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Sustainable Development Goals and children in Norway

A discussion paper on the SDGs indicators

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Norsk institutt for forskning om oppvekst, velferd og aldring (NOVA) er et forskningsinstitutt ved Senter for velferds- og arbeidslivsforskning (SVA) på Høgskolen i Oslo og Akershus (HiOA).

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Preface

The project ‘SDG’s in Norway with focus on children – A Discussion Paper on Some of the Sustainable Development Goal Indicators’ was commissioned by UNICEF Norway and conducted by NOVA. The discussion paper was written in a short period during the autumn 2016 (close to three weeks of work). NOVA thanks UNICEF Norway for the opportunity to examine some of the indicators in this field in this discussion paper (here: work in progress). Special thanks to legal advisor Ivar Stokkereit and project coordinator Pedro Melo in UNICEF Norway as NOVA’s contact persons. Both have given us very good advices. Thanks also to senior researchers Ida Hydle, Margaret Ford and research director Tonje Gundersen, NOVA, for good comments.

Oslo, February 2017

Lars Bjarne Kristofersen

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Summary

UNICEF Norway initiated this project in order to follow up The United Nation's *Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators* (United Nations, 2016) for children and youth aged 18 or younger.

The project's goal is to review *Norway's ability to report statistics to the UNITED NATIONs according to the Sustainable Development Goal Indicators* for children and youth on a few selected SDGs and targets within those SDGs, using statistics and research published before 15 November 2016. The basis for the study is the UN Report mentioned above, a discussion- paper from 2015 about the more general questions to be addressed (Grønningsæter & Stave, 2015) and some of the indicators launched in July 2016 with specific focus on the indicators suggested by UNICEF Norway.

This paper reviews 18 indicators chosen for 8 goals and 12 targets (see table 1) of the total 17 goals. The method used was reviews of relevant literature, documents and published statistics.

The chosen goals are:

- Goal 1 End poverty in all its forms everywhere,
- Goal 3 Ensure healthy lives and promote well-being for all
- Goal 4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all,
- Goal 5 Achieve gender equality and empower all women and girls,
- Goal 8 Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all,
- Goal 11 Make cities and human settlements inclusive, safe, resilient and sustainable and
- Goal 12 Ensure sustainable consumption and production patterns.
- Goal 16 Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

The chosen *indicators on poverty* indicate that child poverty increases. We recommend continued use of the European indicators, instead of a national poverty line. As previous research in Norway has suggested, a price adjusted increase in the universal child benefit could be one solution to partly solve the problem with child poverty. The measure has not been adjusted since 1996.

Regarding *the indicators on health,* our conclusion is that the communicable diseases AIDS/HIV and tuberculosis are rare in Norway, although the incidence rates of tuberculosis have not been reduced in later years. The register as well as the research potential seems suitable for communicable diseases in Norway.

Mental health problems and suicide behavior seems to be a challenge in Norway. Research conducted in recent years, show lacks in management of mental health problems in children and young people, especially among the more disadvantaged groups. The suicide rate among youth seems to have been stable in recent years, but there is a need for more specified analyses and updated research.

The *indicators on education*: In Norway a very large part of the child population learns how to read, write and do mathematics. They also often learn two-three languages. However, some children leave compulsory school (10 school years in Norway) without adequate reading, writing and mathematical skills. Many young people start university studies, and a large part succeed with academic degrees and relevant jobs. However, an increasing part encounter difficulties in the transition from youth to adulthood: to carry out the 'right education' and having a job.

When it comes to domestic violence, Norway has good surveys about 18 year olds experience of domestic violence during their upbringing. But we lack good data for children and younger persons. Research has been planned and conducted for younger age groups. But one survey was denied from both the Norwegian Data Protection Authority and from The Data Protection Tribunal Norway. To improve the knowledge of violence against children, we suggest that the Norwegian legislation in various areas (when it comes to allowing children to take part in research) should be better harmonized. Today one state authority denies the type of research (without consent from parents) that another state authority allows.

Introduction

Background

UNICEF Norway initiated this project in order to follow up The United Nation's *Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators* (United Nations, 2016) for children and youth aged 18 or younger. UNICEF has contracted NOVA to give an overview of the Norwegian situation on a selection of specific Sustainable Development Goal Indicators (SDG) and some of their underlying targets.

A preliminary meeting was held between UNICEF Norway (Stokkereit and Gabrielli) and NOVA (Kristofersen and Hougen) at NOVA's office in Oslo before the SDG-indicators were published in July 2016 (The Norwegian Government, 2016; UNICEF, undated). Subsequently NOVA received the SDG-indicators from UNICEF Norway. In September, UNICEF Norway provided NOVA with a prioritized selection of the 17 SDGs and targets to be included in this NOVA overview.

A second meeting was held in UNICEF Norway's office 4. November with Ivar Stokkereit, Pedro Melo (both UNICEF Norway) and Lars Kristofersen (NOVA) to sort out more details about the indicators and the method chosen for this study.

Goal of the project

The project's goal is to review *Norway's ability to report statistics to the UNITED NATIONs according to the Sustainable Development Goal Indicators* for children and youth on a few selected SDGs and targets within those SDGs, using statistics and research published before 15 November 2016. In addition, we intend to point out areas for improvement. The results of this review are presented in this discussion-paper from NOVA.

Basis for the study/problem description from UNICEF Norge

The basis for the study is the UN Report mentioned above (United Nations, 2016), in addition to a discussion- paper from 2015 about the more general questions to be addressed (Grønningsæter & Stave, 2015) and the indicators launched in July 2016 with specific focus on the indicators suggested by UNICEF Norway (See Table 1).

Table 1. SDG Goals, targets and indicators in the UNICEF-NOVA-project.

SDG Goal	Target[1]	Indicator
1 End poverty in all its forms everywhere	**1.2**	**1.2.1** Proportion of population living below the national poverty line, by sex and age
		1.2.2 Proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions
3 Ensure healthy lives and promote well-being for all at all ages – (here children)	**3.3**	**3.3.1** Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations
		3.3.2 Tuberculosis incidence per 1,000 population
	3.4	**3.4.2** Suicide mortality rate
	3.8	**3.8.1** Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)
	3.9	**3.9.2** Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)
4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all	**4.1**	**4.1.1** Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum profi-ciency level in (i) reading and (ii) mathematics, by sex
5 Achieve gender equality and empower all women and girls	**5.2**	**5.2.1** Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psycho-logical violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
		5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
8 Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	**8.7**	**8.7.1** Proportion and number of children aged 5-17 years engaged in child labour, by sex and age
11 Make cities and human settlements inclusive, safe, resilient and sustainable	**11.1**	**11.1.1** Proportion of urban population living in slums, informal settlements or inadequate housing
12 Ensure sustainable consumption and production patterns	**12.8**	**12.8.1** Extent to which (i) global citizenship education and (ii) education for sustainable development (including climate change education) are mainstreamed in (a) national education policies; (b) curricula; (c) teacher education; and (d) student assessment
16 Promote peaceful and inclusive societies for sustainable develop-ment, provide access to justice for all and build effective, accountable and inclusive insti-tutions at all levels	**16.1**	**16.1.1** Number of victims of intentional homicide per 100,000 population, by sex and age
		16.1.2 Conflict-related deaths per 100,000 population, by sex, age and cause
		16.1.3 Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months
	16.2	**16.2.1** Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month
		16.2.3 Proportion of young women and men aged 18-29 years who experienced sexual violence by age 18

[1] See Appendix 1 for specification of the targets.

Method and design

The method used was to review the relevant literature, documents and published statistics.

Statistics that are obtainable from Statistics Norway, the Causes of Death Register and other official statistics, are included. The project does not have funds for ordering/ buying special analysis, nor does the project's timeframe permit such acquisitions, since deliveries from Statistics Norway may take anywhere from a few weeks to months, depending on the complexity of the order and the que for processing data orders at SSB.

Examples (in project description)

Research based knowledge and available statistics in Norway for the 17 SDG-indicators vary. We already have data regarding some of the selected indicators, other indicators will need further investigation. Suggestions, examples and additional details will appear in this discussion paper.

The following are examples of existing knowledge for three of the selected SDGs; *Poverty among families and children* (SDG1 -indicators1.2.1 and 1.2.2 in Table 1). In Norway this has been studied by Statistics Norway (Epland & Kirkeberg, 2014), The Ministry for Children and Equity (Barne-likestillings- og inkluderingsdepartementet, 2015), The Norwegian Directorate for Children, Adolescents and Families (Bufdir, 2015, 2016) and in several Norwegian research projects (Fløtten, 2009; Sandbæk & Pedersen, 2010; Seim & Larsen, 2011).

Suicide mortality rate (SDG3 -indicator 3.4.2) Suicide in children and adolescents, aged 18 or younger, are also included in the Causes of Death Register (causes of death by age groups, annually including the year 2015) (Folkehelseinstitutttet, 2016) and was the topic of a PhD dissertation a few years ago (Freuchen, 2013).

Gender equality and empowerment of all women and girls (SDG5 - indicators 5.2.1 and 5.2.2) We have new research based knowledge about adolescents' experiences of sexual violence from their parents and peers (Mossige & Stefansen, 2016)

Results for each of the indicators

This work does due to limited time and resources, only take a part of all the sustainable goal indicators into consideration. The indicators for this study were chosen by UNICEF Norway among all the SGD'indicators published in July 2016.

1 End poverty in all its forms everywhere (Goal 1)

ABOUT THE GOAL

The first goal – End poverty in all its forms everywhere – is both a powerful symbol and very ambitious.

The indicators

1.1 Proportion of population living below the national poverty line, by sex and age (indicator 1.2.1.) and

1.2. Proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions (indicator 1.2.2.)

Norway does not have a defined national poverty line. Nor do many other European countries, who often use the standardized measures that European Statistics have developed. We are not sure if it would be fruitful to construct national poverty line(s) for Norway. It might perhaps be possible to construct national poverty line(s) that gives better understanding of the specific Norwegian child poverty. But a national poverty line could also be accused to give the country 'a better scaling' than if the most used European measures were used instead? If a national poverty line should be worked out for Norway, we would recommend that it should be used only as an additional measure. It is very important to stick to the most used European 'standard measures'.

Research in this field in Norway has followed the European statistics 'standard measures' (see below). The most up-dated measures of poverty among children in Norway can be found in an article by Epland and Kirkeberg (Epland & Kirkeberg, 2014) and by Omholt and colleagues (Omholt, 2016).

One of the more general findings Omholt and colleagues write about is the following:

> ‘Some people experience only a short period of low household income. Accordingly, fewer persons have persistent low income, compared to annual low income. If we define persistent low income based on the average household equivalent income in the three-year period 2012-2014, 9 per cent of the population had persistent low income using the EU measure. The proportion with persistent low income (EU-definition) has remained stable at approximately 8 per cent for many years, and decreased between 2006 and 2011. In recent years, the share of persons with persistent low income has risen again.’ (Omholt, 2016:5).

Table 2 Share of persons with persistent low income 2) by different background variables. Per cent. 1997-1999 – 2012-2014. (Reference: from table 4.13, pp. 55-56, Omholt 2016)

	1997/ 1999	1999/ 2001	2001/ 2003	2003/ 2005	2005/ 2007	2007/ 2009	2008/ 2010	2009/ 2011	2010/ 2012	2011/ 2013	2012/ 2014
Families with children											
Per cent of all children (0-17 years)	4,1	3,3	5,6	6,7	7,3	7,7	7,7	7,6	8,0	8,6	9,4
Personer som har tilhørt enslig forsørgerhushold-ning i alle årene i treårsperioden	8,6	4,5	10,0	11,1	15,8	17,6	17,8	17,9	19,6	21,6	23,3
Personer i husholdningstyper par med barn, yngste barn 0-6 år	3,4	3,4	5,1	6,4	6,5	6,6	6,7	6,8	7,3	7,9	8,6
Personer i husholdnings-typen par med barn, yngste barn 0-17 år, med fem eller flere barn	:	:	:	:	40,8	40,8	40,6	40,7	42,7	43,8	47,1
Females and males											
Females	10,8	9,9	10,0	10,2	10,6	10,6	10,3	10,1	10,3	10,5	10,7
Males	7,1	7,1	7,7	8,7	8,1	8,2	8,3	8,3	8,6	8,8	9,2

Epland and Kirkeberg (in Omholt, 2016) writes the following concerning children (NOVA’s translation):

> In 2014 there were 978 000 children under the age of 18 that had also been living in Norway the two previous years. Among these children 9,4 per cent lived in households with persistent low incomes. This

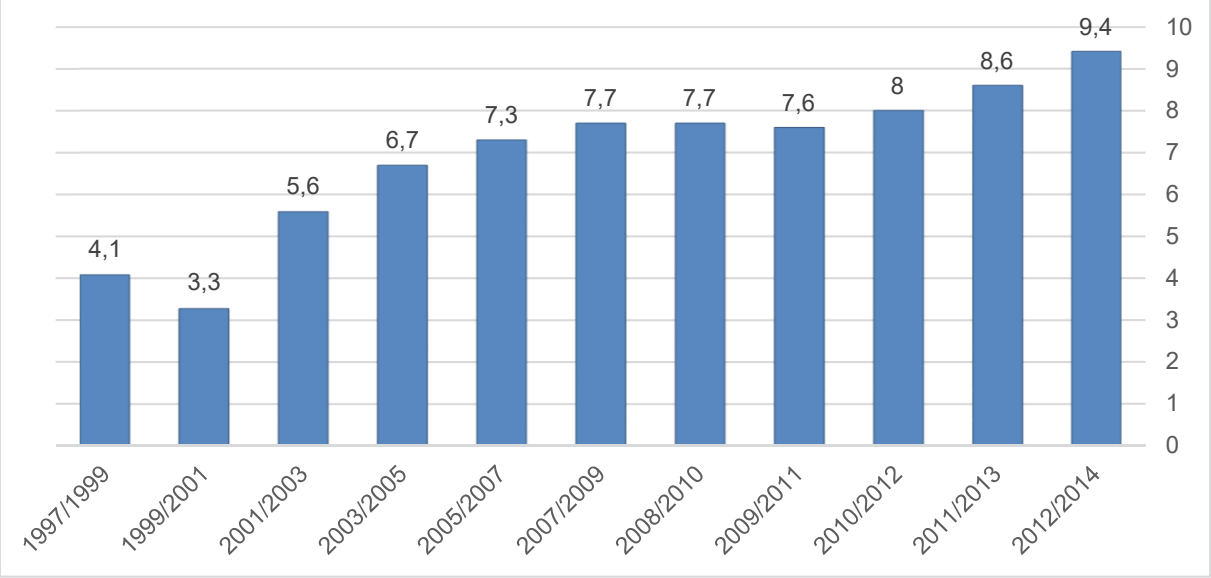
[2] Average equivalized income after tax (EU scale) during a three-year periode with less than 60 per cent of the median during the same three year periode.

corresponds to 92 000 children in the population at large. The amount of children in low income households have increased every year since 2011.

There has been an increase in the number of children of all ages living in households with persistent low income, although the increase has been most distinct for the youngest children. A more thorough presentation of the development of low income among families with children is given in Epland and Kirkeberg (2016) (Omholt, 2016).

The main finding regarding children of all ages (0-17 years) is illustrated in figure 1. As we can see the share of children who lived in a household with persistent low income more than doubled from 4,1 per cent in 1997-1999 to 9,4 per cent in 2012-2014. The share was at its lowest in 1999-2001 (3,3 per cent) and rose to almost three times as many in 2012-2014.

Figure 1 Per cent of all children (0-17 years) in Norway with persistent low income. Three year periods (1997/1999 - 2012 /2014).



(Source: Figure 1 is based on figures from Table 4.13 in Omholt 2016)

Epland and Kirkeberg have also written a report specifically about the financial situation of families with children (Epland & Kirkeberg, 2016). In their report (page 31-32) they discuss the empirical data regarding children in different age groups. We see an increase in per cent of persistent low income in all the three age groups 0-5, 6-10 and 11-17 years from 2011 to 2014. In the preschool age group more than 10 per cent lived in a household with persistent low income

in 2014. Among the 6-10 year olds, more than nine per cent lived in a similar low income household, and among the 11-17 year olds the percentage was just above eight. In 2011 the percentages were about seven to eight in all three age groups. In 2006 the percentage was slightly lower in all three age groups, about 6,5 - 7,5 per cent. Thus for all three groups the number of children living with persistent low income have increased, and the diversity between the groups also increased during the period 2012-2014.

Epland and Kirkeberg also studied variations between regions and found large differences. Especially Oslo and other large towns had large percentages of children living in persistent low income households. But also cities like Drammen, Skien, Sarpsborg and Fredrikstad had high shares of poor children. In Oslo differences were also large between city districts. The possibility for a child to grow up in a persistent low income household was seven times higher in the city district Grünerløkka (central eastern part of Oslo) as in the city district Ullern (outskirts, western part of Oslo).

Epland and Kirkeberg show that if the Child Benefit[3] was adjusted up to the 1996 level in accordance with increase in the consumer price index, close to 18 000 children would leave the low income group. They forecast that the number of children in poverty will increase each of the forthcoming years if the Child Benefit is not adjusted in Norway.

CHALLENGES

Several Norwegian governments have been working with the issue of child poverty since early 2000. The present Government presented it's latest action plan in 2015 (Barne- likestillings- og inkluderingsdepartementet, 2015).

A clear message from research the last 5-10 years to Norwegian politicians, is that to increase the Child Benefit is a good universal instrument to reduce the number of low income families with children (see for instance also Sandbæk and Pedersen 2010). Hovewer, Norwegian parliamentariants (the majority) have not included this message from research in their policy plans. Some politicians argue that the State expenditure spent on Child benefits could come to better use by supporting education, equal opportunitites and integration.

[3] The Child Benefit is a universal benefit given for all children under the age of 18, who live in Norway. The purpose of the benefit is to help cover the cost of raising a child.

3 Ensure healthy lives and promote well-being for all at all ages – (Goal 3 - for children)

ABOUT THE GOAL – FOR CHILDREN

This is also a very important goal – worldwide and for Norway. Even if Norwegian children generally have good health and the child mortality rate is low in Norway, childrens state of health is crucial for the children and young people themselves, for their families and for society. We find evidence that some groups of children have more extensive health issues than other groups also in Norway. The targets and indicators following this goal are important both as standard of living issues and as issues of importance in social economic matters.

THE INDICATORS

3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations (indicator 3.3.1)

From the Norwegian Institute of Public Health (https://www.fhi.no/en/) we have found statistics about new HIV-infections the last twenty years measured through the health statistics system MSIS (msis.no). The statistics were available by sex and age-groups (ten-year groups, 0-9 years,10-19 etc. up to 80+years). The results might be calculated by the number per 1.000 population, at a later point in time (source for population data: Statistics Norway).

Table 3. Cases of diagnosed HIV-infections 1996–2015. Age-groups 0–19 years.

Alders-grupper	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
0–9	4	1	1	4	3	2	3	5	1	4	4	7	5	4	1	3	4	1	1	1
10–19	3	2	5	3	7	8	7	9	6	5	13	6	5	4	3	4	5	3	5	3

Source: Norwegian Institute of Public Health, MSIS.

The absolute number of HIV- infected children and young people was highest in 2006 (see table 3).

That year, four children aged 0-9 years and 13 children and youth between 10-19 years of age, were infected. Some years the number of children 0-9

infected has been about 4-7 [4]. From 2009 until 2015 the number of infections among 0-9 year olds have gone down from 5 to 1 (only 1 new child was registered each of the years 2013, 2014 and 2015). From 2007 until 2015 the number of new registrations of HIV-infections has also decreased among the 10-19 year olds (from 6 new registered young persons in 2007 and since the number has varied between 3 and 5 each year until 2015).

3.2 Tuberculosis incidence per 1,000 population (indicator 3.3.2)

In latter years appoximately 350-400 new cases of tuberculosis are diagnosed in Norway each. Although the incidence has increased in recent years, there are few new cases in Norway. Most cases are seen amongst people born in countries with high occurrence of tuberculosis, who were carriers of dormant bacteria and became ill without infecting others first.

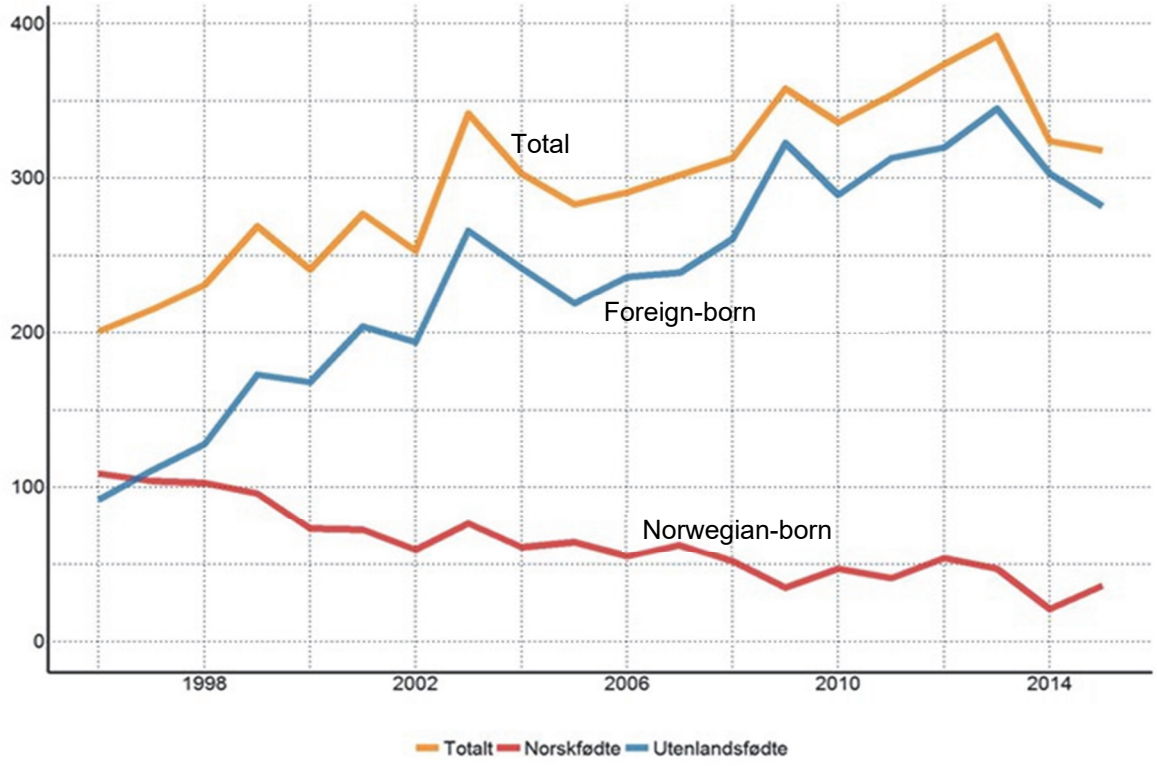
The following information about the incidence of Tuberculosis in Norway is from the 'Fact sheet' the Norwegian Institute of Public Health 2016 has on their homepage.

About 350-400 cases per year

"Every year in Norway, 350-400 new cases of tuberculosis are registered, i.e., approximately seven cases per 100,000 inhabitants. 318 new cases of tuberculosis were reported in Norway in 2015 (figure 1). All cases of tuberculosis disease must be reported to the Norwegian Institute of Public Health (NIPH).

[4] From the MSIS-statistics it is only possible to download the 10-year group 10-19 years. But hopefully other age groups such as 10-17 year olds might be possible to order by email or ordinary mail from this system (payable order).

Figure 2: Tuberculosis cases in Norway 1990-2015 by place of birth; Norwegian-born (norskfødte), foreign-born (utenlandsfødte) and total (totalt). Source: Norwegian Institute of Public Health.



About two out of three cases are pulmonary tuberculosis. Approximately 85 per cent of new tuberculosis cases occur among immigrants (see figure 1). They are often young adults, half are under 30 years of age and the proportion of men and women is equal. Most are believed to be infected in their country of origin before arriving in Norway.

Norwegian-born patients with tuberculosis are mostly elderly people who were infected when tuberculosis was common in Norway, and who have developed the disease as they become older and weaker. In 2013, there was an outbreak connected to a dance institute in Eastern Norway, where nine people became ill with tuberculosis.

Internationally, drug addicts and homeless people are a risk group for tuberculosis but few cases of infectious tuberculosis are diagnosed so far in these environments in Norway.

Most tuberculosis cases in Norway occur in Oslo, mainly because it is the largest city in Norway and because there is a higher proportion of foreign-born inhabitants than in other regions. Low numbers within each county lead to some random variations from year to year." (Norwegian Institute of Public Health, 2016).

From the same institute we also downloaded the number of people with tuberculosis reported through the msis.system for the same years. The statistics were published with ten-year groups for children (0-9, 10-19 years) for each year 1996-2016 (figures read 21.November 2016).

Table 4. Number of children and young people (0-19 years) with diagnosed tuberculosis in Norway in each of the years 1996-2016. Age groups 0-9 years, 10-19 years and total (0-19). Absolute figures. Source: The Norwegian Institute of Public Health (figures read 21.November 2016)

Age groups	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
0–9	11	16	5	16	15	14	8	11	15	11	18	8	10	5	6	9	12	7	7	9	8
10–19	12	11	18	24	16	31	22	40	34	36	32	34	37	41	30	40	34	55	30	57	34
Total 0–19	23	27	23	40	31	45	30	51	49	47	50	42	47	46	36	49	46	62	37	66	42

As shown in table 4 the number of children and young people diagnosed with tuberculosis has varied during this period. In 1996 the lowest number 23 persons received the diagnosis and the highest number diagnosed was 66 people in 2015.

We were not able to find published rates (diagnosed cases per 1000 in each age group), nor find the number of persons 0-17 years with tuberculosis. But we believe it might be possible to order such data from the Norwegian Institute of Public Health.

3.3 Suicide mortality rate (indicator 3.4.2)

During the 20-year period 1995-2015 more than 10.000 persons died from suicide or self-inflicted harm in Norway. The total number of suicides each year has varied between 500 and 600 the last ten years. In 2011 suicide was the second leading cause of death in the age group under 14 years in Norway, equal to accidents and behind tumors (Freuchen & Grøholt, 2015).

The total number of deaths by suicide among young people seems to have decreased in the last ten years from around 10-20 per year (age group 10-19 years) in the period 2005-2010 to around 10-15 these last five years (2011-2015) (see table 5).

We have not found more detailed suicide mortality figures published (suicides per 10.000 population for detailed age groups (10-14, 15-17 years)) for five year periods.

Table 5: Annual numbers of suicides in different age groups of young persons under 18 years of age during the period 1996-2015.

Cause of death	Age groups	Total, all years 1996-2015	Year of death																			
			1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Suicide (X60-X84, Y870)	Age groups 5–17 year	296	25	15	12	24	20	12	11	22	15	19	12	11	14	18	10	15	13	12	8	8
	1-4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	5-9	2	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	1	-	-	-	-
	10-14	66	9	3	5	2	4	-	2	8	3	5	1	2	1	4	1	6	2	1	3	4
	15-17	228	16	12	7	22	16	12	9	13	12	14	11	9	13	14	9	8	11	11	5	4

Source: Cause of Death Register, Norwegian Public Health Institute Table D9.

As mentioned earlier a PdD-dissertiation 2013 published more details regarding suicide in children and young people (Freuchen, 2013). «There have been several studies of suicide by children and adolescents, but few specifically address the youngest age groups. The present study was conducted in order to investigate if children and adolescents who commit suicide exhibit common characteristics which could possibly distinguish them from their peers and help us to regognize the ones at increased risk." (Freuchen 2013, page 8).

Freuchen conclude that "..symptoms of sub-treshold depression, suicidal interest, personal losses and stressful conflict that suicide victims age 15 and younger experienced, seemed to be the main precipitant factors. But none of these factors were of such a nature that they elicited enough worry among their caregivers to engage any kind of help strategy at the time. The majority of suicide victims seemed not to differ much from their peers. Moreover, to the child and young adolescent, the stressful conflict she or he experienced prior to death may have been perceived as much more important, shameful and difficult to handle than it would when seen form an adult's perspective." (Freuchen 2013, page 65). Very few of the young suicide victims had been in contact with the Child and Adolescent Mental Health Service (CAMHS).

Population based cohort studies of suicide in young people in Norway have been published for previous periods (Gravseth, Mehlum, Bjerkedal & Kristensen, 2010; Groholt, Ekeberg & Haldorsen, 2006; Grøholt, Ekeberg, Wichstrøm & Haldorsen, 1997; Grøholt, Ekeberg, Wichstrøm & Haldorsen, 2000). Both suicides, suicidal behavior and suicide notes from young persons have been analysed. The most recent journal article found was an analysis of 23 suicide notes from 42 suicide victims 15 years and younger 2007-2009 (Freuchen & Grøholt, 2015). The key messages was that the young persons explained the reason for suicide, delared love (often to their parents) and gave instructions (18 of the 42 victims had written notes, some of them more than one note). In addition to the analyzing of notes, the parents of the victims gave interviews to the researchers. In the notes from the young suicide victims they present themselves as fully responsible and without confusion or overwhelming despair. The researhers conclude that the notes from these young persons are likely equally informative as the notes of older victims (Freuchen & Grøholt, 2015).

From other Scandinavian research we know that young people with previous experience with Child Welfare Services and some other groups with higher risks, have higher rates of attempted suicide and higher rates of suicide mortality than

other groups of young people (Björkenstam, Björkenstam, Vinnerljung, Hallqvist & Ljung, 2011; Christoffersen, Poulsen & Nielsen, 2003; Kristofersen, 2005; Kristofersen, 2014; Vinnerljung, Hjern & Lindblad, 2006). Also international studies have found higher risks of suicide and suicide attempts in young people with child welfare experience (Katz et al., 2011).

We also know from research that behind each committed suicide among young people there are several suicide attempts. Following the 1966 and 1980 birth cohorts[5] in Dennark in the age span 15 to 24 years revealed that risk of suicidal behaviour had increased by 30 per cent (Christoffersen, 2009). The increase in suicidal behaviour in Denmark may be explained by poor parenting (child abuse and neglect, child in care), and poor parental support (more separations) together with structural factors related to the family during adolescence (e.g. parental unemployment, increased income inequality). An increased part of the youth in Demnark was exposed to following risk factors: poverty, being incarcerated, having mental illness and substance abuse problems, which all, according to Christoffersen, were precursors of suicidal behaviour. A considerable part of the increase in suicidal behaviour in Denmark in this period was caused by constrains on young girls, even when other risk factors were taken into account (Christoffersen, 2009).

3.4 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population) (indicator 3.8.1).

The coverage of essential health services has been debated for many years also in Norway. In 1989 a discussion paper was commissioned from NIBR about the school health services, which seemed to be inadequate at that point in time (Kristofersen, 1989).

Both before that discussion paper was published – and probably later on - the discussions about maternal, newborn and child health services have been and will continue to be lively.

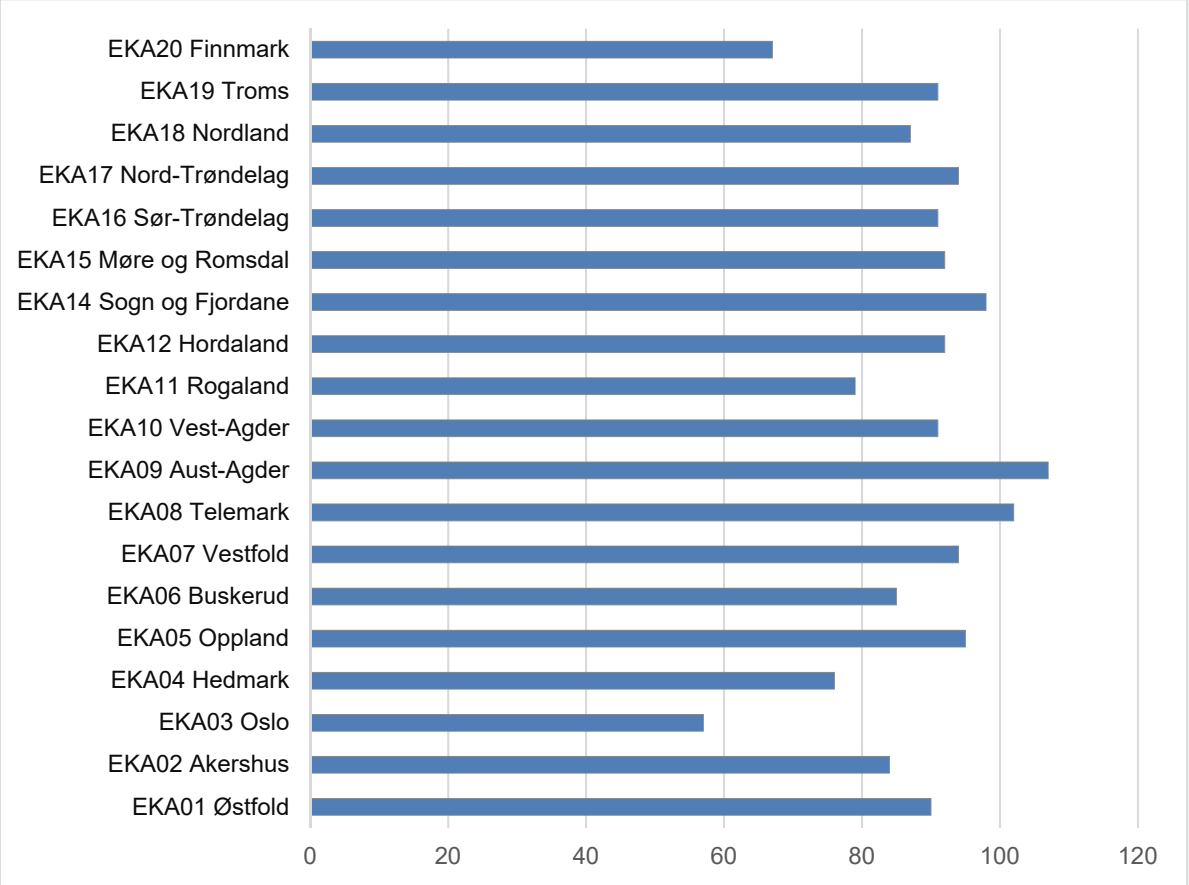
Norwegian statistics include the coverage of public health nurses in the municipalities and how many children that visit public health centre/public

[5] Data gathered during a 10-year longitudinal study of two birth cohorts of more than 145 000 young people born in 1966 and 1980.

health nurse at different age groups – vaccination included (Statistics Norway, 2016).

The most recent published website on this issue from Statistics Norway shows that 8 in 10 new-borns receive home visits from the public health centres. This percentage varies between city districts in the larger cities.

Figure 3. Share of newborn with visit from health nurse at home within two weeks after discharge from the hospital. Percentage. Counties. 2015. Source: SSB



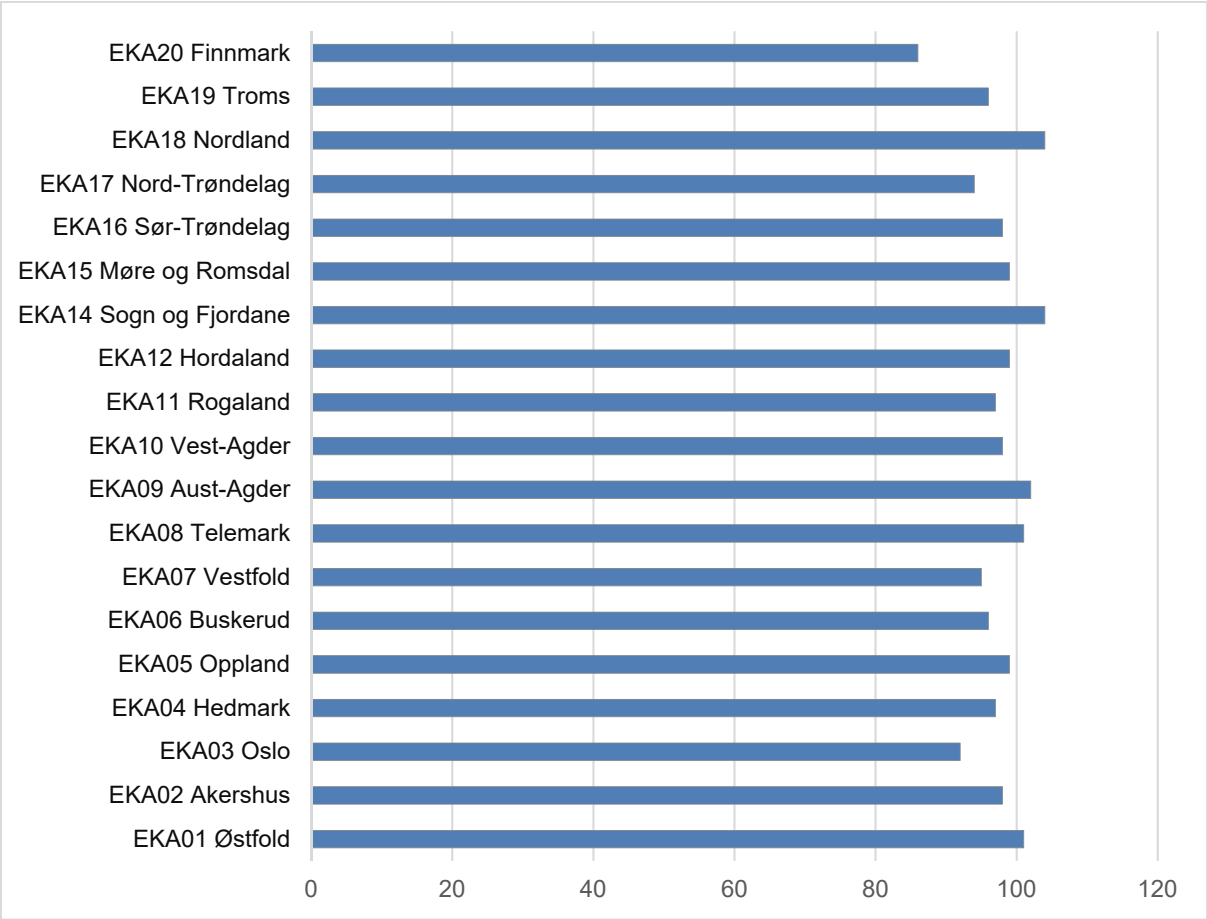
Source: Statistics Norway (Statistikkbanken).

As can be seen from figure 3, there are large variations between counties. That is a sure sign of the even larger variations within the 428 municipalitites[6] in Norway. Oslo is both a county and the largest municipality in Norway. In Oslo only 57 per cent of newborn got visits from health nurse within 14 days from hospital discharge. There was large variations in this measure between the 15 city districts (Source: Statistics Norway, tables downloaded early January 2017, not published here).

[6] The number of municipalities in Norway in 2015 and 2016 (as of 1. January 2017 the number is a bit lower, 426).

The regional variations in health examinations after eight weeks of living is not as large, this can be seen from figure 4. The most northern county, Finmark, is here registered with the lowest percentage: 85 per cent of the newborn had a medical examination in their municipality within their 8. week of living. Several counties/municipalities were registered with more than 100 per cent[7].

Figure 4. Share of newborn which have completed health examination within the end of their eight week of living. Per centage. Counties. 2015



Source: Statistics Norway (Statistikkbanken).

In addition to the statistics from the municipality health services from Statistics Norway, Norway has other quality health registers – one of them deals with the

[7] This might be explained by geographical movements (immigration or migration between counties/municipalities) and/or slow registratrion of new adresses. In counties/ municipalities/city districts with figures over 100, more infants in this age groups were examined than the number of newborns in the corresponding ages registered in this county/municipality/ district. Another possibility might be to low quality of this statistics (summary based, not based on personal identification numbers)?

situation around births and infants. One of the topics that has been researched the last years is early enhanced parenetral nutrition, hyperglycemia and death among infants with an extremely low birth-weight (Stensvold et al., 2015).

In Norway and other Scandinavian countries research gives some evidence that especially a disadvantaged part of the adult population have had some more problems in receiving medical care after periods of economic recession (Elstad, 2016). During The Great Recession, unmet need for medical care increased in Europe, and social inequalities in foregone medical care widened. Overall, countries with a more egalitarian income distribution have been more able to protect their populations, and especially disadvantaged groups, against deteriorated access to medical care when the country is confronted with an economic crisis (Elstad, 2016).

A focus on mental health

Several recent articles and reports focus on mental health in children and young people. Though young girls more often report having mental problems than before (Bakken, 2015; Bakken, Frøyland & Sletten, 2016). The extent of mental health problems are two to three times higher among girls than among boys. Another finding in the youth survey (Ungdata-survey) is that social inequalities in health are more evident among girls than among boys. Girls from the lower strata more often suffer from anxiety and depressive symptoms. For both sexes it is found that young persons in lower social strata more often experience physical ailments and use painkillers more frequently than young persons in general (Bakken et al., 2016).

Other research and supervisory reports from the authorities have focused on mental health problems for more disadvantaged groups, e.g. children and young persons in child welfare institutions (Helsetilsynet, 2015; Kayed et al., 2015)[8].

Mental health treatment is given to about 5 per cent of the population 0-17 years in specialized mental health services for children and adolescents each year (Helsedirektoratet, 2016). Very few children are hospitalized for such problems, most of them are treated in outpatient clinics (poliklinikker). There are large

[8] The Norwegian Board of Health Supervision (Helsetilsynet) is a national public institution organized under the Ministry of Health and Care Services, with responsibility for supervision of child welfare services, social services, and health and care services.

regional variations in the percentage of the child population who receive specialist mental health treatment both for 2016 and earlier years. Children in Northern Norway have the highest prevalence, with children in the Western part having the lowest. We also see large variations between age groups. Infants and small children are seldom given specialist mental health treatment (1-2 per cent), while about 7-8 per cent of youth aged 15-17 years receive treatment in outpatient mental health clinics each year (Helsedirektoratet, 2016).

Data from the 2013/2014 wave of the Health Behaviour in School-aged Children (HBSC) study are reported (UNICEF, 2016:8).

This report ranks 35 countries in terms of the size of the relative gap in children's self-reported health symptoms. For each country, the relative gap compares a child with frequent reporting of health symptoms and an 'average' child at the median of the health scale, with the gap measured as the difference between the two calculated as a share of the median. This captures the extent to which children at the bottom are allowed to fall behind the 'average' child in health [9] (UNICEF, 2016:9). The smallest relative health gaps are found in Austria (23.6 per cent), Germany (24.8 per cent) and Switzerland (25 per cent). Denmark, Finland and Norway also have comparatively small gaps in self-reported health. 35 contries were ranked on these indicators in this survey.

3.5 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services) (indicator 3.9.2)

This indicator is perhaps not very important for Norway.

We know that the Norwegian Public Health Institute work with registration/ research on unsafe water but mortality from unsafe water is almost non-existent in Norway (only incidence of different diseases, e.g. salmonella, are relevant). But climate change may perhaps lead to a higher risk of pollution of drinking water in the future, so the indicator should be supervised by Norwegian authorities.

[9] Students aged 11, 13 and 15 were asked how often in the previous six months they had experienced the following psychosomatic symptoms: headache; stomach ache; backache; feeling low; irritability or bad temper; feeling nervous; difficulties in getting to sleep; and feeling dizzy. The response options were "about every day", "more than once a week", "about every week", "about every month", "rarely or never". These responses are summed to produce a composite scale that captures the frequency of selfreported health complaints. It ranges from 0 to 32, where 0 corresponds to frequent occurrence of all eight symptoms and 32 refers to no health complaints at all.

CHALLENGES

The indicator must be supervised. Climate change may lead to more problems with drinking water in the future.

4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all (Goal 4)

ABOUT THE GOAL

This goal is also of high importance both worldwide and for Norway. A high proportion of Norwegian children get a good education and high shares reach university and university college levels. But we also still see a tendency that children and young people become marginalized while in pursuing their educational goals.

THE INDICATORS

4.1 Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex (indicator 4.1.1)

We are not aware of national statistics or surveys that measure the proficiency level in reading and mathematics for children in grades 2/3 (7-8 year olds) in Norway. If this indicator should be measured through the whole nation, surveys probably have to be started in a few years. Other countries ability to measure this indicator for a large number of girls and boys, are not known to NOVA.

Norway does have national proficieny tests for pupils in 5th, 8th and 9th grade in mathematics, reading and English. The Norwegian 5. graders (about 11 year olds) are best in the Nordic countries in mathematics, and the pupils in 9. grade (about 15 year olds) are in the middle compared to the other countries. This was stated from the Ministry of Education in a press release in November (Kunnskapsdepartementet, 2016; Utdanningsdirektoratet, 2016). The Norwegian newspaper Aftenposten refers 30. November in an article to the TIMSS[10]-report just published and the forthcoming PISA-report (the last one was expected around 6. December). Norway also participates in OECD's Programme for International Student Assessment (PISA) that measures 15 year olds scholastic performance in mathematics, reading and science.

[10] Trends in International Mathematics and Science Study.

The PISA-results for Norway were published 7. December 2016. Statistics Norway published a document on schoolbased and municipality based education indicators 8. December (Zachrisen & Steffensen, 2016).

Statics Norway has previous published *Facts about education 2016* (SSB Fakta om utdanning 2016)[11].

Several studies, both in Norway and in other countries, have shown that school results vary with parents' socioeconomic position. Here we will only refer to some examples (Bakken, 2010; Bakken et al., 2016; Sandbæk & Pedersen, 2010).

We see a socio-economic gradient in the possibilities of reaching various educational levels. Several projects have found that young adults with a previous child welfare experience (and often lower family income) have larger problems than a comparison group in achieving both secondary and university college /university educations (Backe-Hansen, Madsen, Kristofersen & Hvinden, 2014; Clausen & Kristofersen, 2008; Dæhlen, 2013; Dæhlen, 2015a, 2015b, 2015c, 2016).

Two Norwegian studies have shown that aftercare in child welfare probably contributes to an increased tendency for young people to attain higher levels of education (Bakketeig & Backe- Hansen, 2008; Kristofersen, 2009). But independent of this, the last study published found higher levels of education among young people with child welfare experiences until 2009 compared with an earlier study with child welfare experiences until 2005 (Backe-Hansen et al., 2014).

Also groups of young persons with functional impairments/various chronic health conditions experience difficulties in reaching their desired educational level (Grue & Finnvold, 2014).

CHALLENGES

For a few decades knowledge has been available about children and young people missing educational opportunities in Norway. Socio-economic differentials in illness/impairment, dyslexia, bullying, child welfare problems and other difficulties have been pointed at from research. Also today about 20-30 per cent in the young genereation will not succeed with their secondary

[11] *Facts about education 2017* (Fakta om utdanning 2017) was published 15. December 2016).

education (will not pass their necessary exams after 13 years of education). Several programs have been launched to tackle these problems. Early intervention in kindergarten/school has been identified as being important to prevent severe social problems at a later stage in life. Some young people receive their first intervention when they are in their 10.-12. Grade. For some of them intervention in this age group is late.

5 Achieve gender equality and empower all women and girls (Goal 5)

ABOUT THE GOAL

This goal is of importance also in Norway, even though the Nordic countries in many respects have more gender equality than many other countries worldwide. High shares of small children in kindergartens makes the possibilities easier for both women and men to continue with their (higher) education and to stay in work even after they have got children. Empowering girls and women is important because physical, sexual and psychological violence in childhood is more often reported by young women than among young men.

THE INDICATORS

5.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (indicator 5.2.1)

5.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence (indicator 5.2.2)

In a Norwegian study conducted in 2013 interviews with 16- and 17 year olds about childhood experiences with violence and rape. 1 012 girls and 1 050 boys took part in the survey. The telephone interview had detailed questions about violence and abuse in addition to questions regarding mental health and sociodemographic conditions (Myhre, Thoresen & Hjemdal, 2015).

- One out of ten young persons reported that they had been exposed to some sort of physical violence from their parents (9,6 %)
- The majority of these had been exposed to less serious violence (7,8%)

- Serious violence was experienced more seldom (1,7%)
- Girls and boys had experienced about the same degree of physical violence from their parents
- About 1 of 5 of the children that had experienced physical violence from parents had experienced violence from both parents
- A total of 6,6% experienced psychological violence from superiors during their childhood (10 per cent of the girls and 3,3 per cent of the boys)
- A total of 8,5 % reported one or more forms of lack of care during their childhood. The experience here was the same for girls and boys.
- A total of 13,3 % of the girls and 3,7 % of the boys reported having experienced any form of sexual assault (seksuelt overgrep) during their life.
- A total of 3,4 % had been sexually assaulted in a way the Norwegian law defines as rape

Several Norwegian researchers have commented on difficulties with the necessary permissions to conduct research with children 15 years and older when it comes to physical, sexual or psychological violence (G. Dyb et al., 2016). The Norwegian health research legislation is questioned about its age limitations. In Norway you can decide on your own if you will have a specific treatment when you are sixteen years old (the 'medical age of majority', but not decide on your own whether to take part in research projects involving serious questions about abuse etc. – then your parents will have to give their consent as well).

In Norway a research project that was granted by Norwegian authorities (Bufdir) to question young persons (under 18 years) about their experiences with violence and sexual assaults, was not granted permission (NOVA[12]; source senior researcher Svein Mossige) by the Norwegian Data Protection Authority. The appeal to the Data Protection Tribunal Norway did not change this decision.

NOVA could not complete this study because both The Norwegian Data Protection Authority (Datatilsynet) and later the Data Protection Tribunal required parental consent if children under 18 were to participate in the survey. NOVA's project manager concluded that it was not possible, due to

[12] Source: Senior researcher Svein Mossige.

professional, ethical[13] and other reasons, to seek parental approval for participation in a study where one asks if the children are exposed to violence and / or threats from their parents, or if they have been witnesses to violence between parents. NOVA had received funding from public authorities[14] to do this study, but were not able to implement the proposed method because of the current privacy rules and regulations for conducting research involving minors.

Later a similar study of 18-year olds was launched and a report was published (Mossige & Stefansen, 2016). This study compared results between 18-year olds males and females in Norway in 2007 and 2016. The study and the results of this study are described in more detail in section 16.3 – 16.5 in this discussion paper.

CHALLENGES

The previously mentioned study with 16 and 17 year olds in Norway showed that one out of ten had experienced violence from their superiors during their childhood. Nearly 2 per cent had experienced serious violence from superiors. Nearly 4 per cent had experienced sexual assault equal to rape (as defined in Norwegian law) by some person in their childhood.

8 Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all (Goal 8)

ABOUT THE GOAL

This goal is also of high importance. Both necessary and diversified working places for the young and adult population, and proper restrictions against letting very young children work are necessary to maintain and develop a good and healthy work life.

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[13] For example, endangering the child. Similar arguments are used by other agencies involving adults. An example is the requirement to notify persons convicted of violence when an application for research related to their victims is submitted. NOVA-researchers find it difficult to understand that regulatory agencies (including public data owners) for privacy concerns want people convicted in cases of violence and / or violent offenders notified of research, when this could lead to further risk for past and / or present victims.

[14] The Norwegian Directorate for Children, Youth and Family Affairs.

8.1 Proportion and number of children aged 5-17 years engaged in child labour, by sex and age (indiactor 8.7.1)

Although child labour was relatively common in Norway earlier, Norway imposed restrictions on child labour as early as in the beginning of the 20th century.

Current Norwegian statistics from Statistics Norway do not include children under the age of 15 who work.

A recent article in a Norwegian journal for family and child law, is about 'de castbergske barnelover' (the Castberg Children Acts) and six different acts are covered in the article (Asland, 2016). Among the acts described, the author Asland, also mentions a lesser known but quite as important law that was initiated by Castberg in Norway in 1915 (the Act of 18. September 1915). The law is about protecting workers in industrial work environments. This Act was seen as a break-through in the struggle against child labour, by prohibiting children under the age of 12 in general to work in industy. Before this law was passed child labor was quite common in Norway.

> «..En mindre kjent, men vel så viktig lov for barn som ble initiert av Castberg i 1915, nemlig lov av 18. september 1915 om arbeiderbeskyttelse i industrielle virksomheter. Denne loven var et gjennombrudd i kampen mot barnearbeid, med et generelt forbud mot at barn under 12 år kunne arbeide i industrien. Før loven var barnearbeid svært utbredt i Norge, særlig i fyrstikkindustrien, tobakksindustrien og tekstilindustrien». (Asland, 2016:3)

Asland also discusses in the book about Castberg, edited by Andersland, other relevant questions about child labour (Andersland, 2015).

Elisabeth Gording Stang discusses as part of her chapter in this book, the new Constitution of Norway (Grunnloven § 104 – en styrking av barns rettsvern?) in relation to children's rights to health, development and economic security[15] (Stang, 2015).

Another view is presented in another article, in a different journal, that discusses children and young people being care takers of parents with different types of diseases, often related to mental health and addiction problems (Kallander, 2010). We do not know the amount of this unpaid care work in

[15] Part 7 'Retten til helse, utvikling og økonomisk trygghet', pp. 132-134.

which children take part, but it should be considered a type of 'child labour' – especially in cases in which the child has not received help from the authorities (Grinderud, 1992).

CHALLENGES

Even if child labour is not very common in Norway, there are probably some unregistered forms of child labour (in shops, farms, other places). According to The Norwegian Labour Inspection Authority, children under the age of 13 are allowed to do light work such as harvest potatoes, pick berries and help take care of animals on family farms.

One journal article mentions care for other persons in the household (parents with diseases/drug addiction, younger siblings) as part of the child labour issue.

11 Make cities and human settlements inclusive, safe, resilient and sustainable (Goal 11)

ABOUT THE GOAL

In Norway, most settlements have been both inclusive and safe for quite a while. It is although of importance to maintain settlements both inclusive, safe and make them more resilient and sustainable.

THE INDICATOR

11.1 Proportion of urban population living in slums, informal settlements or inadequate housing (indicator 11.1.1)

In this field there are no official statistics in Norway. The problem has been subject to research in several surveys since the year 1996. The last survey published was conducted in 2012. Previous studies were conducted in 1996, 2003, 2005 and 2008.

In 2012, a research survey Dyb, Johannesen, Lied & Kvinge (2013:5-8) estimated that there was a population of 6.259 adult homeless persons in Norway (1,26 per 1000 adult population). The survey also investigated if the adult person without housing had daily responsibility for children under 18 years.

A study of homelessness in Norway in 2012 registered if the homeless person had children who were minors (younger than 18 years of age), if the homeless was with their children in the situation of being without a home, or if they had other forms of contact with the child/children (see chapter 1.3 as

well). Table 6 (table 2.8 in Dyb et al.) shows the proportion of homeless that have children under the age of 18 by size of municipality in the four municipal groups and nationally. (Dyb et al. 2013, pp. 18-19, our translation).

Table 6 Homeless persons with and without children in four types of municipalities 2012. Percentage.

Children under 18 years	Large cities	More than 40.000 inhabitants	10.000-39.999 inhabitants	Less than 10.000 inhabitants	Total
Have children	26	28	30	37	29
Do not have children	66	67	64	60	65
Do not know / unanswered	9	5	6	3	7
Total	101	100	100	100	101

Source: Dyb, Johannesen, Lied & Kvinge, 2013, tabell 2.8).

29 per cent of all the homeless have children, who are minors. There are large differences between the types of municipalities. The extremes were between the large cities and the smallest municipalities. About 25 per cent in the 4 major cities and 37 per cent in the group of the smallest municipalities had children who were minors. The other municipal groups were in-between. This does not imply that there are more homeless people with children in the smaller municipalities than in the larger municipalities. Homelessness is most comprehensive in the major cities and in the larger municipalities, both in actual numbers and relative to the population, and most minor children live in the larger municipalities.' (E. Dyb et al., 2013)

CHALLENGES

Especially in some of the larger cities, it is important to have better and more coordinated registration of the dwelling situation of children and young people both in poor families and in other types of marginalized situations.

12 Ensure sustainable consumption and production patterns (Goal 12)

ABOUT THE GOAL

The goal has several targets. UNICEF Norway has chosen one of the indicators to be reviewed in this discussion paper.

THE INDICATOR

12.1 Extent to which (i) global citizenship education and (ii) education for sustainable development (including climate change education) are mainstreamed in (a) national education policies; (b) curricula; (c) teacher education; and (d) student assessment (indicator 12.8.1)

The specifications in the Norwegian curriculums for primary schools that involve sustainable development seem to be rather vague. Local authorities and teachers are given a lot of freedom to develop the content in these subjects.

The following are two examples that include an aspect of / element of sustainability in the curriculum for 3.-4. Graders. The first is from the area of natural sciences (NOVA has been in contact with Oslo municipality regarding this question).

Example 1 Main topic diversity in nature.

> A main focus in the topic is the development of knowledge about and respect for nature's diversity. Knowledge about ecosystems' biotic and abiotic factors are important in order to understand interactions in nature. Another important aspect are the prerequisites for sustainable development, human's place in nature, and how human activities have changed and continue to change the natural environment locally and globally. Fieldwork is a good foundation for knowledge and attitudes in this field.

Example 2 Main topic Technology and design.

> This topic is about planning, developing, producing and assessing functional products. The interaction between natural sciences, technology and sustainable development is central to the area. Technology and design are multidisciplinary topics in science, math, art and crafts.

CHALLENGES

There are curricula for 'education for sustainable develompent' in primary schools in many of the Norwegian municipalities. One would probably have to do an evaluation to find out how well and to what extent, the students and their teachers, experience that the objectives are accomplished.

16 Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels (Goal 16)

ABOUT THE GOAL

This goal, Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels, is important and has several targets. The indicators chosen by UNICEF Norway for this discussion paper are the following:

THE INDICATORS

16.1 Number of victims of intentional homicide per 100,000 population, by sex and age (indicator 16.1.1)

The Norwegian Institute of Public Health has, as previously mentioned, the responsibility for The Cause of Death Register in Norway, and for the official statistics in this field nationally.

This institute has an online version of the register – where researchers, health personnel and other professionals can make their own tables from the period 1996-2015.

There are some problems in interpreting the tables when it comes to homicides in children.

When one of the tables was downloaded, it did not seem to be homicides ('drap' – ICD numbers not stated) in children and young people (0-14 years) as we assumed (see table 7). In age group 15-19 years[16] 53 young people died as victims of homicide in 2011. (Many or most of them probably were victims in the 22. July 2011 terrorism act at Utøya (or a few victims in the Government Offices (Regjeringskvartalet)) (NOU, 2012:14). Four other young people in the same age group died of homicide in both 2000 and 2001. According to this table 61 young people died of homicide (rates in 100 000 population for these age groups are not presented for this cause of death – but might be ordered from the National Public Health Institute).

[16] It is not possible to extract "children" under the age of 18 from the aggregated age group in the table (without special application to the institute).

Table 7 Deaths due to homicide as underlying cause of death, 1996-2015. All age groups (total), and age groups under 1 year, 1-4, 5-9, 10-14 and 15-19 years. Absolute figures (table D1: in Cause of Death Register, the Norwegian Institute of Public Health)(reading date 07.12.2016)

Cause of death	Age-groups	Year of death																				Sum
		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	1996-2015
Homicide	All age groups – adults included in total	47	42	44	38	53	33	40	48	39	29	45	33	27	31	33	114	31	51	31	21	830
	Under 1 year	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
	1-4 years	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
	5-9 years	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
	10-14 years	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
	15-19 years	-	-	-	-	4	4	-	-	-	-	-	-	-	-	-	53	-	-	-	-	61

Table 8 Deaths among children 1-17 years due to homicide, assault and some other underlying cause of death (ICD-numbers X85-Y09, Y871) 1996-2015. Age groups 1-4, 5-9, 10-14 and 15-17 years). Absolute figures. (Source: Cause of Death Register (table D9), the Norwegian Institute of Public Health)(reading date 07.12.2016)

Cause of death	Age-groups	Year of death																				Sum
		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	1996-2015
Homicide, assault (X85-Y09, Y871)	Age groups 1-17 years	4	5	3	3	8	4	4	4	-	-	6	5	3	1	4	33	1	3	4	1	96
	1-4 years	1	1	1	-	2	1	-	2	-	-	2	-	-	-	1	-	-	1	2	-	14
	5-9 years	1	2	-	-	3	2	1	-	-	-	1	2	2	-	3	-	-	-	-	-	17
	10-14 years	2	1	-	1	1	-	3	1	-	-	2	2	-	-	-	2	-	-	1	1	17
	15-17 years	-	1	2	2	2	1	-	1	-	-	1	1	1	1	-	31	1	2	1	-	48

From another table, however, we find a different picture. This is a table with specific focus on children and young people (1-17 years). We have presented a part of the table, the part with 'Homicide and assault' in the left column (table 8)[17].

In table 8, deaths from homicide and assault (only absolute figures) is presented for each of the years 1996-2015 for the age groups 1-4, 5-9, 10-14 and 15-19 years.

Table 8 lists more homicides and assaults on young persons than the homicides in table 7. For the time being, it seems as an open question if, how, and when the murdered children were registered as murdered, i.e. due to the cause of death. The reason is that this particular cause of death has emerged years later, due to the delay of sentencing in the court system (a few example cases will be presented later in this discussion paper). Are such cases later on corrected in The Cause of Death Register?

According to table 8, 14 children aged 1-4 years died because of homicide and assault through all the years 1996-2015 (less than one child each year in average). In the age group 5-9 years, the table shows 17 registered deaths during this 20-year period (also less than one child each year in average). In the group 10-14 years, 17 deaths were registered in the period. In the age group 15-17 years, 48 deaths from such causes were registered – of these 31 died in 2011[18].

Thus a total of 96 dead children in homicide and assault were registered during the years 1996-2015.

A major Norwegian newspaper, Aftenposten, published an article about this issue the 18. November 2016. In the article they quoated a Professor in Forencics.

They wrote (NOVAs translation):

> "Especially violence towards infants is difficult to comprehend. It's easy to make excuses and avoid drawing the correct conclusion. But such violence is exercised. Professor Torleiv Ole Rognum at the Department of Forensic examination of children at the NIPH said that

[17] A similar table was earlier made annually by Statistics Norway in the period when they were responsible for the cause of death statistics.

[18] The terror attack at Utøya in 2011 is included here. Please note that in this table (8) the *15-17 year* age group is published. In the previous table (7) the age group published is *15-19 year*.

> every year eight to ten children die in Norway as a result of neglect, maltreatment and murder. According to the Professor, most of them are killed by their closest caretakers. That there often are no neutral witnesses, makes police investigations very difficult in such matters. In addition, approximately ten infants get fatal injuries annually because of abuse in their home. Some become crippled for life. The most common cause of injury is called shaking. Children who survive abuse, are not infrequently sent home after medical treatment, says Rognum. ... "

According to Rognum's statement to Aftenposten in November this year, the numbers in the table are low for the youngest children (8-10 children in 20 years means 160-200 child deaths due to these causes – serious maltreatment/lack of care are probably not included in the homicide figures). Figures are not published in table 8 for infants (under 1 year olds). Even if a line is published for the infants in table 7, the results are zero deaths from this cause the whole 20 year period.

In a PhD-thesis defended and published earlier this year, filicide in Norway was analysed (Ottesen, 2016). The study defined filicide as caretaker perpetrated child homicide where the victims were less than 18 years of age. Included in the definition of caretakers were genetic parents, stepparents (including current and former intimate partners of the generic parent, and adoptive and foster parents. The study used the National Criminal Investigation Service (NCIS) national archive of homicides, where the perpetrators have been convicted for intended murder, including incidents where the perpetrator is adjudicated 'not guilty by reason of insanity' and incidents where the perpetrator committed suicide in conjunction with the homicide. There were 39 confirmed incidents of filicide with as many perpetrators in Norway during the years 1990-2009. There were in total 48 children and 11 partners or former parents of the perpetrators who were killed in these incidents (Ottesen, 2016).

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Swedish authorities publish a report about these issues regularly - how many children, die or are hospitalized due to accidents, violence and self-destructive actions (Socialstyrelsen, 2015). This last report presents data from three different registers: The Swedish Cause of death register, The Swedish Patient Data Base and the Swedish Injury Database. In the analyses, they make

relevant and reliable connections between the situation when it comes to both violence against children and suicide/self-harm in children and to a larger degree than comparable Norwegian analyses.

This type of report is not made for Norway. It should be possible in the future, with Norwegian health register data both from hospitals and from other part of the health services, to make a report of the same type for Norway? Might a larger number of health registers in Norway – and more bureaucracy regarding the use of data in research, make it more difficult to make a corresponding report here? The Minster of Health and Care Services has noticed some of the problems with use of the Norwegian registers, and a governmental commission is currently writing a report on these general problems [19].

A public inquiry after the death of an eight-year-old girl in England (Laming, 2003), lead to major changes in British child protection and other services. In contrast, in presenting Norwegian national longitudinal studies in 2005, disclosing mortality in young people with earlier child welfare experiences and mentioning the British case, professionals in the audience maintained that such a case as Victoria Climbié 'could not happen in Norway'.

Some years later Norway experienced a similar case, eight-year-old Christoffer. He was seriously injured by his stepfather (2005) and died shortly after from head injuries. First the police case was closed and the death of the boy was diagnosed as self-inflicted harm leading to his death. The Prosecutor General later reopened the case after the police had closed the case (Gangdal, 2010). Subsequently the stepfather was sentenced and convicted to several years in prison. Also the boy's mother was charged and sentenced for not protecting the boy well enough from the stepfather. There have been other known cases of children being maltreated and murdered in Norway both before and since the Christoffer case (Kristofersen, forthcoming 2017).

Also in another case, Monika; the death of an eight-year-old girl who was, according to newspaper articles and a book, first categorized by the police with suicide/self-inflicted harm. A police investigator in Bergen worked tiredlessly to have the case reopened. After a period of more than a year, he succeeded in having the case reopened (Schaefer, 2015). Later, a

[19] https://www.regjeringen.no/no/dep/hod/org/styrer-rad-og-utvalg/helsedatautvalget/id2503765/

former adult friend of the eight-year-old girl's mother was sentenced to fourteen year in prison for the murder of the young girl.

In 2016 the Director of Public Prosecutions sent a letter to the Public Prosecutors and The Prosecuting Authority in the Police with advice and orders titled "Report about the Monika case " about how to deal with these types of cases in the future. That the authorities are giving violence against children and domestic abuse priority is demonstrated by the fact that Circular 1/2016 Objectives and Priorities, from the Director of Public Prosecutions, had this as one of the priorities especially mentioned in the circular.

The question is, as mentioned above, whether these later cases and convictions lead to corrections in The Cause of Death Register (there are several more cases).

16.2 Conflict-related deaths per 100,000 population, by sex, age and cause (indicator 16.1.2)

This indicator is difficult to analyse separately from the previous indicator. It seems that some causes of deaths are diagnosed as 'assault' and others as 'homicides'. It seems like The Cause of Death Register has problems up-dating the causes of death for children who are killed in homicides. Perhaps this is because the court system, and sometimes also the police investi-gations, take place a year or several years after the child's death (see for instance the Norwegian cases of Christoffer, Monika, and others – some of them mentioned in newspaper articles, others also in Norwegian books (C and M)). This is a preliminary hypothesis; but it has to be followed up in a future debate - when "Barnevoldsutvalget"[20] (see more about this below) delivers its Official Norwegian Report (NOU) in 2017.

5. December 2016 a boy (14) and an adult woman were fatally injured when stabbed by a knife in a Norwegian town. Both of them died in the hospital few hours after the attack. Two days later another boy (15) was charged with the assault. It would be of interest to follow these cases both in regard to the categorization of the causes of death in The Cause of Death Register and in criminal court decision/child welfare decisions. The law regulating privacy protection protects details. The question is wether the

[20] A government appointed committee, which is looking into serious cases where children and youth have been victims of violence, sexual abuse and neglect.

cause of death will be homicide (if a sentence is not ready) or assault/conflict related death? It seems that when children are in focus (as victims or offenders) the homicide-concept is not always used.

Some of these problems are dealt with by the Barnevoldsutvalget [21].

The Barnevoldsutvalget has been granted access to confidential information[22] in order to study current cases involving children.

The report from the Barnevoldsutvalget was due by the end of 2016, but they have probably been given an extension until spring 2017, since it has not been publicized yet.

16.3 Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months (indicator 16.1.3)

There is no regular census regarding persons subjected to physical, psychological or sexual violence in the previous 12 months in Norway. The percentage subjected to physical violence for the whole population (in the previous 12 months), is known from a national prevalence study with a life course perspective (Thoresen & Hjemdal, 2014). They conducted a cross-sectional study of Norwegian men and women from 18 to 75 years of age during the spring 2013. Altogether, 2 435 women and 2 092 men participated in the telephone interviews. Some of the results concerning physical violence and sexual violence/assault the previous 12 months and at any point during their life, are referred to here:

- A similar proportion of women (5,0 %) and men (6,0 %) reported 'less severe' physical violence the last 12 months (slapping, hair pulling, scratching, pinched hard). Younger men and women were more frequently exposed than older men and women.
- More men (45,5 %) than women (22,5 %) had experienced severe physical violence at least once after the age of 18 (hit with a fist or an object, kicked, strangled, beaten up, threatened with a weapon, or attacked physically in other ways).

[21] https://www.regjeringen.no/no/dep/bld/org/styrer-rad-og-utvalg/eksisterende/barnevoldsutvalget/id2470018/

[22] https://www.regjeringen.no/no/aktuelt/gir-barnevoldsutvalget-tilgang-til-taushetsbelagt-informasjon/id2500617/

- 13,9 % of males and 11,2 % of females and at least once after the age of 18 experienced severe physical violence where they were afraid of being severely injured or killed.
- The prevalence of lifetime rape was 9,4 % in women and 1,1 % in men.
- The prevalence of any sexual contact before the age of 13 with a person at least five years older was 10,2 % for women and 3,5 % for men.

(Thoresen & Hjemdal, 2014)

16.4 Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month (indicator 16.2.1)

This indicator is partly reviewed and discussed before (indicator 5.2.2) in this discussion paper. We have not been able to find a good indicator of this type for small children in Norway.

16.5 Proportion of young women and men aged 18-29 years who experienced sexual violence by age 18 (indicator 16.2.3)

One study had been able to conduct interviews with Norwegian 16- and 17-year olds about violence and rape in childhood ((Myhre, Thoresen & Hjemdal, 2015). Results from this study were referred in paragraph 3.

No statistics or surveys are available about these issues for more extensive age groups of youth.

Although two surveys with 18 year olds were conducted in 2006 (Huang & Mossige, 2015; Mossige & Huang, 2010; Mossige & Stefansen, 2007, 2008) and 2015 (Mossige & Stefansen, 2016).

NOVAs survey from 2015 (Mossige & Stefansen, 2016:107) showed that 21 per cent of the participating youth had experienced physical violence from at least one parent during their childhood.

The proportion that had experienced severe forms of violence from at least one parent (hit with fist, hit with object, been beaten) was six per cent – significantly lower than the experience of all forms of violence.

In total eight per cent of the young persons reported that they had seen or heard one of their parents being exposed to physical partner violence at least once. The proportion that had seen or heard severe violence to one of their parents, was lower: four per cent.

In total 23 per cent reported that they had experienced at least one form of sexual violence during their childhood. Girls are more exposed than boys (Mossige & Stefansen, 2016).

In the report, findings about the youths' experience with violence and sexual offenses are compared with findings from a similar survey in 2006, also conducted by NOVA (Mossige & Huang, 2010; Mossige & Stefansen, 2007). The 2007-report is based on responses from about 7 000 senior students at 67 high schools in Norway. The study deals with three main forms of violations of children and youth, focusing on risk factors and also possible consequences associated with each of the three forms of violations. The three forms of violations examined were 1) direct violence from their own parents, 2) to see or hear violence directed at their own parents, 3) sexual abuse. Most Norwegian youth grow up without having experienced these forms of violations. Relatively many have experienced mild forms of offenses. 25 percent had experienced at least one incident of physical violence from a parent, while seven percent had (ever) experienced physical violence from both parents. Relatively few had experienced what the survey defines as serious violations. Eight percent had experienced severe violence from at least one parent, while two percent had experienced such violence from both parents. Very few (half a percent) had experienced both severe violence, witnessed coarse violence and serious sexual assaults. Financial problems in the family, alcohol problems among the adult family members and having a minority background were associated with an increased risk of experiencing direct violence from parents, witnessing violence and sexual abuse. Experiences of sexual abuse increased the risk of these consequences: Self-destructive behavior in the form of: suicide, self-mutilation, antisocial behavior. The survey also found that sexual abuse was related to having their own sexual problems later in the form of: Early sexual debut, selling sex, having multiple sexual partners, forcing others to have sex (concerned only severe sexual offenses), as well as psychological problems such as poor self-esteem (after severe sexual abuse), anxiety, depression and dissociation. Severe violence from both mother and father increased the risk of reporting depression. Severe violence from the father increased the risk of reporting eating disorders, anxiety and dissociation. Severe violence from the mother increased the risk of suicide. To have witnessed severe violence against the father and aggravated assault against the mother increased the risk of

reporting suicide attempts, depression and dissociation. To have witnessed severe violence against the mother also increased the risk of reporting anxiety (Mossige & Stefansen, 2007).

Since the consequences often are severe for children and adolescents who have been exposed to violence and neglect, the "Barnehus" ("Childrens-houses") have a very important function. Barnehus were started in Norway in 2007, modeled after the Barnahus in Iceland. The "Barnehus" interviews with children are facilitated and conducted by specially educated and trained police investigators. The forensic child investigative interview is recorded on video and via a link the defender, child welfare employee and other specialists (psychologist) may follow the interrogation. The video is used if there is a trial, so that the child will not have to explain her/himself several times. Services such as the Child Welfare Services and health/ forensic services are also present to offer the child assistance in a single location. Barnehus in Norway have been evaluated by NOVA and the Police Academy in two reports in 2012 (Bakketeig, Berg, Myklebust & Stefansen, 2012; Stefansen, Gundersen & Bakketeig, 2012). A Nordic book about the Barnehus-model is forthcoming in 2017 (Johansson, Bakketeig, Stefansen & Kalldal, forth-coming 2017)[23].

Police statistics are difficult to analyse regarding how many children and young people younger than 18 years of age, have been victims of violent crimes. This issue has also previously been criticized by the Norwegian Ombudsman for Children and by Grønnningsæter and Stave (Grønningsæter & Stave, 2015).

Denmark has more extensive registers. In Denmark, not only young people charged with a crime are registered in the statistics. But also victims of reported crimes, including children and young people, are registered. These data are of such good quality that The Danish National Centre for Social Research (SFI) in Copenhagen is conducting research using the register data on young adults charged with violent crimes against children/youth[24].

[23] Two of the editors, Bakketeig and Stefansen, are researchers at NOVA working with The Domestic Violence Research Program.

[24] Personal communication with Senior Researcher Mogens Christoffersen at The Danish National Centre for Social Research, SFI, Copenhagen, 15.-22. November 2016.

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Even if the Norwegian Cause of Death Register data generally is considered to be of good quality, we find signs that causes of death from homicide is reported differently in two different tables from The Cause of Death Register in the Norwegian Public Health Institute. Homicide of children and infants is very rare in Norway, but there have been some cases in the last few years that have caused debates about children that were murdered (with later convictions of a mother, a stepfather and of former friend of one mother). We have seen that children in different age groups have initially been registered with self-harm/suicide instead of homicide. The public debate after such serious cases has also partially focused on the insufficient cooperation between health services for children, the Child welfare Services, the school system and the police.

Norway has good surveys regarding 18-year-olds experience of domestic violence during their upbringing (based on what they can remember when they are 18 years old). But we lack good data for children and younger persons.

Research has been planned for younger age groups. A NOVA-survey was denied permission to be conducted by both the Norwegian Data Protection Authority and from The Data Protection Tribunal. This was due to the Norwegian Privacy Protection Regulations and research regulations concerning children and young people under 18.

We also, as earlier criticized by the Norwegian Ombudsman for Children, lack good data on children and young people being victims of violent crimes. Denmark has statistics about victims of violent crimes (children and young people) with such good quality that the data are used in social science research. With the Norwegian personal identity numbers and central population register[25] it should be technically possible – with good enough reporting practices – to make such statistics/ research also in Norway in the future.

The privacy protection bureaucracy is more comprehensive in Norway than in Denmark, which makes it more difficult to manage research based on data from various public databases in Norway. This is obvious in regards to public health research involving children, researching violent crimes against children and research about child welfare services [26].

[25] The central person register systems have similarities in all the Nordic countries.
[26] Several discussions with both other Norwegian researchers (in medicine, child welfare and social science) and Danish researchers (child welfare and criminology) during the autumn 2016.

Conclusion and suggestions

The international work with the UN Sustainable Development Goal Indicators is important – when it comes to children's situation globally –as well as Norway. It has been interesting for NOVA to take part in the discussion about what actual knowledge we have (selected indicators for Norway) in this discussion paper commissioned by UNICEF Norway.

Even though most children in Norway have excellent living conditions according to international overviews, a proportion of children both in Norway and other Nordic countries experience considerable challenges on some of the indicators. Norway is a rich country with both a relatively comprehensive welfare system and well dispersed welfare. The country has well developed public welfare statistics. The quality of public statistics in general is good. Norway has a relatively long tradition of doing research about children. The findings mentioned earlier in this discussion paper demonstrate that even Norway will face challenges concerning the lack of ability to report on some of the UN-suggested indicators for children.

The Norwegian authorities are aware of some of the problems disadvantaged children in our country have. In addition to various action plans (Barne- likestillings- og inkluderingsdepartementet, 2015; Justis- og beredskapsdepartementet, 2013), the White Paper on the long-term plans for research and higher education also highlights some of these groups: Children in the Child Welfare Services and disadvantaged groups of young adults (Meld. St. 7, 2014-2015).

While NOVA worked with this document new knowledge (public statistics, surveys and research of relevance) was being published. NOVA and UNICEF Norway agreed that 15. November would be the final date for inclusion of new knowledge, but we have also included a few studies published in December 2016.

Child poverty

Child poverty is a great challenge in Norway as in other countries. Especially a rich country like Norway should be able to decrease child poverty, but despite the efforts of different governmental administrations and parliaments

the last 10-15 years, Norway has not succeeded in decreasing the proportion of children living in poverty.

Several action plans have been launched. Hopefully the latest action plan can have an impact, but if Parliament is not willing to listen to an important message from research, to raise the Child Benefit (the Child Benefit has not been price adjusted since 1996), it seems difficult to reduce child poverty with for instance 50 percent.

Health of children and young people

The communicable diseases, especially AIDS/HIV, but also tuberculosis, are relatively uncommon in Norway. But the incidence rates of tuberculosis have not been reduced in later years. The quality of the data seems to be good, as well as their potencial [27] for use in research on communicable diseases in Norway.

Other challenges are related to mental health problems, suicide, homicide and assaults in Norway. Several research findings the last few years show that we do not deal well with children and youth that have mental health problems, especially not those in the more disadvantaged groups. Suicide among young persons seems to remain at about the same level the last years, but more specified analyses and updated research is needed.

When it comes to homicides and assaults we have found indications of inconsistencies in the use of categories when deaths are classified in The Cause of Death Register, as illustrated by the mismatch between figures in two of their tables. Perhaps the report from the Barnevoldsutvalget which is expected to be presented soon, may contribute to a clarification. This issue still has to be addressed by the Norwegian Public Health Institute. Since it is difficult to get permission to do research on violence towards children under 18 years of age in Norway, it is very important that The Cause of Death Register and other health registers publish more details about how they construct their data bases/statistics with regards to children. Another problem addressed by NOVA in 2013 to four different Ministries, is the need for better education, and perhaps also revisions, of the many different laws regulating

[27] With the previous mentioned problem: 'Long waiting lists' to get all the permissions needed to conduct register based health and social science research – problems dealt with by Helsedatautvalget since August 2016.

how cooperating public service providers implement their rights and duties regarding confidentiality and disclosure (Stang, Aamodt, Sverdrup, Kristofersen & Winsvold, 2013)[28].

Education of children and young people

In Norway, a very large proportion of the child population learn how to read, write, and do mathematics [29].

Some children have learning problems and still have difficulties reading, writing and doing mathematics after compulsory school (10 school years in Norway). Many young people start in secondary school, second level (11. grade), but about 30 per cent do not succeed in getting through the 11-13. grade (completion of the second level of secondary school is necessary to receive exam papers). Some children have too much absence from different school-subjects or not enough attendance in secondary school to receive grades/get their full exam.

Even if Norwegian children/ youth have improved their PISA-results during the latter years, there also is concern about children not enjoying school.

Many young people start studying at universities or university colleges, and a large part succeed getting their academic degrees and get relevant jobs. But an increasing part of the child and youth population meet difficulties in the transition from youth to adulthood: getting the "right education" and finding and keeping a job. Even if the unemployment rate in Norway is relatively low in a European context, research shows that some groups have difficulties in the labour market (for instance there has been a relatively sharp increase of young persons that receive disability pension the last 4-5 years).

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[28] The following Ministries commissioned the report (2012) that they received March 2013: Minstry of Health and Care Services, Ministry of Children and Equality, Minstry of Education and Research, and Minstry of Justice and Public Security. The report has through the period March 2013 – December 2016 been publically debated on several occasions.

[29] In primary and lower secondary education they learn Norwegian, mathematics, social science, Christianity, religion and ethics education (CREE), arts and crafts, natural science, English, foreign languages/language in-depth studies, food and health, music, physical education, student council work and optional programme subject (The Norwegian Ministry of Education and Research).

Violence against children and young people

A survey from 2015 showed that he proportion of 18-year-olds that had experienced severe forms of violence from at least one of their parents (hit with fist, hit with object, been beaten) during their childhood/youth, was six per cent.

This proportion was significantly lower than those who had experienced any of the forms of violence - 21 per cent.

Severe forms of violence to children and youth had not been reduced in Norway (reported in 2015) when we compared with the results in a similar survey that took place in 2007.

Norway has good surveys regarding the 18-year-olds experience with domestic violence during their upbringing. But we lack good data for children and younger persons. Research has been planned and conducted for younger age groups. Other projects have been stopped, as the one survey that was denied permission from both the Norwegian Data Protection Authority and from The Data Protection Tribunal Norway, due to the Norwegian Privacy Protection Regulations that regulate research concerning children and young people under 18 years of age. To better understand violence against children we suggest that the Norwegian legislation in various areas (such as allowing children to take part in research) should be harmonized better. As it stands today one state authority denies research (e.g. without consent from parents) that another state authority allows or even commissions.

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Appendix 1:
Specification of the targets in Table 1: SDG Goals, targets and indicators in the UNICEF-NOVA-project

Target:

1.2 By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

4.1 By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes

5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

8.7 Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition and elimination of the worst forms of child labour, including recruitment and use of child soldiers, and by 2025 end child labour in all its forms

11.1 By 2030, ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums

12.8 By 2030, ensure that people everywhere have the relevant information and awareness for sustainable development and lifestyles in harmony with nature

16.1 Significantly reduce all forms of violence and related death rates everywhere

16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children