


2017

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Recommended Citation

Moyi, P. (2017). School Enrolment and Attendance for Children with Disabilities in Kenya: An Examination of Household Survey Data. *FIRE: Forum for International Research in Education*, 4(2). <http://dx.doi.org/10.18275/fire201704021133>

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Abstract

While evidence confirms that children with disabilities face significant obstacles to schooling, especially in low-income countries like Kenya, there is limited empirical research on which to develop policy. The government of Kenya has long neglected the plight of people with disabilities. Despite numerous policy recommendations from the various education commissions, few, if any, have been fully implemented. Despite the rich information that may inform policy, household surveys are an overlooked source of data on children with disabilities. Therefore, using two sources of household survey data, this paper examines school enrolment and attendance patterns for children with disabilities in Kenya. The evidence suggests lower school participation for children with disabilities. This may be due to the limited availability of educational services. Despite the need for educational services, the analysis also shows that the majority of children with disabilities were not aware of any of the services offered by the government.

Keywords

Kenya; school enrolment, school attendance, disability

SCHOOL ENROLMENT AND ATTENDANCE FOR CHILDREN WITH DISABILITIES IN KENYA: AN EXAMINATION OF HOUSEHOLD SURVEY DATA

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Introduction

The prevalence of disability varies worldwide (Durkin, Gottlieb, Maenner, Cappa, & Loaiza, 2008; Mont 2007; UNICEF, 2015). Research shows a higher prevalence of children with disabilities in low-income countries compared to high income countries (Durkin et al., 2008; Mont 2007). The higher prevalence has been attributed to nutritional deficiency, limited access to quality healthcare, higher exposure to disease and environmental toxins, and injury due to harsh living conditions found in low-income countries (DFID, 2000; Durkin et al. 2008; Yeo & Moore, 2003). Children with disabilities face unequal access to social services, especially education (DFID, 2000; Hoogeveen, 2005; UNESCO, 2010). UNESCO (2010) described disability as “one of the least visible but most potent factors in educational marginalization.” (p. 181)

There are several factors that explain the educational marginalization of children with disabilities. First, many schools, especially in rural areas, are physically inaccessible to children with certain disabilities (UNESCO, 2010). The inability to walk the distance to school and/or the cost of obtaining transport for children with disabilities limit access to school. Second, the costs of assistive devices (like wheelchairs) are prohibitive and access to these devices is limited (Borg, Lindström, & Larsson, 2009; UNICEF, 2013). There are also substantial costs associated with the medical care of certain disabilities; this is likely to divert resources from education (Gona, Mung’ala-Odera, Hartley, 2011). Lastly, the stigma associated with certain physical and mental disabilities discourage parents from sending their children to school (Gona et al., 2011; Kristensen, Omagar-Loican, Onen, & Okot, 2006). Stigma is felt by both the child with the disability and the care giver(s) (Gona et al., 2011).

While we know that children with disabilities face significant obstacles to schooling, especially in low-income countries, there is limited empirical research on which to develop policy (Durkin et al., 2008; Filmer, 2008; Lamichhane, 2015). Limited research and policy attention towards children with disabilities in low-income countries

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has been an obstacle to universal education (UNESCO, 2010; World Health Organisation and World Bank, 2011). Differences in definition and measures of disability make it difficult to collect quality data (UNICEF, 2013). Without quality data, it is difficult to determine the number of children with disabilities and the kinds of disabilities they face (UNICEF, 2015). Household survey data is an important source of detailed socio-economic and demographic data. Despite their rich information, household surveys are an overlooked source of data on marginalized children (UNICEF, 2015).

Therefore, the purpose of this paper was to examine school enrolment and attendance patterns for children with disabilities in Kenya using household survey data. The paper used two household surveys. First, the 2007 Kenya National Survey for Persons with Disabilities. This survey was the first, and only survey, of people with disabilities in Kenya. The survey was designed to provide a nationally representative sample of people with disabilities. Second, the 2011 Nyanza province Multiple Indicator Cluster Survey. The Nyanza province Multiple Indicator Cluster Survey was conducted as part of the fourth global round of surveys by UNICEF. The survey was designed to provide health and education indicators at the provincial and county level, for urban and rural areas.

Concepts of Disability

In disability research, there are two major strands to the concept of disability - the medical model and the social model (Burchardt, 2004; Llewellyn & Hogan, 2000; Lamichhane, 2015). The medical model views disability as the result of physiological impairment, directly caused by the disease, trauma or other health conditions, which require medical attention. Disability, in this model, calls for medical attention or intervention, to help the individual adapt to society. Under the medical model “the human being is flexible and “alterable” while society is fixed and unalterable” (Llewellyn & Hogan, 2000, p. 158). Therefore, the medical model seeks to intervene so that the individual can function in society. Therefore, under the medical model the focus is on interventions that can help the individual participate in society.

The social model views disability as socially constructed (Burchardt, 2004; Llewellyn & Hogan, 2000; Lamichhane, 2015). Unlike the medical model, the social model distinguishes between impairment and disability. Impairment is a physiological condition; an individual attribute. Disability is the limitation of opportunities to fully participate in society due the environment being inaccessible. Within the social model, it “identifies systemic barriers, negative attitudes and exclusion by society (intentional or inadvertent) and argues that societal attitudes and environment are the main barriers for people with disabilities” (Lamichhane, 2015, p. 5). Individuals are not disabled by their impairment but by the barriers created by society. Therefore, within the social model, disability demands a political and/or policy response, since the problem is created by an unaccommodating sociopolitical environment. Lamichhane (2015) argued that there are two dimensions to the social model – change social attitudes and influence state/government policies. A change in social attitudes and government policies is required for people with impairments to fully participate in society.

The Constitution of Kenya (Republic of Kenya, 2010) defines a disability as, “any physical, sensory, mental, psychological or other impairment, condition or illness that has, or is perceived by significant sectors of the community to have, a substantial or long-term effect on an individual’s ability to carry out ordinary day-to-day activities” (p.

161). The 2007 Kenya National Survey for Persons with Disabilities Report distinguishes between disability and impairment; disability is the result of environmental barriers that prevent full participation in society (National Coordinating Agency and Development & Kenya National Bureau of Statistics, 2008). The questionnaires also focus on individual experience with and without assistive devices to determine the extent of the disability. The KNSPWD includes the following six domains in determining impairment: hearing, visual, mental, physical, self-care, multiple and other disabilities.

Education for Children with Disabilities in Kenya

The provision of education services for children with disabilities is relatively recent in Kenya. The first school for children with visual disabilities was started by the Salvation Army in 1946. In 1948, the Catholic Church and the Aga Khan Community set up the first two schools for the children with mental disabilities (UNESCO, 1974). The civil society also established the Kenya Society for Deaf Children and the Association for the Physically Disabled of Kenya in the 1950s, to provide advocacy, assistive and rehabilitation services to people with disabilities (UNESCO, 1974).

Until 1960, Kenya had an education system that was meant to serve the interests of the European settlers and not the indigenous Africans (Republic of Kenya, 1964). At independence, in 1963, the primary focus of the government of Kenya was to train indigenous Kenyans to fill the positions vacated by departing Europeans. (Republic of Kenya, 1964). Whereas the government sought to address the racial imbalances in the colonial education system, little was done to address the issues facing children with disabilities. The Education Act 1968 (revised in 1970) prohibited exclusion from school based on sex, race or colour, or on any other reasonable grounds. Although “other reasonable grounds” could have included children with disabilities, the Kenya National Commission on Human Rights argued that these children had limited legal recourse if they were excluded from school (Kenya National Commission on Human Rights, 2007).

From 1963 Government reports made policy recommendations to address the issues of people with disabilities; however, none of the recommendations were fully implemented. The reports included: The Ngala Report (1964), the Ominde Report (1964), the Gachathi Report (1976), the Kamunge Report (1988), the Koech Report (1999), and the Kochung Report (2003). For example, the 1964 Ngala Report recommended a survey be conducted to determine the number and distribution of people with disabilities. The Ngala Report argued that policies could not be developed without knowledge of the prevalence and regional distribution of children with disabilities. The government of Kenya did not conduct the survey until 2007. Another example, the 1976 Gachathi Report, the 1999 Koech Report and the 2003 Kochung Report all recommended the development of a policy framework for special needs education. The National Special Needs Education policy framework was not launched until 2010. A 2005 government report acknowledged that the issues children with disabilities faced had not been adequately addressed (Republic of Kenya, 2005a).

From 2003, the social, policy and legislative context started to change. The newly elected government fulfilled its 2003 election promise by launching the Free Primary Education (FPE) program. The government abolished school fees for all primary school children. Unlike previous free primary education initiatives, this new government initiative provided additional funds for schools that provide services to children with disabilities (Republic of Kenya, 2005b). Parliament also passed the

Persons with Disabilities Act (2003). The Act established equal rights for people with disabilities. The Act also created the National Council of Persons with Disabilities (NCPD) to oversee the welfare of people with disabilities in Kenya.

In 2007, the Kenya National Survey for Persons with Disabilities (KNSPWD) was conducted. The aim of the survey was to “determine the types and causes of the disabilities; the problems faced and coping mechanisms, and the nature of services and rehabilitation programmes available.” (National Coordinating Agency and Development & Kenya National Bureau of Statistics, 2008, p. xi). This survey was a major milestone; previous government initiatives had been hampered by the lack of accurate and current data. For example, the Kenya Institute of Special Education (KISE) was unable to effectively function because there was no accurate data on children with disabilities (Republic of Kenya, 2008).

In 2010, a new constitution was enacted. The new constitution guaranteed every child the right to free and compulsory education; it also granted the government the authority to put in place affirmative action policies to address disparities. With the new constitution, the government is legally bound to provide education to all its citizens, including those with disabilities. The constitution guarantees children with disabilities the right to free and compulsory education; it requires the government to take measures to ensure that children who were previously marginalized receive education by enacting affirmative action policies. The government is legally required to provide better access to education and also establish infrastructure for education children with disabilities. The new constitution also spelt out the rights of people with disabilities:

No. 54. “(1) A person with any disability is entitled— (a) to be treated with dignity and respect and to be addressed and referred to in a manner that is not demeaning; (b) to access educational institutions and facilities for persons with disabilities that are integrated into society to the extent compatible with the interests of the person; (c) to reasonable access to all places, public transport and information; (d) to use Sign language, Braille or other appropriate means of communication; and (e) to access materials and devices to overcome constraints arising from the person’s disability.” (Republic of Kenya, 2010, p. 37).

In 2009, the government also presented the National Special Needs Education Policy Framework. The aim of the policy framework was to “provide a comprehensive framework of the principles and strategies to be followed in order to create equal access to quality and relevant education and training for these learners.” (Republic of Kenya, 2009, p. 15). The framework was developed to implement education policies for children with special needs and ensure access to quality and relevant education for children with special needs. The framework put in place multi-agency interdisciplinary strategies with the primary responsibility falling on the Ministry of Education.

Data and Analysis

This study used data from the 2007 Kenya National Survey for Persons with Disabilities (KNSPWD) and the 2011 Nyanza province Multiple Indicator Cluster Survey (Nyanza MICS). The KNSPWD was conducted by National Coordinating Agency for Population and Development with technical and financial support from the Kenya National Bureau of Statistics; Ministry of Gender, Sports, Culture and Social Services; Ministry of Health; Ministry of Education, Science and Technology; United Disabled Persons of Kenya; Kenya Programmes of Disabled Persons; Association for the

Physically Disabled of Kenya; Africa Mental Health Foundation; and International Development Project; World Bank; UK's Department for International Development.

The KNSPWD data was collected from 14,569 households in 69 districts. Mt Elgon district was excluded due to security concerns. Questionnaires were administered between July and November 2007 to individuals with disabilities, households, and heads of institutions serving people with disabilities. Focus groups discussions were also conducted from groups comprised of people with disabilities, service providers, and teachers. This was the first time the Kenya government set out to establish the number of people with disabilities, their regional distribution, and their demographic and socio-economic characteristics. Beyond the demographics, the survey sought to determine the types of the disabilities; the challenges facing people with disabilities, and the services provided by the government and civil society groups.

The Nyanza MICS was conducted by Kenya National Bureau of Statistics (2011) in collaboration with the county governments of the regions and support from UNICEF. The Nyanza MICS data was drawn from 6828 households from the 6 counties of Nyanza region, namely: Siaya, Kisumu, Homa Bay, Migori, Kisii, and Nyamira. Questionnaires were administered between October and December 2011. The survey was drawn using the 2009 Census Enumeration Areas (EAs) as the sampling frame. The questionnaires collected information on the household, the parent or guardian, and the eligible children (6–17 years). The questions asked were used to provide current information on situation of women and children and monitor progress towards goals and targets (Kenya National Bureau of Statistics, 2011).

The study used county and national data for two main reasons. First, the KNSPWD was the first national survey of people with disabilities in Kenya; it provided the national context of educational services provided to children with disabilities. However, national estimates of education services for children with disabilities are likely to mask county differences. Second, since independence in 1963, Kenya had a highly-centralized system of government. Under the 2010 constitution, government structures were reconstituted into 47 created counties in the new devolved form of government. Given this greater role of county governments it is important to systematically examine the challenges of education access for children with disabilities at the county level. County governments need to fully understand the challenges they face to ensure that all school age children enroll and attend school. If we are to reach all out of school children and adolescents, we need to clearly understand who they are, where they are, and why they are not in school.

The models include independent variables based on previous research on the factors that determine school enrolment and attendance. The research highlighted the individual (age and gender), and household characteristics (size, structure, education of the head of household, place of residence – rural/urban and district) that influence school enrolment and attendance. Individual characteristics included age and gender of the child.

Data: 2007 KNSPWD and 2011 Nyanza MICS

Data on people with disabilities depend upon the definition and measurement of disability (Durkin et al., 2008; Mont, 2007). Mont (2007) found that instruments used to measure disability in the same country can produce different prevalence rates for people with disabilities. For example, in Kenya, the 2009 Population and Housing Census reported there were 1.3 million (3.5%) people with disabilities (Kenya National Bureau

of Statistics, 2010). The 2011 WHO World Disability Report, using 2002-2004 World Health Survey data, estimates there are about 5.8 million (15.2%) living with disabilities in Kenya.

These differences in the prevalence rates are due, in part, to the differences in the definition of disability and the measurement instruments used to identify people with disabilities (UNICEF, 2015). The stigma associated with disability also makes it difficult to generate accurate data because people with disabilities may be hidden by households (Kristensen et al., 2006; UNICEF, 2015). Therefore, as we examine the data on children with disabilities it is important to first present how the survey instruments measure disability.

The KNSPWD household questionnaire used the following questions to determine people with disabilities. *Does (NAME) have difficulty hearing even when having hearing aids? Does (NAME) have difficulty in speaking? Does (NAME) have difficulty seeing even when wearing spectacles/glasses? Does (NAME) have (intellectual, emotional or psychological disturbances, difficulty remembering things, being understood)? Does (NAME) have/had delays in walking, talking, feeding or social interactions or is hyper active, aggressive or has mannerism? Does (NAME) have difficulty in (walking, climbing stairs, using hands, sitting upright, standing)? Does (NAME) have difficulty in eating, bathing /washing self, toileting etc.? Does (NAME) have other type of disability not falling among previous categories mentioned?* The questionnaires were tailored to the Kenyan context from instruments developed by WHO and the Washington Group Consortium (National Coordinating Agency and Development & Kenya National Bureau of Statistics, 2008). The KNSPWD consisted of a household questionnaire and an individual questionnaire; the household questionnaire was used to identify people with disabilities who were eligible for the individual questionnaire.

The 2011 Nyanza province MICS household questionnaire used the following questions to determine people with disabilities. Unlike the KNSPWD which administered the questionnaire to people of all ages, MICS administered the questionnaire to parents/guardians of children 2 through 9 years. This ten question questionnaire (TQQ) was developed to screen children 2 – 9 years for disabilities (Mungala-Odera et al., 2004). *Compared with other children does or did (name) have any serious delay in sitting, standing or walking? Compared with other children does (name) have difficulty seeing, either in the daytime or at night? Does (name) appear to have difficulty hearing? When you tell (name) to do something, does he/she seem to understand what you are saying? Does (name) have difficulty in walking or moving his/her arms or does he/she have weakness and/or stiffness in the arms or legs? Does (name) sometimes have fits, become rigid or lose consciousness? Does (name) speak at all (can he/she make him or herself understood in words; can say recognizable words? Does (name) learn to do things like other children his/her age? (For 3-9 year olds): Is (name)'s speech in any way different from normal (not clear enough to be understood by people other than the immediate family? Compared with other children of the same age, does (name) appear in any way mentally backward, dull or slow?*

The TQQ was found to be a reliable and valid measure of disability in rural areas in sub-Saharan Africa (Msall & Hogan, 2007; Mungala-Odera et al., 2004). Research found TQQ useful as a screening tool for disability; however, further tests by professional are needed to ascertain the extent of disability (Msall & Hogan, 2007; Mungala-Odera et al., 2004). Gottlieb, Maenner, Cappa, and Durkin (2009) reminded us that TQQ results, “should not be interpreted as diagnostic; rather, children screening positive to the Ten Questions are considered at increased risk of disability.” (p. 1832)

Olusanya and Okolo (2006) question the continued use of TQQ given the difficulty of conducting accurate disability surveys and the inability of TQQ to detect mild disability. They argued, "...within the context of the millennium development goal of ensuring that every child completes full primary education as against mere school enrolment, any tool that focuses only on children with moderate-to-severe disabilities will disenfranchise children who are likely to be impeded educationally by mild sensory impairments" (p. 1103). Despite its limitations, the TQQ is the most commonly used screening tool for childhood disability in poor countries (Durkin et al 2008; Gottlieb et 2009). Gottlieb et al. (2009) described TQQ as an instrument "designed to be applicable in almost any cultural setting by including questions about a child's functional abilities relative to peers" (p. 1832).

Descriptive Statistics

People in low-income countries have a disproportionately higher risk of disability because many have poorer diet, higher exposure to disease and environmental toxins, limited access to quality healthcare, and greater likelihood of injury due to their living conditions (DFID, 2000; Durkin et al. 2008; Yeo and Moore 2003). The individual disability questionnaire of the KNSPWD asks respondents the causes of their disability. The KNSPWD data show that about 37% reported that their disability was caused by a health-related issue such as stroke, lack of immunization, disease, and wrong medication. Injuries – accident, burnt, pollution, and fighting/domestic violence-accounted for about 15% of the disabilities.

The KNSPWD sampled 70,605 people; 4.38% (3,095) reported some form of disability. About 4.37% of girls and 4.40% of boys reported some form of disability. In rural areas 4.38% reported a disability compared to 4.39% in urban areas. The prevalence rate reported in KNSPWD is much lower compared to the 15.5 percent reported in the 2011 World Report on Disability (World Health Organisation and World Bank, 2011). The underreporting of disability generally may be attributed to the ways in which data collection questions are framed. It is also difficult to access accurate data on the number of children with disabilities, not only because of different classifications and definitions, but also because of stigma. The term "disability" has negative connotations. The stigma, often rooted in traditional beliefs, impacts on data collection, as parents may be reluctant to report that a child has a disability. In many cultures disability is seen as punishment for transgressions committed in previous lives (Gona et al., 2011). The differences in disability prevalence by gender and rural/urban are relatively small; the largest differences were between the eight regions. Nyanza reported the highest prevalence (6.45%) while North Eastern reported the lowest (2.12%).

The Nyanza MICS sampled 8,148 children ages 2 – 9 years; about 34.42% reported some form of disability. There are differences in the disability prevalence rates between the KNSPWD and the Nyanza MICS data; this is not surprising given the survey instruments are different. About a third of children 2 – 9 years in the Nyanza are at increased risk of disability. Within the Nyanza region there were differences in disability prevalence. Homa Bay county reported the highest prevalence (56.01%) while Kisii county reported the lowest (20.31%). This data does not allow us to explain the causes of these county differences. The county differences warrant further investigation when the data is available. As in the case of the KNSPWD data, it is possible that in some counties households were less willing to report disabilities.

Table 1: School participation for children (6-17 years) by demographic characteristics.

	Without disabilities		With disabilities	
	In school (%)	Out of school (%)	In school (%)	Out of school (%)
Age				
6	85.70	14.30	67.92	32.08
7	91.40	8.60	71.15	28.85
8	93.61	6.39	68.63	31.37
9	94.95	5.05	87.50	12.50
10	94.62	5.38	82.50	17.50
11	95.95	4.05	83.33	16.67
12	94.57	5.43	88.33	11.67
13	95.01	4.99	80.72	19.28
14	92.26	7.74	83.33	16.67
15	88.65	11.35	71.60	28.40
16	83.34	16.66	73.82	26.18
17	75.36	24.64	61.11	38.89
Gender				
Boys	91.79	8.21	79.43	20.58
Girls	89.57	10.43	76.42	23.58
Residence				
Urban	90.31	9.68	81.56	18.44
Rural	90.77	9.22	77.27	22.74
Education of the head of household				
0 - 8 years	94.02	5.98	78.41	21.59
9 - 12 years	94.94	5.06	81.70	18.30
13 + years	95.57	4.42	86.13	13.88
Child of the head of household				
Other	87.59	12.41	73.05	26.94
Son/Daughter	91.49	8.50	79.40	20.60
Region				
Nairobi	91.72	8.29	91.11	8.84
Central	95.07	4.97	82.09	17.46
Coast	88.68	11.37	77.59	22.48
Eastern	93.53	6.49	78.52	21.37
North Eastern	65.25	34.56	50.00	50.00
Nyanza	95.75	4.27	82.94	17.04
Rift Valley	89.60	10.42	72.07	27.50
Western	95.33	4.63	76.04	24.29

Source: Author analysis of KNSPWD data.

Table 1 presents the school participation of school age children, using KNSPWD data, by demographic characteristics. Children were considered out of school if they had never enrolled in school or had dropped out. Out of school means the respondents answered 'no' to either of these questions: *Has (name) ever gone to school? Is (name) currently in school/college?* Table 1 shows participation differences between those who reported disabilities and those who did not. The differences were more pronounced in the early ages; before age 8 about 30% of children with disabilities were out of school compared to about 10% of those without disabilities. Children with disabilities were more likely to delay school enrolment.

There were gender differences in access to school for children with or without disabilities. Access to school favored boys; about 10% of girls and about 8% of boys without disabilities reported they were out of school compared to about 24% of girls and 21% of boys with disabilities. Table 1 also shows that children with disabilities who reside in rural areas had lower levels of school participation. About 23% of rural children with disabilities reported they were out of school compared to about 18% of urban children with disabilities. The more educated the head of household, the greater the access to school for children with disabilities. For children with disabilities, about 21% were out of school if the head had 0 – 8 years of education compared to about 14% if the head had 13+ years of education. This suggests that the educated heads of households either had the resources to provide education for their children with disabilities and/or knew where educational services were available. Access to school also depended on the region the children lived; about 50% of children with disabilities in the North Eastern region participated in school compared to about 91% in Nairobi. North Eastern is an educationally marginalized region; for children with disabilities the marginalization is compounded. Overall, Table 1 indicates a greater proportion of children with disabilities were out of school compared to those without disabilities. The proportion that was out of school was greater among the following groups: children below age 8 and above age 14, girls, children from lower socioeconomic status (as measured by the education level of the head of household), and children outside Nairobi.

The KNSPWD sought to determine the reasons why these children were not in school. The households were asked: *Why did (name) leave school?* Figure 1 shows the reasons why children were out of school. The lack of money was the main reason children had dropped out of school; 39.59% reported they did not have the money to continue school. This was followed by a lack of interest in school. Only 2.91% of children out of school reported that disability had forced them out of school. Poverty is the main reason children were out of school in Kenya. However, when we disaggregate the out of school data by disability, the picture changes. There were distinct differences between the responses of children with disabilities and those without disabilities. Lack of money (41.61%) and lack of interest (28.22%) were the top two reasons children without disabilities were out of school. However, for children with disabilities, disability (42.11%) and illness (29.82%) were the top two reasons for being out of school. The lack of money is only reported by about 12% of children with disabilities. The different responses from households with children with disabilities and those without disabilities indicate that many households were taking their disabled children out of school or not enrolling them because of the problems associated with disability. It is important to point out that the burden of care for children with disabilities is far greater among poor households (Gona et al., 2011). This difference in responses could

also be the result of stigma and/ or the lack of educational services offered in schools in Kenya.

Figure 1: Reasons why children (6-17 years) are out of school (Source: KNSPWD data).

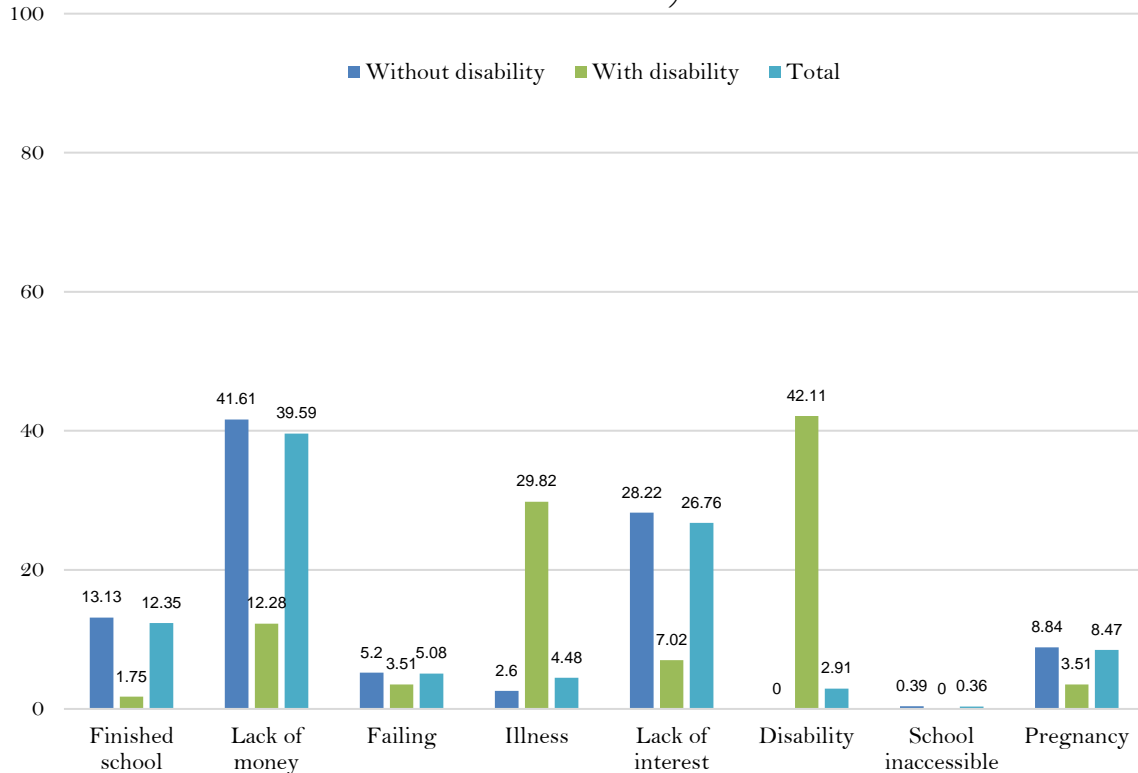


Table 2 presents school participation, by demographic characteristics, using the Nyanza MICS data. Children were considered out of school if they had never enrolled in school or had dropped out. These households answered ‘no’ to either of these questions: *Has (name) ever attended school, preschool or non-formal education? During the current (2011) school year did (name) attend school, preschool or non-formal education at any time?* Overall, 3.5% of children (6-9 years) with disabilities were not in school compared to 2.7% of those without a disability.

The data presented above indicates that children with disabilities are disadvantaged when it comes to access to school. There are differences in school participation by rural/urban residence, education level of the head of household, wealth quintiles, and county of residence. Although the differences in school participation between children with disabilities and those without disabilities are small at these young age groups, it is likely that the gap will increase as children get older because the direct costs of schooling tend to rise as children get to higher grades/levels.

The type of the disability also impacts the level of school participation. In India, UNICEF (2015) found that children with multiple disabilities and intellectual disabilities were the most disadvantaged. Figure 2 presents the proportion of children (6 – 17 years) who are not in school by the type of disability, using KNSPWD. Figure 3 presents the proportion of children (6 – 9 years) who were not in school by the type of

disability, using MICS Nyanza data. From both sets of data, it is evident that children with visual and hearing impairments fared better than those with intellectual and severe physical disabilities. For example, in Figure 2, 60% of children who face difficulty

Table 2: School participation for children (6-9 years) by demographic characteristics.

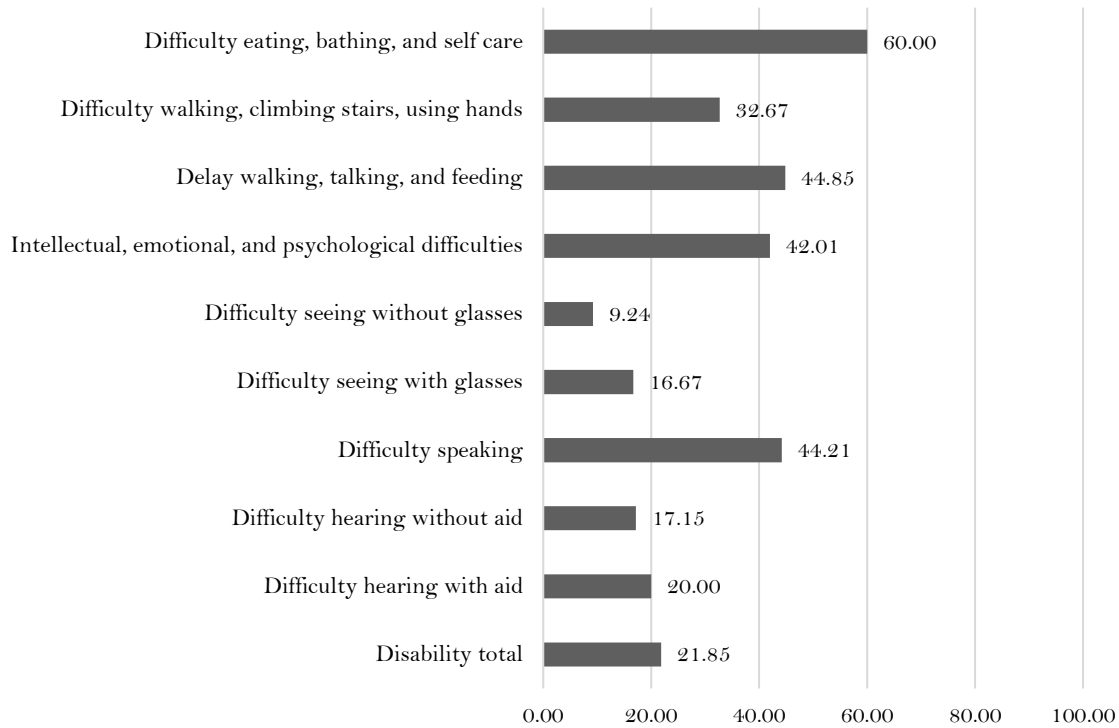
	Without disabilities		With disabilities	
	In school (%)	Out of school (%)	In school (%)	Out of school (%)
Age				
6	93.84	6.16	92.77	7.23
7	98.24	1.76	95.99	4.01
8	98.47	1.53	97.55	2.45
9	98.90	1.10	98.00	2.00
Gender				
Boys	96.98	3.01	96.07	3.93
Girls	97.77	2.26	95.58	4.44
Residence				
Urban	96.75	3.21	95.12	4.90
Rural	97.45	2.57	95.90	4.11
Education of the head of household				
None	98.12	1.87	96.88	3.08
Primary	96.93	3.20	94.55	5.43
Secondary+	98.00	1.90	98.66	1.39
Wealth quintiles				
Poorest	95.82	4.22	94.14	5.84
Poor	97.72	2.31	96.98	3.00
Middle	97.63	2.41	96.62	3.37
Rich	97.58	2.44	95.35	4.64
Richest	98.63	1.37	96.48	3.50
County				
Siaya	96.24	3.75	92.18	7.72
Kisumu	96.57	3.53	96.75	3.23
Homa Bay	98.24	1.54	97.67	2.36
Migori	98.12	1.87	96.88	3.10
Kisii	97.15	2.81	95.45	4.54
Nyamira	97.62	2.41	95.00	5.01

Source: Author analysis of Nyanza MICS data.

eating, bathing or taking care of themselves were not in school compared to about 9% of children with difficulty seeing without glasses. In Figure 3 about 9% of children who were unable to speak recognizable words were out of school compared to about 3% of

those who had difficulty seeing. The more severe the disability the greater the likelihood the children were out of school.

Figure 2: Children (6-17 years) with disabilities who are out of school by the type of disability (Source: KNSPWD).

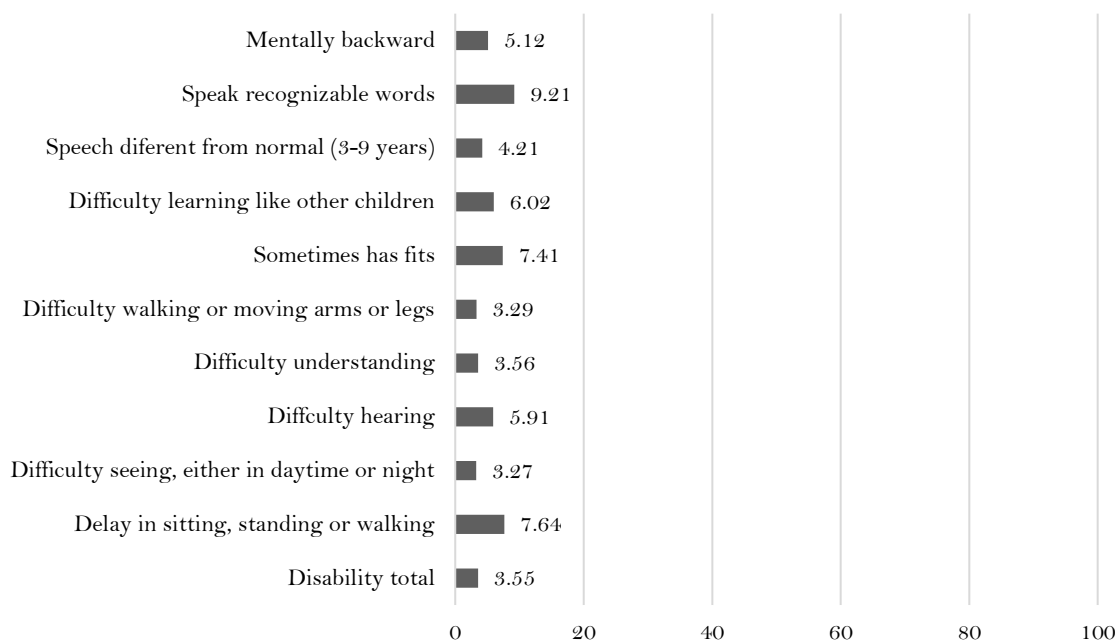


There are two main reasons for differences in school participation by the type of disability. First, households may be unwilling to send their children with disabilities to school because of the social stigma (Kristensen et al., 2006; UNICEF, 2015). It is likely some types of disability carry greater stigma than others. For example, it is likely that difficulty with eating, bathing, and self-care has greater stigma than difficulty seeing without glasses. Gona et al. (2011) found that the stigma of disability affects the child with the disability and the care giver. Second, many schools in poor countries are not physically equipped to meet the needs of children with disabilities, especially with more severe forms of disability, neither are the teachers trained to teach children with disabilities. Children who face difficulty speaking require speech therapy and those facing difficulty eating, bathing or caring from themselves also require specialized care in school. However, in the case of Kenya, resources to provide specialized services may not be available and/or households are not aware of the services available (see Table 3).

The individual disability questionnaire of the KNSPWD asked the respondents another important question: *Which services, if any, are you aware of and have ever needed/received?* Educational services include remedial therapist, special school, early childhood stimulation, regular schooling, inclusive education set up, etc. (National Coordinating Agency and Development & Kenya National Bureau of Statistics, 2008). The data show that 30.09% of the respondents were not aware of educational services and only 24.02% of children (6 – 17 years) received any educational services. As

expected, households in rural areas were less aware of educational services only about 1 in 5 receive such services.

Figure 3: Children (6-9years) with disabilities who are out of school by the type of disability (Source: Nyanza MICS).



*Table 3: Household with disabilities - awareness of and access to educational services.**

	Aware of educational services			Received educational services		
	Yes	No	Total	Yes	No	Total
Residence						
Urban	81.29	18.71	100	34.53	65.47	100
Rural	67.48	32.52	100	21.78	78.22	100
Region						
Nairobi	88.24	11.76	100	45.10	54.90	100
Central	88.24	11.76	100	36.76	63.24	100
Coast	66.67	33.33	100	19.66	80.34	100
Eastern	68.66	31.34	100	17.91	82.09	100
North Eastern	62.50	37.50	100	16.67	83.33	100
Nyanza	77.16	22.84	100	26.90	73.10	100
Rift Valley	67.65	32.35	100	30.39	69.61	100
Western	42.86	57.14	100	7.14	92.86	100
Total	69.91	30.09	100	24.02	75.98	100

Source: Author analysis of KNSPWD data.

*Educational services (e.g. remedial therapist, special school, early childhood stimulation, regular schooling, inclusive education set up etc.)

When we examined the data by region, we found that educational services were concentrated in Nairobi and Central regions. Table 3 shows that about 88% of households in Nairobi and Central were aware of educational services compared to about 42% in Western region. The level of awareness of educational services in the Western region was very low; only 7% of children with disabilities in Western received any educational services compared to 45% Only in Nairobi, Central and Rift Valley do we find at least a third of children with disabilities received services. This lack of awareness of available educational services most likely reduces the number of children with disabilities who enrol and attend school. From the literature review we saw evidence of the lack of government commitment to the disabled; non-implementation of policy recommendations; limited funding to EARCs and KISE, lack of special education teachers, and limited facilities in schools (Ministry of Education, Science and Technology, 2003; Republic of Kenya, 2005b).

The data presented above illustrated several issues about the education of children with disabilities. First, there were differences in access to school between children with disabilities and those without. The differences are evident by rural/urban residence, education level of the head of household, wealth of households and county of residence. Second, the types of disabilities affect participation in school. Children with more severe disabilities, like difficulty with self-care, speech, and intellectual, were more disadvantaged than those with visual or hearing impairments. The data indicate that the more severe the disability the greater the likelihood that the child will be out of school. This may be due to the greater stigma associated with severe disabilities and the greater cost of providing these educational services. Third, in households with a disabled child, disability was seen to be the main reason the child was not in school. This may be due to stigma and/or the availability of educational services. Lastly, the data showed the limited availability of educational services in Kenyan schools and the lack of awareness of educational services. Only about 1 in 4 children with disability had access to any educational services. This lack of services most likely negatively impact children with disabilities especially those children who required assistive devices such as wheel chairs and hearing aids.

Multivariate Analysis

The aim of this study was to examine school participation for children with disabilities in Kenya using household survey data. This section used logistic regression to estimate the probability of school enrolment and attendance for children with disabilities controlling for various household characteristics. The models included the following independent variables: children's gender, children's age, number of children, disability status, education of the head of household, wealth quintiles, and region (Rift Valley, Coast, Central, Eastern, Nairobi, Nyanza, North Eastern, Western), rural/urban residence.

The results of the logistic regression analysis are presented in Table 4 in the form of odds ratios. Models 1 and 2 present the odds ratios for the analysis using the 2011 Nyanza MICS data while Models 3 and 4 present the odds ratios using the 2007 KNSPWD data. The odds ratio enables us to interpret the likelihood that a child will either enrol in school (1) or not (0) for Models 1 and 3. And the likelihood that a child will either attend school (1) or not (0) for Models 2 and 4. In this analysis 1 represents no effect of the independent variable, a ratio greater than 1 indicates that the

independent variable increases the odds of school enrolment and attendance, and a ratio less than 1 indicates that it diminishes the odds of school enrolment and attendance. For example, the odds ratio for female in Model 4, the odds ratio 0.682 indicates that girls have a lower probability of attending school compared to boys. Specifically, the odds of a girl attending school are 31.8% ($1-0.682$) less than the odds of a boy attending school.

Models 1 and 3 show the probability of school enrolment for children. In the questionnaire respondents were asked: *Has (name) ever attended school, preschool or non-formal education?* (Nyanza MICS) and *Has (NAME) ever gone to school/college?* (KNSPWD). From Model 1, older children were more likely to enrol in school. The odds of enrolling in school increased by about 1.9 times for every year increase in the age of the child. Children with disabilities had a lower probability of enrolling in school; they were about 44% less likely to enrol in school compared to those without disabilities. With the large wealth effect evident in Model 1 children with disabilities from low income households face significant barriers to schooling.

The results from Model 3 show that girls, compared to boys, had a lower probability of enrolling in school; however, the difference is not statistically significant. As expected, older children were more likely to enrol in school. The odds of enrolling in school increased by about 1.4 times for every year increase in the age of the child. Children who reported some form of disability had a lower probability of ever enrolling in school; they were significantly less likely to enrol in school compared to those who reported no disabilities. For children with disabilities, the odds of being in school were 90% less than the odds of a child without a disability.

The place of residence compared the probability of enrolling school between rural and urban residents. Rural residents had a lower probability of ever enrolling in school; the odds of enrolling in school in rural areas were about 0.35 times less than those of urban residents. The household socioeconomic status was measured by education level of the head of household. The results show that households of higher socioeconomic status, as measured by the education of the head of household, had a higher probability of enrolling in school. Children in North Eastern region, a region that has been historically disadvantaged, had the lowest probability of school enrolment. The odds of enrolling in school for a child in the North Eastern region was about 98% less than the odds of enrolling in school for a child in the Central region.

This study also examined the probability of school attendance; the results of the logistic regression analysis. The dependent variable was created from the question: *During the current (2011) school year did (name) attend school, preschool or non-formal education at any time?* (Nyanza MICS) and *Is (NAME) currently in school /college?* (KNSPWD). From Model 2 the only statistically significant variable in the age of the child; as children get older the odds of attending school increased by 1.746 times for every year increase in the age of the child.

In Model 4, being female was negatively associated with school attendance. According to the odds ratio, girls were 31.8% less likely to attend school compared to boys. As children get older they had a lower probability of school attendance; the odds of attending school decreased by 0.55 times for every year increase in the age of the child. Children of the head of household were about 3.68 times more likely to attend school compared to non-biological children of the head of household. Children with disabilities had a lower probability of attending school; these children were about 60% less likely to attend school compared to those without disabilities. The more educated the head of household the greater the probability of school attendance for children. The

multivariate analysis indicated that individuals who reported disabilities had a significant disadvantage in school enrolment and attendance.

Table 4: Odds ratios of school enrollment and attendance.

	Nyanza MICS		KNSPWD data	
	Model 1 - Enrollment	Model 2 - Attendance	Model 3 - Enrollment	Model 4 - Attendance
Female	1.068	1.547	0.849	0.682**
Age	1.947**	1.746**	1.364**	0.554**
Child of head	0.886	0.439	1.580**	3.632**
Disability	0.561*	0.895	0.094**	0.404**
Rural	2.336+	1.596	0.655*	1.175
Education of head of household (years)			1.043**	1.069**
Wealth ¹				
Poor	2.554**	0.977		
Middle	2.122*	1.123		
Rich	2.401**	0.757		
Richest	7.698**	0.909		
Region ²				
Rift Valley			0.361**	1.486**
Coast			0.181**	1.192
Eastern			0.621+	1.076
Nairobi			0.920	0.640*
Nyanza			0.718	1.637**
North Eastern			0.025**	0.965
Western			0.386**	1.864**
N	3786	3697	17,503	17,098
chi ²	63.404**	15.217+	657.941**	1534.393**

+ p<0.10, * p<0.05, ** p<0.01

¹ Reference group is Poorest

² Reference group in Central region

Discussion and Conclusion

The government of Kenya has long neglected people with disabilities. Despite numerous policy recommendations from the various education commissions, few, if any, have been fully implemented (Republic of Kenya, 1999; Republic of Kenya, 2005a). Lack of quality data was one of the factors that hindered the development and implementation of education policies (Republic of Kenya, 2005b). This study used two household survey data sources – 2007 KNSPWD and 2011 Nyanza MICS – to examine the school participation of children with disabilities. Household survey data can

complement administrative data that typically only includes data on children who are in school. Household surveys are important in understanding school participation of children with disabilities because many of these children, due to stigma, remain hidden at home.

Before we discuss the findings, it is important to acknowledge some limitations of household survey data. First, the data may be unreliable because disability was self-reported. Given the stigma associated with disability (Kristensen et al., 2006; UNICEF, 2013), it is likely that some households may be ashamed of their disabled children and will not report them. Second, the KNSPWD survey did not report the poverty levels hence the education level of the head of household was used as a proxy for poverty. Third, the Nyanza MICS only administered the disability questionnaire to children 2 – 9 years. Despite the data limitations, we can learn important things that may inform policy.

Results show that age, gender, relationship to the head of household, rural/urban residence, education of the head of household, wealth, and region are all significantly associated with school participation. This aligns with previous research both in Kenya and other developing countries. The key variable in this study was disability. The results show that disability had a relatively large negative impact on school participation – enrolment and attendance. The descriptive statistics indicated that a greater proportion of children with disabilities were out of school especially in the early years. School participation is also affected by the type disability; those with the most severe disabilities, such as difficulty speaking and self-care, were least likely to be in school. This may be due to the stigma associated with these severe disabilities and the need for extra care and services that school are not equipped to provide.

The KNSPWD asked households why their children were out of school. The responses differed by whether or not the child reported a disability. Households with children with disabilities gave “disability” and “illnesses” as the major reasons they were not in school; however, households without children with disabilities largely blamed the “lack of money” and “lack of interest” for staying out of school. This is an important finding of this paper. Without disaggregating the data, the government will likely focus on the larger obstacles (lack of money) and ignore the obstacles facing those with disabilities. It is easier (and politically expedient) to develop a policy to tackle a problem that affects about 40% of out-of-school children; and it is easier to ignore a problem that affects about 3% of out-of-school children. This may be one of the reasons why children with disabilities have been ignored in the policy debate. Policies that generally seek to lower costs of school, such as free primary education, may not send children with disabilities to school because their main challenge is the lack of educational services in schools – the schools are unable and in some cases unwilling to cater for the needs of their children (KNCHR, 2007). Despite this finding we cannot ignore the fact that households with children with disabilities struggle with poverty and the poverty is compounded by the disability (Gona et al., 2011).

If the government can provide more educational services, it may increase access for children with disabilities. The data analysis showed that less than 25% of children with disabilities received any services. The proportion receiving educational services range from about 7% in Western region to about 45% in Nairobi. This means that majority of children with disabilities in Kenya have not been adequately catered in the schools. An increase in funding to ensure that schools provide educational services may increase school participation. This will require increased funding to train special

education educators, provide assistive orthopaedic devices, hearing and visual aids etc. Given the struggle to provide to care for children with disabilities it is likely care givers would take the children to schools to receive needed educational services.

There was also a lack of awareness of the educational services offered for children with disabilities. About 30% were not aware of educational services offered by schools for children with disabilities. The government therefore must increase efforts to create awareness of the services offered. A program to increase awareness must be developed and combined with increased funding to schools so that they can provide educational services. However, the greatest challenge facing the education of children with disabilities is the lack of policy implementation.

History shows that policy implementation has been a problem in Kenya. Education policy implementation has been hampered by poor economic conditions, high population growth, poor planning, teacher shortages, and corruption/wastage (Amutabi 2003; Cooksey, Court & Makau, 1994; Eshiwani, 1990; Kimenyi, Mwege, & Ndungu 2016; Nkinyangi, 1982). The 2010 constitution guaranteed children with disabilities the right to free and compulsory education. The government is now legally obligated to enact affirmative action policies that ensure children with disabilities have equal access to education. The constitution also requires the government to provide better access to education and establish infrastructure for education children with disabilities. Despite its legal requirements, the government has not fully implemented the policies. An examination of the government reports indicate that the government of Kenya has focused on the outcomes of the special needs policy framework and largely ignored the process. One of the main challenges facing education of children with disabilities was that the lack of guidelines on how to implement policy recommendations (KNCHR, 2014; Republic of Kenya 2012). The challenge facing the government is not policy development but policy implementation.

In March 2010, the government launched The National Special Needs Education Policy Framework. The framework put in place multi-agency interdisciplinary strategies; however, the primary responsibility for implementing this policy remained with the Ministry of Education. A KNCHR (2014) survey found that “many persons with disabilities were not aware of their rights including the various legislations put in place to protect and promote their rights.” (p. 22). If people are not aware of their rights they cannot push for the full implementation of government policies. A campaign to increase awareness of the rights of people with disabilities will likely ensure the policies are fully implemented.

Valuable next steps in research should focus on educational services and policy implementation. We need to understand the types of services needed, where to provide the services, the cost of providing these services. We also need to understand to what extent the provision of educational services would encourage households to send their children to schools and reduce the stigma associated disability. Policy implementation is probably the biggest challenge facing the government. Future research must seek to better understand why policies have not been implemented. Economic conditions, population growth, poor planning, teacher shortages, and corruption have hindered implementation of education policies; however, it is important to understand what other issues hinder the implementation of disability policies.

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