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**CHALLENGES IN THE SOCIAL SECTOR  
CONFRONTING CARIBBEAN SIDS**

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# **CHALLENGES IN THE SOCIAL SECTOR CONFRONTING CARIBBEAN SIDS**

## **INTRODUCTION**

The Economic Commission for Latin America and the Caribbean/Caribbean Development and Cooperation Committee (ECLAC/CDCC) secretariat has identified a number of areas from which the main challenges in the social sector are derived. These areas have been identified in the course of fulfilling its mandate as received from the World Conferences on Women, the International Conferences on Population and Development, the World Assembly on Ageing and the World Summit on Social Development and the Millennium Development Summit . Annex I presents an overview of the secretariat's involvement in the global conferences in activities specific to the social sector.

The areas selected for discussion in this paper are the population dynamics of Caribbean SIDS; gender equality and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS); and poverty reduction and human development.

This paper seeks to present the main challenges in the area of social development which have been identified by governments in the subregion over the preceding biennium.

These issues discussed are in no way meant to represent a full and comprehensive exploration of social development issues, as there are other pressing issues such as health sector reform, reform of the education sector, public sector reform, pension reform and the rights of persons with disabilities which deserve attention. In fact, many have gained the recognition of governments and the ECLAC/CDCC secretariat during the biennium. There are others still that impact directly and/or indirectly on the social development prospects of countries that have not been included in this discussion such as substance abuse prevention and control.

These areas are presented with the suggestion that they may indeed represent a core aspect of the thrust of governments' efforts to address sustainable human development from a social development perspective.

## SECTION 1: THE POPULATION DYNAMICS OF CARIBBEAN SIDS

### 1.1 Ageing

The United Nations has undertaken various efforts to draw governments' attention to the consequences of the demographic transition, which brings along encompassing and profound demographic changes for all populations. Various initiatives on the global as well as on the regional and subregional level have been undertaken to highlight the pressing need for concerted action.

Of importance are the numerous agreements reached at the global conferences on social development, population and women orchestrated by the United Nations in the 1990s, which all refer to ageing as an issue of particular concern. The year 1999 was proclaimed by the General Assembly<sup>1</sup> of the United Nations as the Year of Older Persons, recognizing ageing as one of the major achievements but, at the same time, as one of the major challenges in the twentieth century. At the Second World Assembly on Ageing, which was held in Madrid 2002, governments agreed to the implementation of a global action plan. This new Plan of Action focuses both on political priorities such as improvements in living conditions of older persons, combating poverty, social inclusion, individual self-fulfilment, human rights and gender equality. To an increasing degree, attention is also devoted to such holistic and overarching themes as intergenerational solidarity, employment, social security, health and well-being.

To assist Caribbean governments in addressing this phenomenon coherently, the ECLAC/CDCC secretariat conducted an analysis of the demographic ageing process in the Caribbean along with an assessment of existing policies and programmes in the subregion. This document has been integrated into the regional background document (ECLAC, 2003a/2003b) on the situation of the elderly in the Latin American and Caribbean region. This document has been presented to the Regional Intergovernmental Conference on Ageing, which was organized by the Latin American and Caribbean Demographic Centre (CELADE) in November 2003, as mandated by the Second World Assembly on Ageing.

Population ageing is a global phenomenon, which has major implications on all aspects of human life. This process is enduring and irreversible and follows different patterns and distinct paces in various regions and countries.

Population ageing in the Caribbean generally follows global trends. It is estimated that the Caribbean will experience absolute and relative increases in the elderly<sup>2</sup> population over the next 50 years and that the elderly population, which constituted 4.5% in 1950, will increase to 18% in 2050 (United Nations, 2000). The changes in the age-composition of the Caribbean population over the observed 100

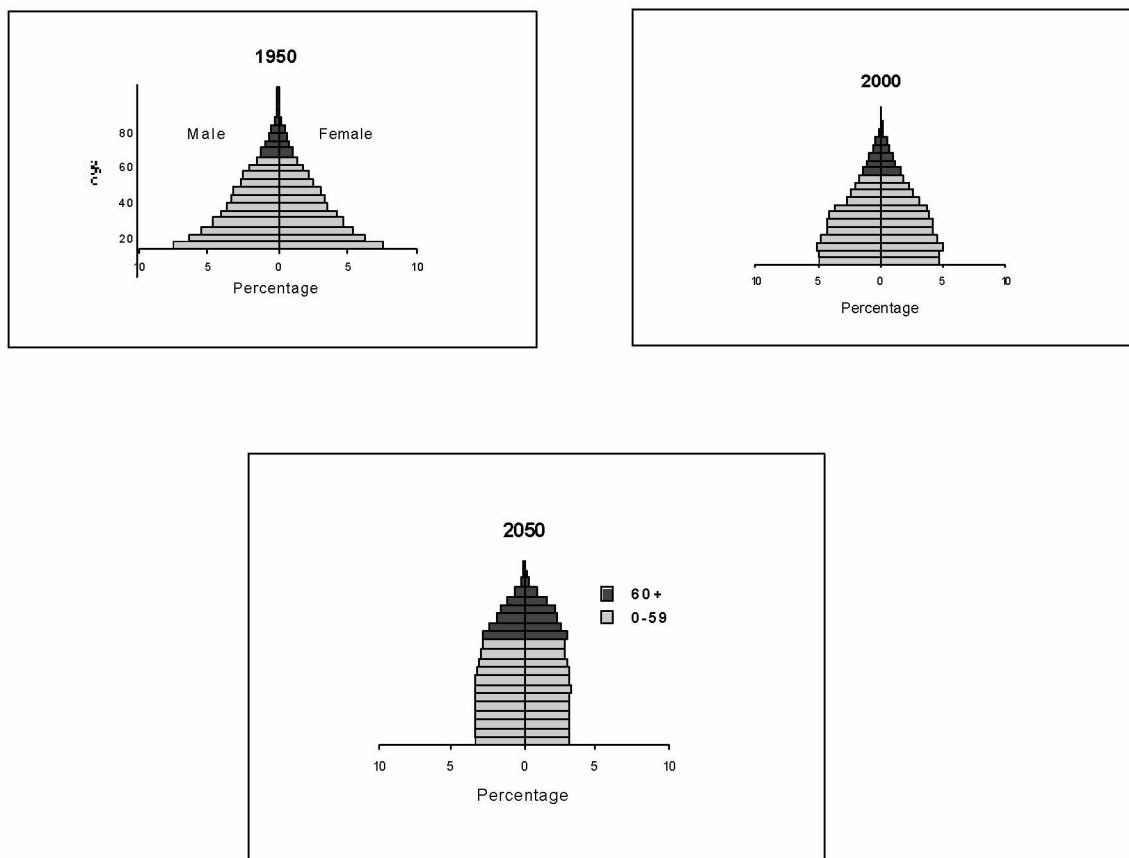
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<sup>1</sup> General Assembly resolution 47/5 of October 1992.

<sup>2</sup> The age-group 'older persons' is defined by the United Nations as those persons who are 60 years and older, whereas the 'oldest old' age group comprises persons aged 80 years and over.

years have been illustrated in the population pyramids below<sup>3</sup>. Pyramids representing young and growing populations typically consist of a large base and subsequently decreasing older age-groups. This was typical for all countries in the Caribbean in the early 1950s. The second half of the twentieth century was marked by declining fertility rates and increasing longevity for most countries in the Caribbean. This evolution is reflected in the pyramid for the year 2000. This trend towards smaller young age-groups and increasingly larger older age-groups is expected to continue over the next 50 years, as visualized in the pyramid for the year 2050.

**Figure 1:  
Population pyramids for the Caribbean**



Source: United Nations Population Division, 2000 Revision<sup>1</sup>

Individual countries in the Caribbean differ considerably in the timing of the onset of this process as well as in its pace. Relatively advanced are Barbados, Cuba and Puerto Rico, whereas Haiti, Belize, the Dominican Republic and Guyana still have rather young populations.

<sup>3</sup> Population pyramids are composed of consecutive five-year age-groups from age zero to age 100 and represent the age structure for both sexes of any given population at a given time.

## 1.2 Policies and programmes

The provision of social welfare plays a key role in poverty alleviation and providing decent living conditions for the elderly. However, in most countries in the Caribbean, the majority of the elderly population and particularly those in the informal labour market, the self-employed, rural workers and the non-economically active are quite often not covered. Even for those who receive assistance from such schemes, the real value of the benefits has declined over the last decade. Thus, the proportion of the population in receipt of public assistance is low as is the level of benefits.

Governments in the Caribbean have engaged in developing the necessary strategies to address the consequences of the changing population age structure and some have already adopted various policies and programmes to respond to these emerging problems. National policies on ageing are being adopted and implemented and different welfare programmes, specifically designed to meet the needs of the elderly population, are being put in place. It is understood that most of the elderly cannot draw on any formal pension or welfare system and are thus dependent on other sources of income, such as own work and family support. The changing health needs of the elderly and the growing demand on the public health system have been recognized by almost all national machineries and increasingly provisions are made to cope with these new challenges.

Social security schemes in the subregion are rather recent particularly in the English-speaking Caribbean where they were only established after independence in the late 1960s and early 1970s. The majority of these schemes are government-funded, with some exceptions, particularly in the Organisation of Eastern Caribbean States (OECS) countries, where contributions are to be made by employer and employee. The social safety net systems in the Caribbean countries typically combine three elements: (a) social insurance concerned with the provision of security and the spreading of income over a life cycle, (b) means-tested social assistance designed to alleviate poverty, and (c) categorical transfers directed at redistribution among specific groups. The benefits are granted as in-kind transfers, cash payments or the provision of services.

Most of the countries in the subregion provide assistance to the elderly through one or several of the following safety-net programmes:

- (a) Social insurance schemes;
- (b) Contributory and non-contributory old-age pensions;
- (c) Social or public assistance;
- (d) In-kind assistance, food stamps;
- (e) Social funds (communities, elderly, low income families); and

## (f) Residential homes.

The table below presents available safety net programmes in selected countries:

**Table 1: Country safety net programmes: Overview**

Target groups & Programmes	Ang	BVI*	B'dos	Belize	Dca	Dom Rep*	G'da	Guy	J'ca	St. Lucia	T & T
<b>Elderly</b>											
Non-contrib. Pension	X	X	X	X	X		X	X	X	X	X
NIS Pension	X	X	X	X	X	X	X	X	X	X	X
In-kind assist.			X		X			X	X	X	X
Homes for the aged	X	X	X	X	X		X	X	X	X	X
<b>Disabled</b>											
NIS			X	X	X		X	X	X	X	X
Social Assist.			X	X	X		X	X	X	X	X
Resid. Care			X	X	X		X	X	X	X	X

Source: World Bank (1996), p. 132 and \*information provided by the Government

Ang – Anguilla

BVI – British Virgin Islands

B'dos – Barbados

Dca – Dominica

Dom Rep – Dominican Republic

G'da – Grenada

Guy – Guyana

J'ca – Jamaica

T & T – Trinidad & Tobago

The challenges emerging from this 'silent revolution' are immense and will grow in the years to come. With the pace of the demographic transition expected to be much faster than the changes already experienced, less time will be available to adjust to the consequences of this transition. Moreover population ageing in most of the Caribbean countries is taking place under tight socio-economic conditions with only limited resources available to devote to the development of the necessary strategies and policies. However this transition offers a 'window of opportunity'- the so called 'demographic bonus'. The 'demographic bonus' describes a situation where, with declining fertility rates and still small proportions of elderly people, the working population is having proportionally fewer old and young dependants to support. Under such circumstances, more public and private resources could become available for investment into social safety systems to provide for the aged at present and in the future. Policy makers at all levels of government are called upon to seize this opportunity to invest now in health, education and job creation for the younger generations to ensure that the resulting economic gains will improve the overall quality of life and provide the necessary resources to meet the challenges of an ageing society.

### 1.3 Migration – The brain drain revisited

Migration in the Caribbean is not a new phenomenon. Slave-trade, indentureship and since emancipation and more so with the move towards independence, movements of people between the Caribbean islands have become a substantive part of the

Caribbean culture. Better working conditions and higher wages often made working on a neighboring island a way out of unemployment and poverty. Over the last 50 years, the growing demand for highly qualified people in North America and the United Kingdom has been triggering a mass exodus of professionals, particularly in the area of teaching and nursing. In total, based on the most recent estimates provided by the United Nations Population Division (United Nations, 2002) the Caribbean has lost more than five million people over this period of time. The present net-migration rate<sup>4</sup> for the Caribbean is one of the highest worldwide, however, with a great variation within the region.

With the supply and demand gaps widening and the competition for skilled labor growing, increasingly smaller and more vulnerable countries are targeted by the international recruitment machinery. Ads are posted in local newspapers and recruitment drives launched which directly target new graduates and, increasingly, the more senior and more experienced professionals in the desired areas of expertise. Fast track immigration procedures for those possessing the required credentials are being implemented and immigration rules and regulations are amended to facilitate visa and green-card applications to find the required human resources which the domestic labor market cannot supply.

Recent global and regional agreements supporting the free movement of professionals enhance these trends. The entry into force of the General Agreement on Trade in Services (GATS) in 1995 provides the framework for further liberalization of cross-border movements of professionals. The Caribbean Single Market and Economy (CSME) is currently implementing regulations for free cross-border traveling of professionals. Nurses holding a Caribbean Community (CARICOM) license<sup>5</sup> can practice their profession in virtually any member State desired and are even permitted to register with the Nursing Council in the United Kingdom. The Free Trade Area of the Americas (FTAA) framework also includes a chapter on services which discusses the cross-border movement of the skilled and trained.

The departure of the best affects the sending countries in many ways. For those with a surplus of labor, emigration provides access to employment which could not be offered at home. Moreover the inflow of remittances is often welcomed as a boost to the national economy and the enhancement of skills of return-migrants is considered by many as an important asset of migration. However, smaller islands and developing countries like the Caribbean Small Island Developing States (SIDS) can barely cope with the negative consequences of the loss of their best. Deprived of their teachers and health professionals, many nations are no longer in a position to improve or even sustain the quantity and quality of the public services delivered.

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<sup>4</sup> Net migration: Net average number of migrants: the annual number of immigrants less the number of emigrants, including both citizens and non-citizens. *Net-migration rate*: The net number of migrants, divided by the average population of the receiving country. It is expressed as the net number of migrants per 1,000 population. Source: Population Division of the United Nations Secretariat, International Migration, Wall chart, 2002, ST/ESA/SER.A/219, Sales No. E03.XIII.3

<sup>5</sup> Nurses in the Caribbean write a common final nursing examination referred to as the 'Regional Nursing Examination'.

To enhance the understanding of the underlying push and pull factors determining the brain-drain in the Caribbean, the ECLAC/CDCC secretariat has conducted a case study on nurse migration in Trinidad and Tobago. The findings of this study reflect pretty much the situation in most of the other countries and territories in the subregion (ECLAC, 2003c).

A general weakness in the Caribbean is the lack of timely and reliable data. Particularly difficult has been the task of gathering information on migrating nurses from various sources in the home and destination country. Data collection systems are weak and the available data do not allow for further in-depth analysis of the current nursing crises. No systematic monitoring of the in- and outflow of migrants has been established and only scattered information is available on the emigration of nurses. No data are available on return migration, which would be essential to systematically trace return and recurrent migrant flows. The lack of such a monitoring tool is a significant weakness for human resources planners, since, without the knowledge of the available and lost human resources, sound human resources planning is almost an impossible task to accomplish.

Data from the early 1970s already pointed to the main weaknesses of the public health system, which would have needed immediate coherent policy responses and critical political commitment to avert the future crisis. Over the years some efforts were initiated to improve the situation. It is assumed that the implementation of selected policies along with the worldwide economic recession in the 1980s seems to have slowed down global international recruitment. The world-wide economic boom in the 1990s provided the funds for the public administrations in the developed world to engage in international recruitment as a viable strategy to overcome the growing nursing shortage. Recently adopted international initiatives to control recruitment from already drained countries seem to have had only a temporary impact. Regardless of such strategies, international recruitment from already brain-drained countries has resumed and fast track immigration procedures have been put in place in the United States and the United Kingdom to allow for easy access to the skills needed.

The analysis of the nursing situation in Trinidad and Tobago has shown that the present nursing crisis has been caused over several decades by a variety of push and pull-factors summarized as follows:

- (a) Inadequate remuneration and benefits;
- (b) Unfavorable working conditions;
- (c) Lack of management and leadership;
- (d) Insufficient training and professional development;
- (e) Insufficient career-perspectives;

- (f) Underutilization of acquired skills;
- (g) Burn-out due to increased workload as a consequence of understaffing;
- and
- (h) Lack of recognition of the profession.

Similarly, with the growing nurse shortage in the United States and the United Kingdom, the pull factors already identified in the early 1960s have become stronger over the past decades:

- (a) Attractive payments and benefits;
- (b) Modern human resources management;
- (c) Professional work-environment;
- (d) Possibility of permanent residency in the receiving country;
- (e) Financial support for registration and immigration procedures provided by foreign employers;
- (f) Supportive network of family and friends;
- (g) Opportunities for professional development and career advancement;
- (h) Professional recognition; and
- (i) Improved quality of life for self and family.

#### **1.4 *What are the consequences for the public health system of the source country?***

Data on vacancy rates in hospitals and health care centers for the year 2000 indicate an acute shortage of nurses since on average only every second nursing post was held by a professional nurse. The other half of the posts was either vacant or filled with retirees, who came back to work on a part-time basis, or with less qualified support staff.

According to information furnished by the Ministry of Health, half to two thirds of all head nurses posts in the country were vacant in 2000, with the situation worse in hospitals than in community health care centers.

The following assumptions were made to forecast the future needs:

(a) About one sixth of the nursing personnel workforce (as of December 2001) at hospitals will have retired by 2005; and

(b) Ten per cent of the present nursing staff (as of December 2001) will have left the public health sector prior to retirement by 2005.

### **1.5 *What can be done to cope with the ongoing brain-drain in the public health sector?***

The following is a list of strategies suggested for adoption by policy makers at various levels. These policy recommendations are based on a set of recommendations designed by the World Health Organization (WHO) (2001) to address the current global nursing crisis:

#### 1.5.1 Policies at the national level

- (a) Strengthen national health policies, plans and systems;
- (b) Establish comprehensive health workforce planning that will ensure that the nursing and midwifery human resources can meet the actual demands for services;
- (c) Engaging in dialogue with internal and external entities to seek solutions to the low levels of remuneration and strengthen the incentives for effective recruitment, development and retention;
- (d) Identify priority areas in which solid evidence is needed to inform national health policy makers and invest in systematic data collection, analysis and dissemination systems for best practices;
- (e) Increase the opportunities to build leadership for nurses and midwives and strengthen their involvement in the management of the health system, in health policy development and in the decision-making process;
- (f) Set-up a national steering committee of crucial stakeholders, such as national nursing representatives, to develop a comprehensive strategic plan;
- (g) Provide opportunities for professional growth and develop supportive work environments and compensation commensurate with roles and responsibilities;
- (h) Enforce bonding, also for graduates from higher-level programmes;
- (i) A national clearing house for international recruiters needs to be set up and a body that regulates and/or monitors the contents of contracts needs to be designated, so as to protect young and desperate nurses from unscrupulous recruitment agencies;

(j) Develop a national action plan in collaboration with all important stakeholders in the public and private sector as well as with international and regional organizations; and

(k) Since nurses play a crucial role in caring for our beneficiaries, the issue of nurse staffing needs to be dealt with the utmost priority by concerned governmental authorities.

#### 1.5.2 Policies on the regional and international recruitment level

More collaboration and coordination is needed with the main absorbing countries and their national machineries. A properly structured partnership approach between the developed and the developing world could result in increased staffing for developing countries' health systems while at the same time facilitating subsequent recruitment of paramedical personnel to the developed world. The following strategies are suggested:

(a) Increased collaboration of the countries within the subregion and the region is necessary to further implement already existing mechanisms, such as 'Managed Migration' in the Caribbean;

(b) More collaboration is needed between the recruiting country and the source country to cover the costs of basic and advanced nursing training. Bilateral agreements on cost-sharing arrangements need to be put into place. Industrialized countries must recognize their responsibility to provide financial assistance to developing countries to train nursing staff, since many will ultimately work in the more developed world;

(c) More awareness of the impact of the brain drain on the well-being of SIDS caused by the departure of even small numbers of health professionals is needed on the part of the recruiting countries; and

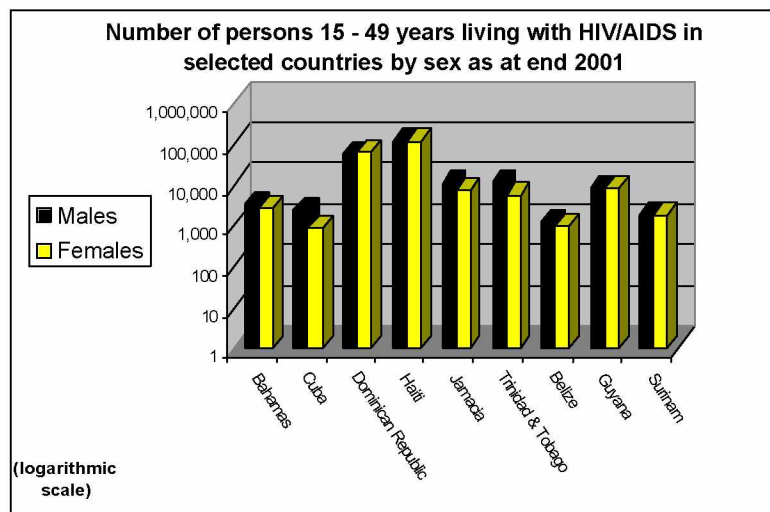
(d) Global initiatives to guide international recruitment of nurses, such as the 'Code of Conduct' adopted by the Commonwealth of Nations provide ethical guidance for international recruitment. These guidelines should be applied more strictly and should also address private sector recruitment activities.

## SECTION 2: GENDER EQUALITY AND HIV/AIDS

### 2.1 HIV/AIDS trends in the Caribbean

It is estimated that some 470,000 men, women and children are living with HIV/AIDS in the Caribbean and the prevalence rate,<sup>6</sup> estimated at 2.5%, is second only still to sub-Saharan Africa (UNAIDS 2002; UNAIDS 2003). Prevalence rates nevertheless vary across the subregion and some countries are more affected than others. In addition, the Caribbean has the highest incidence rate in the Americas and the fastest acceleration rate outside of sub-Saharan Africa. The incidence of reported AIDS cases to the Caribbean Epidemiology Centre (CAREC) member countries<sup>7</sup> rose steadily in the 1980s and 1990s, and in the English-speaking Caribbean alone, the AIDS incidence rate rose from 142.3 AIDS cases per million in 1991 to 246.2 per million in 1996 (World Bank, 2000).

**Figure 2**



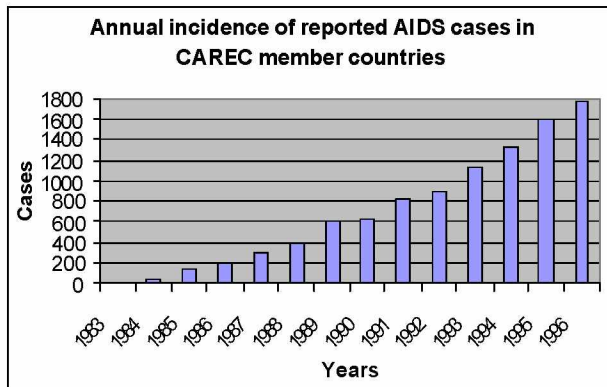
Source: Report on the Global HIV/AIDS epidemic - UNAIDS 2002

Young people are particularly at risk of HIV infection. CAREC data indicate that for the period 1982-1996, 70% of cases diagnosed were between 15-44 years, with 50% being in the 25-34 age group. AIDS is also now the most important cause of death among young men in the Caribbean between the ages of 15 and 44 (Camara 2000; World Bank 2000).

<sup>6</sup> The percentage of adults (15-49 years) living with HIV/AIDS.

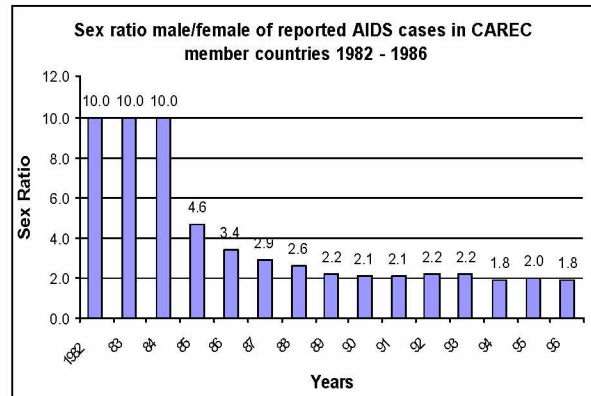
<sup>7</sup> CAREC Member Countries: Anguilla, Antigua and Barbuda, Bahamas, Barbados, Bermuda, Belize, British Virgin Islands, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad and Tobago, Turks and Caicos Islands, and Suriname.

Figure 3



Source: PAHO/WHO (1997)

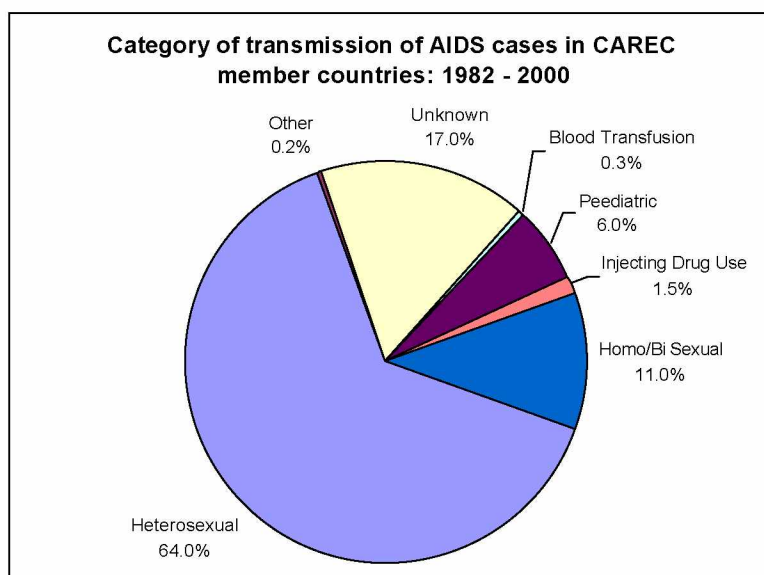
Figure 4



Source: Camara 2000

The predominant mode of HIV transmission in the Caribbean is heterosexual contact (Camara 2000; World Bank 2000). For the period 1982- 2000, heterosexual contact accounted for 62% of the total cumulative AIDS cases reported to CAREC. Heterosexual contact is also an important indicator of HIV transmission among the female population and represents up to 90% of cases among the female population (Camara, 2000). As the face of the epidemic changed to a primarily heterosexual one, accelerating infection rates among women were observed. The Caribbean currently has one of the highest rates of new AIDS cases among women in the Americas and, in some cases, the average annual increase in new cases among females has been twice that of males. Accelerating rates of infection among females are also mirrored by the declining male to female ratio for reported HIV infections. In the early 1990s, the male to female ratio in the Caribbean was 2:1, whereas in 1996 it had declined to 1.7:1. In some countries the ratio is 1:1. Females now comprise 50% of the newly infected adults in the subregion (UNAIDS 2000; World Bank, 2000).

There are also significant age variations in the patterns of infection between the two sexes. Among men, the majority of AIDS cases are in the 30-34 and 25-29 age groups. Among women, the majority of cases are in the 25-29 age group followed by 30-34 age group. In several countries of the subregion, the HIV prevalence rate among young people aged 15-24 is higher for females compared to males. Dramatic reversals in the male:female ratios in the 15-19 age group have been observed in the 1990s and in some countries females are now up to three to seven times more likely to be infected compared to males in that age category.

**Figure 5**

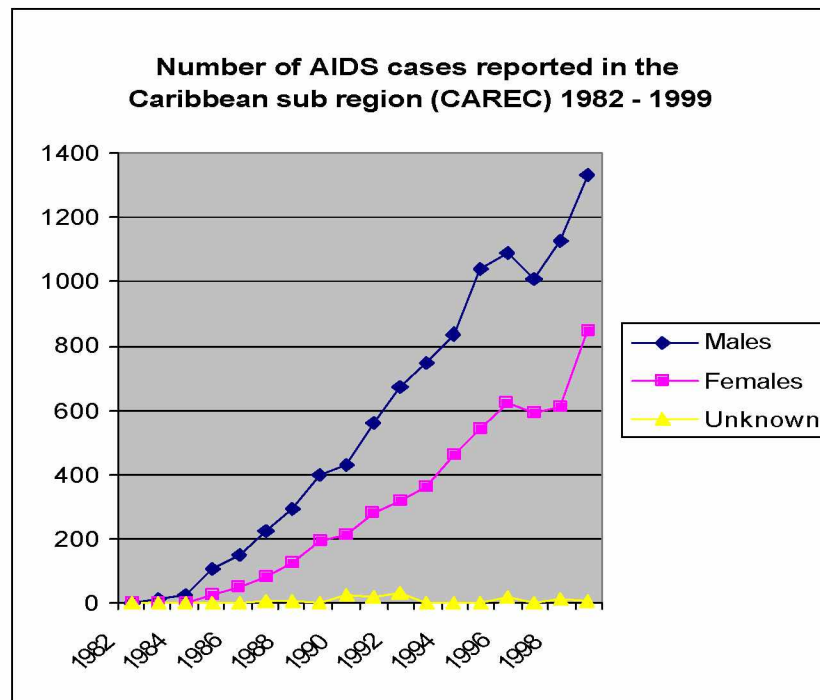
Source: Camara (2000)

Reported homosexual and bisexual transmission of HIV is relatively low, accounting for just 11% of the cases reported to CAREC over the period 1982-2000. It is nevertheless considered an important route of spread among the heterosexual population, primarily through the bisexual route.

**Table 2:**  
**Estimated number of persons (15-24) living with HIV/AIDS,**  
**as at end 2001 in selected Countries**

Country	(Low Estimate) Females 15 - 24 prevalence rate (%)	(High Estimate) Females 15 - 24 prevalence rate (%)	(Low Estimate) Males 15 - 24 prevalence rate (%)	(High Estimate) Males 15 - 24 prevalence rate (%)
Bahamas	1.97	4.09	1.72	3.56
Cuba	0.03	0.06	0.06	0.12
Dominican Republic	2.22	3.30	1.69	2.51
Haiti	3.22	6.69	2.64	5.48
Jamaica	0.69	1.03	0.66	0.98
Trinidad & Tobago	2.09	4.37	1.56	3.27
Belize	1.59	2.39	0.88	1.32
Guyana	2.60	5.41	2.13	4.43
Suriname	0.99	2.05	0.79	1.64

Source: UNAIDS (2002)

**Figure 6**

Source: Quarterly AIDS Surveillance Reports submitted to CAREC

## **2.2 Access to sexual and reproductive health and rights**

### 2.2.1 The global context

The gender dimensions of the HIV/AIDS epidemic are of increasing concern to Caribbean governments. The increasing infection rates observed among the female population have devastating consequences for women's morbidity and mortality, for the health and well-being of their families and the wider community, and for perinatal transmission. Women are the nurturers and carers within the family and as such bear the primary responsibility for the health and well-being of future generations.

At the global level, as reflected in the Beijing Platform for Action, governments (including Caribbean governments) acknowledge that gender inequality is an important factor underlying women's vulnerability to HIV infection. Social vulnerability and unequal power relationships between men and women are identified as obstacles to safe sex and there is a recognition that women "often do not have the power to insist on safe sex practices" (Beijing Platform for Action, para. 98). Hence, women often do not have the power to safeguard their sexual and reproductive health. The Beijing+5 Political Declaration and Outcome Document, reiterates that "such obstacles as unequal power relationships between men and women, in which women often do not have the power to insist on safe and responsible sex practices and a lack of understanding between men

and women on women's health needs, *inter alia*, endanger women's health particularly by increasing their susceptibility to sexually transmitted infections, including HIV/AIDS..." Governments also acknowledge that the consequences of HIV/AIDS extend beyond women's health to their role as mothers and caregivers and their contribution to the economic support of their families.

Very significantly, both the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action situate sexual and reproductive health and rights within a human rights framework. Paragraph 96 of the Beijing Platform for Action specifically states that the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Nevertheless, governments acknowledge that reproductive health (including the right to have a satisfying and safe sex life) elude many persons due to factors such as the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. In this regard, governments committed to undertake a series of gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues. (ICPD Programme of Action, paras 7.2 and 7.3; the Beijing Platform for Action, paras 94 and 95).

In their efforts to reverse the epidemic, Caribbean governments have focused on surveillance, information, education and communication for behaviour change, control of HIV transmission through blood and blood products, and prevention and control of the HIV perinatal transmission (Camara 2000). Transforming national agendas on HIV/AIDS in keeping with international commitments to ensure that the social, developmental and health consequences of HIV/AIDS are seen from a gender perspective remains a major challenge in the context of limited resources.

### 2.2.2 Systematic gender inequality

Despite the human rights guarantees assured to women regarding their access to reproductive and sexual health and rights, the reality is that women often lack the power to make decisions about their bodies, their sexuality and their fertility (Dixon-Mueller, 1993, Correa 1994, Charles 2003, Beijing Platform For Action, ICPD Programme of Action). As such, women's and girl's vulnerability to HIV infection is increased. As noted earlier, this is rooted in gender inequality and unless national agendas are transformed so that gender equality can be achieved, women and girls will continue to be increasingly vulnerable to HIV/AIDS. In this context, it may be useful to review the concepts of gender, gender relations and related concepts to enable an understanding of the structures that underpin gender equality and the conceptual shift in approaches to HIV reduction this will therefore necessitate.

Contemporary feminist theory distinguishes between sex and gender. It takes the view that sex is biological and that gender behaviour is a social construct. Andaiye

(2003) notes that gender refers to a system of roles and relationships between women and men that is determined not by biology but by socialization. She cites the definition put forward by Kabeer (1990) that gender is created in “the process by which individuals who are born into biological categories of male and female become the social categories of men and women through the acquisition of locally defined attributes of masculinity and femininity”. Our gendered identities and the meanings and value attached to “masculinity” and “femininity” are derived from these sets of values, with masculinity valued more highly and seen as superior. Attached to these differentiated values between the masculine and the feminine are also differentiated responsibilities, expected behaviour and attitudes which are internalized at an early age and maintained or shaped by norms, institutions and social structures (Reddock 1993). Expressions of male and female sexuality are also determined by these constructs.

Andaiye (2003) writes further that “a direct result of the “gendering process” is the gender division of labour, whereby women and men cluster in the different kinds of work for which they have been socialized. This socialization takes place first within the household and family and then in the wider society and the economy. Based on biological difference (the fact that women bear children and breastfeed) women are socialized into having the main responsibility for child and family care, including housework, although there is no biological basis for this. In turn and the work women perform unwaged in their families is low-waged when performed for strangers...”

Gender, like class, is a basic criterion that structures most societies around the world. (Johnson 1997, Barriteau 2003, Mukhopadhyay 2003.) The main axis of power in this gender order is the overall subordination of women and the dominance of men, the structure referred to as ‘patriarchy’ (Johnson 1997, ICPD Programme of Action, para 4.29). It exists despite reversals at certain levels (e.g. female-headed households) or resistance of many kinds, now articulated in feminism (Connell, 1995). Relations of gender arise therefore from this structuring of society along gender lines. Barriteau (2003) posits that there are two dimensions of gender relations: the material dimension and the ideological relations of gender. The material dimension speaks to how men and women gain access or are allocated material resources in a society while the ideological relations of gender speaks to how a society constructs what it accepts (and contests) as the appropriate expression of masculinity and femininity. Barriteau notes that the two dimensions interact and as such the ideological relations of gender structure complicate relations of gender in both the private and public spheres. Gender relations are therefore social relations (like race and class) and interact with other relations of domination and subordination and are a major component of social structure as a whole.

Gender inequality is thus inextricably bound to these relations of power between men and women. As a category, gender inequality cannot be measured, but it is manifested in many complex ways which are organically linked such as limited access to sexual and reproductive rights; violence against women and girls; the clustering of women in the low paid sectors of the economy; the significant wage gap between men and women; the relative absence of women from economic and political decision-

making; women's continuing burden for social reproduction, sexual harassment and all other forms of discrimination against women. Acceptable expressions of male and female sexuality, including male and female adolescent sexuality, are but another manifestation of differences in gender power relations. Unequal relations between men and women are thus crucially linked to women's access to sexual and reproductive health and rights.

To understand these complex ways in which women experience unequal relations or gender subordination, it is useful to examine the multidimensional nature of power itself as presented by Kabeer (1994). The first dimension which refers to the "power to" is associated with decision-making and the capacity to affect outcomes. This relates largely to the interpersonal. A second dimension refers to the "power over" and shifts to the institutionalized basis of power. At this level, institutions, such as the State, determine which issues get placed on the decision-making agenda and how resources get allocated. The third formulation is concerned with ideology and with social constructions and patterning of behaviour. It shapes attitudes, needs and preferences of both the dominant and the subordinate group such that both accept the existing order. Feminist analysis has shown how social norms and values mask the reality and pervasiveness of gender inequality and defuse gender conflict. For instance, the value society places on childbearing and motherhood masks the discrimination that women face. Societal acceptance of differentiated male and female sexual behaviour is another example.

How major societal structures such as the family, religion and the State itself sustain gender subordination is also crucially important to women's vulnerability.

Control over women's bodies is central to the construction of gender and associated ideas and beliefs about femininity and masculinity, noted earlier. Charles (2003) notes that an important aspect of gender hierarchical relationships is body politics: in most societies powerful forces are at play regarding the regulation and control of women's bodies. This social construct conferred on a husband proprietary rights to his wife's body which were embodied in the law: rape of a wife was also a crime against her husband, a husband had the legal right to beat his wife, and a husband also had a right to sexual intercourse. The husband's entitlement to sexual intercourse also meant his immunity from prosecution for marital rape, a position only recently abolished in some English-speaking countries of the Caribbean and still applicable in others. A husband therefore had authority for sexual and reproductive decision-making while a wife was expected to submit to this authority. This was also in keeping with male authority (unequal relations) within the family. Women lacked power over sexual decision-making and hence the power to negotiate around issues of sex, including safer sex practices. The ideology remains pervasive and underpins other forms of conjugal relationships in the Caribbean or other relationships involving commitment.

Constructs of female sexuality are also in keeping with the notion of a husband's proprietary rights to his wife's body. Women are socialized to be monogamous in

preparation for their roles as wives and their sexuality is guarded and watched over by structures within the society such as the family, the community and religion (Senior, 1991) Contravention of this norm attracts negative social sanctions. Constructions of masculinity, on the other hand, privilege male sexual prowess such as having multiple partners and maintaining a sexual relationship outside marriage. (Senior, 1991 and Kempadoo, 1999). While some men may reject this ideology, it nevertheless allows boys and men to have multiple partners without societal sanction. Protected sex is not part of this construct. There is the further issue that marriage is premised on the concepts of monogamy and procreation. As such unprotected sex tends to be the norm within most marriages, and sex within marriage is deemed safe whether in fact this is the case. (Women also usually bear the responsibility for contraception and have to rely on methods other than protected sex). Unprotected sex outside of marriage, notwithstanding, the charade of safe sex continues with the marriage partner.

As a direct result of such socialization practices and deference to male authority in sexual decision-making, increasing numbers of females in committed relationships are unable to safeguard their sexual and reproductive health increasing their vulnerability to HIV infection.

It appears to be evident therefore that providing people with information and expecting them to act upon it would not lead to behaviour change if the underlying factors which produce such behaviour are not addressed. In such a model, sexuality is equated with weakness and indoctrination is expected to change individual behaviour. Indeed, as noted earlier, male and female sexual behaviour is far more complex and is underpinned by social and cultural structures which sustain gender inequality. Reducing gender inequality requires long-term strategies with the goal of empowering women. Policies and programmes at the national level are not sufficiently informed by research and analysis of the gender issues which are central to producing and shaping male and female sexual behaviour. More research is needed to determine how masculinities and femininities are constructed across class, age, education, religion and ethnicity, and geographical area and how these constructions in turn define male sexuality and female sexuality. In addition, as noted in para 4.24 of the ICPD “men play a key role in bringing about gender equality, since in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of their families to the policy and programme decisions taken at all levels of government. It is essential therefore to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life”.

Childbearing as a cultural expectation also needs further exploration as a factor which increases women’s vulnerability to HIV infection. Contemporary notions of female independence may yet mask internalization of traditional roles of wife and mother and the high cultural value ascribed to such roles. Chevannes (2002) notes that human reproduction is a function of adult sexuality and that both womanhood and manhood are fully achieved not by the act of intercourse but by reproduction. For the woman,

pregnancy and childbirth are the fulfilment of womanhood; for the man impregnation is the proof of manhood. In her analysis of the findings of the Women and Caribbean Project in relation to the family, McKenzie (1982) asserts that it is in the domains of “sexual and emotional involvement with men, the fathers of their children...that [Caribbean] women appear to be weakest”. Durant–Gonzalez (1982) also notes that childbearing may also enable women to gain social rewards and social recognition, which may be the only route open to them. Teenage pregnancy can be linked to this need for social recognition.

### **2.3 Poverty and access to reproductive and sexual health and rights**

Although it is not clear whether economic independence within heterosexual relationships empowers women to be able to more successfully negotiate safe sex (due to factors such as childbearing and motherhood), it is perhaps the case that women in situations of economic dependence are less likely to do so or to terminate relationships which place them at risk of HIV transmission. Studies across the subregion which examined women’s role in sexual decision-making and its relationship with women’s vulnerability to HIV infection confirmed the importance of economic factors (Ulin, 1993). Poverty and lack of employment opportunities have also forced some women and girls to resort to direct and indirect sex work as a survival strategy. Sex (usually unsafe) may be exchanged for money, food or other necessities and women are generally unable to negotiate condom use in these situations. The sex trade across borders presents a further set of challenges for women’s access to their sexual and reproductive health. There is also a link between drug use, in particular cocaine, prostitution and HIV/AIDS. Laws that criminalize prostitution and the stigmas that exist around prostitution are often the cause of women migrating and moving from their own communities and homes to work elsewhere. For perhaps the majority of women who work in the sex trade industry, their vulnerability to HIV/AIDS is rooted in the fact that they are economically disadvantaged and their poverty is related to systemic class and gender inequalities, of which the increasing feminization of poverty is but another manifestation. It is clear that while men and women experience poverty, women experience poverty in very specific ways which are linked to their burden for social reproduction. In most countries of the subregion, poor female-headed households exceed poor male-headed households; the vast majority of child maintenance applications across the subregion are made by women from the low-income sectors; women are clustered in the low wage sectors of the economy; and a significant wage gap exists between the sexes. Poverty has been identified as a factor driving the HIV/AIDS epidemic in the Caribbean. It is nevertheless important that in national, regional and international responses to HIV/AIDS specific attention be paid to addressing women’s poverty and the systemic gender inequalities to which it is linked if women’s and girls’ vulnerability to HIV infection is to be reduced. It may be noted that one outcome of the discourse which frames HIV/AIDS as a development issue has been a closer examination of the social and economic divisions within countries, of poverty, income distribution, social, political and economic exclusion and generally all forms of discrimination. Central to these issues and to the HIV/AIDS epidemic is the issue of gender. It does not seem to be possible anymore to construct an analysis of an economy or of a society either at the micro or macro levels which does

not take gender into account. This is because, as noted earlier, men and women have different social and economic roles, differential access to income and resources and different economic behaviours.

## **2.4 Gender-based violence and access to reproductive and sexual health and rights**

Gender violence is yet another manifestation of gender inequality. The relationship between physical violence and HIV is often indirect. In situations of domestic violence, women have less ability to negotiate safe sex practices and hence safeguard their sexual and reproductive health. During the 1990s a great deal of effort was focused on the eradication of domestic violence in the subregion. However, the evidence suggests that notwithstanding the many policy and programmatic interventions by governments, Non-Governmental Organizations (NGOs) and community-based organizations including the enactment of domestic violence legislation, the establishment of shelter, hotline and counselling facilities, public education and sensitization, and police training programmes, the incidence of this form of violence remains high in the subregion (Gopaul, 1994, Clarke, 1998). The available statistics do not present a clear picture of its actual extent and prevalence due to inadequate data collection systems and the problem of underreporting. However applications made under domestic violence legislation for protection have climbed steadily in many countries reaching close to 10,000 in one and over 50,000 in another (Pargass and Clarke, 2003). While this may also be explained by an increase in the numbers of applications being made, the figures are nevertheless unacceptably high. Increasing severity and brutality in this form of violence have also been observed in the subregion.

Police statistics also suggest that there may be an increasing incidence of sexual violence both within the home (rape, incest and child sexual abuse) and outside the home. Rape directly increases transmission risks for women and girls and there is emerging evidence which provides support for this (Okoye, 2000). There is also evidence to suggest that childhood sexual abuse is frequently a precursor to adolescent female prostitution or an increased number of sexual partners (Lee and Felix, 1997).

The sexual exploitation of women and girls for prostitution through trafficking and the violence which women and girls may experience as a result also make them vulnerable to HIV infection (Kempadoo, 1999).

## **2.5 Adolescents and access to sexual and reproductive health**

Sexual initiation occurs at a relatively young age in the Caribbean and by age 18 the vast majority of Caribbean youths have had their first sexual encounter. The age of sexual initiation for boys tends to be earlier than that for girls yet the epidemiological trends reveal higher rates of infection for girls in the 15-19 age cohort compared to boys (Russell-Brown, 1988, and Stuart, 2000). Emerging studies suggest the existence of a phenomenon of younger girls exchanging sex with older men in exchange for money,

gifts or other material gain (transactional sex) which is being driven by peer pressure as well as early internalization of clear gender roles with the male as provider. Teenage pregnancy and subsequent serial relationships for financial support (pregnancy often being a feature of such subsequent relationships) also point to the vulnerability of young girls to HIV infection. Throughout the subregion teenage pregnancy is correlated with low education, unemployment or underemployment and poverty. Adolescent female prostitution either because of poverty or childhood sexual abuse is another route of infection for young girls. In this instance much effort has been devoted to changing adolescent sexual behaviour through education and health communication. However, various studies around the subregion are showing that high levels of awareness of HIV/AIDS are not impacting significantly on sexual behaviour change among young people. The evidence reveals clear gender differences but more research is needed to understand the precise factors that explain male and female adolescent sexuality across *inter alia* education, class and religion.

## **2.6 The Way Forward**

Some of the challenges which Caribbean governments face in dealing with the issue of gender inequality and HIV/AIDS include:

(a) Gender inequality facilitates increasing HIV infection levels among women and girls with devastating consequences for their health, their families and the wider community. In the context of the HIV/AIDS epidemic it is important to note that efforts targeted at individual behaviour is likely to have minimal impact (as the experience of domestic violence has shown) on reducing gender inequality. The structural and cultural factors that sustain gender inequality need to be addressed with the clear understanding that the complex manifestations of gender inequality are organically linked. Gender must be seen as central to planning and development;

(b) There is a need therefore to mainstream gender into all sectoral policies and programmes, including those addressing HIV/AIDS. This requires skills in gender analysis and planning; the capacity to collect and interpret sex-disaggregated data; commitments by governments to achieve gender equality in keeping with the mandate of the Beijing Platform for Action and the availability of human, technical and financial resources. Gender analysis essentially involves the analysis of sex-disaggregated data to determine how development activities impact on women and men and the effect gender roles have on development efforts. Gender analysis will also allow identification of how the social constructs of men and women and male and female adolescents affect their susceptibility to HIV/AIDS and significantly how the economic and social condition of women increase their vulnerability;

(c) The collection of sex disaggregated data through research and through the implementation of adequate data collection systems is critical to the gender analysis process at the national level;

(d) Conducting gender assessments of national and regional policies and plans of actions is also critical to the above analysis and to ensuring that gender is incorporated in all plans and policies;

(e) Developing a legislative agenda to address all forms of discrimination against women in keeping with the mandate of the Beijing Platform for Action is a crucial aspect of gender mainstreaming strategies. In the context of HIV/AIDS, particular attention should be paid to the stigma and discrimination associated with commercial sex work, equal opportunity legislation, sexual harassment in the workplace, the strengthening and enforcement of domestic violence, child abuse and child maintenance legislation; and

(f) Gender training at all levels of the public and private sectors is needed to implement the above strategies.

(g) Critical attention needs to be placed on the role of men and boys in achieving gender equality.

The ECLAC/CDCC secretariat has placed critical focus on the issue of gender equality and HIV/AIDS in the subregion in the present biennium. Gender equality and HIV/AIDS was one of the three themes at the Fourth Ministerial Conference on Women held in St Vincent and the Grenadines from 12-13 February 2004. Caribbean ministers with responsibility for women's/gender affairs and other heads of delegations discussed the issue and made recommendations for action. ECLAC/CDCC secretariat is also undertaking, in collaboration with UNIFEM and the Caribbean Health Research Council (CHRC), a gender assessment of national level plans and policies of selected countries as well as an assessment of the programmes of regional institutions and international agencies based in the Caribbean with a view to making recommendations to governments for the incorporation of a gender perspective in their policies and plans of actions.

## SECTION 3: POVERTY REDUCTION AND HUMAN DEVELOPMENT

### 3.1 The poverty status of Caribbean SIDS

The challenge to develop a poverty reduction strategy that both reduces poverty and advances sustainable human development at one and the same time is the challenge facing Caribbean SIDS. It is in no way a new one. Since the coming of independence, Caribbean SIDS took up the challenge to address the elimination of what scholars, such as Beckford, called persistent poverty.

Today as countries face the social dimensions of the impact of globalization there is need to address this problem more urgently.

There is little disagreement among governments in the subregion that in order to reduce poverty one first has to understand its magnitude and dimensions. In the latter part of the 1990s the subregion made significant progress in the area of collection of data on poverty. Some 15 countries in the subregion have undertaken in one form or another processes to measure the living conditions of their populations. Box 1 details the surveys of living conditions undertaken by countries in the subregion between 1990 and 2002. Unfortunately, most of the surveys have been one-off studies except in the case of Jamaica, which has collected continuous data on the conditions of their population on an annual basis since 1987, and Belize which has undertaken its second such survey within a seven-year period.

**Box 1:  
Caribbean countries with household and  
income surveys 1994-2002**

- Country poverty assessments for Anguilla (2002) Belize (1995, 2002), Grenada (1999), St Kitts/Nevis (2001), Saint Lucia (1995), Saint Vincent and the Grenadines (1995) and Turks & Caicos Islands (2001);
- Living standard measurement surveys for Guyana (1994) and Trinidad and Tobago (1993/94) sponsored by the World Bank;
- Survey of living conditions for the Bahamas (2001) and Jamaica (1989-2001) by the Planning Agency of Jamaica;
- The survey of social and income inequality in Barbados, sponsored by the IDB;
- The survey of poverty in the Dominican Republic, Fundacion Economica y Desarrollo, Inc (1994);
- Food security and living standards survey in Haiti, conducted by the USAID, 1995; and
- Poverty assessment in Suriname (1999), sponsored by the UNDP

Source: ECLAC LC/CAR/G.609, 29 February 2000 and ECLAC Survey (2003)

Even if poverty is understood, it has become very clear that no one policy approach can address the specific situation in each country. One obvious reason for such is the economically, culturally and socially diverse nature of the subregion. This is well illustrated in Table 3 which presents a number of indicators that point to among other things, the wide gap in GDP per capita, which exists in the subregion with a high of US\$30,000 in the Cayman Islands and a low of US\$1,467 in Haiti. Of the 23 countries for which data is presented, five had GDP per capita incomes over US\$15,000; another five had per capita incomes between US\$8,000 and US\$14,000; and another six, had per capita incomes between US\$5,000 and US\$7,000. The remaining four, for which data was provided, had per capita incomes between

US\$1,000 and US\$4,000. It is not unexpected to find varying levels of poverty as illustrated in Figure 7. In the English-speaking Caribbean alone, for those countries for which poverty data is available, poverty levels range from a low of 14% in Barbados, to a high of 39% in Dominica, and even a higher proportion, that of 62% in Suriname. A look at other indicators suggests that inequality within countries is a reality as well. Data in Table 4 points to what may be considered medium to high Gini co-efficient<sup>8</sup>, such as found in St. Vincent and the Grenadines, Suriname, Grenada and St. Kitts of .56, .46, .45 and .40, respectively. Such indicators tell the tale of high levels of inequality.

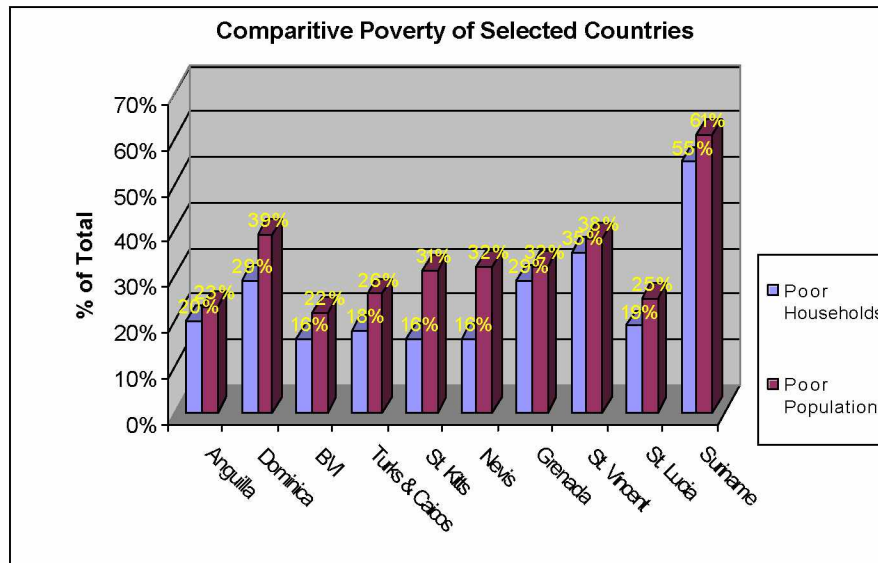
**Table 3: Macro socioeconomic indicators**

Country	Population 2001	Population Growth 2002	Life Expectancy 2000 (in years)	Infant Mortality (per 1000) 2000	GDP per cap PPP U.S.\$ 2000[i]
Anguilla	12,446	2.44	76.5	23.7	8,600
Antigua and Barbuda	68,487	0.69	73.9	13	10,541
Aruba	104,000	0.59	78.7	6.3	28,000
Bahamas	307,153	0.86	69.2	15	17,012
Barbados	268,189	0.46	76.8	12	15,494
Belize	247,107	2.65	74	34	5,606
British Virgin Islands	21,272	2.16	75.9	19.6	16,000
Cuba	11,221,723	0.35	76	7	N/A
Dominica	73,199	-0.81	72.9	14	5,880
Dominican Republic	8,505,204	1.61	67.1	42	6,033
Grenada	99,000	0.02	65.3	21	7,580
Guyana	766,256	0.23	63	55	3,963
Haiti	8,114,161	1.42	52.6	81	1,467
Jamaica	2,668,230	0.56	75.3	17	3,639
Montserrat	8,437	N/A	78.2	8	N/A
Netherlands Antilles	216,808	0.93	75.2	11.1	11,400
Puerto Rico	3,950,473	0.51	75.9	9.3	11,200
St. Kitts and Nevis	41,082	0.01	70	21	12,510
St. Lucia	158,134	1.24	73.4	17	5,703
St. Vincent & the Grenadines	115,881	0.37	69.6	21	5,555
Suriname	419,656	0.55	70.6	27.4	3,799
Trinidad and Tobago	1,309,608	-0.52	74.3	17	8,964
U.S. Virgin Islands	123,498	1.04	78.4	9.2	15,000

Sources: World Bank, <http://www.worldbank.org/data/>; United Nations, <http://hdr.undp.org/default.cfm>; CIA World factbook, <http://www.odci.gov/cia/publications/factbook/index.html>

Note: [i] Gross domestic product per capita purchasing power parity in US\$

<sup>8</sup> Gini coefficient is an indicator of equality and inequality. A coefficient as G ? 0 suggests equality; a coefficient as G ? 1 suggests inequality

**Figure 7: Poverty indicators for selected Caribbean countries**

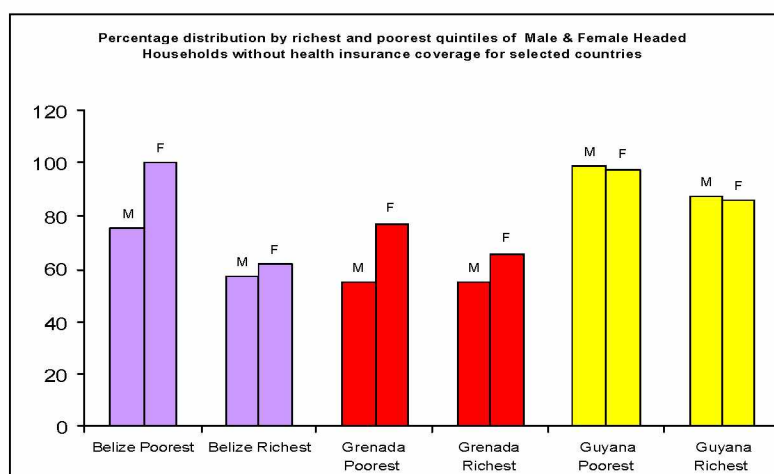
Sources: 1. Caribbean Development Bank; and 2. ECLAC/CDCC Social Statistical

Because much of the data on poverty indicated that female-headed households comprised a significant proportion of the poor, and due to the high proportions of female-headed households in the subregion, as detailed in Table 5, it is important to ensure that a gender analysis of the existing data is undertaken. At the recently concluded Fourth Caribbean Ministerial Conference on Women it was recommended that new approaches to collecting and analyzing the poverty data in the Caribbean was needed to better understand issues such as the kind of resources female-headed households had at their disposal to allow them to sustain families adequately; and how did State provisioning support female-headed households. It was agreed that additional research was also required into intra-household allocation of resources and how such resources were utilized in order to address the burden of care at the household level. As Figure 8 illustrates, health insurance coverage to female-headed households affords them a precarious nature of social protection. For the countries for which data was available, in every instance, whether among the richest or poorest quintile, female-headed households had less health coverage than their male counterparts.

**Table 4: Poverty indicators**

Country	Survey Year	Headcount		Poverty Gap	Poverty Gap squared	Gini
		Households	Population			
Anguilla	2002	20%	23%	6.9	3.2	0.31
Barbados	1998	-	14%	-	-	-
Belize	1996	-	33%	8.7	4.3	0.51
Dominica	2002	29%	39%	10.2	4.8	0.35
BVI	2002	16%	22%	4.1	1.7	0.23
Turks and Caicos	1999	18%	26%	5.7	2.6	0.37
St Kitts	1999/2000	16%	31%	2.5	8.9	0.4
Nevis	1999/2000	16%	32%	2.8	10	0.37
Grenada	1998	29%	32%	15.3	9.9	0.45
St Vincent	1995	Na	38%	12.6	6.9	0.56
St Lucia	1995	Na	25%	8.6	4.4	0.5
Suriname	1999/2000	55%	61%	-	-	0.49

Source: 1. Caribbean Development Bank; and 2. ECLAC/CDCC Social Statistical Databases

**Figure 8: Health insurance coverage**

Source: ECLAC/CDCC Social Statistical Databases

**Table 5: Proportion of households and unemployment rates by sex for ECLAC/CDCC member countries**

Country	Head of household by sex -1995		Unemployment rate by sex -2000*	
	Proportion of males (%)	Proportion of females (%)	Male (%)	Female (%)
Anguilla	67.8	32.2	6.3	9.0
Antigua & Barbuda	58.5	41.5	6.4	5.6
Aruba	77.3	22.7	6.7	8.4
Bahamas	64.1	35.8	6	9.7
Barbados	56.5	43.5	7.5	11.4
Belize	78	22	9	20.3
Br. Virgin Islands	71.3	28.7	3.4	3.1
Cuba	72	28	...	...
Dominica	62.7	37.3	19.6	27.2
Dominican Republic	70	30	...	...
Grenada	57.3	42.7	10.5	21.2
Guyana	70.5	29.5	6.2	14.3
Haiti	61.3	38.7	...	...
Jamaica	58	42	10.2	22.3
Montserrat	60	40	...	...
Netherlands Antilles	66	34	10.4	18.1
Puerto Rico	72	28	...	...
St Kitts and Nevis	56.1	43.9	...	...
Saint Lucia	59.6	40.4	12.6	20.7
St Vincent and the Grenadines	60.5	39.5	18.4	22.1
Suriname	80	20	7.2	17
Trinidad and Tobago	73.5	26.5	10.2	15.2
U.S. Virgin Islands	67	33	...	...
Mean	66	33.9		
Low	56.1	20		
High	80	43.9		

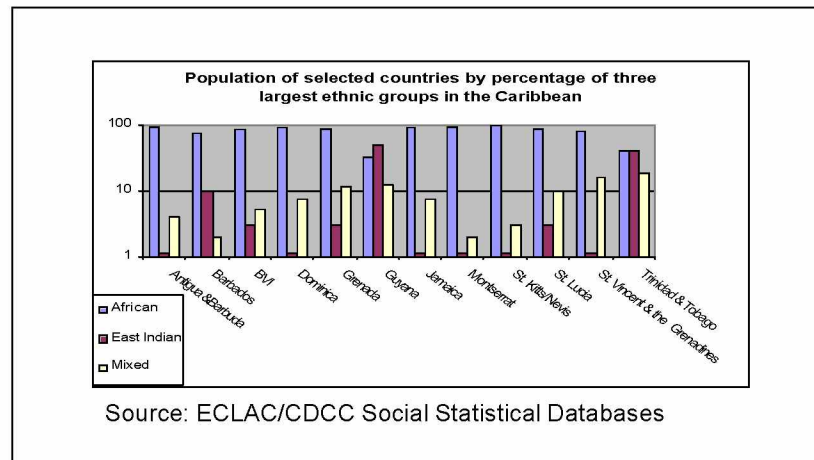
\* 2000 or most nearest available

Source 1: Poverty Eradication & Female-Headed Households (FHH) in the Caribbean (POV/96/2) ECLAC

Source 2 : ILO Subregional Office for the Caribbean

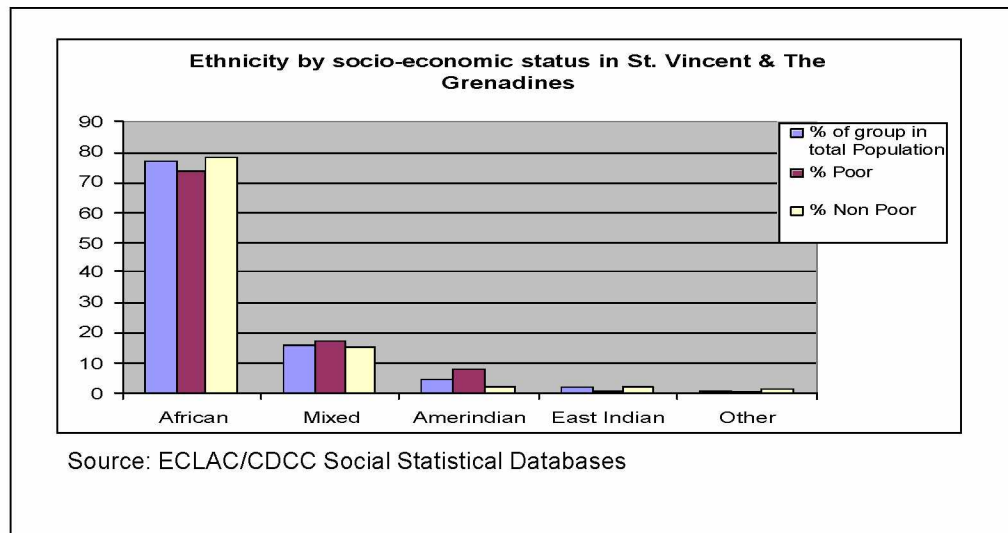
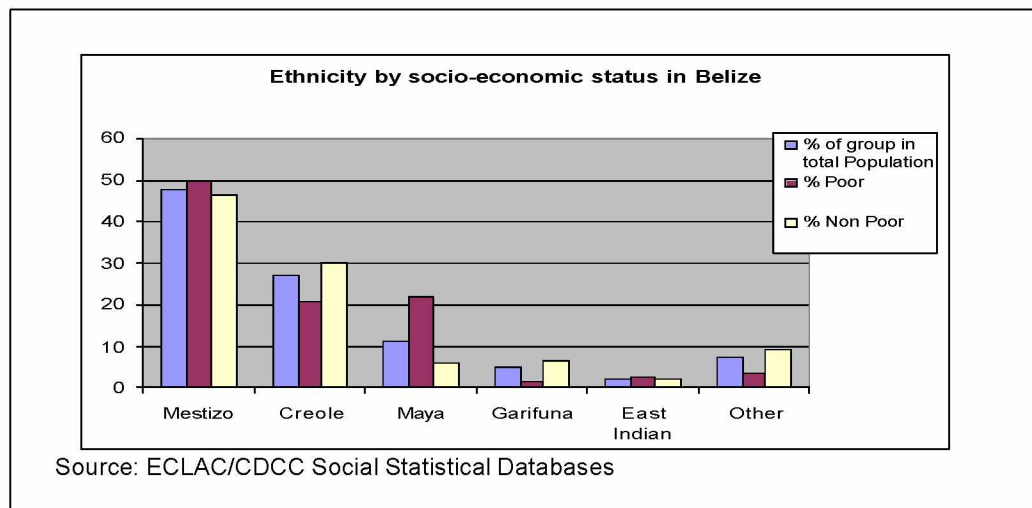
Caribbean diversity is also displayed by its composition. In this subregion there are thousands of islands and cays; a Central American country, Belize; and two countries on the South American mainland, Suriname and Guyana, which all share a common socio-historical bond. Its population of some 35 million speaks English, Spanish, Krewol, French, Dutch, Sranan Tongo, Papiamentu, Creole, Hindustani, Garifuna and numerous Mayan and other languages.

**Figure 9: Population of selected countries by percentage of three largest ethnic groups in the Caribbean**



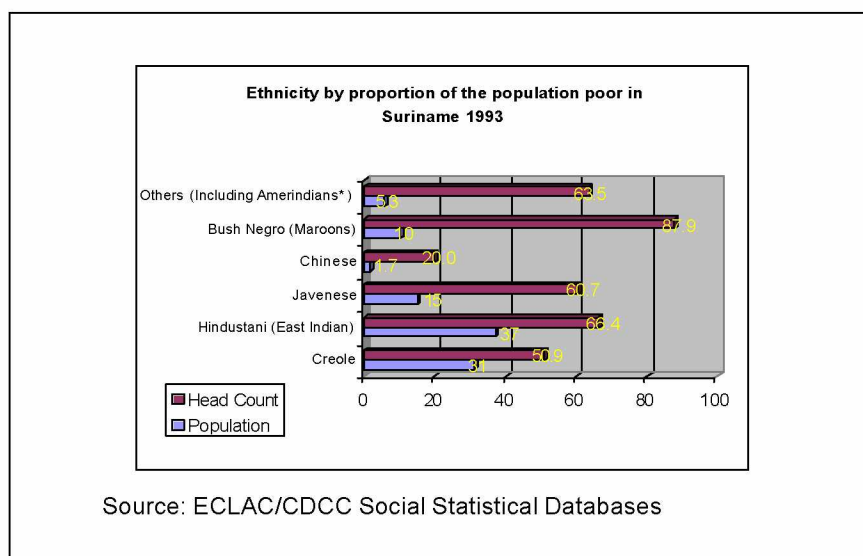
The ethnic heterogeneity of the English-speaking Caribbean is presented in Figure 9. From the data presented it is understandable why the Caribbean has been described as multicultural societies or classical plural societies. Most countries in the English-speaking Caribbean are populated predominantly by Africans and their descendants, however, significant proportions of the populations of countries such as Belize, Dominica, Guyana, St. Vincent and the Grenadines, Suriname and Trinidad and Tobago comprise different ethnicities such as the East Indians.

Poverty assessments conducted in the 1990s seem to suggest that not all groups in the Caribbean have fared equally. The Amerindian populations, where they exist, appear to be in a position of disadvantage when compared to other groups in the society. Both in Belize and St. Vincent and the Grenadines, for which data are available, the Amerindian, are overrepresented among the poor in proportion to their share in the general population. In the case of St. Vincent and the Grenadines, although the Amerindian represents only 5% of the population, they amounted to 8% of the poor and for the Maya in Belize who represent 11% of the population, they accounted for 22% of the poor. Conversely they were underrepresented among the non-poor as illustrated in Figures 10 and 11.

**Figure 10: Ethnicity by socio-economic status in St Vincent and the Grenadines****Figure 11: Ethnicity by socio-economic status in Belize**

In the case of Suriname, as illustrated in figure 12, the group that appears to be the most disadvantaged is the Maroon community or so-called Bush Negroes. Maroons are descendants of enslaved Africans who escaped enslavement and established their own communities with separate social structures and lines of authority. Maroons maintained their separate cultural beliefs, practices and languages. Figure 12 indicates that among Maroons 88% experienced poverty. This was the highest proportion for any group in Suriname. The other group with a significantly high proportion of its population experiencing poverty were the Hindustani (East Indians) among whom 66% was so identified.

**Figure 12: Ethnicity by proportion of the population poor in Suriname 1993**



Unlike what obtains in Latin America, persons of African descent in the English-speaking Caribbean do not experience similar degrees of exclusion that are apparent in the neighbouring Latin American societies. This is due to a number of factors, such as that of Africans being in the demographic majority and the structural changes that were brought about by Independence, which resulted in government being devolved into the hands of African majorities in the post independence era. The equalizing influence of full access to education, which was granted to all segments of the society, regardless of ethnicity or sex, has also played a major role. The right to equal access to education is one of the corner stones upon which social mobility in the English-speaking Caribbean has rested. It has been the basis for increasing employment opportunities and incomes.

As the subregion struggles to better position its economies in the global market place, it is expected that a higher proportion of its population would have attained education at the tertiary level. Data for highest level of education attained for Belize and St. Vincent and the Grenadines demonstrate that, on the whole, a significant proportion of their population have not attained University education. More importantly, some groups such as the Amerindian, in the case of St. Vincent and the Grenadines, and the Maya, in the case of Belize, have no reported cases of members of their population having attained University education. A positive sign, however, is what appears as a catching-up of all groups who attained secondary level education in both societies. In the case of Belize 21% of the Maya indicate that the highest level of education attained is at the secondary level. This, although still behind the Creole and the Garifuna who lead with 27% and 30%, respectively, is not too far behind. The low showing of the Mestizo population of 13% attaining secondary level education may be attributable to the recent and significant influxes of that population group into Belize as refugees from neighbouring Guatemala and their slow integration into Belize society. In the case of St.

Vincent and Grenadines the African population fares only slightly better than the Amerindian with 22% and 17%, respectively, of the population groups indicating secondary level as the highest level of education attained. The East Indian's position of 32% having attained secondary level education in St. Vincent and the Grenadines may be attributable to that group's new arrival in St. Vincent and the Grenadines and their economic position in the society as entrepreneurs.

The better position of the Amerindian populations in the English-speaking Caribbean, in regard to education, *vis a vis* their Latin American counterparts, may be ascribed to the legislative framework for education in the English speaking Caribbean. This framework supports compulsive education for all until the age of 14 in most countries.

Much more research is required in the Caribbean to obtain a fuller picture of the manner in which ethnicity and poverty are intertwined. As countries build up their stock of social statistics either through the conduct of surveys of living conditions, the collection of selective administrative data or through further analysis of census data, the role that ethnicity plays in issues of poverty, social exclusion and inclusion will be better understood.

### **3.2 Evidence-based policy formulation**

How to strengthen an evidence-based culture within the social policy arena in the subregion is an issue that continues to concern governments as they struggle to improve the quality of life of persons in the subregion. This has arisen due to the substantive criticisms of social policy in the Caribbean which have been directed both at the level of methodology and ideas. At the methodological level, the criticisms have revolved around the disjuncture between the objectives of social policy and the programmes designed to meet the stated objectives, often termed the 'planning, implementation gap' (Brown, 1996). Social policy has also been criticised for the lack of cohesiveness within the implementation processes itself (Pujadas, 1996) often demonstrated by the number of public institutions involved in similar tasks with little or no connections, resulting in inefficient use of limited resources. At the level of ideas, criticisms have been directed at the continuance of social policy in a welfare mode and its sluggishness in shifting towards a more development orientation (Green, 1999, Duncan, 1999, ECLAC, 1996). It has also been critiqued for the manner in which it is derived, being too top-down instead of more bottom-up.

Regardless of the differing nature of the criticisms, there is general agreement that a fundamental weakness in the social policy arena in the Caribbean has been its inadequate and often inaccurate information base. It has been suggested that this has lead to misguided policy formulation. This weakness has been defined to be not only at the root of the problems of formulation but also analyses, implementation, appraisal, monitoring and evaluation of social policies and programmes (Lucas, 2000, Brown, 1996). The notion that there is a need for more evidenced-based social policy

formulation in the Caribbean has been supported by leading researchers in the subregion (Henry, 1998, Green, 1999, and Thomas, 1995).

In a study on social policy and a global society, Morales-Gomez and Torres suggest that social policies are increasingly becoming vulnerable to the effects of globalization. Just as trade liberalization and globalization have brought with it rapidly changing social structures, so too, it has brought with it new social problems and exacerbated old ones. In a recent United Nations Research Institute for Social Development (UNRISD) paper on globalization, it was suggested that although the manifestations of social ills –growing poverty and insecurity, crime, extremism, violence and gender-based violence, child labour occur at the local or national level, the sources of these ills involve global problems.

The impact of these global problems has been felt almost immediately in small open societies, such as the Caribbean. Countries have responded by strengthening the regional integration processes and have arrived at a critical stage of that process, especially regarding the free movement of people, international competitiveness and human resource development. The deadlines for removal of restrictions with respect to the movement of persons under Protocol II are within the period 2003 and 2005. Many activities, such as the arrangements for the free movement of University graduates, were to be completed by June 2002 and that of cultural, media and sports personnel by December 2002. In light of this quickened pace of integration, the CARICOM Secretariat has suggested that among the major challenges in elaborating its Human Resource Development Strategy is the imperative to access and assess relevant research and data. This, it has indicated at the Fifth Meeting of the Council for Human and Social Development, Georgetown, Guyana 3-5 October 2001, is an essential requirement to inform decision-making, evaluation of progress and future planning.

Policy makers, in trying to cope with the challenges of regional integration and trade liberalization and its socio-economic impact on their populations, have articulated the need for more evidenced-based social policy at a number of Caribbean meetings. Most notably, at the Caribbean Ministerial Meeting on the Implementation of the Programme of Action for the Sustainable Development of Small Island Developing States (SIDS/POA), Barbados, 1997, governments recommended, inter alia, that "Governments in collaboration with international and regional organizations, NGOs and civil society ...establish a programme which would strengthen the capacity of the countries to apply methodologies and to collate, disseminate, analyze and use indicators within the context of guiding the sustainability of current development".

This was once again discussed at the eighteenth Session of the CDCC, at the ministerial level and commemorating its twenty-fifth anniversary, Port of Spain, Trinidad and Tobago, 30 March to 1 April 2000, governments adopted resolution 52(XVIII), sponsored by Anguilla, Antigua and Barbuda, St. Kitts/Nevis and Aruba, which noted, inter alia, "the importance of economic and social data to the planning and policy formulation process in the CDCC countries".

But for countries to arrive at a point where evidenced-based social policy could be adopted as the norm rather than the exception, it is acknowledged that certain fundamentals must be put in place. Significant among those is the strengthening of the central role of information in social policy. In that regard, relevant data must be made available, accessible and be placed in a format that is useable. Correcting for the data insufficiencies of social policy formulation is not a panacea for the social policy formulation process itself, but should enhance efficiency and lead to greater transparency.

### **3.3 Using integrated planning with a social perspective to address poverty reduction and strengthen evidence-based policy formulation**

Increasingly, in the subregion there is recognition that integrated planning which should take into consideration the economic and social dimensions of development could be a useful tool in addressing poverty reduction. However because of its holistic nature which seeks to capture the multidimensional nature of development, and its methodology which calls for time bound targets that are measurable and derived through participatory processes, engaging in the process is not an easy task. Despite its difficulties evidence points to this approach to planning as having had the most efficient, attainable and effective outcomes.

In the adoption of the Millennium Declaration, governments made clear their commitment to accept the Millennium Development Goals (MDGs) as a framework for measuring development progress. In so doing, they have committed to long-term social planning. Governments also reaffirmed their commitment to working towards a world in which sustaining development and eliminating poverty would have the highest priority. The MDGs grew out of the agreements and resolutions of world conferences organized by the United Nations in the past decade. The MDGs have time-bound targets with measurable indicators. Through the process of working towards achieving the goals, greater policy coherence and cooperation is expected to be achieved not only amongst the United Nations, its agencies and the Bretton Woods institutions but more importantly, at the national level itself.

The MDGs consist of eight goals, 18 targets and 48 indicators. The first seven goals are mutually reinforcing and are directed at reducing poverty in all its forms. The last goal, global partnership for development, deals with the means to achieve the first seven.

Caribbean countries, which in the main are middle income countries, will need to carefully consider if additional targets and indicators might be required to assist them in monitoring the achievement of their development goals.

In an expert group meeting on integrated planning, from a social perspective, convened by the ECLAC Subregional Headquarters for the Caribbean, 28 November 2003 in Belize, experts from the subregion detailed some of the difficulties and successes involved in engaging in long-term social planning. In addressing the

difficulties the successes and the lessons learnt, the following was highlighted: the need for leadership which appreciated institutional memory, understood the process of long-term planning and supported its vision; the need for the use of existing plans thus demonstrating the value of the work of the technocrats; earmarking and making available adequate financial resources from the outset; and the use of simple administrative structures to manage the process. The notion of an integrated and participatory approach to the planning process was endorsed and it was suggested that in order to achieve an integrated approach there was need to address an outcome-focused approach; an alignment between priorities and resources; full participation by key stakeholders; cross-sectoral planning; linking social and economic concerns; and comparative benchmarking of performance. Contrary to what was thought, there was evidence to suggest that there was a willingness on the part of communities to participate in the planning process. A positive outcome from the integrated planning approach could be measured by the extent of agreement between the political and administrative levels of government regarding the planning process. It was found that the process allowed both technocrats and political actors 'to be speaking from the same page' about the goals and targets for national development. Another benefit to be derived from an integrated approach to planning for the social sector is the way it is able to reduce the segmentation found in most social policy programmes and to bring together various ministries within a coherent social policy framework.

It was agreed that there were certain essential factors necessary to achieve success in the planning process. These included: the institutionalisation of the planning machinery; the development of an integrated planning approach; the promotion of broad-based ownership of the plans; public sector reform to ensure effective implementation; and reform of attitudes and values within the society. Members States such as Jamaica, Trinidad and Tobago and St. Kitts and Nevis were acknowledged for their efforts at long-term integrated planning with a social perspective.

### **3.4 Exploring the social vulnerability of Caribbean SIDS**

In seeking to address the issues of poverty reduction and sustainable human development, governments in the subregion have grappled with the issues of the vulnerability of Caribbean SIDS. The call for an undertaking to pursue work on the development of a methodological approach for the formulation of a Social Vulnerability Index came initially through the Global Conference on the Sustainable Development of Small Island Developing States, convened in Bridgetown Barbados, 26 April – 6 May 1994. At that conference governments made the call for "the development of vulnerability indices" in addition to "other statistical measures as quantitative indicators of fragility". More recently at the Alliance of Small Island States (AOSIS) interregional preparatory meeting for the World summit on Sustainable Development, held in Singapore from 7-11 January 2002, representatives called for international support for the development of a social vulnerability index "to complement" the work on the "operationalisation of the economic and environmental vulnerability indices".

Over the last three years the ECLAC/CDCC secretariat has convened a number of expert group meetings to explore the social dimension of vulnerability as it relates to Caribbean SIDS, and to develop the methodology for the construction of an SVI.

While acknowledging that vulnerability was not a new concept and that familiarity with the concept already existed in the economic and environmental field, the application of the concept of vulnerability to issues of social development proved to be complex both conceptually and operationally.

Conceptually, social vulnerability could be considered to be the opposite of social sustainability, which was economically viable, environmentally responsible, and politically, socially and culturally acceptable (St Bernard, 2003). To the extent that these virtues were being threatened and were at risk, then the process could be said to be vulnerable. In order to ascertain the vulnerability of an entity it had been suggested that one would need to question whether the strengths and opportunities inherent in a system, together with its weaknesses, were sufficient to overcome any threats that might come its way. The extent that these strengths and opportunities, mitigated by the weaknesses of the system, were not sufficient to overcome the threats showed then that the system was becoming vulnerable. This conceptualization of social vulnerability was not inconsistent with ECLAC's own conceptualization of social vulnerability as the net effect of the competition between social risk and social resilience, with resilience being a critical factor in enabling units to withstand internal and external shocks.

According to Dr. St. Bernard, the SVI could be developed using the following units of analysis: (a) the nation; (b) sub-institutions within a country e.g. community; (c) households; or (d) individuals. His proposal, however, was to focus on social vulnerability at the level of the nation. This would identify a logical and systemic approach within which indicators would be developed, starting with the nation as the largest social entity. It was also the level, according to Dr. St. Bernard, that was likely to yield the most reliable estimates of the required input data.

In this context, the following five main domains from which indicators for an SVI would be developed were identified: (a) education; (b) health; (c) the economy; (d) communications infrastructure – including the media and information technology; and (e) security systems – including governance. These were the domains that were deemed to be important in the discussion of social vulnerability in SIDS. Within these domains, Dr. St. Bernard presented a total of 13 indicators for discussion (see Table 6).

**Table 6: Recommended domains and indices to a Social Vulnerability Index**

<b>Domain</b>	<b>Indicator</b>
<b>Health</b>	1. Life expectancy at birth
<b>Security</b>	2. Index of rule of law 3. Measure of minority groups' participation in the economy 4. Measure of new/present government's respect for the commitments of previous governments. 5. Indictable crimes per x population
<b>Resource Allocation</b>	6. Proportion of children under 15 belonging to the two poorest quintiles 7. Proportion of the population 15-64 belonging to the two poorest quintiles 8. Proportion of the population 15-64 belonging to the two poorest quintiles which have no medical insurance 9. Proportion of the population belonging to the two poorest quintiles in which the head is unemployed
<b>Education</b>	10. The proportion of the population 20 years and over with exposure to tertiary level education 11. The proportion of the population 20 years and over that has successfully completed secondary education with a minimum of five GCE/CXC passes or equivalent secondary school leaving qualifications. 12. Adult literacy rate of population aged 15 years and over
<b>Communications Architecture</b>	13. Computer literacy rate of population aged 15 years and over

With regard to the collection of the requisite data for the computation of the proposed indicators, there was little disagreement that variability in the availability of data in countries across the subregion existed. The strengthening of the national statistics offices is essential to conduct the necessary surveys to elicit the data. In addition if an SVI is to be developed, greater efforts at institutional strengthening in areas such as the collection of crime data would have to be pursued.

In terms of measurement, a linear combination of the indicators, which are weighted equally, has been prepared (St. Bernard, op cit). For each input indicator, a deprivation index was to be computed by transforming scores on the indicators into a standard format.

It is the intention of the ECLAC/CDCC secretariat to continue working to test the methodology among a number of selected countries.

## **SECTION 4: CHALLENGES IN THE SOCIAL SECTOR**

The preceding sections have sought to present an overview of the current discourse on a number of the core issues involved in social development. This concluding section will seek to outline the challenges arising out of the concerns.

### **4.1 The challenges: Population dynamics of Caribbean SIDS**

Based on the lessons learnt from the analysis of the demographic transition process in the subregion and the review of existing policies and programmes, the following guidelines to address population ageing efficiently can be provided:

(a) Enhancement of research and data collection to better understand the socio-economic living conditions of the elderly. More needs to be understood on the causes of poverty at old age and the way various aspects of poverty affects the lives of elderly men and women in order to identify areas for critical intervention to enhance the quality of life for those concerned;

(b) Enhance the provision as well as coverage of social welfare programmes along with improvements of the quality of the services delivered; and

(c) The fact that women outlive men with little or no access to social welfare benefits needs to be urgently addressed. Considering the payment of widow/er benefits after the death of a beneficiary spouse (in most cases women) would greatly reduce the risk of the surviving spouse from being deprived of the main source of income.

### **4.2 The challenges: Gender equality and HIV/AIDS**

(a) Gender does not appear to be a major focus of the various plans and policies in the subregion for dealing with HIV/AIDS. The focus seems to be on changing individual sexual behaviour through approaches, such as health and behaviour communication, which thus far have proved to be largely ineffective. In order to reduce transmission risks to both men and women and especially to reverse the accelerating rates of HIV infection among women, gender relations and the structures which produce, maintain and reinforce unequal gender relations must be addressed;

(b) Women's relative lack of power and autonomy in the society is a manifestation of the unequal relations of social, economic and political power between men and women and this, in turn, is linked to their increased transmission risks for HIV/AIDS. The analysis must explore women's location in the economy and how their resulting economic dependency/poverty and its many variables, such as low educational status make them less able to access their sexual and reproductive rights and also how this leads to further erosion of other rights such as the right to bodily integrity which has direct implications for the spread of HIV/AIDS. The linkages between poverty and commercial sex work also need to be established;

(c) The specific ways in which abuse of drugs (especially cocaine) by males and by females drive the epidemic must be differentiated and responses developed accordingly; and

(d) Respect for human rights is fundamental to preventing the spread of HIV/AIDS and lessening the impact on those already infected or affected. Stigma and discrimination against persons living with HIV/AIDS must be seen in the context of all human rights violations, which are perpetrated against marginalized groups identified or perceived as 'high risk'. An analysis of the nature of these discriminations, their cultural contexts and how they prevent the adoption of safer sexual behaviour is required. Such groups include commercial sex workers, homosexuals and bisexuals, the prison population, drug addicts, etc. For example, because prostitution is illegal, prostitutes are vulnerable to abuse and as such HIV/AIDS prevention programmes may not reach them. Men who have sex with men may also avoid getting tested or seeking treatment and may get married in order to hide their sexual preference.

### **4.3 The challenges: Poverty reduction and human development**

(a) The paucity of data continues to be one of the main challenges to poverty reduction. It is necessary to collect data regarding the living conditions of populations in the Caribbean on a regular basis, certainly if not once a year then at least once every three to four years, so as to enable robust analysis for policy design, development, monitoring and evaluation;

(b) More research should be undertaken to ensure a comprehensive gender analysis of the existing poverty data despite the known weakness of social statistics in the subregion, generally, and administrative data, specifically;

(c) Political will for long-term social planning is a necessary ingredient for its success, therefore, mechanisms to better demonstrate such, must be derived;

(d) Strengthen the culture of evidence-based social policy formulation and planning in the Caribbean in order to reduce approaches to social development which have been described at best, as 'ad hoc' and at worst, as 'fire fighting approach'. This should increase efficient and effective use of limited resources; and

(e) There is a need for capacity-building in the public service, especially in the field of social planning and policy analysis. This capacity-building should be extended to the citizenry in skills building for the participatory process, which would result in the shaping of better social policy.

## Annex

### **Subregional review processes in follow-up to global international United Nations conferences: Mandates and activities**

Over the last biennium the ECLAC/CDCC secretariat has pursued its mandate to conduct subregional reviews of the implementation of the numerous agreements reached at the global conferences on social development, population and women convened by the United Nations in the 1990s. Of particular importance have been the World Summit on Social Development (WSSD), held in Copenhagen, the ICPD convened in Cairo in 1994, the Fourth World Conference on Women (FWCW), convened in Beijing in 1995 as well as the Second World Assembly on Ageing, held in Madrid in 2002. In September 2000, in resolution 55/2, the General Assembly of the United Nations adopted the United Nations Millennium Declaration. Heads of State and governments reaffirmed their commitment to peace, development, human rights and the protection of the environment.

#### **Gender and development**

Based on an overall mandate for promoting and assisting governments in monitoring and implementing the outcome of the FWCW from the outcome document itself and, in particular, on General Assembly resolution 52/100, which stresses the importance of regional and subregional monitoring of the global and regional platforms for action by regional commissions, ECLAC/CDCC convened the Fourth Caribbean Ministerial Conference on Women in St. Vincent and the Grenadines from 12 to 13 February 2004.

The task of this meeting was to review the objectives of the 1995 Beijing Platform for Action and assess their implementation. It was preceded by a technical meeting on 11 February 2004, which was attended by the heads of national machineries for women in the subregion. The Caribbean Conference was preparatory to the Ninth Regional Conference on Women, which is scheduled to take place in Mexico by mid-2004.

The Beijing Platform for Action (POA), adopted at the FWCW in 1995 reflects fundamental assumptions about the action needed to improve the lives of women. These include the need for gender mainstreaming strategies; acknowledgement of women's rights as a manifestation of human rights; and the application of gender analysis to policies and programmes for sustainable development. In addition, it assigns specific responsibilities to a range of stakeholders at the international, regional and national levels, such as governments, policy makers, and non-governmental organizations as well as the other institutions of civil society.

## Population and development

Twenty Caribbean countries reaffirmed their unequivocal commitment to the Programme of Action (POA) of the 1994 ICPD in Port of Spain on 12 November 2003. They also declared that implementation of the ICPD POA "is essential for the achievement of the Millennium Development Goals" including the eradication of extreme poverty and hunger. The Meeting adopted a Declaration in which all governments present pledged their full support to the ICPD Programme of Action. The background document as well as the declaration constitutes the Caribbean input to the Latin America and Caribbean regional assessment of the ICPD Programme of Action in May 2004.

The mandate to conduct this technical review and appraisal exercise in the subregion is based on an agreement reached by the *Ad Hoc Committee on Population and Development* at its last session held in Brasilia, Brazil, in May 2002, to review progress made in implementing the ICPD Programme of Action at its next meeting in 2004. It was also agreed that such a review should be conducted on the basis of a document to be prepared by ECLAC, in cooperation with the United Nations Population Fund (UNFPA) and using inputs from countries derived from their national reviews. The *Ad Hoc Committee on Population and Development*, a subsidiary body of ECLAC, was established based on a mandate derived from the Latin American and Caribbean Plan of Action to be responsible for the follow-up of issues pertaining to population and development. During its session held in Mexico in 2000, ECLAC adopted a resolution in which it instructed the Ad Hoc Committee to follow up on the implementation of the ICPD Programme of Action on an ongoing and systematic basis. The same responsibility was entrusted to the ECLAC/CDCC secretariat in the case of the Caribbean.

Within the responsibilities as outlined above, ECLAC/CDCC, with support from UNFPA prepared the subregional background document 'Review of the Implementation of the Cairo Programme of Action in the Caribbean (1994-2004): Achievements and Constraints' to support the national review processes as well as to assist the deliberations of this meeting. This final document also served as the Caribbean's input into the overall regional report to be prepared by the ECLAC population division (CELADE) to be presented to next meeting of the *Ad Hoc Committee* in Puerto Rico in May 2004.

## Population ageing

The continuous call for action to respond to the global challenges arising out of rapid population ageing culminated in the Second World Assembly on Ageing, which was held in Madrid 2002, where governments agreed to the implementation of a global

action plan. This new Plan of Action focuses both on political priorities such as improvements in living conditions of older persons, combating poverty, social inclusion, individual self-fulfilment, human rights and gender equality. To an increasing degree attention is also devoted to such holistic and overarching themes as intergenerational solidarity, employment, social security, health and well-being. At the regional level, ECLAC/CELADE convened the Regional Intergovernmental Conference on Ageing in Santiago, Chile, in November 2003. Caribbean officials present pledged their full support to the regional strategy developed and agreed to pursue the translation of these agreements into national policies and programmes. To assist the Caribbean governments to address this phenomenon coherently, the ECLAC/CDCC secretariat conducted an analysis of the demographic ageing process in the Caribbean along with an assessment of existing policies and programmes in the subregion. This document has been integrated into the regional background document (ECLAC, 2003a) on the situation of the elderly in the Latin American and Caribbean region, formed prepared by ECLAC/CELADE and presented to the Regional Intergovernmental Conference on Ageing.

### **Poverty reduction and sustainable human development**

Arising out of the Copenhagen Declaration and Programme of Action of the WSSD, 6-12 March, member States expressed commitments that ensured that reliable statistics and statistical indicators were developed to monitor progress made in the implementation of the said Programme of Action. This is followed by the continuous need for social data to monitor the progress made and to identify gaps in the fulfilment of Millennium Development Goals at the national and subregional level.

The ECLAC/CDCC secretariat derived its mandate to facilitate the review process with its member States by resolutions of the United Nations General Assembly. The objective of this meeting was to review the process of the WSSD+5 implementation and to report on issues of particular relevance to the Caribbean subregion. This was undertaken through the study of the capacity of the National Statistical Offices (NSOs) for the preparation of social statistics and ... in the document entitled "Challenges in Meeting the monitoring requirements of the MDGs: An Examination of Selected Social Statistics for four Caribbean Small Island Developing States (LC/CAR/G.776)".

In keeping with its mandate to support governments in the subregion addressed both the Programme of Action of the WSSD and the goals of the MDGs, the ECLAC/CDCC secretariat has, in collaboration with CARICOM and the University of the West Indies, established a fully searchable database of selected social statistics in the subregion and has organized training in evidence-based social policy formulation for some 49 senior technocrats from 19 CDCC member and associate member countries.

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