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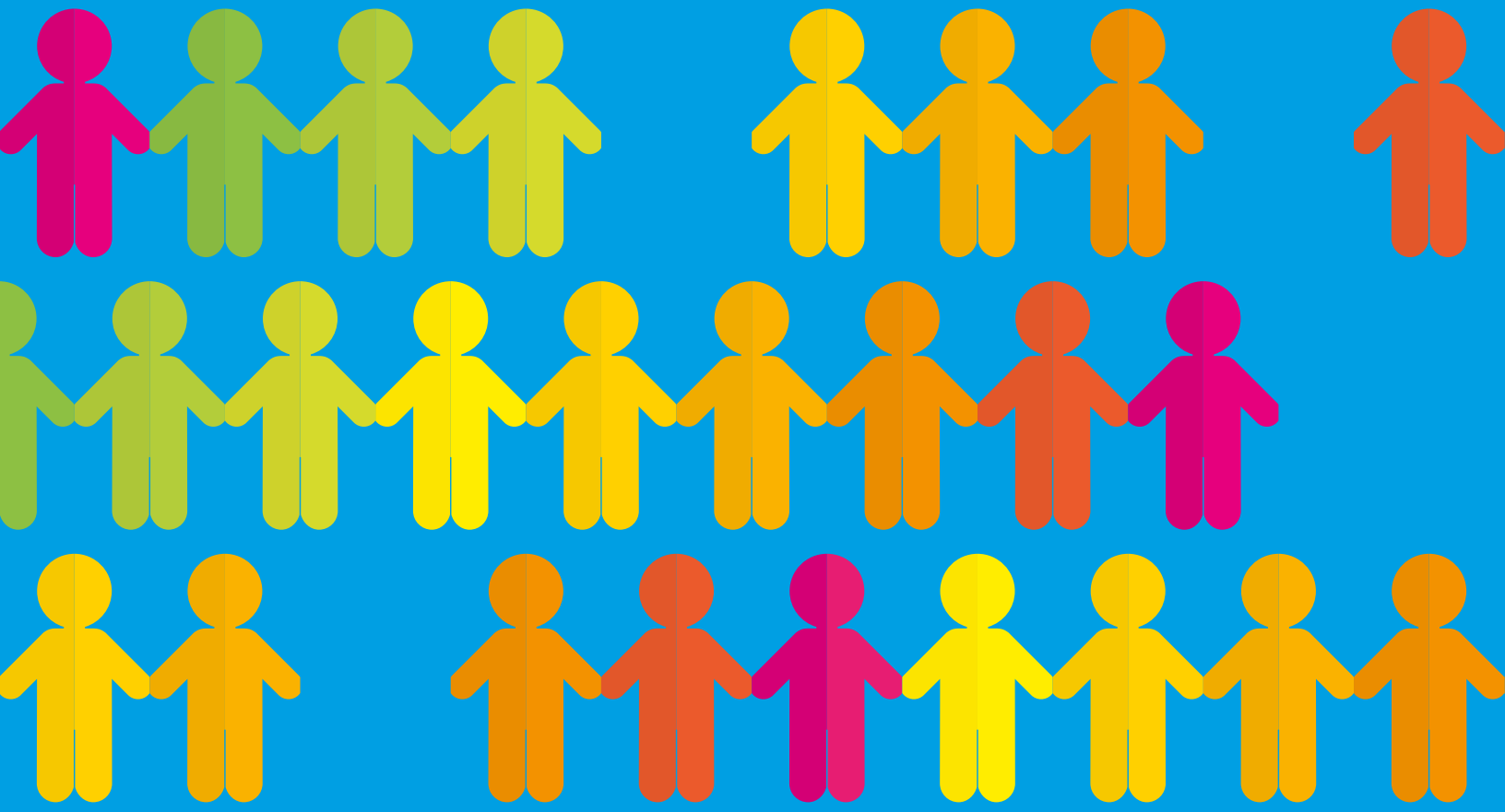
PROGRESS FOR CHILDREN

BEYOND AVERAGES: LEARNING FROM THE MDGS



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Progress for Children

Beyond averages: learning from the MDGs

NUMBER 11, 2015

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FOREWORD

LEARNING FROM THE MILLENNIUM DEVELOPMENT GOALS

"[We have a duty] to all the world's people, especially the most vulnerable, and in particular the children of the world, to whom the future belongs."
The United Nations Millennium Declaration

With these words, affirmed by the governments of the world at the dawn of a new millennium, the global community resolved to achieve change on a massive scale for millions of people. To build a more peaceful, prosperous, and just world for the children who will inherit it – and generations to come.

And since 2000, the Millennium Development Goals (MDGs) have helped drive tremendous progress for children, proving how much can be achieved by galvanizing global efforts around concrete, common goals.

Much of that progress is captured in the pages of this report. These are not merely statistics. Every child saved from disease or malnourishment … every baby protected from HIV … every girl learning in school ... every community enjoying a safer source of water … every family escaping crushing poverty … is a victory.

But even as we celebrate these successes, we cannot – and we must not – ignore the failures.

Because for all our progress, we *have* failed millions of children: the most vulnerable children, to whom we owe our greatest efforts. And even as some gaps have narrowed, others have persisted and in some cases widened – even within countries reporting national gains.

What can we learn from this?

The problem is not what we might think: that we were too ambitious, or aimed too high, and so naturally did not reach every child we thought we could.

The problem is not that we were too ambitious. It is that we were not ambitious enough.

In setting broad global goals the MDGs inadvertently encouraged nations to measure progress through national averages. In the rush to make that progress, many focused on the easiest-to reach children and communities, not those in greatest need. In doing so, national progress may actually have been slowed.

This is because we were not strategic enough. Though it was once assumed that reaching the hardest-to-reach was unrealistic, we now know that investing in the most disadvantaged children can actually be more cost-effective, as we reported in the pages of the 2010 study, *Narrowing the Gaps to Meet the Goals*. In the five years since then, more and more evidence is showing that an equity approach – disaggregating data and targeting programmes to reach the most disadvantaged and overcome the barriers that exclude them from critical services – can accelerate progress.

And we were not far-sighted enough. The data contained in this report show that equitable progress is more than possible. It is being achieved. Equity-focused programming can make a huge difference in the lives of millions of children. We *can* narrow the gaps between those who want for nearly nothing and those who want for almost everything.

Why does this matter? Because inequity today is the foundation of inequality

tomorrow. Persistent gaps in opportunity – between rich and poor households, urban and rural communities, boys and girls, majority and minority groups – perpetuate vicious intergenerational cycles of deprivation and disadvantage and deepen rifts in society that harm us all.

As we publish this report, the global community is increasingly reflecting on the social, economic, political and human costs of inequality. Stories fill the media about lower life expectancy for children born only blocks apart in the same city, divided by economic, ethnic and social disparities. Or on rampant unemployment and gang violence among youth denied a quality education or an opportunity to participate.

And these illustrations are often from wealthy countries. Inequality is a disease whose symptoms can be found in virtually every society – tallied in lives and missed opportunities, and marked by lower productivity, slower growth, and social resentments.

But as the economist Joseph Stiglitz recently wrote, inequality is not inevitable. It is a disease that can be cured – but only if we address its major cause: the inequities of opportunity that limit children's futures from the first days of their lives.

Every child deserves a fair chance in life. Our future depends on it. As the global community comes together around the Sustainable Development Goals, we should set our sights first on reaching the children left behind as we pursued the MDGs.

That means doing a better job in collecting and using data to find out who the most vulnerable and excluded children are and where they can be found. It means overcoming the bottlenecks that stand in their way – including by strengthening local health and education systems and social protection. It means shaping programmes, services and investments directly around the needs of the most disadvantaged.

And it means measuring our progress toward global development goals not only by statistical averages, but also by the degree to which the most disadvantaged children benefit from that progress.

For if development is to be truly sustainable, it must be truly equitable – and seek to reach every child. For children who have equal opportunities will in turn create greater opportunities for their own children and the generations that follow.

This must not be seen as optional. The stakes are enormous and so are the needs – especially with population growing quickly in the places where children are already most disadvantaged … with the effects of climate change growing … and with a rising tide of conflicts, disasters and other humanitarian emergencies affecting millions of children every year.

Innovation, new technologies, better data about the lives and needs of the most disadvantaged children, and more effective ways of working together all are expanding our ability to reach the most vulnerable – and to help them reach us and make their voices heard by their governments.

We have the chance now to learn from the MDGs, stopping vicious cycles of intergenerational disadvantage and setting in motion a virtuous cycle of opportunity and truly sustainable development.

This is the moment to seize that chance. Future generations will and should hold us accountable for a failure to do so.

Anthony Lake
Executive Director
UNICEF

INTRODUCTION

A child's chance to survive and thrive is much greater in 2015 than it was when the global community committed to the MDGs in 2000.

Data show significant progress in areas such as child survival, nutrition, mother-to-child transmission of HIV and primary school enrolment, among others. These are impressive achievements, but they are only part of the story.

This report also shows progress for the most vulnerable, proving that a more equitable world is within reach. But despite this progress, millions of the children in greatest need have been left behind – the most marginalized and vulnerable children whose future the MDGs were designed to safeguard.

Children from the poorest households, for example, are one third as likely to be born with a skilled birth attendant present and two times as likely to die before their fifth birthday as children from the richest households. They are also far less likely to achieve minimum learning standards.

Leaving these children behind has serious consequences – both for their lives and for the long-term strength and stability of their countries.

The world has a chance to greatly reduce unequal opportunity among children within a generation – if we address the underlying drivers of disadvantage. This means investing in equity-focused programmes and policies, based on robust data that identify the children missing out. And it means more innovative thinking, better methods for community engagement and stronger systems for health, education and protection.

As we learn from the successes and failures of the last 15 years and set a course for achieving the Sustainable Development Goals, we face a choice: Focus on reaching the hardest-to-reach children or fail them yet again? Making the right choice now is our best chance at a sustainable future for generations to come.

A FAIR START IN LIFE

Before she draws her first breath, a child's chances in life are shaped by circumstances beyond her control: her gender, place of birth and the social and economic situation of her family.

A poor start in life can leave indelible imprints on a child. Whether she survives or succumbs to childhood disease; whether she is provided or deprived of what she needs for her mind and body to develop properly; whether she is protected from or exposed to risks – all have significant long-term consequences for the strength of her society.

The MDGs provided targets against which to measure progress for children, and against which to hold the global community accountable. Nearly 15 years of concerted effort have resulted in tremendous strides in improving the starting conditions for millions of children.

As this report shows, a child born today has far greater advantages than she would have had a generation ago. She has a much better chance of reaching her fifth birthday. She is less likely to suffer stunting and more likely to go to school. Being educated increases the odds that she won't marry as a child, reduces the risk of an early birth, and makes it more likely that her own children will be healthy and educated.[1]

While stark disparities still exist, there is strong progress for vulnerable groups. Poor households have seen greater absolute gains in child survival than rich ones. There is a smaller difference in stunting rates, malaria prevention and access to improved sanitation between children in urban homes versus those living in rural homes. And the ratio of boys to girls in primary school has reached parity in four regions of the world, while more children – both from the richest and poorest households – are now attending school in every region.

But the data make it all too clear that millions of the world's most vulnerable children were left behind.

By many measures – such as antenatal care, early childhood education and child marriage – the gulf between the advantaged and the disadvantaged remains wide. In Africa and South Asia, the two regions where half of the world's children live, the challenges that remain often disproportionately affect the poorest and most disadvantaged children and communities. While these inequities persist in every region, demographic changes already under way in Africa and South Asia threaten to increase the numbers of disadvantaged children.[2]

If the most deprived young children are not given a fair chance for basic opportunities, they can fall further behind and equity gaps can widen. As children grow up, initial inequities often manifest themselves in worse health outcomes, poorer learning outcomes and lower employment rates.[3] Eventually, these unequal outcomes weigh down overall economic growth and prosperity.[4]

An investment in giving every child a fair chance is an investment in tackling inequality, offering the potential for both immediate and long-term returns for children and societies. This eleventh edition of *Progress for Children* presents data that mark progress towards that vision.

GLOBAL ACHIEVEMENTS, BUT NOT FOR EVERY CHILD

The MDGs provided countries with direction – purpose – and a 1990 baseline against which to measure success. But in many cases, measuring global averages masked differences at regional, national and subnational levels. And so, despite achievements during the MDG period, millions of the most disadvantaged children are being left behind – partly because without concerted efforts to track different results for different groups, inequities can go unnoticed.

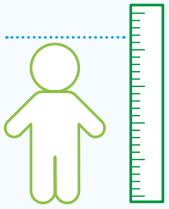
For example, data from 1990 and projected to 2015 show:

- Children from the poorest quintile are two times as likely to die before their fifth birthday as children from the richest households.
- Across regions, children from the poorest households are far less likely to achieve minimum learning standards than those from the richest.
- In most sub-Saharan African countries, girls from the poorest households remain most disadvantaged in terms of school participation.
- Adolescent girls are disproportionately affected by HIV, accounting for nearly two thirds of all new HIV infections among adolescents in 2013.[5]
- Disparities in maternal health are persistent and profound. Women in the richest quintile were almost three times as likely to deliver with a skilled health attendant as women in the poorest quintile. This disparity has not changed in 15 years.
- Over the course of about two decades, the gap in global levels of child marriage between women from the richest and poorest quintiles has dramatically increased.

Progress and disparities for children...

NUTRITION

41% reduction in the stunting rate since 1990

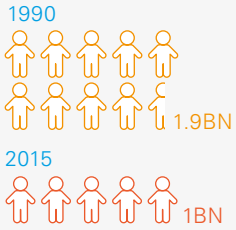


Yet today...

Rural children are more likely to be stunted than urban children

POVERTY

Number of people living in absolute poverty

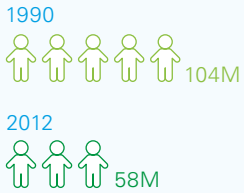


Yet today...

47% of people living in extreme poverty are 18 years old or under

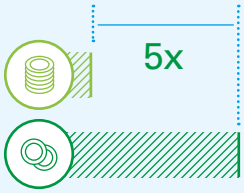
PRIMARY EDUCATION

Number of out-of-school children



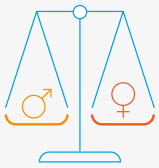
Yet today...

The poorest children are more likely to be out of school than the richest children



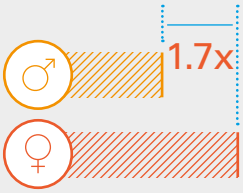
GENDER EQUALITY

Four regions have achieved gender parity at the primary school level since 1990



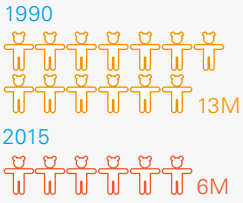
Yet today...

Female youths are more likely to be illiterate than male youths



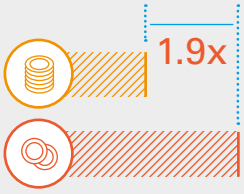
CHILD MORTALITY

53% reduction in the number of under-five deaths



Yet today...

The poorest children are more likely to die before age 5 than the richest children

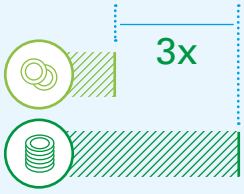


MATERNAL HEALTH

45% reduction in maternal mortality ratio since 1990

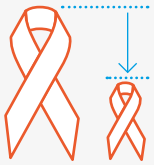
Yet today...

The richest women are more likely to give birth with a skilled attendant than the poorest



HIV/AIDS

58% reduction in new HIV infections (0–14 years old) since 2001

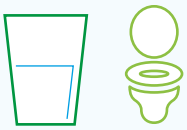


Yet today...

Girls account for nearly 2/3 of all new HIV infections among adolescents (15–19 years old)

WATER AND SANITATION

People who gained access to improved drinking water and sanitation facilities since 1990



Yet today...

90% of people who still use surface water live in rural areas

DATA FOR EVERY CHILD

We owe our progress towards achieving the MDGs to political will and the drive of communities to improve their own lives. But we also owe a great deal to the credibility, availability and depth of data, which have improved exponentially since 1990.

Much of the recent progress on data for children over the past couple of decades has been spurred by the rapid expansion and innovation of international household survey programmes, such as the UNICEF-supported Multiple Indicator Cluster Survey Programme. These programmes are crucial to identifying and tracking the equity agenda through the disaggregation of information by wealth status, geographic area, sex, ethnicity, language, religion, age and other factors that may signal parameters of disadvantage. Household surveys have provided insights – far beyond disaggregating data – to advance knowledge about the lives and attitudes of adolescents and to improve programming around gender issues such as female genital mutilation/cutting.

The unprecedented increase in data since 1990 has allowed better reporting, monitoring and targeting of policies and programmes to reach the unreached. In addition, data provide evidence for civil society to advocate on behalf of children and for citizens to hold their governments to account.

Despite significant advances in the quantity and quality of data and how it is analysed, there are still critical gaps in our knowledge about the children in greatest need – and in our ability to measure our success in reaching them. In order to give voice to these children, we need to collectively invest in improving data collection methods and systems to be able to count those who are not being counted.

THE IMPACT OF A CHANGING WORLD ON THE MOST DISADVANTAGED CHILDREN

Data can demonstrate the degree to which the most disadvantaged and marginalized children are denied equal opportunities in life. Data can also indicate the trends and issues that are shaping the world in which children live, and will be living in the future. From population growth and technological advances to the effects of chronic violent conflict and climate change – how the world adapts to the following trends will affect children well into the future.

Population growth

By 2030, the world's population is expected to grow by 1 billion and by 2050 it will probably reach 9.5 billion.[6] The world population of children under 18 will increase only slightly, by 5 per cent, from 2.2 billion in 2015 to 2.4 billion by 2030 and stay at a similar level in 2050.[7] While other regions see falling or steady child populations, a sharp rise is expected in sub-Saharan Africa.[8] By 2030, about one in four people under age 18[9] – and one in three under age 5 – will live in that region.[10]

Such demographic shifts have potential advantages, however investments need to be made in expanded and improved health care, education and protection to account for the projected increase in live births and child population in many countries in sub-Saharan Africa.

For example, in order to keep the same coverage of birth attendance as in 2012 (53 per cent) for the year 2030, roughly 25 million births need to be attended – 7 million births more than the 18 million in 2012, requiring many more health personnel and facilities.

Urbanization

The world is becoming more and more urbanized. By 2050, an additional 2.5 billion people are expected to be living in the cities of Africa and Asia – making up nearly 90 per cent of the global increase in urban population.[11] By 2018, Asia will have more people living in urban areas than in rural areas; that change will come to Africa by 2037.[12] How can the world be certain that the most vulnerable are not left behind in this transition? Without the capacity to identify and report on the experience of children living in urban slums, how will their needs be met?

Technological advances

The poorest and most marginalized children often live in geographically hard-to-reach communities. New technologies make an equity-based approach more feasible than ever before. Mobile technology is allowing more remote access to health and education; and the rise of social media is transforming how people share ideas, collaborate and organize.[13] Innovators are drawing on unconventional sources of knowledge and collaboration, disrupting established processes and structures, and using available resources creatively to produce practical solutions that deliver higher quality or greater impact at lower cost.[14]

Conflicts

The impacts of conflicts underscore the urgent need for an equitable approach to development. Progress for children, in education for example, has been slowest in conflict-affected and fragile states,[15] and the heaviest burden falls on the most marginalized children and families. Children and young people living in conflict-affected countries are more likely to be poor, malnourished, out of school or in generally poor health. The interplay of conflict, poverty and discrimination often compounds the harmful consequences for children.[16]

Globally, an estimated 230 million children currently live in countries and areas affected by armed conflicts.[17] These children are often witnesses to and victims of violence, or are forced into joining armed groups. As their access to health, nutrition, safe water and sanitation decreases, they are also more vulnerable to diseases. Displaced from their homes or forced to flee their countries, they are likely to be out of school and, if separated from their families, are at greater risk of exploitation, violence and abuse.

Disease epidemics and other emergencies

Disease outbreaks can occur at any time, with potentially catastrophic effects on the communities, countries and regions with the weakest health systems. The greatest long-term impact of these emergencies is borne by the poorest.[18] The swift spread of the Ebola virus – putting to date 9.8 million children and young people under 20 years old at risk[19] – was greatly exacerbated by ill-equipped health systems in the countries hardest hit. A lack of adequate facilities, knowledge and capacity, as well as poor hygiene and sanitation practices, are among the factors that put affected countries at a great disadvantage in responding to the disease. Stronger health systems that target those at greatest risk can dramatically decrease a country's vulnerability to major health emergencies.

Natural disasters and climate change pose further threats to maintaining the gains that have been made for children. Every year from 1990 to 2000, climate change-related disasters affected approximately 66.5 million children, 600,000 of whom died. In the coming decade, the number affected is projected to reach 175 million a year.[20] From the earthquake in Haiti to Typhoon Haiyan in the Philippines, the ramifications of disasters on countries and communities can be felt for generations. In these situations, as in conflicts, it is the most marginalized children and families that bear the disproportionate burden of natural hazards, shifting agricultural patterns, land erosion and more.

Mass migration

Disaster and conflicts around the world have another consequence: mass migration and internal displacement. In 2013, global levels of forced displacement were remarkably high, with 33.3 million people internally displaced and 16.7 million refugees – half of whom were children under 18.[21] Children who migrate or are displaced may face challenges including difficulty accessing social services, challenges to their rights to citizenship and identity, and danger of social exclusion.[22]

Left unaddressed, the compounding challenges of changing demographics, disaster risk, poverty, conflict and instability can create traps from which escape becomes ever more difficult. Meaningful progress for children in the coming decades will require special attention to children, families and communities with the greatest need in the countries and regions most affected by these trends.

A FAIR CHANCE FOR EVERY CHILD

A fair start in life for all children is not only right; it is necessary to achieve global development goals.

Five years ago, using child mortality as a case study, UNICEF demonstrated that prioritizing the most disadvantaged children and the countries in greatest need is both cost-effective and can fast-track progress towards global goals.[23]

For individual nations, making – or failing to make – progress towards equity will have lasting ramifications for stability and economic growth. Evidence shows that rising inequality in key dimensions like education can increase the risk of conflict.[24] Low levels of inequality, in contrast, are strongly associated with longer and more sustained economic growth. These findings make it clear that the path towards peace and prosperity must be a shared one.

Unless we accelerate our current rate of progress, millions more children will be left behind. In education, for example, with population growth in lower-performing regions, there will be little reduction in the number of children out of school in 2030 compared to today. Current rates of decline in stunting will still leave 119 million children stunted by 2030, denying them a fair chance at survival, growth and development. If we continue on the current path, 68 million more children under five will die from mostly preventable causes and half a billion people will still be practicing open defecation 15 years from now. Eliminating open defecation by 2030 will require doubling the current rate of reduction.[25]

But it doesn't have to be this way. With sufficient investments focused on the most disadvantaged children and communities and backed by committed leadership, great strides are possible. If we focus greater investment and attention on reaching the hardest to reach – with better, more inclusive, disaggregated data, systems strengthening, innovation and local engagement to overcome the last barriers – we can make a dramatic and lasting difference in the lives of millions of excluded children. A focus on equity is the only way to achieve our global development goals in a way that is truly sustainable – and truly equitable for all.

MDG 1

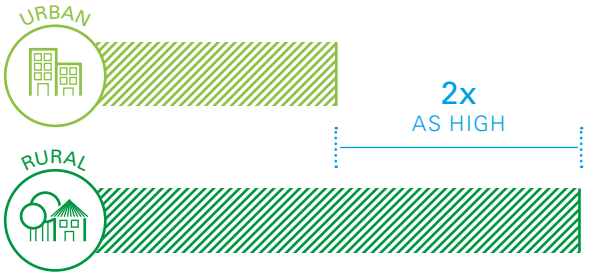
ERADICATE EXTREME HUNGER AND POVERTY

Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Halve, between 1990 and 2015, the proportion of people whose income is less than $1.25 a day

NUTRITION AND POVERTY

STUNTING PREVALENCE AMONG CHILDREN UNDER AGE 5



PROPORTION OF ALL STUNTED CHILDREN LIVING IN LOW- AND LOWER-MIDDLE-INCOME COUNTRIES

BREASTFEEDING WORLDWIDE

Less than half
of infants under 6 months of age worldwide are exclusively breastfed

EXTREME POVERTY WORLDWIDE

Nearly half
of people living in extreme poverty are 18 years old or under

Stunting

Improving children's nutrition brings about positive changes in productivity, economic development and poverty reduction that contribute to society as a whole. Good nutrition enhances health, cognitive development and school performance. Action needs to be taken early on, however, as poor nutrition in the first 1,000 days of a child's life can lead to stunted growth, which is irreversible and can cause life-long consequences associated with impaired cognitive ability and reduced school performance.

Since 1990, the number of overweight children under five in low-income countries has nearly quadrupled, compared to a decrease of 20% among upper-middle-income countries.[29]

Nearly half of all deaths in children under five are attributable to undernutrition.[26] Being undernourished puts children at greater risk of dying from common infections; increases the frequency and severity of such infections; and contributes to delayed recovery. In addition, the link between undernutrition and infection can create a potentially lethal cycle of worsening illness and deteriorating nutritional status.

Between 1990 and 2015, the global rate of underweight prevalence will have been reduced by an estimated 42 per cent – coming close to the 50 per cent MDG-targeted reduction. Over the same time period, stunting, which has gained precedence as a key global marker of child undernutrition, will have been reduced by 41 per cent.

Three regions will have exceeded a 50 per cent reduction in stunting prevalence (Fig. 1.B) and, since around 2000, will have achieved a marked reduction in the urban-rural gap for stunting (Fig. 1.C).

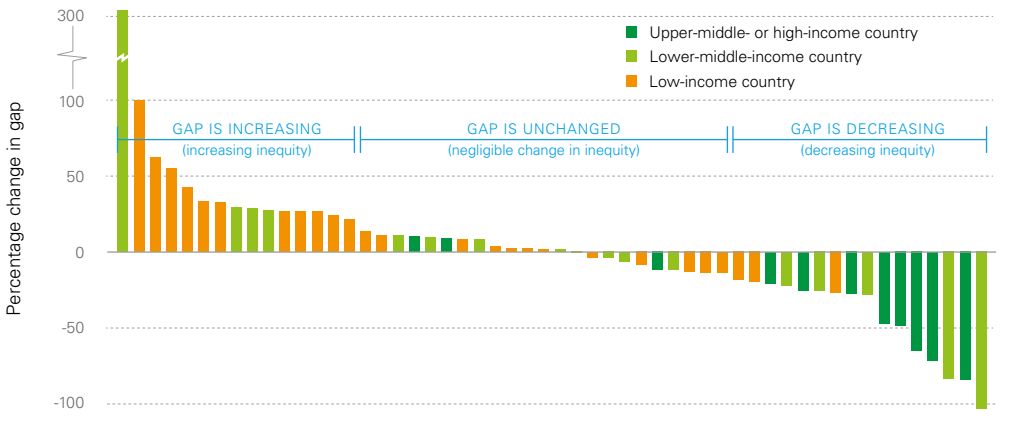
An analysis of 54 countries (Fig. 1.A), with comparable trend data between around 2000 and around 2014, shows that gaps between the poorest 20 per cent and richest 20 per cent of children under five have closed by at least 20 per cent in the majority of upper-middle-income countries. However, more low-income countries show increasing stunting inequities than decreasing inequities.[27]

There is no evidence that girls are at a disadvantage relative to boys with regard to stunting rates.[28]

FIGURE 1.A

Wealth gap in stunting is increasing in more low-income countries than decreasing

Relative change in the gap in stunting prevalence between the richest 20% and poorest 20%, by country, around 2000 and 2014[30]

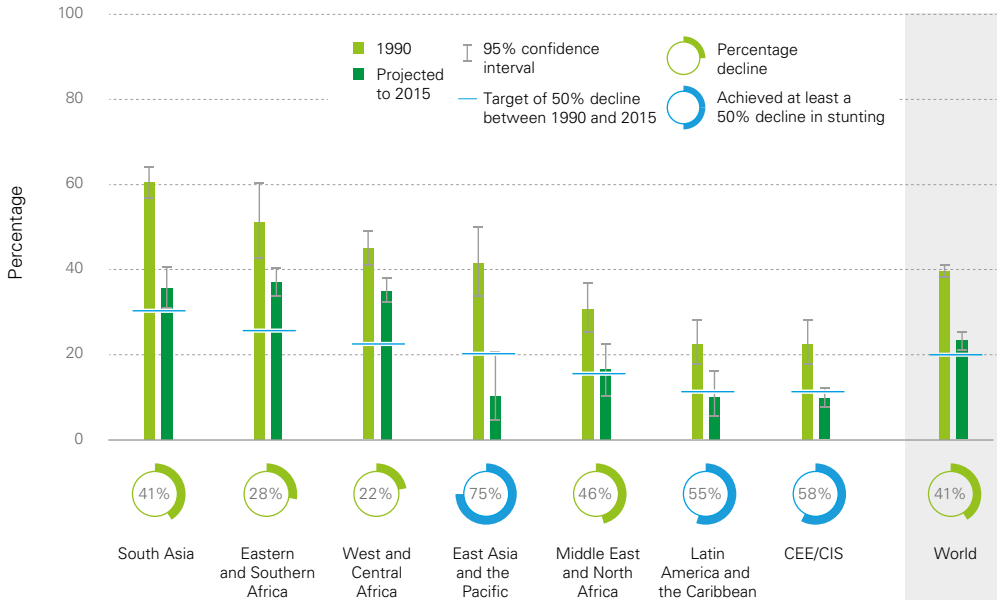


Source: UNICEF global databases, 2015, based on Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS) and other nationally representative sources.

FIGURE 1.B

Three regions have achieved at least a 50% decline in stunting prevalence since 1990

Percentage of children under age 5 moderately or severely stunted and percentage decline, by region, 1990 to 2015[31]



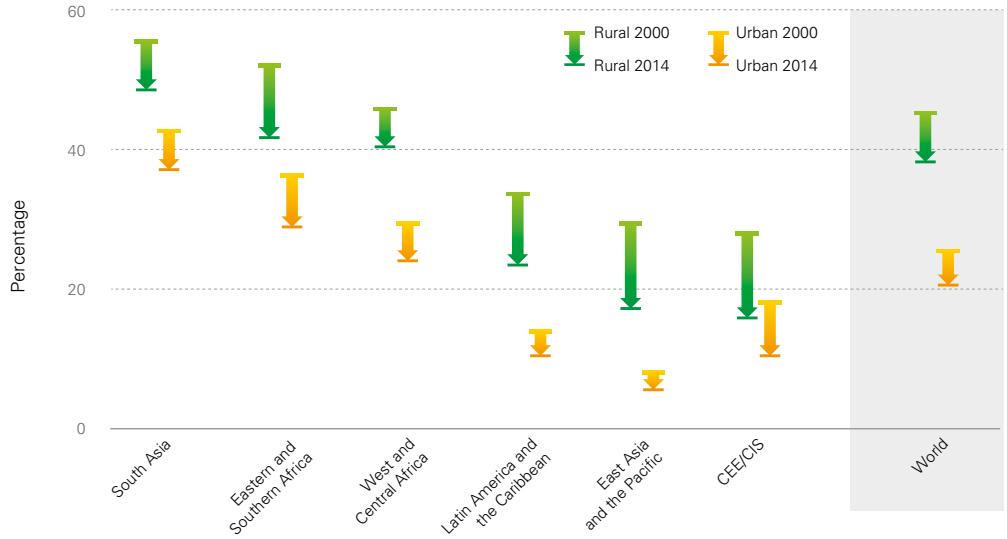
Note: The baseline for CEE/CIS is 1995 and not 1990 because of a lack of any data prior to 1995. This region also excludes the Russian Federation, for which data are not available.

Source: UNICEF, WHO, World Bank Joint Malnutrition Estimates, September 2014 update including projections to 2015.

FIGURE 1.C

Greater progress for rural than urban children in three regions, with the largest declines in stunting since 1990

Percentage of children under age 5 moderately or severely stunted, by area of residence, around 2000 and 2014[32]



Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources.

Infant and young child feeding

Proper feeding of infants and young children can increase their chances of survival. It also supports optimal growth and development, especially in the critical window from birth to 2 years of age. Ideally, infants should be breastfed within one hour of birth – exclusively for the first 6 months of life – and continue to be breastfed up to 2 years of age and beyond. Timely initiation of breastfeeding is a key practice that provides benefits to both the newborn and mother, setting the stage for appropriate breastfeeding practices thereafter. At 6 months of age, breastfeeding should be combined with safe, age-appropriate feeding of solid, semi-solid and soft foods.

An infant who is not exclusively breastfed is at a substantially greater risk of death from diarrhoea or pneumonia than one who is. Breastfeeding supports infants' immune systems and helps to protect them later in life from chronic conditions such as obesity and diabetes. In addition, breastfeeding contributes to protecting mothers against certain types of cancer and other health conditions. Adequate feeding from 6 months of age onwards helps prevent stunting and decrease the risk of infectious diseases.

Yet, despite the potential benefits, less than half of infants under 6 months of age worldwide are exclusively breastfed, with large disparities between regions (Map 1.A). Newborns in West and Central Africa fare the worst. In only one region do more than half of infants 0–5 months of age benefit from this critical practice.

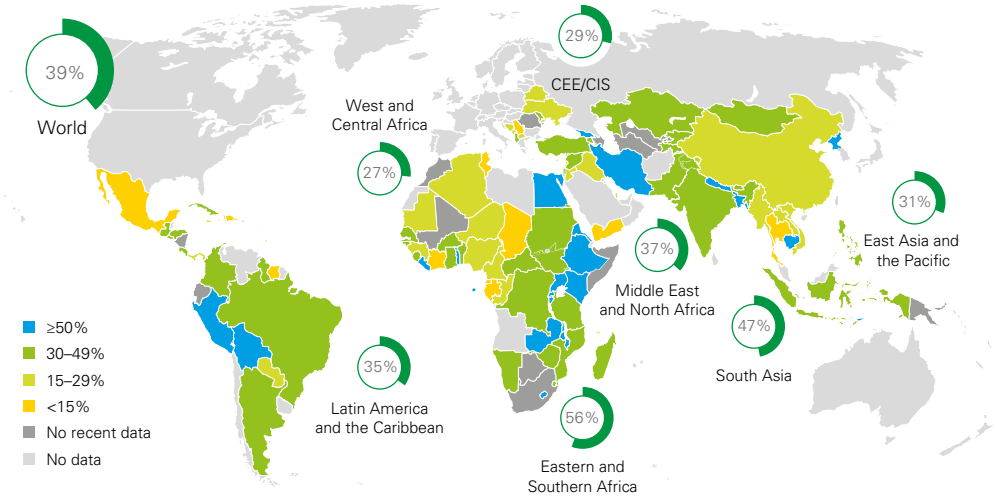
Children living in the poorest households are less likely to be breastfed within one hour of birth than those living in the richest households in South Asia, sub-Saharan Africa and CEE/CIS. The inverse is seen in Latin America and the Caribbean and the Middle East and North Africa (Fig. 1.D), where the highest levels for this indicator are seen among children in the poorest households. Overall, newborns in the poorest households in South Asia and West and Central Africa are at the greatest disadvantage globally in terms of early initiation of breastfeeding.

Starting at 6 months of age, when infants increasingly start to rely on nutrients in other food for their optimal growth and development, the diversity of their diet becomes a key measure of how well they are eating and acts as a proxy for their micronutrient intake. Using available data from 38 countries, an analysis between low-income, lower-middle-income and upper-middle-income countries indicates large disparities in diversity of diet between country incomes as well as wealth quintiles within these country groupings. When it comes to dietary diversity, just over one third of the wealthiest are meeting the minimum requirement in low-income countries (Fig. 1.E).

MAP 1.A

Globally, 61% of infants are not exclusively breastfed

Percentage of infants aged 0–5 months that are exclusively breastfed[33]



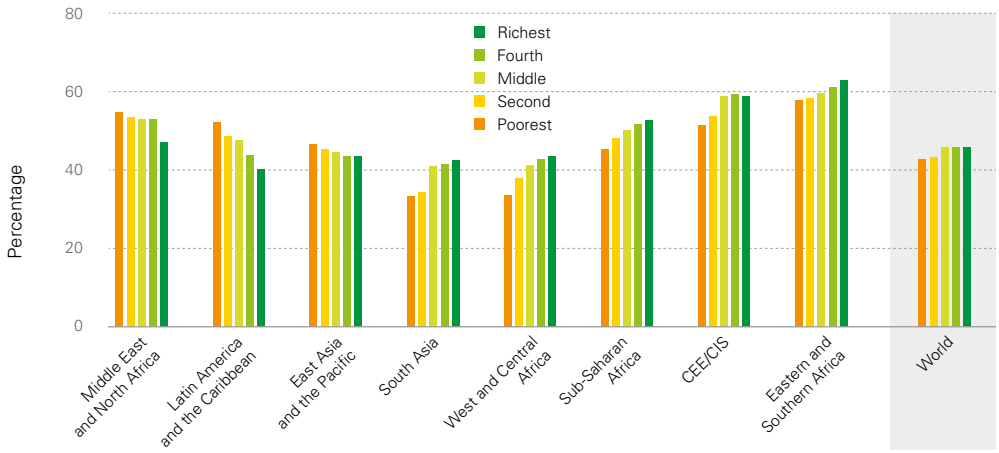
Note: This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not 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: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources, 2008–2014.

FIGURE 1.D

For early initiation of breastfeeding, mixed relationships exist between regions, with the richest households at an advantage in some, and the poorest in others

Percentage of newborns put to the breast within one hour of birth, by region and by household wealth quintile[34]



Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources, 2008–2014.

FIGURE 1.E

Even young children from the richest households in low-income countries are not getting a diverse enough diet

Percentage of children aged 6–23 months who receive food from four or more food groups, median values by income group and by household wealth quintile

Note: Data are presented as medians for countries with comparable data. The values in brackets represent the number of countries included in the analysis for each income group.

Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources, 2010–2014.

Extreme poverty

For children, poverty can last a lifetime. Children growing up in poverty often find their life chances limited at each step, from before birth until well into adulthood.

The Millennium Development Goal of halving the proportion of people living in extreme poverty, measured internationally as living on less than $1.25 a day, was achieved in 2010 – five years ahead of schedule. Yet, more than a billion people still live in extreme poverty.[35] Furthermore, children are significantly overrepresented: while children make up nearly a third of the global population,[36] nearly half of those living on less than $1.25 a day – or 569 million[37] – are 18 years old or under (Fig. 1.G).[38]

Extreme poverty has declined across all regions (Fig. 1.F), with faster progress in East Asia and the Pacific. Although extreme poverty has also been declining in South Asia and sub-Saharan Africa, the majority of people living in extreme poverty are still in these two regions.[39]

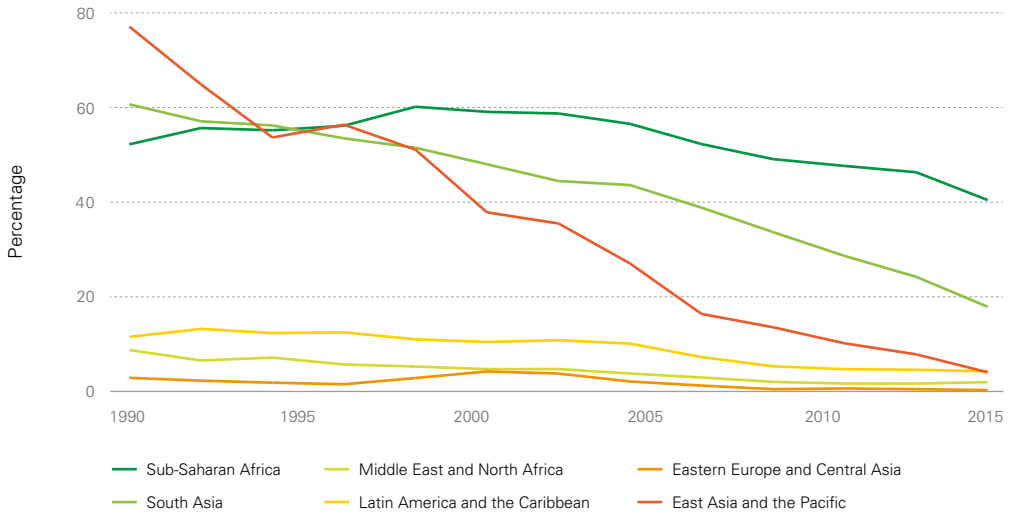
It is the world's poorest countries, those classified as low-income countries, that have faced the greatest challenges to reduce poverty.[40] In these countries, extreme poverty rates have fallen by less than 33 per cent and the number of people living in extreme poverty increased between 1990 and 2010.[41] More than half of the children under age 12 living in low-income countries live in extreme poverty (Fig. 1.H).[42]

A family's income or consumption is only one dimension against which to assess poverty for children. Poverty also means lacking access to critical goods and services such as nutritious food, life-saving vaccines, an education, or clean water and decent sanitation – resources that all children need to grow and thrive.

FIGURE 1.F

Global poverty is declining across the globe (1990–2015)

Percentage of people living on less than $1.25 a day by World Bank region



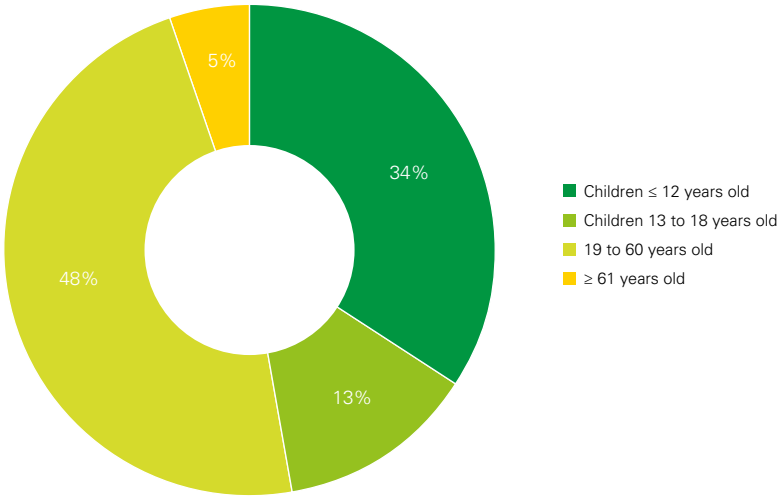
Note: Figures for 2015 are poverty forecasts published by the Development Research Group of the World Bank based on PovcalNet.

Source: Regional aggregates from World Bank PovcalNet.

FIGURE 1.G

Children make up nearly half of the people living in extreme poverty

Percentage of people living on less than $1.25 a day by age, 2010

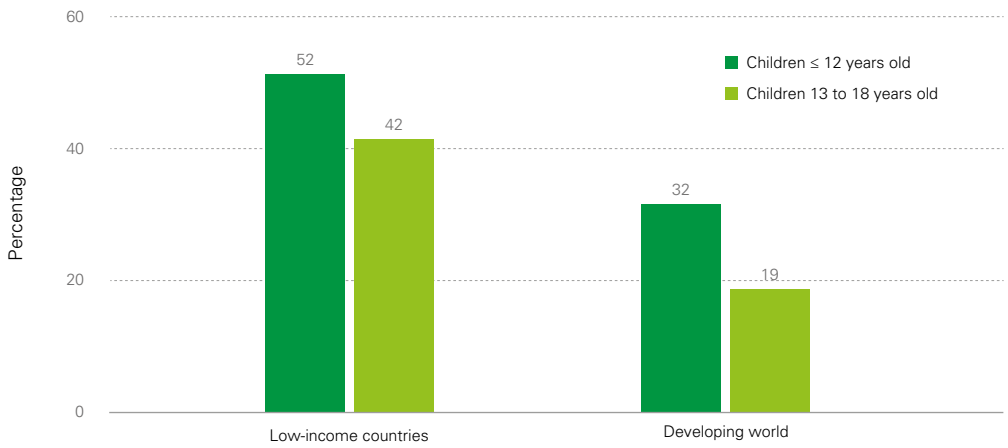


Source: World Bank staff estimates based on I2D2. Olinto, Pedro, et al., 'The State of the Poor: Where are the poor, where is extreme poverty harder to end, and what is the current profile of the world's poor?, *World Bank – Economic Premise,* issue no. 125, October 2013, pp. 1–8.

FIGURE 1.H

Child poverty is particularly acute in low-income countries and among younger children

Percentage of children of different ages living on less than $1.25 a day, 2010



Source: World Bank staff estimates based on I2D2. Olinto, Pedro, et al., 'The State of the Poor: Where are the poor, where is extreme poverty harder to end, and what is the current profile of the world's poor?, *World Bank – Economic Premise,* issue no. 125, October 2013, pp. 1–8.

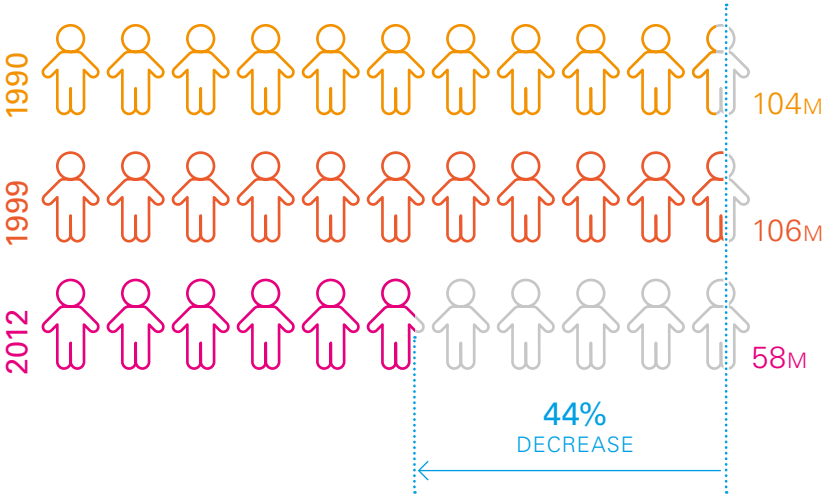
MDG 2

ACHIEVE UNIVERSAL PRIMARY EDUCATION

Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

PRIMARY EDUCATION

GLOBAL NUMBERS OF PRIMARY-SCHOOL-AGED CHILDREN OUT OF SCHOOL



OUT-OF-SCHOOL RATE AMONG PRIMARY-SCHOOL-AGED CHILDREN

MINIMUM LEARNING STANDARDS

Primary education

93% of primary-school-aged children are estimated to be enrolled in school, but the most disadvantaged are still left behind.

Universal primary education provides the foundation for societal progress and has been linked to better health and well-being outcomes.

Although the target of universal primary education will not be met in 2015, remarkable progress was made in lowering the number of out-of-school children (OOSC). Globally, between 1999 and 2012, the number of primary-school-aged children out of school decreased by 45 per cent – from 106 million to 58 million (Fig. 2.A). South Asia made the greatest progress in reducing the absolute number of OOSC – from 36 million (1999) to 10 million (2012). While West and Central Africa significantly decreased the proportion of OOSC as well, reducing the absolute number has been much slower largely because of the rapid growth of the primary-school-aged population. Still, in the region, more than a quarter of children (19 million) are denied their right to education.

The rate of progress towards universal primary education worldwide has significantly stagnated since 2007, with virtually no change in the global rate or number of OOSC, while the percentage of OOSC in conflict-affected countries has increased in recent years. In 2012, more than one third of the world's out-of-school children were living in conflict-affected countries.[43]

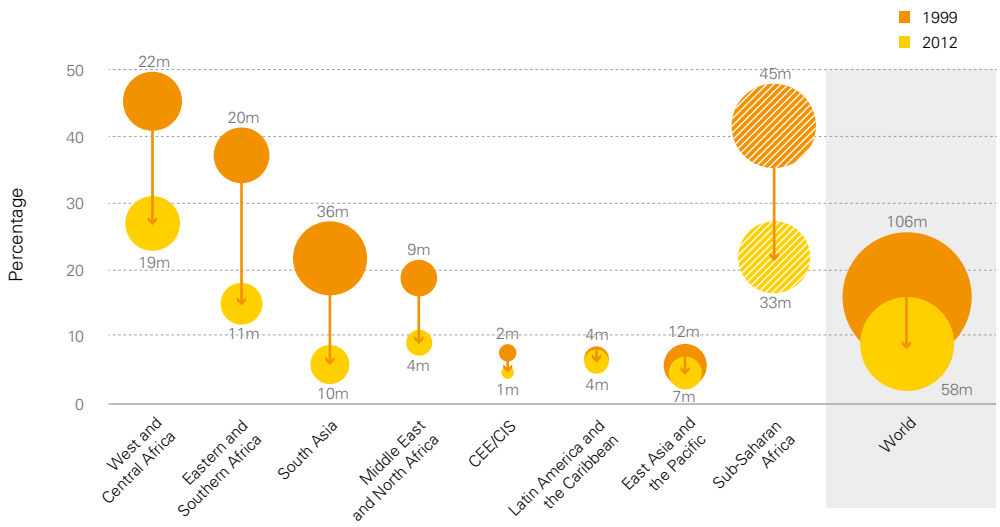
In the majority of countries with data, disparities[44] by wealth (Fig. 2.B) in primary school attendance have narrowed – with the greatest gains among children from the poorest quintile. However, in a number of countries, the wealth gap remains large, and disadvantages based on gender, disability and other markers persist. For instance, in West and Central Africa, children of primary school age from the poorest quintile are on average six times more likely to be out of school as those from the richest.

Disparities are also seen in learning outcomes. Data reveal significant gaps in children's learning performance between the richest households and the poorest. For example, while the learning level remains low – even among children of primary school age in the richest countries – in almost all countries, children from the richest households are far more likely to achieve minimum learning standards in reading than those from the poorest households (Fig. 2.C).

FIGURE 2.A

Globally, the number of primary-school-aged children out of school has decreased by 45%

Number and percentage of out-of-school children of primary school age, by region, 1999 and 2012



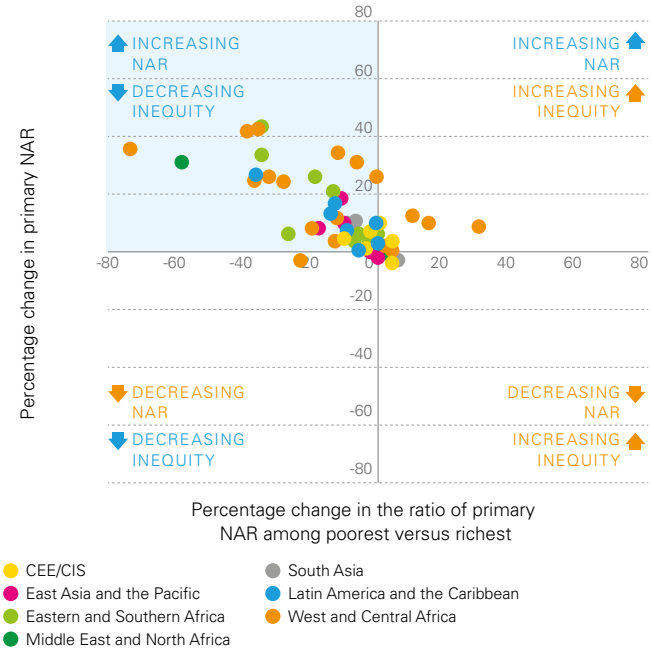
Note: Each bubble represents the number and percentage of out-of-school children of primary school age in a particular region of the world. The vertical position of the bubbles indicates the out-of-school rate in percentage terms (Y-axis) while the size of the bubbles indicates the number of out-of-school children.

Source: UNICEF analysis based on data from the UNESCO Institute for Statistics global databases, 2015.

FIGURE 2.B

With more children in school, disparities between children from the richest households and those from the poorest households have diminished

Change in primary net attendance rate (NAR), and change in the ratio of primary NAR among the poorest 20% versus the richest 20%, for countries with two data points between 2000 and 2014[45]



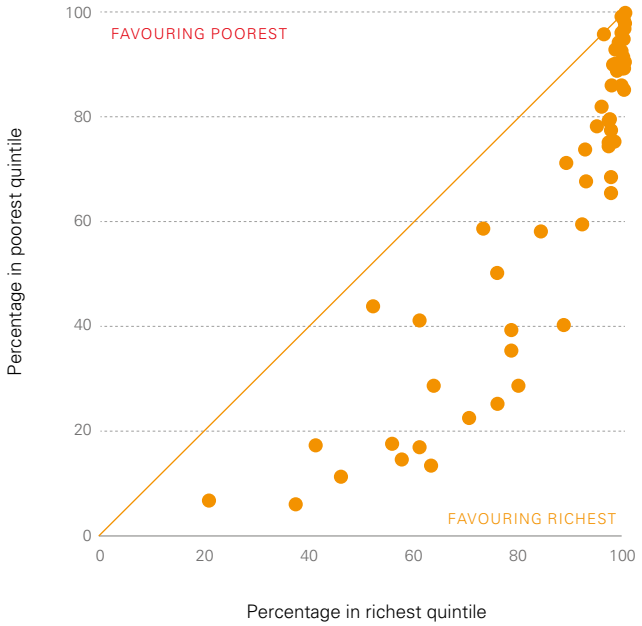
Note: Each dot represents a country and its colour represents the region the country belongs to. The quadrant highlighted in blue indicates a positive trend in both improvement of overall levels and in the reduction of disparities.

Source: UNICEF global databases, 2015, based on MICS and DHS.

FIGURE 2.C

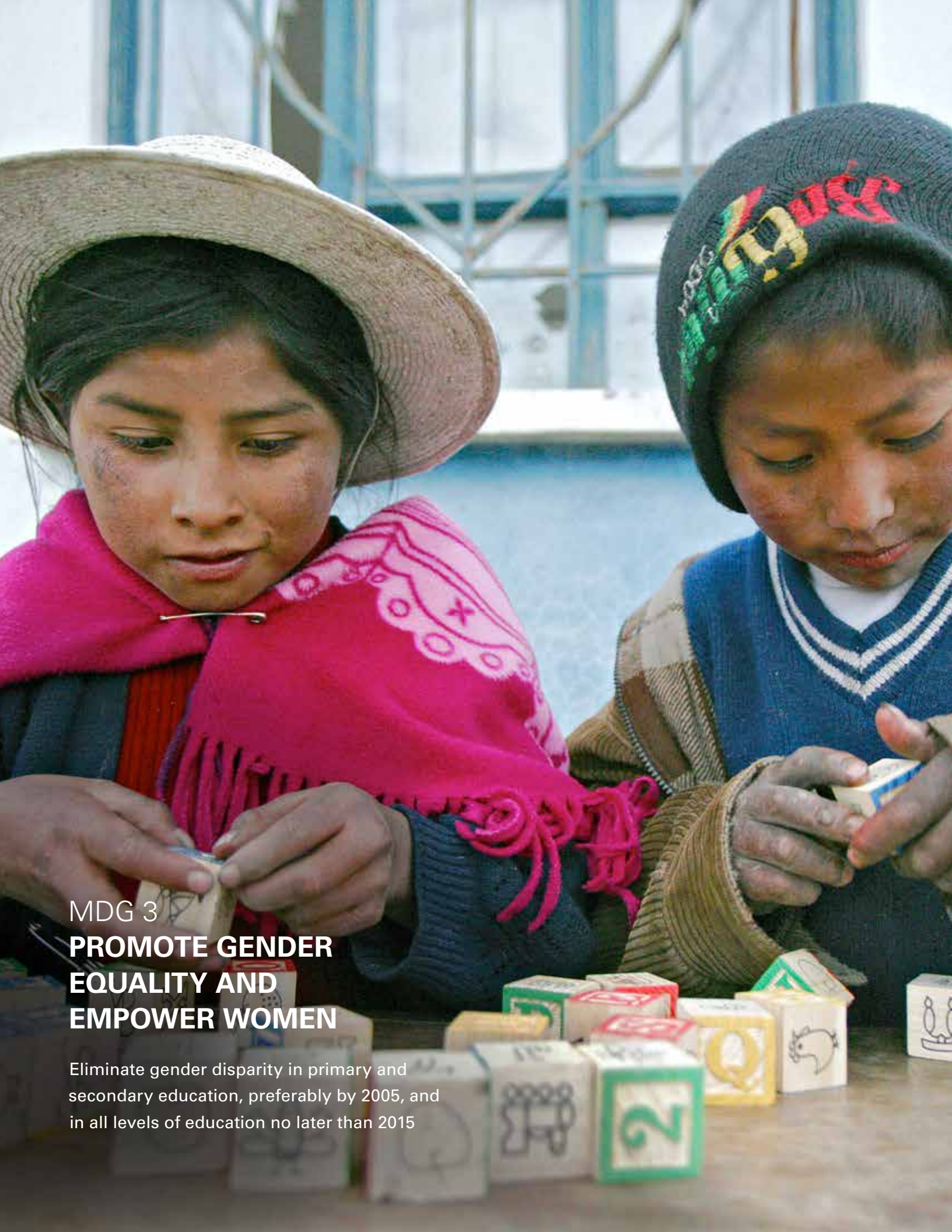
Alarming gaps exist in learning between children in the richest and poorest households

Percentage of children who achieved minimum learning standards in reading, by household wealth quintile[46]



Note: Each dot represents a country. Dots along the diagonal line represent countries where achievement of learning standards is similar among the richest and poorest households, while those above or below the line represent disparity.

Source: UNICEF analysis based on *Education for All Global Monitoring Report* World Inequality Database on Education (WIDE), 2015.



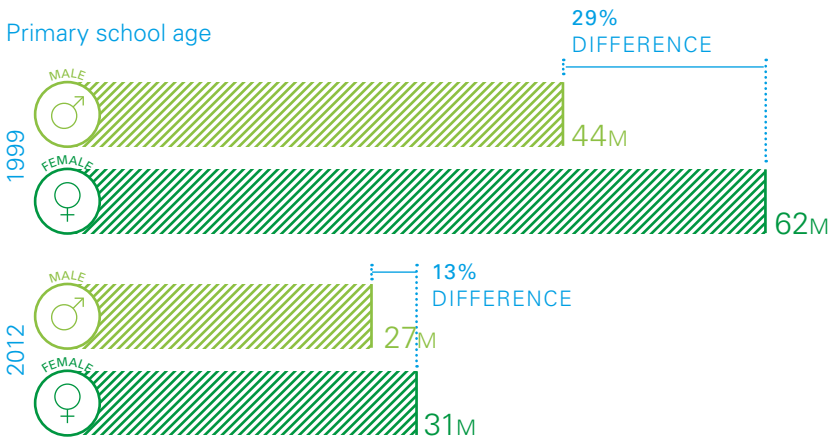
MDG 3

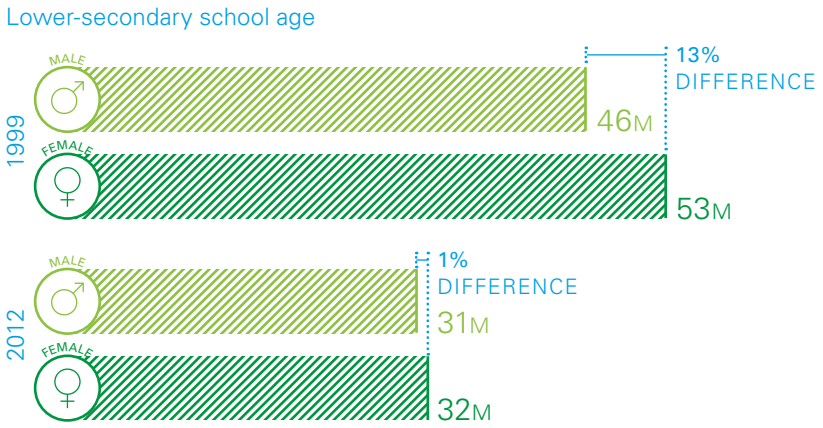
PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

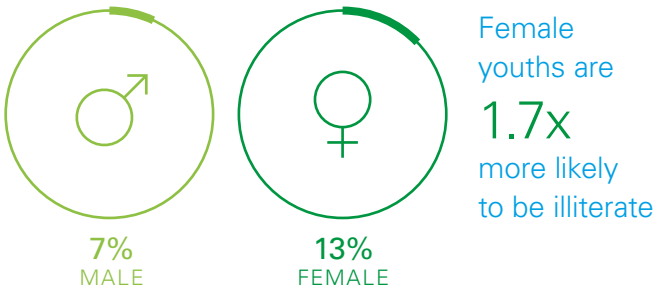
GENDER EQUALITY

GLOBAL NUMBERS OF OUT-OF-SCHOOL CHILDREN





YOUTH (15–24 YEARS OLD) ILLITERACY RATES



Female youths are **1.7x** more likely to be illiterate

Gender equality

Providing girls with an education helps break the cycle of poverty: educated women are less likely to marry early and against their will; less likely to die in childbirth; more likely to have healthy babies; and more likely to send their children to school. When all children have access to a quality education it creates opportunities that influence generations to come.[47]

Four regions have achieved gender parity at the primary level (Fig. 3.A). Among all regions, South Asia experienced the most accelerated progress between 1999 and 2012.

Enrolment rates at the secondary and tertiary levels show mixed outcomes. At the secondary level, only CEE/CIS and East Asia and the Pacific have achieved gender parity. While South Asia has been rapidly catching up, Eastern and Southern Africa appears stagnant and the gap in West and Central Africa remains large.

Female enrolment ratios at the tertiary level are considerably higher than those of males in four regions. Males are more likely to be enroled at this level in South Asia and West and Central Africa – and in Eastern and Southern Africa, where the gap in favour of males at the tertiary level has increased.

Regional aggregates mask large variations among countries. Even in the regions that have achieved gender parity, pockets of girls or boys remain disadvantaged in many countries. Globally, in 2015, 69 per cent of countries with data will have achieved gender parity at the primary level, while 48 per cent will have achieved it at the secondary level.[48]

While increased primary-school attendance rates were accompanied by reduced disparity between boys' and girls' attendance (Fig. 3.A), the gender gap remains large – particularly in sub-Saharan Africa. Poverty and other forms of social disadvantage magnify gender disparities. In most sub-Saharan African countries, girls from the poorest households remain most disadvantaged in terms of school participation. If current trends continue, these girls are only expected to achieve universal lower secondary completion in 2111.[49]

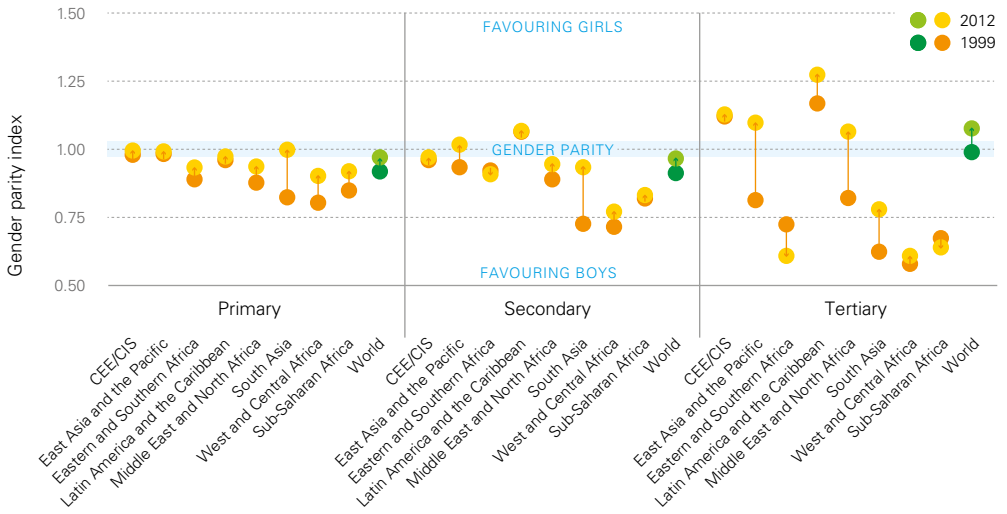
Significant gender disparities also persist in children's learning performance. Data reveal that, overall, girls perform better than boys in reading (Fig. 3.C). Performance in mathematics is mixed: in some countries boys perform better than girls, while in others, it is the opposite. However, in low-performing countries, where less than half of children achieve minimum learning standards, boys are more likely to perform better than girls in mathematics.[50]

While the gender gap is narrowing, in sub-Saharan Africa still only 84 girls were enrolled in secondary school for every 100 boys.

FIGURE 3.A

Gender gaps remain large in sub-Saharan Africa and at the tertiary level

Gender parity index of gross enrolment ratios by level of education and by region, 1999 and 2012



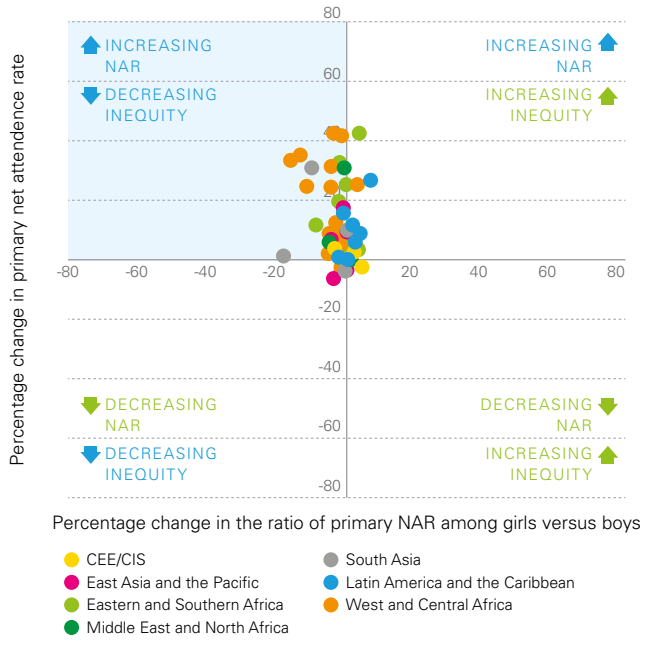
Note: The gender parity index (GPI) is a ratio of female gross enrolment ratio to male gross enrolment ratio. A GPI equal to 1 indicates absolute parity between females and males. A value less than 1 indicates a disparity favouring boys and a value greater than 1 indicates a disparity favouring girls. The MDG sets GPI between 0.97 and 1.03 as a parity target.

Source: UNICEF analysis based on data from the UNESCO Institute for Statistics global databases, 2015.

FIGURE 3.B

With more children in school, there is also less gender disparity

Change in primary net attendance rate and change in the ratio of primary NAR among girls versus boys, for countries with two data points between 2000 and 2014[51]



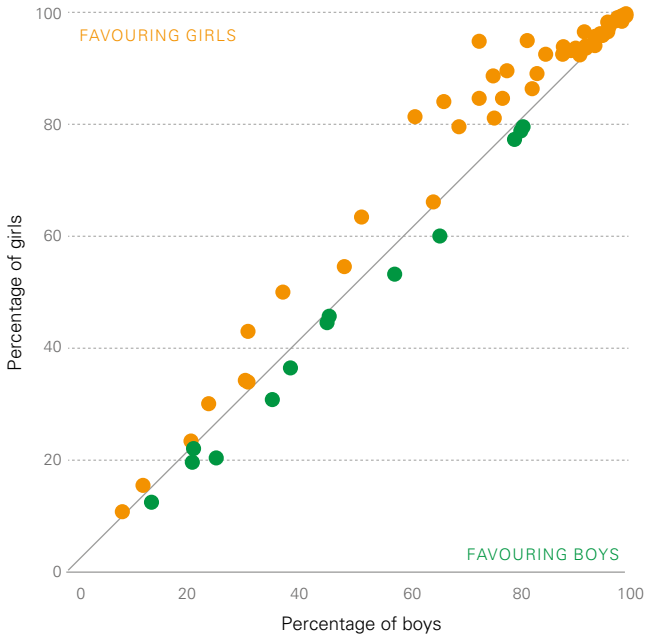
Note: Each dot represents a country and its colour represents the region the country belongs to. The quadrant highlighted in blue indicates a positive trend in both improvement of overall levels and in the reduction of disparities.

Source: UNICEF global databases, 2015, based on MICS and DHS.

FIGURE 3.C

Girls outperform boys in reading, but learning levels are low in many countries

Percentage of children who achieved minimum learning standards in reading, by sex[52]



Note: Each dot represents a country. Dots along the diagonal line represent countries where achievement of learning standards is similar among girls and boys, while those above or below the line represent disparity.

Source: UNICEF analysis based on *Education for All Global Monitoring Report* World Inequality Database on Education (WIDE), 2015.

MDG 4

REDUCE CHILD MORTALITY

Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

CHILD MORTALITY

IN 2015

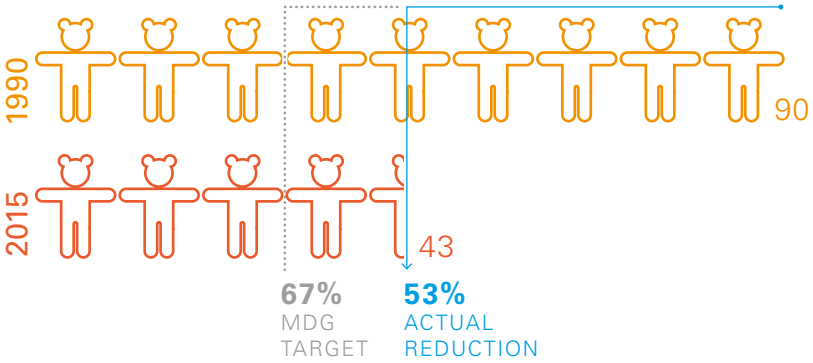
EVERY DAY

16,000 children under 5 will die

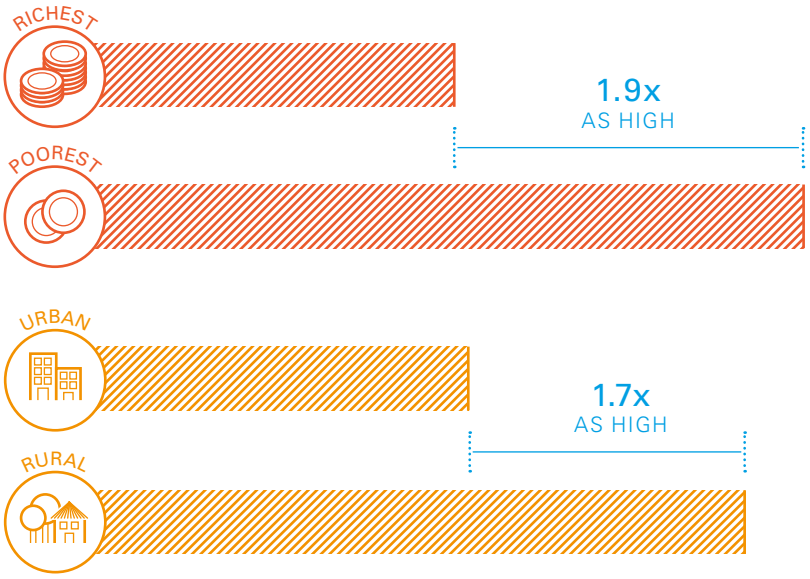
EVERY MINUTE

11 children under 5 will die

REDUCTION IN GLOBAL UNDER-FIVE MORTALITY RATE (DEATHS PER 1,000 LIVE BIRTHS)



INEQUITY IN UNDER-FIVE MORTALITY RISK



Under-five mortality

Child mortality – a key indicator for child well-being – reflects a country's social and economic development. It tells of children's access to basic health interventions such as vaccinations, medical treatment and adequate nutrition.[53]

The global under-five mortality rate has dropped by more than half since 1990. The rate of under-five mortality is decreasing faster than at any other time during the past two decades, with the global annual rate of reduction more than tripling since the early 1990s.[54]

Despite such achievements, by the end of this year, almost 6 million children will have died before their fifth birthday – most from preventable causes.[55]

The first days are the most critical for a child's survival. Neonatal deaths currently represent a larger share of the total under-five deaths than they did in 1990.[56] By the end of 2015, about 1 million children will have taken their first and final breath on the day they were born, accounting for 16 per cent of all under-five deaths.

Glaring disparities persist across regions and countries. In sub-Saharan Africa, the risk of a child dying before her or his fifth birthday is almost 15 times higher than the risk facing a child born in a high-income country.[57]

Only two regions have met the MDG target of reducing their under-five mortality rate by two thirds (Fig. 4.A). At current rates, it will take more than 10 years to reach the global target.[58]

The poorest households in every region saw far greater absolute gains in child survival compared to the richest (Fig. 4.B). And, except in sub-Saharan Africa, the proportional declines in under-five mortality rates among the poorest households also tended to be larger than those among the richest.[59]

As the pace of progress accelerates among the poorest households, the gap in under-five mortality rates between the richest and poorest households is narrowing in most regions (Fig. 4.C). However, children from poorer households remain disproportionately vulnerable: on average, the risk of dying before age 5 is twice as high for children born into the poorest households as it is for those born into the richest.

A mother's education remains a powerful determinant of inequity (Fig. 4.D). Analysis of a subset of countries reveals that when overall child mortality declines, gaps between children born to mothers with secondary or higher education and those born to mothers with no education are narrowing in more countries and widening in fewer countries.[60]

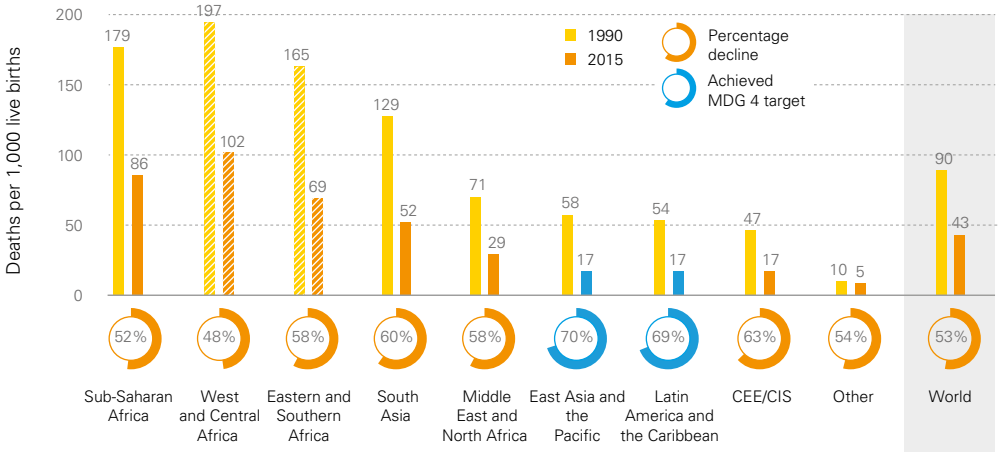
Disparities between urban and rural children have been narrowing in more than half of the 47 countries studied with trend data since 2000 (Fig. 4.E). However, children in rural areas still face added risk: they are on average about one and a half times more likely to die before their fifth birthday than urban children.

Children of mothers with no education are on average about two and a half times more likely to die before their fifth birthday than children of mothers with secondary or higher education.

FIGURE 4.A

Under-five mortality is declining, but only two regions met MDG 4

Under-five mortality rate and percentage decline, by region, 1990 and 2015

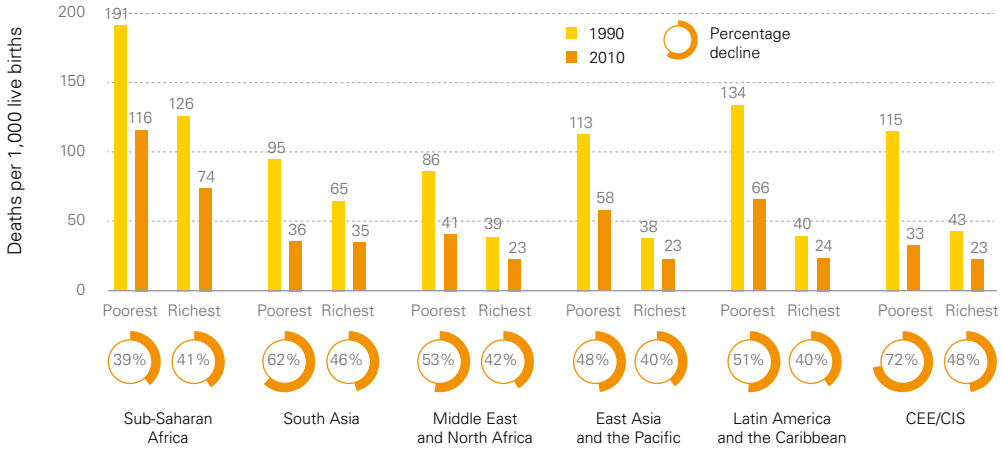


Source: UNICEF analysis based on the preliminary estimates of the United Nations Inter-agency Group for Child Mortality Estimation (IGME), 2015.

FIGURE 4.B

Under-five mortality is declining faster in the poorest households

Under-five mortality rate and percentage decline, by region and by household wealth quintile, 1990 and 2010[61]

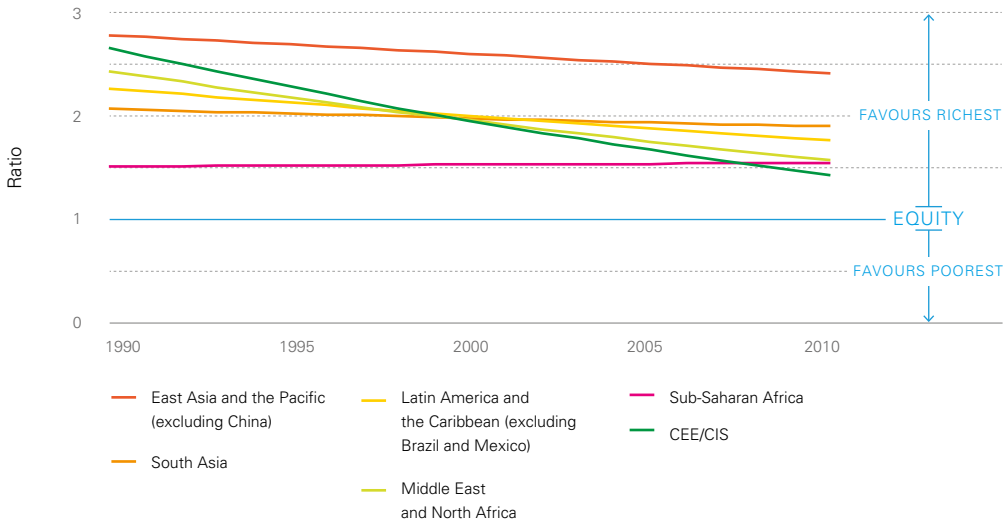


Source: UNICEF analysis based on DHS and MICS or UNICEF analysis based on J. Pedersen, L. Alkema and J. Liu. 'Levels and trends in inequity and child mortality: Evidence from DHS and MICS surveys.' Working paper, forthcoming 2015.

FIGURE 4.C

Gaps between the poorest and the richest in under-five mortality are narrowing but remain large

Ratio of under-five mortality among the poorest 20% versus the richest 20%, by region, 1990 to 2010[62]

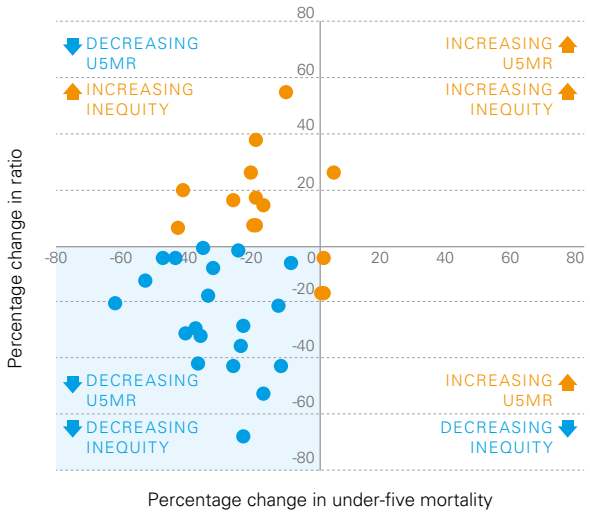


Source: UNICEF analysis based on DHS and MICS or UNICEF analysis based on Pederson, Jon, Leontine Alkema and Jing Liu. 'Levels and trends in inequity and child mortality: Evidence from DHS and MICS surveys.' Working paper, forthcoming 2015.

FIGURE 4.D

Gaps in mortality between children born to a mother with no education and those born to a mother with secondary or higher education are narrowing in more countries

Change in under-five mortality, and change in the ratio of under-five mortality among children born to mothers with no education versus those with secondary or higher education, for countries with data for 2000–2004 and 2005–2010[63]



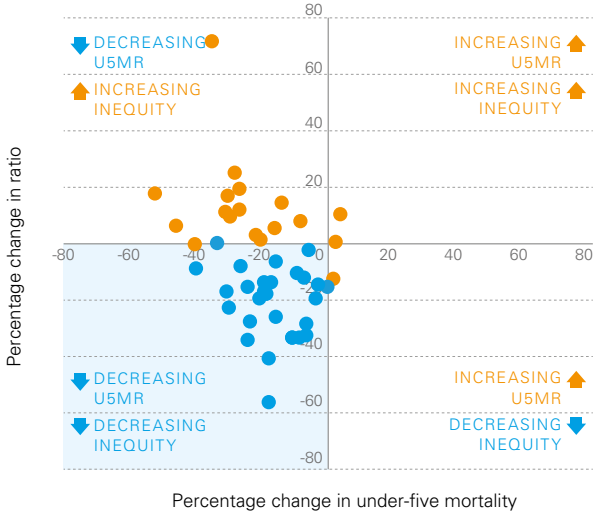
Notes: The quadrant highlighted in blue indicates a positive trend in both improvement of overall levels and in the reduction of disparities.

Source: UNICEF global databases, 2015, based on DHS, MICS and other nationally representative sources.

FIGURE 4.E

As under-five mortality declines, mortality disparities between urban and rural child populations are decreasing in some countries

Change in under-five mortality, and change in the ratio of under-five mortality among urban versus rural children, for countries with data for 2000–2004 and 2005–2010[64]



Notes: The quadrant highlighted in blue indicates a positive trend in both improvement of overall levels and in the reduction of disparities.

Source: UNICEF global databases, 2015, based on DHS, MICS and other nationally representative sources.

Measles

Although 84% of infants received MCV1 during 2013, an additional 15 million children needed to be reached to attain target coverage of 95% with MCV1 worldwide.

Measles was responsible for an estimated 145,700 deaths and nearly 279,000 cases globally in 2013. Compared with estimated mortality assuming the complete absence of measles vaccination, an estimated 15.6 million deaths were averted by measles vaccination during 2000–2013.[65]

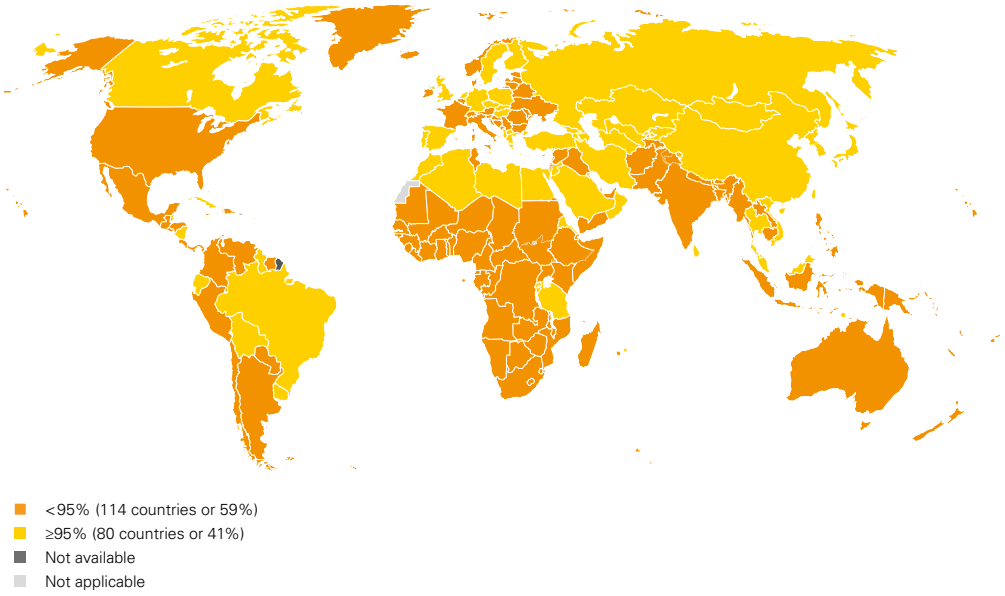
Notable improvements in routine immunization among children in the appropriate age group who received the first dose of measles-containing vaccine (MCV1) and in supplementary immunization activities in vaccinating children who are beyond the reach of existing health services have led to major successes to date. During 2000–2009, global coverage with MCV1 increased from 73 per cent to 83 per cent and then remained at 83–84 per cent through 2013. However, an estimated 21.6 million infants – many of whom are among the poorest, most marginalized children residing in especially hard-to-reach areas – did not receive MCV1 in 2013. Although 84 per cent of infants received MCV1 during 2013, an additional 15 million children needed to be reached to meet target coverage of 95 per cent with MCV1 worldwide.[66]

Although few countries report reaching 95 per cent coverage in every district, it is difficult to comment on progress towards such district-level targets – critical for achieving measles elimination. (Map. 4.A and Map 4.B). This is because district data are not available or are invalid from one third of countries, reflecting a wider problem with the quality and use of vaccination data within national immunization programmes.

MAP 4.A

Fewer than half of countries achieved at least 95% coverage nationally with a first dose of measles-containing vaccine during 2013

Countries achieving at least 95% coverage nationally with a first dose of measles-containing vaccine among children of the appropriate age according to the national immunization schedule during 2013

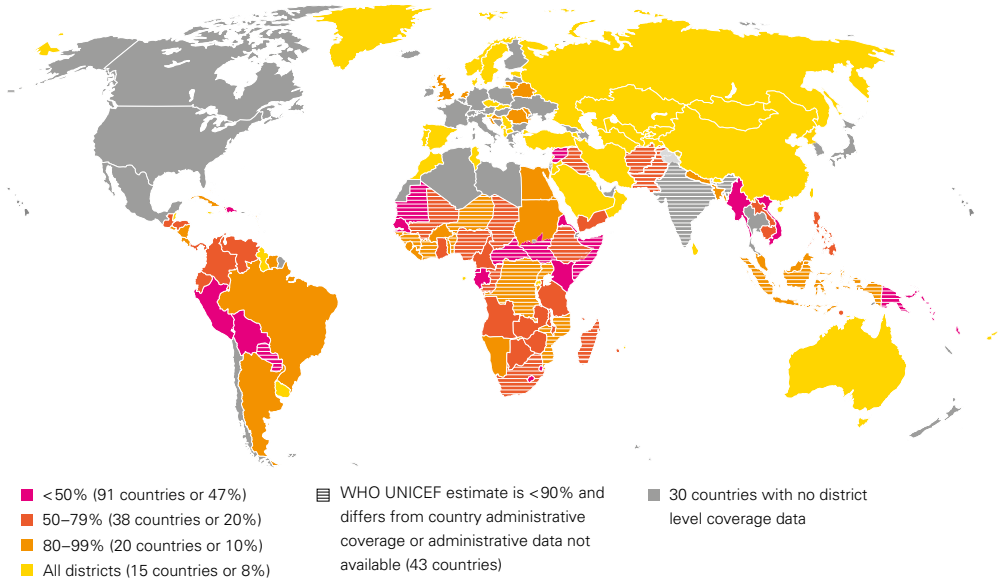


Source: WHO and UNICEF estimates of national immunization coverage, 2013 revision (completed July 2014).

MAP 4.B

Far too few countries have achieved sub-national level targets critical for measles elimination

Percentage of districts achieving at least 95% coverage with a first dose of measles-containing vaccine among children of the appropriate age according to the national immunization schedule during 2013



Source: WHO and UNICEF estimates of national immunization coverage, 2013 revision (completed July 2014) and nationally reported district-level administrative coverage for 2013 as reported in submitted Joint Reporting Forms on Immunization to WHO and/or UNICEF during 2014.

Note: These maps do 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.

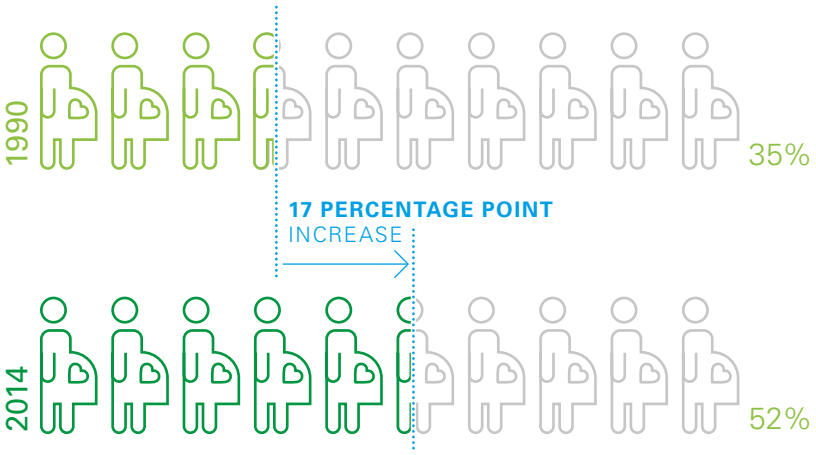
MDG 5

IMPROVE MATERNAL HEALTH

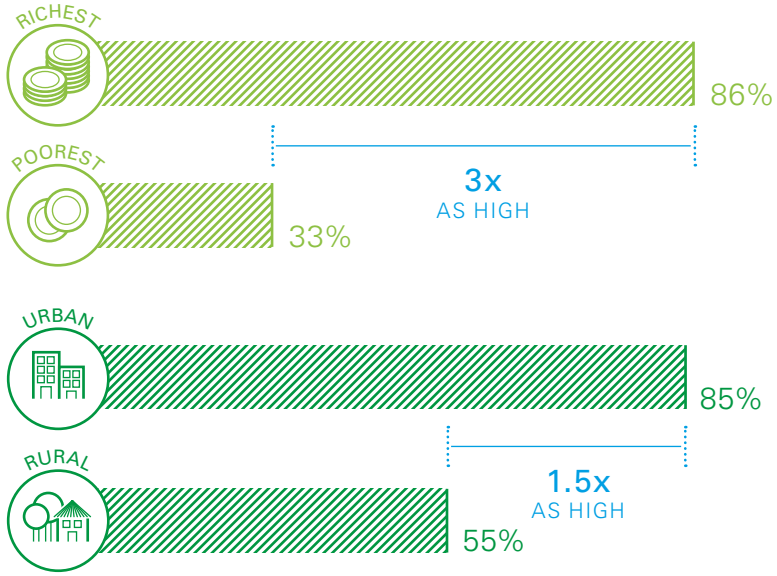
Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

MATERNAL HEALTH

PREGNANT WOMEN WITH FOUR OR MORE ANTENATAL CARE VISITS



SKILLED ATTENDANT AT BIRTH



LIFETIME RISK OF MATERNAL DEATH

Maternal health

Providing quality reproductive health services and improving the health and nutrition of mothers-to-be are pivotal not only to reducing maternal morbidity and mortality, but also in addressing many underlying causes of neonatal and child mortality.[67]

The number of women and girls who died each year from complications of pregnancy and childbirth fell from 523,000 in 1990 to 289,000 in 2013. This 45 per cent decline in maternal deaths is impressive given the rapid population growth in many of the countries where maternal deaths are highest. Still, about 800 women are dying each day from maternal causes.

Despite narrowing gaps in the maternal mortality ratio across regions, large and stagnating wealth gaps within countries in antenatal care and skilled attendance at birth remain in almost all regions.

Progress in the global maternal mortality ratio (MMR) (Fig. 5.A) fell short of the target: the annual rate of decline (2.6 per cent) from 1990 to 2013 is considerably below the 5.5 per cent required to reach MDG 5.[68] Globally, there has been a large reduction in the MMR gap based on income group. In 1990, the MMR in low-income countries was 38 times higher than in high-income countries. In 2013, the gap decreased to 19 times higher. Between middle-income and high-income countries, the MMR gap was also halved, from 14 to 7 times higher (Fig. 5.B).

Maternal deaths are increasingly concentrated in sub-Saharan Africa where, despite a declining MMR, the share of global maternal deaths increased, rising from 44 per cent (1990) to 62 per cent (2013).[69] In 2013, for a 15-year-old girl in this region, the risk of maternal death during her lifetime is 1 in 38 (Fig. 5.C). The higher fertility rate in this region contributes substantially to the elevated risk of death.

Antenatal care and skilled health attendance at delivery are necessary to ending every preventable maternal death. In this respect, modest progress is seen in the average percentage of women who delivered with the support of a skilled health attendant: from 59 to 71 per cent between 1990 and 2014 (Fig. 5.D). Progress has accelerated in the past decade after a stall in the 1990s.[70] South Asia and West and Central Africa remain the regions with the lowest proportions of births attended by a skilled health attendant.

Women from the poorest quintile are particularly excluded from the benefits of having a skilled attendant at birth. Around 2014, women in the richest quintile were almost three times as likely to deliver with a skilled health attendant as women in the poorest quintile (Fig. 5.E). This large gap has not changed since around 2000.

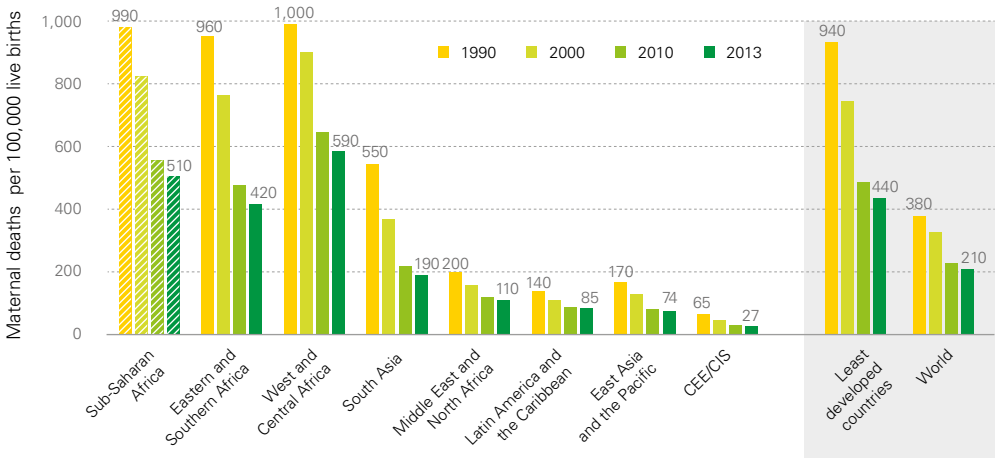
Women living in rural areas are also left behind: the absolute gap in skilled birth attendance between urban and rural populations diminished only by 7 percentage points – from 37 percentage points (around 1990) to 30 percentage points (around 2014). Only in East Asia and the Pacific – the region with the highest coverage of skilled attendance at birth and lowest equity gap – has the urban-rural gap substantially narrowed: from 19 to 7 percentage points since 1990.[71]

Progress in the recommended minimum of four antenatal care visits has been slow: just over half of pregnant women benefited from four or more antenatal care visits around 2014. Modest improvements in antenatal care did not contribute to a reduction in the gap between rich and poor – except in East Asia and the Pacific. In least developed countries, the gap in antenatal care between urban and rural areas also did not narrow substantially between 2000 (25 percentage point difference in coverage) and 2014 (22 percentage point difference) (Fig. 5.F).

FIGURE 5.A

The maternal mortality ratio (MMR) fell by 45% between 1990 and 2013

Maternal mortality ratio, by region, 1990 to 2013

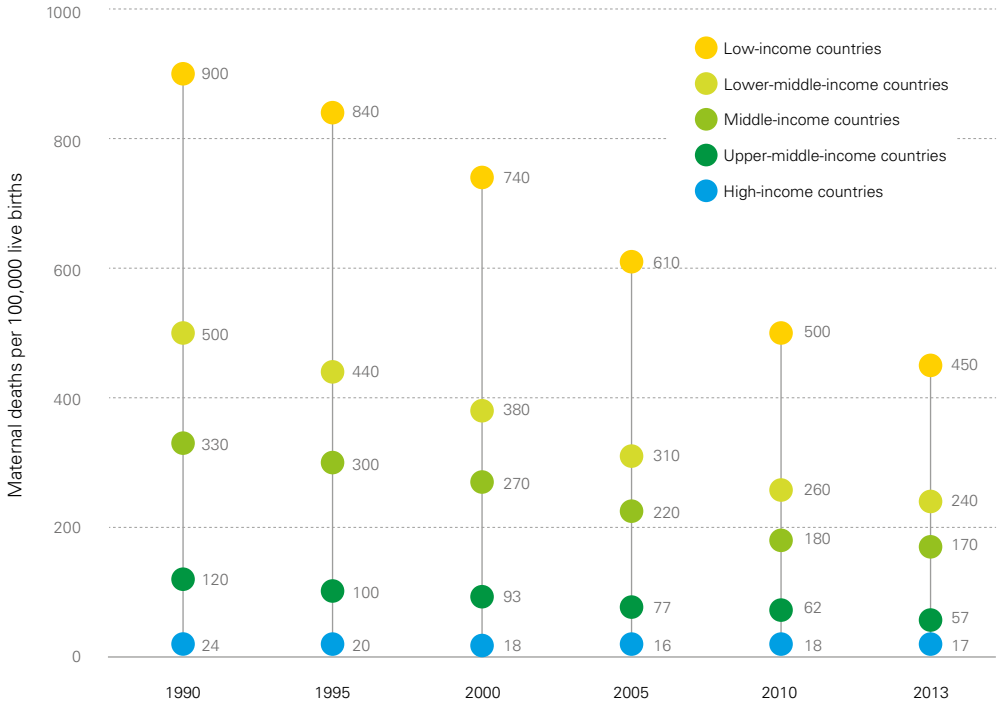


Source: WHO, UNICEF, UNFPA and World Bank, *Trends in Maternal Mortality*: 1990 to 2013, WHO, Geneva, 2014.

FIGURE 5.B

The gap in maternal mortality ratio between low- and high-income countries has substantially reduced

Maternal mortality ratio by income group, 1990 to 2013

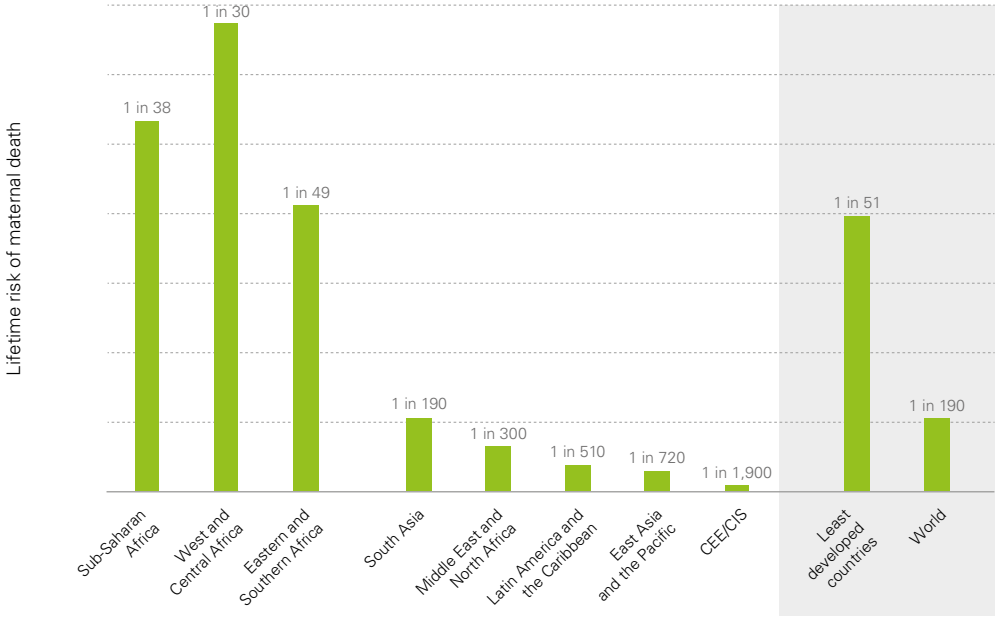


Source: UNICEF analysis based on WHO, UNICEF, UNFPA and World Bank, *Trends in Maternal Mortality*: 1990 to 2013, WHO, Geneva, 2014.

FIGURE 5.C

In West and Central Africa, the lifetime risk of maternal death for a 15-year-old girl is 1 in 30 compared to 1 in 190 for the world

Lifetime risk of maternal death, 2013

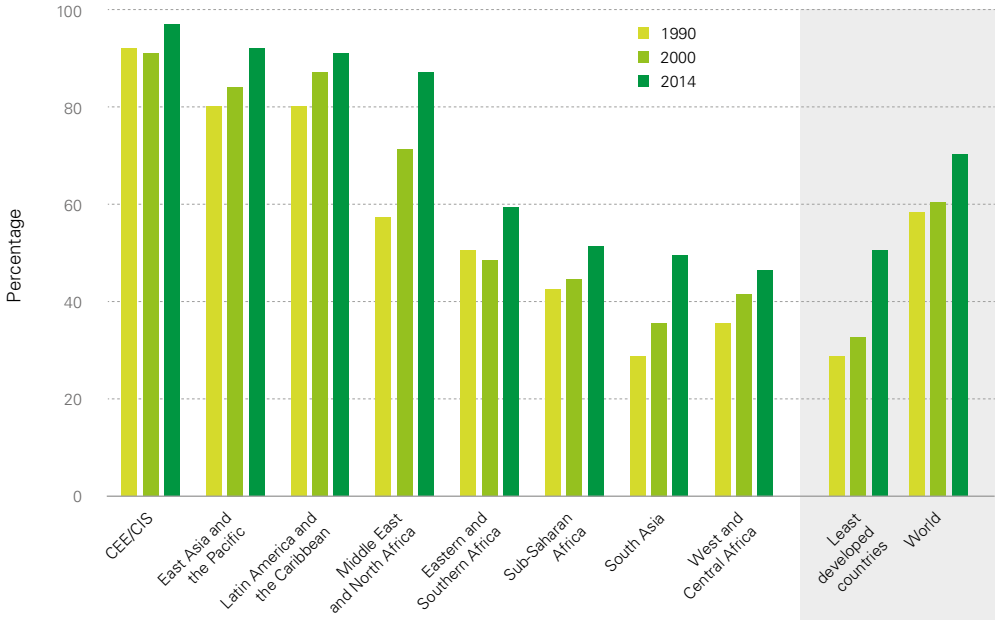


Source: WHO, UNICEF, UNFPA and World Bank, *Trends in Maternal Mortality*: 1990 to 2013, WHO, Geneva, 2014.

FIGURE 5.D

South Asia and West and Central Africa remain the regions with the lowest proportions of births delivered with skilled health personnel

Percentage of births attended by skilled health personnel, by region, around 1990 to 2014[72]

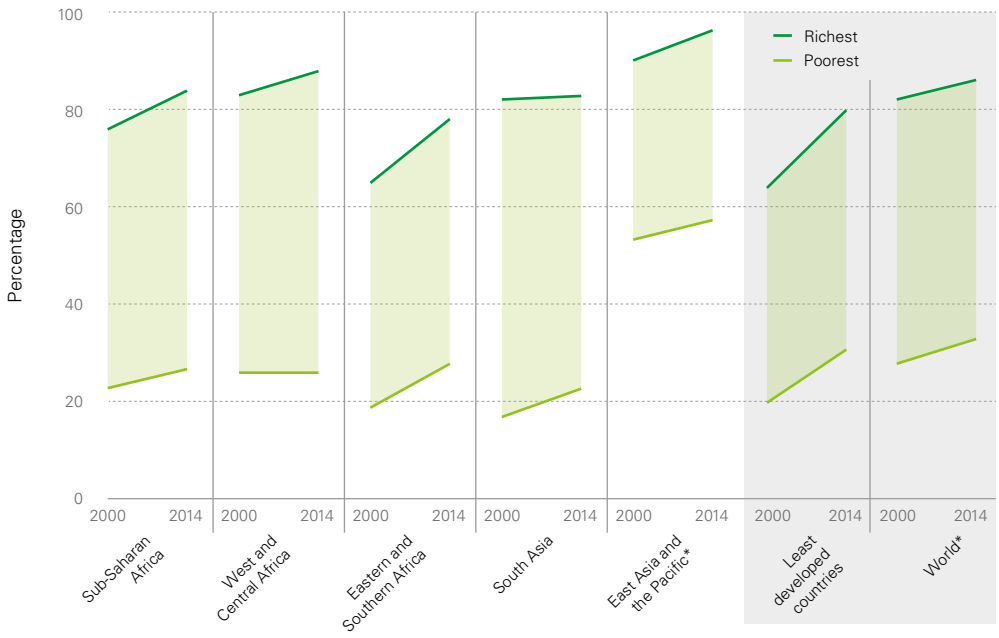


Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources.

FIGURE 5.E

Women from the richest households are almost three times more likely to deliver with skilled health personnel as women from the poorest

Percentage of births attended by skilled health personnel, by region and by household wealth quintile, around 2000 and 2014[73]



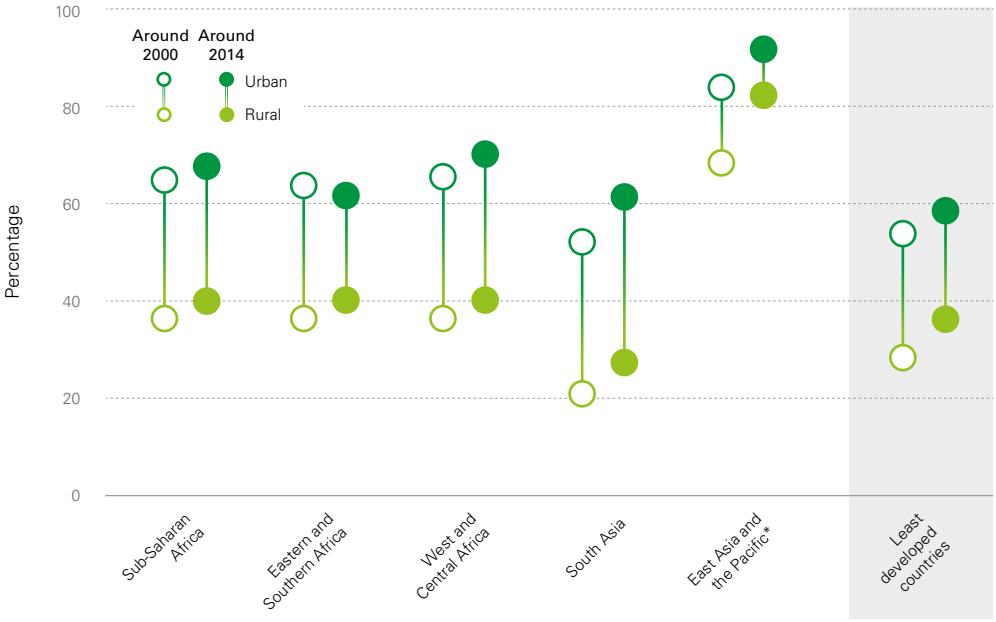
Note: *Excluding China.

Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources.

FIGURE 5.F

Little progress has been made in closing the gap in antenatal care between urban and rural women

Percentage of women who received four or more antenatal care visits, by region and by area of residence, around 2000 and 2014[74]



Note: *Excluding China.

Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources.

MDG 6

COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Have halted by 2015 and begun to reverse the spread of HIV/AIDS

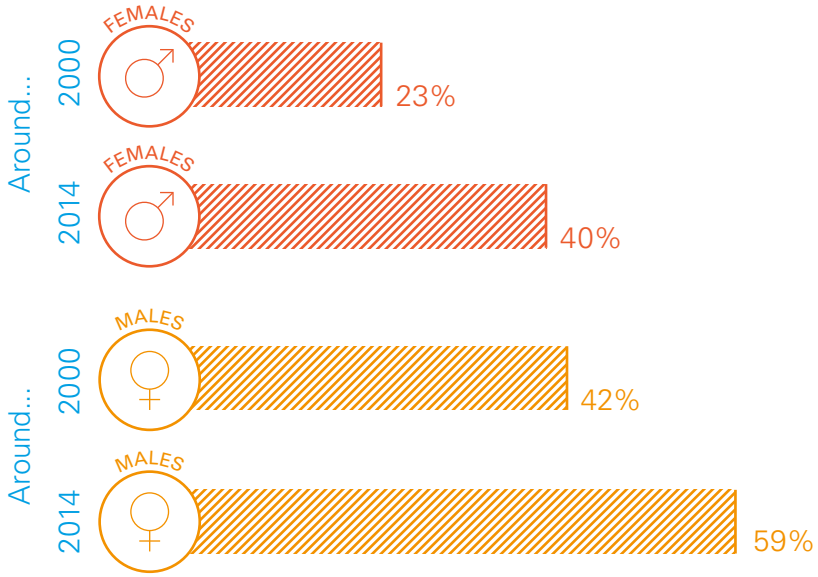
Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

HIV/AIDS AND MALARIA

MOTHER-TO-CHILD TRANSMISSION OF HIV

CONDOM USE AMONG YOUNG PEOPLE (15–24 YEARS OLD) REPORTING HIGHER-RISK SEX



SUB-SAHARAN AFRICAN CHILDREN UNDER AGE 5 NOT PROTECTED AGAINST MALARIA THROUGH THE USE OF ITNS

HIV/AIDS

Globally, investments in the HIV and AIDS response have generated positive results. Improved care and treatment options have increased the lifespan of people living with HIV, and AIDS-related deaths decreased rapidly between 2001 and 2013 among all age groups except adolescents (aged 10–19), where there was no decrease (Fig. 6.E). HIV remains the leading cause of death among women of reproductive age (aged 15–49) globally.

Of the 1.9 million adults aged 15 and over who were newly infected with HIV globally in 2013, about 35 per cent (670,000) were young people (aged 15–24), and 13 per cent (250,000) were adolescents (aged 15–19). Marked differences between boys and girls emerge during adolescence. Adolescent girls are disproportionately affected by HIV. In some countries, adolescent girls are two to three times more likely to be infected than boys of the same age group.[75]

In sub-Saharan Africa, the ratio of school attendance of orphans and non-orphans aged 10–14 has almost reached parity (0.96), a substantial improvement from around 2000 (0.80).[80]

Between 2001 and 2013, new HIV infections declined across all age groups but more markedly among children under 15 years old (Fig. 6.A). This trend is attributed to the prevention of mother-to-child transmission (PMTCT) of HIV (Fig. 6.B), through HIV testing of pregnant women during antenatal visits and the provision of antiretroviral medicines to those found to be HIV positive.

An estimated 1.5 million girls and women aged 15 years and above were pregnant and living with HIV globally in 2013 – more than 90 per cent of them in sub-Saharan Africa.[76] Without any interventions to prevent mother-to-child transmission of HIV, about half of these girls and women will pass the infection on to their children during pregnancy, delivery or breastfeeding.

Through the UN-supported *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*, results have been achieved in providing effective antiretroviral medicines for PMTCT across all regions and in the Global Plan's 21 priority countries in sub-Saharan Africa. Consequently, between 2001 and 2013, rapid reductions in new HIV infections among children have been observed in most countries.

Because the virus progresses rapidly in infants, early treatment is vital to their survival. In all low- and middle-income countries, only 23 per cent of children (aged 0–14) living with HIV in 2013 received antiretroviral therapy (ART), compared to 37 per cent of adults living with HIV (aged 15 or older) (Fig. 6.C).

Recent WHO guidelines recommend early HIV testing for children within two months of birth and at the end of breastfeeding. They also recommend immediate treatment to all pregnant and breastfeeding women and all children under five years old living with HIV. However, in 2013, only 37 per cent of HIV-exposed infants in all low- and middle-income countries were tested early for HIV.[77]

Since 2000, there has been moderate progress in HIV-prevention efforts among young people (aged 15–24). In sub-Saharan Africa, the region most affected by the epidemic, most recent surveys indicate that less than 40 per cent of young men and women aged 15–24 have comprehensive, correct knowledge of HIV (Fig. 6.D) and that is only about 10 percentage points more than around 2000.

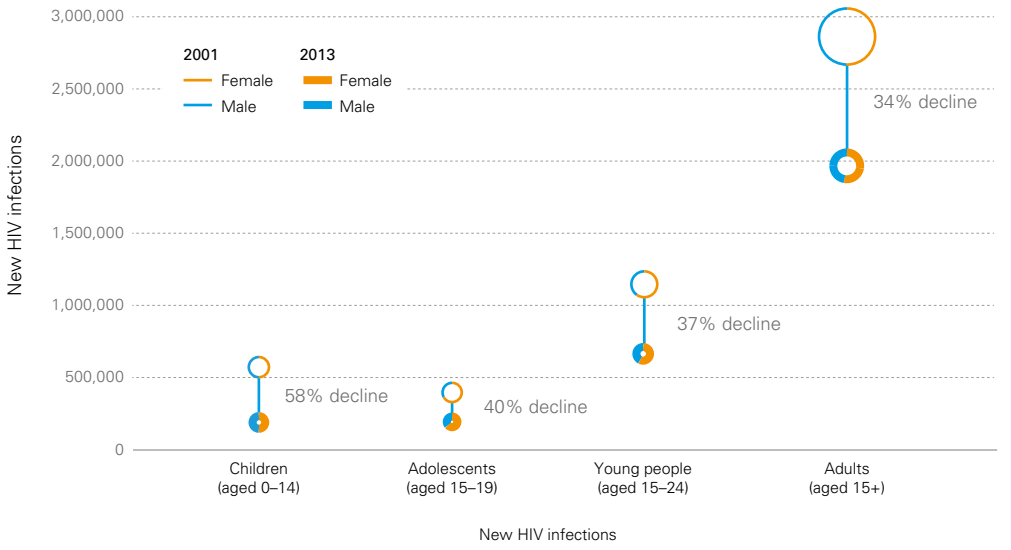
In sub-Saharan Africa, disparities in the level of comprehensive knowledge among young men and women (aged 15–24) persist between women in the poorest and richest quintiles (17 per cent and 35 per cent respectively), and between women living in rural and urban areas (23 per cent and 36 per cent respectively).

Each year, between 2000 through the present, there have been at least 10 million children under age 18 who had lost either one or both parents to AIDS. This number peaked in 2009 when there were an estimated 18.5 million children who had lost one or both parents to AIDS. Although this number has gradually fallen, there were still approximately 17.7 million children in 2013 who had lost one or both parents to AIDS (Fig. 6.F). Remarkable gains have been achieved in mitigating the economic and social impact of HIV and AIDS on children and families over the past decade.[78] Investments for economic and psychosocial support remain critical beyond 2015, as well as strengthened linkages to testing children who have lost one or both parents to AIDS and their families; also HIV treatment to those who need it, as well as community and health facility linkages to ensure that the most vulnerable are reached.[79]

FIGURE 6.A

Girls accounted for nearly two thirds of all new HIV infections among adolescents in both 2001 and 2013

Estimated global number of new HIV infections among adults aged 15+, young people aged 15–24, adolescents aged 15–19 and children aged 0–14, 2001 and 2013

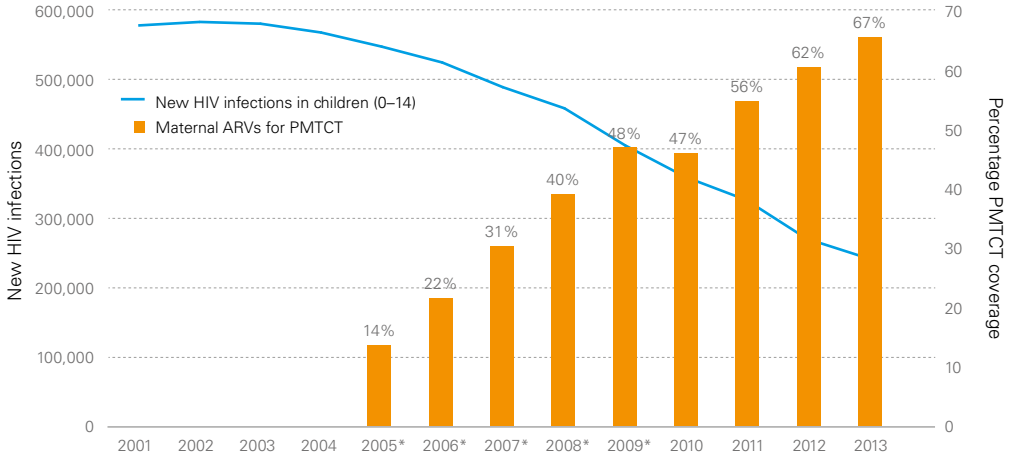


Source: UNICEF analysis of UNAIDS, 2013 HIV and AIDS estimates, July 2014.

FIGURE 6.B

Rapid decline in new HIV infections among children thanks to increasing PMTCT coverage

Estimated number of new HIV infections among children aged 0–14 and coverage of maternal ARVs for PMTCT in all low- and middle-income countries, 2001 to 2013



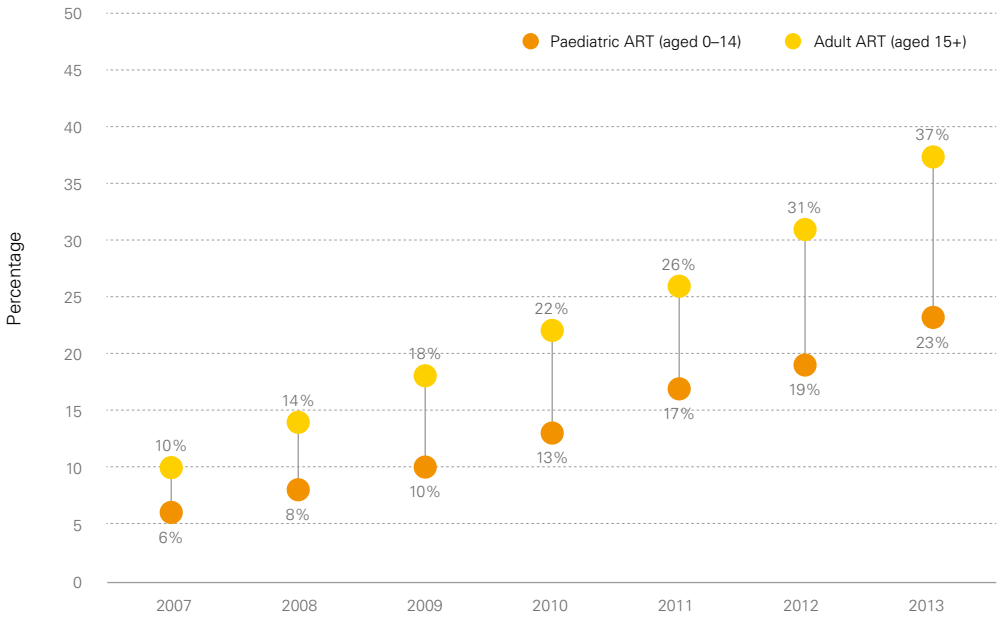
*Note: Data from 2005 through 2009 include single-dose nevirapine, a regimen no longer recommended by WHO; therefore values from 2005 to 2009 are not comparable to those from 2010 to 2013.

Source: UNAIDS, UNICEF and WHO, 2005–2013 Global AIDS Response Progress Reporting, and UNAIDS 2013 HIV and AIDS estimates, July 2014.

FIGURE 6.C

Children lag behind adults in access to ART

Percentage of adults aged 15+ and children aged 0–14 living with HIV receiving ART in all low- and middle-income countries, 2007 to 2013[81]

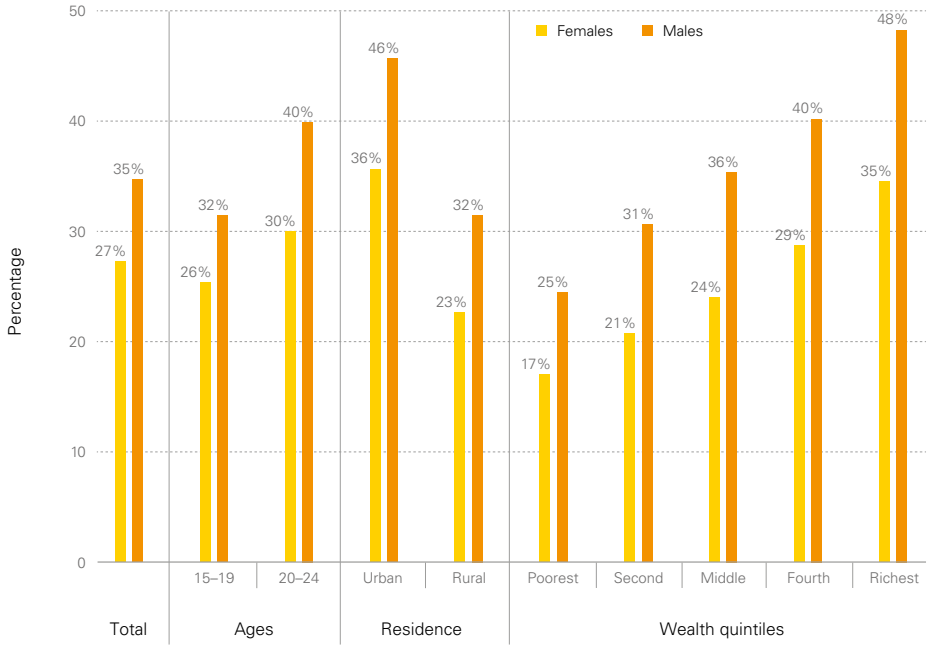


Source: UNAIDS 2013 HIV and AIDS estimates, July 2014

FIGURE 6.D

Only 17% of young women from the poorest households have comprehensive knowledge of HIV

Percentage of young men and women aged 15–24 with comprehensive, correct knowledge of HIV, by age, area of residence and household wealth quintile, sub-Saharan Africa[82]

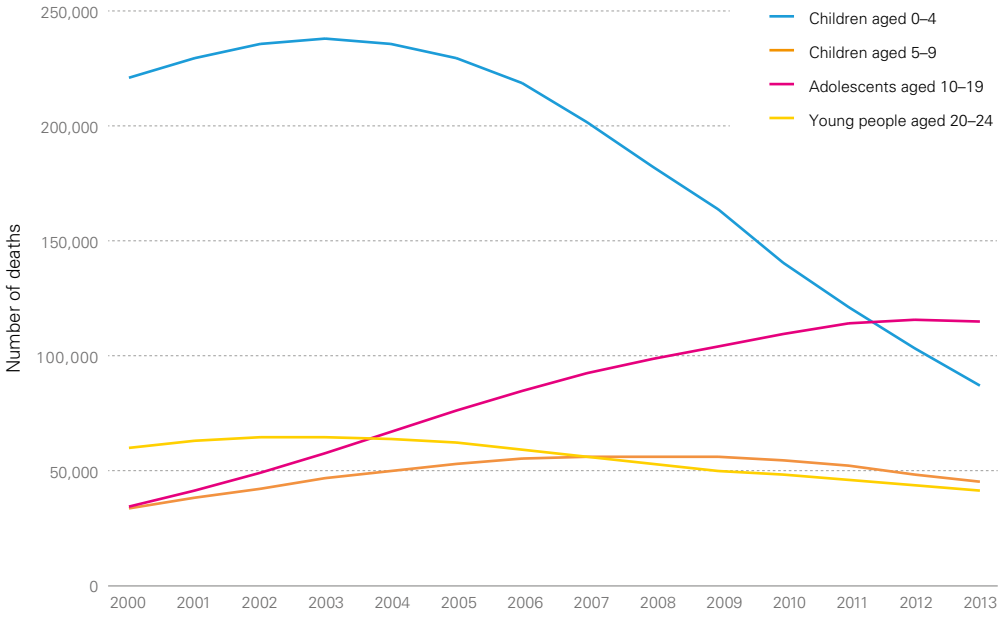


Source: UNICEF global databases, 2015, based on MICS, DHS, AIDS Indicator Surveys (AIS) and other nationally representative sources, 2009–2014.

FIGURE 6.E

AIDS-related deaths are declining for all age groups except adolescents

Estimated global number of AIDS-related deaths among children aged 0–4, children aged 5–9, adolescents aged 10–19 and young people aged 20–24, 2000 to 2013

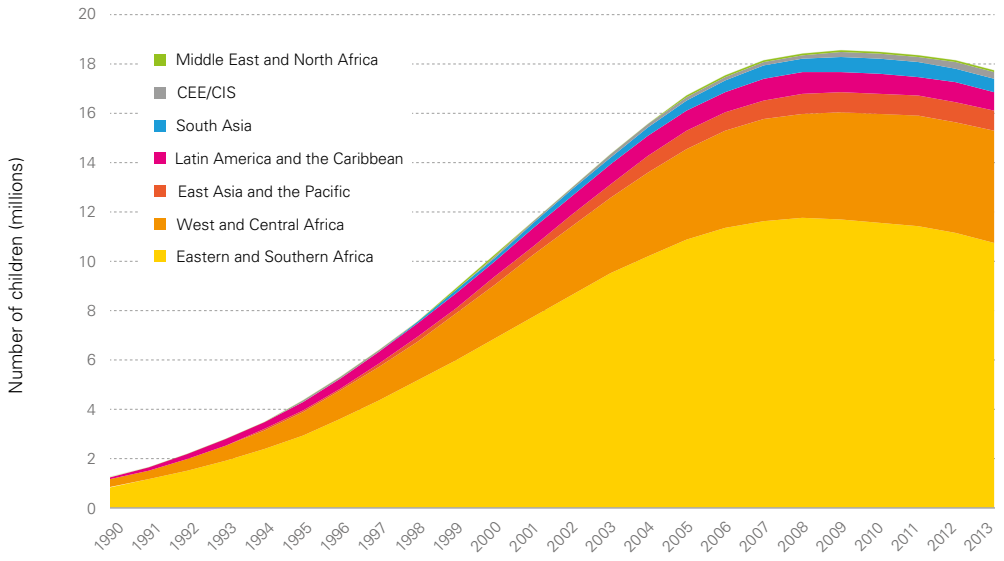


Source: UNICEF analysis based on UNAIDS 2013 HIV and AIDS estimates, July 2014.

FIGURE 6.F

There are an estimated 17.7 million children who have been orphaned by AIDS-related causes

Estimated global number of children aged 0–17 who have lost one or both parents to an AIDS-related cause, by region, 1990 to 2013



Source: UNICEF analysis based on UNAIDS 2013 HIV and AIDS estimates, July 2014.

Malaria

The latest data indicate that only 1 in 5 children with fever received a diagnostic test for malaria in sub-Saharan Africa.[88]

Malaria prevents children from going to school and their parents from engaging in productive activities. It also decreases the likelihood of a healthy pregnancy.[83] The disease contributes to 7 per cent of global deaths among children under five – 14 per cent in sub-Saharan Africa in 2013.[84]

In 2014, 97 countries worldwide had ongoing malaria transmission, most of which were in sub-Saharan Africa. In 2013, 4 in 5 deaths (or 78 per cent) due to malaria were in children under five. Between 2000 and 2013, malaria mortality rates among children under five decreased by 53 per cent globally and 58 per cent in sub-Saharan Africa.[85]

Use of insecticide-treated nets (ITNs) is one of the most cost-effective interventions to prevent malaria and related death. There has been a large increase in the use of ITNs by children under five in the past decade, although coverage remains generally low at less than 50 per cent in most malaria-endemic countries in Africa (Map 6.A).

In sub-Saharan Africa, more than 1 child in 3 (37 per cent) slept under an ITN around 2014. This corresponds to about 100 million sub-Saharan African children under five who are not protected against malaria through the use of ITNs.[86]

Free distribution of ITNs helped reach poor and rural populations, which has led to a small gap in the use of ITNs by children under five between richest and poorest populations, and between rural and urban populations (Fig. 6.G). However, too many children are left out.

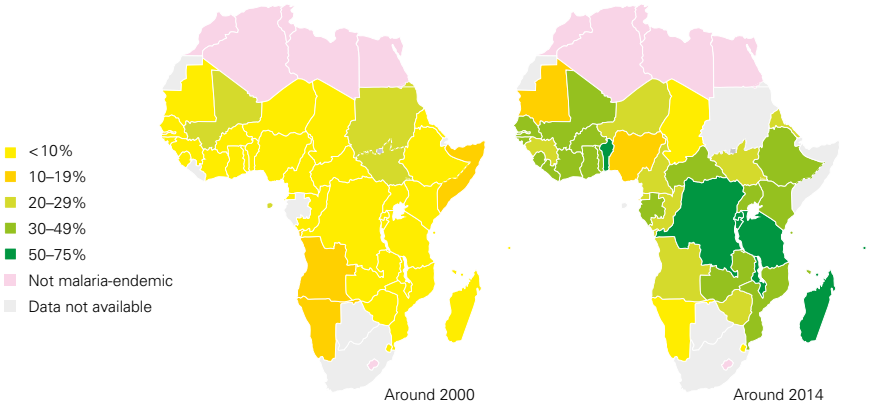
Children sick with malaria must be immediately diagnosed and treated with an antimalarial. *Plasmodium (P.) falciparum*, the most lethal malaria parasite, is mainly prevalent in sub-Saharan Africa, where 90 per cent of malaria deaths occur. Artemisinin-based combination therapy (ACT) is the recommended first-line antimalarial drug in countries where *P. falciparum* is endemic. To follow the current recommendation by WHO, countries are now moving away from presumptive treatment of malaria based on fever, to treatment based on malaria confirmed by a diagnostic test.[87]

Treatment with ACT of malaria in children is low in sub-Saharan Africa with just over one third of children treated with antimalarial drugs receiving the first-line drug. The lowest proportions – 21 per cent – are observed in West and Central Africa (Fig. 6.H).

MAP 6.A

ITN use by children under five in Africa has dramatically increased between 2000 and 2014

Percentage of children under age 5 sleeping under an insecticide-treated mosquito net, Africa, around 2000 and 2014[89]



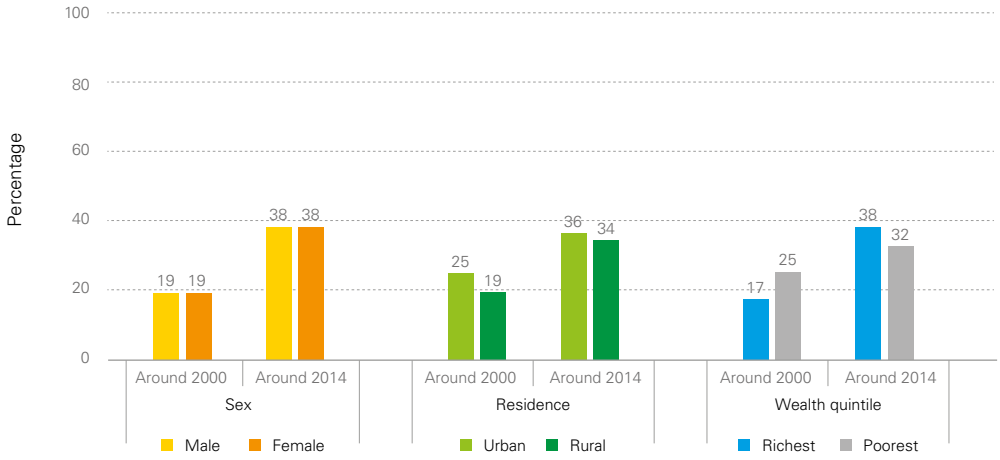
Note: This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The final boundary between the Sudan and South Sudan has not yet been determined. The final status of the Abyei area has not yet been determined.

Source: UNICEF global databases, 2015, based on MICS, DHS, Malaria Indicator Surveys (MIS), and other nationally representative sources.

FIGURE 6.G

Use of ITNs by children under five is almost equitable within most malaria-endemic countries in Africa

Percentage of children under age 5 sleeping under an ITN, by sex, residence and household wealth quintile, around 2000 and 2014[90]

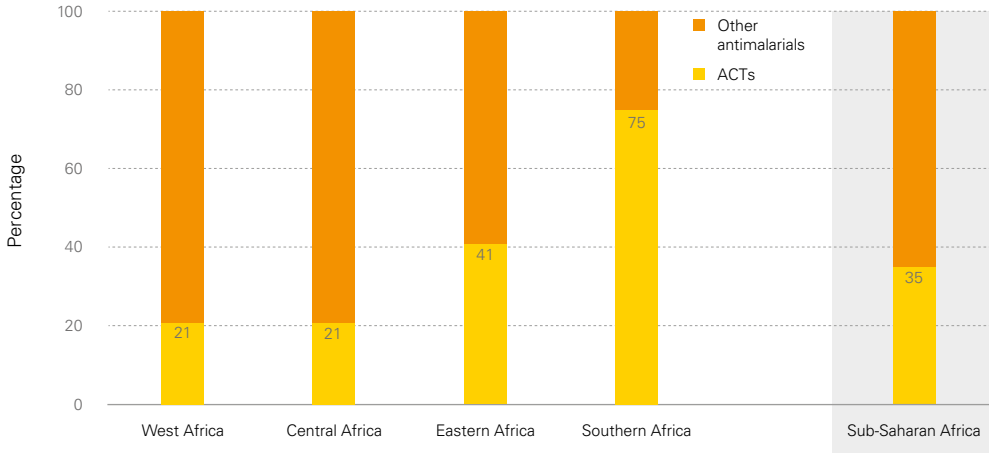


Source: UNICEF global databases, 2015, based on MICS, DHS, MIS and other nationally representative sources.

FIGURE 6.H

Two thirds of children under five in sub-Saharan Africa are not receiving the right antimalarial treatment

Percentage of febrile children under age 5 receiving first-line treatment among children who received any antimalarial treatment, by subregion[91]



Note: See regional classification on page 66 for details on the sub-regions of Africa.

Source: UNICEF global databases, 2015, based on MICS, DHS, MIS, and other nationally representative sources, 2010–2014.

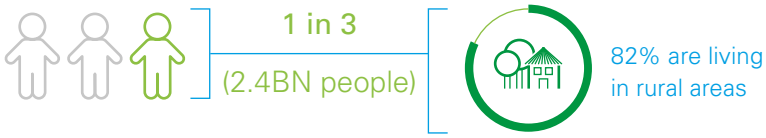
MDG 7

ENSURE ENVIRONMENTAL SUSTAINABILITY

Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

WATER AND SANITATION

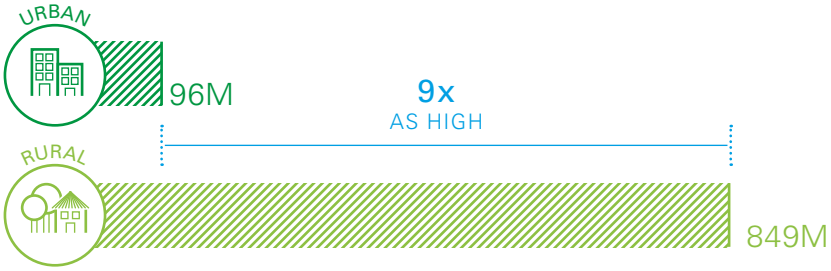
PEOPLE WHO STILL LACK IMPROVED SANITATION



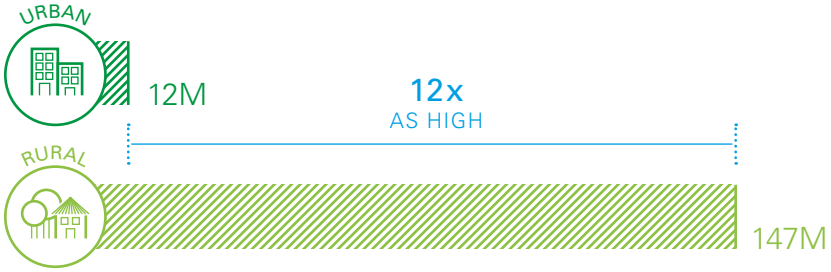
PEOPLE WITHOUT ACCESS TO IMPROVED DRINKING WATER SOURCES

INEQUITY IN WATER AND SANITATION

People practicing open defecation



People relying on surface water for drinking



Water and sanitation

Globally, 90% of people who use surface water or who practice open defecation live in rural areas.

Diarrhoeal diseases caused by a lack of safe water, sanitation and basic hygiene remain a leading cause of death among children under five. Improved access to drinking water, sanitation and hygiene is not only key for child survival but also for achieving MDG targets relating to nutrition, education and gender equality.

Since 1990, 2.1 billion people have gained access to improved sanitation, but the 2015 target has been missed for almost 700 million. The world has increased access to improved sanitation facilities, but there are significant disparities in the rates of progress achieved across regions (Fig. 7.A). All regions have made faster progress on rural sanitation, but coverage of improved sanitation remains substantially higher in urban areas (Fig. 7.C).

Least developed countries have more than halved the proportion of the population practicing open defecation – from 45 to 20 per cent (Fig. 7.B). Globally, there are still 946 million people who practice open defecation (and almost two thirds live in South Asia), with 9 out of 10 living in rural areas.

The world met the MDG target for drinking water in 2010. However, the global average masks inequalities between regions in both coverage and service levels (Fig. 7.D). Sub-Saharan Africa is the only region that will have not halved the proportion of the population without access to improved drinking water between 1990 and 2015.

During the same period, the number of people using surface water has more than halved (from 346 million to 159 million), but in sub-Saharan Africa, 1 in 10 still relies on surface water for drinking.

Of the 2.6 billion people who have gained access to improved drinking water sources since 1990, 1.9 billion gained a piped supply on premises. Piped supplies now account for 63 per cent of improved sources globally, compared with just 17 per cent of improved sources in the least developed countries.[92]

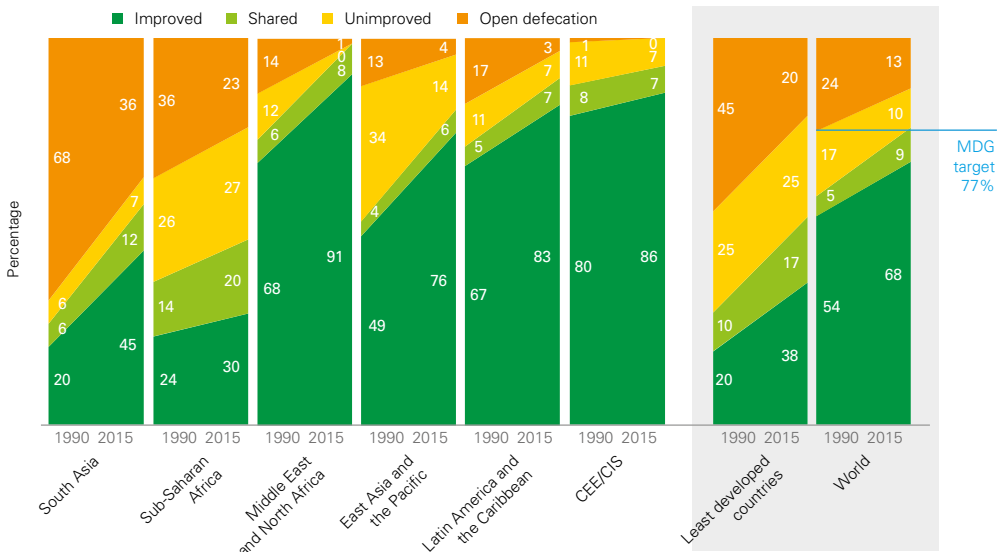
Urban dwellers are more than twice as likely to have piped water on premises as those living in rural areas; the disparity is evident across regions (Fig. 7.E).

Many countries are approaching universal access to improved drinking water but service levels vary widely and the remaining unserved 9 per cent – including some of the poorest and most vulnerable – will be hard to reach (Map. 7.A).

FIGURE 7.A

All regions have increased access to improved sanitation facilities, but there are significant disparities in the rates of progress achieved

Trends in percentage sanitation coverage, by region, 1990 to 2015

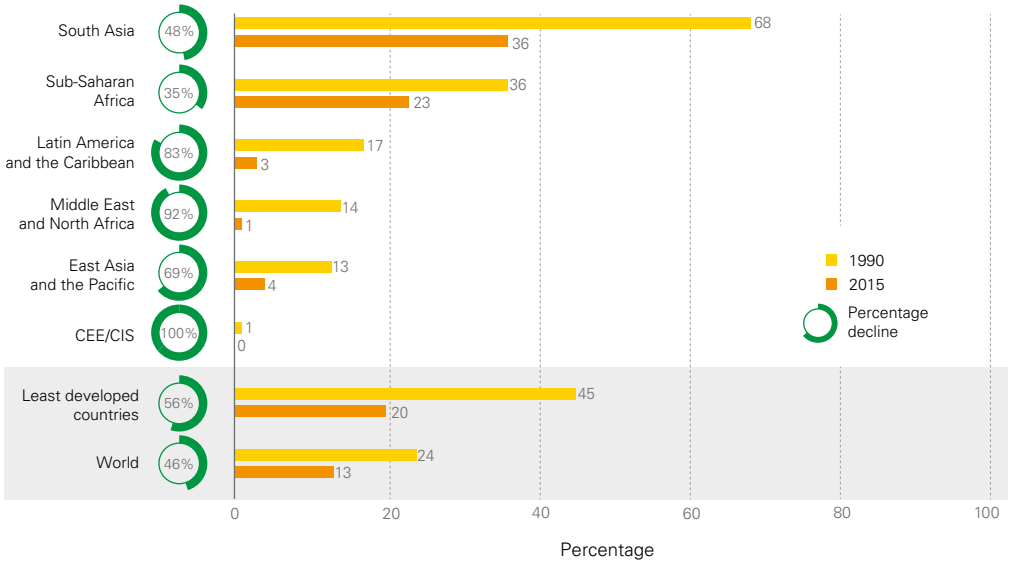


Source: WHO and UNICEF, *Progress on Sanitation and Drinking Water: 2015 update and final MDG assessment*, WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, New York, 2015.

FIGURE 7.B

Open defecation rates have declined by more than 50% in least developed countries

Rate of open defecation and percentage decline, by region, 1990 to 2015

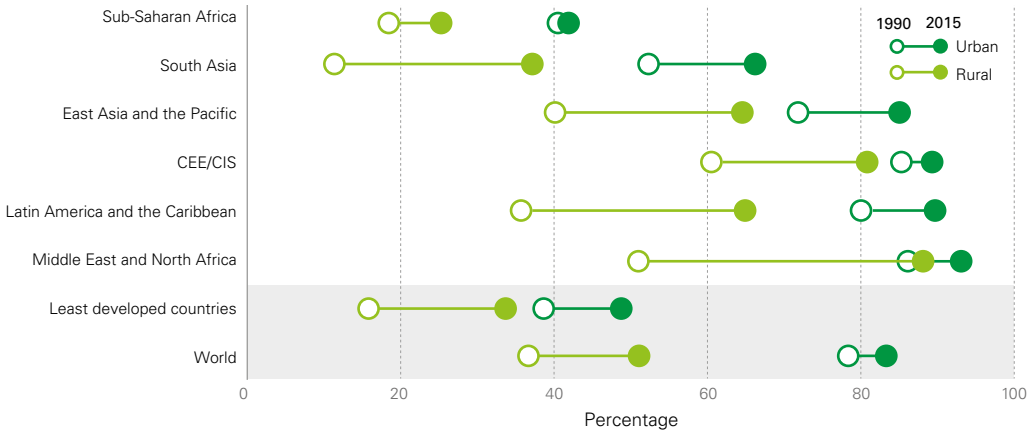


Source: WHO and UNICEF, *Progress on Sanitation and Drinking Water: 2015 update and final MDG assessment*, WHO/ UNICEF Joint Monitoring Programme for Water Supply and Sanitation, New York, 2015.

FIGURE 7.C

All developing regions have made faster progress on rural sanitation, but coverage remains higher in urban areas

Percentage coverage of improved sanitation, by region and by area of residence, 1990 to 2015

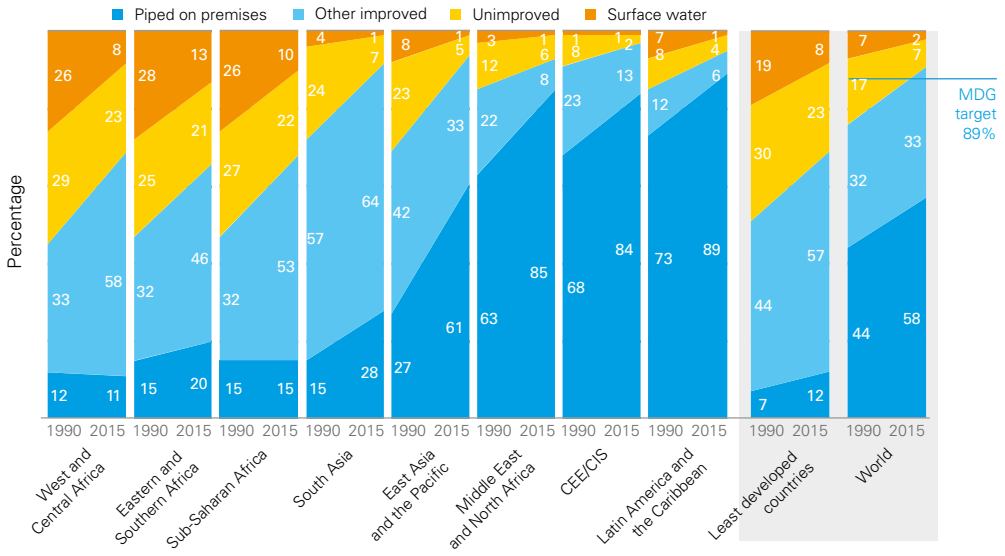


Source: WHO and UNICEF, *Progress on Sanitation and Drinking Water: 2015 update and final MDG assessment*, WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, New York, 2015.

FIGURE 7.D

The world met the MDG target for drinking water in 2010

Trends in percentage drinking water coverage, by region, 1990 to 2015

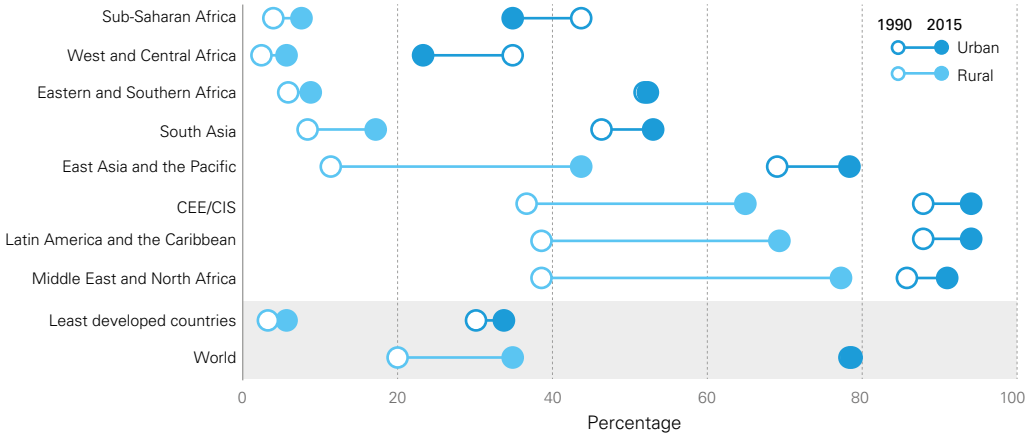


Source: WHO and UNICEF, *Progress on Sanitation and Drinking Water: 2015 update and final MDG assessment*, WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, New York, 2015.

FIGURE 7.E

Rural areas have made significant progress in increasing access to piped water on premises, but coverage remains well below urban areas

Percentage coverage of piped water on premises, by region, 1990 to 2015

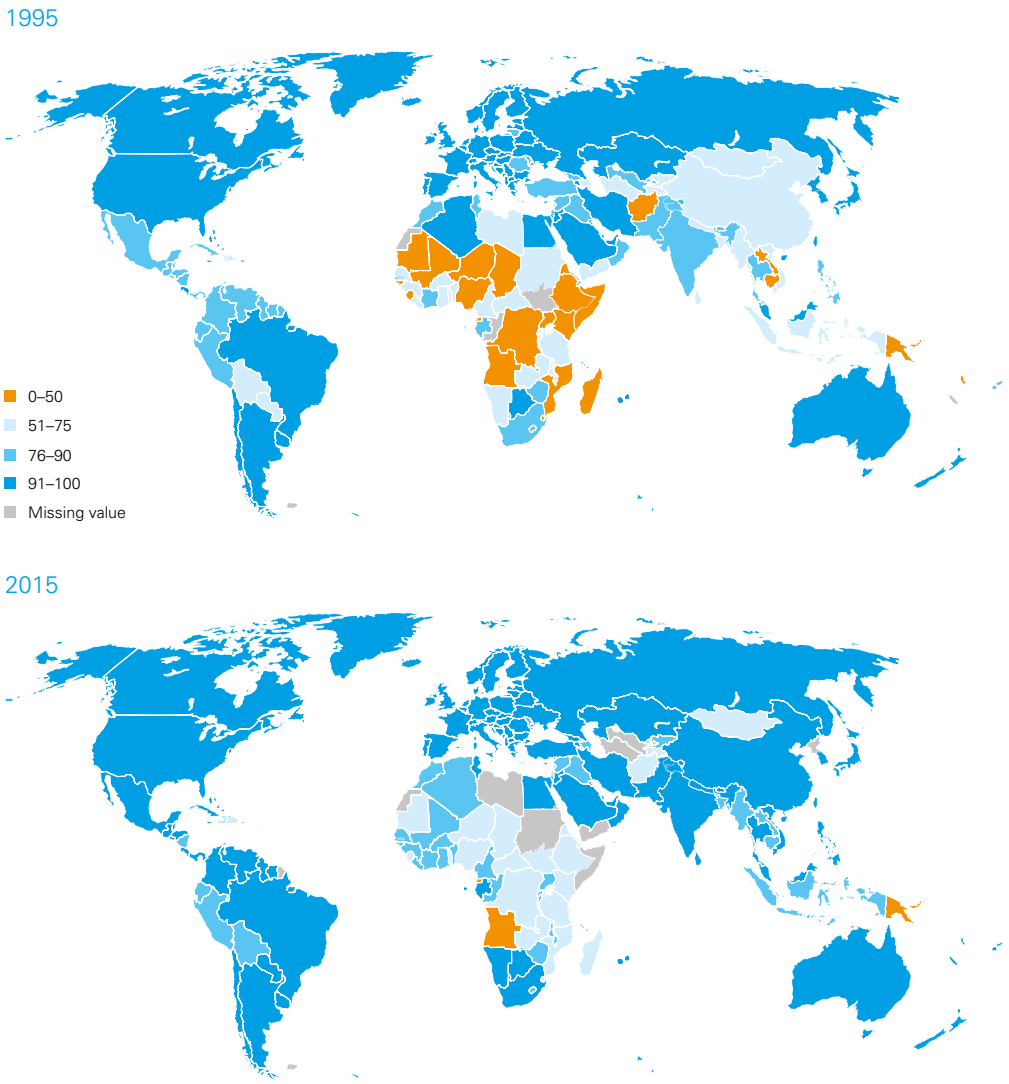


Source: WHO and UNICEF, *Progress on Sanitation and Drinking Water: 2015 update and final MDG assessment*, WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, New York, 2015.

MAP 7.A

In 2015, only 3 countries still have less than 50% improved drinking water coverage

Improved percentage drinking water coverage, 1995 and 2015

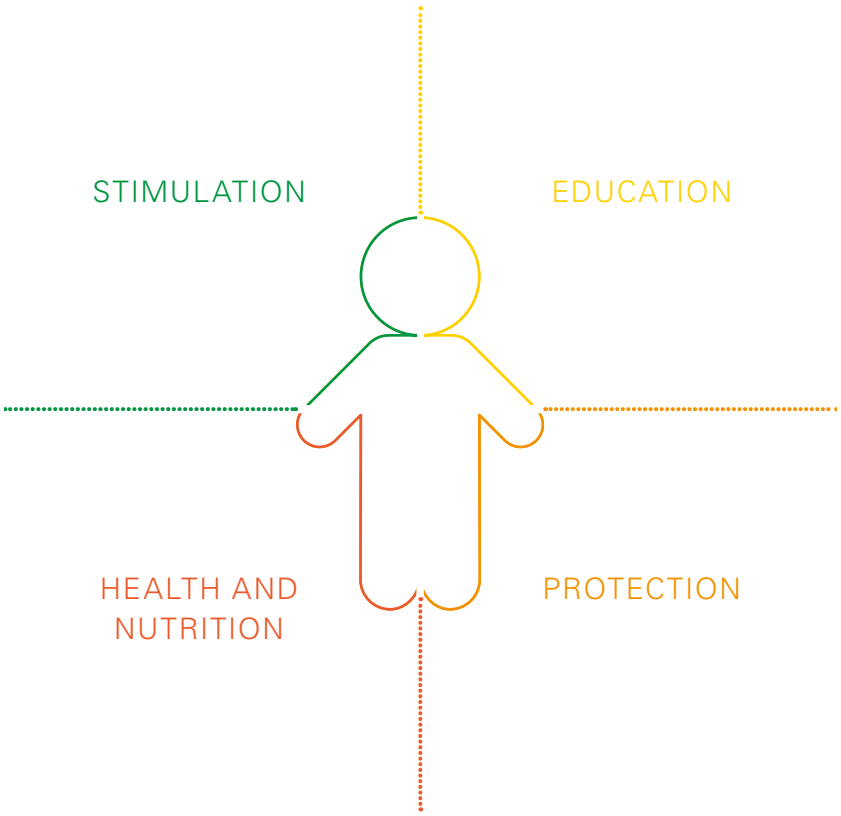


Note: This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not 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: WHO and UNICEF, *Progress on Sanitation and Drinking Water: 2015 update and final MDG assessment*, WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, New York, 2015.

EARLY CHILDHOOD DEVELOPMENT

COMPONENTS OF EARLY CHILDHOOD DEVELOPMENT



THE POOREST CHILDREN LAG BEHIND IN ALL 4 COMPONENTS

Early childhood development

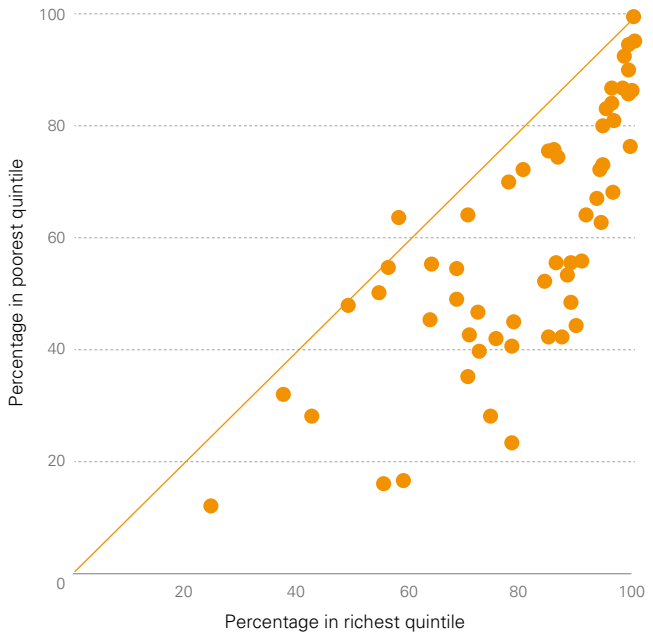
Early childhood, which spans the period up to 8 years of age, is critical for cognitive, social, emotional and physical development. During these years, a child's developing brain is responsive to change as billions of integrated neural circuits are formed through the interaction of genetics, environment and experience. Optimal brain development requires a stimulating environment, adequate nutrients and social and responsive interaction with attentive caregivers.

While internationally comparable data remain sparse, available figures reveal significant inequities associated with household wealth in caregiver support for children's development and early learning at home (Fig. 8.A). While overall levels of adult support for development and learning are generally quite high, children in the poorest quintile are much less likely to receive such support, which is a key influencer of children's development.

FIGURE 8.A

Children from the poorest quintile are less likely to be engaged in early learning activities at home

Percentage of children aged 36–59 months engaged by an adult household member in four or more activities to promote learning and school readiness in the past three days, by household wealth quintile[94]



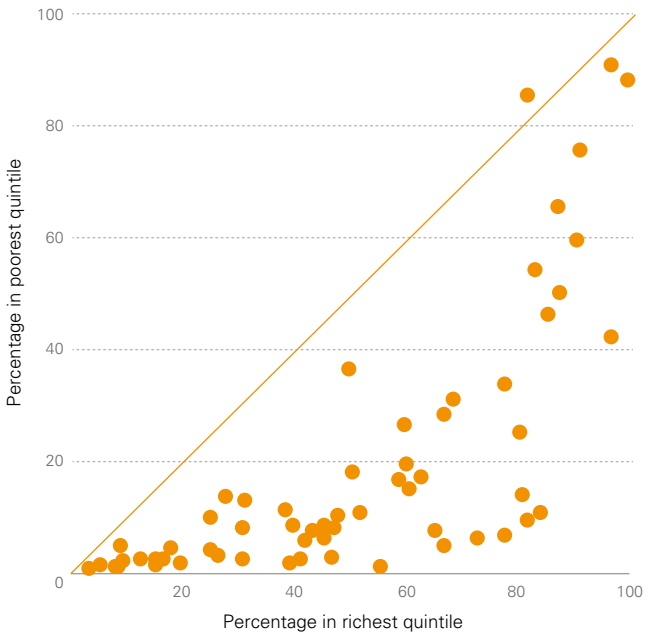
Note: Each dot represents a country. Dots along the diagonal line represent countries where engagement in early learning activities is similar among children in the richest and poorest households, while those above or below the line represent disparity.

Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources, 2005–2014.

FIGURE 8.B

Access and utilization of early childhood education programmes are often denied to children living in the poorest households

Percentage of children aged 36–59 months who attend some form of early childhood education programme, by household wealth quintile[95]



Note: Each dot represents a country. Dots along the diagonal line represent countries where attendance is similar among children in the richest and poorest households, while those above or below the line represent disparity.

Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources, 2005–2014.

Children from the poorest quintile continue to be disadvantaged in their ability to access and utilize quality care and education programmes (Fig. 8.B). These early inequalities translate into gaps in developmental outcomes. Data from 39 countries show significant variation in the overall levels of literacy-numeracy, with children from the poorest quintile less likely to have achieved relevant milestones in this area (Fig. 8.C).

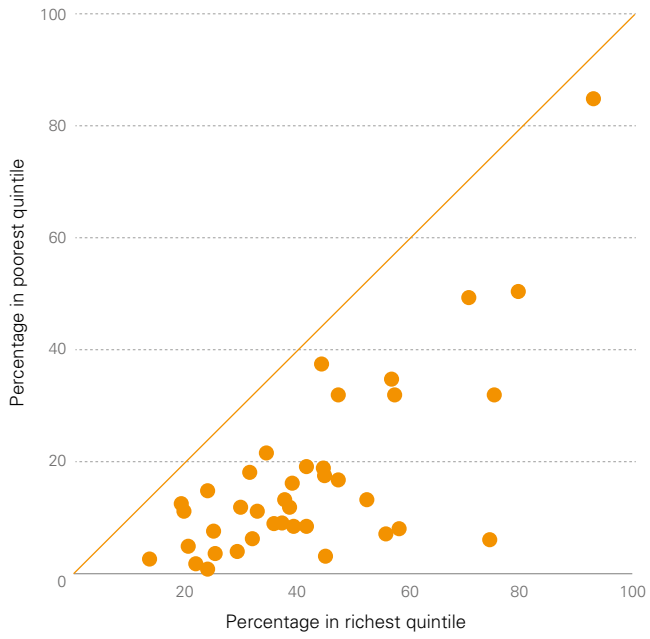
Investing in early childhood care, development and education can be a powerful way to reduce gaps that often put children with low social and economic status at a disadvantage. Moreover, the returns on such investments are highest among poorer children and may help serve as a stepping stone out of poverty and exclusion.[93]

Optimal brain development requires a stimulating environment, adequate nutrients and social and responsive interaction with attentive caregivers.

FIGURE 8.C

Children from the poorest quintile are more likely to experience developmental delays in literacy and numeracy

Percentage of children aged 36–59 months who are developmentally on track in the literacy-numeracy domain, by household wealth quintile[96]



Note: 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 above or below the line represent disparity.

Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources, 2005–2014.

CHILD MARRIAGE

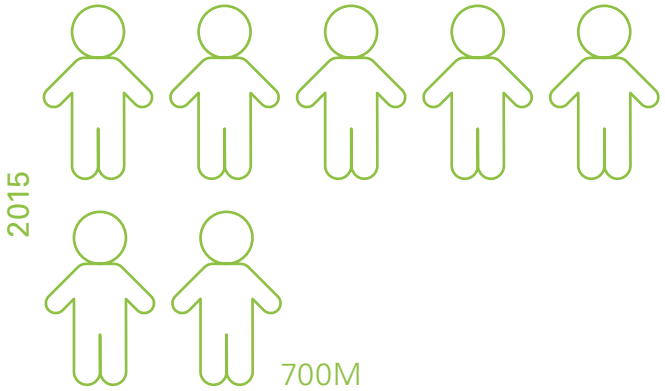
PROPORTION OF WOMEN MARRIED IN CHILDHOOD

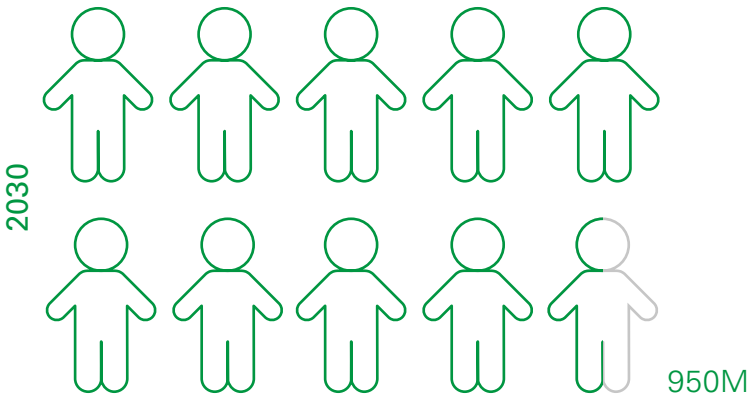
Around 1990

Around 2010

NUMBER OF WOMEN MARRIED IN CHILDHOOD

More than 700 million women were married as children. With population growth, this number could grow to 950 million by 2030 if there is no reduction in the practice.





Child marriage

Marriage before the age of 18 is a fundamental violation of human rights. Child marriage often compromises a girl's development by resulting in early pregnancy and social isolation, interrupting her schooling, limiting her opportunities for career and vocational advancement and placing her at increased risk of domestic violence.

The practice of child marriage is slowly declining, with the most dramatic progress occurring among girls married before age 15. Globally, around 1 in 4 young women (aged 20–24) was married in childhood, versus 1 in 3 in 1990. The proportion of those entering marriage before age 15 declined from 12 to 8 per cent over the same period (Fig. 9.A). Despite this progress, the overall number of women who were married as children has increased over time because of population growth and currently stands at more than 700 million, including more than 70 million young women between the ages of 20 and 24 who were married before their eighteenth birthday.

Levels of child marriage vary significantly across regions – with the greatest prevalence in sub-Saharan Africa and South Asia – and progress has been uneven (Fig. 9.B). The Middle East and North Africa region has seen the fastest reduction, where the proportion of women married before age 18 has dropped by about half over approximately the last two decades. Although levels of child marriage in Latin America and the Caribbean are low overall, there have been no significant changes in the prevalence over time.

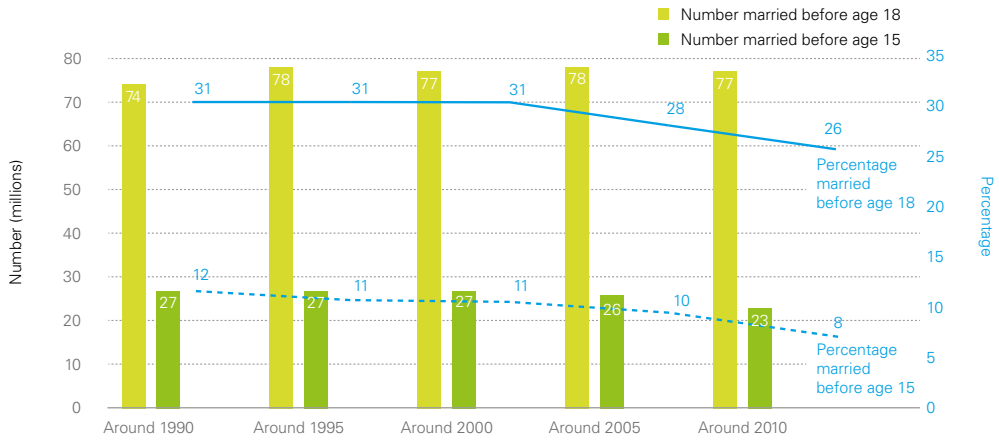
Even within countries, not all girls face the same risk of child marriage. In the course of about two decades, the gap in global levels of child marriage between women from the richest and poorest quintiles has dramatically increased (Fig. 9.C).

If there is no reduction in the practice of child marriage, the number of girls under age 18 married each year will grow from 15 million today to 16.5 million by 2030.[97]

FIGURE 9.A

Globally, the practice of child marriage is declining, especially when it comes to the marriage of girls under age 15

Percentage and number (in millions) of women aged 20–24 who were married or in union before age 15 and before age 18[98]

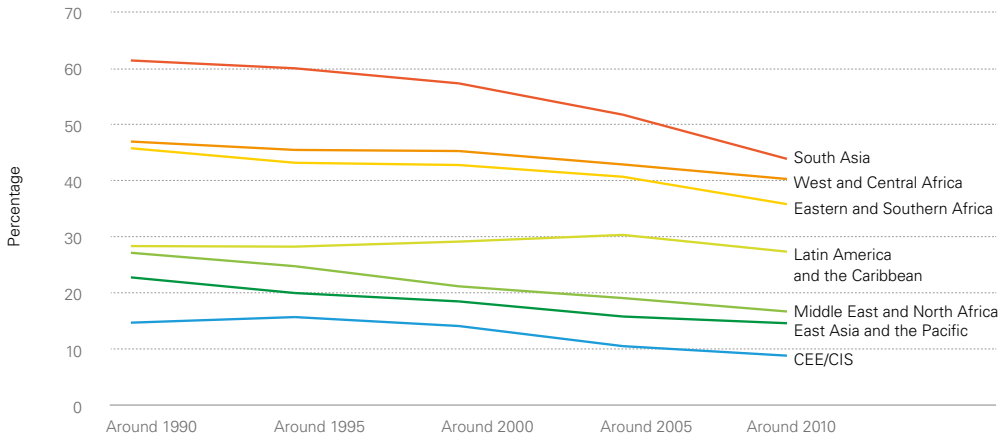


Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources, 2005–2014.

FIGURE 9.B

The Middle East and North Africa has made the fastest progress in reducing child marriage

Percentage of women aged 20–24 who were married or in union before age 18, by region[99]

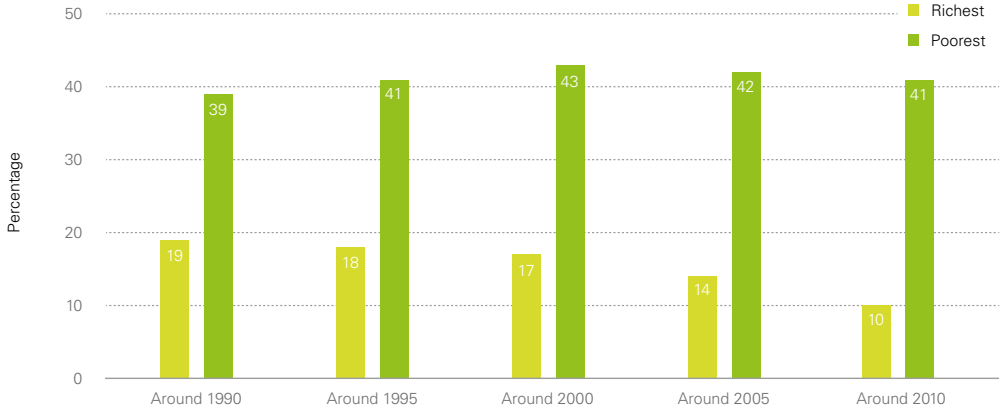


Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources, 2005–2014.

FIGURE 9.C

The gap in levels of child marriage between richest and poorest quintiles has dramatically increased

Percentage of women aged 20–24 who were married or in union before age 18, by household wealth[100]



Source: UNICEF global databases, 2015, based on MICS, DHS and other nationally representative sources, 2005–2014.

DATA ON THE SITUATION OF CHILDREN: 1990 TO 2015

When heads of state assembled for the World Summit for Children in 1990, they had very limited information upon which to base targets to promote the survival, protection and development of children. Since then, there has been a revolution in the availability of robust, high-quality data on the situation of children around the world. Increased investment in data collection and monitoring during the 1990s helped inform the formulation of Millennium Development Goal (MDG) targets, which, in turn, further increased demand for data to track and compare progress at national, regional and global levels.

In 2015, as we approach the end of the MDG period, the world knows more than ever about the situation of its children. Our investment in building capacity to collect, analyse and report on key indicators of progress for children has paid off. It has given us a much better understanding of how the overall situation of children has changed since 1990, which children have benefited and which have been left behind. Not only are more countries generating child-related data at a growing rate, but also the number of topics with data that we can compare across different populations and over time has greatly increased. In addition, the availability of data on issues such as early childhood development, disability and female genital mutilation/cutting has provided a compass for programmatic action that was previously lacking.

Having reliable data has enabled better targeting of programmes and interventions where they are needed most. For example, around 1990, just 28 low- and middle-income countries had data to indicate whether levels of malnutrition were rising or falling, compared with 119 today. And the increase in comparable data on oral rehydration salts (ORS), which can save the life of a child with diarrhoea, has risen from 22 countries with survey estimates for around 1990 to 121 countries with survey estimates for around 2010 (2008–2014). Since 2000, the number of internationally comparable datasets on access to water and sanitation has increased tenfold, to nearly 1,900 datasets in 2015.

Much of the recent progress on data for children has been spurred by the rapid expansion and innovation of international household survey programmes. The UNICEF-supported Multiple Indicator Cluster Survey (MICS) Programme and USAID-supported Demographic and Health Survey (DHS) Programme have assisted governments in collecting data on a range of topics. These programmes have been the largest producers of child-related data that are comparable among countries and over time, yielding statistics that can be disaggregated by a number of key background characteristics such as sex, residence, household wealth and ethnicity to provide insight into the lives of the most vulnerable. In the 20 years of the MICS programme, 275 surveys have been conducted in 108 countries.

As the world prepares for a new development agenda, data and evidence will only increase in importance and national systems must be strengthened to meet new demands. The new data agenda will need to harness the potential of new technologies to collect, synthesize and speed up the use of data, and also reinvigorate efforts to ensure complete

and well-functioning registration systems. The new data agenda will need to provide insight into the most vulnerable children, relying on household surveys that provide data regardless of whether or not a child attends school or is taken to a health facility, as well as developing new approaches for collecting information about children who are homeless, institutionalized or internally displaced.

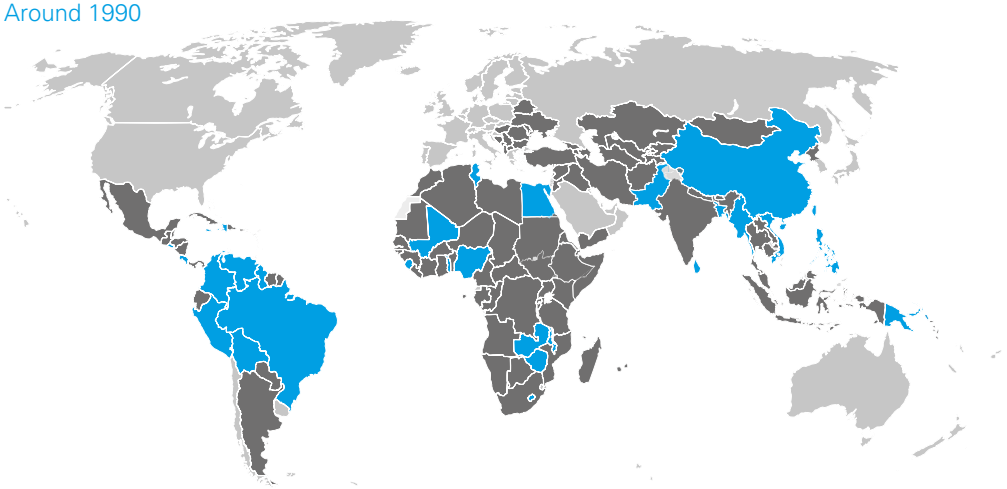
If the new data agenda is successful, every child will be guaranteed a voice.

Evolution of data availability in low-income and middle-income countries since 1990

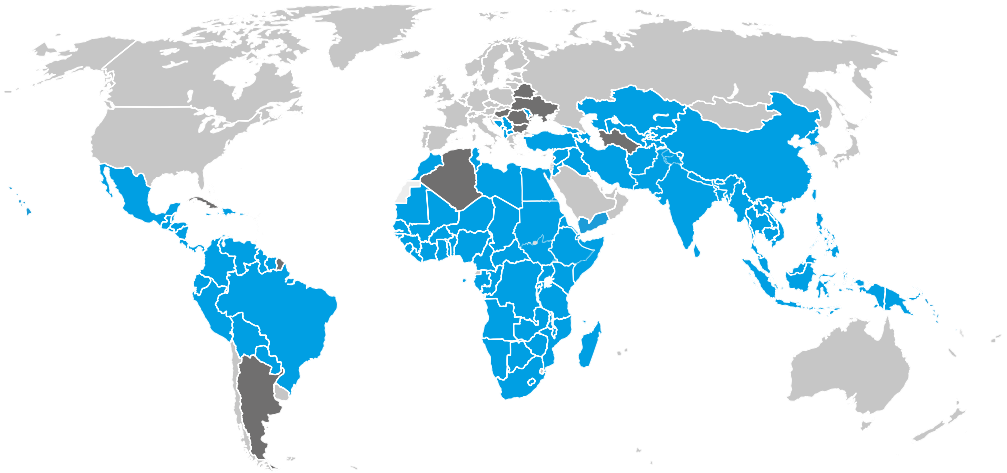
Around 1990, 28 low-income and middle-income countries had trend data on child malnutrition

Today, 119 low-income and middle-income countries have current trend data on child malnutrition

Around 1990



2015



- Low-income and middle-income countries with trend data
- Low-income and middle-income countries without trend data
- High-income countries

Note: This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. Income levels refer to the latest classification, as per The World Bank, July 2014. See page 65 for details on the classification.

Source: Based on underweight prevalence estimates. Data are from UNICEF Data and Analytics, June 2015. An earlier version of these maps appeared in *The Lancet* S0140-6736(14)6081-7. These have been updated based on UNICEF global databases, June 2015.

GENERAL NOTE ON THE DATA

Data presented in this report are derived from UNICEF's global databases, which include only data that are internationally comparable and statistically sound. The report draws on inter-agency estimates and nationally representative household surveys such as Multiple Indicator Cluster Surveys (MICS) and Demographic and Health Surveys (DHS). In addition, data from administrative sources and other United Nations organizations have been used. Data presented in this report generally reflect information available as of March 2015. Given the time necessary to collect, analyse and report nationally representative data, the data presented here may not always reflect the current situation. This is especially the case in countries and areas recently experiencing crises, where the situation of children and women can deteriorate rapidly. More detailed information on methodology and data sources is available at <data.unicef.org>.

This report includes the latest population estimates and projections from *World Population Prospects: The 2012 revision* and *World Urbanization Prospects: The 2014 revision* (United Nations Department of Economic and Social Affairs, Population Division). Data quality is likely to be adversely affected for countries that have recently suffered disasters, especially where basic country infrastructure has been fragmented or where major population movements have occurred.

Efforts have been made to maximize the comparability of statistics across countries and over time. Data presented here are subject to evolving methodologies, revisions of time series data (e.g., immunization rates, under-five mortality rates, maternal mortality ratios) and changing regional classifications. Also, data comparable from one year to the next are unavailable for some indicators. It is therefore not advisable to compare data from consecutive editions of *Progress for Children*, or to compare data across other UNICEF reports over time.

The numbers presented in this report are available online via the UNICEF global statistical databases at <data.unicef.org>. Please refer to this website for the latest data.

NOTE TO THE READER ON INTERPRETING DATA IN THIS REPORT

In the preceding pages, there is a focus on trends in disparities between different groups for key indicators of children's well-being. Ultimately, these comparisons are meant to inform the reader as to whether there are differences for a given indicator between boys and girls, children in urban and rural areas, the poorest and the richest households, etc. Because such differences in indicator levels can depend on an array of factors, the reader should be aware that comparisons across groups are susceptible to misinterpretation.

Data availability

The conclusions we draw are driven by the data we have available. The analyses in this report are based on a limited number of indicators and a limited number of background characteristics. Thus, the analysis may indicate a narrowing of gaps by urban-rural residence or household wealth, but they may be widening among other background characteristics that are not available for analysis, including different ethnic groups or by sexual orientation.

Survey coverage

Data collected from population-based surveys are a primary source of information for the disaggregated data displayed in this document. In fact, evidence-based discussions of disparities for these indicators would be difficult, if not impossible, without survey data. However, because the marginalized populations of interest are often hard to reach, samples of these sub-populations may not be entirely representative unless additional efforts are made to oversample them. Urban areas such as slums or informal peri-urban settlements are a particular challenge, because defining such areas can be problematic and because records of households living in these areas often may not exist. While oversampling of hard-to-reach populations is often conducted to address potential gaps in survey coverage, readers should be aware of the challenges and trade-offs involved.

Underlying burden

Comparisons across groups may also be misinterpreted owing to a failure to account for the underlying burden within a population. This is particularly important to consider over time, as the underlying populations may change over the period studied. For example, sub-Saharan Africa is experiencing rapid population growth, with a steadily increasing number of births each year. This situation can create an uphill battle for intervention coverage – for example, the region has seen a modest increase in coverage of skilled attendance at birth (43 per cent around 1990 to 52 per cent around 2014), but because of demographic changes, this small increase in the percentage translated to an additional 9 million births attended by a skilled attendant in 2014 compared to 1990, or nearly twice as many.

Understanding different measures

In an equity analysis, the measure selected is very important. Different measures can give a different sense of the situation. In a hypothetical example, in two countries, stunting in the rural areas may be three times as high as in urban areas (a ratio of 3). However, in the first country the absolute difference between the rates could be just six percentage points (rural = 9 per cent and urban = 3 per cent) whereas in the second country, the absolute difference could be 20 percentage points (rural = 30 per cent and urban = 10 per cent). Thus, the assessment of differentials between population groups will vary depending on whether absolute or relative differences (or both) are presented.

Confidence intervals

It is important to note that estimates for subpopulations are bracketed by a larger range of uncertainty than aggregate estimates and thus must be interpreted with caution.

ENDNOTES

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32 Estimates are based on a subset of 93 countries, covering 81 per cent of births in 2014. Regional estimates represent data from countries covering at least 50 per cent of regional births. Data for Brazil (2006) are outside of the noted year range. The CEE/CIS averages exclude the Russian Federation, for which comparable data are not available.

33 Estimates are based on a subset of 72 countries with available data, covering 56 per cent of the global urban and 75 per cent of the global rural population in 2000 and covering 60 per cent of the global urban and 75 per cent of the global rural population in 2014 (excluding India). Regional estimates represent data from countries that cover at least 50 per cent of the regional population. Data coverage was insufficient to calculate averages for the MENA region. Data coverage was only met for the CEE/CIS region after removing the Russian Federation from the denominator, hence data for that region are presented without the Russian

Federation. 'Data from around 2000' refers to 1997–2003, and 'around 2014' refers to 2008–2014. Data for Brazil (1996 and 2006), India (1998 and 2005–06), and Uzbekistan (1996 and 2006) fall outside of the noted year ranges. Note that the methods used to derive these estimates by area of residence vary from those used to generate the total estimates in Map 1a.

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46 Analysis is based on 94 countries that have data from the following international, regional or national learning assessments during the period between 2004 and 2012: Annual Status of Education Report (ASER), Programme for the Analysis of Education Systems (PASEC), Progress in International Reading Literacy Study (PIRLS), Southern and Eastern African Consortium for Monitoring Educational Quality (SACMEQ) and Second Regional Comparative and Explanatory Study (SERCE).

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51 Analysis is based on 73 countries that have at least two data points (one for 2000–2007 and the other for 2008–2014) either from MICS or DHS.

52 Analysis is based on 94 countries that have data from the following international, regional or national learning assessments during the period between 2004 and 2012: Annual Status of Education Report (ASER), Programme for the Analysis of Education Systems (PASEC), Progress in International Reading Literacy Study (PIRLS), Southern and Eastern African Consortium for Monitoring Educational Quality (SACMEQ) and Second Regional Comparative and Explanatory Study (SERCE).

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62 The main findings of an analysis of more than 280 household surveys for the regional mortality estimates by wealth quintile are derived from a model based on the assumption of a constant relative change within country quintiles, i.e., linear changes in under-five mortality on a logarithmic scale at the country level per wealth quintile group, therefore not weighted by country-specific numbers of live births or under-five population. Caution should be used in interpreting these results. Results from weighted regional averages also show faster declines among the poorest households than the richest, and disparities in under-five mortality have declined in most regions except sub-Saharan Africa.

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73 Global estimates are based on a subset of 54 countries covering 59 per cent of urban births and 77 per cent of rural births in 2014. Regional estimates represent data from countries covering at least 50 per cent of regional births.

Data coverage was insufficient to calculate regional trend averages for the CEE/CIS region, Latin America and the Caribbean, as well as Middle East and Central African region. Data from around 2000 refers to 1999–2007, and around 2014 refers to 2008–2014.

74 Estimates for the least developed countries are based on a subset of 22 countries, covering 68 per cent and 73 per cent of births in urban and rural areas respectively in 2014. Regional estimates represent data from countries covering at least 50 per cent of regional births. Data coverage was insufficient to calculate a global average as well as regional average for CEE/CIS, Latin America and the Caribbean and Middle East and North Africa. Data from around 2000 refers to 1999–2007, and around 2014 refers to 2008–2014 (plus one exception for India data from 2006).

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82 Disparity analysis is based on household survey data (2009–2014) collected for males in 38 sub-Saharan African countries and for females in 43 sub-Saharan African countries, representing 94 per cent and 98 per cent of the population aged 15–24, respectively; 42 countries for age, representing 89 per cent of the male and 93 per cent of the female population; 39 countries for residence, representing 79 per cent of the male and 88 per cent of the female population; and 24 countries for household wealth quintiles, representing 59 per cent of the male and female population. Comprehensive knowledge of HIV is defined as correctly identifying the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), rejecting the two most common local misconceptions about HIV transmission, and knowing that a healthy-looking person can have HIV.

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88 UNICEF analysis based on based on MICS, DHS, Malaria Indicator Surveys (MIS), and other nationally representative sources

89 Data from around 2000 refers to (1997–2007), and around 2014 refers to (2009–2014).

90 Regional estimates are based on a subset of 37 countries, covering 90 per cent of population under five in sub Saharan Africa in 2014. Subregional estimates represent data from countries covering at least 50 per cent of regional population under five. Data from around 2000 refers to (2000–2009), and around 2014 refers to (2010–2014).

91 Regional estimates are based on a subset of 38 countries, covering 94 per cent of the population under five in sub-Saharan Africa in 2014. Subregional estimates represent data from countries covering at least 50 per cent of regional population under five.

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95 Analysis includes 61 countries with available data.

96 Analysis includes 39 countries with available data

97 UNICEF global databases, 2015, based on MICS, DHS, and other nationally representative sources.

98 Estimates are based on a subset of countries covering at least 50 per cent of the global population of women aged 20–24.

99 Estimates are based on a subset of 117 countries. Regional estimates represent data covering at least 50 per cent of the regional population of women aged 20–24. Data coverage is below 50 per cent for East Asia and the Pacific due to the lack of comparable data on child marriage for China in UNICEF global databases.

100 Estimates are based on a subset of 82 countries covering at least 50 per cent of the global population of women aged 20–24 (excluding China, for which comparable data on child marriage is not available in UNICEF global databases).

REGIONAL CLASSIFICATIONS

Sub-Saharan Africa
Eastern and Southern Africa; West and Central Africa; Djibouti; Sudan

Eastern and Southern Africa
Angola; Botswana; Burundi; Comoros; Eritrea; Ethiopia; Kenya; Lesotho; Madagascar; Malawi; Mauritius; Mozambique; Namibia; Rwanda; Seychelles; Somalia; South Africa; South Sudan; Swaziland; Uganda; United Republic of Tanzania; Zambia; Zimbabwe

West and Central Africa
Benin; Burkina Faso; Cabo Verde; Cameroon; Central African Republic; Chad; Congo; Côte d'Ivoire; Democratic Republic of the Congo; Equatorial Guinea; Gabon; Gambia; Ghana; Guinea; Guinea-Bissau; Liberia; Mali; Mauritania; Niger; Nigeria; São Tome and Principe; Senegal; Sierra Leone; Togo

Middle East and North Africa
Algeria; Bahrain; Djibouti; Egypt; Iran (Islamic Republic of); Iraq; Jordan; Kuwait; Lebanon; Libya; Morocco; Oman; Qatar; Saudi Arabia; State of Palestine; Sudan; Syrian Arab Republic; Tunisia; United Arab Emirates; Yemen

South Asia
Afghanistan; Bangladesh; Bhutan; India; Maldives; Nepal; Pakistan; Sri Lanka

East Asia and the Pacific
Brunei Darussalam; Cambodia; China; Cook Islands; Democratic People's Republic of Korea; Fiji; Indonesia; Kiribati; Lao People's Democratic Republic; Malaysia; Marshall Islands; Micronesia (Federated States of); Mongolia; Myanmar; Nauru; Niue; Palau; Papua New Guinea; Philippines; Republic of Korea; Samoa; Singapore; Solomon Islands; Thailand; Timor-Leste; Tonga; Tuvalu; Vanuatu; Viet Nam

Latin America and the Caribbean
Antigua and Barbuda; Argentina; Bahamas; Barbados; Belize; Bolivia (Plurinational State of); Brazil; Chile; Colombia; Costa Rica; Cuba; Dominica; Dominican Republic; Ecuador; El Salvador; Grenada; Guatemala; Guyana; Haiti; Honduras; Jamaica; Mexico; Nicaragua; Panama; Paraguay; Peru; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Suriname; Trinidad and Tobago; Uruguay; Venezuela (Bolivarian Republic of)

Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS)
Albania; Armenia; Azerbaijan; Belarus; Bosnia and Herzegovina; Bulgaria; Croatia; Georgia; Kazakhstan; Kyrgyzstan; Montenegro; Republic of Moldova; Romania; Russian Federation; Serbia; Tajikistan; the former Yugoslav Republic of Macedonia; Turkey; Turkmenistan; Ukraine; Uzbekistan

Least developed countries/areas
(Classified as such by the United Nations High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States [UN-OHRLLS]).
Afghanistan; Angola; Bangladesh; Benin; Bhutan; Burkina Faso; Burundi; Cambodia; Central African Republic; Chad; Comoros; Democratic Republic of the Congo; Djibouti; Equatorial Guinea; Eritrea; Ethiopia; Gambia; Guinea; Guinea-Bissau; Haiti; Kiribati; Lao People's Democratic Republic; Lesotho; Liberia; Madagascar; Malawi; Mali; Mauritania; Mozambique; Myanmar; Nepal; Niger; Rwanda; São Tome and Principe; Senegal; Sierra Leone; Solomon Islands; Somalia; South Sudan; Sudan; Timor-Leste; Togo; Tuvalu; Uganda; United Republic of Tanzania; Vanuatu; Yemen; Zambia

For details on the subregions of Africa as classified by the United Nations Economic Commission for Africa, please see: <www.uneca.org/pages/subregional-offices>.

For details on the classification of countries by income group as defined by the World Bank, please see: <http://data.worldbank.org/about/country-and-lending-groups>.

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