

GENDER COUNTS

South Asia

A quantitative assessment of gender inequality
and its impact on children and adolescents



Gender counts

Sub-regional report for South Asia

This is one of four reports for the Asia and the Pacific region. Other assessments are available for East & Southeast Asia, Central Asia and the Pacific.

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Prepared for UNICEF East Asia and Pacific and UNICEF South Asia Regional Office by



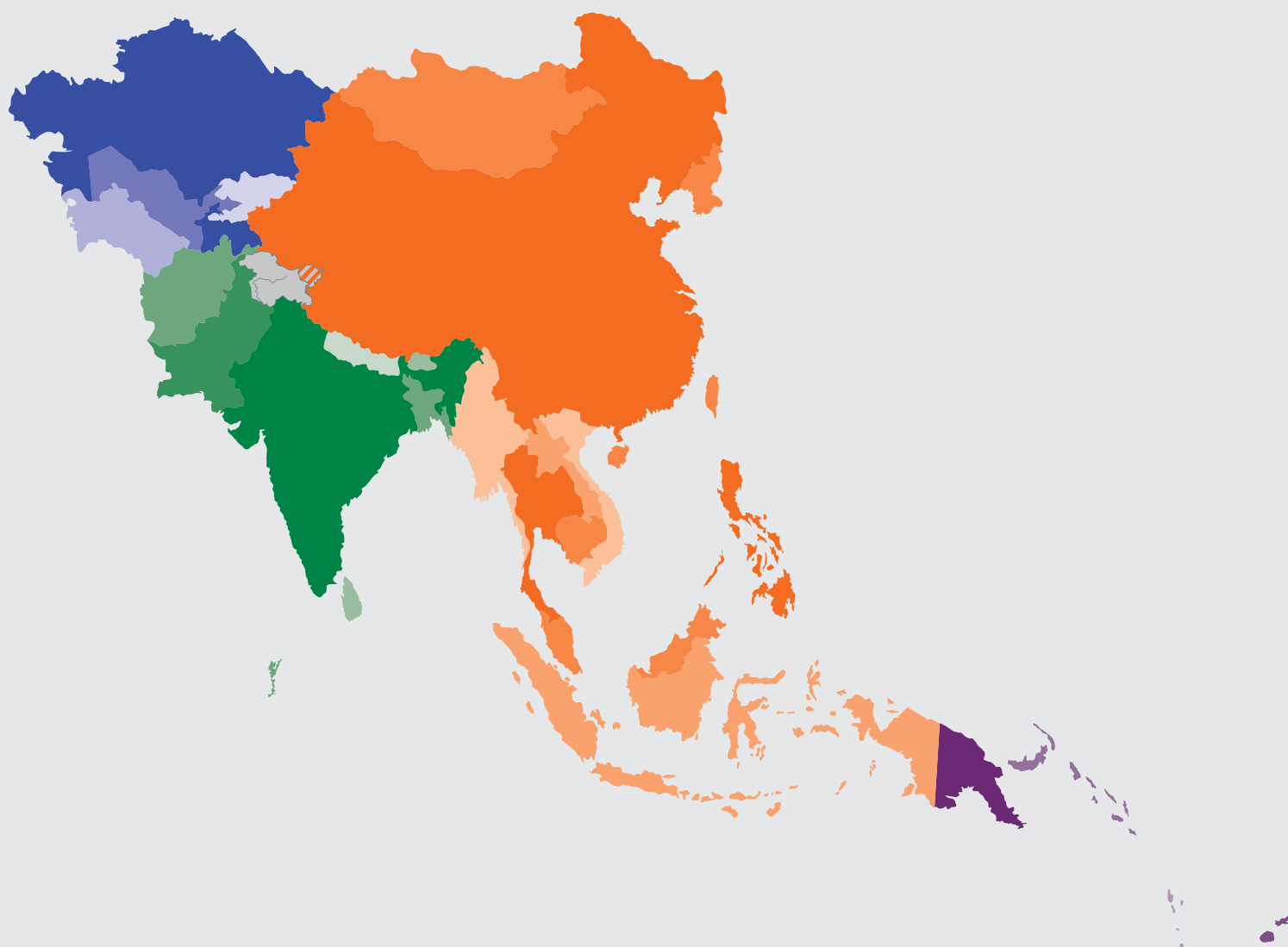
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GENDER COUNTS

South Asia

1 of 4 sub-regional reports for Asia and the Pacific



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Abbreviations and acronyms

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSE	Comprehensive Sexuality Education
DALY	Disability-Adjusted Life Year
DHS	Demographic and Health Survey, USAID
FAO	The Food and Agriculture Organization of the United Nations
FGM/C	Female Genital Mutilation/Cutting
GBD	Global Burden of Disease
GBV	Gender-based Violence
GPIA	Adjusted Gender Parity Index
GSHS	Global School-based Student Health Survey
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IHME	Institute for Health Metrics and Evaluation (Global Burden of Disease)
ILO	International Labour Organization
IPU	Inter-Parliamentary Union
ITU	International Telecommunication Union
LMIC	Low and middle-income countries
MICS	Multiple Indicator Cluster Surveys, UNICEF
MSM	Men who have Sex with Men
NEET	Not in Education, Employment, or Training
OECD	Organisation for Economic Co-operation and Development
SOWC	State of the World's Children, UNICEF
SRHR	Sexual and Reproductive Health and Rights
STEM	Science, Technology, Engineering & Mathematics
STI	Sexual Transmitted Infection
UN DESA	United Nations Department of Economic and Social Affairs
UN IGME	United Nations Inter-agency Group for Child Mortality Estimation
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNCRC	United Nations Convention on the Rights of the Child
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNPD	United Nations Population Division, Department of Economics and Social Affairs (DESA)
UNSD	United Nations Statistics Division
WB	World Bank
WHO	World Health Organization
WHO GHO	Global Health Observatory
WHO/UNICEF JMP	The Joint Monitoring Programme for Water Supply, Sanitation and Hygiene
WLII	World Legal Information Institute



Glossary and definition of key terms

Term	Definition	Source
Adolescents (10-19 years)	Persons between the ages of 10-19 years in the phase known as adolescence, which is a key developmental stage between childhood and adulthood. Adolescence involves transitions in neurocognitive (brain) function, sexual maturation and physical changes in muscle mass and body composition, social role transitions (including formation of new relationships, transitions from school to employment and financial independence) and identity formation, including sexual orientation and gender identity.	UNICEF, WHO
Children (< 18 years)	Below the age of eighteen years unless relevant law stipulates that majority (adulthood) is attained earlier. Given the inclusion of adolescents in this report, the term 'child' is more commonly used to refer to those below the age of 10 years.	UNCRC
Cisgender	Gender identity and/or gender expression is aligned with the assigned sex at birth.	UNESCO
(DALYs)	DALYs (Disability adjusted life years) are the years of healthy life lost within a population. DALYs are the sum of years lost due to premature death and years lived with disability.	IHME, WHO
Discrimination	The exclusion or unfair treatment of a person/group of people based on different traits such as sex, class, gender identity, sexual orientation, religion or ethnicity.	UNESCO
Discrimination against girls and women	Discrimination against girls and women means directly or indirectly treating girls and women differently from boys and men in a way which prevents them from enjoying their rights. Direct discrimination is more obvious e.g. in some countries women cannot legally own property; or they are forbidden by law to take certain jobs. Indirect discrimination refers to situations that may appear to be unbiased but result in unequal treatment of girls and women. For example, a job for a police officer may have minimum height and weight criteria, which women may find difficult to fulfil and prevents them from becoming police officers.	UN Women
Empowerment	Empowerment involves gaining power and control over one's own life. Empowerment of women and girls involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources and actions to transform the structures and institutions which reinforce and perpetuate gender discrimination and inequality.	UN Women

Gender	Gender refers to the roles, behaviours, activities, and attributes that a given society at a given time considers appropriate for men and women. In addition to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, gender also refers to the relations between women and those between men. These attributes, opportunities and relationships are socially constructed, learned through socialisation and are context/time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context.	UN Women
Gender-based violence	Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between females and males. The nature and extent of specific types of GBV vary across cultures, countries and regions. Examples include sexual violence, including sexual exploitation/abuse and forced prostitution; domestic violence; trafficking; forced/early marriage; harmful traditional practices such as female genital mutilation; honour killings; and widow inheritance.	UNESCO
Gender discrimination	Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on the basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.	CEDAW
Gender diversity	An umbrella term referring to those who do not conform to either of the binary gender definitions of male or female, as well as those whose gender expression may differ from standard gender norms.	UNESCO
Gender equality	Gender equality refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born male or female.	UN Women
Gender Equality in Health	Women and men have equal conditions to realise their full rights and potential to be healthy, contribute to health development and benefit from the results. Achieving gender equality will require specific measures designed to support groups of people with limited access to such goods and resources.	WHO

Gender Equity	The preferred terminology within the United Nations is gender equality, rather than gender equity. Gender equity denotes an element of interpretation of social justice, usually based on tradition, custom, religion or culture, which is most often to the detriment to women. Such use of equity, in relation to the advancement of women, has been determined unacceptable. During the Beijing conference in 1995, it was agreed that the term equality would be utilised.	UN Women
Gender expression	How a person communicates one's gender to others including clothing, hairstyle, voice, behaviour and the use of pronouns.	UNESCO
Gender identity	How a person identifies as being a man, woman, transgender or third gender person. Unlike gender expression, gender identity is not visible to others.	UNESCO
Gender norms	Gender norms are ideas about how men and women should be and act. We internalise and learn these 'rules' early in life. This sets up a life-cycle of gender socialisation and stereotyping. Put another way, gender norms are the standards and expectations to which gender identity generally conforms, within a range that defines a particular society, culture and community at that point in time.	UN Women
Gender parity	Gender parity is another term for equal representation of women and men in a given area, for example, gender parity in organisational leadership or higher education.	UN Women
Gender roles	Social and behavioural norms which, within a specific culture, are widely considered to be socially appropriate for individuals of a specific sex.	UN Women
Gender socialisation	A process by which individuals develop, refine and learn to 'do' gender through internalising gender norms and roles as they interact with key agents of socialisation, such as their family, social networks and other social institutions.	UNICEF
Gender stereotypes	Gender stereotypes are simplistic generalisations about the gender attributes, differences and roles of women and men. Stereotypical characteristics about men are that they are competitive, acquisitive, autonomous, independent, confrontational and concerned about private goods. Parallel stereotypes of women hold that they are cooperative, nurturing, caring, connecting, group-oriented and concerned about public goods. Stereotypes are often used to justify gender discrimination more broadly and can be reflected and reinforced by traditional and modern theories, laws and institutional practices.	UN Women

Improved sanitation facilities at school	Improved sanitation facilities at school are single-sex and usable (available, functional and private) at the time of the survey.	WHO/ UNICEF JMP
Modelled data	Modelled data is based on the best available primary data and uses mathematical modelling to harmonise estimates and fill data gaps.	IHME
School-related gender-based violence	Acts or threats of sexual, physical or psychological violence occurring in and around schools, perpetuated as a result of gender norms and stereotypes and enforced by unequal power dynamics.	UNESCO
Sex	The classification of people as male, female or intersex, assigned at birth, typically based on anatomy and biology.	UNESCO
Sex-disaggregated data	Sex-disaggregated data is data that is cross-classified by sex, presenting information separately for men and women, boys and girls.	UN Women
Sexual orientation	Sexual orientation refers to each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different sex/gender or the same sex/gender or more than one sex/gender.	UN Women
Stereotype	A generalised or simplified idea about people based on one or more characteristics.	UNESCO
Sustainable development	Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs.	UN
Third gender	A person who identifies as being neither male nor female. Third gender is a legal identity in some countries.	UNESCO
Transgender	An umbrella term for people whose gender identity or expression differs from the sex assigned at birth. Transgender identity is not dependent on medical procedures. It includes, for example, people assigned female at birth but who identify as a man (trans man) and people assigned male at birth but who identify as a woman (trans woman).	UNESCO
Youth (15-24 years)	Persons between the ages of 15 and 24 years, as defined by UNFPA.	UN

Executive Summary

Gender inequality has been highlighted as one of the most fundamental challenges to sustainable development. While efforts have been made to understand how gender inequality impacts on women, **little is known about how gender impacts on the wellbeing and development of children and adolescents.** This is despite childhood and adolescence being where gender inequalities first emerge, with these early years of life also critical to shaping gender norms.

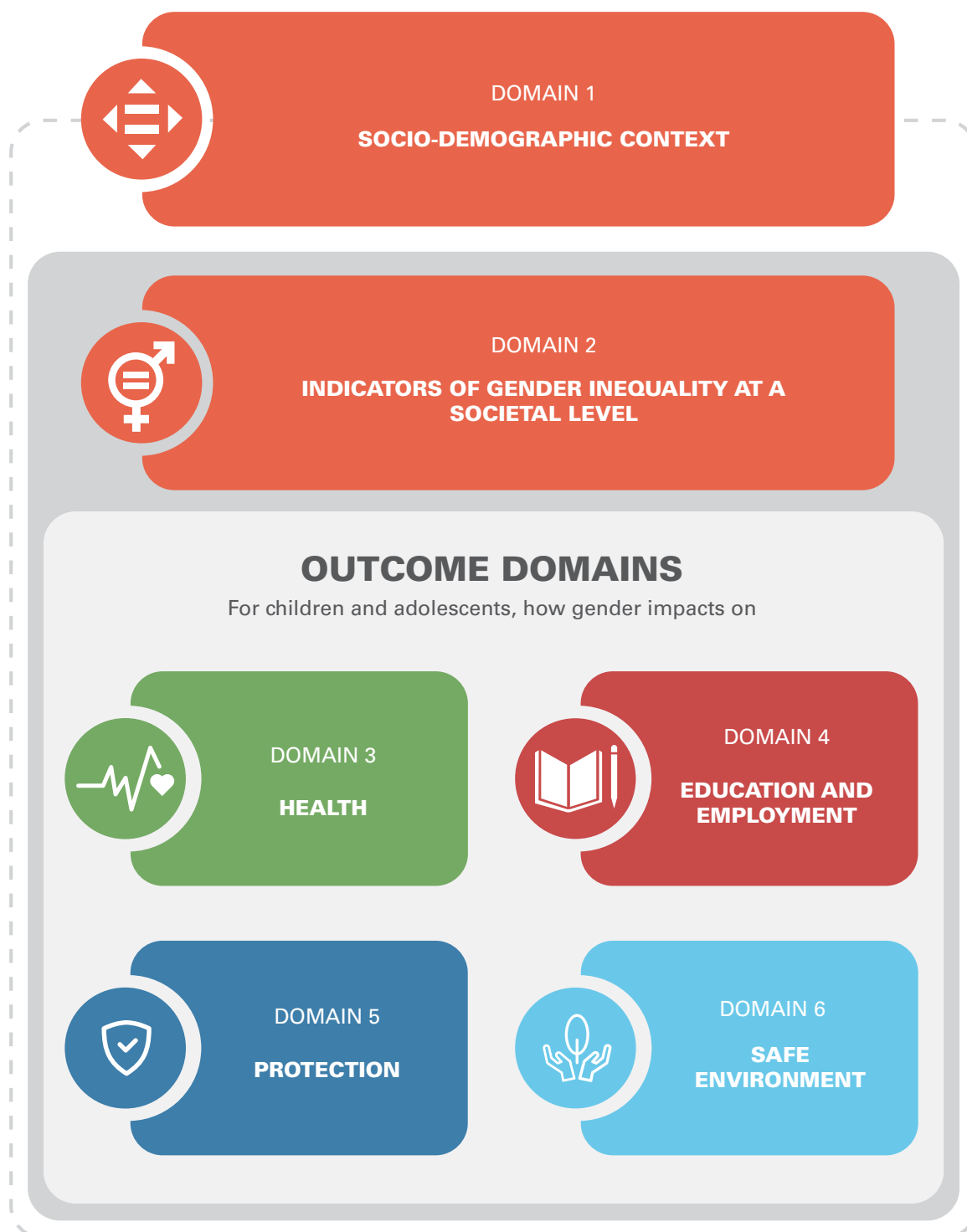
To help guide more effective and inclusive policy, **this report provides a comprehensive account of how gender inequality impacts on the lives of children and adolescents.** This report focuses on low and middle income countries of South Asia, with other reports in the series focusing on East & South East Asia, Central Asia and the Pacific. The report is intended for policy makers, programmers and those working in research, development and national statistics offices.

The first of its kind, this report is framed around a conceptual framework that includes six domains. The first **two domains focus on the context** in which gender inequality manifests and is perpetuated. The remaining **four domains relate to how gender inequality impacts on health and wellbeing at an individual level** and in particular on children's and adolescent's outcomes related to health; education and transition to employment; protection; and safe environment.

Over 100 indicators were defined across these domains and subsequently populated with the best available data.

This report focuses on quantitative measurement of gender inequality, and as such, is dependent on high quality data. There were numerous indicators which could not be readily populated, including: sexual and reproductive health of children aged under 15 years, adolescent boys, and unmarried adolescents; wellbeing of young people with diverse gender identity and sexual orientation; measures of menstrual health and hygiene; prevalence of disability amongst children and adolescents; and the individual-level impacts of conflict, disaster and climate change, urbanisation and food security. There were however many indicators with data available and these findings identify some key areas of need and a baseline from which progress can be measured.

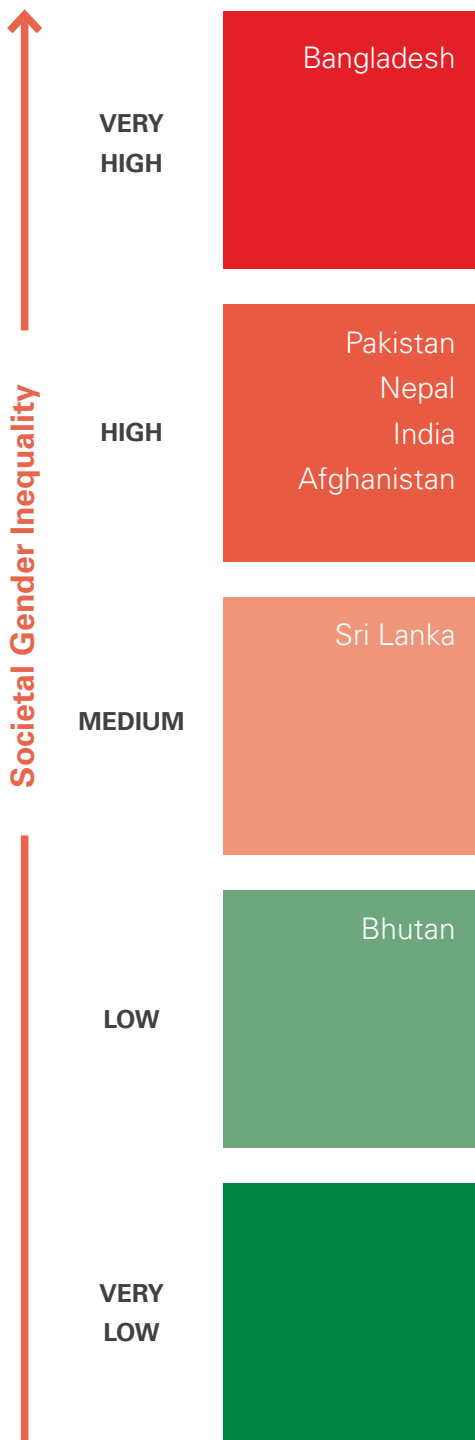
Conceptual framework developed to guide the quantitative analysis of gender equality for children and adolescents





Context (Domains 1 and 2)

Social Institutions Gender Index



This region is rapidly developing, however the low- and middle-income countries of South Asia vary substantially in their levels of human development. Countries with a lower level of development (such as Afghanistan) are generally at greater risk of gender inequality given that socioeconomic poverty disproportionately affect women and girls. Development however can also be detrimental as urbanisation and migration (in countries like Sri Lanka and the Maldives) has the potential to fragment social supports and may increase women's work burden, including domestic work and child care.

Available data suggest that children and adolescents growing up in this region are exposed to high levels of household, institutional and societal gender inequality:

- Bangladesh has a very high level of gender discrimination in social institutions, with Afghanistan, India, Nepal and Pakistan having high levels of discrimination.
- Males earn more than females across most countries where data is available.
- Females are under-represented in the parliaments and police forces of the region, limiting legislative and justice system responses for women and girls.

- While most women are able to make decisions about spending their own earnings, many women are not able to make decisions about healthcare and household purchases and access of social networks, indicating less control over household resources and bodily autonomy.
- Half of women in Afghanistan, one in four in Bangladesh and one in five in India and Pakistan, have experienced intimate partner violence in the past year.
- Justification of intimate partner violence is high, particularly in Afghanistan, India and Pakistan. Where data are available, females are also more likely to justify violence. This may reflect women's internalised acceptance of gender-based violence, and under-reporting by men.
- Substantial regional variation exists with regard to the proportion of married women whose demand for contraception is satisfied with modern methods; with married women in Afghanistan, Pakistan and Nepal being the least satisfied.
- In most countries, except Bhutan and Nepal, marital rape is not criminalised.
- Collectively, these exposures adversely impact on the wellbeing and development of children and adolescents in the region, particularly so girls. This disadvantage is likely reflected in the smaller female population aged under 18 years - in all countries there are fewer girls than there are boys.

**For every 10 boys under the age of 18 years
there are only 9 girls**





Health (Domain 3)

Available data demonstrated significant gender inequalities in health outcomes for girls and boys in this region:

- Girls under-5 years of age have a higher than expected mortality across the region, with substantial excess mortality in India.
- Adolescent girls experience a disproportionate burden of anaemia.
- Girls experience a greater burden of Group 1 Conditions (communicable, maternal and nutritional) than boys.
- Boys experience an excess burden from injuries compared to girls.
- Boys have higher rates of health risk behaviour such as tobacco smoking.
- In contrast with global patterns, adolescent girls in Bangladesh, India, Nepal and Pakistan have an excess risk of suicide compared to boys.
- Poor reproductive health outcomes for girls remains a substantial issue across the region with high rates of adolescent pregnancy, particularly in Afghanistan, Bangladesh, Nepal and Pakistan. In these same countries, demand for contraception amongst adolescents goes largely unmet. Maternal mortality rates are particularly high for adolescents in Afghanistan and Pakistan.

For the most part, these differing health outcomes for girls and boys are likely attributable to social norms, roles and relations which place greater value on boy children; harmful masculine norms which support risk-taking and discourage help-seeking; and imbalances in power relations that negatively impact girls' lack of autonomy and self-determination.

Gender disparities in suicide



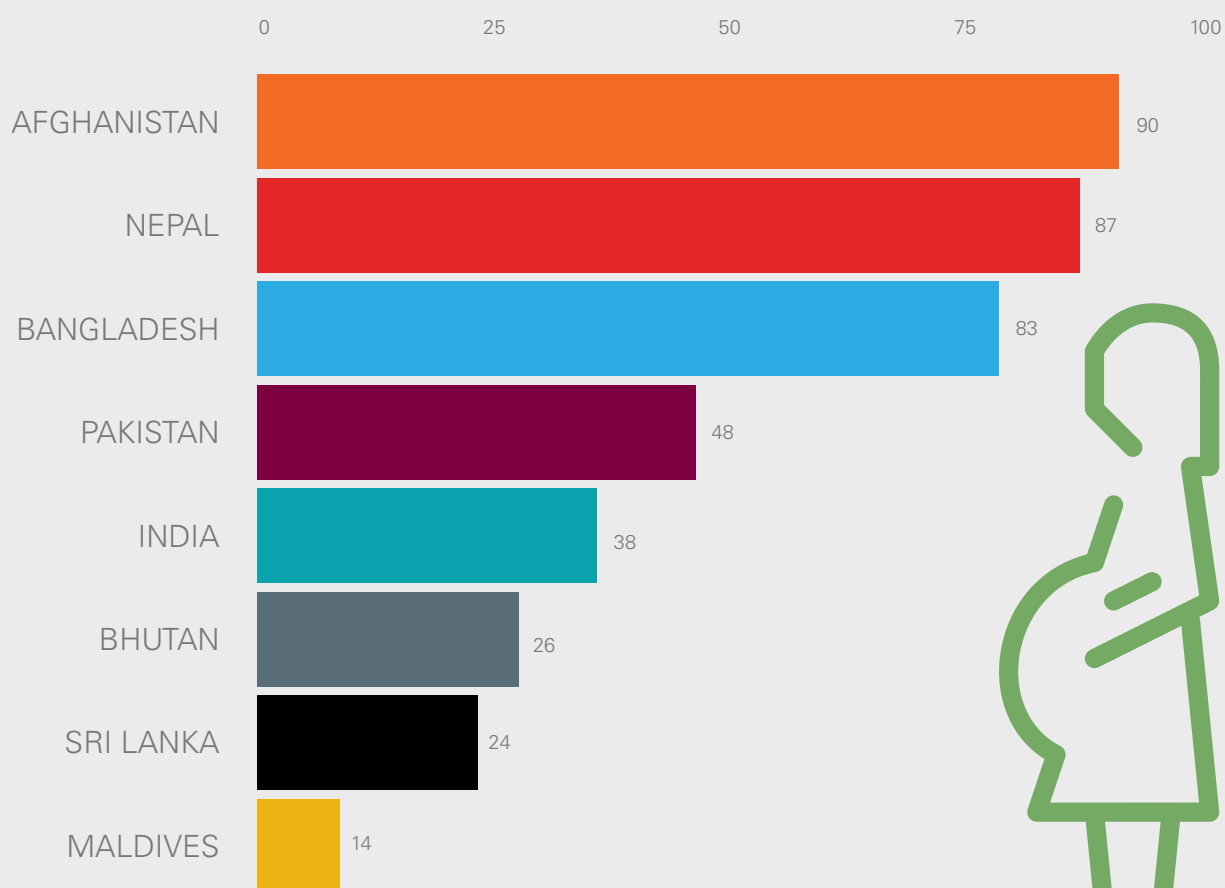
At least twice as many boys die from suicide than girls in Afghanistan, Bhutan and the Maldives



More girls die from suicide than boys in Bangladesh, India and Pakistan

Adolescent pregnancy rates remain high

Adolescent fertility rate (births per 1000 15-19 year olds)





Education and employment (Domain 4)

Available data demonstrate some important inequalities in educational and employment outcomes between girls and boys:

- With the exception of Afghanistan, girls have school attendance rates that are comparable or in some instances slightly better than those of boys.
- Gender disparities become more evident in secondary school completion, with boys being more likely than girls to complete secondary school in all countries.
- Girls and women are more likely than boys and men to not be in employment, education or training in adolescence and early adulthood. This gender gap is likely related to highly differentiated gender roles that allocate unpaid domestic and care work to women, and paid work to men.
- Women are underrepresented in teaching in most countries, particularly as schooling progresses, a factor related to gender-disparities in education completion rates, as well as gender-biased recruitment/hiring practices.

- In Bangladesh, India and Bhutan, a quarter or more of schools do not have basic sanitation facilities. This may be a barrier to attendance for girls, particularly during menstruation.

In summary, gains made in improving equity in education have not yet achieved equality in upper secondary schooling nor in the transition to employment and further training. This has the potential to undermine progress and entrench women and girls in poverty and socioeconomic disadvantage.

Girls are less likely to be in secondary school than boys

Secondary school aged children not in upper secondary school



Girls are much less likely to be in post-school employment, education or training than boys

15-24-year-olds not in employment, education or training (NEET)





Protection (Domain 5)

Available data show that girls and boys South Asia are not being adequately protected from violence, exploitation and abuse:

- Sex preference favouring boys is reflected in the sex imbalance at birth in India and Pakistan and excess female infant mortality in India.
- Child marriage is very common in this region, particularly in Bangladesh where three out of five girls, aged 20 – 24 years, are married before 18 years of age and one in five are married before 15 years of age.
- Available data suggest high rates of physical and/or sexual intimate partner violence, with one in three girls affected in Afghanistan and one in five in Pakistan.
- There is broad acceptance of violence against women by young people in the region.
- In countries with available data, around 80% of children have experienced violent discipline.
- Adolescent boys are at much greater risk of intentional homicide.
- Bullying is common in most countries, more so for boys in Bangladesh and Nepal.
- Girls have a greater burden of household chores.
- Girls and boys from marginalized and socio-economically vulnerable communities face a greater likelihood of violence and exploitation.

These findings reflect not only a failure of protective legislation in the region but also harmful social and gender norms. These norms include son-preference, the relegation of women and girls to domestic and reproductive roles, male dominance and masculine violence. The exposure of children to violence, exploitation and abuse likely shapes the harmful attitudes to domestic violence observed in adolescents.

Child marriage and intimate partner violence affect many girls

20-24-year-olds married by 18 years



BANGLADESH



AFGHANISTAN, NEPAL



BHUTAN, INDIA, PAKISTAN

Females, aged 15-19 years, who have experienced intimate partner violence in last 12 months



AFGHANISTAN



INDIA, NEPAL, PAKISTAN

More males die from homicide than girls

Homicide mortality, 10-19 years, deaths per 100,000

In some countries more than 4 times as many boys die as girls



AFGHANISTAN NEPAL BHUTAN



Safe environments (Domain 6)

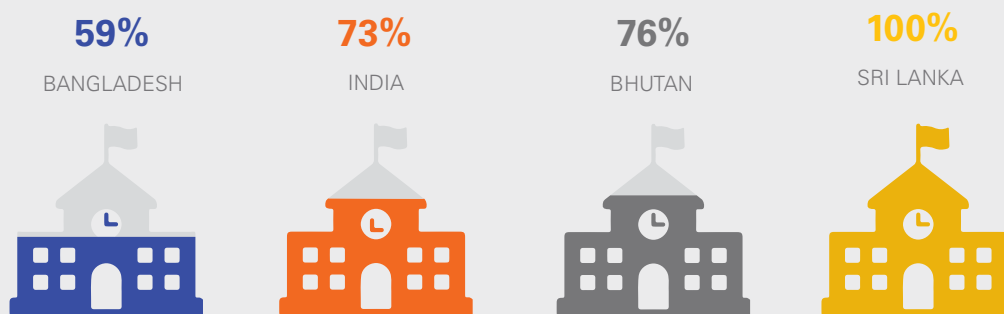
Data and indicators were most limited for this domain, however available data did demonstrate substantial gender inequality in the safety of environments that girls and boys grow up in:

- Household air pollution causes substantial harms for girls and boys in this region. Girls in this region come to greater harm despite boys being more biologically vulnerable. This may reflect gender and social norms that result in girls spending more time within the household and in labour-intensive activities that compromise their health, such as bending over an open, smoke-filled hearth for preparing meals.
- Improved sanitation facilities are not available in one in four schools in India and Bhutan and two in five in Bangladesh. Inadequate sanitation facilities place a disproportionate burden on girls' health and safety, particularly during menstruation.
- Girls in most countries in this region, and particularly in India, experience a larger burden of disease attributable to inadequate WASH than do boys.
- There are more than one million international child migrants across the region. In Bhutan and the Maldives (relatively developed countries) international migrants are more likely to be boys. These gender-differences may reflect patterns in child labour.
- Mobility is very limited for many adolescent girls: only one in five married girls in Nepal and Pakistan and two in five in Afghanistan and Bangladesh can make decisions to visit family and friends.
- Adolescent boys' increased traffic accident mortality reflects gender norms that encourage freedom, financial independence and risk taking among boys but limit girls' mobility.

The available data suggest substantial gender inequality in the safety of environments that girls and boys grow up in. Girls are perceived as more vulnerable and in need of protection from the environment, and this limits their mobility. They are more likely than boys to be tied to the home and engaged in domestic chores, including those related to inadequate WASH, such as collecting water. By contrast, while boys are more mobile and independent, masculine norms supportive of risk-taking and toughness also place them at risk of harm.

Many schools have inadequate sanitation

Schools with improved sanitation facilities



Mobility is limited for many girls

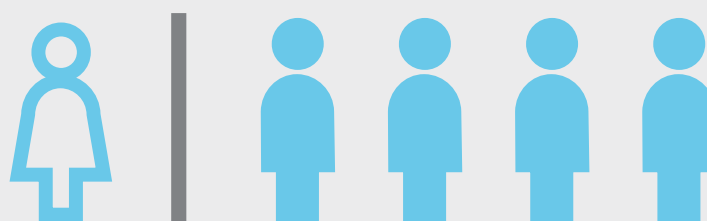
7 in 10 girls can't make decisions about visiting family or friends



More boys die from road traffic accidents than girls

Road traffic mortality, 10-19 years, deaths per 100,000

In some countries, more than four times as many boys die from road traffic accidents as girls



BANGLADESH NEPAL INDIA AFGHANISTAN

Key recommendations

This analysis provides the basis for four key recommendations:

Recommendation 1

Integrate priority gender indicators for children and adolescents into routine reporting

This analysis identified a key group of indicators where outcomes between girls and boys were substantially different, and/or indicators that measured key dimensions of gender inequality in child wellbeing. These are summarised in the Box R1 below. These indicators should be integrated into routine reporting, and given they are harmonized with current data availability, these indicators can be readily populated using existing data collection.



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BOX R1: PRIORITY INDICATORS TO TRACK PROGRESS TOWARDS GENDER EQUALITY THROUGH ROUTINE MONITORING

INDICATORS THAT TRACK CRITICAL GENDER DISPARITIES

Girls currently disadvantaged

- Prevalence of anaemia (Indicator 3.09)
- Suicide mortality rate per 100,000 population (Indicator 3.15)
- Adolescent birth rate (births per 1,000 females) among 15-19 year-olds (Indicator 3.20)
- School completion rate by level of schooling (Indicator 4.02)
- Youth literacy rate among 15-24 year-olds (Indicator 4.05)
- Proportion of youth (15-24 years) not in education, employment or training (%) (Indicator 4.12)
- Sex-ratio at birth (Indicator 5.01)
- Proportion of 20-24 year-olds who were married before 15 years and before 18 years (Indicator 5.06)
- Proportion of adolescents subjected to violence from an intimate partner in the previous 12 months (Indicator 5.11)
- Average number of hours children aged 5-17 years spend performing household chores per week (Indicator 5.22)
- Proportion of married 15-19 year-olds females who make decisions about visiting family and friends themselves or jointly with husband (Indicator 6.05)

Boys currently disadvantaged

- Injury-specific DALY rate among adolescents 10-19 years (Indicator 3.12c)
- Suicide mortality rate per 100,000 population (Indicator 3.15)
- Mortality rate due to intentional homicide among 10-19 year olds (Indicator 5.15)
- Mortality rate due to road traffic accidents among 10-19 year olds (Indicator 6.07)

Other indicators that track critical gender issues

- Proportion of female teachers, by level of schooling (Indicator 4.07)
- Proportion of schools with basic sanitation facilities (improved, single-sex and usable) (Indicator 4.08)
- Proportion of people aged 15-19 who justify wife beating (Indicator 5.13)
- Legal age of consent to sex (heterosexual and same-sex sexual relationships) (Indicator 5.07)
- Legal age of consent to marriage (Indicator 5.08)

Recommendation 2

Invest in gender data collection for children and adolescents in priority areas

The review has also identified critical gaps in data relevant to priority topics for promoting gender equality.

2a

Invest in developing and promoting use of standard indicators for priority topics

Additional investment is recommended to address data gaps in:

- wellbeing of children and adolescents with disability;
- sexual and reproductive health of adolescent boys, unmarried adolescent girls and boys, and girls and boys aged less than 15 years;
- menstrual health and hygiene;
- wellbeing of young people with diverse gender identity and sexual orientation; and
- individual-level indicators relating to urbanisation, conflict, disaster and climate change.

2b

Invest in collecting data against established indicators in areas with data gaps

There were indicators for which no country in the region had data, or indicators for which only modelled data were available (outlined in Box R2). These represent important areas for investment in primary data collection. Further, for the majority of indicators in this report it was not possible to disaggregate data by urban/rural status or ethnicity, two important determinants of gender inequality in this region. As such, efforts around data collection should ensure that these indicators can be further disaggregated.

2c

Invest in data collection methodologies appropriate to gender-diverse children and adolescents

There is a need to invest in developing sensitive and appropriate data collection strategies so as to be more inclusive of young people with diverse gender identity and sexual orientation. This would help increase the visibility of the experiences and needs of this vulnerable group of children and adolescents.

BOX R2:**INDICATORS WITH NO DATA, OR NO PRIMARY DATA, AVAILABLE IN SOUTH ASIA****Indicators with no data available:**

- HIV and sexuality education in lower and upper secondary schools (Indicators 4.06b, 4.06c)
- Informal sector employment (Indicator 4.14)
- Proportion of females, aged 20-24 years, who experienced forced sex by 18 years of age (%) (Indicator 5.12).
- Harassment and discrimination experienced by young people with diverse gender identity and sexual orientation (Indicators 5.17a, 5.17b)
- Prevalence of female genital mutilation/cutting among girls 0-14 years (Indicator 5.18)
- Number of detected trafficked children (indicator 5.19)
- Young people's perceptions of safety in their neighbourhoods (Indicator 6.06)

Indicators with only modelled data available:

- Anaemia (Indicator 3.09)
- Overweight and obesity (Indicator 3.11)
- DALY rates (all-cause and cause-specific) (Indicators 3.12, 3.16, 6.01, 6.02)
- NCD risk factors (binge drinking and tobacco smoking) (Indicators 3.13, 3.14)
- Suicide mortality rate (Indicator 3.15)
- Maternal mortality rate among 15-19 year olds (Indicator 3.21)
- Mortality due to intentional homicide (Indicator 5.15)
- Mortality due to road traffic accidents (Indicator 6.07)

Recommendation 3**Conduct additional research to understand observed gender disparities for children and adolescents**

This review focused on understanding how gender equality impacts on the health and wellbeing of children and adolescents across the region. It provides a cross-sectional snapshot using the most recent data. For some indicators, it may be beneficial to explore trends over time. This review also used comparable data for countries so as to build a regional profile of gender. An extension of this work may involve assembling country level profiles, drawing on the best available data at a country level. This may also include the analysis of sub-national trends, likely to be of value to local programming.

Recommendation 4**Address key drivers of gender inequality in the region**

The findings of this review indicate that the likely drivers of unequal outcomes for girls and boys in the region include: binary and unequal gender roles; gendered division of labour and associated restrictions on opportunities for both girls and boys; and norms around female passivity and compliance and male independence and risk taking. Further research will be invaluable to confirm and better understand how social norms and gender inequality contribute to these differences for girls and boys and to develop strategies moving forward.

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Introduction

Gender equality is critical to the health and wellbeing of children and adolescents

Asia and the Pacific is home to over half of the world's 2.3 billion children and adolescents, aged less than 18 years. They make up almost a third of the entire population in this region (Figure A).^{1,2} This review considers the impact of gender inequality on these girls and boys, with the focus of this report being those living in the South Asia sub-region. Other reports are available for the Central Asia, East and Southeast Asia and Pacific sub-regions.

In South Asia, an estimated 620 million children and adolescents (295 million girls and 325 million boys) reside in low- and middle-income countries (LMICs) Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka. The countries with the largest under-18 populations are India (213 million), Pakistan (38 million) and Bangladesh (28 million). The proportion of children and adolescents varies from 28% of the population in the instance of the Maldives, to 52% in Afghanistan (Figure A). In all countries, there are more boys than girls.

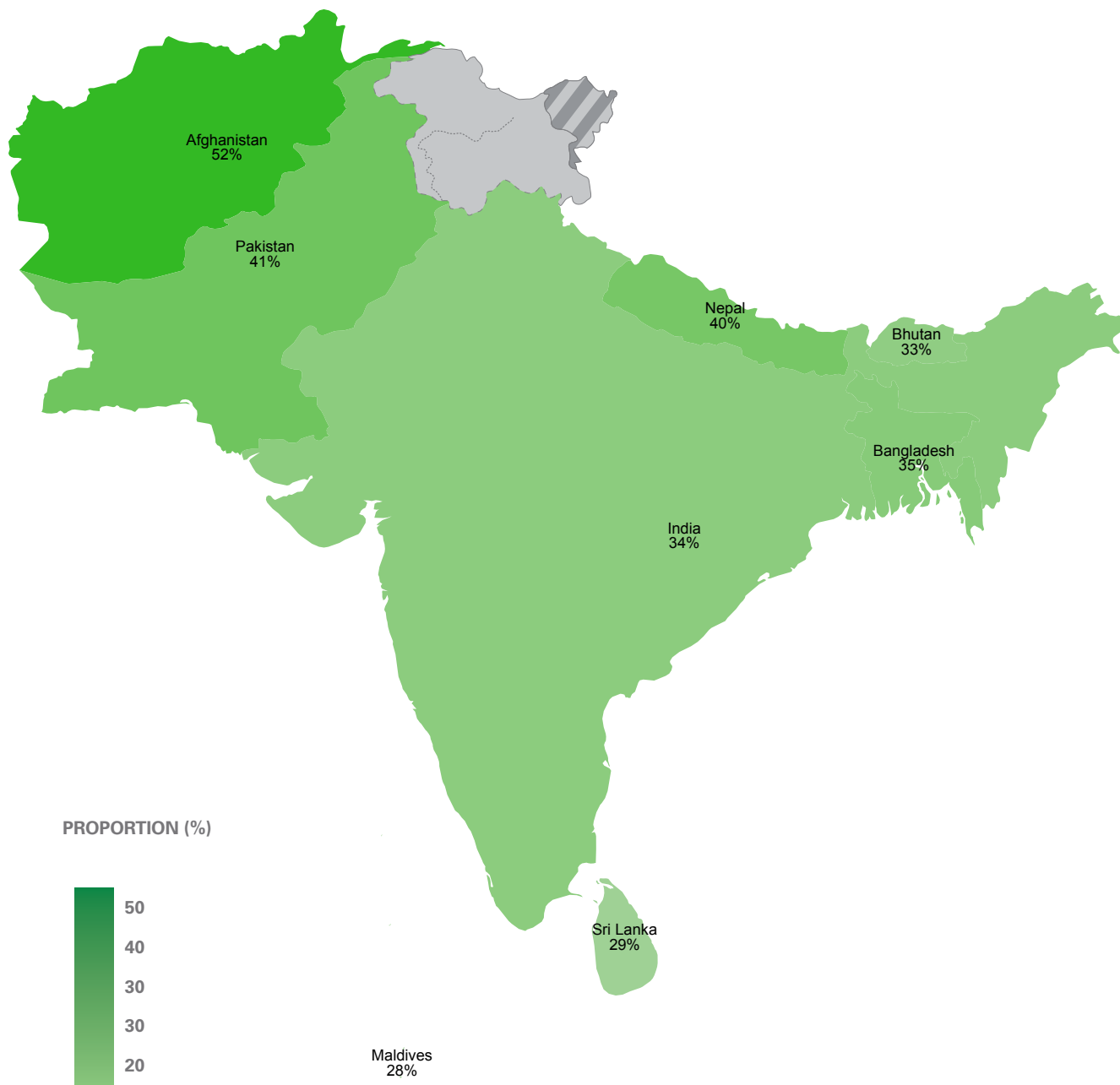
UNDER-18-YEAR-OLDS IN EACH COUNTRY BY SEX

FEMALE		MALE
212,685,000	INDIA	237,015,000
37,527,000	PAKISTAN	40,461,000
27,971,000	BANGLADESH	29,220,000
8,514,000	AFGHANISTAN	8,974,000
5,524,000	NEPAL	5,805,000
3,003,000	SRI LANKA	3,047,000
129,000	BHUTAN	132,000
56,000	MALDIVES	59,000

FIGURE A: POPULATION AGED UNDER 18 YEARS IN SOUTH ASIA.

The map shows the proportion of the population aged under-18 years.

The data table reports the number of under-18-year-olds in each country by sex. (source: UNPD 2015)



This map is for illustrative purposes only and does not reflect a position by the United Nations or other collaborative organizations on the legal status of any country or territory or the delimitation of any boundaries. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties

Significant progress has been made in many countries towards poverty reduction, child survival and universal education. However, considerable challenges remain to ensuring the health and wellbeing of children and adolescents and to reduce increasing inequality between and within countries. A key challenge is achieving gender equality which is central to improving outcomes for girls and boys and identified as one of the most fundamental issues for sustainable development at a regional level.³ This is particularly true for girls, for whom persistent and pervasive low status and discrimination contribute to poor health, educational, social and economic outcomes that extend across the life-course into adulthood and to the next generation.

Pervasive gender discrimination contributes to poor health, education, social and economic outcomes for girls that extends across their life-course and the next generation

Governments and development partners across South Asia have committed to respect and ensure the rights of every child⁴ and to accelerate progress towards gender equality. The Convention on the Elimination of All Forms of Discrimination Against Women,⁵ the Fourth World Conference on Women and the Beijing Platform for Action,⁶ and more recently, the Sustainable Development Goals and Agenda 2030, have helped to focus efforts around gender equality. The Sustainable Development Goals

in particular, provide a new opportunity to measure, monitor and hold governments accountable in this regard.⁷ Further to gender equality and women's empowerment being included as a stand-alone goal (SDG5) with its own indicators and targets, there is also a recommendation to measure and track progress for women and girls across all other goals and targets.

Despite these commitments, women and girls across Asia and the Pacific, including South Asia, continue to face household, societal, cultural, institutional and political barriers that violate their rights and limit their potential.⁸ A potential barrier to action for gender equality has been a lack of well-defined indicators and data so as to enable accountable policy response. In particular, there is limited information about how gender-inequality impacts the health and wellbeing for children and adolescents in the region. An understanding of gender inequality early in the life-course is important not only because this is when disadvantages first emerge, but also because it is when gender norms are internalised.

A lack of well-defined indicators and data for accountable policy responses has been a barrier to ensuring gender equality for children and adolescents.

A quantitative assessment of gender inequality is needed to inform policy and action

Several existing global and regional frameworks include indicators to measure and monitor women and girls' empowerment and gender equality (see *Appendix 1*). While many include some gender indicators specific to children and adolescents, they do not provide a comprehensive assessment of gender issues impacting children and adolescents.

The need for comprehensive, valid and reliable gender data to inform policy, enable monitoring and ensure accountability has been noted by governments at a regional level.⁸ However, to date, there has been limited systematic analysis of nationally comparable data related to gender inequality and its impacts on children and adolescents. While progress has been made to improve the collection and reporting of gender data, many gaps still exist. Two-thirds of the SDG indicators relevant to girls are limited or non-existent.^{9,10} Reported data gaps with respect to gender include, among others, accurate information on maternal deaths; data on violence against women and girls; girls' transition from education to workforce and what happens to those who do not enter employment; the gender aspects of conflict; the unmet need for contraception for girls neither married or in an union; adolescent fertility for girls 10-14 years of age; and girls' challenges in managing menstruation.^{9,11} Gaps in gender statistics and indicator frameworks mean that there are likely to be critical gender issues not readily visible through currently reported data.

The need for comprehensive, valid and reliable gender data to inform policy, enable monitoring and ensure accountability has been noted by governments at a regional level

Even when data is available, poorly defined indicators, lack of validated measures and limited age and sex disaggregation of data are noted challenges.¹² Traditional gender roles can introduce bias into survey design. For example, when estimating women's informal economic behaviour and unpaid activities or when male family members respond to surveys on behalf of other household members.¹³ To fully appreciate the impacts of gender inequality on children and adolescents, there is a need to conduct a broad and comprehensive review that encompasses multiple domains of wellbeing, and identifies issues that are of importance to both girls and boys. This approach aligns with the focus of the Sustainable Development Goals on assessing gender norms, roles and relations and their impact at an institutional and societal level.

Approach and Methods

Purpose of this report

The **purpose** of this report is to review gender inequality and its impact on children and adolescents (defined here as below the age of 18) in low- and middle-income countries in South Asia, as part of a broader initiative to review gender inequality and its impact across Asia and the Pacific (including the Central Asia, South Asia, East and Southeast Asia, and Pacific sub-regions – see Box A). While

the primary focus is to identify and describe gender inequality and gender issues that are of critical importance to girls, the review also identifies harmful gender norms and roles that impact boys. Current data non-availability means it is not possible to report on factors affecting gender diverse young people for the region, which is an important gap both in the report and in available data.

BOX A. LOW & MIDDLE INCOME COUNTRIES OF ASIA AND THE PACIFIC, BY SUBREGION¹⁴

Central Asia

Kazakhstan
Kyrgyzstan
Tajikistan
Turkmenistan
Uzbekistan

South Asia

Afghanistan
Bangladesh
Bhutan
India
Maldives
Nepal
Pakistan
Sri Lanka

East and Southeast Asia

Cambodia
China
DPR Korea
Indonesia
Lao PDR
Malaysia
Mongolia
Myanmar
Philippines
Thailand
Timor-Leste
Viet Nam

Pacific

Cook Islands
Fiji
Kiribati
Marshall Islands
Micronesia
Niue
Nauru
Palau
Papua New Guinea
Samoa
Solomon Islands
Tokelau
Tonga
Tuvalu
Vanuatu

The **aim** of this work is to provide a comprehensive profile of how gender inequality impacts children and adolescents for countries in each of the four sub-regions, using available national-level quantitative data.

The specific **objectives** are to:

- 1** Identify and define a core set of gender-relevant indicators for children and adolescents in Asia and the Pacific, harmonised with available data;
- 2** Identify and describe the extent of gender inequality affecting children and adolescents in the region; and
- 3** Identify key data and knowledge gaps relating to gender inequality in children and adolescents.



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Scope and overarching principles

This report focuses on children below the age of 18, as defined by UNICEF and the Convention on the Rights of the Child, in the eight low and middle-income countries of South Asia. This age range includes several important age groups and developmental stages including infancy (under 12 months of age), early childhood (0-8 years of age), and adolescence (10-19 years of age). For the purposes of this review, persons aged above 10 years but below 18 years are referred to as 'adolescents' and those aged less than 10 years as 'children'. For many indicators included in this review, estimates were only available for 15-19 or 15-24-year-olds (youth), and these are presented as such.

To provide a meaningful picture of the impact of gender inequality on children and adolescents, a conceptual framework was developed. Against this framework, key indicators were then defined, harmonised with global frameworks and data availability. This approach allows not only an assessment of gender inequalities but also identification of critical issues where data and indicators are currently limited.

The following principles have guided the approach of the review:

1

This review is an important initial step to determine the availability of existing data, and to make better use of available data to identify issues of critical importance.

2

This review is not intended to be an exhaustive, in-depth analysis of gender issues and their determinants in this region. This review is limited to analysis of the available quantitative, national-level, comparable data to identify the key gender issues in this region that are of direct relevance to children and adolescents. We hope that the identification of key issues will help inform further analyses around why these gender inequalities have arisen, what can be done to address them and what additional data are needed in order to gain a comprehensive understanding of the respective gender issues in the region.

3

The review aims to identify and define a core set of indicators, harmonised with existing indicator frameworks and data availability, that allow critical aspects of gender inequality to be identified, compared across countries and sub-regions, and further described.

4

Data for some countries is limited for many indicators of interest. To provide as comprehensive a profile as possible, modelled estimates are used where primary sourced databases are not available. Where included, modelled data are clearly identified.

In this report, we have adopted the pragmatic approach of drawing on national-level data from established databases wherever possible. The reporting of national data may have masked important gender disparities at a sub-national level and for other social groups. The use of datasets may also have resulted in some more recent data sources not being included. Where possible, we have aimed to amend this with the assistance of stakeholders. Further, we have focused our analysis on the most recent estimate for each indicator, only showing trends over time for select indicators.

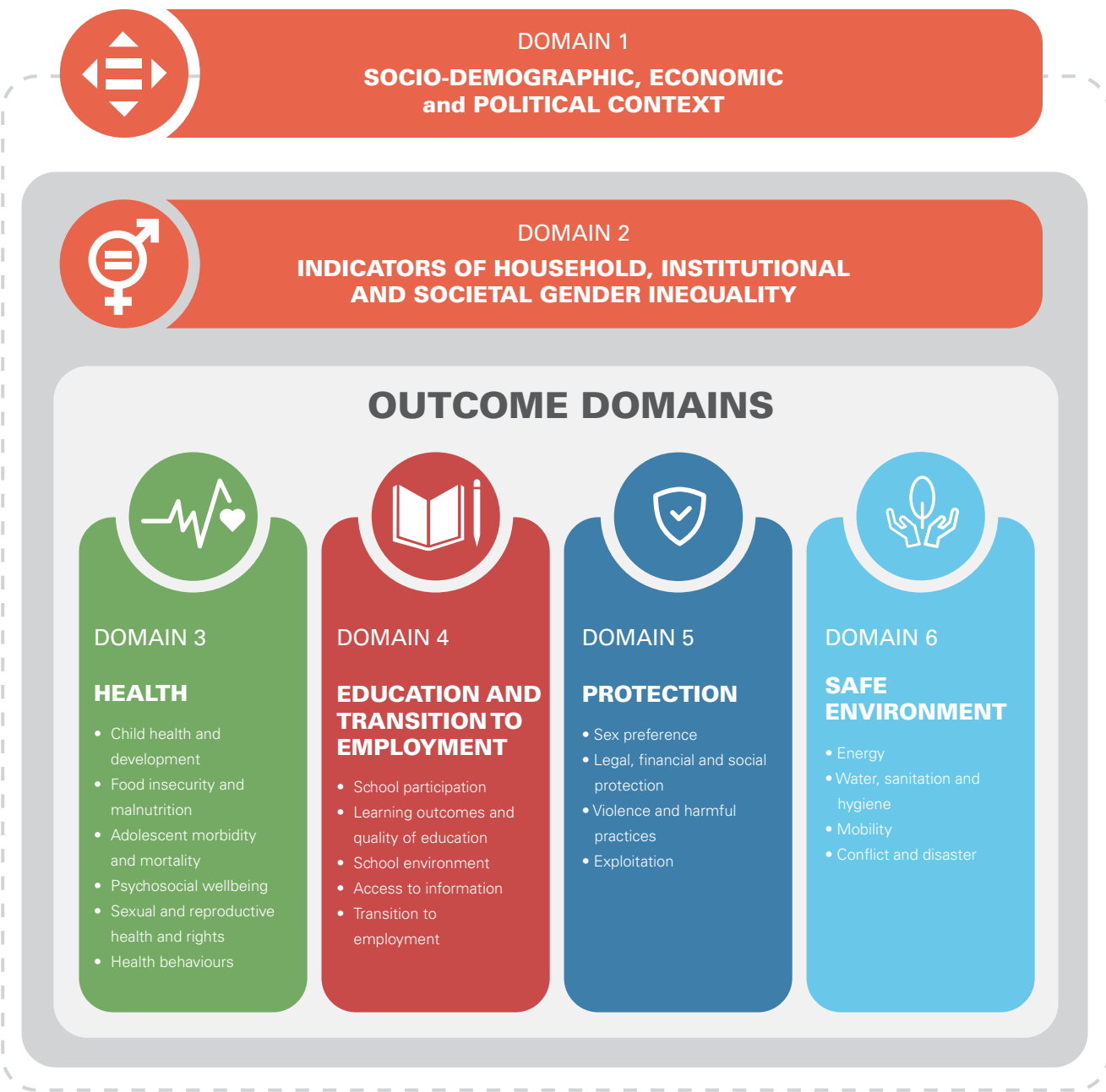
Conceptual framework

Figure B details the conceptual framework used to guide indicator selection for this review. This framework was defined through a review of the literature and existing indicator frameworks (see Appendix 1). In addition, extensive consultation was undertaken with key sub-

regional, regional and global stakeholders. This framework takes a socio-ecological approach to understanding gender inequality and its impacts,¹⁵ recognising that gender inequality is a social system that operates at multiple levels giving rise to unequal outcomes between girls and boys.

FIGURE B: CONCEPTUAL FRAMEWORK

This conceptual framework identifies the key domains of gender and gender inequality to be measured for children and adolescents in this analysis.



Six domains were defined, at two broad levels:

(i) Contextual domains

The first two domains of the framework measure the broader context in which gender inequality manifests and is perpetuated. The first domain in the framework is designed to capture the political, economic and socio-demographic context in which children live, and in which unequal gender norms, roles and power relations influence child outcomes. The second domain in the framework is designed to capture the gendered environment in which children live and is focused on gender inequality at household, institutional and societal levels.

(ii) Outcome domains

The remaining four domains relate to how gender inequality impacts on health and wellbeing at an individual level: health; education and transition to employment; protection; and safe environment. They measure key outcomes for children and adolescents, as well as critical social and behavioural determinants of wellbeing across the life-course. There is intentionally considerable overlap between the conceptual framework and the goals and targets of the SDGs (Figure C).

Within each domain, sub-domains were identified through a review of the literature and existing conceptual and indicator frameworks (see Appendix 1) and based on extensive consultation with regional stakeholders.



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FIGURE C: INTERSECTION BETWEEN SDGS AND THE CONCEPTUAL FRAMEWORK

This figure summarises the intersection between the conceptual framework domains and SDGs. Shaded areas indicate SDG indicators that explicitly address the conceptual framework sub-domains and proposed indicators for this review.

		CONTEXTUAL DOMAINS 1-2		OUTCOME DOMAINS 3-6			
		Socio-economic Context	Gender Inequality Context	Health	Education and Employment	Protection	Safe Environment
1	NO POVERTY	●		●			●
2	ZERO HUNGER	●		●			
3	GOOD HEALTH AND WELLBEING		●	●		●	●
4	QUALITY EDUCATION		●		●		●
5	GENDER EQUALITY		●	●	●	●	●
6	CLEAN WATER AND SANITATION		●		●		●
7	AFFORDABLE AND CLEAN ENERGY						●
8	DECENT WORK AND ECONOMIC GROWTH		●		●		●
9	INDUSTRY, INNOVATION AND INFRASTRUCTURE				●		
10	REDUCED INEQUALITIES	●	●			●	
11	SUSTAINABLE CITIES AND COMMUNITIES	●					●
12	RESPONSIBLE CONSUMPTION AND PRODUCTION						
13	CLIMATE ACTION						●
14	LIFE BELOW WATER						
15	LIFE ON LAND						
16	PEACE, JUSTICE AND STRONG INSTITUTIONS	●	●				●
17	PARTNERSHIPS FOR THE SDGs				●		

Indicators to measure gender inequality

For each sub-domain of the conceptual framework, indicators were selected to measure gender inequality among children and adolescents using criteria defined in Box B. It should be noted that data availability was an important consideration in defining these indicators given the aim of this task was to profile gender inequality as best as possible. Indicators were defined in consultation with sub-regional, regional and global stakeholders, and through a review of existing literature and frameworks (see Appendix 1). The indicators defined for this analysis are detailed in Table B.

BOX B: CRITERIA USED TO DEFINE INDICATORS

Adapted from criteria for the SDGs^{16,17} and UN MSG¹²

- Harmonised with existing global and regional indicator frameworks;
- Conceptually clear, well defined and measurable;
- Nationally-comparable;
- Address issues of importance with respect to gender equality in Asia and the Pacific;
- Policy-relevant;
- Data (including age- and sex-disaggregated data where applicable) available for countries in this region.

Many relevant issues were not included in the indicator framework due to a lack of defined indicators and/or lack of age- and sex-disaggregated data for this region (Tier II or III SDG indicators). These include: individual-level indicators of poverty, financial protection, educational achievement and quality, menstrual health and hygiene, prevalence of disability and wellbeing of children and adolescents with disability, sexual and reproductive health of children aged under 15 years and adolescent boys, wellbeing of young people with diverse gender identity and sexual orientation, and the individual-level impacts of conflict, disaster and climate change, urbanisation and food security. Furthermore, the definition of some indicators needed to be restricted to align with data availability. For example, the indicator for adolescent birth rate was initially defined for girls aged 10-19 years, to align with SDG indicator 3.7.2. However, data is scarce for those aged 10-14 years, and inclusion potentially introduces substantial measurement error into estimates. The indicator was therefore revised to the adolescent birth rate for girls aged 15-19 years to provide better quality data.

Many relevant gender issues could not be assessed because of a lack of indicators and/or data.

TABLE B: INDICATORS TO IDENTIFY GENDER INEQUALITY AND ITS CONSEQUENCES FOR GIRLS AND BOYS

This table shows indicators as aligned with domains and sub-domains of the conceptual framework. The short-label for indicators is also shown. All indicators are disaggregated by sex where possible.

1. SOCIO-DEMOGRAPHIC, ECONOMIC AND POLITICAL CONTEXT		
SUB-DOMAIN	INDICATOR	SHORT LABEL
DEMOGRAPHY	1.01a Population aged under 18 years (in 1000s), by sex	Population <18y (1000s)
	1.01b Proportion of total population aged under 18 years (%), by sex	Proportion of population <18y (%)
	1.01c Ratio of girls to boys aged under 18 years	Ratio of girls to boys aged <18y
	1.01d Population difference between girls and boys aged under 18 years (in 1000s)	Population difference of <18y (girls – boys, 1000s)
SOCIOECONOMIC AND HUMAN DEVELOPMENT	1.02 Proportion of total population below international poverty line of \$US1.90 per day (%)	Proportion living in poverty, total population (%)
	1.03 Human Development Index	Human Development Index
	1.04 Prevalence of severe food insecurity in the total population (%)	Prevalence of severe food insecurity, total population (%)
	1.05 Proportion of the population living in urban areas (%)	Proportion urban, total population (%)
	1.06 Total annual net migration rate (per 1000)	Migration rate, total population (per 1000 annually)
GOVERNMENT EXPENDITURE	1.07 Government expenditure on health as a percentage of GDP	Health expenditure (% GDP)
	1.08 Government expenditure on education as percentage of GDP	Education expenditure (% GDP)

2. HOUSEHOLD, INSTITUTIONAL AND SOCIETAL GENDER INEQUALITY		
SUB-DOMAIN	INDICATOR	SHORT LABEL
TIME USE AND DIVISION OF LABOUR	2.01 Average number of hours per day spent on unpaid domestic and care work among 15 to 49-year-olds, by sex	Unpaid work, 15-49y (hours per day)
	2.02 Average number of hours spent per day on paid and unpaid domestic work combined among 15 to 49-year-olds, by sex	Total work, 15-49y (hours per day)
	2.03 Proportion of households where a person over 15 years of age is usually responsible for water collection (%), by sex	Adult collects water for household, >15y (%)
ACCESS AND CONTROL OVER RESOURCES	2.04 Average monthly earnings of employees aged 15-49 years (\$USD), by sex	Average monthly earnings, 15-49y (\$USD)
	2.05 Proportion married/partnered women, aged 15-49 years, in paid work, who make decisions about how earnings are used, themselves or jointly with husband (%)	Married women in paid work who can decide spending, 15-49y (%)
	2.06 Proportion of adults aged over 15 years who own a bank account (%), by sex	Own bank account, >15y (%)



INTRA-HOUSEHOLD DECISION-MAKING	2.07 Proportion of married/partnered women, aged 15-49 years, who make decisions about healthcare, themselves or jointly with husband (%)	Can decide healthcare, married women 15-49y (%)
	2.08 Proportion of married/partnered women, aged 15-49 years, who make decisions about major household purchases, themselves or jointly with husband (%)	Can decide household purchases, married women 15-49y (%)
WOMEN'S PARTICIPATION IN PUBLIC LIFE	2.09a Proportion of seats held by women in the lower house of national parliament (%)	Proportion lower house seats held by women (%)
	2.09b Proportion of seats held by women in the upper house of national parliament (%)	Proportion upper house seats held by women (%)
	2.10 Proportion of police officers who are female (%)	Proportion of police who are female (%)
VIOLENCE AGAINST WOMEN	2.11 Women who have experienced physical and/or sexual violence by an intimate partner in last 12 months (%)	Women experiencing IPV last 12m (%)
	2.12 Proportion of 15 to 49-year-olds who think that a husband is justified to beat his wife for at least one specific reason (%), by sex.	Proportion who think husband is justified to beat wife, 15-49y (%)
WOMEN'S BODILY AUTONOMY	2.13 Legality of abortion - index from 0 (not legal any circumstance) to 100 (legal on request and no restriction)	Abortion legality index (0-100)
	2.14 Proportion of women of reproductive age, aged 15-49 years, married or in a union, who have their need for family planning satisfied with modern methods (%)	Contraception demand satisfied, married women 15-49y (%)
	2.15 Proportion of women of reproductive age, 15-49 years, married or in a union, who can say no to sex with their husband (%)	Married women who can say no to sex with husband, 15-49y (%)
ACCESS TO PUBLIC SPACES AND SERVICES	2.16a Mean years of schooling (ISCED 1 or higher), population aged 25+ years, by sex	Mean years education, >25y
	2.16b Mean years of education in age-standardised population (modelled), by sex	Mean years education, age-standardised (modelled)
	2.17a Percentage of women, aged 15-49 years, attended at least once during pregnancy by skilled health personnel (doctor, nurse or midwife)	One antenatal visit, 15-49y (%)
	2.17b Percentage of women, aged 15-49 years, attended at least four times during pregnancy by skilled health personnel (doctor, nurse or midwife)	Four antenatal visits, 15-49y (%)
	2.18 Proportion of married/partnered women, aged 15-49 years, who make decisions about visiting family/friends themselves or jointly with husband (%)	Married women make decisions visiting family or friends, 15-49y (%)
INSTITUTIONAL MECHANISMS FOR THE ADVANCEMENT OF WOMEN AND GENDER EQUALITY	2.19 Existence of national legislation that explicitly criminalises marital rape (yes=1, no=0)	Marital rape criminalised (yes=1, no=0).
	2.20a Social Institutions Gender Index score (lower score indicates lower discrimination of women)	Social Institutions Gender Index (lower score is better)
	2.20b Social Institutions Gender Index, categories indicating level of discrimination	Social Institutions Gender Index, categories
GENDER GAP IN HUMAN DEVELOPMENT	2.21 Gender Development Index (score of 1 indicates parity between males and females in the Human Development Index)	Gender Development Index (higher score better)
	2.22 Gender Inequality Index (lower scores indicate less inequality between males and females)	Gender Inequality Index (lower score better)
	2.23 Global Gender Gap Index (score of 1 indicates parity between males and females)	Global Gender Gap Index (higher score better)



3. HEALTH

SUB-DOMAIN	INDICATOR	SHORT LABEL
CHILD HEALTH AND DEVELOPMENT	3.01 Number of deaths of children under 5 years of age per 1000 live births, by sex	Deaths in <5y per 1000 births
	3.02 Expected to estimated mortality rate for females under 5 years of age	Expected : estimated mortality for females <5y
	3.03 Proportion of children, aged 12-23 months, who have received all basic vaccinations (BCG, MCV1, DTP3, Polio3) (%), by sex	Vaccine coverage (all) in 2y (%)
	3.04 Proportion of children, aged 12-23 months, who have received BCG (%), by sex	Vaccine coverage (BCG) in 2y (%)
	3.05 Proportion of children, aged 12-23 months, who have received MCV1 (%), by sex	Vaccine coverage (Measles) in 2y (%)
	3.06 Proportion of children under 5 years of age with fever in the last two weeks for whom advice or treatment was sought from a health facility or provider (%), by sex	Care seeking for fever in <5y (%)
	3.07 Proportion of children, aged 0-59 months, left alone or in the care of another child younger than 10 years of age for more than one hour at least once in the past week (%), by sex	Inadequate supervision of child, 0-59m (%)
FOOD SECURITY AND NUTRITION	3.08 Proportion of children under 5 years of age with stunting (<-2 SD from median height for age) (%), by sex	Stunting in <5y (%)
	3.09a Prevalence of anaemia for 0-19-year-olds (based on WHO age and sex specific haemoglobin thresholds) (%), by sex	Anaemia 0-19y (%)
	3.09b Prevalence of anaemia for 0-4-year-olds (based on WHO age and sex specific haemoglobin thresholds)(%), by sex	Anaemia 0-4y (%)
	3.09c Prevalence of anaemia for 5-9-year-olds (based on WHO age and sex specific haemoglobin thresholds) (%), by sex	Anaemia 5-9y (%)
	3.09d Prevalence of anaemia for 10-14-year-olds (based on WHO age and sex specific haemoglobin thresholds) (%), by sex	Anaemia 10-14y (%)
	3.09e Prevalence of anaemia for 15-19-year-olds (based on WHO age and sex specific haemoglobin thresholds) (%), by sex	Anaemia 15-19y (%)
	3.10 Prevalence of thinness among 5–19-year-olds (BMI < -2 standard deviations below the median of reference population) (%), by sex	Thinness 5–19y (%)
	3.11 Prevalence of overweight among 5-19-year-olds (BMI > +1 standard deviations above the median) (%), by sex	Overweight 5–19y (%)
ADOLESCENT MORBIDITY AND MORTALITY	3.12a DALY rate due to all causes amongst 10-19-year-olds (DALYs per 100,000), by sex	Total DALYs per 100,000 in 10-19y
	3.12b DALY rate due to communicable, maternal and nutritional disease amongst 10-19-year-olds (DALYs per 100,000), by sex	Group 1 DALYs per 100,000 in 10-19y
	3.12c DALY rate due to injuries amongst 10-19-year-olds (DALYs per 100,000), by sex	Injury DALYs per 100,000 in 10-19y
	3.12d DALY rate due to NCDs amongst 10-19-year-olds (DALYs per 100,000), by sex	NCD DALYs per 100,000 in 10-19y
HEALTH BEHAVIOURS	3.13 Proportion of 15-19-year-olds who report an episode of binge drinking (>48g females, 60g males) in the last 12 months (%), by sex	Binge drinking, 15-19y (%)
	3.14 Prevalence of daily tobacco smoking among 10-19-year-olds (%), by sex	Daily tobacco smoking, 10-19y (%)



PSYCHOSOCIAL WELLBEING	3.15 Suicide mortality rate among 10-19-year-olds (deaths due to intentional self-harm per 100,000 population per year), by sex	Suicide mortality per 100,000 in 10-19y
	3.16 DALY rate due to mental disorder among 10-19-year-olds (DALYs per 100,000), by sex	Mental disorder DALYs per 100,000 in 10-19y
	3.17 Proportion of 13-17-year-olds who report being so worried about something that they could not sleep at night most of the time or always in the past 12 months (%), by sex	Significant worry last 12m in 13-17y (%)
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS	3.18a Demand for contraceptives satisfied with a modern method in females 15-24 years of age (%)	Demand for modern contraception satisfied 15-24y (%)
	3.18b Demand for family planning satisfied with modern methods in females 15-19 years of age (%)	Demand for family planning satisfied 15-19y (%)
	3.19 Proportion of females, 15-19 years of age, married/partnered who can say no to sex with their husband/partner (%)	Married 15-19y females can refuse sex (%)
	3.20a Number of live births per 1000 females aged 15-19 years (SOWC)	AFR 15-19y per 1000 (measured)
	3.20b Number of live births per 1000 females aged 15-19 years (GBD)	AFR 15-19y per 1000 (modelled)
	3.21 Mortality rate due to maternal disorders among 15-19-year-olds (Deaths per 100,000)	Maternal mortality rate per 100,000 in 15-19y
	3.22a Annual number of new cases of HIV in adolescents aged 15-19 years, by sex	New cases of HIV in 15-19y
	3.22b.1 HIV prevalence in sex workers under 25 years of age (%)	HIV in sex workers < 25y (%)
	3.22b.2 HIV prevalence in men who have sex with men under 25 years of age (%)	HIV in MSM < 25y (%)
	3.22b.3 HIV prevalence in transgender people under 25 years of age (%)	HIV in transgender people < 25y (%)
	3.22b.4 HIV prevalence in injecting drug users under 25 years of age (%)	HIV in injecting drug users < 25y (%)
	3.23 Proportion of 15-19-year-olds with comprehensive knowledge of HIV (%), by sex	Comprehensive knowledge of HIV in 15-19y (%)
	3.24 Existence of a national HPV vaccination program	Existence of HPV program



4. EDUCATION AND TRANSITION TO EMPLOYMENT

SUB-DOMAIN	INDICATOR	SHORT LABEL
SCHOOL PARTICIPATION	4.01a Adjusted net attendance ratio: primary school (number of children attending primary or secondary school who are of official primary school age, divided by number of children of primary school age) (%), by sex	Adjusted net attendance ratio, primary school (%)
	4.01b Adjusted net attendance ratio: lower secondary school (number of children attending lower secondary or tertiary school who are of official lower secondary school age, divided by number of children of lower secondary school age) (%), by sex	Adjusted net attendance ratio, lower secondary school (%)
	4.01c Adjusted net attendance ratio: upper secondary school (number of children attending upper secondary or tertiary school who are of official upper secondary school age, divided by number of children of upper secondary school age) (%), by sex	Adjusted net attendance ratio, upper secondary school (%)
	4.02a Completion rate for primary school (household survey data) (%), by sex	Completion rate, primary school (%)
	4.02b Completion rate for lower secondary school (household survey data) (%), by sex	Completion rate, lower secondary school (%)
	4.02c Completion rate for upper secondary school (household survey data) (%), by sex	Completion rate, upper secondary school (%)
	4.03a Proportion not in school: primary school (number of children of primary school age who are not enrolled in primary or secondary school, as a proportion of primary school aged children) (%), by sex	Not in school, primary school (%)
	4.03b Proportion not in school: lower secondary school (number of children of lower secondary school age who are not enrolled in secondary school, as a proportion of lower secondary school aged children) (%), by sex	Not in school, lower secondary school (%)
	4.03c Proportion not in school: upper secondary (using household survey data) (%), by sex	Not in school, upper secondary school (%)
	4.04 Pre-primary education: Number of children enrolled in pre-primary school (regardless of age) as a proportion of all children of pre-primary school age (%), by sex	Pre-primary school enrolment (%)
LEARNING OUTCOMES AND QUALITY OF EDUCATION	4.05 Proportion of 15-24-year-olds who are literate (%), by sex	Youth literacy, 15-24y (%)
	4.06a Proportion of primary schools that provide life skills-based HIV and sexuality education (%)	Primary schools teaching sex education (%)
	4.06b Proportion of lower secondary schools that provide life skills-based HIV and sexuality education (%)	Lower secondary schools teaching sex education (%)
	4.06c Proportion of upper secondary schools that provide life skills-based HIV and sexuality education (%)	Upper secondary schools teaching sex education (%)
SCHOOL ENVIRONMENT	4.07a Proportion of primary school teachers who are female (%)	Female primary school teachers (%)
	4.07b Proportion of lower secondary school teachers who are female (%)	Female lower secondary teachers (%)
	4.07c Proportion of upper secondary school teachers who are female (%)	Female lower secondary teachers (%)
	4.08 Proportion of schools with basic sanitation facilities (improved, single-sex and usable) (%)	Schools with improved sanitation facilities
ACCESS TO DIGITAL INFORMATION	4.09 Proportion of adolescents, aged 15-19 years, who own a mobile phone (%), by sex	Mobile phone ownership, 15-19y (%)
	4.10 Proportion of adolescents, aged 15-19 years, who used the internet in the last 12 months (%), by sex	Internet used last 12mth, 15-19y (%)
	4.11 Proportion of adolescents, aged 15-19 years, with access to information media (newspaper, TV or radio) at least once a week (%), by sex	Weekly access to information media, 15-19y (%)
TRANSITION TO EMPLOYMENT	4.12 Proportion of youth, aged 15-24 years, not in education, employment or training (%), by sex	Not in education, employment or training, 15-24y (%)
	4.13 Proportion of youth, aged 15-24 years, currently unemployed as a percent of the total number of employed and unemployed persons (the labour force) (%), by sex	Proportion of labour force unemployed, 15-24y (%)
	4.14 Proportion of employed persons, aged 15-24 years, in the informal sector (%)	Proportion employed in informal sector, 15-24y (%)

5. PROTECTION

SUB-DOMAIN	INDICATOR	SHORT LABEL
SEX PREFERENCE	5.01 Sex-ratio at birth (number of male births per one female birth)	Sex ratio at birth (male : female)
	5.02 Infant mortality rate (Probability of dying between birth and exactly 1-year-of-age, expressed per 1000 live births), by sex	Infant mortality rate (per 1000 births)
	5.03 Expected to estimated female infant mortality rate ratio (ratio less than 1 suggests excess female infant mortality)	Expected to estimated female infant mortality ratio
LEGAL, FINANCIAL AND SOCIAL PROTECTION	5.04 Proportion of children under five years whose birth has been registered with a civil authority (%), by sex	Birth registration in <5y (%)
	5.05 Proportion of children aged 0-17 years who live with neither biological parent (%), by sex	Children not living with biological parent, 0-17y (%)
	5.06a Child marriage: proportion of 20-24-year-olds who were married before 15yrs (%), by sex	Child marriage before 15y (%)
	5.06b Child marriage: proportion of 20-24-year-olds who were married by 18years (%), by sex	Child marriage <18y (%)
	5.07 Legal age of consent to intercourse (heterosexual), by sex	Age of consent for heterosexual intercourse
	5.08 Legal age of consent to marriage, by sex	Legal age of consent to marriage
	5.09 Legal age of consent to same-sex intercourse, by sex	Age of consent for same-sex intercourse
	5.10 Proportion of youth, aged 15-24 years, who have their own bank account (%), by sex	Bank account ownership, 15-24y (%)
	5.11a Proportion of ever partnered females aged 15-19 years who have experienced intimate partner violence in the last 12 months – physical (%)	Physical intimate partner violence in last 12m, 15-19y (%)
VIOLENCE AND HARMFUL PRACTICES	5.11b Proportion of ever partnered females, aged 15-19 years, who have experienced intimate partner violence in the last 12 months – sexual (%)	Sexual intimate partner violence in last 12m, 15-19y (%)
	5.11c Proportion of ever partnered females, aged 15-19 years, who have experienced intimate partner violence in the last 12 months – physical and/or sexual (%)	Physical and/or sexual intimate partner violence in last 12m, 15-19y (%)
	5.12 Proportion of females, aged 20-24 years, who experienced forced sex by 18 years of age (%)	Females aged 20-24y experiencing forced sex before 18y (%)
	5.13 Proportion of adolescents, aged 15-19 years, who think that a husband/partner is justified in hitting or beating his wife or partner under certain circumstances, by sex	Adolescents 15-19y who think husband is justified to beat wife (%)
	5.14 Proportion of children, aged 1-14 years, who experience violent discipline (psychological aggression and/or physical punishment) from a caregiver (%), by sex	Children experiencing violent discipline, 1-14y (%)
	5.15 Mortality rate due to intentional homicide among 10-19-year-olds (deaths per 100,000), by sex	Homicide mortality, 10-19y (per 100,000)
	5.16 Proportion of 13-17-year-olds who report experiencing bullying in the past 30 days (%), by sex	Bullying last month, 13-17y (%)
	5.17 Proportion of adolescents, aged 15-19 years, who report having personally felt discriminated against or harassed in the previous 12 months due to (a)gender or (b) sexual orientation	Discriminated against because of gender or sexual orientation, 15-19y (%)
	5.18 Prevalence of female genital mutilation/cutting among girls aged 0-14 years (%)	FGM/C, 0-14y (%)
	5.19 Number of detected trafficked children under 18 years of age, by sex	Number of detected trafficked children <18y
EXPLOITATION	5.20 Proportion of children, aged 5-17 years, engaged in child labour (%), by sex	Child labour, 5-17y (%)
	5.21 Proportion of children, aged 5-17 years, engaged in child labour who are in hazardous work (%), by sex	Hazardous work amongst those in child labour (%)
	5.22 Average number of hours, children aged 5-14 years, spend performing household chores per week, by sex	Hours per week spent on chores, 5-14y



6. SAFE ENVIRONMENT

SUB-DOMAIN	INDICATOR	SHORT LABEL
ENERGY	6.01a DALYs due to household air pollution in under 5-year-olds (DALYs per 100,000), by sex	Household air pollution, <5y (DALYs per 100,000)
	6.01b DALYs due to household air pollution in 5-9-year-olds (DALYs per 100,000), by sex	Household air pollution, 5-9y (DALYs per 100,000)
	6.01c DALYs due to household air pollution in 10-14-year-olds (DALYs per 100,000), by sex	Household air pollution, 10-14y (DALYs per 100,000)
	6.01d DALYs due to household air pollution in 15-19-year-olds (DALYs per 100,000), by sex	Household air pollution, 15-19y (DALYs per 100,000)
WATER, SANITATION AND HYGIENE	6.02 Proportion of schools with improved sanitation facilities that are single-sex and usable (available, functional and private) (%)	Schools with improved sanitation facilities (%)
	6.03a DALYs due to unsafe water, sanitation and hygiene in under 5-year-olds (DALYs per 100,000), by sex	Water, sanitation and hygiene, <5y (DALYs per 100,000)
	6.03b DALYs due to unsafe water, sanitation and hygiene in 5-9-year-olds (DALYs per 100,000), by sex	Water, sanitation and hygiene, 5-9y (DALYs per 100,000)
	6.03c DALYs due to unsafe water, sanitation and hygiene in 10-14-year-olds (DALYs per 100,000), by sex	Water, sanitation and hygiene, 10-14y (DALYs per 100,000)
	6.03d DALYs due to unsafe water, sanitation and hygiene in 15-19-year-olds (DALYs per 100,000), by sex	Water, sanitation and hygiene, 15-19y (DALYs per 100,000)
	6.04 Proportion of households where a person under 15 years of age is usually responsible for water collection (%), by sex	Child collects water for household, <15y (%)
MOBILITY	6.05a Number of international migrants aged under 20 years of age (1000s), by sex	International migrants <20y, (count in 1000s)
	6.05b Proportion of population who are international migrants aged under 20 years of age (%), by sex	International migrants <20y, (population %)
	6.06 Proportion of married/partnered females, aged 15-19 years, who make decisions about visiting family/friends themselves or jointly with husband (%)	Married females make decisions visiting family or friends, 15-19y (%)
	6.07 Proportion of 15-19-year-olds who feel safe walking around their neighbourhood after dark (%), by sex	Feel safe walking at night, 15-19y (%)
	6.08 Mortality due to road traffic accidents among 10-19-year-olds (deaths due to road traffic injuries per 100,000), by sex	Road traffic mortality, 10-19y, (deaths per 100,000)
CONFLICT AND DISASTER	6.09 Number of refugees, asylum seekers, internally displaced, stateless or other persons of concern aged under 18 years of age (thousands), by sex	Refugees, displaced and stateless persons, <18y (1,000s)

Populating indicators with data

Data was sourced and selected using the following principles:

Data sources:

- Where possible, indicators were populated using data available from global and regional databases (encompassing population and household surveys and administrative data) including those of UNICEF, UNDP, UN DESA, UNESCO, UNFPA, UNHCR, UNODC, UNPD, UNSD, World Bank, WHO, UNAIDS, FAO, ILO, and ITU (see Appendix 2 for list in full).
- Where age- and/or sex-disaggregated data were not available from existing databases, data was sought from the relevant national-level surveys, such as the DHS, MICS, household census, labour force survey, and GSHS.
- National-level surveys were prioritised over administrative data as they are more likely to be complete and produce representative estimates and have less biases.
- Where primary data were of limited coverage or quality, modelled data were used to populate indicators. These modelled data were sourced from the IHME and Global Burden of Disease study and clearly identified in tables and reports.

Data selection:

- A single estimate (best quality most recent data) was selected for each indicator, age and sex disaggregated where applicable.
- Data for years prior to 2010 was excluded.
- While the focus of this review is on 0-17-year-olds, for many indicators estimates were only available for 15-19 or 15-24-year age-bands and where relevant these have been reported.

Estimates were reported as defined in the indicator (typically prevalence rates). Where relevant, we also report the 'ratio' of outcomes in females divided by the outcomes in males. A ratio of greater than 1 suggests that the outcome is greater in females; for less than 1 that it is more common in males. Standard errors for estimates were not available in global datasets and we were not able to calculate confidence intervals.

We reported estimates for all indicators relating to the context and key determinants of gender inequality. For indicators relating to child and adolescent wellbeing, we report the rate ratio of outcomes for females compared to males. Where inequality in outcomes existed (rate ratio either greater or less than 1), we then report specific estimates.

Case studies

In addition to the quantitative data reported, illustrative case studies are included to contextualise findings, address topics where the review has identified data gaps and highlight key linkages between inequalities. Case studies include both quantitative and qualitative data, including data from relevant studies and reports.

Findings:

Context and key determinants of gender inequality

Unequal status and outcomes between girls and boys result from structural gender inequality operating beyond the individual level. Domain 1 focuses on broad structural factors including demography and level of development to provide an important context in which gender inequality operates and is perpetuated. Domain 2 then focuses on indicators of gender inequality at a population level. The factors considered in these context domains contribute to the gender inequality experienced by children and adolescents, the focus of Domains 3–6.



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Domain 1



Socio-demographic, economic and political context

This first domain captures the political, economic and socio-demographic context in which children and adolescents live. It includes data on adults, adolescents and children and describes societal factors which can contribute to gender inequality and girls' and boys' differing health and wellbeing outcomes.

Data availability

The data for the socio-demographic, economic and political context was sourced from collated datasets as compiled by the United Nations Development Programme, United Nations Population Division, World Health Organisation and World Bank datasets (indicators and data sources are summarised in Table 1.1). Data was available for most countries across indicators in this domain, the exception being the prevalence of food insecurity (Indicator 1.04) which was only available for Afghanistan.

TABLE 1.1: INDICATORS OF SOCIO-DEMOGRAPHIC, ECONOMIC AND POLITICAL CONTEXT AND DATA SOURCES.

Data sources are shaded as blue (compiled dataset, such as UNICEF SOWC), green (primary survey data such as MICS) or amber (modelled dataset, such as Global Burden of Disease). The table is shaded dark grey where data are not available.

		AFGHANISTAN	BANGLADESH	BHUTAN	INDIA	MALDIVES	NEPAL	PAKISTAN	SRI LANKA
Demography	Population <18y (1000s) 1.01a	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD
	Proportion of population <18y (%) 1.01b	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD
	Ratio of girls to boys aged <18y 1.01c	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD
	Population difference of <18y (girls - boys, 1000s) 1.01d	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD
Development	Proportion living in poverty, total population (%) 1.02		UNICEF	UNICEF	UNICEF		UNICEF	UNICEF	UNICEF
	Human Development Index 1.03	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP
	Prevalence of severe food insecurity, total population (%) 1.04	FAO							
	Proportion urban, total population (%) 1.05	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP
Govt. expenditure	Migration rate, total population (per 1000 annually) 1.06	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD
	Health expenditure (% GDP) 1.07	WHO	WHO	WHO	WHO	WHO	WHO	WHO	WHO
	Education expenditure (% GDP) 1.08	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO



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Detailed findings across indicators

It should be noted that indicators in Domain 1 describe the context in which gender inequality exists. Many indicators in this domain are not disaggregated by sex.

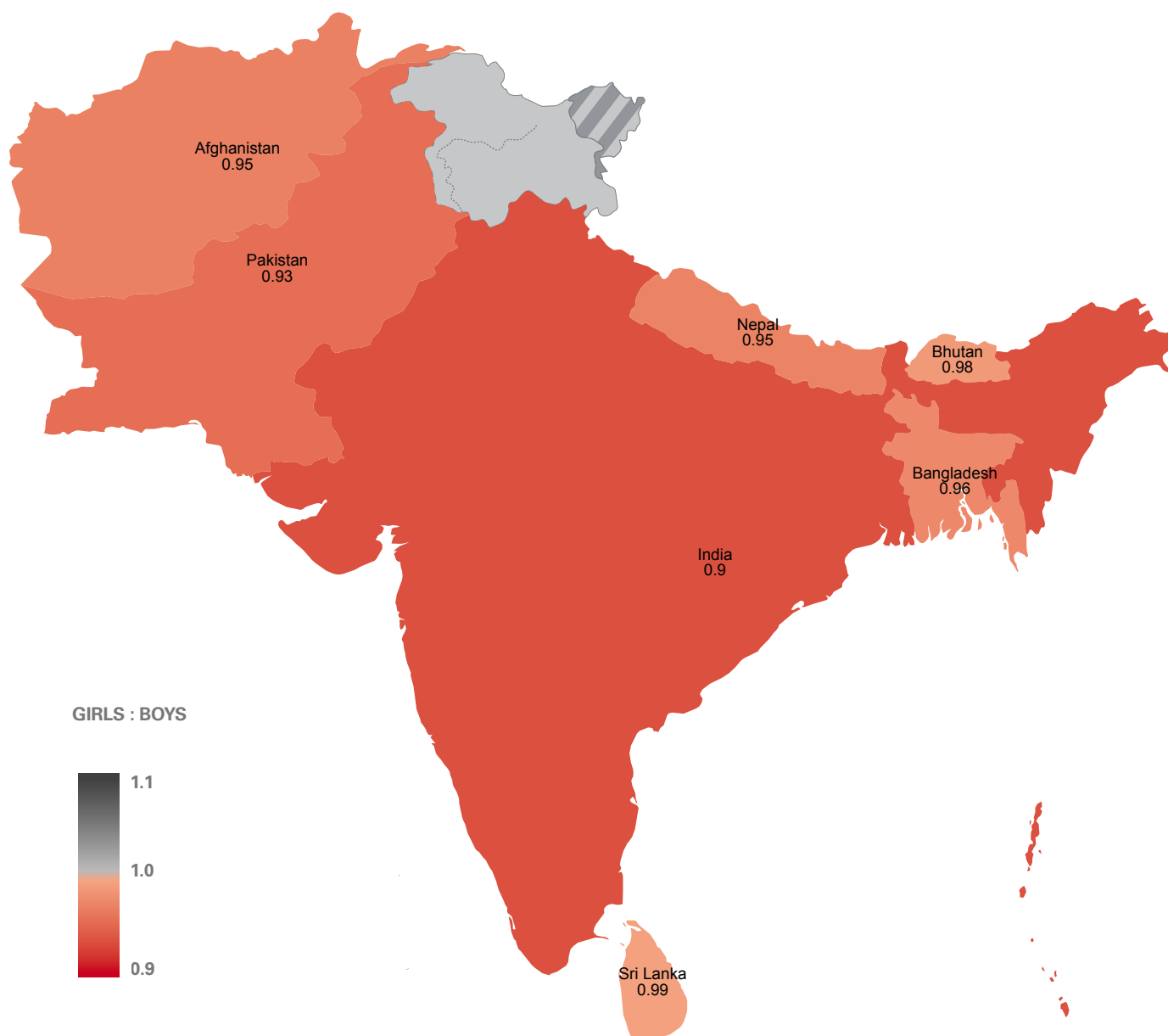
Demography (Indicators 1.01a – 1.01d)

There are an estimated 620 million children and adolescents (295 million girls and 325 million boys) in South Asia. In each country, there are fewer girls under 18 years of age compared with boys (Figure 1.1). In India, Pakistan and Bangladesh there are respectively 24.3 million, 2.9 million and 1.2 million fewer girls than boys (see *Appendix 3 for detailed estimates*). Likely contributors to this disparity include sex selection before birth and excess mortality among girls under 5 years of age. Gender differences in migration patterns, particularly immigration of boys and/or emigration of girls, may also contribute to this trend in some countries. These issues are discussed further in Domains 3-6.

In each country of South Asia there are fewer girls below the age of 18 years than boys.

FIGURE 1.1: RATIO OF GIRLS TO BOYS AGED UNDER 18 YEARS

This map shows the ratio of females to males aged under 18 years (Indicator 1.01c), with a ratio less than 1 indicating less female than males. Data source: UNPD, 2015.



This map is for illustrative purposes only and does not reflect a position by the United Nations or other collaborative organizations on the legal status of any country or territory or the delimitation of any boundaries. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties

Maldives
0.95

POPULATION GIRLS – BOYS

A negative value indicates fewer girls compared to boys

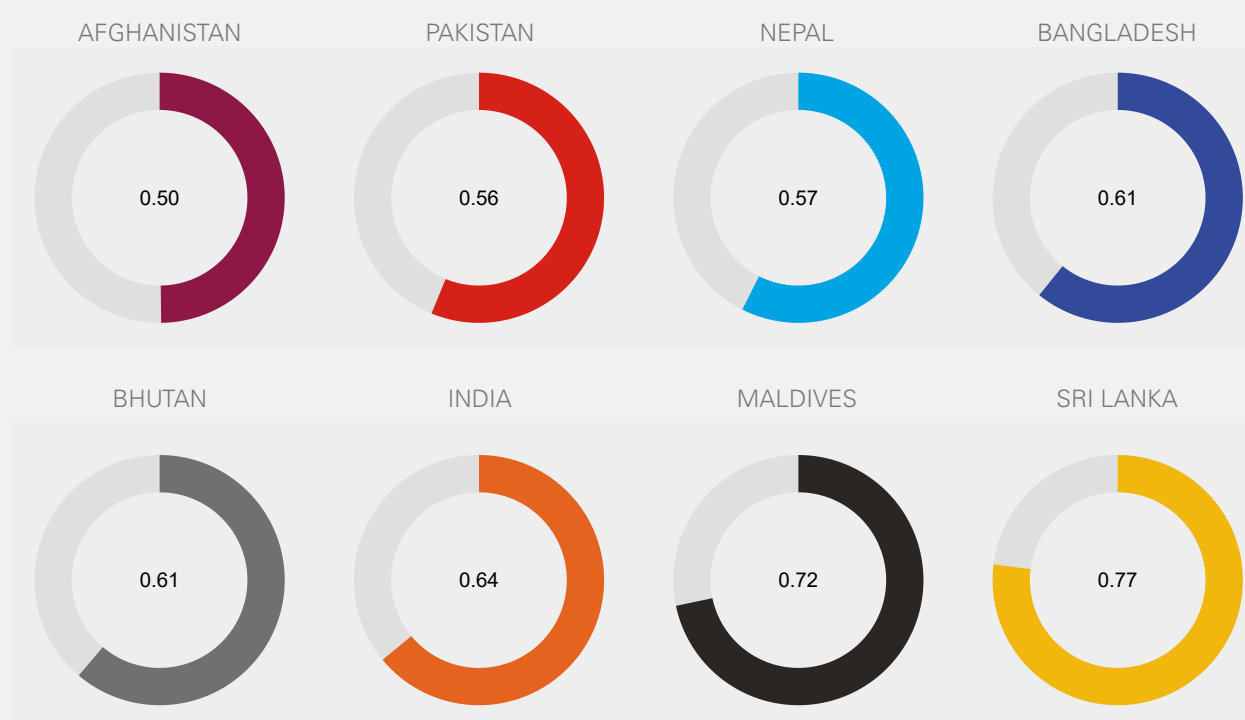
INDIA	-24,330,000	AFGHANISTAN	-460,000	BHUTAN	-3,000
PAKISTAN	-2,934,000	NEPAL	-281,000	MALDIVES	-3,000
BANGLADESH	-1,249,000	SRI LANKA	-44,000		

Socioeconomic and human development (Indicators 1.02 – 1.06)

South Asia is a region characterised by socio-economic diversity, with rapid economic growth in many countries. Despite the pace of economic growth, countries in the region have a **Human Development Index** (HDI, Indicator 1.03) ranging from 0.5 (Afghanistan) to 0.8 (Sri Lanka) as shown in Figure 1.2.

FIGURE 1.2: HUMAN DEVELOPMENT INDEX

This graph shows the Human Development Index (HDI) for each country in the region (Indicator 1.03). The HDI includes three dimensions: health as measured by life expectancy at birth; education as measured by mean years of schooling for adults aged over 25 years and expected years of schooling for children of school entering age; and standard of living as measured by gross national income per capita. The HDI is expressed from 0 to 1, with higher values signifying a higher level of human development. Data: UNDP 2017.



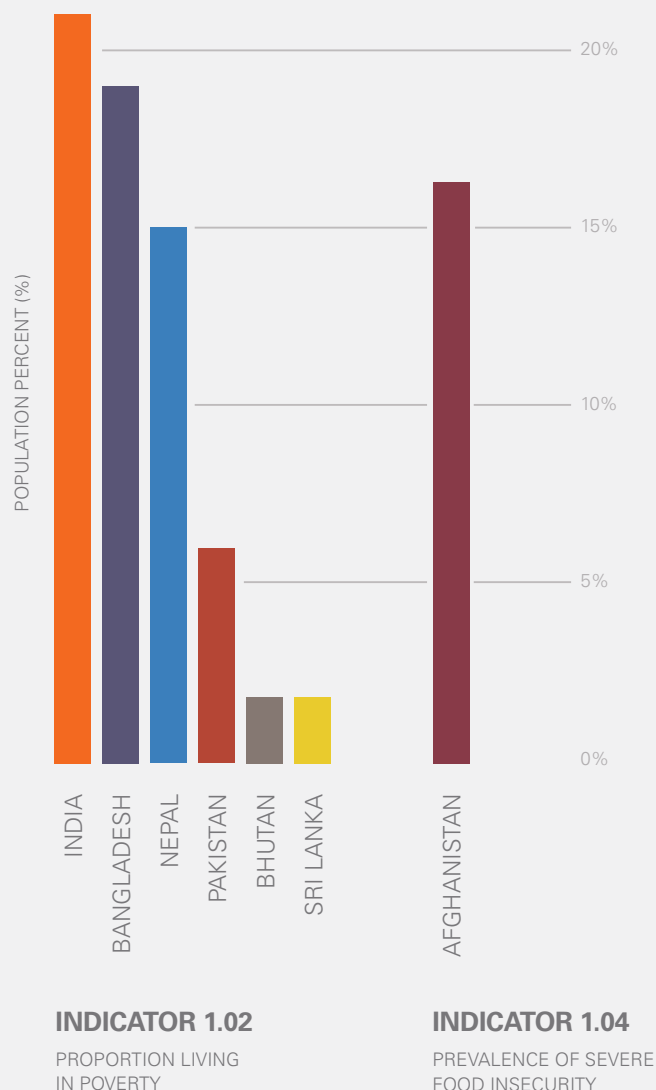
INDICATOR 1.03

A substantial proportion of the population lives below the international **poverty** line (Indicator 1.02) in Bangladesh (19%), India (21%) and Nepal (15%). While no data on poverty rates is available for Afghanistan, high rates (16%) of **severe food insecurity** (Indicator 1.04) indicate substantial deprivation at a population level (Figure 1.3). Women

and girls generally bear a disproportionate burden from poverty and food insecurity.¹⁸ In households living below the international poverty line, women and girls are particularly disadvantaged in their access to household resources, including food and nutrition, as well as the productive resources of education, employment, land and credit.^{19,20}

FIGURE 1.3: POVERTY AND SEVERE FOOD INSECURITY

This graph reports country level estimates for the proportion of the population living below the international poverty line of \$US1.90 per day (Indicator 1.02, data sourced from UNICEF 2015) and the proportion with severe food insecurity (Indicator 1.04, data sourced from FAO 2016). Food insecurity is measured at the household level and relates to at least one adult in the household reporting to have been forced to reduce the quantity of the food, to have skipped meals, having gone hungry, or having to go for a whole day without eating because of a lack of money or other resources, over the course of a year. Data: UNICEF 2014 and FAO 2016.



Food insecurity also makes it difficult for women to fulfil their roles in food production, preparation, processing, distribution and sales.

There are differences in the proportion of the population **living in urban centres** (Indicator 1.05) across the region, from 18% in Sri Lanka to 47% in the Maldives. However, most countries have between one- and two-fifths of the population living in urban centres. The relationship between urbanisation and gender equality is not straightforward. Women and men often do not

benefit equally from urbanisation, including in access to work, housing security, financial assets, access to health and social services, and personal security.²¹⁻²³

Urban migration can be associated with increased education and economic opportunities for women and girls and relaxation of sociocultural restrictions. This may change the gender socialisation of children and adolescents as they see more non-traditional gender roles, with women and mothers making monetary contributions to the household, possibly

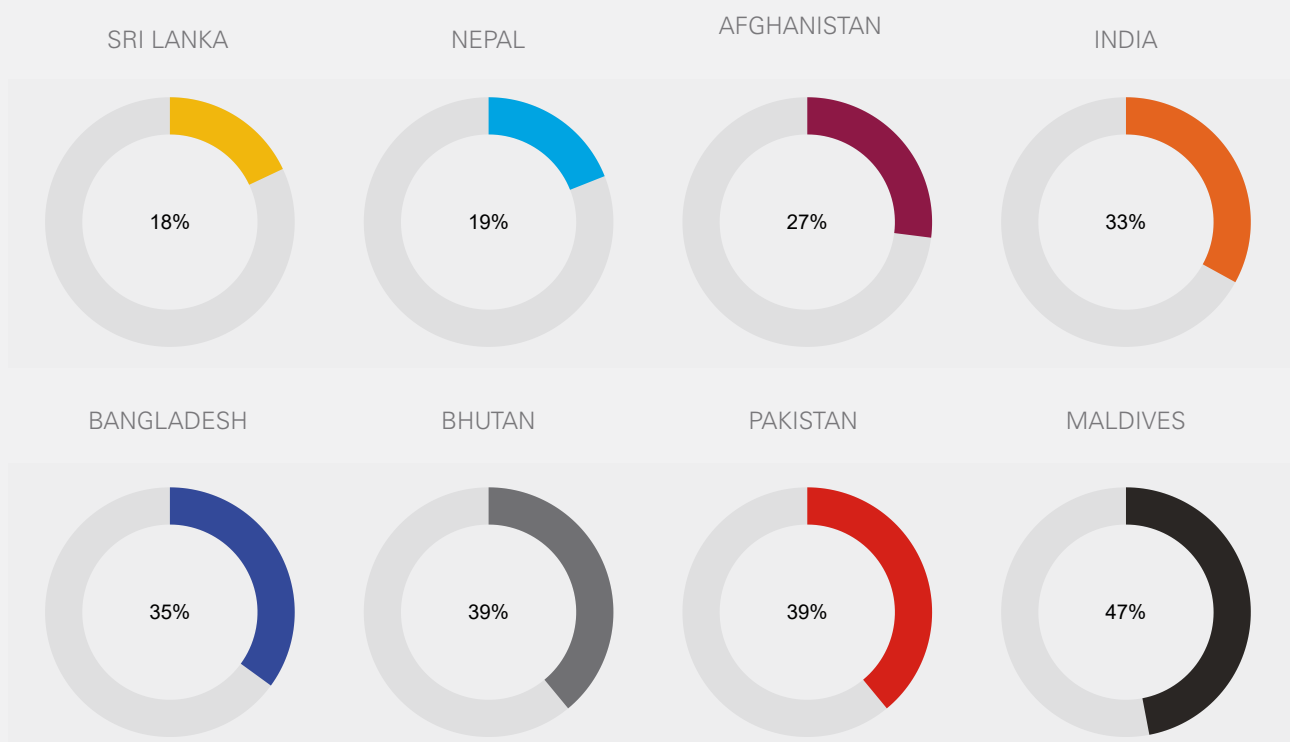
associated with greater decision-making power. Urban migration, including economic migration between countries, can also fragment established support networks, particularly support available for care work. Women in urban centres may be more likely to bear a double burden of paid work, and unpaid care and domestic work. In addition, the ability of urban parents and communities to monitor and enforce behaviour may be more limited.²³

There is notable variation in **migration** patterns (Indicator 1.06) across the region, with some

countries exhibiting net in-migration and others net out-migration (Figure 1.4b). In Bhutan and the Maldives net in-migration, of 3% and 11% respectively, is likely to be driven by economic opportunities in these two countries. By contrast, there is more out-migration in Bangladesh and Nepal (both 3%) and Sri Lanka (5%). An estimated 1.7 million Sri Lankans are working outside of the country – mostly women. The gender implications of this international migration are similar to those associated with urban migration. There is potential for fragmentation of social support networks – in

FIGURE 1.4(A): URBANISATION

This graph reports the proportion of the population living in urban areas (Indicator 1.05). Data sourced from UNPD 2016.



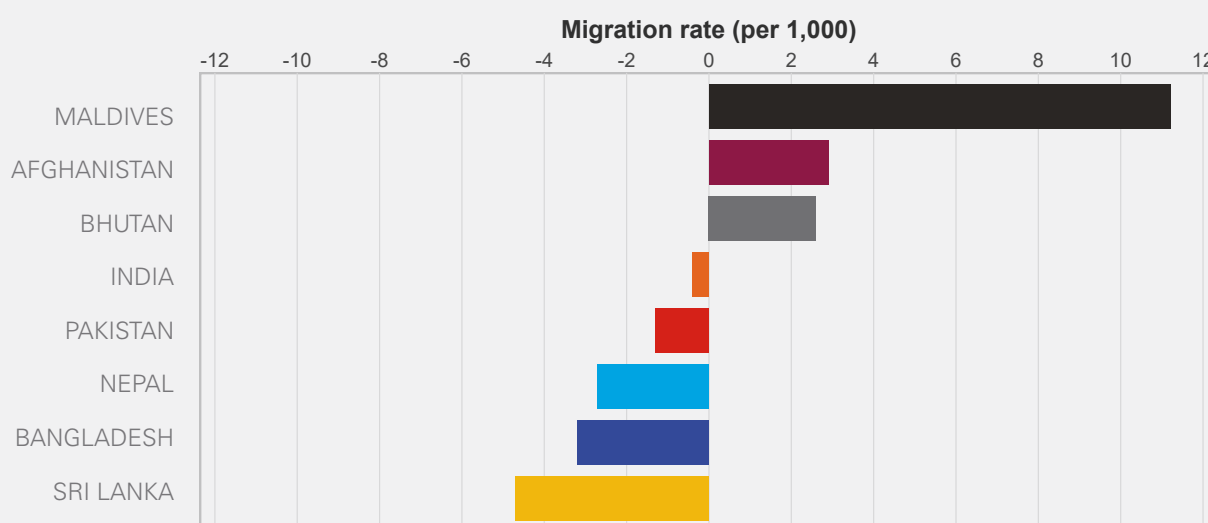
INDICATOR 1.05: PROPORTION URBAN, TOTAL POPULATION (%)

both the country of origin as well as the destination country – leading to an increased burden of domestic and child care work that typically falls to women and girls. The absence of mothers has also been reported to have negative impacts on children in Sri Lanka, particularly girls, including higher risks of sexual and physical abuse, greater household workload and lower learning achievement.^{24,25} In Nepal, men's international migration has been reported to negatively impact the physical and mental health of left-behind wives including increased rates of depression.²⁶

The migration seen in most countries, including to urban centres, fragments support networks and increases the burden of domestic and childcare work that typically falls on women and girls

FIGURE 1.4(B): MIGRATION

This graph reports migration in thousands of people (Indicator 1.06). Maldives, Bhutan and Afghanistan have net in migration, all other countries have net outward movement. Data source: UNPD 2015.



INDICATOR 1.06: TOTAL ANNUAL NET MIGRATION RATE (PER 1,000)

Government expenditure (Indicators 1.07 – 1.08)

There is low public spending on health and education in most countries in the region.

Government expenditure on education

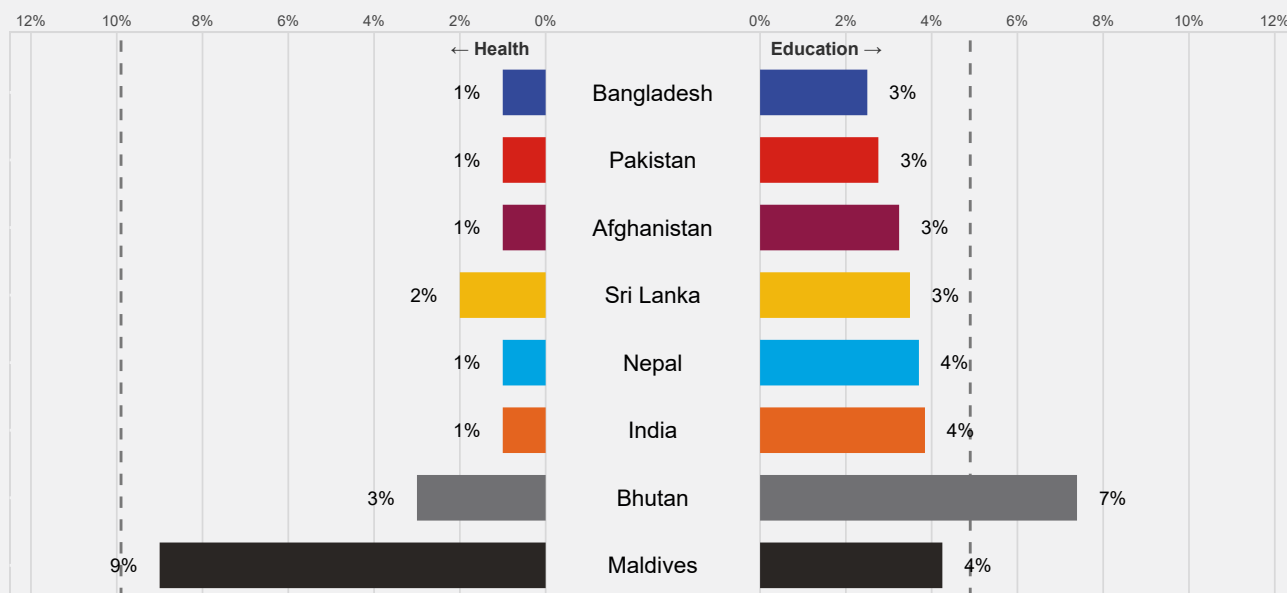
(Indicator 1.08) is below the world average (5% of GDP) in all countries, except Bhutan. **Health expenditure** (Indicator 1.07) is very low and well below the world average (10% of GDP) in all countries, except the Maldives, which affects the quality of and access to healthcare. This is complicated by a large private health sector in South Asia which incurs costs at all levels of access.

In the context of low public spending on human capital, household-level decision-making about resource allocation becomes an increasingly important determinant of household members' wellbeing. These financial decisions are influenced by gender inequality, whether due to differences in the decision-making power of men and women or the level of investment in girl children compared with boys.²⁸ For example, women and girls in many South Asian countries are reported to be more likely to access the public health sector rather than private services.²⁷ Women also report decisions about seeking hospital care for births and emergencies are largely made by the husband or elder members of his family.²⁸ Women's and girls' needs for sexual, reproductive and maternal health care, are particularly at risk in the face of low expenditure. In contrast, investment in health and education leads not only to improvements for women and their children but also more productive and better-educated societies.^{29,30}

Low public expenditure on health and education, places more strains on household resources, which may disadvantage women and girls.

FIGURE 1.5: GOVERNMENT EXPENDITURE ON HEALTH & EDUCATION

This graph shows government expenditure on health (bars to the left, Indicator 1.07) and education (bars to the right, Indicator 1.08) where data are available. Dashed lines indicate global averages. Data sourced from WHO and UNESCO, 2013–16.



1.07 HEALTH EXPENDITURE (%GDP)

1.08 EDUCATION EXPENDITURE (%GDP)

Summary

Domain 1

Socio-demographic, economic and political context

Key data gaps

- Limited data for food security across the region.

Key findings relating to the socio-demographic, economic and political context:

In all countries, there are fewer girls than boys - overall in this region there are 9 girls for every 10 boys. Likely contributors include sex selection before birth, excess mortality among girls under 5 years of age and migration patterns.

**For every 10 boys under the age of 18 years
there are only 9 girls**



South Asia is a rapidly developing region, but there remains wide variation in the level of development across countries as measured by the Human Development Index (HDI). Sri Lanka is the most developed; Afghanistan the least developed. Bhutan, Maldives, and Pakistan have the greatest proportion of people living in urban centres. Urbanisation often disrupts support networks, increasing the burden of domestic work and childcare which typically falls on women and girls.

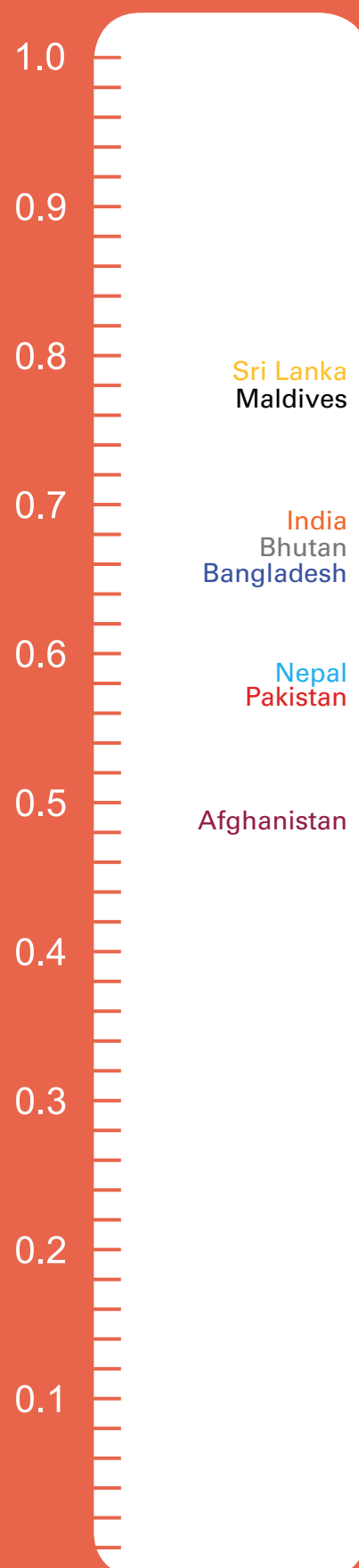
The proportion of the population living in poverty varies considerably across the region. The highest levels are found in India and Bangladesh. Rates of food insecurity are high in Afghanistan. Women and girls are particularly vulnerable to the impacts of poverty and food insecurity.

Other than the Maldives and Bhutan, there are low levels of government expenditure on health and education (<5% GDP) in this region. This may place a greater dependence on household resources and decision-making which may disadvantage women and girls.

Collectively, these exposures adversely impact on the wellbeing and development of children and adolescents in the region, particularly so girls. This disadvantage is likely reflected in the smaller female population aged under 18 years - in all countries there are fewer girls than there are boys.

These findings provide an important context to understanding the gender inequalities as described in subsequent Domains.

Human Development Index





Domain 2

Household, institutional and societal gender inequality

This domain captures the gendered environment in which children live and is focused on gender inequality at household, institutional and societal levels. Gender discrimination in the home and society can impact access to justice, rights and opportunities for women and girls. Domain 2 includes data on children, adolescents and adult populations, reflecting the societies in which girls and boys live.

Data availability

Data for household, institutional and societal gender inequality were drawn from a range of sources (Figure 2.1) with the majority of indicators being populated using collated datasets (UNICEF SOWC, UNSD, ILO, OECD, WB, IPU and the new UNFPA violence against women dataset kNowVAWdata). Primary surveys including MICS and DHS were used to populate some indicators relating to women's empowerment and decision-making. Modelled data from GBD were included for educational attainment (Indicator 2.16b) due to the poor coverage of primary data. The index of abortion legality, also sourced from GBD, grades abortion legality from 0 (not legal any circumstance) to 100 (legal on request and no restriction).

There were some sub-domains for which data availability were limited, particularly for indicators of time-use and division of labour where there was no data for Indicators 2.01 or 2.02, and data for only three countries for Indicator 2.03. Data were also limited for household decision-making, violence against women and women's bodily autonomy. Of the countries in the region, Sri Lanka and the Maldives had the least data coverage for these indicators.

It should be noted that data for Indicator 2.12 (attitudes around domestic violence) are captured slightly differently for MICS and DHS surveys. DHS surveys in Afghanistan, Bangladesh and Pakistan only include those ever-married 15-49-year-olds, with DHS surveys in the Maldives and Sri Lanka including only ever-married females.

TABLE 2.1: INDICATORS OF HOUSEHOLD, INSTITUTIONAL AND SOCIETAL GENDER INEQUALITY

Data sources are shaded as blue (compiled dataset, such as UNICEF SOWC), green (primary survey data such as MICS) or amber (modelled dataset, such as Global Burden of Disease). The table is shaded dark grey where data is not available.

		AFGHANISTAN	BANGLADESH	BHUTAN	INDIA	MALDIVES	NEPAL	PAKISTAN	SRI LANKA
Division of labour	Unpaid work, 15-49y (hours per day) 2.01								
	Total work, 15-49y (hours per day) 2.02								
	Adult collects water for household, >15y (%) 2.03	UNSD		UNSD			UNSD		
Resource control	Average monthly earnings, 15-49y (I) 2.04		ILO					ILO	ILO
	Married women in paid work who can decide spending, 15-49y (%) 2.05	DHS	DHS		DHS		DHS	DHS	
	Own bank account, >15y (%) 2.06	WB	WB	WB	WB		WB	WB	WB
Decision-making	Can decide healthcare, married women 15-49y (%) 2.07	DHS	DHS		DHS		DHS	DHS	
	Can decide household purchases, married women 15-49y (%) 2.08	DHS	DHS		DHS		DHS	DHS	
Representation	Proportion lower house seats held by women (%) 2.09a	IPU	IPU	IPU	IPU	IPU	IPU	IPU	IPU
	Proportion upper house seats held by women (%) 2.09b	IPU		IPU	IPU		IPU	IPU	
	Proportion of police who are female (%) 2.10			UNODC	UNODC	UNODC			
IPV	Women experiencing IPV last 12m (%) 2.11	UNFPA	UNFPA		UNFPA	UNFPA	UNFPA	DHS	
	Proportion who think husband is justified to beat wife, 15-49y (%) 2.12	DHS	DHS	MICS	DHS		DHS	DHS	
Autonomy	Abortion legality index (0-100) 2.13	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Contraception demand satisfied, married women 15-49y (%) 2.14	UNSD	UNSD	UNSD	UNSD		UNSD	UNSD	
	Married women who can say no to sex with husband, 15-49y (%) 2.15						DHS		
	Mean years education, >25y 2.16a			UNESCO	UNESCO		UNESCO	UNESCO	
Access	Mean years education, age-standardised (modelled) 2.16b	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	One antenatal visit, 15-49y (%) 2.17a	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF
	Four antenatal visits, 15-49y (%) 2.17b	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF
	Married women make decisions visiting family or friends, 15-49y (%) 2.18	DHS	DHS		DHS		DHS	DHS	
Structural equality	Marital rape criminalised (yes=1, no=0) 2.19			WB			WB		
	Social Institutions Gender Index (lower score is better) 2.20	OECD	OECD	OECD	OECD		OECD	OECD	OECD
Gender gap	Gender Development Index (higher score better) 2.21	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP
	Gender Inequality Index (lower score better) 2.22	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP	UNDP
	Global Gender Gap Index (higher score better) 2.23		WEF	WEF	WEF	WEF	WEF	WEF	WEF

Detailed findings across indicators

Time use and division of labour (Indicators 2.01 - 2.03)

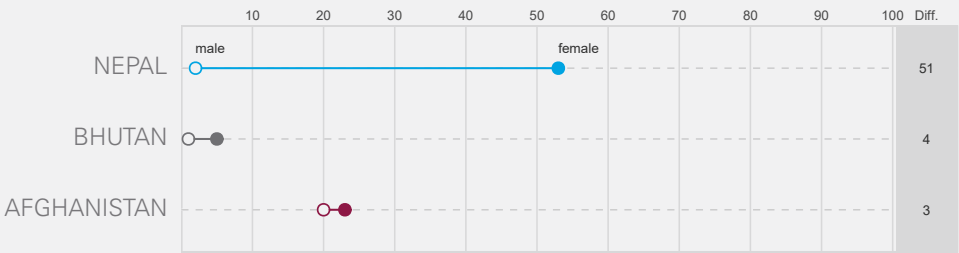
Data for unpaid work and total **work burden** (Indicators 2.01 and 2.02) were not available for any countries in the South Asia region. However, women in South Asia are reported to bear a disproportionate burden of unpaid work, a reflection of their lower human capital as compared to men, which also limits their access to the labour market and to capacity building opportunities.^{29,30} Three countries had data on **who is responsible for collecting water** (Indicator 2.03); with this burden falling on females in all countries with data (Figure 2.1). The gender disparity was greatest in Nepal where women and girls are approximately twenty-five times more likely to collect water than men and boys. These data indicate entrenched gender roles persist that typically allocate unpaid domestic and child care work to women and girls (see Case Study 2.1 on gender socialisation). Women and girls who travel long distances alone, across isolated areas, to collect

water may also be at greater risk of physical or sexual violence while repeated heavy loads may lead to physical injuries.

Women do considerably more unpaid work than men, reflecting distinct gender roles that assign domestic and child care work to women and girls.

FIGURE 2.1: DIVISION OF LABOUR

This graph shows the proportion of women and men in households who are responsible for collecting water (Indicator 2.03). The solid filled circles indicate females and the hollow circles males, with difference between females and males shown in the panel on the right. A positive difference indicates women and girls do more work in water collection than men. Data source: DHS and MICS, 2010 – 17.



INDICATOR 2.03: ADULT COLLECTS WATER FOR HOUSEHOLD, >15Y (%)

CASE STUDY 2.1: GENDER SOCIALISATION

Gender socialisation is the process by which individuals learn about the norms and behaviors associated with their assigned sex or what is expected of them as a male or female member of society.³¹⁻³⁴ Most gender expression is believed to be attributable to differences in socialisation rather than genetic and biological factors. Children are taught these gender norms consciously and subconsciously, by parents, peer, siblings, school, society and religion, from a very early age. This socialisation can determine girls' and boys' beliefs, behaviours, identities, expressions, interests and career path. Gender socialisation is important as it is a significant driver of gender inequality and harmful consequences for girls, boys, women and men around the world.

Recent research on early adolescence has revealed some gender expectations are common across continents.³⁵ This includes the hegemonic myths that girls are vulnerable while boys are strong and independent, and pubertal boys are sexual predators while girls are potential targets or victims. These perceptions lead to restrictions in girls' mobility and gender segregation in public spaces as they are frequently warned to stay away from boys.

In South Asia, females generally have lower status than males and many parents perceive sons to be of more value than daughters.^{37,38} For example, the birth of a boy in Nepal is celebrated, however a girl is a disappointment.³⁶ This is not uncommon in patrilocal societies where male children are expected to care for their parents in their old age while daughters leave their biological family once married.^{37,38} The exception is in parts of rural Sri Lanka where girls are more valued and expected to take on the role of parental caregiver.³⁶

Son-preference is demonstrated in families' lower investment in the nutrition, health and education of girls compared to boys.³⁷⁻⁴² Girls bear a greater burden of household chores than boys, reinforcing the gender stereotype that this is women's work.³⁷ Parents would rather invest in their son's education to maximize his earning potential than have him work in the home.³⁷

Child marriage is often seen both as a means of divesting a family of the financial burden of a girl child, and protecting her chastity and the family honour. Social expectations place great pressure on girls to fulfil their reproductive role, marry and bear children early in life. Males are socialised to believe they have the right to control female sexuality and reproduction.^{2,42} Systems of dowry and bride price further objectify girls, by treating them as commodities, reinforcing the perception that they do not have self-agency. This discriminatory socialisation perpetuates existing patriarchal power structures that support women as subservient to men. It limits girls' future opportunities, and has significant negative impacts on the mental and physical health.

“If we don’t conceive immediately, then they will talk about us and keep taunting us. They will say ‘look she has no children’, and in this way a finger will be pointed at us.”

Young mother in Rayalaseema.⁴³

Access and control over resources (Indicators 2.04 and 2.06)

In all countries, where data is available, women's **average monthly earnings** (Indicator 2.04) are substantially less than that of males (Figure 2.2 panel A). The absolute gender gap in earnings is greatest in Pakistan where women earn \$US58 or 38% less than men per month. In most South Asian countries, women are substantially less likely to be in the labour force than men.⁴⁴ The perpetuation of gender stereotypes also sees more women employed in lower paid 'feminine' roles such as care work and in service provision while more men are in management.⁴⁵ The double burden for women, in managing work and home commitments, also

negatively impacts women's careers and retention in the workforce.

Across the region, few women have their **own bank account** (Indicator 2.06) compared to men (see Figure 2.2 panel B), with rates particularly low in Afghanistan (4% women compared to 16% males) and Pakistan (5% of women compared to 21% of men). In India, 20% more men than women have a bank account. With the exception, of Sri Lanka, women in this region appear to have reduced access and control of money as compared to men.

FIGURE 2.2 PANEL A: AVERAGE MONTHLY EARNINGS BY GENDER

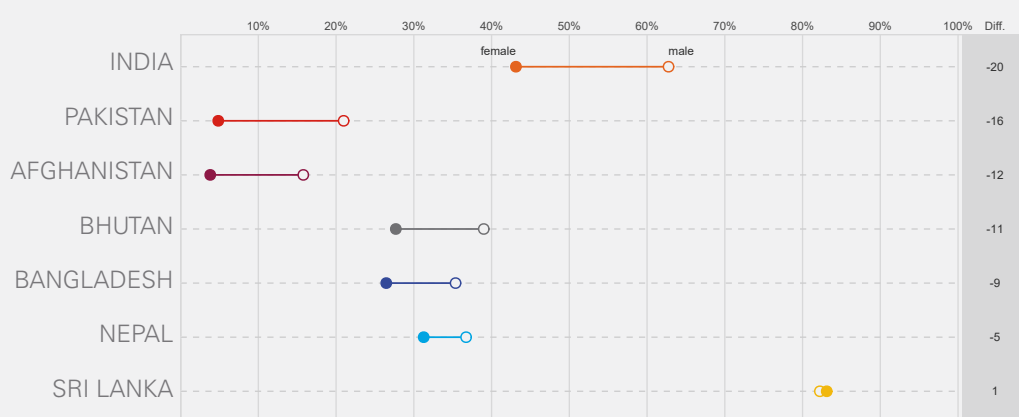
This graph shows the average monthly earnings in \$US for men and women aged 15-49 years (Indicator 2.04). The column on the right indicates the difference in earnings per month – a negative amount indicates that women earn less than men. Data: ILO 2016.



INDICATOR 2.04: AVERAGE MONTHLY EARNINGS, 15-49Y (\$USD)

PANEL B: BANK ACCOUNT OWNERSHIP

This graph shows bank account ownership for women and men in the region as a population percentage (Indicator 2.06). The column on the right shows the difference in account ownership between women and men (a negative value indicates fewer women have a bank account than men). Data: World Bank 2014.



INDICATOR 2.06: OWN BANK ACCOUNT, >15Y (%)

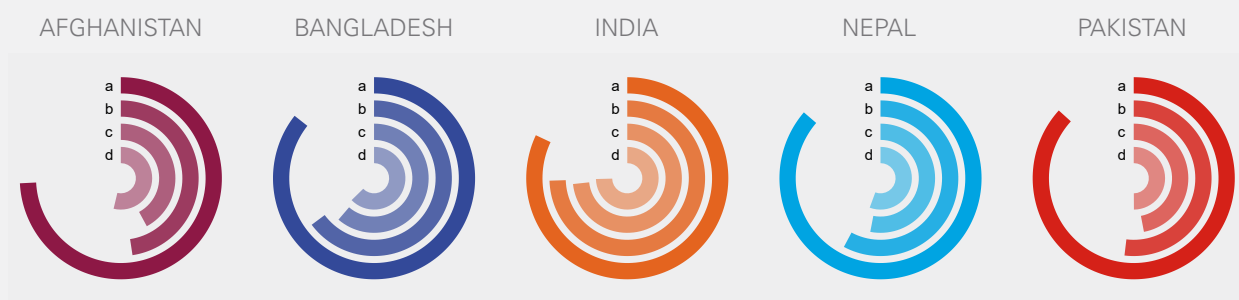
Intra-household decision making (Indicators 2.05, 2.07, 2.08)

While most married women, in countries with data, can **make decisions about how their earnings are used** (Indicator 2.05), they are less likely to be able to decide about healthcare, household purchases or their own mobility (Figure 2.3). Only about half of women in Afghanistan, Pakistan and Nepal report being able to make decisions about **healthcare, household purchases or visits to family and friends** (Indicators 2.07, 2.08, 2.18),

themselves or jointly with their husbands. These findings suggest women in this region experience great restrictions in their decision-making power within their households. Further, it is important to note that these indicators are for married women, and do not reflect the situation of unmarried girls who may face greater limitations in movement and decision-making.

TABLE 2.3: DECISION MAKING BY MARRIED WOMEN

This graph shows the ability for married/ partnered women aged 15-49 years to make decisions about use of earnings (outer ring a), healthcare (ring b), major household purchases (ring c) and visiting family or friends (inner ring d). Data source: DHS 2012 -16.



INDICATOR A - 2.05 MARRIED WOMEN IN PAID WORK WHO CAN DECIDE SPENDING, 15-49Y (%)

INDICATOR B - 2.07 CAN DECIDE HEALTHCARE, MARRIED WOMEN, 15-49Y (%)

INDICATOR C - 2.08 CAN DECIDE HOUSEHOLD PURCHASES, MARRIED WOMEN, 15-49Y (%)

INDICATOR D - 2.18 MARRIED WOMEN MAKE DECISIONS VISITING FAMILY OR FRIENDS, 15-49Y (%)



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Women's participation in public life

(Indicators 2.09 – 2.10)

Women are under-represented in **parliaments** (Indicator 2.09) across the region, particularly in the lower houses of parliament in the Maldives and Sri Lanka (both 6%); and both the upper and lower houses in Bhutan (8%) and India (12%). For those countries where data is available, namely Bhutan, India and the Maldives, women are also under-represented in **police forces** (Indicator 2.10), making up only 7% to 9% of officers in these countries. This lack of representation limits legislative and justice system responses for women and girls.

Women are under-represented in parliaments and police forces across the region – this limits legislative and justice system responses for women and girls



Violence against women (Indicators 2.11 – 2.12)

Recent data from the UNFPA kNOwVAWdata project shows **Intimate partner violence** (Indicator 2.11) is a significant issue in this region.⁴⁶ Almost half of married women in Afghanistan, a quarter of married women in Bangladesh and one in five married women in India and Pakistan report intimate partner violence in a 12 month period (Figure 2.4). Reported rates likely underestimate the extent of violence, as women often do not mention or report abuse due to embarrassment, fear of retaliation and economic dependency. Societal norms such as the power imbalance between women and men, family privacy, and victim blaming also discourage reporting.⁴⁷ Protection mechanisms for those who experience domestic violence are limited throughout the region, leaving those who report violence vulnerable to further abuse.

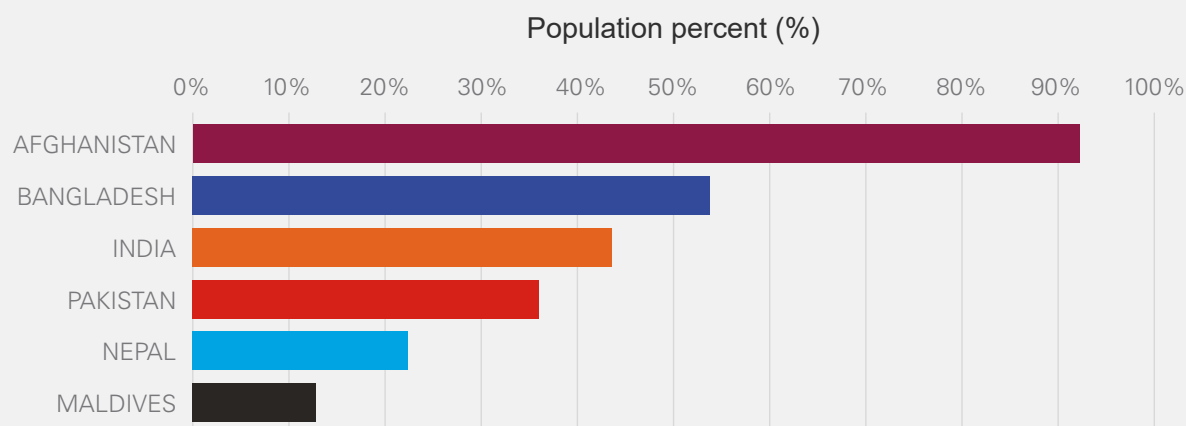
Intimate partner violence
is very common in several
countries in South Asia

Harmful **attitudes towards domestic violence** (Indicator 2.12) are common in this region (Figure 2.5). Beliefs supportive of wife-beating as justifiable in certain circumstances are most common in Afghanistan (80% of females and 72% of males, aged 15-49 years), India (45% of females and 32% of males) and Pakistan (42% and 32%). Even in those countries, with the lowest rates of justification for wife beating (Bangladesh and Nepal), one in four women believe it is an understandable response, if a woman goes out without permission, neglects the children, argues with her husband, refuses sex or burns the food. In all countries, where sex-disaggregated data are available, more women than men report that intimate partner violence is justified (Figure 2.5). This may reflect internalised norms among women who have witnessed and been subjected to violence, as well as the impact of social desirability bias in data collection with men.

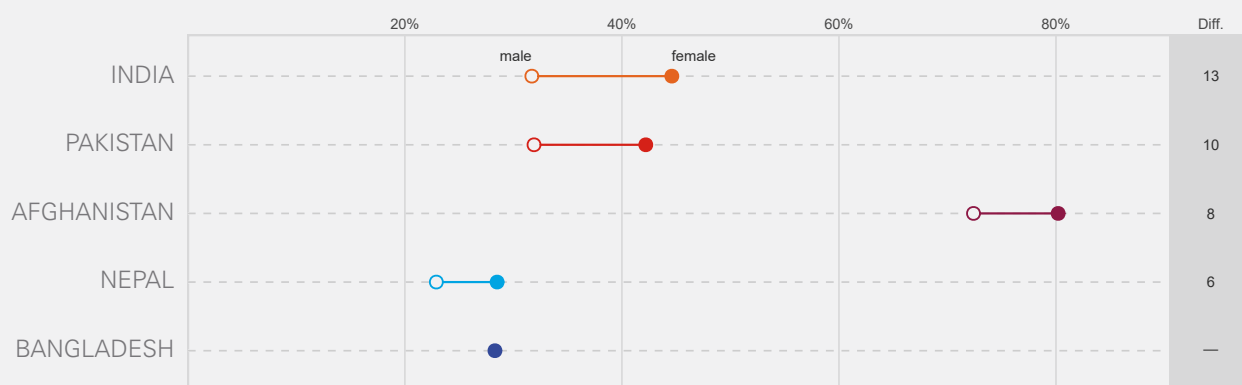
While data are extremely limited, people who are gender diverse are generally at great risk of violence and harm (see Case Study 2.2)

FIGURE 2.4: INTIMATE PARTNER VIOLENCE

This graph shows the prevalence of intimate partner violence (Indicator 2.11) amongst women over the preceding 12 months. Data source: UNFPA 2017.

**INDICATOR 2.11: PREVALENCE OF INTIMATE PARTNER VIOLENCE****FIGURE 2.5: ATTITUDES TOWARDS DOMESTIC VIOLENCE**

This graph shows the proportion of 15–49-year-olds (in the countries for which data is available) who think that a husband is justified to beat their wife, by sex (Indicator 2.12). Data source: DHS 2011-17.

**INDICATOR 2.12: PROPORTION WHO THINK HUSBAND IS JUSTIFIED TO BEAT WIFE, 15-49Y (%)**

CASE STUDY 2.2: HIJRA - THE THIRD GENDER

In Asia-Pacific there are many young people who identify or express themselves in a manner which differs from the sex they were assigned at birth. There are also individuals who identify as a third gender which is neither male nor female; those who identify with both genders; and people who do not identify as having a gender.^{48,49} In many South Asian countries, including Bangladesh, India, Pakistan and Nepal, hijra and kothis, who may identify as transgender women or third gender, have long been part of the culture. In India alone, the hijra population has been estimated to be five million and many consider this to be a conservative estimate.^{50,51} Historically, they were treated with great respect, often vested with social and spiritual power in society; however, attitudinal changes have led them to be the targets of stigma, discrimination and mistreatment.^{51,52}

Hijras are today reported to be excluded from many parts of society, including from education, family, employment and health services.⁵¹ Most have suffered physical, verbal and sexual abuse. Some run away from home at an early age while many find schools to be hostile environments and drop out.⁵¹ This marginalisation leads to increased risk of low self-esteem, anxiety, depression, risk-taking behaviours, such as alcohol and drug abuse, and suicide.^{51,53} In India, the suicide rate among transgender people is estimated to be 31 %, with half the population attempting suicide before they turn 20.^{20,53}

When I went to school, the classmates used to criticize me. They pointed me by saying, “he is a maigya pola (effeminate boy). He will end up as hijra. He cannot play with us. He cannot sit with us.” They used to throw me out of the class. When I went to play with the boys, they did not accept me, and even the girls also did not want to play with me.

Hijra, Bangladesh⁵¹

Women's bodily autonomy (Indicators 2.13 – 2.15)

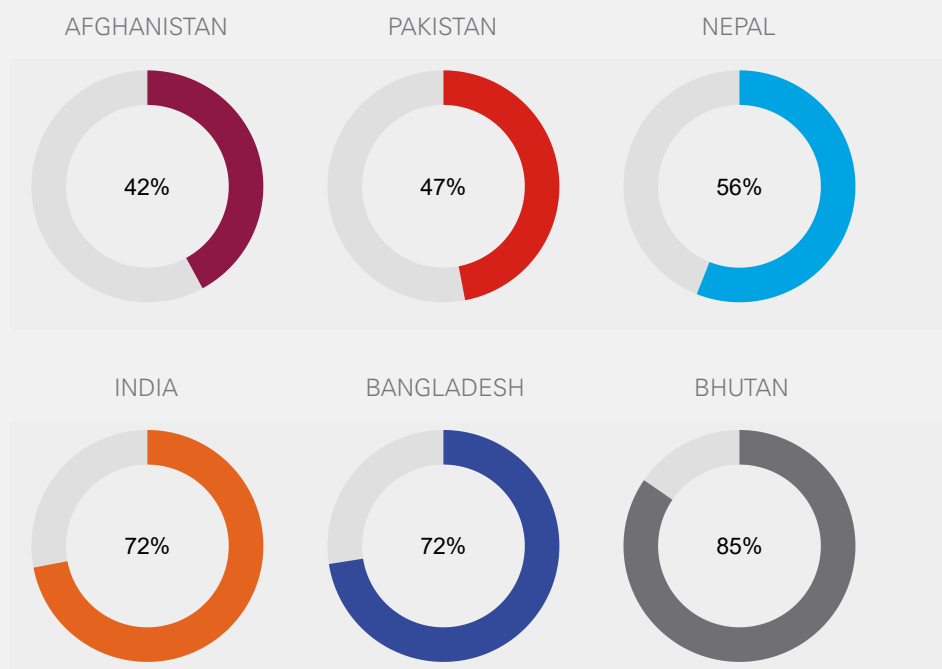
There is regional variation in **abortion legality** (Indicator 2.13) with substantial restrictions in Afghanistan, Bangladesh, the Maldives, Pakistan and Sri Lanka. A notable exception is Nepal where there are no restrictions. Less than half of married women in Afghanistan have their **contraception demand satisfied** with modern methods (Indicator 2.14) and approximately half of those in Pakistan and Nepal (Figure 2.6). Collectively, these data indicate that many women in this region have limited bodily autonomy. Socio-cultural norms and gender power relations, particularly in countries like

Afghanistan and Pakistan, continue to negatively impact women's sexual and reproductive health rights.

Data for the proportion of **married/partnered women who can say no to sex** (Indicator 2.15) with their partner is only available for Nepal where 90% of women can refuse sex. However, the lack of criminalisation of marital rape in many countries in the region, the exceptions being Bhutan and Nepal, suggests social norms persist that are supportive of male entitlement to sex within marriage.

FIGURE 2.6: DEMAND FOR CONTRACEPTION MET WITH MODERN METHODS

This graph shows the proportion of married women aged 15-49 years whose demand for contraception is satisfied with modern methods (Indicator 2.14). Data source: UNSD 2012-16.



INDICATOR 2.14: CONTRACEPTION DEMAND SATISFIED, MARRIED WOMEN 15-49Y (%)

Access to public spaces and services (Indicators 2.16 – 2.18)

Primary data on **educational attainment** (Indicator 2.16a) for men and women aged 25 years and over was only available for four countries - Bhutan, India, Nepal and Pakistan - with men completing more years of education than females across all of these countries. In three out of four countries, males completed twice as many years of education as females. Modelled data (which fills data gaps with estimates based on mathematical modelling) was available for all countries in this region (Indicator 2.16b). These modelled estimates confirm substantial differences in educational attainment by gender across the region, the exception being Sri Lanka where years of education are more evenly matched (see Appendix 3). The significance of this trend is that lesser educational attainment is likely to limit women's access to employment opportunities and income in competitive labour markets. Discriminatory investment in boys' education compared to girls' at the household level, may be related to the patrilocal nature of societies, where parents believe sons' schooling and employment to be of greater benefit to the family, bolstered by the expectation that in return boys will assume responsibility for the care of parents in their old age.

The WHO recommends a minimum of eight antenatal care contacts for a positive pregnancy experience (one in the first trimester, two in the second trimester and five in the third trimester), however, data is not available for this level of care.⁵⁴

Most women in the region receive at least one **antenatal visit with a skilled health provider** (Indicator 2.17a) during pregnancy, with the lowest rates being in Afghanistan and Bangladesh where only 59% and 64% of women respectively receive this care. Fewer women have **four antenatal visits** (Indicator 2.17b), with rates being lowest in Afghanistan (18%), Bangladesh (31%), India (51%) and Pakistan (37%). Sri Lanka has the greatest proportion of women receiving four antenatal visits in the region (93%) and the lowest rates of maternal mortality. Barriers to women receiving this antenatal care may be financial; mobility restrictions including lack of transport, risks of violence and the double burden of work (domestic and paid); poor quality of services possibly linked to inadequate funding; and cultural norms which view pregnancy as a normal life event not requiring healthcare.^{55,56}

Married women's ability to make decisions to **visit family and friends** (Indicator 2.18) is shown in Figure 2.3, with available data showing that many women in this region are limited in their decision-making power in this regard. This is particularly true in Afghanistan, Nepal and Pakistan where only 54%, 56% and 50% of women, respectively, can make decisions about visiting family and friends, a factor that also corresponds to their mobility restrictions.

Institutional mechanisms for the advancement of women and gender equality (Indicators 2.19 – 2.20)

Marital rape (Indicator 2.19) is criminalised in only two countries – Bhutan and Nepal – suggesting that most women and girls in the region do not have legal protection from sexual assault within marriage. This lack of criminalisation creates legal impunity for men who sexually assault or rape their wives and legitimises this form of violence against women.⁵⁷

The OECD **Social Institutions and Gender Index** (SIGI, Indicator 2.20) measures discrimination against women in social institutions as assessed through formal and informal laws, social norms and practices relating to areas including family law, control over resources and assets, and civil liberties (described in Table 2.2). Discrimination against women has been assessed as being high in Afghanistan, India, Nepal and Pakistan and very high in Bangladesh (see Appendix 3 for numeric scores and categories). These findings indicate entrenched gender discrimination in social institutions across these countries. In contrast, discrimination against women is rated as being low in Bhutan and of a medium level in Sri Lanka.



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Gender gap in human development (Indicators 2.21 – 2.23)

There are a number of indices that measure the **gap in human development as a result of gender inequality** including the Human Development Index (HDI) Gender Inequality Index (GII) and Global Gender Gap Index (GGGI) (see Table 2.2 for description). Women experience lower levels of human development compared to males as measured by the HDI in Afghanistan, Pakistan, and India (Indicator 2.21). These same countries have gender inequalities in human development as measured by the

Gender Inequality Index (Indicator 2.22), as do Bangladesh and Bhutan. While aligned to other indices, the **Global Gender Gap Index** (Indicator 2.23) brings a stronger focus to economic, educational and political engagement. This index demonstrates an overall lack of gender parity across the region, with this being most pronounced in Pakistan (see Appendix 3). Of note, there are no indices available that specifically measure gender inequality for the girl child or adolescent.

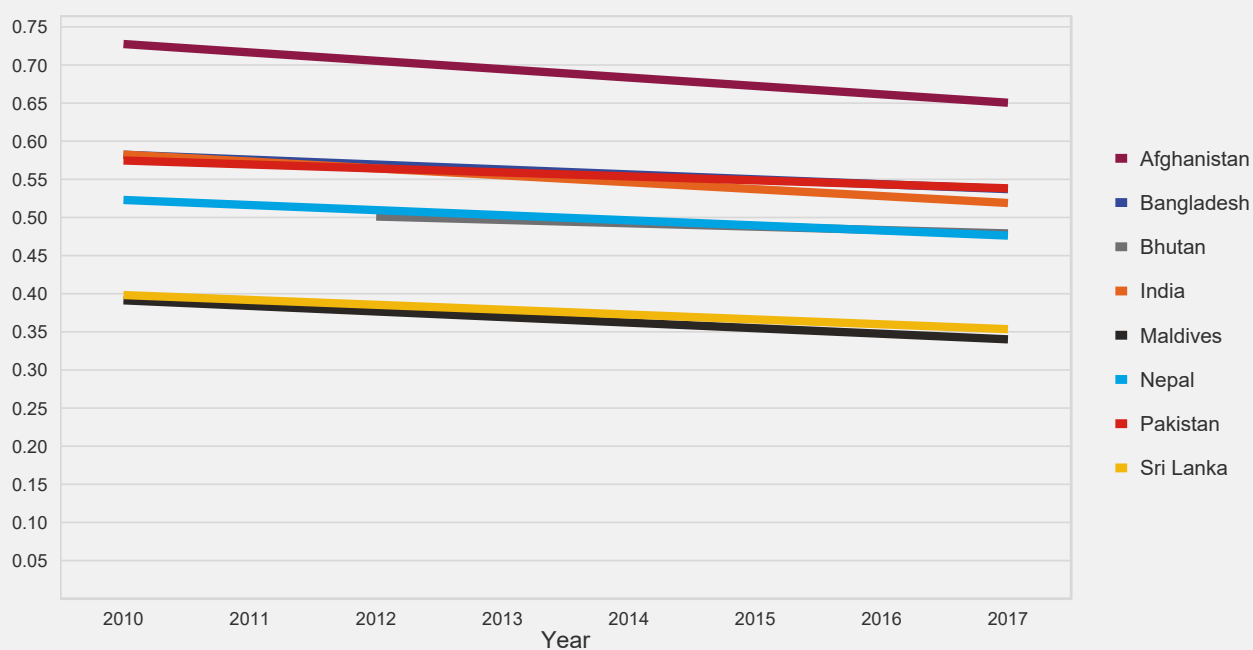
TABLE 2.2: KEY GENDER INDICES

This table summarises key gender indices and their interpretation.

Indicator	Description	Interpretation of index
2.20 Social Institutions Gender Index (SIGI) ⁵⁸	Defined by OECD, SIGI measures discrimination against women in social institutions (formal and informal laws, social norms and practices) across five dimensions: discriminatory family code (including legal age of marriage), restricted physical integrity (including laws on domestic violence and rape), son bias, restricted resources and assets, and restricted civil liberties (including access to public place and political voice).	Lower is better: Lower scores on the index relate to lower levels of discrimination, with suggested thresholds being: SIGI < 0.04 very low discrimination; 0.04 < SIGI < 0.12 low level discrimination; 0.12 < SIGI < 0.22 medium level discrimination; 0.22 < SIGI < 0.35 high levels of discrimination; and SIGI > 0.35 very high discrimination.
2.21 Gender Development Index (GDI) ⁵⁹	Defined by UNDP, the GDI measures the gap in human development between females and males. The HDI includes three dimensions: health as measured by life expectancy at birth; education as measured by mean years of schooling for adults aged over 25 years and expected years of schooling for children of school entering age; and standard of living as measured by gross national income per capita.	Higher is better: The GDI is simply the HDI for males divided by the HDI for females. These values are then transformed to an index from 0 to 1 (using the highest and lowest observed values as goalposts) so that a GDI closer to 1 indicates greater gender parity in the HDI.
2.22 Gender Inequality Index (GII) ⁶⁰	Defined by UNDP, the GII measures gender inequalities in three aspects of human development: reproductive health (as measured by maternal mortality ratio and adolescent birth rates); empowerment (as measured by parliamentary seats and secondary education attainment by gender); and labour force participation across genders.	Lower is better: The higher the GII, the greater the disparities between men and women and the more loss to human development.
2.23 Global Gender Gap Index (GGGI) ⁶¹	Defined by the World Economic Forum, the GGGI aims to identify gender inequality across four key outcomes: economic participation; educational attainment; health and survival; and political empowerment. These four outcomes are available as subscales but more commonly aggregated to provide the GGGI.	Higher is better: A score of 1 indicates gender parity across the four Domains, with the lowest possible score indicating gender imparity.

FIGURE 2.7: GENDER INEQUALITY INDEX OVER TIME

This graph shows the gender inequality index over time for individual countries. Data: UNDP, 2010 – 17. Please see definition of the Gender Inequality Index (GII) on previous page.



INDICATOR 2.22: GENDER INEQUALITY INDEX (LOWER SCORE BETTER)

Summary

Domain 2

Household, institutional and societal gender inequality

Key data gaps

- Data is limited for time use and the division of labour, household decision-making, violence against women and women's bodily autonomy.
- Of the countries in the region, Sri Lanka and the Maldives had the least data coverage for these indicators despite the fact that in general they both evidence greater degrees of gender parity across many indicators.

Social Institutions Gender Index

VERY
HIGH

Bangladesh

HIGH

Pakistan
Nepal
India
Afghanistan

MEDIUM

Sri Lanka

LOW

Bhutan

VERY
LOW

Key findings for household, institutional and societal gender inequality:

Males earn more than females across most countries where data is available.

Females are under-represented in the parliaments and police forces of the region, limiting legislative and justice system responses for women and girls.

While most women are able to make decisions about spending their own earnings, many women are not able to make decisions about healthcare and household purchases and access of social networks, indicating less control over household resources and bodily autonomy.

Half of women in Afghanistan, one in four in Bangladesh and one in five in India and Pakistan, have experienced intimate partner violence in the past year.

Justification of intimate partner violence is high, particularly in Afghanistan, India and Pakistan.

Where data are available, females are also more likely to justify violence. This may reflect women's internalised acceptance of gender-based violence, and under-reporting by men.

Substantial regional variation exists with regard to the proportion of married women whose demand for contraception is satisfied with modern methods; with married women in Afghanistan, Pakistan and Nepal being the least satisfied.

In most countries, except Bhutan and Nepal, marital rape is not criminalised.

Bangladesh has a very high level of gender discrimination in social institutions, with Afghanistan, India, Nepal and Pakistan having high levels of discrimination.

Collectively, these findings suggest that children and adolescents growing up in South Asia are exposed to high levels of household, institutional and societal gender inequality which are likely to adversely impact their wellbeing, explored in Domains 3–6.



Findings:

Inequalities in child wellbeing outcomes

This section examines how gender equality or inequality affects wellbeing at an individual level by measuring key outcomes for children and adolescents. The four outcome domains of wellbeing - Health, Education and Employment, Protection and Safe Environment - are aligned with the UNICEF Strategic Plan 2018-2021 and are designed to capture critical health and wellbeing outcomes for children and adolescents, as well as key social and behavioural determinants of outcomes across the life-course.

Given the large amount of data (all reported in detail in Appendix 3), we have focussed the discussion on those indicators where there is substantial inequality by gender, or where the observed data is different to that expected.

Domain 3



Impact of gender inequality on health

This section focuses on how gender inequality impacts on the health of girls and boys. It explores common issues including gender differentials in mortality, disease, injury, psychosocial wellbeing and access of health services, as well as sexual and reproductive health outcomes.

Data availability

Data for the impact of gender inequality on health was sourced from a variety of sources as shown in Table 3.1. Data sources included primary surveys (DHS and UNICEF MICS), collated datasets of primary data (UNICEF SOWC, UNIGME, UNAIDS, WHO) and modelled datasets (Global Burden of Disease and NCD Risk Factor Collaboration).

Primary data for health outcomes for girls and boys are of variable quality, and as such, we have used modelled data from the 2016 Global Burden of Disease where possible to provide a more complete assessment of gender disparities. Indicators that were populated using modelled data include indicators of anaemia, risk behaviours (tobacco smoking and binge drinking), disease burden, mental disorder, and mortality relating to suicide and maternal causes. Data from the GBD study were also included to improve coverage for Indicator 3.18 (demand for contraception satisfied) and to allow analysis of time trends for adolescent fertility (Indicator 3.20). It should be noted that while the GBD study is modelled data, estimates are based on and similar to primary data where they are available (see estimates for Indicators 3.20a and 3.20b in Appendix 3). Modelling in GBD adjusts for known biases in some primary data

(such as under-recording of suicide mortality) and in these instances may be preferable to unadjusted primary data.

Data were unavailable for maternal mortality ratio specific to adolescents. In its place, we have reported the maternal mortality rate per 100,000 population (Indicator 3.21). There were also some proposed indicators, likely to be associated with gendered vulnerability, that were excluded from this domain due to a lack of routine data collection and reporting, including: disability, menstrual hygiene management, family planning for unmarried girls and sexual and reproductive health of adolescents aged less than 15 years and adolescent boys.

TABLE 3.1: HEALTH-RELATED INDICATORS AND DATA SOURCES FOR COUNTRIES IN THE REGION

Data sources are shaded as blue (compiled dataset, such as UNICEF SOWC), green (primary survey data such as MICS) or amber (modelled dataset, such as Global Burden of Disease). The table is shaded dark grey where data are not available.

		Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Child health	Deaths in <5y per 1000 births 3.01	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME
	Expected : estimated mortality for females <5y 3.02	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME
	Vaccine coverage (all) in 2y (%) 3.03	DHS	DHS		DHS		DHS	DHS	
	Vaccine coverage (BCG) in 2y (%) 3.04	DHS	DHS		DHS		DHS	DHS	
	Vaccine coverage (Measles) in 2y (%) 3.05	DHS	DHS		DHS		DHS	DHS	
	Care seeking for fever in <5y (%) 3.06		UNICEF				UNICEF	UNICEF	
	Inadequate supervision of child, 0-59m (%) 3.07	UNICEF	UNICEF	UNICEF			UNICEF		
Nutrition	Stunting in < 5y (%) 3.08		UNICEF	UNICEF			UNICEF	UNICEF	
	Anaemia 0-19y (%) 3.09a	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Thinness in 5-19y (%) 3.10	WHO	WHO	WHO	WHO	WHO	WHO	WHO	WHO
	Overweight 5-19y (%) 3.11	WHO	WHO	WHO	WHO	WHO	WHO	WHO	WHO
Health risk	Total DALYs per 100,000 in 10-19y olds 3.12a	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Binge drinking, 15-19y (%) 3.13	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Daily tobacco smoking, 10-19y (%) 3.14	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
Mental health	Suicide mortality per 100,000 in 10-19y 3.15	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Mental disorder DALYs per 100,000 in 10-19y 3.16	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Significant worry last 12m in 13-17y (%) 3.17	WHO	WHO	WHO		WHO	WHO	WHO	WHO
	Demand for modern contraception satisfied 15-24y (%) 3.18a	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
SRHR	Demand family planning satisfied 15-19y (%) 3.18b		DHS		DHS		DHS	DHS	
	Married 15-19y females can refuse sex (%) 3.19						DHS		
	AFR 15-19y per 1000 (measured) 3.20a	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF
	AFR 15-19y per 1000 (modelled) 3.20b	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Maternal mortality rate per 100,000 in 15-19y 3.21	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	New cases HIV in 15-19y 3.22a								
	HIV in sex workers <25y (%) 3.22b.1	UNAIDS	UNAIDS		UNAIDS			UNAIDS	UNAIDS
	HIV in MSM <25y (%) 3.22b.2	UNAIDS	UNAIDS		UNAIDS		UNAIDS	UNAIDS	UNAIDS
	HIV in transgender people <25y (%) 3.22b.3		UNAIDS					UNAIDS	
	HIV in injecting drug users <25y (%) 3.22b.4	UNAIDS	UNAIDS		UNAIDS			UNAIDS	
	Comprehensive knowledge of HIV in 15-19y (%) 3.23	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	
	Existence of HPV program 3.24		WHO	WHO					



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Key gender inequalities observed

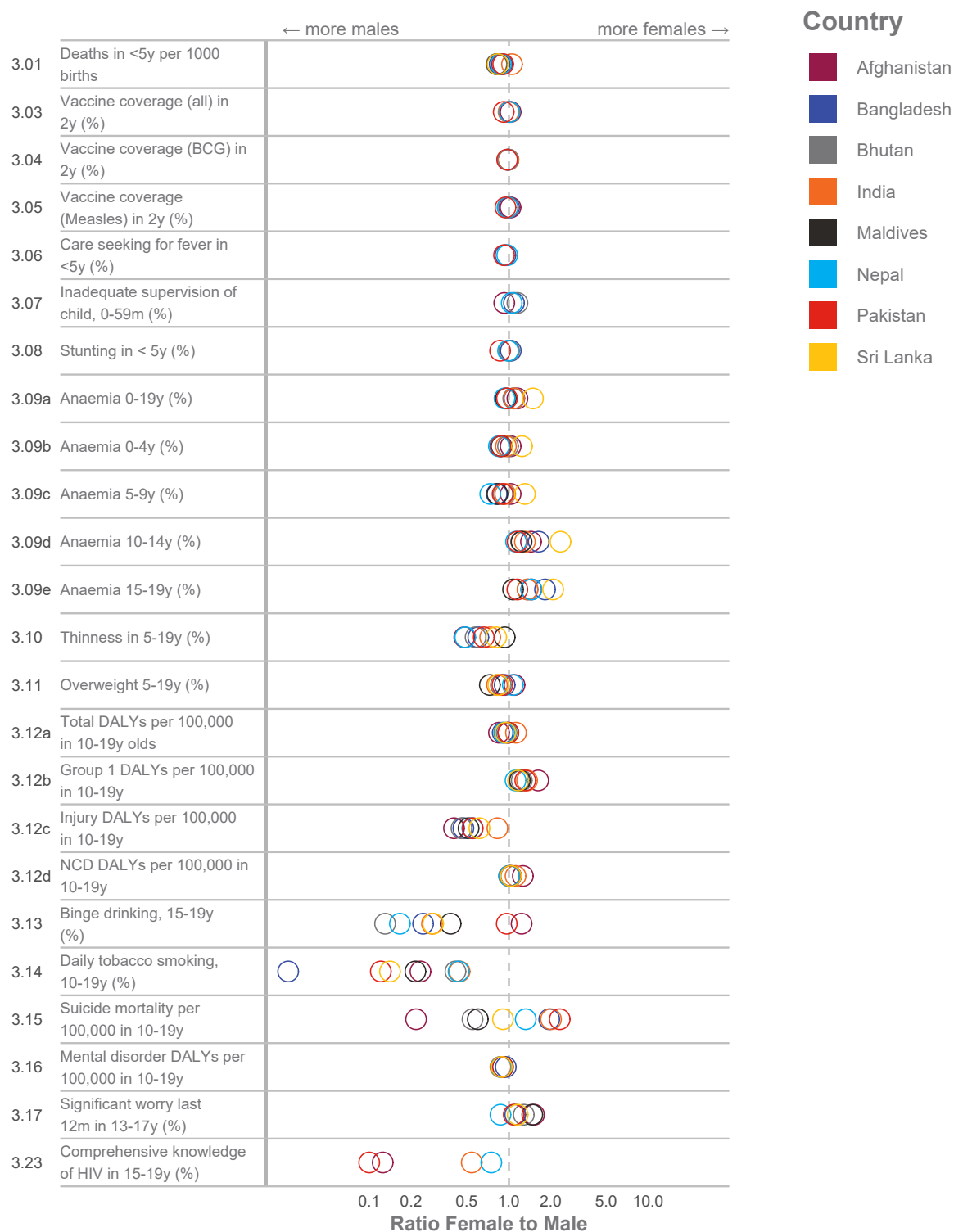
In several countries, girls under-5 years of age have a higher than expected mortality, with substantial excess mortality in India. In adolescence, more girls than boys die from suicide in South Asia and girls are more likely to have anaemia (Figure 3.1). Girls are also more likely to experience an excess burden of disease from Group 1 Conditions (communicable, maternal and nutrition diseases). Poor reproductive outcomes also remain a substantial issue for girls across the region, including adolescent pregnancy and unmet needs for contraception.

Boys demonstrate higher levels of risk behaviour such as binge drinking and tobacco smoking and are also at excess risk of injury. They are more likely to be thin than girls and to have a comprehensive knowledge of HIV.

It should be noted that the following inequality plot does not include indicators for which data was only available for females, particularly for those indicators of sexual and reproductive health where considerable needs exist, largely as the result of gender inequality. These indicators are detailed in the following sections.

TABLE 3.1: HEALTH-RELATED INDICATORS AND DATA SOURCES FOR COUNTRIES IN THE REGION

This graph shows the ratio of outcomes in females to males for indicators of health where possible to do. Note that ratios are shown on the log scale. A rate ratio of greater than 1 means that the outcome is more common in females than males; a ratio of less than one indicates that the outcome is more common in males. Data sources are detailed in Appendix 3.





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Detailed findings across indicators

Child health and development (Indicators 3.01 – 3.07)

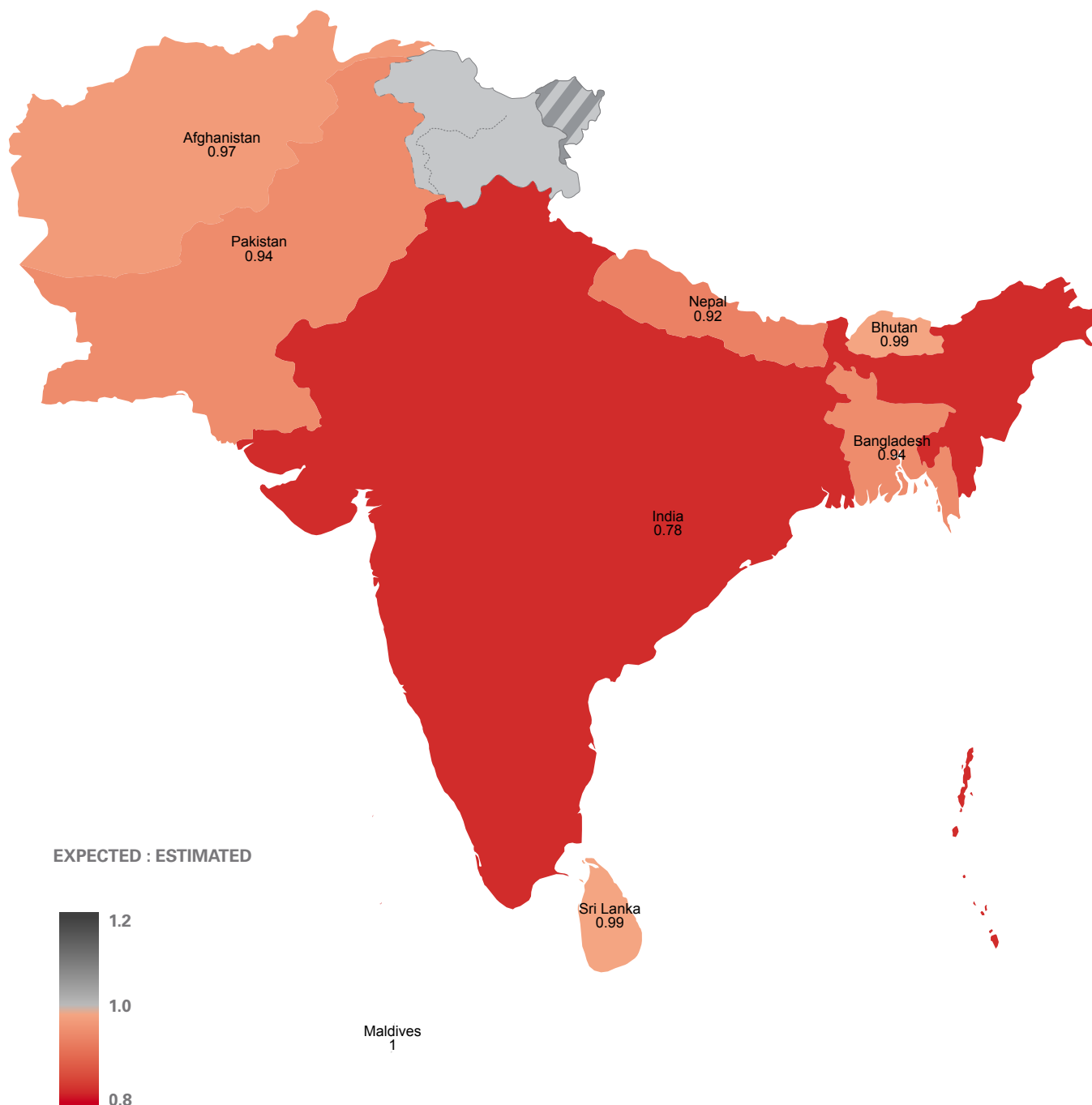
The data for **under-five mortality** (Indicator 3.01) indicates a slightly higher mortality for boys than girls (see Figure 3.1). However, this is to be expected as boys' greater biological frailty leads to increased mortality in this age group. Taking girls' survival advantage into account, under-5 mortality is actually higher than expected for girls in Bangladesh, India, Nepal and Pakistan, with excess female mortality being substantial in India (see Figure 3.2). This is explored in greater detail in Case Study 3.1.

While there is little difference in caregiving of young children by gender, there are small but consistent differences in care-seeking for young girls in response to child illness, such that caregivers are less likely to seek care for their illness compared to boys.

Overall there were minimal gender difference in **vaccine coverage** with the exception of Pakistan where slightly more boys are vaccinated than girls.

FIGURE 3.2: EXPECTED TO ESTIMATED FEMALE MORTALITY FOR UNDER 5-YEAR-OLDS

This map shows the expected to estimated under-5 mortality rate for females under-5 years across the region. Countries shaded in red have a higher female mortality than that expected (a ratio of less than 1). Data source: UNIGME 2017.



This map is for illustrative purposes only and does not reflect a position by the United Nations or other collaborative organizations on the legal status of any country or territory or the delimitation of any boundaries. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.



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CASE STUDY 3.1: EXCESS MORTALITY AMONG GIRLS UNDER-FIVE YEARS OF AGE

Under-5 mortality is higher than expected for girl children in Bangladesh, Nepal and Pakistan however the discrepancy is marked in India where estimated mortality rates for girls are 28% higher than those biologically expected. This inequality is supported by census data which estimates 7.1 million fewer females than males aged 0-6 years in India.⁶² This equates to 239,000 excess female deaths under five annually or 2.4 million in a decade.⁶³ Excess female child mortality has been found in almost all districts (90%) but it was most pronounced in the rural, agricultural areas of northern India where four states account for two thirds of the excess deaths.⁶³ It is worth noting, that while the northern regions are more pronounced in excess mortality, the western regions of India are characterised by skewed sex ratios at birth in favour of male children (see the Case Study Sex imbalances at birth).

High fertility, underdevelopment and gender bias have been identified as the main predictors of excess female mortality which is suggested to be also related to unplanned child bearing, son preference and subsequent neglect. Whilst this review was not able to locate data for febrile illness, neglect and stunting for India, other studies suggest a correlation between excess female mortality and: 1) lower access to effective prevention and treatment health services, particularly for the leading infectious causes of death, pneumonia, diarrhoea, and febrile illness; and 2) inequality in feeding practices and nutritional status.⁶⁴ For example, Indian girls are reported to be breastfed for shorter periods of time and consume less milk than boys.⁶⁵ This discrepancy has been suggested to relate to pressure on the mother of a girl to become pregnant again and deliver a male child.

“.. if they don’t like females they are putting paddy (rice on the stalk) in the baby’s mouth and it will die. Another one, they don’t feed the baby for 2–3 days and it will die. Or they give herbal plants, milk of some plant to kill...”.⁶⁶

Food security and nutrition (Indicators 3.08 - 3.11)

Malnutrition affects girls and boys differently in the region. Boys are more likely to be **thin** (Indicator 3.10) compared with girls across all countries (Figure 3.3). Thinness is most common in India where 23% of girls and 31% of boys, aged 15-19 years, are reported to be thin. This has implications for both genders, but places girls at particular risk of poor sexual and reproductive health. Gender differences in **overweight or**

obesity rates (Indicator 3.11) are relatively small in most countries, the exception being the Maldives where rates are highest and boys (19%) are more likely to be overweight than girls (14%). There do not appear to be significant gender differences in **stunting** (Indicator 3.08), other than in Pakistan where rates are the highest and slightly more boys (48%) are stunted than girls (42%).

FIGURE 3.3: STUNTING IN < 5-YEAR-OLDS

This figure shows the prevalence (%) of stunting in <5-year-olds (Indicator 3.08) for females (filled circle) and males (unfilled circle). The panel to the right shows the difference in estimates, with a negative number indicating more stunting among boys and a positive number indicating more stunting among girls. Data source: UNICEF 2010-14.



INDICATOR 3.08: STUNTING IN < 5-YEAR-OLDS (%)

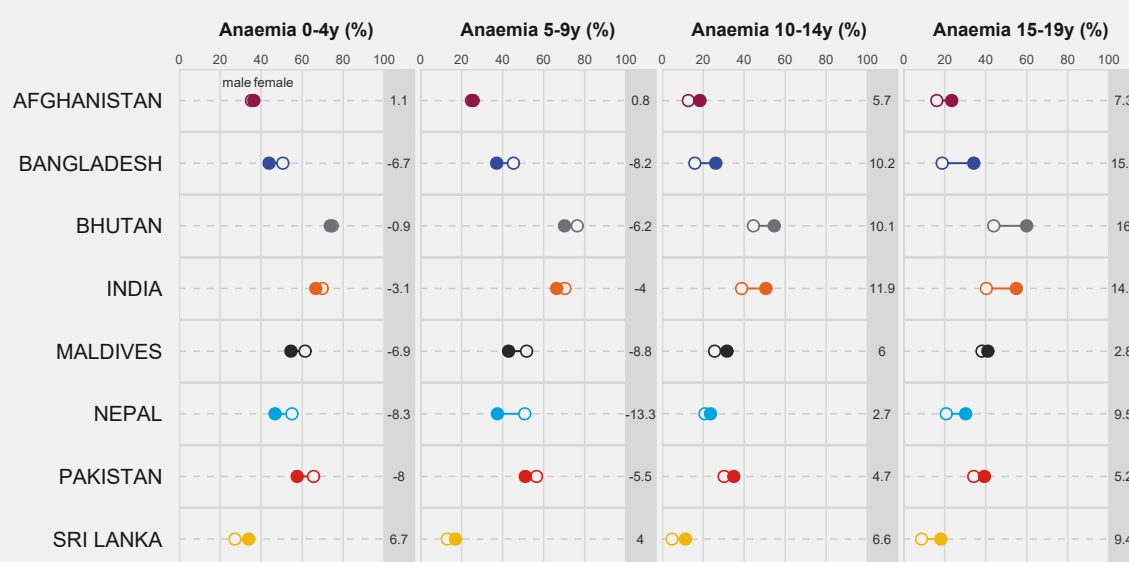
The burden of **anaemia** (Indicator 3.09) is very high for both boys and girls across the region, and generally changes over the course of child development (Figure 3.4). For children under nine years of age there is not a significant gender disparity in anaemia. However, there is increasing gender disparity throughout adolescence, with increasing rates of anaemia observed among adolescent girls compared to boys. This is a significant concern, given its implications for inter-generational nutrition, since the nutritional status of a mother has a direct bearing on the nutritional status of her offspring. It is also a concern given the high rate of adolescent marriage and pregnancy in many countries in the region.

This gender discrepancy in anaemia rates may be reflective of inadequate nutritional intakes

among adolescent girls in the region, partly due to cultural beliefs about appropriate types of food during menstruation. It is a critical concern given that their iron requirements increase significantly around menarche. The absence of specific data on iron-deficiency anaemia means that it is challenging to draw conclusions about the relative influence of malnutrition on girls' and boys' anaemia rates. Nevertheless, the gender disparities in thinness and overweight in most countries, combined with disparities in anaemia, indicate that both over-nutrition and under-nutrition are affecting children and adolescents in the region, and that these effects differ by gender. There are likely to be substantial health and equity benefits to identifying drivers of gender disparities in nutrition outcomes.

FIGURE 3.4: ANAEMIA IN CHILDREN AND ADOLESCENTS

This figure shows estimates of anaemia (Indicator 3.09) across childhood and adolescence for females (filled circles) and males (unfilled circles). The panels to the right show the differences in estimates, with a positive number indicating higher rates of anaemia among girls and a negative number indicating higher rates among boys. Data source: GBD 2016.



INDICATOR 3.09: PREVALENCE OF ANAEMIA BY AGE AND SEX (%)



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Adolescent morbidity and mortality (Indicators 3.12a - d)

Adolescents in this region experience a large burden of disease (Figure 3.5). Adolescent girls are disproportionately affected by **Group 1 Conditions** (Indicator 3.12b), namely communicable, maternal and nutritional diseases, likely mainly as a result of differential care practices and their unmet sexual and reproductive health needs. The gender disparities are highest in Afghanistan, India and Pakistan. In Afghanistan, girls experience 63% more disease burden from Group 1 Conditions than boys.

In contrast, adolescent boys are disproportionately affected by **injury** (Indicator 3.12c) including homicide, suicide, purposeful and accidental injuries. This is a substantial gender disparity with adolescent boys around twice as likely to be affected by injury compared with adolescent girls, in all countries except India. The disproportionate burden for boys reflects a global pattern, linked to harmful masculine norms that encourage violence and risk-taking but discourage vulnerability and weakness.⁶⁷⁻⁶⁹

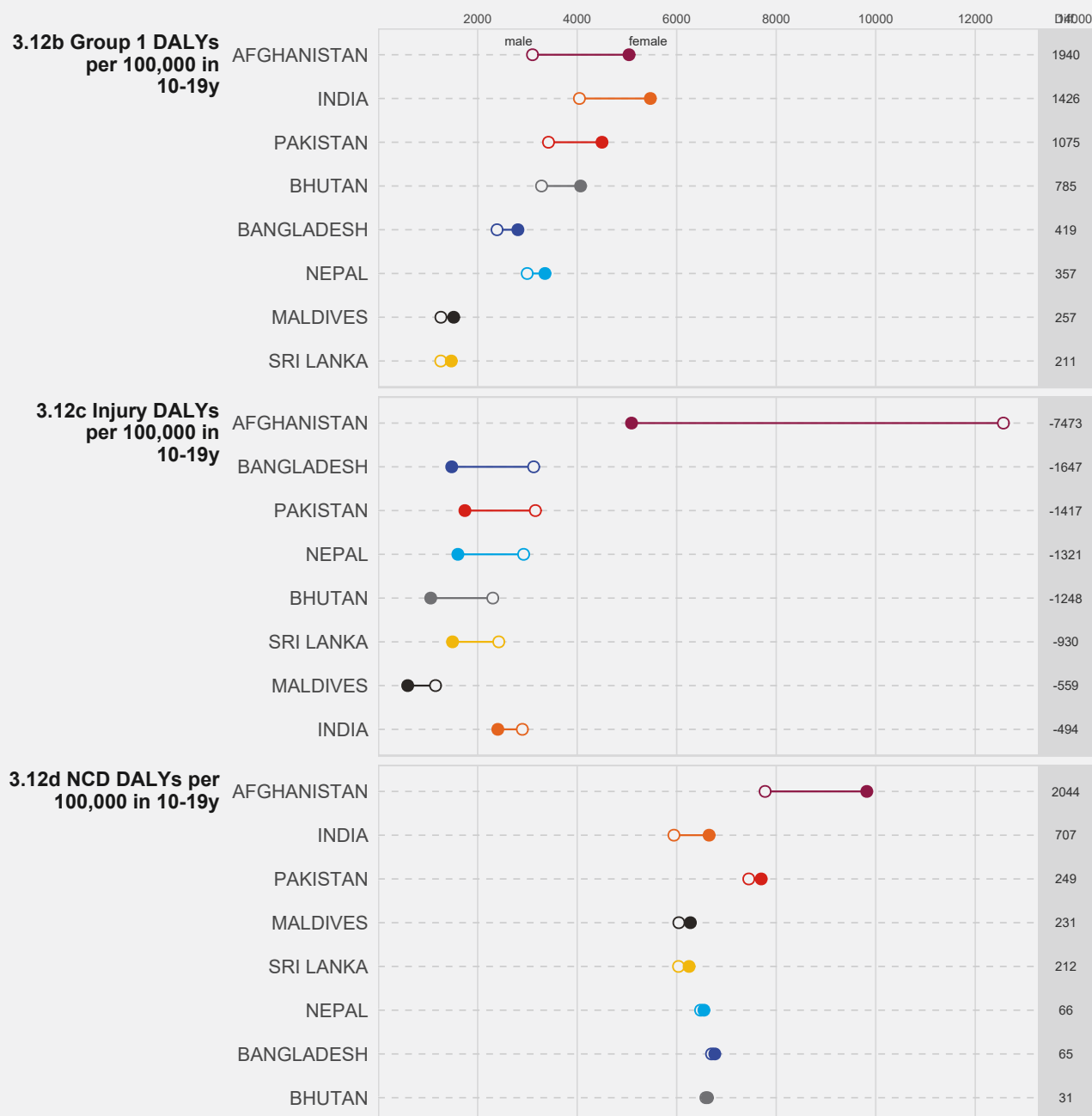
Non-communicable diseases (NCDs, Indicator 3.12d), including chronic physical conditions and mental health disorders, demonstrate no clear pattern of gender disparity. The exception being Afghanistan, where girls have a higher burden of non-communicable diseases than boys.

Adolescent boys are twice as likely to be affected by injury as girls.

FIGURE 3.5: DISEASE BURDEN IN ADOLESCENTS

This figure shows estimates of the burden of disease measured in DALYs (years of life lost due to disease, injury or death) due to Group 1 Conditions (including communicable, maternal and nutritional diseases), injuries and non-communicable diseases for adolescents aged 10-19 years. Estimates are shown for females (filled circles) and males (unfilled circles). The panel to the right shows the difference in estimates - a positive number indicates a greater burden for girls and a negative indicates a greater burden for boys.

Data source: GBD 2016.



INDICATOR 3.12: DALYs PER 100,000)

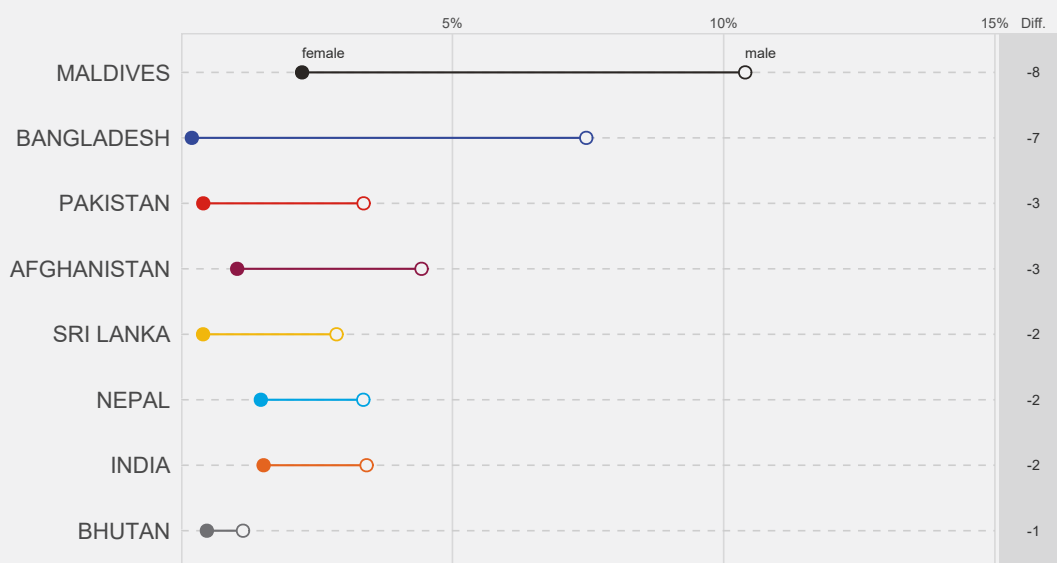
Health behaviours (Indicators 3.13 - 3.14)

Considerable gender disparities exist in key non-communicable disease risk factors that emerge in adolescence. Across the region, adolescent boys have much higher rates of daily **tobacco smoking** (Indicator 3.14) compared with adolescent girls, which is in line with current global patterns. The greatest disparities are in countries with the highest rates of male smoking, namely Bangladesh (7.5% of boys and 0.2% of girls) and the Maldives (10.4% of boys and 2.2% of girls). The prevalence of **binge drinking** (Indicator 3.13) is low by global standards in most countries, and generally conforms to the

global pattern of higher rates among adolescent boys. The gender differences are greatest in the Maldives (19% of boys and 7.3% of girls) and Sri Lanka (12.4% of boys and 3.6% of girls), where binge drinking is most common. Gender norms, which support toughness and male camaraderie, may encourage smoking and binge drinking.⁷⁰ For females, social norms that discourage alcohol consumption by women, combined with fears of vulnerability to gender-based violence may prevent adolescent girls from drinking.⁷⁰

FIGURE 3.6: TOBACCO SMOKING IN ADOLESCENTS

This figure shows estimates of daily tobacco smoking (Indicator 3.14) for 10–19-year-old females (filled circles) and males (unfilled circles). The panel to the right shows the difference in estimates – a negative number indicates smoking is more common among boys. Data source: GBD 2016



INDICATOR 3.14: DAILY TOBACCO SMOKING, 10-19Y

Psychosocial wellbeing (Indicators 3.15 - 3.17)

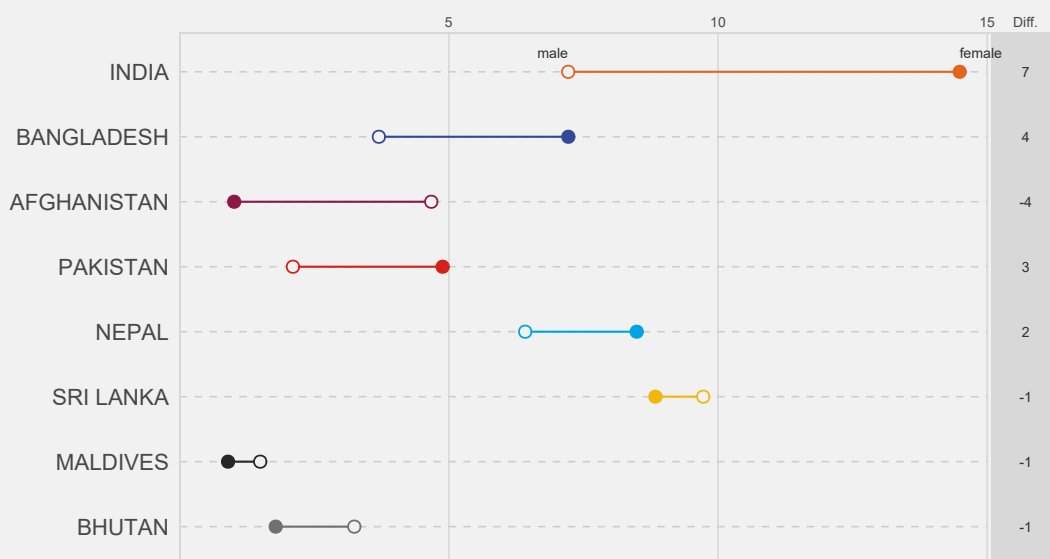
Suicide mortality (Indicator 3.15) is high among 10-19-year-olds, particularly in India, Nepal and Sri Lanka (Figure 3.7). Girls are at greater risk of suicide mortality compared with boys, in most countries where differences exist. In Bangladesh, India and Pakistan, death by suicide is twice as common for girls than boys. This pattern is in direct contrast to global trends where boys are generally at more risk (see Case Study 3.2 for further discussion). Adolescent girls in South Asia, are also more likely than boys to report **significant worry** in the last 12 months (Indicator 3.17). This anxiety is most common in Afghanistan and the Maldives, where approximately 50% more girls than boys report significant worry. The high suicide mortality and lower psychosocial wellbeing among girls in

most countries suggest that they are exposed to gender-related stressors that severely compromise autonomy and quality of life, and limit access to support networks and other protective factors. The burden of **mental disorders** (Indicator 3.16) does not differ greatly between girls and boys.

In contrast to global trends, in South Asia, more adolescent girls die from suicide than boys.

FIGURE 3.7: SUICIDE MORTALITY AMONG ADOLESCENTS

This figure shows estimates of suicide (deaths per 100,000) for 10–19-year-old females (filled circles) and males (unfilled circles). The panel to the right shows the difference in estimates – a positive number indicates more female deaths; a negative indicates more male deaths. Data source: GBD 2016



INDICATOR 3.15: SUICIDE MORTALITY PER 100,000 IN 10-19Y

CASE STUDY 3.2: WHY DO SO MANY GIRLS COMMIT SUICIDE IN SOUTH ASIA?

Worldwide, suicide is the second leading cause of death among young people. Adolescence is a period of rapid biological, psychological and social change, and puberty can trigger psychological stress for both girls and boys.⁷¹ Globally, more adolescent boys commit suicide than girls, however in several South Asian countries the opposite is true. In Bangladesh, India and Pakistan rates of adolescent female suicide are two-fold those of males. Even though rates of female suicide are high in most South Asian countries, the stigma surrounding mental illness and suicide still likely leads to under-reporting.^{72,73} India has the highest suicide rates for girls 10-19 years (14.5/100,000) but this still likely underestimates the magnitude of the problem since suicide is illegal and a girl's family or husband may be held responsible.

Suicide is generally more prevalent in rural or socioeconomically deprived areas. For example, the suicide rate is 17 times higher in rural than urban areas in Bangladesh.⁷² In rural Southern India, rates of suicide by young women are nearly three times those of young men (148/100,000 versus 58/100,000).^{73,74} Low educational attainment, unemployment and family or marriage problems increase the risk of suicide.^{36,74,75} High rates of violence against women and girls and the harmful practice of forced child marriage are also suggested to be significant contributors to female suicides. The types of violence experienced by girls in the sub-region are reported to include sexual and physical violence in the home, rape, acid attacks, stove burnings, trafficking and sexual exploitation in brothels.^{72,76} A study from Nepal, found the majority of female patients at health clinics reported having experienced domestic

abuse; 50%-70% had a history of sexual abuse by husbands or a family member.³⁶ In Bangladesh, up to 2% of females, aged 10-30 years, are employed in legal brothels where suicide is common and young, prepubescent girls are reported to be sold to older men as chattels, servants, domestic and sexual slaves.⁷²

Child marriage, of girls to older men, places them at risk of sexual and physical violence. Women in Bangladesh who reported physical violence by their husbands were twice as likely to have suicidal thoughts than those who did not suffer such violence.⁷² Violence against married girls is likely to increase if the girl's family defaults on dowry payments. Added to this violence is the great pressure on young brides to have children, particularly boys, when they are neither physically or psychologically ready.^{36,72} These factors may combine to make girls feel physically and psychologically trapped, with no other alternative than taking their own life.

Sexual and reproductive health and rights (Indicators 3.18 -3.24)

Adolescent fertility rates (Indicator 3.20)

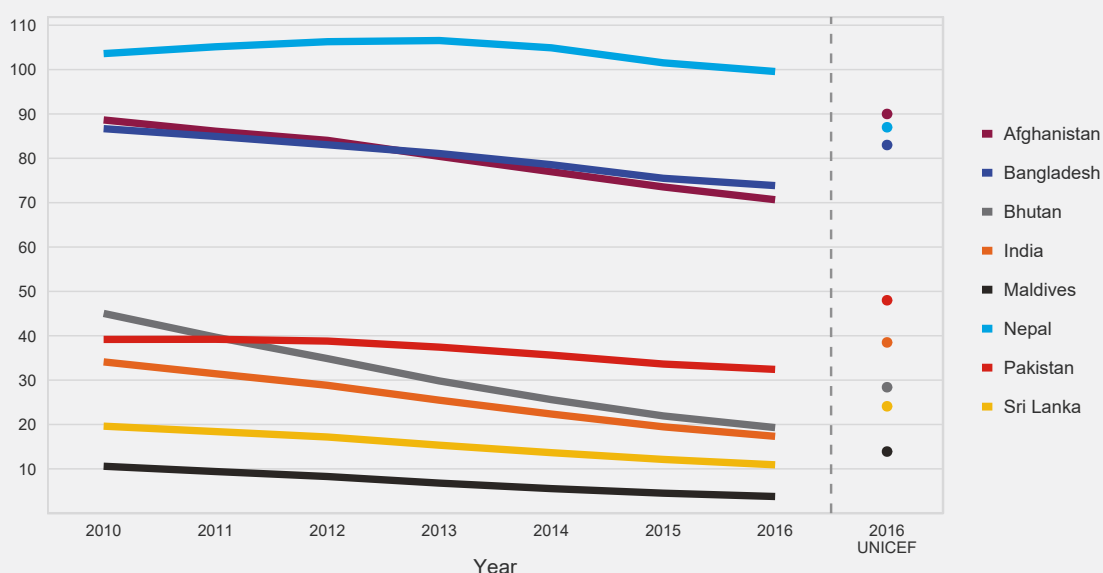
remain unacceptably high for many countries in the region particularly Afghanistan, Bangladesh and Nepal. Whilst births to teenage mothers are slowly declining in some countries, rates in Nepal and Pakistan appear stagnant. Adolescent pregnancy and child marriage both compromise girls' development, interrupting their schooling and limiting their future work and opportunities while also influencing inter-generational health and wellbeing outcomes. Adolescent pregnancy is associated with increased risk of low birth-weight for newborns, higher pre-natal and infant mortality and morbidity as well as higher mortality rates for adolescents giving birth. An unintended pregnancy, particularly outside of marriage, can have negative

Adolescent fertility rates remain unacceptably high for many countries in the region particularly Nepal, Afghanistan and Bangladesh.

consequences for a girl including stigma, social isolation, school expulsion, forced marriage and in some cases violence and suicide.⁷⁷

FIGURE 3.8: ADOLESCENT FERTILITY RATE

This figure shows the adolescent fertility rate (live births per 1000 females aged 15–19 years). The line chart to the left of the dashed line shows trends over time using modelled data (based on UNPD) as available from GBD. The single estimates to the right of the dashed line show point estimates from primary data, sourced from UNICEF.



INDICATORS 3.20b, 3.20a

INDICATOR 3.20b: AFR 15-19Y PER 1000 (MODELLED)

Maternal mortality rates (Indicator 3.21) among adolescents are declining across South Asia, although there remains substantial variation in rates. High-burden countries include Afghanistan (22 deaths per 100,000 girls), Pakistan (16 deaths), and to an extent Nepal (10 deaths).

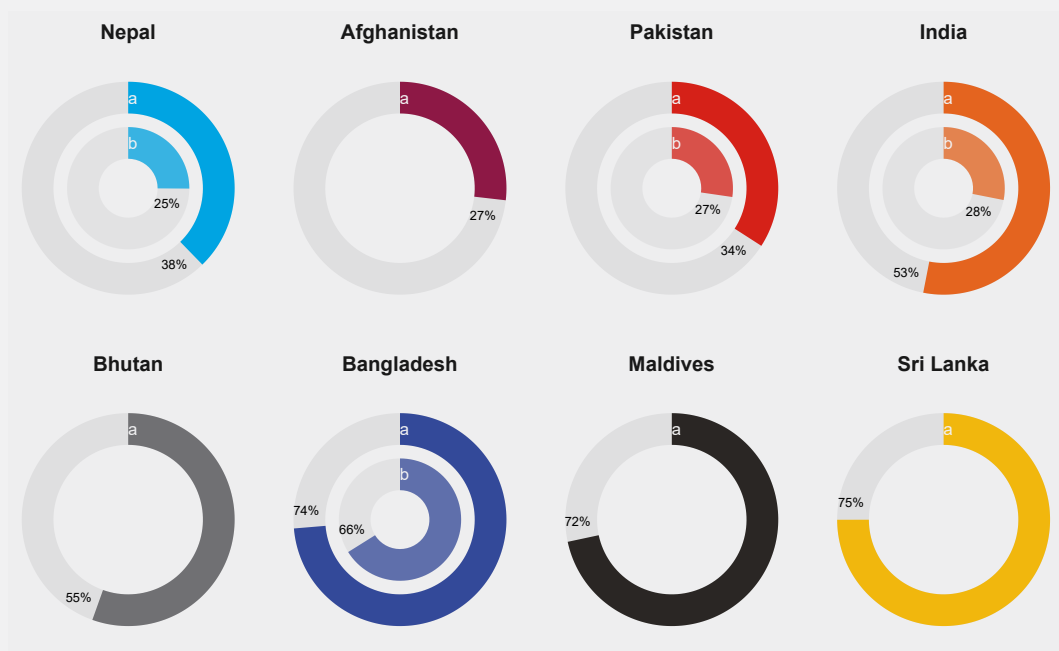
Many girls and young women in the region are not able to access **modern methods of contraception** (Indicator 3.22). In Afghanistan,

India, Nepal and Pakistan less than 30% of girls aged 15-19 years report their demand for family planning or modern contraception to be satisfied.

Where sex-disaggregated data are available, girls have less **knowledge of HIV** (Indicator 3.23) than boys. Boys greater knowledge may be reflective of their extended years in education or greater access to information. There is minimal gender disparity in **HIV incidence** (Indicator 3.22) in countries

FIGURE 3.9: DEMAND FOR CONTRACEPTION SATISFIED FOR FEMALES

This figure shows demand for contraception satisfied for females using two different data sources (Indicators 3.18a and 3.18b). The outer ring (labelled a) reports demand for contraception amongst 15-24-year-olds using modelled data from the GBD study. The inner ring (labelled b) reports the demand for contraception using data from DHS and MICS surveys for 15-19-year-olds (data coverage somewhat limited).



INDICATOR 3.18A: DEMAND FOR MODERN CONTRACEPTION SATISFIED 15-24Y (%)
INDICATOR 3.18B: DEMAND FAMILY PLANNING SATISFIED 15-19Y (%)

where data is available for both girls and boys. However, gender inequality is likely to play an important role in the HIV epidemic. For example, in Nepal, HIV is closely associated with the migrant workforce, with some men acquiring HIV whilst working in other countries.^{78,79} The low rates of barrier contraception in marriage contributes to the transmission of the virus to their wives. In India, the country with the highest number of adolescent cases, key populations are those most affected by HIV, including transgender people, men who have sex with men and sex workers. These young people are likely to lack power in their relationships and this may prevent them from refusing sex or negotiating safe sex due to risks of violence or rejection.^{80,81} In addition, stigma and discrimination may serve as a barrier to their engagement with health services.

Human papillomavirus (HPV, Indicator 3.24) is an important cause of cervical cancer in females, with growing evidence of its role in anogenital cancers (anus, vulva, vagina, and penis) and head and neck cancers (particularly oropharyngeal cancers such as tonsil and tongue cancer).^{82,83} Currently, WHO recommends that the primary target population for HPV vaccination is girls aged 9–14 years, prior to becoming sexually active.

Available data from WHO show that HPV national vaccination programmes exist in Bhutan and Bangladesh (see Indicator 3.22, *Appendix 3*), however it is unclear if the program in Bangladesh is a full national programme or pilot.⁸⁴ India and Nepal also have pilot programmes. There have been significant challenges in the introduction of the HPV vaccine for young adolescent girls. Barriers have included opposition from anti-vaccine and religious groups; lack of parental knowledge regarding HPV and cervical cancer; problems reaching out-of-school girls; difficulties linking HPV vaccination data to women's health programmes; financial barriers; and unfounded fears of side effects.⁸⁵⁻⁸⁷

Gender inequality and norms also act as barriers to the introduction of the vaccine and control of HPV. Social norms which value girls' chastity and discourage girls' sexual debut serve as barriers to HPV vaccination uptake, based on the rationale that girls' rates of sexual activity is low. There has also been some debate that HPV has been over-identified as a female-specific disease resulting in the 'feminisation of HPV' and HPV vaccines.⁸⁸⁻⁹⁰ This feminisation reinforces gender norms, which place women as responsible for sexual and reproductive health and stigmatise women as hosts for HPV. It is suggested that this not only limits public awareness of the importance of vaccinating boys but may have also impacted the inclusion of the vaccine on immunisation schedules and uptake by parents.

Summary

Domain 3

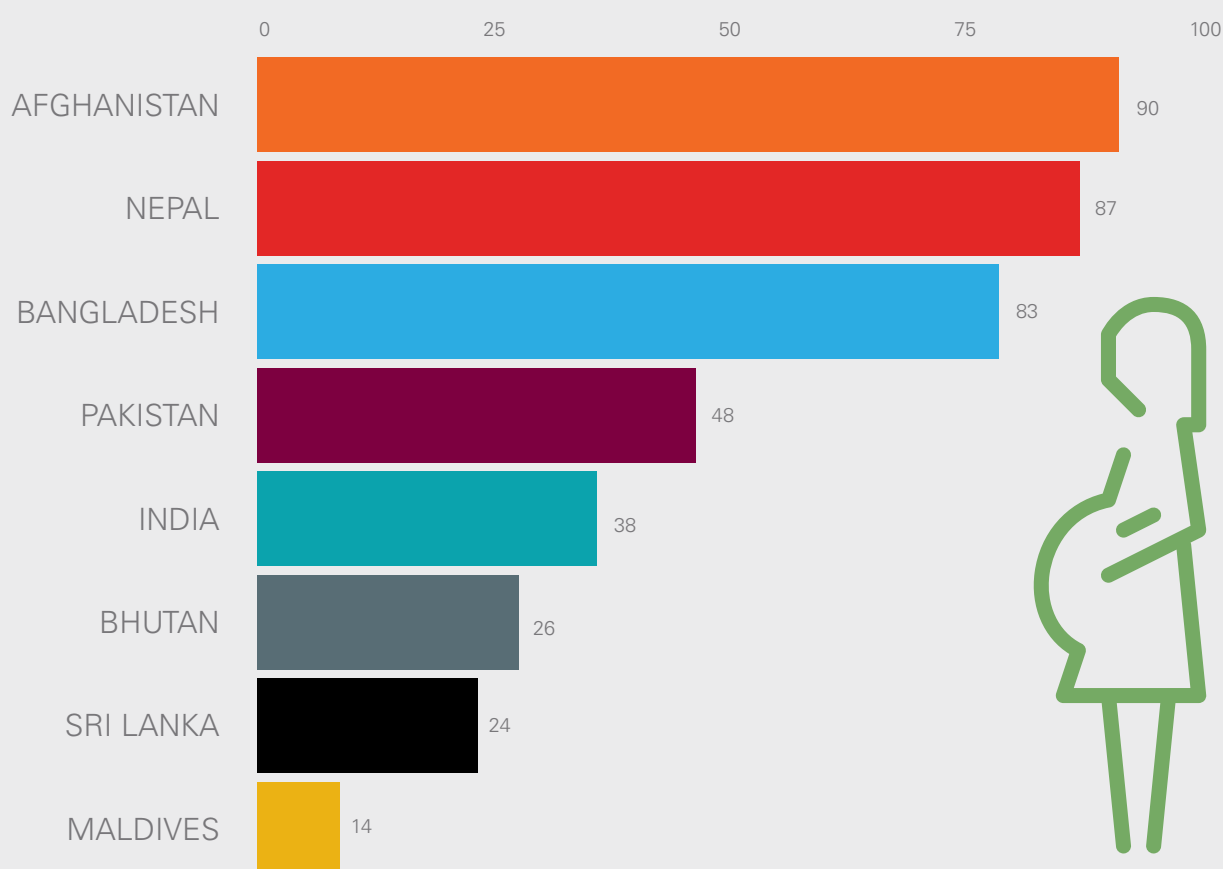
Impact of gender inequality on health

Key data gaps

- There are a number of data gaps for adolescent health, particularly relating to: disability; menstrual health and hygiene; family planning for unmarried girls; and the sexual and reproductive health for adolescents aged less than 15 years and adolescent boys;
- Bhutan, the Maldives and Sri Lanka were the countries with the most data gaps.

Adolescent pregnancy rates remain high

Adolescent fertility rate (births per 1000 15-19 year olds)



Key gender issues in child and adolescent health outcomes include:

Girls under-5 years of age have a higher than expected mortality across the region, with substantial excess mortality in India.

Adolescent girls experience a disproportionate burden of anaemia.

Girls experience a greater burden of Group 1 Conditions (communicable, maternal and nutritional) than boys.

Boys experience an excess burden from injuries compared to girls.

More boys participate in health risk behaviours such as tobacco smoking.

In contrast with global patterns, adolescent girls in Bangladesh, India, Nepal and Pakistan have an excess risk of suicide compared to boys.

Poor reproductive health outcomes for girls remains a substantial issue across the region with high rates of adolescent pregnancy, particularly in Afghanistan, Bangladesh, Nepal and Pakistan. In these same countries, demand for contraception amongst adolescents goes largely unmet. Maternal mortality rates are particularly high for adolescents in Afghanistan and Pakistan.

Gender disparities in suicide



At least twice as many boys die from suicide than girls in Afghanistan, Bhutan and the Maldives



More girls die from suicide than boys in Bangladesh, India and Pakistan

These gender inequalities in health are likely to reflect discrimination against girls; the higher value placed on boy children; harmful masculine norms which support violence and risk-taking; and/or imbalances in power relations that negatively impact girls' lack of autonomy and self-determination.

Domain 4



Impact of gender inequality on education and employment

This section explores how gender inequality may impact the educational outcomes of girls and boys and their transition to employment.

Data availability

Data for gender inequality in education and employment were sourced from collated datasets (UNICEF SOWC, UNESCO, ILO and WHO/UNICEF Joint Monitoring Programme) and primary surveys (MICS and DHS) (Table 4.1). Data were available across all indicators with the exception of Indicator 4.14 (proportion of young people in informal employment) and sex education in secondary schools (Indicators 4.06b-c). Data coverage was sparse for access to information for young people (Indicators 4.09–4.11). With respect to countries, data were most limited for Sri Lanka and the Maldives.

Data on attendance for primary and lower secondary (Indicators 4.01a and 4.01b) were available from UNICEF SOWC (collated from available MICS, DHS and other national surveys), with data on attendance at upper secondary (4.01c) provided by UNICEF. Data for Indicator 4.03 (out-of-school children and adolescents), which is a complement to Indicator 4.01, was available from UNICEF for primary and lower secondary and sourced from UNESCO for upper secondary. Note that data from UNESCO for Indicator 4.03c were restricted to household surveys to harmonise with the estimates for Indicators 4.03a and 4.03b.

Indicator 4.05 measures the youth literacy rate. Beyond this, it was not possible to measure indicators relating to dimensions of educational achievement and quality (which relates to SDG 4.1) given these indicators remain to be fully defined and there is a lack of routine data collection and reporting for these key outcomes.

TABLE 4.1: INDICATORS AND DATA AVAILABILITY FOR EDUCATION AND TRANSITION TO EMPLOYMENT

Data sources are shaded as blue (compiled dataset, such as UNICEF), green (primary survey data such as MICS) or amber (modelled dataset, such as the Global Burden of Disease). The table is shaded dark grey where data are not available.

		Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Participation	Adjusted net attendance ratio, primary school (%) 4.01a	UNICEF	UNICEF	UNICEF			UNICEF	UNICEF	
	Adjusted net attendance ratio, lower secondary school (%) 4.01b	UNICEF	UNICEF	UNICEF			UNICEF	UNICEF	
	Adjusted net attendance ratio, upper secondary school (%) 4.01c	UNICEF	UNICEF	UNICEF			UNICEF	UNICEF	
	Completion rate, primary school (%) 4.02a	UNESCO	UNESCO	UNESCO	UNESCO		UNESCO	UNESCO	
	Completion rate, lower secondary school (%) 4.02b	UNESCO	UNESCO	UNESCO	UNESCO		UNESCO	UNESCO	
	Completion rate, upper secondary school (%) 4.02c	UNESCO	UNESCO	UNESCO	UNESCO		UNESCO	UNESCO	
	Not in school, primary school (%) 4.03a	UNICEF	UNICEF	UNICEF		UNICEF	UNICEF	UNICEF	
	Not in school, lower secondary school (%) 4.03b	UNICEF	UNICEF	UNICEF		UNICEF	UNICEF	UNICEF	
	Not in school, upper secondary school (%) 4.03c	UNESCO	UNESCO		UNESCO		UNESCO	UNESCO	
Quality	Pre-primary school enrolment (%) 4.04		UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF
	Youth literacy, 15-24y (%) 4.05	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF	UNICEF
	Primary schools teaching sex education (%) 4.06a								
	Lower secondary schools teaching sex education (%) 4.06b								
Environment	Upper secondary schools teaching sex education (%) 4.06c								
	Female primary school teachers (%) 4.07a	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO
	Female lower secondary teachers (%) 4.07b	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO	UNESCO
	Female upper secondary teachers (%) 4.07c	UNESCO	UNESCO	UNESCO	UNESCO		UNESCO	UNESCO	
Information access	Schools with basic sanitation facilities (%) 4.08		JMP	JMP	JMP				JMP
	Mobile phone ownership, 15-19y (%) 4.09		DHS				DHS	ITU	
	Internet used last 12mth, 15-19y (%) 4.10		MICS				DHS		
	Weekly access to information media, 15-19y (%) 4.11	DHS	DHS		DHS		DHS	DHS	
Employment	Not in education, employment or training, 15-24y (%) 4.12		ILO		ILO	ILO		ILO	ILO
	Proportion of labour force unemployed, 15-24y (%) 4.13	ILO	ILO	ILO	ILO	ILO		ILO	ILO
	Proportion employed in informal sector, 15-24y (%) 4.14								

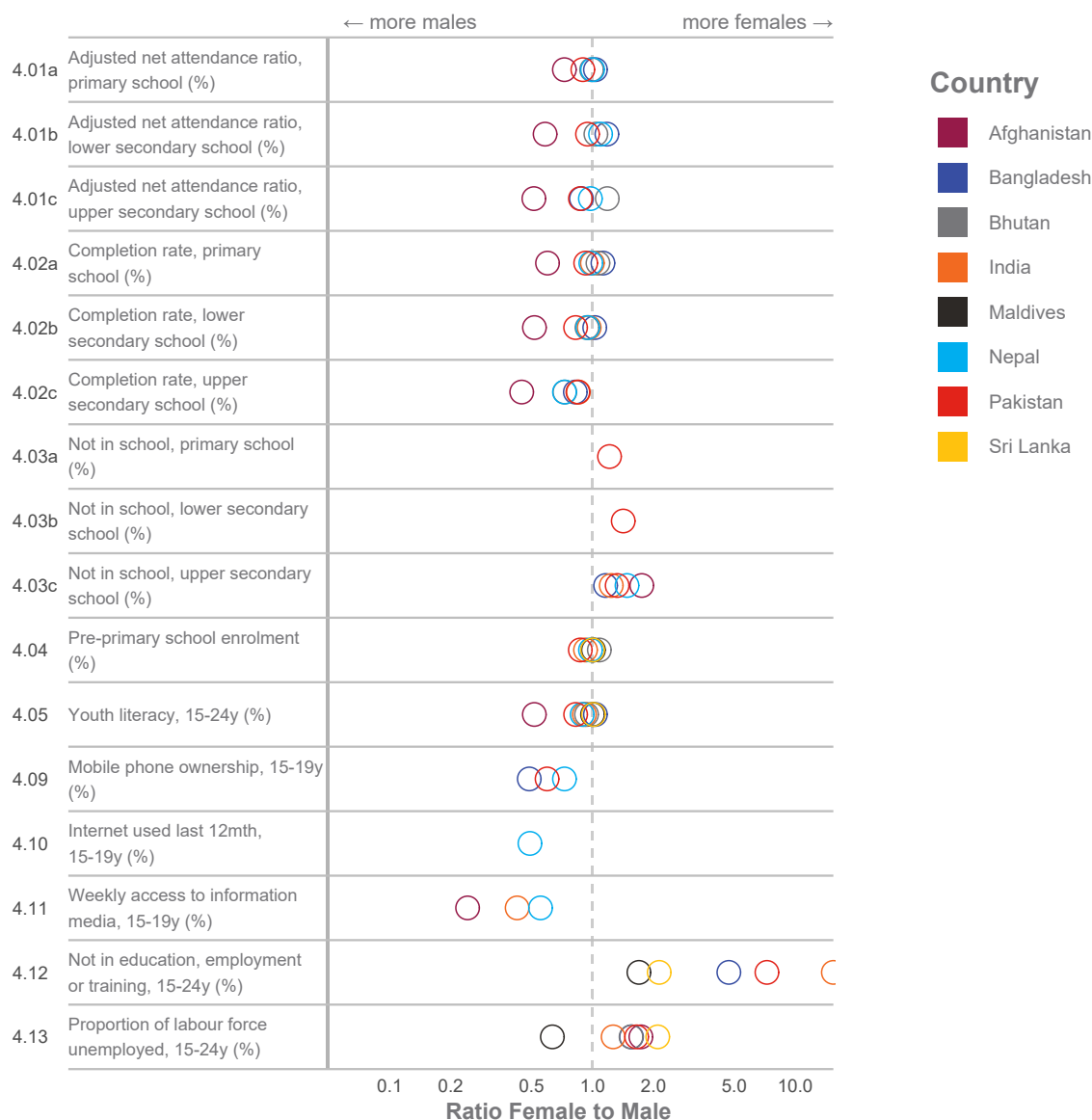
Key gender inequalities observed

In South Asian countries, with the exception of Afghanistan, girls are equal to boys or advantaged in their attendance and completion of primary and lower secondary school. However, girls are less likely than boys to complete upper secondary school and on leaving school, females aged 15-24

years are more likely than males the same age, to not be in education, training and employment (Figure 4.1). Boys are more likely to have access to information, including use of mobile phones, the internet or media, for the few countries where data are available.

FIGURE 4.1: INEQUALITY PLOT FOR INDICATORS IN THE EDUCATION AND EMPLOYMENT DOMAIN

This graph shows the ratio of outcomes in females to males for indicators of education and employment, where data is available. Note that ratios are shown on the log scale. Data sources are detailed in Appendix 3.



Detailed findings across indicators

School participation (Indicators 4.01 – 4.04)

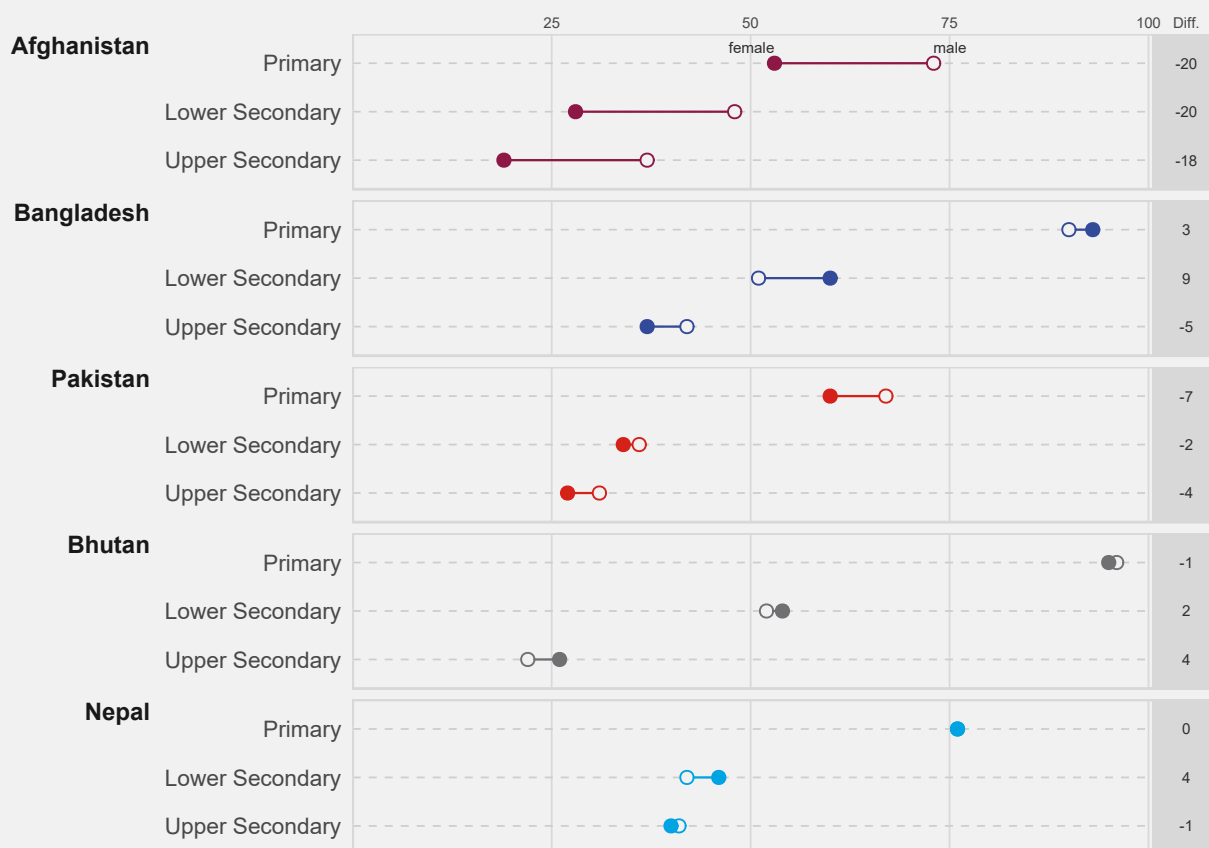
For most countries in the region, there are minimal gender disparities in **school attendance** rates (Indicator 4.01) (Figure 4.2). The exception is Afghanistan, where girls are substantially less likely than boys to attend each level of schooling, which is partly related to the conflict circumstances of the country. At upper secondary level in Afghanistan, where the disparity is most

marked, almost twice as many boys (37%) as girls (19%) attend school.

Gender disparities in **school completion** (Indicator 4.02) increase over levels of schooling. There are minimal gender disparities in primary school completion, again, the exception being in Afghanistan where only 40% of girls complete

FIGURE 4.2: SCHOOL ATTENDANCE

This graph shows school attendance (Indicator 4.01) across primary, lower secondary and upper secondary school for girls (solid circle) and boys (hollow circle) in this region. The panel to the right shows the difference in estimates between girls and boys – a negative indicates boys have higher attendance; a positive number indicates a greater proportion of girls attend. The order of countries is based on the magnitude of the gender disparity with those with the greatest differences being first. Data source: UNICEF and UNESCO, 2010-16.



INDICATOR 4.01: ADJUSTED NET ATTENDANCE RATIO



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primary school compared to 67% of boys. In other countries, disparities emerge during secondary education, such that girls are less likely than boys to complete upper secondary school in all countries for which data are available. This gender disparity is superimposed upon declining rates of school completion over successive levels of schooling among both girls and boys. The differences are most marked in lower secondary in Afghanistan and Pakistan and upper secondary in Bhutan, India and Nepal. These gender disparities in school completion are likely to contribute to differences in youth literacy, where young women's literacy is lower than young men's, in most countries across the region.

Data for children and adolescents **out-of-school** (Indicator 4.03) varies substantially across the region. In all countries, there are more girls out of upper-secondary school than boys, with the greatest disparities found in Afghanistan, Nepal and Pakistan. In Afghanistan and Pakistan, there are more girls out-of-school at all levels, with the disparities increasing over the course of education, until in upper-secondary there are respectively 72% and 56% of girls out-of-school compared to 41% and 42% of boys. Only in lower-secondary school in Bangladesh are there substantially more boys not in school than girls,

These differences in schooling, for girls and boys, likely reflect the impact of entrenched gender norms that devalue women and girls' contributions beyond a domestic and reproductive role. These norms exclude women from civic participation including employment, education, and other related elements of the public sphere. Where boys do leave school they appear more likely to enter employment, further education or training (see Transition to employment, Indicators 4.12 – 4.14). This is likely due to social expectations that boys and men fulfil the role of provider for the family.

Learning outcomes and quality of education (Indicators 4.05- 4.06)

There is limited data by which to assess learning outcomes. There are substantial differences in **youth literacy**, (Indicator 4.05) in Afghanistan and Pakistan, where respectively, 62% and 80% of boys aged 15-24 years are literate compared to 32% and 66% of girls. Smaller disparities, in boys' favour, can also be seen in Bhutan, India and Nepal. No data was available on the implementation of life skills-based HIV and sexuality education in the region.

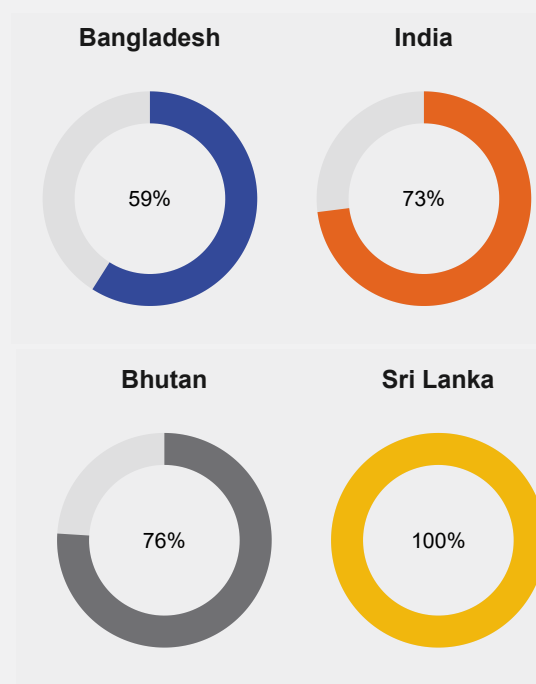
School environment (Indicators 4.07- 4.08)

Data indicate that school environments may be less supportive of girls' education compared with boys' education. **Female teachers** (Indicator 4.07) are under-represented in most countries particularly as schooling progresses. The disparities are most marked in: Afghanistan where only about one third of teachers across all levels are female; and Nepal where 44% of primary teachers, 27% of lower-secondary and 18% of upper-secondary teachers are women. This distinct pattern of fewer female teachers at more advanced stages of schooling is repeated in most countries. Even in Bangladesh, where 60% of primary school teachers are women, the proportion of female lower and upper secondary teachers drop to the same levels as Nepal. The under-representation of female teachers in higher stages of schooling indicates a lack of female role-models and can serve to reinforce norms that undermine girls' academic achievement.

One quarter of schools in Bhutan and India, and more than one-third of schools in Bangladesh, do not have **improved sanitation facilities** (Indicator 4.08). Where schools do not have improved, single-sex, functional sanitation facilities, girls are likely to find it more difficult to attend school while navigating privacy and safety challenges around sanitation and hygiene, including management of menstruation.

FIGURE 4.3: IMPROVED SANITATION

This graph shows the proportion of schools with basic sanitation facilities (Indicator 4.08) where data are available. Data source: WHO/ UNICEF Joint Monitoring Programme, 2016.



INDICATOR 4.08: SCHOOLS WITH BASIC SANITATION FACILITIES (%)

Access to information (Indicators 4.09 - 4.11)

Available data on gender differences in access to information is limited, but where available there are considerable gender disparities. In all three countries with data, more boys **own mobile phones** (Indicator 4.09) than girls. The disparity is greatest in Bangladesh where the proportion of boys owning phones (63%) is twice that of girls (31%). Sex-disaggregated data on **internet usage** (Indicator 4.10) is only available for Nepal, where once again boys are twice as likely to have access as girls – 62% of boys reported using the internet in the last 12 months as compared to only 30% of girls. Only a small percentage of adolescents report weekly **access to information media** (Indicator 4.11) however in all three countries with data, the proportion of boys with access is at least twice that of girls. In Afghanistan, 6% of boys report weekly access but only 2% of girls. Where girls and boys have different access to the internet or to mass media, there are implications for exposure to important information about health and rights, opportunities for political participation and connection with broader social networks. See Case study 4.1 for more information.

CASE STUDY 4.1: GIRLS ACCESS TO TECHNOLOGY - GIRLS DISCONNECTED

South Asia has the widest gender gap in mobile phone ownership in the world.^{91,92} Women in South Asia are 26% less likely to own a mobile than men and 70% less likely to use the internet.⁹³ This gap emerges as girls enter puberty, broadens as they reach older adolescence and persists after marriage.⁹² Research in India, has found almost twice as many boys have phones as girls, and in Bangladesh about two-thirds more.⁹⁴ Gaps in male-female ownership are higher in rural and poor areas.⁹² Affordability is one obstacle to ownership however in wealthier areas while male phone ownership increases, the same cannot be said for females.

When girls do get hold of mobile phones, their access is often temporary and the phone is often borrowed or shared.⁹⁴ They are more likely than boys to have to ask permission to use a phone. In India and Bangladesh, male family members particularly brothers and fathers, are girls' main source of a phone - 95% of girls in Bangladesh reported borrowing phones, 42% from a younger or older brother. As a result, girls often lack the consistent access and support required to understand the full potential of mobiles and the internet. They are less likely to use mobile internet and develop digital literacy skills.⁹⁴ When girls do get online, difficulty finding media relevant to their lives reinforces the same gender norms that restrict their access.⁹⁴

People say that the girl
who touches the phone is
a bad girl.

(Girl, 16, Bangladesh, Girl Effect)⁹⁴

The greatest barrier to girls' and women's use of phones is lack of agency due to restrictive social norms.^{92,94} South Asian societies are generally patriarchal with strong social norms governing many aspects of girls' and women's lives.⁹² By broadening girls' contacts and access to information, mobile phone usage challenges many of these traditional gender norms. This includes the need for female 'purity' prior to marriage and concerns regarding a girl's reputation; risk of her forming relationships or eloping; and potential for digital harassment including phone calls from men, suggestive text messages, and potential blackmail threats.^{92,94,95} Norms regarding female subservience and a woman's primary role as caregiver also leave girls and women with fewer opportunities to use the phone for socially acceptable "productive" purposes.⁹² These norms mean girls can experience strong negative social judgment for phone use.⁹⁴ Parental concern regarding phone contact with men can even lead to removal from school and early marriage. In

some communities in North India, where there are bans or severe restrictions on mobile phone use by girls and unmarried women, families of girls using phones may face humiliating punishments or fines.⁹⁵ Females in such restrictive environments often internalise these ideas of risk, perceive phones as dangerous and girls as being not capable of responsible use.⁹⁴

Girls' lack of mobile phone access, means they are missing out on the transformative opportunities offered by mobile connectivity including the internet as a source of education and information, safe messaging in their communities, access to services and guidance, including health and financial services and employment opportunities. Girls are even more disconnected with the rapidly evolving social media, forums and networks that trigger discourse on norms, rights and social development issues.

If it's a 15-year- old girl (caught using a phone), she won't be allowed to go out of her home, she will be beaten and her educational privileges will be taken from her. It can also happen that she is married off.

(Girl, aged 17 years, India)⁹⁴

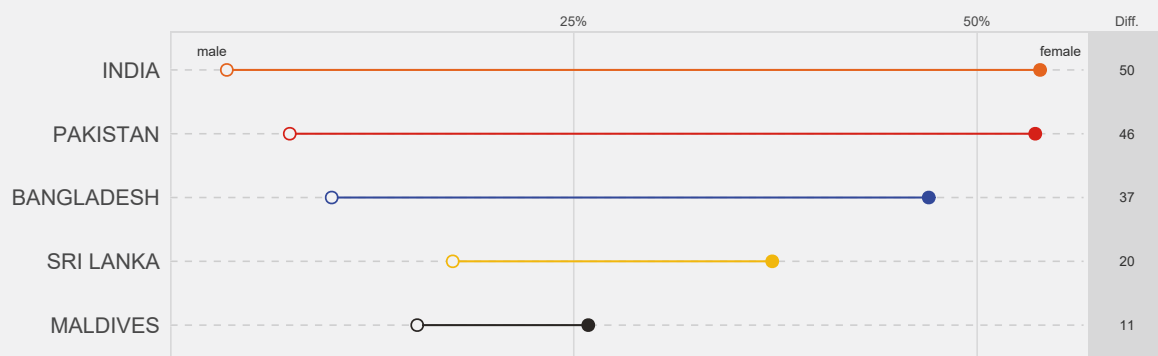
Transition to employment (Indicators 4.12 - 4.14)

In all countries, except the Maldives, young women seeking work are more likely to be **unemployed** (Indicator 4.13) compared with young men. The difference is greatest in Sri Lanka where twice as many females (33%), aged 15-24 years are unemployed as males (16%). The proportion of young people **not in employment, education or training** (NEET, Indicator 4.12) is also far higher among young women compared with young men across the region. For example, in Bangladesh, Pakistan and India almost half of females aged 15-24 years are NEET, compared to 4-10% of males. This may indicate that girls have limited opportunities to engage in paid work and post-school education and training compared with boys in the region and/or that girls revert to their gendered roles in the domestic sphere after completing schooling. See Case Study 4.2: Valuing girls' and boys' contributions differently for more discussion on this topic.

Girls are less likely to transition to post-school employment, education or training than boys.

FIGURE 4.4: NOT IN EDUCATION, EMPLOYMENT OR TRAINING

This graph shows NEET (Indicator 4.12) for girls (solid circle) and boys (hollow circle). The panel to the right shows the difference in estimates between girls and boys – a positive number indicates there are more girls than boys not in post-school education, employment or training. Data source: ILO, 2010 – 16.



INDICATOR 4.12: NOT IN EDUCATION, EMPLOYMENT OR TRAINING, 15-24Y (%)

CASE STUDY 4.2: VALUING GIRLS' AND BOYS' CONTRIBUTIONS DIFFERENTLY: A CYCLE OF GENDER INEQUALITY

While globally there have been significant increases in girls' school participation over the past decades, progress in some South Asian countries lags behind. Completion rates for upper secondary are higher for boys across the region, with the greatest disparities evident in Afghanistan, Bhutan and Nepal. While boys face social expectations to be providers, generally leaving school to enter the workforce, girls are far less likely to make this transition to employment. This is evidenced by the higher proportion of girls not in post-school education, employment or training.

Underlying reasons for girls' drop out may include child marriage, preference for investing in boys rather than girls' education; concerns regarding safety; perceptions that school is not relevant to a women's role as wife and mother; poor performance linked to malnutrition; lack of functional toilets; the burden of domestic work; and lack of female role models in schools.⁹⁶⁻⁹⁹ Sexual harassment or "eve teasing" is widely reported across South Asia and girls run the risk of assault, abduction and even murder on the way to and from school. Girls who live in remote areas, with long distances of travel, are particularly at risk.⁹⁷ Boys in contrast do not face such limitations in their mobility. Once at school, things are still not equal - there is still risk of sexualised behaviour by male teachers towards girls, pervasive gender-bias in textbooks, and a lack of female teachers at higher levels of education.¹⁰⁰ A lack of female teachers, particularly in rural and remote areas, is reported to be a barrier to girls' enrolment in some countries.^{97,101}

Gender differences in schooling lead to subsequent economic segregation of women and men. Young women face more barriers in securing paid employment, leaving them economically vulnerable. These factors perpetuate highly differentiated gender roles, further entrenching norms that discourage girls' secondary education.

"Girls get married, and then they have more responsibilities to undertake, such as raising their children. At this point, I think taking care of their families is much more important than attending school and if they do go to school, people will misjudge them and say bad things".¹⁰²

Summary

Domain 4

Key data gaps

- Learning outcomes and achievement are an important focus of the SDGs, but an area where indicators and data are very limited.
- Data coverage was sparse for young people's access to information (newspaper, TV or radio).
- Data were most limited for Sri Lanka and the Maldives.

Key gender issues in educational and employment outcomes include:

With the exception of Afghanistan, girls have school attendance rates that are comparable or in some instances slightly better than those of boys.

Gender disparities become more evident in secondary school completion, with boys being more likely than girls to complete secondary school in all countries.

Girls and women are more likely than boys and men to not be in employment, education or training in adolescence and early adulthood. This gender gap is likely related to highly differentiated gender roles that allocate unpaid domestic and care work to women, and paid work to men.

Women are underrepresented in teaching in most countries, particularly as schooling progresses, a factor related to gender-disparities in education completion rates, as well as gender-biased recruitment/hiring practices.

In Bangladesh, India and Bhutan, a quarter or more of schools do not have basic sanitation facilities. This may be a barrier to attendance for girls, particularly during menstruation.

Girls are less likely to be in secondary school than boys

Secondary school aged children not in upper secondary school



Girls are much less likely to be in post-school employment, education or training than boys

15-24-year-olds not in employment, education or training (NEET)



In summary, gains made in improving equity in education have not yet achieved equality in upper secondary schooling nor the in transition to employment and further training. This has the potential to undermine progress and entrench women and girls in poverty and socioeconomic disadvantage.

Domain 5



Impact of gender inequality on protection

This domain explores how gender inequality impacts on the protection of girls and boys from violence, exploitation and abuse, in the South Asia region.

Data availability

Data on the impact of gender inequality on the protection of girls and boys was sourced from collated datasets (UNICEF, UNDP, UNIGME, World Legal Information Institute, UNSD, UNODC, ILO), primary surveys (MICS and DHS) and modelled datasets (Global Burden of Disease). Coverage of data in this domain varies considerably across indicators and countries (Table 5.1). Data coverage was complete for indicators measuring sex ratio at birth (Indicator 5.01), infant mortality (Indicators 5.02–5.03), legal age of intercourse and marriage (Indicators 5.07–5.09), and homicide mortality rate (Indicator 5.15). Data were available for only some countries for indicators relating to birth registration and child living arrangements (Indicators 5.04–5.05), child marriage (Indicator 5.06), intimate partner violence (Indicators 5.11–5.12), attitudes and experience of violence (Indicators 5.13–5.14), and child labour (Indicators 5.20–5.22), with data available for only one country for the proportion of youth with a bank account (Indicator 5.10). There was no data regarding discrimination on the basis of gender or sexual orientation (Indicator 5.17), prevalence of female genital mutilation/cutting (FGM/C) (Indicator 5.18) or the number of trafficked children (Indicator 5.19). In terms of countries, data was particularly limited for Sri Lanka and the Maldives.

To optimise coverage for the indicator of child marriage (Indicator 5.06), data were sourced from both collated UNICEF datasets and DHS primary surveys. Most data for this indicator were only available for girls and women for this region. Modelled data from the Global Burden of Disease study were used for homicide (Indicator 5.15) to improve data coverage, but also because modelling adjusts for inconsistencies in the recording of homicide mortality in many registries.

Some proposed indicators were not able to be included due to a lack of routine data collection. Measures regarding discrimination and harassment of young people with diverse gender identity and sexual orientation (Indicator 5.17) have been included in MICS-6 and should be available in the future. Data on discrimination and violence against children and adolescents (including intimate partner violence) are also currently limited, however there are initiatives underway including Violence Against Children surveys and the kNOVAwdata project that will contribute to improved data coverage.^{103,104}

TABLE 5.1: INDICATORS AND DATA AVAILABILITY FOR PROTECTION.

Data sources are shaded as blue (compiled dataset, such as UNICEF SOWC), green (primary survey data such as MICS) or amber (modelled dataset, such as Global Burden of Disease). The table is shaded dark grey where data are not available.

		Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Sex preference	Sex ratio at birth (male : female) 5.01	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD	UNPD
	Infant mortality rate (per 1000 births) 5.02	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME
	Expected to estimated female infant mortality ratio 5.03	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME	UNIGME
Social protection	Birth registration <5y (%) 5.04	UNICEF	UNICEF	UNICEF	UNICEF		UNICEF	UNICEF	
	Children not living with biological parent, 0-17y (%) 5.05	UNICEF	UNICEF	UNICEF	UNICEF		UNICEF	UNICEF	
	Child marriage before 15y (%) 5.06a	DHS	DHS	UNICEF	DHS		DHS	DHS	
	Child marriage <18y (%) 5.06b	DHS	DHS	UNICEF	DHS		DHS	DHS	
	Age of consent for heterosexual intercourse 5.07	WLII	WLII	WLII	WLII	WLII	WLII	WLII	WLII
	Legal age of consent to marriage 5.08	UNSD	UNSD	UNSD	UNSD	UNSD	UNSD	UNSD	UNSD
	Age of consent for same-sex intercourse 5.09	WLII	WLII	WLII	WLII	WLII	WLII	WLII	WLII
	Bank account ownership, 15-24y (%) 5.10						DHS		
	Physical intimate partner violence in last 12m, 15-19y (%) 5.11a	DHS			DHS		DHS	DHS	
Violence	Sexual intimate partner violence in last 12m, 15-19y (%) 5.11b	DHS			DHS		DHS		
	Physical and/or sexual intimate partner violence in last 12m, 15-19y (%) 5.11c	DHS			DHS		DHS	DHS	
	Females aged 20-24y experiencing forced sex before 18y (%) 5.12	DHS			DHS		DHS		
	Adolescents 15-19y who think husband is justified to beat wife (%) 5.13	UNICEF	UNICEF	UNICEF	UNICEF		UNICEF	UNICEF	
	Children experiencing violent discipline, 1-14y (%) 5.14	UNICEF	UNICEF				UNICEF		
	Homicide mortality, 10-19y (per 100,000) 5.15	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Bullying last month, 13-17y (%) 5.16	GSHS	GSHS	GSHS		GSHS	GSHS		
	Discriminated against because of gender, 15-19y 5.17a								
	Discriminated against because of sexual orientation, 15-19y 5.17b								
Exploitation	FGM/C, 0-14y (%) 5.18								
	Number of detected trafficked children <18y 5.19								
	Child labour, 5-17y (%) 5.20	UNICEF	UNICEF	UNICEF			UNICEF		UNICEF
	Hazardous work amongst those in child labour (%) 5.21		ILO				ILO		ILO
	Hours per week spent on chores, 5-14y 5.22	UNICEF		UNICEF			UNICEF		



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Key gender inequalities

Girls and boys in South Asia are not being adequately protected from violence, exploitation and abuse.

Girls in the region are substantially more likely than boys to be married as children (Figure 5.1). In certain countries, there remains a strong preference for sons, as demonstrated by an excess number of males compared to females at birth and excess female infant mortality. There is broad acceptance of violence against women by young people, with girls being more likely than

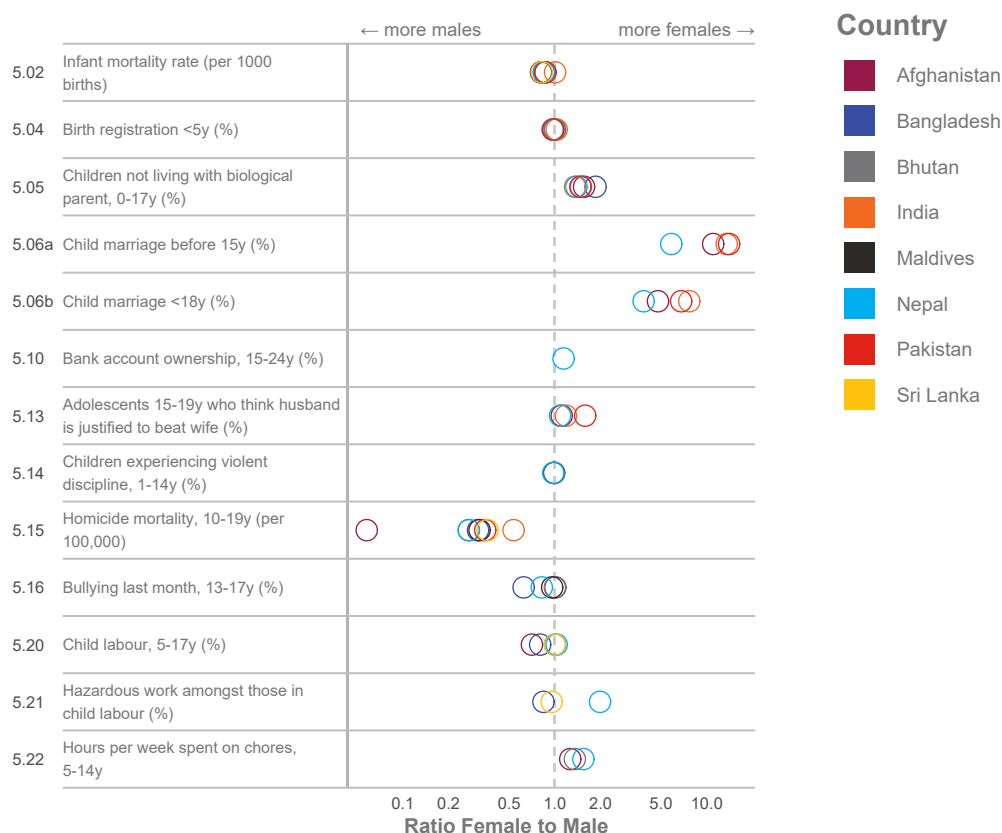
boys to justify a husband beating his wife beating. Girls also spend more hours on household chores than do boys.

Boys in this region are substantially more likely to die from intentional homicide than girls. There is also a trend for boys to experience higher rates of bullying.

There was no substantial difference by gender in birth registration. There was also no difference in the experience of violent discipline between boys and girls, however rates overall were very high.

FIGURE 5.1: INEQUALITY PLOT FOR INDICATORS OF PROTECTION

This graph shows the ratio of outcomes in females to males for indicators of health where possible to do. Note that ratios are shown on the log scale. Data sources are detailed in Appendix 3.



Detailed findings across indicators

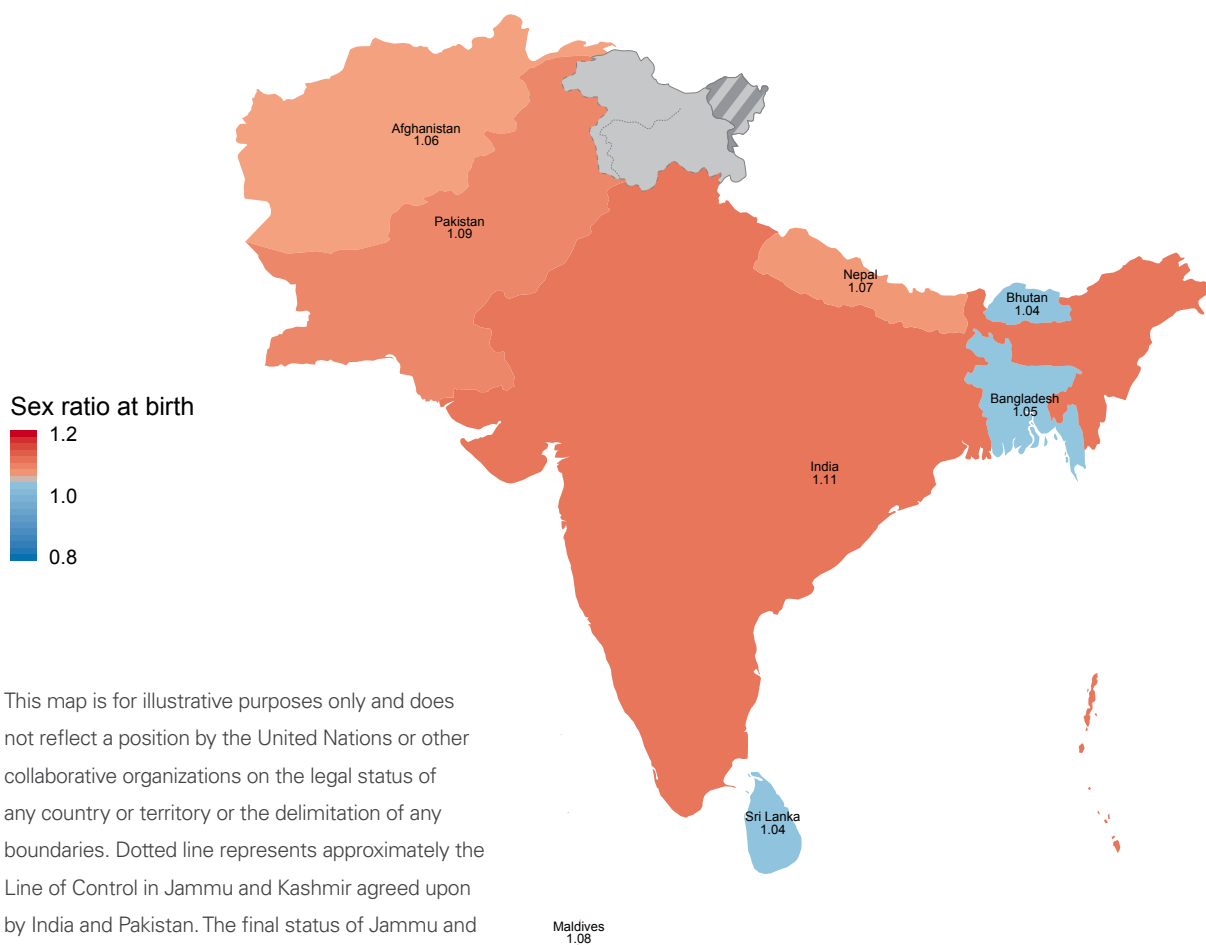
Sex preference (Indicators 5.01 – 5.03)

There were substantial differences in **sex ratio at birth** (Indicator 5.01), particularly for India and Pakistan (Figure 5.2). The expected sex ratio is 1.05 (105 boys should be born for every 100 girls to account for excess male mortality)¹⁰⁵ however the ratios in India and Pakistan (1.11 and 1.09, respectively) indicate a substantial deviation from the natural sex ratio. These missing girls are likely

the result of son-preference, enabled by prenatal sex determination and selective abortion. Son-preference refers to the greater value of boys in patrilineal and patrilocal families and the lesser economic and social status afforded to girls (see Case Study 5.1 on son preference for more information).

FIGURE 5.2: SEX RATIO AT BIRTH

This map shows the countries in the region, shaded according to the sex ratio at birth (number of male births to one female birth, Indicator 5.01). The shading changes colour at a ratio of 1.05 which is the expected number of males born to a female. An orange colour indicates more male births than would be expected, with the shade deepening with increasing disparity. Data source: UNDP, 2015.

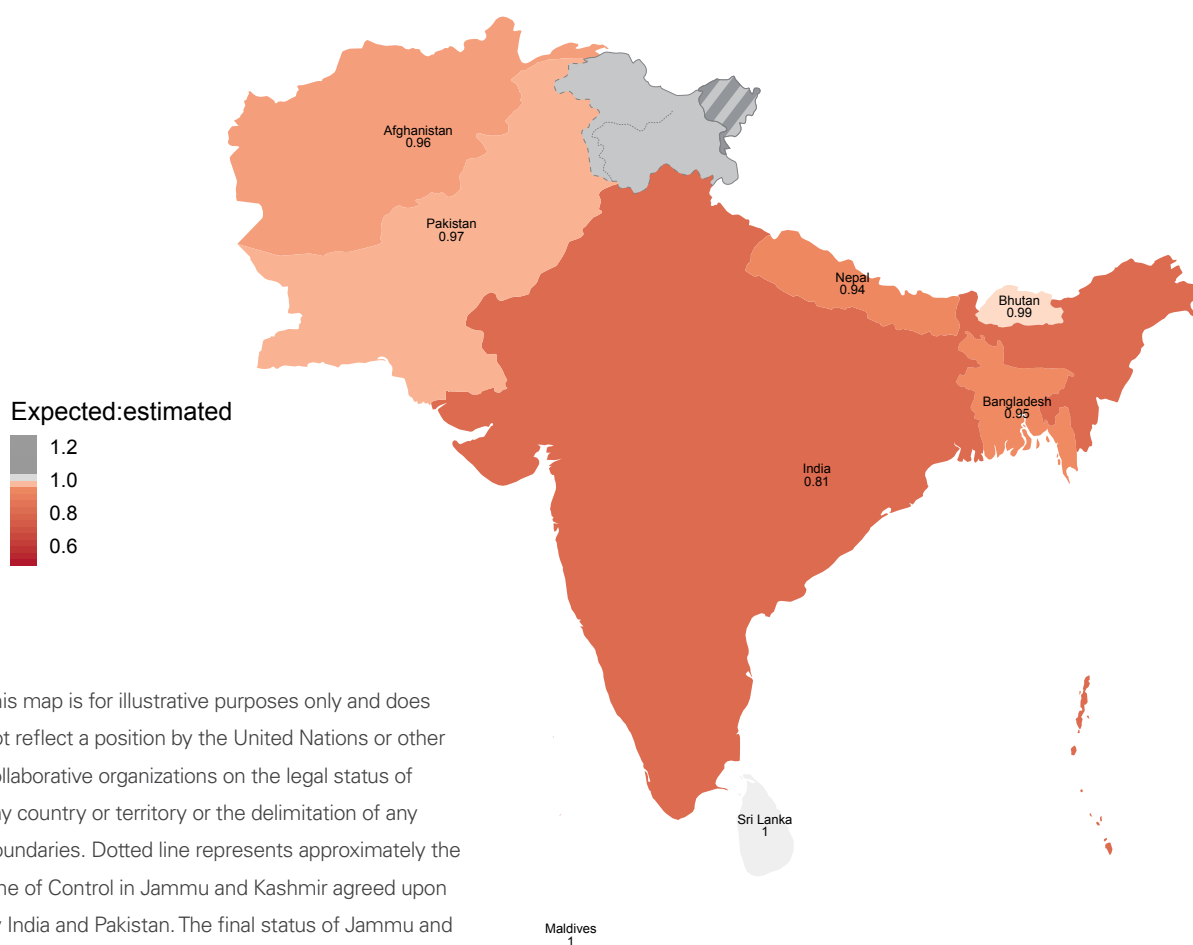


While boys' **infant mortality** (death between birth and 1 year of age, Indicator 5.02) is higher than for girls in countries across this region, this sex difference is expected due to girls' biological advantage in infancy.¹⁰⁶ Figure 5.3 shows countries where there is an excess female mortality, that is, countries where the estimated infant mortality amongst girls is higher than expected for that

country. India has the greatest **excess infant female mortality**. This data indicates that girls' survival in the region is negatively impacted by gender bias not only before birth but also during the first year of life. It is difficult to estimate to what extent neglect and inequitable allocation of household resources, contributes to this disparity.

FIGURE 5.3: EXCESS FEMALE INFANT MORTALITY RATE

This map shows countries in the region, shaded by the expected to estimated female infant mortality rate ratio (Indicator 5.03). The greater the intensity of the colour signifies a female infant mortality rate that is greater than expected (a ratio of less than 1). Data source: UNIGME 2016.



This map is for illustrative purposes only and does not reflect a position by the United Nations or other collaborative organizations on the legal status of any country or territory or the delimitation of any boundaries. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties

CASE STUDY 5.1: SON PREFERENCE LEADING TO SEX IMBALANCES AT BIRTH IN SOUTH ASIA

In both India and Pakistan, there are many more boys born than would be biologically expected. In India, it has been estimated that between 2007 and 2012, approximately one third of a million girls were missing at birth annually.¹⁰⁷ Several states in the western and north-western India show particularly high levels of birth masculinity and sex-ratio at birth levels of 120 are not uncommon in Punjab, Haryana and Delhi.¹⁰⁷⁻¹⁰⁹ High sex ratios are more common in prosperous cities, states and classes. In Nepal, there is also a trend towards birth masculinity in the country's wealthiest valleys.¹⁰⁹ Generally, birth masculinity is less pronounced among poor and rural households, for whom access to medical services may be limited.^{108, 109}

In India, this sex imbalance has been increasing since the late 1980s facilitated by the increased use of diagnostic technology that enables: 1) prenatal sex determination followed by abortion of female babies; and 2) sperm sorting or

preimplantation genetic diagnosis combined with selective implantation of male fetuses by IVF. It has also been suggested that mothers in India may be more likely to seek care and deliver at hospital, where there is an official record of the birth, if the child is male.¹¹⁰

The main reason for this marked birth masculinity is son preference. This greater value of boys arises in patrilineal and patrilocal families where girls have less economic and social status.¹⁰⁸ This gender discrimination can be considered as a cost-benefit decision whereby girls represent a greater cost to the family, as they require dowry payments and will leave to live with the husband's family, and boys a greater benefit as they will care for their parents in their old age. Ironically, this son preference and the consequential lack of marriageable females, may mean that many sons will have to undertake their filial duties as bachelors, without heirs to carry on the family line.



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Legal, financial and social protection (Indicators 5.04 – 5.10)

There are no apparent sex differences in **registration** of girls and boys with civil authorities (Indicator 5.04). However, in some countries the gender of the parent can be a barrier to registration of children, where only senior male household members can register the birth of a child or where the father or both parents are required to be present at registration.¹¹¹

Girls (aged 0-17 years) appear slightly more likely to **live with neither biological parent** (Indicator 5.05) across the region, particularly in Bangladesh (5% of girls compared to 2.7% of boys). This may represent girls who have married or entered into union at an early age, or could indicate girls are left behind more often than boys when parents migrate.

While great progress has been made in addressing **child marriage** (Indicator 5.06) in South Asia it remains common by global standards. While boys can be married off as children, particularly in countries like Nepal, child marriage overwhelmingly affects girls. The region is home to the largest number of child brides worldwide with the highest prevalence reported in Bangladesh, Nepal and Afghanistan where 59%, 40%, and 35% of girls aged 20-24 years, respectively, report being married before age of 18 years (Figure 5.4 and Case study 5.2). In Bangladesh, one in five girls are married before 15. In these settings girls frequently marry adult men rather than boys of a similar age. Girls subjected to child marriage

FIGURE 5.4: CHILD MARRIAGE

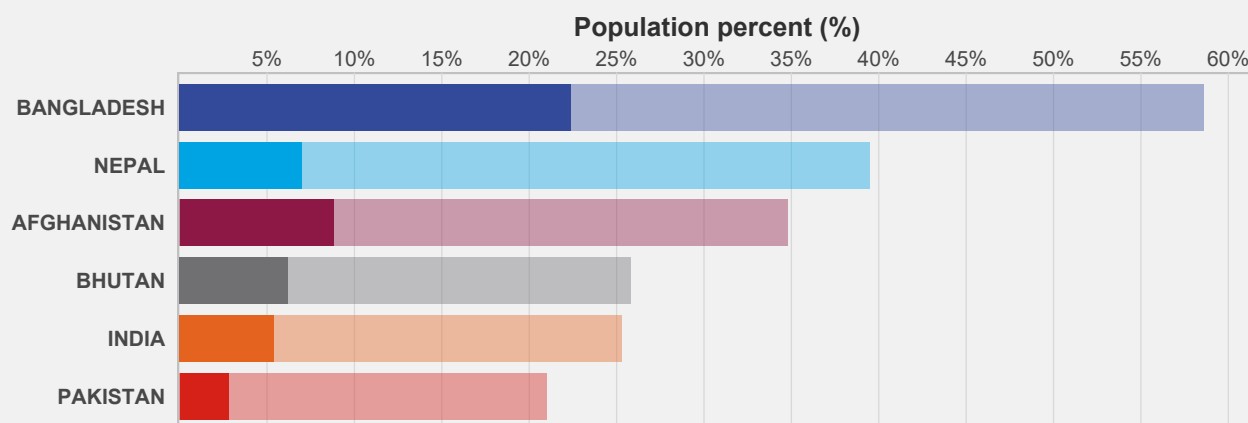
This graph shows the proportion of females, aged 20-24 years, who were married before the age of 15 years (darker bar) and 18 years (lighter bar) for countries in the region.

Data source: UNICEF and DHS, 2012 – 16.

Indicators

5.06a Child marriage before 15y (%)

5.06b Child marriage <18y (%)



INDICATOR: 5.06 CHILD MARRIAGE (A) BEFORE 15 YEARS (B) BEFORE 18 YEARS.

are commonly excluded from further education, exposed to sexual and physical violence, and physically and socially isolated. Child marriage is closely linked with harmful and unequal gender norms, notably the desire to regulate and control female fertility and sexuality. Child marriage also perpetuates gender inequality by not only entrenching disadvantage among married girls but also operating at a societal level to devalue women's and girls' potential beyond reproductive and domestic roles.

There is substantial regional variation in age of **consent to marriage** (Indicator 5.08). In Afghanistan, Maldives, Pakistan and among some ethnic communities in Sri Lanka it is possible for a girl and her parents to consent to her marriage before the age of 18 years, providing limited protection for girls from child marriage. Additionally, there are gender disparities in the age of consent to marriage in many countries in the region, except Bhutan, Maldives and Nepal, whereby girls may marry at an earlier age than boys. These disparities reflect and perpetuate norms around male dominance in marital relationships.

There is also considerable variation in **age of consent to heterosexual sex** (Indicator 5.07) across the region. In several countries – Afghanistan, the Maldives and Pakistan - marriage is required for girls or boys to legally have sexual relations. In Bangladesh, the age of consent for girls is low (14 years of age) while among some Tamil and Muslim communities in Sri Lanka a girl may consent at age 12 years if married but at age 16 years if unmarried. A low age of consent or reliance on marriage as a requisite, may leave girls at higher risk of sexual debut at a young age, not aligned with global evidence on physical, mental and sexual maturity. Given that girls married before 18 years typically enter unions with adult men and generally have limited power their relationships, it is unlikely that a young married girl will be in a position to refuse sex with

her husband. In Bangladesh and Nepal, there is no age of consent to heterosexual sex stipulated for men and boys. This is likely to relate to norms around men and boys initiating sex; these norms undermine women's and girls' agency in sexual relationships.

Male same-sex sexual relationships (Indicator 5.09) are illegal in most countries in the region, except India where the age of consent is consistent with heterosexual sexual relationships and Nepal where same-sex sexual relationships are not regulated. Criminalisation of same-sex sexual relationships increases the vulnerability of non-heterosexual and transgender people and perpetuates binary gender roles and norms.

CASE STUDY 5.2: TOO YOUNG TO BE MARRIED - TOO YOUNG TO BE MOTHERS

Despite great progress in reducing child marriage in South Asia, rates remain high, particularly in Afghanistan (35% married before 18 years of age), Bangladesh (59%) and Nepal (40%). While some marriages in Nepal are consensual unions between peers, in general child marriage in South Asia reflects the discriminatory patriarchal norms prevalent in the region. These norms view a girl as an economic burden and a commodity whose value lies in her virginity and reproductive capacity.^{2,42} Marrying girls early is seen as a protective measure to ensure her chastity and maintain family honour which can be harmed if she engages, by force or choice, in pre-marital sex. Early marriage also generally decreases the expenditure required for a girl's dowry.

Child marriages often deny girls their right to education, and lead to social isolation and financial dependence.² It also exposes them to risk of forced sex, violence and early pregnancies.²

“My sister wasn’t ready to be a bride at 17....Her marriage was against her will. Right after her marriage, she became a mother. She had to quit her studies, too, after that.”

Puja, Nepal¹¹²

“I knew about condoms, but could not ask my husband to use one. I was only 16 when I got married and felt he would get angry, as I was less educated than him.”

Pinki, 19, India⁷⁷

Countries with high rates of child marriage generally have more teenage mothers. In Nepal, one in ten girls aged 15-19 years are mothers, in Afghanistan and Bangladesh approximately one in fourteen. Both child marriage and teenage pregnancy are more common in poor and rural areas and where educational attainment is low.^{2,42,113} Inadequate sexual and reproductive health knowledge and inaccessibility of family planning services also contribute to adolescent fertility. In South Asia, while many teenage girls report having basic sexual and reproductive health knowledge, few are able to utilise this in practice.¹¹³ Barriers lie in gender power dynamics which prevent girls making decisions about their sexual activity and fertility, combined with norms that dictate a woman's primary role and value is in bearing children.⁷⁷ Girls are often expected, by their husband, family and community, to become pregnant shortly after marriage.

Violence and harmful practices (Indicators 5.11 – 5.18)

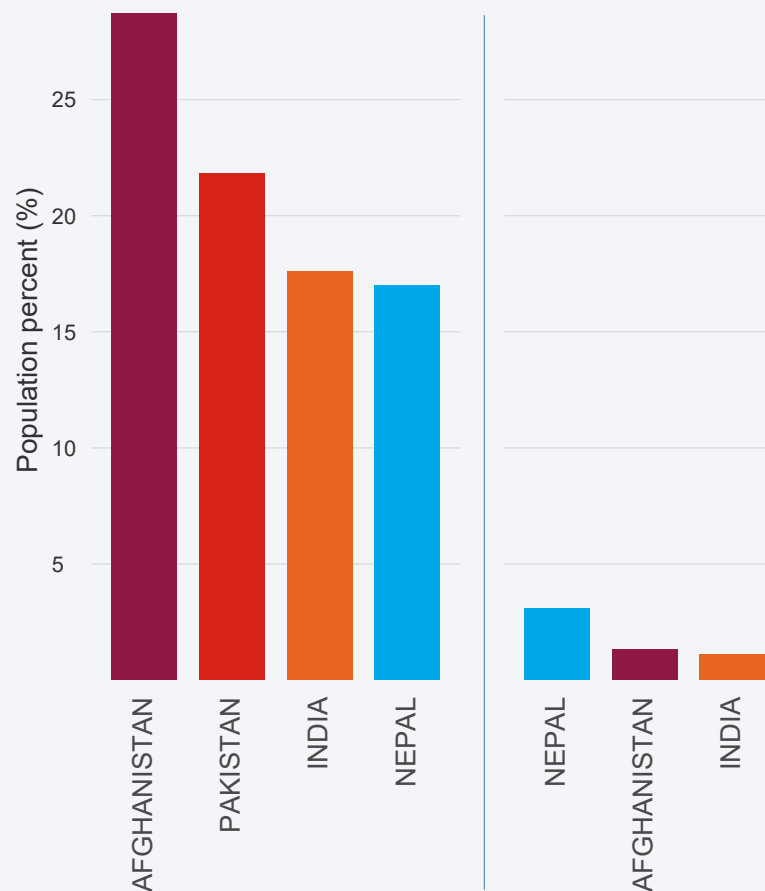
Data is only available for four countries regarding adolescent girls' (aged 15-19 years) experiences of **sexual and/or physical intimate partner violence** (IPV, Indicator 5.11) in the last 12 months prior to data collection. In comparison to global estimates, rates of IPV experienced by adolescent girls are high. Physical violence is particularly common and reported more often than sexual violence. At least one in five ever-partnered adolescent girls report experiencing physical IPV in Afghanistan and Pakistan (Figure 5.5). Reported rates of IPV likely underestimate the extent of violence, as women and girls often do not mention

abuse due to embarrassment, fear of retaliation and economic dependency. In addition, societal norms such as power imbalances between women and men, family privacy and victim blaming, also contribute to girls' reluctance to report this violence.⁴⁷ Protection mechanisms for those that experience domestic violence are limited throughout the region, leaving those who report violence vulnerable to further abuse.

Acceptance of violence against women is high in the region, as demonstrated by the proportion of young people who **justify domestic violence**

FIGURE 5.5: INTIMATE PARTNER VIOLENCE AND SEXUAL ASSAULT

This graph shows the proportion of ever-partnered adolescents, aged 15-19 years, who experienced physical and/or sexual intimate partner violence in the preceding 12 months (Indicator 5.11c) and the proportion of women, aged 20-24 years, who experienced forced sex before the age of 18 years (Indicator 5.12). Data source: DHS, 2010–16.



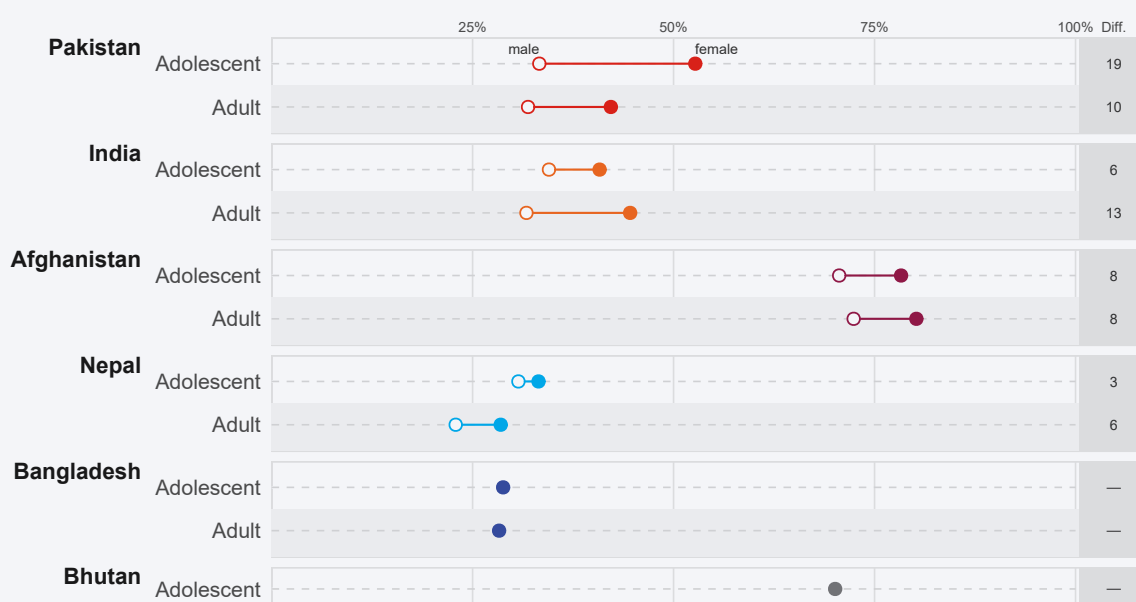
INDICATOR: 5.11C: INTIMATE PARTNER VIOLENCE
INDICATOR: 5.12: SEXUAL ASSAULT

in many countries. In countries for which data are available, many young people believe a husband is justified to beat his wife under certain circumstance (Indicator 5.13), with adolescent girls being more likely to justify this violence than boys. There is also little difference between attitudes supportive of violence among adolescents (aged 15-19 years) and people aged 15-49 years (Figure 5.6). The widespread perception that violence is a normal part of intimate partner relationships, with little change in attitudes across generations, is a known contributing factor to high rates of violence.

Many young people in South Asia believe domestic violence to be justifiable.

FIGURE 5.6: ATTITUDES TOWARDS DOMESTIC VIOLENCE

This graph shows the proportion of adolescents, aged 15-19 years, who think that a husband is justified to beat his wife under certain circumstances, by sex (Indicator 5.13). To provide comparison, the proportion of adults aged 15-49 years who believe a husband is justified to beat his wife is also shown on grey shading (Indicator 2.12). The right panel provides the difference between the female-male results – a positive number indicates that a greater proportion of females justify wife-beating than males. Data: DHS, 2010 – 16.



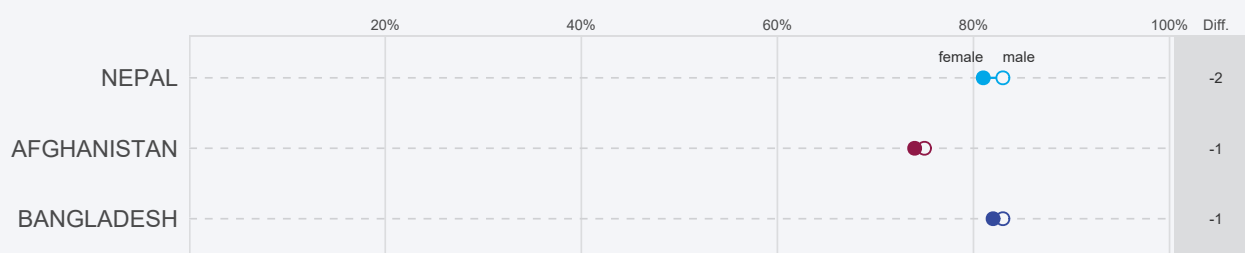
INDICATOR: 5.13: PROPORTION WHO THINK HUSBAND IS JUSTIFIED TO BEAT WIFE (%)

Rates of **violent discipline by a caregiver**

(Indicator 5.14) are very high in the region with almost 80% of girls and boys reporting such violence, in countries with data (Figure 5.7). Rates are similar for girls and boys. Children who witness or experience violence are more likely to perpetrate or experience violence as adults.

FIGURE 5.7: VIOLENT DISCIPLINE OF CHILDREN

This graph shows the proportion of children (aged 1-14 years) who experience violent discipline from a care-giver (Indicator 5.14). Data source: UNCIEF SOWC, 2016.



INDICATOR: 5.14: CHILDREN EXPERIENCING VIOLENT DISCIPLINE, 1-14Y (%)

Adolescent boys are at substantially increased risk of **intentional homicide** (Indicator 5.15) compared to girls (Figure 5.8). This is particularly so in Afghanistan where rates of male adolescent homicide are highest and 18 boys per 100,000 die from homicide to every girl. Globally, males lead homicide trends both as victims and perpetrators and this pattern is associated with gender norms that are supportive of male violence and confrontation.^{114,115} These same norms around violent masculinity are also associated with acceptance of intimate partner violence by both women and men (see Case study 5.3).

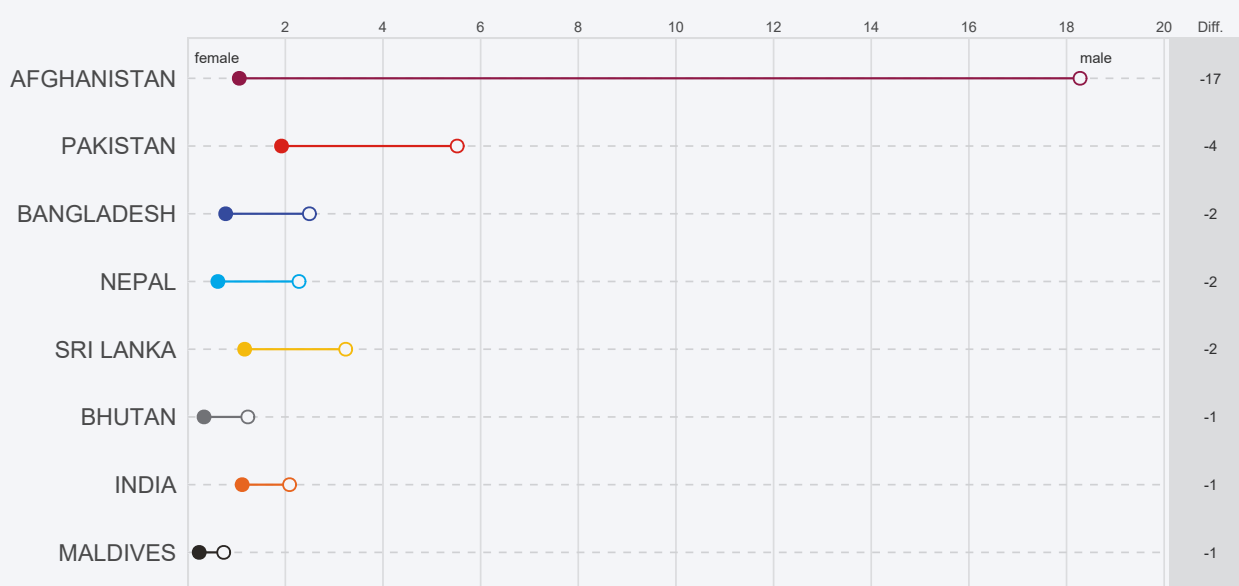
Many adolescent girls and boys report experiencing **bullying** (Indicator 5.16), with particularly high rates in Afghanistan and Nepal where almost half of 13-17-year-olds report bullying over the preceding 30 days. Gender disparities are notable in Bangladesh

and Nepal with boys being more likely to report bullying than girls. Bullying may be physical, emotional or verbal violence and this higher prevalence among boys, may once again reflect masculine norms associated with violence and confrontation. Whilst no data was identified during this review on LGBT young people, research from other regions has identified that people of diverse gender and sexual orientation are more at risk of peer bullying and violence than their heterosexual or cisgender peers.¹¹⁶

No data was available to assess the prevalence of **female genital mutilation** (Indicator 5.18) in this region. However, the harmful practice is reported to continue in some Muslim communities, in India, Pakistan and Sri Lanka.¹¹⁷⁻¹¹⁹

FIGURE 5.8: MORTALITY RATE DUE TO INTENTIONAL HOMICIDE

This graph shows the mortality rate due to intentional homicide (per 100,000) for adolescents aged 10 – 19 years (Indicator 5.15). The panel to the right shows the difference between females and males – a negative number indicates more boys than girls die from intentional homicide. Data: IHME, 2016.



INDICATOR: 5.15: HOMICIDE MORTALITY, 10-19Y (PER 100,000)

CASE STUDY 5.3: HOMICIDE MORTALITY AND INTIMATE PARTNER VIOLENCE: TWO SIDES OF A SINGLE COIN

Gender inequality in roles and relations can result in differing outcomes for girls and boys. Boys in South Asia, are at greater risk of intentional homicide than girls. However, girls are at high risk of intimate partner violence and many believe wife-beating to be justifiable. In some countries, particularly Afghanistan, India and Pakistan, honour killings of women and girls, by husbands and brothers, continue to be perpetrated. This is in keeping with global findings, that males are most common perpetrators of homicide, with men being more likely to be victims in public spaces but women being disproportionately affected by homicide in the home.¹¹⁵

Harmful masculine norms that support aggression, risk taking and male dominance are likely to be important contributors to these gender inequalities. For many, men's use of violence to control family members and settle disputes may be socialised with boys and girls at an early age, when they experience and witness violence in the home. These gender norms have negative consequences for both girls and boys, which are expressed differently across a range of outcomes. For both girls and boys, what appears to be an advantage in one area may be linked with a disadvantage in another area. This illustrates the broader value of addressing the underlying causes of gender disparities, since it is likely to have benefits for both girls and boys.

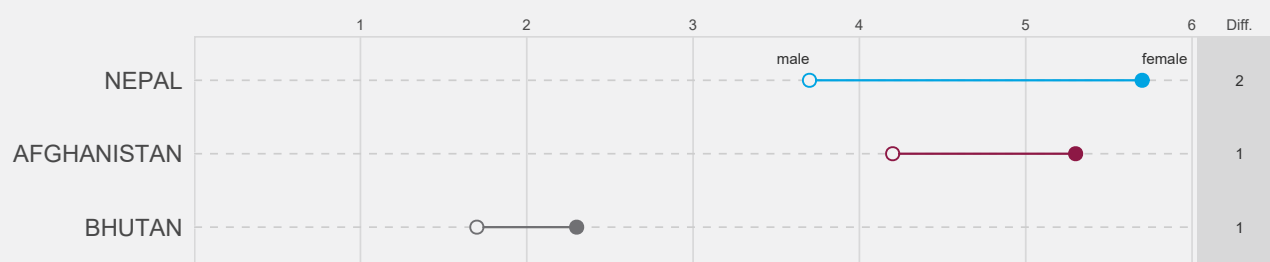
Exploitation

(Indicators 5.19 – 5.22)

Entrenched, unequal gender norms that allocate domestic work to women and girls are demonstrated by the differential **time spent on household chores** (Indicator 5.22). In all countries, where data is available, girls spend more time on household chores than boys. The disparity is greatest in Nepal where girls, aged 5-14 years, spend two hours more per week on chores than boys. This is likely to reflect household members' expectations around the roles that children will take on in adulthood.

FIGURE 5.9: TIME SPENT ON CHORES BY CHILDREN

This graph shows the hours per week spent on chores by children, aged 5-14 years, by sex (Indicator 5.22). Girls are shown as the solid filled circle and boys as the unfilled circle. The panel to the right showing the difference in count between females and males – a positive number indicates girls spend more time on chores than boys. Note that data for this graph include children aged 5-11 years, 5-14 years and 5-17 years, all used as estimates of 5-14 years. Data source: UNICEF 2010 -14.



INDICATOR: 5.22: HOURS PER WEEK SPENT ON CHORES, 5-14Y

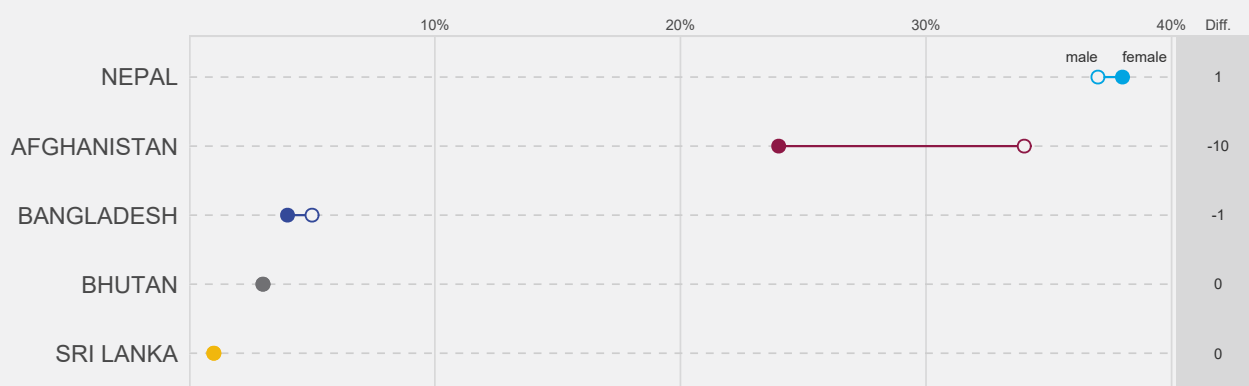
Similarly, gender norms that support male ‘toughness’ and allocate the male role as provider are likely to influence gender disparities in **child labour** (Indicator 5.20). While rates of child labour are similar for boys and girls in four of the five countries with data, boys are more likely to be working than girls in Afghanistan, where 34% of males, aged 5-17 years, are reported to be in child labour compared to 24% of girls. Boys are more likely to be in hazardous work in Bangladesh and Sri Lanka, while in Nepal girls are twice as likely to be employed in hazardous work than boys. In Nepal, traditional attitudes favour educating boys who are seen as a family’s future breadwinners.¹²²

Data on the number of **trafficked children** was not available (Indicator 5.19). However, in Bangladesh, Nepal and Pakistan, women and children of both sexes are more frequently identified as victims. Trafficking for sexual exploitation is one of the most common types of trafficking and the

main form detected in Nepal.¹²³⁻¹²⁷ Trafficking of children from marginalized and vulnerable communities tends to be higher than of children from upper income brackets and social categories. In Bangladesh, for example Rohingya girls are reported to be subjected to high rates of sex-trafficking while Rohingya girls and boys are recruited from refugee camps to work as shop hands, fishermen, rickshaw pullers and domestic workers.¹²⁵ Girls from Afghanistan, are reported to be subjected to sex trafficking and domestic servitude in Pakistan and India, including through forced marriages.¹²⁴ Boys from Afghanistan are reported to be subjected to forced labour in agriculture and construction, in a number of countries including Pakistan, with some also being subjected to sex trafficking.

FIGURE 5.10: CHILD LABOUR

This graph shows the proportion of children, aged 5-17 years, engaged in child labour (Indicator 5.20). Girls are shown as the solid filled circle and boys as the unfilled circle. The panel to the right showing the difference in count between females and males – a negative number indicates more boys in child labour than girls. Data source: UNICEF, 2014.



INDICATOR: 5.20: CHILD LABOUR, 5-17Y (%)



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Summary

Domain 5

Impact of gender inequality on protection

Key data gaps

- Data is limited for indicators of violence, harmful practices and exploitation;
- Indicators regarding the wellbeing of young people with diverse gender identity and sexual orientation are unavailable;
- No country had complete data for this Domain - coverage was poorest for Sri Lanka and the Maldives.

Key gender issues relating to the protection of children and adolescents:

Sex preference favouring boys is reflected in the sex-ratio at birth in India and Pakistan and excess female infant mortality in India.

Child marriage is very common in this region, particularly in Bangladesh where 3 out of 5 girls, aged 20 – 24 years, are married before 18 years of age and one out of 5 are married before 15 years of age.

Available data suggest high rates of physical and/or sexual intimate partner violence, with one in three girls affected in Afghanistan and one in five in Pakistan.

There is broad acceptance of violence against women by young people in the region.

In countries with available data, around 80% of children have experienced violent discipline.

Adolescent boys are at much greater risk of intentional homicide.

Bullying is common in most countries, more so for boys in Bangladesh and Nepal.

Girls have a greater burden of household chores.

Girls and boys from marginalized and socio-economically vulnerable communities face a greater likelihood of violence and exploitation.

Child marriage and intimate partner violence affect many girls

20-24-year-olds married by 18 years



BANGLADESH



AFGHANISTAN, NEPAL



BHUTAN, INDIA, PAKISTAN

Females, aged 15-19 years, who have experienced intimate partner violence in last 12 months



AFGHANISTAN



INDIA, NEPAL, PAKISTAN

More boys die from homicide than girls

Homicide mortality, 10-19 years, deaths per 100,000

In some countries, more than four times as many boys die as girls



BANGLADESH NEPAL INDIA AFGHANISTAN

Girls and boys in this region are not being adequately protected from violence, exploitation and abuse. These findings reflect not only a failure of protective legislation in the region but also harmful social and gender norms. These norms include son-preference, the relegation of women and girls to domestic and reproductive roles, male dominance and masculine violence. The exposure of children to violence, exploitation and abuse likely shapes the harmful attitudes to domestic violence observed in adolescents.

Domain 6



Impact of gender inequality on safe environments

This section examines if there is gender equality in the safety of environments that girls and boys grow up in including: pollution; unsafe water, sanitation and hygiene; and road traffic safety. It also includes measures of mobility as a proxy measure for unsatisfactory environments, including perceptions of safety in local travel; international migration; and the numbers of refugees, displaced and stateless persons. This domain is distinct to the impact of the social environment on gender equality which is the focus of Domains 1 and 2. To date, there has been limited research on the differing impact of environmental hazards on girls and boys.

Data availability

It was challenging to identify indicators and data for environmental exposures, disaggregated by age and gender, for this domain (Table 6.1). Disaggregated data on exposure to household air pollution and access to WASH are largely unavailable; as a proxy, the burden of disease attributable to these exposures by gender was measured using modelled data from the Global Burden of Disease. This data had good coverage across all countries in the region. Modelled data from the Global Burden of Disease study was also used to measure the mortality rate due to road traffic accidents by gender (Indicator 6.08), a measure of the relative safety of the built environment and roads across the genders. There was also reasonably good coverage of data for indicators relating to the number of migrants (Indicator 6.05) and the number of displaced persons (Indicator 6.09) by gender.

Data on access to WASH by gender are limited. The recent WHO-UNICEF Joint Monitoring Program report provides estimates of handwashing

in schools and the availability of drinking water and sanitation (improved, single-sex and usable).¹²⁸ Of note, this report only measures availability within a school and not access by sex. Improved sanitation is an important measure of an enabling environment for girls and women, particularly for management of menstruation, so we report on the availability of school sanitation within this domain (Indicator 6.02) as well as the Education Domain (Indicator 4.08). Data were available for four of the eight countries in this region.

No data was available for young people's perceptions of safety in their neighbourhoods, for any country in the region (Indicator 6.07) - this indicator was included in MICS wave 6 which is yet to be captured for this region. There were other important areas, such as urbanisation, conflict, disaster and climate change, which could not be included in this domain due to a lack of agreed indicators and data.

Data and indicators to assess the impact of gender inequality on safe environments for girls and boys are limited

TABLE 6.1: INDICATORS AND DATA AVAILABILITY FOR SAFE ENVIRONMENT

Data sources are shaded as blue (compiled dataset, such as UNICEF SOWC), green (primary survey data such as MICS) or amber (modelled dataset, such as Global Burden of Disease). The table is shaded dark grey where data are not available.

		Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Energy	Household air pollution, <5y (DALYs per 100,000) 6.01a	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Household air pollution, 5 - 9y (DALYs per 100,000) 6.01b	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Household air pollution, 10-14y (DALYs per 100,000) 6.01c	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Household air pollution, 15-19y (DALYs per 100,000) 6.01d	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
Sanitation	Schools with improved sanitation facilities (%) 6.02		JMP	JMP	JMP				JMP
	Water, sanitation and hygiene, <5y (DALYs per 100,000) 6.03a	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Water, sanitation and hygiene, 5-9y (DALYs per 100,000) 6.03b	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Water, sanitation and hygiene, 10-14y (DALYs per 100,000) 6.03c	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Water, sanitation and hygiene, 15-19y (DALYs per 100,000) 6.03d	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
Mobility	Child collects water for household, <15y (%) 6.04	MICS					MICS		
	International migrants <20y, (count in 1000s) 6.05a	UN	UN	UN	UN	UN	UN	UN	UN
	International migrants <20y, (population %) 6.05b	UN	UN	UN	UN	UN	UN	UN	UN
	Married females make decisions visiting family or friends, 15-19y (%) 6.06	DHS	DHS				DHS	DHS	
	Feel safe walking at night, 15-19y (%) 6.07								
Conflict	Road traffic mortality, 10-19y, (deaths per 100,000) 6.08	GBD	GBD	GBD	GBD	GBD	GBD	GBD	GBD
	Refugees, displaced and stateless persons, <18y (thousands) 6.09	UNHCR	UNHCR		UNHCR		UNHCR	UNHCR	UNHCR

Key gender inequalities

The available data suggest substantial gender inequality in the safety of environments that girls and boys grow up in.

In countries like Nepal, girls have limited mobility within their environments and are more likely than boys to be tied to the home and engaged in domestic chores such as collecting water. There is also a trend for girls to be more adversely affected by the inadequate sanitation and hygiene facilities, particularly in adolescence. A lack of basic sanitation in across schools in the region is likely to particularly impact on girls.

In most countries, girls bear more burden of disease due to household air pollution. This likely reflects restrictions on girls mobility that keep them in the home and greater time spent on domestic chores such as cooking. Girls also bear a greater burden of disease due to inadequate water, sanitation and hygiene which may be related to differences in nutrition or care-seeking. Boys' higher mortality from traffic accidents however likely reflects gender norms that encourage independence and risk taking among boys but limit girls' mobility. In countries like the Maldives and Bhutan, international migrants are more likely to be boys.

Overall, there appears to be gender balance in the number of young people who are displaced or refugees.

FIGURE 6.1: INEQUALITY PLOT FOR INDICATORS OF ENVIRONMENT

This graph shows the ratio of outcomes in females to males for indicators of health where possible to do. Note that ratios are shown on the log scale. Data sources are detailed in Appendix 3.





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Detailed findings across indicators

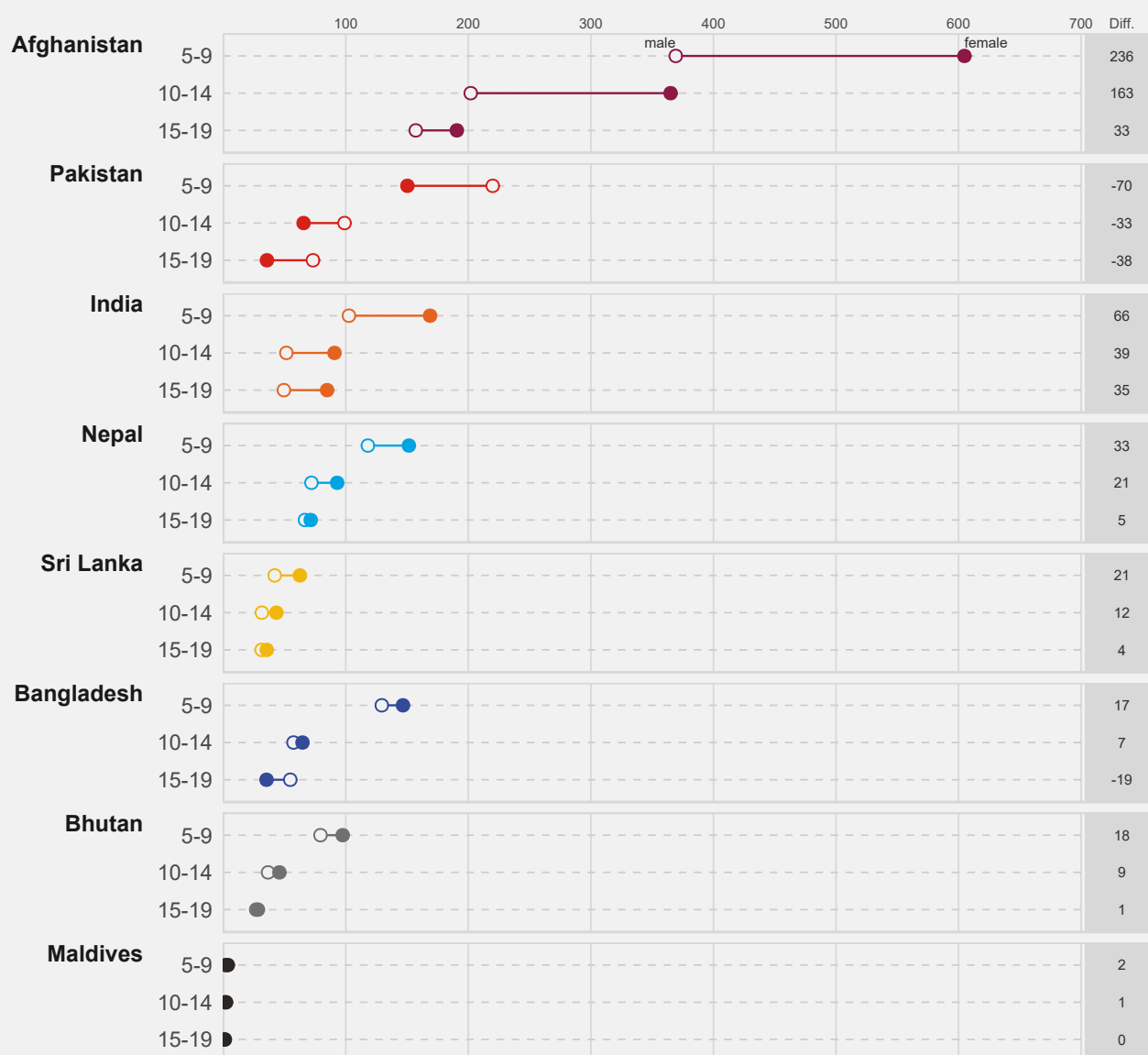
Energy (Indicator 6.01)

Household air pollution (Indicator 6.01) is a leading environmental risk factor for health worldwide.¹²⁹ Fine particles from fires and stoves are responsible for almost one third of LMIC deaths from chronic obstructive pulmonary disease and significantly increase the risk of death from stroke, lung cancer and ischaemic heart disease. In addition, it is estimated that more than half of pneumonia deaths among children under-5 are caused by exposure to household air pollution. In LMICs around the world, due to gender roles and division of labour, women and girls are the primary users of household energy services. Household air pollution is therefore a leading risk factor for the health of women and girls globally.

In most countries in South Asia, girls and young women typically experience a greater burden of disease attributable to household air pollution than boys, particularly in Afghanistan and India (Figure 6.2). This is despite boys being more vulnerable to impact of air pollution, especially in early childhood, due to biological differences in lung maturity and function.¹³⁰ Higher rates of DALYs due to household air pollution in girls likely reflect gender differences in allocation of household chores and mobility. For example, where girls are more likely to be responsible for cooking and have less freedom of movement outside the home, they are more likely to be exposed to the harmful effects of indoor air pollution.

FIGURE 6.2: HOUSEHOLD AIR POLLUTION

This graph shows the health impact (measured in DALYs per 100,000) of household air pollution on girls and boys aged 5–19 years (Indicators 6.01b – 6.01d). The solid filled circles are for females and the unfilled circles are for males. The difference between female and male estimates is shown in the panel on the right – a positive number indicates the burden is greater for females, while a negative number indicates greater burden for males. Data for under 5-year-olds are not shown here given their substantially larger burden but are summarised in Appendix 3. Data: GBD, 2016.



INDICATOR: 6.01: HOUSEHOLD AIR POLLUTION (DALYS PER 100,000)

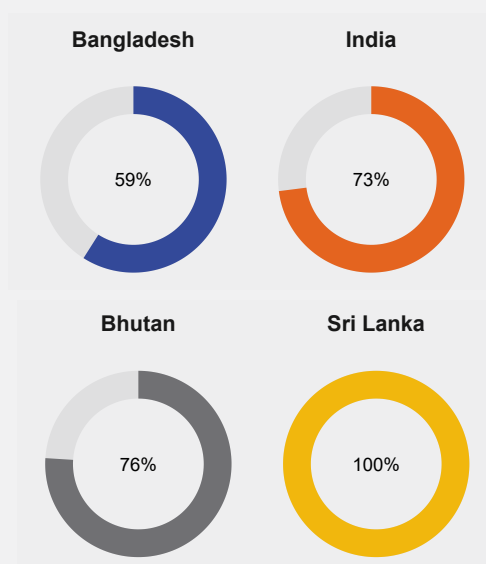
Water, sanitation and hygiene

(Indicators 6.02 – 6.04)

Access to **water, sanitation and hygiene** (WASH, Indicator 6.02) has a disproportionate impact on women and girls and is important for girls' management of menstruation. Between 24% and 41% of schools in Bangladesh, India and Bhutan do not have improved, single-sex, usable sanitation facilities (Figure 6.3). The lack of improved sanitation facilities in schools can lead to girls missing classes and activities when they are menstruating. Also, where improved facilities for sanitation are not available, women and girls are at higher risk of harassment and assault while managing their sanitation and hygiene needs. Case study 6.1 explores these issues further.

FIGURE 6.3: SCHOOL SANITATION FACILITIES

This graph shows the proportion of schools with improved, single-sex, usable sanitation facilities (Indicator 6.02). Data source: WHO UNICEF JMP, 2018.



INDICATOR: 6.02: SCHOOLS WITH IMPROVED SANITATION FACILITIES (%)

CASE STUDY 6.1: THE IMPACT OF INADEQUATE SANITATION GIRLS

In South Asia, as in other parts of the world, inadequate sanitation has an impact on the lives of girls, that extends beyond disease burden. Gender norms and physiology mean that the privacy and proximity of facilities are more important for girls, particularly during menstruation. When facilities are inadequate, girls are at more risk than boys, of humiliation, harassment and even assault.^{131,132} These experiences can negatively influence girls' health and wellbeing, confidence, self-esteem and relationships with others.

Research has found a lack of household sanitation facilities raises the risk sexual assault for women and girls.¹³³⁻¹³⁵ In India, a country where only 44% of the population have access to basic sanitation and 40% practice open defecation, women who defecate in the open are reported to be twice as likely to face non-partner sexual violence than women who have access to a household toilet.^{133,136} Women are also reported to be vulnerable when travelling to or using public facilities or pit latrines. Poor urban women are particularly at risk of non-family violence when they lack access to a household toilet.¹³⁴ The risk is higher when girls and women, seek the cover of dark to relieve themselves in the early morning or late evening. This risk of sexual harassment and assault, leads to psychosocial stress including feelings of shame and anxiety, for women and girls.¹³⁵

In schools, inadequate hygiene and sanitation facilities can affect girls' concentration and participation and may result in their absence or even drop-out. Despite considerable progress to improve sanitation and hygiene in schools

in South Asia, many sanitation facilities remain inadequate. In India, only 62% of schools have separate facilities for girls, 69% in Nepal.¹³⁷⁻¹⁴⁰ Even when schools have toilets, they are often insufficient for number of students. In many countries, schools do not meet the WHO standard for toilet to schoolgirl ratio of 1:25 – in Bangladesh the ratio is 1:187, in Nepal 1:69 with fewer toilets in some areas such as Udayapur where the ratio is 1:170.¹³⁷⁻¹⁴⁰ Effective operation and maintenance of school facilities remains a major issue in many settings and non-functioning or unclean toilets are a common problem. In Bhutan, while 97% of schools have toilets, only 65% are functional.¹³⁷⁻¹⁴⁰ There is also a lack facilities for the private and dignified management of menstruation including lockable doors, access to water, soap, sanitary materials, changing areas, and lighting, as well as incinerators and rubbish bins inside cubicles to ensure safe disposal of used sanitary pads. This combination of factors mean many girls may be reluctant to use toilets when at school.

When girls do not use the latrines to urinate they often decrease their water consumption, increasing their risk of both dehydration and urinary tract infections. When they do not change their sanitary pads for long periods of time they risk skin irritation, genital infections, and blood leakage. Most girls live in fear of blood staining their clothing and many report being teased and embarrassed when this occurs.^{131,132} Compounding these issues, taboos surrounding menstruation frequently restrict open discussion and access to accurate information. As a result, there are many myths surrounding periods which limit girls' diets and activities. This includes harmful practices, such

Chaupadi in Nepal where menstruating women and girls must eat separately, have no physical contact with other people or water sources and, in some instances, sleep outside in tiny huts that are often dirty and cold.¹⁴¹ The misinformation and harmful practices surrounding menstruation combined with lack of improved sanitation make girls lives more stressful and can place their health and wellbeing at significant risk.

“I don’t feel like going to school during my menstruation because of various reasons, such as hygiene and unavailability of pads and rooms for changing them. If we have girls-friendly toilets in our schools, I along with my friends would be really happy, and we would not have to miss out on our classes.”

Girl, 15, Nepal.¹³⁷⁻¹⁴⁰

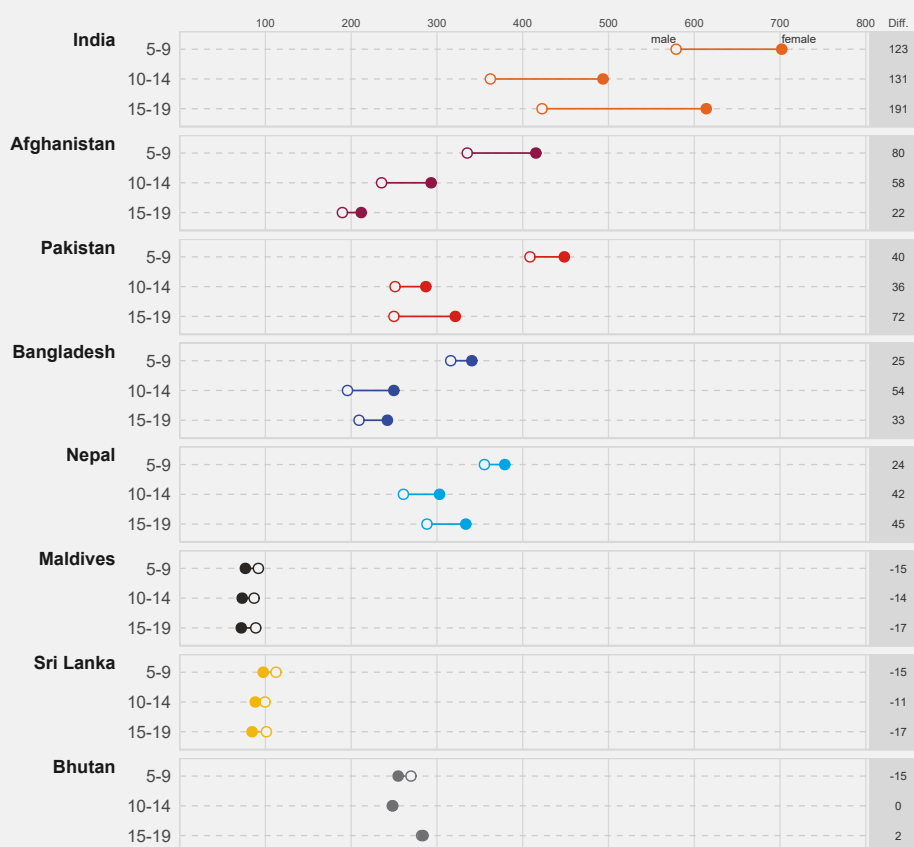
Where access to water is limited there is a need for people in the household to be responsible for **water collection** (Indicator 6.04). As shown in Figure 6.4, available data suggest that children in this region have generally low level of responsibility for water collection and there are not substantial gender differences. The high rates of water collection by adult women in Nepal is discussed in Domain 2.

Indicator 6.03 measures the **disease burden attributable to inadequate WASH** on girls and boys across childhood and adolescence (Figure 6.4). This includes, for example, the burden of diarrheal disease and pneumonia due to inadequate hygiene.

For this region, the disease burden attributable to WASH is generally greater for girls than boys, with the exceptions of the Maldives and Sri Lanka. In India for example, the burden of disease is 614 DALYs per 100,000 for girls aged 15-19 years, compared to 422 DALYs per 100,000 for boys. The greater burden borne by girls is marked when boys' greater biological vulnerability to infectious diseases in early childhood is considered. This greater disease burden may be related to differences in nutrition or care-seeking for girls and boys. It should be noted, that this burden does not include measure of the increased risk of gender-based violence associated with unsafe sanitation.

FIGURE 6.4: WATER, SANITATION AND HYGIENE

This graph shows the health impact (measured in DALYs per 100,000) of water, sanitation and hygiene on girls and boys aged 5–19 years (Indicators 6.03b–6.03d). The solid filled circles are for females and the unfilled circles are for males. The difference between female and male estimates shown in the panel on the right – a positive number indicates a greater burden for girls whilst a negative number indicates a greater burden for boys. Data for under 5 year olds are not shown here given the substantially larger burden but are summarised in the appendix. Data: GBD, 2016.



INDICATOR 6.03: WATER, SANITATION AND HYGIENE (DALYS PER 100,000)

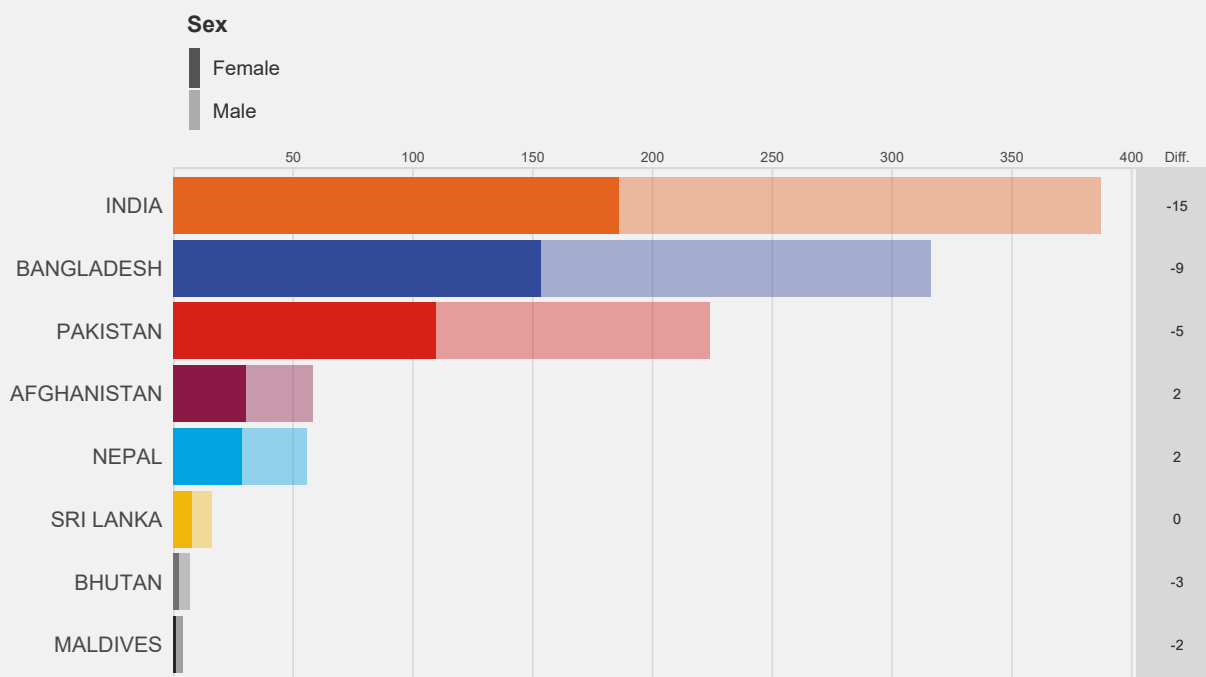
Mobility (Indicators 6.05-6.08)

Sustainable development is defined as meeting the needs of the present without compromising the ability of future generations to meet their own needs.¹⁴² An environment that lacks environmental or economic sustainability will stimulate migration – people will leave to find better environments in which to live. Across the region, there more than one million **international migrants** under 18 years (Indicator 6.05, Figure 6.5). The largest populations of migrants (in count) are in India, Pakistan and Bangladesh. There are minimal gender differences in migration across the region; the exceptions being Bhutan and

the Maldives, which both have a high proportion of in-migration, with more male than female migrants. These patterns likely indicate variation in economic opportunities for child migrants, with boys more likely to be employed in sectors such as manufacturing, and construction and girls in domestic work, hospitality and food services.¹⁴³ In keeping with other employment data, migrants employed in jobs viewed as ‘women’s work’ generally receive lower remuneration.¹⁴³ However, all migrant girls and boys are vulnerable to isolation from social networks, poverty, and exploitation.

FIGURE 6.5: INTERNATIONAL MIGRANTS

This graph shows the count of international migrants, aged <20 years, in thousands (Indicator 6.05a) as a stacked bar chart of females (darker shading) and males (lighter shading). The difference between female and males shown in the grey panel on the right – a positive number indicates more female migrants, a negative number indicates more male migrants. Data source: UN 2017.



INDICATOR 6.05A: INTERNATIONAL MIGRANTS <20Y, (COUNT IN 1000S)

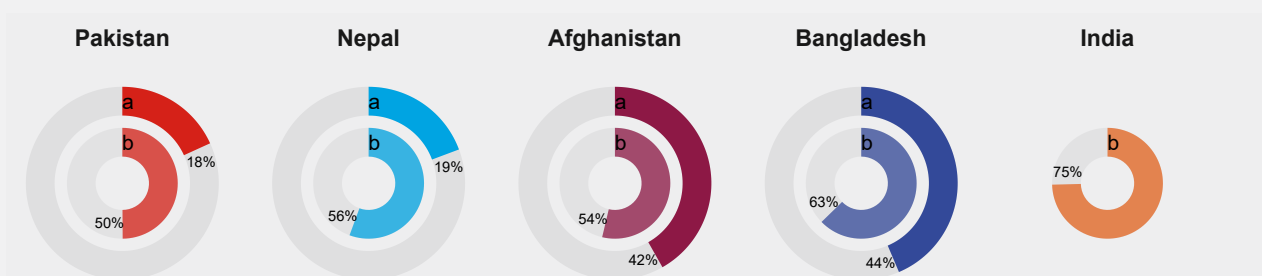
Perceptions of environmental safety will affect the freedom young people are given to move around their communities. Gender norms frequently lead to girls being more restricted in their freedom of movement than boys, due to concerns regarding their safety. For these reasons, married girls' **decision-making** power to visit family and friends (Indicator 6.06) is being considered a proxy measure of perceptions of environmental safety. In countries for which data are available, freedom of movement for married girls is very low (Figure 6.6), reflecting the relatively powerless position of girls who are subjected to child marriage. In Pakistan and Nepal, only one in five married girls can make decisions to visit family and friends; in Afghanistan and Bangladesh only two out of five girls can make these decisions. There is also a consistent pattern for married adolescent girls to have less decision-making power than married women across the region. For those married girls who remain unable to freely access their family and social networks, this underscores their entrenched vulnerability, both within their marital relationship

Approximately 80% of married girls in Pakistan and Nepal and more than half of married girls in Afghanistan and Bangladesh cannot make decisions to visit family and friends.

and within their broader marital household or extended family. It also indicates persistent power imbalances in relationships between men and women, with girls having limited self-determination and being at risk of gender-based violence. No data is available on the situation of unmarried girls who may face greater limitations in movement and decision-making than boys and married girls.

FIGURE 6.6: DECISION-MAKING

This graph shows the proportion of married adolescents aged 15-19 years who can make decisions around visiting friends (outer ring, Indicator 6.06) as compared to the proportion of married adult women aged 15-49 years who can make decisions about visiting friends (inner ring, Indicator 2.18). Data source: DHS 2010 – 16.



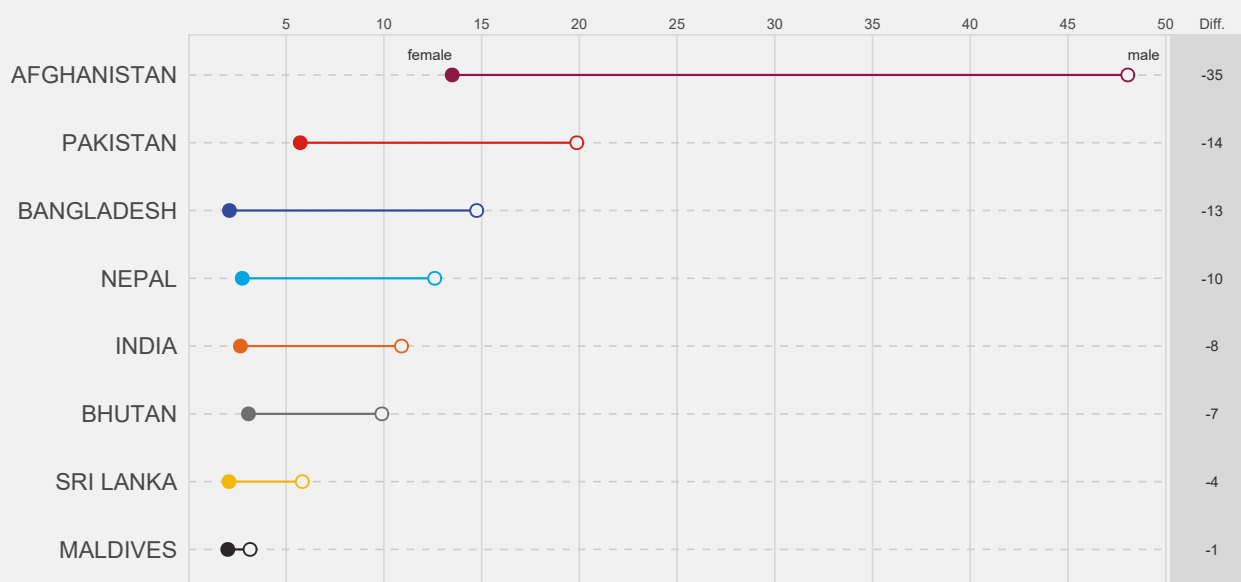
(A) INDICATOR 6.06 : MARRIED FEMALES MAKE DECISIONS VISITING FAMILY OR FRIENDS, 15-19Y (%)
 (B) INDICATOR 2.18: MARRIED WOMEN MAKE DECISIONS VISITING FAMILY OR FRIENDS, 15-49Y (%)

Adolescent boys are at substantially increased risk of **mortality due to road traffic accidents** (Indicator 6.08) in all countries compared to adolescent girls (Figure 6.7). This is likely to be associated with boys' increased mobility in urban settings and greater freedom of movement in public spaces. Adolescent boys are likely to have more access to modes of transport other than walking, such as bicycles or motorised transport. Gender norms and boys' greater participation in vocational training and paid work may lead to more family support for boys' mobility as well as

increased access to financial resources. In contrast, perceptions that girls are vulnerable and require more protection than boys, restricts their mobility and independence.¹⁴⁴ Higher levels of alcohol misuse and masculine norms that encourage risk taking may also make boys at higher risk of traffic accidents. In this way, adolescent boys' increased traffic accident mortality reflects gender norms that encourage freedom, financial independence and risk taking among boys but limit girls' mobility and control over resources.

FIGURE 6.7: ROAD TRAFFIC MORTALITY

This graph shows the mortality rate due to road traffic accidents per 100,000 annually (Indicator 6.08) for females (solid circle) and males (hollow circle). The difference between females and males is shown in the panel on the right – a negative number indicates more male than female deaths. Data source: GBD 2016.



INDICATOR: 6.08: ROAD TRAFFIC MORTALITY, 10-19Y, (DEATHS PER 100,000)

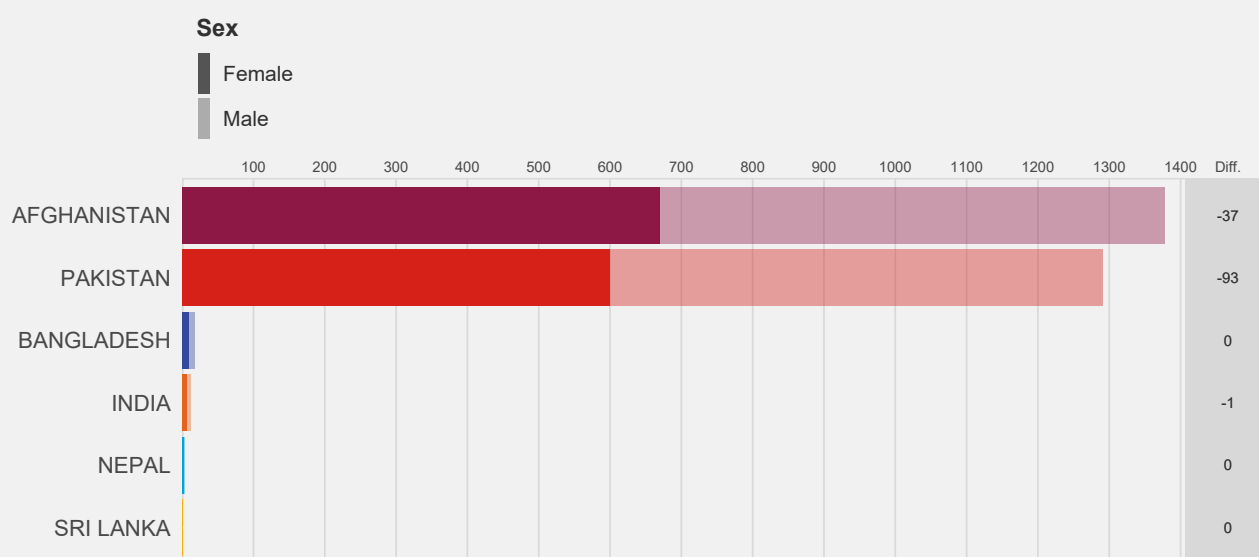
Conflict and disaster (Indicator 6.09)

The available data indicates that boys are more likely than girls to be **refugees, displaced, stateless or otherwise a person of concern** (Indicator 6.09, Figure 6.8). This indicates that boys are more likely to leave their homes and home countries unaccompanied – whether in pursuit of economic opportunities or in response to an unsafe environment – compared with

girls. These boys are vulnerable to isolation from social networks, poverty and exploitation. The gender disparities in migration, are likely another reflection of boys' greater independence and mobility compared with girls being more restricted in their movements. See Case study 6.2 for more discussion of how natural disasters exacerbate gender inequalities.

FIGURE 6.8: REFUGEES AND DISPLACED PERSONS

This graph shows the count of refugees, displaced, stateless or otherwise a person of concern, aged <18 years, in thousands (Indicator 6.09) as a stacked bar chart of females (darker shading) and males (lighter shading). The difference (in thousands) between female and males shown in the grey panel on the right – a negative number indicates more male refugees or displaced persons. A negative number indicates more males than females are displaced or refugees. Data source: UNHCR 2016.



INDICATOR: 6.09: REFUGEES, DISPLACED AND STATELESS PERSONS, <18Y (THOUSANDS)



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CASE STUDY 6.2: NATURAL DISASTERS EXACERBATE GENDER INEQUALITIES

Asia Pacific is the most disaster-prone region in the world. Four countries in South Asia, Bangladesh, India, Nepal and Pakistan, rank at high risk of humanitarian crises and disasters, the risk for Afghanistan is very high.¹⁴⁵ The region is regularly impacted by destructive natural hazards including earthquakes, cyclones, floods, droughts, and landslides. The increasing frequency and severity of these events is generally attributed to climate change.

Worldwide women and children are disproportionately impacted by natural disasters.^{146,147} They are 14 times more likely to die in a disaster than men.¹⁴⁷ In South Asia, women represented 90% of deaths in the 1991 cyclone in Bangladesh.¹⁴⁸ Research also suggests that adolescent girls are more affected by disasters than boys the same age.¹⁴⁷ Following an event, girls are often at greater risk of school drop-out and early marriage due to the increased economic burden and domestic workload. This was the case in India following the 2001 Gujarat earthquakes when girls were kept at home to help other female family members care for the injured and infirm.¹⁴⁹ Social norms which limit female mobility can restrict their access to aid, as was reported by women in Pakistan following the 2010 floods.¹⁴⁹ Female responsibility for other family members, livestock and the household can further impede their evacuation to safety.

Women and girls are also more likely to be exposed to gender-based violence during disasters due to the loss of normal community protection mechanisms and networks. This is particularly the case when they are housed in crowded shelters, or need to travel increased distances to collect water or wood. Natural disasters also create an opportunity for

traffickers to prey on children and adolescents, who may have lost family, homes and livelihoods. There is limited data available on trafficking in South Asia however following the 1998 floods in Bangladesh, girls were reported to be exposed to increased levels of sexual exploitation including trafficking to Dhaka for sex work.¹⁴⁸ Recently, drought in the western provinces of Afghanistan, has displaced families and lead to an increase in child marriages.^{150,151} Between July and October 2018 there were 161 betrothals or marriages of which 155 were girls and six were boys.

Natural disasters exacerbate gender inequalities and differing risks for girls and boys. While many environmental factors increase the risk for girls, discriminatory gender norms lie at the heart of these threats. Negative masculine norms which encourage dominance, violence and predatory behaviour, combined with female stereotypes which cast girls as vulnerable and subservient to the needs and desires of males, place girls at greater risk of harm than boys. Lack of inclusion of women in planning and decision-making means women's and girls' needs are also not adequately addressed.

a father “who, when unable to hold on to both his son and his daughter from being swept away by a tidal surge in the 1991 cyclone in Bangladesh – released his daughter, because ‘[this] son has to carry on the family line’.”¹⁴⁷

Summary

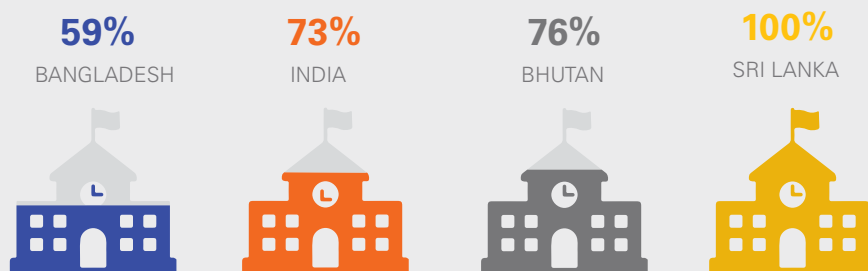
Domain 6

Key data gaps

- There is an overall lack of agreed indicators and data that measure gender equality related to safe and sustainable environments.
- Key data gaps included data on perceived safety of environments (data not yet available from MICS-6), gender-specific data on access to WASH, urbanisation, conflict, disaster and climate change.
- Most data used for Domain 6 were modelled and available for all countries.
- Only half the countries had primary data for the burden of water collection and whether married girls can make decisions to visit family and friends.

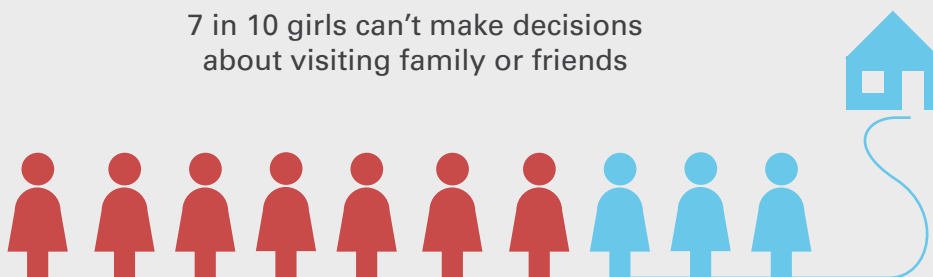
Many schools have inadequate sanitation

Schools with improved sanitation facilities



Mobility is limited for many girls

7 in 10 girls can't make decisions about visiting family or friends



Key gender issues relating to environment of children and adolescents:

Household air pollution causes substantial harms for girls and boys in this region. Girls in this region come to greater harm despite boys being more biologically vulnerable. This may reflect gender and social norms that result in girls spending more time within the household and doing domestic work such as cooking.

Improved sanitation facilities are not available in one in four schools in India and Bhutan and two in five in Bangladesh. Inadequate sanitation facilities place a disproportionate burden on girls' health and safety, particularly during menstruation.

Despite their biological advantage, girls in most countries experience a larger disease burden than boys from inadequate WASH. This may be related to differences in nutrition and care-seeking

There are more than one million international child migrants across the region. In Bhutan and the Maldives (relatively developed countries) international migrants are more likely to be boys. These gender-differences may reflect patterns in child labour.

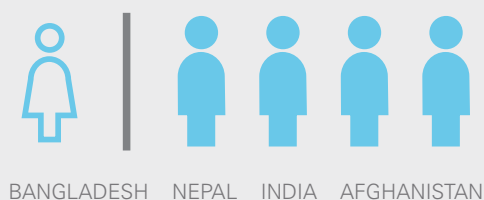
Mobility is very limited for many adolescent girls: only one in five married girls in Nepal and Pakistan and two in five in Afghanistan and Bangladesh can make decisions to visit family and friends.

Adolescent boys' increased traffic accident mortality reflects gender norms that encourage freedom, financial independence and risk taking among boys but limit girls' mobility.

More boys die from road traffic accidents than girls

Road traffic mortality, 10-19 years, deaths per 100,000

In some countries, more than four times as many boys die from road traffic accidents as girls



The available data suggest substantial gender inequality in the safety of environments that girls and boys grow up in. Girls are perceived as more vulnerable and in need of protection from the environment, and this limits their mobility. They are more likely than boys to be tied to the home and engaged in domestic chores. By contrast, while boys are more mobile and independent, masculine norms supportive of risk-taking and toughness also place them at risk of harm.

Conclusions

An important conclusion from this assessment is that it is possible to define indicators to capture gender inequality for children and adolescents, and that despite data gaps, it is possible to provide quantitative measure of gender inequalities impacting on girls and boys across countries in this region.

By global standards, South Asia demonstrates progress towards gender equality with almost all countries showing improvements in the Gender Inequality Index over time. However, the available data indicates persistent gender inequalities exist for children and adolescents.



Health (Domain 3)

Available data for **health** indicate girls to be at excess risk of under-5 mortality in India. Adolescent girls experience a disproportionate burden of anaemia, and there remains a large burden of poor reproductive health for girls with high and unshifting rates of adolescent pregnancy and substantial unmet needs for contraception. Maternal mortality rates are particularly high for adolescents in Afghanistan and Pakistan. Boys in this region demonstrate higher levels of risk behaviour, such as tobacco

smoking, and are also at excess risk of injury. However, In contrast with global patterns, adolescent girls in Bangladesh, India, Nepal and Pakistan have an excess risk of suicide compared to boys. These differing outcomes for girls and boys likely reflect social norms that value boys more highly than girls; harmful masculine norms which support risk-taking and discourage help-seeking; and imbalances in power relations that negatively impact girls' autonomy and self-determination.



Education and employment (Domain 4)

Available data for **education and transition to employment** indicate that with the exception of Afghanistan, girls have school attendance rates that are comparable or in some instances slightly better than those of boys. However, after leaving school, girls and young women (aged 15-24 years) are more likely than boys to not be in education,

training and employment. As such, gains made in assuring equity in school enrollment and completion have not translated to gender equality in transition to employment and further training. This has the potential to undermine progress and entrench women and girls in poverty and socioeconomic disadvantage.



Protection (Domain 5)

Available data for **protection** outcomes indicates that girls and boys in South Asia are not being adequately protected from violence, exploitation and abuse. Girls in the region are substantially more likely than boys to be married as children or trafficked. In certain countries, there remains a strong preference for sons as demonstrated by an excess number of males than females at birth and excess female infant mortality. There is broad acceptance of violence against women by young people, with girls being more likely to justify a husband beating his wife than boys. Girls also spend more hours on household labour than do boys. By contrast, boys in this region are substantially more likely to die from intentional

homicide than girls. Boys report higher rates of bullying, and they are also more likely to be in child or hazardous labour. These findings reflect not only a failure of protective legislation in the region but also harmful social and gender norms. They demonstrate that for many, exposure to violence, exploitation and abuse occur from early childhood, likely contributing to harmful attitudes towards domestic violence and male-female relationships, that are established by adolescence. The differing outcomes for girls and boys are likely attributable to social norms which support male dominance, violence and toughness but limit girls to subservient, domestic and reproductive roles.



Safe environments (Domain 6)

The available data suggest substantial gender inequality in the safety of environments that girls and boys grow up in. Girls have limited mobility within their environments and are more likely than boys to be tied to the home and engaged in domestic labour. This likely contributes to the greater harm done to girls by household air pollution, despite boys being more biologically

vulnerable. Girls are also more likely to be adversely affected by inadequate sanitation and hygiene facilities in the schools of the region. Boys experience higher mortality from traffic accidents likely reflecting gender norms that encourage independence and risk taking among boys but limit girls' mobility.

Recommendations

The findings of this analysis provide the basis for four key recommendations, detailed below:

Recommendation 1

Integrate priority gender indicators for children and adolescents into routine reporting

From this review of gender differences across a comprehensive range of indicators, findings highlight a subset of indicators where gender disparities are most substantial, or that capture key dimensions of gender inequality in child wellbeing outcomes (Box 1). These indicators should be integrated into routine reporting. Importantly, since this review has drawn on available data, these indicators can be readily populated using existing data collections. However, this list of indicators cannot be considered exhaustive as there are other critical gender issues that are not captured in existing data.

BOX 1. PRIORITY INDICATORS TO TRACK PROGRESS TOWARDS GENDER EQUALITY THROUGH ROUTINE MONITORING.

INDICATORS THAT TRACK CRITICAL GENDER DISPARITIES

Girls currently disadvantaged

- Prevalence of anaemia (Indicator 3.09)
- Suicide mortality rate per 100,000 population (Indicator 3.15)
- Adolescent birth rate (births per 1,000 females) among 15-19 year-olds (Indicator 3.20)
- School completion rate by level of schooling (Indicator 4.02)
- Youth literacy rate among 15-24 year-olds (Indicator 4.05)
- Proportion of youth (15-24 years) not in education, employment or training (%) (Indicator 4.12)
- Sex ratio at birth (Indicator 5.01)
- Proportion of 20-24 year olds who were married before 15 years and before 18 years (Indicator 5.06)
- Proportion of adolescents subjected to violence from an intimate partner in the previous 12 months (Indicator 5.11)
- Average number of hours children aged 5-17 years spend performing household chores per week (Indicator 5.22)
- Proportion of married 15-19 year old females who make decisions about visiting family and friends themselves or jointly with husband (Indicator 6.05)

Boys currently disadvantaged

- Injury-specific DALY rate among adolescents aged 10-19 years (Indicator 3.12c)
- Suicide mortality rate per 100,000 population (Indicator 3.15)
- Mortality rate due to intentional homicide among 10-19 year-olds (Indicator 5.15)
- Mortality rate due to road traffic accidents among 10-19 year-olds (Indicator 6.07)

Other indicators that track critical gender issues

- Proportion of female teachers, by level of schooling (Indicator 4.07)
- Proportion of schools with basic sanitation facilities (improved, single-sex and usable) (Indicator 4.08)
- Proportion of people aged 15-19 years, who justify wife beating (Indicator 5.13)
- Legal age of consent to sex (heterosexual and same-sex sexual relationships) (Indicator 5.07)
- Legal age of consent to marriage (Indicator 5.08)

Recommendation 2

Invest in gender data collection for children and adolescents in priority areas

The review has also identified critical gaps in data relevant to priority topics for promoting gender equality.

2a

Invest in developing and promoting use of standard indicators for priority topics

Some proposed topics known to be linked with gendered vulnerability were excluded from the indicator framework due to a lack of routine data collection and reporting against defined indicators. Additional investment is recommended to address data gaps in these areas, which included:

- wellbeing of children and adolescents with disability;
- sexual and reproductive health of adolescent boys, unmarried adolescent girls and boys, and girls and boys aged less than 15 years;
- menstrual health and hygiene;
- quality of education;
- wellbeing of young people with diverse gender identity and sexual orientation; and
- individual-level indicators relating to urbanisation, conflict, disaster and climate change.

2b

Invest in collecting data against established indicators in areas with data gaps

There were also indicators included in the indicator framework for which no country in the region had data, or indicators for which only modelled data were available. These are outlined in Box 2 and represent important areas for investment in primary data collection. Further, for the majority of indicators in this report it was not possible to disaggregate data by urban/rural status or ethnicity, two important determinants of gender inequality in this region. As such, efforts around data collection should ensure that these indicators can be further disaggregated.

BOX 2. INDICATORS WITH NO DATA, OR NO PRIMARY DATA, AVAILABLE IN SOUTH ASIA.**Indicators with no data available**

- HIV and sexuality education in lower and upper secondary schools (Indicators 4.06b, 4.06c)
- Informal sector employment (Indicator 4.14)
- Proportion of females, aged 20-24 years, who experienced forced sex by 18 years of age (%) (Indicator 5.12).
- Harassment and discrimination experienced by young people with diverse gender identity and sexual orientation (Indicators 5.17a, 5.17b)
- Prevalence of female genital mutilation/cutting (Indicator 5.18)
- Number of detected trafficked children (Indicator 5.19)
- Young people's perceptions of safety in their neighbourhoods (Indicator 6.06)

Indicators with only modelled data available

- Anaemia (Indicator 3.09)
- Overweight and obesity (Indicator 3.11)
- DALY rates (all-cause and cause-specific) (Indicators 3.12, 3.16, 6.01, 6.02)
- NCD risk factors (binge drinking and tobacco smoking) (Indicators 3.13, 3.14)
- Suicide mortality rate (Indicator 3.15)
- Maternal mortality rate among 15-19 year olds (Indicator 3.21)
- Mortality due to intentional homicide (Indicator 5.15)
- Mortality due to road traffic accidents (Indicator 6.07)
- Mortality due to intentional homicide (Indicator 5.15)
- Mortality due to road traffic accidents (Indicator 6.07)

2c Invest in data collection methodologies appropriate to gender-diverse children and adolescents

As described above, this review excluded some topics relating to the wellbeing of young people with diverse gender identity and sexual orientation. Young people who identify as transgender or third gender along with young people who are lesbian, gay, bisexual or intersex, face particular forms of discrimination that undermine their ability to fulfil their potential. There is increasing recognition of the diversity of gender identity, and the changing social constructions of gender, with young people in many societies being more likely to reject normative gender categorisation. Despite this recognition, collection of data about gender overwhelmingly privileges the binary categorisation of individuals as male or female. This means that the experience of people with diverse gender identity or expression is rendered invisible in research and demographic data sets; it can also mean that transgender people are misgendered, or required to misgender themselves, in their participation in routine data collection and other research. This can be particularly harmful to young people, already dealing with the consequences of prejudice and discrimination in relation to their gender identity. While collection of sex-disaggregated data can make visible challenges linked to gender inequality, it is increasingly important to collect data in ways that do not increase the harms experienced by young people with diverse gender identity. Investment in developing data collection strategies that include young people with diverse gender identity and sexual orientation would increase the visibility of the experiences and needs of this vulnerable group of children and adolescents.

Recommendation 3:

Conduct additional research to understand observed gender disparities for children and adolescents

This review focused on understanding how gender equality impacts on the health and wellbeing of children and adolescents across the region. It provides a cross-sectional snapshot using the most recent data. For some indicators, it may be beneficial. This review also used comparable data for countries so as to build a regional profile of gender. An extension of this work may involve assembling country level profiles, drawing on the best available data at a country level. This may also include the analysis of sub-national trends, likely to be of value to local programming.

There were some indicators for which findings were inconsistent or not as expected (Box 3). Further exploration of these indicators and their underlying determinants may help develop a more complete picture of gender equality.

BOX 3. INDICATORS THAT MAY REQUIRE IN-DEPTH REVIEW TO EXPLORE OBSERVED GENDER DIFFERENCES.

Prevalence of anaemia (disaggregated in 5-year age bands) (indicator 3.09)

Prevalence of overweight and obesity among 10-19 year olds (indicator 3.11)

Proportion of children and adolescents out-of-school (indicator 4.03)

Proportion of children aged 5-17 years engaged in child labour who are in hazardous work (indicator 5.21)

DALY rate due to household air pollution (indicator 6.01)

DALY rate due to unsafe water, sanitation and hygiene (indicator 6.02)

Recommendation 4:

Address key drivers of gender inequality in the region

The findings of this review indicate that the likely drivers of unequal outcomes for girls and boys in the region include: binary and unequal gender roles; gendered division of labour and associated restrictions on opportunities for both girls and boys; and norms around female passivity and compliance and male independence and risk taking. Further research will be invaluable to confirm and better understand how social norms and gender inequality contribute to these differences for girls and boys and to develop strategies moving forward. Action to address drivers of gender inequality is likely to be required in order to address the underlying causes of disparities in child wellbeing outcomes, and to improve wellbeing for all children and adolescents in the region. Examples of action include criminalisation of marital rape throughout the region and enforcing legislation around child marriage. There is also space for formal support for women's increased representation in government and the justice system.



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Appendix 1

Existing frameworks to measure gender equality

Several existing global and regional frameworks include indicators to measure and monitor women's and girls' empowerment and gender equality. These include:

- The Sustainable Development Goals;¹⁵²
- United Nations Minimum Set of Gender Indicators;¹⁵³
- UNESCAP's Regional core set of gender statistics and indicators for Asia and the Pacific;¹²
- The Beijing Platform for Action;⁶
- UNICEF Strategic Plan (2018-2021) and Gender Action Plan;¹⁵⁴ and
- UNICEF 5x5 adolescent health indicators.¹⁵⁵
- UNFPA Strategic Plan 2018-2021

There are additionally frameworks that include measure of gender that have been developed by UNFPA, the World Bank, ADB, WHO, and international non-government organisations such as Plan International and CARE. Further, the ADB and UN Women have recently defined and populated indicators of gender equality for Women in the Asia Pacific region.¹⁵⁶ While many of these include some gender indicators relating to children and adolescents, they do not provide a comprehensive assessment of gender issues for children and adolescents.

Established gender issues for children and adolescents (with a focus on girls) in East and South East Asia as related to four of the Domains of the UNICEF's strategic plan 2018-2021 are summarised below:

Every Child Survives & Thrives	<ul style="list-style-type: none">● Access to safe abortion and post-abortion care.^{157, 158}● Increased smoking rates among boys and girls.¹⁵⁹● Female infanticide and sex selective abortion.^{108, 158}
Every Child Learns	<ul style="list-style-type: none">● Gender disparities in school dropout rates.^{8, 160}
Every Child is Protected	<ul style="list-style-type: none">● Child labour and labour rights, particularly in the informal sector.¹⁶¹● Trafficking and sexual exploitation.¹⁶²
Every Child Lives in a Safe and Clean Environment	<ul style="list-style-type: none">● Urban migration influencing vulnerability of girls in urban, peri-urban and rural areas.¹⁶³● Lack of water and sanitation for girls to manage menstrual hygiene.¹⁶⁴

Appendix 2

Data sources and access for indicators

This appendix details the data sources and access for indicators reported in this analysis.

Data were sourced in 2018.

INDICATOR	Data source	Access details	Notes
1.01a Population aged under 18 years (in 1000s), by sex	UNPD	https://esa.un.org/unpd/wpp/Download/Standard/Population/	
1.01b Proportion of total population aged under 18 years (%), by sex	UNPD	https://unstats.un.org/sdgs/indicators/database/?indicator=1.1.1	
1.01c Ratio of girls to boys aged under 18 years	UNPD	https://unstats.un.org/sdgs/indicators/database/?indicator=1.1.1	
1.01d Population difference between girls and boys aged under 18 years (in 1000s)	UNPD	https://esa.un.org/unpd/wpp/Download/Standard/Population/	
1.02 Proportion of total population below international poverty line of \$US1.90 per day (%)	UNICEF	https://data.unicef.org/resources/state-worlds-children-2017-statistical-tables/	
1.03 Human Development Index	UNDP	http://hdr.undp.org/en/composite/GDI	
1.04 Prevalence of severe food insecurity in the total population (%)	FAO	http://www.fao.org/faostat/en/#data/FS	
1.05 Proportion of the population living in urban areas (%)	UNDP	https://population.un.org/wup/DataQuery/	
1.06 Total annual net migration rate (per 1000)	UNPD	https://population.un.org/wpp/Download/Standard/Migration/	
1.07 Government expenditure on health as a percentage of GDP	WHO	http://apps.who.int/nha/database/Select/Indicators/en	
1.08 Government expenditure on education as a percentage of GDP	UNESCO	http://data.uis.unesco.org/	
2.01 Average number of hours per day spent on unpaid domestic and care work among 15 to 49-year-olds, by sex	UNSD	https://genderstats.un.org/#/indicators	
2.02 Average number of hours spent per day on paid and unpaid domestic work combined among 15 to 49-year-olds, by sex	UNSD	https://genderstats.un.org/#/indicators	
2.03 Proportion of households where a person over 15 years of age is usually responsible for water collection (%), by sex	UNSD	https://unstats.un.org/unsd/gender/chapter7/chapter7.html	

INDICATOR	Data source	Access details	Notes
2.04 Average monthly earnings of employees aged 15-49 years (\$USD), by sex	ILO	https://www.ilo.org/ilostat/faces/oracle/webcenter/portalapp/pagehierarchy/Page3.jspx?MBI_ID=435&_adf.ctrl-state=168ms9j3m2_4&_afLoop=2993341060500052&_afWindowMode=0&_afWindowId=null#!%40%40%3F_afWindowId%3Dnull%26_afLoop%3D2993341060500052%26MBI_ID%3D435%26_afWindowMode%3D0%26_adf.ctrl-state%3D11tjgsdtq_17	
2.05 Proportion of married/partnered women, aged 15-49 years, in paid work, who make decisions about how earnings are used, themselves or jointly with husband (%)	DHS	https://www.statcompiler.com/en/	Combined two estimates (decision themselves and decision jointly with husband)
2.06 Proportion of adults aged over 15 years who own a bank account (%), by sex	WB	http://databank.worldbank.org/data/reports.aspx?source=g20-basic-set-of-financial-inclusion-indicators	
2.07 Proportion of married/partnered women, aged 15-49 years, who make decisions about healthcare, themselves or jointly with husband (%)	DHS	https://www.statcompiler.com/en/	Combined two estimates (decision themselves and decision jointly with husband)
2.08 Proportion of married/partnered women, aged 15-49 years, who make decisions about major household purchases, themselves or jointly with husband (%)	DHS	https://www.statcompiler.com/en/	Combined two estimates (decision themselves and decision jointly with husband)
2.09a Proportion of seats held by women in the lower house of national parliament (%)	IPU NMDI	http://archive.ipu.org/wmn-e/classif.htm https://www.spc.int/nmdi/mdg3	Two data sources utilised to increase coverage for the Pacific
2.09b Proportion of seats held by women in the upper house of national parliament (%)	IPU	http://archive.ipu.org/wmn-e/classif.htm	
2.10 Proportion of police officers who are female (%)	UNODC	https://data.unodc.org/#state:1	
2.11 Women who have experienced physical and/or sexual violence by an intimate partner in last 12 months (%)	UNFPA DHS know-vavdata	https://asiapacific.unfpa.org/ https://www.statcompiler.com/en/	Two data sources utilised to increase coverage for Central Asia
2.12 Proportion of 15 to 49-year-olds who think that a husband is justified to beat his wife for at least one specific reason (%), by sex.	DHS MICS	https://www.statcompiler.com/en/ http://mics.unicef.org/surveys	Two data sources utilised to increase coverage. MICS data downloaded from country reports
2.13 Legality of abortion - index from 0 (not legal any circumstance) to 100 (legal on request and no restriction)	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	

INDICATOR	Data source	Access details	Notes
2.14 Proportion of women of reproductive age, aged 15-49 years, married or in a union, who have their need for family planning satisfied with modern methods (%)	UNSD	https://unstats.un.org/sdgs/indicators/database/?indicator=3.7.1	
2.15 Proportion of women of reproductive age, 15-49 years, married or in a union, who can say no to sex with their husband (%)	DHS	https://www.statcompiler.com/en/	
2.16a Mean years of schooling (ISCED 1 or higher), population aged 25+ years, by sex	UNESCO	http://data.uis.unesco.org/	
2.16b Mean years of education in age standardised population (modelled), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
2.17a Percentage of women, aged 15-49 years, attended at least once during pregnancy by skilled health personnel (doctor, nurse or midwife)	UNICEF NMDI	http://data.unicef.org/resources/state-worlds-children-2017-statistical-tables/ https://www.spc.int/nmdi/mdg3	Two data sources utilised to increase coverage for the Pacific
2.17b Percentage of women, aged 15-49 years, attended at least four times during pregnancy by skilled health personnel (doctor, nurse or midwife)	UNICEF	http://data.unicef.org/resources/state-worlds-children-2017-statistical-tables/	
2.18 Proportion of married/partnered women, aged 15-49 years, who make decisions about visiting family/friends themselves or jointly with husband (%)	DHS	https://www.statcompiler.com/en/	Combined two estimates (decision themselves and decision jointly with husband)
2.19 Existence of national legislation that explicitly criminalises marital rape (yes=1, no=0)	WB	http://wbi.worldbank.org/data/exploretopics/protecting-women-from-violence	
2.20a Social Institutions Gender Index score (lower score indicates lower discrimination of women)	OECD	https://www.genderindex.org/ranking/	
2.20b Social Institutions Gender Index, categories indicating level of discrimination	OECD	https://www.genderindex.org/ranking/	
2.21 Gender Development Index (score of 1 indicates parity between males and females in the Human Development Index)	UNDP	http://hdr.undp.org/en/composite/GDI	
2.22 Gender Inequality Index (lower scores indicate less inequality between males and females)	UNDP	http://hdr.undp.org/en/composite/GDI	
2.23 Global Gender Gap Index (score of 1 indicates parity between males and females)	WB	https://tcdata360.worldbank.org/indicators/af52ebe9?country=BRA&indicator=27962&viz=line_chart&years=2010,2016	
3.01 Number of deaths of children under 5 years of age per 1000 live births, by sex	UNIGME	http://www.childmortality.org/files_v22/download/UNIGME%20Rates%20&%20Deaths_Under5.xlsx	
3.02 Expected to estimated mortality rate for females under 5 years of age	UNIGME	http://www.childmortality.org/files_v22/download/UNIGME%20Rates%20&%20Deaths_Under5.xlsx	

INDICATOR	Data source	Access details	Notes
3.03 Proportion of children, aged 12-23 months, who have received all basic vaccinations (BCG, MCV1, DTP3, Polio3) (%), by sex	DHS, UNICEF Data provided by UNICEF	https://www.statcompiler.com/en/	<i>Two data sources utilised to increase coverage</i>
3.04 Proportion of children, aged 12-23 months, who have received BCG (%), by sex	DHS, UNICEF Data provided by UNICEF	https://www.statcompiler.com/en/	<i>Two data sources utilised to increase coverage</i>
3.05 Proportion of children, aged 12-23 months, who have received MCV1 (%), by sex	DHS, UNICEF Data provided by UNICEF	https://www.statcompiler.com/en/	<i>Two data sources utilised to increase coverage</i>
3.06 Proportion of children under 5 years of age with fever in the last two weeks for whom advice or treatment was sought from a health facility or provider (%), by sex	UNICEF Data provided by UNICEF. Also accessible at:	http://data.unicef.org/resources/state-worlds-children-2017-statistical-tables/	
3.07 Proportion of children, aged 0-59 months, left alone or in the care of another child younger than 10 years of age for more than one hour at least once in the past week (%), by sex	UNICEF	https://data.unicef.org/topic/early-childhood-development/home-environment/	
3.08 Proportion of children under 5 years of age with stunting (<-2 SD from median height for age) (%), by sex	UNICEF	Data provided by UNICEF. Also accessible at: https://data.unicef.org/resources/dataset/malnutrition-data/	
3.09a Prevalence of anaemia for 0-19-year-olds (based on WHO age and sex specific haemoglobin thresholds) (%), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.09b Prevalence of anaemia for 0-4-year-olds (based on WHO age and sex specific haemoglobin thresholds) (%), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.09c Prevalence of anaemia for 5-9-year-olds (based on WHO age and sex specific haemoglobin thresholds) (%), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.09d Prevalence of anaemia for 10-14-year-olds (based on WHO age and sex specific haemoglobin thresholds) (%), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	

INDICATOR	Data source	Access details	Notes
3.09e Prevalence of anaemia for 15-19-year-olds (based on WHO age and sex specific haemoglobin thresholds) (%), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.10 Prevalence of thinness among 5-19-year-olds (BMI < -2 standard deviations below the median of reference population) (%), by sex	WHO	http://apps.who.int/gho/data/view.main.NCDBMIMINUS205-19Cv?lang=en	
3.11 Prevalence of overweight among 5-19-year-olds (BMI > +1 standard deviations above the median) (%), by sex	WHO	http://apps.who.int/gho/data/view.main.BMIPLUS1C10-19v?lang=en	
3.12a DALY rate due to all causes amongst 10-19-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.12b DALY rate due to communicable, maternal and nutritional disease amongst 10-19-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.12c DALY rate due to injuries amongst 10-19-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.12d DALY rate due to NCDs amongst 10-19-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.13 Proportion of 15-19-year-olds who report an episode of binge drinking (>48g females, 60g males) in the last 12 months (%), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.14 Prevalence of daily tobacco smoking among 10-19-year-olds (%), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.15 Suicide mortality rate among 10-19-year-olds (deaths due to intentional self-harm per 100,000 population per year), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.16 DALY rate due to mental disorder among 10-19-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.17 Proportion of 13-17-year-olds who report being so worried about something that they could not sleep at night most of the time or always in the past 12 months (%), by sex	WHO	https://www.who.int/ncds/surveillance/gshs/en/	<i>Data extracted from individual country reports</i>
3.18a Demand for contraceptives satisfied with a modern method in females 15-24 years of age (%)	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.18b Demand for family planning satisfied with modern methods in females 15-19 years of age (%)	DHS	https://www.statcompiler.com/en/	
3.19 Proportion of females, 15-19 years of age, married/partnered who can say no to sex with their husband/partner (%)	DHS	https://www.statcompiler.com/en/	

INDICATOR	Data source	Access details	Notes
3.20a Number of live births per 1000 females aged 15-19 years (SOWC)	UNICEF	http://data.unicef.org/resources/state-worlds-children-2017-statistical-tables/	
3.20b Number of live births per 1000 females aged 15-19 years (GBD)	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.21 Mortality rate due to maternal disorders among 15-19-year-olds (Deaths per 100,000)	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
3.22a Annual number of new cases of HIV in adolescents aged 15-19 years, by sex	UNICEF	Data provided by UNICEF. Also accessible at: http://data.unicef.org/resources/state-worlds-children-2017-statistical-tables/	
3.22b.1 HIV prevalence in sex workers under 25 years of age (%)	UNAIDS	Data provided by UNICEF. Also accessible at: https://data.unicef.org/resources/dataset/gender-and-hiv-data/	
3.22b.2 HIV prevalence in men who have sex with men under 25 years of age (%)	UNAIDS	Data provided by UNICEF. Also accessible at: https://data.unicef.org/resources/dataset/gender-and-hiv-data/	
3.22b.3 HIV prevalence in transgender people under 25 years of age (%)	UNAIDS	Data provided by UNICEF. Also accessible at: https://data.unicef.org/resources/dataset/gender-and-hiv-data/	
3.22b.4 HIV prevalence in injecting drug users under 25 years of age (%)	UNAIDS	Data provided by UNICEF. Also accessible at: https://data.unicef.org/resources/dataset/gender-and-hiv-data/	
3.23 Proportion of 15-19-year-olds with comprehensive knowledge of HIV (%), by sex	UNICEF	https://data.unicef.org/topic/hiv/aids/adolescents-young-people/	
3.24 Existence of a national HPV vaccination program	WHO	http://apps.who.int/gho/data/view.main.24766	
4.01a Adjusted net attendance ratio: primary school (number of children attending primary or secondary school who are of official primary school age, divided by number of children of primary school age) (%), by sex	UNICEF	https://data.unicef.org/resources/state-worlds-children-2017-statistical-tables/	
4.01b Adjusted net attendance ratio: lower secondary school (number of children attending lower secondary or tertiary school who are of official lower secondary school age, divided by number of children of lower secondary school age) (%), by sex	UNICEF	https://data.unicef.org/resources/state-worlds-children-2017-statistical-tables/	
4.01c Adjusted net attendance ratio: upper secondary school (number of children attending upper secondary or tertiary school who are of official upper secondary school age, divided by number of children of upper secondary school age) (%), by sex	UNICEF	Data provided by UNICEF. Also accessible at: https://data.unicef.org/resources/dataset/net-attendance-rates/	
4.02a Completion rate for primary school (household survey data) (%), by sex	UNESCO	http://data.uis.unesco.org/	
4.02b Completion rate for lower secondary school (household survey data) (%), by sex	UNESCO	http://data.uis.unesco.org/	
4.02c Completion rate for upper secondary school (household survey data) (%), by sex	UNESCO	http://data.uis.unesco.org/	

INDICATOR	Data source	Access details	Notes
4.03a Proportion not in school: primary school (number of children of primary school age who are not enrolled in primary or secondary school, as a proportion of primary school aged children) (%), by sex	UNICEF	https://data.unicef.org/topic/education/primary-education/	
4.03b Proportion not in school: lower secondary school (number of children of lower secondary school age who are not enrolled in secondary school, as a proportion of lower secondary school aged children) (%), by sex	UNICEF	https://data.unicef.org/topic/education/secondary-education/	
4.03c Proportion not in school: upper secondary (using household survey data) (%), by sex	UNESCO	http://data.uis.unesco.org/	
4.04 Pre-primary education: Number of children enrolled in pre-primary school (regardless of age) as a proportion of all children of pre-primary school age (%), by sex	UNICEF	https://data.unicef.org/resources/state-worlds-children-2017-statistical-tables/	
4.05 Proportion of 15-24-year-olds who are literate (%), by sex	UNICEF	https://data.unicef.org/resources/state-worlds-children-2017-statistical-tables/	
4.06a Proportion of primary schools that provide life skills-based HIV and sexuality education (%)	UNESCO	http://data.uis.unesco.org/	
4.06b Proportion of lower secondary schools that provide life skills-based HIV and sexuality education (%)	UNESCO	http://data.uis.unesco.org/	
4.06c Proportion of upper secondary schools that provide life skills-based HIV and sexuality education (%)	UNESCO	http://data.uis.unesco.org/	
4.07a Proportion of primary school teachers who are female (%)	UNESCO	http://data.uis.unesco.org/	
4.07b Proportion of lower secondary school teachers who are female (%)	UNESCO	http://data.uis.unesco.org/	
4.07c Proportion of upper secondary school teachers who are female (%)	UNESCO	http://data.uis.unesco.org/	
4.08 Proportion of schools with basic sanitation facilities (improved, single-sex and usable) (%)	JMP	Data provided by WHO/UNICEF Joint Monitoring Programme	
4.09 Proportion of adolescents, aged 15-19 years, who own a mobile phone (%), by sex	DHS	https://dhsprogram.com/publications/publication-search.cfm?type=5	Two data sources utilised to increase coverage. DHS data extracted from individual country reports.
	ITU	https://www.itu.int/en/ITU-D/Statistics/Pages/facts/default.aspx	

INDICATOR	Data source	Access details	Notes
4.10 Proportion of adolescents, aged 15-19 years, who used the internet in the last 12 months (%), by sex	MICS	http://mics.unicef.org/surveys	Two data sources utilised to increase coverage. MICS and DHS data extracted from individual country reports.
	DHS	https://dhsprogram.com/publications/publication-search.cfm?type=5	
4.11 Proportion of adolescents, aged 15-19 years, with access to information media (newspaper, TV or radio) at least once a week (%), by sex	DHS	https://dhsprogram.com/publications/publication-search.cfm?type=5	DHS data extracted from individual country reports.
4.12 Proportion of youth, aged 15-24 years, not in education, employment or training (%), by sex	ILO	https://www.ilo.org/ilostat/faces/oracle/webcenter/portalapp/pagehierarchy/Page27.jspx?subject=LUU&indicator=EIP_NEET_SEX_RT&datasetCode=A&collectionCode=YI&_afLoop=3079906359473359&_afrWindowMode=0&_afrWindowId=43e243krm_1#!%40%40%3Findicator%3DEIP_NEET_SEX_RT%26_afWindowId%3D43e243krm_1%26subject%3DLUU%26_afLoop%3D3079906359473359%26datasetCode%3DA%26collectionCode%3DYI%26_afWindowMode%3D0%26_adf.ctrl-state%3D43e243krm_57	
4.13 Proportion of youth, aged 15-24 years, currently unemployed as a percent of the total number of employed and unemployed persons (the labour force) (%), by sex	ILO	https://www.ilo.org/ilostat/faces/oracle/webcenter/portalapp/pagehierarchy/Page27.jspx?indicator=UNE_DEAP_SEX_AGE_RT&subject=LUU&datasetCode=A&collectionCode=YI&_adf.ctrl-state=pxhkidyiq_182&afLoop=3080097991561145&_afrWindowMode=0&_afrWindowId=null#!%40%40%3Findicator%3DUNE_DEAP_SEX_AGE_RT%26_afWindowId%3Dnull%26subject%3DLUU%26_afLoop%3D3080097991561145%26datasetCode%3DA%26collectionCode%3DYI%26_afWindowMode%3D0%26_adf.ctrl-state%3D43e243krm_128	Two data sources utilised to increase coverage for the Pacific
	NMDI	https://www.spc.int/nmdi/mdg3	
4.14 Proportion of employed persons, aged 15-24 years, in the informal sector (%)		No data available	
5.01 Sex-ratio at birth (number of male births per one female birth)	UNDP	https://population.un.org/wpp/Download/Standard/Fertility/	
5.02 Infant mortality rate (Probability of dying between birth and exactly 1-year-of-age, expressed per 1000 live births), by sex	UNIGME	Data provided by The United Nations Inter-agency Group for Child Mortality Estimation	
5.03 Expected to estimated female infant mortality rate ratio (ratio less than 1 suggests excess female infant mortality)	UNIGME	Data provided by The United Nations Inter-agency Group for Child Mortality Estimation	
5.04 Proportion of children under five years whose birth has been registered with a civil authority (%), by sex	UNICEF	https://data.unicef.org/topic/child-protection/birth-registration/	
5.05 Proportion of children aged 0-17 years who live with neither biological parent (%), by sex	UNICEF	http://mics.unicef.org/surveys	Two data sources utilised to increase coverage. MICS and DHS data extracted from individual country reports.
		https://www.statcompiler.com/en/	

INDICATOR	Data source	Access details	Notes
5.06a Child marriage: proportion of 20-24-year-olds who were married before 15yrs (%), by sex	DHS UNICEF	https://www.statcompiler.com/en/ https://data.unicef.org/topic/child-protection/child-marriage/	<i>Two data sources utilised to increase coverage for both genders.</i>
5.06b Child marriage: proportion of 20-24-year-olds who were married by 18years (%), by sex	DHS UNICEF	https://www.statcompiler.com/en/ https://data.unicef.org/topic/child-protection/child-marriage/	<i>Two data sources utilised to increase coverage for both genders.</i>
5.07 Legal age of consent to intercourse (heterosexual), by sex	WLII	http://www.worldlii.org/	
5.08 Legal age of consent to marriage, by sex	UNSD	http://data.un.org/DocumentData.aspx?id=336	
5.09 Legal age of consent to same-sex intercourse, by sex	WLII	http://www.worldlii.org/	
5.10 Proportion of youth, aged 15-24 years, who have their own bank account (%), by sex	DHS	https://dhsprogram.com/publications/publication-search.cfm?type=5	<i>DHS data extracted from individual country reports.</i>
5.11a Proportion of ever partnered females aged 15-19 years who have experienced intimate partner violence in the last 12 months – physical (%)	DHS	https://www.statcompiler.com/en/	
5.11b Proportion of ever partnered females, aged 15-19 years, who have experienced intimate partner violence in the last 12 months – sexual (%)	DHS	https://www.statcompiler.com/en/	
5.11c Proportion of ever partnered females, aged 15-19 years, who have experienced intimate partner violence in the last 12 months – physical and/or sexual (%)	DHS	https://www.statcompiler.com/en/	
5.12 Proportion of females, aged 20-24 years, who experienced forced sex by 18 years of age (%)	DHS	https://www.statcompiler.com/en/	
5.13 Proportion of adolescents, aged 15-19 years, who think that a husband/partner is justified in hitting or beating his wife or partner under certain circumstances, by sex	UNICEF	Data provided by UNICEF	
5.14 Proportion of children, aged 1-14 years, who experience violent discipline (psychological aggression and/or physical punishment) from a caregiver (%), by sex	UNICEF	https://data.unicef.org/topic/child-protection/violence/violent-discipline/	
5.15 Mortality rate due to intentional homicide among 10-19-year-olds (deaths per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
5.16 Proportion of 13-17-year-olds who report experiencing bullying in the past 30 days (%), by sex	GSHS	http://www.who.int/ncds/surveillance/gshs/datasets/en/	<i>Data extracted from individual country reports.</i>

INDICATOR	Data source	Access details	Notes
5.17 Proportion of adolescents, aged 15-19 years, who report having personally felt discriminated against or harassed in the previous 12 months due to (a) gender or (b) sexual orientation		No data available	
5.18 Prevalence of female genital mutilation/cutting among girls aged 0-14 years (%)	UNICEF	https://data.unicef.org/topic/child-protection/female-genital-mutilation/	
5.19 Number of detected trafficked children under 18 years of age, by sex	UNODC	https://www.unodc.org/documents/data-and-analysis/glotip/UNODC_GLOTIP_2016_-_Detected_victims_and_their_profiles_-_2014_or_more_recent.xlsx	
5.20 Proportion of children, aged 5-17 years, engaged in child labour (%), by sex	UNICEF	https://data.unicef.org/resources/state-worlds-children-2017-statistical-tables/	
5.21 Proportion of children, aged 5-17 years, engaged in child labour who are in hazardous work (%), by sex	ILO	https://www.ilo.org/global/topics/child-labour/lang-en/index.htm	
5.22 Average number of hours, children aged 5-14 years, spend performing household chores per week, by sex	UNICEF	Data provided by UNICEF	
6.01a DALYs due to household air pollution in under 5-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
6.01b DALYs due to household air pollution in 5-9-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
6.01c DALYs due to household air pollution in 10-14-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
6.01d DALYs due to household air pollution in 15-19-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
6.02 Proportion of schools with improved sanitation facilities that are single-sex and usable (available, functional and private) (%)	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
6.03a DALYs due to unsafe water, sanitation and hygiene in under 5-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
6.03b DALYs due to unsafe water, sanitation and hygiene in 5-9-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
6.03c DALYs due to unsafe water, sanitation and hygiene in 10-14-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
6.03d DALYs due to unsafe water, sanitation and hygiene in 15-19-year-olds (DALYs per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	

INDICATOR	Data source	Access details	Notes
6.04 Proportion of households where a person under 15 years of age is usually responsible for water collection (%), by sex	MICS and DHS	https://unstats.un.org/unsd/gender/chapter7/chapter7.html https://www.statcompiler.com/en/	
6.05a Number of international migrants aged under 20 years of age (1000s), by sex	UN	http://www.un.org/en/development/desa/population/migration/data/estimates2/estimates17.shtml	
6.05b Proportion of population who are international migrants aged under 20 years of age (%), by sex	UN	http://www.un.org/en/development/desa/population/migration/data/estimates2/estimates17.shtml	
6.06 Proportion of married/partnered females, aged 15-19 years, who make decisions about visiting family/friends themselves or jointly with husband (%)	DHS	https://www.statcompiler.com/en/ Combined two estimates (decision themselves and decision jointly with husband)	
6.07 Proportion of 15-19-year-olds who feel safe walking around their neighbourhood after dark (%), by sex		No data available.	
6.08 Mortality due to road traffic accidents among 10-19-year-olds (deaths due to road traffic injuries per 100,000), by sex	GBD	http://ghdx.healthdata.org/record/global-burden-disease-study-2016-gbd-2016-covariates-1980-2016	
6.09 Number of refugees, asylum seekers, internally displaced, stateless or other persons of concern aged under 18 years of age (thousands), by sex	UNHCR	http://popstats.unhcr.org/en/demographics	

Appendix 3

		Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
1.01a Population <18y (1000s)		UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)
	female	8514	27971	129.0	212685	56.0	5524	37527	3003
	male	8974	29220	132.0	237015	59.0	5805	40461	3047
	both	17488	57191	261.0	449700	115.0	11328	77988	6051
1.01b Proportion of population <18y (%)		UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)
	female	52.1	35.0	35.0	33.7	30.8	37.4	40.7	28.0
	male	51.6	35.9	31.6	34.9	24.9	41.8	41.6	30.5
	both	51.8	35.5	33.2	34.4	27.5	39.5	41.2	29.2
1.01c Ratio of girls to boys aged <18y		UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)
	both	0.95	0.96	0.98	0.90	0.95	0.95	0.93	0.99
1.01d Population difference of <18y (girls - boys, 1000s)		UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)
	both	-460	-1249	-3.0	-24330	-3.0	-281	-2934	-44.0
1.02 Proportion living in poverty, total population (%)			UNICEF (2014)	UNICEF (2014)	UNICEF (2014)		UNICEF (2014)	UNICEF (2014)	UNICEF (2014)
	both		19.0	2.0	21.0		15.0	6.0	2.0
1.03 Human Development Index		UNDP (2017)	UNDP (2017)	UNDP (2017)	UNDP (2017)	UNDP (2017)	UNDP (2017)	UNDP (2017)	UNDP (2017)
	both	0.498	0.608	0.612	0.640	0.717	0.574	0.562	0.770
1.04 Prevalence of severe food insecurity, total population (%)		FAO (2016)							
	both	16.1							
1.05 Proportion urban, total population (%)		UNDP (2016)	UNDP (2016)	UNDP (2016)	UNDP (2016)	UNDP (2016)	UNDP (2016)	UNDP (2016)	UNDP (2016)
	both	27.0	35.0	39.0	33.0	47.0	19.0	39.0	18.0
1.06 Migration rate, total population (per 1000 annually)		UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)	UNPD (2015)
	both	2.9	-3.2	2.6	-0.4	11.2	-2.7	-1.3	-4.7
1.07 Health expenditure (% GDP)		WHO (2011)	WHO (2014)	WHO (2015)	WHO (2015)	WHO (2015)	WHO (2015)	WHO (2015)	WHO (2015)
	both	1.0	1.0	3.0	1.0	9.0	1.0	1.0	2.0
1.08 Education expenditure (% GDP)		UNESCO (2015)	UNESCO (2016)	UNESCO (2015)	UNESCO (2013)	UNESCO (2016)	UNESCO (2015)	UNESCO (2017)	UNESCO (2016)
	both	3.2	2.5	7.4	3.8	4.3	3.7	2.8	3.5

	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
2.01 Unpaid work, 15-49y (hours per day)								
2.02 Total work, 15-49y (hours per day)								
2.03 Adult collects water for household, >15y (%)	UNSD (2011)		UNSD (2010)			UNSD (2010)		
female	23.0		5.0			53.0		
male	20.0		1.0			2.0		
2.04 Average monthly earnings, 15-49y ()		ILO (2016)					ILO (2016)	ILO (2010)
female		154.0					93.0	107.0
male		167.0					151.0	131.0
both		165.0					142.0	123.0
2.05 Married women in paid work who can decide spending, 15-49y (%)	DHS (2015)	DHS (2014)		DHS (2015)		DHS (2016)	DHS (2012)	
female	74.2	85.6		82.0		86.3	86.7	
2.06 Own bank account, >15y (%)	WB (2014)	WB (2014)	WB (2014)	WB (2014)		WB (2014)	WB (2014)	WB (2014)
female	3.8	26.5	27.7	43.1		31.3	4.8	83.1
male	15.8	35.4	39.0	62.8		36.7	21.0	82.2
2.07 Can decide healthcare, married women 15-49y (%)	DHS (2015)	DHS (2014)		DHS (2015)		DHS (2016)	DHS (2012)	
female	47.6	64.8		74.5		57.8	51.9	
2.08 Can decide household purchases, married women 15-49y (%)	DHS (2015)	DHS (2014)		DHS (2015)		DHS (2016)	DHS (2012)	
female	42.1	61.3		73.3		53.0	47.0	
2.09a Proportion lower house seats held by women (%)	IPU (2018)	IPU (2018)	IPU (2018)	IPU (2018)	IPU (2018)	IPU (2018)	IPU (2018)	IPU (2018)
female	27.7	20.3	8.5	11.8	5.9	32.7	20.6	5.8
2.09b Proportion upper house seats held by women (%)	IPU (2018)	IPU (2018)	IPU (2018)	IPU (2018)		IPU (2018)	IPU (2018)	
female	26.5		8.0	11.9		37.3	19.2	
2.10 Proportion of police who are female (%)			UNODC (2013)	UNODC (2013)	UNODC (2013)			
female			7.7	6.6	8.5			
2.11 Women experiencing IPV last 12m (%)	UNFPA (2017)	UNFPA (2017)		UNFPA (2017)	UNFPA (2017)	UNFPA (2017)	DHS (2013)	
female	46.1	26.9		21.8	6.4	11.2	18.0	
2.12 Proportion who think husband is justified to beat wife, 15-49y (%)	DHS (2015)	DHS (2014)	MICS (2010)	DHS (2016)		DHS (2016)	DHS (2013)	
female	80.2	28.3		44.6		28.5	42.2	
male	72.4			31.7		22.9	31.9	
both			68.4					
2.13 Abortion legality index (0-100)	GBD (2016)	GBD (2016)	GBD (2016)	GBD (2016)	GBD (2016)	GBD (2016)	GBD (2016)	GBD (2016)
both	40.0	30.0	60.0	80.0	45.0	100.0	53.6	40.0
2.14 Contraception demand satisfied, married women 15-49y (%)	UNSD (2016)	UNSD (2014)	UNSD (2010)	UNSD (2016)		UNSD (2011)	UNSD (2013)	
female	42.1	72.5	84.6	72.0		56.0	47.0	
2.15 Married women who can say no to sex with husband, 15-49y (%)						DHS (2016)		
female						90.0		
2.16a Mean years education, >25y			UNESCO (2012)	UNESCO (2011)		UNESCO (2011)	UNESCO (2014)	
female			1.6	4.1		2.2	3.8	
male			3.2	6.7		4.6	6.5	
2.16b Mean years education, age-standardised (modelled)	GBD (2016)	GBD (2016)	GBD (2016)	GBD (2016)	GBD (2016)	GBD (2016)	GBD (2016)	GBD (2016)
female	1.8	4.5	5.4	5.4	6.7	3.4	4.2	9.6
male	2.3	5.4	6.1	7.3	7.0	5.9	6.3	9.0
2.17a One antenatal visit, 15-49y (%)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)
female	59.0	64.0	98.0	74.0	99.0	84.0	73.0	99.0
2.17b Four antenatal visits, 15-49y (%)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)	UNICEF (2016)
female	18.0	31.0	85.0	51.0	85.0	69.0	37.0	93.0
2.18 Married women make decisions visiting family or friends, 15-49y (%)	DHS (2015)	DHS (2014)		DHS (2016)		DHS (2016)	DHS (2013)	
female	53.7	62.7		74.6		55.6	49.9	
2.19 Marital rape criminalised (yes=1, no=0)			WB (2017)			WB (2017)		
both			1.0			1.0		
2.20 Social Institutions Gender Index (lower score is better)	OECD (2014)	OECD (2014)	OECD (2014)	OECD (2014)		OECD (2014)	OECD (2014)	OECD (2014)
both	0.322	0.390	0.114	0.265		0.322	0.301	0.189
2.20b Social Institutions Gender Index, categories								
both	high	very high	low	high		high	high	medium
2.21 Gender Development Index (higher score better)	UNDP (2015)	UNDP (2015)	UNDP (2015)	UNDP (2015)	UNDP (2015)	UNDP (2015)	UNDP (2015)	UNDP (2015)
both	0.609	0.927	0.900	0.819	0.937	0.925	0.742	0.934
2.22 Gender Inequality Index (lower score better)	UNDP (2017)	UNDP (2017)	UNDP (2017)	UNDP (2017)	UNDP (2017)	UNDP (2017)	UNDP (2017)	UNDP (2017)
both	0.653	0.542	0.476	0.524	0.343	0.480	0.541	0.354
2.23 Global Gender Gap Index (higher score better)		WEF (2017)	WEF (2017)	WEF (2017)	WEF (2017)	WEF (2017)	WEF (2017)	WEF (2017)
both		0.719	0.638	0.669	0.669	0.664	0.546	0.669

		Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
3.01 Deaths in <5y per 1000 births	female	UNIGME (2016) 66.4	UNIGME (2016) 31.6	UNIGME (2016) 29.0	UNIGME (2016) 44.2	UNIGME (2016) 7.7	UNIGME (2016) 32.3	UNIGME (2016) 75.0	UNIGME (2016) 8.5
	male	74.3	36.7	35.5	41.9	9.3	36.7	82.2	10.2
3.02 Expected : estimated mortality for females <5y	female	UNIGME (2016) 0.97	UNIGME (2016) 0.94	UNIGME (2016) 0.99	UNIGME (2016) 0.78	UNIGME (2016) 1.00	UNIGME (2016) 0.92	UNIGME (2016) 0.94	UNIGME (2016) 0.99
3.03 Vaccine coverage (all) in 2y (%)	female	DHS (2015) 46.4	DHS (2014) 84.1		DHS (2015) 61.9		DHS (2016) 78.4	DHS (2012) 51.5	
	male	45.0	83.6		62.1		77.4	56.0	
3.04 Vaccine coverage (BCG) in 2y (%)	female	DHS (2015) 73.4	DHS (2014) 97.5		DHS (2015) 91.7		DHS (2016) 96.5	DHS (2012) 84.0	
	male	74.0	98.3		92.1		98.3	86.3	
3.05 Vaccine coverage (Measles) in 2y (%)	female	DHS (2015) 61.3	DHS (2014) 86.4		DHS (2015) 80.5		DHS (2016) 89.4	DHS (2012) 59.7	
	male	59.5	85.9		81.7		91.2	63.0	
3.06 Care seeking for fever in <5y (%)	female	UNICEF (2014) 54.0					UNICEF (2016) 79.0	UNICEF (2013) 62.0	
	male		57.0				81.0	67.0	
3.07 Inadequate supervision of child, 0-59m (%)	female	UNICEF (2011) 39.0	UNICEF (2013) 12.0	UNICEF (2010) 15.0			UNICEF (2014) 21.0		
	male	42.0	11.0	13.0			20.0		
3.08 Stunting in < 5y (%)	female		UNICEF (2011) 42.0	UNICEF (2010) 33.6			UNICEF (2012) 35.7	UNICEF (2013) 41.8	
	male		40.6	33.4			36.1	48.2	
3.09a Anaemia 0-19y (%)	female	GBD (2016) 26.3	GBD (2016) 35.0	GBD (2016) 64.8	GBD (2016) 59.4	GBD (2016) 42.6	GBD (2016) 35.0	GBD (2016) 46.4	GBD (2016) 19.7
	male	22.8	32.0	60.2	54.4	44.7	37.6	47.8	13.2
3.09b Anaemia 0-4y (%)	female	GBD (2016) 36.4	GBD (2016) 43.9	GBD (2016) 73.7	GBD (2016) 66.7	GBD (2016) 54.5	GBD (2016) 46.8	GBD (2016) 57.6	GBD (2016) 33.9
	male	35.3	50.6	74.6	69.8	61.5	55.1	65.6	27.3
3.09c Anaemia 5-9y (%)	female	GBD (2016) 25.6	GBD (2016) 37.1	GBD (2016) 70.2	GBD (2016) 66.3	GBD (2016) 42.9	GBD (2016) 37.4	GBD (2016) 51.1	GBD (2016) 17.0
	male	24.8	45.3	76.4	70.3	51.7	50.8	56.5	13.0
3.09d Anaemia 10-14y (%)	female	GBD (2016) 18.4	GBD (2016) 26.2	GBD (2016) 54.7	GBD (2016) 50.6	GBD (2016) 31.6	GBD (2016) 23.6	GBD (2016) 34.9	GBD (2016) 11.4
	male	12.8	16.0	44.5	38.8	25.6	20.9	30.2	4.9
3.09e Anaemia 15-19y (%)	female	GBD (2016) 23.4	GBD (2016) 34.2	GBD (2016) 59.9	GBD (2016) 54.9	GBD (2016) 41.0	GBD (2016) 30.2	GBD (2016) 39.4	GBD (2016) 18.1
	male	16.2	18.8	43.9	40.3	38.2	20.8	34.2	8.7
3.10 Thinness in 5-19y (%)	female	WHO (2016) 11.1	WHO (2016) 13.5	WHO (2016) 11.4	WHO (2016) 22.6	WHO (2016) 13.1	WHO (2016) 10.3	WHO (2016) 15.3	WHO (2016) 13.5
	male	23.1	22.3	19.7	30.7	14.0	21.1	23.1	16.6
	both	17.2	18.0	15.6	26.9	13.6	15.8	19.3	15.1
3.11 Overweight 5-19y (%)	female	WHO (2016) 9.9	WHO (2016) 8.7	WHO (2016) 9.4	WHO (2016) 6.1	WHO (2016) 14.2	WHO (2016) 7.7	WHO (2016) 9.1	WHO (2016) 11.8
	male	9.0	9.3	10.7	7.4	19.4	7.2	10.1	14.0
	both	9.4	9.0	10.1	6.8	16.9	7.5	9.7	12.9
3.12a Total DALYs per 100,000 in 10-19y olds	female	GBD (2016) 19955	GBD (2016) 11054	GBD (2016) 11743	GBD (2016) 14528	GBD (2016) 8388	GBD (2016) 11503	GBD (2016) 13941	GBD (2016) 9215
	male	23445	12217	12176	12889	8459	12401	14033	9721
3.12b Group 1 DALYs per 100,000 in 10-19y	female	GBD (2016) 5042	GBD (2016) 2809	GBD (2016) 4068	GBD (2016) 5471	GBD (2016) 1519	GBD (2016) 3353	GBD (2016) 4499	GBD (2016) 1471
	male	3102	2390	3284	4045	1262	2996	3424	1259
3.12c Injury DALYs per 100,000 in 10-19y	female	GBD (2016) 5093	GBD (2016) 1479	GBD (2016) 1057	GBD (2016) 2405	GBD (2016) 594.5	GBD (2016) 1603	GBD (2016) 1744	GBD (2016) 1495
	male	12566	3127	2305	2899	1154	2924	3161	2425
3.12d NCD DALYs per 100,000 in 10-19y	female	GBD (2016) 9820	GBD (2016) 6766	GBD (2016) 6618	GBD (2016) 6651	GBD (2016) 6275	GBD (2016) 6547	GBD (2016) 7698	GBD (2016) 6249
	male	7776	6700	6587	5944	6043	6481	7449	6037
3.13 Binge drinking, 15-19y (%)	female	GBD (2016) 4.5	GBD (2016) 0.1	GBD (2016) 0.3	GBD (2016) 0.9	GBD (2016) 7.3	GBD (2016) 0.3	GBD (2016) 0.2	GBD (2016) 3.6
	male	3.7	0.3	2.2	3.1	19.0	1.6	0.2	12.4
	both	4.2	0.2	1.1	1.9	13.5	1.0	0.2	9.0
3.14 Daily tobacco smoking, 10-19y (%)	female	GBD (2016) 1.0	GBD (2016) 0.2	GBD (2016) 0.5	GBD (2016) 1.5	GBD (2016) 2.2	GBD (2016) 1.5	GBD (2016) 0.4	GBD (2016) 0.4
	male	4.4	7.5	1.1	3.4	10.4	3.4	3.4	2.9
	both	2.8	3.9	0.8	2.5	6.4	2.4	1.9	1.6
3.15 Suicide mortality per 100,000 in 10-19y	female	GBD (2016) 1.0	GBD (2016) 7.2	GBD (2016) 1.8	GBD (2016) 14.5	GBD (2016) 0.9	GBD (2016) 8.5	GBD (2016) 4.9	GBD (2016) 8.8
	male	4.7	3.7	3.2	7.2	1.5	6.4	2.1	9.7
3.16 Mental disorder DALYs per 100,000 in 10-19y	female	GBD (2016) 1979	GBD (2016) 1582	GBD (2016) 1485	GBD (2016) 1401	GBD (2016) 1540	GBD (2016) 1490	GBD (2016) 1490	GBD (2016) 1515
	male	2176	1661	1661	1607	1707	1690	1653	1700
3.17 Significant worry last 12m in 13-17y (%)	female	WHO (2014) 29.3	WHO (2014) 4.9	WHO (2014) 9.1		WHO (2014) 18.0	WHO (2014) 4.1	WHO (2014) 8.8	WHO (2014) 5.1
	male	19.3	4.4	7.1		12.2	4.7	8.1	4.4
3.18a Demand for modern contraception satisfied 15-24y (%)	female	GBD (2016) 26.8	GBD (2016) 73.7	GBD (2016) 55.5	GBD (2016) 53.1	GBD (2016) 71.7	GBD (2016) 37.7	GBD (2016) 34.1	GBD (2016) 75.0
3.18b Demand family planning satisfied 15-19y (%)	female	DHS (2011) 66.1			DHS (2015) 28.1		DHS (2016) 25.1	DHS (2012) 27.3	
3.19 Married 15-19y females can refuse sex (%)	female						DHS (2016) 87.7		
3.20a AFR 15-19y per 1000 (measured)	female	UNICEF (2014) 90.0	UNICEF (2014) 83.0	UNICEF (2014) 28.4	UNICEF (2014) 38.5	UNICEF (2014) 13.9	UNICEF (2014) 87.0	UNICEF (2014) 48.0	UNICEF (2014) 24.1
3.20b AFR 15-19y per 1000 (modelled)	female	GBD (2016) 70.7	GBD (2016) 73.8	GBD (2016) 19.3	GBD (2016) 17.3	GBD (2016) 3.8	GBD (2016) 99.6	GBD (2016) 32.4	GBD (2016) 10.9
3.21 Maternal mortality rate per 100,000 in 15-19y	female	GBD (2016) 22.0	GBD (2016) 5.5	GBD (2016) 6.9	GBD (2016) 7.6	GBD (2016) 1.2	GBD (2016) 10.2	GBD (2016) 16.0	GBD (2016) 1.3
3.22a New cases HIV in 15-19y	female	UNICEF (2016) <100	UNICEF (2016) <100		UNICEF (2016) 7700		UNICEF (2016) <100	UNICEF (2016) <1000	UNICEF (2016) <100
	male	<100	<100		8700		<100	<500	<100
	both	<100	<100		16000		<100	<1000	<100

		Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
3.22b.1 HIV in sex workers <25y (%)	both	UNAIDS (2018) 0.5	UNAIDS (2018) 0.5		UNAIDS (2016) 1.2			UNAIDS (2018) 3.8	UNAIDS (2018) 0.5
3.22b.2 HIV in MSM <25y (%)	male	UNAIDS (2016) 0.5	UNAIDS (2016) 0.5		UNAIDS (2016) 3.4		UNAIDS (2016) 1.0	UNAIDS (2016) 3.6	UNAIDS (2016) 0.5
3.22b.3 HIV in transgender people <25y (%)	both		UNAIDS (2016) 1.1					UNAIDS (2016) 6.2	
3.22b.4 HIV in injecting drug users <25y (%)	both	UNAIDS (2016) 2.7	UNAIDS (2016) 0.5		UNAIDS (2016) 7.6			UNAIDS (2016) 17.5	
3.23 Comprehensive knowledge of HIV in 15-19y (%)	female	UNAIDS (2016) 0.5	UNAIDS (2016) 12.0	UNICEF (2016) 22.0	UNICEF (2010) 19.0	UNICEF (2016) 22.0	UNICEF (2016) 18.0	UNICEF (2016) 0.5	
	male	4.0			35.0		24.0	5.0	
3.24 Existence of HPV program	both		WHO (2015) 1.0	WHO (2015) 1.0					

4.01a Adjusted net attendance ratio, primary school (%)	female	UNICEF (2015) 53.0	UNICEF (2014) 93.0	UNICEF (2012) 95.0			UNICEF (2014) 76.0	UNICEF (2013) 60.0	
	male	73.0	90.0	96.0			76.0	67.0	
	both	64.0	91.0	95.0			76.0	64.0	
4.01b Adjusted net attendance ratio, lower secondary school (%)	female	UNICEF (2015) 28.0	UNICEF (2014) 60.0	UNICEF (2010) 54.0			UNICEF (2014) 46.0	UNICEF (2013) 34.0	
	male	48.0	51.0	52.0			42.0	36.0	
	both	38.0	55.0	53.0			44.0	35.0	
4.01c Adjusted net attendance ratio, upper secondary school (%)	female	UNICEF (2015) 19.0	UNICEF (2014) 37.0	UNICEF (2010) 26.0			UNICEF (2014) 40.0	UNICEF (2013) 27.0	
	male	37.0	42.0	22.0			41.0	31.0	
	both	28.0	39.0	24.0			41.0	29.0	
4.02a Completion rate, primary school (%)	female	UNESCO (2015) 40.4	UNESCO (2014) 84.4	UNESCO (2010) 70.0	UNESCO (2016) 91.5		UNESCO (2016) 82.4	UNESCO (2012) 58.4	
	male	67.3	75.1	65.9	91.7		84.0	63.1	
4.02b Completion rate, lower secondary school (%)	female	UNESCO (2015) 25.2	UNESCO (2014) 55.5	UNESCO (2010) 37.6	UNESCO (2016) 79.2		UNESCO (2016) 68.0	UNESCO (2012) 41.3	
	male	48.7	54.1	40.1	82.4		71.8	50.0	
4.02c Completion rate, upper secondary school (%)	female	UNESCO (2015) 15.0	UNESCO (2014) 17.5	UNESCO (2010) 17.9	UNESCO (2016) 39.6		UNESCO (2014) 21.1	UNESCO (2012) 18.0	
	male	33.5	21.2	24.6	46.5		29.0	21.3	
4.03a Not in school, primary school (%)	female	UNICEF (2015) 47.0	UNICEF (2014) 7.0	UNICEF (2010) 5.0		UNICEF (2016) 5.0	UNICEF (2014) 23.0	UNICEF (2013) 40.0	
	male	27.0	10.0	5.0		7.0	23.0	33.0	
4.03b Not in school, lower secondary school (%)	female	UNICEF (2015) 56.0	UNICEF (2014) 12.0	UNICEF (2010) 18.0		UNICEF (2016) 3.0	UNICEF (2014) 6.0	UNICEF (2013) 34.0	
	male	25.0	21.0	20.0		6.0	4.0	24.0	
4.03c Not in school, upper secondary school (%)	female	UNESCO (2015) 72.2	UNESCO (2014) 51.1		UNESCO (2016) 33.2		UNESCO (2016) 26.8	UNESCO (2012) 55.7	
	male	41.3	44.0		26.9		18.1	42.1	
4.04 Pre-primary school enrolment (%)	female		UNICEF (2016) 31.0	UNICEF (2016) 27.0	UNICEF (2016) 12.0	UNICEF (2016) 102.0	UNICEF (2016) 83.0	UNICEF (2016) 67.0	UNICEF (2016) 93.0
	male		31.0	25.0	13.0	101.0	85.0	77.0	93.0
4.05 Youth literacy, 15-24y (%)	female	UNICEF (2016) 32.0	UNICEF (2016) 94.0	UNICEF (2016) 84.0	UNICEF (2016) 82.0	UNICEF (2016) 99.0	UNICEF (2016) 80.0	UNICEF (2016) 66.0	UNICEF (2016) 99.0
	male	62.0	91.0	90.0	90.0	99.0	90.0	80.0	98.0
4.06a Primary schools teaching sex education (%)									
4.06b Lower secondary schools teaching sex education (%)									
4.06c Upper secondary schools teaching sex education (%)									
4.07a Female primary school teachers (%)	female	UNESCO (2017) 34.0	UNESCO (2016) 60.3	UNESCO (2016) 40.7	UNESCO (2016) 50.7	UNESCO (2016) 73.6	UNESCO (2016) 44.0	UNESCO (2016) 51.0	UNESCO (2016) 86.7
4.07b Female lower secondary teachers (%)	female	UNESCO (2015) 33.0	UNESCO (2016) 27.0	UNESCO (2016) 44.4	UNESCO (2016) 45.0	UNESCO (2016) 46.9	UNESCO (2017) 28.9	UNESCO (2016) 68.6	UNESCO (2016) 70.4
4.07c Female upper secondary teachers (%)	female	UNESCO (2015) 33.5	UNESCO (2016) 18.3	UNESCO (2016) 36.6	UNESCO (2016) 41.3		UNESCO (2017) 17.6	UNESCO (2016) 36.9	
4.08 Schools with basic sanitation facilities (%)	both		JMP (2016) 59.0	JMP (2016) 76.0	JMP (2016) 73.0				JMP (2016) 100.0
4.09 Mobile phone ownership, 15-19y (%)	female		DHS (2014) 30.7				DHS (2016) 58.5	ITU (2013) 13.9	
	male		63.0				80.5	23.3	
4.10 Internet used last 12mth, 15-19y (%)	female		MICS (2013) 2.6				30.2		
	male						61.5		
4.11 Weekly access to information media, 15-19y (%)	female	DHS (2015) 1.5	DHS (2014) 0.4		DHS (2016) 6.2		DHS (2016) 3.6	DHS (2013) 0.1	
	male	6.2			14.6		6.5		
4.12 Not in education, employment or training, 15-24y (%)	female		ILO (2015) 47.0		ILO (2010) 53.9	ILO (2014) 25.9		ILO (2015) 53.6	ILO (2014) 37.3
	male		10.0		3.5	15.3		7.4	17.5
4.13 Proportion of labour force unemployed, 15-24y (%)	female	ILO (2012) 4.5	ILO (2017) 16.8	ILO (2015) 12.7	ILO (2012) 12.0	ILO (2016) 12.1		ILO (2015) 9.4	ILO (2014) 32.7
	male	2.6	10.8	8.2	9.5	19.1		5.7	15.6
4.14 Proportion employed in informal sector, 15-24y (%)									

		Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
5.01 Sex ratio at birth (male : female)	both	UNPD (2015) 1.06	UNPD (2015) 1.05	UNPD (2015) 1.04	UNPD (2015) 1.11	UNPD (2015) 1.08	UNPD (2015) 1.07	UNPD (2015) 1.09	UNPD (2015) 1.04
5.02 Infant mortality rate (per 1000 births)	female	UNIGME (2016) 49.2	UNIGME (2016) 25.8	UNIGME (2016) 23.9	UNIGME (2016) 34.6	UNIGME (2016) 6.5	UNIGME (2016) 26.1	UNIGME (2016) 59.4	UNIGME (2016) 7.2
	male	56.9	30.5	29.5	34.5	8.0	30.7	68.5	8.8
5.03 Expected to estimated female infant mortality ratio	female	UNIGME (2016) 0.96	UNIGME (2016) 0.95	UNIGME (2016) 0.99	UNIGME (2016) 0.81	UNIGME (2016) 1.00	UNIGME (2016) 0.94	UNIGME (2016) 0.97	UNIGME (2016) 1.00
5.04 Birth registration <5y (%)	female	UNICEF (2014) 42.0	UNICEF (2014) 20.0	UNICEF (2010) 100.0	UNICEF (2014) 73.0		UNICEF (2014) 57.0	UNICEF (2013) 33.0	
	male	43.0	20.0	100.0	71.0		59.0	34.0	
5.05 Children not living with biological parent, 0-17y (%)	female	UNICEF (2015) 1.4	UNICEF (2013) 5.0	UNICEF (2010) 8.9	UNICEF (2016) 3.8		UNICEF (2016) 7.9	UNICEF (2013) 2.5	
	male	0.9	2.7	6.0	2.8		5.7	1.7	
5.06a Child marriage before 15y (%)	female	DHS (2015) 8.8	DHS (2014) 22.4	UNICEF (2010) 6.2	DHS (2016) 5.4		DHS (2016) 7.0	DHS (2013) 2.8	
	male	0.8			0.4		1.2	0.2	
5.06b Child marriage <18y (%)	female	DHS (2015) 34.8	DHS (2014) 58.6	UNICEF (2010) 25.8	DHS (2016) 25.3		DHS (2016) 39.5	DHS (2013) 21.0	
	male	7.3	4.4		3.3		10.3	3.1	
5.07 Age of consent for heterosexual intercourse**	female	WLII (2015) AM	WLII (2015) 14	WLII (2015) 18	WLII (2015) 18	WLII (2015) AM	WLII (2015) 16	WLII (2015) m16	WLII (2015) 16 m12
	male	AM	NS	18	18	AM	NS	AM	16
5.08 Legal age of consent to marriage**	female	UNSD (2011) 16 p15	UNSD (2004) 18	UNSD (2009) 18	UNSD (2011) 18	UNSD (2007) 18 p<18	UNSD (2011) 20 p18	UNSD (2013) 16	UNSD (2001) 18 p16
	male	18	21	18	21	18 p<18	20 p18	18	18
5.09 Age of consent for same-sex intercourse**	female	WLII (2015) Illegal	WLII (2015) NS	WLII (2015) NS	WLII (2015) 18	WLII (2015) Illegal	WLII (2015) NS	WLII (2015) Illegal	WLII (2015) Illegal
	male	Illegal	Illegal	Illegal	18	Illegal	NS	Illegal	Illegal
5.10 Bank account ownership, 15-24y (%)	female						DHS (2016) 21.3		
	male						18.7		
5.11a Physical intimate partner violence in last 12m, 15-19y (%)	female	DHS (2015) 28.5			DHS (2015) 16.3		DHS (2016) 14.0	DHS (2012) 21.8	
5.11b Sexual intimate partner violence in last 12m, 15-19y (%)	female	DHS (2015) 4.7			DHS (2016) 5.5		DHS (2016) 5.7		
5.11c Physical and/or sexual intimate partner violence in last 12m, 15-19y (%)	female	DHS (2015) 28.7			DHS (2016) 17.6		DHS (2016) 17.0	DHS (2012) 21.8	
5.12 Females aged 20-24y experiencing forced sex before 18y (%)	female	DHS (2015) 1.3			DHS (2016) 1.1		DHS (2016) 3.1		
5.13 Adolescents 15-19y who think husband is justified to beat wife (%)	female	UNICEF (2015) 78.3	UNICEF (2014) 28.8	UNICEF (2010) 70.1	UNICEF (2016) 40.8		UNICEF (2016) 33.2	UNICEF (2013) 52.7	
	male	70.6			34.5		30.7	33.3	
5.14 Children experiencing violent discipline, 1-14y (%)	female	UNICEF (2016) 74.0	UNICEF (2016) 82.0				UNICEF (2016) 81.0		
	male	75.0	83.0				83.0		
5.15 Homicide mortality, 10-19y (per 100,000)	female	GBD (2016) 1.1	GBD (2016) 0.8	GBD (2016) 0.3	GBD (2016) 1.1	GBD (2016) 0.2	GBD (2016) 0.6	GBD (2016) 1.9	GBD (2016) 1.2
	male	18.3	2.5	1.2	2.1	0.7	2.3	5.5	3.2
5.16 Bullying last month, 13-17y (%)	female	GSHS (2014) 42.8	GSHS (2014) 17.5	GSHS (2016) 26.3		GSHS (2014) 26.1	GSHS (2015) 46.0		
	male	42.5	28.1	26.3		27.2	56.1		
5.17a Discriminated against because of gender, 15-19y									
5.17b Discriminated against because of sexual orientation, 15-19y									
5.18 FGM/C, 0-14y (%)									
5.19 Number of detected trafficked children <18y									
5.20 Child labour, 5-17y (%)	female	UNICEF (2014) 24.0	UNICEF (2013) 4.0	UNICEF (2010) 3.0			UNICEF (2014) 38.0		UNICEF (2016) 1.0
	male	34.0	5.0	3.0			37.0		1.0
5.21 Hazardous work amongst those in child labour (%)	female		ILO (2013) 68.1				ILO (2012) 54.1		ILO (2016) 86.0
	male		81.0				27.3		90.4
5.22 Hours per week spent on chores, 5-14y	female	UNICEF (2011) 5.3		UNICEF (2010) 2.3			UNICEF (2014) 5.7		
	male	4.2		1.7			3.7		

**Legend:

18 p/r16: 18, or 16 with parental or religious consent

18 p16: 18, or 16 with parental consent

16 m12: 16, or 12 if married

m16: 16 after marriage

Ambiguous: 16 if sex between females is considered intercourse

NS: Not specified

AM: After marriage

		Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
6.01a Household air pollution, <5y (DALYs per 100,000)	female	GBD (2016) 12586	GBD (2016) 3929	GBD (2016) 1542	GBD (2016) 4216	GBD (2016) 17.6	GBD (2016) 3677	GBD (2016) 3913	GBD (2016) 154.4
	male	11510	4706	1632	3655	17.8	4651	3561	214.0
6.01b Household air pollution, 5 - 9y (DALYs per 100,000)	female	GBD (2016) 604.8	GBD (2016) 146.7	GBD (2016) 97.5	GBD (2016) 168.8	GBD (2016) 3.8	GBD (2016) 151.5	GBD (2016) 150.3	GBD (2016) 62.6
	male	369.2	129.4	79.4	102.6	2.0	118.0	219.9	42.0
6.01c Household air pollution, 10-14y (DALYs per 100,000)	female	GBD (2016) 365.0	GBD (2016) 64.7	GBD (2016) 45.9	GBD (2016) 90.8	GBD (2016) 2.4	GBD (2016) 93.0	GBD (2016) 65.5	GBD (2016) 43.4
	male	202.0	57.3	36.6	51.5	1.5	72.0	99.0	31.5
6.01d Household air pollution, 15-19y (DALYs per 100,000)	female	GBD (2016) 190.6	GBD (2016) 35.3	GBD (2016) 28.3	GBD (2016) 84.8	GBD (2016) 1.3	GBD (2016) 71.4	GBD (2016) 35.7	GBD (2016) 35.5
	male	157.1	54.7	26.9	49.5	1.1	66.7	73.2	31.3
6.02 Schools with improved sanitation facilities (%)	both		JMP (2016) 59.0	JMP (2016) 76.0	JMP (2016) 73.0				JMP (2016) 100.0
6.03a Water, sanitation and hygiene, <5y (DALYs per 100,000)	female	GBD (2016) 10600	GBD (2016) 3261	GBD (2016) 2271	GBD (2016) 6536	GBD (2016) 246.3	GBD (2016) 3033	GBD (2016) 13062	GBD (2016) 254.2
	male	9831	3119	2109	5196	336.9	2794	10285	291.7
6.03b Water, sanitation and hygiene, 5-9y (DALYs per 100,000)	female	GBD (2016) 415.3	GBD (2016) 340.7	GBD (2016) 254.8	GBD (2016) 702.0	GBD (2016) 76.7	GBD (2016) 379.1	GBD (2016) 448.5	GBD (2016) 97.5
	male	335.3	316.1	269.7	578.8	91.9	355.3	408.5	112.4
6.03c Water, sanitation and hygiene, 10-14y (DALYs per 100,000)	female	GBD (2016) 293.2	GBD (2016) 249.8	GBD (2016) 248.1	GBD (2016) 493.6	GBD (2016) 73.0	GBD (2016) 303.0	GBD (2016) 287.0	GBD (2016) 88.2
	male	235.4	195.7	248.4	362.3	86.9	260.9	251.2	99.6
6.03d Water, sanitation and hygiene, 15-19y (DALYs per 100,000)	female	GBD (2016) 211.7	GBD (2016) 242.2	GBD (2016) 283.8	GBD (2016) 614.0	GBD (2016) 71.9	GBD (2016) 333.7	GBD (2016) 321.4	GBD (2016) 84.5
	male	189.8	209.2	282.2	422.5	88.8	288.4	249.9	101.2
6.04 Child collects water for household, <15y (%)	female	MICS (2011) 6.0					MICS (2010) 2.0		
	male	9.0					1.0		
6.05a International migrants <20y, (count in 1000s)	female	UN (2017) 30.1	UN (2017) 153.5	UN (2017) 2.2	UN (2017) 186.2	UN (2017) 1.1	UN (2017) 28.7	UN (2017) 109.4	UN (2017) 7.9
	male	28.1	162.5	4.8	200.9	2.7	26.8	114.6	8.2
6.05b International migrants <20y, (population %)	female	UN (2017) 0.3	UN (2017) 0.5	UN (2017) 1.6	UN (2017) 0.1	UN (2017) 1.7	UN (2017) 0.5	UN (2017) 0.3	UN (2017) 0.2
	male	0.3	0.5	3.3	0.1	4.1	0.4	0.3	0.2
6.06 Married females make decisions visiting family or friends, 15-19y (%)	female	DHS (2015) 41.8	DHS (2014) 43.6				DHS (2016) 19.3	DHS (2012) 18.2	
6.07 Feel safe walking at night, 15-19y (%)									
6.08 Road traffic mortality, 10-19y, (deaths per 100,000)	female	GBD (2016) 13.5	GBD (2016) 2.1	GBD (2016) 3.1	GBD (2016) 2.7	GBD (2016) 2.0	GBD (2016) 2.8	GBD (2016) 5.7	GBD (2016) 2.1
	male	48.1	14.7	9.9	10.9	3.2	12.6	19.9	5.8
6.09 Refugees, displaced and stateless persons, <18y (thousands)	female	UNHCR (2016) 670.1	UNHCR (2016) 8.8		UNHCR (2016) 6.2		UNHCR (2016) 2.0	UNHCR (2016) 599.2	UNHCR (2016) 0.3
	male	707.5	9.1		6.7		2.1	691.8	0.3

References

1. UNICEF. State of the World's Children UNICEF, 2016.
2. Centre for Reproductive Rights. Child Marriage in South Asia: International and constitutional legal standards and jurisprudence for promoting accountability and change. ; 2013.
3. UNESCAP, ADB, UNDP. Asia-Pacific sustainable development goals outlook. Bangkok: United Nations (ESCAP), Asian Development Bank, United Nations Development Programme, 2017.
4. Office of the High Commissioner UNHCR. Convention on the Rights of the Child: UNHCR, 1990.
5. Convention on the Elimination of All Forms of Discrimination against Women. In: United Nations General Assembly, editor.; 1979.
6. Beijing Declaration and Platform for Action. Fourth World Conference on Women; 1995 4-15 September; Beijing; 1995.
7. Transforming our world: the 2030 Agenda for Sustainable Development. In: United Nations General Assembly, editor.; 2015.
8. UNESCAP. Gender equality and women's empowerment in Asia and the Pacific. Perspectives of governments on 20 years of implementation of the Beijing Declaration and Platform for Action. Bangkok: United Nations (ESCAP), 2015.
9. United Nations Children's Fund. Harnessing the Power of Data for Girls: Taking stock and looking ahead to 2030. New York, 2016.
10. UN Women. Gender Statistics. 2018. <http://data.unwomen.org/en/gender-statistics>.
11. Buvinic M, Furst-Nichols R, Koolwal G. Mapping Gender Data Gaps. Washington, DC, 2014.
12. UN ESCAP Regional core set of gender statistics and indicators for Asia and the Pacific. Bangkok: United Nations Economic and Social Commission for Asia and the Pacific, 2013.
13. Vaitla B, Bosco C, Alegana V, et al. Big data and the well-being of women and girls: applications on the social scientific frontier, 2017.
14. UNICEF. Regional Classifications. 2017. <https://data.unicef.org/regionalclassifications/>.
15. Heise LL. Violence against women: an integrated, ecological framework. *Violence Against Women* 1998; **4**(3): 262-90.
16. United Nations Statistics Division. Discussion paper on Principles of Using Quantification to Operationalize the SDGs and Criteria for Indicator Selection United Nations, 2015.
17. UN DESA. Tier classification for global SDG indicators: United Nations Department of Economic and Social Affairs, 2017.
18. Boudet AMM, Buitrago P, de la Briere BL, et al. Gender differences in poverty and household composition through the life-cycle. 2018.
19. United States Department of State. Global Women's Issue: Women in the World Today, 2012.
20. Asian Development Bank. Gender equality and food security—women's empowerment as a tool against hunger. Mandaluyong City, Philippines, 2013.
21. Tacoli C, Satterthwaite D. Gender and urban change. *Environment and Urbanization* 2013; **25**(1): 3-8.
22. Pozarny P. Gender roles and opportunities for women in urban environments (GSDRC Helpdesk Research Report 1337). Birmingham, UK, 2016.
23. John NA, Stoebeu K, Ritter S, Edmeades J, Balvin N. Gender Socialization during Adolescence in Low- and Middle-Income Countries: Conceptualization, influences and outcomes. UNICEF Office of Research - Innocenti, Florence, 2017.
24. Rathnayaka M, Perera N. Sri Lanka's Missing Mothers; A working paper on effects of mother migration on children; 2013.

25. Dissanayake L, Chandrasekara V, D M Jayasundara D. The Impact of Mothers Migration for Work Abroad on children's Education in Sri Lanka; 2014.
26. Bhurtyal YM. Effects of male international migration on wives left behind in Nepal. UK: The University of Sheffield; 2015.
27. Zaidi S, Saligram P, Ahmed S, Sonderp E, Sheikh K. Expanding access to healthcare in South Asia. *BMJ* 2017; 357.
28. Fikree FF, Pasha O. Role of gender in health disparity: the South Asian context. *BMJ* 2004; **328**(7443): 823-6.
29. Bhaduri S. Burden of Unpaid Work on Women and Gender Relations Emerging Thereof in Rural India; 2018.
30. UNDP. Gender and Economic Policy Management Initiative Asia and the Pacific: Unpaid Work. Bangkok, Thailand, 2012.
31. Neetu JA, Stoebeuau K, Ritter S, Edmeades J, Balvin N. Gender Socialization during Adolescence in Low-and Middle-income Countries: Conceptualization, influences and outcomes, 2017.
32. Yoder JD. Socialization Practices: Learning to be Ourselves in a Gender-Polarized World. *Women and gender : transforming psychology*. Upper Saddle River, New Jersey: Prentice Hall; 1999.
33. Basu S, Zuo X, Lou C, Acharya R, Lundgren R. Learning to be gendered: gender socialization in early adolescence among urban poor in Delhi, India, and Shanghai, China. *Journal of Adolescent Health* 2017; **61**(4): S24-S9.
34. Marcus R, Harper C, Brodbeck S, Page E. Social norms, gender norms and adolescent girls: a brief guide. *From the Knowledge to Action Resources Series* 2015.
35. Blum RW, Mmari K, Moreau C. It begins at 10: How gender expectations shape early adolescence around the world. *Journal of Adolescent Health* 2017; **61**(4): S3-S4.
36. Simkhada P, Van Teijlingen E, Winter R, Fanning C, Dhungel A, Marahatta S. Why are so many Nepali women killing themselves? A review of key issues. *Journal of Manmohan Memorial Institute of Health Sciences* 2015; **1**(4): 43-9.
37. Lin T-c, Adserà A. Son preference and children's housework: the case of India. *Population research and policy review* 2013; **32**(4): 553-84.
38. Qadir F, Khan MM, Medhin G, Prince M. Male gender preference, female gender disadvantage as risk factors for psychological morbidity in Pakistani women of childbearing age-a life course perspective. *BMC public health* 2011; **11**(1): 745.
39. Mishra V, Roy TK, Retherford RD. Sex differentials in childhood feeding, health care, and nutritional status in India. *Population and development review* 2004; **30**(2): 269-95.
40. Pande RP. Selective gender differences in childhood nutrition and immunization in rural India: the role of siblings. *Demography* 2003; **40**(3): 395-418.
41. Raj A, McDougal LP, Silverman JG. Gendered effects of siblings on child malnutrition in South Asia: cross-sectional analysis of demographic and health surveys from Bangladesh, India, and Nepal. *Maternal and child health journal* 2015; **19**(1): 217-26.
42. Khanna T, Verma R, Weiss E. Child marriage in South Asia: Realities responses and the way forward. Bangkok, Thailand: ICRW, 2013.
43. Oxford Department of International Development. Policy Brief 29: Tackling Child Marriage and Early Childbearing in India: Lessons from Young Lives: Oxford Department of International Development. , 2016.
44. The World Bank. Ratio of female to male labor force participation rate (%) (modeled ILO estimate). 2017.
45. International Labour Organization. Women in business and management: Gaining momentum in Asia and the Pacific. Bangkok, Thailand, 2015.
46. UNFPA. kNOwVAWdata: Measuring prevalence of violence against women in Asia-Pacific. 2018. <https://asiapacific.unfpa.org/en/knowvawdata>.
47. Gracia E. Unreported cases of domestic violence against women: towards an epidemiology of social silence, tolerance, and inhibition. *Journal of Epidemiology and Community Health* 2004; **58**(7): 536-7.
48. Winter S. Lost in transition: transgender people,. Rights and HIV vulnerability in the Asia-Pacific region. *Focus* 2012; **69**.
49. Monro S. Transmuting gender binaries: The theoretical challenge. *Sociological research online* 2007; **12**(1): 1-15.
50. Shaikh S. India's "third gender": A marginalised social class. 2013. <http://ajmn.tv/26tav>.
51. Khan SI, Hussain MI, Parveen S, et al. Living on the extreme margin: social exclusion of the transgender population (hijra) in Bangladesh. *Journal of health, population, and nutrition* 2009; **27**(4): 441.
52. Nanda S. Neither man nor woman: The hijras of India: Cengage Learning; 1999.
53. Virupaksha H, Muralidhar D, Ramakrishna J. Suicide and suicidal behavior among transgender persons. *Indian*

journal of psychological medicine 2016; **38**(6): 505.

54. Tunçalp, Were W, MacLennan C, et al. Quality of care for pregnant women and newborns—the WHO vision. *BJOG: an international journal of obstetrics & gynaecology* 2015; **122**(8): 1045-9.
55. Finlayson K, Downe S. Why Do Women Not Use Antenatal Services in Low- and Middle-Income Countries? A Meta-Synthesis of Qualitative Studies. *PLOS Medicine* 2013; **10**(1): e1001373.
56. Roozbeh N, Nahidi F, Hajiyan S. Barriers related to prenatal care utilization among women. *Saudi Medical Journal* 2016; **37**(12): 1319-27.
57. Randall M, Venkatesh V. The Right to No: The Crime of Marital Rape, Women's Human Rights, and International Law. *Brook J Int'l L* 2015; **41**: 153.
58. OECD Development Centre. Social Institutions and Gender Index. 2018. <https://www.genderindex.org/>.
59. UNDP. Gender Development Index (GDI). 2018. <http://hdr.undp.org/en/content/gender-development-index-gdi>.
60. UNDP. Gender Inequality Index (GII). 2018. <http://hdr.undp.org/en/content/gender-inequality-index-gii>.
61. World Economic Forum. Global Gender Gap. Cologny/ Geneva: World Economic Forum, 2017.
62. Nair H, Campbell H, Park J, Brondi L, Shi T, Olsson S. Common childhood infections and gender inequalities: a systematic review. *UNICEF Maternal, Newborn and Child Health Working Papers* New York, NY 2015.
63. Guilmoto CZ, Saikia N, Tamrakar V, Bora JK. Excess under-5 female mortality across India: a spatial analysis using 2011 census data. *The Lancet Global Health* 2018; **6**(6): e650-e8.
64. Collaborators MDS. Causes of neonatal and child mortality in India: a nationally representative mortality survey. *The Lancet* 2010; **376**(9755): 1853-60.
65. Fledderjohann J, Agrawal S, Vellakkal S, et al. Do girls have a nutritional disadvantage compared with boys? Statistical models of breastfeeding and food consumption inequalities among Indian siblings. *PLoS one* 2014; **9**(9): e107172.
66. Diamond-Smith N, Luke N, McGarvey S. 'Too many girls, too much dowry': son preference and daughter aversion in rural Tamil Nadu, India. *Culture, health & sexuality* 2008; **10**(7): 697-708.
67. Amin A, Kågesten A, Adebayo E, Chandra-Mouli V. Addressing Gender Socialization and Masculinity Norms Among Adolescent Boys: Policy and Programmatic Implications. *The Journal of Adolescent Health* 2018; **62**(3 Suppl): S3-S5.
68. Fleming PJ, Lee JG, Dworkin SL. "Real Men Don't": constructions of masculinity and inadvertent harm in public health interventions. *American journal of public health* 2014; **104**(6): 1029-35.
69. Patton GC, Coffey C, Sawyer SM, et al. Global patterns of mortality in young people: a systematic analysis of population health data. *Lancet* 2009; **374**(9693): 881-92.
70. Schulte MT, Ramo D, Brown SA. Gender differences in factors influencing alcohol use and drinking progression among adolescents. *Clinical Psychology Review* 2009; **29**(6): 535-47.
71. World Health Organization. Suicide Fact Sheet. 2014. <http://www.who.int/news-room/fact-sheets/detail/suicide>.
72. Bagley CA, Shahnaz A, Simkhada P. High Rates of Suicide and Violence in the Lives of Girls and Young Women in Bangladesh: Issues for Feminist Intervention. *Social Sciences* 2017; **6**(4): 140.
73. Patel V, Ramasundarahettige C, Vijayakumar L, et al. Suicide mortality in India: a nationally representative survey. *The lancet* 2012; **379**(9834): 2343-51.
74. Ponnudurai R. Suicide in India—changing trends and challenges ahead. *Indian journal of psychiatry* 2015; **57**(4): 348.
75. Radhakrishnan R, Andrade C. Suicide: an Indian perspective. *Indian journal of psychiatry* 2012; **54**(4): 304.
76. García-Moreno C, Stöckl H. Violence against women, its prevalence and health consequences. Violence against women and mental health: Karger Publishers; 2013: 1-11.
77. UNFPA. Motherhood in Childhood: Facing the challenge of adolescent pregnancy, 2013.
78. Simkhada PP, Regmi PR, van Teijlingen E, Aryal N. Identifying the gaps in Nepalese migrant workers' health and well-being: a review of the literature. *Journal of Travel Medicine* 2017; **24**(4): tax021-tax.
79. Weine SM, Kashuba AB. Labor Migration and HIV Risk: A Systematic Review of the Literature. *AIDS and Behavior* 2012; **16**(6): 1605-21.
80. World Health Organization. Gender and HIV/AIDS. Geneva, Switzerland: World Health Organisation 2003.
81. Greig A, Peacock D, Jewkes R, Msimang S. Gender and AIDS: time to act. *AIDS* (London, England) 2008; **22**(Suppl 2): S35.

82. Bruni L, Barrionuevo-Rosas L, Albero G, et al. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in the World. Summary Report 27 July 2017. 2018.
83. World Health Organization. Human papillomavirus and HPV vaccines: a review 2018. <http://www.who.int/bulletin/volumes/85/9/06-038414/en/>.
84. World Health Organization Bangladesh. HPV vaccine introduced in Bangladesh. 2018. <http://www.searo.who.int/bangladesh/HPVvaccinelaunch/en/>.
85. Gallagher KE, Howard N, Kabakama S, et al. Lessons learnt from human papillomavirus (HPV) vaccination in 45 low-and middle-income countries. *PloS one* 2017; **12**(6): e0177773.
86. Jaspers L, Budiningsih S, Wolterbeek R, Henderson F, Peters A. Parental acceptance of human papillomavirus (HPV) vaccination in Indonesia: a cross-sectional study. *Vaccine* 2011; **29**(44): 7785-93.
87. Grandahl M, Paek SC, Grisurapong S, Sherer P, Tydén T, Lundberg P. Parents' knowledge, beliefs, and acceptance of the HPV vaccination in relation to their socio-demographics and religious beliefs: A cross-sectional study in Thailand. *PloS one* 2018; **13**(2): e0193054.
88. Daley EM, Vamos CA, Thompson EL, et al. The feminization of HPV: How science, politics, economics and gender norms shaped U.S. HPV vaccine implementation. *Papillomavirus Research* 2017; **3**: 142-8.
89. Smith M. Should HPV vaccination be gender neutral? : *Can Med Assoc*; 2015.
90. Orvos J. Gender-based reasons for avoiding HPV vaccination. 2018. <http://www.contemporaryobgyn.net/modern-medicine-feature-articles/gender-based-reasons-avoiding-hpv-vaccination2018>.
91. GSMA. Connected Society: State of Mobile Internet Connectivity 2018, 2018.
92. Barboni G, Field E, Pande R, Rigol N, Schaner S, Moore S. A Tough Call: Understanding barriers to and impacts of women's mobile phone adoption in India. Cambridge, MA: Evidence for Policy Design, Harvard Kennedy School, 2018.
93. GSMA. Connected Women: The Mobile Gender Gap Report 2018, 2018.
94. Girl Effect, Vodafone Foundation. Real girls, real lives, connected: A global study of girls' access and usage of mobile told through 3000 voices, 2018.
95. Kovacs A. 'Chupke, Chupke': Going Behind the Mobile Phone Bans in North India. 2017. https://genderingsurveillance.internetdemocracy.in/phone_ban/#setting-the-scene.
96. Shanker A, Marian D, Swimmer C. Effective Interventions Aimed at Reaching Out-of-School Children: A Literature Review. Kathmandu, Nepal, 2015.
97. Jennings J. Asia and the Pacific Education for All (EFA) Mid-Decade Assessment: South Asia Sub-Region Synthesis Report. Bangkok: UNESCO Bangkok, 2009.
98. United Nations Girls' Education Initiative. Disparities in Education in South Asia: A Resource Toolkit. Kathmandu, Nepal: UNICEF Regional Office for South Asia, 2011.
99. Narayan S, Rao N, Lourdes A, Khan MM. Gender, Equality and Education: A Report Card on South Asia. Mumbai: Asia South Pacific Association for Basic and Adult Education/UNGEI; 2010.
100. Islam KMM, Asadullah MN. Gender stereotypes and education: A comparative content analysis of Malaysian, Indonesian, Pakistani and Bangladeshi school textbooks. *PloS one* 2018; **13**(1): e0190807.
101. Mitchell C, Yang K. Woman+Teacher+Rural: Bringing Gender into the Policy Framework on Teacher Deployment in Rural Areas: Institute for the Study of International Development, 2012.
102. Oxfam International. High Stakes: Girls' Education in Afghanistan, 2011.
103. UNFPA. Project Overview - kNowVAWdata. 2018. <https://asiapacific.unfpa.org/publications/knowvawdata-project-overview>.
104. Girls Tf. Violence Against Children Surveys. 2018. <https://www.togetherforgirls.org/violence-children-surveys/>.
105. World Health Organization South-East Asia Regional Office. Health situation and trend assessment. 2018. http://www.searo.who.int/entity/health_situation_trends/data/chi/sex-ratio/en/.
106. Costa JC, da Silva ICM, Victora CG. Gender bias in under-five mortality in low/middle-income countries. *BMJ Global Health* 2017; **2**(2).
107. UNFPA. How many girls are missing at birth in India? Trends in Sex Ratio at Birth (2001-2012). New Delhi, India, 2015.
108. UNFPA. Sex imbalances at birth: current trends, consequences and policy implications, 2012.
109. Guilmo C, Tovey J. The Masculinization of Births. Overview and Current Knowledge. *Population* 2015; **70**(2):

185-242.

110. Roberts LR, Montgomery SB. India's Distorted Sex Ratio: Dire Consequences for Girls. *Journal of Christian nursing : a quarterly publication of Nurses Christian Fellowship* 2016; **33**(1): E7-e15.
111. United Nations Human Rights Council. Birth registration and the right of everyone to recognition everywhere as a person before the law : Report of the Office of the United Nations High Commissioner for Human Rights, 2014.
112. UNFPA. Top 5 things you didn't know about child marriage. 2018. <https://www.unfpa.org/news/top-5-things-you-didnt-know-about-child-marriage#>.
113. Acharya D, Bhattarai R, Poobalan A, van Teijlingen E, Chapman G. Factors associated with teenage pregnancy in South Asia: a systematic review. *Health Science Journal* 2010; **4**(1): 3-14.
114. Polk K. A Scenario of Masculine Violence: Confrontational Homicide. Victoria, Australia: Department of Criminology, University of Melbourne, 2018.
115. United Nations Office on Drugs and Crime. Homicide and Gender 2015. https://www.heuni.fi/material/attachments/heuni/projects/wd2vDSKcZ/Homicide_and_Gender.pdf.
116. United Nations Educational Scientific and Cultural Organization. From Insult to Inclusion: Asia-Pacific report on school bullying, violence and discrimination on the basis of sexual orientation and gender identity. Bangkok, 2015.
117. Moin A, Mustansar I. Female Genital Mutilation/Cutting: A Well-Kept Secret in Pakistan. *Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC* 2017; **39**(12): 1127-8.
118. Nazeer S. Female Genital Mutilation: Secret Practice in India *International Journal of Scientific and Research Publications*, 2017; **7**(7): 341-4.
119. Wickramage K, Senanayake L, Mapitigama N, Karunasinghe J, Teagal E. The need for an evidence-informed, multi-sectoral and community participatory action framework to address the practice of female genital mutilation in Sri Lanka. *The Ceylon medical journal* 2018; **63**(2): 53-7.
120. Nasrullah M, Haqqi S, Cummings KJ. The epidemiological patterns of honour killing of women in Pakistan. *European journal of public health* 2009; **19**(2): 193-7.
121. Honour Based Violence Awareness Network. Honour Killings by Region - South & Central Asia. 2018. <http://hbv-awareness.com/regions/>.
122. IRIN. NEPAL: Girls worst exploited as child labourers. 2011. <https://reliefweb.int/report/nepal/nepal-girls-worst-exploited-child-labourers>.
123. UNODC. Global Report on Trafficking in Persons, 2009.
124. United States Department of State. 2018 Trafficking in Persons Report - Afghanistan, 2018.
125. United States Department of State. 2018 Trafficking in Persons Report - Bangladesh, 2018.
126. United States Department of State. 2018 Trafficking in Persons Report - India, 2018.
127. United States Department of State. 2018 Trafficking in Persons Report - Pakistan, 2018.
128. United Nations Children's Fund (UNICEF) and World Health Organization. Drinking Water, Sanitation and Hygiene in Schools: Global Baseline Report 2018 New York, 2018.
129. GBD 2016 Risk Factors Collaborators. Global, regional, and national comparative risk assessment of 84 behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet* 2017; **390**(10100): 1345-422.
130. Clougherty JE. A growing role for gender analysis in air pollution epidemiology. *Environmental health perspectives* 2010; **118**(2): 167-76.
131. Sommer M, Robles P, Comey D, Yamakoshi B, Burgers L, Cavill S. WASH in Schools Empowers Girls' Education: Proceedings of the 5th Annual Virtual Conference on Menstrual Hygiene Management in Schools New York, 2016.
132. UNICEF. WASH in Schools: Empowers Education: Proceedings of the 4th Virtual Conference on Menstrual Hygiene Management in Schools New York, 2016.
133. Jadhav A, Weitzman A, Smith-Greenaway E. Household sanitation facilities and women's risk of non-partner sexual violence in India. *BMC Public Health* 2016; **16**(1): 1139.
134. Srinivasan R. Lack of Toilets and Violence Against Indian Women: Empirical Evidence and Policy Implications SSRN 2015.
135. Kulkarni S, O'Reilly K, Bhat S. No relief: lived experiences of inadequate sanitation access of poor urban women in India; 2017.
136. Tewary A, Bihar P. India Bihar rapes 'caused by lack of toilets'. 2013. <https://www.bbc.com/news/world-asia-india-22460871>.

137. Keatman T, Cavill S, Manton T. Menstrual hygiene management in schools in South Asia and Menstrual hygiene management in schools in South Asia: Synthesis report and Country Snapshots: Bangladesh: WaterAid and UNICEF, 2018.
138. Keatman T, Cavill S, Manton T. Menstrual hygiene management in schools in South Asia and Menstrual hygiene management in schools in South Asia: Synthesis report and Country Snapshots: Bhutan: WaterAid and UNICEF, 2018.
139. Keatman T, Cavill S, Manton T. Menstrual hygiene management in schools in South Asia and Menstrual hygiene management in schools in South Asia: Synthesis report and Country Snapshots: India: WaterAid and UNICEF, 2018.
140. Keatman T, Cavill S, Manton T. Menstrual hygiene management in schools in South Asia and Menstrual hygiene management in schools in South Asia: Synthesis report and Country Snapshots: Nepal: WaterAid and UNICEF, 2018.
141. Robinson H. Chaupadi: The affliction of menses in Nepal. *International journal of women's dermatology* 2015; **1**(4): 193-4.
142. World Commission on Environment and Development. From One Earth to One World: An Overview. Oxford: Oxford University Press; 1987.
143. Harkins B, Lindgren D, Suravoranon T. Risks and rewards: Outcomes of labour migration in South-East Asia: International Labour Organization, 2017.
144. Mmari K, Moreau C, Gibbs SE, et al. 'Yeah, I've grown; I can't go out anymore': differences in perceived risks between girls and boys entering adolescence. *Cult Health Sex* 2018; **20**(7): 787-98.
145. INFORM Index for Risk Management. Inform Global Risk Index Results 2018, 2018.
146. Committee on the Elimination of Discrimination against Women. General Recommendation No. 37 on Gender-related dimensions of disaster risk reduction in the context of climate change. 2018.
147. Plan. Because I am a Girl - In Double Jeopardy: Adolescent Girls and Disasters, 2013.
148. International Federation of Red Cross and Red Crescent Societies. Unseen, Unheard - Gender-based Violence in Disasters: Asia Pacific case studies. Kuala Lumpur, Malaysia 2016.
149. The Economist Intelligence Unit. The South Asia Women's Resilience Index Examining the role of women in preparing for and recovering from disasters, 2014.
150. Ferrie J. Drought drives desperate Afghans to marry of children for money: U.N. 2018. <https://www.reuters.com/article/us-afghanistan-children-marriage/drought-drives-desperate-afghans-to-marry-off-children-for-money-idUSKCN1NW0VJ>.
151. UNICEF. Afghanistan Western Region Drought Response Humanitarian Situation Report #1, 2018.
152. UN DESA. Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development: United Nations Department of Economic and Social Affairs, 2017.
153. UNSD. United Nations minimum set of gender indicators: Inter-Agency and Expert Group on Gender Statistics, United Nations Statistics Division, 2017.
154. UNICEF EAPRO. Concept note: regional review of gender data and situation analysis for girls in Asia Pacific. Bangkok: UNICEF, UNFPA, UN ESCAP, UN Women, WFP, 2017.
155. UNICEF. UNICEF adolescent country tracker matrix 5x5: UNICEF, 2017.
156. Asian Development Bank, UN Women. Gender Equality and the Sustainable Development Goals in Asia and the Pacific: Baseline and pathways for transformative change by 2030. Bangkok, 2019.
157. WHO. Health worker roles in providing safe abortion care and post-abortion contraception, 2015.
158. UNFPA, UNESCO, WHO. Sexual and reproductive health of young people in Asia and the Pacific: A review of issues, policies and programmes. Bangkok, 2015.
159. Patton GC, Sawyer SM, Santelli JS, et al. Our future: a Lancet commission on adolescent health and wellbeing. *Lancet* 2016; **387**(10036): 2423-78.
160. Food and Agriculture Organization of the United Nations (FAO). Gender dimensions of agricultural and rural employment, 2010.
161. International Labour Organization. World report on child labour, 2015.
162. UNODC. Global report on trafficking in persons, 2016.
163. World Bank. Toward gender equality in East Asia and the Pacific, 2012.
164. Dutta D, Badloe C, Lee H, House S. Supporting the Rights of Girls and Women Through Menstrual Hygiene Management (MHM) in the East Asia and Pacific Region: Realities, progress and opportunities. Bangkok, Thailand: UNICEF East Asia and Pacific Regional Office (EAPRO), 2016.

