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Sociodemographic vulnerability in the Caribbean: an examination of the social and demographic impediments to equitable development with participatory citizenship in the Caribbean at the dawn of the twenty-first century

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Abstract

This study identifies and discusses sociodemographic structures, processes and trends that entail risks for individuals, households and communities in the small island developing States of the Caribbean, on the basis of the analysis of the environmental, geographical, economic and institutional vulnerability of these States conducted by ECLAC in the document *Equity, development and citizenship,* which was presented at the twenty-eighth session of the Commission.

The analysis focuses on three sociodemographic issues. First, fertility, which continues to occur early and at high rates among poor groups of the population and entails pronounced gender inequalities, especially for female heads of household who are required to undertake the responsibility of bringing up children. Second, population ageing, which is fairly advanced in a number of the Caribbean islands and calls for carefully planned measures. Third, migration —in particular of the international type— which reaches very high levels in some of the region's countries. Migration offers opportunities for individuals and households, but it also drains part of the skilled labour force from the countries of the Caribbean and exposes migrants, in particular the least skilled, to discriminatory and unfair treatment. The document concludes with policy guidelines for addressing these issues, which together comprise the sociodemographic vulnerability of the Caribbean.

I. Introduction

This document addresses the issue of sociodemographic vulnerability in the Caribbean.[1] The concept of vulnerability stems from the ECLAC approach to development in Latin America and the Caribbean in the twenty-first century, as described in the publication *Equity, development and citizenship*, which was presented at the twenty-eighth session of the Commission. The present document argues that the small island developing States in the Caribbean exhibit elements of vulnerability that are related to the physical, geographical, economic and institutional features of their societies. In order to grasp the significance of vulnerability, it is necessary to distinguish between risks, or potential dangers, and threats, or immediate dangers, faced by individuals, households and countries. An understanding of the risk or danger alone is not enough to determine vulnerability, however. We must also be aware of the features or capacities of the entity at risk that enable it to comprehend its vulnerability to danger. Low capacity thus indicates vulnerability. By contrast, high capacity indicates resistance, that is the capacity of the entity to deal with the danger. It is maintained that the Caribbean countries have a low capacity, owing to certain features that they share, and are therefore highly vulnerable to risks and threats. These features relate to their small size, open economy, institutional heritage, shortage of skilled labour and other factors. Some of these risks and threats are specific to a particular geographical location, while others are not.[2]

[1] Antigua and Barbuda, Barbados, Belize, British Virgin Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago. The analysis also makes reference to Anguilla and to the experience of Haitians in the Turks and Caicos Islands.

[2] The debate of social vulnerability is the outcome of an exchange of ideas between the author and Lynette Brown and Asha Kambon, of the Social Affairs Unit of the ECLAC Subregional Headquarters for the Caribbean in Port of Spain.

This document proposes to extend the discussion on vulnerability to the sphere of population, by analysing the ways in which demographic variables interact with social and institutional factors and capacities to generate vulnerability. We raise the question: to what extent do the demographic structures and processes typical of the Caribbean region at this stage of its social and economic development predispose its population to risk and social vulnerability? In other words, in view of the rights, capacities, processes of independence and physical, geographical, economic and institutional features of the Caribbean countries and their peoples, what type of risks and threats are posed by the population variables that generate vulnerability in these States?[3] We examine this issue at the community, household and individual levels, insofar as the available information allows.

This study is structured as follows: after the introduction the main development efforts since the period immediately following the second world war are outlined. This includes a discussion on the region's position in today's globalized world and considers factors that affect the region's capacities, by either promoting or hindering the creation of new capacities. This section outlines the importance of capacities in the assessment of demographic risks and threats, including the health, educational and employment status of the population —factors which are also affected by low capacity in the form of poor governance and social integration. Low economic capacity partly accounts for the risk posed by internal and international migration, while poor health capacity refers to the risks represented by HIV/AIDS, etc.

The third section of the document analyses the major population trends observed in the Caribbean in recent history, covering the period from 1840 to 1980 and the two final decades of the twentieth century, together with the population structure which emerged as a result of these trends. This section also includes an analysis of the urbanization process, which is the framework for internal migration.

The fourth section examines sociodemographic vulnerability in the Caribbean, with an analysis of the social impact of demographic processes and structures, seeking to establish how demographic and social factors interact to produce socially vulnerable situations. The effect of demographic processes and structures on socioeconomic status is examined at the level of communities, households and individuals. This analysis encompasses a number of variables that are considered to be risks and threats. The first of these is fertility. We examine the extent to which lags in the decrease of fertility among poor women place them and their communities and households in a position which prevents them from meeting their basic needs. We seek to understand how this population variable relates to the immediate social and institutional context and to establish how effectively existing social policies address the situation.

The second demographic variable analysed is the age structure of the population. The emphasis here is on identifying ways in which population ageing affects a series of closely related variables, such as the health status of the population and the burden of dependent family members supported by the working population. The third variable is internal and international migration. Our interest here is to comprehend the nature of the process at the local and international levels and how it predisposes households, communities and individuals to risk and social vulnerability.

The study also examines sociodemographic risks which take a particular form in the region, such as adolescent fertility and the formation, dissolution and recomposition of unions. The last section of the document draws conclusions about the incidence of population factors in the growth of social vulnerability among Caribbean communities, households and individuals. Some of the policy implications deriving from the conclusions of the study are also discussed.

[3] Demographic lags and transitions can represent potential risks for countries that are ill-prepared to deal with them. The developed countries that underwent the transition which led to the ageing of their population had to face risks to their society, as they were not prepared for this process. Their economic, institutional, social and political capacities, however, enabled them to resist up to a certain point. They were thus able to implement measures —social security and employment policies— that enabled older people who were in a position to do so to have access to employment, health care and other similar services.

II. The global context

The more recent of the social and economic policies that have affected the Caribbean are closely related to the globalization of world economy and society that has taken place in the last two decades of the 20th century. The process is perhaps best characterized as a multidimensional phenomenon in which developments in the realms of information technology and telecommunications have been associated with the lessened significance of the spatial and temporal barriers to communication and production. This has been accompanied by dissolution of the global geopolitical arrangements that emerged out of the post World War 2 period and the institutionalization of economic Neoliberalism as the guiding principle for the conduct of economic activities across the globe. It is within this context that the impact of Neoliberalism on the Caribbean has to be considered. The internal reordering of economic arrangements that was brought about by structural adjustment had varied outcomes, depending on the way in which the adjustment programme was managed and the characteristics of the local economy and society. Those countries with weak and inefficient social institutional and productive capabilities, or which have not been able to negotiate any special arrangements within the new global framework have had less success in coping with these changes than others. The centralization of the competitive principle in local and international economic processes resulted in a fragmentation of the region. The result is the division of the region over a spectrum stretching between poles of prosperity and economic malaise.[4]

[4] This state of affairs of course has important implications for the analysis of demographic trends. Whereas it is possible to speak of overall trends in demographic processes we have to recognize that there will be divergences based on socioeconomic differences that will be masked by the overall trend.

III. Development in the Caribbean

The close of the 20th century marked the end of nearly fifty years of effort aimed at institutionalizing productive and efficient systems of economy and society in the Caribbean. These have had as their main objective the establishment of a viable socioeconomic basis for nationhood and the improvement of the well being of the region's citizens. The new international context that took shape following the end of the Second World War gave fillip to earlier moves towards decolonization in the Caribbean and other parts of the colonial world. The Depression in the 1930s had spawned Keynesianism in the Industrial world as well as social and political unrest in the Caribbean region. This school of thought was to provide much of the theoretical inspiration for the emergence of Development Economics, the first of a number of theories that were to attempt to guide the efforts that were being made at development in the region and elsewhere. Development Economics converted the extant colonial economics into a set of policies and strategies that now placed the mass of the people, and their demands for a better life at the centre of policy objectives in the newly emerging nation states. Its arguments presumed the existence of something called 'market failure' and made the case for the full involvement of the newly created state in a process of large scale planning. Modernization theory was a close accompaniment to this school of economic thought. This theory represented the broadening of the approaches to the problem of development as it presented itself in the early stages of nationhood. Besides economics, disciplines such as sociology, political science and psychology now offered prescriptions to the newly independent countries for moving from a state of backwardness to one akin to the situation of the former colonial

masters. In all of these formulations it was assumed that the circumstances of these young nations necessitated some role for social planning led by the state. For another 30 years or so the market led variety of development thought, was forced to take a backseat in the efforts at development in the Third World. During this time the world went through economic boom followed by slump followed by boom followed by crisis. In this era some of the countries of the region moved unsuccessfully in the direction of development policies that were informed by theories based on a radical critique of Capitalism.

At the end of the 1970s the Caribbean region along with much of the rest of the Third World found itself with problems of an economic and social nature that it was unable to resolve. Some of these had their genesis in the state centered policies that had been pursued over the years, 'government failure' as it is referred to in some quarters. Others had their basis in the wider structural problems of the world economy, still not recovered from the effects of the oil crisis of earlier years. In addition to political corruption, stagnant, undiversified economies plagued by fiscal deficit and debt, a weak local productive sector and an inefficient State added to the woe of these societies. These countries were left with no choice but to go to the international financial institutions for aid and assistance and to adopt the Neo-liberalist structural adjustment policies that they promote.

The results have been mixed. On the one hand, the countries that embraced these policies starting in the late 1970s and early 1980s have experienced changes that have led to the correction of some of the macroeconomic problems that faced them during these years. Fiscal deficits have been removed, the state has become more streamlined in its operations, the private sector has been strengthened and given a more active role in the economy and a potential wealth of opportunities has been opened up through involvement with a now Globalized world economy.[5] On the other hand, the programme of reform has imposed a set of policies that often times ignored the peculiar circumstances of individual cultures, economies and societies. In many instances the policies have resulted in the concentration of resources in the hands of ethnic and social minorities at the same time that they have hobbled the involvement of the state in the provision of social services. This has led to increases in historically based social disparities, social alienation and erosion of social capital. At the end of the 20th Century the Caribbean still had unacceptably high levels of its population living below the poverty line. Many countries across the region were also plagued by high rates of crime and unemployment among the youth; a decline in performance at the primary and secondary school levels; declines in the quality of service in the public health care sector and in some instances a reversal of gains in health status made during the course of earlier decades. The initial set of neoliberal policies aimed at correcting 'government failure' is commonly referred to as the Washington Consensus. Paradoxically, some of these policies themselves destroyed institutions that were important to the proper working of the market (ECLAC, 2000). The negative social outcomes that have been identified above are the consequences of this kind of approach to development.

Against this background the need for a set of policies aimed at institutional building and reform has become evident.[6] These will have to fill the void left by a diminished State, as well as market and government failures through the involvement of various actors from civil society in a process aimed at rebuilding some of the institutions destroyed by the policies of the Washington consensus and creating the new ones that the present circumstances demand. This is necessary to

[5] 'Potential' because the framework within which international trade is conducted has a distinct bias against small nation states such as the Caribbean. See Benn (2001).

[6] Market led policies have corrected problems and inefficiencies such as fiscal deficit and inflation, created greater openness to opportunities associated with trade on the international market, increased the role of the private sector in economic affairs and made the state more efficient. At the same time it has exacerbated problems associated with the historical legacy of social and economic inequality and the skewed distribution of resources, distanced some of the basic social services from the poor, exposed the local productive structure to international competition whilst not preparing it. The question arises as to how to save what is worthwhile whilst correcting that which is harmful. There is obviously need for reform of some the reforms that have left our societies in a state of limbo.

overcome some of the disparities and social dislocation created by the first round of policies and the region's historical legacy of social and economic inequality. This has to be done while at the same time ensuring that the macroeconomic gains made during the first round are not lost. It is only by ensuring that equity and social integration are at the center of these policies that this will be guaranteed. The era in which the citizens of this region were mere bystanders in the process of societal building is obviously past. The present historical juncture calls for the creation of a path that safeguards the gains from economic Neoliberalism through the creation of a new public policy. This policy will be characterized by its seeking of the interest of the collectivity rather than being merely the expression of the will of the elected representatives. Civil society with its concern for social well-being now has to play a central role in the governance of a society that respects the efficacy of the market.

Those factors that stand in the way of an informed, active, participatory citizenry represent susceptibility to risk. Some of these are lack of education, employment and the skewed distribution of income and other material resources. In some countries of the Caribbean more than others this is accompanied and reinforced by the absence of an ethical frame of reference that recognizes the value of human rights, equality and justice in their own right as well as being the cornerstone of vibrant, sustainable economic systems. The concern we have in this paper is to try to understand the extent to which demographic processes and structures contribute to the maintenance or furtherance of processes that lead to ignorance, poverty and inequity in Caribbean society.

IV. Demographic trends in the Caribbean 1840-1980

We turn now to an examination of the major demographic trends that have occurred in the Caribbean. This will be divided into two sections. The first will examine population movement from the inception of census taking to 1980. The second will examine trends in movement over the period 1980-2000. Population censuses were first taken in the Caribbean in the early 1840s, just after the end of slavery. Between the years 1841-1844 and 1943, at decennial intervals, seven comprehensive censuses of the British Caribbean were taken.[7] Since that time censuses have been conducted throughout the region at the beginning of the decades of the 1960s, 70s, 80s, 90s and now 2000.

A. Trends in population growth

In terms of absolute numbers, population growth has taken place differentially over the period since the first census. The region registered its first one million persons in the census of 1861. It took 60 years, 1861-1921 for the second million to be added to the region's population. Yet, the third, fourth, and fifth million were added in only 25, 18 and 16 years respectively. Between the inception of census

[7] In 1851 British Guiana, British Honduras, the British Virgin Islands and Dominica failed to take censuses. In 1861, only the tiny territory of Saint Kitts and Nevis failed to do so. In 1901, Barbados, British Guiana, Jamaica and Saint Vincent did not take part in the census exercise. Finally in 1931, only British Guiana, British Honduras, Trinidad and Tobago and Saint Vincent conducted censuses. In the historical period, comprehensive census counts were therefore taken in 1841-1844, 1861,1871,1881,1891, 1911, 1921 and 1943.

taking and 1980 the region's population has grown in absolute terms by some four million persons to number approximately 5 million at the end of that period.[8]

The annual rates of growth increased from 1.07 per cent during the first intercensal period 1841-1861, to 1.52 per cent during the period 1871-1881. After this it declined to a low of 0.24 during the period 1911-1921. Population growth in the region peaked at 2.0 per cent during the years 1943-1960. By the time of the 1980-82 census it had declined to 0.96. High fertility levels of 31 per 1000 were balanced by high mortality levels of 21 per 1000 during the period prior to 1921. During these years inward migration had made a modest contribution to the increases in the region's population. In the intercensal period 1911-1921 however outward movements slowed the growth rate in a significant way through the removal of two thirds of the natural increase.

It is during the intercensal period 1921-1943 that differences in fertility and mortality begin to make an impact on population growth in the region. In this period migration wanes, deaths decline to under 21 per 1000 for the first time in the region's history, but fertility remains high at 34.0 per 1000. By the time of the 1960 census the impact of the difference between the two processes is so great that even in the face of high levels of movement of persons out of the region the annual rate of growth peaks at 2.0 per cent. Between 1960 and 1970 mortality continued to decline reaching a low of 8 deaths per 1000 persons, while fertility climbed to an all time high of 38 per 1000. In the absence of the movement of massive numbers of persons out of the region during this period the region's population growth would have exceeded 3.0 per cent placing it among the highest in the world (Roberts, no date). Birth rates are higher and death rates lower than in the previous intercensal period, but population growth is lower because of an increase in outward migration. External migration results in the removal of 54 per cent of the region's natural increase during this period. The 1970-1982 intercensal interval is one in which population growth declines to the lowest of the three intercensal intervals since 1943, 0.96 per annum. This interval witnesses a further decline in mortality as measured by the crude birth rates to 7 per 1000, a decline in fertility as measured by the crude birth rate, 26 per 1000 and continued high rates of external migration. On the basis of these aggregated figures it seems safe to conjecture that for the region as a whole the first three decades of the second half of the 20th century represent a period in which mortality has begun to approach levels characteristic of the Developed World. This is so in spite of the fact that it has not experienced the social transformations that accompanied such declines in the Developed world. See table 1.

[8] This of course only speaks to those persons that reside only in the Caribbean. Estimates vary but it is generally felt that as many Caribbean persons live outside of the region as live within it. In this era of Globalization and the circular travel that is associated with it this is a very important constituency of persons socioeconomically as well as demographically.

Table 1

POPULATION MOVEMENT IN THE ENGLISH-SPEAKING CARIBBEAN 1840-1980

Year of census	Census population	Intercensal increase	Annual rate (%)	Births during intercensal interval	Deaths during intercensal interval	Natural increase	Indenture immigrants Net total (1839-1981)	West Indian emigrants	Migration balance	Natural increase as a % of Inter-Censal increase	Rates per 1000 population		
											Births	Deaths	Natural incr.
1841-44	863,900						24,500						
1861	1,068,400	204,500	1.07			79,700	124,800			39			
1871	1,238,300	169,900	1.49			88,300	81,600			52			
1881	1,440,000	201,500	1.52	412,600	281,900	130,700	72,400	1,600	70,800	65	30.8	21	10
1891	1,607,300	167,300	1.11	443,00	320,500	122,500	45,200	500	44,700	73	29	21	8
1911	1,951,300	344,000	0.97	1,067,600	746,400	321,200	64,000	41,200	22,800	93	30	21	9
1921	1,999,200	47,900	0.24	560,000	413,900	146,100	12,500	110,800	-98,300	305	28	21	7
1943-1946	2,851,000	851,800	1.43	1,980,300	1,147,900	832,400				98	34	19	14
1960	3,766,800	915,800	2.00	1,705,400	832,400	873,000		245,300		95	34.4	17	18
1970	4,319,500	552,700	1.38	1,518,700	320,400	1,198,300		645,700		217	38	8	30
1980-1982	4,845,147	525,647	0.96	1,430,858	338,548	1,092,310		566,663		208	26	7	24
1990-1991	5,095,662	250,515	0.51		-	-		-	-		22	-	-

Source: Derived in part from G.W. Roberts “Main Phases of Migration Affecting the English-Speaking Caribbean”.

B. The contribution of the components of growth

1. Mortality

The three components of growth have varied in importance over the period. Morbidity and mortality have had a varied history in the Caribbean. During the Nineteenth century and up until the end of the second decade of the Twentieth, extremely high rates of morbidity and mortality were commonplace. One of the major causes of this state of affairs was the poor living conditions of the population and the absence of a coherent set of public health policies and legislation. During the 19th century, territories such as Barbados and British Guiana suffered very high rates of mortality associated with congested housing in the case of the former and extremely filthy conditions on the sugar plantations in the case of the latter. Similar conditions prevailed elsewhere in the region as well during these years.

It was not uncommon for as much as a quarter of any given birth cohort to perish before the age of four years (Roberts and Harewood, 1966). Vector borne, and communicable diseases of the respiratory tract and the stomach were the principal contributors to this situation. Beginning in the last two decades of the Nineteenth Century a series of legislation was introduced throughout the region that addressed the issue of public health. This, coupled with advances in medical science, the control of the vector population associated with diseases such as malaria, and work in the area of social welfare by international philanthropic organizations was to result in marked improvements in the sanitary conditions under which the population lived. In addition, there were improvements in the nutritional status of the population. The result was a dramatic reduction in morbidity and mortality in the region. By the end of the second decade of the Twentieth Century what has been termed an 'era of mortality control' had been ushered into the region. For much of the present century the Caribbean built on the advances in health-care made during the early years. Economic growth, scientific advances, international assistance, continuing improvements in public health and social infrastructure and publicly oriented health-care policies all contributed to continued improvements in the health status of the population. In recent years the fiscal and monetary structures associated with economic crisis, and HIV, have led to slight reversals of these gains in some territories in the region.

2. Fertility

For much of the 19th century and up to the 1950's, fertility in the Caribbean was high. Given the high levels of mortality that prevailed during this era this is hardly surprising. Fertility was been high but its contribution to population growth depended on the levels of mortality and outward migration that prevailed. As we have seen, mortality declines, which began in the second decade of the 20th century, have continued since. This has meant high levels of natural increase for much of the 20th century. These high levels of natural increase have only begun to decline in the last two decades. Beginning in the intercensal period 1960-1970, fertility registered declines that have continued up to the present time.

3. Migration

Migration has been a very important component of population growth in the region. In the historical period there were three streams of external migration affecting the region: indenture immigration (consisting of the movement of East Indians from the Indian sub-continent into mainly the territories of Trinidad and British Guiana), inter-Caribbean movement (largely between the Winward Islands and the 'new' colonies of Trinidad and British Guiana) and extra regional travel to places such as Panama, the Dominican Republic, Cuba and the United States. In the post World

War 2 period the inter Caribbean movement has continued, shaped by the variations in the levels of socioeconomic development that have come to characterize the region.[9] Extra regional travel has taken the form of movement to the North Atlantic countries starting with Britain in the late 1940s and continuing in the present period with movement mainly to North America. Accompanying this external movement, have been movements out of the countryside into the primate urban centers. This has meant a redistribution of the population rather than an increase in its size.

4. Urbanization

Historically, movement out countries of the region has been has also been associated with movement from the rural to the urban areas. Urbanization does not make any direct contribution to population growth. Rather, it contributes to the process of population redistribution within territories in a way that has important implications for the social and economic life of the country. As part of the background to the discussion of sociodemographic vulnerability, the features of urbanization in the Caribbean are considered.

As primary agricultural exporting countries, economic life centered on what was taking place in this sector. In the best of times the rural economy would be unable to absorb significant proportions of the labour force, many of which would find their way into the urban, commercialized area in search of alternative employment. The fact that the urban centers of the region were not seats of industrial production with a growing demand for labour meant that they also were unable to provide sufficient economic activity to absorb the 'surplus' labour from the countryside.[10] These problems were compounded whenever there was a downturn in the export agricultural sector. In such circumstances the population responded by moving out of the rural areas in search of economic opportunities overseas and within the primate city. [11]

C. Trends in Caribbean urbanization 1950-1980

During the period 1950-1970 the urban population of the Commonwealth Caribbean grew at more than twice the rate of rural populations. In the period 1970-1980 the rate of increase was double to four times that of the rate of increase of rural populations.

Demographically, the two sources of growth of the urban population are natural population increase and rural to urban migration. For the Caribbean as a whole natural increase has been responsible for the majority of the urban population growth (72 per cent 1970-75). For individual Caribbean territories the relative importance of the two factors varies. In the case of Jamaica natural increase was responsible for 47.4 per cent of urban growth. For Trinidad and Tobago the corresponding figure was 57.9 per cent. Notwithstanding declines in the fertility of urban women, fertility still remains an important source of increase in the growth rate of the urban population.

In the territory of Guyana the urban population growth rate was 6.8 per cent. Internal migration was responsible for 51 per cent of this growth. In Jamaica the rate of growth was 3.8 per

[9] The pattern that obtains is one that sees the movement of persons from the poorer countries in the region to a number of relatively prosperous countries. Some of this movement such as the one from St. Vincent and Grenada to Trinidad and Tobago represents the continuation of a historical trend. Others such as the movement of Jamaicans and Guyanese to Antigua, St. Kitts and the Cayman Islands are associated with developments that have taken place as a result of Globalization.

[10] This of course is the problem that the early development theorists addressed themselves to. The literature of Development Economics is comprised of the work of theorists such as A.W.Lewis, R. Nurske, P. Roseinstein-Rodan who attempted to devise theoretical formulations that would provide an answer to the quest of regions such as the Caribbean to industrialize their economies and escape from the poverty and underdevelopment associated with their role as exporters of primary agricultural produce.

[11] For example downturns in the West Indian sugar industry in the late 19th Century were associated with movement by men overseas and women into the urban centers of the region. The historical movement into urban centers such as Kingston, Jamaica is quite closely related to the fortunes of Jamaican sugar on the world market. The same thing happened in Trinidad and Tobago during the 1930s and 40s when downturns in that country's sugar industry were associated with movement off the sugar lands into the urban centers of Port of Spain and San Fernando.

cent with internal migration responsible for 52.6 per cent. In the case of Trinidad and Tobago the rate of growth of urban population was 2.0 per cent with internal migration responsible for 42.1 of the share of growth.

Urban growth in the region tends to be dominated by a primate capital city. This usually contains more than 80 per cent of the urban populace. For example, one in four of the population in Jamaica lives in Kingston. Females tend to outnumber males in Caribbean cities and most of the urban population tends to be below the age of 35.

D. Regional variations in Caribbean demography

The territories have had a common social and economic history in the form of the dominance of primary agricultural export activity carried out in most instances using the institutional framework associated with the Plantation (Best and Levit, 1968). They therefore have a common place in the global economy and locally have been shaped by a common institutional framework. Within this commonality, though, there is a limited set of variations that herald the insular aspects of existence of these territories. The historical domination of the plantation in most of the territories of the Caribbean was mediated by the emergence of a partial peasantry, a domestic agricultural sector and a limited number of alternative staples and activities. The extent of this variation within individual territories was a function of the manner in which the accidents of geography and history allowed them to adapt to the vicissitudes of the world economy (Brown, 2000). Each of these small societies although having a common sociohistorical heritage is faced with individualized circumstances of physical place, society, economy and demography. Barbados, for example has had a fertility measure of below 3 since 1975-1980. This was at a time when Belize had a measure of 6 children per woman and St. Lucia 5 children per woman. See table 2.

Table 2

TOTAL FERTILITY PER WOMAN - 1960-1980

Country	1955-1960	1960-1965	1965-1970	1970-1975	1975-1980
Bahamas	4.31	4.50	3.79	3.44	3.22
Barbados	4.67	4.26	3.45	2.74	2.19
Belize	6.55	6.45	6.35	6.25	6.20
Guyana	6.77	6.15	6.11	4.90	3.94
Haiti	6.30	6.30	6.00	5.76	5.96
Jamaica	5.08	5.64	5.78	5.00	4.00
Saint Lucia	6.94	6.79	6.48	5.69	5.20
Suriname	6.56	6.56	5.95	5.29	4.20
Trinidad andTobago	5.30	4.99	3.79	3.45	3.40

Source: World Population Prospects: The 2000 Revision (vol. 1 Comprehensive Tables).

Similarly, in 1980 when Barbados and Jamaica had an expectation of life at birth of at least 70 years Guyana' was only 61 (table 3). More than this, the pace at which the declines in mortality and fertility that each territory has experienced has been different. Between 1955 and 1980 there was a 25 per cent decline in the total fertility rate in Saint Lucia. For the same period Trinidad and Tobago experienced a decline of approximately 40 per cent.

Table 3

LIFE EXPECTANCY AT BIRTH (YEARS) FOR SELECTED CARIBBEAN COUNTRIES (1955-2000)

Country	1955-1960			1960-1965			1965-1970			1970-1975		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Bahamas	60.8	63.8	62.4	61.0	67.3	64.2	62.9	68.6	65.8	63.2	69.9	66.5
Barbados	60.2	65.0	62.6	63.5	68.3	65.9	65.2	70.1	67.6	66.9	72.0	69.4
Belize	59.6	60.8	60.2	62.1	63.3	62.7	64.6	65.8	65.2	66.9	68.3	67.6
Guyana	53.3	56.4	54.8	55.8	58.9	57.3	57.5	61.0	59.2	58.0	62.1	60.0
Haiti	39.4	42.0	40.7	42.2	44.9	43.6	44.9	47.6	46.2	47.1	50.0	48.5
Jamaica	60.8	64.5	62.6	63.7	67.5	65.6	65.7	69.3	67.5	67.3	70.7	69.0
Saint Lucia	55.1	58.5	56.8	57.6	61.6	59.7	60.0	64.7	62.5	62.4	67.9	65.3
Suriname	57.0	60.5	58.7	58.7	62.5	60.5	60.5	64.5	62.5	61.7	66.5	64.0
Trinidad and Tobago	60.1	63.5	61.8	62.9	67.1	64.9	63.4	67.6	65.4	63.6	68.3	65.9

Country	1970-1975			1975-1980			1980-1985		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Bahamas	63.2	69.9	66.5	63.5	71.2	67.3	64.5	72.6	68.2
Barbados	66.9	72.0	69.4	68.7	73.9	71.3	70.5	75.5	73.2
Belize	66.9	68.3	67.6	68.9	70.6	69.7	70.4	72.6	71.4
Guyana	58.0	62.1	60.0	58.3	63.2	60.7	58.2	64.1	61.0
Haiti	47.1	50.0	48.5	49.1	52.2	50.6	50.3	53.0	51.6
Jamaica	67.3	70.7	69.0	68.4	71.8	70.1	69.6	72.9	71.2
Saint Lucia	62.4	67.9	65.3	64.9	71.0	68.0	67.3	73.7	70.5
Suriname	61.7	66.5	64.0	62.8	67.7	65.1	64.8	69.7	67.1
Trinidad and Tobago	63.6	68.3	65.9	65.9	70.9	68.3	67.8	72.8	70.2

Country	1985-1990			1990-1995			1995-2000		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Bahamas	65.8	73.6	69.4	65.1	73.1	68.7	64.8	73.5	69.1
Barbados	71.9	76.9	74.6	72.9	77.9	75.4	73.7	78.7	76.4
Belize	71.4	73.8	72.5	71.9	74.3	72.9	72.4	75.0	73.6
Guyana	59.4	65.5	62.3	61.1	68.1	64.4	59.8	67.8	63.7
Haiti	50.3	53.8	52.0	49.7	54.5	52.1	49.1	55.0	52.0
Jamaica	70.7	74.2	72.5	71.9	75.8	73.7	72.9	76.8	74.8
Saint Lucia	68.3	73.6	71.0	69.3	74.6	71.9	70.3	75.6	73.0
Suriname	65.8	70.8	68.2	66.5	71.5	69.0	67.5	72.7	70.1
Trinidad and Tobago	69.8	74.5	72.1	70.5	75.2	72.6	71.5	76.2	73.8

Source: World Population Prospects, The 2000 Revision (vol. 1 Comprehensive Tables).

A number of factors are responsible for the timing and pace of fertility declines and their variation across the region underlies the variation experienced by the individual territories. These factors can be divided into demographic and socioeconomic. The demographic factors are declines in mortality and infant mortality and contraception (Bongaarts, 1982). The socioeconomic factors are related to the social and economic transformation of these societies over the period in question.

E. Population dynamics and the demographic transition in the Caribbean

Fertility levels are generally reflective of trends in mortality. According to the theory of demographic transition mortality decline is a sin qua non of declines in fertility (Davis, 1945). As outlined by the original proponents of this theory this relationship is implicit, the chief area of focus being on changes in the social structure of which mortality and the factors that influence it is a part. One hypothesis that could be put forward on the basis of the above data is that where mortality declines take place outside of the transformation of the social structure then changes in opportunity structure that young people face as well as the social conventions, values and norms that govern fertility will not occur. Fertility will therefore continue to be high, leading to an increase in

population over the short to medium term. Furthermore, improvements in the health status of the population is likely to lead to a reduction of spontaneous abortions.

In the long term even if there are no changes in the ways in which the society and economy is organized then declining mortality will produce demographic effects that will lead to reductions in fertility. The first such effect is the change in the age/sex structure. Declining mortality will lead to an increase in the relative size of the age groups outside of the childbearing age range and therefore lead to declines in the crude birth rate. The second change in the age/sex structure will be an increase in the proportion of women five years younger than the men with whom they are likely to cohabit, thus making it more difficult for women to find suitable mates, thereby increasing the number of women outside of a sexual union. The two other means whereby mortality declines give rise to fertility declines are the so-called child replacement and child survival hypotheses. Briefly, these suggest that where mortality declines, parents will be less concerned to produce children for the sake of replacing those who have died. It also means that couples will be less inclined to produce offspring as a means of ensuring the continuity of their family, given the likelihood that more of their offspring will survive.

These arguments seem to make sense of the trends in Caribbean population movement that we have examined so far. If we think of the region in aggregate terms and argue that for much of the 20th century it could be characterized as one primarily engaged in the export of primary produce to the developed world, with a skewed resource distribution and increasing but still limited opportunities for social advancement on the part of its people, then the demographic profile outlined above is understandable. What we should expect to find in the more recent period is a continuation of declines in mortality, declining fertility with resistance to this downward trend being evinced among certain socioeconomic and demographic categories in the population.[12] There should also be a problem of over-urbanization and continued high levels of outward migration, given the lack of diversity in the economies and the underdevelopment of the rural areas. There will be variations in these patterns across the region given the differential impact that Globalization would have had on it over the past two decades. Thus, some societies might be experiencing first demographic transition population movements while others might have completed the first transition and be well into the second. In addition, HIV is likely to have reversed some of the gains made in longevity in recent years in many of the territories of the region. In the next section of the paper we see to what extent the most recent trends in population processes and structures bear out these arguments. We then proceed to an examination of the ways in which the demographic configuration that obtains might represent a risk or threat to the attainment of the region's development objectives.

[12] Socially disadvantaged groups that fall outside of the pale of what ever social transformations might have taken place.

V. Demographic trends in the Caribbean 1980-2000

A. Population growth

The intercensal period 1980-1981/1990-1991 witnessed a continuation of the trend in population growth rate that was noted over the recent decades. The rate of population growth continued to slow down. Indeed during this intercensal interval it fell to 0.51, the second lowest annual rate of growth that the region's population has experienced since the inception of census taking.[13] It is only during the intercensal interval 1911-1921 when the annual rate of growth slowed to 0.24 per cent per annum that there has been a lower rate of growth. The question that arises at this point has to do with the causes of the most recent declines in population growth rate. Are the declines reflective of a full fledged demographic transition taking place in the region, or is it another instance of high levels of outward migration dampening the population growth rate, as happened in 1911-1921? It could also be that the two things are happening simultaneously.

The data for mortality in the territories is incomplete but that which is available suggests a continuation of the declines witnessed over the recent decades.[14] Migration data is also not readily available. Anecdotal evidence seems to indicate that the trend of high levels of outward movement has continued in this intercensal interval. Fertility, as measured by the crude birth rate, registered a decline of 15 per cent

[13] This estimate excludes the population of Antigua, which took no census in 1980. When the interpolated population of 57584 is included in the 1980-81 census the population growth rate for the 1982-1991 intercensal interval falls to 0.43.

[14] Jamaica's deaths for 1990 are not available and there are no data for Guyana for the decade.

over the previous intercensal interval when it was 26 per 1000. These data allow us to speculate that in aggregate terms the region continues to register declines in mortality and fertility that puts it well on the road towards a demographic transition, although it still has not achieved it[15] (see table 1).

The opportunities for personal advancement in life that the region offers to its people are still insufficient to satisfy their aspirations. This leads them to continue to seek personal advancement overseas in large numbers. In recent times, conditions associated with the adjustments that these economies and societies have had to make to economic Neoliberalism and the greater ease of movement between countries that is a part of the Globalization process would seem to have led to continued or increased high levels of movement of persons outside of the region. A reasonable conclusion seems to be therefore that outward migration not only continued to be the major damper on the region's population growth in the period 1980-1990, but that during this intercensal interval it rose to levels that resulted in the second lowest rate of population growth in the region's history.[16]

Even in the absence of data for the 1990-2000 period, it would seem safe to assume that the trends evinced in the previous decade have continued in the present one. In particular, mortality as measured by the CDR would be expected to continue at between 5-6 per 1000. Estimates of this indicator for a number of countries in the region indicate that with the exception of two countries, Barbados and Guyana, which have CDRs of 8.3 and 8.4 respectively this is indeed the case (see table 4).

Table 4

CRUDE DEATH RATE (CDR) FOR SELECTED CARIBBEAN COUNTRIES (PER 1,000 POPULATION)

Country	1955-1960	1960-1965	1965-1970	1970-1975	1975-1980	1980-1985	1985-1990	1990-1995	1995-2000
Bahamas	9.0	7.7	7.1	6.1	5.6	6.1	5.9	6.5	6.8
Barbados	10.3	9.2	8.5	8.7	8.7	8.0	8.7	9.1	8.3
Belize	11.0	9.6	8.3	7.3	6.5	5.7	5.2	4.9	4.5
Guyana	15.9	13.7	11.6	10.3	9.2	9.0	8.5	7.9	8.4
Haiti	24.8	22.2	19.7	17.8	16.5	15.9	15.0	13.7	13.4
Jamaica	9.8	9.1	8.5	8.2	7.4	6.7	6.5	6.4	5.9
Saint Lucia	14.5	11.8	8.4	8.0	7.1	6.2	6.2	6.2	5.7
Suriname	11.4	10.3	8.8	7.5	7.3	7.0	6.4	6.2	6.0
Trinidad and Tobago	9.4	7.6	7.2	7.4	7.1	7.1	6.8	6.1	5.9

Source: World Population Prospects: The 2000 Revision (Vol. 1 Comprehensive Tables).

Barbados and Guyana have histories of relatively high mortality levels. In the case of Barbados this was due to high population densities and congested living conditions. These are circumstances that facilitated the transmission of the contagious diseases that wreaked havoc among the historical population in the era when exogenous diseases were in ascendance. In the case of Guyana the condition was due to the filthy conditions that prevailed on the sugar estates and the conduciveness of the topography to the breeding of vectors of the exogenous diseases. During the course of the 20th century, the Barbadians have corrected their situation through an improvement in living conditions and the control of most of these diseases. The continued high crude rate in this country is a function of the relatively high proportion of its population that now falls in the 65+ age group. When the more refined expectation of life at birth measure is used Barbados has a statistic of 76.4 years, one of the longest average life spans in the region. However, a greater proportion of the

[15] The region's CBR of 22 per1000 population for 1980-1990 is still much greater than the rates in Western Europe where it was 12.2 in 1985-1990. From as early as 1950-55 the CBR in W. Europe was 17.5.

[16] By now it has become apparent that external migration is perhaps the most important regulator of West Indian population growth. The normal propensity to look outward that is a part of life on small islands is given impetus by the limited economic diversity and the skewed and narrow opportunity structures that are features of these societies. The 'normal' outward movement from these societies is modulated by shifts in economic circumstances at home and abroad. Given the economic distresses of adjustment in the region during the 1980s then the expectation would be high outward flows. This movement would have been given fillip by economic boom in the United States starting in the late 1980s. Movement out of the region should therefore have accelerated during the 1990s in keeping with the continuation of economic boom during this time.

country's population is elderly and therefore at a higher risk of dying than similar age spans in countries where they are proportionately smaller. In the case of Guyana the higher CDR is reflective of lesser control over mortality and the greater probability of dying faced by certain groups in the population. This is reflected in the relatively low expectation of life at birth for this country, 63.7 years.

B. Infant mortality

Not withstanding the impressive gains that have been made in mortality control in the region there is still room for improvement. This is so particularly in the area of infant mortality. This becomes evident when infant mortality figures for the region are compared with the Developed world. This is shown in table 5. The level of infant mortality that prevails in a country is a particularly sensitive marker of the state of the health care system and the living conditions of the population. The social and demographic factors that are associated with the relatively high levels of infant mortality that prevail in the region will be discussed later.

Table 5

INFANT MORTALITY RATE (PER 1,000)

Country	1955-1960	1960-1965	1965-1970	1970-1975	1975-1980	1980-1985	1985-1990	1990-1995	1995-2000
Bahamas	56	48	41	38	35	31	23	21	19
Barbados	87	61	46	33	27	17	15	14	12
Belize	78	69	60	52	45	39	36	34	32
Guyana	105	95	82	79	67	71	63	56	56
Haiti	193	176	165	152	139	124	106	74	68
Jamaica	78	61	52	45	37	31	27	24	22
Saint Lucia	105	81	48	39	29	23	20	16	14
Suriname	76	63	55	49	44	40	36	33	29
Trinidad and Tobago	63	48	46	41	32	25	20	16	14
Belgium	35	26	23	19	14	11	8	7	4

Source: World Population Prospects: The 2000 Revision (Vol. 1 Comprehensive Tables).

C. Fertility

A continued downward trend is also evident in the case of fertility. The estimates of this indicator are provided for the same set of countries examined above in regard to mortality. In the case of the CBR the rates range from a high of 28.5 in the case of Belize to a low of 12.9 in the case of Barbados for the period 1995-2000. Furthermore these rates represent a decline from those that prevailed in the period prior to 1990. When fertility is examined using the more refined Total Fertility Rate, a similar picture emerges. The rates range from a high of 3.4 children per woman in Belize to a low of 1.5 in Barbados. Trinidad and Tobago with a TFR of 1.65 is the only other territory with below replacement levels of fertility. In this case these rates also represent a decline on the ones that prevailed in the previous period (see table 6).

The fertility data for individual countries make it clear that aggregated figures for the region as a whole conceal trends that either run counter to the general pattern of decline, or resist the downward movement. The same is true for national level data. These tend to conceal trends among certain demographic and social categories within the country that may run counter to the national pattern of decline. In the analysis of sociodemographic vulnerability the impact of lagging fertility at the national as well as group levels on the household, the individual and the community will be examined. This, in order to ascertain how it constrains or prohibits these respective units from realizing their potential as human beings and as entities whose proper functioning is important for the well being of the wider society.

Table 6

TOTAL FERTILITY PER WOMAN, 1980-2000

Country	1980-1985	1985-1990	1990-1995	1995-2000
Bahamas	3.16	2.62	2.60	2.40
Barbados	1.92	1.75	1.60	1.50
Belize	5.40	4.70	4.18	3.41
Guyana	3.26	2.70	2.55	2.45
Haiti	6.21	5.94	4.79	4.38
Jamaica	3.55	2.87	2.76	2.50
Saint Lucia	4.20	3.65	3.05	2.70
Suriname	3.70	2.92	2.45	2.21
Trinidad and Tobago	3.22	2.80	2.10	1.65

Source: World Population Prospects: The 2000 Revision (Vol. 1 Comprehensive Tables).

D. Migration

In the case of migration, it is more difficult to provide data to substantiate the notion that there has been a continuation in the 1990-2000 period of the trends evinced in the previous intercensal period. During most of the decade the economy of the United States of America experienced boom conditions. This existed alongside situations of economic distress in Caribbean territories such as Jamaica and Guyana. It seems reasonable to conclude therefore that the movement of persons that characterized the previous decade continued into the 1990s. Confirmation of this will have to await the publication of the 2001 census figures for the Caribbean.[17] In the analysis of sociodemographic vulnerability we will try to understand the ways in which migration affects the household and the community in the Caribbean.

E. Urbanization

In the contemporary period there has been some diversification of the regional economies through the development of additional export staples such as minerals and tourism.[18] In addition, there has been the development of small manufacturing sectors and an increase in commercial activities. The role of the Caribbean urban center as administrative hub for the interaction of the local economy with the metropolitan has been enhanced by the fact that these areas now serve as the place where the infrastructure that enables the global transnational economy is based (Sassen, 1998). However, not only does the tradition of rural underdevelopment and urban primacy persist, but the advent of Neoliberalism has been associated with increases in relative, if not absolute, poverty in the urban areas and the persistence of severe and intense poverty in some rural areas (Brown and others, 1995).

Urban growth in the region tends to be dominated by a primate capital city. This usually contains more than 80 per cent of the urban populace. For example, one in four of the population in Jamaica lives in Kingston. Females tend to outnumber males in Caribbean cities and most of the urban population tends to be below the age of 35.

[17] This will provide the basis for the derivation of Caribbean migrants during the decade using the balancing equation formula.

[18] For a recent account of how these developments has affected the pattern of urbanization in the region see A. Portes, et al, The Urban Caribbean.

F. Population structure

The analysis so far, therefore, seems to suggest that in the last two decades of the 20th Century population movement in the Caribbean was characterized by declines in mortality and fertility and sustained high levels of migration. This kind of population movement will tend to produce a population structure in which the aged comes to occupy a greater share of total population. In the analysis of sociodemographic vulnerability we will address the question of the extent to which the population structure that has emerged might prove inimical to the efforts of the individual, the household and the community to improve the circumstances with which they are faced.

VI. Caribbean demography as a source of social vulnerability

In this section of the paper we examine the extent to which the demographic processes and structures that have been described could be sources of social vulnerability to the region. Social vulnerability as used here is best understood with reference to the efforts of the region's people at social development over the past half century. These efforts have been given expression in the form of social and economic policies framed by the polarities of market and state. It is now recognized that the two are not so much antinomies as they are complementarities. In the contemporary period it is understood that the region operates within a global marketplace governed by the principles of free trade and competition. Effective participation in this system is a sin qua non for improvement in the quality of life of the region's people. In order to do so there has to be a unity between efficient and productive economic processes, an efficient polity that is watchful but not intrusive and a civil society that through the action of the various interests of which it is comprised promotes a vision of the common good. In order for this type of arrangement to be feasible the citizens of the region have to be able to be free from the want of basic needs and be given the facilities that enable them to realize their potential as human beings. There are a number of factors that can frustrate the realization of this arrangement. It is to an analysis of the risks posed by demographic phenomena in this regard that we now turn.

A. Fertility

Fertility in the Caribbean has followed the historical trend of decline towards replacement and below replacement levels. This is in keeping with the hypothesis that the Caribbean is experiencing a demographic transition governed by the control of mortality in general and infant mortality in particular (Guengant, 1990). This argument suggests that over the period 1960-1980 against the background of these mortality declines contraceptive usage among women in sexual unions rose from 10% to between 50-70%, except in Belize where it was estimated to be below 10% at that time. Of course the mere availability of contraception will not lead to its usage by the populace. Indeed, the conventional argument is that it is only when faced with prospects of self-improvement that women will utilize these devices and procedures on a systematic basis. It has been suggested though that in the case of the Caribbean the failure of agriculture coupled with non-industrialization, over urbanization and massive emigration in these societies led to the emergence of a mind set that shifted from the view that a large family was a good thing. This process was aided by the spread of primary schooling (Guengant, 1990).

There are nonetheless pockets of women within the population that have not followed this trend. These women are usually from disadvantaged social backgrounds, oftentimes the victims of chronic or intergenerational poverty. They are usually educated to the Primary level only, lack employable skills and face bleak economic prospects. Their high fertility is as much a product as it is a cause of their poverty. In terms of our central thesis, the poverty that reduces the capabilities of these women to cope with their social and economic circumstances is itself reinforced by their fertility behaviour. They exist in sizable enough proportions in a number of the countries of the region to put a brake on the general decline that characterizes fertility at the national level. The existence of LSMS data in Grenada and Belize allow us to look a little closer at their circumstances.

Table 7 shows the relationship between poverty and age in Grenada. The data reveals that poverty is a youthful phenomenon. Over 56 per cent of the poor were less than 25 years old. More disturbing is the fact that 51 per cent of those people living below the poverty line in Grenada are below the age of 20 years. At the other end of the spectrum, 5.6 per cent of the poor were 65 years and over. These comprised 22.5 per cent of all persons aged 65 year and over in the country.

The greater proclivity of poor women to have large families is demonstrated in the table by the fact that children 0-14 make up 41 per cent of the poor as opposed to 28 per cent of the non-poor. Poor women tend to have relatively high rates of fertility and therefore poor households tend to have a high number of children. The higher fertility is brought about by the fact that poor women have children more frequently and start childbearing at a younger age, usually in their teens or earlier.[19] Even where national fertility rates are declining, the circumstances of the poor tend to foster attitudes of hopelessness, powerlessness and fatalism that make them less receptive to the family planning message than the non-poor are. This seems to be the case in Grenada where even though national fertility rates have been in decline during recent times, the 0-4 age group comprises approximately twelve per cent of the poor as opposed to eight per cent of the non-poor. The differences in the relative sizes of the 0-4 and 5-9 age groups among the poor and non-poor points to higher rates of fertility and less receptivity to family planning among poor than non-poor women.

[19] Cumulative fertility, 'children ever born' is a very important component of fertility. The younger women start the childbearing process the more likely it is that they will have larger families. These data point to the need to understand teenage pregnancy in relation to socioeconomic status.

Table 7
SOCIO-ECONOMIC STATUS BY AGE IN GRENADA

Age distribution	Socio-economic status		Total
	Poor	Non-poor	
0-4 years	11.6	7.7	9.0
5-9 years	13.7	9.6	10.9
10-14 years	15.6	10.9	12.4
15-19 years	10.4	10.1	10.2
20-24 years	5.5	7.0	6.6
25-29 years	5.5	6.1	5.9
30-34 years	4.8	6.2	5.7
35-39 years	6.7	6.2	6.4
40-44 years	3.0	4.6	4.1
45-49 years	3.5	3.5	3.5
50-54 years	2.4	3.1	2.9
55-59 years	2.1	3.2	2.8
60-95 years	1.7	4.1	3.3
65 and over	5.6	9.1	8.0
Not stated	8.1	8.5	8.4
Total	**100.0**	**100.0**	**100.0**
No.	**1,303**	**2,758**	**4,061**

Source: Poverty Assessment Report-Grenada, Caribbean Development Bank,1999.

Case study 1
Constance Cooper, 24 years of age

Constance is a shy, retiring young woman who speaks in very soft tones. The shack in which she lives rests precariously on a hillside. It has one bedroom, a dining room and a kitchen. The bedroom has a makeshift bed made from a large piece of sponge framed by some pieces of board. It has no electricity, no water and the household uses the neighbour's toilet, as it has none of its own. The shack belongs to Constance's sister. Besides Constance and her sister, the household consists of four of Constance's six children. Her other two children live in Carriacou, one with its father and the other with 'a lady'. The children are aged 13, 11, 8, 5, 2, and 9 months. It is the four youngest children that live with Constance. Of these only one, the 8 year old, attends school.

Constance grew up in St Georges, the Capital Town of Grenada. She is the last child of her mother. She has 4 brothers and 3 sisters. Their mother who worked as a cleaner in the Catholic Church raised them. Constance attended Primary school up to standard 7. She left school at age 11 to have her first child. She has not done much work, only being able to point to the seasonal Crash Programme work as a job experience.

Constance receives $150 per month from the father of her last two children. She also receives help from a male friend who works in a supermarket, and she gets clothes from the Church as well. Nonetheless, she still finds herself without food at times. Today is one of those times. During the interview she reveals that she and the children have had no food for the past 24 hours. She last saw her boyfriend, the father of her last two children, on Sunday (today is Tuesday) and he told her that he would not get any money until Friday. Whenever she finds herself without food she gives the children some sweet water (sugar and water) and sends them to bed. Sleep she reveals is one of the means through which she deals with hunger. She frequently finds herself without any food.

Case study 1 (concluded)

Constance has attempted to get a job, as a cleaner at an office but has not been successful. She has not sought another job since failing to get the one at the office. She reports that if she were to get a job her father's mother would mind her children during her absence. Her sister has one child who lives with her mother. She works as a maid and uses most of her pay to support that household. Constance reports that she would like her children to stay in school for as long as possible and try and get jobs when they are through.

Constance does not have any plans for the future. She would not like to have any more children and intends to go on 'Family Planning'. Yet, to this point in time, nine months after the birth of her last child, she has not made any effort to acquire any form of birth control. She relies instead on post partum infertility.

Source: Interviews conducted by Dennis A.V. Brown in Grenada, West Indies, Summer 1998.

Constance at 24 years of age has already had six children. She is typical of a number of young women from the poor households in the country and obviously personifies a transitional lag in the process of fertility decline in the region. These young women are, in a sense, victims of their social and demographic circumstances. Both sets of circumstances reinforce each other. Constance is the product of a poor female-headed household in which her mother was unable to exercise the control necessary to keep her away from early initiation into sex and child bearing. Because of the early age at which she embarked on the process of childbearing her education was terminated before she would have had the opportunity to acquire the fundamental skills necessary to earn a living, or to participate effectively in any important decision making process in her society. Furthermore, if she even got a job she would be constrained by the need to care for her children. Constance's social circumstances conduced towards early childbearing. Early child bearing, in turn, reinforced the nature of her social circumstances. Beginning childbearing at such an early age has thwarted Constance's prospects for the realization of her potential as a human being. Furthermore, she is in the process of passing these circumstances on to her own children and thus converting an individual vulnerability into a social one. Her children will inherit a legacy of poor development of their physiology, sporadic schooling, early initiation into sex and childbearing in the case of the girls and delinquency and early fatherhood on the part of the boys. This situation repeated itself with minor variations throughout the poor communities in Grenada.

Case study 2

May is a 61 year old grandmother. She lives in a one bedroom wooden house in a rural district. The house is in an advanced state of disrepair. The house is furnished with a long chair, a table and a cabinet, which has no glass. The house is located on a quarter acre of land, which belongs to May's husband. It has no running water, and uses the public standpipe and the nearby river as its water sources. The house has a pit latrine, and does not have any electricity.

May has lived in this house since 1955 with her husband. He is 71 years old. May is of East Indian ancestry and was born in the rural community of Clonmel. She comes from a small family of one brother and two sisters and grew up with her mother and stepfather. Both were agricultural labourers. She attended Primary school up to sixth standard, leaving school when she was 10 years old. In keeping with the Indian cultural tradition of the day she got married at age 12 and went to live with her husband. He was a labourer who never attended school. She had her first child at age 14 and had five others subsequent to that. They are now aged 47, 40, 41, 37, 31 and 30. She sent her children to Primary school; some attended up to grade 7. These children themselves started having children in their teens. She now has 24 grandchildren and 6 great grand. Many of these do not go to school regularly because there is no money for lunch.

The three grand children who live with May and her husband belong to her fourth child, a daughter Cindy, who is unemployed. Cindy has six children by three different fathers. The other three children live with her. She does not use any form of birth control and has no immediate plans of doing so. She attended primary school up until standard 8. She is at present unemployed and has no skill, although she has a school-leaving certificate. Cindy earns some income by doing washing for a family in the District. She also receives some income in the form of child-support, from one of the fathers of her children. Her final source of income is from the sale of produce from a 'garden' that she plants on one acre of land. The corn, peas and pumpkin that she reaps are sold to people in the District in which she lives. Cindy has not gone in search of a substantial job. She maintains however that if one became available she would take it. She maintains that a job in, say, a store in the nearby town would not pay enough to cover daily bus fare and lunch and buy clothes. Even though the family for whom she washes has a restaurant she has never asked them for a job. She has no plans to do anything else in life. May's other daughters are either unemployed or work as domestic workers or small-scale cultivators.

Source: Interviews conducted by Dennis A.V. Brown in Grenada, West Indies, Summer 1998.

The fertility behaviour of May's daughters, especially Cindy gives stark portrayal to the link between socioeconomic status, age and high fertility. It also points to the link between the values of parent and child in the perpetuation of high fertility. In a sense, Cindy did what was 'expected' of her given the circumstances of her life and the family that she came from. Cindy's endowment of low levels of educational attainment and lack of marketable skills leaves her dependent on her mother and with a sense of powerlessness and fatalism about life. At a time when other young women in the national community to which she belongs are delaying child bearing and reducing the rate at which they bear children, Cindy along with other poor women is making no effort to curtail the number of children that she bears Caribbean Development Bank, 1999). She reflects very much the hypothesis regarding low levels of expectation being passed on from parent to child. It is instructive that in spite of the fact that well-established family planning programmes exist in Grenada, the sense of fatalism and powerlessness associated with their inherited poverty places young women such as Cindy beyond the immediate reach of these programmes. This attitudinal dimension is very important, both May and Cindy in their attitudes give expression to it and it seems safe to conjecture that the daughter learnt it from the mother.

The association between low socioeconomic status and relatively high fertility levels that started with early childbearing is reproduced in other countries in the region. Table 8 shows the relationship between age and socioeconomic status in St. Lucia, this time measured in terms of

consumption status. Here, quintile 1 is the poorest consumption grouping while quintile 5 is the wealthiest.

The table shows that there is an inverse relationship between socioeconomic status and the sizes of the age groups that reflect recent fertility levels. Quintiles 1 and 2 contain 62 per cent of the children aged 0-4. The relative share of this age cohort declines as we move up the socioeconomic ladder. This relationship has been the same for at least 10 years as the age group 5-9 reflects the same pattern.

Table 8

AGE BY CONSUMPTION QUINTILE, SAINT LUCIA, 1995

(In percentages)

Age	Per capita consumption quintiles					
	I	II	III	IV	V	Total
0-4	39.8	22.3	19.9	6.6	11.4	100.0
5-9	36.5	24.7	18.4	12.2	8.3	100.0
10-14	29.5	23.1	23.7	16.9	6.8	100.0
15-19	27.6	26.1	22.6	17.7	6.0	100.0
20-24	18.5	29.4	23.2	20.9	8.1	100.0
25-29	25.0	17.9	20.4	19.4	17.3	100.0
30-34	23.1	18.9	17.5	23.1	17.5	100.0
35-39	20.6	18.2	19.4	18.8	23.0	100.0
40-44	17.8	21.1	24.4	18.9	17.8	100.0
45-49	19.8	26.7	17.4	20.9	15.1	100.0
50-54	18.4	25.0	19.7	17.1	19.7	100.0
55-59	21.2	23.1	13.5	11.5	30.8	100.0
60-64	31.6	10.5	17.5	24.6	15.8	100.0
65 and over	20.1	29.6	17.8	16.6	16.0	100.0

Source: Survey of Living Conditions, Saint Lucia, 1995.

Table 9 shows that there is a clear relationship between age of first birth and socioeconomic status. The majority of first births to women in the lower quintiles (1-3) take place during the teen years. The majority of births to women in the top two consumption quintiles take place in the age groups beyond the teen years. Furthermore, the majority of first births occur to women less than 20 years of age. In the Caribbean high adolescent fertility is thus a feature of high total fertility. High fertility among adolescents, however, is attributable to the fact that even in countries with a low overall fertility rate, a large proportion of women have their first child during adolescence. This phenomenon implies that there is a need to take a broader and more diversified approach to the social, economic and cultural factors that are conducive to adolescent maternity/paternity.

At the community level the high fertility pattern is associated with a particular household and demographic structure and with the absence of certain amenities and facilities. These features tend to be associated with a lack of job market and socialization capabilities. In St. Lucia a demographic profile of the households in the ten poorest communities selected as part of the 1995 Poverty Assessment Study shows that the majority of the households were female headed and many were single-parent female headed (Caribbean Development Bank, 1995). In Bacadere, an urban community 24 per cent of the households are female headed, single-parent. Whereas 10 per cent of the community had access to family planning services only 5 per cent actually used them. In Baron's Drive another poor urban community one third of the households were single parented and 80 per cent of these were female headed. In this community 54 per cent of the population report having access to family planning services but only 9 per cent used them. This community identifies teenage pregnancy as one of its major problems. These young mothers are constrained from involvement in the job market or return to school after pregnancy as the community reports that the absence of daycare/preschool facilities is one of its major problems.

Table 9
AGE AT FIRST BIRTH BY QUINTILE

Age and quintile	Belize	Grenada	Saint Kitts and Nevis	Saint Lucia	Saint Vincent and the Grenadines
10-14					
I	26.7	36.4	42.1	28.6	18.2
II	20.0	18.2	31.6	42.9	36.4
III	33.3	9.1	10.5	14.3	27.3
IV	13.3	27.3	15.8	-	18.2
V	6.7	9.1	-	14.3	-
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
15-19					
I	22.5	16.9	27.4	31.3	22.1
II	20.4	25.5	19.8	24.4	19.5
III	20.7	22.9	24.4	21.9	26.1
IV	19.4	22.1	18.8	14.9	19.9
V	17.0	12.6	9.6	7.5	-
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
20-24					
I	11.2	16.9	11.1	27.1	17.9
II	16.3	16.2	28.1	17.8	22.6
III	18.4	18.4	23.0	13.1	10.4
IV	21.9	27.9	20.7	22.4	25.5
V	32.1	20.6	17.0	19.6	23.6
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
25-29					
I	14.7	19.6	15.5	30.0	7.1
II	14.7	13.7	13.8	13.3	21.4
III	2.9	11.8	24.1	13.3	19.0
IV	17.6	21.6	20.7	16.7	21.4
V	50.0	33.3	25.9	26.7	31.0
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
30-34					
I	8.3	12.5	9.5	-	10.0
II	41.7	-	9.5	41.7	10.0
III	8.3	25.0	19.0	25.0	20.0
IV	-	25.0	38.1	8.3	10.0
V	-	37.5	23.8	25.0	50.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: SLC Country data.

Vulnerability linked with marriage patterns (formation and dissolution of couples)

In the Caribbean a complex pattern of mating and union formation exists. This has its genesis in the region's African cultural antecedents and its historical experiences in the era of Plantation slavery (Patterson, 1982). The outcome among the population of African descent has been a system of union formation in which formal marriage often represents the culmination of a mating system that begins with a Visiting Union and progresses to a Common-Law Union. Formal marriage therefore takes place late in life and more often than not represents the embellishment of an existing union between a man and a woman rather than its initiation (Roberts, 1955). The majority of mothers are involved in a socially but not formally sanctioned relationship with a man at any given point in time. Some of the households counted as being single-mother-female headed, in fact represent a family spread between two households with the male member of the family living in a separate household. In this situation, the divorce rate therefore cannot be used as a marker of single motherhood, since child bearing does not commence with marriage.

Not all visiting relationships lead to cohabitation and a woman might in the course of her childbearing years enter into a number of visiting or common law unions without ever entering into formal marriage.a/ It is those unions that do not lead to permanence of one sort or another that represent a demographic source of risk. This is especially so in socially ill defined situations (e.g. urban slums, economically depressed rural communities, or communities in which migratory labour forms a significant part of the population). Here, women who have had a child or children for a man with whom they no longer have a sexual relationship may bear a child for another man in an attempt to secure his financial and emotional support. This pattern may continue until the woman finds herself with a number of children for different fathers with no guaranteed support from any of these men. This has repercussions for the socialization of the children and exposes them to certain types of risks from the current partner who is not their biological father. This situation also has implication for intra household allocation of resources and the general welfare of the children that belong to the household.

a/ Furthermore, some women move from formal marriage into common-law and visiting unions in which, if they are young enough, they produce children.

B. Population structure: ageing and dependency

Population structure is the distribution of a country's population by age and sex. The two potential sources of vulnerability that will be addressed in regard to population structure are youth dependency elderly dependency. Table 10 depicts both types of dependency. It shows that not withstanding declines in mortality and fertility that have been in evidence throughout the region the dependency ratios are still relatively high. The elderly dependencies are probably the highest they have ever been in the region's history. Not to take heed of impending increases would be foolhardy. Nonetheless they are still some way off from the levels of 33 per cent that characterize the developed world. Furthermore, the youth dependencies are still significantly high. In the Table, high fertility rates contribute to Belize's high total dependency ratio. St.Kitts' high elderly age dependency ratio might be due to high levels of return migration and high levels of outward migration. Barbados with the lowest fertility and mortality rates in the region has the lowest total dependency and youth dependency and the highest elderly dependency. Barbados probably points the way the rest of the region is heading.

Table 10

POPULATION STRUCTURE (YOUTH, ACTIVE WORK FORCE AND ELDERLY) FOR SELECTED COUNTRIES

Age structure	Belize		Grenada		Saint Kitts and Nevis		Saint Lucia		Barbados	
	No.	%	No.	%	No.	%	No.	%	No.	%
0-14	81,644	43.9	32,269	37.9	13,920	34.2	48,972	36.7	59,587	24.1
15-64	96,425	51.8	44,993	52.8	22,706	55.9	75,645	56.7	158,379	64.0
65+	7,901	4.2	6,576	7.7	3,986	9.8	8,691	6.5	29,263	11.8
Not Stated	-	-	1,285	1.5	6	0.01	-		59	0.02
Total	**185,970**	**100.0**	**85,123**	**100**	**40,618**	**100.0**	**133,308**	**100.0**	**247,288**	**100.0**
¦atios										
Elderly Dependency	8.1		14.6		17.5		11.5		18.4	
Youth Dependency	84.6		71.7		61.3		64.7		37.6	
Total Dependency	**92.8**		**86.3**		**78.9**		**76.2**		**56.1**	

Source: 1990-1991 Population Census.

Its low dependency and relatively high proportion of population in the economically active age groups is probably the demographic basis of its high per capita income and economic prosperity. It is of critical importance that it uses the respite from demographic dependency that its present demographic position affords it to increase its investment in its human resources and social and capital infrastructure. This will determine the extent to which reduced numbers in the work force will be able to provide for the much higher proportion of aged that is going to characterize its population structure in the coming years.

At the other end of the demographic spectrum the lagging declines in fertility, which is a feature of the reproductive behaviour of women in the lower socioeconomic grouping has produced a burden of dependency on the poor household that is often obfuscated by the national level data.

Table 11 demonstrates the high dependency burdens that are borne by households at the lower end of the socioeconomic order. The majority of these dependents are likely to be young persons, the product of high fertility levels among poor women. This dependency burden borne by poor households is more of a threat than a risk since its repercussions are being felt on a wide scale at the present time.

Table 11

DEPENDENCY RATIOS BY QUINTILE FOR SELECTED COUNTRIES

Quintiles	Belize	Grenada	Saint Kitts and Nevis	Saint Lucia	Saint Vincent and the Grenadines
I	141.9	97.0	110.7	100.6	97.0
II	120.1	106.0	85.2	76.9	88.6
III	108.9	102.5	69.3	69.9	83.3
IV	92.2	90.1	67.8	48.5	57.1
V	56.4	80.3	44.6	47.5	57.1
Total	**99.5**	**94.8**	**72.9**	**71.0**	**74.9**

Source: ECLAC, Quality of Life Data: A compendium of Social Statistics from Five Countries of the Caribbean Subregion (1995-2001).

In this section of the paper the ageing of the population as a source of risk to the society will be considered. Ageing is here taken to mean the process whereby persons aged 60 years and over come to increase their proportionate share of the total population. One of the outcomes of the declining mortality, fertility and migration of working age persons that the region has witnessed is an increase in the relative share of the total population by the older age groups of which it is comprised. In addition, the elderly population of the region will also be incremented by the return of

migrants, now elderly, that left the region in the period beginning in the 1960s.[20] In Jamaica the proportion of the population over age 60 was approximately 10 per cent in 1990. World Bank estimates suggest that by the year 2030, the share of the aged of the total population will have moved to 19 per cent (World Bank, 1994).

The United Nations defines older persons as those persons in the population aged 60 years and over. However, distinctions are made between the younger elderly aged 60-74 and the older elderly aged 75 years and older. The process of ageing poses risk at the community and national levels from the standpoints of health care and social security. Susceptibility to disease increases with age and we should therefore expect an ageing population to make increased demands on a country's health-care system. Similarly, as individuals grow older their ability to earn an income diminishes. Therefore as the population ages we should expect greater demands to be placed on the social security system as means of support. The question therefore arises as to the extent to which these systems in the Caribbean are adequately prepared to cope with such demands. At the individual and household levels there are the risks of isolation and inability to survive.

Table 12 indicates that except for the territories Trinidad and Tobago and Barbados the proportion of the population of pensionable age in a number of territories in receipt of pension is woefully inadequate. Furthermore, case study data in the study indicate that the monies received as pension by the aged in Trinidad do not allow them to meet their basic needs.

Table 12
COVERAGE OF PUBLIC PENSIONS AND PENSION EXPENDITURE

Country	Proportion of population of pensionable age in receipt of pension income	Public pension spending as a % of GDP
Barbados	92	n/a
Trinidad and Tobago	82	3.4
Guyana	37	1.4
Jamaica	27	0.7
Dominica	26	n/a
Belize	10	1.1
Grenada	< 5	1.5
United Kingdom	84	9.5
United States	83	6.5

Source: World Bank, 1994. Averting the Old Age Crisis.

1. Health and the aged

Apart from an increase in the susceptibility to diseases in general, ageing brings with it greater susceptibility to chronic diseases such as cancer, hypertension and diabetes. These are diseases that have their origins in the degeneration of the body and are counter posed to those that are exogenous in origin. The ageing of the population in any country is therefore likely to be accompanied by an epidemiological transition involving a shift in the prevalence of diseases with their origins in the environment to the chronic degenerative illnesses.

[20] A recent survey on return migrants in Trinidad and Tobago, for example, indicates that approximately 12% of return migrants to that country in 1989 were 60 years and over (Paul, 2001).

The epidemiological transition

During the first three quarters of the present century, the region's epidemiological profile was characterized by declines in environmentally based illnesses and the rise of illnesses with endogenous sources. The declines in exogenous illnesses derived largely from four sources. The first of these was the efforts of the State in the provision of legal, administrative, organizational and financial in-puts in the efforts at the control of disease. The second source of improvement was the changes in the conditions of living of the individual members of society. The third source of improvement in the region's health status has been developments in medical science, and aid and assistance from the international community. The fourth source is demographic. It has to do with the increases in life expectancy that these populations have experienced. Older populations will experience an increased proportion of diseases that originate in the deterioration of their physiology.

A case in point is Jamaica. Health data indicate that Jamaica has undergone the epidemiological transition from infectious to chronic non-communicable disease as the primary causes of morbidity and mortality. In part this is related to improved living conditions and changes associated with the adoption of 'modern' lifestyles. It is also due to declines in fertility and the resultant aging of the population. The data point to the fact that the Non Communicable Chronic Diseases(NCCD) were responsible for 60 per cent of all the disease and disability in Jamaica. Violence and accidents were responsible for 25 per cent and communicable diseases accounted for the remainder.a/

This transition, of course, alerts us to the fact that national health-care budgets will increasingly have to make provision for the treatment of the NCCDs, while at the same time not neglecting environmental sanitation and health care. Furthermore, the demands associated with the care and treatment of the NCCDs will become greater as the population ages. One very immediate risk posed by the transition arises due to the absence of a well-developed culture of preventive health care in the region. The NCCDs are also known as 'silent killers because in many instances there are no obvious symptoms associated with the onset of these illnesses. In a societal context where there are low levels of education and awareness, or where the cost of good quality medical care is prohibitive then there is a danger of needless loss of life and productivity because of the non treatment of these diseases until they have reached debilitating stages. In the Caribbean there is need for public education in this regard.

a/ At the same time, the economic crisis associated with the coming of Neoliberalism would seem in some instances to have been associated with reversals in the historical gains made in the fight against deseases with a basis in the external environment. This has happened in those societies which: never attended sufficiently to the development of their social infrastructure (Belize); allowed the social infrastructure to fall into a state of disrepair (Guyana); or have been characterized by high levels of social differentiation and inequality and differential access to good quality health care (Jamaica).

As the population grows older the medical systems in the territories of the region should be equipped to deal with the treatment of these kinds of ailments. This has to be done for a population that will not always be able to afford the real cost of these services.

Table 13 demonstrates the burden of the non-communicable chronic diseases borne by the elderly in Jamaica in 1990. PAHO estimates that in 1995 9.4 per cent of the Jamaican population was 60 years of age or older (PAHO, 1998). In keeping with the findings above the organization points out that mainly chronic, non-communicable diseases affect this group. In 1991, cardiovascular diseases, diabetes and neoplasms were the diseases that most affected the population aged 65 years and over. In similar vein, the 1994 Jamaica Survey of Living Conditions reports that the elderly exhibited the greatest prevalence of chronic illnesses. Most of the ill, 81 per cent turned to private medical institutions in their time of need. At the community level, the aged in August Town a working class community in the parish of St. Andrew reported that their major health problems were hypertension, diabetes, arthritis and heart disease (PAHO, 1998).

Table 13

DISTRIBUTION OF DISEASE BURDEN, BY SELECTED AGE GROUPS, 1990 (JAMAICA)

	Young adults 15-44		Mature adults (45-59)		Elderly (60+ years old)	
	Female	Male	Female	Male	Female	Male
Communicable and maternal	23.0	3.9	2.6	3.3	3.1	3.0
Infectious and parasitic	20.2	2.9	2.0	2.1	1.3	1.4
STD's excluding HIV	16.5	0.1	0.2	0.0	0.0	0.0
Pelvic inflammatory disease	15.9		0.1			
Others	2.8	0.9	0.8	1.1	1.8	1.6
Non-communicable	64.1	36.5	93.1	82.7	94.0	93.1
Malignant neoplasms	9.8	3.9	22.5	16.2	14.1	17.2
Diabetes mellitus	1.7	1.0	12.7	6.4	12.5	6.9
Nutritional endocrine	5.3	2.5	1.4	1.6	1.2	1.5
Neuro-psychiatric	17.8	13.9	9.5	13.0	9.0	9.5
Cardiovascular disease	11.6	6.3	26.5	24.6	45.9	39.4
Chronic respiratory diseases	3.9	2.8	4.4	5.0	2.3	4.6
Digestive system diseases	2.3	2.2	3.0	6.2	2.7	4.1
Genito-urinary diseases	3.8	1.3	3.5	3.4	2.4	6.3
Musculo-skeletal diseases	6.5	1.5	6.4	4.1	1.9	1.6
Oral health	0.9	0.5	0.9	0.6	0.5	0.4
Injuries	12.9	59.7	4.3	14.1	2.9	3.9
Unintentional	10.4	23.6	3.3	7.9	2.7	2.8
Motor vehicle accidents	8.3	17.3	2.1	5.3	0.4	1.3
Falls	1.2	3.8	0.3	1.8	2.0	1.2
Intentional	2.3	36.1	1.1	6.1	0.2	1.0
Self-inflicted	0.2	0.5				
Homicide and violence	2.1	34.9	1.0	6.0	0.1	1.0

Source: World Bank, Draft Report, No. 13407 JM, Jamaica Health Sector Review, HRM Division, Country Department III, September, 1994.

PAHO reports that in the BVI the leading cause of morbidity and mortality among the aged were cardiovascular and cerebrovascular diseases. In Trinidad and Tobago, the population aged 65 and older constituted only 6 per cent of the population in 1995, but it is a proportion that is growing. The leading causes of death among this age grouping were circulatory diseases, neoplasms and diabetes (PAHO, 1998). According to the National Health Survey of 1995, 49 per cent of the persons aged 65 years and over reported that they were afflicted with a long term impairment that restricted activities such as walking, carrying packages, reading or dressing themselves.

As far as ageing and its impact on health-care is concerned the picture that emerges is one of aged populations in the region that are growing in terms of their share of the total population. This is associated with an increase in the importance of Chronic, Non-communicable Diseases in the national epidemiological profile. The ready availability of good quality, affordable health-care in these circumstances is of critical importance. However, changes in the global economy that began in the last three decades of the present century have been associated with economic crisis that threatens the capability of the Caribbean state in terms of its ability to subsidize social services for the population. The alternative to state subsidy is private sector health insurance. However only a minute percentage of the population is covered by private health insurance. The other dimension to this issue is that the aged population needs to develop a culture of regular visits to the doctor. Once the service is available and affordable then it should be used. It is important that the aged population develops a preventive approach to health care. Where this does not exist then public education campaigns should be mounted to promote it.

The quality and availability of health-care systems vary throughout the Caribbean. Belize's public health care sector, for example, is divided into primary, secondary and tertiary levels. There are a total of seven public sector hospitals and two private sector ones. Each of the six

administrative districts into which the country is divided, except Cayo District, which has two, has one hospital. At the primary level there are 44 health centres, 11 of which do not function, and 17 rural health posts. The spread of the hospitals reflect the distribution of the population, with the most heavily populated districts of Belize and San Ignacio carrying 50 percent of the population and approximately half of the total number of hospitals. The health centres are less evenly spread among the population. Thus the district of Stan Creek with a population of 20,140 has 8 health centres whereas Corozal with 31,710 persons only has 5 centres. Approximately 11 per cent of the persons reporting illness in Belize at the time of the Poverty Assessment Report in 1995 were 60 years and over. Approximately, 80 per cent of these persons reported that they sought medical attention. The majority of these persons utilized the public health-care facilities. Approximately 84 and 93 per cent of those belonging to the age groups 60-64 and 65 and over did not have any health insurance. If the aged are able to gain access to good quality health-care in the public sector this lack of health coverage should not represent a problem. The government has to ensure however that the quality of service in these institutions is good and that drugs are readily available to the aged sick for the treatment of their ailments. Short-run monetary and fiscal considerations, however, have made it increasingly difficult for countries in the region to maintain a commitment to the philosophy of health care as a human right. This means that the institutionalization of health insurance is the course that should be pursued with regard to the provision of health-care for the aged. [21]

The public sector health care system also dominates the provision of health care in Saint Vincent. The public health care sector is bifurcated into primary and secondary sub-sectors. The primary care sub-sector has a focus on prevention, public education in health matters and some curative health. The secondary sub-sector has as its concern the provision of curative and rehabilitative services. The aim of pursuing promotional and preventive aspects of health care is furthered through the provision of community and environmental health services. The major secondary health institution the Kingstown General Hospital provides secondary care. These services are supplemented by five small rural hospitals. The private sector provides similar services through two small hospitals that are located in Kingstown. There is also a psychiatric hospital and a geriatric hospital, each with a total of 120 beds. Thirty-eight health centres spread across the country facilitate the delivery of primary health care. Reproductive health, nutrition and health education programmes are administered by district health teams and health committees.[22]

The data from the SLC for St. Vincent reveal that 14 per cent of those persons who reported being ill belonged to the age grouping 60 years and over. Of this amount one third did not seek medical care. The reasons given were ‘don’t know’, ‘not necessary’, ‘went to a friend’ and ‘had medicine at home’. Significantly, none of the aged respondents in Saint Vincent indicated that they were constrained by lack of money or distance from the health facility. With regard to medication none of the aged population reported that they were unable to obtain medication. However as in the case of Belize only a small proportion of the aged in Saint Vincent reported having any health insurance. Only 12 per cent of the aged reported this type of coverage. Given the budgetary constraints that are likely to result from reduced revenues from the export of bananas (the chief export of the country) to Britain the ability of the state to continue subsidizing the provision of health care to the aged has to be seriously questioned. In the absence of health insurance the increased number of aged that will be a feature of the population of this country are faced with the risk that they might not be able to afford the cost of proper health-care.

[21] It might be useful here to apply the distinction between risk and vulnerability. The former indicates potential danger, whereas the latter indicates resilience. The inability of governments to continue sponsoring social services for the population due to economic policy considerations would represent a risk, whereas the institutionalization of health insurance would represent a reduction of the aged population’s vulnerability to the risk.

[22] CPA, Saint Vincent.

The situation is the same in a number of other territories. In Jamaica, for example, as a result of cuts in government's social sector expenditures that started in the 1980s there have been reductions in the public share of financing of health care. By 1993 the public share of financing of health care in Jamaica had declined to 35 per cent down from a high of 60 per cent in 1980. The gap was filled by out-of-pocket expenditures by individuals and private insurance (World Bank, 1994). This is a situation therefore where access to health care has become increasingly dependent on the ability of the individual to pay. Furthermore, conditions in the public health care system are such that in 1992 about twice as many Jamaicans received health care from the private sector as the public sector (Statin, 1994). However, in 1997 only 13 per cent of the respondents in the SLC were covered by health insurance. With reference to the aged only 9 per cent of the 60-64 age group and 5 per cent of the 65 and over age grouping were covered by health insurance.

2. Health insurance

Since susceptibility to disease increases with age we should therefore expect an ageing population to make increased demands on a country's health-care system. Apart from an increase in the susceptibility to diseases in general, ageing brings with it greater susceptibility to chronic diseases such as cancer, hypertension and diabetes. These are diseases that have their origins in the degeneration of the body and are counter posed to those that are exogenous in origin. The ageing of the population in any country is therefore likely to be accompanied by an epidemiological transition involving a shift in the prevalence of diseases with their origins in the environment to the chronic degenerative illnesses. As the population grows older the medical systems in the territories of the region should be equipped to deal with the treatment of these kinds of ailments. The Survey of Living Conditions data indicate that the aged across the region make use of the public healthcare system. The exception to this was Jamaica where deterioration in this sector has led to a preference for the private health care system. In the case of those territories where the public health care system is utilized the threat that emerges as the population ages is that Government's faced with increased fiscal discipline imposed in accordance with Neoliberalism will be unable to continue to provide cheap medical services to the population in general and the aged in particular. The data on health insurance by age is shown in table 14. It indicates the relatively small proportions of the economically active and the even smaller proportions of the aged that are covered by this kind of insurance. Only 28 per cent of the population aged 15-64 and 6 per cent of persons aged 65 years and over in St. Vincent for example reported this type of coverage. In the other territories listed the proportions are not vastly different with Grenada, at 13 per cent, registering the highest level of health insurance coverage for the 65 and over age group.

Table 14

POPULATION COVERED BY HEALTH INSURANCE BY AGE GROUP 15-64 AND 65+

Country	Health insurance			
	15-64		65+	
	Percentage	Number	Percentage	Number
Belize	21.0	453	8.7	18
Grenada	28.1	585	13.0	86
Saint Kitts and Nevis	23.7	379	11.2	34
Saint Lucia				
Saint Vincent and the Grenadines	28.4	323	6.6	9

Source: Survey of Living Conditions for respective countries, 1995-1999.

Provisions for the care of the elderly is a matter that is closely related to health care. With increases in the relative size of the aged population institutionalization will become of greater importance in the future. Experts in the field estimate that at any given time only 5 per cent of the population will be institutionalized, but over time as much as 25 per cent of the aged will have been institutionalized. Projections are that by the year 2020 the population of Trinidad and Tobago will have more aged in its population (235,000) than school-aged children (230,000) (Paul, 2001). As much as one quarter of these persons, or just less than 60,000 will live in institutions for the aged at some point in time. It is therefore important that provision be made for such institutions and that they be organized on the basis of principles that are humane and enabling. The present state of some of these institutions in Trinidad and Tobago does not augur well for the future.

A distinction has been made between nursing homes that are bureaucratic and those that are professional (Paul, 2001). The former is characterized by impersonality and authoritarianism and the latter by decentralized authority systems and openness. Too many of the nursing homes that are in operation at present seem to approximate the bureaucratic rather than the professional model (Paul, 2001). According to Kalish, (Paul, 2001), the staff in the bureaucratic institutions tend to be poorly trained, poorly paid and take no delight in the job that they do (Paul, 2001). Not surprisingly, the elderly in these institutions are often subjected to physical and psychological abuse by the staff (Paul, 2001). This is often coupled with feelings of isolation and financial insecurity.

Case study 3

One 86 year old resident of a home in Port of Spain Trinidad reports that even though she was a member of a credit union and saved on a consistent basis during her working life she was unable to save for her retirement. She lives on the basis of her old age pension, which amounts to $720.00 per month. Of this amount $600 goes for the monthly charge of living in the institution and $120 for medical needs. In answer to the question of what society can do to improve her status she replies, "..people could take us out sometimes because we are just here waiting on death." She points to a lack of respect and dehumanization of the aged by society as one of the negative things about growing old. The respondent reports that upon admission to the institution she was told that she had too many 'good clothes', her clothes were taken from her and distributed to staff and other inmates. During the final interview held with her, the respondent reports that a female member of staff physically abused her a few days before. The woman, she claims, slapped her face and 'stomped upon her as if she was dancing cocoa'. The name of the institution she said should be changed from 'L'hospice to 'Lost Peace' given the physical and verbal abuse the inmates suffer there (Paul, 2001).

Source: C. Paul, "The Life of the Institutionalized Persons in Trinidad and Tobago", Bridgetown, Faculty of Humanities, University of the West Indies, 2001.

The aged are a repository of experience, wisdom and tradition. This kind of treatment of them is not only inhumane and undignified, but also represents a waste of human and social capital that can strengthen the capabilities of these societies at this stage in their development thrust. As the population ages this problem will become of increasing importance.

C. Migration

Migration as here conceptualized has an internal as well as an external dimension to it. These two dimensions although different are quite closely related. They are both manifestations of a quest for personal improvement that the local opportunity structures do not allow to be satisfied. In this section we will consider the impact of internal migration on the community of origin as well as the urban destination. International migration will be considered in terms of its impact on the society of origin. Perhaps no other region in the world has been more profoundly affected by the movement of

its people than the Caribbean. In the historical period this movement was quite closely tied to the fortunes of export agriculture. Crises in this sector were usually followed by an exodus from the land into the urban centers and overseas in search of work. In the modern period (post World War 2) the matter has become a little more complex than that however. The internal and external movement of persons poses similar risks to the region's development. In simple terms, this movement represents a loss of human resources to the community and country of origin. When migration is examined within the context of Globalization it brings into view the fact that the rural to urban move is very often the first stage of a movement that culminates in the metropolitan country (Saskia, no date).

1. External migration

In the case of external migration the mere fact of *greater access* to the North Atlantic countries now has to be factored into the account of why movement takes place. This means that even in conditions of economic boom within the region there would still be high levels of outward movement as long as the North Atlantic countries are willing to receive people from the region. This explains the fact that there were high levels of outflow from the region during the 1960s even while it enjoyed relatively prosperous economic conditions. Having said that, we still have to be cognizant that the tendency to move out of the region will be greatest where limiting social, political and economic conditions exist.

Another way of conceptualizing this issue is to think of the 'pull' factor of 'ability to enter' North America or Western Europe as fixed, or constant, for the territories of the region and then seek to account for cross national variations in emigration rates in the territories. The extent of economic diversification would probably be a good predictor of levels of outward movement in this context. A useful indicator of economic diversity would be the proportion of the labour force involved in agriculture. Those societies that have found alternatives to agriculture would presumably be able to offer greater opportunities for personal advancement at home. This would be reflected in lower levels of outward movement than in countries where such diversification had not taken place. [23] Non-economic factors such as social and political unrest or instability would also influence the magnitude of outward movement from these societies. A case in point is Guyana of the 1970s. This territory saw significant increases in outward movement in the 1970s that coincided with political unrest and uncertainty. Also, note in the table below that it is St. Kitts, which is totally dominated by Sugar and which offers very little alternative to this industry that had the highest levels of outward movement over the 1950-79 period (see table 15).

[23] Historically, these principles have been manifested in the migratory patterns that obtained in territories such as Grenada, Barbados and Trinidad during the late 19th century. The latter territory with its greater economic diversity had very little outward flows at a time when opportunities beckoned elsewhere in the region. Grenada and Barbados on the other hand were dominated by one export staple and saw the exodus of great numbers of its male population to capitalize on these opportunities (Simmons and Guengant, no date).

Table 15
EMIGRATION FROM THE CARIBBEAN

Country	Emigration rate per 100*	Emigration to the United States of America by country (% of population)**
	(1950-1979)	1980-1988
Antigua and Barbuda	23	14.5
Barbados	29	7.2
Belize	19	
Dominica	38	7.2
Grenada	56	9.8
Guyana	25	10.3
Jamaica	35	7.8
Montserrat	67	
Saint Kitts and Nevis	71	22.3
Saint Lucia	44	4.2
Saint Vincent	46	5.5
Trinidad and Tobago	19	2.7

Source: *J. Guengant and D. Marshall, Emigration and Population Dynamics in the Caribbean. **The World Bank, Caribbean Region: Access, Quality and Efficiency in Education. Washington D.C. The World Bank 1993.

2. Internal migration

Movement out of the rural area is given fillip by circumstances of skewed resource distribution and the poverty that is usually associated with it. It is also prompted by the urban bias in the development policies of the governments. A case in point is Jamaica, the largest of the island territories of the English-speaking Caribbean. The existing pattern of settlement in rural Jamaica can be traced to the mid nineteenth century when emancipated slaves moved from the plantations to the hilly interiors. Here, farming villages were established which afforded the former slaves some sense of independence and dignity. Primary economic activity centered on the production of domestic food crops that were marketed in an elaborate marketing system that had its outlets in Kingston and other coastal towns.

In general terms, the system described above has continued until the present day. It constitutes the economic setting within which rural poverty occurs. The small cultivator's income is supplemented by work on large farms and plantations, occasional work overseas, the production of export crops such as banana and cocoa and work on government projects. Approximately one half of the country's population is to be found in the rural area but agriculture contributed only 5.7 percent to GDP in 1991. Domestic agriculture contributed 3.1 percent to GDP in the same year (Statin, 1991). Low levels of productivity in this sector are associated with a number of factors. Poor interior roads, the small size of land holdings, poor quality lands, the absence of irrigation facilities, and technical advice services, the low educational levels of the farmers and a generally poorly developed rural infrastructure go a far way in accounting for rural poverty. In addition there is the difficulty of gaining access to credit due to its high cost and the absence of land titles that would enable land to be used as collateral. Estimates from officials in the ministry of Agriculture suggest that these factors are associated with the impoverishment of sixty thousand rural families.

The skewed distribution of land bears emphasis. Studies conducted in the rural parish of Westmoreland have indicated a clear relationship between the size of land holdings and malnutrition.[24] Figures from the latest agricultural census indicate that of the 1,327,045 acres of

[24] Omawale and McLeod, 1978, "Food Consumption and Poverty in Rural Jamaica", mimeo: 1978. This study found that while protein-energy ratios were generally adequate, fully one-third of the households had energy intakes below 80% of the recommended dietary allowance. This food deficit varied with size of land holding, being greatest among landless households and least amongst the 3-6 acres category, the largest surveyed.

farmlands in the country 212,679 acres or 16 percent were in farms of between 0-5 acres. These constituted 82 percent of all the farms in the country. On the other hand, farms 500 acres or more in size occupied 588,371 acres or 44 percent of the land, and amounted to only 0.15 percent of all the farms in the country (Statin, 1985).

Internal migration in Jamaica became significant with the collapse of the sugar industry in the late 19th century. Along with external migration it signaled the population's response to increased levels of unemployment, underemployment, and low wages. In this era there was a sexual division in the response with males going overseas as labourers and women to newly emerging urban centers as domestic servants (Austin-Broos, 1985). By 1911-1921 some 6 percent of the island's population was involved in the internal migration process. This rose to an all time high of 20 percent in the 1943-1960 period; declined to 13 percent in 1960-1970 before rising to 15 percent in 1970-1982, the last intercensal interval for which data are available. In the pre-war era the movement was mainly from rural parishes into the parish Kingston. Beginning in the 1950's the parish of St. Andrew (The suburban area of Kingston) became the most popular destination of rural migrants.

During the period 1943-1960, Kingston's annual growth rate declined to under 1% per year whilst that of St. Andrew was in excess of 5% per year. The period 1960-1970 saw a reversal of Kingston's growth position to one of decline (1.2 % per year) and a slowing down of St Andrew's previously high growth rates. St. Catherine, a parish contiguous to St. Andrew, became the second fastest growing parish during this period. This development had to do with the creation of huge housing estates in the Portmore area of the parish. These became home for many who had previously resided in the parishes of Kingston and St. Andrew. The primacy of the growth of St. Catherine due to its popularity as a destination for internal movers has been the distinguishing feature of the internal migration process since the 1970's. Preliminary estimates from the 1991 census put Portmore's population at 96,700 and the number of dwellings in excess of 20,000 (Statin, 1991). The only other parish to experience net inward migration besides St. Andrew and St. Catherine has been St. James. This parish, with its well-developed tourism sector, is the second most urbanized area behind the Kingston Metropolitan Area. Throughout all the periods females have had greater involvement in the process of internal movement than men (Roberts and Nam, no date).

D. Migration as a source of risk

1. International migration

In considering international migration as a source of risk we have to be mindful of the fact that its character has changed in the past two or three decades. Migration has it has occurred in recent years can be conceptualized as a transnational process in which Caribbean migrants have had to forge a Janus-faced existence in order to cope with the recent circumstances created by global capitalism. In practical terms, this means that many Caribbean migrants now live in two places, the host society and the society of origin (Pessar, no date). The immediate loss that the process represents has to be factored against the returns that the transnational migrant brings on his/her return or sends in the form of remittances.[25] The magnitude of the return process is not exactly known. A recent study of the process in the OECS Territories in the Eastern Caribbean estimates that up to 10 per cent of the population was involved in return travel to these territories during the 1980s (ECLAC, 1998). Even so it seems clear that the movement of professional manpower out of the public sector via the route of external migration does have adverse effects on the provision of social services.

[25] Remittances constituted one of the mainstays of the Jamaica economy in the late 1990s.

A recent study of the effect of external migration on the public health care system in Jamaica found that external migration was responsible for 60-70% of the shortages in the public health care sector in the country in 1990 (Brown, 1997). This has had a negative impact on the quality of the care provided by the public health care system. In practical terms the shortage finds expression in the breakdown in the professional socialization of the young nurse due to the absence of senior nurses on the wards. It also is expressed by the nurse/patient ratio that exists in the public institutions. Senior nursing personnel indicate that ideally the nurse patient ratio should be 1:10 in the case of able patients and 1:3 in the case of critically ill patients. In practice the ratio that obtains in the public health care system is 1:50. The following extract from the study is illustrative of how the shortage of nurses has affected the delivery of health care at one of the major public hospitals in Jamaica.

Case study 4

"When the orthopaedic ward of the hospital was visited a lone nurse was on duty. She gave the impression of being an amicable sort of person but was obviously angry and frustrated about her job and the conditions under which she had to work. She had only been a nurse for six months. This evening she was in charge of the ward since she was the only nurse on duty. This was not unusual, indeed, all of next week she expects to work by herself on this ward.

The nurse said that eight registered nurses should man the ward, yet the maximum amount which ever worked on it was two. Oftentimes in circumstances such as these she was not relieved at the end of her shift and had to do a second one. She reported that sometimes when no one came to relief the lone nurse on duty the ward was split in two and the patients distributed to other wards.

The only assistant whom she had, a cadet or auxiliary worker repeatedly interrupted my conversation with her. The cadet asked for directions as to how to comfort patients who were in discomfort, or was given instructions as to how to administer medication. The nurse complained that the work left her feeling exhausted and did not allow for social life. She was in an advanced state of pregnancy and feared that overwork would cause her to have a premature baby as, she said, has been the case with a number of other nurses. This was not the worst of her fears. The policy of the hospital prohibits pregnant nurses from attending to AIDS patients. The shortage has, however, caused her to have to nurse these patients (Brown, 1997)."

Source: Dennis A.V. Brown, "Workforce, losses and return migration: a case study of Jamaican nurses", *Caribbean Circuits: New Directions in the Study of Caribbean Migration*, Patricia Pessar (ed.), New York, Centre for Migration Studies, 1997.

This study demonstrates that notwithstanding the fact that many of the nurses who migrate send remittances, upgrade their existing skills and obtain new ones, and in many instances return home, their absence form the health care sector has a negative impact. Therefore while we have to be cautious in our use of net migration figures as indicators of net loss to the society, they do provide some indication of immediate loss of capacity within the society. The loss of professionals through emigration is also illustrated by the recent efforts at the recruitment of secondary school teachers throughout the Caribbean region to the New York Public School System.

(a) Intra-regional migration

Apart from travel outside of the region there is a well-established process of intra regional travel. This pattern of travel has its origins in the 19th Century when the sugar industries of Trinidad and Guyana boomed while the industry in the rest of the region suffered decline. In recent times the differential impact of the Globalization process has been associated with the creation of poles of economic growth and zones of economic decline in the region. This has led to the movement of persons from the poorer to the wealthier countries in the region. In some cases this movement has involved vast numbers of persons and has had profound demographic and social effects on the

receiving countries. Countries such as the Anguilla, Antigua and Barbuda, the Bahamas, Barbados, the British Virgin Islands, Nevis and Trinidad and Tobago, as well as Montserrat, and the Turks and Caicos Islands[26] have been affected in this way.

The outcomes of these movements have a number of sociodemographic, economic, environmental and political risks for both sending and receiving countries that subjects them to vulnerability. These include, in many receiving countries, the formation of squatter settlements; increases in household size leading to overcrowding; problems of assimilation, especially in cases where the migrant population speaks a different language; increased burdens on social services, including health and education; and the loss of the rewards of productivity due to remittances being sent out of the country by the migrant to his or her country of origin. The host society has access to a pool of cheap labour that is often ready and willing to take jobs that are perceived as inferior by nationals, as well as filling labour gaps where the necessary skills cannot be found among nationals. Migrant labour is also often willing to work for lower wages than nationals. This can cause a general depression of wages in the labour market.

Demographically, the influx of persons in search of work has resulted in increased population size, there has been a distortion of the age structure in these countries, increased fertility rates and increased population density. Socially, there is often times friction in the relationship between immigrant and local. In some instances this is exacerbated by language and cultural differences as in the case of the Haitians in the Turks and Caicos islands. Just as important is the burden that is placed on the existing housing stock and the provision of social services (ECLAC, 1998). The situation in the Turks and Caicos Islands a small set of islands at the foot of the Bahamas chain of islands illustrates the situation of a number of microstates in the Caribbean. Until relatively recent times these islands had been in a state of economic stagnation. They were in fact net exporters of people. The emergence of a tourism product on one of the island, Providenciales, reversed this situation and led to economic boom and the inflow of large numbers of persons from across the Caribbean in search of work. Table 16 below shows the dramatic increases in population associated with the economic boom in the tourism sector beginning in 1980.

Table 16

POPULATION IN CENSUS YEARS BY ISLAND

Island	1960	1970	1980	1990	1998 estimated
Grand Turk	2,180	2,287	3,098	3,691	4,000
Salt Cay	448	334	284	208	100
South Caicos	840	1,018	1,380	1,198	1,200
Middle Caicos	532	362	396	272	200
North Caicos	1,150	999	1278	1,275	1,500
Providenciales	518	558	977	4,821	17,000
Total	**5,668**	**5,558**	**7,413**	**11,465**	**24,000**

Source: Turks and Caicos, Census of Population; Institute for Health Sector Development, Turks and Caicos Islands: Development of Health Sector Strategy.

Similar inflows in the British Virgin Islands were associated with a 47% increase in population between 1980-1991. The number of persons in three age groups 35-39, 40-44 and 45-49 years more than doubled during this period. The median age of the population moved from 23.1 to 27.0 years changing it from a young to an intermediate population. The movement to the BVI was dominated by males. By 1991 26 per cent of the households in that country had at least one foreigner as a principal (ECLAC, 1998).

[26] The Turks and Caicos Islands is a British dependency in the Caribbean that up until the 1960's was administered as a part of Jamaica. Their migration experience highlights the effect of intra-regional migration on Caribbean microstates. The migrants are made up of returning nationals, Haitians, Santo Domingans, Jamaicans, Guyanese and nationals from the OECS, among others.

The issues relating to immigrants in host societies are numerous. The problems they face in their new society represent risks to their societies and communities of origin. Living conditions and the labour market are two such problems. In Anguilla, for example, many nationals have improved their own housing conditions by exploiting the housing shortage caused by the influx of foreign persons. They rent substandard housing to immigrants and use the rent to buy new houses or upgrade their own housing. This has meant that the housing condition of many immigrants is appalling (Brown and Brown, no date). In Antigua and Montserrat, there is a perception by nationals that the willingness of migrants to accept employment at low wages has served to unfairly depress wage rates in the labour market. This in turn, it is felt, has led to unemployment among nationals. This claim may in fact have some validity since data already reveal that the majority of migrants in the more common occupations are female. The combined effect of being a migrant and a female might serve to noticeably depress wages in the labour market. Table 17 is illustrative of this situation. It shows monthly average earnings by industry and sex for Antigua and Barbuda.

Table 17

MONTHLY AVERAGE EARNINGS BY INDUSTRY AND SEX - ANTIGUA AND BARBUDA

Type of industry	Monthly average earnings 1996 ($EC)		
	Male	Female	Total
Hotels and restaurants	1,848	1,400	1,602
Wholesale and retail trade	3,600	2,050	2,845
Banks	4,906	3,586	3,962
Other financial institutions, real estate and shipping	2,818	2,111	2,494
Chemicals, paints and detergents	2,980	2,389	2,749
Printing and publishing	3,019	1,910	2,499
Manufacture of wearing apparel	2,246	1,073	1,266
Manufacture of food and beverage	1,850	1,082	1,407
Manufacture of wooden furniture and fixture	1,478	1,373	1,440
Petroleum wholesale establishments	4,489	3,533	4,340
Manufacture of fabricated metal products	1,834	1,950	1,852
Manufacture of bakery products	1,969	1,048	1,679
Electrical assembly and manufacture	1,969	1,048	1,679
Dairy products	1,882	1,048	1,679
Agricultural sector	1,524	1,252	1,396
Airline industry and related fields	5,100	3,350	4,447
Construction and engineering	2,983	2,172	2,902
Accounting companies	4,818	1,394	3,899
Primary and pre-schools, secondary and other educational institutions	1,926	2,068	2,037
Marinas and yacht charters	2,395	1,975	2,212
Car dealers service stations	2,867	1,446	2,185
Jewelry and perfume shops	3,158	2,432	2,550
Other manufacturers	1,833	1,158	1,327
Clothing,variety and general merchandise stores	1,391	922	1,021
Pharmacy and medical establishments	3,228	2,009	2,300

Source: Annual Report of the Labour Department 1996-1997.

In regard to social acceptance, locals do not always view migrants favourably. They have been seen as directly and indirectly influencing criminal activity and social disorder in some of the host countries. The Government of Antigua and Barbuda has directly addressed these issues, and it was one of the campaign issues in the elections held in March 1999, following the rise in criminal activities in the island. In the Turks and Caicos Island, locals, or 'Belongers' have viewed the inflow of Haitians, both legal and undocumented negatively. At the same time, the undocumented

Haitians are exploited sexually as well as for their labour power.[27] Informed estimates put the number of non-nationals, including Haitians, as high as 50% of the total TCI population. While their labour power is needed to service the economic development that is taking place they are regarded as outsiders even in cases where they have lived in the country for many years. The flow of undocumented Haitian immigrants into Turks and Caicos has resulted in the creation of a substantial 'bush' community on the island of Providenciales. Here, newly arrived undocumented immigrants and those who have been unsuccessful in finding a livelihood live in the bushes under very harsh and dehumanizing physical and social conditions. The case of Jean Pierre is instructive.

Case study 5

Jean Pierre arrived in TCI by boat five days before the interview took place. He used to be a vendor of small items in Haiti. He has a wife and child in Haiti. He describes his conditions of living there as "not good". He did not have a house and even though he had food to eat, life was a struggle. Jean Pierre is 41 years of age, he has no skill and is not able to read and write, as he got no opportunity to go to school. His wife and children are surviving on monies that he acquired by selling some of his possessions. They are waiting for him to send monies back to Haiti. If they don't hear from him they will have to go back to family and relatives. Given the situation with which he is now faced he realizes that the prospects for him in the Turks and Caicos Islands are not very good and that he will probably have to return home. However, he wants very much to at least acquire the monies he spent for his passage from Haiti. He came with no money and has survived on the kindness of people in the local community. In the bushes where they live, mosquitoes feast on them. When it rains a number of them stand up holding a big piece of plastic. On one occasion the rain was so heavy that they had to end up letting go of the plastic and just letting it wet them. In the bushes they are not able to build permanent structures since local immigration officials raid the area frequently and they constantly have to be on the move. Jean Pierre says there are women but no children living under these conditions in the bushes (Brown, no date).

Source: Dennis A.V. Brown, "Between Two Worlds: A Study of Migration and Poverty Among Haitians in the Turks and Caicos Islands", unpublished, 1999.

Although not among the countries covered by this study the situation of these undocumented Haitian immigrants portrays in a dramatic way the risks posed to poor communities and households when their members venture overseas in search of betterment. It is not only the undocumented immigrant that faces problems of this nature. Policy-makers in these territories are beginning to consider measures to limit the outward flow of resources in the form of remittances to families in the home country of all immigrants. It is argued by these policy makers that policies need to be put in place to ensure that more of the returns from productive activity stay within the country in which this activity is taking place. More than this is the fact that many countries in the Caribbean have also felt the need to put strict immigration policies in place to limit immigration into their countries. In Antigua, for example, a policy of standing operational procedures has been initiated to guide Labour and Immigration Policy into the present century. It is referred to as the Labour Immigration Alliance procedure. Other countries in the Caribbean, for example Anguilla, have variants on such policies and are actively considering modifications to existing policies for more effective control of visitors to the islands.

[27] A young Haitian woman, an undocumented immigrant, related how drug addicts would come into the bush and rape the young women knowing that they would not be able to go to the police because of their immigration status.

There are other influences in the host societies that are induced by the inflows of migrants. These include for example:

- changes in the kinds of food stocked by supermarkets;
- the need to address the problem of language in order to integrate the non-English speaking children into the school system, and
- increased rates of divorces and separation in the island, partly due to marriages of convenience in order to gain citizenship and residence status.

Migrants have displayed different tendencies, depending on their countries of origin, in the manner in which they choose to integrate themselves into their host society. Migrants from Santo Domingo, for example, have banded together and are living in specific and identifiable communities in Anguilla. They have also taken specific steps presumably to keep their own culture alive and deal with the language problem that many confront. One such action was to have their own radio station. Other migrants like the Guyanese and Jamaicans have integrated themselves into the society and by living wherever housing was available.

2. Rural to urban migration

Since it is the population of working age that usually moves away it means that demographically this movement would be associated with the ageing of the population in the community of origin. Table 18 shows the age distribution for the urban and rural areas of Jamaica.

Table 18

AGE PROFILE OF POPULATION BY AREA, 1993 - JAMAICA

Age group	KMA	Other towns	Rural areas
0-14	31.1	36.5	37.4
15-64	61.8	57.6	51.9
65+	7.2	6.0	10.6
Total	100.0	100.0	100.0
Age dependency ratio	62.0	73.8	92.5

Source: Jamaica Survey of Living Conditions 1997, PIOJ.

Table 19 shows that the pattern of relatively high proportion of aged and very young is repeated in Swift River Valley a rural community in Portland, one of the poorest parishes in Jamaica. It is a community that would be subject to high rates of outward migration. The greater age dependency ratio brought about by out migration from the rural areas may be one of the sociodemographic bases for the higher incidence, intensity and severity of poverty in rural Jamaica (Survey of Living Conditions, 1992). High dependency ratios in rural households are compounded by the fact of high levels of population with primary school education only and high rates of unemployment among the 15-29 age group. In Portland for example, in 1991 43% of the population had primary school education only, while 31% of the population aged 15-29 was unemployed. This compared to 15 and 20% respectively in St. Andrew, the major urban center in the country and to which it is contiguous (Planning Institute of Jamaica, 1996).

Table 19
AGE PROFILE OF SWIFT RIVER VALLEY (A RURAL DISTRICT IN JAMAICA) POPULATION CENSUS 1990

Age group	Frequency	Percent
0-14	492	34.6
15-64	747	52.6
65+	181	12.7
Total	1,420	100.0
Age dependency ratio		90.1

Source: Statistical Institute of Jamaica 1990 Population Census.

High levels of outward movement from the rural areas in Jamaica have resulted in heavy concentrations of population in the main urban centres in the country. The turn to export oriented growth in the 1980s has been associated with the promotion of export oriented economic development and the promotion of export production centers in the fields of agriculture, textiles, small manufactures and tourism. In many instances this took place away from the main urban centre. At the same time the old import substitution industries concentrated in the established urban center have waned. This it is argued has led to a decline in urban primacy as the rural migrant has targeted these destinations, outside of the main urban center (Portes, 1997). Still, Kingston has been identified as one of the most socially polarized cities in the Caribbean and Central America (Portes, 1997). The social configuration reflected in its residential pattern is said to resemble an inverted ice-cream cone. Here the squatter/shantytown settlements are located at the base with the elite settlements in the upper socioeconomic category being found at the apex (Portes, 1997). The residential pattern and conditions of living in Jamaica's main urban center has mirrored the economic circumstances that have confronted the country. Economic decline and stagnation has been reflected in residential patterns and conditions of living in the Kingston Metropolitan area.

Table 20 shows that the difficult economic times gave rise to increased unemployment, growth in the informal labour market and reductions in the numbers who bothered to seek for employment. The emergence of new high-income housing settlements in the north and middle of the traditional suburban area was matched by a 'rapid growth of inner ring irregular settlements', in the same areas by the poor. This gave rise to juxtaposed extremes of wealth and poverty (Portes, 1997). These 'irregular settlements' were some of the areas in which the urban unemployed and those involved in the informal labour market resided. These developments have coincided with an explosion of crime and drug related activities.

The levels of unemployment and overcrowding in these new poor communities and the already established ones are noteworthy. Using 1991 census data a report on the spatial representation of poverty in Jamaica notes unemployment rates as high as 40 and 45 per cent in the poor urban communities of Rennock Lodge and Riverton City, (at the base of the cone) (Planning Institute of Jamaica, 1996). A measure of overcrowding is the statistic from the report that indicates that approximately 60 per cent of the households lack exclusive use of water closets (Planning Institute of Jamaica, 1996).

Table 20

KINGSTON'S LABOUR MARKET, 1977-1989

	1977	1983	1989
Formal sector employment %	60.4	-	53.3
Public sector and services	23.7	-	14.0
Informal sector employment %	17.4	-	26.0
Vendors			
Males	4.1	-	5.8
Females	8.8	-	12.5
Small services and agriculture %			
Males	10.7	-	6.8
Females	8.6	-	7.7
Unemployment %			
Males	17.5	21.0	11.4
Females	29.9	35.3	21.8
Labour force participation %			
Males	82.9	83.5	78.1
Females	70.1	71.1	64.0

Sources: Gordon and Dixon 1991 in *Portes, et. al*., 1997.

VII. Conclusion

This paper has examined the role of demographic factors in predisposing Caribbean society to vulnerability. It has been argued that there are aspects of the region's demography that represent potential or immediate danger to the its people in their quest for equity, participation and sustainable improvements in their standard of living. Against the background of an examination of the major demographic trends that have occurred in the region the paper examines the extent to which risk or threat to its development objectives reposes in recent movements in the areas of fertility, mortality, migration and population structure. It is suggested that vulnerability is a function of the region's stock of capabilities that enables it to respond to threats posed by different sociodemographic risks.

In the area of fertility, threat presented itself in the form of lags, or delays in the general pattern of decline evident in the region. This occurred among women in disadvantaged socioeconomic groupings across the region and was manifested in teenage pregnancy and frequent births thereafter. Case study data seem to suggest an intergenerational dimension to the phenomenon. This situation obviously presents a threat to the region in terms of the inability of these young women to properly prepare themselves and their families for full and active participation in the economy and society of the countries to which they belong.

The attitude of fatalism and a sense of powerlessness seem to shield these young women from the influence of the conventional family planning strategies. The policy recommendation in this area centres on the targeting of young girls from socially disadvantaged backgrounds while they are still in primary school in order to help

them understand the possibilities that life has to offer if they are properly trained and qualified. This calls, as well, for tangible support at the level of the household from which these girls come. Apart from the provision of material support (books, uniforms, lunch money) this should take the form of counseling for the mother and child. Funds that are now used by the Family Planning Associations to send diffuse messages to the population might be one source of finance for such a programme.

The analysis of demographic dependency pointed to the fact that the region was in a transitional stage of its demographic development. Whereas fertility and mortality had registered varying levels of decline across the region this had been recent enough to mean that the population structure although showing signs that the aged are about to become a significant grouping in the population still reflected high levels of youth dependency. This meant that overall the economically active age groups carried a relatively heavy dependency burden. This was reflected more so in the poorer households where relatively high levels of fertility had left a legacy of many young people. In the case of the aged the data indicate that many of their basic needs are not being met. To these persons this represents an immediate danger or threat to their existence. In global terms, however, the situation of the aged at present constitutes a risk, or less than immediate threat to the region since at the present they still constitute a relatively small part of its population. The data on the aged in Barbados, though, seems to indicate that in the not too distant future the aged will come to represent a significant proportion of the region's population. With the exception of this country and possibly Trinidad and Tobago the relatively heavy youth dependency in the population is going to constrain government's ability to attend to the aged through the provision of adequate pension and health insurance and proper old age institutional facilities. Even in these two countries there is some indication that the provisions as they exist are inadequate. Barbados especially, because of its low levels of dependency has a window of opportunity to make proper plans for the provision of old age benefits while at the same time devoting resources to provide the young with first rate opportunities in their education and training. In a short while the aged in that society are going to increase in size relative to the economically active population, thus making it increasingly difficult to find the revenue to make proper provisions for them.

Migration in its internal as well as its external dimensions has been an extremely important factor in the shaping of the region's demographic circumstances. Both types of migration can be seen as attempts to broaden the scope of opportunities available to the population. In this regard, limiting circumstances in the rural areas of the countries of the region and the mere existence of access to the countries of the Developed World have prompted a movement to that part of the world that in many instances used the regional cities as staging areas. Certainly in the case of Jamaica, this cannot be divorced from the greater hardships experienced by rural households. The urban economy has been unable to absorb rural emigration, leading to high levels of unemployment, the growth of an informal economy and irregular housing development in the midst of planned high income housing schemes. This latest development has seen the emergence of shanty type communities in the interstices around the upper income housing estates. This supplements the older pattern of spatial segregation of wealthy and poor communities. Neither modality of social segmentation augurs well for the development of social capital in the Caribbean.

International migration poses the sociodemographic risk of loss of the skilled and qualified economically active workforce. These have to be considered, though, in the light of the obvious benefits that the societies of the region enjoy as a result of the circular movement of people and resources. Having said that, it has to be acknowledged that high levels of movement of the skilled and qualified human resources of the region weakens the capacity of the state to provide high quality services to those members of the public who have no alternative to this source. One recommendation that comes to mind in this regard is the declaration of these professionals as international public goods whose training is undertaken by the countries that benefit from their services. The professional would then be obliged to devote professional time in all of the societies that undertook the cost of their training.

A second area in which international migration represents a source of vulnerability to these societies in their quest for development centered on equity and participatory citizenship is intraregional migration. Here the pattern that emerges is movement from the less economically to the more economically prosperous societies in the region. This disparity has been heightened with the advent of Globalization and Neoliberalism. Where the prosperous societies happen to be very small countries then the impact of the inward movement has been quite socially deleterious for them. In many instances the inward movement has distorted the demographic structures and processes of the host society, created social tensions and overwhelmed the capacity of the country to provide adequate housing and social services to the public. Threat to the emigrant inheres in the form of marginalization, lack of acceptance and exploitation by the host society. Policies need to be put in place to regulate the flow of persons into these societies. This is especially the case where large numbers of undocumented immigrants are involved. The strengthening of cooperation between authorities in the sending and receiving countries is important in this regard.

The period at the dawn of the 21st century represents a juncture in the region's development where economic growth cannot be successfully pursued outside of a framework of equity, human rights and justice. The region's recent history seems to suggest that those societies that attempt to do so run the risk of serious loss of social capital and the establishment of inefficient and unproductive economic systems. The region ought to aim for the synergy produced by these seemingly disparate factors. In doing so we have to be aware of the risks posed by its demography.

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