

CHILDREN

AND THE

Millennium Development Goals



Progress towards A World Fit for Children

BAN KI-MOON, SECRETARY-GENERAL OF THE UNITED NATIONS



This is an adapted version of the Secretary-General's report 'Follow-up to the special session of the General Assembly on children' (A/62/259) of 15 August 2007, considered by the General Assembly at its sixty-second session in September 2007. It contains updated data and presents information from 121 country and territory reports. For a full list of participating countries and territories, see Annex, page 90.

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December 2007

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ISBN: 978-92-806-4219-3
Sales no.: E.08.XX.7

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Preface

At the 27th Special Session of the General Assembly in May 2002, Governments committed to a set of time-bound and specific goals, strategies and actions in four priority areas for the rights and well-being of children: promoting healthy lives; providing quality education; protecting against abuse, exploitation and violence; and combating HIV/AIDS. These commitments reaffirmed and complemented the Millennium Declaration and its goals as a framework for development and a means for decisively reducing poverty.

This report provides new information and analysis on how far the world has come in reducing child and maternal mortality and malnutrition, ensuring universal primary education, protecting children against abuse, exploitation and violence, and combating HIV/AIDS. It is based on an extensive and valuable set of reports by United Nations Member States, which show that results are mixed, but positive in many respects. In the five years since the Special Session, there has been progress in many countries; but the national reports make clear that actions are still needed everywhere to accelerate progress.

Together, we can reach these critical goals, if we act now and with renewed resolve. This requires us to invest more in basic social services, enhance public-private partnerships, scale up strategies, and provide a healthy, safe and protective environment for children.

The evidence and analysis in this report point to clear directions for our collective efforts to build a world in which all children can survive, grow and develop to their full potential, protected from the many threats that jeopardize their rights. I commend it to all delegates to the General Assembly's commemorative high-level plenary meeting in December 2007, and to all individuals and organizations dedicated to building a world fit for children.



A handwritten signature in black ink that reads "Ki Moon Ban". The signature is fluid and cursive, with the first and last names being more prominent.

Ban Ki-moon
Secretary-General of the United Nations

CHAPTER



What have
we done for
children?

Parents take pride in the progress of their children. They are delighted to see another daughter or son enter the world. They are proud to witness the infant taking his or her first faltering steps, and they feel a mixture of pleasure and apprehension as the child leaves for the first day at school. Family stories tend to be tales of sons and daughters. When old friends meet and exchange family news, one of the first questions is, How are the children?

A similar mixture of hope and concern is evident in the global family. When the international community reflects on its achievements and failures it soon asks about its youngest members. What have we done for children? Are today's children healthy and well nourished? Are they going to school? Are they protected from harm and preparing themselves for adult life?

These questions have echoed down the years at a series of international gatherings. One of the principal landmarks was in 1989, when the UN General Assembly adopted the Convention on the Rights of the Child (CRC). It says that children 'should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations'.

This was soon followed, in 1990, by the remarkable World Summit for Children, at which 159 Heads of State and Government and other high-level representatives proclaimed that 'there can be no task nobler than giving every child a better future'. And just as parents are willing to sacrifice for their children, so the governments at the Summit promised that they would always act in the 'best interests of the child' and ensure that children would have 'first call' on all resources. To put these promises into effect they established a Plan of Action incorporating 27 specific goals relating to children's survival, health, nutrition, education and protection.

This focus on children continued. Ten years later, in 2000, the world's leaders met and signed the Millennium Declaration, pledging 'to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty'. Soon after, they also committed themselves to a series of targets that came to be known as the Millennium Development Goals (MDGs), all of which involve the rights of the world's children.

Lest there be any doubt, these commitments were reiterated in May 2002, when the General Assembly devoted its 27th Special Session exclusively to children, in order to review progress since the 1990 Summit. While acknowledging many achievements, they concluded that they were still falling short. They adopted a Declaration committing themselves to seizing 'this historic opportunity to change the world for and with children'.

The resulting plan of action aimed to create a world fit for children, one in which all children get the best possible start in life. The plan emphasized that families, the basic units of society, have the primary responsibility, and that they and other caregivers should have the appropriate support so they can enable children to grow in

Five years after the Special Session, more than 120 countries and territories have prepared reports on their efforts to meet the goals of A World Fit for Children.

a safe and stable environment. With the plan, governments committed to a time-bound set of specific goals, strategies and actions in four priority areas: promoting healthy lives; providing quality education; protecting against abuse, exploitation and violence; and combating HIV and AIDS.

Five years after the Special Session, more than 120 countries and territories have prepared reports on their efforts to meet the goals of 'A World Fit for Children' (WFFC). Most have developed these in parallel with reports on the Millennium Development Goals, carrying out two complementary exercises. Reports on the Millennium Development Goals highlight progress in poverty reduction and the principal social indicators, while the World Fit for Children reports go into greater detail on some of the same issues, such as education and child survival. But they also extend their coverage to child protection, which is less easy to track with numerical indicators.

The purpose of this document is to assemble some of the information contained in these reports, along with the latest global data – looking at what has been done and what remains to be done. It is therefore organized around the four priority areas identified in A World Fit for Children, discussing each within the overall framework of the Millennium Development Goals.¹

To appreciate the achievements for children over the past two decades, it is also useful to reflect briefly on how their world has changed. Children born in 1989, the year when the Convention on the Rights of the Child was adopted, are now on the brink of adulthood. They have lived through a remarkable period of social, political and economic transformation.

Opportunities for participation

One change is that today's children and young adults have many more channels for social and political participation. In fact, members of the generation of 1989 may already have exercised their right to vote. Many have also witnessed momentous geopolitical changes. The years following the break-up of the Soviet Union, for example, offered millions of people far more scope to express their views, often as citizens of new states, and many other countries have moved from authoritarian rule to democracy. The growth of the United Nations reflects that increasing diversity: In 1990 the United Nations had 159 members; in 2007 it has 192.

The Convention on the Rights of the Child underscored the importance of child participation: 'States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child'. The UN Special Session on Children itself benefited from the presence of child representatives from all over the world who prepared the children's declaration 'A World Fit for Us'.

Since then, as is clear from the World Fit for Children country reports, children have increasingly been making their voices heard in their schools, in their communities and even at the level of national politics – and in many different ways according to their own capacities and inclinations. Some speak through clubs or associations,

others as part of the management of schools or other institutions. Child-run publications, TV programmes and websites have also been making their mark. And at both local and national levels children have participated in the process of government – becoming familiar with what government involves and offering their own insights.

Children in war

Some 1.5 million children – two thirds of the world's child population – lived in the 42 countries affected by violent, high-intensity conflict between 2002 and 2006. But the impact of armed conflict on children is difficult to estimate because of the lack of reliable and up-to-date statistics.

Most vulnerable of all are the millions of children displaced, either within their own countries or outside their homeland as refugees. Globally, 11 to 17 million people are refugees. Of these, 41 per cent are believed to be children and 26 per cent women. Global estimates of internally displaced persons range between 16 million and 25 million, with an average estimate of 24.5 million internally displaced persons worldwide. Displaced children and adolescents are particularly vulnerable to violence, sexual exploitation, HIV infection, forced labour and slavery, and they risk being forcibly recruited by armed groups.

The plan of action of A World Fit for Children addressed the need to 'strengthen the protection of children affected by armed conflict and adopt effective measures for the protection of children under foreign occupation'. Some governments have focused on children in the middle of warfare. Their efforts have included days of tranquillity to reach children with immunizations, vitamin A supplementation and other child health interventions. A major nutrition breakthrough in emergency situations involves treating malnourished children at home with ready-to-use therapeutic foods, a safer and more accessible alternative to hospital care in conflict zones.

When peace returns, children are among the first beneficiaries, as schools and health clinics reopen and immunization programmes restart. During the transition from emergency situation to stable government, children have played an important part in truth, justice and reconciliation activities and in creating new and promising outcomes – as, for example, in Afghanistan, Liberia, Sierra Leone and Timor-Leste.

At the international level a number of actions have strengthened the commitment to children affected by war. In 2003 the European Union approved Guidelines on Children and Armed Conflict, which call for regular reporting on the effects of European Union actions on children in conflict situations. In July 2005 Security Council resolution 1612 created a formal monitoring and reporting mechanism and a Working Group on Children and Armed Conflict. To mark the tenth anniversary of the landmark United Nations report on this issue by Graça Machel, the Special Representative of the Secretary-General for Children and Armed Conflict and UNICEF united to embark on a strategic review of the current situation. And UN agencies continued to seek practical solutions to protect children affected by conflict and occupation, including negative repercussions on their health, education and welfare.

Measures to support universal primary education and achieve the Millennium Development Goals do not always reach children living in fragile states affected by

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conflict. Despite accounting for half of the world's out-of-school children, such states receive only a fifth of global education aid. When aid is provided to conflict-affected fragile states, education is not prioritized in either development or humanitarian contexts.²

In their reports on A World Fit for Children, a number of governments have detailed the situation of children both during wars and in the process of returning to peace.

- **Nepal** – The period since the Special Session in 2002 coincided with the country's most recent armed conflict, in which children and women were hit the hardest by all kinds of violence. Nevertheless, child protection remained a high priority, through the 'Children as Zones of Peace' campaign, for example, and other 'do no harm' strategies pursued by development partners and human rights and humanitarian agencies.
- **Sierra Leone** – Several entities have catered for the needs of children affected by war, including the National Commission for War-Affected Children, the Truth and Reconciliation Commission and the Ministry of Social Welfare, Gender and Children's Affairs. These provided forums where children's voices could be heard and their stories listened to. Through these institutions, children who were forced to participate in the war have been rehabilitated as well as reunified and reintegrated with their families and communities.

Exposed to natural disasters

In addition to the man-made disasters of war, many countries have also suffered from a series of natural disasters that have undermined their efforts to fulfil the rights of children. Over the period 2000–2005, an average of 400 natural disasters took place each year, affecting many millions of people. Asia was the hardest-hit region, with more than 80 per cent of the victims. In 2004, the Indian Ocean tsunami killed 226,405 people and affected millions more – in Sri Lanka more than 1 million people were affected; in Indonesia more than 500,000. In 2006, the earthquake in Yogyakarta, Indonesia, affected more than 3 million people, and an earthquake in Pakistan affected an estimated 2.9 million.³

Natural disasters place children at greatest risk. They threaten children's nutrition and health and often separate them from their families, depriving them of schooling and exposing them to a wide range of abuses, including gender-based violence.

World Fit for Children country reports on the response to natural disasters include:

- **Indonesia** – In Aceh, the province most affected by the 2004 tsunami, the government established Children's Centres to provide better protection for children who were victims, and in 2006 the government developed a 'children-friendly village' programme in 50 villages.
- **Kenya** – In 2003 the government laid out a comprehensive plan to accelerate development in the arid districts where it has frequently had to launch emergency humanitarian programmes.

Born in an era of globalization

Many economies in Asia have grown rapidly in the era of globalization, while others, particularly in Africa, are lagging behind. Over the period 1980–2000 economic growth in the Asia-Pacific region averaged 8.5 per cent annually, but in sub-Saharan Africa the rate was only 2.2 per cent. More recently, growth in sub-Saharan Africa has increased to around 3 per cent, but the gaps between countries continue to widen.⁴ At the same time disparities have often widened within countries: Those that account for more than 80 per cent of the world's population have seen rising inequality.⁵

Globalization has also changed the children's world of communications. Many now take for granted that they live in an electronic ether of fast-moving data available for instant access. In richer countries like the United Kingdom, more than 90 per cent of 12-year-olds now own a mobile phone,⁶ and the proportions are similar among affluent children in developing countries. Young people are also among the primary users of the Internet: In a range of developing countries they account for 40 per cent or more of Internet users.⁷ Fast flows of goods and information are also creating new cultural spaces, allowing children all over the world to share ideas and experiences – while growing, the number of children who have access to such technology is still relatively low.

Just as money, goods and ideas are moving around the world, so too are people. In 2005, the total number of migrants globally was 191 million, 3 per cent of the world's population.⁸ While there are fewer data on children, it seems likely that international migration affects one child for every three adults, because the child either migrates with or without the parents or is left behind.⁹

Growing up in poverty or wealth

Skewed economic growth is leaving millions of children poor. They face multiple disadvantages. The starkest is that children born into poor families are less likely to survive. In some African countries those from the poorest 20 per cent of households are 1.7 times more likely to die before the age of five than children born into the richest 20 per cent. They are also less likely to receive adequate nutrition in the first years of life, leading to irreparable damage at a critical stage of physical and mental development. In addition, poor children have a smaller chance of completing primary education and acquiring the knowledge and skills that would help them escape from poverty – thus perpetuating an intergenerational cycle of impoverishment.¹⁰

Millennium Development Goal 1

Millennium Development Goal 1 is 'Eradicate extreme poverty and hunger', and the first target is to halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day. Globally, we are well on track towards this target.

On present trends, by 2015 the proportion of people living in extreme poverty should pass below the 14 per cent target.

On present trends, by 2015 the proportion of people living in extreme poverty should pass below the 14 per cent target. This achievement owes much to progress in East Asia and the Pacific. South Asia is also on track, as is Latin America and the Caribbean. But sub-Saharan Africa is proceeding at a much slower pace: By 2004 the region had only reduced the proportion living in extreme poverty from 47 per cent to 41 per cent.¹¹ The target of 24 per cent by 2015 seems increasingly out of reach. As a result, by then close to half of the world's poorest people will be concentrated in sub-Saharan Africa.

The poverty goal includes targets on nutrition – aiming to halve the prevalence of underweight children under five by 2015 (see *Chapter 2*). Globally, this target is likely to be missed.

Continuing the fight against poverty will require sustained investment in human development – ensuring that families have the standards of education, nutrition and health that allow them to develop their capacities, as well as creating employment and other opportunities that allow them to use those capacities. At the same time, however, many governments have demonstrated their determination to address poverty directly through targeted programmes of cash transfer. In their *World Fit for Children* reports, a number of countries have reported on these schemes, including:

- **Belarus** – A network of social service institutions has been established to work with socially at-risk families, aiming to detect early any family troubles that will have a bearing on children. During the period 2001–2005, 19,895 children who had been orphaned were transferred from boarding schools to families, with support from the social services institutions. A number of boarding schools for orphans were closed as a result.
- **Brazil** – Bolsa Família is considered to be one of the world's most comprehensive and focused cash transfer programmes. As of June 2006 it was reaching its target of 10.9 million families. The programme associates the transfer of a financial stipend with school attendance and access to health care and social assistance.
- **Kenya** – A cash transfer programme started in December 2004 and is now active in 17 districts, with around 10,000 children enrolled in 2007. The government has a target of reaching 300,000 to 1 million children by 2010. Reaching 750,000 children with cash transfers would cost only around 2 per cent of government expenditure, or 0.5 per cent of gross domestic product.
- **Ukraine** – Social services financing provided through local government budgets covers 80 per cent of expenditure on health care, 70 per cent on education and nearly half the expenditure on social protection. More than 1 million families receiving state support were provided with 1,682.4 million Ukrainian hryvnja (US\$333.2 million) in 2005. In addition, child care allowances were provided to 328,100 families with children up to age 3 years, to 225,800 women without state social insurance and to 48,500 persons caring for children under guardianship.

While the most severe challenges to the well-being of children are found in the developing countries, other parts of the world also face many issues. In CEE/CIS, most countries have shown signs of recovery and economic growth in recent years.

But large numbers of children still experience poverty and deprivation, particularly within certain groups and geographical areas. As reported to a 2006 conference in Palencia, Spain, the situation of children across Europe and Central Asia has deteriorated on every indicator over the last two decades.

Even the richest countries need to be vigilant to ensure the well-being of their children. A recent survey by UNICEF examined the situation of children in 21 nations of the industrialized world – looking at their material well-being, health and safety, education, peer and family relationships, and behaviours and risks, along with young people's own subjective sense of well-being. It found that all countries had weaknesses: No country featured in the top one third of the rankings for all six dimensions of child well-being. It also found no clear relationship between levels of child well-being and national income: The Czech Republic, for example, achieved a higher overall rank on children's well-being than several much wealthier countries.¹²

Commitment to children

In *A World Fit for Children*, governments committed themselves to 'Putting in place, as appropriate, effective national legislation, policies and action plans and allocating resources to fulfil and protect the rights and to secure the well-being of children'.

By the end of 2006, around 50 governments had established specific national plans of action for children. Some of these are explicitly aligned with the World Fit for Children goals, as for example, 'A Canada Fit for Children', 'A Finland Fit for Children' and 'A Latvia Fit for Children'. In many cases, these plans have evolved through extensive participatory processes. In the Occupied Palestinian Territory, for example, the Plan of Action for Palestinian children was developed with the participation of 112 institutions working in the field of children's rights. Some countries have also produced child-friendly versions of their plans. In Belize, for example, a child-friendly version of the National Plan of Action has been distributed so children can be aware of its contents – and better equipped to lobby and advocate for its implementation.

Some 100 governments have also incorporated goals for children within their overall national plans or, particularly in sub-Saharan Africa, in their poverty reduction strategies. These overall national plans may cover critical issues such as health and education, but they often pay less attention to child protection issues. However, many have also developed new sectoral plans for priority areas such as violence against children, sexual exploitation, child labour, HIV and AIDS, malaria, and orphans and other vulnerable children.

A number of countries have also been establishing goals and plans for children at lower levels of government. China, for example, has formulated child development plans in all its provinces, prefectures and counties. The Philippines has issued a document titled 'Mainstreaming Child Rights in Local Development Planning', and both Serbia and Montenegro have put in place local plans of action for children in many of their municipalities. In Croatia, cities or municipalities are rated on their fulfilment of children's rights. Those achieving scores of at least 80 per cent are awarded the title of 'friend of children' – marked on a signboard at the entrance of the city or municipality.

In some countries children's rights have become election issues. During the 2002 presidential election campaign in Brazil, the NGO Fundação Abrinq launched the 'Child-Friendly President' initiative. As a result, the presidential candidates committed themselves to the goals and the corresponding budgetary allocations. Similarly, in Guinea-Bissau, the NGO AMIC, the Institute for Women and Children and the Children's Parliament prepared a 'Presidential Agenda for Children and Adolescents 2005', which was signed by all 13 presidential candidates.

Investment in children

To fulfil the rights of children and give them the best possible start in life, many governments need to step up their levels of investment in basic social services. This was recognized at the 1995 World Summit for Social Development in Copenhagen, when governments agreed to the '20/20' compact. This called for an allocation of at least 20 per cent of developing country budgets, and at least 20 per cent of official development assistance, to basic social services.

In recent years, while a number of countries have cut social spending, others can report a more positive picture, including:

- **Bhutan** – In 2004 and 2005, the health and education sectors accounted for 27 per cent of total government outlay. In 2006 this increased to 30 per cent – 18 per cent for the education sector, with the emphasis on primary education, human resources development and infrastructure expansion, and 12 per cent for the health sector, for construction of water supply schemes, basic health units and outreach clinics.
- **Mongolia** – Since 2002, the government has spent 18 to 20 per cent of the state budget on social security and social welfare, 17 to 20 per cent on education and 9 to 11 per cent on health services.
- **Vanuatu** – In 2007, the social service sector budget (39 per cent) had the largest share of the state budget; of which education had 26 per cent and health 12 per cent. The expenditure on education went up from 24.6 per cent in 1999/2000 to over 28 per cent in 2001/2002.
- **Viet Nam** – Investment from the state budget in social areas has gradually increased in recent years, focusing more on poverty reduction, universal education, health care, maternal health, child health and HIV and AIDS prevention and control. By 2005, 27 per cent of total government investment was going into social areas.

Most investment in children will come from national resources, but developing countries, and especially the least developed countries, should also be able to rely on support from the international community.

In March 2002 world leaders gathered at the International Conference on Financing for Development in Monterrey, Mexico, and committed themselves to a 'new partnership' between industrialized and developing countries. They urged industrialized countries to increase official development assistance. As a result, aid flows started to

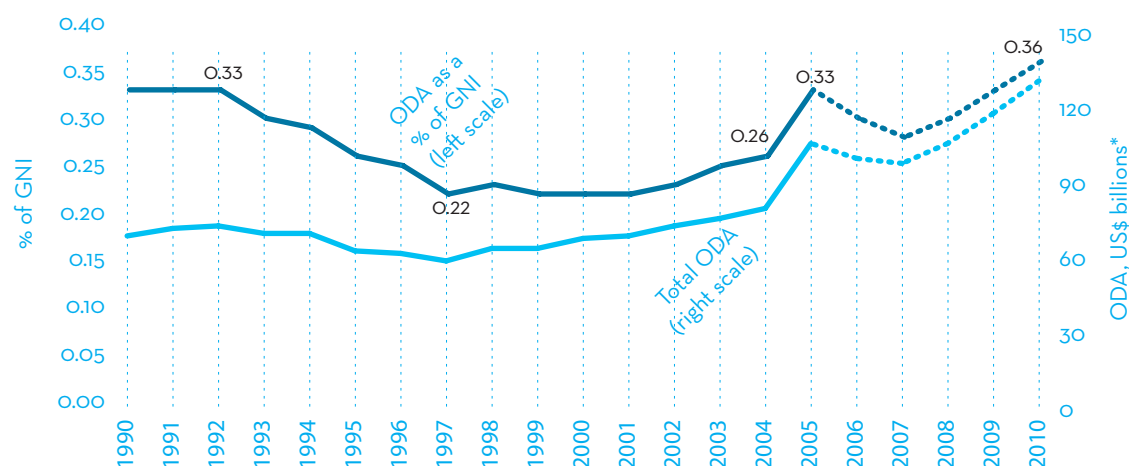
rise, by around 5 per cent per year. At their 2005 summit meeting, the Group of Eight industrial countries made further commitments on aid and debt relief. By 2005, total net official development assistance had reached US\$107 billion – equivalent to 0.33 per cent of donors' gross national income (GNI).¹³ Of this, 6.1 per cent went to education, 4.8 per cent to water supplies and sanitation, 3.8 per cent to health and 2.3 per cent to reproductive health.

This is a laudable advance, but today's flows of aid still fall far short of what will be needed to achieve the Millennium Development Goals and in particular to finance investment in essential services for children. The Organisation for Economic Co-operation and Development (OECD) has projected flows of official development assistance based on current and likely commitments (see Figure 1-1). The dip before 2008 is partly because the 2005 figure was boosted by one-off debt relief schemes. By 2010, if the rich countries keep their promises, official development assistance could reach 0.36 per cent of gross national income.

But even this is much less than what is required. The UN Millennium Project has estimated the 'financing gap' – the difference between what developing countries need to invest to achieve the goals and what they can get from their own resources. To fill the gap with official development assistance would require raising total volumes to 0.54 per cent of rich country gross national product by 2015.¹⁴ On a smaller but rising scale is aid from private sources, foundations, charities and other non-governmental organizations, estimated in 2005 at around US\$15 billion.¹⁵

Concern that governments would not reach these targets was raised at the G8 summits in St Petersburg in 2006 and in Heiligendamm in Germany in 2007 – and in 2007 by children who held their own Junior 8 Summit (the 'J8') and urged governments to pledge sufficient funding for priority issues including health care, education, combating HIV and AIDS, and developing 'green technologies' to address climate change.

Figure 1-1
Official development assistance (ODA), 1990–2010



* At constant 2004 prices

Source: Organisation for Economic Co-operation and Development, *Development Co-operation Report 2006*, OECD Journal on Development, vol. 8, no. 1, 2007, p. 17.

Building partnerships

One of the clearest lessons of the past five years of striving to achieve the goals for children is the importance of partnerships. Neither governments nor local communities nor international organizations nor NGOs can fulfil the rights of children by working in isolation. They will need to collaborate even while assuming different responsibilities. With cooperation, their efforts will reinforce and amplify each other.

Among NGOs and other agencies one of the most striking examples is the Global Movement for Children, which brings together 11 organizations and networks: Alliance of Youth, BRAC, CARE, ENDA, Latin American and Caribbean Network for Children, NetAid, Oxfam, Plan, Save the Children, UNICEF and World Vision.

There have been many other notable partnerships. Political cooperation, for example, has been fostered by the Inter-Parliamentary Union, whose current membership includes more than 150 national parliaments. At its annual assemblies in recent years the Union has organized sessions on the impact of armed conflict on children and women and on children and AIDS. It has also published handbooks for parliamentarians on child protection and on combating child trafficking.

Another major example of global partnerships at work is among the member countries of the Organization of the Islamic Conference (OIC). In 2005 the OIC held the First Islamic Ministerial Conference on the Child in Morocco. The conference called for an end to harmful practices, elimination of gender disparity in education and urgent action to address the high rates of child and maternal mortality in some Islamic countries. It also called for an exchange of expertise among OIC member countries on policies relating to children's rights. Another example of faith-based cooperation is through the World Conference of Religions for Peace. At its World Assembly at Kyoto in 2006, religious communities committed themselves to confronting violence against children and to protecting children in their communities.

A number of notable regional initiatives have also taken place. For example, in 2006 the European Union presented 'Towards an EU Strategy on the Rights of the Child', aiming to promote and safeguard the rights of children in the European Union's internal and external policies and to advance children's rights at national and global levels.

Many organizations have also united behind a range of globally shared initiatives in support of children's rights. These include:

- GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization)
- Global Alliance for Improved Nutrition (GAIN)
- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- Roll Back Malaria Partnership
- Health Metrics Network
- The Partnership for Maternal, Newborn & Child Health

- The United Nations Girls' Education Initiative
- *Unite for Children, Unite against AIDS*
- Ending Child Hunger and Undernutrition Initiative.

These initiatives often have a strong element of cooperation between the private and public sectors, which opens up new opportunities for both research and investment. Some of the most striking contributions have been in health. The world's largest private foundation, the Bill & Melinda Gates Foundation, has been a major contributor to the GAVI Alliance, GAIN and the Global Fund to Fight AIDS, Tuberculosis and Malaria as well as a number of other important health initiatives that directly benefit children.

As the country reports for A World Fit for Children have shown, partnerships for children are also reflected within countries. For example:

- **Colombia** – The Colombian Childhood Alliance is a network of organizations representing the state, civil society, NGOs, academics and international organizations. Created to guarantee and defend the rights of children in Colombia, it also publishes policy documents and holds national and regional forums.
- **Gambia** – The Child Protection Alliance is a coalition of over 40 organizations, institutions and individuals committed to the rights of children. These partners and others have mounted a massive multimedia awareness campaign – with children and many groups, including law enforcement and security officers, the tourism industry, government officials and religious and community leaders.
- **Mauritania** – Alliances and networks are now forming a national movement for children. These include networks of religious leaders, traditional leaders, journalists associations and mayors – all dedicated to defending the rights of women and children.
- **Togo** – A number of strategic alliances have been helpful in addressing subjects that are often taboo. For example, collaboration between traditional chiefs and NGOs has contributed to changes in behaviour on issues such as child marriage, birth registration, girls' education, child labour and child trafficking.

Legislating for children's rights

One of the most important steps for realizing children's rights is to ensure that they are established in national legislation – which is best achieved by enshrining the Convention on the Rights of the Child in national and provincial legislation. Some countries have specifically included children's rights in their constitutions, while others have incorporated them into laws and regulations. In addition a number of governments have an ombudsperson who works specifically for children. Others have made efforts to ensure that parents and children know the rights embodied in legislation and how to exercise them.

- **Dominican Republic** – In 2004 the government passed a new code for the protection and the fundamental rights of boys, girls and adolescents.

- **Mali** – The Child Protection Code, adopted in 2002, harmonizes national legislation with international treaties. The Code lays out the principles and values to be followed and establishes that everyone has the duty to monitor the situation of children and to offer the necessary support.
- **Mozambique** – In 2004 the country adopted a new constitution that unequivocally protects the rights of children enshrined in the Convention and in the African Charter on the Rights and Welfare of the Child. In addition, the government enacted the Family Law, which strengthens guarantees of women's and children's rights, and the Social Security Law.
- **Occupied Palestinian Territory** – Perhaps the greatest achievement in the field of Palestinian children's rights in the past five years has been enactment of the Palestinian Child Rights Law. Passed in January 2005, it is a hopeful step in terms of prioritizing children's rights and creating positive legal frameworks.
- **Qatar** – Following a ministerial decision, a 'child rights culture' is being spread in schools. This includes explaining rights and principles contained in the Convention by connecting them with children's rights in Islam, supported by verses from the Koran and prophetic speeches and using educational cards with stories and coloured illustrations.
- **Sweden** – The Children's Ombudsman represents the rights and interests of children and young people and pursues compliance with the Convention. The work also includes providing various stakeholders with support and information about the rights of children and compiling knowledge and statistics on their living conditions.
- **Tuvalu** – The constitution protects children under the age of 10 and precludes them from being held criminally responsible. Children aged 10 to 14 are not criminally responsible unless it can be proven that the child has capacity to know that he or she ought not to do the act or make the omission. Further, the courts have the power to provide for alternative care for children who are victims of abuse, neglect or other forms of maltreatment or torture.

Reporting on rights

Reporting to the Committee on the Rights of the Child is an important element of each government's duties with respect to child rights. As of 4 September 2007, the 193 States that had ratified or acceded to the Convention had in total submitted 325 reports. In addition to government reports, NGO alliances submit alternative reports. The preparation of these reports itself can reveal gaps and issues that need to be tackled. The Committee's Concluding Observations also help identify outstanding problems and issues of concern. For example:

- **Azerbaijan** – Work on the second report to the CRC Committee in 2006 made it clear that some laws and policies were not compatible with the articles of the Convention, leading the government to undertake a review of national legislation in 2007. The NGO Alliance for Child Rights coordinated the preparation of a second alternative report with input from a range of NGOs and children.

- **Yemen** – The government submitted reports in 1994, 1997 and 2003, and alternative reports were submitted in 1995, 1998 and 2004. Save the Children Sweden is working with the government and the NGO Coalition for Children's Rights to ensure follow-up on recommendations and to improve future reporting.

Monitoring progress

Since the Special Session in 2002, the availability of data has improved significantly. Two important sources of information on children are Multiple Indicator Cluster Surveys, undertaken by governments with UNICEF support, and Demographic and Health Surveys, undertaken with support from the US Agency for International Development. In the 2005–07 period Multiple Indicator Cluster Surveys were conducted in 56 countries and Demographic and Health Surveys in more than 40 countries. To help make best use of this and other data, 82 countries have adopted a UN-promoted database package, DevInfo.

In their World Fit for Children reports, governments have detailed their national information systems for children. For example:

- **Bosnia and Herzegovina** – The DevInfo database is currently operating in 10 municipalities and includes child-centred poverty indicators. Ten NGOs have also prepared reports on child rights indicators at the municipal level. The Council for Children is drafting CRC indicators and finalizing a strategy to apply them at different levels of government.
- **Colombia** – Indicators for children, both national and regional, are published online for public consultation along with relevant research reports in the National Information System on Children and Youth.
- **Costa Rica** – The country has been using DevInfo, as Costa Rica-Info, in a number of ways to monitor both the Millennium Development Goals and the World Fit for Children goals. It is also being used by local authorities: The municipalities of San José and Desamparados are using Costa Rica-Info to monitor their own plans and programmes.
- **Slovenia** – In 2004 Slovenia set up a Child Observatory within the national Social Protection Institute to monitor the status of children. In 2005 the Observatory drafted a comprehensive situation analysis of the status of children and youth, assessing changes during the economic transition and the consequences for children.
- **Turkmenistan** – The Multiple Indicator Cluster Survey carried out in 2006 found substantial reduction in child mortality during the period 1999–2004. Current statistics suggest an increase in child survival rates and falling mortality rates in all age groups among both sexes. This has resulted in an increased life expectancy at birth in the country.

These and many other improvements in information gathering are providing an increasingly rich set of data, which is being used to monitor both the objectives of A World Fit for Children and the Millennium Development Goals.

Children's participation is likely to feature more strongly in the years ahead – to the benefit not just of children but also of adults.

For children and by children

The world's governments set themselves ambitious targets with the Millennium Development Goals and the Plan of Action of A World Fit for Children. Achieving them was never going to be easy. In many countries, particularly those afflicted by war and natural disaster, the situation has become even more difficult. On the other hand are more positive indications. Governments have maintained their commitment to their international declarations, drawing up new plans and enacting the necessary legislation – even if they have not always matched these with the resources or the determination to implement programmes as fully or as rapidly as they could.

At the international level too there is a stronger sense of commitment to boost flows of development assistance as well as to public-private partnerships that can tackle some of the most persistent health problems.

But probably the most encouraging sign is that children themselves are now becoming more involved in shaping thinking and policy – whether in the running of their schools or in expressing their views to local or national policy makers. Children's participation is more evident in some countries than others, but it is likely to feature more strongly in the years ahead – to the benefit not just of children but also of adults, who should be able to welcome fresh thinking and ideas.

In their reports on the implementation of A World Fit for Children many governments have given examples of child participation. These include:

- **Cameroon** – In more than 300 schools, pupils are becoming increasingly involved in school governance – administrative, pedagogical and social. Children have become much more prominent in decision-making through a 'parliament of children', expanding networks of young people and the creation of municipal youth councils.
- **Cape Verde** – Children's parliaments have created a forum for debate, discussion and reflection, with participation of children and young people from throughout the country. Their opinions and comments, presented by the group in parliament, are taken into consideration in the development and implementation of programmes.
- **Chad** – The opinions of young people are being taken into account more and more in the elaboration of policies and programmes that concern them, thanks to the participation of youth organizations and their links with other organizations, both national and international. This has been reinforced by the establishment of a children's parliament.
- **Jordan** – The 2006 Youth Forum 'We are all Jordan' examined the opportunities and challenges facing youth as 'knights of change'.
- **Lesotho** – During the process of developing the Child Protection and Welfare Bill 2005, a Junior Committee of Children was constituted to review the laws pertaining to children. Some of these children also took part in other processes, such as preparations for the UN Special Session on Children and development of the country's poverty reduction strategy.

- **Liechtenstein** – On the International Day of the Rights of the Child in 2001, 2004 and 2006, all municipalities set up ‘listening benches’. Sitting on the benches were adults, including in some cases mayors, who listened to the opinions and concerns of children, acknowledging their right to have their own ideas and to be heard.
- **Madagascar** – In 2006 a National Youth Council was created, along with councils in the country’s 22 regions. Municipal councils of children were also created in two cities, Mahajanga and Antsiranana.
- **Tunisia** – Municipal councils for children have been in place since 1987, and since 2002 there has been a children’s parliament, which works with members of the country’s parliament on such issues as environmental education and sport. Children also have delegates in the councils of various educational institutions.

CHAPTER

2



Promoting
healthy
lives

In 2006, for the first time in the modern era, the number of children dying before their fifth birthday fell below 10 million. This decline, to 9.7 million, is the outcome of a steady fall over the past 45 years in under-five mortality rates in all the world's regions.

Notable progress has been made in many aspects of children's health, particularly in reducing deaths from measles and providing insecticide-treated mosquito nets to protect children in Africa from malaria. More children are also receiving essential micronutrients such as iodine and vitamin A, and the developing world seems likely to meet the target for access to safe drinking water.

Goals of A World Fit for Children

Goal: Reduction in infant and under-five mortality rates

Millennium Development Goal 4 aims for a two-thirds reduction in under-five mortality between 1990 and 2015. Only 82 of 147 developing countries are on track to meet the goal, and 27 are making no progress or slipping into reverse.¹⁶ Millions of children will pay the ultimate price for this failure.

Many of these deaths are clearly related to poverty. Children born in poorer countries are more exposed to contaminated water and poor housing. They are also more likely to be undernourished and to suffer greater exposure to infectious diseases. This link between poverty and child death is also evident within countries, where rates of under-five mortality are typically much higher in poorer households.

But a number of countries with relatively low incomes have succeeded in reducing child deaths. Between 1990 and 2006 under-five mortality per 1,000 live births declined in Timor-Leste, for example, from 177 to 55, in Viet Nam from 53 to 17, in Eritrea from 147 to 74, and in Bhutan from 166 to 70.¹⁷

Globally, neonatal causes contribute to 37 per cent of under-five deaths, and the largest single cause is pneumonia (19 per cent) followed by diarrhoea (17 per cent).¹⁸ These causes are similar across the lower-income countries where 90 per cent of these deaths take place. In sub-Saharan Africa, however, malaria also accounts for a large proportion (18 per cent) of under-five deaths. Around 80 per cent of global malaria deaths occur in sub-Saharan Africa among children under five.

Of the 9.7 million child deaths in 2006, almost half were in sub-Saharan Africa and almost one third in South Asia. While global rates of under-five mortality have been falling, in many countries they have not been doing so fast enough to meet the Millennium Development Goal. For the developing countries as a whole, the goal is to reduce the child mortality rate from 103 to 34 per 1,000 live births. But more than halfway through the period, the developing regions collectively have been

Box 2-1 Pneumonia

Every year, developing countries experience more than 150 million episodes of under-five pneumonia. This is the disease that kills the most children, around 2 million each year, accounting for close to one fifth of all under-five deaths. In addition, up to 1 million more infants perish from severe infections, including pneumonia, during the neonatal period.

The lives of around 600,000 children could be saved yearly through universal treatment with antibiotics, at a cost of US\$600 million. South Asia and sub-Saharan Africa, where 85 per cent of childhood pneumonia deaths occur, have the lowest treatment costs. Scaling up coverage to universal levels in these regions would cost only around US\$200 million annually.

World Fit for Children country reports on pneumonia include:

- **Canada** — Children regularly exposed to second-hand smoke are at least 50 per cent more likely to suffer lung damage and to develop breathing problems such as asthma, and they face an increased risk of developing emphysema as adults. In 2006, the government launched a marketing campaign to raise awareness of the harmful effects of second-hand smoke on children and how to reduce exposure in homes and cars.
- **Iraq** — Data from 2006 indicate that 82 per cent of children with suspected pneumonia received antibiotics, an example of good care-seeking behaviour that can be partly attributed to the success of earlier programmes in raising awareness.
- **Sao Tome and Principe** — Between 2005 and 2006 the proportion of children under five with suspected pneumonia who received treatment increased to 56 per cent. Even so, pneumonia remains the leading cause of death for this age group.

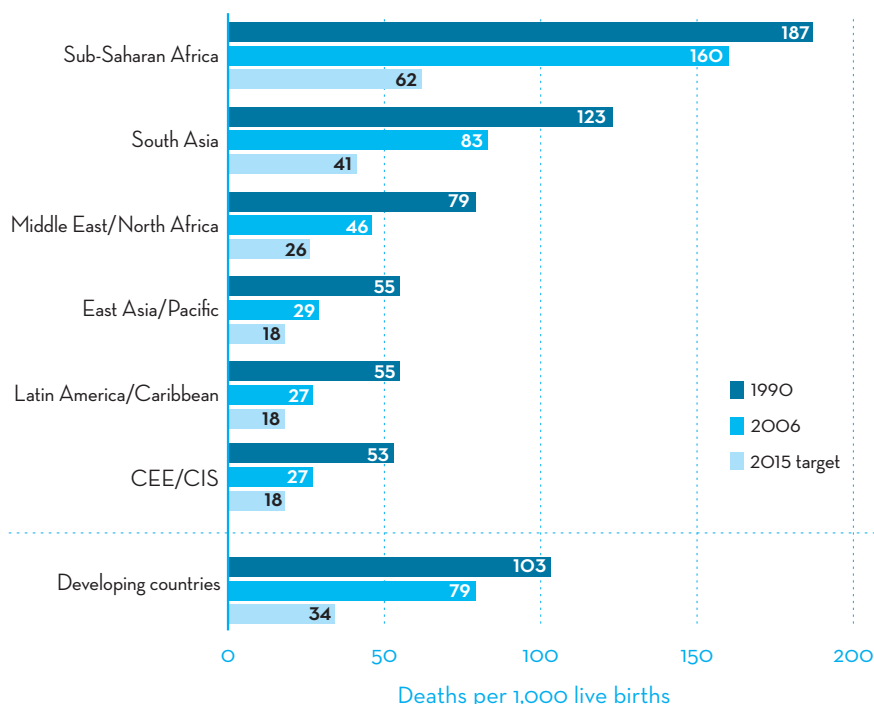
progressing too slowly to meet the goal. By 2006, they had only reduced the under-five mortality rate to 79 (see Figure 2-1). Over the same period infant mortality also came down, though more slowly, from 70 to 54 deaths per 1,000 live births.¹⁹

Proven high-impact and cost-effective interventions and practices, if fully implemented, could prevent 63 per cent of current childhood mortality.²⁰ The essential set of interventions judged to be feasible for high levels of implementation in low-income countries comprise both preventive and curative options. They include, among others, breastfeeding, vaccinations, zinc and vitamin A supplementation, insecticide-treated mosquito nets, oral rehydration therapy, antibiotic treatment of infection and treatment of malaria.

Across the world, tackling under-five mortality will need an integrated approach to child health. These essential interventions can be implemented through a mix of delivery channels that are already in wide use, including outreach and community- and facility-based services, while also taking advantage of longer-term opportunities such as community capacity to deliver integrated services. This will help address neonatal causes of under-five mortality and diseases that still have high mortality rates, most notably pneumonia, diarrhoea and malaria (see Boxes 2-1 to 2-4).

Achieving the Millennium Development Goal will require reaching out to the many women and children who have little contact with public services. This will mean encouraging more integrated, community-based activities to support the most vulnerable children.

Figure 2-1
Regional under-five mortality rates, 1990, 2006 and the 2015 MDG target



Source: United Nations Children's Fund, *State of the World's Children 2008*, UNICEF (forthcoming, 2007).

World Fit for Children reports on overall health services include:

- **Ghana** – The ‘high impact rapid delivery programme’ has been used to improve the health of children under five. Based on successful piloting in two regions, the government has adopted this approach, a cost-effective package of health and nutrition interventions, to pursue achievement of Millennium Development Goals 4 and 5. The interventions include immunization, vitamin supplementation, exclusive breastfeeding, complementary feeding, use of insecticide-treated mosquito nets and treatment of malaria.
- **India** – The National Rural Health Mission, 2005–2012, seeks to provide effective health care to rural residents, with special focus on 18 states that have weak public health indicators or infrastructure. This includes providing a female ‘health activist’ in each village and preparing a health plan headed by the health and sanitation committee of the panchayat (village council).
- **Kyrgyzstan** – From 2006, health and medical services are free to pregnant women and children under five years old. This is expected to have major benefits on the health and well-being of families living below the poverty line.
- **Lao People’s Democratic Republic** – Village revolving funds have been expanded to cover thousands of villages. These funds provide essential medicines and medical supplies to tackle the major killers of children such as diarrhoea and pneumonia.
- **Mexico** – In addition to offering regular services in health facilities, Mexico organizes three National Health Weeks each year. These combine vaccination campaigns for children and women with many other health interventions such as distribution of vitamin A for children and oral rehydration salts for treatment of diarrhoea.

Vaccine-preventable diseases

Immunization is one of the most successful and cost-effective health interventions and the only one that has consistently reached close to 80 per cent of young children in recent years. This undertaking has averted more than 2 million deaths annually and countless episodes of illness and disability. Immunization services also offer a platform to deliver other health and nutrition interventions. Yet across the world 26 million children below the age of one year are still not immunized with DPT3 (diphtheria, pertussis, tetanus), and over 40 million women are not reached with the minimum two doses of tetanus vaccine to protect them and their newborns against tetanus.

As a result, vaccine-preventable diseases cause more than 2 million deaths every year, including 1.4 million deaths of children under five. A further 1.1 million young children die from infections such as rotavirus and pneumococcus, for which new vaccines will be widely available soon.

- **Diphtheria, pertussis and tetanus** – Between 1980 and 2006, coverage of the combined vaccine against these diseases increased from 20 to 79 per cent globally and 77 per cent in developing countries. But the rates vary considerably around the world. Some developing countries have been very successful;

Box 2-2 Diarrhoea

Diarrhoeal diseases are the second leading cause of child deaths worldwide, accounting for nearly 2 million deaths a year among children under five in 2006. Preventing diarrhoeal episodes is critical to reducing deaths. Strategies include promoting exclusive breastfeeding during the first six months of life and complementary feeding beginning at six months, increasing vitamin A supplementation rates, improving hygiene, hand washing with soap and water before and after feeding and after defecation, increasing the use of improved drinking water sources and sanitation facilities, and more recently, promoting zinc supplementation and vaccination against rotavirus.

For more than two decades oral rehydration therapy has been the cornerstone of treatment programmes for childhood diarrhoeal diseases, although recommendations on the use of this therapy along with other measures have changed over time. Likewise, indicators to measure treatment coverage have evolved, leading to challenges in monitoring trends over time.

While trend data are limited, results show that treatment coverage across the developing world (excluding China) has increased significantly over the past decade, including in sub-Saharan Africa (except Nigeria). However, overall treatment levels still remain too low.

Box 2-3 Malaria

Of the 1 million or more people who die from malaria each year, most are children under five years of age living in Africa.

The Roll Back Malaria Partnership, formed in 1998, has significantly raised attention and mobilized resources for malaria prevention and control. Malaria-endemic countries and their development partners have at their disposal several highly effective and cost-efficient tools for both prevention and treatment, such as insecticide-treated mosquito nets, preventive treatment for pregnant women and antimalarial drug combination therapy.

In 2000, 54 governments attended the African Summit on Roll Back Malaria and pledged that by 2010 at least 60 per cent of those suffering from malaria would have access to treatment within 24 hours, at least 60 per cent of those at risk would have access to preventive measures and at least 60 per cent of pregnant women at risk would have access to treatment. These targets have since been increased to 80 per cent coverage.

In recent years the prospects for achieving these targets have improved greatly as a result of a dramatic increase in funding, including from sources such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank Malaria Booster Programme; the US President's Malaria Initiative; and the Bill & Melinda Gates Foundation, among others.

World Fit for Children country reports on malaria include:

- **Angola** – In 2003 the government started the Programme to Combat Malaria, and in 16 provinces it has distributed more than half a million insecticide-treated mosquito nets along with treatment kits.
 - **Ethiopia** – Scaling up the malaria programme contributed to a dramatic reduction in epidemics in 2006. The Ethiopian government has distributed 8.6 million long-lasting insecticide-treated nets to malaria-prone households, and it should now be possible to reach the target of 20 million nets by the end of 2007.
 - **Zambia** – With a grant from the Global Fund, the National Malaria Control Programme is rapidly expanding free mosquito net programmes. In addition, 58 per cent of febrile children are now treated with anti-malarial medicines.
- in 2005, 115 countries had reached 90 per cent coverage. In other countries – particularly in sub-Saharan Africa, where conflict and natural disasters have displaced millions of people and disrupted immunization programmes – coverage has plummeted. As a result, the world is still falling far short of the 2010 target of 90 per cent coverage.
- **Polio** – This has been one of the most successful immunization programmes. Between 1980 and 2006, the proportion of infants receiving three doses of polio vaccine increased from 22 to 80 per cent. This had a striking impact. In 1988, 350,000 children were being crippled by the virus in 125 countries, but by 2006 the number of confirmed polio cases was down to 2,000. The Americas were certified polio free in 1994, the Western Pacific in 2000 and Europe in 2002. Although outbreaks emerged between 2002 and 2006, most have now been stopped, and in 2007, only in parts of four countries had transmission of indigenous wild polio virus not been interrupted. The endemic polio reservoirs in limited populations and geographic areas of Afghanistan, India, Nigeria and Pakistan accounted for 94 per cent of all new polio cases.
 - **Measles** – The campaign against measles has been a remarkable success: Between 1999 and 2005, the total number of deaths fell from 871,000 to an estimated 345,000, a reduction of 60 per cent. Ninety per cent of these deaths were among children under five years of age. The most comprehensive push against measles unfolded across Africa, where deaths decreased by 75 per cent. Many countries have combined measles immunization campaigns with other interventions that will significantly contribute to the achievement of Millennium Development Goal 4. The challenge of reducing global measles deaths by 90 per cent by 2010 remains.
 - **Maternal and neonatal tetanus** – The global Maternal and Neonatal Tetanus elimination initiative, jointly launched by UNICEF, WHO and UNFPA, has made great strides in the last few years. It has both gained increasing commitment from national governments in planning and implementing the needed activities and showed results in eliminating the disease. Between 1994 and 2005, the number of countries yet to eliminate maternal and neonatal tetanus fell from 82 to 49. Annual neonatal tetanus deaths decreased from 215,000 in 1999 to less than 130,000 in 2004, and currently only 7 per cent of all neonatal deaths are attributed to neonatal tetanus.
 - **Hepatitis B** – Worldwide, an estimated 350 million people are carriers of the hepatitis B virus. Pregnant mothers who are carriers can infect their newborn children. Between 1992 and 2006 global coverage of infants with three doses

of hepatitis B vaccine increased from 3 to 60 per cent; 158 countries had introduced the vaccine into their routine immunization programmes by 2005.

- **New vaccines** – Other new vaccines have also been introduced, including the conjugate vaccine against *Haemophilus influenzae* type b (Hib). By 2005, 101 countries had introduced the Hib vaccine as part of their routine immunization programme. In addition improvements have been made in vaccines against pneumococcal and meningococcal diseases and rotavirus.

However, these new vaccines tend to be more expensive than the traditional ones, and few developing countries can afford to incorporate them into their routine immunization programmes. UNICEF and GAVI Alliance partners are continuing to assist countries to make evidence-based decisions on introducing these and other new vaccines in routine immunization programmes.

Various efforts have been undertaken to improve the coverage and quality of immunization services. Fifty three countries implemented some or all elements of the Reach Every District (RED) strategy to improve programme management of immunization service delivery in 2005. The components included in the RED strategy, such as re-establishing outreach services, monitoring, use of data, and planning and managing resources, have proven very effective in increasing district-level coverage and reaching the 80 per cent coverage target for all districts or administrative units.

These services are increasingly being delivered in an integrated manner. In 2005, 57 countries in Africa and Asia provided an integrated package of preventive services including vaccines during child health days or weeks. The main objective of this approach is to optimize contacts with health practitioners using a combination of fixed sites and outreach systems and making use of primary health care staff, village health workers and community volunteers. The package of services is determined by local epidemiological needs and therefore is country specific. The impact of this approach on coverage, child mortality and morbidity, and sustainability is being assessed.

In 1999, at a time when immunization coverage was dropping in many countries, the Global Alliance for Vaccines and Immunization (now the GAVI Alliance) was created as a public-private global health partnership to enable even the poorest countries to vaccinate all children. Countries with gross national incomes of less than US\$1,000 per head per year are eligible to receive financial support. The Alliance now has over US\$3 billion in commitments over the next 10 years.

Prospects improved further in 2006 with the establishment of the International Finance Facility for Immunization, with the support of France, Italy, Norway, Spain, Sweden and the United Kingdom. This instrument channels additional funds through the GAVI Alliance to support immunization services and strengthen health systems.

World Fit for Children reports on vaccine-preventable diseases include:

- **Belize** – Immunization coverage of infants is now sustained at a very high level, with coverage for measles sustained at over 95 per cent since 2003. The schedule includes 10 antigens that are provided to every child. Belize has had no reported cases of poliomyelitis since 1981, of measles since 1991 or of tetanus since 1997. In 2002 and 2003 the country had no cases of vaccine-preventable diseases.

Box 2-4 Neonatal mortality

An estimated 37 per cent of under-five deaths—around 4 million—take place in the first 28 days of life, the neonatal period.

Why are these children dying so soon? The main causes are infection, pneumonia, pre-term birth and asphyxia. As with under-five mortality generally, neonatal mortality is closely linked to poverty, either because a poor mother is more likely to have an infection or low nutritional status or because families in poor communities have less access to effective care—such as an institutional delivery or the services of a skilled birth attendant. Also important is whether or not the mother has been breastfeeding her child.

- **Congo**—DPT₃ coverage increased from 49 per cent in 2003 to 77 per cent in 2006. Around 73 per cent of children had a measles vaccination in 2006, and over 90 per cent were immunized against polio through campaigns. Vaccinations for hepatitis B and yellow fever have also been introduced—accompanied by vitamin A supplementation.
- **Kazakhstan**—Around 900 field teams provide vaccinations to the rural population, and since 2005 about 7,000 medical staff have been trained and certified to give inoculations. The regions can now rely on an uninterrupted supply of vaccines, and 99 per cent of all children are immunized with DPT₃.
- **Slovakia**—The Rights of the Child Monitoring Project is focusing, among other issues, on vaccinating children belonging to the Roma minority.

Goal: Policies and programmes for adolescents

Having survived the diseases of the early years, adolescents are generally energetic and healthy. But as they near puberty, they begin to encounter a new series of biological, psychological and social challenges.

Both adolescent boys and girls run the risk of sexually transmitted infections, including HIV. But girls face the further hazard of unwanted pregnancy. One tenth of all births are to teenage girls. Maternal mortality in girls under 18 is two to five times higher than in women between 18 and 25.²¹

Adolescents are also tempted to experiment with what they consider adult behaviour, such as smoking and taking illicit drugs. Tobacco use, for example, usually begins in adolescence; few people start after age 18. Half of regular smokers who start in adolescence and smoke all their lives will eventually be killed by tobacco.²² In Western Europe, where youth smoking rates are highest, one third of boys and nearly one third of girls smoke.²³

Alcohol and drug use are often related to the main cause of death among young men worldwide: traffic accidents. For every adolescent killed, another 10 are seriously injured or maimed for life. Another major cause of death among adolescents is suicide. Around 4 million adolescents attempt suicide around the world each year; at least 100,000 are successful.²⁴

Adolescents will be most able to protect themselves and thrive if they are supported and encouraged by caring adults. This is particularly important in the early years of adolescence—ages 10 to 14—when children are more likely to listen to adult advice. If they have consistent, positive, emotional connections with a caring adult, adolescents are more likely to feel safe and secure, which should enable them to cope with the challenges they face. A study of American, Australian, Colombian, Indian, Palestinian and South African 14-year-olds found, for example, that adolescents who are well connected with their parents have more social initiative, fewer thoughts about suicide and less depression.²⁵

Adolescents should also be able to rely on public health services. As well as looking to parents or teachers for advice on health, they should have access to adolescent-friendly public services that address their psychological and reproductive health needs and well-being and provide professional, non-judgemental advice.

Child health balance sheet

Goals	Gains	Unfinished business
Under-five and infant mortality		
WFFC – Reduce under-five and infant mortality by one third by 2010 MDG – Reduce under-five mortality by two thirds by 2015	Under-five mortality rates have come down in all regions. Between 1990 and 2006 child mortality fell in the developing countries from 103 to 79 deaths per 1,000 live births and infant mortality from 70 to 54.	The overall rate of decline is too slow for developing countries as a group to meet the MDG target. In 27 countries the rate in 2006 is either the same or worse than in 1990. The greatest challenge in most countries is now neonatal mortality.
Routine immunization		
WFFC – Fully immunize 90% of children by 2010	In 2006 both DPT3 and measles immunization coverage had reached 78% in developing countries. In 115 countries, DPT3 coverage reached 90%.	Around 26 million children are still missing out on immunization, and 1.4 million children are dying from vaccine-preventable diseases.
Measles		
WFFC – Reduce measles deaths by half by 2005	By 2006, global measles immunization coverage was 80%. Between 1999 and 2005, the total number of measles deaths was reduced by 60%.	An estimated 345,000 people, the majority of them children, died from measles in 2005.
Maternal and neonatal tetanus		
WFFC – Eliminate maternal and neonatal tetanus by 2005	Between 1994 and 2005, 33 more countries eliminated maternal and neonatal tetanus.	Maternal and neonatal tetanus has yet to be eliminated in 49 countries. Each year around 130,000 infants die from neonatal tetanus and 30,000 women die from tetanus infection after giving birth.
Acute respiratory infections		
WFFC – Reduce deaths from respiratory infections by one third by 2010	More than half of children with suspected pneumonia in developing countries are taken to appropriate health providers. The wealth of new data on antibiotic use for childhood pneumonia allows for a more comprehensive assessment of treatment coverage.	Every year developing countries experience more than 150 million episodes of under-five pneumonia. Around 2 million children die.
Malaria		
MDG – By 2015 halt and begin to reverse the incidence of malaria and other major diseases WFFC – Reduce by half by 2010 and ensure that 60% of all people at risk sleep under insecticide-treated mosquito nets	The Roll Back Malaria campaign has made significant progress in a number of countries, especially in increasing the distribution and use of insecticide-treated nets. All sub-Saharan African countries with trend data have shown real progress in expanding coverage of treated mosquito nets, with 16 of 20 countries showing at least a threefold increase since 2000.	Around 3 billion people remain at risk from malaria, the majority in Africa. Of the more than 1 million people who die each year most are children under 5 living in Africa.

World Fit for Children reports on adolescent health include:

- Burkina Faso** – The African Network for Youth, Health and Development in Burkina Faso, with 280 member associations, plays an important part in developing policies, particularly in such areas as sexual and reproductive health for adolescents.
- Guatemala** – ‘Friendly spaces’ have been designated in 41 municipalities by the Ministry of Public Health and Social Assistance to offer appropriate and integrated attention to adolescents, with the emphasis on reproductive health.

In addition to providing advice and medical services, these offer workshops and self-help groups to promote adolescent participation.

- **Senegal** – The strategy for reproductive health includes the creation of ‘centres for adolescents’ offering voluntary testing, counselling and treatment for sexually transmitted diseases.
- **Switzerland** – Since 2001 a national campaign against smoking has concentrated particularly on schoolchildren. In 2005, for example, 60,000 children took part in the ‘non-smoker experience’ project, undertaking not to smoke for six months. These and other efforts have been working. Between 2001 and 2005, the proportion of youth aged 14 to 19 who smoke fell from 31 per cent to 25 per cent.
- **Syrian Arab Republic** – In 2005, the Syrian General Administration for Palestine Arab Refugees launched an initiative to promote ‘adolescent-friendly spaces’ for Palestinian adolescents living in camps across the Syrian Arab Republic. This may also lead to similar projects for Syrian adolescents.

Goal: Reduction in the maternal mortality ratio

The health of children is closely connected with the health of women. Healthy and strong women are more likely to give birth to healthy babies and be prepared to care for them. So ensuring that all women are well nourished, healthy and well educated not only fulfils the basic rights of half the adult population but also creates the best possible conditions for child survival.

Millennium Development Goal 5 is to reduce maternal mortality by three quarters between 1990 and 2015. Given the apparently slow progress in the countries with the highest levels of maternal mortality, this will be hard to achieve.

Figure 2-2

Maternal mortality ratios and lifetime risk of maternal death, 2005

	Maternal mortality ratio (maternal deaths per 100,000 live births)	Lifetime risk of maternal death, 1 in:
Sub-Saharan Africa	920	22
South Asia	500	59
Middle East/North Africa	210	140
East Asia/Pacific	150	350
Latin America/Caribbean	130	280
CEE/CIS	46	1,300
Industrialized countries	8	8,000
Developing countries	450	76
World	400	92

Source: World Health Organization, United Nations Children's Fund, United Nations Population Fund and the World Bank, *Maternal Mortality in 2005*, WHO, Geneva, 2007, p. 35.

Unfortunately, the world is some way from realizing women's rights, and one of the most shocking consequences is that every year more than half a million women die from complications of pregnancy and childbirth. This is a reflection both of poor standards of women's health and of inadequate medical care.²⁶ In addition, millions more women who survive a pregnancy complication are left with lifelong, painful and disabling physical conditions. These complications can also result in the child's death or long-term disability.

Adolescents face particularly high risks. According to data from a set of Demographic and Health Surveys, 23 per cent of women aged 20 to 24 in the developing world give birth before the age of 18.²⁷

Is the number of deaths falling? This is hard to judge, since maternal mortality data are difficult to gather. Some causes of death may be misclassified, and complications that are sensitive, such as induced abortion, may not be reported at

all. In addition, reliable estimates need large sample sizes. As a result, the countries with the highest ratios do not have reliable trend data.

In principle any woman, however healthy or well nourished, can suffer complications in pregnancy requiring emergency obstetric care. Almost all these conditions are treatable, so it can be argued that ideally women should give birth in hospitals or health centres capable of providing the necessary emergency care. But this is not always possible, or for many women even desirable. In this case they should have the support of a skilled birth attendant who can recognize any danger signs, take the necessary action and refer the mother quickly to an appropriate health facility.

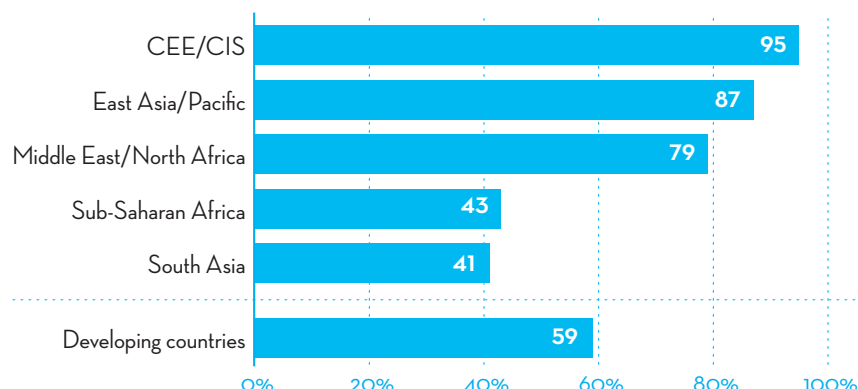
In CEE/CIS, 95 per cent of births are attended by skilled health personnel (doctor; nurse or midwife). But for developing countries as a group, the proportion is 59 per cent. In sub-Saharan Africa and South Asia – two regions facing the highest levels of maternal mortality – less than half of births are attended by skilled health personnel.²⁸

World Fit for Children reports on maternal health include:

- **China** – As a result of investments in equipment and capacity building and the establishment of county-level maternal emergency centres and a ‘fast-referral’ system connecting the centres to townships and villages, the maternal mortality rate in the middle and western regions dropped by 25 per cent between 2001 and 2005.
- **Maldives** – Currently every inhabited island has either a hospital or a health centre or post. More than 90 per cent of mothers have antenatal care, and 85 per cent of all deliveries are attended by skilled attendants.
- **Bolivarian Republic of Venezuela** – The recently created Mission Madre aims to reduce maternal and child mortality through community mobilization, health promotion networks and improved hospital care with an emphasis on emergency obstetric care.

Figure 2-3

Percentage of births attended by skilled health personnel, 2000–2006



Source: United Nations Children's Fund, *Progress for Children: A World Fit for Children* statistical review, Number 6, UNICEF (forthcoming, 2007).

Maternal health balance sheet

Goals	Gains	Unfinished business
Maternal mortality		
MDG – Reduce maternal mortality ratio by three quarters between 1990 and 2015	Some countries have made striking progress, reducing their rates by 50% or more.	More than 500,000 women still die from complications of pregnancy and childbirth.
Reproductive health services		
WFFC – Access through the primary health-care system to reproductive health for all individuals of appropriate age as soon as possible, and no later than 2015	For the developing countries as a whole, the contraceptive prevalence rate is now 61%.	At least 200 million women want to use safe and effective family planning methods but are unable to do so.
Skilled birth attendants		
WFFC – All women to have skilled delivery care	Many countries have been training more attendants. They now attend 59% of births in the developing world.	Coverage is still low in many parts of the world: 43% in eastern Africa, for example, and 41% in south-central Asia.

Goals: Reduction in child malnutrition and reduction in the rate of low birth weight

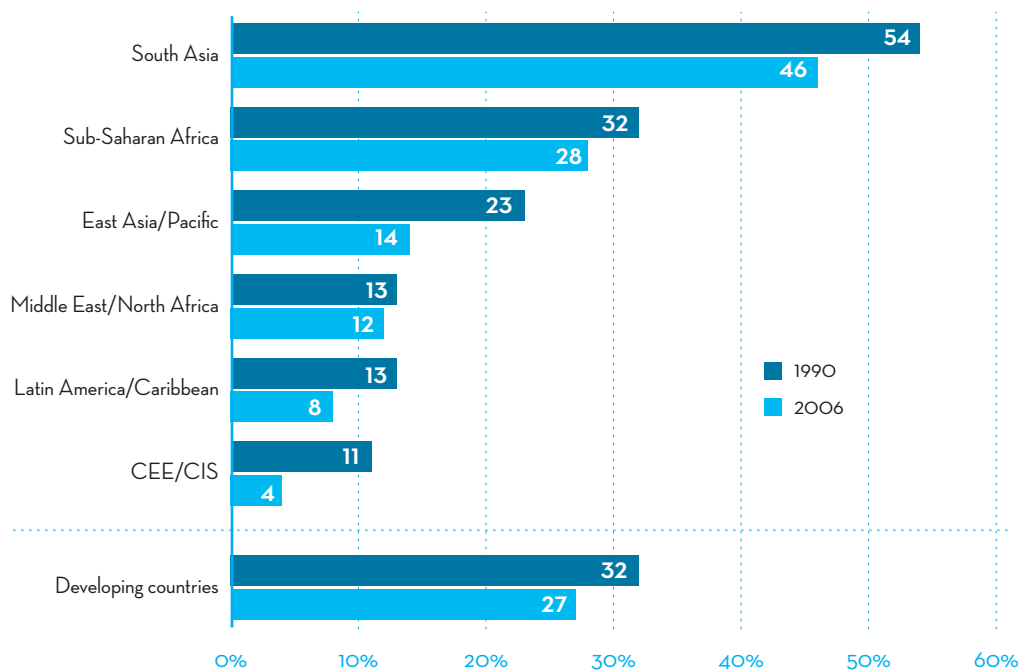
One of the most critical factors for children's health and development is their nutritional status. Children who are undernourished are less able to fight off infections and more likely to die young. More than half of child deaths are attributable to undernutrition. Undernourished children who survive the dangerous early years will struggle to fulfil their full physical and mental potential – and will be less able to escape from poverty. Undernutrition includes being underweight for one's age, too short for one's age (stunted), dangerously thin (acutely undernourished) and deficient in vitamins and minerals (suffering from micronutrient malnutrition).

The World Fit for Children target is to reduce the prevalence of underweight children by one third by 2010. The Millennium Development Goal target is to halve it by 2015. On present trends these targets will be missed – in the case of the Millennium Development Goal, by 30 million children.²⁹ The overall picture is sobering, but there has been some progress. For the developing countries as a whole, between 1990 and 2006 the proportion of children underweight fell from 32 to 27 per cent.

Yet 143 million under-five children in the developing world continue to suffer from undernutrition. Of these more than half live in South Asia. On present trends only 58 countries are moving fast enough to achieve the Millennium Development Goal of halving child undernutrition by 2015.

Figure 2-4

Percentage of children under five who are underweight, 1990 and 2006



Note: Data are based on a subset of 71 countries with available trend data covering 78 per cent of the developing world's under-five population. For CEE/CIS, due to data limitations, the baseline year is 1996.

Source: United Nations Children's Fund, *Progress for Children: A World Fit for Children statistical review, Number 6*, UNICEF (forthcoming, 2007).

Across all these regions the problems are most severe in rural areas, where children are twice as likely to be underweight as those in urban areas. The differences between boys and girls do not appear to be significant. There is, however, a strong association with poverty.

A similar pattern is evident for stunting, the process of growth failure generally occurring before age 2. Once a child is stunted, the effects are largely irreversible, making it difficult for a child to catch up and leaving a legacy of delayed motor development, impaired cognitive function, poor school performance and overall reduced productivity. Across the developing world one third of under-five children are stunted. Again the highest levels are in South Asia, where 46 per cent of all

under-fives are stunted, followed by sub-Saharan Africa, with a prevalence of 38 per cent.

Wasting, low weight for height, is a strong predictor of mortality among under-five children. Wasting rates above 10 per cent indicate serious levels of acute undernutrition requiring urgent response. Twenty four countries have wasting rates of 10 per cent or more, including almost all countries in South Asia and many in sub-Saharan Africa.

One major breakthrough has been the advent of community-based management of severe acute malnutrition, an innovative approach to treating the majority of affected children at home with ready-to-use therapeutic foods rather than hospitalizing them. By reducing the costs of treatment and engaging communities in malnutrition prevention and treatment, these programmes have consistently achieved dramatic increases in coverage and high recovery rates in emergency contexts.

Infant and young child feeding

The best possible start for most children is to be exclusively breastfed for the first six months of life. This has the potential to avert 13 per cent of all under-five deaths in developing countries, making it the most effective preventive practice to save children's lives.

Nearly 40 per cent of all infants aged 0 to 6 months in the developing world are exclusively breastfed. The proportion has been increasing, particularly in sub-Saharan Africa, where it rose by more than one third over the 1996–2006 period, and in the CEE/CIS countries, where it almost doubled – though from a very low base.

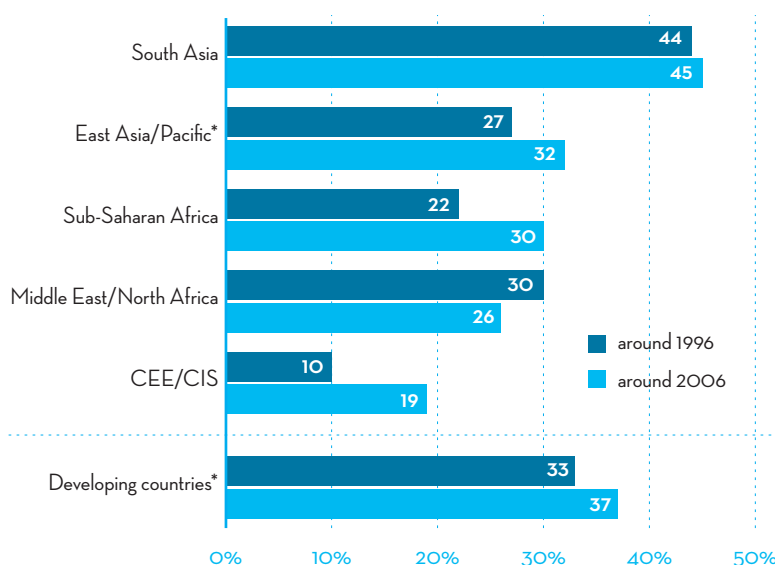
Breastfeeding should be continued from six to twenty four months and beyond. From six months babies should receive nutritionally appropriate, safe and adequate complementary foods. Currently an estimated 56 per cent of infants six to nine months old in developing countries are breastfed and fed complementary foods. However, the complementary foods are often very watery – thin gruels, soups or broths – and efforts are under way to better understand the extent of the problem.

World Fit for Children country reports related to infant and young child feeding include:

- **Argentina** – In 2005 a major survey was undertaken on the state of nutrition and the health of women and children to serve as the basis for the country's national food and nutrition policy.
- **India** – Regulations on infant foods were amended in 2002. They now encourage exclusive breastfeeding for the first six months of life and the use of complementary foods up to the first two years. They also prohibit all forms of

Figure 2-5

Percentage of infants exclusively breastfed for the first six months of life, 1996 and 2006



* Excluding China

Note: Latin America/Caribbean was excluded due to insufficient data coverage. Regional trends excluding Brazil and Mexico indicate, however, an increase from 30 to 45 per cent.

Source: United Nations Children's Fund, *Progress for Children: A World Fit for Children statistical review, Number 6*, UNICEF (forthcoming, 2007).

Nutrition balance sheet

Goals	Gains	Unfinished business
Undernutrition		
WFFC – Reduce the prevalence of underweight children by one third by 2010	Most countries have reduced child malnutrition since 1990. Two regions could meet the MDG goal – East Asia and the Pacific and Latin America and the Caribbean.	Only 58 countries are on track to achieve the MDG goal.
MDG – Halve the prevalence of underweight children under five years of age by 2015		
Low birth weight		
WFFC – Reduce the rate of low birth weight by at least one third	Limited trend data suggest that the incidence of low birth weight may not have changed over the past 10 years.	More than 19 million children, 16% of births in developing countries, are born underweight.
Infant and young child feeding		
	Striking improvements in exclusive breastfeeding among infants under 6 months old, particularly in CEE/CIS, which nearly doubled its rate, and sub-Saharan Africa. In addition, 36% of newborns in developing countries receive timely initiation of breastfeeding.	Nearly 60% of children under 6 months old are still not exclusively breastfed. Major promotional efforts are still needed to scale up initiatives for infant and young child feeding.
Iodine deficiency		
WFFC – Sustainable elimination of iodine deficiency disorders by 2005	Progress has been substantial in developing countries. The proportion of households using iodized salt is now 69%.	In 36 countries less than 50% of households consume adequately iodized salt. Each year in the developing world 38 million newborns are still unprotected, of whom 17 million are in South Asia.
Vitamin A deficiency		
WFFC – Sustainable elimination of vitamin A deficiency by 2010	From 1999 to 2005, the proportion of children aged 6 months to 5 years fully protected with two doses of vitamin A increased more than fourfold to 72%.	The success in two-dose coverage needs to extend to all children, particularly those in poor and rural areas.

advertising and promotion of infant milk substitutes, feeding bottles and infant foods, including promotion by electronic and audio-visual means.

- **Samoa** – In 2006 the Ministry of Health adopted a child/young infant safe feeding practices plan of action that encourages exclusive breastfeeding for the first six months of life.

Overweight and obesity

Malnutrition can also take the form of overnutrition. Around 155 million school-aged children, 10 per cent of the world's children aged 5 to 17, are overweight. And of these, 30 million to 45 million are classified as obese – accounting for 2 to 3 per

Box 2-5 Micronutrients

More than a third of people alive today are deficient in key vitamins and minerals, particularly vitamin A, iodine, iron, folate and zinc. Micronutrient deficiencies affect children's physical, motor and cognitive development and increase the risk of infectious illness and of death from diarrhoea, measles, malaria and pneumonia.

- **Iodine deficiency** – This is the world's single greatest cause of preventable mental retardation. Severe iodine deficiency causes cretinism, stillbirth and miscarriage, and even mild deficiency can cause a significant loss in learning ability. Iodine deficiency, particularly damaging during early pregnancy and childhood, is easily preventable through consumption of adequately iodized salt.

The last 10 years have seen an unprecedented improvement in consumption of iodized instead of non-iodized salt. Between 2000 and 2005, the number of countries with salt iodization programmes increased from 90 to 120, and 34 countries have reached the universal salt iodization goal of 90 per cent of households consuming adequately iodized salt. In addition, 60 countries have achieved an increase of 20 per cent or more over the last decade.

- **Vitamin A deficiency** – This is the leading cause of preventable childhood blindness and substantially increases a young child's risk of death from common illnesses. At present the principal strategy for controlling vitamin A is to give high-dose supplements every six months to children aged six months to five years. Recent progress has been remarkable: Between 1999 and 2005, two-dose coverage increased more than fourfold, from 16 to 72 per cent.
- **Iron deficiency** – Around 2 billion people worldwide suffer from anaemia, most commonly iron-deficiency anaemia, and little improvement has taken place over the past 15 years. Pregnant women are particularly vulnerable, as are infants and children up to twenty four months of age. Lack of iron is a risk to the normal mental development of 40 to 60 per cent of the

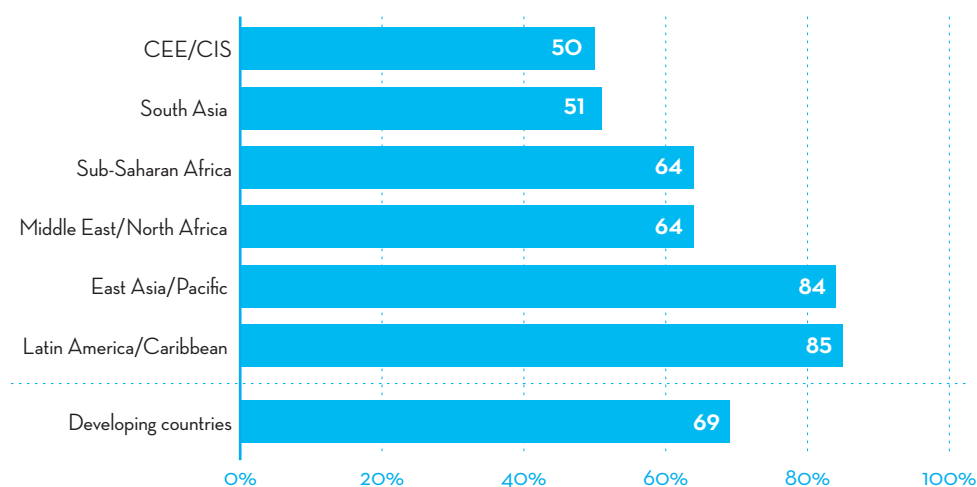
developing world's infants. Iron deficiency also debilitates the health and productivity of an estimated 500 million women and leads to more than 60,000 childbirth deaths a year. Anaemia is very prevalent in adolescent girls, affecting their school performance.

World Fit for Children country reports related to micronutrients include:

- **Bolivia** – Since 2002, after the creation of Seguro Universal Materno Infantil, children aged six months to two years receive packets of micronutrients, and children under five receive an iron supplement.
- **Cambodia** – Following the 2003 Sub-Decree on the Management and Exploitation of Iodized Salt, iodization of edible salt increased from 20 per cent to 100 per cent by 2005. That year the salt producers' community signed the Core Commitments to Children to prevent and eliminate child labour in salt production. The 2005 Cambodia Demographic and Health Survey found that 73 per cent of households consume iodized salt.
- **Mongolia** – Since 2002, the government has undertaken the Improvement of Food and Nutrition of Poor Mothers and Children project with the support of the Asian Development Bank and the Government of Japan. By 2005, 60 per cent of flour produced in Mongolia was enriched with iron, and 83 per cent of all households use iodized salt since local salt factories have received iodizing equipment and materials.

Figure 2-6

Percentage of households using iodized salt, 2000–2006*



* Consuming adequately iodized salt

Source: United Nations Children's Fund, *Progress for Children: A World Fit for Children statistical review, Number 6*, UNICEF (forthcoming, 2007).

cent of the world's children aged 5 to 17. Obesity appears to be increasing in several western countries; and in many developing countries overweight coexists with undernutrition, leading to a double burden of malnutrition.

World Fit for Children country reports related to obesity include:

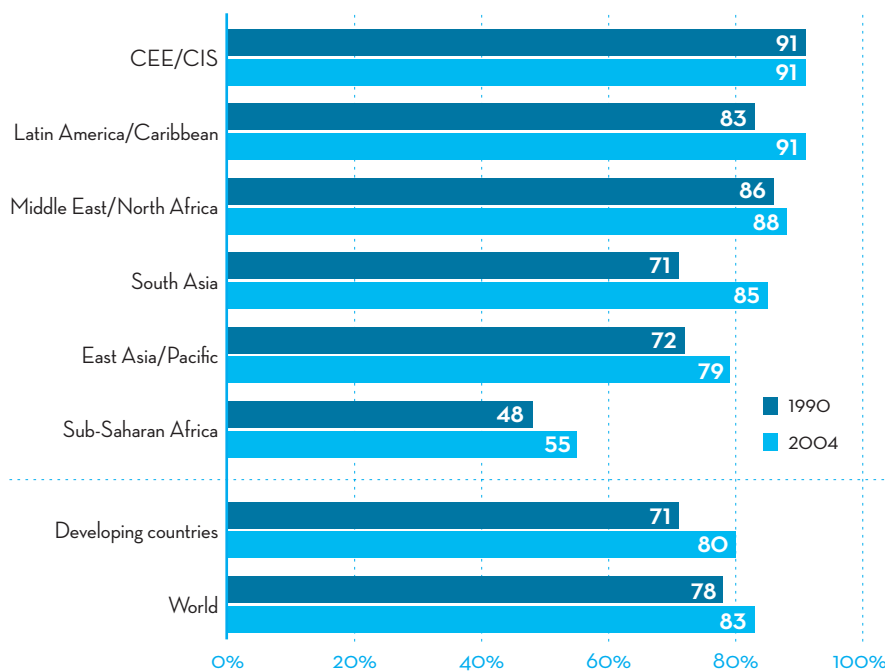
- **New Zealand** – The government has launched Mission-On, a NZ\$67 million package of initiatives to help young New Zealanders improve their nutrition and be more active.

Goals: Improved access to water, sanitation and hygiene

Children's chances of survival and their prospects for good health and nutrition are closely bound up with access to clean water and achieving good standards of hygiene and sanitation. Every year around 1.5 million children die as a result of diarrhoea and other diseases caused by unclean water and poor sanitation.

Without reliable water supplies and basic sanitation, children are constantly exposed to infections and diseases that threaten their lives and prevent absorption of many essential nutrients. Children of all ages are harmed by poor quality water and sanitation; these effects are also compounded by poor standards of hygiene, notably the lack of hand washing with soap.

Figure 2-7
Percentage of population using improved drinking-water sources, 1990 and 2004



Source: United Nations Children's Fund, *Progress for Children: A World Fit for Children statistical review, Number 6*, UNICEF (forthcoming, 2007).

Water

The drinking water target within Millennium Development Goal 7 is to halve by 2015 the proportion of people without sustainable access to safe drinking water. On average WHO estimates that each person needs at least 20 litres of drinking water per day for hygiene, drinking and cooking. Ideally, everyone should have treated water, piped under managed conditions into their homes or compounds. Failing that, they should at least be able to get water from improved sources – typically public standpipes, tube wells, boreholes, protected dug wells, protected springs or rainwater.

Figure 2-7 gives an indication of progress. Between 1990 and 2004, the proportion of households with access to drinking water from improved sources increased from 71 to 80 per cent across the developing world. And globally, the world is just barely on track for the goal. Regionally the picture is more mixed. South Asia and Latin America

and the Caribbean have almost achieved the goal already, but CEE/CIS and sub-Saharan Africa have much further to go.

Throughout developing countries more than 125 million children under five live in households that are using unimproved sources of drinking water – from unprotected dug wells or from rivers, lakes or streams.³⁰ Rural communities have the greatest difficulty in accessing an improved drinking water source: Only 70 per cent of rural households have access, and of the more than 1 billion people without access, the large majority, around 900 million, live in rural areas. To meet the Millennium Development Goal target for 2015, around 1.1 billion people would need to gain access.

Poor water supplies have time costs in addition to health costs. Most rural residents have to collect water for cooking and washing from communal sources. This can take up a considerable part of the day. UNICEF surveys of 23 countries found that about half of households spent more than 30 minutes per trip collecting water, while more than one fifth spent more than an hour. Most of the people carrying this water are women and girls.³¹

The situation is typically better in urban areas. Across the developing countries 95 per cent of the urban population has access – a proportion that has stayed fairly constant since 1990. Urban homes are also more likely to have piped connections. In the developing countries as a whole, around 70 per cent of urban households have piped connections, compared with 25 per cent in rural areas.³² However because of rapid urbanization the number of urban households without access has been increasing, particularly in informal, overcrowded peri-urban settlements. In fact, just to maintain the current urban drinking water coverage of 95 per cent would require a further 717 million people to gain access by 2015.

In both rural and urban areas, those least likely to have access are the poor. A WHO/UNICEF analysis of surveys for 20 developing countries found that in the richest 20 per cent of households 9 out of 10 people used an improved water source, while in the poorest 20 per cent of households the number was only 4 in 10.³³

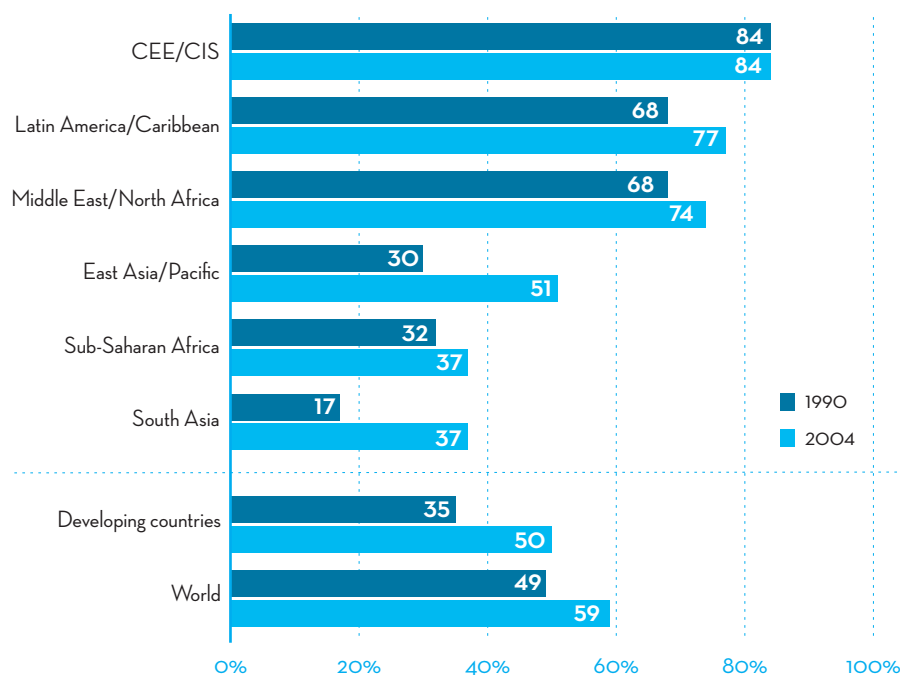
Sanitation

The sanitation target within Millennium Development Goal 7 is to halve by 2015 the proportion of people without sustainable access to basic sanitation. The indicator is the proportion of people who have access to an ‘improved’ sanitation facility. This includes, for example, household toilets or latrines connected to a piped sewerage system, septic tank or pit; ventilated improved pit latrines; or composting toilets. People without these facilities might use open pits or bucket latrines, or they might be forced to defecate in fields or dispose of faeces in plastic bags or in rivers. ‘Improved’ sanitation facilities are those that reduce the chances of people coming into contact with human excreta and are likely to be more sanitary than unimproved facilities.

The proportion of the population with access to improved facilities has increased, but relatively slowly. For the developing countries as a group coverage increased from 35 to 50 per cent between 1990 and 2004. Only three regions are on track to meet the Millennium Development Goal sanitation target – East Asia and the Pacific, Latin America and the Caribbean, and the Middle East and North Africa.

Figure 2-8

Percentage of population using improved sanitation facilities, 1990 and 2004



Source: United Nations Children's Fund, *Progress for Children: A World Fit for Children* statistical review, Number 6, UNICEF (forthcoming, 2007).

Of the approximately 122 million children born in developing countries in 2006, half will live in households without access to improved sanitation facilities. As with water supplies, the disparities are marked depending on income: The richest 20 per cent of families are four times as likely to use an improved sanitation facility as the poorest 20 per cent.

Again too, disparities are marked between urban and rural areas. In this case, however, the pattern is more consistent across global regions, with urban sanitation coverage generally twice as high as coverage in rural areas. But even within urban areas the contrasts can be dramatic, with very low coverage in slum areas. For people to construct even a basic sanitary facility in slum areas is particularly difficult because of high population densities, poor urban infrastructure, lack of space, lack of secure tenure and sustained poverty.

In response to the poor progress towards the MDG sanitation target, the UN General Assembly has declared 2008 the International Year of Sanitation to encourage countries to move sanitation higher on the national and international devel-

opment agenda. The aims are to raise global awareness at all levels and to mobilize human and financial resources, while also encouraging governments and others to reassess their plans for meeting the sanitation targets.

Water and sanitation for all

More than 90 countries have established the right to water in their constitutions. Fulfilling that right would bring enormous benefits. World Fit for Children country reports related to water and sanitation include:

- **Lao People's Democratic Republic** – Environmental health and water supply programmes have been implemented to expand coverage and improve services. Emphasis was placed on strengthening community-based management for sustainable services.
- **Pakistan** – Under the President's New Initiative, by 2007 all the Union Councils (village councils) will have water filtration plants for safe drinking water. An allocation of Rs.7 billion has been made to meet this target, which is likely to be achieved.

- **Tanzania** – The government has adopted Participatory Hygiene and Sanitation Transformation as a key methodology for community-based hygiene, water and sanitation, along with the promotion of rainwater-harvesting technologies.

Guinea worm eradication

Global eradication of Guinea worm disease, or dracunculiasis, is in its final stage. This painful and debilitating infection is caused by a parasite spread through contaminated water. The number of cases dropped from over 75,000 in 2000 to less than 11,000 in 2005. As of May 2007, dracunculiasis was still endemic in 9 of the 20 countries cited in 1986. In 2006, approximately 98 per cent of cases worldwide were reported from Ghana and Sudan. Five other countries (Burkina Faso, Côte d'Ivoire, Ethiopia, Nigeria and Togo) reported fewer than 30 cases each. The number of cases increased from 10,674 in 2005 to 25,217 in 2006, nearly all of them reported

Water and sanitation balance sheet

Goals	Gains	Unfinished business
Drinking water		
WFFC – Reduce the proportion of households without access to affordable and safe drinking water by at least one third by 2010	Between 1990 and 2004, the proportion of people without access to an improved drinking water source decreased from 29% to 20% across developing countries. This means that the developing world as a whole is on track to reach the MDG drinking water target.	Across the developing world more than 125 million children under 5 live in households using unimproved sources of drinking water.
MDG – Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation		
Safe sanitation		
WFFC – Reduce the proportion of households without access to hygienic sanitation facilities by at least one third by 2010	Between 1990 and 2004 the proportion of people without access to an improved sanitation facility decreased from 65% to 50% in developing countries.	On present trends the sanitation target will be missed, by around 600 million people. Of the approximately 122 million children born in the developing world in 2006, half will live in households without access to improved sanitation facilities.
MDG – Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation		
Guinea worm eradication		
WFFC – Eradicate Guinea worm disease	The number of cases dropped from over 800,000 in 1990 to less than 11,000 in 2005, and the number of endemic countries fell from 20 to 9. Two more were expected to interrupt transmission in 2006; this is being validated. The peace process in Sudan aided detection, raising the number of cases found in 2006.	Four more countries are expected to interrupt transmission by the end of 2007. If the remaining three countries interrupt transmission by the end of 2009, global certification is possible by 2012.

in Sudan, before decreasing from 9,510 during January–May 2006 to 4,460 cases during January–May 2007.

Progress achieved in these countries in the coming years will determine the chance of success in the eradication effort. Of the nine remaining endemic countries, Burkina Faso and Ethiopia were expected to interrupt transmission by the end of 2006, and Côte d'Ivoire, Niger, Nigeria and Togo by the end of 2007. The remaining three countries, Ghana, Mali and Sudan, are expected to interrupt transmission by 2009. If this plan is achieved, all countries can be certified free of disease transmission by 2012.

What we can do for children

The Millennium Development Goals and World Fit for Children goals cover a wide range of health-related issues and targets, as summarized in the balance sheets throughout this chapter. Although heartening progress has been achieved in many areas, it is clear that many of the targets will be missed.

Child mortality

The most evident failures concern the child mortality targets, which, on present trends, the developing countries as a group are likely to miss. The main problems are in South Asia and sub-Saharan Africa, where most deaths result from infectious diseases, including HIV and AIDS, and undernutrition. Even countries that have had more success in reducing under-five deaths are finding it difficult to bring down neonatal mortality. On the other hand, there are encouraging signs that progress could be accelerated – as, for example, with wider use of insecticide-treated mosquito nets to combat malaria.

Accelerating progress in child survival essentially means extending services and life-saving interventions to the most vulnerable children. Since many of these may be in remote areas, this involves expanding community-based activities. One approach is Integrated Management of Childhood Illness, which focuses on three main areas of improvement: health worker skills, health systems, and family and community practices.

Adolescent health

The World Fit for Children goal is to 'develop national health policies and programmes for adolescents, including goals and indicators, to promote their physical and mental health'. More countries have programmes, but they are typically small scale and reach only a small proportion of adolescents. Relatively few countries have specific goals or indicators.

For the future many more governments will have to address the rights of adolescents. This will mean providing more health and protection services while also offering adolescents greater opportunities to protect themselves and to develop the skills that will allow them to reach their full potential while contributing fully to their communities and societies.

Maternal health

Some middle-income countries have made rapid progress in reducing maternal deaths. Nevertheless, maternal mortality levels remain unacceptably high across the developing world, particularly in sub-Saharan Africa and South Asia.

The vast majority of maternal deaths and disabilities could be prevented through appropriate reproductive health services before, during and after pregnancy, and by ensuring that women have access to life-saving interventions should complications arise. Progress will depend significantly on ensuring that births take place in the presence of skilled birth attendants.

Nutrition

On present trends for developing countries as a whole the goals on undernutrition are likely to be missed – as are those for eliminating iron and vitamin A deficiencies. At the same time a number of developing countries are seeing rising levels of childhood obesity.

Much more attention needs to be paid to early childhood development programmes, with a focus on infant and young child nutrition to encourage better feeding, along with the extension of proven methods of preventing and combating micronutrient deficiencies.

Water and sanitation

Overall the developing countries are just about on track to meet the targets for improved sources of drinking water but likely to miss those for basic sanitation. Accelerating progress for both these goals will require much higher levels of investment and stronger partnerships between public providers and local communities.

CHAPTER

3



Providing quality education

In 1989 the UN General Assembly adopted the Convention on the Rights of the Child, which says: 'Make primary education compulsory and available free to all'. In 1990, at the World Conference on Education for All in Thailand, representatives from 155 countries again committed themselves to 'taking all necessary steps to achieve the goals of education for all'. In 2000, world leaders issued the Millennium Declaration, which asserted that 'girls and boys will have equal access to all levels of education' (reflected in Millennium Development Goal 3). They also pledged to promote gender equity and empower women, with a target to eliminate gender disparity in primary and secondary education. Then in 2002, at the UN General Assembly Special Session on Children, leaders reaffirmed in *A World Fit for Children* that 'all boys and girls must have access to and complete primary education that is free, compulsory and of good quality'.

Early childhood development

All these declarations highlighted the importance of primary education. But they also emphasized that a child's education starts long before the first day of school. Indeed, children start to learn from their very first minutes of life. They take cues from their parents and other carers, absorbing and organizing the myriad new experiences that assail their senses. This is a critical development period, as the child picks up skills in language and learns to think critically. Such is the pace of change that over the first three years a child's brain can nearly double in size in twelve months.

This is also a time when children develop their sense of personal and physical security and strengthen their bonds with family and community. Healthy and well-nourished infants should be able to play and learn by exploring objects, making choices and interacting with family members and other children.

Although they will get most of their early stimulation within the home and from neighbours and friends, children should also be able to take advantage of structured group activity from a very early age. The aim should not be to substitute for the care of parents and other family or community members but to supplement it.

Formal systems appear under a variety of guises – preschool education, kindergarten, early childhood education or nursery education – but they can be referred to generally as 'pre-primary education'. Since 1970 the proportion of children enrolled has tripled, and by 2004 almost 124 million children around the world were benefiting from some form of pre-primary education. In fact 30 countries make it compulsory.

In most cases children commence pre-primary schooling at three years old, though sometimes at four or later. Girls and boys tend to enrol in pre-primary schools more or less equally. The main disparities are between rural and urban areas; enrolment rates for rural children can be 10 to 30 percentage points lower. Poorer children are

less likely to have pre-primary education, as are those whose mothers have had only primary education.

Pre-primary schooling differs substantially from one country to another, but the strongest programmes share three basic characteristics. First, they support parents during the children's earliest years; second, they integrate educational activities with other services, notably health care, nutrition and social services; and third, they provide children with educational experiences that help ease the transition to primary school.

Not all pre-primary education is carried out by teachers or other trained workers. Another option is the child-to-child approach through which school-age children are encouraged, often with special kits, to stimulate their younger brothers and sisters at home.

World Fit for Children country reports related to early childhood development include:

- **Denmark** – Local authorities are obliged to guarantee day care for all children from 26 weeks old to school age. Parents pay around one quarter of the actual cost, and poorer children may get further subsidies or free places. Alternatively parents can receive a subsidy for a private childminder or to look after their own child.
- **Malawi** – Children below the age of five years are eligible for free programmes prioritizing early childhood physical, psychological and development needs. An important initiative has been the establishment of community-based child centres. This has tremendously improved access to pre-primary education, especially for children in rural communities, from 3 per cent in 2000 to about 23 per cent in 2005.
- **New Zealand** – The government outlined the direction for early childhood development from 2002 to 2012 in a strategic plan, 'Pathways to the Future: Ng Huarahi Arataki', and is making good progress in implementing it. This has involved significant increases in funding and employment of many more teachers.
- **Spain** – Over the past 15 years services for the youngest children have improved substantially. Almost all children between the ages of three and five years attend a preschool centre, though the quality differs greatly between regions.
- **The former Yugoslav Republic of Macedonia** – The Project for Inclusion of Roma children aims to improve and support the integration of Roma children by increasing their attendance at public kindergartens.

Primary education

The second Millennium Development Goal is to achieve universal primary education. Across the world in 2005, based on enrolment data, about 72 million children of primary-school age were not in school, of whom 57 per cent were girls.³⁴ However

this understates the extent of the problem since many of those enrolled are not attending, and other estimates, based on enrolment and attendance data, place the number of children out of school at 93 million in 2006.

Figure 3-1 shows the changes between 1999 and 2005. For both boys and girls, the most serious problems are in remote rural areas, and especially for children from ethnic, religious, linguistic, racial or other minorities. For the same group of countries over that period, 18 per cent of urban children were out of school, but for rural children the proportion was 31 per cent.³⁵ Also likely to be excluded are children with disabilities – around 90 per cent of children with disabilities in developing countries do not attend school.³⁶

Late enrolment and low completion

The net enrolment ratio tells only a part of the story and to some extent underestimates national progress. This is because the net figure records the enrolment only of children of the official age for each primary school grade. But primary schools also have many underage and overage children. An analysis of data from 89 developing countries found that in 31 countries, two thirds of them in sub-Saharan Africa, at least half the intake were outside the appropriate age group. Some were younger, but most were overage children enrolling late.³⁷ For developing countries as a whole, the gross enrolment ratio in primary education in 2000–2006 was 111 per cent for boys and 105 per cent for girls.

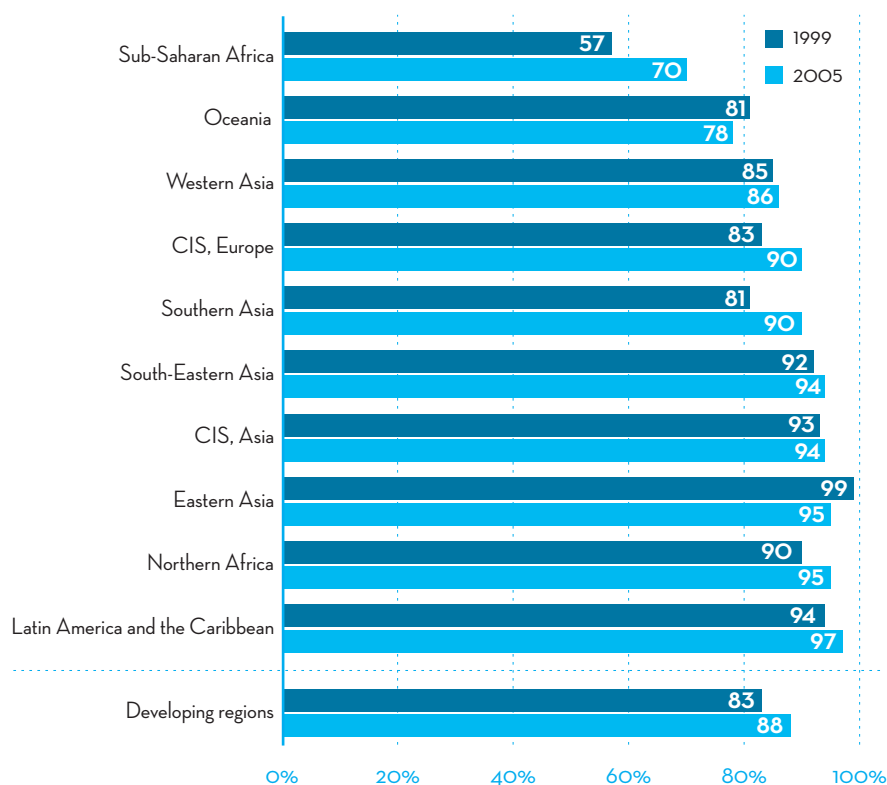
In countries where enrolment ratios are low, many children fail to make sufficient progress to pass to the next grade. In some countries 10 to 20 per cent of children have to repeat a class.

As is clear from Figure 3-2, large numbers of children are dropping out before the final grade, and almost everywhere completion rates are lower for girls than boys.³⁸ In addition, many children may subsequently drop out during the final grade: In the majority of countries in sub-Saharan Africa, one third or more of children may not actually graduate from primary school.³⁹

Low rates of completion have serious implications for the Millennium Development Goal, which is to ensure that, by 2015, children everywhere, boys and girls alike, are able to complete a full course of primary schooling. Between 2000 and 2005, the number of countries that had achieved universal primary education increased

Figure 3-1

Net enrolment rate in primary education, 1999 and 2005



Source: United Nations, *The Millennium Development Goals Report 2007*, United Nations Department of Economic and Social Affairs, New York, 2007, p. 10.

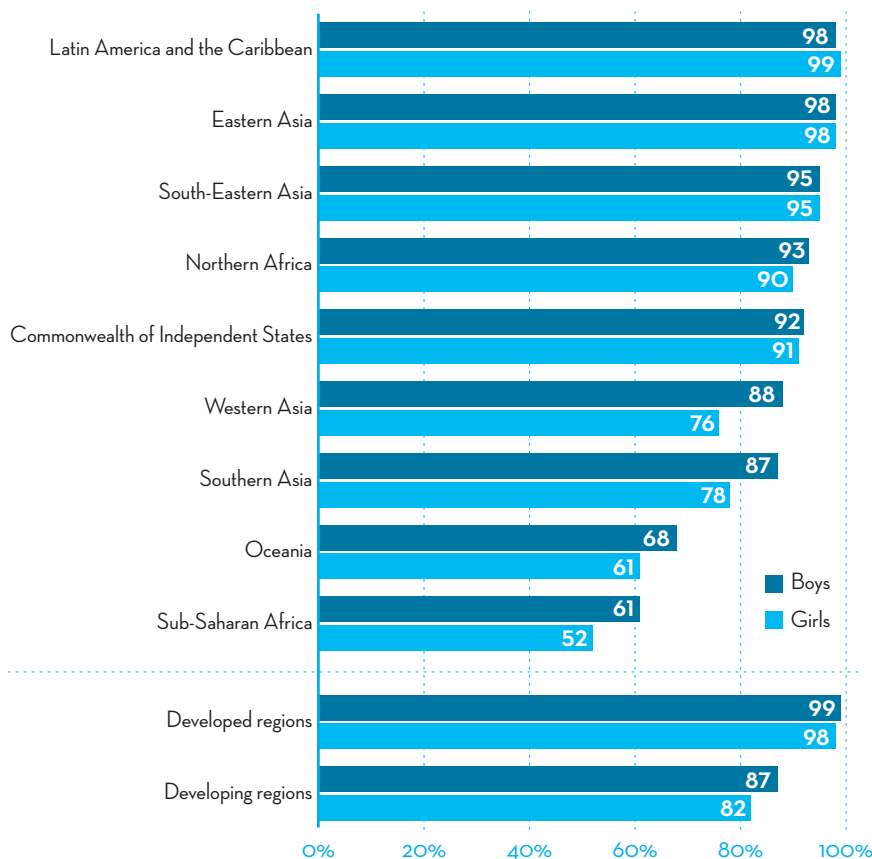
from 37 to 52. But of the 147 developing countries for which data are available over 80 are off track for this goal.⁴⁰

In their World Fit for Children progress reports, many governments have reported on efforts to boost primary enrolment and attendance, including:

- **Georgia** – The Law on General Education ensures the right to inclusive education for children with disabilities, integrating them into regular schools. Ten schools in Tbilisi now provide them with inclusive education. The government has also produced manuals on methods of teaching children with disabilities in grades 1 to 3.
- **Lebanon** – As a first practical step towards implementation of free primary education, Lebanon dropped all registration fees for the preschool and primary cycles in 2003 and reduced the price of school books by 35 per cent in the basic education cycle and 45 per cent in the secondary cycle. These measures were complemented by legislative efforts, including alternative educational and rehabilitation measures that avoid incarcerating children in conflict with the law.

Figure 3-2

Primary completion rate, 2004*



* See source below for full definition

Source: United Nations, *The Millennium Development Goals Report 2006: Statistical annex*, United Nations Department of Economic and Social Affairs, New York, 2006, p. 7.

- **Solomon Islands** – The net primary education enrolment rate rose to 63 per cent in 2005, up from 56 per cent in 2000. Gender parity is also being achieved, with almost equal numbers of girls and boys enrolling in school. The total expenditure on education was almost 26 per cent in 2004, with almost half these resources devoted to primary education. The child-friendly school initiative in Isabel province is further improving the quality of primary education.

Gender parity

Millennium Development Goal 3 has the target to 'eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015'. Here there have been significant advances. By 2005, out of 106 developing countries with data available, 83 had achieved gender parity in primary and secondary enrolment.⁴¹

Between 1990 and 2005 the global gap in net primary enrolment narrowed from eight percentage points to four, and in secondary education from three percentage points to

two (see Figure 3-3). In primary education the greatest gap is in West and Central Africa, where girls were 9 percentage points behind in the 2000–2006 period. In secondary education, however, the narrow overall gap masks the fact that in Latin America and the Caribbean girls are ahead while in other regions girls are behind – by five percentage points in both South Asia and West and Central Africa.

Increasing school enrolment has also resulted in higher literacy rates among young people aged 15 to 24. But there are still gender gaps. Over the period 2000–2004, of the nearly 140 million illiterate young people, 63 per cent were female. Women are furthest behind in West and Central Africa, the Middle East and North Africa, and South Asia – regions that also have female disadvantages in primary and secondary enrolment.

Girls' disadvantages are often compounded by other forms of exclusion. A recent study concluded that of the 60 million girls still not in school nearly three quarters belong to various excluded groups.⁴² In sub-Saharan Africa, for example, the excluded girls are likely to be from a tribe other than the dominant one. In South Asia they are often from scheduled castes and tribes. In East Asia and the Pacific they come from hill tribes, Muslim minorities or other ethnic groups. In Latin America and the Caribbean they are indigenous and Afro-Latino populations. And in Eastern Europe and the CIS they include groups like the Roma.

World Fit for Children country reports on addressing gender disparities in education include:

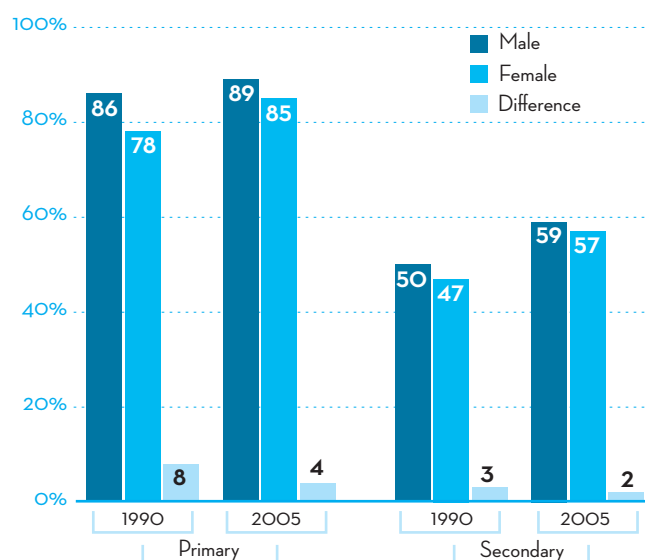
- **Equatorial Guinea** – A campaign to get girls into school has carried out advocacy activities in communities and schools, along with public meetings and national media advertising.
- **Nepal** – The 'Welcome to School' initiative combines enrolment drives focusing on girls and disadvantaged groups with steps to improve the learning environment. The initiative was taken to scale nationally in 2005, resulting in an almost 12 per cent increase in primary enrolment.

Secondary education

In most regions the vast majority of children, more than 90 per cent, progress to lower secondary education – except in sub-Saharan Africa, where the average is only around two thirds. This pattern is reflected in the enrolment figures for secondary education. These are lower than for primary school, but in some regions the gender pattern is different. In Latin America and the Caribbean, and to a lesser extent in East Asia and the Pacific and in the industrialized countries, enrolment is higher for girls (see Figure 3-4).

Figure 3-3

Gender disparities in primary and secondary net enrolment rates, 1990 and 2005



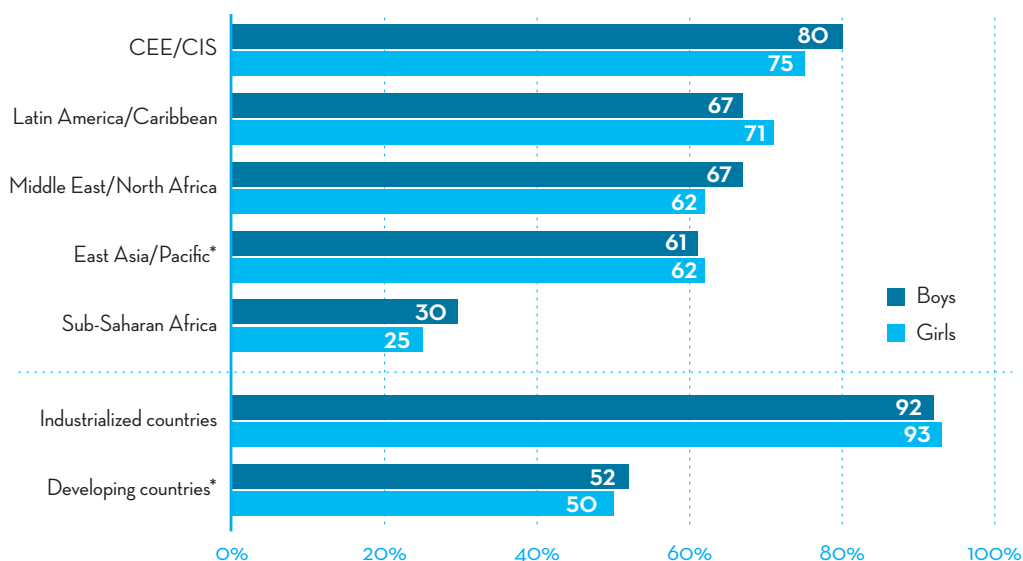
Source: United Nations Children's Fund, *Progress for Children: A World Fit for Children* statistical review, Number 6, UNICEF (forthcoming, 2007).

These data refer to secondary education as a whole. Normally, however, secondary education is in two stages. Junior secondary school is essentially a continuation of primary school, together with which it provides 'basic education', often completing the period of compulsory education. Far fewer children progress to senior level, partly because they may not wish to but also because governments exclude them by rationing places through examinations.

In their World Fit for Children progress reports, governments have reported on efforts to expand secondary education, including:

- **Bangladesh** – To provide support and assistance to the eligible female students of secondary level (grades 6 to 10), education was made free for girls up to grade 10 in 1994. This benefit was extended up to grade 12 from 2002.
- **Indonesia** – The government has now initiated a Compulsory Nine-Year Basic Education Plan, aiming to meet a 2008/09 deadline. It has already made substantial progress: By 2005 net enrolment in primary school was 93 per cent and for the three years of junior high school had reached 84 per cent. The government has also committed itself to spending 20 per cent of both central and local government budgets on education.
- **Mauritius** – The Education Act was amended in 2004 to make education compulsory for every child up to the age of 16. A parent or guardian who fails to ensure the child's regular attendance faces criminal prosecution. Since September 2005, the government has introduced free transport for all schoolchildren.

Figure 3-4
Net enrolment in secondary education, 2000-2006



* Excluding China

Source: United Nations Children's Fund, *The State of the World's Children 2008*, UNICEF (forthcoming, 2007).

Quality of education

Whether or not children go to school depends at least in part on the quality of the schools. When making their decisions, parents consider whether the school provides a healthy, safe and protective learning environment. They also look for schools that enable their children to acquire the appropriate attitudes, knowledge and skills. In short, they want the schools to reach high standards. Too many do not – with serious consequences for the learning achievements of their pupils. It has been suggested that the rapid increases in enrolment make it more difficult to achieve higher standards. But there is no inherent trade-off between quantity and quality. A number of countries have been able to increase access to schools while also raising levels of learning.

Learning assessments

At the national level, the most direct method of evaluating education quality is various types of learning assessment. Recent years have seen an increase in the number of national assessments. Most of these, carried out either by the Ministry of Education or by research institutions, monitor progress in the primary grades, though some countries in Asia and Latin America also evaluate progress at the secondary level. These national studies can be supplemented by regional or global studies such as those carried out by the International Association for the Evaluation of Educational Achievement and the Organisation for Economic Co-operation and Development, which apply standardized tests to a number of countries across a limited range of subjects.⁴³

What do these assessments show? The most important conclusion is that the children who perform best usually have better educated and wealthier parents. So if a country is to improve its performance it should not only aim to achieve high marks but ensure that this achievement is distributed equally across the country, as well as between socio-economic groups. One study of 14 sub-Saharan African countries concluded that the best performers were Kenya, Mozambique and Tanzania, which not only had above-average mathematics scores but distributed them quite well across different regional and socio-economic groups.⁴⁴

International comparisons also highlight the importance of language. In high-income countries pupils who speak the test language at home do better, even in mathematics. And some countries have striking differences between immigrant and non-immigrant children. In both high- and middle-income countries children seem to do worse if they work at paid jobs outside school hours.

School buildings

If children are to be well educated they need well-equipped and well-maintained schools. This is partly a question of assuring adequate numbers of school buildings near the pupils' homes – particularly important for girls, for whom a long journey to school can be unsafe: Many girls experience harassment and physical attacks either on public transportation in cities or on remote paths in rural areas.

School buildings also need to be well maintained and have good services. The most basic requirement should be clean water supplies and sanitation. Lack of school

facilities also wastes time, and when pupils have to leave school and walk significant distances for clean drinking water, for example, they may not return to class.

The absence of such facilities hits girls particularly hard. In rural areas girls fearing to be seen while urinating may have to go far into the bush, where they may be exposed to snake bites or even sexual attack. They may therefore prefer to 'hold on' all day – risking urinary and bladder problems.⁴⁵ The situation is particularly difficult for teenage girls who are menstruating. Clean water and sanitation facilities are important not just for children's safety but also to enable them to learn habits of hand washing and general hygiene, which they can take into their homes and wider communities.

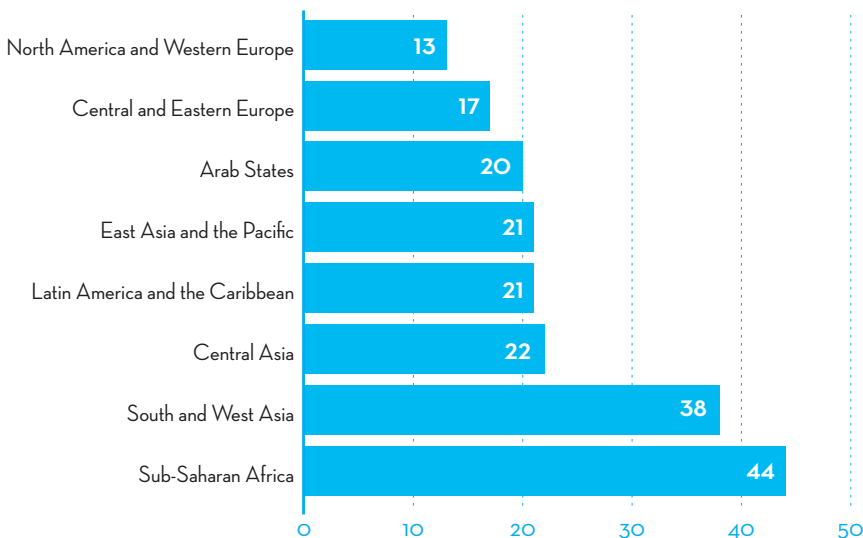
Teachers

The standard of education that children receive also depends heavily on the availability and quality of the teachers. When class sizes are 40 or above the quality of education suffers (see Figure 3-5). In most regions the total number of pupils per teacher is around 20 or fewer – though it is much higher in south and west Asia and particularly in sub-Saharan Africa, where in some countries the ratio is 55 or more. This problem is exacerbated by the AIDS pandemic, from which teachers are not immune.

But even these data on pupil-teacher ratios understate the problem, since they are derived by dividing the total number of pupils by the total number of teachers. Actual class sizes will always be higher. This is partly because these figures do not always distinguish between teachers who work full time versus part time or account for the part of the day when most teachers have responsibilities beyond teaching. Another problem is uneven distribution. Teachers are frequently unavailable where they are needed most, particularly if they are reluctant to move to remote rural areas. Many prefer to stay in cities, where they create an oversupply. Schools may also lack sufficient teachers with appropriate ethnic backgrounds.

Inadequate numbers of teachers are compounded by absenteeism. One survey in 2000 that involved making unannounced visits to schools in six developing countries found that on average about 19 per cent of teachers were absent, along with 35 per cent of health workers.⁴⁶ This may be because teachers have to offset low salaries by taking on other jobs to survive. In many countries salaries have declined in recent years, and teachers are not always paid on time. In addition, many teachers cannot find housing close enough to the school so they struggle to arrive on time or to stay until the end of the school day. Beyond the quantity of teachers are concerns about quality. In about half the countries with 2004 data available – 76 coun-

Figure 3-5
Pupils per teacher in primary education, 2004



Source: United Nations Educational, Scientific and Cultural Organization, *Education for All Global Monitoring Report 2007: Strong foundations – Early childhood care and education*, UNESCO, Paris, 2006, pp. 336–337.

tries for primary and 59 for secondary – one fifth of both primary and secondary teachers lacked pedagogical training.⁴⁷

Curriculum and learning materials

Schools in developing countries increasingly are covering 'life skills', which includes such topics as health, hygiene and vocational skills. While these often focus on improving employment prospects, the life skills curriculum is also concerned with attitudes, values and behavioural change.

The necessary life skills vary depending on local circumstances. Children caught up in conflict or other emergencies, for example, need an awareness of landmines and the knowledge to protect themselves from diseases such as cholera. And they and other children can benefit from education for peace to help prevent conflicts and learn to resolve them peacefully.

For many subjects the quality of teaching is affected by the availability of good learning materials. These typically fall far short of what is required. Many classrooms in developing countries have little more than a blackboard and a few textbooks. The lack of equipment or books may be the consequence of a lack of resources, which is frequently exacerbated by inefficient distribution systems and corruption. Relatively few developing countries can provide every pupil with a complete set of textbooks. To address these problems governments are now involving the private sector in textbook production and distribution and decentralizing procurement. There is a danger, however, that privatizing production may also push the prices of books beyond what is affordable for the poorest pupils. Not all teaching materials need to be 'purpose built', however. Imaginative teachers can always use local materials from crops to household goods as teaching aids.

Another important factor is the language of instruction, which can have a major impact on learning and on general academic achievement. The best approach is to start primary education in the student's home language. But in many schools children have to start learning in a language they do not understand. This may be due to deliberate policy or to a simple lack of teachers with appropriate language skills. But some parents may actually prefer their children to learn in a language not spoken at home – either the national language or a foreign language such as English or French that they consider more useful. The problems are greatest in sub-Saharan Africa, which has more than 2,500 languages, and where only 13 per cent of children receive primary education in their mother tongue.⁴⁸

Child-friendly schools

The Convention on the Rights of the Child calls for education to be directed to the 'development of the child's personality, talents and mental and physical abilities to their fullest potential' and for the child to be prepared for 'responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples'. It also calls for education to develop a child's 'respect for the natural environment'.

Some governments aiming to realize children's rights have been developing child-friendly schools. These have two main characteristics. First, they are 'child seeking'

Box 3-1 Free education boosts enrolment in Africa

More countries have now eliminated all or almost all school fees, resulting in rising demand for education. In Tanzania, for example, free education boosted the number of children enrolled from 1.4 million to 3 million. In Kenya the increase was 22 per cent in the first week alone. Uganda's offer of free education to the first four children in each family has also succeeded in popularizing education while making it unnecessary for parents to make the difficult choice about which children go to school and which remain at home. From 2002, Zambia has allowed children to attend grades 1 to 7 without having to pay fees or buy uniforms or learning materials, resulting in a rise in net primary enrolment from 80 to 89 per cent between 2002 and 2005.

*Child-friendly schools
are 'child seeking' –
they actively work
to identify excluded
children and enrol
them in school.*

Box 3-2

Keeping school doors open in Iraq

In Iraq, the war and its violent after-effect is compounding the corrosive effects of years of underinvestment, depleting teaching staff and eroding school infrastructure. Iraq's education system is now dangerously vulnerable, with many schools not operating normally. Over 800,000 children may now be out of school.

As part of an effort to boost enrolment, a national school supply drive organized by Iraq's Ministry of Education is delivering school bags, books, pencils and other essential learning materials to Iraq's primary school children. This drive, with support from UNICEF and the European Commission, aims to reach all Iraqi primary schools, bringing basic learning tools to millions of children aged 6 to 11. Materials are being distributed both centrally from Baghdad and directly to local governorates, reaching even the most remote schools. In planning for children's education in Iraq's current setting, the government has been emphasizing that children need more protection, both inside and outside school.

– they actively work to identify excluded children and enrol them in school. This should include welcoming children with disabilities and providing the necessary adaptive equipment and educational aids. Second, these schools are 'child centred' – aiming to help children realize their full potential while also being concerned about the 'whole child', including his or her health, nutritional status and well-being. Child-friendly schools also have close links with the community; they are concerned about what happens to children both in and out of school.

Such schools enable children to acquire the essential skills of writing, reading and mathematics along with general knowledge and life skills, including useful traditional knowledge plus the values of peace, democracy and acceptance of diversity. At the same time child-friendly schools encourage children to think critically, ask questions, express their opinions – and learn how to learn.

Non-formal education

The first priority should be to ensure that all children attend primary school and continue to junior secondary education. But it is also vital to fulfil the rights of children who have never entered school or who have dropped out. Many children are 'pushed out' by the costs of schooling or an unfriendly learning environment, or are 'drawn out' to start working.

Many countries have strong systems of non-formal education, either through governments or non-governmental organizations. These can enable children to combine study with work or help children enter or rejoin mainstream education, such as through an examination or other means of establishing equivalency between the two systems. Unfortunately non-formal education is still often perceived as second rate, with less-qualified teachers and staff and inadequate political and financial support.

Non-formal education programmes work best when they are community based, flexible and relevant to children's lives. They also play an important role for children and youth affected by conflict and can help ease child soldiers back into formal schooling.

In their World Fit for Children progress reports, governments have reported on efforts to improve the quality of formal and non-formal education. In addition to reducing school fees (see Box 3-1), these efforts include:

- **Austria** – An Early Linguistic Support Programme in kindergartens evaluates language levels and provides necessary support for immigrant children. Special primary school courses are also offered in German.
- **Germany** – The National Action Plan for A Germany Fit for Children (2005–2010) provides for an investment of 4 billion euros to the *Länder* (states) and municipalities for 'future education and care' to build up and expand all-day schooling in the country. The aim is to give all children and young people individual support and promote an atmosphere conducive to learning through new forms of cooperation between schools and extracurricular partners. The primary goal is to raise the quality of education and break the close ties between social background and academic performance.

- **Guinea-Bissau** – To respond to the shortage of qualified teachers the government has been introducing multi-grade teaching methodologies in selected schools.
- **Latvia** – To create a school environment in which children feel safe, healthy and protected, the country is implementing a child-friendly school project. District and city conferences have discussed the issue, and more than 400 schools have given their views on what a child-friendly school is and how the project should be carried out.
- **Palau** – School health programmes have been expanded with the launch of annual health and psychosocial screening for all children from preschool through high school. This programme includes physical, dental and vision screening and has been expanded to include screening for hearing impairment, mental health problems and health behavioural risk factors.
- **Thailand** – Schools have joined WHO's Health Promoting School project, which encourages them to become centres for health development. By 2003, 88 per cent of schools across Thailand had joined, and 40 per cent had achieved the 10-component standard endorsed by WHO. In addition student leaders are trained to disseminate knowledge and information on health issues to their peers in school, at home and in their communities. In 2005, this project was implemented in all schools.

Resources for education

Most governments have increased investment in education in general and in primary education in particular. Industrialized countries spend around 6 per cent of GNP on education, but developing countries tend to spend a lower proportion: In 2004, over half the 124 developing countries for which data were available were spending less than 5 per cent, though there were exceptions: over 7 per cent of GNP in Cape Verde, Kenya, Kuwait, Lesotho, Malaysia, Namibia and Tunisia. As a proportion of government expenditure, in most countries this represents between 10 and 40

Education balance sheet

Goals	Gains	Unfinished business
Early childhood development and pre-primary education		
WFFC – Expand and improve early childhood care and education especially for the most vulnerable and disadvantaged children.	Enrolment in pre-primary education has been increasing. By 2004, almost 124 million children around the world were enrolled, and enrolment in developing countries had reached 32%.	Children in rural areas, and especially those of poorer families, are still missing out.
Primary education		
WFFC – Increase net primary school enrolment or participation in alternative, good-quality primary education programmes to at least 90% by 2010	For the developing countries as a whole, net primary enrolment has reached 88%, and many countries are now close to full enrolment. Between 2000 and 2005, the number of countries that had achieved universal primary completion increased from 37 to 52.	As a result of low enrolment and completion 57 countries are off-track for the MDG goal. Globally 93 million children are still out of school based on enrolment and attendance data.
MDG – Ensure that, by 2015, children everywhere will be able to complete a full course of primary schooling		
Gender parity		
WFFC – Eliminate gender disparities in primary and secondary education by 2005 and achieve gender equality in education by 2015	By 2005, 83 out of 106 developing countries with data available achieved parity in primary and secondary enrolment.	Almost everywhere primary completion rates are lower for girls than boys. Poor facilities in many schools discourage girls, particularly adolescents.
MDG – Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015		
Children with disabilities		
WFFC – Ensure that all basic education programmes are accessible, inclusive and responsive for children with various forms of disability	Many more education systems are recognizing the importance of integrating children with disabilities into mainstream schools.	Around 90% of children with disabilities in developing countries do not attend school.
Literacy		
WFFC – Achieve a 50% improvement in levels of adult literacy by 2015, especially for women	Some regions are close to 100% literacy for 15- to 24-year-olds.	Of nearly 140 million illiterate youths, over the period 2000–2004, 63% were female.

Box 3-3 United Nations Girls' Education Initiative (UNGEI)

In 2000, girls made up more than half the global number of primary-school-age children who were not enrolled. In some regions and countries, the gender disparity in access to primary school was even more severe than it was globally. In response, former UN Secretary-General Kofi A. Annan launched UNGEI as a partnership of 13 agencies and organizations, to be led by UNICEF, with the objective of jump-starting efforts to achieve Education for All (EFA).

UNGEI's work is driven by Millennium Development Goal 2, achieve universal primary education by 2015, and by the target of Millennium Development Goal 3, eliminate gender disparity in primary and secondary education by 2005 as a step towards the 2015 goal of empowering women and promoting gender equality. The 2005 target was missed, despite best efforts to remove such barriers for girls as school fees and to implement country-level strategies that place the needs of girls and women centrally in education policies, plans and budgets.

Undiscouraged, the partnership, with significant donor support – in particular from Norway and the United Kingdom – expanded and became more integral to the work of Education for All: Of the 31 countries with education sector plans endorsed by the EFA Fast Track Initiative, 20 have UNGEI partners – including the Danish International Development Agency, UK Department for International Development, United Nations Educational, Scientific and Cultural Organization, United Nations Children's Fund and the World Bank.

per cent, and the figure has generally been rising. The share going to primary education varies according to the level of development.

Non-governmental organizations and education

Many developing countries have relied substantially on the efforts of NGOs to fulfil children's right to education. South Asia in particular has a strong tradition of these groups as education providers. Bangladesh, for example, has a number of large NGOs such as BRAC that run thousands of informal schools for children who were previously being deprived of their right to schooling. But there are also many smaller non-governmental organizations working in education; without them the country's gross enrolment ratio might be 5 to 10 percentage points lower. In India, on the other hand, such groups tend to serve less as providers and more as innovators in education, testing out potential solutions for eventual adoption by the state.

Non-governmental organizations have also played a key role in promoting education for girls, particularly in Africa. In Ethiopia, for example, total enrolment increased by 9 per cent and girls' enrolment by 14 per cent in the region where World Learning operates a community school programme. Similarly in Guinea, the gross enrolment ratio for girls increased from 31 to 37 per cent in one district with schools operated by Save the Children.⁴⁹

NGOs have also boosted girls' education indirectly. In many countries they have, for example, been the driving force behind the expansion of micro-finance – helping the poorest families to save money and invest in their children's education. Many of these programmes are aimed specifically at empowering women, who generally take a strong interest in educating their daughters.

What we can do for children

All countries are committed to achieving education for all, and this has been reflected in higher enrolment ratios and rising levels of literacy. Nevertheless, millions of children are still out of school, while many others do not complete their schooling or fail to get the quality of education that is their right. Among the priorities for the years ahead are:

- **Invest in early childhood development** – This offers children the best possible start in life. Well-integrated programmes of health, nutrition and cognitive development enable young children to develop and exercise the capacities and skills that will help them get the most out of pre-primary and primary education.
- **Bring education to every child** – All countries have ensured that the majority of children are now in school. But they are finding it more difficult to enrol the most marginalized, especially ethnic minorities, orphaned and other vulnerable

children, and those affected by wars and other emergencies. To go further many more countries will need to invest more resources and eliminate school fees. Many countries have demonstrated the value of reaching out to more marginalized children with flexible and creative schooling systems, including multigrade teaching, schedules that respond to community needs and effective distance learning structures. Linking formal schooling with non-formal systems allows children to transfer to formal schools when they can.

- **Ensure that schools are child friendly** – As well as finding ways to attract and embrace the most marginalized children, schools need to be child friendly, offering a safe and enjoyable environment in which all children can study academic subjects, acquire basic life skills and learn to think critically and creatively. Child-friendly schools are also well integrated with their communities, serving as places where children can feel safe, without fearing violence from teachers or peers.
- **Aim for quality** – Wherever they are, the best schools constantly strive to improve the quality of their facilities, their teaching and their learning materials. While all are important they also need to be improved together – so that well-trained teachers have the best materials and facilities.
- **Reach out to girls** – Better schools should attract both boys and girls. But they may also need to take special measures to reduce barriers to girls. Many countries have shown the value of such measures as putting up boundary walls to make campuses more secure, setting up separate classrooms and hand-washing and toilet facilities for girls and boys, and appointing female teachers exclusively to teach girls. A number of governments are also taking action to tackle gender-based violence in school.

Box 3-4

Donors leverage resources for education in emergencies and post-crisis transition countries

With a commitment of US\$201 million over four years, the Government of the Netherlands took a bold step in 2006, soon followed by a commitment from the United Kingdom for £20 million to ensure that children in crisis-affected countries are able to exercise their right of access to a quality education. Other donors, Norway and Sweden especially, continued to show leadership and commitment with significant amounts of funding for basic education and gender equality programmes, including in crisis-affected countries.

Monitoring and reporting the results of this partnership is supported and enhanced by the Rolling Progress Report, a wiki, Web-based platform developed to allow highly disaggregated reporting by country, as well as by objective, activity and financing trends – and the closest thing to real time reporting.

As the UNICEF-Netherlands partnership began its work, the Education for All Fast Track Initiative showed increasing engagement in fragile states, and the United Nations Inter-Agency Standing Committee recognized education by forming a global Education Cluster, co-led by UNICEF and the International Save the Children Alliance, as part of the humanitarian reform agenda. Also in this context, emergency education was included in the Central Emergency Response Fund, and Save the Children undertook a study on education financing in conflict-affected countries.

CHAPTER

4



Protecting
against abuse,
exploitation
and violence

Governments have taken a number of measures, particularly through legislation, to address issues such as child labour, child trafficking, female genital mutilation/cutting (FGM/C) and child marriage. Some governments have also been developing systems of juvenile justice, and those emerging from wars have been demobilizing child soldiers. Families and communities are catalysts of social change, which is fundamental to child protection. Communities are making the collective choice to abandon FGM/C. Nevertheless, children all over the world remain subject to sexual, physical and other forms of abuse – including that perpetrated by the adults who should be their protectors.

Birth registration

Societies all over the world have traditionally welcomed new arrivals in their own way. Some parents place symbolic food or drink on the child's tongue. Others whisper into the child's ear or sprinkle him or her with water. And at public ceremonies they give the child a name.

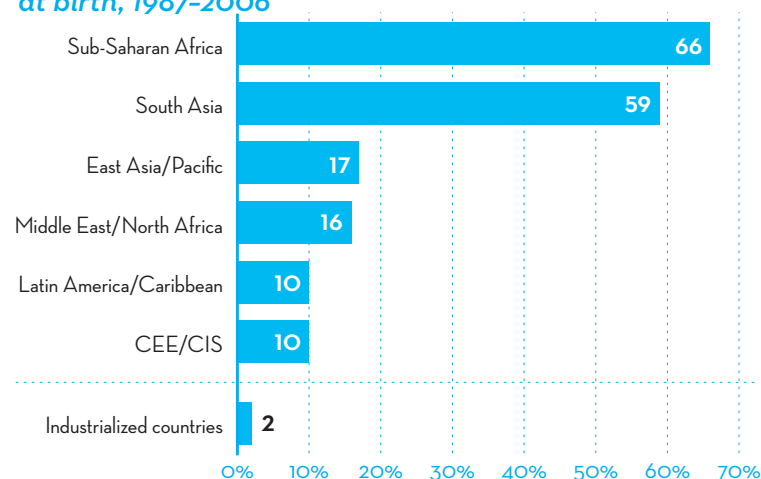
But children have to be welcomed not just into their family or community but also into the state. Registration ensures their recognition before the law, helping to safeguard their rights.⁵⁰ A child without a birth certificate is at a serious disadvantage. A boy or girl whose birth is not fully registered and who does not receive a birth certificate is denied the right to a name and identity. She or he may find it difficult to access other rights and entitlements including health care, education, social assistance and in some instances ownership of property.⁵¹ Birth registration supports the implementation of national policies as well as legislation regulating the minimum age for child labour, child recruitment and child marriage, and it is a valuable basis for tracing efforts when children are separated from their parents. If accused of a crime, an unregistered child risks being prosecuted as an adult.

Many developing countries have achieved universal rates of registration – 100 per cent in Bosnia and Herzegovina, Cuba, Ukraine and Uzbekistan, for example. But some countries have rates of 10 per cent or below. Globally, around 51 million children born in 2006 have not had their birth registered.⁵² As shown in Figure 4-1, sub-Saharan Africa has the highest proportion of children under five who are not registered – two out of three. The largest number of unregistered children, however, is in South Asia: nearly 23 million. Nevertheless some countries have made significant progress, notably Cambodia, the Gambia and Viet Nam.

Why are children being denied their right to birth registration? The fault may lie partly in the process. In some

Figure 4-1

Percentage of children under five who are not registered at birth, 1987-2006



Source: United Nations Children's Fund, *Progress for Children: A World Fit for Children statistical review, Number 6*, UNICEF (forthcoming, 2007).

countries the systems are simply missing; in others they are inadequate or overly complex. Another issue is weak and underfunded administration: Governments frequently underinvest in civil registration systems and offer little support to local registrars.⁵³

A further issue is cost. Parents usually have to pay a fee that, no matter how small, can still be out of reach for families with little cash income. They may also have to bear 'opportunity costs' if travelling to a distant registry office means they have to spend time away from work.

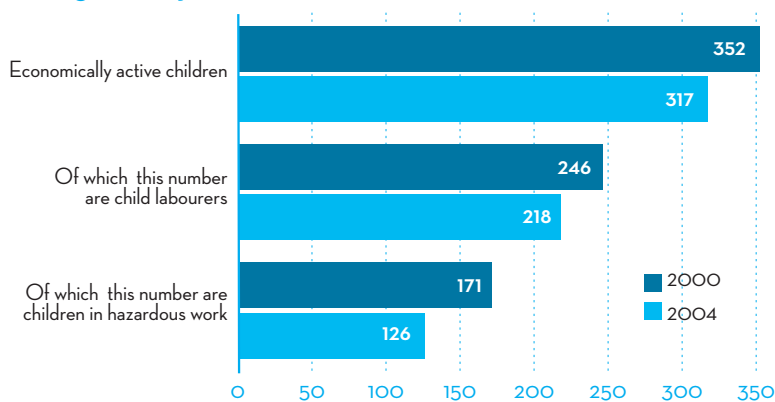
Governments determined to improve their registration systems are taking steps to reduce the barriers – simplifying procedures, reducing costs and making registry offices more accessible. Some, for example, integrate birth registration with other services such as education or immunization. Others are stimulating demand by parents – such as by highlighting the benefits of registration and the value of a birth certificate and by ensuring that children, whether or not their parents are married to each other, are not discriminated against legally or socially.

World Fit for Children country reports on birth registration include:

- **Pakistan** – The government has created a National Committee on the Registration of the Child at Birth and requires local governments to simplify their procedures.
- **Papua New Guinea** – Birth registration rates have increased from 1 to 10 per cent in some provinces and up to 70 per cent in the National Capital District.
- **Swaziland** – The Registrar's office extended registration to children in 55 communities in 2005 and to 100 chiefdoms in 2006. All payments and late fees for certificates were waived. As a result, 43,528 children had been registered by November, including 6,159 children under 18 whose mother and father had died, 17,128 children who had lost one parent, and 11,603 otherwise vulnerable children.

Figure 4-2

Estimated number of children aged 5-17 in different categories of work, 2000 and 2004 (in millions)



Source: International Labour Organization, *The End of Child Labour: Within reach*, ILO, Geneva, 2006, p. 6.

Child labour

Child labour and especially the worst forms of child labour, as defined by International Labour Organization (ILO) Conventions, damage children's health, threaten their education and lead to further exploitation and abuse.

For statistical purposes the International Labour Organization classifies working children in three main categories. The first and broadest comprises those who are 'economically active' but who are not considered as child labourers.⁵⁴ This covers most work except household chores. To be counted as economically active, a child must have worked for at least one hour on any day during a seven-day reference period.

A subset of economically active children is 'child labourers'. These are children who are not just doing a little light work but are working for longer periods, often engaged in tasks that compromise their safety, physical or mental health, or development.

A subset of child labourers is those caught up in the 'worst forms' of child labour, which are addressed in Convention 182. These include all forms of slavery or practices similar to slavery such as the sale and trafficking of children, debt bondage and serfdom, and forced or compulsory labour, including compulsory recruitment into armed groups. This Convention also addresses the exploitation of children for pornography or prostitution, production and trafficking of drugs, or any other activity that harms their health, safety or morals.

In 2004, 317 million children were economically active. Of these, 218 million were considered to be child labourers, of whom 126 million were engaged in the most hazardous types of child labour. Between 2000 and 2004, when the world's total child population rose by 2 per cent, the number of economically active children fell by 10 per cent. The number of child labourers fell by 11 per cent, with a significant decline among those doing hazardous work (see Figure 4-2).

The majority of working children, 69 per cent, are employed in agriculture, with the remainder in services (22 per cent) or industry (9 per cent).⁵⁵ Almost all these children work in the informal sector, where they have little legal or no regulatory protection. Estimates from 2000 suggest that 5.7 million children were in forced or bonded labour, 1.8 million worked in prostitution and pornography, and 1.2 million were victims of trafficking.⁵⁶

Eliminating child labour

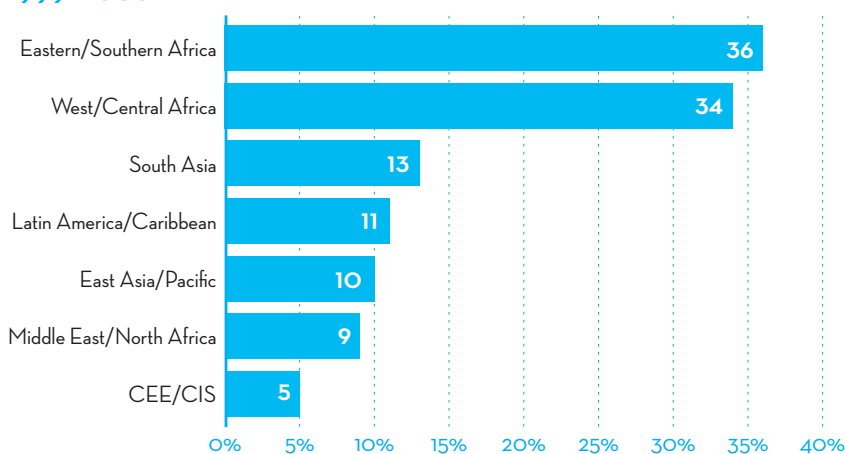
Eliminating child labour requires determined action across a broad front – economic, social and cultural.⁵⁷ It cannot be eliminated solely by government action. A broad and committed coalition is needed – including educational institutions, teachers' organizations, NGOs, mass media and community-based organizations, along with support from trade unions and employers' organizations.

The first task is to ensure effective legislation. This is important but not sufficient. Most countries already prohibit child labour, and a small but growing number are establishing systems to monitor the situation and enforce the laws.

Education

Probably the most effective strategy, however, is to prevent children from working in the first place. For this purpose the most powerful tool is compulsory basic education. For the poorest families, particularly those from socially excluded groups, a

Figure 4-3
Percentage of 5- to 14-year-olds who are child labourers, 1999–2006



Source: United Nations Children's Fund, *Progress for Children: A World Fit for Children* statistical review, Number 6, UNICEF (forthcoming, 2007).

legal requirement for education can be reinforced by incentives in the form of free food or scholarships. Social protection programmes, such as Brazil's Bolsa Escola, provide financial incentives for families to keep their children in school. Poor households should also be offered other sources of economic security. In rural areas, for example, agricultural communities can usually benefit from better credit facilities.

One of the most critical issues for child labour is its relationship with education.⁵⁸ Some children can combine work with school, particularly if they are working at home with flexible hours. Indeed, they may be working to earn the funds needed to pay for school. But in general, starting work usually means leaving school. At the same time, the lack of adequate education facilities can push children into work.⁵⁹

In some countries children already working are returning to school, some with the help of transitional education programmes to ease them into the formal education system. For children who cannot stop working completely, more programmes are being offered that provide more flexible forms of schooling, particularly through non-formal education.

World Fit for Children country reports on child labour include:

- **Bangladesh** – A project titled Basic Education for Hard to Reach Urban Children has proved a valuable way of addressing child labour issues. A second phase, launched in 2005, aims to enrol 200,000 urban working children, at least 60 per cent of them girls, to impart literacy and numeracy competencies equivalent to primary education.
- **Egypt** – Through 14 centres, 620 children who had started working before the age of 14 and their families receive support through social, psychological, cultural, health and education services.
- **Federated States of Micronesia** – The Division of Labour is currently reviewing existing legislation to determine the need for child labour safeguards including minimum hours, wages and working conditions.
- **Moldova** – Around 25 per cent of children aged 5 to 14 are working. With support from the International Programme on the Elimination of Child Labour the government has developed a mechanism to monitor child labour using multidisciplinary teams. In conjunction with the National Centre for Child Abuse Prevention it has developed child labour guides for both parents and children.
- **Morocco** – In 2004 the government introduced major legal reforms to combat child labour. One measure raised the minimum age of employment from 12 to 15 years and prohibited dangerous work for children under 18. The government has also been carrying out a legislative project to prohibit employing girls under 15 for domestic work.
- **Tonga** – The 2003 labour force survey found that children are extensively involved in 'non-economic' household activities including cooking, cleaning, shopping, caring for the sick and for younger children, and minor household repairs. Children aged 10 to 14 years spent an average of 11 hours a week on these and other household activities compared to the adult average of 22 hours a week. With the recent government initiative to prepare the initial report to the

Committee on the Rights of the Child, the children's agenda will be included at all levels of planning, policy, legislation and programmes.

Armed conflict

Children caught up by armed conflict are cruelly deprived of their childhood. Lost to their families and communities, they miss opportunities for education while being exposed to death, serious injury and brutal treatment. They also suffer profound psychosocial distress: To make them fearless, the adults controlling them have forced some of these children to become dependent on drugs, and to ensure that they have 'no way back home' some may have been forced to perpetrate atrocities against their own communities. As a result of rape and sexual assault many young girls become pregnant or acquire sexually transmitted diseases including HIV.

No reliable global or country-level estimates exist on the number of children who are actively or were formerly associated with armed forces. Some place it as high as 250,000. The largest numbers of these children are in sub-Saharan Africa, but children are also fighting in ongoing conflicts in several Asian countries and also in Latin America.

Some of these children fight on the front lines. Others serve as cooks, porters or messengers, or gather intelligence. And while the archetypal 'child soldier' is a small boy with a large gun, in fact more than 30 per cent of the children involved in many conflicts are girls.⁶⁰ They too can be used as fighters or helpers, but girls are also often taken for sexual purposes including forced marriage.

In addition, many other non-combatant children have fallen victim to warfare. In the 1990s more than 2 million children died as a result of armed conflicts, while 6 million more were seriously injured or permanently disabled.⁶¹ Each year an estimated 8,000 to 10,000 children are injured or killed by the scourge of landmines,⁶² and untold numbers have fallen to improvised explosive devices, explosive remnants of war or suicide bombings.

None of this should happen. The Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict prohibits the direct use of children under 18 in hostilities. Nor can these children be subject to compulsory recruitment by governments or recruited by non-government armed groups. As of 26 September 2007, the Optional Protocol had been ratified by 118 states, many since 2002, when it first entered into force. The International Criminal Court, through the Rome Statute, has also established the recruitment of children under 15 as a war crime. The International Labour Organization defines the forced or compulsory recruitment of any person under 18 for use in armed conflict as one of the worst forms of child labour (Convention 182, ratified by 165 states as of September 2007).

The UN Security Council has also played an increasingly important role in condemning the use of children in warfare and in calling for international accountability of those who recruit and use child soldiers. In 2005, for example, Security Council Resolution 1612 requested the establishment of a monitoring and reporting mechanism on six specific child rights violations: killing and maiming, abduction, attacks on schools and hospitals, sexual violence, child recruitment and denial of

humanitarian access. The Security Council has also created a Working Group on Children and Armed Conflict, which is responsible for reviewing the monitoring and reporting system and action plans. In addition the Working Group can recommend to the Council possible measures against parties who have committed violations as well as measures to protect children.

At the 2007 Free Children from War conference in Paris, ministerial delegations of 59 countries endorsed the 'Paris Commitments' with the aim 'to protect children from unlawful recruitment or use by armed forces or armed groups'.

Some governments, with the support of international agencies, NGOs and others, have been making efforts to release children, either during conflicts or as a part of peace processes. In many countries they have developed demobilization, disarmament and reintegration programmes to help children acquire new skills and return to their communities.

World Fit for Children country reports on children associated with armed groups include:

- **Afghanistan** – Between 2004 and 2005, 7,444 boy soldiers aged 13 to 18 were trained on landmine risks and were offered voluntary testing for HIV and other sexually transmitted diseases. They were given the option to return to school, enrol in vocational training programmes or engage in income-earning activities such as sheep or poultry farming.
- **Angola** – From 1999 onwards during the armed conflict, the government created 'child-friendly spaces' to offer children security, care and protection – including psychosocial support and information about mines and HIV. Following the peace accord in 2002, these were continued, benefiting 40,000 children between 2003 and 2004.
- **Burundi** – In 2006 the government completed the demobilization and reintegration of 3,013 former child soldiers. Most of these children completed an 18-month programme that included assistance to go back to school, vocational training, help with finding work, health care, education on HIV and AIDS prevention, and psychosocial assistance. Youth organizations also received assistance.

Child Trafficking

Child trafficking is a very dispersed and complex activity, occurring across borders and within countries. It is often conflated with prostitution, though children are also trafficked for many other purposes, such as child domestic labour. The International Labour Organization estimates that at any given time 2.45 million people are forced labourers who have been trafficked and that 40 to 50 per cent of these are children.⁶³

Measures against trafficking are similar to measures against violence; one element is empowering women and children to help them protect themselves. Education is a vital tool, since educated parents and children are much less likely to be exploited

by traffickers. Vigorous media and advocacy campaigns are also crucial in throwing a spotlight on trafficking as an important public issue, countering the lies of the traffickers.

Most countries have criminal legislation against exploitive child labour, exploitation and sexual violence, and although implementation of these laws is lagging, it is moving in the right direction. Enforcement includes prosecuting criminals as well as improving judicial procedures so that child victims of sexual abuse and exploitation are not revictimized during the judicial process.

At the same time it is vital to address the rising demand for exploitative labour and sexual services that fuel the growth in trafficking. This requires enacting and enforcing the necessary legislation as well as working to change public attitudes and values that allow the perpetrators to continue unpunished – particularly attitudes related to male entitlement that foster the notion that it is acceptable to sexually exploit children and women.⁶⁴

World Fit for Children country reports on child trafficking include:

- **Benin** – The government has introduced new legislation that defines the conditions under which children may travel, and in June 2005 it signed a bilateral agreement with neighbouring Nigeria to combat human trafficking. The government and NGOs have also set up nine centres that have cared for thousands of children and helped them return to their families.
- **Bulgaria** – Three crisis management centres have been established to work with trafficked children. The International Organization for Migration also has six centres working on prevention in schools and other educational establishments. In addition to publicizing the dangers of trafficking these centres also offer support to girls who have been victims.
- **Guinea** – The creation of a policy unit to investigate child prostitution, child trafficking and abuse has significantly improved government capacity to investigate crimes involving children. Since its creation, more cases of abuse and trafficking have been identified and processed in the judicial system. The government has also created a national committee against trafficking, linking responsible officials, the police and justice system, and NGOs to address this problem. At the sub-regional level, Guinea and Mali signed an anti-child trafficking accord in 2005.

There are many instances of concerted multilateral international action. In the Mekong sub-region of South-East Asia in 2004, for example, the governments of Cambodia, China, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam established the Coordinated Mekong Ministerial Initiative Against Trafficking. A number of bilateral and trilateral agreements have been made on trafficking, with the participation of children. These agreements vary in form and scope and in the nature of obligations they impose upon states: Some call for implementing joint activities while others are legally binding instruments. Some of the arrangements refer to broader judicial cooperation while others are limited to child repatriation and reintegration.

Twenty six countries in West Africa have signed a treaty on trafficking, and countries are cooperating in Latin America and the Caribbean. Honduras, along with other

countries in the region, has pledged to create a regional information network to prevent and fight crimes such as trafficking, child prostitution and child sexual abuse.

In CEE/CIS a regional framework for counter-trafficking activities that includes special protection measures and guidelines on protecting child victims has been developed. The Council of Europe Convention on Action against Trafficking in Human Beings also provides a regional legal framework, though it has not yet entered into force.

Sexual exploitation

The dividing lines between commercial and non-commercial exploitation are hard to draw. Their manifestations range from sex tourism and child pornography to looser arrangements through which adults employ children for a variety of services, some sexual and some not, in exchange for food, clothing, shelter or some kind of protection. But at its heart this is an exploitive relationship in which older people use their superior power, physical or financial, to ensure that children comply with their wishes.

An estimated 1.8 million children were ensnared in the commercial sex trade in 2000. In South-East Asia alone, 1 million children are thought to be involved. This is the 'formal' end of the spectrum, whereby sex is traded as a commodity – bought and sold through brothels or bars or in the form of pornographic images. Many children enter this industry under coercion, though others may be attracted by the expectation of high incomes. But much of the child sex trade is more informal, arranged on the beaches of Asia or the Caribbean.⁶⁵

Progress has been made in addressing the tourism sector within the framework of the Code of Conduct for the Protection of Children from Sexual Exploitation in Travel and Tourism.

World Fit for Children country reports on activities to combat the sexual exploitation of children include:

- **Italy** – In 2006 the government enacted a new law covering 'sexual acts with children in exchange for money or other economic gain'. The same law also addresses sex tourism and pornographic images of children.
- **Monaco** – Action Innocence Monaco is an association providing resources for the police to monitor child pornography. It also advises schoolchildren on safe use of the Internet by distributing materials such as mouse pads with 'Ten tips for safe surfing'.
- **Netherlands** – The government is taking firm action against Internet pornography, including the use of webcams, as well as against child sex tourism. Netherlands law is applicable even if the abuse is not an offence in the country in which it is committed. Suspects arriving at Schiphol Airport from high-risk countries can now be detained and questioned and if necessary arrested and prosecuted in the Netherlands.

- **Philippines** – The Department of Tourism, in partnership with Child Wise Australia, has adopted the Child Wise Tourism Campaign, which encourages hotels, resorts, tour operators and others to report suspected cases of child sex tourism. It also provides training on how and where to report cases.

Violence against children

Violence against children was the subject of a global study by an independent expert submitted to the UN General Assembly in August 2006.⁶⁶ The study looked at violence in the home and family, in schools and other education settings, in care and justice systems, at work and in the community. It pointed out that much of this violence remains hidden. Children are often afraid to identify perpetrators – parents, schoolmates, teachers or employers – since they also usually depend on them. But as the report points out, violence against children is extensive and can take many forms, including:

- **Homicide** – In 2002 almost 53,000 children worldwide died as a result of homicide. The rates are twice as high in low-income countries as in high-income countries and they are highest among older adolescent boys.
- **Armed violence** – With an estimated 640 million small arms and light weapons in circulation, abuse by adults or fights between children often lead to severe injuries and death.
- **Corporal punishment** – The vast majority of children suffer physical punishment in their homes. One third or more experience severe punishment with implements. Boys are at greater risk than girls.
- **Bullying** – The Global School-based Health Survey found that 20 to 65 per cent of school-aged children in developing countries had been verbally or physically bullied. Bullying is also frequent in industrialized countries.
- **Sexual violence** – The World Health Organization estimates that 150 million girls and 73 million boys experienced forced sexual intercourse or other forms of sexual violence during 2002.

Among the most vulnerable are children with disabilities. Compared with their peers, these children are at greater risk of violence, abuse, exploitation and neglect. This can be due to misperceptions as well as to their increased vulnerability due to their specific physical, sensory or intellectual difference. They may have difficulty in defending themselves or in reporting abuse, and even when they are able to make a report, their accounts are often dismissed or not believed. Also at greater risk are children from ethnic minorities and other marginalized groups, children living on the street, those in conflict with the law and refugee and other displaced children.

Through the Convention on the Rights of the Child and other instruments, almost all governments have committed themselves to combating violence against children. But often they fail to translate international commitments into national action. And programmes to combat violence tend to be fragmented and lacking in resources. They

also tend to target only sexual or physical violence and fail to address psychological abuse.

The Report of the Independent Expert for the United Nations study on violence against children made a series of detailed recommendations. These cover a wide range of issues to prevent violence, urging governments to establish national plans and strengthen legislation while creating child-friendly reporting systems and effective services for recovery and social reintegration (*see Box 4-1*). An NGO Advisory Council has been established to support follow-up to the study.

World Fit for Children country reports on actions to combat violence against children include:

- **Belgium** – A campaign concerning sexual violence has been running since 2001. It aims to dispel myths and explain to young people where they can get advice and support and how to recognize the signs of physical, psychological or sexual violence in their peers.
- **Croatia** – The government has produced a comprehensive plan, ‘Seven steps to a safe school’, and provides the necessary training to teachers and others. So far 115 schools have successfully taken all the steps and been awarded the title School Free of Violence.
- **Guyana** – The government has carried out a sensitization workshop on ‘Discipline without Beating’, highlighting the effects of physical punishment as well as humiliation on children and the need to abolish corporal punishment.
- **Norway** – In September 2002, a Manifesto against Bullying was signed by the government Ombudsman for Children, the Association of Local and Regional Authorities, the Union of Education and the National Parents’ Committee for Primary and Lower Secondary Education. The parties committed themselves to promoting zero tolerance of bullying and to promoting commitment and motivation in respect of anti-bullying efforts in day-care centres, schools and homes as well as in connection with organized leisure activities. The Manifesto has been renewed for the period 2006–2008.
- **Paraguay** – The National Secretariat for Childhood and Adolescence has been working to create a system to protect children against abuse, exploitation and violence. Its telephone helpline received 1,700 calls concerning maltreatment of children in 2006.

Children in conflict with the law

Although the statistics are incomplete, it is thought that around the world at least 1 million children are in jail. And most detained children have yet to be convicted or even brought to trial. Children can be detained even without having committed a criminal offence: In some cases, children are put in jail because they are sleeping on the street, have run away from home, or are travelling without their identity papers.

How much information should countries be able to report regarding children in conflict with the law? The consensus is increasing that they should be able to provide information on the numbers of children in detention, the proportion who have yet to stand trial and the amount of time children spend behind bars. Analysing this data by type of offence and the children's characteristics helps determine whether juvenile justice is being administered appropriately.

The Convention on the Rights of the Child stipulates that children in conflict with the law have the right to treatment that promotes their sense of dignity and worth, takes into account their age and aims to reintegrate them into society. It also says that detaining children in a closed facility should be a last resort and for the shortest possible time. For offences committed by persons under age 18, the Convention also prohibits the death penalty or sentences of life imprisonment.

The first priority is to strengthen families and communities to reduce the likelihood that children will commit offences. Community-based systems of child protection involving social workers and others can be very effective at reducing child offences. But for those children who do commit crimes the aim should be to encourage rehabilitation – helping the child acknowledge responsibility for his or her actions and understand their impact on the victims. In some countries authorities organize mediation conferences bringing the victim together with the offender and his or her family, along with social workers and law enforcement officials. The most developed approach is a careful screening process to keep children out of court.

World Fit for Children country reports on children in conflict with the law include:

- **Afghanistan** – In 2005 Afghanistan's new Juvenile Code raised the minimum age of criminal responsibility from 7 to 12 years old. It requires children to be separated from adult detainees and provincial capitals to have official juvenile courts. However, many of its provisions have yet to be enacted.
- **Armenia** – The Ministry of Justice and the Association of Judges have organized juvenile justice training for judges and conducted seminars for prison wardens on the psychological, legal and educational aspects of dealing with imprisoned minors.
- **Central African Republic** – The government has created tribunals for children in Bangui and eight other prefectures and plans to extend them throughout the country.
- **Montenegro** – Since 2004, the Ministry of Justice has been promoting the juvenile justice system and rehabilitation and re-socialization of minor offenders. The Ministry has also organized many education programmes for representatives of the judiciary, police, social workers and the education system and has distributed publications and bulletins on the rights of children in conflict with the law.
- **Suriname** – In 2004 the NGO Lawyers Without Borders Netherlands engaged more than 20 lawyers to carry out a project to strengthen the legal status of juvenile suspects. Now almost all juvenile offenders in pre-trial detention receive immediate legal aid within 24 hours.

Children in conflict with the law have the right to treatment that promotes their sense of dignity and worth.

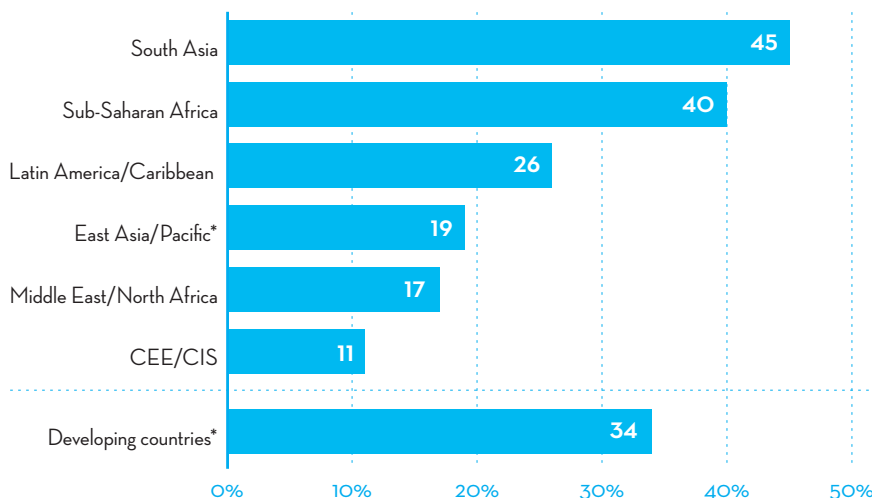
Child marriage

Marriage should represent a milestone in adult life. Too often, however, marriage is imposed on children. Though it is a problem for both sexes, it primarily affects girls. Child marriage has physical implications for young girls, notably premature pregnancy and childbirth, which entail vastly increased risks of maternal and neonatal mortality. Pregnancy-related deaths are the leading cause of mortality for 15- to 19-year-old girls worldwide, whether they are married or not – and those under 15 are five times more likely to die than women in their twenties. Their children are also less likely to survive: If a mother is under 18, her baby's chance of dying in the first year of life is 60 per cent higher than that of a baby born to a mother older than 19.

A child bride will also be severely disadvantaged by the age gap with her husband or partner and the resulting unbalanced household power relationship. This can lead to domestic violence, bonded labour, lack of freedom and decreased opportunity for education. Child marriage has been imposed on more than 60 million girls worldwide. Across the developing world, according to data collected over the period 1987–2006, 34 per cent of women aged 20 to 24 were married or in union before the age of 18. The practice is most extensive in South Asia and sub-Saharan Africa (see Figure 4-4).

The World Fit for Children goal is to end early and forced marriage by 2010. At its 51st session in 2007, the UN Commission on the Status of Women urged states to enact and strictly enforce laws concerning the minimum age of consent and ensure that marriage is entered only with free and full consent of the intending spouses. At present, however, many countries are far from achieving this.

Figure 4-4
Percentage of women aged 20–24 who were married or in union before age 18, 1987–2006



* Excluding China

Source: United Nations Children's Fund, *Progress for Children: A World Fit for Children* statistical review, Number 6, UNICEF (forthcoming, 2007).

How can child marriages be prevented? The first requirement is to raise awareness of the extent of child marriage and the human rights abuse it constitutes. Reducing child marriage will therefore also require sustained advocacy. In the past this would have been severely hampered by taboos on discussing sexual relations. But in recent years this reticence has been eroded somewhat as a result of changing lifestyles and the HIV epidemic. Indeed, many adolescents are demanding the right to know about such intimate matters.

Another imperative is to ensure appropriate legislation. Most countries have a minimum age for marriage, generally 18, which is often the same for males and females (if the ages are different, it is almost always lower for

girls). And many countries have applied reservations to Article 16 of the Convention on the Elimination of All Forms of Discrimination against Women, which requires them to 'eliminate discrimination against women in all matters relating to marriage and family relations'. Even when legally prohibited, however, the practice is widely condoned by customary practice and religious laws.

Another important step is to support girls' right to education. On average, women with seven or more years of education marry at age 20 or above.⁶⁷ In addition, offering adolescent girls greater opportunities for training and employment can enhance their status and thereby decrease the likelihood of child marriage.

World Fit for Children country reports on efforts to eliminate child marriage include:

- **Gambia** – Three NGOs (the Foundation for Research on Women, the Gambia Committee on Traditional Practices and the Association for the Promotion of Girls and Women's Advancement) are tackling the prevailing cultural attitudes and preferences that encourage early marriage and motherhood. The 1999–2009 National Women's Policy is also raising awareness on forced adolescent marriages, emphasizing their harmful effects on children.
- **Sierra Leone** – Child marriage is common, with 26 per cent of girls married before age 15 and 62 per cent before age 18. The government is now drafting a Child Rights Bill that would make marriage below 18 illegal and bring Sierra Leone's laws in line with the Convention on the Rights of the Child.

Female genital mutilation/cutting

An estimated 70 million women and girls aged 15 to 49 in 27 countries in Africa and the Middle East have been subjected to female genital mutilation or cutting. Aside from the sustained psychological distress it causes, FGM/C has long-term health consequences, including adverse impact on obstetric outcomes.⁶⁸ In extreme cases, FGM/C can result in death.

The World Fit for Children goal is to end these practices by 2010. On present trends this goal will be missed, but if efforts were stepped up many countries could stop this abuse of women's rights by 2015, and sub-Saharan Africa and Egypt could do so in one generation.

In every society that practises female genital mutilation/cutting it is deeply entrenched in social, economic and political structures and is a manifestation of persistent gender inequality – a factor that may not even be recognized by those who support and perpetuate it.

Understanding the procedure as a social convention provides insight as to why some women who have themselves been cut and suffered the health consequences nevertheless favour its continuation. They resist initiatives to end it not because they are unaware of its harmful aspects but because its abandonment is perceived to entail a loss of status and protection.⁶⁹ This also helps to explain why individual families expressing a desire to abandon the practice nonetheless submit their daughters to

it. The convention can only be changed if a significant number of families within a community make a collective and coordinated choice to abandon the practice, so that no single girl or family is disadvantaged by the decision.

World Fit for Children country reports on efforts to address female genital mutilation/cutting include:

- **Austria** – The government has conducted a survey on the practice and has established a European Union-wide Network Against Harmful Traditions. Its purpose is to exchange information, share experiences and promote good practices at the community level as well as to prepare possible legal measures for the European Union and responsible member states.
- **Djibouti** – Almost all Djiboutian females aged 15 to 49 have been subjected to the practice. In response the government is conducting campaigns to raise awareness of the dangers and has prohibited the practice through the penal code.
- **Niger** – The Association of Traditional Chiefs has become a major force for positive change in a number of child protection issues, including child marriage and female genital mutilation/cutting.

Children without parental care

Millions of children around the world are growing up without one or both of their parents due to the impact of poverty, disability, HIV and AIDS, and such crises as natural disasters and armed conflict. Many wind up in institutional care.

Children without parental care find themselves at a higher risk of discrimination, inadequate care, abuse and exploitation. They are often placed unnecessarily and for too long in institutions, where they receive less of the stimulation and individual attention needed to grow to their full potential. They may be deprived of adequate care and opportunities for emotional and social development, including the acquisition of life skills and vocational training. They can also be vulnerable to exploitation, sexual abuse and physical violence.

In CEE/CIS, 1.5 million children live in public care, and in Europe and Central Asia, over 1 million children live in residential institutions.⁷⁰ Not all are orphans. Many children end up in institutional care, despite having one or both parents, because of poverty or family breakdown. Others are orphans. Figure 4-5 shows the total number of children in sub-Saharan Africa, Asia, and Latin America and the Caribbean who have been orphaned by any cause (note that this includes children who may still be in the care of one parent), including estimated numbers up to 2010. In 2005, the total number of orphans in all three regions was around 133 million.⁷¹ The largest numbers are in Asia, which has two thirds of the world's children, although here, as in Latin America and the Caribbean, the numbers are falling. In sub-Saharan Africa, on the other hand, the numbers are rising, which is due almost entirely to the impact of AIDS.

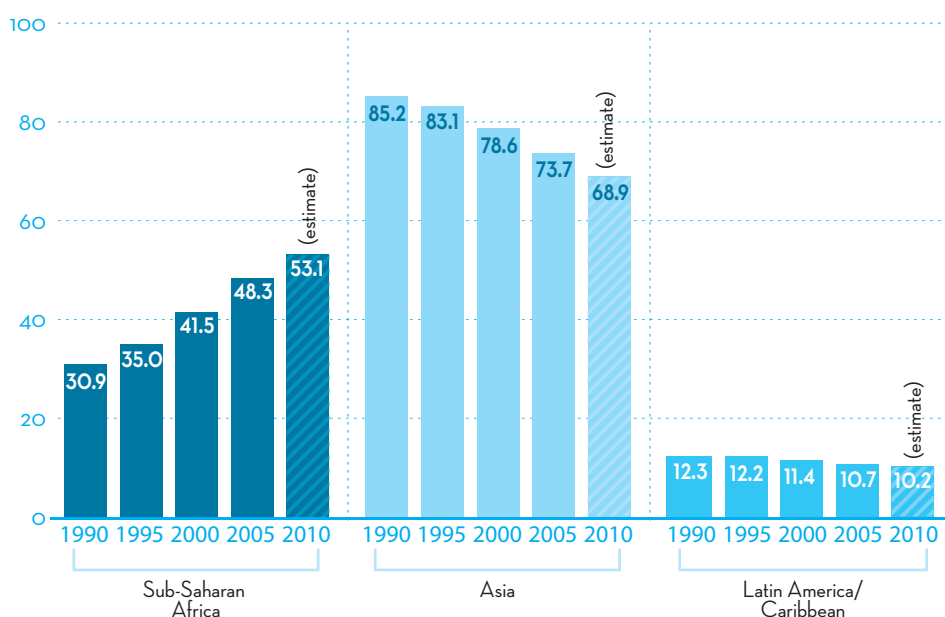
The first priority is to ensure that as many children as possible can continue to live at home. Efforts to reduce poverty, prevent violence and provide effective child welfare services help keep families together – as can accessible day care, parenting education, home support for children with disabilities and measures to strengthen family capacity to provide a safe and stable home environment. Governments also need to ensure that legislation protects children from unnecessary separation from their families.

Many options are available for children who can no longer live at home. Countries and communities have developed their own ways of caring for children who are not with their parents. Some are taken care of, informally or through fostering, by members of the extended family or by friends or neighbours. In some circumstances, such as when children are rescued from trafficking or seeking asylum, they may be temporarily looked after in ‘safe houses’. As a last resort, a few children may need to be cared for in institutions – though this is typically very expensive, and many such institutions are underfunded.

However, fewer than 10 per cent of children who have been orphaned or made vulnerable receive public support or services within the community. Nevertheless more countries in sub-Saharan Africa are providing some social protection. In Uganda, for example, 23 per cent of households receive some form of external support for the care of orphans and vulnerable children. Kenya, Malawi and Mozambique have piloted cash-transfer programmes in some of the poorest areas for families whose children are especially vulnerable to leaving home or dropping out of school.

Figure 4-5

Number of orphans aged 0–17, 1990–2010 (in millions)



Source: United Nations Children’s Fund, Joint United Nations Programme on HIV/AIDS and U.S. President’s Emergency Plan for AIDS Relief, *Africa’s Orphaned and Vulnerable Generations: Children affected by AIDS*, UNICEF, New York, 2006, p. 3.

World Fit for Children country reports on children without parental care include:

- **Cyprus** – The government provides home help services to prevent children’s removal from their homes and to meet the needs of multi-problem families, aiding them to develop necessary skills.
- **Finland** – Starting at age 12 children have the right to speak independently alongside their guardian in matters concerning emergency care orders and access to their parents.

- **Namibia** – Extended families and communities are encouraged to assume care of orphans and other vulnerable children through the Child Welfare Grants programme. Between 2004 and 2006 the number of orphaned and vulnerable children and families receiving grants increased from 7,000 to 55,000.
- **Serbia** – The government's National Investment Plan has been investing in various types of social care, including building family-type accommodation for children without parental care after they turn 18 and leave foster families.
- **Turkey** – Despite increased numbers of children living without parental care, the Social Services and Child Protection Agency has been reducing the number of children in institutional care, giving priority to fostering, adoption and support for families. More services are also being provided in community and day-care centres.

Children with disabilities

Children with disabilities have the same rights as all other children. In practice, however, these children experience profound and widespread violations of their rights – in health, education, family life and participation. Despite obligations to address their rights in the Convention on the Rights of the Child, many governments have made insufficient progress.

In December 2006 the UN General Assembly adopted the Convention on the Rights of Persons with Disabilities. This Convention represents a significant advance in recognizing the rights of people with disabilities, including children. It reinforces and complements the Convention on the Rights of the Child by introducing a range of explicit measures to strengthen protection of rights for children with disabilities, including the right to participation, information, access to justice, family life, registration at birth and freedom from violence. Countries signing and ratifying the Convention on the Rights of Persons with Disabilities agree to ensure that these children are not separated from their families against their will, except when necessary for the best interests of the child. Should the immediate family be unable to care for a child with disabilities, every effort should be made to provide alternative care within the wider family or, failing that, within the community in a family setting.

Since the convention's opening for signature on 30 March 2007, 110 Member States and the European Community have signed it, and five countries – Croatia, Cuba, Hungary, Jamaica and Panama – have ratified it. This convention needs to be ratified by 15 more States Parties before entering into force.

World Fit for Children country reports on children with disabilities include:

- **Netherlands** – Pupils with a serious disability, illness or disorder can be registered for Special Education, but if parents wish they may enrol their disabled child at a mainstream school. The pupil will then be eligible for a personal budget that the school will use to provide appropriate tuition. A total of 60,000 pupils are enrolled at schools for special education and approximately 20,000 have been allocated personal budgets.

What we can do for children

Millions of children continue to suffer from abuse and exploitation, partly the result of a lack of attention and political will. Compared with their efforts in health and education, governments have generally devoted less attention to protection issues, for which there are no Millennium Development Goal targets. They often approach child protection as an issue of welfare rather than of human rights and development.

Instead governments need to adopt a more holistic approach. The threats to children can take many forms, so the response needs to be equally comprehensive, with the overall aim of creating a 'protective environment'. Rather than reacting to child exploitation with ad hoc interventions, the protective environment assumes that all children have a right to protection.

The key elements of this environment include securing government commitment; creating and enforcing the necessary legislation; changing attitudes, customs, behaviours and practices; promoting open discussion; enhancing children's life skills, knowledge and participation; building the capacities of families and communities; providing essential services; and ensuring monitoring, reporting and oversight.

Box 4-1

Recommendations of the UN study on violence against children

Paulo Sérgio Pinheiro is the independent expert appointed by the United Nations Secretary-General in August 2006 to perform a global study of violence against children. He presented a report to the General Assembly that includes recommendations for preventing violence and responding to this issue. The report also included a series of overarching recommendations, which can be summarized as follows:

1. Strengthen national and local commitment and action
2. Prohibit all violence against children
3. Prioritize prevention
4. Promote non-violent values and awareness-raising
5. Enhance the capacity of all who work with and for children
6. Provide recovery and social reintegration services
7. Ensure participation of children
8. Create accessible and child-friendly reporting systems and services
9. Ensure accountability and end impunity
10. Address the gender dimension of violence against children
11. Develop and implement systematic national data collection and research
12. Strengthen international commitment.

Child protection balance sheet

Goals	Gains	Unfinished business
Birth registration WFFC – Take measures to ensure the registration of every child at or shortly after birth and fulfil his or her right to acquire a name and nationality	A number of countries have made progress by integrating child registration into mother and child health services.	Around 51 million births have not been registered. One out of three developing countries has birth registration rates below 50%. Birth registration is neither free nor universal; direct and indirect costs persist and some groups are excluded (ethnic minorities, children born outside wedlock, internally displaced persons).
Armed conflict WFFC – Protect children from the impact of armed conflict and ensure compliance with international humanitarian law and human rights law	Today fewer children fight in official government forces. The Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict was ratified by 118 states as of 26 September 2007.	In 2006 at least 250,000 children were estimated to be serving as child soldiers. Each year around 8,000–10,000 children are injured or killed by landmines or unexploded ordnance. Demobilization, disarmament and reintegration programmes often remain poorly adapted to children, in particular girls.
Child trafficking and sexual exploitation of children WFFC – Identify and address the underlying factors WFFC – Ensure the safety, protection and security of victims and provide assistance and services	Many more governments have been taking national action and signing international agreements to combat trafficking and protect victims. The private sector is increasingly engaged in combating commercial sexual exploitation in tourism via subscription to the Code of Conduct for Protection of Children from Commercial Sexual Exploitation in Tourism and Travel.	Around 1.8 million children are still ensnared in the commercial sex trade, and millions more have experienced forced intercourse or other forms of sexual violence. Child victims of sexual exploitation are still being re-victimized by judicial procedures – and exploiters are not going to jail.
Child labour WFFC – Take immediate and effective measures to eliminate the worst forms of child labour and implement strategies for the elimination of child work that is contrary to international standards	Favourable national policies on child labour, increased access to education and private sector engagement are helping to reduce child labour. The greatest declines are among those engaged in the ‘worst forms’ of child labour. As of 26 September 2007, 165 countries had ratified ILO Convention 182.	There are still an estimated 218 million child labourers, of whom 126 million are engaged in the worst forms of child labour. The largest proportions of children working are found in sub-Saharan Africa. Many countries have not yet produced their national listings – required under ILO Convention 182 – of the worst forms of child labour.
Children in conflict with the law WFFC – Promote the establishment of prevention, support and caring services as well as justice systems specifically applicable to children, taking into account the principles of restorative justice and fully safeguarding children’s rights. Provide specially trained staff who promote children’s reintegration into society	A number of countries are now adapting their justice systems and seeking alternatives to the detention of children, and juvenile justice indicators have been developed.	Few offences committed by children justify detention, especially given that most children are eventually acquitted.

Goals	Gains	Unfinished business
Children without parental care WFFC – Adopt and implement policies for the prevention, protection ... and reintegration ... of children at risk, including orphans, abandoned children ...	Governments in some regions, particularly in CEE/CIS, have made headway in reforming child-care systems to prevent institutionalization and developing community-based alternative care.	Foster care and other forms of family-based alternative care are not sufficiently developed and available relative to the large number of children living in institutions.
Violence against children WFFC – Adopt and enforce laws, and improve the implementation of policies and programmes to protect children from all forms of violence and abuse	The UN Study on Violence against Children has exposed the appalling scale and impact of all forms of violence against children. Many governments have strengthened their commitment to prevent and respond to violence against children by banning corporal punishment and improving legislation and judicial procedures for child victims of sexual violence.	Millions of children still suffer from violence at home, in the community, while working or in institutional care. National commitment should translate into effective services – justice, health and education – to prevent and respond to violence, including promotion of social change.
Female genital mutilation/cutting WFFC – End female genital mutilation by 2010	A large number of communities have abandoned female genital mutilation/cutting. Many countries have adopted legislation banning it. Religious leaders have issued statements condemning this practice.	The goal to end female genital mutilation/cutting by 2010 will be missed, but accelerating actions to address this issue could lead to abandonment of the practice in many countries by 2015 and end it in one generation in sub-Saharan Africa and Egypt. The practice remains deeply entrenched in many societies.
Child marriage WFFC – End early and forced marriage by 2010	Child marriage is becoming less common overall. Some countries have adopted legislation setting a minimum marriage age of 18.	Across the developing world more than one third of women aged 20 to 24 have been married or cohabiting since before the age of 18. The practice is most extensive in South Asia and sub-Saharan Africa, especially in rural areas. Adoption of national legislation that sets a minimum marriage age is pending in many countries.
Children with disabilities WFFC – Adopt special measures to eliminate discrimination against children on the basis of ... disability ... and ensure their equal access to education, health and basic social services	More than 100 countries had signed the Convention on the Rights of Persons with Disabilities as of 26 September 2007. It sets forth the right of children with disabilities to family life.	Children with disabilities are placed in institutional care at significantly higher rates than other children. Additionally, they are particularly vulnerable to violence.

CHAPTER

5



Combating HIV and AIDS

HIV is primarily thought of as a disease affecting adults. It is true that the majority of the 39.5 million people living with HIV in 2006 were 15 to 49 years old, as were the majority of the 2.9 million people who died. However, among those affected by HIV and AIDS are millions of children under the age of 15. In 2006, of the 2.3 million children under 15 who were living with HIV, 530,000 were newly infected.⁷²

Mother-to-child transmission

Many young people acquire HIV in the same ways as adults – engaging in sexual activity for example, or through injecting drugs. But the majority of children under 15 who are HIV infected acquired the virus during their mother’s pregnancy, at birth or during breast-feeding. The greatest number of young children infected with HIV is in sub-Saharan Africa. In one of the worst-affected areas of Namibia, 43 per cent of pregnant women are HIV infected. In the absence of any intervention, between 20 and 45 per cent of infants born to HIV-infected women will contract the virus. Without early diagnosis and treatment, the prospects for these infants are bleak: Half will die before they reach their second birthday.⁷³

In 2006, an estimated 380,000 children under 15 died of AIDS-related illnesses, accounting for one in every eight AIDS-related deaths. This need not have happened. Most high-income countries have significantly reduced transmission rates, to 2 per cent or lower, by providing HIV-infected pregnant women with antiretroviral drugs, breastmilk substitutes for their infants, and other interventions.

Preventing transmission

The primary task is to prevent women and men from becoming HIV infected. It is also important to ensure that all adolescent girls and women between the ages of 10 and 49, as well as boys and men, have appropriate health care services. But successfully preventing mother-to-child transmission also depends on four other critical interventions:

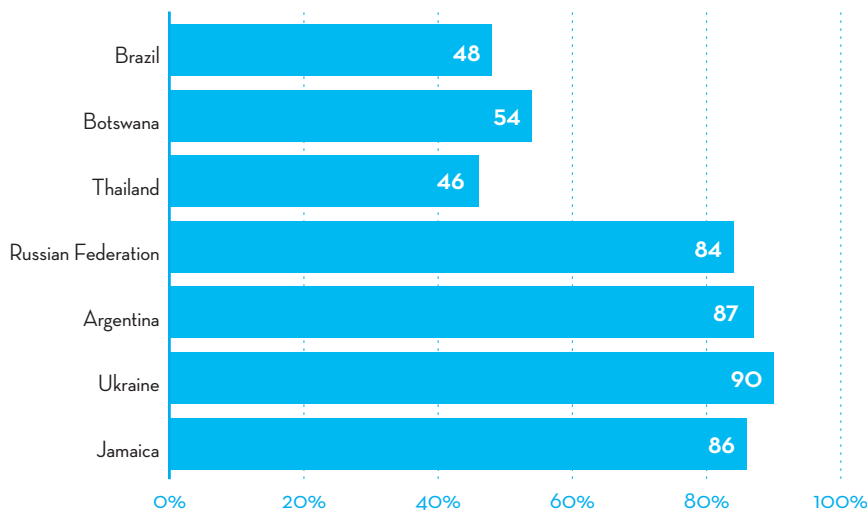
- **Facilities for testing and counselling** – Providing access and services for HIV testing and counselling in routine antenatal care settings so that women can be tested and provided with appropriate interventions if they are found to be infected.
- **Access to antiretroviral therapy** – The UN 2001 Special Session on HIV/AIDS established a target of 80 per cent coverage of access to antiretroviral treatment for HIV-infected pregnant women by 2010. A woman with advanced HIV infection, according to recent WHO guidelines, should receive antiretroviral treatment for her own health and also to reduce considerably the risk of transmitting the infection to the unborn child. If the pregnant woman is HIV infected but not yet at the stage of needing antiretroviral therapy, she should nevertheless take a short course during pregnancy to protect her child. The baby should also receive a course of antiretroviral treatment for the first few days or weeks of life.

- **Safe delivery practices** – The aim should be to minimize the child’s contact with the mother’s blood and secretions. The mother should therefore give birth in a clean environment, with the support of a trained birth attendant. One option for a safer delivery is a planned elective Caesarean section.
- **Breast milk substitutes** – Data from different studies indicate that breast-feeding for up to two years may be responsible for one third to one half of HIV infections in infants and young children in African countries. But recent evidence suggests that exclusive breastfeeding poses less risk for mother-to-child transmission than when breast milk is given with other foods. Exclusive breastfeeding is therefore recommended for HIV-infected women for the first six months of the child’s life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants.

Figure 5-1

Percentage of HIV-infected pregnant women receiving antiretroviral prophylaxis for PMTCT, 2005

Countries with at least 40 per cent coverage



Source: United Nations Children’s Fund, *Children and AIDS: A stocktaking report*, UNICEF, Joint United Nations Programme on HIV/AIDS and World Health Organization, New York, 2007, pp. 29–31.

New mothers who are HIV infected should receive counselling that includes information about both the risks and benefits of various infant feeding options based on local assessments as well as guidance in selecting the most suitable option for their situation. They should also have access to follow-up care and support, including family planning and nutritional support.

More than 100 countries have established programmes to prevent mother-to-child transmission (PMTCT), though few developing countries have yet scaled up these programmes to meet the need. Nevertheless, awareness of the issue has increased greatly. In 2005, seven countries provided antiretroviral prophylaxis for PMTCT to more than 40 per cent of HIV-infected women.

Global efforts were reviewed in 2005 at a High Level Global Partners PMTCT Forum, which resulted in a call to action to support measures needed to eliminate HIV in infants and young children.

New momentum was evident in regional follow-up meetings held in Kenya and Senegal in 2006. Health ministers of the East, Central and South African Health Community Secretariat have now identified key programme areas and those in which they urgently need technical support.

World Fit for children reports on reducing mother-to-child transmission include:

- **Botswana** – In 2006, evidence from a PMTCT programme showed that out of 9,977 infants tested for HIV infection, 334 were found to be HIV positive. Since Botswana introduced an antiretroviral treatment programme in 2002, the number of people enrolling has increased enormously.

- **Cuba** – In 2005, all children born to HIV-infected women received antiretroviral treatment. They also received artificial feeding according to international standards and will continue to be monitored until they are 18 months old.
- **Uganda** – The government has continued to open PMTCT centres to reduce transmission of HIV to children. Between 2001/02 and 2004/05, the number of sites grew from 11 to 224.
- **Uzbekistan** – The government has adopted WHO protocols, and with the help of external funding is implementing a programme that provides all HIV-infected pregnant women and their newborn children with antiretroviral drugs.

Providing paediatric treatment

For children, the course of HIV is particularly aggressive. The virus multiplies rapidly, destroying their defences against infection and opening the way for pneumonia and other opportunistic infections. Without adequate care and treatment up to half of these children will die before their second birthday. However, it is difficult to diagnose HIV in children under 18 months, and there is an urgent need for research and development to enable production of inexpensive and simple diagnostic equipment.

At present, the best way to protect children against opportunistic infections is to provide all children born to HIV-infected mothers with the broad-spectrum antibiotic cotrimoxazole from six weeks of age. This has been shown to reduce mortality in children living with HIV and AIDS by more than 40 per cent, primarily by reducing the risk of pneumonia.⁷⁴ Cotrimoxazole can also postpone the need for antiretroviral treatment. Priced as low as three cents a day, cotrimoxazole is a low-cost intervention that could make a real difference to children living with HIV and AIDS, and in many countries it is now on the essential drugs list. Estimates put the number of children in need of this drug at about 4 million in 2005 – but only around 4 per cent of these were being treated.⁷⁵

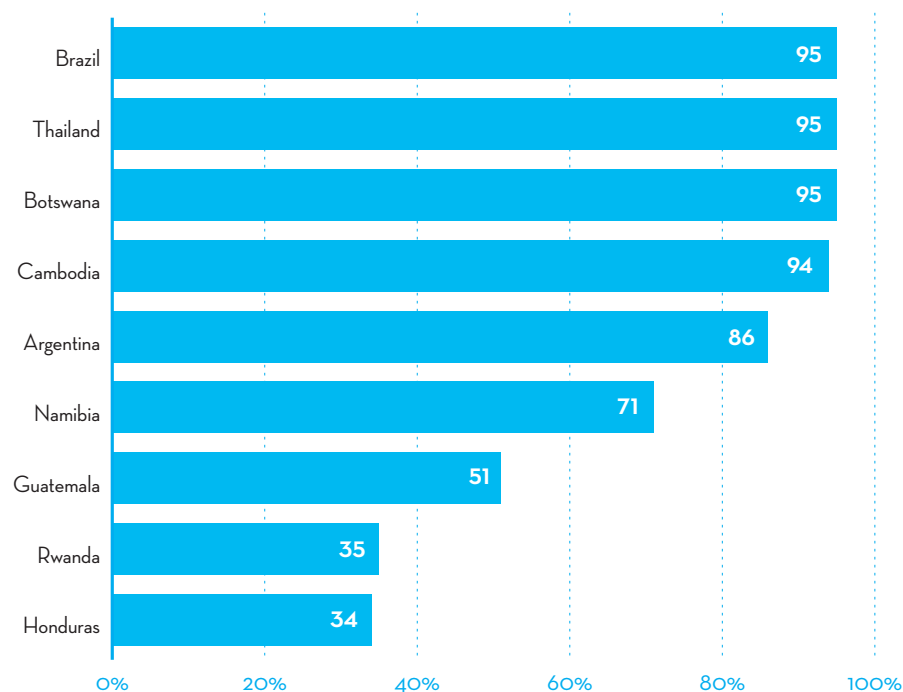
Moreover, young children need appropriate drug regimens formulated for their use. Simply reducing the adult dose can lead to under-treatment, which may encourage drug resistance, or to over-treatment, which can lead to side effects because of the drugs' toxicity. At present, appropriate formulations for use in children are quite limited and are typically more expensive than adult regimens – though since 2004 the prices of generic formulations have fallen considerably. They are often unpleasant-tasting syrups that children may not wish to take regularly, and some have to be stored in a refrigerator, which many poor households lack. Manufacturers are now testing mini-pills suitable for young children, but it will take some time before these are licensed for use.

The number of children with access to treatment has increased significantly over the last few years, notably in Africa, but from a very low base, and overall coverage remains low. Of the 2.3 million children under 15 living with HIV in 2006, about 780,000 needed antiretroviral therapy, but only 15 per cent were actually receiving it – significantly lower than the treatment rate for adults.⁷⁶

Figure 5-2

Percentage of children under 15 in need of antiretroviral treatment who are receiving it, 2006

Low- and middle-income countries with at least 30 per cent coverage and at least 1,000 children in need



Source: World Health Organization, Joint United Nations Programme on HIV/AIDS and United Nations Children's Fund, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector - Progress report*, WHO, Geneva, 2007, p. 18.

In 2005, UNAIDS and UNICEF issued a global call to action challenging the world to ensure that antiretroviral therapy and prophylaxis with cotrimoxazole reach 80 per cent of affected children by 2010.

At the international level a number of new partnerships have been formed that can enhance the global response. One of the most significant is the UNAIDS Inter-Agency Task Team on preventing mother-to-child transmission and paediatric AIDS. A major breakthrough for HIV-infected mothers and children was a 2006 announcement by the International Drug Purchase Facility UNITAID, a sustainable financing mechanism. It pledged to support expansion of PMTCT programmes by providing more effective antiretroviral regimens; diagnostic reagents; cotrimoxazole and paediatric formulations for treating children with HIV.

Among donor governments, the US President's Emergency Plan for AIDS Relief reported that it had prevented HIV infections in about 101,500 infants as of September 2006. Other agencies, including Médecins Sans Frontières, Baylor International Pediatric AIDS Initiative, Columbia University and the

Elizabeth Glaser Pediatric AIDS Foundation, are also helping national governments to scale up paediatric treatment capacity. The G8 leaders also recently agreed to contribute towards the US\$1.8 billion needed for paediatric treatment.

In their reports on progress towards A World Fit for Children, a number of governments have reported on efforts to address paediatric AIDS, including:

- **Cambodia** – By mid-2006 around half of children in need were receiving antiretroviral treatment. Since then the focus on paediatric treatment has increased significantly, so the number of children being treated is likely to have risen further.
- **Côte d'Ivoire** – The state offered 100 per cent subsidies for paediatric antiretroviral treatment. Therapeutic care and treatment were offered free of charge to infected children up to age 15 and pregnant women in 41 health districts.
- **Guyana** – Since 2002, children, young people and pregnant women who are HIV positive have benefited from the free distribution of locally produced antiretroviral drugs. Specialist paediatric management for HIV and AIDS and

related infections has been introduced and paediatric antiretroviral drugs are available.

- **Zimbabwe** – The government has prepared a comprehensive plan for rolling out prevention of mother-to-child transmission and prevention, care, treatment and support for paediatric HIV for the period 2006–2010, which will consolidate the work already in progress.

Infection among adolescents and young people

Globally, more than 10 million people aged 15 to 24 are infected with HIV.⁷⁷ In many regions of the world, young people aged 15 to 24 accounted for about 40 per cent of new HIV infections in 2006.⁷⁸

At the end of 2005, of the more than 10 million 15- to 24-year-olds who were HIV infected, almost two thirds were in sub-Saharan Africa, and of these 76 per cent were female. The region with the second highest prevalence is Asia, which has an estimated 2.2 million young people living with the virus. However, the regions where young people account for the largest share of HIV-infected people are Eastern Europe and Central Asia.⁷⁹

Young people at risk

In many countries, the HIV epidemic is still not widespread in the general population of adolescents and young people. Instead it remains concentrated among certain populations who are most at risk – typically injecting drug users, sexually exploited children and young men who have sex with men.

- **Injecting drug users** – The biggest risk of HIV infection comes from the use of non-sterile injecting equipment – which in Eastern Europe and many Asian countries causes the most HIV infections. In some countries adolescents as young as 13 or 14 years old are injecting drugs. Drug use often starts in adolescence, most frequently among boys, and unsafe practices heighten the risk of HIV infection: In Eastern Europe over the period 1993–2003, 40 per cent of newly diagnosed HIV infections in injecting drug users were among those aged 15 to 24 years.⁸⁰
- **Children exploited for commercial sex** – Girls and boys exploited for sex generally have far higher rates of HIV infection, often many times higher than in the general population. In some countries, the prevalence among young female commercial sex workers is 40 per cent or more. Most are younger than 25. For many exploitation starts at a very early age; in some countries, one half to one third of those in commercial sex establishments are under 18 years old.
- **Men who have sex with men** – Unprotected penetrative sex between men with several concurrent partners accounts for a substantial proportion of new infections in the industrialized countries as well as in a number of countries in Latin

America and Asia. Many are under 25. In Central Asia and Eastern Europe, for example, people aged 15 to 24 make up 14 to 20 per cent of new diagnoses attributed to this form of transmission. Male sex workers are also likely to be young.

High-risk behaviours are noted to be higher among children in conflict with the law and among children living on the street. Such populations then serve as a bridge to others. Young injecting drug users, for example, are likely to be sexually active, jeopardizing the health of their partners. And many young men who have sex with men also have sex with women, thus passing on the infection to unsuspecting partners.

In countries that have ‘generalized epidemics’ – with HIV prevalence among pregnant women greater than 1 per cent – the main mode of HIV transmission is through penetrative heterosexual sex. In these countries the greatest risks are for young women: In one sample of 11 countries, young women aged 15 to 24 were between 1.3 times and 12 times more likely to be infected than young men – partly because women are often considerably younger than their male sexual partners.⁸¹

Preventing infection

The starting point for preventing future infections among adolescents and young people is to ensure that they are fully informed. Although significant progress has been made over the past decade and more young people are aware of HIV and AIDS, their knowledge is not sufficient to help them prevent infections. For survey purposes, people are deemed to have comprehensive knowledge of HIV and AIDS if they correctly identify two major ways of preventing sexual transmission, reject two common misconceptions about the disease and know that a healthy-looking person can have HIV. One question that young women have been asked in repeated surveys in more than 25 countries is ‘Can a healthy-looking person have the AIDS virus?’ The good news is that in seriously affected countries in southern Africa around 80 per cent of respondents now answer correctly.

Schools are one of the main channels for information. Many schools do inform their pupils of risks, but may not be able to do so very effectively since teachers often lack the appropriate skills or feel uncomfortable addressing HIV, AIDS and sexuality. In a survey of 15 countries with data available – 10 in sub-Saharan Africa – only 3 had managed to ensure that at least 90 per cent of their schools had teachers properly trained to provide life skills– based HIV education.⁸² Across all these countries it appears that at best only about half of the children attending school actually received school-based HIV and AIDS education. However, even if fully implemented, school-based programmes would fail to reach a substantial number of adolescents, especially females, because they are not in school.

In addition to information and opportunities to build life skills, young people need youth-friendly services that can offer voluntary counselling and testing along with treatment and care for sexually transmitted diseases and HIV infection. Such services are few and far between. In 25 of 39 countries surveyed, less than 50 per cent of young women aged 15 to 24 knew where they could go to be tested for HIV. And adolescents are less likely to seek treatment for sexually transmitted infections because they are embarrassed or fear that their privacy will not be respected.⁸³ Poverty too is a significant obstacle to accessing reproductive health care, HIV testing and treatment for HIV and other sexually transmitted diseases.

Young people need youth-friendly services that can offer voluntary counselling and testing along with treatment and care for sexually transmitted diseases and HIV infection.

Behaviour change

However, some very encouraging trends are apparent. For one, children appear to be having first sex at a later age. In 9 of 14 countries in sub-Saharan Africa for which trend data are available, fewer young people are initiating sexual activity before the age of 15.⁸⁴

Another way of reducing risk is to reduce the number of sexual partners. Here the picture is mixed. In sub-Saharan Africa and in Latin America and the Caribbean the proportion of young people who have had sex with a non-marital, non-cohabitating partner in the last 12 months varies dramatically from country to country, from less than 10 per cent to over 90 per cent. Across the world, however, the rates are generally twice as high for young men as for young women. In the countries that can measure trends through a sequence of surveys there has been little overall change.

World Fit for Children country reports on efforts to prevent infection among young people include:

- **Burundi** – As a result of nationwide youth consultations, the country has adopted a national strategy of youth-centred HIV and AIDS involvement. HIV and AIDS youth clubs have sprung up across the country, helping to reinforce education and counselling among youth.
- **Romania** – Staff working with children in various centres deliver information regarding HIV and AIDS. Messages are based on the children's degree of understanding about hygiene, health, sexual education, ways of transmitting and preventing HIV, and treatment. In addition 7,500 children participated in health education sessions held by specialized staff, and 150 children with HIV or AIDS benefited from self-education activities.

Children affected by HIV and AIDS

In addition to the 2.3 million children under 15 living with HIV, many more have had their lives radically changed by the epidemic among adults. Children, in many cases girls more than boys, may have to take premature responsibility for housework and caregiving – at times leaving school to do so. This can lead to an important change in the roles of school-age and adolescent children.

The effects of HIV and AIDS on children become evident when their parents become ill. At this point families make extraordinary efforts to continue feeding and educating their children while caring for the sick – often at great cost and sacrifice. In addition to suffering emotional and psychosocial stress, the family is likely to become poorer. Studies in four African countries found, for example, that orphaned children and those with chronically ill caregivers are less likely than other children to have a blanket, shoes or an extra set of clothes.⁸⁵

At this point the effects will differ somewhat depending on the age of the child. The youngest children have the greatest need for physical care and nurturing. The older

children, especially girls, will have to take on greater responsibilities within the household, which can mean leaving school. They may then have to start work outside the home, where they are at risk from exploitive labour. Those who leave school are also less likely to obtain information or to develop the skills needed to abstain from sex or practise safe sex. As a result they may themselves become vulnerable to HIV and other sexually transmitted infections.

Losing a parent

Between 1990 and 2005 the proportion of children in sub-Saharan Africa who had lost one or both parents to AIDS, as a percentage of all orphans, rose from 1 to 25 per cent. As of 2005, this amounted to over 12 million children, and by 2010 it is likely to rise to about 16 million.

To date, more orphans have lost their fathers than their mothers. This is primarily because men tend to have children when they are older compared to their partners. Such men with HIV infection in poorer societies with inadequate access to care and treatment are more likely to die before their children are grown. When one parent dies, the child may stay in the family, especially if the surviving parent is the mother. Even so, the family is likely to become poorer. Relatively few people in poorer communities in sub-Saharan Africa make official wills, increasing the risk that a deceased person's property will simply be taken by other members of the extended family or the community.

Most children orphaned from any cause in countries with high HIV prevalence will be taken in by the extended family.⁸⁶ For around half of children that responsibility is likely to pass to grandparents. The rest may be taken in by other members of the extended family or the community. Demographic and Health Surveys in 10 sub-Saharan countries show that children who are orphaned are less likely than other children in the same household to be enrolled in school, although access to education for children who are orphaned has improved in several sub-Saharan countries. Some qualitative studies have discovered orphaned children being given different food and clothing from other children in the household, as well as being overworked or beaten. And when care arrangements break down children can find themselves being moved from one household to another.⁸⁷

In addition, children who have been orphaned, along with other children in the community, are affected by the erosion of public services. Health facilities in areas with many cases of HIV and AIDS are often overwhelmed with patients – while nurses and doctors are themselves falling sick and dying. As of May 2006, over 20 countries had drawn up national plans of action for orphaned and otherwise vulnerable children.⁸⁸ One indicator of progress is school attendance by children who have lost both parents. Of 24 sub-Saharan African countries that have measured this over time, 15 countries show a decline in disparity between orphaned and non-orphaned children.

Kenya and Malawi have piloted cash-transfer programmes in some of the poorest areas for families where children are especially vulnerable to leaving home or dropping out of school. International organizations too have been increasing their efforts – for example using the Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS, which outlines key strategies and actions.

Unite for Children, Unite against AIDS

In the response to HIV and AIDS, national governments and the international community have become steadily more aware of the need to give greater attention to children. In 2005, UNAIDS, UNICEF and partners launched *Unite for Children, Unite against AIDS* to provide a platform for everyone involved in halting and reversing the spread of HIV among children, adolescents and young people. Running through 2010, it will advocate for a prominent place for children on the global HIV and AIDS agenda and raise funds. *Unite for Children, Unite against AIDS* focuses on four priorities for children infected or affected by HIV and AIDS.

1. **Prevent mother-to-child transmission of HIV** – Increase access to voluntary and confidential testing and counselling, to medicines that reduce infection rates in newborns and to treatment for women who are HIV infected.
2. **Provide paediatric treatment** – Increase the availability of antiretroviral medicines to help keep children alive and of the antibiotic cotrimoxazole to prevent opportunistic infections.
3. **Prevent HIV infection among adolescents and young people** – Carry out targeted and youth-friendly AIDS awareness campaigns, supporting intensive prevention efforts to help young people acquire the comprehensive and balanced knowledge and skills needed to protect themselves from infection.
4. **Protect and support children affected by HIV and AIDS** – Strengthen families and communities where HIV and AIDS have hit hardest, and provide essential services, including education, and other support for children and adolescents who must confront HIV and AIDS while also tackling stigma and discrimination. Ensure that governments protect affected children.

HIV and AIDS affect so many aspects of children's lives that any adequate response has to be equally wide ranging – and closely integrated. Integration means ensuring that children and families have access to health systems and services that provide quality care and support, and that girls and children who are orphaned complete a full course of primary education. Behaviour change communication needs to help children learn how to protect themselves. Integration also means providing good nutrition for children affected by AIDS and securing safe water and basic sanitation for AIDS-affected households. And it means empowering women to make decisions based on their own health and the best interests of their children and families.

Resources and partnerships

The response to HIV and AIDS among children and young people will need a substantial increase in resources. Available annual funding for the response to AIDS in low- and middle-income countries has increased 28-fold, from US\$300 million to \$8.3 billion. Estimates based on 2005 UNAIDS resource needs assessments suggest, however, that nearly US\$30 billion will be needed by the end of the decade to provide a dramatically scaled-up response to the needs of children.⁸⁹ Several governments have earmarked a minimum of 10 per cent of their HIV and AIDS resources for children, including those of Ireland, the United Kingdom and the United States.

Advocacy efforts for children, in partnership with non-governmental organizations, civil society, treatment activists, women's organizations and faith-based groups, have been responsible for many of the gains made for children in recent years.

Across the world, addressing the HIV epidemic will depend critically on stronger partnerships at national and international levels. *Unite for Children, Unite against AIDS* is increasingly bringing partners together and fostering common approaches to scaling up of the 'Four Ps' – Prevent mother-to-child transmission of HIV; Provide paediatric treatment; Prevent infection among adolescents and young people; and Protect and support children affected by HIV and AIDS. This framework can also be used to boost advocacy efforts for children, in partnership with non-governmental organizations, civil society, treatment activists, women's organizations and faith-based groups – which have been responsible for many of the gains made for children in recent years.

Monitoring

One of the key objectives of *Unite for Children, Unite against AIDS* is to more accurately reflect the situation of children and AIDS and to set a baseline for measuring progress and identifying the gaps in the response. UNICEF and UNAIDS have been working together with national governments and partners to develop a core set of coverage- and survey-based indicators that can be used to track progress on the 'Four Ps' at the country level. These include the number of HIV-infected pregnant women, the number of pregnant women counselled on PMTCT services and the number who receive antiretrovirals to prevent mother-to-child transmission of HIV.

HIV and AIDS balance sheet

Goals	Gains	Unfinished business
Reduce prevalence in young people WFFC – Reduce HIV prevalence among young men and women aged 15-24 in the most-affected countries by 25% by 2005, and by 25% globally by 2010 MDG – Have halted by 2015 and begun to reverse the spread of HIV and AIDS	Six of the most-affected countries show a 25% reduction in HIV prevalence among young people aged 15-24 years.	Worldwide, HIV infections continue to rise, and young people, especially young women and girls, are disproportionately represented in these numbers.
Prevention of mother-to-child transmission WFFC – By 2005, reduce the proportion of infants who become HIV infected by 20% and by 2010 by 50%	A number of countries are on track to increase PMTCT services to cover 80% of HIV-infected pregnant women by 2010.	Only 1 in 10 HIV-infected pregnant women in low- and middle-income countries is receiving antiretroviral prophylaxis to prevent mother-to-child transmission.
Paediatric AIDS WFFC – By 2010, provide antiretroviral treatment or cotrimoxazole or both to 80% of children in need	At the end of 2006, over 115,000 children under 15 in need of treatment were receiving it, up from approximately 75,000 in 2005 (a 50% increase in one year).	Antiretroviral coverage for children is still significantly lower than for the general population. The need is great for paediatric fixed-dose combinations as well as improved ability to diagnose children prior to onset of severe disease.
Develop a supportive environment WFFC – By 2005, implement national policies and strategies to provide a supportive environment for orphans and vulnerable children	Over 20 countries have drawn up national plans of action for orphaned and vulnerable children.	Many other countries have yet to prepare plans.

What we can do for children

Twenty five years into the AIDS epidemic, many countries have shown that it is possible to reduce the risks and to save the lives of millions of children. Most countries have national plans of action, and many have been able to reduce the incidence of HIV infection among young people and the rates of mother-to-child transmission. This suggests four priorities for future action:

- **Mobilize resources and put the care and protection of children first** – While international funding to combat the epidemic has increased, further commitments will be needed. National governments too will need to reallocate resources to the ‘Four Ps’, in particular by strengthening health care and education systems.
- **Come as close as possible to universal access to treatment** – The development of appropriate, effective and affordable medications and diagnostics will need stronger public-private partnerships and larger investments in procurement and supply management.
- **Strengthen health and education services** – Routine testing should be available to all women, adolescents and young children along with access to quality health care for children and adolescents affected by HIV and AIDS. Governments should also eliminate school fees and other indirect costs of education for children who are orphaned or otherwise made vulnerable by HIV and AIDS.
- **Build stronger partnerships** – No single country, donor or development agency can on its own provide everything that children need. Partnerships can allow different agencies to tackle different tasks, pursue complementary goals and achieve bigger and better results. At the national level such partnerships can be based on the ‘Three Ones’: one agreed-upon national AIDS action framework, one national AIDS coordinating authority with broad-based multisectoral support and one country-level system for monitoring and evaluation.

CHAPTER

6



Not
Enough

In 1990 at the World Summit for Children, world leaders declared that the essential needs of children should have ‘first call’ on the resources of families, countries and the international community. In 2000 at the Millennium Summit, the world’s governments issued the Millennium Declaration, reaffirming their duty ‘to all the world’s people – especially the most vulnerable, and in particular, the children of the world, to whom the future belongs’. Five years ago at a Special Session, the UN General Assembly called on all members of society to join ‘a global movement to build a world fit for children’.

Have governments been discharging that duty? Have they been building that movement? As this report has shown, the answer is a guarded ‘yes’ – to a great extent they have. There have, for example, been striking successes in primary schooling. Many countries are now close to enrolling all children of the appropriate age in primary school. Just as heartening, at the primary level these educational opportunities are being extended equally to girls and boys.

There is also good news on the health front. The world is close to eradicating polio and is also making rapid progress on measles: Over the period 1999–2005 child deaths from measles fell by 60 per cent worldwide and 75 per cent in Africa. In addition, on malaria, one of the most persistent scourges of children particularly in Africa, international agencies and governments have been moving fast to protect children with long-lasting insecticide-treated mosquito nets. Governments have also been ensuring that many more children have essential micronutrients, by iodizing salt and providing vitamin A supplements.

States have also demonstrated their commitment to the Convention on the Rights of the Child, which 193 have ratified. In addition, as of 26 September 2007, 122 States had ratified the Optional Protocol on the sale of children, child prostitution and child pornography, and 118 had ratified the Optional Protocol on the involvement of children in armed conflict.

Against these successes, however, have to be set some persistent failures. Many countries have disturbing gaps between aspiration and achievement – in nutrition, for example, with one quarter of children in developing countries underweight. Almost 425 million children under the age of 18 lack access to an improved water supply, and over 980 million lack access to improved sanitation.

Half a million women still die needlessly during pregnancy and childbirth, and millions of children are without adequate protection against exploitation and abuse or from the many forms of violence, as revealed in disturbing detail in the 2006 World Report on Violence against Children.

The journey to 2015, the year on which most targets for children converge, will be difficult. Achieving the goals will require unprecedented efforts.

To some extent the problems are rooted in inequality and injustice – a failure to extend the rights and protections already enjoyed by some children to all children. Stark disparities remain within countries, between rural and urban children, for example, and between those living in richer or poorer regions. Others are evident between social groups: Racial or ethnic minority children are often excluded from national progress, such as Roma and immigrant children in Europe, for example, and those from minority indigenous and tribal groups in Asia and the Pacific, Africa, North America and Latin America. Children with disabilities also face exclusion.

Running through all these patterns of injustice is the persistent reality of gender discrimination, which denies millions of girls equal rights to health and opportunities. It also renders them vulnerable to sexual and other forms of violence.

The emergence of HIV and AIDS was a sudden reminder of human vulnerability in an increasingly globalized world. Further health threats inevitably lie in wait – demanding constant vigilance and stronger and more extensive forms of international cooperation that can generate swift and effective responses.

Another major hazard for the years ahead is climate change. The scale of future global warming may be uncertain but the process is already underway, threatening the prospects of millions of children. Climate change will affect everyone, but it will impinge most directly on the poorest communities, who tend to occupy marginal land and are the most exposed to the elements. Rising sea levels and more frequent or severe droughts and floods or other extreme weather events may cause serious economic damage in richer societies. But in poorer ones these hazards represent an immediate threat to child health and survival.

Globalization is also associated with rapid technological change. As with climate change, this can sometimes lead us in unforeseen and dangerous directions, but it still holds the promise of new forms of progress and protection. For children the potential benefits lie, for example, in information communication technologies that are unlocking vast stores of previously inaccessible human knowledge. Children should also benefit directly from the development of new vaccines and cheaper and more readily available treatment for many childhood illnesses.

As ever, the benefits of technological advance are likely to be spread unevenly. The Internet and mobile phone technology may have revolutionized global communications, but millions of children have little prospect of owning a computer or handset. New vaccines are vital and welcome, but millions of children have yet to be protected by the old ones.

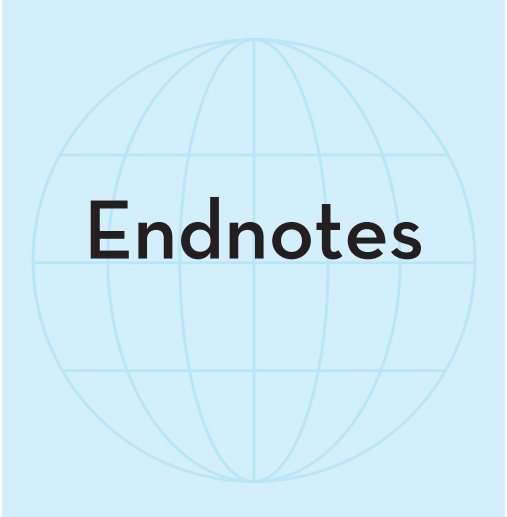
The core issues, as always, are commitment and delivery. To a large extent, the world already knows how to meet children's rights, and it has made the commitment. As expressed in the Convention on the Rights of the Child: 'With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources'.

Yet we still fall far short. The problems are partly political and partly economic and social. Technological fixes can be applied fairly rapidly. Political and social transformations are more complex and less susceptible to quick or neat solutions.

For all the difficulties, we should take heart from our successes. Indeed, a number of governments, having already achieved some of the Millennium Development

Goal targets, are now raising the bar by setting 'MDG Plus' goals or looking to see what they can achieve beyond 2015. At the same time the outlines of the next wave of change are emerging, and they seem to be taking shape around the children themselves. Certainly adults have to sustain an environment in which children can grow and flourish, and we can never absolve ourselves of responsibility to encourage and protect them. But in the future it is likely to be children themselves who take more of the initiative – identifying emerging issues and suggesting potential solutions.

They will also reflect on the contribution of earlier generations – looking back at the Millennium Development Goals and the plans that governments made to achieve A World Fit for Children. They may well ask us 'What did you do for children?' As things stand at present, the answer has to be: 'Not enough.'



Endnotes

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ANNEX

A World Fit for Children country and territory reports

Submitted for Special Session plus five 2007

1	Afghanistan	42	Georgia	83	Pakistan
2	Angola	43	Germany	84	Palau
3	Argentina	44	Ghana	85	Papua New Guinea
4	Armenia	45	Guatemala	86	Paraguay
5	Austria	46	Guinea	87	Philippines
6	Azerbaijan	47	Guinea-Bissau	88	Qatar
7	Bangladesh	48	Guyana	89	Romania
8	Belarus	49	India	90	Samoa
9	Belgium	50	Indonesia	91	Sao Tome and Principe
10	Belize	51	Iraq	92	Senegal
11	Benin	52	Italy	93	Serbia
12	Bhutan	53	Jordan	94	Sierra Leone
13	Bolivia	54	Kazakhstan	95	Slovakia
14	Bosnia and Herzegovina	55	Kenya	96	Slovenia
15	Botswana	56	Kyrgyzstan	97	Solomon Islands
16	Brazil	57	Lao People's Democratic Republic	98	Spain
17	Bulgaria	58	Latvia	99	Suriname
18	Burkina Faso	59	Lebanon	100	Swaziland
19	Burundi	60	Lesotho	101	Sweden
20	Cambodia	61	Liechtenstein	102	Switzerland
21	Cameroon	62	Madagascar	103	Syrian Arab Republic
22	Canada	63	Malawi	104	Tanzania, United Republic of
23	Cape Verde	64	Maldives	105	Thailand
24	Central African Republic	65	Mali	106	The FYR of Macedonia
25	Chad	66	Mauritania	107	Togo
26	China	67	Mauritius	108	Tonga
27	Colombia	68	Mexico	109	Tunisia
28	Congo	69	Micronesia (Federated States of)	110	Turkey
29	Costa Rica	70	Moldova	111	Turkmenistan
30	Côte d'Ivoire	71	Monaco	112	Tuvalu
31	Croatia	72	Mongolia	113	Uganda
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Prepared by UNICEF
for the United Nations

December 2007

US \$15.00
ISBN: 978-92-806-4219-3
Sales no.: E.08.XX.7

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