CHAPTER II
CHILD WELL-BEING ACROSS THE AMERICAS

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II.1 Introduction

The objective of this chapter is to provide an overview of the state of demographics and well-being of children around the continent. In some cases, an indicator for all countries comes from the same information source, which facilitates comparison between countries, while in other cases the indicator for each country comes from country-specific surveys, which makes the comparison more difficult. In all cases though, possible caveats that should be taken into account before arriving to conclusions are mentioned. We tried to include all possible indicators that have been analyzed in other studies (see, for example, OECD 2009), but data availability makes this impossible. However, the conclusions presented at the end of the Chapter would not change if more standardized information were available.

Information indicates that there have been significant improvements in the majority of countries in terms of infant health and primary education, but that many aspects remain to be improved, such as early childhood development, attainment of higher educational levels, promotion of healthy behavior in adolescents and eradication of child labor. In recent years, limits are being reached in changes driven mainly by public interventions, such as immunization campaigns or the provision of clean water supplies. On the other hand, the improvement in some of the more "private behavior" indicators, such as not leaving the school or avoiding youth pregnancy depend more on the decisions by families and children themselves, and seem to be more difficult to move by external interventions.

Social security institutions should take this into account. They are meant now not only to function as agencies that collect money, administer risk, and deliver benefits. Indeed, they are in a position that can be very close to families and children, capable of influencing personal decisions with adequately trained personnel. Of course, social security institutions should be seen as part of national strategies focused on children. They have to coordinate their efforts with other governmental agencies, such as the educational sector and the family courts.

II.2 Child Demographics

II.2.1 Child Population

Knowing the current and projecting the future number of children is a basic piece of information, since it affects demand and investments for schools, health care, and other services (America's Children: Key National Indicators of Well-Being 2009). Currently, children are an important share of total population in

most of the countries of the continent, but for the next forty years there is a marked tendency towards a decline.

During 2010, the figure for children between 0 and 19 years old ranges from 22 to 27% of the country's total population in Canada, Cuba, some countries in the English Speaking Caribbean, and in the United States, to between 48 and 50% in Belize, Honduras, Haiti, and Guatemala.

According to population projections, it is expected that by 2050, children will comprise from 15 to 19% in countries like St. Lucia, Cuba, and Trinidad and Tobago, to around 29 to 31% in countries such as Dominican Republic, Guatemala, Belize, and Haiti. The country that is expected to have the smallest decline in forty years is the United States, with a total decrease of approximately 5%. St. Lucia, by contrast, will probably experience a decrease in its child population in 50% (Figure II.1).

If we focus our attention on the subgroup of children aged 0 to 4, we observe no marked tendency towards either decrease or growth as a share of the child population. In 2010, the percentage of children between 0 and 4 years old represents around 22 to 26% of the overall child population. This percentage is expected to remain stable between 23 and 25% through 2050. There are 19 countries in the Americas that are expected to experience a decrease in its proportion of children aged 0 and 4, 16 countries that will likely see an increase in their proportion, and 5 with no perceptible change (Figure II.2).

Figure II.1
Child Population as a Percentage of Total Population (2010, 2030, and 2050)

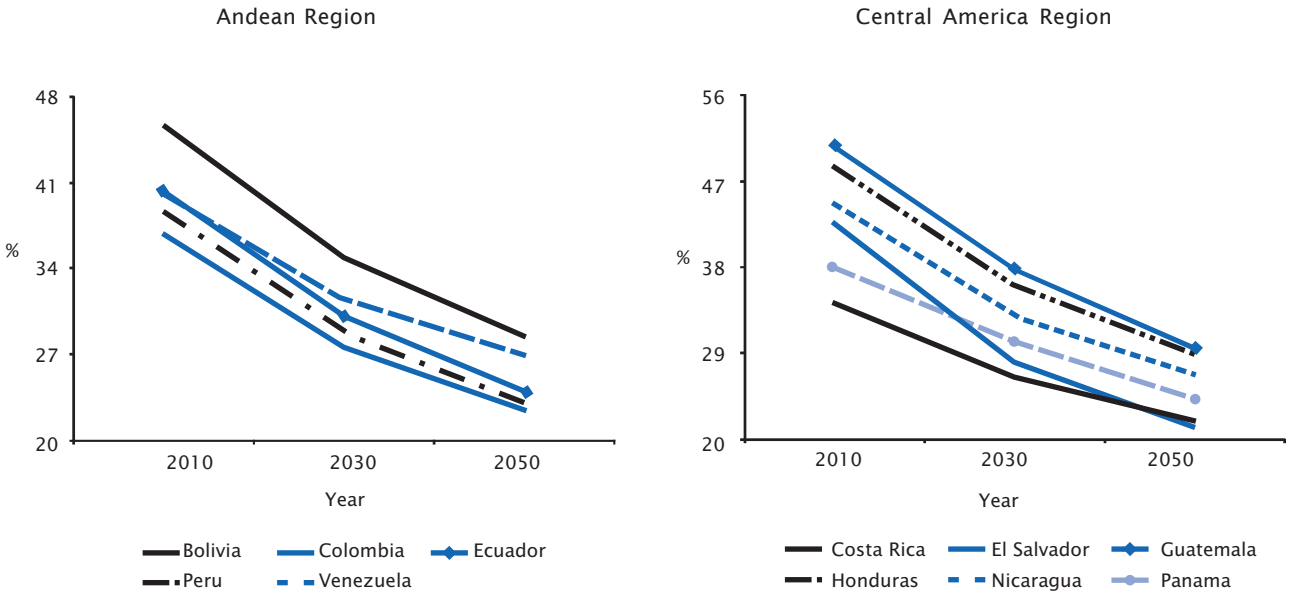
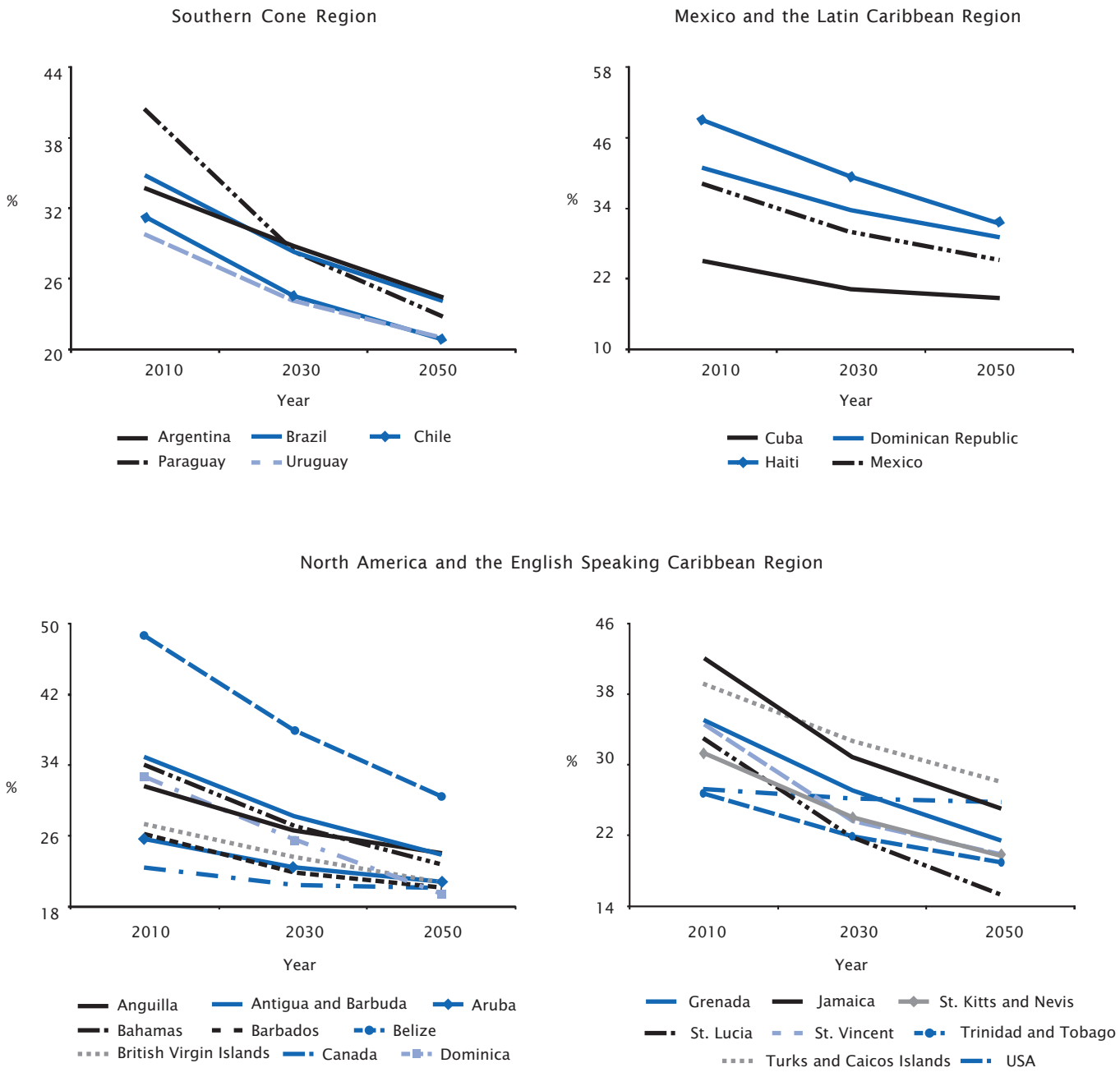


Figure II.1 (continued)



Source: U.S. Census Bureau (2010).

Figure II.2
Child Population (0-4 Years Old) as a Percentage of Total Child Population (2010, 2030, and 2050)

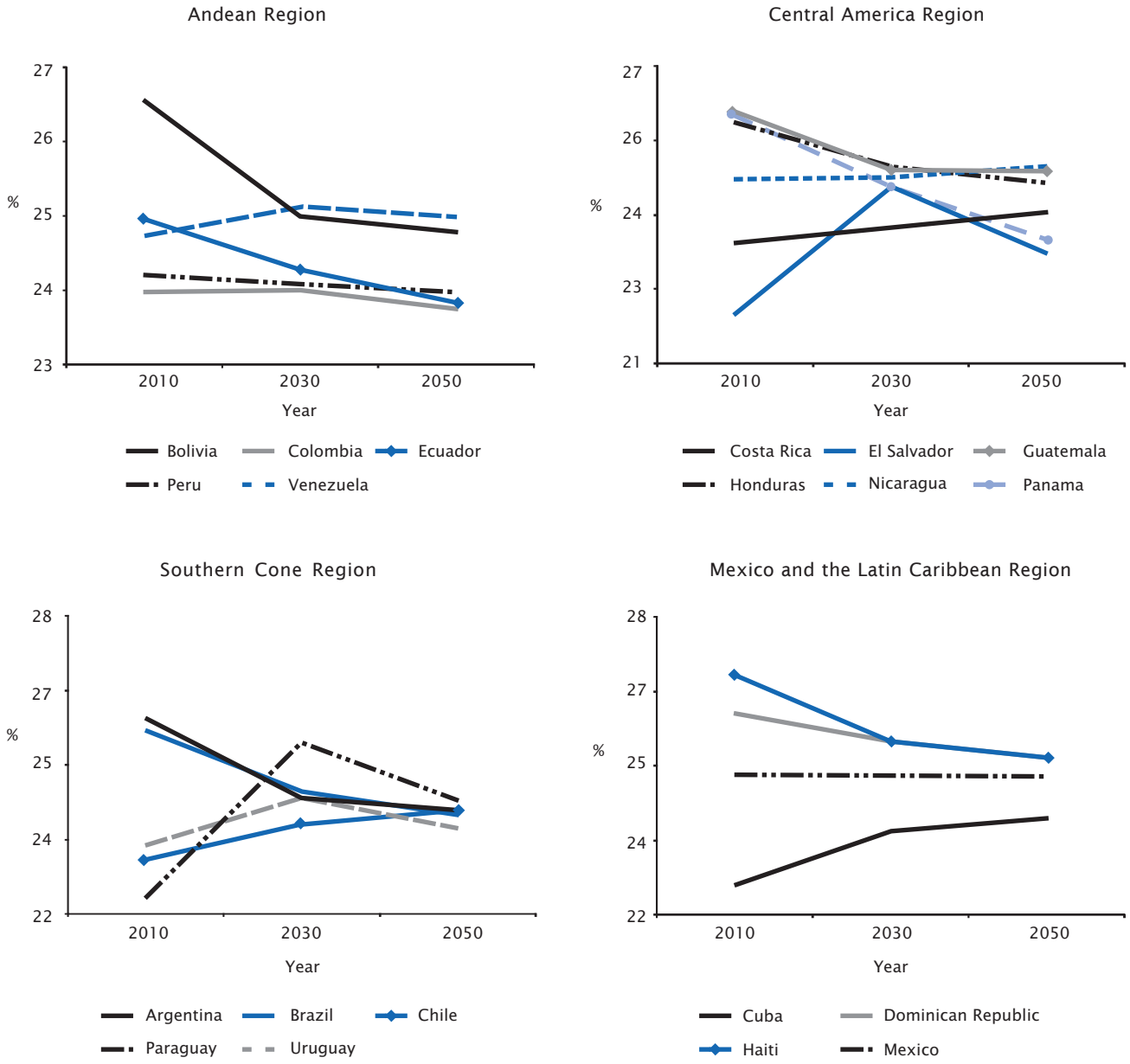
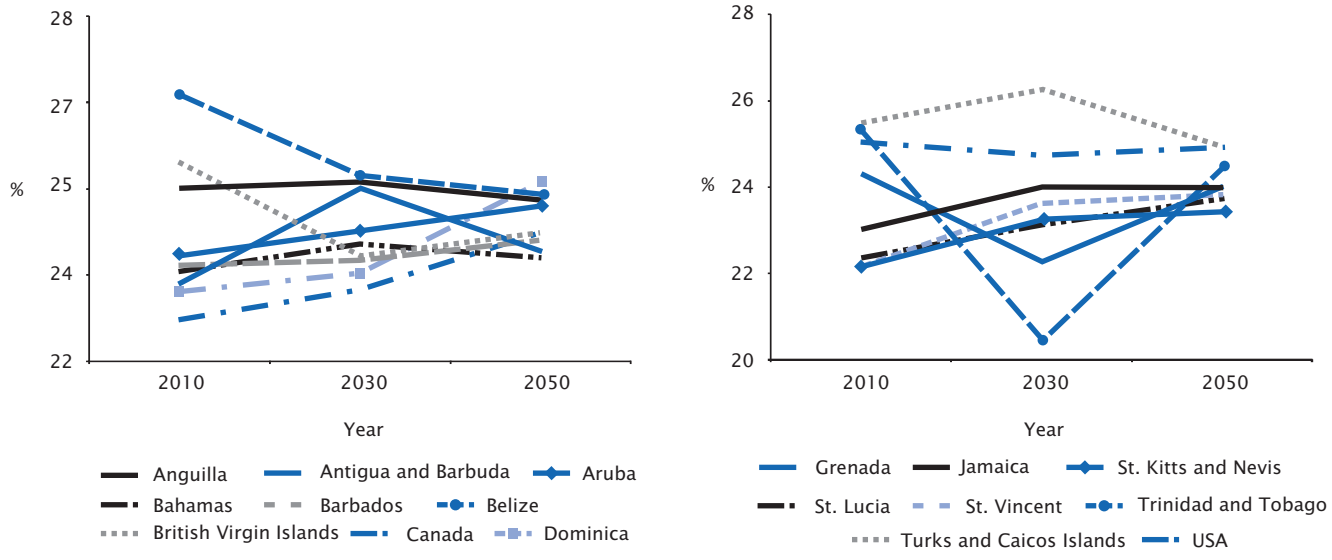


Figure II.2 (continued)

North America and the English Speaking Caribbean Region



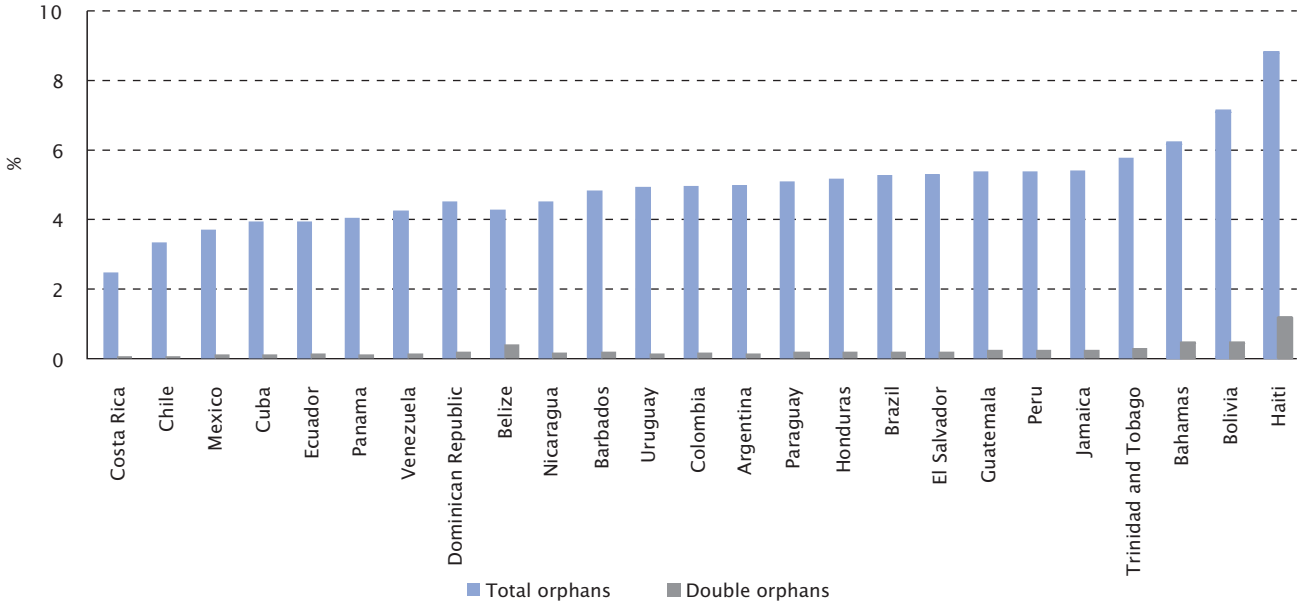
Source: U.S. Census Bureau (2010).

II.2.2 Orphans

In explaining the difference in outcomes between orphans and non-orphans three hypotheses arise. First, orphans can be poorer than non-orphans, investment in orphans by caregivers is lower than investment in non-orphans even within the household, and orphans have lower return of investments because of the emotional stress suffered and the time wasted in non-productive activities while their parents were sick. Being an orphan puts a child at risk, even when poverty control measures are in place, indicating that specific public policies should be enacted to further protect this vulnerable segment of the population. Studies of orphans in Africa have suggested that orphans have lower schooling attainments and, interestingly, that the effect is not attributable to poverty (Case, Paxson, and Ableidinger 2004).

Data counting the number of orphans is very scarce, since most surveys are household based. Recently, UNICEF (2009) provided estimates about children who have lost one or both parents. As illustrated in Figure II.3, the percentage of orphans varies from 2% in Costa Rica to almost 10% in Haiti. We also can see from this figure that poverty is associated with the number of orphans. This can be explained in part by maternal mortality, which is highly correlated with socioeconomic conditions.

Figure II.3
Total Orphans [1/] and Complete Orphans,[2/] 0-17 Years Old, 2007



Notes: 1/ Includes orphans under age 18 whose mothers and perhaps fathers, have died (includes complete orphans) plus orphans under age 18 whose fathers, and perhaps mothers, have died (includes complete orphans) minus complete orphans. 2/children who have lost both parents.
Source: Own calculations using UNICEF (2009) and U.S Census Bureau (2010).

One of the main programs of social security is the survivors' pension. As we will see in Chapter IV, children of active workers or pensioners affiliated to social security usually receive a pension in the event that a working mother or father dies. Of course, since this only covers the formal population, the protection of orphans with this benefit is partial in many countries. Using data of beneficiaries from social security agencies and the orphan population, we calculate that in Costa Rica for example 40% of orphan children receive a social security pension, but this percentage can be as low as 5 or 7% in the cases of Nicaragua and El Salvador.

What happens to orphan children without pensions? In most cases they are adopted by relatives; in some cases, the state provides public housing or has programs to support them, like foster care in the United States. Nevertheless, in some cases, the children end up living on the streets. The study of orphans and the impact of public interventions in their well-being is probably one of the most abandoned areas of research in social issues in countries of LAC, so there is a lack of even basic information to shape public policies.

But what happens to those orphan children with pensions? As we will see in Chapter IV, the current design of social security programs limits the agencies' ability to deliver the cash benefit, without having a more active role in looking out for the well-being of the child(ren). Little is known about the quality of care orphan children are receiving. For practical purposes, both orphan children with and without pensions resort to the same state tools for their protection.

II.2.3 Disabled Children

Usually disability definitions do not provide a clear and definitive description of this condition (individuals included within one definition may not be incorporated

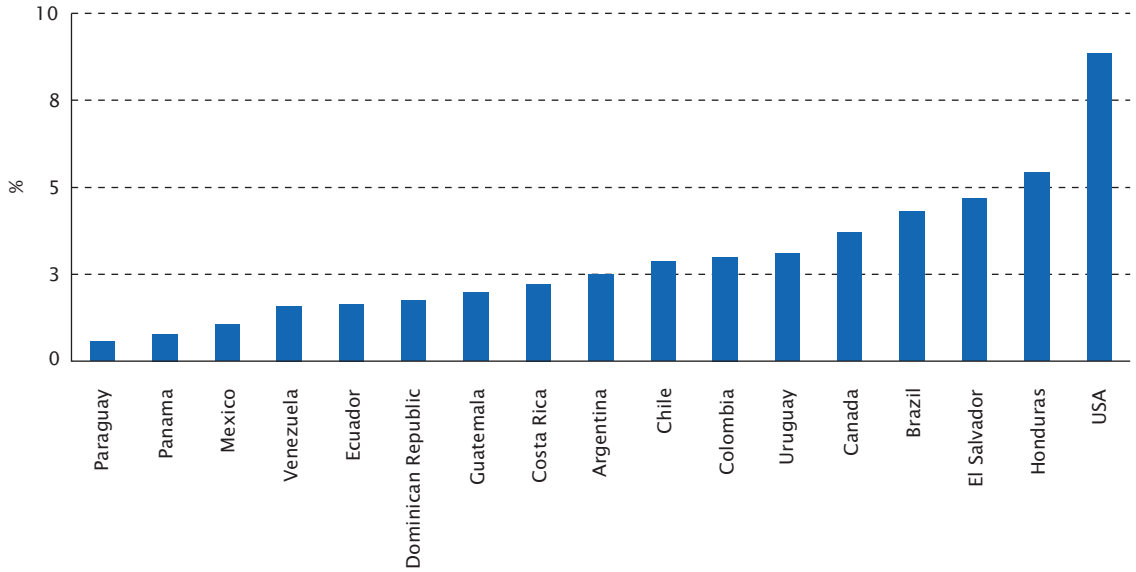
into another). Nowadays, the term "disability" is considered to be not only a medical condition, but a combination of personal, environmental, and social factors that can affect the person's ability to perform daily activities.

The measurement of disability faces various problems because there is no consensus on the precise definition. There are two types of measurements regularly used: i) the new World Health Organization (WHO) definition, which allows a greater reliability and comparability between countries, by considering the impact of the physical and social environments on each person's performance; and, ii) the Index of Daily Life Activities used in the United States, which is based on self-reported data on the ability to perform certain activities, rather than relying on the symptoms of the disease (CISS 2006).

In analyzing the information about disabled children presented in Figure II.4, we should take into account that countries use different definitions. Some of the questions asked in the disability surveys by countries in LAC are related to visual, hearing, speaking, and mobility limitations, as well as to psychiatric diseases. Countries such as El Salvador and Paraguay ask more specific questions related to the incapacity to bathe (in the first case) and to the presence of Down's syndrome, Parkinson's disease or autism (in the second case). As we can see, the percentage of disabled children varies from 1 to 9%. We observe that the United States shows the highest percentage of disabled children. This is not necessarily bad, as it may reflect greater awareness and wider protection programs.

Disabled children from parents entitled to survivors' pensions are covered with cash pensions and health insurance, in some cases for life (see Chapter IV). An additional challenge is how to protect disabled children, especially disabled orphans, whose parents worked in the informal sector. Only a few countries offer non-contributive pensions to disabled children.

Figure II.4
Disabled Children, 0-14 Years Old, 2000-2008



Notes: Data is for various years between 2000 and 2008. In Guatemala and Colombia the age range is from 0 to 17 years old.
Source: Own calculations using DGEEC (2002), Statistics Canada (2006), U.S Census Bureau (2010), U.S Census Bureau (2005), Contraloría (2000), INEGI (2000), INEC (2001), ONE (2002), U.S Census Bureau (2005), INE (2005), INEC (2000), INDEC (2003), INE (2004), IBGE (2000), DIGESTYC (2007), INE (2001), and UNICEF (2009).

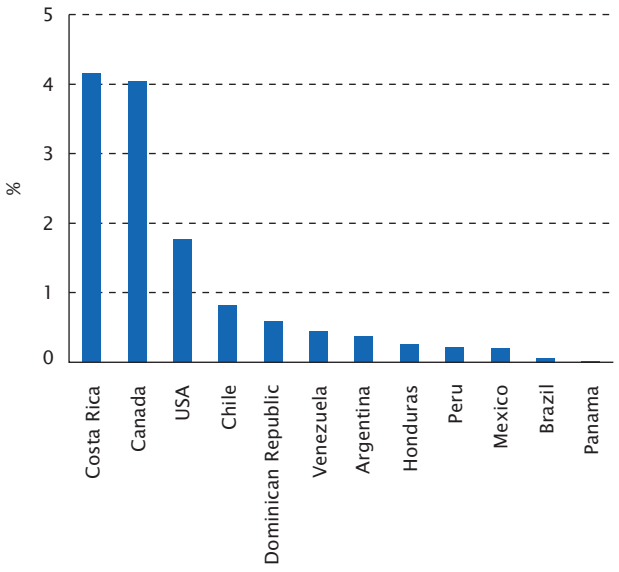
II.2.4 Migrant Children

Migration is a condition that can affect child well-being. One scenario is that migrant children must adjust to the process of moving from one country to another, in some cases without full documentation, and have to adapt to a different society. Another scenario is that children left in the home country by migrant parents are in an adverse situation because they are cared by relatives or other community members, even where they may benefit from remittances that allow them to have higher consumption and education (see for example Arias et al, 2010).

Unfortunately, data on child migration and children left behind by migrant parents is very scarce. Figure II.5 shows an estimate of immigrant children for selected countries. As we can see, immigrant children in Costa Rica and Canada account for 4% of all children in those countries, while in United States (the next highest) this number reaches almost 2%.

Migration within the same country is not free of risks. Inter-country migration can usually be associated with job availability. In some cases, such as agriculture, children follow their parents, and even help them with their job. But, what is best for the children? They may stay with their parents and share in the work load, or they can stay with relatives and attend school. While child labor in migrant families is widely condemned, in practice it has been very difficult to eradicate it because the answer to the posed question is ambiguous for low-income families. In this situation governments are responsible for offering flexible schemes to children to support them in any situation. Health insurance programs, family allocation funds and other institutions of social security can play a basic role in supporting families and the educational system in solving this problem.

Figure II.5
Immigrant Children, 0-14 Years Old, 2000-2009



Notes: Data is for various years between 2000 and 2009. In the United States, the age range is from 0 to 18 years of age, although another indicator for 2000 says that 3.8% of children aged 0-14 years are foreign. In Mexico, the age range is from 5 to 14 years old.
Source: Own calculations using INEC (2000), Statistics Canada (2009), DHS (2009), U.S Census Bureau (2000), La Nación (2006), INE (2001), INDEC (2001), INE (2006), INEGI (2005), OIM (2007), ONE (2002), IBGE (2000) and Contraloria (2002).

II.3 Child Well-Being

There is no unique, universally accepted way of measuring child well-being. There are at least two approaches to do it. Under the first approach, dimensions that may influence a child's quality of life are defined and indicators within each dimension are identified and measured. Under the second approach, children are directly asked about their subjective assessment of their well-being. Each approach has advantages and disadvantages. While the multidimensional approach uses objective data, the lack of a clear definition regarding which indicators to include and how to aggregate them can lead to results that can be very controversial, especially if cross-country or cross-population group comparisons between countries are made. The self-assessment option avoids this problem, however, it cannot be performed by small children, and results do not have a clear link to policy measures. In some cases, self-assessment has been included as a dimension in the multidimensional approach (OECD 2009).

Within the multidimensional definition there are two other issues. The first is a controversy regarding whether indicators should focus on current well-being, or on future well-being. Current well-being indicators place more weight on here-and-now activities, like sparse time with friends, while the second set of indicators focuses on the conditions that determine future quality of life, such as education. The second issue refers to whether indicators should reflect positive or negative conditions.

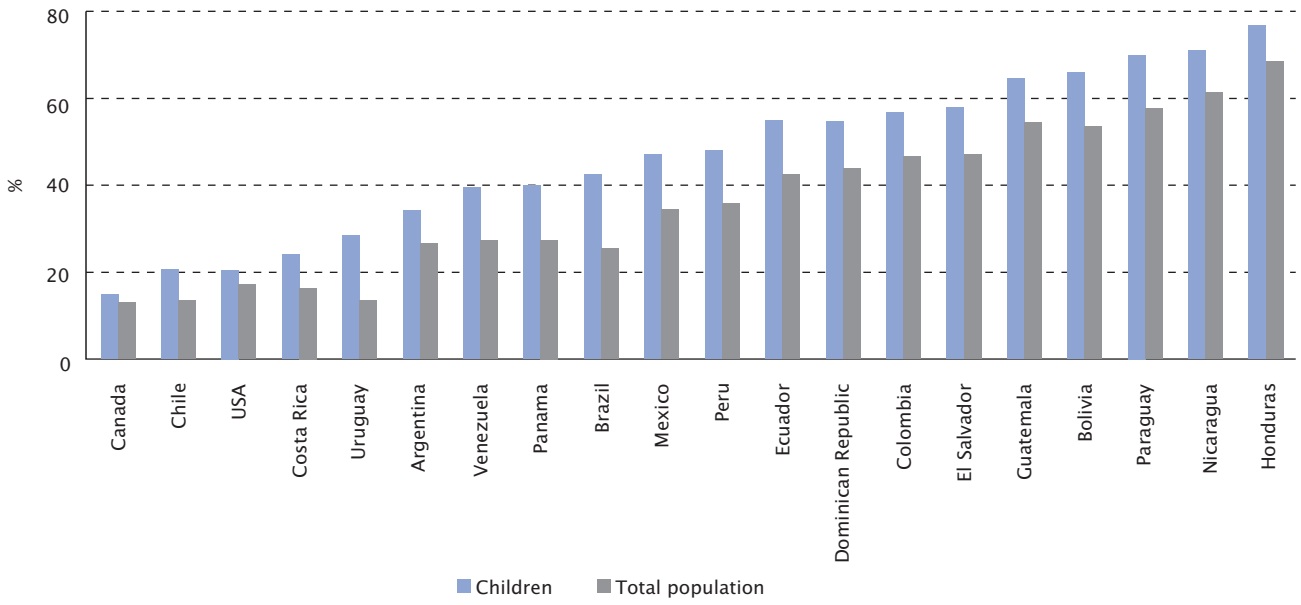
In this report we use the "multidimensional definition" with a strong emphasis on the variables that determine the future well-being, including positive and negative indicators. There were several reasons for this decision. First, more data is available on objective indicators than for subjective assessments. Second, we wanted to highlight some specific aspects related to social protection programs. Third, we want to provide information that could be compared to other studies that have tackled the topic, specifically to the OECD (2009) study that have done the same analysis for industrialized countries. The indicators included in this study are justified by the child research literature, and by the United Nations Convention on the Rights of Children.

II.3.1 Material Well-Being

Child poverty is the most important indicator of material well-being because poverty affects several aspects of human life, such as education and health. Figure II.6 shows the percentage of children living in poverty across the Americas. There is a great difference between countries: in Guatemala, Bolivia, Paraguay, Nicaragua, and Honduras more than 60% of children live in poverty; in Canada on the other extreme the percentage of children living in poverty is 20%. In all countries, the percentage of children living in poverty is higher than the percentage of the whole population living in poverty.

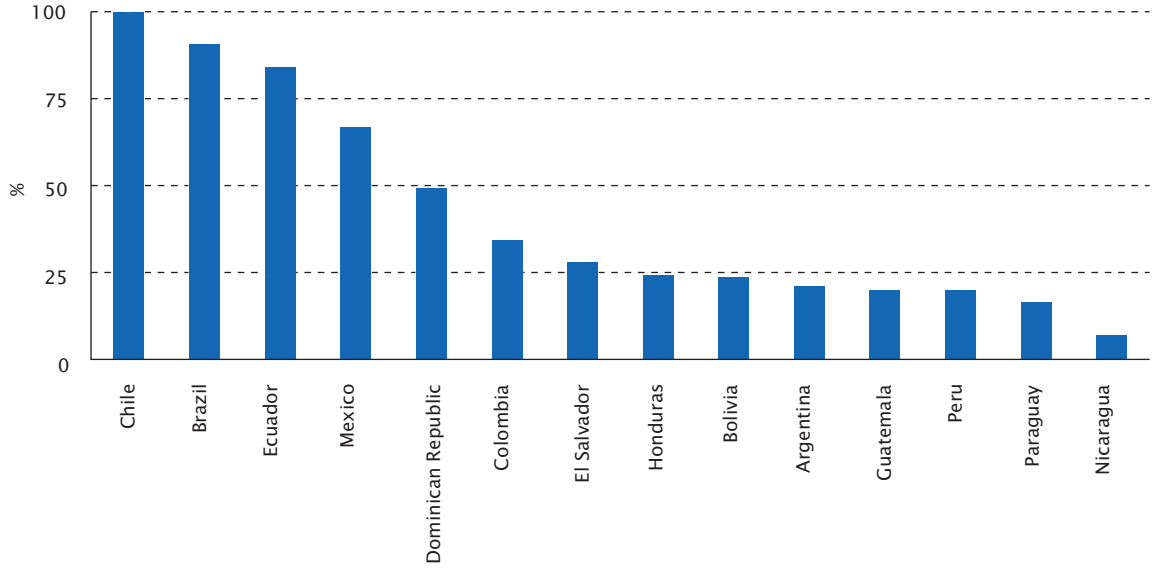
To fight poverty, especially intergenerational poverty, many countries around the world have implemented conditional cash transfer (CCT) programs. The estimated percentage of persons receiving CCT in the countries of the continent is presented in Figure II.7.

Figure II.6
Children Living in Poverty, 2004-2008



Note: In Canada and United States, the age covered is from 0 to 18 years. Argentina data are from urban areas only, but another indicator shows that 54% of children and adolescents aged 0-17 years in 2001 live under the poverty line.
Source: CEPAL (2010). Argentina data was taken from INDEC (2009), and Canada and United States data were taken from OECD (2009).

Figure II.7
Poor Population Receiving Conditional Cash Transfers, 2005-2009



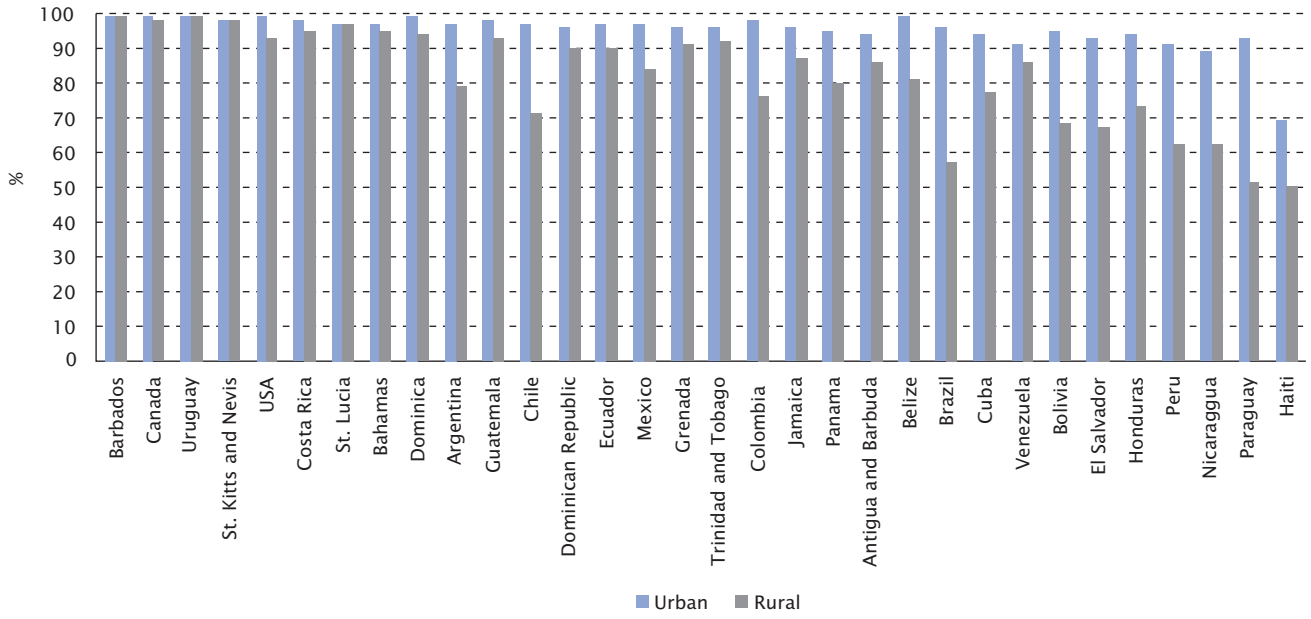
Source: Own calculations using WB (2009), CEPAL (2010) and US Census Bureau (2010) data.

II.3.2 Housing and Environment

Access to a healthy living and to an environment conducive to learning has proven to be an important factor determining health of the population. Sanitation systems and improved drinking water are two key aspects in a good environment and two features mentioned in the Millennium Development Goals.

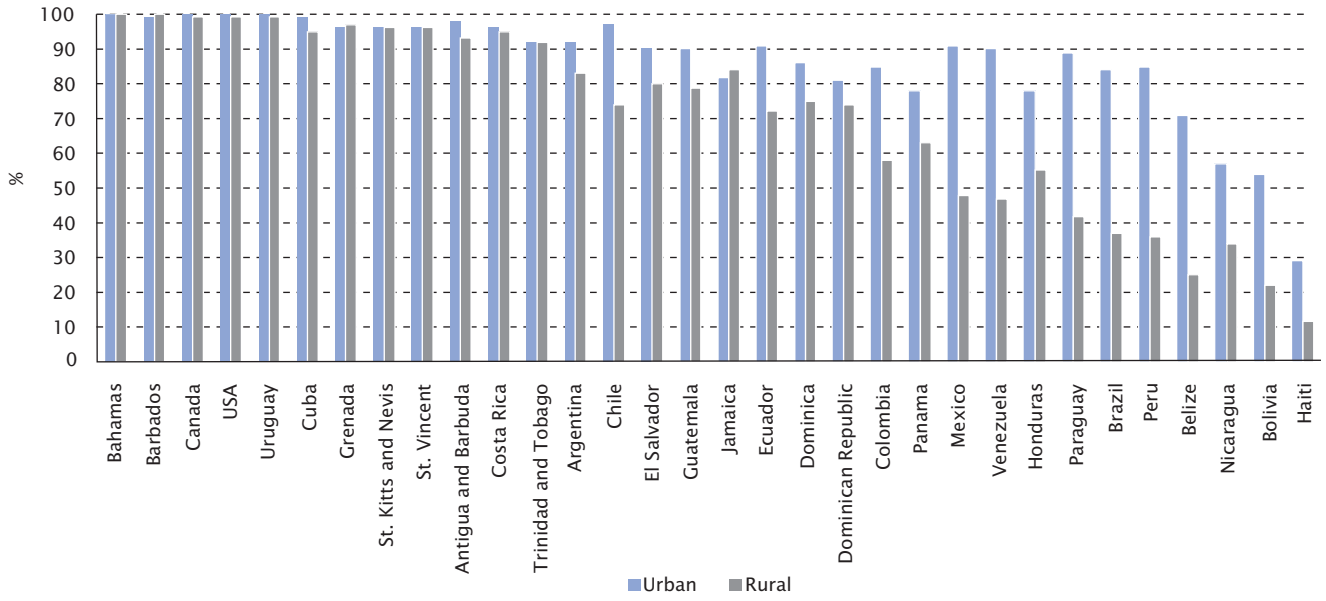
Access to improved drinking water sources has become a high priority in almost every country in the region. A few exceptions are the poorest countries, like Haiti, Paraguay, and Peru, the rural areas in those same countries, and in other not-so-poor countries (Figure II.8). The use of improved sanitation facilities shows a lower penetration. Nonetheless, in some countries, such as Bahamas, Barbados, Canada, and the United States, virtually the whole population has access to improved sanitation facilities. As expected, the poorest countries of the continent and rural areas have lower coverage (Figure II.9).

Figure II.8
Population with Sustainable Access to Improved Drinking Water Sources, 2006



Note: Venezuela data is for 1990.
Source: UNICEF (2009) and WHO (2009).

Figure II.9
Population Using Improved Sanitation Facilities, 2006



Note: Dominica and Belize data is for 2000 and Venezuela data is for 1990.
Source: UNICEF (2009) and WHO (2009).

II.3.3 Educational Achievement

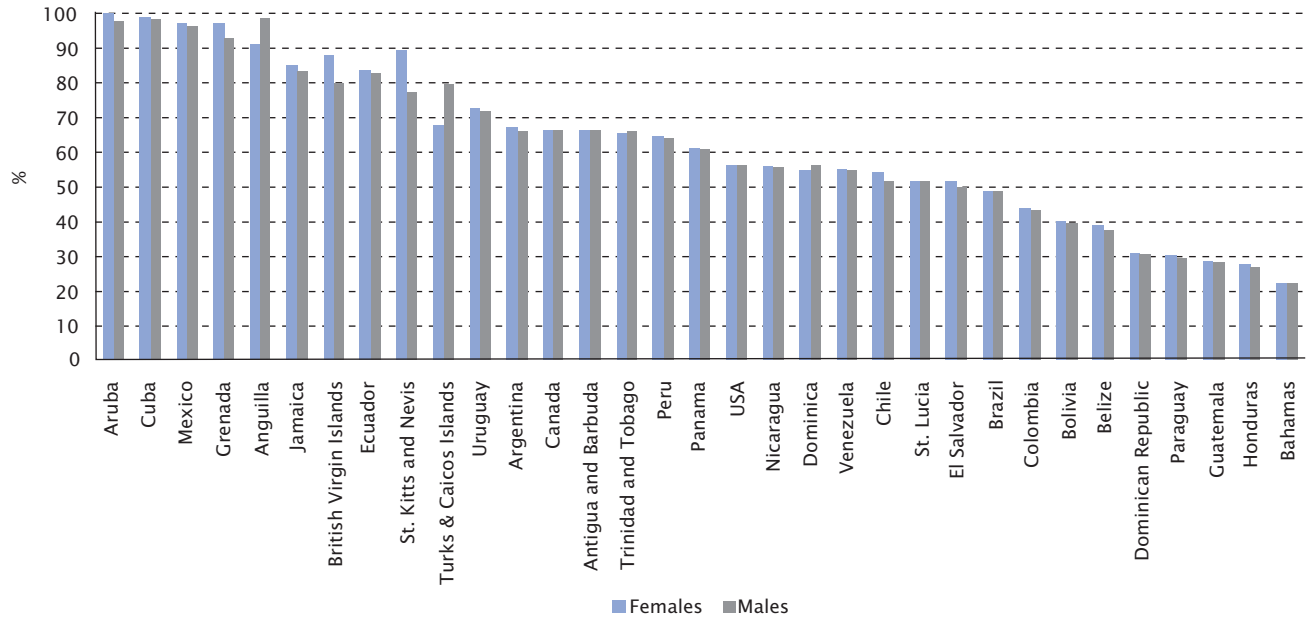
Education is an important variable of future well-being of children, since it is highly correlated to earnings, good health, and other variables. In this subsection, we offer six indicators: children in preschool education, youth literacy rate, primary school enrolment ratio, survival rate to last primary grade, rate of primary school age children out of school, and secondary school enrolment ratio.

As we will see in the next chapter, early childhood development has proven to be a crucial factor for many aspects of short and long term well being. Having pre-school education is an important aspect in the development of children. Figure II.10 shows the net enrolment rate in pre-primary. As we can see, while enrolment is almost universal in a few countries, coverage does not reach half of the population in most of them. In Chapter IV we discuss some initiatives to help families with early childhood education that do not require children to be enrolled in an institution, and that have proven to be a successful option for low-income families.

As we can see in Figures II.11 and II.12, literacy rates and primary school enrolment are very high in most countries and the variation between countries is low. The higher performing countries are Canada, Cuba, and Uruguay, showing basically a 100% literacy rate. The lower performing countries are Haiti and some countries in Central America and the Caribbean. By gender, we observe that in the higher performing countries there is not an important difference between boys and girls, while in the lower performing countries there are differences by gender: in some cases girls are more educated, while in other countries the opposite holds.

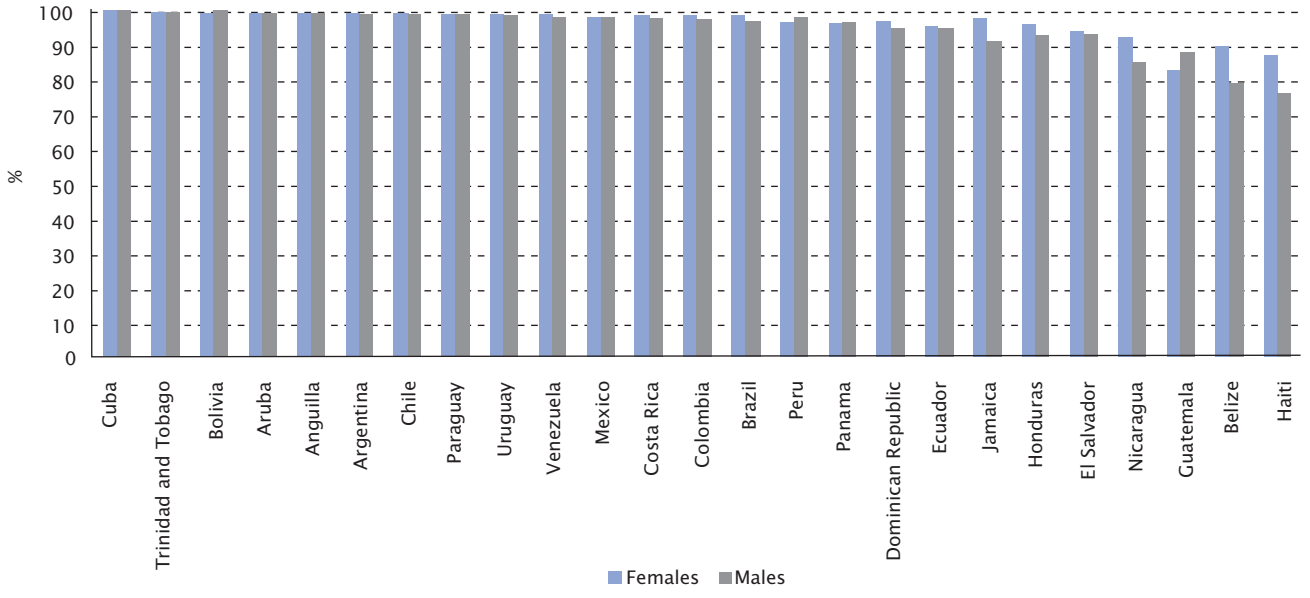
In Figures II.13 to II.15, we analyze indicators that measure achievements of older children, and now we observe greater differences between countries. For example, the survival rate to last primary grade ranges from 95% in Chile to 50% in Nicaragua (Figure II.13), the number of children in primary age out of school reaches 70% in Haiti (Figure II.14), while the ratio of secondary school enrolment ranges from 85% in Barbados to 40% in Guatemala (Figure II.15).

Figure II.10
Net Pre-Primary School Enrolment Rate, 2000-2008



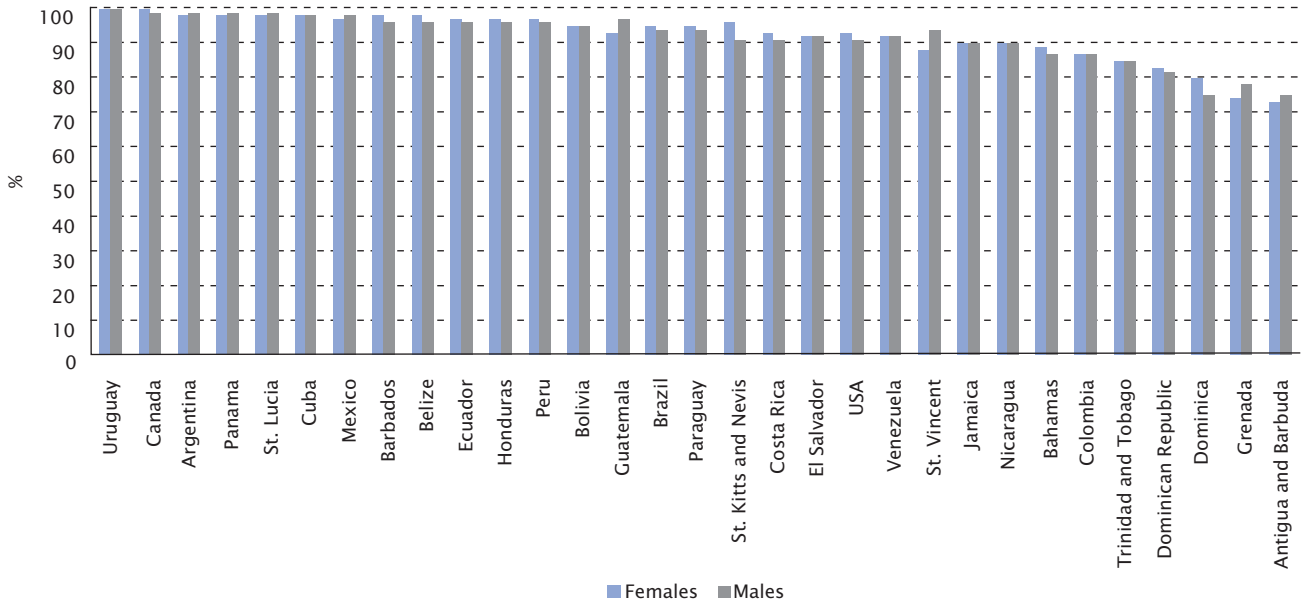
Source: UNESCO (2009).

Figure II.11
Youth (15-24 Years) Literacy Rate, 2003-2008



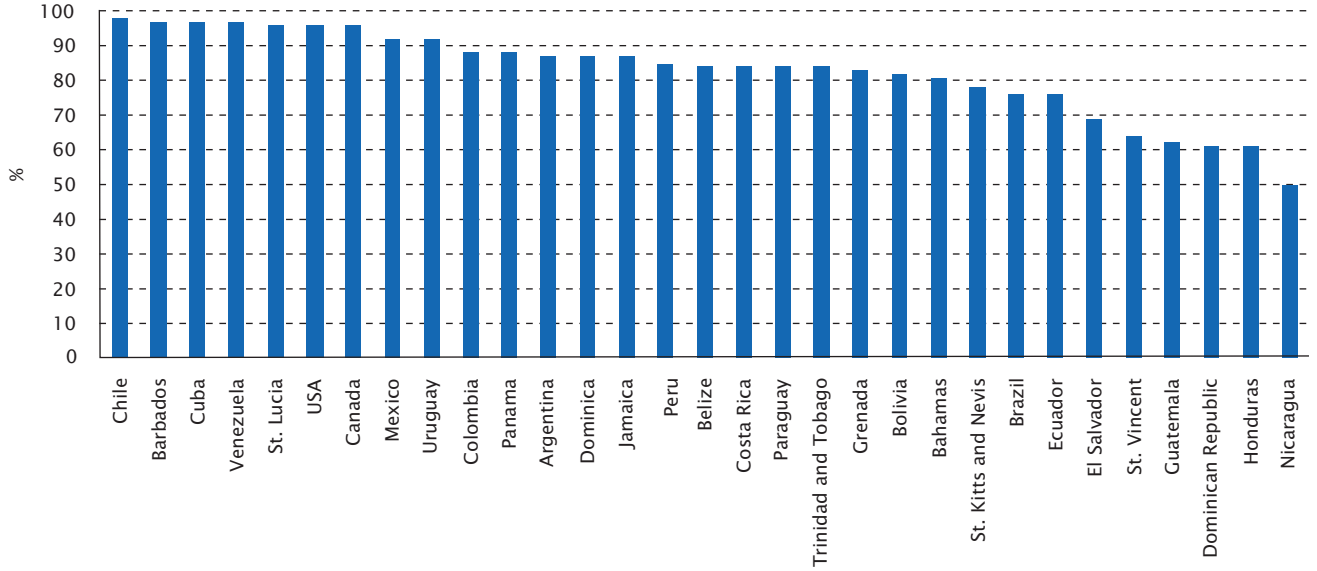
Note: Data is for various years between 2003 and 2008. Anguilla data is for 1984. There was no data for Canada and the United States.
Source: UNICEF (2009) and UNESCO (2009).

Figure II.12
Net Primary School Enrolment Ratio, 2003-2008



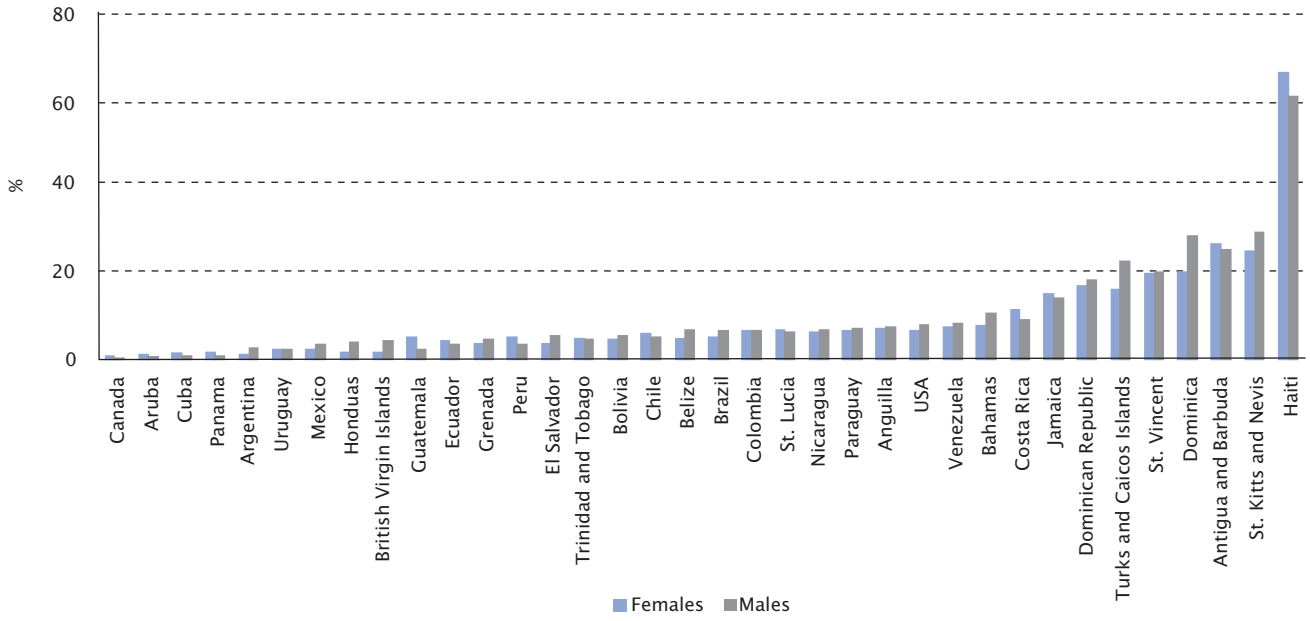
Note: Data is for various years between 2003 and 2008.
Source: UNICEF (2009).

Figure II.13
Survival Rate to Last Primary Grade, 2003-2008



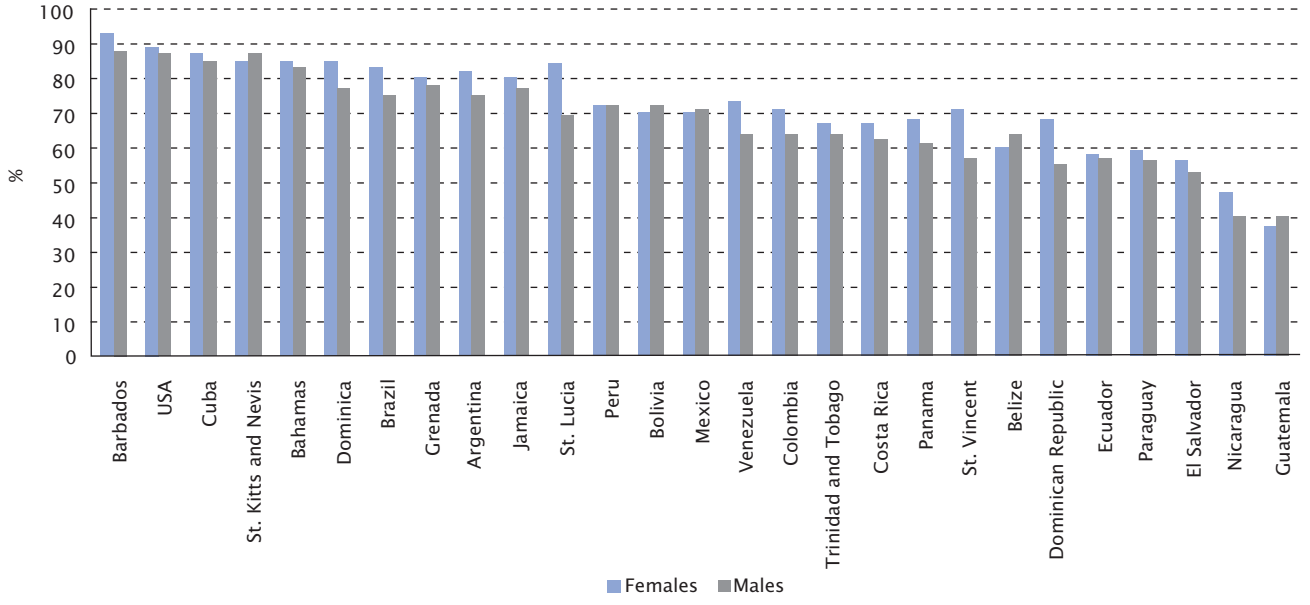
Note: Data is for various years between 2003 and 2008.
Source: UNICEF (2009). Canada data was taken from UNSTATS (2009).

Figure II.14
Rate of Primary School Age Children Out of School, 2003-2008



Note: Data is for various years between 2003 and 2008. Official primary age varies between countries, but usually ranges from 6 to 11 years old.
Source: UNICEF (2009).

Figure II.15
Net Secondary School Enrolment Ratio, 2003-2008



Note: Data is for various years between 2003 and 2008.
Source: UNICEF (2009).

II.3.4 Health

To measure health in infants, several indicators are reported annually by international organizations. To organize the discussion, we can group variables into: i) mortality rates, including, infant mortality and under-five mortality; ii) low birth weight; iii) nutritional indicators, such as stunting for age, malnutrition, overweight, and indicators of breastfeeding; and, iv) immunization rates.

Mortality Rates. Figure II.16 shows the infant mortality rate and the under-five mortality rate of countries grouped by the sub-regions of the Americas. There is a high variability across regions and countries. With some exceptions, North America and the English Speaking Caribbean countries show very low mortality rates, which is also the case of Chile and Cuba. Mexico and countries of the southern cone (with the exception of Paraguay and the Andean region) show higher mortality rates, while the poorest countries of the continent (Haiti and Bolivia) show the highest mortality rates. The relationship between income per capita and infant mortality rate has been analyzed extensively. Indeed, the Preston Curve (Preston 1975) is highly popular to show that infant mortality is higher in poorer countries and lower in richer countries, following a non-linear relationship: at higher levels of income per capita infant mortality rates decline at decreasing rates.

Low Birth Weight. Low birth weight is a condition that may affect in the short and long-term the health of persons and has been associated to other variables such as educational achievement. Low birth weight rates vary significantly between countries of the region (Figure II.17). Many countries have a low percentage of children with low birth weight such as Antigua and Barbuda, Cuba, Canada, and Chile. However, as expected, the rate reported by Haiti is very high where 25% of children are born with low birth weight.

Nutritional Indicators. In the literature, two commonly used indicators to measure under-nutrition are low weight in relation to age and children under five years stunted for age. Stunting (low height for age) may reflect long-term malnutrition. Malnutrition is related to under-five mortality rates and is a very important risk factor. There has been great progress in reducing the level of malnutrition in the world in the last decades. Still, as we can see in Figure II.18, children malnutrition rates are very high in many countries, most of them poor. Malnutrition is associated with poverty between countries and within countries (Wagstaff and Watanabe 1999).

Childhood obesity is a relatively recent phenomenon and is growing rapidly around the world, challenging both dietary habits and lifestyle in many countries. Overweight children are not only at risk for health issues, but their weight may have adverse effects on school and labor markets (Cawley 2004; Cawley, Markus and Lillard 2005; Burkhauser and Cawley 2008; Cawley and Spiess 2008). Moreover, the issue requires a large amount of public resources to be diverted to address obesity-related health problems. Figure II.19 shows the percentage of overweight children in each country. In countries such as Haiti and Bolivia about 4% of children are overweight, while in countries like Peru and Argentina, the problem is more serious since approximately 10% of children suffer from this condition. Box II.1 shows the changes in the prevalence of malnutrition and overweight at the time.

Recent research has recognized that children's nutritional status may be influenced by breastfeeding habits, beyond the positive benefits of breastfeeding on overall child health and immunity to illness and disease. Figure II.20 shows the percentage of children under 6 months of age who were exclusively breastfed. In countries like Venezuela, Dominican Republic, and Belize, that value is only 10%. On the contrary, in Peru, Bolivia, and Uruguay, that number is above 50%.

The social security maternity subsidy and leave benefit, as will be explained in Chapter IV, is meant to allow mothers to stay with their newborns. The leave period, however in most cases is well below six months; noticeably, this situation indicates that

social security and employers must establish improved protocols to support mothers while raising small children.

Immunization Rates. In terms of immunization, we studied six different vaccines (Figure II.21). Most countries have coverage above 80% for all cases, with the same countries almost always appearing at the top: Antigua and Barbuda, Cuba, and Brazil. The same goes for those with lower rates in almost all vaccines; Haiti and Paraguay have coverage below 80%.

Figure II.16
Infant Mortality Rate and Under 5 Mortality Rate (per 1,000 Live Births), 2008

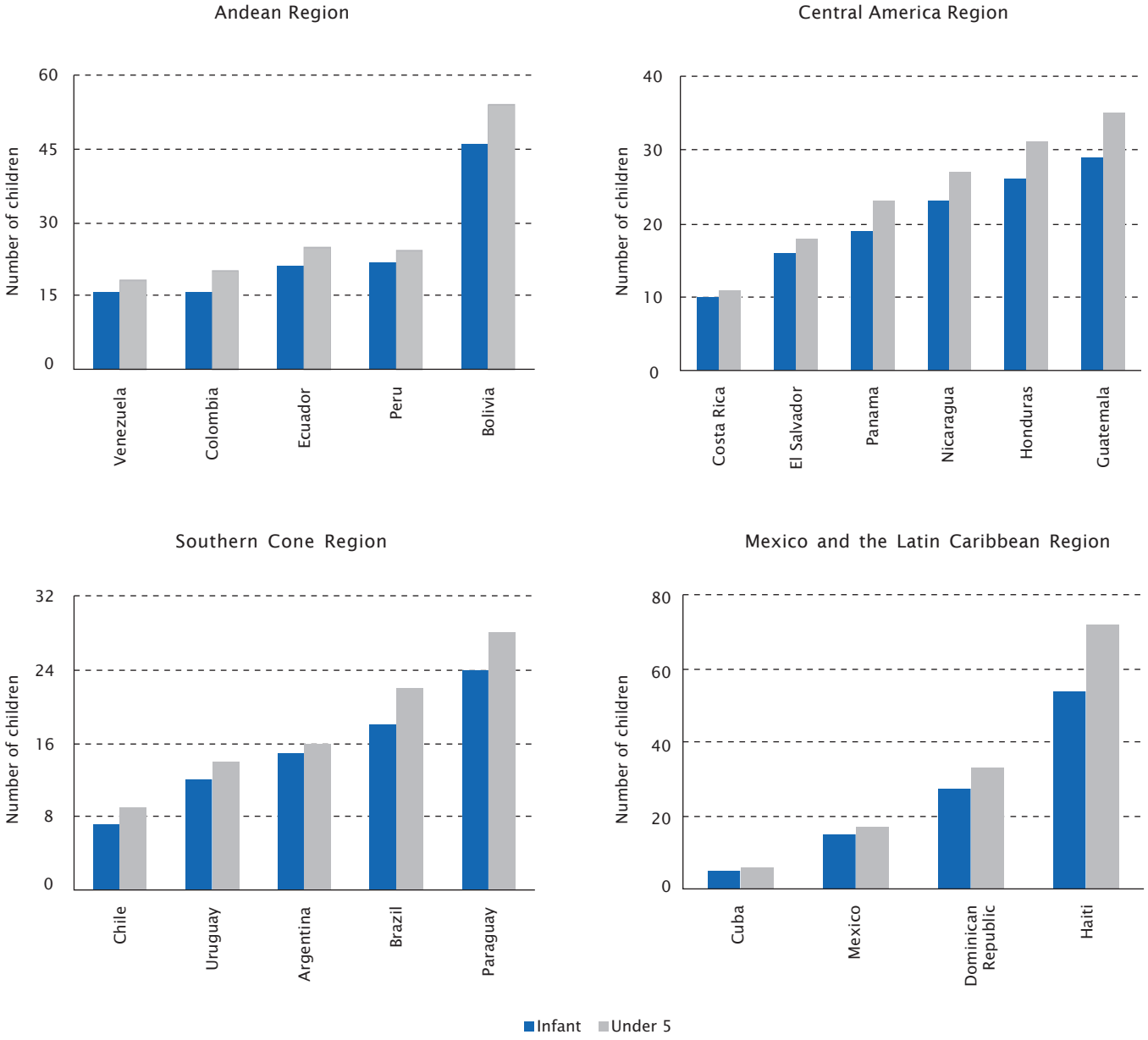
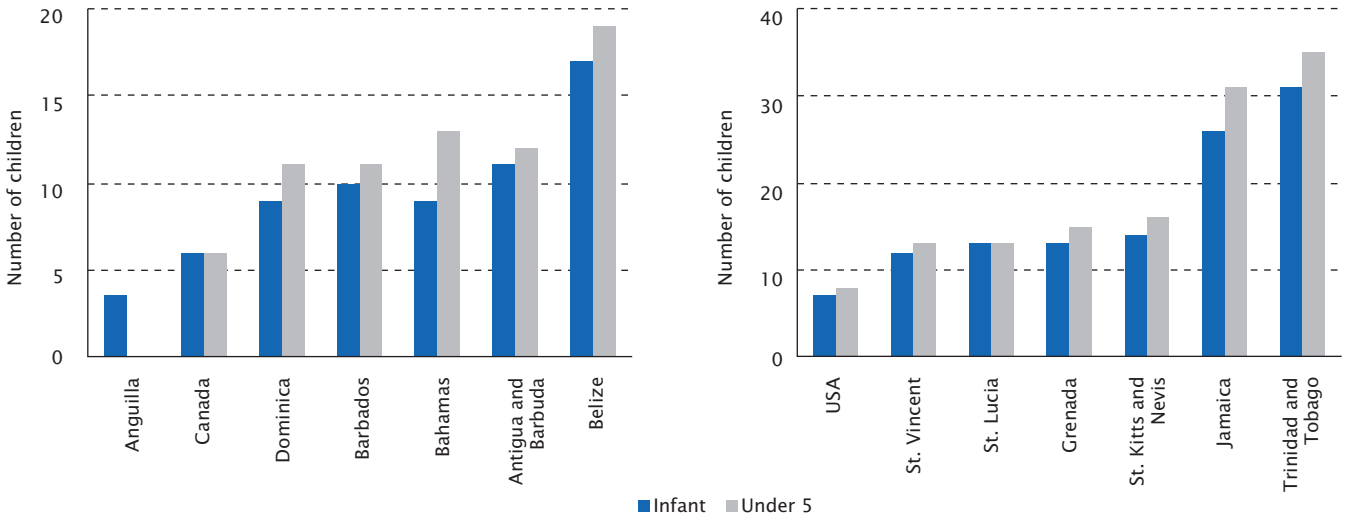


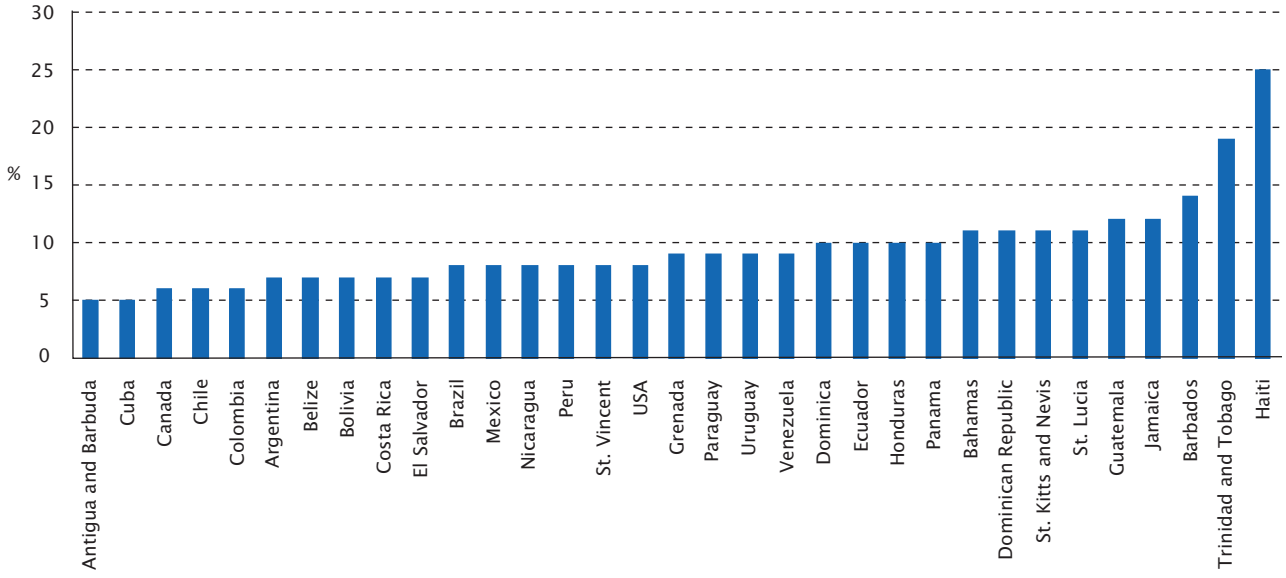
Figure II.16 (continued)

North America and the English Speaking Caribbean Region



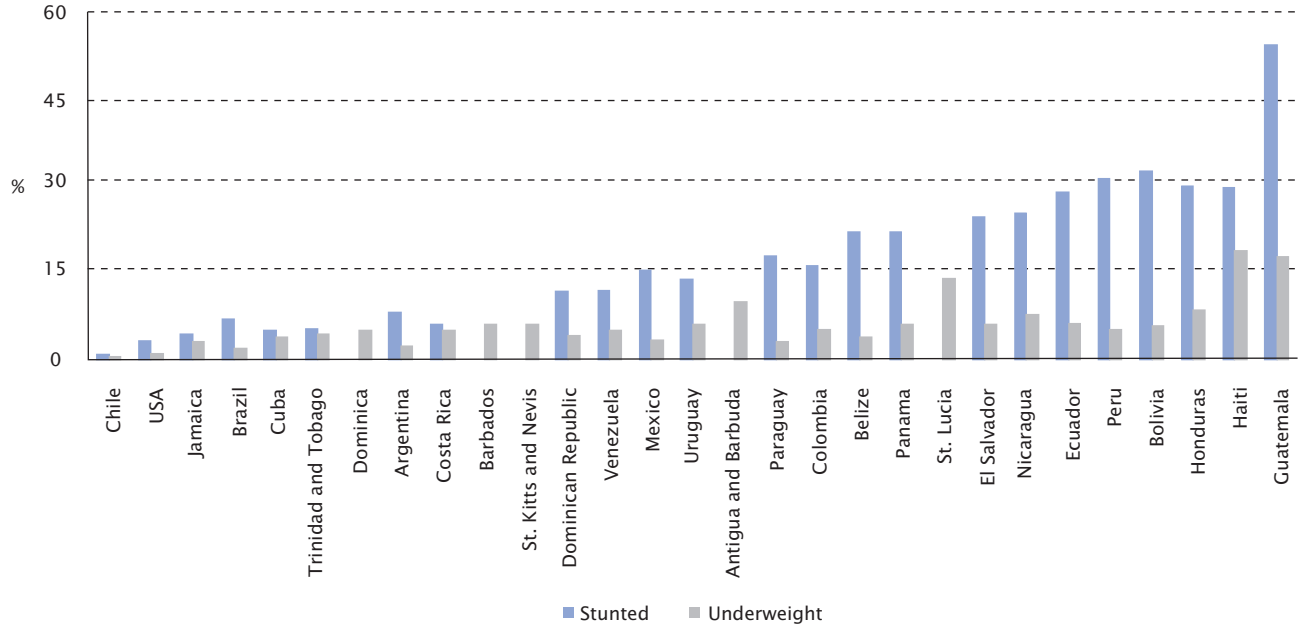
Note: Anguilla data is for 2009. Infant refers to children less than one year.
Source: UNICEF (2009) and for Anguilla the CIA (2009).

Figure II.17
Infants with Low Birth Weight, 2003-2008



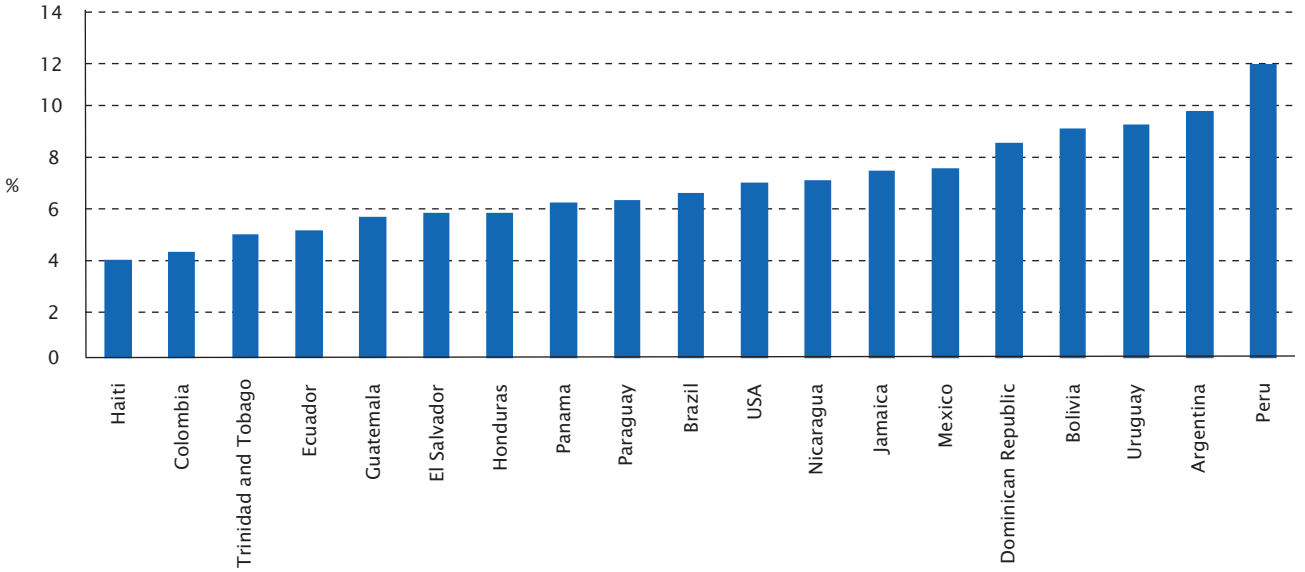
Note: Data is for various years between 2003 and 2008. An infant is considered to have low birth weight if it weighs less than 2.5 kg at birth.
Source: UNICEF (2009).

Figure II.18
Children under Five Years of Age Stunted and Underweight for Age, 2000-2007



Note: Data is for various years between 2000 and 2007. Barbados, Dominica, and Saint Lucia underweight data refer to an earlier year outside the range of years specified. For Dominica, Barbados, St. Kitts and Nevis, Antigua, Barbuda, and St. Lucia there were no data on stunted for age.
Source: WHO (2009), UNICEF (2009) and UNDP (2009). Belize and Chile stunted data were taken from the GHF (2009). St. Kitts and Nevis underweight data was taken from PRB (2007).

Figure II.19
Children under Five Years of Age Overweight for Age, 2000-2007



Note: Data is for various years between 2000 and 2007. Brazil data is for 1996 and Paraguay data is for 1990.
Source: WHO (2009).

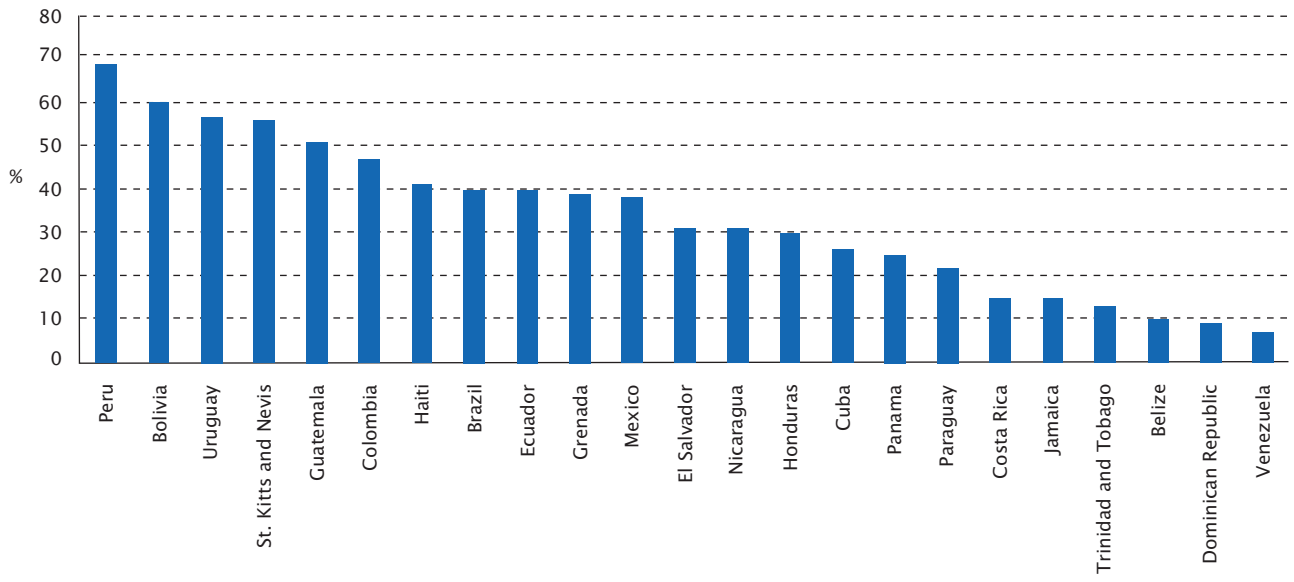
Box II.1
Underweight and Overweight Children

Countries around the globe have moved from a concern over under-nutrition to one over obesity in children. Wang, Monteiro and Popkin (2002) have gathered comparable information on the body mass of children in the 70s and 90s for Brazil, China, Russia, and the United States. The following table shows the prevalence of underweight and overweight in Brazil and the United States. In both cases we see a major increase in overweight; in Brazil, underweight has not been nearly eliminated. Overweight and obesity are major examples of a result of individual behavior, and where the concept of public health intervention is not likely to be successful in solving the problem, posing a challenge to health and social insurance policy.

	Brazil		United States	
	1974	1997	1971 -1974	1988 -1994
Overweight				
All	4.1	13.9	15.4	25.6
Children (6 -9)	4.9	17.4	11.8	22.0
Adolescents (10-18)	3.7	12.6	16.8	27.3
Males	2.9	13.1	14.5	25.0
Females	5.3	14.8	16.3	26.3
Underweight				
All	14.8	8.6	5.1	3.3
Children (6 -9)	12.3	6.1	4.1	3.4
Adolescents (10-8)	16.1	9.6	5.5	3.3
Males	18.3	10.6	5.2	3.6
Females	11.4	6.5	5.0	3.0

Source: Wang, Monteiro and Popkin (2002).

Figure II.20
Children who are Exclusively Breastfed (<6 Months), 2003-2008



Note: Data is for various years between 2003 and 2008.
Source: UNICEF (2009).

Figure II.21
One-Year-Old Children Immunized, 2008

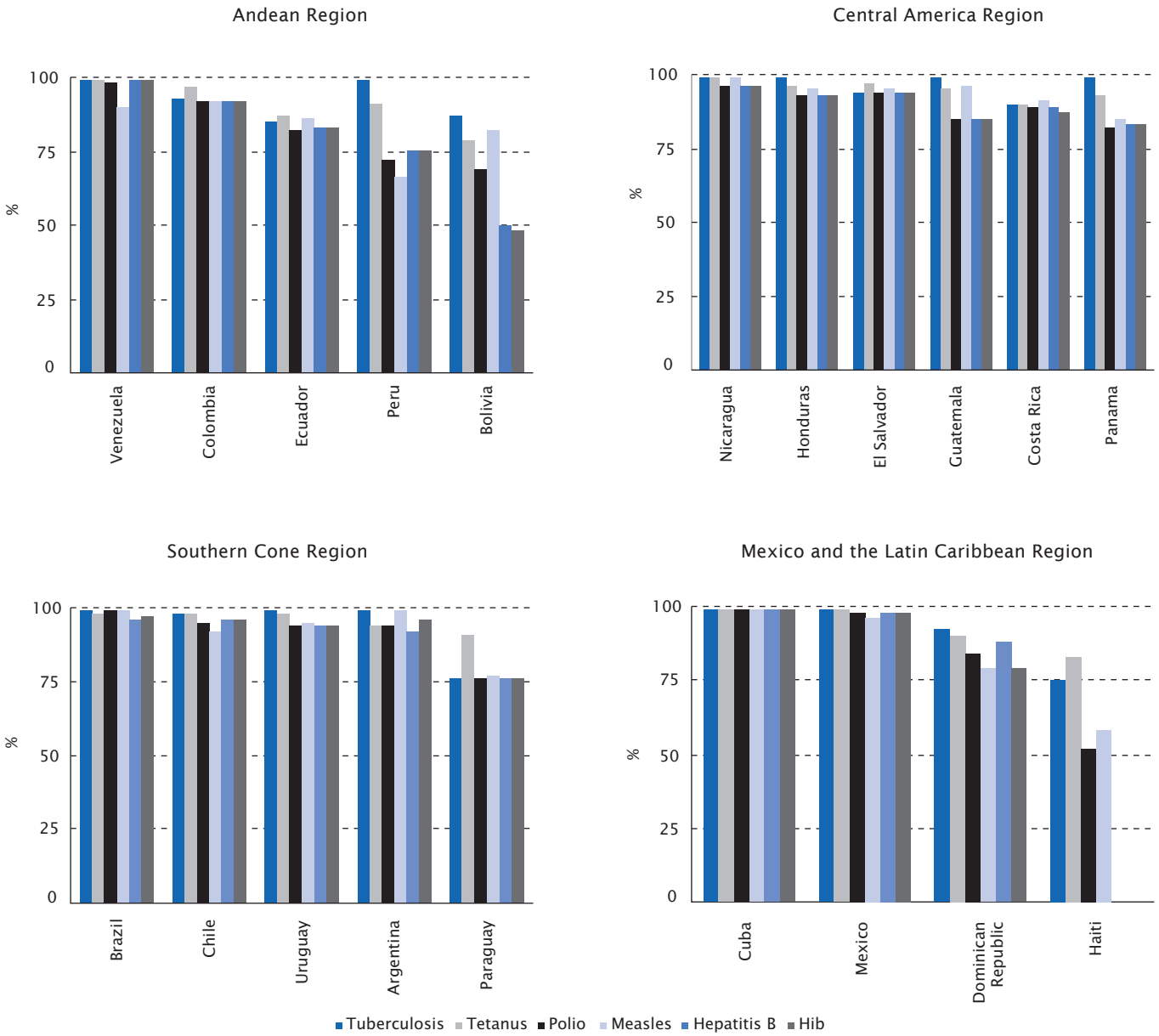
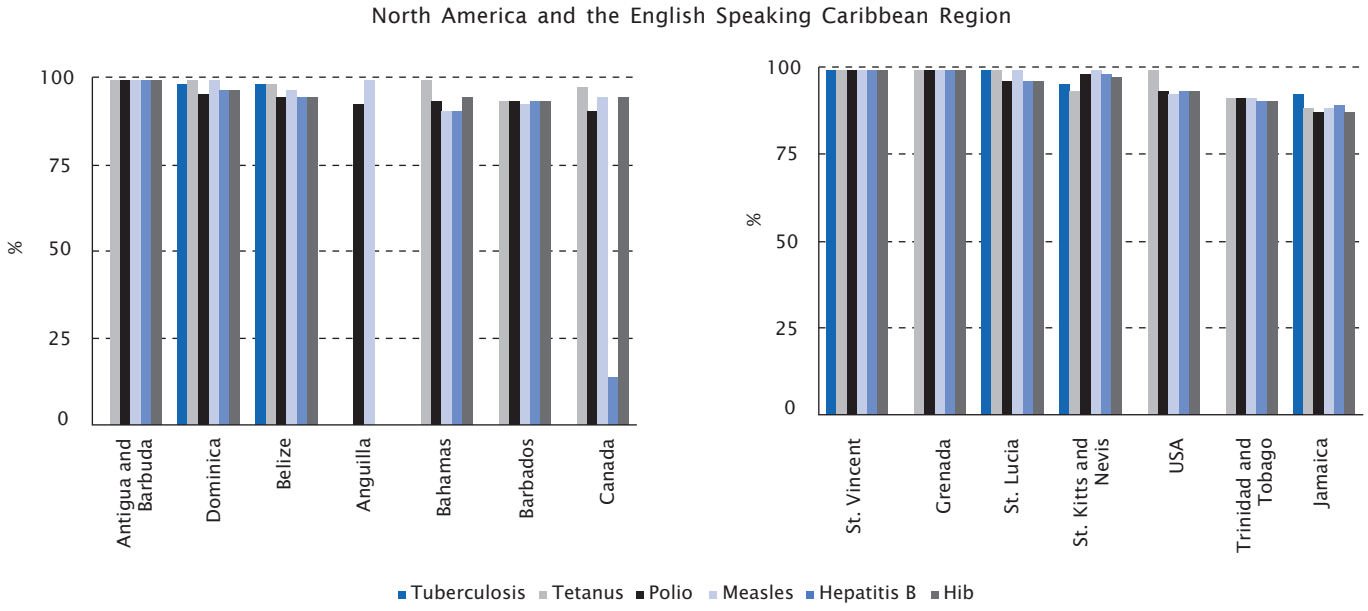


Figure II.21 (continued)



Note: Hib disease is caused by a bacterium, *Haemophilus influenza*. Anguilla data is for 2001.
Source: UNICEF (2009). Anguilla data was taken from the WHO (2009).

II.3.5 Risk Behaviors

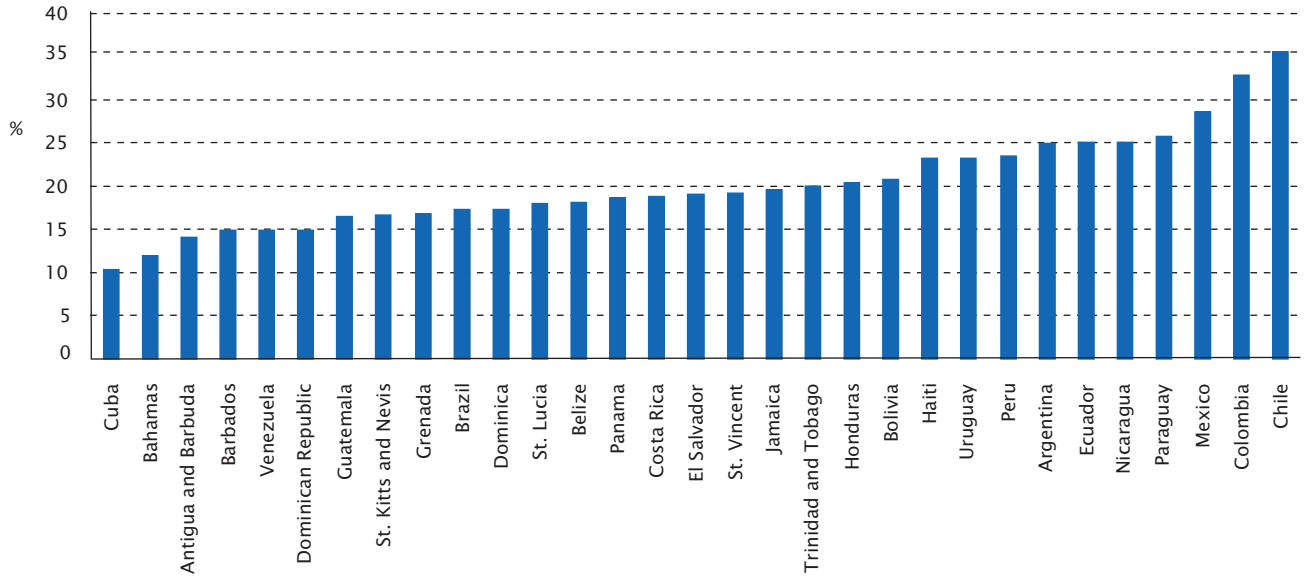
Risk behaviors refer to those actions explained by individual decisions that put adolescents at risk, since their health and general well-being can be adverse affected.

Smoking. One of the risk factors among young people is the prevalence of tobacco use. Figure II.22 shows the percentage of smokers in each country. Usually, the Caribbean countries (Cuba, Bahamas, Antigua and Barbuda, and Barbados), have a lower percentage of smokers with less than 15% of young people, while in Chile more than 35% of young people smoke regularly.

Drunkenness. Figure II.23 shows the prevalence of alcohol consumption among adolescents. As we can see, the rate varies significantly between countries. In St. Lucia the prevalence is higher than 60%, while in Honduras it is only 13%.

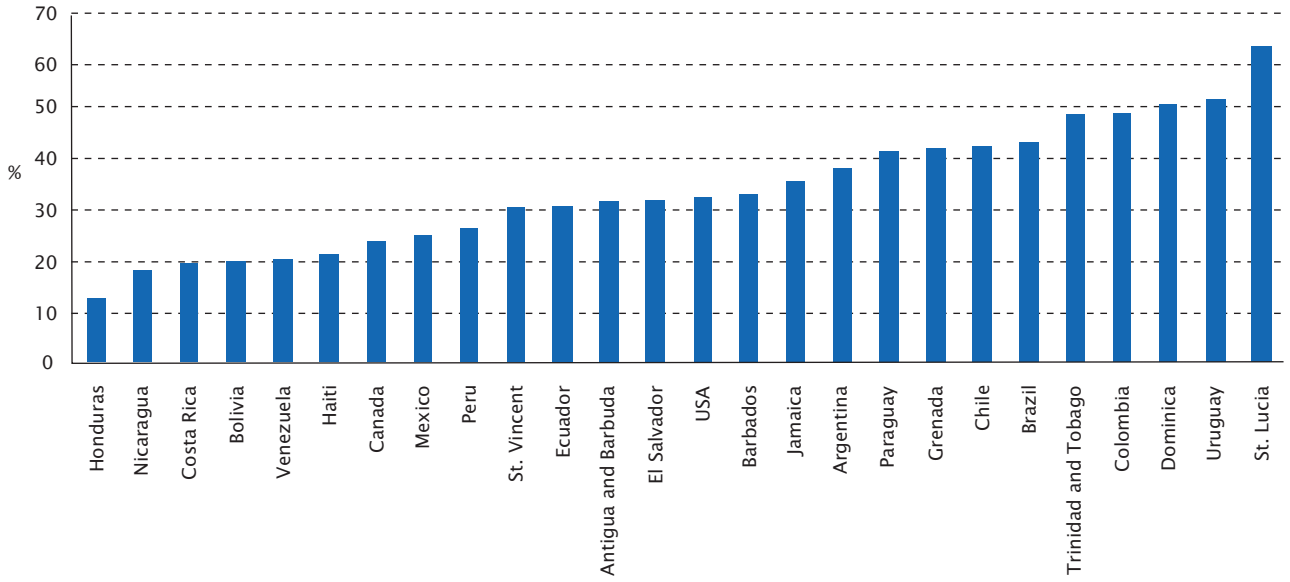
Prevalence of Condom Use. Condom use in Latin American countries is very low so young people are exposed to sexually transmitted diseases and unwanted pregnancies. Although our sample is small, we see condom use is less common in poorer countries and higher in richer countries (Figure 11.24).

Figure II.22
Prevalence of Current Tobacco Use Among Adolescents (13-15 Years), 2001-2007



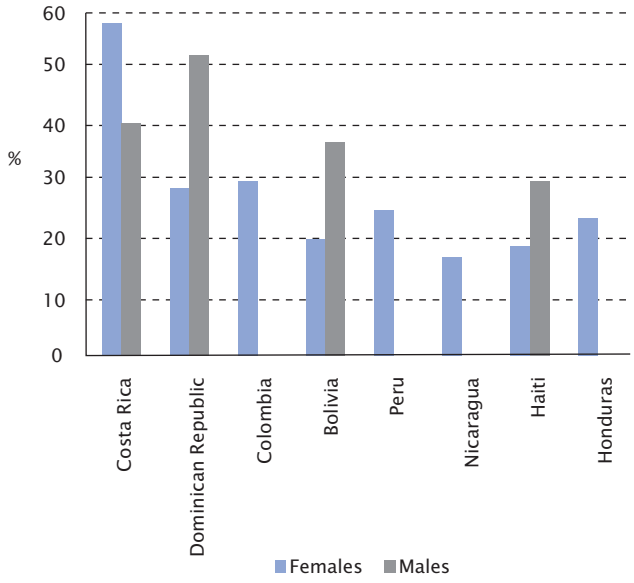
Note: Data is for various years between 2001 and 2007. Venezuela data is for 1999.
Source: WHO (2009).

Figure II.23
Prevalence of Alcohol Consumption Among Adolescents[1/] (13-17 Years), 2002-2007



Note: 1/ Refers to whether teenagers consumed alcohol in the last 30 days, with the exception of the United States, which is the percentage of children who have been drunk at least twice. In Nicaragua, the age range is from 15 to 30 years old; in Canada from 13 to 15; in Mexico from 12-17; and in EL Salvador from 15 to 24.
Source: CICAD (2009), INEC and MINSA (2002), OECD (2009), INEGI (2002), IUDOP/UCA (2007).

Figure II.24
Prevalence of Condom Use by Young People (15-24 Years) at Higher Risk Sex, 2000-2006



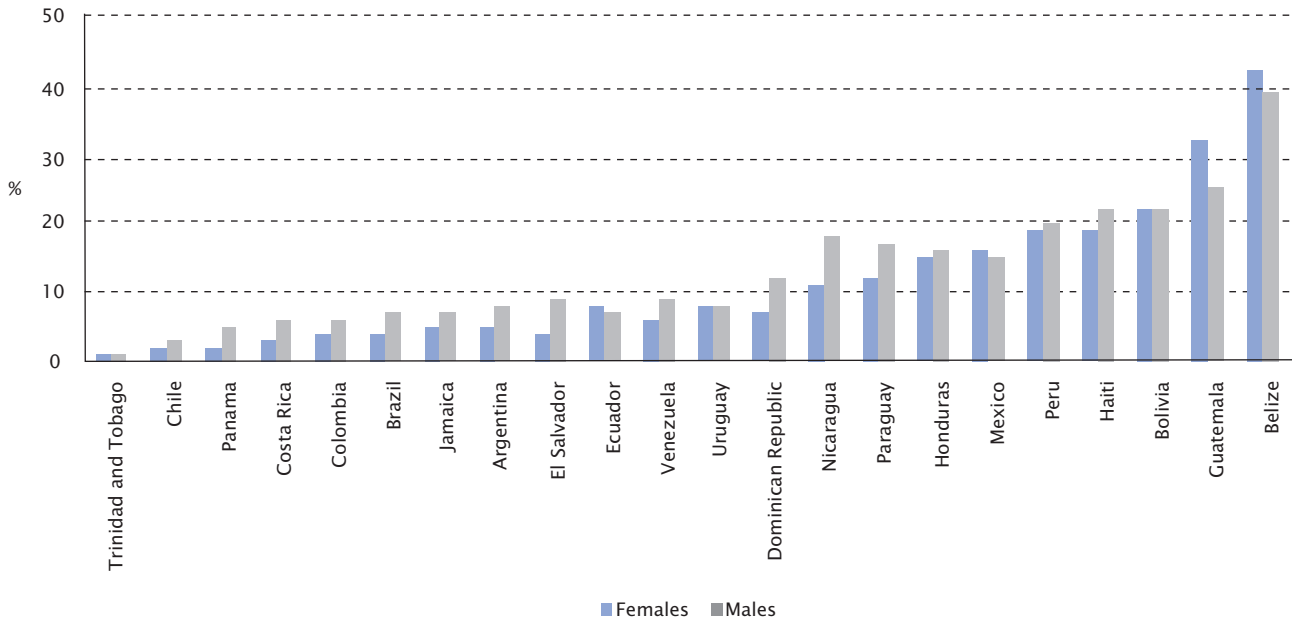
Note: Data is for various years between 2000 and 2008.
Source: WHO (2009). Costa Rica data was taken from Consejo Nacional de Política Pública de la Persona Joven (2008) and Honduras data was taken from SS, INE, and Macro International Inc. (2006).

II.3.6 Child Labor

Our research has revealed that many children in the continent leave school at an early age. While some of them go on to work, others do not take a productive role in society. In Chapter V, we will analyze in detail the youth labor market participation. In this subsection we would like to focus our discussion on child labor.

Prohibiting child labor has been one of the main areas of social protection and human rights in the world since the beginning of the last century. Yet, as we can see in Figure II.25, child labor is still a current phenomenon in many countries of our region.

Figure II.25
Child Labor (5-14 Years), 1999-2008



Note: Data is for various years between 1999 and 2008.
Source: UNICEF (2009).

II.4 Synthesis and Final Thoughts

Aggregation of indicators is always a problem because weights of variables have to be decided. Nevertheless, aggregation of data is useful to assess overall performance of a country and highlight urgent actions. The exercise of classification and aggregation was performed for each of the categories analyzed in the third section. First, we ranked all countries according to the value of each indicator. Second, we averaged the indicators within categories. Finally, we ranked all countries within the categories' averages. This methodology is similar to the one used by OECD (2009). Results are presented in Table II.1. When we aggregate all indicators at country level and do the same for the progress shown in the Millennium Development Goals (MDG Monitor 2008), we calculate that our indicator has a correlation coefficient to the MDG equal to 0.6,[1] which makes us feel confident of our aggregation.

[1] To compare our data against the MDG, we calculate the correlation between the two rankings of countries. We took an average with the data in Table II.1, and thus have the ranking of countries according to our data. Then we did the same for the MDG.Using information from the MDG Monitor (2008) which classifies each goal depending on progress, we gave four points if it had been achieved, 3 points if it was very likely to be achieved, 2 points if it was possible to achieve with some changes, and one point if it was off track; then, we averaged all points by country and arrived at the mentioned ranking.

Table II.1
Classification of All Indicators

Country	Material well-being	Housing and environment	Educational achievement	Health	Risk behaviors	Child labor
Anguilla	n.a	n.a	9	4	n.a	n.a
Antigua and Barbuda	n.a	17	36	3	8	n.a
Argentina	6	10	6	11	30	6
Aruba	n.a	n.a	1	n.a	n.a	n.a
Bahamas	n.a	4	32	23	2	n.a
Barbados	n.a	1	3	22	10	n.a
Belize	n.a	27	25	20	16	24
Bolivia	17	29	16	25	12	3
Brazil	9	26	21	5	22	14
British Virgin Islands	n.a	n.a	7	n.a	n.a	n.a
Canada	1	2	4	13	6	n.a
Chile	3	12	10	2	33	7
Colombia	14	22	23	10	27	13
Costa Rica	4	8	24	16	5	12
Cuba	n.a	16	2	1	1	n.a
Dominica	n.a	14	27	8	24	n.a
Dominican Republic	12	19	35	33	3	17
Ecuador	13	18	17	24	25	18
El Salvador	15	23	30	17	21	21
Grenada	n.a	11	15	9	18	n.a
Guatemala	16	13	31	31	7	23
Haiti	n.a	33	37	34	13	25
Honduras	20	28	28	26	11	20
Jamaica	n.a	20	20	30	23	19
Mexico	10	21	8	12	26	11
Nicaragua	19	32	33	19	14	22
Panama	8	24	11	28	19	16
Paraguay	18	30	26	29	31	8
Peru	11	31	13	18	15	15

Table II.1 (continued)

Country	Material well-being	Housing and environment	Educational achievement	Health	Risk behaviors	Child labor
St. Kitts and Nevis	n.a	6	22	14	9	n.a
St. Lucia	n.a	7	12	21	28	n.a
St. Vincent and the Grenadines	n.a	9	34	6	17	n.a
Trinidad and Tobago	n.a	15	18	27	29	2
Turks & Caicos Islands	n.a	n.a	29	n.a	n.a	n.a
United States	2	5	14	7	20	n.a
Uruguay	5	3	5	15	32	9
Venezuela	7	25	19	32	4	10

Notes: n.a: not available. 1 ranks the best performing country. Blue means higher than the average, white means similar to average and grey lower than the average.
Source: Own elaboration based on this chapter.

Beyond the high heterogeneity presented among countries of the continent, which is not surprising, it is undisputable that there have been important improvements in some indicators of child health and education, with some exceptions (mainly Haiti but also other poor countries of the continent). The high coverage of improved water supplies, sanitation services, immunization, and primary education has helped reduce infant mortality and illiteracy rates. Nonetheless, much still needs to be done especially in early childhood and adolescence, even in not-so-poor countries. The challenge is huge since in many cases the behavior of both, children and parents needs to be modeled so they can make better decisions, such as not drinking, staying in school, using contraceptives to avoid unwanted pregnancies, maintaining a healthy diet during pregnancy, and breastfeeding their babies.

Fortunately, recent literature on human capital formation sheds light on the intervening factors in promoting human capital acquisition and their role on decisions taken by families. These findings will be very instrumental in shaping successful public interventions, including social security programs. We discuss this issue in more detail in the next chapter.