

Overview of Health and Nutrition Disparities

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SECTION I**I. INTRODUCTION AND OVERVIEW**

Health disparities continue to be evident in the Region. Differences on access to care (e.g., infrastructure, cost, and geographical location), gender, knowledge (e.g., health literacy, and access to health information), ethnic and cultural differences, among other health issues remain.

To understand health and nutrition disparities we must understand all aspects of daily life, including: educational attainment, parental schooling, childhood labor, social aspects such as gender and ethnic differences and cultural practices. A clear delineation exists between structural factors, biological factors and socio-cultural factors that affect health and the wellbeing of children. For example, a single young mother that does not complete secondary education is more likely to have her family be affected by health issues.

U5MR among the children in the worst off province tends to be about 2.5 times larger than in the best off one. This level of disparity is similar to the quintile differentials. While there is a clear overlap between the two dimensions of disparities, the geographic angle supplements the wealth perspective as it identifies children where political responsibility, duty bearers and community based groups can be located and engaged to work for children.

Teen pregnancy is also skewed according to wealth. The likelihood that an adolescent girl will become pregnant is 3.7 times larger for the ones in the bottom quintile compared to the top quintile. This likelihood ranges between 2 and 7 for the 19 countries with available data. In a quarter of these countries the likelihood exceeds 4.5.

In sum, disparities in the region are wide, they range across the various aspects of childhood experience, and they are manifested in several interacting dimensions. While some countries show some of the highest disparities in the world, there is heterogeneity. This means that there are also countries where disparities are not as high, which should give us hope that it is possible to reduce inequalities in the region.

Community Capacity Indicators.**Stunting.****Anemia.**

Undernutrition.

Acute Malnutrition.

Prenatal Care.

Skilled Birth Attendance.

Open Defecation.

Immunization Practices.

Sanitation.

SUMMARY TABLES ON HEALTH and NUTRITION DISPARITIES**TABLE 1. SKILLED BIRTH ATTENDANCE DISPARITIES IN LATIN AMERICA AND THE CARIBBEAN. Disparities Shown in Ratios.**

Country	Quintiles	Rural/Urban
Argentina	-	-
Barbados	-	-
Belize	-	-
Bolivia*	4.6	2.0
Brazil	-	1.0
Chile	-	-
Colombia	1.1	
Costa Rica	-	-
Cuba	-	-
Dominican Republic		1.0
Ecuador	-	-
El Salvador	1.8	1.2
Guatemala	-	2.2
Guyana	1.3	1.1
Suriname	1.2	1.2
Trinidad & Tobago	1.0	-
Haiti	11.0	2.0
Honduras	3.0	1.8
Jamaica	-	1.0
Mexico	-	-
Nicaragua	2.4	1.6
Panama	-	1.3
Paraguay	-	1.3
Peru	3.2	2.0
Uruguay	-	-
Venezuela	-	-
AVERAGE	2.9	1.5
STANDARD DEVIATION	2.94	0.43

SOURCE: CHILDIRINFO/ UNICEF Disparity Database. Latest available data.

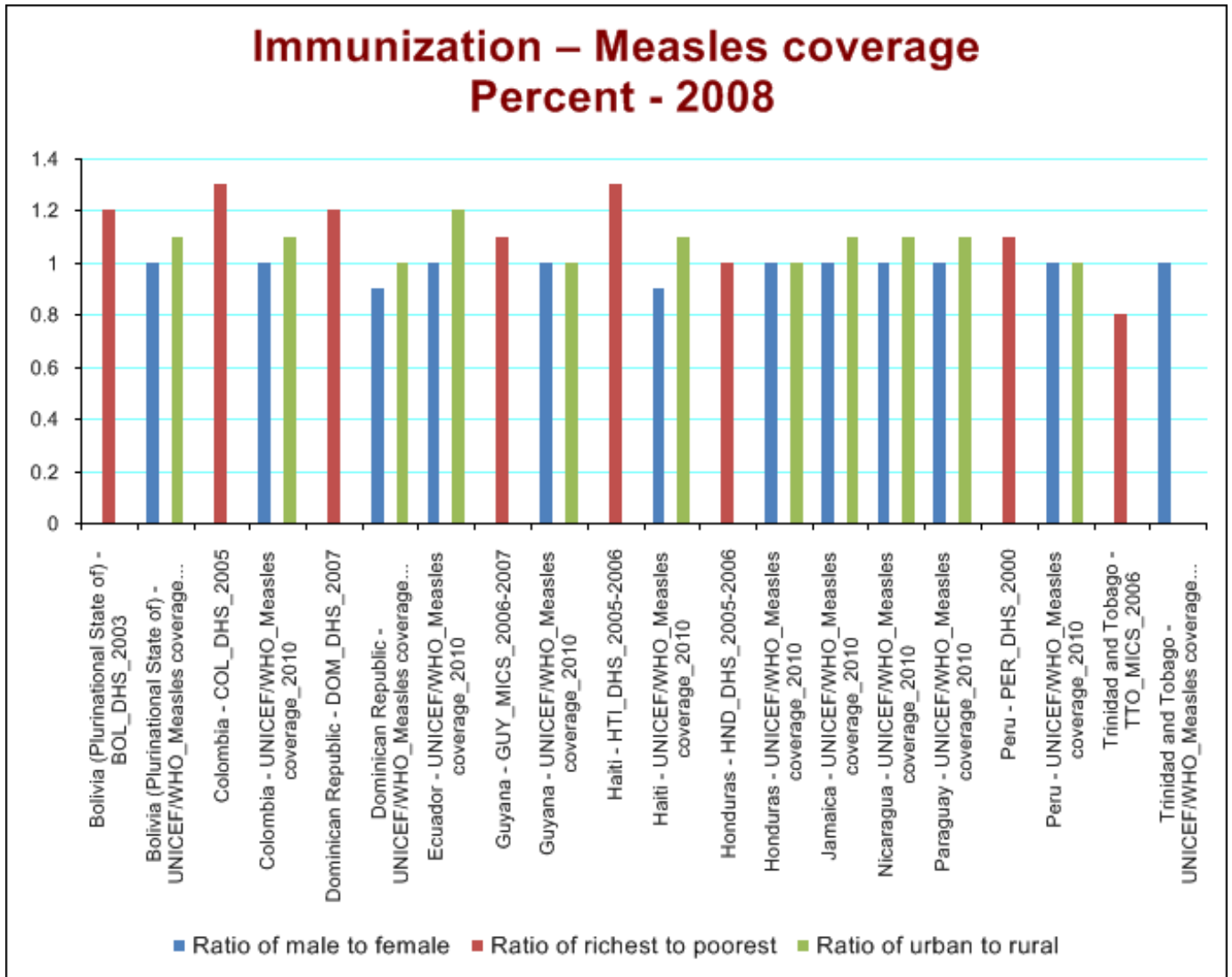
TABLE 2. UNDER 5 MORTALITY RATE. By Quintile.

Country	Period	Q1	Q2	Q3	Q4	Q5	T	Ratio
Bolivia	2003	119.20	114.80	87.20	70.70	37.10	92.70	3.2
Brazil	1996	98.90	56	39.20	26.70	33.30	56.70	3.0
Colombia	2005	38.80	27.30	24	15.90	15.90	25.70	2.4
Dominican Republic	2007	53	39.70	33.40	24.90	27.60	37.10	1.9
Guatemala	1998-1999	77.60	71.40	75.90	46.90	39.30		2.0
Haiti	2005-2006	125	114.20	109.80	83.10	54.90	102.30	2.3
Honduras	2005-2006	50.20	47.10	38.50	22.30	20	37.30	2.5
Nicaragua	2001	64.30	52.20	38.60	32.40	19.20		3.3
Peru	2000	92.60	75.50	43.90	34.50	17.60	60.40	5.3

Source: Macro International Inc_MEASURE DHS STATcompiler_ <http://www.measuredhs.com>_2010

Of the available data, the country with the largest difference per Quintile is Peru. Showing the largest gap between richest to poorest (5.3). Bolivia, Brazil and Nicaragua show similar ratios ranging from 3.0 to 3.3, respectively. Colombia, Guatemala, Honduras, and Haiti present ratios of around 2.0 to 2.5. The lowest identified ratio of U5MR in this analysis is the Dominican Republic with 1.9.

GRAPH 1. IMMUNIZATION MEASLES COVERAGE.
Disparities Shown in Ratios.



The graph depicts ratios of disparities by gender (male/female), richest to poorest (Q5/Q1) and Urban/Rural. In countries such as Bolivia, Colombia, Dominican Republic, Haiti, and Peru the difference between richest to poorest is more evident, all depicting ratios over 1.0 and in some cases over 1.2. Gender does not seem to be an indicator of disparities for immunization coverage in the Region. Ecuador shows the highest ratio of difference for Urban/Rural coverage reaching 1.2.

NUTRITION**TABLE . STUNTING PREVALENCE**

	Stunting Prevalence (WHO Child Growth Standards, %)											
	Gender			Residence			Wealth Quintile					
	Male	Female	Ratio of male to female	Urban	Rural	Ratio of urban to rural	Poorest	Second	Middle	Fourth	Richest	Ratio of richest to poorest
Belize	23	20	1.2	14	28	0.5						
Bolivia	34	31	1.1	24	44	0.5	49	42	28	18	9	0.2
Brazil	8	6	1.3	7	8	0.9						
Colombia	17	14	1.2	12	22	0.5	25	16	13	10	4	0.2
Dominican Rep	22	14	1.6				23	19	7			
Guyana	18	16	1.1	14	18	0.8	28	14	10	11	12	0.4
Suriname	11	10	1.1	8	15	0.5	17	10	8	7	4	0.2
Haiti	31	26	1.2	19	34	0.6	40	37	33	18	7	0.2
Honduras	31	28	1.1	17	38	0.4	50	38	25	15	7	0.1
Nicaragua	23	19	1.2	14	29	0.5	35	24	18	11	6	0.2
Peru	34	26	1.3	13	47	0.3	56	42	19	7	5	0.1

TABLE . STUNTING DISPARITIES IN LATINAMERICA AND THE CARIBBEAN. Disparities Shown in Ratios.

Country	Quintiles	*Rural/Urban	Gender (M/F)
Argentina	-	-	-
Barbados	-	-	-
Belize	-	-	-
Bolivia*	5.4	2.6	1.0
Brazil	10.7	3.4	1.5
Chile	-	-	-
Colombia	6.3	2.8	1.3
Costa Rica	-	-	-
Cuba	-	-	-
Dominican Republic	2.9	1.4	1.4
Ecuador	-	3.0	0.9
El Salvador	-	3.5	0.9
Guatemala	10.2	1.7	1.0
Guyana	-	-	-
Suriname	4.3	-	-
Trinidad & Tobago	-	-	0.0
Haiti	5.7	1.9	1.1
Honduras	7.1	3.3	1.1
Jamaica	-	-	-
México	-	-	-
Nicaragua	5.8	1.3	1.5
Panama	-	-	-
Paraguay	6.4	-	0.9
Perú	11.2	5.1	1.1
Uruguay	-	-	-
Venezuela	-	-	-
AVERAGE	6.9	2.7	1.1
STANDARD DEVIATION	2.69	1.13	0.38

Source: UNICEF Nutrition Stat Profile/ DHS

TABLE .UNDERWEIGHT PREVALENCE.

Country	Underweight Prevalence (WHO Child Growth Standards, %)											
	Gender			Residence			Wealth Quintile					
	Male	Female	Ratio of male to female	Urban	Rural	Ratio of urban to rural	Poorest	Second	Middle	Fourth	Richest	Ratio of richest to poorest
Belize	3	5	0.6	2	6	0.3						
Bolivia	6	5	1.2	4	8	0.5	9	7	3	3	1	0.1
Brazil	2	2	1	2	2	1						
Colombia	5	4	1.3	4	7	0.6	8	5	3	3	2	0.3
Dominican Rep	10	5	2				11	5	1			
Guyana	10	9	1.1	10	9	1.1	10	12	9	9	4	0.4
Suriname	8	7	1.1	7	8	0.9	9	7	6	7	5	0.6
Haiti	19	17	1.1	12	20	0.6	22	23	22	13	6	0.3
Honduras	8	8	1	4	11	0.4	16	10	6	3	2	0.1
Jamaica	2	3	0.7									
Nicaragua	6	4	1.5	4	7	0.6	9	6	6	3	1	0.1
Peru	6	5	1.2	2	9	0.2	12	7	3	0	1	0.1

TABLE . WASTING PREVALENCE

	Wasting Prevalence (WHO Child Growth Standards, %)											
	Gender			Residence			Wealth Quintile					
	Male	Female	Ratio of male to female	Urban	Rural	Ratio of urban to rural	Poorest	Second	Middle	Fourth	Richest	Ratio of richest to poorest
Belize	2	1	2	1	2	0.5						
Bolivia	2	2	1	2	2	1	2	2	2	1	1	0.5
Brazil	2	1	2	2	2	1						
Colombia	2	1	2	2	2	1	2	2	2	1	1	0.5
Dominican Republic	3	2	1.5				5	5	4			
Guyana	8	9	0.9	12	7	1.7	4	11	10	12	5	1.3
Suriname	5	5	1	5	5	1	3	4	7	6	6	2
Haiti	11	10	1.1	8	12	0.7	10	12	13	10	6	0.6
Honduras	2	1	2	1	2	0.5	2	1	1	1	1	0.5
Nicaragua	1	1	1	1	1	1	2	1	2	1	1	0.5
Peru	1	1	1	1	1	1	2	1	1	0	0	

TABLE . INFANTS NOT WEIGHED AT BIRTH

	Infants not weighed at birth (%)											
	Gender			Residence			Wealth Quintile					
	Male	Female	Ratio of male to female	Urban	Rural	Ratio of urban to rural	Poorest	Second	Middle	Fourth	Richest	Ratio of richest to poorest
Belize				6	9	0.7						
Bolivia				19	54	0.4	65	43	26	10	1	0
Colombia				2	19	0.1	23	4	2	1	1	0
Dominican Republic				3	5	0.6	7	3	3	2	2	0.3
Guyana				27	21	1.3	30	23	14	21	17	0.6
Trinidad and Tobago							13	12	11	7	7	0.5
Suriname				23	31	0.7	36	25	22	16	23	0.6
Haiti				70	85	0.8	87	87	82	76	59	0.7
Honduras				14	43	0.3	57	41	22	14	7	0.1
Jamaica				2	5	0.4						
Peru				5	36	0.1	49	24	7	2	1	0

TABLE . EARLY INITIATION OF BREASTFEEDING

	Early Iniciation of Breastfeeding (%)											
	Gender			Residence			Wealth Quintile					
	Male	Female	Ratio of male to female	Urban	Rural	Ratio of urban to rural	Poorest	Second	Middle	Fourth	Richest	Ratio of richest to poorest
Belize				45	55	0.8						
Bolivia	60	61	1	61	61	1	59	63	60	63	58	1
Colombia	49	49	1	50	47	1.1	44	51	50	51	49	1.1
Cuba	70	71	1	68	75	0.9						
Dominican Rep	73	75	1				76	71	73			
Guyana				42	44	1	45	43	47	42	34	0.8
Trinidad and Tobago							43	47	38	40	37	0.9
Suriname				35			34	36	33	33	35	1
Haiti	44	45	1	42	45	0.9	47	48	41	43	43	0.9
Honduras	78	79	1	75	82	0.9	85	83	77	74	73	0.9
Jamaica				66	57	1.2						
Nicaragua	54	54	1	47	61	0.8						
Paraguay	21	21	1	23	19	1.2						
Peru	45	50	0.9	45	50	0.9	52	51	51	42	37	0.7

TABLE . WOMEN WITH LOW BMI

	Women with low BMI (<18.5 kg/m ² , %)											
	Gender			Residence			Wealth Quintile					
	Male	Female	Ratio of male to female	Urban	Rural	Ratio of urban to rural	Poorest	Second	Middle	Fourth	Richest	Ratio of richest to poorest
Bolivia		2		2	2	1	2	2	2	2	3	1.5
Brazil		6		6	8	0.8						
Colombia		6		6	5	1.2	6	6	6	5	4	0.7
Guatemala		2		2	2	1						
Trinidad and Tobago												
Haiti		16		12	19	0.6	21	23	16	13	10	0.5
Honduras		4		4	4	1	4	4	5	4	4	1
Nicaragua		4		4	3	1.3	2	2	3	4	4	2
Peru		2		2	2	1	1	2	2	2	2	2

**TABLE . ACCESS TO WATER-Used of Improved Drinking Water Sources.
Disparities Shown in Ratios.**

Country	Quintiles Q5/Q1	*Rural/Urban	Gender (M/F)
Argentina	1.1	1.20	1.0
Barbados	-	1.00	-
Belize	0.3	1.00	-
Bolivia*	1.9	1.40	1.0
Brazil	1.6	1.20	-
Chile	1.5	0.76	1.0
Colombia	1.9	1.36	-
Costa Rica	1.1	1.10	1.0
Cuba	-	1.08	-
Dominican Republic	2.9	3.9	1.04
Ecuador	-	1.10	1.0
El Salvador	2.5	1.20	-
Guatemala	1.5	1.10	-
Guyana	1.4	1.10	-
Suriname	1.5	1.20	-
Trinidad & Tobago	1.1	1.10	-
Haiti	3.7	1.30	-
Honduras	1.7	1.20	1.0
Jamaica	-	1.10	-
México	1.4	1.10	1.0
Nicaragua	1.5	1.40	1.0
Panama	-	1.20	-
Paraguay	1.6	1.50	1.0
Perú	2.4	1.48	1.0
Uruguay	1.1	1.00	1.0
Venezuela	1.9	2.37	1.0
AVERAGE	1.7	1.21	1.0
STANDARD DEVIATION	2.69	0.84	0.29

SOURCE: CHILDINFO/CEPAL.

*Quintile of Assets Index by Attila Hancioglu.

**TABLE . ACCESS TO SANITATION.
Disparities Shown in Ratios.**

Country	Quintiles Q5/Q1	*Rural/Urban	Gender (M/F)
Argentina	1.1	1.2	1.0
Barbados	-	1.0	-
Belize	1.3	1.1	-
Bolivia*	0.8	3.8	1.0
Brazil		2.4	1.0
Chile	1.6	1.2	1.0
Colombia	1.7	1.5	1.0
Costa Rica	1.3	1.0	1.0
Cuba	-	1.2	-
Dominican Republic	2.9	1.3	1.2
Ecuador	4.9	1.1	1.0
El Salvador		1.1	1.0
Guatemala		1.2	1.0
Guyana	2.1	1.1	-
Suriname	1.8	1.4	-
Trinidad & Tobago	1.0	1.0	-
Haiti		2.3	-
Honduras	2.2	1.3	1.0
Jamaica		1.0	-
México		1.3	1.0
Nicaragua		1.7	1.0
Panama		1.5	-
Paraguay		2.3	1.0
Perú	5.2	2.3	1.0
Uruguay		1.0	1.0
Venezuela		1.7	1.0
AVERAGE	2.0	1.5	1.0
STANDARD DEVIATION	2.69	1.40	0.64

SOURCE: CHILDINFO/CEPAL.

*Quintile of Assets Index by Attila Hancioglu.

SECTION II**II. Caribbean**

- Barbados and Eastern Caribbean States
 - Antigua and Barbuda
 - Barbados
 - Commonwealth of Dominica
 - Grenada
 - Saint Kitts and Nevis
 - Saint Lucia
 - Saint Vincent and the Grenadines
 - British Overseas Territories of British Virgin Islands
 - Montserrat and Turks and Caicos Islands
- Cuba
- Haiti
- Jamaica
- Trinidad & Tobago



BARBADOS AND EASTERN CARIBBEAN STATES

As of 2007, Barbados had a population of 294,000 with about half of the total population living in urban areas.¹ In terms of population size, the other countries (Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, and Saint Vincent and the Grenadines) range between 50,000 (Saint Kitts) and 165,000 (Saint Lucia). Dominica is the most urbanized (73%). Urbanization rates in the other islands ranges from 28% (St Lucia) to 47% (Saint Vincent)

According to the MDG Observatory for Latin America and the Caribbean, all MDGs are on track to be reached by 2015 except for MDG 6, which is probable. The top 10 % earns 530 dollars per 100 earned by the bottom 10%.²

Limited or no available segregated data for: Antigua and Barbuda, Barbados, Commonwealth of Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, British Overseas Territories of British Virgin Islands, or Montserrat and Turks and Caicos Islands.

HEALTH

NUTRITION. Almost no data is available from UNICEF country profiles for Barbados and the Eastern Caribbean Islands. Only data on Anemia presented, with a prevalence of 17%, 23% (moderate public health problem) and 17% respectively for non pregnant women, pregnant women, and preschool children.

UNICEF ACTIVITIES: No nutrition related activities are supported by the CO at this time

CHALLENGES: The lack of updated and reliable data hinders the possibility of capturing the nutrition situation in country.

WASH

¹ UNICEF. State of the World's Children, 2009.

² UNDP. Human Development Report, 2009.

CUBA

As of 2007, Cuba had a population of 11,268,000 with a little over 3/4 of the total population living in urban areas.³

According to the MDG Observatory for Latin America and the Caribbean, all MDGs are on track to be reached by 2015 except for MDG 7, which is possible and MDG 5 that is off track.

HEALTH

NUTRITION. According to the DI profile, based on 2005, the prevalence of stunting, underweight and wasting in Cuba, is of 5%, 4% and 2%, respectively (NCHS reference population). According to data from MICS 2008, exclusive breastfeeding < 6 months is down to 28% from 40% in 2000. The most recent estimate of household consumption of iodized salt is 88% (2005); 14,000 were at risk of IDD in 2008. Even though anemia can be considered between light and moderate, it is estimated that its high frequency makes it a serious public health problem. Around 50% of infants aged 6-11 months and 30% of boys and girls aged 6-23 months suffer from anemia. Anemia is also present in 30% of reproductive-age women and in 24% of pregnant women in their third quarter. Twelve percent of this latter population group is also affected by insufficient weight gain. In absolute numbers, from a population of around 11.2 million inhabitants, approximately one million Cubans suffer from anemia.⁴

UNICEF ACTIVITIES: The office is engaged in a variety of activities including breastfeeding promotion, anemia prevention and control, and general nutrition education. Most notably the country office leads the interagency group *Joint Program Support for the Fight against Anemia in Vulnerable Groups in Cuba*

Most notable nutrition challenges: anaemia, vulnerability to emergencies, breastfeeding

WASH

³ UNICEF. State of the World's Children, 2009.

⁴ Sources: (1) Gay J., Padrón M., Amador M. (1995) Prevention and control of anemia and iron deficiency in Cuba, *Rev. Cubana Aliment Nutr* 9:52-61; (2) Rebozo J., Jiménez S., Macías C. & Pita G.: Anemia in Cuban children aged 6 months to 2 years, summary book, III ACTAC Congress, Havana, Cuba. March 2000. (3) Cuban Public Health Projections up to 2015. Ministry of Public Health. February 2006. (4) Pan-American Health Organization (PAHO). Family and Community Health (FCH) area. Situation Analysis, 2004.

HAITI

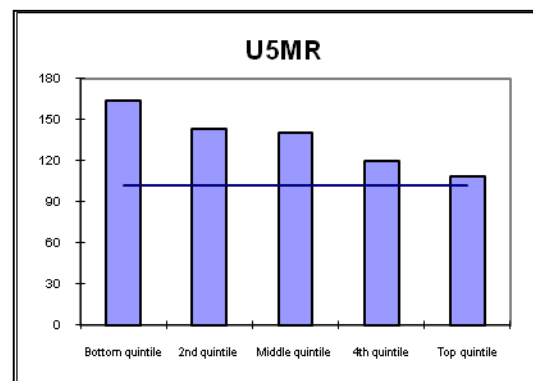
As of 2007, Haiti had a population of 9,598,000 with 2/3 of the total population living in urban areas.⁵

According to the MDG Observatory for Latin America and the Caribbean, MDG 3 is on track, while 2, 6 and 7 are possible. However, MDG 1 and 5 are off track and MDG 4 is unlikely to be reached by 2015. In terms of the Gini coefficient (59.2)⁶ Haiti is ranked as the second most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 5400 dollars per 100 earned by the bottom 10%.⁷ For most social inequality dimensions with available data, Haiti shows high levels of disparities.

The likelihood that a child from the bottom quintile will be stunted is 5.7⁸ times that of a child from the richest quintile. This is higher than the relative gap (1.8) between urban and rural children. The level of stunting for all quintiles is significantly different⁹. Stunting among children in the Department of Centre is 3 times larger than children in the Department of Aire Métropolitaine.

While primary attendance and literacy, among the bottom quintile, are at 72.1 and 71.8 respectively, primary completion among the bottom quintile is 26.7 percentage points lower than among the top quintile. There is a 25 percentage point difference in primary completion between urban and rural children.¹⁰

HEALTH. The U5MR distribution by quintile follows a segmented distribution. There are significant differences only between some quintiles. A child in the poorest quintile is 1.5 times more likely to die before reaching age five than a child from the top quintile. The relative gap between urban and rural children is the same. The highest under five mortality rate is 155 per 1000 live births in Centre, while the lowest is 59 per 1000 live births in Aire Métropolitaine. Therefore, children under five in Centre are 2.6 times more likely to die than the same population in Aire Métropolitaine.¹¹



⁵ UNICEF. State of the World's Children, 2009.

⁶ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

⁷ UNDP. Human Development Report, 2009.

⁸ Calculated from UNICEF disparity database (based on DHS 2005)

⁹ DHS 2005

¹⁰ SEDLAC 2001

¹¹ DHS 2005

There are some differences between quintiles on immunization (measles) with a relative gap between rich and poor of 1.3.¹²

With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 1.9, while the urban-rural gap is at 1.2.¹³ The urban-rural difference for antenatal care (“at least one visit”) is at around 1.1, while for “at least four visits” it is at 1.5. The relative gap of skilled birth attendance is significantly different between the richest and poorest quintiles (10.5), while urban-rural is at 3.1.¹⁴

In relation to comprehensive HIV/AIDS knowledge, the gap between the lowest and highest quintiles for women (ages 15-49) is 2.6, while the urban-rural gap on comprehensive knowledge on how HIV is transmitted is at 1.6. Likewise, adolescents in the poorest quintile are 3 times more likely to become pregnant than the richest.¹⁵

HEALTH.

NUTRITION. Haiti was struck by a devastating earthquake on January 12th, 2010. While the country report provides information, most of it has been deemed irrelevant after the facts.

UNICEF ACTIVITIES: Need updated information

Most notable nutrition challenges: Chronic malnutrition, acute malnutrition, breastfeeding, nutrition and HIV

WASH

¹² Ibid

¹³ Ibid

¹⁴ Calculated from UNICEF disparity database (based on DHS 2005)

¹⁵ DHS 2005

JAMAICA

As of 2007, Jamaica had a population of 2,714,000 with little over half of the total population living in urban areas.¹⁶

According to the MDG Observatory for Latin America and the Caribbean, MDGs 1,2 and 6 are on track to be reached by 2015, while MDG 5 is possible and MDGs 3,4 and 7 are off track. In terms of the Gini coefficient (55.1)¹⁷, Jamaica is ranked as the 6th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 1700 dollars per 100 earned by the bottom 10%.¹⁸

Primary attendance and literacy are high even among the bottom quintile (94.9 and 99.1 respectively). Primary completion among the bottom quintile is 1.0 percentage points higher than among the top quintile.¹⁹

HEALTH

NUTRITION. GENERAL SITUATION SUMMARY: According to the country report low levels of Exclusive Breastfeeding (EBF) persist; it is hoped that the development of an Infant and Young Child Feeding (IYCF) Policy and National Plan of Action (NPA) and the support for the comprehensive implementation of the two exclusive breastfeeding pilot projects in the parishes of St. Catherine and Clarendon will contribute to increased EBF rates. **Exclusive breastfeeding continues to decline.** At six weeks 43.1% infants are breastfed exclusively compared to 43.7% in 2007; this rate further declines to 15% at six months.

Based on the DI nutrition profile the prevalence of stunting, underweight and wasting is low in children <5 years of age (4%, 4% and 2%, respectively according to WHO guidelines). The percentage of exclusive breastfeeding is very low, estimated to be 15% in 2005. No data on Vitamin A supplementation or use of iron folic acid supplements among women. Anemia is a moderate public health problem among non-pregnant women (24%). Dated, but most recently available information (1999), indicates anaemia among pregnant and school age children is a severe public health problem, with a prevalence of 41% and 48%, respectively.

UNICEF ACTIVITIES: With regards to nutrition the country office is engaged in supporting breastfeeding promotion initiatives and programs.

MOST NOTABLE NUTRITION CHALLENGES: Low breastfeeding rates and anaemia

WASH

¹⁶ UNICEF. State of the World's Children, 2009.

¹⁷ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹⁸ UNDP. Human Development Report, 2009.

¹⁹ SEDLAC 2002

TRINIDAD AND TOBAGO

As of 2007, Trinidad and Tobago had a population of 1,333,000 with around 13% of the total population living in urban areas.²⁰

According to the MDG Observatory for Latin America and the Caribbean, MDGs 2, 3, 5 and 7 are on track to be reached by 2015, while MDG 5 is unlikely and MDG 4 is off track. There is not sufficient information to determine the status of MDG 1. Trinidad and Tobago's Gini Coefficient is at 40.3. The top 10 % earns 1400 dollars per 100 earned by the bottom 10%.²¹

HEALTH. With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 1.2.²² The relative gap of skilled birth attendance is significantly different between the richest and poorest quintiles (1.0).²³

In relation to comprehensive HIV/AIDS knowledge, the gap between the lowest and highest quintiles for women (ages 15-49) is 1.5.²⁴

NUTRITION. Unlike Guyana and Suriname 2000 MICS data indicated a lower prevalence of stunting, undernutrition and wasting in children <5 living in Trinidad & Tobago (4%, 6%, 4%, respectively). It should be noted that wasting is high compared to other countries in the region. The prevalence of exclusive breastfeeding to 6 months of age is low at 13% (2006 MICS). Only 28% of households consumed properly iodized salt in 2006, putting 14,000 newborns at risk for IDD. Anemia is a moderate public health problem among non-pregnant, pregnant and school children alike with prevalences of 24%, 30% and 30%, respectively.

WASH

²⁰ UNICEF. State of the World's Children, 2009.

²¹ UNDP. Human Development Report, 2009.

²² MICS 2006

²³ Calculated from UNICEF disparity database (based on MICS 2006)

²⁴ MICS 2006

SECTION III

III. South America

- Brazil
- Guyana
- Suriname

a. Andean

- Bolivia
- Chile
- Colombia
- Ecuador
- Peru
- Venezuela

b. Southern Cone

- Argentina
- Brazil
- Uruguay
- Paraguay



SOUTH AMERICA

BRAZIL

As of 2007, Brazil had a population of 191,791,000 with more than 3/4 of the total population living in urban areas.²⁵ The proportion of indigenous population was 0.43%, while its afro descendant population is at 45%.

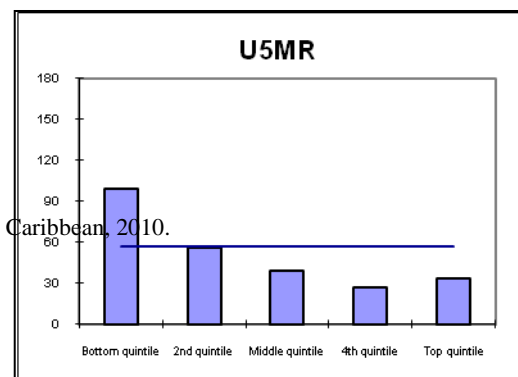
According to the MDG Observatory for Latin America and the Caribbean, most MDGs are either achieved or on track to be reached by 2015 except MDG 5 that is off track and MDG 7 that is possible. In terms of the Gini coefficient (55.9)²⁶ Brazil is ranked as the 3rd most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 4100 dollars per 100 earned by the bottom 10%.²⁷ For most social inequality dimensions with available data, Brazil shows high levels of disparities.

The likelihood that a child from the bottom quintile will be stunted is 10.7²⁸ times that of a child from the richest quintile, which is above the regional average. This is higher than the relative gap (6.2) between urban and rural children. The level of stunting for all quintiles is significantly different²⁹. Stunting among children in the Northeast Region is 6.2 times larger than children in the Rio Region.

While primary attendance and literacy are high even among the bottom quintile (97.3 and 95.6 respectively), primary completion among the bottom quintile is 46.9 percentage points lower than among the top quintile. There is only a 26.9 percentage point difference in primary completion between urban and rural children.³⁰ When cross tabulating gender and ethnic background, some slight differences appear particularly for indigenous populations. For example, the difference between primary completion between indigenous men and women is only 3.9 percentage points (with women faring better), while the difference between indigenous and non-indigenous women is 1.6 percentage points.³¹

Secondary school attendance among children from the bottom quintiles is about 65, while among the top quintile it reaches 87 (a 1.3 relative gap). Similar values apply between the highest secondary enrolment state (86) and the lowest one (61).

HEALTH. The U5MR distribution by quintile follows a segmented distribution. There are significant differences between all quintiles.



²⁵ UNICEF. State of the World's Children, 2009.

²⁶ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

²⁷ UNDP. Human Development Report, 2009.

²⁸ DHS 1996

²⁹ DHS 1996

³⁰ SEDLAC 2008

³¹ CEPAL data produced at request of UNICEF TACRO

A child in the poorest quintile is 3 times more likely to die before reaching age five than a child from the top quintile. The relative gap between urban and rural children is lower at 1.6. The highest under five mortality rate is 89 per 1000 live births in the Northeast Region, while the lowest is 29 per 1000 live births in Southern Region. Therefore, children under five in the Northeast are 3.1 times more likely to die than the same population in the South.³²

There are some differences between quintiles on immunization (measles).³³

With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 1.4³⁴, while the urban-rural gap is slightly different at around 1.0.³⁵ Adolescents in the poorest quintile are 4 times more likely to become pregnant than the richest.³⁶

Child labor is estimated at 17% (of the children older than 10 years old). It ranges between 21% and 12% for boys and girls respectively. In rural areas child labor stands at 32% and in urban areas at 13%. Among children whose parents have not completed primary schooling child labor is 22%, but for children whose parents have completed secondary schooling it is 10% (a relative gap higher than 2). Among children whose parents are working informally, it reaches 35% - twice the average rate.

NUTRITION. Similar to other health/nutrition indicators, acute malnutrition has dropped significantly over the last 10 years. Based on the UNICEF nutrition profile, among children < 5 Brazil has a prevalence of stunting, underweight and wasting of 7%, 2%, and 2%, respectively (NCHS standards, MOH2006). The percentage of children exclusively breastfed <6mo is 40%. Early initiation of breastfeeding is estimated at 43%; timely introduction of complimentary foods with continued breastfeeding is 70%. ICMBS has been implemented. Regarding micronutrients, no information is available on Vitamin A. Household consumption of iodized salt is estimated at 96%. Anemia is a public health problem. Among non-pregnant and pregnant women it is considered of moderate severity, with a prevalence of 23% and 29% respectively. It is a severe public health problem among preschool age children (1998), when it was estimated at 58%; no information is available on children <2.

UNICEF ACTIVITIES: The UNICEF country office is involved with numerous activities in the area of nutrition, most which are related to Seal of Approval program in the Semi-Arid and Amazon Regions. Other important and relevant activities in the area of M&E are also taking place, specifically support of the National System for Food and Nutrition Surveillance. Other efforts are also being

³² DHS 1996

³³ Ibid

³⁴ Ibid

³⁵ Calculated from UNICEF disparity database (based on PNDS 2006)

³⁶ DHS 1996

carried out to use DevInfo as a tool to develop necessary and relevant nutrition indicators. The CO is interested in strengthening the NiE component as well as in becoming more involved in MNP distribution in collaboration with the MOH.

CAPACITIES

- The team gathers solid technical expertise in the area of health (comprised of 4 medical doctors and 1 nurse)
- Need for capacity building in NiE

WASH

GUYANA

As of 2007, Guyana had a population of 738,000 with nearly a third of the total population living in urban areas.³⁷ The proportion of indigenous population was 9.2%.

According to the MDG Observatory for Latin America and the Caribbean, MDGs 2 and 3 are on track to be reached by 2015, while 1 and 7 are probable. However, MDGs 4, 5 and 6 are off track. In terms of the Gini coefficient (51.8)³⁸, Guyana is ranked as the 14th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 2500 dollars per 100 earned by the bottom 10%.³⁹ For most social inequality dimensions with available data, Guyana shows medium levels of disparities.

The likelihood that a child from the bottom quintile will be stunted is 2.3⁴⁰ times that of a child from the richest quintile. This is higher than the relative gap (1.3) between urban and rural children. The level of stunting for the poorest quintiles is significantly different⁴¹. Stunting among children in the Regions 07, 08, 09, and 10 is 1.9 times larger than children in Region 04.

While primary attendance and literacy are high even among the bottom quintile (95.9 and 97.3 respectively), primary completion among the bottom quintile is 8.9 percentage points lower than among the top quintile. There is a 9 percentage point difference in primary completion between urban and rural children.⁴²

Differences between quintiles on immunization (measles) are slightly different and are consistent with national average of around 95.5 with the middle and richest quintiles reaching 100%.⁴³

HEALTH. With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 1.1, while the urban-rural gap is around the same at 1.⁴⁴ Urban-rural differences for antenatal care (at least one visit) are at 1.1. The relative gap of skilled birth attendance is significantly different between the richest and poorest quintiles (1.5), while urban-rural follows the same pattern as antenatal care.⁴⁵

³⁷ UNICEF. State of the World's Children, 2009.

³⁸ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

³⁹ UNDP. Human Development Report, 2009.

⁴⁰ Calculated from UNICEF disparity database (based on MICS 2006)

⁴¹ MICS 2006

⁴² SEDLAC 1992-1993

⁴³ MICS 2006

⁴⁴ Calculated from UNICEF disparity database (based on MICS 2006)

⁴⁵ Ibid

In relation to comprehensive HIV/AIDS knowledge, the gap between the lowest and highest quintiles for women (ages 15-49) is 2, while the urban-rural gap on comprehensive knowledge on how HIV is transmitted is at 1.4.⁴⁶

NUTRITION. According to the DI Profile, based on MICS 2005-2006 information, stunting, undernutrition and wasting affect 17%, 10% and 8%, respectively, of the population under 5 (WHO standards). The percentage of children that exclusively breastfeed is 21%. No information on Vitamin A supplementation or iodized salt consumption is available, but currently an effort is being carried out to document it. Information on the prevalence of anemia is dated (1997), but at that time it was estimated that more than half the population of pregnant and non-pregnant women and school aged children suffered from Anaemia.

UNICEF ACTIVITIES: Although this set of countries face important nutrition challenges the Guyana country is the only one partially engaged in nutrition activities. Currently, they are supporting an Iodized Salt study and a study on infant feeding.

Most notable nutrition challenges: High prevalence of acute undernutrition (8%), anaemia and very low rates of breastfeeding among the population.

WASH

⁴⁶ Ibid

SURINAME

As of 2007, Suriname had a population of 458,000 with around three quarters of the total population living in urban areas.⁴⁷ The proportion of indigenous population was 1.5%.

In terms of the Gini coefficient (52.8)⁴⁸, Suriname is ranked as the 11th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 4000 dollars per 100 earned by the bottom 10%.⁴⁹

The likelihood that a child from the bottom quintile will be stunted is 4.3⁵⁰ times that of a child from the richest quintile. This is higher than the relative gap (2) between urban and rural interior children. The level of stunting for all quintiles is significantly different⁵¹. Stunting among children in Commewijne and Marowijne is 2.5 times larger than children in Paramaibo.

While primary attendance and literacy are high even among the bottom quintile (92.7 and 95.2 respectively), primary completion among the bottom quintile is 16.1 percentage points lower than among the top quintile.⁵²

There are some differences between quintiles on immunization (measles), yet they do not vary immensely from the national average of around 81.⁵³

HEALTH. With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 1.8, while the urban-rural interior gap is around 3.3.⁵⁴ Urban-rural differences for antenatal care are at 1.2. The relative gap of skilled birth attendance is significantly different between the richest and poorest quintiles (1.2), while urban-rural follows the same pattern as antenatal care.⁵⁵

In relation to comprehensive HIV/AIDS knowledge, the gap between the lowest and highest quintiles for women (ages 15-49) is 2.8, while the urban-rural interior gap on comprehensive knowledge on how HIV is transmitted is at 2.5.

NUTRITION. MICS 2005 data point to a prevalence of stunting, underweight and wasting of 11%, 7% and 5%, respectively, in children <5 (WHO standards). The percentage of exclusively breastfed children <6 months is scarcely 2%. The

⁴⁷ UNICEF. State of the World's Children, 2009.

⁴⁸ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

⁴⁹ UNDP. Human Development Report, 2009.

⁵⁰ Calculated from UNICEF disparity database (based on MICS 2006)

⁵¹ MICS 2006

⁵² SEDLAC 1999

⁵³ Ibid

⁵⁴ Ibid

⁵⁵ Calculated from UNICEF disparity database (based on MICS 2006)

prevalence of Anaemia is high and represents a moderate public health problem among non pregnant (20%), pregnant (32%) and school aged children (26%).

WASH

ANDEAN REGION

BOLIVIA

As of 2007, Bolivia had a population of 9,525,000 with around 2/3 of the total population living in urban areas.⁵⁶ The proportion of indigenous population was 60.8%.

Using the same weights for wealth rankings in urban and rural areas, 48% of the rural population belongs to the bottom quintile. The regions with the highest number of people from the bottom quintile are: La Paz, Cochabamba and Santa Cruz. These are also the regions with the largest share of the population. The regions with a disproportionate share of members of the poorest quintile are: Potosi and Chuquisaca.⁵⁷

According to the MDG Observatory for Latin America and the Caribbean, most MDGs are on track to be reached by 2015. In terms of the Gini coefficient (59.3)⁵⁸ Bolivia is ranked as the most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 9000 dollars per 100 earned by the bottom 10%.⁵⁹ For most social inequality dimensions with available data, Bolivia shows high levels of disparities.

The likelihood that a child from the bottom quintile will be stunted is 5.4⁶⁰ times that of a child from the richest quintile. This is higher than the relative gap (2.4) between urban and rural children. The level of stunting for all quintiles is significantly different⁶¹. Stunting among children in the Department of Potosi is 3.6 times larger than children in the Department of Santa Cruz.

While primary attendance and literacy are high even among the bottom quintile (92.2 and 99.2 % respectively), primary completion among the bottom quintile is 27.8 percentage points lower than among the top quintile. There is only a 0.8 percentage point difference in primary completion between urban and rural children.⁶² When cross tabulating gender and ethnic background, some slight differences appear particularly for indigenous populations. For example, the difference between primary completion between indigenous men and women is only around 2.7 percentage points, while the difference between indigenous and non-indigenous women is 6.6 percentage points.⁶³

⁵⁶ UNICEF. State of the World's Children, 2009.

⁵⁷ DHS 2008

⁵⁸ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

⁵⁹ UNDP. Human Development Report, 2009.

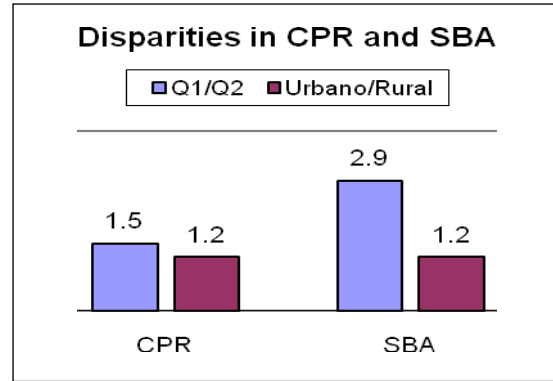
⁶⁰ Calculated from UNICEF disparity database (based on DHS 2003)/Based on DHS 2008 the relative gap is around 7.1

⁶¹ DHS 2008

⁶² SEDLAC 2007

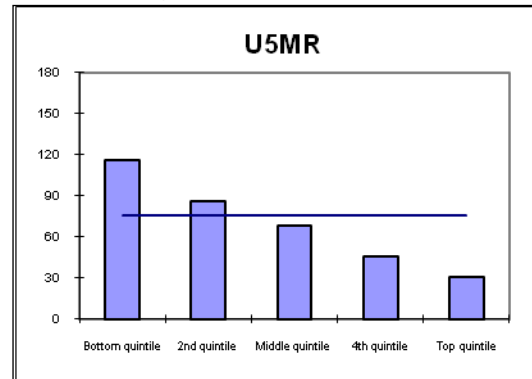
⁶³ CEPAL data produced at request of UNICEF TACRO

HEALTH. The U5MR distribution by quintile follows a classic distribution. There are significant differences between all quintiles. A child in the poorest quintile is 3.7 times more likely to die before reaching age five than a child from the top quintile – which is above the regional average. The relative gap between urban and rural children is lower at 1.8. The highest under five mortality rate is 101 per 1000 live births in Potosi, while the lowest is 31 per 1000 live births in Santa Cruz. Therefore, children under five in Potosi are 3.3 times more likely to die than the same population in Santa Cruz.⁶⁴



Differences between quintiles on immunization (measles) are not significant and are consistent with national average of around 85%.⁶⁵

With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 1.5, while the urban-rural gap is around the same at 1.2.⁶⁶ Urban-rural differences are similar for antenatal care (both for “at least one visit” as well as “at least four visits”). The relative gap of skilled birth attendance is significantly different between the richest and poorest quintiles (2.9), while urban-rural follows the same pattern as antenatal care.⁶⁷



In relation to comprehensive HIV/AIDS knowledge, the gap between the lowest and highest quintiles for women (ages 15-49) is 12.5 (which is higher than the regional average), while the urban-rural gap on comprehensive knowledge on how HIV is transmitted is at 4. Likewise, adolescents in the poorest quintile are 4 times more likely to become pregnant than the richest.⁶⁸

Child labor is estimated at 28% (of the children older than 7 years old). It ranges between 31% and 26% for boys and girls respectively. In rural areas child labor stands at 57% and in urban areas at 12%. Among children whose parents have not completed primary schooling child labor is 42%, but for children whose parents have completed secondary schooling it is 10% (a relative gap higher than 4). Among children whose parents are working informally, it reaches 50% - twice the average rate.

⁶⁴ DHS 2008

⁶⁵ Ibid

⁶⁶ Ibid

⁶⁷ Calculated from UNICEF disparity database (based on DHS 2003)

⁶⁸ DHS 2008

NUTRITION. According to DHS data (2008) the prevalence of stunting, underweight and wasting among children <5 is 22%, 6% and 1% respectively. Sixty percent (60%) of children are exclusively breastfed <6 mo. Early initiation of breastfeeding stands at 61%. Regarding micronutrients full coverage implementation of Vitamin A supplementation is 45% and 88% of households have access to adequately iodized salt. Use of folic acid supplements is currently 22%. (DHS,2008). Anemia is a severe problem among the population; it is considered to be a moderate public health problem among non pregnant women and pregnant women (33% and 37%, respectively). It is a severe problem among pre-school children and children < 2 years, alike (52% and 76% prevalence, respectively).

In a country where approximately 60% of the child population was poor in 2007, chronic malnutrition in children under the age of three years has decreased from 37.7% in 1989 to 23.7% in 2008. Yet, the percentage was almost twice (28%) amongst indigenous children than amongst non-indigenous children (16%), according to the 2003 DHS, illustrating that severe disparities prevail.

UNICEF ACTIVITIES: Close support to Desnutricion Zero program and collaborations with MOH on multiple projects.

CAPACITIES

- NiE: country officer trained in NiE, Panama 2009 (Leda Azad)
- MNP: country officer participated in MNP Workshop, Mexico 2010 (Leda Azad)

WASH

CHILE

As of 2007, Chile had a population of 16,635,000 with nearly 90% of the total population living in urban areas.⁶⁹ The proportion of indigenous population was 4.6%.

According to the MDG Observatory for Latin America and the Caribbean, all MDGs have been achieved or are on track to be reached by 2015 except for MDG 6, which is possible. In terms of the Gini coefficient (51.8)⁷⁰ Chile is ranked as the 15th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 2600 dollars per 100 earned by the bottom 10%.⁷¹ For most social inequality dimensions with available data, Chile shows medium levels of disparities.

Primary attendance and literacy are high even among the bottom quintile (98.3 and 98.6 respectively). Primary completion among the bottom quintile is 9.5 percentage points lower than among the top quintile.⁷² When cross tabulating gender and ethnic background, some slight differences appear particularly for indigenous populations. For example, the difference between primary completion between indigenous men and women is only 0.8 percentage points (with women faring better), while the difference between indigenous and non-indigenous women is 1.1 percentage points, a relatively low value for the region.⁷³

Secondary school attendance among children from the bottom quintiles is about 73, while among the top quintile it reaches 87 (a relative gap of roughly 2). Similar values apply between the highest secondary enrolment region (85) and the lowest one (77).

HEALTH. Adolescents in the poorest quintile are almost 3 times more likely to become pregnant than the richest.

Child labor is estimated at 3% (of the children older than 12 years old). It ranges between 4% and 2% for boys and girls respectively. In rural and urban areas child labor shows similar levels to the national average. Among children whose parents have not completed primary schooling child labor is 4%, but for children whose parents have completed secondary schooling it is 2.5% (a relative gap lower than 2). Among children whose parents are working informally, it reaches 5% - less than twice the average rate.

NUTRITION. Chile fares better than the majority of countries in the region. According to UNICEF data, the prevalence of both, stunting and wasting, is 1%.

⁶⁹ UNICEF. State of the World's Children, 2009.

⁷⁰ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

⁷¹ UNDP. Human Development Report, 2009.

⁷² SEDLAC 2009

⁷³ CEPAL data produced at request of UNICEF TACRO

HEALTH DISPARITIES

Wasting is <1%. The percentage of children exclusive breastfeed <6 mo was 63% in 2004 (most up to date information provided). No information on Vitamin A supplementation is provided. Already by 1999, 100% consumed iodized salt; no newborns are unprotected against IDD. Anemia among pregnant women and pre-school children, with a prevalence of 28 and 28%, respectively, is a moderate public health problem. There is only partial implementation of the ICMBS.

UNICEF ACTIVITIES: In the area of nutrition the office supports some activities executed through the program *Chile Crece Contigo*, namely workshops to control health, nutrition, malnutrition, overweight, growth.

WASH

COLOMBIA

As of 2007, Colombia had a population of 46,156,000, three quarters of which lived in urban areas.⁷⁴ The proportion of indigenous population is 3.4% and afro-descendants are 10.5%.

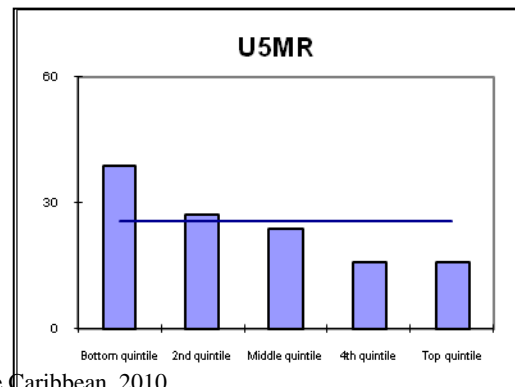
Using the same weights for wealth rankings in urban and rural areas, 62.5 of the rural population belongs to the bottom quintile. The regions with the highest number of people from the bottom quintile are: Atlántica and Central. These are also the regions with the largest share of the population. The regions with a disproportionate share of members of the poorest quintile are: Atlántica and Oriental.⁷⁵

According to the MDG Observatory for Latin America and the Caribbean, Colombia is unlikely to meet MDGs 1, 5 and 6 by 2015. In terms of the Gini coefficient (55.4) Colombia is ranked as the 4th most unequal country in the region (among the 23 countries with income distribution data).⁷⁶ The top 10 % earns 6,000 dollars per 100 dollars earned by the bottom 10%.⁷⁷ For most social inequality dimensions with available data, Colombia shows medium levels of disparities.

The likelihood that a child from the bottom quintile will be stunted is 6.3 times that of a child from the richest quintile, an average value for the region. This is higher than the relative gap (1.8) between urban and rural children. The level of stunting for the first and second quintiles is significantly different but the second and the third are basically the same. Stunting among children in the Department of Atlántica is 1.8 times larger than children in the Departments of Orinoquía and Amazonía.⁷⁸

While primary attendance and literacy is high even among the bottom quintile (94 % and 96 % respectively), primary completion among the bottom quintile is almost 15 percentage points lower than among the top quintile. There is 14.4 percentage point difference in primary completion between urban and rural children.⁷⁹

The U5MR distribution by quintile follows a segmented distribution. There are significant differences between the first and second but not between the second and third quintiles. These are different from the fourth and fifth quintiles, which are similar



⁷⁴ UNICEF. State of the World's Children, 2009

⁷⁵ DHS 2005

⁷⁶ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

⁷⁷ UNDP. Human Development Report, 2009

⁷⁸ Calculated from UNICEF disparity database (based on DHS 2005)

⁷⁹ SEDLAC 2006

and about 40% lower than the national average. A child in the poorest quintile is 2.4 times more likely to die before reaching age five than a child from the top quintile. The relative gap between urban and rural children is lower at 1.4. The highest under five mortality rate is 28.7 per 1000 live births in Atlántica, while the lowest is 22.2 per 1000 live births in Central. Therefore, children under five in Atlántica are 1.3 times more likely to die than the same population in Central.⁸⁰

HEALTH. Immunization (measles) differs somewhat among the first three poorest quintiles; however, it is quite similar in the two top quintiles.⁸¹

With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 1.1, while the urban-rural gap is around the same at 1.0. Urban-rural differences are similar for antenatal care (both for “at least one visit” as well as “at least four visits”). The relative gap of skilled birth attendance is significantly different between the richest and poorest quintiles (1.1), while urban-rural follows the same pattern as antenatal care.⁸² Adolescents in the poorest quintile are 2.9 times more likely to become pregnant than the richest, a relatively low value for the region.⁸³

Child labor is estimated at 10% (of the children older than 9 years old). It ranges between 13% and 6% for boys and girls respectively. In rural areas child labor stands at 13% and in urban areas at 8%. Among children whose parents have not completed primary schooling child labor is 13%, but for children whose parents have completed secondary schooling it is 4% (a relative gap higher than 3). Among children whose parents are working informally, it reaches 14% - forty percent higher than the average rate.

NUTRITION. Based on the UNICEF nutrition profile, the current nutritional status of children <5 (DHS 2005) with regards to stunting, underweight and wasting is 15%, 5% and 2% (based on WHO guidelines), respectively. The percentage of infants <6 months old exclusively breastfed is 47% (2005). Anemia is considered a moderate public health problem among non pregnant women (24%), pregnant women (31%) and pre-school children (28%). Although by 1997 92% of households reported consumption of iodized salt, 2008 data indicates that 73,000 newborns are unprotected against IDD alike. According to the 2009-2010 COAR the nutritional status of rural, indigenous and displaced children -- particularly girls -- is well below the national average. While in urban areas 5.6% of children under age five were underweight, in the rural areas the same indicator was 9.7%. The difference in the stunting measure was even more dramatic: 9.5% of children under age five, living in urban areas suffered from stunting, whereas 17.1% of children living in rural households of the same age suffered stunting. According

⁸⁰ DHS 2005

⁸¹ Ibid

⁸² Calculated from UNICEF disparity database (based on DHS 2005)

⁸³ DHS 2005

to the Survey on the Situation of Indigenous Populations in Chocó⁸⁴, 94.3% of indigenous households in this Pacific Coast department suffer from food insecurity.

UNICEF ACTIVITIES: The Colombia CO is engaged in various nutrition related activities. In 2009 the office has supported strengthening of the Mother and Baby Friendly Hospital Initiative in collaboration with other partners. The key challenge has been that local health territorial entities do not comply with their obligation of commissioning external evaluations of the MBFH strategy for accreditation, hence possible gains are undermined. In collaboration with the HIV/AIDS Theme Group and the joint interagency team to support the National Response Plan for HIV/AIDS, 2007-2011 UNICEF has contributed to positioning the theme of nutrition and HIV. In collaboration with the Ministry of Social Protection they are working on decreasing the prevalence of chronic malnutrition, among other activities with particular attention to rural, indigenous and displaced children -- particularly girls. With regards to nutrition in emergencies- a priority area for the CO- the CO is involved with two projects in the affected areas. However, lack of structure has been reported with regards to the nutritional response. Moreover, there is no protocol for the management of acute malnutrition.

CAPACITIES: The CO has 2 regular staff members with experience in Public Health, Child and Maternal Health and nutrition. Consultants also work on a need basis to fill necessary gaps. The need for additional training in NiE has been expressed.

WASH

⁸⁴ Joint UNICEF, WFP and UNDP study implemented by Profamilia

ECUADOR

As of 2007, Ecuador had a population of 13,341,000 with around two thirds of the total population living in urban areas.⁸⁵ The proportion of indigenous population was 6.83%, while afro descendants account for 5% of the population.

According to the MDG Observatory for Latin America and the Caribbean, it is possible that MDGs 2, 3, 4 and 5 will be met by 2015, while MDGS 1 and 6 are off track. In terms of the Gini coefficient (53.4)⁸⁶, Ecuador is ranked as the 10th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 3500 dollars per 100 earned by the bottom 10%.⁸⁷

Primary attendance and literacy are high even among the bottom quintile (95.8 and 97.3 respectively). Primary completion among the bottom quintile is 11.5 percentage points lower than among the top quintile.⁸⁸ When cross tabulating gender and ethnic background, some slight differences appear particularly for indigenous populations. For example, the difference between primary completion between indigenous men and women is only 0.6 percentage points (with women faring better), while the difference between indigenous and non-indigenous women is 5 percentage points.⁸⁹

Secondary school attendance among children from the bottom quintiles is about 67, while among the top quintile it reaches 92 (a relative gap of roughly 1.35). Similar values apply between the highest secondary enrolment region (94) and the lowest one (60).

HEALTH. Adolescents in the poorest quintile are almost 2.5 times more likely to become pregnant than the richest.

Child labor is estimated at 12% (of the children older than 5 years old). It ranges between 15% and 9% for boys and girls respectively. In rural areas child labor stands at 21% and in urban areas at 7%. Among children whose parents have not completed primary schooling child labor is 19%, but for children whose parents have completed secondary schooling it is 5% (a relative gap of almost 4). Among children whose parents are working informally, it reaches 23% - twice the average rate.

NUTRITION. Ecuador did not record any increases in its infant mortality or malnutrition rates. The Government declared that reducing the chronic

⁸⁵ UNICEF. State of the World's Children, 2009.

⁸⁶ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

⁸⁷ UNDP. Human Development Report, 2009.

⁸⁸ SEDLAC 2008

⁸⁹ CEPAL data produced at request of UNICEF TACRO

malnutrition rate from 26% in 2006 to 14% in 2013 was a national priority, drafted multi-sector policies and programs to achieve this goal, and organized a national surveillance system. According to the DI Nutrition Profile the prevalence of stunting, underweight and wasting in children <5yrs of age is 23%, 9% y 2% respectively (NCHS, 2004). The Percentage of infants < 6 months old exclusively breastfed is 40% (2004). No data on Vitamin A supplementation or folic acid in pregnant women is available. Anemia is a severe public health problem among all interest groups, namely non-pregnant (29%), pregnant (38%) and school age children (38%).

UNICEF ACTIVITIES: Nutrition related activities are undertaken by the office include advocacy and some technical assistance, with a particular focus on breastfeeding. Plan to contribute to the development of a nutrition surveillance system is in place.

Most notable nutrition challenges: Anemia, breastfeeding

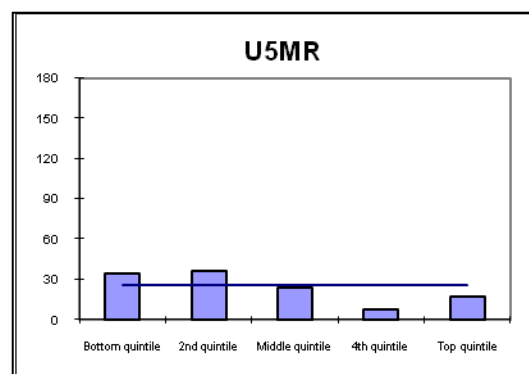
WASH

PERU

As of 2007, Peru had a population of 27,903,000 with nearly three quarters living in urban areas.⁹⁰ The proportion of indigenous population was 13.89%. However, this figure is highly questionable given its method of estimation, namely, counting only as indigenous population those who are from the Peruvian Amazon.

Using the same weights for wealth rankings in urban and rural areas, 57.4 of the rural population belongs to the bottom quintile. The region with the highest number of people from the bottom quintile is Metropolitan Lima. It is also the region with the largest share of the population. The regions with a disproportionate share of members of the poorest quintile are: Sierra and Selva.⁹¹

According to the MDG report, most MDGs are on track or probable, while MDG 6 is possible to be reached by 2015. Moreover, in terms of the Gini coefficient (at 49.6)⁹² it is ranked as the 19th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 2600 dollars per 100 earned by the bottom 10%.⁹³ For most social inequality dimensions with available data, Peru shows high levels of disparities.



While primary attendance and literacy are high even among the bottom quintile (97.4 and 99.6 % respectively), primary completion among the bottom quintile is 15.6 percentage points lower than among the top quintile.⁹⁴ There is 10.4 percentage point difference in primary completion between urban and rural children.

HEALTH. The U5MR distribution by quintile follows a segments distribution. There are significant differences between the three richest quintiles. A child in the poorest quintile is 2 times more likely to die before reaching age five than a child from the top quintile. The relative gap between urban and rural children is lower at 1.7. The highest under five mortality rate is 34 per 1000 live births in Selva Region, while the lowest is 15 per 1000⁹⁵ live births in Metropolitan Lima. Therefore, children under five in Selva are 2.3 times more likely to die than the same population in Metropolitan Lima.⁹⁶

⁹⁰ UNICEF. State of the World's Children, 2009.

⁹¹ DHS 2009

⁹² UNDP. Human Development Report for Latin America and the Caribbean, 2010.

⁹³ UNDP. Human Development Report, 2009.

⁹⁴ SEDLAC 2008/2009

⁹⁵ DHS 2009 indicated some issues with the sample for Metropolitan Lima

⁹⁶ DHS 2009

Differences between quintiles on immunization (measles) are not significant and are consistent with national average of around 76.1.⁹⁷

With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 1.1, while the urban-rural gap is the same.⁹⁸ Urban-rural differences are similar in antenatal care (both for “at least one visit” as well as “at least four visits”). The relative gap of skilled birth attendance is significantly different between the richest and poorest quintiles (3.8, which is above the regional average), while urban-rural is at around 2.⁹⁹ Adolescents in the poorest quintile are 6.1 times more likely to become pregnant than the richest, a value above the regional average.¹⁰⁰

Child labor is estimated at 41% (of the children older than 14 years old). It ranges between 45% and 37% for boys and girls respectively. In rural areas child labor stands at 59% and in urban areas at 29%. Among children whose parents have not completed primary schooling child labor is 53%, but for children whose parents have completed secondary schooling it is 28% (a relative gap of almost 2). Among children whose parents are working informally, it reaches 63% - 50 % higher than the average rate.

NUTRITION. GENERAL SITUATION SUMMARY: According to the Annual Country report, notwithstanding the efforts made to diminish chronic malnutrition among children under the age of 5, the incidence of this disease continues to be high, disproportionately affecting children in rural areas. According to the National Centre for Health Statistics (NCHS) measurement guide, two of every ten children were chronically malnourished in 2007 and 2008 (23% and 22% respectively) nationwide. However, while in urban areas this indicator is one in ten (12%), in rural areas it rises to almost four in ten (36%). The Demographic and Family Health Survey 2009, suggest that chronic malnutrition further declined by 2.5% in 2009. This claim is disputed by WHO measurements that suggest rates of 24.5% instead of the 19.5% claimed by the INEI.

The likelihood that a child from the bottom quintile will be stunted is 11.2¹⁰¹ times that of a child from the richest quintile – one of the highest in the region. This is higher than the relative gap (3.6) between urban and rural children. The level of stunting for the first three quintiles is significantly different, but is relatively similar for the two richest quintiles.¹⁰² Stunting among children in the Department of Huancavelica is 25.5 times larger than children in the Department of Tumbes.

⁹⁷ DHS 2003

⁹⁸ Ibid

⁹⁹ Calculated from UNICEF disparity database (based on DHS 2003)

¹⁰⁰ DHS 2008

¹⁰¹ Calculated from UNICEF disparity database (based on DHS 2004-2006)/Based on DHS 2009 the relative gap is around 16.1

¹⁰² DHS 2009

Iron deficiency anaemia affects more than 2 of every 5 children (43%) between the ages of 6 and 59 months, and the situation gets worse in rural areas, where the percentage is 48%. Anaemia is suffered by 32% of Peruvian children between the ages of 10 and 14. While the departments with the highest percentages are Puno (49%) and Pasco (52%), those with the lowest values are Lambayeque (14%) and San Martin (12%).

UNICEF ACTIVITIES: The Peru CO program is ver involved in nutrition related activities. Most notably it supports initiatives like 'Creceer' (The national strategy for the rationalization of initiatives designed to overcome poverty and chronic child malnutrition), "Good Bye Anaemia", the Initiative for the Fight against Malnutrition, the BFHI, and other breastfeeding promotion initiatives. It has also been involved in M&E efforts such as the preparation of a guide on community surveillance of early growth and development and the preparation of a study to detect iodine deficiencies.

MOST NOTABLE NUTRITION CHALLENGES: disparities, chronic undernutrition, anaemia

WASH

VENEZUELA

As of 2007, Venezuela had a population of 27,657,000 with around 93% of the total population living in urban areas.¹⁰³ The proportion of indigenous population was 2.3%.

According to the MDG Observatory for Latin America and the Caribbean, MDGs 1, 2, 3 and 4 are on track to be reached by 2015, while MDG 7 is possible and MDGs 5 and 6 are off track. In terms of the Gini coefficient (45.5)¹⁰⁴, Venezuela is ranked as the 22nd most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 2000 dollars per 100 earned by the bottom 10%.¹⁰⁵

Primary attendance and literacy are high even among the bottom quintile (95.8 and 96.7 respectively). Primary completion among the bottom quintile is 8.9 percentage points lower than among the top quintile.¹⁰⁶

Secondary school attendance among children from the bottom quintiles is about 60, while among the top quintile it reaches 85 (a relative gap of roughly 1.4). Similar values apply between the highest secondary enrolment region (82) and the lowest one (62).

HEALTH. Adolescents in the poorest quintile are almost 4.5 times more likely to become pregnant than the richest.

Child labor is estimated at 8% (of the children older than 10 years old). It ranges between 12% and 4% for boys and girls respectively. Among children whose parents have not completed primary schooling child labor is 13%, but for children whose parents have completed secondary schooling it is 5% (a relative gap of almost 3). Among children whose parents are working informally, it reaches 13% - about 50% higher than the average rate.

NUTRITION

WASH

¹⁰³ UNICEF. State of the World's Children, 2009.

¹⁰⁴ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹⁰⁵ UNDP. Human Development Report, 2009.

¹⁰⁶ SEDLAC 2006

SOUTHERN CONE

ARGENTINA

As of 2007, Argentina had a population of 39,531,000 with around 90% of the total population living in urban areas.¹⁰⁷ The proportion of indigenous population was 1.7%.

HEALTH. Adolescents in the poorest quintile are 3 times more likely to become pregnant than the richest.

NUTRITION. Nutrition challenges prevail. No data was available from UNICEF country profile for exclusive breastfeeding or vitamin A supplementation. According to the 2006 WHO indicators, the prevalence of stunting is 8%. The prevalence of anemia is 18% among non-pregnant women, 25% among pregnant women (moderate public health problem), and 18% among children preschool children (Other NS, 2008). According to WBTi 80.9% of children are breastfed an hour after birth; only 55% of those children are exclusively breastfed to 6 mo. In line with this prevalence it should be noted that only partial implementation of the Code has been achieved. [Child & Maternal Health]

UNICEF ACTIVITIES: At this time the Argentina country office program has limited nutrition related activities in place. However, it supports various programs including REDINFA, and emergency and food assistance response in the Chaco region.

CAPACITIES

- No nutrition specialist

OPPORTUNITIES

1. Partnerships: Argentine Association of Pediatrics, Alianza Argentina para la Salud de las Madres, Recién Nacidos y Niños

PRIORITY AREAS: breastfeeding and anemia control and prevention
Opportunities

WASH

¹⁰⁷ UNICEF. State of the World's Children, 2009.

PARAGUAY

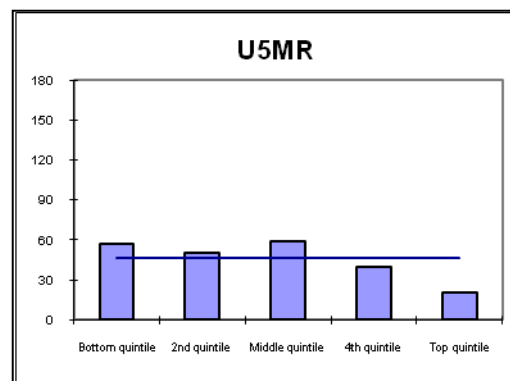
As of 2007, Paraguay had a population of 6.1 million with around 60% of the total population living in urban areas.¹⁰⁸ The proportion of indigenous population was 3%.

According to the MDG Observatory for Latin America and the Caribbean, MDGs 3 and 4 are on track to be reached by 2015, while MDG 7 is probable, 2 and 5 are possible. MDG 1 is off track and MDG 6 is unlikely to be met. In terms of the Gini coefficient (54.9)¹⁰⁹ Paraguay is ranked as the 7th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 4000 dollars per 100 earned by the bottom 10%.¹¹⁰

While primary attendance and literacy are high even among the bottom quintile (98.3 and 95.8 respectively), primary completion among the bottom quintile is 17.6 percentage points lower than among the top quintile. There is a 12.2 percentage point difference in primary completion between urban and rural children.¹¹¹ When cross tabulating gender and ethnic background, some slight differences appear particularly for indigenous populations. For example, the difference between primary completion between indigenous men and women is around 7.7 percentage points (with women faring better), while the difference between indigenous and non-indigenous women is 6.6 percentage points.¹¹²

Secondary school attendance among children from the bottom quintiles is about 45, while among the top quintile it reaches 75 (a relative gap of roughly 1.6).

HEALTH. The U5MR distribution by quintile follows a segmented distribution. There are significant differences between all quintiles. A child in the poorest quintile is 2.8 times more likely to die before reaching age five than a child from the top quintile. The relative gap between urban and rural children is lower at 1.1. The highest under five mortality rate is 53.2 per 1000 live births in the Northern Region, while the lowest is 38 per 1000 live births in the Greater Asunción Region. Therefore, children under five in the Northern Region are 1.4 times more likely to die than the same population in Greater Asunción.¹¹³



Differences between quintiles on immunization (measles) are significant.¹¹⁴

¹⁰⁸ UNICEF. State of the World's Children, 2009.

¹⁰⁹ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹¹⁰ UNDP. Human Development Report, 2009.

¹¹¹ SEDLAC 2007

¹¹² CEPAL data produced at request of UNICEF TACRO

¹¹³ DHS 1990

With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 2.1¹¹⁵, while the urban-rural gap is around 1.0.¹¹⁶ Adolescents in the poorest quintile are 7.3 times more likely to become pregnant than the richest.¹¹⁷

Child labor is estimated at 22% (of the children older than 10 years old). It ranges between 31% and 13% for boys and girls respectively. In rural areas child labor stands at 31% and in urban areas at 14%. Among children whose parents have not completed primary schooling child labor is 30%, but for children whose parents have completed secondary schooling it is 12% (a relative gap of 2.5). Among children whose parents are working informally, it reaches 29% - a third higher than the average rate.

NUTRITION. According to the Annual Report Chronic malnutrition affects 14.2%¹¹⁸ of the children under age of 5 and 29.2%¹¹⁹ of the indigenous population in the same age group. The 2010 DI Profile, based on 2005, indicates that prevalence of stunting, based on WHO standards is slightly higher. The prevalence of stunting, undernutrition and wasting among children <5 years of age is 18%, 3% and 1%, respectively. The percentage of children <6 months old exclusively breastfed is 22% (2004). No data on Vitamin A supplementation or the use of iron folic acid was reported. The use of iodized salt in households is nearly 100% (96% in 2006). Anaemia represents a moderate public health problem among non-pregnant, pregnant and school age children with a prevalence of 26%, 29, and 30%, respectively. Approximately, 30% of the pregnant women are below normal weight¹²⁰, which increases their risk of having low-birth-weight infants.

The likelihood that a child from the bottom quintile will be stunted is 6.4¹²¹ times that of a child from the richest quintile. The level of stunting for all quintiles is significantly different¹²². Stunting among children in the Northern Region is 3 times larger than children in the Greater Asunción Region.

UNICEF ACTIVITIES: The Paraguay CO is engaged in numerous nutrition related activities, particularly by providing technical support and supporting advocacy efforts. Activities include support of monitoring activities of the implementation of the Code, ensure proper iodization of salt, support of the National Food and Nutrition Assistance Programme, support of the design and

¹¹⁴ Ibid

¹¹⁵ Ibid

¹¹⁶ Calculated from UNICEF disparity database (based on Encuesta Nacional de Demografía y Salud Sexual y Reproductiva 2008)

¹¹⁷ DHS 1990

¹¹⁸ Análisis de la situación de salud infantil y antropometría. Paraguay, EPH 2005. Martha Sanabria.

¹¹⁹ Estimaciones del Programa Conjunto UNICEF-PNUD-UNFPA “Invertir en la Gente” con datos de la Encuesta de Hogares Indígenas DGEEC. Estimaciones sujetas a verificación

¹²⁰ Análisis de la situación de salud infantil y antropometría. Paraguay, EPH 2005. Martha Sanabria.

¹²¹ DHS 1990

¹²² DHS 1990

implementation of a National Information and Management System, and support of South -South collaboration with Chile to strengthen PROAN.

MOST NOTABLE NUTRITION CHALLENGES: Anaemia, low breast feeding

WASH

URUGUAY

As of 2007, Uruguay had a population of 3,340,000 with around 92% of the total population living in urban areas.¹²³ The proportion of indigenous population was 3.6%, while afro descendants account for 9.1% of the population.

According to the MDG Observatory for Latin America and the Caribbean, MDGs 1,2 and 4 are either on track to be reached by 2015 or achieved, while MDGs 3,5,6, and 7 are possible. In terms of the Gini coefficient (44.7)¹²⁴, Uruguay is ranked as the most equal country in the region (among the 23 countries with income distribution data). The top 10 % earns 2000 dollars per 100 earned by the bottom 10%.¹²⁵

Primary attendance and literacy are high even among the bottom quintile (98.6 and 97.0 respectively). Primary completion among the bottom quintile is 12.2 percentage points lower than among the top quintile.¹²⁶

Secondary school attendance among children from the bottom quintiles is about 54, while among the top quintile it reaches 82 (a relative gap of roughly 1.5). Similar values apply between the highest secondary enrolment region (76) and the lowest one (62).

Child labor is estimated at 13% (of the children older than 14 years old). It ranges between 18% and 7% for boys and girls respectively. In rural areas child labor stands at 23% and in urban areas at 12%. Among children whose parents have not completed primary schooling child labor is 20%, but for children whose parents have completed secondary schooling it is 8% (a relative gap of 2.5). Among children whose parents are working informally, it reaches 18% - about 50% higher than the average rate.

HEALTH. Adolescents in the poorest quintile are 3.3 times more likely to become pregnant than the richest.

NUTRITION. A source of particular concern is chronic malnutrition (deficit in height-age ratios) that in Uruguay affects mainly the younger children percentage of children exclusively breastfed <6 mo is 57% (2007). No data is available on vitamin A supplementation or iron folic acid supplementation. Anaemia is a moderate public health problem among pregnant women and school aged children, with a prevalence of 27% and 19% respectively. Timely introduction of complimentary foods (with breastfeeding) is 35%.

¹²³ UNICEF. State of the World's Children, 2009.

¹²⁴ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹²⁵ UNDP. Human Development Report, 2009.

¹²⁶ SEDLAC 2009

UNICEF ACTIVITIES: The CO supports some nutrition related activities, specifically the BFHI and Canelones Crece Contigo, which distributes micronutrient powders to the interes population.

MOST NOTABLE NUTRITION CHALLENGES: Anaemia and other micronutrient deficiencies.

WASH

SECTION IV

IV. Mexico



MEXICO

As of 2007, Mexico had a population of 106,535,000 with a little over $\frac{3}{4}$ of the total population living in urban areas.¹²⁷ The proportion of indigenous population was 9.4%.

According to the MDG Observatory for Latin America and the Caribbean, MDGs 2, 3, 4, 6 and 7 are on track to be reached by 2015, while MDG 1 is probable and MDG 5 is off track. In terms of the Gini coefficient (49.9)¹²⁸, Mexico is ranked as the 17th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 2100 dollars per 100 earned by the bottom 10%.¹²⁹

Primary attendance and literacy are high even among the bottom quintile (97.5 and 95.9 respectively). Primary completion among the bottom quintile is 10 percentage points lower than among the top quintile.¹³⁰

Secondary school attendance among children from the bottom quintiles is about 58, while among the top quintile it reaches 82 (a relative gap of roughly 1.4). Similar values apply between the highest secondary enrolment region (80) and the lowest one (57).

Child labor is estimated at 19% (of the children older than 12 years old). It ranges between 25% and 12% for boys and girls respectively. In rural areas child labor stands at 26% and in urban areas at 14%. Among children whose parents have not completed primary schooling child labor is 27%, but for children whose parents have completed secondary schooling it is 10% (a relative gap of almost 3). Among children whose parents are working informally, it reaches 30% - about 50% higher than the average rate.

HEALTH. Adolescents in the poorest quintile are almost 6 times more likely to become pregnant than the richest.

NUTRITION. According to the DI Nutrition Profile, the prevalence of stunting, underweight and wasting is 16%, 3% y 2% respectively (2005, based on WHO standards). No information is presented on Vitamin A supplementation. It is known that 184,000 newborns are unprotected against IDD (2008). Anemia is a moderate public health problem among pregnant women and pre-school aged children (21% y 24%, respectively). However, there is most recent data from the NNS that should not be overlooked, and that shows that while important improvements have been made in nutrition, a new nutritional challenge is

¹²⁷ UNICEF. State of the World's Children, 2009.

¹²⁸ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹²⁹ UNDP. Human Development Report, 2009.

¹³⁰ SEDLAC 2009

emerging in Mexico. Childhood overweight and obesity represents an important problem in the Country.

UNICEF ACTIVITIES: The UNICEF country program is only partially involved with nutrition activities, as part of a set of actions. No specific programs or collaborations in this area exist.

MOST NOTABLE NUTRITION CHALLENGES: Stunting, overweight and obesity, anemia

WASH

SECTION IV**VII. Central America and the Dominican Republic**

- Belize
- Costa Rica
- Dominican Republic
- El Salvador
- Guatemala
- Honduras
- Nicaragua
- Panama



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BELIZE

As of 2007, Belize had a population of 288,000 with just half of the total population living in urban areas.¹³¹ The proportion of indigenous population was 16%.

Belize is ranked in the middle among the 23 countries with income distribution data (Gini Coefficient at 52.6).¹³²

Primary attendance is high even among the bottom quintile (96%). Primary completion among the bottom quintile is 1.4 percentage points higher than among the top quintile.¹³³

HEALTH.

NUTRITION. Based on WHO guidelines the prevalence (2008) of stunting, underweight and wasting among children <5 is 22%, 4% and 2%, respectively. Only 10% of women are reported to exclusively breastfeed <6mo (MICS, 2006); about half of new mothers start early breastfeeding (51%) The prevalence of anemia is considered a moderate public health problem among non pregnant women (31%) and preschool children (36%); it's a severe problem among pregnant women (52%)

According to the country office Belize is severely 'off-track' in regards to MDG 1. Preliminary results from the 2009 Country Poverty Assessment (CPA) suggests that 43% of the population and 33% of households. Deeply rooted disparities, in particular the chronic poverty among indigenous populations in the Toledo district remain a significant challenge. Child malnutrition has a national prevalence of 18 per cent and 44 per cent for children under five in the indigenous populations. Moreover, Basic food items such as four, rice, and chicken increased by at least 42% in 2009. National nutrition survey expected to take place in 2010.

UNICEF ACTIVITIES: Supporting the NNS efforts

OPPORTUNITIES: As part of the Child Friendly School Project initiative, a nutrition component could be incorporated. Recent interest in developing a nutrition proposal on nutrition through the life cycle. New CR with interest and commitment to nutrition. Active engagement in South-South cooperation

CAPACITIES:

- One person (Denise Robateau) in charge of ECD, Education, Nutrition
- Trained in NiE, Panama 2009 (Denise Robateau)
- Participated in MNP Workshop, Mexico 2010 (Denise Robateau)

¹³¹ UNICEF. State of the World's Children, 2009.

¹³² UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹³³ SEDLAC 2002

WASH

COSTA RICA

As of 2007, Costa Rica had a population of 4.5 million with around 63% of the total population living in urban areas.¹³⁴ The proportion of indigenous population was 0.71%, while afro descendants account for 2% of the population.

According to the MDG Observatory for Latin America and the Caribbean, MDGs 1, 3 and 7 are either achieved or on track to be reached by 2015 while 2, 4 and 6 are possible. MDG 5 is off track. In terms of the Gini coefficient (48.3)¹³⁵ Costa Rica is ranked as the 20th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 2300 dollars per 100 earned by the bottom 10%.¹³⁶

Primary attendance and literacy are high even among the bottom quintile (98.0 and 97.4 respectively). Primary completion among the bottom quintile is 13 percentage points lower than among the top quintile.¹³⁷

Secondary school attendance among children from the bottom quintiles is about 78, while among the top quintile it reaches 58 (a relative gap of roughly 1.3).

Child labor is estimated at 10% (of the children older than 12 years old). It ranges between 15% and 5% for boys and girls respectively. In rural areas child labor stands at 14% and in urban areas at 8%. Among children whose parents have not completed primary schooling child labor is 16%, but for children whose parents have completed secondary schooling it is 5% (a relative gap higher than 3). Among children whose parents are working informally, it reaches 13% - thirty percent higher than the average rate.

HEALTH. Adolescents in the poorest quintile are almost 3 times more likely to become pregnant than the richest. This is a relatively low value for the region.

NUTRITION. Moreover, in 2009 a national nutrition survey was conducted, with preliminary results that reflect deterioration in respect of the situation in 1996. The information available shows that for 2008 / 2009, 16.3 percent of children under five years of age suffer from chronic malnutrition. In 1996, anemia was considered a moderate public health problem among all groups: non-pregnant (19%) and pregnant women (28%), preschool children (21%) and children <2 (37%). **UNICEF Nutrition Profile for the country still reports 1996 data**. According to the 2009-2010 COAR, More attention and adjustments to reach MDG 1, 2 and 3 are necessary. Nutritional energy consumption below the basic levels is rampant in extreme poverty and especially affects children under twelve

¹³⁴ UNICEF. State of the World's Children, 2009.

¹³⁵ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹³⁶ UNDP. Human Development Report, 2009.

¹³⁷ SEDLAC 2009

years of age. Moreover, the inequality gap with respect to income distribution had shown a small reduction in 2008 but increased in 2009 to its highest point in the last twenty years, following a sustained rate of growth over the past twelve years.

The incidence of poverty is highest among children, surpassing 25 percent on average and reaching almost 30 percent for those aged between 7 and 12 years. Similarly, the indigenous population continues to be one of the most marginalised groups, with alarming levels of vulnerability, given that they are far behind in matters of health, nutrition, education and poverty reduction.

UNICEF ACTIVITIES: General support is given to the Ministry of Health, National Women's Institute and other entities promoting child development, and nutrition and organizational support was given to the Department of Child Nutrition

WASH

DOMINICAN REPUBLIC

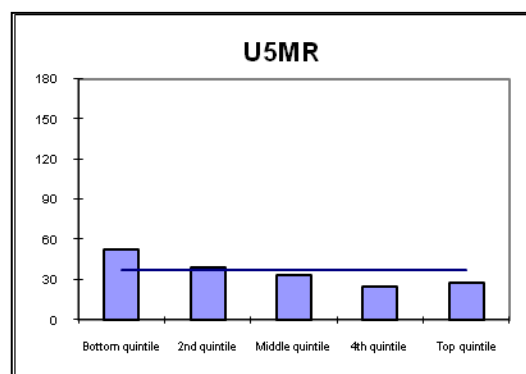
As of 2007, Dominican Republic had a population of 9,760,000 with nearly three quarters of the total population living in urban areas.¹³⁸

Using the same weights for wealth rankings in urban and rural areas, 42.9 of the rural population belongs to the bottom quintile. The region with the highest number of people from the bottom quintile is: Region 0. It is also the region with the largest share of the population. The regions with a disproportionate share of members of the poorest quintile are: Regions 0 and II.¹³⁹

According to the MDG Observatory for Latin America and the Caribbean, while MDGs 2 and 3 are on track and MDG 6 is possible, MDGs 1, 2, 5 and 7 are unlikely to be reached by 2015. In terms of the Gini coefficient (50.8)¹⁴⁰ Dominican Republic is ranked as the 16th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 2500 dollars per 100 earned by the bottom 10%.¹⁴¹

While primary attendance and literacy are high even among the bottom quintile (95.6 and 96.1 respectively), primary completion among the bottom quintile is 24.3 percentage points lower than among the top quintile. There is only a 11.4 percentage point difference in primary completion between urban and rural children.¹⁴²

HEALTH. The U5MR distribution by quintile follows a segmented distribution. A child in the poorest quintile is 1.9 times more likely to die before reaching age five than a child from the top quintile. The relative gap between urban and rural children is lower at 1. The highest under five mortality rate is 49 per 1000 live births in Region IV, while the lowest is 26 per 1000 live births in Region II. Therefore, children under five in Region IV are 1.9 times more likely to die than the same population in Region II.¹⁴³



There are differences between quintiles on immunization (measles), particularly between the poorest and richest quintiles with the other quintiles.¹⁴⁴

¹³⁸ UNICEF. State of the World's Children, 2009.

¹³⁹ DHS 2008

¹⁴⁰ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹⁴¹ UNDP. Human Development Report, 2009.

¹⁴² SEDLAC 2007

¹⁴³ DHS 2007

¹⁴⁴ Ibid

With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 1.1, while the urban-rural gap is around the same at 1.¹⁴⁵ Urban-rural differences are similar for antenatal care (both for “at least one visit” as well as “at least four visits”). There is a statistically significant difference between the richest and poorest quintiles in skilled birth attendance, while urban-rural follows the same pattern as antenatal care.¹⁴⁶

In relation to comprehensive HIV/AIDS knowledge, the gap between the lowest and highest quintiles for women (ages 15-49) is 1.7. Likewise, adolescents in the poorest quintile are 4.7 times more likely to become pregnant than the richest.¹⁴⁷

NUTRITION. There are worrying indicators regarding **nutrition**. The percentage of children under six months that are exclusively breastfed is only 7.8%, one of the lowest in the region¹⁴⁸, severe malnutrition in children under six months is 5.6%, and the percentage of infants with low birth weight is 11%. Only 29% of children between 5 a 59 months received supplements of vitamin A and 16% received iron supplementation, down from 30% just two years ago. Anemia affects 37% of women that gave birth during the last 12 months, and 34% of all women¹⁴⁹. On the positive side, there has been a significant increase in the percentage of households consuming iodized salt, rising from 19% in 2007 to 43% in 2009¹⁵⁰. Part of this improvement could be attributed to the joint MoH-UNICEF communication and social mobilization campaign to increase this type of consumption.

The likelihood that a child from the bottom quintile will be stunted is 2.9¹⁵¹ times that of a child from the richest quintile. This is higher than the relative gap (1.5) between urban and rural children. The level of stunting for all quintiles is significantly different¹⁵². Stunting among children in Region VI is 2 times larger than children in Region 0.

UNICEF ACTIVITIES:

Most notable nutrition challenges: One of the lowest breastfeeding rates in the region.

WASH

¹⁴⁵ Ibid

¹⁴⁶ Calculated from UNICEF disparity database (based on DHS 2007)

¹⁴⁷ DHS 2007

¹⁴⁸ ENDESA 2007

¹⁴⁹ Encuesta Nacional de Micronutrientes 2009 (Draft)

¹⁵⁰ Op cit.

¹⁵¹ DHS 2007

¹⁵² DHS 2007

EL SALVADOR

As of 2007, El Salvador had a population of 6,857,000 with nearly 2/3 of the total population living in urban areas.¹⁵³ The proportion of indigenous population was 0.23%.

According to the MDG Observatory for Latin America and the Caribbean, MDGs 1, 2, 4, and 5 are on track to be reached by 2015, while MDG 3 and 6 are possible and MDG 7 is probable. In terms of the Gini coefficient (49.7)¹⁵⁴, El Salvador is ranked as the 18th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 3900 dollars per 100 earned by the bottom 10%.¹⁵⁵

Primary attendance and literacy are among the bottom quintile are at 84.0 and 88.7 respectively. Primary completion among the bottom quintile is 52 percentage points lower than among the top quintile.¹⁵⁶

Secondary school attendance among children from the bottom quintiles is about 33, while among the top quintile it reaches 70 (a relative gap of roughly 2). Similar values apply between the highest secondary enrolment region (67) and the lowest one (31).

Child labor is estimated at 13% (of the children older than 10 years old). It ranges between 17% and 8% for boys and girls respectively. In rural areas child labor stands at 16% and in urban areas at 9%. Among children whose parents have not completed primary schooling child labor is 15%, but for children whose parents have completed secondary schooling it is 4% (a relative gap of almost 4). Among children whose parents are working informally, it reaches 18% - about 50% higher than the average rate.

HEALTH. Adolescents in the poorest quintile are about 2 times more likely to become pregnant than the richest.

NUTRITION. The Family Health Survey (Encuesta de Salud Familiar—FESAL) was conducted in 2008, providing information about the current status of child nutrition. According to its results, it was found that 19.2% of children under five years of age suffer from chronic malnutrition. Likewise, the results on the level of household welfare indicate that the highest levels for the indicator on low height for age (stunting) of children from the lowest welfare quintile (31.4 %) is 6.8 times higher than that for children who belong to the highest welfare level (4.6%), highlighting once again the disparity that prevails in the country. Anemia is considered a severe public health problem; the prevalence of anemia among

¹⁵³ UNICEF. State of the World's Children, 2009.

¹⁵⁴ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹⁵⁵ UNDP. Human Development Report, 2009.

¹⁵⁶ SEDLAC 2009

children from 12 to 59 months of age has increased over the past five years from 19.8% in 2003 to 22.9% in 2008. It should be indicated that the population group with the highest prevalence of anaemia is 6 to 11 months of age (46.1%) and the one with the lowest prevalence is 48 to 59 months of age (14.7%), highlighting the existence of a nutritional problem in the transition period from breast-feeding to solid foods for infants. In terms of gender, low height for age (stunting) is greater among boys (20.4%) than among girls (17.4%). Likewise, the prevalence of anaemia for the population from 6 to 59 months of age is greater among boys (27%) than among girls (24.9%). In terms of welfare, the prevalence of anaemia for the lowest welfare quintile is 30.8% and for the highest welfare quintile it is 17.4%, highlighting not only problems of disparity but also food education problems education for all welfare levels. Data from 2008 indicates that 48,000 children are unprotected against IDD.

UNICEF ACTIVITIES: Support is given to MSPAS to promote breastfeeding and to undertake evaluations on the micronutrient status of the population

Most notable nutrition challenges: Anemia, breastfeeding and complimentary feeding, nutrition transition

WASH

GUATEMALA

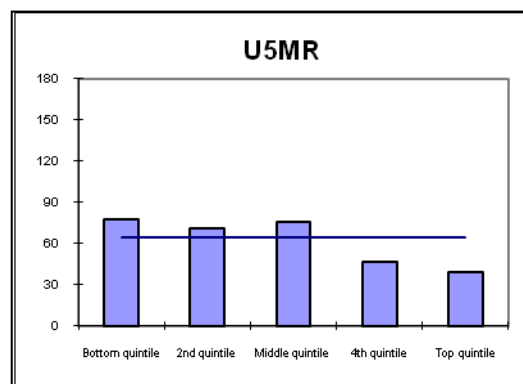
As of 2007, Guatemala had a population of 13,354,000 with nearly half of the total population living in urban areas.¹⁵⁷ The proportion of indigenous population was 9.2%.

According to the MDG Observatory for Latin America and the Caribbean, most MDGs 2, 3, 4 and 7 are possible to be reached by 2015, while 1, 5 and 6 are off track. In terms of the Gini coefficient (53.6)¹⁵⁸ Guatemala is ranked as the 9th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 4000 dollars per 100 earned by the bottom 10%.¹⁵⁹ For most social inequality dimensions with available data, Guatemala shows high levels of disparities.

While primary attendance and literacy, among the bottom quintile, are at 80.5 and 71.7 respectively, primary completion among the bottom quintile is 58.6 percentage points lower than among the top quintile. There is a 33.7 percentage point difference in primary completion between urban and rural children.¹⁶⁰ When cross tabulating gender and ethnic background, some slight differences appear particularly for indigenous populations. For example, the difference between primary completion between indigenous men and women is 18.1 percentage points, while the difference between indigenous and non-indigenous women is around 28 percentage points.¹⁶¹

Secondary school attendance among children from the bottom quintiles is about 22, while among the top quintile it reaches 71 (a relative gap of 3.2). Similar values apply between the highest secondary enrolment region (60) and the lowest one (22).

HEALTH. The U5MR distribution by quintile follows a plateau distribution. The first three quintiles show no significant differences. A child in the poorest quintile is 2 times more likely to die before reaching age five than a child from the top quintile. The relative gap between urban and rural children is lower at 1.2. The highest under five mortality rate is 79 per 1000 live births in the Central region, while the lowest is 52 per 1000 live births



¹⁵⁷ UNICEF. State of the World's Children, 2009.

¹⁵⁸ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹⁵⁹ UNDP. Human Development Report, 2009.

¹⁶⁰ SEDLAC 2005

¹⁶¹ CEPAL data produced at request of UNICEF TACRO

in the Metropolitan region. Therefore, children under five in the Central are 1.5 times more likely to die than the same population in the Metropolitan region.¹⁶²

Differences between quintiles on immunization (measles) are not significant and are consistent with national average of around 90 %.¹⁶³

With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 8.7¹⁶⁴, while the urban-rural gap is around the lower at 1.9.¹⁶⁵ Urban-rural differences are similar for antenatal care (at least one visit) at 1.1. The relative gap of skilled birth attendance is urban-rural is at 2.2.¹⁶⁶

Adolescents in the poorest quintile are 3.6 times more likely to become pregnant than the richest.¹⁶⁷

Child labor is estimated at 25% (of the children older than 7 years old). It ranges between 34% and 16% for boys and girls respectively. In rural areas child labor stands at 30% and in urban areas at 20%. Among children whose parents have not completed primary schooling child labor is 26%, but for children whose parents have completed secondary schooling it is 3% (a relative gap higher than 8). Among children whose parents are working informally, it reaches 36% - 50% higher than the average rate.

NUTRITION. Most recently, HQ identified Guatemala as a priority country due to the very high prevalence of chronic malnutrition in the country (2010). According to the 2009 Annual Report chronic malnutrition (low height for age) is the main nutritional problem in Guatemala. It affects 43.4% of the population under five, according to data from the 2008-2009 National Mother and Child Health Survey. It had gone down by approximately one percentage point a year during the last six years. There are wide gaps between urban and rural areas; rural malnutrition is almost double (51.8% and 28.8%, respectively). Chronic malnutrition among the indigenous rural population is much higher because of extreme poverty and inappropriate child feeding practices. Only 49.6% of children aged 0 to 5 months are exclusively breastfed. This percentage has remained unchanged during the last six years. About two-thirds of all children aged 6 to 8 months receive complementary foods. The shortage of funds drastically limits the State's ability to respond.

According to the DI Nutrition Profile (2010) which is mostly based in 2002 data, Stunting, underweight and wasting in children <5 is highly prevalent with a prevalence of 54%, 18% and 2% respectively (2002). The prevalence of exclusive breastfeeding of infants <6 months was estimated 51%. Percentage of

¹⁶² DHS 1998-1999

¹⁶³ Ibid

¹⁶⁴ Calculated from UNICEF disparity database (based on DHS1998-1999)

¹⁶⁵ DHS 1998-1999

¹⁶⁶ Calculated from UNICEF disparity database (based on Encuesta Nacional de Salud, Materno Infantil 2002)

¹⁶⁷ DHS 1998-1998

children 6-59 months old receiving two doses of vitamin A during calendar year. Prevalence of anemia among selected populations is only 20% (2008). Moreover, 109,000 newborns are unprotected against IDD (2008). According to the 2002 data anemia is a severe public health problem among children < 2 years of age with a prevalence of 59%, and a moderate problem among non-pregnant (20%), pregnant (22%) and school age children (38%).

The likelihood that a child from the bottom quintile will be stunted is 10.2¹⁶⁸ times that of a child from the richest quintile – one of the highest ratios in the region. This is higher than the relative gap (1.7) between urban and rural children. The level of stunting for all quintiles is significantly different¹⁶⁹. Stunting among children in the region of Nor-Occidente is 2.4 times larger than children in the Metropolitan region.

UNICEF ACTIVITIES: The nutrition operation in the CO in Guatemala is large and diverse. It includes collaborations with governmental partners in the promotion of breastfeeding and monitoring of micronutrient status in fortified foods. Moreover, two strong program partnerships exist: 1) one project with PLAN international aimed at tackling the undernutrition problem in 16 communities emphasizing the role of community health workers and 2) the Ventana grant, from the Spanish Government, to address the problem of chronic undernutrition as a result of triple burden (poor, indigenous population living in rural areas) in Totonicapan.

Most notable nutrition challenges: Chronic malnutrition, Anaemia, micronutrient deficiencies, breastfeeding, complementary feeding.

WASH

¹⁶⁸ UNICEF DI Profiles

¹⁶⁹ DHS 1998

HONDURAS

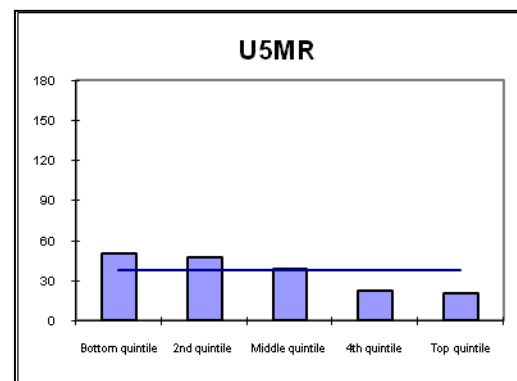
As of 2007, Honduras had a population of 7,106,000 with nearly half of its total population living in urban areas.¹⁷⁰ The proportion of indigenous population is 7% and afro-descendants are 1%.

Using the same weights for wealth rankings in urban and rural areas, 36.8 of the rural population belongs to the bottom quintile. The departments with the highest number of people from the bottom quintile are: Cortés and Francisco Morazán. These are also the departments with the largest share of the population. The regions with a disproportionate share of members of the poorest quintile are: Lempira and Olancho.¹⁷¹

According to the MDG Observatory for Latin America and the Caribbean, MDGs 4 and 6 are unlikely to be met, while MDG 5 is off track. In terms of the Gini coefficient (55.3)¹⁷² Honduras is ranked as the fifth most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 5900 dollars per 100 earned by the bottom 10%.¹⁷³ For most social inequality dimensions with available data, Honduras shows high levels of disparities.

While primary attendance and literacy is high even among the bottom quintile (87.4 and 83.5 % respectively), primary completion among the bottom quintile is 37.3 percentage points lower than among the top quintile. There is only a 0.4 percentage point difference in primary completion between urban and rural children.¹⁷⁴

The U5MR distribution by quintile follows a segmented distribution. There are significant differences between the two poorest quintiles, but there are differences between the three poorest quintiles and the two wealthiest. A child in the poorest quintile is 2.5 times more likely to die before reaching age five than a child from the top quintile. The relative gap between and rural children is lower at 1.3. The highest under five mortality rate is 43 per 1000 live births in La Paz, while the lowest is 22 per 1000 live births in Cortés. Therefore, children under five in La Paz are nearly twice as likely to die as the same population in Cortés.¹⁷⁵



¹⁷⁰ UNICEF. State of the World's Children, 2009.

¹⁷¹ DHS 2005-2006

¹⁷² UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹⁷³ UNDP. Human Development Report, 2009.

¹⁷⁴ SEDLAC 2007

¹⁷⁵ DHS 2005-2006

HEALTH. Immunization (measles) follows plateau pattern, although differences between quintiles are not significant.

With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 1.4, while the urban-rural gap is around the same at 1.1.¹⁷⁶ Urban-rural differences are slight in antenatal care, both for “at least one visit” as well as “at least four visits”. The relative gap of skilled birth attendance is significantly different between the richest and poorest quintiles (3), while the urban-rural is around 1.8.¹⁷⁷

In relation to comprehensive HIV/AIDS knowledge, the gap between the lowest and highest quintiles for women (ages 15-49) is 1.6, while the urban-rural gap on comprehensive knowledge on how HIV is transmitted is at 1.8. Likewise, adolescents in the poorest quintile are 3.3 times more likely to become pregnant than the richest.¹⁷⁸

Child labor is estimated at 22% (of the children older than 10 years old). It ranges between 31% and 9% for boys and girls respectively. In rural areas child labor stands at 26% and in urban areas at 13%. Among children whose parents have not completed primary schooling child labor is 24%, but for children whose parents have completed secondary schooling it is 11% (a relative gap of almost 4). Among children whose parents are working informally, it reaches 27% - about a quarter higher than the average rate.

NUTRITION. According to the 2009 Annual Report global malnutrition has declined in 8.8% from 21.4% in 1991 to 12.6% in 2005/6. The goal set in the MDG Declaration will be achieved with a reduction of 1.9%. A more significant achievement is evident in the chronic malnutrition rate that was reduced in 15% from 42.4% in 1991 to 27.4% in 2005/6. This goal will be achieved if a decrease of 6.2% is attained.

The DI Nutrition Profile, based on DHS data 2005-2006, points to important nutrition challenges with a prevalence of stunting, undernutrition and wasting of 29%, 8% and 1%, respectively in children <5yrs of age. The percentage of children <6 months exclusively breastfeed is 30%. No data on Vitamin A supplementation is available. Use of iron folic acid supplements is 70%. Anemia levels are worrisome and represent a moderate public health problem among pregnant and non pregnant women (19% and 21%, respectively) but a severe public health challenge among the pre school and <2 yr old child population (37% and 56% respectively).

¹⁷⁶ Ibid

¹⁷⁷ Calculated from UNICEF Disparity database(based on DHS 2005-2006)

¹⁷⁸ DHS 2005-2006

Case Study: Honduras

The likelihood that a child from the bottom quintile will be stunted is 7.1¹⁷⁹ times that of a child from the richest quintile. This is higher than the relative gap (2.2) between urban and rural children. The level of stunting for the all quintiles is significantly different¹⁸⁰. Stunting among children in the Department of Lempira is 3.4 times larger than children in the Department of Cortés.

UNICEF ACTIVITIES: The CO is engaged in numerous nutrition activities, including the support of breastmilk banks and therapeutic feeding centers in Amapala and Choluteca. There is interest and aperture to strengthen monitoring and evaluation activities in collaboration with other partners, namely PAHO. It should be noted that high turnover of health ministry employees is an important challenge for the implementation of programs in country.

MOST NOTABLE NUTRITION CHALLENGES: Chronic and acute malnutrition, poor infant feeding practices

WASH

¹⁷⁹ Calculated from UNICEF disparity database (based on DHS 2005-2006)

¹⁸⁰ DHS 2005-2006

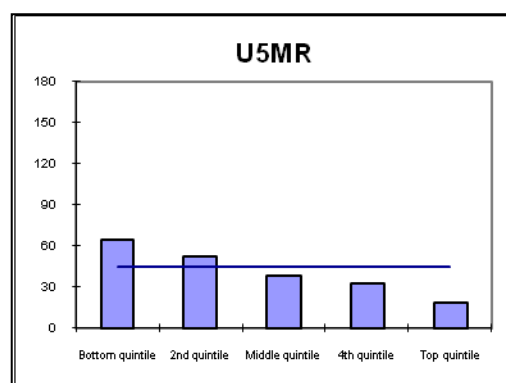
NICARAGUA

As of 2007, Nicaragua had a population of 5,603,000 with slightly more than half of the total population living in urban areas.¹⁸¹ The proportion of indigenous population was 5.7.

According to the MDG Observatory for Latin America and the Caribbean, only MDG 3 is on track to be reached by 2015. In terms of the Gini coefficient (52.3)¹⁸² Nicaragua is ranked as 13th the most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 3100 dollars per 100 earned by the bottom 10%.¹⁸³

While primary attendance and literacy among the bottom quintile are at 86 % and 81% respectively, primary completion among the bottom quintile is 47.7 percentage points lower than among the top quintile. There is a 32.8 percentage point difference in primary completion between urban and rural children.¹⁸⁴ When cross tabulating gender and ethnic background, some slight differences appear particularly for indigenous populations. For example, the difference between primary completion between indigenous men and women is an 8.9 percentage points (with women faring better), while the difference between indigenous and non-indigenous women is 15.1 percentage points.¹⁸⁵

HEALTH. The U5MR distribution by quintile follows a segmented distribution. There are significant differences between all quintiles. A child in the poorest quintile is 3.3 times more likely to die before reaching age five than a child from the top quintile. The relative gap between urban and rural children is lower at 1.6. The highest under five mortality rate is 66 per 1000 live births in Jinotega, while the lowest is 21 per 1000 live births in Boaco. Therefore, children under five in Jinotega are 3.1 times more likely to die than the same population in Boaco.¹⁸⁶



Differences between the bottom quintile and the other quintiles on immunization (measles) are significant.¹⁸⁷

¹⁸¹ UNICEF. State of the World's Children, 2009.

¹⁸² UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹⁸³ UNDP. Human Development Report, 2009.

¹⁸⁴ SEDLAC 2007

¹⁸⁵ CEPAL data produced at request of UNICEF TACRO

¹⁸⁶ DHS 2001

¹⁸⁷ Calculated from UNICEF disparity database (based on DHS 2006-2007)

With regards to contraceptive prevalence rate the relative gap between the poorest and richest quintiles is 1.2, while the urban-rural gap is around the same at 1.¹⁸⁸ Urban-rural differences are similar for antenatal care (both for “at least one visit” as well as “at least four visits”) around 1.2. However the gap between richest and poorest in antenatal care (at least four visits) is higher at 1.5. The relative gap of skilled birth attendance is significantly different between the richest and poorest quintiles (2.4), while urban-rural is around 1.6.¹⁸⁹

Adolescents in the poorest quintile are 2.5 times more likely to become pregnant than the richest.¹⁹⁰ The UNICEF Global Database for Disparities presents the antenatal coverage for at least four time visits for the lowest quintile (Q1) at 60.70 and for the highest quintile (Q5) at 92.30, for a ratio of 1.5 (2006-07).

NUTRITION. Based on the DI Nutrition Profile Nicaragua faces important nutrition challenges. Stunting, undernutrition and wasting affect 22%, 7% and 1% of the population under 5 years of age. Information from 2005-2006 indicates that the national prevalence of exclusive breastfeeding of infants <6months of age is 31%. No data on Vitamin A supplementation is presented, however, according to the 2009 Annual Report In terms of nutrition, there has been a rise in vitamin A deficiency among the general public (from 0% to 5% since 2003), while exclusive breastfeeding for the first six months has seen a marked drop in urban areas, from 74% in 2001 to 47% in 2007.¹⁹¹ Data on anaemia is dated (2000-2004), but points to a moderate public health problem among pregnant women.

The likelihood that a child from the bottom quintile will be stunted is 5.8¹⁹² times that of a child from the richest quintile. This is higher than the relative gap (2) between urban and rural children. The level of stunting for all quintiles is significantly different¹⁹³. Stunting among children in the Department of Jinotega is 4.5 times larger than children in the Department of Managua.

UNICEF ACTIVITIES: The CO is engaged in a variety of nutrition related activities in the areas of breastfeeding, nutrition in emergencies, and advocacy. The local office has also provided support to supply the purchase of iodine by local salt producers and to the national nutrition surveillance system.

MOST NOTABLE NUTRITION CHALLENGES: Breastfeeding, anaemia and other micronutrient deficiencies. Nutrition in emergencies is a topic the country office is very interested in working in.

WASH

¹⁸⁸ Ibid

¹⁸⁹ Calculated from UNICEF disparity database (based on DHS 2006-2007)

¹⁹⁰ DHS 2001

¹⁹¹ 2001-2007 MINSa

¹⁹² Calculated from UNICEF disparity database (based on DHS 2006-2007)

¹⁹³ DHS 2001

PANAMA

As of 2007, Panama had a population of 3,343,000 with just under $\frac{3}{4}$ of the total population living in urban areas.¹⁹⁴ The proportion of indigenous population was 10.1%.

According to the MDG Observatory for Latin America and the Caribbean, MDGs 1, 2, 3 are probable, on track, and achieved respectively, while MDGS 4, 5, and 6 are off track to be reached by 2015. In terms of the Gini coefficient (54.8)¹⁹⁵, Panama is ranked as the 8th most unequal country in the region (among the 23 countries with income distribution data). The top 10 % earns 5000 dollars per 100 earned by the bottom 10%.¹⁹⁶

Primary attendance and literacy are high even among the bottom quintile (95.6 and 92.3 respectively). Primary completion among the bottom quintile is 17.6 percentage points lower than among the top quintile.¹⁹⁷ When cross tabulating gender and ethnic background, some slight differences appear particularly for indigenous populations. For example, the difference between primary completion between indigenous men and women is a 7.8 percentage points, while the difference between indigenous and non-indigenous women is 35.3 percentage points.¹⁹⁸

Secondary school attendance among children from the bottom quintiles is about 32, while among the top quintile it reaches 66 (a relative gap of almost 2). Similar values apply between the highest secondary enrolment region (66) and the lowest one (22).

Child labor is estimated at 6% (of all the children regardless of age). It ranges between 10% and 3% for boys and girls respectively. In rural areas child labor stands at 9% and in urban areas at 5%. Among children whose parents have not completed primary schooling child labor is 10%, but for children whose parents have completed secondary schooling it is 2% (a relative gap of 5). Among children whose parents are working informally, it reaches 14% - more than twice the average rate.

HEALTH. Adolescents in the poorest quintile are almost 2.75 times more likely to become pregnant than the richest.

NUTRITION. The available information in the DI Profile is dated using data from 1997. A more recent national nutrition survey was conducted and the information gathered points to existing nutritional challenges, particularly among indigenous and afro descendent populations. According to the results of the national

¹⁹⁴ UNICEF. State of the World's Children, 2009.

¹⁹⁵ UNDP. Human Development Report for Latin America and the Caribbean, 2010.

¹⁹⁶ UNDP. Human Development Report, 2009.

¹⁹⁷ SEDLAC 2006

¹⁹⁸ CEPAL data produced at request of UNICEF TACRO

nutrition survey, the prevalence of chronic malnutrition increased to 13% in 2003. The pattern is particularly noticeable among indigenous population. In fact, in the three indigenous Comarcas over 60% of children under five were stunted. Information on breastfeeding is also dated; MICS 2005-2006 indicates the percentage of exclusively breastfed children was 25%. Anemia has also been identified as a key challenge, affecting over thirty percent of non pregnant and pregnant women and school aged and preschool children alike.

UNICEF ACTIVITIES: The country program supports a number of nutrition activities in collaboration with other partners (WHO, OPS, MOH). In line with the challenges mentioned above, emphasis is placed on breastfeeding promotion and micronutrient monitoring and evaluation.

WASH

SECTION V

DISCUSSION AND CONCLUSION

The American Public Health Association recommends the following activities to decrease health disparities:

- Creating tools/assessments/audits to improve health care
- Reducing geographic challenges (Ex: Rural or Urban)
- Creating private/public partnerships to fix health care disparities
- Improving quality of health care for ethnic and racial groups
- Improving quality of health care for all
- Improving quality of health care for the poor and other underserved communities
- Increasing health literacy of specific communities
- Fighting a disease-specific health care disparity