SCHOOL FEEDING PROGRAMME

66. The School Feeding Programme is one of two major welfare programmes provided for students at the pre-primary and primary levels and, to a limited extent, at the secondary level. The programme is funded largely by the Government with the assistance of a number of international agencies, viz, The World Food Programme, USAID, and the Italian Government. Two types of feeding programmes are in place, the Traditional - where cooked meals are provided, and the Nutribun and Milk, where students are provided daily with a snack consisting of a half pint of milk or fruit drink and a solid (bun/bulla/bread).

67. A total of 3982 records were available from persons responding to the question on school feeding. Unfortunately, the questionnaire was so designed that the question on participation in the programme was not asked of Basic school students, a large percentage of whom currently benefits from the programme.

68. The data show, however, that students in the Primary and All-Age schools are the principal beneficiaries, accounting for 79% of those who said that they were provided with meals at school. However, some 39% of students in these schools reported, not having received any meals at school within the reference week.

69. The number of children who did not receive meals was therefore some 9% higher than expected, as the Ministry of Education contends that the coverage of the SFP is approximately 70% at this level. Students in New Secondary Schools represent 12% of those receiving meals and Secondary High students, 7%.

70. Of the 2127 students receiving meals, 56% receive the Nutribun/Milk, 35% Cooked Meals, and 9% Other (not specified).

Table 3.8
Percentage Distribution of School Feeding Benefits By School Type

School Type	Nutribun	Traditional	Other	None
Primary (N=1270)	38	17	4	41
All-Age (N=1505)	41	19	3	37
New Sec.(N=567)	14	20	10	55
Comp. (N=48)	2	17	0	79
Secondary High (N=507)	2	20	8	69
Technical (N=57)	0	28	10	60
Vocational/ Agricultural (N=14)	0	21	0	71

Table 3.9 shows that the Nutribun and Milk programme has a wider coverage among students in Primary and All-Age schools than any other programme; 38% of primary students responding said that they receive the Nutribun, compared to 17% who receive the cooked meal.

71. Among those in the All Age schools, 41% receive Nutribun compared to 19% who received the cooked meal. A small percentage participates in Other programmes.

72. At the Secondary level however, the tendency is for greater participation in the Cooked Meal programme than in the Nutribun and Milk programme. This is understandable, given the fact that the Government's priority area in school feeding, especially with the Nutribun programme, is at the Primary level.

Table 3.9
Percentage Distribution of Children
Receiving Meals By Quintile

	Population Quintile				
Type of Meal	Poorest	2	3	4	5
Nutribun (N=1192)	30	27	20	14	9
Cooked (N=746)	25	22	18	19	16
Other (N=189)	13	24	20	33	10
Total Meals (N=2127)	27	25	19	17	12
No meal (N=1828)	18	19	23	23	16

Student participation in Programme

73. The feeding programme as currently operated by Government is targetted to students who wish to participate in it. Students participating in the Nutribun-and-Milk programme make a voluntary contribution of $0.20 per day per snack, while those benefitting from the Cooked Meal programme contribute between $1.50 and $4.00 per meal.

74. Data from the Survey show that of the 2127 students reporting having received meals from the programme, those in the poorest quintiles benefit most. The level of benefit decreases as consumption status rises. This clearly indicates that the programme operates to benefit students according to their degree of need (See Table 3.9). Of those students receiving Nutribun, 57% are in the two poorest quintiles while only 9% of the wealthiest participates; 47% of those participating in the Cooked Meal programme are in the two poorest quintiles, while 16% of the wealthiest quintile participates. The lower level of participation of the poorest in the cooked lunch programme is understandable because of the higher cost of the meal.

Table 3.10
Daily Expenditure on School Feeding
By Quintile

Contribution $	Jamaica	Population Quintile				
		Poorest	2	3	4	5
< 0.20 (N=96)	8	2	7	13	11	17
0.20 (N=751)	63	69	62	64	63	50
0.25 (N=11)	1	0	2	0	0	4
0.30 (N=72)	6	9	6	3	5	5
0.40 (N=68)	6	6	4	3	11	7
0.50 (N=79)	7	5	11	6	4	3
0.60 - 0.80 (N=11)	1	2	0	1	1	0
1.00 (N=57)	5	4	4	7	1	10
> 1 - > 2 (N=22)	2	2	2	2	1	3
> 2 - > 5 (N=16)	1	1	1	6	3	3
Total (N=1183)	100	100	100	100	100	100

Discrepancies are due to rounding

Expenditure on School Lunches

75. In general, expenditure on school lunches is not commensurate with means. In fact, persons in the lowest quintiles are more likely to pay for the lunches and also to spend more on school feeding than their wealthier counterparts. Of the total number of students receiving meals, 56% reported that they make contributions. The percentage making contributions, by quintiles, is as below:

	Poorest	2	3	4	5	All Quintiles
Percentage Contributing	62	60	59	43	45	56

76. The incidence of payment among the wealthiest quintiles is thus significantly lower than among the poorest. It is noteworthy that the regressive distribution of payments was also observed in the July 89 survey. Furthermore, examination of the actual expenditure of the students on the programme (**See Table 3.10**) shows that of the students spending between $1.00 and $5.00 per day, 50% are among the two poorest quintiles while only 25% of those in the upper quintiles pay that much. Most respondents pay $0.20 for the lunch, in keeping with the voluntary contribution of $0.20 required for the Nutribun programme.

Table 3.11
Distribution by Region of Children Receiving School Lunch

	Region		
Type of Meal	KMA	Other Towns	Rural
Nutribun (N=1192)	23	14	62
Cooked (N=745)	17	19	65
Other (N=188)	16	28	56
Total Meals (N=2125)	32	18	47
No meal (N=1829)	20	17	62

77. Distribution of school lunches by area is presented in **Table 3.11.** The table shows that the Cooked Meal programme has a slightly higher participation rate in Other Towns and Rural Areas than the Nutribun programme and that the widest level of participation in all programmes combined is in the Rural Areas.

78. This distribution of school meals is consistent both with the welfare status of these areas and the geographical spread of the school population. Rural Areas account for 56% of the Primary and Secondary School population and for 62% of those receiving meals; Other Towns with 18% of the population account for 17% of those receiving meals, while the KMA with 26% of the student population accounts for 20% of those receiving meals.

Conclusions

79. Education coverage at the pre-primary, primary and lower secondary levels is high and on target with Government's policy towards basic education as set out in the Education Sector 5 Year Plan 1990-95. However, at approximately 70%, attendance rates at the crucial plank of the education system - primary level - are well behind the target of 85% average daily attendance.

80. Low attendance is particularly noticeable among students in the more rural areas, All Age Schools, and among boys. Attendance is relatively uniform, showing no strong pattern by consumption groups, but children of the wealthiest quintile are likely to attend school more regularly than their poorest counterparts. Repetition rates are generally low both at the primary and secondary levels, but because of the local practice of promotion by age the repetition data do not provide any useful indication of either the level of efficiency within the system or of students' performance.

81. The data on patterns of enrolment in secondary and tertiary institutions are perhaps the most instructive in terms of the role of education in status and class mobility in the society. The enrolment pattern in schools at the secondary level suggests a lack of social equity, as most of the poorest students are enrolled in All Age and New Secondary Schools, which do not offer much prospect for improvement in economic and social status, while the wealthiest have access to the type of education which can enhance their status. The percentage of students of tertiary age group enrolled in institutions is low. This fact may well be a function of limited availability of institutional space. However, the strong correlation between high levels of consumption and enrolment in tertiary education indicates that affordability plays a critical role.

82. Assessment of the school feeding programme, the only welfare programme addressed in the education module, shows that benefits are positively skewed to the poorest groups but that those in the upper quintiles nevertheless derive substantial benefits from the programme. This is possible because the programme is available to all students in Primary and All Age schools and is generally self-targetting. The pattern of payment on the programme however, indicates that those who can least afford to pay for the lunches are the ones who most often do.

83. Overall the data show little or no gender bias in the distribution of welfare benefits, or enrolment. Female students, however, account for the higher portion of enrolment in the better types of secondary schools, viz, Secondary High, Comprehensive and Technical High, and are predominant in enrolment at the tertiary level.

CHAPTER 4: Health

INTRODUCTION

84. The November 1989 round of the Survey of Living Conditions included an expanded health module which, in addition to the core questions, examined fertility, perinatal care and adult health. This report deals with the core questions and adult health and makes some comparisons with previous rounds. Comparisons were not always possible because of changes made to the core questions.

SELF-REPORTED ILLNESS OR INJURY

85. Only 17.7% of Jamaicans reported an illness or injury in the four weeks preceding the survey interview (Table 4.1). There were notable differences in the prevalence of reported illness or injury among different age groups and residents of different locations. The elderly were most likely to be unwell - 30.7% reported being so, followed by the very young, i.e., children 1 - 4 years old, of whom, 26.2% reported illness or injury. This trend is normal.

86. The prevalence of reported illness or injury among persons in other towns was nearly twice that of those living in Kingston metropolitan area. Women were more likely to report an illness or injury than men, 20.0% compared with 15.7% respectively.

87. These trends were similar to those found in the previous rounds of the SLC but in the cases of male/female and area comparisons the differences were more marked in the November round. Differences in reported illness or injury by consumption quintile were not marked in any of the rounds of the SLC.

88. The severity of the illness or injury is indicated by the average length of illness or injury and the average number of days of restriction of normal activities, which were 11.4 and 5.5 days respectively for the whole population (Table 4.2). In other words, the length of impairment was approximately half that of the total length of illness or injury. These observations were similar to previous rounds of the SLC. Overall, reported illness/injury was least severe in children and greatest in persons sixty years and over. When these indicators are disaggregated by age, sex and area, a similar pattern was observed. The elderly were ill or impaired for considerably longer, and women for slightly longer. The rural population reported slightly longer illness or injury than those in towns and in KMA.

THE USE OF MEDICAL CARE

89. The percentage of persons seeking medical care was 49.0, somewhat lower than in the earlier rounds of SLC when this figure was 54.6, even though the severity of illness as indicated by length of illness and of impairment was the same. The November round reported the use of medical care by children less than one year and found that this age group sought medical care more frequently than any other. With the exception of the two youngest age groups, the percentage of those seeking medical care increased with increasing age. In both the July and November round, more persons in KMA and females sought medical care. The higher percentage of KMA dwellers is probably associated with proximity to medical care rather than greater need. No differences in consumption quintiles were observed.

Table 4.1
Self-Reported Illness or Injury, October 1988 - November 1989

	October, 1988	July 1989	November 1989
Consumption Quintile			
Poorest	13.7	14.9	18.8
2	17.1	17.1	17.2
3	14.5	17.1	17.2
4	14.9	17.9	16.6
5	18.9	17.1	19.1
Area			
K.M.A.	11.5	12.0	12.8
Towns	17.9	18.2	23.0
Rural	17.8	18.2	19.0
Sex			
Male	14.3	15.0	15.7
Female	17.3	18.5	20.0
Age			
0	23.1	-	22.4
1 - 4		24.3	26.2
5 - 13	12.1	12.0	13.0
14 - 39	11.7	11.5	11.8
40 - 59	19.2	19.7	18.2
60+	31.8	37.3	30.7
JAMAICA	15.8	16.8	17.7

90. It must be noted that reported illness or injury and seeking medical care are also measures of perception of and concern about one's health. The life expectancy of Jamaican males is not longer than females and therefore it is unlikely that the lower percentage of reported illness or injury and of seeking health care is due to better health among males. It is more likely that males often do not perceive that they have health problems and do not take active steps to deal with them. However, it is possible that the problems reported by women were related to childbearing.

91. The pattern of usage of different sources and levels of care is shown in **Table 4.3.** Of those who sought medical care, 38.9% went to public facilities, with the majority, 75.7% using primary care services. Very few persons (2.9%) required hospitalisation. The use of private and public, primary and secondary services differed according to patient characteristics.

92. While half of the poorest population quintile used public health facilities only one-quarter of the wealthiest quintile did so. It is notable, however, that one half of the poorest quintile also used private facilities, in spite of the cost and the relatively wide availability of public health services. Similarly, use of public facilities decreased with increasing age. There were no differences in the source of care by gender or area.

Table 4.2
Severity of self-reported illness/injury and use of medical facilities

	Mean days of illness/ injury	Mean days of impairment	Percent Seeking Medical Care
Consumption Quintile			
Poorest	12.4	6.6	43.7
2	11.7	5.6	49.8
3	12.3	5.5	47.5
4	11.2	5.5	52.7
5	9.4	4.3	51.6
Area			
K.M.A.	10.4	4.5	56.7
Towns	10.8	4.6	45.5
Rural	12.0	6.2	47.2
Sex			
Male	10.9	5.1	44.7
Female	11.8	5.8	52.8
Age			
0	9.3	3.9	63.2
1 - 4	7.8	3.2	45.6
5 - 13	8.8	3.6	42.7
14 - 39	8.6	3.9	47.9
40 - 59	10.8	4.7	50.2
60+	15.6	8.3	50.6
JAMAICA	11.4	5.5	49.0

93. There were no significant variations according to economic capability, age or gender in the medical care sought by the population in general, at all levels - primary, out-patient, or hospitalisation. (See Table 4.3.) However, a greater percentage of elderly persons required hospitalization.

94. The private doctor's office was by far the most frequent choice of consultation - 52.1% of those seeking medical care; followed by the public health centres (18.7%) and outpatient services at public hospitals (16.9%) **(Table 4.4)**. Private hospitals, whether for out-or in- patient services were infrequently used. Costs for services varied widely by level and source of consultation. Private facilities were considerably more expensive than public ones being up to ten times more for comparable services. There were marked increases in the cost of these consultations over the five month period between the two rounds conducted in 1989. In spite of this, Jamaicans appear not to be deterred by cost in seeking the attention of private doctors, which suggests that they are prepared to pay for health services if necessary.

4.3
Source and Level of Care by Patient Characteristics

	SOURCE OF CARE		LEVEL OF CARE		
	Public %	Private %	Primary %	Outpat-ient %	Hospital-isation %
Consumption Quintile					
Poorest	50.7	47.4	74.0	20.9	2.8
	46.7	51.8	76.4	16.9	3.1
	44.1	53.8	73.5	19.7	2.9
	35.7	62.5	74.3	20.6	2.9
	24.2	75.2	79.5	16.6	3.0
Area					
K.M.A.	39.9	58.9	66.0	27.7	3.7
Towns	38.3	60.1	74.9	19.8	3.3
Rural	38.6	59.7	80.7	14.3	2.4
Sex					
Male	37.7	60.5	73.6	19.8	3.8
Female	39.7	58.9	77.2	18.2	2.4
Age					
0	61.4	38.6	72.9	25.7	0.0
1 - 4	48.8	50.0	80.2	14.5	2.9
5 - 13	46.5	51.6	72.1	22.3	1.9
14 - 39	32.6	66.4	77.6	16.8	3.3
40 - 59	29.2	67.7	75.0	19.3	2.6
60+	34.6	63.9	74.7	19.3	4.5
JAMAICA	38.9	59.6	75.7	18.9	2.9

Table 4.4
Choice of Provider; and Mean Cost of Service July and Nov. 1989

	Of those consulting % who utilize Nov. 1989	Cost of Service	
		July 89 J$	Nov.89 J$
Public Hospital			
-outpatient	16.9	4	12
-inpatient	2.6	-	58
Private Hospital			
-outpatient	2.0	33	117
-inpatient	0.4	-	300
Public Health Centre	18.7	4	4
Private Health Centre	2.9	35	40
Private Doctors Office	52.1	56	76

EXPENDITURE FOR HEALTH CARE

95. The average costs for consultations and drugs in the private and public sectors by patient characteristics are presented in Table 4.5. The lack of any clear trend in the cost of public sector visits for different consumption quintiles, age and sex is indicative of the uniformity of fees in that sector. There was a clear trends of increasing private sectors costs with increasing consumption quintile, and age.

96. A similar trend was observed for drugs except that rural purchases of drugs from the private sectors were lower than urban purchases. This pattern was seen in both the July and November round of the SLC and may be due to prescription patterns of doctors which lead rural pharmacies to stock the lower cost drugs. Of course, rural households also had lower consumption levels and could be expected to spend less on health care than their urban counterparts.

97. Differentials in expenditure on health care become more marked when health insurance is taken into account. The percentage of persons with health insurance increased dramatically with consumption quintile and age, excepting the elderly. Thus, the total cost of health care in the higher consumption and age groups was that much higher. On the other hand, the higher costs of consultations in the rural area and among the elderly may be explained by the lower health insurance coverage and may be a better estimate of the actual costs of consultations.

98. The differences in expenditure among different groups are clearly related to affordability and those who choose public sector health care probably do so because they cannot afford private sector costs. Thus any plans to extend fee collection for public health services must ensure that the medically indigent are adequately protected and that the situation is properly monitored.

Table 4.5
Health Care Expenditures

	Mean Cost per Visit for all Visits in last 4 weeks excluding drugs and costs reimbursed by health insurance		Mean Cost for Drugs, by Source		Percent with Health Insurance
	Public J$	Private J$	Public	Private	
Consumption Quintile					
Poorest	17	54	3	36	1.2
2	6	50	4	31	2.1
3	7	51	6	42	6.0
4	7	57	6	60	11.6
5	20	66	6	62	19.8
Area					
K.M.A.	5	47	9	55	14.9
Towns	9	52	2	51	10.4
Rural	17	65	4	44	4.1
Sex					
Male	10	61	6	42	8.1
Female	13	55	5	54	8.2
Age					
0 - 4	5	49	4	40	5.2
5 - 13	7	41	4	32	7.5
14 - 39	16	61	5	48	9.0
40 - 59	18	57	7	61	12.4
60+	13	68	7	66	3.8
JAMAICA	11	57	5	48	8.1

99. Half of those reporting illness/injury also reported purchasing drugs **(Table 4.6).** The proportion of ill/injured who purchased drugs was directly related to consumption quintile i.e., the higher the consumption quintile the greater the proportion of persons purchasing drugs. There was no clear trend in relation to age but the elderly had the lowest proportion of persons reporting drug purchases. Fewer rural persons reporting problems purchased drugs. These patterns are somewhat similar to those of insurance coverage and the relationship between the two needs to be explored.

Table 4.6
Drug Availability November 1989 SLC

	% of ill/ Injured reporting Drug Purchases	All medicines Available from: Public Sources	Private Sources
Consumption Quintile			
Poorest	40.8	26.7	78.3
2	46.3	25.8	78.2
3	55.7	26.6	81.0
4	54.7	23.5	81.7
5	59.8	13.0	89.8
Area			
K.M.A.	64.1	24.0	83.2
Towns	57.0	17.3	84.6
Rural	45.4	22.5	81.5
Sex			
Male	50.9	21.5	83.3
Female	52.6	21.6	82.3
Age			
0 - 4	54.7	25.2	81.2
5 - 13	50.3	26.1	78.7
14 - 39	56.3	17.9	86.1
40 - 59	52.4	21.7	82.7
60+	45.1	18.2	83.9
JAMAICA	51.8	20.9	80.3

100. The majority of persons purchased drugs from private sources but even so, there were differences according to patient characteristics. The poorer quintiles and younger age group were more likely to purchase from public sources. The higher acquisition of drugs from private sources is probably related more to non-availability of drugs in the public sector than to choice.

VACCINATION COVERAGE

101. Vaccination coverage of children under five years was good, with over 80% receiving the required number of doses of OPV and DPT, 95% receiving BCG and 79% receiving measles. The figures are consistent with those reported by the Ministry of Health and suggest that the Ministry's immunisation programme has been successful in reaching the majority of its target group. Vaccination coverage appeared not to be related to consumption levels or areas of residence (**Table 4.7**).

Table 4.7
Vaccination Coverage

	Percent receiving 3 or more Doses OPV	Percent receiving 3 or more Doses DPT	Percent receiving BCG	Percent receiving Measles
Consumption Quintile				
Poorest	78	78	94	78
2	79	79	94	76
3	84	84	95	82
4	84	85	97	83
5	82	83	96	76
Area				
K.M.A.	82	82	95	80
Towns	79	79	95	77
Rural	81	82	94	79
JAMAICA	81	81	95	79

NUTRITIONAL STATUS

102. Nutritional status, as determined by the anthropometric measurements of weight and height is a reasonably sensitive indicator of health. These indicators respond to changes in purchasing power, food availability and accessibility, access to health care, inter alia. Nutritional status of the child is often indicative of the well-being of the household. Nutritional status also affects the individual's susceptibility to illness.

103. In the November round, there were 1697 children under five years old in the households surveyed. Of these, 1589 children, 766 males and 823 females, were weighed and measured by STATIN interviewers who had been trained by Ministry of Health Personnel.

104. There were a few cases for whom both measurements were not available, whose ages were unknown or for whom consumption or area data were missing. Consequently, there are some insignificant differences in the sample size depending on the indicators under study.

105. Nutritional status can be examined in three ways - weight for height that measures acute malnutrition or wasting, height for age that measures chronic malnutrition or stunting and weight for age that is a measure of both simultaneously. The November round of the SLC found that 2.2% of the children were wasted; 2.9% were stunted and 7.3% were low weight for age. Approximately 1% were either severely wasted, stunted or low weight for age **(Table 4.8)**.

Table 4.8
Prevalence of Malnutrition Survey Data, 1978 -1989

	Wasting			Stunting			Low Wt.for Age		
Survey	**Mod. %**	**Sev. %**	**Tot. %**	**Mod. %**	**Sev. %**	**Tot. %**	**Mod. %**	**Sev. %**	**Tot %**
2nd round 89	1.5	0.6	2.2	1.7	1.2	2.9	6.5	0.8	7.3
1st round 89	1.3	0.1	1.4	4.5	0.4	4.9	8.5	0.7	9.2
MOH 85	3.8	1.3	5.1	4.8	2.3	7.1	13.6	1.0	14.6
MOH 78	-	-	5.1	-	-	5.0	-	-	15.0

106. In this round, the trend of improvements in nutritional status continued among the moderately stunted and low weight for age children. There was, however, no improvement in the level of wasting nor in the severe category of stunting or low weight for age. This suggests that while some groups have shown improvement, those who are extremely marginalised have not benefitted from social services and remain in a poor state.

107. This section describes the relationship between nutritional status and correlates, namely consumption quintile, area of residence, sex and age. The previous rounds did not have a sufficiently large number of children to disaggregate the information by severity of the malnutrition. In this round, the sample size lent itself to that type of analysis but the low prevalence of malnutrition overall, made it difficult to determine significant differences with any degree of confidence. However, notable patterns exist.

108. ***Consumption*** The prevalence of malnutrition, judged by weight for age and stunting as indicators of nutritional status, decrease with increasing per capita consumption (Table 4.9). The differences between the two lowest consumption quintiles and the highest were statistically significant ($p<0.001$). Lack of a correlation between wasting and per capita consumption appears strange in view of the correlation with the other indicators. However, a closer examination of the two children in the severely wasted category, show that both were only two months old and were probably low birth weight infants. All other wasted children were over four months old. This association between consumption quintile and nutritional status was observed in the previous round of the SLC.

109. ***Area*** No clear pattern of malnutrition appeared by area. Among the rural population, the prevalence of low weight for age was less than the national average but for stunting the prevalence was somewhat higher. Kingston and Metropolitan area had a higher than average prevalence of both low weight for age and wasting **(Table 4.10)**.

110. ***Age*** The prevalence of low weight for age and stunting rose with increasing age up to twenty-three months but thereafter, no clear pattern emerged **(Table 4.11)**. The increase in malnutrition during the weaning age is typical. In cases of chronic under-nutrition, stunting increases with aging up to about 35 months, levelling off at that time. However, this can be confounded by the effect of adverse or extremely favorable nutrition on a particular cohort of children; but the survey of living conditions is not designed to determine this. In general, wasting decreases after the critical weaning age period but at any point, rapid depletion and restoration owing to inadequate intakes and/or infection can occur.

111. ***Sex*** Sex differences reported in the previous round of the SLC were not observed in the November round. For all three anthropometric indicators males had a similar prevalence of malnutrition as females **(Table 4.12)**.

Table 4.9
Prevalence of Malnutrition by Per Capita Consumption Quintile

Consumption Quintile	Low Weight for Age					
	Severe		Moderate		Total	
	No.	%	No.	%	No.	%
Poorest (N=421)	5	1.2	29	6.9	34	8.1
2 (N=381)	4	1.0	38	10.0	42	11.0
3 (N=352)	2	0.6	17	4.8	19	5.4
4 (N=246)	1	0.4	14	5.7	15	6.1
5 (N=187)	-	-	5	2.7	5	2.7
JAMAICA (N=1587)	12	0.8	103	6.5	115	7.3

Consumption Quintile	Stunting					
	Severe		Moderate		Total	
	No.	%	No.	%	No.	%
Poorest (N=424)	6	1.4	10	2.4	16	3.8
2 (N=381)	8	2.1	11	2.9	19	5.0
3 (N=351)	3	0.9	4	1.1	7	2.0
4 (N=246)	2	0.8	2	0.8	4	1.6
5 (N=185)	-	-	-	-	-	-
JAMAICA (N=1587)	19	1.2	27	1.7	46	2.9

Consumption Quintile	Wasting					
	Severe		Moderate		Total	
	No.	%	No.	%	No.	%
Poorest (N=422)	1	0.2	7	1.7	8	1.9
2 (N=376)	4	1.0	10	2.7	14	3.7
3 (N=351)	2	0.6	3	0.9	5	1.5
4 (N=249)	1	0.4	3	1.2	4	1.6
5 (N=187)	2	1.1	1	0.5	3	1.6
JAMAICA (N=1585)	10	0.6	24	1.5	34	2.1

Table 4.10
Prevalence of Malnutrition by Area

Area	Low Weight for Age					
	Severe		Moderate		Total	
	No.	%	No.	%	No.	%
K.M.A (N=405)	4	1.0	31	7.7	35	8.7
Other Towns (N=281)	1	0.4	22	7.8	23	8.2
Rural (N=902)	7	0.8	50	5.5	57	6.3
JAMAICA (N=1588)	12	0.8	103	6.5	115	7.3

Area	Stunting					
	Severe		Moderate		Total	
	No.	%	No.	%	No.	%
K.M.A (N=403)	5	1.2	7	1.7	12	2.9
Other Towns (N=281)	3	1.1	2	0.7	5	1.8
Rural (N=901)	11	1.2	18	2.0	29	3.2
JAMAICA (N=1585)	19	1.2	27	1.7	46	2.9

Area	Wasting					
	Severe		Moderate		Total	
	No.	%	No.	%	No.	%
K.M.A (N=403)	7	1.7	10	2.4	17	4.1
Other Towns (N=281)	-	-	3	1.1	3	1.1
Rural (N=901)	3	0.3	11	1.2	14	1.5
JAMAICA (N=1585)	10	0.6	24	1.5	34	2.1

Table 4.11
Prevalence of Malnutrition by Age

Low Weight for Age						
Age	Severe No.	%	Moderate No.	%	Total No.	%
0 - 5 (N=150)	1	0.7	6	4.0	7	4.7
6 - 11 (N=150)	-	-	9	6.0	9	6.0
12 - 23 (N=320)	5	1.6	29	9.1	34	10.6
24 - 35 (N=327)	2	0.6	19	5.8	21	6.4
36 - 47 (N=324)	1	0.3	13	4.0	14	4.3
48 - 59 (N=317)	3	0.9	27	8.5	30	9.4
JAMAICA (N=1588)	12	0.8	103	6.5	115	7.3

Stunting						
Age	Severe No.	%	Moderate No.	%	Total No.	%
0 - 5 (N=150)	-	-	1	0.7	1	0.7
6 - 11 (N=150)	2	1.3	2	1.3	4	2.6
12 - 23 (N=320)	9	2.8	10	3.1	19	5.9
24 - 35 (N=327)	3	0.9	2	0.6	5	1.5
36 - 47 (N=324)	3	0.9	7	2.1	10	3.0
48 - 59 (N=317)	2	0.6	5	1.6	7	2.2
JAMAICA (N=1588)	19	1.2	27	1.7	46	2.9

Wasting						
Age	Severe No.	%	Moderate No.	%	Total No.	%
0 - 5 (N=155)	3	1.9	2	1.3	5	3.2
6 - 11 (N=147)	-	-	2	1.4	2	1.4
12 - 23 (N=318)	2	0.6	6	1.9	8	2.5
24 - 35 (N=327)	1	0.3	5	1.5	6	1.8
36 - 47 (N=322)	1	0.3	1	0.3	2	0.6
48 - 59 (N=316)	3	0.9	8	2.5	11	3.4
JAMAICA (N=1585)	10	0.6	24	1.5	34	2.1

Table 4.12
Prevalence of Malnutrition by Sex

Low Weight for Age						
Sex	Severe No.	%	Moderate No.	%	Total No.	%
Males (N=823)	8	1.0	55	6.7	63	7.7
Females (N=766)	4	0.5	48	6.3	52	6.8
JAMAICA (N=1589)	12	0.8	103	6.5	115	7.3

Stunting						
Sex	Severe No.	%	Moderate No.	%	Total No.	%
Males (N=819)	9	1.1	16	2.0	25	3.1
Females (N=768)	10	1.3	11	1.4	21	2.7
JAMAICA (N=1585)	19	1.2	27	1.7	46	2.9

Wasting						
Sex	Severe No.	%	Moderate No.	%	Total No.	%
Males (N=823)	6	0.7	11	1.3	17	2.0
Females (N=762)	4	0.5	13	1.7	17	2.2
JAMAICA (N=1585)	10	0.6	24	1.5	34	2.1

ADULT HEALTH

112. The November round, in addition to the information on self-reported illness, examined the general health status of the adult population using two measures, also self-reported. These were a measure of general health and measures of physical functioning. This information was collected on all individuals 14 years and over in the households surveyed. A total of 10,375 males and females answered the questions relating to adult health. The following section presents the findings on the general health of the adult population.

113. The majority of adults enjoyed good or very good/excellent health with only 16% enjoying poor health (**Table 4.13**). However, there were statistically significant correlations between general health of the adult population and socio-economic indicators such as consumption quintile, sex and age.

114. The two poorest consumption quintiles reported the highest prevalence of poor or fair health i.e.,18%, and the lowest percentage of good/excellent health, i.e., 54%. The percentage with poor/fair health gradually decreased with increasing consumption quintile, the difference between the poorest and the wealthiest being significant ($p<0.01$). The percentage with good health fluctuated around 27%. The slightly lower percentage of persons in the highest consumption quintile in that category is due to the fact that significantly more are in the very good/excellent health category.

115. The relationship between per capita consumption and health can be a causal one in either direction. On the one hand, it may be poor health that reduces productivity and as a result, earning power. In the Jamaican situation, however, it is more likely that the per capita consumption impacts on health.

116. Rural adults reported significantly more poor/fair health than adults living in the Kingston metropolitan area and other towns ($p<0.001$). However, rural populations were also poorer and the differences seen here may be less related to area than to per capita consumption. Adults living in Other Towns enjoyed the best health, with 63% reporting very good/excellent health, compared with 58% and 55% for KMA and Rural Areas respectively.

117. Significantly more women reported poor/fair health than males ($p<0.001$). Other studies have also reported gender differences. Further study is needed to determine whether these differences result from differences in biological or social functioning, or reporting biases. Fertility related ill-health could also account for the differences observed.

118. Age appeared to be have the most pronounced effect on health status. Whereas less than 5% of those under 19 years reported poor/fair health, this figure increased steadily with age, so that among the sixty year-old population nearly one-half reported a state of poor or fair health. These differences were also highly significant ($p<0.0001$).

119. The patterns seen here are much more marked than those observed for self-reported illness/injury described earlier. The self-reported illness gives an indication of the likely demand for services at any point in time. These data, however, provide some information about those groups who have poor/fair health and are therefore likely to demand health care.

CHAPTER 5: Food Stamp Programme

INTRODUCTION

123. Unlike general subsidies, food stamp benefits represent precisely targetted state aid. They are intended to assist population groups particularly vulnerable to becoming malnourished and also to help to provide minimum nutrition intake levels for persons who have little or no income. The benefit is thus intended for the neediest members of the population.

124. Pregnant and lactating women, and children under five are considered to be at nutritional risk and are therefore targetted. Any such individual can obtain stamps by enrolling at government health clinics. It is generally known that public health clinics are patronised much more by the poorer members of society, hence an inherent selection process is being utilised. Other individuals qualify for stamps based on having a total household income not exceeding J$2,600[4] per year. Persons receiving poor relief and public assistance fall into this group and automatically receive food stamps.

125. At the time of the survey an administrative ceiling of 400,000 (16.7% of the population) beneficiaries was in place; one half (200,000) was intended for children under five and pregnant/ lactating women and the other half for elderly poor and heads of households with income of less than $2,600. Households may have more than one beneficiary, and each beneficiary was entitled to $40 worth of stamps, issued every two months. Stamps could then be used for the purchase of rice, cornmeal and powdered milk only, from any retail outlet.

126. The survey questions which furnish the basic data for the analysis of the food stamp programme are the following:- firstly, households were asked if anyone in the household received food stamps in September or October (i.e. just prior to the start of the survey in November). Households which said "yes" were required to specify household beneficiary type and also the total value of all food stamps received by all household members during the reference period. Households which had not received food stamps were required to state whether any household member had ever applied for any. Those who had applied, were asked to state the outcome of the application: Was it approved, put on file for the future or turned down? Those whose applications had been approved were asked to state why they had not received in September or October. Finally, households which had never received nor applied for food stamps were asked to state why they had never applied.

127. In examining the factors affecting the distribution of benefits, and the degree of coverage and leakage, the responses to the preceding questions are integrated with other SLC data. The latter includes data on welfare status, nutrition status, immunisation coverage and geographic location.

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4 This income level was applied at the time of the November '89 SLC.

TARGETTING

128. Success in targetting is measured as the extent to which a benefit is available to the target group and prevented from leaking to the non-target group. The primary measure of coverage used is the proportion of targetted beneficiaries obtaining food stamps.

129. When the survey was conducted (November 1989) the Food Stamp Programme was not targetted at households per se, but at individuals, including heads of low income households. It is realistic to assume, however, that a recipient's entire household benefits from their participation in the Programme, and the first two SLC reports (August 1988 and July 1989) analysed the findings purely on a household basis. This report departs from the earlier approach and assesses the Programme in relation to individuals as well as households. This improves the assessment as follows: Firstly, since households may have any number of food stamp recipients in any number of categories, under-counting of benefits is possible when the household is treated as the beneficiary unit. Secondly, the average household size is not constant across the consumption quintiles, there being smaller households and thus more households per quintile with increasing levels of consumption. Hence the spread of benefits by quintiles is more precisely compared on the basis of individuals rather than households.

Household Coverage

130. **Table 5.1** shows the degree of both coverage and leakage for households in November 1989 and August 1988. Data from the July 1989 round are not used because those data are considered less reliable than the others. This is due to the fact that there was a suspension of the food stamp programme some months before the survey, i.e. between March and May, hence the reference period was January and February instead of the two months (May and June) preceding the survey. This apparently introduced recall error and only few beneficiaries were identified.

131. In November 1989, a total of 580 households from the sample of 3,885, or 15% of the households, received food stamps in the two months prior to the survey. This compares with 23% of the sample in August 1988. The decline in coverage was reflected across all quintiles, with the poorest quintile, for example, falling from having one half to having one third of its households receiving stamps.

132. As regards coverage by beneficiary type, 20% of households with children under 5 were in receipt of stamps at the time of the survey (cf. 38% in August 1988); 19% of households with elderly members received stamps (cf. 35% in August 1988); and 33 % of those with total consumption below J$2,600 (cf. 47% in August 1988). Information was not obtained to ascertain the number of households in the sample with pregnant or lactating women, hence the proportion receiving stamps cannot be calculated. It should be noted that the table includes a category for the "Handicapped", because they are identified as a distinct sub-group of the poor though they are not targetted per se by the Programme.

Table 5.1
Households Receiving Food Stamps

Household Characteristic	No. in Sample	No. in Receipt of Stamps	Percent of Quintile Receiving Stamps					
			Jamaica	1	2	3	4	5
November 1989								
Children < 5 years	1218	242	20.0	24.7	27.4	19.2	12.6	10.2
Pregnant/lactating women	n/a	25	n/a	n/a	n/a	n/a	n/a	n/a
Elderly	1164	216	18.6	32.5	22.8	21.3	10.8	6.7
Handicapped	n/a	30	n/a	n/a	n/a	n/a	n/a	n/a
Consumption < $2600	61	20[5]	32.8	34.7	25.0	-	-	-
None of the above	n/a	17	n/a	n/a	n/a	n/a	n/a	n/a
All H' holds	3885	580[6]	14.9	33.7	26.	17.	8.7	4.0
August 1988								
Children < 5 years	607	228	37.6	61.0	45.3	34.9	26.3	11.2
Pregnant/lactating women	182	68	37.6	71.8	39.6	31.6	24.2	4.4
Elderly	550	194	35.3	54.9	45.7	37.2	28.7	13.0
Consumption < $2600	73	34	46.6	47.2	45.0	-	-	-
None of the above	805	62	7.7	27.1	18.8	8.9	7.5	2.7
All H' holds	1900	445[7]	23.4	50.6	37.1	26.3	17.0	6.0
November 1989								
Number of H' holds Receiving			568	174	158	116	74	46
Distribution by Quintile (%)			100	31	28	21	12	8
August 1988								
Number of H' holds Receiving			445	137	115	89	69	35
Distribution by Quintile (%)			100	31	26	20	15	8

N.A. = Not Available

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5 An additional 81 households with 89 members were receiving stamps in the category "Poor" i.e. total income <$2600, see text for further discussion.

6 This total is not the sum of the categories because a household may be counted in more than one category.

7 See above

133. In relation to those benefitting on the basis of having low household income, certain points need to be made. The target beneficiaries in this instance are heads of households with total incomes below $2,600.[8] However,the survey instrument cannot precisely identify such households, since consumption is used in the survey as a proxy for income. According to the survey data 61 households had a total consumption of <2,600, and 20 of these households were in receipt of food stamps. On the other hand, a total of 101 households stated that they were receiving stamps on the basis of having low incomes. These were categorised by consumption quintile as follows:

1	2	3	4	5	Total
38%	26%	14%	16%	6%	100%

To the extent that the SLC is correct in its measurement of welfare status, there must be doubt about the eligibility of many of those receiving food stamp benefits on the basis of low household income. It is noted that means testing has always been applied in determining the eligibility of persons in this category, but the present data indicate that more careful screening of these applicants may be necessary.

134. The general contraction in provision of food stamp benefits between August 1988 and November 1989 may be attributed to the fact that in 1989 there was intensive cleaning of the rolls resulting in a significant reduction in the list of beneficiaries. This effect was apparently still in evidence at the time of the survey. Since the objective in cleaning the rolls is to reduce the extent of leakage to ineligible beneficiaries, it is of special interest to assess the degree to which the exercise was successful.

135. Examination of the data shows that there was marked improvement in relation to the removal of beneficiaries who possessed none of the characteristics of eligibility. In 1988, these persons represented 14% of the beneficiaries in the SLC sample, while in November 1989, they represented only 3%. At the same time, leakage is also reflected in the proportion of benefits going to higher income groups even if such beneficiaries meet the broad eligibility criteria. Here, there was minor reduction in the quantum of leakage resulting in a slightly more progressive distribution. The wealthiest and poorest quintiles actually maintained exactly the same share of benefits. However, there was a 3% reduction in the share going to the fourth quintile, with the decrement going to the second and third quintiles.

136. One may conclude, therefore, that meaningful improvements were effected in the selection of participants on the basis of eligibility. In terms of welfare status, however, a stable pattern has been maintained where at least 20% of beneficiary households are amongst the better-off residents (i.e. in quintiles 4 and 5), and should not be in receipt of food stamps. To eliminate or minimise this, so as to spread the benefits to the real target group, more testing may be required. In this connection, particular attention would need to be paid to those categories of beneficiaries with the most regressive distribution. This is identified in the following section where benefits are examined as they relate to individuals. Consideration of further means testing must, however, take into account the administrative costs associated with the benefits to be derived.

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8 The Ministry of Labour, Welfare & Sports in checking household means focuses not only on individual income but checks for other sources of support.

Individual Beneficiaries

137. **Table 5.2** shows the distribution of benefits to individuals in the population. It is revealed there that only 708 or 4% of the sample of 16,455 persons participated in the Food Stamp Programme. This compares with the official administrative ceiling of 400,000 persons or 16% of the population.

138. The target of having equal distribution of benefits between mothers/children and the elderly/poor was not met according to the survey findings. If we exclude the ineligible beneficiaries ("None of the above"), the findings show that 45% of benefits went to the mothers/ children category and 55% to the elderly/poor.

Table 5.2
Individuals Receiving Food Stamps

Beneficiary Category	No. in Sample	No. in Receipt of Stamps	Percent of Quintiles Receiving Stamps					
			Jamaica	1	2	3	4	5
Children < 5 years	1859	284	15.3	17.7	20.1	14.6	9.7	8.9
Pregnant/lactating women	N.A	26	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
Elderly	1473	240	16.3	28.6	19.6	19.5	8.8	5.7
Consumption < $2600	61	20*	32.8	34.7	25.0	-	-	-
Handicapped	N.A.	30	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
None of the above	N.A.	19	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
All Individuals	16,455	708	4.2	7.2	6.1	4.2	2.5	1.5
Number of Individuals	-	-	708	237	199	138	82	52
Distribution by Quintile	-	-	100.0	33.4	28.1	19.5	11.6	7.3

* See Footnote (2) for Table 5.1
N.A. = Not available

Coverage by Category and Quintile

139. The coverage of individuals, overall, and for each beneficiary category, is clearly very progressive. There are marked, steady declines in the proportions receiving stamps, going from the poorest to the richest quintiles, and overall, the members of the former are five times more likely to receive stamps than the latter. The elderly who are least well off are also five times more likely to participate in the programme than their wealthy counterparts. By contrast, children from the poorest households are only twice as likely to obtain food stamps as the wealthiest children.

140. The situation as regards effective screening of beneficiaries under 5 years old is thus less than satisfactory, as too many of these children are members of the wealthier quintiles. It is unfortunate that data are not available to assess this question in relation to pregnant and lactating mothers as well.

141. A final point of interest is that the data for individual beneficiaries reveals a somewhat more progressive distribution of benefits than that for households. For example, 62% of the food stamps distributed went to persons in the poorest two quintiles, whereas this is true in relation to 59% of households.

Coverage by Region

142. In **Table 5.3** is presented the distribution of food stamp recipients by geographic area. It is seen there that in November 1989 the vast majority of recipients (73%) lived in rural areas. A comparison may be made between this distribution and the distribution of the sample population, which is also shown in the Table. According to these data, the K.M.A. and Other Towns received disproportionately less than their share of food stamps while rural areas received considerably more than their share. In order to judge the fairness of the regional allocation of stamps, however, it would be necessary to take into account factors such as the number of eligible persons and the percentage of persons in poverty in each area.

Under-coverage

143. In view of the fact that the Food Stamp Programme is intended to impact on the nutritional status of vulnerable groups it is pertinent to examine the question of coverage of households exhibiting nutritional problems. The SLC collects anthropometric data for children under age five in all households in the sample thereby permitting the identification of some of the households with such problems. In the discussion following, malnourished children are defined as those who have moderate or severe low weight for height or low height for age or low weight for age.

Table 5.3
The Distribution of Food Stamp Recipients by Region

Region	Distribution of Recipients	Distribution of Sample
Kingston Metropolitan Area	12.8	26.9
Other Towns	14.0	18.1
Rural Areas	73.2	55.0
Jamaica	100.0	100.0

144. In 1988, just under half (42%) of the households with malnourished children received food stamps. According to the November 1989 data, shown in **Table 5.4**, a much lower proportion (12%) of households with malnourished children under 5 received food stamps, as against 20% of all households with children under 5. (**See Table 5.1**) Low coverage of malnourished households is a feature of all the quintiles, ranging from a low of 0% for malnourished households of quintile 4 to a high of 19% for households in quintile 2.

Table 5.4
Food Stamp Benefits Among Malnourished Households

	Consumption Quintile					
	1	2	3	4	5	ALL
Number of Malnourished Households	33	42	20	17	8	120
Number of Malnourished H'holds Receiving Stamps	4	8	2	0	1	15
%age of Malnourished H'holds Receiving Stamps	12	19	10	0	12	12

145. Since children under 5 are automatically eligible for stamps, and can obtain them by registering in the programme at a primary health care facility, the question must be asked - why is such a large proportion of malnourished households not reached by the programme? In probing this, two further questions need to be answered. First, do malnourished children attend the health centres as much as normal children? Second, what is the likelihood of the children attending the health centres actually becoming recipients of food stamps?

146. In the July '89 SLC report, children's contact with the health care system was examined in relation to attendance for preventive and curative care, and the conclusion was drawn that both healthy and malnourished children are making contact with the system but are not being enrolled in the Food Stamp Programme. The degree of immunisation coverage also provides evidence of contact with the system, but it should be noted that in many instances contact for BCG coverage takes place at birth, and at this time registration for food stamps would not normally be done. As shown in **Table 5.5**, a fairly large proportion of children in the sample do have immunisation coverage, i.e., 92% with BCG and 78% with OPV. Malnourished children, however, have less coverage (89% with BCG and 70% with OPV), and this finding supports the view of Ministry of Health staff that such children are less likely to have contact with the health care system.

147. The data also reveal that for children with BCG immunisation, 15% of normal children but 12% of malnourished children receive food stamps. For those with OPV coverage, 16% of normal children but 13% of malnourished children receive food stamps. Thus, taking immunisation as evidence of contact with the health care system, one may conclue that the malnourished children who do make such contact have slightly less chance of being registered for food stamps than normal children. Greater vigilance in identifying those in need and improved efficiency in registration of eligible clinic attenders are, therefore, matters for priority attention.

Table 5.5
Normal and Malnourished Children by Reported Immunisation and Receipt of Food Stamps

Category of Children	Complete BCG Coverage --at least one visit		Complete OPV Coverage--at least three visits	
	Yes %	No/ Don't Know %	Yes %	No/ Don't Know %
Normal	(N=1317)	(N=102)	(N=1118)	(N=301)
Food Stamp Recipient	15	6	16	6
Not Food Stamp Recipient	85	94	84	94
Sub-Total	100	100	100	100
Malnourished	(N=133)	(N=16)	(N=105)	(N=44)
Food Stamp Recipient	12	6	13	7
Not Food Stamp Recipient	88	94	87	93
Sub-Total	100	100	100	100
All Children	(N=1450)	(N=118)	(N=1223)	(N=345)
Food Stamp Recepient	15	6	16	6
Not Food Stamp Recepient	85	94	84	94
Total	100	100	100	100

SELF-REPORTED REASONS FOR NON-RECEIPT OF STAMPS

148. Households were asked why they were not receiving food stamps, and Table 5.6 sets out the frequency of different responses for different groups. Overall, 24% of the households not receiving stamps had applied to become beneficiaries, but 76% had not. The most frequently cited reason for not participating in the programme was perceived ineligibility (27%). This was followed by those who did not know how to obtain the stamps (22%), and then by those who had applied but had not been approved (18%).

149. Ineligibility was also the principally cited reason in the three geographic regions (KMA, Other Towns and Rural Areas), but there were slight deviations in the KMA and Rural Areas. In the KMA, 15% of the total felt that it was not worth the trouble to apply for the stamps and this proportion outstripped those who had applied but were not approved (12%). In Rural Areas, however, as many as 23% fell in the latter category, which thus ranked as the second reason for non participation. Lack of knowledge about the programme was then the third (20%) most common factor in Rural Areas.

150. It is of great significance that of the poor, 34% had applied for stamps but had not been approved. This was followed by those who did not know how to obtain the stamps (23%) while 13% did not consider themselves eligible. A surprising 10% did not think it worth the trouble. Households with malnourished children followed exactly the same pattern as the poor, possibly indicating a high degree of overlap between the two categories.

151. In summary, it may be stated that the most consistent reason for not applying for food stamps is ignorance of how to do so. Households in the KMA and Other Towns are far less inclined to participate in the programme than Rural Areas. The poor, the malnourished and those with children under 5 years of age are most likely to apply, and rightly so, but alarmingly, very many are turned down without a reason being given.

152. The conclusion to be drawn is that greater dissemination of information on the Food Stamp Programme is required. The screening process also requires improvement since needy households who take the trouble to apply have not been approved. It may be that this is an administrative problem related to slow processing of applications or inadequate communication with applicants due to staff shortages. In any event this issue needs to be speedily addressed.

Table 5.6
Self-Reported Reasons for Not Receiving Food Stamps

Reason	Household Characteristics						
	All Jamaica N=3300	KMA N= 1001	Other Towns N=647	Rural Areas N=161	Poor <2600 N=432	Child <5yrs N=609	Mal-nourished N=88
Has not applied	76	84	80	69	53	64	59
Doesn't consider household eligible	27	29	27	26	13	16	11
Do not know how to obtain	22	25	21	20	23	24	23
Not worth the trouble	13	15	11	12	10	12	10
Do not want stigma	10	10	18	7	3	8	9
Other	4	5	3	4	4	4	6
Applied but not Approved	18	12	16	23	34	27	31
Eligible but quota filled	2	2	2	3	4	4	5
Turned down	4	3	4	5	10	5	2
Don't know why	12	7	10	15	20	18	24
Approved but did not Receive	6	4	4	8	13	9	10
No longer eligible	2	1	0	3	4	4	6
Other	4	3	4	5	9	5	4
Total	100	100	100	100	100	100	100

CHAPTER 6: Housing

INTRODUCTION

153. Module 1 of the 1989 Survey of Living Conditions contains 30 general questions on the Status of Housing conditions. These questions were designed to give a quick "snap-shot" picture of current housing conditions during that year.

154. The questions address issues such as the construction of dwellings, with respect to the type and main materials used in their erection, and the availability of basic sanitary facilities. Also included are the availability of and, in some instances, cost of utilities, (lighting, water and telephone) plus the ownership pattern of the households. This document examines that data and describes the regional variations, as well the disparities discerned over different consumption groups with respect to the above variables.

155. Generally, the response rate for most questions was in the region of 90-95%, however the questions which demanded quantitative responses had a low response rate of 40-50%. As a result of this the questions related to cost will not be discussed in this analysis.

HOUSING CONSTRUCTION

156. This section examines two main questions, the type of dwelling and the main materials used to construct the outer walls. The different types of dwelling have been grouped in three main categories: separate detached house;part of a house; and the final group which includes semi-detached, apartment buildings, town houses, improvised units, commercial buildings and others.

157. The predominant housing patterns in both urban and rural areas have historically been that of "individual ownership of a detached dwelling unit", using the local traditional types of building materials. This pattern has continued over time, as shown in **Table 6.1** which gives a breakdown of the type of dwellings by region and by quintile. **Table 6.2** gives a similar breakdown of the main type of materials of outer walls.

158. With regard to the main types of dwellings, the vast majority, 77%, were separate detached houses, 18 percent fell into the category "part of a house" and a further 5% was spread over semi-detached, apartment buildings, town houses, improvised units, commercial buildings and other.

159. On a regional basis the prevalence of separate detached housing is maintained with 90.5% in Rural areas, 70.6% in Other Main Towns but only 56.7% in the KMA. Of the 3 regions, KMA therefore, had the lowest percentage of this type of housing and the greatest degree of variation in housing types. 34.2% of the KMA sample lived in part of a house and 9% of the units were spread over semi-detached, apartment buildings, town houses, improvised units, commercial buildings and other types.