

Child Poverty and Disparities in Jamaica

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Acronyms

ARI	Acute Respiratory Infection
CBR	Crude Birth Rate
CCF	Christian Children's Fund
CCPA	Child Care and Protection Act
CDR	Crude Death Rate
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHIP	Childhood Poverty Research and Policy Centre
CIDA	Canadian International Development Agency
CRC	Convention on the Rights of the Child
EC	European Commission
ECC	Early Childhood Commission
ESSJ	Economic and Social Survey of Jamaica
EU	European Union
FCUBE	Free Compulsory Basic Education Programme
GDP	Gross Domestic Products
GOJ	Government of Jamaica
HDI	Human Development Index
HDR	Human Development Report
HFLE	Health and Family Life Education
HIV/AIDS	Human
IDASA	Institute of Democracy in South Africa
ILO	International Labour Organization
IMF	International Monetary Fund
IPEC	International Programme of the Elimination of Child Poverty
JSLC	Jamaica Survey of Living Standards
KMA	Kingston Metropolitan Area
MDG	Millennium Development Goals
MEGS	Maharashtra Employment Guarantee Scheme
MICS	Multiple Indicator Cluster Survey
MLSS	Ministry of Labour and Social Security
MTF	Medium Term Social and Economic Policy Framework
n.a.	Not Applicable
NDP	Vision 2030 Jamaica National Development Plan
NEPAD	New Partnership for Africa's Development
NFAC	National Framework of Action for Children
NGO	Non Governmental Organization
NPC	National Policy on Children
ORS	Oral Rehydration Solution
OVC	Orphans and Vulnerable children
PAHO	Pan American Health Organization
PATH	Programme of Advancement through Health and Education
PEAS	Programa de Educacion Afectivo Sexual
PHASE	Personal Hygiene and Sanitation Education

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PIOJ	Planning Institute of Jamaica
PMTCT	Prevention of Mother to Child transmission
RCP	Roving Caregivers Programme
RGD	Registrar General Department
SSHE	School Sanitation and Hygiene Education
STI	Sexual Transmitted Infection
UK	United Kingdom
UNICEF	United Nations Children's Fund
USA	United States of America
U5MR	Under 5 Mortality Rate
WHO	World Health Organization
YASRH	Youth Adolescent Sexual Reproductive Health Programme

Executive Summary

This study is not only a component of the Global Study of Child Poverty and Disparities commissioned and guided by UNICEF in 40 countries, but also seeks to extend local knowledge on the poverty and related aspects of Jamaican children. Estimates of poverty in Jamaica have been made annually since 1989 based on the Jamaica Survey of Living Conditions (JSLC). The percentage of the population below the national poverty line has been declining steadily, and the estimates of the percentage of the child population below the poverty line has followed this trend while maintaining a margin greater than the national average.

This study investigates the deprivation of Jamaican children in seven (7) dimensions selected by UNICEF's Global Study Guide, using data from the Multiple Indicator Cluster Survey (MICS) of 2005 with criteria for "severe" and "less severe" deprivation adopted from the Bristol Study. Of the seven (7) dimensions, data was collected on only four (4) – sanitation, water, education and health. No data was collected on the deprivation of children with respect to food, shelter and deprivation. The sample size of 5813 children proved to be too small to draw robust inferences. However, the study indicated that of the four (4) areas where data was collected, the highest frequency of "severe" deprivation was estimated for health, 9%, followed by water, 5%. No Jamaican children were reported to be severely deprived of education, and only a marginal 1% was severely deprived of sanitation. As with the headcount, children with a severe deprivation were more likely to be found in rural households, in large households, in households headed by persons with low levels of education, and in households composed with vulnerable and unemployed persons

The framework of policy to foster child development and in particular to eliminate child poverty has grown rapidly since the signing of the Convention on the Rights of the Child (CRC). Policies were classified according to the "pillars of wellbeing" recommended by the Study Guide: nutrition, health, child protection, education, and social protection. A sample of current programmes supporting the various categories of policies was also collated.

The study recommends that the relevant agencies of the Government of Jamaica (GOJ) aggressively implement existing policies over the next seven (7) years. On the basis of the

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relevant reviews and assessments, these agencies will be able to identify gaps in the policy framework with respect to children who are now infants, children who are entering early childhood, primary and secondary education, and children with special needs.

The study needs to be repeated with a more comprehensive MICS, and employing definitions of deprivation that are more relevant and appropriate to monitoring and promoting child development in Jamaica. For example, the study suggests that dimensions of child development that warrant study in Jamaica are security, environment and family life. Further, for the dimensions already targeted, more focus on indicators of the quality of services, particularly in education and health, will be of great benefit to policy-makers.

1. Children and Development

1.1. *Introduction*

This study of child poverty and disparity in Jamaica is one component of the United Nations Children’s Fund (UNICEF) Global Study on Child Poverty and Disparity; being conducted in over 40 countries using a common standardized methodology to facilitate comparative analysis across countries. According to the study guide that sets out the methodology, “the Global study seeks to respond to the need for a systematic inventory of the diverse arrangements by which economic and social policies benefit, or fail to benefit, children, and advance, or fail to advance, gender equality.”¹ Taking its point of departure from the Bristol Study² by David Gordon et al, the Global Study sought to investigate the frequency of children who are severely deprived in “one or more of the following seven dimensions of poverty: nutrition, health, education, water, sanitation, information and housing conditions”.³

Like the other country studies, this study was based primarily on the Multiple Indicator Cluster Survey (MICS) conducted in Jamaica in 2005. The survey used “a nationally representative sample survey of 4,767 households (0.6% of all households), 3,647 women (age 15-49) and 1,427 children under age five.”⁴ In many instances, the number of observations was too small for there to be confidence in the associated relative frequencies.

The principal secondary source was the Jamaica Survey of Living Standards (JSLC) that has been conducted annually since 1989. Data from the JSLC was drawn from modules conducted in 2005 or in the closest year. For parish data, this study relied exclusively on the JSLC for 2002 which included a special module for parish-level data.

1.2. *Children Poverty and Disparities*

The poverty headcount for households with children declined after 1990, and particularly sharply after 1995, by both the national and international poverty lines. In the case of children both the

¹ UNICEF, 2007, p.6

² D. Gordon et al, 2003

³ Ibid, p.4

⁴ MICS, 2005, p.xi

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number and the percentage below the national poverty line increased marginally between 1990 and 1995, and then declined rapidly after 1995. With respect to the international poverty line, both the number and the relative frequency of children below the line declined sharply after 1990, and very sharply after 1995. Between 1990 and 2005, the percentage of children below the national poverty line declined from 33% to 18%, and the percentage below the international poverty line of US\$1.00 per day declined from 19% to 2%.

The study disaggregated the data according to a standard set of social stratifiers so as to probe the relative importance to child poverty and deprivation of the age and sex⁵ of the child, household size, gender and level of education of the head of household, various indicators of the vulnerability of the household, a wealth index for the household, and the location of the household. The Global Study proposed to classify households by ethnicity, religion and language, but no data⁶ was collected for these categories by the MICS.

The poverty rate for children has been consistently higher than the rate for all individuals in the review period, and the poverty rate for rural children is higher than for urban children. Inferences have to be drawn carefully because of the small sample size. There are indications of differences across sex and age group for children, but no clear inequalities are in evidence. However, of the stratifiers of household type, household size, the education level of the head of household and the location of the residence appear to be the most important determinants of child poverty and deprivation.

Of the seven (7) dimensions of deprivation targeted by the Global Study, the MICS collected data on only four (4) in Jamaica: sanitation, water, education and health. Using the criteria for “severe” deprivation employed in the Bristol Study, the most severe deprivation of Jamaican children was estimated for health, 9%, followed by water, 5%. No Jamaican children were reported to be severely deprived of education, and only a marginal 1% was severely deprived of sanitation.

Two possible areas for subsequent research are re-examining deprivation with respect to the targeted seven dimensions by with the criteria for “severe” and “less severe” modified to be more relevant and appropriate to Jamaica, and the investigation in other dimensions of

⁵ The study uses both “sex” and “gender” as categories

⁶ The relevance of these categories to Jamaica is debatable. To the extent that some version of these categories are relevant to understanding the social system, appropriate and relevant definitions would have to be used.

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deprivation. With regard to the latter, definitions of deprivation, and criteria for “severe” and “less severe” were proposed in **Section 2** for security, the environment and family life.

Progress toward the MDGs

The official report in 2009 on the progress made toward the achievement of the Millennium Development Goals (MDGs) provided indicators showing that MDG 1 – eradicate poverty and hunger - had been achieved by December 2007.⁷ The deterioration of economic conditions in the subsequent two years in the context of the global economic crisis has probably reversed some of the gains made in the fight against poverty, especially in the case of children because of their vulnerability.

Similarly, universal primary education – MDG 2 – has been achieved with net enrolment over 90% and gross enrolment approximation 100%. The challenge for Jamaica is now to address the quality of the education that the enrolled students receive and to improve attendance rate which lags behind that of enrolment.

On the other hand, the official report is that Jamaica is “lagging” in the promotion of gender equality and the empowerment of women – MDG 3 – and “far behind” in reducing child mortality – MDG 4 – and improving maternal health – MDG 5.

1.3. The Political, Economic and Institutional Context

Jamaica is located in the Northwest of the Caribbean Sea, due south of Cuba and Miami. A direct flight on a commercial passenger jet aircraft takes an hour from Kingston to Havana, an hour and a half to Miami, and a little over two hours to Santo Domingo in the Dominican Republic and San Juan in Puerto Rico. Jamaica lies on the shipping route from the Panama Canal to Miami, and the Port of Kingston has developed a lively transshipment business to take advantage of its location.

Like other Caribbean islands and coastal territories, Jamaica is vulnerable to the anticipated rising sea levels, more intense hurricane activity, shifting rainfall patterns, and warmer temperatures associated with global warming.

After 307 years as a British colony, Jamaica became politically independent in 1962. It adopted the Westminster political system, and continued the tradition of the British civil service that had been instituted in the colonial period. Two main political parties have alternately led the

⁷ See *Progress ---*, 2009, Table 1, p.8

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government following general elections, every 4-5 years. Despite, episodes of electoral violence, there have generally been free and fair elections since Independence. In recent years, perceptions of corruption have dogged the Jamaican civil service and political directorate and resulted in poor ratings in Transparency International's corruption index. In 2006, Jamaica ranked 61st out of 179 countries⁸, and that ranking has declined since then.

Population and Economic Growth

Children, aged birth to 17 years, constituted about 35% of the population of approximately 2.65 million persons of Jamaica in 2005. Marginally more than a half of the population is urban. The average household had 3.3 persons, with rural households being a little larger – 3.6 persons on average – and female-headed rural households having 4.1 members on average. Females headed 46.3% of the households, varying from a low of 42.2% of rural households to a high of 52.2% of households in the Kingston Metropolitan Area (KMA). The JSLC reported that “--- [children are] more highly represented in female-headed households (79.2% compared with 66.2%) [in male-headed households] and moreso for female-headed households in Rural Areas (83.0%).”⁹

In 2005, children were being born at the rate of 19.6 per 1000 persons. This crude birth rate (CBR) had been declining since 1995 when it was 25.6 per 1000 persons, reaching 17.6 in 2004. In 2005 the crude death rate (CDR) – number of deaths per 1000 persons – was 7.7, up from 5.3 in 2002 and 2003. With the CBR falling faster than the CDR, the rate of natural increase of the population has also been declining. Whereas it was 19.4 per 1000 in 1995, it was estimated to be 11.2 per 1000 in 2005, up from 10.3 in 2004.

The population as a whole was growing at an annual rate of 0.5% in 2005, having declined steadily from an annual rate of 1% in 1997. The population growth rate has been moderated by migration, but that rate too has been declining. From a high for the last decade of 23,900 (1% of the population) in 2001, the number of migrants fell to 17,200 (0.6 % of the population) in 2005.

The main flows have been to North America – USA and Canada, in that order – and to a lesser extent the UK. In 2005, 24.6% of Jamaican migrants to the USA, and 30.7% of migrants to the UK were less than 18 years old.

⁸ The higher the ranking, the least corrupt the country.

⁹ JSLC, 2005, p.1.5

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Jamaica is classified as a country of medium human development according to its Human Development Index (HDI). It is in the top half of this group, ranking 101st of the 177 ranked countries. Life expectancy at birth was 72.2 years, but the literacy levels for the population 15 years old and over of 79.9% was among the lowest of the Anglophone Caribbean countries.

Challenges to human development and equity

Jamaica's record of economic growth has been unimpressive since the end of the first decade of Independence. The average annual rate of growth for the period 1981-2005 was 1.5%, and the average annual growth in per capita GDP was 0.5%. These rates were far less than what was required to address the backlog of social needs carried forward from the colonial period. Income inequality is high as indicated by a Gini coefficient of 0.38 in 2001. The overall unemployment rate has trended down from as high as 27.6% in 1982 to 11.2% in 2005. The unemployment rate for women and men followed the same pattern of decline, but the rate for women was more than twice the rate for men. In 1982, the unemployment rate for women was 40.2% and the rate for men was 16.1%; in 2005, the unemployment rate for women was 15.8%, and the rate for men was 7.6%. The decline in the unemployment rate should be interpreted cautiously, since discouraged job seekers and others who have withdrawn from the labour force are not accounted for by these estimates.

Since the 1980s, the governments of Jamaica have pursued export-led growth strategies, led by the tourism and bauxite/alumina sectors. Traditional exports of sugar, bananas and other agricultural primary commodities contributed marginally to export earnings and in the recent years have been in precipitous decline in the face of the loss of preferential access to the markets of the European Union. The current global crisis has virtually shut down the entire bauxite/alumina industry, and while the decline of visitor arrivals has not been as sharp as feared, the expenditure by the visitors has fallen significantly. The loss of foreign exchange earnings associated with the global crisis has been compounded by the 17% decline in 2009 of the receipt of remittances which in recent years has rivalled tourism expenditure as the largest inflow of foreign exchange.

Overall, the human development picture is mixed. Life expectancy is high and has been increasing. Poverty rates and unemployment rates have been in decline over the past two decades. Several traditional diseases – malaria, typhoid fever, small pox, yellow fever – have

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been eliminated, though periodically there is a threat of return. There is full enrolment at the primary level and almost full enrolment at the secondary level of education. Tertiary enrolment too has been growing. However, there is a clear national consensus that attention must now be focused on the quality of education to prepare the labour force for the challenges of the 21st century.

On the negative side, income inequality persists, poverty levels remain unacceptably high and there is a high probability that many who are only living just above the poverty line could fall back into poverty. Self-employment accounts for about a third of total employment, and the majority of it consists of very small scale low income petty trade and related activities.

In addition to the threat of the return of traditional diseases, Jamaica is challenged by a high incidence of HIV/AIDS¹⁰, unacceptably high infant mortality rates, and high rates of cardiovascular diseases.

The backlog of housing has challenged all governments, and presents itself in burgeoning squatter settlements in the major urban centres and the tourism resort towns. High levels of crime and violence are at once problems of security, issues of public health and deterrents of investment and general economic activity. Finally, in addition to the vulnerability to natural hazards because of the island's geographic location, unplanned settlement patterns on the coasts and in natural water courses, and deforestation by hillside farming have made the island particularly vulnerable to flooding and drought.

1.4. Macroeconomic Strategies and Resource Allocation

Pro-poor growth and child results

Since 1977 when the government entered into its first Stand-By agreement with the International Monetary Fund (IMF), there has been a tension in macro-economic policy formation between the perceived need for economic stabilization and the desire for economic growth as the basis for economic development. In most years, stabilization policies dominated in the form of attempts to compress and reduce the fiscal deficit, and since the 1990s the singular focus of monetary policy has been to fight inflation, usually with high interest rates. Simultaneously, foreign

¹⁰ PIOJ, 2006, p. 2: "The *HIV/AIDS/STI National Strategic Plan 2002-2006* identified HIV/AIDS as the second leading cause of death in children aged 1 to 4 years, and the *National Plan of Action for Orphans and other Children made vulnerable by HIV/AIDS in Jamaica* estimated in 2003 that between 10,000 and 20,000 children were at risk of the loss of one or both parents to HIV/AIDS."

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capital was wooed to provide the investment boost for economic growth, and the economy progressively liberalized to encourage market-led economic growth.

Constrained by the austerity requirements of stabilization approach while eager to promote economic growth, governments have been less discriminating about the pattern of economic growth, and have opted implicitly to let the benefits of economic growth trickle down to the poor. Income redistribution was done by market forces instead of public sector programmes, with the inevitable risk that it would lead to more inequality. Employment targets and requirements were seen as disincentives to investors.

Public budgets and partnerships as evidence of commitment

With political Independence, governments were pressured by a public with rising expectations for social services against a historical backdrop of colonial neglect. On the other hand, public revenues grew slowly because of the poor growth of the economy and weaknesses in the revenue collection system. Since the late 1970s, the fiscal deficits have been financed by loans, external loans at first, and in the most recent years, predominantly domestic loans. In fiscal year 2005/6, the debt to GDP ratio was estimated to be 118.3%, making Jamaica one of the most highly indebted¹¹ countries in the world. In 2009, the national debt is a little over US\$14 billion, or US\$5,200 per capita, 56% of which is domestic debt. As a consequence, debt servicing has commanded the lion's share of public expenditure, exceeding 50% since 1997/98 and as high as 67% in 2004/5. To maintain basic social services, the government has had to forego public investment in infrastructure and programmes of economic services to support the drive for economic growth.

On the other hand, the basic services provided to children have been maintained. A UNICEF-Planning Institute of Jamaica (PIOJ) study of fiscal expenditure on children in 2006 concluded that: “--- a significant share of the fiscal resources is targeted to children at the various stages of their life-cycle primarily in the forms of educational and health services. With a little more than 16% of the recurrent budget and more than 20% of the Capital B budget funding services for children, the GOJ has almost satisfied the 20/20 Initiative for social expenditure on children

¹¹ PIOJ, 2009, p.6: “The country is heavily indebted and with a debt-to-GDP ratio of 111.3% (2007) has the fourth highest ratio in the world. “

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alone.”¹² Of course, not only would children benefit from more and improved social services, so would other vulnerable groups in the society. Whereas 9.6% of Jamaica’s population was over 60 years in 2000, this share is expected to rise to 14.2% by 2025.

The Government of Jamaica (GOJ) has many bilateral and multilateral international partners whose expertise and resource contributions have helped it to maintain the basic social services, and in particular a social safety net, in the face of fiscal austerity. In addition, partnerships with local business groups and service clubs are promoted to augment and complement publicly funded services. Examples of these are the support for schools and the children’s hospital and the road safety programme.

1.5. Conclusions

Studies of Jamaica’s economic development are struck by the strong indicators of human development despite the decades of virtual economic stagnation. Increasing longevity, high enrolment rates in primary and secondary education levels, and declining poverty rates are three such social indicators. In addition, economic growth has eluded Jamaican policy makers despite implementing the policy prescriptions of the international financial institutions. With one of the most open and liberal economies that has attracted significant flows of foreign investment and has access to international markets, economic growth rates have been disappointingly low.

The modest gains in human development are under threat from the sharp economic decline in the context of the global economic crisis. Policy-makers expect a recovery in Jamaica to lag the recovery of its major markets. At this point, Jamaica has lost most of its traditional agricultural export industries, no early re-start for the energy intensive alumina industry is foreseen by its owners, and the inherently fragile tourism industry is facing increasing competition from other Caribbean destinations that are in the similar struggle as Jamaica to reposition themselves in the global economy. If this study is repeated 2-3 years from now, the poverty and deprivation rates that Jamaican children will be experiencing are likely to be much higher than reported here.

¹² PIOJ, 2006, p. 50

2. Poverty and Children

This study follows a growing consensus in the research literature on child poverty, and endorsed in several studies conducted under the auspices of UNICEF, that extends the concept of child poverty beyond income/consumption insufficiency to deprivations in various aspects of a child's social, cultural and even spiritual life. In particular, the study focuses on deprivations in sanitation, water, education, and health since the MICS collected data on these. Other sources, particularly the JSLC, are used to quantify deprivations of shelter, information, security, environment, and family life.

Definitions of Child Poverty

The definition of child poverty has a direct impact on the way in which policies and programmes are designed to benefit children and to reach the ultimate goal of global poverty elimination. Once the definition of poverty focuses only on absolute income then policies designed to reduce poverty will most likely target economic growth. However, if the definition takes a comprehensive view of human development then poverty reduction policies will move beyond economic growth and focus to a diversified approach.

Policy makers and analysts of child poverty are increasingly embracing a multidimensional approach which provides a broader understanding of children's deprivation and well-being. Perhaps, the most common approach is Sen's capability approach. This approach strongly recommends people's capabilities to be at the centre of "normative evaluations"¹³ such as those relating to poverty measurement, development ethics and others. Here, capabilities refer to "people's potential functionings".¹⁴ In the case of children, the functionings represent what children are able to do and what they can become. Together, all capabilities provide the "overall freedom to lead the life that a person has reason to value".¹⁵ One aspect of this approach states, ".....capabilities that adults enjoy are deeply conditional on their experience as children".¹⁶

¹³ Robeyns, Ingrid (2003). "Sen's Capability Approach and Gender Inequality: Selecting Relevant Capabilities", forthcoming in *Feminist Economics* (2), p. 4.

¹⁴ Ibid, p. 4.

¹⁵ Ibid, p. 4.

¹⁶ Sen, Amartya (1999). *Investing in Early Childhood: Its Role in Development*. Presentation at the Annual Meeting of the Inter-American Development Bank on "Breaking the Poverty Cycle: Investing in Early Childhood", 14 March 1999, Paris, p.4.

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Authors such as Biggeri et al maintained that children's capabilities are paramount to their development and as such analyzed child poverty as deprivation of their capabilities. A lack of important capabilities decreases children's well-being and increases the possibility of continuous poverty during adulthood. Since this approach sees capabilities as central to the human development of children, it has been argued that "policy makers should place a higher focus on children's capabilities for a better future".¹⁷

Sen's capability approach is not the only multifaceted approach adapted to child poverty. The European Union (EU) adopts a child rights approach to child poverty. This approach uses a human rights perspective to conceptualize child poverty. It considers the inherent rights of all children, recognizing the child as a separate observational unit within the family in his/her own right. Although the child is seen as distinct from their parents, the EU still emphasizes the responsibility of parents to care for their children. Like the capability approach, it includes more factors in explaining child poverty and not just the conventional household poverty which results from a lack of economic resources. The rights based approach also considers not only the rights of families to secure and protect their children but a variety of human rights in economic, social, cultural, civil and political areas.¹⁸

Although there may be more approaches that are multifaceted in nature, most international institutions seem to subscribe to the same notion that children's well-being goes well beyond income and material wealth. The most widely used definition of child poverty is that of UNICEF:

"Children living in poverty experience deprivation of the material, spiritual, and emotional resources needed to survive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential or participate as full and equal members of society".¹⁹

This definition synthesizes both the Sen approach and the right based approach to the study of child poverty.

Other Institutions

¹⁷ Biggeri ,Mario et al (2008). *Child's poverty as Capability Deprivation: theoretical and measurement issue*, p.1.

¹⁸ Eurochild (2007). *A Child Rights Approach to Child Poverty*. Discussion Paper, p.3.

¹⁹ UNICEF (2007). *Global Study on Child Poverty and Disparities 2007-2008 Guide*. Global Policy Section, New York September, p.7.

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Below are the definitions of child poverty used by a selected group of international development agencies involved in the fight against child poverty.

Canadian Development International Agency (CIDA)

“Poverty prevents children from reaching their full potential. It denies them human rights – like those related to education, health and nutrition, participation in decisions that affect their lives and freedom from abuse, exploitation and discrimination”.²⁰

Christian Children’s Fund (CCF)

“Child poverty centres around three areas:

- 1 Deprivation – a lack material conditions and services generally held to be essential to the development of children’s potential.
- 2 Exclusion – the result of unjust processes through which children’s dignity, voice and rights are denied or their existence threatened.
- 3 Vulnerability - an inability of society to cope with existing or probable threats to children in their environment”.²¹

Childhood Poverty Research and Policy Centre (CHIP)

“Childhood poverty means children and young people growing up without access to different types of resources that are vital for their well-being and for them to fulfil their potential. By resources we mean economic, social, cultural, physical, environmental and political resources”.²²

European Commission (EC)

“Child poverty is the denial of child’s rights. It restrains a children from achieving their full potential, adversely affecting health, inhibiting personal development, education and general well-being”.²³

²⁰ Minujin Alberto et al (2006). “The definition of child poverty: a discussion of concepts and measurements,” in *Environment and Urbanization* October 2006, 18: 2, p. 487.

²¹ Minujin, Alberto et al (2006). “The definition of child poverty: a discussion of concepts and measurements,” in *Environment and Urbanization* October 2006, 18: 2, p. 486-487.

²² Ibid, p. 487.

²³ European Commission (2008). *Child Poverty*. http://ec.europa.eu/employmentsocial/spsi/child_poverty_en.htm.

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Her Majesty's Treasury (UK)

“The lives of poor children depend upon a complex combination of low income household, lack of equal opportunities and social exclusion. Child poverty encompasses:

- 1 Damages to childhood experience through limiting access to activities, services and opportunities, increasing exposure to risks, and diminishing access to resources and support that increase resilience.
- 2 Social exclusion – this happens when people or areas suffer from linked problems such as unemployment, poor skills, poor housing, high crime, bad health and family breakdown.
- 3 Denying equal opportunity which can blight adult life, leading to cycles of disadvantage”.²⁴

Institute for Democracy in South Africa (IDASA)

“Child poverty covers four categories of suffering/deprivation:

- 1 Insufficient income and income-earning opportunities – low level of income affects access to necessities and limit consumption opportunities.
- 2 Lack of human development opportunities – lack of access to health, education, sanitation services and recreational facilities and the impact of this lack of access.
- 3 Feelings of economic and physical insecurity – fluctuations in household income and access to public services and experience of abuse and child labour.
- 4 Feelings of powerlessness – feeling of oppression in the family and exclusion from community”.²⁵

²⁴ HM Treasury (2004). *Child Poverty Review*. United Kingdom, p.15.

²⁵ Minujin, Alberto et al, op. cit., p. 488.

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International Guidelines and Commitments

International institutions heading the fight against child poverty set out principles to guide member countries to develop local strategies, policies and programmes for the elimination of child poverty globally.

International Labour Organization (ILO)

ILO Minimum Age Convention, June 26, 1973

The ILO Minimum Age Convention provides guidance for the minimum age of entrance into the workforce.

Article 2 – “the minimum age shall not be less than the age of completion of compulsory schooling, and in any case, shall not be less than 15 years”; and “a member country whose economy and educational facilities are insufficiently developed may, after consultation with the organizations of workers and employers concerned, may initially specify a minimum age of 14”.²⁶

Article 3 – “the minimum age of admission into jobs which by nature and circumstances may jeopardize health, safety or morals of young persons, shall not be less than 18”.²⁷

Article 7 – “national laws can allow the employment of person 13 to 15 on light work providing that the job is not harmful to health and development and does not prevent them from attending school and other educational programmes”.²⁸

*International Programme for the Elimination of Child Poverty (IPEC)*²⁹

To progressively eliminate child labour, ILO operates in 88 countries carrying out technical projects geared towards fighting and eradicating child labour.

ILO priorities follow those set out in the ILO Convention on the worst forms of child labour (1999, no. 182). They include, eliminate:

- 1 all forms of slave practices - sale and trafficking of children
- 2 debt bondage or compulsory labour

²⁶ International Labour Organisation (1973). *Minimum Age Convention*, No. 138. Adopted on 26 June 1973 by the General Conference of the International Labour Organization at its fifty-eighth session, p. 1-2.

²⁷ Ibid, p. 2.

²⁸ Ibid, p. 3.

²⁹ International Labour Organization 1992). *International Programme on the Elimination of Child Labour*. <http://www.ilo.org/ipec/programme/lang--en/index.htm>.

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- 3 child prostitution (pornography)
- 4 the use of children to traffic drugs
- 5 any other activities harmful to child development

United Nations

Millennium Development Goals (MDGs)

These are eight goals to be achieved by 2015. These goals were set out to address the world's main development challenges. Four of the goals specifically relates to children.

1. "Achieve universal primary education - ensure that all boys and girls complete a full course of primary schooling".³⁰
2. "Promote gender equality and empower women - eradicate gender disparity in primary and secondary schools preferably by 2005 and to all levels no later than 2015".³¹
3. "Reduce child mortality - reduce the mortality rate of children under five by two-thirds between 1990 and 2015".³²
4. "Combat HIV/AIDS, malaria and other diseases - halt and reverse the spread of HIV/AIDS as well as the incidence of malaria and other major diseases".³³

Protocol to prevent, suppress and punish trafficking in persons, especially women and children

This protocol is in support the United Nations Convention against Transnational Organized Crime. Its goal is to punish traffickers and protect victims including their international human rights.

Article 9-1a. "State parties shall establish comprehensive policies and programmes to prevent and combat trafficking in persons".³⁴

³⁰ European Commission (2004). *European Commission Report on Millennium Development Goals 2000-2004*, p.16.

³¹ Ibid, p. 17.

³² Ibid, p. 19.

³³ Ibid, p. 23.

³⁴ United Nations (2000). *Protocol to prevent, suppress and punish trafficking in persons, especially women and children*, p.5.

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Article 9-1b. “State parties shall establish comprehensive policies and programmes to protect victims especially women and children from re-victimization”.³⁵

Universal Declaration of Human Rights

Article 26 - This declaration speaks about the right that everyone has to education including the right to receive information on HIV/AIDS. This implies that HIV/AIDS information must also be delivered in schools.³⁶

Declaration of Commitment on HIV/AIDS

United Nations General Assembly Special Session on HIV/AIDS

The purpose of this assembly was for members of the international community to set common targets on the response to HIV/AIDS and alleviation methods.

Several goals were established, three of which directly relate to orphans and other children made vulnerable by HIV/AIDS.

65. “By 2003, develop, and by 2005, implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans, girls and boys, infected and affected by HIV/AIDS, including providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance”;³⁷

66. “Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS”;³⁸

67. “Urge the international community, particularly donor countries, civil society, as well as the private sector, to complement effective national programmes to support programmes for children

³⁵ Ibid.

³⁶ United Nations (1948). The Universal Declaration of Human Rights. <http://www.un.org/en/documents/udhr/>.

³⁷ United Nations (2001). *Declaration of Commitment on HIV/AIDS*. United Nations General Assembly Special Session on HIV/AIDS, p. 29.

³⁸ Ibid.

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orphaned or made vulnerable by HIV/AIDS in affected regions and in countries at high risk and to direct special assistance to sub-Saharan Africa”.³⁹

United Nations Children’s Fund (UNICEF)

The Conventions on the Rights of the Child (CRC)

The Convention on the Rights of the Child outlines principles to guide plans of action to be undertaken to ensure that children develop to their full potential. There are several articles referring specifically to actions that must be taken for the health care, education, social inclusion and protection, child labour and nutrition. These include:

Article 3 – “State Parties to ensure the child such protection and care that is necessary for his/her well-being.....”⁴⁰

Article 7 – “The child shall be registered immediately after birth and shall have the right to a name and nationality.....”⁴¹

Article 17a – “encourage the mass media to disseminate information and material of social and cultural benefit to the child.....”⁴²

Article 17c – “encourage the dissemination of children's books”.⁴³

Article 28a – “make primary education compulsory and available free to all”.⁴⁴

Article 28d – “make educational and vocational information and guidance available and accessible to all children”.⁴⁵

Article 34 – “prevent sexual exploitation of children”.⁴⁶

World Summit for Children on the Declaration on the Survival, Protection and Development of the Child (September 30, 1990)

³⁹ Ibid.

⁴⁰ UNICEF (1989). The Convention of the Rights of the Child. <http://www2.ohchr.org/english/law/crc.htm>.

⁴¹ Ibid.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Ibid.

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The World Summit brought together world officials on the 29th-30th September 1990. A declaration on the survival, protection and development of children was adopted as well as a plan for its implementation during the 1990s.

The tasks:⁴⁷

- 1 reduce child mortality by enhancing children's health and nutrition
- 2 provide care and support for disabled children
- 3 ensure equal rights for women for the benefit of the world's children - equal opportunities for girls
- 4 provide basic education and literacy for all children
- 5 safe motherhood for women
- 6 self-identification for children and their role in society

Policies and Programmes Implemented in Various Countries

Various countries have implemented policies, programmes and laws to fight against child poverty. Many countries were acting in accordance with the international guidelines and commitments to which they are signatories. For some countries, however, policies and programmes implemented were not directly aimed at children but the objectives implied positive impacts on their development. The tables below feature policies and programmes aimed at tackling child poverty for selected countries.

Policies

Following the establishment of international covenants on eradicating all forms of child poverty, countries developed and implemented policies. In the literature, there is hardly any clear distinction between policies and programmes. Some child poverty writers, government agencies and others in the field consider programmes and plans of action as policies. However, a plan of action actually drives policies which in turn guide programme development. Legislation relevant to child poverty has also been instituted which presumably emanate from policies. The focus here though is on identifying policies. It is quite a difficult task to highlight actual policies that have been implemented to eradicate child poverty. It can be assumed, however, that some countries through the implementation of programmes are using some form of policy, implied

⁴⁷ UNICEF (1990). *World Declaration on the Survival, Protection and Development of Children*.
<http://www.unicef.org/wsc/delcare.htm>

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rather than explicitly stated. Despite the common imprecise use of the term “policy”, **Table 1.1** presents a sample of the ‘policies’ found in the literature on child poverty eradication. Policies that are implied are written in *italics*.

Table 1.1: Policies supporting the fight against Child Poverty

Title of Policy	Policy	Objectives/Description	Poverty Dimension	Country
Social Protection Policy	<i>All vulnerable groups will be protected from all types of activities that will threaten their survival and inhibit development</i>	“To connect, coordinate and complement programs and projects geared towards protecting the vulnerable.” ⁴⁸	Protection	Nicaragua
National Policy for Orphans and Other Vulnerable Children	<i>Orphans and other vulnerable children must be helped to reach their full potential, live their lives and have the same opportunities as other children</i>	“To protect the rights of children and to guarantee the physical and psychosocial long-term development of orphans and other vulnerable children.” ⁴⁹	Protection	Rwanda
National Orphan Policy	<i>Care and protection will be provided for all Orphans</i>	Policy points out that the “care and protection provided must be in line with the principles of the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of children; any care provided by an institution must be a last and temporary resort; activities raising public awareness to the needs of orphans and children must be undertaken; and a legal framework is to be established to guarantee education for all children.” ⁵⁰	Protection	Zimbabwe

⁴⁸ Badame, Aja et al (2005). *Are Poverty Reduction Strategy Papers Impacting Child Poverty? A Nicaraguan Case Study*, p. 25.

⁴⁹ Ministry of Local Government, Information and Social Affairs (2003). *National Policy for Orphans and Other Vulnerable Children in Rwanda*. Kigali, p. 10.

⁵⁰ Smart, Rose (2003). *Policies for Orphans and Vulnerable Children: A Framework for Moving Ahead*. Futures Group International, p. 16.

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Title of Policy	Policy	Objectives/Description	Poverty Dimension	Country
National Health Policy	“Every citizen has the basic right to adequate health care”	This policy has 15 goals and objectives. As it relates directly to children: “To reduce the intensity of malnutrition among people, especially children and mothers; and implement effective and integrated programmes for improving nutrition status of all segments of the population”; “to undertake programmes for reducing the rates of child and maternal mortality within the next 5 years (since the approval of the Health Policy in 2000) and reduce these rates to be acceptable level”;” and to adopt satisfactory measures for ensuring improved maternal and child health at the union level and install facilities for safe and clean child delivery in each village.” ⁵¹	Health	Bangladesh
Integrated Management of Childhood illness	<i>All children under 5 years are entitled to quality health care</i>	“To improve the management skills of health care staff, overall health systems and family & community health practices.” ⁵²	Health	Ghana
National Policy for Children	“It shall be the policy of the State to provide adequate services to children, both before and after birth and through the period of growth, to ensure their full physical, mental and social development”.	This policy speaks to the general welfare of children covering all dimensions of child poverty. With respect to health, the policy states: “All children shall be covered by a comprehensive health programme”. “Programmes will be undertaken for the general improvement of the health and for the care, nutrition and nutrition education of expectant and nursing mothers.” ⁵³	Health	India
Early Childhood Education Policy	<i>All Australian children will be provided with access to a high quality, free, public early childhood education</i>	“The policy focuses on preschool years in settings such as kindergarten, preschools, primary schools, early childhood education units and day care. Keen attention is directed to children with special needs.” ⁵⁴	Education	Australia

⁵¹ Government of Bangladesh (2000). *Health Policy of Bangladesh*.

<http://www.bangladeshgateway.org/healthpolicy.php>

⁵² United Nations Economic and Social Council (2009). *Development Strategies that Work*.

<http://webapps01.un.org/nvp/frontend!policy.action?id=129>.

⁵³ Government of India (2005). *National Policy for Children*. Department of Social Welfare, p.1- 2.

⁵⁴ Australian Education Union (2007). *Early Childhood Education Policy 2007*. Adopted at the 2007 Annual Federal Conference, p. 1-2.

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Title of Policy	Policy	Objectives/Description	Poverty Dimension	Country
Education Policy	<i>Free primary and secondary education compulsory for all children from 5 to 16yrs</i>	“To ensure active participation at schools, the government has implemented: school meals (primary school); a text book loan scheme; public transportation fare subsidization; uniform grants; and financial assistance through bursaries and scholarships.” ⁵⁵	Education	Barbados
National Policy for Persons with Disabilities	“Free and compulsory education has to be provided to all children with disabilities up to the minimum age of 18 years”	“Under the guidelines of a Constitution (Article 21a) and the Disabilities Act of 1995, the government of India has sought to get children with disabilities integrated into the formal education system so as to enable their social and economic empowerment.” ⁵⁶	Education	India
National Food Policy	<i>The poor and hungry will experience poverty alleviation</i>	“To alleviate poverty and hunger with special emphasis on the poor and hungry”; focus is directed to children, pregnant and lactating mothers.” ⁵⁷	Nutrition	Bangladesh
National Policy for Children	“It shall be the policy of the State to provide adequate services to children, both before and after birth and through the period of growth, to ensure their full physical, mental and social development”.	“Programmes shall be implemented to provide nutrition services with the objective of removing deficiencies in the diet of children.” ⁵⁸	Nutrition	India
Food and Nutrition Policy	The policy covers food security, care for special groups, essential human services, food and nutrition committee and roles of various sectors in policy implementation	The aim of the policy as it directly relates to children is: “To improve the nutritional status of the Tanzanian community especially, women and children.” ⁵⁹	Nutrition	Tanzania
Income Support Policy	New Zealanders, impaired, unemployed, underemployed, low wage earners and others in domestic circumstances must be	The aim is to transform the income support system. Objectives include to: “Set benefit amounts at a level such that beneficiary income is sufficient for all basic needs.”	Household Income	New Zealand

⁵⁵ United Nations Economic and Social Council, op. cit.

⁵⁶ Government of India (2005). *National Policy for Persons with Disabilities*. Ministry of Social Justice and Empowerment. <http://www.disabilityindia.org/nationalpolicyfordisable.cfm>

⁵⁷ United Nations Economic and Social Council, op. cit.

⁵⁸ Government of India (2005). *National Policy for Children*. Department of Social Welfare, p.1.

⁵⁹ Ministry of Health (1992). *Food and Nutrition Policy for Tanzania*. The United Republic of Tanzania, p.12.

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Title of Policy	Policy	Objectives/Description	Poverty Dimension	Country
	able to earn enough income to satisfy their basic expenses.	“Ensure supplementary assistance payments including Working for Families Tax Credits (a form of income support) also keep pace with the cost of living.” ⁶⁰		
National Policy for Persons with Disabilities	<i>All disabled persons both in the rural and urban will have productive and rewarding jobs.</i>	This policy caters to the economic empowerment of persons with disabilities. In this regard, the policy ensures that disabled individuals have employment opportunities available to them. Self-employment of these individuals will also be promoted”. ⁶¹	Household Income	India

Programmes

Household Income

Children are directly affected by household income and the means by which heads of households earn a living. Many countries worldwide, including Jamaica, have implemented cash transfer programmes to support the income of poor households. The cash transfer programmes are usually of two types – conditional and unconditional. In some countries, governments with the aid of international institutions provide unconditional monthly financial resources while under specified conditions some transfers take place on the basis of unemployment or to keep children in school. The World Bank, for example, finances conditional cash transfer programmes such as the Programme of Advancement Through Health and Education (PATH), to assist households living below the poverty line providing that their children attend school regularly and health centres as scheduled. The Bank points out that cash transfer programmes “allow for better targeting of the poor” and “establish a social protection network for times of crisis”.⁶²(See **Table 1.2**)

⁶⁰ Green Party of Aotearoa New Zealand (2008). *Income Support Policy*. Authorized by Jon Field, 73 Eden Street, Wellington, p.3.

⁶¹ Government of India (2005). *National Policy for Persons with Disabilities*. Ministry of Social Justice and Empowerment. <http://www.disabilityindia.org/nationalpolicyfordisable.cfm>

⁶² World Bank (2003). *Workshop on Conditional Cash Transfers Programs (CCTs): Operational Experiences*. Final Report Ayala Consulting Co. March, p. 10.

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Table 1.2: Programmes supporting Household Income

Programmes	Country	Region
Social Insurance System: “Unemployed persons who have made contributions to the system while employed receive unemployment benefit; The benefit is equal to 60% of the insured’s average covered weekly earnings. It is paid after a 3-day waiting period for up to 26 weeks in any 52-week period”. ⁶³	Barbados	Americas & Caribbean
Social Safety Net Programme: “This is designed to address both current and future poverty via cash transfers targeted to households living in extreme poverty in rural Nicaragua”. ⁶⁴	Nicaragua	Americas & Caribbean
Social Insurance: “Family allowances are provided for all persons receiving remuneration for work or service rendered”. ⁶⁵		
Cash for Education Program: “Households with poor children get cash transfers but children must be enrolled at school and have minimum attendance record”. ⁶⁶	Bangladesh	South Asia
The Maharashtra Employment Guarantee Scheme (MEGS): “This is to induce poverty reduction through employment of unskilled work on demand”. ⁶⁷	India	South Asia
Jawahar Rojgar Yohana: “Poverty alleviation is carried out via supplemental employment opportunities for rural poor during agricultural slack periods”. ⁶⁸		
Priority Public Works: “Jobs are provided to help alleviate urban poverty”. ⁶⁹	Ghana	West & Central Africa
Social Insurance System: “Unemployed persons who have made contributions to the system while employed receive unemployment benefit; the benefit is 60% of the average monthly earnings in the 6 months before unemployment. It is paid for 3 months with 12 to 35 months of contributions, for 6 months with 36 to 71 months of contributions, for 9 months with 72 to 143 months of contributions, and for 12 months with 144 months of contributions or more”. ⁷⁰	Vietnam	East & Pacific Asia

⁶³ Social Security Online (2007). *Social Security Programs throughout the World: The Americas*, 2007. <http://www.socialsecurity.gov/policy/docs/progdesc/ssptw/2006-2007/americas/barbados.pdf>, p. 4.

⁶⁴ Barrientos, Armando & Rebecca Holmes (2006). Social Assistance in Developing Countries Database. IDS, University of Sussex, p. 63.

⁶⁵ Social Security Online (2007). *Social Security Programs throughout the World: The Americas*, 2007. <http://www.socialsecurity.gov/policy/docs/progdesc/ssptw/2006-2007/americas/nicaragua.html>.

⁶⁶ Barrientos, Armando & Rebecca Holmes, op. cit., p.11.

⁶⁷ Shah, Amita and Aasha Kapur Mehta (2008). *Experience of the Maharashtra Employment Guarantee Scheme: are there lessons for NREGS?* Chronic Poverty Research Centre, India.

⁶⁸ Barrientos, Armando & Rebecca Holmes, op. cit., p. 42.

⁶⁹ Public Works Department (2006). *Expanded Public Works Programme*. Republic of South Africa. <http://www.epwp.gov.za/>

⁷⁰ Social Security Online (2008), *Social Security Programs throughout the World: Asia and the Pacific*, 2008. <http://www.socialsecurity.gov/policy/docs/progdesc/ssptw/2008-2009/asia/vietnam.html>

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Child Nutrition

The World Health Organization (WHO) defines nutrition as *the intake of food considered in relation to the body's dietary requirements*. WHO points out that poor nutrition can result in “weak immunity, increased susceptibility to disease, impaired physical and mental development, and reduced productivity”.⁷¹ Good nutrition is the foundation of good health; a lack of good health results in children’s inability to function effectively and will impact on them being able to reach their full potential as individuals. Accordingly, countries have implemented school feeding programmes and other types to improve the nutritional status of children and to assist them to function effectively while in the school environment. **Table 3** provides examples of programmes of various countries that target the vulnerability of children to malnutrition. All these programmes have one common objective – “to promote the nutritional health of children”.

⁷¹ World Health Organization (2009). *Nutrition*. <http://www.who.int/topics/nutrition/en/>.

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Table 1.3: Programmes supporting Child Nutrition

Programmes	Country	Region
School Meals Programme: “To promote life-long healthy habits physical activities among children”. ⁷²	Barbados	Americas & the Caribbean
School Feeding Programme: “This provides school children in the Hinterland regions with meals when they attend school; the level of poverty, cost of living and scarcity of basic food items in those regions are significant”. ⁷³	Guyana	Americas & the Caribbean
New Partnership for Africa’s Development (NEPAD) School Feeding Programme: “This programme provides at least one nutritious meal per day to children from poor rural areas in some 500 schools”. ⁷⁴	Ghana	West & Central Africa
School Nutrition Program: “To improve the nutritional status of the school children, increase the enrolment and attendance rates, reduce the dropout rate, alleviate short-term hunger, and increase the attention span and learning capacity so that children get an educated start in life”; currently covers 631 schools. ⁷⁵	Bangladesh	South Asia
School Health and Nutrition: “Mejorando Nuestra Vida” (Improving Our Lives): “To provide micronutrient supplementation – Iron and Vitamin A; personal hygiene and sanitary education; and sanitary improvement in schools”. ⁷⁶	Bolivia	Americas & the Caribbean
School Health and Nutrition: “This programme conducts routine de-worming and micronutrient supplementation, improvements to school water supplies and toilet facilities and curriculum-based health education.” ⁷⁷	Egypt	Middle East and North Africa

Child Health

The WHO is an international advocate for the healthy growth and development of children; it encourages countries to make the health of children a primary goal. A child’s health becomes

⁷² Ministry of Education and Human Resource Development (2009). *School Meals Programme*. <http://www.mes.gov.bb/pagesselect.cfm?page=50&CFID=5639220&CFTOKEN=68647400>.

⁷³ Partnership for Child Development (2009). *School Feeding Programme*. Ministry of Education, Guyana. <http://www.schoolsandhealth.org/Lists/List%20by%20Country/DispForm.aspx?ID=133&Source=http%3A%2F%2Fwww.schoolsandhealth.org%2FPages%2FCountry.aspx>.

⁷⁴ Partnership for Child Development (2009). *NEPAD School Feeding Programme*. Ghana. <http://www.schoolsandhealth.org/Lists/List%20by%20Country/DispForm.aspx?ID=39&Source=http%3A%2F%2Fwww.schoolsandhealth.org%2FPages%2FCountry.aspx>.

⁷⁵ Partnership for Child Development (2009). *School Nutrition Program*. Land O’Lakes International Development. Bangladesh. <http://www.schoolsandhealth.org/Lists/List%20by%20Country/DispForm.aspx?ID=8&Source=http%3A%2F%2Fwww.schoolsandhealth.org%2FPages%2FCountry.aspx>.

⁷⁶ Partnership for Child Development (2009). “School Health and Nutrition: “Mejorando Nuestra Vida” (Improving Our Lives)”, *School Health and Nutrition Newsletter*. Bolivia. <http://www.schoolsandhealth.org/Lists/List%20by%20Country/DispForm.aspx?ID=13&Source=http%3A%2F%2Fwww.schoolsandhealth.org%2FPages%2FCountry.aspx%3FView%3D%257b77DEDC47%252d2D47%252d47F4%252d9F0D%252d4C0958FC986E%257d>.

⁷⁷ Partnership for Child Development (2009). “School Health and Nutrition”, *School Health and Nutrition Newsletter*. Egypt. <http://www.schoolsandhealth.org/Lists/List%20by%20Country/DispForm.aspx?ID=28&Source=http%3A%2F%2Fwww.schoolsandhealth.org%2FPages%2FCountry.aspx%3FView%3D%257b77DEDC47%252d2D47%252d47F4%252d9F0D%252d4C0958FC986E%257d>

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important from the maternity period, during infancy and throughout childhood. In light of this, programmes have been implemented to care for mothers and babies during pregnancy; to promote immunization of infants against infectious diseases; and monitor and stabilize the health of children as they develop. There is a wide variety of child health programmes carried out by countries. They focus on health issues such as: child obesity and physical health, personal hygiene, breast feeding, child delivery, vitamin deficiency and de-worming. **Table 1.4** presents examples of programmes promoting child health in selected countries.

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Table 1.4: Programmes supporting Child Health

Programmes	Country	Region
National Health and Fitness Programme for students: “To reduce the rate of obesity among school children”. ⁷⁸	Barbados	Americas & the Caribbean
Mobile Life Education Centre: “Students are educated about living a healthy life - exercising, eating and non-consumption of alcohol”. ⁷⁹		
Water and Sanitation Programme: “This carries out on-going health campaigns & non-formal education”. However, “access to safe drinking water is not yet realized; there are regular water shortages; unhygienic storage containers and basic sanitation is limited”. ⁸⁰	Ghana	West & Central Africa
Expanded Programme on Immunization: “To ensure child immunization against the six childhood diseases - diphtheria, measles, pertussis, poliomyelitis, tetanus, and tuberculosis”. ⁸¹		
Health Sector Development Programme (2007: “This focuses on national child survival, blindness in children and on improving the safe delivery of babies and on promoting healthy pregnancies”. ⁸²	Ethiopia	Eastern & Southern Africa
School Health and Nutrition: “Intestinal worms, anemia and iodine deficiency prevent children from focusing or attending school regularly. This programme provides de-worming and micronutrient supplementation to increase school attendance and participation”. ⁸³	Haiti	Americas & the Caribbean
School Sanitation and Hygiene Education (SSHE): “SSHE works towards establishing safe and sustained hygiene behaviours among children; it also involves a child’s family and community”. ⁸⁴	India	South Asia
Personal Hygiene and Sanitation Education (PHASE): “The aim is to decrease diarrhoea-related diseases related to poor hygiene and to improve children’s overall health and wellbeing”. ⁸⁵	Bangladesh	South Asia

⁷⁸ United Nations Economic and Social Council (2009). *Development Strategies that Work*. <http://webapps01.un.org/nvp/frontend!policy.action?id=129>.

⁷⁹ Ibid.

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² Ibid.

⁸³ Partnership for Child Development (2009). “School Health and Nutrition”, *School Health and Nutrition Newsletter*. Haiti.

<http://www.schoolsandhealth.org/Lists/List%20by%20Country/DispForm.aspx?ID=46&Source=http%3A%2F%2Fwww.schoolsandhealth.org%2FPages%2FCountry.aspx%3FView%3D%257b77DEDC47%252d2D47%252d47F4%252d9F0D%252d4C0958FC986E%257d>.

⁸⁴ Partnership for Child Development (2009). *School Sanitation and Hygiene Education (SSHE)*. India.

<http://www.schoolsandhealth.org/Lists/List%20by%20Country/DispForm.aspx?ID=50&Source=http%3A%2F%2Fwww.schoolsandhealth.org%2FPages%2FCountry.aspx%3FView%3D%257b77DEDC47%252d2D47%252d47F4%252d9F0D%252d4C0958FC986E%257d>.

⁸⁵ Save the Children (2006). *Personal Hygiene and Sanitation Education (PHASE)*, *School Health and Nutrition Newsletter*. Bangladesh. www.savethechildren.org.

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Child Protection

UNICEF's use of the phrase 'child protection' signifies "*preventing and responding to violence, exploitation and abuse against children – including commercial sexual exploitation, trafficking, child labour and harmful traditional practices, such as female genital mutilation/cutting and child marriage*". Countries that have ratified international documents such as the Convention on the Rights of the Child have been struggling to establish a protective environment for children. In some countries, children may confront violence, abuse, hunger, mental and physical incapacity daily and the situation gets worse for orphans and those living with and affected by HIV/AIDS. As a result, countries following international guidelines implement programmes to protect children from forms of exploitation, exclusion and abuse that are considered as detrimental to their survival. **Table 1.5** gives a sample of programmes carried out in some countries worldwide.

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Table 1.5: Programmes supporting Child Protection

Programmes	Country	Region
Orphan's Pension: "The government pays a percentage of the insured's pension to children under 16. A disabled child receives a higher percentage". ⁸⁶	Barbados	Americas & the Caribbean
Preventing Mother to Child Transmission: "To prevent transmission of HIV to newborns by providing antiretrovirals, monitoring through viral load testing and CD4 counts, following-up with clients before and after delivery and ensuring proper infant feeding practices". ⁸⁷		
Orphan's Pension: "Each orphan less than age 15 receives 25% of deceased's pension; 50% for a full orphan". ⁸⁸	Nicaragua	Americas & Caribbean
Chile Crece Contigo (Chile grows with you): "A comprehensive child protection system protecting boys and girls from conception through to their complete development as individuals". ⁸⁹	Chile	Americas & the Caribbean
Action against child labour through education and training: "This programme introduced issues relating to child labour in the primary school curriculum and implemented interactive learning methods to alert students, teachers and education officials to the existence of child labour and child rights". ⁹⁰	Kenya	Eastern & Southern Africa
Youth Adolescent Sexual Reproductive Health Programme (YASRH): "A primary objective is help young people to make decisions about their sexual reproductive; target groups – orphans, vulnerable children and people living with HIV/AIDS". ⁹¹	Zimbabwe	Eastern & Southern Africa
Programa de Educacion Afectivo Sexual: A Sex Education Program (PEAS): "With 825 participating schools, this programme aims to contain the spread of HIV/AIDS by instilling values, attitudes and behavioural changes in children and teachers at the secondary level; it focuses on STI/HIV/AIDS prevention and transmission". ⁹²	Dominican Republic	Americas & the Caribbean

⁸⁶ Social Security Online (2007). *Social Security Programs throughout the World: The Americas*, 2007.

<http://www.socialsecurity.gov/policy/docs/progdesc/ssptw/2006-2007/americas/barbados.pdf>, p. 4.

⁸⁷ United Nations Economic and Social Council, op. cit.

⁸⁸ Social Security Online (2007). *Social Security Programs throughout the World: The Americas*, 2007.

<http://www.socialsecurity.gov/policy/docs/progdesc/ssptw/2006-2007/americas/nicaragua.html>.

⁸⁹ United Nations Economic and Social Council, op. cit.

⁹⁰ International Programme on the Elimination of Child Labour, (2004), *Combating Child Labour through Education*. International Programme on the Elimination of Child Labour.

⁹¹ Partnership for Child Development (2009). *Youth Adolescent Sexual Reproductive Health Programme (YASRH)*. Zimbabwe.

http://www.schoolsandhealth.org/Lists/List%20by%20Country/DispForm.aspx?ID=128&Source=http%3A%2F%2Fwww.schoolsandhealth.org%2FPages%2FCountry.aspx%3FPaged%3DTRUE%26p_Title%3DRussia%2520%26p_ID%3D96%26View%3D%257b77DEDC47%252d2D47%252d47F4%252d9F0D%252d4C0958FC986E%257d%26PageFirstRow%3D101.

⁹² Partnership for Child Development (2009). *Programa de Educacion Afectivo Sexual: A Sex Education Program (PEAS)*. Dominican Republic.

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Child Education

Education is an important instrument in eliminating child poverty. UNICEF states, “*Education is a fundamental human right: Every child is entitled to it. It ends generational cycles of poverty and disease and provides a foundation for sustainable development. When we ensure that children have access to a rights-based, quality education that is rooted in gender equality, we create a ripple effect of opportunity that impacts generations to come.*” Programmes have been put in place to ensure that children attend school and prevent them from taking early leave from the formal education system. The formal education system has been used to achieve the goals of the other dimensions of child poverty. For example, nutrition through school feeding programmes; health such as emphasizing hygiene practices and enforcing child immunization; protection such as HIV/AIDS and eliminating child labour; supporting household income conditional on school attendance. The non-formal education system also works well to preserve a child’s right to education – this system assists those who have dropped out to re-enter the formal system or continue to other educational levels such as vocational and others. (See **Table 1.6**)

Table 1.6: Programmes supporting Child Education

Programmes	Country	Region
Female School Secondary School Stipend Programme: “This is designed to pay school & exam fees and give stipend to girls; objective is to increase female enrolment & retention in school”. ⁹³	Bangladesh	South Asia
Primary Education Stipend: “This is a conditional cash transfer system to keep children in primary school”. ⁹⁴		
Expanded Public Works Programme: “This provides poverty & income relief to the poor by providing temporary jobs”.	Zimbabwe	Eastern & Southern Africa
Free Compulsory Basic Education Programme (FCUBE): “To afford every child the opportunity to access basic education by 2005”. ⁹⁵	Ghana	West Africa
Education Sector Development Programme: “Initiated in 1996 to assist the government’s long-term development and poverty eradication targets”. ⁹⁶	United Republic of Tanzania	Eastern & Southern Africa
Accelerated Learning Programme – “This programme is designed for children who have never attended school or for those whose learning has been interrupted by civil conflict. The overall aim is to restore basic right to education.” ⁹⁷	Liberia	West & Central Africa
Abolition of Primary School Fees: “Enabled orphans and other vulnerable children to attend school; this has caused school enrolment to increase dramatically”. ⁹⁸	Kenya	Eastern & Southern Africa

⁹³ Barrientos, Armando & Rebecca Holmes, op. cit., p. 17.

⁹⁴ Ibid, p. 18.

⁹⁵ United Nations Economic and Social Council, op. cit.

⁹⁶ Ibid.

⁹⁷ UNICEF (2007). Liberia accelerated learning programme 1998-2007. Presentation on the achievements and challenges of the accelerated learning programme.

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Definitions of Child Poverty

Table 1.7: Definitions of Child Poverty

Definition	Source	Comments
<p>“Children living in poverty experience deprivation of the material, spiritual, and emotional resources needed to survive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential or participate as full and equal members of society.”</p>	<p>The United Nations Children’s Fund (UNICEF), January 2007</p> <p>Global Study on Child Poverty and Disparities 2007-2008 Guide Page 11</p>	<p>Material - income, food, education and health</p> <p>Spiritual - stimuli, meaningfulness, expectations, role models and per relationships</p> <p>Emotional - love, trust, feelings of acceptance, inclusion, lack of abusive</p>
<p>“The lives of poor children depend upon a complex combination of low income household, lack of equal opportunities and social exclusion. Child poverty encompasses:</p> <ul style="list-style-type: none"> a. Damages to childhood experience through limiting access to activities, services and opportunities, increasing exposure to risks, and diminishing access to resources and support that increase resilience. b. Social exclusion – this happens when people or areas suffer from linked problems such as unemployment, poor skills, poor housing, high crime, bad health and family breakdown. c. Denying equal opportunity which can blight adult life, leading to cycles of disadvantage. 	<p>Department for Works and Pensions & HM Treasury, UK</p> <p>Child Poverty Review July 2004 Page 15</p>	
Definition	Source	Comments
<p>“Child poverty centres around three areas:</p> <ul style="list-style-type: none"> a. Deprivation – a lack material conditions and services generally 	<p>The Christian Children’s Fund (CCF), 2002</p>	<p><i>taken from</i></p> <p>Minujin, Alberto et al (2006). The definition of child</p>

⁹⁸ UNICEF (2009). *Basic Education and Gender Equality*. <http://www.unicef.org/girlseducation/>

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<p>held to be essential to the development of children’s potential.</p> <p>b. Exclusion – the result of unjust processes through which children’s dignity, voice and rights are denied or their existence threatened.</p> <p>c. Vulnerability - an inability of society to cope with existing or probable threats to children in their environment.”</p>	<p>Understanding how children experience and respond to poverty, CCF 2004 presentation at UNICEF</p>	<p>poverty: a discussion of concepts and measurements, <i>Environment and Urbanization</i>, pg. 486-487.</p>
<p>“Childhood poverty means children and young people growing up without access to different types of resources that are vital for their well-being and for them to fulfill their potential. By resources we mean economic, social, cultural, physical, environmental and political resources.”</p>	<p>The Childhood Poverty Research and Policy Centre (CHIP)</p> <p>Children and poverty – some questions answered in <i>Children and Poverty</i>, CHIP Briefing 1 2004</p>	<p>Economic, physical and environmental – financial and nutritional resources</p> <p>Social, cultural and physical – quality education, life skills, health and water/sanitation</p> <p>Social and cultural – parents or guardians to nurture and protect them and a community caring and protecting its younger generation</p>
<p>“Poverty prevents children from reaching their full potential. It denies them human rights – like those related to education, health and nutrition, participation in decisions that affect their lives, and freedom from abuse, exploitation and discrimination.”</p>	<p>Canadian Development International Agency (CIDA)</p> <p>Child Protection, CIDA Quebec 2004</p> <p>http://www.acdi-cida.gc.ca/childprotection</p>	<p><i>taken from</i></p> <p>Minujin, Alberto et al (2006). The definition of child poverty: a discussion of concepts and measurements, <i>Environment and Urbanization</i>, pg. 487</p>

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Definition	Source	Comments
<p>“Child poverty is the denial of child’s rights. It restrains a children from achieving their full potential, adversely affecting health, inhibiting personal development, education and general well-being.”</p>	<p>European Commission (EC)</p> <p>http://ec.europa.eu/employment_social/spsi/child_poverty_en.htm</p>	

Methodology and Indicators

Indicators

Income is generally used as a measure of poverty. However, it is not an easy task for developing countries to use this measure. As a result more and more of these countries have opted to use non-income indicators to measure poverty. This section pulls together the indicators used to measure non-income childhood poverty as well as the methodology employed in calculating child poverty. The indicators are based on various non-income dimensions of poverty.

Table 1.8: Non-Income Indicators of Poverty

Dimension	Indicators	Source	Comments
Education	1. Primary school enrolment rate	Mehrotra (2006), UNDP	
	1. Educational attainment 2. School attendance 3. Destination at age 16	Bradshaw (2009), Communities and Local Government UK	1. Highest exam passed 2. Absent rates 3. Proportion of children not advancing to further education
	1. Primary school net enrolment ratio 2. Secondary school net enrolment ratio	Canto-Sanchez & Mercader-Pratz (1998)	
	1. Non-enrolment rate	Hague (2008)	The percentage of children at primary school age who are not in school
		Jean & Relano	

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Dimension	Indicators	Source	Comments
		(2007)	who have never been enrolled in a school or not currently attending
		UNICEF (2008)	Percent of children not enrolled at the appropriate level Percent of children not completing primary school
	1. Reading literacy 2. Mathematics literacy 3. Science literacy	Bradshaw et al (2006)	
Malnutrition/ Nutrition	1. Low birth weight	Mehrotra (2006), UNDP	
	1. Height 2. Weight	Gordon et al (2003), UNICEF Jean & Relano (2007)	Height and weight more than 3 standard deviations below the median of international population used
	1. Weight (under 5)	Hague (2008) Save the Children, UK	The percentage of children under five “who are moderately or severely underweight”
	1. Stunting	Gunther and Klasen (2007)	Nutrition poverty : z-score below -2
Health	1. Infant Mortality rate 2. Under 5 mortality rate 3. Births attended by skilled health professionals 4. immunization	Mehrotra (2006), UNDP	Births attended by skilled health professionals is an key indicator of child survival (“a high percent of death takes place in the first four weeks after birth”)

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Dimension	Indicators	Source	Comments
	<ol style="list-style-type: none"> 1. All emergency admissions to hospital for children aged 0-18 as a proportion of all children aged 0-18 in each Lower Super Output Area (LSOA) 2. All outpatient hospital attendances for children aged 0-18 as a proportion of all children aged 0-18 in each LSOA 3. The proportion of children aged 0-16 receiving Disabled Living Allowance 	Bradshaw (2009), Communities and Local Government UK	Indicators 1. – 3. mirrors: <ol style="list-style-type: none"> 1. the frequency of acute illness & accidents 2. the frequency of chronic illness & attendance 3. extensiveness of disability
	<ol style="list-style-type: none"> 1. Children under five years not immunized 	Jean & Relano (2007)	This can also include children who suffered from diseases (ARI) and received no treatment
	<ol style="list-style-type: none"> 1. No visit to Health Facility 	UNICEF (2008)	Percent of children not having visited a health facility in the last 12 months
	<ol style="list-style-type: none"> 1. Health at birth 2. Immunization 3. Child Mortality 	Bradshaw et al (2006)	<ol style="list-style-type: none"> 1. Low birth weight 2. Measles, DPT3, Pol3 3. Accidental and non-accidental deaths
Water & Sanitation	<ol style="list-style-type: none"> 1. Diarrhoeal diseases 2. Access of sources of water 	Mehrotra (2006), UNDP	Diseases due to poor sanitation and over-crowding (more than 5 people per room)
	<ol style="list-style-type: none"> 1. Access to toilet 	Jean & Relano (2007)	Children under 18 with no access to toilet (incl. communal toilets & latrines) in their environs
		Gordon et al (2003),	Nearest water source is more than 15 minutes or more than

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Dimension	Indicators	Source	Comments
	1. Access to safe water	UNICEF Jean & Relano (2007)	200m from dwelling Children under 18 whose access is just surface water (rivers)/those children whose access to water is more than 30 minutes from dwelling
Crime	1. Burglary rate 2. Theft rate 3. Criminal damage rate 4. Violence rate	Bradshaw (2009), Communities and Local Government UK	To focus on children each indicator is weighted based on the likelihood of risk for those 0-15 yrs
Housing	1. Over-crowding 2. Shared accommodation 3. Homelessness 4. Lack of central heating	Bradshaw (2009), Communities and Local Government UK	Indicators 1. – 3 represent access variables 1. Uses occupancy rate 2. people living in shared dwellings, aged 0 to 15 as a proportion of all children 0-15 3. concealed families containing dependent children as a proportion of all families with dependent children Indicator 4 reflects quality of housing 4. children aged 0 to 15 years old living in accommodation without central heating as a proportion of all children aged 0 to 15

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Dimension	Indicators	Source	Comments
	1. Improper dwelling	UNICEF (2008)	Percent of: 1. children living in dwellings without electricity 2. children living in dwellings without proper roofing 3. children living in dwellings without proper flooring
Environment	1. Air quality 2. The natural environment 3. The number of bird species 4. Road Safety 5. Opportunities for sports and leisure 6. Distance to school	Bradshaw (2009), Communities and Local Government UK	Indicators 1. – 4 captures environmental quality & are measured by: 1. combined air quality indicator 2. percentage of green space & woodland 3. ----- 4. severity of accidents per 1000 children under 16 Indicators 5 & 6 capture environmental access 5. average number of different types of sports and leisure facility within walking distance for children aged 11 to 16 6. average road distances to primary and secondary schools for children aged 4 to 10 years and 11 to 16 years
Information	1. No access to radio, television, newspaper or telephone at home	Jean & Relano (2007)	
Work	1. Percent of children in household working	UNICEF (2008)	
Leisure	1. No toys or books	UNICEF	Percent of children with no

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Dimension	Indicators	Source	Comments
		(2008)	toys Percent of children not in possession of at least one book
Social Inclusion and Protection	<ol style="list-style-type: none"> 1. No birth registration 2. Unemployed caregivers 	UNICEF (2008)	<ol style="list-style-type: none"> 1. Percent of children with no birth registration 2. Percent of caregivers not able to work.
Behavioral Styles	<ol style="list-style-type: none"> 1. Risk Behaviour 2. Experiences of Violence 3. Health Behaviour 	Bradshaw (2006)	<ol style="list-style-type: none"> 1. Pregnancy rate, smoking, condom use 2. Fighting, bullying 3. Eating fruit and breakfast everyday 4. Physical activity 5. Overweight

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Methodology

Equal Weighting

In constructing a local index for child well-being, Bradshaw et al (2009) used various approaches to calculate the sub-indices for each dimension of child poverty. That index captured health, education, environment, crime, housing, children in need and material well-being. The method of constructing each sub-index varied across dimensions. Of interest are the methods used in constructing the non-income dimensions.

Table 1.9: Methodological Approaches

Sub-index	Methodology
Health	Equal weights
Education	<i>Maximum likelihood factor analysis</i> generated weights (indicators are related)
Crime	<i>Maximum likelihood factor analysis</i> generated weights (indicators normalized)
Housing	Equal weights
Environment	Environmental Quality: Equal weights (indicators normalized) Environmental Access: Distance to school for both age groups (0.25 each), sports & leisure (0.5) (indicators normalized) Overall: Equal weights

Hague (2006) used three indicators of child well-being: health (less than five mortality rate), nutrition (children under five who are underweight) and education (children not in school) were aggregated using equal weighting.

Jean & Relano (2007) adopted the deprivations based indicators from Gordon et al (2003) to calculate child poverty. These indicators captured deprivations in health, education, water, sanitation, shelter, information and nutrition. Equal weights were assigned to all dimensions of child deprivation. This approach was adopted by this study for the purposes of international comparability and to avoid subjectivity.

Squared Domain (dimension) Severity Index

Constructing the Child Poverty Index for Vietnam (UNICEF, 2008)

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- Poverty rates are calculated for each indicator. This considers the percent of children that do not meet the threshold established for each indicator. The poverty rate indicates whether or not a child is poor.
- Scores (Poverty rates) for each dimension are ascertained by averaging the poverty rates for the indicators in the dimension.
- For the composite index, compute the sum of each dimension score squared and divide by the total number of domains.

Z score Approach

Bradshaw et al (2006) developed a Child Well-being index for OECD countries using 18 dimensions of child poverty disaggregated into 18 dimensions and 40 indicators. For example, reading literacy, mathematics literacy and science literacy constitute the component educational achievement which helps to define the dimension, education. Method:

- Z scores for each indicator are calculated and an average of the z scores is taken to produce a score for a component.
- The average of all component scores is calculated to produce a dimension score.

No weights were used in deriving the combining indicators into components and components into dimensions.

2.1. Percentage of Children below the poverty line

Table 2.1.1⁹⁹ summarizes the dimensions of child poverty in Jamaica on the basis of consumption being below the national poverty line. This line was constructed on the criterion of

⁹⁹ Estimates based on poverty line for adult equivalents for selected years

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affordability of a basket of basic foods supplying the WHO's recommended dietary allowances, and taking account of the share of food in average household consumption in the bottom two quintiles of the income distribution.

Table 2.1.1 - Trends in income/consumption poverty since 1990

	1990	1995	2000	2005
<i>Poverty headcount among households with children (0 - 17)</i>				
by national poverty line	0.31	0.31	0.22	0.17
by international poverty line	0.17	0.14	0.03	0.02
<i>Poverty headcount among all households</i>				
by national poverty line	0.28	0.27	0.19	0.15
by international poverty line	0.15	0.12	0.02	0.02
<i>Number of children in poverty</i>				
by national poverty line	315309	322040	227997	170004
by international poverty line	180031	160301	30448	22487
National Poverty line (local currency)	3837.9	20074.1	31313.9	48163.3
Number of households with children	368335	387894	429830	438315
Total number of households	580945	631366	725792	776677
Total number of children	969400	960925	953654	940154
Average household size	4.1	4.0	3.6	3.4
Average household size among families with children	5.4	5.4	4.8	4.8

Source: Jamaica Survey of Living Conditions, 1990, 1995, 2000, 2005

Notes

Calculations were done using the regional poverty lines

The international poverty line was calculated using US\$1 per day

Table 2.1.1 shows data for every fifth year since 1990; specifically, 1990, 1995, 2000, and 2005. Over the 15 year period, the number of households and the number of households with children were increasing, but the number of children and the average size of households with children were declining. The headcount indicator of poverty for all households declined steadily after 1990, and particularly sharply after 1995. This was the case for the headcount computed with respect to both the national and international poverty lines. The data show that while the pattern of change is the same for households with children as for all households, the rate of decline of the poverty headcount for households with children was much slower and the headcount was consistently higher than for all households, and by implication, for households without children. The number of children below the national poverty line shows a different trend – it increased

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from 1990 to 1995, and declined sharply from 1995 to 2005. With respect to the international poverty line, the number of children also declined steadily after 1990.

The percentage of households with children and the percentage of all households below the international poverty line of US\$1.00 per day have steadily declined between 1990 and 2005, and particularly sharply between 1995 and 2000.

The data on the headcount and the poverty gap have been disaggregated in **Table 2.1.2**¹⁰⁰ by age group, gender, household size, gender of the head of household, quintile of wealth distribution, parish and location of residence. All data were drawn from the JSLC 2006, except the parish data which were drawn from the special module done in 2002.

Table 2.1.2 - Correlates of consumption poverty among households with children

	Poverty Headcount Rate (%)	Poverty Gap (income/consumption shortfall as a % of poverty line)
All households with children (0 - 17)	18.0	23.7
Individual Dimension		
<i>Sex & Age</i>		
Male		
0 - 14	21.4	24.1
15 - 17	15.6	26.7
15 - 24	15.2	26.2
25 - 44	13.8	25.6
45 - 64	14.9	19.3
65+	22.0	29.3
Female		
0 - 14	20.9	23.1
15 - 17	16.9	22.8
15 - 24	18.2	22.9
25 - 44	15.6	22.7
45 - 64	15.0	23.4
65+	18.1	22.4
Household Dimension		

¹⁰⁰ Estimates are based on the percapita poverty line for JSLC 2006

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Table 2.1.2 - Correlates of consumption poverty among households with children

	Poverty Headcount Rate (%)	Poverty Gap (income/consumption shortfall as a % of poverty line)
All households with children (0 - 17)	18.0	23.7
<i>Household Size</i>		
less than 3	1.2	10.0
3 - 4 members	9.9	23.3
5 - 6 members	16.0	23.2
7+ members	28.3	22.8
Education of Head of Household		
None	25.0	72.0
Primary	16.6	23.1
Secondary +	13.7	22.3
Gender of the head of household		
Male	13.9	21.0
Female	14.4	24.5
Wealth Index Quintile		
Q1	78.4	23.8
Q2	0.5	0.2
Q3	0.0	0.0
Q4	0.0	0.0
Q5	0.0	0.0
Ethnicity/language/Religion		
	n.a.	n.a.
Work (among households with children)		
Both parents working	14.1	21.7
None of the parents working	31.8	22.7
No adult in primary working age (18 - 54)	15.8	23.4
At least one child under 15 working	no data	no data
Illness and Disability in the household		
Adult(s) with chronic illness	13.2	23.4

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Table 2.1.2 - Correlates of consumption poverty among households with children

	Poverty Headcount Rate (%)	Poverty Gap (income/consumption shortfall as a % of poverty line)
All households with children (0 - 17)	18.0	23.7
Child/Children with disability	Not available	Not available
Family Vulnerability		
Single Parent	17.0	23.5
Orphan child in household	Not available	Not available
High Dependency ratio (4+ children/adult)	34.6	30.9
Elder (70+) person in household	21.5	25.9
Geographic Dimension		
<i>Region</i>		
Kingston	18.1	16.5
St. Andrew	16.9	24.2
St. Thomas	30.7	23.2
Portland	35.7	19.8
St. Mary	30.1	16.9
St. Ann	39.6	20.1
Trelawny	34.6	21.3
St. James	16.4	14.0
Hanover	14.4	16.1
Westmoreland	21.4	26.2
St. Elizabeth	22.0	26.7
Manchester	28.3	18.4
Clarendon	29.0	30.4
St. Catherine	7.0	24.3
<i>Residence</i>		
Urban	10.6	25.4
Rural	24.8	23.0

Sources: JSLC 2002, 2006 & LFS 2006

Notes:

Regional poverty lines used to calculate above and below poverty line variables

$$\frac{1}{n} \sum \frac{(\text{per capita pov line} - \text{per capita consumption})}{\text{per capita pov line}}$$

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Table 2.1.2 - Correlates of consumption poverty among households with children

	Poverty Headcount Rate (%)	Poverty Gap (income/consumption shortfall as a % of poverty line)
All households with children (0 - 17)	18.0	23.7

Poverty Gap calculated as:

n.a. means not applicable

By way of summary, the highlights are:

- For males, the headcount and the poverty gap are highest for the age group 65+. Among children, the headcount is highest for the age group 0-14 years, and the poverty gap is highest for the 15-17 years age group
- For females, the headcount of the youngest group, 0 – 14 years, is again the highest, and marginally less than the headcount for males of the same group. The poverty gap for the youngest age group of females was slightly smaller than that of the corresponding age group of males and the largest for all female children.
- For both male and female children, the headcount of the older age group is smaller than for the younger age group.
- The headcount for the youngest group, 0 – 14 years, of males was approximately 55% higher than the headcount for the age group 25 – 44 years. In the case of females, the headcount for the youngest group, 0 – 14 years was 34% higher than the headcount for the age group 25 – 44 years. The poverty gap for the youngest male group was about 18% smaller than for the males in the age group 25 - 44 years, and the poverty gap for the youngest females was marginally greater than for the age group 25-44 years.
- The most significant difference in the headcount between the genders occurs in the oldest age group with the headcount for males 65 years and older being much higher (22.0%) than for females (18.1%)
- The headcount rises sharply with household size. The headcount for households of 7 or more persons (28.3%) is more than 23 times that of households with 3 or less members (1.2 %). For households with 3 or more members, the poverty gap is more than twice the

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poverty gap for households of less than 3 members. However, the poverty gap declines marginally with household size.

- The headcount is inversely proportional to the education level of the head of household. The headcount for households whose heads have no education (25.0%) is almost twice the headcount for households with heads who have education at the secondary level or above (13.7%). In the case of the poverty gap, the difference between households with uneducated heads and households with heads with primary or higher level of education is more than a factor of 3. However, the difference in the poverty gap between households whose heads have primary or secondary education and above is very small. It appears that the lack of education is an important determinant of the frequency and depth of poverty. The JSLC sample had very few households with heads who had no education, and indeed, most household heads had at least secondary education. Accordingly, while the data is suggestive of the determining role of the education level of the head of household, caution is advised in making inferences until the result is confirmed by analysis of data from a larger sample.
- In 2006, both the headcount and the poverty gap of male-headed households were marginally lower than for female-headed households.
- Not surprisingly, the poor were concentrated in the two lowest wealth quintiles, with 78.4% of quintile 1 and a marginal share, 0.5%¹⁰¹, of quintile 2 falling below the poverty line.
- The headcount is lower for households with both parents working than with none of the parents working, and similarly the poverty gap for the former is smaller than that of the latter. It is assumed that households with “no adult in primary working age (18-54)” has an adult older than 54, which would explain why the headcount is lower for this set of households than for households with none of the parents working.
- The headcount of poverty among households with 4 or more children per adult (34.6%) was higher than households (21.5%) with an elderly (70+ years) person and for single parent households (17.0%). The differences in the poverty gaps among these three types

¹⁰¹ This is suspiciously low.

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of households were not as great, but the order of ranking was the same as with the headcount

- The headcount in rural areas was marginally more than twice (41.1%) the headcount for urban areas (19.2%), but the poverty gap in the rural areas was actually smaller. **Table 2.1.2** lists the headcount and poverty gap of the parishes, and it is clear that the parishes that were relatively more urban were reporting a lower incidence of poverty and smaller poverty gaps on average than the parishes that were predominantly rural.

In summary, the incidence of poverty as measured by the headcount was disproportionately higher for children, and significantly higher for all age groups in rural areas than in urban areas. The education level of the head of household and the size of the household were important determinants of the poverty of the household, but the gender of the head of household does not appear to have been that significant. The poverty gap was not as sensitive as the headcount to changes in the age, household size, gender and education level of the household head, and the geographical location as the headcount. However, the poverty gap was significantly high for the youngest age groups, the oldest males, and households with heads who had no education. **Table 2.1.3**¹⁰² uses the same variables to compare the odds of living below the poverty line for persons in households with children with persons in all households.

¹⁰² Estimates based on percapita poverty lines from SLC 2006

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Table 2.1.3 - Odds Ratios for the probability of consumption poverty (using regional poverty lines)

Odds Ratios of Living Under the Poverty Line		
	Among Households with Children	Among all Households
Individual Dimension		
<i>Sex & Age</i>		
Male		
0 - 14	0.27	0.27
15 - 17	0.19	0.19
15 - 24	0.18	0.16
25 - 44	0.16	0.12
45 - 64	0.18	0.13
65+	0.28	0.15
Female		
0 - 14	0.26	0.26
15 - 17	0.20	0.20
15 - 24	0.22	0.20
25 - 44	0.19	0.17
45 - 64	0.18	0.13
65+	0.22	0.15
Household Dimension		
<i>Household Size</i>		
less than 3	0.01	0.05
3 - 4 members	0.11	0.11
5 - 6 members	0.19	0.19
7+ members	0.40	0.40
Education of Head of Household		
None	0.33	0.67
Primary	0.20	0.17
Secondary +	0.16	0.10
Gender of the head of household		
Male	0.16	0.10
Female	0.17	0.14

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Table 2.1.3 - Odds Ratios for the probability of consumption poverty (using regional poverty lines)

Odds Ratios of Living Under the Poverty Line		
	Among Households with Children	Among all Households
Wealth Index Quintile		
Q1	3.63	3.67
Q2	0.005	0.004
Q3	0.00	0
Q4	0.00	0
Q5	0.00	0
Ethnicity/language/Religion		
	n.a.	n.a.
Work (among households with Children)		
Both parents working	0.16	n.a.
None of the parents working	0.47	n.a.
No adult in primary working age (18-54)	0.19	0.12
At least one child under 15 working	0.00	0.00
Illness and Disability in the household		
Adult(s) with chronic illness	0.15	0.12
Child/Children with disability		
Family Vulnerability		
Single Parent	0.20	n.a.
Orphan child in household		
High Dependency ratio (4+ children/adult)	0.53	n.a.
Elder (70+) person in household	0.27	0.16
Geographic Dimension		
<i>Region</i>		
Kingston	0.22	0.08
St. Andrew	0.20	0.16
St. Thomas	0.44	0.45
Portland	3.81	0.22
St. Mary	0.43	0.25
St. Ann	0.66	0.21

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Table 2.1.3 - Odds Ratios for the probability of consumption poverty (using regional poverty lines)

Odds Ratios of Living Under the Poverty Line		
	Among Households with Children	Among all Households
Trelawny	0.53	0.37
St. James	0.20	0.06
Hanover	0.17	0.19
Westmoreland	0.27	0.12
St. Elizabeth	0.28	0.20
Manchester	0.40	0.16
Clarendon	0.41	0.43
St. Catherine	0.08	0.11
<i>Residence</i>		
Urban	0.12	0.10
Rural	0.33	0.28

Source: JSLC 2002, 2006

Notes:

Regional poverty lines used to calculate above and below poverty line variables

Odds Ratio calculated as the number of persons in poverty divided by the number of persons not in poverty

- According to the data in **Table 2.1.3**, there was no difference in the odds of children living in poverty for households with children and for all households. This is understandable since the households with children are the same ones that will appear in “all households”. The differences in the odds appear for the older age groups where the odds are uniformly higher for households with children than for all households, and by extension, for households without children. Furthermore, the differences in the odds increase as the ages increase, with the difference being greatest for the age group, 65+.
- The differences between the sexes are insignificant for the two age groups of children. Females of working age tend to face marginally higher odds of being in poverty for both types of households. The situation is reversed for the oldest age group where the odds of males in households with children being in poverty is significantly higher (0.28) than the corresponding age group for females (0.22).

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- Note that there is no difference between the odds of living in poverty for households with children and for all households regardless of size, except for households with less than 3 persons. Once households have three (3) or more members, it is likely that children are in the household, and as such households with children and “all households” are the same.
- With respect to the education level of household heads, the limited data suggest that the odds of living in poverty in households headed by someone without education is much greater than for households with at least a primary education, both for households with children and for all households. Above we urged caution in drawing inferences with regard to such household heads since there were so few in the JSLC sample. However, the data does suggest that there was a significant difference between households of both types according to whether the head had only primary education or secondary education and above. It is clear that the odds of living in poverty are greater for households with children than for all households, and by extension, for households without children.
- Again, the odds of living in poverty in households with children are much greater than for all households, for household heads of both genders, but the difference between the genders is small for both households with children and all households.
- In the case of the location of the residence of households, the odds of living in poverty are again significantly higher for households with children than for all households, and the odds of living in poverty were more than twice as great in rural as in urban households of both types.
- The profile that emerges is that the odds of children living in poverty are greatest in large rural households, with heads with no more than primary level education.

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2.2. Child Poverty as Deprivations

Table 2.1.4a shows the categories of deprivations used in the Bristol study¹⁰³ and the indicators proposed to measure them. In column 2, the proposed adaptations of the criteria for “severe” and for “less severe” for Jamaica are shown, and will be discussed below.

Table 2.1.4a: Deprivations: Bristol Study Adapted for Jamaica

Bristol indicators of deprivation and their thresholds	Adaptations of the Bristol indicators and thresholds for Jamaica
<p>Food deprivation:</p> <p>Severe: children under the age of five years whose height and weight for their age were more than three standard deviations below the median of the international reference population, that is, severe anthropometric failure;</p> <p>Less severe: children under the age of five years whose height and weight for their age were more than two standard deviations below the median of the international reference population, that is, severe anthropometric failure;</p>	<p>Food deprivation:</p> <p>Severe: children under the age of five years whose height and weight for their age were more than three standard deviations below the median of the international reference population, that is, severe anthropometric failure;</p> <p>Less severe: children under the age of five years whose height and weight for their age were more than two standard deviations below the median of the international reference population, that is, severe anthropometric failure;</p>
<p>Water deprivation:</p> <p>Severe: children who only had access to surface water (for example, rivers, streams and dams) for drinking, or who lived in households where the nearest source of water was more than 30 minutes away (indicators of severe deprivation of water quality or quantity);</p> <p>Less severe: children who only had access to unimproved source (open wells, open springs) or surface water or who lived in households where the nearest source of water was more than 30 minutes away;</p>	<p>Water deprivation:</p> <p>Severe: children who only had access to surface water (for example, rivers, streams and dams) for drinking, or who lived in households where the nearest source of water was more than 30 minutes away (indicators of severe deprivation of water quality or quantity);</p> <p>Less severe: children who only had access to unimproved source (open wells, open springs) or surface water or who lived in households where the nearest source of water was more than 30 minutes away;</p>
<p>Deprivation of sanitation facilities:</p> <p>Severe: children who had no access to a toilet of any kind in the vicinity of their dwelling, that is, no private or communal toilets or latrines;</p> <p>Less severe: children who only have access to unimproved sanitation facilities (pour flush latrines, covered pit latrines, open pit latrines, buckets);</p>	<p>Deprivation of sanitation facilities:</p> <p>Severe: children who had no access to a toilet of any kind in the vicinity of their dwelling, that is, no private or communal toilets or latrines; <u>or who use buckets regularly;</u></p> <p>Less severe: children who only have access to unimproved sanitation facilities (pour flush latrines, covered pit latrines, open pit latrines) and with no access to drainage system (piped connection to canal, connection to ground water);</p>

¹⁰³ D. Gordon et al, 2003

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Bristol indicators of deprivation and their thresholds	Adaptations of the Bristol indicators and thresholds for Jamaica
<p>Health deprivation:</p> <p><i>Severe:</i> children under the age of five years who had not been immunized against any diseases, or young children who had recently suffered from an illness involving diarrhoea and had not received any medical advice or treatment;</p> <p><i>Less severe:</i> children between the age of two and 5 years who have not been immunized or young children who had recently suffered from an illness involving diarrhoea and had not received any medical advice or treatment;</p>	<p>Health deprivation:</p> <p><i>Severe:</i> children under the age of five years who had not been immunized against any diseases, or young children who had recently suffered from an illness involving diarrhoea and had not received any medical advice or treatment;</p> <p><i>Less severe:</i> children between the age of two and 5 years who have not been immunized or young children who had recently suffered from an illness involving diarrhoea and had not received any medical advice or treatment;</p>
<p>Shelter deprivation:</p> <p><i>Severe:</i> children in dwellings with more than five people per room (severe overcrowding) or with no flooring material (for example, a mud floor);</p> <p><i>Less severe:</i> children in dwellings with more than four people per room (severe overcrowding) or with no flooring material (for example, a mud floor);</p>	<p>Shelter deprivation:</p> <p><i>Severe:</i> homeless children, children in dwellings without electricity and/or water and/or floors</p> <p><i>Less severe:</i> children in dwellings with more than four people per room (severe overcrowding) or with no flooring material (for example, a mud floor);</p>
<p>Educational deprivation:</p> <p><i>Severe:</i> children aged 7-17 years who had never been to school and were not currently attending school;</p> <p><i>Less severe:</i> children aged 7-17 years who are not currently attending school or who did not complete their primary education;</p>	<p>Educational deprivation:</p> <p><i>Severe:</i> children aged 4-17 years who had not completed primary school and were not currently attending school;</p> <p><i>Less severe:</i> children aged 12-17 years who had not completed secondary school and were not currently attending school;</p>
<p>Information deprivation:</p> <p><i>Severe:</i> children aged 3-17 years with no access to radio, television, telephone, newspapers or computer at home (i.e. all forms of media);</p> <p><i>Less severe:</i> children aged 3-17 years with no access to radio or television.</p>	<p>Information deprivation:</p> <p><i>Severe:</i> children aged 3-17 years with no access to radio, television, telephone, newspapers or <i>Internet</i> at home (i.e. all forms of media);</p> <p><i>Less severe:</i> children aged 3-17 years with access to at least one, but not all of radio, television, telephone, newspapers or <i>Internet</i> at home</p>

Table 2.1.4b – Table 2.1.11 below report on data on deprivations collected in the MICS using the thresholds of deprivation of the Bristol Study conducted in Jamaica in 2005.

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Table 2.1.4b: Child poverty as multiple deprivations			
Country	Number of children in relevant age cohort	Of which experiencing 'severe' deprivation, %	Of which experiencing 'less severe' deprivation, %
a) Incidence (prevalence) of deprivation			
1. Shelter	5,775	No data	No data
2. Sanitation	5,775	1	3
3. Water	5,775	5	8
4. Information	5,775	No data	No data
5. Food	1,445	No data	No data
6. Education	3,707	0	6
7. Health	1,445	9	22
Total	5,775		
b) The incidence of the most frequent combinations of deprivations			
The most frequent case of any deprivation*	Health	9	
Two most frequent combinations*	No data	No data	No data
Two second most frequent combinations*	No data	No data	No data
Three most frequent combinations*	No data	No data	No data
Three second most frequent combinations*	No data	No data	No data
The most frequent associate of food*	No data	No data	No data
The most frequent associate of education*	No data	No data	No data
The most frequent associate of health*	No data	No data	No data
c) The incidence of multiple deprivations			
No deprivations		92	81
Only one (any) deprivation		8	18
Two of any deprivations		0	1
Three of any deprivations		0	
Four of any deprivations		0	
Five of any deprivations		0	
Six of any deprivations		0	
Seven of any deprivations		0	

Source: MICS, 2005

Unfortunately, of the seven (7) areas targeted, there was no data collected on three (3) of them – shelter, information and food. Of the other four (4) – sanitation, water, education and health –

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the highest frequency of “severe” deprivation was estimated for health, 9%, followed by water, 5%. No Jamaican children were reported to be severely deprived of education, and only a marginal 1% was severely deprived of sanitation. **Table 2.1.4c** compares these four deprivations with corresponding estimates for the region of Latin America and the Caribbean.

**Table 2.1.4c: Severe Deprivation,%
Jamaica vs Latin America and the Caribbean**

Severe Deprivation	Latin America and the Caribbean			Jamaica
	Rural	Urban	Total	
Sanitation	41	6	17	1
Water	20	1	7	5
Education	7	2	3	0
Health	11	4	7	9

Source: MICS, 2005; Gordon et al 2003

Jamaica compares well with the wider region with regard to severe deprivations in these four services, with health services being relatively less accessible to the children than even the region as a whole.

For “less severe” deprivation, the reported frequencies were significantly higher, with health deprivation again being the highest at 22%, followed by water at 8%, education at 6%, and sanitation at 3%.

The Statistical Template for this study proposes that **Table 2.1.5** present comparative data for “2005 or latest since 2000” with the “Last available [data] between 1990 and 1995”. This is not possible for the Jamaica study since the MICS collected data for 2005 only. *Accordingly, this study has no data for Table 2.1.5*

Table 2.1.6 presents correlates of severe deprivation by individual age group and gender, household size and headship, and geographic location. It is clear that the frequency of more than one severe deprivation is marginal.

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Table 2.1.6 Correlates of severe child deprivations (by individual, households and geographic dimensions in 2005)

		At least one severe deprivation		At least two severe deprivations		Number of Children in sample
		Number	%	Number	%	Number
Age group by sex	Male, 0-2 years	69	16			431
	Male, 3-4 years	34	12	2	1	290
	Male, 5-9 years	46	6			820
	Male, 10-14 years	54	6			902
	Male, 15-17 years	28	5			528
	Female, 0-2 years	52	12	2	0	431
	Female, 3-4 years	51	17	2	1	293
	Female, 5-9 years	58	7	0	0	787
	Female, 10-14 years	52	6			867
	Female, 15-17 years	25	6			426
Household size	< 3 members	12	6			207
	3-4 members	101	5	2	0	1,885
	5-6 members	141	7			1,965
	7+	215	13	4	0	1,718
Education level of head of household	No education	12	21			55
	Primary	112	9			1,233
	Secondary+	331	8	6	0	4,382
	Non standard	7	15	1	1	49
Sex of Head of Household	Male	250	9	4	0	2,800
	Female	219	7	2	0	2,975
Wealth index quintiles	No data	No data	No data	No data	No data	No data
Ethnicity/Religion/Language	not applicable					

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Table 2.1.6 Correlates of severe child deprivations (by individual, households and geographic dimensions in 2005)

		At least one severe deprivation		At least two severe deprivations		Number of Children in sample
		Number	%	Number	%	Number
Adult of primary working age in household	No	10	6			165
	Yes	460	8	6	0	5,609
Working child in household	No	375	8	4	0	4,482
	Yes	45	8	2	0	537
Adult(s) with chronic illness in household	No	425	8	6	0	5,301
	Yes	39	11			355
Child living with disability ¹⁰⁴ in household	No	299	8	5	0	3,567
	Yes	92	12	1	0	799
Single parent (adult) household	No	403	8	4	0	4,865
	Yes	67	7	2	0	910
Orphan child in household	No	428	8	6	0	5,252
	Yes	36	7			486
High dependency ratio (4+ children per adult)	No	423	8	2	0	5,551
	Yes	47	21	4	2	218
Elder person (70+) in household	No	405	8	6	0	5,101
	Yes	65	10			674

¹⁰⁴ This term has been adopted in preference to "disabled child".

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Table 2.1.6 Correlates of severe child deprivations (by individual, households and geographic dimensions in 2005)

		At least one severe deprivation		At least two severe deprivations		Number of Children in sample
		Number	%	Number	%	Number
Region	KMA ¹⁰⁵	74	4	2	0	1,816
	Urban	69	5			1,426
	Rural	326	13	4	0	2,533
Residence	Urban	143	4	2	0	3,242
	Rural	326	13	4	0	2,533
Total		469	8	6	0	5,775

Source: MICS, 2005

Gordon et al posited two or more deprivations as the definition of absolute child poverty. It is clear that the MICS does not point to absolute child poverty in this sense in Jamaica.

- In the case of one deprivation, it is the youngest children 0 – 4 years, male and female, who have the highest frequency of a severe deprivation. Curiously, the order of the frequency by the two youngest age groups is almost exactly reversed for males and females, with males 0 – 2 years and females 3 – 4 years having the highest frequencies, 16% and 17% respectively. For both genders, the frequency of one severe deprivation declines sharply as the ages of the age groups increase.
- The frequency of a child with one severe deprivation differs marginally among households with less than 6 members, but is approximately double at 13% the frequency for households with 7 or more members.
- It is also quite high, 21%, in households with 4 or more children per adult.
- On the other hand, the frequency of severe deprivation varies inversely with the level of education of the head of household, as high a 21% for heads with no education, and as low as 8% for heads with secondary education or higher.
- **Table 2.1.6** also shows correlates of a child with one severe deprivation and several other household characteristics. The most significant differences in the frequency of having a

¹⁰⁵ The KMA in the MICS did not include Spanish Town and Portmore, two major population centres normally included in the definition of the KMA.

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child with one severe deprivation is between households with chronic illness in the household (11%) and households without this condition (8%), and between households with a disabled child (12%) and those without (8%).

- A child with one severe deprivation is marginally more likely to occur in male headed households (9%) than in female headed households (7%).
- Finally, rural households (13%) are more than three times likely to have a child with one severe deprivation than urban households (4%).

In **Table 2.1.7**, the odds ratios for a child having “not even a less severe deprivation” and “at least one severe deprivation” are listed for children of various ages, both genders, and the various social stratifiers that have been used in the previous tables.

Table 2.1.7 Odds ratios for the probability that children will or will not experience deprivations, 2005		
	Odds ratio of child having	
	not even 'less severe' deprivations	at least one 'severe' deprivation
Individual dimension		
Sex and age		
Male, 0-2 years	<i>0.91</i>	3.04
Male, 3-4 years	0.63	2.14
Male, 5-9 years	3.01	<i>0.96</i>
Male, 10-14 years	3.07	<i>1.03</i>
Male, 15-17 years	<i>0.96</i>	<i>0.88</i>
Female, 0-2 years	<i>1.29</i>	2.21
Female, 3-4 years	0.50	3.35
Female, 5-9 years	2.70	<i>1.28</i>
Female, 10-14 years	3.30	<i>1.02</i>
Female, 15-17 years (Ref)	1.00	1.00
Household dimension		
Household size		
Less than 3 (Ref)	1.00	1.00
3-4 members	<i>1.06</i>	<i>0.95</i>
5-6 members	<i>0.99</i>	<i>1.30</i>
7+	0.67	2.39
Education of Head of Household		

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Table 2.1.7 Odds ratios for the probability that children will or will not experience deprivations, 2005		
	Odds ratio of child having	
	not even 'less severe' deprivations	at least one 'severe' deprivation
No education	<i>0.74</i>	3.25
Primary	<i>0.98</i>	<i>1.23</i>
Non standard	<i>1.03</i>	<i>2.09</i>
Secondary+ (Ref)	1.00	1.00
Gender of the head of the household		
Male (Ref)	1.00	1.00
Female	1.22	0.81
Wealth index quintiles		
Q1 (poorest)	No data	No data
Q2	No data	No data
Q3	No data	No data
Q4	No data	No data
Q5 (Ref)	No data	No data
Ethnicity/Language/Religion	n.a.	n.a.
Work (among households with children)		
Both parents working	No data	No data
None of the parents are working	No data	No data
No adult in primary working age (18-54)	<i>1.46</i>	<i>0.70</i>
At least one child under 15 working	<i>0.88</i>	<i>1.00</i>
Illness and disability in the household		
Adult(s) with chronic illness	<i>0.83</i>	<i>1.41</i>
Child/children with disability	0.75	1.42
Family vulnerability (not mutually exclusive categories)		
Single parent	<i>0.98</i>	<i>0.88</i>
Orphan child in household	<i>1.06</i>	<i>0.90</i>
High dependency ratio (4+children per adult)	0.42	3.28
Elder (70+) person in household	<i>0.95</i>	<i>1.23</i>
Geographic dimension		
Region		
KMA (Ref)	1.00	1.00
Urban	<i>0.83</i>	<i>1.19</i>
Rural	0.43	3.48
Residence		

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Table 2.1.7 Odds ratios for the probability that children will or will not experience deprivations, 2005		
	Odds ratio of child having	
	not even 'less severe' deprivations	at least one 'severe' deprivation
Urban (Ref)	1.00	1.00
Rural	0.47	3.21

Source: MICS, 2005

We summarize the highlights of **Table 2.1.7** below:

- The odds of having at least one severe deprivation were greater than the odds of having “not even a less severe deprivation” for children of both sexes less than 4 years old. The converse was true for children of all ages, 5 years and above; that is, the odds of having at least one severe deprivation were less than the odds of not even a less severe deprivation.
- For the age group, 0 – 2 years, the odds of males (0.91) having not even a less severe deprivation were less than females (1.29), and the odds of males having at least one severe deprivation (3.04) were greater than for females (2.21).
- For the age group, 3 – 4 years, the order of magnitude for the genders was reversed. That is, males were more likely (with odds of 0.63) than females (0.50) of not having even a less severe deprivation, and less likely (with odds of 2.14) than females (3.35) of having at least one severe deprivation. The reason for this apparent reversal of vulnerability to poverty is not apparent.
- As the ages increase, the differences between the sexes for each age group get smaller, and even disappear in some instances. The age groups with the highest odds of not having even a less severe deprivation are 5 -9 years and 10 – 14 years. Correspondingly, these age groups are less vulnerable to severe deprivation than the younger age groups. The oldest male group, 15 – 17 years, was the least vulnerable to severe deprivation, with males being less vulnerable than their female counterpart which was the reference group.
- Using a household of less than 3 members as the reference, the data indicate that as household size increases the odds of not even a less severe deprivation declines, and the odds of at least one severe deprivation increases.

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- Using household heads with at least secondary education as the reference with odds of 1.0, it is clear that the odds of children having not even a less severe deprivation are least for heads of household with no education, and highest for having at least one severe deprivation.
- The data also indicate that the odds of children having at least one severe deprivation is greater in male-headed households. This appears to contradict a common perception of female-headed households being relatively more vulnerable to poverty.
- Not surprisingly, the children in rural residences were more likely to be vulnerable to at least one severe deprivation than children in urban areas.

The MICS obtained data on four deprivations. **Table 2.1.8** profiles these by region, primarily urban versus rural, but also for the Kingston Metropolitan Area (KMA), which is the largest of the urban centres in Jamaica. Again, the two significant deprivations are water and health. In the case of water, the frequency of a child being deprived of water is more than three times as great in the rural areas (10%) than in urban areas (3%), and twice the national average (5%). In a water-surplus country, this is a consequence of inadequate supply/delivery facilities rather than lack of production.

Table 2.1.8 Prevalence of severe deprivations by region and residence								
		Shelter	Sanitation	Water	Information	Food	Education	Health
		%	%	%	%	%	%	%
Region	KMA	No data	1			No data	0	12
	Urban	No data	1	3	No data	No data	0	5
	Rural	No data	1	10	No data	No data	0	8
Residence	Urban	No data	1	1	No data	No data	0	9
	Rural	No data	1	10	No data	No data	0	8
National average		No data	1	5	No data	No data	0	9

Source: MICS, 2005

In the case of health, the largest frequency of child deprivation occurs in the KMA (12%). The rate for the other urban areas (5%) is less than half the rate for the KMA, and less than the rate for the rural communities (8%), which is marginally less than the national average of 9%. It is difficult to understand why it was more likely that in the KMA, with the most facilities and the

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best medical services nationally, children would be more likely not to be immunized against any diseases, nor to receive treatment for a recent illness involving an acute respiratory infection or diarrhoea.

The MICS report found marginally positive and negative correlations among the deprivations of sanitation, water, education and health – see **Table 2.1.9**.

	Two or more deprivations	First four deprivations (S,S,W,I)	Last three deprivations (F,E,H)	Sanitation	Water	Education	Health
Two or more deprivations	1.00	0.13	0.20	0.16	0.09	0.00	0.20
First four deprivations (S,S,W,I)	0.13	1.00	-0.01	0.37	0.92	-0.01	-0.01
Last three deprivations (F,E,H)	0.20	-0.01	1.00	0.01	-0.02	0.21	0.98
Sanitation	0.16	0.37	0.01	1.00	-0.02	0.00	0.02
Water	0.09	0.92	-0.02	-0.02	1.00	-0.01	-0.02
Education	0.00	-0.01	0.21	0.00	-0.01	1.00	0.00
Health	0.20	-0.01	0.98	0.02	-0.02	0.00	1.00

Source: MICS, 2005

There was a small positive correlation (0.20) between severe health deprivation and a child experiencing two or more deprivations, and even smaller correlations between deprivation of sanitation (0.16) and deprivation of water (0.09) and a child experiencing two or more deprivations. In contrast, there was no correlation between being severely deprived of education and “two or more deprivations.”

Table 2.1.10 compares children living in households under the 1US\$ day/person line with children who are experiencing some degree of deprivation in households who live above the 1US\$ day/person line.

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Table 2.1.10 - Combined child poverty incidence

	% of children in the relevant category		
	Who live in households under the 1US\$ day/person ppp-s threshold	Who are experiencing severe deprivation of human need	Who are experiencing less severe deprivation of human need
		while their households live above the 1US\$ day/person ppp-s threshold	
All children (0 - 17)	2.0		No data
Individual Dimension			
<i>Sex & Age</i>			
Male			
0 - 2	2.0	16.0	No data
3 - 4	2.8	12.0	No data
5 - 9	2.4	6.0	No data
10 - 14	1.7	6.0	No data
15 - 17	1.8	5.0	No data
Female			
0 - 2	1.2	12.0	No data
3 - 4	1.7	17.0	No data
5 - 9	2.9	7.0	No data
10 - 14	1.9	6.0	No data
15 - 17	1.4	6.0	No data
Household Dimension			
<i>Household Size</i>			
less than 3	0.0	6.0	No data
3 - 4 members	1.7	5.0	No data
5 - 6 members	1.6	7.0	No data
7+ members	2.6	13.0	No data

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Table 2.1.10 - Combined child poverty incidence

	% of children in the relevant category		
	Who live in households under the 1US\$ day/person ppp-s threshold	Who are experiencing severe deprivation of human need	Who are experiencing less severe deprivation of human need
		while their households live above the 1US\$ day/person ppp-s threshold	
Women's Education			
None	1.0	21.0	No data
Primary	1.6	9.0	No data
Secondary +	1.2	8.0	No data
Gender of the head of household			
Male	1.2	9.0	No data
Female	2.0	7.0	No data
Wealth Index Quintile			
Q1	8.4	No data	No data
Q2	0.7	No data	No data
Q3	0.0	No data	No data
Q4	0.0	No data	No data
Q5	0.0	No data	No data
Work (among households with Children)			
Both parents working	0.0	No data	No data
None of the parents working	4.2	No data	No data
No adult in primary working age (18 - 54)	3.2	6.0	No data
At least one child under 15 working	0.0	8.0	No data
Illness and Disability in the household			
Adult(s) with chronic illness	1.2	No data	No data
Child/Children with disability	Not available	11.0	No data
		12.0	No data
Family Vulnerability			
Single Parent	1.5	7.0	No data
Orphan child in household	Not available	7.0	No data
High Dependency ratio (4+ children/adult)	3.8	21.0	No data
Elder (70+) person in household	6.4	10.0	No data

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Table 2.1.10 - Combined child poverty incidence

	% of children in the relevant category		
	Who live in households under the 1US\$ day/person ppp-s threshold	Who are experiencing severe deprivation of human need	Who are experiencing less severe deprivation of human need
		while their households live above the 1US\$ day/person ppp-s threshold	
Geographic Dimension			
<i>Region</i>			
Kingston	5.3	No data	No data
St. Andrew	3.6	No data	No data
St. Thomas	6.7	No data	No data
Portland	12.0	No data	No data
St. Mary	4.0	No data	No data
St. Ann	7.0	No data	No data
Trelawny	9.3	No data	No data
St. James	2.6	No data	No data
Hanover	3.0	No data	No data
Westmoreland	5.2	No data	No data
St. Elizabeth	6.6	No data	No data
Manchester	5.6	No data	No data
Clarendon	6.8	No data	No data
St. Catherine	1.8	No data	No data
<i>Residence</i>			
Urban	0.9	4.0	No data
Rural	3.1	13.0	No data

Data Sources:

Column 2 – JSLC 2006 Dataset

Column 3 – MICS, 2005 Dataset

Notes:

International poverty line calculated using \$1US/day as advised by PIOJ

Column 4 – Information cannot be calculated from given information

- Estimates of the percentage of children living in households below the 1US\$ day/person were based on the JSLC 2006 dataset, and estimates of the children experiencing on severe

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deprivation while living in households that live above the 1US\$day/person line were based on the MICS.

- The percentage of children living below the 1US\$ day/person line are low for all age groups of children, with the frequency of females being marginally lower than for males in the two youngest groups.
- Indeed, the frequencies are low for all the social stratifiers, with the highest ones being 8.4% for children in quintile 1 of the household wealth index and 6.4% for households with an elderly person, 70+ years old.
- In the case of children with one severe deprivation, it is clear that the frequencies are greatest for the youngest age groups. Whereas the frequency of having one severe deprivation for males less than 2 years old is significantly higher than for females of the same age group, the order is reversed and the difference in magnitude is comparable for females of the age group 3-4 years when compared to their male peers.
- The frequency of children with one severe deprivation increases with household sizes greater than 3 persons. Earlier results have suggested that the odds of children being poor increases with household size.
- The estimates suggest that the frequency of children with one severe deprivation is twice as high when women¹⁰⁶ have no education, compared with those with at least primary education.
- The difference between the frequency of children in male-headed households and female-headed households was small, with children in male-headed households being marginally more likely to have one severe deprivation.
- The highest frequency, 21%, was reported for the “High Dependency Ratio” of 4+ children per adult in a household.
- Finally, the frequency for rural children is more than three (3) times the frequency for urban children, but is still moderate to small at 13%.

Table 2.1.11a reviews the number of children in public care, private homes and adopted.

Table 2.1.11a - Children in Public Care or Adopted

¹⁰⁶ It is not clear why this table uses “women’s education” instead of the “education level of the head of household” as in previous tables. Nor is it clear what role the women whose education is reported plays in the household.

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	1990	1995	2000	2005
Total number of children in public care				
of which: children in public institutional care of which:				
Government places of safety	371	466	No data	440
Government children's home	347	220	No data	176
Total number of children in private care of which:				
Private place of safety	146	114	No data	136
Private children's home	1064	1671	No data	1748
of which in foster care or similar arrangements	No data	No data	947	1121
Total number of children adopted	381	328	709	1037
of which: international adoption	28	25	24	42

Data Sources:

Economic and Social Survey of Jamaica (ESSJ), PIOJ, various years

These are children who do not live in a traditional household with family members related by blood, and at least one parent or grandparent. In this sense, these children may be deprived, but we must recognize that in some instances, the conditions of life for these children may be better than in their traditional homes for one reason or another. Also, the data does not account for the quality of life that the children in government and private “places of safety” and homes enjoy.

It is clear that between 1990 and 2005:

- The number of children in government “places of safety” has increased by 18.5% between 1990 and 2005, and the number in government homes for children have declined by more than 50%
- The number of children in private places of safety has also changed very little, but the number in children’s homes rose by 57% between 1990 and 1995, and by 4.6% between 1995 and 2005
- The number of children adopted declined between 1990 and 1995, and then more than doubled between 1995 and 2000. Between 2000 and 2005, the numbers grew by 46% over 2000. International adoptions were actually declining between 1990 and 2000, and then rose sharply in the last 5 years to 2005. However, the numbers are still quite small.

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The other category of children, who are not captured in household surveys, is children who live on the street. Reference is made to this group below.

Deprivation on the criteria adapted to Jamaica

As **Table 2.1.4a** shows that this study is proposing to adapt the Bristol Study's indicators for use in the analysis of child poverty in Jamaica as follows:

- Ignore Food Deprivation because there is no data to measure it. Neither the MICS nor the JSLC collected data on food deprivation.
- Include “standpipes” as a source for assessing less severe water deprivation.
- Include the “regular use of buckets” in the criteria for severe deprivation of sanitation facilities
- Change the criteria of severe shelter deprivation to homelessness, or habitation of dwellings without electricity and/or water and/or floors, and change the criterion of less severe shelter deprivation to habitation of rooms with four (4) or more persons per room. This latter number is midway between the number five (5), stipulated for severe shelter deprivation, and the number, three (3), stipulated for less severe shelter deprivation.
- Change the criteria for severe educational deprivation to embrace children from four (4) years old, and to focus on the failure to complete primary school. This includes non-attendance. Similarly, for less severe educational deprivation, the age group covered is 12 – 17 years, and the criterion is failure to complete secondary school. These adaptations seem more appropriate for Jamaica where enrolment ratios have long been very high – more than 90% - at the primary and secondary level
- Change severe information deprivation to include access to the Internet instead of possession of a computer, and change less severe information deprivation to access to at least one of the listed media, but not all.

There are other aspects of childhood in Jamaica that warrant attention in a study that seeks to profile child poverty. **Table 2.1.11b** below lists services and conditions that are important to child development, and proposes indicators for identifying children who are deprived in any of these services and conditions.

Table 2.1.11b: Additional Indicators of Child Deprivation for Jamaica

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Type of Service/Condition for child development	Rationale	Indicators
Security	In recent years, there has been increasing international attention to security as an essential element to human development ¹⁰⁷ . This concern is particularly strong in Jamaica where the risks of violence to children recurs regularly in public discussion and has prompted a senior researcher to conduct a study.	<p>Security Deprivation:</p> <p><i>Severe:</i> children who have experienced violent crime as victims or perpetrators</p> <p><i>Less Severe:</i> children who have experienced household violence, not necessarily criminal</p>
Environment	Two aspects of the environment of the child that impacts on the quality of life are the <i>conditions of transportation</i> and the <i>accessibility of solid waste disposal services</i> . These two aspects of the child's environment pose substantial risks to the health and well-being of the child, and therefore the quality of life	<p>Environmental Deprivation:</p> <p><i>Severe:</i> children who have been in motor vehicle accidents that caused personal injury, or live in dwellings that lack access to solid waste disposal services</p> <p><i>Less Severe:</i> children who have been in motor vehicle accidents that did not cause personal injury, or live in dwellings that have irregular access to solid waste disposal services</p>
Family Life	Several definitions of child poverty insist on addressing the spiritual and cultural needs of the child. The family is the primary institution for the satisfaction of these needs.	<p>Family Life Deprivation:</p> <p><i>Severe:</i> children whose parents share 3 or less of a selected list of family activities. The list is reproduced below</p> <p><i>Less Severe:</i> children whose parents share 4 or 5 of a selected list of family activities.</p>

These additional services and conditions for child development are included¹⁰⁸ in all the attempts for a comprehensive listing of deprivations that ought to be accounted for in an expanded notion of child poverty. They have been selected for inclusion in the list of deprivations for Jamaica because of the availability of data to measure the indicators

Table 2.1.4a proposes adaptations of the criteria for severe and less severe deprivation as used in the Bristol study, and **Table 2.1. 11b** proposes additional indicators of child deprivation that are particularly relevant to Jamaica. Estimates of the frequency of deprivation on the basis of the

¹⁰⁷ UNDP, HDR, 1994, P25

¹⁰⁸ See "Child Poverty – Meaning and Measurement", which is a companion document to this one.

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adapted criteria are compared with the estimates based on the criteria used in the Bristol study are shown in **Table 2.1.11c**.

Table 2.1.11c: Comparison of Frequency of Deprivations: Bristol vs Adaptations for Jamaica

Jamaica	Bristol	Adapted to Jamaica	Number of children in relevant age cohort - from population	Bristol	Adapted to Jamaica	Bristol	Adapted to Jamaica
	Number of children in relevant age cohort - from sample	Number of children in relevant age cohort - from sample		Of which experiencing 'severe' deprivation, %		Of which experiencing 'less severe' deprivation, %	
a) Incidence (prevalence) of deprivation							
1. Shelter	5,775	No data	940,154	No data	No data	No data	No data
2. Sanitation	5,775	5,813 ¹⁰⁹	940,154	1	0.9	3	41.6
3. Water	5,775	5,813	940,154	5	0.0	8	0.3
4. Information	5,775		940,154	No data	No data	No data	No data
5. Food	1,445		940,154	No data	No data	No data	No data
6. Education	3,707	5,813	940,154	0	8.7	6	2.5
7. Health	1,445		940,154	9	No change to definition	22	No change to definition
Total	5,775						

The differences are clear to see. Under the adapted criteria:

- The frequency of less severe deprivation of sanitation is much greater (41.6%) than on the Bristol criterion (3%)
- The frequency of severe deprivation of water is 0% compared to 5% on the Bristol criterion, and the frequency of the less severe deprivation of water is much less (0.3%) on the adapted criterion than on the Bristol criterion (8%)

¹⁰⁹ The number of children is bigger than reported by the MICS.

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- The frequency of severe deprivation of education is much greater (8.7%) compared to 0% on the Bristol criterion, but the frequency of less severe deprivation was less (2.5%) than on the Bristol criterion (6%).

Deprivation on the additional criteria relevant to Jamaica

Security Deprivation

The Economic and Social Survey, 2006, reported the following data on children as offenders and victims of selected major crimes.

Table 2.1.12a: Children as Offenders and Victims of Selected Major Crimes

Age Group	Murder			Shooting			Robbery			Breaking and entering			Rape	Carnal Abuse	Grand Total
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	
Children as Offenders															
12-14	4	0	4	0	0	0	3	0	3	18	1	19	1	7	34
14-18	78	0	78	82	0	82	100	2	102	86	0	86	60	41	449
Children as Victims															
	Murder			Shooting			Robbery			Breaking and entering			Rape	Carnal Abuse	Grand Total
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Female	Female	
0-13	80	16	96	68	10	78	75	40	115	6	17	23	413	434	1159
15-18	69	10	79	54	5	59	75	30	105	6	13	19	204	134	600

Source: Adapted from ESSJ, 2006, P.24.8, Tables 24.9 and 24.10

It is clear that males are overwhelmingly the youth offenders, and also to a lesser degree, the victims of selected crimes. Note that all of the selected crimes are violent, with perhaps the exception of “Breaking and Entering”. On the other hand, females were overwhelmingly the victims of rape and carnal abuse Data¹¹⁰ from Accident and Emergency Departments of Public Hospitals also indicate that the rape of females is reported more than six (6) times greater than reports of the rape of males.

These data are likely to be underestimates for the well-known reasons of underreporting¹¹¹, which means that the deprivation of security for children which they indicate is probably higher.

¹¹⁰ Ministry of Health, Annual Report, 2006, Table 6.14, p.109

¹¹¹ There are indications that the rape of males is severely underreported.

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The Ministry of Health tallied and analyzed “Violence Related Injuries” as reported in the Accident and Emergency Departments of most government hospitals¹¹². The two youngest age groups in the report were 0 – 10 years and 10 – 19 years.

Table 2.1.12b: Children Injured by Violence as reported to selected hospitals

Age	Gender						Circumstances of Injury	
	Male		Female		Total		Child abuse	Sexual Assault
	n	%	N	%	N	%	%	%
Under 10	310	3.7	224	3.9	534	3.8	49.7	17.6
10-19	1803	21.6	1726	29.7	3529	24.9	50.0	57.3

Source: Ministry of Health, *Violence Related Injuries, 2007*, Table 1 and Figure 3

There was hardly any difference between males and females under 10 years in their relative shares of injury from violence toward their respective genders. On the other hand, the 10 – 19 year old females accounted for a large share (29.7%) of all females than the 10 – 19 year old males (21.6%) did of all males. Overall, almost 25% of all injuries from violence were inflicted on 10 – 19 year olds.

The two main circumstances in which the injuries were received were classified broadly as child “abuse” and “sexual assault”. As **Table 2.1.12b** shows, the share of injuries received was even across age groups – 49.7% for 0 – 10 year olds and 50.0% for 10 – 19 year olds. In the case of sexual assault, the frequency of victims in the older age group (57.3%) was more than three times the frequency for the younger (17.6%). Both of these circumstances tended to occur in the home. Whereas “the main perpetrators of robberies/burglaries and sexual assaults were strangers (approx. 73% and 39% respectively), relatives were the main persons responsible for child abuse and accounted for (67%)”¹¹³

Environmental Deprivation

It is proposed to use injury in road accidents and lack of access to solid waste disposal services as indicators¹¹⁴ of environmental deprivation.

¹¹² Bustamante, Cornwall Regional, Kingston Public, Mandeville, May Pen, Savanna La Mar, Annotto Bay and Spanish Town

¹¹³ Ministry of Health, *Violence --*, Table 5

¹¹⁴ Other indicators, such as the frequency of respiratory infections, suggest themselves.

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Lack of Road Safety

Table 2.1.13 shows the numbers of children, 14 years and younger, and the numbers of young people in the age group 15 – 19 involved in traffic crashes for the period 2004 to 2008 by gender. Again, it is likely that these estimates are low because of underreporting.

Table 2.1.13: Accident Fatalities by Age Group and Gender

Age group	2004		2005		2006		2007		2008	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Not known	11	2	13	1	24	4	15	5	24	1
0-4	1	0	3	0	2	0	3	0	0	1
05-09	4	2	4	2	5	6	3	1	5	4
10-14	5	2	4	6	5	1	2	3	1	1
15-19	5	2	6	1	9	3	5	1	6	7
20-24	12	3	12	0	7	5	15	3	16	5
25-29	9	1	10	3	17	1	12	3	15	1
30-34	15	4	8	4	14	4	14	1	12	4
35-39	14	0	14	2	9	1	15	2	16	3
40-44	6	5	8	3	16	4	15	1	7	3
45-49	8	1	3	1	8	1	5	2	7	2
50-54	9	2	4	2	7	1	7	2	6	2
55-59	3	1	4	1	2	3	7	1	3	3
60 and over	28	11	20	9	15	7	26	3	13	5
Total	130	36	113	35	140	41	144	28	131	42

Source: Adapted from Table 6, P.4, “*Traffic Crash Report, June 2009*”, Ministry of Transport

The reported data show that the accident rate was lowest in 2005 for the period under review, and for all years the frequency of total male fatalities was 3-4 times the rate for females.

However for children, including the age group 15-19, the difference between the rate of fatalities of males and females is much smaller, and in 2008, there were more female fatalities among children than males.

Table 2.1.14 shows the total frequency of children being involved in traffic crashes by gender is fairly even with male victims being marginally greater in number. There were, however, significant differences in the categories of victims. Males were much more likely to be pedestrian victims than females, whereas females were more likely to be passenger victims. The study also notes that most crashes involving children occurred during school days.

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Table 2.1.14: Children involved in traffic crashes¹¹⁵ by category of road user and gender, 2007

Category	Gender		
	Male	Female	Total
Pedestrian	51	36	87
Passenger	45	66	111
Pedal cyclist	11	1	12
Pillion	3	2	5
Total	110	105	215

Source: *Movements ---, 2007, Table 2, P.7*

Lack of Access to Solid Waste Disposal Services

The JSLC in 2006 reported the distribution of garbage disposal services (to all households) as shown in **Table 2.1.15** below. It was reported that 44.7% of households have no access to garbage disposal services, and have to burn, dump, bury or some other non-specified means of disposal.

Table 2.1.15: Access to Garbage Disposal Services

Method of Disposal	Percentage
Collected by Garbage Truck	51.6
Burn	41.6
Place in Skip	3.5
Dump (empty lot or gully)	2.3
Bury	0.6
Other (not specified)	0.2

Source: JSLC, 2006

Children in these households are deprived of garbage disposal services, and in this sense are severely environmentally deprived. Less severe environmental deprivation – irregular garbage

¹¹⁵ Hospital records report larger numbers of injuries from accidents, with the same pattern of male injuries exceeding female injuries for children under 9 years old. Published reports, however, do not allow for the breakout of children from young adults

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services – applies to households that dispose of their waste in skips on the side of the road which are emptied from time to time by trucks.

Family Life Deprivation

The JSLC 2004 collected data on family life. One question in particular, sought responses on a list of activities that parents shared with their children. In particular, the question was:

“In the past month, did you or any other adult family member do any of the following with any of your children? (multiple answers allowed)

- Read books or look at picture books with child
- Tell stories to a child
- Sing songs with child
- Play games/play with child
- Take child out
- Spend time with child in learning activities (eg drawing, painting, helping with school work)
- Do household chores with child (eg cooking, caring for animals)
- Teach child about spiritual/religious practices, ethical or moral”

This study proposes that the criterion for severe deprivation be three (3) or less activities on the above list checked, and that the criterion for less severe deprivation be four (4) or five (5) activities checked. By these criteria, 89% of children were severely deprived of family life and 7% were less severely deprived.

Table 2.1.16: Activities Parents share with children

Number of Activities	Percentage
0	76.3
1-3	12.7
4	4.2
5	2.8
6 or more	4.0

Source: JSLC, 2004

2.3. Child Survival and Equity

The MICS¹¹⁶ estimated the under five mortality rate (U5MR) for males and females in 2005 to be 33 and 30 per 1000 live births respectively. Pan American Health Organization (PAHO)¹¹⁷ reports only the U5MR for 2000 and 2005 for both sexes to be 19.3 and 17.9 per 1000 live births respectively. The magnitude of the difference between the estimates raises questions about the methodologies of both sources.

There are no estimates of the U5MR for gender and wealth quintile as required by **Table 2.2.1** of the UNICEF Guidelines. Nor are there estimates for any year for parishes, or for any other sub-region of the island of Jamaica. Accordingly, it is not possible to correlate the number of people under the household consumption poverty threshold at either the parish or any sub-regional level as required by **Table 2.2.3** in the UNICEF Guidelines for this study.

¹¹⁶ Table CM.1, P.50

¹¹⁷ PAHO web site

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2.4. Causal Analysis: factors explaining the levels and trends in poverty

Jamaica has an exceptionally long series of 18 years of annual estimates of the incidence of poverty. The poverty line has been based on the market value of a basket of food that provides the minimum recommended dietary allowances estimated by the WHO and the share of food in expenditure of households in the lowest two quintiles of consumption expenditures as reported by the JSLC. The relative numbers of children who consume less in value terms than the poverty line has consistently been higher than the frequency for individuals as a whole. It is also true that the households with children are more likely to be poor than households with no children.

The percentage of individuals in poverty has been in secular decline since it peaked in 1991, for all sections of the population.

Ultimately, poverty measured in terms of the level of consumption is explained by insufficient production and, hence income, coupled with a skewed distribution of national income. The data collected by the MICS identified several factors that determine who is poor. As shown above, the incidence of poverty is highest for the youngest and the oldest age groups for both sexes.

Further, the frequency varies directly with household size, and inversely with the level of education of the head of the household. The probability of being poor is much higher for rural households and their members than for their urban counterparts. Gender differences of individuals and household heads are small to marginal determinants of the incidence of poverty. The poverty gap as measured by the consumption shortfall as a percentage of the poverty line varies with all of the factors that determine the percentage of the population in poverty, but the variation is much less than the percentage that are poor.

This study seeks to extend the concept of child poverty to include deprivation in access to several services and conditions deemed essential to the development of the child and to which children have rights. The MICS was able to collect data on the percentage of children who were deprived of sanitation, water, education and health. By the criteria for severe deprivation used by the Bristol study, a relatively small number of Jamaican children were severely deprived of water (5%), and health (9%) services. The frequency of “less severe” deprivation was a little higher for the same two services. On the other hand, the number of children who were severely deprived of two or more services was insignificant.

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It is proposed to extend the consideration of deprivations to children who are deprived of security, positive/healthy environmental services, Family Life and freedom from work. Together with the criteria for “severe” and “less severe” deprivation adopted from the Bristol study and adapted to Jamaica, these additional services and conditions will further broaden the concept of child poverty and make it more relevant to Jamaica.

3. The Pillars of Child Well Being

3.1 Nutrition

3.1.1. National Laws, policies and key programmes

The National Infant and Young Child Feeding Policy (1995) was adopted to reduce morbidity and mortality rates among children and was intended to “serve as a reference guide for the promotion, protection and support of breastfeeding and safe and adequate weaning practices throughout Jamaica.” [see **Table 1 in Appendix**] The policy seeks to promote breastfeeding exclusively for the first six (6) months of a child’s life, and complement breast milk with other foods for the subsequent period of 6 months to 2 years old. The basis for this is conclusive scientific evidence that the mental development of children who are exclusively breast-fed is better than those who are not, as well as the endorsement of breast-feeding as the optimal nutritional strategy by the WHO and UNICEF.

The National Breastfeeding Programme is the immediate and direct embodiment of the Infant and Young Child Feeding Policy. However, there are several other programmes designed to address some aspect of child nutrition:

- The National School Feeding Programme was designed to “encourage regular school attendance and to provide nutritional support to the most vulnerable students attending public institutions.”¹¹⁸ The programme has two components. The Nutri-bun component produces and distributes nutribun snacks for 136,000 students island-wide. The Cooked Lunch component provides a feeding grant and commodities to public schools at all levels from infant schools to high schools.
- The concern for the nutrition of children is also part of the rationale for the cash transfer programme, PATH, which provides benefits conditional upon attendance at school and at health clinics. The Ministry of Labour and social Security (MLSS) which administers PATH also has a small School feeding programme that is charged with receiving and administering Food Aid received by the Government of Jamaica.

¹¹⁸ Estimates of Expenditure, 2009-2010, P. 4100-58

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- The Roving Caregivers programme (RCP) is executed by an NGO and seeks to address child-rearing knowledge and practices of parents of children 0 – 4 years old through home visits in three rural parishes by teams of trained persons. Two of the main objectives are the health and nutrition of children. The programme also addresses the “self-esteem and child rearing knowledge and practices of the parents, as well as – assist[s] with income-generating activities for families.”

3.1.2. Child outcomes, disparities, and gender inequality

Table 3.1.1 summarizes child nutrition outcome and its correlates, according to the set of social stratifiers used throughout this study. The estimates were based on data collected in the JSLC of 2002 and 2006.

Table 3.1.1 - Child nutrition outcome and its correlates (by individual, household and geographic dimensions), % Repeat headings where table breaks

	Stunting	Wasting	Underweight
Total Frequency	2.2	0.3	0.9
Individual Dimension			
<i>Sex & Age</i>			
Male			
0 - 3 months	0.0	0.0	0.0
4 - 6 months	11.1	0.0	0.0
7 - 12 months	0.0	2.3	2.3
13 - 23 months	4.0	0.0	0.0
24 - 35 months	1.4	0.0	1.4
36 months +	1.7	0.0	0.8
Female			
0 - 3 months	0.0	0.0	0.0
4 - 6 months	0.0	0.0	14.3
7 - 12 months	3.7	0.0	0.0
13 - 23 months	4.9	0.0	0.0
24 - 35 months	2.9	1.5	1.5
36 months +	1.6	0.0	0.0
Household Dimension			

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Table 3.1.1 - Child nutrition outcome and its correlates (by individual, household and geographic dimensions), % Repeat headings where table breaks

	Stunting	Wasting	Underweight
<i>Household Size</i>			
less than 3	0.0	0.0	0.0
3 - 4 members	3.0	0.6	1.8
5 - 6 members	1.9	0.0	0.0
7+ members	3.7	0.7	1.5
Women's Education			
None	0.0	0.0	0.0
Primary	0.0	0.0	2.1
Secondary +	2.9	0.5	1.0
Gender of the head of household			
Male	3.7	0.5	0.5
Female	2.0	0.4	1.6
Wealth Index Quintile			
Q1	3.7	0.0	0.0
Q2	0.7	0.0	1.4
Q3	1.1	1.1	1.1
Q4	4.7	0.0	1.2
Q5	1.5	1.5	1.5
Ethnicity/language/Religion			
	not applicable	not applicable	not applicable
Work (among households with Children)			
Both parents working	1.3	0.0	1.3
None of the parents working	4.2	0.0	1.8
No adult in primary working age (18 - 54)	0.0	0.0	0.0
At least one child under 15 working	0.0	0.0	0.0
Illness and Disability in the household			
Adult(s) with chronic illness	0.0	0.0	1.4
Child/Children with disability	not available	not available	not available
Family Vulnerability			
Single Parent	3.9	0.7	1.4

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Table 3.1.1 - Child nutrition outcome and its correlates (by individual, household and geographic dimensions), % Repeat headings where table breaks

	Stunting	Wasting	Underweight
Orphan child in household	not available	not available	not available
High Dependency ratio (4+ children/adult)	0.0	0.0	0.0
Elder (70+) person in household	0.0	0.0	2.3
Geographic Dimension			
<i>Region</i>			
Kingston	0.8	0.8	0.8
St. Andrew	1.9	0.5	1.0
St. Thomas	2.2	0.0	0.0
Portland	0.0	0.0	0.0
St. Mary	0.9	0.0	0.0
St. Ann	1.6	1.1	1.1
Trelawny	0.0	0.0	0.0
St. James	2.7	0.5	1.1
Hanover	0.8	0.8	0.0
Westmoreland	1.2	0.0	0.0
St. Elizabeth	1.2	1.2	1.2
Manchester	1.1	0.5	0.5
Clarendon	3.1	0.9	0.9
St. Catherine	0.3	0.3	0.3
<i>Residence</i>			
Urban	1.2	0.5	1.1
Rural	1.3	0.6	1.3

Source: SLC 2002, 2006 Expand where/which source applies

Notes:

Stunting: any child's height which is less than the median height (for cohort) - 2 s.d.

Underweight: any child's weight which is less than the median weight (for cohort) - 2 s.d.

Wasting: any child's weight/height ratio which is less than the underweight/stunting ratio benchmarks calculated for stunting and underweight

This study highlights the following:

- In general, the frequencies reported are quite small, and many estimates are 0%. The highest total reported frequency was for stunting, 2.2%, which was more than twice the

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frequency of underweight, 0.9%, and more than seven times the frequency for wasting 0.3%.

- Most noticeable are the relatively high percentage of stunting for males in the age group, 4-6 months (11.1%), and the relatively high percentage of underweight among females of the same age group (14.3%). These are much higher frequencies than for all other age groups of both sexes, and appear to be anomalies.
- Of the three indicators, stunting is positive for most of the age groups of both sexes, and wasting the least frequently positive. Stunting was not reported for females less than 6 months and males less than 3 months old. It appears to be most significant, though still small – 4.0% for males and 4.9% for females – in the second year of life, 13 – 23 months. Thereafter, the frequency declines for both sexes, but a little more slowly for females, as the ages increase.
- Only two age groups reported any wasting, and these two age groups also reported similarly small frequencies of underweight. Apart from the apparently anomalous frequency of underweight – 14.3% - for females in the age group 4-6 months, there appears to be no significant difference between the sexes in the frequency of underweight children.
- Households of less than 3 members reported no stunting, wasting or underweight children. The reported frequencies were small for the other household sizes, with no obvious pattern related to household size. For example, the middle sized household of 5-6 members reported the lowest frequencies for all three indicators.
- Curiously, the indicators were all positive for households with women with a secondary or greater education level, and positive for underweight for households with women with a primary education. All the frequencies were, however, very small, and no inference on the influence of women’s education¹¹⁹ on stunting, wasting or underweight children can be readily drawn.
- While the differences are marginal across households with heads of different genders, male-headed households were almost twice as likely (3.7% for male, 2% for female-

¹¹⁹ In all the other tables, the comparable category is “Education of head of household”. It is not clear why this category “women’s education” was used in this table.

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headed households) to have children who are stunted. There is no difference between these two types of households for the frequency of wasting, but female-headed households were more than three times as likely to have underweight children as were their male counterparts.

- The estimates for each type of nutritional outcome were counterintuitive for the quintiles of wealth. Though the frequencies were all very low, stunting was highest in quintile 4, and wasting and underweight were highest in quintile 5.
- Note that the frequency of each indicator of under-nutrition was more about twice as great for single parent households as for the national average. The indicators were small but they were clearly bigger for this type of household than the national average.
- For the parishes, the indicators are again all very small, and in the cases of some parishes, like Portland and Trelawny, are quite suspiciously low. The frequency of these three outcomes – stunting, wasting underweight - were marginally lower for urban than rural households.

3.1.3. Analysis on causality and correlation

The data suggest that under-nutrition is not a major problem for Jamaican children as a whole as measured by deviation from expected benchmarks height, weight and weight for height. This is a good base to build on to target the small number of children that are nutritionally deprived. As noted above, the frequencies are too small for unqualified inferences. Nevertheless, the indications are that the under-nourished children are most likely to be in their second year of life, living in male-headed households or living in single parent households.

3.1.4. Building blocks and partners for a strategy

Parents have the prime responsibility for the care of their children, with support where necessary from the government. The business community too have a vested interest in the children of their employees and clients/customers. In the immediate near term, the fiscal crisis of the Jamaican state will severely constrain its abilities to fund non-debt expenditures, and particularly social programmes. It is arguable that social safety net programmes should remain a priority for the balance of public resources after debt payment, and further, that children should have primary claim among the vulnerable groups since they are the future of the society.

The relatively good base of widespread breastfeeding practices, effective school feeding programmes and as a result, low frequencies of under-nutrition in Jamaica needs to be protected

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and enhanced during the years of tight expenditure restraints. Accordingly, more attention to efficiency of delivery of the limited resources, as well as innovative ways to have the business community assume a greater share of the burden of funding child nutrition programmes suggest themselves as medium term approaches. Since so much of the nutrition programmes are educational, it should also be possible to incorporate the relevant messages in formal public education programmes as well as informal channels of communication. Jamaica, for example, has successfully used the powerful medium of popular music to promote all kinds of messages for business, politics, and health education. Educational programmes can also benefit from the energies of young Jamaicans visiting from the Diaspora, as well as the know-how and financial resources of working adults and business persons in the Diaspora.

3.2. *Health*

3.2.1. *National Laws, policies and key programmes*

The National Health Policy, 2006-2015 and Strategic Plan 2006-2010 identified maternal mortality alongside HIV/AIDS and lifestyle diseases as its three most important foci. It explicitly identified the MDGs as a central element in the international context that guided the formulation of the Policy and the accompanying strategic plan. Three of these goals¹²⁰ are directly relevant to children, two directly relevant to women, and therefore indirectly relevant to children, and the other three are relevant to all people.

The legal instrument that impacts most directly on children is the Immunization regulations (1986) that require parents to have their children immunized. The regulations are enforced by the Public Health Act (2003) [see **Table 1 in Appendix**].

More indirectly, the Water Resources Act that provided the legal basis for the Water Resources Authority seeks to ensure the development and maintenance of an efficient system for the production of good quality water. One of the instruments to effect its mandate is the Jamaica Water Sector Policy, Strategy and Action Plan. Together with the regulations for the collection and disposal of garbage in the Public Health Act, these legal instruments address environmental health which impinges on child health.

¹²⁰ Recall that the goals are “Eradicate poverty and hunger; Achieve universal primary education; Promote gender equality and empower women; Reduce Child Mortality; Improve Maternal health; Combat HIV/AIDS, malaria and other diseases; Ensure environmental sustainability; Develop a global partnership for development”.

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Also important are the National Policy on Children (NPC) and the National Policy Statement on Women. The former speaks directly to the “highest health standards” for children and the latter is concerned with the availability of adequate child care services for women.

Table 8 features the HFLE programme which is concerned with education to promote healthy children and good family life for nurturing children. There is further discussion below in section 3.4.

3.2.2. *Child outcomes, disparities, and gender inequality*

Table 3.2.1 presents the data collected by the MICS on the frequency of young children having diarrhoea and acute respiratory infections (ARI).

- The highest frequency of diarrhoea among the selected age groups was 6.9% for males in the 4-6 month age group and 7.2% for females in the 7-12 month age group. Except for the 7-12 month age group, the frequency of young male children having diarrhoea was greater, and in the case of the age group, 24-35 months, males had diarrhoea four (4) times as much as females. Whereas all females who contracted diarrhoea received some Oral Rehydration Solution (ORS) or increased fluids and continued feeding, not all males above 12 months old were so treated.

		Child had diarrhoea in last 2 weeks		Had diarrhoea and received ORS or increased fluids, and continued feeding	Child had ARI		Child ren with ARI received antibiotics	Child had fever in last 2 weeks		Child aged 0-4
		Number	Per 1000		Number	Per 1000		Number	Per 1000	
Age group by sex	Male, 0-3 mths	No data	No data	No data	No data	No data	No data	No data	No data	46
	Male, 4-6 mths	1	69	1	2	93	2	No data	No data	21
	Male, 7-12 mths	1	23	1	6	106	6	No data	No data	60
	Male, 13-23 mths	7	59	4	10	79	6	No data	No data	122
	Male, 24-35 mths	3	16	1	16	92	12	No data	No data	171
	Male, 36 mths+	7	24	5	15	51	13	No data	No data	293

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Table 3.2.1: Young child health outcomes, related care and correlates (by individual, households and geographic dimensions in 2005)

		Child had diarrhoea in last 2 weeks		Had diarrhoea and received ORS or increased fluids, and continued feeding	Child had ARI		Child ren with ARI received antibiotics	Child had fever in last 2 weeks		Child aged 0-4
		Number	Per 1000	Number	Number	Per 1000	Number	Number	Per 1000	Number
	Female, 0-3 mths	No data	No data	No data	No data	No data	No data	No data	No data	45
	Female, 4-6 mths	1	28	1	2	46	2	No data	No data	39
	Female, 7-12 mths	5	72	5	3	46	3	No data	No data	73
	Female, 13-23 mths	3	24	3	10	80	9	No data	No data	126
	Female, 24-35 mths	1	4	1	13	90	11	No data	No data	143
	Female, 36 mths+	4	15	4	16	55	12	No data	No data	288
Household size	< 3 members	1	16	1	2	41	2	No data	No data	38
	3-4 members	10	21	10	28	57	26	No data	No data	495
	5-6 members	11	25	8	26	58	20	No data	No data	455
	7+	11	25	7	37	80	29	No data	No data	456
Education level of head of household	No education	2	91	2	1	59	1	No data	No data	18
	Primary	6	22	5	19	74	12	No data	No data	252
	Secondary+	26	23	19	72	63	63	No data	No data	1,148
	Non standard	1	41	1	0	32	0	No data	No data	15
Sex of Head of Household	Male	18	24	14	55	73	44	No data	No data	753
	Female	16	23	11	38	55	32	No data	No data	691
Wealth index quintiles	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
Ethnicity/Language/Religion	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Adult of primary working age in household	No	1	101	1	2	195	2	No data	No data	11
	Yes	33	23	25	91	63	74	No data	No data	1,434
Working child in household	No	20	23	14	57	64	45	No data	No data	883
	Yes	3	33	3	7	68	6	No data	No data	106
Adult(s) with chronic illness in household	No	28	20	21	79	58	66	No data	No data	1,360

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Table 3.2.1: Young child health outcomes, related care and correlates (by individual, households and geographic dimensions in 2005)

		Child had diarrhoea in last 2 weeks		Had diarrhoea and received ORS or increased fluids, and continued feeding	Child had ARI		Child ren with ARI received antibiotics	Child had fever in last 2 weeks		Child aged 0-4
		Num ber	Per 1000	Number	Num ber	Per 1000	Num ber	Num ber	Per 1000	Num ber
	Yes	6	82	5	14	185	11	No data	No data	76
Child with disability in household	No	20	19	18	56	55	46	No data	No data	1,019
	Yes	7	30	2	24	106	18	No data	No data	228
Single parent (adult) household	No	32	25	24	82	65	66	No data	No data	1,269
	Yes	2	13	2	10	59	10	No data	No data	176
Orphan child in household	No	32	23	24	87	63	72	No data	No data	1,367
	Yes	2	31	2	6	82	4	No data	No data	74
High dependency ratio (4+ children per adult)	No	34	24	26	93	66	76	No data	No data	1,397
	Yes							No data	No data	48
Elder person (70+) in household	No	28	22	22	82	62	67	No data	No data	1,312
	Yes	6	42	4	11	80	9	No data	No data	133
Region	KMA	6	12	4	29	64	22	No data	No data	449
	Urban	9	25	8	23	64	22	No data	No data	358
	Rural	19	31	14	41	64	33	No data	No data	638
Residence	Urban	15	18	12	52	64	44	No data	No data	807
	Rural	19	31	14	41	64	33	No data	No data	638
National		34	24	26	93	64	76	No data	No data	1,445

- Similarly, for children less than 6 months old, males contracted ARIs more than twice as frequently as females. For the other age groups, the frequency was approximately the same across the sexes. Both male and female children less than 12 months old who contracted ARIs were treated with antibiotics. For the older children, the frequency of treatment with antibiotics was less, and marginally smaller for males than for females.

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The lowest frequency of antibiotic treatment was 60% for males in the 13–23 month age group.

- There is clearly a higher frequency of both types of illnesses in households with more than 3 members compared to smaller households. In the case of ARIs, the frequency increases with household size, but the frequency of antibiotic treatment for the children declines with household size.
- There appears to be little difference in the frequency of diarrhoea between children living in households with heads that have either primary or secondary and greater education. There is a slight difference in the case of ARIs, with the frequency being greater for households with heads with primary education. Certainly, the children in households with heads with education at the secondary level or greater were more likely to receive antibiotic treatment. Please note that the sample had very few households with heads who had no education, and many more heads had at least secondary education than only primary education.
- Comparing the frequency of each type of illness with respect to the sex of the head of household, there is no difference with regard to diarrhoea, but the frequency of ARIs is greater in children in male-headed households, and these children were less likely to receive antibiotics than in female-headed households.
- The frequency of children living in rural residences having diarrhoea (3.1%) was much higher than for children living in urban residences (1.8%), but they had only marginally more access to ORS. In the case of ARIs, there was no difference between children contracting these illnesses based on the location of their residence, but urban children had much more access to antibiotics than rural children.

Table 3.2.2 turns attention to adolescent health outcomes by examining the frequency of comprehensive knowledge of HIV prevention, and the percentage of women who had given birth within the preceding two years before the MICS (that is, since 2003) who had received counselling for prevention of mother-to-child transmission (PMTCT) of HIV.

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		Comprehensive knowledge of HIV prevention		Aged 15 to 24	Birth in last 2 years and received counselling for PMTCT of HIV		Woman aged 15-49 who gave birth in the 2 years preceding the survey
		Count	%		Count	%	
Sex and age	Female, 15-24	822	63	1,296	182	89	204
	Female, 25-49	No data	No data	No data	264	80	330
Household size	< 3 members	70	63	111	12	71	17
	3-4 members	269	66	408	162	84	192
	5-6 members	239	61	391	134	83	161
	7+	244	63	386	138	84	164
Education level of head of household	No education	4	57	8	7	73	9
	Primary	180	61	294	75	82	91
	Secondary+	614	64	959	359	84	426
	Non standard	10	83	12	3	62	5
Sex of Head of Household	Male	357	62	571	236	82	287
	Female	466	64	725	210	85	247
Wealth index quintiles	No data	No data	No data	No data	No data	No data	No data
Ethnicity/Religion/Language	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Adult of primary working age in household	No	13	60	21	1	100	1
	Yes	810	63	1,275	445	83	533
Working child in household	No	447	62	719	262	84	312
	Yes	51	69	73	39	90	43
Adult(s) with chronic illness in household	No	762	64	1,199	422	84	504
	Yes	51	62	82	22	78	28

¹²¹ The age group, 15 – 24 years is usually referred to as youth, and not adolescent. This table follows the Study Guide.

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Table 3.2.2 Adolescent¹²¹ health outcomes, care and correlates (by individual, households and geographic dimensions in 2005)

		Comprehensive knowledge of HIV prevention		Aged 15 to 24	Birth in last 2 years and received counselling for PMTCT of HIV		Woman aged 15-49 who gave birth in the 2 years preceding the survey
Child with disability in household	No	372	62	599	238	86	275
	Yes	67	63	105	55	80	69
Single parent (adult) household	No	756	64	1,190	381	83	461
	Yes	66	62	106	65	89	73
Orphan child in household	No	650	64	1,012	419	84	499
	Yes	62	59	106	23	77	30
High dependency ratio (4+ children per adult)	No	813	64	1,276	428	83	514
	Yes	9	47	20	18	87	20
Elder person (70+) in household	No	734	64	1,141	406	83	487
	Yes	89	57	155	39	84	47
Region	KMA	294	67	440	140	84	167
	Urban	218	64	340	104	77	135
	Rural	311	60	516	202	87	232
Residence	Urban	512	66	780	244	81	302
	Rural	311	60	516	202	87	232
National		822	63	1,296	446	84	534

Source: MICS , 2005

Table 3.2.2 focuses on females. It is clear from a cursory inspection that the frequencies of a comprehensive knowledge about HIV were above 60% for all but four cases, two of which referred to very small absolute occurrences. Only 9 households in the sample had a high dependency ratio of 4+ children per adult, and only 4 households had heads with no education. In the former case, 47% had a comprehensive knowledge of HIV, and in the latter case, the frequency was 57%. Nationally, 63% of households had a comprehensive knowledge of HIV.

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It is easily seen that the estimates in **Table 3.2.2** are marginally different across the social stratifiers, such as household size, gender of the head of household, level of education of the head, and so on.

The frequencies are much higher of women who had children within two years of the MICS having received counselling on PMTCT of HIV. Few of the frequencies are below 80% for all the social stratifiers, with a national average of 84%.

3.2.3. Analysis on causality and correlation

Male children appear to be marginally more vulnerable to diarrhoea and ARIs than females, and in some instances have less access to medication, as indicated by access to antibiotics for treatment of ARIs. It is also worth investigating whether there are child-rearing practices that put male children at relatively more risk to these illnesses, and behaviours---

The size of the household and the location of the residence of the child also seem to be important in determining his/her susceptibility to diarrhoea and ARIs, and access to the relevant medication for these.

Knowledge of HIV/AIDS seems to be relatively widespread among women, particularly among those who had given birth and received counselling, based on the high frequencies. On the other hand, because of the deadly character of the disease, no levels of ignorance, however small, can be tolerated. For comparative purposes, it would have been interesting to assess men's knowledge of HIV/AIDS as well.

3.2.4. Building blocks and partners for a strategy

Much of what was proposed in section 3.1.3 for child nutrition is applicable for child health programmes as well, especially with regard to education programmes to protect the population against major epidemics and lifestyle diseases. Jamaica has one of the most open economies with an international flow of visitors, migrants and residents approximately equivalent to the total population on the island. The movement of goods and people exposes the population to risks of infectious diseases.

International, and particularly regional, partnerships to build local capabilities to manage epidemics and to promote wellness are necessary and appropriate to confront the modern challenges to public health. Special attention should be given to mobilizing professional expertise from the Diaspora, many of whom benefited from public investment in education and training while they were resident in Jamaica. Such partnerships are necessary from the perspective of increasing local access to resources and know-how, and they are appropriate

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because modern diseases move quickly across borders in company with the movement of goods and people.

The survey indicated that children in larger households and resident in the rural areas are more vulnerable to the two selected illnesses – diarrhoea and ARIs – and less likely to receive the appropriate medication. More research will be necessary to ascertain how much of this is due to financial resource constraints in these households, and in the extreme, the poverty of the household.

3.3. Child Protection

3.3.1. National Laws, policies and key programmes

The legislative roots of protection for children reach back to the Births and Deaths Act of 1881 that required a child to be registered within 14 days of its birth. Almost 125 years later, the National Framework of Action for Children (NFAC) re-stated the commitment of the government of the day to "Full registration for all children at/soon after birth with rights to name and nationality".

Apart from the Adoption of Children Act in 1958 which provided legal protection for adopted children, the bulk of the current legislation to protect children was passed after 2003. The most important of these was the Child Care and Protection Act (CCPA) of 2004 which was designed to foster the development of the child while protecting the child from abuse. This Act became the legal centrepiece for policies toward children as articulated in documents such as the Medium Term Social and Economic Framework (MTF) 2009-2012, and the long run plan, Vision 2030 Jamaica National Development Plan (NDP).

Table 1 (see Appendix) summarizes the policies that are classifiable under the heading, 'Child Protection'. Of the fifteen (15) selected programmes in **Table 8 (see Appendix)**, six (6) programmes support the child protection policy objectives. The Social and Economic Support programme includes the school expenses of poor children among its principal objectives. Three other programmes – Necessary Educational Training Programme, Pathways to Competence for Young Children Parenting Programme, and Early Childhood Simulation Programme - target their educational activities to youth-at-risk out of school, parental training and early childhood education. Two small programmes, the Safe Schools and Possibility Programmes, are specifically designed to provide protective services to children.

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3.3.2. *Child outcomes, disparities, and gender inequality*

Table 3.3.1 below presents data collected by the MICS on the frequency of children whose births were not registered by the social stratifiers used throughout this study.

Table 3.3.1 Birth registration and its correlates (individual, HH and geographic dimensions in 2005)						
		Number of children whose birth is not registered		Birth not registered due to cost, distance or fear of penalty		Children aged 0-59 months
		Count	%	Count	% of all unregistered births	Count
Age group by sex	Male, 0-3 mths	25	54	13	51	46
	Male, 4-6 mths	8	39	4	43	21
	Male, 7-12 mths	11	18	4	35	60
	Male, 13-23 mths	15	12	7	47	122
	Male, 24-35 mths	20	12	7	36	171
	Male, 36 mths+	20	7	11	53	293
	Female, 0-3 mths	23	50	7	29	45
	Female, 4-6 mths	18	46	10	53	39
	Female, 7-12 mths	17	23	3	20	73
	Female, 13-23 mths	13	10	4	29	126
	Female, 24-35 mths	12	9	6	49	143
	Female, 36 mths+	28	10	12	44	288
Household size	< 3 members	2	7			36
	3-4 members	72	15	23	32	492
	5-6 members	60	13	30	49	447
	7+	75	17	34	45	451
Education level of head of household	No education	7	37	6	87	18
	Primary	46	18	17	38	250
	Secondary+	150	13	62	41	1,131
	Non standard	5	31			15
Sex of Head of Household	Male	118	16	51	43	742
	Female	91	13	36	39	685

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**Table 3.3.1 Birth registration and its correlates
(individual, HH and geographic dimensions in 2005)**

		Number of children whose birth is not registered		Birth not registered due to cost, distance or fear of penalty		Children aged 0-59 months
		Count	%	Count	% of all unregistered births	Count
Wealth index quintiles	No data					
Ethnicity/Religion/Language	n.a.					
Adult of primary working age in household	No	1	10	1	100	11
	Yes	208	15	85	41	1,416
Working child in household	No	123	14	56	45	869
	Yes	19	18	7	37	106
Adult(s) with chronic illness in household	No	200	15	81	40	1,342
	Yes	8	11	4	53	75
Child with disability in household	No	131	13	57	44	1,005
	Yes	39	18	17	43	225
Single parent (adult) household	No	186	15	77	42	1,254
	Yes	23	14	9	39	173
Orphan child in household	No	190	14	75	40	1,353
	Yes	18	25	11	63	70
High dependency ratio (4+ children per adult)	No	202	15	80	40	1,378
	Yes	7	15	6	85	48
Elder person (70+) in household	No	183	14	70	38	1,295
	Yes	26	20	17	64	132
Region	KMA	65	15	31	48	444
	Urban	46	13	15	33	354
	Rural	99	16	40	41	629
Residence	Urban	111	14	46	42	798
	Rural	99	16	40	41	629
National		209	15	86	41	1,426

Source: MICS, 2005

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- For both male and female children, the percent of unregistered births decline with age. Of the six (6) age groups, unregistered male births were higher than female unregistered births in three of them, and unregistered female births were higher in the other three age groups. Based on the small sample, there was no discernable gender inequality with regard to registration of births.
- The differences in the frequency of unregistered births appear to be insignificant across household sizes, except for households with less than 3 members. There were only two such households, and therefore the high frequency can be ignored.
- Similarly, the number of households headed by persons with no education or non-standard education was very small. However, it appears that for households headed by persons with secondary or above education, the frequency of unregistered births was slightly smaller (13% as opposed to 18%).
- The percentage of unregistered births in male-headed households (16%) was slightly higher than for female-headed households (13%). This difference may be an indicator of gender inequality, but again the small size of the sample qualifies any conclusions that can be made from such small differences.
- Two cases of note are the relatively higher frequencies of unregistered births in households with orphans and with children with disabilities. Although the numbers of such households in the sample were small, the differences between these households and the rest are worth noting. Households with orphans had 25% unregistered births as opposed to 14% for the rest, and households with children with disabilities had 18% unregistered births again compared with 14% for the rest of households.
- In the case of the other social stratifiers, including the location of residence, the frequency of unregistered birth approximates the national average of 15%.
- The national average for children not being registered because of “Birth not registered due to cost, distance or fear of penalty” was 41%. This was marginally more frequent for male-headed households (43%) than female-headed households (39%). In the case of household size, again ignoring the result for the very small number of households of size less than 3, there is a 13%-17% difference between households of size 3-4 members and the bigger households. It is likely that the financial burdens are relatively greater for the larger households.

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Table 3.3.2 reports on the frequency of orphans and other vulnerable children by age group and the usual social stratifiers of households. Of the total sample of children, 11% were classified as orphans and vulnerable children (OVC), and of this subgroup, 40% were orphans. Orphans¹²² were defined by study guide to be children with one or both biological parents dead.

Table 3.3.2 Orphanhood, child vulnerability and their correlates (by individual, households and geographic dimensions in 2005)						
		Orphans and vulnerable children		Of which are orphans		Number of children aged 0-17 years
		Count	%	Count	% of OVC	Count
Age group by sex	Male, 0-2 years	35	8	12	34	431
	Male, 3-4 years	12	4	1	8	290
	Male, 5-9 years	80	10	26	33	820
	Male, 10-14 years	119	13	55	46	902
	Male, 15-17 years	77	15	36	46	528
	Female, 0-2 years	34	8	5	14	431
	Female, 3-4 years	27	9	5	19	293
	Female, 5-9 years	75	10	28	38	787
	Female, 10-14 years	116	13	49	42	867
	Female, 15-17 years	70	16	42	61	426
Household size	< 3 members	20	10	11	56	207
	3-4 members	187	10	106	56	1,885
	5-6 members	215	11	79	37	1,965
	7+	222	13	63	28	1,718
Education level of head of household	No education	7	13	4	57	55
	Primary	155	13	53	34	1,233
	Secondary+	477	11	199	42	4,382
	Non standard	2	4	1	76	49
Sex of Head of Household	Male	251	9	71	28	2,800
	Female	394	13	187	48	2,975
Wealth index quintiles	No data					
Ethnicity/Religion/Language	n.a.					

¹²² In Jamaica, the “orphan” means a child whose both biological parents are deceased. This study follows the definition of the Study Guide.

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**Table 3.3.2 Orphanhood, child vulnerability and their correlates
(by individual, households and geographic dimensions in 2005)**

		Orphans and vulnerable children		Of which are orphans		Number of children aged 0-17 years
		Count	%	Count	% of OVC	Count
Adult of primary working age in household	No	29	18	19	65	165
	Yes	615	11	240	39	5,609
Working child in household	No	497	11	200	40	4,482
	Yes	80	15	28	35	537
Adult(s) with chronic illness in household	No	273	5	218	80	5,301
	Yes	355	100	27	7	355
Child with disability in household	No	356	10	124	35	3,567
	Yes	96	12	38	40	799
Single parent (adult) household	No	534	11	192	36	4,865
	Yes	111	12	67	61	910
Orphan child in household	No	341	6			5,252
	Yes	299	62	259	87	486
High dependency ratio (4+ children per adult)	No	612	11	247	40	5,551
	Yes	32	15	11	34	218
Elder person (70+) in household	No	545	11	217	40	5,101
	Yes	99	15	41	42	674
Region	KMA	210	12	106	51	1,816
	Urban	177	12	73	41	1,426
	Rural	257	10	79	31	2,533
Residence	Urban	387	12	180	46	3,242
	Rural	257	10	79	31	2,533
National		645	11	259	40	5,775

Source: MICS, 2005

- Except for the age group, 3-4 years, there was either no difference between the frequency of orphans and vulnerable children between the sexes, or it was insignificant. Of the OVCs, orphans constituted between 8% and 46% for both sexes and all age groups, except for females of the oldest age group, 15-17 years. Orphans were 61% of the OVCs of this age group. By definition, vulnerable children were those who lived in households with adults who had parents with a chronic illness, or had an adult who had died from a

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chronic illness, or had an adult who had been sick for 3 months of the 12 months preceding the MICS.

- In the case of household size, the frequency of having OVCs was 13% for the households of 7+, or 2%-3% (percentage points) higher than for smaller households. However, orphans were only 28% of the OVCs, but as high as 56% for the smallest households.
- Again, discarding the data for households headed by persons with no education or with non-standard education because of the small sample size, it appears that the frequency of OVCs in households headed by someone with at least secondary level (11%) was slightly less than households headed by persons with primary education only (13%). For these categories, orphans were a minority (34% - 42%) of the OVCs.
- The difference in the frequency of OVCs is even greater in the case of households classified according to the gender of the head. OVCs appeared in only 9% of male-headed households compared to 13% in female-headed households. It is possible that the female-headed households are more welcoming of OVCs. Only 28% of the OVCs were orphans in the male-headed households, compared to 48% in the female-headed households. This begs the question as to the health of adults in male-headed households, and hence the frequency of vulnerability of children as defined by the MICS.
- There were a small number, 165, or 3% of all children in the sample, who lived in households with no adult of primary working age. Such households probably have adults above the primary working age, say headed and supported by a retiree. Only 29, or 18% of the children in these households were OVCs, and 65% of these were orphans. On the other hand, more than 97% of children lived in households with an adult of primary working age, 11% were OVCs, and 39% of these were orphans.
- Households with no adult(s) with a chronic illness accounted for 94% of the children in the sample. In these households, only 5% of the children were OVCs, and of these 80% were orphans. The implication is that the other 20 were deemed vulnerable because an adult had died from a chronic illness. For the households with an adult with a chronic illness, by definition 100% of these children were OVCs, and only 7% were orphans.
- The frequency of OVCs seemed to be independent of whether households had a child with a disability. The frequency was marginally (2% points) higher for those with a disability, and the order of magnitude of the percentage of the OVCs who were orphans

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was approximately the same – 35% for households with no disabled child versus 40% for households with a disabled child.

- Similarly, the frequency of OVCs was almost the same for single-parent and non single-parent households. However, the percentage of the OVCs that were orphans was much higher (61%) than for non single parent households (36%).
- Less than 8% of children lived in households with an orphan child. Of these households, only 6% of the children were OVCs. On the other hand, for households with an orphan child, 62% of the children were OVCs and 87% of these were orphans.
- Less than 4% of children lived in households with a high dependency ratio – 4+ children per adult- but 15% of these children were OVCs, and 34% of these OVCs were orphans. For the majority who lived in households with less than 4 children per adult, 11% of the children were OVCs, and 40% of these were orphans. The likelihood of an OVC does increase with the size of the household.
- Again the frequency of OVCs in households appears to be independent of the presence of an elder person (70+) in the household. The frequency of OVCs in households without an elder was 11% and for households with an elder, it was 15%. In both cases, the percentage of orphans in the OVCs was 40-42%.
- The frequency of OVCs was about the same – 10-12% - in the urban, and particularly the KMA, and the rural areas. However, the percentage who were orphans was much higher in the urban (46%) than the rural areas (31%), and highest in the KMA (51%).
- Nationally, 11% of children were OVCs and 40% of these were orphans.

3.3.3. Analysis on causality and correlation

There appears to be little difference between the sexes of the children with regard to being an orphan or vulnerable as defined by the MICS. But there appears to be a difference, however small, between the frequency of OVCs in male-headed households compared to their female counterpart. There are more likely to be OVCs in the latter. This study surmises that female heads are more open to caring for OVCs because of the cultural patterns of nurturing for females as opposed to males.

The frequency of OVCs appears to be relatively independent of the social stratifiers used in the study, with differences between the presence and absence of the stratifying variable being small

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to marginal. Because the sample size is so small, inferences on the small differences have to be drawn with great care.

As shown above, about 11% of children are OVCs. The percentage of orphans in the OVCs does vary a lot around the national average of 40%. This is seen clearly in the case of single parent households and the location of the residence – urban vs rural – of the household. By implication, 60%, on average of the OVCs are vulnerable by the definition used by the MICS. It would be interesting to see what percentage of the OVCs is classifiable as consumption-poor, and/or deprived by any of the criteria used in this study.

3.3.4. Building blocks and partners for a strategy

To be compliant with the Births and Deaths Act almost 120 years after it was promulgated, Jamaica has another 15% of its children to be registered. MICS reports that 41% of the children were not registered because their parents and guardians found the costs too high. There are certainly technological means for reducing costs. But technological solutions require relevant changes in institutional processes. The current reform process at the Registrar General Department (RGD) should speak to some of these. For example, the provision of free bed side registration in hospitals

There have been several studies that have criticized the quality of protection and care provided to wards of the state housed in public facilities or in private homes that are supposed to be supervised by the relevant government agencies. The strategic partnership between the state and families seems conceptually to be a sound basis for caring for orphans and vulnerable children. The studies referred to above support advocacy for improved efficiency and effectiveness in the management of the protection services offered to OVCs. Here again, efforts to address these demands can only benefit from additional resources from the business community and the international development partners, especially in the context of austerity programmes that the government is forced to adopt in the context of the global crisis.

3.4. Education

3.4.1. National Laws, policies and key programmes

Table 1 sets out the principal legislation and policies governing and guiding the education of children. Starting with the Education Act of 1965, there have been a series of policy documents addressing the education needs of children with regard to health matters, and particularly HIV/AIDS, as well as policy documents targeting children and women. All of these underpin

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the attention given to addressing the needs and providing for the development of children in the MTF and the NDP.

The Education Act charges parents with the responsibility for securing education for their children of school age, and stipulates sanctions for non-compliance. One of the goals of NDP is “world class education and training” with a view to improving the “capacity to support the holistic development of the child”. The MTF focuses on the education of children under 8 years by way of support for the Early Childhood Commission’s (ECC) work to ensure “access to early childhood education and development programmes”. It is clear that the Act forms the legislative basis for the medium and long range policies, and that all three seek to promote the development of children.

In 1994, the National Policy for Health and Family Life Education (HFLE) was drafted and subsequently revised in 1999. The policy focused on providing education to promote healthy lifestyles and healthy family life as the nurturing institution for the development of children. One of the central themes was education for responsible sexual behaviour and reproductive health, which later facilitated a further focus on HIV/AIDS. In 2001, the National Policy for the Management of HIV/AIDS in Schools was drafted to sharpen the focus of education programmes and activities on this epidemic toward young people and children. The rationale was both the risk to them as well as promoting responsible sexual behaviour among them as a strategy for containing the spread of the epidemic.

Also important are the policies targeting children and women specifically. The National Policy Statement on Women of 1987 expressed the commitments of the Government’s ratification of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1981.

The NPC was prepared in 1997 to reflect the commitment made when the CRC was ratified in 1991. Three years earlier, the government had issued a National Youth Policy targeting the age group 15-24 years which overlaps with the age group for children, youth less than 18 years old, at the lower end of the range for youth. The NPC set out guarantees of health, education, protection and the rights to full participation in civil society, and committed the government to providing special care, education and training for children with disabilities.

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Of the 15 selected programmes in **Table 8**, 10 are educational at least. This reflects the fact that education receives the largest share of fiscal support for social services for children, and twice as much as the second most funded social service, health.

3.4.2. *Child outcomes, disparities, and gender inequality*

Table 3.4.1 presents data on school attendance and correlates with the social stratifiers used in this study.

Table 3.4.1 School attendance and correlates (by individual, households and geographic dimensions in 2005)		
		Enrolled in school, %
Age	6	99
	7	99
	8	100
	9	99
	10	100
	11	100
Total		100
Sex	Male	100
	Female	100
Household size	< 3 members	100
	3-4 members	100
	5-6 members	100
	7+	100
Education level of head of household	No education	100
	Primary	99
	Secondary+	100
	Non standard	100
Sex of Head of Household	Male	99
	Female	100
Wealth index quintiles	No data	
Religion/ethnicity/Language	n.a.	
Adult of primary working age in household	No	100
	Yes	100
Working child in household	No	100
	Yes	99
Adult(s) with chronic illness in household	No	100
	Yes	100
Child with disability in household	No	100
	Yes	99

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Table 3.4.1 School attendance and correlates (by individual, households and geographic dimensions in 2005)		
		Enrolled in school, %
Single parent (adult) household	No	100
	Yes	99
Orphan child in household	No	100
	Yes	98
High dependency ratio (4+ children per adult)	No	100
	Yes	99
Elder person (70+) in household	No	100
	Yes	100
Region	KMA	100
	Urban	99
	Rural	99
Residence	Urban	100
	Rural	99

Source: MICS 2005

It is clear that for children between 6 and 11 years old, there was full enrolment, for both sexes, for both genders of household heads, regardless of their level of education, for all locations of residence, and indeed, for all the other social stratifiers in the table.

3.4.3. Analysis on causality and correlation

Jamaica has long met its full enrolment targets for the primary level, but there are long-standing concerns for the attendance and drop-out rates, especially at the secondary level, and particularly for males. In recent years, policy-makers have been concentrating on the quality of the education experience in the schools. Relevant indicators will have to be defined to capture these dimensions of the education of children in Jamaica.

3.4.4. Building blocks and partners for a strategy

It has long been established practice in the formulation and implementation of education policy that there are important roles for all stakeholders beginning with families, and especially the parents and their children, with support from the teachers, the government, the business community and several international and regional donor institutions. The balance of responsibilities has shifted from time to time, but the imperative of providing quality of education for Jamaican children is recognized by all.

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Current government policy is to provide free tuition up to secondary school. In the foreseeable future, the tight fiscal constraints will pressure the government to seek international funding for almost all capital expenditure for education, and to consider redistributing at least some of the costs of staffing the schools and other operating costs to families and the business communities. As with the other areas discussed above, both efficiency and effectiveness of expenditure must be high priorities for education. Many countries in the Americas and the Commonwealth have similar challenges of educating their youth to varying degrees. Regional and International cooperation with the Jamaican state is perhaps the best approach to address the macro issues of the education system. Community cooperation with the family is perhaps the most effective approach to address the local or micro issues in education. Again, these are not new approaches, and as before the balance of responsibilities may have to shift so as to re-distribute some of the financial burden from the state to the other stakeholders and partners.

3.5. Social Protection

3.5.1. National Laws, policies and key programmes

The centre piece of social protection in Jamaica is the PATH programme, a conditional cash transfer programme, that was formed out of the consolidation of several public sector programmes in 2001. “Before the development of the PATH, GOJ financed 45 safety net programmes through 12 ministries (National Poverty Eradication Strategy 1998), including three income support programmes—the Food Stamp, Poor Relief, and Public Assistance Programmes—four school-based programmes, five labour market programmes, two subsidized drug programmes, and an indigent housing programme, among others.”¹²³

3.5.2. Child outcomes, disparities, and gender inequality

Table 3.5.2 focuses on health insurance coverage for children and women, and households with any form of social protection¹²⁴.

¹²³ Mathematica, Sept. 2006, P.4

¹²⁴ The study was unable to access data on remittances. The Global Study Guide recommended the inclusion of remittances in expenditure on social protection. As such, the estimate in **Table 3.5.2** is low.

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Table 3.5.1: Access to social protection and its correlates by individual, households and geographic dimensions 2005									
		Has health insurance	Women aged 15-49	Women covered by health insurance	Child received free medication		Children requiring medication	Households or population covered by any form of social protection	
		Number	Number	%	Number	%	Number	%	
Total Frequency				21					
Age group by sex	Male, 0-3 mths	..					7	..	
	Male, 4-6 mths	..					13	..	
	Male, 7-12 mths	..					28	..	
	Male, 13-23 mths	..			0	1	44	..	
	Male, 24-35 mths	..					51	..	
	Male, 36 mths+	..			1	1	91	..	
	Female, 0-3 mths	..					4	..	
	Female, 4-6 mths	..					12	..	
	Female, 7-12 mths	..			2	5	34	..	
	Female, 13-23 mths	..					50	..	
	Female, 24-35 mths	..			1	1	45	..	
	Female, 36 mths+	..					94	..	
		Female, 18 - 24 yrs			15				
		Female, 25 - 44 yrs			22				
	Female, 45 - 64 yrs			22					

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Table 3.5.1: Access to social protection and its correlates by individual, households and geographic dimensions 2005

		Has health insurance	Women aged 15-49	Women covered by health insurance	Child received free medication		Children requiring medication	Households or population covered by any form of social protection
		Number	Number	%	Number	%	Number	%
	Female, 65+ yrs			25				
Household size	< 3 members	..	466	26			8	..
	3-4 members	..	1,445	22	2	1	154	..
	5-6 members	..	1,095	21	1	1	152	..
	7+	..	839	15			159	..
Education level of head of household	No education	..	23	0	1	13	5	..
	Primary	..	727	13	0	1	75	..
	Secondary+	..	3,003	18	2	0	388	..
	Non standard	..	37	..	1	36	2	..
Sex of Head of Household	Male	..	1,731	25	3	1	250	..
	Female	..	2,114	23	1	0	224	..
Wealth index quintiles								
	Q1			9				
	Q2			13				
	Q3			18				
	Q4			22				
	Q5			40				
Religion/Ethnicity/Language	n.a.							
Adult of primary working age in household	No	..	21	..			4	..
	Yes	..	3,824	..	3	1	470	..
Working child in household	No	..	2,294	..	0	0	289	..
	Yes	..	233	..			40	..

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Table 3.5.1: Access to social protection and its correlates by individual, households and geographic dimensions 2005

		Has health insurance	Women aged 15-49	Women covered by health insurance	Child received free medication		Children requiring medication	Households or population covered by any form of social protection
		Number	Number	%	Number	%	Number	%
Adult(s) with chronic illness in household	No	..	3,595	..	3	1	434	..
	Yes	..	224	27			39	..
Child with disability in household	No	..	1,829	..	3	1	296	..
	Yes	..	361	..			112	..
Single parent (adult) household	No	..	3,451	..	3	1	419	..
	Yes	..	394	21			56	..
Orphan child in household	No	..	2,993	..	3	1	448	..
	Yes	..	233	..			25	..
High dependency ratio (4+ children per adult)	No	..	3,785	..	3	1	457	..
	Yes	..	59	23			18	..
Elder person (70+) in household	No	..	3,434	..	3	1	429	..
Geographic Dimension								
<i>Region</i>								
				24				
				8				
				13				
				10				
				8				
				5				
				17				
				11				

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Table 3.5.1: Access to social protection and its correlates by individual, households and geographic dimensions 2005

		Has health insurance	Women aged 15-49	Women covered by health insurance	Child received free medication		Children requiring medication	Households or population covered by any form of social protection
		Number	Number	%	Number	%	Number	%
				9				
				6				
				6				
				10				
				23				
				24				
	Yes	..	411	29	1	1	45	..
Region	KMA	..	1,386	..	2	1	144	..
	Urban	..	955	..			132	..
	Rural	..	1,505	..	2	1	198	..
Residence	Urban	..	2,340	17	2	1	276	..
	Rural	..	1,505	11	2	1	198	..
National		..	3,845	..	3	1	474	..

Source: MICS, 2005, JSLC, 2002, 2006

It can be seen from the limited information in **Table 3.5.1** that a majority of women, 55%, lived in female-headed households, and that the vast majority of women in the MICS sample:

- Lived in households:
 - of size 3 – 6 members, 66%
 - with at least one adult of primary working age, 99%
 - with no working children, 91%
 - with no adult with chronic illness, 94%
 - with no child with disability, 83%
 - with both parents, 90%
 - with no orphan child, 93%

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- with 3 or less children per adult, 98%
- Had secondary education or higher, 79%

The frequency of women having health insurance:

- Varied directly with:
 - Age, increasing from 15% for the youngest group to 25% for the oldest
 - Educational level of the head of households, from 0% for heads with no education to 18% for heads with secondary education or greater
 - Wealth quintiles, from 9% for the poorest to 40% for the richest
- Varied inversely with:
 - Household size, from 26% for the smallest to 15% for the largest households

Of the other types of households, only those with an adult with chronic illness had a frequency (27%) of having health insurance greater than the average (22%) for women in the sample. Note also that the frequency of women in male-headed households having health insurance (25%) was only 2% greater than those in female-headed households (23%).

With regard to location, the estimates for the parishes based on JSLC data for 2002 indicate a wide range for women having health insurance from 5% for St. Ann to 24% for Kingston. There are apparent anomalies, such as the low 8% for St. Andrew, and the high 17% for Trelawny and 23% for Clarendon. It is not easy to see why women in Trelawny would be more than 3 times as likely, nor why women in Manchester would be twice as likely, as women in St. Ann to have health insurance. Much more credible is the estimate that women in urban areas were far more likely to have health insurance than rural women (17% vs 11%).

3.5.3. Analysis on causality and correlation

It is difficult to say how representative this sample of women, given the high frequencies reported in **Table 3.5.1**. The estimates point to affordability as the key determinant of women having health insurance. This is a clear indication from the correlations with wealth quintiles, and is supported by the likelihood of older persons, with higher levels of education, and smaller households having more ability to afford health insurance. Similarly, affordability probably explains much of the higher frequency of urban women being covered by health insurance compared to rural women.

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3.5.4. Building blocks and partners for a strategy

The PATH has been funded by the World Bank from its inception, and new funding has recently been agreed. At some point, the government will have to assume more of the responsibility to provide financial resources to sustain this programme, and even to strengthen the whole social safety net. Once again, the government should cultivate partnerships with the business community, civil society organizations, and organizations and individuals in the Diaspora to share the burden of providing financial and other kinds of resources.

Business enterprises can be encouraged to attend to their pensioned employees, the children of their employees, and to contribute to the welfare of children in the communities where they are located. Adopt-a-school programmes and support for local clinics come to mind readily. Churches and other civil society organizations have traditionally played an integral role in the provision of services to children and other vulnerable groups. In the past, whenever government austerity programmes have been implemented, the responsibility for the provision of social services has been explicitly and implicitly divested to civil society. This proposal is not intended to advocate the abandonment of public responsibility and partnership in the provision of services in the social safety net, but realignment of the partnerships may be inevitable in the context of fiscal austerity.

3.6. Conclusions

The policy framework for children has grown rapidly especially since the ratification of the CRC. This study has focused on areas where the policy framework is most developed – nutrition, protection, education and health. Even so, policy formation is a process of regular review and refinement in response to empirical review of the circumstances that the policies are intended to address.

Invariably, there is room for improvement of the implementation of policies. With the weakening fiscal capabilities of the government in the short to medium run, more attention has to be paid to issues of efficiency of project and programme implementation to improve the impact per dollar of expenditure. The study has helped to sharpen the targeting of policies and programmes for children, even as it has indicated the need for further research to address aspects of child well-being that are peculiar to Jamaica. In general, Jamaican children benefit from a range of basic services. The focus should be on removing the inequalities of access and improving the overall quality of services.

4. Addressing Child Poverty and Disparities: A strategy for results

4.1. *What needs to be done*

The study has advanced the understanding of the frequency and dimensions of child poverty and deprivations in Jamaica, but has left an agenda for further research. The low frequency of deprivations reported by the MICS for four (4) dimensions is encouraging but not conclusive. Indeed, the study feels a sense of urgency to conduct the MICS again with a larger sample and a focus on the areas of shelter, food and other dimensions such as security, the environment and family life. Since the study will not be constrained by the need for international comparisons as required by this Global Study, the criteria for “severe” and “less severe” deprivation can be redefined to be more relevant to and appropriate for Jamaica.

The study did not identify any major policy gaps, but some policies need to be revised and updated. It is recommended that there should be a period of focused implementation of existing policies, with constant monitoring, followed by an assessment of the relevance and appropriateness of policies. With this global assessment, a corresponding global review of policies can be conducted so as to have a more streamlined framework of policies that avoids undue overlapping while filling the gaps that are identified.

4.2. *How it could happen*

In 2027, the babies born this year will complete their childhood. According to NDP, Jamaica should then be 4 years away from the status of a first world country. Before that, Jamaica is committed to a set of MDG targets in 2015. In light of the assessment of progress toward the achievement of the MDGs, plans have to be assessed and perhaps goals rescheduled to honour even the spirit of the national commitment to achieving the MDGs. These have to be reflected in the rolling MTF. Together, the MTF, the MDGs and the NDP constitute a framework for strategies, plans, policies and programmes or projects that can address the human development of children as an integral component of the envisioned social and economic development.

The GOJ will need to redouble its efforts to build partnerships to undertake the range of programmes required for social and economic development. With regard to addressing child development, including child poverty and deprivations, the natural partners are the international

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development partners, the local business community, the organizations and individuals in the Diaspora, locally based civil society organization and resident families. This is all the more urgent in light of the imperative of reducing public expenditure in line with public revenues, and the corresponding reduction of the already limited capabilities of the public sector.

The precise balance of the partnerships will vary according to the interests and capabilities of the partners. International partners are probably best placed for funding programmes, and accessing international information, especially on best practices. The local business enterprises have a vested interest in the children of their employees and customers, and the children in the communities in which their facilities are located. Organizations and individuals in the Diaspora can mobilize resources and expertise for projects that are transparent and fully accountable. Civil society organizations, including religious organizations, have been providing social services to their membership and others since Emancipation in 1838. The spirit of voluntarism is alive, and can be encouraged by national leadership, but the time, energies and resources of their membership will be all the more limited in periods of poor economic performance. They can partner with international development institutions and the local business community to provide services within their respective areas of interest and expertise. Finally, the government must insist that parents take proper care of their children and be compliant with the legislation governing the care of children. In addition, the government can cultivate partnerships with families especially with regard to care for OVCs and for sponsoring support for poor children.

In all these cases, efforts in the past have too often been hampered by government regulations, however well intentioned. For example, a common complaint of voluntary organizations is that clearing imports through the customs is extremely difficult and the government is too often unwilling to grant concessions for duty-free entry. Cutting the red tape of bureaucracy for investors should also be extended to organizations and individuals who are investing in the development of children. Foregoing fees and duties can substitute for fiscal resources that the government would be willing to, but cannot afford to grant, because of budget restrictions.

Table 4.1 in the **Appendix** outlines an action plan for the principal age groups of children and for the vulnerable categories that covers a seven (7) year period. During this period, current plans, programmes and projects for each group can be implemented, monitored and the results assessed in parallel. Specifically, if the action plan were implemented in 2010, then assessments could be done:

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- in 2012 for new-borns in 2010
- in 2013 for the early childhood experience of 2 year olds in 2010
- in 2017 for the primary education experience of 5 year olds in 2010
- in 2015 for the secondary education experience of 12 year olds in 2010
- in 2011 and every other year for children in poverty and with deprivations till 2017
- in 2012 and every other year for OVCs till 2016

By 2017, there would be 7 years of experience addressing the challenges of each group as set out in **Table 4.1 (See End)**. The assessments would then inform the review of existing policies, and the accompanying legislation, and the drafting of policies to fill any gaps in the framework that are identified.

4.3. Conclusions

Child poverty has been declining with poverty levels in general, but it still remains above the national average. There is a high risk of the reversal of the progress in reducing poverty in the context of the economic downturn associated with the global crisis. The headcount measure of child poverty is positively related to the size of the household, is inversely related to the level of education of the head of household, is more likely to obtain in rural households, and is influenced by the composition of the household.

The study of child deprivations indicated that of the four (4) areas where data was collected – sanitation, water, education and health – the highest frequency of “severe” deprivation was estimated for health, 9%, followed by water, 5%. No Jamaican children were reported to be severely deprived of education, and only a marginal 1% was severely deprived of sanitation. Data from the MICS sample indicated that children with two (2) or more deprivations were rare. As with the headcount, children with a severe deprivation were more likely to be found in rural households, in large households, in households headed by persons with low levels of education, and in households composed with vulnerable and unemployed persons. The study points to areas for further research, but did not provide conclusive information on deprivations or sufficient information to investigate the relationships between child poverty and deprivations.

The policy framework governing Jamaican children has developed rapidly following the government’s ratification of the CRC. The study was able to find policies and associated programmes in all the “pillars of child wellbeing” – nutrition, health, child protection, and education. On the other hand, the implementation of these policies has moved at a slower pace for a variety of reasons. Data to estimate public expenditure in support of policies was either difficult to obtain or did not exist.

While section 4.2 outlines a strategy based on the findings of the study, the immediate tasks should be to minimize the number of children falling into poverty and to provide a cushion for those who might fall into poverty as a result of the current economic difficulties.

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