

The State of Children in OIC Member Countries



OIC Outlook Series
June 2015



ORGANISATION OF ISLAMIC COOPERATION
STATISTICAL, ECONOMIC AND SOCIAL RESEARCH AND TRAINING CENTRE
FOR ISLAMIC COUNTRIES

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(SESRIC)

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Foreword

Today, there is a widespread recognition of children's right to attain full physical, intellectual, and emotional development. The universal acceptance of human rights for all children was mainly spearheaded by the Convention on the Rights of the Child (UNCRC), the first legally binding international convention on child welfare and protection. Looking broadly, today children are healthier and safer from social, economic and cultural exploitations than 30 years ago. However, despite remarkable progress, it remained a painful reality that millions of children across the world, including many OIC countries, are still dying due to preventable diseases and complications, and those who manage to survive their lives are full of misery, ignorance, deprivation and abuse.

OIC countries, as a group, are characterized by the youngest demographic distribution, with over one third of population below age 15. This underlines the huge demand for health care, schooling, food, recreation, and social protection and welfare services for the infants and young children in these countries. Over the years, many OIC countries have made significant progress in terms of fulfilling children's right to a safe and nurturing childhood, with more resources than ever being invested in health care, education and social protection and welfare services. However, despite significant improvement in this area, OIC countries, as a group, are still lagging behind the world and non-OIC developing countries averages.

Improvement in the state of children is distributed unevenly across the OIC regional groups. South Asia and Sub-Saharan Africa regions, which were home for around 60% of OIC children aged under 5 in 2013, remained the most difficult places for the children to survive and live. Majority of countries in these two regions are characterized by low public and private investments in basic health, education, and social protection and welfare services and lack proper policies and implementation mechanisms to improve the state of children. This state of affairs necessitates more commitment and efforts by the governments and other stakeholders to consider this important issue at a higher level on their development agendas. There is also an urgent need for strengthening and enhancing cooperation and collaboration in various child welfare related issues at both regional and international level.

Against this backdrop, this report provides a detailed analysis and evaluation of the state of children in OIC countries. The report gauges the performance of OIC countries in four dimensions: child health and well-being, child nutrition and food security, basic education and schooling and child protection and welfare by analysing the latest data on indicators like child mortality trends, prevalence of under nutrition and micronutrient deficiencies, school enrolment and attendance and incidence of child labour and maltreatment. The report concludes with some policy recommendations aiming to enhance the implementation of interventions both at national and intra-OIC and international cooperation level to improve the state of children in OIC countries.

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Executive Summary

Demographic Profile of Children

OIC countries are characterized by the youngest demographic distribution, with over one third of population under age 15 (i.e. 562 million children under 15). In sharp contrast, developed countries have much older population, with just 17% below 15. Largely driven both by declining birth rates and longer life expectancy, children have accounted for a dwindling share in total population over the years. In 1990, 42% of the OIC population was younger than 15 compared to 34% in 2013. A decreasing trend could also be observed in case of non-OIC developing and developed countries.

Child Health and Well-being

Child Mortality

Over the last two decades, many OIC countries have witnessed significant improvement in health care coverage and services and, consequently, they recorded declining trends in child mortality rates. According to the latest estimates, starting from a higher base rate of 125 deaths per 1000 live births in 1990 OIC countries managed to reduce U5MR by 47% to 66 per 1000 live births by 2013. Nevertheless, despite improvement, OIC group made the least progress in reducing child deaths since 1990. As of 2013, one in 15 children in OIC countries dies before their fifth birthday compared to one in 25 in other developing countries and one in 22 children in the world. Though child mortality has declined across the OIC regional groups, SSA and SA regions remained the most difficult place for a child to survive until age five.

Major Causes of Child Death

The major causes of under-five mortality in OIC members are similar to those in other developing countries. In 2013, about 43% of under-five deaths were caused by three infectious diseases: pneumonia/sepsis (23%), malaria (11%), and diarrhea (9%). Among the pregnancy and birth related complications, prematurity (15%) remained the major cause of under five deaths followed by birth asphyxia (11%) and congenital abnormalities (6%). Though the major causes of under-five deaths remained quite similar in all OIC regions, the relative burden of these causes varies among regions depending, among others, on socio-economic conditions and coverage of health care services in these regions. As of 2013, 83% of total child deaths in OIC countries were recorded in two regions SSA (60%) and SA (23 %).

Child Health Care Services

Majority of under five deaths are preventable through interventions like antenatal care, skilled attendance during birth, immunization, and early care seeking for infectious diseases. The provision of quality antenatal care remained a major concern in many OIC countries with 80% of total pregnant women benefiting from one and 56% benefiting from recommended four antenatal checks up. In both cases, OIC average remained below the averages of world and non-OIC developing countries in 2008-2012. A significant number of births in OIC countries are still taking place unassisted as only 62% of deliveries were assisted by a doctor, nurse or midwife in 2008-2012 compared to 70% in non-OIC developing countries and 67% in the world. DTP3 vaccination has increased in OIC countries from 67% in 2000 to 80% in 2013. Though OIC coverage remained slightly below the world (84%) and non-OIC developing countries average (83%), they are catching up rapidly with a 13 percentage point increase during 2000-2013.

Prevention and Control of Infectious Diseases

In 2009-2013, the combined burden of three infectious diseases: pneumonia, diarrhea, and malaria stood at 43% for OIC countries compared to 38% in the world and 36% in non-OIC developing countries. Majority of OIC's deaths caused by infectious diseases (80% to 90%) were recorded in SSA and SA regions. The latest

estimates show that 60% of children with symptoms of pneumonia in OIC group were taken to a health provider for checkup and only 48.2% received antibiotic treatment. A similar situation prevails both in the world and non-OIC developing countries. Diarrhea is another major killer of children, accounting for 9% of OIC's total deaths. Although childhood diarrhea can be treated with oral rehydration salts (ORS), only 39% of children with diarrhea in OIC countries were treated with ORS. The coverage rate was recorded at 36.5% in the world and 35% in other developing countries. OIC countries accounted for 62% of the global burden of child deaths caused by malaria in 2009-2013. Though sleeping under insecticide-treated nets (ITNs) is the most effective way to prevent the malarial infection and reduce deaths, only 11% of children were sleeping under ITNs in OIC countries and 8.4% in the world.

Child Nutrition and Food Security

Stunting, Underweight, Wasting and Overweight

Latest estimates shows that about 33% of under five children in OIC countries were stunted in 2009-2013 compared to 29% in other developing countries and in the world. During the same period, proportion of children under five years old who were underweight was recorded at 21.3% in OIC countries followed closely by the other developing countries (20.8%). Wasting represents an acute form of under nutrition with heightened risk of disease and death for children. Globally, more than 50 million children under 5 years of age were moderately or severely wasted in 2009-2013, accounting for about 10% of children. Wasting prevalence remained more or less the same in OIC and other developing countries with a rate of 11.1% and 9.4% respectively. Though overweight was once associated mainly with high-income countries, 72% of world total overweight children of 42 million were living in low-and middle-income countries in 2009-2013. OIC countries accounted for 32% of world total overweight children with an overweight prevalence rate of 7.4% compared to 4.6% in other developing countries.

Child Feeding Practices

Proper feeding especially during the first two years of life is critical for a child's survival, growth and development. The latest estimates on feeding practices reveal that in spite of its crucial importance for child nutrition a significant number of infants and children are not breastfed. In OIC countries, only 42.9% of infants were put to the breast within first hour of birth, and 34.9% were exclusively breastfed during the first six months of life compared to 44.9% and 37.4% in the world. The coverage of breastfeeding until age 2 remained comparatively better in OIC countries with 46.7% of the total children breastfed until age 2. The estimates for appropriate feeding of children with adequate and safe complementary food reveal that about two third of infants in OIC countries were introduced to solid, semi-solid or soft foods at 6 to 8 months.

Micronutrient Deficiencies

Micronutrient deficiencies like deficiencies of vitamin A, iron, iodine, zinc and folic acid are very common among women and children in low income developing countries, including some OIC countries. Globally, about two-third of children aged 6 to 59 months received two doses of vitamin A in 2009-2013 while this ratio was recorded at 69% for OIC and 61% for Non-OIC developing countries. During the same period, 59% of households were consuming adequately iodized salt in OIC countries compared to 74% in non-OIC developing countries and 69% in the world. Iron deficiency and anemia also remained a major health challenge. According to the latest estimates, over 43% of children under 5 in the world were anemic in 2011. While prevalence of anemia was just 12% for developed countries, the numbers were staggering in non-OIC developing and OIC countries with 42% and 53% of children suffering from anemia respectively.

Basic Education and Schooling

School Enrolment and Attendance

Access to basic education is a fundamental child right. Education helps children to learn and develop their personality and identity and it shapes their social, economic and cultural standing in future. Looking at selected indicators on education from a children well-being perspective reveals that OIC countries made a significant improvement in terms of literacy, enrolment and completion rates since the 1990s. However, OIC countries, on average, still have a long way to reach the level of developed countries in terms of literacy, enrolment and completion rates. Compared with 1990, in 2012 young literacy rate in the OIC group was 10 percentage points higher. In the same period, the average of non-OIC developing countries increased only by 2 percentage points. As of 2013, the number of primary school pupils in OIC countries reached 196.0 million, representing 28.0% and 30.9% in total world and developing country primary school enrolments, respectively.

Completion and Progression

OIC countries, on average, achieved to increase their completion rates from 55% in 1990 to 81.3% in 2012. The repetition rate in the OIC group dropped from 16.1% in 1990 to 5.9% in 2012. In terms of survival rates OIC countries, on average, experienced an increase from 58.1% in 1990 to 82.7% in 2012. In OIC countries, governments' spending on the education sector accounted for 15% of their total expenditures in 2011 where the world average was 12.5%. Government spending on education accounted for 3.8% of their GDP in 2011 where the world average was 5.1%.

Adequacy of Education Services

In terms of adequacy of education services for children, OIC countries, on average, are lagging behind non-OIC developing countries. Governments in OIC countries, on average, spent only \$928 per pupil in 2011 whereas the average of non-OIC developing countries was \$1860 in the same year. In terms of quality of education for children, OIC countries also encounter problems. One major problem is the existence of crowded classrooms in the OIC group where student-teacher ratios are remarkably higher than those seen in developed countries. Another fact that is observed in education services for children in OIC countries is the lack of gender equality dimension.

Child Protection and Welfare

Birth Registration

Apart from being the first legal acknowledgement of a child's existence, birth registration is central to ensuring that children are counted and have access to basic services. According to the latest data, OIC group has the lowest average birth registration rate compared with other country groups during the period between 2005 and 2013. Only 73.4% of children have a birth registration in the OIC group compared to 81.3% in the world 77.6% in non-OIC developing countries.

Child Maltreatment and Abuse

Apart from being a violation of human rights, child maltreatment and abuse leads to serious health problems for children. During the period 2005-2013, the prevalence of violent discipline (against children) in the OIC group, on average, was 83.0% that is being the highest average compared with the average of non-OIC developing countries (73.2%) and the world average (78.3%). In terms of difference between girls and boys, in the OIC group, boys are exposed to violent discipline to higher extent (84.1%) compared with girls (81.8%). In addition to violence against children, the data for OIC countries showed that violence against women (mothers of children) and female genital cutting are highly prevalent that constitute another threat for children's physical and mental health.

Child Marriage

Marriages at young ages (before 18) may lead to serious health problems for men and women who are not ready for marriage. According to the dataset for the period 2008-2013, the OIC group has the highest child marriage prevalence where 7.9% of all marriages are being exercised before 15 years old and 27.3% of all marriages are being performed before 18 years old. The global average prevalence of marriages before 15 years old is 6.3% and for marriages before 18 years old the average is 25.0%. Poverty, protection of girls, family honour and the provision of stability during unstable social periods are some of the main driving factors behind child marriage.

Conflicts and Children

Rise in conflicts in OIC countries constitute a major threat for children well-being. Between 2008 and 2014, the OIC group has had the highest average global peace index score compared with other country groups indicating the presence of a lower degree of peacefulness and a higher number of conflicts. These facts imply that in OIC countries each year increasing number of children suffer from conflicts and the lack of peace. They are more exposed to armed conflicts, human trafficking, violence and abuse, and the lack of basic services.

Child Labour

Child labour is one of the worst forms of exploitations widespread across the developing world. Though child labour is prohibited in the majority of OIC countries, 13.5% of children aged 5 to 14 years were still trapped in child labour in 2009-2013. Meanwhile, this ratio was recorded at 14.0% in non-OIC developing and 13.9% in the world. In general, boys are more likely to be engaged in child labour than the girls. In 2009-2013, 14.9% of male children aged 5 to 14 years were engaged in child labour in OIC countries compared to 12.1% of female children.

1 Introduction

Childhood is a precious time for the physical, intellectual, and emotional development of a human being. It is of great importance, therefore, that all children have access to quality health care, good nutrition, education and protection from harm, abuse and discrimination. Provided that children are the most vulnerable beings in this world, it is the shared responsibility of parents and family members, civil society and governments to ensure that their rights are respected, protected and fulfilled. Over the recent decades, the world has paid special attention to the issue of protection and welfare of children. The Convention on the Rights of the Child (UNCRC), which came to force in 1989, is one of the most important landmarks achieved in this regard. In fact, the Convention is the first international human rights treaty to bring together the universal set of standards concerning children to ensure that every child enjoys a safe and nurturing childhood.

OIC countries are characterized by the youngest demographic distribution, with over one third of population below age 15. This underlines the huge demand for health care, schooling, food, recreation, and social protection and welfare services for the infants and young children in these countries. Over the years, OIC countries in collaboration with the subsidiary, specialized and affiliated OIC institutions and relevant international partners have made extensive efforts to promote child welfare, child well-being, and protect children's rights in the Muslim world¹. In this regard, OIC countries held four Ministerial Conferences on Childhood and chalked out the Covenant on the Right of the Child in Islam which was adopted by the 32nd Session of the Islamic Conference of Foreign Ministers (CFM) held in Sana'a, Yemen. In addition, maternal, newborn and child health and nutrition is one of the six thematic areas of cooperation identified under the OIC Strategic Health Programme of Action (OIC-SHPA) 2014-2023 which was adopted by the 4th Islamic Conference of Health Ministers held in Jakarta, Indonesia.

These noble efforts actually paid off and looking broadly, today children are healthier and safer from social, economic and cultural exploitations than 30 years ago. However, despite all positive developments, global community is falling short in fulfillment of its promise and commitment to ensure that every child enjoys a safe and nurturing childhood. Millions of children across the world, including many OIC countries are still dying due to preventable diseases and complications, and those who manage to survive their lives are full of misery, ignorance, deprivation and abuse. This state of affairs necessitates more commitment and efforts by the governments and other stakeholders to consider this important issue at a higher level on their development agendas. There is also an urgent need for strengthening and enhancing cooperation and collaboration in various child welfare related issues at both regional and international level.

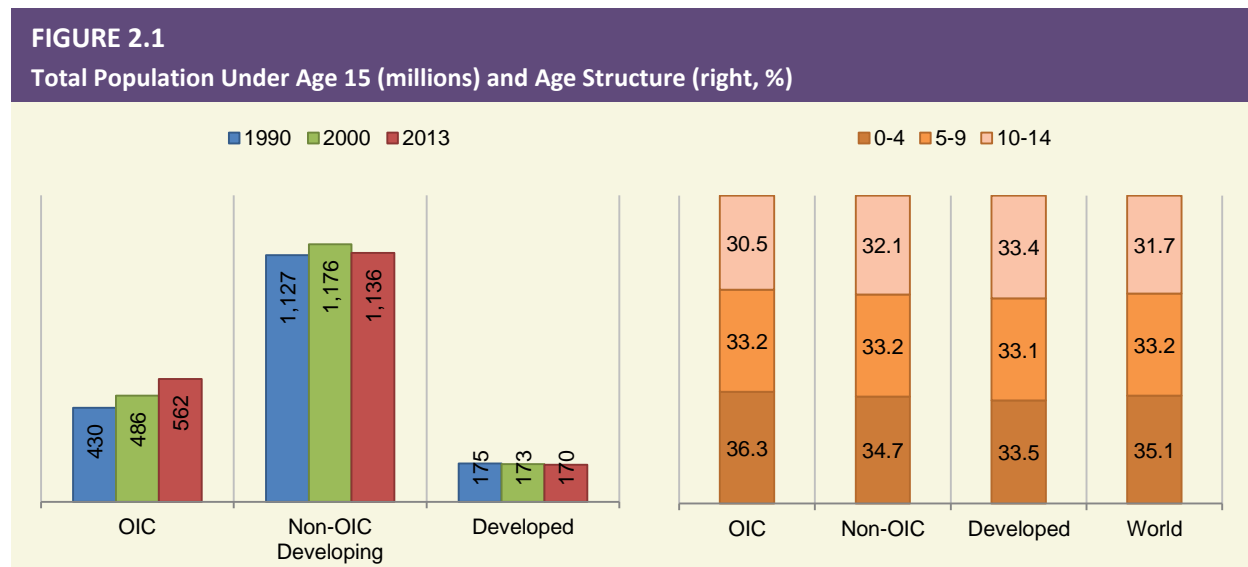
Against this background, this report looks at the state of children in OIC countries in a comparative perspective. To set the stage, the report begins with an overview of demographic profile of children in OIC countries. Section 3 investigates the health and well-being status of children by analyzing the latest data on child mortality trends, major causes of child deaths and the coverage of child health care services. State of child nutrition and food security is discussed and analyzed in Section 4, with a particular focus on major indicators of child nutrition, prevalence of micronutrient deficiencies and infant and young child feeding practices. Section 5 gives a detailed picture of child education and schooling by analysing the primary and secondary school enrolment, attendance, completion and progression trends along with some highlights of the adequacy of basic education services in OIC countries. Section 6 of the report focuses on child protection and welfare by looking into some major issues regarding birth registration, child labour, child maltreatment and impacts of armed conflicts on children. The main findings of the report are summarized in Section 7. The report concludes with policy recommendations aiming to enhance the implementation of interventions both at national and intra-OIC and international cooperation level to improve the state of children in OIC countries.

¹Detailed information on OIC efforts to improve the state of children is given in the Annex 1.

2 Demographic Profile of Children

Worldwide children make up a substantial part of total population. According to the latest estimates of the World Bank (WDI, 2015), over a quarter of the world total population of 7 billion was aged under 15 in 2013 (Figure 2.1). Around 90% of these children are living in developing countries. The trend shows a steady increase in population of children in OIC countries from 430 million in 1990 to 562 million in 2013, corresponding to growth of 31% during this period. OIC countries are currently home for 30% of the world and 33% of the developing countries total children. In 2013, over one third of OIC children (36%) were living in Sub-Saharan Africa (SSA), 22% in South Asia (SA) and 21% in Middle East and North Africa (MENA) region. The relative shares of East Asia and Pacific (EAP) and Europe and Central Asia (ECA) regions remained quite low, accounting for 14% and 7% of total child population respectively (See Annex 2 for OIC Regional Groups).

Age decomposition of child population reveals that 0-4 years old make up the majority followed by 5-9 years old across the globe. In line with the global trends, majority of children in OIC countries are aged 0-4 years (36.3%) followed by aged 5-9 years (33.2%). The relative share of children aged 0-4 in OIC countries remained slightly higher than the other groups.

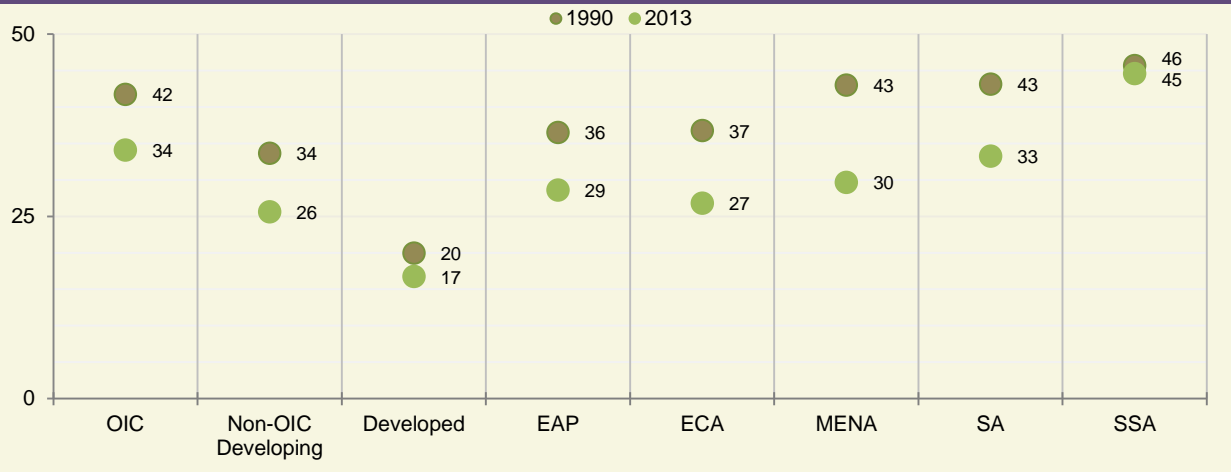


Source: SESRIC staff calculations based on World Bank, WDI

OIC countries are characterized by the youngest demographic distribution, with over one third of population under age 15 (Figure 2.1). In sharp contrast, developed countries have much older population, with just 17% below 15. Largely driven both by declining birth rates and longer life expectancy, globally children have accounted for a dwindling share in total population over the years. In 1990, 42% of the OIC population was younger than 15 compared to 34% in 2013. A decreasing trend could also be observed in case of non-OIC developing and developed countries. Nevertheless, decline in share of children in total population of developed countries was comparatively less steep than the other groups.

Among the OIC regions, SSA remained the youngest region with 45% of its total population under age 15 followed by SA (33%) and MENA (30%) regions (Figure 2.2). During the period of 1990-2013, MENA region witnessed the highest decline in share of children in total population, with a fall of 13 percentage points. Among others, ECA and SA regions have recorded decline of 10 percentage points since 1990. On the contrary, the share of children remained largely unchanged in SSA region.

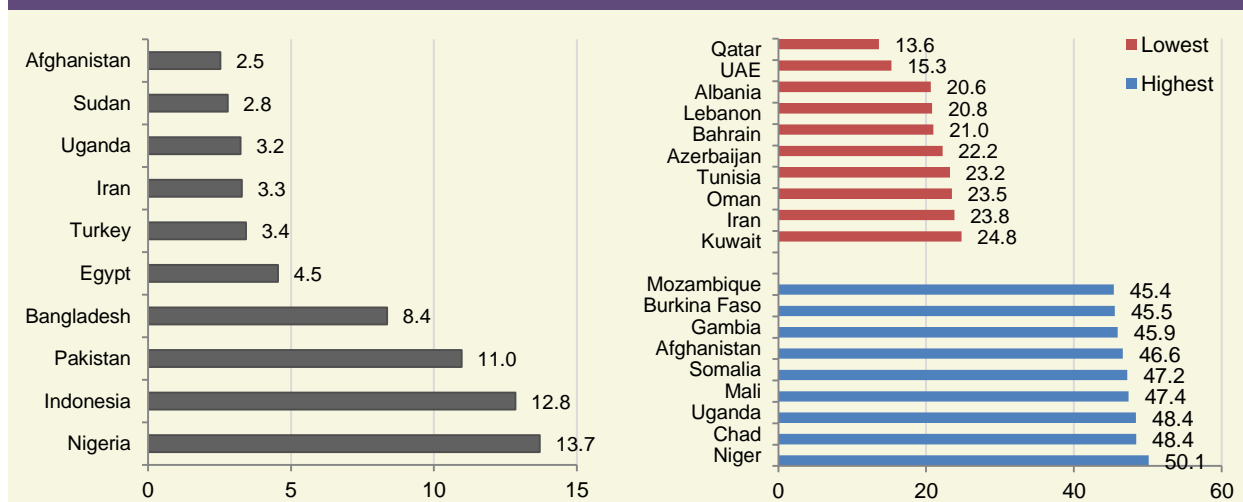
FIGURE 2.2
Share of Children Under Age 15 in Total Population (%)



Source: SESRIC staff calculations based on World Bank, WDI

The total number of children under age 15 remained highly concentrated among a handful of OIC countries. As shown in Figure 2.3, in 2013, around two third (65.7%) of OIC total children were living in ten countries. Among these countries, Nigeria accounted for the largest share (13.7%) of OIC total children followed by Indonesia (12.8%), Pakistan (11.0%), and Bangladesh (8.4%). In terms of relative share of children in total population of a country, nine OIC countries from the SSA region were ranked among the top-10 youngest countries in OIC. As shown in Figure 2.3, Niger was ranked first with 50% of total population under age 15 followed by Chad (48%) and Uganda (48%). In contrast, share of children in total population remained significantly low in most of the OIC countries from MENA region. For 2013, Qatar registered the lowest share of children in total population (13.6%), followed by United Arab Emirates (15.3%) and Albania (20.6%). At the global level, Qatar was ranked third after Japan and Germany with the lowest share of children in total population.

FIGURE 2.3
Share in OIC total Child Population (%. left) and OIC Countries with the Highest and Lowest Share of Children in Total Population (%. right), 2013



Source: World Bank, WDI

3 Child Health and Well-being

Health is vital for the well-being of all human beings. According to the definition of World Health Organization (WHO), health does not only mean an absence of illness or disease but it is a multidimensional concept which encompasses the state of physical, mental and social well-being of a person. Right to health is vital for everyone, but it is especially important for children because they are vulnerable and more at risk to illness and health complications. Furthermore, when children are free from diseases they are more likely to attain higher level of physical, intellectual, and emotional development and hence grow into more healthy and productive adults. Over the years, world has made significant progress in terms of fulfilling children's right to health and child mortality is on decline across the world. Among others, improvement in living standards, rising education and the widespread access to basic health care services are the major drivers of this progress. However, despite remarkable gains, significant challenges remained especially in low income developing countries, including many OIC countries. This section aims to investigate the state of children's health in OIC countries by analyzing mortality trends, major cause of child deaths and coverage of child health care services.

3.1 Child Mortality

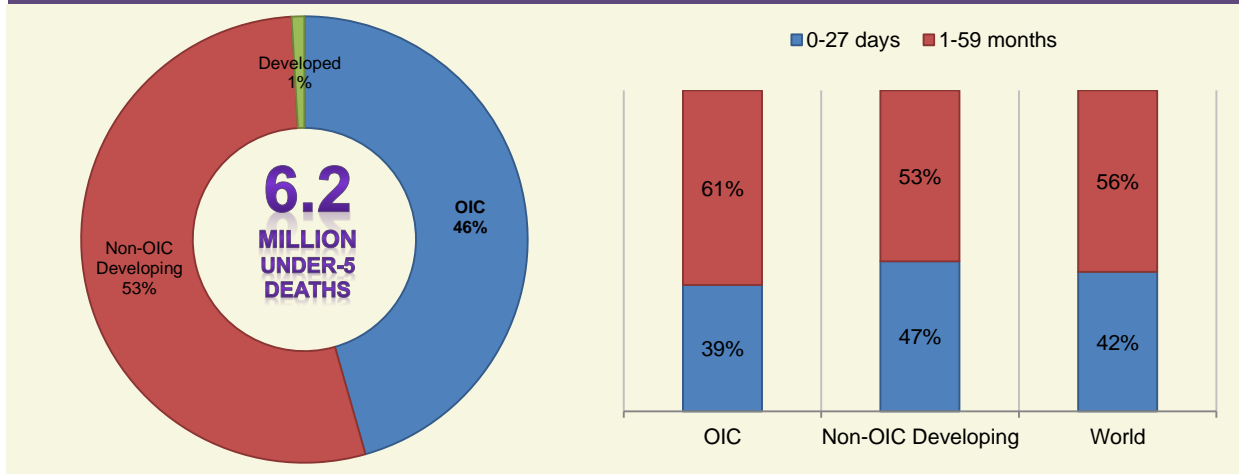
The child mortality rate is the number of deaths of children under 5 per 1,000 live births. It is one of the most important indicators on child health which basically reflects the overall coverage and effectiveness of health care services along with socio-economic development in a country. It is the benchmark indicator for the United Nations Millennium Development Goal 4 which set a target to reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate (UN, 2014). Globally, over 6 million children died before reaching their fifth birthday in 2013. A child's risk of dying is highest in the neonatal period, the first 28 days of life. In 2013, 44% of under-five deaths were reported during the neonatal period. Majority of these deaths can easily be prevented by ensuring access to effective safe childbirth and neonatal care services (WHO, 2015a).

Under-five mortality remained highly concentrated in developing countries which accounted for over 99% of world total in 2013. This means that on average about 17000 children died every day in developing countries. Being a substantial part of the developing world, OIC countries accounted for 46% of the world total under-five deaths in 2013. In other words, about 8000 under-five children died every day in OIC countries. Over 39% of child deaths in OIC countries occurred during the first 28 days of life.

Over the years, child mortality has seen a declining trend across the globe (Figure 3.1). Since 1990, world has managed to halve its under-five child mortality rate (U5MR) to 46 deaths per 1000 live births in 2013. Non-OIC developing countries also registered remarkable progress with 53% decline in U5MR since 1990. In line with the global trends, child mortality situation has also been improved in the OIC countries. Starting from a higher base rate of 125 deaths per 1000 live births in 1990 OIC countries managed to reduce U5MR by 47% to 66 per 1000 live births by 2013. Nevertheless, despite improvement, OIC group made the least progress in reducing child deaths since 1990. As of 2013, one in 15 children in OIC countries dies before their fifth birthday compared to one in 25 in other developing countries and one in 22 children in the world.

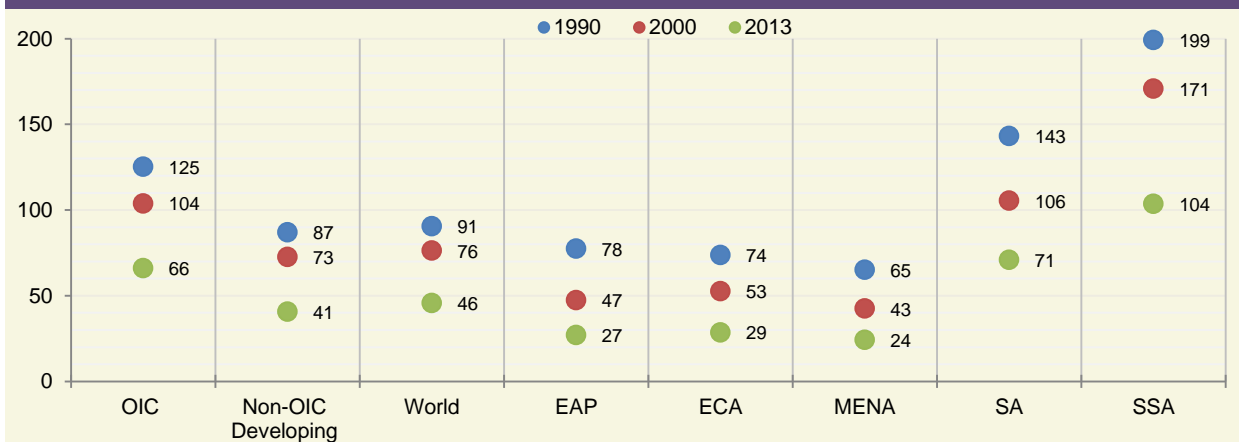
Child mortality has declined across the OIC regional groups (Figure 3.2). During 1990-2013, EAP region registered the most remarkable progress with 65% of decrease in U5MR followed closely by MENA (63%) and ECA (61%) regions. SA and SSA regions also managed to halve their under-five mortality rates during this period. Nevertheless, among the OIC regional groups, SSA and SA regions remained the most difficult place for a child to survive until age five. In 2013, U5MR for SSA region was 104 per 1000 live births, meaning that 1 in every 10 children failed to reach their fifth birthday whereas; U5MR for SA region was 71 per 1000 live births, meaning that 1 in every 14 children failed to reach their fifth birthday. In contrast, this ratio stands at 1 in every 41 children for MENA, 1 in 37 for EAP and 1 in 35 for ECA region.

FIGURE 3.1
Distribution of Under 5 Deaths by Region and Age Structure (right), 2013



Source: SESRIC staff calculations based on WHO, Data Repository

FIGURE 3.2
Under 5 Child Mortality Rate (per 1000 live births)

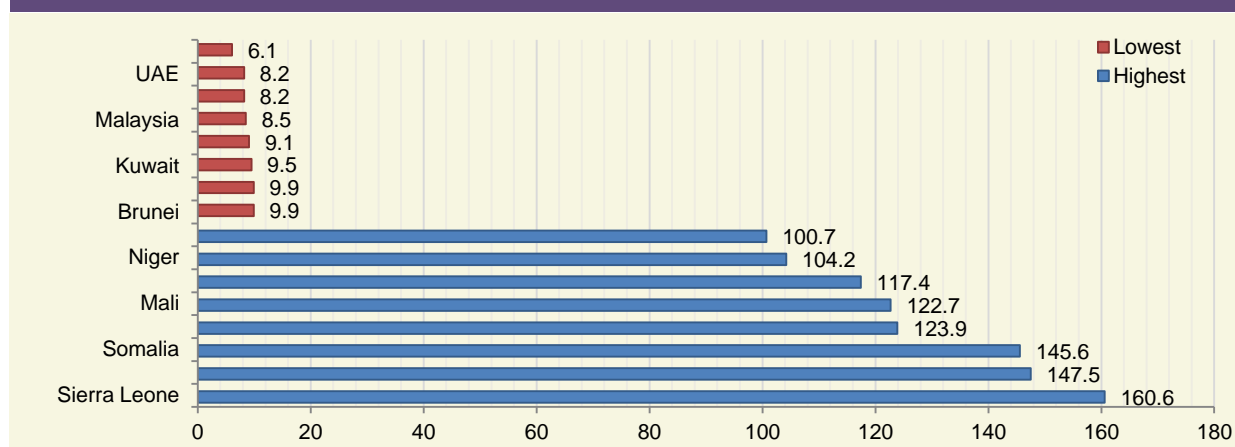


Source: SESRIC staff calculations based on WHO, Data Repository

At the national level, many OIC countries have made great strides against the child mortality since the last two decades. During 1990-2013, 23 OIC countries registered over 60% reduction in under-five deaths whereas it ranged between 40 to 58% for 24 countries. As of 2013, U5MR in OIC countries ranged from a low of 6 deaths per 1000 live births in Bahrain to a high of 161 in Sierra Leone (Figure 3.3). Eight OIC countries have registered U5MR lower than 10 deaths per 1000 live births. In contrast, eight OIC countries from SSA region registered U5MR higher than 100 deaths per 1000 live births. Seven of these eight countries are ranked among the top-10 countries with the highest U5MR in the world. In 2013, Sierra Leone was ranked 2nd with respect to U5MR in the world followed by Chad (ranked 3rd), Somalia (ranked 4th), Guinea Bissau (ranked 6th), and Mali (ranked 7th). In general, 28 OIC countries registered U5MR lower than the non-OIC developing countries average of 41 deaths per 1000 live births in 2013.

FIGURE 3.3

OIC Countries with the Lowest and Highest U5MR (per 1000 live births), 2013



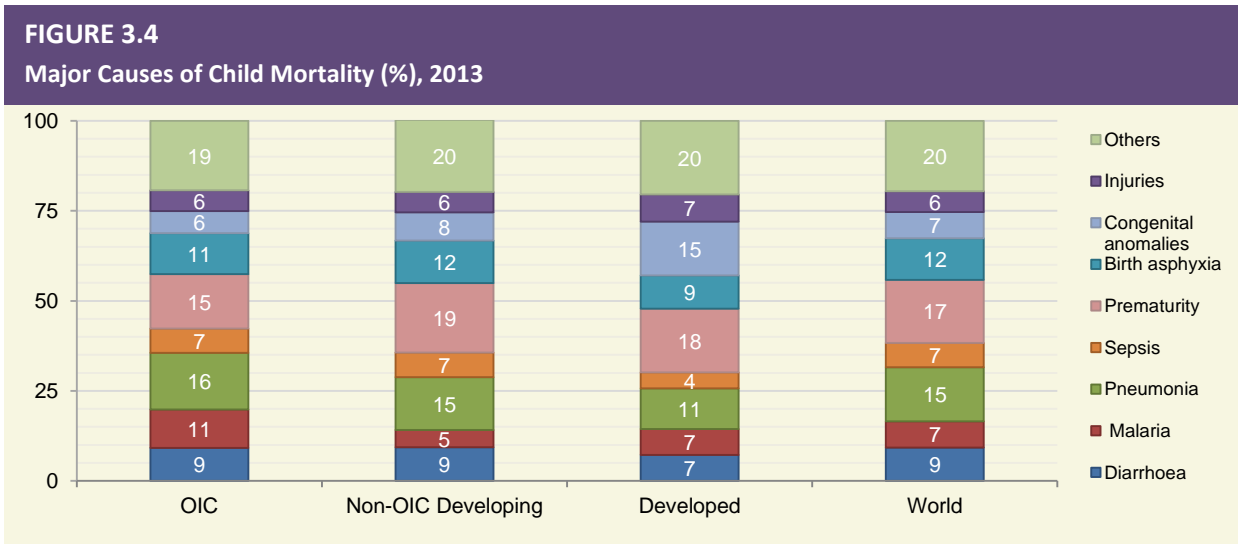
Source: WHO, Data Repository

3.2 Major Causes of Child Mortality

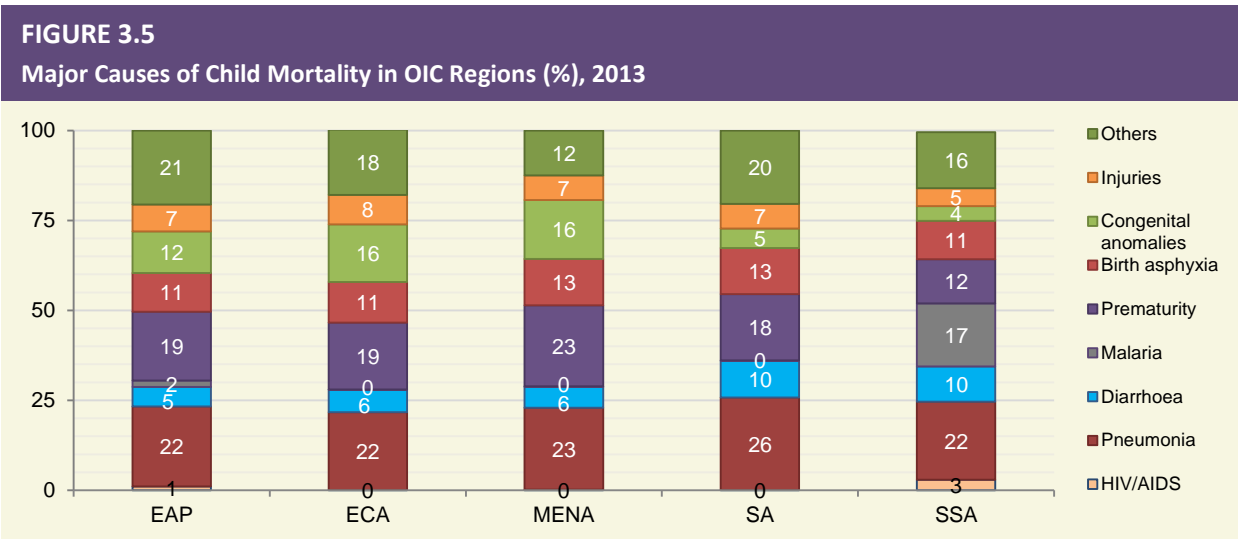
Globally, over three quarters of total deaths in children under five were caused by infectious diseases and pregnancy and birth related complications that could be prevented or treated by ensuring access to simple and affordable interventions like vaccination, antenatal health care and skilled attendance of birth.

As shown in Figure 3.4, prematurity was the largest single cause of death in children under five in 2013, and approximately 50% of under-five deaths were due to infectious causes like pneumonia /sepsis (neonatal pneumonia) , diarrhea, malaria and other communicable diseases. A similar situation could also be observed in case of non-OIC developing countries where leading causes of death among under-five children are preterm birth complications, pneumonia, birth asphyxia, diarrhea and malaria. In contrast, causes of childhood deaths in developed countries are more skewed toward complications associated with pregnancy and delivery than the infectious diseases. The major causes of under-five mortality in OIC members are similar to those in other developing countries. As shown in Figure 3.4, 43% of under-five deaths were caused by three infectious diseases: pneumonia/sepsis (23%), malaria (11%), and diarrhea (9%). Among the pregnancy and birth related complications, prematurity (15%) remained the major cause of under five deaths followed by birth asphyxia (11%) and congenital abnormalities (6%).

Among the OIC regional groups, Sub-Saharan Africa and South Asia region bear the largest burden of OIC under five deaths. As of 2013, 83% of total child deaths in OIC countries were recorded in these two regions (60% in SSA and 23 % in SA). Though the major causes of under-five deaths remained quite similar in all OIC regions, the relative burden of these causes varies among regions depending, among others, on socio-economic conditions and coverage of health care services in these regions. As shown in Figure 3.4, infectious diseases like pneumonia, malaria, diarrhea and AIDS accounted for half of total deaths in SSA followed by 37% in SA, 30% in EAP, 27% in ECA and 26% in MENA. Compared to other regions, deaths attributed to malaria remained quite high in SSA (17%). On the other hand, complications related to pregnancy and delivery (prematurity, birth asphyxia and congenital anomalies) caused 52% of deaths in MENA, 46% in ECA, 41% in EAP, 37% in SA and 27% in SSA region.



Source: SESRIC staff calculations based on WHO, Data Repository



Source: SESRIC staff calculations based on WHO, Data Repository

3.3 Child Health Care Services

Health experts are of the view that majority of under five deaths are preventable and interventions like antenatal care, skilled attendance during birth, immunization, and early care seeking for pneumonia, diarrhoea and malaria are critical for the survival and well-being of children. This sub-section aims to evaluate the performance of OIC countries with respect to coverage of some of these selected interventions.

Antenatal Care

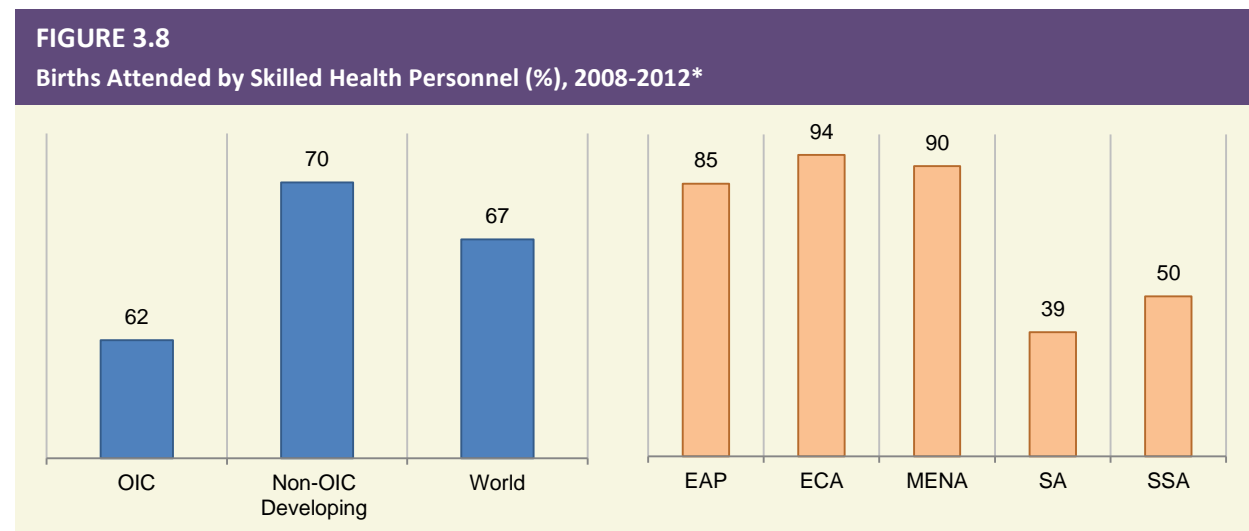
Antenatal care and counselling is the entry point to the formal health care system and provides a solid base to monitor and improve the mother-baby health by identifying and preventing/controlling antenatal complications at the earliest stage (WHO, 2010). Antenatal care (ANC) coverage measures the proportion of total pregnant woman aged 15-49 who visited a skilled health professional for reasons related to pregnancy. For the quality and effectiveness of ANCC, number of visits and their timing are also considered very important. In this regard, WHO recommends at least four antenatal visits for uncomplicated pregnancies.

and Chad recorded the lowest ANC coverage rate where 60%, 55% and 53% of women visited health facility once during pregnancy respectively (Figure 3.7). With respect to four visits, over two third of pregnant women paid four visits to health clinic in 15 OIC countries. Out of these 15 countries, Oman and Palestine remained at the top with ANC coverage rate of over 90%. Among others, six OIC countries registered ANC coverage rate of 50% to 65%. In contrast, ANC coverage rate remained less than 50% in 11 countries. The situation was particularly alarming in Afghanistan, where even less than 15% of total pregnant women actually benefitted from WHO recommended four antenatal visits during 2008-2012 (Figure 3.7).

Births Attended by Skilled Health Personnel

Skilled health care and assistance at the time of delivery are critical for the health and very survival of both mother and baby. According to the latest estimates of the WHO, globally, about 2 million maternal and newborn deaths every year are caused by lack of proper health care during labor and child birth. These deaths are largely preventable by ensuring assistance of skilled health personnel - a doctor, nurse or midwife - during the birth.

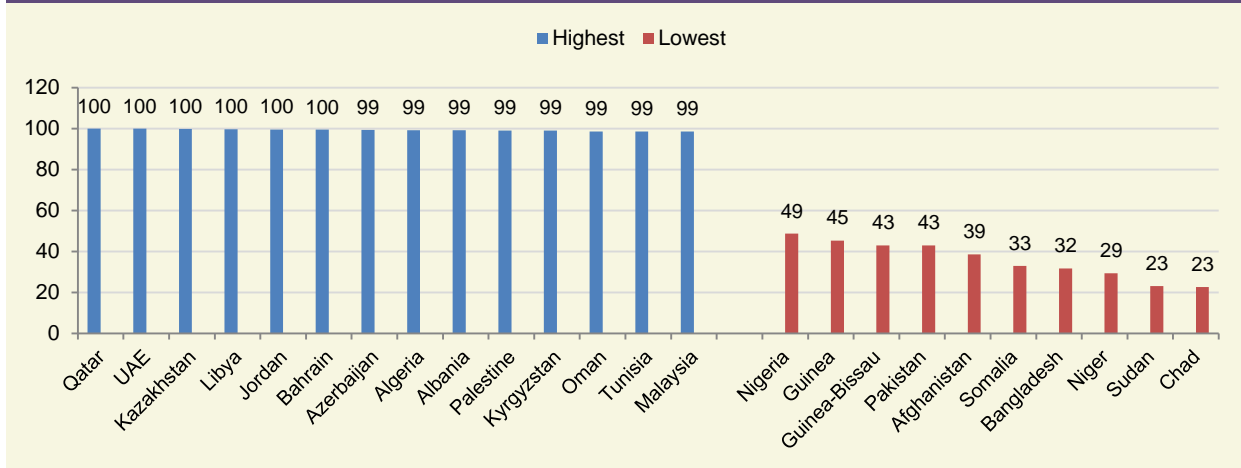
According to the latest estimates, globally, one third of births are still taking place without skilled assistance and care (Figure 3.8). Majority of these unassisted deliveries are occurring in developing countries. In 2008-2012, 62% of deliveries were assisted by a doctor, nurse or midwife in OIC countries. Meanwhile, this ratio was recorded at 70% in non-OIC developing countries and 67% in the world. As shown in Figure 3.8, coverage of skilled personnel attendance at the time of delivery has been significantly high in OIC regional groups with the exception of SA and SSA regions. ECA region registered the highest coverage of 94% followed by MENA (90%) and EAP (85%). These three regions maintained coverage rates higher than the world and non-OIC developing countries averages. In contrast, the situation remained particularly alarming in SA region where 61% of total births took place without any skilled health care and assistance at the time of delivery. This ratio stood at 50% for SSA region.



Source: SESRIC staff calculations based on WHO, Data Repository

Over the years, majority of OIC countries witnessed improvement in number of births assisted by skilled health personnel. During 2008-2012, more than 90% of deliveries were assisted by skilled health personnel in 23 OIC countries. In 16 of these 23 countries all births were attended by skilled health personnel (Figure 3.9). In contrast, less than 50% of total pregnant women received skilled health care during birth in 10 OIC countries. Chad and Sudan were at the bottom of the scale with only 23% of total births attended by skilled health personnel during 2008-2012.

FIGURE 3.9
Births Attended by Skilled Health Personnel in OIC Countries (%), 2008-2012*



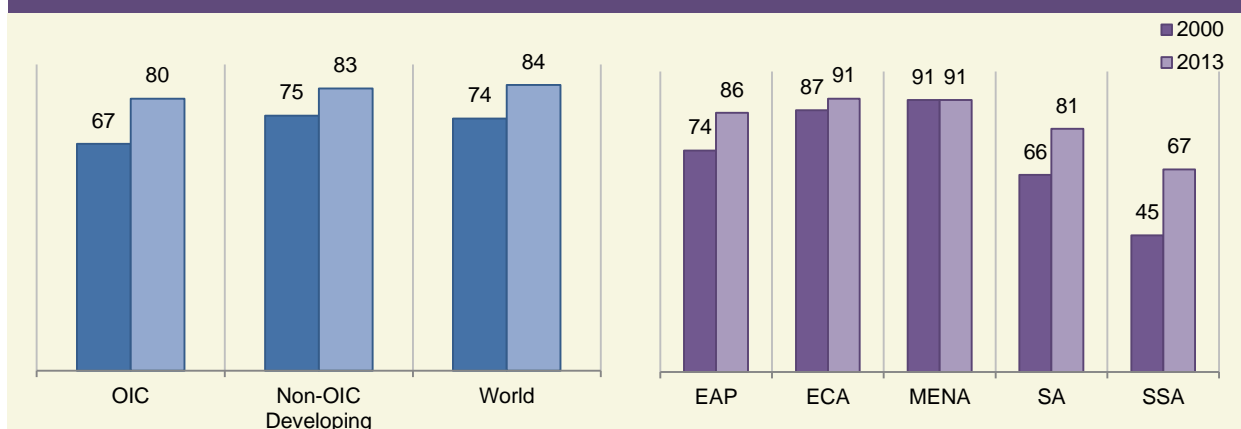
Source: WHO, Data Repository.

Immunization

Keeping in view the age-specific health risks, childhood immunization is one of the most efficient and effective methods of preventing diseases like measles, meningitis, diphtheria, tetanus, pertussis (whooping cough), yellow fever, polio and hepatitis b. Over the years, world has exerted serious efforts to develop and improve national immunization programmes and coverage by ensuring excess to needed vaccines and training for health workers. These noble efforts paid off and increase in immunization coverage helped to prevent millions of child deaths across the world.

Coverage of DTP3, a combination of vaccines against three infectious diseases: diphtheria, tetanus and pertussis (whooping cough), is used as the benchmark indicator of routine immunization programme in a country/region by the United Nations Children's Fund (UNICEF) and WHO (WHO, 2015b). Globally, DTP3 immunization coverage during the first year of life has increased from 74% in 2000 to 84% in 2013, corresponding to an increase of 10 percentage points (Figure 3.10). A similar trend prevailed in non-OIC developing countries with immunization coverage climbing up from 75% in 2000 to 83% in 2013. OIC countries also witnessed improvement in DTP3 vaccination among one year olds as thier coverage rate

FIGURE 3.10
DTP3 Immunization Coverage (%), 2013



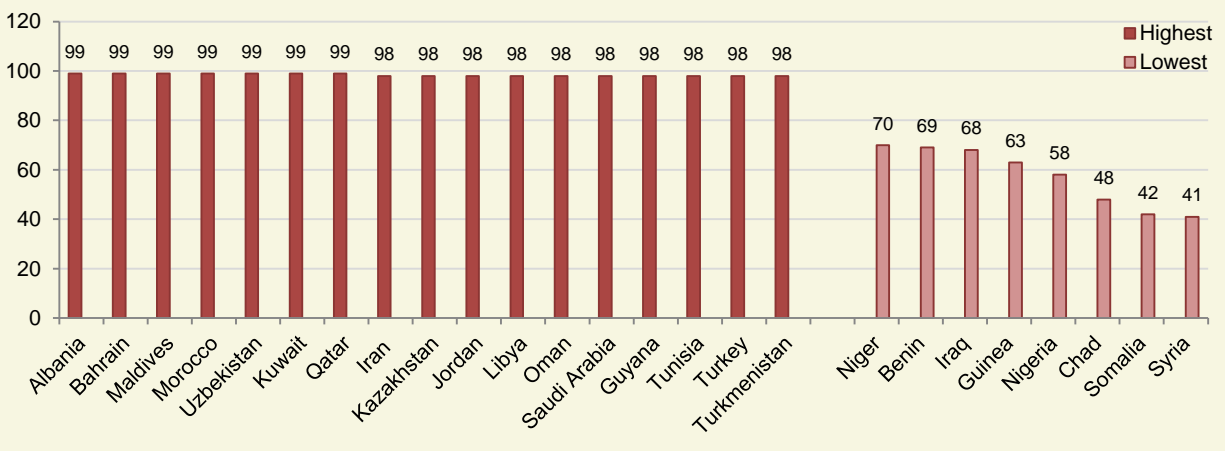
Source: SESRIC staff calculations based on WHO, Data Repository

increased from 67% in 2000 to 80% in 2013. Though OIC coverage remained slightly below the world and non-OIC developing countries averages, they are catching up rapidly with a 13 percentage point increase during 2000-2013 compared to 8 percentage point increase in non-OIC developing countries and 10 percentage point in the world.

During the period under consideration, all OIC regions witnessed improvement in DTP3 immunization among one year olds (Figure 3.10). Coverage rates remained highest in ECA and MENA regions with 90% children immunized against the diphtheria, tetanus and pertussis. In contrast, despite an increase of 22 percentage during 2000-2013, SSA region registered the lowest immunization coverage as about one third of children were missed out in this region. Meanwhile, the share of children receiving DTP3 vaccine during the first year of life has increased from 66% to 81% in SA and 67% to 80% in EAP.

DTP3 immunization coverage remained quite high in majority of OIC countries. In 2013, 30 member countries recorded coverage rate of 90% or more. Among these 30 countries, seven OIC countries registered immunization coverage of 99% (Figure 3.11). Among others, 12 countries were within the 80-89% range and coverage rate remained between 70 to 79% for seven other OIC countries. In contrast, about one third of one year old children were not immunized against DTP in seven OIC countries. Among these countries, as shown in Figure 3.11, lowest coverage rate was recorded in Syria (41%) followed by Somalia (42%) and Chad (48%).

FIGURE 3.11
Highest and Lowest DTP3 Immunization Coverage in OIC Countries (%), 2013



Source: WHO, Data Repository

3.4 Prevention and Control of Infectious Diseases

Globally, over 38% of total under five deaths are caused by only three infectious diseases: pneumonia, diarrhea, and malaria. The combined burden of these three diseases stands at 36% for non-OIC developing countries and over 43% for OIC countries. Majority of these deaths are preventable by using cost-effective, affordable and easy to implement measures (Figure 3.12).

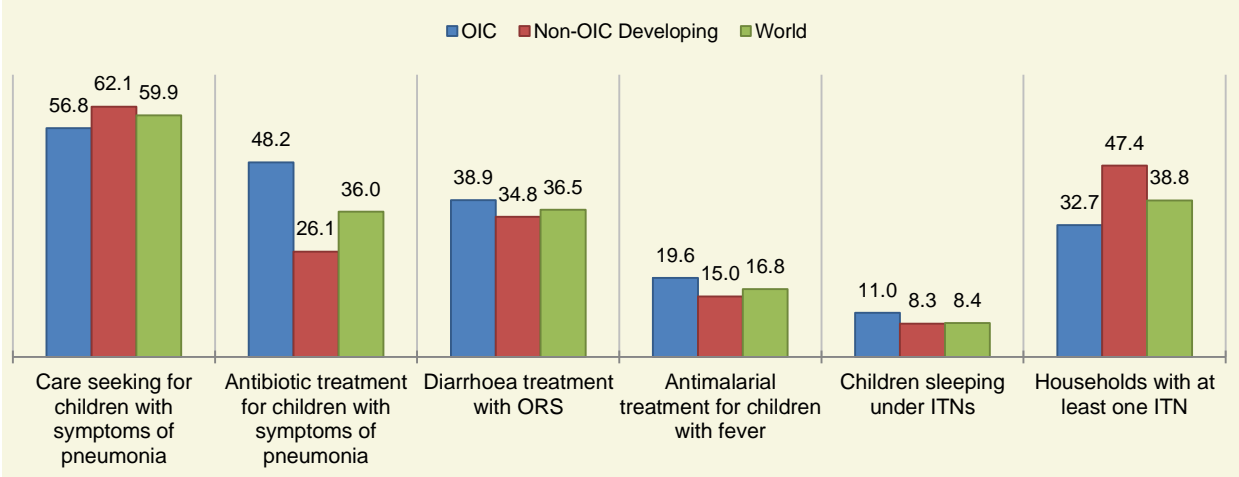
Reduction of childhood mortality caused by acute respiratory infections remained an elusive goal mainly due to incomplete immunization schemes, malnutrition, late care seeking and inadequate treatment. The latest estimates show that 60% of children with symptoms of pneumonia in the world were taken to a health provider for checkup and only 36% received antibiotic treatment in 2009-2013. A similar situation prevails

both in OIC and non-OIC developing countries. Nevertheless, antibiotic treatment for pneumonia was significantly high in OIC countries with a coverage rate of 48.2% (Figure 3.12).

Diarrhea is another major killer of children, accounting for 9% of world’s total deaths of children under 5. Although childhood diarrhea can be treated with a simple solution made from oral rehydration salts (ORS), just over one third of children (36.5%) with diarrhea worldwide were treated with ORS in 2009-2013. The coverage rate was recorded at 39% in OIC and 35% in other developing countries (Figure 3.12).

Globally, over 7% of total deaths in children are attributed to malaria. Most of these deaths occurred in OIC countries which accounted for 62% of the global burden in 2009-2013. Sleeping under insecticide-treated nets (ITNs) is the most effective way to prevent the malarial infection and reduce malaria related deaths. Nevertheless, worldwide, only 8.4% of children were sleeping under ITNs in 2009-2013. Though coverage rate remained comparatively better in OIC countries, still only 11% of total children were sleeping under ITNs (Figure 3.12). In general, around half of the total households (47.4%) had at least one ITN in non-OIC developing countries compared to the OIC average of only 32.7%.

FIGURE 3.12
Coverage of Measures for Infectious Diseases (%), 2009-2013*



Source: SESRIC staff calculations based on UNICEF Database

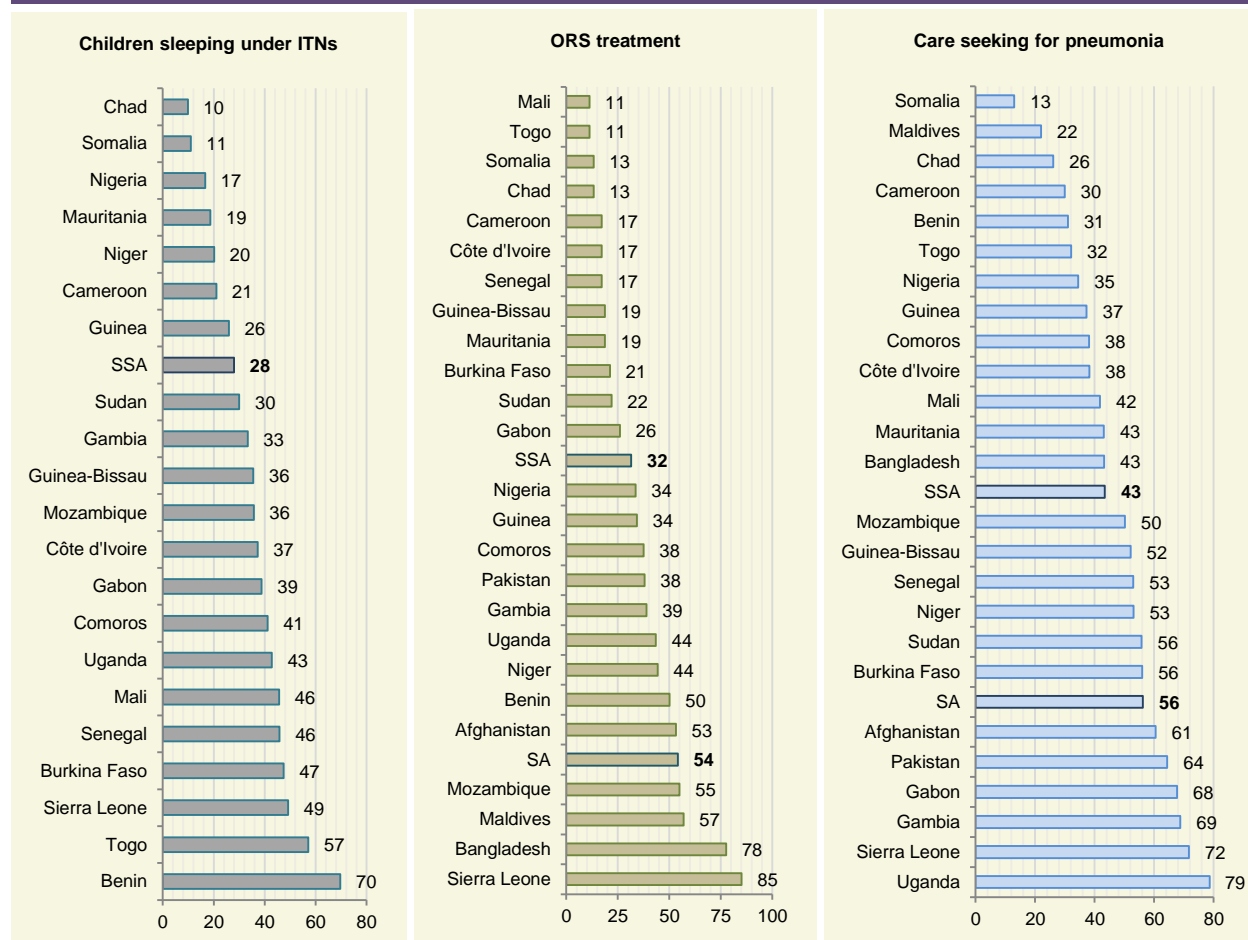
Deaths of children caused by pneumonia, diarrhea and malaria remained highly concentrated in two OIC regions namely: Sub-Saharan Africa and South Asia. As of 2013, SSA region accounted for 99% of under five deaths caused by malaria in OIC countries. Despite this heavy toll, recent estimates show that only 28% of children in this region sleep under ITNs and only a half of the total households (51%) had at least one ITN. For many countries in SSA region, ITNs coverage remained even lower than the regional average (Figure 3.13). Over all, the lowest coverage was recorded in Chad where only 9.8% children were sleeping under ITNs followed by Somalia (11%), and Nigeria (16.6%).

In 2009-2013, 90% of diarrhea-related child deaths in OIC countries were reported in SSA (64%) and SA (26%) regions. Nevertheless, even in these high burden regions, ORS treatment remained low with just over half (54%) of children with diarrhea treated with ORS in SA and only 31% in SSA region. Usually, OIC countries with highest burden of diarrhea related deaths recorded the lowest coverage of ORS treatment. As shown in Figure 3.13, less than 30% of children with diarrhea were treated with ORS in 12 countries, all from SSA region. Mali recorded the lowest coverage of ORS (11.2%) followed by Togo (11.3%), Somalia (13.2%) and Chad (13.3%).

In case of pneumonia, 85% of OIC's child deaths were reported in SSA (60%) and SA (25%) regions. Once children develop symptoms of pneumonia, early care seeking and prompt treatment can save their lives. Yet in 2009-2013, only 43% children with symptoms of pneumonia in SSA and 56% in SA were seen by a health provider. At the individual country level, as shown in Figure 3.13, more than two thirds of children with pneumonia were taken to a health provider in four OIC countries namely: Uganda (79%), Sierra Leone (72%), Gambia (69%) and Gabon (68%). On the opposite side of the scale, care seeking for pneumonia remained lowest in Somalia (13%) followed by Maldives (22%) and Chad (26%).

FIGURE 3.13

Coverage of Measures for Infectious Diseases in Selected OIC Countries (%), 2009-2013



Source: SESRIC staff calculations based on UNICEF Database

4 Child Nutrition and Food Security

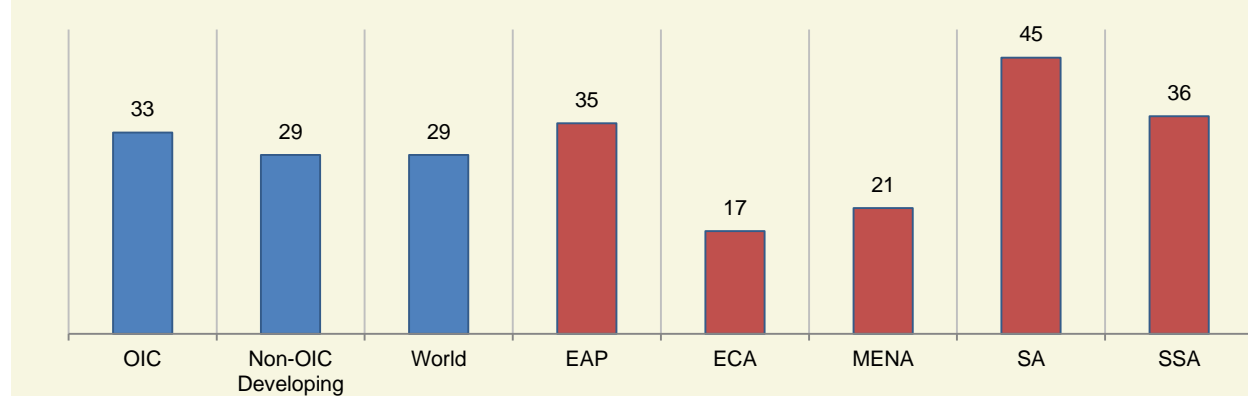
Proper child nutrition is one of the most powerful tools to raise a healthy and productive generation. It helps not only in improving children's chances of survival during the early years of life but also contribute towards their physical and cognitive development. On the other hand, malnutrition not only increases the risk of child death from common illness such as diarrhoea, pneumonia, and malaria but can also lead to stunted growth, which is irreversible and associated with impaired cognitive ability and reduced school and work performance. According to the UNICEF (2013a), nutritional status of children is assessed through measurement of their weight and height. The most commonly used indicators of nutritional status are stunting, underweight, wasting, overweight and low birth weight. This section will provide a detailed analysis of the performance of OIC countries with respect to major nutritional indicators.

4.1 Stunting

According to the UNICEF (2013), all children under 5 years with height-for-age less than minus two (-2) standard deviations (SD) of the WHO Child Growth Standards median are considered as stunted. The latest estimates show that about 180 million children mostly from developing countries have stunted growth in 2009-2013. Number of stunted children, both severe and moderate, accounted for 29% of the world total population under five. In other words one in four children under age 5 had stunted growth. While, non-OIC developing countries accounted for the lion share of the world total stunted children (63%), OIC countries bear two third of global burden of stunted children in 2009-2013.

As shown in Figure 4.1, about 33% of under five children in OIC countries were stunted in 2009-2013 compared to 29% in other developing countries and in the world. Among the OIC regions, highest prevalence of stunting was recorded in SA (45%), followed by SSA (36%) and EAP (35%). In terms of number of stunted children, these three regions accounted for 83% of OIC's total stunted children in 2009-2013. Distribution of stunted children remained highly uneven across the OIC countries and more than half of OIC's stunted children were living in four countries namely: Nigeria (17% of OIC total), Pakistan (15%), Indonesia (13%) and Bangladesh (9%).

FIGURE 4.1
Stunting Prevalence (%), 2009-2013

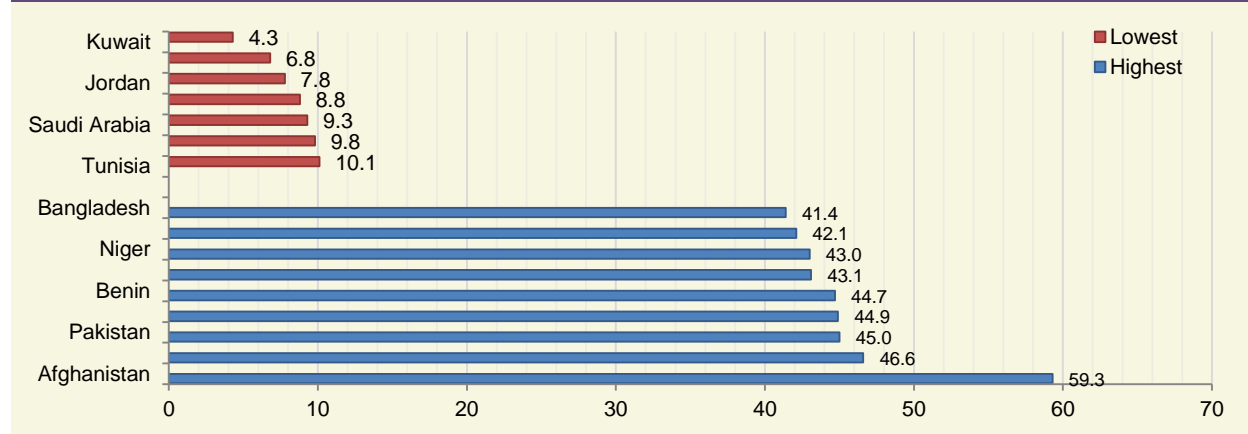


Source: SESRIC staff calculations based on UNICEF Database

At the country level, more than 40% of total children had stunted growth in nine OIC countries (Figure 4.2). Among these countries, highest prevalence rate was recorded in Afghanistan (59.3%), Yemen (46.6%) and Pakistan (45%). On the opposite side of the spectrum, 10% or lesser under five children were stunted in

seven OIC countries. Six of these countries are from MENA region. With just 4.3% of children with stunted growth, Kuwait remained the top-performer followed by Iran (6.8%) and Jordan (7.8%).

FIGURE 4.2
Lowest and Highest Stunting Prevalence in OIC Countries (%), 2009-2013



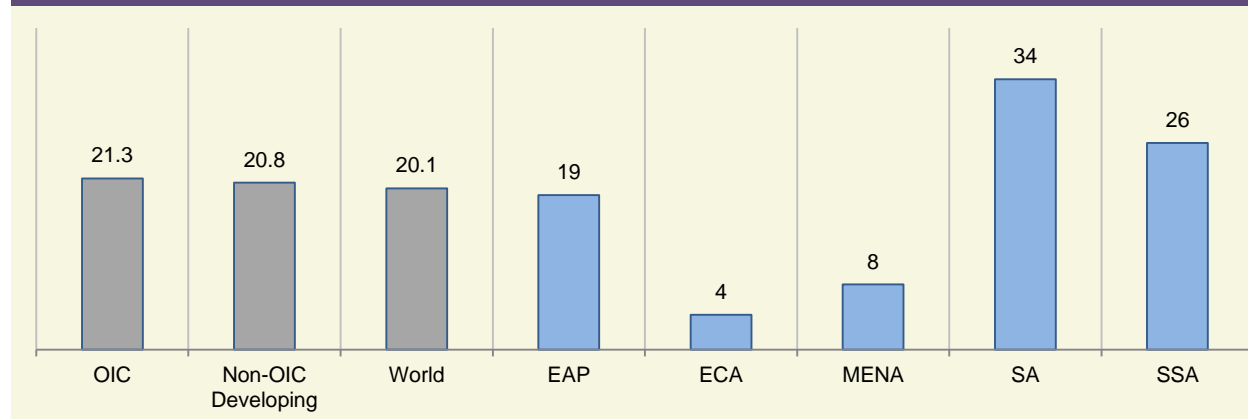
Source: UNICEF Database

4.2 Underweight

Children aged 0–59 months who are below minus two standard deviations from median weight-for-age of the WHO Child Growth Standards are considered as underweight. According to the latest estimates, in 2009–2013, 20.1% or 120 million children under five years of age in the world were underweight. Total number of underweight children remained highly concentrated in developing countries which accounted for 95% of the world total in 2009–2013. Among the developing countries, non-OIC developing group accounted for the highest share of underweight children (65%) followed by OIC countries (35%). As shown in Figure 4.3, the proportion of children under five years old who were underweight was recorded at 21.3% in OIC countries followed closely by the other developing countries (20.8%).

Among the OIC regions, as shown in Figure 4.3, underweight prevalence remained the highest in SA (34%), followed by SSA (26%) and EAP (19%). ECA region registered the lowest underweight prevalence of less than 4% whereas; this ratio was recorded at 8% in MENA region. In terms of absolute numbers of underweight

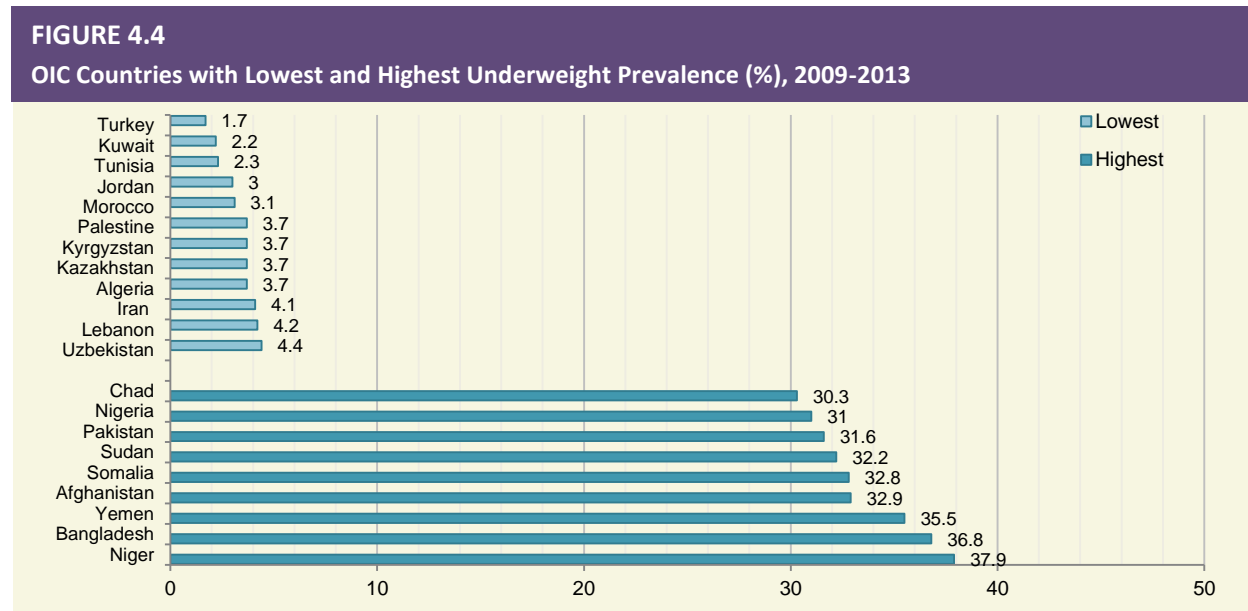
FIGURE 4.3
Underweight Prevalence (%), 2009-2013



Source: SESRIC staff calculations based on UNICEF Database

children, SSA and SA were home to about 80% of total underweight children in OIC countries. About two third of underweight children in OIC countries were living only in five countries namely: Nigeria (22% of OIC total), Pakistan (16%), Bangladesh (13%), Indonesia (11%) and Sudan (4%).

At the individual country level, prevalence of underweight children remained more than 30% in nine OIC countries (Figure 4.4). Niger recorded the highest underweight prevalence (37.9%), followed by Bangladesh (36.8%), and Yemen (35.3%). On the opposite side, underweight children accounted for less than 5% of total children age under five years in 12 OIC countries. Eight of these 12 countries are from MENA region and four from ECA region. Turkey recorded the lowest underweight prevalence (1.7%) followed by Kuwait (2.2%) and Tunisia (2.3%).



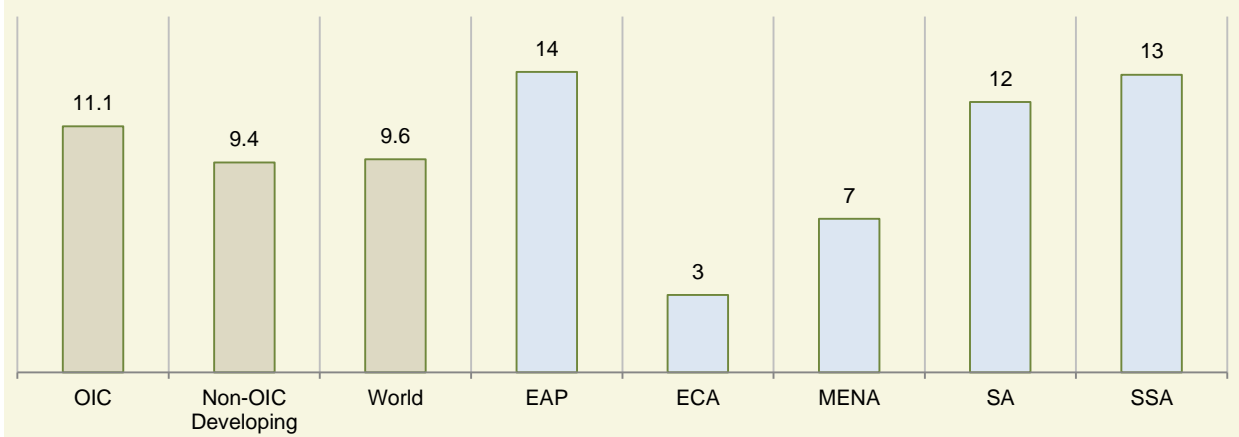
Source: UNICEF Database

4.3 Wasting

Wasting is a major health problem. It represents an acute form of under nutrition with heightened risk of disease and death for children. For the statistical purpose, all children aged 0–59 months who are below minus two standard deviations from median weight-for-height of the WHO Child Growth Standards are counted as wasted. Globally, more than 50 million children under 5 years of age were moderately or severely wasted in 2009-2013, accounting for about 10% of children in the world. Currently, about 38% of wasted children in the world are living in OIC countries while this ratio stands at 62% for other developing countries. Nevertheless, as shown in Figure 4.5, wasting prevalence remained more or less the same in OIC and other developing countries with a rate of 11.1% and 9.4% respectively.

Among the OIC regions, wasting is more prevalent in EAP, where one in every seven children (14%) is moderately or severely wasted (Figure 4.5). A similar situation exists in SSA and SA regions whereas wasting prevalence remained lowest in ECA (3%) and MENA (7%). The burden of wasting is highest in SSA and SA regions, which accounted for 70% of total wasted children in OIC countries (with 47% living in SSA and 23% in SA). It is worth noting that more than half of OIC total wasted children were living only in three countries namely: Nigeria (25% of OIC total), Indonesia (15%) and Bangladesh (11%).

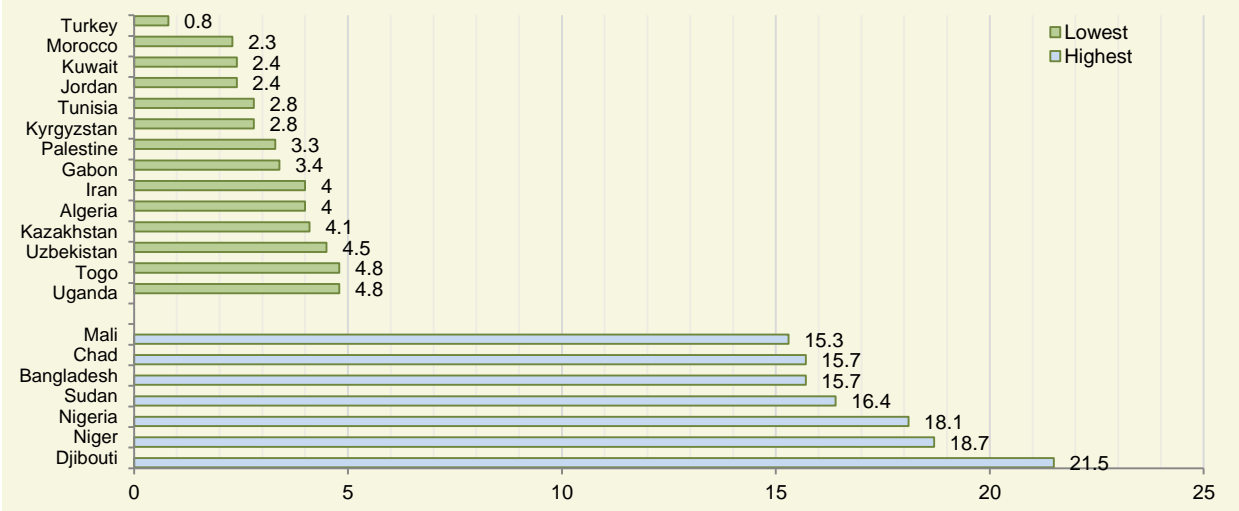
FIGURE 4.5
Wasting Prevalence (%), 2009-2013



Source: SESRIC staff calculations based on UNICEF Database

At the individual country level, more than 15% of total children were wasted in seven OIC countries (Figure 4.6). Among these countries, highest prevalence rate was recorded in Djibouti (21.5%), Niger (18.7%) and Nigeria (18.1%). On the opposite side of the scale, less than 5% of children were stunted in 14 OIC countries. Half of these countries are from MENA region. With stunting prevalence of less than 1%, Turkey remained the top-performer followed by Morocco (2.3%), Kuwait (2.4%) and Jordan (2.8%).

FIGURE 4.6
OIC Countries with Lowest and Highest Wasting Prevalence (%), 2009-2013



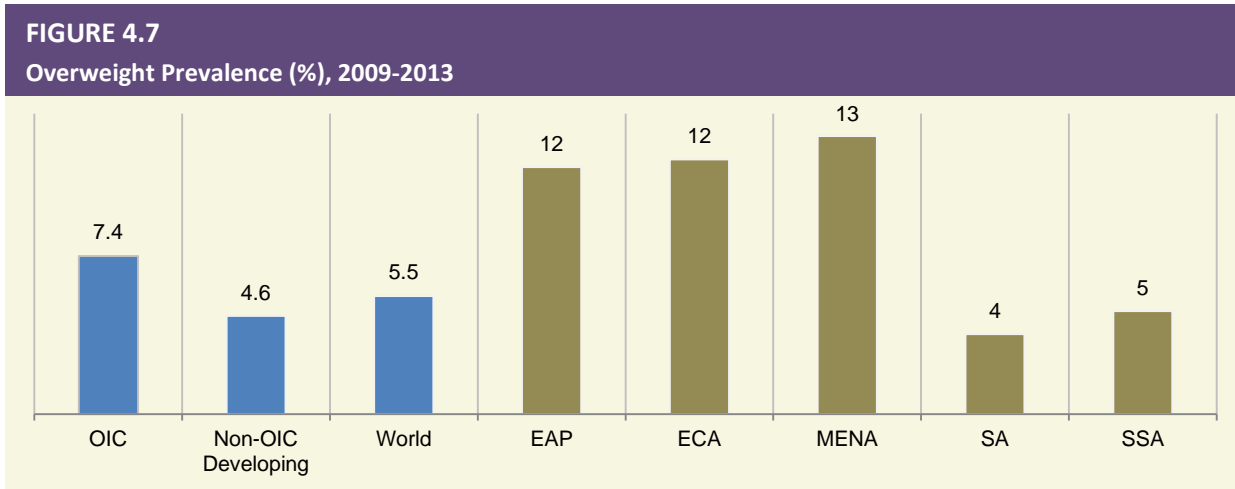
Source: UNICEF Database

4.4 Overweight

Childhood overweight and obesity is on rise across the globe especially in the developing world. There are serious health consequences for childhood overweight and obesity including cardiovascular disease, diabetes, and many cancers. By definition, all children aged 0-59 months who are above two standard deviations from median weight-for-height of the WHO Child Growth Standards are overweight. Globally, in 2009-2013 the number of overweight children under the age of five was estimated to be over 42 million. Though overweight

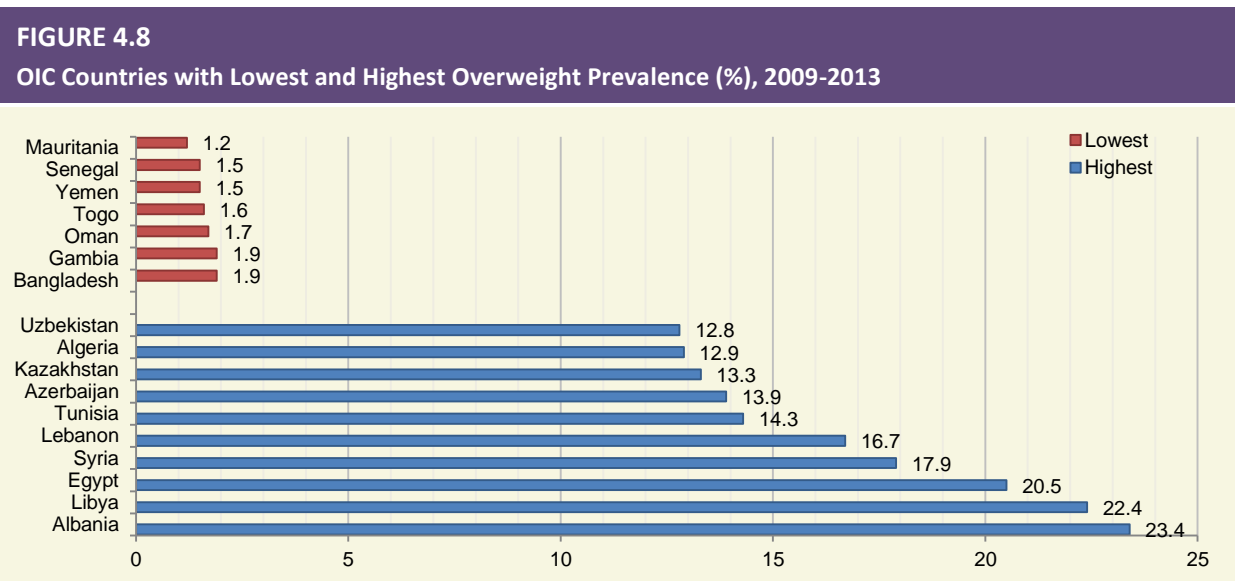
was once associated mainly with high-income countries, 72% of world total overweight children were living in low-and middle-income countries. As of 2009-2013, OIC countries accounted for 32% of world total overweight children while other developing countries were home for 40%. However, as shown in Figure 4.7, the prevalence of overweight among children remained higher in OIC countries (7.4%) than the other developing countries (4.6%).

In 2009-2013, over 4.5 million children in MENA, 3.3 million in SSA and 2.8 million in EAP were overweight. These three regions accounted for 81% of the OIC burden of overweight children (with 35% living in MENA, 25% in SSA and 21% in EAP). Overweight prevalence remained highest in MENA, ECA and EAP regions, where one in eight children was moderately or severely overweight (Figure 4.7). SA region registered the lowest overweight prevalence (4%) followed by SSA (5%).



Source: SESRIC staff calculations based on UNICEF Database

Looking at the individual countries, the highest proportion of the OIC’s total overweight children (21%) lives in Indonesia followed by Egypt (14%) and Nigeria (11%). Overweight prevalence remained higher than 12% in ten OIC countries (Figure 4.8). Albania recorded the highest overweight prevalence (23.4%), followed by Libya (22.4%), and Egypt (20.5%). On the opposite side of the scale, overweight children accounted for less than 2% of total children age under five years in seven OIC countries. Among these countries, Mauritania



Source: UNICEF Database

recorded the lowest underweight prevalence (1.2%) followed by Senegal (1.5%) and Yemen (1.5%).

4.5 Child Feeding Practices

Proper feeding especially during the first two years of life is critical for a child’s survival, growth and development. Regarding best child feeding practices, international health agencies like UNICEF and WHO recommend that infants should be breastfed within one hour of birth, breastfed exclusively for the first six months of life and continue to be breastfed up to 2 years of age and beyond. Starting at 6 months, breastfeeding should be combined with safe, age-appropriate feeding of solid, semi-solid and soft foods. According to the recent findings of UNICEF (2013) implementation of these interventions could reduce the global deaths of children under 5 years of age by 20%.

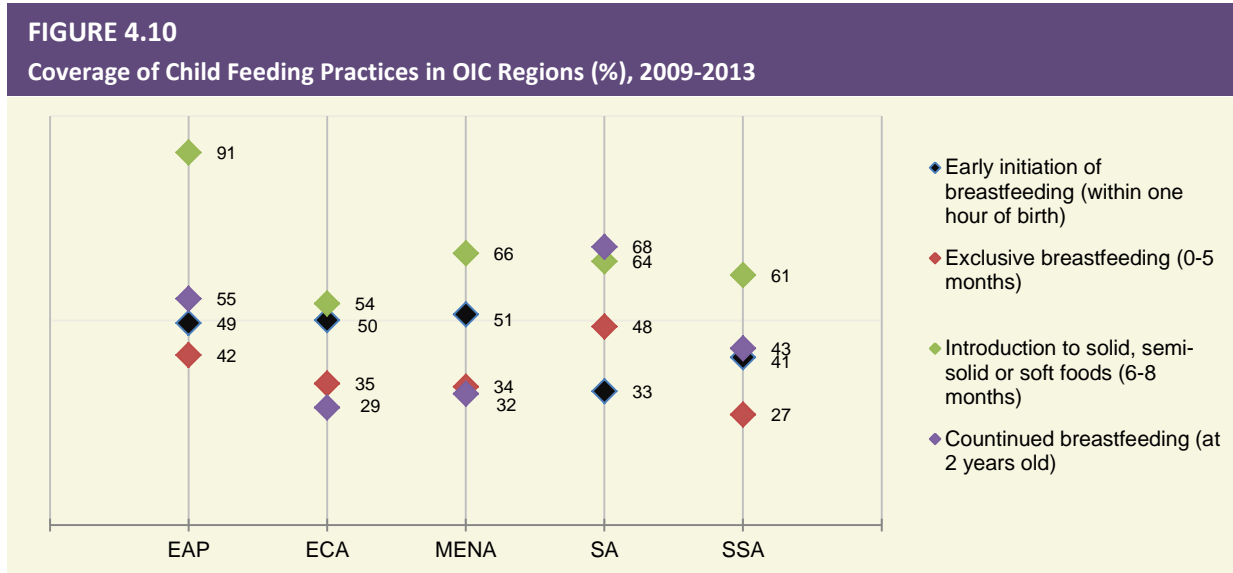
The latest estimates on feeding practices among infants and young children reveal that in spite of its crucial importance for child nutrition a significant number of infants and children are not breastfed. Globally, only 44.9% infants were breastfed within one hour of birth and 37.4% were exclusively breastfed for 0-5 months (Figure 4.9). In line with the global trends, coverage of infant and child feeding practices remained more or less the similar both in OIC and non-OIC developing countries. For the OIC countries, only 42.9% of infants were put to the breast within first hour of birth, and 34.9% were exclusively breastfed during the first six months of life. The coverage of breastfeeding until age 2 remained comparatively better in OIC countries with 46.7% of the total children breastfed until age 2. The estimates for appropriate feeding of children with adequate and safe complementary food reveal that about two third of infants in OIC countries were introduced to solid, semi-solid or soft foods at 6 to 8 months. Coverage for introduction of complementary food for infants remained more or less the similar both in the world and non-OIC developing countries. In general, OIC countries average for the early initiation of breast and exclusive breastfeeding for six months remained visibly lower than the world and non- OIC developing countries averages (Figure 4.9).



Source: SESRIC staff calculations based on UNICEF Database

Coverage of recommended breastfeeding practices varies substantially among the OIC regions (Figure 4.10). The share of infants which are breastfed within one hour of birth ranges from 33% in SA to 51% in MENA region. On the other hand, in terms of continued breastfeeding at 2 years of age, coverage ranges from 29% in ECA to 68% in SA region. In general, data from three indicators relating to breastfeeding reveals that children in SSA, MENA and ECA region remained particularly vulnerable to malnutrition. Regarding the introduction of

complementary food, EAP region registered the highest coverage rate of 91% whereas, about two thirds of infants were introduced to solid, semi-solid or soft foods at 6 to 8 months in MENA, SA and SSA regions (Figure 4.10).



Source: SESRIC staff calculations based on UNICEF Database

4.6 Micronutrient Deficiencies

Micronutrient deficiencies like deficiencies of vitamin A, iron, iodine, zinc and folic acid are very common among women and children in low income developing countries, including some OIC countries. While efforts to improve the nutritional status of children through breastfeeding and complementary feeding are crucial, interventions like supplementation are regarded as a fast-track approach to improve the intake of vital micronutrients among women and children. This sub-section will give a brief overview of efforts exerted by the OIC countries to improve the micronutrient deficiencies among children.

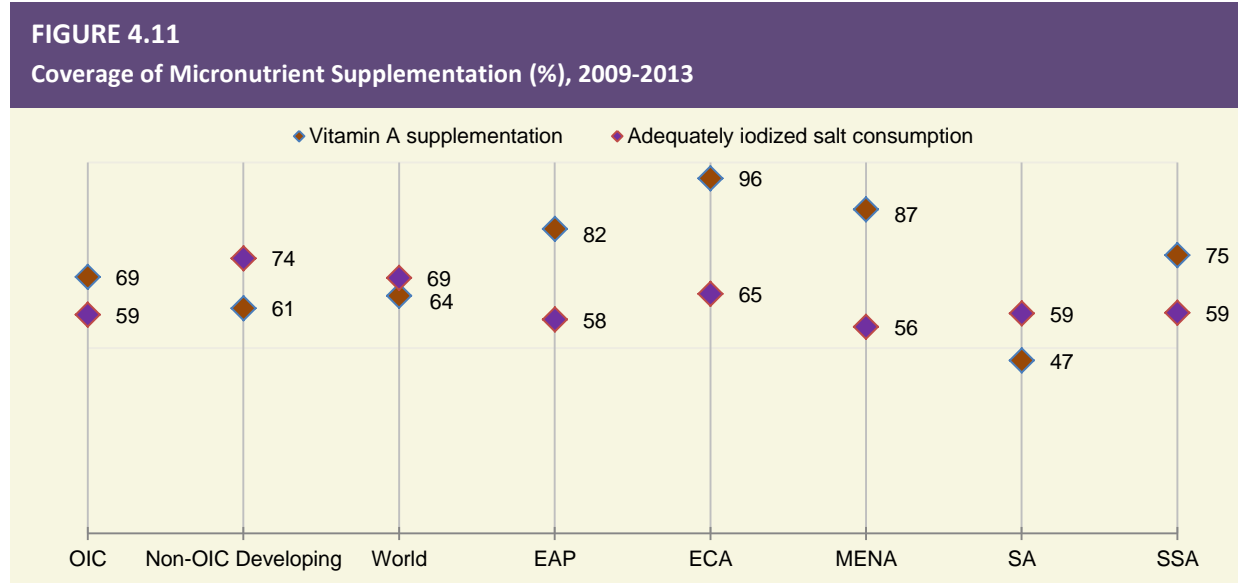
Vitamin A Supplement

According to the WHO (2015c), vitamin A deficiency is a public health problem especially in Africa and South-East Asia. It is not only the leading cause of preventable blindness in children but it also increases the risk of disease and death from severe infections. Globally, about two-third of children aged 6 to 59 months received two doses of vitamin A in 2009-2013 (Figure 4.11). Coverage for vitamin A supplementation remained highest in OIC countries where 69% of children received two doses of vitamin A. Non-OIC developing countries registered comparatively low coverage of 61%. Vitamin A supplementation coverage varies greatly across the OIC regions. In 2009-2013, ECA registered the highest coverage rate of 96% followed by MENA (87%) and EAP (82%). In contrast, children remained most vulnerable to vitamin A deficiency and hence blindness in SA, with more than half of children aged 6 to 59 months did not receive two doses of vitamin A (Figure 4.11).

Iodized Salt Consumption

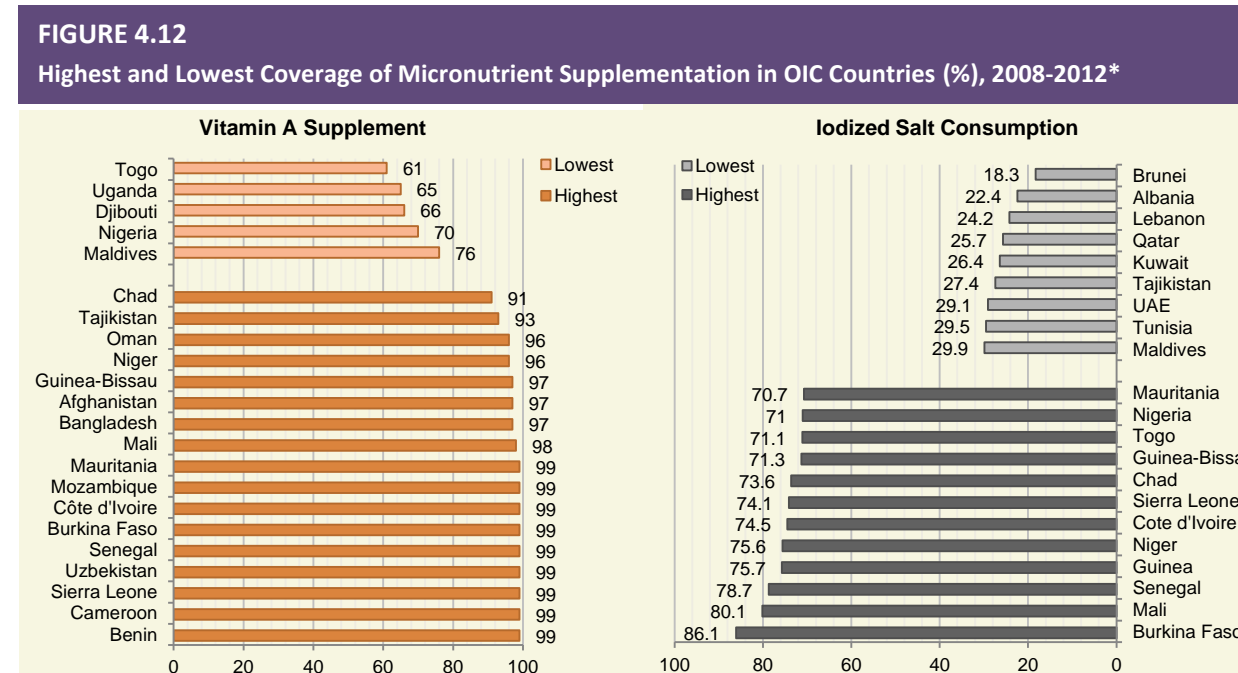
Consumption of adequately iodized salt is another major intervention to prevent and improve the iodine deficiency and its consequences. According to the WHO (2015c), iodine deficiency is the most common cause of mental impairment in childhood. As a result, it does not only affect children’s performance at school but also affects their productivity and the ability to find a job in adulthood. Globally, nearly 50 million people suffer from some degree of iodine deficiency-related brain damage. According to the latest estimates, globally, 69% of households have adequately iodized salt (15 parts per million or more), but coverage varies

considerably among the developing countries (Figure 4.11). Non-OIC developing countries registered the highest coverage, with 74% of households consuming adequately iodized salt. In contrast, only 59% of households were consuming adequately iodized salt in OIC countries. Consumption of adequately iodized salt remained more or less the similar across the OIC regions except ECA, where 65% of households were consuming adequately iodized salt in 2009-2013.



Source: SESRIC staff calculations based on UNICEF Database

At the individual country level, 20 out of 27 OIC countries with data had reached the universal target of 80% coverage for vitamin A supplementation. Among these 20 countries, coverage remained over 90% in 17 OIC countries, 12 of them from SSA region (Figure 4.12). For the adequately iodized salt consumption, among the 43 OIC countries with data, only Tunisia managed to reach the global target of 90% coverage (Figure 4.12).



Source: UNICEF Database

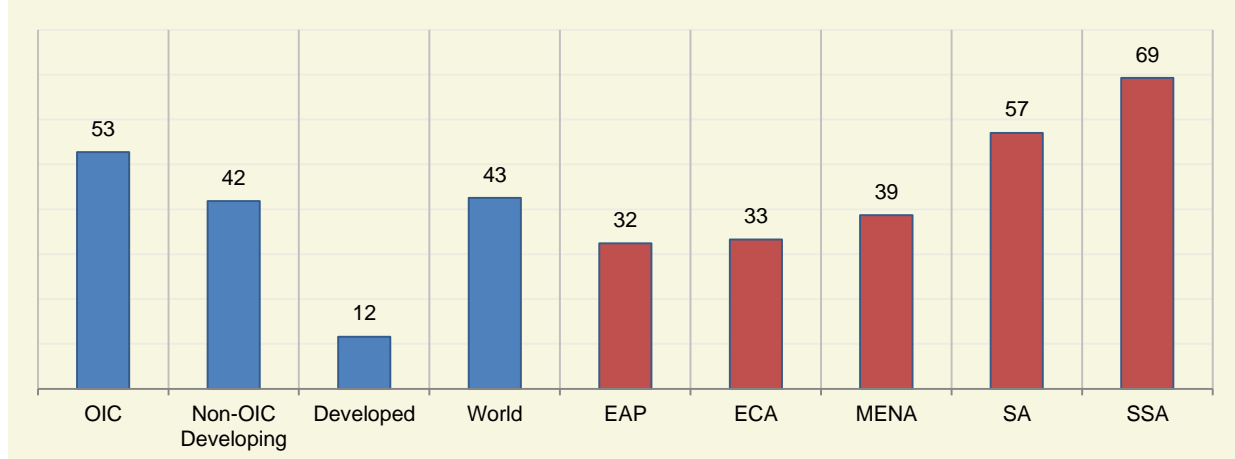
Among others, consumption of iodized salt ranged from 50 to 88% in 23 OIC countries. For 14 of these countries coverage remained over 70%. On the bottom side, less than 30% of households were consuming adequately iodized salt in 11 OIC countries. Among these countries, coverage remained even less than 15% in Somalia, Mauritania, Sudan, Guyana and Guinea-Bissau.

Iron Deficiency Anemia

Iron deficiency is one of the most common and wide spread nutritional disorders in the world. Though, it is mostly prevalent among children and women in low income developing countries, it is the only nutrient deficiency which is also significantly prevalent in developed countries as well. Iron deficiency is indicated as the most common cause of anemia in children. There is overwhelming evidence that iron deficiency anemia during the first two years of life leads to impairments in the cognitive and behavioral development of children that persist even after treatment of iron deficiency.

According to the latest estimates, over 43% of children under 5 were anemic in 2011. While prevalence of anemia was just 12% for developed countries, the numbers were staggering in non-OIC developing and OIC countries with 42% and 53% of children suffering from anemia respectively (Figure 4.13). Among the OIC region, anemia in children remained a major health challenge in South Asia and Sub-Saharan Africa. These two regions accounted for over 70% of total anemic children in OIC countries. As shown in Figure 4.13, about 69% of children were suffering from anemia in SSA and 57% in SA region. In contrast, less than 40% of children were anemic in other regions.

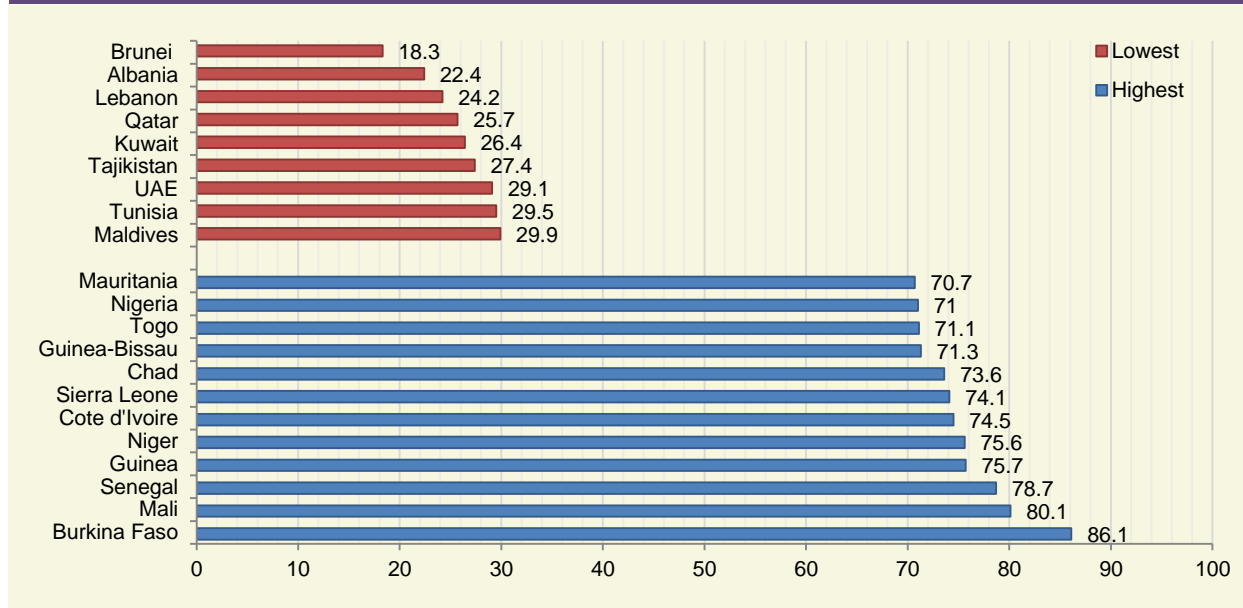
FIGURE 4.13
Prevalence Iron Deficiency Anemia (%), 2009-2013



Source: SESRIC staff calculations based on World Bank, WDI

Looking at the individual countries, as shown in Figure 4.14, Brunei recorded the lowest prevalence of anemia among children (18.3%) followed by Albania (22.4%) and Lebanon (24.2%). On the opposite side of the scale, prevalence remained highest in Burkina Faso (86%) followed by Mali (80.1%) and Senegal (78.7%). In general, more than half of the children were anemic in 24 OIC countries, 21 of them from SSA region.

FIGURE 4.14
OIC Countries with Lowest and Highest Overweight Prevalence (%), 2009-2013



Source: World Bank, WDI

5 Basic Education and Schooling

The ability to produce and use knowledge is a major factor in sustaining development and achieving comparative advantage. “Education is a precondition for economic development and the fight against poverty, and the Koran sets the education of girls and boys as a high priority” (UNICEF, 2005). Demand for education in many parts of the world continues to increase, which in turn offers developing countries an invaluable opportunity to prepare a well-trained workforce for growth and development. Educated, or skilled, workers are able to perform complex tasks and thereby contribute to producing more technologically sophisticated products. Skilled workers increase the absorptive capacity of the country by acquiring and implementing the foreign knowledge and technology, which is of crucial importance in successful economic diversification and development.

Access to basic education is a fundamental child right. Education helps children to learn and develop their personality and identity and it shapes their social, economic and cultural standing in future. Over the years, there were significant gains towards achieving universal access to education however; still millions of children of primary and secondary school age remained out of school while millions of others were unable to finish their primary and secondary levels. This section portrays the detailed picture of child education and schooling in OIC member countries by looking into the state of primary and secondary school enrolment, completion and progression trends. The section finally focuses on the adequacy of basic education services in OIC member countries in a comparative perspective.

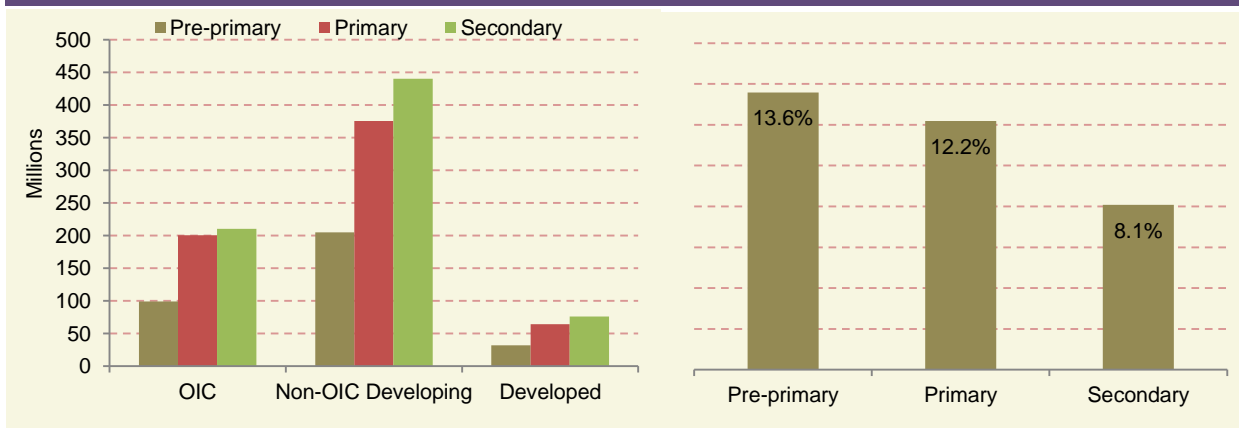
5.1 School Enrolment and Attendance

School Age Population

Population in OIC member countries is on the rise. OIC member countries’ total population has exceeded 1.6 billion that represents about 23% of the world population as of 2014. School age population at primary and secondary schools reached 200 million and 210 million in the OIC group, respectively (Figure 5.1). In the OIC group school age population also continues to grow up rapidly over time thanks to the high fertility rate observed in OIC member countries (Figure 5.2). This implies that each year OIC member countries need to provide additional educational services to its children at all levels (pre-primary, primary and secondary) in order to prepare them for the life that will help OIC member countries to build up their human capital. In the OIC group, the highest percentage increase (13.6%) in school age population has been observed at pre-primary school level stemming from high fertility rate between 2003 and 2013 (Figure 5.2). In the OIC group,

FIGURE 5.1 & 5.2 (right)

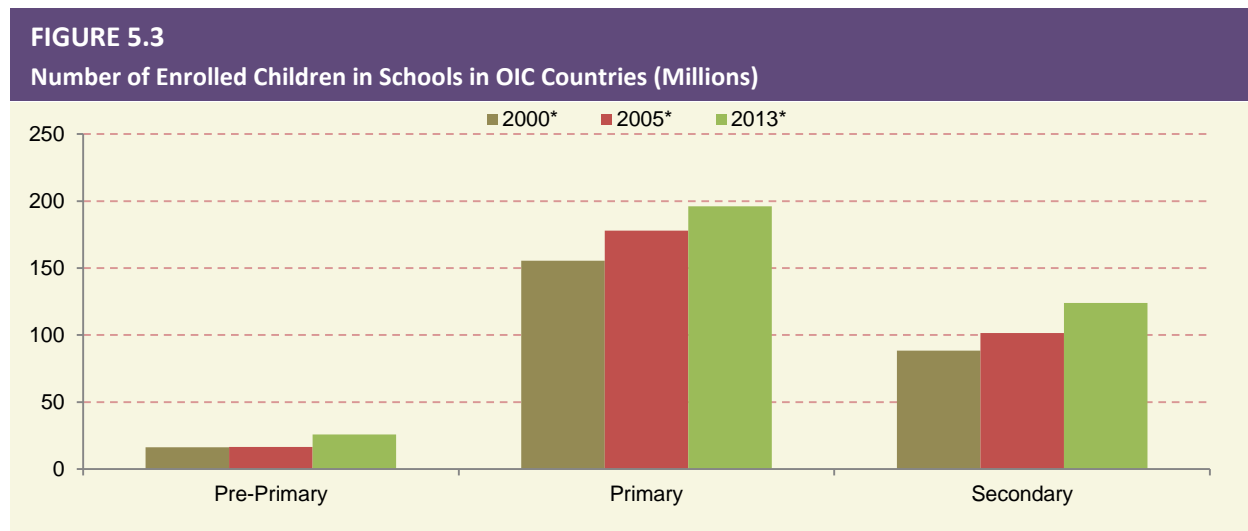
School Age Population, 2013; Percentage Change in School Age Population in OIC btw. 2003 and 2013



Source: SESRIC staff calculations based on UNESCO, UIS Database

primary school age population also increased by 12.2% during the same period.

Stemming from population dynamics and increasing importance of education, many OIC member countries heavily invested into education and achieved to increase the numbers of enrolled children. Figure 5.3 depicts that as of 2013, the number of enrolled children into pre-primary education peaked up to 25 million, children at primary education exceeded 195 million and at secondary school level this figure reached 123 million. In this regard, a relatively moderate improvement has been observed during the period under consideration at pre-primary school level, which implies that the OIC group needs to further realize investments at pre-primary school level (Figure 5.3).



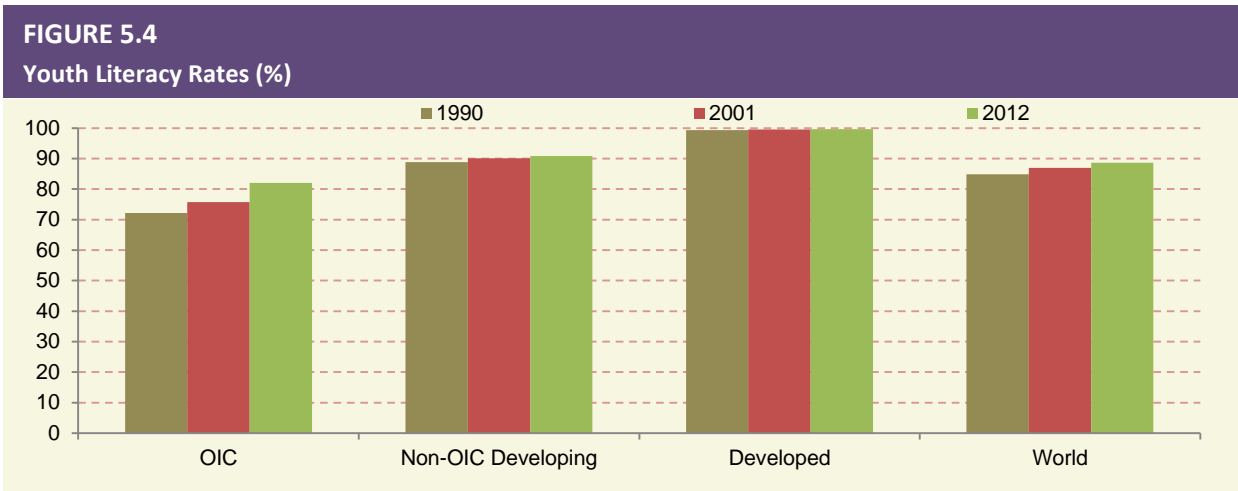
Source: SESRIC staff calculations based on UNESCO, UIS Database

In OIC member countries not only population but also average years of schooling have substantially increased. According to SESRIC (2014), within the OIC group the number of countries with average years of schooling more than 6 years was only 4 in 1970. This number increased to 26 in 2010. According to UN estimations, it is projected that the minimum average years of schooling will be 4 years in 2030 and it will reach to 6 years in 2050 in OIC member countries where majority of the countries are expected to have average schooling rates over 8 years as of 2050 (SESRIC, 2014).

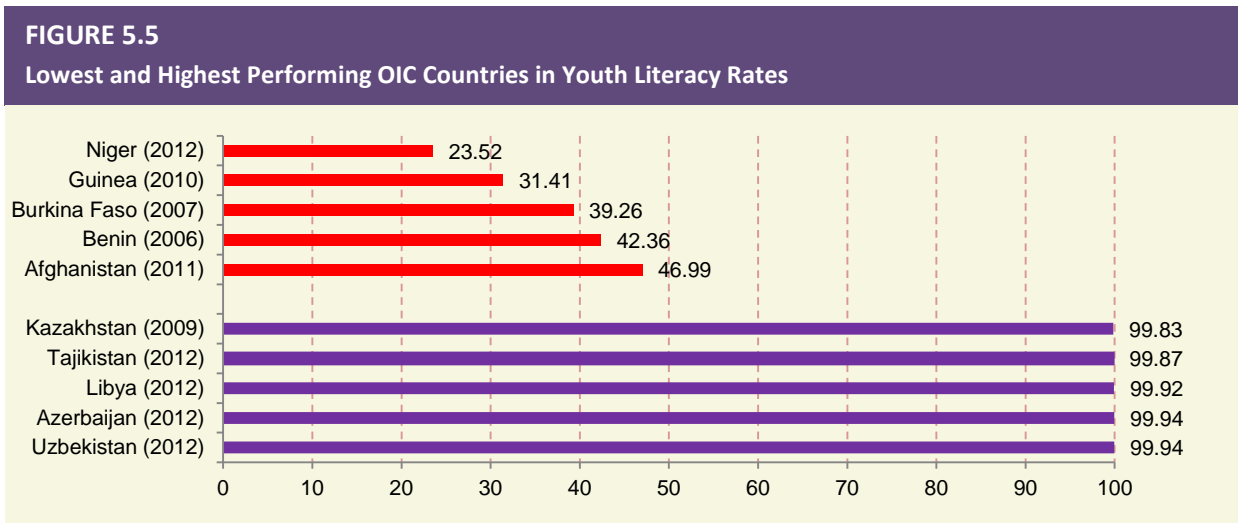
Despite significant progress shown in education, there are still OIC member countries where children stay out of school. For instance, in Niger, the share of population with no-schooling remained as high as 84% in 2010. Worst of all, there is high inter-regional disparity within OIC member countries in terms of schooling that hinders many children to enrol in formal educational institutions.

In spite of all positive developments in schooling in the OIC group, illiteracy still stays as a major problem among children and young population in terms of actual numbers. However, the positive trend observed over the two last decades for the OIC group is really promising. Compared with 1990, in 2012 young literacy rate in the OIC group was 10 percentage points higher. In the same period, the average of non-OIC developing countries increased only by 2 percentage points. The world average was 88% in 2012 that is still higher than the OIC average of 82% in the same year (Figure 5.4).

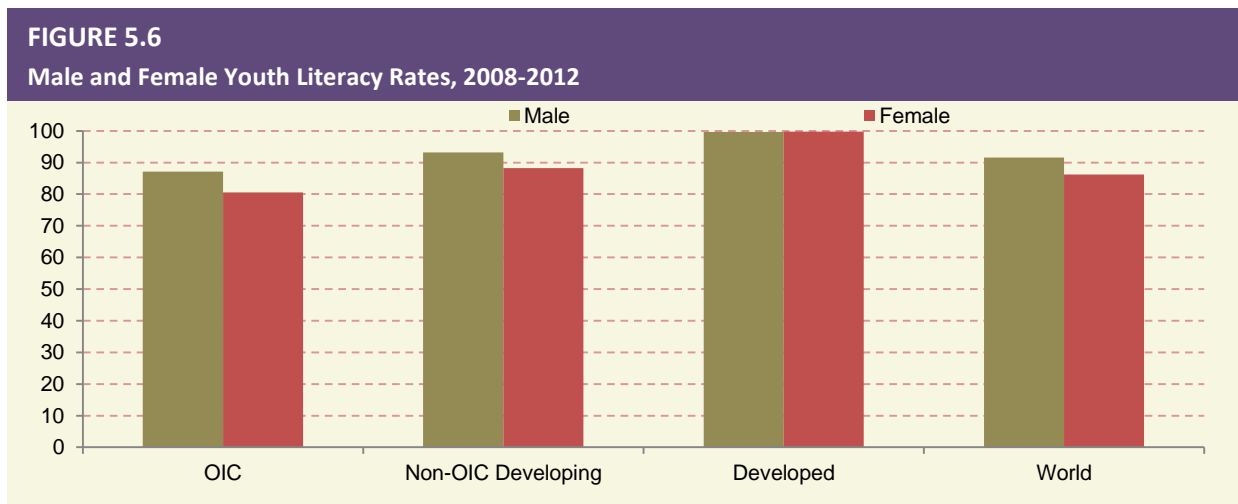
Some OIC member countries reached 99% literacy rates such as Uzbekistan and Azerbaijan. On the other side, in Niger only 23.5% of young population including children can read and write (Figure 5.5). Another dimension of the problem seen in OIC member countries is the existence of gender disparity in literacy rates. Despite having female and male youth literacy rates above 80%, the gender disparity among youth male and female exceeds 6.5 percentage points (Figure 5.6).



Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database



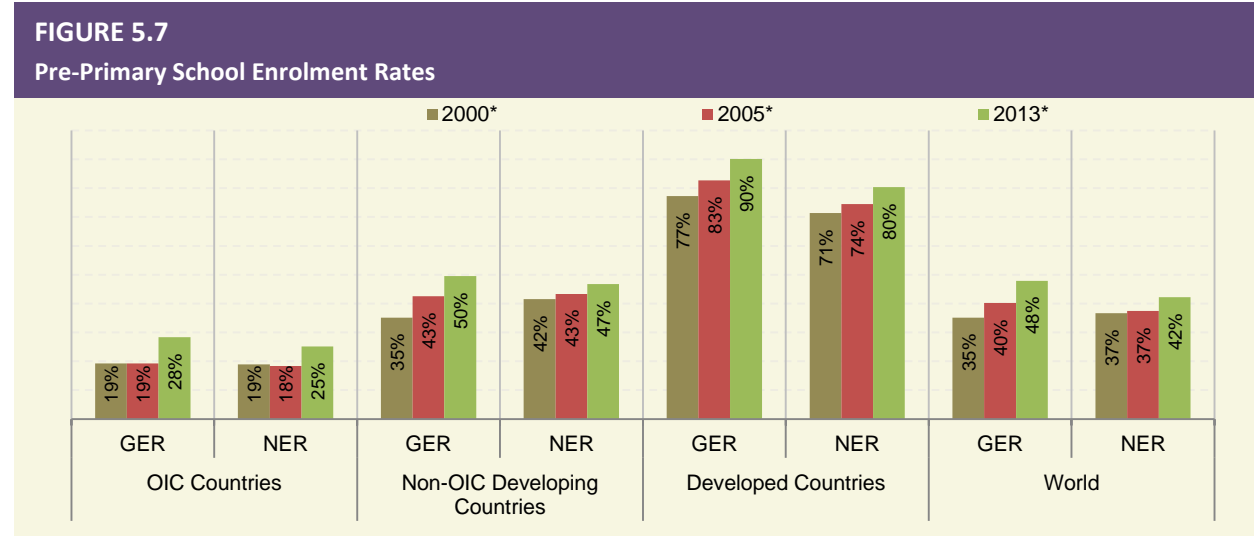
Source: WDI and UNESCO, UIS Database



Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

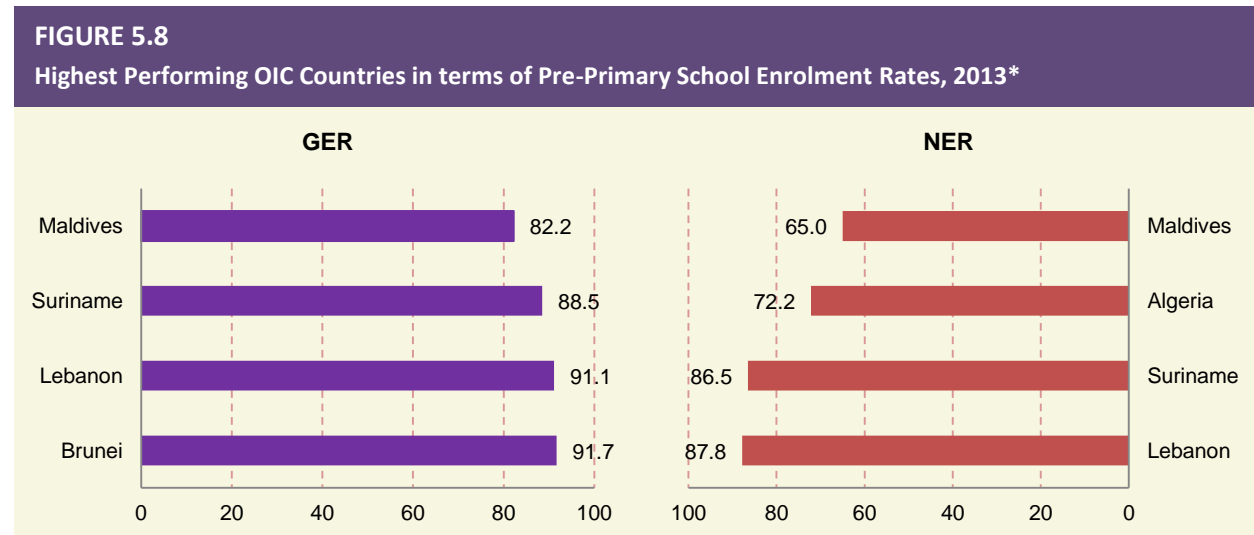
Enrolment Rate

Participation in pre-primary education programs can not only improve the subsequent primary school performance of children, but also serve as child care for working parents. Between 2000 and 2013, the number of children who attend pre-primary schools all over the world has risen from 116.7 million to 181.8 million (SESRIC, 2014).



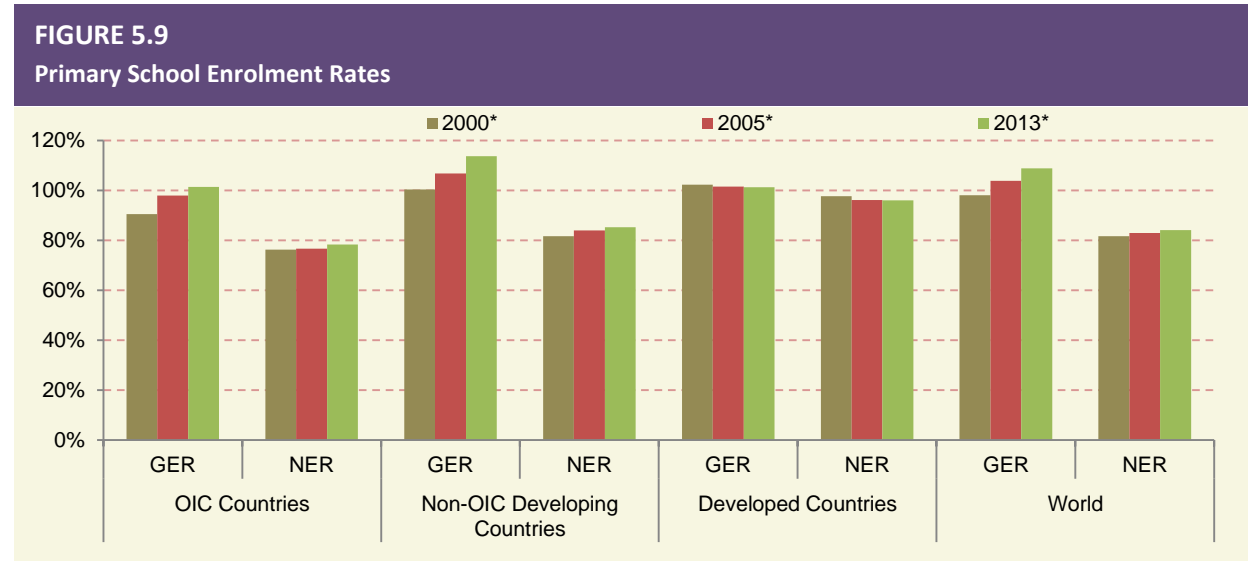
Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database. * Or latest year

For OIC member countries, the pace of growth in pre-primary school enrolment has been relatively slower than that of the world, although the number of pre-primary education enrolments increased from 16.3 million to 25.9 million. In non-OIC developing countries, the number of pre-primary school attendants increased from 76.5 million in 2000 to 127.4 million in 2013 – which corresponded to a surge by two-thirds. The average of OIC member countries is far lower than the world average and the average of developed countries as of 2013 both in terms of NER (Net Enrolment Rate) and GER (Gross Enrolment Rate) at pre-primary school level. In the OIC group, on average, GER was recorded as 28.3% and NER was measured as 25.0% in 2013 (Figure 3.7). Brunei had the highest GER (91.7%) in 2013. Lebanon was the top performer country in terms of NER in 2013 with a NER of 87.8% (Figure 5.8).

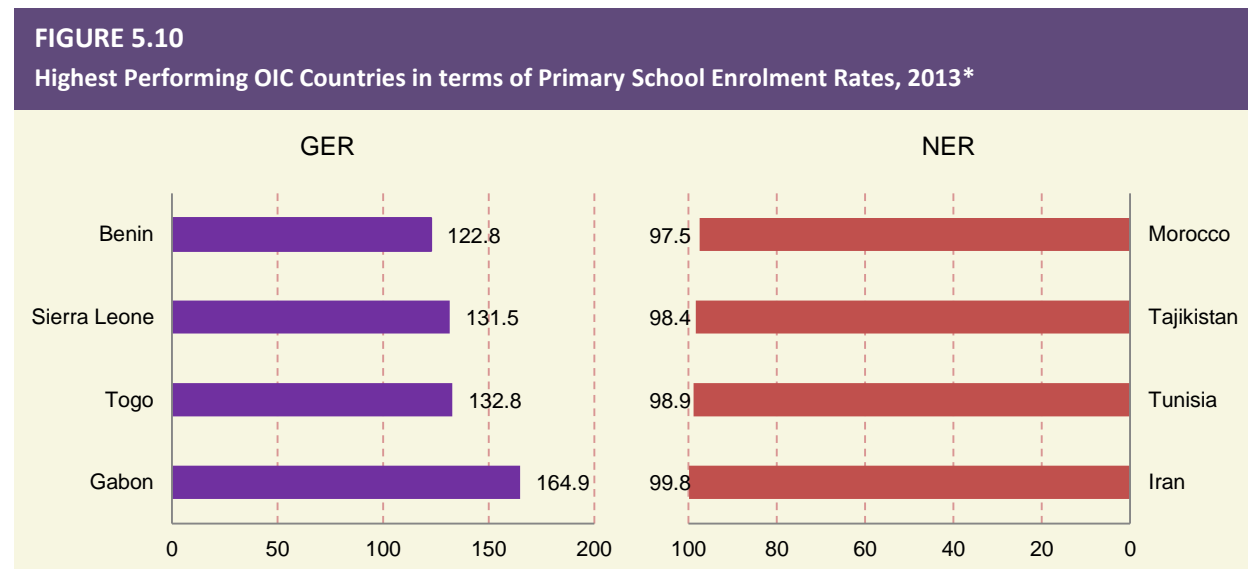


Source: WDI and UNESCO, UIS Database. * Or latest year

Primary or elementary education involves programmes normally designed on a unit or project basis to give pupils a sound basic education in reading, writing and mathematics along with an elementary understanding of other subjects such as history, geography, natural science, social science, art and music. In this connection, Figure 5.9 reflects the trends in primary school GER and NER in OIC member countries as compared to other country groups and the world. As of 2013, the number of primary school pupils in OIC member countries reached 196.0 million, representing 28.0% and 30.9% in total world and developing country primary school enrolments, respectively. Both GER and NER figures increased steadily in the OIC group and reached 101.3% and 78.3%, respectively in 2013. However, both figures are lagging behind the averages of non-OIC developing countries. At individual country level, Gabon had the highest GER (164.8%) in 2013 and Iran reached the highest (99.8%) NER in 2013 in primary schools (Figure 5.10).



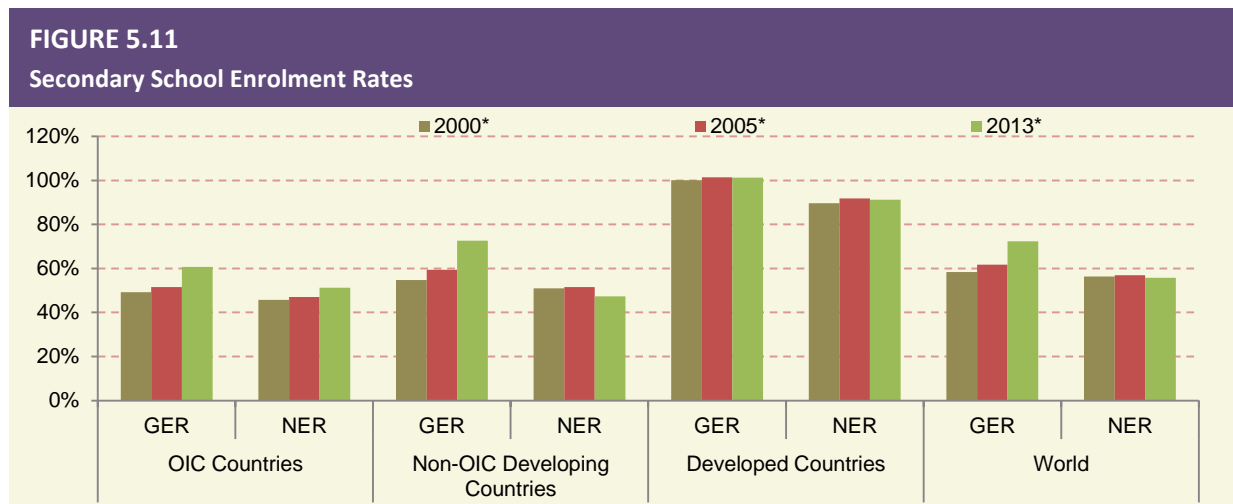
Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database. * Or latest year



Source: WDI and UNESCO, UIS Database. * Or latest year

Formally, secondary education refers to the programmes at International Standard Classification of Education (ISCED) Levels 2 and 3. Lower secondary education (ISCED Level 2) is generally designed to continue the basic programmes of the primary level but the teaching is typically more subject-centric – which, in turn, requires more specialized teachers for each subject area. The end of this level often coincides with the end of compulsory education. In upper secondary education (ISCED Level 3), the final stage of secondary education in most countries, courses are often classified into various subject areas and offered by typically more qualified teachers – as compared to ISCED Level 2 – in terms of their level of subject specification.

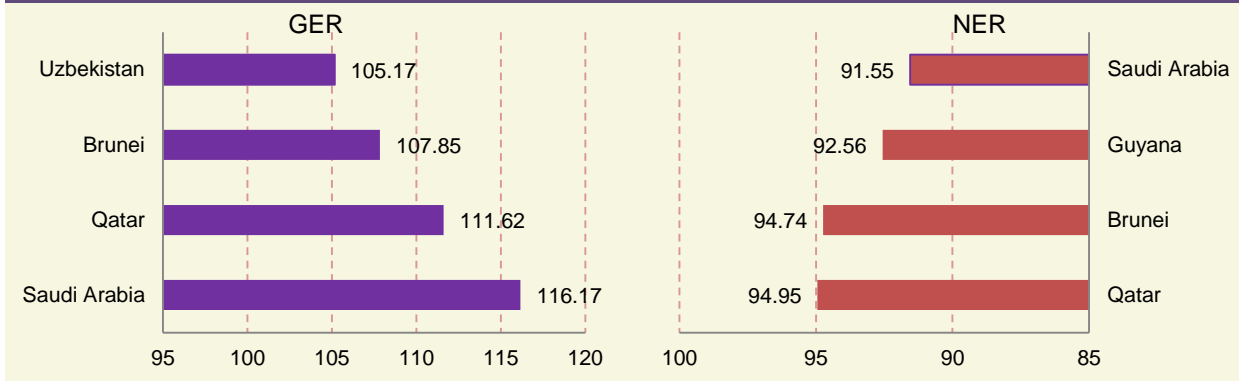
The total number of students enrolled in the secondary schools in OIC member countries increased from 88.4 million in year 2000 to 123.9 million in 2013 (SESRIC, 2014). The figures on secondary school enrolments also reveal that the total number of secondary school pupils in OIC countries increased at a slightly higher pace when compared to non-OIC developing countries and the world as a whole. Like GER for primary schools, GER for secondary schools have also exhibited an upward trend all over the world –excluding developed countries where the average secondary school GER has relatively been stable (Figure 5.11). In OIC member countries, the average secondary school GER increased from 49.3% in 2000 to 60.7% in 2013 and NER was recorded as 51.2% in the same year. As of 2013, non-OIC developing countries registered an average secondary school GER of 72.7%, as compared to only 54.8% in 2000. At secondary schools, Saudi Arabia had the highest GER (116.1%) in the OIC group. In terms of NER, Qatar (94.9%) was the top performer OIC member country in 2013 (Figure 5.12).



Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

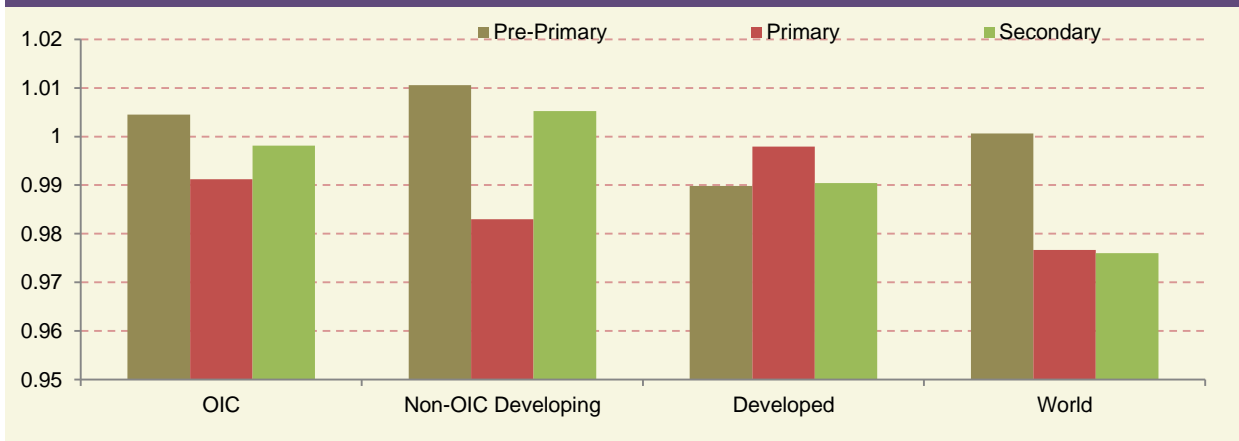
Finally, Figure 5.13 presents Gender Parity Index (GPI) scores (based on GER) at education levels of pre-primary, primary, and secondary schools for four country groups. According to 2012 dataset obtained from the UNESCO, the OIC group has a GPI score of 1.004 at pre-primary education that there is no significant gender inequality. However, at primary and secondary education GPI score goes down to 0.99 level that implies a small disparity in favour of boys. Therefore, in the OIC group, the gender disparity in terms of participation into education is more concentrated at the primary and secondary education that mostly disfavours girls.

FIGURE 5.12
Highest Performing OIC Countries in terms of Secondary School Enrolment Rates, 2013*



Source: WDI and UNESCO, UIS Database. * Or latest year

FIGURE 5.13
Gross Enrolment Ratio Gender Parity Index (GPI), 2012



Source: SESRIC staff calculations based on Source: UNESCO, UIS Data Centre. **Note:** The GPI measures progress towards gender parity in education participation and/or learning opportunities available for girls in relation to those available to boys. A GPI equal to 1 indicates parity between females and males. In general, a value less than 1 indicates a disparity in favour of boys and a value greater than 1 indicates a disparity in favour of girls.

Overall, the OIC group has achieved a lot in terms of schooling and providing basic education for children over the last decades. However, the OIC averages are far below than the averages of the world in enrolment rates and literacy rates. Moreover, there exists gender disparity in education in many OIC member countries in favour of boys that needs to be addressed by policy-makers.

5.2 Completion and Progression

Previous sub-section looked at the participation in education by using literacy and enrolment rates in a comparative perspective. However, enrolling into a school is only the first step of the education life of a child. Staying in schools, going on education until the last grade and most importantly graduating successfully from the educational institution are other important steps of the education life. In this context, this sub-section examines completion and progression indicators in education in OIC member countries.

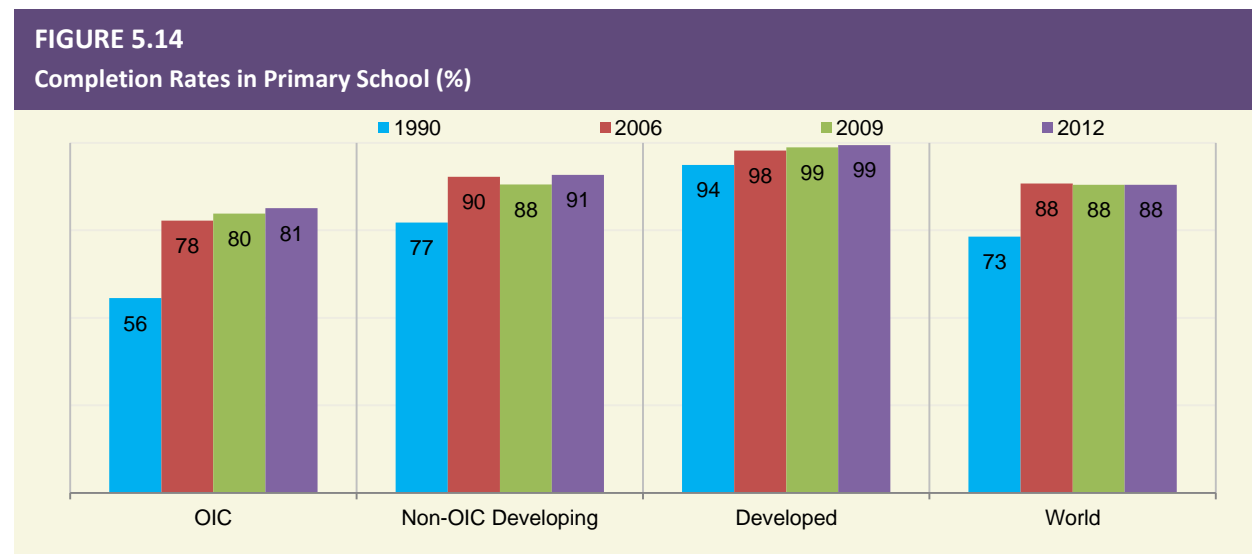
Completion Rate

Completion rate indicates the total number of students completing (or graduating from) the final year of primary or secondary education, regardless of age, expressed as a percentage of the population of the official graduation age.

Figure 5.14 displays the completion rates for different country groups from 1990 to 2012 at primary education. The world average of completion rate increased from 73% in 1990 to 88% in 2006. After that it did not change significantly between 2006 and 2012, although some country groups have achieved to improve their completion rates. Developed countries witnessed an increase by 6 percentage points since 1990. Innovative technology, no doubt, played an important role which not only led to higher graduation rates but also resulted in a decrease in retention. The non-OIC developing countries group did not see a remarkable change in the completion rates over the 2006-2012 period, however, compared with 1990s they improved their completion rate significantly. OIC member countries, on average, achieved to increase their completion rates from 55% in 1990 to 77.7% in 2006. By 2012, it reached 81.3% for the OIC group (Figure 5.14). In other words, compared with 1990, the increase is 26 percentage-points for the OIC group. Despite this improvement in the OIC group, its average still lags behind the averages of non-OIC developing countries, developed countries and the world as of 2012.

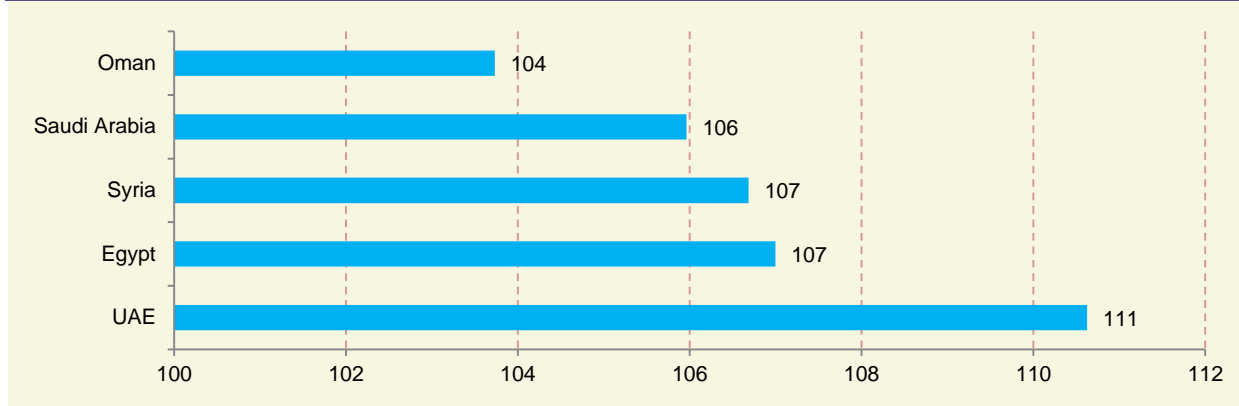
The completion rate is also known as gross intake rate to the last grade of primary. The ratio can exceed 100% due to over-aged and under-aged children who enter primary school late/early and/or repeat grades. In 2012, only 14 OIC countries, among those for which the data are available, achieved higher completion rate than the world average of 87%. At the individual country level, in 2012 United Arab Emirates and Egypt took the lead with completion rates of 111% and 107%, respectively (Figure 5.15).

In terms of gender disparity, the OIC group, on average, had a completion rate about 85.6% for males and 80.6% for females in 2012 that both figures exceed the world average. On the other hand, developed countries, on average, reached a completion rate of 98.8% for males and 96.6% for females. To this end, the existing gender disparity in favour of male population in primary education completion rate still remains as a concern for many OIC member countries (Figure 5.16).



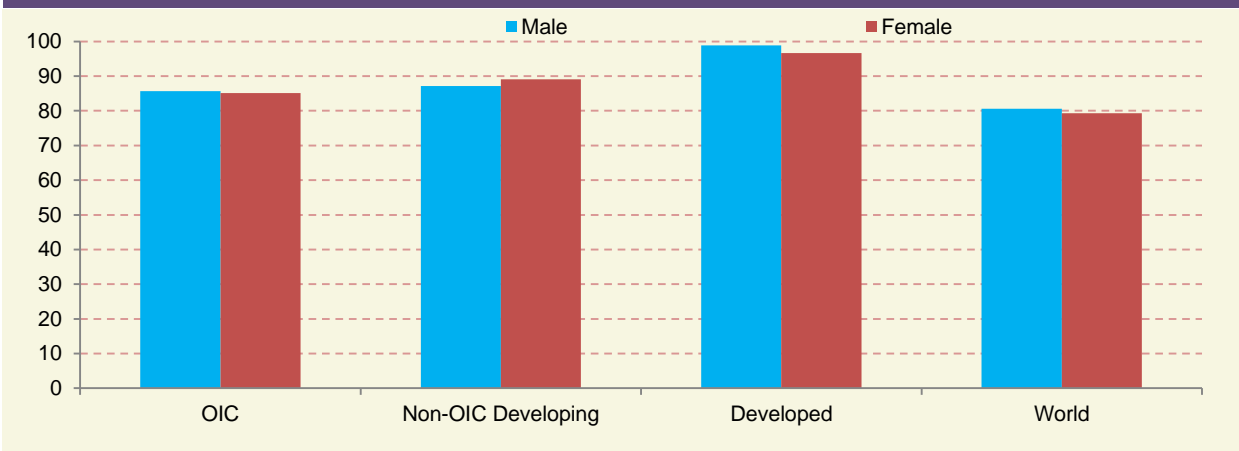
Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

FIGURE 5.15
OIC Countries with the Highest Completion Rates, 2012



Source: WDI and UNESCO, UIS Database

FIGURE 5.16
Completion Rates in Primary School, (%), 2012



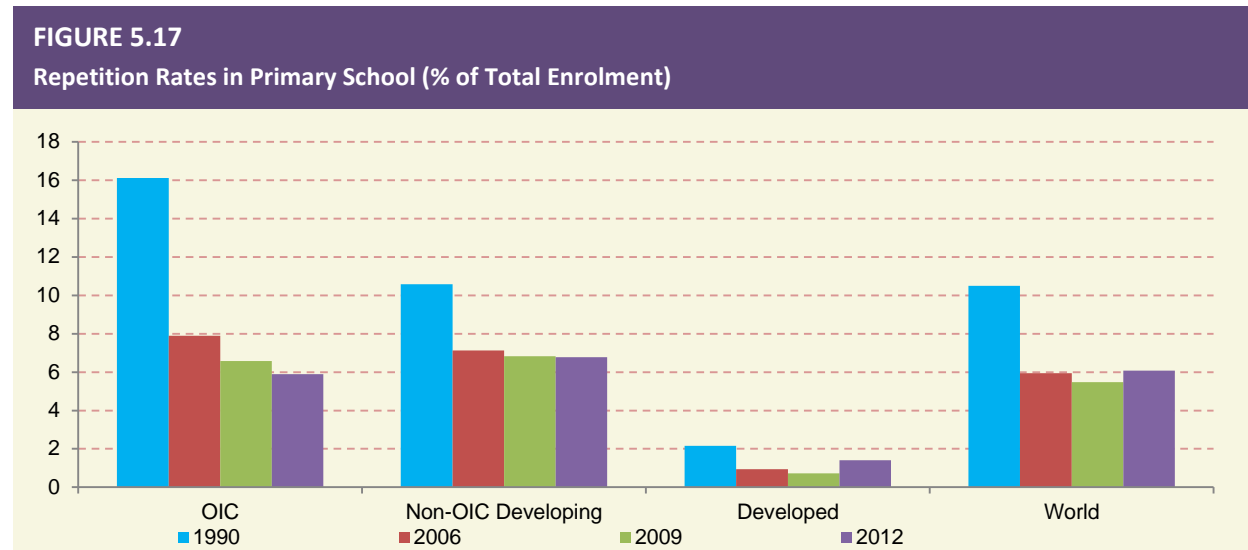
Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

Repetition Rate

Repetition rate is the proportion of students from a cohort enrolled in a given grade at a given school-year who studies in the same grade in the following school-year. It simply measures the phenomenon of students repeating a grade, and its effect on the internal efficiency of educational systems. In addition, it is one of the key indicators for analysing and projecting student flows from one grade to a higher grade within an educational cycle.

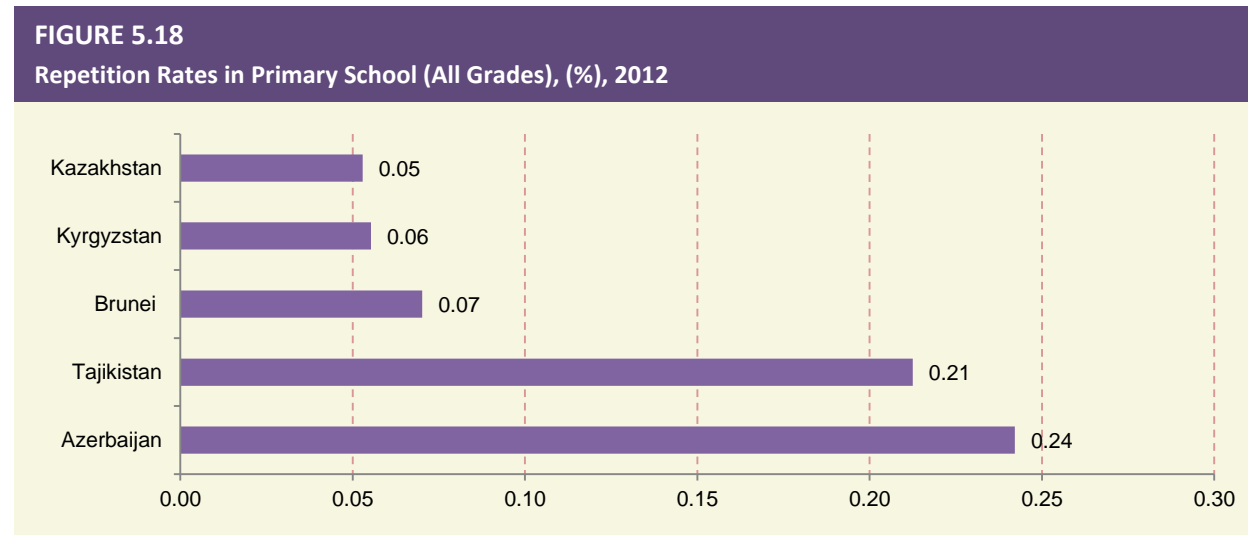
Figure 5.17 shows the repetition rates in primary school for different country groups between 1990 and 2012. The global repetition rate in primary school decreased from 10.4% in 1990 to 6.0% in 2012. In the developed countries group a similar trend was observed. Both non-OIC developing countries group and the OIC group reduced their repetition rates in the period under consideration. The OIC group successfully decelerated the rate from 16.1% in 1990 to 5.9% in 2012. This decreasing trend in developing countries, including the OIC members, throughout the last decade is mainly stemming from because of the improving education system as a result of higher quality of teaching staff and increasing number of distance learning

alternatives. However, the figures show that the OIC group has to show further progress in order to reduce the repetition rates to the level of developed countries.



Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

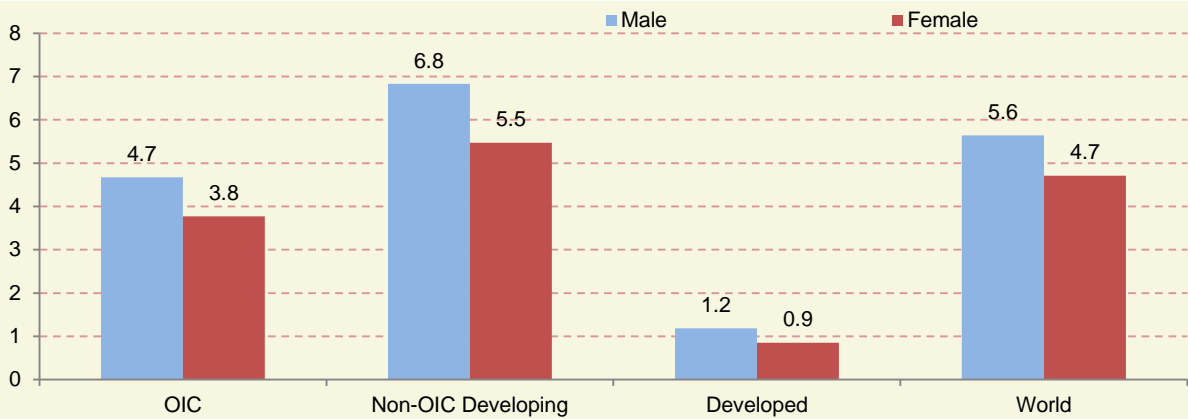
At the individual country level, 19 OIC member countries achieved lower repetition rates in primary schools than the world average of 6.0% in 2012. Among them Kazakhstan stood first by possessing 0.05% repetition rate in primary schools, followed by Kyrgyzstan (0.06%), Brunei (0.07%) and Tajikistan (0.21%) (Figure 5.18).



Source: WDI and UNESCO, UIS Database

Figure 5.19 displays the repetition rates at all grades for different country groups in 2012 both for male and female population. The OIC group, on average, had a repetition rate about 4.6% for males and 3.7% for females in 2012 that both figures are below the world average. On the other hand, developed countries, on average, reduced their completion rates to 1.1% for males and 0.8% for females.

FIGURE 5.19
Repetition Rates in Primary School (% of Total Enrolment)

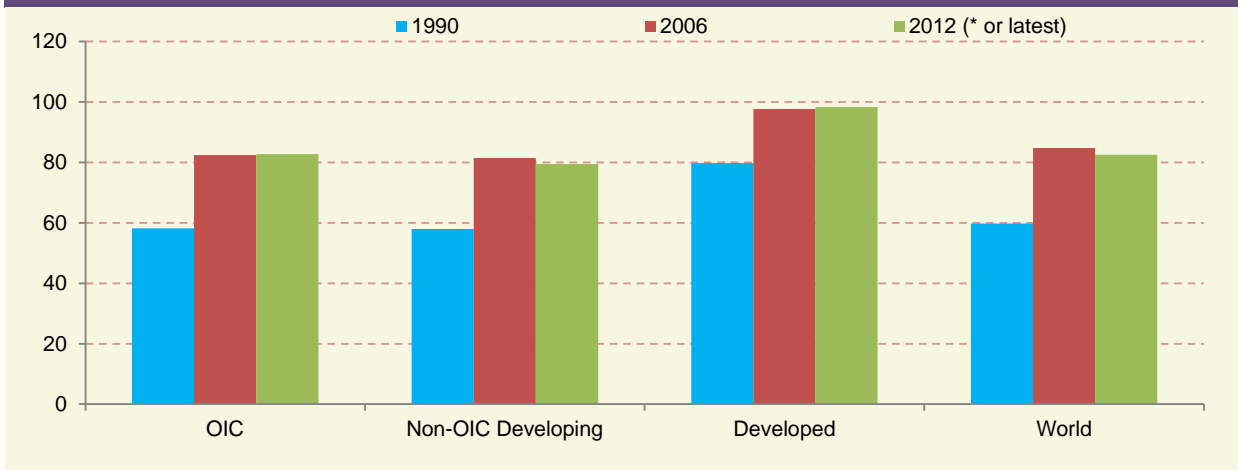


Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

Survival Rate

Survival rate is an indicator which shows the share of children enrolled in the first grade of primary school who eventually reach the last grade of primary school. Figure 5.20 shows the survival rates for different country groups between 1990 and 2012. The global survival rate reduced from 59% in 1990 to 82.5% in 2012. OIC member countries, on average, also experienced an increase from 58.1% to 82.7% in the period under consideration, which is being very close to the world average of 82.5% as of 2012. Relatively lower survival rates in developing countries reflect problems associated students’ and their families’ commitment on continued education.

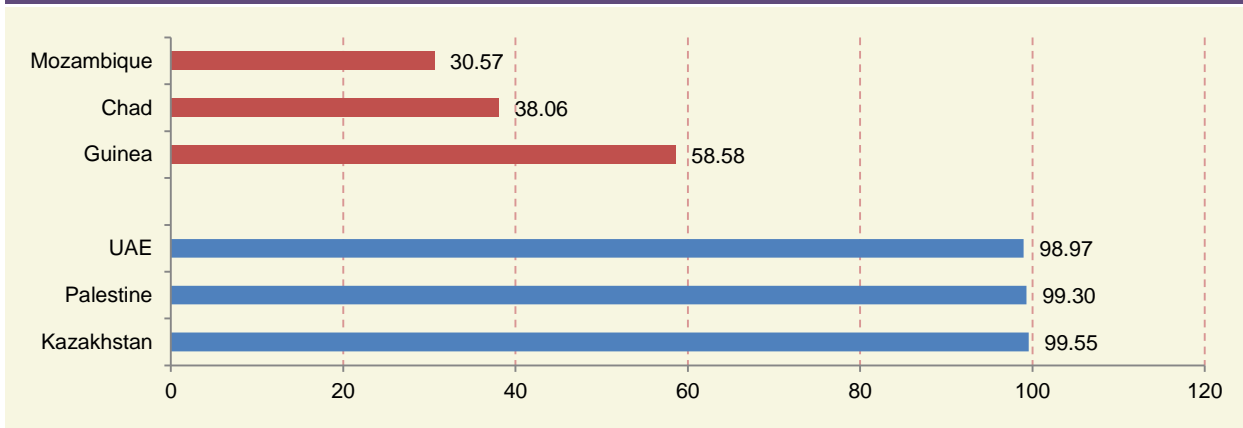
FIGURE 5.20
Survival Rate to the Last Grade of Primary School



Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

At the individual country level, OIC member countries exhibited large variations over a wide scale. On the one hand, countries like Kazakhstan, Palestine, United Arab Emirates possess survival rates that are greater than 98%. On the other hand, there are member countries like Mozambique and Chad where about only around one-third of the students could reach the last grade of the primary school (Figure 5.21).

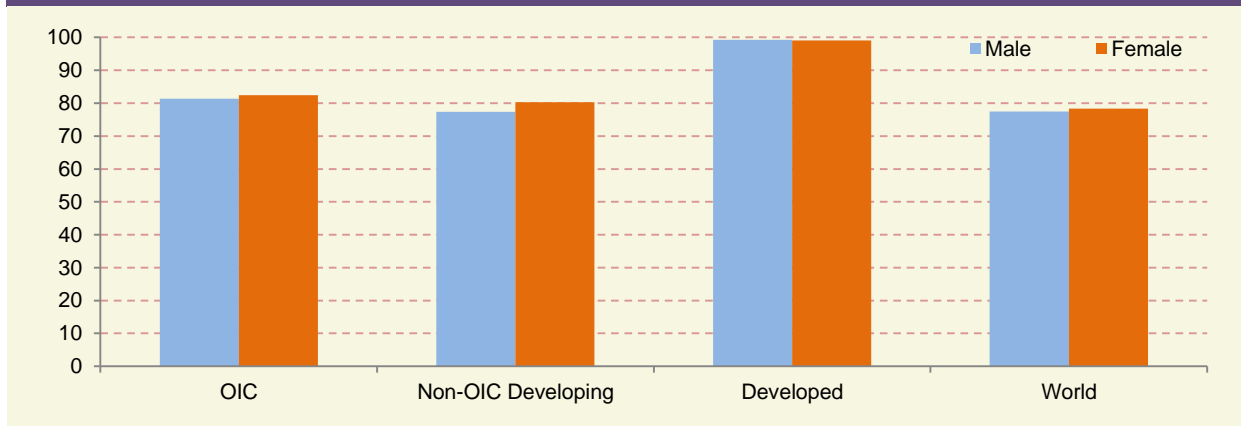
FIGURE 5.21
OIC Countries with the Highest and Lowest Survival Rates, 2012



Source: WDI and UNESCO, UIS Database

Figure 5.22 presents the survival rates for different country groups in 2012 both for male and female population. The global survival rate is calculated as 77.4% for male and 78.3% for female population. OIC member countries, on average, had a survival rate 81.3% for male and 82.5% for female population that both figures are higher than the world averages. However, in developed countries, on average, survival rate reached up to 99% both for male and female population as of 2012. The relatively low survival rates observed in developing countries, including OIC members, reflect problems associated with students' and their families' commitment on continued education. Therefore, OIC member countries need to put more efforts to further improve the survival rate. Meanwhile, these efforts should be orchestrated carefully in terms of gender equality in order to boost both male and female survival rates in a balanced way.

FIGURE 5.22
Survival Rate to the Last Grade of Primary Education, 2012



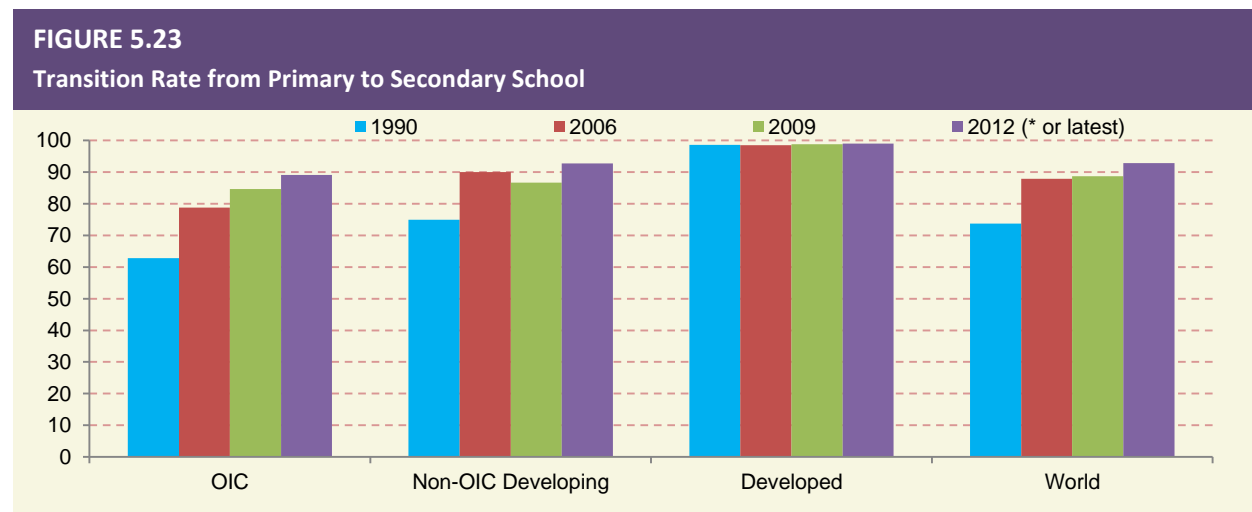
Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

Transition Rate

Transition rate is the number of new entrants to the first grade of secondary education in a given year, expressed as a percentage of the number of students enrolled in the final grade of primary education in the previous year.

Figure 5.23 shows the transition rates for different country groups between 1990 and 2012. The global transition rate went up from 73.7% in 1990 to 92.8% in 2012 whereas in the developed countries group the average remained around 98% throughout the period. OIC member countries, on average, successfully increased their average transition rate from 62.8% in 1990 to 89% in 2012. The average of OIC group still lags behind the world average (92.8%) and the average of non-OIC developing countries (92.7%).

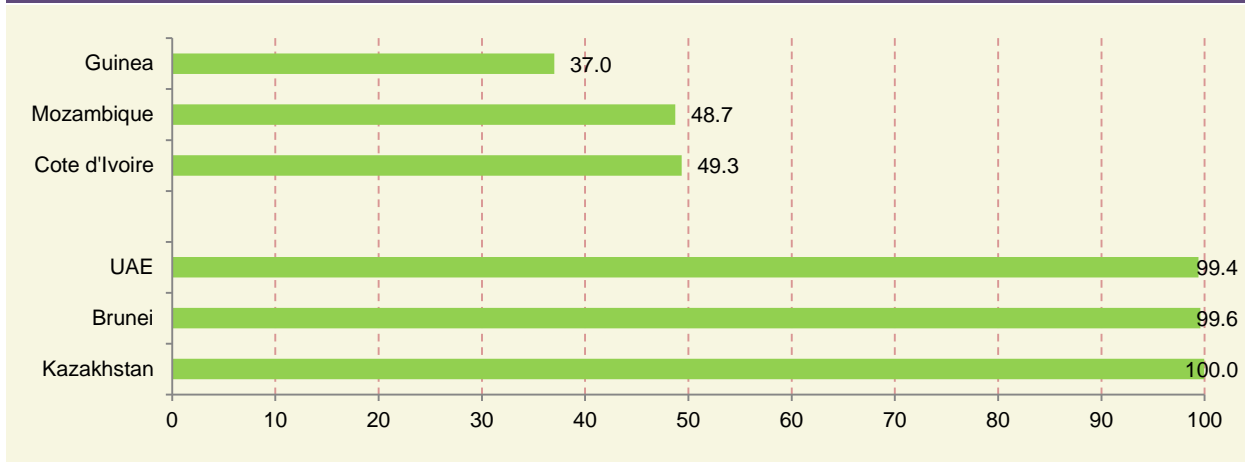
Figure 5.24 displays the transition rates for the best and worst performing OIC member countries as of 2012. As shown, Kazakhstan recorded the highest transition rate (99.9%), followed by Brunei (99.6%) and United Arab Emirates (99.4%). It is clear from the figure that, the OIC member countries exhibited significant variations over a wide scale. In this context, some OIC member countries exhibited very low transition rates such as Guinea (37.0%), Mozambique (48.7%) and Cote d'Ivoire (49.3%).



Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

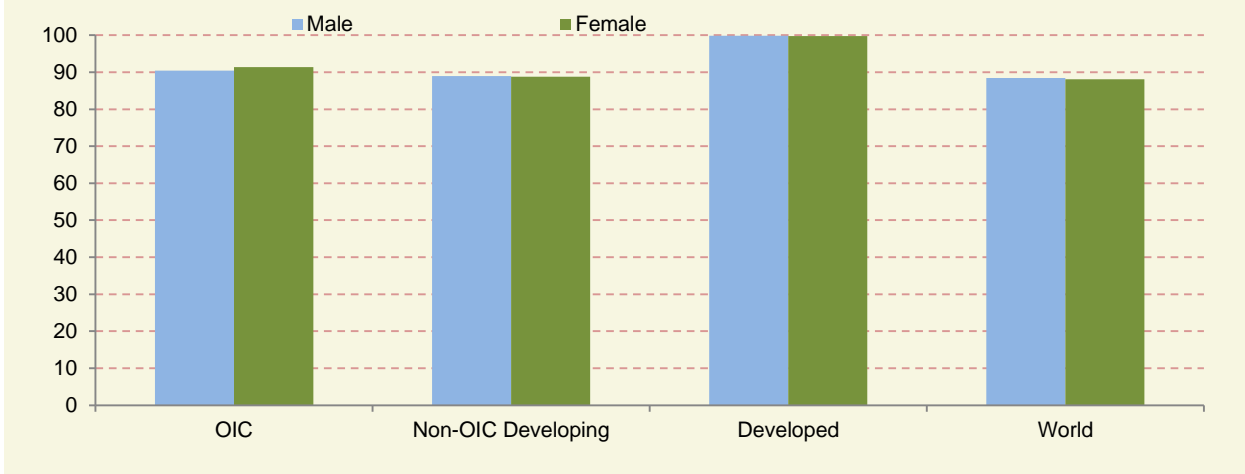
Finally, Figure 5.25 shows the transition rates for different country groups in 2012 both for male and female population. The average of OIC group, as of 2012, reached 90.4% for male and 91.4% for female population where both figures slightly exceeded the averages of non-OIC developing countries (both for male and female) as well as the world averages (both for male and female). In developed countries, the transition rate peaked up to 99% that is almost equal for both sexes. In this regard, OIC member countries need to design policies both to increase the transition rate in general and to eradicate the existing gender disparity that is evolving around 1 percentage-point.

FIGURE 5.24
OIC Countries with the Highest and Lowest Transition Rates, 2012



Source: WDI and UNESCO, UIS Database

FIGURE 5.25
Transition Rate from Primary to Secondary Education (%), 2012



Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

Overall, OIC member countries achieved to increase survival rates and reduce repetition rates that indicate a remarkable improvement in progression in education. However, the averages of OIC member countries on the selected indicators show that the OIC group still lags behind the world averages in many of them. Given the positive trend observed in the OIC group, it is likely for the OIC group to catch up the world averages in many dimensions. By achieving this, children in OIC member countries can complete their education to a higher extent and would gain additional skills and broaden their knowledge. In this way, children in OIC member countries would earn higher salaries as well as would live under better conditions in general.

5.3 Adequacy of Education Services

Previous sub-sections looked at the indicators on education for the OIC group, non-OIC developing countries, developed countries and the world in terms of participation, progression and completion in education. This

sub-section focuses on adequacy of education services from financial and human capital aspects. In this way, it would be possible to shed some light on the main reasons behind the relatively poor performance of OIC member countries on education.

Education Finance

Provision of education to children is important both for economic growth and development. However, it is a costly service that a high level of public intervention is required. In this respect, this sub-section analyses the levels of government expenditures on education in the group of OIC countries in comparison with their counterparts in other groups.²

Share of Government Expenditures on Education in Total Government Expenditures

The share of a government's spending on education in its total expenditures is another major indicator that measures the relative importance of the education sector on part of the government. The higher the share of education expenditures in total government expenditures, the higher is the government's support for the education sector. This also implies a higher investment to children and to the future of the country.

The share of government expenditures on education in total government expenditures was higher in OIC member countries than in both developed and developing countries in the period under consideration (Figure 5.26). This implies that the governments in OIC member countries, on average, have spent on the education sector proportionally more than the developed and world averages. In OIC member countries, governments' spending on the education sector accounted for 15.8% of their total expenditures in 2002. This ratio was 13.5% in developed countries and 14.1% in non-OIC developing countries, with the world average being 13.6%. By 2011, the ratio decreased to 15.0% in OIC member countries and 12.0% in developed countries while it increased to 15.0% in non-OIC developing countries, registering an overall decrease of a percentage point in the world average to 12.5%.

Among the OIC member countries with available data, Benin has the highest ratio of government expenditures on education as percentage of total government expenditures (26.1%). It was followed by Niger (21.7%), Malaysia (20.9%), Senegal (20.7%), and Tunisia (20.1%), all dedicating over one fifth of the total government expenditures to the education sector (Figure 5.27).

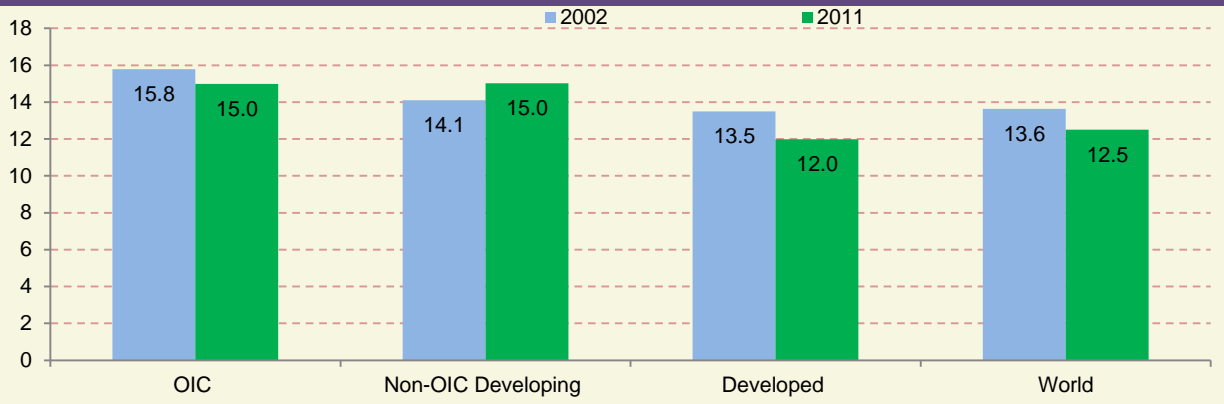
Share of Government Expenditures on Education in GDP

A way to analyse the size of public expenditures on education is to compare these expenditures with the gross domestic product (GDP) of an economy, which represents the total expenditures in that economy. Thus, it can be calculated how much of the GDP is dedicated to education sector by the government. The measure used to calculate this ratio is "government expenditures on education as percentage of GDP". This indicator also reflects the importance given by the government to investment in children and human capital in general.

As shown in Figure 5.28, governments around the world spent, on average, 4.9% of GDP on education in 2002 while this figure slightly increased by 0.2 percentage point in a decade to reach 5.1% in 2011. Developed countries had been spending more than developing countries. Public spending on education in developed countries accounted for 5.0% of the GDP in 2002 and this ratio increased further to 5.2% by 2011. However, governments in non-OIC developing countries could spend only 4.3% of their GDP on the education sector in 2002 and this ratio increased by 0.5 percentage points in a decade to reach 4.8% in 2011.

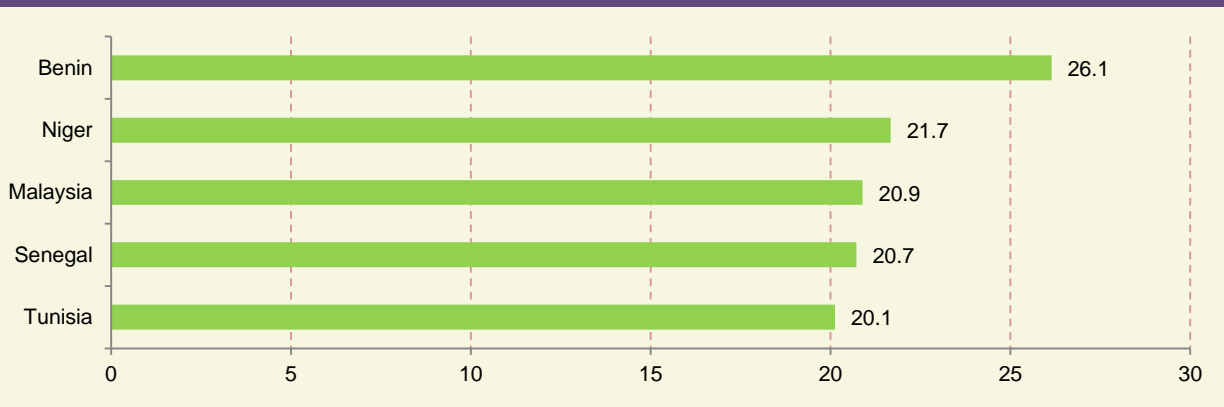
² The latest data years in the databases are 2012 and 2013 for the indicators used in this sub-section. However, due to missing data for many OIC member countries for 2012 and 2013, 2011 is used as the latest year where a representative OIC average can be calculated.

FIGURE 5.26
Government Expenditures on Education (% of Total Government Expenditures)



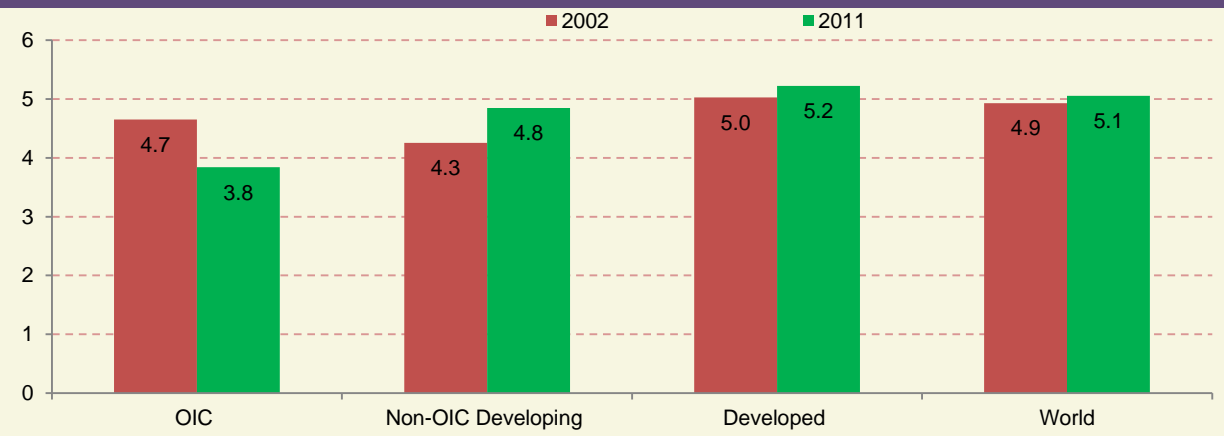
Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

FIGURE 5.27
OIC Countries with the Highest Government Expenditures on Education (% of Total Government



Source: WDI and UNESCO, UIS Database

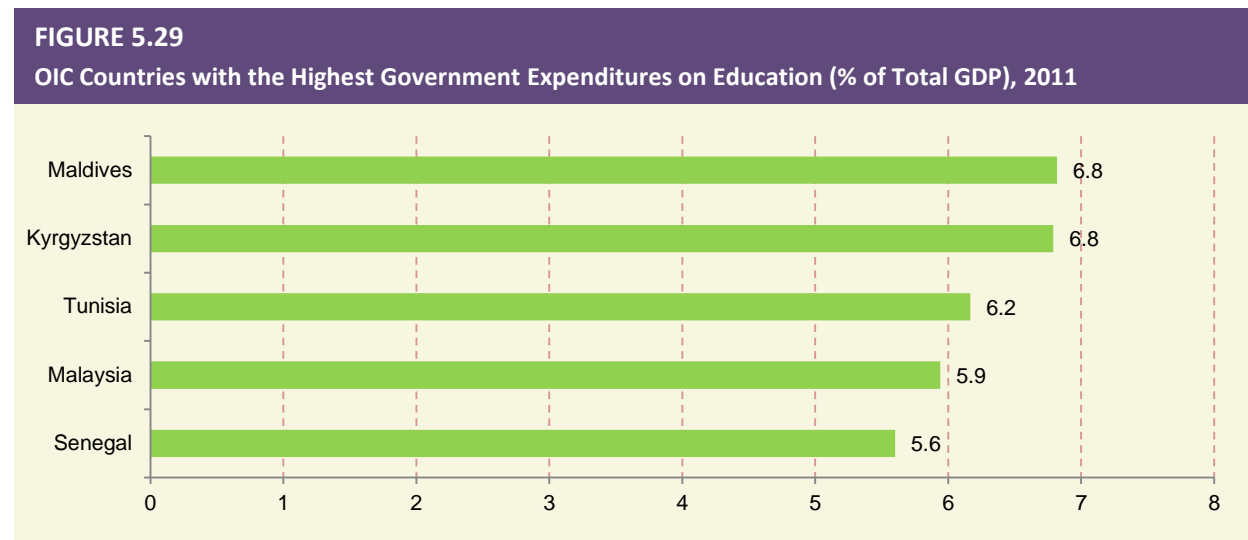
FIGURE 5.28
Government Expenditures on Education (% of Total GDP) Expenditures), 2011



Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

The situation in OIC countries was not optimistic though government spending on education accounted for 4.7% of their GDP in 2002, which was higher than the average of the non-OIC developing countries at that time, decreased by 0.9 percentage points to 3.8% in 2011. It is obvious that the public spending on education sector with respect to the size of the economy was, on average, lower in OIC countries than in both developed and non-OIC developing countries (Figure 5.28).

At the individual country level, government spending on education accounted for 6.8% of the GDP in Maldives, which was the highest rate among the OIC member countries with available data. Together with Maldives (6.8%), Kyrgyzstan (6.8%), Tunisia (6.2%), Malaysia (5.9%) and Senegal (5.6%) comprised the top five OIC countries in terms of the highest government expenditures on education as percentage of GDP (Figure 5.29).



Source: WDI and UNESCO, UIS Database

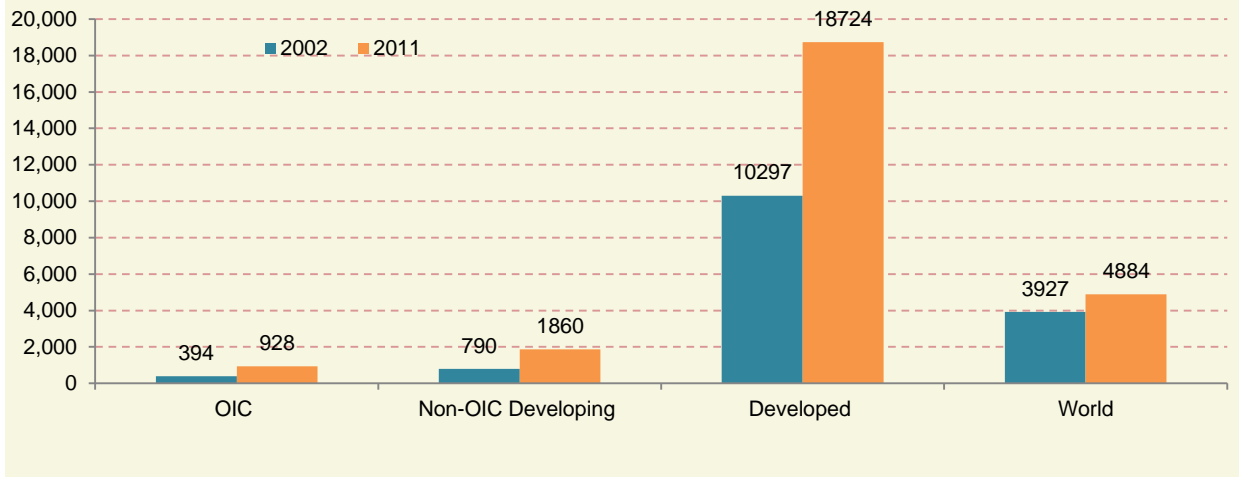
Government Expenditures on Education per Pupil

In addition to the abovementioned macro-level indicators that compares government expenditures on education with GDP or total government expenditures, governments' financial contribution to education sector can also be explained at micro-level by measuring how much is spent by the government per student. Unlike the former ones, this approach focuses directly on the level of government spending on education regardless of the size of the economy or the total expenditures of the government.

Government expenditures on education per pupil increased all over the world between 2002 and 2011 (Figure 5.30). In this period, the world average increased from \$3,927 to \$4,884, corresponding to an annual average growth rate of 2.5%. The average for developed countries, with an annual average increase of 6.9%, increased from \$10,227 to \$18,724. The average for non-OIC developing countries increased from \$790 to \$1,860, corresponding to an annual average growth rate of 10.0%. As for OIC member countries, the average spending per pupil increased from \$394 to \$928, registering an annual average growth rate of 10.0%.

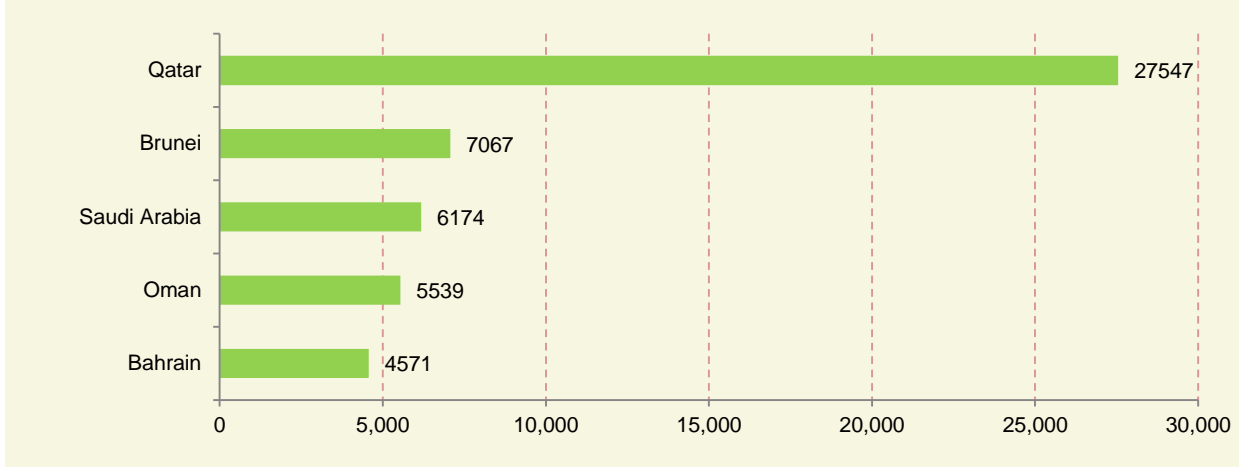
Among the OIC countries with available data, Qatar has the highest government expenditure on education per pupil (\$27,547), followed by Brunei (\$7,067), Saudi Arabia (\$6,174) and Oman (\$5,539) (Figure 5.31).

FIGURE 5.30
Government Expenditures per Pupil (US\$)



Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

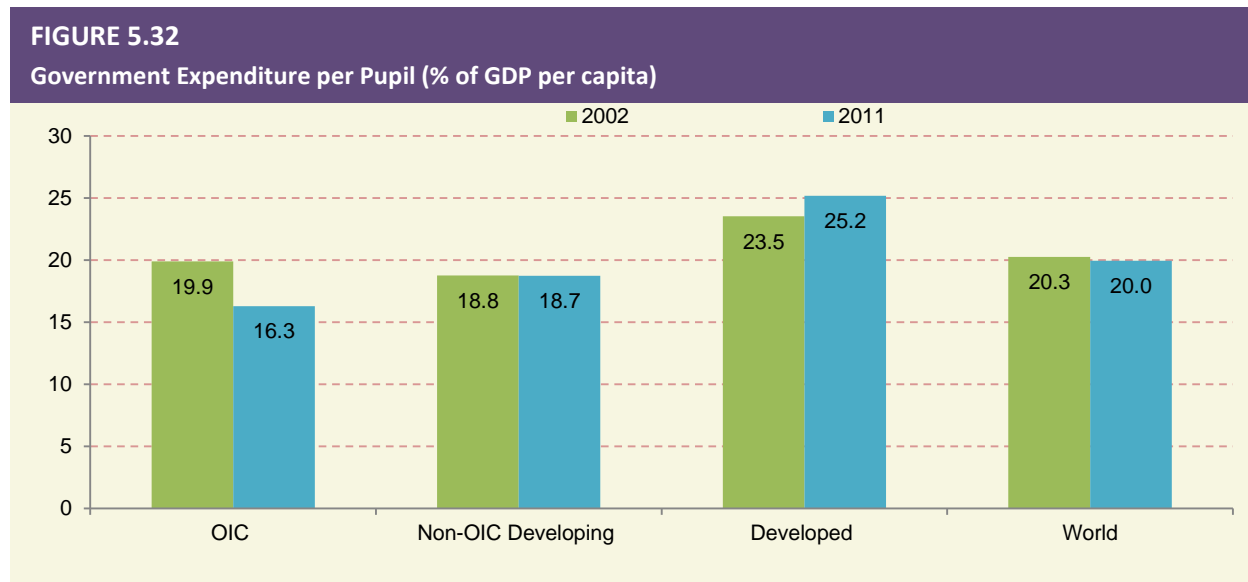
FIGURE 5.31
OIC Countries with the Highest Government Expenditures per Pupil (US\$), 2011



Source: WDI and UNESCO, UIS Database

Analysing the government expenditures on education per pupil in nominal terms may be misleading when comparing countries of widely different levels of income. The differences in purchasing power parities among countries are also problematic to such an analysis. To eliminate such problems to some extent and ensure more comparable data among countries, the nominal value of government expenditures on education per pupil is expressed as a percentage of GDP per capita, whereby it becomes more reasonable to make comparison between countries as governments' spending are measured with respect to the income level of countries.

World average government expenditures on education per pupil as percentage of GDP per capita decreased from 20.3% in 2002 to 20.0% in 2011 (Figure 5.32). The ratio for developed countries increased from 23.5% to 25.2% in this period while the ratio for non-OIC developing countries remained stable at around 18.7%. The ratio for OIC member countries decreased from 19.9% in 2002 to 16.3% in 2011, remaining below the averages for non-OIC developing and developed countries.



Source: SESRIC staff calculations based on WDI and UNESCO, UIS Database

Student – Teacher Ratios

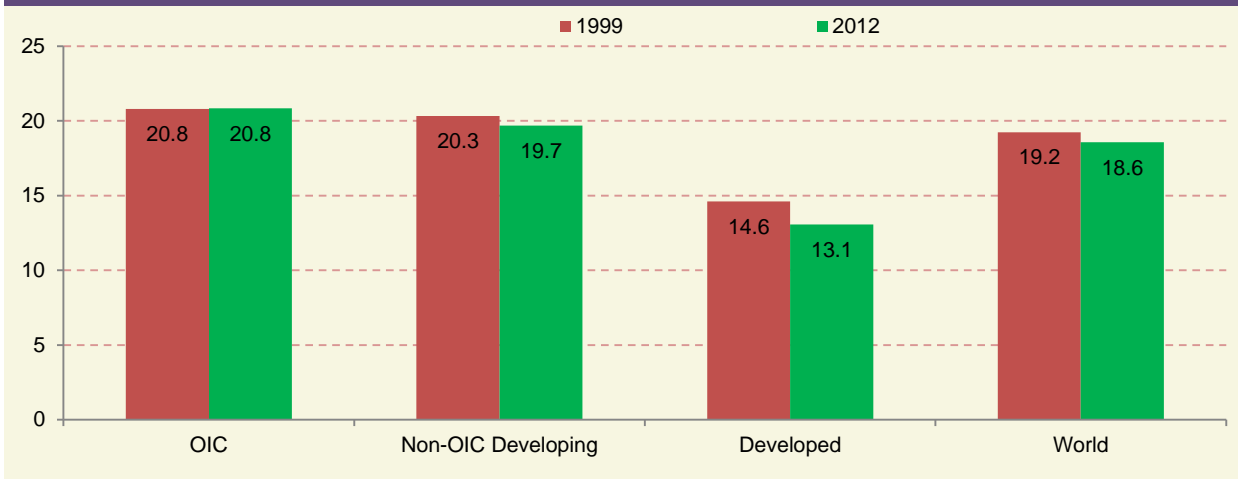
Student-teacher ratios give the number of students enrolled in a school per the number of teachers working at that institution. While low student – teacher ratio is indicative of quality education, high student-teacher ratio often gives evidence about proportionately underfunded schools or school systems, or need for legislative change or more funding for education. Additionally, too many students in a class results in a diverse group of students with varying degrees of learning ability and information uptake. Consequently, the class will spend time for less academic students to assimilate the information, when that time could be better spent progressing through the curriculum. It is also argued that the lower student-teacher ratios are better at teaching students complex subjects such as mathematics, chemistry and physics than those with a higher ratio of students to teachers.

Though it is showed that students attending schools with a lower student-teacher ratio and a better educated teaching staff find jobs more easily and earn higher wages after graduation, some governments could claim that high student-teacher ratios have no significant negative outcomes. On the other hand, there are countries enacting legislations mandating a maximum student-teacher ratio for specific grade levels to improve quality of education.

Pre-Primary Schools

Given the high population growth rates in many OIC member countries, the growth in student enrolment surpasses the growth in the number of teachers. As a result, OIC member countries, on average, see high student-teacher ratios. The world average of student-teacher ratio was 13.1 in 1999 that went down to 18.6 by 2012 at pre-primary schools. In developed countries and non-OIC developing countries the average ratio also declined. In 2012, on average the ratio was measured as 13.2 for developed countries and 19.7 for developing countries. However, in the OIC group during the period under consideration, there was not a change where the average stayed as 20.8. In other words, the OIC group could only achieve to maintain the same ratio between 1999 and 2012 where it is significantly higher than the average of developed countries (Figure 5.33).

FIGURE 5.33
Student – Teacher Ratios at Pre-Primary Schools

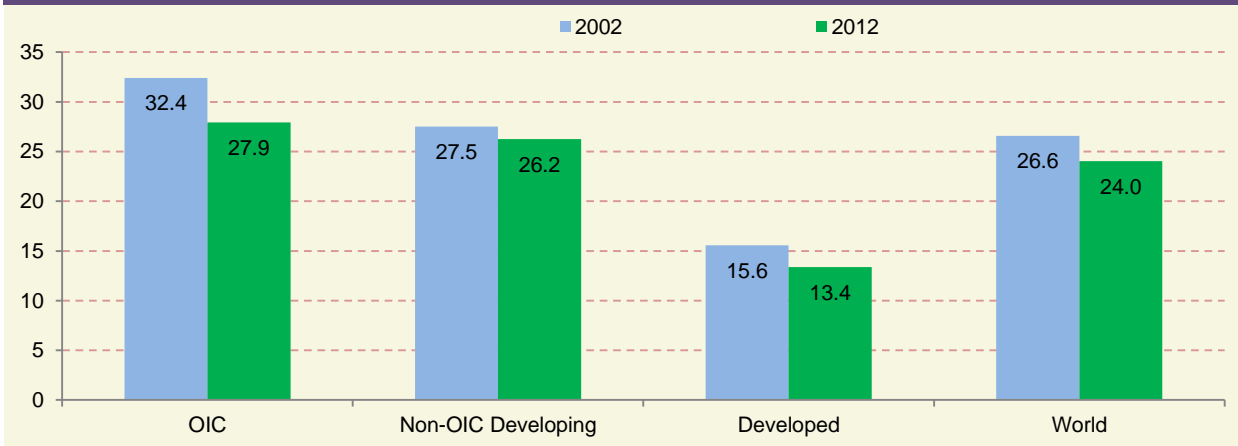


Source: SESRIC staff calculations based on UNESCO, EFR Database

Primary Schools

At primary schools, in 2012 the OIC average was measured as 27.9 whereas the non-OIC developing countries group has an average ratio of 26.2. In the same year, the world average scored as 24 students per teacher, which went down from 26.6 in 2002. Compared with the other country groups examined in the given period (2002-2012), it becomes evident that the most significant improvement took place in the OIC group where the average went down from 32.4 in 2002 to 27.9 in 2012. These figures also suggest that even though OIC member countries achieved to reduce the student-teacher ratio in primary schools from 32.4 in 2002 to 27.9 in 2012, there needs to be done more in order to reach the average of developed countries in student-teacher ratios that is being 13.4 as of 2012 (Figure 5.34).

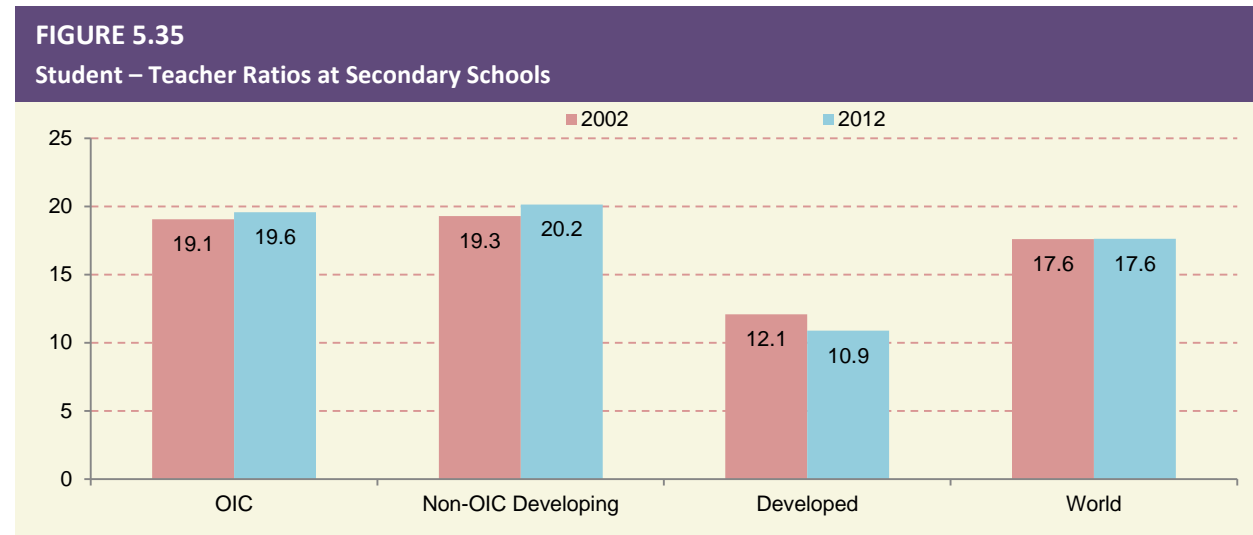
FIGURE 5.34
Student – Teacher Ratios at Pre-Primary Schools



Source: SESRIC staff calculations based on UNESCO, UIS Database

Secondary Schools

The average number of secondary school students per teacher in the world remained the same as 17.6 between 2002 and 2012 (Figure 5.35). In the same period, both non-OIC developing countries and the OIC group have witnessed a small increase. The average of non-OIC developing countries reached 20.2 in 2012 from 19.3 in 2002. In the OIC group, the ratio went up from 19.1 in 2002 to 19.6 in 2012. Only the developed countries group successful reduced the student-teacher ratio during the period under consideration from 12.1 in 2002 to 10.9 in 2012. In other words, as of 2012, 19.6 students were taught by a single teacher in OIC member countries whereas a teacher in developed countries has to deal only with 10.9 students.



Source: SESRIC staff calculations based on UNESCO, UIS Database

6 Child Protection and Welfare

Children are potentially more vulnerable to social, economic and cultural exploitations compared to adults. Their higher vulnerability, therefore, necessitates development and implementation of some special social protection and welfare mechanisms to safeguard their rights. By having an effective and well-functioning child welfare and protection system children would access to essential services like birth registration, social security, health care, education and they can be prevented of child maltreatment and abuse. Though limited availability of data may preclude a detailed analysis of social protection and welfare systems in OIC member countries, this chapter will attempt to highlight some major concerns regarding birth registration, prevalence of child labour, social security coverage and child maltreatment and abuse in OIC member countries.

6.1 Birth Registration

Birth registration, the official recording of a child's birth by the government, establishes the existence of the child under law and provides the foundation for safeguarding many of the child's civil, political, economic, social and cultural rights. Article 7 of the Convention on the Rights of the Child specifies that every child has the right to be registered at birth without any discrimination (UNICEF, 2015).

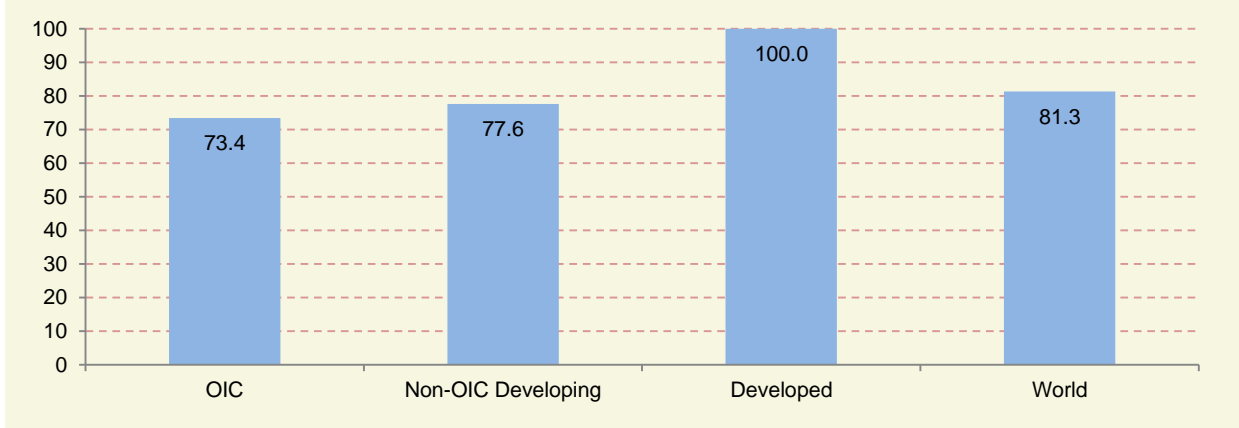
Apart from being the first legal acknowledgement of a child's existence, birth registration is central to ensuring that children are counted and have access to basic services such as health, social security and education. Birth registration is a 'passport to protection' for children that the age of a child can be identified with birth certificate. Children can also be prevented from child marriage to abuse and exploitation in a relatively easy manner, if there is an official birth certificate. Despite its crucial importance, around 290 million children (or 45% of all children under age five worldwide), do not possess a birth certificate.

Universal birth registration is one of the most powerful instruments to ensuring equity over a broad scope of services and interventions for children. Birth registration has a key importance for governments in terms of planning, investments and monitoring demographic trends.

Registration levels, for children under five, are almost universal in developed countries. The vast majority of unregistered children are living in less developed countries, particularly in the South Asian and sub-Saharan Africa regions. The presence of armed conflict, civil unrest and war leads to higher number of unregistered children.

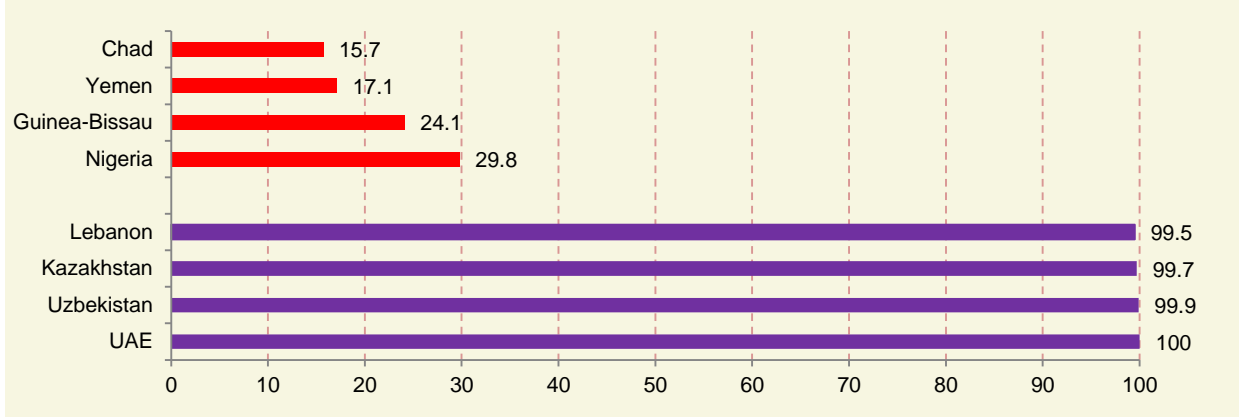
According to Figure 6.1, the OIC group has the lowest average compared with other country groups in terms of registered birth between 2005 and 2013. Only 73.4% of children have a birth registration in the OIC group where the world average is 81.3% in this period. The average of non-OIC developing countries was 77.6% that is being slightly higher than the OIC average. At the individual country-level, Chad has the lowest birth registration rate (15.7%) followed by Yemen (17.1%). On the other side, in the United Arab Emirates, Uzbekistan, Kazakhstan and Lebanon more than 99% of all births are being registered in the period under consideration (Figure 6.2).

FIGURE 6.1
Birth Registration (% of all births), 2005-2013



Source: SESRIC staff calculations based on UNICEF Database

FIGURE 6.2
OIC Countries with the Highest and Lowest Birth Registration Rates, 2005-2013



Source: UNICEF Database

6.2 Child Maltreatment and Abuse

Apart from being a violation of human rights, child maltreatment and abuse leads to serious health problems for children. Despite its importance for building up healthy generations, international datasets could provide limited information stemming from the limited presence of birth registrations and difficulty to prove and document cases of child maltreatment and abuse. Despite their limitations, looking at selected indicators related with maltreatment and abuse would be helpful to understand the relative stance of children in OIC member countries compared with other country groups and would help policy-makers while designing their policies.

Violence against Children

As the previous sub-section showed, violence against women is very high in developing countries including OIC members. According to UNICEF (2014), violence against children can be grouped under four categories:

sexual violence, physical violence, mental violence and negligent treatment that are hard to measure and find comparable datasets. The UNICEF (2014) Report states that violence against children negatively affects health and education achievement of children. Table A further provides a full account of consequences of violence against children that groups these consequences under five broad categories: physical, psychological, sexual and reproductive consequences, other longer-term health consequences, and financial consequences. This list shows that violence against children leads to many unforeseen serious consequences both for children and society.

TABLE A
Acute and Long-Term Consequences of Violence against Children

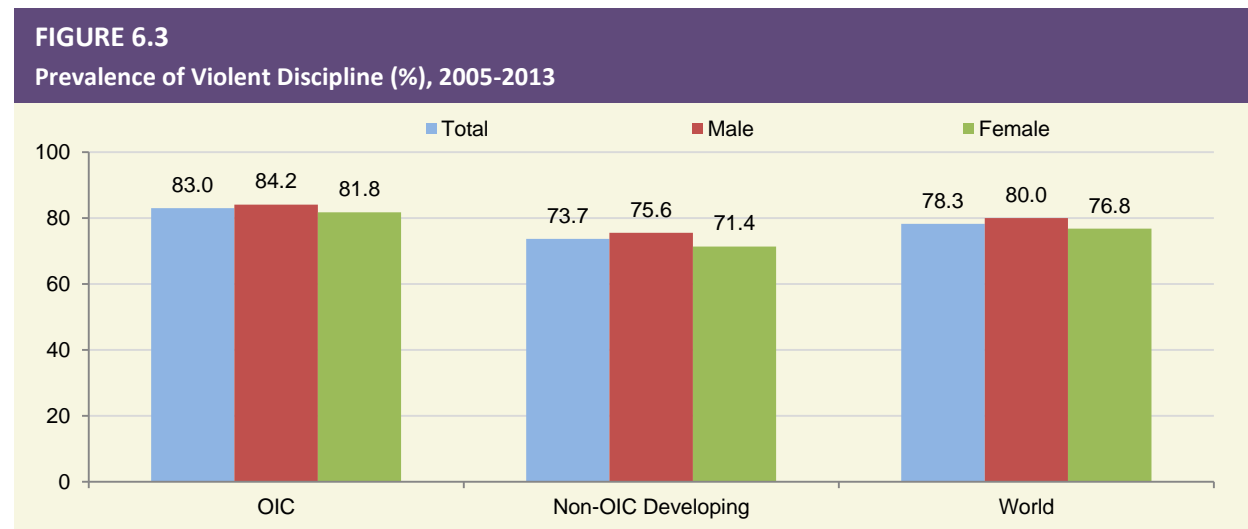
Physical health consequences	Psychological consequences
Abdominal/thoracic injuries	Alcohol and drug abuse
Brain injuries	Cognitive impairment
Bruises and welts	Criminal, violent and other risk-taking behaviours
Burns and scalds	Depression and anxiety
Central nervous system injuries	Developmental delays
Fractures	Eating and sleep disorders
Lacerations and abrasions	Feelings of shame and guilt
Damage to the eyes	Hyperactivity
Disability..	Poor relationships
Sexual and reproductive consequences	Poor school performance
Reproductive health problems	Poor self-esteem
Sexual dysfunction	Post-traumatic stress disorder
Sexually transmitted diseases, including HIV/AIDS	Psychosomatic disorders
Unwanted pregnancy.	Suicidal behaviour and self-harm.
Other longer-term health consequences	Financial consequences
Cancer	Direct costs: Treatment, visits to the hospital doctor and other health services.
Chronic lung disease	Indirect costs: Lost productivity, disability, decreased quality of life and premature death.
Irritable bowel syndrome	Costs borne by criminal justice system and other institutions: Expenditures related to apprehending and prosecuting offenders.
Ischaemic heart disease	Costs to social welfare organisations, costs associated with foster care, to the educational system and costs to the employment sector arising from absenteeism and low productivity.
Liver disease	
Reproductive health problems such as infertility.	

Source: Runyan et al. (2002). *Child Abuse and Neglect by Parents and Other Caregivers*. In: Krug EG et al. (Eds). *World Report on Violence and Health*. Geneva, World Health Organization, pp 59–86.

Violence against children also costs to society a lot. Fang et al. (2012) estimated the life time economic costs of new cases of child abuse in the United States in 2008 at \$124 billion (in 2010 dollars). The estimated lifetime cost was comprised of productivity losses as well as special education, medical and health care, child welfare and criminal justice costs emerging from children’s experiences of abuse, with the largest component stemming from productivity losses. In another study, Fang et al. (2013) estimated the economic cost of child abuse in East Asia and the Pacific to exceed \$160 billion (in 2004 dollars) based on economic losses due to death, disease and health risk behaviours attributable to child abuse.

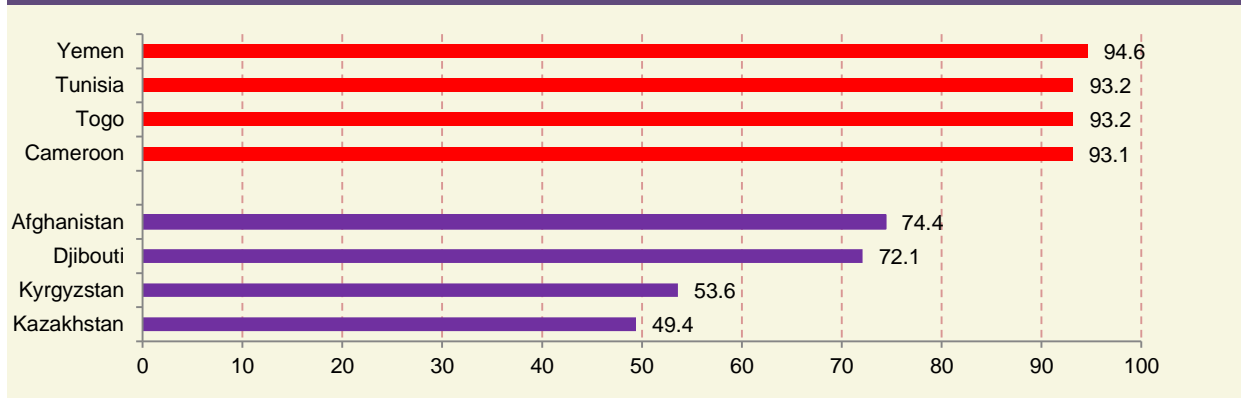
In this sub-section, given the data limitations, a selected indicator called “violent discipline” is used to assess the state of violence against children in OIC member countries in a comparative perspective. The UNICEF defines violent discipline as actions taken by a parent or caregiver that are intended to cause a child physical pain or emotional distress as a way to correct behaviour and act as a deterrent. It can take two forms: psychological aggression and physical (corporal) punishment. The former includes shouting, yelling and screaming at the child, and addressing her or him with offensive names. Physical (corporal) punishment covers actions intended to cause the child physical pain or discomfort but not injuries. 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. The dataset on violence discipline was collected by making surveys with mothers and caregivers where they are asked whether their children experienced any such violent discipline in the household during the past month. According to UNICEF (2014), around 6 in 10 children between the ages of 2 and 14 worldwide (almost a billion) are subjected to physical punishment by their caregivers on a regular basis.

According to Figure 6.3, during the period 2005-2013, the prevalence of violent discipline (against children) in the OIC group, on average, was 83.0% that is being the highest average compared with the average of non-OIC developing countries (73.2%) and the world average (78.3%). In terms difference between girls and boys, in the OIC group, boys are exposed to violent discipline to higher extent (84.1%) compared with girls (81.8%), as in seen in non-OIC developing countries. At the individual country, Yemen is the OIC member country with the highest prevalence of violent discipline that 94.6% of all children experienced some form of violent discipline. On the other hand, in Kazakhstan only 49.4% of all children were exposed to some form of violent discipline (Figure 6.4).



Source: UNICEF Database

FIGURE 6.4
OIC Countries with the Highest and Lowest Prevalence of Violent Discipline (%), Both Sexes, 2005-2013

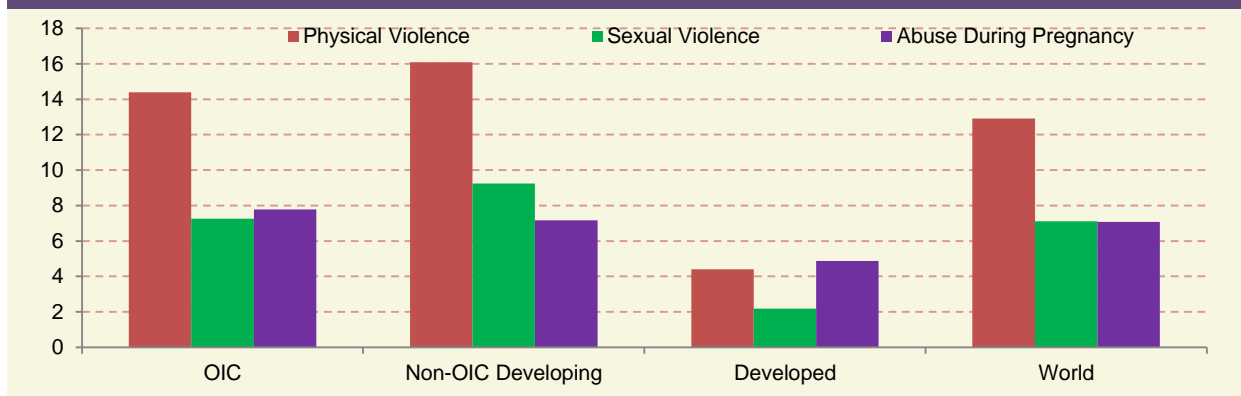


Source: UNICEF Database

In a society where women are treated unequally and being abused, it is more likely that children are also maltreated and abused in different ways. Women are mostly maltreated and abused where their children are with them. To this end, violence against women cannot be isolated easily from violence against children in many cases. OIC member countries host more than 750 million women that represent 48.4% of all population. According to UN Women, more than 370 million women in OIC member countries live without legal protection from violence. The term “violence against women” encompasses many forms of violence, including violence by an intimate partner (intimate partner violence) and rape/sexual assault and other forms of sexual violence perpetrated by someone other than a partner (non-partner sexual violence) (WHO, 2013b). Violence that women suffer from their intimate partners carries particularly serious and potentially long-lasting consequences, as it tends to be repetitive and accompanied by psychological and sexual violence as well (UN, 2010).

In this regard, Figure 6.5 displays the intimate partner physical and sexual violence rates as well as the prevalence of abuse during pregnancy in 2012 based on the UN Women Survey results. According to available data, the OIC group has the second highest physical violence rate after non-OIC developing countries. In OIC member countries, on average, 14.4% of women reported that they experienced physical violence where the world average is 12.9%. In developed countries, this rate goes down to 4.4%. In terms of sexual violence, non-OIC developing countries have the highest prevalence rate that is 9.2%. In OIC member countries, the average

FIGURE 6.5
Intimate Partner Violence against Women (%), 2012



Source: UN Women, Violence against Women Prevalence Dataset 2012. Note: OIC average is calculated for 15 OIC member countries due to data constraints.

is calculated as 7.3% where the world average is 7.1%. Finally, in the OIC group the prevalence of abuse during pregnancy is recorded as 7.8% that is the highest rate among other country groups where the world average of prevalence of abuse during pregnancy is 7.1%.

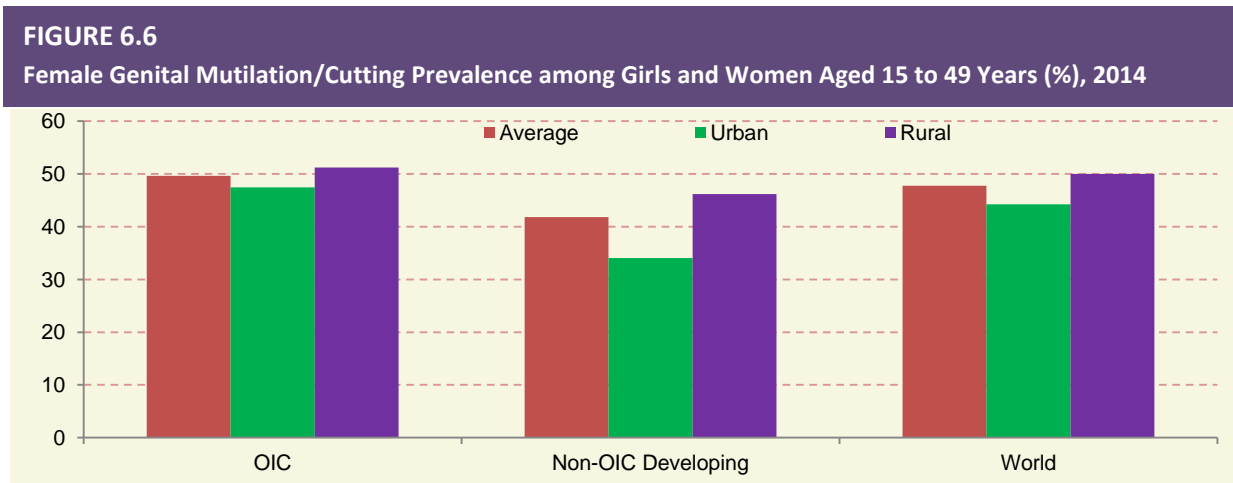
Overall, in developing countries, including OIC member countries, on average, violence and abuse against women is more prevalent compared with the average of developed countries and the world average. The high incidence of violence against women has a lot of implications for children as discussed above. Therefore, policy-makers need to develop policies in order to protect women against violence and abuse more effectively. By doing this, both women and children can stay calm and would live in their comfort zones with peace of mind.

Female Genital Mutilation/Cutting (FGM/C)

The term “female genital mutilation” (FGM, also called “female genital cutting” and “female genital mutilation/cutting”) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (UN, 2010). Female genital mutilation has been reported to occur in all parts of the world. It is recognized internationally as a violation of the human rights of girls and women, and constitutes an extreme form of discrimination against women (WHO, 2013b).

Female genital mutilation is always traumatic. Apart from excruciating pain, immediate complications can include shock, urine retention, ulceration of the genitals and injury to the adjacent tissue. Some of the other major outcomes resulting from FGM/C are septicaemia (blood poisoning), infertility and obstructed labour (UN, 2010). Moreover, haemorrhaging and infection can lead to death (UNICEF, 2005a). Mostly, the female genital mutilation occurs at early ages without any medical help under severe conditions. No doubt, it is an extreme form of violence against children.

According to the UNICEF 2014 dataset, in 29 countries, of which 22 are OIC member countries, the prevalence of FGM/C is common. Figure 6.6 indicates the average of OIC member countries in 2014 as 49.6%.³ In OIC member countries prevalence of FGM/C differ across urban and rural areas. In urban areas the average goes down to 47.5% whereas in rural areas it goes up to 51.2%. The average of 7 non-OIC developing countries is measured as 41.8% in 2014 that is lower than the average of OIC. In this regard, OIC member countries need to intensify their efforts to fight against this traumatic form of violence that affects both physical and mental health of girls during their entire life span.



Source: UNICEF Global Databases 2014, based on DHS, MICS and other nationally representative surveys. Note: Data are available for 29 countries in total where 22 are OIC member countries and 7 are non-OIC developing countries.

³ Although the figure reports FGM/C prevalence among girls and women aged 15 to 49 years, majority of them experienced it during childhood.

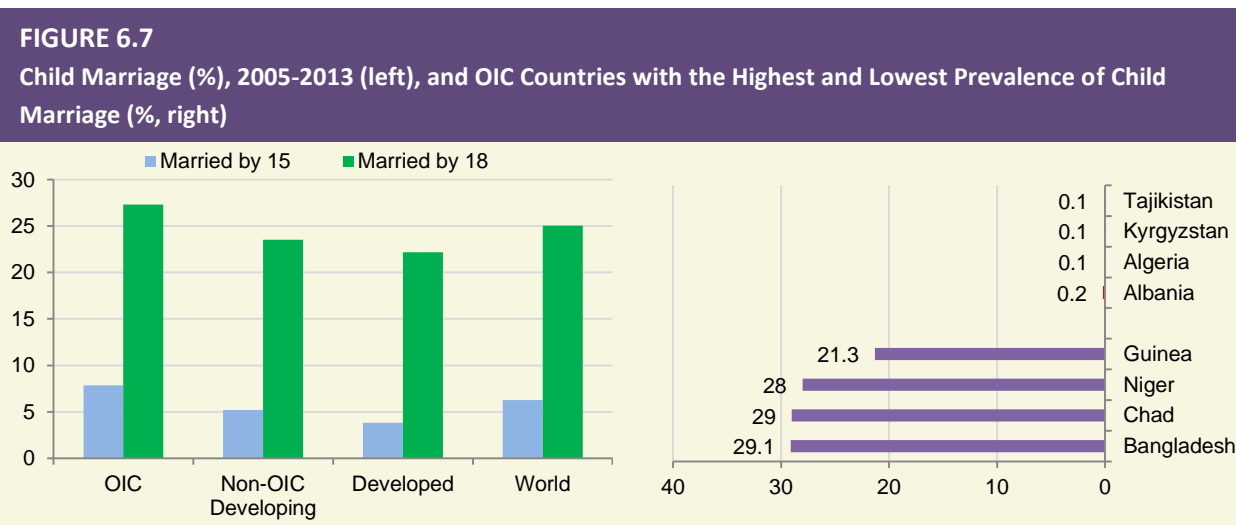
6.3 Child Marriage

Families are accepted as the smallest unit of a society. Marriage is the first step in the formation of a family union, which is the essential part of a healthy and well-functioning society. Age at first marriage (AFM) differs across countries due to culture, socio-economic development level, local customs as well as climate, which affects the adolescent development. AFM has serious implications for women and family well-being. Marriages at young ages may lead to health problems for men and women who are not ready for marriage both mentally and physically. Moreover, marriages at very early ages generally stem from social and family pressures that are important factors behind unhappy marriages (Haloi and Limbu, 2013). Unhappy families with unhealthy couples constitute a threat for the society.

The right to ‘free and full’ consent to a marriage is recognized in the Universal Declaration of Human Rights – with the recognition that consent cannot be ‘free and full’ when one of the parties involved is not sufficiently mature to make an informed decision about a life partner (UNICEF, 2005, p. 1). However, in many parts of the world marriage before 18, i.e. child marriage is a reality. The literature suggests that poverty, protection of girls, family honour and the provision of stability during unstable social periods are some of the main driving factors behind child marriage (UNICEF, 2001). Although most countries have laws that regulate marriage, both in terms of the minimum age and consent, but such laws usually do not apply to traditional marriages. The UNICEF (2001) Report states that many girls and a smaller number of boys enter marriage without being able to exercise their right to choose their marriage partner. This is more often the case with younger and uneducated girls since assuming a wife’s responsibilities usually leaves no room for schooling and almost certainly removes the girl from the educational process (UNICEF, 2001). This also results in early childbearing, which is identified as having higher health risk both for mother and child.

Figure 6.7 displays the prevalence of child marriage (both for marriages before 15 and 18 years) across country groups between 2008 and 2013. According to this, the OIC group has the highest child marriage prevalence in both groups where 7.9% of all marriages are being exercised before 15 years old and 27.3% of all marriages are being performed before 18 years old. The global average prevalence of marriages before 15 years old is 6.3% and for marriages before 18 years old the average is 25.0%. In non-OIC developing countries, child marriage is less common than the OIC group that their average is 5.2% and 23.5% for marriages before 15 and 18 years old, respectively.

At the individual country level, the highest prevalence of child marriage in the OIC group was seen in Bangladesh (29.1%) followed by Chad (29.0%). On the other side, the lowest prevalence of child marriage in the OIC group was observed in Tajikistan (0.1%) and Kyrgyzstan (0.1%) (Figure 6.7).



Source: UNICEF Global Databases 2014, based on DHS, MICS and other nationally representative surveys.

6.4 Conflicts and Children

The world is facing increasingly more challenges with respect to conflicts. Developmental gains accumulated over many years are exposed to greater risks of devastation with the onset of a conflict. Children are always among the first affected by conflict, whether directly or indirectly. Conflicts are likely to mean that children are deprived of key services such as education and health care.

In a World Bank report, Walter (2010) identifies three patterns that exist regarding conflicts and their recurrence. First, civil wars have a surprisingly high repetition rate. Of the 103 countries that experienced some form of conflict during 1945-2009, 59 countries could not avoid a subsequent return to civil war. This indicates that once a country experiences a conflict, it is significantly more likely to experience additional episodes of violence, confirming “conflict trap” argument of Collier and Sambanis (2002). The second trend identified by Walter is that recurring civil wars have become the dominant form of armed conflict in the world today. In fact, since 2003 every civil war that has started has been a continuation of a previous civil war, suggesting that the problem of civil war is not a problem of preventing new conflicts from arising, but of permanently ending the ones that have already started. Finally, civil wars are increasingly concentrated in a few regions of the world. The result is a greater number of civil wars concentrated in sub-Saharan Africa, suggesting that civil wars are increasingly being concentrated in the poorest and weakest states of the world.

In view of the above, this sub-section reviews the conflicts in OIC countries in a historical perspective and assesses the potential impacts of conflicts on children.

No doubt, the prevalence of conflicts hit vulnerable members of the society (i.e. children and women) the most. As mentioned above, conflicts initiate episodes of violence where children and women suffer a lot both physically and mentally. In other words, conflicts damage the future of countries through harming the health status of generations in different ways. Worst of all, the existence and prolonged conflicts kill dreams and hope of children for the future. In a society where children cannot dream and make plans for their future, it is almost impossible to reach a better development level over time.

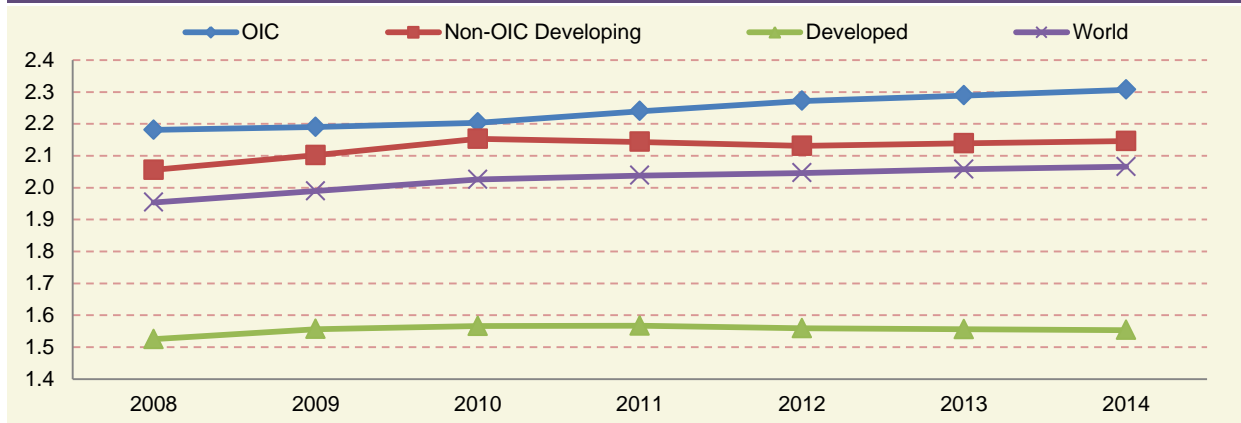
Children, caught in the midst of critical stages of personal development, are affected by war more profoundly than adults. They depend, even more than adults, on the protection afforded in peacetime by family, society, and law (MOFA, 2000). Wars can threaten to strip away these layers of protection, with adverse consequences for children's development and consequently for peace and stability for generations to come.

Conflicts affect children in various ways. Children are maimed and killed, and uprooted from home and their community. Children are made orphans, separated from their parents and subjected to sexual abuse and exploitation. Children are used as combatants, made to suffer from trauma and deprived of education and healthcare. Particularly conflicts damage the future of girls. Disadvantaged even in peacetime, girls undergo sexual abuse, rape, enslavement and other tribulations during conflicts (MOFA, 2000).

According to SESRIC (2014a), during the period 1946-2005, 53 OIC member countries have spent a total of 621 years in conflicts, or 11.7 years per country. Almost 3 million people have died in OIC countries during these conflicts, or more than 4,600 per conflict. This average is almost the same for 107 non-OIC countries with 11 years of conflict. However, the death toll in non-OIC countries reached to over 7 million during this period. Based on a dataset derived from the Uppsala Conflict Database, SESRIC (2014a) showed that the share of the OIC group in the worldwide conflicts increased from 32% in 2003 to 48.9% in 2011 where the nature of conflicts in the OIC group generally takes the form of “intrastate conflicts”.

Looking at another index called the Global Peace Index (GPI) prepared by the Institute for Economics and Peace (IEP) conveys a similar message that “conflicts in the OIC region are on the rise”. According to Figure 6.8, the worldwide average global peace index score has been increasing since 2008 and reached 2.07 (a historical peak-level) in 2014 indicating the decreasing peacefulness or increasing conflicts globally.⁴ The average index score of the OIC group also followed a positive trend between 2008 and 2014 that the average index score increased from 2.18 in 2008 to 2.30 in 2014. With that score, the OIC group has the highest average score compared with other country groups indicating the presence of a lower degree of peacefulness and a higher number of conflicts.

FIGURE 6.8
Global Peace Index, 2008-2014



Source: GPI Database, Institute for Economics and Peace (IEP).

Overall, the figures reveal that conflicts in OIC member countries, on average, are on the rise. The average level of peacefulness has been decreasing year by year in the OIC region. These facts imply that in OIC member countries each year increasing number of children suffer from conflicts and the lack of peace. They are more exposed to armed conflicts, human trafficking, violence and abuse, and the lack of basic services. In particular, children in several hot spots of the OIC group suffer a lot including Syria, Afghanistan, Palestine, Nigeria, Iraq, and Yemen. Due to nature of conflicts, it is not easy to report how many children have been affected in total and to what extent they suffer from these conflicts. However, estimates of the UNICEF on two OIC member countries can provide some clues to what extent children are under fire in the Islamic world. Nearly 700 children have been killed only in Iraq in 2014. More than 10,000 children have been killed in Syria since the outbreak of conflict in 2011 (UNICEF, 2013b). These figures are only showing death tolls but are far from reflecting the degree of violence against children in these conflict areas. Moreover, the damaged infrastructure (sanitation, drinking water, and transportation systems), collapsed hospitals and schools are other negative impacts of conflicts in these countries. For example, in Aceh, Indonesia, as part of the conflict between government forces and rebel groups, 460 schools were systematically burned to the ground during May 2003 alone.

⁴ The Global Peace Index (GPI) is an indicator used to measure national peacefulness or the absence of violence and conflict. It ranks 162 nations and prepared by the Institute for Economics and Peace (IEP). It is composed of 22 indicators, ranging from a nation's level of military expenditure to its relations with neighbouring countries and the percentage of prison population. The data is sourced from a wide range of respected sources, including the International Institute of Strategic Studies, the World Bank, various UN Agencies, peace institutes and the IUI. Nations considered more peaceful have lower index scores. In other words, a lower score implies a lower number of conflicts or the presence of higher peacefulness.

Displacement is another negative effect of conflicts. Children suffer from displacement process and continue to be exposed different forms of violence and abuse at their new destinations. For instance, in less than a year, the conflict in South Sudan has displaced 490,000 children. It is not easy to provide necessary services to such amount of children in a short period of time even in developed countries. It is almost impossible to fully protect these children against violence and abuse. Therefore, conflicts lead to tragedies for many children all across the world.

Children who are exposed to conflicts mostly continue to suffer throughout their entire life due to long-term mental effects of conflicts even they are placed far from conflict areas. A case study of UNICEF (2013) on Syrian adolescent refugees (aged between 5-17), who are living in camps in Jordan show that the most common serious mental health concerns for adolescents are enuresis, intellectual disability and autism/developmental disorders. The top three general concerns for adolescents are: fear in the camp, feeling sad and managing grief, and child abuse in the family.

In a nutshell, conflicts in OIC member countries are on the rise. These conflicts heavily affect children in different ways and make them more vulnerable. Worst of all, children who are exposed to conflicts, become less hopeful about their future. This not only negatively affects their life quality and but also constitute a threat for the development of their countries. Therefore, OIC member countries need to find ways to solve their problems with diplomacy as much as possible rather than being part of conflicts. Moreover, both OIC member countries and the OIC Secretariat General need address children in conflict areas in a more systematic way. Building camps and provision of basic services can only partially improve life quality of children. As shown by the UNICEF (2013), children living in camps, who moved out from conflict regions, continue to suffer in different ways from abuse and violence to mental disorders. Therefore, policy-makers should include all these different aspects into their agenda.

The extensive impact of armed conflict on children has prompted several significant actions worldwide to address this phenomenon. In 1990, the UN Convention on the Rights of the Child, which contains important provisions for children affected by armed conflict, came into force. After the publication of the Machel report, the UN General Assembly created the Office of the Special Representative of the Secretary General for Children and Armed Conflict in 1997. The office is mandated inter alia to "assess progress achieved, steps taken, and difficulties encountered in strengthening the protection of children in situations of armed conflict; raise awareness and promote the collection of information about the plight of children affected by armed conflict and encourage the development of networking; as well as foster international cooperation to ensure the respect for children's rights in the various stages of armed conflict."⁵

Despite all these international efforts, children continue to suffer from conflicts that the number of conflicts does not go down worldwide in general and goes up specifically in the OIC region. This implies that each year more children are facing adverse effects of conflicts. Over the long-run, it seems that the least costly and the most effective solution is to ensure peace. Otherwise, any other solution to conflicts and efforts to protect children would only be partially successful. Moreover, these efforts would only help children in some regions of the world where the rest of children in living other regions of the world would go on living under threat.

6.5 Child Labour

According to the definition of International Labour Organization (ILO), "child labour refers to employment of children in any work that deprives children of their childhood, interferes with their ability to attend regular school, and that is mentally, physically, socially or morally dangerous and harmful." Over the years, international community in collaboration with the governments and other stakeholders has made great strides to develop and enact proper legislative and policy framework to address the issue of child labour.

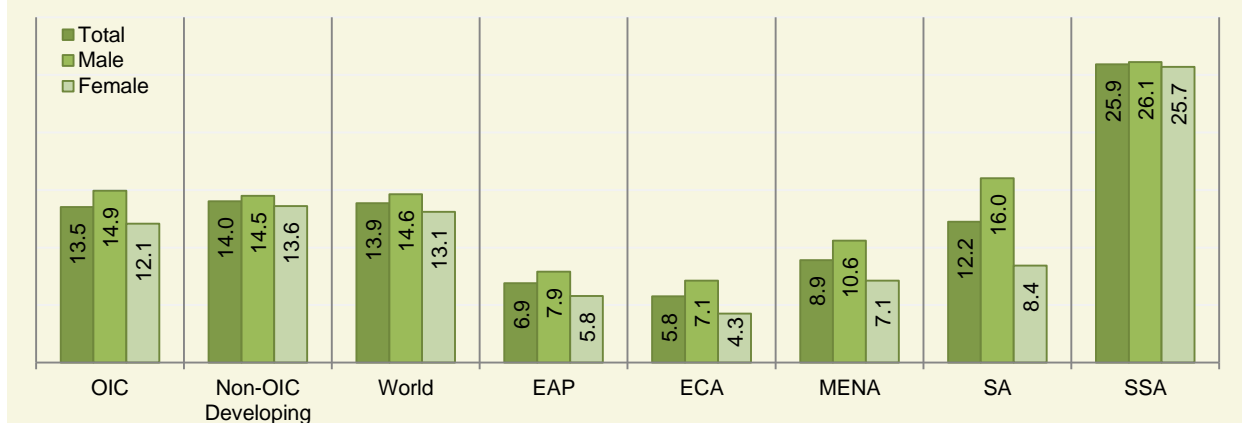
⁵ The efforts of the OIC are summarized in Annex.

Today, child labour is prohibited across the world and number of child labourers is on decline (ILO, 2013). Nevertheless, despite all achievements and progress, it is a grim reality that millions of children around the world remained trapped in child labour.

The recent estimates of UNICEF indicate that 106 million children aged 5 to 14 were engaged in child labour⁶ around the world in 2009-2013. Almost all of these children are living in developing countries. The largest absolute number of child labourer is found in the non-OIC developing countries (73 million) and the incidence of child labour also remained highest, though globally comparable, in these countries. As shown in Figure 6.9, globally, 13.9% of children aged 5 to 14 were trapped in child labour whereas, this ratio stood at 14.0% in non-OIC developing and 13.5% in OIC countries. Overall, prevalence of child labour remained higher among boys than girls for the 5-14 years age group. In case of prevalence of child labour among the male children, OIC countries recorded a rate of 14.9% compared to 14.6% in the world and 14.5% in other developing. Although OIC countries registered globally comparable performance in terms of total and male child labourers, the situation remained slightly better in case of prevalence of child labour among female children. As shown in Figure 6.9, 12.1% of female children were trapped in child labour in OIC countries compared to 13.1% in the world and 13.6% in other developing countries.

As shown in Figure 6.9, prevalence of child labour varies significantly across the OIC regions. In 2009-2013, the highest prevalence rate among children aged 5 to 14 was recorded in SSA region (25.9%) whereas the lowest prevalence was recorded in ECA region (5.8%). Among other regions, SA recorded child labour prevalence of 12.2% followed by MENA (8.9%), and EAP (6.9%). Prevalence of child labour among children aged 5 to 14 remained lower than the OIC average in all regions except the SSA. Prevalence of child labour remained generally skewed towards male children across the OIC regions. With a rate of 26.1%, SSA region registered the highest prevalence for male children among the OIC regions whereas, on the opposite side, it was only 7.1% in ECA region (Figure 6.9). In other regions, 16.0% male children were trapped in child labour in SA, 10.6% in MENA, and 7.9% EAP region. The share of male child labourers in SSA and SA regions remained higher than the global regional averages whereas it was visibly lower than the global regional averages in ECA, EAP and MENA regions.

FIGURE 6.9
Prevalence of Child Labour (%), 2009-2013



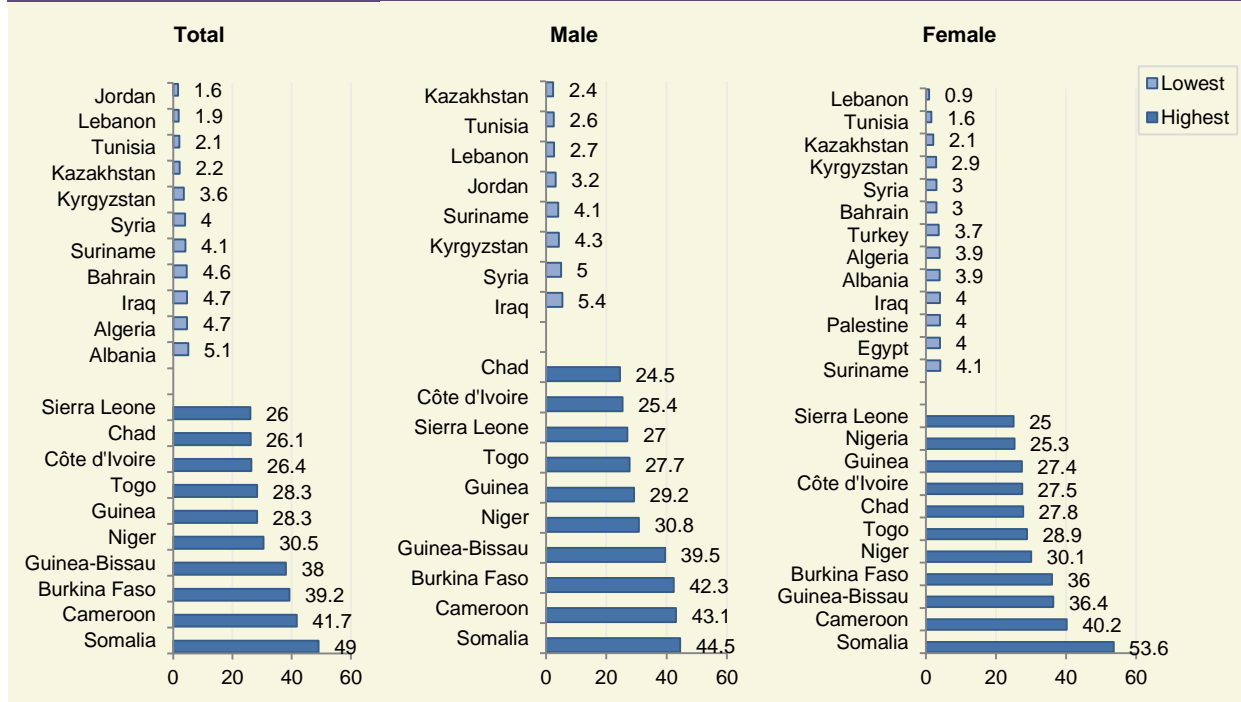
Source: SESRIC staff calculations based on UNICEF Database

⁶ According to the UNICEF, a child is considered to be involved in child labour under the following conditions: (a) children 5–11 years old who, during the reference week, did at least one hour of economic activity or at least 28 hours of household chores, or (b) children 12–14 years old who, during the reference week, did at least 14 hours of economic activity or at least 28 hours of household chores.

In case of female child labourers, once again SSA and SA regions registered the highest prevalence of 25.7% and 8.4% respectively whereas it was just 4.3% in ECA, 5.8% in EAP, and 7.1% in MENA region (Figure 6.9). With the exception of SSA region, prevalence of child labour among female children remained significantly lower than the global regional averages in 2009-2013.

There are again wide discrepancies in incidence of child labour across OIC countries (Figure 6.10). Jordan (1.6%), Lebanon (1.9%), Tunisia (2.1%) and Kazakhstan (2.2%) were the countries with the lowest prevalence of child labour among children aged 5 to 14 in 2009-2013, which are also ranked among top ten countries in the world (Figure 1.16). In contrast, the highest prevalence of child labour was estimated in Somalia (49%), followed by Cameroon (41.7%), Burkina Faso (39.2%), and Guinea-Bissau (38%). These four countries were also ranked among the top five countries in the world. Overall, prevalence of child labour was above 20% in 15 OIC countries whereas this ratio was below 10% in 18 OIC countries. In general, child labour remained highest in OIC countries from SSA region. A similar situation could also be observed in case of gender of child labourers. OIC countries with the highest incidence of child labour among male and female children are the same as mentioned above (Figure 6.10).

FIGURE 6.10
OIC Countries with the Lowest and Highest Prevalence of Child Labour (%), 2009-2013



Source: UNICEF Database

7 Concluding Remarks

This report looked at the state of children in OIC countries in a comparative perspective. The report focused on socio-economic factors ranging from health, education and nutrition to the conflicts and child labour that affect children well-being and development. All these dimensions, which impact children, were discussed in details and analysed by using available data for OIC countries in relevant sections throughout the report.

OIC countries are characterized by the youngest demographic distribution, with over one third of population below age 15. This underlines the huge demand for health care, schooling, food, recreation, and social protection and welfare services for the infants and young children. Over the years, many OIC countries have made significant progress in terms of fulfilling children's right to health, with more resources than ever being invested in the primary health care services. There are important country success stories within the OIC group in implementing interventions like antenatal care, skilled attendance during birth, immunization, and early care seeking for pneumonia, diarrhoea and malaria. These efforts paid off and child mortality is on decline across the OIC countries. Latest estimates show that if children were still dying at 1990 rates, there would have been 4.5 million deaths in OIC countries in 2013 (where the actual figure was 2.9 million). This difference of 1.6 million means that 4,372 children's lives were saved every day. However, despite this remarkable progress, OIC countries as a group made the least progress in reducing child deaths since 1990. With alarmingly low coverage of important child health care interventions, situation remained significantly poor in South Asia and Sub-Saharan Africa regions, which were home for around 60% of OIC children aged under 5 in 2013.

Child nutrition and food security is another major area of concern for the OIC countries. As a result, not only the risk of child death from common illness such as diarrhoea, pneumonia, and malaria remained quite elevated in OIC countries but also many children are suffering from physical and cognitive impairments caused by the malnutrition and deficiencies of vital micronutrients like vitamin A, iodine and iron. In 2009-2013, around one third of children in OIC countries were stunted, 21.3% were underweight, 11% were wasted and 7.4% were overweight. Though these complications are largely preventable and curable through proper child feeding practices recommended by the WHO and UNICEF, only 42.9% of infants in OIC countries were put to the breast within first hour of birth, 34.9% were exclusively breastfed during the first six months of life, 46.7% were breastfed until at age 2 and 66.1% of infants were introduced to complementary foods at 6 to 8 months.

Looking at selected indicators on education from a children well-being perspective reveals that OIC member countries made a significant improvement in terms of literacy, enrolment and completion rates since the 1990s. However, OIC member countries, on average, still have a long way to reach the level of developed countries in terms of literacy, enrolment and completion rates.

In terms of adequacy of education services for children, OIC member countries, on average, are lagging behind non-OIC developing countries. For instance, in terms of government expenditures per pupil, OIC member countries, on average, spend \$928 per pupil whereas the average of non-OIC developing countries is \$1860 in the same year. In terms of quality of education for children, OIC member countries also encounter problems. One major problem is the existence of crowded classrooms in the OIC group where student-teacher ratios are remarkably higher than those seen in developed countries. Another fact that is observed in education services for children in OIC member countries is the lack of gender equality dimension. It is seen that there are important disparities among boys and girls in access to education that mostly girls are disfavoured. Finally, in terms of cross-country differences among OIC member countries, the figures on enrolment and completion rates differ widely. It is therefore clear that some OIC member countries, especially situated in Sub-Saharan Africa, compared with other OIC member countries, such as those placed in

Central Asia, have to show some extra efforts in order to reach high enrolment rates and provide quality education to children.

In order to protect children and provide them the basic services, the birth certificate carries a particular importance. However, birth registration figures for OIC member countries, on average, are lagging behind the average of non-OIC developing countries as well the world average. To this end, many children in OIC member countries need to stay out of public services and are facing different forms of violence due to lack of an official birth certificate. It is therefore an important and urgent issue that policy-makers in OIC member countries need to address to improve the well-being of children.

No violence against children is justifiable. However, the figures show that many countries all across the world experience different forms of violence and abuse against children at varying degrees, which cannot be negligible. Unfortunately, the figures reveal that maltreatment and violence against children in OIC member countries are relatively higher in terms violence discipline against children, violence against women (mothers of children), female genital cutting and child marriage.

Conflicts in OIC member countries constitute a major threat for children well-being. Conflicts are extremely harmful for children by leading to death and injuries, destroying infrastructure, creating a chaotic environment where violence and abuse cannot be controlled, and displacing children from their families and countries. Overall, the number of conflicts is on the rise in the OIC region in recent years where each year increasing number of children suffering from conflicts at varying degrees.

Child labour is one of the worst forms of exploitations widespread across the developing world. Though, child labour is prohibited in the majority of OIC countries, 13.5% of children aged 5 to 14 were still trapped in child labour in 2009-2013. In general, boys are more likely to be engaged in child labour than the girls. Among the OIC regional groups, prevalence of child labour remained highest in SSA and SA regions, which are currently home for 45% of OIC's total children 5 to 14 years old.

8 Policy Recommendations

State of child health and nutrition remained significantly poor in many OIC countries. The challenge now facing the high-burden OIC countries is how to achieve universal coverage of effective interventions including antenatal and postnatal care, safer deliveries, care for new-borns and infants, breastfeeding, micronutrient supplementation and routine immunization against preventable diseases while optimizing investments and enhancing accountability to improve the health and nutritional status of children.

With respect to health, priority actions include training of antenatal care providers; improving supplies and logistics for health facilities; strengthening the referral linkages between communities and hospitals providing emergency maternal and child care; investing for more and better trained and equipped health workers to reach the majority of children who today do not have access to basic health care; developing home-based maternal and new-born care programmes based on successful models of community health workers; educating families and communities in how best to bring up their children healthily and deal with sickness when it occurs; and making better use of data to monitor and improve child health care coverage and quality. To improve the immunization coverage among children, priority actions for the governments and other stockholders include formulation of innovative strategies to achieve high and equitable immunization coverage; development and use of new vaccines and technologies; synchronization of Vaccination Week within the OIC countries; fighting taboos against vaccination through the involvement of political and religious community leaders; operationalizing the OIC Pooled Vaccine Procurement mechanism to secure timely supply and access to quality vaccines, particularly to new and underutilized ones, at competitive prices.

Governments should take necessary measures to improve the nutritional status of children by targeting the incidence of underweight, stunting, wasting and overweight among children. Provided the fact that health of mother is critical for the child, countries should develop and improve public health programs and services to provide education and resources to women of child bearing age to promote healthy nutrition prior to conception and during pregnancy, and provide assessments to at-risk pregnant women to help ensure that they receive appropriate medical attention. In addition, efforts should also be made to prevent women from becoming smokers and encouraging those who do smoke to quit. Academic and clinical research on major causes of malnutrition-related disorders is another area of paramount importance which needs due consideration of policy makers. In order to address the obesity, population-wide weight-control campaigns to raise awareness among medical staff, policy-makers and the public at large to reduce obesity have been very effective. In addition, keeping a check on the marketing of unhealthy foods and sugary drinks to children, and controlling the use of misleading health and nutrition claims is also very important. In some countries, governments have also increased taxation on high-calorie, low-nutrition foods to reduce the consumption of such products.

Promotion of exclusive breastfeeding for 6 months and continued breastfeeding up to two years of age and beyond is critical for the nutritional status of babies. As recommended by the Global Strategy for Infant and Young Child Feeding (WHO, 2003), all mothers should have access to skilled support to initiate and sustain exclusive breastfeeding for 6 months and ensure the timely introduction of adequate and safe complementary foods with continued breastfeeding up to two years or beyond. To address the grievances of working mothers, governments should enact legislation protecting the breastfeeding rights of working women and establishing means for its enforcement in accordance with international labour standards. Furthermore, fortification of foods; micronutrient supplementation; and treatment of severe malnutrition are also important policy areas especially for the high burden countries. In this regard, OIC countries can benefit from the technical and financial support of international institutions and development partners through initiatives like Scaling Up Nutrition Movement (SUN) which helps countries in developing and implementing national

infant and young child feeding policies; collaborating with partners to implement programmes with shared nutrition goals; and mobilising resources to effectively scale up nutrition with a core focus on empowering women. Currently, 55 countries are part of this movement including 26 OIC countries.

Given facts and figures on children education, OIC member countries need to allocate more financial and human sources to education. Increasing spending on education can only partially address the problems related with children education. The allocated sources for education should be used very carefully with proper planning. Policy-makers need to give priority to disadvantaged regions (remote areas within countries) where children suffer a lot in order to reduce disparity seen in children education across regions. Also education policies for children should be designed with a gender equality perspective. In OIC countries and regions where girls are disfavoured, policy-makers need to develop some education policies to encourage girls to enrol education institutions and to get the support of their families. These policies can include financial and non-financial incentives. Also policies to raise public-awareness would be helpful in this context. Specifically, NGOs and Islamic scholars would be important enablers for the success of education policies for children in OIC member countries. Many NGOs and Islamic scholars have a higher impact on families than public institutions in some regions of the OIC member countries. Therefore, policy-makers should not underestimate the importance of NGOs and Islamic scholars for the success of their policies on children education.

The figures on birth registration suggest that OIC member countries needs to intensify their efforts in order increase birth registration rate, which would help children to have better life standards in terms of education, health and other socio-economic aspects. According to the UNICEF, policies to support of birth registration include the following items: legal and policy reform; civil registry strategic planning, capacity building and awareness-raising; the integration of birth registration into other services, such as health and education; community-based registration and social mobilization campaigns. Innovative approaches can also be used, including SMS technology and support to governments to develop online birth registration information systems. As listed by the UNICEF, there is a wide-range of policy options to increase birth registration rates. To this end, each OIC member country depending on its current situation can benefit from these policy options at varying degrees.

In general, several policies from organising public awareness campaigns to enacting legislations can be used in order to fight against different forms of violence against children. Nevertheless, the most effective way of fighting against violence is “prevention”. Therefore, policy-makers in OIC member countries need to take this fact into account. The best way to increase prevention is to invest into education and re-organise education curriculums (including adult-learning programmes) with an aim to raise awareness and to reduce violence and abuse against children. Organising public campaigns would also help policy-makers both in their efforts to get public support and to increase the effectiveness of their policies on violence. Nevertheless, the success these policies depends on long-term planning and political willingness in developing countries, including OIC members. Therefore, short-sighted policies without addressing the root-causes of violence against children, such as ignorance and lack of understanding on basic rights of human-being, can only bring a partial solution.

The least costly and the most effective way to cope with conflicts are to establish and sustain peace. However, it is not always possible to prevent conflicts given the state of affairs in the world. To this end, policy-makers need to work on how to reduce the impacts of conflicts on children and to improve the well-being of children in conflict regions. To this end, in order to minimize impacts of conflicts on children the UNICEF Report (2004) suggests international community: to consider the impact on children before engaging in conflict, and allow for the protection of children and women during conflict; to end the recruitment of child soldiers; strengthen the protective environment for children at every level, from the family right through to the level of national and international laws; to prevent conflict by addressing the underlying causes of violence and

investing more resources in mediation and conflict resolution; to make monitoring and reporting on child rights violations in conflict zones a priority, including gathering reliable data on children who are actively involved in armed conflict; to expand demobilization and mine-awareness campaigns; to restart education for children caught up in armed conflict as soon as possible; to enhance the capacity of humanitarian agencies to respond to conflicts by developing early warning systems and better preparedness.

With its 57 members, there are policy options that the OIC can use in order to help children in conflict zones. First of all, the OIC can organise ordinary and extraordinary meetings/foras to highlight the importance of the issue and to set up a monitoring mechanism in this field. Second, the OIC can intensify its efforts with the UN in order to stop conflicts especially in hot spots such as in Yemen and Syria, where thousands of children have been affected. Moreover, if possible, these efforts can include formation of secure zones/camps within countries for protection of women and children. Finally, the OIC can also form a specialized body/envoy that would raise funds for children, monitor, coordinate and provide humanitarian help for them in conflict zones in collaboration with the Islamic Development Bank Group. Overall, both OIC member countries and international community need to work together with a full respect to each other to build up a better future for children.

A majority of OIC countries have already adopted legislation to prohibit or place severe restrictions on the employment and work of children, in line with the standards adopted by the International Labour Organization (ILO). In spite of these efforts, child labour continues to exist across the OIC countries with varying degrees of incidence. The progress has been comparatively very slow especially in OIC countries located in Sub-Saharan Africa region. This state of affairs underlines the need for rigorous enforcement of laws and regulations against child labour by the governments. To do so, OIC countries need to develop an integrated response to child labour in the light of International Roadmap for Eliminating of the Worst Forms of Child Labour by 2016 and the Brasilia Declaration on Child Labour (2013). Over the years many countries have managed to curb the child labour by employing simple, affordable and effective measures like: engagement of civil society and media to change attitudes that condone child labour; increasing public awareness of abuse and its harmful effects on health and development of children; initiating social programmes to support families in need and helping them find alternative income to prevent child labour; collecting and disseminating data and information on child labour to improve the implementation of preventive and protective measures.

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Annexes

Annex 1: Towards a Safe Childhood ⁷

Every child has the right to a full and productive life; and it is a shared responsibility to ensure that our children grow up in environments that build confidence, well-being, happiness and security. Islam has established a legal framework, and embodied a code of ethics, designed to protect the rights of an individual including his or her right to live in a secure society. For children, security is of the utmost importance. The Quran and Sunnah of Prophet Muhammad (peace be upon Him) emphasized on the rights of children for health, education, security and stability. Throughout Islamic history and in Islamic literature the rights and responsibilities pertaining to children are clear-cut. Parents, families, communities, and government have certain responsibilities towards children. All of them are obliged to fulfil and secure these rights.

Today, the escalating conflict around the world is resulting with an increased and complex protection risks for vulnerable members in the family, especially in children. According to recent humanitarian reports, since 2013, more people became refugees (16.7 million) and are internally displaced (33.3 million) than at any time before (since 1994). Children and women suffer disproportionately, physically and psychologically, when their country is ripped apart by war and conflict. OIC Member States countries; such as; Palestine; Syria; Iraq; Somalia; Nigeria and Azerbaijan; are undergoing civil wars, armed conflict, occupation, and/or general instability, children at these countries are Islamic world, are facing huge challenges and obstacles that deprive them from practicing a normal and secured childhood. They are daily exposed to life-threatening dangers if not death. Millions of children are caught up in conflicts in which they are not merely bystanders, but targets. Some fall victim to a general onslaught against civilians; others die as part of a calculated genocide. Still other children suffer the effects of sexual violence or the multiple deprivations of armed conflict that expose them to hunger or disease. Nonetheless, the impact of armed conflict, displacement and exploitation result with severe negative effect on the children's psychological and mental health. They continue suffering traumatic disorder that prevents them from moving on and living a normal life with positive contribution to their societies.

Therefore, the Secretariat General of the OIC, along with the Member States and the subsidiary, specialized, and affiliated OIC institutions have to take effective measures to improve the unacceptable conditions and plight of endangered children living under armed conflict.

The justification behind the call to stand for children's safety and security

The current situation for millions of children affected by war and armed conflict in the Muslim's world is dire and those children continue to suffer each of "The Six Grave Violations against Children during Armed Conflict", and even more. According to UNICEF, nearly 700 children have been killed in Iraq in 2014 only. More than 10,000 children have been killed in Syria since the outbreak of conflict in 2011. Boko Haram kidnapped 276 schoolgirls in northeast Nigeria in 2014. 153 Kurdish boys were abducted by ISIL during 2014. Schools and hospitals continue to be attacked –at least 244 schools in Gaza have been damaged by shelling and air strikes and half of Gaza's hospitals were damaged since the beginning of 2014. In Syria, more than half of all school-age children do not attend school as a result of the conflict. Children continue to be denied their right to live a safe childhood, not to mention their basic humanitarian rights and needs. Although the OIC General Secretariat in coordination with the Member States have made lots of progress in addressing challenges and issues that endanger children in the Muslim world, these efforts still fall short particularly within the contemporary escalating armed conflict situation in the Muslim world. Therefore, the

⁷ This Annex is prepared by the Department of Cultural, Social and Family Affairs of the OIC-GS.

OIC General Secretariat should recall Member States and all related OIC institutions to take more effective measures aimed to ensure the protection of Muslim children in the world and particularly in areas of conflict.

The Six Grave Violations against Children during Armed Conflict

The Six Grave Violations against Children during Armed Conflict, enumerated by the Security Council to advance the goal of protecting children during armed conflict in its resolutions. The UN Security Council – in UNSC Res. 1612 of 2005 – established a Working Group on Children and Armed Conflict and a Monitoring and Reporting Mechanism (“MRM”) to systematically monitor, document and report on heinous abuses of the rights of children in situations of armed conflict.⁵ Subsequent Security Council resolution, UNSC Res. 1882 of 2009, has further expanded and strengthened the MRM.⁶

During times of conflict, international humanitarian and human rights law must be respected, with special regard to children who often have no means to defend themselves against abuses. The *full* range of children’s rights – economic, social and cultural as well as political and civil – should be respected, protected and promoted. However, after broad consultations within the UN, its peacekeeping missions, member States and non-governmental organizations, the UN Security Council identified six categories of violations that warrant priority attention. These **Six Grave Violations against children during armed conflict** were selected due to their ability to be monitored and quantified, their egregious nature and the severity of their consequences on the lives of children. The Six Grave Violations against Children during Armed Conflict are listed as follows:

1. Killing or maiming of children,
2. Recruitment or use of child soldiers,
3. Rape and other forms of sexual violence against children,
4. Abduction of children,
5. Attacks against schools or hospitals,
6. Denial of humanitarian access to children.

OIC Activities and Efforts for the Child Well-Being in the Muslim World

Since its establishment, the Organization of Islamic Cooperation (OIC) has always been dedicating extensive efforts to promote child welfare, child well-being, and protect children’s rights in the Muslim world in pursuance of:

- The 1959 Declaration of the Rights of the Child;
- The 1989 Convention of the Rights of the Child;
- The Cairo Declaration on Human Rights in Islam;
- The OIC Covenant on the Rights of the Child in Islam, which stresses on the importance of the rights of the child;
- The Ten Year Program of Action (2005-2015); and the Tenth Islamic Summit decisions on children.

The Ministerial Conferences for Childhood Ministers in the Member States

The Islamic Conference of Ministers in Charge of Childhood is one of the specialized Islamic Conferences held by ISESCO, in coordination with the OIC General Secretariat and the competent parties in the host countries, in the fields of higher education and scientific research, culture, the environment and childhood.

The 1st, 2nd, 3rd and 4th Islamic Conferences of Ministers in-charge of Childhood, which were held respectively in Rabat, Khartoum, Tripoli and Baku in 2005, 2009, 2011 and 2013 in coordination between the General Secretariat, ISESCO and UNICEF, adopted Rabat Declaration, Khartoum Declaration, Tripoli Declaration and Baku declaration on the issues of Children in the Islamic World.

- 1- The first Conference held in Rabat, Morocco (7-9 November 2005) issued the *“Rabat Declaration on Child’s Issues in the Member States of the Organization of Islamic Conference”*.
- 2- The second Conference held in Khartoum, Sudan (2-4 February 2009) issued the *“Khartoum Declaration: Towards a Brighter Future for Our Children”*.
- 3- The third conference held in Tripoli, Libya (10-11 February 2011) issued the *“Tripoli Declaration on Accelerating Early Childhood Development in the Islamic World”*.
- 4- The fourth conference held in Baku, Azerbaijan (11-12 November 2013) issued the *“Baku: Declaration: Toward a Better Future for Children in Urban Settings in the Islamic World”*.

The Ministerial Conferences for Childhood at the OIC Level

First Islamic Ministerial Conference on Child Affairs

The First Islamic Ministerial Conference on Child Affairs - Rabat, Kingdom of Morocco, from 7th to 9th Nov, 2005, focused on topics related to Health, HIV/AIDS, Child Protection against Violence, Exploitation and Abuse, Education, and Investing on Children. The Conference was organised in collaboration with the ISESCO, UNICEF and the OIC-GS.

The conference set the foundations and the basic needs of children in the Islamic world upon the contemporary social, economic and political situation of the Islamic world at that time.

The conference highlighted the main issues that need to be tackled by the Member States and the different measures and methods to be used and followed in each issue in order to achieve the desired outcomes for the benefits and wellbeing of children in the Islamic world.

The main issues that were recommended to be followed up are in the areas of:

- Child Protection against Violence;
- Child education;
- Investing on Children.

The main recommendations of this conference were:

- Entrust ISESCO, UNICEF and the OIC with the responsibility of following up the implementation of this Declaration in conjunction with the Chairman of the Conference, and of supporting individual and joint efforts of Member States with a view to assisting them in fulfilling their obligations and commitments to children.
- Entrust ISESCO with the responsibility of convening the Islamic Ministerial Conference on the Child on a regular basis, and of following up the implementation of its resolutions and recommendations in conjunction with the General Secretariat of the OIC and UNICEF.
- Recommend in this context, the development of mechanisms to promote the exchange, among OIC Member States, of expertise in the development and implementation of policies pertaining to the child rights, and to provide oversight of progress in the implementation of this Declaration, any future Declarations or Resolutions relating to the rights of the child and of the “A World Fit for Children” Document.

Second Islamic Ministerial Conference of Ministers in charge of Childhood Affairs: *Towards a brighter future for our children*

The Second Ministerial Meeting on Children in the OIC Member States was held in Khartoum, Sudan under the theme “Towards a brighter future for our children”. The Conference was organised in collaboration with the ISESCO, UNICEF and the OIC-GS.

The conference focused on areas of ‘Child Health’, ‘Education’, ‘Child Protection’, and ‘Globalization’ in relation to children and discussed methods of accelerating progress in these areas in relation to children. The conference came out with the issuance of the Khartoum Declaration, which highlighted the issues and concerns facing children and their development in the Member States and decided on a set of recommendations and proposals to address them. The Declaration, commended, inter-alia, the role of the OIC General Secretariat in giving importance and priority to children issues in line with the vision and goals set in the OIC Ten-Year Program of Action (2005-2015).

The Conference called for the need of empowering children and, creating opportunities, and facilitating access to proper education, health-care, recreation facilities etc.

The conference also emphasized strongly on the need to enact preventive measures against child abuse, child labour and recruitment of child soldiers.

The massacre of innocent Palestinian children who were killed, injured and orphaned by the brutal Israeli aggression in Gaza, was highlighted in the conference, condemning the Israeli government for their continuous act of exploitation of human rights; and emphasizing that the perpetrators of these acts of war crimes should be prosecuted in international courts.

While drawing the attention of the Conference to the **OIC Covenant on the Rights of the Child in Islam**⁸, the conference urged the Member States to sign and ratify it.

The activities of the OIC General Secretariat for providing concrete relief and assistance to the 25,000 Indonesian children orphaned by the Tsunami disaster in December 2004, were highlighted. Also the contributions of the OIC in the process of developing and implementing similar programs for children in Darfur and Gaza were appreciated.

The main recommendations of this conference were:

- Entrust ISESCO with the responsibility of following up on the implementation of the Khartoum Declaration in conjunction with the Chairman of the Conference, and with supporting individual and joint efforts of Member States with a view to assisting them in fulfilling their obligations and commitments towards children.
- Request ISESCO to establish programmes and activities aiming to promote the situation of children, and to prepare, in coordination with Member States and the competent parties, studies, researches, data and

⁸ The Covenant on the Right of the Child in Islam was adopted by the 32nd Session of the Islamic Conference of Foreign Ministers (CFM) held in Sana’a, Republic of Yemen (Resolution No 1/32-LEG on Human Rights). This Covenant was adopted out of the OIC commitment to the security, welfare, and well-being of children and as such considers the ratification of this covenant a critical step towards the actualization of its overall action plan. Therefore, the OIC, through all its ministerial meetings, regional and international events, continually call on Member States to sign and ratify the various agreements; which the Covenant on the Right of the Child, is amongst.

indicators concerning the situation of children in general, with a view to assisting Member States in the implementation of the contents of Khartoum Declaration, and following up its implementation.

- Call upon ISESCO to coordinate and cooperate with specialized Islamic and international institutions to undertake studies aimed at improving the status of women, children and families in the Member States, especially in the target areas identified in this Khartoum Declaration.
- Urge Member States to report regularly to ISESCO on the measures taken in the implementation of this Khartoum Declaration.
- Call upon the OIC and ISESCO General Secretariats to submit the Khartoum Declaration to the specialized conferences of the relevant Arab, Islamic and international organizations to highlight the Islamic perspective with regard to child issues and their specificities in the Islamic world, and propound the Member States' expectations and future action plans in that respect.

Third Islamic Ministerial Conference of Ministers in charge of Childhood Affairs: *Accelerating Child Development in the Islamic World*

The Third Islamic Ministerial Conference on Child Affairs was organised in collaboration with the ISESCO, UNICEF and the OIC-GS in Tripoli, Libyan Arab Jamahiriya, from 10th to 11th February, 2011.

Tripoli Declaration was a turning point on the agenda usually followed for Childhood wellbeing and development in the Islamic World.

The conference did not only follow up on the outcomes and achieved targets of the second meeting in Khartoum in 2009; but it also displayed additional concerns with rising importance and major effect on the safety and wellbeing of children in the Islamic World and Member States. In particular, the meeting discussed measures to safeguard and protect children in areas affected by natural disasters and war in the Member States.

The conference called all Member States to accelerate progress in the following areas:

- National Policies.
- Health Care and Nutrition.
- Pre-school Education.
- Community Support and Improving Parenting Programs.
- Protection of early childhood in emergencies.
- Enhancing Islamic Solidarity and International Cooperation for Financing ECD Programs.
- Fostering the Role of Civil Society in the Media.

The main recommendations of this conference were:

- The review of ISESCO about their responsibility of ensuring the follow-up of the implementation of this Tripoli Declaration with the competent parties in the Member States, in coordination with the General Secretariat of the Organization of the Islamic Conference (OIC), the Chairman of the Conference; and with maintaining support for the efforts of Member States to honour their obligations and commitments towards children.
- Follow up on the outcomes of the reporting to ISESCO on the measures taken by the competent parties towards implementing this Tripoli Declaration.
- Status of the recommendation about ISESCO to schedule ECD programmes and activities under its action plans, to continue preparing relevant studies, research, data and indicators, to enhance coordination with UNICEF for drawing up an inventory of the world leading mechanisms and experiences in this areas, and to set appropriate standards for monitoring the situation of early childhood and ensuring the follow-up of ECD programmes, in coordination with the Member States and international, Islamic and regional partners.

- Status of the recommendation to call for ISESCO, an Islamic observatory on child rights to be entrusted with setting up a database on the situation and issues of childhood in the Islamic world and facilitating experience and information sharing among competent national structures and bodies in the Member States.
- Re-recommending on the adoption of the Legal Framework for the Establishment of ISESCO Forum for Children of the Islamic World; and entrust ISESCO with supervising the Forum and holding its regular and special sessions in order to enforce such a legal framework.
- Assuring provision of comprehensive protection and care for early childhood in the occupied Palestinian territories and the occupied Syrian Golan; and urge further solidarity with the countries whose children are exposed to death and forced migration because of wars and natural disasters;
- Call to support the humanitarian efforts the OIC Secretary General deploys in OIC Member States, jointly with the cooperating parties, in favour of children orphaned by natural disaster and war in Member States.

Forth Islamic Ministerial Conference of Ministers in charge of Childhood Affairs: *Children and the Challenges of Urbanization in the Islamic World*

The 4th Session of the Islamic Conference of Ministers In-charge of Childhood, held in Baku, Republic of Azerbaijan, in Nov 2013, was under the theme “Children and the Challenges of Urbanization in the Islamic World. The Conference was organised in collaboration with the ISESCO, UNICEF and the OIC-GS.

The conference looked into the challenges facing children from rapid urbanization in the Member States and decided on an action plan to address these challenges and their ramifications. The plan included:

- Children’s right to education;
- Proper health care;
- Protection from abuse, forced labour, recruitment of child soldiers and their trafficking.

The Conference discussed the main document on “Children and the Challenges of Urbanization in the Islamic World” and a draft document on “Pre-school Education in the Islamic World: Some successful experiences”.

The Conference also presented the outcome of the First Session of Forum for Children of the Islamic World. In addition, the heads of Member States’ delegations presented their statements and reports on childhood issues in the Muslim world. Furthermore, participants adopted the conference resolutions and the “Baku Declaration: Toward a Better Future for Children in Urban Settings in the Islamic World” where member countries called for:

- Integrated policies.
- Appropriate measures and adequate services for children.
- Improve equal access to decent living conditions for urban children in the Islamic World.

The conference also called on the international community to come forward to the cause of children, especially those living in dire conditions and suffering as victims of civil strife, conflicts and natural disasters.

Annex 2: Composition of OIC Regional Groups

East Asia and Pacific (EAP-3)	Europe and Central Asia (ECA-10)	Middle East and North Africa (MENA-19)	South Asia (SA-4)	Sub-Saharan Africa (SSA-21)
Brunei	Albania	Algeria; Bahrain	Afghanistan	Benin; Burkina Faso;
Indonesia	Azerbaijan	Djibouti; Egypt	Bangladesh	Cameroon; Chad; Comoros;
Malaysia	Kazakhstan	Iran; Iraq; Jordan;	Maldives	Côte d'Ivoire; Gabon;
	Kyrgyzstan	Kuwait; Lebanon; Libya;	Pakistan	Gambia; Guinea; Guinea-
	Tajikistan	Morocco; Oman;		Bissau; Mali; Mauritania;
	Turkey	Palestine ; Qatar; Saudi		Mozambique; Niger; Nigeria;
	Turkmenistan	Arabia; Syria; Tunisia;		Senegal; Sierra Leone;
	Uzbekistan	United Arab Emirates;		Somalia; Sudan; Togo;
	Guyana*	Yemen		Uganda
	Surinam*			

Note: OIC Regional Groups are based on the World Bank Country Classification. Guyana and Suriname are located in Latin America. However due to the limited number of OIC countries in that region; they are included in the ECA group only for the calculation purposes.



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