The children most at risk of missing out on the Millennium agenda, and on their rights under the Convention on the Rights of the Child, live in all countries, societies and communities. An excluded child is one who lives in an urban slum in Venezuela and takes care of her four siblings; a Cambodian girl living alone with her brothers because her mother had to go elsewhere to find a job; a Jordanian teenager working to help his family and unable to play with his friends; an orphan in Botswana who lost his mother to AIDS; a child confined to a wheelchair and unable to attend school in Uzbekistan; or a young boy working as a domestic in Nepal.

At first glance, these children’s lives may appear poles apart: Each of them faces a different set of circumstances and struggles to overcome distinct obstacles. Yet they all have something in common: They are almost certainly excluded from essential goods and services – vaccines, micronutrients, schools, health-care facilities, water and sanitation, among others, and denied the protection from exploitation, violence, abuse and neglect, and the ability to participate fully in society, which is their right.

Exclusion harms children on many levels

At the national level, the exclusion of children from their rights to essential services is often the product of macro factors, such as mass poverty, weak governance, the uncontained spread of major diseases such as HIV/AIDS, and armed conflict. At the sub-national level, among vulnerable and marginalized groups, exclusion is also the result of disparities in access to services on the basis of income and geographic location, and through overt discrimination on the grounds of gender, ethnicity or disability.

Violations of protection rights – including the loss or lack of a formal identity, the

SUMMARY

**ISSUE:** Exclusion acts against children in all countries, societies and communities. At the national level, the root causes of exclusion are poverty, weak governance, armed conflict and HIV/AIDS. Statistical analyses of key MDG indicators related to child health and education show a widening gap between children growing up in countries with the lowest level of development, torn by strife, underserved by weak governments or ravaged by HIV/AIDS and their peers in the rest of the developing world. These factors not only jeopardize these children’s chances of benefiting from the Millennium agenda, they also increase the risk that they will miss out on their childhood and face continued exclusion in adulthood.

Because the MDGs are based on national averages, inequalities among children within the same country that contribute to, and result in, their exclusion may be obscured. Disaggregated data from national statistics and household surveys indicate sharp disparities in health-care and education outcomes on the basis of household income and geographic location. Inequalities in children’s health, rate of survival and school attendance and completion also fall along the lines of gender, ethnicity or disability. These inequities may occur because children and their caregivers are directly excluded from services, because they live in areas that are poorer and more poorly serviced, because of the high costs of access to essential services, or because of cultural barriers such as language, ethnic discrimination or stigmatization.

**ACTION:** Tackling these factors requires swift and decisive action in four key areas:

- **Poverty and inequality.** Adjusting poverty-reduction strategies and expanding budgets or reallocating resources to social investment will assist millions of children in the poorest countries and communities.
- **Armed conflict and ‘fragile’ States.** The international community must seek to prevent and resolve armed conflict and engage with countries with weak policy/institutional framework to protect children and women and provide essential services. Emergency responses for children caught up in conflict should include services for education, child protection and the prevention of HIV transmission.
- **HIV/AIDS and children.** Greater attention should be given to the impact of HIV/AIDS on children and adolescents and to ways of protecting them from both infection and exclusion. The Global Campaign on Children and HIV/AIDS will play a significant role in this regard.
- **Discrimination.** Governments and societies must openly confront discrimination, introduce and enforce legislation prohibiting it, and implement initiatives to address exclusion faced by women and girls, ethnic and indigenous groups and the disabled.
absence of state protection for children deprived of family support, the exploitation of children and premature entry into adult roles – also leave individual children exposed to exclusion.

This chapter focuses on the factors that cause children to be excluded from essential services – mostly of health care and education – at the national and subnational levels. These impediments, often long-standing and deeply entrenched, are the product of economic, social, gender and cultural processes that can be addressed and must be altered. Even if they persist, our binding commitments to children compel us to take the necessary actions to mitigate their impact. (The many factors that deprive children of protection against violations of their rights at the individual level, which lessens their visibility in their societies and communities, will be examined in Chapter 3).

Macro-level causes of exclusion

Poverty, armed conflict and HIV/AIDS are among the greatest threats to childhood today. They are also among the most significant obstacles to the achievement of the M illennium agenda for children at the regional and country levels. Statistical analyses of key M DG indicators related to child health and education – under-five mortality, malnutrition, primary school enrolment, among others – show a widening gap in the health and education of children growing up in countries with the lowest level of development, torn by strife or ravaged by HIV/AIDS, compared with their peers in the rest of the world. Without a concerted effort, children in these countries will become even more excluded over the next decade.

Children in the least developed countries are most at risk of missing out

Children are disproportionately represented among the poor, since the least developed countries tend to have the youngest populations, and income-poor families tend to have more children than richer ones. Poor children are more likely to be engaged in labour, which could mean missing out on an education and, as a result, on the opportunity to generate a decent income that would allow them to escape poverty in the future. Denied a decent standard of living and, often, education, information and vital life skills, they are vulnerable to abuse and exploitation.

Raising incomes through economic growth is an essential component of poverty-reduction strategies and has been particularly successful in Asia since 1990. But economic growth by itself is insufficient to address the ways in which children experience material poverty – i.e., as deprivation of essential services and goods. The extent of this deprivation is appalling: More than 1 billion children suffer from one or more extreme forms of deprivation in adequate nutrition, safe drinking water, decent sanitation facilities, health-care services, shelter, education and information.

Children living in the least developed countries are the most likely to face severe
Why children in the least developed countries risk missing out

<table>
<thead>
<tr>
<th></th>
<th>Least developed countries</th>
<th>Developing countries</th>
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<tr>
<td><strong>Survival</strong></td>
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<tr>
<td>Under-five mortality rate (per 1,000 live births, 2004)</td>
<td>155</td>
<td>87</td>
<td>79</td>
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<td>Infant mortality rate (per 1,000 live births, 2004)</td>
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<td>59</td>
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<td><strong>Nutrition</strong></td>
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<tr>
<td>Proportion of under-fives who are moderately or severely underweight (percentage, 1996-2004(^a))</td>
<td>36</td>
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<tr>
<td>Proportion of under-fives suffering from moderate or severe stunting (percentage, 1996-2004(^a))</td>
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<td>31</td>
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<td><strong>Immunization</strong></td>
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<tr>
<td>Proportion of one-year-old children immunized against DPT3 (percentage, 2004)</td>
<td>75</td>
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<tr>
<td>Proportion of one-year-old children immunized against HepB3 (percentage, 2004)</td>
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<td>46</td>
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<td><strong>Health care</strong></td>
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<tr>
<td>Proportion of under-fives with an acute respiratory infection taken to a health provider (percentage, 1998-2004(^a))</td>
<td>38</td>
<td>54(^b)</td>
<td>54(^b)</td>
</tr>
<tr>
<td>Proportion of under-fives with diarrhoea receiving oral rehydration and continued feeding (1996-2004(^a))</td>
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<td>33(^b)</td>
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<td><strong>HIV/AIDS</strong></td>
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<td>Adult prevalence rate (15-49 years, end-2003)</td>
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<td>Adults and children living with HIV (0-49, thousands, 2003)</td>
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<td><strong>Education and gender parity</strong></td>
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<td>Percentage of primary school entrants reaching grade 5 (administrative data, 2000-2004(^a))</td>
<td>65</td>
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<tr>
<td>Net primary school attendance ratio, boys (1996-2004(^a))</td>
<td>60</td>
<td>76</td>
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<tr>
<td>Net primary school attendance ratio, girls (1996-2004(^a))</td>
<td>55</td>
<td>72</td>
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<tr>
<td>Net secondary school attendance ratio, boys (1996-2004(^a))</td>
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<td>40(^b)</td>
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<td>Net secondary school attendance ratio, girls (1996-2004(^a))</td>
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<td>37(^b)</td>
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<td><strong>Demographics</strong></td>
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<td>Life expectancy at birth (years, 2004)</td>
<td>52</td>
<td>65</td>
<td>67</td>
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<tr>
<td>Proportion of population urbanized (percentage, 2004)</td>
<td>27</td>
<td>43</td>
<td>49</td>
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<tr>
<td><strong>Women</strong></td>
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<tr>
<td>Adult literacy parity rate (females as a percentage of males, 2000-2004(^a))</td>
<td>71</td>
<td>84</td>
<td>86</td>
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<tr>
<td>Antenatal care coverage (percentage, 1996-2004(^a))</td>
<td>59</td>
<td>71</td>
<td>71</td>
</tr>
<tr>
<td>Skilled attendant at delivery (percentage, 1996-2004(^a))</td>
<td>35</td>
<td>59</td>
<td>63</td>
</tr>
<tr>
<td>Lifetime risk of maternal death, 2000 (1 in:)</td>
<td>17</td>
<td>61</td>
<td>74</td>
</tr>
</tbody>
</table>

\(^a\) Data refer to the most recent year available during the period specified.

\(^b\) Excludes China.

**Sources:** For a complete list of the sources used to compile this table, see Statistical Tables 1-10, pp. 95-137.
deprivation and, consequently, are among those at greatest risk of missing out on the Millennium agenda. The statistical evidence of their impoverishment is alarming, particularly those indicators related to children and women’s development and well-being (see Panel: Why children in the least developed countries risk missing out, page 13). In almost all cases, the least developed countries are lagging far behind the rest of the developing world.

Two MDG indicators—under-five mortality and completion of primary education—aptly illustrate the risks of exclusion faced by children living in the least developed countries. In 2004, 4.3 million children—one out of every six live births—died before the age of five in these countries alone. Although under-fives in the least developed countries make up only 19 per cent of the world’s under-fives, they account for over 40 per cent of all under-five deaths. Of those who live to reach primary school age, 40 per cent of boys and 45 per cent of girls will not attend school. Of those who enter primary school, over one third will not reach grade five; and around 80 per cent of all children of secondary school age will not attend secondary school.

Armed conflict and poor governance escalate the risk of exclusion for children

Armed conflict causes children to miss out on their childhood in a multitude of ways. Children recruited as soldiers are denied education and protection, and are often unable to access essential health-care services. Those who are displaced, refugees or separated from their families face similar deprivations. Conflict heightens the risk of children being exposed to abuse, violence and exploitation—with sexual violence often employed as a weapon of war. Even those children who are able to remain with their families, in their own homes, may face a greater risk of exclusion because of the destruction of physical infrastructure, strains on health-care and education systems, workers and supplies, and increasing personal insecurity caused by the conflict or its remnants—such as landmines and unexploded ordnance.
Firm evidence of the impact of armed conflict on children’s exclusion is limited, in part because of gaps in research and data collection on the numbers of children caught up in conflict. Nevertheless, the available linkages are indicative of the extent of exclusion – and alarming. Of the 12 countries where 20 per cent or more of children die before the age of five, nine have suffered a major armed conflict in the past five years (see Figure 2.3: Most of the countries where 1 in 5 children die before five have experienced major armed conflict since 1999, page 14), and 11 of the 20 countries with the most elevated rates of under-five mortality have experienced major armed conflict since 1990. Armed conflict also has devastating effects on primary school enrolment and attendance. For example, the nine conflict-affected countries where 1 in 5 children dies before the age of five have an average net primary school attendance ratio of 51 per cent for boys and 44 per cent for girls, well below the corresponding averages of 60 and 55, respectively, for the least developed countries as a whole.8

The breakdown in governance that often accompanies armed conflict and the destruction caused to public administration and infrastructure are key reasons for the high rates of under-five mortality and low rates of educational participation and attainment. But armed conflict is not the only form of state failure. ‘Fragile’ States are characterized by weak institutions with high levels of corruption, political instability and weak rule of law.9 Such States often lack the resources to adequately support an efficient public administration.10 As the government is often incapable of providing basic services to its citizens, the standard of living in these countries can degenerate both chronically and acutely.

Tragically, these governance failures result in children becoming more excluded from essential services. Children living in countries that are unable to implement national development strategies to meet the MDGs will be among those most at risk of missing out on whatever benefits are derived from the millennium agenda. One such country is Haiti, already the poorest country in the Americas by most indicators and plagued by political violence for most of its recent history. The country has seen a further deterioration in child well-being amid the political turmoil of the last two years. Access to education has been affected by hikes in school fees, and some 60 per cent of rural households still suffer from chronic food insecurity, with 20 per cent extremely vulnerable.

Another example of a fragile State is Somalia, a country that has long been among the least developed. Its progress on human development has been further constrained by the lack of a functioning national administration since 1991. Over this 14-year period, progress on human development has been scant, with rival warring factions claiming jurisdiction over specific territories. The result is starkly apparent in education: The net primary attendance ratio is lower than anywhere else in the world, at just 12 per cent for boys and 10 per cent for girls, according to the latest estimates.11 The recent re-establishment of schooling by many
Strengthening governance in fragile States is considered by many, and with good justification, to be a prerequisite for meeting the goals of the Millennium agenda. Donors and international agencies may be wary of increasing non-humanitarian assistance to the government of a fragile State, but their commitments to children must compel them to engage with these States to ensure that children’s rights are protected and their needs met. The simple truth is that children cannot wait until governance improves – long delays may result in them missing out on their childhood altogether.

HIV/AIDS is wreaking havoc with children’s lives in the worst-affected countries

Combating HIV/AIDS is a central objective of the Millennium Development Goals, specifically addressed in MDG 6. Children living with or affected by HIV/AIDS, or in countries with high prevalence rates, face an extremely high risk of exclusion from access to essential services, care and protection, as parents, teachers, health workers and other basic service providers fall sick and eventually die. The epidemic is tearing away at the social, cultural and economic fabric of families, the first line of protection and provision for children that safeguards against their exclusion from essential services and exposure to harm. Some 15 million children have already lost one or more parents to the disease, and millions more have been made vulnerable as the virus exacerbates other challenges to the health and development of families, communities, provinces and, in the worst-affected countries, whole nations. Of those orphaned by AIDS, 12.1 million, or more than 80 per cent, are in sub-Saharan Africa, reflecting not only the region’s disproportionate burden of HIV infection, but also the epidemic’s relative maturity.

The protracted illness and eventual death of parents and other caregivers exert enormous pressures on children, who often have to assume adult roles in treatment, care and support. Surviving siblings can suffer stigma and discrimination in their communities and societies, experience greater exposure to violence, abuse and exploitation and drop out of school for a variety of reasons.

In addition to orphaning and the loss of caregivers, lack of access to essential services and increased risk of missing out on an education, HIV/AIDS also threatens the very survival of children and young people. Every day, nearly 1,800 children under 15 are infected. Children under 15 account for 13 per cent of new global HIV infections and 17 per cent of HIV/AIDS deaths annually. The pandemic has reversed the gains in child survival made in many of the worst-affected countries and has dramatically reduced average life expectancy in those countries, particularly in southern Africa.

With the pandemic spreading to more and more countries and population groups, the worst impact on children is still to come. It is estimated that in 2004, almost 5 million people became infected with HIV – the most
in a single year since the pandemic began in the early 1980s. Young people aged between 15 and 24 years now account for nearly one third of people living with HIV/AIDS globally.\(^\text{17}\) Given that it can take up to a decade for any decrease in HIV prevalence to be translated into lower death rates from AIDS – owing in large part to the slow roll-out of antiretroviral treatments – deaths from AIDS will continue and the number of orphans will rise. In those countries where HIV/AIDS is already at epidemic levels, tackling the disease is imperative not only to meet MDG 6, but also to reverse recent increases in under-five mortality rates – particularly in Eastern and Southern Africa – and to reduce the risk of exclusion from education and the protection of a family environment for orphans and other vulnerable children.

**Subnational factors that can result in exclusion**

**National aggregates fail to capture the full picture of exclusion for children**

Assessment of indicators related to children’s well-being is most frequently undertaken at the national level. There are a number of reasons for this: The national level is the fundamental unit of statistical analysis for countries; estimates for national aggregates are generally more widely available than for any sub-country group; standardization of statistics often requires national-level and nationally funded survey programmes; and international agencies also compile national aggregates on key indicators related to the MDG agenda. The national government is also the signatory to international commitments to children and the principal trustee for their implementation.

However, assessing child well-being on the basis of national aggregates alone has its limitations. National averages are, by nature, summary measures that most clearly depict the situation of the majority; as such, they do not provide a full picture. To gain a more complete understanding of the exclusion that some children face within a country, disaggregated indicators derived from national statistics or household surveys are required. Data that are disaggregated geographically – as well as by gender, ethnic group or other salient dimensions – are key to identifying the risk of exclusion and are immensely useful as a tool for programme design. Disaggregated data are particularly important for advocacy and policy purposes in countries where the national averages may indicate that, based on current trends, some or all of the MDGs will be met.

Disaggregated national statistics or household surveys on children’s well-being are not available in all countries. But the existing evidence, based on the Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), is fairly comprehensive and indicates a clear result: Within countries, there are usually significant disparities in child well-being and development across geographical and other axes.

These disparities reflect exclusion in relative terms, quantifying a child’s well-being compared to that of his or her peers. A country with a high national average of primary school attendance or enrolment, for example, may still face wide internal variations owing to the marginalization of particular segments of the population. One such coun-
try is Venezuela, where survey data from DHS and MICS indicate that although net primary school attendance approaches 94 per cent, almost 15 per cent of children of primary school age living in the poorest 20 per cent of households miss out on primary education, compared with less than 2 per cent in the richest quintile.

One of the biggest risks for children is that, with the MDGs being based on national averages, such inequalities within countries may be obscured. The magnitude of these disparities can be great, and they risk being ignored when MDG-based strategies are being developed and implemented. This is particularly true in countries where the majority of children are afforded the minimum health-care and education thresholds set out in the Millennium agenda. In such settings, the sharp divide between the most privileged children and those denied access to essential services contributes to their further marginalization and may in itself be a root cause of discrimination.

**Income inequalities threaten children’s survival and development**

In every developing country where disaggregated data by household income are available, children living in the poorest 20 per cent of households are significantly more likely to die before the age of five than those living in the richest 20 per cent.

Latin America and the Caribbean is the region with the highest inequalities in household income in the developing world; countries in this region also have among the highest inequalities in child mortality. The country with the greatest inequality in under-five mortality is Peru, where children living in the poorest quintile are five times more likely to die before their fifth birthday than children from the wealthiest 20 per cent of the population.

Though disparities in under-five mortality rates are not as sharply pronounced in other regions, they can still be marked. On average, a child born into the poorest 20 per cent of households is three times more likely to die than a child born into the richest quintile in East Asia and the Pacific region, two and a half times more likely to die in the Middle East and North Africa and around twice as likely in the South Asia and CEE/CIS regions. Although several of the countries in these regions are either on track or making good progress towards MDG 4, the poorest children are still twice as likely
to die before five as the richest children (see Panel: Income disparities and child survival, page 20).

Within countries, low income is a major deterrent to primary school participation. Children of primary school age from the poorest 20 per cent of households in developing countries are 3.2 times more likely to be out of primary school than those from the wealthiest 20 per cent. Moreover, 77 per cent of children out of primary school come from the poorest 60 per cent of households in developing countries; this disparity is even greater in Latin America and the Caribbean (84 per cent) and Eastern and Southern Africa (80 per cent).19

**Children living in rural areas and among the urban poor often face a high risk of exclusion**

Rural areas tend to be poorer and more difficult to reach with health-care services and education than urban areas. Accordingly, in nearly all countries where household data on child mortality rates are available, rural children are more likely to die before the age of five than their urban peers. Some 30 per cent of rural children in developing countries are out of school, compared with 18 per cent of those living in urban areas, and over 80 per cent of all children out of primary school live in rural areas. Possible barriers to their attendance include distance, the likelihood that their parents are less educated or do not value formal education and the failure of governments to attract good teachers to the countryside.20

Geographic divides often overlap with income inequality within urban communities. In many of the world’s cities, the most impoverished citizens live in slums, tenements and shanty towns, areas which are geographically separate from the most affluent. More than 900 million people live in slums; most lack access to safe drinking water, improved sanitation facilities, sufficient living space and decent quality housing with secure tenure.21 The exclusion of children living in these communities – which are often severely lacking in essential services and state protection – can sometimes approach levels experienced in rural areas.22

Inequalities in children’s health, rate of survival and school attendance and completion also fall along the lines of gender, ethnicity

**Figure 2.6: In several regions, girls are more likely to miss out on primary school than boys**

![Graph showing net primary school attendance rate for different regions, including male and female percentages.](image)

*Data refer to the most recent year available during the period specified.

In 2004, an estimated 10.5 million children died before they reached age five, most from preventable diseases. Combating these unnecessary deaths and meeting Millennium Development Goal 4 – reduce child mortality by two thirds between 1990 and 2015 – will be a central focus for all those working towards the fulfillment of the promises of the Millennium agenda for children.

Addressing the inequalities and disparities within countries must be an essential component of all programmes and policies that aim to reduce child mortality.

In countries where household data are available from surveys such as the Demographic and Health Surveys and the Multiple Indicator Cluster Surveys, it is clear that children living in the poorest 20 per cent of households are significantly more likely to die during childhood than those living in the richest 20 per cent of the population.

The least developed countries tend to have lower inequalities in child survival between rich and poor, with mortality rates remaining high even in the richest families. Countries in sub-Saharan Africa, for example, have lower levels of disparity in child mortality rates than less impoverished developing regions.

Vaccine-preventable diseases cause more than 2 million deaths every year, of which approximately 1.4 million occur in children under age five. While huge strides have been made worldwide to increase vaccination coverage, there is still room for improvement. Tragically, the poorest children are also at a disadvantage when it comes to immunization. The richest children are more than twice as likely to have received the measles vaccination as the poorest 20 per cent of children in Azerbaijan, the Central African Republic, Chad, the Democratic Republic of the Congo, Niger and northern Sudan.

**How likely is a poor child to be underweight compared to a rich child?**

In 13 countries where data are available, children from the poorest 20 per cent of the population are more than twice as likely to be underweight for their age, and in Swaziland they are five times as likely to be underweight.

**Source:** UNICEF calculations based on data from Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS).
If income disparities are not addressed, it is likely that the poorest children will continue to make up a disproportionate share of the child mortality figures, even if national goals are met. Overall, in 23 of the 56 countries with household surveys allowing for disaggregation by income, poorer children are more than twice as likely to die before their fifth birthday, with some of these countries making progress towards the goals at the national level and others failing.

See References, pages 90-91.
or disability. These inequities occur when children and their caregivers are directly excluded from services because they live in areas that are poorer and more poorly serviced, or because cultural barriers such as language, ethnic discrimination or stigmatization prevent them from receiving needed services.

**Discrimination against girls excludes them from education**

Gender discrimination is specifically addressed by MDG 3, which promotes gender equality and the empowerment of women, with the attached target of eliminating gender disparity in education.

Education provides the opportunity for girls (and boys) to become more empowered and self-confident as they acquire the range of knowledge, skills, attitudes and values critical to negotiating an equal place in society. Gender inequality in education means that for every 100 boys out of primary school, there are 117 girls who also miss out on primary education. While the gender gap in primary education has been closing steadily since 1980, many countries have failed to meet the MDG 3 target of gender parity in primary education by 2005, and the regions with the highest gaps will have to make even greater gains if gender parity is to be achieved as part of universal primary school completion by 2015.

Gender gaps in secondary education are even more pronounced: of 75 developing countries surveyed by UNICEF, only 22 were on course to meet the MDG 3 target of gender parity at the secondary school level, while 25 were far from the goal. Girls’ exclusion from education in comparison to boys – especially in South Asia, sub-Saharan Africa and the Middle East and North Africa – is one of the clearest statistical indicators of gender discrimination.

But gender discrimination is both more subtle and all-pervasive than can be measured in the statistics about gender parity in schooling. Gender plays a major part in determining which children end up being excluded from essential services and are, therefore, most at risk of missing out on the Millennium agenda. Many of the groups of
children considered in this report are not taken beyond the reach of international development efforts by their gender alone, but their gender clearly plays a major part in determining their vulnerability. Gender discrimination also results in limited access of women to basic health-care services, which increases the risk of maternal and child mortality.

Women’s disempowerment results in exclusion for their children. Mothers are generally the first caregivers for children. In situations and settings where they are denied access to basic services, essential resources, or information, it is the children who suffer the greatest exclusion. Impediments to progress in the fight against gender discrimination include the continued lack of good quality data disaggregated by sex, the paucity of financial and technical resources for women’s programmes at both international and national levels and the lack of representation in the political sphere.25

**Discrimination on the basis of ethnicity is widespread**

Ethnicity is a set of characteristics – cultural, social, religious and linguistic – that forms a distinctive identity shared by a community of people. It is a natural expression of human diversity and a source of strength, resilience and richness in the human family. But when a child faces discrimination because of ethnicity, the risk of exclusion from essential services and protection rises sharply.

There are some 5,000 ethnic groups in the world, and more than 200 countries have significant minority ethnic or religious groups. Most countries – around two thirds – have more than one religious or ethnic group that accounts for at least 10 per cent of the population.26 Some ethnic groups are spread across national borders – for example, the Roma in Central and Eastern Europe or residents of Chinese descent in many countries in South-East Asia. Some are minorities, accounting for a small proportion of the national population, while others make up a significant share of the population but have little power in society as a result of their isolation and, very often, deep historical disadvantage.27

A common thread among ethnic groups is that they often face considerable marginalization and discrimination. Almost 900 million people belong to groups that experience disadvantage as a result of their identity, with 359 million facing restrictions on their religion. Around the world, some 334 million people face restrictions or discrimination related to their language. In over 30 sub-Saharan African countries (containing 80 per cent of the region’s population), for instance, the official language is different from the one most commonly used, and only 13 per cent of children in these countries are taught in their mother tongue in primary school.28

Discrimination on the basis of ethnicity can erode self-worth and confidence in
The marginalization of Roma communities and their children

The Roma population constitutes Europe's largest and most vulnerable minority, estimated at between 7 and 9 million people. With no historical homeland, roughly 70 per cent of Roma live in Central and Eastern Europe (CEE), and in former Soviet Union countries. Nearly 80 per cent live in countries that joined the European Union (EU) in 2004 or are in the process of negotiating EU membership.a

Exclusion in all its dimensions – social, political, economic or geographic – has affected Roma for centuries and has taken the form of overt ethnic discrimination. Faced with prejudices and fears that they are an inferior and dangerous people, Roma tend to live in ghettos, segregated from the rest of society, and are even barred from restaurants and other public places.b

Roma are also among the most impoverished cultural groups in Central and Eastern Europe. Research shows that nearly 84 per cent of Roma in Bulgaria and 88 per cent of Roma in Romania live below the national poverty lines. Poverty among Roma is even higher in Hungary, with 91 per cent of the group living below the national poverty line.c Because of limited education, a low level of skills and discrimination in the labour market, in some Roma settlements not a single person is regularly engaged in formal employment.d Many Roma children attend separate schools or are segregated when attending mainstream schools. Roma children attending Roma-only schools find themselves in overcrowded classes as a result of geographic and socio-economic segregation.e

As many as 75 per cent of Roma children in Central and Eastern Europe are placed in special schools for the mentally disabled,f but not for genuine health reasons. This practice, which is common, is related to the economic benefits that come with special education. In some CEE countries, children who are sent to schools for the mentally challenged receive food subsidies, educational materials and transportation, as well as room and board. Roma parents often agree to place their children in special schools without fully understanding the long-term consequences of their action, and even if they do, some families think they have no other alternatives.g

A study conducted in 2001 by the Open Society Institute (Budapest), a private grant-making foundation, found that 64 per cent of Roma children in the second grade placed in special schools in Bulgaria, the Czech Republic, Hungary and Slovakia were considered 'mentally challenged'. Over a two-year period, the majority of these students, when placed in special-education pilot classes, were able to meet the requirements of the mainstream curriculum.h

As disturbing as it is, this picture of exclusion is by no means complete. For instance, in Serbia and Montenegro, national statistics on education do not always include the most-excluded children. Issues affecting Roma girls are still not addressed in Romania, where the greatest number of Roma people, between 1 and 2 million, live. Moreover, in Bosnia and Herzegovina, attendance of Roma children in schools is sporadic, and they are almost completely absent from the upper grades of primary and secondary schools.

The education system is not the only one that is failing Roma children. More than half of the children abandoned in medical institutions in Romania – 57 per cent – are of Roma ethnic origin. Often lacking the appropriate identity documents and birth certificates necessary for health insurance enrolment, Roma communities

children and deprive them of opportunities for growth and development, blunting the promise that is every child's birthright. Prejudice at community and institutional levels can restrict opportunities for members of an ethnic group. In terms of career choices and advancement, access to political office or community leadership, members of ethnic minorities may find their participation in society limited – even where there are laws prohibiting bias and exclusion. Exclusion based on ethnicity can lead to armed conflict and even ethnic violence – witness the atrocities along ethnic lines being committed in Darfur, Sudan, since 2003.

Indigenous children can face multiple barriers to full participation in society

Indigenous peoples have many characteristics and experiences in common with ethnic minorities, but they are distinct from them. Indigenous communities are more likely than ethnic minorities to insist on their right to a separate culture linked to a particular territory and their history. They have generally maintained their own language, culture
and social organization distinct from the dominant trends of the societies in which they live. They are also likely to identify themselves as indigenous and be identified as such by other groups. In certain countries, such as Bolivia, Denmark (Greenland) and Guatemala, they represent the majority of the population. There are some 300 million indigenous peoples in more than 70 countries, around half of whom live in Asia.

Indigenous children can suffer cultural discrimination and economic and political marginalization. They are often less likely to be registered at birth and more prone to poor health, to low participation in education and to abuse, violence and exploitation. The Committee on the Rights of the Child has expressed concern about the particular position of indigenous children in Australia, Bangladesh, Burundi, Chile, Ecuador, India, Japan and Venezuela. Any of them are still denied their rights under the Convention on the Rights of the Child, especially with regard to birth registration, access to education and health-care services.

Information on the extent to which indigenous children are denied their rights to survival, health-care services and education relative to the national average is limited. Case studies in individual countries suggest that infant and child mortality rates are higher among indigenous groups than in the national population. In the hill province of Ratanakiri, Cambodia, for example, infant mortality rates are more than twice the national average, while in Australia the mortality rate for indigenous infants is three times the overall rate. Many factors contribute to these disparities, including environmental conditions, discrimination and poverty. Health-care services – including vaccination against preventable diseases – are often lacking in areas inhabited by indigenous peoples. In Mexico, for instance, there are an estimated 96.3 doctors per 100,000 people nationally but only 13.8 per 100,000 in areas where indigenous people make up 40 per cent or more of the population.

Indigenous children are less likely to be registered at birth, in part owing to the absence of information on the issue in their mother tongue. This can result in chronically low levels of registered children at birth: For example, in the Amazonian region of Ecuador only 21 per cent of under-fives have a birth certificate, compared with the national average of 89 per cent. The distance to the nearest registration office and the cost of the certificate can also be severe deterrents. National legislation that prohibits indigenous peoples from registering their children with indigenous names can also prove a strong disincentive to obtaining a birth certificate; in Morocco, for example,
I spent the first two weeks of my life in a neonatal intensive care unit in Bremerhaven, Germany, on a United States military base. Shortly after I took my first breath, a young captain told my father that I had a condition that would cause most people around the world to take me to the top of a mountain and leave me there.

The condition is a rare congenital bone disease called osteogenesis imperfecta, which affects only about 0.008 per cent of the world's population. It causes brittle bones resulting in fractures and, in its most extreme form, death. I have a moderate type in fractures and, in its most extreme form, a. It causes brittle bones resulting in fractures and, in its most extreme form, death. I have a moderate type of osteogenesis imperfecta and have only had 55 fractures. I have undergone 12 surgeries to strengthen my legs through the insertion of metal rods into my bone marrow, as well as one attempt to prevent further curvature of my spine by fusing bone into the curves.

In addition to the physical pain of operations and fractures, I have been plagued with feelings of shame and self-contempt as a result of the social stigma of disability. This is an issue I continue to grapple with today as a 24-year-old law student. As a child, I did not realize how significant the social reality of being disabled was, as I felt that I was a normal child who simply had physical limitations. Still, the reality of fracturing on a random basis was frightening and stressful to both my mother and myself. When I was younger, my mother believed that I might fracture while playing so she isolated me from my peers. I calculated how much time I have spent alone, healing from various injuries, and came up with seven years of my life - a figure that does not include the years prior to my schooling.

My first educational experience was at the age of three when I began to attend a preschool in Colorado, USA, composed exclusively of disabled children. I thought it would be wonderful to get to interact with my peers, but our ability to socialize was limited by their significantly more extreme disabilities. A few years later we moved to California, where I began attending an elementary school as the only disabled child integrated with able-bodied students. I loved school because it gave me the much-needed opportunity to engage in human interaction. But there were still times when I felt socially isolated because of my disability, particularly when it came to socializing beyond the confines of my school.

When I was eight years old, I was sent to a school for disabled children to receive top-quality physical therapy following a re-rodding procedure on my legs. While I received excellent physical therapy, the education was remedial at best. What I learned in my first year of school was taught to me a second time. It was a nice mental hiatus, but I am glad and lucky that my time there lasted only one year.

I returned to my small elementary school in the mountains of California and was content to interact with people of similar intellectual calibre. I began to develop friendships, but had to leave school for about a year to receive a spinal fusion. While healing, I was taught by a home-schoolteacher for an hour a day. Again, I experienced a void in mental stimulation.

During the early 1990s, I enjoyed several years without experiencing any substantial medical issues and remained in school. But when I entered adolescence and - like all children my age - began to become aware of my changing body and to experience physical attraction to other people, things took a turn for the worse. I developed feelings of sexual attraction at the same rate as my peers, yet experienced a significant temporal gap between having these feelings and being able to express them. I felt lost, alone and angry at myself and the world.

I internalized feelings of hatred towards my body, which I now believe were garnered through images of normalized beauty standards perpetuated by the media and by social stigma. Nowhere did I find positive images expressing the humanity of disabled people – only those in which we were depicted as objects intended to provoke pity or sympathy. My self-esteem plummeted, and I felt like I would never escape from feelings of despair. These intense emotions were exacerbated by the fact that I had to leave all of my good friends behind and go to a school on the other side of town, as the school my friends were going to attend was inaccessible to disabled students.

These feelings did not magically disappear when I moved across the country to a small town in South Carolina. If anything, they grew. From the ages of 11 to 16 I hated myself; when I looked in the mirror I would cringe. This period of my life resonates with me today, as I can still feel the scars of those experiences.

My life’s purpose became clear when I began attending the University of Florida. As a student, I developed a passion for disability activism. Through arguing points of equality, beauty and pride in disability, I
internalized these ideas and developed the desire to catalyse positive change for disabled people. I have had the opportunity to represent the United States at two international conferences on disability rights in Norway, published reports through the United Nations and Rehabilitation International, and organized large campus events featuring various notable disabled individuals.

Through these experiences, I came to understand how the stigma related to disability leads to social and economic oppression all over the world. The reality is that the majority of people, around 80 per cent in the United States alone, will become disabled at some point in their lifetime. It is my professional aspiration to initiate a national lobbying agency that would work not only within the established legal system, but also through direct action to encourage individuals, legislators and corporations to reconstruct the social identity of disability.

Positive social evolution for disabled persons can occur with education. Information about issues affecting the disabled could be added to public school curriculums, and training sessions to raise awareness about these issues could be mandated for large companies, similar to race and sexual harassment training. Governments need to include disability issues in educational requirements. People often harbour negative ideas about other groups of people because of lack of awareness and knowledge.

There is a duality in the need for a cognitive revolution, existing within able-bodied and disabled populations. All too often we internalize negative stigmas concerning our disability because we cannot see our beauty. For most of my life I was the only disabled person I knew, and I found it truly difficult to look into the mirror and see an aesthetically different person, and yet still see beauty. We need a sense of internal pride, as much as society needs to accept our abilities and assets. This realization has catalysed my desire to compile a book about the beauty in disability, featuring interviews and photographs of both notable and unknown disabled persons. The book will be dedicated to all disabled people who struggle to see their beauty, much as I did for so many years.

After years of struggling to overcome the feeling of inadequacy and shame that plagued my childhood and early adulthood, I now believe that being disabled is the best thing that has ever happened to me. Never would I have been afforded the wonderful opportunities I have experienced had it not been for my disability. These opportunities and the development of pride in my existence came with a pivotal move into my father’s home when I was 16 years old. He recognized my humanity and encouraged it to flourish, teaching me how to drive and supporting my securing of a job. He allowed me freedom that my mother would have never condoned, and with it I forged an identity that I love. It is wonderful to finally love myself. It is crucial that other parents of children with disabilities allow their children to obtain a sense of independence because it is necessary for self-sufficiency. It is my hope that I can assist those living with disability in my community, as my father did me, so that young people like me no longer internalize feelings of shame about being disabled.

Bethany Stevens is a law student at the University of Florida (UF) and has been a disability activist for five years. Ms. Stevens directed a campaign and petition process that resulted in the opening of an accommodated testing centre for students with disabilities at UF. She is the president of the Union of Students with Disabilities, founder of Delta Sigma Omicron and recently directed the Building a DisAbility Movement conference hosted at UF.

See References, page 91.
Amazigh people must register their children with a recognized Arabic name (see Chapter 3: Invisible Children, for a fuller discussion on the risk of exclusion from birth registration).

In most countries, indigenous children have low school enrolment rates. Scarce educational facilities, governments’ failure to attract qualified teachers prepared to work in the remote areas where many indigenous people live and the perceived irrelevance of much of the school curriculum for the local community – all act as disincentives to school participation. When they attend school, indigenous children often begin their formal education at a disadvantage to other children because they are unfamiliar with the language of instruction. Research indicates that it takes until the third grade before their comprehension begins to match that of children who speak the dominant language.

Neglect and stigmatization can result in exclusion for children with disability

There are an estimated 150 million children with disabilities in the world, most of whom live with the reality of exclusion. The vast majority of children with disabilities in the developing world have no access to rehabilitative health-care or support services, and many are unable to acquire a formal education. In many cases, disabled children are simply withdrawn from community life; even if they are not actively shunned or maltreated, they are often left without adequate care. Where special provision is made for children with disabilities, it often still involves segregating them in institutions – the proportion of disabled children living in public institutions has increased, for instance, in the countries of Central and Eastern Europe since the onset of political transition.

Many disabilities in developing countries are directly attributable to deprivations of essential goods and services, especially in early childhood. Lack of prenatal care adds to the risk of disability, while malnutrition can result in stunting or poor resistance to disease. Disabilities resulting from poor nutrition or lack of vaccines can be addressed by concerted action and donor support. The worldwide assault on polio – a major cause of physical disability in the past – has resulted in a dramatic reduction in the disease, from 350,000 cases in 1988, when the Global Polio Eradication Initiative was launched, to 1,255 at the end of 2004. The disease is now endemic in only six countries – Afghanistan, Egypt, India, Niger, Nigeria and Pakistan – although transmission has been re-established in several countries. But despite this remarkable progress, not every child has been reached, and the
gains remain at risk of reversal until every child is immunized.

Between 250,000 and 500,000 children are still blinded each year by vitamin A deficiency, a syndrome easily prevented by oral supplementation costing just a few cents (given every 4-6 months). Children involved in hazardous labour or who have been conscripted as soldiers face greatly heightened risks of disabling physical injury. Landmines and explosive remnants of war continue to maim or disable children even in countries that are no longer in conflict. Of the 65 countries that suffered mine casualties between 2002 and 2003, nearly two thirds had not experienced active conflict during the period.

Regardless of the cause, or where they live, children with disabilities require special attention. Given the higher risk they face of being excluded from school and within their societies, communities and even households, children living with disabilities are liable to end up forgotten in campaigns for development that focus on statistical targets based on national aggregates.

**Tackling the root causes of exclusion**

The strategies to achieve the Millennium agenda advanced in the reports of the United Nations Millennium Project and of the Secretary General address many of the broad factors mentioned in this chapter and call on governments, donors and international agencies to tackle them. Less emphasis is given, however, to specific measures that would prevent exclusion for children facing extreme poverty, armed conflict, weak governance, HIV/AIDS, and discrimination in all its forms – particularly if, despite the increased efforts of the international community, these factors persist over the coming decade.

**Children in the least developed countries require special attention**

Addressing the special – and urgent – needs of the least developed countries has become a priority objective for the international community in recent years. In May 2001, the Brussels Declaration and Programme of Action for the Least Developed Countries for the Decade 2001-2010 were endorsed by the United Nations General Assembly. But progress on the plan has not matched its ambition. Despite significant advances by some least developed countries towards the plan's individual goals, as a group they have made only limited inroads towards eradicating poverty and fostering sustainable development.

Reducing poverty in the least developed countries will require greater efforts in five major areas: national development strategies, official development assistance, full debt cancellation, fair trade and enhanced technical assistance from donors.

Measures agreed in 2005 at both the Group of Eight (G-8) Summit in July and the World Summit in September will go some way towards increasing official development assistance and reducing external debt burdens for the least developed countries. But for development strategies to be truly effective and sustainable, they require a stronger focus on children, who account for around half of the population in these countries. As Chapter 4 will attest, poverty-reduction processes, and budgets in particular, will need to be adjusted to expand or reallocate resources for the social development required to diminish the deprivations faced by millions of children living in the least developed countries. In addition, even bolder initiatives may well be required on official development assistance, debt reduction and fair trade to ensure that the Millennium agenda is met for the world's most impoverished nations.

**Conflict resolution and prevention are required to safeguard children and women**

Preventing and resolving armed conflict are central objectives of the peace and security aims of the Millennium agenda, outlined in detail in the Millennium Declaration. With children and women most at risk from armed conflict - accounting for around 80 per cent of all deaths among civilians due to armed conflict since 1990 – conflict prevention and resolution are vital to ensure their protection and access to essential services. Where conflict does occur, emergency
Every minute, a child under 15 dies of an AIDS-related illness. Every minute, another child becomes HIV-positive. Every minute, four young people between the ages of 15 and 24 contract HIV.

These stark facts underline the devastating impact that HIV/AIDS is having on children and young people. The children of sub-Saharan Africa are hardest hit, but unless the HIV pandemic is halted and sent into retreat, Asia is on course to have higher absolute numbers of HIV infections by 2010. Millions of children, adolescents and young people orphansed, made vulnerable or living with HIV are in urgent need of care and protection. If rates of HIV infection and AIDS-related deaths continue to rise, the crisis will persist for decades, even as prevention and treatment programmes expand.

HIV/AIDS is denying millions of children their childhood. The disease exacerbates the factors that cause exclusion, including poverty, malnutrition, inadequate access to basic social services, discrimination and stigmatization, gender inequities and sexual exploitation of women and girls.

National governments committed themselves to addressing the impact of HIV/AIDS on children in the Declaration of Commitment endorsed at the United Nations General Assembly Special Session on HIV/AIDS in 2001. But progress has been slow. Children are often overlooked when strategies on HIV/AIDS are drafted, policies formulated and budgets allocated. At the 2005 World Summit, world leaders pledged to scale up responses to HIV/AIDS through prevention, care, treatment, support and mobilization of additional resources.

The Global Campaign on Children and AIDS – Unite for Children. Unite against AIDS – launched in October 2005, is a concerted push to ensure that children and adolescents are not only included in HIV/AIDS strategies, but become their central focus. An overarching aim of the campaign is to meet Millennium Development Goal 6, which aims to halt and reverse the spread of HIV/AIDS by 2015. Achievement of the campaign goals will also have positive implications for the other MDGs.

Although global in reach, the campaign will have a strong focus on the most-affected countries in sub-Saharan Africa, home to 24 of 25 countries with the world’s highest levels of HIV prevalence. The campaign seeks to provide a child-focused framework around country programmes in four main areas, dubbed the ‘Four Ps’:

**Prevent infection among adolescents and young people**
Reduce HIV/AIDS risks and vulnerability by increasing access to and use of youth-friendly and gender-sensitive prevention information, life skills and services.

**Prevent mother-to-child HIV transmission**
Increase provision of affordable and effective services that help HIV-positive pregnant girls and women avoid transmitting the virus to their children. Prioritize care, support and treatment programmes for HIV-infected children and pregnant women.

**Provide paediatric treatment**
Provide affordable paediatric HIV drugs, such as cotrimoxazole, to prevent opportunistic infections.

**Protect and support children affected by HIV/AIDS**
Make sure a higher proportion of the neediest children receive quality family, community and government support, including education, health care, birth registration, nutrition and psychosocial support.

The Global Campaign on Children and AIDS involves partners from every sector of the global community. It aims to unite as many people, organizations and agencies as possible under its call to action. From the outset, the campaign was positioned within harmonized approaches, especially the ‘Three Ones’ principles that were endorsed by a consensus of governments, international organizations, donors and civil society; the WHO and UNAIDS ‘3 by 5’ Initiative, which aims to provide sustained treatment for 3 million people living with HIV/AIDS; and national poverty reduction strategies.

In partnership, governments and agencies, activists and scientists, corporations and community workers, and as many others as possible will work through the campaign to ensure that this is the last generation of children that bears the bitter burden of HIV/AIDS.

See References, page 91.
Responses should consist not only of providing essential services and goods, but also preventing the separation of families and helping to reunite them, initiating the resumption of schooling, organizing child protection and preventing HIV/AIDS.45

Children living in ‘fragile’ States must not be forgotten

‘Fragile’ States require particular attention, since a dysfunctional government will complicate efforts to implement any policy or obtain any non-humanitarian development assistance. Nonetheless, continued engagement with governments of such States – and also non-state actors who may wield substantial power within these countries – is often vital to safeguard children living in these countries from exclusion. Children must not be forgotten by the international community because of their countries’ failings.

A global campaign to mitigate the impact of HIV/AIDS on children is under way

The international community is stepping up its efforts to tackle HIV/AIDS through a series of initiatives. These efforts are crucial to check the spread of the disease and to make treatment widely available. Far greater attention must be given, however, to the impact of the pandemic on children and adolescents, especially girls, and to ways of protecting them from both infection and exclusion. To this end, UNICEF and its partners have launched a global campaign on children and AIDS (see Panel page 30).

Governments and societies must openly address discrimination

Tackling discrimination requires a multi-pronged approach. Many elements of discrimination are rooted in long-held societal attitudes, which often governments, civil society and the media are reluctant to confront. Yet confront them they must, if they are to fulfil their commitments to children. Targeted initiatives to address the exclusion faced by women and girls, ethnic and indigenous groups and the disabled are needed, along with legislation to prohibit discrimination, and greater research on these groups’ needs and well-being. Taken by themselves, however, such measures may only serve to reduce discrimination, not tackle its root causes. For these initiatives to bring about lasting change, they must be accompanied by a courageous, open discussion – involving the media and civil society – on societal attitudes that foster or tolerate discrimination. The future of children at risk of exclusion as a result of discrimination depends on such courageous action.

Swift and decisive action is required

A childhood cannot wait for extreme poverty to be eradicated, armed conflict to abate, the HIV/AIDS pandemic to subside, or for governments and societies to openly challenge attitudes that entrench discrimination and inequalities. Once past, a childhood can never be regained. For millions of children, their childhood and their future depend on swift and decisive action being taken now to address these threats.
Extreme and Relative Poverty: Precursors to Exclusion

MDG 1 focuses on halving extreme poverty by 2015. While the most widely used measure of poverty is the proportion of people whose income is less than $1 a day, poverty has multiple definitions and numerous ways of affecting children. Children experience extreme poverty differently than adults: Child poverty cannot be understood only in terms of family income, and responses must take children’s experiences into account. For them, poverty is experienced as both material and developmental deprivation.* The exclusion resulting from poverty can have lifelong impacts.

Children do not have to live in extreme poverty to feel excluded. Research suggests that when children do not consider themselves to be part of families whose material conditions are close to what is considered ‘normal’ for their community, the impact is greatly felt.** This relative deprivation is based on the idea that people decide how well off or deprived they are – what they should deserve or expect – by comparing themselves to others. Measuring the distribution of wealth within a country or territory by comparing the differences in resources available to the wealthiest and poorest sections of society is one simple way to gauge inequality.

Even if the goal to end the extreme poverty faced by millions is achieved, relative deprivation – the inequality and exclusion faced by children and their families – will continue unless specific measures to encourage equality and social mobility are pursued, including the allocation of resources for education, health care and other interventions to ensure that the rights of every child are fulfilled.

** See, for example, Christian Children’s Fund, Children in Poverty: The Voices of Children, 2003.
This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

Distribution of income: ratio between richest 10% and poorest 10%

0 - 9 times greater
10 - 19 times greater
20 - 39 times greater
40 - 59 times greater
Over 60 times greater
No data


Proportion of the population living on less than one dollar a day (where greater than 2%)

Source: World Bank, 2006 World Development Indicators.