

General note on the data

The data presented in the following statistical tables are based on internationally comparable and statistically sound data, and are accompanied by definitions, sources and explanations of symbols. Data from the responsible United Nations organization have been used wherever possible, such as for the economic and demographic indicators. In the absence of such internationally standardized estimates, the tables draw on other sources, particularly data received from the appropriate UNICEF field office. More detailed information on methodology and sources of the data presented is available at <www.childinfo.org>.

Several of the indicators, such as the data for life expectancy, total fertility rates, and crude birth and death rates, are part of the regular work on estimates and projections undertaken by the United Nations Population Division. These and other internationally produced estimates are revised periodically, which explains why some data will differ from earlier UNICEF publications. This report includes the latest estimates and projections from the *World Population Prospects 2006*.

Data quality is likely to be adversely affected for countries that have recently suffered from human-caused or natural disasters. This is particularly true where basic country infrastructure has been fragmented or major population movements have occurred.

Mortality estimates

Each year, UNICEF includes in *The State of the World's Children* mortality estimates, such as the infant mortality rate, under-five mortality rate and under-five deaths, for at least two reference years, if possible. These figures represent the best estimates available at the time the report is produced and are based on the work of the Inter-agency Group for Child Mortality Estimation, which includes UNICEF, the World Health Organization (WHO), the World Bank and the United Nations Population Division. This group updates these estimates every year, undertaking a detailed review of all newly available data points. At times, this review will result in adjustments to previously reported estimates. Therefore, estimates published in consecutive editions of *The State of the World's Children* may not be comparable and should not be used for analysing mortality trends over time. It is important to note that comparable under-five mortality estimates for the periods 1970, 1990 and the latest year are available in Table 10. In

addition, the full time series for all countries is published at <www.childinfo.org>. This time series is based on the most recent estimates produced by the Inter-agency Group for Child Mortality Estimation.

In addition, updated maternal mortality estimates for the year 2005 are presented in this report. These estimates, based on the work of a WHO/UNICEF/United Nations Population Fund UNFPA/World Bank inter-agency group, were jointly published by the group in *Maternal Mortality in 2005*, WHO, Geneva, 2007. These model-based estimates use a dual approach to adjust these data to take into account the frequent under-reporting and misclassification of maternal deaths.

Multiple Indicator Cluster Surveys (MICS)

For more than a decade, UNICEF has supported countries in collecting statistically sound and internationally comparable data through the Multiple Indicator Cluster Surveys (MICS). Since 1995, nearly 200 surveys have been conducted in approximately 100 countries, and the latest round of MICS surveys was conducted in over 50 countries in 2005–2006, allowing for a new and more comprehensive assessment of the situation of children and women globally. The UNICEF-supported MICS, along with the Demographic and Health Surveys, are among the largest sources of data for monitoring progress towards the Millennium Development Goals and may be used for reporting on 21 of the 53 MDG indicators. These data are also used for monitoring other internationally agreed commitments, such as the World Fit for Children Plan of Action and the global goals on AIDS and malaria. They have been incorporated into the statistical tables appearing in this report and have also been used to inform the report's analyses. More information on these data is available at <www.childinfo.org>.

Revisions

Several statistical tables have been revised this year.

Table 2. Nutrition: The vitamin A supplementation coverage rate is now reported for children aged 6–59 months receiving two high-dose vitamin A supplements, in addition to the previously reported indicator of children aged 6–59 months receiving at least one dose in the last six months. Full coverage is defined as receiving two high-dose vitamin A supplements in the previous calendar year.

Table 3. Health: There are two major changes in this year's child health indicators.

Immunization – A new methodology has been developed by WHO and UNICEF to estimate protection at birth (PAB) against tetanus, and the figures presented in this year's report are therefore not comparable to estimates published in previous editions.

This new methodology tracks cohorts of women from infancy through life, using both WHO/UNICEF estimates of coverage by three doses of diphtheria, pertussis and tetanus vaccine (DPT3) and reported and survey-based estimates of the proportion of pregnant women who are routinely vaccinated with tetanus toxoid (TT). Adjustments are then made to account for the proportion of women who were reached with TT in supplementary immunization activities. Reported data may also be adjusted to take into account coverage patterns in other years and/or results available through surveys. The duration of protection is then calculated based on published WHO estimates of the duration of protection by all doses ever received. The end result is the probability that a child is protected against tetanus as a result of maternal immunization if she or he is born in a given year.

Antibiotic use for suspected pneumonia – Data now include estimates of the percentage of children under five with suspected pneumonia who receive antibiotics, in addition to the previously reported estimates of children with suspected pneumonia taken to appropriate health providers. The recently implemented Multiple Indicator Cluster Surveys have provided a wealth of new data on antibiotic use for childhood pneumonia.

Table 4. HIV and AIDS: The data on estimated adult HIV prevalence and the estimated number of people living with HIV are based on Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO estimates generated in 2005. These estimates were scheduled to be updated at the end of 2007, but the new figures were not available at the time of publishing this report.

Global surveillance of HIV and AIDS and sexually transmitted infections is a joint effort of WHO and UNAIDS. In countries with a generalized epidemic, national estimates of HIV prevalence are based on data generated by surveillance systems that focus on pregnant women attending selected sentinel antenatal clinics. More recently,

an increasing number of countries are implementing HIV testing as part of their nationally representative population-based surveys. When available, the results of this population survey are included in the estimation of a country's adult HIV prevalence. In countries with a low-level or concentrated epidemic, national estimates of HIV prevalence are primarily based on surveillance data collected from populations at high risk (commercial sex workers, men who have sex with men, injecting drug users) and on estimates of the size of populations at high and low risk. More information on these estimates is available at <www.epidem.org>.

Table 5. Education: The adult literacy rate has been replaced by the youth literacy rate (ages 15–24 years), disaggregated by gender.

Table 8. Women: There are three major changes to this year's table:

Female primary and secondary school enrolment/attendance – Previously, this table reported the gross enrolment ratio (females as a percentage of males) for both primary and secondary education. This year, those figures have been replaced by the net attendance ratio (females as a percentage of males) for both levels of education, and these data are presented alongside the net enrolment ratio (females as a percentage of males) for both levels. The net enrolment/attendance ratios better reflect levels of school participation in both primary and secondary education.

Institutional deliveries – In addition to presenting the proportion of births attended by skilled health personnel, this year's table presents the proportion of births taking place in health facilities.

Maternal mortality – As mentioned above, updated maternal mortality estimates for the year 2005 presented in this report are based on the work of the WHO/UNICEF/UNFPA/World Bank inter-agency group and are published in *Maternal Mortality in 2005*, WHO, Geneva, 2007. These maternal mortality estimates are adjusted to take into account the under-reporting and misclassification of maternal deaths. More information is available at <www.childinfo.org>.

Table 9. Child Protection: Three new indicators have been included in this table, which is largely based on the wealth

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of new child protection data that has recently become available through MICS, DHS and other national-level surveys.

Attitudes towards domestic violence – This indicator is defined as the percentage of girls and women aged 15–49 who responded that a husband or partner is justified in hitting or beating his wife under certain circumstances. Respondents were asked whether a husband or partner is justified in hitting or beating his wife under certain circumstances, i.e., if his wife neglects the children, goes out without telling him, argues with him, refuses sexual relations, or burns the food.

Child disability – This indicator is defined as the percentage of children aged 2–9 years who screened positive on at least one of the questions on disability (i.e., cognitive, motor, seizure, vision or hearing). Questions on disability are addressed to the parent or caretaker of the child, who is asked to provide a personal assessment of the child's physical and

mental development and functioning. Data on the prevalence of disability refer to the percentage of children who screened positive on these questions and therefore must be considered an indication of the percentage of children who are likely to have a disability and who may require further medical and developmental assessment.

Child discipline – This indicator is defined as the percentage of children aged 2–14 years who experience any psychological or physical punishment. Psychological punishment includes shouting, yelling and screaming at the child, and addressing him or her with offensive names. Physical or corporal punishment comprises actions intended to cause physical pain or discomfort but not injury. Minor physical punishment includes shaking the child and slapping or hitting him or her on the hand, arm, leg or bottom. Severe physical punishment includes hitting the child on the face, head or ears, or hitting the child hard or repeatedly.

Explanation of symbols

Because the aim of these statistical tables is to provide a broad picture of the situation of children and women worldwide, detailed data qualifications and footnotes are seen as more appropriate for inclusion elsewhere. The following symbols are common across all tables; symbols specific to a particular table are included in the table footnotes.

- Data are not available.
- x Data refer to years or periods other than those specified in the column heading, differ from the standard definition or refer to only part of a country. Such data are not included in the calculation of regional and global averages.
- y Data refer to years or periods other than those specified in the column heading, differ from the standard definition or refer to only part of a country. Such data are included in the calculation of regional and global averages.
- * Data refer to the most recent year available during the period specified in the column heading.
- § Includes territories within each country category or regional group. Countries and territories in each country category or regional group are listed on page 148.