

5 Vulnerable Children in Developing Countries: special considerations

This chapter describes the common challenges facing vulnerable children in developing countries, taking a life-cycle approach. It examines selected dimensions of well-being, including educational attainment, health and child protection measures. Child outcomes can vary based on household income, parents' education, gender, ethnicity and place of residence.

Introduction

Despite remarkable progress in poverty reduction since 2000, children in developing countries remain exposed to many risks that compromise their development and well-being and prevent them from reaching their potential. In part, these risks stem from a failure of economic growth to be inclusive, widening inequalities within countries. Large numbers of children have limited and poor access (or in some cases, no access at all) to health services, adequate nutrition, positive early learning environments, quality education and other protections.

As is the case in developed countries, inequalities develop early in life and childhood experiences are important determinants of later life outcomes (Chapters 2 and 3). Focussing on the primary child development stages, this chapter provides a cursory overview of child vulnerability in developing countries along three key dimensions for measuring child well-being and intervening to improve outcomes: health, education, and child protection/rights (Table 5.1).

Table 5.1. Indicators of child well-being and potential vulnerability used in this chapter

Age cohort	Dimension of well-being	Influencing variables	Selected indicators
Infants and young children (0-5 y/o)	Health	<ul style="list-style-type: none"> • Household income • Socioeconomic status • Ethnicity and culture • Religion • Place of residence 	Infant, child and maternal mortality; malnutrition (stunting, wasting, overweight)
	Education		Early childhood development (ECD)
	Child protection/rights		Birth registration; female genital mutilation (FGM)
School-aged children (6-14 y/o)	Health		Regular healthcare; water, sanitation and hygiene (WASH); Disability adjusted life years (DALYs)
	Education		Access to education and retention in school
	Child protection/rights		Violence; child labour; subjective-well-being
Adolescents (15-18 y/o)	Health	Risky health behaviours	
	Education	Youth literacy	
	Child protection/rights	Early marriage and childbearing	

Infants and young children (0-5 years old)

Zero to five years of age is a critical period for child development. Yet in developing countries, persistent poverty, malnutrition, poor healthcare and non-stimulating home environments deprive young children of opportunities to develop strong foundations in cognitive, motor, and social-emotional skills (Grantham-McGregor et al., 2007^[1]). The 0-5 age group has the highest rate of child mortality in developing countries: 5.4 million of a total 6.3 million deaths in 2017 (UN IGME, 2018^[2]). This group is also particularly vulnerable to poor health outcomes, impaired physiological development and violation of their fundamental rights.

Gaps in progress on reducing infant and child mortality persist within regions

Despite unprecedented global progress in reducing infant and child mortality, wide gaps still exist between and within world regions (Figure 5.1). According to estimates by the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), Sub-Saharan Africa remains the region with the highest under-five mortality rate in the world, with an average of 76 deaths per 1 000 live births. About 1 in 13 children die in Sub-Saharan Africa before their fifth birthday. This ratio is 14 times higher than the high-income country average of 1 in 185, and 20 times higher than the region with the lowest average under-five mortality rate (Australia and New Zealand, where the average is 1 in 263) (UN IGME, 2018^[2]).

Figure 5.1. Sub-Saharan Africa has the highest under-five mortality rate in the world

Under-5 mortality rate (2017)



Source: [UN IGME \(2018\) Levels and Trends in Child Mortality Report 2018](#).

Numerous factors influence early child survival outcomes, but an important share is attributable to health service provision and the social determinants of health (Table 5.2) (Silva et al., 2018^[3]). Maternal care, namely the availability of prenatal care, medically assisted deliveries and health facility delivery, significantly reduces infant mortality (Rutstein, 2000^[4]). Good sanitation coupled with access to health services, and good quality of care play a role (Silva et al., 2018^[5]). Public health interventions, including access to and availability of quality nutrition, are important. Other factors associated with infant and child mortality include poverty, location (urban/rural), access to electricity, and caregivers' level of education (Rutstein, 2000^[4]).

Table 5.2 The leading causes of death in children 0-5 years old are largely preventable

Leading causes of death in post-neonatal children: risk factors and response

Cause of death	Risk factors	Prevention	Treatment
Pneumonia, or other acute respiratory infections	Low birth weight		Appropriate care by a trained health provider
	Malnutrition	Vaccination	
	Non-breastfed children	Adequate nutrition	Antibiotics
	Overcrowded conditions	Exclusive breastfeeding Reduction of household air pollution	Oxygen for severe illness
Childhood diarrhoea	Non-breastfed children	Exclusive breastfeeding	Low-osmolality oral rehydration salts (ORS)
	Unsafe drinking water and food	Safe water and food	
	Poor hygiene practices	Adequate sanitation and hygiene	Zinc supplements
	Malnutrition	Adequate nutrition Vaccination	

Source: WHO (2014^[6]), Leading causes of death in post-neonatal children: risk factors and response in Weekly epidemiological record 89(38), World Health Organization, Geneva, www.who.int/wer/2014/wer8938.pdf.

Inequalities in child survival outcomes are evident within countries, with location, poverty prevalence and other socio-economic factors often determining access to life-saving health interventions. For example, infant, child, and maternal mortality are disproportionately higher in rural areas.

A combination of factors, including low maternal education and low concentration of health professionals and health facilities, contributes to 50% higher under-five mortality rates in rural areas (UN IGME, 2018^[2]). Poor children are more likely to be exposed to health risks that they are less able to withstand due to undernutrition and other hazards that are typical in poor households (Victora et al., 2003^[7]). Children in indigenous households are less likely to access preventive and curative care, with inadequate public health subsidies locking this population in a vicious cycle of poverty and poor health (Victora et al., 2003^[7]).

Stunting and wasting, measured by low height-for-age and low weight-for-height respectively, are typical indicators of childhood malnutrition. While less than half of the world's children live in low- and middle-income countries, these countries host two in three of all stunted children and three in four of all wasted children (UNICEF/WHO/World Bank, 2019^[8]). Unsafe sanitation and foetal growth restrictions are the most significant risk factors (Danaei et al., 2016^[9]). As of 2018, South Asia has the highest prevalence of child malnutrition, with 32.7% of children stunted and 14.6% wasted, as compared to 2.6% of stunted children and 0.4% of wasted children in Northern America. Oceania and Sub-Saharan Africa have the next highest overall malnutrition prevalence, with 38.2% and 32.2% of children stunted and 9.4% and 7.1% of children wasted, respectively (UNICEF/WHO/World Bank, 2018^[10]). In Sub-Saharan Africa, stunting is more common among boys and children living in rural areas; sanitation and access to health care are factors (Keino et al., 2014^[11]). In India, girls are more affected by stunting, as nutritional resources may be allocated in preference to boys and girls play a bigger role in the care of younger infants. Higher maternal education is a protective factor (Pillai and Nahar, 2019^[12]).

Undernutrition is the main cause of nearly half of under-five mortality (Black et al., 2013^[13]). Evidence from low- and middle-income countries suggests that early exposure to undernutrition and poverty is closely linked to deficits in subsequent cognitive and social-emotional development, educational performance, adult income and chronic disease risks (Lu, Black and Richter, 2016^[14]). Children born to adolescent mothers are particularly at risk of undernutrition, as they are more likely to be undernourished, have a lower level of education, poorer access to health services and live in poorer conditions. Delaying childbirth to an older maternal age can reduce child stunting. (Nguyen et al., 2019^[15]).

Public health interventions aimed at reducing preventable diseases and conditions often fail to reach populations in need. A review of public health interventions in the 42 countries where 90% of child deaths worldwide occurred in 2000 showed that 63% of these deaths could have been prevented by full implementation of a few well-known and effective interventions. Overall, breastfeeding was the preventive intervention that reached the most children (measured by the breastfeeding rate at 6-11 months), followed by coverage of the measles vaccination (two-thirds of children under 5 years). However, 60% of children remained in need of common and effective interventions such as insecticide-treated nets and diphtheria-pertussis-tetanus vaccinations (Bryce et al., 2013^[16]).

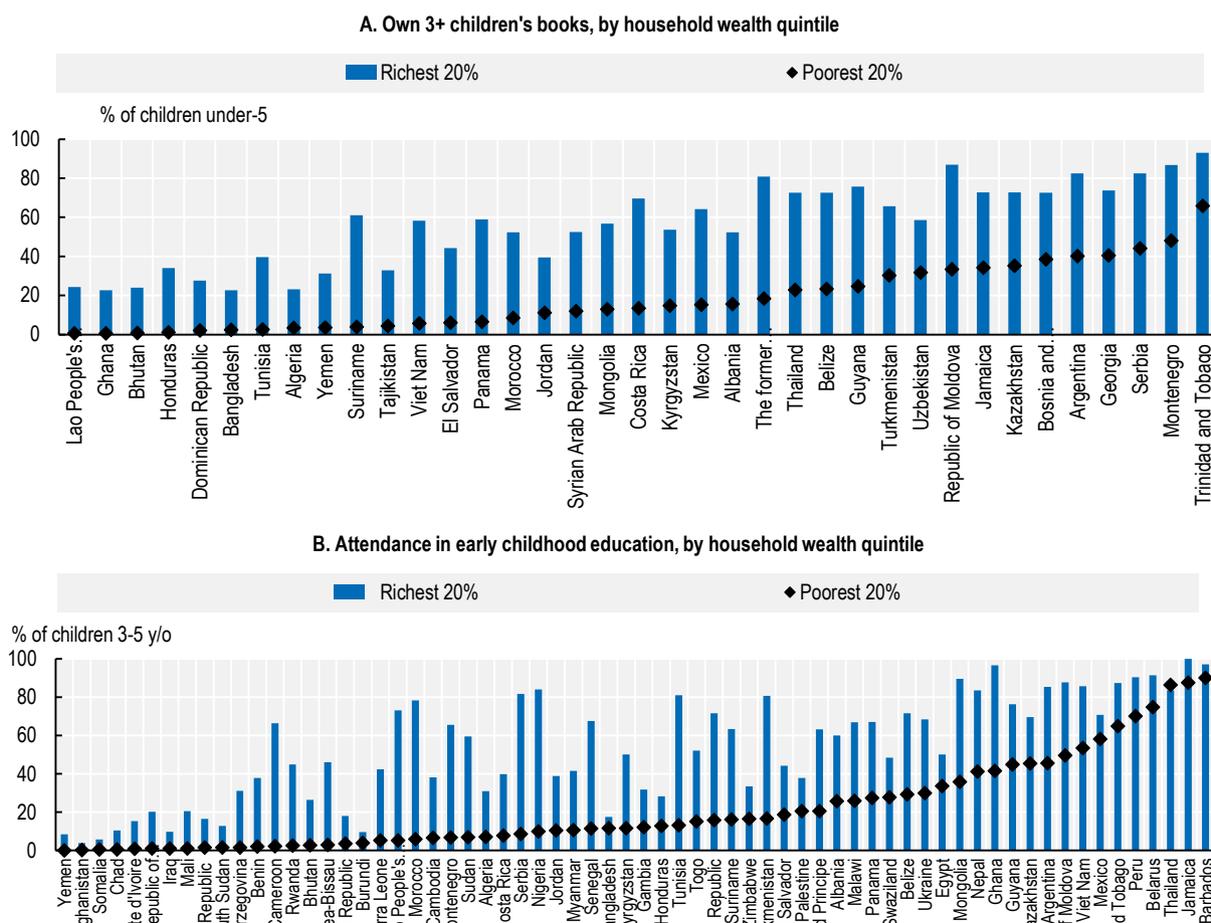
Early childhood development programmes are not accessible to the poorest children

The brain develops faster and has a higher plasticity during early childhood than at any other point in life. Evidence suggests that activities that provide optimal opportunities for positive stimulation of children's developing sense of sight, sound, touch, taste and smell are critical to healthy cognitive, social, emotional and physical development in infancy and beyond. To this end, early childhood development (ECD) programmes offer a safe and nurturing environment for young children to develop to their fullest potential, and can mitigate some of the negative effects of poverty and other adverse circumstances on their development (The Lancet Child & Adolescent Health, 2019^[17]).

The United Nations Convention on the Rights of the Child (UNCRC) affirms the right of children to develop to the maximum extent possible (Article 6). Early childhood is a critical period for child learning, yet ECD is often under-exploited as an opportunity to assist the development of children from poorer households (UNICEF, 2013_[18]). Children in rural areas have fewer opportunities to attend pre-primary programmes, with less than 25% of children accessing ECD in 24 out of 52 low and middle-income countries (UNESCO, 2017_[19]).

Across most countries in development, children in the poorest households are less likely to have access to a favourable learning environment (i.e. one that is safe and physically well organised with access to developmentally appropriate books and toys) at home or through an ECD programme, compared with affluent children (Figure 5.2). These children are also less likely to interact with adults who engage in activities that promote early learning and school readiness, such as reading books, playing, singing songs and spending time with the child outside the home. This is especially true in least-developed countries (LDC), where an estimated 29% of children in the wealthiest quintile were enrolled in ECD, compared with only 7% of children in the poorest quintile (UNICEF, 2017_[20]).

Figure 5.2. The poorest children in developing countries lack access to learning materials and early education



Source: UNICEF (2017^[20]), “Early childhood development - early childhood education data” and “Early childhood development – home environment data”, United Nations Children’s Fund, New York.

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Home environments favourable to children’s early development and enrolment in ECD can serve as a measure of child cognitive development, as well as the likelihood of children staying in school. In Sub-Saharan Africa, 69% of children aged 36-59 months old in the top 20% of the wealth distribution had adult support for early learning and school readiness, compared with only 44% of children in the bottom 20%. (UNICEF, 2016^[21]).

The human rights of infants and young children are not always adequately protected, especially in the poorest households

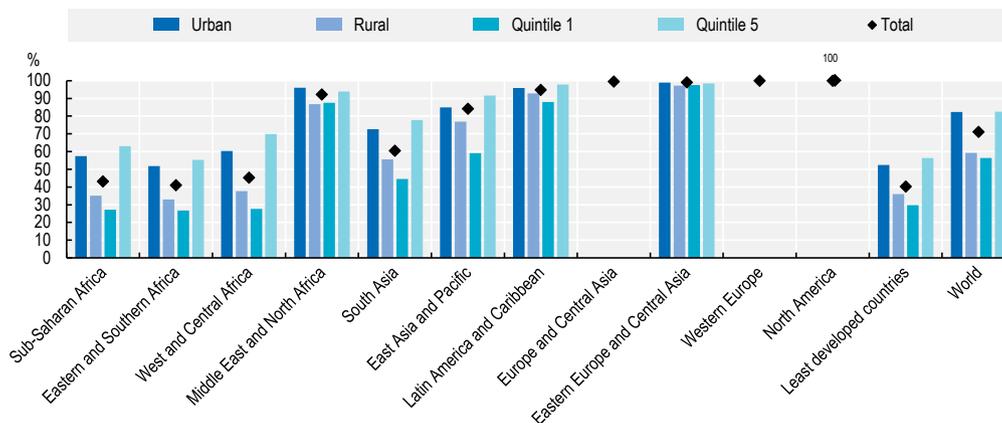
Birth registration is the process of formally recording a child’s birth in a government’s civil registry. It is a prerequisite for accessing government services and social protection, and provides protection from exploitation (child labour, early marriage, forced conscription into armed services, sexual abuse and trafficking) and access to juvenile justice. Although most countries have a legal framework in place for birth registration, laws are not always enforced or sufficiently comprehensive (UNICEF, 2003^[22]). In many developing countries, birth registration systems have fallen into disuse due to high associated costs, low bureaucratic engagement and lack of oversight. Individual factors such as poverty, religion, maternal education and access to a health facility play a role (Bhatia et al., 2017^[23]).

Eight of the ten countries with the lowest birth registrations for children under five are in Sub-Saharan Africa: Somalia (3%), Liberia (4%), Ethiopia (7%), Zambia (14%), Chad (16%), Tanzania (16%), Guinea-Bissau (24%) and the Democratic Republic of the Congo (28%) (UNICEF, 2013^[24]). Low birth registration remains a prevalent child rights issue for countries affected by armed conflict. According to UNICEF’s Innocenti Research Centre, war and high poverty were factors in the majority of countries where children’s birth registration is lower than 40% (UNICEF-IRC, 2007^[25]). In a number of conflict-torn countries, civil registration systems are likely to be weak and caregivers lack information. In Afghanistan, less than 10% of mothers whose children were unregistered knew how to register their child’s birth, as did less than 20% in the Democratic Republic of the Congo (UNICEF, 2013^[24]).

Birth registration rates vary widely within countries and are particularly low in rural areas and among the poorest households (Figure 5.3). Prohibitive factors include distance to the nearest registration facility and associated opportunity costs. Overall, across most regions, children from the wealthiest households are 1.5 times more likely have their births registered than children from the poorest households (Figure 5.3). Birth registration is highest in Latin America and the Caribbean (95%), the Middle East and North Africa (92%), and Eastern Europe and Central Asia (99%).

Figure 5.3. Birth registration is particularly low in rural areas and for the poorest households

Percentage of children under age 5 whose births are registered, by location and household wealth quintile



Source: UNICEF (2017_[26]), "Birth registration data", UNICEF Data. <https://data.unicef.org/resources/dataset/percentage-children-age-5-whose-births-registered-sex-place-residence-household-wealth-quintile/>.

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Female genital mutilation/cutting (FGM/C) refers to "all procedures that involve partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons" (WHO, 2018_[27]). Across 29 countries studied, an estimated 39% of women and girls aged 15-49 have undergone some form of FGM/C (OECD, 2019_[28]). Various reasons are given for the persistence of FGM/C, including it being a rite of marriage, a prerequisite for inheritance or a purported means of safeguarding girls' chastity or controlling their sexuality. FGM/C is not endorsed by any religion in particular, but religious narratives are commonly deployed to justify the practice.

Where FGM/C is practised, it disproportionately affects infant and young girls under five. In half of African countries with available data, the majority of girls who underwent FGM/C were cut before 5 years of age (UNICEF, 2013_[29]). Evidence has shown that in some contexts the practice of FGM/C is associated with women of low socio-economic status (Sakeah et al., 2018_[30]).

School-aged children (6-14 years old)

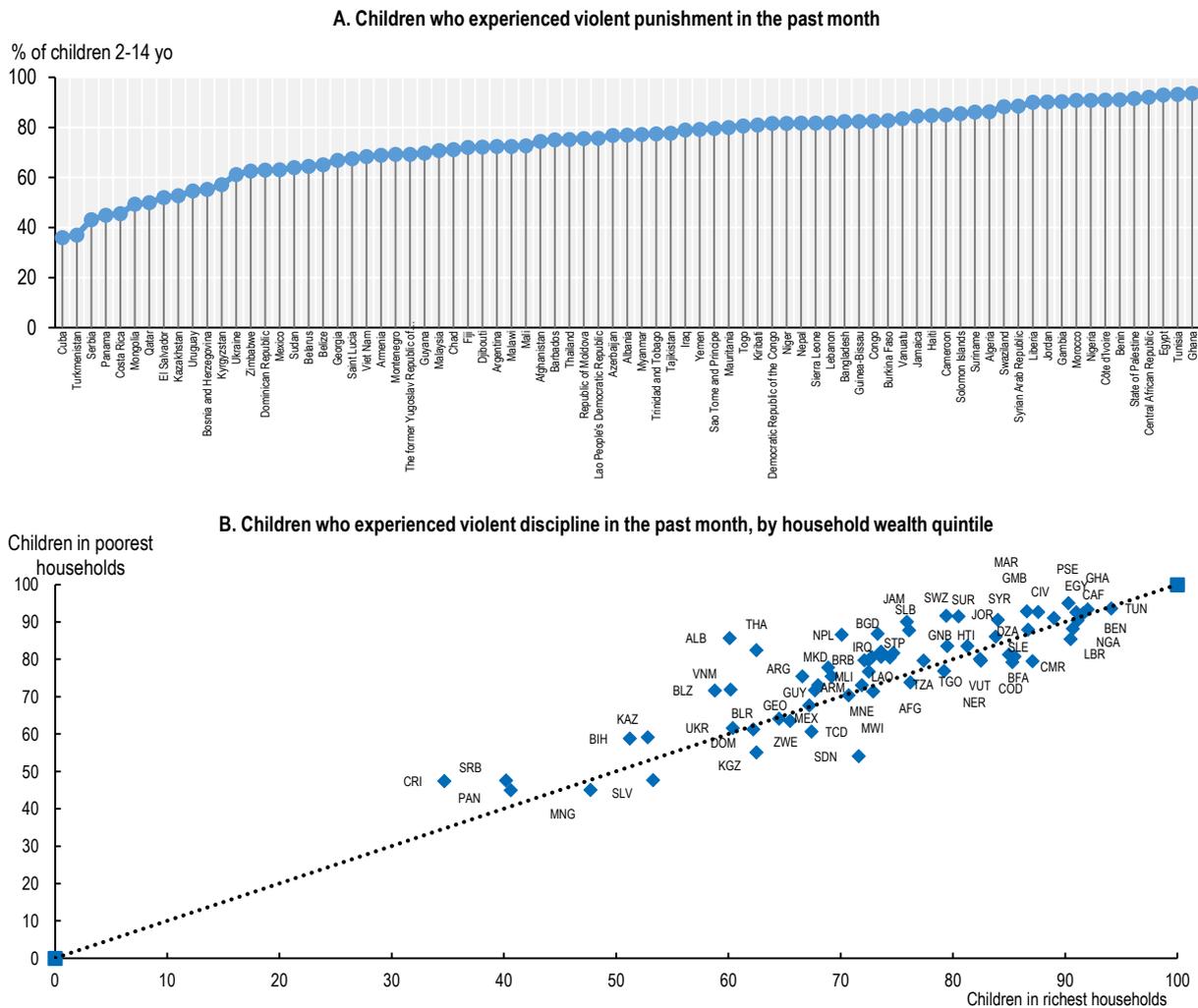
School-aged children (children and young adolescents) are in a period of physiological transition into puberty and are even more vulnerable to external pressures such as economic impoverishment, societal gender expectations and educational performance, among others. In developing countries, barriers to healthcare and water, sanitation, and hygiene (WASH) continue to affect children's health outcomes. Protecting children against violence and labour exploitation is fundamental to helping them develop to their fullest potential.

Violence disrupts the healthy development of children

The UNCRC declares the right of children to protection from all forms of physical and psychological violence, maltreatment and exploitation, including sexual abuse. Significantly, children's first exposure to violence is likely to be in the home through violent forms of discipline (physical punishment and/or psychological aggression) and exposure to intimate partner violence (UNICEF, 2017_[31]).

Data collected from the Demographic and Health Surveys (DHS) Program, UNICEF’s Multiple Indicator Cluster Surveys (MICS3) and national surveys indicates that violent discipline is extremely common. Around 79% of children between the ages of 1-14 in least-developed countries experience either physical punishment or psychological aggression each year (Figure 5.4). The percentage of children subjected to violent discipline does not vary significantly between quintiles of household wealth (Figure 5.4B). One in four children under five years of age worldwide is in the care of a mother who has been a recent victim of intimate partner violence (UNICEF, 2017^[31]). Chapter 4 of this report explores the impact of exposure to intimate partner violence on child development.

Figure 5.4. Violent forms of discipline are common in many developing countries



Note: Violent discipline is defined as physical punishment and/or psychological aggression.
 Source: UNICEF (2017), *A Familiar Face: Violence in the lives of children and adolescents*, United Nations Children’s Fund, New York.

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Data on the prevalence of sexual abuse in developing countries suggests that girls are at heightened risk, particularly from the age of 10 onwards. In 20 countries with data, nine out of ten adolescent girls who have been a victim of forced sex (sexual intercourse or any other forced sexual act) report the first occurrence happening during adolescence. In 28 countries with data, nine out of ten adolescent girls report

being victimised by somebody close or already known to them. Very few girls, around one out of ten, report ever accessing professional help. Despite the lack of data evidencing boys' exposure to sexual violence, boys are also vulnerable. Among boys aged 13-17 years, the most common perpetrators are classmates/friends and partners (UNICEF, 2017^[31]). Chapter 2 of this report explores the impact of child sexual abuse on child well-being.

Child labour threatens the health and education of children worldwide

Child labour captures forms of work that are harmful to the physical, social, mental or moral development of children, including work that deprives them of the opportunity to attend school, obliges them to leave school prematurely or requires them to combine school attendance with excessively long and heavy work. The minimum employment age of 15 only applies to work not defined as one of the worst forms of child labour.

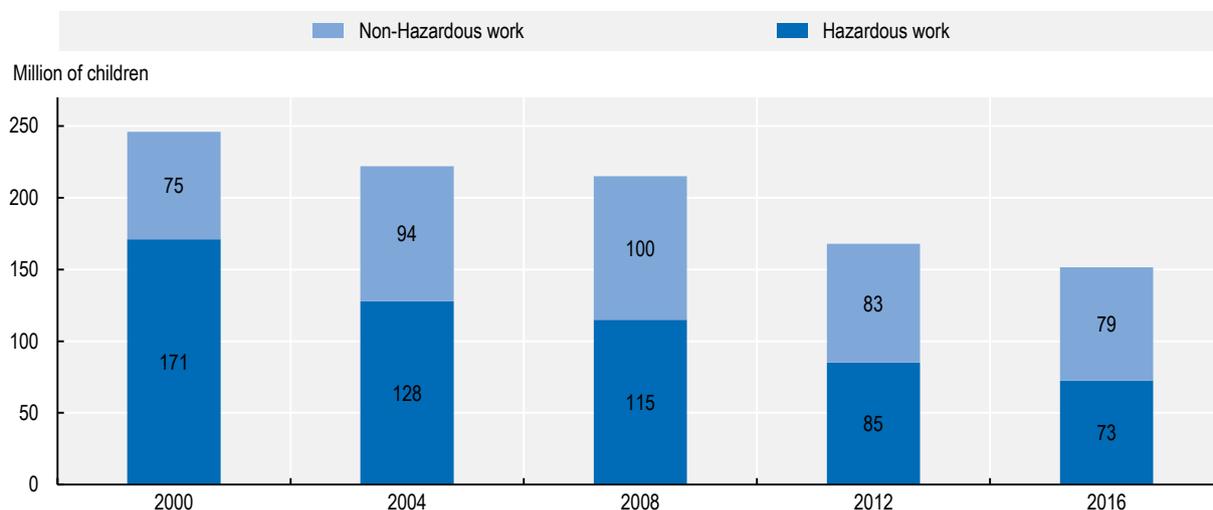
Not all work carried out by children is child labour, and not all child labour falls under the internationally recognised legal definition of the worst forms of child labour. The worst forms of child labour involve children being enslaved, separated from their families, exposed to serious hazards and illnesses and/or left to fend for themselves on the streets of large cities, often from a very early age. Whether or not particular forms of work are classified as child labour depends on a child's age, working conditions and the type and hours of work performed.

Eradicating the worst forms of child labour is not only a moral imperative, it is essential for ensuring that children can enjoy their childhoods and fulfil their potential. Sustainable Development Goal target 8.7 aims to eradicate child labour in all its forms by 2025.

The adoption in 1999 of the ILO Worst Forms of Child Labour Convention was followed by a significant reduction in child labour: in 2016, around 152 million children were in child labour worldwide, down from 246 million in 2000, when data on child labour was first estimated (Figure 5.5). Nevertheless, after a significant decline in the late 2000s, the pace of progress has slowed. Since 2012, numbers of children in child labour are growing again, mainly in Sub-Saharan African countries.

Figure 5.5. Child labour has declined, but progress has slowed

Millions of children aged 5-17 years old in child labour, 2000-16



Source: ILO (2012), ILO Global Child Labour Trends 2008-2012 and ILO (2017) Global Estimates of Child Labour Report.

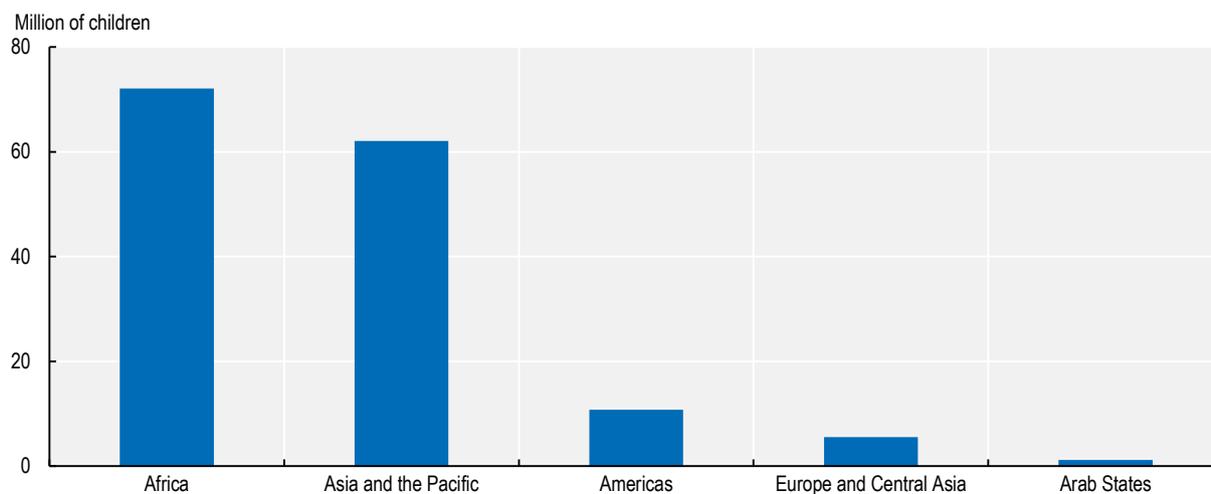
In 2013, the OECD issued *Due Diligence Guidance for Responsible Supply Chains of Minerals from Conflict-Affected and High-Risk Areas*, an effort by member countries of the International Conference on the Great Lakes Region¹, industry, civil society and UN experts on the Democratic Republic of the Congo to reinforce protections against the worst forms of child labour. In 2017, the OECD published *Practical Actions for Companies to Identify and Address the Worst Forms of Child Labour in Mineral Supply Chains*.

Child labour is a heterogeneous phenomenon characterised by large differences across and within countries in the same region. The global picture includes the following key facts (ILO, 2017^[32]):

- In 2016, about one in ten children aged 5-17 years engaged in some form of child labour, and nearly half in hazardous forms of work. Forty-eight percent were in the 5-11 age bracket, 28% aged 12-14 years and 25% aged 15-17 years.
- Children engaged in child labour typically work in paid or unpaid household-based economic activities, mostly agricultural work. ILO figures for 2016 suggest that 108 million boys and girls worked in the agricultural sector, an increase of 10 million children from 2012. This rise was mainly driven by an increase in child labour in the African region.
- Boys are more involved in paid work than girls. Girls do more unpaid work and spend longer hours on household chores (which often prevents them from attending school).
- Although roughly two-thirds of children engaged in child labour are enrolled in school, they are more likely to leave school prematurely or perform poorly on tests.
- The worst forms of child labour, particularly hazardous child labour, contribute to chronic health problems that have serious repercussions for physical and/or mental health outcomes in adulthood.
- Children doing unpaid household work such as cooking, cleaning and caring are typically not counted in child employment and child labour statistics, but 2016 ILO estimates indicate that around 800 million children aged 5-17 years spend at least some time each week performing household chores. Girls do far more, spending more than 14 hours per week engaged in these tasks.
- About nine in ten children in child labour live in Africa or in the Asia and the Pacific region (Figure 5.6). Africa ranks highest, with one in five children in child labour. The share is 7% in Asia and the Pacific.

Figure 5.6. Nine in ten children in child labour live in Africa or in Asia and the Pacific

Regional estimates of child labour, 5-17 years old, million (2016)



Note: The Africa region comprises both northern Africa and Sub-Saharan Africa, while the Arab States region excludes northern Africa. The Americas region comprises both Latin American and the Caribbean and northern America. Regional estimates based on the new regional classifications are therefore not comparable with the regional estimates based on the previous ILO regional classification system employed in the 2012 and 2008 global estimate reports.

Source: ILO (2017) Global estimates of Child labour.

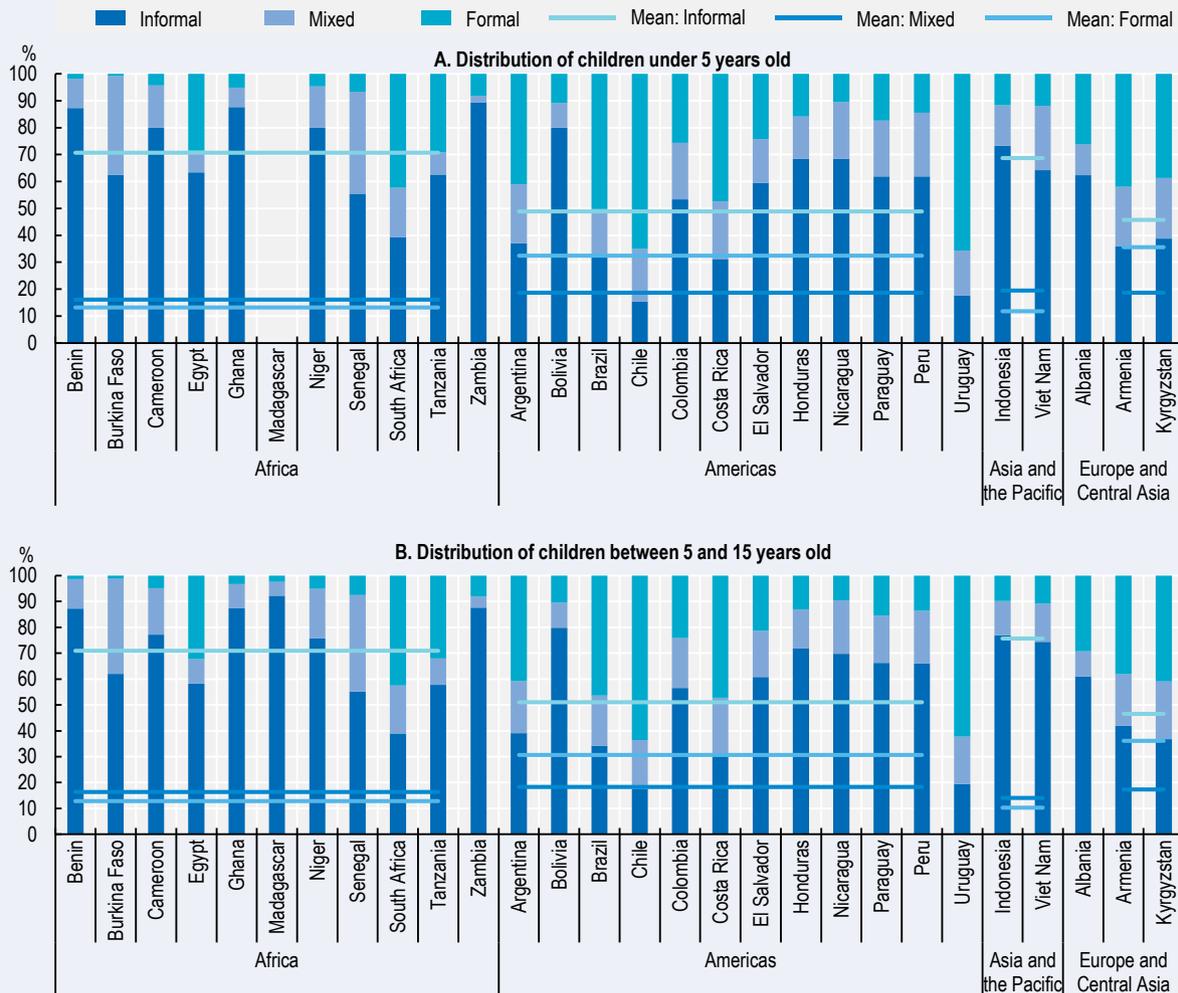
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Box 5.1. Informal household employment contributes to the vulnerability of children in developing countries

The majority of children in developing countries live in households where all workers are informally employed (informal households) or households with a mix of workers employed in formal and informal employment (mixed informal households) (OECD, 2019^[33]). Based on estimates from the OECD's *Key Indicators of Informality based on Individuals and their Households (KIIBIH) Database*, on average around 60% of children in developing countries live in some kind of informal household (Figure 5.7). In Sub-Saharan Africa, the rate is even higher, at 70%. In Latin America and the Caribbean, the rate is just under 50%. In the more advanced economies sampled, the proportion of children in households where all workers are formally employed is larger.

By definition, informal employment implies the absence of social protection for workers. This exposes the dependents of informal workers more to shocks than those living in mixed or formal households. Children in informal households are less likely to have access to consistent and affordable healthcare and other social protection programmes.

Figure 5.7. Children (aged 0-15) are overrepresented in informal households



Note: Data is not available for children under 5 in Madagascar.

Source: OECD (2019), *Key Indicators of Informality based on Individuals and their Household* (database).

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Children from poorer households have less chance of completing their education

Statistically, children in the least developed countries are unlikely to complete primary school. Only 50% of children in low-income countries who enter the first grade pass through to the last grade of primary school, compared to the world average of 80% in 2016. Students in Sub-Saharan Africa and small island developing states (SIDS) have the worst outcomes (54.3% and 58.9% respectively), followed by the Arab States (80.7%) (UIS.Stat, 2018^[34]).

Rates of attendance, retention and attainment typically decline as children progress through the education system. More than half of young people worldwide have not completed upper secondary school (UNESCO, 2017^[19]). Barriers to education range from high costs to lack of disability-inclusive programmes. While many developing countries have mandated school attendance for primary through to secondary school, not all children are able to comply. For example, less than one in five countries guarantee twelve years of free and compulsory education (UNESCO, 2017^[35]).

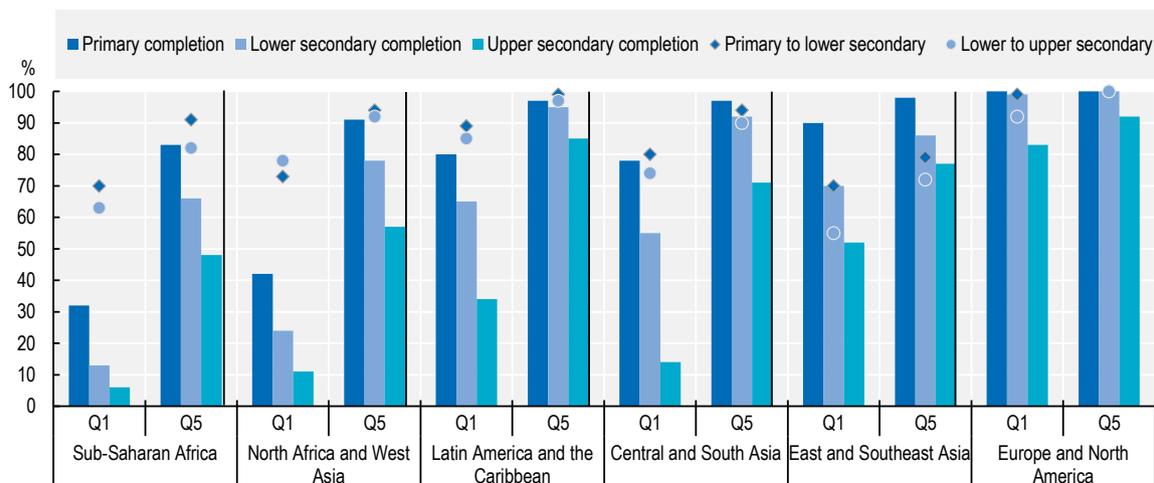
Children from poor households are the most vulnerable to leaving school prematurely. Poor households have fewer economic and educational resources to invest in children. Across all regions of the world, children from wealthier families are more likely to attain a completed education than those from poor families. There is a strong association between inequality and educational completion rates (Figure 5.8). Children from families in the top wealth quintile complete primary school and proceed to secondary school at much higher rates than children from families in the lowest wealth quintile. Mitigating factors include parents' level of education, low teacher-to-student ratios, adequate schooling facilities, distance to school facilities, and the presence of white-collar jobs in the district, though poverty remains one of the most influential factors for school completion (Huisman and Smits, 2009^[36]).

Across all levels of schooling, girls are much less likely to receive an education than boys. At the primary level, only two out of three countries have achieved gender parity, falling to one out of two at lower-secondary level and one in four at high-secondary level. Some regions are progressing faster at closing the gap, for instance Southeast Asia and in particular India. Sub-Saharan Africa remains far from achieving parity at all levels of education. Barriers to girls' participation include access to sanitation facilities for menstrual hygiene management, early marriage and early pregnancy. In 2016, only half of schools had access to handwashing facilities with soap and water. Four sub-Saharan African countries exercise a full ban on young mothers returning to school (UNESCO, 2019^[37]).

Poverty moderates children's educational aspirations, which in turn influences children's participation, motivation and achievement at school. For example, children from disadvantaged socio-economic backgrounds are also likely to experience pressure to drop out of school in favour of paid work. Family environment and socio-economic status are the most immediate barriers to upward mobility, despite external factors that also influence children's knowledge, development and aspirations. Family environment affects children's aspirations and can contribute to a self-fulfilling prophecy of low expectations and educational attainment. Low socio-economic status is associated with low-educational attainment and limited or no economic mobility (see also Box 5.2.).

Figure 5.8. Students from poorer families are less likely to attain a complete education

Primary through upper secondary education completion rates and transition rates, by household wealth quintile



Note: Primary completion rate is the percentage of (i) children and young people aged 3-5 years above primary school graduation age and (ii) young people aged 15-24 years, who have completed primary school. The transition rate to lower secondary education is the number of young people attending the first grade of lower secondary school as a percentage of those attending the final grade of primary school. The lower secondary completion rate is the percentage of (i) young people aged 3-5 years above lower secondary school graduation age and (ii) young people aged 15-24 years, who have completed lower secondary school. The lower to upper secondary transition rate is the number of young people attending the first grade of upper secondary school as a percentage of those attending the final grade of lower secondary school. The upper secondary completion rate is the percentage of (i) young people aged 3-5 years above upper secondary school graduation age, and (ii) people aged 20-29 years, who have completed upper secondary school.

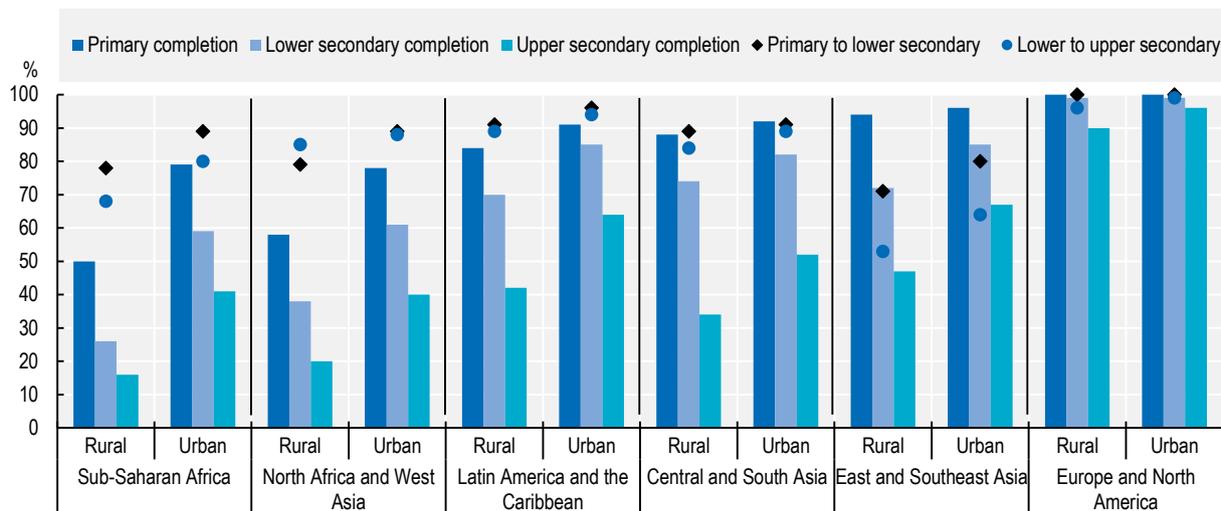
Source: Authors' calculations based on UNESCO (2017^[19]), *World Inequality Database on Education (WIDE)*.

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Rural areas generally lag behind urban centres in grade completion at every level of education. There is a gradual reduction in the number of students moving through the education system from primary to upper secondary school level (Figure 5.9). The primary level completion rate is high in both urban and rural areas in the majority of world regions. However, despite the high transition rates, completion rates of lower and upper secondary schooling are low, with the exception of Europe and North America. All other regions have low upper secondary completion rates, particularly in rural areas, for instance Sub-Saharan Africa (16%), followed by rural Central and South Asia (34%) and rural Latin America and the Caribbean (42%).

Figure 5.9. School completion rates are higher in urban areas, across all regions

Primary through upper secondary education completion rates and transition rates, by location



Note: Primary completion rate is the percentage of (i) children and young people aged 3-5 years above primary school graduation age and (ii) young people aged 15-24 years, who have completed primary school. The transition rate to lower secondary education is the number of young people attending the first grade of lower secondary school as a percentage of those attending the final grade of primary school. The lower secondary completion rate is the percentage of (i) young people aged 3-5 years above lower secondary school graduation age and (ii) young people aged 15-24 years, who have completed lower secondary school. The lower to upper secondary transition rate is the number of young people attending the first grade of upper secondary school as a percentage of those attending the final grade of lower secondary school. The upper secondary completion rate is the percentage of (i) young people aged 3-5 years above upper secondary school graduation age, and (ii) people aged 20-29 years, who have completed upper secondary school.

Source: Authors' calculations based on UNESCO (2017^[19]), [World Inequality Database on Education \(WIDE\)](https://doi.org/10.1787/888934039198).

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Box 5.2. School completion and parental migration in Cambodia

A recent empirical study based on the 2009 Cambodia Socio-Economic Survey examined the impact of migration on the well-being of children whose parents have migrated and found a significant negative effect on children's school attendance (Hing, Lun and Phann, 2011^[38]).

Children in migrant families are more likely to drop out of school. Reasons include little to no aspiration to study and obligation to contribute to household chores and income (OECD/CDRI, 2017^[39]). Girls are disparately impacted; 73.8% of surveyed household stated they would take female children out of school if needed (OECD/CDRI, 2017^[39]). According to the OECD/CDRI report *Interrelations between Public Policies, Migration and Development in Cambodia*, this reflects gender-biased customary thinking, wherein almost 50% of household heads believe girls are better suited to household chores than attending school, and 20.3% say it is risky for girls to go far from home. The study also found that children in migrant households have a 27% higher probability of participating in economic activities than those in non-migrant households.

Source: OECD/CDRI (2017^[39]), *Interrelations between Public Policies, Migration and Development in Cambodia*, OECD Publishing Paris.

Access to WASH improves health and educational outcomes

Children from poor households are less likely to have access to clean water, sanitation, and hygiene (WASH). Children's entry into schooling systems provides an opportunity to access these facilities. Undisrupted access to regular healthcare, water, sanitation and hygiene services – in and outside of schools – is necessary to curtail vectors of disease and adverse health outcomes, and improve hygiene behaviours in students' households and communities, such as handwashing with soap to reduce contact with and contraction of diarrhoea. Universal, sustainable, and equitable access to safe drinking water, sanitation and hygiene is key for achieving other public health agendas (i.e. health and nutrition, education, economic growth and gender equality).

Disadvantaged girls stand to benefit greatly from "WASH at school" interventions, for instance bathroom facilities separated by gender. These girls often lack the economic resources to meet menstrual hygiene needs (Sommer et al., 2016^[40]). In Ghana, Kenya and Uganda, for example, unmet need for menstrual pads or tampons is cited as one of the major reasons for surveyed girls to miss school (Jewitt and Ryley, 2014^[41]; Montgomery et al., 2016^[42]; Montgomery et al., 2012^[43]). Recent evidence shows an association between early puberty and economic impoverishment. This underlines the importance of basic WASH facilities in schools (Kelly et al., 2016^[44]; Arim et al., 2007^[45]; Sun et al., 2017^[46]).

Older adolescents (15-18 years old)

Adolescents aged 15-18 occupy a unique space at the intersection between children (0-18) and youth (15-24). Many programmes in developing countries focus specifically on child vulnerabilities or the challenges of youth transitioning into adulthood, overlooking the needs of older adolescents.

Basic literacy rates are improving, and functional literacy is more important than ever

Literacy is the ability to read and write. It is a fundamental necessity for day-to-day life in much of the world. Over the last 65 years, the global literacy rate has increased from 42% in 1960 to 86% in 2015 (UNICEF, 2015^[47]). Overall, school enrolments have increased, leading to the highest rate of basic literacy rates among youth (15-24 years old) ever: on average, 90.5% of the world's youth are literate, with a slight gap between men (92.5%) and women (88.5%) (UNICEF, 2015^[47]).

Results from PISA for Development (PISA-D) highlight the gap between OECD countries and developing countries in school progression and student core skills proficiency. Among the seven participating countries – Cambodia, Ecuador, Guatemala, Honduras, Paraguay, Senegal and Zambia – only 43% of all 15 year-olds enrolled in at least grade seven were eligible to participate in PISA, compared to the OECD average of 89%. Lower eligibility was associated with students being absent from school or in a lower grade. Twenty-three percent of participating students attained the minimum level of reading proficiency (Level 2 in PISA) compared to the OECD average of 80%. At Level 2 in PISA, students can read simple and familiar texts and understand them literally. They can also demonstrate, even in the absence of explicit directions, some ability to connect several pieces of information, draw inferences that go beyond explicitly stated information, and connect a text to their personal experience and knowledge (Ward, 2018^[48]).

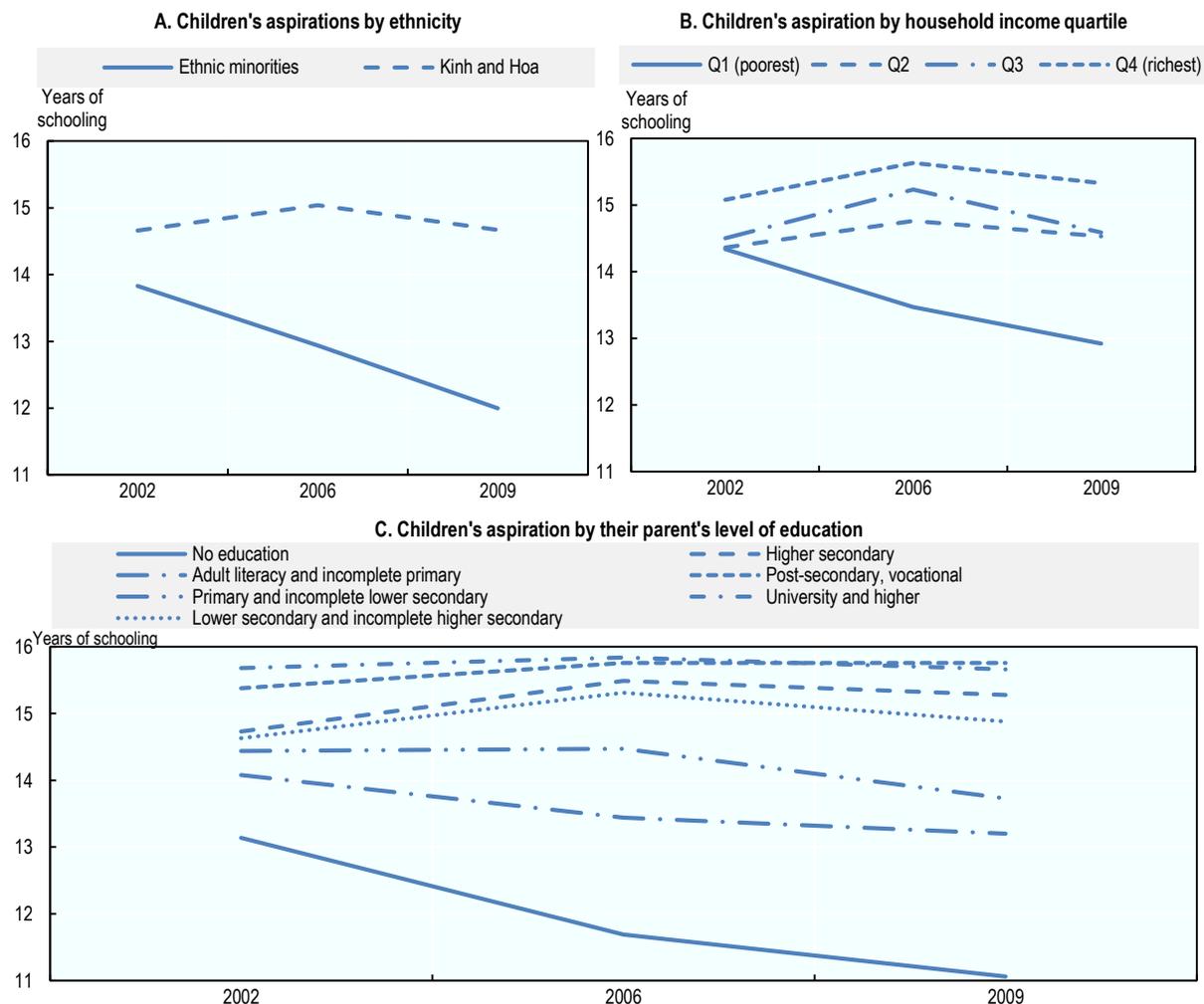
Attaining basic literacy is often not enough for young people in developing countries to succeed in an ever increasingly digital world. While basic literacy measures the ability to read and write a simple sentence, functional literacy and numeracy requires additional competencies. UNESCO defines functional literacy and numeracy as the ability to identify, understand, interpret, create, communicate and compute, using printed and written materials associated with varying contexts. This implies the ability to produce and engage with knowledge in a larger variety of contexts (UNESCO, 2017^[49]).

Functional and digital literacy are increasingly important for employment and full participation in society. Evidence supports the relationship between poverty and illiteracy in a handful of countries (Christoffels et al., 2016^[50]; UNESCO/Indian National Commission for co-operation with UNESCO, 2001^[51]). In the Netherlands, functionally illiterate people have a considerably lower income on average than those who are literate, with 19% of functionally illiterate people living below the national poverty line for at least one year, and 6% living in long-term poverty (Christoffels et al., 2016^[50]).

Improving youth functional literacy levels can help in meeting rising youth aspirations. At all education levels young people enter the labour market with high career aspirations, but often these aspirations are not satisfied by current employment, due in-part to skills mismatch (OECD, 2017^[52]). Skills mismatch – whether measured as over- or under-qualification in education or skills – can be mitigated by development of functional literacy and numeracy skills and complemented with high-quality career guidance counselling, investments in the quality, relevance and responsiveness of education and initial training, and opportunities to learn on the job and to receive continuing training at work (OECD, 2017^[52]).

By and large, youth career aspirations are driven by young people's position in society, with the notable exception of female students, who have high career preferences (OECD, 2017^[52]). Panel analysis based on the Young Lives dataset for Viet Nam on children aged between 12-19 years (Figure 5.10) shows the negative association between children's aspiration and ethnicity, household income, and parental education. Household income and parental education positively influence children's aspirations. Moreover, as they get older, children from an ethnic minority, in the poorest wealth quartile and with parents lacking primary education tend to adjust their aspirations downwards. Readjusting downwards educational aspiration is linked with the maturing of children's own attitudes and preferences, but also barriers to further education and accessing a good job, and existing job opportunities.

Figure 5.10. Children's educational aspirations by socio-economic status of the household, by years of schooling



Source: OECD (2014^[53]), *Social Cohesion Policy Review of Viet Nam*

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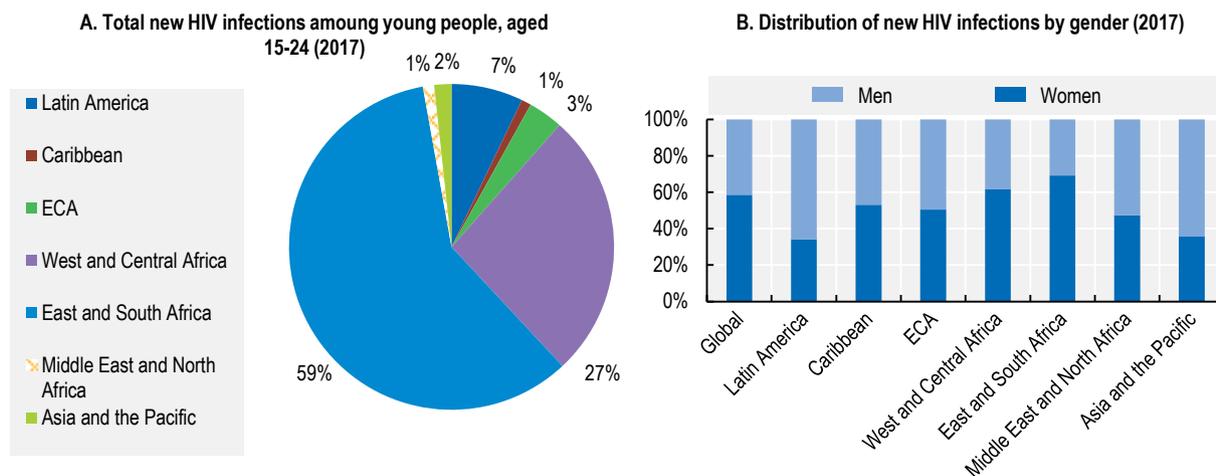
Risky health behaviours among youth can jeopardize long-term health

Risky behaviours amongst adolescents, such as drug and alcohol abuse or unprotected and unsafe sex, increase vulnerability to adverse health outcomes and chronic health conditions. Unprotected and unsafe sex facilitates the spread of sexually transmitted diseases and infections such as HIV/AIDS and HPV, among others, and can lead to early and/or unwanted pregnancy.

HIV/AIDS is one of the more serious and lethal transmitted diseases that can be acquired through risky health behaviours. Young people bear a major share of new HIV/AIDS infections, with global estimates of 1 600 young people acquiring HIV per day, and one young person dying from AIDS-related illnesses every ten minutes (UNAIDS, 2018^[54]). Currently, over 30% of all new HIV infections occur among youth aged 15 to 25 years, with 59% of the world's newest HIV transmissions among youth in Sub-Saharan Africa (Figure 5.11) (UNAIDS, 2018^[54]).

Young women (15-24 years) are disproportionately impacted by new HIV infections among youth. For instance, in Sub-Saharan Africa, 67% of new infections among youth are contracted by women. Worldwide, 58% of new HIV infections globally are contracted by women (UNAIDS, 2018^[54]). Young gay men are 27 times more likely to contract HIV/AIDS than heterosexual men, forming an important key population at risk (UNAIDS, 2018^[54]).

Figure 5.11. Percentages of new HIV infections in young people, by region and gender



Source: UNAIDS (2018^[54]), [Youth and HIV — Mainstreaming a three-lens approach to youth participation](#).

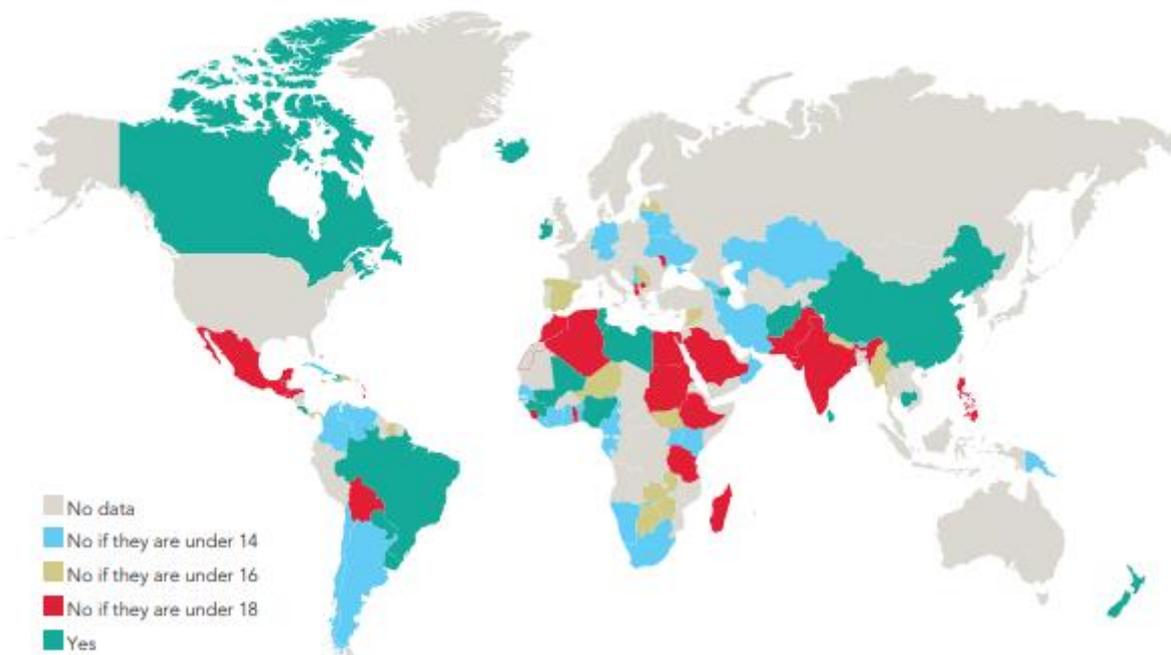
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Restricted medical rights for youth under 18 years old contribute to difficulties in receiving a diagnosis and accessing treatment. Many young people are unaware of having contracted HIV/AIDS and can be reluctant to seek testing services that require the consent of a parent or caretaker. Among countries for which data is available, 60% require adolescents to have parental consent in order to access HIV treatment services (Figure 5.12). Of these countries requiring consent, 29% require parental consent for adolescents younger than 18 years of age, 19% require it for adolescents younger than 16, and 12% require it for adolescents younger than 14 (UNAIDS, 2018^[54]).

In summary, children living with HIV/AIDS deal with stigma and can be the subject of discrimination, exclusion, and violence, all of which have long-term effects on well-being.

Figure 5.12. Parental consent is still largely necessary for young people to access HIV/AIDS testing

ARE ADOLESCENTS LEGALLY ALLOWED TO ACCESS HIV TESTING WITHOUT PARENTAL CONSENT?



Source: UNAIDS (2018^[54]), *Youth and HIV: Mainstreaming a Three-lens Approach to Youth Participation*

Early pregnancy and marriage can hinder the healthy transition of girls and boys into young adulthood

Early marriage (before the age of 18) and early pregnancy (before the age of 20) remain common in developing countries. Most countries have set a legal age for marriage (usually 18 years), however 93 countries provide exceptions upon parental consent or court application. Furthermore, 54 countries allow girls to marry between one and three years earlier than boys (Heymann and McNeill, 2013^[55]). In total, 39 000 girls marry every day, of which one in three marry before the age of 19 and one in nine before the age of 15.

Early marriage is closely linked to early motherhood. Ninety percent of the 16 million adolescent girls who give birth each year are married. Of these 16 million, two million are under the age of 15. Access to education is a major protective factor against early pregnancy, as more years in school correlates with fewer pregnancies (WHO, 2014^[56]). In all, a significant number of women have their first baby while still children themselves. Between 2010 and 2015, over 45% of women in the 20–24 age cohort reported having given birth for the first time by age 18. Early marriage and pregnancy are linked with lower educational attainment, higher rates of poverty, higher rates of maternal mortality, lower likelihood of accessing health services, HIV exposure, domestic violence and reduced decision-making power within the family) (Nguyen et al., 2019^[57]; Jones, Harper and Watson, 2010^[58]). In fact, complications from childbirth and pregnancy is the leading cause of death among females in the 15-19 age cohort in low- and middle-income countries (WHO, 2014^[56])

Poverty disparately affects the proportion of girls who are married early. In many developing countries, adolescent pregnancy rates are higher among girls from poor families. In Latin America and the Caribbean, for example, pregnancy rates are 3-5 times higher for poor adolescents versus their richer counterparts (Fatusi and Hindin, 2010^[59]). Across poorer rural areas, pregnancy rates are also higher than in urban

areas (Fatusi and Hindin, 2010^[59]). Girls with no education are also at higher risk of early pregnancy than those who have at least attended secondary education (Fatusi and Hindin, 2010^[59]).

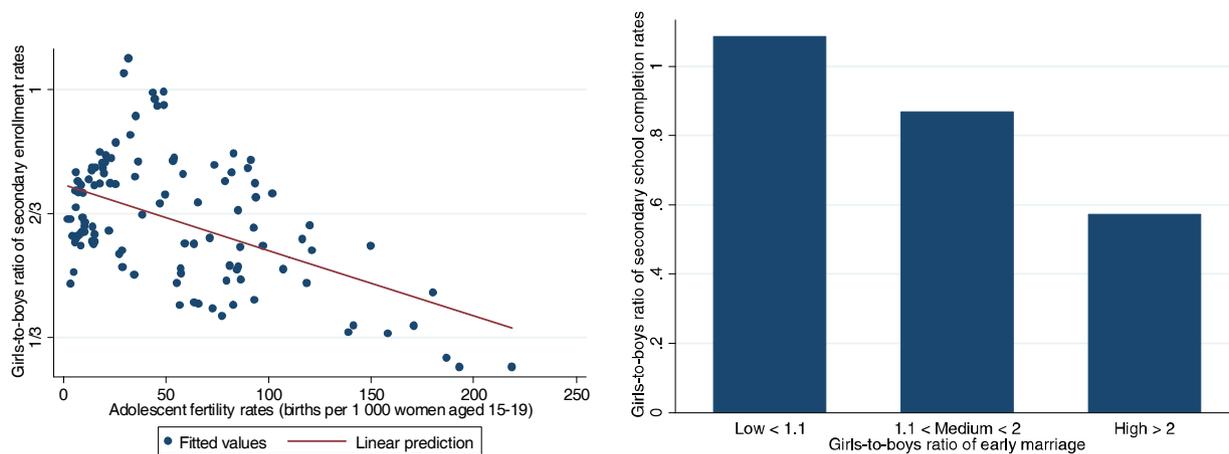
Since 2010, early marriage rates have dropped significantly, though global absolute numbers remain high. Today one in five girls is married before the age of 18, compared with one in four a decade ago (UNICEF, 2018). South Asia has the highest rates of child marriage in the world: 45% of all women aged 20-24 years reported being married before the age of 18, and 17% are married before the age of 15 (UNICEF, 2018).

Early marriage and pregnancy cut short girls' educations and explain persistence in gender gaps at the secondary school level. Societal expectations and heavy domestic workloads force many married girls to abandon their education. In Nigeria, marriage and childbearing account for 15-20% of girls' dropping out of school (Nguyen and Wodon, 2012). Where adolescent fertility rates are high, fewer girls enrol in secondary school, thereby increasing the gender gap in enrolment and completion rates (Figure 5.13).

Likewise, in countries where more girls than boys aged 15-19 are married, fewer girls complete secondary school (Figure 5.13). As the rates of prevalence of both early marriage and early pregnancy increase, girls' secondary school enrolment rates and completion rates decrease. This is the case regardless of other factors at the country level, including poverty, share of female teachers, government expenditure on education, female unemployment rates, urbanisation rates and region-specific characteristics.

Figure 5.13. Early pregnancy and early marriage are linked to low secondary school completion rates among girls

Correlation between secondary school enrolment and adolescent fertility, early marriage and school completion



Note: This graph shows the relationship between the predicted total fertility rate and the SIGI 2014, controlling for the country's human development index score, gender gap in unemployment rates, and urbanisation rates.

Source: OECD (2014^[60]), SIGI 2014 Synthesis Report, OECD Development Centre, Paris.

Conclusion

This chapter described the common challenges facing vulnerable children in developing countries under three dimensions of well-being. While the factors contributing to child vulnerability overlap with those discussed in earlier chapters, in developing countries place of residence and gender are especially pertinent. Infant, child and maternal mortality are disproportionately higher in rural areas and with low maternal education. Low concentration of health workers and health facilities are associated factors. Poverty and lack of access to education contribute to large numbers of girls marrying before the age of 18.

The six areas of policy action for improving the well-being of vulnerable children discussed in Chapter 5 are equally valid in the context of developing countries. However, there is wide variation in the modalities developing countries can use to implement desired policy objectives, from programme types to supporting legislation.

In the context of high infant mortality, maternal and child health interventions are critical for improving children's health and survival. Perinatal mortality accounts for more than 20 percent of deaths in children under five, underscoring the necessity of good quality and accessible maternal health care. Child health interventions should focus on the root causes of child mortality, which are in most cases attributable to five preventable communicable diseases: pneumonia, diarrhoea, measles, malaria and HIV/AIDS. Malnutrition increases the risk of dying from these diseases.

The potential for high returns in early child development makes investing in the early years a priority. Within developing countries, there are large differences in the quality of children's home learning environments. In the majority of developing countries, children from the poorest wealth quintile are unlikely to access early child development (ECD) programmes, though ECD can go a long way in assisting families in meeting children's basic needs. Interventions include nutritional supplementation; socio-emotional and cognitive stimulation; health care; training, support and education of parents, caregivers, and teachers in effective childcare; and public awareness campaigns to enhance parents' knowledge of child development and parenting practices.

Notes

¹ The International Conference on the Great Lakes Region include countries Angola, Burundi, Central African Republic, Republic of Congo, Democratic Republic of Congo, Kenya, Rwanda, Sudan, Tanzania, Uganda and Zambia.

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