



IS EVERY CHILD COUNTED?

Status of data for children
in the SDGs



unicef 
for every child

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Fatou, 14, stands outside a boarding school for primary students in the town of Bura, Garissa County.
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Contents

Section 1

4

The SDGs and data on children	1.1 Introduction	7
	1.2 Children are central to the 2030 Agenda	8

Section 2

14

Current status of data on children in relation to the SDGs	GOAL 01: NO POVERTY	16
	Child poverty	18
	GOAL 02: ZERO HUNGER	22
	Child nutrition	24
	GOAL 03: GOOD HEALTH	28
	Child and adolescent mortality	30
	Maternal and reproductive health	34
	HIV and AIDS, tuberculosis and malaria	38
	GOAL 04: QUALITY EDUCATION	42
	Early childhood development	44
	Education	46
	GOAL 05: GENDER EQUALITY	50
	Intimate partner and sexual violence against girls and women	52
	Child marriage	54
	Female genital mutilation/cutting	56
	GOAL 06: CLEAN WATER AND SANITATION	58
Water, Sanitation and Hygiene (WASH)	60	
GOAL 08: GOOD JOBS AND ECONOMIC GROWTH	64	
Child Labour	66	
GOAL 16: PEACE AND JUSTICE	70	
Violence against Children	72	
Birth registration	78	

Section 3

80

Enhancing data on children in the SDG era	Annex 1	92
	Endnotes	99



The SDGs and data on children

1.1 Introduction

1.2 Children are central to the 2030 Agenda

SECTION ONE



1.1



Street children watch a skit performed by other street children at the Child Restoration Outreach, an organization helping street children.

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Introduction

The 2030 Agenda for Sustainable Development charts an ambitious course for the coming decade and beyond. Reaching further than its precursor, the Millennium Development Goals, the Agenda brings together the social, economic and environmental dimensions of development. The Sustainable Development Goals (SDGs) are a clarion call for a more equitable future, and at their core is a commitment to leave no one behind.

The SDGs can only deliver on the promise of equity if the world knows which children and families are thriving and which are being left behind – both at the launch of the Agenda and throughout its implementation. This recognition is built directly into the Goals themselves: Goal 17, focused on the means of implementing the Agenda, includes an explicit target on supporting countries to increase the availability of high-quality, timely and disaggregated data. The global framework for SDG monitoring calls for indicators to be disaggregated wherever relevant to direct government investments, shape service delivery and policy and, ultimately, fulfil the rights of every child.

UNICEF has a long history of meeting data challenges as bold as those set out in the SDGs. Over the past 70 years, the organization has played a leading role in highlighting inequities in the situation of children. The first report on the *State of the World's Children*, published 35 years ago, underlined the need for 'hard evidence' to support the implementation and monitoring of international targets. Since then, UNICEF has actively supported countries all over the world to improve the availability and use of child-related data.

Thanks to the increasing availability of disaggregated data, we know more than ever about the deprivations faced by children around the world; and thanks to the increasing use of such data, policies and programmes are increasingly able to focus on advancing equity for children and families. This progress, however, is incomplete. There are still critical gaps in the availability of relevant data, particularly in countries with large numbers of poor and vulnerable children. Closing these data gaps is the first step towards closing the underlying equity gaps.

Understanding the situation of children in relation to the SDGs is crucial both for the well-being of children and for reaching the targets of the Global Goals. While there is no goal that exclusively addresses the needs of children, most SDGs have targets that are either directly or indirectly related to children. The world cannot and will not reach most goals unless the specific needs of children are monitored and addressed throughout the course of the 2030 Agenda.

This report considers both the implications of the 2030 Agenda for children and the data required to monitor the situation of children within the SDG framework. The first section identifies 50 global SDG indicators across 14 goals that are likely to be the main focus of future thematic reporting on children in relation to the SDGs. This initial section focuses on a subset of eight goals which include direct references to children, while the second section examines the global availability of indicators for these goals and ongoing efforts to address key data gaps. The final section identifies priorities for enhancing the collection, analysis and use of data for children within the SDG framework.



1.2 Children are central to the 2030 Agenda

The 2030 Agenda includes 17 Global Goals addressing the social, economic and environmental dimensions of sustainable development. Attached to the goals are 169 targets, which lay out the specific aims towards which the global community is working. In total, 95 of the targets are either directly (48) or indirectly (47) connected to children. Underlying the entire agenda is a commitment by United Nations Member States to tackle inequalities and to leave no one behind. This commitment is especially crucial for ensuring that the most disadvantaged children and families benefit from the Agenda in the years to come.

Direct references to children are found throughout the SDG framework, encouraging countries to think holistically and consider the linkages between different policies and investments that impact children. This report details goals that include commitments to:

- End child poverty and achieve universal access to basic services and social protection [Goal 1];
- End hunger and all forms of malnutrition [Goal 2];
- End preventable child and adolescent deaths [Goal 3];
- Improve maternal, newborn and child health; end the epidemics of AIDS, tuberculosis and malaria; and achieve universal health coverage [Goal 3];
- Improve early childhood development and ensure that all children receive quality education in safe and inclusive learning environments [Goal 4];
- Achieve gender equality and eliminate violence against women and girls [Goal 5];
- Achieve universal access to safe drinking water, sanitation and hygiene [Goal 6];
- Ensure productive employment for all and eliminate child labour [Goal 8]; and
- End abuse, exploitation and violence against children and provide a legal identity for all [Goal 16].

FIGURE 1.1

The SDGs impact every aspect of a child's life

EVERY CHILD SURVIVES AND THRIVES	EVERY CHILD LEARNS	EVERY CHILD IS PROTECTED FROM VIOLENCE AND EXPLOITATION	EVERY CHILD LIVES IN A SAFE AND CLEAN ENVIRONMENT	EVERY CHILD HAS A FAIR CHANCE IN LIFE
Goal 1	Goal 1	Goal 1	Goal 6	Goal 1
Goal 2	Goal 4	Goal 3	Goal 7	Goal 5
Goal 3	Goal 10	Goal 5	Goal 10	Goal 8
Goal 10	Goal 17	Goal 8	Goal 11	Goal 10
Goal 17		Goal 10	Goal 13	Goal 16
		Goal 16	Goal 15	Goal 17
		Goal 17	Goal 17	



SDG monitoring and reporting

The 2030 Agenda calls for ‘systematic follow-up and review’ of SDG implementation at country, regional and global levels. An Inter-Agency and Expert Group on SDG Indicators (IAEG-SDG) has been established, which consists of 28 national statistical offices representing every region of the world, as well as ‘observers’ including United Nations agencies, regional commissions and civil society. In March 2016, the IAEG-SDG proposed a global indicator framework comprising 230 indicators, which was approved by the United Nations Statistical Commission for global monitoring of the 169 SDG targets. These indicators will be compiled in an annual SDG progress report by the United Nations Secretary-General and will inform discussions among Member States at the High-level Political Forum (HLPF) on Sustainable Development. Additional indicators may also be identified for the purpose of national, regional or thematic monitoring. Review mechanisms will be established at national and regional levels, and the HLPF will convene Member States annually at the United Nations Economic and Social Council (ECOSOC) and every four years at the United Nations General Assembly to assess progress.

Winy Moreira, 17, checks her mobile phone on a street in Taiobeiras municipality in the Southeastern state of Minas Gerais, Brazil
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Children are also connected to other larger goals that do not explicitly reference them. Although these goals are not covered in detail in this initial report, they include commitments to:

- Ensure clean and renewable energy for all [Goal 7];
- Reduce income inequality and ensure that migration is well managed [Goal 10];
- Build sustainable cities and communities [Goal 11];
- Mainstream education for sustainable development [Goal 12];
- Establish strategies for disaster risk reduction [Goal 13]; and
- Establish vital registration systems and produce disaggregated data to ensure that no one is left behind [Goal 17].

Table 1.1 shows the global SDG indicators that have been identified by UNICEF as most relevant for monitoring the situation of children under each goal.

Two of these goals in particular have broad and striking implications for children. Progress towards Goal 10, which is focused on reducing inequalities, and Goal 17, regarding the partnerships and work that are needed to

implement the agenda, will shape whether and how children benefit from the SDGs. Reducing inequalities – not only in traditional income terms but across all development outcomes and opportunities – is a cornerstone of both the SDGs and UNICEF’s own work. While Goal 10 is not covered in depth in the chapter that follows, the target and the Agenda’s overall commitment of leaving no one behind underpin work on all of the goals as well as UNICEF programming. The emphasis on disaggregated data laid out in Goal 17, which is covered in more depth in the final section of this report, will ultimately reveal whether the Agenda has reached the most disadvantaged children and families.

Efforts to implement and monitor the 2030 Agenda will also need to take account of population dynamics. Demographic shifts during the SDG era are likely to significantly influence the nature and scale of the challenges faced by children in different parts of the world (*see boxes 1.2 and 1.3*).

The potential of SDG monitoring to drive change for children will depend on countries fulfilling their commitment that ‘SDG indicators should be disaggregated, where relevant, by income, sex, age, race, ethnicity, migratory status, disability and geographic location, or other characteristics.’¹ Meaningful commitments to high-quality, timely and disaggregated data will allow governments and their partners to track progress on children and implement course corrections as needed. Insufficient investment, in contrast, could undermine the commitment of the goals to reaching the furthest behind and constrain efforts to address inequities. Today’s choices about investing in data – including collection, analysis and use – shape tomorrow’s outcomes for children.

Improving the coverage and quality of child-related data is essential to harnessing the power of the 2030 Agenda for children and ensuring that no child is left behind

TABLE 1.1: PRIORITY CHILD-RELATED SDG GOALS, TARGETS AND INDICATORS

<p>01</p>  <p>NO POVERTY</p> <p>1.1, 1.2, 1.3, 1.4</p>	<p>1.1.1 Children living below US\$1.90 per day</p> <p>1.2.1 Children living below the national poverty line</p> <p>1.2.2 Children in multidimensional poverty</p> <p>1.3.1 Children covered by social protection</p> <p>1.4.1 Access to basic services</p>	 <p>02</p> <p>ZERO HUNGER</p> <p>2.2</p>	<p>2.2.1 Stunted children</p> <p>2.2.2 Wasted children</p> <p>2.2.2a Overweight children</p>		
 <p>03</p> <p>GOOD HEALTH</p> <p>3.1, 3.2, 3.3, 3.4, 3.6, 3.7, 3.8, 3.9</p>	<p>3.1.1 Maternal mortality</p> <p>3.1.2 Skilled birth attendance</p> <p>3.2.1 Under-5 mortality</p> <p>3.2.2 Neonatal mortality</p> <p>3.3.1 New HIV infections in children</p> <p>3.3.2 Tuberculosis incidence in children</p> <p>3.3.3 Malaria incidence in children</p> <p>3.4.2 Adolescent suicide</p> <p>3.6.1 Child road traffic deaths</p> <p>3.7.1 Family planning</p> <p>3.7.2 Adolescent birth rate</p> <p>3.8.1 Universal health coverage</p> <p>3.9.1 Deaths attributed to air pollution</p> <p>3.9.2 Deaths attributed to unsafe WASH</p>	 <p>04</p> <p>QUALITY EDUCATION</p> <p>4.1, 4.2, 4.5, 4.6, 4.a</p>	<p>4.1.1 Minimum proficiency in reading and maths</p> <p>4.2.1 Early childhood development</p> <p>4.2.2 Pre-primary participation</p> <p>4.5.1 Parity in education</p> <p>4.6.1 Youth literacy</p> <p>4.a.1 WASH in schools</p>		
 <p>06</p> <p>CLEAN WATER AND SANITATION</p> <p>6.1, 6.2</p>	<p>6.1.1 Safely managed drinking water</p> <p>6.2.1 Safely managed sanitation and hygiene</p>	 <p>07</p> <p>RENEWABLE ENERGY</p> <p>7.1</p>	<p>7.1.2 Primary reliance on clean fuels</p>	 <p>08</p> <p>GOOD JOBS AND ECONOMIC GROWTH</p> <p>8.7, 8.b</p>	<p>8.7.1 Child labour</p> <p>8.b.1 Spending on social protection and employment</p>
 <p>10</p> <p>REDUCED INEQUALITIES</p> <p>10.1</p>	<p>10.1.1. Growth in income per capita among bottom 40%</p>	 <p>11</p> <p>SUSTAINABLE CITIES AND COMMUNITIES</p> <p>11.1</p>	<p>11.1.1 Population living in slums</p>	 <p>12</p> <p>RESPONSIBLE CONSUMPTION</p> <p>12.8</p>	<p>12.8.1 Countries mainstreaming education for sustainable development</p>
 <p>13</p> <p>CLIMATE ACTION</p> <p>13.1</p>	<p>13.1.1 Countries with national and local disaster risk reduction strategy</p> <p>13.1.2 Disaster affected population</p>	 <p>16</p> <p>PEACE AND JUSTICE</p> <p>16.1, 16.2, 16.9</p>	<p>16.1.1 Child homicide</p> <p>16.1.2 Conflict-related deaths</p> <p>16.2.1 Punishment by caregivers</p> <p>16.2.3 Sexual violence against children</p> <p>16.9.1 Birth registration</p>	 <p>17</p> <p>PARTNERSHIPS FOR THE GOALS</p> <p>17.18, 17.19</p>	<p>17.18.1 Disaggregated SDG indicators at national level</p> <p>17.19.1 Countries registering births and deaths</p>

The analysis is limited to the list of indicators proposed by the Inter-Agency and Expert Group on SDG Indicators (IAEG-SDG) for global SDG monitoring, although countries may still propose additional indicators for national, regional and thematic monitoring (see box 1.1). Shorthand versions of official SDG indicators have been used for ease of communication.

Taking account of population dynamics

Understanding population trends matters because programming and planning for children depend on many features of a population, including the way that its members are currently distributed by age, sex and location, as well as projected changes in these distributions. Current and future population levels and trends therefore need to be taken into consideration to achieve results for children and adolescents in the SDG era and beyond.

The world population reached 7.3 billion in 2015, almost tripling in size since 1950, when it stood at 2.5 billion. At current projections, it will reach 8.5 billion by 2030 and 9.7 billion in 2050. By mid-century, four fifths (80 per cent) of the world's population will live in Africa or Asia. While Asia's population will expand slowly compared with previous growth, Africa – and especially sub-Saharan Africa – is projected to continue to have the greatest population increase.

FIGURE 1.2

Total population (in billions) and increasing share of Africa in total population, 1950, 2000, 2015, 2030, 2050 and 2100



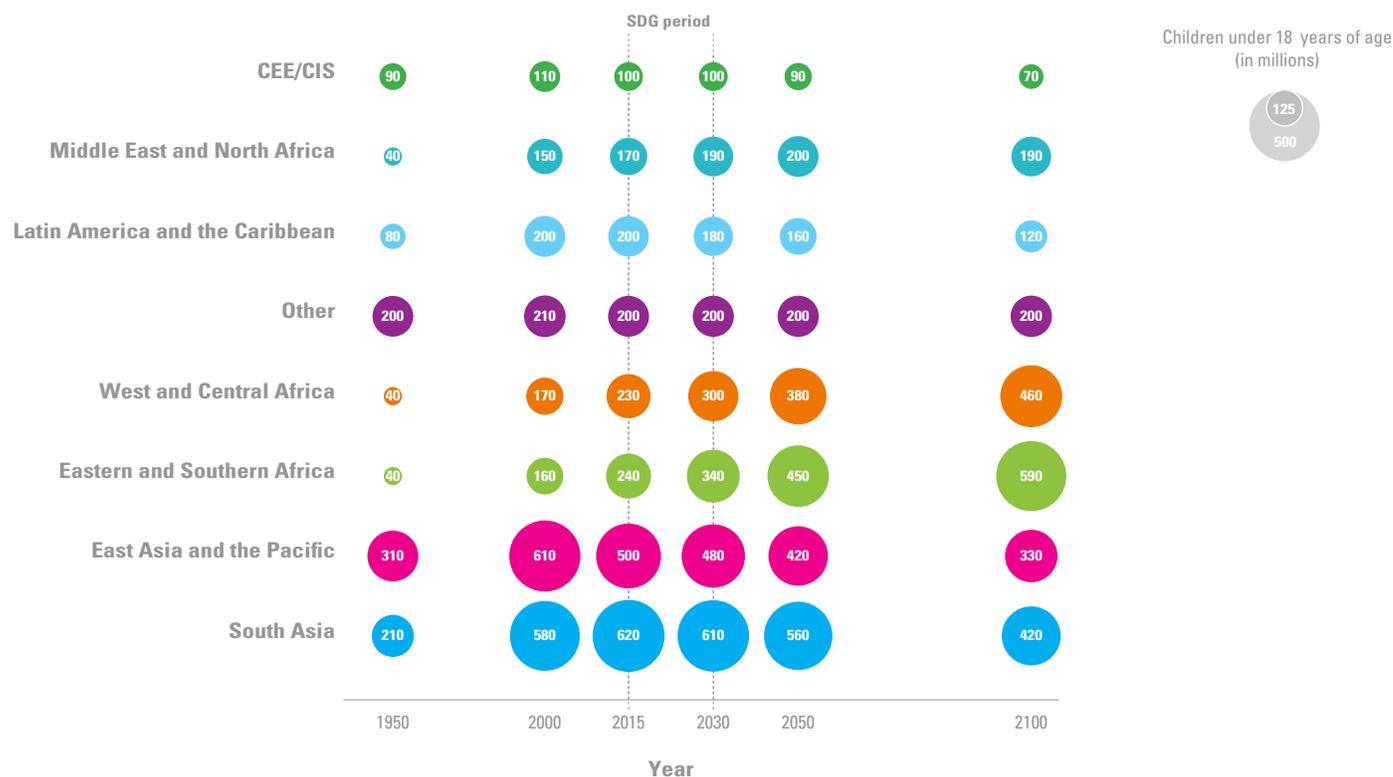
The global population is expected to reach 8.5 billion by 2030 and 9.7 billion in 2050

The under-18 population in the regions of sub-Saharan Africa will increase from 496 million in 2015 to a projected 661 million in 2030 and 866 million in 2050 (see figure 1.3). Sub-Saharan Africa’s under-5 population will rise from 163 million in 2015 to 207 million in 2030 and further to 259 million in 2050. However, due to the expected decrease or stagnation in the under-18 population in all other regions, the world population of children will increase only slightly over the next 35 years, by 5 per cent from 2.3 billion in 2015 to 2.5 billion by 2030, and then remain at a similar level in 2050.

By mid-century, more than one in every three children younger than 18 years old will live in sub-Saharan Africa

FIGURE 1.3

Children under 18 years of age by region (in millions), 1950, 2000, 2015, 2030, 2050 and 2100



Source: UNICEF analysis based on United Nations, Department of Economic and Social Affairs, Population Division, 'World Population Prospects: The 2015 revision', United Nations, New York, 2015.



Current status of data on children in relation to the SDGs



NO POVERTY
Child poverty



ZERO HUNGER
Child nutrition



GOOD HEALTH
Child and adolescent mortality
Maternal and child health
HIV, malaria and tuberculosis



QUALITY EDUCATION
Early childhood development
Education



GENDER EQUALITY
Violence against girls and women
Child marriage
Female genital mutilation/cutting



CLEAN WATER AND SANITATION
Water, sanitation and hygiene



GOOD JOBS AND ECONOMIC GROWTH
Child labour



PEACE AND JUSTICE
Violence against children
Birth registration



SECTION TWO



NO POVERTY

Child poverty

The SDG poverty targets include both global and national-level commitments and differ from the Millennium Development Goals (MDGs) by including an explicit multidimensional focus and specifically mentioning children. A multidimensional focus is important to additionally understand how children are experiencing poverty and in what form, and to allow a more nuanced set of policy responses in poverty-reduction strategies. The indicators under target 1.2 are therefore of particular relevance to capture child poverty in both monetary and non-monetary forms.



1.1 Eradicate extreme poverty for all people everywhere, currently measured as people living on less than US\$1.90 a day

1.1.1 Proportion of the population below the international poverty line, disaggregated by sex, age group, employment status and geographical location (urban/rural)

1.2 Reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions

1.2.1 Proportion of the population living below the national poverty line, disaggregated by sex and age group

1.2.2 Proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions

1.3 Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable

1.3.1 Percentage of the population covered by social protection floors/ systems, disaggregated by sex, and distinguishing children, the unemployed, old-age persons, persons with disabilities, pregnant women/newborns, work-injury victims, the poor and the vulnerable.

1.4 By 2030, ensure that all men and women, in particular the poor and the vulnerable, have ... access to basic services ...

1.4.1 Proportion of the population living in households with access to basic services





GOAL 01 Child poverty



Responding to the humanitarian situation in South Sudan, 2016
© UNICEF/UN016656/Holt

Current status and trends

'Extreme poverty', measured at US\$1.90 per person per day, is estimated to affect 767 million people, or 10.7 per cent of the population in 2013.¹ Global prevalence of multidimensional poverty in developing countries is higher, affecting an estimated 1.6 billion people.² Estimates of poverty for Organisation of Economic Co-operation and Development (OECD) countries indicate that 11.5 per cent of the population are poor (live in households with less than 50 per cent of median disposable income) and that poverty levels have not fallen between 2007 and 2014.³

Current profiles show that child poverty is higher compared with that of adults for each of these global poverty measures. Some 385 children were in extreme poverty (living in households with less than US\$1.90 per capita) in 2013, a child poverty rate that is more than twice that for

those 18 years old and older. Extreme poverty is disproportionately affecting children (*figure 2.1*) who are a far larger proportion of the poor compared with their underlying population share. Children are similarly over-represented in the global Multidimensional Poverty Index (MPI) profile. Exploratory estimates for global MPI in 2010 estimate children are poorer by a factor of 1.6 compared to adults. However, these estimates reflect extrapolations of earlier data in part and are no longer accurate for reporting contemporary poverty profiles. Validation and updating of age-disaggregated Global MPI profiles represents a data gap for regular reporting⁴. OECD poverty data also show a clearly higher poverty risk for children in the vast majority of member states (*figure 2.2*); the overall average across all OECD members is that child poverty in 2014 is 13.3 per cent, compared with 10 per cent for 25–64-year-olds.



However, trends in child poverty are less available compared with trend data on overall poverty. Trends in extreme poverty in the developing world show clear declines since 1990, but large regional differences in such declines and there is a resulting gap in data on regional concentration of extreme child poverty over time. Trends for global MPI are not available apart from a subset of countries. However, OECD has a time series from the 1990s and earlier for both child and adult poverty for a selection of member states.

Data availability

The SDGs call for reducing poverty in all its dimensions, according to national definitions. Nationally defined monetary poverty lines, which have the great advantage of being specific to the country, reflect its particular characteristics and level of development. Different approaches are used, however. Most developing countries estimate an 'absolute' poverty line to capture the basic minimum standard of living, while most high-income countries, such as those in the European Union and the OECD, tend to use relative poverty lines based on what is normal for that society.

Child poverty using national poverty lines can be easily computed by estimating the proportion of children living in households with income or consumption levels below this line. An increasing number of countries are already using this approach, and UNICEF has been leading attempts to compile and report national monetary child poverty rates through its Country Reporting on Indicators for the Goals (CRING) data.

FIGURE 2.1

Extreme poverty for children 2013: Higher rates, and disproportionate shares of poverty



Children have higher and disproportionate levels of extreme poverty in 2013

Source: Newhouse, David, et al., 'New Estimates of Extreme Poverty for Children'. Policy Research Working Paper no. 7845, Table 3, World Bank, Washington, D.C., 2013.

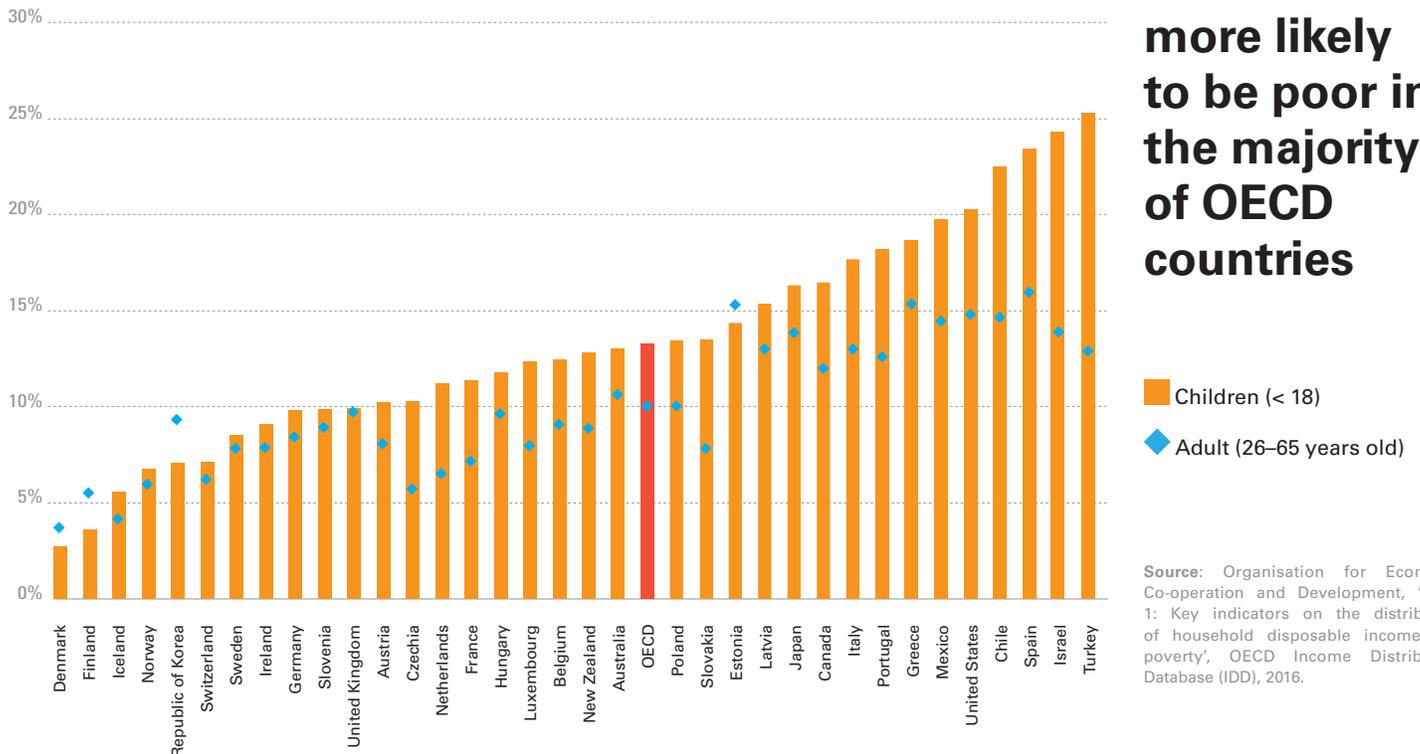


UNICEF has also been a leading exponent of multidimensional approaches to child poverty through the *Global Study of Child Poverty and Disparities*, which began in 2007, through the joint Economic Commission for Latin America and the Caribbean (ECLAC)/UNICEF child poverty analysis in Latin America,⁵ and the more recent Multiple Overlapping Dimension Analysis (MODA) methodology.⁶ Other measures, such as the MPI developed by the United Nations Development Programme and by the Oxford Human Poverty and Human Development Initiative,⁷ have also been adapted for children, both by the production of national child-specific MPI measures and by disaggregation of general MPI data.⁸

Regular high-quality poverty data from household surveys are needed to measure progress on poverty and child poverty and, while available in most countries, national reporting remains limited, depriving of the crucial data to assess progress towards reducing child poverty in all its dimensions. A recent survey of UNICEF's country offices found that more than one third of the countries surveyed do not have official measurements of child poverty, and about half of those with such data are not producing them routinely.⁹

FIGURE 2.2

Relative child and adult poverty in OECD countries, 2014



Children are more likely to be poor in the majority of OECD countries

Source: Organisation for Economic Co-operation and Development, 'Table 1: Key indicators on the distribution of household disposable income and poverty', OECD Income Distribution Database (IDD), 2016.



Addressing data gaps

All countries should report on the number of children living in poverty using both monetary and multidimensional measures to monitor progress towards the goal of halving national poverty prevalence for children. UNICEF has been collaborating with partners to fill crucial data gaps. Child-specific global profiles of extreme child poverty with the World Bank were published in October 2016 and will be updated biannually in the first instance. UNICEF is collaborating with the Oxford Poverty and Human Development Initiative (OPHI) to produce the first disaggregation of the global MPI and is also supporting national governments to set their own national poverty measures and ensure that children are included as part of their efforts to routinely monitor progress in order to address child poverty in all its dimensions.

In terms of target 1.3, UNICEF has been leading work on developing a household survey module to measure social protection programme coverage and thus monitor the extent to which vulnerable households and children are being reached with economic support and with resources to ensure access to basic services. The draft module was customized through testing in Kenya (2014) and in Belize, Viet Nam and Zimbabwe (2015) and was included in the pilot testing of the sixth round of the Multiple Indicator Cluster Surveys (MICS) for further refinement. Further work is required to agree on a definition of 'basic services' which can be used for monitoring progress towards SDG target 1.4.



Syrian refugee Fares, 9, sits in the two room flat which he shares with his mother Hanaa and little brother in the Bekaa Valley, Lebanon
© UNICEF/UN052419/Halldorsson

GOAL



ZERO HUNGER

Child nutrition

Measures of child malnutrition that will be used to officially track progress towards target 2.2 cover chronic and acute undernutrition (stunting and wasting) as well as overweight among under-5 children (*see box 2.1*). Additional indicators related to child nutrition that are important for global nutrition monitoring include exclusive breastfeeding, minimum diet diversity, low birthweight and anaemia prevalence.



Stunting refers to a child who is too short for his or her age. Stunting is the failure to grow both physically and cognitively and is the result of chronic or recurrent malnutrition. The devastating effects of stunting can last a lifetime.



Overweight refers to a child who is too heavy for his or her height. This form of malnutrition results from expending too few calories for the amount of food consumed and increases the risk of non-communicable diseases later in life.



Wasting refers to a child who is too thin for his or her height. Wasting, or acute malnutrition, is the result of recent rapid weight loss or the failure to gain weight. A child who is moderately or severely wasted has an increased risk of death, but treatment is possible.



2.2 By 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons

2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age

2.2.2 Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5, disaggregated by type (wasting and overweight)



GOAL 02 Child nutrition



A baby girl is fed therapeutic milk in Madarounfa Hospital, near the city of Maradi, capital of the southern Maradi Region.

© UNICEF/UNI92966/Holtz

Current status and trends

An estimated 156 million under-5 children – or nearly one in four – were affected by stunting in 2015 (*figure 2.3*). The highest rates as well as highest numbers affected (three quarters of the global stunting burden) were in South Asia and sub-Saharan Africa. Between 2000 and 2015, the number of stunted children fell in all regions except sub-Saharan Africa, where it increased from 48 million to 55 million. If the current global trajectory continues, 119 million under-5 children will be stunted in 2030.

In 2015, 7.4 per cent of children were wasted globally. Wasting rates in South Asia (14.7 per cent) and West and Central Africa (10.0 per cent) are approaching a level associated with a critical public health emergency. In the same year, 6.2 per cent of children were affected by overweight globally. Overweight rates are highest in Central

and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) (15.0 per cent) and the Middle East and North Africa (8.9 per cent) (*figure 2.3*), but every region except Latin America and the Caribbean has seen an increase in numbers affected since 2000 (data not shown).

While joint estimates for disaggregated malnutrition data are not yet available, an analysis of 87 countries with recent data suggests that children from the poorest quintile have stunting rates that are, on average, twice as high as those from the richest quintile.¹⁰ The relative disparities are greatest in Latin America and the Caribbean, where the rate among the poorest is more than three times that among the richest.

Data availability

UNICEF has been reporting on child stunting, wasting and overweight and maintaining disaggregated databases on these indicators for more than 20 years. Today, global and regional malnutrition estimates are produced jointly by UNICEF, WHO and the World Bank employing a joint global dataset and previously published methods.¹¹ The joint estimates and dataset have been updated annually since 2012.

Data availability in 2010–2016 varies by region, indicator and disaggregation. A total of 106 countries (representing 85 per cent of the global population) have recent data on stunting, while 85 countries (60 per cent of the global population) have recent stunting data by wealth quintiles (*figure 2.3*). Data availability for overweight is lower, with 102 countries (66 per cent of the total global population) having recent estimates; while 83 countries



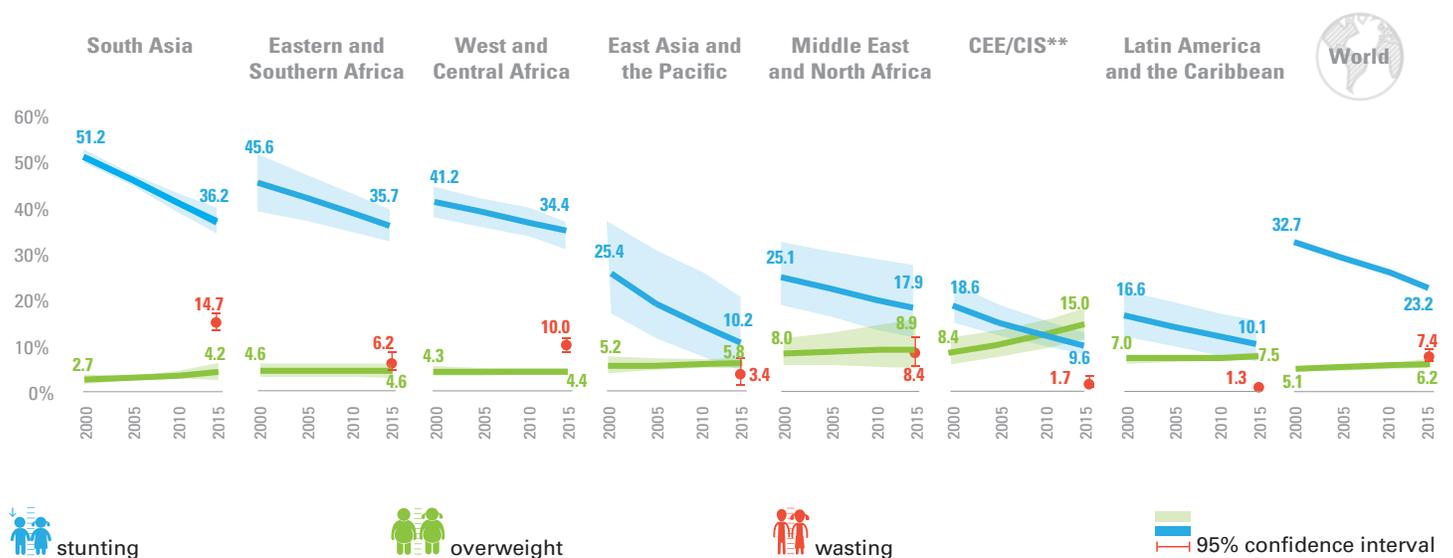
have disaggregated overweight data by wealth quintile, this only makes up 41 per cent of the global population (figure 2.5). The CEE/CIS region has the lowest population coverage for stunting, with data representing only 43 per cent of the region’s population. South Asia has the lowest population coverage for overweight, with data representing less than one third of the population.

Addressing data gaps

UNICEF, WHO and the World Bank are currently working towards a revised model for joint malnutrition estimates, with possible future directions including joint estimates disaggregated by background characteristics as well as improved guidance to support the availability of high-quality nutrition data. National statistical systems responsible for reporting on malnutrition could provide support by ensuring that data on the three child malnutrition indicators, including key disaggregations, are available at least every three to five years and also by following revised global guidance on the quality of anthropometry data once available.

FIGURE 2.3

Percentage of children under 5 who are stunted, overweight and wasted,* by region, 2000–2015



Rates of stunting have fallen but remain high globally, while rates of overweight are on the rise in several regions

*Trend data are not available for wasting, thus only 2015 data are presented in this graph.
 ** CEE/CIS estimates exclude the Russian Federation due to lack of data.
 Source: UNICEF, WHO and the World Bank, 'Joint Child Malnutrition Estimates: 2016 edition'.



FIGURE 2.4

Number of countries with at least one recent (2010–2016) stunting estimate and population coverage for various disaggregations



* Recent data refers to at least one data point between 2010 and 2016.
Source: UNICEF analysis based on UNICEF, WHO and the World Bank, Joint Malnutrition Dataset, 2016 edition (total) and UNICEF global database, 2016 (disaggregations).

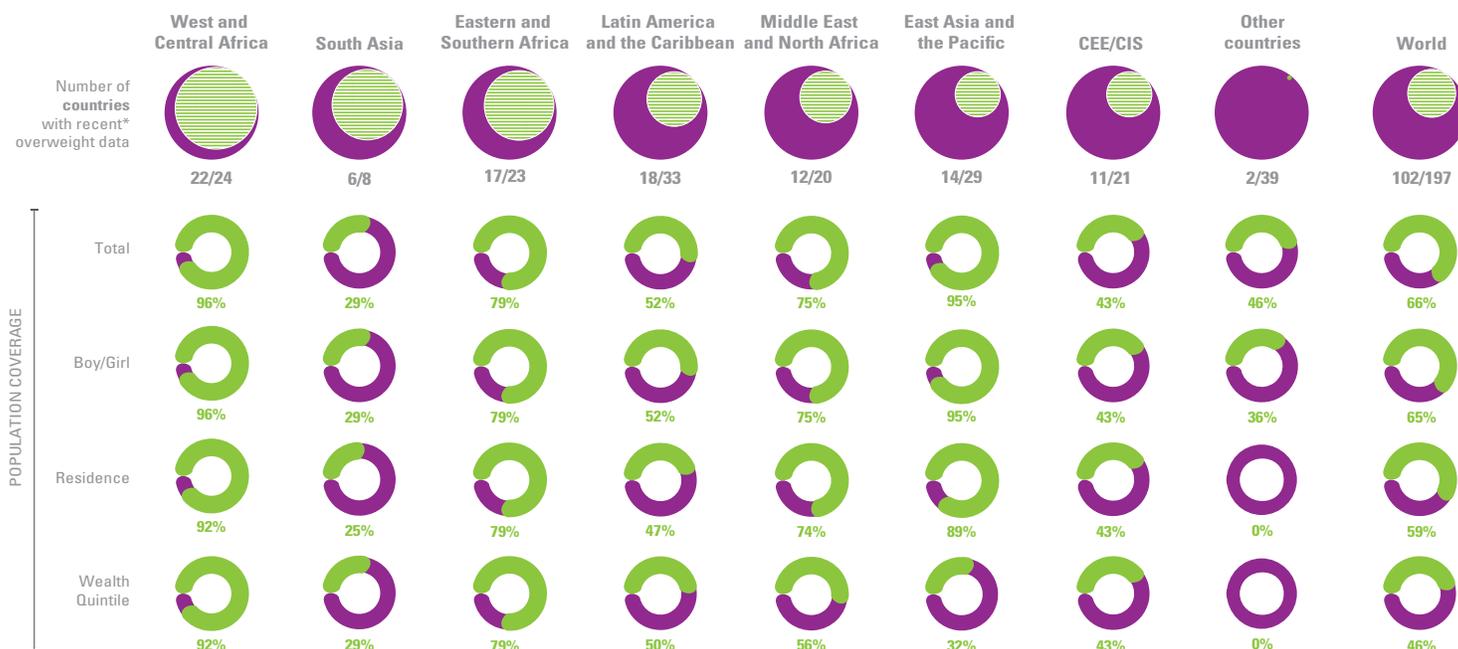
■ With stunting data for under-5-year-olds
■ Without stunting data for under-5-year-olds

Stunting data are only available for about half of all countries in the most recent time period, but vary among regions and disaggregations



FIGURE 2.5

Number of countries with at least one recent (2010–2016) overweight data point and population coverage for various disaggregations



* Recent data refers to at least one data point between 2010 and 2016.
 Source: UNICEF analysis based on UNICEF, WHO and the World Bank, Joint Malnutrition Dataset, 2016 edition (total) and UNICEF global database, 2016 (disaggregations).

■ With overweight data for under-5-year-olds
 ■ Without overweight data for under-5-year-olds

Fewer countries have available data for overweight than stunting, and many regions have insufficient population coverage for a variety of disaggregations



GOOD HEALTH

Child and adolescent mortality

Maternal and child health

HIV, malaria and tuberculosis

Child and adolescent mortality are key output indicators for child and adolescent health and well-being, and more broadly, for social and economic development. While substantial progress has been made in reducing under-5 and neonatal mortality in the past few decades, increased efforts to improve child survival are needed to address the remaining and unequal burden. Infectious diseases and neonatal complications are responsible for the vast majority of these deaths. Many children also die from causes related to household pollution and unsafe water and sanitation, which are addressed in targets 3.9.1 and 3.9.2.¹²

Adolescent deaths remain low compared with under-5 deaths, but there is still significant mortality in adolescents aged 10–19 that can be further reduced or prevented. The top five causes of death in this age group in 2015 were road injuries, lower respiratory infections, self-harm, diarrhoeal diseases and drowning.¹³

Child and adolescent mortality

3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

*3.2.1 Under-5 mortality rate
(deaths per 1,000 live births)*

*3.2.2 Neonatal mortality rate
(deaths per 1,000 live births)*

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

3.4.2 Suicide mortality rate

3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents

3.6.1 Number of road traffic fatal injury deaths within 30 days, per 100,000 population (age-standardized)

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

3.9.1 Mortality rate attributed to household and ambient air pollution

3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene.

Maternal and child health

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

3.1.1 Maternal mortality ratio

3.1.2 Proportion of births attended by skilled health personnel

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

3.7.1 Proportion of women of reproductive age (aged 15–49) who have their need for family planning satisfied with modern methods

3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

3.8.1 Coverage of essential health services

HIV, malaria and tuberculosis

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

3.3.1 Number of new HIV infections per 1,000 uninfected population (by age group, sex and key populations)

3.3.2 Tuberculosis incidence per 1,000 persons per year

3.3.3 Malaria incident cases per 1,000 persons per year



GOAL 03

Child and adolescent mortality

Substantial progress has been made in reducing child mortality since 1990

Current status and trends

The chances for children to survive have increased substantially over the past 25 years. Globally, under-5 mortality fell from 91 deaths per 1,000 live births in 1990, to 76 in 2000 and to 43 in 2015 and neonatal mortality from 36 deaths in 1990, to 31 in 2000 and to 19 in 2015 (figure 2.6). Yet, in 2015, 5.9 million children still died before they reach their fifth birthday, 2.7 million of whom were newborns.¹⁴

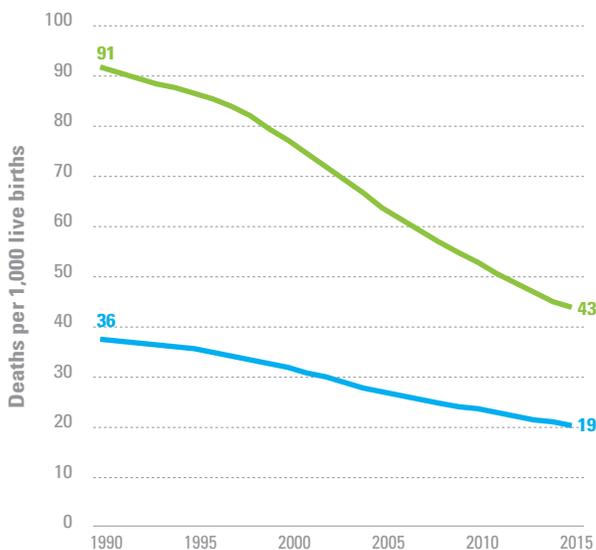
Huge disparities exist across countries, with under-5 mortality rates ranging from 2 to 157 deaths per 1,000 live births in 2015 (figure 2.7) and neonatal mortality from 1 to 49 deaths per 1,000 live births. Countries with the highest rates were concentrated in sub-Saharan Africa

and South Asia. There are also large disparities within countries. Household survey data from about 50 countries show that children from the poorest households are on average nearly twice as likely to die before the age of 5 as children from the richest households, and under-5 children of mothers who lack education are 2.8 times as likely to die as those whose mothers have secondary or higher education. Girls' risk of dying before age 5 is also significantly higher than would be expected based on global patterns in some countries, primarily in South Asia and the Middle East. However, the number of countries showing these gender disparities fell by more than half between 1990 and 2015, from 20 to 9.

FIGURE 2.6

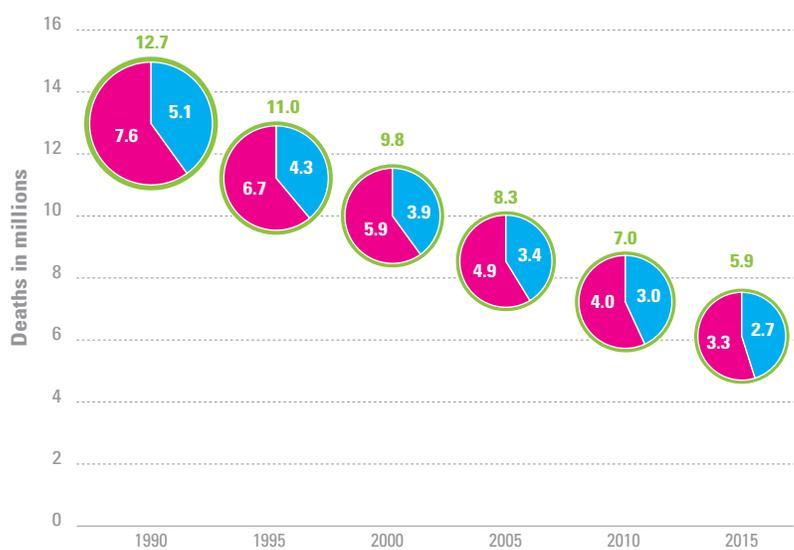
Global under-5 and neonatal mortality rates and distribution of under-5 deaths by age, 1990–2015

a) Mortality rates



Under-5 mortality rate Neonatal mortality rate

b) Number of deaths



Under-5 deaths of which:

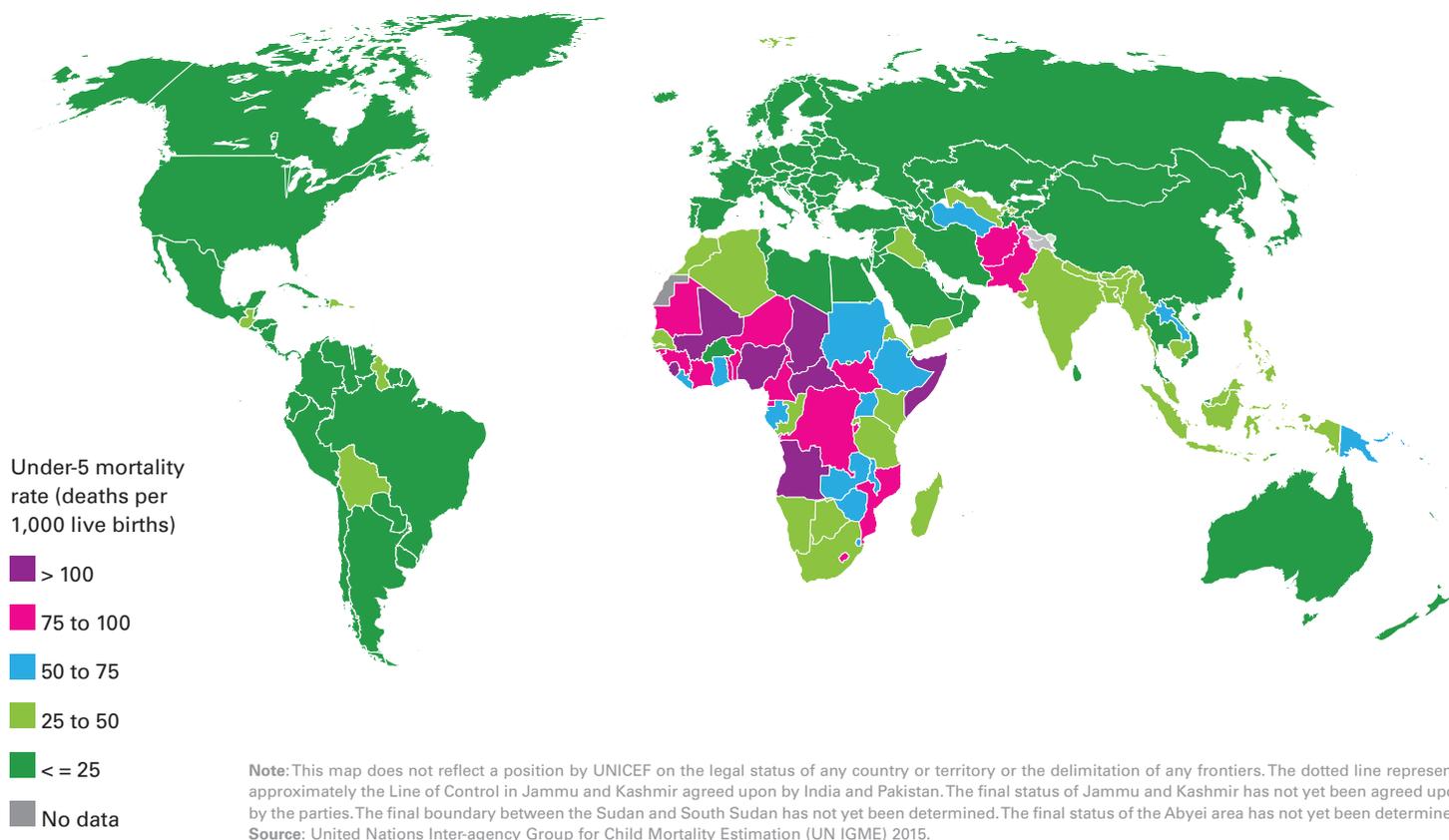
Neonatal deaths Post-neonatal under-5 deaths (aged 1–59 months)

Source: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), 2015.



FIGURE 2.7

Under-5 mortality rate by country, 2015



If the pace of reduction in child mortality does not accelerate, about 69 million children – more than the current population of Thailand – will die before they reach their fifth birthday between now and 2030, with 3.6 million of these lives lost in 2030 alone. Among 10–19-year-olds, there were an estimated 1.2 million deaths worldwide in 2015 – a modest drop in the adolescent mortality rate from 121 deaths per 100,000 in 2000 to 101 per 100,000.¹⁵ However, global AIDS-related deaths among adolescents aged 10–19 have more than doubled – from 18,000 in 2000 to 42,000 in 2015 – despite decreasing among all other age groups.¹⁶ Sub-Saharan Africa carries the greatest burden (about 85 per cent) of AIDS-related deaths among adolescents.

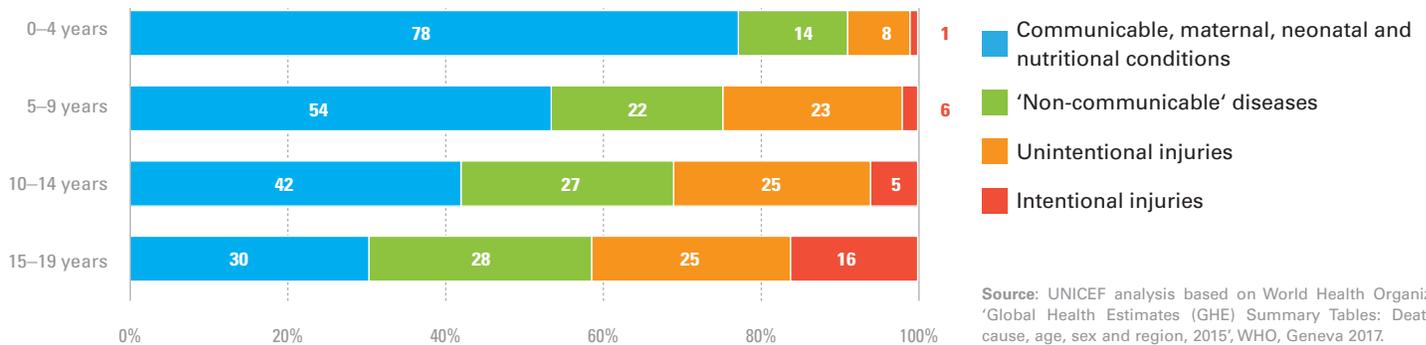
Adolescent mortality patterns differ by sex and age,¹⁷ with environmental and behavioural factors playing a more central role. For instance, the proportion of deaths due to intentional injuries among boys rises from 7 per cent at ages 10–14 to 19 per cent at ages 15–19, while it increases among girls from 6 per cent to 13 per cent.¹⁸ For girls aged 15–19, complications related to pregnancy and childbirth are the leading cause of death (followed by self-harm), with little change since 2000.¹⁹ However, there was a significant drop in the number of deaths from maternal causes among 15–19-year-old girls in all regions between 2000 and 2015.²⁰

The highest national under-5 mortality rates are found in sub-Saharan Africa



FIGURE 2.8

Percentage distribution of deaths among children aged 0–19 years in 2015, by cause and age group



Injuries become more prominent as a cause of death as children become adolescents

For adolescent girls and boys, suicide is a major cause of death, accounting for 6 per cent of all deaths, particularly among 15–19-year olds. Road injuries are the leading cause of deaths for all adolescents – 10 per cent of all adolescents die from road injuries. This number is particularly high for boys, accounting for 16 per cent of deaths among boys aged 15–19 years and 8 per cent among boys aged 10–14 years.

Children are particularly susceptible to air pollution because they breathe in more air per unit of body weight than adults, and studies indicate that ultrafine particles can even do permanent damage to children's brain tissue.²¹ In addition, nearly 600,000 children under 5 die from diseases caused or exacerbated by the effects of air pollution in 2012.²²

Data availability

Only about 60 countries have child mortality data exclusively from vital registration systems. Estimations for the remaining countries rely on a mixture of vital registration, sample vital registration and census and/or household survey data, which may suffer from errors such

as misreporting of age and under-reporting of child deaths. Disaggregation of child mortality by subgroups can also be challenging (*figure 2.9*). From 2000 onward, there are almost twice as many survey or census data for under-5 mortality than for neonatal mortality. Even fewer data are disaggregated by sex and socio-economic dimensions. In addition, the most recent data for more than 70 countries in 2015 were more than five years old. Estimating adolescent mortality is problematic as well due to lack of high-quality data.

Addressing data gaps

To collect mortality data, strengthening of vital registration systems is imperative, both to improve the accuracy, timeliness and disaggregation by age, sex and sub-national level of mortality estimation and to track more closely those children whose rights to health, education, equality and protection remain unrealized. In the shorter term, household surveys will remain the primary sources of information on child mortality for most countries. Sample registration systems and or surveillance systems are also useful for collecting mortality data.



FIGURE 2.9

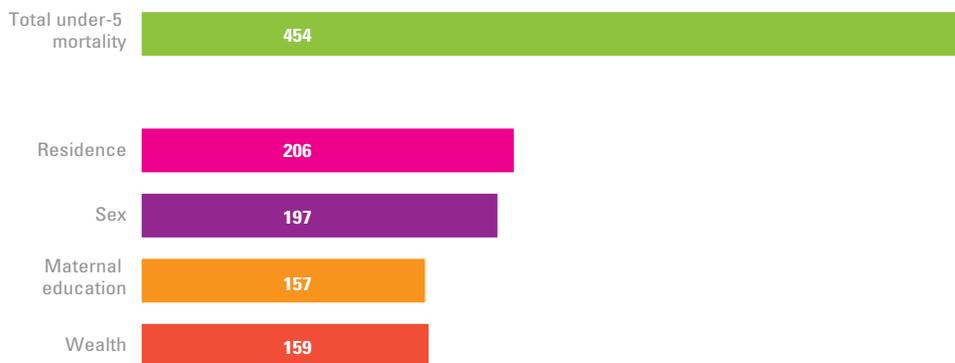
Number of available surveys/censuses since 2000 by disaggregation
a) By age group



Availability of disaggregated child mortality data is limited

Note: The number of data series reflects the number available for each country. Some of these data may have low quality.
Source: UNICEF analysis based on the database of the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) as of September 2015.

b) Under-5 mortality by residence, sex, maternal education and wealth



Okelo Faruq, 13-year-old boy, outside Kitgum hospital in northern Uganda.

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 Bongyereirwe

In 2004, the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) was formed to harmonize child mortality estimates on behalf of the United Nations system. The UN IGME is led by UNICEF, which has been working on child mortality monitoring and reporting for decades. The group generates child mortality estimates for monitoring progress on child survival, including progress on equity; updates the methodology to estimate child mortality; and reinforces national capacity to produce timely and accurate child mortality estimates. UNICEF together with the UN IGME is currently working on further improving methods to estimate adolescent mortality. Plans have been made to collect better adolescent mortality data and generate more reliable mortality estimates.





GOAL 03

Maternal and reproductive health

Despite significant declines in maternal deaths worldwide, rates remain very high in some regions

Current status and trends

In 2015, there were an estimated 303,000 maternal deaths worldwide, equivalent to 830 per day. The maternal mortality rate (MMR) declined between 1990 and 2015 by 44 per cent (from 385 to 216 per 100,000 live births), but large disparities still exist across countries. The SDG target is a global average MMR of less than 70 maternal deaths per 100,000 live births by 2030. To achieve the *global* target for maternal mortality reduction requires every country to reduce its national MMR from baseline by two thirds in that time frame. The average rates in sub-Saharan African countries reached 546 in 2015. West and Central Africa had the highest rate, at 679, and is home to the country with the highest MMR in the world (Sierra Leone: 1,360).

Sub-Saharan Africa also experienced the slowest decline in MMR (45 per cent between 1990 and 2015), with West and Central Africa showing a decline of just over a third (37 per cent). South Asia experienced the greatest decline, cutting its MMR by two thirds (67 per cent), mainly due to maternal deaths being reduced by more than 70 per cent in India (*figure 2.10*).

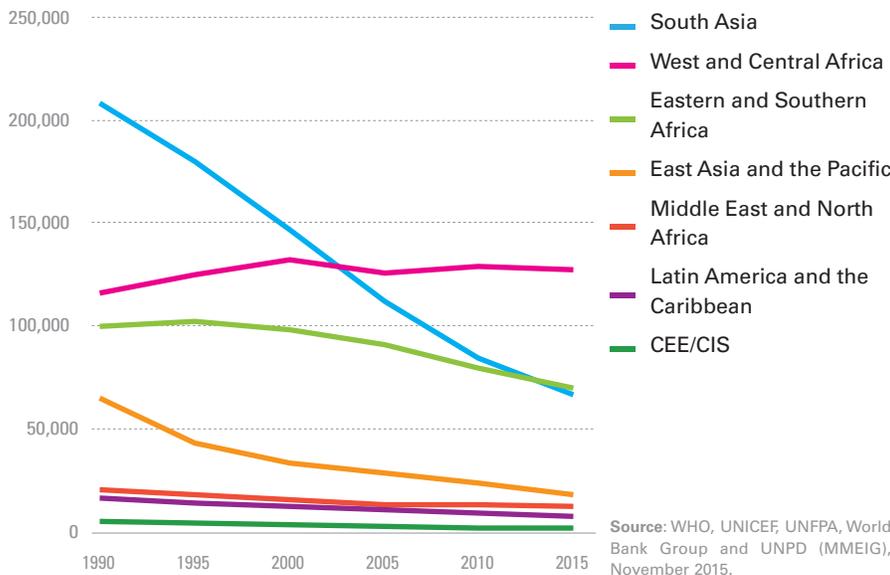
Based on projections by the United Nations Maternal Mortality Estimation Inter-Agency Group (MMEIG), maintaining the current annual rate of reduction will result in a global MMR of 161 by 2030, far above the SDG target.

One critical strategy for reducing maternal morbidity and mortality is ensuring that every baby is delivered with the assistance of a skilled birth attendant. Globally, three out of four births – an estimated total of more than 100 million – were delivered with the attendance of a skilled health professional in 2015. However, large disparities remain across regions and countries. West and Central Africa have the lowest rate in the world, while East Asia and the Pacific, Latin America and the Caribbean and CEE/CIS have reached almost universal coverage (*figure 2.11*). Although substantial progress has been observed in the past decade in most regions, the poor-rich gap has not been reduced except in CEE/CIS. In 2015, in Sub-Saharan Africa, women in the richest 20 per cent of the population are 3 times more likely than women in the poorest quintile to have a skilled birth attendant at delivery (85 per cent versus 30 per cent).

More than three women in four around the world had their demand for family planning satisfied with modern methods in 2015, but this rate has remained unchanged since 2000.

FIGURE 2.10

Trends in number of maternal deaths by region, 1990–2015





Regions with the highest fertility rates, such as sub-Saharan Africa, also have the lowest rates of demand satisfied – only about a third of women of reproductive age in West and Central Africa in 2015 (*figure 2.12*). However, sub-Saharan African countries had the largest increases in demand satisfied since 2000, including a rise from 39 per cent to 60 per cent in Eastern and Southern Africa.

The global rate for adolescent birth rate is 50 births per 1,000²³ adolescents 15–19. Pregnancy during adolescence can affect an adolescent girl for the rest of her life, including through adverse effects on health (such as fistula), chances of continuing schooling and economic status. The highest rates were in high fertility settings such as sub-Saharan Africa, with more than 100 births per 1,000 adolescents on average and many countries reaching more than 150 (*figure 2.13*).

Universal health coverage

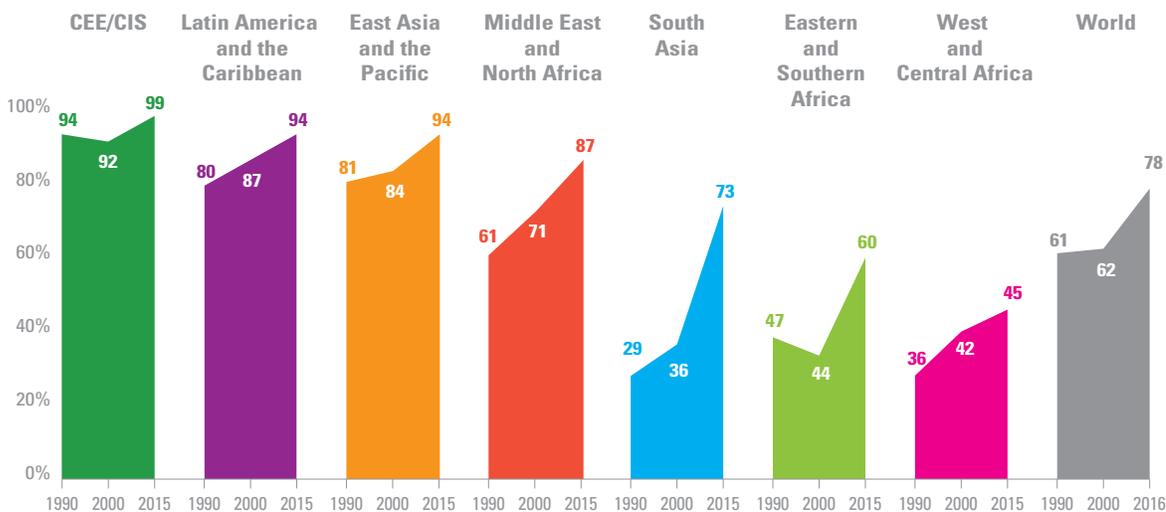
The universal health coverage (UHC) target aims to ensure that everyone obtains good-quality essential health services that they need, without undue financial hardship. Health services refer to promotion, prevention, treatment, rehabilitation and palliation. The financial part of the definition refers to protection from financial hardship, including possible impoverishment, due to out-of-pocket payments for health services. The concept of UHC is that both components benefit the entire population.²⁴

While recognizing that each country may have different health priorities and will develop its own indicators accordingly, a set of 16 tracer indicators has been proposed following extensive review and discussion.²⁵ Data for these

Skilled birth attendance has substantially increased in most regions since 2000

FIGURE 2.11

Percentage of births attended by a skilled health personnel by region, 1990-2016



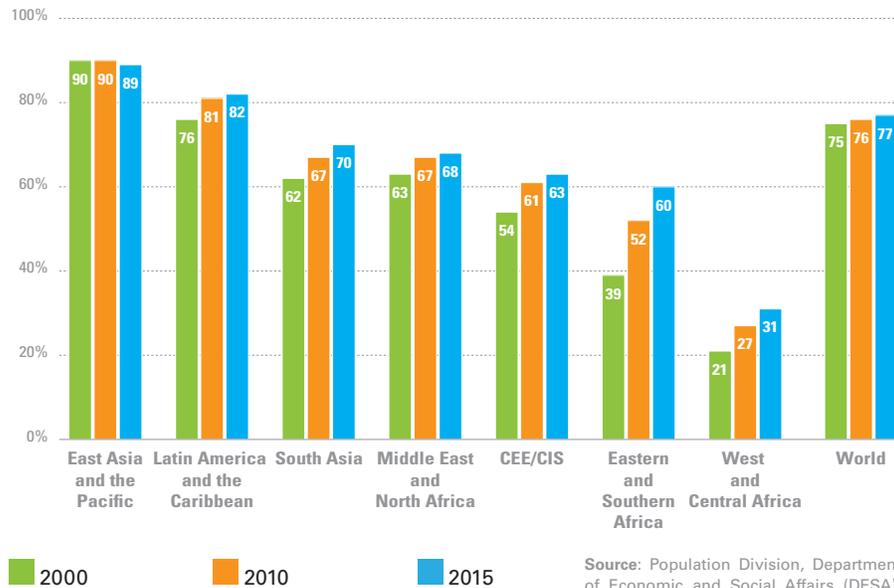
Note: Includes data on institutional births for countries in which data on skilled attendance at birth were not available.

Source: Joint UNICEF/WHO database 2016 of skilled health personnel, based on population-based national household survey data and routine health systems.



FIGURE 2.12

Percentage of women aged 15–49 with demand for family planning satisfied with modern methods by region



Source: Population Division, Department of Economic and Social Affairs (DESA), United Nations, 2016 estimates.

In West and Central Africa, just one third of the demand for family planning is satisfied by modern methods

indicators come from a mix of sources including household surveys and administrative data. The indicators are grouped into four main categories, each with four indicators: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) non-communicable diseases; and (4) service capacity and access, and health security. These are then combined into a UHC service coverage index. With regard to tracking levels of financial coverage, the framework is somewhat simpler, proposing the use of two indicators: the incidence of impoverishment resulting from out of pocket health payments, and the incidence of financial catastrophe from the same cause. However, wide availability of such data across countries is still a challenge.

Out of the 16 suggested tracer indicators, 8 are directly related to the well-being of mothers and children and UNICEF has been monitoring them over the past two decades: full child

immunization, health-seeking behaviour for child pneumonia, tuberculosis effective treatment, HIV antiretroviral treatment, insecticide-treated net (ITN) coverage for malaria prevention, family planning coverage, antenatal and delivery care, and improved water and sanitation facilities. The remaining eight are: prevalence of raised blood pressure, prevalence of raised blood glucose, cervical cancer screening, tobacco (non-use), basic hospital access, health-worker density, access to essential and health security, and international health regulations compliance medicines.

Given the number of indicators, there is a potential risk that the index obscures lack of progress for specific child and maternal health interventions because of the averaging effect, so it will be essential not to lose track of the individual tracers or the index.

Data availability

Although noteworthy improvement occurred in the past decade, wide availability of reliable and accurate data on maternal mortality remains a global and national challenge. Maternal mortality data generally come from vital registration statistic systems, population-based household surveys, censuses and specialized studies (e.g., confidential enquiries). The 2015 MMR estimates developed by the MMEIG were based on data available for 171 countries; no data had been provided since 2010 by 55 of these countries or since 2005 by 9 others. Available data remain insufficient for generating reliable estimates disaggregated by age, geography and socioeconomic status.

Since 2010, some 70 per cent of 197 countries have data available for skilled attendance at birth. Data come mainly from household surveys such as MICS and DHS and allow disaggregation.



However, when they come from administrative records, disaggregation is limited. Comparability of this indicator across countries is also challenging as specific categories of 'skilled' providers vary.

In regards to the indicator on demand for family planning satisfied, since 2010, only 50 per cent of 197 countries have data available. These data mainly come from household surveys such as MICS and DHS, which allow disaggregation. However, frequency of these surveys varies by country. Only 75 per cent of countries have data available on adolescent birth rates since 2010 and these are only for adolescents aged 15–19. For the younger age group of 10–14, data on this indicator is rarely available, even though this is an issue of increasing relevance.

Addressing data gaps

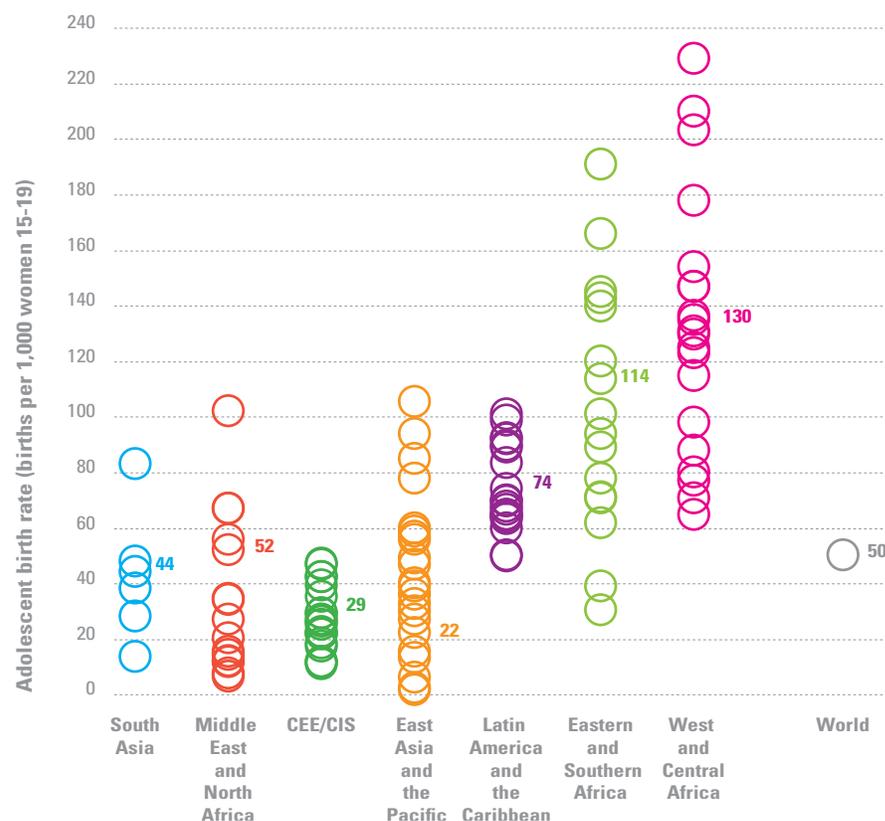
Data gaps for maternal and newborn care include those related to content and quality of antenatal, intra-partum and post-partum care, especially in cases of complication. The Every Newborn Action Plan, Ending Preventing Maternal Mortality and Global Strategy for Women's, Children's and Adolescents' Health have all identified critical areas where further indicator development and data collection are needed and work towards the validation of indicators to improve measurement capacity at the country and global levels, including indicators at the health facility level.

In addition, as custodian of SDG indicator 3.1.2 'Skilled attendant at birth', UNICEF, along with WHO and others, has taken steps to address issues regarding comparability and measurability of this key indicator. Current work includes the harmonization of global databases, systematic review of the literature looking at the different health cadres in country, creation

of country specific meta-data and revision of the definition to allow for more appropriate measurement. This work has been conducted along with other organizations including UNFPA as well as professional and academic institutions.

FIGURE 2.13

Adolescent Birth Rate by Region, 2009–2014* (annual number of births per 1,000 women aged 15–19)



Source: Most recent estimates for each country taken from 2015 Update for the MDG Database: Adolescent birth rate (UNFPA/United Nations Population Division).

Note: Empty circles refer to country values. Data values inside the chart refer to regional averages.

Adolescent birth rates vary widely by country and region



GOAL 03

HIV and AIDS, tuberculosis and malaria

Significant progress has been made in reducing new HIV infections in adolescents

HIV and AIDS

Current status and trends

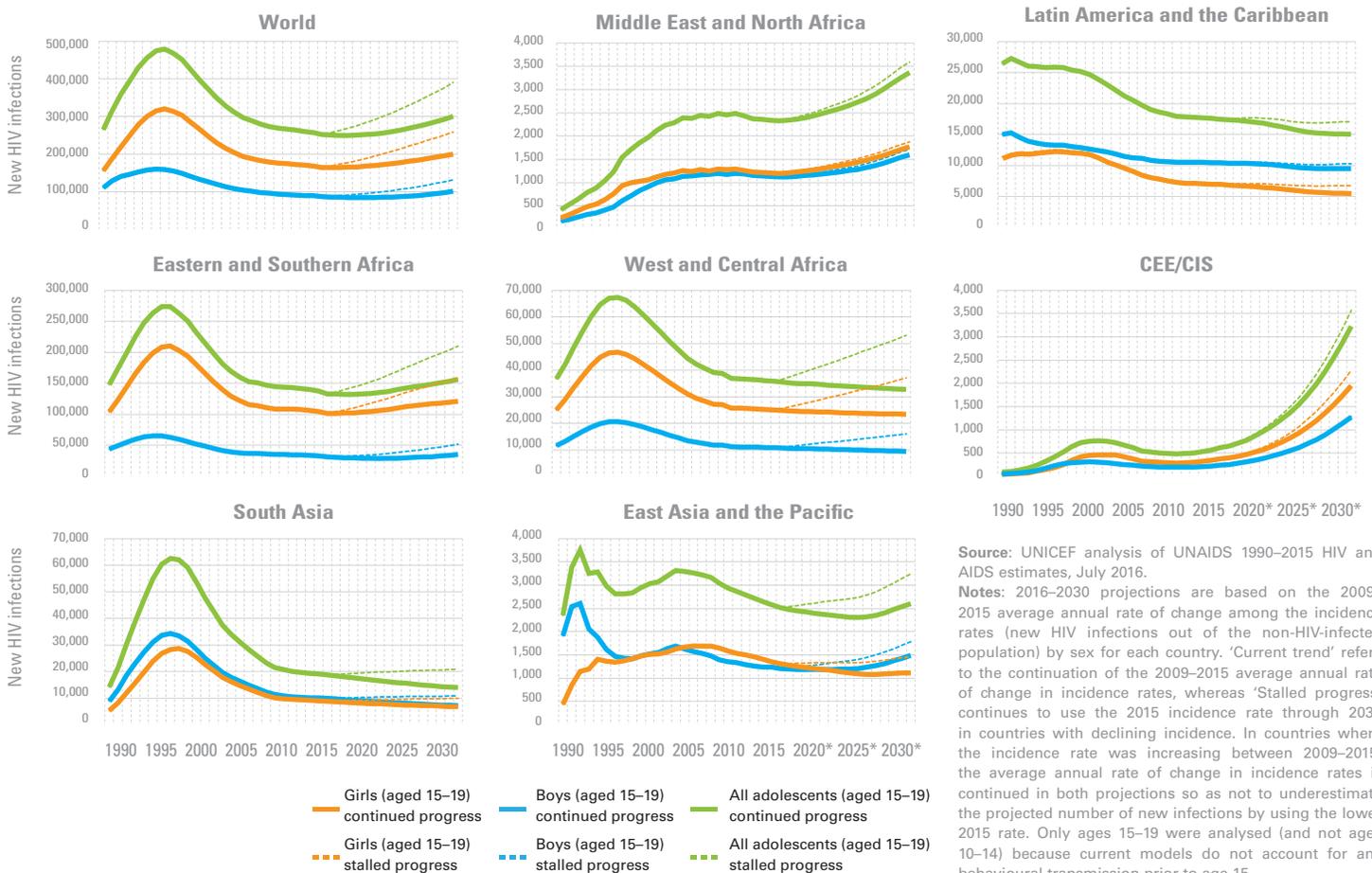
Globally, 150,000 children (aged 0–14) and 250,000 adolescents (aged 15–19) were newly infected with HIV in 2015 – with two out of every three new HIV infections among adolescents affecting adolescent girls.²⁶ This represents significant reductions from 490,000 children and 420,000 adolescents in 2000 (figure 2.14).²⁷

Due to scale-up of efforts to prevent mother-to-child transmission (MTCT) and for antiretroviral treatment (ART) (figure 2.15), the number of AIDS-related deaths among children declined from 240,000 in 2000 to 110,000 in 2015.²⁸ Many countries are now striving to virtually eliminate mother-to-child transmission of HIV in order to achieve the first HIV-free generation in decades.

The population aged 0–19 in sub-Saharan Africa, the region most affected by HIV, is expected to

FIGURE 2.14

Trends in estimated number of new HIV infections among adolescent girls and boys (aged 15–19), 1990–2015, with projections for 2016–2030 accounting for demographic shifts



Source: UNICEF analysis of UNAIDS 1990–2015 HIV and AIDS estimates, July 2016.
Notes: 2016–2030 projections are based on the 2009–2015 average annual rate of change among the incidence rates (new HIV infections out of the non-HIV-infected population) by sex for each country. 'Current trend' refers to the continuation of the 2009–2015 average annual rate of change in incidence rates, whereas 'Stalled progress' continues to use the 2015 incidence rate through 2030 in countries with declining incidence. In countries where the incidence rate was increasing between 2009–2015, the average annual rate of change in incidence rates is continued in both projections so as not to underestimate the projected number of new infections by using the lower 2015 rate. Only ages 15–19 were analysed (and not ages 10–14) because current models do not account for any behavioural transmission prior to age 15.



increase from 520 million in 2015 to 700 million in 2030. Substantially more resources will thus be required just to maintain current rates of coverage for key interventions. Globally, even if current progress continues, population growth could cause the number of new HIV infections among adolescents to increase, while stalled progress could result in as many as 740,000 additional adolescents being newly infected between 2016 and 2030. This varies significantly by region, based on demographic and epidemiological projections, but will impact both boys and girls, with adolescent girls particularly affected in high-burden regions such as sub-Saharan Africa. The potential impact of these projections remains a critical issue for the future of HIV programming.

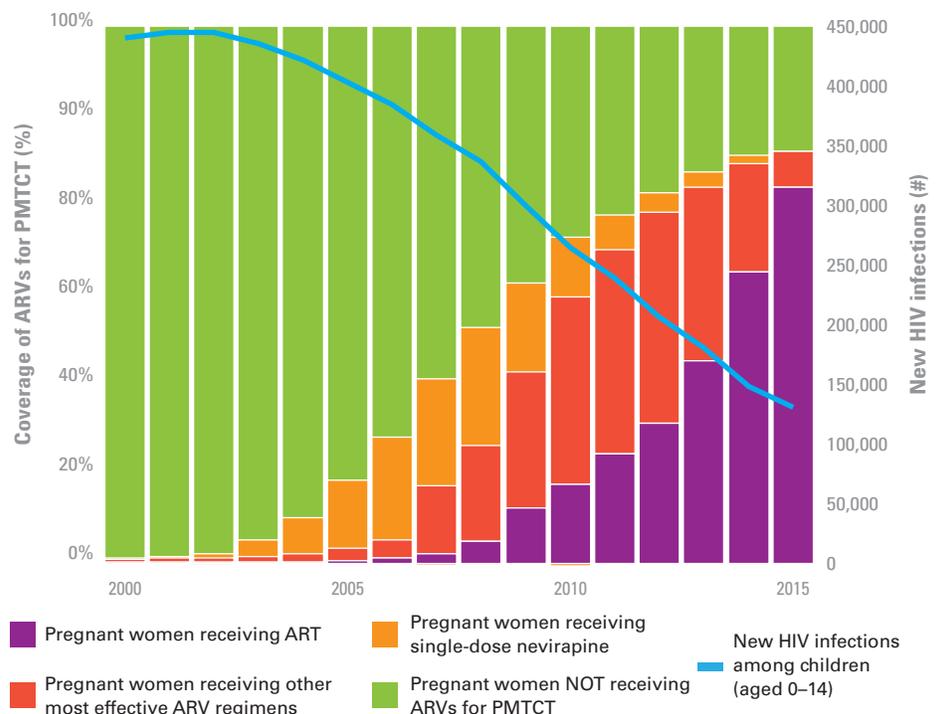
Data availability

The HIV and AIDS sector possesses a wealth of data spanning a substantial number of years. Data to report on the SDG indicator come from UNAIDS' annually modelled estimates and include global, regional, national and sometimes sub-national estimates of new HIV infections by age and sex. These estimates are produced annually for 160 countries representing 98 per cent of the global population. However, although drawing on the best available information, modelled estimates are based on many assumptions, and persistent input data gaps continue to affect their accuracy.

Specific data gaps include breastfeeding rates/duration among women living with HIV by antiretroviral (ARV) status, ART adherence/retention and ART coverage by age and sex. Surveys and surveillance survey data remain limited, particularly outside sub-Saharan Africa,

FIGURE 2.15

Distribution of the estimated number of pregnant women living with HIV receiving antiretroviral medicines for PMTCT by regimen and estimated number of new HIV infections among children (aged 0–14), global, 2000–2015



as do comparable data on younger populations (under 15). Data on HIV prevalence and fertility data among key population groups are also limited.

Addressing data gaps

To improve data collection and analysis for children and adolescents, priority areas include continuing to support countries to report on five-year age-disaggregated data; supporting national use of longitudinal registers to track mother-infant pairs; supporting harmonization between monitoring of HIV and other sectors

Source: UNICEF analysis of UNAIDS 2015 HIV and AIDS estimates, June 2016.

MTCT declined significantly between 2000 and 2015



(e.g., nutrition or immunization); and developing innovative ways to co-monitor HIV and other sectors and enable a comprehensive response.

Tuberculosis

Children with vulnerable immune systems, such as the very young, HIV-infected or severely malnourished, are most at risk for falling ill or dying from tuberculosis. Children with tuberculosis are often poor and living in vulnerable communities that lack access to health care. Adolescents are at particular risk of developing adult type disease, i.e., often sputum smear-positive and highly infectious.

Current status and trends

Tuberculosis is now the leading cause of death from infectious diseases globally, with an estimated 10.4 million new cases in 2015, 1 million of which were in children under age

15. Only 39 per cent of the estimated child tuberculosis cases were notified to tuberculosis programmes, pointing to massive under-diagnosis. In 2015, some 210,000 children died of the disease (about 575 children per day). Children represent about 10 per cent of all tuberculosis cases.²⁹ More than 67 million healthy children have latent tuberculosis infection and are at risk of developing the disease in the future,³⁰ and only 7 per cent of at least 1.2 million eligible children received preventive therapy in 2015.³¹ Researchers estimate that more than 25,000 children develop multi-drug-resistant tuberculosis every year.³²

Due to their large population size, South Asia and East Asia and the Pacific accounted for the majority of new child tuberculosis cases in 2015 (63 per cent), while African regions accounted for about 30 per cent (*figure 2.16*).

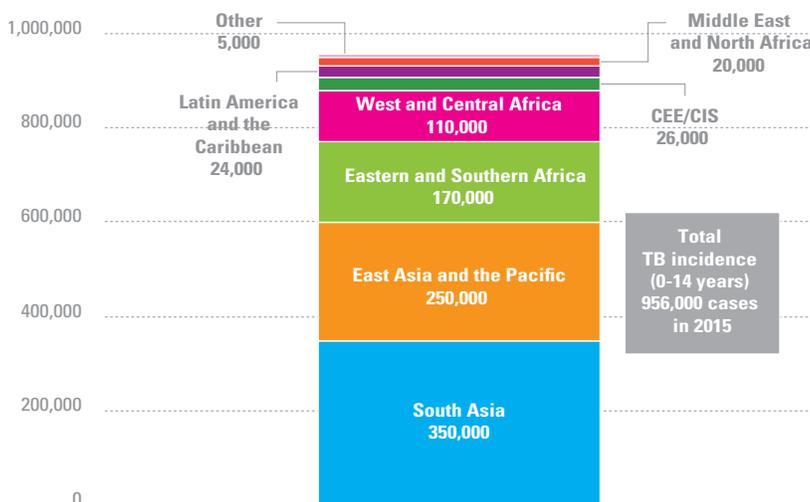
Data availability

Data to measure tuberculosis incidence come from countries' routine reporting on case notification and treatment outcomes, supplemented by national tuberculosis prevalence surveys (22 of which have been conducted between 2009 and 2016).

Tuberculosis incidence amongst children varies widely and the largest number of cases are concentrated in Asia

FIGURE 2.16

Tuberculosis - estimated number of cases among children under age 15



Source: World Health Organization, Global Tuberculosis Report 2016, WHO, Geneva, 2016.



Malaria

Current status and trends

WHO estimates that in 2015, there were 212 million cases of malaria worldwide across all age groups, a decrease of 22 per cent since 2000. Malaria remains a major killer of children under age 5, accounting for more than 300,000 child deaths, or 5 per cent of such deaths globally and 10 per cent in sub-Saharan Africa. Malaria takes the life of a child every two minutes. In areas with high transmission of malaria, children under 5 are particularly susceptible to infection, illness and death; about 70 per cent of all malaria deaths occur in this age group (*figure 2.17*). Malaria deaths among children have decreased by 60 per cent since 2000 and by 29 per cent since 2010.

Sleeping under an ITN and spraying the inside walls of a house with an insecticide – indoor residual spraying are the most commonly used methods to prevent malaria transmission. Use of ITNs has been shown to reduce malaria incidence rates by 50 per cent in a range of settings, and to reduce malaria mortality rates by 55 per cent in children aged under 5 years in sub-Saharan Africa.³³ WHO estimates that for countries in sub-Saharan Africa, 53 per cent of the population at risk slept under an ITN in 2015. Estimates for the 2010–2015 period derived from population-based household surveys indicate that in the region, 44 per cent of children slept under ITNs, which represents a drastic increase from less than 2 per cent in 2000.

Data availability

Data on key malaria control interventions, including availability and use of ITNs, diagnosis and treatment, particularly for children and pregnant women, come from nationally representative population-based surveys such as the MICS, DHS or Malaria Indicator Surveys.

These allow data to be disaggregated by socio-demographic and economic stratifiers. However, as the malaria control landscape changes rapidly, and household surveys are conducted every 3–5 years, in some instances data may not reflect the current malaria control situation in a timely manner. National malaria control programmes are also important sources of data at the national level. Availability of data on malaria deaths also varies between countries of low transmission and high transmission. Therefore, an innovative approach of increasing importance is to combine all these sources of data to generate data at national and sub-national levels.

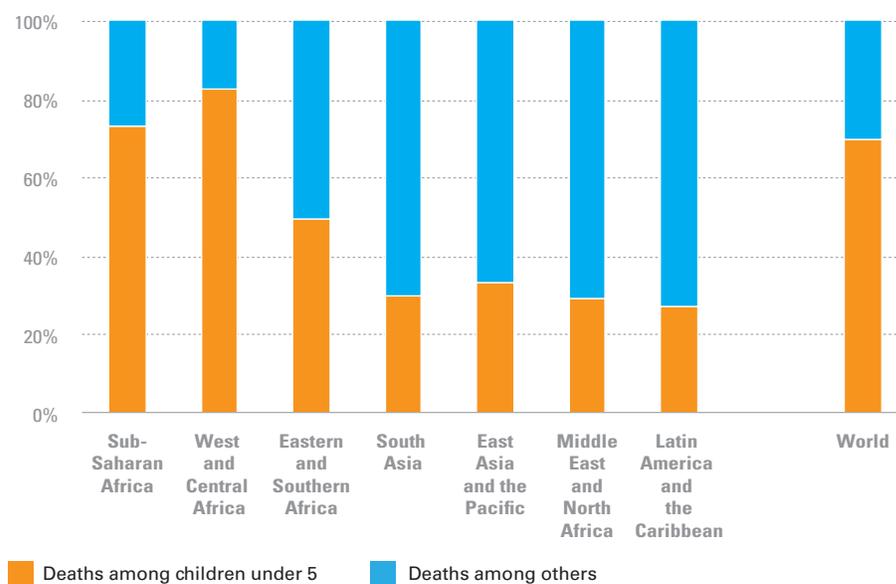
Addressing data gaps

Measurement priority areas range from expanding the scope of national malaria control programmes to regularly reporting on interventions in country as well as innovative ways to use household and facility surveys to provide better quality data on case management and treatment at the population level.

7 in 10 malaria deaths occur among children under five

FIGURE 2.17

Estimate of malaria deaths among children under 5 and total population, 2015



Source: World Health Organization estimates.

Early childhood development

4.2. By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education

4.2.1 Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being.

(Disaggregations: sex, location, wealth (and others where data are available))

4.2.2 Participation rate in organized learning (one year before the official primary entry age), by sex

Education

4.1 By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education, leading to relevant and effective learning outcomes

4.1.1 Percentage of children/young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary, achieving at least a minimum proficiency level in (i) reading and (ii) mathematics.

Disaggregations: sex, location, wealth (and others where data are available)

4.5 By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations

4.5.1 Parity indices (female/male, rural/urban, bottom/top wealth quintile and others such as disability status, indigenous people and conflict-affected as data become available) for all indicators on

this list that can be disaggregated

4.6 By 2030, ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy

4.6.1 Percentage of population in a given age group achieving at least a fixed level of proficiency in functional (a) literacy and (b) numeracy skills, by sex

4.7 By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development

4.7.1 Extent to which (i) global citizenship education and (ii) education for sustainable development, including gender equality and human rights, are mainstreamed at all levels in (a) national education policies, (b) curricula, (c) teacher education and (d) student assessment

4.a Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all

4.a.1 Percentage of schools with access to: (a) electricity; (b) the Internet for pedagogical purposes; (c) computers for pedagogical purposes; (d) adapted infrastructure and materials for students with disabilities; (e) single-sex basic sanitation facilities; and (f) basic hand-washing facilities (as per the Water, Sanitation and Hygiene (WASH) indicator definitions)



GOAL 04

Early childhood development

Children from the poorest quintile are less likely to be on track in literacy and numeracy

Early childhood is the most rapid period of development in a human life and forms the foundation for future well-being and learning.³⁴ Early childhood development (ECD) is multidimensional and refers to several aspects of a child’s well-being: physical, social, emotional and cognitive. As ECD sets the stage for lifelong thriving, it is one of the most critical and cost-effective investments a country can make. Economic analyses have found that investing in the early years yields some of the highest rates of return to families, societies and countries. Tracking children’s developmental outcomes (indicator 4.2.1) is therefore vital.

While indicator 4.2.2 looks at global monitoring of children’s enrolment in pre-primary education, it is important for countries to

also collect data on and monitor the status of children’s attendance in early childhood care and education (ECCE) programmes. Quality ECCE as early as age 3 promotes school readiness, builds social competency, improves learning outcomes and fosters overall developmental health and well-being.

Current status

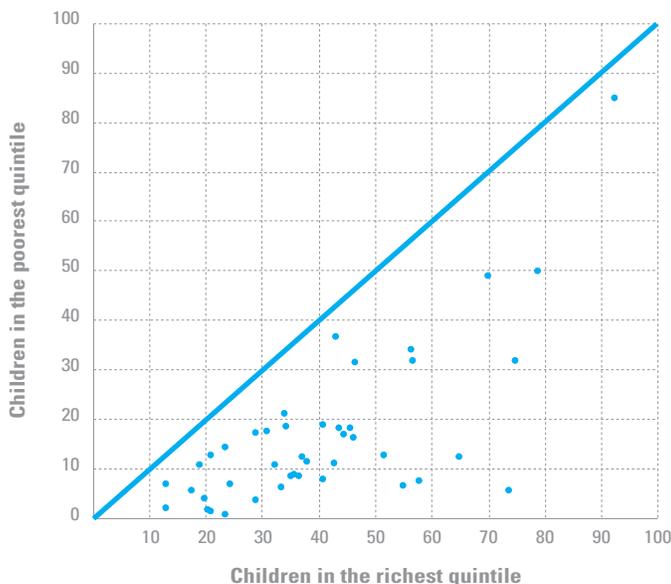
In general, children develop in a series of predictable stages as they learn increasingly advanced skills and capacities.³⁵ In the majority of the 58 countries with available data, more than half of children aged 3 to 4 are developmentally on track (*figure 2.19*). In all countries with comparable data, more than 85 per cent of children this age are considered to be on track in their physical development. With regard to learning and social-emotional development, the proportions of children on track vary widely but are above 50 per cent in nearly all countries. Children are least likely to be considered on track in the area of literacy-numeracy.

Available data indicate that children who attend ECCE programmes are more likely to be developmentally on track than those who do not. Children from the poorest quintile continue to be disadvantaged in access to quality ECCE, and data from 43 countries show they are less likely to achieve relevant milestones in literacy-numeracy (*figure 2.18*).

Data availability

While data and global monitoring efforts have existed for some time for certain domains of child development, there remains a critical lack of comparable evidence on children’s overall developmental status. UNICEF began working

FIGURE 2.18
Percentage of children aged 36–59 months who are developmentally on track in the literacy-numeracy domain, by household wealth quintile



Notes: Each dot represents a country. Dots along the diagonal line represent countries where literacy-numeracy is similar among children in the richest and poorest households, while those below the line are countries where children in the richest quintile are more likely to be developmentally on track in literacy-numeracy than children in the poorest quintile.
Source: UNICEF global databases, 2016, based on MICS, DHS and other nationally representative sources, 2010–2014.

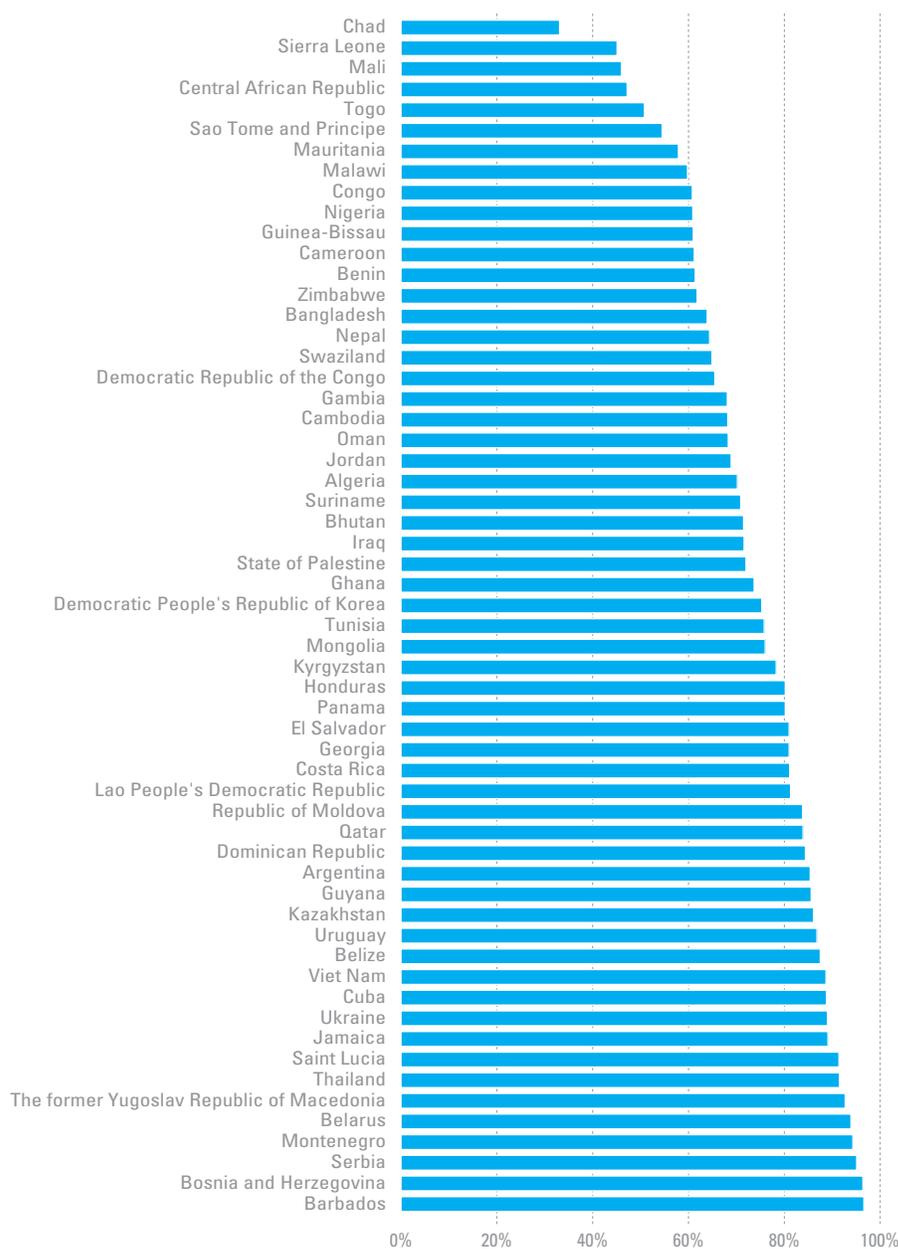


FIGURE 2.19

Percentage of children aged 36–59 months who are developmentally on track in at least three of the following domains: literacy-numeracy, physical development, social-emotional development and learning, in countries with available data

with partners in 2007 to address this knowledge gap. Following a review of existing tools, discussions and consultations among a broad group of experts, field testing and validation, an Early Childhood Development Index (ECDI) was developed to measure four domains – literacy-numeracy, physical, social-emotional and learning – and to monitor children’s achievement of universal developmental milestones across countries. UNICEF is currently leading new methodological work to further refine the ECDI and ensure that data collected through this tool align closely with the monitoring requirement for SDG target 4.2. With the inclusion of the ECDI for the first time in 2009, MICS has become an important source of data not only on factors that contribute to ECD, such as care and education, but also on actual developmental outcomes among children during the early years. MICS is now the largest source of comparable data on children’s developmental status across a variety of low- and middle-income countries and, along with existing evidence about the developing brain, provides a compelling case for more effective and better resourced and targeted interventions in ECD.

**In most countries,
more than half
of children are
developmentally
on track**



Notes: For Argentina, the sample was national and urban (municipalities with a population of more than 5,000), since the country's rural population is scattered and accounts for less than 10 per cent of the total. Data for Cambodia, the Democratic Republic of the Congo, Jordan and Togo refer to the youngest child in the household aged 36–59 months. Source: UNICEF global databases, 2016, based on MICS and DHS, 2009–2015.



GOAL 04 Education

Despite remarkable progress, the world missed the MDG target of universal primary education by 2015. SDG 4 calls for an even higher level of ambition, focusing on maximizing equity, quality and learning outcomes of education at all levels. The specific target on equity indicates that monitoring indicators should capture not only national averages but also the disparities and inequalities that exist among socio-demographic groups, including gender, wealth, location, and ethnicity or disability status.

Current status and trends

Recent household survey data reveal significant disparities in primary school completion rates (*figure 2.20*). While gender parity has been achieved in about half of the countries with data (parity index between 0.97 and 1.03), girls are still notably disadvantaged in a number of countries, particularly in Africa and the Middle East. Far bigger disparities are revealed, however, in terms of location of residence and household wealth. In the great majority of countries with data, children in rural areas have a much lower chance of completing primary education, and in almost all countries with data, children from the richest households are more likely to complete primary education than those from the poorest households. In some countries in sub-Saharan Africa, less than 20 children from the poorest households have completed primary education for every 100 children from the richest households.

Five out of the 10 targets under SDG 4 explicitly focus on learning outcomes. One of the important lessons learned from the MDGs is that expansion of access to education is not always accompanied by improvement in educational quality and learning outcomes. It is estimated that globally 250 million children are neither literate nor numerate, although more than half of them have completed at least four years of education.³⁶ Data from international and regional standardized learning assessments indicate that children struggle to acquire even the most basic academic skills in many countries (*figure 2.21*). For example, in the majority of the countries with data more than a quarter of children of lower secondary school graduation age did not achieve a minimum learning standard in mathematics. The learning challenge appears to start early, with a large proportion of children in early/middle grades of primary education struggling to master basic academic skills in many countries.

Safe and inclusive learning environments are imperative for children and young people to reach their full potential in education. Lack of school infrastructure and materials adapted for people with disabilities hinder many children and young people from accessing effective learning opportunities. Access to safe water, sanitation facilities and hygiene (WASH) in schools (indicator 4a.1) can improve educational opportunities and decrease the potential for disease transmission. Such access varies considerably by region (*figure 2.22*).



Data availability

Global monitoring of the ambitious education targets necessitates greater availability of robust, cross-nationally comparable data – particularly in areas such as equity and learning outcomes. However, data that capture the educational situation of the most disadvantaged and vulnerable populations are difficult to come by in most countries. Robust, let alone comparable learning outcome data (e.g., math and reading proficiency and functional literacy and numeracy) are also scarce in most of the world. In addition, while preliminary estimates for water and sanitation in schools are available for 149 countries, indicators are not harmonized between countries and do not always include criteria specified in the SDGs, such as single-sex toilets. Data on the availability of adapted infrastructure for students with disabilities are almost non-existent in the majority of countries. SDG monitoring also requires qualitative data in areas such as the adoption of education for sustainable development (targets 4.7 and 12.8), but such data are not yet widely available.

There are significant disparities in primary school completion rates, especially by residence and wealth

Note: Each dot represents the parity index of one country. The primary completion rate is defined as the percentage of a cohort of children aged 3–5 years above the intended age for the last grade of primary education who have completed that grade. The parity index is calculated by dividing the primary completion rate of one group (female, rural and poorest quintile) by that of another group (male, urban and richest quintile). The value of 1.00 indicates absolute parity, and values between 0.97 and 1.03 are considered to be an acceptable parity level.

Source: UNICEF global databases, 2017 based on MICS, DHS and national household surveys.

FIGURE 2.20

Parity index of primary completion rate by gender, residence and wealth quintile for countries with data between 2010 and 2016

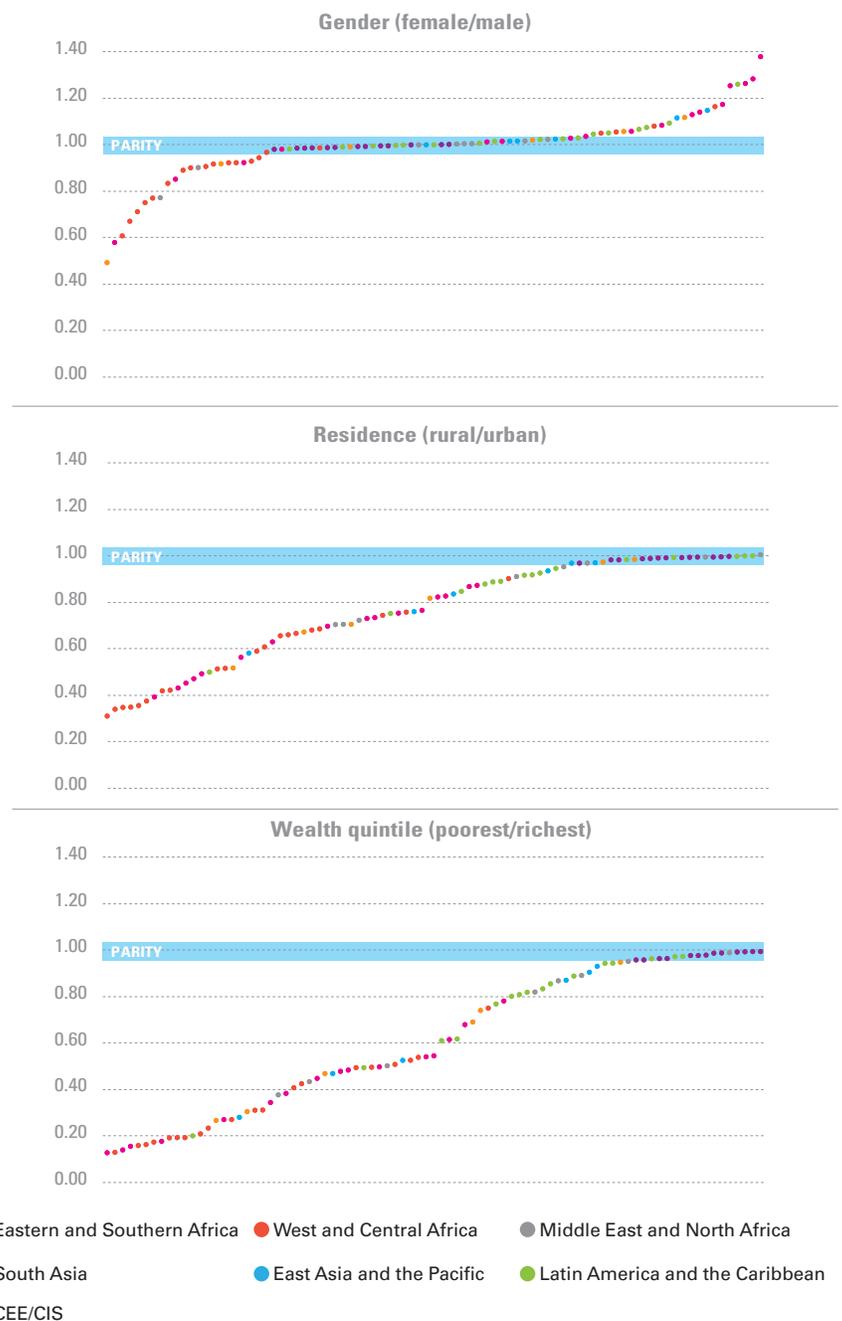
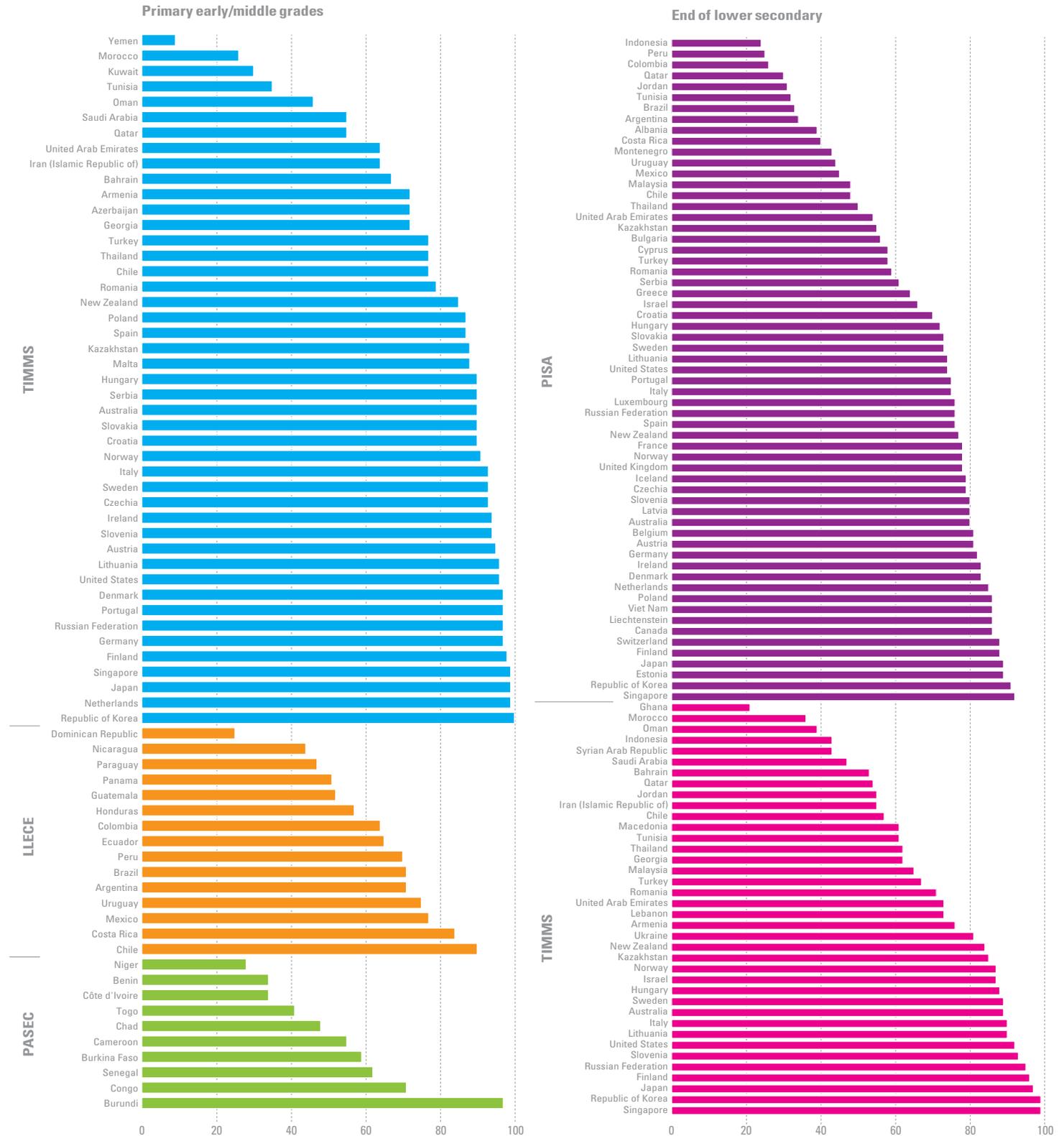




FIGURE 2.21

Percentage of children who achieved minimum learning benchmarks in mathematics in early primary grades and at the end of lower secondary education, selected countries with data from international and regional learning assessments





Many children around the world struggle to achieve basic academic skills

Note: The definition of achievement of a minimum learning benchmark is specified in each of the following surveys: the Analysis Programme of the CONFEM Education Systems (PASEC) – Level 2; Latin American Laboratory for the Assessment of the Quality of Education (LLECE) – Level 2; Trends in International Mathematics and Science Study (TIMSS) – Low international benchmark; Programme for International Student Assessment (PISA) – Level 2.

Source: UNICEF analysis based on World Bank EDSTATS learning outcome database, 2016.

Addressing data gaps

UNICEF has played and continues to play important roles in developing new data collection methods and instruments through household surveys. The MICS programme is developing a new module to capture the basic literacy and numeracy skills of children in order to avail cross-nationally comparable data on them. This will be an important addition to the existing MICS education module that has collected educational attainment and school attendance data in more than 100 countries over the past 20 years. The new learning module will be administered to children aged 7–14 years, including out-of-school children. The collected learning data will be disaggregated by socio-economic groups and used for the analysis of their links to home environments and individual characteristics. After going through field tests in three countries, the module is now part of the new round of MICS.

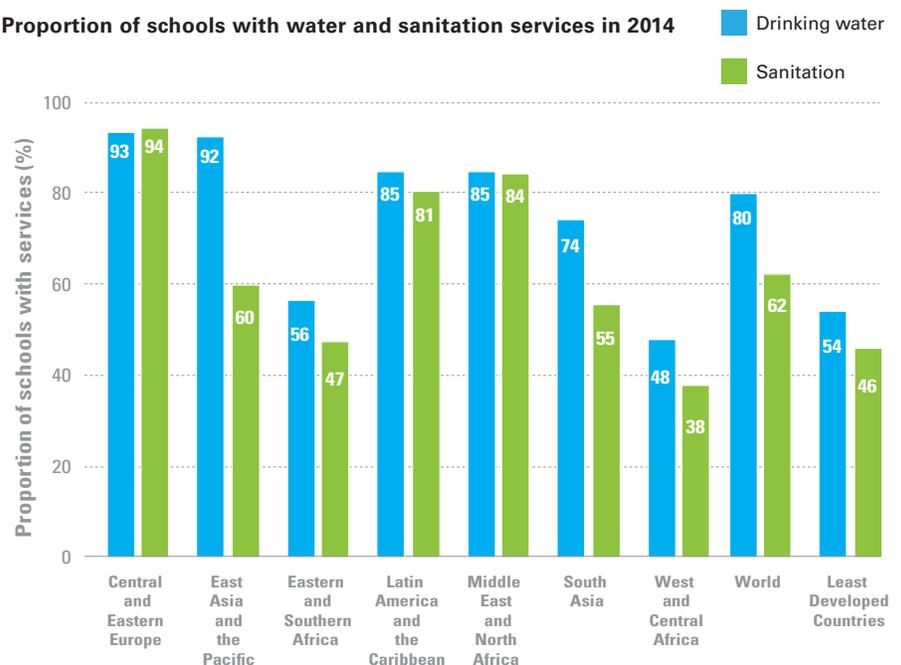
Access to water and sanitation in schools varies considerably by region



A teacher at an elementary school in Arua District, Uganda.
© UNICEF/
UN03350/Ose

FIGURE 2.22

Proportion of schools with water and sanitation services in 2014



Source: WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation global database, 2015.

GOAL



GENDER EQUALITY

**Violence
against girls
and women**

**Child
marriage**

**Female
genital
mutilation/
cutting**

Gender-based discrimination is one of the most ubiquitous forms of discrimination that girls and women face and is found in the family, school, community and society. Gender equality therefore cuts across all the goals,³⁷ but it is the specific focus of Goal 5. The most relevant indicators for girls are under targets 5.2 and 5.3 and cover intimate partner and sexual violence as well as harmful traditional practices.

Violence against girls and women

5.2. Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age

5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence

Child marriage

Female genital mutilation/cutting

5.3. Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

5.3.1 Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18

5.3.2 Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting, by age

5.6 Ensure universal access to sexual and reproductive health as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

5.6.1 Proportion of women aged 15–19 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care





GOAL 05

Intimate partner and sexual violence against girls and women³⁸

Intimate partner violence includes any abuse perpetrated by a current or former partner within the context of marriage, cohabitation or any other formal or informal union. Although anyone can experience it, intimate partner violence has been cited as the most common form of gender-based violence against girls and women.³⁹ Research confirms that girls who marry in childhood are at greater risk for intimate partner violence than same-age peers who marry later.⁴⁰ Partner violence can have devastating consequences for the health, well-being and overall development of these girls. Moreover, exposure to partner violence can also have intergenerational implications and be detrimental to children's development.⁴¹

Sexual violence has been defined as 'any sort of harmful or unwanted sexual behaviour that is imposed on someone'.⁴² A recent estimate published by WHO indicated that 7 per cent of all women worldwide have been sexually assaulted by someone other than a partner at some point in their lives.⁴³ Experiences of sexual violence during adolescence, an especially vulnerable period, hinder all aspects of development and can lead to early pregnancy (in cases of rape) as well as greater risks of experiencing intimate partner violence.⁴⁴ Research suggests that other groups at heightened risk include women with disabilities⁴⁵ and those living in emergencies and conflict situations.⁴⁶

Current status

Comparable data from 48 low- and middle-income countries indicate that prevalence rates for recent partner violence among girls and women aged 15 to 49 range from 8 per cent in Comoros to 46 per cent in Liberia (results not shown). In nearly

two thirds of the countries, girls aged 15 to 19 are more likely to report recent experiences of partner violence than older women aged 45 to 49 (*figure 2.23*). In three quarters of the countries with available data, more than one in five adolescent girls have experienced some form of violence at the hands of their partners in the past 12 months.

Around one in seven girls and women aged 15 to 49 in the 37 low- and middle-income countries with comparable data reported experiences of non-partner sexual violence in the past 12 months, with the proportion among adolescent girls aged 15 to 19 below 5 per cent in all but one of the countries (results not shown).⁴⁷

Data availability

The primary sources of prevalence data on violence are either dedicated national surveys or international household surveys such as DHS. DHS includes a standard module that asks all girls and women aged 15 to 49 who have ever been married or cohabited whether they have ever experienced various forms of physical, sexual or emotional violence perpetrated by a current or former spouse or partner. The module also includes questions on whether, at any time in their lives (as children or adults), anyone ever forced them – physically or in any other way – to have sexual intercourse or to perform other sexual acts against their will. Questions about both intimate partner and sexual violence are also asked in reference to experiences that occurred in the 12 months preceding the survey. Although administrative data can be a source of information on violence against girls and women, they reflect only cases officially reported to authorities – often the most severe ones – and are considered to be underestimates.



Addressing data gaps

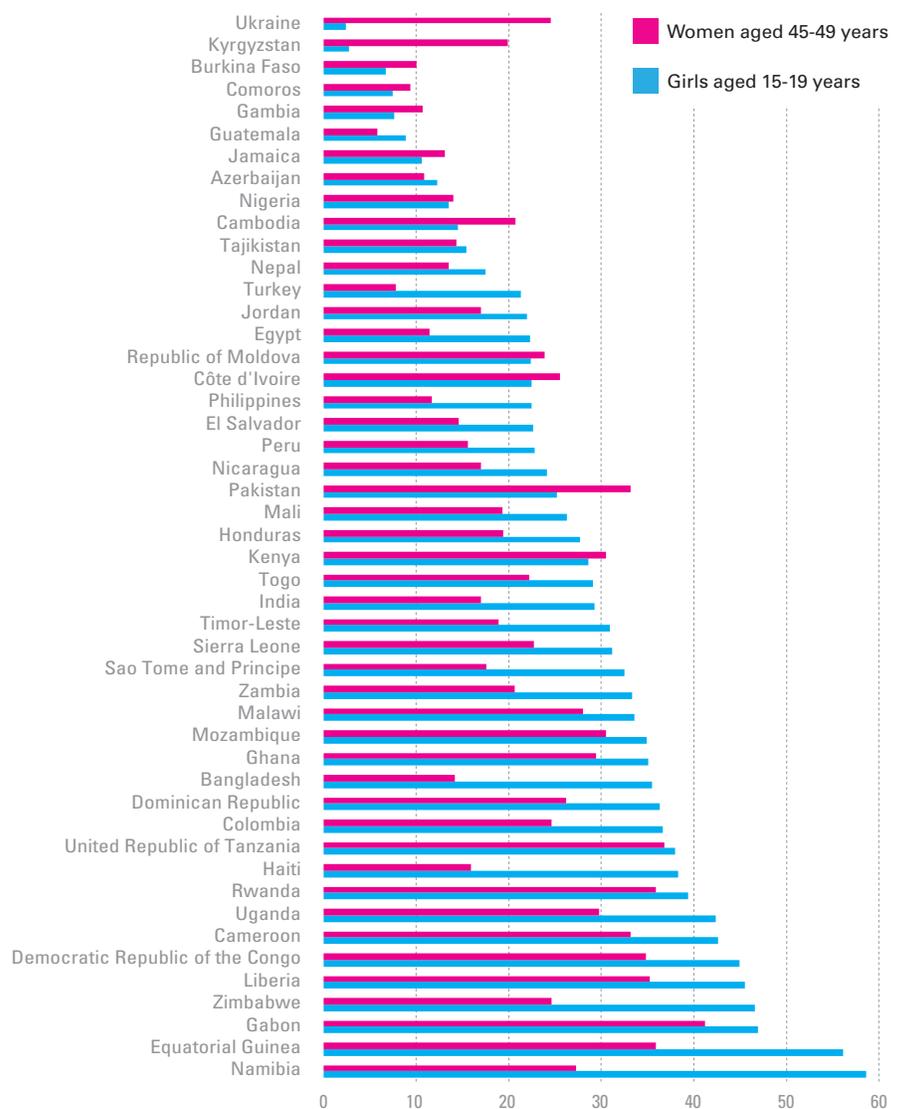
Although violence against women has been widely researched over the years, particularly in many high-income countries, the lack of comparable data is a serious obstacle to global monitoring. Many data collection efforts have relied on different study methodologies and used different definitions and diverse age groups, and limited data have been collected on forms such as sexual harassment or unwanted sexual touching.

Collecting reliable data on violence against girls and women is a complex and sensitive undertaking. One key consideration is girls' and women's willingness to disclose that they have been victims of violence and the need to maintain confidentiality, which involves taking careful steps to ensure that data collection is undertaken in a way that safeguards the privacy of respondents and ensures their safety.

In almost two thirds of countries with available data, adolescent girls are more likely to report experiencing intimate partner violence than older women

FIGURE 2.23

Percentage of ever-married girls aged 15–19 years and ever-married women aged 45–49 years who experienced any emotional or physical or sexual violence committed by a husband or partner in the past 12 months



Notes: Data for Bangladesh and Côte d'Ivoire refer to currently married girls and women only. For Equatorial Guinea, data refer to women aged 40–49 years and only to physical or sexual violence and data for girls aged 15–19 are based on 25–49 unweighted cases. Data for Guatemala refer to women aged 40–49 and all data refer only to physical or sexual violence. Data for Jamaica refer to girls aged 15–24 years and women aged 35–49. Data for Namibia and Ukraine for girls aged 15–19 are based on 25–49 unweighted cases. Data for Pakistan refer only to emotional or physical violence. Data for Turkey refer to girls aged 15–24 and women aged 45–59 who experienced any physical or sexual violence. Source: UNICEF global databases, 2016, based on DHS and other nationally representative surveys, 2005–2015.



GOAL 05 Child marriage

Marriage before the age of 18 is a fundamental violation of human rights. Many factors interact to place a girl at risk of marriage, including poverty, the perception that marriage will provide 'protection', family honour, customary or religious laws that condone the practice, deeply embedded social or gender norms associated with womanhood, an inadequate legislative framework and the state of a country's civil registration system. Child marriage (or cohabitation) often compromises a girl's development by resulting in early pregnancy and social isolation, interrupting her schooling, limiting her life opportunities and increasing her risk of experiencing domestic violence.

The issue of child marriage is addressed in a number of international conventions and agreements.⁴⁸ Although not mentioned directly in the Convention on the Rights of the Child, it is linked to other rights, such as freedom of expression and protection from all forms of abuse and from harmful traditional practices.

Current status and trends

Worldwide, almost 750 million women and girls alive today were married before their eighteenth birthday. Child marriage is most common in West and Central Africa, where over 4 in 10 girls were married before age 18; about 1 in 7 were married or in union before age 15 (*figure 2.24*). The Niger has the highest overall prevalence of child marriage in the world, while the Central African Republic and Chad have the highest rates of marriage involving girls under age 15.

Globally, child marriage has been slowly declining, with around one in four young women alive today married in childhood versus around

one in three in 1990, and the fastest progress has been recorded in the Middle East and North Africa (*figure 2.25*). Moreover, the marriage of girls under 15 years of age has declined, from 10 per cent in 1990 to 6 per cent today. If the current rate of progress is sustained, the proportion of young women married as children will continue to decrease; however, due to population growth, the total number will remain around 750 million in 2030. If current trends continue, a third of child brides in 2030 will be African.

Data availability

International household survey programmes have been collecting data on the issue of child marriage in low- and middle-income countries since around the late 1980s. In some countries, such data are also collected through national censuses or other national household surveys. UNICEF and ICF International have worked closely together over the years to harmonize survey questions on child marriage in the DHS and MICS, which together represent the world's largest source of internationally comparable data on this issue. Currently, data on child marriage are available from more than 400 sources, spanning 1985 to 2015 and covering 124 low- and middle-income countries. Data can be disaggregated by a number of important background characteristics and trend analyses at the global, regional and country level are also possible.

Because data on marital status and age at first marriage collected through MICS and DHS are also available for boys and men (in addition to girls and women), these surveys allow for a determination of the levels of child marriage among boys as well (*see box 2.2*).

BOX 2.2

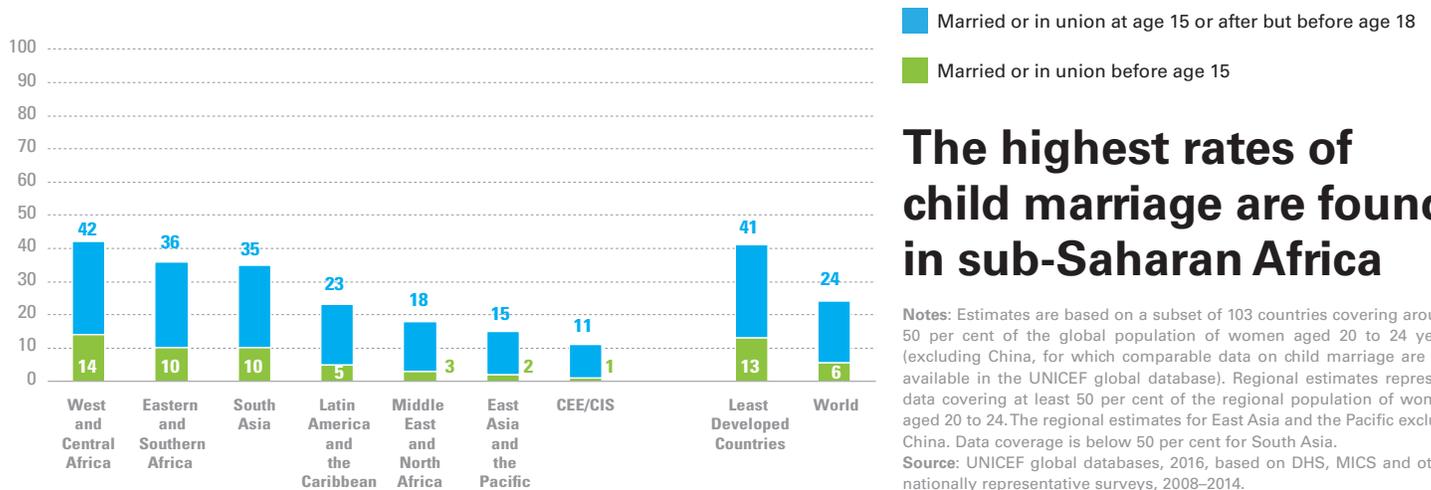
Child marriage among boys

Analysis of child marriage typically focuses on girls, who are the most affected. However, child marriage also exists among boys. While a child groom does not face the health risks of early childbearing that a child bride does, he may face different challenges in fulfilling adult roles while still a child, such as the pressure to provide for his family. Globally, levels of child marriage among boys are about one fifth of the levels among girls.



FIGURE 2.24

Percentage of women aged 20–24 years who were first married or in union before age 15 and before age 18, by region

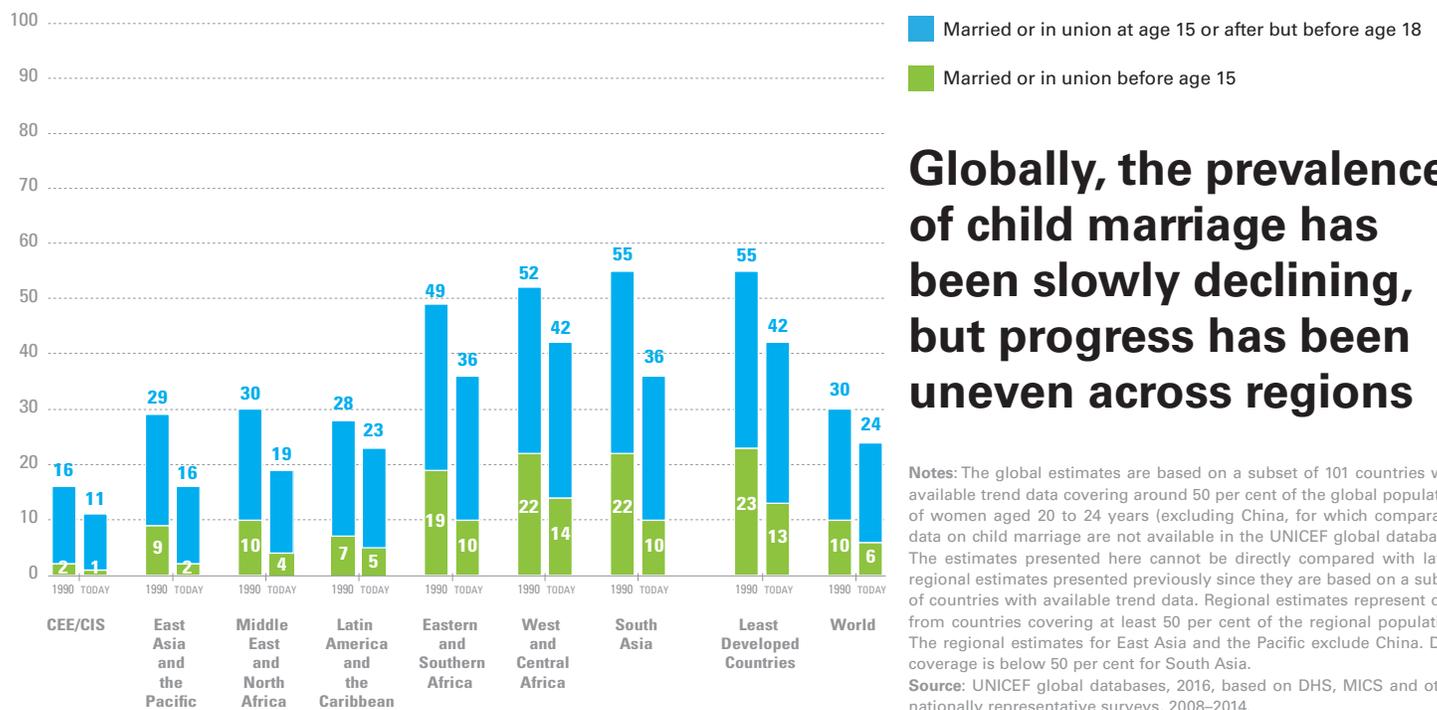


The highest rates of child marriage are found in sub-Saharan Africa

Notes: Estimates are based on a subset of 103 countries covering around 50 per cent of the global population of women aged 20 to 24 years (excluding China, for which comparable data on child marriage are not available in the UNICEF global database). Regional estimates represent data covering at least 50 per cent of the regional population of women aged 20 to 24. The regional estimates for East Asia and the Pacific exclude China. Data coverage is below 50 per cent for South Asia. Source: UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys, 2008–2014.

FIGURE 2.25

Percentage of women aged 20–24 years who were married or in union before age 15 and before age 18, by region



Globally, the prevalence of child marriage has been slowly declining, but progress has been uneven across regions

Notes: The global estimates are based on a subset of 101 countries with available trend data covering around 50 per cent of the global population of women aged 20 to 24 years (excluding China, for which comparable data on child marriage are not available in the UNICEF global database). The estimates presented here cannot be directly compared with latest regional estimates presented previously since they are based on a subset of countries with available trend data. Regional estimates represent data from countries covering at least 50 per cent of the regional population. The regional estimates for East Asia and the Pacific exclude China. Data coverage is below 50 per cent for South Asia. Source: UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys, 2008–2014.



GOAL 05 Female genital mutilation/cutting



Women of Baghdad village attend an awareness-raising session on female genital mutilation/cutting with UNICEF's implementing partner CORDAK.
© UNICEF/UN05215/Dragaj

Female genital mutilation/cutting (FGM/C) refers to 'all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons'.⁴⁹ There is a large body of literature documenting its adverse health consequences over both the short and long term.

FGM/C is condemned by a number of international treaties and conventions.⁵⁰ Moreover, since it is regarded as a traditional practice prejudicial to the health of children, it violates the Convention on the Rights of the Child. National legislation in many countries also includes explicit bans against FGM/C. In 2012, the United Nations General Assembly adopted a milestone resolution calling on the international community to intensify efforts to end this abuse of human rights.⁵¹

Current status and trends

While exact numbers remain unknown, at least 200 million girls and women have undergone FGM/C in the countries with representative data on prevalence.⁵² Levels are above 90 per cent in Djibouti, Guinea and Somalia, but only 1 per cent in Cameroon and Uganda (*figure 2.26*).⁵³

Overall, the practice of FGM/C has been declining over the past three decades. In countries with nationally representative data, around one in three girls aged 15 to 19 today have undergone the practice, versus one in two in the mid-1980s. However, not all countries have made progress and the pace of decline has been uneven. Even if the rate of progress achieved over the past 30 years is sustained, the number of girls affected is estimated to reach close to 235 million by 2030.

Data availability

To date, nationally representative data on FGM/C have been generated mainly through DHS and MICS: 60 DHS surveys for 25 countries and more than 30 MICS for 19 countries. There have also been other efforts to collect data in countries where it is widely known to be taking place. For instance, in 2013, the Ministry of Health in Indonesia included questions on FGM/C among the youngest girls aged 0–11 years in a household survey, thus producing national prevalence data on the issue for the first time.

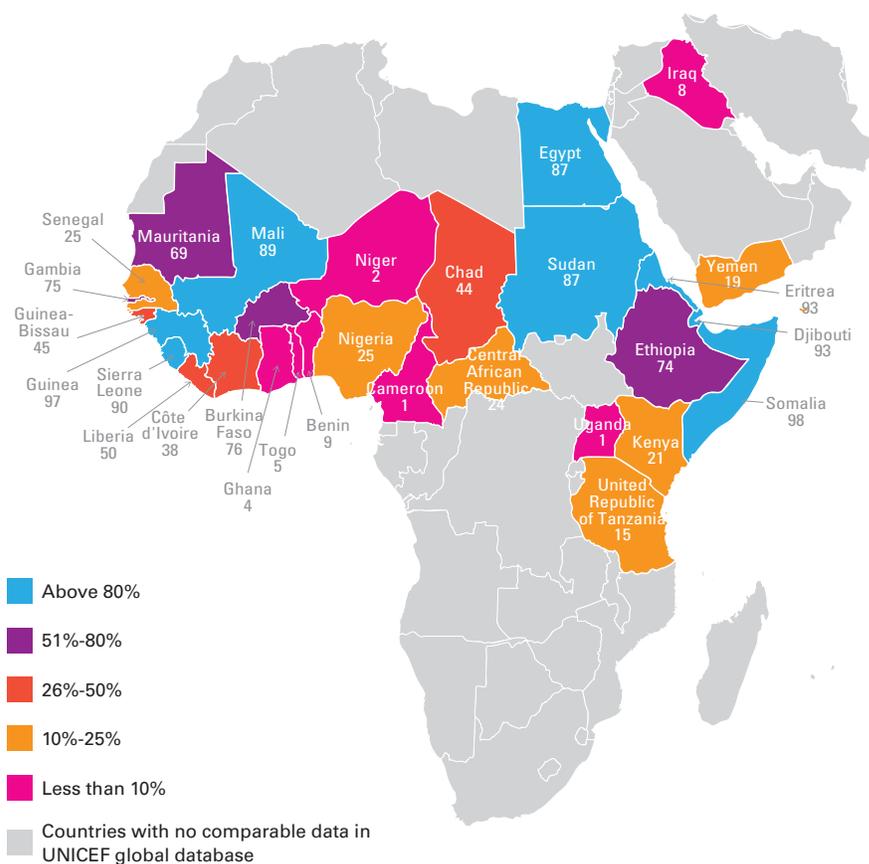


Addressing data gaps

More data collection is urgently needed in high-income countries that are destinations for migrants from countries where the practice still occurs, as well as low- and middle-income places such as Colombia,⁵⁴ India,⁵⁵ Malaysia,⁵⁶ Oman,⁵⁷ Saudi Arabia⁵⁸ and the United Arab Emirates,⁵⁹ where small-scale studies and anecdotal accounts suggest that FGM/C exists. This will ensure a more reliable and complete picture of the practice in order to accurately measure progress towards the common goal of eliminating FGM/C.

FIGURE 2.26

Percentage of girls and women aged 15–49 years who have undergone FGM/C



The prevalence of FGM/C varies greatly across countries with available data

Note: In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM/C, since it is performed during initiation into the society.
Source: UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys, 2004–2015.



CLEAN WATER AND SANITATION

Water, sanitation and hygiene

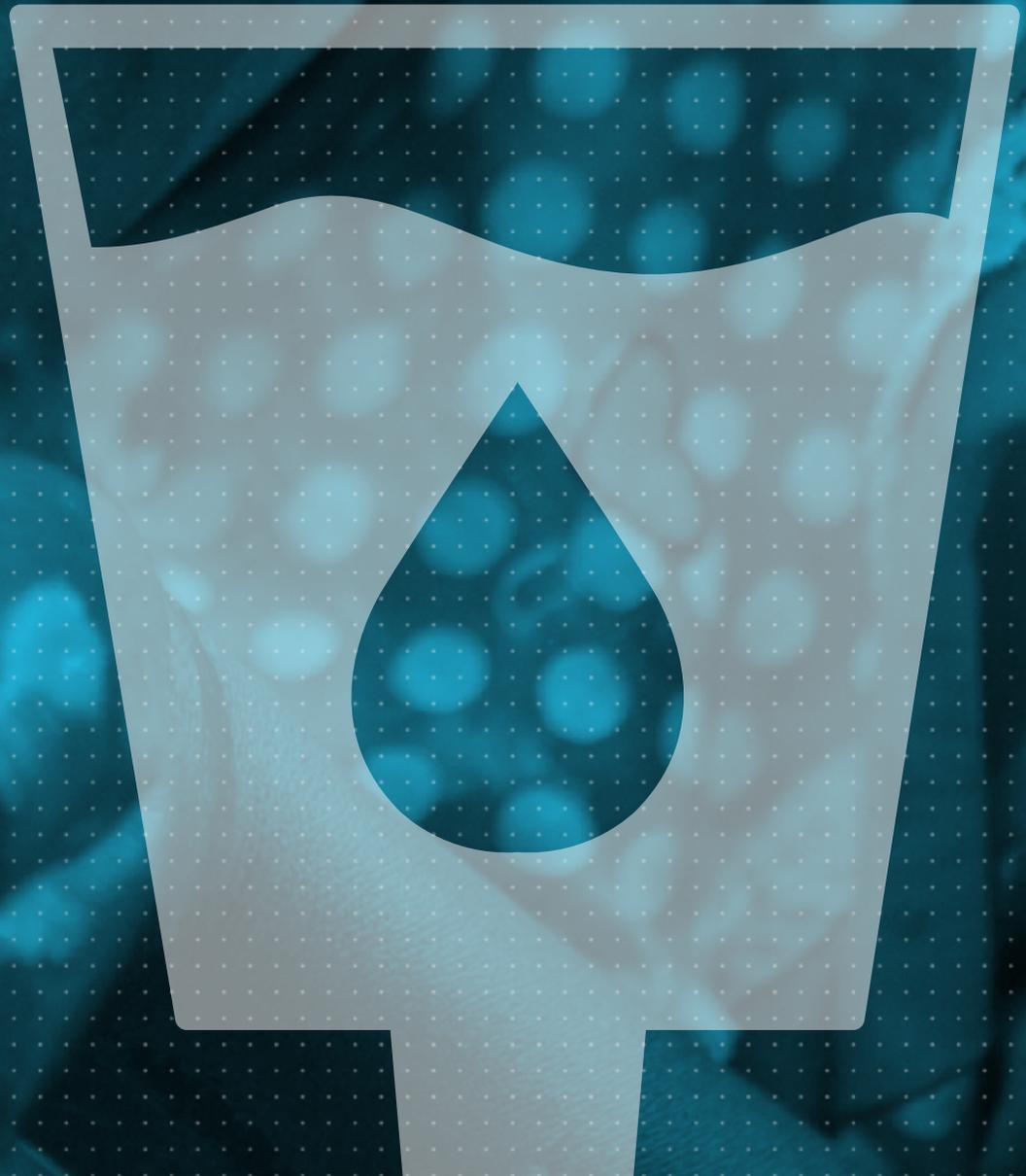
Goal 6 addresses all aspects of the water cycle, but targets 6.1 and 6.2 are directly relevant to children. Inadequate water, sanitation and hygiene (WASH) remains a leading cause of child and adolescent mortality, and extending service coverage is essential for achieving many other child-related SDG targets. Universal access implies going beyond monitoring access at the household level and addressing access to WASH in institutional settings including schools (SDG 4a), health-care facilities and workplaces.

6.1 By 2030, achieve universal and equitable access to safe and affordable drinking-water for all

6.1.1 Proportion of population using safely managed drinking-water services

6.2 By 2030, achieve adequate and equitable sanitation and hygiene for all, ending open defecation and paying special attention to the needs of women and girls and people in vulnerable situations

6.2.1 Percentage of population using safely managed sanitation services, including a hand-washing facility with soap and water.





GOAL 06

Water, sanitation and hygiene

Current status and trends

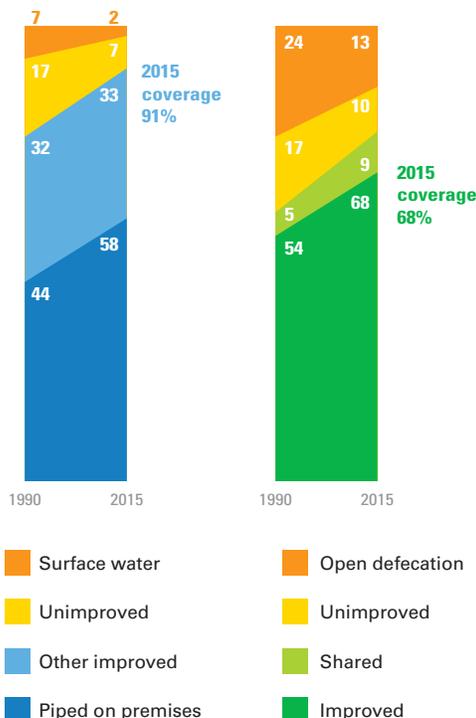
Between 1990 and 2015, 2.6 billion people gained access to an improved drinking-water source and coverage reached 91 per cent, with 58 per cent using piped water on premises and 33 per cent using public standpipes, boreholes, protected wells and springs and rainwater (figure 2.27). However, 1 in 10 (663 million) people still use unimproved sources, while some improved sources are far from home and unsafe. The WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (JMP) estimates that about 1.8 billion people drink water containing faecal contamination and proposes to include data on water quality in future estimates (see below).

The JMP estimates that 2.1 billion people gained access to a basic improved sanitation facility between 1990 and 2015, with global coverage rising to 68 per cent. However, one in three (2.4 billion) people still used unimproved or shared facilities, of which 946 million had no facility and practiced open defecation (figure 2.27). The SDG target of ending open defecation by 2030 will not be met at current rates of progress (figure 2.28).

Hand washing with soap is a very cost-effective intervention for improving child health. Observation of a hand-washing facility with soap and water available, a proxy for hand-washing behaviour, has been a standard component of the MICS and DHS since 2009. However, data for 57 countries show that hand-washing rates remain low, particularly in Africa and South Asia (figure 2.29).

FIGURE 2.27

Trends in global drinking water and sanitation coverage (%), 1990–2015



More than 90 per cent of the world's population now has access to improved drinking-water sources, but access to improved sanitation remains a challenge

Data availability

The JMP has been monitoring progress for the past 25 years and has established a global database with estimates for almost all countries and territories between 1990 and 2015. Data on drinking water, sanitation and hygiene facilities come from national household surveys and censuses, and at least five data sets are available in the JMP database for 142 countries, representing more than 90 per cent of the global population. This enables not only analysis of trends in access, but also disaggregation by socio-economic dimensions of inequality. Household surveys also provide data that can be used to identify inequalities in service levels.

The new SDG indicators for drinking water, sanitation and hygiene establish a higher service threshold than the MDGs that goes beyond the

Source: WHO/UNICEF JMP, 2015.



type of facility used and includes information on the accessibility, availability and quality of services provided (figure 2.31). While almost all countries have data on access to basic WASH services (SDG 1.4), service-level data required to estimate 'safely managed' water and sanitation services (SDG 6.1 and 6.2) are less widely available and will need to be drawn from a combination of household surveys and censuses and administrative sources including regulators. The JMP is currently compiling national data and will publish baseline regional and global estimates for SDG targets 6.1 and 6.2 in 2017.

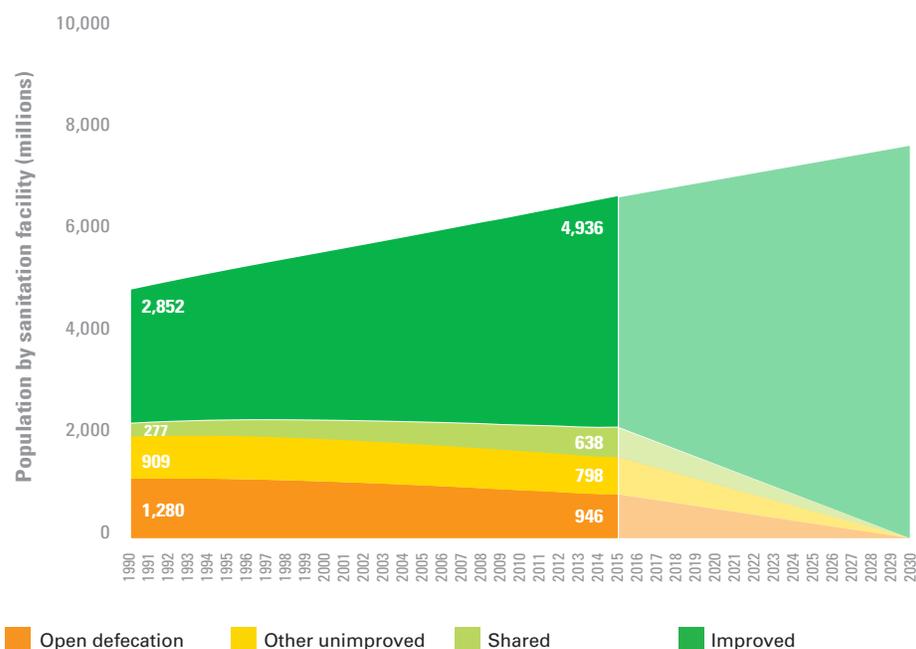
Addressing data gaps

The JMP has collaborated with the UNICEF MICS team to develop a module for direct testing of drinking-water quality and piloted it in ten national household surveys. Field teams test for E. coli, which indicates the risk of faecal contamination, in different water sources and across population groups to identify inequalities. Drinking water can also be tested for chemicals such as arsenic and fluoride. New questions relating to the accessibility and availability of drinking water, the management of faecal waste and barriers to menstrual hygiene management have also been tested and validated for use in the sixth round of MICS household surveys.

Universal access to WASH goes beyond the household and is particularly important in schools⁶⁰ and health-care facilities, but available data for these settings are not yet harmonized. The JMP has convened a global task force to develop harmonized indicators for 'basic' WASH service outside the household and determine appropriate data disaggregation to support the SDG focus on equity.⁶¹

FIGURE 2.28

Progress towards universal access to sanitation by 2030



Source: WHO/UNICEF JMP global database, 2015

Universal access to sanitation will not be achieved by 2030 without accelerated progress

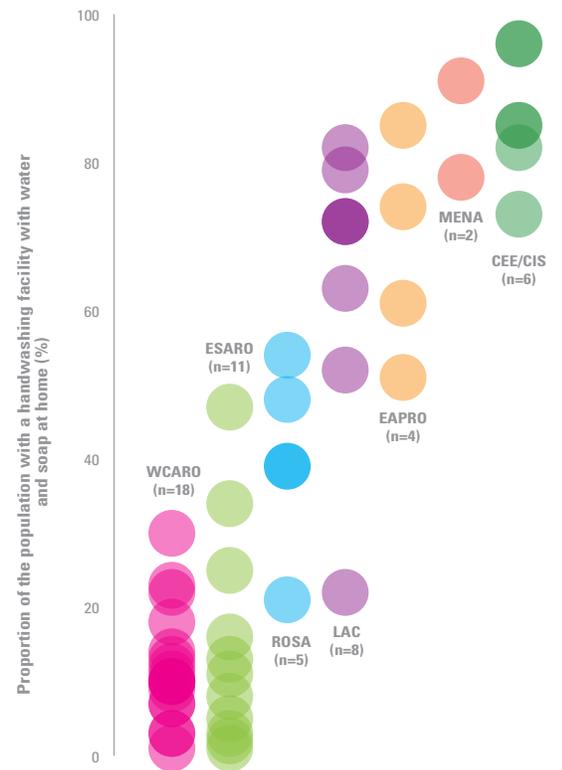


Alice Justin collects water in a jerrycan from a new water point built by UNICEF next to the Seventh-Day Adventist School in the Bakindo residential area, in Yambio, Western Equatoria.

© UNICEF/UN049180/Gonzalez Farran

FIGURE 2.29

Availability of hand-washing facilities with soap and water at home, by region



Source: WHO/UNICEF JMP, 2015.

Rates of hand washing at home remain low despite its benefits for child health



FIGURE 2.30

The transition from the MDGs to the SDGs

SDG ambition	Safely managed Drinking water from an improved source which is located on premises, available when needed and free from faecal and priority chemical contamination	Safely managed Use of an improved sanitation facility which is not shared with other households and where excreta are safely disposed in situ or transported and treated offsite
MDG continuity	Basic Drinking water from an improved source provided collection time is not more than 30 minutes for a round-trip including queuing	Basic Use of an improved facility which is not shared with other households
	Limited Drinking water from improved sources which require over 30 minutes for a round-trip including queuing	Limited Improved facility shared with other households
	Unimproved Drinking water from unprotected dug wells or unprotected springs	Unimproved Use of pit latrines without a slab or platform, hanging latrines and bucket latrines
	No service Drinking water from a river, dam, lake, pond, stream, canal or irrigation channel	Open defecation Human faeces disposed of in fields, forest, bushes, open bodies of water, beaches or other open spaces or disposed of with solids waste

The new SDG indicators focus on accessibility, availability and quality of WASH services



GOOD JOBS AND ECONOMIC GROWTH

Child labour

Goal 8 calls, among other targets, for achieving full and productive employment and decent work for all women and men, including for young people and persons with disabilities; substantially reducing the proportion of youth not in employment, education or training; and taking immediate measures to prohibit and eliminate the worst forms of child labour. While it includes an indicator (8.b.1) of government spending on social protection and employment programmes, such data are not yet available in a standardized form.



8.7. Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition and elimination of the worst forms of child labour, including recruitment and use of child soldiers, and by 2025 end child labour in all its forms

8.7.1 Proportion and number of children aged 5–17 years engaged in child labour, by sex and age

8.b.1 Total government spending in social protection and employment programmes as a proportion of the national budget and Gross Domestic Product (GDP)



GOAL 08 Child labour

Target 8.7 is of direct relevance to children. Although children around the world are routinely engaged in various forms of paid and unpaid work that are not harmful to them, they are considered to be involved in child labour when they are either too young to work or are carrying out activities that could compromise their physical, mental, social and/or educational development. As per the 2008 resolution concerning statistics of child labour, the definition of child labour is based on the number of hours spent working and working conditions and includes engagement in both economic activities and household chores. A number of international conventions frame the concept and form the basis for national legislation among signatories.⁶²

Current status

West and Central Africa has the largest proportion of child labourers (28 per cent of children aged 5 to 14).⁶³ In both the Middle East and North Africa and East Asia and the Pacific, 10 per cent of children in this age group are performing potentially harmful work, compared with 9 per cent in Latin America and the Caribbean. In the world's poorest (i.e., least developed) countries, nearly one in four children is engaged in child labour (*figure 2.31*). Boys and girls are equally likely to be involved in child labour in all regions except Latin America and the Caribbean, where slightly more boys are involved (*figure 2.32*). Gender disparities are found, however, in the types of activities carried out, with girls far more likely to perform domestic work.

BOX 2.3

From legal frameworks to the measurement of child labour

While legal standards and conventions have been developed and used to define the issue of child labour and its underlying concepts, the translation of these frameworks into operational definitions for measurement purposes has been a subject of considerable debate and disagreement. In December 2008, the International Conference of Labour Statisticians (ICLS) adopted the resolution concerning the measurement of working time, which confirmed UNICEF's long-standing view that household chores, along with other types of work undertaken by children, should be considered in the measurement of child labour. The resolution covers children aged 5 to 17 who, during a specified time period, were engaged in any of the following: worst forms of child labour, employment below the minimum age or unpaid household services. It provided an important foundation for future statistical work in this area and offers the promise of easier comparability of national data.

Data availability

The main sources of data on child labour are household surveys such as MICS, DHS and International Labour Organization (ILO)-supported Statistical Information and Monitoring Programme on Child Labour (SIMPOC) surveys, as well as national labour force and employment surveys. Nationally representative data on child labour are currently available from more than 250 sources, spanning 1999 to 2015 and covering 116 low- and middle-income countries. The resolution concerning the measurement of working time is expected to make national data more easily comparable (*see box 2.3*).

Addressing data gaps

Despite the availability of national data on child labour for a large number of low- and middle-income countries, the worst forms of child labour



In the world's poorest countries, nearly one in four children is engaged in work that is potentially harmful to his or her health

have still not been captured in measurement efforts.⁶⁴ These include all forms of slavery or similar practices such as trafficking and the recruitment and use of child soldiers, the use or procurement of children for prostitution or other illicit activities, and other work that is likely to harm children's health, safety or well-being. To address some of the data gaps, UNICEF and the ILO are developing a methodology that can be used in diverse conflict settings to produce a global estimate of the number of children recruited and used by armed forces and groups. The estimate is expected to inform global advocacy efforts to end the recruitment and use of children in armed conflict and will provide a baseline to measure progress in achieving one element of target 8.7.

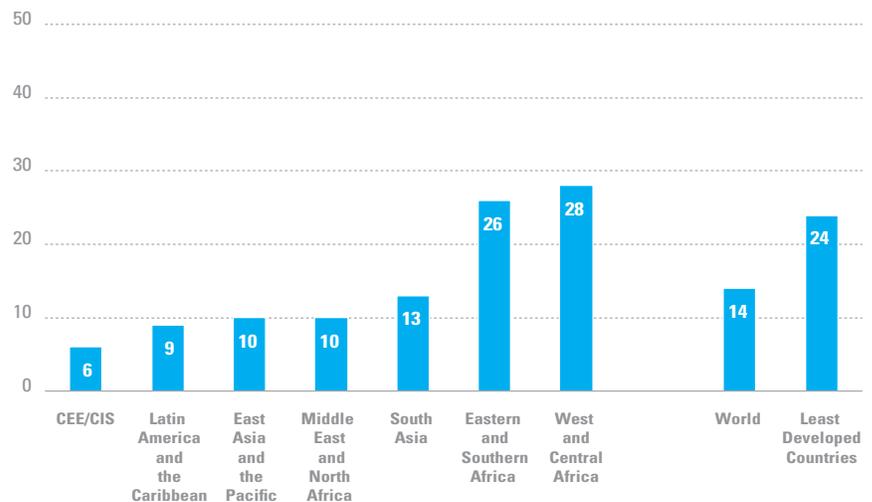
In most regions, boys and girls are equally as likely to be engaged in child labour overall

Notes: Estimates are based on a subset of 70 countries covering around 50 per cent of the global population of girls and boys aged 5 to 14 years (excluding China, for which comparable data on child labour are not available in the UNICEF global database). Regional estimates represent data from countries covering at least 50 per cent of the regional population of children aged 5 to 14. The regional estimates for East Asia and the Pacific exclude China. Data coverage is below 50 per cent for CEE/CIS and South Asia.

Source: UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys, 2009–2015.

FIGURE 2.31

Percentage of children aged 5–14 years engaged in child labour at the time of the survey, by region

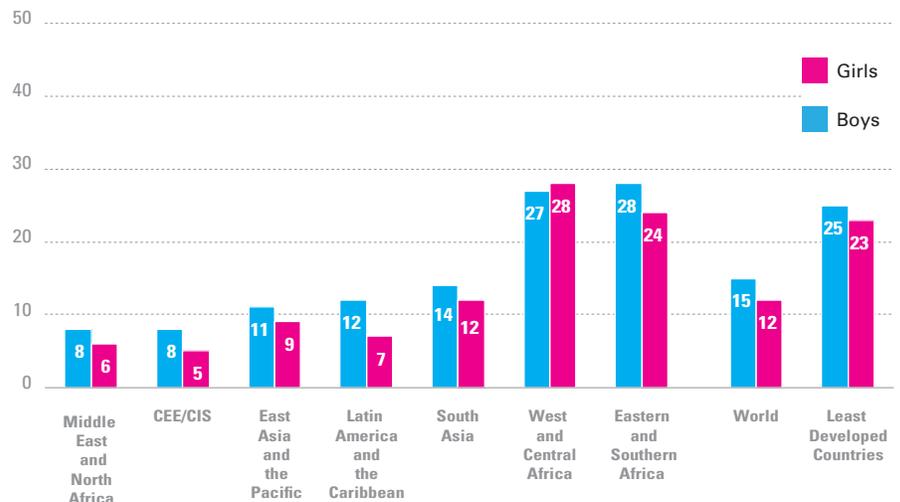


Notes: Estimates are based on a subset of 81 countries covering around 50 per cent of the global population of children aged 5 to 14 years (excluding China, for which comparable data on child labour are not available in UNICEF global database). Regional estimates represent data from countries covering at least 50 per cent of the regional population of children aged 5 to 14. The regional estimate for East Asia and the Pacific excludes China. Data coverage is below 50 per cent for CEE/CIS and South Asia.

Source: UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys, 2009–2015.

FIGURE 2.32

Percentage of children aged 5–14 years engaged in child labour at the time of the survey, by sex of the child and by region



Migration and displacement

The SDGs will not be monitored in a static world. Not only are conditions changing for children in every part of the world, but children and their families are also moving within and across borders. Whether children are moving for better opportunities or fleeing for safety, monitoring progress towards the SDGs must take into account migration and displacement. This, in turn, will require better data.

In 2015, an estimated 244 million people worldwide were living outside their country of birth; 31 million of them were children (see figure A). In 2015, 1 in every 70 children worldwide was estimated to live outside the country of his or her birth. Conflict and violence had forcibly displaced nearly 28 million children worldwide by the end of 2015, including 10 million child refugees, approximately 1 million asylum-seeking children and an estimated 17 million children displaced within their own countries. Recent trends have made the numbers much starker for child refugees: today, nearly 1 in every 200 children in the world is a refugee. In 2005, the ratio was roughly 1 in every 350 children.

Comparable, reliable, timely, disaggregated and accessible data are essential for understanding and addressing the implications of migration and displacement for children and their families. Data need to cover a range of key questions, including who migrants and displaced persons are, how old they are, where they come from, when they move, where they move to, why they move and how they fare.

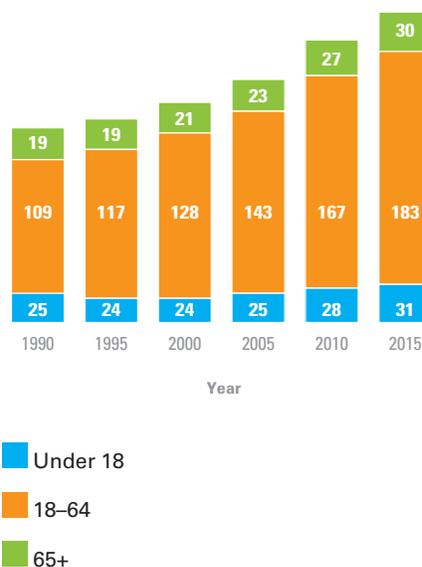
The current reality, however, falls far short of these needs. Data on international migration and displacement are incomplete and policymakers often rely on estimates for the total number of international migrants and the number of migrant and displaced children.

We do not know where all the world's child refugees and migrants were born, how old they are, or whether their migration was forced or voluntary. There are even fewer comprehensive and comparable indications about how child migrants fare in their countries of origin, transit and destination.

There are many understandable reasons why this data gap exists: people are difficult to track when they move; families with uncertain legal status are often missed in official statistics; and some of the worst violations of children's rights are regularly under-reported. When data about children are available, they are frequently for just a small, compartmentalized subset of children.

FIGURE A

Number of international migrants by age, 1990 to 2015 (in millions)



Source: UNICEF analysis based on United Nations, Department of Economic and Social Affairs, Population Division, 'Trends in International Migrant Stock: Migrants by age and sex', United Nations, New York, 2015.

A girl covered in a heavy blanket, stands outside a tent at the Vojvodina reception centre for refugees and migrants in Gevgelija, on the border with Greece.

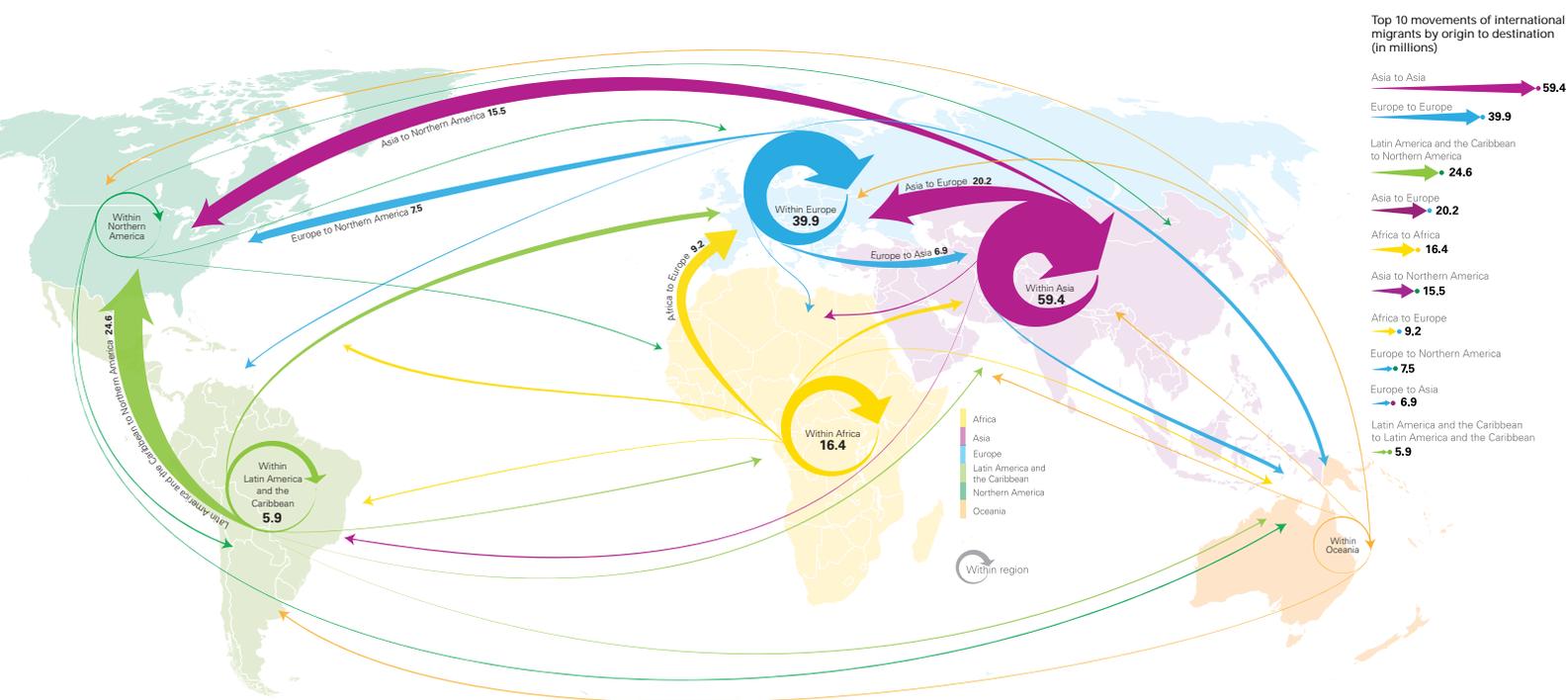
© UNICEF/UN03023/
Gilbertson

Data gaps about childhood migration and displacement must be addressed by improving data collection through population registers and census. Further data disaggregated by migratory status will be particularly important for measuring progress for vulnerable children and families across the SDGs. To bolster the overall quality of information about the well-being and progress of migrant children, pertinent administrative data should be more accessible and household surveys should be adjusted to include relevant migration questions.

New technologies and data sources also have tremendous potential to improve current knowledge about migration movements. Data from social media, mobile phones and other sources can provide geospatial and temporal information about population movements in real time, facilitating timely and relevant responses for people on the move. Continued investment in both new and traditional data sources will be essential to effectively meet the rights and needs of children and families in the years to come.

FIGURE B

Number of international migrants by region of origin and destination, 2015



Note: This figure does not include 9.8 million international migrants with origin classified as other or unknown.

This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. The final boundary between the Sudan and South Sudan has not yet been determined. The final status of the Abyei area has not yet been determined.

Source: United Nations, Department of Economic and Social Affairs, Population Division, 'Trends in International Migrant Stock: Migrants by destination and origin', United Nations, New York, 2015.

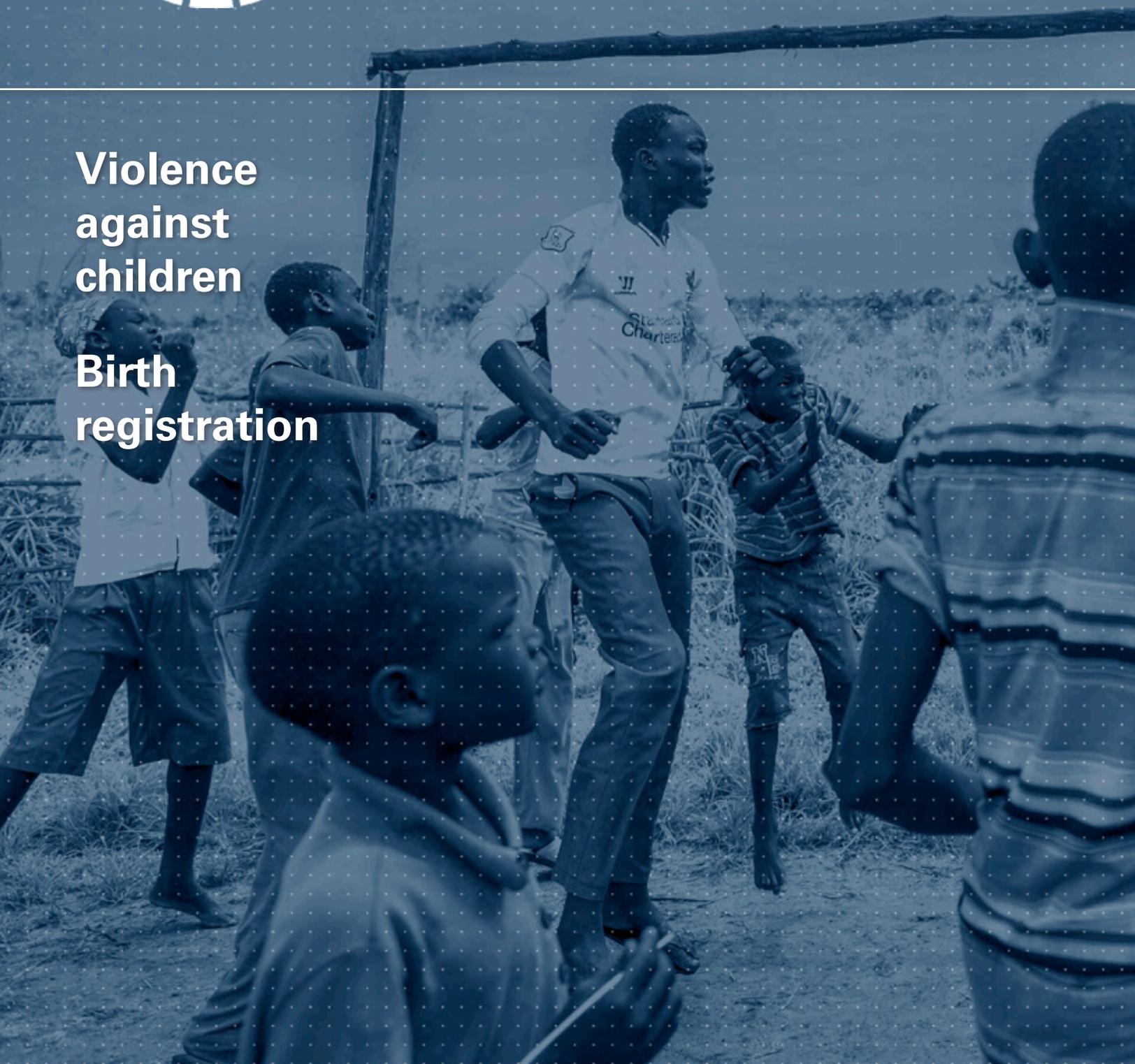
GOAL



PEACE AND JUSTICE

**Violence
against
children**

**Birth
registration**



Violence against children

16.1 Significantly reduce all forms of violence and related death rates everywhere

16.1.1 Number of victims of intentional homicide per 100,000 population, by age group and sex

16.1.2 Conflict-related deaths per 100,000 population (disaggregated by age group, sex and cause)

16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children

16.2.1 Proportion of children aged 1–17 years who experienced any physical

punishment and/or psychological aggression by caregivers in the past month

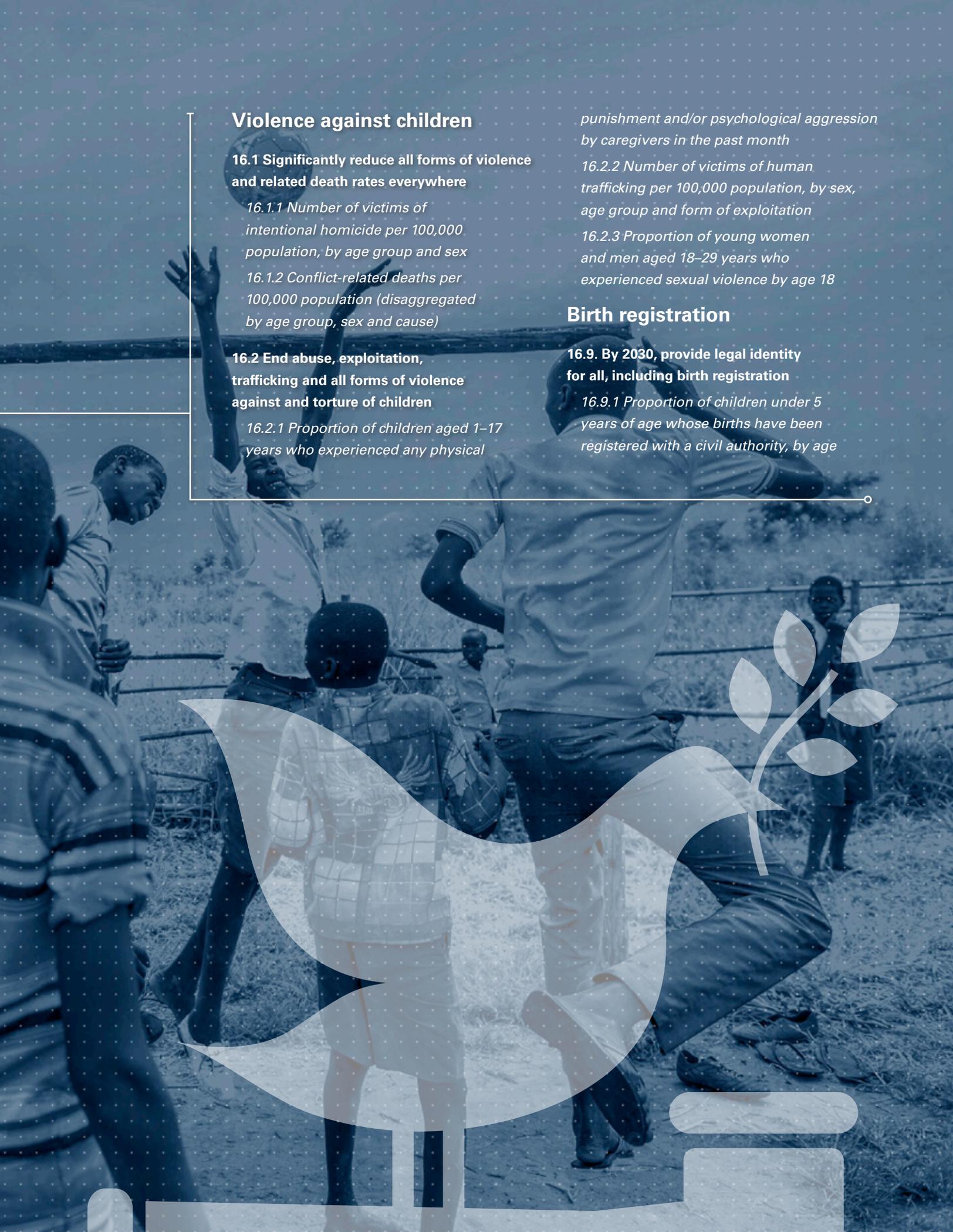
16.2.2 Number of victims of human trafficking per 100,000 population, by sex, age group and form of exploitation

16.2.3 Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18

Birth registration

16.9. By 2030, provide legal identity for all, including birth registration

16.9.1 Proportion of children under 5 years of age whose births have been registered with a civil authority, by age





GOAL 16

Violence against children

All children have the right to protection from all forms of violence, which can not only physically harm them but also reduce their sense of self-worth, affront their dignity and hinder their development. Violence against children takes many forms, including physical, sexual and emotional abuse. It can occur in many settings, such as the home, school, community and over the Internet, and can be perpetrated by both adults – family members, teachers, neighbours and strangers – and also by other children. In fact, slightly more than one in three students aged 13 to 15 worldwide have reported regular experiences of bullying by peers.⁶⁵ Two of the indicators selected to monitor target 16.2 represent specific forms of violence against children: the most widespread (violent discipline) and one of the gravest (sexual violence).

Homicide and conflict-related deaths

Current status

In 2012 alone, it was estimated that homicide took the lives of almost 95,000 children and adolescents aged 0–19 years (almost one in five of all homicide victims that year). The majority lived in low- and middle-income countries, with the highest numbers in Latin America and the Caribbean. In all regions of the world, homicide rates are found to increase dramatically when children enter adolescence, particularly among boys, who account for 70 per cent of all victims under age 20. More than half of all young homicide victims worldwide are aged between 15 and 19.⁶⁶

Civil unrest and armed conflict often place children at heightened risk of experiencing violence and can also make them vulnerable to recruitment or use by armed forces or groups. UNICEF estimates that almost 250 million children are currently living in countries and areas affected by armed conflict, but accurately counting the number of conflict-related deaths, particularly those of minors, remains challenging.

Data availability

Producing reliable estimates of the number and causes of death among children and adolescents, in both conflict and non-conflict settings, is difficult. Such deaths may not be systematically collected by criminal justice or vital registration systems, and determining cause of death, particularly when victims are very young, can be challenging even in countries with advanced and well-functioning health and registration systems. In the absence of reliable figures from actual counts, modelled estimates (including those presented above on homicide) are used.

Punishment by caregivers

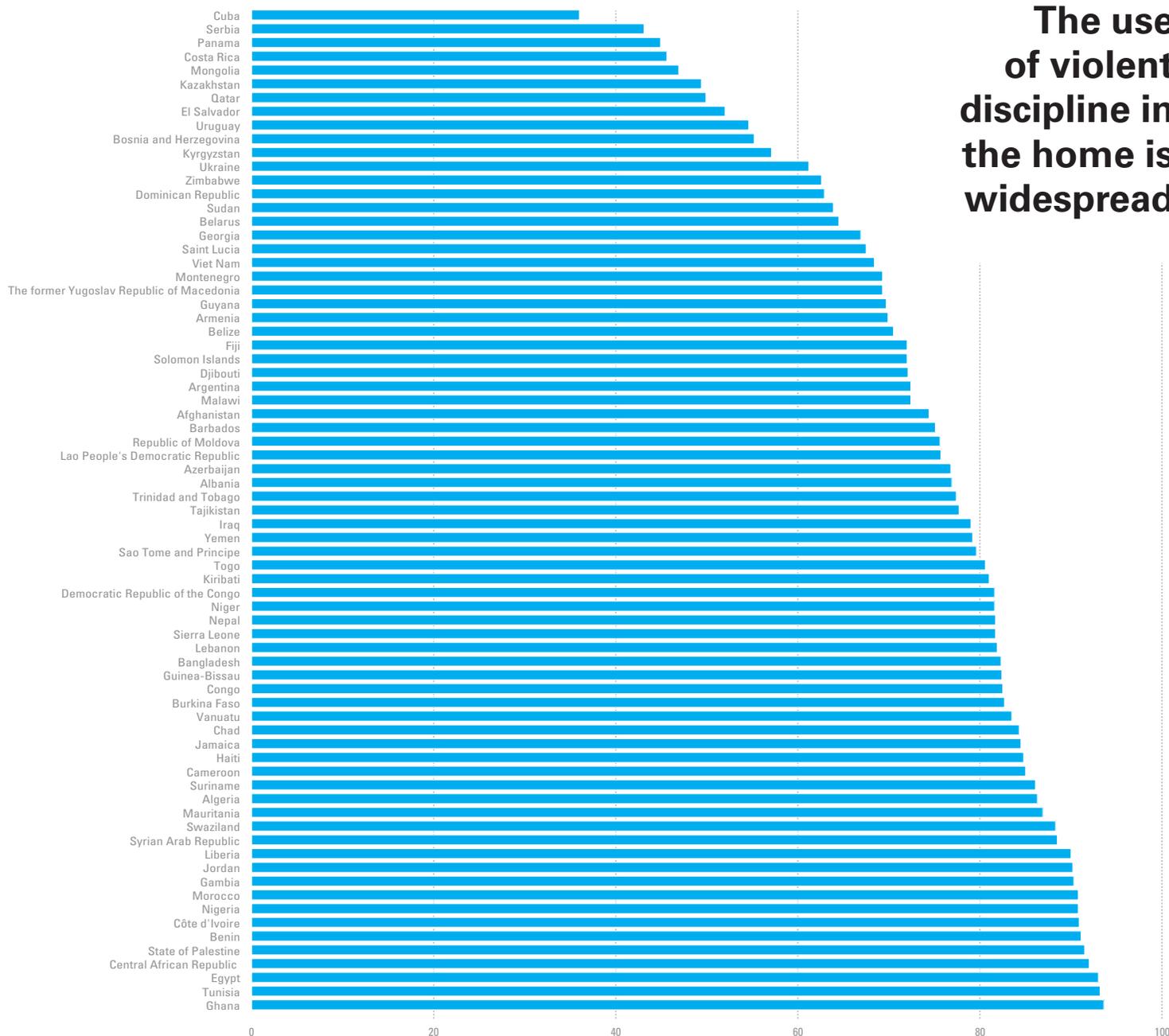
Current status

All too often, children are raised using discipline methods that rely on physical force or verbal intimidation to punish unwanted behaviours and encourage desired ones. Both physical (or corporal) punishment and psychological aggression are violations of children's rights. They frequently occur together, exacerbating the



FIGURE 2.33

Percentage of children aged 1–14 years who experienced any violent discipline (psychological aggression and/or physical punishment) in the past month



The use of violent discipline in the home is widespread

Notes: Data for Belarus, Qatar and Yemen differ from the standard definition. Data for Fiji, Kiribati and Solomon Islands refer to adult reports of whether they have used physical discipline on their children. Data for Afghanistan, Albania, Algeria, Argentina, Armenia, Azerbaijan, Barbados, Belarus, Belize, Bosnia and Herzegovina, Burkina Faso, Central African Republic, Chad, Costa Rica, Côte d'Ivoire, Djibouti, Gambia, Georgia, Ghana, Haiti, Iraq, Jamaica, Jordan, Lao People's Democratic Republic, Liberia, Kazakhstan, Lebanon, Mauritania, Republic of Moldova, Morocco, Niger, Nigeria, Qatar, Saint Lucia, Sierra Leone, Suriname, Syrian Arab Republic, Tajikistan, the former Yugoslav Republic of Macedonia, Trinidad and Tobago, Tunisia, Ukraine, Uruguay, Vanuatu, and Yemen refer to children aged 2 to 14 years. For Argentina, the sample was national and urban (municipalities with a population of more than 5,000), since the country's rural population is scattered and accounts for less than 10 per cent of the total.

Source: UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys, 2005–2015.



harm they inflict, and can have both immediate effects and long-term consequences that children carry into adulthood.

In all but 7 of the 73 countries with available data, more than half of children aged 1–14 are subjected to some kind of violent discipline in the home (*figure 2.33*).⁶⁷ In both West and Central Africa and the Middle East and North Africa, more than 8 in 10 children are disciplined in a violent manner.

Data availability

The availability of comparable data on caregivers' use of violent discipline has significantly increased in the past two decades, mainly through the inclusion of a module on disciplinary methods in international household surveys such as MICS. The module developed for use in MICS is adapted from the parent-child version of the Conflict Tactics Scale (CTSPC)⁶⁸ and includes a standard set of questions covering non-violent forms of discipline, psychological aggression and physical means of punishing children.

Since 2005, the number of countries using the module in MICS has grown from 33 to around 61, while 13 countries have collected data on child discipline through a version of the module used in DHS. Data on children's experiences of violent discipline can be disaggregated by age, sex, geographic area, place of residence, caregiver education and household wealth, as well as other background characteristics.

Sexual violence against children⁶⁹

According to General Comment Number 13 on the Convention on the Rights of the Child, sexual violence against children 'comprises any sexual activities imposed by an adult on a child against which the child is entitled to protection by criminal law.'⁷⁰ Experiences of sexual violence in childhood hinder all aspects of development: physical, psychological/emotional and social. Apart from the physical injuries that can result, researchers have consistently found that sexual abuse of children is associated with a wide array of mental health consequences and adverse behavioural outcomes in adulthood.⁷¹ The psychological impact can be severe due to the intense shame, secrecy and stigma that tend to accompany it.⁷²

Current status

Across the 34 low- and middle-income countries with comparable data, the proportion of women aged 18 to 29 years who reported experiencing sexual violence for the first time before age 18 varies widely, ranging from none in Kyrgyzstan to 16 per cent in Cameroon (*figure 2.34*).⁷³ In five countries (Cameroon, the Democratic Republic of the Congo, Ghana, Rwanda and Zimbabwe), more than 1 in 10 young women reported sexual violence during childhood. Comparable data on sexual violence in childhood among men aged 18 to 29 years are only available for five countries, and figures are lower than those reported among women in the same countries.

Data availability

Collecting reliable data on sexual violence against children raises a number of methodological challenges and has some serious ethical implications.⁷⁴ One of the major hurdles in collecting such data is the likelihood



of under-reporting. Research suggests that children who are sexually abused by a close family member, experienced the most severe forms and have been victimized over a longer period, as well as boys, are least likely to disclose their experiences.⁷⁵ Possible errors can also result because respondents may not answer truthfully or accurately recall events that may have happened years ago. Moreover, data collection efforts have often relied on different definitions, study methodologies, samples and questions. This has made the aggregation or comparison of such statistics nearly impossible.

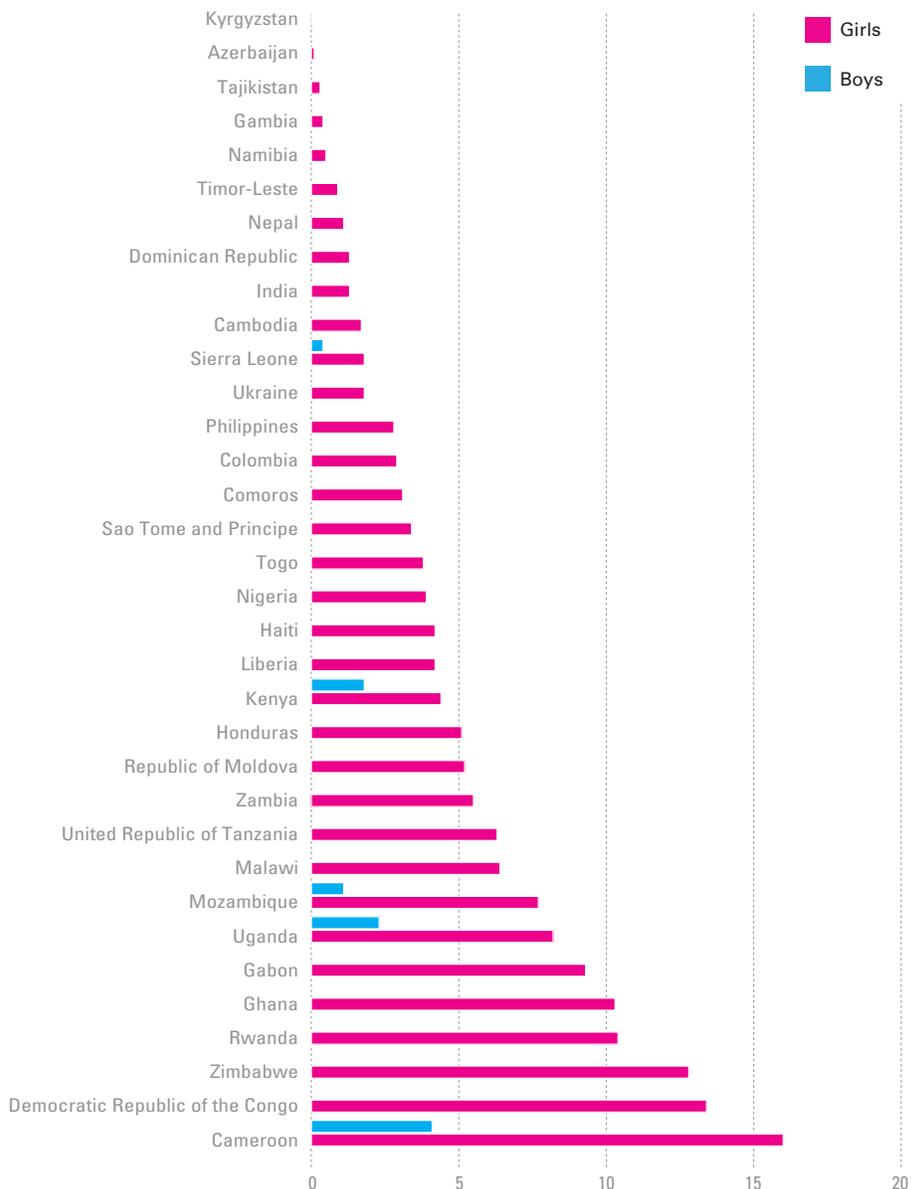
Addressing data gaps

It is crucial that fundamental principles are followed for the ethical collection of sound data when children are involved in research on violence. Key considerations include ensuring that questions are asked in a sufficiently sensitive manner and are tailored to children's developmental stage and capabilities; securing informed consent and, if appropriate, parental consent; protecting children from unnecessary danger or risk of re-traumatization; maintaining confidentiality; and instituting clear procedures for providing follow-up support for children who report being at risk.

To this end, UNICEF has been leading the work of the Technical Working Group on Data Collection on Violence against Children under the global Child Protection Monitoring and Evaluation Reference Group (CP MERG). To date, UNICEF and partner agencies have collaborated on two publications, including a review of studies on violence against children, and a literature review of ethical issues that will inform the development of guidelines on how to ensure the reliable, ethical and valid collection, analysis and use of data on violence against children. UNICEF also has plans to establish a country-led expert group that will explore tools for data collection.

FIGURE 2.34

Percentage of women and men aged 18–29 who reported experiencing forced sexual intercourse or any other forced sexual acts before age 18



Experiences of sexual violence in childhood are not uncommon among women in some countries

Notes: Data on the proportions of men who experienced sexual violence in childhood are only available for a subset of countries. Source: UNICEF global databases, 2016, based on DHS, 2005–2014.

Continuous challenges in accurately measuring trafficking among children

Trafficking in persons has been defined as the recruitment, transport, harbouring or receipt of persons through the use of threats, force, deception/fraud, abduction, other forms of abuse or offering of remuneration for the purposes of exploiting the victim.^a Several international conventions and treaties, including the Convention on the Rights of the Children (article 35) and the Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, provide explicit protection against trafficking of children for any purposes (including sexual exploitation).

A recent global report estimated that of the 31,766 victims of human trafficking detected by authorities for whom age information was available, children under the age of 18 years accounted for around 30 per cent.^b

Human trafficking, however, includes both detected and undetected victims. Statistics that reflect only those victims who are detected by authorities are therefore severe underestimates of the total victim population. Additionally, there are considerable gaps in the availability of disaggregated data, including further age breakdowns. There are also ongoing concerns about the reliability of information used for age determination in order to define child victims, particularly in countries where rates of birth registration are low and where many children lack birth certificates.

a. United Nations, *Annex II: The Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*, supplementing the United Nations Convention against Transnational Organized Crime, United Nations document A/RES/55/25.

b. United Nations Office on Drugs and Crime, *Global Report on Trafficking in Persons 2014*, UNODC, Vienna, 2014.





A father kisses his baby boy inside a train outside Vojvodina transit center. A 4 to 5-hour train ride will take them to Tabanovce, near the border with Serbia.

© UNICEF/UN012729/Georgiev



GOAL 16 Birth registration

A name and nationality is every child’s right, and obtaining this is typically accomplished through a formal process of registering a child’s birth. Birth registration is defined as ‘the continuous, permanent and universal recording, within the civil registry, of the occurrence and characteristics of births in accordance with the legal requirements of a country’⁷⁶ and is the first step in securing children’s recognition before the law, safeguarding their rights and ensuring that any violation of these rights does not go unnoticed.⁷⁷ Making sure that every child is registered is also an essential part of a functioning system of vital statistics, which is crucial for sound economic and social planning.

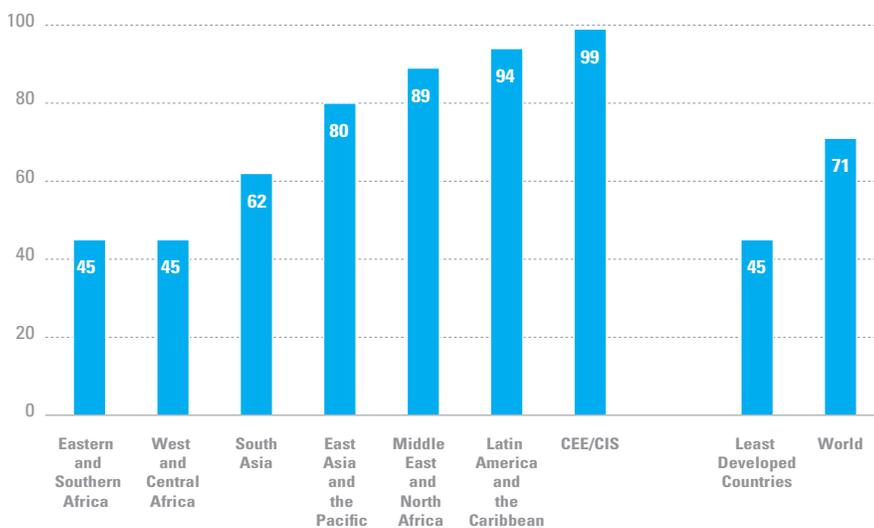
Current status and trends

Despite the importance of birth registration, the births of more than one in four children under age 5 years worldwide have never been recorded, with large differences among regions (figure 2.35). The region with the highest level of birth registration is CEE/CIS, where practically all (99 per cent) children under 5 are registered. This is followed closely by Latin America and the Caribbean, at 94 per cent, and the Middle East and North Africa, at 89 per cent. The lowest levels are found in Eastern and Southern Africa and West and Central Africa, where less than half (45 per cent in each region) of under-5 children are registered.

The births of more than one in four children under age 5 worldwide have never been recorded

FIGURE 2.35

Percentage of children under age 5 whose births are registered, by region



Notes: Estimates are based on a subset of 144 countries covering 80 per cent of the global population of children under age five. Regional estimates represent data from countries covering at least 50 per cent of the regional population. The regional estimate for East Asia and the Pacific excludes China, for which comparable data on birth registration are not available in the UNICEF global database.

Source: UNICEF global databases 2016, based on DHS, MICS, other nationally representative surveys, censuses and vital registration systems, 2010–2015.



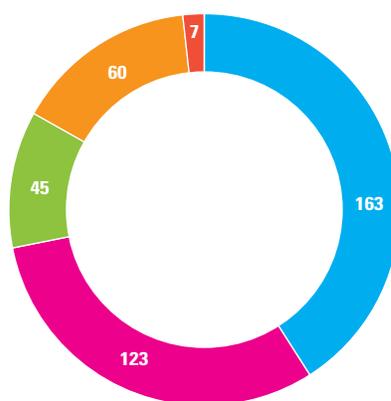
There has been an overall rise in birth registration levels over the past 15 years, but not all regions have made progress. Although with sustained progress there will be fewer unregistered under-5 children by 2030 than there are today, this pattern might not be universal due to rapidly growing child populations and slow rates of change in some places.

Data availability

Data on birth registration is drawn mainly from civil registration systems and household surveys. Effective civil registration systems compile vital statistics that are used to compare the estimated total number of births in a country with the number of registered births during a given period. While a majority of high-income countries have well-developed systems for capturing births, a lack of resources and investment in establishing an accurate, comprehensive and functioning civil registration system, coupled with barriers in accessing services, makes the systematic recording of births in many countries difficult. In the absence of reliable administrative data, household surveys have become a key source of data on birth registration (*figure 2.36*). In most low- and middle-income countries, such surveys represent the sole source of this information. Over the past 15 years, the number of countries with household survey data on birth registration has grown dramatically, from about 70 in 2000 to nearly 120 today.

FIGURE 2.36

Number of data sources on birth registration available in the UNICEF global database, by type



■ MICS ■ DHS ■ Other national household surveys ■ Vital registration systems ■ Censuses

Source: UNICEF global databases, 2016.

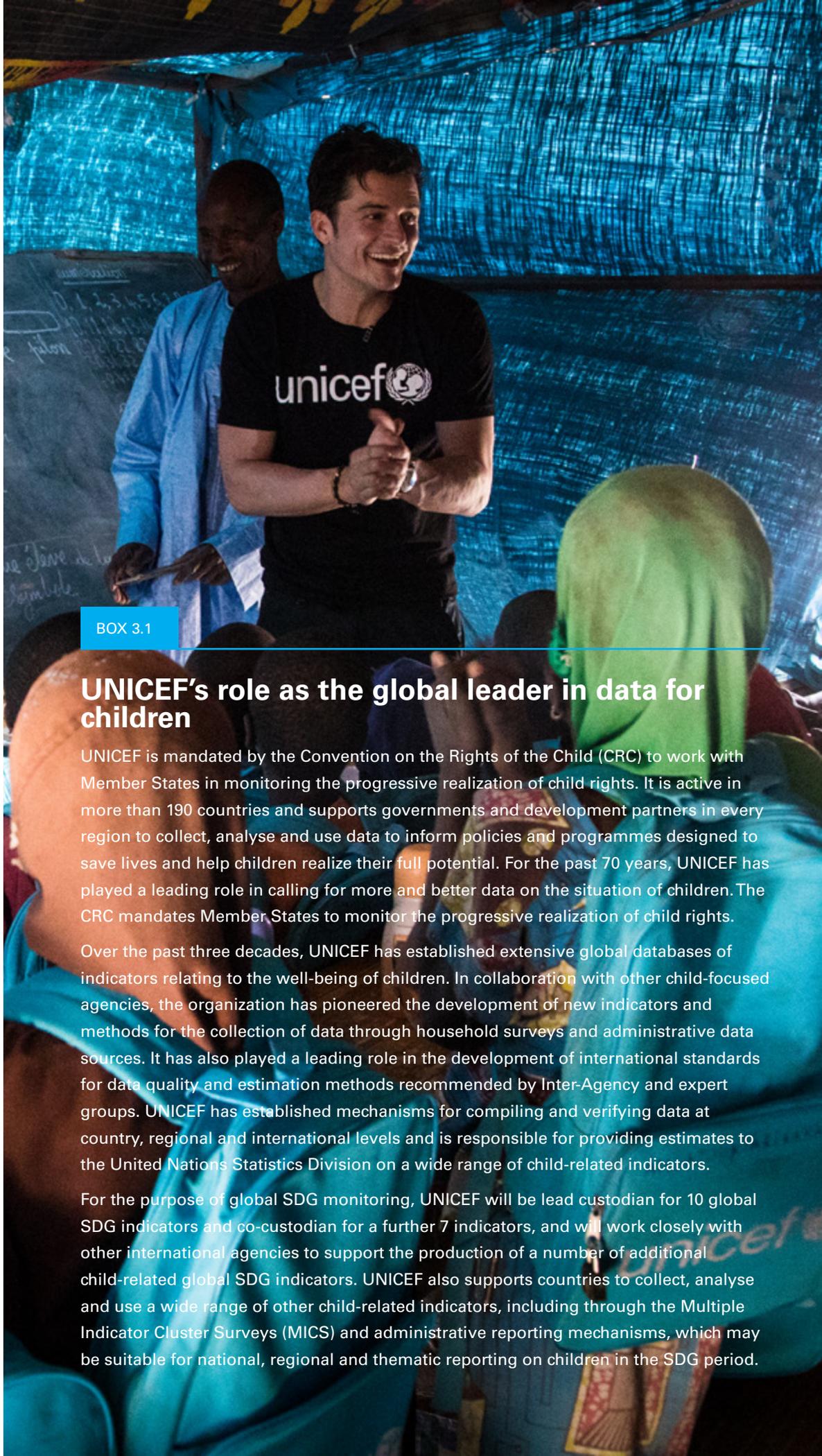
Household surveys represent the largest source of comparable data on birth registration for low- and middle-income countries



Enhancing coverage and quality of data for children in the SDG era



SECTION THREE



BOX 3.1

UNICEF's role as the global leader in data for children

UNICEF is mandated by the Convention on the Rights of the Child (CRC) to work with Member States in monitoring the progressive realization of child rights. It is active in more than 190 countries and supports governments and development partners in every region to collect, analyse and use data to inform policies and programmes designed to save lives and help children realize their full potential. For the past 70 years, UNICEF has played a leading role in calling for more and better data on the situation of children. The CRC mandates Member States to monitor the progressive realization of child rights.

Over the past three decades, UNICEF has established extensive global databases of indicators relating to the well-being of children. In collaboration with other child-focused agencies, the organization has pioneered the development of new indicators and methods for the collection of data through household surveys and administrative data sources. It has also played a leading role in the development of international standards for data quality and estimation methods recommended by Inter-Agency and expert groups. UNICEF has established mechanisms for compiling and verifying data at country, regional and international levels and is responsible for providing estimates to the United Nations Statistics Division on a wide range of child-related indicators.

For the purpose of global SDG monitoring, UNICEF will be lead custodian for 10 global SDG indicators and co-custodian for a further 7 indicators, and will work closely with other international agencies to support the production of a number of additional child-related global SDG indicators. UNICEF also supports countries to collect, analyse and use a wide range of other child-related indicators, including through the Multiple Indicator Cluster Surveys (MICS) and administrative reporting mechanisms, which may be suitable for national, regional and thematic reporting on children in the SDG period.

UNICEF Goodwill
Ambassador Orlando Bloom
(centre) greets students at
a temporary learning space
in a camp for internally
displaced people in Ngagam,
near Diffa, Niger.
© UNICEF/UN053272/
Tremeau

Enhancing coverage and quality of data for children in the SDG era

This initial review of the status of child-related SDG indicators has highlighted critical gaps in the availability of data for children in many parts of the world. Data availability for more than half of the 50 child-related global SDG indicators is either limited or poor. Furthermore, the quality of data varies across countries, and only a small number of child-related indicators are sufficiently disaggregated to enable analysis of the most relevant dimensions of inequality (see *annex 1*).

Better collection, analysis and use of data can drive better results for children. When the right data are in the right hands at the right time, decisions can be better informed, more equitable, and more likely to protect children's rights.

Disaggregated data – which can reveal the children who are thriving and those being left behind – are an essential tool for realizing the rights of every child. Goal 17 explicitly recognizes the importance of disaggregated data as well as the investments needed to realize their potential.

UNICEF is committed to advancing the rights of children and the goals outlined in the SDGs by supporting investments in data for children. This chapter outlines both UNICEF's overall approach to supporting data for children as well as its specific commitments to harnessing the power of data for children through the SDGs. These commitments include:

- Supporting countries to collect and analyse data from different sources to estimate baseline status and trends for child-related SDG indicators;
- Supporting countries to develop and test new indicators and methods for enhanced

SDG monitoring through household surveys, censuses and other relevant data sources;

- Leading the development of methods and tools for progressive disaggregation to ensure that no child is left behind; and
- Continued custodianship of data for children at local, national and international levels, including the maintenance of global databases enabling analysis of progress for children across countries and over time.

Supporting countries to collect and analyse data

The SDGs place an unprecedented demand on national statistical systems to generate the information required to monitor trends in SDG indicators. UNICEF supports the collection and analysis of a wide range of data relating to children, including government surveys and censuses, administrative and regulatory data, and participatory reporting by service users and citizens including parents, adolescents and children themselves.

UNICEF and other child-focused agencies have a strong track record of supporting both government and non-government partners to collect robust data and conduct rigorous analysis of critical indicators of child health and welfare. Continued support will be critical to consolidate the gains made to date and to enable national authorities and development partners to respond to new and increasing demands for data.



The MICS programme has built the capacity of national statistical authorities and other local partners around the world to conduct robust household surveys and generate data on the situation of children (*see box 3.2*).

UNICEF also actively supports the development of censuses and administrative data sources, including civil registration and vital statistics systems and sectoral management information systems (e.g., health, HIV and AIDS, education, and water and sanitation). Official statistics for SDG monitoring will continue to depend heavily on household surveys and censuses but will also draw on a range of administrative sources. Increasingly, data from these different sources can be compared and combined to enhance analysis. They can also be complemented with data from a wide range of other sources, including geospatial data, big data and social media (*see box 3.3*).

BOX 3.2

Two decades of MICS

The UNICEF-supported MICS programme was established more than 20 years ago to support countries to strengthen national household surveys and address critical data gaps. Nearly 300 surveys have now been completed in more than 100 countries. By systematically building the capacity of national statistical offices and other local partners, the MICS programme has dramatically increased the availability and quality of data for children and is now one of the leading sources of comparable nationally representative data on the situation of children around the world. It has also pioneered new measurement techniques and helped to develop many of the new indicators in the SDG global indicator list. Of the global SDG indicators that are expected to come from household surveys, about 50 per cent are either already included or have recently been tested in MICS. The MICS programme is therefore expected to remain a key source of data for SDG monitoring.

Supporting countries to develop and test new indicators and methods

Developing new indicators and measurement techniques

The list of SDG global indicators is designed to reflect the ambition of the targets as closely as possible. Some of these draw on recent innovations in measurement techniques that have enabled the collection of valuable new data. For example, the MICS-DHS-Living Standards Measurement Surveys (LSMS) collaborative group is developing a number of new household survey questions and modules which will enable more accurate assessment of the situation of children in the SDG era (*see box 3.4*). Once finalized, these new methods and tools will be widely disseminated and integrated into subsequent rounds of national household surveys supported by MICS, DHS, LSMS and other international household survey programmes.

For example, UNICEF has collaborated with partners to develop new survey modules on child discipline, ECD, child and adult functioning, child learning assessments, water-quality testing, clean cooking technologies, migratory status and social protection. UNICEF has also played a leading role in the development of new methods for measuring multidimensional child poverty (*see box 3.5*). Many of the indicators and methods developed by UNICEF and partners have been included on the list of global SDG indicators and will now be used to monitor progress towards the SDGs at national, regional and global levels.



BOX 3.3

Bringing multiple data sources together to strengthen adolescent HIV and sexual and reproductive health programmes

In 2015, UNICEF and UNAIDS launched the All In initiative to end the AIDS epidemic in adolescents. Analytical tools and guidance have subsequently been developed to support countries in undertaking comprehensive assessments aimed to strengthen national responses to HIV and sexual and reproductive health in adolescents. The tools help countries identify the issues limiting the impact of investments in adolescent programming as well as focus better on the adolescents at greatest risk of HIV infection, illness and death. This is done by, for example, finding adolescents who are excluded from services, identifying poor performing services and defining the bottlenecks to effective prevention, treatment and care.

UNICEF, UNAIDS and partners – including adolescents – have supported the implementation of these assessments in 25 countries to date, with technical assistance coordinated by UNICEF regional offices. In each country, UNICEF has worked alongside the government to convene representatives from multiple government sectors accountable for programmes serving adolescents, as well as implementing partners, civil society and youth networks, to provide, review and analyse data together to inform recommendations for national programme improvement. The data sources include demographic and epidemiologic data, modelled estimates of people living with HIV, AIDS deaths and new HIV infections, survey data, administrative data and service utilization data.

In all countries, this process has helped to reinvigorate the national and sub-national coordination mechanisms concerned with adolescent health and well-being, including the HIV response, and enabled governments and partners to appreciate the value-added from systematic collection, consolidation, joint review and monitoring of age-disaggregated data and translation of these findings into context-specific programme plans.



BOX 3.4

Water-quality testing in household surveys

While most countries have reliable information about the type of drinking-water source that people use, many still lack nationally representative data on the quality of water supplied. The WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation has supported MICS to develop a water-quality testing module for integration into national household surveys which uses innovative cost-effective, field-based tests to assess water quality both at the source and at the point of use. The module has now been implemented in 11 countries and is being adapted for use in other international and national survey programmes. The results will enable countries to report against the new, more ambitious SDG indicator of access to 'safely managed' drinking-water services.

BOX 3.5

New methods for child poverty measurement

For more than 15 years, UNICEF has been a global leader in highlighting child poverty and developing ways to measure multidimensional poverty among children. Joint work at the global level is currently under way with partners in the United Nations Development Programme (UNDP), World Bank and Oxford Poverty and Human Development Initiative to establish the best ways of measuring national and global child poverty. UNICEF is also working with the European Commission Joint Research Council's Composite Indicators Research Group to review current methodologies for measuring multidimensional child poverty. In addition, innovative work with the World Bank Poverty and Equity team is under way on children's monetary poverty risk, using international poverty lines to establish the number of children affected. One of UNICEF's priorities for SDG 1 is to move beyond measurement alone to ensure that poverty reduction for children is actually prioritized by governments. In this regard, new forms of analysis such as micro-simulation are being developed that both demonstrate risk and indicate the types of policies needed to prevent and respond to poverty.

Developing international data standards and harmonizing indicators

The development and refinement of international standards for new and emerging child-related indicators will be critical to improving the quality and comparability of data collected by countries in different parts of the world. UNICEF leads or co-leads a number of inter-agency and expert groups on data for children and is actively involved in several global data partnerships.

While international standards already exist for many of the indicators in the global SDG database, these are not always consistently applied in all countries. The child-related global indicators include several that have only recently been developed and are not yet collected on a routine basis. Others are available for many countries, but the data collection approaches used in surveys and administrative records vary and need to be further harmonized to improve comparability.

For example, since 1990 the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation has been instrumental in the development of norms used to benchmark progress around the world and is now developing updated guidance for monitoring access to WASH in homes, schools and health-care facilities during the SDG era.

Although violence against women has been widely researched over the years, particularly in many high-income countries, the lack of comparable data is a serious obstacle to

global monitoring. Collecting reliable data on sexual violence against children raises several methodological challenges and has some serious ethical implications, so it is crucial that fundamental principles are followed when children are involved in research and data collection.

While indicators for exclusive breastfeeding have been largely standardized across low- and middle-income countries, high-income countries use a range of different indicators that are not directly comparable. UNICEF is working with partners to advocate for all countries, including high-income countries, to report against standard international breastfeeding indicators, and has also made available tools to support countries in reporting appropriately through the MICS programme.

Leading the development of methods and tools for disaggregation

Disaggregating data to ensure that no child is left behind

The 2030 Agenda commits all Member States to reduce inequalities between and within countries (Goal 10) and to ensure that ‘no one is left behind’ by disaggregating SDG indicators, where relevant, by income, age, sex, race, ethnicity, migratory status, disability, geographic location and other characteristics. Some SDG indicators already specify disaggregation. For example, one of the indicators for poverty is ‘proportion of population living below the national poverty line, by sex and age’. Others

are not specific, and further discussion will be required to determine where disaggregation is relevant to policy (and whether the necessary resources are available for producing these data).

UNICEF has played a leading role in promoting the disaggregation of child-related indicators wherever possible by age, sex, location, wealth, residence, education, religion and other stratifiers. This includes both further analysis of existing data sets and the collection of new data on specific target populations. In collaboration with others, it has successfully pioneered new data collection modules for identifying children with disabilities (*see box 3.6*) and supported the collection and analysis of age-specific data to draw attention to the challenges faced by adolescents (*see box 3.7*).

In many countries, national household surveys and censuses will remain the main source of data disaggregated by social and economic characteristics and can be readily disaggregated into urban and rural areas and other sub-national administrative units. Enhanced monitoring of inequalities will involve systematically identifying those types of disaggregation which are most relevant for each of the child-related SDG indicators and developing new tools for assessing the progressive reduction and elimination of inequalities between and within countries.

Children with disabilities

The 2030 Agenda calls for equal opportunity for all, making explicit reference to the need to ensure that persons with disabilities are not excluded from efforts to eradicate global poverty. However, the lack of reliable, accurate and comprehensive statistics has long impeded the development, implementation and evaluation of policies and programmes aimed at promoting the rights of people with disabilities. Children with disabilities have been particularly overlooked in data collection efforts. Information gaps include how many children experience functional difficulties and how the environment (including physical, social and attitudinal factors) affects children's participation in their communities.

To address the need for comparable and reliable data, UNICEF and the Washington Group on Disability Statistics have developed a module on child functioning for use in surveys and censuses. This new data collection tool reflects current thinking around disability and can produce internationally comparable data. Questions cover children aged 2 to 17 and assess functional difficulties in domains such as communication, hearing, vision, learning, mobility and management of emotions. Since 2011, the module has been presented and discussed at several expert consultations involving representatives of disabled people's organizations, academic institutions and national statistical offices.

Additionally, UNICEF and the Washington Group are in the process of developing a new survey module to measure the school environment and participation in education by children with disabilities and are hosting a series of technical workshops on the measurement of child disability. The purpose of the workshops is to strengthen local capacity for data collection, analysis and use. Training is offered to national statistical offices, other government staff, representatives of disabled people's organizations and researchers.

Strengthening data demand, supply, use and leadership beyond the SDGs

In addition to data work specific to the SDGs and their indicators, UNICEF is expanding its data work in ways that will put data directly to use in improving children's lives. Specifically, it has committed to:

- Drive intelligent demand for data. Data that are not used are useless. UNICEF will sensitize decision makers at all levels – from ministers to activists – on how they can improve results for children by advocating for the use of appropriate data and data analysis.
- Integrate data. With partners in and outside of government, UNICEF will develop, use and share tools that bring multiple data sources and types together to provide new insights about the well-being of children. UNICEF will also support governments in linking administrative data systems across sectors to better address issues that transcend traditional silos.
- Maximize the value of real-time monitoring and response. UNICEF will expand the commitment and capacity of governments to track and respond to intermediate outcomes for children in real time. This will include strengthening administrative data systems across all UNICEF areas of work, from identifying whether teachers are in school and teaching to tracking whether child survivors of violence are receiving protection and support services, or how well health clinics are serving the most marginalized.
- Build common platforms and coordination. UNICEF will increase efficiency and

BOX 3.7

Adolescents: Focusing on the second decade of life

Far more is known today than in the past about the state of adolescents in the world thanks to the development of rich data on various dimensions of their lives. Countries are increasingly adjusting national statistical tools to better capture the lives of adolescents and the threats and opportunities that they face. Available data allow for the analysis of dimensions such as: demographics, or who adolescents are and where they live; health, in particular reproductive health and HIV and AIDS; mortality and its causes; education, including literacy and school participation; work, including participation in the labour force as well as exploitative child labour practices; and experience of violence and harmful practices.

Household surveys, especially MICS, have been instrumental in increasing the base of available data on adolescents. MICS collect a wealth of information, including age-specific indicators for adolescents aged 15–19 on reproductive health, education, sexual behaviour and HIV and AIDS. There are also modules on select topics relevant to some or all of the adolescent age group, including child labour and child discipline. New modules relevant to adolescents' lives have been added in recent years, including measures of access to media and technology, use of alcohol and tobacco and subjective well-being. Household survey data are particularly useful for equity analyses as they can be disaggregated by characteristics including sex, age, area of residence, household wealth, ethnicity and religion in order to identify the sub-national populations most at risk.

effectiveness by promoting the sharing of data in common platforms – across ministries at country level, within United Nations country teams and among international organizations and similar stakeholders.

- Simplify data communication. The overwhelming majority of people in a position to help children – from allocating resources to providing better services – are not data specialists. They need data tools that allow them to quickly understand how data about children apply to their jobs and what action they can take in response. UNICEF will meet their needs by simplifying its own data communication through dashboards,



data-driven graphics and other simple interactive tools that provide fast and actionable information. National authorities and development partners will also need to continue investing in core data skills and capacities to ensure that staff are able to present data in a format that is easy for decision makers at all levels to interpret and use.

- Strengthen capacity to use data. While most stakeholders need simple, data-informed headlines rather than complex tables and caveats, they also need a basic understanding of what kinds of data are fit for different kinds of purposes. UNICEF will invest in focused capacity development for key stakeholders in governments and its partners when more advanced data skills are required.
- Foster global partnerships and coordinate country support. Empowering countries to implement and monitor the SDG targets will require global partners to align their financial and technical resources around a common agenda for measurement and accountability. Child-focused agencies will need to work together to support countries to customize the global SDG targets and to strengthen national systems for collection, analysis and reporting of progress. Inter-agency and expert groups will continue to play an important role in elaborating norms and standards to guide the collection and use of specific types of data that will be required for the progress of children in the SDG era.
- Engage children and communities as demanders, suppliers and users of data. The 2030 Agenda calls for an inclusive approach to SDG monitoring with active participation of all relevant stakeholders. This not only implies making official statistics about children accessible to the public but also establishing mechanisms to enable children to express their own perceptions

of progress towards SDG targets. UNICEF will build on the success of some of its pioneering community engagement tools to increase government and non-government collection and use of data that reflect the views, priorities and insights of children and communities.

The world faces a perfect storm in terms of data for children, where data needs and opportunities are expanding simultaneously. Timely and sustained commitments to addressing the demand for, supply and use of data can realize the potential of data to improve children's lives and – in so doing – meet the goals towards which the world is striving. UNICEF believes that this is a challenge that can be met and is a shared global responsibility.



Sifar Shaabu kisses her
3-year-old daughter Nur, in
Presevo, in southern Serbia.
© UNICEF/UN08795/Vas

ANNEX 1

Children play with a tent being installed in the school “31 de Marzo”, which is being used as a shelter for families affected by the earthquake in Nuevo Pedernales, Manabi, Ecuador.

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Summary of the status of data for children in the SDGs

Annex 1 provides an overview of the current availability of disaggregated data for child-related SDG indicators identified in section 1. It shows the percentage of countries with comparable data available and the number of relevant stratifiers such as location, age, wealth and sex. It shows that at the start of the SDG

era data availability for more than half of these indicators is either limited or poor. Enhancing the coverage and quality of data is therefore essential in order to effectively track progress in the situation of children in the SDGs, and this is discussed further in section 3.

ANNEX 1 STATUS OF DATA FOR CHILDREN IN THE SDGs

Child-related SDG global indicators	Data availability ^a (% countries)	Disaggregation ^b of available data (● good, ● limited, ● poor)
1.1.1 Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)	●	●
1.2.1 Proportion of population living below the national poverty line, by sex and age	●	●
1.2.2 Proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions	●	●
1.3.1 Proportion of population covered by social protection floors/systems, by sex, and distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work injury victims, and the poor and the vulnerable	●	●
1.4.1 Proportion of population living in households with access to basic services	●	●
2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age	●	●
2.2.2 Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and 2.2.2a overweight)	●	●
3.1.1 Maternal mortality ratio	●	●
3.1.2 Proportion of births attended by skilled health personnel	●	●



ANNEX 1 STATUS OF DATA FOR CHILDREN IN THE SDGs

Child-related SDG global indicators	Data availability ^a (% countries)	Disaggregation ^b of available data (● good, ● limited, ● poor)
3.2.1 Under-5 mortality rate	●	●
3.2.2 Neonatal mortality rate	●	●
3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	●	●
3.3.2 Tuberculosis incidence per 1,000 population	●	●
3.3.3 Malaria incidence per 1,000 population	●	●
3.4.2 Suicide mortality rate	●	●
3.6.1 Death rate due to road traffic injuries	●	●
3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	●	●
3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group	●	●
3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)	●	●
3.9.1 Mortality rate attributed to household and ambient air pollution	●	●
3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe WASH services)	●	●
4.1.1 Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex	●	●
4.2.1 Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex	●	●

ANNEX 1 STATUS OF DATA FOR CHILDREN IN THE SDGs

Child-related SDG global indicators	Data availability ^a (% countries)	Disaggregation ^b of available data (● good, ● limited, ● poor)
4.2.2 Participation rate in organized learning (one year before the official primary entry age), by sex	●	●
4.5.1 Parity indices (female/male, rural/urban, bottom/top wealth quintile and others such as disability status, indigenous peoples and conflict-affected as data become available)	●	●
4.6.1 Percentage of population in a given age group achieving at least a fixed level of proficiency in functional (a) literacy and (b) numeracy skills, by sex	●	●
4.a.1 Proportion of schools with access to: (a) electricity; (b) the Internet for pedagogical purposes; (c) computers for pedagogical purposes; (d) adapted infrastructure and materials for students with disabilities; (e) basic drinking-water; (f) single-sex basic sanitation facilities; and (g) basic hand-washing facilities (as per the WASH indicator definitions)	●	●
5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner, in the previous 12 months, by form of violence and by age	●	●
5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner, in the previous 12 months, by age and place of occurrence	●	●
5.3.1 Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18	●	●
5.3.2 Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting, by age	●	●
5.4.1 Proportion of time spent on unpaid domestic and care work, by sex, age and location	●	●
5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	●	●
6.1.1 Proportion of population using safely managed drinking-water services	●	●
6.2.1 Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water	●	●



ANNEX 1 STATUS OF DATA FOR CHILDREN IN THE SDGs

Child-related SDG global indicators	Data availability ^a (% countries)	Disaggregation ^b of available data (● good, ● limited, ● poor)
7.1.2 Proportion of population with primary reliance on clean fuels and technology	●	●
8.7.1 Proportion and number of children aged 5–17 years engaged in child labour, by sex and age	●	●
8.b.1 Total government spending in social protection and employment programmes as a proportion of the national budgets and GDP	●	●
10.1.1 Growth rates of household expenditure or income per capita among the bottom 40 per cent of the population	●	●
11.1.1 Proportion of urban population living in slums, informal settlements or inadequate housing	●	●
12.8.1 Extent to which (i) global citizenship education and (ii) education for sustainable development (including climate change education) are mainstreamed in (a) national education policies; (b) curricula; (c) teacher education and; (d) student assessment	●	●
13.1.1 Number of countries with national and local disaster risk reduction strategies	●	Not applicable
13.1.2 Number of deaths, missing and persons affected by disaster per 100,000 people	●	●
16.1.1 Number of victims of intentional homicide per 100,000 population, by sex and age	●	●
16.1.2 Conflict-related deaths per 100,000 population, by sex, age and cause	●	●
16.2.1 Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month	●	●
16.2.3 Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18	●	●
16.9.1 Proportion of children under 5 years of age whose births have been registered with a civil authority, by age	●	●
17.18.1 Proportion of sustainable development indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics	●	●

ANNEX 1 STATUS OF DATA FOR CHILDREN IN THE SDGs

Child-related SDG global indicators	Data availability ^a (% countries)	Disaggregation ^b of available data (● good, ● limited, ● poor)
17.19.2 Proportion of countries that a) have conducted at least one Population and Housing Census in the past 10 years, and		
b) have achieved 100 per cent birth registration and 80 per cent death registration		Not applicable

a. Percentage of countries with available data (since 2010): $\geq 75\%$ = , $50\text{--}74\%$ = , $< 50\%$ = 

b. Number of relevant stratifiers available (location, wealth, age, sex, other): 3 or more =  (good), 1–2 =  (limited), 0 =  (poor)



6 month old Luis Zambrano
looks up to his mother -
Esmeralda Zambrano.
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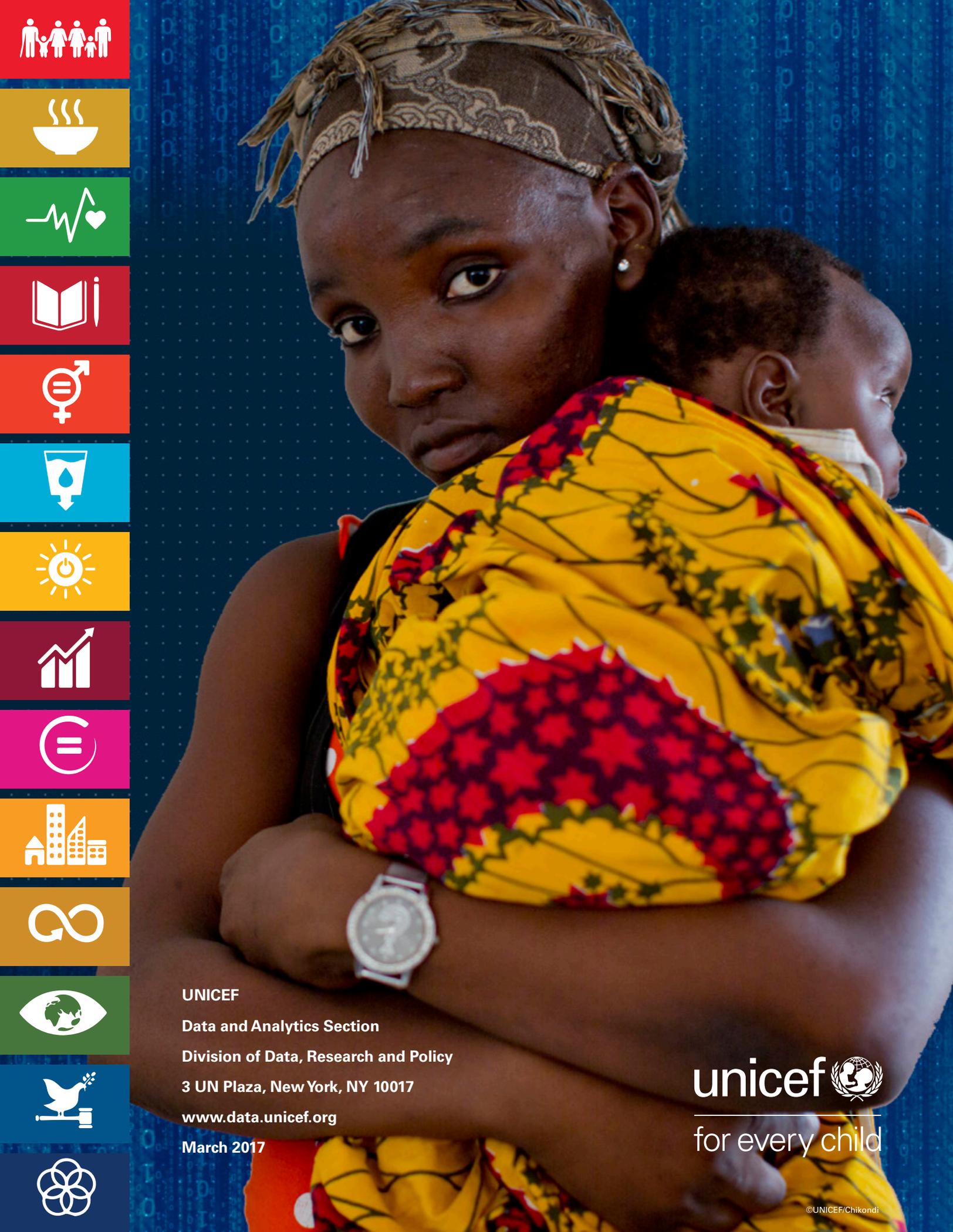
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63. Estimates presented here are based on children aged 5–14 instead of 5–17 (as per the SDG indicator definition) because data collection on child labour in the DHS and MICS has only recently expanded to include the age group 15 to 17 years and therefore data availability for the full age group 5–17 is currently limited.
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