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Poverty Reduction Strategies: The Role of Health and Education - A Trinidad and Tobago Perspective

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46 Poverty Reduction Strategies: The Role of Health and Education - A Trinidad and Tobago Perspective. First of the Series of papers presented at the Seminar on Poverty Reduction and Social Policy in the Caribbean

BIBLIOGRAPHY SERIES

No.1 Bibiliografía Políticas Sociales
No.2 Bibiliografía sobre Seguridad Social
No.3 Bibliografía sobre Legislación en Salud
Poverty Reduction Strategies: The Role of Health and Education - A Trinidad and Tobago Perspective

by

Karl Theodore
University of West Indies

Public Policy and Health Program
Health and Human Development Division
Pan American Health Organization
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NOTE

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-Poverty Reduction Strategies: The Role of Health Education -A Trinidad and Tobago Perspective
-Strategies for Poverty Reduction and Social Policy in Venezuela: The Role of Health and Education
-Poverty Reduction Strategies in Jamaica: The Role of Health and Education
-Strategies for Reducing Poverty in the Dominican Republic: The Role of Health and Education
-Barbados Poverty Reduction Strategies: The Role of Health and Education
-Poverty Reduction and Social Policy in the Caribbean: The Role of Health and Education, México
-Poverty and Interventions in Health and Education: Guyana
-Reducing Poverty in the Caribbean: Implications for Health and Education

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PREFACE

This study is not meant to be a comprehensive analysis of any of the sectors and/or institutions to which reference is made. The recognition here is that a thorough evaluation of the role of the individual areas in poverty reduction is beyond the scope of this particular undertaking. As such, even the case studies should be viewed within the context of the specific terms of reference.

The main sources of data were secondary in nature. However, interviews were conducted with key informants within the public sector, with informal interviews being done with members of the consuming public. In addition, this final report has greatly benefited from feedback received from the in-country seminar of February 9th, 1995, which was organized by the Pan American Health Organization (PAHO).

Although some analyses of the role of the private sector in the provision of services have been done (especially in relation to welfare services and within the context of the changing role(s) of the State), the researcher acknowledges that the presentation of quantitative data is skewed in favor of the public sector. As such, no comparison was made of the cost of providing health and education services within the private sector vs. the public sector. In the case of education, data is provided for both public and government assisted schools, but not for "fully private" institutions.
INTRODUCTION

In addition to the usual reasons which are identified as contributing to the concern with poverty are the potential for persistent poverty to disturb civil life and the fact that persistent poverty is an intellectual embarrassment. It indicates a lack of understanding as to how to deal with one of the fundamental objectives of development.

The evidence gleaned from a review of various documents/studies, that have attempted to analyze the social sectors in Trinidad and Tobago in general, and the health and education sectors in particular, seems to point to inadequate access by the poor to social programs (Halpin, 1991; McIntyre, 1993; Coopers and Lybrand, 1994; Health and Life Sciences Partnership, 1994; Ministry of Education, 1994; University of West Indies (UWI), 1994).

Even more importantly though, is the fact that most of the documents have found that the problems of lack of efficiency in targeting and delivery of services to “appropriate” groups, are by no means a recent phenomenon.

Here, it should be noted that although the above references are concentrated within the last two to three years, a number of previous studies have been conducted, as evident from the following sections, and most attest to similar inadequacies. The data spanning 1982-1992, show a marked decline in the level of real public expenditure in the social sectors. However, as the McIntyre Report (1993) rightly noted, this decline has not yet had any strong negative impact on the social indicators themselves (that is, life expectancy, infant mortality, primary school enrolment, illiteracy etc.). In fact we have had gains in these areas over the period under review.

Looking at the economic indicators and the trends in the poverty profile of the country, though, one should resist the temptation to overly indulge in self-congratulation or even for that matter, passive acceptance of such gains. It is not just that there is still a lot to be done, but maybe even more importantly, that there is less to do it with. It would seem that the impact of the structural adjustment process has had a "crunch-effect" on the pockets and well being of the more unfortunate in society and the numbers falling within this bracket have increased. This has led to a growing concern on the part of policy makers, with attempts being made to address the problem by measuring the extent of poverty, identifying the poor and providing adequate programs.
Moreover, it is evident that the issues surrounding poverty should be more the direction of the changes in the profile than the absolute level of poverty itself. Here the concern should be whether there are fluctuations in the observed levels or whether the country is on a steady path to the reduction of poverty. In Trinidad and Tobago, the evidence has shown that there has been a definite increase in the rate of poverty from 1980/1981 to 1992.

At present, poverty is what we may term a "hot" topic. What seems clear is the need for dispassionate attempts to deal with it. In this regard, any policy approach should benefit from a scientific approach.
1. OVERVIEW OF HEALTH AND EDUCATION SECTOR AND
ISSUES OF ACCESSIBILITY

1.1 Overview

Before launching into an analysis of reform projects in health and education which are
aimed at poverty reduction, or even for that matter, at the trends in accessibility, it may be
useful to locate the analysis within a conceptual framework.

Poverty may reduce access to educational opportunities as the opportunity cost of current
consumption becomes lower than the rewards of a longer term investment in education. On the
other hand, ignorance of the power of a proper education in reducing poverty, and promoting
income and welfare levels, can also lead to limited or marginal opportunities for the poor.

It has been said that "Big trees grow from little seedlings." By similar reasoning, tertiary
health care demands result from primary health care inadequacies (M. Over, 1991). A lack of
education can, and often does, lead to the under-utilization of primary health care (PHC)
facilities, and in many cases illnesses of the "undereducated" are only addressed when the
discomfort or inconvenience becomes unbearable. The flip side of this is that the more educated
are likely to be in a better position to access safer living conditions and engage in healthier
sanitary practices. Their children are also likely to be the beneficiaries of proper vaccination
and other procedures at an earlier age.

In addition, the emerging evidence seems to suggest that healthier workers earn more
because their level of productivity is relatively higher and they hold better paying jobs (The
World Bank, 1993). From the foregoing, it becomes increasingly evident that ill health can
accentuate poverty by resulting in loss of income. It is also possible that the high cost of
medical treatment may lead to impoverishment among afflicted households.

Whereas the above outlined relationship between health, education and poverty has been
somewhat microanalytical, Mead Over (1991), has noted that the health sector is related to the
rest of the economy as indicated in Figure 1-1 below.
Figure 1.1 Schematic representation of the link between health and the rest of the economy


For the purposes of this paper, we need only concern ourselves with the production function. If we depict an economy-wide production function by:

$$X = f(L, K, E)$$

Where:
\begin{itemize}
  \item $X =$ output;
  \item $L =$ labor;
  \item $K =$ capital; and
  \item $E =$ entrepreneurial ability,
\end{itemize}

then we can begin to see the makings of a more macro relationship between the three variables of poverty, health and education. Ideally we would wish to express each of the above variables as a function of either poverty, health or education. If we choose health status as a proxy for health, we can say that both labor (mental and physical) and entrepreneurial ability, are positive functions of health status. That is,
L: L (HS)

and

E: E (HS)

Expressing K as a function of HS (health status) is a bit more involved. If we allow I(investment) to represent the change in K, and we denote savings by S, we have

\[ \Delta K = S \]

and

\[ S = s \text{ (HS)} \quad (s' < 0) \]

To the extent that savings are inversely related to health status, then we also have investment inversely related to health status. That is, since investment is the change in K, we have the capital stock being a function, however indirectly, of health status (HS). It follows that:

\[ X = X \left[ L(\text{HS}), K(\text{HS}), E(\text{HS}) \right] \]

\[ = X \left[ \text{HS} \right] \]

The implications of this reduced-form function are tremendous. It provides an economic basis for promoting health status which, according to Figure 1-1, would directly affect the other two socio-economic concerns of poverty and education.

Having outlined the theoretical underpinnings of the perceived relationship between health, education and poverty, we now turn to an analysis of what the data suggest for Trinidad and Tobago.

1.2 Trends in Social Indicators

With the exception of 1991, when a positive growth rate of some 2.6 percent was realized, the Trinidad and Tobago economy has experienced negative real growth since 1983 (See Table 1-1). Real Gross Domestic Product (GDP) (1985 prices) fell from an average of TT$20,924 million to TT$16,085 million over the period 1980-1982 to 1990-1992. This in effect represents an overall decline of some 23%. At the same time, the growth rate of the economy fell from an average of close to 5% for the three-year period 1980-1982, to an average of just under 0.3% for the three-year period, 1991-1993. Since the intervening period, 1983-1990 was one of continuous contraction (averaging approximately -3.8%), the period 1991-1993 constituted a significant improvement.

On the labor front, the market conditions have led to a decidedly upward trend in the rate of unemployment. Unemployment rose from 9.9% of the labor force in 1980 to a high of 22.2
% in 1987, falling off to approximately 18.5% in 1991 after which the estimated rates continued to climb upward, averaging approximately 19.8% by 1993.

Inflation rates, which fluctuated throughout the period have been moderate, even in the midst of the “floating” of the currency in April 1993. In fact, the average rate of inflation was some 14.4% over the period 1980-1982, compared with an average of less than half of this(7.0%) for the period 1991-1993. This is encouraging, especially given recent emphasis on the inflation rate as one of the single most important indicator of macroeconomic stability (Greene and Villanueva, 1991).\(^1\)

During the period 1980-1993, both the fiscal and the external current account balances were predominantly negative, with the current account balance of external payments standing at an extreme of negative 16% of GDP in 1983, and the fiscal balance at an extreme of 12.5 percent in 1982. However, while the current account balance seemed somewhat unstable, moving from very large values to very small values in consecutive years, the fiscal balance has been improving.

When we consider the above indicators from the perspective of the country’s ability to meet the needs of the social sectors, including health and education, the only positive index seems to be the inflation rate. With negative or very low rates of growth, increasing levels of unemployment, negative current account and fiscal balances, and a rapidly declining real per capita GDP, it should come as no surprise that during the necessary adjustment process, the social sectors have been, and from all appearances would continue to be called upon, to bear a relatively heavy burden.

\(^1\)International Monetary Fund (IMF) Staff Papers, 1991.
Table 1.1 Selected Economic Indicators (1980-1993)

<table>
<thead>
<tr>
<th>Year</th>
<th>Real GDP Growth Rates</th>
<th>Unemployment Rate (%)</th>
<th>Inflation Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>6.9</td>
<td>9.9</td>
<td>17.5</td>
</tr>
<tr>
<td>1981</td>
<td>2.7</td>
<td>10.4</td>
<td>14.3</td>
</tr>
<tr>
<td>1982</td>
<td>5.3</td>
<td>9.9</td>
<td>11.4</td>
</tr>
<tr>
<td>1983</td>
<td>-8.5</td>
<td>11.1</td>
<td>15.2</td>
</tr>
<tr>
<td>1984</td>
<td>-6.7</td>
<td>13.4</td>
<td>13.3</td>
</tr>
<tr>
<td>1985</td>
<td>-4.5</td>
<td>15.6</td>
<td>7.7</td>
</tr>
<tr>
<td>1986</td>
<td>-1.8</td>
<td>17.2</td>
<td>7.7</td>
</tr>
<tr>
<td>1987</td>
<td>-4.6</td>
<td>22.2</td>
<td>10.8</td>
</tr>
<tr>
<td>1988</td>
<td>-3.7</td>
<td>22.0</td>
<td>7.8</td>
</tr>
<tr>
<td>1989</td>
<td>-0.7</td>
<td>22.0</td>
<td>11.4</td>
</tr>
<tr>
<td>1990</td>
<td>-0.1</td>
<td>20.0</td>
<td>11.1</td>
</tr>
<tr>
<td>1991</td>
<td>2.6</td>
<td>18.5</td>
<td>3.8</td>
</tr>
<tr>
<td>1992</td>
<td>-0.4</td>
<td>19.6</td>
<td>6.5</td>
</tr>
<tr>
<td>1993</td>
<td>-1.3</td>
<td>19.8</td>
<td>10.8</td>
</tr>
</tbody>
</table>

Source: Central Statistical Office.  
Central Bank of Trinidad and Tobago, 1994.

Central government’s nominal recurrent expenditure on the social sectors, including health, education, housing, pension and welfare payments etc., decreased from TT$ 2.2 billion in 1982 to TT$ 2.1 billion in 1990. This in effect translates into a 46.9% decline in real recurrent expenditure (1985 prices), or from TT$ 3.2 billion in 1982 to TT$ 1.7 billion in 1990 (C. Bourne, 1993).
<table>
<thead>
<tr>
<th>Year</th>
<th>Health Expenditure % of Total Exp.</th>
<th>Health Expenditure % of GDP</th>
<th>Per Capita Health Exp.*</th>
<th>Per Capita Education Exp.*</th>
<th>Education Exp. as % of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>4.2</td>
<td>1.7</td>
<td>519</td>
<td>816</td>
<td>2.8</td>
</tr>
<tr>
<td>1982</td>
<td>5.4</td>
<td>2.5</td>
<td>483</td>
<td>1333</td>
<td>4.7</td>
</tr>
<tr>
<td>1983</td>
<td>6.3</td>
<td>2.8</td>
<td>447</td>
<td>1160</td>
<td>4.9</td>
</tr>
<tr>
<td>1984</td>
<td>6.9</td>
<td>3.1</td>
<td>421</td>
<td>1023</td>
<td>5.1</td>
</tr>
<tr>
<td>1985</td>
<td>7.3</td>
<td>3.1</td>
<td>394</td>
<td>868</td>
<td>5.4</td>
</tr>
<tr>
<td>1986</td>
<td>8.7</td>
<td>3.1</td>
<td>387</td>
<td>769</td>
<td>5.4</td>
</tr>
<tr>
<td>1987</td>
<td>8.3</td>
<td>3.4</td>
<td>299</td>
<td>627</td>
<td>5.5</td>
</tr>
<tr>
<td>1988</td>
<td>7.5</td>
<td>3.1</td>
<td>255</td>
<td>545</td>
<td>4.5</td>
</tr>
<tr>
<td>1989</td>
<td>7.8</td>
<td>2.8</td>
<td>221</td>
<td>451</td>
<td>3.8</td>
</tr>
<tr>
<td>1990</td>
<td>7.9</td>
<td>2.4</td>
<td>221</td>
<td>403</td>
<td>3.6</td>
</tr>
<tr>
<td>1991</td>
<td>7.7</td>
<td>2.3</td>
<td>221</td>
<td>325</td>
<td>4.2</td>
</tr>
<tr>
<td>1992</td>
<td>7.3</td>
<td>2.2</td>
<td>197</td>
<td>260</td>
<td>3.5</td>
</tr>
</tbody>
</table>


*: Real TTS, 1982 = 100.

There is some indication of central government’s commitment to the social sectors, as indicated by the stability and in some cases the growth of the percentage share of the various social sector allocation to GDP and/or total government expenditure over the period 1981 to 1992. However, the real value of expenditure has fallen off dramatically as indicated by the 62 percent decline in real per capita expenditure on health and the 68% decline for education (See Table 1.2).

Turning to three basic indicators for education and health status (Table 1.3), we observe that Trinidad and Tobago has indeed experienced gains in these areas over the past decade. Both infant mortality and illiteracy rates are down, while we have had a 4.7 point increase in life expectancy, up from 66 years in 1970 to just over 70 years in 1990.

It may well be though, that this is reflective of a possible time lag. It is also possible that we are now reaping the benefits of positive past intervention strategies at the primary level. From the discussions undertaken, it would seem that there is some general agreement on the
existence of a time lag. What this would mean is that we can expect a deterioration in the indicators if resources are not properly channelled in the future.

Table 1.3  Selected Education and Health Status Indicators  
(1970-1990)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Expectancy (Years)</td>
<td>66.2</td>
<td>68.2</td>
<td>70.9</td>
</tr>
<tr>
<td>Infant Mortality (per'000)</td>
<td>34.4</td>
<td>33.8</td>
<td>20.4</td>
</tr>
<tr>
<td>Illiteracy Rate (%)</td>
<td>9</td>
<td>4</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Central Statistical Office

1.3  Estimates of Accessibility

Accessibility of education

According to Table 1.4 below, approximately 11% of the Trinidad and Tobago population did not have any formal education at the time of the 1990 Population and Housing Census. The majority of the population (47.8%), had attained formal education up to at least the primary school level, with 34.1% going on to access the secondary school system and some 1.9% reaching university level.
Table 1.4 Highest Level of Educational Attainment (1990) (%)

<table>
<thead>
<tr>
<th>Area</th>
<th>None</th>
<th>Nursery</th>
<th>Primary</th>
<th>Secondary</th>
<th>University</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trinidad &amp; Tobago</td>
<td>11.0</td>
<td>2.9</td>
<td>47.8</td>
<td>34.1</td>
<td>1.9</td>
<td>0.0</td>
</tr>
<tr>
<td>P.O.S</td>
<td>7.9</td>
<td>2.8</td>
<td>42.4</td>
<td>41.0</td>
<td>2.8</td>
<td>0.0</td>
</tr>
<tr>
<td>San Fernando</td>
<td>7.6</td>
<td>3.4</td>
<td>42.2</td>
<td>40.9</td>
<td>3.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Arima</td>
<td>9.2</td>
<td>3.5</td>
<td>43.8</td>
<td>37.3</td>
<td>2.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Pt.Fortin</td>
<td>9.8</td>
<td>3.5</td>
<td>49.8</td>
<td>34.2</td>
<td>1.0</td>
<td>0.0</td>
</tr>
<tr>
<td>St.George</td>
<td>10.8</td>
<td>3.1</td>
<td>44.7</td>
<td>36.5</td>
<td>3.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Caroni</td>
<td>9.8</td>
<td>3.0</td>
<td>49.0</td>
<td>32.6</td>
<td>1.5</td>
<td>0.7</td>
</tr>
<tr>
<td>Nariva</td>
<td>12.4</td>
<td>2.3</td>
<td>55.9</td>
<td>25.5</td>
<td>0.4</td>
<td>0.9</td>
</tr>
<tr>
<td>St.Andrew/St.David</td>
<td>13.8</td>
<td>2.4</td>
<td>53.5</td>
<td>28.5</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td>Victoria</td>
<td>12.0</td>
<td>2.7</td>
<td>49.2</td>
<td>33.3</td>
<td>1.3</td>
<td>0.6</td>
</tr>
</tbody>
</table>


In effect, although primary school education seems to be attainable by most, a sample of some areas based on the 1990 census data, suggests that persons residing in rural areas access secondary and tertiary schooling at a smaller percentage rate than their urban counterparts. Moreover, the percentage of the population attending university seems to be way below the average for middle-income developing countries (Table 1-4), and there is still room for overall improvement in the percentage of persons going on to post-primary formal education. Secondary school education has been attained by roughly one-third of the population.

We now turn to an analysis of the accessibility of education based on the number of school places and enrolment rates at the level of the primary school system.
Table 1.5 Availability of School Places and Enrollment Levels in Government and Assisted Primary Schools (1980/81 - 1990/91)

<table>
<thead>
<tr>
<th>Year</th>
<th># School Places</th>
<th>Pop. 5-14 yrs.</th>
<th>Places per '000 Student Pop.</th>
<th>Level of Enrollment</th>
<th>Enrollment per '000 Student Pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980/81</td>
<td>166350</td>
<td>-</td>
<td>-</td>
<td>167083</td>
<td>-</td>
</tr>
<tr>
<td>1981/82</td>
<td>166700</td>
<td>-</td>
<td>-</td>
<td>164452</td>
<td>-</td>
</tr>
<tr>
<td>1982/83</td>
<td>168150</td>
<td>241026</td>
<td>702</td>
<td>169803</td>
<td>705</td>
</tr>
<tr>
<td>1983/84</td>
<td>166100</td>
<td>244981</td>
<td>678</td>
<td>166739</td>
<td>681</td>
</tr>
<tr>
<td>1984/85</td>
<td>166900</td>
<td>244779</td>
<td>682</td>
<td>168790</td>
<td>690</td>
</tr>
<tr>
<td>1985/86</td>
<td>171350</td>
<td>-</td>
<td>710</td>
<td>172433</td>
<td>715</td>
</tr>
<tr>
<td>1986/87</td>
<td>176650</td>
<td>238168</td>
<td>742</td>
<td>176544</td>
<td>741</td>
</tr>
<tr>
<td>1987/88</td>
<td>181950</td>
<td>241580</td>
<td>753</td>
<td>182764</td>
<td>757</td>
</tr>
<tr>
<td>1988/89</td>
<td>185550</td>
<td>244182</td>
<td>760</td>
<td>186189</td>
<td>763</td>
</tr>
<tr>
<td>1989/90</td>
<td>189150</td>
<td>253977</td>
<td>768</td>
<td>189913</td>
<td>747</td>
</tr>
<tr>
<td>1990/91</td>
<td>192820</td>
<td>247275</td>
<td>-</td>
<td>193711</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Central Statistical Office.

There has indeed been improvement in the level of accessibility to education at the primary school level as indicated by increases in the absolute number of available primary school places, the places per one thousand children aged 5 to 14 years, and even enrolment, over the period 1980/81 - 1990/91 (See Table 1-5).

According to the data presented in Table 1-5, there were approximately 232 children aged 5 to 14 years who could not be physically accommodated in the primary school system in 1990. To the extent that a number of children aged 11 to 14 would have either gone on to secondary or vocational schools, then this figure is likely to be somewhat overstated. However, a limited informal survey of teachers within the primary school system (both government and government assisted), suggested that there are indeed cases in which post-common entrance students (those failing) are sometimes "forced" to "drop-out" of the system because their needs are not being met. The problem exists on at least two levels:
(i) In some cases, there are schools with no post-primary classes; and

(ii) In other cases, there is limited accommodation for post-common entrance students.

Of course this needs to be tempered by the fact that post primary centers exist and cater for surrounding schools that do not have such centers. There are 20 post-primary centers in Trinidad and Tobago. Four in Tobago and 16 in Trinidad. In Trinidad, the centers are divided based on seven education districts as follows:

**District I:- Caroni**

Preysal Government School  
Esperanza Presbyterian  
Ragoonanan Road Government

**District II:- North Eastern**

Coryal R. C.  
Manzanilla Government Primary

**District III - Port of Spain and Environs**

St. Phillip’s Primary School  
Chinapoo Government

**District IV - St. George East**

Five Rivers T. I. E.

**District V - St. Patrick**

Brighton A. C.  
Fyzabad Presbyterian  
Egypt Village Government

**District VI - South Eastern**

New Grant Government  
St. Therese R. C.  
Mayaro Post Primary Centre

**District VII - Victoria**

Point a Pierre Government  
Tabaquite R. C.
In addition to these twenty centers, there are about 15-16 associate schools which cater to the needs of this target group and receive both financial and technical assistance from the Central Government (See Annex I). Plans are also under way for 52 additional associated post-primary classes. Additionally, it should be noted that some primary schools themselves, have post-primary classes.

At present, the question of accessibility still remains valid though, because of the limited number of such centers and the distance and costs involved in reaching these facilities.

**Accessibility to Health Care**

Turning to the question of the accessibility of health care, we find that although there are just over 100 health centers in Trinidad and Tobago the appropriateness of the distribution remains somewhat questionable (Bourne, 1993).

Bourne (1993) notes "...based on the distribution and capabilities of the health centres in the country, the rural population does not have access to basic health facilities on the scale and range available to their urban counterparts." In addition, as Table 1.6 illustrates, public medical care facilities tend to be relatively more urban-based.

The above data, combined with declining economic performance, prompted Theodore to note that "...it is possible that over 30% of the population are unable to access health care either due to their financial constraints or to the inaccessibility of health care as a result of shortage of the necessary manpower at the various public health institutions." (K. Theodore, 1993).

**1.4 Factors Affecting Accessibility**

**Factors in Accessibility of Health Care**

Notwithstanding the difficulty involved in measuring accessibility of health care, there are indicators which may be used to get a feel for what is happening within the system. The indicators focused on here are demand and supply indicators, including financial, physical, materials and supplies and manpower.
Among the most common factors cited as affecting the level of access to health care are:

(i) *Real Income Constraints*: including the incomes of individuals and/or households, the cost of transport to and from the health care facility and the cost of obtaining medical care (fees and drug costs, and others). See Table 1-8.

<table>
<thead>
<tr>
<th>County</th>
<th>Number of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. George:</td>
<td></td>
</tr>
<tr>
<td>West</td>
<td>2</td>
</tr>
<tr>
<td>Central</td>
<td>1</td>
</tr>
<tr>
<td>East</td>
<td>2</td>
</tr>
<tr>
<td>St. Andrew/St. David</td>
<td>1</td>
</tr>
<tr>
<td>Caroni</td>
<td>1</td>
</tr>
<tr>
<td>Victoria</td>
<td>2</td>
</tr>
<tr>
<td>Nariva/Mayaro</td>
<td>1</td>
</tr>
<tr>
<td>St. Patrick</td>
<td>1</td>
</tr>
<tr>
<td>Tobago</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>


(ii) *Supply Constraints*: on the supply side, it is possible to identify limits as they relate to personnel, hours of service provided, material (including drugs and related supplies). These may sometimes be traced back to financial constraints of the supplier (Central Government budgetary allocation). In other cases the problem may be one of resource allocation.

While this listing is by no means exhaustive, it should be noted that the majority of accessibility factors could be located as an extension of one or other of those presented above.
Between 1987 and 1991, Central Government's expenditure on health as a percentage of GDP, declined from approximately 3.4% to 2.3%. In addition, the fiscal austerity measures which were implemented have served to increase the difficulties experienced by lower-income groups, in terms of accessing proper health care. An estimated 30% of the population find health services inaccessible, by dint of budget constraints, concomitant with insufficient manpower at public health institutions. According to Coopers and Lybrand (1994), this may be detrimental in a situation where the medically indigent population is expected to increase with economic contraction and the negative impact of structural adjustment.

A word of warning should be sounded here. Although the previous section (1.3) made use of the availability of infrastructure and its distribution as a measure of accessibility, one should use such statistics with caution. The warning here is that infrastructure is not necessarily indicative of the quality of service. While Trinidad and Tobago houses somewhere in the vicinity of 100 plus primary health care centres, the distribution of these facilities has not necessarily addressed the health care needs of the population, as is evident from the documents coming out of the reform initiative. Distribution was most probably based on demographic factors, especially the size of the population. In consequence, there was a more limited distribution of health centers in rural areas. This would partly be the reason why the economic and social costs of commuting to major urban hospitals pose a barrier to residents of rural districts.

The provision and thus access to quality health care may be also affected by the dilapidated state of plant and equipment and the shortage of skilled manpower. With reference to the latter, the ratio of nurses to population decreased by 12 percent, from 236 in 1981 to approximately 208 per 100,000 persons in 1990. Cases of extreme shortages in manpower allocation in health centres are found in counties St. George and Nariva/Mayaro. It is possible that such shortages have influenced the functional decay of health care institutions, as well as the long waiting lists at district and general hospitals, since individuals are increasingly bypassing health centers in preference for Accident and Emergency Departments of hospitals (K. Kassarie, 1993).  

---

Table 1.7 Distribution of Government Recurrent Expenditure for the Ministry of Health in Trinidad and Tobago (1982-1992) TTS M

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>384.94</td>
<td>388.09</td>
<td>415.98</td>
<td>421.68</td>
<td>424.76</td>
<td>384.44</td>
<td>373.91</td>
<td>312.35</td>
<td>301.21</td>
<td>336.40</td>
<td>372.16</td>
</tr>
<tr>
<td>Goods &amp; Services</td>
<td>84.71</td>
<td>86.42</td>
<td>93.30</td>
<td>85.91</td>
<td>86.28</td>
<td>94.32</td>
<td>92.29</td>
<td>105.80</td>
<td>117.38</td>
<td>124.18</td>
<td>115.56</td>
</tr>
<tr>
<td>Minor Equip. Purchases</td>
<td>2.94</td>
<td>6.15</td>
<td>4.00</td>
<td>4.03</td>
<td>2.08</td>
<td>2.74</td>
<td>0.42</td>
<td>0.11</td>
<td>1.04</td>
<td>1.44</td>
<td>-</td>
</tr>
<tr>
<td>Current Transfers &amp; Subsidies</td>
<td>39.93</td>
<td>49.37</td>
<td>51.47</td>
<td>38.71</td>
<td>28.35</td>
<td>19.31</td>
<td>1.52</td>
<td>14.75</td>
<td>52.85</td>
<td>41.28</td>
<td>55.29</td>
</tr>
</tbody>
</table>

Total Recurrent Expend. | 512.52  | 530.03  | 564.75  | 550.33  | 541.47  | 500.81  | 468.14  | 433.01  | 472.48  | 503.30  | 544.39  |

Source: Ministry of Finance

Table 1.8 Percentage of Government Recurrent Expenditure for the Ministry of Health in Trinidad and Tobago (1982-1992)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>75.1</td>
<td>73.2</td>
<td>73.7</td>
<td>76.6</td>
<td>78.4</td>
<td>76.8</td>
<td>79.9</td>
<td>72.1</td>
<td>63.8</td>
<td>66.8</td>
<td>68.4</td>
<td>73.2</td>
</tr>
<tr>
<td>Goods &amp; Services</td>
<td>16.5</td>
<td>16.3</td>
<td>16.5</td>
<td>15.6</td>
<td>15.9</td>
<td>18.8</td>
<td>19.7</td>
<td>24.4</td>
<td>24.8</td>
<td>24.7</td>
<td>21.2</td>
<td>19.5</td>
</tr>
<tr>
<td>Minor Equipment Purchases</td>
<td>1.6</td>
<td>1.2</td>
<td>0.7</td>
<td>0.7</td>
<td>0.4</td>
<td>0.5</td>
<td>0.1</td>
<td>0.03</td>
<td>0.2</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Current Transfers and Subsidies</td>
<td>7.8</td>
<td>9.3</td>
<td>9.1</td>
<td>7.0</td>
<td>5.2</td>
<td>3.9</td>
<td>0.3</td>
<td>3.4</td>
<td>11.2</td>
<td>8.20</td>
<td>10.2</td>
<td>6.9</td>
</tr>
</tbody>
</table>

Total Recurrent Expenditure | 100  | 100  | 100  | 100  | 100  | 100  | 100  | 100  | 100  | 100  | 100  | 100            |
Table 1.9 Health Facility Visited First by Socio-Economic Status

<table>
<thead>
<tr>
<th>Socio-Economic Status</th>
<th>Public Hospital No. (%)</th>
<th>Public Health Centre No. %</th>
<th>Pharmacy No. %</th>
<th>Private Clinic Hospital No. %</th>
<th>Private Doctor No. %</th>
<th>Other No. %</th>
<th>Total No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolutely Poor</td>
<td>48(52)</td>
<td>16(64)</td>
<td>3(25)</td>
<td>2(25)</td>
<td>46(44)</td>
<td>0(0)</td>
<td>115(47)</td>
</tr>
<tr>
<td>Non-poor</td>
<td>44(48)</td>
<td>9(36)</td>
<td>9(75)</td>
<td>6(75)</td>
<td>59(56)</td>
<td>4(100)</td>
<td>131(53)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>92(100)</strong></td>
<td><strong>25(100)</strong></td>
<td><strong>12(100)</strong></td>
<td><strong>8(100)</strong></td>
<td><strong>105(100)</strong></td>
<td><strong>4(100)</strong></td>
<td><strong>246(100)</strong></td>
</tr>
</tbody>
</table>


According to Tables 1.7 and 1.8, of an approximate total recurrent expenditure of some TT$ 544.39 million in 1992, 68.4 percent was allocated to personnel while only 21.2 percent was allocated to the provision of goods and services. Although there was a tendency for the percentage allocated to goods and services to increase over the period, one should bear in mind that whereas nominal wages were more or less frozen, the rate of inflation on drugs and related supplies has been positive over the period (with the exception of 1991).

In other words, the same nominal expenditure on personnel in 1992 should have effectively allowed the health sector to acquire the 1982 quantity of personnel, all else being equal. On the other hand, if we hold all else constant (eg. types and quality of drugs etc.), and allow only the rate of inflation to change, the nominal expenditure on drugs and related supplies would have had to increase if the quantum purchased in 1992 were to be the same as in 1982.

The point here is that effective access to health care goes beyond physical structures, to the depth and width of goods and services provided. A health care facility, for example, which offers services to the public twice or even three times weekly (or which is totally closed for one reason or another), may not represent the most accessible medium of health care delivery, when we consider the nature of the commodity being demanded, and the manner in which demand may arise.

According to the data presented in Table 1.9, of those seeking care at the health centers first, a relatively larger portion are the "absolutely poor." However, when we turn to Tables 1.10 and 1.11, we observe that, of a total recurrent expenditure of TT$ 544.39 million in 1992, only TT$ 34.53 million or 6.34% was allocated to the county/district health services. Interestingly enough also, is the finding that whereas nominal expenditure on hospitals and laboratories have increased over the period 1982-1992, by some 25%, at a time when, following Alma Ata, more emphasis was expected to be placed on primary health care. County/District health services experienced a cut of 36.6% in nominal allocation (1982-1992). In real terms (using 1982 prices), the value of spending on county and district services had fallen from TT$
54.43 million in 1982 to about TT$ 14 million in 1992, representing a 74.3% decrease in real expenditure.

Admittedly, this is not a new phenomenon, nor is it unique to Trinidad and Tobago. Firstly, because secondary and tertiary care services are relatively more costly, it would seem "natural" that more funds would be required in these areas to do less in terms of quantity. Secondly, although it is hardly likely that district/county facilities would be called upon to directly shoulder expenses/costs which should rightly reside with the hospitals/labs, the latter are frequently being called upon to provide services (and incur costs), which should be rightly undertaken by the former. Thirdly, there are difficulties (technical, political and social), in shifting resources away from the hospitals via closure of services/facilities.

What is clear though, is that although there may be some identified direction in which policy is intended to take the sector, shorter-term decisions may sometimes be made which does not adhere to such policy direction. At the same time, one would wish to acknowledge that there has been a definite thrust in the correct direction as is evident from the emphasis that is being placed on environmental issues. This is so much so, that, the recognition is that we can no longer afford to speak about health in isolation of the environment.

Factors in Accessibility of Education

Similar factors also affect the degree of access to education in Trinidad and Tobago. That is, financial constraints on both the part of individual households and the institutions, manpower constraints and the distribution of the institutions.

In addition, the point was made at the in-country seminar (February 9th, 1995), that notwithstanding the lack of finances, improved planning/collaboration, at the level of the ministries, may lead to greater accessibility (eg. school mapping strategies).

The period 1980 to 1990 was indicative of increased pressure on the local primary school system. This was illustrated by a gentle increase in the supply of available primary school places between 1985 and 1990, in contrast to the dramatic 16% increase in demand between 1980 and 1990(K. Theodore, 1993). In addition, the main pressure group for teachers in the country (The Trinidad and Tobago Unified Teachers’ Association (TTUTA), has asserted that the estimated 8.5% increase in the pupil/teacher ratio between 1980 and 1989, has been greatly underestimated by the Ministry of Education.

It should be noted that after reaching a level of approximately TT$1,333. in 1982, real per capita expenditure on education fell to TT$ 260 in 1992. Thus, it may be inferred that government spending on education has been negatively affected by the decline in its revenue. This reduction in spending on education raises the question of the effectiveness and efficiency of government education facilities, in terms of access by lower-income groups.
Table 1.10  Government Health Expenditure Allocated to Hospitals and Laboratories vs. County/District Health Services in Trinidad and Tobago (1982-1992) TT$ M

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals and Labs</td>
<td>270.77</td>
<td>336.56</td>
<td>359.93</td>
<td>371.30</td>
<td>371.56</td>
<td>117.06</td>
<td>331.88</td>
<td>289.40</td>
<td>279.01</td>
<td>304.55</td>
<td>337.34</td>
</tr>
<tr>
<td>County/District Health Services</td>
<td>54.43</td>
<td>34.64</td>
<td>36.25</td>
<td>35.89</td>
<td>36.64</td>
<td>31.94</td>
<td>65.70</td>
<td>28.83</td>
<td>26.97</td>
<td>30.92</td>
<td>34.53</td>
</tr>
<tr>
<td>Other</td>
<td>187.32</td>
<td>158.83</td>
<td>168.57</td>
<td>143.14</td>
<td>133.26</td>
<td>151.81</td>
<td>70.56</td>
<td>114.77</td>
<td>166.47</td>
<td>167.83</td>
<td>172.52</td>
</tr>
<tr>
<td>Total</td>
<td>512.52</td>
<td>530.03</td>
<td>567.76</td>
<td>550.33</td>
<td>541.46</td>
<td>500.81</td>
<td>468.14</td>
<td>433.00</td>
<td>472.45</td>
<td>503.30</td>
<td>544.39</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance

Table 1.11  Percentage Distribution of Government Health Expenditure Allocated to Hospitals and Labs vs County/District Health Services in Trinidad and Tobago (1982-1992)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals &amp; Labs</td>
<td>52.83</td>
<td>63.50</td>
<td>63.73</td>
<td>67.47</td>
<td>68.62</td>
<td>63.31</td>
<td>70.89</td>
<td>66.84</td>
<td>59.06</td>
<td>60.51</td>
<td>61.97</td>
</tr>
<tr>
<td>Other</td>
<td>36.55</td>
<td>29.97</td>
<td>29.85</td>
<td>26.01</td>
<td>24.61</td>
<td>30.31</td>
<td>15.07</td>
<td>26.51</td>
<td>35.24</td>
<td>33.35</td>
<td>31.69</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance

Here one would also need to consider the issue of the capacity of the education system to provide appropriate training for its students. Primary schools and to some extent, secondary educational institutions may not always equip their students with marketable skills and appropriate work ethics needed for competition in a commercial environment.

1.5 Major Poverty Related Projects in Health and Education (including complementary approaches)

Among the "major" existing poverty reduction programs which can be located within health and education are:
(i) Targeted Food Distribution and Feeding Programs;
(ii) Subsidized Services: for example, The bus pass system;
(iii) Training and Retraining Programs; and
(iv) Other Services Provided in Collaboration with the Ministry of Social Development.

The school feeding program targets the children of poor households and has been in existence for quite some time. There are some areas in which teachers are convinced that the program may be offering some children the only "decent" meal for the day.

As indicated in Section 2-2, the Ministry of Education holds responsibility for the Youth Training and Employment Partnership Program (YTEPP), and the Adult Education Program. The former, YTEPP, can be undoubtedly termed major. It caters to the needs of unemployed youths with a major objective of training and/or retraining them to allow for better chances of employment.

In the case of the health sector, although there are public programs which service the needs of poorer individuals (e.g., the maternal and child immunization program), it may not be entirely correct to term them direct poverty reduction programs. This is not to say, however, that these programs cannot or indeed, do not impact upon the poverty profile of individuals. Here one should note that although it may not be termed major, there is in fact a program within the health sector which involves the distribution of food supplies to low-income households via the health centers. This program has suffered severe cuts over the years.

There is some degree of communication between the sectors (for example, collaboration between the Ministry of Health and the Ministry of Social Development, also allows for the payment of welfare allowances, if the Ministry of Health identifies an individual as having a medical problem which prevents him/her from working). However, the linkages still appear to be a bit weak, although measures are underway to strengthen same.

Indeed, the government has recognized the need for integration of social services and is taking what would seem to be serious steps to address the problem. In this regard, it is possible to point to the existence of and interministerial steering committee which has already started meeting, an which incorporated the involvement of NGOs in service delivery.

Concluding Statement

In this Section, we have relied mainly on the use of interviews and reviews of past documents with emphasis being placed on the recent McIntyre Report. In speaking with personnel in the various social sector divisions, a recurring area of concern was the lack of, or weak intersectoral collaboration at all levels. In the case of the health sector, the general feeling has been accurately captured by Sir George Alleyne (1993), in the McIntyre Report, where he noted that:
"...the view was expressed that it was not enough to rely on decentralization and local action... There needed to be interministerial cooperation, perhaps mandated at cabinet level, to ensure that the various sector resources were brought to bear on many so called health problems whose solutions often lay outside the area of responsibility of the Ministry of Health." (Alleyne 1993, p.55-56).

It would seem that, due to the approach to the provision of social services, programs tend to parallel each other. As a result, inter-agency links are mainly informal and weak, allowing duplication of efforts.

In conclusion therefore, it is clear that a number of programs exist which have been designed to address specific socio-economic problems which impact upon individuals'/households' poverty profile. However, there is a tendency for programs to parallel each other, and at time there is a clear indication that a more holistic approach needs to be adopted, if social protection is to be efficiently and effectively administered and delivered. The point being made here, is that there are costs attached to separateness in the approaches to poverty reduction.

2. NATIONAL POVERTY POLICIES AND THEIR APPLICATION IN HEALTH AND EDUCATION

2.1 Definition of Poverty Reduction Policies

According to Demery, "Poverty exists in a society when some of its members fail to attain a level of well-being considered by that society to be a reasonable minimum standard. For policy purposes, it is important to measure the extent of poverty in society, to establish which groups are more prone to it, and to gain some understanding of its causes. The poverty profile seeks to do this." (L. Demery, 1993).

In conducting an update to Henry's 1978 poverty survey in Trinidad and Tobago, Henry and Melville identified the absolutely poor as those whose income does not allow them to obtain goods and services which are regarded as "essential" or "basic" within the society (R. Henry and J. Melville, 1989).

Poverty reduction would therefore entail a reduction of the numbers that fall within the above defined category. This could be done through a combination of direct and/or indirect policy measures or what has been termed "primary" and "secondary" claims in Section 2.2. It follows, that any poverty reduction policy should be aimed at the improvement of the well-being of individuals and households within the society.

The World Bank's World Development Report 1990, suggested a two-pronged strategy for the sustainable reduction of poverty as follows:
(i)"...broadly based economic growth generates efficient income-opportunities for the poor."

(ii)"...improved access to education, health care, and other social services helps the poor take advantage of these opportunities."

(The World Bank, 1993)

The foregoing would seem to suggest that it is possible to locate a large portion of the measures which are undertaken to reduce poverty within the social sectors.

Included in the programs which have been developed with the aim of targeting specific groups (mainly the "disadvantaged," in the society are those programs which fall under the ministries of:

- Community Development; Culture and Women's Affairs;
- National Commission for Self-Help, and others;
- Consumer Affairs;
- Education: Adult Education, School Feeding Program, and others;
- Health;
- Housing and Settlements, and
- Ministry of Social Development.

What seems to be becoming increasingly clear, is the fact that anti-poverty programs should essentially be comprised of two elements: (i) a welfare element; and (ii) a human capital development element. To these we can add a third component. Anti-poverty policies should also have a growth oriented element which would make for sustainability.

2.2 Major Approaches to Poverty Reduction

It is possible to identify at least two major forms of interventions aimed at the reduction of poverty at all levels:²

(i) **Primary Claims**: such claims to incomes or other resources which are a direct result of engaging in productive activities; and

(ii) **Secondary Claims**: these claims are basically transfers from primary claims and do not add directly to productivity.

The McIntyre Report (1993) outlined a number of programs which may be identified as being specially tailored to meet the needs of special groups in society. Some of the programs outlined were:

(a) Free Bus Pass;
(b) Old Age Pensions;
(c) Social Allowances;
(d) Burial Assistance;
(e) Emergency cases Fund Grants;
(f) Urgent Temporary Assistance Grants;
(g) Education Grants;
(h) Food Subsidy, and
(i) Homes for the Aged

In Trinidad and Tobago, there is some presence of both government and non-governmental organizations (NGOs), in the fight against poverty. The NGOs (mainly church-based), which are actively involved at the level of the community, mainly intervene by way of transfers. In some cases, for example the St Vincent De Paul Society, needy members of the community are targeted and receive a regular monetary allowance which may vary depending on the size of the household. In addition, lunches are distributed at least once per week (e.g. Sunday lunches), and hampers are given (eg. at Christmas time).

The state intervenes on both levels by:

(i) Improving the opportunities for employment: here it is possible to cite some examples of what may be termed “make-work” programs. These are targeted at the unskilled, unemployed, and include such programs as the Unemployment Relief Program (URP). There is also the Youth Training and Employment Partnership Program, and the Adult Education Program, which have had as objectives, the improvement of skills to increase chances of employment. Youth Camp programs also undertake technical/vocational training in order to enhance employability.

(ii) Transfers: including old age pensions, social allowances, book grants and food stamps;

(iii) Targeted Exemptions: aimed at indirectly increasing income by, increasing the rate of return on investments. Examples would include exemptions, for the elderly, from taxes on interest earned on savings; and

(iv) Assurance of access to health and education: the State provides health and educational services at minimal or zero cost. In more recent times, this has extended to include the projection of a National Health Insurance Scheme (NHIS), which intends to provide a safety net for the poor.
As the last area of intervention would no doubt suggest, the methods of intervention may not always enjoy a 100 percent success rate.

2.3 Importance, commitment to and success of poverty reduction policies in national development plans

Among the questions which one would wish to address here, in attempting to determine the importance of, commitment to, and success of these policies in the Plans, would be:

(i) Do they feature in the national developmental plans’ goals and/or objectives?
(ii) To what extent are the stated objectives (e.g. increased access, improvements in health status, literacy rates, employment rates, etc.) achieved?
(iii) How does expenditure on the sector(s)/area(s) of concern compare, relative to that on other sectors?
(iv) What level of variance is there between estimated or approved estimates of expenditure on the sector(s), and actual expenditure? and
(v) How does this variance compare across sectors?

Among the goals and objectives identified in the Medium Term Planning Framework 1994, are:

(i) "...a sustainable and substantial expansion in employment generation;"
(ii) "...an effective social safety net program..."

It has been widely acknowledged, that there are both direct and indirect links between the macro-economy and health and education, and that the latter two impact upon the level of poverty within a society, which in turn impacts upon the wider economy (See Section 1).

To the extent that we could meaningfully locate a large portion of the poverty reduction measures within the social sectors, then it is possible to argue that, policies aimed at the reduction of poverty in Trinidad and Tobago have always had a presence in the Development Plans. Five sectors, including health and education are identified in Tables 2.1 and 2.2.

Although the disaggregated picture is not shown (School Feeding Program, YTEPP etc.), they give an idea of the presence of these sectors in the Development Program of the country.

In terms of real 1985 dollars, total government expenditure on the social sector decreased from TT$ 877.4 million in 1982 to approximately TT$ 89 million in 1990. This in effect represents a 90% fall in real expenditure. However, when we look at the percentage distribution
of the development expenditure within the social sector, it is seen that both health and education enjoyed fairly substantial increases.

Although the development expenditure tells a story, it is of utmost importance that we recognize that, to the extent that expenditure in the social sector does not necessarily foster growth, what may be a more critical indicator of the level of commitment would be the level of the total commitment (capital and recurrent). The point being made here is that we need to analyze expenditure on health and education differently, because they are more directly linked to development than some other areas.

With this in mind, we observe that the percentage change of the social sector in total Central Government expenditure remained fairly stable over the period 1982-1990. Moreover, we do not see any negative, disproportionate treatment of the sector. As a whole, the social sectors suffered a 65.1% decrease in real spending by Central Government between 1982-1990. On the other hand, total government spending had decreased by 64.5 percent over the same period (Table 2.2).

It is also possible to measure the level of commitment to a particular undertaking by evaluating the extent to which one did what one indicated one would do (i.e. what one set out to do in the first place). In relation to the level of commitment to poverty reduction policies in the Development Plans, then, one indicator of commitment may be the percentage variance between the approved estimates of expenditure (that is, the estimates of the level of spending needed to accomplish stated objectives), and the actual level of expenditure at the end of the fiscal year.

### Table 2.1 Percentage Distribution of Development Expenditure in the Social Sectors (1982-1990)

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>Health</td>
<td>3.1</td>
<td>4</td>
<td>2.5</td>
<td>1.9</td>
<td>1.6</td>
<td>6.5</td>
<td>5.3</td>
<td>1.7</td>
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<tr>
<td>Education</td>
<td>29</td>
<td>31.1</td>
<td>34.4</td>
<td>32</td>
<td>78.1</td>
<td>32.2</td>
<td>61.3</td>
<td>55.3</td>
<td>43.1</td>
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<td>Housing</td>
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<td>61.2</td>
<td>58.2</td>
<td>58.1</td>
<td>3</td>
<td>0.9</td>
<td>1.6</td>
<td>20.2</td>
<td>16</td>
</tr>
<tr>
<td>YSCCA</td>
<td>2.9</td>
<td>3.1</td>
<td>4.4</td>
<td>8.1</td>
<td>16.2</td>
<td>20.2</td>
<td>31</td>
<td>22.4</td>
<td>24.2</td>
</tr>
<tr>
<td>SDFS</td>
<td>0.4</td>
<td>0.5</td>
<td>0.2</td>
<td>0</td>
<td>1</td>
<td>0.2</td>
<td>1</td>
<td>0.2</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total Development</strong></td>
<td><strong>28.4</strong></td>
<td><strong>29</strong></td>
<td><strong>25.3</strong></td>
<td><strong>16</strong></td>
<td><strong>8</strong></td>
<td><strong>6.2</strong></td>
<td><strong>6.3</strong></td>
<td><strong>8.2</strong></td>
<td><strong>8.3</strong></td>
</tr>
</tbody>
</table>

YSCCA: Youth, Sport, Culture and Creative Arts
SDFS: Sport, Development and family Services

23
Table 2.2  Government Real Development Expenditure in the Social Sector  
(1982-1992) 1985 = 100

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<tr>
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<td>Health</td>
<td>27.6</td>
<td>32.5</td>
<td>15.6</td>
<td>6</td>
<td>2.4</td>
<td>6.8</td>
<td>4.4</td>
<td>1.6</td>
<td>14.7</td>
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<td>Education</td>
<td>250.5</td>
<td>252</td>
<td>215</td>
<td>102.4</td>
<td>117</td>
<td>33.9</td>
<td>50.5</td>
<td>49.8</td>
<td>38.4</td>
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<td>Housing</td>
<td>570.6</td>
<td>496.1</td>
<td>364.5</td>
<td>186.2</td>
<td>4.5</td>
<td>43.2</td>
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<td>21.3</td>
<td>25.5</td>
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<td>3.2</td>
<td>0</td>
<td>1.5</td>
<td>0.2</td>
<td>0.8</td>
<td>0.2</td>
<td>0.5</td>
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<td>Total</td>
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<td>810</td>
<td>625.8</td>
<td>320.7</td>
<td>149.8</td>
<td>105.3</td>
<td>82.4</td>
<td>90</td>
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<th>Total Exp.(SS)</th>
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<td></td>
<td>3091.5</td>
<td>2838.4</td>
<td>2474.3</td>
<td>2041.2</td>
<td>1965.7</td>
<td>1710.6</td>
<td>1303.3</td>
<td>1098.3</td>
<td>1078.6</td>
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<tr>
<td></td>
<td>Total Gov't Exp.</td>
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<tr>
<td></td>
<td>12055</td>
<td>9403.6</td>
<td>8999.5</td>
<td>8173.7</td>
<td>7481.3</td>
<td>6440.7</td>
<td>5754.5</td>
<td>4371.1</td>
<td>4276.5</td>
</tr>
<tr>
<td>Social Sector As % of TCE</td>
<td>25.6</td>
<td>30.2</td>
<td>27.5</td>
<td>24.9</td>
<td>26.3</td>
<td>26.6</td>
<td>22.7</td>
<td>25.1</td>
<td>25.2</td>
</tr>
</tbody>
</table>

YSCCA: Youth, Sport, Culture and Creative Arts  
SDFS: Sport, Development and Family Services  
TCE: Total Central Government Expenditure  

Table 2.3 Percentage shortfall of actual development expenditure in relation to estimated expenditure under the consolidated funds (selected years)

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>-29.4</td>
<td>-44.4</td>
<td>-76.4</td>
<td>-56.7</td>
<td>-45.9</td>
<td>-6.1</td>
<td>-24.3</td>
<td>-9.0</td>
</tr>
<tr>
<td>Health</td>
<td>-40.1</td>
<td>-37.7</td>
<td>-33.3</td>
<td>-80.93</td>
<td>-28.4</td>
<td>-60.6</td>
<td>-91.2</td>
<td>-61.7</td>
</tr>
<tr>
<td>Other</td>
<td>53.1</td>
<td>4.4</td>
<td>-2.2</td>
<td>-28.6</td>
<td>-2.7</td>
<td>-53.4</td>
<td>-38.0</td>
<td>-8.1</td>
</tr>
<tr>
<td>Total</td>
<td>50.2</td>
<td>3.9</td>
<td>-2.3</td>
<td>-29.1</td>
<td>-2.9</td>
<td>-53.7</td>
<td>-38.1</td>
<td>-10.4</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance

Following the same principle, the level of success of programs may be measured as the extent to which one achieved what one set out to do in the first place. This measure differs from the one above, in that it seeks to measure, the level of achievement of stated goals and

"The delivery of services within the social sector is founded upon the view that a strong and efficient social infrastructure facilitates economic expansion and leads to an improvement in the quality of life of the citizenry.

Capital formation in social infrastructure is geared toward moral, physical and intellectual development of our human resources, improvements in the quality, accessibility and efficiency of health care, and the fostering of appreciation and respect for legal and related institutions."

Although there has undoubtedly been an expansion in the physical infrastructure, and in some cases improvements in the level of services as evidenced in Section 1 (increased accessibility to primary school education etc.), the findings of past reports seem to suggest that "...the quality, accessibility and efficiency..." of the provision of services in the social sector leave much to be desired. In fact, the ongoing reforms are a direct result of the recognition of such failings.

Using the first measure of commitment, the percentage shortfall in actual expenditure when compared to estimated expenditure, we observe that we have not had actual expenditure exactly matching estimated expenditure over the period under review (Table 2.3). In 1991, of a total estimated development expenditure of TT$ 121 million for health and education under the Consolidated Fund, only TT$ 89.37 million was actually spent. This represents a little over 70% of estimated expenditure.

According to Table 2.3, the percentage shortfall in actual expenditure varied from a high of 91.2% for health in 1989, to a low of some 9% for education in 1991. When compared to the overall picture we note that whereas health and education experienced an average of some 54.2% and 36.5% shortfall respectively, between estimated and actual expenditure over the reported period, the overall average shortfall amounted to only 10.3%.

A major shortcoming of the above measure of commitment would be firstly, the fact that only the development expenditure under the Consolidated Funds is examined, while the bulk of the expenditure on development is undertaken under the Long-Term Development Fund.

Secondly, development expenditure cannot be analyzed in isolation of what is happening on the recurrent side of the equation. The recognition here is that the flip side of the development coin, we have recurrent expenditure and there have indeed had shortfalls in actual recurrent expenditure in the sectors identified. In some cases, these have had major adverse effects as in the case of health, where it is not unusual for drugs and related supplies to be inadequate to service the needs of users. In the case of education, the recent Task Force Report (Ministry of Education, 1994), also lamented the fact that recruitment of personnel has been adversely affected by the economic environment.
To the extent that a large portion of the poverty reduction programs, especially those that impact directly upon poverty, can be located within the social sectors, it then becomes possible to impose yet another measure of commitment to, and importance of these programs.

According to the McIntyre Report (1993):

"From what we have seen there is quite a wide range of services which constitute the social safety net in Trinidad and Tobago. The question is the nature of the government’s commitment, this can be measured by the ratio of the relevant public sector spending to the GDP.

This ratio can be compared with a similar ratio in respect of overall safety net spending which would include social security benefit payments."

Over the eight year period 1982 to 1990, an average of some 26% of government’s total expenditure was channelled into the social sectors (See Table 2.2).

Referring to the data in Table 2.2, we get a sense of the high level of commitment, when we consider that the percentage share of GDP, which was allocated to health and education not only rose when the down turn started, but even when it fell under the fiscal pressures already outlined, it remained at almost the same level since 1985 (about 9% of GDP).

2.4 Wider scale implementation of successful programs: constraints, disadvantages, problems

It is not clear to what extent we can safely speak about the wider scale implementation of successful programs in health and education.

In order to do so, we would first of all have to establish that programs are expanded because they have been evaluated and found to be successful. It would seem that it is generally the norm for expansion to take place provided that the program is part of a strategy that is linked to the global trend. This has been the experience with the Maternal and Child Health and Immunization Program. In fact, the United Nations Children’s Fund (UNICEF) has congratulated the country on improvements in health status indicators (Section 1), and the program is now moving into what is termed the Expanded Immunization Program.

In general though, it would seem that when decisions are taken to implement local programs, any potential expansion does not necessarily follow a comprehensive evaluation of the previous phase of the program to determine success rate. This is not to say that evaluations of ongoing programs do not take place. In the case of the health sector, program evaluation is not uncommon even at the level of the community, albeit at varying degrees of technicality. The point remains though that there is no strong sense of the expansion of programs being hinged on success of the program in another area, nor does it seem for that matter, that a program

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would be necessarily implemented in other areas where there may be a need, even when the ongoing program appears to be successful.

The main constraints and/or problems which are encountered in the implementation of various programs aimed at poverty reduction, are not independent of those already addressed as factors affecting the level of access to facilities in Section 1 above. To the above constraints we would now add: (i) execution capability; and (ii) lack of clarity on precisely what is needed.

Broadly speaking, the financial constraints may be identified as a recurring problem. However, even if financial constraints are removed as major obstacles, as is most probably the case with the Development Programs, we observe that one of the major constraints turns out to be the power of execution.

Concluding Statement

In addition to the two broad categories of anti-poverty interventions outlined above, it is possible to identify at least three fronts on which poverty reduction strategies should rest:

1. *the biological front*: implications for what poverty may do to the labor market. Consumption deficits tend to reduce people's incentive to work;

2. *putting people in a position to provide for themselves*: this fits the "new view of poverty policy, which suggest that the way to effectively deal with poverty is to put the economy on a growth oriented path; and

3. *question of delivery*: how are we going to deliver the goods/services? Here the key question is that of the optimal role of the public/private sector(s).

3. POVERTY REDUCTION STRATEGIES

3.1 The Nature of Poverty Assessments Undertaken

It is possible to identify at least four major poverty assessments which have been undertaken within more recent years for Trinidad and Tobago. These are, Henry and Melville (1989), Teekens (1990), Survey of Living Conditions (1992), and McIntyre (1993).

Henry and Melville (1989), derived estimates of the existing level of poverty in 1988, in order to make comparisons with an earlier study done by Henry (Henry, 1978). The 1989 assessment made use of the 1988 Household Budgetary Survey (CSO), and attempted to
operationalize the concept of poverty, by deriving a methodology that would facilitate its measurement in Trinidad and Tobago.

Among the stated objectives of the assessment were: (i) identification of the poor; and (ii) measurement of the extent of poverty in households of varying demographic compositions.

Henry and Melville defined absolute poverty as "the condition or failure to meet the bare essentials of physical existence." (Henry and Melville, 1989 p.3). They proceeded to cost the minimum bundle of goods and services which was deemed "necessary" for sustenance, for a family of given size and structure. A total cost was then arrived at and assumed to represent the minimum income needed to be classified as non-poor.

Rudolf Teekens (1990), derived a poverty profile for Trinidad and Tobago, and in so doing, attempted to clarify the difference between absolute and relative poverty. Whereas Henry and Melville calculated absolute poverty based on income data, Teekens used per capita household expenditure and extended his analysis to include relative poverty. In essence, he used two relative poverty lines set at 40% and 50% of the median per capita expenditure. Additionally, he used the poverty line developed by Henry and Melville as a starting point, but extended it to include the cost of accommodation.

The McIntyre Report (1993), updated the poverty profile of the country using data on income and expenditure obtained from the 1992 Survey of Living Conditions to make comparisons with the situation in 1988.

An idea of income and expenditure distribution was provided. In addition, the Gini coefficient, an indicator of inequality, was estimated for income from all sources. 4

3.2 How are these poverty studies used and how successful are they in identifying the poor

The poverty studies outlined above are useful to the extent that they help to estimate the percentage of the population lying below some minimum acceptable standard. The studies therefore become useful in providing an insight into the proportion of the population that is poor, and can assist policy makers in deciding on the nature and size of the required safety net(s). With the possible exception of the much talked about McIntyre Report with its implications for the expansion and mending of the safety net, it is not clear that policy makers have made much use of these poverty assessments in terms of population and service targeting, by tailoring policies based on the findings. Below are the main findings of the various studies.

---

4 Details on the Survey of Living Conditions are addressed in another paper (by another presenter).
Based on a sample of some 2,017 households, Henry and Melville (1989) found that 374 or 18.5% were living in poverty. In terms of household composition, three-person households were least found among the poor. They represented only 11.2%, compared with one-person households, which accounted for 19.5% (the highest recorded). It was also observed that county St. George, the most populous, had the highest incidence of poverty accounting for some 30.1% of the total number of households.

However, the highest concentration of poverty was in Nariva/Mayaro, where 37% of the households in the district were classified as poor. Of the counties listed, St. Andrew/St. David recorded the smallest number of poor households (3.73%). The county with the lowest concentration of poverty was also St. Andrew/St. David, where 18.18% of the households were poor.

To extend the analysis, Henry and Melville compared poverty rates for the various counties with unemployment rates from the Continuous Sample Survey of Population for the corresponding period. When distributed by county, the rate of unemployment generally mirrored the distribution of poverty for all but county Nariva/Mayaro, which had the highest intra-county level (27.12%). In this particular case the conclusion was that poverty was largely unrelated to unemployment.

Teekens (1989) found that the rate of poverty in 1981-1982 was highest among households for which the employment state of the head was unclassifiable. Though not stated, these may coincide with persons involved in sundry informal sector activities. These activities are only recently being explicitly taken into account in employment surveys. Poverty was also found to be particularly high among households with:

- Female heads;
- Comprising persons with little or no secondary education; eight or more persons;
- No income-earners; and
- Four or more children.

By 1988, both the level and composition of poverty had changed significantly. The most affected were households headed by:

- Agricultural workers;
- Unemployed persons; and
- Females between the ages of 25 and 44 years.

The highest levels recorded were among households with two adults and four or more children, where the figure was 39.4%, compared with a mere 8% observed in 1981-1982. Consistent with Henry and Melville (1989), the Teekens study found the Nariva/Mayaro county to be most affected by poverty. The level recorded was 28.0%, almost twice the national average.
The McIntyre Report found that the distribution of income had worsened over the decade. The Gini coefficient stood at an estimated 0.592 in 1992, compared to 0.468 in 1988 and 0.45 in 1981-1982. This suggests a steady deterioration in the distribution of income over the period.

The McIntyre Report also found that the rate of poverty has worsened. This rate stood at an estimated 22.53% in 1992, compared to 18.54 percent (Henry and Melville, 1989), and 14.8% (Teekens, 1989), in 1988. According to the Report then, there was a four percentage point increase in the number of poor households, in one case, and an eight percentage point increase in the other.

In terms of household composition, there were significant changes in the groups that had the highest poverty rates. Whereas the two previous studies had found a significant level of poverty among single-person households, the pattern seems to have shifted somewhat by 1992. The poorest households were found to be those with more than three persons.

The geographic distribution of income in 1992 was not generally different from 1988. Perhaps the most significant change took place in St. Andrew/St. David, where 18.18% were poor in 1988, and where this percentage had more than doubled by 1992. Although the studies employed different methodologies (to some extent), the general trend seems to be one of increased poverty.

3.3 The Role of the Social Security System

"The Social Security System (SSS) in Trinidad and Tobago has a long history with public provision and public assistance pensions for public sector employees being introduced as long ago as the 1930's. A compulsory and contributory National Insurance System was introduced in 1972." (Halpin, 1991).

The contributory aspect of the SSS, administered by the National Insurance Board (NIB), was introduced in 1972 to assist employees when contingencies arising out of loss of income (retirement, illness, death, accident, invalidity, and others) arise. The system is financed by both employers and employees. Among the benefits provided are:

(i) Retirement;
(ii) Sickness;
(iii) Invalidity;
(iv) Maternity; and
(v) Survivors.

There is also the non-contributory system administered by the Ministry of Social Development. Under this system Old Age Pensions and Social Allowances are paid to beneficiaries.
The non-contributory Social Security System also provides:

(i) Urgent Temporary Assistance;
(ii) Education Grants;
(iii) Bus Passes; and
(iv) Assistance with Funeral Costs.

The purpose of the non-contributory Social Security System is to provide a "safety net" for the special group of people who, of their own free will and ability, are unable to adequately provide for themselves.

In excess of 90,000 persons were receiving old age pensions and public assistance grants in 1992 (CSO). However, the case has been made that the social security schemes should not only offer protection, but that such protection should be effective (ILO, 1984). In principle then, what we would expect is that the nominal value of benefits would change as prices change, with the real value either increasing or remaining constant.

Although the nominal value of non contributory social security benefits has tended to increase over the years, the real value of these benefits have been falling, being eroded by inflation. In fact, the real value of old age pension payments in Trinidad and Tobago fell by 11.5% between 1985 and 1991, with the real value of public assistance benefit payments falling by approximately 40%. The real value of benefit payments by the National Insurance Board has also experienced negative rates of growth since 1986, with the exception of 1988, when the growth rate was 2.8%.

As a result, the social relevance of the social security schemes has been increasingly questioned (Theodore and Pantin, 1991). In the case of the National Insurance Board, Theodore and Pantin have suggested a definite link between the percentage of incomes collected and the relevance of the scheme’s benefit payments. Both Pantin and Theodore and the recent Actuarial reviews of the Board’s operations indicate that the erosion of the purchasing power of benefits may be a signal of the almost imminent erosion of the relevance of the system and its ability of deal with increasing poverty. Within this context, of rising pressure to increase the social relevance of benefits, it has been recommended that the Board should increase both the level of contributions and of benefits.

**Concluding Statement**

The issue seems to be more the direction of the changes in the poverty profile than the absolute level of poverty itself. Is it that we have a fluctuating trend, or are we on a steady path to the reduction of poverty. in Trinidad and Tobago, the evidence has shown that there has been a definite increase in the rate of poverty from 1981-1982 to 1992.
4. DECENTRALIZATION AND LOCAL CAPACITY BUILDING FOR POVERTY REDUCTION

Decentralization has been described as "...an effective transfer of political power, which includes full decision-making capacity in regard to the use of economic, human, technological and material resources, together with full responsibility for the results and consequences of any decisions that are taken." (RPIHE, p.3).

In Trinidad and Tobago we can identify the move towards decentralization as part of the overall restructuring and reform of the public service. The basic assumption is that decentralization would facilitate dual improvement in this sector. In essence, it should allow for improvements in both the efficiency and the effectiveness with which goods and services are delivered to the public. It should be noted, however, that devolving management to empower on-line managers would translate into increased autonomy. As a consequence, there will be a need for greater accountability, with built-in safeguards in order to ensure a smooth transition from a centralized system.

Thus far, the movement towards decentralization has concentrated on the social sectors. We can safely say that this is indicative of a commitment, on the part of government, to target certain social sectors. These include: health, education and social development.

As it relates to poverty reduction, decentralization within the social sector aims at improving efficiency and effectiveness in the delivery of goods and services to those who need them. The general thinking is that under a decentralized system, management takes place closer to the point of delivery and is therefore better able to practice more effective targeting. Moreover, if the decentralization exercise is properly undertaken, there should exist greater autonomy as regards budgetary allocations. This in turn has direct implications for poverty reduction intervention programs which can be tailored to suit the particular community.

As indicated above, studies for the decentralization of some ministries are ongoing in Trinidad and Tobago. There are however, certain caveats which must be observed in order for the decentralization process to be successful. These include:

- **Consultation at all levels:** political mapping must be undertaken in order to receive meaningful feedback from the community, staff and intellectuals. To the extent that it is feasible, full information should be provided for the consultation process.

- **Training and Retraining:** existing staff must be equipped in order to effectively fulfill any new roles they may assume. The importance of technical training cannot be over-emphasized, and although it may be costly, the training and retraining programs must be relevant and targeted.
Sustainability: capital injection is necessary for the start-up of most projects. In times of economic downturn it may be tempting to build up a system on borrowed funds (external financing). It is key that the implications for the recurrent expenditure which would be needed to maintain systems be considered in any implementation /design process. One therefore has to adapt and tailor programs to suit particular needs within the context of the economic environment.

Here it is helpful to examine the concept of "Ricardian Equivalence" which in essence states that in economics there is nothing like a free lunch. If a good/service is not paid for in period t, then it must be paid for in period t+1. The implications of this theory are enormous for developing countries. Large external borrowings can impact negatively on the welfare functions of future generations (See Figure 1.1).

Developing countries in particular, need to focus on the issue of sustainable development. If this is not done, we may well find ourselves in a situation in which we end up hurting those who we are attempting to help (and here we should not forget that the nature of the health and education sector strongly suggest that we will be also hurting ourselves and our children).

In 1993, foreign consultants along with local counterparts collaborated to formulate policies and conduct various studies on the decentralization exercise in Health. Two Consultancy teams, Coopers and Lybrand (Canada); and The Health and Life Science Partnership (England), were engaged in this venture. The former deliberated over the National Health Insurance System, while the latter engaged in Policy Reform, Rationalization Studies and the "commissioning" of the Mt.Hope Medical Sciences Complex.

The concept of decentralization is not new in Health. The 1960s witnessed the regionalization of this sector. Included among these regions were the north, the south and Tobago.

In the contemporary period, we have actually had the appointment of five Regional Health Authority boards in Trinidad and Tobago, four of which are located in Trinidad and one in Tobago. The process of operationalization of the work of these boards began as of January 1st, 1995. Although they are yet to become fully functional, it is hoped that this will occur in the near future.

Among the lessons that we have learnt from the decentralization exercise(s) thus far, are that when problems are identified and are not corrected, or corrections are based on external intervention, the solutions may not necessarily address the real grievances. In addition, another lesson of decentralization has been the need to involve both staff and the wider community in the exercise. When this is not done, difficulties will of necessity arise. At the same time, however, it is acknowledged that this is not an easy task. A major constraint may be posed by the fact that this could be a time-consuming process and that there may well be individuals and/or groups of individuals who oppose the change. Nevertheless, the recognition of these problems cannot justify exclusion from the consultation process.
Yet another lesson emerging from the decentralization exercise(s) is the need to clearly define the objectives of the exercise from the outset and to keep such in mind. It should be noted that the possibility exists for a goal to become clouded by the views of different actors involved in the reform process.

With decentralization comes the need for the building-up of skills and capabilities of relevant staff at all levels. Under a centralized system, certain categories of staff are usually located at one central location and seldom interact at the level of the community.

As a result, the need may arise for the retooling and re-skilling of personnel to perform tasks on a local level that may previously have been done at central levels.

Decentralization and Poverty Reduction

In addition to building the capacity of staff, there exists the need for upgrading the capacity of community groups and the informal sector, if we are to see any meaningful links between the decentralization process and poverty reduction. Labor market data shows a growing informal sector. Any consideration of a reduction of poverty must take cognisance of the importance of the role of this sector due to the relationship between increases in poverty and increases in unemployment. The question is therefore, how can we strengthen the informal sector? One answer can involve the provision of seed capital for investment in small informal (and formal) businesses. In October, 1994, the Prime Minister (Trinidad and Tobago) hosted a symposium on small business in Trinidad and Tobago. It is pertinent to note that the session was over-subscribed in the first instance and had to be shifted to larger facilities. This tells of the existence of an interest in the small business sector, and hints at the tremendous potential that this sector may have in terms of unemployment and poverty reduction.

Through efforts such as self-help programs, several communities have improved their living conditions via participation in self-help projects which improve water supply and road conditions. While the former has direct implications for improvements in sanitation and health status, the latter directly affects transportation, communication, and market accessibility. This impacts on the ability to receive social services and improve standards of living. The self-help concept embodies the principle of solidarity and encourages community groups to realize that they have to participate in their own upliftment.

There is the general acknowledgement that there are some services that can best be provided by the State/Government. By the same token, it is also recognized that there are some things that the Government alone cannot do. This being the case, there is the need for the combining of efforts between the public and private sector, that is, finding the "right mix" of services within the social sector in the fight against poverty. Additionally, given the pressure on Central Government revenues, and because we don’t see this pressure being alleviated in the near future, there must be cooperation between Government and both for profit and non-profit
Non-Governmental Agencies. In effect then, decentralization and local capacity building recognizes the need for Government/State intervention to complement private sector efforts.

A Case of Decentralization: the regional health authorities

The issue of providing efficient and cost-effective health care features on political agendas world-wide. Trinidad and Tobago is no exception. Over the period 1982-1992 there have been large reductions in real Central Government expenditure on health care, and there has been little or no capital investment over the period. In addition to this, of the amount spent on health care, the lion’s share has gone towards the funding of hospitals. In Trinidad and Tobago, TT$270.77 million was spent on hospitals and laboratories (52.8%) in 1982, compared to TT$54.43 million (10.6%) on county/district health services. By 1987, as much as 63.3% of Central Government’s recurrent expenditure within the public health sector was being allocated to hospitals and laboratories while the county/district (primary) health services’ share had fallen to 6.4%. In 1992, the distribution was 62.0% and 6.3% respectively.

Given the trend in current thinking, and in fact thinking in the recent past, as evidenced by the World Bank’s World Development Report 1993: Investing in Health, the lower down the health pyramid one invests, the more cost effective are the programs likely to be.

Concomitant with declining real overall expenditure on health is the issue of exploding costs. Between 1980 and 1985 the cost of medical and personal care increased by as much as 76.8%. Over the period 1986 to 1992, the cost increased by 46.3%. It is not surprising therefore, that given existing conditions, the Government of Trinidad and Tobago embarked upon a massive overhaul of the health care delivery system in an attempt to control costs and increase the quality and efficiency of service. It is within this framework that the Reform Policies have been undertaken.

The key element of the Health Reform Package is the decentralization of health services in order to:

- "Make services more responsive to consumer needs and preferences."
- "Introduce general management - the delegation of decision making to appropriate levels of management and, in the case of operational matters, to those actually providing the services."

The chief institutions of the decentralization initiatives are the Regional Health Authorities (RHAs), four of which are located in Trinidad and one in Tobago. The major objectives of the RHAs are to achieve better services for patients and to enhance job satisfaction among staff, which it is hoped would result in better quality care for the public. In addition, the regions are mandated to provide primary clinical care and aims to do this through regionally owned health centers, and service contracts with independent medical practitioners and other professionals. In fact, strong primary care is described as the key to the restructuring process. Each region
is to receive a per capita allocation based on its population, to be provided for primary care services, while the funding of hospitals is to be based on the volume and quality of services it provides. Overall, the RHAs are expected to allow for fewer hospitals and upgraded polyclinics, which will be owned and managed closer to the consumer so that staff and management can be more responsive to the needs of patients.

Effectiveness of the System

The implementation of the RHAs became effective January 1st, 1995. However, they have yet to become fully operational and as such their effectiveness cannot be properly assessed.

5. CASE STUDIES

Case Study I: Youth Training and Employment Partnership Program

5.1 Objectives and Rationale

The Youth Training and Employment Partnership Program (YTEPP) Limited, emerged out of a growing recognition that the unemployment rate among the 15-25 year old youth was on the upswing. Moreover, it was found that a number of these youths were effectively unemployable and as a result, needed special training in order to increase their marketability. At the same time, there was a recognition that the nature of the existing vocational camps (which had targeted this group), hampered their ability to effectively retrain these youths for absorption into the labor market. Since they were really residential camps, with limited physical capacity, as the numbers demanding the service increased, and as the nature of demand changed (youths not necessarily being attracted to residential camps), the pressure for alternative training programs increased.

The YTEPP was launched in the late 1980s with its corporate mission being a commitment to high-performance, efficient state-assisted training and development. It aims to provide quality instruction and career enhancement to its target group of unemployed 15 to 25 years old, who are not enrolled in academic institutions. YTEPP endeavors to better equip such persons in becoming either self-employed or wage-employed.

A significant objective of YTEPP is identified in the attempt to create a culture of entrepreneurship among trainees, through human resource development. They use the medium of mottos that charge trainees to "learn to earn" and to gain through training. Attempts are made to impart positive attitudes and values to trainees in order to build their self-esteem. Talks with a senior officer indicated that YTEPP perceives proper motivational and attitudinal
training as being mandatory for competing in a commercial environment. The training received by students is free of charge and attempts are made to ensure a holistic approach.

5.2 The Main Activities of YTEPP

Courses at YTEPP take the form of center and community-based training. The former is offered in secondary and junior secondary schools at the end of normal classroom sessions, with the duration of instructions being approximately nine months.

On the other hand, community-based training is offered in rural areas, where access to YTEPP centers is relatively more difficult. Instructions are conducted at homes, community centers and churches, using the resources of the given area. The introduction of YTEPP in rural areas resulted from consultation with members of the communities. In addition, the age bracket for community-based training has expanded to accommodate unemployed youths up to age 30 who wish to acquire certain skills.

The core training proffered by YTEPP falls under fourteen occupational areas. These are:

- Agriculture
- Applied Arts
- Automotive Maintenance Repairs
- Beauty Culture
- Construction
- Craft
- Electronics/Electricity
- Family Services
- Food Preparation
- Garment Construction
- Metal Design and Fabrication
- Performing Arts
- Secretarial and Business Support Services
- Tourism/Hospitality Services.

Attempts have been made to offer a wide range of courses under each area. Cognizant of the flood of academically qualified persons on the labor market, attempts to concentrate on training in specific, marketable skills is complemented by Career Enhancement Training. The latter purports to mould positive work attitudes among students, as well as offer basic education and counselling services to those needing them. Training in micro-entrepreneurship, in terms of job-creation and management, is provided by Entrepreneurial Development and Support Services during two four-month cycles. Assistance is also rendered to graduates who aim for self-employment or wage-employment by:
(i) Annually referring approximately 1,500 YTEPP graduates to the National Apprenticeship Scheme through the National Training Board;

(ii) Advising and training graduates who want to become self-employed; and

(iii) Compiling a skills-bank of potential wage-employees and leasing with employers to secure both temporary and permanent employment.

The Public Relations Department of YTEPP tries to involve the business community in the program (for example in the conducting of seminars). Up-to-date research on the implementation, outcomes and impact of YTEPP is also conducted by the Research and Evaluation Department Unit. This course of action is seen as necessary, since the program is monitored by the World Bank on an annual basis. The World Bank has funded the program since 1989, terming it as one that should accompany the austerity measures which were in place.

5.3 Program Effectiveness

As indicated above, the Research and Evaluation Department Unit of YTEPP monitors and evaluates the program with a view to determining its effectiveness. Various indicators may be used to decide the extent of YTEPP’s effectiveness. In terms of achieving objectives, it should be noted that a study on youth training projects (prior to the inception of YTEPP), revealed that there were about five major barriers to youth employability. These were:

(i) The lack of marketable skills;
(ii) Poor work ethics;
(iii) The lack of basic education;
(iv) The lack of work experience; and
(v) The lack of technical support.

YTEPP has attempted to address these shortcomings. Thus, vocational skills training aims to provide graduates with a marketable skill. Career Enhancement Training addresses their work ethic and level of education, and Entrepreneurial Development and Support Services caters for work experience and provides technical support for both trainees and graduates.

Whereas national youth camps and most secondary schools focus on vocational and academic training, YTEPP attempts to move beyond this by equipping the students with entrepreneurial skills. In effect therefore, the inability to procure wage-employment should not be a deterrent to the YTEPP graduate, but rather, should direct her/him towards self-employment through micro-entrepreneurship.

Perhaps the merit of the program may be seen in the receipt of the National Youth Award for Small Business by a graduate of YTEPP in 1992. Another graduate of the Program placed second in this national competition in 1993.
The success of a program can also be evaluated alongside a benchmark of interest generated and maintained. In this respect, since its inception in 1989, YTEPP’s centre-based project has witnessed an approximate enrollment of 60,000 trainees, with 32,601 (or 54.3%), of them going on to graduate.

While this in itself is no mean achievement, one would still need to acknowledge that over 45% of those who originally enrolled in the course did not follow through to graduation. Of course, a number of external factors may be at play here, including domestic, financial and even the fact that some trainees may well have completed the course but merely failed to actually graduate.

Trainees are encouraged to help the program grow. Thus, regional managers of centers and communities hold meetings with representatives from trainee classes, in order to get feedback on the operation. In addition, the YTEPP network includes links with graduates, as is evidenced by tracer studies that assess the impact of the program on graduates.

According to the tracer study that targeted graduates of YTEPP’s Cycle IV (1991-1992), the program had a positive impact on lower-income earners. They experienced a 6.2% increase in income, as opposed to estimated income if they had not attended YTEPP. The study also revealed that YTEPP increased employment in this group by an average of 12.4%.

It is interesting to note that the YTEPP graduate is given an end-of-phase questionnaire to complete. Analysis of these questionnaires reveals that some graduates have a higher inclination to return to school (academic instruction), whether as evening students or as private candidates for examinations. YTEPP has, therefore, assisted in building their self-esteem and restoring some level of hope.

It must be emphasized the YTEPP is not the "perfect program" and should not be seen as “the” answer to the high rate of unemployment among youths. The effectiveness of the program is largely dependent on individual ambition and determination. What YTEPP has attempted to do, is guide its trainees, and indeed we have seen success in some areas.

5.4 Factors that affect the successful implementation of YTEPP

Problems encountered by YTEPP in the implementation of its program are not financial in nature, since funding is received from the World Bank. However, the temporary nature of the program affects its development.

YTEPP is forced to share a school plant to conduct its courses. Access to plant and equipment is therefore limited to afternoons and evenings, after normal classroom hours. This means that YTEPP classes may end at hours that are not conducive to students who have to travel long distances to and from centers.
School principals also sometimes insist on using their teachers as YTEPP tutors. These tutors might not accord with the YTEPP approach to teaching (practical, as opposed to classroom instruction). However, they are usually enrolled as tutors to facilitate cooperation from the plant.

A major constraint to the successful implementation of the program is depicted in the absence of growth in the economy. YTEPP’s success is hinged on economic growth, as this would mean a faster absorption rate for graduates (as employed members of the labor force). Further difficulties are posed by access to consumables needed for courses, in terms of distribution and responding to demands.

The successful implementation of the YTEPP, in terms of increasing the trainees’ chances of employment was largely dependent on assistance from three main areas:

(i) Targeting areas of growth and retardation in marketable skills to determining areas of training. In recent years however, the section which was responsible for collecting this information and making it available to YTEPP, was disbanded;

(ii) Provision of loans by Youth Employment Support Services (YESS), upon completion of training. This organization has been disbanded; and

(iii) The placement of YTEPP graduates in apprenticeship schemes by the National Apprenticeship Scheme, under the auspices of the National Training Board. However, the absorption of graduates under this scheme is as a result of minimal industrial growth in the economy.

Nevertheless, YTEPP has had some success in attempting to transcend some of these difficulties through its partnership program. Assistance is rendered to the program by various industries, such as in the areas of finance, on-the-job training and the hosting of exhibitions.

Concluding Statement

There are basically three groups that training and retraining programs would need to target. These are:

1. New entrants into the labor market;

2. "Old" groups: that is, those who are already trained and are now in need of retraining; and

3. A group of "untrainable" individuals; these individuals may not necessarily fit into any of the training programs.
The flexibility of anti-poverty programs are reflected by the extent to which transfers are made available to the latter group.

Maybe the most sustainable response of anti-poverty programs, is realized through labor market interventions. One of the major challenges facing YTEPP is the changing face of the labor market. Indeed there is now a need to train individuals for entry into the global labor market.

Case study II: The School Feeding Program

5.5 Objectives

The School Feeding Program of Trinidad and Tobago is an ancillary body of the Ministry of Education, stationed in separate premises and managed by a Program Coordinator. It enacts the role of precursor to academic instruction, as the focus is on the physiological well-being of students. This is manifested in the attempt of actors to improve the nutritional status of meal-recipients and, in consequence, strengthen their learning capacity. In an effort to address and minimize the problem of under nourishment among the student population, menus are compiled to provide one-third of the Recommended Daily Allowance of nutrients (RDA). In addition, the target group comprises students attending government-assisted secondary, primary and kindergarten schools throughout the country. Cognizant that the management of the Tobago branch of the program is conducted by the Tobago House of Assembly, information in this case study is specific to Trinidad.

5.6 Method of Operation

Although the School Feeding Program has been in existence prior to 1989, a change of government occurred concomitant with the restructuring of the program. Today, the major actors include a ministerial committee and officials from the ministries of Health and Education. The Head Office of the School Feeding Program commissions four Food Nutrition Officers (in accordance with the four zones into which the country is placed) and twenty-seven Food Service Officers, who frequent schools and kitchens. It is interesting to observe that Food Service Officers pay daily visits to kitchens and weekly visits to schools. This occurs in tandem with regular visits by Public Health Inspectors. While the former group of officials monitors the preparation and boxing of meals, the latter randomly selects lunches for laboratory testing. Inspection is also carried out by representatives of lending agencies, such as the International Development Bank, which fund the program. This monitoring represents the attempt by the major parties involved to ensure that acceptable standards are met in school meal preparation and distribution.
Prior to 1982, the state-owned School Nutrition Company hired persons to package and distribute meals in schools. However, in the post-1982 period, the onus is on the caterer to prepare and package meals, as well as take them to schools. (Distribution within schools is then conducted by appointed teachers, older students or members of the Parents and Teachers Association.) Tenders are offered by the Central Tenders Board and caterers are chosen on their experience in Food Service and Handling, along with their ability to acquire necessary plant and equipment. Present caterers have been contracted for a two-year period.

In the event that kitchens are not on par with the required standard dictated in School Feeding Program manuals, they are accorded a reduced workload until their facilities are upgraded. Thus, it is imperative that the daily reports of Food Service Officers identify kitchens that are not up to standard. As an addendum, caterers have the authority to hire staff for their kitchens. Caterers spoken to have tried to employ persons with some experience in the Food Industry. During an impromptu visit to one kitchen, it was noticed that members of staff possessed food badges issued by the Ministry of Health. These were placed in a prominent place (not on the owner’s person) should Health or Head Office officials visit the premises.

In 1995, the School Feeding Program is operating within a budget of TT $72 million, deriving from a loan by the International Development Bank and allowances from the Consolidated Fund. This represents an increase of some 58% from 1990 ($29.9 million). Approximately 64,000 primary school children receive meals, as compared to 1900 secondary school students, and just under 10,000 pre-school children. While meals are distributed to secondary schools three times weekly, both pre-schools and primary schools receive meals five days per week. Caterers are paid TT$ 3. per pre-school meal and TT$ 4. per primary school meal.

The joint work between the Ministry of Health and the Ministry of Education on the School Feeding Program is part of an attempt to forge intersectoral linkages in the country. Caterers are also encouraged to purchase local produce in a bid to aid local farmers. It is also hoped that the inclusion of vegetables and fruits in meal packages will enhance the taste buds of recipients, fostering a gravitation towards nutritious food.

5.7 Effectiveness of the Program

An assessment of the effectiveness of the School Feeding Program might direct attention to the acceptability of most meals as far as recipients are concerned. Proper nutrition during formative years is mandatory for healthy adulthood. Reports submitted by school principals, especially those from secondary schools, have shown a positive correlation between increased school attendance and the days on which meals are served.

Management disseminating from Head Office has also tried to make quality an integral part of quantity food production. This is illustrated in training courses offered in 1989 to approximately 600 persons enlisted for work in kitchens, as well as Food Officers. Indirect
assistance has also been rendered by the School Feeding Program in terms of alleviating the level of unemployment in the country. As a result of the time constraint involved in data compilation, the extent of employment provided by the program could not be ascertained. However, it must be stated that kitchens are found throughout the country and employ many single female heads of households. In addition, in the north-eastern district of Matelot, staff is hired on a rotational basis, permitting unemployed villagers to earn some money. The School Feeding Program in Moruga operates as a cooperative system, providing further services in terms of community projects.

Among some of the observations made by personnel of the program for its improvement are:

- Notwithstanding the successful implementation of the School Feeding Program to date, the image of an utopian arrangement should not be perpetuated.

- In light of the approximate cost of TT$120,000 to establish kitchen facilities and purchase equipment, additional funding by lending agencies may very well mitigate the outlay burden for the new caterer.

- Intersectoral linkages should also be expanded to include the business community. In consequence, problems such as the increased price of necessities (for example, pre-packaged drinks) would not require the exclusion of these items from meal packages.

- One problem that has remained with the program from inception is that of the stigma attached to meal-recipients. According to the Program Coordinator, "Children don't like to be identified as being needy." However, the nutritional benefit derived from meals should outweigh this negativity.

Here it should be noted that the request by the Head Office for the upgrading of kitchens, has led to the change (by most kitchens) from wooden tabletops and tiled counters, to the widespread use of stainless steel. This product is not only more durable, but acts as a barrier to the spread of germs. There has also been a gradual decline in the use of plastic totes to insulated "cambros." Head Office maintains that the latter ensures that meals are still hot when being distributed. According to key personnel. The School Feeding Program has progressed since its 1989 "re-structuring." and it is hoped that this level of improvement will be maintained and superseded by further gains in efficiency.
Table 5.1 Summary of schools served in 1994

<table>
<thead>
<tr>
<th>County</th>
<th>No. of caterers</th>
<th>Primary schools</th>
<th>Pre-schools</th>
<th>Secondary Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of meals</td>
<td>No. of schools</td>
<td>No. of meals</td>
<td>No. of meals</td>
</tr>
<tr>
<td>St. Andrew/St. David</td>
<td>7</td>
<td>52</td>
<td>6510</td>
<td>15</td>
</tr>
<tr>
<td>St. George East</td>
<td>9</td>
<td>68</td>
<td>10174</td>
<td>8</td>
</tr>
<tr>
<td>St. George West</td>
<td>12</td>
<td>91</td>
<td>12970</td>
<td>16</td>
</tr>
<tr>
<td>Caroni (A)</td>
<td>3</td>
<td>31</td>
<td>4513</td>
<td>2</td>
</tr>
<tr>
<td>Caroni</td>
<td>5</td>
<td>37</td>
<td>5343</td>
<td>3</td>
</tr>
<tr>
<td>Victoria</td>
<td>8</td>
<td>50</td>
<td>7269</td>
<td>5</td>
</tr>
<tr>
<td>Nariva/Mayaro</td>
<td>3</td>
<td>19</td>
<td>2465</td>
<td>1</td>
</tr>
<tr>
<td>Victoria (A)</td>
<td>7</td>
<td>48</td>
<td>6505</td>
<td>6</td>
</tr>
<tr>
<td>St. Patrick</td>
<td>12</td>
<td>61</td>
<td>8575</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>66</strong></td>
<td><strong>457</strong></td>
<td><strong>64324</strong></td>
<td><strong>64</strong></td>
</tr>
</tbody>
</table>
# ANNEX I

## Post Primary Centres Program

<table>
<thead>
<tr>
<th>District</th>
<th>Center</th>
<th>Address of Center</th>
</tr>
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<td>Church Street, Diego Martin</td>
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<td>Lootoo Street, El Socorro</td>
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<td>Sixth Avenue, Barataria</td>
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<td>5. South Eastern Town</td>
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<td>Iere Village, Princess</td>
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<td>Estate Road, Hindustan</td>
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<td>Ecclesville P.O., via Rio Claro</td>
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<tr>
<td>6. Victoria Presbyterian</td>
<td>Bonne Aventure</td>
<td>School Road, Bonne Aventure, via Gasparillo</td>
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ANNEX II:

Reports Issued from the Research, Evaluation and Documentation Unit of the Youth Training and Partnership Program Limited

The following is a listing of reports done on the YTEPP by this unit as of October 1994.

**Cycle II (1989 - 1990)**

- Analysis of Second Cycle Graduates
- Overview of the Second Cycle

**Cycle III (1990 - 1991)**

- Profile of Applicants and Graduates - Cycle III
- Report on Pilot Pou Cycle
- Report on Attrition in Caroni
- Report on Awareness Day Activities 1991 (Pre Cycle IV)
- Feedback Report on Trainees’ Perceptions

**Cycle IV (1991 - 1992)**

- Feedback Report on Trainees’ Perceptions
- Trainees’ Concerns Re: Cycle IV
- Paper on the Role of the Research Unit and Preliminary Data from the Tracer Study
- The Effect of Trinidad and Tobago’s Youth Training and Employment Partnership Program on Graduates’ Earnings
- Report on Certification Exercises - Cycle IV - Challenges
- Report on Methods and Implementation Schedule of Evaluation Procedures
- Program Evaluation - Cycle IV with the following sub-sections:
  - Pre-commencement Exercises
  - Profile of Applicants
  - Attrition
  - Guidelines for the Determination of Attrition Graduates
  - Major Findings of the Attrition Study - Caroni
  - Trainee Performance Evaluation
  - Trainee Performance Evaluation Certification
  - Key Indicators and Output for Monitoring and Evaluation
  - Trainees’ Perceptions - Emerging Trends between Cycles III and IV
  - Financial Considerations
Post Training Support  
Community-based Projects

- Report for the establishment of a Centralized Processing Unit
- Report on YTEPP for Director of Restructuring Support Unit
- Report on YTEPP Limited for Minister of Youth for Budget Debate 1992
- Report on Meeting - Employment and Job Creation, Chaired by the Minister of Labor
- Statistical Reports - Phases I, II and III - Cycle IV
- Profile of Applicants and Graduates
- The Effectiveness of Promotional Strategies - Pre-Cycle V

**Cycle V (1992 - 1993)**

- Monitoring and Evaluation Action Plan - Cycle V
- Report on Pre-Cycle Activities (Awareness) - Cycle V
- Key Indicators and Outputs for Monitoring and Evaluation - Cycle V
- Statistical Reports - Phases I, II and III - Cycle V
- Proposal for Subsistence Report
- Evaluation of the Basic Education Program at the Tabaque Centre
- YTEPP’s Labor Market Information Study (Pre Cycle VI)

**Cycle VI (1993 - 1994)**

- Technical Design Manual for the YTEPP Monitoring Information System (YMIS)
- Monitoring and Evaluation Action Plan - Cycle IV
- Key Indicators and Output for Monitoring and Evaluation - Cycle VI
- Environmental Scan for Strategic Plan
- Proposal for the Establishment of a Resource Centre
- Information Technology Needs Assessment - Preliminary Status
- Statistical Reports - Phases I, II and III - Cycle VI
- Reports for the Minister of Education and Senator Andre Maloney for Budget Debates
- Report on the Effectiveness of Promotional Strategies Employed for YTEPP VI
- Field Audit of the Implementation of the continuous Assessment Instruments and Attendance Registers
- Compilation of Trainee Evaluation and Certification Reports - Cycles IV and V
- YTEPP’s Needs Assessments Report (Pre Cycle VIII):

Special Evaluation Studies of the Research, Evaluation and Documentation Unit of YTEPP Limited

Cycle IV

- Report on Attrition in Victoria
- Report on Awareness Day Activities 1991

Cycle V

- YTEPP's L. M. I. S. Report
- Promotional Strategies
- Report on Pre-Cycle Activities (Awareness)

Cycle VI

- YTEPP's L. M. I. S. Report (Needs Assessment Exercise)
- Evaluation of the Basic Education Program at the Tabaquite Centre
  - The Effectiveness of Promotional Strategies
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Pan American Health Organization
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Washington, D.C.  20037
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