OVERVIEW

INTRODUCTION

Annual reporting on the living standards of the Jamaican population is done through the Jamaica Survey of Living Conditions (JSLC), which spans over two decades, having commenced in 1988. The JSLC allows for tracking and monitoring of changes in living standards and is a useful tool for guiding policy formulation and targeted interventions. The standard report is based on a 0.3 per cent sample of Jamaican households, which are canvassed by the Statistical Institute of Jamaica (STATIN). Of the households selected in 2015, some 1 716 responded, translating to 5 154 individuals.

Using this Report

The report is comprised of six chapters: Demographic Characteristics, Household Consumption and Poverty, Health, Education, Housing, and Social Protection. Each chapter presents an analysis of occurrences over 2015 in relation to 2014 and, in some instances, over the decade from 2006. National level data are provided, with disaggregation by region—Kingston Metropolitan Area (KMA), Other Towns and Rural Areas—age, sex or sex of household head as applicable, and socioeconomic status (quintile). The data provided are based on self-reported responses of a household respondent, in some cases on behalf of the entire household and in others, on behalf of individual household members. Data in relation to children are based on responses provided by an adult respondent. In the case of health, the data represent self-reports of illness, as no testing is done by the interviewer, nor is proof of medical diagnosis requested.

Each chapter is supplemented by tables and charts, with additional (standard) tables provided in appendices to the publication. Other appendices provide technical details of the survey and a Glossary of Terms and Abbreviations is also located at the back of the publication.

A number of changes have been introduced in this year's report. An adjustment was made to the methodology for calculating the Gini coefficient, which is reported in the Household Consumption and Poverty chapter. Details of the change are provided in Appendix IV. The Education chapter now includes mean years of schooling, an indicator—also used by the United Nations (UN) in determining the Human Development Index—that is considered in reference to the expected years of education of a population. In recognition of the effects of changing climatic conditions on living standards, the Housing module was adjusted to capture data on households' methods of storing water for periods of water shortage. Additionally, in this year's report, the Social Protection chapter—which inter alia reports on the Programme of Advancement Through Health and Education (PATH)—presents a detailed analysis of the Programme over the period since its inception in 2002.

Executive Summary

Mean household consumption increased in both nominal and real terms between 2014 and 2015. Despite a relatively small nominal increase, when combined with the low rate of inflation for the period, the net result was a real increase, meaning that households increased their actual consumption of goods and services over the period. The largest real increase was observed in Other Towns, while the KMA and Rural Areas changed only marginally. The Gini coefficient highlighted an increase in inequality over the period and poverty increased marginally to 21.2 per cent from 20.0 per cent in 2014.

The demographic profile of the country, viewed over the long term, continued to highlight an ageing population, with a declining share of children (0–14 years), increasing working age population (15–64 years), and an increasing dependent elderly population (65 years and over). One manifestation of this population structure is declining household size, combined with a change in household structure, whereby households are generally smaller and made up of fewer children. Another population feature, which has also contributed to the falling mean household size, is the prevalence of people living alone, with single-person households being the most common type of household by size.

Chronic non-communicable diseases (NCDs) were reported by a quarter of sample respondents. However, this figure masks the wide disparity by age, as the proportion of NCDs increased with age and rose sharply to percentages well above the national proportion from age 50 upwards. Of the six NCDs captured in the survey (hypertension, diabetes, heart disease, asthma, arthritis and mental disorder), hypertension remained the most common and a larger proportion of females than males generally reported having at least one NCD.

Having achieved universal enrolment up to age 16 for approximately two decades, the country is now seeing improved enrolment among older age groups, namely those 17–18 and 9–24 years. With respect to students' attendance at school over a 20-day reference period, money continued to factor as the most common reason given for absence, despite various interventions to address the cost to parents. As the majority of children travelled to school by public

transport, the issue of money may be linked to the cost of transport.

The indicators that comprise the Housing Quality Index (HQI) have pointed to incremental improvements over time and an overall positive assessment of housing quality in Jamaica. This has been due to a number of factors, including an absolute as well as proportionate increase in houses of block-and-steel—which dominate new additions to the housing market—and increased access to electricity over time. In addition, as average household size has fallen, there has been a decline in the average number of persons per habitable room. However, disaggregation by region shows that Rural Areas consistently lag behind the urban areas of the KMA and Other Towns. The effects of development were also less evident among the lower consumption groups, which recorded lower HQI than the upper groups. Likewise, the sub-indicators of the HQI were consistently lower in Rural Areas and among lower consumption groups than in urban areas and among higher consumption groups.

Although the majority of households reported that they used a formal method of garbage disposal, burning of garbage continued to be the most commonly reported informal method. Rural Areas and the poorest quintile recorded the highest incidence of informal methods of disposal. With respect to utility payments, the survey recorded real (inflation adjusted) increases in payments for electricity, telephone and water in 2015 relative to 2014.

The data continued to show that the Programme of Advancement Through Health and Education (PATH) has been consistent in reaching its target, as the poorest 40.0 per cent of households (Quintiles 1 and 2) were the majority of current beneficiaries (based on the April 2015 payment). Nonetheless, of all beneficiary households, the majority had been receiving benefits for at least five years and 65.9 per cent of the poorest 20.0 per cent of households (Quintile 1) had been recipients for five or more years.

CHAPTER SUMMARIES

Demographic Characteristics

The demographic characteristics chapter highlights the ageing population, declining household size, changing household structure and a continued increase in the number of people living alone. Children 0–14 years old accounted for 26.7 per cent of the population, the working age cohort (15–64 years) 63.4 per cent, and the dependent elderly (65 years and older) 9.9 per cent. By comparison, in 2006, children were 31.0 per cent of the population, while the two older age groups accounted for 59.0 per cent and 10.0 per cent, respectively. The same pattern was observed in all three regions. The decline in the proportion of children in the population has been a significant contributor to the change in the size and structure of households, leading to smaller households with fewer children. Average household size fell to 3.0 from 3.3 in 2006 and the mean number of children fell from 1.0 in the same year to 0.8 in 2015. While there was little variation by region, by consumption status, households in the poorest quintile were larger, with an average size of 4.3 and an average of 1.6 children. Female-headed households were larger on average and had more children than those headed by males.

The population dynamics described above have led to a trend of decline in age dependency ratios (ADRs). The total ADR registered 57.7 dependents per 100 persons of working age in 2015, down from 69.5 in 2006. Regional ADRs followed the same pattern of decline, however, the ADR for Rural Areas remained above the national average at 60.3 dependents per 100 persons of working age.

With respect to household size, the trend has been towards smaller households and, in 2015, more than half of all households (51.5 per cent) were classified as "small sized", meaning they comprised 2–4 persons. Single-member households were the largest household type by size, accounting for more than a quarter (28.9 per cent) of all households. These single-member households were predominantly male (i.e., 38.1 per cent of male-headed households were single-member versus a comparable 17.9 per cent for female-headed), in the dependent elderly age group (26.0 per cent) and in Rural Areas, which was above average, with 32.0 per cent. Nearly a quarter (23.7 per cent) of female-headed households consisted of five or more persons compared with 16.0 per cent of male-headed households. Also, at 44.7 per cent, the poorest 20.0 per cent of households recorded the largest proportion of households with at least five members.

Children formed a part of most female-headed households, with 71.8 per cent including children, while just over a fifth (22.4 per cent) included an adult male. On the other hand, the largest proportion of male-headed households had an adult female resident (68.5 per cent), while 58.2 per cent had children.

Household Consumption and Poverty

Households' per capita consumption increased nominally by 4.3 per cent to $296 902.00 between 2014 and 2015. All three regions also registered nominal increases of 3.8 per cent (KMA), 10.4 per cent (Other Towns) and 3.2 per cent (Rural Areas) to record per capita consumption of $385 338.00, $300 266.00 and $238 647.00, respectively. Real per capita consumption went up by 1.2 per cent, highlighting an increase in the

quantity of goods and services consumed by households over the period. While per capita consumption rose by 7.2 per cent in Other Towns, marginal changes were recorded for the KMA and Rural Areas (–1.4 per cent and 1.1 per cent, respectively). Per capita consumption expenditure was 23.9 per cent higher in male-headed households than in female-headed households, at $328 881.00 versus $265 485.00. However, average expenditure on Education was 17.4 per cent higher in female-headed households.

Four commodity groups accounted for three-quarters of mean household consumption both nationally and at the regional level. These were Food & Non-Alcoholic Beverages; Housing, Water, Electricity, Gas & Other Fuels; Restaurants & Accommodation Services; and Transport.

Per capita consumption expenditure was close to seven times higher in the highest consumption group (Quintile 5) than it was in the lowest (Quintile 1): $611 071.00 versus $90 132.00. The top 20.0 per cent of households (Deciles 9 and 10) accounted for 44.8 per cent of national consumption expenditure and per capita expenditure in Decile 10 was some $788 000.00 relative to $72 000.00 in Decile 1. The Gini index further underscored the inequality, registering a coefficient of 0.3803 up from 0.3786 in 2014.

Approximately one-half (50.8 per cent) of households received remittances in 2015. Regionally, the proportions ranged from 47.5 per cent in the KMA to 53.7 per cent in Other Towns. Quintile 1 recorded the lowest proportion of remittance receiving households at 39.6 per cent compared with more than 50.0 per cent for all other quintiles.

Some 21.2 per cent of individuals were in poverty, meaning that they consumed at a level below the adult equivalent poverty line. Rural Areas continued to record a higher level of poverty, with 28.5 per cent compared with 14.3 per cent in the KMA and 14.7 per cent in Other Towns. Regionally, poverty moved from 15.3 per cent to 14.3 per cent in the KMA; from 16.2 to 14.7 per cent in Other Towns; and increased to 28.5 from 24.9 per cent in Rural Areas. Generally, poverty was lower among older age groups than among younger ones. The prime working age group (35–59 years) recorded the lowest proportion, 16.3 per cent, while the elderly (60 years and older) recorded 17.9 per cent. On the other hand, the younger age groups—including children under 18 years, youth (15–24 years) and children in the early childhood cohort (0–8 years)—recorded above average rates, ranging from 24.6 per cent to 24.2 per cent. Poverty was 16.6 per cent in female-headed households compared with 14.0 per cent in male-headed households.

Some 6.9 per cent of individuals were consuming at a level below the individual food poverty line, i.e., they were unable to meet basic nutritional requirements and were in extreme poverty or food poor.

Health

While some 85.7 per cent of Jamaicans perceived themselves to be in good or very good health, 25.1 per cent reported having a chronic non-communicable disease (NCD). There was little variation by region in either health perception or reports of NCDs. However, by age, positive perceptions of health (good and very good) declined with age, while the proportion reporting NCDs increased with age, with "at least one NCD" ranging from 9.1 per cent in the 0–4 age group to 77.2 per cent among those 65 years and older. A larger proportion of males (88.2 per cent) than females (83.3 per cent) reported their health status perception as good to very good and 29.5 per cent of females reported at least one chronic illness relative to 20.4 per cent of males. Generally, the proportion of individuals reporting at least one NCD was higher as consumption group increased, with the largest proportion (30.2 per cent) recorded in Quintile 5 and the smallest (21.4 per cent) in Quintile 2.

Of the six NCDs captured by the survey (arthritis, asthma, diabetes, heart disease, hypertension, and mental disorder), hypertension continued to be the most commonly reported, recording 13.0 per cent in 2015. This was followed by asthma, 5.8 per cent; arthritis, 4.8 per cent; and diabetes 4.7 per cent. While proportions rose with increasing age for most of the NCDs, in the case of asthma, children 5–9 years recorded the largest proportion, 12.5 per cent. This has also shown an increase, from 7.0 per cent in 2010.

Approximately 12.3 per cent of individuals 14 years and older smoked. While by consumption group and region there was little variation from the average, considerably more males (22.5 per cent) than females (3.0 per cent) smoked.

Some 7.7 per cent of individuals reported having an illness or injury over a four-week reference period, continuing a trend of decline over the 10 years since 2006. Regionally, proportions ranged from 5.4 per cent in the KMA to 8.8 per cent in Rural Areas. Generally, higher consumption groups had larger proportions of illness/injury than lower ones and above-average proportions were recorded at both ends of the age continuum.

Of those who reported illness or injury, 72.4 per cent sought care. Among those who sought care, 48.7 per cent visited only public health facilities versus 46.2 per cent who went only to private facilities. Some 74.2 per cent of females sought care compared with 70.1 per cent of males. Exclusive use of public health facilities by the majority of the ill/injured was evident in the KMA (49.9 per cent); individuals in the poorest 40.0 per cent of households (Quintile 1: 73.6 per cent;

Quintile 2: 64.4 per cent); among males (51.5 per cent); and among age groups between 10 and 29 years and those over 50 years. Average waiting time at public hospitals was 4.7 hours and 3.2 hours at public health/maternity centres. Despite the removal of user fees at public facilities, of those who did not seek care, 15.1 per cent cited an inability to afford care as the reason. However, this is a decline from 22.2 per cent in 2006.

Approximately 18.9 per cent of all individuals were recorded as having health insurance, however, there was wide variation by region, age and consumption status. In the KMA, health insurance coverage was 31.1 per cent, while in Other Towns the comparable figure was 18.3 per cent and 11.3 per cent in Rural Areas. By consumption group, the pattern of health insurance coverage has been consistent over time, increasing from the lowest consumption group towards the highest consumption group. In 2015, Quintile 1 recorded 3.7 per cent relative to 40.3 per cent in Quintile 5. Health insurance also increased generally with increasing age, from 12.5 per cent of the 0–4 age group to 24.0 per cent of the 65 years and older group.

Expenditure on health care was understandably low to negligible for those who used public facilities, due to the no-user fee policy. On the other hand, users of private facilities paid an average of $2 757.00, which was an increase of 51.2 per cent relative to 2014. The purchase of medication by those reporting illness or injury continued to occur mainly at private pharmacies. Some 73.0 per cent bought medication, of which 84.6 per cent bought prescribed medication and 80.5 per cent purchased solely at private pharmacies. Average expenditure for medication at private drug facilities was $3 194.00, representing an 8.3 per cent increase over 2014. Mean expenditure on drugs at public pharmacies was $577.00, a 45.5 per cent decline compared with 2014.

Education

Enrolment of the school-age population (3–24 years) was 74.4 per cent. However, there were wide differences between age groups, with proportions declining steeply after age 16. For each age group up to age 16, enrolment rates were over 95.0 per cent. By contrast, for the 17–18 age group, the enrolment rate was 50.0 per cent, and for the 19–24 years group, it was 18.8 per cent. Nonetheless, these two groups have recorded noteworthy increases over the 10 years since 2006. Enrolment for the former group was 45.9 per cent in 2006, with a corresponding figure of 5.5 per cent for the latter group. The majority of students (85.4 per cent) were enrolled in public institutions.

For students up to age 16, the vast majority was registered at the level of the education system appropriate to their age: 95.8 per cent (early childhood level); 92.9 per cent (primary level); 78.3 per cent (first cycle secondary level); and 96.3 per cent (second cycle secondary level). Among students of appropriate age for enrolment at the first cycle of the secondary level (12–14 years), some 20.6 per cent were still enrolled at the primary level. This may be partly due to the government's Alternative Secondary Transition Education Programme (ASTEP), which is aimed at ensuring student readiness before transition to the secondary level. However, there was a strong gender imbalance as, for boys in this age cohort, some 26.9 per cent were enrolled at primary level compared with 12.7 per cent of comparable females.

Consistent with government policy, enrolment in schools offering three years of secondary education has declined over time. The share of enrolment in five-year schools increased to 93.8 per cent in 2015 from 89.5 per cent in 2010. Nonetheless, boys and students from the poorest quintile (Quintile 1) continued to make up the larger proportion of three-year schools' populations.

With respect to attendance, 82.1 per cent of students (early childhood to secondary levels) attended school for all of the 20-day reference period used in the survey. The KMA had a higher rate of full attendance (84.7 per cent) relative to Rural Areas (81.1 per cent) and Other Towns (80.9 per cent). Students in the poorest quintile recorded a rate of 75.1 per cent, which was well below the other quintiles, which were upwards of 83.0 per cent. Money was the main reason given for students' absence, as was reported by 42.4 per cent. Money was the reason given for 51.4 per cent of Quintile 1 students' absence; 60.7 per cent in Quintile 2; 52.6 per cent in Other Towns; and 46.7 per cent in Rural Areas. By contrast, money was cited for 22.7 per cent of KMA students' absence and 20.6 per cent in Quintile 5.

The average distance travelled to school by pupils at the primary level was 4.2 km and 13.7 km for their secondary level counterparts. Compared with the MOYEI's benchmarks, primary school students were within the standard of 3 miles (approximately 5 km) for students at that level, but the average for secondary level students exceeded the 7-mile distance established for them (approximately 10 km). On average, students travelled longer distances to the school they attended than the distance from home to the nearest school of appropriate level. The overall mean distance travelled was 8.5 km while the nearest school was an average of 3.3 km away.

Public passenger vehicle (bus, taxi) was most students' mode of transport to school (66.8 per cent) both nationally and regionally, while 24.1 per cent walked. For those using public transport, comparable proportions by region were 73.4 per cent in Other

Towns; 71.6 per cent in Rural Areas; and 54.2 per cent in the KMA. Some 61.4 per cent of Quintile 1 students took public transport and 74.5 per cent of those in Quintile 4, while 54.1 per cent in Quintile 5 got to school in this way.

Some 67.9 per cent of students were reported as having all the textbooks required by their schools. These would include government-supplied books and those recommended by the school. By consumption status, while 88.2 per cent of Quintile 5 students had all the textbooks, only 47.3 per cent of their Quintile 1 counterparts possessed all. Regional differences were less stark, with 72.5 per cent of KMA students having all the required textbooks compared with 68.4 per cent in Other Towns and 64.8 per cent in Rural Areas.

School lunches were accessed by 88.7 per cent of students. Of these, 73.6 per cent received a cooked meal. Participation in school feeding programmes has increased over time from 68.4 per cent in 2006. Children at the Early Childhood level registered the largest rate of participation, with some 95.6 per cent reported. Some 81.5 per cent of children in the poorest consumption group (Quintile 1) received cooked meals under the programme and 73.0 per cent in Quintile 5. Despite the relatively low cost to households for accessing the meals, 23.7 per cent of those who did not participate reported that they could not afford the meal.

Housing

The housing quality index (HQI) was 72.2 per cent, meaning that close to three-quarters of households lived under housing conditions that were consistent with the standards established as acceptable. Rural households continued to lag behind their urban counterparts, as Rural Areas recorded an HQI of 67.3 per cent, relative to 78.5 per cent in the KMA and 73.6 per cent in Other Towns. Nevertheless, this was an increase of 7.2 percentage points in Rural Areas relative to 2006. The poorest consumption group was below the overall average, with 57.5 per cent, while the highest consumption group, with 84.3 per cent, was above the average.

With regard to the components of the HQI, concrete block and steel was the most common material of dwellings' outer walls, reported by 68.1 per cent of households. Approximately a half of all households (49.2 per cent) had indoor tap water, although eight of every 10 reported an improved source of drinking water. While 99.5 per cent of KMA households reported an improved source of drinking water and 88.9 per cent in Other Towns, Rural Areas reported 63.9 per cent. Also, the poorest quintile reported 64.3 per cent compared with 68.6 per cent in Quintile 5. Some 65.9 per cent of households had exclusive use of flush toilets (water closet), despite 77.7 per cent having this type of toilet facility. Approximately 95.0 per cent of households reported electricity as their main source of lighting, with over 90.0 per cent in all regions. Some 92.6 per cent of households had exclusive use of their kitchen facility, with all households reporting access to a kitchen facility in 2015.

Some 37.8 per cent of households lived in overcrowded housing conditions, which was 12.2 percentage points lower than in 2006. The reduction may be considered in conjunction with the decline in average household size and the increase in single-member households over the same period. There were no major differences by region. As poorer households are typically larger, households in Quintile 1 registered above average overcrowding, recording 67.9 per cent.

More than three-quarters of households (78.9 per cent) lived in detached dwelling houses, with stark distinctions by region. Some 93.1 per cent of rural households lived in detached houses compared with 79.3 per cent in Other Towns and 57.1 per cent in the KMA. Other dwelling types were more common in the KMA, which recorded 18.4 per cent of households in semi-detached houses, 13.3 per cent in part of a house, 6.7 per cent in townhouses and 4.3 per cent in apartments. Households in the poorest quintile lived mainly in detached housing units (93.3 per cent), while those in Quintile 5 showed more diversity in terms of their dwelling units.

In aggregate, ownership of the dwelling house occupied by the household was the most common tenure type recorded (55.3 per cent), while households living rent-free accounted for one-quarter (25.7 per cent). Some 17.5 per cent rented or leased their dwelling house. Ownership of the land occupied by the dwelling house was lower at 42.6 per cent, 17.3 per cent rented, 5.3 per cent leased and 3.5 per cent reported that they squatted. Of households that reported owning the land that they occupied, 59.3 per cent had a registered title.

Although most households (66.0 per cent) reported using a formal method of garbage disposal, and regular public collection was reported by 50.4 per cent, burning continued to be the most common informal method, used by 32.1 per cent. Outside of urban areas, informal methods were more standard, with 53.2 per cent of Rural Area households reporting burning. Some 60.8 per cent of the poorest households burnt their garbage, declining steadily to 20.7 per cent of those in Quintile 5.

Real (inflation adjusted) increases relative to 2014 were observed for all three utilities captured by the survey. Electricity payments registered a real increase of 10.9 per cent, telephone, 9.7 per cent and water, 14.9 per cent.

Social Protection

The data have consistently shown that approximately one-third of households in the population have at some point applied to the Programme of Advancement Through Health and Education (PATH) since the programme began. The data have also shown that the largest percentage of applicant households are in Rural Areas and that the proportion of applicant households declines from the poorest consumption group to the wealthiest consumption group. In 2015, some 73.0 per cent of Quintile 1 households reported that they had applied and 11.1 per cent in Quintile 5.

Of households that had applied, some 59.6 per cent reported in 2015 that they had at some point been in receipt of a benefit under the programme since its start. Some 72.8 per cent of applicant households in the poorest quintile had been beneficiaries in the past, or were current beneficiaries, compared with 45.8 per cent in Quintile 5.

While the data verify that programme benefits are reaching the vulnerable, they also highlight the fact that the majority of households have been on the programme for extended periods. Of households that were still in receipt of benefits, 61.1 per cent had been receiving for at least five years. Some 65.9 per cent of Quintile 1 households had been beneficiaries for at least five years. Using the payment made closest to the survey period as a proxy for current beneficiaries, the data revealed that 66.7 per cent of the poorest 40.0 per cent of households were current recipients. This shows that those most in need make up the larger share of programme beneficiaries.

Some 47.1 per cent of those 18 years and over had registered with the National Insurance Scheme (NIS). Proportions were higher in the KMA (57.7 per cent) and Other Towns (56.3 per cent) than in Rural Areas (36.2 per cent). Also, between Quintile 1 and Quintile 5, proportions varied from 28.7 per cent to 61.0 per cent.

While registration with the National Health Fund (NHF) is contingent on having at least one of the medical conditions covered by it, the 10.1 per cent reported in the survey was well below the proportion of the population identified as having at least one non-communicable disease (NCD) (approximately 25.0 per cent). Regional proportions varied widely from the national mean and the poorest households (Quintile 1) recorded just 6.0 per cent. Similarly, for the Jamaica Drugs for the Elderly Programme (JADEP), while the 22.9 per cent registered was above the NHF, this figure was considerably below the proportion of individuals 60 years of age who reported at least one NCD.

CONCLUSION

In 2015, the living standards of both individuals and households showed some advances in both the short and long terms, even though there were areas that require attention. Marginal progress in economic indicators translated into increased household consumption. Nevertheless, the imbalance in distribution meant increased inequality and an increase in the rate of poverty.

The country's demographic profile has continued to highlight the demographic dividend that is a consequence of the ageing population. The declining share of children in the population has led also to smaller average household size, with single-member households now being the most common type. However, there are various implications of individuals living alone, particularly the vulnerable—such as the elderly—who make up a significant proportion of single-member households. On the positive side, the data also show a decline in overcrowding, or average number of persons per habitable room.

While, over time, there has been a reduction in reports of illness and injury, NCDs persist as a critical burden on the health care system. Of note, females continue to report NCDs in larger proportions than males, although this may be a factor of having been diagnosed rather than one of prevalence.

Recent developments in education include increasing enrolment among older age groups (17–18 and 19–24 years), which have traditionally numbered heavily among the out-of-school population. Government policies to increase attendance, such as the provision of meals and textbooks, have been mostly successful, yet money continues to be cited as a foremost reason for absence from school. This may point to other financial barriers to education, such as transport costs. Also, a small proportion of students who did not take the school-provided meal, cited affordability as the reason.

Based on the six indicators of the housing quality index (HQI), the quality of the housing stock continued to be fairly high overall, though there remained disparities by region and consumption group. Disposal of garbage—particularly among rural and poor households—remained an issue for attention, as large proportions in these two groups used informal methods, mainly burning.

The data corroborated the reach of the Programme of Advancement Through Health and Education (PATH) to the most vulnerable. However, other social protection programmes, such as the National Insurance Scheme and health-related benefits, which have voluntary application, appeared to be poorly accessed by eligible groups.