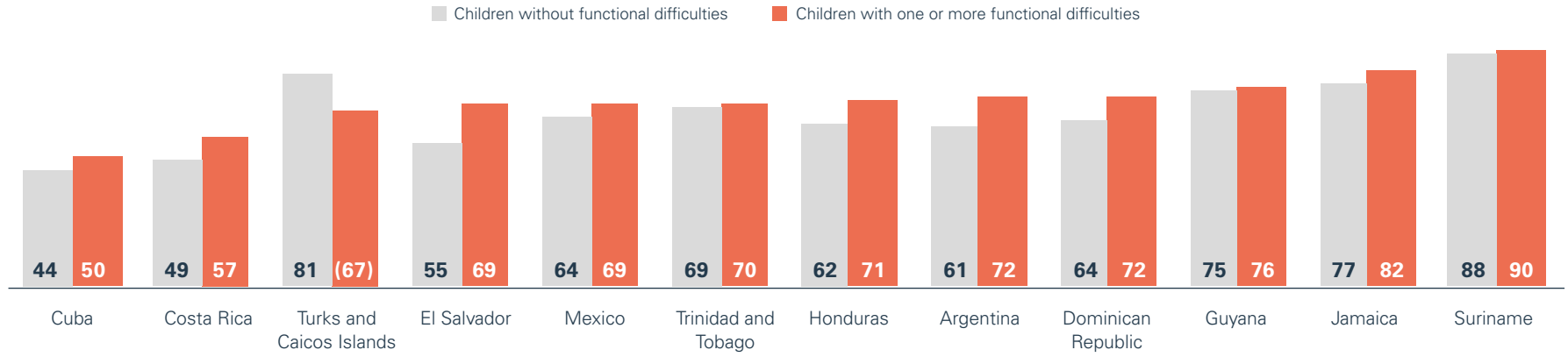
FIGURE 22 Percentage of children aged 24 to 59 months whose births are registered with a civil authority



Notes: Differences for Cuba, Guyana, Honduras, Mexico and Trinidad and Tobago are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Values for the Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for Costa Rica were not available.

In almost half of countries, children with disabilities are more likely to experience violent discipline than children without disabilities

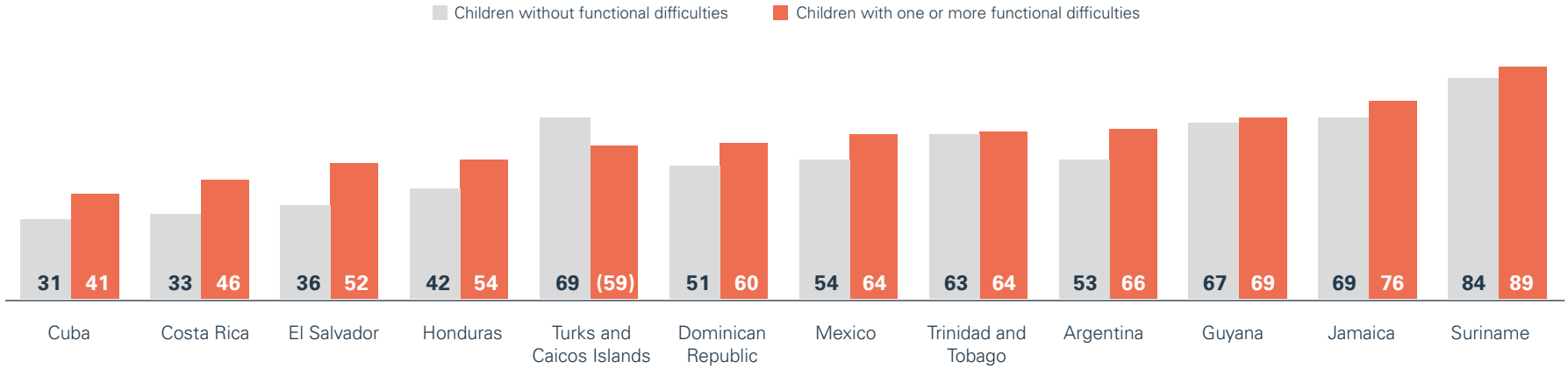
FIGURE 23 Percentage of children aged 2 to 14 years who experienced any violent discipline by caregivers in the past month



Notes: Differences for Cuba, Guyana, Jamaica, Mexico, Suriname, Trinidad and Tobago, and Turks and Caicos Islands are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations.

In most countries, children with disabilities are significantly more likely to experience psychological aggression from caregivers than children without disabilities

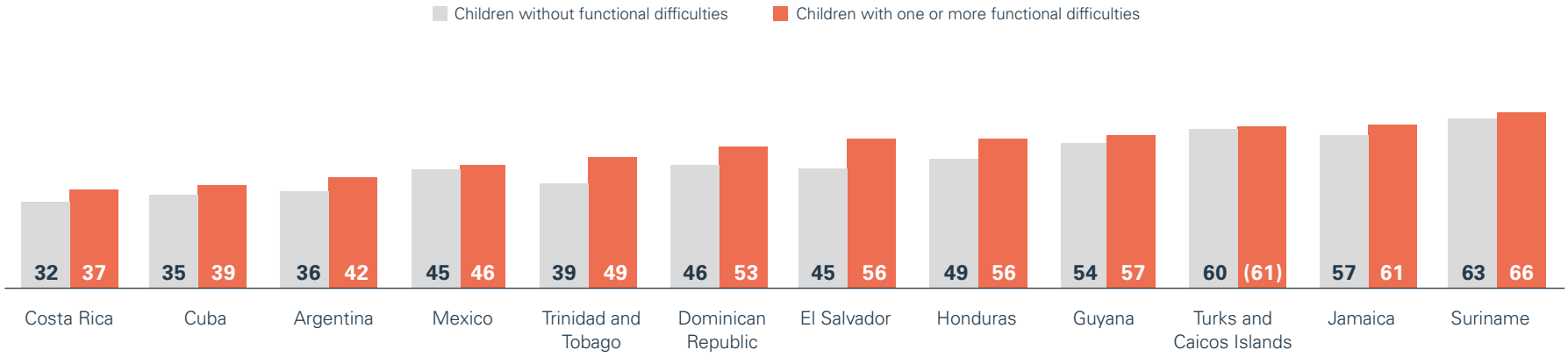
FIGURE 24 Percentage of children aged 2 to 14 years who experienced any psychological aggression by caregivers in the past month



Notes: Differences for Guyana, Jamaica, Suriname, Trinidad and Tobago, and Turks and Caicos Islands are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations.

In one third of countries, children with disabilities are more likely to experience physical punishment than children without disabilities

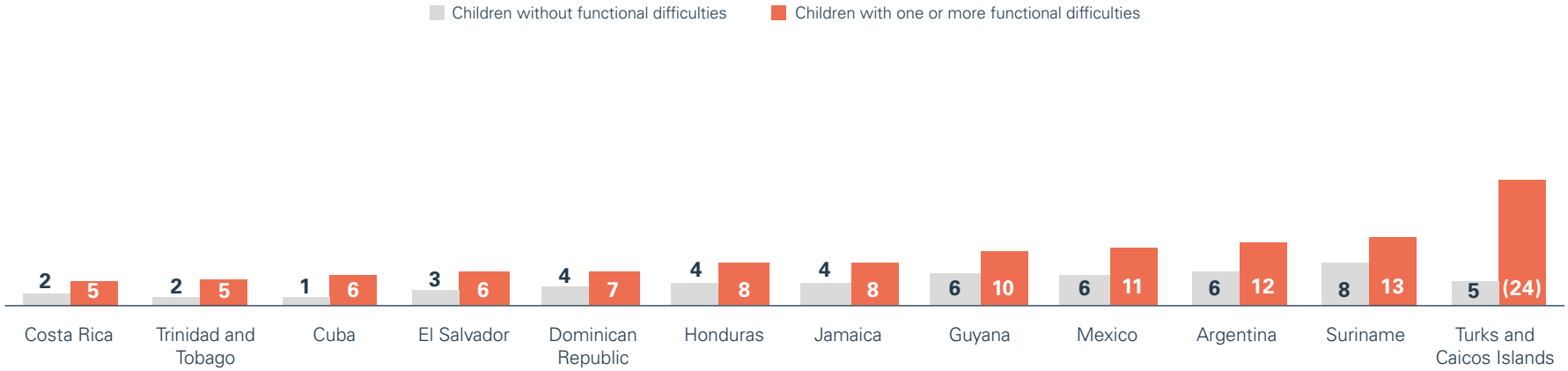
FIGURE 25 Percentage of children aged 2 to 14 years who experienced any physical punishment by caregivers in the past month



Notes: Differences for Argentina, Costa Rica, Cuba, Guyana, Jamaica, Mexico, Suriname and Turks and Caicos Islands are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations.

In most countries, children with disabilities are more likely to experience severe physical punishment than children without disabilities

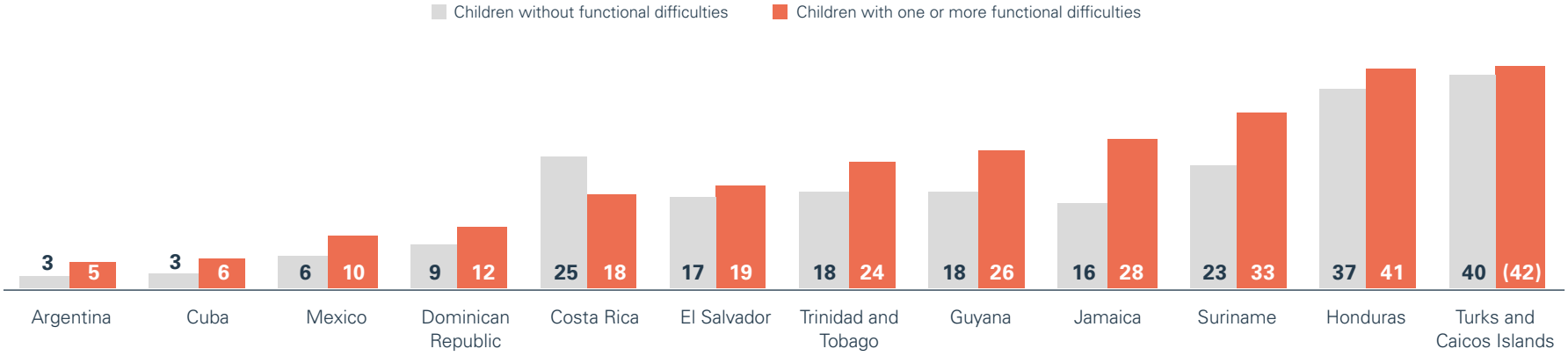
FIGURE 26 Percentage of children aged 2 to 14 years who experienced severe physical punishment by caregivers in the past month



Notes: Differences for Jamaica and Turks and Caicos Islands are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations.

In half of countries, mothers of children with disabilities are significantly more likely to believe that physical punishment is needed to raise a child properly

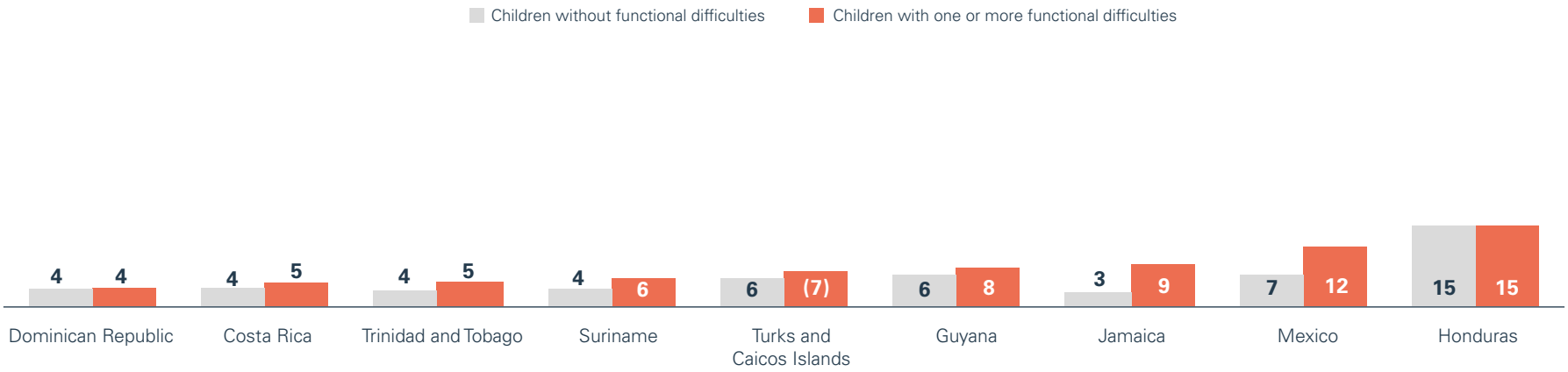
FIGURE 27 Percentage of mothers of children aged 2 to 14 years who believe physical punishment is needed to bring up, raise or educate a child properly



Notes: Differences for Costa Rica, Cuba, El Salvador, Mexico, Trinidad and Tobago, and Turks and Caicos Islands are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations.

In only two countries are children with disabilities significantly more likely to engage in child labour than children without disabilities

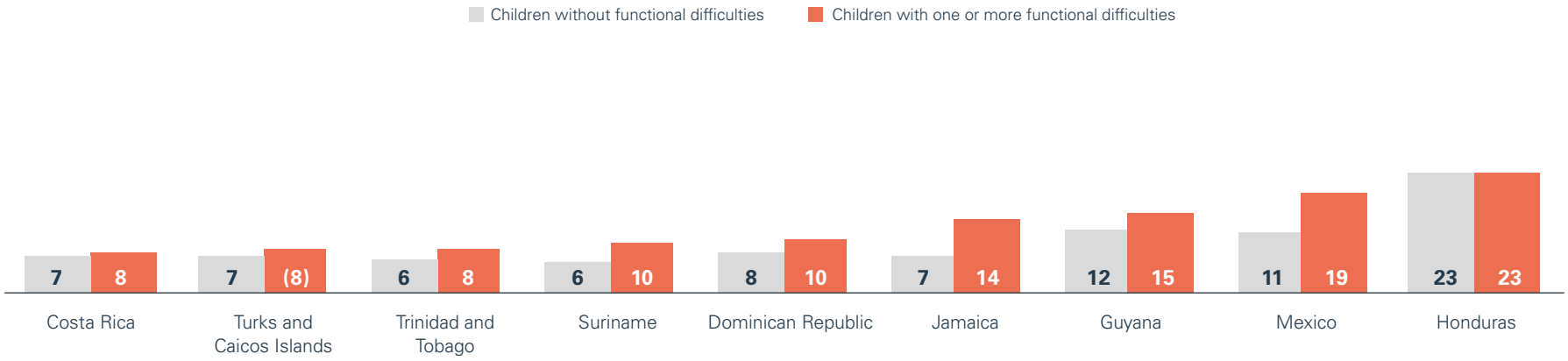
FIGURE 28 Percentage of children aged 5 to 17 years who are engaged in child labour



Notes: Differences for Costa Rica, Dominican Republic, Guyana, Honduras, Suriname, Trinidad and Tobago, and Turks and Caicos Islands are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Data for Argentina, Cuba and El Salvador were not available.

In one third of countries with available data, children with disabilities are more likely to engage in hazardous work than children without disabilities

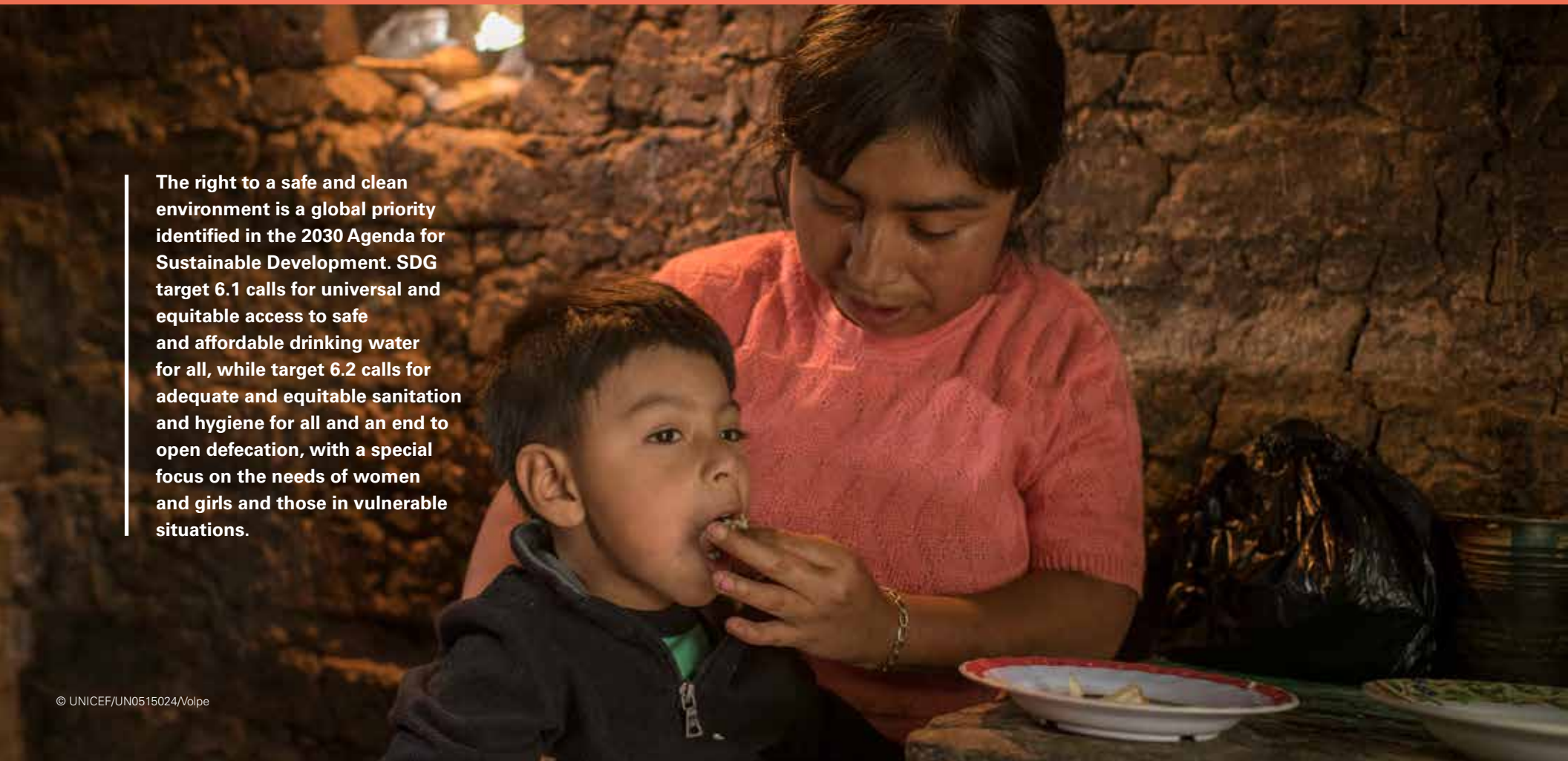
FIGURE 29 Percentage of children aged 5 to 17 years who work under hazardous conditions



Notes: Differences for Costa Rica, Dominican Republic, Guyana, Honduras, Trinidad and Tobago, and Turks and Caicos Islands are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Data for Argentina, Cuba and El Salvador were not available.

Every child has the right to a safe and clean environment

The right to a safe and clean environment is a global priority identified in the 2030 Agenda for Sustainable Development. SDG target 6.1 calls for universal and equitable access to safe and affordable drinking water for all, while target 6.2 calls for adequate and equitable sanitation and hygiene for all and an end to open defecation, with a special focus on the needs of women and girls and those in vulnerable situations.



Indicators and data sources used in this chapter

The country data presented in this chapter are drawn from MICS conducted in Argentina, Costa Rica, Cuba, Dominican Republic, Guyana, Honduras, Jamaica, Mexico, Suriname, Trinidad and Tobago, and Turks and Caicos Islands between 2015 and 2022, as well as the national health survey in El Salvador from 2021.

Basic drinking water service on premises: Percentage of children aged 2 to 17 years living in a household that uses an improved source of drinking water located in their own dwelling or their own plot/yard.

Basic sanitation service on premises: Percentage of children aged 2 to 17 years living in a household with improved sanitation facilities not shared with other households and located in their own dwelling or in their own yard/plot.

Basic hygiene service: Percentage of children aged 2 to 17 years living in a household with a place for handwashing, where water and soap or detergent are present.

Definitions and data interpretation issues

Indicators used in this chapter are based on definitions established by the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene, known as the JMP.[13] In assessing and measuring water, sanitation and hygiene services, it is important to consider not only the types of facilities available to households but also whether they are easily accessible and/or shared with other households. The distinction between availability and access is particularly significant for children with disabilities since they often face unique and disproportionate barriers to access even when services are available.[14]

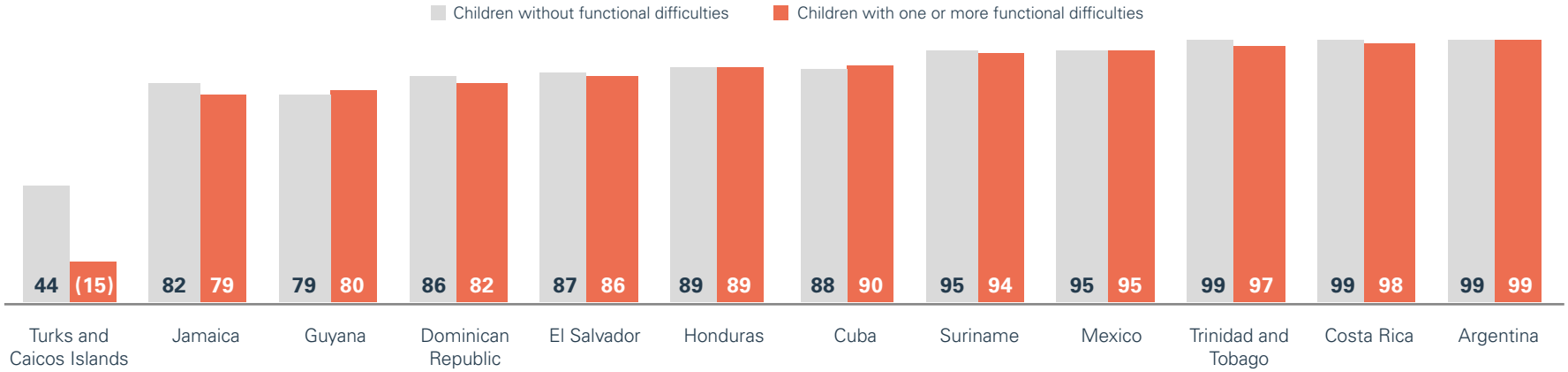
The JMP defines improved drinking water sources as those that have the potential to deliver safe water due to the nature of their design and construction. They include piped water, boreholes or tube wells, protected dug wells, protected springs, rainwater and packaged or delivered water. 'Basic drinking water service' is defined as an improved drinking water source that involves a round-trip collection time of no more than 30 minutes, including queuing. If water is accessible on premises, however, this represents a higher level of service. A 'safely managed drinking water service' is defined as drinking water from an improved source that is located on premises, available when needed and free from faecal and certain chemical contaminants.[15]

According to the JMP, improved sanitation facilities include flush or pour-flush toilets connected to piped sewer system, septic tank pit latrines, pit latrines with slabs (including ventilated-improved pit latrines), and composting toilets. To meet the criteria for a 'basic sanitation service', households must use an improved sanitation facility that is not shared with other households. A 'safely managed sanitation service' is defined as an improved facility that is not shared with other households and where excreta are safely disposed of on-site or transported or treated off-site.[16]

Handwashing facilities can take many forms and may be fixed or mobile. They include a sink with tap water, buckets with taps, tippy taps and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent and soapy water, but it does not include ash, soil, sand or other traditional handwashing agents. If a household has a handwashing facility on premises with soap and water available, then it meets the criteria for a 'basic hygiene service'.[17]

In only two countries are children with disabilities significantly less likely to have basic drinking water service on premises than children without disabilities

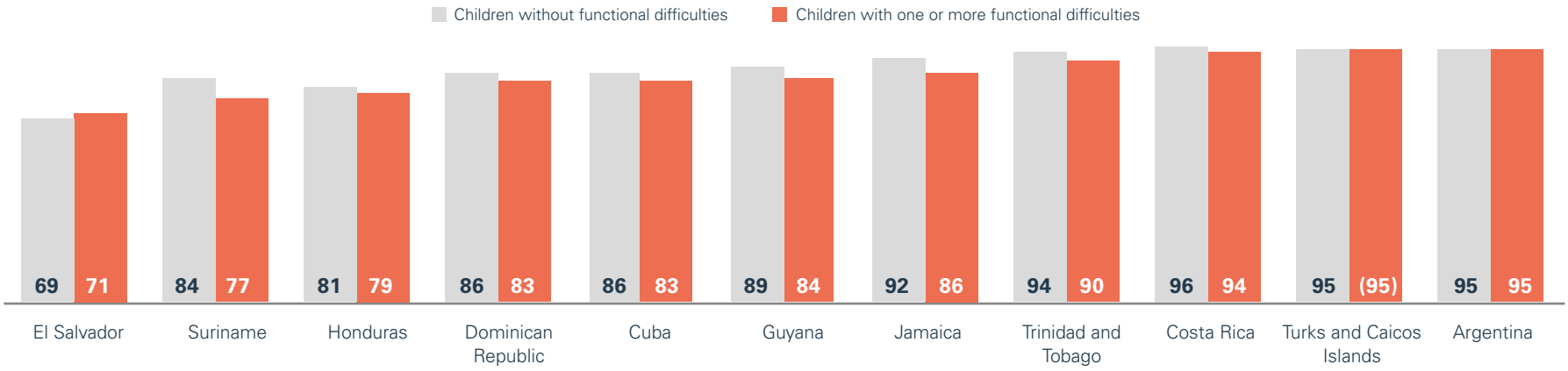
FIGURE 30 Percentage of children aged 2 to 17 years who live in a household that uses an improved source of drinking water on premises



Notes: Differences for Argentina, Costa Rica, Cuba, El Salvador, Guyana, Honduras, Jamaica, Mexico, Suriname and Trinidad and Tobago are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations.

In only two countries are children with disabilities significantly less likely to have basic sanitation services on premises than children without disabilities

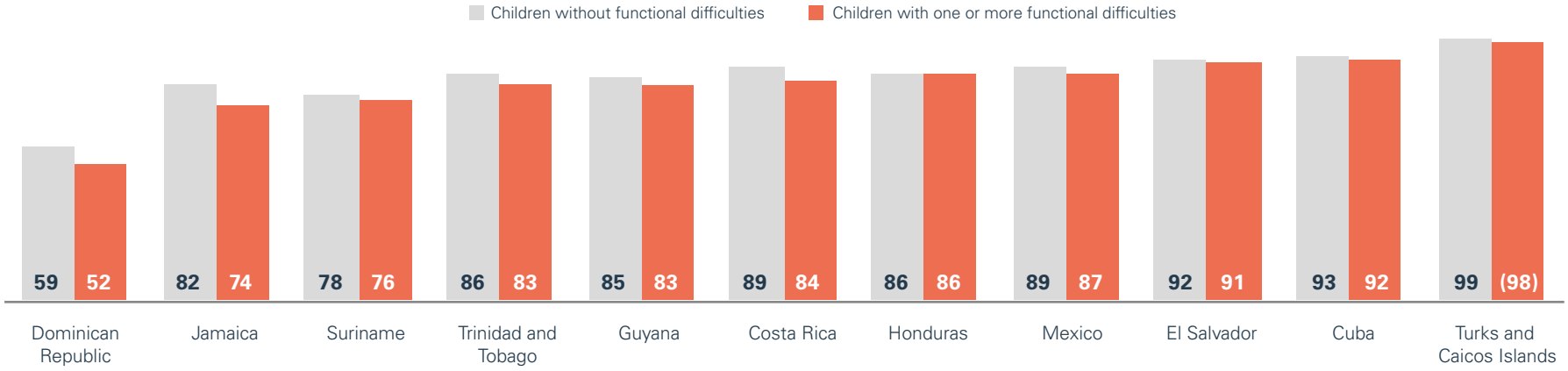
FIGURE 31 Percentage of children aged 2 to 17 years living in a household with improved sanitation facilities not shared with other households and located on premises



Notes: Differences for Argentina, Costa Rica, Cuba, Dominican Republic, El Salvador, Guyana, Honduras, Trinidad and Tobago, and Turks and Caicos Islands are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Data for Mexico were not available.

In one fourth of countries, children with disabilities are significantly less likely to have access to basic handwashing facilities on premises

FIGURE 32 Percentage of children aged 2 to 17 years living in a household with a place for handwashing, where water and soap or detergent are present



Notes: Differences for Cuba, El Salvador, Guyana, Honduras, Mexico, Suriname, Trinidad and Tobago, and Turks and Caicos Islands are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Data for Argentina were not available.

Every child has the right to a fair chance in life

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Goal 1 of the SDGs calls for an end to poverty everywhere, in all its forms, and acknowledges the need for a holistic view of poverty that extends beyond income levels. The SDGs also recognize the importance of mechanisms such as health insurance and social protection to achieve this goal, and target 1.3 calls for the implementation of nationally appropriate social protection systems and measures for all. Goal 10 acknowledges the need to ensure equal opportunity and reduce inequalities in achieving positive outcomes, including through the elimination of discriminatory laws, policies and practices and the promotion of appropriate legislation, policies and action.

Indicators and data sources used in this chapter

The country data presented in this chapter are drawn from MICS conducted in Argentina, Costa Rica, Cuba, Dominican Republic, Guyana, Honduras, Jamaica, Mexico, Suriname, Trinidad and Tobago, and Turks and Caicos Islands between 2015 and 2022, as well as the national health survey in El Salvador from 2021.

Multidimensional child poverty: Percentage of children aged 2 to 17 years who experience multidimensional poverty.

The multidimensional poverty indicator follows a two-step calculation. The first step identifies whether a child is deprived of any of the rights that contribute to poverty, namely access to housing, water and sanitation, health, nutrition and education. This information is gathered through surveys producing comparable data. If a child experiences deprivation in one or more of these areas, then she or he is identified as living in poverty (the second step), according to standards developed by UNICEF.

The indicators are assigned three thresholds: no deprivation, moderate deprivation and severe deprivation. For example, to assess nutrition in children under 5 years of age, stunting is measured in accordance with an international reference population. Deprivation is considered moderate when a child's height-for-age is two standard deviations below the WHO Child Growth Standards; it is considered severe when it falls below three standard deviations. Indicators also vary by the age of the child, since what is needed to fulfil the rights of an adolescent is different from what is needed for a young child. For example, moderate deprivation in education in children aged 6 to 14 years is defined as not currently attending school; severe deprivation is defined as never having been in school. Among children aged 15 to 17 years, moderate deprivation is defined as those who are not currently attending secondary school, and severe deprivation is defined as those who have not completed primary school.

Social transfers: Percentage of children aged 2 to 17 years living in a household that received any type of social transfers and benefits in the last three months.

Discrimination: Percentage of adolescents aged 15 to 17 years who report having personally felt discriminated against or harassed within the previous 12 months on the basis of disability or on one of the other grounds for discrimination prohibited under international human rights law.

Happiness: Percentage of adolescents aged 15 to 17 years who are very or somewhat happy.

Definitions and data interpretation

As with other indicators in this report, certain issues need to be taken into account in the interpretation of results.

The multidimensional poverty indicator aggregates information from a variety of indicators in different areas of a child's life related to the core domains of housing, water and sanitation, health, nutrition and education. As discussed in previous chapters, some of these indicators present limitations since they do not consider the barriers that are specific to children with disabilities. For example, while WASH indicators convey information about the availability of services, they do not reveal whether children with disabilities are able to use such services. Similarly, nutrition status indicators are not calculated for a significant proportion of children with disabilities due to limitations in anthropometric measurement of children with certain impairments. Other limitations of the various indicators are expanded upon in their respective chapters. Therefore, the ability of the multidimensional poverty indicator to accurately capture the deprivations affecting children with disabilities is affected by the limitations of each of the indicators it comprises. As a result, the number of children experiencing multidimensional poverty is likely to be underestimated. For children with disabilities to realize the same rights as other children, they often require different material resources. In so far as these differences are not measured, underreporting occurs. Moreover, if the various indicators allowed for a more accurate measurement of inclusion, the reported disparities between children with and without disabilities would likely be much greater.

A further consideration in data interpretation concerns social transfers (in cash or in kind) as an indicator of social protection coverage. While social protection encompasses a host of interventions beyond social transfers, there is a dearth of internationally comparable data about many, if not most, non-cash interventions. Moreover, the MICS Social Transfers Module is designed to be customized at the country level and, therefore, the resulting data are not always comparable.

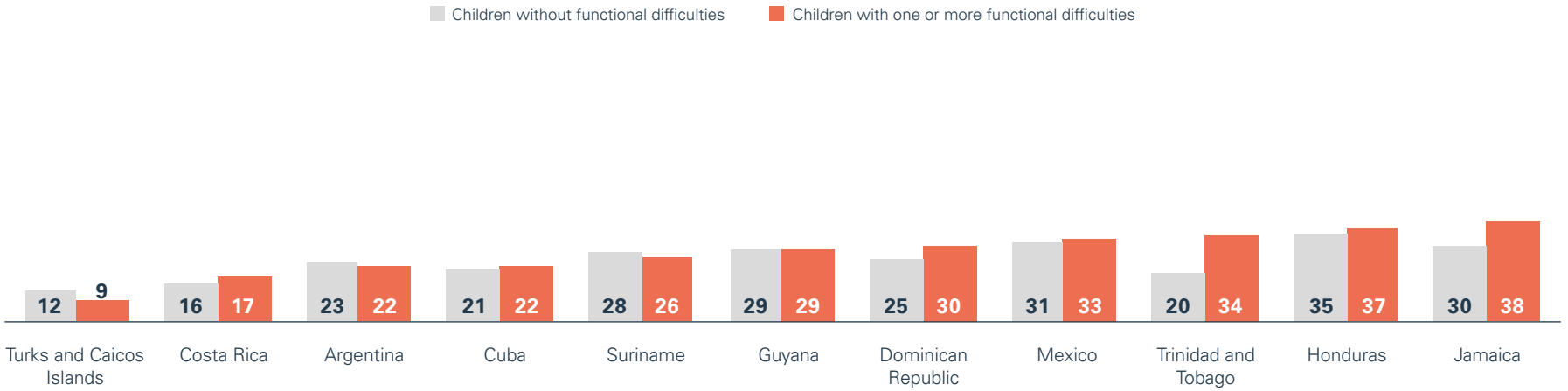
One limitation regarding the results on discrimination is the high proportion of missing information among children with difficulties in certain domains. Since these data are collected through a questionnaire that is directly administered to children aged 15 to 17 years, those with certain difficulties could not be interviewed due to accommodation constraints during the survey implementation.

Another limitation regarding discrimination is the challenge inherent in a perception-based question. While results for discrimination can measure whether adolescents perceive that they have been discriminated against, either because of their disability or for another reason, these results cannot definitively show whether discrimination actually occurred. For this reason, results involving discrimination should be understood as being based on perception.

To assist respondents in answering questions on happiness, they were shown a card with smiling faces (and not-so-smiling faces) that correspond to the response categories 'very happy', 'somewhat happy', 'neither happy nor unhappy', 'somewhat unhappy' and 'very unhappy'. They were then shown a picture of a ladder with steps numbered from 0 at the bottom to 10 at the top. They were subsequently asked to indicate at which step of the ladder they feel they are standing at the time of the survey, which is intended to indicate their level of life satisfaction. The resulting score has values ranging from 0 (lowest level of satisfaction) to 10 (highest level of satisfaction).

In only two countries are children with disabilities more likely to experience moderate multidimensional poverty than children without disabilities

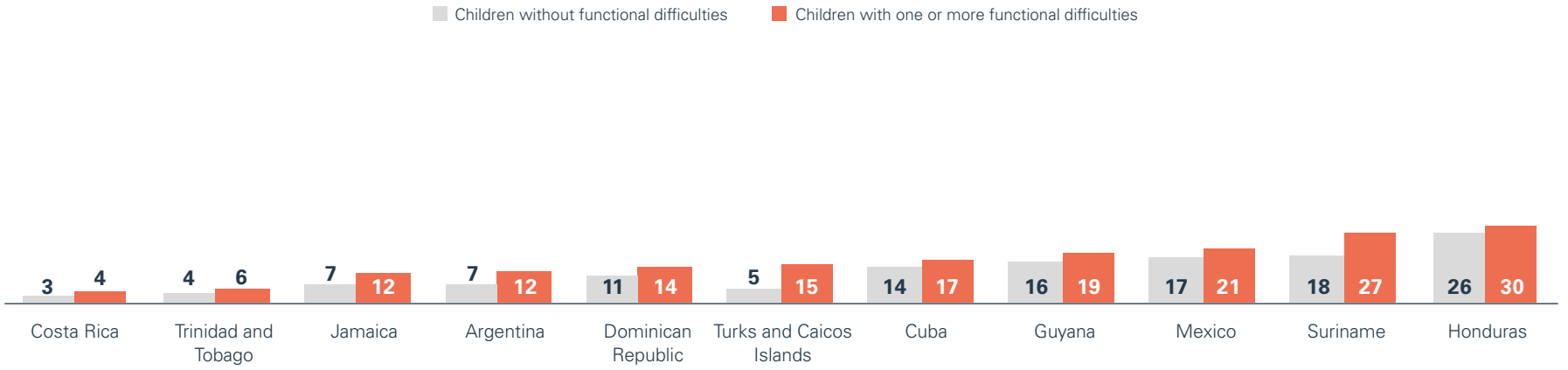
FIGURE 33 Percentage of children aged 2 to 17 years who experience moderate multidimensional poverty



Notes: Differences for Argentina, Costa Rica, Cuba, Guyana, Honduras, Jamaica, Mexico, Suriname and Trinidad and Tobago are not statistically significant. Estimates for Argentina do not include data on vaccination. Estimates for Trinidad and Tobago do not include anthropometry data. Estimates for Jamaica do not include anthropometry data and data on unmet contraceptive need. These exceptions may result in an underestimation of multidimensional poverty. Estimates are not available for El Salvador as the national health survey does not follow the standard MICS format.

In 10 out of 11 countries with available data, children with disabilities are just as likely to experience severe multidimensional poverty as children without disabilities

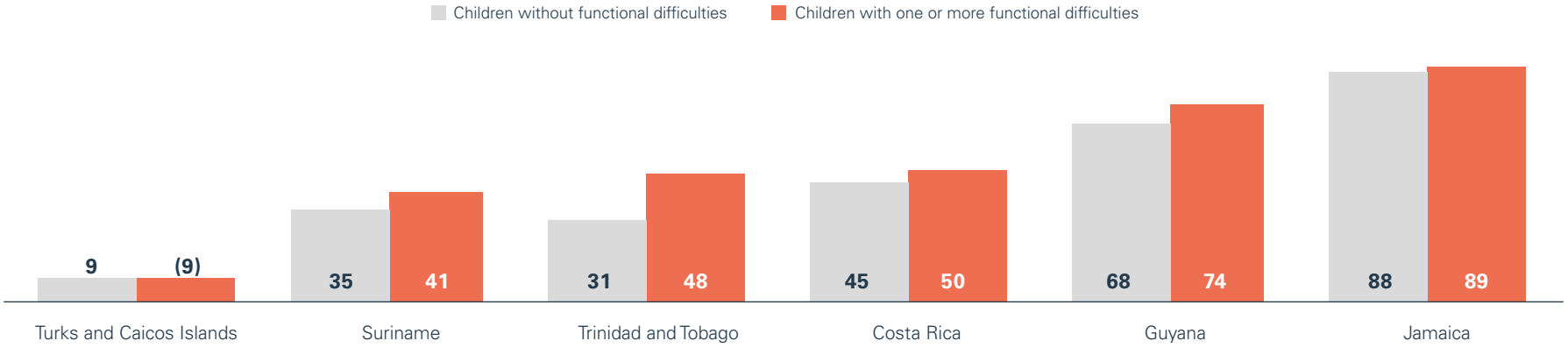
FIGURE 34 Percentage of children aged 2 to 17 years who experience severe multidimensional poverty



Notes: Differences for Argentina, Costa Rica, Cuba, Dominican Republic, Guyana, Honduras, Jamaica, Mexico, Trinidad and Tobago, and Turks and Caicos Islands are not statistically significant. Estimates for Argentina do not include data on vaccination. Estimates for Trinidad and Tobago do not include anthropometry data. Estimates for Jamaica do not include anthropometry data and data on unmet contraceptive need. These exceptions may result in an underestimation of multidimensional poverty. Estimates are not available for El Salvador as the national health survey does not follow the standard MICS format.

In one third of countries with available data, children with disabilities are more likely to live in households that receive social transfers and benefits than children without disabilities

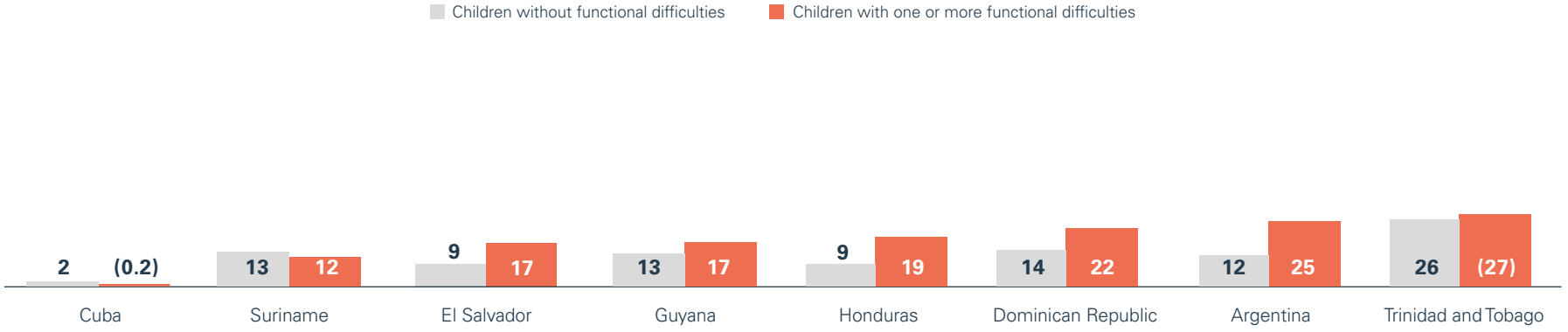
FIGURE 35 Percentage of children aged 2 to 17 years living in a household that received any type of social transfers and benefits in the last three months



Notes: Differences for Costa Rica, Guyana, Jamaica and Turks and Caicos Islands are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Data for Argentina, Cuba, Dominican Republic, El Salvador, Honduras and Mexico were not available.

The proportion of adolescents with disabilities who feel discriminated against varies across countries

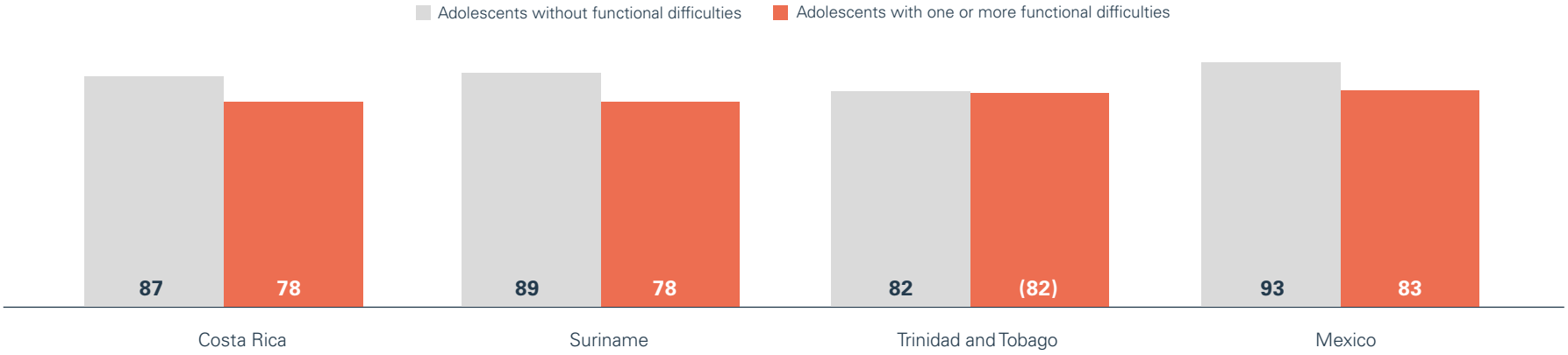
FIGURE 36 Percentage of adolescents aged 15 to 17 years who report having personally felt discriminated against or harassed within the previous 12 months on the basis of disability or on one of the other grounds for discrimination prohibited under international human rights law



Notes: Differences for Argentina, Dominican Republic, Guyana, Suriname and Trinidad and Tobago are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Values for Jamaica and Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for Costa Rica and Mexico were not available.

In almost half of the countries with available data, adolescents with disabilities are less likely to describe themselves as very or somewhat happy than adolescents without disabilities

FIGURE 37 Percentage of adolescents aged 15 to 17 years who are very or somewhat happy



Notes: Differences for Costa Rica, Suriname and Trinidad and Tobago are not statistically significant. Numbers in parentheses are based on 25 to 49 unweighted observations. Values for Jamaica and Turks and Caicos Islands were suppressed as they were based on fewer than 25 observations. Data for Argentina, Cuba, Dominican Republic, El Salvador, Guyana and Honduras were not available.

Fulfilling the rights of every child in Latin America and the Caribbean

Including children with disabilities in all aspects of life must be a priority – in Latin America and the Caribbean as in the rest of the world. Every child, everywhere, has something to offer. His or her energy, talents and ideas can make a positive difference to families, communities and the world.

Over 19 million children in Latin America and the Caribbean have some form of disability.

Comparable data from 12 countries in the region provide insights into the characteristics and well-being of these children. The proportion of children with disabilities ranges from 6 per cent in Turks and Caicos Islands to 18 per cent in Costa Rica. However, most children with disabilities have difficulties in only one domain of functioning. Psychosocial difficulties, particularly signs of anxiety, affect the largest proportion of children.

Notable differences are found in the way children with and without disabilities are parented. In the Dominican Republic and Honduras, children with disabilities are more likely than children without disabilities to experience physical punishment. In these countries, children with disabilities are also more likely to have mothers who believe that physical punishment is necessary to properly raise a child. In Guyana, Jamaica and Trinidad and Tobago, children with disabilities are more likely to be out of school than children without disabilities and are less likely to demonstrate foundational reading and numeracy skills. Taken altogether, these data illustrate the deprivations experienced across Latin America and the Caribbean by children with disabilities. They also suggest that their lived experiences vary significantly. Findings can provide a starting point from which policies can be crafted to address inequities and ensure equal opportunities for all children.

From knowledge to action

All children with disabilities deserve the opportunity to thrive. For this to become a reality, governments must consider the full range of needs of these children and their families in providing programmes and services. They need to work together with persons or associations of persons with disabilities to ensure that:

- All social services and environments are inclusive and accessible, so that community-based care and assistance, critical information and opportunities to play and engage are available to every child, in times of stability as well as in humanitarian emergencies.
- Education is inclusive and accessible, so that children with disabilities can go to school in their communities and learn alongside their peers without disabilities.
- Children with disabilities are protected against violence, abuse, neglect and exploitation, are able to benefit from birth registration and family support, and can seek child-friendly, disability-inclusive support and justice when their rights are violated.
- Children with disabilities access psychosocial support, so that they are able to maintain their well-being and receive care for mental health issues such as anxiety and depression.
- Stigma and discrimination against children with disabilities and their families are eradicated, and the voices of children with disabilities are heard.
- Children with disabilities and their families are covered by adequate social protection that supports their individual needs, links them with critical services, and helps break the cycle of poverty, deprivation and exclusion.
- Parents and caregivers of children with disabilities receive support to raise their children in the best way possible while maintaining their own mental health and well-being.
- Robust, relevant and inclusive data are generated at regular intervals.

For every child, inclusion

The extent to which children with disabilities are deprived, feel discriminated against and lack hope for the future makes it clear that societies are not doing enough to realize the most basic human rights of all children. As a result, the vicious cycle of exclusion and disadvantage that leaves children with disabilities behind continues. Knowing that the problem comes down to barriers that society creates – which are a matter of choice, not immutable realities – means that there is potential for change. Part of that change will involve celebrating children with disabilities and embracing diversity in all its forms.

It starts right here, right now. When children with disabilities are seen and counted, they are no longer invisible, and the promise of inclusion becomes a real possibility.

The steps in between depend upon every stakeholder. They involve shared responsibility, accountability and working together to ensure that all children, including children with disabilities, are able to achieve their inherent potential.

Technical annex

The technical work behind this report aimed to produce estimates of the number of children with disabilities aligned with the Convention on the Rights of Persons with Disabilities and a biopsychosocial concept of disability. The regional and global estimates presented here rely mainly on information about functional difficulties or limitations among children gathered through sources with some degree of international comparability. While most of the data sources included in the estimates refer to data collected from 2017 onwards, the data points used for some countries are not the most recent ones but those most aligned with the concept of disability underlying the global estimate.

Until this report, no estimation of the global number of children with disabilities had been made that took into account a broad range of functional difficulties along with behavioural and mental health issues.

The only estimate available for many years indicated that 10 per cent of the world's population had some form of disability.[18] In 2011, this was updated to 15 per cent, and an estimate was produced on the number of children aged 14 or younger with a moderate or severe disability: 93 million children, or 5 per cent of children in that age group.[19] Such global estimates are affected by well-known limitations surrounding disability measurement.

The concept of disability described in the WHO's *The Global Burden of Disease: 2004 Update* (upon which the 2011 estimate for children is based) refers to the perceived short- or long-term loss of health associated with a condition and is not entirely aligned with the ICF definition of disability. This metric of disability has been criticized for its lack of consideration of core participatory and rights-based principles and for being discriminatory on the value of persons with disabilities.[20]

Another limitation to this approach is that the weights attributed to each impairment do not account for the differential impact that an impairment may have on various individuals as a result of environmental conditions.[21] Since the weights used by *The Global Burden of Disease: 2004 Update* do not vary across geographic regions, they disregard the multiple contextual factors that can worsen functionality in persons with the same impairments.[22]

The use of medical concepts of disability also has implications for the quality of data. Reporting of these impairments usually depends on parents' awareness of symptoms and a pre-existing diagnosis. Therefore, under-identification remains a problem since diagnosis depends on the availability of health-care facilities where children can be screened.

More recent estimates have introduced improvements, such as increasing the internal consistency of different sources of data by using a meta-analytic approach and adjusting estimates for comorbidity.[23] That said, these latest estimates are still largely focused on the burden of different impairments and medical conditions, rather than on the functional difficulties or restrictions to participation experienced by children with disabilities.

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How data were selected

UNICEF maintains a global database of disability data sources from 194 countries and areas. The database includes more than 1,000 data points together with information on methodological aspects that can impact the number of children who are identified as having a disability. The selection of data sources involved an extensive process of data compilation and consultations with country-level experts to overcome limitations on data availability and comparability, and to ensure their views were reflected in the data selection, harmonization and estimation process.

After screening the disability global database, sources of data collected prior to 2005, as well as those not derived from censuses or household surveys, were excluded. An additional selection criterion focused on identifying data aligned as closely as possible with the concept of disability described earlier. This meant selecting sources of data gathered through measurement tools that collect information on functional difficulties rather than specific impairments or health conditions. Another selection criterion was the use of a rating scale to capture the severity of functional difficulties, rather than the use of 'yes' or 'no' questions.

On the basis of these considerations, and in consultation with experts, 103 data sources were selected, including 37 sources for countries in Latin America and the Caribbean. Collectively, these data sources represent 74 per cent of the world's population of children and at least 50 per cent of the population of children within each region (Table 2).

Technical consultations

Heterogeneity across data sources is a common concern when generating global estimates. While this can be dealt with using a strictly statistical approach, incorporating country-level expertise into the data selection and harmonization process was considered important.

TABLE 2 Countries and areas, population coverage and data collection instruments

	Countries and areas		Percentage of child population	Type of instrument			
	Total number	Number included in the analysis		Child Functioning Module	Washington Group Short Set	Global Activity Limitation Indicator	Other
East Asia and the Pacific	33	16	80	10	5	0	1
Eastern and Southern Africa	25	13	74	5	7	0	1
Europe and Central Asia	55	31	59	9	1	20	1
Latin America and the Caribbean	37	14	74	10	3	0	1
Middle East and North Africa	19	10	73	5	5	0	0
North America	2	2	100	2	0	0	0
South Asia	8	5	96	3	1	0	1
West and Central Africa	24	12	74	9	3	0	0
Total	**203**	**103**	**84**	**53**	**25**	**20**	**5**

The estimation work was part of an iterative process that included three technical consultations with experts in the field of data on children with disabilities. They included professionals from national statistical offices, organizations of persons with disabilities and academia.

Following a standard protocol, the consultation sought to obtain the experts' views on the prevalence of children with functional difficulties in their countries. The initial part of the consultation was dedicated to building a common understanding of disability aligned with the ICF and the Convention on the Rights of Persons with Disabilities. This was followed by in-depth discussion of the available country-level information and the results of the data harmonization analyses and estimation work. For each consultation, UNICEF shared details on the process and methodology used for estimations as well as on the selected data sources for each region and country. Experts' inputs in relation to the data harmonization approach were incorporated and reflected in the regional and global estimates.

Data harmonization

Harmonization of age groups: Results by age group were harmonized to match the Child Functioning Module's age groups (children aged 2 to 4 years and 5 to 17 years). For some data sources, prevalence for the harmonized age groups was calculated directly from empirical results available at the country level. For the remaining sources, the harmonized results by age group were obtained using weighted averages of the data points available.

Adjustment of the Washington Group Short Set: Instruments that collect data based on a restricted number of functional domains tend to underestimate the proportion of children with disabilities. Results from several countries and areas that used both the Child Functioning Module and the Washington Group Short Set show that the number of children aged 5 to 17 years who are identified as having functional difficulties by the six domains covered by the Short Set is substantially lower than the number identified by the 13 domains included in the Child Functioning Module. While this underestimation is mostly due to the larger number of domains in the Child Functioning Module, other sources of underestimation should be considered, given that the two instruments are typically implemented under different conditions. For example, while the Child Functioning Module is intended to be administered to the child's mother (or if the mother is deceased or living in another household, to the child's primary caregiver), the Short Set is typically administered to the household head. Table 3 shows the differences in the estimates generated by the two instruments in seven countries and areas.

To correct for the underestimation of the percentage of children with disabilities, the data points based on the Short Set were adjusted. The process was as follows. First, microdata from 36 countries that used the Child Functioning Module were processed to generate country-level results of the percentage of children aged 5 to 17 years identified as having one or more functional difficulties based on: a) the full set of 12 functional domains, and b) the subset of 6 functional domains that are common to the two measures. Second, linear regression models were used to predict country-level results for the 12 functional domains based on the country-level results of the 6 functional domains and the country's under-five mortality rate.

TABLE 3 Percentage of children aged 5 to 17 years with functional difficulties measured by the six domains covered by the Short Set, by the same six domains in the Child Functioning Module and by the 12 domains in the Child Functioning Module

	Washington Group Short Set (6 domains)	Child Functioning Module (6 domains only)	Child Functioning Module (12 domains)
Costa Rica	4.0	7.1	21.1
Guyana	2.2	5.6	17.5
Mexico	1.5	4.1	11.2
Pakistan	2.5	5.0	17.9
State of Palestine	1.5	3.0	14.9
Tonga	1.4	2.7	9.8
Zimbabwe	4.7	4.9	10.1

Imputation of the estimate for children under 2 years of age

Data on disability among children under the age of 2 are scarce. To date, no questions on functional difficulties have been validated that could be implemented to collect data about very young children in surveys and generate results that are reliable and comparable cross-nationally. While most severe impairments manifest early, sometimes even before children are born, many functional difficulties only become evident as children grow up. Measuring functional difficulties in children under the age of 2, in the context of surveys or censuses, is thus complicated since mothers or primary caregivers might not be aware of such difficulties, especially if they are not severe. Yet, excluding children under this age would lead to a systematic underestimation of the number of children with disabilities. Estimates of major and severe impairments at birth among surviving children, and neurodevelopmental and cognitive impairments among babies born pre-term and full-term, range between 2.4 per cent and 2.8 per cent.[24] Even though these estimates are restricted to more severe impairments and conditions, they provide evidence that functional difficulties are to be expected from birth at a prevalence of at least that magnitude. Finally, since some functional difficulties only become evident to mothers as children grow older, it is also reasonable to expect that, within the first two years of age, a higher proportion of children with functional difficulties would be reported. Therefore, based on these considerations, it seemed reasonable to assume that the estimate for children under the age of 2 could be informed by the estimate for children aged 2 to 4 years in each country.

Estimation of the regional and global number of children with disabilities

The estimations use a meta-analytical approximation to calculate the regional and global number of children with disabilities. Meta-analysis of proportions was implemented using the prevalence rates of children with disabilities for each country, 95 per cent confidence intervals and the child population for all age groups. Country-level prevalence rates were transformed into the number of cases using the child population. Regional estimates were generated using random effects models considering that, despite harmonization efforts, the methods used to estimate the prevalence of disability were heterogeneous. This approach also assumed that prevalence estimates from countries that could not be included in the analysis were better informed by the random effects model. Random effects meta-analysis incorporates the heterogeneity of prevalence across countries rather than relying on the prevalence of larger countries, as assumed by the fixed effects model. The only exception was the North America region, where the two countries that constitute the region (Canada and the United States) used the same instrument and a fixed effects model was used. For all other regional estimates, random effects were utilized to incorporate the within- and between-country variability. The regional estimates were then used to generate the population-weighted global estimate (Table 4).

Analysis using country-level microdata

All data were obtained from publicly available MICS datasets. MICS survey design follows a probabilistic, clustered, stratified and multi-stage sampling approach to generate population-level indicators that are representative at the national level and for urban-rural and other domains (usually regions), according to the country-specific stratification strategy.

As of September 2024, data were available across 12 countries in Latin America and the Caribbean. Results for country analyses that are based on 25 to 49 unweighted observations should be interpreted with caution. Results based on fewer than 25 unweighted observations were suppressed. Within figures, all numbers except those valued under one were rounded to the nearest whole value.

TABLE 4 Regional and global estimates

	Children aged 0 to 4 years				Children aged 5 to 17 years				Children aged 0 to 17 years			
	%	Lower bound	Upper bound	Number of children with disabilities (in thousands)	%	Lower bound	Upper bound	Number of children with disabilities (in thousands)	%	Lower bound	Upper bound	Number of children with disabilities (in thousands)
East Asia and the Pacific	3.5	3.3	3.8	5,333	9.5	7.5	11.6	37,788	7.8	6.7	9.1	43,121
Eastern and Southern Africa	5.2	4.5	6.0	4,509	12.8	11.2	14.4	24,356	10.4	9.5	11.3	28,865
Europe and Central Asia	2.7	2.4	3.1	1,515	6.5	5.6	7.4	9,299	5.5	4.9	6.0	10,814
Latin America and the Caribbean	3.8	3.3	4.5	1,978	12.6	11.5	13.7	17,102	10.2	9.6	10.8	19,080
Middle East and North Africa	4.5	3.3	6.0	2,246	16.9	13.5	20.5	18,694	13.1	11.3	15.1	20,940
North America	4.4	3.9	4.9	943	12.0	11.3	12.7	7,073	9.9	9.5	10.4	8,016
South Asia	3.7	2.9	4.7	6,254	13.0	10.2	16.1	58,177	10.5	9.0	12.2	64,431
West and Central Africa	6.8	5.8	7.9	6,139	18.9	15.3	22.7	34,944	14.9	12.8	17.2	41,083
World	**4.3**	**4.1**	**4.6**	**28,917**	**12.5**	**11.7**	**13.3**	**207,433**	**10.1**	**9.7**	**10.6**	**236,350**

Notes: For a list of countries and areas in the regions and subregions, see <data.unicef.org/regionalclassifications>. Demographic data are from: United Nations, Department of Economic and Social Affairs, Population Division, *World Population Prospects 2019*, Rev. 1, online edition.

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