

ISSN 1728-5445

SERIES

# STUDIES AND PERSPECTIVES

ECLAC SUBREGIONAL  
HEADQUARTERS  
FOR THE CARIBBEAN

## Disability, human rights and public policy in the Caribbean

A situation analysis

Francis Jones  
Luanne Serieux-Lubin



UNITED NATIONS



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United Nations publication

ISSN: 1728-5445 (electronic version)

ISSN: 1727-9917 (print version)

LC/TS.2017/151

LC/CAR/TS.2017/12

Distribution: Limited

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Printed at United Nations, Santiago

S.17-01279

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## **Abstract**

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This study presents a situation analysis of persons with disability in the Caribbean. It includes a compilation and analysis of national census data from 16 countries including data from both the 2000 and the 2010 census rounds. The study also assesses national laws, policies and programmes in the context of relevant international treaties and agreements. The topics covered include health and rehabilitation, accessible buildings, transport, information and communications technology, education and labour market participation. In each of these areas, good practices, gaps, and priorities for action are identified and there are policy recommendations to support governments in further addressing the issue of disability.



## Introduction

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Disability is a part of life. Many of us will experience some form of disability at some stage during our lives or will have family members with disabilities. Approximately 15 per cent of the world's population, over one billion persons, experience some form of disability. About three per cent experience significant disabilities (World Bank, 2016). In the Caribbean, there are approximately 1.3 million persons with a disability of some kind and around 250,000 persons with a significant disability. The number and proportion of people with disabilities is expected to increase over the coming decades primarily due to population ageing.

Among this group, there are people of different ages, with different types of disability, living in very different circumstances. The effect of disability on people's lives varies according to the type and severity of disability, socio-economic status, the communities in which they live, and many other factors. However, many people with disabilities face barriers which prevent their full and equal participation in society. Across the Caribbean, few schools, workplaces, public spaces, buildings, transport systems and cultural services are designed to be accessible to persons with disabilities. They are therefore excluded from participation in activities which others take for granted with serious implications for their social and economic well-being. Persons with disabilities experience worse outcomes in education, employment, health and housing among other areas. This systematic discrimination is now widely recognized as violating fundamental human rights.

Previously, disability was seen as primarily a medical problem and persons with disabilities were seen as being in need of treatment, charity and care. However, the recognition that persons with disabilities are full and equal members of society, with the same human rights as everyone else, has much wider implications. Societies themselves must also change to remove the barriers that prevent equal participation thereby enabling the effective exercise of rights. Human rights have thus become a focus for advocacy and a framework for public policy on disability.

The global consensus on the human rights of persons with disabilities is now well established. It led to the adoption of the Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities (IACPD) in 1999. This Convention obliges member States of the OAS (Organization of American States) to adopt legislative, social, educational and employment-related measures to protect the rights of persons with disabilities; to prioritize the prevention of disability; to promote independence, a high quality of life for persons with disabilities and public awareness of



disability. The IACPD also set up rules, measures, processes, and support mechanisms, including precise reporting procedures to ensure accountability among signatories.

In 2006, the adoption of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) saw the establishment of a universal treaty to “promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity” (United Nations, 2006). There is also a related Optional Protocol which provides a monitoring mechanism through the Committee on the Rights of Persons with Disabilities. The CRPD has received worldwide support with 172 member States having ratified it (or acceded to it) at the time of writing, including 11 of 13 Caribbean member States.

CARICOM member States have also sought to cooperate to strengthen protection for the rights of persons with disabilities. The Kingston Accord (2004) reaffirmed “that every Caribbean citizen has the same human, civil, political, economic, social and cultural rights” and expressed support for a binding internal human rights treaty (subsequently realized in the form of the CRPD). More recently, in the Declaration of Pétion-Ville (2013), Caribbean Governments affirmed their commitment to develop national legal frameworks to give effect to the commitments set out in the CRPD.

Nationally, the picture is more mixed. Four countries have passed comprehensive legislation addressing disability: the Bahamas, Cayman Islands, Guyana, and Jamaica. Guyana was the first in 2010; the other three countries followed in 2014. The Government of Trinidad and Tobago adopted a slightly different approach and since 2008 has had an Equal Opportunities Commission and an Equal Opportunities Act which addresses multiple types of discrimination (sex, race and disability, among others). Other countries have legislation addressing specific forms of discrimination against persons with disabilities, for example in employment law.

These treaties, agreements and laws provide the context for this study which has three main objectives. The first objective is to provide an assessment of the situation of persons with disabilities in the Caribbean. The second is to provide an evaluation of the current status of government legislation, policies, and programmes for persons with disabilities. Finally, the study will provide evidence and policy recommendations to facilitate the implementation of international agreements, particularly the Convention on the Rights of Persons with Disabilities. It has been produced using statistical information about persons with disabilities collected in the 2000 and 2010 census rounds; using information from governments and other sources about policies, programmes and other measures to promote and protect the rights of persons with disabilities.

The study comprises five main chapters and a statistical annex. Chapter I, Disability in the Caribbean, explains some key concepts essential to an understanding of disability and the formulation of public policy for disability. It provides statistical information on disability in the Caribbean subregion and considers the link between population ageing and disability.

Chapter II addresses health, rehabilitation and social care services for persons with disabilities. It considers the inequalities they face, and ways to reduce those inequalities. The chapter also discusses rehabilitation and the availability of rehabilitation services as well as assistance and care services for those with disabilities and their families.

Chapter III assesses enabling environments and how these facilitate the participation of persons with disabilities in society. Environmental factors –social, physical and attitudinal– play a crucial role in either mitigating or aggravating disability. Moreover, governments and other organizations can act to influence and shape these different aspects of the environment. This chapter examines the accessibility of buildings, public spaces, transport, information and communications technology and cultural services.

Chapter IV, on access to education, analyses the education of children and young persons with disabilities. The chapter discusses the importance of education in creating inclusive and equitable societies and the different approaches to the education of children with disabilities which have been used in the Caribbean. The chapter reviews the progress that has been made in special needs education, integrated and inclusive education.

Chapter V, on economic activity and income protection, discusses opportunities for employment and self-employment and barriers faced by persons with disabilities. This chapter also considers the additional costs faced by persons with disabilities and the need for income protection for those who are either unable to work or are otherwise excluded from the labour force. It reviews existing programmes and makes recommendations to further promote employment of persons with disabilities.



## **I. Disability in the Caribbean**

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Following years of advocacy and activism, the human rights of persons with disabilities are now well-established in international law and serve as an important paradigm for public policy on disability. Linked to this rights-based approach to disability, has been a profound change in thinking about the very nature of disability. It is now recognized that disability is not purely a personal medical issue, but a more complex affair involving the interaction between people's health conditions or impairments and the wider society and environment. Understanding and promoting this rights-related conception of disability is fundamental to the implementation of the Convention on the Rights of Persons with disabilities.

There has also been a gradual change in the way that disability is measured in official statistics. Since 2002, the Washington Group on Disability Statistics has sought to guide and harmonize the production of statistics on disability, primarily through developing questions for use in national censuses (or surveys). The new Washington Group questions place much greater emphasis on people's ability to function as opposed to physical or mental impairments. These questions have been partially adopted by Caribbean countries and territories in their censuses, with important implications for the interpretation of statistics.

The population structure of the Caribbean is also evolving, with the population ageing. Older persons are much more likely to have disabilities and, all other things being equal, the number and proportion of persons with disabilities can be expected to increase over time. This chapter provides an overview of disability in the Caribbean, paying particular attention to these conceptual, statistical, and demographic changes and trends, each of which has important implications for our understanding of disability.

### **A. Disability, human rights and public policy**

The principle of the universality of human rights was established in the Universal Declaration of Human Rights (1948), namely that everyone is entitled to the same fundamental rights and freedoms irrespective of age, nationality, sex, ethnic origin, religion, language, or any other status. The content of these rights was further clarified in the treaties comprising the so-called International Bill of Human

Rights,<sup>1</sup> or in the case of the Inter-American Human Rights System, in the American Declaration of the Rights and Duties of Man (1948) and the American Convention on Human Rights (1969). Nevertheless, certain groups remained more vulnerable to rights violations of different kinds and found it more difficult to realize their rights. Therefore additional protections and measures have been necessary for these groups to fully enjoy their basic human rights.

The need to strengthen protection for the fundamental human rights of specific groups, such as women, children, migrants and persons with disabilities led to the creation of specific conventions addressing the rights of these groups, within both the United Nations and Inter-American human rights systems. It is important to emphasize that the human rights to which these groups are entitled are, at root, the same fundamental human rights to which everyone else is entitled. These additional treaties define in greater detail how fundamental human rights should be interpreted for these groups: what specific rights must be protected and fulfilled in order that these subgroups can fully enjoy their basic human rights; and what actions are necessary to make this happen. The rights of persons with disabilities (or women, children or migrants) should not therefore be understood as either new rights or special rights, but rather as an interpretation, a further specification, and an application of existing human rights for these groups.

In the case of persons with disabilities, very many rights –the right to education, to work, to an adequate standard of living, the right to take part in cultural life and public affairs, the right to privacy and self-determination– were manifestly problematic. These rights were not enjoyed by all persons with disabilities because societies are predominantly shaped by the common needs of the able-bodied majority, not the varied and disparate needs of the disabled minority. Therefore the physical, social and economic environment has tended to develop in ways which include the able-bodied while excluding those with disabilities. The human rights perspective is very important because it shifts the focus onto the role that society plays in disability. The recognition that persons with disabilities have the same human rights as everyone else necessarily implies, and moreover demands, that society itself must change, removing the barriers that prevent equal participation and enabling the full and free exercise of rights.

The Convention on the Rights of Persons with Disabilities (CRPD) is a universal and binding treaty and a tool for development that protects and promotes the human rights of persons with disabilities. Similar to other human rights treaties, it obligates States Parties to respect, protect and promote the human rights of persons with disabilities. This means that governments must refrain from interfering with the enjoyment of human rights; they must protect individuals and groups against human rights abuses; and they must take measures to facilitate the enjoyment of rights. Non-discrimination is a fundamental principle and States commit to take all possible measures to eradicate discrimination against persons with disabilities by any individual, organization, or public or private entity; and to foster an environment that provides dignity, autonomy and encourages full and equal participation in society.

The Convention incorporates civil and political rights; economic, social and cultural rights; it addresses the rights of groups such as women with disabilities, children with disabilities, and persons in situations of risk (such as natural disasters). In particular, the articles of the CRPD address issues including accessibility; freedom from torture or cruel, inhuman, or degrading treatment; freedom from exploitation, violence, and abuse; living independently and being included in the community; personal mobility; freedom of expression and opinion, and access to information; respect for privacy; respect for home and the family; education; health; habilitation and rehabilitation; work and employment; participation in political and public life; participation in cultural life, recreation, leisure, and sport (see diagram 1). Countries which have ratified the treaty have an obligation to report on how it is being implemented. States must report initially within two years of ratifying the Convention and thereafter every four years. Reports are submitted to the Committee on the Rights of Persons with Disabilities which is the body of independent experts which monitors implementation of the Convention.

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<sup>1</sup> The International Bill of Human Rights consists of the Universal Declaration of Human Rights (1948), the International Covenant on Economic, Social and Cultural Rights (1966), and the International Covenant on Civil and Political Rights (1966) and its two Optional Protocols.

**Diagram 1**  
**Overview of the Convention on the Rights of Persons with Disabilities**



Source: Adapted from Worm, 2012.

There is also an Optional Protocol which establishes an individual complaints mechanism. Countries having ratified the Optional Protocol agree to recognize the competence of the Committee on the Rights of Persons with Disabilities to consider complaints from individuals or groups who claim their rights under the Convention have been violated. The Committee may then make recommendations

to the country concerned. States Parties may also recognize the competence of the Committee to investigate further when there are reliable indications of "grave or systematic violations."

The Convention on the Rights of Persons with Disabilities (CRPD) entered into force in May 2008 (upon ratification by twenty member States). To date, the Convention has been ratified by 172 countries, while the Optional Protocol has been ratified by 92 nations. In the Caribbean, 11 of 13 countries have ratified the Convention (see table 1). Saint Kitts and Nevis and Saint Lucia have yet to ratify the CRPD. With most Caribbean countries now having ratified the treaty, many are now also due to report on the status of implementation although Caribbean countries are yet to go through this reporting process. Just two countries have ratified the Optional Protocol: Dominica and Saint Vincent and the Grenadines.

**Table 1**  
**CRPD and Optional Protocol signatories and ratifying States**

|                                  | CRPD       |              | Optional Protocol |              |
|----------------------------------|------------|--------------|-------------------|--------------|
|                                  | Signature  | Ratification | Signature         | Ratification |
| Antigua and Barbuda              | 30/03/2007 | 07/01/2016   | 30/03/2007        |              |
| Bahamas                          | 24/09/2013 | 28/09/2015   |                   |              |
| Barbados                         | 19/07/2007 | 27/02/2013   |                   |              |
| Belize                           | 09/05/2011 | 02/06/2011   |                   |              |
| Dominica                         | 30/03/2007 | 01/10/2012   |                   | 01/10/2012   |
| Grenada                          | 12/07/2010 | 27/08/2014   |                   |              |
| Guyana                           | 11/04/2007 | 10/09/2014   |                   |              |
| Jamaica                          | 30/03/2007 | 30/03/2007   | 30/03/2007        |              |
| Saint Kitts and Nevis            |            |              |                   |              |
| Saint Lucia                      | 22/09/2011 |              |                   |              |
| Saint Vincent and the Grenadines |            | 29/10/2010   |                   | 29/10/2010   |
| Suriname                         | 30/03/2007 | 29/03/2017   |                   |              |
| Trinidad and Tobago              | 27/09/2007 | 25/06/2015   |                   |              |

Source: United Nations Treaty Collection (UNTC, 2017).

In 2013, CARICOM member States reaffirmed their commitment to the rights of persons with disabilities in the Declaration of Pétion-Ville<sup>2</sup> (CARICOM, 2013). They committed to the development of national laws protecting persons with disabilities and to enhance national and regional policies and frameworks. In addition, signatories agreed to support families of persons with disabilities, recognize the diversity of persons with disabilities and their unique needs, and establish a mechanism to ensure monitoring and assessment of progress.

## **B. National implementation of the CRPD, disability legislation and policies**

International human rights treaties, and the decisions of the corresponding treaty bodies, are the primary frame of reference in relation to human rights. Where human rights have been incorporated into domestic law, international treaties have generally been the primary source of law. Regarding the relationship between international and domestic law, Caribbean countries have dualist legal systems. The signing or ratification of treaties is an executive act, while any implementation of treaty obligations involving changes to domestic law requires a separate legislative act. Therefore, treaties such as the CRPD require implementing legislation in order to give full effect to the rights and obligations in

<sup>2</sup> Access the Declaration of Pétion-Ville at <http://caricom.org/media-center/communications/news-from-the-community/declaration-of-petion-ville>.

domestic law (Anderson, 1998). This does not always happen in practice which can lead to a situation where, although the treaty is still binding on the State, implementation is undermined and citizens do not have recourse to domestic law to protect their rights. This situation contrasts somewhat with that in, for example, Latin America where in most cases there are clear mechanisms for the incorporation of international treaties in domestic law.

A number of countries have developed comprehensive policies and subsequently legislation for persons with disabilities. Guyana formulated a National Policy on the Rights of Persons with Disabilities in 1997, Jamaica established a National Policy for Persons with Disabilities in 2000, and Trinidad and Tobago launched its National Policy in 2006, followed by the Cayman Islands Disability Policy (2014-2033). Some of these countries have now passed disability Acts. In Guyana, the Persons with Disabilities Act became law in 2010; in the Bahamas the Persons with Disabilities (Equal Opportunities) Act was passed in 2014 and is being implemented; Jamaica's Disabilities Act was also passed in 2014 but is not yet in force; while the Cayman Island's Disabilities (Solomon Webster) Bill was approved at the end of 2016.

Guyana's Persons with Disabilities Act (2010) seeks to: promote and protect the full and equal enjoyment of rights; to facilitate the enforcement of rights; to eliminate discrimination on the basis of disability; to provide for the welfare and rehabilitation of persons with disabilities; to provide for the registration of persons with disabilities; and to establish the National Commission on Disabilities. It states that the United Nations Convention on the Rights of Persons with Disabilities shall inform decisions taken in the administration of the Act.

The Act sets out the responsibilities of employers to ensure equal opportunities for employment without discrimination; the responsibilities of the Government with respect to vocational training; with regard to promoting the education of children with disabilities in regular schools or special schools as appropriate, the training of teachers in special education, and financial support for persons with disabilities in post-secondary and tertiary education. It also sets out the responsibilities of Government with regard to prevention of disability, free rehabilitation services and affordable health services; housing and water; social services such as provision of prosthetic devices; family care and substitute family care services; day care services for pre-school age children with disabilities; and opportunities to participate in sports and cultural activities. It establishes the requirement for some sign language and subtitling in national television (by 2020); building codes for the construction and renovation of buildings to allow barrier-free access for persons with disabilities; formulation of policies for adapted motor vehicles and access to public transport; and the right to vote. It also sets out the responsibilities of those in charge of public premises or other service providers not to discriminate against persons with disabilities; and includes provisions against the concealment of persons with disabilities (for example by parents).

The Act also established a National Commission on Disability which serves as a national focal point on disability and is required to: monitor implementation of the Act and the CRPD; establish registers of persons with disabilities, and service providers; receive complaints from persons with disabilities; issue adjustment orders, and facilitate the enforcement of the rights of persons with disabilities. In cases of discrimination or rights infringements, the Commission may institute legal proceedings to enforce the Act.

The Bahamas Persons with Disabilities (Equal Opportunities) Act was passed in 2014 and has many similarities to the Guyana Act. Some of its provisions came into force that year and others in 2016. Owners of buildings to which members of the public are given access have until 2018 to make appropriate adaptations. The Act also created a National Commission for Persons with Disabilities with similar responsibilities to that in Guyana. In cases of discrimination or rights infringements the Commission may request the Attorney-General to take appropriate legal action.

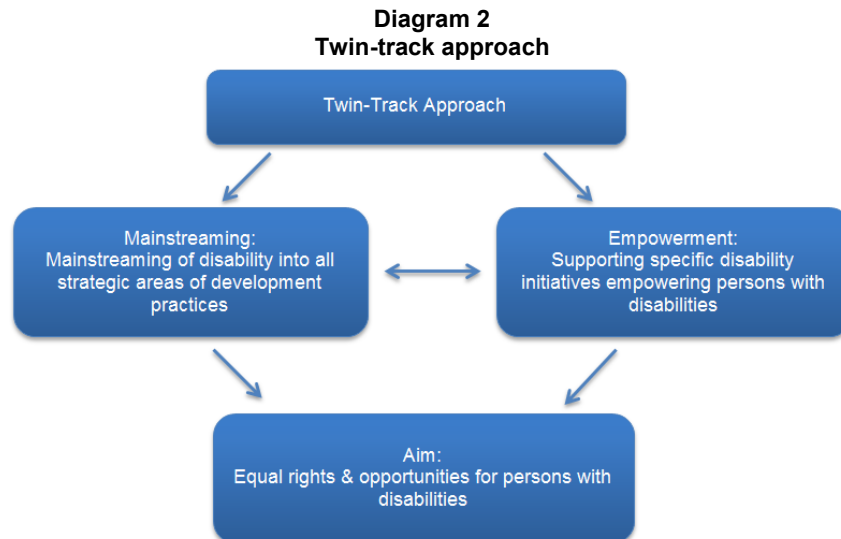
The Jamaica Disabilities Act was enacted in 2014 but the Act is not yet in force. Again, it is broadly similar to the Guyana and Bahamas Acts (although unlike those Acts it does not make explicit



reference to the CRPD). It provides a legal basis for the role of the Jamaica Council for Persons with Disabilities<sup>3</sup> which includes advice, monitoring, public education, and preparing codes of practice to guide implementation of the Act. It also envisages that the Council will receive and investigate complaints of discrimination, breaches of relevant codes of practice or any other contravention of the Act. The Act additionally provides for the creation of a Disabilities Rights Tribunal to which the Council will be able to refer complaints for resolution. Resolution could mean a declaration with respect to the rights of a complainant and/or the obligations of the respondent; an order for payment of compensation; an order for some other action by the respondent; or an alternative dispute resolution procedure. The Council may arrange for legal advice or representation for a complaint.

In the Cayman Islands, the Disabilities (Solomon Webster) Bill which implements a number of proposals in the Disabilities Policy (2014-2033) was recently approved. The Act is less comprehensive than the other Acts although it does address the rights to personal liberty, privacy, access to justice, and participation in political and public life. Otherwise it restricts itself to a general statement about the progressive realization of economic, social and cultural rights. Trinidad and Tobago also had a National Policy on Persons with Disabilities and accompanying action plan which was launched in 2006. The policy is now due for renewal.

The disability Acts in the Bahamas, Guyana and Jamaica are broad in scope and have implications for most sectors: education, employment, health, social welfare, transport, information and communications technologies (ICTs) and culture among others. The advantage of a single disability Act, as opposed to amending the existing legislation in each sector, is that it addresses issues across all sectors in a single piece of legislation thereby facilitating the twin-track approach to the rights of persons with disabilities (see figure 2). Mainstreaming a disability-inclusive and human rights perspective across sectors constitutes one track. So this might include making schools, hospitals, employers and other service providers more accommodating to persons with disabilities. Disability-specific initiatives to empower persons with disabilities and enhance their inclusion in society constitute the other track. Examples of such initiatives would include capacity development to strengthen disabled persons' organizations (DPOs); vocational training for persons with disability; or provision of assistive devices, financial support or other services (Worm, 2012).



Source: Adapted from Worm, 2012.

<sup>3</sup> The Jamaica Council for Persons with Disabilities is the Government Agency responsible for rehabilitation, vocational training and placement of persons with disabilities in Jamaica.

Some other islands without disability Acts or policies have instituted protections for persons with disabilities in other pieces of legislation. For example, employment law in Bermuda, Grenada and Saint Vincent and the Grenadines; the building code used by the countries and territories of the Organisation of Eastern Caribbean States (OECS); and education policies in Saint Lucia and Saint Vincent and the Grenadines which address the education of children and young persons with disabilities.

In the absence of any such general or specific legislation, a more limited form of protection is provided by the anti-discrimination provisions of some national constitutions such as that of Antigua and Barbuda. To take this example, the constitution of Antigua and Barbuda states that no law, or no person acting by virtue of any law or public office or authority, shall discriminate against persons with disabilities. In theory, this provides some protection against discrimination by the State but not by third parties or other circumstances not relating to actions of the State.

Even for countries which have passed legislation providing legal protection for the rights of persons with disabilities, legal and regulatory enforcement is inadequate and persons with disabilities generally do not yet have access to mechanisms which would enable them to make complaints and to seek redress. At present, national human rights institutions in accordance with Paris Principles are not in place, public prosecutor or ombudsman institutions have limited mandates and are under resourced, and justice systems are slow and often ineffective for rights claims. Internationally, there are limited avenues for pursuing rights claims. Only Dominica and Saint Vincent and the Grenadines have ratified the Optional Protocol to the CRPD. No country has yet ratified the Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities. Many countries do not recognize the Inter-American Court of Human Rights or the Inter-American Commission on Human Rights. Specialized mechanisms for persons with disabilities are not yet in place. For all countries, much remains to be done, both to strengthen and give practical effect to the legal protections for the rights of persons with disabilities.

### **C. Estimates from the 2000 and 2010 censuses and projections to 2050**

In most Caribbean countries, the decennial population and housing censuses are the only source of statistical information about persons with disabilities. This study presents information collected through both the 2000 and 2010 census rounds. In interpreting the data, it should be remembered that national censuses use different questions to collect data on disability. The estimates that are obtained through censuses are sensitive to these apparently small changes in question wording, which creates problems of comparability both over time and between countries. This was particularly true following the 2010 round of censuses when some countries made changes to their census questions to bring them closer into line with international best practice –using the Washington Group Short Set of Questions on Disability or something similar– while other countries either made no changes, or made other changes not related to the Washington Group questions. Therefore while the data presented here provides plenty of information about persons with disabilities in the Caribbean, including their demographic characteristics and their living situation, the differences observed between the countries, for example in the proportion of persons with disabilities in each country, can be due as much to differences in the questions as to real population differences.

In the 2000 census round and earlier census rounds, countries used traditional census questions which asked about impairments. A typical question took the form: do you (or does person *x*) suffer from any disability or infirmity? This question functioned as a filter, with only those that responded affirmatively then being asked about the type of disability they had, for example sight, hearing, speech etc. These questions had a tendency to use old fashioned and stigmatizing language about disability, for example phrases like ‘mental retardation’. Starting its work in 2001, the Washington Group on Disability Statistics developed questions for censuses and surveys intended to provide internationally comparable statistics on disability. The Washington Group questions differ in some important ways from the questions which were previously used to measure disability in Caribbean censuses. The questions are focused on functioning rather than impairments. Instead of being asked directly whether they have a

disability, respondents are asked if they have difficulty seeing, hearing, walking etc. The Washington Group questions do not include a filter question. All respondents are asked if they have difficulty with each of six activities or functions: seeing; hearing; walking or climbing steps; remembering or concentrating; self-care; and communicating. They are also asked to indicate the level of difficulty that they have: no difficulty; some difficulty; a lot of difficulty; or cannot do at all. In this way, disability is no longer measured as a binary concept but has three distinct levels of severity.

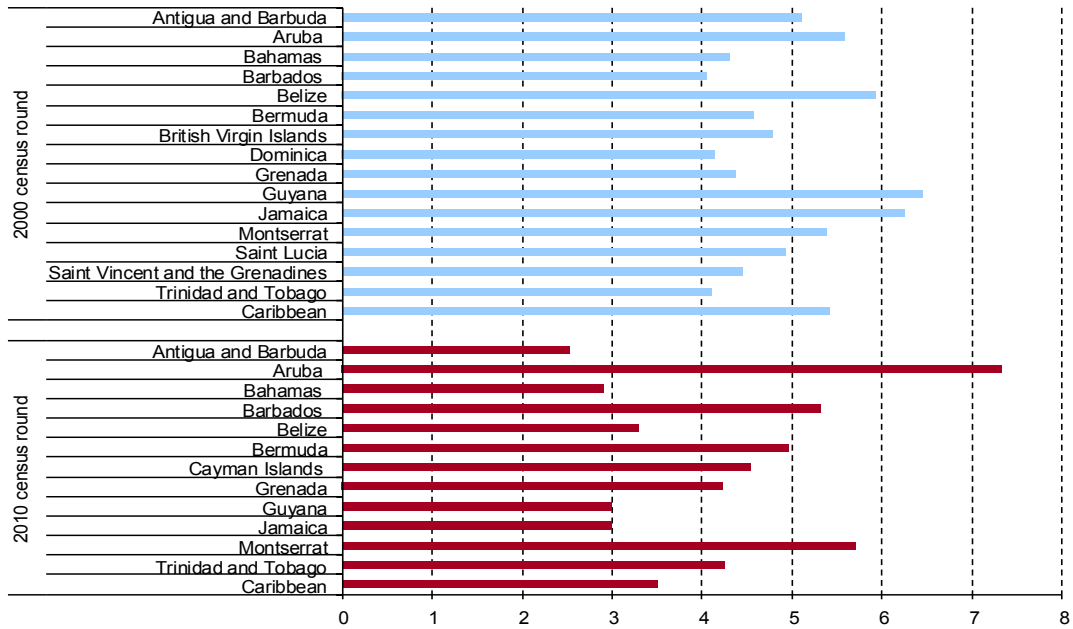
There are particular difficulties associated with measuring disability among young children. In part, this is because the diagnosis of disability among young children is challenging. It is clear that the Washington Group questions, for example questions such as ‘do you have difficulty walking or climbing stairs?’ are not appropriate to the identification of disability in young children. Therefore the Washington Group questions in particular should only be asked of persons aged five years and above.

When prevalence rates for disability are calculated, it is recommended that only those persons responding that they have a ‘lot of difficulty’ or ‘cannot do (it) at all’ are regarded as having a disability. This is because there are a significant number of respondents who indicate that they have ‘some difficulty’ seeing, hearing etc. but who would not describe themselves, or be generally regarded, as having a disability. The ‘some difficulty’ response category is used to capture these people and to ensure that only those persons with relatively more serious disabilities, those falling into the categories ‘a lot of difficulty’ or ‘cannot do at all’, are counted as having a disability. There may be circumstances in which it is useful to analyse this group of people in the ‘some difficulty’ category but they are not generally counted as having a disability.

In the 2000 census round, although countries used a broadly similar style of questions about disability, there were nevertheless variations from country to country in the exact wording that was used which affected the comparability of the estimates. In the 2010 census round, some countries modified their census questions in response to the Washington Group Short Set of Questions on Disability. However, those countries did not necessarily use the exact wording of the Washington Group questions, perhaps using questions which represented a compromise between their previous census question and the Washington Group questions (for example, a different list of functions/activities). Some countries went further than others in adopting the new questions. Statisticians have to deal both with the need for comparability between countries and for comparability with previous censuses carried out in the same country. These goals necessarily come into conflict and in different countries, different decisions were taken about how, and to what extent, to implement the new Washington Group questions. The consequence of this is that there are problems of comparability between the data collected in the 2000 round and that collected in the 2010 round, and also problems of comparability between countries, in respect of both the 2000 and the 2010 estimates.

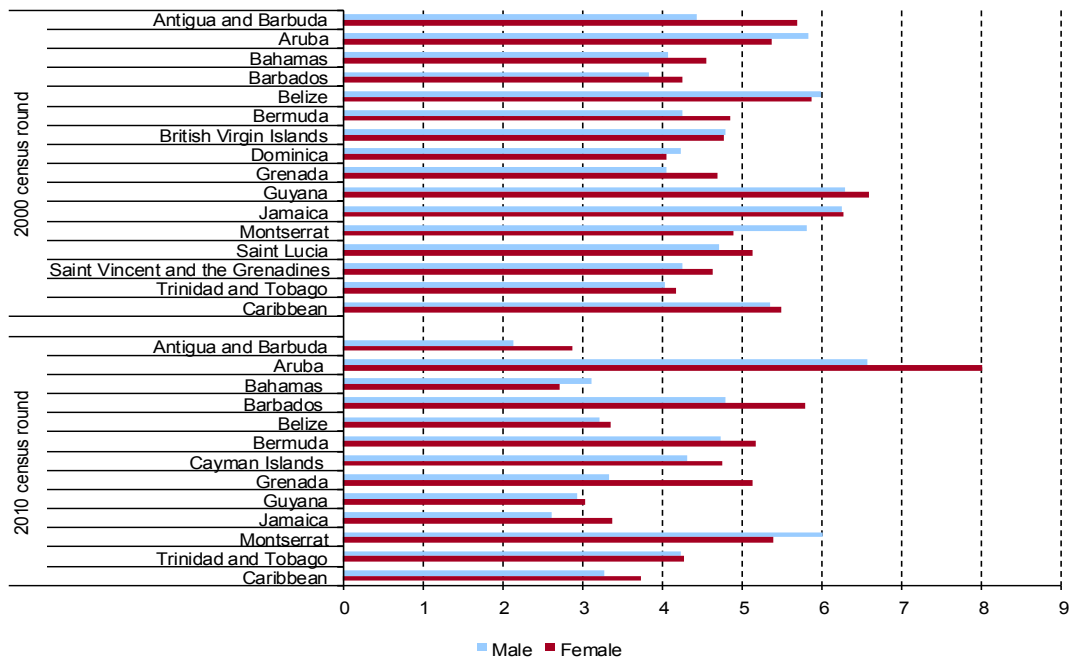
Figure 1 shows the percentage of the population with a disability across sixteen countries and territories. Estimates based on data collected in the 2000 census round, show the prevalence of disability varied between approximately 4.0 and 6.4 per cent, and was 5.4 per cent for the Caribbean as a whole. Based on data from the 2010 census, the range of estimates was wider, from 2.5 per cent to 7.3 per cent, and 3.5 per cent overall. In some cases, the change in the prevalence rate between the 2000 and 2010 rounds appears to have been affected by changes to question wording. For example, the census question used by Guyana in the 2000 round was different to that used in the 2010 round. The disability prevalence rate from the 2000 round was 6.4 per cent while the prevalence rate from the 2010 round was 3.0 per cent. This ‘fall’ in the prevalence of disability in Guyana was highly likely to be due to the change in question wording. In the 2010 round, the countries using ‘Washington Group-style’ questions were Antigua and Barbuda (2.5 per cent), Aruba (7.3 per cent), Belize (3.3 per cent), Grenada (4.2 per cent), and Jamaica (3.0 per cent). Aruba has the highest prevalence rate which is likely due, at least in part, to the fact that Aruba has a relatively old population compared to the other countries. Unlike the other censuses, the Aruba census also used an introductory statement: “The following questions concern difficulties you may have when doing certain activities - due to a health problem.” This may also have had some effect. The prevalence rates in figure 1, therefore, provide a general indication of the proportion of the population with disabilities in the Caribbean but need to be treated with some caution.

**Figure 1**  
**Prevalence of disability, 2000 and 2010**  
*(Percentage of persons with disabilities)*



Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

**Figure 2**  
**Prevalence of disability by sex, 2000 and 2010**  
*(Percentage of persons with disabilities)*

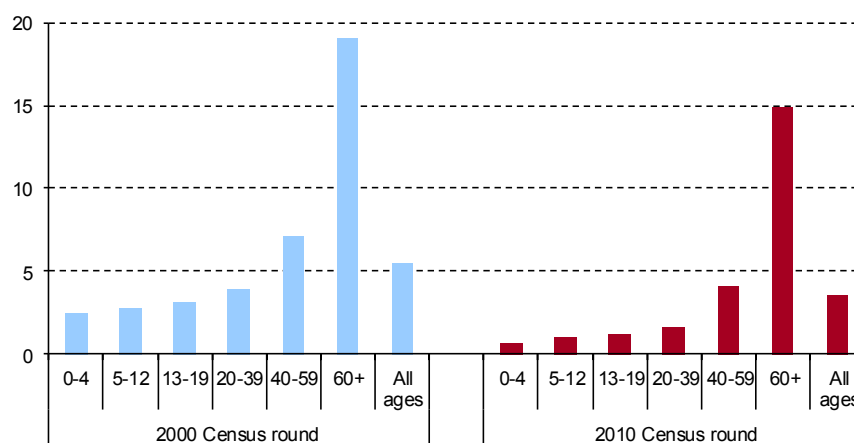


Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

As illustrated in figure 2, the prevalence rates are higher for women than for men although the difference is not large. In 2000, the average prevalence rates were 5.4 per cent for men and 5.5 per cent for women while in 2010 the figures were 3.3 per cent for men and 3.7 per cent for women. There are various explanations for the different rates observed for men and for women. The greater longevity of women is a factor: there are more older women than older men and older persons are more likely to have a disability therefore there will be more women overall with disabilities. The gender difference could also be because men and women respond differently to the questions even when there is no underlying difference in their disability (men may simply be less inclined to report difficulty seeing, hearing etc.)

The prevalence of disability is much higher among older persons (see figure 3). For those ages up to 39, the prevalence of disability is low: around four per cent or lower based on data from the 2000 round and two per cent or lower based on data from the 2010 round. For persons aged 40 to 59 the rate is a little higher. For persons aged over 60, the corresponding rates are approximately 19 per cent (2000 round) and 15 per cent (2010 round). Within the 60 years and over age group, prevalence rates would be even higher for the oldest persons, say those over 80 years. Viewed from a different perspective, around 40 per cent of persons with disabilities are aged 60 and over and this proportion is likely to increase.

**Figure 3**  
**Prevalence of disability by age, 2000 and 2010**  
(Percentage of persons with one or more disabilities)



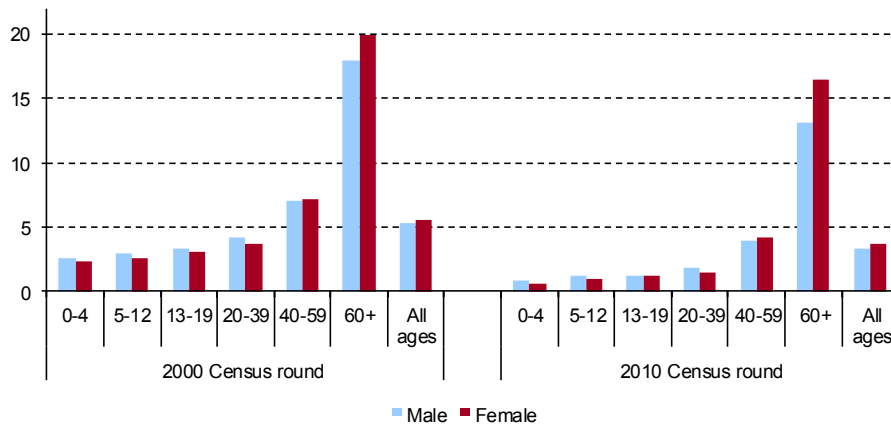
Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

Data from numerous OECD countries have shown that boys tend to have a slightly higher prevalence of disability compared with girls (OECD, 2017). Boys are more prone than girls to some disabilities for genetic reasons (for example autism and Cerebral Palsy). However, it is also thought that this gender disparity is partly due to some disabilities being under-identified in girls (particularly learning and behavioural disabilities). For all ages below 40, prevalence rates were higher among males than females (in both 2000 and 2010 rounds) (see figure 4). Rates among men are between 10 and 25 per cent higher for males than for females depending on the age group. The pattern is reversed for persons aged 60 and over with more women having disabilities. Among persons aged 60 and over, the prevalence rates for men and women were 18.0 versus 19.9 per cent (2000), and 13.1 versus 16.5 (2010).

The most common types of disability are those relating to difficulty seeing and walking (13 and 14 per 1,000 persons in 2010, respectively) (see figure 5). Disabilities related to hearing, communicating, remembering, self-care and upper body have lower prevalence rates (between five and eight persons per 1,000 in 2010). Census questions use broadly similar lists of response categories for different types of disabilities but with some differences of wording and in respect of the number of types of disability which are offered as response categories. The estimates above are compiled using response

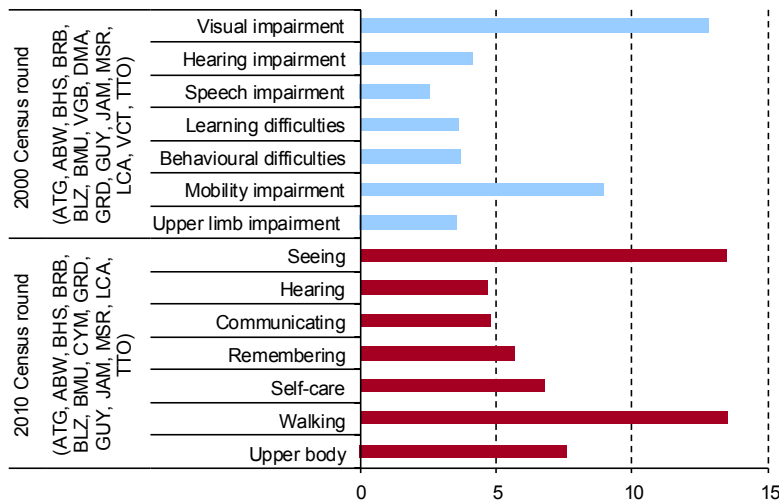
categories for different countries which correspond approximately if not always exactly. Based on the data collected in 2010, the prevalence rates for women were higher than those for men for all types of disability except difficulties communicating (see figure 6). For disabilities related to seeing, walking and upper body, the prevalence rates for women were about one third higher than the rates for men. In respect of difficulties communicating, the prevalence rate for men was higher (5.2 per thousand versus 4.4 per thousand for women).

**Figure 4**  
**Prevalence of disability by age and sex, 2000 and 2010**  
*(Percentage of persons with one or more disabilities)*



Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

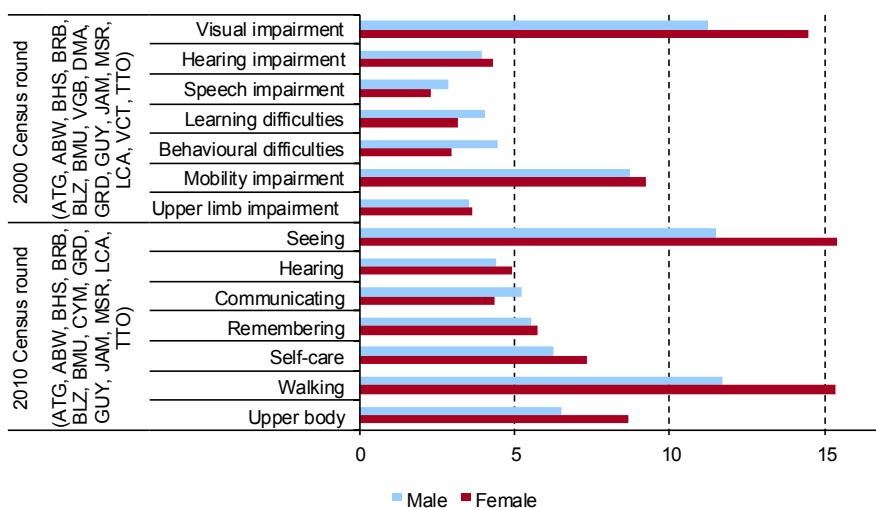
**Figure 5**  
**Prevalence of disability by type, 2000 and 2010**  
*(Number of persons with disabilities per thousand)*



Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

Over the next few decades, the Caribbean will see a rapid and dramatic ageing of its population. In the next two decades, the number of older persons will double: the number of persons aged 60 and over will increase from 1.2 million (or 14 per cent of the population) in 2015 to two million (or 22 per cent) in 2035. By 2050, this will have increased to 2.3 million (26 per cent). At the same time, more people are living longer into old age. Population ageing affects all countries and is a product of the demographic transition: the transition from the high birth/high death rate societies of the pre-industrial era, to the low birth/low death rate societies of the modern world.

**Figure 6**  
**Prevalence of disability by type and sex, 2000 and 2010**  
*(Number of persons with disability per thousand)*



Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

Associated with the demographic transition is an epidemiological transition. A much smaller proportion of persons die from infectious diseases and so most people survive until their old age when they are more likely to suffer from non-communicable diseases (NCDs). Non-communicable diseases (NCDs), also referred to as chronic diseases, are generally long-term conditions. There are four main types of NCDs: cardiovascular diseases (such as stroke and heart attacks); cancers; chronic respiratory diseases (like chronic obstructed pulmonary disease); and diabetes.

Unhealthy lifestyles also increase the incidence of NCDs and disability. Rising incomes in Caribbean countries and globalization have brought with them unhealthy diets, unfair trade and irresponsible marketing, and increasingly sedentary lifestyles (WHO, 2011b). Foods high in salt, fat, and sugar have become relatively cheaper and global marketing campaigns promote unhealthy ‘junk’ food and alcohol consumption to people of all ages. An unhealthy lifestyle can contribute greatly to ill health and disability, especially among those living in poverty. An unhealthy lifestyle also increases the risk that someone will suffer from an NCD in their 40s or 50s. Non-communicable diseases are a major cause of disability among older persons and therefore policies to address non-communicable diseases will be crucial to control this increase in the number of persons with disabilities.

The ageing of the Caribbean population and the related rise in the number of persons suffering from non-communicable diseases will have a major impact on the number of persons suffering from disability. Older persons are much more likely to have disabilities and therefore as the age structure of the population changes, it is to be expected that the proportion of persons with disabilities will increase. Table 2 shows projections of the prevalence of disability from 2015 to 2050, calculated by using national

disability prevalence rates by age and sex from the 2010 census round (which are assumed to remain constant from 2015 to 2050) combined with population projections for this period.

It is projected that the disability prevalence rate will increase by anything from 25 to 70 per cent between 2015 and 2050. The smallest rises are expected in Bahamas (+1.5 per cent) and Guyana (+0.9 per cent) while the largest will be in Grenada (+2.7) and Jamaica (+2.3 per cent). Coupled with the rise in NCDs, it is incumbent upon States to plan, prepare, and implement policies with these realities in mind.

**Table 2**  
**Projections of the prevalence of disability by sex, 2015-2050**  
(Percentage of persons with disabilities)

|  | Antigua<br>and<br>Barbuda | Aruba | Bahamas | Barbados | Belize | Grenada | Guyana | Jamaica | Trinidad<br>and<br>Tobago | Caribbean |
|--|---------------------------|-------|---------|----------|--------|---------|--------|---------|---------------------------|-----------|
| <b>All persons aged over 60 (percentages)</b>          |                           |       |         |          |        |         |        |         |                           |           |
| 2015   | 10.8                      | 18.5  | 12.5    | 19.8     | 5.9    | 10.2    | 8.3    | 12.8    | 14.2                      | 13.7      |
| 2020   | 12.8                      | 22.1  | 15.1    | 22.9     | 6.6    | 11.3    | 10.5   | 14.4    | 16.4                      | 15.7      |
| 2025   | 15.5                      | 26.1  | 17.9    | 25.8     | 7.7    | 13.4    | 12.8   | 16.5    | 18.9                      | 18.2      |
| 2030   | 19.7                      | 28.4  | 20.1    | 27.7     | 8.9    | 14.3    | 14.9   | 18.7    | 20.2                      | 20.3      |
| 2035   | 22.1                      | 29.7  | 22.2    | 29.4     | 10.2   | 15.6    | 15.8   | 20.9    | 21.5                      | 22.2      |
| 2040   | 22.8                      | 30.1  | 23.5    | 30.2     | 11.4   | 17.5    | 15.5   | 22.8    | 23.1                      | 23.1      |
| 2045   | 23.8                      | 29.6  | 25.4    | 30.9     | 12.9   | 20.8    | 14.7   | 25.1    | 26.1                      | 24.5      |
| 2050   | 24.9                      | 28.8  | 27.1    | 31.1     | 14.7   | 25.1    | 13.8   | 28.0    | 28.2                      | 26.1      |
| <b>Persons with disabilities (percentages)</b>         |                           |       |         |          |        |         |        |         |                           |           |
| 2015   | 2.5                       | 7.5   | 3.3     | 5.7      | 3.0    | 3.5     | 3.1    | 3.2     | 4.4                       | 3.6       |
| 2020   | 2.7                       | 8.2   | 3.6     | 6.1      | 3.2    | 3.7     | 3.4    | 3.5     | 4.7                       | 3.9       |
| 2025   | 3.1                       | 8.8   | 3.9     | 6.5      | 3.4    | 4.1     | 3.6    | 3.8     | 5.0                       | 4.2       |
| 2030   | 3.5                       | 9.2   | 4.1     | 6.8      | 3.6    | 4.4     | 3.8    | 4.1     | 5.3                       | 4.5       |
| 2035   | 3.8                       | 9.5   | 4.3     | 7.0      | 3.9    | 4.6     | 3.9    | 4.5     | 5.4                       | 4.7       |
| 2040   | 3.9                       | 9.6   | 4.5     | 7.1      | 4.2    | 5.0     | 4.0    | 4.8     | 5.6                       | 5.0       |
| 2045   | 4.1                       | 9.6   | 4.6     | 7.2      | 4.5    | 5.5     | 4.1    | 5.1     | 5.8                       | 5.2       |
| 2050   | 4.2                       | 9.5   | 4.8     | 7.2      | 4.8    | 6.2     | 4.0    | 5.5     | 6.0                       | 5.4       |
| <b>Persons with disabilities, male (percentages)</b>   |                           |       |         |          |        |         |        |         |                           |           |
| 2015   | 2.1                       | 6.7   | 3.4     | 5.1      | 2.9    | 2.7     | 3.1    | 2.8     | 4.3                       | 3.4       |
| 2020   | 2.3                       | 7.2   | 3.6     | 5.4      | 3.0    | 2.9     | 3.2    | 3.0     | 4.5                       | 3.5       |
| 2025   | 2.5                       | 7.7   | 3.9     | 5.7      | 3.2    | 3.2     | 3.4    | 3.2     | 4.8                       | 3.8       |
| 2030   | 2.8                       | 7.9   | 4.1     | 5.9      | 3.3    | 3.4     | 3.6    | 3.5     | 5.0                       | 4.0       |
| 2035   | 3.0                       | 8.1   | 4.3     | 6.0      | 3.5    | 3.6     | 3.7    | 3.8     | 5.1                       | 4.2       |
| 2040   | 3.1                       | 8.1   | 4.4     | 6.1      | 3.7    | 3.9     | 3.8    | 4.0     | 5.2                       | 4.3       |
| 2045   | 3.2                       | 8.1   | 4.6     | 6.2      | 3.9    | 4.3     | 3.9    | 4.2     | 5.4                       | 4.5       |
| 2050   | 3.3                       | 8.0   | 4.7     | 6.2      | 4.1    | 4.8     | 3.9    | 4.5     | 5.6                       | 4.7       |
| <b>Persons with disabilities, female (percentages)</b> |                           |       |         |          |        |         |        |         |                           |           |
| 2015   | 2.9                       | 8.3   | 3.2     | 6.2      | 3.1    | 4.3     | 3.2    | 3.6     | 4.5                       | 3.9       |
| 2020   | 3.2                       | 9.1   | 3.5     | 6.7      | 3.3    | 4.5     | 3.5    | 4.0     | 4.8                       | 4.2       |
| 2025   | 3.6                       | 9.9   | 3.8     | 7.2      | 3.6    | 5.0     | 3.7    | 4.3     | 5.2                       | 4.6       |
| 2030   | 4.2                       | 10.4  | 4.1     | 7.6      | 3.9    | 5.3     | 3.9    | 4.8     | 5.5                       | 4.9       |
| 2035   | 4.6                       | 10.7  | 4.4     | 7.9      | 4.3    | 5.7     | 4.1    | 5.2     | 5.7                       | 5.3       |
| 2040   | 4.7                       | 11.0  | 4.5     | 8.0      | 4.6    | 6.1     | 4.3    | 5.6     | 5.9                       | 5.6       |
| 2045   | 4.9                       | 11.0  | 4.7     | 8.1      | 5.0    | 6.7     | 4.3    | 6.1     | 6.2                       | 5.9       |
| 2050   | 5.1                       | 10.8  | 4.9     | 8.2      | 5.4    | 7.5     | 4.1    | 6.5     | 6.5                       | 6.1       |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses and United Nations, Department of Economic and Social Affairs, Population Division (2015), World Population Prospects: The 2015 Revision.





## II. Health, rehabilitation and social care services

Persons with disabilities, as a group, have a greater need for health and care services than the general population. In addition to their disability (or disabilities), and the health condition(s) underlying them, they may also be more vulnerable to other health conditions. Furthermore, they may require rehabilitation services to improve their ability to function. Where individuals are not able to retain or regain sufficient levels of functioning, they may need some form of care, either from family or social services, to support them in their daily lives.

**Table 3**  
**International commitments regarding health and rehabilitation**

| Convention or agreement                           | Commitments   |
|---|---|
| SDGs  | Goal 3: Ensure healthy lives and promote well-being for all at all ages   |
| CRPD Article 19 – Living independently            | Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community.  |
| CRPD Article 25 – Health                          | States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.  |
| CRPD Article 26 – Habilitation and rehabilitation | 1. States Parties shall...enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation all aspects of life. States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes...in such a way that these services and programmes: (a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths; (b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas. 2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services. 3. States Parties shall promote availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation. |

Source: United Nations General Assembly Resolution 70/1 “Transforming our world: the 2030 Agenda for Sustainable Development” and United Nations Convention on the Rights of Persons with Disabilities (2006).

## A. Health and health care

“Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). Persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. This right to health has also been recognized in CARICOM agreements on disability and in several national disability laws or policies. Despite the progress made towards universal health coverage, significant inequalities in access persist and much remains to be done to fully realize the right to health for persons with disabilities.

The relationship between health and disability is a complex one. Disabilities are the outcome of interactions between health conditions (diseases, disorders and injuries) and contextual factors (personal and environmental). A primary health condition is the possible starting point for impairment, an activity limitation, or participation restriction (WHO, 2011a). Those persons with a primary health condition or a disability are also more vulnerable to secondary conditions (related conditions) and co-morbidities (unrelated conditions). These secondary conditions or co-morbidities may themselves cause a disability.

The way in which health and disabilities interact and their relationship to general health varies significantly according to the nature and severity of the health conditions and disabilities involved. The health conditions associated with disabilities may or may not require on-going health care. For example, a blind or deaf person may not require any on-going health care for their condition while someone whose disability is associated with a chronic disease or a traumatic injury may have short and/or long term health care needs for these conditions coupled with rehabilitation to manage their disability.

Persons with disabilities are at risk of developing secondary conditions<sup>4</sup> like depression, osteoporosis, ulcers, urinary tract infections, and pain; co-morbidities<sup>5</sup> in the form of chronic diseases with early onset like diabetes; and age-related conditions<sup>6</sup> like Alzheimer’s disease, osteoporosis, and dementia brought on by early ageing. Some conditions are common companions, for example schizophrenia and diabetes.<sup>7</sup> Persons with disabilities are also more likely to practice risky health behaviours like neglecting to exercise and smoking, which lead to further negative health outcomes like obesity and chronic diseases. (WHO, 2011a).

They also have a higher risk of exposure to violence and unintentional injury. They are at risk of sexual abuse, particularly women with intellectual disabilities. They suffer more from traffic accidents, falls, burns, and accidents related to their assistive devices (again, particularly those with intellectual disabilities). Fortunately, in most cases the injuries are not fatal. However, the aforementioned conditions, exposures, and practices can result in the premature death of persons with disabilities. Persons with learning impairments and mental health disorders, in particular, have lower life expectancy. They are also more likely to be suffering from poverty and social exclusion which also contribute to these health inequalities. (WHO, 2011a; 2016c).

Persons with disabilities are likely to have greater unmet needs for health care. They are often stigmatized in a way that encourages exclusion (Gayle-Geddes, 2016) and their needs are therefore often overlooked. People with disabilities are also less likely to be targeted by health promotion and preventative care programmes. They are less likely to utilize health services effectively. When they do attempt to access healthcare, persons with disabilities do not receive the same treatment as non-disabled persons. Health conditions may go untreated due to diagnostic ‘overshadowing’ or there may be problems with communication. Fear, ignorance, and insufficient training have been suggested as

<sup>4</sup> Secondary conditions are related to the primary health condition. They can be predicted and therefore there is scope for managing the risk that a particular secondary condition will develop.

<sup>5</sup> Co-morbidities are unrelated to the primary health condition.

<sup>6</sup> For some persons with disabilities, the ageing process starts earlier than usual. Premature ageing, in the 40s and 50s may occur in persons with developmental disabilities (WHO, 2016d).

<sup>7</sup> Among schizophrenics, the rate of diabetes is 15 per cent compared to 2-3 per cent in the general population (WHO, 2016d).

possible reasons why those with disabilities do not receive the same standard of care as non-disabled persons. (WHO, 2011a).

Moreover, persons with disabilities face additional barriers in their attempts to access healthcare. These may include the cost of health care; limited availability of services in the area; having to travel long distances to access services; or a lack of transportation (Gayle-Geddes, 2015). The barriers may also be attitudinal. For instance, prejudices about disability and sexuality may mean that health care providers do not offer adequate and appropriate sexual and reproductive health services. Health care workers may themselves be ill-equipped in respect of their knowledge and experience of treating persons with disabilities. Barriers may also be physical. For example, health care providers' offices may not be wheelchair accessible and therefore ill-equipped to deal with wheelchair users. They may not provide good general health care to persons with mental disorders.

National laws and policies for disabled persons (where they exist) identify the importance of healthcare for persons with disabilities. The Persons with Disabilities (Equal Opportunities) Bill, 2014 of Bahamas contains a firm affirmation of the right to health care services and states that “a person with a disability shall be provided with the same quality and standard of affordable healthcare treatments, health information and health programmes as provided to other persons”. They also recognize the importance of: accessible community based health centres and services including mental health services; outreach services including home visits; programmes to detect, intervene, assess, and treat impairments early including efforts to prevent pre- and post-natal disability; adequate training for all healthcare personnel and provision of accessible health-related information; education and counselling in pre- and post-natal care and family planning; and programmes to prevent and/or minimize further disability. Jamaica's Disabilities Act (2014), contains similar provisions and also addresses the issue of free and informed consent for medical treatment.

In practice, access to health care for persons with disabilities is highly dependent on the availability or non-availability of care and treatment through stretched public health services. Most Caribbean countries have two-tier health systems with around 60 per cent of total health expenditure being public and 40 per cent being private, most of which is out-of-pocket expenditure (WHO, 2017). Public health systems provide free care, medications and treatment to large numbers of people many of whom would be otherwise unable to afford it. But these public services are heavily rationed due to limited resources. As a result, there is widespread use of private health services, not only by high-income households (for example, through insurance schemes or out-of-pocket expenditure), but also by low-income households (for example the purchase of medicines in private pharmacies). The ability to pay, therefore, still plays an important role in determining access to health care with obvious implications for the right of persons with disabilities to the highest attainable standard of health. Specialist services like speech or occupational therapy or costly assistive devices are often only available at a cost.

Hospitals are, however, being made more accessible to persons with disabilities. Through the SMART Hospitals programme, promoted by PAHO/WHO, measures have been taken to make hospitals more resilient to disasters, environmentally sustainable, and accessible for persons with disabilities. Adaptions can include, for example installing ramps, lifts, guardrails, or accessible toilets. The first phase of the SMART Hospitals programme was carried out from 2012 to 2014 in hospitals in Georgetown, Saint Vincent and the Grenadines and in Saint Kitts and Nevis, and it has since been extended to a dozen hospitals in Dominica, Grenada, Saint Lucia, and Saint Vincent and the Grenadines.

There has also been progress in the area of mental health policy, services and systems. Expenditure on mental health (as a percentage of the total health budget) ranges from one per cent to seven per cent (Abel and others, 2012a). However, mental health legislation in many countries is in need of reform. Some countries have developed an innovative community based, secondary care treatment model: treatment in the medical wards of general hospitals. Progress has been made in integrating mental health into primary healthcare and making psychotropic medication more widely available at the primary care level. Nevertheless, greater effort is required to phase out mental hospitals and integrate mental health into primary care more fully. (Abel and others, 2012a).

Transportation can also be a barrier to accessing health care, particularly where people require some form of accessible transport from their home to the health care facility. In a number of countries, health centres can offer home visits usually by nurses. For example, in Barbados polyclinic staff provide care in people's home which enables them to: establish effective client relationships; detect and manage health risks; encourage family support systems; provide nursing care procedures in the home (such as wound care); and, where necessary, make referrals to other levels of care. Similar schemes operate in Aruba, Dominica and Trinidad and Tobago (PAHO, 2012). The Government of Bahamas operates a dial-a-ride scheme specifically to provide wheelchair accessible transportation for persons who are mobility impaired, to and from medical and therapeutic appointments.

In many countries, there have been sexual and reproductive health (SRH) programmes specifically aimed at persons with disabilities. Persons with disabilities have just the same SRH needs as other people yet they often face barriers to information and services primarily due to ignorance and negative attitudes towards the sexuality of persons with disabilities, including among health-care providers. In fact, existing services can usually be easily adapted to accommodate persons with disabilities. UNFPA (United Nations Population Fund) have actively promoted the provision of sexual and reproductive health services for persons with disabilities. Through collaboration with Ministries of Health, Family Planning Associations, and Disabled Persons Organizations there have been workshops and other activities addressing sexual and reproductive health for this neglected group.

Continuing to expand provision of public health services to reduce the need for out-of-pocket expenditure is the most effective way to reduce health inequalities for persons with disabilities. Health services also need to be tailored to the needs of persons with disabilities, for example educating and supporting people to manage their own chronic health conditions. Where necessary adequate provision should be made for family members and caregivers to attend appointments, facilitate communication and support persons with disabilities in managing their health conditions.

Where persons with disabilities have complex health care needs, the planning, coordination and monitoring of treatment is vital. Primary care providers should coordinate care including referral and communication with other providers. Information and communication technologies such as electronic medical records can make the transfer of information more reliable. Clinical practice guidelines can support health professionals in providing appropriate care.

To help improve health care provision for persons with disabilities, all hospitals and health care facilities should be made physically accessible. This includes features such as ramps, lifts, guardrails, accessible toilets, easy to open doors, clear signage, and information in accessible formats. When medical equipment is purchased, care should be taken to ensure that it is appropriate for persons with physical disabilities. Partnerships with local disability organizations can provide flexible low-cost advice and support to improve service provision for persons with disabilities. For example, if the services of someone who signs are needed, the local school for the deaf should be able to provide a person who signs to the health service facility.

All tertiary level educational programmes and in-service training programmes for health care personnel should include disability education to make staff more aware of the assumptions and stereotypes which can lead to exclusion and to equip them to provide an equal standard of care to persons with disabilities. This should include the rights-based approach and standardized concepts and terminology used in the ICF. National or regional institutions could consider providing incentives to students pursuing studies related to disability, health and care.

Policymakers should also encourage regular meetings with community and national organizations to discuss the evolving needs of persons with disabilities. Moreover, persons with disabilities should be included in decision-making and the design and operation of health care systems.

## **B. Rehabilitation services**

Rehabilitation, like disability, is an evolving concept. However, there are four common ways of conceptualizing it. The World Health Organization defines rehabilitation as the process of regaining

physical, cognitive, or psychological function lost due to illness or trauma (2011). For example, after the surgical repair of a torn Achilles tendon, an athlete may undergo rehabilitation in the form of light but progressive training sessions so as to regain strength and mobility in the affected limb. Similarly, a soldier who suffers from post-traumatic stress disorder (PTSD) may also undergo rehabilitative treatment. Rehabilitation may also be defined as the acquisition of required function that the individual never possessed (WHO, 2011a). As an example, rehabilitation may take the form of therapeutic sessions for a toddler whose motor skills have not developed as anticipated. Rehabilitation may also be compensatory in nature (WHO, 2011a). Strategies may be employed that allow an individual to overcome certain physical or cognitive limitations. An individual with memory impairments may learn to repeat phrases or use mnemonics to enhance retention (Kurtz, 2011). Compensatory rehabilitation also includes the use of assistive implements and adapting the individual's immediate personal environment. This includes such items as hearing aids, prostheses, and the instalment of fixtures such as toilet rails. Finally, preventative rehabilitation aims to preclude or retard the loss of function (WHO, 2011a). This form of rehabilitation is most commonly seen in the treatment of certain degenerative illnesses such as multiple sclerosis or Parkinson's disease.

Persons who require rehabilitative care may receive treatment through medicine, therapy, and/or assistive technology. Rehabilitative medicine is the diagnosis and treatment of a health condition that can or has led to loss of function. It is used with the aim of re-acquiring lost functioning as well as acquiring new functioning. It is also used preventatively in an effort to avoid loss of function. Rehabilitative care typically involves surgery or the administration of medication. Therapy may be used in any rehabilitation process and in collaboration with other methods of rehabilitation. It is described as the maintenance or increase in physical and cognitive function through training sessions. Assistive technology may also be used in the process of rehabilitation. For example, wheelchairs or speech synthesizers that are used to maintain or increase function beyond current physical limitations. Assistive technology is used when rehabilitation medicine and therapy can provide limited or no improvement or it can be temporarily used in the interim where improvement from these other measures is slow. Despite the plethora of assistive devices and their numerous applications, they all have essentially the same purpose. By maintaining and increasing function, assistive implements can facilitate the independence and productivity of the person. For example, a hearing aid may enhance a student's learning experience just as prostheses may allow an employee to seek out and/or return to gainful employment.

There has been a gradual expansion of rehabilitation services in the Caribbean although unmet needs persist. The longest established centre for treatment of disability is the Sir John Golding Rehabilitation Centre in Kingston, Jamaica. It is the only specialized inpatient rehabilitation facility in the country and is therefore a referral centre for all hospitals in the country. Some parts of the Centre are Government-run while others are services that depend on charitable donations. Its services include: inpatient and outpatient care; management of Cerebral Palsy, Occupational Therapy; Physiotherapy; Post-polio Syndrome Management; Psychological Counselling; Rehabilitation of Stroke Patients; Spinal Cord Injuries and Rehabilitation. The Athlone Wing provides a home to 34 severely disabled children, while the Cheshire Village provides accommodation for adults with disabilities although there continues to be a huge shortage of housing suitable for persons with physical disabilities.

Other countries provide only outpatient rehabilitation services. In Bermuda, adults and persons aged 65 and over with disabilities can obtain wheelchairs and other adaptive devices and they, and their carers, are offered advice, training and support to help them carry out tasks necessary for daily life. There is also a programme for young children which includes assessment of motor skills (gross motor, fine motor, and sensory motor); direct or indirect intervention to promote functional independence; parental support and family education. In many countries there are gaps in rehabilitation services. Sometimes people are forced to travel abroad in order to receive the services or simply have to manage without.

In several countries there are NGO's active in community based rehabilitation (CBR). The Inspiration Centre in Belize is an outpatient rehabilitation centre for children with disabilities from 0 to 16 years. The Centre itself provides medical and nursing services, diagnostic testing, comprehensive evaluation and treatment by physical, occupational, and speech therapists and referrals to specialists.

However, the Inspiration Centre also embraces the community based model of rehabilitation working in partnership with families and other grassroots organizations to improve the lives of children with disabilities in the areas of health, education, social inclusion, skill development and empowerment.

In Jamaica, Community Based Rehabilitation Jamaica (CBRJ) operates: day care centres; supports assessment and therapeutic intervention; and has a particular focus on advocacy, seeking to empower families, equipping them with the knowledge to advocate on behalf of their children. In Saint Lucia, chAMPS is an adaptive sports, recreation and rehabilitation program specifically targeting people who have become physically disabled, primarily due to amputation caused by diabetes and hypertension, and will provide a structured sports-based rehabilitation program, public education campaign, and workshops on limb care.<sup>8</sup> CARPHA (Caribbean Public Health Agency) has sought to promote dialogue and sharing of best practice on community-based rehabilitation. There was a Caribbean Community-Based Rehabilitation Conference in Aruba, in 2014, with a follow-up meeting in Grenada, in 2015.

Where expertise is not to be found locally it may be necessary to bring in skills from further afield as was done by the Dominica Association of Persons with Disabilities which enlisted the help of French NGO Keep Walking Association (KWA). In 2015, two professional prosthetic technicians came from France and a temporary laboratory workshop was set up in Mero, Dominica where they manufactured, adjusted, and equipped prostheses for five persons and repaired prosthesis for two others. Training was also provided so that follow-up maintenance could be provided locally.

National disability legislation and policies provide some indication of respective national priorities. For example, the Cayman Islands Disabilities Policy (2014) discusses the need for an inpatient rehabilitation centre in the territory. In the Bahamas, there are already a number of institutions, associations and organizations (public and private) that provide rehabilitation services, most notably the Government's Sandilands Hospital which cares for children and adults with mental and physical disabilities. However, the Bahamas Disabilities Bill additionally emphasizes that persons discharged from residential care or rehabilitation centres should have access to continuing rehabilitation in community-based settings. In Guyana, the Persons with Disabilities Act has made the Minister of Health responsible for establishing and operating rehabilitation centres throughout the country.

Rehabilitation has a crucial role to play in meeting Sustainable Development Goal 3 (on Good health and well-being) and, bearing in mind the population trends discussed in the previous chapter, it is essential that rehabilitation services are scaled up to meet current and future demands. Countries that lack policies and legislation on rehabilitation should consider introducing them in order to align national law with Articles 25 and 26 of the Convention. Rehabilitation can also be incorporated into general legislation on health, and into relevant employment, education, and social services legislation, as well as into specific legislation for persons with disabilities. (WHO, 2011a).

The rehabilitation needs of people with different types and severity of disability, and different health conditions, are so varied that provision of rehabilitation services will continue to depend on a wide range of actors, with different expertise, and a range of public, private and voluntary organizations. Resource constraints will continue to mean that flexibility and creativity will be needed to meet the rehabilitation needs of each individual.

National public health systems have a key role to play in expanding access to services. The use of limited public resources must be monitored carefully to ensure that it is allocated as effectively as possible between hospital, clinic and community-based provision. Essential services should be made available free to those without the ability to pay. National or international donors can sometimes supplement local funds as was the case recently in the Bahamas where the Public Hospitals Authority's Rehabilitation Services Department took receipt of ultrasound and electrotherapy equipment donated by the local Rotary Club.

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<sup>8</sup> The chAMPS programme is supported by the Australian High Commission's Direct Aid Program (DAP) and run by the Sacred Sports Foundation Inc (SSF).

Equally important is the state's role in the coordination and monitoring of the services provided by public, commercial and voluntary organizations. Government has an obligation to organize, strengthen and extend comprehensive rehabilitation services and programmes based on individual needs. For this to be successful, effective coordination and clear division of responsibilities is essential. Regional cooperation could also help to extend access particularly to specialist services.

The supply and use of assistive devices is an integral part of rehabilitation. Whether the device concerned is a prosthesis, a hearing aid, an adapted car, or a piece of software, its appropriateness to the individual and the environment is of crucial importance. Appropriate training and follow-up support is often necessary to ensure that the user receives the full benefit.

Caribbean public health systems are plagued by general skills shortages with many Caribbean doctors and nurses working abroad. Recruitment, training, and retention of staff to work in the various specialisms involved in rehabilitation are even more challenging. Since 2008, the University Hospital of the West Indies has offered a Master's degree in clinical care and physical therapy. In addition to staff with full professional training, it is equally important to have a wider pool of staff with mid-level training that can provide rehabilitation care as part of primary or secondary care. Even basic training for community-based workers, supported by appropriate clinical guidelines, including for referral, can help to expand provision more widely. In this way networks are created which eventually constitute a continuum of care.

### **C. Care and support services**

Persons with disabilities should have access to a range of in-home, residential and other community support services, including the personal assistance necessary to support them in living independently and being included in the community. According to the World Report on Disability (2011), the need for support and assistance varies depending on environmental factors, stage of life, underlying health condition(s), and the level of the individual's functioning.

Most families with children with disabilities care for them with limited external support and often face a struggle to try and ensure that their child receives the education, care or rehabilitation services that they need. When care for children with disabilities must be combined with income generating activities, it is especially difficult for single parents.

Respite care services offer support to families caring for a disabled family member, whether that person is a child, an adult or an elderly relative. Normally, care is provided for a few hours or days at a time, which is intended to relieve the burden on family carers. Care might be provided in the home, at an educational centre, a day care centre or a residential care facility. Respite services are particularly valuable for families with members who need near continuous care. There is a severe shortage of respite care in the Caribbean with private nursing care being the main option for families requiring support of this kind.

Adults or older persons with disabilities may also need home care services so that they can continue living independently. They may need assistance to accomplish daily tasks like bathing, cleaning, cooking, shopping as well as companionship. Such services enable people to live independently, which is usually better for their health and wellbeing in addition to being much more cost-effective than residential care.

Those with more severe disabilities may require residential care. Services can be provided in a shared home or small community. Persons with disabilities may also require advocacy services, particularly if they have learning disabilities or other intellectual disabilities. The job of an advocate is to ensure that when important decisions are made, for example about living arrangements, that proper consideration is given to their preference and their rights are not violated.

When older persons with disabilities are unable to live independently they may require a residential home, a nursing home or assisted living facilities. Day care centres, meanwhile, provide older



persons with disabilities with social and rehabilitative services which may include: transport to and from their home; social, physical and recreational activities; health monitoring; meals; and advice for carers.

There is a strong international consensus that persons with disabilities should not be segregated from the rest of the population in institutions but should be integrated into communities. Institutions isolate people from their friends, families and communities and place them at risk of abuse or other human rights violations. Community-based care on the other hand, either where people live independently, with other family members, or in small communal settings, offers greater autonomy, and more opportunities for participation in all aspects of society. Integration is a prerequisite for the creation of inclusive societies.

Historically, assistance, care and support services for disabilities have not been accorded a high priority, particularly those services which are intended to promote autonomy and independence. Caring for someone with a disability tended to be thought of as a responsibility of the family, which contributed to those with disabilities being kept hidden out of public view and led to social stigma. In circumstances where resources were scarce, it may have been difficult to convince policymakers that the money spent on care and support services for persons with disabilities would benefit all of society. Fortunately, attitudes are changing.

In order to support frail older persons to live independently, most Caribbean countries have developed home care schemes (Jones, 2016). Although they are generally aimed at older persons, many of the beneficiaries have disabilities of some kind. Some national home care schemes, such as the Barbados National Assistance Board's Home Care Programme also provide care services to working age persons with disabilities.

The most common forms of institutional care for persons with disabilities are residential and nursing homes for older persons; homes for children with disabilities; and psychiatric hospitals. There are public and private long-stay institutions catering to older persons who are unable to live independently due either to long-standing disabilities or age-related functional decline. The number of older persons living in long-stay institutions is still relatively low but the sector is expanding. There are increasing numbers of older persons that need care and support, and elderly persons living independently cannot necessarily depend on family carers. Most Caribbean countries have a small number of government run residential homes which are free and which care for older persons who would otherwise be destitute. Most residential homes are run as businesses although there are also some run by churches. Some of these homes receive public subsidies. The managers or owners of homes are commonly registered nurses although many of the care workers employed have little or no training. The quality of care is a real concern across the sector and problems in some institutions have included: inadequate buildings; overcrowding; inadequately trained staff; lack of equipment and problems related to nutrition and medical care; and inadequate monitoring and regulation by government. Approximately half of Caribbean governments have passed legislation to regulate residential and nursing homes (Jones, 2016).

There are also one or more residential homes for children with mental and physical disabilities in most countries. Examples include the Westhaven Children's Home near Montego Bay in Jamaica, the Care Project in Antigua and Barbuda, and the Nightingale Children's Village in Barbados. Homes of this kind are either run by government or by charitable foundations with the support of public and private funding. In fact, many of these residential homes also have adult residents as well, normally those who have grown up in the home and continued living there due to the lack of adult facilities.

These institutions are home to individuals who often have severe physical and mental disabilities. The staff provide the best care that they are able to with resources insufficient to the huge demands made on them by the individual needs of each resident. In some cases, the housing of different age groups and sexes within the same facility can itself represent a risk to the residents. While persons with disabilities living in long-term residential care make up only a small proportion of the total number of disabled persons, they are some of the most vulnerable and therefore governments should pay particular attention to protect the rights of persons living in institutions. In some instances, these institutions also provide a day programme for children with disabilities who live with their families.

Most Caribbean countries, excluding the smallest islands, have a single psychiatric hospital (9 of 15 countries or territories) (Abel and others, 2012a). These are generally government-run facilities such as the St Ann's Psychiatric Hospital in Trinidad and Tobago. Community residential facilities were less common and found only in Bahamas, Barbados, Jamaica and Trinidad and Tobago (Abel and others, 2012a). In the region as a whole, around 2010, there were 3,700 beds in mental hospitals and 700 in community residential facilities with the vast majority of the mental health budget (typically close to 90 per cent) allocated to the psychiatric hospital (WHO, 2013a). There is still some way to go in the transition from institutional to community based care for persons with mental disabilities. Two countries have achieved varying degrees of success in phasing out the mental hospital. Belize phased out its mental hospital in 2008 (WHO, 2009) while in Jamaica, there has been a 50% reduction in the population of the mental hospital over the past 50 years as a result of systematic implementation of community mental health services (Abel and others 2012a).

The national disability laws of both Guyana and the Bahamas now confer on the respective Ministers of Social Services the responsibility to provide a comprehensive range of services to persons with disabilities: the acquisition of prosthetic devices, assistive or adaptive devices and medical intervention; specialized training activities to improve communicative skills; counselling and orientation to help develop a positive self-image and life skills; family care services; and facilities that serve abandoned, neglected, abused, and unattached persons with disabilities; community based rehabilitation; and day care services for pre-school age children with disabilities.

There should be further efforts to replace hospital-based services with community-based mental health services. PAHO/WHO experts have argued strongly for a shift in mental health spending from psychiatric hospitals toward community-based services that are decentralized, participatory, integrated, and focused on prevention. There is considerable international experience of deinstitutionalisation. Some lessons from other countries include: the need for a transition period, perhaps of several years, during which time some 'double funding' of institutional and community systems will be necessary; coordinated assistance and support services are required, including health care, crisis response systems, housing assistance, income support, and support for social networks of people living in the community (WHO, 2011a). International experience suggests that care in the community yields better outcomes. It may be cost-neutral in the medium term but should not be seen as a cost-saving measure.

While there are people living in institutions for the mentally or physically disabled, particular attention should be paid to the protection of their human rights. The institutional setting puts them at particularly high risk of rights violations relating to freedom from abuse; being included in the community; respect for privacy; and medical treatment on the basis of free and informed consent, among others.

Governments should assess whether there are working age persons with disabilities who either need assistance and support in their home or could live more independently if such assistance were available. In many countries, services could be provided relatively easily through extension of the existing home care schemes for older persons. Greater attention should be paid to the availability of respite care which is particularly lacking in the Caribbean. Respite services can be developed at relatively low cost by extending and drawing upon existing infrastructure and expertise in institutions, day care centres, in special education or in the provision of home care.

There are a growing number of residential and nursing homes which care for older persons, many with disabilities. Governments should adopt legislation for the regulation of these homes or, if legislation is already in place, develop appropriate mechanisms to enforce the legislation, for example guidelines for home owners, inspections, fines or other sanctions.

Assisted living facilities represent a compromise between the provision of care in the home and in a long-stay institution. They enable persons with disabilities to live independently within a communal environment with both disabled and non-disabled persons, with assistance and support close at hand. Residents may have their own rooms or living space with central dining spaces and communal areas for interaction, or they may have their own individual housing unit. At present, there are relatively few assisted living facilities in the Caribbean but the model could be applied more widely.

Community-based rehabilitation (CBR) and support programmes that provide professional assistance offer a range of benefits. CBR in the Caribbean should include supported decision-making programmes. As an example, the Personal Ombudsman (PO) programme in Sweden employs persons to assist those with psychosocial disabilities who are isolated, difficult to reach, or lacking other supports. Supported decision-making programmes are one of a number of services that can help to support persons with intellectual and developmental disabilities who live on their own or with family.

### III. Enabling environments

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An enabling environment is one in which adaptations and reasonable accommodations facilitate the full and equal participation of persons with disabilities in the society. It is clear that Caribbean societies currently fall well short of this ideal. Buildings, public spaces, and transport services are often not designed to be accessible to persons with disabilities making it difficult or impossible for them to navigate the built environment independently. Similarly information, technology, cultural and recreational services are far from being universally accessible. These participation restrictions combine to exclude persons with disabilities from education, work, and community life. Furthermore, they are now recognized as violating fundamental human rights.

A more enabling environment would actually benefit everyone (WHO, 2011a). For example, simple language on signage and public communications intended to benefit persons with learning and intellectual disabilities also helps language novices like second language speakers and young children; announcing stops on public transport not only helps the hearing impaired but all passengers. Elevators in buildings and sidewalk ramps within the city assist persons with physical mobility impairments along with the very young, the elderly, and persons pushing prams and strollers. Slip resistant ramps and pedestrian crossings benefit everyone, especially during the rainy season.

Changing attitudes to disability is just as important as changing the physical environment. Many people often do not have a good understanding of disability and perhaps feel awkward when they meet persons with disabilities. People have a tendency to see the disability rather than the person. As a result, they may treat persons with disabilities badly even if this is not their intention. This in turn, can lead people to exclude themselves or result in negative self-perceptions (Heron and Murray, 2003).

Education campaigns and direct contact with persons with disabilities may help dispel negative attitudes and prevent discrimination. Attitudes toward disability can also have a pivotal impact on the other environmental factors. Positive attitudes make people more inclined to include persons with disabilities and to be more willing to make adaptations or accommodations to include them. For example, including persons with disabilities in decision-making or administration processes may lead to more accessible infrastructure and more disability friendly policies, organizations and services.

**Table 4**  
**International commitments regarding enabling environments**

| Convention or agreement       | Commitments   |
|-------------------------------|---|
| Sustainable Development Goals | Goal 9: Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation<br>Goal 11: Make cities and human settlements inclusive, safe, resilient and sustainable  |
| CRPD Article 9                | To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:<br>a. Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;<br>b. Information, communications and other services, including electronic services and emergency services. |
| Declaration of Pétion Ville   | We resolve to take the necessary steps towards building a physical and social environment that promotes the habilitation, rehabilitation and integration of persons with disabilities, taking into account issues with respect to their access to facilities open to the public including buildings, transportation, and other public social and health services, including counselling and access to reproductive health care and services, while also promoting their equal opportunity to education and employment.  |

Source: United Nations General Assembly Resolution 70/1 “Transforming our world: the 2030 Agenda for Sustainable Development”; United Nations Convention on the Rights of Persons with Disabilities (2006); and Declaration of Pétion Ville (CARICOM, 2013).

The disabilities Acts in the Bahamas and Guyana both include provisions relating to the accessibility of the environment, including buildings and public spaces, transport, and information and communications technology (ICT). The Jamaica Disabilities Act addresses buildings and transport but not public spaces or ICT. The Cayman Islands Disability Policy sets a goal of improving the accessibility of the built environment, including transport, although does not address ICT.

## **A. Accessible buildings and public spaces**

Being able to enter and move around buildings and public spaces is fundamental to daily life and the exercise of rights. Across the Caribbean, many buildings (for example schools, offices, shops, police stations, libraries) present serious obstacles to persons with disabilities because they were not designed and built to be easily accessible. Buildings commonly lack ramps, wheelchair accessible entrances, doors, elevators and emergency exits, accessible toilets, or reserved parking. Streets and sidewalks are often inaccessible due to their unevenness, the absence of audible or tactile signs, and curb-cuts.

Buildings and public spaces should follow the principles of universal design. This means that they can be used easily by all but particularly persons with disabilities. Universal designs address the features deemed necessary for all built environments like doors and pathways that are accessible to persons with lower mobility impairments; large and contrasting print on public signage; ‘talking’ elevators, teller machines, and pedestrian crossings; and braille signs in public buildings (WHO, 2011a).

Detailed accessibility requirements are set out in national building codes. These codes provide minimum specifications such as the maximum gradient and width of ramps; the width, space and other accessibility requirements for entrances, elevators and emergency exits; requirements for signage; a minimum number of places for wheelchair users, for example in cinemas or stadiums; a minimum number of accessible parking bays. In order that all new buildings comply with these accessibility requirements it is important that the building code has proper legal status, that is, that there is legislation

which obliges construction firms to follow and implement the code and that there are enforcement mechanisms.

For new construction, the cost of full compliance with accessibility standards has been estimated to be no more than around one per cent of the total cost (WHO, 2011a). Making older buildings accessible requires more flexibility, because of technical constraints, the costs involved, or sometimes restrictions applying to historic buildings. Legislation should still require that pre-existing buildings which are used by the public should be accessible to persons with disabilities. However, it is normal that owners of buildings are only required to make adaptations to existing buildings where they are “technically feasible” or can be implemented “without undue hardship”. In this way, there is some recognition of the impossibility of adapting all pre-existing structures to meet modern accessibility criteria.

The disabilities Acts of the Bahamas, Guyana and Jamaica all adopt a similar approach requiring that public building are made accessible to persons with disabilities. The Bahamas Persons with Disabilities Bill now requires that owners of buildings to which the public is given access are accessible. The Bill sets out the role of the National Commission for Persons with Disabilities in assessing whether a building is considered accessible and serving an adjustment order if necessary. The Bill establishes a legal process through which it can be determined whether these adaptations are reasonable, feasible and whether or not they impose an undue burden on the owner.

The Guyana Act also gives the National Commission on Disabilities similar powers to issue adjustment orders. In addition, the Act requires the Central Housing Authority to publish and enforce building codes and guidelines for the construction and renovation of buildings in order to allow barrier-free access for persons with disabilities. The building codes are currently being reviewed in preparation for publication.

Once in force, the Jamaica Disabilities Act will require that all public and commercial buildings are accessible and are built in accordance with the National Building Code. The Jamaica Act also goes further than the others in addressing issues related to private housing with provisions requiring reasonable adaptation of private premises and outlawing discrimination, for example the refusal to lease premises or the eviction of someone on the basis of disability. In Jamaica, more direct measures have also been taken to provide access to housing for persons with disabilities. The National Housing Trust has a policy whereby five per cent of the Housing provided by the National Housing Trust is set aside for persons with disabilities.

National building codes are crucial in order to guarantee the accessibility of new buildings in particular, because it is the building code which specifies in detail how the building should be designed and built in order to be accessible for all. Older building codes tended to focus on the structural integrity of buildings, their ability to withstand fire, wind and other threats, and issues of spatial planning. The Caribbean Uniform Building Code (CUBiC) (CARICOM, 1985) served as the basis for national building codes in many Caribbean States. However, CUBiC itself made very limited reference to the issue of accessibility for persons with disabilities. For detailed accessibility requirements, the code simply refers to standards from Canada, the United Kingdom and New Zealand but makes clear that none of these are firm requirements of CUBiC. Furthermore, in many States, building legislation did not make reference to the building code and therefore the codes often did not have a proper basis or could not be enforced. Against this background, it is not surprising that many buildings are not fully accessible to persons with disabilities

The Organisation of Eastern Caribbean States (OECS) has its own building code, which does address disabled access more fully than CUBiC. It includes many of the international requirements and standards for creating accessible public buildings and spaces. Appendix F of the OECS Building Code, *Accessibility Guidelines for Persons with Disabilities* (OECS, 2015), specifies the design features which must be incorporated to ensure accessibility. The code consists of specifications for building approaches, entrances, walkways and sidewalks; doors and corridors; elevators and emergency exits. It also specifies provisions for ground and floor surfaces, protruding objects, walls, detectable objects, headroom, bathroom and toilet facilities, parking lots, illumination, and signage. The Code also includes measures

to improve accessibility in stadiums and sports facilities such as swimming pools, as well as buildings like banks and supermarkets.

However, the adaption of the building code to individual countries –particularly in respect of administrative aspects, the incorporation in national legislation, and enforcement– remains a work in progress. In Saint Lucia, for example, building design and construction companies can take the OECS Building Code as mere guidelines and suggestions as the provisions contained within it are not legislated by law and therefore are unenforceable. This results in low compliance with the OECS Building Code. The situation is similar in Jamaica and Trinidad and Tobago where building legislation does not yet enforce building codes with up to date accessibility standards.

To encourage and enforce compliance, plans for new buildings must be reviewed at the design stage. This process can involve input from a range of stakeholders. The National Councils or Commissions on Disability that exist in many countries and territories could also participate in this process as part of their advocacy role. Civil society has an important role to play in ensuring enabling environments. Sustained pressure from civil society groups and organizations can help ensure that the needs of persons with disabilities remain at the forefront of national politics.

Mandating requirements and enforcing compliance are necessary but not sufficient. Education programmes are also necessary to explain why the rules exist and provide training to persons involved in design and construction. This type of mainstreaming can help remove attitudinal barriers by creating familiarity and normalizing the concept of accessibility. Policymakers could mandate that engineers, designers, developers and contractors, business owners and managers, government regulators, and other persons involved in creating accessible buildings, have to go through a training course/module on accessibility in the Caribbean, regardless of where they earned their qualification and training. The idea is not novel: lawyers who have been trained outside of the Caribbean, and may have missed certain aspects of Caribbean law, have to partake in regional training before being able to practice in the respective countries and territories. Additionally, relevant stakeholders must be trained to include persons with disabilities in all evacuation and disaster plans and policies. This may have the added advantage of making non-disabled adults think not only of persons with disabilities, but also of other persons more vulnerable than themselves like children and the elderly, thus promoting attitudes that are conducive to social inclusion more generally.

## **B. Accessible transport**

For persons with disabilities, transport is a major barrier to participation in education, work and society in general. The majority of those with disabilities do not have access to a private car, often for economic reasons but also in some cases because their disability prevents them from driving. For those without access to a car, public transportation systems are a means of access to one's community and society. The importance of transport and personal mobility cannot be overstated.

Public transportation in the Caribbean mainly comprises buses, minibuses, and collective taxis. Private taxis are also used, albeit to a lesser degree. Public transport can also include ferries. Public transport services may or may not be run by the government but should be subject to government regulation. While some countries like Antigua and Barbuda, Barbados, Belize, Guyana, Jamaica, and Trinidad and Tobago have both government-run and privately-run public transport services, others like Saint Kitts and Nevis and Saint Lucia only have privately owned (but government registered) minibuses that provide transport services. Given this mix, accessibility provisions must be suitable, and enforceable, for both public and privately-run services.

Special transport services (STS) serve persons with disabilities and others for whom accessing public transportation presents some difficulties. STS are generally demand driven and respond to requests from customers. This is similar to calling for a taxi service, however, because the service requires specialized equipment it can be expensive to operators and, consequently, problematic for Caribbean countries. To help offset costs, States may be able to offer incentives to provide special services for persons with disabilities for whom the existing system of transport is insufficient.

Reductions in vehicle and operations costs may sufficiently incentivize transport operators. For example, Saint Lucia allows registered minibus and taxi operators to purchase their vehicles free of import duty charges. An even deeper discount and further incentives, where possible, may be afforded for accessible public transport vehicles.

Additionally, STS may take the form of shared mini-buses and flexible transport systems (WHO, 2011a). Low floor and “kneeling” buses may be an option for government owned and operated public transport. However, because of the expense associated with them, private owners and operators may be less willing to invest in this way without guaranteed returns and/or significant incentives. With this in mind, Brazil and India used the cost-efficient option of shared vans, which saw old vehicles retrofitted to be disability accessible (WHO, 2011a). Caribbean countries may be able to adopt and adapt similar measures and modify vehicles to accommodate persons with disabilities. Guyana’s Persons with Disabilities Act (2010) goes further to state that modifications can be made to the personal vehicles of persons with disabilities so that, where permissible by law, they can drive themselves. Furthermore, with the vast amount of human capital and skill in the subregion, small businesses, technical and mechanical schools at the secondary and tertiary levels, as well as individual citizens may be encouraged to create relevant and inexpensive solutions aimed at retrofitting and adapting old vehicles to provide public transport for persons with disabilities.

Physical barriers in public transport systems may represent the most common obstacles faced by persons with disabilities. They include lack of vehicle ramps, gaps between platforms and vehicles, non-existent anchorings for wheelchairs, and inaccessible stations and stops. Any such issue at any given point in one’s journey presents a problem of continuity in the travel chain and makes the entire trip difficult. Each journey is an “all or nothing” proposition that requires all aspects of the transport system to cater to persons with disabilities. Importantly, public transport systems do not operate in a vacuum and require accessibility of the built environment so that persons can get to and from the areas where public transport is provided. It is important that in the areas surrounding, say the bus stop, nearby pavements should be well maintained and uncluttered; talking traffic lights are functional; that there is high contrast signage perhaps with audio and braille translations; that traffic conditions are safe and conducive for persons with disabilities; and that in general nearby areas are also suitable and accessible for persons with disabilities (WHO, 2011a).

Education also plays an important role as operators must be aware of and sensitive to the needs of persons with disabilities and be ready and willing to address these needs. Persons with disabilities commonly complain that they are ignored or treated badly by bus and taxi drivers. Education programmes and campaigns may also be used to sensitize the general public to the needs of persons with disabilities. Additionally, these programmes and campaigns can serve to let the public, including persons with disabilities, know what is available in terms of accessible services, products, and infrastructure.

Member States can play an important role in ensuring that enforceable legislation exists. Since the necessary expertise may be in private and external groups and organizations, States can also ensure that they partner with such groups in making sure that standards are met and in creating and disseminating information to stakeholders and the public in general. Future transport policy and infrastructure too must incorporate persons with disabilities in the planning, design, and analysis and review processes.

Additionally, a reduced charge for persons with disabilities to use the public transportation system may be in order. While not explicitly stated in the existing disabilities acts/policies in the subregion, older persons (many of whom suffer some form of impairment) receive a reduced rate on government owned and operated buses in countries including the Bahamas, Barbados, Belize, Jamaica, and Trinidad and Tobago. As a further example, Trinidad and Tobago’s free, by request, transport shuttle, *Elderly and Differently-abled Mobile (ELDAMO)*, seeks to address the public transportation needs of elderly persons with disabilities (Jones, 2016). In Jamaica, there are four accessible buses and persons with disabilities are entitled to a concessionary bus fare.

The disabilities Acts that exist in the subregion do not all make provisions related to public transport for persons with disabilities. In fact, the Bahamas Persons with Disabilities Bill (2014) simply states that the country will formulate public transport policy. Guyana’s Persons with Disabilities Act



(2010) adds a provision for private persons with disabilities who wish to drive. Jamaica's Disabilities Act (2014) on the other hand, specifies what comprises a public passenger vehicle, stating that they must be "accessible and usable by persons with a disability."

The Cayman Islands Disability Policy (2014) articulates the goal for a public transport system with enough options to make it accessible for persons with disabilities. It proposes disability awareness training for providers, incentives for the provision of accessible vehicles and further adds that service animals also have equal access to public transportation.

### **C. Accessible information and communication technology**

The changes associated with the rise of the digital and information society are rapidly transforming the way in which people learn, work, spend their leisure time, and interact with each other. Between 2006 and 2015, the proportion of internet users in the region more than doubled from 21 to 54 per cent of the population. Nevertheless, it is clear that the benefits of these technologies are not equally available to all. Those with lower socio-economic status, and particularly persons with disabilities, are less likely to use or have access to ICTs. They may not have been exposed to ICTs at school or in the workplace and are unlikely to be able to afford a smart phone or a laptop.

Even when those with disabilities are able to overcome these barriers, the technologies themselves are not necessarily very accessible or easy to use. For example, people with hearing impairments need sign language, subtitles or devices compatible with hearing aids; people who are blind cannot use visual displays and therefore need to use audio and voice control for either consuming information or two-way communication; those with dexterity impairments will have difficulty with touch screens and keyboards, and will need alternative means of using devices. However, if these challenges can be overcome, ICTs offer the potential to facilitate communication across time and space, in ways which were previously impossible. They also enable the development of new forms of assistive device (either hardware or software) to further facilitate communication and interaction. In this way, ICTs could play an important role in helping persons with disabilities to overcome social exclusion.

Additionally, accessibility features on computers now allow persons with sight and hearing disabilities to use them. Modern computer operating systems include several accessibility features including speech recognition, text or visual alternatives to sound, magnifiers, and narration (Microsoft Corporation, 2015). There are also Braille computer keyboards, notetakers and printers. Communication support features are also available on mobile devices.

There are a number of ICT-based solutions that can be used to assist people who are blind. Cost is a major barrier to the adoption of these solutions, but in many cases, prices are being reduced as the landscape of offerings shifts from specially-designed assistive equipment to general-purpose ICT that has been adapted to meet a particular need. The expansion of general-purpose computing has enabled a broad range of services for the blind and visually impaired and these services have improved greatly in recent years. For example, screen reader software is now built into commercial operating systems, including Windows and Macintosh. However, the role of personal computers as the primary general-purpose computing device has been eroded by new generations of mobile devices. In particular, smartphones, and the apps that run on them, hold significant potential for making day-to-day tasks easier for blind people to accomplish. The KNFB Reader app provides a text reading capability using a smartphone. It can take a picture of text on a sheet of paper and use optical character recognition (OCR) to convert it to an audio file that the user can listen to. Video Remote Assistance (VRA) applications use human volunteers to help guide blind people through the real-time use of the camera on a smartphone (assuming a responsive internet connection and a significant amount of bandwidth).

A major problem for the newly blind is that they are unlikely to have very much knowledge about these tools, and about other resources available to support people's daily lives. One organization working to resolve this problem is The Blind Way Forward, in Trinidad and Tobago. With initial support from a government grant, the organization distributes MP3 players to the blind that contain an

audiobook which explains what resources are available and how tasks may be accomplished using these resources.

Digital technology helps members of the deaf community to engage in unmediated interactions with non hearing-impaired persons. The advent of the internet, most notably, has increased the immediacy of text-based communications, which had previously been bound to slower media, such as print, or pen-and-paper. Written text on the internet –supplemented with images– and text messages on mobile phones offer unprecedented information access to deaf people, as compared to earlier, sound-reliant communication technologies such as radio, television and the telephone. These technologies are enabling the hearing impaired to become active participants in a global conversation, as opposed to being passive recipients of media.

However, online communications are now evolving in a direction that is less text-centric than it used to be. The past decade has seen the rising prominence of video, with Netflix and YouTube being the two largest consumers of internet bandwidth in the Caribbean region. In keeping with the internet becoming far less text-centric, it is now important to ensure that the hearing-impaired do not become excluded from full participation in online activities. In many cases, technology exists that can enable access for the deaf to audio-based content, but it will take sustained effort and conscientiousness to ensure that it can be effectively used in the Caribbean context. The provision of text-versions of podcasts and the transcription of video files into text, which enable services such as closed captioning of internet videos, offer good examples of inclusive solutions for the hearing impaired. Transcription services can be carried out either by a human or by software. While transcriptions carried out by humans are of better quality, software-generated transcripts can be delivered in real time, at low cost on a virtually unlimited scale. This is already taking place. For example, YouTube has the ability to auto-generate closed-captions from the speech in a video, and encourages those who post videos to edit these captions for clarity and to remove any transcription mistakes. However, while the software for the speech-to-text process tends to be somewhat effective in transcribing dialogue spoken in some British or American accents, at present the language models used tend to be poorly adapted to other accents, including those from Caribbean countries.

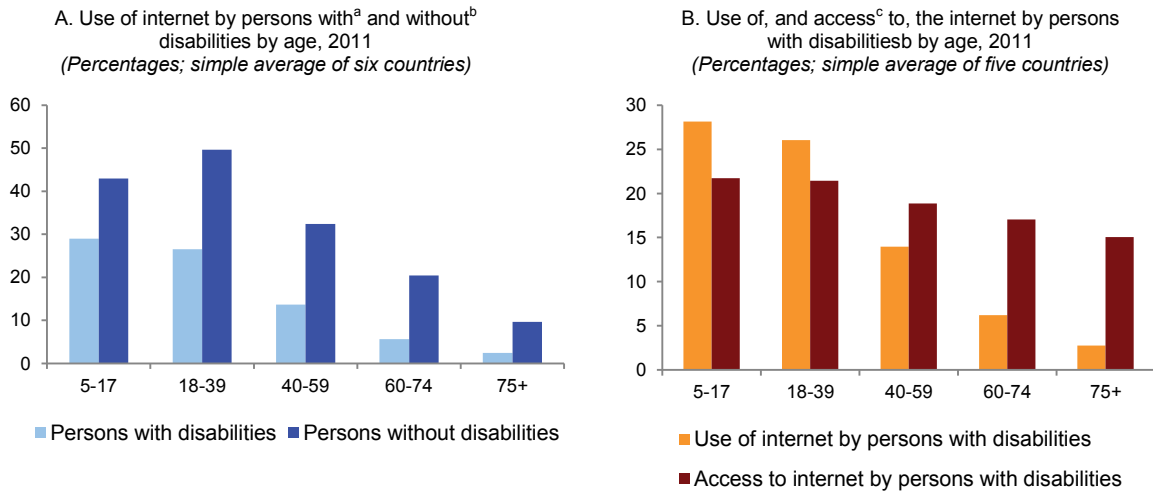
An analysis of data from seven countries indicates that persons with disabilities are much less likely to be internet users compared to the non-disabled population and this is the case for every age group (see figure 7). Levels of internet use are lower among older persons generally and are particularly low for older persons with disabilities. At the time of the 2010 round of censuses, only around five per cent of older persons with disabilities (aged 60 or over) were internet users.

The cost of a home internet connection and a home computer are major impediments which prevent persons with disabilities from accessing the internet. However, even where older persons with disabilities were living in a home with an internet connection, only around one third of these people actually used the internet. This could have been because the internet connection or computer were not shared or due to a lack of knowledge or interest (see figure 7).

Use of the internet is strongly correlated with the severity of disability. Those persons with a moderately severe disability have rates of internet usage similar or only slightly lower than the non-disabled population. It is primarily those persons with more severe disabilities among whom rates of internet use are significantly lower (see figure 8).

Among those with disabilities, people with visual impairments are more likely to use the internet (see table 5). This is because there are many people whose sight is impaired, having deteriorated with age, but not so severely that they are unable to use a computer. Those with hearing, mobility and upper body impairments are around half as likely to use the internet as persons without impairments. For those with impaired cognition, communication or inability to care for themselves, their internet use is only about one quarter that of persons without disabilities.

**Figure 7**  
**Use of internet by persons with disabilities by age**



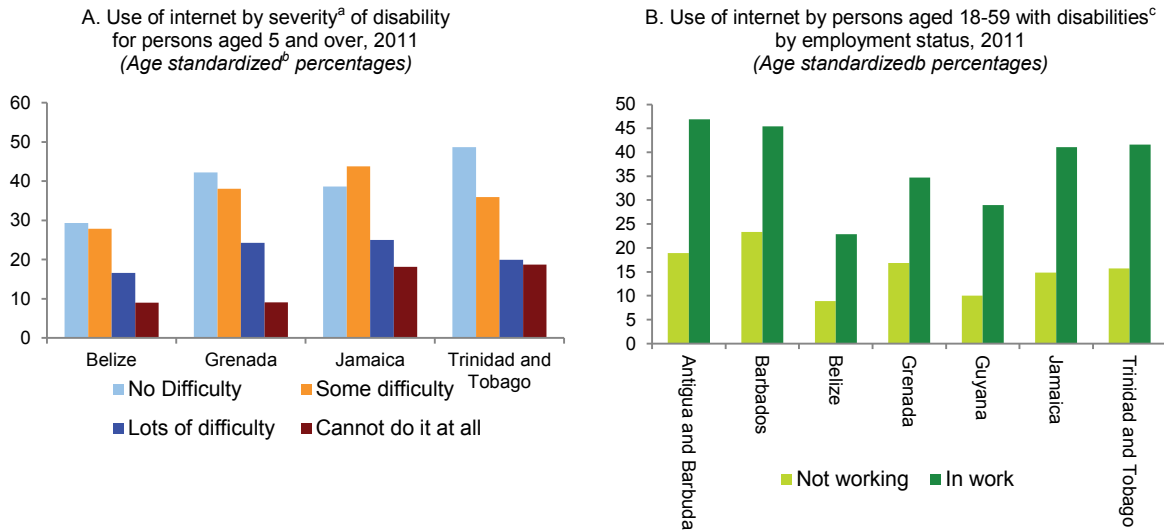
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of population and housing censuses conducted in Antigua and Barbuda (2011), Belize (2010), Grenada (2011), Guyana (2012), Jamaica (2011) and Trinidad and Tobago (2011).

<sup>a</sup> A lot of difficulty or cannot do at all (seeing, hearing, walking, communicating, remembering etc...).

<sup>b</sup> No difficulty.

<sup>c</sup> Access refers to whether the household in which a person lives has an internet connection.

**Figure 8**  
**Use of internet by persons with disabilities by severity and employment status**



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of population and housing censuses conducted in Antigua and Barbuda (2011), Belize (2010), Grenada (2011), Guyana (2012), Jamaica (2011) and Trinidad and Tobago (2011).

<sup>a</sup> Severity of disability is measured by the level of difficulty that persons have seeing, hearing, walking etc.

<sup>b</sup> Disability and internet use are both strongly correlated with age therefore percentages have been age standardised (using the age structure of the total national population as the standard) so that the relationship between disability and internet use can be examined independent of age effects.

<sup>c</sup> A lot of difficulty or cannot do at all (seeing, hearing, walking, communicating, remembering etc...).

**Table 5**  
**Use of the Internet by type of disability<sup>a</sup> for persons aged 5 and over, 2011**  
*(Age standardized<sup>b</sup> percentages)*

|                     | Type of disability |         |         |                          |           |            |                       |                   |
|---------------------|--------------------|---------|---------|--------------------------|-----------|------------|-----------------------|-------------------|
|                     | Seeing             | Hearing | Walking | Remember and concentrate | Self-care | Upper body | Communicate and speak | None <sup>c</sup> |
| Antigua and Barbuda | 49                 | 24      | 27      | 16                       | 12        | 20         | 7                     | 55                |
| Barbados            | 27                 | 28      | 29      | ..                       | 10        | 28         | 10                    | 45                |
| Belize              | 24                 | 15      | 11      | 7                        | 7         | 11         | 6                     | 29                |
| Grenada             | 31                 | 15      | 20      | 11                       | 11        | 19         | 7                     | 42                |
| Guyana              | 28                 | 12      | 12      | ..                       | ..        | 9          | 6                     | 25                |
| Jamaica             | 36                 | 20      | 15      | 7                        | 7         | 14         | 6                     | 39                |
| Trinidad and Tobago | 27                 | 22      | 20      | 13                       | ..        | 18         | 10                    | 49                |

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of population and housing censuses conducted in Antigua and Barbuda (2011), Barbados(2010), Belize (2010), Grenada (2011), Guyana (2012), Jamaica (2011) and Trinidad and Tobago (2011).

<sup>a</sup> A lot of difficulty or cannot do at all (seeing, hearing, walking, communicating, remembering etc...).

<sup>b</sup> Disability and internet use are both strongly correlated with age therefore percentages have been age standardized (using the age structure of the total national population as the standard) so that the relationship between disability and internet use can be examined independent of age effects.

<sup>c</sup> No difficulty.

Some types of disability impact more obviously upon a person's ability to use a computer and therefore the internet. For example, one might expect that a visual or an upper body impairment would have more effect upon someone's ability to use a computer than would, say, impaired mobility. The need to use adaptive devices and technologies is clearly dependent on the type and severity of disability. However, the fact that persons with disabilities of all types are much less likely to use the internet suggests that, in addition to the direct impact of disability, the wider social and economic disadvantage experienced by those with disabilities is also a major cause of the digital divide.

There is a strong correlation between those persons with disabilities that use the internet, and both level of education and employment status (just as there is for persons without disabilities). Those with disabilities that are in work are typically more than twice as likely to be internet users (see figure 8). These people are more likely to be able to afford access to the technology. In some cases, their use of technology is also likely to have helped them to find employment which would suggest that addressing factors which limit the use of ICT by persons with disabilities will also reduce barriers to their gainful employment.

It is reasonable to assume that internet use has increased since 2010-2012, particularly through the use of mobile devices, although it is not known whether the digital divide between persons with and without disabilities has narrowed (or even widened). Despite the speed of change, and despite the barriers that exist, these obstacles can be overcome. Even as new problems emerge, ICT is bringing new solutions to the table. With the support of the public sector, the business community, technologists, social workers, volunteers, family members, and, of course, by drawing upon their own resources, persons with disabilities can be empowered by ICT to prosper as active and fully participating members of society.

There needs to be greater coordination among the different public sector, private sector and civil society entities that organize programmes to promote ICT usage among persons with disabilities so that the programmes reinforce each other. It is important to take into account the heterogeneity of the disabled population by type of disability, level of education, socioeconomic status, and the difficulties faced by first time users. Persons with disabilities themselves must be involved in developing plans and strategies to expand ICT access, since they have the best appreciation of the challenges and the potential benefits.

Addressing the physical and technical barriers which are preventing persons with disabilities from using internet technology (or fully exploiting it) should be a central part of strategies to build disability-inclusive societies. The exclusion of persons with disabilities is a social problem, more than a technical one, but ICT access for those with disabilities is worthy of special attention because of the contribution it can make to overcoming the discrimination that disabled people face more generally.

## IV. Access to education

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The education system in a country reflects national economic and social realities and also perpetuates and reproduces those realities. However, reform of the education system can also be a driver of wider social and economic change (Joseph, 2007; Amadio, 2009). The inclusion of children with disabilities in mainstream education is a crucial step towards the creation of inclusive societies. For children with disabilities, it is vital for their social development, the fulfilment of their academic potential, and ultimately their future well-being as adults. More broadly, education systems in which children with disabilities participate on a full and equal basis with non-disabled children help to change attitudes towards disability (among both groups).

There is an international consensus on the universality of the right to education, and on the importance of Education for All to development and growth. The responsibilities and commitments of governments with regard to the education of children with disabilities are set out in the CRPD and in the Declaration of Pétion Ville (see table 6). The CRPD makes clear the right of children and young people with disabilities to be educated within the mainstream education system, in non-segregated settings. National laws, policies, legislations, and education plans also emphasize the importance of the best possible education for children and young persons with disabilities although without expressly committing to fully inclusive education.

**Table 6**  
**International commitments regarding the education of children with disabilities**

| Convention or agreement | Commitments  |
|-------------------------|--|
| SDGs                    | Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all   |
| Article 24 – Education  | States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and lifelong learning...<br>States Parties shall enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community. |

Table 6 (concluded)

| Convention or agreement  | Commitments  |
|--|--|
| Article 7 – Children with disabilities   | States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.  |
| Declaration of Pétiou Ville  | We resolve to take the necessary steps towards... promoting... equal opportunity to education... We are committed to promoting within our homes, schools and communities a greater awareness of the needs of children and youth with disabilities, and agree to develop and implement measures to ensure continued improvement in the home, the school and the community that assures their equal right to education and participation.  |
| Jomtien World Declaration on Education for All (1990); also reaffirmed in the Dakar Framework for Action (2000): | In order to attract and retain children from marginalized and excluded groups, education systems should respond flexibly... Education systems must be inclusive, actively seeking out children who are not enrolled, and responding flexibly to the circumstances and needs of all learners...   |
| Salamanca Framework for Action:  | ...schools should accommodate all children regardless of their physical, intellectual, social, emotional, linguistic or other conditions.<br>Regular schools with this inclusive orientation are the most effective means of combating discriminatory attitudes, creating welcoming communities, building an inclusive society and achieving education for all; moreover, they provide an effective education to the majority of children and improve the efficiency and ultimately the cost-effectiveness of the entire education system. |

Source: United Nations General Assembly Resolution 70/1 “Transforming our world: the 2030 Agenda for Sustainable Development”; United Nations Convention on the Rights of Persons with Disabilities (2006); Declaration of Pétiou Ville (CARICOM, 2013); Jomtien. World Declaration on Education for All (UNESCO, 1990); Dakar Framework for Action, Education for All: Meeting our Collective Commitments (UNESCO, 2000); and the Salamanca Statement and Framework for Action on Special Needs Education (UNESCO, 1994).

## A. Approaches to education of children with disabilities

For many children with disabilities, progression through the education system is fraught with complications. Attitudes and beliefs towards persons with disabilities are a major barrier to equal access to education. Persons with disabilities are often stigmatized, viewed as a burden and subjected to name-calling, resentment, and exclusion (Ajodhia-Andrews and Frankel, 2010). At every stage there are potential obstacles which can obstruct the education of a child with disabilities. In most cases, in the Caribbean, they will be faced with a very limited set of schooling options. For many parents, public schooling for a child with disabilities can generate feelings from anxiety and discomfort to dread and fear. These feelings may lead parents to keep children out of school; staying at home to take care of their child; leaving their child with grandparents or others who may not be in a position to provide adequate care; taking their child to work or other unsuitable arrangements. All of these outcomes constitute a denial of the right to education.

For children with disabilities in the Caribbean, there have been three main approaches to education: special schools and institutions, special classes in integrated schools; and inclusive schools where students with disabilities participate alongside non-disabled students in mainstream classes. Most Caribbean countries have an education system that combines the three approaches. Indeed, individual children may be educated using a mix of approaches, for example a child with disabilities being educated in regular classes may also spend some time receiving more specialized support in a segregated setting. However, it should be noted that only inclusive education, where children are not segregated from their peers, can provide both quality education and social development for persons with disabilities, and a guarantee of universality and non-discrimination in the right to education (United Nations, 2013).

Special schools and institutions provide an education, typically with some segregation of students based on their type of disability. Examples of special schools include the schools for the deaf or hard-of-hearing and schools for the blind and visually impaired in many Caribbean countries. Children with disabilities in special schools miss out on socializing with peers who either have a different disability, or are non-disabled. Special schools reinforce the social segregation of those with disabilities which further contributes to ignorance and prejudice. The very act of knowing a person with a disability lessens

negative attitudes toward disabled persons in general. Successful inclusive education promotes respect for the equal rights and the capabilities of persons with disabilities.

Inclusive schools serve and educate all children –those with and without disabilities– together in the same mainstream schools and classrooms. “Inclusive education entails identifying and removing barriers and providing reasonable accommodation, enabling every learner to participate and achieve within mainstream settings” (WHO, 2011a). Ajodhia-Andrews and Frankel (2010) described inclusion as “the practice of establishing heterogeneous classrooms in neighbourhood schools, where every child strives to accomplish individual goals while fully participating in social and academic activities.” Children with disabilities are at high risk of social exclusion and inclusive schools offer an avenue for them to interact more with other children and participate more in community life (UNESCO, 2001).

Inclusive education recognises the capacity of every person to learn, and high expectations are established for all learners, including learners with disabilities. Inclusive education offers flexible curricula and teaching and learning methods adapted to different strengths, requirements and learning styles. This approach implies the provision of support, reasonable accommodation and early intervention so that all learners are able to fulfil their potential. It aims at ending segregation by ensuring inclusive classroom teaching in accessible learning environments with appropriate supports. An inclusive education system provides a personalized educational response, rather than expecting students to fit the system. (United Nations, 2016).

In the Caribbean, there has been research into the opinions and attitudes of teachers with respect to inclusive education. Many reported feelings of inadequacy at teaching in an inclusive school because they feel that they lack training, knowledge, and the skills to be effective. They also cited concerns related to lack of resources and facilities, administrative and other support, funding, and class sizes. Nevertheless, teachers participating in a study the Bahamas maintained an overall positive attitude toward inclusive education in some contexts despite concerns regarding the need for better and more resources and facilities; training on how to deal with students; and knowledge about what constitutes inclusive education (Cambridge-Johnson and others, 2014). Teachers also cited the need for more government support and collaboration, more funding, smaller class sizes, changes to the curriculum, and support sessions where best practices are shared. Teachers’ attitudes are important because in addition to affecting their own efficacy and work, they can influence the ways in which students learn and socialize (Cambridge-Johnson and others, 2014) and are central to the success of inclusive education programmes (Ajodhia-Andrews and Frankel, 2010). The concerns expressed by teachers highlight that it is not sufficient to simply place children with disabilities in mainstream classes and that adopting inclusive education requires an investment in teacher training, support services, equipment, flexible curricula, and school environments among other things.

Integrated schools are essentially mainstream schools that have special classrooms for students with disabilities. Children with disabilities attend mainstream schools, however, they are taught in special classrooms that have the necessary resources. While this may appear to be a practical compromise there is a real risk that such arrangements will not offer sufficient opportunities for interaction between disabled and non-disabled children. Separate classrooms are still a form of segregation and given the tendency of students to self-segregate, merely co-locating children with disabilities on the same site as their non-disabled peers is not likely to be sufficient on its own to achieve a genuine integration of the two students groups.

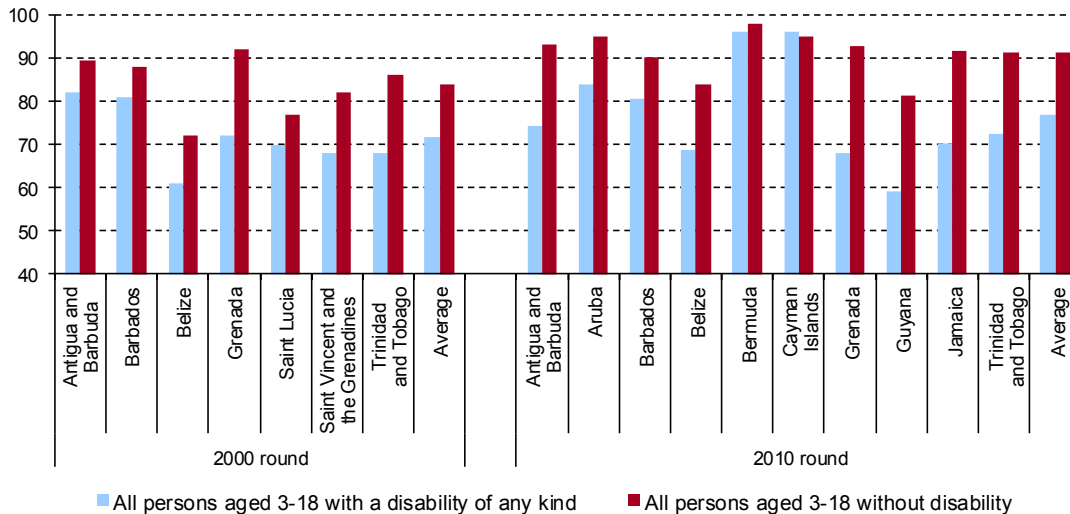
## **B. Participation, integration and inclusion in the Caribbean**

There have certainly been improvements to the educational opportunities for children with disabilities in the Caribbean although there are still significant inequalities between the rate of school attendance for children with and without disabilities, and similarly for educational attainment. Many children with disabilities, particularly those with more severe disabilities, are unable to attend mainstream schools either because schools are not physically accessible or because the schools are not able to meet their educational needs. These children may have to attend segregated special schools, possibly far from their home. In recent years, several countries have restructured provision of special education making greater



use of special education units attached to mainstream schools, which has improved the situation somewhat. There has also been some progress towards the inclusion of children with disabilities in mainstream classes, particularly blind and visually impaired children. On the other hand, there continue to be some children –primarily those with more severe disabilities– who remain outside the education system.

**Figure 9**  
**School attendance of persons aged 3-18 by disability status, 2000 and 2010<sup>a</sup>**  
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

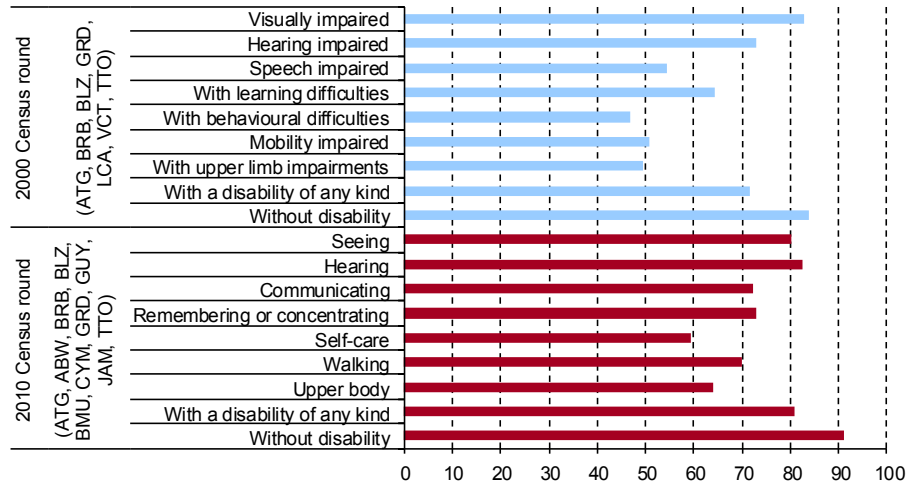
<sup>a</sup> Estimates for Aruba (2010), Belize (2010), Cayman Islands (2010) and Jamaica (2011) are based on data for persons aged 5-18.

School attendance by children with disabilities still lags behind that for children without disabilities. Among those countries for which data is available, only in Bermuda and the Cayman Islands was school attendance for children with disabilities comparable to that for children without disabilities. The countries with the largest differences in school attendance between children with and without disabilities were Grenada (25 per cent in 2010), Guyana (22 per cent in 2010), and Jamaica (22 per cent in 2010) (see figure 9). The countries with the smallest gap were Barbados (10 per cent in 2010), Saint Lucia (seven per cent in 2000) and, as mentioned above, Bermuda and the Cayman Islands.

Children with difficulties seeing or hearing are more likely to attend school than children with other types of disability (see figure 10). However, they are still less likely than children without disabilities to attend school. In 2010, 80 per cent of children with difficulty seeing attended school, and 82 per cent of children with difficulty hearing, compared with 91 per cent of children without disabilities (see figure 10). School attendance was lower for children with difficulties remembering and concentrating (73 per cent), communicating (72 per cent), walking (70 per cent), upper body impairments (64 per cent), and were lowest for children that had difficulties with self-care (59 per cent).

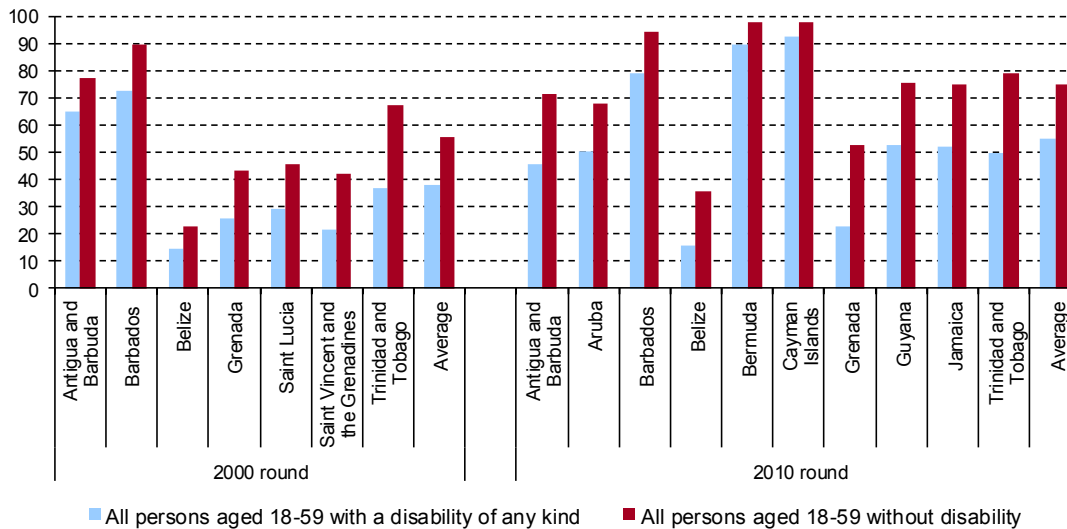
As a group, persons with disabilities have lower levels of education. The countries with the largest differences in completion of secondary education between working age adults with and without disabilities were Grenada (30 per cent), Trinidad and Tobago (30 per cent) and Antigua and Barbuda (26 per cent), all in 2010 (see figure 11). The countries with the smallest gap were Belize (eight per cent in 2000), Bermuda (eight per cent in 2010) and the Cayman Islands (five per cent in 2010).

**Figure 10**  
**School attendance of persons aged 3-18 by type of disability, 2000 and 2010**  
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

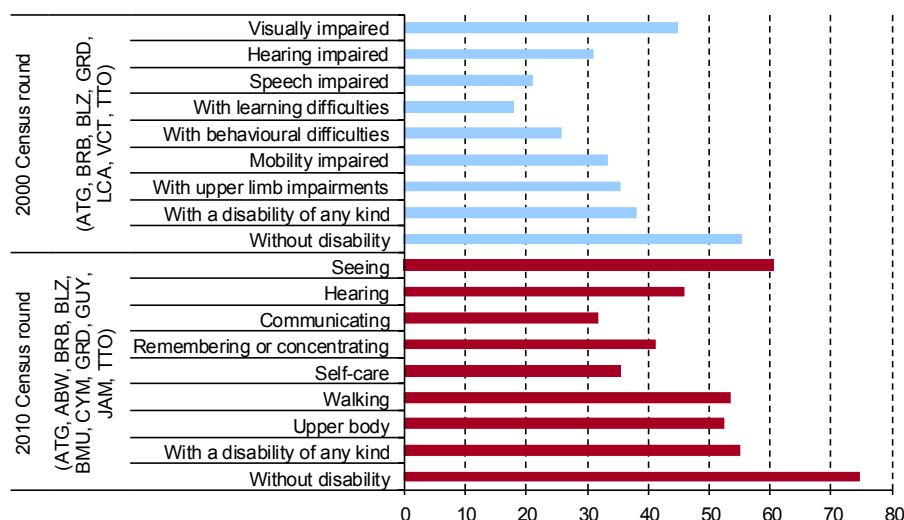
**Figure 11**  
**Persons aged 18-59 who have completed secondary education by disability status, 2000 and 2010**  
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

Among persons aged 18 to 59 with difficulty seeing, 61 per cent had completed secondary education compared with 46 per cent of persons with difficulty hearing. This compared to 75 per cent of persons with no disability (see figure 12). Level of education was lower among persons with difficulties walking (54 per cent); with upper body impairments (53 per cent); remembering or concentrating (41 per cent); that had difficulties with self-care (36 per cent); and were lowest for those with difficulties communicating (32 per cent).

**Figure 12**  
**Persons aged 18-59 who have completed secondary education by type of disability, 2000 and 2010**  
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

## C. Provision of special needs education in the Caribbean

The Ministry of Education of Bahamas has worked over recent years to improve the quality of special education. The Ministry has been guided by the Salamanca Statement and Framework for Action on Special Needs Education (1994), and there were also important contributions from the National Task Force on Disabilities (which reported in 1999) and the National Commission on Special Education (reporting in 2005). It was found that one of the main barriers which prevented children with disabilities from participating in mainstream education was negative attitudes, low expectations and a shortage of expertise in special needs education. A number of improvements to special needs education were implemented during this period: routine screening of all preschool children to identify those with special needs; greater use of teachers' aides and special needs support staff; resource rooms for children with learning disabilities; and a greater emphasis on the inclusion of children with disabilities in mainstream schools.

A special education unit was created in the Ministry of Education to coordinate special needs education nationally including screening, diagnosis and remediation for children with disabilities, parental and family support and teacher education. Teams of service providers that include special education teachers, school psychologists, guidance officers, and school social workers have been placed throughout the school system. In 2013, the Government of the Bahamas sponsored its first graduate cohort of special education teachers specializing in Literacy and Inclusive Education at the local college (Newton and others, 2014). In 2015, the Marjorie Davis Institute for Special Education was opened. Its responsibilities include diagnostic and consultative services, intervention, training and research and it supports children with moderately severe disabilities to attend mainstream schools.

The geography of the Bahamas provides further challenges with the school population scattered across 22 inhabited islands. The role of the local community is therefore vital if children with special needs are to be identified and supported. In the Bahamas, collaboration, alliances and partnerships have been vital to strengthening special educational needs (SEN) provision with construction companies, clubs, churches, commerce groups, medical services, banks, and advocacy groups being just some examples of organizations and individuals who can support educational activities (Taylor and Wildgoose, 2014).

Bermuda is also relatively advanced with respect to the integration of children with disabilities in mainstream schools. In 1989, it was decided that the majority of students with SEN should be integrated into mainstream schools alongside other students, with teaching assistants or therapists to assist with their needs. Prior to this proposal, students with SEN had been placed in separate schools. Now, the only students who are not educated in mainstream classrooms are those with multiple physical challenges or severe behavioural problems who are educated in a single special school, the Dame Marjorie Bean Hope Academy. When this change in approach was first implemented, it was opposed by many teachers but has now become widely accepted (Christopher, 2014).

In Antigua and Barbuda, inclusion in mainstream schools is less advanced. Children with disabilities are generally able to attend school although they are more likely to be offered a place in one of the three special schools in the country (ABAPD, 2015). At present, either a lack of support services or physically inaccessible school buildings prevents many children with disabilities from attending mainstream schools. There has, however, been more progress on the inclusion of children with visual impairments with a unit supporting the inclusion of these children in mainstream schools. The situation is similar in Belize, where special schools commonly provide education between the ages of 3 and 15. However, according to the Belize Association for Persons with Diverse Abilities, there are diminishing opportunities for children with disabilities beyond the age of 15 preventing some from continuing their education (BAPDA, 2015).

In Caribbean education systems generally, there is a shortage of professionally trained teachers and a number of countries publish statistics on the proportion of teachers who are professionally trained (see table 7). Special education is no exception: in countries for which figures are published, the proportion of special education teachers with professional training is similar to that in mainstream primary and secondary education or, if anything, a little lower. Jamaica has been relatively successful in the professionalization of teaching following a major restructuring and upgrading of teacher education during the 1980s including the introduction of a teacher education programme focused on special education (Miller and Munroe, 2014).

**Table 7**  
**Teachers with professional training in primary, secondary and special education**  
(Percentage of teachers with training)

|                           | Trained teachers in special education | Trained teachers in mainstream primary education | Trained teachers in mainstream secondary education |
|---------------------------|---------------------------------------|--|--|
| Barbados (2013 - 2014)    | 62                                    | 62   | 54   |
| Grenada (2012 - 2013)     | 65                                    | 67 <sup>a</sup>                                  | 39   |
| Guyana (2011 - 2012)      | 45                                    | 73   | 68   |
| Jamaica (2015 - 2016)     | 80                                    | 93   | 83   |
| Saint Lucia (2013 - 2014) | 59                                    | 90   | 71   |

Sources: Statistics on Education in Barbados at a Glance 2013 - 2014; Education Statistical Digest, July 2014, Grenada; Education Statistics, 2011-2012, Guyana; Education Statistics, 2015 - 2016, Jamaica; Education Statistical Digest, 2014, Saint Lucia.

<sup>a</sup> Public schools only.

In Anguilla, most special needs education is provided through special education units in mainstream schools, in other words, on the same site but not in the same classroom (see table 8). Physical therapy, speech therapy and counselling are available in these units and an Individual Education Plan is developed for each child. Only those children with the most severe disabilities are educated in fully segregated centres.

National disability legislation and policies, where they have been formulated, have recognized that a range of approaches are necessary to meet the needs of children with disabilities. The Disability Acts of Guyana and the Bahamas state that children with disabilities must have access to the general education system, including free, compulsory primary and secondary education. Ministers of Education are required to promote the establishment of special schools for children with disabilities (public and private) throughout their respective countries. The Acts refer to *integrated* schools although it is not clear whether this is an explicit endorsement of integrated schools as opposed to inclusive schools, or whether the terms are being used more loosely. The two Acts also ensure that “learning institutions take into account the special needs of persons with disabilities with respect to the entry requirements, curriculum, examinations, auxiliary aids, and services including accessible formatting, use of school facilities, class schedules, physical education requirements and other relevant matters.”

**Table 8**  
**Special education in selected Caribbean counties and territories**

| Country or territory                 | Special Education (including male and female enrolment)  |
|--------------------------------------|--|
| Anguilla<br>(2012)                   | <p>Special education units at the following four primary schools: Adrian T. Hazell (moderate learning difficulties), Orealia Kelly (severe learning difficulties), The Valley (social, emotional and behavioural problems and learning difficulties) and Alywn Allison (children with severe disabilities) (approximately 40 children in total).</p> <p>Special education units at Campus's A and B of the Albena Lake Hodge Comprehensive School, a Pupil Referral Unit at Campus C for students with emotional and behavioural difficulties.</p> <p>There are also two separate special education centres: the Blossom Centre, a private centre providing education, physical and speech therapy for younger children; and the WISE centre for secondary students with behavioural or learning difficulties.</p>       |
| Antigua and Barbuda<br>(2014 – 2015) | <p>School for the Deaf (7 males, 5 females)</p> <p>Adele School for children who have mild to severe handicaps or learning disabilities (43 males, 30 females)</p> <p>Victory Centre for children with ADD, ADHD, Autism, Asperger's, Down Syndrome, developmental delays both mentally and physically as well as children at risk (10 males, 7 females)</p> <p>There is a Unit for the Blind and Visually Impaired which supports the education of blind and visually impaired children in mainstream schools.</p>  |
| Barbados<br>(2013 – 2014)            | <p>Special education units at the following four primary schools: Charles F. Broome Memorial, Eagle Hall, Ellerton and All Saints' (81 males, 47 females in total).</p> <p>Three segregated public special schools: Erdiston Special Needs School for children with learning disabilities, Down Syndrome, cerebral palsy, autism and intellectual disabilities; Ann Hill school for children with disabilities and special needs; The Irving Wilson School for children who are deaf, hard- of-hearing, blind or visually impaired (131 males, 63 females in total).</p> <p>Two private segregated special schools: The Schoolhouse for Special Needs, a private school for children with learning, developmental and physical challenges; and the Learning Centre, a private school for children with disabilities.</p> |
| Bermuda (2012)                       | <p>Dame Marjorie Bean Hope Academy school for children with special needs (15 males, 10 females).</p>  |
| Cayman Islands<br>(2016)             | <p>One public special school, the Lighthouse School, for children with moderate to profound learning disabilities and/or multiple disabilities (108 students).</p> <p>One private institution, the Hope Academy, which offers a full-time educational programme to students including those with specific learning difficulties, ADHD, high-functioning Pervasive Development Disorder (or mild Autistic Spectrum Disorder), anxiety based disorders and/or other challenges. It also provides Behaviour Therapy/Counselling and Speech and Language Therapy.</p>  |
| Grenada<br>(2012 – 2013)             | <p>School for the Hearing Impaired (9 males, 7 females)</p> <p>Grenada School for Special Education for children with intellectual disabilities (34 males, 33 females)</p> <p>St. Andrew's School for Special Education for children with intellectual disabilities, hearing impairments and multiple disabilities (27 males, 21 females)</p>  |

Table 8 (concluded)

| Country or territory                       | Special Education (including male and female enrolment)  |
|--|--|
|  | There were a further 14 males and 23 females with visual impairments most of whom attended mainstream primary or secondary schools.  |
| Guyana<br>(2011 – 2012)                    | David Rose School for Handicapped Children (124 males, 100 females, primarily hearing impaired and with intellectual disabilities)<br>St. Barnabas Special School (41 males, 16 females, primarily with learning disabilities)<br>Sophia Special School (148 males, 48 females with learning disabilities)<br>Grove School for Children with Special Needs (38 males, 35 females with various disabilities)<br>New Amsterdam Special School (45 males, 31 females with various disabilities)<br>Linden Centre for Special Needs (11 males, 10 females with various disabilities) |
| Jamaica<br>(2015 – 2016)                   | There are 10 public special schools (1,160 males, 854 females), 15 independent special schools (694 males, 370 females) and 9 special education units attached to mainstream schools (319 males, 135 females).   |
| Saint Kitts and Nevis<br>(2013 – 2014)     | The Cotton Thomas Comprehensive School for children and adults with disabilities in Saint Kitts (75 males, 32 females). Cecele Brown Integrated School in Nevis.   |
| Saint Lucia<br>(2013 – 2014)               | Special Education Centre for children with disabilities (Vieux Fort) (107 students)<br>Lady Gordon Opportunity Centre for children with disabilities (94 students)<br>Dunnottar School for children with disabilities (85 students)<br>Blind Welfare Association (53 students of whom 10 attend mainstream schools)<br>Soufriere Special Education Centre for children with disabilities (22 students)   |
| Saint Vincent and the Grenadines<br>(2013) | School for Children with Special Needs, Kingstown; School for Children with Special Needs, Georgetown; Sunshine School for Children with Special Needs, Bequia<br>(74 males, 33 females in total)  |
| Turks and Caicos Islands<br>(2013 – 2014)  | (44 males, 31 females)   |

Sources: Report of the National Forum on Disability, 2012, Anguilla; Antigua and Barbuda Education Statistical Digest 2012 - 2015; Statistics on Education in Barbados at a Glance 2013 - 2014; Bermuda Digest Of Statistics, 2013; the National Education Data Report, 2013, Cayman Islands; Education Statistical Digest, July 2014, Grenada; Education Statistics, 2011-2012, Guyana; Education Statistics, 2015 - 2016, Jamaica; Education Statistics Digest, 2013 – 2014, St. Kitts and Nevis; Education Statistical Digest, 2014, Saint Lucia; Educational Statistical Digest, 2013, Saint Vincent and the Grenadines; Education Digest, 2013 – 2014, Turks and Caicos Islands.

The Jamaica Disabilities Act goes further in the sense that it not only guarantees access to the education system in general but would prevent any single educational or training institutions from denying a person with disabilities from being enrolled at, or attending the institution “by reason of their disability”. However, the level of accessibility and special needs provision in Jamaican schools would need to improve dramatically before this provision can be enforced. For example, it was suggested in 2011, that the vast majority of Jamaican schools lacked ramps and accessible bathrooms (Morris, 2011).

Across the region as a whole, there is political commitment to the education of children with disabilities. The greater challenge lies in translating legislation, policies, and commitments into practice, especially in the face of deep-rooted negative and discriminatory social attitudes and practices; resistance from the teaching profession; long established views that special education is synonymous with segregation; and limitations in the budget and lack of resources.

## D. Inclusive education policy

Achieving successful educational outcomes for children with disabilities requires appropriate legislation, policies and providing adequate funding for implementation. Above all, it requires leadership and commitment at national and local level to ensure that all children with disabilities receive an education appropriate to their needs. Ministries of Education should be responsible for the education of all children with disabilities. Ministries therefore need to have detailed information about the number of children with disabilities and an assessment of their needs. There also needs to be comprehensive screening to

ensure that all children with special needs are diagnosed because children who do not have their special needs recognized are likely to underachieve or drop out.

Ministries of Education must improve the accessibility of school buildings. Where possible physical barriers which prevent children with disabilities from attending school must be removed or modifications made to enable access to previously excluded children. All new school buildings should be designed and built to be accessible to all following the principles of universal design. Teachers must have the skills, the materials and the equipment to meet the needs of children with disabilities. Ministries of Education need to ensure that schools are complying with their responsibilities to educate children with disabilities. They should also publicize the support available to children with disabilities and put in place appropriate procedures so that parents of children with disabilities can raise concerns and seek to resolve problems related to the education of their children.

Children with disabilities should be educated alongside non-disabled children, in mainstream classes. Some progress has been made in a number of countries integrating blind or visually impaired children into mainstream classes but many students with disabilities do not yet have access to inclusive education. The expansion of inclusive education will require careful planning, management, training, and resource allocation to ensure that it is done properly and that teachers and children with disabilities have the necessary support, technology and resources. It is not enough to simply include students with disabilities in mainstream classrooms and expect a positive outcome. The school system itself must adapt to the needs of children with disabilities. There have been positive experiences with the integration of children with visual or hearing impairments in mainstream schools and efforts in this direction must continue.

Students with disabilities educated in inclusive settings require additional support tailored to their individual needs. This may include the use of large print, screen readers, Braille or sign language. Alternative formats of examination, such as oral examinations, should be available for those that need them. Teaching assistants or special needs assistants can offer crucial additional support to children with disabilities in mainstream schools although care should be taken to ensure that over-dependence on assistants does not in itself serve to create a barrier between children with disabilities and their peers and teachers. Children with disabilities should have access to occupational therapists, physiotherapists, speech therapists, educational psychologists and assistive devices. Individual education plans can be a useful tool for children with disabilities. These plans should set out personal goals, as well as the accommodations and supports that will be necessary to achieve them. Information and communication technologies should be used whenever possible. Parents and guardians also have to be supported as partners in the education of their child.

There should also be training for teachers on the education of children with disabilities, both as part of initial teacher training and in-service training. This training should emphasize the right to education, and the importance of tackling negative attitudes and prejudices towards children with disabilities. It should also include the use of technologies which can support disabled children in the classroom, for example assistive listening devices for students who are hard-of-hearing. There should be affirmative action and/or incentives to promote the recruitment of persons with disabilities into teacher training and their subsequent employment in the teaching profession.

UNESCO promotes inclusive education and has produced guidelines and toolkits to support policy-makers, managers and administrators in the implementation of inclusive education (see for example *Policy Guidelines on Inclusion in Education* (UNESCO, 2009)). UNICEF has also emphasized the importance of promoting the right to education of children with disabilities. Disabled persons organizations can also be important advocates for Education for All, while community based rehabilitation workers can also support parents in obtaining an education appropriate to their child's needs.

## V. Economic activity and income protection

Equal rights in the workplace are essential if working age adults with disabilities are to be fully independent, able to make choices about how they live their lives, and fulfil their potential. While people with disabilities work in all kinds of different fields, as a group they are systematically disadvantaged and have to overcome physical, social, and particularly attitudinal barriers in order to enter and then to progress in the workplace. The obstacles that persons with disabilities face, first in the education system, then in training and employment have a cumulative effect making it significantly more difficult for them to find employment or generate an income. As a consequence, persons with disabilities are at much higher risk of poverty. Approximately 82 per cent of persons with disabilities in the Latin America and Caribbean region live in poverty (World Bank, 2004). Indeed, not only do persons with disabilities have lower incomes, they can also face substantial additional costs, for example the cost of assistive devices or home adaptations, assistance and support, health care, and personal transport. These additional costs effectively push them further into poverty.

It has also been pointed out that the link between disability and poverty is to some extent circular since poverty may also increase the incidence of disability. Persons living in poverty are more likely to suffer from poor education and healthcare; malnutrition; unsafe working conditions; exposure to pollution; unsafe water; and poor sanitation, all of which increase the risk of disability (World Bank, 2016).

**Table 9**  
**International commitments regarding rights related to work and employment**

| Convention or agreement          | Commitments   |
|----------------------------------|---|
| Article 27 – Work and employment | <p>States Parties recognize the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities.</p> <p>States Parties shall safeguard and promote the realization of the right to work, including for those who acquire a disability during the course of employment, by taking appropriate steps, including through legislation, to, inter alia:</p> <p>(a) Prohibit discrimination on the basis of disability with regard to all matters concerning all forms of employment, including conditions of recruitment, hiring and employment, of</p> |



Table 9 (concluded)

| Convention or agreement | Commitments   |
|-------------------------|---|
| ILO Convention No. 159  | <p>employment, career advancement and safe and healthy working conditions;</p> <p>(b) Protect the rights of persons with disabilities, on an equal basis with others, to just and favourable conditions of work, including equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment, and the redress of grievances;</p> <p>(c) Ensure that persons with disabilities are able to exercise their labour and trade union rights on an equal basis with others;</p> <p>(d) Enable persons with disabilities to have effective access to general technical and vocational guidance programmes, placement services and vocational and continuing training;</p> <p>(e) Promote employment opportunities and career advancement for persons with disabilities in the labour market, as well as assistance in finding, obtaining, maintaining and returning to employment;</p> <p>(f) Promote opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one's own business;</p> <p>(g) Employ persons with disabilities in the public sector;</p> <p>(h) Promote the employment of persons with disabilities in the private sector through appropriate policies and measures, which may include affirmative action programmes, incentives and other measures;</p> <p>(i) Ensure that reasonable accommodation is provided to persons with disabilities in the workplace;</p> <p>(j) Promote the acquisition by persons with disabilities of work experience in the open labour market;</p> <p>(k) Promote vocational and professional rehabilitation, job retention and return-to-work programmes for persons with disabilities.</p> <p>See also ILO Vocational Rehabilitation and Employment (Disabled Persons) Convention (No. 159).</p> |

Source: United Nations Convention on the Rights of Persons with Disabilities (2006).

## A. Economic activity of persons with disabilities

Persons with disabilities experience significantly higher rates of unemployment and lower rates of employment than their non-disabled peers. Moreover, persons with disabilities who are employed frequently earn less than their non-disabled colleagues (WHO, 2011a). In Jamaica, for example, the public perception is that regardless of qualifications, persons with disabilities have fewer employment opportunities than their (similarly qualified) non-disabled counterparts (Huggins, 2009). This discrimination against persons with disabilities represents a violation of human rights. From a purely economic perspective, the participation of persons with disabilities in the labour force is important in order to maximize the use of human capital. Equal access to employment would make it easier for an increasing number of older workers with disabilities to continue working and would promote social cohesion more generally.

There are a number of factors that contribute to lower employment, higher unemployment, and underemployment<sup>9</sup> of persons with disabilities. They fall into three broad groups: there are barriers resulting from discrimination, stigma and prejudices (interpersonal, institutional, legal and structural); barriers resulting from infrastructural gaps; and barriers related to a lack of empowerment or capacity of persons with disabilities themselves to claim their rights.

Stigma and discrimination in the workplace is a major factor limiting employment opportunities for persons with disabilities. Despite a decline in overt discrimination against persons with disabilities, there is still a tendency to perceive them as “incapacitated” by the general public (Government of Barbados, 2012) and “unsuitable” by employers (Heron and Murray, 2003) who may discriminate against persons with disabilities based on misconceptions about their capabilities (WHO, 2011a).

<sup>9</sup> Underemployed is used here to refer to persons working less than full time who would like to work additional hours or persons working in jobs which significantly underutilize their skills.

Additionally employers may be reluctant to promote persons with disabilities to a position where they manage others. Changing employer attitudes is therefore essential if more employment opportunities are to be opened up for persons with disabilities.

Placement officers can provide companies and other organizations with information about the employment of persons with disabilities. They may use success stories to help convince employers that persons with disabilities can be productive, reliable and loyal. Work trials for persons with disabilities have also proven effective (Heron and Murray, 2003). Indeed, the very act of hiring a person with disabilities can help improve the way disabled people in general are perceived in the workplace (WHO, 2011a). New forms of assistive technology can mitigate or even negate disabilities. For example, dictation and speech recognition software can assist persons with upper body impairments and/or vision impairments for whom typing may be difficult. Speech synthesizing technology can enable speech and communication for the speech-impaired. Telecommuting can assist persons with mobility or other accessibility problems.

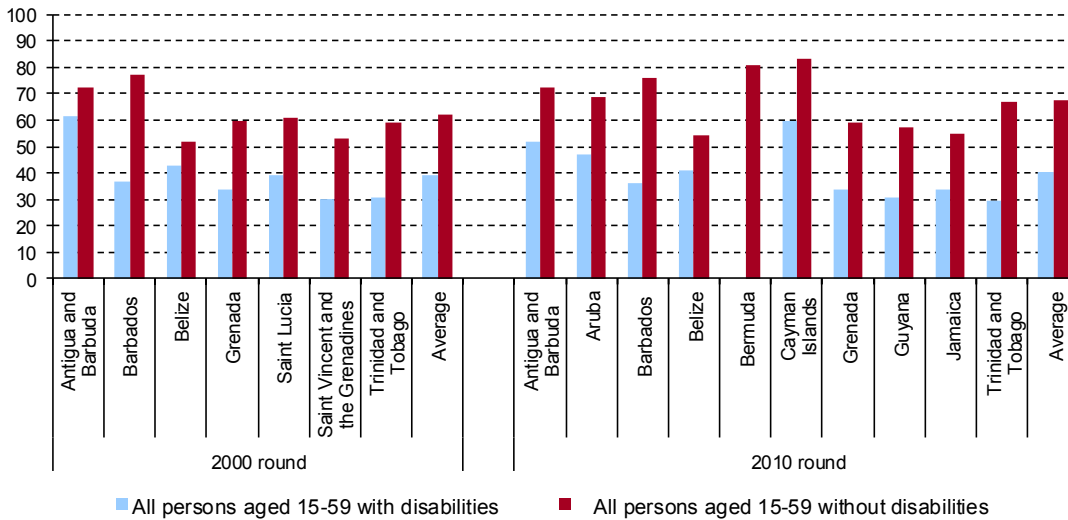
There are also barriers resulting from infrastructural gaps. The workplace itself may be physically inaccessible to some disabled persons. The expense of travelling to and from work every day may prove too much particularly if the inaccessibility of transport, or lack of continuity in the travel chain, makes it necessary to hire private transport and assistance services. Persons with disabilities may also lack opportunities for training and access to finances. Governments could assist persons with disabilities or their employers by covering some of the additional costs associated with workplace adaptations, purchase of technology or transport. In the face of these barriers, persons with disabilities will find it significantly more difficult to enter the labour market than those without disabilities. They emerge from the education system earlier and with fewer qualifications than their non-disabled counterparts and therefore enter the labour market in a disadvantaged position.

Dealing with discrimination can be psychologically difficult and it can affect people's self-confidence and their expectations of themselves. It was reported that in Barbados, persons with disabilities "saw themselves as objects of social exclusion as a result of stigma and discrimination" (Government of Barbados, 2012). Those with disabilities attest that suitable employment helps build positive attitudes. Conversely, not having employment instils and perpetuates a lack of pride and confidence in their own ability. Additionally, because some persons with disabilities have received negative or no responses in their job search, they come to expect this as a part of their impairment (Heron and Murray, 2003). Education and training for persons with disabilities must therefore include a component on the self and positive self-image. As an example, Guyana's Persons with Disabilities Act (2010) provides for counselling sessions and orientations aimed at facilitating the development of a positive self-image among persons with disabilities in order to strengthen their capacity. However, society sends strong messages about what and who it values. Despite the genuine progress that has been made in recent years, more must be done to change attitudes toward disability.

Inadequate work incentives may also play a role in keeping persons with disabilities out of the labour market. Low wages are a strong disincentive, particularly for those facing additional costs such as transport or child care. Long-term disability benefits can also dis-incentivize work since they at least provide a reliable, if not generous, source of income. On the other hand, assistance benefits that support work transitions may incentivize persons with disabilities to seek employment based on the knowledge that their benefits will not be interrupted if the work experience is short-lived (WHO, 2011a).

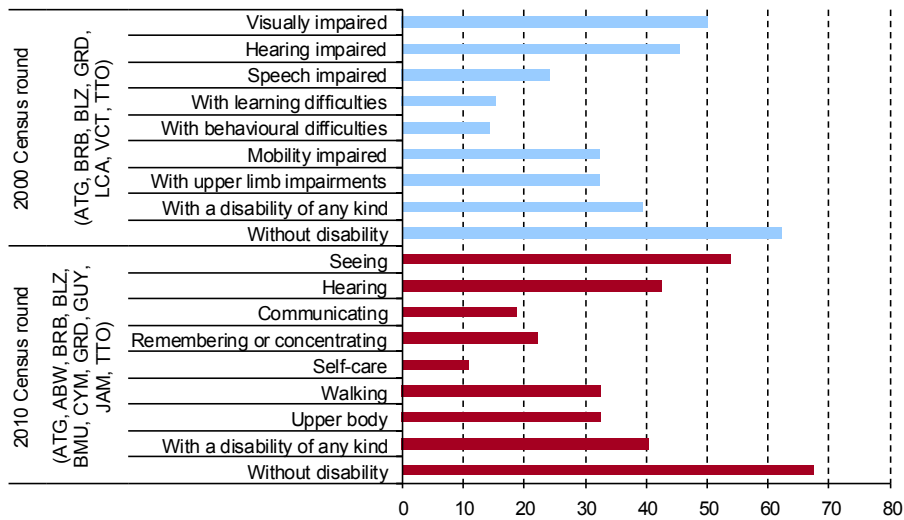
Together, these factors explain why persons of working age with disabilities are much less likely to be economically active than those of working age without disabilities. In many Caribbean countries, in both 2000 and 2010, persons with disabilities were only around half, or just over half, as likely as those without disabilities to be working. Figure 13 illustrates the difference between the economic activity of persons with disabilities and non-disabled persons in the Caribbean. Across the board, persons with disabilities are less economically active than non-disabled persons. In most countries, the differential in the rate of economic activity is between 20 per cent and 40 per cent. The differential is relatively high in Barbados (40 per cent), Trinidad and Tobago (37 per cent) and Guyana (27 per cent), all in 2010. It is lowest in Belize (nine per cent in 2000) and Antigua and Barbuda (11 per cent in 2000).

**Figure 13**  
**Economic activity of persons aged 15 to 59 by disability status, 2000 and 2010**  
*(Percentage of persons who are economically active)*



Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

**Figure 14**  
**Economic activity of persons aged 15 to 59 by type of disability, 2000 and 2010**  
*(Percentage of persons who are economically active)*



Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

In some countries, persons with disabilities appear to be better integrated into the work environment. However, the fact that a person with a disability is working does not necessarily mean that they have decent work. The existence or not of a disability pension in different countries may also affect whether people take paid work. Further work is required to properly understand the factors affecting the economic activity of persons with disabilities in the Caribbean.

Persons with certain types of disability face even greater barriers to employment. In most of the Caribbean, persons with visual impairments have the least difficulty finding employment and participating in the labour market (see figure 14). Some 54 per cent of persons aged 15-59 with difficulty seeing were economically active, compared to 43 per cent of persons with difficulty hearing, and 67 per cent of persons without a disability. Persons with other types of disability were less likely to be in work: those with upper body impairments (33 per cent); difficulty walking (32 per cent); difficulty remembering or concentrating (22 per cent); difficulty communicating (19 per cent); and difficulties with self-care (11 per cent).

## **B. Employment support policies and programmes in the Caribbean**

The national disability laws for Guyana, the Bahamas and Jamaica all address workplace discrimination. The wording is slightly different in each case but the respective laws all outlaw discrimination on the basis of disability. This equal treatment must extend to all aspects of employment: equal terms and conditions of employment, including compensation (monetary and otherwise); placement and opportunities for advancement; recruitment; or termination of employment. Persons with disabilities must be provided with reasonable facilities and accommodations to enable them to perform their work.

The Bahamas Persons with Disabilities Bill (2014) stipulates an employment quota: it requires that all employers with at least 100 workers employ at least one person with disabilities for every 100 staff. The Government of Jamaica has previously committed to allocating five per cent of Government jobs to persons with disabilities although this has not been achieved. One of the goals of the Cayman Islands Disability Policy is for the Government to take the lead in employing persons with disabilities although there is no legal obligation in this regard on either public or private employers. Furthermore, the Bahamas and Guyana Disabilities laws stipulate that the National Commission for Persons with Disabilities (in Bahamas) and the Minister of Labour (in Guyana) will keep a list of persons with disabilities that detail their training, qualifications, and skills to which employers can refer.

The Jamaica Disabilities Act also provides protection for employees who become disabled, requiring the reassignment of employees on the same terms and condition (subject to a disproportionate burden test); and outlaws discrimination with regard to annuities; insurance and some financial services. In a few of the countries in which general disability legislation is lacking, there is some protection for persons with disabilities against discrimination in employment law: in Bermuda, Grenada and Saint Vincent and the Grenadines.

The Cayman Islands Disabilities Policy (2014) addresses the provision of training with a view to creating a pool of well-trained persons with disabilities to overcome what the policy describes as “the first challenge”, that is, convincing employers to consider hiring persons with disabilities and to overcome false assumptions that they reduce business profitability because they lack the training and skills needed to perform the job and/or because of expensive accommodations that have to be made for them. Disabilities legislation in other countries also requires the provision of vocational training.

In Trinidad and Tobago, the National Centre for Persons with Disabilities (NCPD) is a Government-assisted NGO which promotes the full participation of persons with disabilities in society and provides persons with disabilities with quality training and rehabilitative services. In 2015, there were 250 trainees and apprentices engaged in certifiable skill development in the fields of agriculture/horticulture, beauty culture, food preparation, garment construction, information technology, office administration, welding, book binding and woodwork. Graduates are certified by the national examinations council of the Ministry of Education. Trainees also participate in remedial education, life skills training, computer literacy training, entrepreneurial skills training, music, art, craft and sports. NCPD has developed a business portfolio, marketing high quality products and services in the fields in which it offers training. This creates opportunities for trainees to gain on-the-job experience which enhances their competitiveness in the job market. NCPD graduates are therefore both qualified and

experienced in their skill areas. The Centre also assists graduates in securing employment opportunities. They have extended their services to trainees from Antigua and Barbuda and Guyana.

A number of other countries also have vocational training centres for adults with disabilities, for example Antigua and Barbuda's National Vocational Rehabilitation Centre. In the Cayman Islands, the Adult Training Centre provides training, support and services for the empowerment, employment and independence of adults with disabilities. The centre is not currently able to meet the demand for training from persons with disabilities in the Cayman Islands and there are plans to construct a new and expanded facility in a more central location that can offer more programmes to more clients.

CARICOM, together with the Governments of Guyana and Cuba have signed a Tripartite Cooperation and Technical Assistance Agreement for the establishment of a "Regional Training Centre for Development and Stimulation of Children, Adolescents and Young People with Special Educational Needs Associated with Disabilities."

In Jamaica, between 2013 and 2016, the 'Social and Economic Inclusion of Persons with Disabilities Project' facilitated training of 500 persons with disabilities on the PATH programme. The beneficiaries followed one year certified training courses in subjects including furniture-making, food preparation, and merchandising. The project was administered through a collaboration of the Ministry of Labour and Social Security with non-governmental organizations (NGOs) that already work closely with people with disabilities. Of the 172 persons who received training in 2014/15, 27 persons subsequently obtained full time jobs, which is indicative of how difficult it can be for people with disabilities to find employment. The Congress of Trade Unions and Staff Associations of Barbados (CTUSAB) is currently working with the National Council for the Disabled, the National Disability Unit and the Barbados National Organization of the Disabled to promote equal opportunities through awareness raising and education.

All countries should ensure that there is legal protection for persons with disabilities against workplace discrimination either in national employment law, equal opportunities legislation or disability legislation. Legislation should also require employers to make reasonable accommodations to enable persons with disabilities to work; should ensure that recruitment practices are fair and free from discrimination; and that work environments are reasonably adapted. Measures must be taken to promote the right of persons with disabilities to work, so that those with disabilities and employers are aware of their rights and responsibilities. Persons with disabilities should also be made aware of how they can seek redress when they feel they have been unfairly treated.

Given the deeply entrenched nature of the discrimination involved, affirmative action should be considered to make it easier to find work. Governments should lead by setting quotas for persons with disabilities in the public sector and consider imposing quotas on larger employers so that they too are obliged to ensure that persons with disabilities comprise a certain percentage of their workforce. Employers failing to meet their quota would be required to pay a fine, money which could be directed to the provision of vocational rehabilitation services for those with disabilities. In order to support employers, government agencies and disability organizations may need to provide advice and funding for employment related accommodations, workplace adaptations and assistive devices.

There is a need for supported employment programmes to provide individually tailored support to persons with disabilities to enable them to find and retain employment. Such assistance might include support with job applications, finding job placements, specialized job training, transportation, individually tailored supervision, and the provision of assistive technology. As far as possible, this support should try and build on the interests and skills of the individual with a view to long term career development and not just seek to fit people with disabilities into whatever jobs happen to be most easily available. There should be opportunities for vocational training in information technology and well as traditional skills. For those persons whose disabilities will likely make it difficult to compete in the open labour market (even with appropriate support) sheltered employment can provide remunerated work but in a segregated setting.

Employers should consider the management of disability issues in the workplace a priority task which contributes to business success, and regard it as an integral part of the workplace human resources development strategy. The strategy should aim to maximize the contributions and abilities of all staff, including those with disabilities. In addition, employers should evaluate the effectiveness of their workplace strategy on the management of disability at regular intervals and make improvements where required (ILO, 2002). Occupational Health and Safety laws should also include protections for persons with disabilities in the workplace.

Special attention should also be paid to the many people who are in work but then develop a health condition or disability. Government agencies and disability organizations should seek to support and advise these individuals and their employers so that workplace accommodations can be put in place and any absence from work is minimized for the benefit of all concerned.

There is still further work to do to change attitudes to disability among employers and the public. Employers must be made aware of their duty not to discriminate and any benefits and support available to them as employers of persons with disabilities. Positive examples of persons with disabilities achieving success in the workplace should be promoted until their presence in the workplace becomes completely normalized.

### C. Income protection

Income protection serves two principal purposes for persons with disabilities. Firstly, it provides them with an income if they are unable to work due to their disability or perhaps because they are excluded from the labour market for other reasons. Secondly, as mentioned above, persons with disabilities incur costs associated with their disability. The national disability laws in the Caribbean do not address income protection. The Cayman Islands disability policy proposes to “review current...subsidies, grants and/or financial assistance to persons with disabilities.”

The English-speaking Caribbean countries<sup>10</sup> have pay-as-you-go (PAYGO)<sup>11</sup>, defined benefit<sup>12</sup> national insurance schemes (NIS) or social security schemes that all have a fairly similar design, having been influenced by the United Kingdom’s national insurance scheme. Workers pay contributions from their salary and in return may draw benefits in the event of old age, sickness, maternity, disability, industrial injury, death of a spouse etc. In the Caribbean, the schemes differ from country to country in respect of the proportion of the working age population that is covered by the scheme. In countries with higher levels of formal employment, a higher proportion of the working age population are contributing members of the scheme.

Caribbean national insurance schemes provide an earnings-related invalidity pension for working-age persons who are unable to work due to disability. The pension is payable for as long as the recipient is unable to work (perhaps permanently). To be eligible, workers must have contributed to the scheme for a minimum number of years, typically three years. The pension depends on the length of time that contributions were made. In most cases, persons who have contributed for 10 years are eligible to receive a pension worth about 30 per cent of insured earnings. There are some variations from country to country: someone unable to work after 10 years of contributions in Barbados would receive an invalidity pension based on 40 per cent of insured earnings while in Antigua and Barbuda it would be 25 per cent. Most schemes allow a maximum invalidity pension of 60 per cent of insured earnings. However, Belize allows a lower than normal maximum of 30 per cent (subject to a minimum weekly pension). Nevertheless, most invalidity pensions are paid at a lower than maximum rate since the maximum pension amount would require about 40 years of contributions.

<sup>10</sup> Prior to 2015, Suriname did not have a national insurance scheme/social security. The social security system is to be fully implemented by 2017 but is excluded from this analysis.

<sup>11</sup> PAYGO schemes use contributions from employers and employees to pay for the benefits of current retirees and beneficiaries

<sup>12</sup> Defined benefit plans use a formula to determine payouts which is based on employee’s pay, years of employment, age at retirement and other factors.

With the exception of persons in Antigua and Barbuda, schemes also insure separately against disablement in an accident at work or work-related illness. Unlike invalidity pension benefits, the disablement pension depends on the extent of the impairment rather than on the contribution record. Disabilities are assessed on a scale from 0 to 100 per cent with that percentage to a large extent determining the disablement pension. In addition to the disablement pension, an allowance ranging from 20 per cent to 50 per cent of the disablement pension in the various Caribbean countries is given to persons who need constant care (except in Jamaica and Saint Kitts and Nevis where persons may be reimbursed for “reasonable expenses”).

Table 10 indicates the average monthly invalidity pension and the average monthly disablement pension received by persons in various Caribbean countries. The average monthly pensions are highest in Bahamas and Barbados, in the region of US\$500 per month. In Antigua and Barbuda, Saint Kitts and Nevis, Saint Lucia and Trinidad and Tobago they are in the region of US\$200 to US\$300 per month and lower still in Guyana.

For the non-insured sector on the population (which in some countries is half or more of the population), income protection is much weaker. The Bahamas, Saint Kitts and Nevis and Trinidad and Tobago provide non-contributory pensions to adults of working age who are unable to work. They receive monthly pensions of around UD\$250 per month in Bahamas and Trinidad and Tobago. In Barbados something similar is provided to uninsured blind and deaf mute persons. In Antigua and Barbuda there is a food stamp-type programme (equivalent to around US\$200 per month) and in Saint Kitts and Nevis a pension of around US\$100 per month.

In other countries, where persons with disabilities do not have another form of income, they may receive some form of public assistance. Many countries still have some form of public assistance programme through which benefits are disbursed to individuals and families facing severe hardships. Public assistance programmes are intended to provide welfare of last resort. They do not provide pensions where there is an explicit right to a certain income for those who meet objective eligibility criteria. Rather, public assistance programs have a fixed budget that is not related to the needs of the population and this budget is disbursed using criteria which may be more or less objective. While these schemes target the poorest and most needy they tend not to reach everyone who is in need of assistance.

Caribbean national insurance schemes provide a good basic framework for income protection. Governments should continue to seek to improve coverage and the level of protection that they provide, to the extent that economic realities permit. In particular governments should seek to provide a minimum Social Protection Floor which protects the uninsured. As part of this floor, all countries should have a non-contributory pension for working age adults who are unable to work due to disabilities. Such pensions allow people, many with severe disabilities, to live with a minimum degree of independence and dignity.

**Table 10**  
**Contributory and non-contributory disability pensions**  
**in selected Caribbean countries, around 2015**

| Country             | Contributory   | Non-contributory   |
|---------------------|--|--|
| Antigua and Barbuda | Mean monthly invalidity pension: EC\$711.96 per month (2014) (US\$ 264 per month)<br>There is no separate industrial disablement pension.  | People's Benefit Programme: Persons can qualify for the enrolment in this programme by virtue of disability or economic disadvantage. Beneficiaries receive a special debit card for use at designated outlets. Value: EC\$215 per month (US\$79.60 per month) |
| Bahamas             | Mean monthly invalidity pension: B\$478 (US\$478 per month) (2,709 beneficiaries) (2015). Mean monthly industrial disablement pension: B\$633 (US\$633 per month) (856 beneficiaries) (2015) | Invalidity assistance: paid to persons aged between 16 and 65 years who are permanently unable to work, in need, and who do not qualify for contributory benefits. Value: B\$245.18 per month (US\$245.18 per month)   |

Table 10 (concluded)

| Country                          | Contributory   | Non-contributory  |
|----------------------------------|--|---|
|                                  |  | (2,680 beneficiaries)   |
| Barbados                         | Mean monthly invalidity pension: Bds\$1,042 (US\$521 per month) (3,486 beneficiaries) (2009)<br>Mean monthly industrial disablement pension: Bds\$929 (US\$465 per month) (473 beneficiaries) (2009) | Non-Contributory Old Age Pension is available to blind and deaf mute persons aged 18 with little or no income. Value: Bds\$598 per month (US\$299)  |
| Grenada                          | ..   | No minimum income protection; public assistance   |
| Guyana                           | Mean monthly invalidity pension: GY\$24,815 (US\$120 per month) (2013)<br>Mean monthly industrial disablement pension: GY\$8,335 (US\$41 per month) (2013)   | No minimum income protection; public assistance   |
| Jamaica                          | ..   | No minimum income protection; PATH programme  |
| Saint Kitts and Nevis            | Mean monthly invalidity pension: EC\$706 (US\$261 per month) (2010) (254 beneficiaries)<br>Mean monthly industrial disablement pension: EC\$609 (US\$226 per month) (53 beneficiaries)               | Invalidity Assistance: paid to persons aged of 16 and 62 years who are unable to work, are in need and who do not qualify for contributory benefits. Value: \$250 per month (US\$92.60) (147 beneficiaries, 2010) |
| Saint Lucia                      | Mean monthly invalidity pension: EC\$806 (US\$299 per month) (2013/14)<br>Mean monthly industrial disablement pension: EC\$634 (US\$235 per month) (2013/14)   | No minimum income protection; public assistance   |
| Saint Vincent and the Grenadines | ..   | No minimum income protection; public assistance   |
| Trinidad and Tobago              | Mean monthly invalidity pension: TT\$1,839 (2015/16) (US\$283 per month) (4,851 beneficiaries)<br>Mean monthly industrial disablement pension: not available   | Disability Assistance is a monthly payment provided to persons aged 18 and over who are unable to work. Value TT\$1,800 (US\$277) (approx. 20,000 beneficiaries)  |

Source: United Nations Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of information published by departments of social security.





## VI. Conclusions

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Caribbean governments have expressed strong political commitment to protecting the rights of persons with disabilities. Eleven of thirteen Caribbean member States have now ratified the United Nations Convention on the Rights of Persons with Disabilities. In the subsequent Declaration of Pétion-Ville (CARICOM, 2013), countries agreed to address with renewed dedication the development of legal frameworks at the national level to give effect to the commitments made in international and regional instruments to promote and protect the rights of persons with disabilities. Since the signing of the CRPD, four countries have now passed legislation designed to achieve this and are working to implement this legislation. In all countries, governments and non-governmental organizations are actively developing programmes and advocating on behalf of persons with disabilities.

There has also been real progress on the ground with social barriers and attitudes towards disability slowly changing. Persons with disabilities are now no longer kept behind closed doors and are a more visible part of Caribbean society. There are signs of this progress in the form of ramps outside buildings; specialized transport services on the streets; and the presence of some children with disabilities in mainstream schools. Persons with disabilities now have a better chance of being integrated into society and having their rights protected. This progress is to a very large extent a product of persistent lobbying, campaigning and patient advocacy by organizations of disabled persons.

However, despite this progress, it is abundantly clear that as in all regions, discrimination and barriers to equal participation are deeply entrenched and are not overcome overnight or even in the course of a few years. The physical environment, the social environment and, above all, attitudes, still discriminate against persons with disabilities, placing obstacles in their way and often preventing them from fulfilling their potential. If the human rights of persons with disabilities are to be realized in full, it is abundantly clear that much remains to be done.

Accessibility of the built environment, public spaces, and transport systems are especially impactful on the extent to which persons with disabilities can participate in their communities and live with autonomy and independence. Even other disability programmes and services are undermined if people cannot travel to access them and are left isolated from community life. Renewed efforts are needed to make the built environment, public spaces, and transportation more accessible.

Education for All is crucial to achieving the change in attitudes and behaviours which will ultimately lead to the creation of inclusive societies. Children with disabilities must be able to participate equally in education systems which fully realize and embody concepts such as accessibility, reasonable accommodation and adaption of the environment to facilitate the exercise of rights. If education systems continue to segregate and discriminate, future generations will continue to reproduce the same attitudes and behaviours which prevent the equal enjoyment of rights by persons with disabilities.

Work is fundamental to achieving independence, autonomy and an adequate standard of living. In order for all persons with disabilities to be able to enjoy these rights, employers have a particular responsibility to more willingly accept persons with disabilities into the workplace. With policies such as quotas in large organizations, fairness in recruitment and hiring, and reasonable adjustments to support them, persons with disabilities can succeed in the workplace.

Governments should be aware of the connections between population ageing and the consequent increase in the number of persons who will suffer from non-communicable diseases (NCDs), and the implications of these trends for the prevalence of disability among the population. Policies to promote healthy lifestyles in order to prevent NCDs as well as effective care and treatment will be essential to at least limit increases in the incidence of these diseases, and the number of persons who become disabled in old age. Every NCD and every disability which can be prevented contributes to the health and well-being of the population (and the workforce) while helping to control future health and social care costs.

Caribbean population and housing censuses are (and will remain) the primary source of statistical information about disability. This study has made clear that there are differences in the census questions used in each country which introduce serious problems of between-country comparability with regard to the statistical information on disability. Census questionnaires are coordinated through the regional census programme coordinated by CARICOM. In the preparation of the questionnaires for the 2020 census round, particular attention should be paid to improving comparability of the information on disability.

Countries still to ratify the CRPD should do so as soon as possible. In addition, countries should also consider signing the Optional Protocol in order to provide citizens with an individual complaints mechanism. In the case of many countries, reports to the Committee on the Rights of Persons with Disabilities on the implementation of the treaty are now due. Member States should accord high priority to the national review process. An inclusive review process, involving disabled persons organizations and a wide range of stakeholders should serve as an opportunity for national dialogue, and a valuable review and feedback mechanism to support and guide further implementation.

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## **Annex**

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## Statistical Tables

**Table A.1**  
**Prevalence of disability by sex, 2000 and 2010**  
*(Percentage of persons with one or more disabilities)*

|                                  |      | Male | Female | All persons |
|----------------------------------|------|------|--------|-------------|
| 2000 round                       |      |      |        |             |
| Antigua and Barbuda              | 2001 | 4.4  | 5.7    | 5.1         |
| Aruba                            | 2000 | 5.8  | 5.4    | 5.6         |
| Bahamas                          | 2000 | 4.1  | 4.5    | 4.3         |
| Barbados                         | 2000 | 3.8  | 4.2    | 4.0         |
| Belize                           | 2000 | 6.0  | 5.9    | 5.9         |
| Bermuda                          | 2000 | 4.2  | 4.9    | 4.6         |
| British Virgin Islands           | 2001 | 4.8  | 4.8    | 4.8         |
| Dominica                         | 2001 | 4.2  | 4.1    | 4.1         |
| Grenada                          | 2001 | 4.1  | 4.7    | 4.4         |
| Guyana                           | 2002 | 6.3  | 6.6    | 6.4         |
| Jamaica                          | 2001 | 6.2  | 6.3    | 6.3         |
| Montserrat                       | 2001 | 5.8  | 4.9    | 5.4         |
| Saint Lucia                      | 2001 | 4.7  | 5.1    | 4.9         |
| Saint Vincent and the Grenadines | 2001 | 4.3  | 4.6    | 4.4         |
| Trinidad and Tobago              | 2000 | 4.0  | 4.2    | 4.1         |
| Caribbean                        | 2000 | 5.4  | 5.5    | 5.4         |
| 2010 round                       |      |      |        |             |
| Antigua and Barbuda              | 2011 | 2.1  | 2.9    | 2.5         |
| Aruba <sup>a</sup>               | 2010 | 6.6  | 8.0    | 7.3         |
| Bahamas                          | 2010 | 3.1  | 2.7    | 2.9         |
| Barbados                         | 2010 | 4.8  | 5.8    | 5.3         |
| Belize <sup>a</sup>              | 2010 | 3.2  | 3.4    | 3.3         |
| Bermuda                          | 2010 | 4.7  | 5.2    | 5.0         |
| Cayman Islands                   | 2010 | 4.3  | 4.7    | 4.5         |
| Grenada                          | 2011 | 3.3  | 5.1    | 4.2         |
| Guyana                           | 2012 | 2.9  | 3.0    | 3.0         |
| Jamaica <sup>a</sup>             | 2011 | 2.6  | 3.4    | 3.0         |
| Montserrat                       | 2011 | 6.0  | 5.4    | 5.7         |
| Saint Lucia                      | 2010 | ..   | ..     | ..          |
| Trinidad and Tobago              | 2011 | 4.2  | 4.3    | 4.3         |
| Caribbean                        | 2010 | 3.3  | 3.7    | 3.5         |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

<sup>a</sup>Estimates for Aruba (2010), Belize (2010), and Jamaica (2011) are based on persons aged 5 and over.

**Table A.2**  
**Prevalence of disability by age (all persons), 2000 and 2010**  
*(Percentage of persons with one or more disability)*

|                                     |      | 0-4 | 5-12 | 13-19 | 20-39 | 40-59 | 60+  | All ages |
|-------------------------------------|------|-----|------|-------|-------|-------|------|----------|
| 2000 round                          |      |     |      |       |       |       |      |          |
| Antigua and Barbuda                 | 2001 | 0.7 | 1.7  | 2.7   | 2.9   | 7.0   | 22.0 | 5.1      |
| Aruba <sup>b</sup>                  | 2000 | 1.9 | 3.5  | 3.5   | 3.4   | 6.3   | 16.8 | 5.6      |
| Bahamas <sup>b</sup>                | 2000 | 0.9 | 2.0  | 2.0   | 2.8   | 5.7   | 20.3 | 4.3      |
| Barbados                            | 2000 | 0.7 | 1.6  | 1.7   | 2.1   | 3.9   | 13.3 | 4.0      |
| Belize                              | 2000 | 2.5 | 2.3  | 2.6   | 3.8   | 10.4  | 25.1 | 5.9      |
| Bermuda <sup>b</sup>                | 2000 | 0.8 | 2.3  | 2.3   | 2.4   | 4.6   | 13.3 | 4.6      |
| British Virgin Islands <sup>c</sup> | 2001 | 3.3 | 3.4  | 2.5   | 3.8   | 5.1   | 14.9 | 4.8      |
| Dominica <sup>d</sup>               | 2001 | 1.2 | 1.2  | 1.9   | 2.9   | 5.2   | 17.9 | 4.1      |
| Grenada                             | 2001 | 0.8 | 1.3  | 2.0   | 2.8   | 5.5   | 16.5 | 4.4      |
| Guyana <sup>c</sup>                 | 2002 | 1.6 | 2.5  | 2.7   | 3.9   | 10.3  | 38.5 | 6.4      |
| Jamaica <sup>d</sup>                | 2001 | 3.8 | 3.8  | 4.4   | 5.3   | 8.6   | 20.5 | 6.3      |
| Montserrat <sup>b</sup>             | 2001 | 0.0 | 1.6  | 1.6   | 2.7   | 5.0   | 17.4 | 5.4      |
| Saint Lucia                         | 2001 | 1.5 | 2.3  | 2.6   | 3.0   | 6.2   | ..   | 4.9      |
| Saint Vincent and the Grenadines    | 2001 | 0.7 | 2.0  | 2.4   | 2.9   | 6.0   | 17.6 | 4.4      |
| Trinidad and Tobago                 | 2000 | 0.6 | 1.4  | 1.8   | 2.4   | 5.4   | 16.7 | 4.1      |
| Caribbean                           | 2000 | 2.4 | 2.7  | 3.2   | 3.9   | 7.1   | 19.0 | 5.4      |
| 2010 round                          |      |     |      |       |       |       |      |          |
| Antigua and Barbuda                 | 2011 | 1.0 | 0.5  | 0.7   | 1.0   | 2.3   | 12.8 | 2.5      |
| Aruba <sup>a</sup>                  | 2010 | ..  | 1.9  | 2.5   | 3.1   | 6.7   | 22.5 | 7.3      |
| Bahamas                             | 2010 | 0.7 | 1.2  | 1.5   | 1.8   | 3.5   | 11.7 | 2.9      |
| Barbados                            | 2010 | 0.9 | 1.7  | 1.9   | 2.1   | 4.5   | 17.2 | 5.3      |
| Belize <sup>a</sup>                 | 2010 | ..  | 1.7  | 1.3   | 1.6   | 4.7   | 17.5 | 3.3      |
| Bermuda                             | 2010 | 0.8 | 2.3  | 2.6   | 2.6   | 4.7   | 12.0 | 5.0      |
| Cayman Islands                      | 2010 | 1.3 | 3.3  | 3.4   | 2.3   | 4.4   | 19.2 | 4.5      |
| Grenada                             | 2011 | 1.5 | 0.8  | 1.0   | 1.4   | 3.9   | 18.2 | 4.2      |
| Guyana                              | 2012 | 0.6 | 1.0  | 1.2   | 1.6   | 4.7   | 13.9 | 3.0      |
| Jamaica <sup>a</sup>                | 2011 | ..  | 0.8  | 0.9   | 1.2   | 3.0   | 15.2 | 3.0      |
| Montserrat                          | 2011 | 0.0 | 0.4  | 1.5   | 1.4   | 5.2   | 19.7 | 5.7      |
| Saint Lucia                         | 2010 | ..  | ..   | ..    | ..    | ..    | ..   | ..       |
| Trinidad and Tobago                 | 2011 | 0.5 | 1.2  | 1.5   | 2.2   | 5.4   | 13.7 | 4.3      |
| Caribbean                           | 2010 | 0.7 | 1.1  | 1.2   | 1.6   | 4.1   | 14.9 | 3.5      |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

<sup>a</sup>Estimates for Aruba (2010), Belize (2010), and Jamaica (2011) are based on persons aged 5 and over.

<sup>b</sup>Estimates for 5-12 and 13-19 years olds for Aruba (2000), Bahamas (2000), Bermuda (2000), and Montserrat (2001) are single estimates for the age range 5-19 years.

<sup>c</sup>Estimates for British Virgin Islands (2001) and Guyana (2002) are for the age groups 5-14 years and 15-19 years.

<sup>d</sup>Estimates for Dominica (2001) and Jamaica (2001) correspond to the age groups 0-14, 15-24, 25-44, 45-64, and 65+.

**Table A.3**  
**Prevalence of disability by age (males), 2000 and 2010**  
*(Percentage of persons with one or more disabilities)*

|                                     |      | 0-4 | 5-12 | 13-19 | 20-39 | 40-59 | 60+  | All ages |
|-------------------------------------|------|-----|------|-------|-------|-------|------|----------|
| 2000 round                          |      |     |      |       |       |       |      |          |
| Antigua and Barbuda                 | 2001 | 0.6 | 1.8  | 2.5   | 2.7   | 5.6   | 20.0 | 4.4      |
| Aruba <sup>b</sup>                  | 2000 | 2.2 | 4.0  | 4.0   | 3.9   | 6.8   | 16.3 | 5.8      |
| Bahamas <sup>b</sup>                | 2000 | 1.1 | 2.2  | 2.2   | 3.1   | 5.2   | 17.6 | 4.1      |
| Barbados                            | 2000 | 0.8 | 1.8  | 2.0   | 2.2   | 3.9   | 12.7 | 3.8      |
| Belize                              | 2000 | 2.5 | 2.5  | 2.7   | 4.2   | 10.1  | 23.7 | 6.0      |
| Bermuda <sup>b</sup>                | 2000 | 1.0 | 2.5  | 2.5   | 2.3   | 4.3   | 12.8 | 4.2      |
| British Virgin Islands <sup>c</sup> | 2001 | 2.8 | 4.4  | 2.0   | 3.6   | 5.4   | 13.4 | 4.8      |
| Dominica <sup>d</sup>               | 2001 | 1.4 | 1.4  | 2.4   | 3.3   | 5.8   | 17.2 | 4.2      |
| Grenada                             | 2001 | 0.7 | 1.4  | 2.0   | 2.9   | 5.4   | 14.9 | 4.1      |
| Guyana <sup>c</sup>                 | 2002 | 1.9 | 2.6  | 2.7   | 4.2   | 10.3  | 36.2 | 6.3      |
| Jamaica <sup>d</sup>                | 2001 | 3.9 | 3.9  | 4.6   | 5.7   | 8.4   | 19.4 | 6.2      |
| Montserrat <sup>b</sup>             | 2001 | 0.0 | 1.7  | 1.7   | 2.7   | 6.1   | 18.2 | 5.8      |
| Saint Lucia                         | 2001 | 1.4 | 2.6  | 2.5   | 3.1   | 6.0   | 17.5 | 4.7      |
| Saint Vincent and the Grenadines    | 2001 | 0.8 | 2.2  | 2.5   | 3.2   | 6.0   | 15.7 | 4.3      |
| Trinidad and Tobago                 | 2000 | 0.7 | 1.5  | 1.9   | 2.6   | 5.4   | 15.6 | 4.0      |
| Caribbean                           | 2000 | 2.6 | 2.9  | 3.3   | 4.2   | 7.0   | 18.0 | 5.4      |
| 2010 round                          |      |     |      |       |       |       |      |          |
| Antigua and Barbuda                 | 2011 | 0.9 | 0.6  | 0.6   | 1.1   | 1.9   | 10.6 | 2.1      |
| Aruba <sup>a</sup>                  | 2010 | ..  | 2.3  | 2.3   | 3.1   | 6.4   | 19.9 | 6.6      |
| Bahamas                             | 2010 | 1.0 | 1.4  | 1.9   | 2.2   | 3.9   | 11.1 | 3.1      |
| Barbados                            | 2010 | 1.1 | 2.0  | 2.3   | 2.5   | 4.6   | 14.4 | 4.8      |
| Belize <sup>a</sup>                 | 2010 | ..  | 1.8  | 1.4   | 1.8   | 4.3   | 15.5 | 3.2      |
| Bermuda                             | 2010 | 0.8 | 2.8  | 2.8   | 2.7   | 4.5   | 11.5 | 4.7      |
| Cayman Islands                      | 2010 | 1.5 | 4.4  | 3.9   | 2.3   | 4.2   | 16.4 | 4.3      |
| Grenada                             | 2011 | 1.6 | 0.8  | 0.9   | 1.5   | 3.0   | 14.4 | 3.3      |
| Guyana                              | 2012 | 0.6 | 1.0  | 1.3   | 1.8   | 4.7   | 12.9 | 2.9      |
| Jamaica <sup>a</sup>                | 2011 | ..  | 0.9  | 0.9   | 1.3   | 2.6   | 12.8 | 2.6      |
| Montserrat                          | 2011 | 0.0 | 0.0  | 2.0   | 2.3   | 6.5   | 17.5 | 6.0      |
| Saint Lucia                         | 2010 | ..  | ..   | ..    | ..    | ..    | ..   | ..       |
| Trinidad and Tobago                 | 2011 | 0.7 | 1.3  | 1.6   | 2.5   | 5.6   | 12.8 | 4.2      |
| Caribbean                           | 2010 | 0.8 | 1.2  | 1.3   | 1.8   | 4.0   | 13.1 | 3.3      |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

<sup>a</sup>Estimates for Aruba (2010), Belize (2010), and Jamaica (2011) are based on persons aged 5 and over.

<sup>b</sup>Estimates for 5-12 and 13-19 years olds for Aruba (2000), Bahamas (2000), Bermuda (2000), and Montserrat (2001) are single estimates for the age range 5-19 years.

<sup>c</sup>Estimates for British Virgin Islands (2001) and Guyana (2002) are for the age groups 5-14 years and 15-19 years.

<sup>d</sup>Estimates for Dominica (2001) and Jamaica (2001) correspond to the age groups 0-14, 15-24, 25-44, 45-64, and 65+.

**Table A.4**  
**Prevalence of disability by age (females), 2000 and 2010**  
*(Percentage of persons with one or more disabilities)*

|                                     |      | 0-4 | 5-12 | 13-19 | 20-39 | 40-59 | 60+  | All ages |
|-------------------------------------|------|-----|------|-------|-------|-------|------|----------|
| 2000 round                          |      |     |      |       |       |       |      |          |
| Antigua and Barbuda                 | 2001 | 0.8 | 1.6  | 2.9   | 3.0   | 8.1   | 23.6 | 5.7      |
| Aruba <sup>b</sup>                  | 2000 | 1.5 | 3.0  | 3.0   | 2.9   | 5.8   | 17.1 | 5.4      |
| Bahamas <sup>b</sup>                | 2000 | 0.7 | 1.7  | 1.7   | 2.5   | 6.2   | 22.5 | 4.5      |
| Barbados                            | 2000 | 0.6 | 1.3  | 1.5   | 2.0   | 3.9   | 13.7 | 4.2      |
| Belize                              | 2000 | 2.5 | 2.1  | 2.5   | 3.4   | 10.7  | 26.5 | 5.9      |
| Bermuda <sup>b</sup>                | 2000 | 0.7 | 2.1  | 2.1   | 2.5   | 4.8   | 13.7 | 4.9      |
| British Virgin Islands <sup>c</sup> | 2001 | 3.8 | 2.5  | 2.9   | 3.9   | 4.8   | 16.5 | 4.8      |
| Dominica <sup>d</sup>               | 2001 | 0.9 | 0.9  | 1.4   | 2.5   | 4.7   | 18.5 | 4.1      |
| Grenada                             | 2001 | 0.9 | 1.2  | 2.1   | 2.6   | 5.6   | 17.7 | 4.7      |
| Guyana <sup>c</sup>                 | 2002 | 1.3 | 2.4  | 2.6   | 3.6   | 10.3  | 40.5 | 6.6      |
| Jamaica <sup>d</sup>                | 2001 | 3.7 | 3.7  | 4.2   | 5.0   | 8.8   | 21.3 | 6.3      |
| Montserrat <sup>b</sup>             | 2001 | 0.0 | 1.5  | 1.5   | 2.7   | 3.6   | 16.5 | 4.9      |
| Saint Lucia                         | 2001 | 1.5 | 2.0  | 2.7   | 2.9   | 6.3   | ..   | 5.1      |
| Saint Vincent and the Grenadines    | 2001 | 0.7 | 1.8  | 2.2   | 2.5   | 6.1   | 19.2 | 4.6      |
| Trinidad and Tobago                 | 2000 | 0.6 | 1.2  | 1.7   | 2.1   | 5.4   | 17.7 | 4.2      |
| Caribbean                           | 2000 | 2.3 | 2.6  | 3.0   | 3.7   | 7.2   | 19.9 | 5.5      |
| 2010 round                          |      |     |      |       |       |       |      |          |
| Antigua and Barbuda                 | 2011 | 1.1 | 0.3  | 0.7   | 0.9   | 2.6   | 14.6 | 2.9      |
| Aruba <sup>a</sup>                  | 2010 | ..  | 1.5  | 2.6   | 3.1   | 7.0   | 24.5 | 8.0      |
| Bahamas                             | 2010 | 0.4 | 1.0  | 1.2   | 1.3   | 3.2   | 12.2 | 2.7      |
| Barbados                            | 2010 | 0.7 | 1.5  | 1.6   | 1.8   | 4.5   | 19.3 | 5.8      |
| Belize <sup>a</sup>                 | 2010 | ..  | 1.6  | 1.3   | 1.4   | 5.2   | 19.7 | 3.4      |
| Bermuda                             | 2010 | 0.7 | 1.9  | 2.4   | 2.4   | 4.9   | 12.4 | 5.2      |
| Cayman Islands                      | 2010 | 1.0 | 2.3  | 3.0   | 2.3   | 4.6   | 21.8 | 4.7      |
| Grenada                             | 2011 | 1.5 | 0.9  | 1.1   | 1.4   | 4.8   | 21.5 | 5.1      |
| Guyana                              | 2012 | 0.5 | 0.9  | 1.2   | 1.5   | 4.6   | 14.7 | 3.0      |
| Jamaica <sup>a</sup>                | 2011 | ..  | 0.7  | 0.9   | 1.2   | 3.4   | 17.3 | 3.4      |
| Montserrat                          | 2011 | 0.0 | 0.8  | 1.0   | 0.5   | 3.9   | 22.1 | 5.4      |
| Saint Lucia                         | 2010 | ..  | ..   | ..    | ..    | ..    | ..   | ..       |
| Trinidad and Tobago                 | 2011 | 0.4 | 1.0  | 1.4   | 1.9   | 5.2   | 14.5 | 4.3      |
| Caribbean                           | 2010 | 0.5 | 0.9  | 1.1   | 1.5   | 4.2   | 16.5 | 3.7      |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

<sup>a</sup>Estimates for Aruba (2010), Belize (2010), and Jamaica (2011) are based on persons aged 5 and over.

<sup>b</sup>Estimates for 5-12 and 13-19 years olds for Aruba (2000), Bahamas (2000), Bermuda (2000), and Montserrat (2001) are single estimates for the age range 5-19 years.

<sup>c</sup>Estimates for British Virgin Islands (2001) and Guyana (2002) are for the age groups 5-14 years and 15-19 years.

<sup>d</sup>Estimates for Dominica (2001) and Jamaica (2001) correspond to the age groups 0-14, 15-24, 25-44, 45-64, and 65+.

**Table A.5**  
**Prevalence of disability by type (all persons), 2000 and 2010**  
*(Number of persons with disabilities per thousand)*

|                                  |      | Seeing | Hearing | Speaking    | Learning                | Behaviour | Mobility | Upper limb |
|----------------------------------|------|--------|---------|-------------|-------------------------|-----------|----------|------------|
| 2000 round                       |      |        |         |             |                         |           |          |            |
| Antigua and Barbuda              | 2001 | 28     | 4       | 3           | 2                       | 3         | 5        | 12         |
| Aruba                            | 2000 | 11     | 8       | ..          | 33                      | 11        | ..       | ..         |
| Bahamas <sup>a</sup>             | 2000 | 8      | 3       | 4           | 4                       | 4         | 13       | 4          |
| Barbados                         | 2000 | 10     | 5       | 2           | 3                       | 4         | 8        | 3          |
| Belize                           | 2000 | 30     | 11      | 7           | 6                       | 4         | 18       | 7          |
| Bermuda                          | 2000 | 4      | 3       | 2           | 3                       | 12        | 11       | 3          |
| British Virgin Islands           | 2001 | 8      | 5       | 5           | 5                       | 5         | 8        | 5          |
| Dominica                         | 2001 | 11     | 5       | 7           | 4                       | 8         | 16       | 2          |
| Grenada                          | 2001 | 14     | 4       | 4           | 3                       | 6         | 13       | 4          |
| Guyana                           | 2002 | 19     | 6       | 5           | 3                       | 5         | 11       | 4          |
| Jamaica                          | 2001 | 9      | 3       | 1           | 3                       | 3         | 6        | ..         |
| Montserrat                       | 2001 | 13     | 2       | 4           | 7                       | 11        | 21       | 1          |
| Saint Lucia                      | 2001 | 14     | 4       | 4           | 4                       | 5         | 15       | 6          |
| Saint Vincent and the Grenadines | 2001 | 17     | 4       | 5           | 4                       | 7         | 13       | 4          |
| Trinidad and Tobago              | 2000 | 17     | 5       | 3           | 3                       | 3         | 11       | 2          |
| Caribbean                        | 2000 | 13     | 4       | 3           | 4                       | 4         | 9        | 4          |
|                                  |      | Seeing | Hearing | Communicate | Remember or concentrate | Self-care | Walking  | Upper body |
| 2010 round                       |      |        |         |             |                         |           |          |            |
| Antigua and Barbuda              | 2011 | 10     | 3       | 3           | 4                       | 5         | 12       | 3          |
| Aruba                            | 2010 | 31     | 13      | 11          | 14                      | 10        | 29       | ..         |
| Bahamas                          | 2010 | 3      | 2       | 1           | 2                       | ..        | 4        | 1          |
| Barbados                         | 2010 | 9      | 5       | 2           | 8                       | 3         | 23       | 16         |
| Belize <sup>b</sup>              | 2010 | 13     | 5       | 4           | 5                       | 5         | 11       | 5          |
| Bermuda                          | 2010 | 15     | 3       | 3           | 4                       | 10        | 7        | 2          |
| Cayman Islands                   | 2010 | 15     | 5       | 2           | ..                      | ..        | 10       | 4          |
| Grenada                          | 2011 | 18     | 5       | 6           | 8                       | 8         | 21       | 6          |
| Guyana                           | 2012 | 12     | 4       | 4           | 5                       | ..        | 10       | 5          |
| Jamaica <sup>b</sup>             | 2011 | 14     | 5       | 4           | 6                       | 7         | 12       | 11         |
| Montserrat                       | 2011 | 22     | 5       | 5           | 7                       | ..        | 28       | 6          |
| Saint Lucia                      | 2010 | 13     | 4       | 6           | 4                       | 8         | 17       | 5          |
| Trinidad and Tobago              | 2011 | 16     | 5       | 8           | 6                       | 8         | 18       | 4          |
| Caribbean                        | 2010 | 13     | 5       | 5           | 6                       | 7         | 14       | 8          |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

<sup>a</sup> For the Bahamas (2000), the data corresponds to the category “mobility/moving (due to absent or impaled limb)” and “mobility/moving (due to localized paraplegic, quadriplegic paralysis)”.

<sup>b</sup> Estimates for Belize (2010) and Jamaica (2011) are based on persons aged 5 and over.

**Table A.6**  
**Prevalence of disability by type (males), 2000 and 2010**  
*(Number of persons with disabilities per thousand)*

|                                  |      | Seeing | Hearing | Speaking    | Learning                | Behaviour | Mobility | Upper limb |
|----------------------------------|------|--------|---------|-------------|-------------------------|-----------|----------|------------|
| 2000 round                       |      |        |         |             |                         |           |          |            |
| Antigua and Barbuda              | 2001 | 21     | 5       | 3           | 2                       | 3         | 5        | 12         |
| Aruba                            | 2000 | 11     | 8       | ..          | 31                      | 12        | ..       | ..         |
| Bahamas <sup>a</sup>             | 2000 | 6      | 3       | 4           | 5                       | 4         | 12       | 3          |
| Barbados                         | 2000 | 9      | 4       | 2           | 4                       | 5         | 7        | 2          |
| Belize                           | 2000 | 28     | 13      | 8           | 7                       | 5         | 16       | 7          |
| Bermuda                          | 2000 | 3      | 3       | 2           | 3                       | 11        | 10       | 4          |
| British Virgin Islands           | 2001 | 8      | 6       | 5           | 5                       | 5         | 8        | 5          |
| Dominica                         | 2001 | 10     | 5       | 8           | 4                       | 10        | 15       | 2          |
| Grenada                          | 2001 | 12     | 4       | 4           | 4                       | 7         | 11       | 3          |
| Guyana                           | 2002 | 17     | 6       | 5           | 3                       | 6         | 11       | 4          |
| Jamaica                          | 2001 | 7      | 2       | 1           | 3                       | 3         | 6        | ..         |
| Montserrat                       | 2001 | 14     | 2       | 5           | 8                       | 11        | 23       | 1          |
| Saint Lucia                      | 2001 | 13     | 4       | 5           | 4                       | 5         | 14       | 6          |
| Saint Vincent and the Grenadines | 2001 | 13     | 4       | 5           | 4                       | 9         | 12       | 4          |
| Trinidad and Tobago              | 2000 | 14     | 5       | 4           | 3                       | 4         | 11       | 2          |
| Caribbean                        | 2000 | 11     | 4       | 3           | 4                       | 4         | 9        | 4          |
|                                  |      | Seeing | Hearing | Communicate | Remember or concentrate | Self-care | Walking  | Upper body |
| 2010 round                       |      |        |         |             |                         |           |          |            |
| Antigua and Barbuda              | 2011 | 8      | 3       | 4           | 3                       | 4         | 9        | 2          |
| Aruba                            | 2010 | 26     | 14      | 11          | 13                      | 9         | 22       | ..         |
| Bahamas                          | 2010 | 4      | 2       | 1           | 2                       | ..        | 4        | 1          |
| Barbados                         | 2010 | 8      | 5       | 3           | 10                      | 3         | 16       | 9          |
| Belize <sup>b</sup>              | 2010 | 12     | 5       | 5           | 5                       | 5         | 9        | 5          |
| Bermuda                          | 2010 | 12     | 3       | 2           | 5                       | 8         | 7        | 1          |
| Cayman Islands                   | 2010 | 13     | 5       | 3           | ..                      | ..        | 8        | 3          |
| Grenada                          | 2011 | 13     | 5       | 6           | 6                       | 7         | 15       | 5          |
| Guyana                           | 2012 | 10     | 4       | 4           | 5                       | ..        | 10       | 5          |
| Jamaica <sup>b</sup>             | 2011 | 11     | 4       | 5           | 5                       | 6         | 10       | 9          |
| Montserrat                       | 2011 | 17     | 5       | 6           | 5                       | ..        | 25       | 8          |
| Saint Lucia                      | 2010 | 11     | 4       | 6           | 4                       | 8         | 14       | 5          |
| Trinidad and Tobago              | 2011 | 14     | 5       | 9           | 6                       | 7         | 18       | 5          |
| Caribbean                        | 2010 | 11     | 4       | 5           | 6                       | 6         | 12       | 7          |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

<sup>a</sup> For the Bahamas (2000), the data corresponds to the category “mobility/moving (due to absent or impaled limb)” and “mobility/moving (due to localized paraplegic, quadriplegic paralysis)”.

<sup>b</sup> Estimates for Belize (2010) and Jamaica (2011) are based on persons aged 5 and over.

**Table A.7**  
**Prevalence of disability by type (females), 2000 and 2010**  
*(Number of persons with disabilities per thousand)*

|                                  |      | Seeing | Hearing | Speaking    | Learning                | Behaviour | Mobility | Upper limb |
|----------------------------------|------|--------|---------|-------------|-------------------------|-----------|----------|------------|
| 2000 round                       |      |        |         |             |                         |           |          |            |
| Antigua and Barbuda              | 2001 | 35     | 4       | 3           | 1                       | 2         | 5        | 13         |
| Aruba                            | 2000 | 12     | 7       | ..          | 35                      | 10        | ..       | ..         |
| Bahamas <sup>a</sup>             | 2000 | 9      | 3       | 4           | 3                       | 3         | 14       | 5          |
| Barbados                         | 2000 | 11     | 6       | 2           | 3                       | 4         | 10       | 3          |
| Belize                           | 2000 | 31     | 10      | 6           | 6                       | 4         | 20       | 8          |
| Bermuda                          | 2000 | 4      | 3       | 1           | 2                       | 13        | 11       | 3          |
| British Virgin Islands           | 2001 | 8      | 5       | 4           | 6                       | 4         | 9        | 5          |
| Dominica                         | 2001 | 12     | 5       | 6           | 3                       | 6         | 18       | 2          |
| Grenada                          | 2001 | 17     | 5       | 3           | 3                       | 5         | 16       | 5          |
| Guyana                           | 2002 | 22     | 6       | 5           | 3                       | 5         | 10       | 4          |
| Jamaica                          | 2001 | 10     | 3       | 1           | 2                       | 2         | 5        | ..         |
| Montserrat                       | 2001 | 13     | 3       | 3           | 6                       | 11        | 18       | 2          |
| Saint Lucia                      | 2001 | 16     | 4       | 4           | 4                       | 5         | 16       | 7          |
| Saint Vincent and the Grenadines | 2001 | 21     | 4       | 4           | 4                       | 6         | 14       | 4          |
| Trinidad and Tobago              | 2000 | 19     | 5       | 3           | 2                       | 3         | 12       | 2          |
| Caribbean                        | 2000 | 14     | 4       | 2           | 3                       | 3         | 9        | 4          |
|                                  |      | Seeing | Hearing | Communicate | Remember or concentrate | Self-care | Walking  | Upper body |
| 2010 round                       |      |        |         |             |                         |           |          |            |
| Antigua and Barbuda              | 2011 | 12     | 3       | 3           | 5                       | 5         | 14       | 3          |
| Aruba                            | 2010 | 35     | 12      | 10          | 15                      | 12        | 35       | ..         |
| Bahamas                          | 2010 | 3      | 2       | 1           | 2                       | ..        | 4        | 1          |
| Barbados                         | 2010 | 9      | 5       | 2           | 6                       | 4         | 30       | 22         |
| Belize <sup>b</sup>              | 2010 | 13     | 4       | 4           | 5                       | 5         | 13       | 5          |
| Bermuda                          | 2010 | 17     | 4       | 4           | 3                       | 12        | 9        | 2          |
| Cayman Islands                   | 2010 | 17     | 5       | 2           | ..                      | ..        | 12       | 4          |
| Grenada                          | 2011 | 23     | 6       | 6           | 9                       | 9         | 26       | 7          |
| Guyana                           | 2012 | 13     | 4       | 3           | 5                       | ..        | 10       | 5          |
| Jamaica <sup>b</sup>             | 2011 | 17     | 5       | 4           | 6                       | 7         | 14       | 13         |
| Montserrat                       | 2011 | 27     | 5       | 4           | 8                       | ..        | 32       | 4          |
| Saint Lucia                      | 2010 | 15     | 4       | 5           | 4                       | 9         | 20       | 6          |
| Trinidad and Tobago              | 2011 | 18     | 5       | 7           | 6                       | 8         | 19       | 3          |
| Caribbean                        | 2010 | 15     | 5       | 4           | 6                       | 7         | 15       | 9          |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

<sup>a</sup> For the Bahamas (2000), the data corresponds to the category “mobility/moving (due to absent or impaled limb)” and “mobility/moving (due to localized paraplegic, quadriplegic paralysis)”.

<sup>b</sup> Estimates for Belize (2010) and Jamaica (2011) are based on persons aged 5 and over.

**Table A.8**  
**Prevalence of disability by type and age, 2000 census round**  
*(Number of persons with disabilities per thousand)*

|                          | ATG | ABW <sup>a</sup> | BHS <sup>a</sup> | BRB | BLZ | BMU | VGB <sup>a</sup> | DMA <sup>a</sup> | GRD | GUY <sup>a</sup> | JAM <sup>b</sup> | MSR <sup>a</sup> | LCA | VCT | TTO | Caribbean |
|--------------------------|-----|------------------|------------------|-----|-----|-----|------------------|------------------|-----|------------------|------------------|------------------|-----|-----|-----|-----------|
| Visual impairment        |     |                  |                  |     |     |     |                  |                  |     |                  |                  |                  |     |     |     |           |
| 0-4                      | 2   | 1                | 1                | 1   | 2   | 1   | 4                | 0                | 1   | 3                | 2                | 0                | 1   | 2   | 1   | 2         |
| 5-12                     | 5   | 4                | 3                | 1   | 7   | 1   | 4                | 2                | 3   | 5                | 2                | 3                | 5   | 6   | 3   | 3         |
| 13-19                    | 13  | 4                | 3                | 2   | 11  | 1   | 4                | 2                | 4   | 5                | 2                | 3                | 6   | 7   | 5   | 4         |
| 20-39                    | 16  | 5                | 4                | 2   | 17  | 1   | 4                | 2                | 5   | 10               | 4                | 3                | 5   | 6   | 6   | 5         |
| 40-59                    | 41  | 12               | 10               | 7   | 65  | 2   | 6                | 9                | 16  | 38               | 16               | 6                | 15  | 22  | 24  | 19        |
| 60+                      | 126 | 50               | 47               | 46  | 147 | 16  | 48               | 61               | 72  | 120              | 58               | 59               | 128 | 92  | 83  | 69        |
| All ages                 | 28  | 11               | 8                | 10  | 30  | 4   | 8                | 11               | 14  | 19               | 9                | 13               | 14  | 17  | 17  | 13        |
| Hearing impairment       |     |                  |                  |     |     |     |                  |                  |     |                  |                  |                  |     |     |     |           |
| 0-4                      | 0   | 0                | 1                | 0   | 2   | 1   | 3                | 1                | 1   | 1                | 1                | 0                | 1   | 1   | 0   | 1         |
| 5-12                     | 2   | 4                | 2                | 2   | 5   | 1   | 3                | 3                | 1   | 3                | 1                | 1                | 2   | 2   | 2   | 2         |
| 13-19                    | 1   | 4                | 2                | 2   | 4   | 1   | 3                | 3                | 4   | 3                | 1                | 1                | 3   | 3   | 2   | 2         |
| 20-39                    | 3   | 4                | 2                | 2   | 6   | 1   | 4                | 4                | 2   | 4                | 1                | 0                | 3   | 3   | 3   | 2         |
| 40-59                    | 3   | 7                | 2                | 2   | 13  | 1   | 4                | 3                | 3   | 7                | 3                | 3                | 3   | 3   | 4   | 4         |
| 60+                      | 24  | 32               | 19               | 22  | 71  | 12  | 23               | 14               | 18  | 41               | 20               | 8                | 26  | 19  | 25  | 23        |
| All ages                 | 4   | 8                | 3                | 5   | 11  | 3   | 5                | 5                | 4   | 6                | 3                | 2                | 4   | 4   | 5   | 4         |
| Speech impairment        |     |                  |                  |     |     |     |                  |                  |     |                  |                  |                  |     |     |     |           |
| 0-4                      | 1   | ..               | 1                | 1   | 7   | 1   | 2                | 1                | 1   | 3                | 1                | 0                | 2   | 2   | 1   | 2         |
| 5-12                     | 3   | ..               | 4                | 2   | 7   | 2   | 5                | 7                | 2   | 4                | 1                | 4                | 3   | 5   | 3   | 2         |
| 13-19                    | 3   | ..               | 4                | 2   | 6   | 2   | 5                | 7                | 4   | 4                | 1                | 4                | 4   | 4   | 3   | 2         |
| 20-39                    | 2   | ..               | 4                | 2   | 6   | 1   | 4                | 8                | 4   | 5                | 1                | 6                | 4   | 5   | 3   | 3         |
| 40-59                    | 3   | ..               | 4                | 2   | 5   | 1   | 3                | 6                | 4   | 6                | 1                | 5                | 5   | 5   | 3   | 2         |
| 60+                      | 10  | ..               | 11               | 4   | 15  | 4   | 14               | 9                | 7   | 16               | 2                | 3                | 17  | 7   | 6   | 5         |
| All ages                 | 3   | ..               | 4                | 2   | 7   | 2   | 5                | 7                | 4   | 5                | 1                | 4                | 4   | 5   | 3   | 3         |
| Learning difficulties    |     |                  |                  |     |     |     |                  |                  |     |                  |                  |                  |     |     |     |           |
| 0-4                      | 0   | 3                | 1                | 1   | 2   | 0   | 6                | 0                | 1   | 1                | 3                | 0                | 1   | 0   | 1   | 2         |
| 5-12                     | 3   | 24               | 5                | 5   | 6   | 4   | 5                | 4                | 3   | 3                | 3                | 8                | 3   | 5   | 3   | 4         |
| 13-19                    | 3   | 24               | 5                | 6   | 6   | 4   | 5                | 4                | 3   | 3                | 4                | 8                | 4   | 5   | 4   | 4         |
| 20-39                    | 1   | 16               | 4                | 4   | 5   | 2   | 5                | 5                | 3   | 4                | 3                | 7                | 3   | 3   | 3   | 3         |
| 40-59                    | 1   | 32               | 3                | 3   | 6   | 2   | 5                | 3                | 3   | 4                | 2                | 10               | 3   | 4   | 2   | 3         |
| 60+                      | 1   | 121              | 6                | 3   | 13  | 6   | 11               | 3                | 7   | 9                | 2                | 2                | 14  | 6   | 2   | 5         |
| All ages                 | 2   | 33               | 4                | 3   | 6   | 3   | 5                | 4                | 3   | 3                | 3                | 7                | 4   | 4   | 3   | 4         |
| Behavioural difficulties |     |                  |                  |     |     |     |                  |                  |     |                  |                  |                  |     |     |     |           |
| 0-4                      | 1   | 2                | 1                | 0   | 1   | 4   | 5                | 1                | 1   | 1                | 0                | 0                | 1   | 1   | 0   | 1         |



Table A.8 (concluded)

|                       | ATG | ABW <sup>a</sup> | BHS <sup>a</sup> | BRB | BLZ | BMU | VGB <sup>a</sup> | DMA <sup>a</sup> | GRD | GUY <sup>a</sup> | JAM <sup>b</sup> | MSR <sup>a</sup> | LCA | VCT | TTO | Caribbean |
|-----------------------|-----|------------------|------------------|-----|-----|-----|------------------|------------------|-----|------------------|------------------|------------------|-----|-----|-----|-----------|
| 5-12                  | 2   | 7                | 2                | 1   | 3   | 9   | 4                | 4                | 2   | 3                | 0                | 5                | 3   | 4   | 1   | 1         |
| 13-19                 | 2   | 7                | 2                | 1   | 3   | 9   | 4                | 4                | 3   | 3                | 1                | 5                | 4   | 6   | 2   | 2         |
| 20-39                 | 2   | 9                | 4                | 4   | 4   | 5   | 5                | 10               | 7   | 6                | 4                | 9                | 6   | 9   | 4   | 5         |
| 40-59                 | 3   | 12               | 5                | 7   | 5   | 8   | 5                | 11               | 10  | 9                | 6                | 13               | 6   | 12  | 5   | 6         |
| 60+                   | 6   | 28               | 9                | 8   | 9   | 43  | 7                | 14               | 9   | 17               | 4                | 22               | 14  | 8   | 5   | 7         |
| All ages              | 3   | 11               | 4                | 4   | 4   | 12  | 5                | 8                | 6   | 5                | 3                | 11               | 5   | 7   | 3   | 4         |
| Mobility impairment   |     |                  |                  |     |     |     |                  |                  |     |                  |                  |                  |     |     |     |           |
| 0-4                   | 1   | ..               | 2                | 1   | 5   | 2   | 3                | 2                | 1   | 2                | 1                | 0                | 1   | 2   | 1   | 2         |
| 5-12                  | 1   | ..               | 3                | 1   | 3   | 3   | 3                | 3                | 2   | 3                | 1                | 1                | 3   | 3   | 2   | 2         |
| 13-19                 | 1   | ..               | 3                | 1   | 4   | 3   | 3                | 3                | 3   | 3                | 2                | 1                | 4   | 4   | 2   | 2         |
| 20-39                 | 2   | ..               | 6                | 2   | 7   | 5   | 5                | 6                | 5   | 4                | 3                | 4                | 6   | 5   | 4   | 4         |
| 40-59                 | 6   | ..               | 15               | 7   | 27  | 8   | 10               | 14               | 14  | 17               | 10               | 23               | 18  | 15  | 13  | 12        |
| 60+                   | 30  | ..               | 91               | 38  | 124 | 40  | 38               | 82               | 70  | 83               | 33               | 76               | 140 | 72  | 62  | 51        |
| All ages              | 5   | ..               | 13               | 8   | 18  | 11  | 8                | 16               | 13  | 11               | 6                | 21               | 15  | 13  | 11  | 9         |
| Upper limb impairment |     |                  |                  |     |     |     |                  |                  |     |                  |                  |                  |     |     |     |           |
| 0-4                   | 2   | ..               | 0                | 0   | 2   | 1   | 4                | 1                | 0   | 1                | ..               | 0                | 1   | 1   | 0   | 1         |
| 5-12                  | 2   | ..               | 1                | 1   | 2   | 1   | 3                | 1                | 1   | 1                | ..               | 3                | 2   | 2   | 0   | 1         |
| 13-19                 | 3   | ..               | 1                | 1   | 2   | 1   | 3                | 1                | 1   | 1                | ..               | 3                | 2   | 2   | 1   | 1         |
| 20-39                 | 4   | ..               | 2                | 2   | 3   | 2   | 5                | 1                | 2   | 2                | ..               | 1                | 3   | 2   | 1   | 2         |
| 40-59                 | 13  | ..               | 5                | 4   | 12  | 3   | 5                | 2                | 5   | 6                | ..               | 0                | 7   | 6   | 3   | 5         |
| 60+                   | 80  | ..               | 30               | 7   | 43  | 11  | 13               | 8                | 20  | 27               | ..               | 3                | 52  | 19  | 8   | 17        |
| All ages              | 12  | ..               | 4                | 3   | 7   | 3   | 5                | 2                | 4   | 4                | ..               | 1                | 6   | 4   | 2   | 4         |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

<sup>a</sup> Estimates for Aruba, Bahamas, British Virgin Islands, Dominica, Guyana, and Montserrat are for the age groups 0-4, 5-19, 20-39, 40-59, and 60+

<sup>b</sup> Estimates for Jamaica (2001) correspond to the age groups 0-14, 15-24, 25-44, 45-64, and 65+ and those persons reporting both disability and activity limitations.

**Table A.9**  
**Prevalence of disability by type and age, 2010 census round**  
*(Number of persons with disabilities per thousand)*

|                                     | Antigua and Barbuda | Aruba | Bahamas | Barbados | Belize | Bermuda | Cayman Islands | Grenada | Guyana | Jamaica | Montserrat | Saint Lucia <sup>a</sup> | Trinidad and Tobago | Caribbean |
|-------------------------------------|---------------------|-------|---------|----------|--------|---------|----------------|---------|--------|---------|------------|--------------------------|---------------------|-----------|
| <b>Seeing</b>                       |                     |       |         |          |        |         |                |         |        |         |            |                          |                     |           |
| 0-4                                 | 0                   | 2     | 2       | 1        | ..     | 1       | 1              | 2       | 2      | ..      | 0          | 1                        | 1                   | 1         |
| 5-12                                | 2                   | 7     | 0       | 1        | 2      | 1       | 6              | 2       | 3      | 2       | 4          | 3                        | 3                   | 3         |
| 13-19                               | 2                   | 14    | 1       | 2        | 3      | 2       | 8              | 4       | 3      | 3       | 7          | 3                        | 5                   | 4         |
| 20-39                               | 3                   | 16    | 1       | 2        | 5      | 3       | 6              | 4       | 4      | 4       | 2          | 3                        | 6                   | 4         |
| 40-59                               | 10                  | 32    | 4       | 6        | 23     | 13      | 17             | 17      | 20     | 13      | 16         | 10                       | 20                  | 15        |
| 60+                                 | 53                  | 92    | 18      | 35       | 84     | 48      | 67             | 84      | 63     | 71      | 84         | 74                       | 60                  | 63        |
| All ages                            | 10                  | 31    | 3       | 9        | 13     | 15      | 15             | 18      | 12     | 14      | 22         | 13                       | 16                  | 13        |
| <b>Hearing</b>                      |                     |       |         |          |        |         |                |         |        |         |            |                          |                     |           |
| 0-4                                 | 1                   | 2     | 0       | 0        | ..     | 1       | 0              | 0       | 1      | ..      | 0          | 1                        | 1                   | 1         |
| 5-12                                | 1                   | 3     | 1       | 1        | 2      | 1       | 2              | 2       | 1      | 1       | 2          | 1                        | 1                   | 1         |
| 13-19                               | 1                   | 4     | 1       | 2        | 2      | 1       | 3              | 1       | 2      | 1       | 0          | 1                        | 2                   | 2         |
| 20-39                               | 1                   | 5     | 1       | 2        | 2      | 1       | 1              | 2       | 2      | 2       | 1          | 2                        | 3                   | 2         |
| 40-59                               | 2                   | 10    | 2       | 3        | 4      | 1       | 3              | 3       | 4      | 3       | 2          | 3                        | 5                   | 3         |
| 60+                                 | 16                  | 49    | 8       | 19       | 35     | 13      | 38             | 25      | 21     | 25      | 22         | 21                       | 20                  | 23        |
| All ages                            | 3                   | 13    | 2       | 5        | 5      | 3       | 5              | 5       | 4      | 5       | 5          | 4                        | 5                   | 5         |
| <b>Communicating</b>                |                     |       |         |          |        |         |                |         |        |         |            |                          |                     |           |
| 0-4                                 | 3                   | ..    | 0       | 2        | ..     | 1       | 2              | 8       | 1      | ..      | 0          | 11                       | 3                   | 2         |
| 5-12                                | 2                   | 6     | 1       | 3        | 4      | 2       | 4              | 4       | 3      | 2       | 2          | 3                        | 5                   | 3         |
| 13-19                               | 2                   | 5     | 1       | 2        | 4      | 1       | 3              | 3       | 3      | 2       | 2          | 3                        | 5                   | 3         |
| 20-39                               | 3                   | 6     | 0       | 2        | 3      | 1       | 1              | 4       | 3      | 3       | 2          | 4                        | 7                   | 4         |
| 40-59                               | 3                   | 8     | 1       | 3        | 4      | 1       | 2              | 5       | 4      | 4       | 3          | 4                        | 10                  | 5         |
| 60+                                 | 12                  | 34    | 1       | 4        | 12     | 9       | 8              | 13      | 8      | 14      | 17         | 14                       | 13                  | 12        |
| All ages                            | 3                   | 11    | 1       | 2        | 4      | 3       | 2              | 6       | 4      | 4       | 5          | 6                        | 8                   | 5         |
| <b>Remembering or concentrating</b> |                     |       |         |          |        |         |                |         |        |         |            |                          |                     |           |
| 0-4                                 | 2                   | ..    | 0       | 2        | ..     | 1       | ..             | 4       | 1      | ..      | 0          | 1                        | 1                   | 1         |
| 5-12                                | 1                   | 8     | 3       | 7        | 3      | 5       | ..             | 3       | 3      | 2       | 2          | 1                        | 3                   | 3         |
| 13-19                               | 1                   | 5     | 3       | 9        | 3      | 4       | ..             | 1       | 4      | 2       | 4          | 1                        | 4                   | 3         |
| 20-39                               | 2                   | 7     | 2       | 8        | 3      | 4       | ..             | 3       | 5      | 3       | 2          | 2                        | 4                   | 4         |
| 40-59                               | 2                   | 10    | 1       | 9        | 5      | 4       | ..             | 5       | 7      | 4       | 4          | 3                        | 7                   | 5         |

Table A.9 (concluded)

|            | Antigua<br>and<br>Barbuda | Aruba | Bahamas | Barbados | Belize | Bermuda | Cayman<br>Islands | Grenada | Guyana | Jamaica | Montserrat | Saint<br>Lucia <sup>a</sup> | Trinidad<br>and<br>Tobago | Caribbean |
|------------|---------------------------|-------|---------|----------|--------|---------|-------------------|---------|--------|---------|------------|-----------------------------|---------------------------|-----------|
| 60+        | 21                        | 53    | 1       | 8        | 25     | 5       | ..                | 35      | 11     | 26      | 24         | 21                          | 17                        | 20        |
| All ages   | 4                         | 14    | 2       | 8        | 5      | 4       | ..                | 8       | 5      | 6       | 7          | 4                           | 6                         | 6         |
| Self-care  |                           |       |         |          |        |         |                   |         |        |         |            |                             |                           |           |
| 0-4        | 8                         | ..    | ..      | 1        | ..     | 3       | ..                | 11      | ..     | ..      | ..         | 16                          | 2                         | 4         |
| 5-12       | 1                         | 3     | ..      | 1        | 8      | 5       | ..                | 2       | ..     | 2       | ..         | 2                           | 3                         | 3         |
| 13-19      | 2                         | 2     | ..      | 1        | 3      | 4       | ..                | 2       | ..     | 2       | ..         | 2                           | 3                         | 2         |
| 20-39      | 1                         | 3     | ..      | 1        | 2      | 4       | ..                | 2       | ..     | 2       | ..         | 3                           | 3                         | 2         |
| 40-59      | 2                         | 4     | ..      | 2        | 3      | 7       | ..                | 4       | ..     | 3       | ..         | 3                           | 7                         | 4         |
| 60+        | 27                        | 52    | ..      | 13       | 27     | 31      | ..                | 35      | ..     | 38      | ..         | 41                          | 30                        | 33        |
| All ages   | 5                         | 10    | ..      | 3        | 5      | 10      | ..                | 8       | ..     | 7       | ..         | 8                           | 8                         | 7         |
| Walking    |                           |       |         |          |        |         |                   |         |        |         |            |                             |                           |           |
| 0-4        | 4                         | ..    | 0       | 2        | ..     | 0       | 1                 | 6       | 2      | ..      | 0          | 9                           | 2                         | 2         |
| 5-12       | 1                         | 3     | 0       | 3        | 2      | 1       | 1                 | 2       | 3      | 2       | 0          | 2                           | 3                         | 2         |
| 13-19      | 1                         | 3     | 1       | 3        | 2      | 2       | 4                 | 2       | 3      | 2       | 4          | 2                           | 3                         | 2         |
| 20-39      | 3                         | 5     | 2       | 4        | 3      | 2       | 2                 | 4       | 4      | 3       | 4          | 4                           | 7                         | 4         |
| 40-59      | 9                         | 24    | 5       | 15       | 14     | 6       | 8                 | 14      | 14     | 8       | 19         | 11                          | 22                        | 13        |
| 60+        | 69                        | 125   | 19      | 98       | 89     | 29      | 67                | 108     | 61     | 70      | 114        | 103                         | 71                        | 72        |
| All ages   | 12                        | 29    | 4       | 23       | 11     | 7       | 10                | 21      | 10     | 12      | 28         | 17                          | 18                        | 14        |
| Upper body |                           |       |         |          |        |         |                   |         |        |         |            |                             |                           |           |
| 0-4        | 1                         | ..    | 0       | 1        | ..     | 0       | 1                 | 3       | 1      | ..      | 0          | 5                           | 1                         | 1         |
| 5-12       | 0                         | ..    | 0       | 1        | 2      | 1       | 0                 | 2       | 1      | 2       | 2          | 1                           | 1                         | 1         |
| 13-19      | 1                         | ..    | 0       | 1        | 2      | 0       | 1                 | 1       | 2      | 2       | 0          | 1                           | 1                         | 2         |
| 20-39      | 1                         | ..    | 0       | 2        | 3      | 1       | 2                 | 2       | 2      | 2       | 4          | 2                           | 2                         | 2         |
| 40-59      | 2                         | ..    | 1       | 10       | 7      | 2       | 3                 | 4       | 7      | 7       | 4          | 3                           | 6                         | 6         |
| 60+        | 16                        | ..    | 3       | 71       | 31     | 5       | 20                | 28      | 26     | 65      | 20         | 25                          | 12                        | 41        |
| All ages   | 3                         | ..    | 1       | 16       | 5      | 2       | 4                 | 6       | 5      | 11      | 6          | 5                           | 4                         | 8         |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.

<sup>a</sup> Estimates for Saint Lucia (2010) correspond to the age groups 0-4, 5-14, 15-19, 20-39, 40-59 and 60+

**Table A.10**  
**School attendance of persons aged 3-18 by type of disability, 2000 and 2010**  
*(Percentages)*

|                                  | Type of disability |         |          |          |           |          |            |            |         |           | All persons aged 3-18 with a disability of any kind | All persons aged 3-18 without disability |
|----------------------------------|--------------------|---------|----------|----------|-----------|----------|------------|------------|---------|-----------|---|--|
|                                  | Seeing             | Hearing | Speaking | Learning | Behaviour | Mobility | Upper limb | Upper body | Walking | Self-care |   |  |
| <b>2000 round</b>                |                    |         |          |          |           |          |            |            |         |           |   |  |
| Antigua and Barbuda              | 90                 | 86      | 63       | 76       | 66        | 57       | 58         | 82         | 89      |           |   |  |
| Barbados                         | 84                 | 87      | 74       | 79       | 60        | 67       | 79         | 81         | 88      |           |   |  |
| Belize                           | 74                 | 62      | 38       | 46       | 32        | 35       | 26         | 61         | 72      |           |   |  |
| Grenada                          | 88                 | 61      | 55       | 68       | 49        | 54       | 47         | 72         | 92      |           |   |  |
| Saint Lucia                      | 75                 | 68      | 50       | 60       | 37        | 54       | 51         | 70         | 77      |           |   |  |
| Saint Vincent and the Grenadines | 83                 | 72      | 56       | 66       | 45        | 46       | 48         | 68         | 82      |           |   |  |
| Trinidad and Tobago              | 85                 | 75      | 45       | 56       | 38        | 42       | 37         | 68         | 86      |           |   |  |
| Average                          | 83                 | 73      | 54       | 64       | 47        | 51       | 49         | 72         | 84      |           |   |  |
| <b>2010 round</b>                |                    |         |          |          |           |          |            |            |         |           |   |  |
| Antigua and Barbuda              | 76                 | 75      | 58       | 65       | 46        | 38       | 33         | 74         | 93      |           |   |  |
| Aruba <sup>a</sup>               | 87                 | 83      | 61       | 72       | 37        | 63       | ..         | 84         | 95      |           |   |  |
| Barbados                         | 70                 | 79      | 72       | 81       | 40        | 72       | 76         | 81         | 90      |           |   |  |
| Belize <sup>a</sup>              | 71                 | 58      | 39       | 48       | 66        | 34       | 39         | 69         | 84      |           |   |  |
| Bermuda                          | 80                 | 100     | 85       | 82       | 90        | 87       | 67         | 96         | 98      |           |   |  |
| Cayman Islands <sup>a</sup>      | 97                 | 95      | 100      | 97       | ..        | 92       | 83         | 96         | 95      |           |   |  |
| Grenada                          | 88                 | 65      | 46       | 53       | 25        | 41       | 39         | 68         | 93      |           |   |  |
| Guyana                           | 73                 | 62      | 44       | 41       | ..        | 48       | 41         | 59         | 81      |           |   |  |
| Jamaica <sup>a</sup>             | 86                 | 77      | 39       | 46       | 34        | 41       | 36         | 70         | 92      |           |   |  |
| Trinidad and Tobago              | 81                 | 76      | 59       | 63       | 49        | 51       | 53         | 72         | 91      |           |   |  |
| Average                          | 81                 | 77      | 60       | 65       | 48        | 57       | 52         | 77         | 91      |           |   |  |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.  
<sup>a</sup> Estimates for Aruba (2010), Belize (2010), Cayman Islands (2010) and Jamaica (2011) are based on data for persons aged 5-18.

**Table A.11**  
**Persons aged 18-59 with disabilities who have completed secondary education by type of disability, 2000 and 2010**  
*(Percentages)*

|                                  | Type of disability |         |          |          |           |          |            |            |         |           | All persons aged 18-59 with a disability of any kind | All persons aged 18-59 without disability |
|----------------------------------|--------------------|---------|----------|----------|-----------|----------|------------|------------|---------|-----------|--|---|
|                                  | Seeing             | Hearing | Speaking | Learning | Behaviour | Mobility | Upper limb | Upper body | Walking | Self-care |  |   |
| <b>2000 round</b>                |                    |         |          |          |           |          |            |            |         |           |  |   |
| Antigua and Barbuda <sup>a</sup> | 71                 | 48      | 36       | 26       | 37        | 57       | 66         | 65         | 77      | 65        | 77   | 77  |
| Barbados                         | 79                 | 67      | 54       | 47       | 65        | 76       | 81         | 73         | 90      | 73        | 90   | 90  |
| Belize                           | 18                 | 12      | 6        | 2        | 6         | 10       | 9          | 14         | 23      | 14        | 23   | 23  |
| Grenada                          | 32                 | 22      | 19       | 16       | 22        | 24       | 22         | 26         | 43      | 26        | 43   | 43  |
| Saint Lucia                      | 37                 | 26      | 15       | 16       | 11        | 21       | 22         | 29         | 45      | 29        | 45   | 45  |
| Saint Vincent and the Grenadines | 32                 | 13      | 6        | 8        | 13        | 18       | 19         | 22         | 42      | 22        | 42   | 42  |
| Trinidad and Tobago              | 44                 | 29      | 14       | 10       | 27        | 29       | 31         | 37         | 67      | 37        | 67   | 67  |
| Average                          | 45                 | 31      | 21       | 18       | 26        | 34       | 36         | 38         | 55      | 38        | 55   | 55  |
| <b>2010 round</b>                |                    |         |          |          |           |          |            |            |         |           |  |   |
| Antigua and Barbuda <sup>a</sup> | 53                 | 29      | 17       | 35       | 37        | 47       | 39         | 46         | 71      | 46        | 71   | 71  |
| Aruba                            | 56                 | 49      | 29       | 32       | 28        | 48       | ..         | 51         | 68      | 51        | 68   | 68  |
| Barbados                         | 79                 | 76      | 57       | 69       | 55        | 81       | 82         | 79         | 95      | 79        | 95   | 95  |
| Belize                           | 20                 | 15      | 10       | 7        | 8         | 12       | 10         | 15         | 36      | 15        | 36   | 36  |
| Bermuda                          | 93                 | 59      | 32       | 62       | 72        | 88       | 87         | 90         | 98      | 90        | 98   | 98  |
| Cayman Islands                   | 94                 | 91      | 83       | 86       | ..        | 92       | 97         | 92         | 98      | 92        | 98   | 98  |
| Grenada                          | 28                 | 15      | 7        | 13       | 15        | 21       | 21         | 23         | 53      | 23        | 53   | 53  |
| Guyana                           | 65                 | 37      | 26       | 35       | ..        | 50       | 47         | 53         | 76      | 53        | 76   | 76  |
| Jamaica                          | 59                 | 46      | 27       | 36       | 36        | 48       | 47         | 52         | 75      | 52        | 75   | 75  |
| Trinidad and Tobago              | 59                 | 43      | 31       | 37       | 35        | 48       | 45         | 50         | 79      | 50        | 79   | 79  |
| Average                          | 61                 | 46      | 32       | 41       | 36        | 54       | 53         | 55         | 75      | 55        | 75   | 75  |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.  
<sup>a</sup> The response categories for level of education in the Antigua and Barbuda censuses of 2001 and 2011 were different and this affected the comparability of the data.

**Table A.12**  
**Economic activity of persons aged 15 to 59 with disabilities by type of disability, 2000 and 2010**  
*(Percentage of persons who are economically active)*

|                                  | Type of disability |         |          |          |           |          |            | All persons aged 15-59 with disabilities | All persons aged 15-59 without disabilities |
|----------------------------------|--------------------|---------|----------|----------|-----------|----------|------------|--|---|
|                                  | Seeing             | Hearing | Speaking | Learning | Behaviour | Mobility | Upper limb |  |   |
| <b>2000 round</b>                |                    |         |          |          |           |          |            |  |   |
| Antigua and Barbuda              | 72                 | 61      | 33       | 11       | 26        | 45       | 52         | 62                                       | 73  |
| Barbados                         | 51                 | 51      | 25       | 19       | 15        | 32       | 33         | 37                                       | 77  |
| Belize                           | 49                 | 46      | 28       | 16       | 18        | 32       | 32         | 43                                       | 52  |
| Grenada                          | 52                 | 50      | 22       | 12       | 12        | 33       | 36         | 34                                       | 60  |
| Saint Lucia                      | 48                 | 43      | 26       | 24       | 16        | 37       | 31         | 39                                       | 61  |
| Saint Vincent and the Grenadines | 32                 | 37      | 22       | 17       | 5         | 27       | 22         | 30                                       | 53  |
| Trinidad and Tobago              | 46                 | 30      | 13       | 9        | 7         | 20       | 21         | 31                                       | 59  |
| Average                          | 50                 | 45      | 24       | 15       | 14        | 32       | 32         | 39                                       | 62  |
| <b>2010 round</b>                |                    |         |          |          |           |          |            |  |   |
| Antigua and Barbuda              | 66                 | 55      | 24       | 46       | 16        | 40       | 36         | 52                                       | 73  |
| Aruba                            | 56                 | 49      | 13       | 23       | 13        | 35       | ..         | 47                                       | 69  |
| Barbados                         | 44                 | 49      | 27       | 22       | 5         | 39       | 44         | 36                                       | 76  |
| Belize                           | 49                 | 44      | 20       | 23       | 4         | 29       | 38         | 41                                       | 54  |
| Bermuda                          | 66                 | 46      | 14       | 24       | 29        | 40       | 49         | ..                                       | 81  |
| Cayman Islands                   | 72                 | 52      | 36       | 25       | ..        | 53       | 44         | 60                                       | 83  |
| Grenada                          | 44                 | 34      | 17       | 20       | 6         | 29       | 21         | 34                                       | 59  |
| Guyana                           | 47                 | 30      | 16       | 10       | ..        | 21       | 21         | 31                                       | 57  |
| Jamaica                          | 46                 | 36      | 12       | 14       | 7         | 21       | 21         | 34                                       | 55  |
| Trinidad and Tobago              | 48                 | 32      | 10       | 16       | 8         | 20       | 19         | 30                                       | 67  |
| Average                          | 54                 | 43      | 19       | 22       | 11        | 32       | 33         | 40                                       | 67  |

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of national population and housing censuses.


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