

ISSN 1727-9917

SERIES

**STUDIES AND
PERSPECTIVES**

**ECLAC SUBREGIONAL
HEADQUARTERS
FOR THE CARIBBEAN**

Implementation of the Cairo Programme of Action in the Caribbean (1994-2013)

Evaluating Progress and Renewing Commitment

Francis Jones
Andrew Fearon
Michael Hendrickson



UNITED NATIONS

ECLAC

Implementation of the Cairo Programme of Action in the Caribbean (1994-2013)

Evaluating Progress and Renewing Commitment

Francis Jones
Andrew Fearon
Michael Hendrickson



UNITED NATIONS



This document was prepared by Francis Jones of the Social Development Unit, Michael Hendrickson of the Economic Development Unit, ECLAC subregional headquarters for the Caribbean, and Andrew Fearon, Consultant. Candice Gonzales and Sinovia Moonie prepared substantive inputs and processed statistical data. The preparation of the report benefited from the comments of Dillon Alleyne, Sheila Stuart, Dirk Jaspers, Sandra Huenchuan, Patrice La Fleur, Marvin Gunter, Licida Bautista, Jewel Quallo-Rosberg, Alma Virginia Camacho, Vertha Dumont, Erika Goldson, De-Jane Gibbons, Melissa McNeil-Barrett, Mario Aguilar, Aurora Noguera Ramkissoon, Glen Smith, Judith Brielle, Althea Buchanan, Enrique Pelaez, Kathleen Taylor, Barbara Bailey, Upala Devi, Leyla Sharafi, Diane Hines, Rainer Pritzer, Chissey Mueller, Marlon Bristol, Patricia Rivera-Scott and Izola Garcia. Comments received from the Governments of Jamaica and Suriname were incorporated.

The views expressed in this document, which has been reproduced without formal editing, are those of the authors and do not necessarily reflect the views of the Organization.

United Nations publication

ISSN 1727-9917

LC/L.3757

LC/CAR/L.407

ORIGINAL: ENGLISH

Copyright © United Nations, March 2014. All rights reserved.

Printed at United Nations, Santiago, Chile

Member States and their governmental institutions may reproduce this work without prior authorization, but are requested to mention the source and inform the United Nations of such reproduction.

Contents

Abstract	7
I. Introduction	9
II. Population, Sustained Economic Growth, Poverty and Inequality	11
A. Recent Trends in Growth, Poverty and Inequality in the Caribbean.....	11
B. Determinants of poverty and inequality in the Caribbean: Getting behind the numbers	15
C. Strategies used by Caribbean Governments to alleviate poverty and inequality	18
D. Economic Growth for Reduced Poverty and Inequality	19
III. International Migration and Development: Challenges and opportunities	23
A. Trends in International Migration	25
B. International Migration: Barrier or Facilitator to Development?	30
C. Policies to Leverage Migration for Development	32
IV. Population Ageing and the Rights of Older Persons	35
A. The Changing Age Structure of the Caribbean Population	36
B. Economic Security of Older Persons	38
C. Health Care and Chronic Non-Communicable Diseases	40
D. Living Arrangements, Care Services, and Long Stay Institutions	43
E. Social Participation of Older Persons, Equality and Protection against Discrimination	44
V. The Rights of Persons with Disabilities	47
A. Participation in Social, Economic and Cultural Life.....	48
B. National Initiatives to Advance Participation, Self-Reliance and Equality.....	49
C. Realising the Rights of Persons with Disabilities	52
VI. Gender Equality, Equity and Empowerment of Women and Girls	53
A. Women’s Participation in the Formal and Informal Economy	54
B. Increasing Women’s Representation in Political Processes and Public Life	56
C. Ending gender based violence.....	57

D.	Improving the Collection, Analysis, Dissemination and use of sex and age disaggregated data, and data on the Status of Women	60
E.	Ending Child Marriage/Forced Marriage	60
VII.	Sexual and Reproductive Rights and Health	63
A.	Trends in Fertility.....	63
B.	Provision of Sexual and Reproductive Health and Family Planning Services.....	65
C.	Adolescent Sexual and Reproductive Health	67
D.	Improving Health and Family Life Education Programmes	69
E.	Male Responsibilities and Participation.....	70
F.	Improving maternal health	71
VIII.	Achieving Universal Access to HIV Prevention, Treatment, Care and Support.....	73
A.	The State of the Epidemic	74
B.	Impact on Young Women and other at Risk Groups	77
C.	National Responses to the Epidemic	79
IX.	Conclusions and Recommendations for the Further Implementation of the ICPD Programme of Action Beyond 2014	83
A.	Economic Growth for Reducing Poverty and Inequality	85
B.	International migration.....	86
C.	Population Ageing and the Rights of Older Persons.....	87
D.	Realising the rights of persons with disability	88
E.	Gender equality, equity, and the empowerment of women.....	88
F.	Sexual and reproductive rights and health	89
G.	Achieving Universal Access to HIV Prevention, Treatment, Care and Support.....	90
	Bibliography	93
	Studies and Perspectives Series - The Caribbean: issues published.....	97
 Tables		
TABLE 1	POVERTY RATE BY AGE	13
TABLE 2	INDICATORS OF POVERTY AND INEQUALITY	14
TABLE 3	PROPORTION OF MOTHERS WHO HAD THEIR FIRST BABY BEFORE AGE 20 BY QUINTILE	17
TABLE 4	COVERAGE AND AVERAGE LEVEL OF OLD-AGE BENEFITS.....	39
TABLE 5	PERSONS WITH AND WITHOUT DISABILITIES AGED 13-18 WHO ATTEND SCHOOL BY TYPE OF DISABILITY	48
TABLE 6	ECONOMICALLY ACTIVE PERSONS WITH DISABILITIES AGED 15 TO 59 BY TYPE OF DISABILITY	50
TABLE 7	PROGRESS ON IMPLEMENTATION OF MEASURES ADOPTED TO ADDRESS ISSUES REGARDING PERSONS WITH DISABILITIES DURING THE LAST 5 YEARS.....	51
TABLE 8	WOMEN'S REPRESENTATION IN PARLIAMENT	56
TABLE 9	UNMET NEED FOR FAMILY PLANNING AMONG WOMEN AGED 15-49	65
TABLE 10	PERSONS MAKING THEIR SEXUAL DEBUT BEFORE THE AGE OF 15	68
TABLE 11	PERSONS LIVING WITH HIV, 2009	75
TABLE 12	HIV PREVALENCE AMONG YOUNG WOMEN AND MEN AGED 15-24 IN THE CARIBBEAN.....	78
TABLE 13	ART (ANTI-RETROVIRAL THERPAY) COVERAGE, 2009	79
TABLE 14	PREVENTING MOTHER-TO-CHILD TRANSMISSION (PMTCT) COVERAGE, 2009	80

Figures

FIGURE 1	LATIN AMERICA AND THE CARIBBEAN: GROWTH IN REAL GDP, 1991-2011	12
FIGURE 2	UNEMPLOYMENT RATES.....	15
FIGURE 3	DEPENDENCY RATIOS (PERSONS AGED 0-14, 60+, AND TOTAL).....	17
FIGURE 4	EMIGRANTS FROM CARIBBEAN COUNTRIES AND TERRITORIES, 1990, 2000 AND 2010	26
FIGURE 5	IMMIGRANTS IN CARIBBEAN COUNTRIES AND TERRITORIES, 1990, 2000 AND 2010	28
FIGURE 6	THE CARIBBEAN POPULATION BY AGE	36
FIGURE 7	CARIBBEAN POPULATION BY AGE AND SEX, SELECTED YEARS 1990-2060	37
FIGURE 8	TIME TAKEN FOR THE PROPORTION OF PERSONS AGED 60+ TO INCREASE FROM 13 TO 26 PER CENT OF THE POPULATION	38
FIGURE 9	LABOUR FORCE PARTICIPATION OF PERSONS AGED 25-54 BY SEX.....	55
FIGURE 10	PERCENTAGE OF WOMEN AGED 20-24 WHO WERE MARRIED OR IN UNION BEFORE THEY WERE 18 YEARS OLD	61
FIGURE 11	TOTAL FERTILITY, 1970-1975 AND 2005-2010.....	64
FIGURE 12	ADOLESCENT FERTILITY, 1995-2000, 2000-2005, 2005-2010	64
FIGURE 13	CONTRACEPTIVE PREVELANCE RATES, WOMEN AGED 15-49	66
FIGURE 14	MATERNAL MORTALITY, 1990 – 2010	71
FIGURE 15	PERSONS LIVING WITH HIV	74
FIGURE 16	ADULTS AND CHILDREN NEWLY INFECTED WITH HIV PER YEAR	75
FIGURE 17	AIDS-RELATED DEATHS IN ADULTS AND CHILDREN IN THE CARIBBEAN	76
FIGURE 18	MALE FEMALE RATIO OF PERSONS LIVING WITH HIV, 2009.....	77

Maps

MAP 1	MAJOR INTRA-CARIBBEAN MIGRATIONS	29
-------	--	----

Abstract

The implementation of the Cairo Programme of Action in the Caribbean over the period 1994 to 2013 is evaluated and recommendations are made for the further implementation of the programme beyond 2014.

Recent trends in growth, poverty and inequality in the Caribbean include: the negative impact of the global economic crisis on the Caribbean; declines in extreme poverty; the persistence of poverty measured against national poverty lines; and high levels of inequality. Social, labour market and economic policies all need to target reductions not only in poverty, but also in inequality.

The positive and negative impacts of international migration are discussed along with strategies to maximise the benefits of migration such as engagement of the diaspora in national development, managed immigration, liberalisation of movement within the CARICOM Single Market and Economy (CSME), and protection of the rights of migrants. The ageing of Caribbean populations is analysed as the need for Caribbean governments to ensure that older persons are able to enjoy economic security, independence, access to health and care services, and protection from discrimination and abuse.

Using results from the ICPD global survey, the implementation of strategies, programmes and policies for persons with disabilities is shown to be either deficient or behind schedule in many countries. There has been progress towards the goal of gender equality in the Caribbean, with important advances in education and the labour market although progress towards equal female representation in national parliaments has been slow and gender based violence remains a pervasive problem.

In the area of sexual and reproductive health there was an expansion in the provision of services, which contributed to lower fertility rates and there were also reductions in maternal mortality. There was significant progress in reducing the rate of new HIV infections. However, in order to achieve universal access to sexual and reproductive rights and health, service provision must be further strengthened and barriers to access eliminated. This is especially true for groups such as adolescents and youth, women living poverty and in rural areas, men, persons with disabilities and lesbian, gay, bisexual and transgender persons.

I. Introduction

It has now been almost twenty years since the International Conference on Population and Development (ICPD) agreed to a far reaching Programme of Action which integrated population, development and human rights agendas. The Programme agreed in Cairo in 1994 was initially envisaged as a twenty year plan. With the approach of this anniversary, the United Nations General Assembly by its resolution 65/234 (2010) mandated the United Nations Population Fund (UNFPA), in consultation with Member States and in cooperation with relevant organizations of the UN system and other international organizations, to undertake an operational review of the Programme's implementation. It also decided that commitment to furthering implementation of the Programme's goals should be extended beyond 2014.

The ICPD 'Beyond 2014' review thus presents a timely opportunity to evaluate progress on this platform which is fundamental to the shaping of policies and strategies to enhance human development and to assure human wellbeing for the future. Indeed, the crucial linkages between the implementation of the Cairo Programme of Action and achievement of the Millennium Development Goals were affirmed by the international community in resolution 65/234.

The ICPD was significant for the global action agenda that it created which, for the first time, acknowledged and addressed the symbiosis of population and development issues. Building on the work of previous population conferences, it consolidated an international consensus that population trends, sustainable development and human rights were so closely interconnected that none should be addressed in isolation. The Programme of Action thus responds to the need for a systematic approach to population and development, embracing issues of priority concern to the Caribbean including poverty and inequality; the welfare of the family; gender empowerment; ensuring universal access to reproductive health care and family planning services; the integration of population concerns such as international migration and population ageing into development planning; the prevention of sexually transmitted infections including HIV; and the sustainable use of resources. While there has been much progress on these issues, many challenges remain.

The twenty-year review of the Cairo Programme of Action is one of the dynamic review processes currently ongoing at the international level for which clear synergies exist in respect of global human development objectives. These include the twenty-year review in 2014 of the Programme of Action for the Sustainable Development of Small Island Developing States adopted in Barbados in 1994;

the twenty year review in 2015 of the Platform for Action agreed at the Fourth World Conference on Women in Beijing in 1995; and the 2015 assessment of the Millennium Development Goals (MDGs) in anticipation of the shaping of a post-2015 development agenda. These processes have inspired a growing convergence of views on the need for the international community to shape a comprehensive, integrative sustainable development agenda, in collective response to these mandates that will more appropriately address the challenges and embrace the opportunities that countries face in the twenty-first century. Within this framework, it is important that the review of the Cairo Programme of Action rekindles a global commitment to ensure that population concerns remain an integral part of the post-2015 development agenda.

The ICPD agreed that the Regional Commissions should play an active role in the implementation of the Programme of Action through both regional and subregional activities.¹ On this basis, the Economic Commission for Latin America and the Caribbean (ECLAC) joined in partnership with the UNFPA and the Caribbean Community Secretariat (CARICOM) to convene the Caribbean Forum on Population, Migration and Development in Georgetown, Guyana, which was held from 9 to 10 July 2013. The Caribbean Forum was an opportunity for review and evaluation of the implementation of the ICPD Programme of Action in the Caribbean and prepared the subregion for participation in the first Regional Conference on Population and Development in Latin America and the Caribbean held in Montevideo, Uruguay, from 12 to 15 August 2013.

The Forum was also intended to prepare the Caribbean for the second high level dialogue on international migration which was convened by the United Nations General Assembly in October 2013. This topic is of particular relevance to the Caribbean since the subregion, with its highly mobile population, continues to be significantly impacted by the migration of Caribbean nationals, particularly among the more educated and skilled population. The Forum also served as the culmination of an Intra-ACP Migration² initiative intended to build capacity within Caribbean member states to mainstream migration into development planning, so that they can more effectively manage the impact of international migration on their economies, and on the socio-economic wellbeing of their peoples.

This report, prepared by the ECLAC Subregional Headquarters for the Caribbean in consultation with its partners, has been structured to support the dialogue and review of all these initiatives. It provides a comprehensive assessment of progress achieved and continuing challenges in the implementation of the Cairo Programme. The first substantive chapter takes as its starting point an evaluation of progress made in the subregion in terms of economic growth and the reduction of poverty and inequality. Subsequent chapters assess the response to important demographic trends and other aspects of the population and development agenda, with the realisation of rights and links to poverty and inequality remaining recurrent themes throughout the report. There are separate chapters assessing progress towards implementation of those aspects of the Cairo programme which are of greatest importance in the Caribbean: managing international migration; addressing population ageing; realising the rights of persons with disabilities; achieving gender equality; universal access to sexual and reproductive rights and health care services; and the response to the AIDS epidemic. The report closes with a brief summary of progress since 1994, and offers practical recommendations for future action within a framework of renewed commitment by the subregion to implementation of the Cairo Programme of Action.

¹ See paragraph 16.16 of the ICPD Programme of Action.

² A project initiated by the ACP Group of States (African, Caribbean and Pacific).

II. Population, Sustained Economic Growth, Poverty and Inequality

The interrelationships between population, economic growth, poverty and sustainable development are at the heart of the ICPD Programme of Action. The first substantive chapter of the Cairo Programme deals with the integration of population concerns into development planning ‘with the goal of meeting the needs, and improving the quality of life, of present and future generations’, and promoting social justice and the eradication of poverty through ‘sustained economic growth in the context of sustainable development’.

Population trends have important, often unrecognised, impacts on economic and social development. While international migration has long shaped the development of the Caribbean, population ageing is an emerging trend which will have important economic and social effects over the next two decades and beyond. The increasing prevalence of chronic non-communicable diseases and the ongoing AIDS epidemic are also exerting heavy economic and social costs. Meanwhile, high rates of adolescent pregnancy and single parenthood impact upon the lives of women and children. These are all challenges which need to be addressed to mitigate their impact.

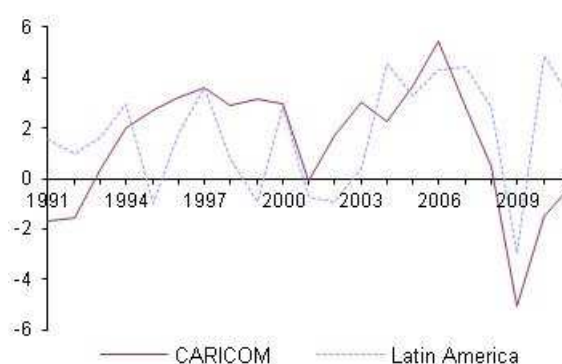
This chapter takes as its starting point an assessment of the subregion’s progress in terms of economic growth, poverty and inequality. Some of the linkages between population trends, growth, poverty and inequality are introduced in a discussion of the determinants of poverty. The chapter provides a review of the efforts of governments to tackle poverty and makes a number of recommendations aimed at promoting sustainable growth for reduced poverty and inequality. More detailed assessments of the population related challenges, within the framework of a rights based approach to development and including links with poverty and inequality, are then the subject of the remaining chapters of the report.

A. Recent Trends in Growth, Poverty and Inequality in the Caribbean

Caribbean economies are small and open with undiversified economic structures and are therefore vulnerable to the influence of economic shocks. This was made evident by the impact of the global

economic crisis on CARICOM states especially those that relied heavily on tourism as the main source of foreign exchange. Growth in real per capita income in the Caribbean was on an upward path before the global economic crisis starting in 2007/8. Real per capita income grew by an average of 1.4 per cent per year from 1991-2000 and 2.2 per cent per year from 2001-2007. However, the region was badly affected by the crisis, particularly the tourism and offshore financial services sectors. This has worsened budget deficits, increased levels of debt, and constrained government expenditure. As a result, growth declined to -1.6 per cent per year during the period 2008-2011. This is in marked contrast to Latin America which due largely to strong demand for commodities, posted relatively strong per capita GDP growth of 2.0 per cent since the onset of the crisis.

FIGURE 1
LATIN AMERICA AND THE CARIBBEAN: GROWTH IN REAL GDP, 1991-2011
(Percentages)



Source: CEPALSTAT.

Since 2000, those Caribbean economies which are exporters of natural resources, which include Guyana, Belize, Trinidad and Tobago and Suriname, performed better than their service-based counterparts (although growth in Belize, Guyana and Suriname was from a low base). Per capita GDP growth was highest in Trinidad and Tobago at 4.3 per cent per year over the two decades, followed by 3.7 per cent in Suriname and 3.6 per cent in Guyana reflecting the impact of strong demand for commodities. Meanwhile, per capita GDP growth was a mere 0.1 per cent in the Bahamas.

Over the last two decades, growth in per capita GDP contributed to the decline in extreme poverty or indigence,³ particularly in Trinidad and Tobago and the Eastern Caribbean. In relatively few countries are significant proportions of the population living beneath the indigence line, although exceptions to this would include Belize and Guyana (see Table 2).

Progress in reducing poverty⁴ has been less evident. In the last two decades, among the ten countries for which there was data for more than one period, poverty declined in five countries while it increased in the other five. Nevis registered the largest decline in poverty in the region (16 per cent) more than twice the rate of its sister island St. Kitts, reflecting strong growth in good quality employment in tourism and improved social programmes to help the poor. In Guyana poverty declined from 43 per cent in 1993 to 36 per cent in 2006. Poverty reduction in Guyana was facilitated by the

³ A household is deemed to be indigent if it is unable to satisfy minimum nutritional requirements. This is an indicator of extreme poverty in the sense that it is a measure of whether a household's expenditure is sufficient to meet its need for food (even if the household has no money for shelter, electricity, clothes or household goods). Indigence should be interpreted as a measure of absolute poverty rather than a measure of relative poverty.

⁴ A household is deemed to be poor if its expenditure falls below a national poverty line. These poverty lines are calculated in such a way that the poverty estimates should be regarded as measures of relative rather than absolute poverty.

revival of growth, macroeconomic reforms and the International Monetary Fund and World Bank's HIPC (Heavily Indebted Poor Countries) debt relief initiative. In Jamaica, poverty declined in the first half of the 1990s but with weak growth in per capita income further gains have not been sustained. The poverty rate fell to 9.9 per cent in 2007, although it has since risen sharply to 17.6 per cent in 2010. Belize registered the largest increase in poverty from 34 per cent to 41 per cent between 2002 and 2009. This was associated with the fall-out from the crisis and the constraint of high debt that limited the ability of government to undertake social spending.

TABLE 1
POVERTY RATE BY AGE
(Percentages)

	0-14	15-24	25-44	45-64	65+	All persons	Poverty line (dollars per adult male per year)	Year
Bahamas ^a	13.9	9.1	4.9	3.5	6.3	9.3	2 863	2001
Jamaica	20.2	18.6	11.9	14.0	18.7	16.5	...	2009
Trinidad and Tobago	23.0	22.1	15.6	11.5	6.7	16.7	...	2005
Antigua and Barbuda	24.6	21.6	14.0	15.3	15.2	18.4	2 366	2005/06
Saint Kitts and Nevis	31.3	28.0	17.6	10.9	10.6	21.8	2 714	2007
Saint Lucia	36.9	32.5	25.0	21.3	19.1	28.8	1 905	2005/06
Saint Vincent and the Grenadines	38.1	36.1	28.0	21.7	18.8	30.2	2 046	2007/08
Dominica	38.7	29.1	27.2	21.2	23.0	28.8	2 307	2008/09
Belize	50.0	43.0	35.0	31.0	34.0	41.3	1 715	2009
Grenada	50.8	47.7	33.0	24.8	13.3	37.7	2 164	2007/08

Source: Country poverty assessments and ECLAC calculations based on Surveys of Living Conditions.

^a Figures correspond to the following age groups: 5-14, 15-19, 35-54, 55-64, 65+.

Country poverty assessments also define a vulnerability line equal to 1.25 multiplied by the value of the poverty line. This naturally includes a further segment of the population living in households which could easily slip into poverty, and whose situation is highly vulnerable to changes in circumstance, for example a reduction of income, additional care responsibilities, rising prices, unexpected expenditures such as medical bills.

As shown in Table 1, a striking feature of poverty in the Caribbean is its impact on children and young people. In all countries where data was available, children and young people were more likely than older persons to be living in poverty. The high number of children living in poverty is a particular concern because the social, health and educational disadvantages experienced by poor children impact their development in a way which can have detrimental effects on the rest of their lives.

The persistence of poverty in the Caribbean is caused in part by continuing high levels of inequality. It is well established that Latin America and the Caribbean is the most unequal region in the world in terms of the distribution of income and consumption. At first sight, the statistics would suggest that Caribbean countries are not as unequal as those in Latin America. However, while Latin American countries use income based measures of inequality, Caribbean countries use expenditure based measures, which tend to produce lower estimates of inequality. At least some of the apparent difference between estimates of inequality in the Caribbean and in Latin America is likely to be due to these different methodologies.

TABLE 2
INDICATORS OF POVERTY AND INEQUALITY

Country	Year	Poverty rate (percentage)	Indigence rate (percentage)	Poverty Gap	Poverty Severity	Poverty Line (dollars per year)	Indigence Line (dollars per year)	Gini coefficient for consumption
Anguilla	2002	23	2.0	6.9	3.2	2 937	1 135	0.31
Antigua and Barbuda	2006	18.4	3.7	6.6	3.8	2 366	917	0.48
Bahamas, The	2001	9.3	5.1	2.8	1.3	2 863	964	0.57
Barbados	1997	13.9	...	...	...	2 751	1 448	0.39
	2010	19.3	9.1	6.0	3.2	3 931	1 985	0.47
Belize	1996	33.0	13.4	8.7	4.3	644	377	...
	2002	33.5	10.8	11.2	6.1	...	...	0.40
	2009	41.3	15.8	11.0	5.0	1 715	1 003	0.42
British Virgin Islands	2002	22.0	<0.5	4.1	1.7	6 300	1 700	0.23
Cayman Islands	2007	1.9	...	0.4	0.2	3 319	...	0.40
Dominica	2002	39.0	15.0	10.2	4.8	1 260	740	0.35
	2008/09	28.8	3.1	8.9	4.0	2 307	902	0.44
Grenada	1999	32.1	12.9	15.3	9.9	1 208	530	0.45
	2008	37.7	2.4	10.1	4.0	2 164	887	0.37
Guyana	1993	43.0	29.0	...	...	380	281	...
	1999	35.0	19.0	12.4	...	510	...	...
	2006	36.1	18.6	11.5	...	...	...	...
Jamaica	1990	28.4	8.3	...	...	...	...	0.38
	1995	27.5	9.0	...	...	...	...	0.36
	2000	18.7	5.0	...	...	...	...	0.38
	2005	14.8	4.3	...	...	...	...	0.38
	2010	17.6	6.3	...	...	...	...	...
Montserrat	2008/09	36	3	10.2	4.8	5 333	1 754	0.39
St. Kitts and Nevis								
St. Kitts	2000	30.5	11.0	2.5	0.9	1 244	791	0.39
	2008	23.7	1.4	6.4	2.6	2 714	961	0.38
Nevis	2000	32.0	17.0	2.8	1.0	1 460	908	0.37
	2008	15.9	0.0	2.7	0.8	3 625	1 086	0.38
St. Lucia	1996	25.1	7.1	8.6	4.4	695	371	0.50
	2006	28.8	1.6	...	...	1 905	588	0.42
St. Vincent & Grenadines								
Grenadines	1996	37.5	25.7	12.6	6.9	450	393	0.56
	2008	30.2	2.9	7.5	3.0	2 046	906	0.40
Suriname	2000	44.2	...	17.8	...	...	...	0.47
	2008	51.3	...	13.5	...	...	...	0.44
Trinidad and Tobago	1992	21.2	11.2	...	...	570	420	0.42
	1997	24.0	8.3	5.3	2.8	753	457	0.39
	2005	16.7	1.2	4.6	2.0	...	...	0.39
Turks and Caicos Islands	1999	25.9	3.2	5.7	2.6	2 424	880	0.37

Source: Caribbean Development Bank Strategic Plan 2010 – 2014; Country Poverty Assessments; Survey of Living Conditions Reports (Bahamas, Barbados, Jamaica and Trinidad and Tobago); MDG Progress Reports (Jamaica, Guyana and Suriname).

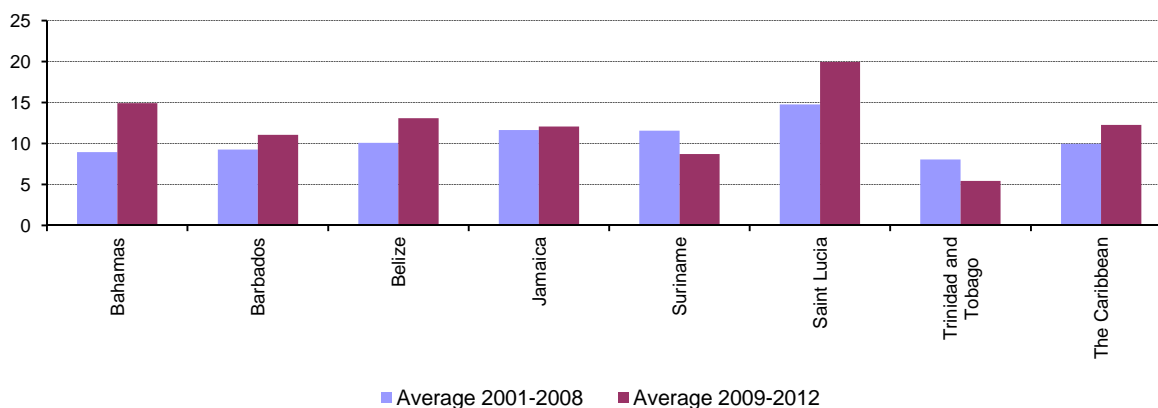
In the majority of Latin American states, income based Gini coefficients are between 0.45 and 0.55 but have been falling since the early 2000s.⁵ Meanwhile, the expenditure based Gini coefficients for the Caribbean countries averaged around 0.41 in the 2000s with, as of yet, no evidence of any decline.

The issue of whether growth is distribution neutral is critical for the Caribbean. Empirical research in a number of developing countries showed that in economies that combined growth with falling inequality, median headcount poverty declined by 10 per cent per year, while it only fell by 1 per cent per year in those where growth came with rising inequality (Ravallion, 2005). This suggests that growth alone is not sufficient, but needs to be combined with policies to address inequality. Moreover, recent work by Berg and Ostry (2011) found that income distribution is a robust determinant of the ability of countries to sustain high growth episodes. Indeed, among other significant determinants of growth sustainability such as trade openness, political institutions and exchange rate competitiveness, income distribution was found to be the most robust variable. This suggests that not only would reducing inequality reduce poverty, but that it would also be good for growth.

B. Determinants of poverty and inequality in the Caribbean: getting behind the numbers

Central to any consideration of poverty and inequality, are the nature and quality of the employment opportunities available and the adequacy of social safety nets to support the most vulnerable. The biggest direct causes of poverty are unemployment, underemployment and inadequate incomes. The twin challenges facing all Caribbean economies are to raise growth and productivity and so provide a greater number of high quality jobs —higher skilled and better paid— in order to raise living standards and reduce poverty. This in turn expands the fiscal space for strengthening social protection systems which further reduce poverty.

FIGURE 2
UNEMPLOYMENT RATES
(Percentages)



Source: ECLAC, based on official data and ECLAC/ILO, available at <http://www.ilocarib.org.tt/images/stories/contenido/pdf/LabourMarketInformation/cepal-oit-nov2012.pdf>.

⁵ Lustig (2012) notes that poverty and inequality in Latin America have benefited from a shift in favour of low income workers, relative to highly skilled workers and much more generous social programmes made possible by higher government revenues with the boom in commodity prices.

Unemployment rates in the Caribbean are relatively high. The average rate (for seven countries) was 10.0 per cent over the period from 2001 to 2008 increasing to 12.3 between 2009 and 2012 (see Figure 2). Unemployment tends to be higher among young persons and women. The extent of formal versus informal sector employment is also a major determinant of poverty. Countries such as Belize, Dominica, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Guyana, and Jamaica where the informal sector accounts for a significant proportion of total employment, tend to have higher poverty rates. The pay or self-employment income of informal sector workers is likely to be lower than formal sector workers, and they are not covered by social security systems.

Formal sector workers have also been affected by a trend towards ‘casualisation’ of employment relations in some sectors. Globalization has seen a steady drive to boost economic efficiency and profitability, and a weakening of the role of trade unions, often at the expense of traditional standards of decent work and a living wage. This has led to employment becoming more precarious with fixed, long-term contracts being replaced by temporary work in a number of sectors and activities, particularly those that face the most intense price competitiveness pressures. One of the clearest manifestations of this casualisation of work is in the free zones in sectors such as garments and call centres.

Caribbean countries have been trying to integrate more into the world economy on more favourable terms. One reason for this is the recognition that improved trade competitiveness can act as a catalyst for reducing poverty and inequality. Trade can help to reduce poverty and inequality by its impact on growth, especially where it stimulates demand for labour intensive products that generate employment for the poor. This has been the case with the development of call centres and electronic parts and other enclave manufacturing in the Caribbean. Nevertheless, there is a need for countries in the region to upgrade the products and services that they trade by incorporating greater knowledge, science and technology in their production systems. This is an imperative of the knowledge economy, where the sophistication of a country’s exports is a key determinant of ability to earn foreign exchange (Hausmann, Hwang and Rodrik, 2005). Caribbean governments have acknowledged the importance of the shift towards the knowledge economy and have been undertaking measures to increase the knowledge intensity of production. Important policies in this regard include the liberalisation of telecommunications regimes to stimulate the widespread diffusion and use of information and communication technology (ICT), upgrading of bureaus of standards to improve standards setting and greater investment in tertiary education and skills training.

The ability of the region to tackle poverty and inequality is also dependent on the extent to which it can restructure to produce exports that use domestic capital⁶ intensively. Upgrading to produce these types of exports, including cultural products and services, as well as education services can help both to increase the sophistication of the regions exports and to provide high quality jobs at home. This is key to increasing the availability of decent work to reduce poverty and inequality. This again implies that poverty and inequality relate not only to the present state of individuals and a society, but to the mechanisms for capability building that allow people to develop the human capital potential and the quality of supporting institutions that assist them in the process.

There is also a spatial dimension to work and poverty. Poverty is generally most severe in rural areas especially in Belize, Guyana and Suriname. The working poor in rural areas comprise mainly small farmers and fishermen who confront low productivity, sporadic wages and in many cases a mere subsistence existence. Their livelihoods are also more easily disrupted by natural disasters. In urban settings on the other hand, the working poor are usually paid higher wages than rural workers, although employment may be insecure. In countries with large informal sectors, the urban poor include ‘hucksters’, ‘higglers’ and other small traders, activities which barely provide liveable incomes.

There is a strong association between poverty and high adolescent fertility (Table 3). Limited career prospects, lack of youth-friendly sexual and reproductive health services, and transactional sex all contribute to adolescent pregnancy. The social and economic skills of adolescents are generally not

⁶ Domestic capital refers to the physical means of production produced within a country along with supporting institutions.

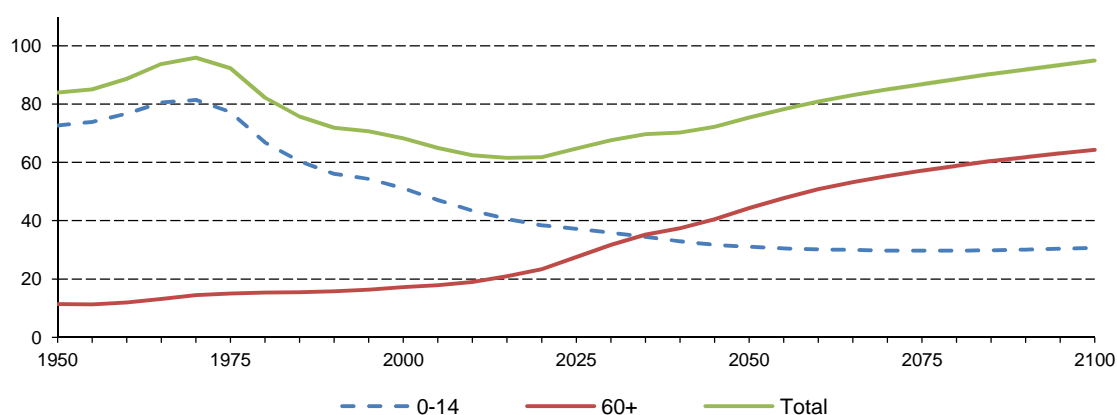
developed enough to manage the double burden of supporting a family and continuing with higher education. In most of the countries, due to stigma and discrimination, lack of supportive services such as child care, and in some cases due to the policies of the education system, girls who become pregnant are not allowed to continue their education. This reduces their opportunities in life and increases gender inequities.

TABLE 3
PROPORTION OF MOTHERS WHO HAD THEIR FIRST BABY BEFORE AGE 20 BY QUINTILE
(Percentages)

	Expenditure quintiles					All	Year
	Bottom	2nd	3rd	4th	Top		
Saint Lucia	74.6	57.6	47.1	44.4	39.4	52.2	2005/06
Saint Vincent and the Grenadines	68.7	53.0	59.7	42.1	31.0	51.8	2007/08
Dominica	57.6	49.7	38.7	37.1	39.3	44.6	2008/09
Grenada	62.4	46.5	43.0	37.4	25.0	44.3	2007/08
Saint Kitts and Nevis	62.2	52.7	40.9	27.6	22.1	42.3	2007
Antigua and Barbuda	54.2	46.3	45.4	27.7	28.7	40.0	2005/06

Source: Surveys of Living Conditions.

FIGURE 3
DEPENDENCY RATIOS, PERSONS AGED 0-14, 60+, AND TOTAL
(Percentages)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2011).
World Population Prospects: The 2010 Revision, CD-ROM Edition.

Since the 1970s the decline in the total fertility rate has led to falling child dependency ratios⁷ which would have contributed to growth in GDP per capita and a decline in absolute poverty (Figure 3). It was shown that over recent years the same age structural transformation in Latin America was the biggest single cause of falling poverty in that region (Ros, 2009). However, from now onwards more rapidly increasing old-age dependency ratios will more than outweigh the impact of further declines in child dependency, and the increase in the total dependency ratio will act as a drag on growth in GDP per capita.

⁷ In this case the child dependency ratio expresses the number of children (aged 0-14) as a percentage of the working age population (aged 15-59); the old age dependency ratio is the number of older persons (aged 60 and over) as a percentage of the working age population; and the total dependency ratio is the sum of the child dependency ratio and the old age dependency ratio.

There will also be an increase in the number of persons suffering from chronic non-communicable diseases (CNCDS) and with disabilities, both linked to the ageing of the population. This will impact the productivity of the workforce and impose additional economic costs arising from health and care needs. In this context, faster growth in GDP per worker, strategies to address the ageing populations and reductions in inequality will be essential to achieve significant reductions in poverty rates.

Governments also recognize the importance of prudent management of territory and environmental resources to growth and poverty reduction. In many parts of the Caribbean there are irregular settlements where the poor occupy marginal land surrounding urban areas. Such settlements may lack proper infrastructure and be at greater risk in the case of natural disasters such as hurricanes, floods, and landslides.

Food vulnerability is also a problem for the poorer segments of the population in the region. The severe impact of food inflation on the poor during the international food price hike in recent years, suggest that major domestic food production constraints remain in the region. In the wake of the crisis, a number of countries have been trying address food sustainability both from the supply and demand sides. On the supply side, incentives including the provision of affordable land, seeds and other inputs have been provided for farmers to increase their production. Also, in countries such as Trinidad and Tobago, the government has established model farms that provide best practice quality benchmarks that could be emulated by small farmers. Governments are also trying to shape demand through education and advocacy by encouraging citizens to consume more unprocessed local foods that are often more nutritious. This is particularly important given the epidemic of life style related illnesses such as heart disease, hypertension and diabetes in region.

C. Strategies used by Caribbean Governments to alleviate poverty and inequality

Caribbean development strategies are focused on sustainable development. This requires sustained high growth rates, improved social welfare, reduction of poverty and inequality, and environmental management, including responding to the effects of climate change. Governments have prioritised high levels of employment centred on decent work as a way of reducing poverty and inequality. However, these priorities need to be met by concrete actions. Many countries are still to implement a documented employment policy to address employment issues in a systematic, sustained and coherent manner. A key factor in this regard may be a functioning labour market information system (LMIS) that could provide the basis for evidenced-based policies. A number of countries including Antigua and Barbuda, Jamaica, St. Lucia, St. Vincent and the Grenadines and Trinidad and Tobago are currently establishing LMIS.

Recent development strategies have prioritized economic restructuring with the promotion of economic sectors and activities that will stimulate growth and job creation. An important aspect of this strategy is promoting a balance of labour and capital intensive activities that can generate more employment on the one hand, and drive productivity and efficiency on the other. This is critical as the employment elasticity of growth in the region has tended to be low, in other words growth has not resulted in the expected levels of job creation. The International Labour Organization (ILO) Global Jobs Pact 2009 suggests that full and productive employment and decent work should be put squarely at the centre of the response to the global crisis. This could include a number of measures, including investing in workers' skills development, supporting job-creating sectors of the economy, improving social protection systems and strengthening labour standards, among others.

Recent policy has given a priority role to the private sector as the engine of growth and employment.⁸ Governments have used a number of incentives including tax breaks, duty free concessions, provision of industrial estates and assistance with marketing among others to encourage the private sector to increase production in a range of activities. Given the important complementary role for

⁸ It must be noted, however, that the state sector is a major employer in most countries, a legacy from the pre-independence period.

foreign direct investment in generating, jobs, tax income and transferring technology, governments have provided generous incentives to foreign investors. These incentives are aimed at stimulating economic activity and job growth, which have been viewed as the surest way to reduce poverty and inequality in the region. Indeed, with the global demand for affordable labour in the ICT sector, a number of Caribbean governments have established call centres, which provide employment, particularly for women, who otherwise might have been excluded from the labour market.

To ignite growth, a number of governments have given priority to small and medium sized enterprises (SMEs), which are often more labour intensive in their activities. To encourage the creation of new SMEs in Trinidad and Tobago a Micro Enterprise Loan Facility, administered through community-based organizations, provides credit to small entrepreneurs. The maximum grant is approximately US\$1,560. The Regional Micro Project Fund provides micro-grants to community based organisations and NGOs to implement poverty reduction projects within their communities. The grant can also be utilised to fund joint projects between Civil Society Organizations (CSOs) and Government Organisations. The maximum Grant is approximately US\$7,800. In addition, SMEs are seen as an avenue for self-employment, which can reduce the role of the public sector as employer of last resort and the public wage bill. Nevertheless, a number of binding constraints, including a lack of venture and other start-up capital, weak management systems and poor business extension services means that SMEs have not nearly met their potential in generating employment in the region.

Economic growth is essential for expanding the public sector's tax and other incomes that can be used to fund improved social protection and social welfare programmes which contribute to reducing poverty and inequality. Generally, those countries that have grown fastest in recent years have made the greatest improvements in their social welfare systems. Growth also enables spending on health and education to be increased which in turn improves the state of health and skill level of the workers.

A number of Caribbean countries have implemented versions of the Puente programme that has been adopted in Chile. This programme provides tailored assistance to individual members of households designed to enable them to support themselves and ultimately to leave the programme.

Some programmes, especially the 'conditional cash transfer' mechanisms have had commendable success. In Jamaica, the Programme for the Advancement through Health and Education (PATH) has been able to make a difference, especially in the lives of children. The programme targets poor families with children under 17 years old, adults over 60 years, unemployed persons in need, persons with disabilities and pregnant and lactating women. The programme provides conditional cash transfers and free access to school meals and health services. Evaluation reveals that the programme has had a significant impact on preventive health visits by children and improved school attendance. In Belize, the BOOST Programme provides a small monthly allowance to persons living in poor households conditional upon children being vaccinated, school attendance, and, for pregnant women, attendance at public health centres.

There are also important initiatives intended to reduce adolescent pregnancy in, for example Jamaica, Belize (strengthening of the HFLE programme), Guyana (Youth Friendly Spaces; Youth Friendly Health Centres) and Suriname (involvement of youth through the Youth Advisory and Youth Advocacy Groups and the Youth Parliament). Efforts have focused on the development of information and counselling services, access to contraceptives, youth-friendly spaces for the provision of services, and involvement of youth groups. The United Nations Population Fund (UNFPA) is currently working with the CARICOM Secretariat to develop a regional strategy to address adolescent pregnancy.

D. Economic Growth for Reduced Poverty and Inequality

Governments, the private sector and civil society need to agree on a package of measures aimed at pro-poor growth, by targeting sectors and activities, especially in labour intensive sectors, that will deliver decent jobs for the poor.

1. Reigniting broad-based growth

The slowing engine of growth in the subregion has been related to the slowdown in productivity and flagging competitiveness of tourism, agriculture and offshore financial services. Given the continued importance of these sectors, especially tourism, there is need for policy makers and the private sector to design programmes to upgrade productivity and competitiveness. The tourism sector in particular would benefit from product/service upgrades to strengthen its competitiveness. In the case of smaller tourist properties this could be facilitated by moderate investment in improving their plant, better use of information and communication technologies (ICT) to strengthen procurement and marketing systems, and sourcing of food and beverage inputs from local suppliers where they meet price and quality benchmarks. There should be a wider focus on improving the tourism value chain, improving recreation, entertainment and product offerings such as souvenirs to increase tourist spend in the region.

2. Strengthening investment in human capital to deliver more decent jobs

More careful attention by policy makers to making labour markets efficient would be welcome. Labour market information systems (LMIS) should be strengthened to enable a more robust fit between the skills required by employers/businesses and what is taught and acquired in tertiary and technical/vocational institutions. Collaboration between governments and the private sector to cultivate a culture of continuous learning in their establishments would ensure that workers are continually retooling their skills and competencies to meet the changing demands of the workplace. There is also need to address the formalization of informal sector activity by streamlining bureaucratic processes and providing incentives such as skills training, entrepreneurship training, and easier access to appropriate sources of credit for businesses. This formalization could help to lift the quality of work and remuneration.

3. Boosting entrepreneurship and self-employment for poverty reduction

There should be a concerted effort to stimulate entrepreneurship, especially among micro, small and medium enterprises (MSMEs) as alternative sources of employment. In this regard, the support of governments through implementation of policies that facilitate and stimulate business activity is desirable. This could include special credit windows to provide start-up finance for SMEs.

4. Tackling the spatial dimension of poverty and inequality

The special situation of the poor in rural areas calls for targeted interventions to reduce their vulnerability. Such initiatives could include the facilitation of strong cooperative schemes among rural producers. Pooled resources could increase the scale of production, storage and marketing facilities, and provide for insurance schemes to facilitate quick recovery in the event of a natural disaster. This would help not only to increase the level of income of rural households, but to smooth income over time, increasing their resilience.

5. Implementing measures to break the intergenerational transmission of poverty

There is need to focus on investing in children through policies including conditional cash transfer programmes which encourage school attendance and regular visits to health centres; improving the quality of health, education and training for poor families; and regularizing land tenure for poor persons who have fair claims to title to land. Rates of adolescent pregnancy should be reduced by strengthening provision of sexual and reproductive health services to young people and providing comprehensive sexuality education in schools.

6. Putting in place a minimum ‘Social Protection Floor’

The International Labour Organization recommends that the minimum Social Protection Floor should consist of four elements: access to essential health care; basic income security at nationally defined minimum levels for: children (providing access to nutrition, education and care); persons of working age (providing protection against sickness, unemployment, maternity and disability); and older persons (a non-contributory pension).

III. International Migration and Development: Challenges and opportunities

In the two decades since the adoption of the Cairo Programme of Action, international migration has had increasing influence on demographic and socio-economic trends in the countries and territories of the Caribbean, most recently with the emergence of the transnational family. The Caribbean region thus continues to be shaped by the process of migration. Attitudes and public policies have also shifted over time as it has become increasingly clear that migration not only helps to alleviate poverty through widening people's choices and opportunities but, also creates costs especially in circumstances in which parents leave their children behind for a considerable period of time. Migration itself embraces economic, social and environmental considerations and any attempt to craft policies to secure the benefits from migration must recognise their various facets.

While the recent discussions have centred on policies towards the emigration of teachers, nurses and doctors and the loss of the highly educated as well as the impact of deportees especially from Britain and the United States, other issues, such as the fate and protection of undocumented migrants, the role of the Diaspora and trafficking in persons are equally urgent. Fundamental challenges lie ahead in articulating a strategy that will allow the region to benefit fully from migration while minimizing the costs to migrants and to the society. Some of the solution may lie at the national level but other aspects require a multilateral approach which may involve actors with divergent views, which explains why thus far progress has been slow. The ICPD Programme of Action encourages dialogue between countries of origin and destination in order to maximise the benefits of migration for both. It also calls for the elimination of poverty as a cause of migration, the integration of documented migrants, for the human rights of undocumented migrants to be protected, and for trafficking in persons to be eliminated.

This chapter examines the development challenges posed both by extra- and intra-Caribbean migration. Consideration is given to migration policies which can help to promote sustainable development as part of the post-2015 agenda. The major pull and push factors which provide the motivations for citizens to migrate from and to the Caribbean are explored. For the foreseeable future, notwithstanding the impact of the recent global economic crisis, migration in general and skilled migration in particular is expected to continue. While the most significant factor causing migration is the

income differential between sending and receiving countries, there are a number of additional factors which will likely continue driving skilled migration in particular.

The increase in knowledge intensive activities that create the demand for a more educated workforce may lead employers in receiving countries, as part of the international value chain, to lobby for increasing numbers of educated migrants. There is also considerable evidence that migrants have had a significant impact on technological innovation, especially in the United States, which attracts the largest pool of graduate students globally (Kapur and McHale, 2005; Chellaraj, Maskus and Mattoo, 2006).⁹ In order to maintain this technological advantage, it is likely that more liberal policies towards skilled labour will be encouraged by the major receiving countries.

Recent trends however indicate a decline in economic growth in major receiving countries and shifts in policies and attitudes towards immigrants especially due to security concerns. At the domestic level, the push factors for migration in the Caribbean will continue to be low growth and high unemployment. The high levels of migration experienced are thus in large measure due to the inability of the small economies of the subregion to absorb the range of skills that are generated within their labour force; the result of both structural limitations and the impact of the existing economic situation.

The phenomenon of transnational families and circular migration in which Caribbean migrants tend to move back and forth as part of the process of adjusting to income uncertainty is also an emerging feature of migration and is a more nuanced process in which households are strongly linked across international borders. In many cases the flow of remittances which attend the migration process moves into and out of the Caribbean depending on household and individual situations. In such circumstances labour markets have become international and diasporic relations an important source of income. Public policies must consequently be crafted to facilitate strengthened networks of relationships at all levels and to encourage greater interaction between migrants and the domestic economies of the region. While a number of Caribbean countries have pursued, through diasporic conferences and other arrangements, opportunities to embrace the diaspora, the real benefits of migration will be realised through the easy movement of migrants and their ability to integrate with the domestic economy at all levels. This requires however both bilateral and multilateral strategies to encourage such facilitation by both the sending and receiving countries. The prospect of migration also increases the willingness of individuals to invest in education and training as the increase in training may be linked to higher earnings abroad. These issues call for a much more careful study of the challenges and opportunities of migration so that policies are calibrated to properly address sustainable development issues.

While the migration of skilled labour has been identified as a major challenge in the Caribbean, unemployment among skilled workers in Caribbean countries remains high, and the local wage premiums are often perceived to be inadequate to compensate persons trained in certain skills. Where such training has been at the expense of the state agencies, policies can be crafted that allow for the export of skilled capital that is mutually beneficial to both sending and receiving countries, as is now being pursued by some countries. The export of domestic capital through trained personnel can become an important resource and a source of additional foreign exchange earnings, particularly for small economies that are no longer productive in traditional export areas and are searching for new engines of growth and development. Thus migration policies must aim to facilitate movement of labour and skills where these are needed and to allow for the protection of those that are involved.

As regards intra-Caribbean migration, considerable movement of both documented and undocumented migrants has occurred in the region. Migration has ebbed and flowed based on the economic and social conditions in CARICOM member states and on the ease with which migration is facilitated in the respective countries. Under the CARICOM Single Market and Economy (CSME) migration is facilitated for some categories of workers although there is still scope for lifting

⁹ Of the 1.3 million foreign students residing in OECD countries in 1998, some 55.5 percent were from non-OECD countries (Kapur and McHale, 2005). In addition, of the engineering and technology companies started between 1995 and 2005 in the United States, 25.3 percent of these companies had at least one key founder who was foreign born. In addition, the World Intellectual Property data base for 2006 showed that 24.2 percent of patent applications in the United States had as a co-inventor a foreign national living in the United States compared with just 7.3 percent in 1998 (Wadhwa and others, 2007).

bureaucratic constraints in respect of acquiring and utilising skills certificates and acquiring contingent rights. As is the case with international migration, a comprehensive approach to liberalise intra-regional migration and to protect the rights of undocumented migrants, including the full movement of labour, access to health services and the status of dependents is yet to be fully developed. Issues related to both extra- and intra-Caribbean migration and their impact on sustainable development are therefore important points of consideration for the post-2015 agenda for the subregion.

A. Trends in International Migration

Patterns of migration in the Caribbean have been shaped by the search for better employment opportunities and living standards. They have also been influenced by historical and cultural links, geographical factors, and by the demand for labour and immigration policies in receiving countries. Caribbean migration has also nurtured relationships in which persons move as part of family reunification, whether by leaving or returning to the region. Thus the phenomenon described as the transnational family has emerged whereby family members migrate as the circumstances in the sending and receiving country change.

The Caribbean now has one of the largest Diasporas in the world in proportion to its population, with an estimated 6.7 million people from the Caribbean living outside the region in 2010. There were 5.3 million migrants from the Caribbean living in the United States, 756,000 migrants living in Europe, 743,000 had migrated within the Caribbean, and 472,000 lived in Canada. The total emigrant population was equivalent to 17 per cent of the domestic Caribbean population.

The largest Diasporas are from Cuba, the Dominican Republic, Haiti, Jamaica, Guyana and Trinidad and Tobago. While the smaller islands of the Caribbean do not produce as many migrants, their emigrant populations can be very large relative to their domestic population. The emigrant populations from Dominica and Montserrat¹⁰ are estimated to be larger than the domestic population and in the case of Antigua and Barbuda, Guyana, Saint Kitts and Nevis, and the former Netherlands Antilles, the emigrant populations are at least half the size of the domestic population.

Many of the people who leave the Caribbean do so to pursue higher education or employment opportunities and a higher standard of living. In 2000, seven Caribbean countries had emigration rates of greater than 75% among persons with tertiary education and a further six countries had rates of greater than 60%. In other words, the majority of the most highly educated segment of these countries' populations have left their home country. Emigration rates for tertiary educated persons in the Caribbean are amongst the highest in the world.

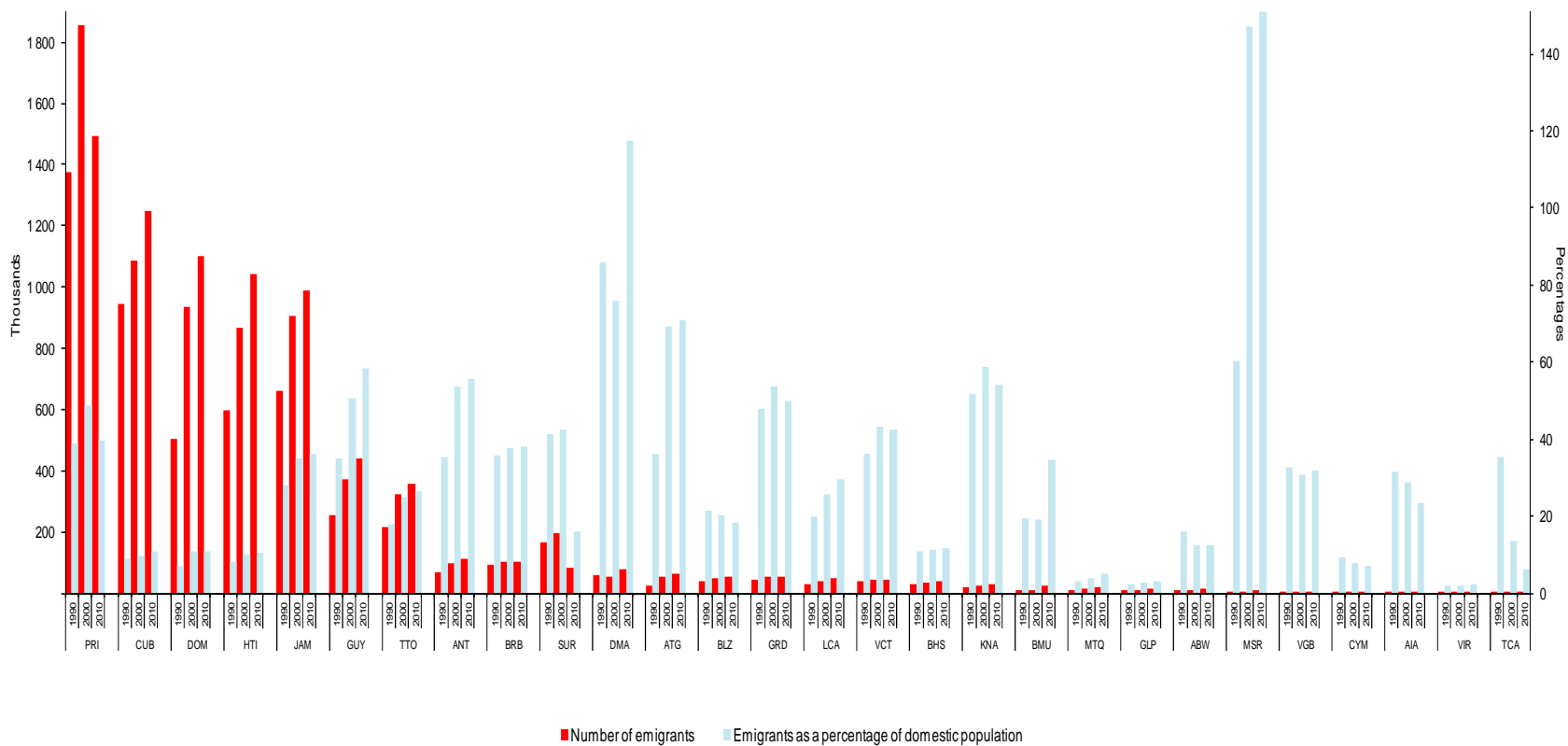
High rates of emigration among those with tertiary education are not a new phenomenon, but these rates have been increasing in recent years. Emigration rates are lower among persons educated up to primary or secondary level, but some countries still lose a substantial proportion of their less well educated population through emigration. These include Belize, Dominica, Grenada, Guyana, Haiti, and Saint Kitts and Nevis. In most Caribbean countries, tertiary educated women are even more likely to emigrate than are men. These trends may be explained by gender inequalities in the Caribbean and therefore higher potential returns from migration for women, and by the shift in demand from manual to skilled workers in receiving countries especially in health related and teaching fields where women predominate.

Parallel with the movement of persons has been the return flow of remittances which in some countries represent a significant contribution to foreign exchange earnings¹¹ and also contribute to lowering the current account deficit. This is especially so for countries that have had ongoing economic and social challenges. For example in 2011, inflows of remittances to Haiti were the equivalent of 21 per cent of GDP, for Jamaica it was 14 per cent, while remittance flows to Barbados were equivalent to only 2 per cent of GDP (World Bank, 2012). Five Caribbean countries (the Dominican Republic, Grenada,

¹⁰ Emigration from Montserrat was prompted by the eruption of the Soufrière Hills volcano in 1995 which left a large part of the island uninhabitable.

¹¹ For Jamaica, before the global economic crisis, remittances in some years have been larger than tourism receipts.

FIGURE 4
EMIGRANTS FROM CARIBBEAN COUNTRIES AND TERRITORIES, 1990, 2000 AND 2010
(Thousands and Percentages)



Source: United Nations, Department of Economic and Social Affairs (2012). Trends in International Migrant Stock: Migrants by Destination and Origin (United Nations database, POP/DB/MIG/Stock/Rev.2012).

Guyana, Haiti and Jamaica) rank among the top 30 remittance-receiving countries worldwide in relative terms (World Bank, 2011b). The Haitian emigrants significantly increased remittances in response to the earthquake of January 2010.

The largest immigrant populations living in the Caribbean are found in the Dominican Republic and Puerto Rico which have received large numbers of migrants from Haiti and the United States respectively. Some of the non-self governing territories also have populations of which migrants form a very substantial proportion. In the Cayman Islands, immigrants account for 63 per cent of the total population and in the United States Virgin Islands, 57 per cent. Immigrants also form a high proportion of the total population in Anguilla, The British Virgin Islands, Aruba and Bermuda. Among Caribbean member states, Antigua and Barbuda, Belize, Grenada, and Barbados all have immigrant populations which make up more than 10 per cent of total population.

In the Caribbean as a whole, there has been only marginal increase in the migrant population over the past decade. Migrants represented 3.5 per cent of total population in 2010 as against 3.3 per cent in 2000. Female migrants accounted for 49 per cent of all migrants; a percentage unchanged since 2000. Of migrants living in the Caribbean, 50 per cent were born in other Caribbean countries, 20 per cent in North America, 12 per cent in Europe, 11 per cent from Central and South America, and 8 per cent from other parts of the world. Belize and to a lesser extent Aruba have received substantial proportions of their immigrants from Central and South America while Cuba, Martinique, the former Netherlands Antilles and Suriname have all received significant numbers of immigrants from Europe.

Within the Caribbean, migrants have generally moved from lower income to higher income countries. Map 1 illustrates the major bilateral intra-Caribbean migrations. The major sending countries have been Haiti, Guyana, Jamaica, Cuba and selected OECS countries (Grenada, St. Vincent and the Grenadines, St. Lucia, and Dominica). Receiving countries have included the Dominican Republic from Haiti; Bahamas from Haiti and Jamaica; the Netherlands Antilles have received migrants from the Dominican Republic, Haiti, Jamaica and Guyana; the United States Virgin Islands from across the Eastern Caribbean; while Trinidad & Tobago and also Barbados receive migrants from the Eastern Caribbean and Guyana.

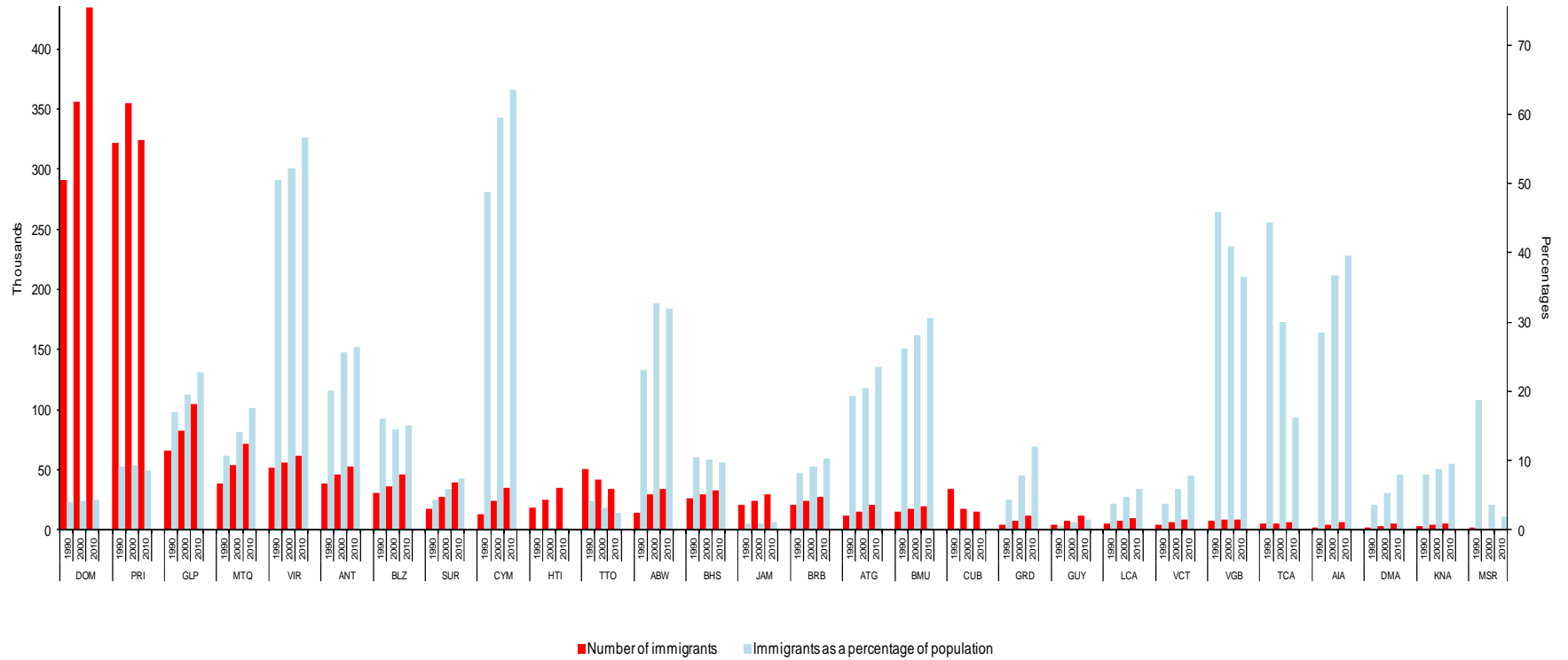
A substantial proportion of intra-Caribbean migration is undocumented. Most commonly this means persons entering a country legally and then overstaying, although there is irregular migration either via boat or unpatrolled land borders (particularly involving Haiti, the Dominican Republic, Cuba, Turks and Caicos Islands, Bahamas and Belize, Guyana and Suriname). There is high correlation between undocumented migration and employment in substandard working conditions, exposure to exploitation, and an absence of coverage under social protection schemes. Due to its strategic location, the Caribbean also receives undocumented migrants en route to North America and has also begun to receive undocumented migrants from Asia and Sub-Saharan Africa (ACP, 2010).

During the 1990s and 2000s Caribbean countries received increasing numbers of deportees from North America and Europe. The integration of deportees presents a particular challenge since many deportations, particularly to CARICOM countries, take place after a criminal conviction. In Jamaica this amounted to some 1,500 deportees per year from the United States alone during the 2000s (Orozco, 2012) with a substantial number from the United Kingdom. Many of these deportees have limited connections and support networks when they arrive and are susceptible to becoming involved in gang and criminal activity. It is reported that 53 per cent of deportees have been involved in criminal activities since their arrival in Jamaica (IOM, 2013).

There is evidence of some level of human trafficking and smuggling¹² in the Caribbean in the areas of forced labour, domestic servitude, and sexual exploitation. Trafficking involves the recruitment

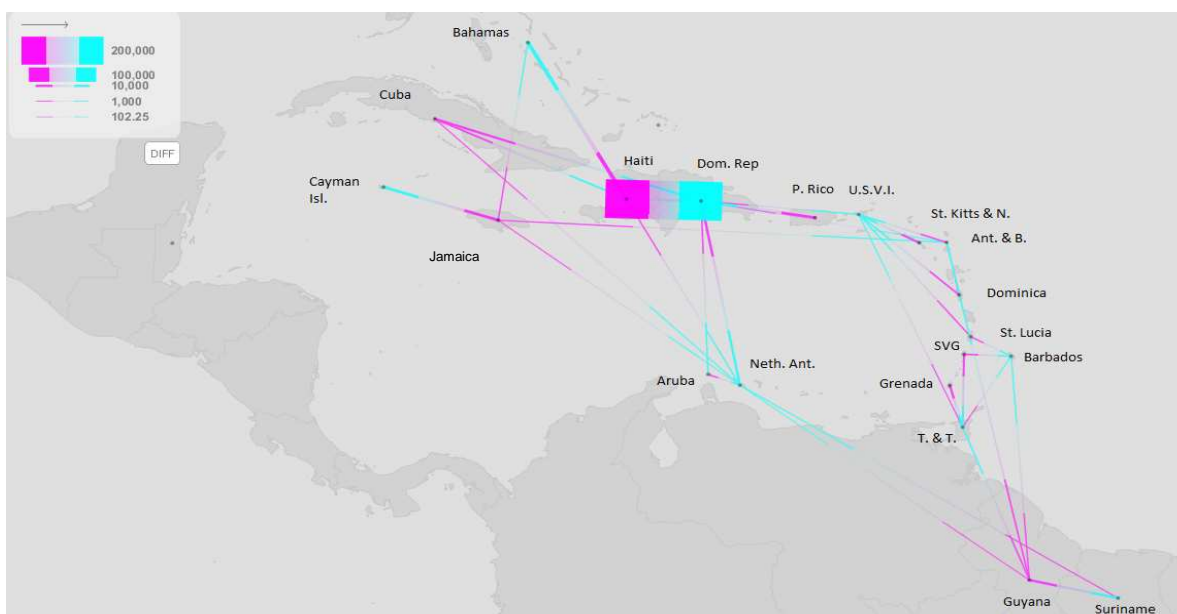
¹² “Smuggling of migrants” refers to the procurement, in order to obtain, directly or indirectly, a financial or other material benefit, of the illegal entry of a person into a state of which the person is not a national or a permanent resident. “Trafficking in persons” is the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation (UNODC, 2000).

FIGURE 5
IMMIGRANTS IN CARIBBEAN COUNTRIES AND TERRITORIES, 1990, 2000 AND 2010
(Thousands and Percentages)



Source: United Nations, Department of Economic and Social Affairs (2012). Trends in International Migrant Stock: Migrants by Destination and Origin (United Nations database, POP/DB/MIG/Stock/Rev.2012).

**MAP 1
MAJOR INTRA-CARIBBEAN MIGRATIONS^a**



Source: Ratha and Shaw (2007) updated with additional data for 71 destination countries as described in the Migration and Remittances Factbook 2011.

Note: The boundaries and names shown on this map do not imply official endorsement or acceptance by the United Nations.

^a Based on estimates of migrant stocks; shows all intra-Caribbean bilateral migrations of greater than 1,300 people.

**BOX 1
HUMAN TRAFFICKING IN THE CARIBBEAN: AN EXPLORATORY ASSESSMENT
BY THE INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM)**

The Bahamas: Haitians comprise the majority of irregular migrants many of whom have willingly engaged smugglers to help them relocate. The islands proximity to Florida, Haiti, Jamaica and Cuba is a key contributing factor (Country report on human trafficking, 2004).

Guyana: Guyana is emerging as a major transshipment point for illegal drugs and migrant smuggling in part because of the un-patrolled borders shared with Brazil, Venezuela and Suriname (Country report on human trafficking, 2004).

Jamaica: There is some human trafficking occurring in Jamaica, primarily for sexual exploitation. Poverty weakened family structures and early exposure to sexual activity can predispose young girls to human trafficking for this purpose. Victims were also recruited to serve as drug couriers, mainly to the United Kingdom and the United States. Studies suggest that human trafficking in Jamaica is highly organized (Country report on human trafficking, 2004).

Suriname: Human trafficking was reported involving foreign women and girls for the purposes of sexual exploitation. The majority of sex workers are foreigners including from Brazil, Guyana, The Dominican Republic, Colombia and Venezuela. There is a high turnover of employees who rotate every three to six months. Suriname shares many miles of borders with Brazil, Guyana and French Guyana which results in relatively easy access the country (Country report on human trafficking, 2004).

Trinidad & Tobago: Human trafficking occurring in Trinidad and Tobago is linked to sexual exploitation but is also linked to drugs and arms trafficking. Females are smuggled in from Venezuela, Colombia, Peru, Panama and Bolivia, and Caribbean countries such as Guyana, the Dominican Republic, Suriname and Belize, and controlled through debt bondage and the withholding of travel documents. Sex workers typically arrive by boat, particularly when coming from Latin America since the coastlines of Trinidad and Tobago are porous borders and border controls weak (Country report on human trafficking, 2007).

Source: International Organization for Migration (IOM), Exploratory Assessment of Trafficking in Persons in the Caribbean Region: The Bahamas; Barbados; Guyana; Jamaica; The Netherlands Antilles; St Lucia; Suriname; Trinidad and Tobago, Second Edition 2010.

and assisted migration of persons for exploitative work. Trafficked migrants – men, women, and children – are often deceived and coerced. Males, for example, are trafficked for forced labour in construction, agriculture, and fishing industries. Domestic servitude tends to consist mainly of female victims of trafficking. The most commonly known form of trafficking in the Caribbean is undertaken for the sexual exploitation of young women and girls at bars, clubs, and private residences in the Caribbean. There are accounts across the Caribbean of the deception of migrant women and girls who were offered work as beauticians, waitresses, cashiers, bartenders, dancers, sales clerks or masseuses, only to be forced into prostitution upon arrival at the destination point. Some, however, were aware that they would be employed in the entertainment industry and even as prostitutes. (IOM, 2010).

B. International Migration: Barrier or Facilitator to Development?

High rates of skilled emigration undoubtedly present a challenge to the building of a skilled workforce. However, it should be remembered that the prospect of migration raises the demand for training and therefore increases the pool of skilled workers. These migrants need not all be lost to the economy if a structure of incentives is developed to facilitate their continued participation in domestic economic development. Of course for some, migration is a path to personal development which offers significant benefits to migrants themselves and, through remittances, to their families helping to reduce poverty especially in lower income countries.

The situation with regard to migration of health sector workers is particularly acute. The top ten countries in the world with the highest expatriation rates among trained nurses are all Caribbean countries with expatriation rates that range from 94 per cent in the case of Haiti to 73 per cent for Trinidad and Tobago (Dumont and Zurn, 2007).

The Spanish speaking Caribbean fares rather better with the Dominican Republic and Cuba experiencing expatriation rates of 11 per cent and 5 per cent respectively. Similar patterns are observed in respect of doctors: five of the ten countries and nine of the top twenty countries in the world with the highest expatriation rates for doctors are Caribbean Community (CARICOM) countries.

Push factors which drive nurses to migrate from CARICOM countries include low pay, poor working conditions, poor career structures, and unstable economic conditions. Pull factors attracting nurses include increased pay, improved standards of living, better working conditions and opportunities to send remittances. (PAHO and CARICOM 2006).

Nursing personnel account for up to 70 per cent of health care staffing in Caribbean states. They provide the majority of direct patient care and are the backbone of the public health system. A shortage of nurses inevitably impacts on the capacity of health services to provide quality health care. It also leads to low staff morale among those that remain. Nursing vacancy rates have at times risen above 50 per cent. Jamaica has recorded a vacancy rate of 58 per cent, Trinidad and Tobago 53 per cent and Barbados 21 per cent (PAHO and CARICOM 2006). These shortages obviously contribute to low nurse/population ratios, for example 16.5 per 10,000 inhabitants in Jamaica compared to 77.3 per 10,000 in North America (Mortley, 2009).

A study by the World Bank suggested strategies for addressing the shortage of nurses in the English-speaking Caribbean (World Bank, 2009).¹³ More importantly, investment in nurses and other related personnel are an investment in human capital and such capital, if perceived as an export, could become an important source of foreign exchange through structured programmes for such exports. In the circumstances, training for export could become an important resource. Such strategy is being pursued in Cuba.

¹³ There are currently high drop-out rates with only 55 per cent of students on nursing courses graduating and shortages of nurse educators which need to be addressed in order to increase nurse training capacity. There have also been calls, including from CARICOM Ministers of Health for a managed migration strategy. This could include a pre-commitment mechanism from nurses which may include temporary migration, and regional agreements with destination countries on ethical recruitment practices.

BOX 2 THE BARREL TRADE AND BARREL CHILDREN

In addition to sending remittances, migrants often send goods to their family members rather than, or in addition to, financial assistance. Goods sent through the 'barrel trade' include those that are more expensive or not available in the home country. Across the Caribbean, but most common in Jamaica, a significant number of citizens migrate leaving their children behind in the care of friends and family. These migrants provide parental support by sending barrels of items which may contain clothes, toys, food and educational material.

The experience of being left behind by their parents can affect the mental, spiritual, moral and social development of children and make them more susceptible to forms of abuse and exploitation. Their psychosocial well-being is significantly impacted by feelings of abandonment, which can lead to low self esteem, anger, depression, material obsession and violence. Increased responsibilities at home and a lack of parental support can significantly affect the child's access to education and their educational performance. Research furthermore indicated that "children separated from parents because of migration were more than twice as likely as other children to have emotional problems although their economic status was improved".

Research from the University of the West Indies has demonstrated that 'barrel children' exhibit behavioural problems and that the absence of mothers was one of the determining factors for children's involvement in violence. According to survey results, the mothers of 80 per cent of the children in conflict with the law were absent from their hearings. Among these cases, the second most common explanation for their mothers' absence was migration. Children that have been left behind are also more at risk of running away from home, "acting out behaviour" or dropping out of school.

Source: C. Bakker, M. Elings-Pels and M. Reis, "The impact of migration on children in the Caribbean", The United Nations Children's Fund (UNICEF) Office for Barbados and Eastern Caribbean, August 2009.

Yet another perspective is that the migration of people who are motivated to pursue educational or employment opportunities abroad is all part of a dynamic development process, developing skills, moving into higher productivity jobs, and becoming productive members of the wider Caribbean community in the diaspora.

The diaspora is an important incubator of networks in host countries. Such networks facilitate emigration, ensuring that modern emigrants from the Caribbean have contacts, places to stay, families and even jobs arranged for them before they step on the plane. These networks need to be developed to facilitate and encourage the settling of migrants, promote increased flows of remittances and investment.

The Caribbean diaspora community can further contribute through the creation of businesses, knowledge and skills transfer, if networks and joint collaboration between the home and host countries were to be enhanced. The engagement of diaspora investors and entrepreneurs with domestic firms can contribute to the internationalization of the economy.

Not all migrants leave permanently. Some return after studying and/or working abroad to contribute to the development of their home countries with skills and experiences acquired abroad. In most countries of the English speaking Caribbean, return migrants account for between 2 and 10 per cent of the population and return migrants are not necessarily retirees (Thomas-Hope, 2009). Even those migrants that do return home upon retirement continue to make a meaningful contribution to the economy by spending their savings or pension income in their home countries.

Loss of skills through emigration is often compensated for by immigration, for example, Caribbean countries receive migrants from other countries in the subregion and the rest of the world. In this context, the CARICOM Single Market and Economy (CSME) was created to facilitate Caribbean economic integration and development, and to address skills shortages. It seeks to establish a single economic space for the free movement of goods, services, capital, business enterprises and people. The free movement of people should contribute to efficient operation of the single market, with labour situated where it is most needed and productive capacity where it is most efficient.

Arrangements have been introduced to enable certain groups of skilled workers to move between states, as a first step towards full establishment of the CSME. CARICOM nationals wishing to work in other CARICOM states are required to obtain a Skills Certificate. Eligibility is currently restricted to university graduates, media workers, sports persons, artists, musicians, nurses, teachers and artisans with a Caribbean Vocational Qualification (CVQ), and holders of associate degrees. If the migrant is from a non-CARICOM member state, work permits are still required and applied for by the employer. In some cases visas are still required as is the case with Suriname. The CSME also provides for the transference

of social security benefits including the portability of pensions and contingent rights for dependants of holders of CARICOM Skills Certificates (although these contingent rights are still under debate).

Caribbean governments had originally agreed to implement migration policies in line with the Revised Treaty of Chaguaramas which established the CSME. This was delayed to allow for further evaluation including determination of Contingent Rights Policy. Contingent rights refer to the entitlements of non-nationals, or spouses and dependents, when they exercise their option to work in another CARICOM Member State. To date, there has been a great deal of caution and a sense of unpreparedness among CARICOM countries to implement the migration policy relating to immigration and contingent rights (Thomas-Hope, 2010).

A study carried out for CARICOM in 2010 showed that some territories had been more willing than others to accept migrants from other CARICOM countries and that there was a tendency for wealthier countries to deny or limit the right of free movement to citizens of less prosperous countries. The study found that there was still a need for greater harmonization of legislation and processes relating to free movement within the CSME.

C. Policies to Leverage Migration for Development

In recent years, Caribbean countries have been looking to develop policies to maximise the benefits of international migration, although these have yet to be fully realised. The fundamental challenge is to mainstream the issue of migration into sustainable development planning examining ways to maximize the welfare effects and to minimize costs of migration. This would mean developing both bilateral and multilateral arrangements to facilitate the integration of migrants in the receiving countries. At the same time, there is need to balance the export of skills and the maintaining of skilled labour to sustain the domestic economy. This could be achieved through a careful calibration to ensure that the efficiency of the local labour force improves. Many Caribbean countries have held diaspora conferences to raise awareness of the opportunities in the domestic economy and there have been many attempts at facilitating resource flows from the Diaspora. Still, there are considerably more opportunities for meaningful engagement through diaspora advocacy, diaspora skill transfer and other forms of engagement.

Attention should be given to removing the bureaucratic challenges to the development of these opportunities. Most Caribbean states with a relatively higher dependence on remittances have addressed this issue through legislation or institutional intervention. The Dominican Republic has created the National Council on Dominican Communities Living Abroad which will promote and protect the rights of the Dominican diaspora and enable foreign based citizens to actively participate in the economic, social, political and cultural life of the country. Grenada established the Office of Diaspora affairs, and Jamaica has a long established Overseas Department. Haiti has created the Ministry for Haitians Living Abroad. Many have made a priority of developing relationships with Diaspora communities, and facilitating investment in the country through remittances or other means.

Attention should be given to facilitating remittance flows and maximising their economic benefits. Remittances can be encouraged by ensuring competition among service providers to reduce costs, making it easier for remittances to be sent through official channels, offering innovative products and promoting the use of new technologies. The economic benefits of remittances can be maximised by the design and marketing of financial products linked to remittances (for example savings and insurance products), and the securitization of remittances (for example through Diaspora bonds), and channelling remittances into community projects. 'Hometown associations' formed by emigrants living overseas often raise funds for community projects and matching diaspora funding with state funding can further stimulate flows of funds (UNCTAD, 2013).

Programmes can be created to facilitate the diaspora's investment of human capital through the transfer of skills, for example through visits to the home country to train citizens in their area of expertise. In addition, there are opportunities to utilise the technology skills of the diaspora to transfer knowledge similar to the model developed by the South African Network of Skills Abroad and the Philippines Brain Gain Network (Alleyne and Solan, 2012). Diaspora relations should be used to help

Caribbean companies to enter new markets, and to facilitate private investment into the Caribbean. In addition to remittances the Caribbean diaspora are a ready-made market for exports of speciality products and tourism which should be exploited.

Participation of the diaspora in national development is facilitated by the relatively free movement of people between their adopted country and their home country. Laws and regulations in receiving countries, for example relating to immigration status, can sometimes prevent extended visits to the home country. Governments should seek, through international cooperation, to make such movements easier rather than more difficult. Fairer recognition of academic and professional qualifications obtained in the Caribbean would also greatly assist migrants and therefore indirectly their home countries.

There is sometimes a tension between those belonging to the diaspora and those that stay behind. Those who left can feel that they have the recipe to fix things at home whereas those who stayed posit that they understand and know better the reality on the ground. Governments can play an important role by putting in place mechanisms to bring both sides together.

In areas where there are skills shortages, Caribbean countries should also actively seek to exploit immigration to bring in skilled working age people. A number of countries are seeking to develop policies in order to attract migrants that will contribute positively to national development. Guyana has developed a five-year multiple entry visa in order to encourage skilled migrants and investors to the country and Suriname are also seeking to attract skilled migrants to work in particular sectors. Barbados developed special entry permits in order to attract ‘high net worth’ individuals to the country.

One of the values of building and maintaining relationships with diaspora communities is that it is likely to encourage return migration. Most CARICOM countries facilitate the return of migrants by allowing them to retain dual nationality and providing them with tax concessions on the import of motor vehicles and household effects. Efforts could be made to recruit skilled workers from among the diaspora and to facilitate their return.

There has been progress towards liberalisation of movement for persons within the Caribbean Single Market and Economy although for the time being at least, moves towards further liberalisation are on hold. The original vision of the CSME, and the potential benefits for the Caribbean and its citizens, are yet to be fully realised. Many intra-Caribbean migrants continue to live and work on an undocumented basis with all the risks that this poses.

There is undoubtedly a need to build capacity to manage borders, to address undocumented migration, and to deal with threats such as trafficking in persons. Data on trafficking in persons are difficult to gather because of the illegal nature of the activity and the victims’ fear of reporting cases. Isolation from the general population because of cultural and in some cases language barriers and the physical isolation of certain immigrant communities from the rest of the general population can create challenges in accessing many of these vulnerable migrant groups. However, the implementation of anti-trafficking legislation, including increasing intelligence and public education programmes to increase awareness among potential victims of trafficking, is proceeding in many Caribbean countries. The following countries have passed anti-trafficking legislation in recent years: Aruba; Antigua and Barbuda; The Bahamas; Barbados; Belize, Dominican Republic; Guyana; Jamaica; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Trinidad and Tobago and Suriname.

In Suriname, the Ministry of Foreign Affairs; the Ministry of Justice and the Police; the Ministry of Labour, Technology and Environment and the Ministry of Public Works cooperate to address issues regarding trafficking and smuggling of persons within the framework of the United Nations Convention against Transnational Organized Crime and the “Palermo Protocols” on Trafficking in Persons and Smuggling of Migrants. There have been workshops on protecting vulnerable migrants, a 24 hour hotline has been created, and a special police anti-trafficking unit which inspects brothels, together with awareness campaigns in border areas. In 2010, a Joint Commission commenced between Suriname and Brazil which deals with issues of undocumented migrants.

In respect of deportees there are ongoing efforts to improve information sharing, notification periods and cooperation between the national authorities of the respecting countries in order to enable governments to develop reintegration programmes, for example the “Rehabilitation and Reintegration Programme”, a support programme for deportees developed between the governments of the United Kingdom and Jamaica.

International migration will continue to be an important feature of life in the Caribbean for the foreseeable future. Therefore the focus of policy should be on international cooperation to maximise the benefits of emigration and immigration. Migration should be seen not as a problem but as contributing positively towards wider national social and economic development goals.

IV. Population Ageing and the Rights of Older Persons

Perhaps the most significant demographic challenge facing the Caribbean is the ageing of the population. In the coming decades there will be larger numbers of older persons and they will form a larger proportion of total population. Between 2015 and 2050 the number persons aged over 65 will increase from 4 million to 9.5 million (or from 9 per cent of the population to 19 per cent).

Population ageing is a global phenomenon. Higher income countries are generally at a more advanced stage in the process, however many middle and lower income countries are now starting to see increasingly rapid population ageing. Almost all Caribbean countries and territories will see more rapid population ageing starting to take place over the next two decades and beyond. In lower and middle income countries, including those in the Caribbean, population ageing will take place more rapidly than it did in higher income countries where the process has been underway for longer.

In the Caribbean, systems of health care, social security and social care are relatively weak and inadequate to meet the needs of the current generation of older persons. If future generations of older persons are to enjoy an acceptable standard of living and quality of life, these systems will need significant strengthening. Changes will also be needed in the workplace, civil society and the family.

In addition to the ICPD Programme, international cooperation on the issue of population ageing and policies for older persons has been advanced through the agreement of the Madrid International Plan of Action on Ageing (2002) and at a regional level, the Brasilia Declaration (2007) and the San Jose Charter (2012). These agreements have sought to place emphasis not just on the needs of older persons, but also on the contribution that older persons make to society, and on the rights of older persons. So instead of being viewed as dependent, older persons are seen as equal and fully participating members of society. Their rights, for example to economic security, health and social care, place an obligation on the rest of society to ensure that these rights are realised.

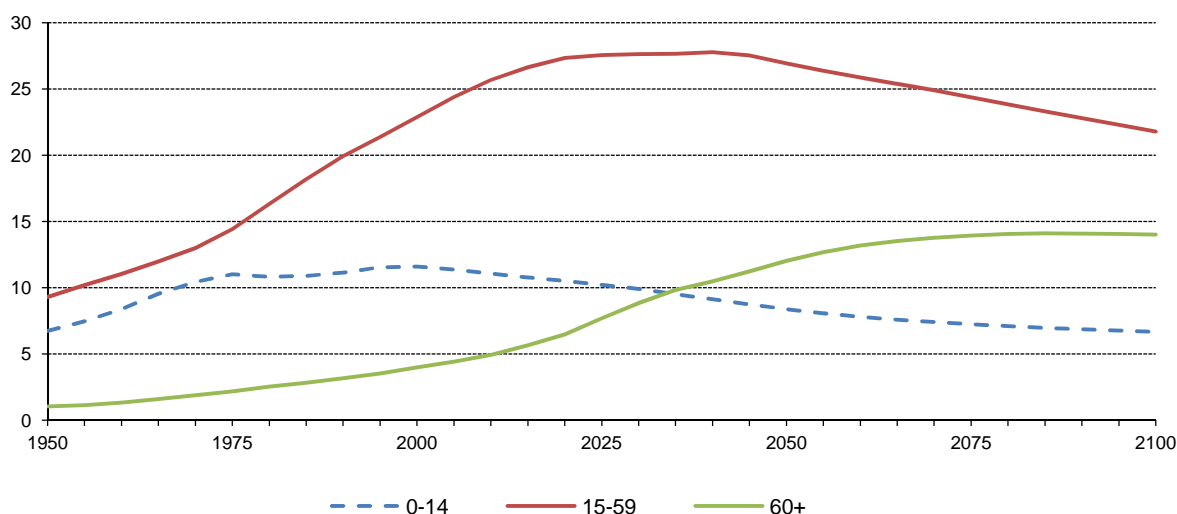
A. The Changing Age Structure of the Caribbean Population

The phenomenon of ageing populations arises as a result of what is called the demographic transition. This is the name given to the process of transition from societies at an early stage of development, with high fertility and high mortality rates, to societies with low fertility and low mortality rates. These changes in fertility and mortality rates lead to changes in the age structure of the population. The changing age structure of the Caribbean population over the period 1990 to 2060 is illustrated in Figure 7. It is clear that younger persons make up a declining proportion of the population while older persons make up an increasing proportion.

The number of persons aged 60 and over in the Caribbean has been growing, but the rate of increase will be significantly higher over the coming decades (Figure 6). The number of young persons aged 0-14 is now declining, and it is projected that the number of working age persons (15-59) will start to fall from around 2040.

Population ageing is more advanced in some countries and territories, most notably Aruba, Barbados, Cuba, Guadeloupe, Martinique, the former Netherland Antilles, Puerto Rico and the United States Virgin Islands. However, all Caribbean countries, with the exception of Haiti, will see noticeably more rapid increases in the number and proportion of older persons in the next 20 years, compared to the previous 20 years.

FIGURE 6
THE CARIBBEAN POPULATION BY AGE
(Millions of persons)

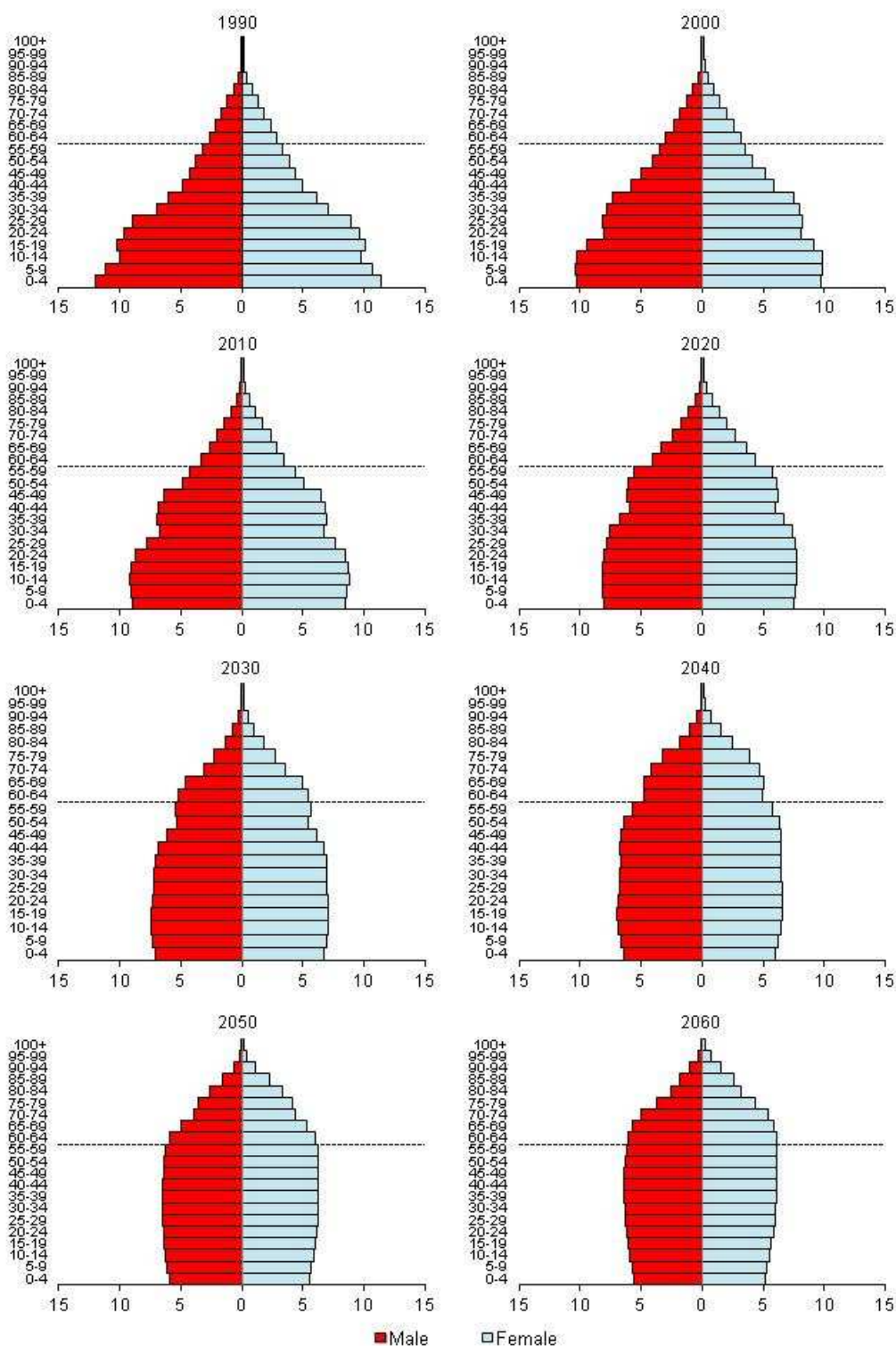


Source: United Nations, Department of Economic and Social Affairs, Population Division (2011). World Population Prospects: The 2010 Revision, CD-ROM Edition.

The Caribbean is now entering that part of the population ageing process which will see the most rapid increases in the number and proportion of older persons. These transformations will take place roughly twice as fast as they did in Europe and North America (Figure 8).

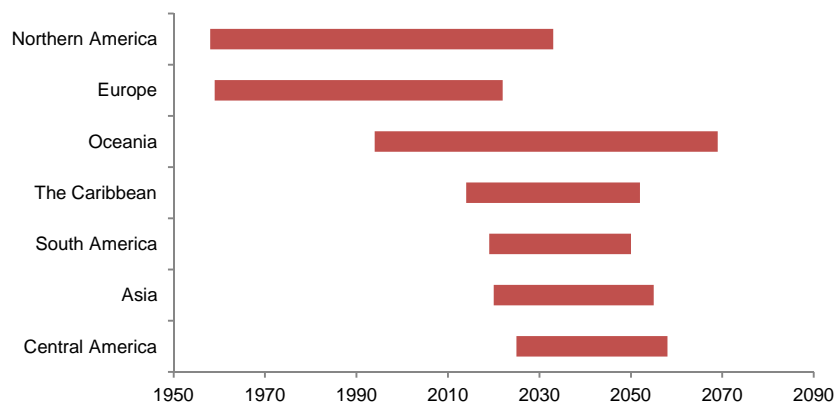
These population trends, and their significance, are widely recognised by Caribbean governments. In 2008-2009, in response to the United Nations Inquiry among Governments on Population and Development, 11 of 16 Caribbean governments indicated that population ageing was a major concern. Indeed, all Caribbean countries, with the possible exception of Haiti, are facing an increasingly urgent need to plan for ageing populations.

FIGURE 7
CARIBBEAN POPULATION BY AGE AND SEX, SELECTED YEARS 1990-2060
(Percentages)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2011). World Population Prospects: The 2010 Revision, CD-ROM Edition.

FIGURE 8
TIME TAKEN FOR THE PROPORTION OF PERSONS AGED 60+ TO INCREASE FROM 13 TO 26 PER
CENT OF THE POPULATION
(Years)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2011). World Population Prospects: The 2010 Revision, CD-ROM Edition.

B. Economic Security of Older Persons

All countries in the English speaking Caribbean have social security systems, also referred to as national insurance schemes of broadly similar design. The functioning of these systems plays a large role in determining the level of economic security or insecurity enjoyed by older persons. All provide earnings related old age pensions which in terms of replacement rates¹⁴ are reasonable by international standards although relatively few countries automatically increase pensions to account for inflation. Barbados and The Bahamas have introduced indexation but in many other countries pension increases have been dependent on political decisions and in some cases the real value of pensions have been eroded.

A challenge to be addressed is the fact that these social security schemes for the most part cover people in formal employment only, excluding many people who work in more informal jobs or are self-employed. The extent of formal versus informal employment varies considerably from country to country, and in some countries significant proportions of the population are not covered by these schemes. Within the formal sector, women tend to have less consistent contribution records than men. Consequently many older persons do not receive contributory pensions or only receive pensions of low value. In the Bahamas about 75 per cent of the population above the state retirement age receive a contributory old age pension, while in Saint Lucia the figure is closer to 25 per cent (Table 4).

Many, although not all, countries have introduced non-contributory pensions intended for those who are not eligible for a contributory pension. However the level of support provided, with the exception of the non-contributory pensions in Trinidad and Tobago and Barbados, are very low, and these pensions provide considerably less income than is necessarily to achieve a standard of living equal or better to the national poverty lines. In other countries there are programmes of public assistance where welfare payments are awarded on a more discretionary basis. While these schemes target the poorest and most needy they tend not to reach everyone who is in need of assistance.

Older persons who do not receive a pension, or do not receive a pension sufficient to live on, may be able to continue working. In some countries a sizeable minority of persons aged over 65 continue to

¹⁴ The percentage of a worker's pre-retirement income that is paid out by a pension program upon retirement.

work. For example in Belize, Jamaica, and Saint Lucia between 25 and 30 per cent of persons aged over 65 are still economically active. In countries where a greater proportion of older persons receive income from pensions, older people are less likely to work, for example in the case of Barbados fewer than 10 per cent of persons aged over 65 are in work.

TABLE 4
COVERAGE AND AVERAGE LEVEL OF OLD-AGE BENEFITS
(Percentages and Dollars)

	Population above retirement age receiving		Estimated average payment per month ^a		Year	Current value (2013) of non-contributory pension per month
	Contributory old age pension	Non-contributory old age pension	Contributory old age pension	Non-contributory old age pension		
Bahamas	74.6	8.8	452	256	2011	268
Barbados	67.7	28.2	478	119	2008	299
Saint Kitts and Nevis	56.4	...	361	98	2005	93
Trinidad and Tobago	54.2	...	303	...	2010	472
Guyana	49.5	100	61	...	2002	63
Antigua and Barbuda	45.7	...	...	...	2002	94
Saint Vincent and the Grenadines	45.6	...	...	...	2005	82
Jamaica	40.0	...	...	...	2003	15
Dominica	37.0	0.0	301	...	2006/07	...
Belize	29.6	32.4	168	44	2010	50
Saint Lucia	24.9	0.0	231	...	2007/08	...
Grenada	...	0.0	127	...	2011	...

Source: The National Insurance Board of The Bahamas, Annual Report 2011; The National Insurance Scheme of Barbados, Annual Report 2008; The Social Security Board of Belize, Annual Report 2010; The Social Security Board Annual Report for Dominica 2011; National Insurance Board Annual Report for Grenada 2011, The National Insurance Scheme of Guyana 2002 Annual Report; Saint Kitts and Nevis Social Security Board Statistics Digest, Volume 2.1 (2011); National Insurance Corporation of Saint Lucia Annual Report 2007-2008; National Insurance Board of Trinidad and Tobago Annual Report 2010; United Nations, Department of Economic and Social Affairs, Population Division (2011). World Population Prospects: The 2010 Revision, CD-ROM Edition; World Social Security Report 2010-2011, International Labour Office.

^a Estimated as: total annual payments/(number of claimants x 12).

Older persons who do remain in work may find it more difficult to find work as paid employees. Compared to workers aged under 60, those aged over 60 are much more likely to be classified as own-account workers. This would include informal work and sales of agricultural or other products.

For reasons of age, health, disability, or lack of suitable employment, not all older persons are able to work. In the participatory poverty assessments carried out in many Caribbean countries, many older persons who are classified as poor described how due to their age they were no longer able to work, and viewed their situation as arising directly from the fact that they could no longer work. Some older persons depend on transfers from family members or remittances from family members overseas. While in many cases this support is welcome, financial dependence on children or other family members can be a source of discomfort or conflict and undermines the independence of older persons.

Given the less than complete coverage of social security systems, the decreasing desire, ability or opportunity to work, and the lottery of depending on family support, it is not surprising that some older persons find themselves living in poverty. Rates of poverty among those aged 65 and over are lowest in those countries such as Trinidad and Tobago, the Bahamas and Saint Kitts and Nevis where the social security coverage is relatively wide and where a majority of older persons receive a contributory old age pension. Poverty among older persons is much higher in countries such as Belize, Dominica, Saint Lucia and Jamaica where fewer people are entitled to contributory old age pensions.

Compared to other age groups, older persons are actually less likely to be living in poverty than younger age groups, children especially. Where older persons are living in multigenerational households their disposable income is likely to be determined by arrangements for income sharing within the household. Poverty among older persons is still a major problem, just not one combined exclusively to this age group.

Some common problems faced by older persons living in poverty have emerged from participatory poverty assessments. Among poor older persons hunger was a frequently cited complaint as was the inability to maintain and repair their homes or afford medical expenses. Loneliness and having no-one to help them were also common complaints.

Many governments have implemented incremental improvements to social security systems. The government of Saint Vincent and the Grenadines instituted the Elderly Assistance Benefit in 2009, a small non-contributory pension for older persons. In recent years several countries have introduced programmes which provide subsidies, rebates or free provision of particular utility services for older persons. Jamaica has a program called PATH (Programme of Advancement through Health and Education) which it has run since 2002 which provides means-tested grants to families with children, the elderly, disabled persons, mothers and the poor.

Despite these incremental improvements, many older persons living in poverty cited the inability to access social security benefits as a major reason for their situation, or complained that benefits that they were receiving were insufficient to lift them out of poverty.

There is clearly a need in many countries to widen social security coverage by expanding the numbers of contributors and increasing the value of non-contributory pensions. To promote efforts in this direction the United Nations initiated the Social Protection Floor Initiative (SPF) in 2009. It is envisaged that countries should seek to provide a minimal level of social protection which would be universally available, and then over time, the level of protection offered would be improved to come into line with internationally agreed minimum standards embodied in ILO conventions. Within the SPF initiative there is an emphasis on individual country level solutions rather than top down solutions.

The introduction of non-contributory pensions, albeit at low levels, is consistent with this initiative. All countries should have non-contributory pensions, which would be available as a right, to any older person without adequate means of support. Over time, non-contributory pensions should be raised in coordination with efforts to strengthen and widen contributory social security coverage. Appropriate indexation of pension should also be considered.

In some countries the state retirement age is still 60, in others 62 or 65 while in Barbados the retirement age is in the process of being raised to 67. In some cases retirement ages for civil servants are lower, down to 55. A number of countries are increasing retirement ages, both for civil servants and other workers, or introducing more flexible arrangements for either early or late retirement. In the context of increasing life expectancy, policy changes relating to retirement ages, are an important aspect of the policy response to ageing populations.

Measures should also be taken to make it easier for older people to work if they wish. Relatively few governments have implemented policies or programmes to encourage older persons to remain or re-enter the workplace. Educational campaigns, pension reform, reconsideration of mandatory retirement ages, more flexible working arrangements, and training could all play a role in this area.

C. Health Care and Chronic Non-Communicable Diseases

An even bigger challenge than the provision of pensions for future generations of older persons, will be providing high quality health care services. Older persons place substantially greater demands on health care systems than working age or younger persons and so population ageing will significantly increase the future demand for health care services. Of course medical advances and the availability of new treatments compounds this pressure.

Research based on the National Transfer Accounts framework suggests that for countries undergoing rapid population ageing, providing adequate health care for ageing populations will be an even bigger challenge than providing adequate pensions. Total spending on health care is expected to increase and if all older persons are to be able to access decent health services, government expenditure on health care as a proportion of GDP will have to increase.

There have been some important recent advances in the extension of free treatment in Caribbean countries. In 2008, the Government of Dominica instituted Universal Health Care for older persons. Those over the age of sixty receive free medical care which includes all diagnostic and other tests, hospitalization, surgical procedures, prescriptions filled at the hospital pharmacy, emergencies and casualty visits. Also in 2008, user fees at government health facilities in Jamaica were abolished. In the Bahamas the National Prescription Drug Plan (NPDP) was launched in 2010 for sufferers of chronic non-communicable diseases. Under this plan all recipients of the main National Insurance Board benefits aimed at older people, and all Bahamian citizens over the age of 65, get access to prescription drugs and medical supplies free of charge.

Trinidad and Tobago also offers free health services at the nation's health clinics and hospitals and selected drugs are available at no cost under the Chronic Disease Assistance Programme. Free health care is provided to persons aged over 62 in Saint Kitts and Nevis, and to persons aged 65 and over in Saint Vincent and the Grenadines.

However, there remain problems with access to some services, treatments and drugs. Waiting times at public health facilities can be a barrier to access and free medication at government pharmacies is not always available in which case the elderly have no option but to purchase their medication from private pharmacies. Policies which have sought to extend access to health care through free or subsidised provision have not always been sufficiently well funded to ensure that services and treatments are available not only in theory, but in practice.

In order to make progress towards universal provision of health care the Pan American Health Organization (PAHO) included in its Strategic Plan 2008-2012 the targets of increasing public expenditures from 3.1 per cent of GDP in 2006 to 5.0 per cent of GDP in 2013, and reducing the share of out-of-pocket expenditures as a percentage of total health expenditures from 52 per cent in 2006 to 40 per cent in 2013. The countries where 'out of pocket' expenditures form a large proportion of health care expenditure tend to be the countries where access to health care is not universal and depends on ability to pay.

In the Caribbean there are small number of countries and territories where expenditures on health are similar (as a proportion of GDP) to those in OECD countries with universal health coverage and where health services can be regarded as universal. These include Aruba, Cuba and the countries of the former Netherlands Antilles. In these countries public expenditure on health care as a percentage of GDP is 10 per cent or greater while 'out of pocket' expenditures are less than 2 per cent. (PAHO, 2012).

In most of the rest of the Caribbean, total health expenditures are lower as a proportion of GDP and 'out of pocket' expenditures account for a larger proportion of health expenditure. Excluding the countries mentioned above, the average proportion of GDP allocated to health services was 3.2 per cent and out of pocket expenditures accounted for a further 2.7 per cent of GDP (or around 45 per cent of total health expenditure). Health expenditures also appear to be relatively independent of the income levels of countries. Higher income Caribbean countries such as the Bahamas and Trinidad and Tobago still have relatively low public expenditures on health. (PAHO, 2012).

Most Caribbean countries fall substantially short of both PAHO targets. In order to widen access to health care services, including for older persons, then, it would be important for Caribbean countries to raise public health care spending as a proportion of GDP.

Population ageing also changes the morbidity profile of the population and therefore the kind of services and treatments that the health care system needs to provide. The demographic transition which leads to population ageing is accompanied by an epidemiological transition whereby chronic and degenerative diseases, as opposed to communicable diseases, become the most common causes of death.

Caribbean countries already suffer from relatively high rates of non-communicable diseases among persons aged over 60. Rates of mortality due to non-communicable diseases among persons over 60 are over one third greater than the corresponding rates for either Latin America or rates in developing countries. This is mainly due to higher mortality caused by heart disease and diabetes.

It was estimated that in 2001 the economic cost of just diabetes and hypertension were of the order of several percentage points of GDP; in Jamaica 5.9 per cent of GDP, in Barbados 5.3 per cent, in The Bahamas 1.4 per cent while in Trinidad and Tobago costs were estimated at 8.0 per cent of GDP (Abdulkadri, Cunningham-Myrie and Forrester 2009).

Persons suffering from NCDs incur significant out-of-pocket costs for treatment and medication. In both Jamaica and Saint Lucia, an average individual suffering from NCDs uses approximately one-third of household income on healthcare services and medicine purchases. In Saint Lucia it was found that among poorer households this proportion could rise to 48 per cent (World Bank 2011a).

A large percentage of deaths from NCDs are preventable and common, preventable risk factors underlie most NCDs. The major NCDs in the Caribbean share common underlying risk factors, namely unhealthy eating habits, physical inactivity, obesity, tobacco and alcohol use and inadequate utilization of preventive health services (PAHO and CARICOM, 2006). The World Health Organization has estimated that the leading NCD risk factor globally is elevated blood pressure (to which 13 per cent of global deaths are attributed), followed by tobacco use (9 per cent), elevated blood glucose (6 per cent), physical inactivity (6 per cent), and being overweight or obese (5 per cent). (WHO, 2011a).

Among these risk factors, obesity and lack of physical activity are clearly becoming more common (World Bank 2011a, PAHO and CARICOM 2006). Evidence in respect of tobacco and alcohol abuse is less clear.

In countries experiencing rapid population ageing, the increase in the proportion of older persons in the population together with the impact of unhealthy lifestyles will only worsen the epidemic of non-communicable diseases. In the Americas as a whole, deaths from non-communicable diseases are forecast to increase by 42 per cent between 2008 and 2030 (WHO, 2008).

In addition to the human cost, non-communicable diseases exert a heavy economic cost. This cost is made up of direct costs i.e. the cost of treatment (born by the state and/or the individual) and indirect costs, namely, the loss of productivity in the labour supply. It is anticipated that the economic costs associated with non-communicable diseases will climb steadily over the next 20 years, with the rate of increase having picked up sharply by 2030 (Gaziano, A.B. and others, 2011), and with middle and upper-middle income countries, such as those in the Caribbean, bearing an increasing share the cost.

It bears repeating that many NCDs are preventable and policy interventions which achieve reductions in the prevalence of key risk factors can potentially have significant public health benefits. The World Health Organization has proposed a range of treatments and policy interventions aimed at reducing risk factors which potentially offer significant health benefits for relatively little cost. These policies have been described as ‘best buys’ and include things like increased taxation of tobacco and alcohol, reducing salt intake, public education and immunisation against hepatitis B at birth.

In response to this threat CARICOM countries have developed a Strategic Plan of Action for the Prevention and Control of Non-Communicable Diseases for countries of the Caribbean Community 2011-2015. The plan covers risk factor reduction, screening and treatment, health information systems, health promotion, advocacy and communications. Measures aimed at risk factor reduction include smoke free public places, regulation of food and cigarette labelling and advertising, provision of recreational facilities, health promotion and public education. More integrated treatment is proposed with the introduction of evidence-based guidelines, supported by training of primary health care personnel, and shared tertiary treatment services. It is planned to introduce annual reporting on NCDs by the end of 2014.

D. Living Arrangements, Care Services, and Long Stay Institutions

Key ICPD objectives for older persons include enhancing the self-reliance of older persons, enabling them to live independently as long as possible and developing support systems to enhance the ability of families to take care of older persons.

Evidence would suggest that older persons have a general preference for living independently, in other words with their spouse only or alone, as opposed to with their children, family or other persons. In high income countries where families have more choices concerning their living arrangements, older persons are more likely to live independently. The same is likely to apply within country. In Belize, for example, it was found that older persons among higher quintile groups were much more likely to be living independently, compared to older persons in lower quintile groups (CDB, 2010). Taking into account this general preference for independent living, and also declining fertility rates, not only will there be increasing numbers of older persons in future, more of them could be living independently.

Nevertheless many older persons continue to live in multigenerational households with other family members who can provide support and care. In the case of older persons with little or no income this is likely to extend to economic support. This dependence can not only make older persons feel uncomfortable, it can also lead to feelings of mutual resentment and ultimately abuse. However, older persons living in multigenerational households may also be the home owner which potentially introduces a different dynamic to inter-household relations.

At particular risk of isolation are persons living alone. Approximately 18 per cent of persons aged over 60 in the English speaking Caribbean live on their own. In most parts of the world more older women live alone compared to men (mainly due to widowhood), although the English speaking Caribbean is something of an exception in this regard. Among persons aged over 60, 20 per cent of men live alone compared to 16 per cent of women (Nam, 2009). This is because older women are more likely to live with other family members.

In order to support older persons to live independently, many Caribbean countries have developed programmes such as home help services, home nursing care, day care and activity centres, and for those older persons who are unable, or do not wish to live independently, long-stay institutions.

Many countries have developed some form of scheme to provide home care services to older people. The services provided include help with shopping, cleaning, cooking, and companionship. The organization, coverage and quality of these schemes vary from country to country. A qualitative study in six Caribbean countries confirmed that there were significant problems of coverage and access to these services (Cloos and others, 2009). In several countries expansion and improvement of the quality of these schemes has been identified as a priority for future action.

A few countries now offer a basic level of medical care in the home as part of their home care service provision. In Barbados the Community Nursing Project provides services such as wound dressing, blood pressure readings and blood sugar tests. In addition, advice on nutrition, sanitary standards and other health care issues can be provided.

In some countries day care centres for older people enable family carers to work, or at least take a break from their duties as carers. These centres also keep older people socially and physically active, provide a nutritious meal and sometimes offer services such as health checks. Such services provide invaluable support to carers (who in many cases are older persons themselves) and should form part of the social care programme for older persons.

The Division of Ageing in Trinidad and Tobago is also proposing to establish a model of Assisted Living Facilities. These would enable older people to live independently within a communal environment with other older people, with easy access to a range of health, social and commercial services. Residents would have their own rooms or living space and central dining spaces and communal areas for interaction. The facilities would be run by non-government organizations.

For older persons who are unable to live independently there are public and private long stay institutions for older persons. There have been efforts to improve the quality of long-stay institutions through legislation (Trinidad and Tobago), improved monitoring (Ministry of Health, Barbados) and increased funding and training (the Fiennes Institute, Antigua and Barbuda). However across the Caribbean the quality of long-stay institutions and equitable access to quality care remain pressing challenges. Problems with some institutions have included: unsuitable buildings, overcrowding, insufficient monitoring and regulation, inadequately trained staff, lack of equipment, and problems related to nutrition and medical care.

All countries should have legislation and regulations governing nursing homes as well as enforcement mechanisms such as inspections and punishment for non-compliance. Given the ageing population, trends in living arrangements and disability, the need for nursing care is likely to increase significantly. Therefore improving the quality of both public and private sector long stay institutions ought to be a high priority and indeed was identified as a priority in a number of countries.

E. Social Participation of Older Persons, Equality and Protection against Discrimination

While older persons undoubtedly have needs which place an obligation on the rest of society, they also have a very important contribution to make in the world of work, in political, cultural, community and family life, as carers and volunteers. The ICPD Programme calls on governments to facilitate the continued participation of older persons in society and enable older persons to make full use of their skills and abilities for the benefit of society.

In several countries in the Caribbean there are national councils of older persons which are either non-governmental organisations or bodies created by governments as a mechanism through which older persons can participate in decision making. There are also associations of retired persons which represent the interests of older persons.

In Jamaica, the National Council for Senior Citizens (NCSC) which under the Ministry of Labour and Social Security oversees the implementation of the National Policy for Senior Citizens, supports and encourages the network of senior citizens clubs across the country. Senior citizens have participated in conferences on ageing at both national and regional level and the clubs have organized activities promoting social interaction between generations such as visits to schools. The Barbados Association of Retired Persons (BARP) is a well established organization whose objectives include: enhancing the quality of life of older persons in Barbados; promoting independence, dignity and purpose in the lives of its members; representing and expressing the views of members; and changing the prevailing attitudes towards older persons. In Trinidad and Tobago, Public Forums for Older Persons and a Senior Citizens Parliament are regular events.

In some other smaller Caribbean states there are similar organizations for older people which have found it more difficult to grow and/or remain active. In Saint Vincent and the Grenadines there was a National Council of Older Persons which recommended programmes and policies to improve the well-being of the elderly. However, this is no longer functioning and so there is currently no formal mechanism for the engagement of older persons in policy making. It was reported that in Saint Kitts and Nevis participation and engagement of older persons in policy making was limited because there are no independent groups involving older people and advocating on their behalf.

In Jamaica and Trinidad and Tobago there are extensive networks of activity centres for older people. For example the eleven centres in Trinidad and Tobago offer activities such as aerobics, yoga, tai chi, home gardening, field trips, art & craft, computer literacy, swimming, dance and reading/adult literacy.

Despite these initiatives there is a significant problem of loneliness and isolation among older persons in the Caribbean. For example, in a study of older persons in Trinidad, 33 per cent reported being lonely (Rawlins and others, 2008). By no means all of these were persons living alone and men

were more likely to suffer from loneliness than women. Poverty studies in several countries also suggested that many older persons living in poverty feel lonely and abandoned.

Social participation of older persons is related to their financial situation, health, and also location with more opportunities for participation in urban areas (Cloos and others, 2009). This reinforces the fact that it is not enough to address individual dimensions of social exclusion, such as social participation, without also addressing, for example economic security and health. In countries where there is no well-established mechanism for involvement of older persons in decision-making, governments should make this a priority. Older persons should be involved in policy development, monitoring and evaluation. Existing government run schemes, such as community education, could target older persons and government may also be able to address logistical obstacles such as transport which prevent people participating.

Social participation is also enhanced by positive perceptions of older persons among other population groups and therefore efforts to raise public awareness about the contribution of older people to society can contribute towards social participation of older persons.

In order to promote a positive image of older persons many Caribbean countries organise events in conjunction with International Day of Older Persons on 1st October. The Jamaican National Council for Senior Citizens established a national education programme to inform the general public about the ageing process, and the beneficial role of seniors in families and communities. Activities included: seminars; publication of oral histories and personal accounts of the experiences of older people; exhibitions to display the work of seniors at libraries and government offices; and conferences to bring together senior citizens with senior members of government. The Senior Games organized in Barbados and Saint Lucia also promote a very positive image of older people.

Legislation to protect older persons from discrimination and abuse can also play an important role in changing perceptions of older persons. A number of countries in Latin America have enacted equal opportunity and anti-discrimination legislation to protect older persons. There has been much less progress in this area in the Caribbean.

While some countries have national policies on ageing, the rights of older people as a minority group are not generally enshrined in legislation. There is no special protection against discrimination for older people, nor any special status attached to the mistreatment of older people. The only exception to this is in Trinidad and Tobago where the new Homes for Older Persons Act (2007) made elderly abuse taking place in a long-stay institution an offence punishable by law.

In Barbados, a national Anti-Elder Abuse Programme Coordinating Committee was established. Over the past five years the committee has successfully raised the level of public awareness and public debate on the issue of elder abuse and has developed the case for legislation to tackle elder abuse and discrimination. Numerous countries have identified legislation and protection of the rights of older persons as priority areas for future action.

Population ageing is often seen as a threat due the looming burden that caring for larger numbers of older persons will place on societies. While those challenges are real indeed, it should be remembered that population ageing itself is a hugely positive development which is an inherent part of the social and economic development of the region. In population terms, ageing is caused by increased life expectancy and falling fertility rates. Both of these phenomena are unquestionably positive developments, in the case of increasing life expectancy for obvious reasons, and in the case of falling fertility rates because they reduce population growth to more environmentally sustainable levels.

Population ageing presents societies with a set of related challenges. Societies must seek to ensure that an increased number of older persons enjoy a good quality of life, in the best possible health, with appropriate systems of social transfers and support. This will demand a renegotiated settlement between the generations, which should seek to strengthen principles of inter-generational solidarity and sharing of risks, in order to meet the needs not only of the current generation of older persons, but future generations as well. Rising to meet these challenges will require planning and analysis, democratic consultation and debate, and commitment to action, but the problems are by no means insurmountable.

V. The Rights of Persons with Disabilities

The explicit inclusion of persons with disabilities in the ICPD Programme of Action reflected a growing international recognition of the need to recognise their right to equality and full participation in economic, social and cultural life. Since the ICPD, international efforts to advance the rights of persons with disabilities have continued culminating in the United Nations General Assembly's adoption of the Convention on the Rights of Persons with Disabilities (CRPD) which opened for signature and ratification in 2007.

The ICPD Programme highlights the importance of participation, equal opportunities, dignity and self-reliance. It calls for governments to recognise the needs and rights of persons with disabilities in respect of their sexual and reproductive rights, HIV and AIDS, education, training and rehabilitation. The CRPD develops in a much more detailed way how all categories of rights apply to persons with disabilities and where adaptations have to be made for persons with disabilities to effectively exercise their rights. There is also an Optional Protocol to the CRPD which establishes procedures for individuals wishing to claim breaches of their rights under the convention and for inquiries by the Committee on the Rights of Persons with Disabilities.

The fifteen year review of the ICPD Programme recognised that although there had been advances in incorporating the rights of persons with disabilities into some regulations, and attention to the sexual and reproductive rights of persons with disabilities, the Caribbean was a long way from achieving the goal of equal participation in social, economic and cultural life. To a large extent this is still the case, although the last four years have seen the demonstration of political commitment to addressing this issue with a further six countries (Barbados, Belize, Dominica, the Dominican Republic, Haiti and Saint Vincent and the Grenadines) joining Jamaica and Cuba in having ratified the CRPD. Dominica, the Dominican Republic, Haiti and Saint Vincent and the Grenadines have also signed the optional protocol. Those countries which haven't ratified the CRPD should seek to do so, and all countries must give greater priority to implementing programmes for persons with disabilities if they are to be able to fully realise their rights in practice.

The CRPD is particularly relevant since very few Caribbean countries have within their domestic legal framework comprehensive anti-discrimination legislation protecting the rights of persons with disabilities. Guyana is a notable example in this respect since in 2010 the Parliament of Guyana passed the Persons with Disability Act, which is guided by the principles enshrined in the CRPD.

A. Participation in Social, Economic and Cultural Life

Around 5 per cent of persons in the Caribbean have some type of disability. The level of participation of persons with disabilities in education and employment strongly suggests that the Caribbean has fallen short of the ICPD objective of participation in ‘all aspects of social, economic and cultural life’.

Within the educational systems of the Caribbean, the rate of school attendance of children and young people with disabilities is lower, and varies more from country to country, than for those without disabilities. In the Cayman Islands and Bermuda there are very high rates of school attendance by children with disabilities, and, to a lesser extent, in Barbados and Aruba. In Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, and Belize attendance rates are much lower. Rates of attendance among the visually impaired and the hearing impaired are higher either because of the existence of special schools or integration within mainstream schools. Rates of attendance for those with learning difficulties, speech, mobility, upper limb impairments, behavioural difficulties, and difficulties with self-care were lower (see Table 5).

Truly inclusive education systems need to incorporate processes for eliminating or minimizing barriers that limit the learning and participation of all students. They need to create an environment that adapts to people rather than passively or actively excluding those who lack the physical, mental or cognitive tools to function in a traditional educational setting (ECLAC, 2013).

Based on a study carried out by ECLAC in 2010, most countries seek to include children with disabilities within mainstream schools where possible but also have separate specialized institutions for children and adolescents with disabilities (ECLAC, 2010). While only a few countries have specific laws guaranteeing equal access for students with disabilities, most have implemented some measures to promote participation of persons with disabilities. There has been provision of teacher training, additional classroom support, and teaching of sign language and/or Braille. For example, Braille and sign language were taught in Barbados, Dominica, the former Netherlands Antilles, Guyana and Trinidad and Tobago.

TABLE 5
PERSONS WITH AND WITHOUT DISABILITIES AGED 13-18 WHO ATTEND SCHOOL
BY TYPE OF DISABILITY
(Percentages)

	Type of disability								Persons without disabilities
	Visually impaired	Hearing impaired	With learning difficulties	Speech impaired	Mobility impaired	With upper limb impairments	With behavioural difficulties	Self-Care	
Cayman Islands	97	95	97	100	92	83	95	...	95
Bermuda	80	100	82	85	87	67	...	90	98
Barbados	84	87	79	74	67	79	60	...	88
Aruba ^a	87	83	72	61	63	...	...	37	95
Grenada	88	61	68	55	54	47	49	...	92
Saint Lucia	75	68	60	50	54	51	37	...	77
Saint Vincent and the Grenadines	83	72	66	56	46	48	45	...	82
Trinidad and Tobago	85	75	56	45	42	37	38	...	86
Belize	74	62	46	38	35	26	32	17	72

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the following housing and population censuses: Antigua and Barbuda (2001); Aruba (2010); Barbados (2000); Belize (2000); Bermuda (2010); Cayman Islands (2010); Grenada (2001); Saint Lucia (2001); Saint Vincent and the Grenadines (2001); Trinidad and Tobago (2000).

^a The estimates for Aruba on learning difficulties are based on a census question regarding difficulties remembering or concentrating, while the data on speech impairments are based on a question relating to communication difficulties.

Efforts have also been made to accommodate students using wheelchairs within mainstream schools. In Trinidad and Tobago, persons with disabilities are increasingly being admitted into the regular school system and recently constructed schools have been built with the infrastructure to accommodate students in wheelchairs. Nevertheless further efforts are required to increase school attendance particularly among children with disabilities other than those related to sight and hearing.

Economic activity among persons with disabilities is also much lower than among persons without disability (Table 6). In some countries persons of working age with disabilities are little more than half as likely as those without disabilities to be in work. Rates of economic activity among persons with disabilities were highest in Antigua and Barbuda and the Cayman Islands, and lower in Barbados, Grenada, Trinidad and Tobago and Saint Vincent and the Grenadines.

According to information from NGOs and governments, there has been some progress in terms of providing more employment opportunities to persons with disabilities. Several countries provide training, sheltered employment, and job placement schemes. In Trinidad and Tobago, the National Employment Service provides trial employment to persons with visual impairments. Only Jamaica and Montserrat reported carrying out reasonable adaptations that contributed to the physical accessibility of the workplace.

Although governments reported that supported employment, self employment and sheltered employment are promoted in certain countries, and that reasonable adaptations that contribute to physical accessibility of the workplace exist, there is clearly scope for increased employment of persons with disability in both the public and the private sectors. According to information provided by NGOs working with persons with disabilities, although there is some limited recruitment of persons with disabilities by the public sector, in for example Guyana, Belize and Jamaica, the practice is not sufficiently widespread and in other countries there were few or no persons using wheelchairs who were employed by the public sector. Most national building codes do not currently oblige businesses to make their office buildings accessible.

Nearly all Caribbean social security systems provide insured persons with employment injury benefit or invalidity benefit in case they are unable to work due to disability. However in countries with a large informal sector, this leaves a large part of the population unprotected.

As regards the accessibility of public buildings, public space and transport, NGOs representing the visually impaired and wheelchair users reported that streets and sidewalks are often inaccessible due to their unevenness, the absence of audible or tactile signs, and curb-cuts. Relatively few courts of law, police stations, libraries and polling stations are accessible to persons using wheelchairs. Most countries have at least some accessible voting procedures for blind and visually impaired persons, although other government information and utility bills are not available in accessible formats. In some countries there are limited public bus services which are accessible to persons using wheelchairs or ‘dial-a ride’ services specially provided for persons with disabilities. However the limited reach of these services has meant that access to public transport remains a major challenge for wheelchair users.

B. National Initiatives to Advance Participation, Self-Reliance and Equality

All governments are making efforts to improve education services for children and young persons with disabilities, either through their inclusion in mainstream schooling, special schools, or the provision of teachers who visit children in their homes. However there is widespread recognition that more work needs to be done to provide high quality education to persons with disabilities. Some examples of good practice included the provision of personal assistants to children with disabilities to support their attendance at mainstream primary and secondary schools (Jamaica and Trinidad and Tobago); attempts to widen the use of sign language (Barbados); community level projects to make schools accessible (Belize); and provision of education to all children with disabilities (Cuba).

TABLE 6
ECONOMICALLY ACTIVE PERSONS WITH DISABILITIES AGED 15 TO 59 BY TYPE OF DISABILITY
(Percentages)

	Type of disability							All persons aged 15 to 59 with disabilities	All persons aged 15 to 59 without disabilities	
	Visually impaired	Hearing impaired	With upper limb impairments	Mobility impaired	Speech impaired	With behavioural difficulties	With learning difficulties			Difficulties with self-care
Antigua and Barbuda	73	68	47	54	37	27	15	...	61	73
Cayman Islands	72	52	44	53	36	39	25	...	60	83
Aruba ^a	56	49	...	35	13	...	23	13	47	69
Belize	49	46	32	32	28	18	16	9	43	52
Saint Lucia	48	43	31	37	26	16	24	...	39	61
Bermuda	66	46	49	40	14	...	24	29	...	81
Barbados	51	51	33	32	25	15	19	...	37	77
Grenada	52	50	36	33	22	12	12	...	34	60
Trinidad and Tobago	46	30	21	20	13	7	9	...	31	59
Saint Vincent and the Grenadines	32	27	22	27	22	5	17	...	30	53

Source: Economic Commission for Latin America and the Caribbean, on the basis of the following population and housing censuses: Antigua and Barbuda (2001); Aruba (2010); Barbados (2000); Belize (2000); Bermuda (2010); Cayman Islands (2010); Grenada (2001); Saint Lucia (2001); Saint Vincent and the Grenadines (2001); and Trinidad and Tobago (2000).

^a The estimates for Aruba on learning difficulties are based on a census question regarding difficulties remembering or concentrating, while the data on speech impairments are based on a question relating to communication difficulties.

Efforts aimed at assisting persons with disabilities have centred on providing sheltered employment. A number of countries provide education and training, vocational training, and job placement programmes aimed at helping persons with disability to find work. The Government of Jamaica is targeting 5 per cent of government jobs to be filled by persons with disabilities. Some countries also offer loans for business start up (Belize and Jamaica).

The fifteen year ICPD review noted that throughout the Caribbean the built environment was far behind the level necessary to guarantee equal participation in social, economic and cultural life by persons with disabilities. The Dominican Republic reported significant progress in respect of infrastructure with 80% of school and hospitals built in the last five years being accessible to persons with disabilities, as well as the Santo Domingo Metro and other public buildings. In Jamaica concrete measures to address this issue included: revision of the Building Code through the Bureau of Standards; revision of the Road Traffic Act; provision of accessible buses in the fleet; dialogue with the Civil Aviation Authority to develop standards for travel for persons with disabilities. However, given the scale of the investment required to improve accessibility, ongoing efforts will be required.

Governments in collaboration with NGOs are seeking to improve habilitation and rehabilitation services through provision of prostheses, assistive devices, and training. Many countries have provided information and run workshops for persons with disabilities on sexuality awareness, sexually transmitted infections, HIV and AIDS and condom use, although many governments reported that their efforts in this area are behind schedule.

TABLE 7
PROGRESS ON IMPLEMENTATION OF MEASURES ADOPTED TO ADDRESS ISSUES REGARDING
PERSONS WITH DISABILITIES DURING THE LAST 5 YEARS
(Numbers)

	Countries addressing Issue (out of 15)	Progress			
		Deficient	Behind Schedule	On Schedule	Ahead of schedule
Ensuring a general education system where children are not excluded on the basis of disability	13	4	6	2	0
Creating employment opportunities for persons living with disabilities	12	4	4	1	0
Ensuring the same rights and access to SRH services, including HIV prevention	13	0	6	2	1
Developing infrastructure to ensure access on an equal basis with others	12	3	7	1	0
Strengthening comprehensive habilitation and rehabilitation services and programmes	10	3	2	3	1
Instituting concrete procedures and mechanisms for participation	11	1	2	4	1
Guaranteeing equal and effective legal protection against discrimination	9	2	2	3	0
Promoting equality by ensuring reasonable accommodation in all aspects of life	10	2	3	2	0
Providing support to families caring for persons with disabilities	11	3	1	5	0
Collecting disaggregated data	10	3	0	5	0

Source: ICPD global survey responses for Antigua and Barbuda, Barbados, Belize, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago.

Information provided in the ICPD survey showed that in many areas policies and programmes aimed at persons with disabilities were either behind schedule or deficient. The inadequacies were most glaring in the following areas: education, employment, SRH services and infrastructure (see Table 7). This is further substantiated by recent studies done by ECLAC Subregional Headquarters for the Caribbean, which found significant deficiencies in the extent to which the concerns of persons with disabilities were integrated into national policies, regulations and laws (ECLAC, 2011; ECLAC, 2010; ECLAC, 2009a).

C. Realising the Rights of Persons with Disabilities

Eight countries in the subregion have now ratified the Convention on the Rights of Persons with Disabilities (CRPD) and four have signed the Optional Protocol which establishes monitoring procedures. These agreements provide a comprehensive framework for addressing the rights of persons with disabilities and they are legally binding and so ratification should be the impetus to concerted action to ensure that persons with disabilities are able to realise their rights under the CRPD.

One of the first steps involved in advancing a better situation for persons with disabilities should be in the design of national laws and legislation. Very few countries have specific anti-discrimination laws which protect persons with disabilities, although most governments have integrated concerns relating to persons with disabilities into national policies as well as some of their generic laws. Governments should develop the national laws, policies, and institutional arrangements necessary to secure for persons with disabilities their rights as recognized in this Convention.

Governments should seek to increase participation by persons with disabilities within mainstream education. Schools should be made accessible to children with visual impairments and users of wheelchairs. Braille books, talking text books, reading machines and computers with speech software should be available for children with visual impairments. Curriculums and teaching methodologies should seek to meet the needs of all children including children with special needs.

Government should take positive action to make it easier for persons with disabilities to work. Persons with disabilities should also be supported with vocational rehabilitation, skills training and opportunities for sheltered or supported employment. Persons with disabilities should be protected against discrimination in employment. An important step towards achieving this goal is to obligate both private and public sectors to make their offices and workspaces accessible to all persons.

Building codes should mandate that all new public buildings, workplaces and public spaces should be made accessible to persons with mobility impairments, visual impairments and hearing impairments. Efforts could also be made to make existing buildings accessible.

Many persons with disabilities are sexually active. Training of medical providers and caregivers on the SRH needs of persons with disabilities is needed. Persons with disabilities should have access to sexual and reproductive health and family planning services. Sexual and reproductive health and family planning programmes must target persons with disabilities with information in accessible formats and services which are sensitive to their needs.

VI. Gender Equality, Equity and Empowerment of Women and Girls

In the Caribbean, all the primary agents of socialization that shape human relations – family, school, workplace, church, and state – have defined roles, values and norms for both genders. The process of gender socialization shapes how men and women view themselves and shapes the gendered behaviours through which they relate to each other. The exercise of power, whether through economic, political or physical means, is equated with masculinity in a way which serves to disempower women and those persons who do not conform to the socially ascribed gender roles and stereotypes. Expressions of violent behaviour are accorded a certain degree of social acceptability and rates of gender based and sexual violence are high. This also contributes to sexual and reproductive ill health including HIV and AIDS and the high rate of teenage pregnancies in the subregion. All these issues are inter-linked and have serious consequences for wellbeing, autonomy, citizenship, human and national development.

The empowerment of women and girls and improvement of their status are important ends in their own right. They are also essential for the reduction of poverty, full realisation of sexual and reproductive rights, and the achievement of sustainable development. Only with full equality and equity, and harmonious partnership between men and women, will women be able to realize their full potential. The ICPD Programme of Action commits countries to establish mechanisms for women's equal participation and equitable representation at all levels of the political process and public life; promote women's education, skill development and employment; eliminate violence against women and girls; and eliminate all other practices that discriminate against women and girls. It also recognises that men play a key role in bringing about gender equality since, in most societies they exercise preponderant power in nearly every sphere of life. This section of the report reviews progress towards the goals and objectives of the ICPD programme relating to gender equality, equity and empowerment of women and girls.

According to the ICPD programme, achieving gender equality requires policy and programme actions by government that will improve women's access to secure livelihoods and economic resources, alleviate their responsibilities for family and household matters, and permit greater female participation in public life. Improving the status of women and girls is essential for the long-term success of population programmes and the achievement of sustainable development.

There are also other important conventions and international agreements aimed at advancing gender equality and women's empowerment. These include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Beijing Platform of Action, the Convention on the Rights of the Child (CRC), the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women 'the Belém do Pará Convention', and the United Nations Secretary-General's UNiTE to End Violence against Women campaign. CEDAW, for example commits countries to undertake a series of measures to end discrimination against women in all forms. All Caribbean countries have ratified or acceded to CEDAW and so are legally bound to put its provisions into practice. Countries are also required to submit reports on the articles of the convention¹⁵ which all countries have done at least once.¹⁶

The fifteen year review of the ICPD programme identified a number of areas where the programme had yet to be fully implemented in the Caribbean. These included under-resourcing of gender equality programmes, under-representation of women in political and governmental decision making, and unacceptable levels of gender based and sexual violence. It was also noted that the burden of family care was highly feminized as women remained the primary carers of children and other dependents including older persons.

In order to support the national implementation of CEDAW, CRC, the Belém do Pará Convention, the ICPD Programme of Action and the Beijing Platform of Action, national gender policies are being developed in the Caribbean. Countries such as Jamaica (2010), Dominica (2006) and Belize (2002; amended 2013) have developed and implemented National Policies on Gender Equality aimed at empowering women, creating gender equity and equality and fostering sustainable human development. Barbados has developed a framework and is currently working on drafting an official Gender Policy, while the Bahamas (2011) and Trinidad and Tobago (2009) both have draft Gender Policies. Suriname has also developed the National Gender Policy and Strategic Plan.

Nevertheless there is an ongoing need for institutional strengthening and capacity development of National Women's/Gender Bureaux. Partnerships with governments, civil society organisations, and subregional partners can further enhance effective programming. Attention must be given as well to the social factors and institutions that aid in the construction of undesirable forms of masculinities. Gender sensitization, awareness and training within the established human-rights based framework must be continued at community, institutional, national and regional levels.

A. Women's Participation in the Formal and Informal Economy

Progress towards gender equality has seen higher educational attainment by women, in fact higher than men, and increased participation in the labour market. Nevertheless, women do not always realise the full economic benefits of increased labour market participation as gender differences persist, for example in male/female rates of participation in the formal versus the informal sector and in private versus public enterprises as well as in unemployment rates and rates of pay. Women's traditional gender roles as carers, particularly in the case of those who are single parents, can either prevent them from working or restrict the kind of work that they are able to do. Many women that do work can find that they are shouldering a 'double burden' of work and care responsibilities.

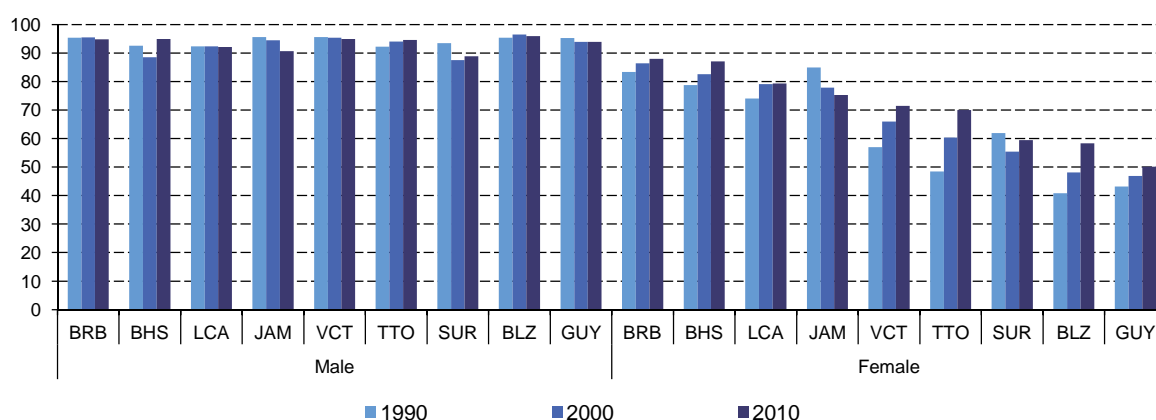
Over the last 10 years, there has been an expansion of opportunities for women in the labour market with increases in the female labour force participation rate in most Caribbean countries (Figure 9). In

¹⁵ CEDAW Articles: 1 Definitions, 2 legal Provision, 3 Development and Advancement of Women, 4 Acceleration of Equality between Men and Women, 5 Sex Roles and Stereotyping, 6 Exploitation of Women, 7 Political and Public Life, 8 International Representation and Participation, 9 Nationality, 10 Education, 11 Employment, 12 Equality in Access to Health Care, 13 Social and Economic Benefits, 14 Rural Women, 15 Equality Before the Law and in Civil Matters, 16 Equality in Marriage and Family Law.

¹⁶ Reports were submitted to the Committee on the Elimination of Discrimination against Women by Antigua and Barbuda (1997), Bahamas (2012), Barbados (2002), Belize (2007), Dominica (2009), Cuba (2013), Dominican Republic (2013), Grenada (2012), Guyana (2012), Haiti (2009), Jamaica (2012), Saint Kitts and Nevis (2002), Saint Lucia (2006), Saint Vincent and the Grenadines (scheduled for 2013), Suriname (2007) and Trinidad and Tobago (2002).

2010, the labour market participation rate for men aged 25-54 was between 90 and 96 per cent in all countries for which data was available, with female participation ranging from 88 per cent in Barbados to 50 per cent in Guyana. But whereas the rate for men has been largely constant over the last twenty years, labour force participation among women in this age group increased in most countries especially in Trinidad and Tobago where there was a 22 per cent increase between 1990 and 2010. Reasons for the increase in female participation include the higher educational attainment of women, the decline in fertility rates and greater social acceptance of women's equality in the workplace. Against the general trend, Jamaica has seen declining labour force participation among both men and women and research has suggested that the receipt of remittances has played a role in reducing labour market participation (Kim, 2007).

FIGURE 9
LABOUR FORCE PARTICIPATION OF PERSONS AGED 25-54 BY SEX
(Percentages)



Source: Key Indicators of the Labour Market (KILM), International Labour Organization (ILO).

Nevertheless, women are more likely to work in informal employment, or are concentrated in certain sectors, for example tourism or the public sector. Time use surveys have shown that women's work in the home makes a substantial but largely unrecognised contribution to national economies. Assumptions about the gender roles of men and women can undermine female participation in the labour market. For example, the World Values Survey (2006) indicated that 25 per cent of respondents from Trinidad and Tobago specified that men have a greater right to a job in times of job scarcity (IBRD/WB 2010).

The majority of Caribbean countries have policies aimed at encouraging women's participation in the formal economy. Countries are implementing programmes aimed at providing guarantees and protection for pregnant workers (Dominican Republic); and microfinance for female entrepreneurs (Trinidad and Tobago, Jamaica and the Dominican Republic). For the Caribbean as a whole there was a particular emphasis on measures to eliminate discrimination against women in rural areas and to increase training in agriculture. Training has focused on small business management, use of technology and land use. Microcredit and small loans have also been emphasised as well as training and technical assistance in the management of loans together with the development of cooperative societies. In some countries specific entities have been created for social investment that channel resources to community based projects that strengthen capacity in agricultural and food production. In some countries, access to resources for business and home construction still remains a problem for women.

In order to continue progress towards the goal of equal access for women to the labour market and social security, policies should focus on three broad areas: equalities legislation and mechanisms for enforcement of legislation; job creation and stimulation of employment for women especially in rural

areas; and policies to promote co-responsibility between men and women for parenthood and other care responsibilities. There should also be greater emphasis on shared control of and contribution to family income.

Most countries in the Caribbean have laws against gender discrimination in employment although in some cases either laws or enforcement mechanisms need to be strengthened as discrimination in hiring, wages, benefits, training and job security still exist within the Caribbean. A number of countries identified the enactment of gender equality legislation as a priority for the next five to ten years. Government and employers should also support women in combining work and family life. The workplace should be made more family friendly through the introduction of policies such as flexible work-hours, day-care facilities, breastfeeding breaks and paternity leave.

B. Increasing Women’s Representation in Political Processes and Public Life

There is need for greater involvement of women in political decision-making. A threshold of 30 per cent is considered necessary by the Inter-Parliamentary Union for female parliamentarians to have an impact on decision-making. Most Caribbean countries continue to fall short of this threshold with female representation averaging 20 per cent across all parliaments in the Caribbean (upper and lower houses) compared to 17 per cent in 2000. Only Cuba, Grenada and Guyana exceed the 30 per cent threshold (Table 8). However, there have been a number of female Prime Ministers over the last 15 years, most notably Dame Eugenia Charles of Dominica, Janet Jagan in Guyana, Portia Simpson Miller in Jamaica and Kamla Persad Bissessar in Trinidad and Tobago. There is also more equal representation of women at lower levels of political decision-making, including local politics.

TABLE 8
WOMEN’S REPRESENTATION IN PARLIAMENT
(Percentages)

Country	Year of Elections	Lower or Single House	Upper House/Senate	Year of Elections	Lower or Single House	Upper House/Senate
Antigua and Barbuda	1999	5.3	11.8	2009	10.5	29.4
Bahamas	1997	15.0	31.3	2012	13.2	25
Barbados	1999	10.7	33.3	2013	16.7	33.3
Belize	1998	6.9	37.5	2012	3.1	38.5
Cuba	1998	27.6	-	2013	48.9	-
Dominica	2000	18.8	-	2009	12.5	-
Dominican Republic	1998	16.1	6.7	2010	20.8	9.4
Grenada	1999	26.7	7.7	2013	33.3	23.1
Guyana	1997	18.5	-	2011	31.3	-
Haiti	2000	3.6	25.9	2011	4.2	0
Jamaica	1997	13.3	23.8	2011	12.7	23.8
Saint Kitts and Nevis	1995	13.3	-	2010	6.7	-
Saint Lucia	1997	11.1	18.2	2011	16.7	18.2
Saint Vincent and the Grenadines	1998	4.8	-	2010	17.4	-
Suriname	2000	17.6	-	2010	11.8	-
Trinidad and Tobago	2000	11.1	32.3	2010	28.6	22.6

Source: Inter-parliamentary Union, Women in National Parliaments, www.ipu.org (situation as of March 2013).

Temporary special measures such as quotas have been shown to accelerate women's participation in politics and in 2012 the former Executive Director of UN Women, Michelle Bachelet encouraged 'countries to use quotas to expand women's participation in parliament' (UN Women, 2012). Guyana is the only country in the Caribbean that has passed legislation which provides for quotas in political representation. At least one third of the candidates selected by political parties contesting national and regional elections in Guyana must be women. Suriname is also working on the development of a quota system.

Attention should be given to the development of mechanisms to ensure greater participation by women and more equitable representation at all levels of the political process and public life. A minimum number of parliamentary seats can be reserved for women or alternatively there can be quotas to ensure the participation of a minimum number or proportion of women candidates participating in elections.

The provision of training for women who are aspiring politicians can help to raise female participation in elections and also increase their access to resources. Support networks and mentors can also help female parliamentarians or aspiring parliamentarians deal with the challenges they face. Measures could be considered to encourage more women to consider a career in politics. The need for such programmes was identified as a priority in several countries, including Antigua and Barbuda, Dominica and Jamaica. In Belize, with support from UNFPA and UN Women, the National Women's Commission of Belize implemented a project entitled Women in Politics that provided training to women who wanted to enter local or national politics or who were already active in politics, and sought to address the inequalities between women and men in political leadership and decision-making.

The Caribbean Institute for Women in Leadership (CIWIL) was launched in 2009 as a networking institute, producing research, providing training and advocating for greater involvement of women in politics, leadership and decision making at all levels in the Caribbean. The Institute engages with Caribbean women's organizations and political parties from across the region. It provides education, training and support in order to increase representation of women in politics and decision-making. Guyana also has a Women's Leadership Institute which provides opportunity for women to access training in leadership and other gender related issues.

C. Ending gender based violence

Gender based violence (GBV) is a manifestation of unequal power in gender relations. The most common form of violence occurs in domestic situations. Available data indicate that women are more likely to suffer physical, sexual, or psychological violence within a family setting. In 2008/09 some 20 per cent of women in Jamaica had been a victim of physical or sexual violence by a partner, 8 per cent of these in the previous 12 month period.¹⁷ Fairly similar rates were observed in the Dominican Republic (Bott and others, 2012). In the Caribbean it continues to be challenging to measure the prevalence of GBV because of low reporting rates. There are many reasons for this, including shame, fear of reprisal, and even a degree of acceptance influenced by prevailing socio-cultural norms.

GBV includes sexual violence and harassment which is of particular concern in the Caribbean. The United Nations Office on Drugs and Crime (UNODC) and the World Bank (2007) note that the Caribbean is home to some of the highest rates of sexual violence worldwide. In 2010, there were 1,206 reported cases in Jamaica, 484 in the Bahamas, 147 in Guyana, 130 in Trinidad and Tobago, 150 cases in Grenada, 62 in Saint Kitts and Nevis and 84 in Saint Vincent and the Grenadines. Sexual violence can have long term physical and psychological effects, and can also lead to unwanted pregnancies among girls and adolescents and an increase in sexually transmitted infections, including HIV. Victims of human trafficking and sex workers are particularly vulnerable both to GBV and sexual abuse and harassment.

¹⁷ Percentage of women who reported physical or sexual violence by a partner, ever and in the past 12 months, among women ever married or in union aged 15-49.

Most countries in the Caribbean have signed or ratified a number of conventions that include obligations to protect women and girls from all forms of violence.¹⁸ The 2013 Agreed Conclusions of the 57th session of the Commission on the Status of Women also reiterated the commitments of Member States to address issues of violence against women and girls. In a bid to meet their regional and international commitments, states have been working assiduously to put in place legislative and policy frameworks to address GBV/SV within the region. Their actions have included the creation of new legislations and legislative functions (and the reshaping of existing ones) to meet the needs of their individual societies. These legislations include the domestic violence acts present in states such as Belize, Barbados, the Bahamas, Dominica, Grenada, Guyana, Jamaica and Suriname. Sexual offences acts have also been enacted in several states including Antigua and Barbuda, Barbados, Guyana and Jamaica. To further strengthen their initiatives, states have strategically implemented other mechanisms to work in tandem with existing legislation. Examples of this can be seen in the Domestic Violence and Sexual Assault Protocol designed by Grenada to operate alongside their Domestic Violence Act; the development of several National Strategic Action Plans to end Gender Based Violence as seen in Antigua and Barbuda (2013); Belize (2010); Grenada (2013-2017); Saint Lucia (2011); Jamaica (draft); and the formation of the National Policy on Domestic Violence in Guyana (2008-2013). These acts represent positive steps in the right direction. Still, there is need to enhance existing systems in order to strengthen their capacity to effectively prevent and address gender based violence.

Other measures being adopted by Caribbean countries to end GBV include improved coordination between different agencies, working with agents of change, including involving men and boys to address the issue and training of police and social workers to deal with cases of domestic abuse. Training of police officers was conducted throughout the Caribbean in collaboration with UN Women and UNFPA. The training involved the management of cases of sexual offences and intimate partner assault, legal issues around domestic violence and victim support. Countries that participated included Antigua and Barbuda, Belize, Grenada, Guyana, Jamaica, Saint Kitts and Nevis and Saint Vincent and the Grenadines. In Guyana, men and boys are sensitised on GBV through faith based organisations, sports clubs and work places. A Domestic Violence Protocol has also been implemented in Belize, in partnership with ECLAC, to develop a reliable data collection system which it is hoped will serve as a model for other governments. The protocol helps to obtain a profile of victims and perpetrators, develop an understanding of the frequency and incidence of domestic violence, identify the groups at risk, develop intervention programmes, and monitor the effectiveness of violence prevention and intervention activities. A Domestic and Sexual Violence Prevention Protocol were also developed with the support of UNFPA and UN Women in Suriname and Belize. The principal objective of this protocol is to establish uniform policies and procedures in responding to survivors of sexual violence.

Gaps in data collection still exist and a survey of six countries in the Caribbean, Belize, Guyana, Jamaica, Suriname, Trinidad and Tobago, and St Lucia, supported by UNFPA in collaboration with CARICOM, made a number of recommendations to improve collection of data on sexual violence.

Almost all Caribbean countries have introduced hotlines to assist victims of GBV. In some countries, temporary shelters for abused victims have been established. Projects that engage men and boys are less common but those that exist seek to address the causes of gender inequality, masculine behaviour, and seek to change the behaviour of perpetrators of violence and to prevent future violence from occurring.

A task force was commissioned to develop a comprehensive policy to address the problem of domestic violence nationwide in Trinidad and Tobago, while in Barbados a legal framework has been implemented to protect victims of domestic violence which recognises marital rape and includes provisions for protection orders. In Jamaica, a National Action Plan to prevent gender-based violence has been developed outlining the importance of a multi-sectoral approach to preventing and addressing

¹⁸ The Convention on the Elimination of All Forms of Discrimination Against Women; the Beijing Declaration and Platform for Action; and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women otherwise known as the Convention of Belém Do Pará.

the issue. The United Nations system in Jamaica has pledged its collective financial and technical support to this initiative.

Some work has been done in the development of health protocols in Barbados and which are being implemented as well as shared with other countries in the Caribbean region. Jamaica and Trinidad and Tobago are presently designing a health protocol to address GBV in the health clinic setting. It will also support strengthened linkages to enhance capacity and networking among sectors and organizations key to responding to GBV in the context of HIV. Also in Jamaica there is a Complaint and Response Protocol for GBV intended to ensure that victims are treated with dignity, courtesy and respect by social and health care providers.

BOX 3
DISCRIMINATION AND VIOLENCE EXPERIENCED BY LESBIAN, GAY, BISEXUAL
AND TRANSGENDER (LGBT) PERSONS

Although not directly addressed in the ICPD Programme of Action, lesbian, gay, bisexual and transgender (LGBT) persons are exposed to discrimination and violence because of their sexual orientation or gender identity and are often ostracised by communities and rejected by their families. Often victims are reluctant to report incidents to the authorities for fear of further abuse. Laws criminalizing sexual activity by LGBT persons are still very prominent in a number of Caribbean countries such as Antigua and Barbuda, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Trinidad and Tobago.^a This fact contributes to discrimination and to the potential for abuse. The first United Nations report on this issue called upon governments to protect lesbian, gay, bisexual and transgender (LGBT) persons by investigating all serious violations of their human rights and repealing discriminatory laws.

Source: Office of the High Commissioner for Human Rights (OHCHR), “Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity”, report to the United Nations Human Rights Council A/HRC/19/41, November 2011.

^a The International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) website <http://ila.org>.

All countries need to continue working towards ensuring that all women and girls realise their right to live free from fear of violence and sexual harassment. Many countries identified actions to address GBV as a future priority including the provision of shelters, improved access to the legal system, revised legislation, programmes to engage men and boys, public education and awareness campaigns, and establishing better information systems. Recently in Jamaica, UNFPA supported training for doctors and police in evidence collection to ensure that the evidence collected can be used in improving access to justice. The intent is that this will continue to expand to other countries in the region.

In order to respond more effectively to gender based violence countries need to consider strategies for a multi-sectoral response involving better coordination among the various providers of services in order to reach victims and survivors. Continued strengthening of institutional capacity to support policy and programme implementation is also important. The rights and safety of vulnerable groups, such as migrants, sex workers, women in domestic service, schoolgirls and women with disabilities are also deserving of greater protection. There is need for the countries in the Caribbean to continue to develop policies and programmes aimed at reducing the incidence of GBV. Improving the response from the key institutions such as the police, health and social services and the legal system is critical to improving management and response to GBV. In 2011, UNFPA developed a Strategy to Prevent and Address Sexual Violence against Women in Latin America and the Caribbean which has been introduced in the Caribbean and formed the basis of UNFPAs intervention in the region with a focus on this aspect of gender based violence. The strategy also serves to guide UNFPAs technical cooperation in sexual violence in the subregion.

D. Improving the Collection, Analysis, Dissemination and use of sex and age disaggregated data, and data on the Status of Women

Access to sex disaggregated data is essential for the formulation and implementation of evidenced based policies intended to address issues affecting women. The ICPD Programme of Action calls for the development of specific procedures and indicators for gender-based analysis of development programmes and for assessing the impact of those programmes on women's social, economic and health status and their access to resources. The need for relevant statistics is also addressed in both the Beijing Platform for Action and the data collection requirements of CEDAW.

The majority of countries are now able to produce sex-disaggregated statistics on population demographics, school enrolment, labour market participation and parliamentary representation. Data collection for the 2010 round of censuses has now been carried out in nearly all Caribbean countries. All countries have completed occasional surveys of living standards and labour force surveys have also been undertaken. Few comprehensive demographic/health surveys have been conducted over the past ten years due to funding constraints. Countries have identified a continuing need for these but the necessary resources have yet to be mobilized. National MDG progress reports were conducted in several countries while the third and fourth round of the Multiple Indicator Cluster Survey continued to monitor the situation of women and children. A number of smaller more targeted surveys have been conducted in very specific thematic areas such as attitudes and behaviour among youth, and domestic violence or violence against women.

Data of interest are routinely collected, for example within Ministries of Health and Education, Gender Departments, and Police Departments but limited use is made of the information. Much administrative data is still recorded manually and there is limited analysis of the data. Where countries are introducing Health Information Systems, priority is always given to collecting and tabulating revenue related data and not to other more health related variables.

In Belize, with the assistance of UNICEF, the National Women's Commission established the Belize Gender Info database which serves as a primary monitoring tool that tracks the progress on the implementation of the national gender policy. Recent studies by UNFPA and CARICOM on data collection systems on GBV including sexual violence in six Caribbean countries, points to strengths, weaknesses and gaps and provides recommendations. Other initiatives to improve the availability of information about GBV include a survey on domestic violence carried out in Barbados in 2009, research on the same topic by the Guyana Women's Bureau in 2011, and a standardised data collection tool developed in Saint Lucia to be used by agencies that come into contact with victims of gender based violence.

The major challenges for Caribbean statistical offices are how to make the best use of very limited resources, limited specialist skills (for example experts in statistics, demography and geographic information systems), and high turnover of staff. However, only through the collection of gender-relevant data can the drivers and consequences of gender inequality be identified and such evidence is critical if countries are to be in a position to design effective and appropriate policies and programmes for the advancement of gender equality.

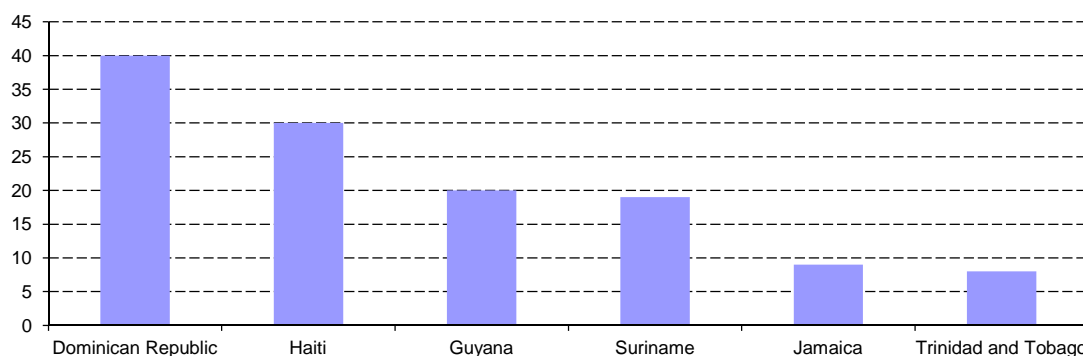
E. Ending Child Marriage/Forced Marriage

Child marriage is classified as marriage before the age of 18. A number of Caribbean countries permit marriage below the age of 16 with parental consent. The most recent data show that the percentage of women aged 20-24 who were married before they were 18 years old was 40 per cent in the Dominican Republic, close to 20 per cent in Guyana and Suriname but under 10 per cent in Jamaica and Trinidad and Tobago (see Figure 10).

Child marriage is accepted in some social and cultural settings but is considered a denial of the rights of the child, and since it overwhelmingly affects girls, is also considered a form of gender discrimination. Child brides are at increased risk of poverty, poor education, poor access to sexual and reproductive health services, gender based violence and unwanted pregnancy which poses risks to their overall health as well as sexual and reproductive health. Girls aged 15-20 are twice as likely to die in childbirth as women in their twenties (UNIFEM, 2008).

In both Belize and Guyana, the marriage acts were reformed in 2005 preventing marriage below the age of 16. In Suriname there are plans to increase the legal age of marriage to 18 for both men and women from the current 15 for girls and 17 for boys. In Trinidad and Tobago consultations will be carried out on the standardisation of the age limit which is presently 12 for girls and 14 for boys. All countries that permit marriage below the age of 18, and especially those that permit marriage below the age of 16, should give consideration to increasing the minimum age for marriage.

FIGURE 10
PERCENTAGE OF WOMEN AGED 20-24 WHO WERE
MARRIED OR IN UNION BEFORE THEY WERE 18 YEARS OLD
(Percentages)



Source: State of the World's Children 2011, based on data from MICS, DHS, and other national surveys, 2002-2009. Adapted from UNICEF: <http://www.unicef.org/protection/TACR.pdf>.

BOX 4

CHILD ABUSE INCLUDING CHILD SEXUAL ABUSE

The problem of child abuse and neglect is 'endemic' in the Caribbean region with surveys of adults and children generally revealing a high prevalence of violence against children even though it is thought that there is significant under-reporting (UNICEF, 2006). Data presented by ECLAC and UNICEF indicate that 93 per cent of women and 87 per cent of men in Haiti believe that it is normal to slap and hit children and 49 per cent of women suffered sexual violence within their families during childhood. In Guyana 33 per cent of children had been physically harmed by violence and in Jamaica and Trinidad and Tobago 73 per cent and 51 per cent of children respectively had received minor physical punishment.

The types of abuse meted out to children in the Caribbean include neglect which is the repeated failure to provide for the child's physical or emotional needs. Risk factors include single parent households, the loss of one or both parents either through separation or migration, parental mental health, drug and alcohol abuse. Physical abuse, inflicted through the use of corporal punishment as a form of discipline, is common in the Caribbean and is regarded as a cultural and social norm. In the majority of reported cases of sexual abuse, the victims are girls, the perpetrators usually male and often known to the victim (UNICEF, 2006). In a study by UNICEF in the Eastern Caribbean the proportion of persons who have experienced behaviour that could be described as child sexual abuse was estimated at between 20 and 45 per cent. Sexual abuse can take the form of intra family violence which includes incest and abuse by step-fathers and mothers' boyfriends and non-family and transactional sexual abuse which in some circumstances is socially sanctioned. Emerging trends have been identified which include cell phone pornography, social media grooming, child sex tourism and transactional sex between young people (Jones and Trotman Jemmott, 2009). The form of violence against children changes as children get older and the abuse is more likely to happen in the community, at school or on public transport rather than at home (UNICEF, 2006).

The institutional response to child abuse and child sexual abuse has been strengthened in some countries. In Jamaica, the Child Development Agency (CDA) was established in 2004. The CDA investigates allegations of child abuse and also engages in advocacy and public education about child abuse. An Office of the Children's Registry is a central registry for receiving, recording, assessing and referring all reports of child abuse. This Agency maintains a register of all reports,

Box 4 (concluded)

and provides statistical information relating to this register. Trinidad and Tobago are currently in the process of creating the Children's Authority of Trinidad and Tobago which will have similar responsibilities. In Suriname, the Foundation for the Child is a service for shelter and psychosocial support to children (3-15 yrs) who are sexually or physically abused and are referred through the judicial system. A child helpline is in operation while a Police Youth Affairs Office conducts 3 visits per week to different schools to provide outreach and raise awareness about child abuse and to solicit and investigate complaints.

While all Caribbean countries have legislation in place that tackles violence against children, a better coordinated response which addresses the protection of children in the legal system, violence against children in the home and violence against children in the community is needed. Existing legislation must be applied for the protection of all children through the sharing of judicial decisions, legal aid and mandatory reporting of child abuse. In addition, there is need for the development of further policies that deal with violence against children, youth crime and youth detention facilities. For the protection of children in the home, Caribbean governments need to train professionals in detection, management and assessment of child abuse, to educate children on their rights and how they can protect themselves against abuse and neglect. At the community level, greater recognition of the role that schools can play in protecting children, especially training in life and basic job skills, is desirable. Partnerships with NGOs in communities with existing high levels of violence can provide alternative activities and improve community support for children. Greater recognition of the role the father should play in child rearing would be welcome, as would increased programmes of support for fathers. Above all, there is need for greater emphasis to be placed on data collection, research and utilisation of information for decision making. (UNICEF 2006).

TABLE 1
THE CARIBBEAN: STUDIES OF THE PREVALENCE OF CHILD ABUSE IN SELECTED COUNTRIES

Country	Year	Findings
Guyana	2004	33% of the children had been physically harmed by family members.
Haiti	2000	93% of women and 87% of men think that it is normal to mistreat children by hitting and slapping. 23% of the men and 15% of the women find corporal punishment, including blows with belts and other items to be normal.
Haiti	2005-2006	49% of the women suffered sexual violence within their families during childhood.
Jamaica	2005-2006	73% of children between 12 and 14 receive minor physical punishments.
Dominican Republic	1997	In 48% of cases physical abuse is the kind of discipline most frequently used by parents.
Trinidad and Tobago	2005-2006	51% of the children between 2 and 14 receive minor physical punishment.

Source: Child abuse: a painful reality behind closed doors, challenges (Newsletter on progress towards the Millennium Development Goals from a child rights perspective), ECLAC, UNICEF (2009).

VII. Sexual and Reproductive Rights and Health

The ICPD Programme determines that sexual and reproductive health rights include the: ‘right of both men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant’.

Sexual and Reproductive rights should be an extension of human rights that already exist within national laws. The Programme of Action commits countries to achieving the highest standards of sexual and reproductive health, and freedom from discrimination, coercion and violence for men and women. Parents and governments should consider the needs of their living and future children and their responsibilities towards the community. Gender relations, education and needs of adolescents, expanding knowledge and awareness of human sexuality, increasing the power of women and girls over their sexual and reproductive lives, and increasing the number of women in leadership roles in the area of sexual and reproductive health are all key objectives that Caribbean governments must strive for.

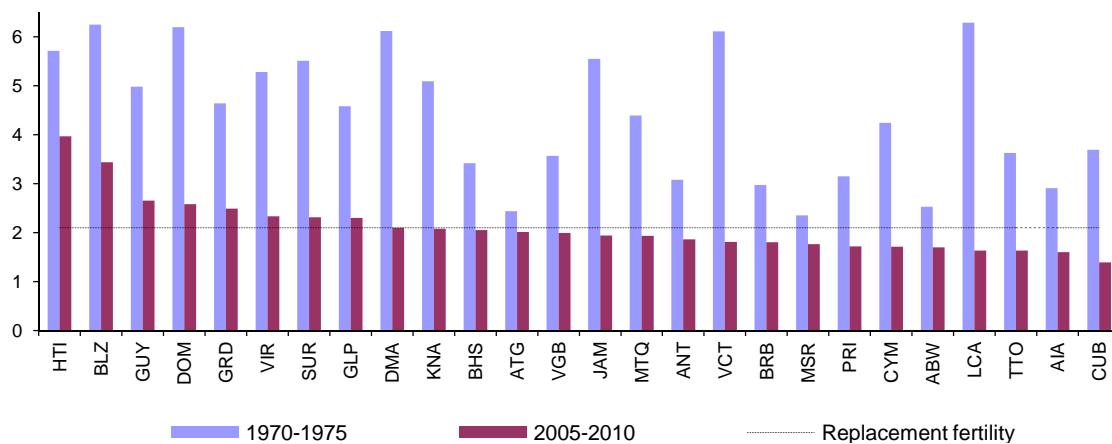
In addition the ICPD Programme of Action calls on governments to implement a number of actions to ensure that sexual and reproductive health rights can be realised in practice. These actions include the assessment of unmet need for contraception and family planning services, implementation of monitoring and evaluation of service providers and continued improvement in the quality of services. Political leaders are encouraged to play a highly visible role in the promotion and legitimisation of family planning services and to expand and upgrade training.

A. Trends in Fertility

There has been a considerable reduction in fertility in the Caribbean which has taken place more quickly than was expected. The extent of the overall reduction in fertility is illustrated in Figure 11 which shows estimated fertility rates for Caribbean countries in 1970-1975 and 2005-2010. Total fertility is now below replacement level in over half of countries, although at 2.36 children per woman, the average for the Caribbean as a whole remains slightly above replacement level. Reasons for this fall in fertility include the increased educational attainment, labour market participation, and general empowerment of

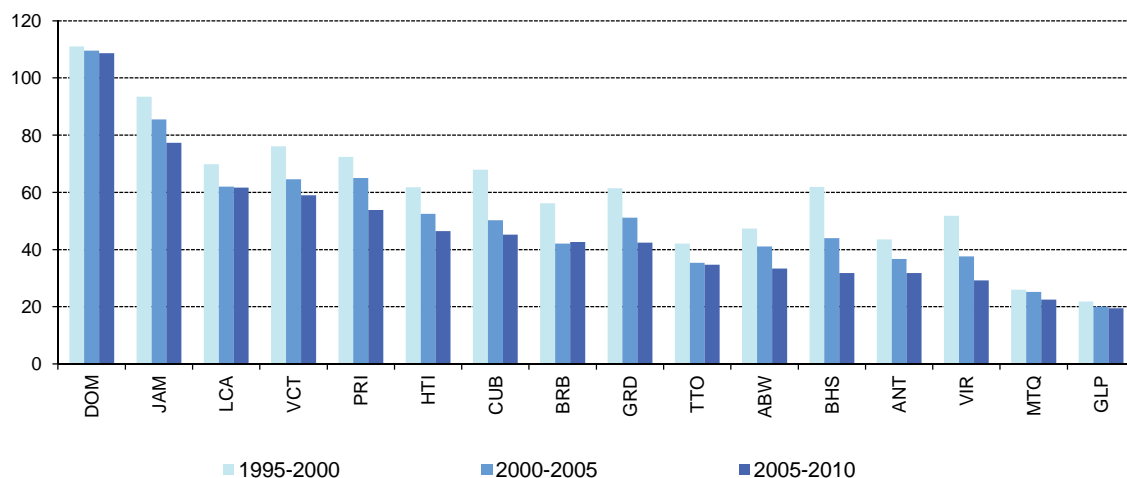
women, and crucially, increased availability of family planning services and access to contraception which has been supported by UNFPA initiatives such as training in contraceptive technology and logistics. After the population of the Caribbean increased from 20 to 40 million between 1958 and 2004, the ongoing fall in fertility is projected to keep the population between 40 and 50 million over the coming century, with important implications for sustainable development.

FIGURE 11
TOTAL FERTILITY, 1970-1975 AND 2005-2010
(Children per women)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2010). World Fertility Patterns 2009.

FIGURE 12
ADOLESCENT FERTILITY, 1995-2000, 2000-2005, 2005-2010
(Number of births per 1,000 women aged 15-19)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2011). World Population Prospects: The 2010 Revision.

Just as the total fertility rate has fallen, so has the adolescent fertility rate (Figure 12). In the Caribbean as a whole around 15 per cent of births are to teenage mothers. The Dominican Republic, Jamaica and Saint Lucia have the highest rates of adolescent fertility while the U.S. Virgin Islands, Martinique and Guadeloupe have the lowest rates. In the Dominican Republic 23 per cent of births are to teenage mothers which compares to 4 per cent in Guadeloupe.

There are still important differentials in fertility rates between urban and rural areas in several Caribbean countries, for example, Guyana and Suriname. In countries and territories where the total fertility rate has fallen significantly below replacement level governments should give some consideration to the implications of this, particularly the consequences for old age dependence rates. If fertility rates continue to fall it may be appropriate to consider policies designed to increase the birth rate, for example supporting families with children in some way.

B. Provision of Sexual and Reproductive Health and Family Planning Services

All countries have increased women's access to sexual and reproductive health services including information, counselling, educational and awareness programmes. With technical and financial support from UNFPA, Belize, Suriname, Trinidad and Tobago, Saint Lucia and Grenada have developed National Sexual and Reproductive Health Policies, which provide the legal framework, the policies, norms and protocols for the delivery of sexual and reproductive health (SRH) services. Nevertheless, ensuring that programmes reach women in rural areas, women living in poverty, and adolescents is an ongoing challenge. In Haiti particularly, which has the highest fertility rate in the Caribbean, limited budgets constrain provision, and therefore access to information, counselling and contraception.

TABLE 9
UNMET NEED FOR FAMILY PLANNING^a AMONG WOMEN AGED 15-49
(Percentages)

Country	Unmet need for family planning			
Haiti	39.6	2000	37.3	2005/2006
Guyana	...	...	28.5	2009
Belize	20.8 ^b	1999	15.9	2011
Dominican Republic	12.4	2002	11.1	2007
Jamaica	11.7	2002/03	7.2	2008
Puerto Rico			4.0	2002
Caribbean	...	...	20.3	2009
Latin America and the Caribbean	...	...	9.9	2009
World	...	...	11.2	2009

Source: United Nations, Department of Economic and Social Affairs, Population Division (2012). World Contraceptive Use 2012 (POP/DB/CP/Rev2012) and World Contraceptive Use 2011; Reproductive Health Survey 2008 (Jamaica); Multiple Indicator Cluster Survey 2011 (Belize).

^a Unmet need for family planning is expressed as a percentage of women of reproductive age who are married or in a union. Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child.

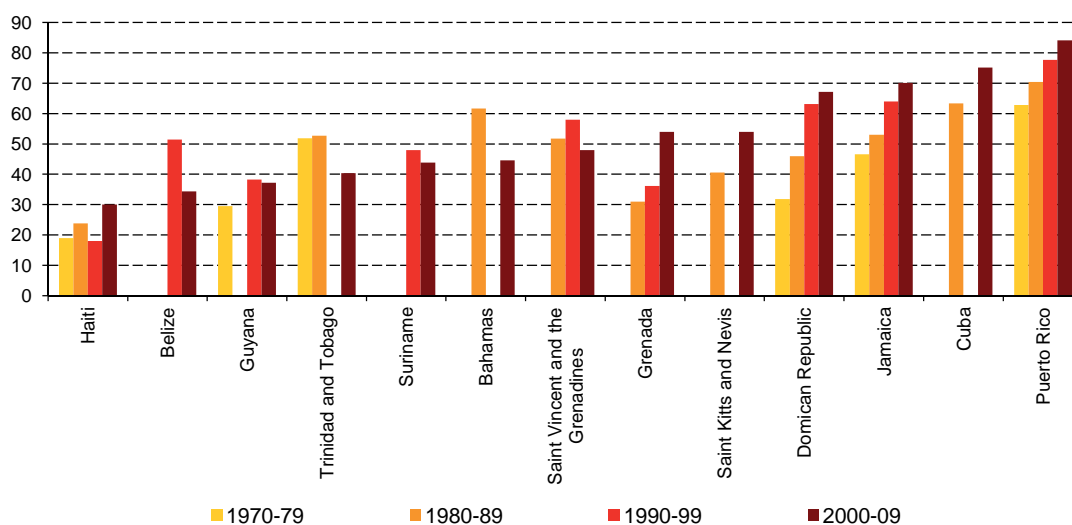
^b Figure refers to women aged 15-44.

All countries in the Caribbean make contraception available through family planning clinics including emergency contraception. However a number of factors can prevent women and adolescent girls from accessing services, for example, geographic barriers, economic and religious reasons, lack of

information, legal barriers, and/or social and cultural norms. Two widely used indicators of access to reproductive health services and family planning programmes are unmet need for family planning and the contraceptive prevalence rate (CPR). Women with unmet need for family planning are those who are sexually active, not using any method of contraception, but report not wanting to have a child at that time (Table 9). The contraceptive prevalence rate measures the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method (Figure 13). More generally, these are also indicators of health, population, development and women's empowerment.

Across the Caribbean, unmet need for family planning was estimated as 20.3 per cent which is above both the regional and world averages. Among those countries for which data was available the highest rates were in Haiti, Guyana and Belize although progress is being made in reducing unmet need. Contraceptive prevalence rates are lowest in Haiti, Belize and Guyana (between 30 and 40 per cent), and highest in Jamaica, Cuba and Puerto Rico (over 70 per cent). Investment in SRH and family planning services across the Caribbean have increased contraceptive prevalence rates in almost all countries.

FIGURE 13
CONTRACEPTIVE PREVALENCE^a RATES, WOMEN AGED 15-49
(Percentages)



Source: World Development Indicators, The World Bank.

^a The Contraceptive Prevalence Rate is the percentage of women who are practicing, or whose sexual partners are practicing, any form of contraception. It is usually measured for married women ages 15-49 only.

Although the use of modern family planning methods has increased dramatically in the Caribbean there are still significant levels of demand for family planning that are unmet in some countries. These are often the countries with the highest prevalence rates for HIV. Public health services and civil society organizations which are active in this area need to focus their efforts on hard to reach groups and tailoring services to meet the needs of these groups.

One of the most important reasons for promotion of SRH services is to reduce the number of unsafe abortions. In many Caribbean countries abortion services are only provided legally in cases where the health of the mother is at risk. Exceptions to this are Cuba, Guyana and Puerto Rico where abortion is available on request and Barbados and Saint Vincent and the Grenadines where abortion is also allowed under a relatively wide range of circumstances. However abortions are available privately and

are carried out in significant numbers sometimes in unsafe circumstances with potentially life threatening risks. Protocols for safe abortions and treating unsafe abortions are needed in the Caribbean.

Across the Caribbean clinics offer reproductive health information, counselling and services. In Trinidad and Tobago, there has been increased distribution of male condoms, the introduction of female condoms, increased distribution of pregnancy testing kits, and introduction of Mirena IUCD (Intrauterine Contraceptive Devices). In Saint Kitts and Nevis, SRH services such as screening, education sessions and counselling have been taken into the workplace and the community. In Jamaica meanwhile the Ministry of Health works with a wide range of NGOs including the National Family Planning Board, the Women's Centre of Jamaica Foundation, and several NGOs. These efforts are supported by a range of Civil Society Organisations, including faith based organizations. There is provision of services for persons with disabilities in Dominica through a programme run in collaboration with the Dominica Association for Persons with Disabilities.

However, there are major gaps between policies and programmes and their implementation. Based on the results of the ICPD global survey: all countries provide at least three methods of contraceptives through the primary health care system in the public sector; all but one, provide emergency contraception; and all but two provide female condoms. However in reality, although there is a policy to provide supplies of contraceptives through clinics, it is common that the commodities are exhausted and there may be fairly long periods of time when none is available. Individuals (mostly women) then have to seek it elsewhere at a higher cost. The implementation of programmes to provide SRH services to persons with disabilities is behind schedule in many countries and not all countries have programmes to provide services to persons with disabilities.

In order to ensure continuing improvement in the quality of SRH and family planning services governments should ensure that there are appropriate systems of monitoring and evaluation including analyses of unmet need. Contraception, including condoms and emergency contraception should be reliably available through the public health care system, and should be promoted along with appropriate information and counselling.

In order to achieve further improvements in sexual and reproductive health, it will be necessary to address structural barriers which prevent people accessing SRH and family planning services. These include social norms, poverty, gender inequalities, and some laws and regulations which prevent access to SRH and family planning services. Clearly these issues can only be addressed by coordinated action from, inter alia, Ministries of Health, Education, Social Development, Gender and Youth. Improved Health and Family Life Education in schools and programmes to address gender based violence, and gender inequality more generally, have an important role to play in improved sexual and reproductive health. Behaviour change communication programmes need to encourage open discussion on human sexuality, and preventive behaviour based on a realistic personal risk assessment.

C. Adolescent Sexual and Reproductive Health

Consistent with the decline in the total fertility rate, has been the fall in adolescent fertility although it is still too high. The highest rates are in the Dominican Republic and Jamaica with the lowest rates in Martinique and Guadeloupe. Pregnancies among adolescents are more likely to be unplanned and adolescents living in poverty are more likely to become pregnant. Pregnancy and child birth make it much more difficult for girls to pursue education, vocational training and employment, and they are therefore at greater risk of either remaining or falling into poverty. Having babies during adolescence has serious consequences for the health of the adolescent mother and her infant, especially in areas with weak health care services. The stillbirth rate is higher, the rate of newborn deaths are 50% higher among infants of adolescent mothers than among infants of women aged 20-29 years, and infants of adolescent mothers are more likely to have low birth weight (WHO, 2012b). The children of adolescent mothers are more likely to grow up in poor households and so are more likely to face nutritional, health and educational disadvantages which impact on their life chances and in this way, adolescent pregnancy contributes to the inter-generational transmission of poverty. Adolescents are also more likely to resort to unsafe abortions.

Sexual initiation in the Caribbean is among the earliest in the world. In most countries, over twenty percent of persons aged 15-24 had had sexual intercourse before the age of 15 (Table 10). There is also evidence that young people who are sexually active engage in high-risk sexual behaviour such as not using a method of contraception, and having multiple sexual partners (Maharaj, Nunes and Renwick, 2009).

TABLE 10
PERSONS MAKING THEIR SEXUAL DEBUT BEFORE THE AGE OF 15
(Percentages)

	Persons aged 15-24 who had sexual intercourse before the age of 15			
	Males	Females	Both Sexes	Year
Bahamas	70	41	58	2009
Jamaica	57	16	36	2008
Saint Lucia	32	20	26	2005
Grenada	32	20	25	2006
Antigua and Barbuda	...	...	25	2006
Cuba	32	15	24	2008
Haiti	43	15	23	2005
Saint Vincent and the Grenadines	31	14	22	2008
Saint Kitts and Nevis	36	10	22	2005
Barbados	22	16	20	2009
Dominican Republic	24	15	19	2007
Guyana	19	10	14	2009
Trinidad and Tobago	...	...	12	2007
Belize	11	5	8	2009

Source: UNAIDS Report on the global AIDS epidemic, 2010.

Risk factors associated with the early onset of sexual behaviour include 'less family stability', single-parent family households especially if there were multiple partners, low socioeconomic status, poor knowledge of STIs and recent substance use. Adolescent girls who are victims of violence and sexual abuse or trafficking are particularly vulnerable to unwanted pregnancy and STIs. Protective factors included a good relationship with both parents living together, involvement in extracurricular activities, and attending church. (Maharaj, Nunes and Renwick, 2009).

Adolescent rights to sexual and reproductive health services are a critical element of the ICPD Programme. Adolescents are vulnerable to STIs, HIV, and unplanned pregnancies as a result of their lack of information and access to relevant services in most countries, together with inadequate levels of knowledge about human sexuality and reproductive health. Health and education services must enable adolescents to deal in a positive and responsible way with their sexuality. SRH programmes should be designed to serve the needs of adolescents, both boys and girls and pay particular attention to those who are victims of sexual violence. The specific objectives of the ICPD with regard to adolescents are: 'to address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted infections, including HIV and AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, consistent and constant use of condoms and the provision of appropriate services and counselling specifically suitable for that age group'.

In many countries, programmes provide education, counselling, contraceptives and other SRH services to adolescents aged 16 and over. Family planning information and services are not available to adolescents under 16 years, unless they are accompanied by a parent. Some countries have developed youth friendly spaces for the delivery of services and youth-friendly information. The issue is also

addressed in Health and Family Life Education programmes in schools, and through engagement with youth and community groups. There is training of service providers to focus on adolescents SRH needs, including the training of peer counsellors. There are many successful partnerships between public health service providers and civil society organizations such as Family Planning Associations.

Nevertheless, greater priority should be given to adolescent and youth friendly SRH services. Around a third of Caribbean countries reported that even the preventative aspects of adolescent and youth friendly comprehensive SRH services were not offered through the primary health care system in the public sector. A quarter of countries had not addressed the issue, and of those that had, nearly half of programmes were behind schedule.

Societal disapproval is also a major obstacle which prevents adolescents from accessing sexual and reproductive health services. Related to this, are the inconsistencies between law and policy regarding access to contraceptives. In Jamaica, for example the Ministry of Health issued a policy in 2004 allowing health care providers to issue contraceptives to minors once certain specific criteria had been met. However, The Child Care and Protection Act indicates that any adult with knowledge of the sexual activities of a minor under the age of 16 years is obligated to report this to the Children's registry or face imprisonment or a heavy fine. As a result, many providers are reluctant to deliver services to young people creating a potentially dangerous situation for the reproductive health of young people. Trinidad and Tobago is one of a number of countries in which there are inconsistencies between the age of consent (16), age of marriage (12 for girls and 14 for boys) and access to SRH services (18 and over).

Adolescents who become pregnant should be provided with appropriate support, and young mothers should be readmitted to the school system where possible. Jamaica has recently developed a policy for the reintegration of adolescent mothers into the formal education system. This policy mandates schools to re-admit a girl who has left the system due to a pregnancy, and will therefore contribute to the goal of universal access to education.

Governments and their partner organizations need to continue their efforts to make their services youth-friendly and accessible to all young people especially those living in rural areas and in poverty. Improved access to information and availability of contraceptives are critical. Of course, equally important are policies which seek to empower adolescents and to offer them opportunities for personal development through education and employment so that they can form partnerships and have children when they are physically, socially and economically better able to do so.

D. Improving Health and Family Life Education Programmes

Health and Family Life Education (HLFE) programmes form part of state education programmes across the Caribbean. In order to strengthen and modernise HLFE, a Caribbean Regional Curriculum Framework was published which is designed to be used and adapted by member states and implemented in schools across the region (UNICEF, CARICOM and EDC, 2008). The Framework is designed to teach life skills, an approach which has been shown to reduce drug use and high-risk sexual behaviours among young people, facilitate anger management and conflict resolution, improve academic performance, and promote positive social adjustment. The four thematic areas of the HFLE Framework include Self and Interpersonal Relationships, Sexuality and Sexual Health, Eating and Fitness and Managing the Environment. The Sexuality and Sexual Health component is designed to augment the role of the family and other social and religious institutions in order to assist in preventing/minimizing those expressions of sexuality that are detrimental to emotional and physical health and wellbeing. The framework outlines a curriculum for three age ranges (9-10, 11-12 and 13-14) and explores areas such as sexuality, gender, SRH, sexual harassment, sexually transmitted infections and HIV.

Unfortunately, the framework has not been fully implemented and has faced a number of obstacles. The programme is popularly misconceived as being solely about sex education. Many teachers feel uncomfortable teaching HFLE, and the training of teachers to implement the programme has proceeded slowly which has impacted on implementation. This was compounded by a high turnover of teachers. Some of the classroom materials used in HLFE are outdated and use fear, and scare tactics, in

an attempt to discourage them from becoming sexually active rather than approaching the issue in a more balanced and objective way. Not only is this likely to be less effective in educating children to deal with their sexuality in a responsible way, it potentially spreads misinformation and reinforces stereotypes, such as conveying the idea that an HIV diagnosis is a death sentence. Due to fears of negative response by faith based organizations and government, there is perceived to be a lack of political commitment to the programme.

Programmes are being implemented in out-of-school settings in some countries. For example, HFLE is being implemented in adolescent health groups (Saint Vincent and the Grenadines), through a skills program for out of school youth (Dominica) and by a number of agencies in Trinidad & Tobago including ASPIRE, the Family Planning Association of Trinidad & Tobago, the Anglican Diocese and as part of the Citizen Security Protection Programme of the Ministry of Security.

HLFE programmes need to be given a higher priority by Ministries of Education with greater investment in training of teachers, sensitizing parents and school administrators and the development of up to date teaching materials. HFLE should also be better integrated into teachers' bachelor degree studies at universities.

E. Male Responsibilities and Participation

'Traditional' population services were implemented almost exclusively through basic family planning programmes serving women. The ICPD Programme acknowledges the role that men play in supporting women's reproductive health and how men can influence the factors that constrain reproductive health and rights. This implies the need for interventions which offer men the opportunity to examine and question the gender norms that harm their health and that of their sexual partners, and shape the way that services are delivered in order to advance gender equity (Greene and others, 2006).

There are many reasons to include men in SRH services such as, inter alia, the role of men in making decisions about family planning; the affects of men's risky sexual behaviour on the health of women and children, for example through transmission of HIV and STIs; the link between gender based violence and negative SRH outcomes; the role of men in supporting partners' prenatal health; and demands from women for more involvement and shared responsibilities.

Most countries in the Caribbean recognize that greater male participation is required and have produced information and education materials to encourage utilization of SRH services. In Barbados Male Health Groups were launched and in Trinidad and Tobago, Male Health Clinics. Other countries are taking men's SRH clinics to work places (Saint Vincent and the Grenadines) or other non-traditional locations (Saint Kitts and Nevis and Guyana); emphasizing detection and treatment for prostate cancer (Cuba, Jamaica and Guyana); and training people who work with men, for example prison offices (Dominica). In addition, the Caribbean Family Planning Associations have implemented a number of community programmes that involve men in family planning together with men's health programmes which encompass components of family planning. CARIMAN is an NGO which works with Caribbean men in several countries and is committed to supporting gender equality by partnering with women to create a just world where all people achieve their fullest potential (Antigua & Barbuda, Dominica and Trinidad and Tobago).

The ten and fifteen year ICPD reviews highlighted that there was insufficient male participation in family planning and sexual and reproductive health, as well as a lack of initiatives that instil attitudes respectful to women and girls in young boys. To build male participation in SRH three intersecting approaches are commonly advocated. The first - men as clients - emphasizes the need to provide reproductive health services to men. The second - men as partners - reflects the view that men can improve, and impede, women's contraceptive use and reproductive health choices including use of contraception, and the role of men in supporting their partners. In third approach - men as agents of positive change - the focus is on transforming or challenging underlying gender norms, values, including stereotypes, and traditional roles and responsibilities, that impede gender equality and lead to harmful behaviors such as violence. Programmes should seek to involve men in a way which links each of these

roles, that is ‘men as clients’, ‘men as partners’ and ‘men as agents of positive change’. Specific programme based recommendations include information, education and communication materials and programmes that focus on the couple rather than the individual. There is an ongoing need for training of service providers to meet men’s reproductive health needs and separate clinics for males with mobile services available in workplaces and community based settings.

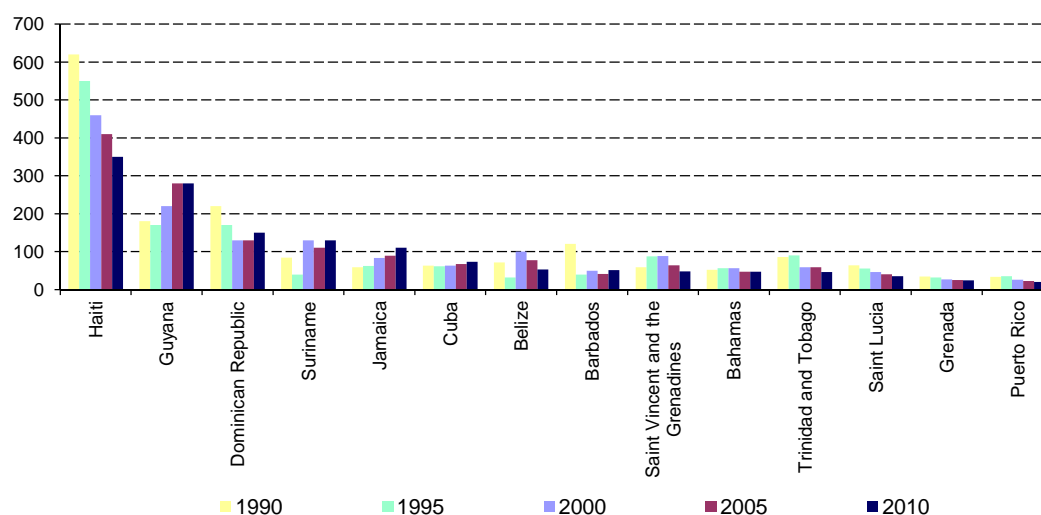
Policies and programmes should aim to support gender equality, including promoting women’s reproductive health and rights, by encouraging greater shared responsibilities enabling women to balance their reproductive and productive roles. Gender transformative programmes, or those that challenge and aim to change the underlying gender norms, should be promoted in order to tackle the dominant forms of masculinity that drive much of the risky and violent behaviors and discourage shared responsibility.

More research and data is needed to understand and address dominant forms of masculinity, including its impact on sexual and reproductive health and rights, men’s attitudes and beliefs, gender issues and sexuality. Data collection mechanisms such as the International Men and Gender Equality Survey (IMAGES) survey can help.

F. Improving maternal health

There have been continuing improvements in maternal health as measured by the maternal mortality ratio. In 2010, the maternal mortality ratio (MMR) for the Caribbean was 190 maternal deaths per 100,000 live births with two-thirds of these deaths occurring in Haiti. This compares to a ratio of 220 in 2000. Millennium Development Goal 5 (to improve maternal health) targeted a reduction in maternal mortality of three-quarters between 1990 and 2015. While no country is likely to achieve this target by 2015, Barbados, Haiti, Trinidad and Tobago and Saint Lucia have all achieved reductions of over 40% in the MMR since 1990.

FIGURE 14
MATERNAL MORTALITY, 1990 – 2010
(Maternal deaths per 100,000 live births)



Source: WHO/UNICEF/UNFPA/World Bank. Trends in Maternal Mortality: 1990 to 2010. WHO, UNICEF, UNFPA and The World Bank estimates. Geneva, World Health Organization, 2012.

The estimated mortality rates for some countries and territories of the Caribbean, for example Puerto Rico (MMR of 20) and Grenada (MMR 24) are close to that for developed regions (MMR of 16).

There are a number of countries with similar MMRs between 45 and 55 including Belize, Barbados, Saint Vincent and the Grenadines, the Bahamas and Trinidad & Tobago. Haiti's MMR of 350 is considered high by world standards. (WHO, 2012a).

In Jamaica, for example, the leading cause of maternal deaths across all age groups is gestational hypertension, however for teenagers and women 30 years and older, abortion is a significant and highly preventable cause of death. Among the indirect causes, HIV, cardiac disorders and sickle cell anaemia are the consistent leading causes (McCaw-Binns and Lewis-Bell, 2007). In the Caribbean as a whole 6 per cent of maternal deaths were attributed to HIV. The antiretrovirals which form part of PMTCT (Preventing Mother to Child Transmission) programmes also improve the chances of surviving the additional demands of pregnancy in immuno-compromised health and so would have contributed to the recent reductions in maternal mortality. Adolescents aged 15 years or younger also had higher risks for maternal death and early neonatal death compared with women aged 20 to 24 years (Conde-Agudelo, Belizán and Lammers, 2005). High MMR is also likely to be related to high expatriation rates for nurses and midwives in some countries, for example Haiti (94 per cent), Guyana (81.1 per cent) and Jamaica (87.7 per cent).

In Trinidad and Tobago, a national committee was established by the Ministry of Health to examine maternal mortality and morbidity. In Guyana there have been recent efforts to reduce the rate of MMR by: increasing the coverage and quality of antenatal care; ensuring skilled attendance at birth; the availability of blood and fluids in referral health services; greater availability of specialist staff trained in obstetrics and gynaecology; medical evacuation; the promotion of better prenatal care including nutrition; access to family planning and strengthening the system of high-risk referrals (Ministry of Finance of Guyana, 2011). Improvements to maternal health care in 2011 and 2012, supported by UNFPA, have led to significant reductions in the level of maternal mortality in Guyana.

There is a National Strategy for Emergency Obstetric Care (2008) in the Dominican Republic which has seen the introduction of care guidelines, training of doctors and nurses throughout the country, and a new training unit specialising in emergency obstetric care. In Saint Vincent and the Grenadines there is a system for identification of high risk cases and for referral to an obstetrician.

In order to maintain ongoing improvements in maternal health, services should focus on informed choice, education, maternal nutrition programmes and quality antenatal care. Critically, all births should be attended by trained nurses, midwives or birth attendants and mechanisms need to be in place that caters for opportune and timely management of obstetric complications and emergencies. Data on maternal morbidity and mortality needs to be collected and the main causes should be identified. Adequate evaluation and monitoring mechanisms are required to assess the progress being made in reducing maternal mortality and morbidity and to ensure that data are used to improve decision-making and policy and programme effectiveness.

VIII. Achieving Universal Access to HIV Prevention, Treatment, Care and Support

Caribbean countries pledged in 2011 to take specific steps to achieve ambitious goals on HIV by 2015. The Political Declaration adopted at the United Nations General Assembly High Level Meeting on AIDS recognized the genuine opportunity to end AIDS. The new Political Declaration contained ten global targets to effectively respond to the AIDS epidemic.¹⁹ Caribbean states also adhere to the UNAIDS “Three Zeros” vision: Zero new infections, Zero discrimination and Zero AIDS-related deaths.

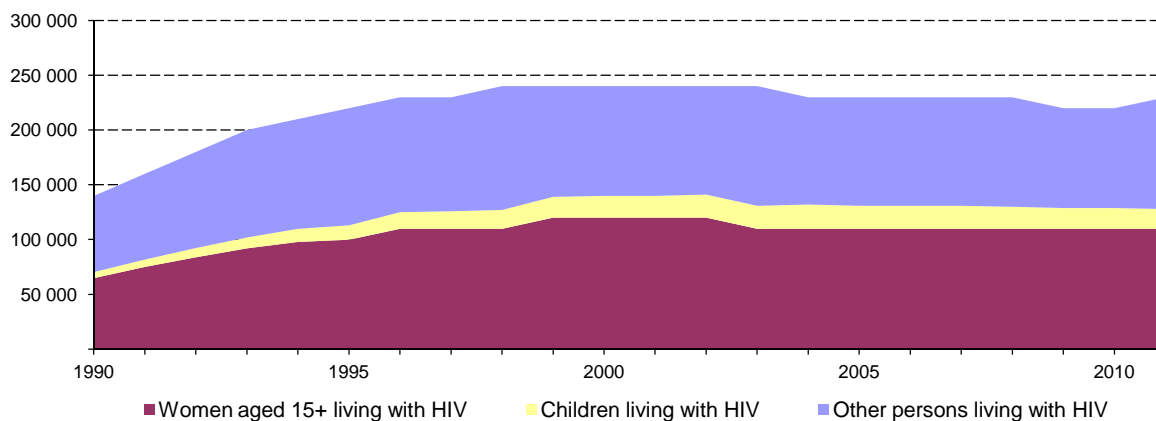
The ICPD Programme of Action recognizes that girls, adolescents and women are especially vulnerable to sexually transmitted infections, including HIV, because of their disadvantaged social and economic position, their exposure to the high-risk sexual behaviour of their partners and their biological vulnerability. Key objectives are to prevent, reduce the incidence of, and provide treatment for sexually transmitted infections, including HIV, with special attention to girls and women; and to provide psychological and emotional support and counselling as part of all sexual health services. Countries are also mandated to provide specialized training for health care providers; promote responsible sexual behaviour, and ensure the reliable supply and distribution of high-quality condoms.

¹⁹ Reduce sexual transmission by 50%; reduce HIV transmission among people who inject drugs by 50%; eliminate new infections among children and substantially reduce the number of mothers dying from AIDS-related causes; provide antiretroviral therapy to 15 million people; reduce the number of people living with HIV who die from tuberculosis by 50%; close the global AIDS resource gap and reach annual global investments of US\$22 billion to US\$24 billion in low- and middle-income countries; eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV; eliminate stigma and discrimination against people living with and affected by HIV by promoting laws and policies that ensure the full realisation of all human rights and fundamental freedoms; eliminate restrictions for people living with HIV on entry, stay and residence, eliminate parallel systems for HIV-related services to strengthen the integration of the AIDS response in global health and development efforts. (UNAIDS 2012a).

A. The State of the Epidemic

Globally, 34 million people were living with HIV at the end of 2011. Of this population, 243,000 live in the Caribbean, including more than 18,000 children under 15 years old. The geographic distribution reveals almost 80 per cent of this group is concentrated in three countries: 48 per cent in Haiti, 18 per cent in the Dominican Republic and 13 per cent in Jamaica (UNAIDS, 2011b).

FIGURE 15
PERSONS LIVING WITH HIV IN THE CARIBBEAN
(Numbers)



Source: UNAIDS Report on the Global AIDS Epidemic 2012.

An estimated 0.8 per cent of adults aged 15 to 49 worldwide are living with HIV, with three regions presenting higher prevalence rates: Sub-Saharan Africa with 4.9 per cent, followed by the Caribbean and Eastern Europe and Central Asia with 1 per cent. While this population has remained unchanged globally, in the Caribbean and Sub-Saharan Africa the number of people living with HIV experienced a 17 per cent reduction between 2001 and 2011.

The Bahamas has the highest HIV prevalence in the Caribbean with 3.1 per cent in adults aged 15-49 and Cuba the lowest with 0.1 per cent. Whilst the average prevalence rate for Latin America is 0.4 per cent, Belize, Guyana and Suriname, situated in central and South America exceed these figures significantly with prevalence rates of 2.3 per cent, 1.2 per cent and 1.0 per cent respectively (UNAIDS, 2010).

Worldwide there has been a 20 per cent reduction in new HIV infections among adults and children between 2001 and 2011, from 3.2 million to 2.5 million. The Caribbean presents the sharpest decline in the number of people acquiring HIV infection during this period (42 per cent) followed by Sub-Saharan Africa (25 per cent). (UNAIDS, 2012a). In the Caribbean approximately 13,000 adults and children were newly infected with HIV during 2011. This represents 9,000 averted new infections when compared with 2001, when 22,000 new infections occurred. New HIV infections among the adult population (15-49 years old) have been halved in the Bahamas, Barbados, Belize, Dominican Republic, Haiti and Suriname; followed by Jamaica and Trinidad and Tobago, which show reductions ranging between 26 and 49 per cent.

Although there is increasing emphasis on testing for HIV and since 2004 significantly more people have been tested, new infections have reduced. HIV tests are performed in the voluntary testing and counselling programmes in many countries either through existing community based health services, health fairs, mobile clinics or work place settings. The 2012 national progress reports submitted to UNAIDS provide much evidence of progress (UNAIDS, 2012b). In Barbados 'there has been a gradual downward trend in the total number of newly diagnosed persons living with HIV to a low in 2009' and

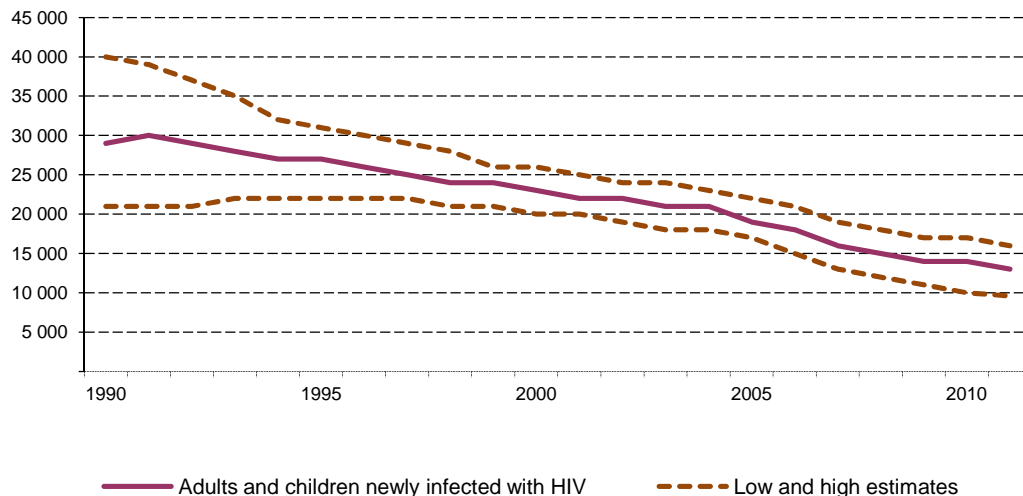
in Cuba there was also a reduction in incidence of HIV in the period 2010 to 2011. In Antigua and Barbuda although there is a reduction in incidence among the general population this may not be the case for all populations: a ‘cause for concern was the increasing incidence in the older age groups which suggests that these individuals are maybe engaged in either unprotected or high risk sexual practices’.

TABLE 11
PERSONS LIVING WITH HIV, 2009
(Numbers, Percentages)

	Estimated adults and children living with HIV	Adult (15-49) prevalence (%)
Bahamas	6 600	3.1
Barbados	2 100	1.4
Belize	4 800	2.3
Cuba	7 100	0.1
Dominican Republic	57 000	0.9
Guyana	5 900	1.2
Haiti	120 000	1.9
Jamaica	32 000	1.7
Suriname	3 700	1.0
Trinidad and Tobago	15 000	1.5

Source: UNAIDS Report on the Global AIDS Epidemic 2010.

FIGURE 16
ADULTS AND CHILDREN NEWLY INFECTED WITH HIV PER YEAR IN THE CARIBBEAN
(Numbers)



Source: UNAIDS Report on the Global AIDS Epidemic 2012.

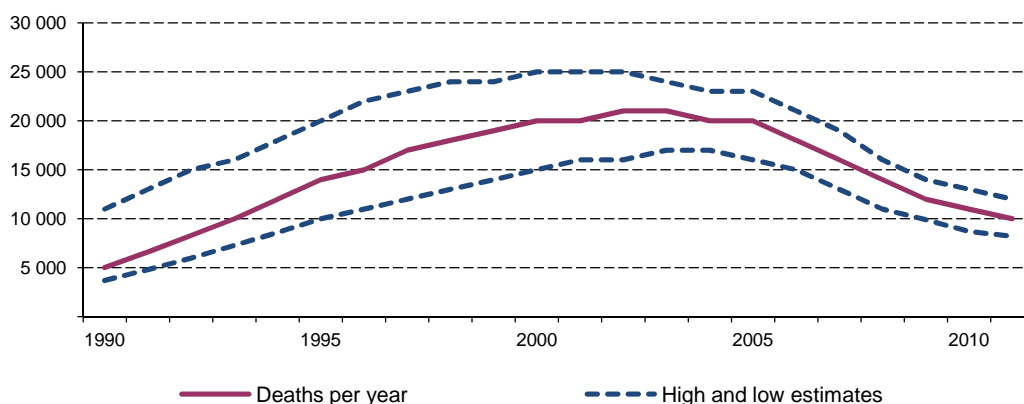
The overall characteristics of the HIV epidemic in Jamaica was described as affecting all persons ‘with the highest case rates in the most urbanized parishes and in tourist areas. The HIV epidemic is closely tied to poverty, developmental and socio-cultural issues including the slow rate of economic growth, high levels of unemployment, early sexual debut, culture of multiple partnerships, and an informal drug and commercial sex sector.

Most Caribbean countries are reporting either a stable or declining prevalence of HIV. For example, the report for Guyana indicated that ‘according to epidemiological data available in 2011, the prevalence of HIV among the general population has steadily declined since 2004, when it was 2.4 per cent to 1.07 per cent in 2011. This is also the case in Jamaica which indicated that the ‘emerging epidemiological data show a decline in HIV prevalence among anti-natal clinic attendees, and STI clinic attendees’. Trinidad and Tobago’s prevalence has held steady at 1.5 per cent with the number of annual new cases declining since 2008.

Stigma and discrimination towards people living with HIV and at risk populations such as men that have sex with men, sex workers and people who inject drugs, hinders the design and implementation of enabling policies to ensure the impact and sustainability of the HIV response. Although considerable progress has been achieved worldwide in the elimination of travel restrictions and criminalizing laws, within the Caribbean context, this remains a challenge.

There has been a 26 per cent reduction in AIDS-related deaths worldwide, between 2005 and 2011. The Caribbean, which halved its AIDS-related deaths during this period, represents the region with the sharpest reduction worldwide (48 per cent), followed by Oceania (43 per cent) and Latin America (10 per cent). The Dominican Republic, Guyana and Suriname have reduced AIDS-related deaths by 50 percent or more. The Bahamas, Haiti and Jamaica, reported reductions between 26 and 49 per cent, while Belize and Cuba remain stable.

FIGURE 17
AIDS-RELATED DEATHS OF ADULTS AND CHILDREN IN THE CARIBBEAN
(Numbers)



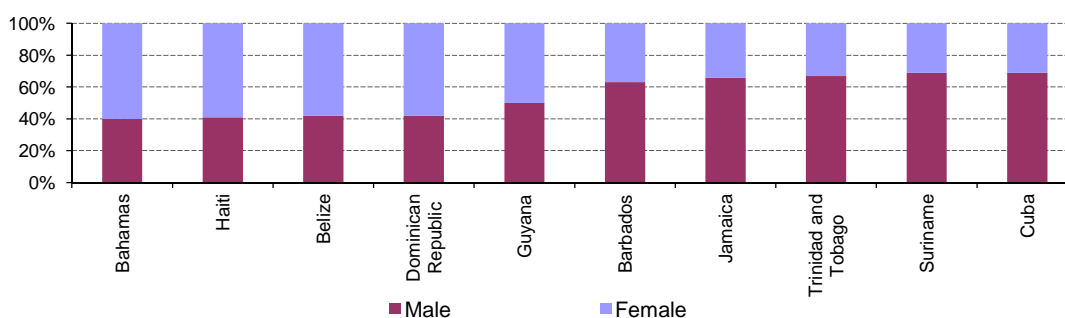
Source: UNAIDS Report on the Global AIDS Epidemic 2012.

Globally AIDS is the sixth biggest cause of death in the world. When countries are disaggregated by income levels, it is the sixth biggest cause of death in middle-income countries but the third biggest in low-income countries (PAHO, 2011). In the Caribbean, deaths as a result of AIDS peaked in 2003, the year when most countries began to introduce free access to anti-retroviral medication. AIDS-related deaths mainly affect the economically active population; for example in Jamaica 8 per cent of all deaths were attributed to AIDS in 2008 but among those aged 15 to 59 it was 25 per cent. In Trinidad and Tobago, the corresponding figures for those age groups were 3 per cent and 9 per cent and in Barbados, 1 per cent and 4 per cent. (WHO, 2011b)

B. Impact on Young Women and other at Risk Groups

The HIV prevalence among young people varies among countries with a low of 0.1 per cent in Cuba to a high of 3.1 per cent in The Bahamas based on figures for 2009. Of concern are the prevalence rates among young girls (15-24) in some countries including the Bahamas with prevalence rate of 3.1 per cent and Belize with 1.8 per cent (UNICEF, 2011). In the Caribbean as a whole there are slightly more women than men living with HIV. In Cuba, Jamaica, Trinidad and Tobago and Suriname between 60 and 70 per cent of persons living with HIV are male, while in Belize, the Dominican Republic, the Bahamas, and Haiti around 60 per cent are women (also based on figures for 2009). The Trinidad and Tobago Country Progress Report identifies a number of factors leading to high prevalence of HIV particularly among young women. These include ‘age-mixing with older partners, concurrent partnerships, transactional sex, lack of ability to negotiate condom use with partners, lack of empowerment and higher poverty levels among young women’. Additionally more females than males access testing, but a greater proportion of males test positive and are hypothesized to be diagnosed late when they present late on account of illness.

FIGURE 18
MALE FEMALE RATIO OF PERSONS LIVING WITH HIV, 2009
(Percentages)



Source: UNAIDS Report on the Global AIDS Epidemic 2010.

An additional factor contributing to the spread of HIV among women is the smuggling and trafficking of young women and girls destined for sex work, especially those islands with a prosperous tourist industry. It is also important to note that women tend to access testing more than men which can result in more women knowing their status and accounting for higher incidence and prevalence rates compared to men.

HIV prevalence among young women aged 15-24 is consistently higher than for men of the same age. Studies conducted across the Caribbean show significant levels of high-risk sexual behaviour among young people. These include the early initiation of sexual activity, not using a contraceptive method, having had multiple sexual partners in the past 12 months, having had more than six sexual partners, and participating in unprotected sex. In addition, many adolescents who experienced early initiation of intercourse report that the initial encounter was forced (Maharaj, Nunes and Renwick, 2009).

Young women can also be victims of sexual violence which increases their vulnerability to HIV. Men’s risky sexual behaviour impacts on the health of women and children especially if these men also have unprotected sex with commercial sex workers or have sex with other men. All these factors place young women at high risk for the transmission of HIV and other STIs.

Most at risk populations such as sex workers, men who have sex with men (MSM) and drug users still remain vulnerable to HIV.²⁰ Commercial sex workers (CSW) bear a substantial burden of the epidemic with prevalence rates ranging from 4.8 per cent in Dominican Republic and 5 per cent in Jamaica and Haiti to 17 per cent in Guyana and 24 per cent in Suriname. Men who have sex with men also have high prevalence rates ranging from 6.7 per cent in Suriname, 8.2 per cent in Bahamas, 11 per cent in Dominican Republic, 19.4 per cent in Guyana, 20 per cent in Trinidad and Tobago and 32 per cent in Jamaica. Various surveys show a significant number of MSMs report sexual relationships with women, 67 per cent in Guyana, 25 per cent in Trinidad and Tobago and 34 per cent in Jamaica. Implementation of and access to prevention programmes remain a significant challenge for both these groups (UNAIDS, 2011a).

TABLE 12
HIV PREVALENCE AMONG YOUNG WOMEN AND MEN AGED 15-24 IN THE CARIBBEAN
(Percentages)

	Prevalence among young women aged 15-24	Prevalence among young men 15-24
2000	1.0	0.5
2001	1.0	0.5
2002	0.9	0.4
2003	0.9	0.4
2004	0.9	0.4
2005	0.8	0.4
2006	0.8	0.4
2007	0.7	0.4
2008	0.7	0.3
2009	0.7	0.3
2010	0.6	0.3
2011	0.6	0.3

Source: UNAIDS Report on the Global AIDS Epidemic 2012.

In Jamaica the HIV epidemic profile has changed from a generalized epidemic to one in which HIV infections are largely concentrated in key populations such as MSM, who are estimated to represent 4.4 per cent of the adult male population but account for an estimated 30 per cent of new HIV infections. In addition, ‘the recently completed Modes of Transmission analysis estimated that 30 per cent of infections in 2012 were among MSM, 7 per cent among female partners of MSM, and 7 per cent among CSW and their male clients’. It is thought that the HIV prevalence rate among CSW is falling due to ‘decades of sustained interventions with this population. However, other most at risk populations such as MSM have not experienced such declines in HIV prevalence prompting a review of strategy and the scale up of effective interventions’. In a 2010 study undertaken in Barbados on the self identified sexual preferences of men newly diagnosed with HIV, results showed that ‘nearly 40 per cent of this cohort were MSM suggesting that this marginalized population are disproportionately affected by HIV’.

Stigma and discrimination are powerful drivers of the HIV epidemic. Where stigma and discrimination are high or common place in communities, most at risk populations such as people who sell sex or men who have sex with men are subject to social exclusion, ostracism, marginalization, abuse and violence. They are more likely to avoid contact with social services including health services due to shame or for fear of discrimination, judgement, ridicule, sanctions and arrest in some instances. This reality has severe implications for the general public health of communities, as well as the welfare of these individuals.

²⁰ Vulnerable and high risk populations: ‘these are populations that are at higher risk of being infected or affected by HIV, who play a key role in how HIV spreads, and whose involvement is vital for an effective and sustainable response to HIV’ (International HIV Alliance 2010).

Criminal laws inherited from colonial legislations result in the absence of legal protection for certain groups of populations, particularly MSMs, sex workers and drug users and consequently invasion of their privacy, inequity by relegating them to inferior status, degradation of their dignity by declaring them unnatural, violence and blackmail, abuse and destruction of their careers and lives.

Challenges remain in addressing HIV & AIDS in the Caribbean. Antigua & Barbuda have indicated that ‘despite increasing levels of knowledge with regards to modes of HIV transmission, the national statistics suggest that sexual behaviours have not changed significantly’. In Jamaica, a lack of knowledge creates problems for managing the responses to HIV ‘as the sexual practice of 40 per cent of men with AIDS is unknown and may reflect under-reporting by MSM who are unwilling to reveal their sexual practices, or reluctance on the part of the health care workers to probe sexual practices in interviews. This gap represents a significant weakness in the national HIV surveillance system’.

C. National Responses to the Epidemic

The Caribbean’s response to the epidemic has been focused on ‘the introduction and expansion of voluntary, counselling and testing (VCT) services, free access to Antiretroviral (ARV) treatment, post exposure prophylaxis (PEP), and prevention of mother-to-child transmission (PMTCT) programmes. Behaviour change communication interventions have also been intensified. There has been extensive collaboration with NGOs dedicated to serving people living with HIV, sex workers, men who have sex with men, and youth. HIV testing which at the commencement of the epidemic was available only at specialized facilities has been decentralized and integrated into the health sector. As the Bahamas reported, the availability of ‘HIV rapid testing at designated primary health care clinics, various health fairs, and selected community events have served to strengthen the decentralization initiative, by increasing the number of sites where persons can access HIV care and testing’.

More recently the Caribbean has responded with more innovative strategies that focus on preventing transmission. In Jamaica the programmes are centred on ‘increasing coverage and support to HIV positive persons. As part of the strategy, Liaison Officers conducted positive prevention workshops. In addition to discussing condom usage and negotiation, nutrition and adherence counselling, these workshops also incorporated empowerment opportunities and access to income generation projects for persons most in need’. There has also been greater involvement of NGOs to assist in the HIV response at the national level. Ministries of Health in many countries provide training to ‘civil society personnel to conduct rapid HIV testing and counselling, strengthening the capacity of this sector to engage in more effective HIV/AIDS prevention’.

TABLE 13
ART (ANTI-RETROVIRAL THERPAY) COVERAGE, 2009
(Percentages)

Country	Coverage	Universal Access
Bahamas	52	Need to scale up
Barbados	89	Achieved
Belize	40	Need to scale up
Cuba	95	Achieved
Dominican Republic	47	Need to scale up
Guyana	95	Achieved
Haiti	43	Need to scale up
Jamaica	46	Need to scale up
Suriname	53	Need to scale up
Trinidad and Tobago	41	Need to scale up
All Caribbean	48	Need to scale up

Source: UNAIDS Keeping Score III.

Highly Active Antiretroviral Therapy (HAART) and treatment for opportunistic infections are available from government funded treatment sites in the Caribbean at no cost to persons living with HIV. However, in many countries there is a need to scale up provision to reach all the people who need it (Table 13).

Sustainability of financing for AIDS related medication may become a challenge given the impact of the global economic crisis for the Caribbean. Many countries in the Caribbean are financed through the Global Fund to Fight AIDS, Tuberculosis and Malaria rather than through domestic sources. The challenge is that funding for the Global Fund has reduced as a result of reduced pledges, commitments and actual contributions by donors, but more fundamentally because the Caribbean region because of its economic status has been graduated from funding and is not eligible for Global or other available funds to address the epidemic.

Nevertheless, countries are improving their treatment and care programmes in partnership with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), for example through the development of diagnostic capacity. This can be seen in Guyana where the 'National Public Health Reference Laboratory' provides CD4 testing for the national treatment programme and began providing early infant diagnosis and viral load monitoring for the national programme, as well as TB identification and drug sensitivity testing in 2010 and 2011 respectively.

TABLE 14
PREVENTING MOTHER-TO-CHILD TRANSMISSION (PMTCT) COVERAGE, 2009
(Percentages)

Country	Coverage	Universal Access
Bahamas	95	Achieved
Barbados	95	Achieved
Belize	22 to 61	Need to scale up
Cuba	95	Achieved
Dominican Republic	32 to 95	Need to scale up
Guyana	95	Achieved
Haiti	60	Need to scale up
Jamaica	83	Achieved
Suriname	83	Achieved
Trinidad and Tobago	55	Need to scale up
All Caribbean	59	Need to scale up

Source: UNAIDS Keeping Score III.

As a result of the global financial crisis, from which Caribbean countries are still recovering, there is increasing awareness of the need to ensure mid and long-term sustainability of the HIV response in the subregion. At present about two-thirds of HIV investments in the Caribbean as a whole come from international donors. However, with increasing constraints in external funding, the region must improve efficiencies, increase domestic investments and strengthen sustained global partnerships. With UNAIDS support and guidance, Caribbean countries are now focusing on the development of investment frameworks to enhance country ownership and sustainability.

While all Caribbean countries have National HIV Strategic Plans some countries have developed these further into National HIV and AIDS Policies, for example Barbados, Belize and Guyana. In Guyana, the policy, originally approved by Parliament in 1998 'was revised in 2003 to reflect changes within the National AIDS Programme and to demonstrate a policy of universal access to prevention, treatment and care. Additional policy provisions, such as those prohibiting stigmatization or discrimination when applying for social benefits and universal access to voluntary counselling and

testing (VCT) and prevention of mother-to-child transmission (PMTCT) have also been integrated into the most recent revision of the National Policy’.

Caribbean countries have also implemented a number of other HIV policies related to the education sector, PMTCT, VCT, post exposure prophylaxis and access to HIV testing and condoms for minors. Sixteen Caribbean countries also participated in the International Labour Organization (ILO) HIV Workplace Education Programme implemented through the various Ministries of Labour which introduced HIV related work place education in the public and private sectors. In Trinidad and Tobago the programme led to the development of the National Workplace Policy on HIV 2010. The policy was implemented by the Ministry of Labour and Small and Micro-Enterprise Development and is designed to bring equity and fairness into the workplace for workers living with HIV and AIDS. It further led to the formation of the HIV and AIDS Sustainability Centre (ASC) within the Ministry of Labour, which is designed to sustain HIV education in the workplace in the formal and informal sectors. Belize also has a Policy on HIV/AIDS in the World of Work.

Several countries in the region are part of the Elimination Initiative led by PAHO to eliminate the transmission of mother to child transmission of HIV and congenital syphilis. According to UNAIDS (2011a) ninety percent of pregnant mothers are tested for HIV however only 59 per cent of positive mothers are captured by the PMTCT programmes (Table 14).

Development partners continued to play a major role in the multi-sectoral response to HIV. In Trinidad and Tobago the government received financial, technical and other support from a number of partners. These included: a cooperative agreement with the President’s Emergency Programme for AIDS Relief (PEPFAR), the World Bank, UNAIDS, UNFPA, UNDP, Pan Caribbean Partnership (PANCAP), Clinton Foundation and PAHO/WHO. Many of the partners provide technical and financial support in the areas of prevention, care and treatment, strategic information, and health systems strengthening. In addition countries that have been in receipt of Global Fund grants have included: Belize, Cuba, Dominican Republic, Guyana, Haiti, Jamaica, Suriname, and regional organizations such as the Pan Caribbean Partnership against HIV & AIDS (PANCAP), the Caribbean Regional Network of People living with HIV/AIDS (CRN+), the Organization of Eastern Caribbean States (OECS) and the IOM.

The ICPD Programme recommends that all countries’ Governments and the international community should provide all means to reduce the spread and the rate of HIV transmission. The UNAIDS Political Declaration in 2011 recommended that efforts should be intensified to end AIDS and this is articulated through the vision of achieving zero new infections, zero AIDS-related deaths and zero stigma and discrimination. Although the HIV epidemic is beginning to stabilise, UNAIDS has indicated that expenditure by countries, especially on prevention was insufficient and that campaigns were often too generic and did not respond to the infection patterns for men who have sex with men, sex workers and drug users. Critical recommendations for the Caribbean are to implement HIV programmes that are more cost effective, evidenced based, deliver better value for money and that are properly coordinated.

The emphasis over the next two and a half years should be in the appropriate implementation of the key commitments. These are: leadership, especially coordination to end the HIV epidemic; expansion of prevention programmes especially to vulnerable groups at most risk of HIV; elimination of AIDS related deaths through universal access to treatment and care; continued advancement of human rights and elimination of the stigma, discrimination and violence that can impede progress against the epidemic; implementation of coordinated national strategic plans that include research, monitoring & evaluation. (UNAIDS, 2011a).

IX. Conclusions and Recommendations for the Further Implementation of the ICPD Programme of Action Beyond 2014

In the nearly twenty years since the ICPD there have been substantial advances in the implementation of the Programme of Action. Much of the international cooperation on population activities has focused on the sexual and reproductive health component of the ICPD Programme of Action and there has been substantial progress in this area.

The ICPD Programme of Action called for facilitation of the demographic transition in order to stabilise population growth. This has taken place with fertility rates falling more rapidly than expected so that in more than half of Caribbean countries fertility rates are now below replacement rates. As a result the population of the Caribbean is expected to peak earlier (sometime in the 2040s), and at a lower level than previously forecast. In the case of small island countries and territories with high population densities, and finite carrying capacities, this is a very positive development. Of course, environmental pressures and threats remain, not least climate change, but facing those challenges with an essentially stable population size is vastly preferable to facing them with rapid population growth.

Adolescent fertility and its consequences on health, education and the ability of young mothers to participate in the productive economy should be a continuing priority for public policy-making. Design and implementation of specific health and education policies for adolescents are needed which focus not just on sexual and reproductive health, but also encourage adolescents to continue their education, and address issues of empowerment and the creation of opportunities for adolescents. Improved access and availability of contraceptives to young people is also a critical area.

There have been reductions in maternal mortality ratios although progress has been uneven and more needs to be done. Maternal mortality ratios in the Caribbean range from 20 to 350 deaths per 100,000 live births which compares to an average of 16 in developed countries. High expatriation rates for doctors and nurses present an additional challenge to attempts to reduce maternal mortality.

Many Caribbean countries are reporting a stable prevalence of HIV and in some cases HIV prevalence is declining. Deaths as a result of AIDS peaked in 2003, the year when most countries began to introduce free access to anti-retroviral medication. There has also been a reduction in new HIV

infections which began reducing rapidly from 2004. Females between the ages of 15-24 have been disproportionately affected by the HIV epidemic in the Caribbean. A number of factors have contributed to this: mixing with older partners; concurrent partnerships; transactional sex; and lack of ability to negotiate condom use with partners.

Outside the domain of sexual and reproductive health there has also been progress in other areas of the ICPD Programme of Action, although the ICPD Programme hasn't necessarily been the driving force and other overlapping international agreements such as those relating to for example, population ageing or persons with disabilities have played a more important role.

There has been progress towards greater gender equality as evidenced by increased participation of women in the labour force, a reduction in the gender pay gap and improved educational attainment by women, especially in the secondary and tertiary sector. However, gender discrimination in hiring, wages, benefits, training and job security still exists within the Caribbean. Further efforts are also needed to address gender based violence, women's political representation and the rights and protection of Lesbians, Gays, Bi-Sexuals and Transsexuals (LGBT).

According to the United Nations Secretary-General's Study on Violence against Children, the problem of child abuse and neglect is 'endemic' in the Caribbean region and large numbers of children are believed to be affected. Surveys of adults and children's experiences of child abuse and neglect generally reveal a high prevalence of violence against children. There needs to be greater recognition of the role the father should play in child rearing.

Emigration has long been a feature of Caribbean life although government efforts to develop policies to exploit diaspora relations are relatively recent and should be developed further. There are skills shortages at all levels in the Caribbean, in part related to the weaknesses in the education system but also through migration of skilled workers to the United States of America, Canada and Europe. Caribbean governments had originally agreed to implement migration policies in line with the Treaty of Chaguaramas in 2009 although this was delayed to allow for further evaluation including determination of Contingent Rights Policy. A number of countries are seeking to develop policies in order to attract migrants that will contribute positively to national development.

Persons with disabilities are still unable to participate fully in education, the labour market and in society in general. Many governments reported that their policies and programmes aimed at enabling persons with disabilities to realise their right to participate fully in society were either behind schedule or inadequate.

Efforts to reduce poverty have reduced the prevalence of the most extreme poverty, but high levels of inequality and relative poverty persist. Reducing inequality should be a goal of public policy. To achieve this social policies alone are unlikely to be sufficient and both labour market policies and economic development strategies need to be geared to reducing inequality.

Population ageing is an increasingly pressing challenge which will be felt over the next two decades and beyond. There will need to be a strengthening of social protection systems for older persons including health and social care as well as efforts to ensure equal participation of older persons in all aspects of society.

There is a need to consolidate gains that have been made in the field of sexual and reproductive health. Some consideration should be given to the issue of below replacement fertility and its implications, for example for old age dependency rates.

The relationship between population and sustainable development has had limited attention although over the last twenty years the environmental agenda, and particularly the threat which climate change poses to small island developing states such as those in the Caribbean, have come to the forefront of international attention. This could become an even more pressing concern with climate change having the potential to create mass movements of population.

The population and development perspective should also be incorporated into disaster risk management. The volcanic eruption in Montserrat (1995), hurricane Ivan which impacted most heavily on Grenada and Jamaica (2004), and the earthquake in Haiti (2010) provide a vivid reminder of the

reality and the potential impact of natural disasters in the Caribbean. These events can lead to catastrophic damage and the internal displacement or migration of populations, so the demographic dimension needs to inform risk assessments, and planning to guarantee support for and protection of migrants and displaced persons.

Gender inequalities can take complex forms in the Caribbean. Until now, understandably, the focus of attention has been on women rather than on an integrated gender agenda. However, ‘reverse inequalities’ are particularly prevalent in the Caribbean. Men, or perhaps more accurately some groups of men, are either disadvantaged, for example in education or health, or systematically manifest self-destructive behaviour, for example violence among young males. Such phenomena are highly gendered and therefore could be addressed within a gender framework.

Full implementation of the ICPD Programme will depend on continued efforts to build on the achievements of the last 20 years, learning lessons in those areas where there has been less progress, and developing new strategies to meet new challenges. With a view to directing these efforts, presented below are a summary of the main recommendations for future action contained in each of the preceding chapters. Implementation of these recommendations would represent a major step towards completing the implementation of the Cairo Programme in the Caribbean.

A. Economic Growth for Reducing Poverty and Inequality

1. Reignite broad-based growth to reduce poverty and inequality

Economic and labour market policies should be geared to reducing not only poverty, but also inequality. Policy priority should be given to pro-poor growth by targeting sectors and activities, especially labour intensive sectors that will deliver decent jobs for those who are unemployed, underemployed or underpaid. Policy makers and the private sector should design a clear programme to upgrade productivity and competitiveness, which would include a particular focus on tourism and agriculture.

2. Strengthen investment in human capital to deliver more decent jobs

Labour market information systems should be strengthened to enable a better fit between the skills required by employers and businesses and what is taught in tertiary, technical and vocational institutions. Governments should embark upon a major drive to formalize informal sector activity through improved incentives, skills training, entrepreneurship training and easier access to appropriate sources of credit for businesses.

3. Boost entrepreneurship and self-employment for poverty reduction

It is recommended that a concerted effort be made to stimulate entrepreneurship, especially among micro, small and medium enterprises as additional sources of employment. Governments should reduce bureaucratic bottlenecks to business start up and improve infrastructure services. In some instances special credit windows would need to be created to provide start-up finance for small and medium enterprises.

4. Tackle the spatial dimension of poverty and inequality

The special situation of the poor in rural areas requires that governments implement targeted interventions to reduce their vulnerability. These could include the facilitation of strong cooperative schemes where a number of small farmers or fisher-folk could pool their resources to increase the scale of their production, better storage and marketing facilities, and a basic pooled insurance scheme to facilitate quick recovery in the event of a natural disaster. Fair claims to land tenure should be recognised.

5. Implement measures to break intergenerational cycles of poverty

These stem from a combination of factors including limited access to high quality primary and secondary education, large family size, and little or no access to formal credit. While much progress has been made Caribbean governments should focus on removing these constraints to poverty alleviation by improving the quality of education and training for poor families, and access to sexual and reproductive health and family planning services.

6. Put in place a minimum ‘Social Protection Floor’

The International Labour Organization recommends that the minimum Social Protection Floor should consist of four elements: access to essential health care; basic income security at nationally defined minimum levels for: children (providing access to nutrition, education and care); persons of working age (providing protection against sickness, unemployment, maternity and disability); and older persons (a non-contributory pension).

B. International migration

1. Strengthen relations with diaspora communities in order to encourage skills exchange, private investment, and trade

Programmes should be created to engage the diaspora in national development. Emigrants should be recruited to provide training in their home country in their area of expertise. Diaspora relations should be exploited to help Caribbean companies to enter new markets, to facilitate private investment into the Caribbean, or to otherwise tap into the financial and human resources of the diaspora.

2. Facilitate flows of remittances through the development of relevant financial services

To encourage greater flows the sending of remittances should be facilitated through: ensuring competition among service providers to reduce costs; making it easier for remittances to be sent through official channels; offering innovative products and promoting the use of new technologies.

3. Meet skills shortages through managed immigration

Managed immigration of skilled workers, both from within and outside the Caribbean, should be used to meet skills shortages in the Caribbean labour market. Where there are such shortages, governments should promote and support international recruitment.

4. Renew efforts to liberalise the movement of people within the CARICOM Single Market and Economy CSME

Further steps should be taken towards liberalisation of movement within the CSME. Where not all member states are in agreement, steps towards further liberalisation could be achieved between some subset of CSME members.

5. Build capacity to manage borders in order to reduce undocumented migration including trafficking in persons, and ensure that the human rights of migrants are protected

There should be cooperation between national authorities in order to minimise undocumented migration. Cases of human trafficking and migrant smuggling should be investigated and where appropriate those responsible should be prosecuted under anti-trafficking legislation. Those in need of international protection should receive it and undocumented migrants, especially women and children, should be protected from exploitation and violence.

6. Create paths for undocumented migrants to regularise their status

Where there are established communities of undocumented migrants, there should be a process through which migrants can regularise their status and attempts should be made to facilitate greater access to health care and other public services.

7. In cases of deportation proceedings, there should be cooperation between sending and receiving countries

There should be cooperation, including information sharing, financial support, and appropriate notification periods between national authorities in order that receiving countries can plan for reintegration of deportees.

C. Population Ageing and the Rights of Older Persons

1. Improve the coverage and level of old age pensions

Pension provision must be strengthened by increasing the coverage of social security systems and increasing the level of non-contributory pensions. Where possible, pensions should be appropriately indexed to account for inflation.

2. Take steps to retain more older persons in the workforce

Measures should also be taken to make it easier for older people to work if they wish. Educational campaigns, pension reform, reconsideration of mandatory retirement ages, more flexible working arrangements, and training should all play a role in this area.

3. Ensure equitable access to comprehensive health care.

Governments should seek to widen access to health care services, including for older persons, and over time must increase public health care spending as a proportion of GDP.

4. Invest in preventative health care in order to reduce the burden of chronic non-communicable diseases (CNCDs)

Governments should develop strategies to reduce the risk factors associated with chronic non-communicable diseases and invest in health promotion and behaviour change. Screening programmes should be used to achieve earlier intervention and health information systems should be used to plan and monitor CNCD programmes.

5. Provide older persons with the support they need to live independently

Programmes which provide home care, home nursing, and respite care services should be further developed to improve their coverage and quality.

6. Regulate and monitor long stay institutions

All countries should have legislation and regulations governing nursing homes as well as enforcement mechanisms such as inspections and punishment for non-compliance. Provision of long-stay accommodation should be expanded through public-private partnership.

7. Protect older persons against discrimination and abuse

Legislation should be introduced to protect older persons and there should be programmes for the prevention of abuse, abandonment and violence against older persons.

8. Encourage greater social participation among older persons

There should be mechanisms for the inclusion of older persons in decision making. Existing government run schemes, such as community education, should target older persons and government should seek to address logistical obstacles such as transport which prevent participation. There should be efforts to raise public awareness of the contribution of older people to society.

D. Realising the rights of persons with disability

1. Ratify and implement the International Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol

Governments should develop national laws, policies, and institutional arrangements necessary to secure for persons with disabilities their rights as recognized in this Convention. In order to achieve this, programmes aimed at persons with disability must be given higher priority by Caribbean governments.

2. Increase participation by persons with disabilities within mainstream education

Schools should be made accessible to children with visual impairments and users of wheelchairs. Braille books, talking text books, reading machines and computers with speech software should be available for children with visual impairments. Curriculums and teaching methodologies should seek to meet the needs of all children including children with special needs.

3. Take steps to make it easier for persons with disabilities to work

Public and private sector employers should make their workplaces accessible to all persons. Persons with disabilities should be supported with vocational rehabilitation, skills training and opportunities for sheltered and supported employment.

4. Ensure that all new buildings and public spaces are accessible to persons with disabilities

Building codes must be fully enforced in order that all new public buildings are accessible to persons with disabilities. Efforts must also be made to make existing buildings accessible.

5. Guarantee access to sexual and reproductive health and family planning services for persons with disabilities

Sexual and reproductive health and family planning programmes must target persons with disabilities with information in accessible formats and services with are sensitive to their needs.

E. Gender equality, equity, and the empowerment of women

1. Strengthen national machineries for gender equality

Stronger political leadership is needed to raise the profile of gender issues and to tackle culturally entrenched inequalities. National gender mechanisms must be adequately resourced with a strong political mandate to implement national policies on gender equality and for mainstreaming gender in all national policies and programmes.

2. Ensure women’s participation in the labour market on an equal basis with men

In order to continue progress towards the goal of equal access for women to the labour market and social security, policy should focus on three broad areas: equalities legislation and mechanisms for enforcement of legislation; job creation and stimulation of employment for women especially in rural areas; and policies to help women combine work with caring responsibilities. There should be education and campaigns to emphasise men's shared responsibility regarding parenthood and shared control and contribution to family income. The workplace should be made more family friendly through the introduction of policies such as flexible work-hours, day-care facilities, breastfeeding breaks and paternity leave.

3. Increase women’s representation in political processes and public life

Governments and political parties should consider the use of quota systems to increase women’s representation in the political process. Training and mentoring should be available to female parliamentarians and aspiring parliamentarians.

4. End gender based violence

There is a need to continue strengthening institutional capacity, for better coordination amongst service providers and for legal systems to more effectively apply existing legislation. Special attention should be paid to the rights and safety of vulnerable groups including migrants, sex workers and women in domestic service. Lesbian, gay, bisexual and transgender (LGBT) persons should be protected by investigating all serious violations of their human rights and repealing discriminatory laws. Governments also need to protect children and youth from sexual abuse. Engaging men and boys to prevent violence is essential.

F. Sexual and reproductive rights and health

1. Develop and provide access to comprehensive sexual and reproductive health (SRH) care and family planning services

The reach and availability of sexual and reproductive health services must be improved while barriers to access should be eliminated for men, youth, persons with disabilities, sex workers, men who have sex with men, undocumented migrants, and persons living in institutions. Improved access to information and availability of contraceptives are critical. SRH should be integrated within wider public health programmes and sexual health training for health professionals should be promoted.

2. Eliminate barriers which prevent access to SRH and family planning services

Coordinated efforts are necessary to eliminate barriers to SRH services including: education and promotion of responsible sexual behaviour; promotion of gender equality; elimination of prejudice, discrimination and hatred related to sexuality and sexual minority groups; elimination of sexual and gender based violence. Greater sensitization on sexual and reproductive health and rights is needed among health care providers, immigration officers and the police.

3. Provide youth friendly health and family planning services

Governments and their partner organizations need to continue their efforts to make their services more youth-friendly and accessible to all young people especially those living in rural areas or in poverty. Adolescents who become pregnant should be provided with appropriate support, and young mothers should be readmitted to the school system where possible. There is a need to address legal anomalies

between the age of consent to sex and the age at which sexual and reproductive health services can be accessed without parental consent.

4. Improve maternal health

Governments should target further reductions in maternal mortality and morbidity. Care and treatment in cases of obstetric emergencies or complications must be improved. Improved statistics on maternal mortality and morbidity and better evaluation and monitoring mechanisms are required in order to evaluate progress.

5. Support the participation of men in women’s reproductive health and rights

There should be greater priority given to programmes to train service providers on men’s reproductive health needs, provision of separate clinics for males with mobile services available in the workplace or in community based settings, and promotion of SRH as the responsibility of couples rather than individuals. Policies and programmes should also aim to support gender equality, shared responsibilities, and enable women to balance their reproductive and productive roles.

6. Provide comprehensive sexuality education to the public including through Health and Family Life Education programmes

Public health information and campaigns should incorporate sexual health. HLFLE programmes need to be given a higher priority by Ministries of Education with greater investment in the training of teachers, the development of up to date teaching materials and monitoring of implementation. HFLE should also be better integrated into teachers’ bachelor degree studies at universities.

G. Achieving Universal Access to HIV Prevention, Treatment, Care and Support

1. Improve the efficiency of HIV programmes and integrate them with sexual and reproductive health services

HIV programmes must become more cost effective, evidenced based, deliver better value for money and be properly coordinated. Where possible, treatment costs should be lowered through collective negotiation with pharmaceutical companies. Integration with other SRH services and greater efficiency will better enable national governments to fund prevention, treatment and care in the context of diminishing external funding.

2. End stigma and discrimination for persons living with HIV

Silence, shame and fear need to be replaced with open informed discussion if stigma and discrimination are to be overcome. Punitive laws which discriminate unfairly against persons living with HIV or men who have sex with men should be abolished. National laws and policies that address equal opportunities should be extended to persons living with HIV.

3. Further reduce the number of new infections

Future actions on HIV and AIDS should be geared towards realising the UNAIDS Vision: zero new HIV infections; zero discrimination; zero AIDS-related deaths. Reducing the number of new infections will generate substantial health benefits, and cost savings, and in order to achieve this expenditure on prevention should be increased. Modes of transmission studies should be carried out to better understand national epidemics and target interventions. Information, support and services should be designed to tackle local infection patterns among groups such as men who have sex with men, sex workers and drug users.

4. Eliminate AIDS related deaths through the universal provision of treatment and care

Civil society organizations must be supported to help expand the reach of treatment programmes and to provide additional support and counselling to persons living with HIV and their partners. The stigma which prevents people seeking treatment must be overcome.

5. Continue to improve the quality of information available about HIV and AIDS

Improved information is essential to plan effective prevention, treatment and care programmes and ongoing efforts are required to improve the availability and quality of statistics on HIV and AIDS.

Bibliography

- Abdulkadri, Abdullahi D., Colette Cunningham-Myrie and Terrence Forrester (2009), “Economic burden of diabetes and hypertension in CARICOM states”, *Social and Economic Studies*, vol. 58, Nos. 3 & 4, pp. 175-197.
- ACP (African, Caribbean, and Pacific Group of States) Observatory on Migration (2010), “Overview on south-south migration and development trends and research needs in the Caribbean”, Brussels, Belgium.
- Alleyne, Dillon and I. Solan (2012) “Leveraging the Diaspora for development: the role of network effects”, ECLAC Subregional Headquarters for the Caribbean and South Carolina State University, unpublished.
- Astatke, Hibist and others (2008), “Determinants of condom use among Haitian youth: improving the validity of quantitative findings through qualitative methods”, Washington, D.C., Population Services International.
- Berg, Andrew, and Jonathan D. Ostry (2011), “Inequality and unsustainable growth: two sides of the same coin?” *IMF Staff Discussion Note 11/08*, Washington, D.C., International Monetary Fund.
- Bott, Sarah and others (2012), “Violence against women in Latin America and the Caribbean: A comparative analysis of population-based data from 12 countries”, Washington, D.C., Pan American Health Organization (PAHO).
- CDB (Caribbean Development Bank) and the Government of Belize (2010), “Final Report, Country Poverty Assessment, Volume 2, Supplementary Material”.
- Chellaraj, Gnanaraj, Keith E. Maskus, and Aaditya Mattoo (2006), “Skilled immigrants, higher education and U.S. Innovation” in Özden and Schiff (eds.) *International Migration, remittances, and the brain drain*, pp. 245-259, Washington, D.C., The International Bank for Reconstruction and Development / The World Bank.
- Clemens, Michael A. (2009) “Skill flow: a fundamental reconsideration of skilled-worker mobility and development”, Human Development Research Paper 2009/08, United Nations Development Programme (UNDP).
- Cloos, Patrick and others (2009), “‘Active ageing’: a qualitative study in six Caribbean countries”, *Ageing & Society*, vol. 30, 2010, Cambridge University Press (2009).
- Conde-Agudelo, Agustin, José M. Belizán and Cristina Lammers (2005), “Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: Cross-sectional study”, *American Journal of Obstetrics and Gynecology*, 192, pp. 342–9.
- Connell, R. W. (2000), *The men and the boys*, Cambridge, UK, Polity Press.
- Dobash, Rebecca E. and Russell P. Dobash (1979), *Violence against wives*, New York, USA, Free press.

- Dumont J-C and Zurn P. (2007), “Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration”, in *International Migration Outlook, Sopemi 2007 Edition*, Paris, Francis, Organisation for Economic Co-operation and Development (OECD).
- ECLAC (Economic Commission for Latin America and the Caribbean) (2013) *Social Panorama of Latin America 2012* (LC/G.2557-P), Santiago, Chile. United Nations publication, Sales No. E.13.II.G.6.
- _____(2012), *Envejecimiento, solidaridad y protección social: la hora de avanzar hacia la igualdad* (LC/L.3451(CRE.3/3), Santiago, Chile.
- _____(2011), “Availability, collection and use of data on disability in the Caribbean subregion”, (LC/CAR/L.283), Port of Spain, Trinidad and Tobago, January.
- _____(2010), “A situational analysis of the implementation of the convention on the rights of persons with disabilities in the Caribbean subregion”, (LC/CAR/L.280), Port of Spain, Trinidad and Tobago, December.
- _____(2009a), “A further study on disability in the Caribbean: rights, commitment, statistical analysis and monitoring”, (LC/CAR/L.237), Port of Spain, Trinidad and Tobago, December.
- _____(2009b), Appraisal and conclusions from the 1994-2009 review of the implementation of the Cairo Programme of Action in the Caribbean, Santiago, Chile.
- _____(2008), Exploring policy linkages between poverty, crime and violence: a look at three Caribbean states.
- ECLAC and UNICEF (2007), “Teenage motherhood in Latin America and the Caribbean: trends problems and challenges”, *Challenges*, No. 4, Newsletter on progress towards the Millennium Development Goals from a child rights perspective.
- Gasman, N. and others (2006), “Violencia sexual en México”, *Informe nacional sobre violencia y Salud*, Mexico City, Mexico, Secretaría de Salud (SSA).
- Gaziano, A.B. and others (2011), “The global economic burden of noncommunicable diseases”, Geneva, Switzerland, World Economic Forum.
- Gillings, Scarlett and Annicia Gayle-Geddes (2012), “Managing social safety nets in an era of declining resources”, presentation to the Second ECLAC Caribbean Development Round Table on “Macroeconomic policy for structural transformation and social protection in small states, Georgetown, Guyana, May.
- Greene, Margaret E. and others (2006), “Involving men in reproductive health: contributions to development”, background paper to the report *Public choices, private decisions: sexual and reproductive health and the Millennium Development Goals*, New York, United Nations Millennium Project.
- Hausmann, Ricardo, Jason Hwang and Dani Rodrik (2005) “What you export matters” *Working Paper Series RWP05-063*, Harvard University, John F. Kennedy School of Government.
- Heise, L., M. Ellsberg, and M. Gottemoeller (1999), “Violence against women”, *Population Reports, Series L*, No. 11, XXVII(4), Baltimore, Maryland, USA, John Hopkins.
- IBRD/WB (The International Bank for Reconstruction and Development/The World Bank) (2010), Women’s economic opportunities in the formal private sector in Latin America and the Caribbean, A focus on entrepreneurship, Washington, D.C.
- IOM (International Organization for Migration) (2013), Country Page Jamaica [online], [date of reference: 15 April 2013] <<http://www.iom.int/cms/en/sites/iom/home/where-we-work/americas/central-and-north-america-and-th/jamaica.html>>.
- _____(2010), “Exploratory assessment of trafficking in persons in the Caribbean region”, second edition.
- IPU (Inter Parliamentary Union 2013), “Women in national parliaments” [online], [date of reference: 2 May 2013] <<http://www.ipu.org/wmn-e/classif.htm>>.
- Jewkes, R., P. Sen and C. García-Moreno (2002), “Sexual violence” in E. G. Krug et al. (eds.) *World report on violence and health*, Geneva, Switzerland: World Health Organization.
- Jones, Adele and Trotman Jemmott, E. (2009), “Child sexual abuse in the eastern Caribbean”, UNICEF.
- Kapur, Devesh and John McHale (2005), *Give us your best and brightest: the global hunt for talent and its impact on the developing world*, Center For Global Development, Washington, D.C.
- Kim, Namsuk (2007), “The impact of remittances on labor supply: the case of Jamaica”, *Policy Research Working Paper 4120*, World Bank, February.
- Lustig, Nora, Luis F. Lopez-Calva and Eduardo Ortiz-Juarez (2012), “Declining Inequality in Latin America in the 2000s: The Cases of Argentina, Brazil, and Mexico”, *Working Paper*, No. 307, Washington, D.C., Center for Global Development.
- Maharaj, Rohan G., Paula Nunes and Shamin Renwick (2009), “Health risk behaviours among adolescents in the English-speaking Caribbean: a review”, *Child Adolescent Psychiatry and Mental Health*, vol. 3, No. 10.
- McCaw-Binns, Affette and Karen Lewis-Bell (2007), “Achieving MDG 5: is Jamaica up to the challenge?”, Kingston, Jamaica, Planning Institute of Jamaica (PIOJ), June.

- Melde, Susanne and Judith Schicklinski (2011), “Remittances in the African, Caribbean and Pacific countries” ACP Observatory on Migration.
- Ministry of Finance, Guyana (2011), “Millennium Development Goals, Guyana, progress report 2011”, Georgetown, Guyana.
- Moreland, Scott, Ellen Smith and Suneeta Sharma (2010), “World population prospects and unmet need for family planning”, Washington, D.C., Futures Group.
- Mortley, Natasha Kay (2009), “Nurse migration and its impacts on Caribbean health care systems: with special focus on St. Lucia and Jamaica”, document presented to the Global Development Network Conference, Prague, January (2010).
- Nam, Valerie (2009), *Regional special topic monograph on the elderly based on analysis of the 2000 round census data of eighteen Caribbean countries*, Georgetown, Guyana, The Caribbean Community (CARICOM) Secretariat.
- Orozco, Manuel (2012), “Future trends in remittances to Latin America and the Caribbean”, *Report of the remittances & development program*, Inter-American Dialogue, Washington, D.C.
- PAHO (Pan American Health Organization) (2012) “Health care expenditure and financing in Latin America and the Caribbean”, *Fact sheet*, Washington, D.C.
- _____ (2011), “The top ten causes of death”, *Fact sheet*, No. 310, Washington, D.C.
- _____ (2006), (Pan American Health organization) and CARICOM (Caribbean Community Secretariat) “Report of the Caribbean Commission on health and development”.
- Ravallion, Martin (2005), “Inequality is bad for the poor?” *World Bank Policy Research Working Paper*, Washington, D.C., World Bank.
- Rawlins, Joan and others (2008) “The elderly in Trinidad: health, social and economic status and issues of loneliness”, *West Indian Medical Journal*, vol. 57, No. 6, pp. 589- 595.
- Ros, Jaime (2009), “Poverty reduction in Latin America: the role of demographic, social and economic factors”, *CEPAL Review*, No. 98, pp. p. 35-45, New York, August.
- Thomas-Hope, Elizabeth (2010), “The future of migration policies in the Caribbean”, *Background Paper World Migration Report*, International Organization for Migration (IOM).
- _____ (2009), “Regional special topic monograph on international migration”, Georgetown, Guyana, The CARICOM Secretariat.
- UN Women (2012), “Michelle Bachelet highlights quotas to accelerate women’s political participation” [online], [date of reference: 24 April 2013], < <http://www.unwomen.org/2012/03/michelle-bachelet-highlights-quotas-to-accelerate-womens-political-participation/>>.
- UNAIDS (2012a) *UNAIDS Report on the global AIDS epidemic 2012*, Geneva, Switzerland.
- _____ (2012b) *Progress reports submitted by countries* [online], [date of reference: 26 April 2013], <<http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/>>.
- _____ (2011a), *Keeping score III: the voice of the Caribbean people*, Port of Spain, Trinidad and Tobago.
- _____ (2011b), *Estimates and projections 2011*.
- _____ (2010), *UNAIDS Report on the global AIDS epidemic 2010*, Geneva, Switzerland.
- UNCTAD (United Nations Conference On Trade And Development) (2013), “Maximizing the development impact of remittances”, New York and Geneva. United Nations publication UNCTAD/DITC/TNCD/2011/8.
- UNHCR (United Nations High Commissioner for Refugees) (2011), “Action against sexual and gender based violence: an updated strategy”.
- UNICEF (The United Nations Children's Fund) (2011) *Opportunity in crisis: preventing HIV from early adolescence to early adulthood*, New York, June.
- _____ (2008), (The United Nations Children's Fund) and EDC (Education Development Center, Inc.) “Health and family life education regional curriculum framework for ages 9-14”.
- _____ (2006), “Violence against children in the Caribbean region: regional assessment”, Panama.
- _____ (2006), *HFLE in Caribbean schools, new approaches, prospects and challenges*, Christ Church, Barbados.
- UNIFEM (United Nations Development Fund for Women) (2008), “Gender equality now: accelerating the achievement of the millennium development goals”, New York.
- United States State Department (2010), “Trafficking in persons report”, June.
- UNODC and World Bank (United Nations Office on Drugs and Crime and the World Bank) (2007), “Crime, violence, and development: trends, costs, and policy options in the Caribbean”, Report No. 37820, March.
- _____ (2000), (United Nations Office on Drugs and Crime) “Protocol to prevent, suppress and punish trafficking in persons, especially women and children”.

- Wadhwa, Vivek and others (2007), “America’s new immigrant entrepreneurs, Part 1”, *Technology & innovation paper*, No. 23, Duke University.
- WHO (World Health Organization) (2012a), “Trends in maternal mortality: 1990 to 2010”, Geneva, Switzerland, May.
- _____ (2012b), “Adolescent pregnancy”, *Fact sheet*, N°364 [online],[date of reference: 4 May 2013] < <http://www.who.int/mediacentre/factsheets/fs364/en/>>.
- _____ (2011a), “Global status report on noncommunicable diseases 2010”, Geneva, Switzerland.
- _____ (2011b), “WHO Global Health Observatory Data Repository”, Geneva, Switzerland.
- _____ (2008), *The global burden of disease: 2004 update*, statistics from the report <http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/>.
- Widmaier, Sarah, and Jean-Christophe Dumont (2011), “Are recent immigrants different? A new profile of immigrants in the OECD based on DIOC 2005/06”, *OECD Social, Employment and Migration Working Papers*, No. 126, Directorate for Employment, Labour and Social Affairs, OECD Publishing.
- World Bank (2012), *Remittance Flows in 2012: An update*, November.
- _____ (2011a), “The growing burden of non-communicable diseases in the eastern Caribbean” Human development unit, Caribbean Country Management Unit, Latin America and the Caribbean Region, The World Bank.
- _____ (2011b), *The Migration and Remittances Factbook 2011*, Washington, D.C.
- _____ (2009), “The nurse labor & education markets in the English-speaking CARICOM: issues and options for reform”, *Report*, No. 48988-LAC, June.
- _____ (2003), “Caribbean youth development issues and policy directions”, *A World Bank Country Study*, Washington, D.C., World Bank.



UNITED NATIONS

Series:**ECLAC****Studies and Perspectives – The Caribbean****Issues published****A complete list as well as pdf files are available at****www.eclac.org/publicaciones**

29. Implementation of the Cairo Programme of Action in the Caribbean (1994-2013): Evaluating Progress and Renewing Commitment, Francis Jones, Andrew Fearon and Michael Hendrickson, LC/L.3757, LC/CAR/L.407, 2014.
28. Economic Survey of the Caribbean 2013 – Improved economic performance with reduced downside risks, LC/L.3753, LC/CAR/L.420, 2014.
27. An assessment of fiscal and regulatory barriers to deployment of energy efficiency and renewable energy technologies in Guyana, LC/L.3755, LC/CAR/L.406, 2014.
26. Caribbean forum: Shaping a sustainable development agenda to address the Caribbean reality in the twenty-first century, LC/L.3756, LC/CAR/L.400 Rev.1, 2014.
25. The use of census data for national development planning – Focus on the 2010 Population and Housing Census, LC/L.3726, LC/CAR/L.414, 2014.
24. Preliminary overview of the economies of the Caribbean 2012-2013: LC/L.3649, LC/CAR/L.410, 2013.
23. Economic Survey of the Caribbean 2011-2012: Positive growth amidst lingering downside risks, LC/L.3623, 2013.
22. Municipal solid waste management in the Caribbean - A benefit cost analysis, LC/CAR/L.349, 2011.
21. Threshold effects in the relationship between inward foreign direct investment and import productivity growth in Latin America and the Caribbean, LC/CAR/L.287, 2011.
20. Knowledge management in the public sector: an online presence as a tool for capture and sharing, LC/CAR/L.351, 2011.
19. Creative industries in the Caribbean: A new road for diversification and export growth? LC/CAR/L.348, 2011.
18. Regional environmental policy and sustainable tourism development in the Caribbean, LC/CAR/L.353, 2011.
17. Social health protection for the elderly in the English-speaking Caribbean, LC/CAR/L.350, 2011.
16. Caribbean Millennium Development Goals Report 2010, LC/CAR/L.371, 2011.
15. An analysis of the status of implementation of the Convention on the Rights of Persons with Disabilities in the Caribbean, LC/CAR/L.280/Rev.1, 2011.
14. Preliminary Overview of the Economies of the Caribbean: 2010-2011, LC/CAR/L.295, 2011.
13. Economic Survey of the Caribbean 2010-2011: Improving economic prospects amid global recovery, LC/CAR/L.308, 2011.
12. Innovation in the tourism sector: a case study from the Commonwealth of Dominica, LC/L.3509, LC/CAR/L.296, 2011.
11. Availability, collection and use of data on disability in the Caribbean subregion, LC/L.3334-P, LC/CAR/L.283/Rev.1, 2011.
10. Sustainable development from a human rights perspective and the challenges it represents for the Caribbean SIDS, LC/L.3024-P, LC/CAR/L.123, 2010.
9. Public debt sustainability in the Caribbean, LC/L.3023-P, LC/CAR/L.175 Rev.1, 2008.
8. Exploring policy linkages between poverty, crime and violence: a look at three Caribbean States, LC/L.2916-P, LC/CAR/L.172, 2008.

STUDIES

AND

PE

SPEC

TIVES

29

STUDIES

AND

PE

SPEC

TIVES

STUDIES AND PERSPECTIVES



ECONOMIC COMMISSION FOR LATIN AMERICA AND THE CARIBBEAN
COMISIÓN ECONÓMICA PARA AMÉRICA LATINA Y EL CARIBE
www.eclac.org