

UNFPA Baseline Study

JAMAICA
ST. LUCIA
SURINAME
TRINIDAD AND TOBAGO
GUYANA
BELIZE

Final Report

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TERMS OF REFERENCE

The terms of reference approved for this project are summarized below:

- 1) Execute a baseline study for the following categories of countries in the Caribbean sub-region:

Group B

Belize
Guyana
St. Lucia

Group C

Jamaica
Trinidad and Tobago
Suriname

- 2) The baseline study should include specific activities detailed under Population and Development Strategies and Reproductive Health Strategies

Output 1 and Output 2

OUTPUT 1

“Improved capacity for socio-demographic data collection, analysis and integration into the formulation, implementation and evaluation.”

SPECIFIC ACTIVITIES

Systematize existing data on:

- Population structure and its characteristics
- Poverty (elderly, women, youth)
- Returning Residents
- Gender-based violence
- Disability
- Contraceptive Use
- HIV/AIDS

STRENGTHENING INSTITUTIONS IN GENERAL

Training programmes (basic, intermediate and advanced training).

OUTPUT 2

“Incorporation of key population and development factors in poverty alleviation and development strategies”.

SPECIFIC ACTIVITIES

1. National policies on:
 - Population
 - Migration
 - Ageing (elderly)
 - Disability
 - Adolescents (youth)
 - Women (gender)
 - HIV/AIDS
 - Health Reform

JAMAICA

BASELINE STUDY REPORT

(i) JAMAICA

Demographic Background

Jamaica has almost completed the demographic transition from high fertility and mortality rates and consequent low growth rates to low fertility, mortality and growth rates. The total fertility rate has declined from 5.7 children in 1960 to 2.8 children per woman in 1997. On the other hand, life expectancy at birth had increased from 37.1 in 1960 to 75 years in 2000. Overall, annual rate of population growth has declined from 1.4% in the 1970s to 0.9% in the 1990s. The structure of the population has also changed considerably in the past forty years. In 1970, 45 per cent of the population were below 15 years of age, but this age group has declined by a third to 32 per cent by 2001. On the other hand, the population aged 60 years or over, the elderly, has risen from 8.5 per cent of the population in 1970 to 10.2 per cent in 2001 (STATIN 2003). As a result of these changes, the proportion of the population between 15 and 59, the engine of development, has risen from 47 per cent in 1975 to 57 per cent in 2001, a potential demographic bonus, if they have skills and opportunities for employment.

With this background material, we turn to a more detailed consideration of the major components of the population and relevant policies pertaining to them.

THE ELDERLY

As indicated in the previous section, the proportion of the elderly in the population has been increasing. The 1991 Census of Population indicated that 10.04 per

cent of the population were 60 years or older. The 2001/2002 census data also show that this proportion marginally increased to 10.15 per cent. Table 1 shows projected data for the elderly up to 2025 and 2050. The elderly will be 14.5 per cent of the population by 2025 and almost a quarter of the population by 2050. Other points are worth noting. The 60+ group is growing faster than the total population (1.2% v 0.9% in 2000-2005) and this is bound to increase in the future. There are more females than males among the 60+ group. The sex ratio worsens as the 60+ ages, that is, 80 males to 100 females by 2025 for the 60+ age group to 61 males to 100 females in 2050 among the 80+ group. Relatedly, at the older ages, females continue to live longer than males. Finally, the labour force participation of elderly females is less than half the level of elderly males, a trend that begins at younger ages. For example, Anderson (2000) has noted that among young persons aged 14-24 years, female unemployment rate was 42.9 per cent compared to males at 23.9 per cent. For youths without any secondary school, 52 per cent of the females were unemployed compared to 13 per cent of young males.

Table 1: Projected Demographic Characteristics of Jamaican Elderly 2025-2050

Total Population	Age	2025	2050
		3263.7m	3815.5m
% in Older Ages			
Total Population	60+	14.5%	24.0%
	65+	9.9	18.1
	80+	2.1	4.8
Female	60+	15.9	25.7
	65+	11.0	19.9
	80+	2.5	6.0
Male	60+	13.0	22.2
	65+	8.8	16.4
	80+	1.7	3.7
Median Age (yrs)		32.7	39.0
Ageing Index		62.9	123.8
Potential Support Ratio		6.8	3.4
Sex Ratio (per 100 women)	60+	80.3	85.4
	65+	78.5	81.8
	80+	67.9	60.9

Growth Rate (%)		2000-2005	2025-2030	2045-2050
Total Population		0.9	0.8	0.4
60+		1.2	3.2	1.9
65+		0.8	4.0	2.4
80+		2.0	3.0	3.1
Life Expectancy (yrs)	Age	2000-2005	2025-2030	2045-2050
Total	0	75.7	79.0	80.8
	60	21.3	22.9	24.0
	65	17.4	18.9	19.9
	80	8.3	9.1	9.7
Female	0	77.8	81.2	83.1
	60	22.4	24.4	25.6
	65	18.4	20.2	21.4
	80	8.7	9.9	10.6
Male	0	73.7	76.8	78.6
	60	20.0	21.3	22.2
	65	16.4	17.5	18.2
	80	7.7	8.2	8.6
Labour Force Participation (%)	Age	1990	2000	2010
Total	65+	37.4	34.3	31.6
Female	65+	23.7	22.3	21.0
Male	65+	53.8	49.3	44.8

Source: United Nations, *World Population Ageing 1950-2050*, New York, 2002, pp. 284-85.

The Elderly and Poverty

Table 2 indicates the relationship between age and poverty.

Table 2: Age Distribution by Poverty, Jamaica 1998

Age Group	Population	% Poor	No. of Poor	Share of Poverty
0 – 3	237,300	18.4	43669	10.2
4 – 5	111,900	20.6	23053	6.0
6 – 11	310,700	18.7	58105	16.1
12 – 18	357,200	17.8	63590	16.2
19 – 24	288,300	15.9	45841	9.8
25 – 64	1,087,000	12.7	138059	32.9
65+	183,800	17.9	32917	9.6
	2,576,400	15.9	405233	100.0

Source: UNICEF, *Jamaican Children and their Families: A Situation Assessment and Analysis 1999-2000*, n.d., Table A4.

Eighteen per cent of the elderly population were poor in 1998, a proportion that would likely have been more, maybe at least 20 per cent, if the elderly had been defined as those aged 60+. Even as defined in document, the elderly aged 65+ experienced more poverty proportionately than the national average of 16 per cent.

Elderly persons tend to have a high rate of self-reported illness, and remain ill for longer periods with reduced ability to undertake activities necessary for daily living. One consequence of the poverty noted above is that an elderly person is not able to take care of the cost of his/her medical bills or afford a reasonable insurance coverage to assist with the bills. This situation aggravates the poor health conditions of the elderly.

WOMEN

Females constitute 51 per cent of the population at present (STATIN, 2003, p. 6). They were more dominant in the past. Table 3 shows the sex ratio (males per 100 females) by age groups for censuses since 1960.

Table 3: Sex ratio (Males per 100 Females) by Age Groups 1960-2001 Census Years

Age Group	1960	1970	1982	1991	2001
0 – 4	101.5	101.6	101.2	101.7	103.7
5 – 14	100.4	101.0	101.5	101.2	102.6
15 – 29	85.0	92.8	94.7	95.1	96.0
30 – 44	87.3	89.6	95.9	93.8	92.2
45 – 64	96.7	94.1	92.3	96.7	100.1
65+	69.4	79.5	84.2	85.4	83.9
Total	92.5	95.5	96.3	96.2	96.9

Source: STATIN, Population Census 1991, vol. 1, Part 15, P. XVI, 1996.

Population Census 2001 Country Report, 2003, pp. xxvi, 6.

G. W. Roberts, Recent Population Movements in Jamaica, CICRED, 1974.

The sex ratio shows that although the proportion of males in the total population has been on the increase since 1960, females outnumber males. Except in the 0-14 age group, this situation holds true in almost all the age groups. The elderly population aged 65 years or older witness the sharpest decrease in the proportion of males, the sex ratio ranging between 69 and 85 males per 100 females during the period. This deficit of males in the older ages is due primarily to the longer life expectancy of females than their male counterparts.

Table 4 below shows the average annual employment in 1999 and 2000.

Table 4: Employment by Age and Gender 1999 and 2000

Age Group	Male		Female	
	1999 Annual Average (000)	2000 Annual Average (000)	1999 Annual Average (000)	2000 Annual Average (000)
Youth (14 – 24)	113.1	113.0	65.8	65.7
Adults 25+	437.1	439.5	327.8	315.4
25 – 34	167.3	168.7	133.2	126.5
35 – 44	106.0	106.9	87.0	83.9
45+	163.8	163.9	107.7	105.0
Total	550.2	552.4	393.6	381.1

Source: PIOJ, Economic and Social Survey Jamaica 2000, April 2001, p. 21.3.

Total average employment for males increased marginally from 550,200 in 1999 to 552,400 persons in 2000 or an increase of 0.4%. However, females experienced a decline from 393,600 to 381,100 persons, or a decrease of 3.2%. Adult women, 25 years or older, experienced a reduction of 3.8% between 1999 and 2000, or a total loss of 12,400 jobs. This indicates that the burden of loss of jobs between 1999 and 2000 was borne by

adult women. According to the *Jamaica Survey of Living Conditions*, this finding “underscores the need for greater emphasis on women in job creation efforts, as in spite of progress made, they continue to display greater labour market vulnerability than men” (PIOJ, 2001, p. 21.6).

Table 5 shows that unemployment among females in 2000 stood at 22.3 % or more than twice the unemployment rate among males (10%). That this trend has long been with us is demonstrated by Table 6 which illustrates unemployment rate by gender since 1990.

Table 5: Levels of Unemployment by Gender and Age Groups, 1999-2000

Age Groups	Males (000)				Females (000)			
	1999 Annual Average	Rate %	2000 Annual Average	Rate %	1999 Annual Average	Rate %	2000 Annual Average	Rate %
Under 25 years	35.6	5.8	35.2	5.7	56.4	11.1	49.2	10.0
25 years or over	25.8	4.2	27.4	4.5	57.4	11.3	60.0	12.2
Total	61.4	10.0	62.5	10.2	113.8	22.4	109.2	22.3

Source: PIOJ, Economic and Social Survey Jamaica 2000, April 2001, p. 21.8.

Unemployment marginally fell between 1999 and 2000 (from 5.8 to 5.7 %) for males under 25 years of age but for females the reduction was by 7.2% (Table 5). It has been argued that this decrease in unemployment for this age group was due to “increases in tertiary level enrolment” (PIOJ, ESSJ 2000, p. 21.9). Unemployment rose between 1999 and 2000 for males and females aged 25 years or older. For males the increase was from 4.2% to 4.5%; for females 11.3% to 12.2%.

Table 6: Unemployment Rate by Gender 1990 – 1998

	Per Cent Male	Per Cent Female
1990	9.1	22.5
1992	9.5	22.8
1994	9.6	21.8
1997	10.5	23.5
1998	10.0	22.1
1999	10.0	22.4
2000	10.2	22.3

Source: PIOJ, Jamaica Human Development Report 2000, p. 136.

PIOJ, Economic and Social Survey Jamaica 2000, April 2001, p. 21.8.

Table 7 shows the incidence of poverty by gender, among other considerations. The proportions of the poor who are males do not differ statistically from the proportions of the poor who are females. However, slightly more female-headed households than male-headed households are poor, a difference less than 3 percentage points on the average over the period discussed. However, consumption measured in constant or current dollars favours males over females. Tables 8 and 9 demonstrate this clearly.

Table 7: Incidence of Poverty by Age and Gender 1993 to 1997

Measures	1993	1994	1995	1996	1997
% of 14 – 24 who are poor	24.80	26.34	28.75	27.75	21.05
% of under 25 who are poor	27.98	26.75	32.09	30.19	23.62
% of male headed HH that are poor	16.64	14.44	18.76	16.35	12.54
% of female headed HH that are poor	19.25	20.12	19.39	18.44	15.0
% of poor who are male	49.30	50.15	50.02	50.74	50.34
% of poor who are female	50.70	49.85	49.98	49.26	49.68
% of poor who are under 25 years	61.64	62.12	62.96	62.48	62.10
% of all households headed by female	44.0	43.80	43.90	n/a	n/a

Source: PIOJ, Jamaica Human Development Report 2000, Kingston, p. 32.

Table 8: Mean Per Capita Consumption and Food Consumption by Gender of Head of Household (Constant Prices) 2000 and 2001

Gender	Mean Per Capita Consumption (\$)		Mean Per Capita Food Consumption (\$)	
	2000	2001	2000	2001
Male	9,596	10,017	3,998	4,320
Female	7,813	9,052	3,434	3,983

Source: PIOJ/STATIN, Jamaica Survey of Living Conditions 2001, p. 2.6.

Table 9: Mean Per Capita Consumption by Gender of Household Head, \$

Gender	1995	1996	1997	1998
Mean Per Capita Consumption				
Male	38140	46682	63895	71567
Female	32536	39015	52620	61748
Food as Per Cent of Total				
Male	54.0	53.5	49.5	50.3
Female	55.7	54.9	51.8	50.6

Source: PIOJ, Jamaica Human Development Report 2000, p. 138.

Finally, Table 10 shows indices of the Jamaica Human Poverty Index (JHPI) for males and females. The sex differentials are only indicated for illiteracy and malnutrition. Females have a lower score on both variables than males, the differences being 12 (for illiteracy) and 3 (for malnutrition). On the overall JHPI, females also have a lower score than males, a difference of 3.6.

Table 10: Jamaica Human Poverty Index (JHPI) by Gender, 1997

Variables	Male	Female	Jamaica
Longevity	5.5	5.5	5.5
Illiteracy	30.8	18.8	24.6
Malnutrition	3.9	6.9	5.6
Safe Water	16.0	16.0	16.0
Health Services	31.3	31.3	31.3
Lack of Security	1.5	1.5	1.5
Housing Quality	65.1	65.1	65.1
Index of Incidence of Poverty	19.9	19.9	19.9
Jamaica HPI	24.7	21.1	22.6

Source: PIOJ, Jamaica, Human Development Report 2000, p. 40.

In summary, data discussed so far (Tables 7 and 10) demonstrate that, with respect to poverty, males and females are almost at par, with females having an advantage in literacy and nutrition.

CONTRACEPTIVE KNOWLEDGE AND USE

Knowledge of contraceptives is virtually universal in Jamaica as a result of more than 30 years contraceptive education in the country. In this regard the 1997 Reproductive Health Survey showed that between 95 and 99 per cent of women aged 15-49 years studied have heard of female sterilization, injectables, condom and the pill. Also between 64 and 84 per cent have heard of spermicides, male sterilization, diaphragm, intrauterine devices and coitus interruptus (withdrawal). The results of young males aged 15-24 years were similar to those of all women.

The 1997 Reproductive Health Survey showed that 80 per cent of all women aged 15-49 had ever used a contraceptive method. However, only 45 per cent of women aged

15-19 and 83 per cent of those aged 20-24 had ever used contraceptives. When we consider current use, we find that only 50 per cent of women aged 15-49 were currently using a method. The most popular contraceptive methods were the pill, condom and tubal ligation in that order. When the analysis is restricted to women who are in union (legally married, living in common law union or having a visiting relationship), the proportion of current users rose to 66 per cent. For these women in union, only 59 per cent of the 15-19 age group were current users. For the 20-24 age, the proportion rose to 67 per cent. For all young men aged 15-24 the picture was very different. For young men aged 15-19, we note that 83 per cent were current users, that is, they used a contraceptive method during the last sexual encounter in the previous 30 days. For young men aged 20-24, the proportion of current users was 78 per cent. As expected the condom was the most popular method and 61 per cent of these young men used it. Of concern is the information that a fifth of these young men aged 15-24 did not use any method during their sexual activity in the past 30 days.

There was no significant difference in current use by place of residence of these women in union. The proportions of current users by residence were 66 per cent (KMA), 67 per cent (other urban areas) and 65 per cent (rural areas). Also, there was no significant difference in current use of contraceptives by education. The proportions of current users by education were 63 per cent (0-9 years of education), 67 per cent (10-12 years) and 68 per cent (13+ years). We also indicate that condom use increased with educational attainment: 12% (0-9 years of education), 19% (10-12 years) and 20% (13+ years). On the other hand, use of tubal ligation was different: 18% (0-9 years), 9% (10-12 years) and 11% (13+ years). The writers of the final report of the survey explain these

findings as follows: "...both of these observations may be influenced by the fact that younger women (who use condoms to a greater extent and sterilization to a lesser extent) were, in general, better educated than older women and less educated women tended to have higher parity, a group with greater use of female sterilization" (NFPB, 1999, p. 49).

Family life and sex education is available in school and out of school. Seventy-one per cent of females aged 15-24 and 65 per cent of males of similar age accessed information in school only. However, 14 per cent of the females and 24 per cent of males of the same age group had no course anywhere on family life or sex education. The courses covered topics such as menstrual cycle, pregnancy, human reproduction, sexually transmitted diseases, condoms, AIDS, and modern contraceptive methods. However, while between 73 and 96 per cent of these young adults indicated that each of the above topics was covered in the courses they took, only two thirds affirmed the counselling was taught. Less than half claimed that a course in clinic services was offered and about a third indicated that contraceptive distribution was included. Knowledge of where to go to treat STD was universal. Ninety-five per cent of the men and 94 per cent of the women have this knowledge.

Seventy per cent of females aged 15-24 and 85 per cent of males of the same age group were sexually experienced by the time of the survey in 1997. The proportion of those sexually experienced increased by age. Thirty eight per cent of the females and 64 per cent of the males both aged 15-17 were sexually experienced; by the age group 20-24, 90 per cent of the females and 98 per cent of the males had attained that status. The mean age at first sexual intercourse was 13.4 years for males and 15.9 years for females. Generally, males started sexual activity at younger mean ages, usually two years younger

than females. For young females, mean age at first sexual activity increased with more years of education, but there was no difference for young males. Also socio-economic status and frequency of church attendance had a positive impact on mean age at first sexual activity for females but not for males.

The relationship with first sexual partner was not a legal marriage or common law union. Eighty-three percent of the females claimed that their first sexual partner was a boy/girl friend. Thirteen per cent indicated that s/he was a friend. For young males the proportions were 38 per cent (boy/girl friend) and 48 per cent (friend).

The contraceptive of choice at first sexual activity was the condom. It was used by 88 per cent of the young females and 94 per cent of the young males who used a contraceptive method at sexual initiation. However, only 56 per cent of young females and 31 per cent of the young males used any contraceptive method during their first sexual intercourse. Those who did not use any contraceptive method gave various reasons, the prominent ones being either that they did not expect to have sex at the time they did (males 31 per cent, females 47 per cent) or they did not know of any methods (males 33 per cent, females 13 per cent).

NEED FOR FAMILY PLANNING SERVICES

The 1997 Reproductive Health Survey explored the phenomenon of unmet need for family planning services. Women have need for family planning services if they “are fecund, sexually active, not currently pregnant, not currently desiring a pregnancy, and not using a contraceptive method” (NFPB, 1999, Table 10.7). Using this definition, it was found that 15.4 per cent of the women aged 15-44 in 1997 had an unmet need for

contraception. This represented a small increase from the figure of 13.7 per cent reported by the 1993 Contraceptive Prevalence Survey.

Women who had no current steady partner had the highest level of unmet need (22%). About a fifth (19%) of young women aged 15-19 had an unmet need for family planning services. Also, 18 per cent of women who attended church services regularly (at least weekly) had an unmet need for contraception. Sixteen per cent of women who had boy friends (with or without sex) also had unmet need for contraception. Finally, unmet need was high for those with 13+ years of education (19%), those who live in the Kingston metropolitan area (17%) or in the parishes of Portland, St. Mary, St. Ann (19%).

YOUNG PERSONS

Young persons, defined as those between ages 10 and 24, constituted about 32 per cent of the 1991 and 29 per cent of the 2001 population of Jamaica. Projections (medium variant) shown in Table 11 illustrate that their share of the population will gradually decline to about 23 per cent by 2020. On the other hand, the youth, those aged 15 – 24 years, will decline from being a fifth of the population in 1991 to about a sixth in 2020.

Table 11: Percentage Distribution of Jamaica’s Young Persons by Age 1991-2020

Age Group	1991	2000	2010	2020
10 – 14	11.35	10.16	9.11	7.51
15 – 19	10.73	9.26	9.23	7.57
20 – 24	9.66	9.08	8.67	7.95
Total	31.74	28.50	27.01	23.03

Source: STATIN, Population Census 1991 Vol. 1, 1996, p. 5, PIOJ, Statement of National Population Policy, Revised 1995, p. 41.

Young Persons and Poverty

Table 7 shows that between 1993 and 1997 between 21 and 29 per cent of youth aged 14 – 24 years were poor. Poverty is predominantly a young person’s phenomenon as more than three of every five poor persons between 1993 and 1997 were under 25 years of age. The underlying factor behind this poverty is the lack of employment as indicated by Table 5 where we observe that both in 1999 and 2000, the unemployment rate for males under 25 was around 6 per cent, and for females of the same age group, about 11 per cent. Preliminary data for 2001 showed that the situation was getting worse (PIOJ, 2002, p. 21.7). Thus, the sluggish economy is part of the explanation of unemployment among the youth. However, at a different level, another contributory factor is the lack of education and appropriate skills. Table 12 shows the distribution of unemployment among the youth by years of secondary education in 1998.

Table 12: Unemployment Rates Among Persons 14-24 Years Old by Gender, 1998

	Years of Secondary Education			
	No Secondary Education	1 – 3 Years Secondary Education	4+ Years Secondary Education	All
All Persons	23.7	37.0	33.6	32.7
Males	12.9	28.1	26.2	23.9
Females	51.9	51.7	40.6	42.9

Source: Patricia Anderson, Labour Market Study, World Bank, 2000.

While secondary education no longer guarantees employment, completion or near completion of secondary education gives some advantage in the labour market, especially if the individual possesses other saleable skills (UNICEF/PIOJ, 2000, P. 97).

DISABLED POPULATION

Approximately 5 per cent of Jamaica's 1991 and 6 per cent of 2001 populations were persons with one or more disabilities. These figures are less than the ten per cent the World Health Organization estimates for persons with a disability in any country. Table 13 shows that more than half (54% in 1991 and 51% in 2001) of those with at least one disability were females. However, the elderly are over-represented among persons with one or more disabilities. For example, 52 per cent of those disabled are 60 years or older according to the 1991 Census. The 2001 Census Report gave a much reduced figure, 29 per cent (STATIN, 1996 P. 36, 2003, p. 116). The discrepancy requires further examination.

Table 13: Percentage Distribution of the Disabled Population of Jamaica by Age and Sex (Persons in Private Households only) 1991 and 2001

Age Group	Male (%)		Female (%)	
	1991	2001	1991	2001
0 – 4	2.2	5.60	1.56	4.99
5 – 9	4.63	7.62	3.15	6.65
10 – 14	4.85	7.87	3.46	6.82
15 – 19	4.65	7.18	3.85	6.46
20 – 24	4.44	6.13	3.15	5.54
25 – 29	5.09	6.40	3.54	5.96
30 – 34	4.79	6.38	3.44	5.58
35 – 39	4.23	6.41	3.22	6.09
40 – 44	4.17	6.10	3.50	5.53
45 – 49	4.31	4.96	4.36	4.77
50 – 54	4.69	4.81	5.04	4.66
55 – 59	5.13	4.35	5.96	4.26
60 – 64	7.30	4.20	8.00	4.84
65+	39.48	-	47.77	-
65 - 69	-	4.58	-	5.25
70 – 74	-	5.07	-	5.80
75+	-	12.32	-	16.80
Total	100.0 n = 50,966	100.0 n = 80,004	100.0 n = 60,148	100.0 n = 82,856

Source: Population Census 1991, Jamaica, Volume I, 1996, p. xxxiv.

STATIN, Population Census 2001, Jamaica, Volume I, Country Report, 2003, p.116.

Table 14 shows that in 1991, 30 per cent of the disabled males and 29 per cent of the females suffer from physical disability only. Also, 12 per cent of the males and 16 per cent of the females have multiple disabilities. The third highest ranking disability is sight. In this case 12 per cent of both males and females suffer from sight disability only. Also to be noted is that one in ten of the male disabled population have mental illness, a figure almost twice that of females.

Table 14: Percentage Distribution of the Disabled Population of Jamaica by Sex and Type of Disability, 1991 and 2001 (Persons in Private Households Only)

Type of Disability	Male (%)		Female (%)	
	1991	2001	1991	2001
Sight only	12.1	28.1	11.9	37.4
Hearing only	4.4	9.0	5.8	12.4
Speech only	2.1	4.0	1.3	3.0
Physical Disability only	29.6	22.1	28.7	20.5
Multiple Disability	12.3	6.2	15.6	6.9
Slowness at Learning	2.7	5.6	1.9	3.4
Mental Retardation	5.5	7.6	3.7	5.6
Mental Illness	10.4	13.4	5.9	6.6
Other	17.1	4.0	21.2	4.2
Not Stated	3.8	-	4.0	-
Total	100.0 n = 50,996	100.0 n = 39,429	100.0 n = 60,148	100.0 n = 39,464

Source: Ministry of Labour and Social Security, National Policy for Persons with Disabilities, Sept. 2000, pp. 24-25, STATIN, Population Census 1991 Jamaica, Volume 1, 1996, p. xxxvi, STATIN, Population Census 2001, Jamaica Vol. 1, Country Report, 2003, p. 117.

Note: Data for 1991 and 2001 reported above are strictly not comparable. Data for 2001 pertain to persons whose disability limited their activities.

Table 15 shows the educational attainment of persons with disability compared with the general population. Half of the population has primary education and thirty per cent have secondary education while three-quarters of persons with disability have only a

primary education and just about ten per cent have secondary level education. This demonstrates that persons with disability are considerably disadvantaged educationally, and this has implications for their chances to access employment.

Table 15: Percentage Distribution of Educational Attainment of Total Population and Persons with Disability, 1991

Level of Education	Total Population (Both Sexes)	Persons with Disability (Both Sexes)
None	10.9	8.9
Nursery/Infant	3.8	-
Primary	50.3	75.7
Secondary	29.5	9.6
University	1.3	0.4
Other	0.8	2.9
Not Stated	<u>3.4</u>	<u>2.5</u>
	100.00	100.0
	N = 2, 302, 175	N = 111, 114

Source: Ministry of Labour and Social Security, National Policy for Persons with Disabilities, Sept. 2000, pp. 24-25.

RETURNING RESIDENTS

A returning resident has been defined as (i) “a Jamaican national who has attained the age of eighteen years and has been resident overseas for not less than three consecutive years; and (ii) is returning to Jamaica to reside permanently.” (Ministry Paper No. 2/93, p. 13).

This definition covers spouses of returning female Jamaicans and returning adult students who have been away for over three years.

In September 1992 the Government approved a Charter for Long-Term Returning Residents and in the process established a framework for handling matters pertaining to returning residents. The objectives of the Charter are to:

- (a) “ensure the creation of appropriate and conducive conditions for the return of overseas Jamaicans and their service and investments, consistent with the national interest;
- (b) recognize returning residents as a source of investment in the country;
- (c) increase the potential human resources available to the country either directly through those which can be provided by the returning residents themselves and their children or indirectly, through the creation of a more conducive environment for service by overseas Jamaicans;
- (d) facilitate the development of a potential ‘retirement industry’ in Jamaica.”

(Ministry Paper 2/93, p. 1)

The Returning Residents Facilitation Unit (RRFU) established within the Ministry of Foreign Affairs and Foreign Trade was charged with the responsibility of administering the Returning Residents Programme. To carry out its mandate the RRFU works through mechanisms it has established such as the Skills Bank Facility, establishment of Internet websites and the development of investments targeted at overseas Jamaicans, and the development of cooperation with ministries/departments, private sector organizations, professional associations and the International Organization for Migration (IOM).

Number of Returning Residents

Fifteen hundred returning residents were registered by the Customs Department in 1992, the last year before the establishment of the RRFU. Between January 1993 and December 1997, more than 2000 returnees per annum were registered by the RRFU. The unit has recorded a cumulative total of 11,659 returning residents, many with spouses and children.

A more accurate reflection of the number of returning residents is given by the 2001 Population Census data. The 2001 Population Census defined a returning resident (migrant) as anyone who has “ever lived outside of Jamaica for five years or more continuously”. A total of 55,589 returning migrants were identified. Table 15b shows that approximately 54 per cent of returned migrants are males. Also, it indicates that the proportions returning increase with age both for males and females, such that 67 per cent are 50 years or older. Also, more than half (males 51%, females 56%) are in the elderly age group of 60+.

Table 15b: Returning Overseas Migrants by Sex and Age

Age Group	Total (%)	Males (%)	Females (%)
Under 20	4.9	4.7	5.2
20 – 29	5.5	5.7	5.2
30 – 39	10.5	11.8	8.9
40 – 49	12.4	13.6	10.9
50 – 59	13.3	13.1	13.6
60+	53.4	51.1	56.2
Total	100.0	100.0	100.0
n	55,589	29,886	25,703

Source: Calculations based on data from STATIN, 2003. Population Census 2001 Jamaica Vol. 1 Country Report, January p. xiii.

Table 15c identify the reasons for returning to Jamaica. A little over two out of every five (41%) migrants returned because “Jamaica is my home” while less than one out of every five (18%) came back because they had retired from their jobs overseas. It is very revealing that less than 10% of the returned migrants came back because they had achieved their objectives they sought in foreign lands.

Table 15c: Returning Overseas Migrants by Reason for Returning

Reason for Returning	Total (%)	Males (%)	Females (%)
Achieved Objective Abroad	7.8	8.7	6.7
Employment	1.9	2.4	1.4
Health Reasons	5.6	5.0	6.4
Jamaica is my Home	41.0	40.1	42.0
Involuntary Return	3.3	4.8	1.5
Retirement	18.3	17.5	19.3
The Weather	1.8	1.8	1.7
Other	8.1	7.7	8.5
Not Reported	12.2	12.0	12.5
Total	100.0	100.0	100.0
N	55,589	29,886	25,703

Source: Calculations based on data from STATIN, 2003. Population Census 2001. January, p. xiii.

Economic and Social Impact

The Returning Residents Programme officially and formally underscored the contribution of overseas Jamaicans to the domestic economy. The available economic data indicate the following:

- (1) 21,500 Retirement/Widow Benefit and 500 Incapacity Benefit recipients were domiciled in Jamaica as at June 1997. For the year January – December 1996 this generated inflows totaling £47 million.

- (2) Net private transfers of foreign exchange increased from US\$306.4 million to US\$583.8 million in 1996 and declined to US\$554 million in November 1997.
- (3) Returning residents have been contributing “to societal values and attitudes and the spirit of community through voluntarism, particularly throughout rural Jamaica” (Ministry Paper 12/98, Appendix II, p. 5).

Human Resource and Development

Through the Skills Bank hundreds of professionals were listed by categories of skills. Between 1994 and 1998, fifty-five overseas Jamaicans were recruited to fill public sector jobs, making positive impact on the public sector and elsewhere.

It should be noted, though data are sketchy, that returning residents are also contributing to the transformation of the landscape by their investments in housing in locations where they are settling, and some are involved in own account operations in various types of business undertakings.

Problems of Integration

The problems of an intending return migrants were succinctly identified by Ministry Paper No. 2/93 and they include:

- (a) Difficulty in Obtaining Information
- (b) High Level of Bureaucracy
- (c) High Customs Duty Structure
- (d) Unclear Regulations
- (e) Inadequate Health Services and Retirement Facilities
- (f) Problems of Personal Security
- (g) Attitude of Resident Jamaicans Towards Returning Residents.

The Charter and RRFU were established to address these issues, among others. A study is needed to evaluate how the provisions have been executed. However, concerns dealing with bureaucratic bottlenecks, adequate health facilities and public utilities, personal security and public attitudes towards the returnees seem to be matters that cannot be easily solved. There is a real gap in our knowledge about the level of satisfaction expressed by returnees on these matters.

HIV/AIDS

The HIV/AIDS epidemic has become a major health issue in the region, especially as the region is rated second to Sub-Saharan Africa in the prevalence rate of the disease. Jamaica's position in the region is moderate when compared with Haiti, Bahamas, or even Guyana and Trinidad and Tobago. Table 16 shows the prevalence rate of HIV in the adult population of selected countries, including countries for this baseline project.

Table 16: Percentage Adult (15-49 Years) HIV Prevalence Rate, 2001

Countries	%
Bahamas	3.5
Barbados	1.2
Belize	2.0
Cuba	<0.1
Dominican Republic	2.5
Guyana	2.7
Haiti	6.1
Jamaica	1.2
Suriname	1.2
Trinidad and Tobago	2.5
Latin American and the Caribbean Region	0.63
Sub-Saharan African Region	8.6

Source: UNICEF, The State of the World's Children 2003, NY Table 3.

Though the rank of Jamaica in the region with respect to HIV/AIDS is moderate, the number of persons involved is large given the population base. The UNAIDS has estimated that at the end of 2001 there were 20,000 adults (aged 15-49) and children (0-14) living with HIV/AIDS. Adults totalled 18,000, with women contributing 7,200 (UNAIDS, 2002). Table 17 shows the percentage distribution of all AIDS cases between 1982 and June 2002. Sixty per cent of all AIDS were males while females made up the remaining 40 per cent. When we examine more recent data (January 2001 – June 2002), the following picture emerges: Fifty-seven per cent of the AIDS cases were males while the remaining 43 per cent were females, continuing a trend since 1999 which has seen the female proportion of AIDS cases rising with time.

Table 17 shows that three percent of the AIDS cases were females in the age group 10 – 19 while less than one per cent were males in the same group, a ratio of more than 4:1. This situation “is a result of social factors whereby young girls are having sexual relations with HIV infected older men” (MOH, 2002), and thereby laying the foundation for many more infections from the girls to other males.

Table 17: Percent Distribution of All AIDS Cases in Jamaica by Age and Sex 1982-June 2002

Age Group	Male	Female	Total
0 – 9	7.12	9.11	7.91
10 – 19	0.71	3.03	1.64
20 – 29	17.74	25.82	20.95
30 – 39	34.92	33.00	34.15
40 – 49	21.21	16.67	19.41
50 – 59	12.19	7.26	10.23
60+	4.46	3.57	4.11
Unknown	1.65	1.54	1.60
	100.00	100.00	100.00
	N ₁ = 3946	N ₂ = 2603	N = 6549

Source: Calculation based data from Ministry of Health, Jamaica AIDS Report 2nd Quarter 2002, p. 8.

More than a third of the cases were males and females at the prime age group of 30-39 years. About a fifth were either in the 20-29 or 40-49 age groups. Thus, about three quarters of the AIDS sufferers from 1982 to date are in the 20-49 age group. Gender differences by age show more females (26%) than males (18%) in the 20-29 age group were AIDS sufferers, while the position is reversed in the 40-49 age group. Here 21 per cent of males as compared to 17 per cent of the females were victims of the AIDS disease. In general, from age 30 onwards, AIDS affected proportionately more males than females for every age group. Finally, 14 per cent, or one in seven of all AIDS were persons 50 years or older.

Statistics from the Ministry of Health indicate that the total number of AIDS cases in Jamaica between 1982 and December 2001 was 6038. The total AIDS deaths were 3,720, yielding a case fatality rate of 62 per 100. Table 18 shows the distribution of AIDS cases in Jamaica by parish arranged by rate per 100,000 population.

Table 18: Total AIDS by Parish Jamaica, 1982 – June 2002

Parish	Cumulative Total	Rate per 100,000	Rank
St. James	1016	606.9	1
Kingston and St. Andrew	2804	399.4	2
St. Ann	349	225.0	3
Hanover	150	224.6	4
Westmoreland	290	221.2	5
St. Catherine	810	217.5	6
Trelawny	147	203.0	7
St. Mary	187	163.7	8
Portland	108	137.2	9
St. Thomas	112	125.3	10
Manchester	174	99.5	11
Clarendon	217	97.2	12
St. Elizabeth	137	93.3	13
Parish Unknown/Overseas Address	48	-	-
Total	6549	251.9	-

Source: Ministry of Health, Jamaica AIDS Report – 2nd Quarter 2002.

The parishes of St. James, Kingston and St. Andrew, St. Ann and Hanover are the leading parishes of AIDS cases and together account for almost two thirds of the cases reported in Jamaica.

Finally, heterosexual relationship is the overwhelming practice through which AIDS sufferers were infected, more than three out of every five cases, while bisexual and homosexual contacts together accounted for less than 6 per cent of all cases.

DOMESTIC VIOLENCE AND GENDER

Domestic violence is defined broadly by the Planning Institute of Jamaica to include violence in individual households and “any act of violence committed by persons associated with the victims and may or may not be related by blood or a wider kinship” (PIOJ, 2002, p. 24.4). Table 19 shows the distribution of the crimes by type and gender of the perpetrator. Males overwhelmingly committed most of the crimes. Males committed all the rapes and carnal abuses. They also committed 66 per cent of the assaults, 77 per cent of the wounding, 87 per cent of the murders and 91 per cent of the shootings. On the other hand, females were responsible for more than a third of the assaults, about a quarter of the wounding, an eighth of the murders and one-eleventh of the shootings. However, women were at the receiving end of the violence with 32 per cent of the victims being females. Also, 71 per cent of the violence occurred in the rural areas of the country (PIOJ, 2002, p. 24.4).

Table 19: Domestic Violence by Gender of Perpetrator, Jamaica 2001

2001

	<u>No.</u>	<u>%</u>
<u>Murder</u>		
Males	331	87.34
Females	<u>48</u>	<u>12.66</u>
Total	379	100.00
<u>Shooting</u>		
Males	1183	90.58
Females	<u>123</u>	<u>9.42</u>
Total	1306	100.00
<u>Rape</u>		
Males	912	100.00
Females	<u>-</u>	<u>-</u>
Total	912	100.00
<u>Carnal Abuse</u>		
Males	306	100.00
Females	<u>-</u>	<u>-</u>
Total	306	100.00
<u>Wounding</u>		
Males	4716	76.91
Females	<u>1416</u>	<u>23.09</u>
Total	6132	100.00
<u>Assault</u>		
Males	4213	65.78
Females	<u>2192</u>	<u>34.22</u>
Total	6405	100.00
Grand Total	15,440	

Source: PIOJ, Economic and Social Survey Jamaica 2001, Kingston, April 2002, Table 24.5, p. 24.6.

Table 20 shows the age distribution of those arrested for major crimes (murder, shooting, rape, carnal abuse, robbery and breaking) in 2000 and 2001. Both in 2000 and 2001, more than half of those arrested were 25 years or younger, 58 per cent in 2000 and 54 per cent in 2001. Also, in both years about a fifth of those arrested were between 26 and 30 years of age.

Table 20: Age Group of Persons Arrested for Major Crimes Jamaica, 2000 - 2001

a) 2000

Age Group	Total Number of Persons	%
10 – 15	57	1.97
16 – 19	564	19.50
20 – 25	1044	36.10
26 – 30	585	20.23
31 – 35	328	11.34
36 – 40	187	6.46
41 – 45	65	2.25
46 – 50	30	1.04
51+	32	1.11
	2892	100.00

b) 2001

Age Group	Total Number of Persons	%
10 – 15	100	2.81
16 – 20	812	22.82
21 – 25	1017	28.58
26 – 30	789	22.18
31 – 35	429	12.06
36 – 40	232	6.52
41 – 45	93	2.61
46 – 50	45	1.27
51+	41	1.15
	3558	100.00

Source: PIOJ, Economic and Social Survey Jamaica 2000, Kingston, April 2001, Table 24.4, p. 24.5; Economic and Social Survey Jamaica 2001, Kingston, April 2002, Table 24.4, p. 24.6

In summary, the picture of violence that emerges is that of a rural phenomenon perpetrated by young males against males most of the time but with females being victims to a significant extent (Table 21). It appears that females seem to be getting more involved in criminal activity. For example, in 2000, 14 females were arrested for murder. In 2001, 19 (3.4%) females were arrested for murder, 8 (1.2%) for shooting, 8 (1.1%) for robbery and 29 (3.2%) for breaking (PIOJ, 2002, Table 24.6, p. 24.6).

Table 21: Gender Classification of Victims of Major Crimes, Jamaica 2001

	Murder			Shooting		
	Male	Female	Total	Male	Female	Total
Number	1030	109	1139	1060	123	1183
Percentage	90.43	9.57	100	89.60	10.40	100
	Robbery			Breaking		
	Male	Female	Total	Male	Female	Total
Number	1409	700	2109	1233	951	2184
Percentage	66.81	33.19	100	56.46	43.54	100

Source: PIOJ, Economic and Social Survey Jamaica 2001, Kingston, April 2002, Table 24.4, p. 24.6

NATIONAL POLICIES

I. NATIONAL POPULATION POLICY

The revised Jamaica national population policy has the general goal of improving “the satisfaction of basic human needs and the quality of life of the Jamaican people” (PIOJ, 1995, p. 2). Specific goals were formulated for several areas pertinent to this study:

(1) Population Growth and Size

“To ensure that the population does not exceed the number of persons that can be supported by the nation at satisfactory standards of living” (PIOJ, 1995, p. 3). To realize this objective the policy expects the population growth rate to be 0.8 per cent per annum till 2020-2025 period and thus yield a total population of 3 million by 2020. It also expects growth in the gross domestic product to be at least one per cent per annum to

avoid deterioration in the standards of living. Jamaica's 2002 population is 2.6 million. Projections of Jamaica's population for 2020 yield a total ranging between 2.7 million (low variant) and 3.4 million (high variant), and making 3 million feasible (PIOJ, 1995, pp. 40-42).

(2) Fertility

The policy expects the total fertility rate (TFR) which was 2.9 children per woman in 1989 to continue declining to reach a replacement level of 2.0 children per woman "by the year 2000 or shortly thereafter and be maintained at that level" (PIOJ, 1995, p. 5). It appears that this objective will be difficult to achieve because the TFR seems to have stabilized since 1989, reducing very slightly to 2.8 in 1997 (NFPB, 1999, Table 3.14). This situation prevailed though the contraceptive prevalence rate has increased from 55 per cent in 1989 to 68 per cent in 1997.

(3) Mortality

The policy wishes to "promote continued improvement in the average length of life" leading to a rise in life expectancy at birth from 70-72 years in 1995 to over 75 years by 2020. Given the present estimate of life expectancy at birth of 75 years by 2001 (UN 2002, p. 209), the desired objective appears to be already in hand.

(4) External Migration

The policy plans to influence international migration to achieve the following specific objectives:

- (i) "reduce unemployment
- (ii) ensure the availability of skilled manpower

- (iii) increase the return flow of skills and resources to meet the development needs of the country; and
- (iv) reduce the social cost of family separation due to emigration” (PIOJ, 1995, p. 5).

The policy assumes that existing levels of emigration will decline overtime and this is a reasonable position to take in light of the political and economic climate in major destination countries of United States of America, Canada and the United Kingdom.

(5) Gender

The policy hoped to “promote an adequate quality of life for both sexes” through ensuring equity between females and males in “social, cultural and economic matters including family life (particularly reproductive behaviour), legal status, educational opportunities, employment and income levels”, including “equal access to decision making processes” (PIOJ, 1995, p. 6).

(6) The Aged

The policy plans “to enable the aged to lead comfortable, functional and productive lives by sensitising the public to their value in the society, recognizing the importance of their roles and by providing opportunities to utilize their skills, as well as support services to meet their needs” (PIOJ, 1995, p. 7).

Government Perceptions and Policies: A Summary

Jamaica

Population policy variable	1996	2001
Population growth and age structure		
View on growth Policy on growth Level of concern about Size of the working-age population Ageing of the population	Too high Lower	Too high Lower
Fertility and family planning		
View on growth Policy Access to contraceptive methods Adolescent fertility Level of concern Policies and programmes	Too high Lower Direct support Major concern Yes ^a	Too high Lower Direct support Major concern Yes
Health and mortality		
View Expectation of life Under-five mortality Maternal mortality Level of concern about AIDS Grounds on which abortion is permitted	Acceptable Unacceptable Major concern 1,2,3 ^b	Acceptable Acceptable Acceptable 1,2,3 ^b
Spatial distribution		
View Policies on spatial distribution Between regions Between rural and urban places Policies on internal migration Into metropolitan areas From rural areas to other locations	Major change desired No intervention Yes Lower Lower	Major change desired
International migration		
Immigration View Policy Permanent settlement Migrant workers Dependants of migrant workers Integration of non-nationals Emigration View Policy Encouraging the return of nationals	Satisfactory Maintain Yes Too high Lower Yes	Satisfactory Maintain Yes Too high Lower Yes

^a Family education programmes in school and communities.

^b Grounds on which abortion is permitted: (1) to save the woman's life; (2) to preserve physical health; (3) to preserve mental health.

Source: UN National Population Policies 2001, NY, 2002, p. 208

II. NATIONAL POLICY FOR SENIOR CITIZENS

Goal

The major goal of the policy is “to meet the challenge of a growing, healthier and more active senior citizen population, by ensuring that those in need are assisted, and protected from abuse and violence” (Ministry of Labour and Social Security, n.d. pp. i-ii).

Objectives

Specifically, the policy has the following objectives:

- (1) Provide senior citizens with protection and care, physically and mentally.
- (2) Guarantee proper resource allocation for the social and economic welfare of senior citizens.
- (3) Encourage formal and informal services for senior citizens.
- (4) Devise strategies and programmes to promote positive images of senior citizens.
- (5) Promote individual responsibility (among younger persons) as they prepare for (their old age).
- (6) Promote the welfare of senior citizens (by legislation).
- (7) Complement measures on the elderly as enunciated in the National Population Policy and the National Policy for Person with Disabilities (Ministry of Labour and Social Security, n.d., pp. 3-4).

The policy document indicates that implementation of the policy will be multi-sectoral involving the Government, Private Sector and NGOs. It promised to strengthen the National Council for Senior Citizens, the agency charged with the responsibility of implementing and monitoring the policy. Finally, the policy

promised to ensure “gender equality” while at the same time recognizing dominance of women among the elderly and their relative poverty in comparison with their male counterparts.

III. NATIONAL POLICY FOR PERSONS WITH DISABILITIES

GOAL

The goal of the policy is “to improve the status and conditions of persons with disabilities so that they can enjoy a better quality of life in areas such as education, employment, health, housing, transportation, and accessibility to all areas of the society” (Ministry of Labour and Social Security, 2000, p. 3).

Within this overall goal, specific sub-sector goals include the following:

- (1) Promotion of a “national health programme which provides an integrated health service for persons with disabilities”.
- (2) Provision of mechanisms to ensure “quality and appropriate education and ample opportunities (for the disabled) to develop their skills in the least restrictive environment”.
- (3) Facilitation of “persons with disabilities... in all vocational programmes offered by the state and other relevant agencies”.
- (4) “Increasing the number of persons with disabilities in gainful employment in the labour market as well as to foster open employment and to encourage economic independence and empowerment of persons with disabilities”.
- (5) Dispelling “the myths associated with disability” and reducing “the level of isolation experienced by persons with disabilities”.

- (6) Promotion of strategies for “a barrier-free environment that will enable persons with disabilities to have physical and technological access to all areas of society” (Ministry of Labour and Social Security, 2000, pp. 5-12).

The Jamaica Council for Persons with Disabilities is the implementing agency while the National Advisory Council is charged with the responsibility of monitoring and evaluation.

IV. NATIONAL YOUTH POLICY

Goal

The National Youth Policy 1994 articulated a Mission Statement which is “to create an environment in which young people will be encouraged and facilitated to develop their full mental, social, spiritual and physical potential through the provisions of economic and training opportunities to enable them to become responsible and productive citizens” (Ministry of Education, Youth and Culture, 1994, p. 8). The draft National Youth Policy 2002 advanced two more specific policy goals:

- (1) “To foster a culture of positive youth development and participation in decision making around activities that affect their lives.
- (2) To increase the capacity of service providers to provide accessible, relevant and quality services for young people” (Ministry of Education, Youth and Culture, 2002, p. 5).

The National Youth Policy 1994 identified the following priority areas for action leading to improvement in the conditions of young persons:

- (i) Deficiencies in education and training
- (ii) Lack of economic opportunities

- (iii) Anti-social behaviour and attitudes
- (iv) Impact of foreign cultural penetration and rising materialism
- (v) Alienation
- (vi) Health problems
- (vii) Inadequate opportunities for recreation, leisure and cultural expression
- (viii) Inadequacies of institutional framework to address the issues raised above.

A Youth Unit (National Youth Service) was set up in the Ministry to implement youth programmes. It has collaborative relationship with other ministries, agencies and the Council of Churches.

A new draft policy is being produced with the objective of adopting a more holistic approach to youth development and improving on past performance. The draft policy has six priority areas for action:

- (i) Living Environment
- (ii) Education and Training
- (iii) Employment and Entrepreneurship
- (iv) Health
- (v) Participation and Empowerment
- (vi) Care and Protection.

Each of these areas has a sub-goal:

Living Environments

Goal: “To foster the development of supportive families and communities that provide youths with an environment conducive to their positive development and well-being”.

Education and Training

Goal: “All youth completing secondary level education and acquiring the skills to enable them to be prepared for livelihood, self-development and citizenship”.

Employment and Entrepreneurship

Goal: “To facilitate the creation of opportunities for employment and an environment that promotes entrepreneurship”.

Health

Goal: “To foster an environment where young people embrace healthy lifestyles and enjoy optimum physical and mental health”.

Empowerment and Participation

Goal: “To foster a culture that allows for the full participation of youths in the social, spiritual, and economic and political processes of the society”.

Care and Protection

Goal: “To promote a society that provides care and protection to those youths whose care and protection rights have been compromised.”

(Ministry of Education, Youth and Culture, 2002, pp. 12-18).

V. JAMAICA HIV/AIDS/STI NATIONAL STRATEGIC PLAN 2002-2006

Goals

The goals of the Plan are:

- (i) “To build an effective multi-sectoral response to the HIV/AIDS epidemic.

- (ii) To mitigate the socio-economic and health impact of HIV/AIDS in the society.
- (iii) To decrease individual vulnerability to HIV infection.
- (iv) To reduce the transmission of new HIV infection.
- (v) To improve care, support and treatment services of People Living with HIV/AIDS” (MOH, 2002, p. 5).

The National HIV/AIDS/STI control programme integrates the following services: surveillance, laboratory services, STI control and prevention, voluntary confidential counselling and testing, prevention of mother to child transmission, behaviour change and communication programmes, condom promotion, research, monitoring and evaluation, training, and liaison with international and regional organizations. The programme also provides technical guidance to the National AIDS Committee.

Indicators of Success

The Programme has identified the following indicators of success since inception:

- (i) Decline in syphilis and other STIs.
- (ii) Slowed trajectory of nation’s HIV epidemic compared to expected rates.
- (iii) Increased condom use and condom availability.
- (iv) High level awareness of HIV/AIDS among the general population.
- (v) Protection of the nation’s blood supply (MOH, 2002, p. 11).

Taking account of the strengths, weaknesses and gaps, the Programme has identified the following priorities:

- (i) Strengthening and supporting current initiatives that are effective.

- (ii) Full operationalization of pilot projects that are effective.
- (iii) Identification of new initiatives that focus on critical areas for implementation.

Given the above priority consideration, five priority areas were indicated:

- (i) Policy, advocacy, legal and human rights.
- (ii) Integrated and multi-sectoral response.
- (iii) Prevention.
- (iv) Care, treatment and support.
- (v) Monitoring, surveillance and evaluation.

MINISTRY OF HEALTH: HEALTH REFORM PROGRAMME

The Ministry of Health has the following Mission Statement: “In partnership with other stakeholders to promote the physical, mental, social and spiritual well-being and enhanced quality of life of the Jamaican people by empowering individuals and communities and ensuring access to adequate health care through the provision of cost-effective, promotional, preventive, curative and rehabilitative services.

The Health Reform Programme initiated in 1975 is one of the mechanisms utilized to actualize the mission statement.

Objectives

The objectives of the Health Reform Programme include:

- (i) enhance equity and accessibility
- (ii) improve efficiency
- (iii) enhance quality

- (iv) increase levels of financial sustainability
- (v) encourage intersectoral collaboration
- (vi) foster social and community participation

Tables 1 and 2 show main health reform projects and goals and targeted activities (Manraj, 2003, pp. 7-9).

Achievements of the Programme

- (i) In 2002 the WHO rated Jamaica 8th best performing health system in the world.
- (ii) Tremendous improvement in overall life expectancy, infant, child and maternal mortality rates.
- (iii) Good network of health facilities (public and private)
- (iv) Trained and committed health workers
- (v) Cost effective mix of skills
- (vi) Fair measure of consumer choice
- (vii) Good controls and regulations (Manraj, 2002, pp. 4, 10).

Despite these achievements Manraj (202, p. 10) has identified the following weaknesses:

Weaknesses

- (i) Inequity in access to services and in sharing the burden of cost.
- (ii) Managerial weaknesses as reflected in project overruns and in the management of change.
- (iii) Inadequate human resources in specialized areas, e.g., nursing and technical disciplines.

- (iv) Continuing conflicts between interest groups on centralization and decentralization, public and private responsibilities, curative and preventive services, technical and administrative roles.
- (v) Weak mechanisms for inter-sectoral and social participation.

Manraj (2002, p. 10) rightly asserted that health sector reform “is always an unfinished activity” and, based on her interviews of officers and study of documents, has outlined the next set of reforms needed.

NEXT REFORMS

- (i) Enhancing capacity to design and implement essential public health functions especially with respect to the regulatory, policy and stewardship roles of the Ministry of Health.
- (ii) Developing policies, mechanisms and practices which pay more attention to client-oriented services and patient rights.
- (iii) Establishing closer collaboration and linkages (e.g. financing and service delivery modalities) between the public and private (profit and non-profit) sectors in health.
- (iv) Devoting more attention to health promotion with individual and community responsibility for health as critical inputs.
- (v) Developing policies and programmes which improve equity in health.
- (vi) Improving human resource management in terms of the skills mix, deployment and remuneration of health workers. (Manraj, 2002, pp. 10-11)

ST. LUCIA

UNFPA Baseline Study

ST. LUCIA

DEMOGRAPHIC BACKGROUND

St. Lucia, like many other countries in the Caribbean, has been very successful in the process of demographic transition. There has been a steady decrease in fertility and mortality rates in the past four decades. Table 1 shows that the total fertility rate fell from 6.7 children per woman in 1960 to 3.2 in 1991 and to 2.1 in 2000. This came about due to a drastic reduction in births from 49 per 1,000 population in 1960 to 28 in 1991 and 19 in 2000. Death rates declined from 14 per 1,000 population in 1960 to 5.3 per 1,000 in 2000. Improvement in mortality conditions is further evidenced by rising life expectancy at birth for both males and females. Life expectancy at birth for males rose from 64.4 years in 1970 to 71 years in 2000 while for females it rose from 70 years in 1970 to 77 years in 2000, a slight advantage over males in terms of years gained over the period.

Table 1: Demographic Statistics for St. Lucia 1960-2000

	1960	1970	1980	1991	2000
Annual Growth Rate	--	1.5	1.3	1.5	1.7
Total Fertility Rate	6.7	6.3	4.0	3.2	2.1
Crude Birth Rate	49	39	32	28	19
Crude Death Rate	14	8	7	6.7	5.3
Total Dependency Ratio	96	117	100	75	--
Life Expectancy					
Males	--	64.4	65.5	69.1	71
Females	--	69.8	70.0	73.9	77
Age (%)					
0 – 4	18	18	14	12	--
5 – 14	26	31	30	25	--
15 – 24	18	20	21	21	--
25 – 64	33	26	29	36	--
65+	5	5	6	6	--

Source: DIGEST of Selected Demographic and Social Indicators 1960-1994 for CDCC Member countries. ECLAC/CDCC Demographic Unit, Trinidad and Tobago. UNFPA, December 1995 and Annual Report of Chief Medical Officer 2000. Ministry of Health, St. Lucia. February 2002.

Table 2: Projected Demographic Characteristics of St. Lucian Elderly 2025 – 2050

		2025	2050	
Total Population (000)		178.9	188.6	
% in Older Ages	<u>Age</u>			
Total Population	60+	12.1%	22.0	
	65+	7.8	16.9	
	80+	1.4	3.9	
Female	60+	13.7	24.5	
	65+	9.2	19.3	
	80+	1.9	5.1	
Male	60+	10.4	19.4	
	65+	6.5	14.6	
	80+	1.0	2.7	
Median Age (yrs)		31.4	38.2	
Ageing Index		51.6	111.4	
Potential Support Ratio		8.8	3.7	
Sex Ratio (per 100 women)	60+	75.1	78.9	
	65+	69.6	75.4	
	80+	50.7	51.8	
Growth rate (%)	<u>Age</u>	<u>2000-2005</u>	<u>2025-2030</u>	<u>2045-2050</u>
	Total	1.1	0.4	0.0
	60+	1.0	3.6	1.0
	65+	0.2	4.3	2.3
	80+	2.3	3.2	3.9
Life Expectancy (yrs)	<u>Age</u>	<u>2000-2005</u>	<u>2025-2030</u>	<u>2045-2050</u>
Total	0	73.8	77.2	79.5
	60	19.7	21.3	22.7
	65	16.3	17.6	18.8
	80	7.9	8.5	9.2
Female	0	76.4	79.8	82.1
	60	21.3	23.3	24.9
	65	17.6	19.4	20.7
	80	8.6	9.4	10.2
Male	0	73.8	77.2	79.5
	60	19.7	21.3	22.7
	65	16.3	17.6	18.8
	80	7.9	8.5	9.2

Source: United Nations, World Population Ageing 1950-2050, NY, 2002, pp. 398-399.

THE ELDERLY

The proportion of the elderly in the population has been growing. In 1975 the proportion of the population aged 60 years or older was 7.4 per cent and it rose to 7.8 per cent by 2000 (UN, 2002, p. 398). Table 2 shows that by 2025, the proportion of those aged 60 years or older would be 12.1 per cent or almost one in every eight persons. By 2050, more than one in every five persons in St. Lucia would be 60 years or older. As noted for other Caribbean countries in this study, the elderly constitutes the fastest growing age group after 2000-2005. By 2045-2050 when the total population would be experiencing zero growth, various categories of the elderly would be having between 1 and 4 per cent growth rate. With females outliving males, we note that there would be between 70 and 79 males per 100 females aged 60+ or 65+ between 2025 and 2050. Among the oldest elderly aged 80+, there would be two females for every male from 2025 and beyond.

Females continue to enjoy the advantage in life expectancy over males that they have at birth. At age 60, while a female can expect to live a little over 21 years, a male can only expect almost 20 years. This differential increases with time as females aged 60 in the 2045-2050 period would have additional 25 years compared to 23 years for males. Even at the oldest ages, this advantage, though reduced, remains.

The potential support ratio would decline from nine in 2025 to four in 2050, but as noted elsewhere, the actual support available to the elderly would be far less than indicated by this number. Therefore, St. Lucian elderly would be participating in the labour force as their counterparts in the region where we have reported the proportions involved.

YOUNG PERSONS

The youth, those aged 15-24, constitutes about a fifth of St. Lucia's population. The censuses of population for 1970, 1980 and 1991 showed that the youth constituted 20%, 21%, and 21% of the total populations of the respective years. The preliminary results of the 2001 Census of Population and Housing show that this age group now accounts for 19 per cent of the mid-year population in 2001. Available data in St. Lucia are for adolescents aged 10-19 and so we shall concentrate on this group in this presentation. Adolescents constitute more than one-fifth (21.64%) of the estimated mid-year population in 2001.

Teenage pregnancy has been a major factor in St. Lucia's fertility with births to teenagers accounting for up to 30 per cent of all births in the early 1980s (Guengant et. al., 1991, p. 14). This proportion then started to decline. By 1991 and 1992 it had declined to 20 per cent of all births. Since 1997 it has stabilized at 16 per cent (MOH, 2002, p. 48). Lack of data precludes any attempt to pinpoint factors, such as contraceptive use, education, sexual behaviours, etc. that would assist in explaining the decline (MOH, 2002, p. 48). To bridge some of the gaps in the demographic data relating to adolescents we rely on the St. Lucia's portion of the Caribbean Youth Health Survey 1996 (Fountain, et. al., 2002).

The Survey covered 1,526 primary and secondary school students between ages 10 and 18. Almost 54 per cent were females. We summarize below the findings relevant to this project.

(i) **Disabilities**

Eleven per cent reported that they had a “disability, handicap or chronic illness” that limited them from doing what persons their age did. Nine per cent of these adolescents indicated that they experienced difficulty using their hands, arms, legs or feet.

(ii) **Sexual Behaviour**

Thirty-five per cent of the sample had had sexual intercourse. There was a gender difference as expected. Fifty-three percent of the males and 20 per cent of the females were sexually experienced. The median age of first sexual intercourse for males was 10 years or less but for females it fell between ages thirteen and fifteen. Given these young ages, it is revealing that 63 per cent of the females and 25 per cent of the males reported that they were forced to engage in their first sexual intercourse. Among the sexually experienced, less than one in four (23.7 per cent) always used some birth control method. There was a small gender difference here as 26 per cent of the females and 23 per cent of the males always used some contraceptive method during sexual intercourse. When asked about their most recent sexual intercourse, 58 per cent of the sexually active respondents affirmed that they did not use any methods of contraception. Among those who used, condom was the most popular (51%), followed by withdrawal/rhythm (18%).

Concern about getting or making someone pregnant or contracting the AIDS virus is expected to impact on one’s sexual behaviour. Fourteen per cent of the respondents worry ‘somewhat’ about pregnancy and 21 per cent worry ‘a lot’. There was no gender difference in worrying a lot about pregnancy (females 21.6%; males 20.8%). Also 14 per cent of the respondents worry ‘somewhat’ about getting HIV/AIDS and 31 per cent

worry 'a lot'. A small gender differential was noticed in the "worry a lot" category (females 29.3%; males 33.7%). For both types of worries, the proportions increased with age, reflecting, probably, increasing sexual activities at older adolescent ages.

WOMEN

The preliminary results of the May 2001 Census of Population and Housing gave the population of St. Lucia as 156,635. Females constitute 50.42 per cent of the population and this proportion yields a sex ratio of 98 males per 100 females. The 2001 census also reported a national unemployment rate of 18.9 per cent (males, 16.7 per cent and females 21.6 per cent). The higher female unemployment rate in 2001 was consistent with the trend noted since 1960 in which the rates have been consistently higher for females. However, this disparity in employment has not translated into higher poverty levels among females as compared to males (see section on Poverty below).

DISABLED

Disability among children and youth in St. Lucia is very low. Of the total population under 15 years of age, only 1.5 per cent has some form of disability. However, there is no identification of the factors associated with prevalence. There is also no indication of diagnosis, which implies that these cases could be somewhat higher than reported (UNICEF and CARICOM, 1997).

POVERTY

On the basis of data on consumption, the National Poverty Assessment 1995 estimated that 25 per cent of the population of St. Lucia were poor. Thirty per cent of the rural population were poor compared with 16 per cent of the urban population. There

was a small gender differential with respect to poverty: 25.5 per cent of males and 24.7 per cent of males were poor (MOH, 2002, p. 13). Table 2b below shows the latest information on poverty in St. Lucia. This table confirms the view that there is a differential between males and females, by residence with respect to absolute poverty.

Table 2b: Proportion of Households Falling Below the Poverty Lines by Gender of Head of Household and Area of Residence, St. Lucia

	Absolute Poverty		Food Only		Food Plus	
	Males	Females	Males	Females	Males	Females
Urban	5.2	2.1	6.9	2.1	7.8	11.3
Rural	4.5	6.2	6.3	8.6	17.5	14.8
Total	4.7	4.6	6.5	6.2	14.2	13.5

Source: OECS Human Development Report 2002 p. 206.

Note

Food Only = Minimum basket for family of four.

Absolute Poverty = 80% of Food.

Food Plus = Food plus the reciprocal of food/non-food of the poorest 40%.

HIV/AIDS

By the end of June 2002, there was a cumulative total of 363 reported cases of HIV infection. Fifty four per cent of these (196) had progressed to full-blown AIDS and 46 per cent (180) had died. Children under 15 years of age accounted for 10 per cent of reported HIV cases and adults (15 – 49) 76 per cent, youth (15 – 24 years of age), 10 per cent.

Table 3 below shows a more detailed analysis of the cumulative HIV/AIDS between 1985 and September 2001. A total of 309 HIV positive cases were reported. Out of this total 48 per cent (147) had developed AIDS and 86 per cent of this group (126) had died of AIDS related causes.

TABLE 3: REPORTED CASES OF HIV/AIDS BY DISEASE STATUS, GENDER AND BROAD AGE GROUPS, ST. LUCIA 1985 – SEPTEMBER 2001

	Adult			Paediatric			Unknown			Total
	M	F	Unk	M	F	Unk	M	F	Unk	
	<u>Cases (Total)</u>	128	124	14	11	15	8	5	3		1	309
AIDS	77	54	0	5	7	0	3	1	0	147
Asymptomatic	51	70	14	6	8	8	2	2	1	162
Deaths	64	47	-	5	7	-	2	1	-	126

Source: Ministry of Health, Human Services, Family Affairs and Gender Relations, HIV and AIDS Surveillance Report, St. Lucia 1985-2001, p. 3.

NB: M = Male; F = Female; Unk = Unknown.

The Surveillance Report found that this modal age group for the cumulated data (1985-1999) was 25-34 years for both males (31%) and females (34%). The Surveillance Report also notes that AIDS morbidity has been rising since 1985. Incidence rates rose from 3.7 cases per 100,000 population during 1985-89, to 6.9 per 100,000 during 1990-1994 to 8.6 per 100,000 during 1995-1999. It also noted that mortality rates have increased similarly with incidence rates. The distribution between the sexes is also changing. Using data for 1987-2001 period and analysing by five-year periods, it was noted that “the number of reported cases among women 25-49 years more than quadrupled for 1997-2001 when compared with 1987-1991. Among the youth (15-24 years) females accounted for about 71% of reported cases” (MOH 2002).

Data on mode of transmission are incomplete as the mode of transmission for 55 per cent of the cases is ‘unknown’ or ‘missing’. Heterosexual transmission only was the mode for 25 per cent of all cases between 1991 and 2001 (males 21%, females 34%). Ten per cent of all cases were heterosexual in conjunction with an additional mode of

transmission. Six per cent of all male cases were through homosexual transmission. Mother-to-child (vertical) transmission represented 4 per cent of all reported HIV cases.

RESPONSE TO THE HIV/AIDS EPIDEMIC

The National HIV/AIDS Programme has been a unit of the Ministry of Health since 1988. Its challenges include rapid staff turnover, and the absence of effective leadership in the 1995-2002 period. The Pan American Health Organization (PAHO) and the Caribbean Epidemiological Centre (CAREC) have played a considerable role in the country's response to HIV/AIDS epidemic (MOH 2002).

Non-Governmental Organizations (NGOs) activities have concentrated on the following areas:

- (1) Education and Training
- (2) Public Information Campaign
- (3) Advocacy and
- (4) Support for people living with HIV/AIDS.

However, NGOs face challenges, including

- (1) Absence of a clear government policy on dealing with HIV/AIDS
- (2) Absence of current and accurate surveillance data
- (3) Efficient institutional capacity
- (4) Funding constraints
- (5) Volunteers ill-equipped for the task
- (6) Programme duplication.

The government of St. Lucia has been active in the following areas:

- (1) Information, education and communication (IEC) activities
- (2) Protection of the national blood supply
- (3) Control and prevention of STDs/STIs
- (4) Reducing mother-to-child transmission.

Finally, people living with HIV/AIDS face many difficulties in the public health care system and these include expensive drugs and care, lack of confidentiality, low social support because of stigmatization, discrimination, and marginalization (MOH, 2002).

The HIV/AIDS Surveillance Report (MOH, 2002), after a detailed evaluation of the HIV/AIDS programme in St. Lucia, advanced the following recommendations and Action Plan:

RECOMMENDATIONS

- (1) Early diagnosis required to facilitate counselling of patients and reduction of transmission
- (2) Increase sexual health education
- (3) Training for health professionals for better services for users
- (4) Improve methodology to identify populations at higher risk and their risky behaviours
- (5) Ensure that the health system offer services relevant to the needs of people living with HIV/AIDS.

ACTION PLAN

The Epidemiology Unit should:

- (1) Improve its database
- (2) Update its form
- (3) Conduct seroprevalence study covering STD clinic patients
- (4) Establish links with doctors in private practice to improve reporting
- (5) Conduct behaviour surveillance survey targeting the youth.

HEALTH SECTOR REFORM

Health Sector Reform (HSR) began with the establishment of the Public Sector Reform Commission in 1997.

OBJECTIVES

- Provide efficient quality health care
- Maintain an adequate program of primary/preventive health care with constant emphasis on health promotion
- Achieve greater equity in the allocation and use of resources
- Design and implement comprehensive and integrative programs for detection, prevention, treatment and rehabilitation
- Improve and maintain mental health services to the level of contemporary international standards
- Reduce the incidence of environmental health problems
- Improve the financing of the system to make it affordable and sustainable.

(MOH, 2002, pp. 65-66)

The program is implemented in three phases:

- 1) Phase 1 (1999 onwards): institutional strengthening, improved management at all levels and reorganization of the service.
- 2) Phase 2 (implemented by April 2002): development of a sustainable financial system.
- 3) Phase 3 (2003): elaboration of the National Health Services Plan.

Cabinet accepted the Health Sector Reform proposals in principle in December 2000. The Planning Unit within the Ministry of Health was charged with the responsibility of revising the implementation plan and developing the communication plan and strategy. The Planning Unit with Heads of Departments and Institutions in the Ministry of Health will implement the reforms. Implementation was scheduled to start in 2001. However, scarcity of the requisite number of trained staff at the Planning Unit, and problems of coordination of information systems, data collection and analysis to provide data for monitoring and evaluation, are responsible for implementation delays.

NATIONAL POLICIES

(1) POPULATION POLICY

Table 4 shows a summary of the Government's position on various elements of population policy.

Government perceptions and policies, Saint Lucia

<i>Population policy variable</i>	1996	2001
Population growth and age structure		
View on growth	Too high	Too high
Policy on growth	Lower	Lower
Level of concern about		
Size of the working-age population	..	..
Ageing of the population	..	..
Fertility and family planning		
View on fertility level	Too high	Too high
Policy	Lower	Lower
Access to contraceptive methods	Direct support	Direct support
Adolescent fertility		
Level of concern	Major concern	Major concern
Policies and programmes	Yes ^a	Yes
Health and mortality		
View		
Expectation of life	Unacceptable	Unacceptable
Under-five mortality	Unacceptable	Unacceptable
Maternal mortality	..	..
Level of concern about AIDS	Major concern	..
Grounds on which abortion is permitted	1,2,3 ^b	1,2,3 ^b
Spatial distribution		
View	Satisfactory	Satisfactory
Policies on spatial distribution		
Between regions	No intervention	..
Between rural and urban places	No intervention	..
Policies on internal migration		
Into metropolitan areas	No intervention	..
From rural areas to other locations	No intervention	..
International migration		
Immigration		
View	Satisfactory	Satisfactory
Policy	Lower	Lower
Permanent settlement	Lower	..
Migrant workers	Lower	..
Dependants of migrant workers	Lower	..
Integration of non-nationals	No	..
Emigration		
View	Satisfactory	Satisfactory
Policy	No intervention	No intervention
Encouraging the return of nationals	No	..

^b family-life education: teenager counseling; family planning staff training.

^a Grounds on which abortion is permitted: (1) to save the woman's life; (2) to preserve physical health; (3) to preserve mental health.

Source: United Nation, National Population Policies, 2001, NY, 2002.

(2) YOUTH POLICY

A draft national youth policy produced in October 2000 defined youth comprehensively to include everyone aged 10-35 years. With this definition, the youth comprised 54 per cent of the 1998 population of St. Lucia.

POLICY GOAL

The broad goal of the policy is to “provide the youth with a voice, equal opportunities and autonomy (to develop) their full potential and (to ensure) their role and participation in all aspects of nation building” (MEHRDYS, 2000, p. 5).

OBJECTIVES

The specific objectives of the policy are to:

- (1) “Provide a vehicle for full participation of youth in national development.
- (2) Reflect the needs, aspirations and interests of youth in all spheres and at all levels.
- (3) Encourage self-assertion and the development of self-esteem.
- (4) Facilitate the holistic development of youth.
- (5) Guarantee equal opportunity for all young persons regardless of gender, race, ability, political affiliation or social status.
- (6) Support the self-development and autonomous governance of the youth movement” (MEHRDYS, 2000, p. 5).

To achieve these objectives detailed recommendations were proffered on various subjects including economic participation, education and training, crime and violence,

substance abuse, spiritual development, sports and recreation, culture, teenage pregnancy, participation in clubs and organizations and health.

Implementation of the policy is expected to be inter-sectoral involving Government Ministries, Private Sector, National Skills Development Centre and National Youth Council. The Department of Youth and Sports and National Youth Council will monitor the implementation of programmes and review the policy every five years in consultation with stakeholders.

(3) HEALTH AND FAMILY LIFE EDUCATION POLICY

The UNICEF Situational Analysis of Children and their Families (1995-1996) has outlined the causes of teenage pregnancies in St. Lucia and several of the immediate causes are structural in nature: scarce employment opportunities, absence or lack of reproductive sexual health services and facilities. However, other factors include early sexual exposure, unprotected sex and promiscuous sexual behaviour. Steps are being taken to assess this problem as the government has taken the initiative to formulate a National Policy on Health and Family Life Education (HFLE) that has a focus of making HFLE a full time subject within the school system and expanding the program within the workplace and the wider community.

The **objectives** of the HFLE national policy are:

- 1) Collaboration between the formal education sector, educational organizations, the formal health sector, health organizations, NGOs, CBOs and the private sector to influence policymakers to comprehensively integrate goals related to the health and well-being of the whole community into the national educational agenda.

- 2) Enhancing the leadership and management in schools and communities.
- 3) The development and implementation of the HFLE programme.
- 4) Inclusion – a system to ensure the delivery of HFLE to children, youth and adults with special needs.
- 5) Assisting in halting the spread of HIV/AIDS.
- 6) Strengthening the skills and preparation of teachers and other professionals involved in the delivery of HFLE in schools and out.
- 7) Inter-agency collaboration with relevant groups.
- 8) Research on students' attitudes, beliefs and behaviour, which will underpin curriculum development and implementation.
- 9) Advocacy for legislative initiatives aimed at enshrining the rights of children as conveyed in the Convention on the Rights of the Child and other human rights legislation.
- 10) Support for HFLE beyond the classroom.

(Ministry of Education, Human Resource Development, Youth and Sport, 2001).

As a result of the high incidence rate of youth with HIV/AIDS, the Ministry of Health has embarked on an aggressive campaign for HIV/AIDS awareness. This should help youth play a more active part in their health.

The government has also given consideration to street children. Laws are now being enacted to curb the increases in the number of these children who are likely to become vulnerable to social deviance.

SURINAME

UNFPA BASELINE STUDY

SURINAME

Suriname is well-advanced on the road to full demographic transition resulting in low fertility, mortality and growth rates. The total fertility rate was 7 children per woman in 1950, 7.3 in the late 1950s, then it fell to 7.1 in 1960, to 3.9 in 1975, 3.6 in 1980 and is estimated to be 2.4 in 1995. On the other hand, mortality conditions have improved considerably since the 1950s. Life expectancy at birth has risen from 56 years during 1950-55 to 65 years in the 1975-80 and to 71 years currently. Population growth rate has fallen from 3.0 per annum in the 1950-55 period to 0.4 currently, and a large part of this reduction is attributable to emigration. The total number of net emigrants for the periods 1972-79, 1980-89, and 1990-97 were 88,635, 37,768 and 32,044 respectively (General Bureau of Statistics, 1999, p. 54; Jagdeo, 1993, pp. 17-18; UN, 2002, p. 427). The structure of the population has changed considerably in the past three decades. The 1964 population census reported that almost 47 per cent of Suriname's population was less than 15 years of age, almost 17 per cent between 15-24 and 6 per cent 60 years old or older. The 1995 population estimates indicated that almost 33 per cent were under 15, 19 per cent between 15 and 24 and almost 8 per cent 60 years or older. As a result of these age structural changes, the proportion between 15 and 59 years of age has risen from 47 per cent in 1964 to 60 per cent of the population in 1995. The publication of the results of 2003 Population Census, though a recent fire destroyed aspects of the data, will enable us to determine how far these parameters have changed since the 1980 Population Census. We now turn to a more detailed analysis of the various components of the population.

THE ELDERLY

As indicated earlier, the 1964 Population Census showed that 6.20 per cent of the population were 60 years old or older. It also reported that 4.1 per cent of the population were 65+ and 0.6 per cent 80+. For the 1995 estimate of the population, persons aged 60+ were 8.6 per cent, the 65+, 4.9 per cent and the 80+ were 0.8 per cent of the population, respectively. Table 1 shows UN projections for the elderly in Suriname for 2025 and 2050. The elderly aged 60 years or older will be 14 per cent of the 2025 population of Suriname. By 2050, almost three persons in every ten in Suriname will be elderly. The median ages in the census years of 1964, 1972 and 1980 were 16.8, 15.7 and 18.4 years, respectively. The figure for the 1995 estimated population was 23.8 years. The median age would rise to 35.3 years in 2025 and to 44 years by 2050. The sex ratio for the elderly aged 60+ in 1995 was 90 males per 100 females; for the 65+ it was 89 per 100 and for the 80+, 91 per 100. Between 2025 and 2050, the sex ratios for the elderly aged 60+ or 65+ will be 67 to 83 males per 100 men. As noted for the countries in this study, the sex ratio for the 80+ from 2025 onwards will be around one male for every two females.

As observed for the other countries, the elderly category is growing faster than the total population. Table 1 shows that this situation is even more pronounced beyond 2000-2005. In 2025-2030 when the total population is expected to achieve zero growth, the growth rate of various categories of the elderly will lie between one and seven per cent per annum. Females maintain the advantage they have over males in life expectancy at birth at the older ages. Between 2000 and 2050, females aged 60 can live two to four more years on the average than their male counterparts. Labour force participation by the

elderly is less pronounced in Suriname than in the other countries under study. From 2000 less than 10 per cent of the elderly aged 65 or older are participating in the labour force. However, most of them are males as less than two per cent of females 65 years or older are working compared to about one in six males of the same age.

Table 1: Projected Demographic Characteristics of Surinamese Elderly 2025-2050

		2025	2050	
<u>Total Population (000)</u>		442.1	417.9	
<u>% in Older Ages</u>	<u>Age</u>			
Total Population	60+	14.0	29.4	
	65+	8.2	22.4	
	80+	1.6	5.6	
Female	60+	15.8	31.9	
	65+	9.7	24.9	
	80+	2.1	7.0	
Male	60+	12.2	26.9	
	65+	6.6	19.8	
	80+	1.1	4.0	
Median Age (Yrs)		35.3	44.0	
Ageing Index		70.3	178.2	
Potential Support Ratio		8.8	2.7	
Sex ratio (males per 100 women)	60+	76.3	82.6	
	65+	67.2	78.0	
	80+	52.1	56.4	
Growth rate (%)	2000-2005	2025-2030	2045-2050	
	Total Population	0.4	0.0	-0.5
	60+	1.0	4.5	1.3
	65+	2.0	6.7	2.6
	80+	3.8	0.7	4.9

Life Expectancy (yrs)	<u>Age</u>	<u>2000-2005</u>	<u>2025-2030</u>	<u>2045-2050</u>
Total	0	71.1	75.8	78.6
	60	18.2	20.1	21.8
	65	14.8	16.4	17.9
	80	7.1	7.8	8.6
Female	0	73.7	78.1	81.0
	60	19.2	21.7	23.7
	65	15.6	17.7	19.6
	80	7.2	8.3	9.4
Male	0	68.5	73.3	76.2
	60	16.9	18.3	19.7
	65	13.8	14.8	16.0
	80	7.0	7.0	7.5
Labour Force Participation (%)	<u>Age</u>	<u>1990</u>	<u>2000</u>	<u>2010</u>
Total	65+	11.3	9.2	7.6
Female	65+	2.2	1.9	1.6
Male	65+	21.7	18.4	15.9

Source: United Nations, World Population Ageing 1950-2050, New York, pp. 426-427.

As indicated earlier the elderly aged 60 years or older comprised 6.32 % of the population in the 1980 census. This proportion was projected to 7.6% in 1995, 14% in 2025 and 29.4% in 2050. Table 9 shows the total number of elderly persons receiving Old Age Pensions. The data show that almost 37,500 persons received these pensions in 2000.

WOMEN

Females are dominant in the population according to data from population censuses of 1950, 1964, 1972 and 1980. Table 2 shows the various sex ratios for the census years.

Table 2: Sex Ratio (Males per 100 Females) by Census Years

	1950	1964	1972	1980
Sex Ratio (Total Population)	98.6	99.7	100.7	98.0

Source: General Bureau of Statistics, 1999, Demographic Data up to 1997, Paramaribo, Suriname, p. 15.

Table 3 shows a detailed breakdown of the sex ratios by age groups for the 1980 census and 1995 estimated data. Only data from the 2003 Population Census can refute or validate the assumptions underlying the most recent estimate which has reversed the trend in sex ratios observed in three of the four census results since 1950.

Table 3: Sex Ratio (Males per 100 Females) by Age Groups 1980 and 1995

	1980	1995
0 – 4	102.4	102.5
5 – 14	101.5	101.7
15 – 29	97.8	105.5
30 – 44	90.6	101.7
45 – 64	98.0	92.3
65+	89.4	88.6
Total	98.0	100.9

Source: Calculated from data reported by General Bureau of Statistics, Demographic Data up to 1997, Paramaribo, 1999, pp. 6, 8.

The following section presents data from the Suriname Multiple Indicator Cluster Survey (MICS) 2000 (Ministry of Social Affairs and Housing 2001) pertaining to women. The MICS was a national survey of 4,293 households with the objective of providing “internationally comparable up-to-date information for assessing the situation of children (under the age of 5 years) and women (aged 12-49 years) in Suriname at the end of the decade” (Ministry of Social Affairs and Housing, 2001, p. 13)

(I) CONTRACEPTION

Forty-two per cent of women who are married or in common law union reported that they are currently using contraceptives. The most popular method is the pill which is being used by 25 per cent of the women, followed by female sterilization, which is used by a little over 9 per cent of the women. Factors including education, residence and age differentiate current users. Almost 53 per cent of current users have secondary education or higher, 51 per cent live in urban areas and 45 per cent are between 25 and 49 years of age. Also, an overwhelming proportion of current users (96%) use modern contraceptives as opposed to traditional methods of contraception.

(II) HIV/AIDS

(a) Knowledge

Almost all women (92.6%) have heard of AIDS. There is no geographical differentiation in knowledge of AIDS as 96 per cent of urban, 92 per cent of rural dwellers and 82 per cent of those living in the interior have heard of AIDS. However, these proportions rapidly decline as we tap specific knowledge. Only 36 per cent of

women know all three ways of preventing HIV transmission, that is, having one faithful uninfected partner (mutual monogamy), consistent condom use and abstinence. Also, only 35 per cent correctly identified the three misconceptions about HIV transmission, that is, HIV can be transmitted by supernatural means, through mosquito bites, and that a healthy looking person cannot be infected. Finally, only a fifth of the women have “sufficient knowledge”, that is, they know all three ways to prevent HIV transmission and three misconceptions about transmission. Detailed knowledge is a function of level of educational attainment as illustrated by Table 4.

Table 4: Per cent distribution of Level of Knowledge about HIV/AIDS by Women’s Educational Attainment, Suriname, 2000

	Knows three ways to prevent HIV transmission	Identifies three misconceptions	Has sufficient knowledge
<u>Women’s Education</u>			
None (n=371)	6	6.5	1.9
Primary (n=1399)	22.4	15.7	9.2
Secondary and over (n=2728)	46.4	49.5	28.3

Source: Ministry of Social Affairs and Housing, 2001, p. 94.

Almost half of those who have at least a secondary education know the three preventive methods and the three misconceptions. Almost three in ten of them have sufficient knowledge. Those who have primary education lagged behind on all three counts: they score between a third and a half of the performance of those with at least a secondary education on the three measures of knowledge of HIV/AIDS.

Seventy-two per cent of the women know that AIDS can be transmitted from mother to child. However, the proportions drop when they are questioned about specific mechanisms for transmission: 67 per cent know that transmission can occur during

pregnancy, 48.5 per cent know that transmission can take place during delivery and 44 per cent indicate that transmission is possible through breast milk. In all, less than a third (31 per cent) of the women know all the three modes of mother-to-child transmission and almost three out of every ten (29%) women did not know any means.

(b) Discriminatory Attitudes

The Multiple Indicator Cluster Survey (MICS) explored aspects of discriminatory attitudes the women may harbour against persons with HIV/AIDS. Almost half (47.5%) of the sampled women subscribes to the view that a teacher with HIV should not be allowed to work but only one in seven (14 %) would not buy food from a person with HIV/AIDS. In all, 49 per cent of the respondents agree with at least one of these attitudes while 51 per cent agree with neither, an even split in the population between negative and positive attitudes towards persons living with HIV/AIDS.

Table 5 shows that the attitude against teachers with HIV/AIDS is harder in urban areas and among those with secondary and higher levels of education. This is rather surprising, and needs further study.

Table 5: Per cent distribution expressing discriminatory attitude by place of residence and education, Suriname, 2000

<u>Residence</u>	Teacher with HIV should not be allowed to Work	
	<u>%</u>	<u>n</u>
Urban	58.7	2371
Rural	40.1	1477
Interior	25.8	707
<u>Education</u>		
None	21.9	371
Primary	25.7	1399
Secondary and over	62.5	2728

Source: Ministry of Social Affairs and Housing, 2001, p. 93.

(c) AIDS Testing

Fifty six per cent of the sampled women know where to go for an AIDS test and ten per cent of these women have been tested. This knowledge varies by residence and educational level of the respondents as shown in Table 6 below.

Table 6: Per cent distribution of knowledge of a testing facility for HIV/AIDS by women's residence and educational level, Suriname, 2000

	Know a place to get tested	n
<u>Residence</u>		
Urban	66.4	2371
Rural	51.0	1477
Interior	32.3	707
<u>Education</u>		
None	18.6	371
Primary	39.0	1399
Secondary and over	70.3	2728

Source: Ministry of Social Affairs and Housing, 2001, p. 95.

Almost two thirds of urban women as opposed to half of the rural residents know where to go for testing. Also, seven out of every ten persons with at least secondary education as opposed to almost four out of every ten persons with primary education know where to be tested for HIV infection.

(d) HIV/AIDS in the General Population

The data presented in the preceding sections deal exclusively with women aged 12-49 years. We have no comparable data for men. However, data from UNAIDS help to fill part of this gap. The following estimates given in Table 7 are taken from UNAIDS 2002 update.

Table 7: Estimated Number of Adults and Children Living with HIV/AIDS, end of 2001

Adults and Children	3,700
Adults (15-49)	3,600
Women (15-49)	1,800
Children (0-15)	190
Adult rate (%)	1.2

Source: UNAIDS/WHO Epidemiological Fact Sheet 2002 Update.

The above estimates are likely to be low. UNAIDS notes that “it is likely that the real figure is 3 or 4 times higher than what appears from tests, especially given the fact that the majority of registered HIV cases were tested because of clinical indications. In Suriname there is no clear policy on voluntary testing for HIV” (UNAIDS/WHO, 2002 Update).

(III) WOMEN AND POVERTY

The Multiple Indicator Cluster Survey 2000 reported that the proportions of urban, rural and interior households living below the poverty line are 52%, 61% and 91% respectively. The Survey advises caution in making geographical comparisons because the poverty assessment depends on “income and the price of a basic food basket. However, in the interior many communities depend on subsistence farming for food intake, rather than earning exclusively a money income” (Ministry of Social Affairs and Housing, 2001, p. 21).

Using mean monthly expenditures reveals similar wide differentials among the three residential areas observed earlier. Mean monthly expenditures are about SRG 244,000 in the urban stratum, SRG 200,000 in the rural stratum and SRG 73,000 in the interior.

Earlier reviews by non-governmental organizations and others reveal the following (UNIFEM, 2000):

- (a) The economic development activities in the 1986-96 decade have sent elderly persons back to work such that elderly women earn their living by working as midwives, child minders, administrators, herbal medical practitioners or masseurs.
- (b) In 1996 and 1997 the unemployment rate of women was twice that of men.
- (c) Government is the main employer of women. However, the proportion of female civil servants decreased from 40 per cent in 1992 to 28.4 per cent in 1997. Most of these employees are in the lowest ranks, for example, seven out of every ten low level civil servants in 1995 were females.
- (d) Women experience substantial difficulty in accessing credit presumably because most of them do not have the needed collateral.

(IV) WOMEN AND VIOLENCE

Women in Suriname face many challenges in dealing with violence directed at them. The UNIFEM (2000) has documented several of these issues:

- (i) There is paucity of reliable data on violence against women and children.
- (ii) Legislations dealing with domestic violence are inadequate and penalties for violence against women minimal.
- (iii) Victims, especially those from the lower classes, face difficulties in accessing legal aid.
- (iv) Crisis centres do not exist to address the needs of victims.

- (v) Official data show that half of the victims of sexual abuse is younger than 16, with the majority being female.
- (vi) Violence against commercial sexual workers is grossly under-reported.

NATIONAL POLICIES AND PROGRAMMES

(i) NATIONAL POPULATION POLICY

Table 8 shows a summary of Government's perceptions of the demographic situation in the country and policies to deal with the various issues. In a nutshell, the data indicate that the Government of Suriname considers the levels of fertility, life expectancy at birth and population growth as satisfactory but deems levels of child and maternal mortality and HIV/AIDS as unacceptable. For a country that is so sparsely populated, it is understandable if it considers emigration as too high and unacceptable but to regard immigration as also too high and unacceptable demands further examination. Another area of major concern is adolescent fertility but no policies or programmes are in place to deal with it. Approximately 70 per cent of the country's population lives on 0.4 per cent (Paramaribo and District of Wanica) of the land. Consequently, it is understandable for the government to call for major changes in spatial distribution.

Table 8: Government perceptions and policies

<i>Population policy variable</i>	1996	2001
Population growth and age structure		
View on growth	Satisfactory	Satisfactory
Policy on growth	No intervention	No intervention
Level of concern about		
Size of the working-age population	..	..
Ageing of the population	..	..
Fertility and family planning		
View on fertility level	Satisfactory	Satisfactory
Policy	No intervention	No intervention
Access to contraceptive methods	Direct support	Direct support
Adolescent fertility		
Level of concern	Major concern	Major concern
Policies and programmes	No	No
Health and mortality		
View		
Expectation of live	Acceptable	Acceptable
Under-five mortality	..	Unacceptable
Maternal mortality	..	..
Level of concern about AIDS	Major concern	..
Grounds on which abortion is permitted	1 ^a	1 ^a
Spatial distribution		
View	Major change desired	Major change desired
Policies on spatial distribution		
Between regions	No intervention	..
Between rural and urban places	Yes	..
Policies on internal migration		
Into metropolitan areas	No intervention	..
From rural areas to other locations	Lower	..
International migration		
Immigration		
View	Too high	Too high
Policy	Lower	Lower
Permanent settlement	No intervention	..
Migrant workers	Lower	..
Dependants of migrant workers	Maintain	..
Integration of non-nationals	No	..
Emigration		
View	Too high	Too high
Policy	Lower	Lower
Encouraging the return of nationals	Yes	..

^a Grounds on which abortion is permitted: (1) to save the woman's life.

Source: United Nation, *National Population Policies, 2001, NY, 2002.*

(II) THE ELDERLY

Table 9 shows the total number of elderly persons receiving Old Age Pensions since 1992.

Table 9: Number of Persons Receiving Old Age Pensions by Years

Year	Total Number of Recipients
1992	31565
1993	32293
1994	32709
1995	33463
1996	34531
1997	34176
1998	35208
1999	36460
2000	37452

Source: General Bureau of Statistics, Statistical Yearbook 2000 of Suriname, 2001, p. 44.

The estimated population of Suriname at the beginning of 2000 is 433,000 (General Bureau Statistics, 2001, p. 1). Using the United Nations' estimate of 8.1 per cent for the elderly in the population for that year, we obtain a total of 35,073. This result may seem to indicate that all the elderly have been well-taken care of by the Pension Scheme. This may be so but it is doubtful if persons in the interior are served as those in Paramaribo.

Beginning in February 1999, each person on the Old Age Pension Scheme receives SF 25,000 per month. There is no other mention of other benefits, if any, available to the elderly in Suriname.

TRINIDAD AND TOBAGO

UNFPA BASELINE STUDY

TRINIDAD AND TOBAGO

Trinidad and Tobago has made significant progress with respect to the demographic transition, a process that entails moving from a regime of high mortality and fertility levels to one characterized by low mortality and fertility. In the process of the transition, population growth rate changes from low to high and back to low rate. Table 1 shows some demographic statistics for 1960-2000. Total fertility rate has declined from 5.6 children per woman in 1960 to 1.6 in 2000, or a decline of more than 70 per cent in 40 years. The life expectancy at birth has increased steadily over the years reaching 72 years for males and almost 77 for females in 2000. In 1960, children under 15 years of age comprised 43 per cent of the population; by 2000 this proportion has fallen to 25 per cent. On the other hand, the economically active population, 15-64 years old, has grown from 53 per cent in 1960 to 68 per cent in 2000. Also, the elderly aged 65 years or older grew from 4 per cent in 1960 to almost 7 per cent in 2000. As a result of the decrease in the numbers of children under 15, the moderate rise in the numbers of the elderly, and the more rapid increase in the economically active population (the denominator), the dependency ratio has declined from 89 in 1960 to 47 in 2000. However, a further disaggregation of the dependency shows that while the child (0-14) dependency ratio has been declining, the old age (65+) ratio has continued to increase. In 2000, child dependency ratio was 37 and old age dependency ratio was 10 per 100.

Table 1: Demographic Statistics for Trinidad and Tobago 1960-1991

	Census Years				
	1960	1970	1980	1991	2000
Total Fertility Rate	5.6	3.6	3.2	2.4	1.6
Crude Birth Rate	40	26	28	20	13.5
Crude Death Rate	8	7	7	7	6
Total Dependency Ratio	89	85	67	67	47
Life Expectancy					
Males	62.1	64.1	66.9	68.4	72
Females	66.3	68.1	71.6	73.2	76.7
Age (%)					
0 – 4	17	13	12	11	} 25
5 – 14	26	28	22	23	
15 – 24	18	19	23	18	} 68.3
25 – 64	35	35	37	42	
65+	4	5	6	6	6.7

Source: ECLAC/CDCC Demographic Unit, Digest of Selected Demographic and Social Indicators 1960-1994 for CDCC Members, Trinidad and Tobago, December 1995; PAHO, Health in the Americas Vol. II, PAHO Science Publication No. 587, 2002. United Nations, World Population Ageing 1950-2050, NY, 2002.

We now turn a more detailed examination of the major components of the population.

THE ELDERLY

As indicated above (Table 1) the proportion of the elderly in the population has been increasing. Table 2 provides further details of the likely characteristics in the future.

Table 2: Projected Demographic Characteristics of the Elderly in Trinidad and Tobago 2025-2050

Total Population % in Older Ages	Age	2025	2050	
		1,437.3m	1,377.7m	
Total Population	60+	20.1%	33.3%	
	65+	13.8	25.7	
	80+	2.5	6.9	
Female	60+	21.6	35.7	
	65+	15.3	28.1	
	80+	3.2	8.6	
Male	60+	18.4	30.7	
	65+	12.4	23.1	
	80+	1.8	5.1	
Median Age (Yrs)		39.5	44.8	
Ageing Index		107.3	203.0	
Potential Support Ratio		4.9	2.3	
Sex Ratio (per 100 women)	60+	82.1	80.9	
	65+	78.0	77.2	
	80+	55.5	55.5	
Growth Rate (%)	Age	2000-2005	2025-2030	2045-2050
	Total Population	0.5	0.1	-0.4
	60+	2.6	2.0	1.2
	65+	2.3	3.6	2.4
	80+	3.2	4.9	1.2
Life Expectancy (Yrs)	Age	2000-2005	2025-2030	2045-2050
Total	0	74.8	78.6	80.5
	60	19.7	21.9	23.3
	65	16.1	18.0	19.3
	80	7.5	8.6	9.4
Female	0	77.2	81.1	83.0
	60	21.2	23.9	25.3
	65	17.3	19.8	21.1
	80	8.2	9.6	10.4
Male	0	72.5	76.1	78.0
	60	18.1	19.7	21.1
	65	14.7	16.0	17.2
	80	6.7	7.2	7.9
Labour Force Participation (%)	Age	1990	2000	2010
Total	65+	12.0	10.2	8.9
Female	65+	5.2	4.5	4.0
Male	65+	18.9	16.2	14.1

Source: United Nations, *World Population Ageing 1950-2050*, New York, 2002, pp. 444-445.

Table 2 shows that the elderly (60+) will be a fifth of the total population by 2025 and a third by 2050. The elderly is growing faster than the total population, between two to five times faster in the 2000 - 2050 period. Also, between 2000 and 2030, the oldest elderly (80+) group will be growing much faster than the total population, the 60+ or the 65+ age groups. Females predominate in the elderly age groups. Among the 60+ or the 65+ age group, on the average, we have about 80 males per 100 females. However, at the 80+ age group, there will be two females for one male in 2025 and beyond. The situation described above is a consequence of the fact that females live longer than males, even at older ages. At ages 60 or 65, females have a life expectancy that is 3 to 4 years higher than males. Though the differential is narrowed, females enjoy this advantage even at age 80 years or older. Finally, some of the elderly continue to work at their advanced age. In 2000 about 10 per cent of the elderly aged 65 years or older continue to work. As noted for Jamaica, gender differentials in labour force participation observed at younger ages continue. Between 2000 and 2010 the male/female labour force participation by the elderly will be of the order of 3:1. This mirrors a rate reported by PAHO recently. It noted that “the labour force participation rate has not experienced major changes over the period 1997 to 1999, with 45.9% to 46.6% for females and 74.8% to 74.9% for females” (PAHO, 2002, p. 515).

A national policy for the elderly in Trinidad and Tobago is being developed, though the government appears to view matters relating to elderly as of major concern (Table 3). Care for the elderly is provided by religious organizations, community and private groups and one public health facility (PAHO, 2002, Blake 2002). In a recent study of three community homes for the elderly, Blake (2002) identified some of the

challenges confronting these homes such as, funding, maintenance, security and staffing. It is hoped that the policy on the elderly that is being formulated would lead to more government involvement in this sector bearing in mind that the elderly would constitute about 20 per cent of the population by 2025 (Table 2).

POVERTY

In 1996, 36 per cent of the population was poor (using a poverty line of US\$100 per capita), though variability among the counties was wide, ranging from a low of 8.3 per cent in Diego Martin to 56.3 per cent in Rio Claro/Mayaro (PAHO, 2002, p. 515). Poverty was concentrated in female-headed households and the least educated. However, only 21 per cent of the population are below the National Poverty Line (UNDP, 2002).

WOMEN

In 1997-99 labour force participation rate for women hovered around 47 per cent compared to that of male labour force participation which was around 75 per cent. Thus underscoring the dominance of males in the labour market where they account for 60 per cent. Unemployment rate is higher among females than males. In 1999 male unemployment rate was 11 per cent compared to 17 per cent among females (PAHO, 2002, p. 515).

HIV/AIDS

The Government's Medium Term Policy Framework (2001-2003) placed HIV/AIDS high on its agenda as a response to increasing incidence of the disease,

especially as the number of new infections doubled every three to four years (PAHO, 2002, p. 518). The AIDS rate in 1996 was 32.5 per 100,000 population, five times higher than the 6.6 per 100,000 in 1986. The UNAIDS (2002) gives the following data for Trinidad and Tobago:

Estimated number of adults and children living with HIV/AIDS, end of 2001

Adults (15 – 49).....17,000

Women (15 – 49).....5,600

Children (0 – 14)..... 300

Estimated number of deaths due to AIDS

Adults and children (2001).....1,200

Estimated number of orphans, end of 2001

Current living orphans under 15.....3,600

PAHO (2002) reported that AIDS data are grossly underreported, probably by as much as 50%.

The median age of reported cases is 34 years (males) and 28 years (females). More females than males are reported as infected in the 15-24 age group. The gap between males and females is narrowing. PAHO (2002) reports that the male-female ratio was 1.9:1 in 1995 and has declined to 1.3:1 in 1999. Paediatric cases now constitute 5 per cent of all reported HIV cases. The major mode of transmission is heterosexual, and multiple partnership is the modal risky behaviour cited.

Health Sector Reform

The Health Sector Reform programme led to the restructuring of the Ministry of Health in 1999. The number of health authorities was reduced from five to four in 2000. The reform programme aimed at improving coverage and access to health services by addressing the following issues:

- (a) Creation of a national health insurance system
- (b) Development of modern management systems within a decentralized model of health services
- (c) Upgrading primary health care facilities countrywide
- (d) Staff training and retraining
- (e) Reorganization of health information and national surveillance systems
- (f) Development of health promotion and prevention (PAHO, 2002, p. 520).

The Disabled

PAHO (2002, p. 517) reports that a survey of 7892 person aged 0-18 showed that 2.1 per cent had disabilities. The proportion with disability by age group is as follows:

<u>Age Group</u>	<u>% with Disabilities</u>
0-4	15.5
5 – 9	39.3
10 – 14	29.2
15 – 18	<u>16.0</u>
	100.0

Males comprise 59 per cent of those with disabilities. The most common disabilities were learning (25%), sight (24%), and speech and hearing (18%).

Population Policy

Table 3 shows a summary of the Government's position on various aspects of population policy.

Table 3: Trinidad and Tobago Government perceptions and policies

<i>Population policy variable</i>	1996	2001
Population growth and age structure		
View on growth	Too high	Too high
Policy on growth	Lower	Lower
Level of concern about		
Size of the working-age population	..	Minor concern
Ageing of the population	..	Major concern
Fertility and family planning		
View on fertility level	Too high	Too high
Policy	Lower	Lower
Access to contraceptive methods	Direct support	Direct support
Adolescent fertility		
Level of concern	..	Major concern
Policies and programmes	..	Yes
Health and mortality		
View		
Expectation of live	Acceptable	Acceptable
Under-five mortality	Acceptable	Unacceptable
Maternal mortality	..	Unacceptable
Level of concern about AIDS	Major concern	Major concern
Grounds on which abortion is permitted	1,2,3 ^a	1,2,3 ^a
Spatial distribution		
View	Major change desired	Satisfactory
Policies on spatial distribution		
Between regions	..	No intervention
Between rural and urban places	..	No intervention
Policies on internal migration		
Into metropolitan areas	..	No intervention
From rural areas to other locations	..	No intervention
International migration		
Immigration		
View	Satisfactory	Satisfactory
Policy	Maintain	Lower
Permanent settlement	..	No intervention
Migrant workers	..	No intervention
Dependants of migrant workers	..	No intervention
Integration of non-nationals	..	Yes
Emigration		
View	Too high	Satisfactory
Policy	Lower	No intervention
Encouraging the return of nationals	..	No

^a Grounds on which abortion is permitted: (1) to save the woman's life; (2) to preserve physical health; (3) to preserve mental health.
Source: United Nation, National Population Policies, 2001, NY, 2002.

Table 3 shows that areas of policy that are either of major concern or unacceptable include ageing of the population, child and maternal mortality, and HIV/AIDS.

GUYANA

UNFPA BASELINE STUDY

GUYANA

DEMOGRAPHIC BACKGROUND

Guyana, just like other countries under study, has made considerable progress in the demographic transition process. Total fertility rate has declined from 6.7 children during 1950-55 to 3.1 in 1990 and is projected to decline further to 2.3 during 2000-2005 (UNECLAC/CDCC 1995, p. 116, UN 2002, p. 261). Mortality conditions have steadily improved over the years yielding a life expectancy at birth of 52.3 years during 1950-55 and rising to 64.8 years in 1998. In 1998 life expectancy at birth for females was 68.2 years and 61.5 years for males (PAHO, 2002, P. 324, UN 2002, p. 261). These figures are slightly higher than U.N. estimates in Table 2. Annual rate of growth has steadily declined from a high of 2.8 per cent during the 1950s to 0.8 per cent during the 1970-80 decade. A negative growth was noted during the following decade. However, a slight positive growth is projected for the 2000-2005 (Table 1).

Table 1: Demographic Statistics for Guyana

	1950/1960	1960/1970	1970/1980	1980/1991	2000/2005
Annual Growth Rate	...	2.2	0.8	-0.5	0.2
	<u>1960</u>	<u>1970</u>	<u>1980</u>	<u>1990</u>	<u>2000/2005</u>
Total Fertility Rate	...	...	3.2	3.1	2.3
Crude Birth Rate	43	34	29	24 (1991)	n.a.
Crude Death Rate	10	7	6	7	
Infant Mortality Rate	...	57	36	28 (1990/91)	
Age (%)					
0 – 4		16	13	12	
5 – 14		31	28	23	
15 – 64		49	55	61	
65+		4	4	4	
Total Dependency Ratio		104	82	64	

Source: UNECLAC/CDCC, 1995. Digest of Selected Demographic and Social Indicators 1960-1994, Port of Spain, Trinidad and Tobago.

Table 1 shows that the structure of the population has also changed in the past thirty years. Forty-seven per cent of the population was under 15 years of age in 1970; by 1991 this proportion had decreased to 35 per cent. The economically active population, that is the 15-64 age group, has increased from almost half (49%) in 1970 to above three-fifths (61%) of the population in 1991. The 65+ age group on the other hand, has remained constant at 4 per cent of the population throughout the 1970-1991 period.

Given the above background, we turn to a more detailed consideration of the components of the population.

THE ELDERLY

In this study the elderly has been defined as persons who are 60 years of age or older. On this basis, we note that this age group is about 7 per cent of the population (6.7% in 1950 and 6.9% in 2000). Table 2 shows this proportion will reach 15 per cent by 2025 and again more than double by 2050 when it will be 31 per cent. At present the 60+ age group is growing at a rate that is six times faster than the growth rate of the total population, i.e. 1.2 vs. 0.2 per cent per annum. This disparity is projected to accelerate even further. By 2025-2030 when the entire population is projected to be decreasing by almost one per cent, 60+, 65+ and 85+ age groups would be growing by three, four and five per cent per annum respectively.

Females outnumber males among the elderly, as noted for other countries being studied. Among the 60+, there would be between 61 and 63 males for every 100 females in 2025 and 2050. At the oldest elderly group, the 80+, the ratio would be more than two females for every male.

Table 2: Projected Demographic Characteristics of Guyanese Elderly 2025-2050

		<i>2025</i>	<i>2050</i>
<i>Total Population (000)</i>		<i>702.9</i>	<i>503.9</i>
<i>% in Older Ages</i>		<i>Age</i>	
<i>Total Population</i>		<i>60+</i>	<i>31.0%</i>
		<i>65+</i>	<i>25.6</i>
		<i>80+</i>	<i>6.9</i>
<i>Female</i>		<i>60+</i>	<i>35.5</i>
		<i>65+</i>	<i>29.8</i>
		<i>80+</i>	<i>9.0</i>
<i>Male</i>		<i>60+</i>	<i>25.8</i>
		<i>65+</i>	<i>20.7</i>
		<i>80+</i>	<i>4.4</i>
<i>Median Age (years)</i>		<i>33.0</i>	<i>44.2</i>
<i>Ageing Index</i>		<i>67.7</i>	<i>179.8</i>
<i>Potential Support Ratio</i>		<i>6.7</i>	<i>2.2</i>
<i>Sex Ratio (per 100 women)</i>		<i>60+</i>	<i>62.8</i>
		<i>65+</i>	<i>60.1</i>
		<i>80+</i>	<i>42.7</i>
<i>Growth Rate (%)</i>		<i>2000-2005</i>	<i>2025-2030</i>
<i>Total Population</i>		<i>0.2</i>	<i>-0.8</i>
<i>60+</i>		<i>1.2</i>	<i>3.0</i>
<i>65+</i>		<i>0.6</i>	<i>3.9</i>
<i>80+</i>		<i>2.9</i>	<i>4.9</i>
<i>Life Expectancy (years)</i>		<i>Age</i>	<i>2000-2005</i>
<i>Total</i>		<i>0</i>	<i>62.4</i>
		<i>60</i>	<i>64.1</i>
		<i>65</i>	<i>20.1</i>
		<i>65</i>	<i>16.5</i>
		<i>80</i>	<i>18.1</i>
		<i>80</i>	<i>7.8</i>
<i>Female</i>		<i>0</i>	<i>66.9</i>
		<i>60</i>	<i>68.7</i>
		<i>65</i>	<i>21.6</i>
		<i>65</i>	<i>17.7</i>
		<i>80</i>	<i>19.5</i>
		<i>80</i>	<i>9.3</i>
<i>Male</i>		<i>0</i>	<i>58.0</i>
		<i>60</i>	<i>59.6</i>
		<i>65</i>	<i>17.9</i>
		<i>65</i>	<i>14.7</i>
		<i>80</i>	<i>16.1</i>
		<i>80</i>	<i>7.5</i>
<i>Labour Force Participation (%)</i>		<i>Age</i>	<i>1990</i>
<i>Total</i>		<i>65+</i>	<i>17.2</i>
<i>Female</i>		<i>65+</i>	<i>14.9</i>
<i>Male</i>		<i>65+</i>	<i>13.1</i>
		<i>65+</i>	<i>5.1</i>
		<i>65+</i>	<i>4.7</i>
		<i>65+</i>	<i>25.0</i>
		<i>65+</i>	<i>27.8</i>
		<i>65+</i>	<i>25.0</i>

Source: United Nations, World Population Ageing 1950-2050, New York, 2002, pp. 260-261.

As noted earlier, life expectancy at birth is higher for females than males. This disparity continues even at older ages. Females aged 60 years can expect to live three to four years longer than males. Even females aged 80+ years can look forward to one to two years longer life than their male counterparts.

The elderly would continue to work to contribute to their upkeep. However, while only about 5 per cent of females aged 65+ would be involved in the labour force, between 25 and 31 per cent of elderly males would be employed. This gender disparity in labour force participation is a feature of the labour force in all the countries and across age groups.

WOMEN

Females are in majority in the Guyanese population as shown by Table 3. Females by the 1991 census comprised 51 per cent of the population. The United Nations projections suggest that the proportion of the population that is female would continue to increase in the years ahead (UN, 2002, p. 260).

Table 3: Sex ratios for Census Years 1960-1991 and 2000, Guyana

Year	Males per 100 Females
1960	99
1970	99
1980	98
1991	97
2000	94

Source: United Nations, World Population Ageing 1950-2050, New York, 2002, pp. 260-261.

YOUNG PERSONS

Table 1 shows that, according to the 1991 Population Census, 35 per cent of the population are under 15 years of age. Adolescents, persons aged between 10 and 19

years of age, make up 22 per cent of the population (Cox, 1997, p. 1). Further breakdown of the latest census data is not available. However, UN medium variant projections (UN, 1998, p. 618) indicate that the youth, persons aged 15 – 24, would be 19.4, 19.5, 19.9 per cent of the population in 1995, 2000 and 2005 respectively. In short, those aged 15 – 24 years of age constitute about a fifth of the population and this is consistent with empirical data for the Caribbean Region and elsewhere.

According to PAHO, 22 per cent of the births in 1998 were to girls aged 15-19. In 1999 this proportion increased to 24 per cent (PAHO, 2002, p. 325). This is probably not an improvement from 1992 when the Contraceptive Prevalence Survey found that 30 per cent of all live births were due to teenage girls. Also, according to the Guyana Adolescent Health Survey, 90 per cent of respondents aged 10-18 had become sexually experienced by age 15. Almost half (48%) of those sexually active never used contraceptive methods (PAHO, 2002, p. 325).

POVERTY

Guyana is one of the poorer Caribbean countries. According to the 1999 Survey of Living Conditions 70 per cent of the population live in rural areas, especially in the rural coastal regions. The survey found that the average household size was 4.2 and also that almost three out of every five (59%) head of household had attained only primary level of education.

The 1999 survey found that 36 per cent of the population lived in absolute poverty, that is, had less than US\$510 per annum. Poverty is concentrated in the rural areas with 78 per cent of the poor living in the rural interior areas (MOH, 2002, p. 6).

HIV/AIDS

Table 4 displays HIV/AIDS data for Guyana by the end of 2001. The adult prevalence rate of 2.7 per cent places Guyana at the top end of the regional ranking behind Bahamas (3.5%) and Haiti (6.1%).

Table 4: Estimated Number of Adults and Children Living with HIV/AIDS, End of 2001

Adults and Children	18,000
Adults	17,000
Women	8,500
Children (0 – 14)	800
Adult rate (%)	2.7

Source: UNAIDS, 2002. Guyana. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections 2002 Update.

Data from the Ministry of Health indicate that females make up 38 per cent of all AIDS cases but overtake males at young ages of 15-24. In all, most AIDS cases are in the 20-49 age group and the modal age group is 30-34. There is also a regional variation in prevalence rates. According to data from 2000, about 80 per cent of HIV/AIDS cases are from Region 4 (prevalence rate of 144.8 per 10,000), and 10 (86.6 per 10,000). Region 3 has a prevalence rate of 33.8 per 10,000 while the rates for the remaining regions range from 6.2 to 28.6 per 10,000 (MOH, 2002, p. 2).

The Ministry of Health further asserts that AIDS is currently the second leading cause of death. The Ministry also observes that “the true extent of the problem is unknown since AIDS data are incomplete and seroprevalence data outdated. A serious situation of underreporting exists, estimated at approximately 60%” (MOH, 2002, p. 8).

NATIONAL POLICIES

We next examine government policies in various areas of national life.

(a) NATIONAL POPULATION POLICY

Table 5 shows aspects of government's population policy.

Table 5: Government Perceptions and Policies: A Summary

Guyana		
Population policy variable	1996	2001
Population growth and age structure		
View on growth	Satisfactory	Satisfactory
Policy on growth	No intervention	No intervention
Level of concern about		
Size of the working-age population	..	..
Ageing of the population	..	..
Fertility and family planning		
View on growth	Satisfactory	Satisfactory
Policy	No intervention	No intervention
Access to contraceptive methods	Direct Support	Indirect support
Adolescent fertility		
Level of concern	..	..
Policies and programmes	..	..
Health and mortality		
View		
Expectation of life	Unacceptable	Acceptable
Under-five mortality	..	Unacceptable
Maternal mortality	..	Unacceptable
Level of concern about AIDS	..	Major concern
Grounds on which abortion is permitted	1,2,3,4,5,6,7 ^a	1,2,3,4,5,6,7 ^a
Spatial distribution		
View	Minor change desired	Minor change desired
Policies on spatial distribution		
Between regions	..	..
Between rural and urban places	..	..
Policies on internal migration		
Into metropolitan areas	..	..
From rural areas to other locations	..	..
International migration		
Immigration		
View	Satisfactory	Too high
Policy	Raise	Lower
Permanent settlement	Raise	Lower
Migrant workers	..	Lower
Dependants of migrant workers	..	Lower
Integration of non-nationals	..	No
Emigration		
View	Too high	Too high
Policy	No intervention	No intervention
Encouraging the return of nationals	..	..

^aGrounds on which abortion is permitted: (1) to save the woman's life; (2) to preserve physical health; (3) to preserve mental health; (4) rape or incest; (5) fetal impairment; (6) economic or social reasons; (7) on request.

Source: *United Nations National Population Policies 2001*, p. 72.

Government indicates that levels of population growth, fertility and immigration are satisfactory and, therefore, deserve no intervention. The levels of life expectancy at birth, child and maternal mortality and emigration are unacceptable. It is rather surprising that no intervention is planned either to reduce emigration which government considers too high or to stimulate population which is currently very low.

(b) HIV/AIDS

The National Strategic Plan for HIV/AIDS 2002-2006 (MOH, 2002) succeeded the National Strategic Plan for HIV/AIDS 1999-2001. Highlights of the 1999-2001 included:

- (1) “Increased availability of voluntary counseling and testing.
- (2) Provision of safe blood and blood products through donor screening.
- (3) Provision of treatment for sexually transmitted infections in order to reduce transmission.
- (4) Greater involvement of NGOs and some large private enterprises.
- (5) Programme to prevent mother-to-child transmission
- (6) Limited provision of antiretroviral therapy” (MOH, 2002, p. 1).

The Ministry identified the following limitations in implementing the 1999-2001 Strategic Plan:

- (1) “Insufficiency of resources – human, technological and financial.
- (2) The preoccupation of the National AIDS Programme Secretariat (NAPS) with implementation rather than management and coordination.

- (3) The multi-sectoral response was less than anticipated – the public sector response being mainly from the Ministry of Health with some involvement of the Ministry of Labour.
- (4) Continued stigmatization and discrimination of HIV infected persons.
- (5) Limited geographical coverage of interventions” (MOH, 2002, p. 1).

The 2002-2006 Plan took account of the experiences emanating from the previous plan and earlier initiatives. More than the first plan, the 2002-2006 Plan involved more stakeholders, that is, public and private sectors, NGOs, religious organizations, individuals and international agencies.

OBJECTIVES OF THE 2002-2006 STRATEGIC PLAN

The broad objective of the Plan is “to reduce the social and economic impact of HIV and AIDS on individuals and communities, and ultimately the development of the economy” (MOH, 2002, p. 6). The specific objectives include:

- (1) “to reduce the risk and vulnerability to infection through prevention and control of the transmission of STIs and HIV, and promoting sexual health
- (2) saving/prolonging and improving quality of life of persons living with STIs, HIV/AIDS” (MOH, 2002, p. 6).

The guiding principles of the Plan are:

- (1) “The use of a coordinated multi/inter-sectoral and inter-disciplinary approach.
- (2) Upholding the rights and responsibilities of persons affected, and striving for active/greater involvement of PLWHA in planning and implementation of the response.

- (3) Providing information and a supportive environment to empower persons to prevent further HIV transmission.
- (4) Guaranteeing voluntary counseling and testing and confidentiality.
- (5) Integration of care and support of PLWHA into existing health and social services.
- (6) Minimizing and eliminating where possible any inequities between regions in the response to the HIV/AIDS epidemic” (MOH, 2002, p. 6).

ORGANIZATION OF THE PLAN

The plan has the following four components, each with its specific objective.

- (a) Surveillance
- (b) Care, Treatment and Support
- (c) Risk Reduction
- (d) Management, Coordination and Policy Formulation

OBJECTIVES OF THE PROGRAMME COMPONENTS

SURVEILLANCE

“To strengthen the surveillance system to produce information that will be most useful in designing interventions for reducing the spread of HIV/AIDS and in planning care for those affected” (MOH, 2002, p. 9).

CARE, TREATMENT AND SUPPORT

“To improve the quality and length of life of persons infected and affected by HIV/AIDS, in a supportive environment, so they could achieve their maximum potential” (MOH, 2002, p. 13).

RISK REDUCTION

“To reduce the risk and vulnerability to infection with HIV” (MOH, 2002, p. 19).

MANAGEMENT, COORDINATION AND POLICY FORMULATION

“National Strategic Plan for HIV/AIDS being managed in a well coordinated and transparent manner, with a multi-sector approach within a supportive environment” (MOH, 2002, p. 23).

NGOs have been active in HIV/AIDS work in six of the ten regions of Guyana. They have focused on Information, Education and Communication (IEC), and Care, Treatment and Support. NGOs have enhanced opportunity to continue this work in the 2002-2006 period especially under the Care, Treatment and Support, and Risk Reduction components of the new plan.

Guyana has also made considerable progress in sensitizing workers about HIV/AIDS. In 2001 HIV/AIDS awareness workshops were conducted at 600 workplaces involving almost 14,000 employees in the public and private sectors. Also, in the recent past sensitization workshops have been carried out for the general public, health care providers, youths entertainers and female sex workers (MOH, 2002, pp. 4-5).

(c) HEALTH SECTOR REFORM

The Public Health Service is organized in five tiers: Local Health Posts, Health centres, District Hospitals, Regional Hospitals and the National Referral Hospital. In addition, there are three national institutions: National Psychiatric Hospital, National

Rehabilitation Centre and Geriatric Hospital. Private hospitals, clinics, dispensaries and diagnostic facilities supplement these public facilities.

The health sector faces major constraints and these include:

- (1) “inequitable access to health care,
- (2) poor quality of care at the lower levels...
- (3) lack of timely information for planning and decision-making
- (4) inadequacy in the training programmes and in health education services.”

(MOH, May 2002, p. 7).

SECTORAL OBJECTIVES

The objectives of the health sector are to:

- (1) “Increase the length of healthy life for all people in Guyana and
- (2) Reduce health disparities among social groups” (MOH, May 2002, p.7).

One approach to advance these objectives is the health sector reform currently being undertaken by the Ministry of Health. The strategies include restructuring and reorganizing the Ministry of Health and decentralizing responsibilities for service delivery. These reforms are “intended to improve targeting and efficiency of spending and to ensure adequacy of resources to health interventions.” The reforms also seek “to improve the effectiveness and quality of the health system (and) use targeted interventions to maximize the benefits of health care spending” (MOH, May 2002, pp. 7-8).

(d) ELDERLY

The Government of Guyana has formulated a national plan for the elderly with policies on aging and a Bill of Rights for the elderly. This Plan has led to initiatives to improve efficiency in the following areas:

- 1) Training programmes for health care workers
- 2) Education materials for training of the elderly
- 3) Improved services for the elderly
- 4) Development of a health information system
- 5) Development of home care services for the elderly

BELIZE

BELIZE

DEMOGRAPHIC BACKGROUND

Belize had made some progress in completing the demographic transition from high to low fertility; mortality and growth rates. The total fertility rate fell from 6.3 children per woman of reproductive age in 1970 to 4.5 in 1991. On the other hand, life expectancy at birth rose from 58 years during the 1950-1955 period to 70 years (males) and 74 years (females) in 1991. The growth rate of the population fell from 3 per cent per annum during 1950-55 to 1.9 per cent during 2000-2005 (ECLAC/CDCC, 1995, UN, 2001). The structure of population has also changed in the past 30 years. In 1970, 49 per cent of the population were children under 15 years of age; by 2000 this proportion has declined to 38 per cent. The elderly aged 60 years or older comprised 6 per cent of the population in 1950 but increased to 7 per cent in 1999.

Table 1 shows the percentage distribution of the 1999 estimated population of Belize. A little over 38 per cent of the population are below 14 years of age while 52 per cent of the population are under 20 years of age. Seven per cent of the population are 60 years or older. It is when the analyses of the 2000 Population Census are published that we will be in a position to check on the accuracy of the 1999 estimates. We next consider the components of the population in some detail.

THE ELDERLY

As shown earlier the proportion of the elderly has been increasing. The proportion that is 65 years or older was 5 per cent in 1980, 5.2 per cent in 1999 and is projected to rise to almost 7 per cent in 2025. By 2050 the elderly aged 65 years or older

would increase to almost 16 per cent of the total population (Table 2). Similarly, the elderly aged 60 years or older comprised 7 per cent of the population according to the 1999 population estimates. Table 2 shows that this figure would rise to more than 10 per cent by 2025 and then almost 22 per cent by 2050.

Table 1: Percentage Distribution of the Population of Belize by Age, April 1999

Age Group	%
0 – 13	38.22
14 – 19	13.86
20 – 24	8.09
25 – 29	6.70
30 – 34	6.33
35 – 39	6.15
40 – 44	4.92
45 – 49	3.51
50 – 54	2.99
55 – 59	2.20
60 – 64	1.85
65+	5.18
	100.00

Source: Central Statistics Office, 1999 Belize Family Health Survey, Males, November 2001, p. 8.

As noted for other countries in the study, there are more females than males among the elderly. The sex ratio among the elderly aged 60 years or older in the estimated 1999 population was 101 males per 100 females. However, the projected data in Table 2 shows that the ratio would decline to 95 in 2025 and 91 by 2050. Among the oldest elderly aged 80+, the decline is steeper. By 2025, the sex ratio among this group would be 82 males per every 100 females and 71 males for every 100 females by 2050.

Table 2: Projected Demographic Characteristics of Belizean Elderly 2025-2050

			2025	2050	
<i>Total Population (thousand)</i>			324.3	392.4	
<i>% in Older Ages</i>		Age			
<i>Total Population</i>		60+	10.2%	21.7%	
		65+	6.7	15.8	
		80+	1.2	3.4	
<i>Female</i>		60+	10.5	22.7	
		65+	7.0	16.8	
		80+	1.3	4.0	
<i>Male</i>		60+	9.9	20.7	
		65+	6.5	14.8	
		80+	1.1	2.8	
<i>Median Age (years)</i>			30.4	38.1	
<i>Ageing Index</i>			41.9	109.8	
<i>Potential Support Ratio</i>			10.2	4.1	
<i>Sex Ratio (per 100 women)</i>		60+	95.2	90.5	
		65+	94.8	87.5	
		80+	81.7	70.8	
<i>Growth Rate (%)</i>		2000-2005	2025-2030	2045-2050	
<i>Total Population</i>			1.9	1.0	
	60+		2.0	4.3	
	65+		2.5	4.7	
	80+		3.6	4.5	
<i>Life Expectancy (years)</i>		Age	2000-2005	2025-2030	2045-2050
Total	0	74.4	77.5	79.7	
	60	21.0	22.3	23.4	
	65	17.2	18.4	19.3	
	80	8.0	8.7	9.3	
Female	0	75.9	79.5	81.8	
	60	22.0	23.7	25.0	
	65	18.0	19.6	20.7	
	80	8.5	9.4	10.2	
Male	0	73.0	75.7	77.7	
	60	20.1	21.1	21.8	
	65	16.4	17.2	17.9	
	80	7.5	7.9	8.3	
<i>Labour Force Participation (%)</i>		Age	1990	2000	2010
Total	65+	29.3	26.7	24.2	
Female	65+	5.2	4.6	4.1	
Male	65+	55.0	50.1	46.0	

Source: United Nations, World Population Ageing 1950-2050, New York, 2002, pp. 140-141.

The elderly is projected to grow faster than the total population. The elderly aged 60 years or older from 2025 onwards will be growing at more than four times the general

population, though both are growing at the same rate at present. Elderly females continue to maintain the advantage females generally have as far as life expectancy is concerned. Elderly females can expect to live 22 to 25 more years, or two to three years more than elderly males of the same age. Finally, the labour force participation of elderly males in 1990 and 2000 was more than ten times higher than that of elderly females. The projected data for 2010 show no difference from past trends.

WOMEN

Table 3 shows the sex ratios for Belize since 1960. The data show that in recent years males and females were well-balanced such that each sex constitutes about half of the population.

Table 3: Sex Ratios (Males per 100 Females) for Belize Since 1960

Year	Sex Ratio
1960	97
1970	100
1980	103
1991	104
1996	100
1997	99
1998	99
1999	100

Source: United Nations Commission for Latin America/Caribbean Development Committee, Digest of Selected Demographic and Social Indicators, 1960-1994, Port of Spain, 1995, p. 16; Central Statistical Office, 1999, Belize Health Survey, Males, 2001, pp. 8.

YOUNG PERSONS

Table 4 shows the proportion of children in the Belizean population in the census years 1960 to 1991. Since 1970 the proportion of children in the population has fallen

from half to about four in ten. However, youths aged 15-24 years have remained approximately one-fifth of the population since 1970.

Table 4: Proportion of Children (0-14 years of age) in Belize 1960-1999

Age Group	Census Years				
	1960	1970	1980	1991	1999 (Est.)
0-14	44	49	46	44	38 (0-13)
15-24	17	21	21	20	22 (14-24)

Source: United Nations Commission for Latin America/Caribbean Development Committee, Digest of Selected Demographic and Social Indicators, 1960-1994, Port of Spain, 1995, p. 16; Central Statistical Office, 1999, Belize Health Survey, Males, 2001, p. 8.

POVERTY ASSESSMENT

Table 5 below shows the results of the 1995 Poverty Assessment for various categories of the Belizean population. The survey found that 25 per cent of the households or 33 per cent of the individuals were poor judging from their expenditure on food and non-food items. Further analysis revealed that almost 10 per cent of the households or 13 per cent of individuals were defined as extremely poor or indigent, that is, their expenditure level was such that they could not meet their basic food requirements. There was no gender differentiation as approximately about a third of both males and females were considered poor. However, gender differentiation existed at the household level; while less than a quarter (24 per cent) of male heads of households were poor, almost 31 per cent of female heads of households were poor. Almost a third (32 per cent) of the youth and 28 per cent of the elderly were considered poor. It was also found that the three lowest quintiles spent 52%, 49%, and 47% respectively of their monthly expenditure on food.

Table 5: Poverty Estimated for Belize, 1995 by Various Categories

Categories	All Belize (%)
Poor Households	25.3
Poor Population	33.0
Indigent Households	9.6
Indigent Population	13.4
Youth Population	31.6
Elderly Population	27.6
Female Population	33.1
Male Population	32.8
Male Heads of Households	23.6
Female Heads of Households	30.5

Source: Kairi Consultants, Poverty Assessment Report-Belize, Executive Summary, Caribbean Development Bank, 1995, Box 1.

There were variations in poverty level by geographical characteristics. The level of poverty (42.5 per cent) in rural areas was more than twice that of urban areas (20.6 per cent). Also, the level of poverty in the districts varied from almost 25 per cent in Belize District and Orange Walk to almost 58 per cent in Toledo.

FAMILY HEALTH SURVEY MALES AGED 15-64 AND FEMALES AGED 15-44

YEARS

In December 1999 Belize conducted surveys of Males' and Females' family health. A sample of 1,773 males aged between 15 and 64 years and 3,613 females aged between 15 and 44 years was interviewed. Our discussion will cover the following areas: sexual behaviour, knowledge and use of contraceptives, HIV/AIDS, drug use and domestic violence.

SEXUAL BEHAVIOUR

(A) SEXUAL EXPERIENCE

More than three quarters of both males (77 per cent) and females (79 per cent) were sexually experienced at the time of the survey. The mean age at sexual initiation was 16.7 years for males and 17.6 years for females. However, the mean ages at first intercourse were lower than this national average at younger ages and higher at older ages. Males usually initiated sexual activity one year earlier than females at all ages. For males aged 15-19, the mean age was 14.8 years and 15.7 years for those aged 20-24 years. These ages are less than the ideal age of 17.4 years chosen by these respondents for males and 17.7 years for females. A similar discrepancy, through to a lesser extent, is also found among young females who indicated a mean ideal age of 18.3 years for both males and females to start sexual activity.

Less than a quarter (24 percent) of males and a sixth (17 per cent) of females who are sexually experienced used any contraceptives at their first intercourse. However, a higher proportion of all males and most females under 30 used contraceptives during their first sexual intercourse. The proportions are 35, 36 and 53 per cent for males aged 25-29, 20-24 and 15-19 years respectively. For females the proportions were 16, 25 and 30 per cent respectively for the same age groups. While the goal of 100 per cent contraceptive use at first sexual intercourse is far from sight, the heartening information is that youths are moving in the right direction of increasing use of contraceptives at sexual initiation. As expected, the contraceptive of choice at first sexual intercourse was overwhelmingly the male condom for 89 per cent of the males and 63 per cent of the females. In addition, 29 per cent of females who used contraceptives chose the pill at

their first sexual encounter. Reasons behind the use of contraceptives at first intercourse for males were to prevent pregnancies (63 per cent), prevent STIs, including HIV/AIDS (13 per cent), or both prevention of STIs and pregnancies (23 per cent). Prevention of pregnancy was uppermost in the minds of females with 77 per cent of them citing it as the reason for using a contraceptive at first sexual activity. Prevention of pregnancy and STIs was a distant second choice with only 21 per cent of females citing this as the motivating factor for contraceptive use. We next examine the current sexual activity of the male and female respondents under study.

(B) CURRENT SEXUAL ACTIVITY

Table 6 shows that 69 per cent of the males and 70 per cent of the females had sexual intercourse in the previous thirty days. For males the proportions ranged from a low of 36 per cent for the 15-19 year olds to 83 per cent for the 40-44 age group. For females the proportions ranged from 57 per cent for the 15-19 age group to 77 per cent for the 25-29 age group. Young persons aged 20-24 were about equally sexually active with 64 per cent of the males and 66 per cent of the females affirming that they had sexual intercourse in the previous thirty days.

A little more than half (53 per cent) of the males had ever fathered a child. For those who have been fathers, the mean number of children fathered is four. A quarter of the youths aged 20-24 had fathered a child with the mean number being 1.5 children. For our respondents who are fathers, we notice that both the first and last children were planned. Seventy five per cent of the fathers claimed that the first child was planned while 72 per cent also indicated that their last child was planned. It is noteworthy that

almost four out of every five (78 per cent) of these men had their children with single partners.

The total fertility rate reported by all females aged 15-44 years of age is 3.7 children per woman. Seventy two per cent of the women claimed that their last pregnancy was planned while 15 per cent indicated that their last pregnancy was that their last pregnancy was mistimed and 10 per cent claimed that they did not want the pregnancy. A fifth of the pregnancies of young woman aged 15-24 was mistimed. In spite of a total fertility of almost four children per woman, a little over a fifth (22 per cent) of the women are either pregnant or desire pregnancy.

(C) IDEAL NUMBER OF CHILDREN

The mean ideal number of children as seen by men who had become fathers was fewer (3.9) than the actual mean number of living children (4.3) sired by these men. The reverse was true for mothers. The mean number of living children (3.3) borne by them was fewer than their ideal number (3.8). While there was a difference by gender in the actual mean number of children these males and females had, their ideal mean number was similar. Also, fathers and mothers with eight years of education or less indicated a higher mean actual and ideal number than fathers and mothers with nine or more years of education. This is in line with the theoretically expected impact of educational attainment on fertility desire or performance. Finally, 80 per cent of the males and 72 per cent of the females studied saw financial consideration as the major reason to limit family size.

(D) ABORTION DECISION

The male subsample is almost evenly split on the right of a woman to decide on the fate of her pregnancy, including decision about aborting the foetus. Forty seven per cent of the males deny a woman the right while 46 per cent affirm a woman's right to decide. Women, on the other hand, have no ambivalence on the matter as more than two thirds (69 per cent) uphold the right of a woman to decide the fate of the pregnancy. Males' pro-life stance led them to refuse a mother the right to abort a pregnancy unless her health is threatened. And, even in such a situation, only 55 per cent of the males find abortion an acceptable option. On the other hand, and therefore more surprising, is the finding that no reason for terminating the pregnancy received the support of a majority of the females. Even a threat to the mother's health only attracted the support of 44 per cent of the females.

(E) CONTRACEPTIVE KNOWLEDGE AND USE

Table 6 shows that only a quarter of the males and about a third of the females received information about contraceptive methods from parents and guardians. About two fifths of both males and females received information about family life and sex education from the same sources. Sixty per cent of the females and 38 per cent of the males received information about pregnancy from parents and guardians. Also, about two fifths of males (43 per cent) and females (42 per cent) received formal classes within the school system on family life education. However, only about one eighth of the males (12 per cent) and females (13 per cent) accessed family life education outside the school system.

Fewer than two out of every five respondents (males, 39 per cent; females, 38 per cent) are currently using contraceptives. However, current use of contraceptives is positively related to levels of educational attainment by males and females. Among males, less than 50 per cent of those with 8 years of education or less are current users while 54 per cent of those with between 9 and 12 years of education are current users. The proportion jumps to 65 per cent for males with more than twelve years of education. The females have a similar profile for users. Less than half of those with seven years of education are current users while 65 per cent of those with 9 or more years of education are current users of contraceptives.

Concerning condom use, about half of male and female condom users (males 50 per cent; females 53 per cent) utilize them consistently, that is, always, with steady partners. Also, only half of the males consistently use condom with non-steady partners. Additionally, 37 per cent of male users and 43 per cent of female users utilize condom occasionally with their steady partners. The indicated pattern of use has serious implications for transmission of STIs, including HIV/AIDS.

Table 6 also shows respondents' attitudes towards condom use. Thirty nine per cent of the males and 17 per cent of the females studied feel that condoms reduce sexual pleasure while 19 per cent of males and 15 per cent of females hold the view that condoms irritate sexual organs. About half of the total sample (males 56 per cent, females 47 per cent) subscribe to the mistaken view that condoms are not needed if the man is faithful in a relationship.

Table 6 shows that almost all males and females irrespective of residence, marital status or current contraceptive use status, have heard of HIV/AIDS. However, while

almost nine out of ten respondents correctly identified heterosexual intercourse as a mode of transmission of the virus, only about half of the male respondents identified blood transfusion, sharing of needles and homosexual intercourse as other modes of transmission. The females have the same pattern of responses as males except that only about a quarter correctly identified homosexual intercourse as a transmission mode. The level of correct knowledge for blood transfusion, sharing of needles and homosexual intercourse increases with rising level of educational attainment. Place of residence does not make a difference in the knowledge level of males, except in the case of blood transfusion where urban dwellers have an advantage over rural dwellers. However, for females, proportionately more urban dwellers than rural dwellers correctly identified blood transfusion, sharing of needles and homosexual intercourse as modes for transmission.

Sixty nine per cent of the males and 62 per cent of the females claimed that they were at no risk of contracting AIDS. The proportion perceiving themselves as risk free varies by age among youths under 30 with about seven out of every ten teenagers claiming to be at no risk. Levels of educational attainment have no impact on the proportion of respondents which claim no risk. However, gender differentials noted earlier remain with young males in all age categories below 30 claiming higher proportions than young females.

(F) DRUG USE, DOMESTIC VIOLENCE AND CONFLICT RESOLUTION

Table 6 indicates that drug use does not appear to be widespread. Almost three out of every five (58 per cent) of the male respondents currently use alcohol but less than

a quarter (23 per cent) use cigarettes. Current use of other drugs, such as, marijuana and cocaine is minimal.

Nine per cent of our male respondents agreed that they have ever been abused (physically, emotionally or sexually) as a child at home. Under no circumstances does a majority of the males subscribe to beating a woman. Even if she has had an affair only 28 per cent of the respondents who have never been abused and 36 per cent of those who were abused as children support beating the female. However, the situation is slightly different for beating a child. Almost three quarters (74 per cent) of those who were abused as children and 62 per cent of those who have never been abused agree that it is proper to beat a child when s/he does not listen or is disobedient.

Finally, these male respondents handle relationships in a mature manner. Fifteen per cent claim that they never have conflicts, 21 per cent walk out if conflicts arise and 50 per cent use dialogue, that is, they discuss with the other party to resolve the problem.

Table 6: Socio-Demographic Characteristics of Males Age 15-64 and Females Aged 15-44, Belize 1999, Family Health Survey

Mean age at 1st Intercourse

<u>Males</u>		<u>Females</u>	
15-64 (n=1210)	16.7 years	15-44 (n=2816)	17.6 years
15-19 (n=99)	14.8 years	15-19 (n=236)	15.6 years
20-24 (n=162)	15.7 years	20-24 (n=534)	17.0 years

Level of Education Completed at the time of 1st Intercourse

	<u>Males (n=1349)</u>		<u>Females (n=2909)</u>
None	36.1%		30.1%
Primary School	52.8		50.0
High School	6.1		14.9
Sixth Form	1.2		3.7
University	0.4		0.7
Others	3.3	BTTC/BCA/BNS	0.6

First Intercourse on Consensual Basis

	<u>Males (n=1349)</u>	<u>Females (n=2909)</u>
Yes	96.8%	96.0%
No	3.2	4.0

Relationship to First Partner

	<u>Males (n=1327)</u>	<u>Females (n=2887)</u>
Wife/Hus./C-Law	4.6%	44.4%
Visiting Partner	2.8	4.3
Fiancee/Girl/boyfriend	33.5	46.5
Friend	37.4	3.5
Casual Acquaintance	7.6	0.3
Others	4.1	1.0

Use of Contraceptives at 1st Intercourse

	<u>Males (n=1325)</u>	<u>Females (n=2919)</u>
Yes- Used	24.4%	17.0
No-Did not use	75.6	81.3
Unknown		1.7
	<u>Yes</u>	<u>Yes</u>
15-19	(n=100) 53.0	(n=241) 29.6%
20-24	(n=168) 35.5	(n=549) 24.9
25-29	(n=217) 34.7	(n=15.8) 15.8

Contraceptive Method Use at 1st Intercourse

<u>Males (n=290)</u>	<u>Females (n=473)</u>		
Condoms	88.7%	Male Condoms	62.6%
Pills/Oral Contraceptives	6.4	Female Condoms	0.5
Withdrawal	3.4	Pills/Oral Contraceptives	29.4
Injection	0.7	Injection	2.4
IUD/Coil	0.2	Foaming Tablets	1.0
Rhythm/Calendar Method	0.6	Rhythm/Calendar Method	1.1
		Withdrawal	2.9
		Male Sterilization/Vasectomy	0.2

Reason for Using Contraceptives

	<u>Males (n=293)</u>	<u>Females (n=473)</u>
Prevent Pregnancies	63.1%	76.9%
Prevent STIs/HIV/AIDS	13.1	2.0
Both	23.3	20.8
Other	0.4	0.3

Who decided in use of Contraceptive Method at 1st Intercourse

	<u>Males (n=292)</u>	<u>Females (n=472)</u>
My decision	56.6%	25.2%
Partner's decision	12.0	13.1
Joint decision	31.4	61.2
Don't remember		0.5

Sexual Intercourse Last 30 Days

	<u>Males (n= 1339)</u>	<u>Females (n=2927)</u>
Yes	69.3%	70.4%
No	30.7	28.4
Unknown		1.2

	<u>Yes</u>	<u>Yes</u>
15-19	(n=104) 36.0%	(n=242) 57.0%
20-24	(n=172) 64.0	(n=552) 66.4

Ever Fathered A Child

	<u>Male (n=1570)</u>
Yes	52.5%
No	43.5
Not Sure	0.2
Never had intercourse	3.7

	<u>Yes</u>
15-19	(n=283) 2.8%
20-24	(n=172) 24.7

Mean Number of Children Fathered

	<u>Males (n=981)</u>
20-24 (n=62)	1.5

Mean Age When 1st Child was born

<u>Males (n=958)</u>	
	23.5 years

Planning Status of 1st Child

<u>Males (n=750)</u>	
Planned 1st Child	74.7
1st Child Unplanned	25.3

Planning Status of Last Child

<u>Males (n=979)</u>	
Planned Last Child	71.8
Last Child Unplanned	22.9
Unknown	5.3

Have Children with Various Number of WomenMales (n=985)

<u>Number of women</u>	
Children with one woman	78.2
Children with two women	9.7
Children with 3+ women	3.8
Children with Unknown Number	8.2

**Number of Births, Woman-Years of Exposure and Age-Specific Fertility Rates
1994-1999, Women 15-44**

<u>Age group</u>	<u># of Births</u>	<u>Years of Exposure</u>	<u>ASFR</u>
15-19	767	8072	95
20-24	1170	6096	192
25-29	971	5393	180
30-34	666	5135	130
35-39	338	4084	83
40-44	127	3386	38
45-49	20	1230	16
<u>Total Fertility Rate</u>			3.67

Union Status, Women 15-44 (n=3354)

Single	37.9%
Married	33.7
Common-Law Union	21.8
Visiting Relationship	6.4
Widowed	0.0
Separated	0.1
Divorced	0.1

Planning Status of Last Pregnancy (n=1396)

Planned	72.1%
Mistimed	15.0
Unwanted	10.1
Unknown	2.8

	Planned	Mistimed	Unwanted	Unknown
15-19 (n=105)	73.1%	20.3%	2.8%	3.7%
20-24 (n=321)	71.8	20.4	5.0	2.9
25-29 (n=400)	77.6	14.0	5.9	2.5

Current Pregnancy Intention, Women 15-44 (n=2327)

1. Currently Pregnant	9.4%
2. Desire Pregnancy	12.2
3. Do not desire pregnancy	76.2
4. Menopausal	0.1
5. Unknown	2.0

1	2	3	4	5
18.9	14.7	65.9	0	0.5
12.3	13.5	71.9	0	2.3
10.4	16.4	71.3	0	1.9

Mean Perception of Ideal Number of Children and Actual Number of Children

	<u>Males (n=826)</u>	<u>Females (n=2070)</u>
1. Ideal Family Size	3.9	1 3.8
2. No. Living Children	4.3	2 3.3

Educational Level (years)	Ideal #	Actual #	Ideal #	Actual #
0-7	(n=228) 4.0	4.8	(n=639) 4.2	4.0
8	(n=307) 4.2	4.6	(n=717) 4.0	3.5
9+	(n=291) 3.6	3.6	(n=714) 3.4	2.5

Opinion on the Main Reason to Limit Family Size

	<u>Males (n=1594)</u>	<u>Females (n=3586)</u>
Financial	79.7%	72.1%
Child Care Problem	5.5	6.9
Work Related	3.8	5.0
Health of Mother	2.9	3.2
Schooling	1.8	3.0
Health of Child	0.1	1.2
Physical Appearance		0.5
Other	1.4	1.7
Unknown	4.9	6.6

Opinion on a woman's right to decide about her pregnancy, including deciding on having an abortion

<u>Males (n=1581)</u>	<u>Females (n=3574)</u>
45.9%	68.6%
47.2	27.6
7.0	3.8

Opinion on Circumstances that are Acceptable to have an Abortion

	<u>Males (n=1594)</u>		<u>Females (3574)</u>	
	Acceptable	Unacceptable	Acceptable	Unacceptable
Mother's health	55.3%	44.7%	44.0	56.0
Child's health reasons	42.3	57.5	35.7	64.3
Pregnancy from rape	35.6	64.4	37.3	62.7
Economic reasons	21.5	78.5	16.9	83.1
Both parents don't want child	19.1	80.9	17.1	82.9
Mother doesn't want child	12.4	87.6	16.2	83.8
Father doesn't want child	9.3	90.7	9.2	90.8
Woman is not married	8.0	92	6.4	93.6
Other			15.6	84.4
Unknown			14.6	85.4

Mean Ideal Age at 1st sexual intercourse

Males (n=1426)	Females (n=1413)
17.4 years	17.7 years

Mean Ideal Age when a man is responsible enough to have 1st child

Males (n=1449)	Females (n=3172)
20.9 years	21.4 years

Mean Ideal Age when a woman is responsible enough to have 1st child

Male (n=1438)	Females (n=3172)
20.3 years	20.4 years

Mean Age of a man/woman before 1st intercourse

Males (n=3072)	Females (n=2881)
18.3 years	18.3 years

Mean Perception of Ideal number of child a woman should have

<u>Males (n=3586)</u>	<u>Females (n=3586)</u>
19.7%	24.4%
14.4	19.1
3.7	4.6
22.0	12.8
32.2	32.1
1.0	0.9
7.0	6.1

Decision on the Number of children a couple want to have

	<u>Total (n=3613)</u>
Both partners	80.2%
Wife/partner	9.2
Husband/partner	5.0
Fate, up to God	3.3
Other	0.3
Unknown	1.9

Decision whether a person should use Contraceptives

	<u>Females (n=3603)</u>
Both partners	80.2%
Wife/partner	9.2
Husband/partner	5.0
Nurse/Doctor/Midwife	0.1
Other/Unknown	5.5

Reason for Currently using Contraception

	<u>Females (n=1294)</u>		
	<u>A</u>	<u>B</u>	<u>C</u>
A. Space Pregnancy	40.4%		
B. Limit Pregnancy	48.5		
C. Other	11.1		
15-19 (n=57)	64.6%	19.0%	16.4%
20-24 (n=304)	65.8	23	11.2
25-29 (n=302)	63.5	29.9	6.5

Received Information From Parents/Guardians About Various Topics

	<u>Males (n=923)</u>	<u>Females (n=2758)</u>
	Yes	Yes
Pregnancy	38.0	60.2%
Birth Control	25.2	34.4
Family Life & Sex Education	42.8	42.2

Received Formal Class or Course

	<u>Males (n=923)</u>	<u>Females (n=2758)</u>
Yes	42.8%	Yes 42.2%
No	56.4	No 56.9
Unknown	0.9	Unknown 0.9

Knowledge of Contraceptive Methods by Method

Methods	Males (n=1589)	Females (n=3613)
Orals	86.4%	91.8%
Female Sterilization	64.9	77.6
Injection	61.8	87.9
Condoms	73.8	85.4
IUD	38.7	62.0
Rhythm	37.6	46.9
Male Sterilization	45.4	43.0
Vaginal Tablets	20.6	29.7
Other Vaginal Tablets	20.1	31.8
Diaphragm	26.6	31.1
Withdrawal	36.4	31.6
Billings Method	8.3	10.6

Current Contraceptive Use by Marital Status

<u>Marital Status</u>	<u>Males</u>	<u>Females</u>
	Currently Using	Currently Using
Married/C. Law	(n=965) 49.3	(n=2353) 56.1
Visit. Partner	(n = 115) 75.9	(n=197) 56.8
Not in Union	(n=500) 17.2	(n=1040) 6.8
Currently Using	(n=1582) 38.6	(n=3596) 37.5

Current Contraceptive Use by Years of Education by Currently Married Men and Women

<u>Years of Education (Males)</u>	<u>Currently Using</u>	<u>Years of Education (Females)</u>	<u>Currently Using</u>
None (n=49)	30.3%	0-7 (n=769)	48.2%
1-7 (n=244)	43.3	8 (n=817)	56.4
8 (n=350)	48.2	9+ (n=764)	64.8
9-12 (n=205)	54.3		
13+ (n=114)	65.1		

Use Condom with Steady Partner

<u>Frequency</u>	<u>Males (n=318)</u>	<u>Females (n=317)</u>
Always	50.3%	53.3%
Most of the Time	22.3	29.5
Seldom	14.2	13.9
Never	7.9	2.2
No Steady Partner	4.7	1.1
Unknown	0.6	0.0

Use of Condom with Non-Steady Partner

<u>Frequency</u>	<u>Males (n=318)</u>
Always	50.9%
Most of the Time	7.5
Seldom	2.8
Never	5.0
Never had sex with non-steady partner	32.1
Unknown	1.6

Statements about Condoms: Men Aged 15-64 and Women Aged 15-44

<u>Statements</u>	<u>Males (n=1594)</u>	<u>Females (n=3613)</u>
Reduce sexual pleasure	39.3%	17.1%
Used if Partner requests	66.2	55.8%
Irritation on Penis & Vagina	19.3	14.9%
New Condom used in every Ejaculation	66.8	52.3%
Does not need to use if faithful partner	56.0	47.4%

Ever Heard of AIDS by Selected Characteristics

	<u>Males (n=1563)</u>	<u>Females (n=3533)</u>
Yes	95.2%	94.8%
<u>Residence</u>		
Urban (n=806)	98.1%	Urban (n=1678) 99.2%
Rural (n=757)	92.1	Rural (n=1856) 90.8
<u>Marital Status</u>		
Ever Married (n=1148)	95.1%	Ever Married (n=2720) 94.7%
Never Married (n=415)	95.4	Never Married (n=813) 95.2
<u>Contraceptive Use</u>		
Currently (n=643)	98.9%	Currently (n=1516) 98.0
Not Using (n=920)	92.6	Not Using (n=2017) 92.4

Correct Knowledge of How AIDS may be Transmitted, Men 15-64 and Women 15-44

	<u>Transfusion</u>	<u>Needles</u>	<u>Intercourse</u>	<u>Heterosexual</u>
<u>Total</u>				
Males (n=1496)	54.9%	53.6%	48.2%	87.8%
Females (n=3392)	52.0	48.3	26.2	88.5
<u>Residence- Males</u>				
Urban (n=797)	60.4%	55.1%	48.7%	87.1%
Rural (n=699)	49.3	52.0	47.7	88.5
<u>Residence- Females</u>				
Urban (n=1694)	60.4%	55.1%	31.3%	88.8%
Rural (n=1698)	43.4	41.5	20.9	88.3
<u>Educational Level (Yrs)- Males</u>				
0-7 (n=357)	41.1%	41.6%	36.0	87.5%
8 (n=545)	50.1	51.0	46.2	84.7
9+ (n=594)	67.8	63.2	57.5	90.7
<u>Educational Level (Yrs)- Females</u>				
0-7 (n=862)	29.4%	29.9%	13.8%	84.1%
8 (n=1141)	45.7	44.9	23.1	89
9+ (n=1389)	69.3	61.1	35.3	90.6

Perceived Risk of Getting AIDS by Selected Characteristics, Men 15-64 and Women 15-44

	<u>Great Risk</u>	<u>Some Risk</u>	<u>Not Much Risk</u>	<u>No Risk</u>	<u>Unknown</u>
<u>Total</u>					
Males (n=1491)	3.7%	9.0	15.7%	68.5%	3.1%
Females (n=3382)	4.7	13.1	13.4	61.9	6.9
<u>Age Group- Males</u>					
15-19 (n=272)	4.8%	8.1%	12.5%	71.4%	3.1%
20-24 (n=191)	7.2	10.5	24.4	54.0	3.9
25-29 (n=216)	2.4	14.3	18.9	62.3	1.9
<u>Age Group- Females</u>					
15-19 (n=654)	4.3%	6.7%	11.4%	71.3%	6.3%
20-24 (n=632)	6.2	14.2	15.4	58.0	6.3
25-29 (n=667)	4.8	14.7	15.4	57.7	7.4
<u>Educational Level (Yrs)- Males</u>					
0-7 (n=357)	5.4%	6.6%	13.6%	70.5%	4.0
8 (n=544)	2.8	8.7	13.8	70.9	3.8
9 (n=590)	3.5	10.9	18.7	65	1.9
<u>Educational Level (Yrs)- Females</u>					
0-7 (n=860)	4.6%	12.4%	8.8%	63.8%	10.4%
8 (n=1140)	5.9	12.1	12.6	62.0	7.5
9+ (n=1382)	3.9	14.3	16.5	60.7	4.6

Ever Used Drugs and Presently Using Drugs by Type of Drugs, Men 15-64

<u>Drug</u>	<u>Males (n=1579)</u>	
	<u>Ever Used</u>	<u>Presently Using</u>
Alcohol	77.4%	58.0
Cigarette	47.1	23.2
Marijuana	19.8	5.8
Cocaine	2.4	0.5

Ways in Which to Handle Conflicts in Relationships by Selected Characteristics, Men 15-64

	<u>Males (n=1572)</u>
Discuss Problems	50.1%
Go Out	21.3
Never Have Conflicts	14.7
Set the rules and regulations	4.2
Respond violently	0.9
Other	2.7
Unknown	6.2

Incidence of Abuse at Home As Children, Men 15-64

	<u>Ever Been Abused (n=1585)</u>
Yes	8.8%
No	91.2

Source: Central Statistical Office, Belize, 2001. 1999 Belize Family Survey Males and Females, November.

HIV/AIDS

The first case of AIDS in Belize was diagnosed in 1986. Table 7 shows the statistics by the end of 2001.

Table 7: Estimated Number of Adults and Children Living with HIV/AIDS, End of 2001

Adults and Children	2,500
Adults (15-49)	2,200
Women	1,000
Children (0-14)	180
Adult Rate (%)	2.0

Source: UNAIDS/WHO Epidemiological Fact Sheets 2002 Update, p. 2.

Analysis of the data as at the end of 1999 indicates the following: the most vulnerable age group is the 15-44 age group, and it accounts for 79 per cent of those affected. More males than females are affected and the ratio of males to females is 1.6:1. The mode of transmission is predominantly heterosexual and this accounts for 68%. Other modes include bisexual (16 per cent), homosexual (11 per cent), perinatal (3 per cent) and blood transfusion (3 per cent).

NATIONAL RESPONSE

According to the National AIDS Task Force “there is no comprehensive national policy specifically for HIV/AIDS” (NATF, 1999, p. 4). Government allocation for the epidemic is minimal. In 1987 the government established the National AIDS Programme. Its activities included the following:

- (i) Information Education Communication Committee charged with developing public awareness about HIV/AIDS.
- (ii) Counselling Committee to support persons living with AIDS.
- (iii) Human Rights Committee to review legislation relating to the rights of infected persons and
- (iv) Medical Management Committee.

In 1997 a National AIDS Task Force was established. It drew members from governmental agencies, non-governmental organizations, people living with HIV/AIDS and international agencies. The NATF was mandated to develop a National Strategic Plan for HIV/AIDS for the country. The NATF produced this plan by December 1999 and consequently ceased to exist. We turn to a consideration of the elements of the Strategic Plan.

NATIONAL STRATEGIC PLAN FOR HIV/AIDS 2000-2003

The plan puts emphasis on prevention and integrated comprehensive services to people with HIV/AIDS. The priority areas for the Plan are:

- (a) Attitudes and Practices
- (b) Inter-sectoral Coordination and
- (c) Services.

HIV/AIDS

PRIORITY AREA 1: ATTITUDES AND PRACTICES

OBJECTIVE

The objective of this aspect of the programme is “to create the enabling environment to foster people empowerment and facilitate change in attitudes and behaviour for the prevention of HIV/AIDS and STI transmission” (NATF, 1999, p. 12).

The target groups are in-school and out-of-school children and youth, pregnant women and their partners, parents and caregivers, teachers and people living with HIV/AIDS.

Activities planned for the achievement of this objective include:

- (i) Implementation of programs to sensitize target groups about HIV/AIDS
- (ii) Full implementation of the School Health and Physical Education Services (SHAPES) programme
- (iii) Evaluation of prevention programmes
- (iv) Implementation of condom distribution programmes through the Reproductive Health Programmes
- (v) Observation of World AIDS Day and promote HIV/AIDS awareness during national events all year round.

PRIORITY AREA 2: INTER-SECTORAL COORDINATION

OBJECTIVE

The objective of this area of the Strategic Plan is “to establish a coordinated multisectoral response to the HIV/AIDS epidemic target groups” (NATF, 1999, p. 16).

The groups and organizations that would be involved in this national effort include the

Government, political and religious organizations, multi-lateral agencies, non-governmental organization, private sector, and the media. Planned activities include:

- (i) Establishment of a legal framework for the national AIDS Committee to play the coordinating role
- (ii) Integration of action plans for control of HIV/AIDS within the approved National Strategy
- (iii) Establishment of monitoring and evaluation mechanisms within the National Strategy
- (iv) Mobilization of resources to finance the National Strategy and strengthen the National AIDS Programmes
- (v) Implementation of an effective surveillance mechanism for STIs, including HIV/AIDS
- (vi) Sensitization of decision makers on the HIV/AIDS situation in Belize

PRIORITY AREA 3: SOCIAL SERVICES

OBJECTIVE

The objective of this priority area is “to design and provide social, economic and health support programmes and services for persons with AIDS and their families” (NATF, 1999, p. 19). The target groups for this sector of the programmes include health care professionals in the public and private sectors, social workers, counsellors, people living with or affected by HIV/AIDS and policy makers. Activities planned for this priority area are:

- (i) Development of comprehensive care programmes and services for people living with HIV/AIDS
- (ii) Mobilization of resources for (i) above
- (iii) Integration of HIV/AIDS related services within existing health and social services
- (iv) Development of training modules for health service providers
- (v) Implementation of programmes to reduce vertical transmission, that is, mother to child

It should be noted that the National Strategic Plan is scheduled to run for the 2000-2003 period and thus the previously listed set of activities should be nearing completion. The level of success attained should be apparent if the National AIDS Commission, established in February 2000 and charged with coordination and monitoring of the implementation of the National Strategic Plan, evaluates the results achieved.

In addition to official activities and services, some NGOs have HIV/AIDS programmes. Among them is the Belize Red Cross which is involved in advocacy, provision of information, training, food and clothing. Others include the Belize Family Life Association which continues to sensitize the public about HIV/AIDS through education for out-of-school youth, provision of STI diagnosis and treatment, counseling and distribution of condoms. Finally, the Alliance Against AIDS provides counseling through its hot line for HIV/AIDS.

NATIONAL POLICIES

(i) Population Policy

Table 8 below shows a summary of the Government's position on various aspects of population policy for 1996 and 2001.

Table 8: Government Perceptions and Policies: A Summary

Belize		
Population policy variable	1996	2001
Population growth and age structure		
View on growth	Satisfactory	Satisfactory
Policy on growth	No intervention	No intervention
Level of concern about		
Size of the working-age population	..	..
Ageing of the population	..	..
Fertility and family planning		
View on growth	Too high	Satisfactory
Policy	No intervention	No intervention
Access to contraceptive methods	Indirect support	Indirect support
Adolescent fertility		
Level of concern	Major concern	Major concern
Policies and programmes	Yes	No
Health and mortality		
View		
Expectation of life	Acceptable	Acceptable
Under-five mortality	Unacceptable	Unacceptable
Maternal mortality	..	Unacceptable
Level of concern about AIDS	Major concern	Major concern
Grounds on which abortion is permitted	1,2,3,4,5,6 ^a	1,2,3,4,5,6 ^a
Spatial distribution		
View	Minor change desired	Minor change desired
Policies on spatial distribution		
Between regions	No intervention	No intervention
Between rural and urban places	Yes	No intervention
Policies on internal migration		
Into metropolitan areas	No intervention	No intervention
From rural areas to other locations	Maintain	No intervention
International migration		
Immigration		
View	Too high	Too high
Policy		
Permanent settlement	Lower	Lower
Migrant workers	Lower	Lower
Migrant workers	Maintain	Lower
Dependants of migrant workers	Maintain	Lower
Integration of non-nationals	Yes	No
Emigration		
View	Too high	Satisfactory
Policy	Lower	No intervention
Encouraging the return of nationals	No	No

^a Grounds on which abortion is permitted: (1) to save the woman's life; (2) to preserve physical health; (3) to preserve mental health; (4) rape or incest; (5) foetal impairment; (6) economic or social reasons.

Source: *United Nations National Population Policies 2001, p. 72.*

It is government's view that the current levels of population growth, fertility, life expectancy at birth and emigration are satisfactory or acceptable. Areas which are unacceptable or of major concern include adolescent fertility, HIV/AIDS, child (0-4) and maternal mortality. However, there are no policies and programmes to deal with adolescent fertility, spatial distribution, internal migration or emigration.

(ii) National Health Policy and Plan

The Ministry of Health national health plan had traditionally been a disease-focused approach. This has now changed to a people focused and life cycle/gender perspective. Four health regions were established with authority devolved to them leaving a more circumscribed role for the national headquarters. Thus, the 1997-2000 period witnessed the development of the Health Sector Reform program. This programmes involved the following:

- (i) Restructuring and strengthening the organizational and regulatory capacity at all levels
- (ii) Service rationalization and thereby improving the coverage and quality of public and private sector services
- (iii) Supporting the National Health Insurance Fund

SUMMARY OF INDICATORS

Country Indicators	BELIZE	GUYANA	JAMAICA	ST. LUCIA	SURINAME	TRINIDAD AND TOBAGO
Basic Indicators						
Life expectancy at birth (2001)	74	63	75	74	71	75
Life expectancy of Females as a% of males (2001)	104	115	106	107	108	107
Life expectancy at birth (years)						
1970-1975	67.6	60.0	69.0	65.3	64.0	65.9
1995-2000	73.6	63.7	74.8	73.0	70.1	73.8
GDP per capita (PPP US\$) (2000)	5,606	3,963	3,639	5,703	3,799	8,964
Health						
(%) Adult HIV Prevalence Rate 15-49 years (2001)	2	2.7	1.2	-	1.2	2.5
(%) Contraceptive Prevalence (1995-2001)	56	41	66	47	42	38
Contraceptive Prevalence (%)	37.5 (1999)	-	62.8 (1997)	-	42.1 (2000)	53 (1990)
Demographic Indicators						
(%) Population Annual Growth Rate (1990-2001)	2.0	0.4	0.8	1.2	0.4	0.6
Annual Population growth rate (%)						
1975-2000	2.1	0.1	1.0	1.4	0.5	1.0
2000-2015	1.6	-0.1	0.9	0.9	0.3	0.5
Annual Population Growth Rate (%)	2.7 (2000)		0.6 (2000)	1.24 (2000)	1.0 (2001)	0.3 (2000)
Crude Birth Rate (2001)	26	22	21	23	19	13
Total Fertility Rate (2001)	3.0	2.4	2.4	2.6	2.1	1.6
Total Fertility Rate (per woman)						
1970-1975	6.2	4.9	5.0	5.7	5.3	3.4
1995-2000	3.4	2.4	2.5	2.7	2.2	1.6
Adolescent Fertility Rate 15-19 years (%)	0.10 (2000)		0.11 (1997)	1.24 (2000)	72.1 (1995)	14.5 (2000)
Total population (millions)						
1975	0.1	0.7	2.0	0.1	0.4	1.0
2000	0.2	0.8	2.6	0.1	0.4	1.3
2015	0.3	0.7	3.0	0.2	0.4	1.4

Country	BELIZE	GUYANA	JAMAICA	ST. LUCIA	SURINAME	TRINIDAD AND
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Indicator						TOBAGO
<i>HIV/AIDS: Leading Global health crises and challenges</i>						
Estimated number of adults and children (0-49 years) living with HIV/AIDS (2001)	2,500	18,000	20,000	-	3,700	17,000
Estimated # of children (0-14 years) living with HIV/AIDS (2001)	180	800	800	-	190	300
HIV Prevalence rate among persons aged 15-24	-	-	-	18	1.26	-
HIV prevalence among pregnant women (15-24 years), major urban areas. Median 15-19 years. (2001)	-	3.0	1.3	-	-	-
HIV prevalence among pregnant women (15-24 years), major urban areas. Median 20-24 years. (2001)	-	7	1.4	-	-	-
Children orphaned by AIDS (0-14 years) (2001)	950	4,200	5,100	-	1,700	3,600
Total number of Orphans due to AIDS (Absolute #) (2005)	2,000	7,000	7,000	-	2,000	6,000
Total number of Orphans due to AIDS (Absolute #) (2010)	2,000	9,000	7,000		2,000	8,000
Orphans due to AIDS as a % of total Orphans. (2005)	40.6	33.0	21.5	-	26.4	33.2
Orphans due to AIDS as a % of total Orphans (2010)	48.7	40.5	20.9	-	28.6	47.1
People living with AIDS						
Adults (% age 15-49) (2001)	2.00	2.70	1.22	-	1.20	2.50
Women (15-49) (2001)	1,000	8,500	7,200	-	1,800	5,600
Children (age 0-14) (2001)	180	800	800	-	190	300

Country Indicator	BELIZE	GUYANA	JAMAICA	ST. LUCIA	SURINAME	TRINIDAD AND TOBAGO
Aging Indicators						
Aging Index (2000)	15.7	22.6	30.6	24.3	26.6	38.3
Broad Age Groups						
0-14	38.4	30.6	31.5	32.1	30.5	25.0
15-59	55.6	62.5	58.9	60.2	61.4	65.4
60+	6.0	6.9	9.6	7.8	8.1	9.6
Median Age (years)	20.1	24.1	24.2	23.5	24.0	27.7
Dependency Ratio 2000, (2025)						
Total	74.2 (45.3)	55.1 (47.9)	63.1 (49.0)	60.7 (45.5)	56.3 (39.1)	46.3 (48.2)
Youth	66.8 (35.5)	47.4 (33.0)	51.3 (34.2)	51.5 (34.1)	47.6 (27.8)	36.6 (27.7)
Old Age	7.4 (9.8)	7.7 (14.9)	11.8 (14.8)	9.2 (11.4)	8.7 (11.3)	9.7 (20.5)
Potential Support Ratio 2000 (2025)	13.5 (10.2)	13.0 (6.7)	8.5 (6.8)	10.9 (8.8)	11.5 (8.8)	10.3 (4.9)
Parent Support Ratio 2000 (2025)	5.5 (4.2)	4.1 (3.7)	9.5 (6.5)	7.1 (4.0)	4.4 (3.8)	4.8 (5.7)
Sex Ratio (per 100 woman 65+) 2000 (2025)	99.2 (94.8)	76.3 (59.0)	81.1 (78.5)	69.7 (69.9)	79.7 (67.2)	82.5 (78.0)
Population aged 65 and above (as a % total)						
2000	4.2	5.0	7.2	5.7	5.6	6.7
2015	4.9	6.5	7.8	6.0	6.3	9.6
Labour Force Participation (%) 2000 (2010)						
Total 65+	26.7 (24.2)	14.9 (13.1)	34.3 (31.6)	-	9.2 (7.6)	10.2 (8.9)
Female 65+	4.6 (4.1)	4.7 (4.4)	22.3 (21.0)	-	1.9 (1.6)	4.5 (4.0)
Male 65+	50.1 (46.0)	27.8 (25.0)	49.3 (44.8)	-	18.4 (15.9)	16.2 (14.1)

Country Indicators	BELIZE	GUYANA	JAMAICA	ST. LUCIA	SURINAME	TRINIDAD AND TOBAGO
Human Development Index Trends						
1990	0.750	0.680	0.720	-	-	0.781
2000	0.784	0.708	0.742	0.772	0.756	0.805
Human and Income Poverty						
Pop. Below income poverty line (%)						
\$1 a day (1993 PPP US\$) 1983-2000	-	-	3.2	-	-	12.4
\$2 a day (1993 PPP US\$) 1983-2000	-	-	25.2	-	-	39.0
National Poverty Line 1987-2000	-	43.2	18.7	-	-	21.0
Proportion % of population below the national poverty line	33 (1995)	-	18.7 (1999)	-	41.38-73.38 (1999-2000)	21 (1992)
Gender related development index						
Life expectancy at birth (years) (2000)						
Female	75.4	67.3	77.3	76.0	73.2	76.7
Male	72.7	58.9	73.3	70.7	68.0	72.0
Adult Literacy rate (% age 15 and above) (2000)						
Female	93.2	98.1	90.7	-	-	92.1
Male	93.3	98.9	82.9	-	-	95.5
Estimated earned income (PPP US\$) (2000)						
Female	2,141	2,228	2,900	-	-	5,532
Male	8,975	5,806	4,400	-	-	12,432
Gender empowerment measure						
Ratio of estimated female to male earned income	0.24	-	-	-	0.37	0.44
Gender inequality in education						
Net secondary enrolment						
Female ratio (%) 1998	43	-	80	-	-	75
Female ratio as % of male ratio (1998)	123	-	103	-	-	107
Gross Tertiary enrolment						
Female Ratio (%) (1998)	-	-	-	-	-	7
Female ratio as % of male ratio	-	-	-	-	-	138
Gender inequality in economic activity						
Female economic activity rate (age 15 and above)						
Rate (%) (2000)	27.1		40.7	67.1	-	36.0
Index (1990=100) (2000)	113		113	101	-	121
As a% of male rate (2000)	32		49	85	-	48

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Also, see References for countries studied.

TRAINING PROGRAMMES

(1) TRAINING NEEDS

At the UNFPA Regional Sub-Programme Development Meeting at Castries, St. Lucia, July 8 – 12, 2002, the following areas of need were identified mainly by the group that worked on Population and Development Strategies:

- (a) relevant information technology
- (b) demographic data analysis at basic, intermediate and specialized levels
- (c) specialized training in Geographical Information System (GIS), Gerontology, Gender mainstreaming, health and family life education, including STI/HIV/AIDS
- (d) service delivery to youth, logistics management and the delivery of other reproductive health services.

There is no doubt in my mind that all of the countries in this study will have need for training in one or more of the areas identified above.

(2) TRAINING PROGRAMMES AT UWI, MONA

(I) Department of Sociology, Psychology and Social Work

(A) Diploma in Population and Development Programme Objectives

The specific objectives of this programme are to:

- (1) “Raise the level of awareness of the impact of population change on social and economic development structures and processes.
- (2) Improve the skill set of those in population-related fields by equipping them with the tools necessary to analyze the factors that contribute to social and economic change, and the responses to that change.

- (3) Expand areas of research and improve the research competence of participants to deal with topics of importance to policy makers and strengthen existing partnerships for research activities.
- (4) Foster new partnerships with non-governmental organizations and the private sector” (Department’s Programme Booklet 2003-2004, P. 25).

TARGET GROUP

The programme admits persons who are university graduates employed in applied settings (economic and social planning, social services, population, labour and social welfare, statistics and communication).

PROGRAMME DURATION

The duration is one academic year on a full-time basis or on a part-time basis for a longer period, usually two academic years.

PROGRAMME CONTENT

Semester I

SY21M	:	Introduction to Population
SY21P	:	Reproductive Health and Family Life Education
SY22G	:	Statistics for the Behavioural Sciences
SY35B	:	Demography 1 (Population Trends & Policies)
SY35G	:	Population, Environment and Development

Semester II

SY14H	:	Sociology and Development
SY35C	:	Demography II (Demographic Techniques)
SY22K:		Statistical Computing for Social Research

Two of the following:

MC57A:	Introduction to Social Marketing
GG32D	: Health and Society
SY34A	: Monitoring and Evaluation of Social Programmes
SY25A	: Health, Society and the Human Services (Semester 1)
SY35M	: Population and Social Policy

(B) Workshops/Seminars

The Department in recent years has organized workshops on the following topics:

- (i) Evaluation of Social Programmes.
- (ii) Techniques of Policy Analysis.

Specialized workshops are regularly conducted on the following areas:

- 1) Data Analysis (basic to advanced levels) using the Statistical Package for the Social Sciences (SPSS) Software.
- 2) Data Collection using Qualitative and Quantitative Instruments.

The Department, on demand, can arrange for workshops on the following:

- 1) Estimates and Projections
- 2) Rapid Appraisal Methods

We are now in the process of building up competence in GIS and should be able to mount a workshop on it in the near future.

(C) Degrees

At the undergraduate level, the Department offers

- (i) B.Sc. Demography (Major)
- (ii) B.Sc. Demography (Minor)

At the post graduate level, the department offers an
M.Sc. Demography degree.

The M.Sc. Demography programme is for persons with a good Bachelor's degree (second class honours) and undergraduate foundation in demography and statistics. Professionals in applied settings in private and public sectors and research institutions are the targets.

Programme Duration

At present this programme is offered on a part-time basis over a period of two and a half years.

Programme Content

Year 1 Semester 1

SY68A : Demographic Methods I
SY62A : Advanced Quantitative Methods I
: Continuing Seminar

Year 1 Semester 2

SY68D : Social Demography
: Elective
: Continuing Seminar

Year 2 Semester 2

SY68C : Applied Demography
: Elective
: Continuing Seminar

Year 2 Semester 3

SY690 : Research Paper
: Continuing Seminar

(II) Advanced Training and Research in Fertility Management Unit (ATRFMU)

Department of Obstetrics and Gynaecology

- (A) In the past decade the ATRFMU has organized the following courses:
- (1) Child Neglect and Abuse – 3 weeks duration.
 - (2) Stopping the Whirlwind: Developing Skills for Healing Troubled Families – 3-day.
 - (3) Community Policing in Jamaica – 12 weeks.
 - (4) Strengthening Rehabilitation Programmes.
 - (5) Caribbean Adolescent Issues – 3 weeks.
 - (6) On-going training – UWI students (Medical Undergraduates, Registered Nurses and Pupil Midwives).
 - (7) Distance Education – UWIDEC for courses in
Reproductive Health
Sexually Transmitted Diseases, including HIV/AIDS
Counselling
Women's Health
Programme Management

(B) Graduate Degree Programme

M.Sc. Counselling – UWIDEC

This is a part-time three-year programme delivered partly by distance and partly by face-to-face mode.

The programme is targeting psychologists, educators, health personnel, social workers and ministers of religion interested in working in counseling in schools, health and community environments.

(C) The Unit is also planning to introduce a Postgraduate Diploma in Reproductive Health in 2005.

The Unit at present is concentrating on delivering the M.Sc. Counselling degree programme. However, it is willing to work with the UNFPA on Workshops/Seminars/Courses on Reproductive health, family planning, adolescent issues, family life education or others that are of mutual interest.

(III) Centre for Gender and Development Studies

(A) Certificate

The Centre has a certificate programme in Gender and Development Studies offered through a Distance Education mode.

OBJECTIVES

The objectives of the programme are to develop in the students

- (1) “an awareness of how gender shapes personal consciousness and interpersonal relationships and determines the social, political, and economic inequalities between men and women in Caribbean society.
- (2) the ability to use gender as a tool of analysis in the development of projects, programmes and policies, and so make them more responsive to the specific needs of women and men” (CGDS Brochure on Certificate in Gender and Development Studies).

Duration

The programme is part-time and it last 18 months.

Delivery Mode

The programme is delivered by Distance Education mode using facilities at UWI Distance Education Centre (UWIDEC).

Target Group

The programme is designed for persons working in NGO's, Women's Bureauz, community and international development agencies, church-related organizations, social service agencies and national planning institutions.

Content

The programme is delivered in five semesters as follows:

Year 1

Semester 1

- i. Research Methods and Interactive Skills
- ii. Cultural Representation and Construction of Masculinity and Femininity
- iii. Issues of Gender and Power in Caribbean Society: Politics, Religion and the Law

Semester 2

- i. Women Organising and the Development of the Women's Movement in the Caribbean
- ii. Gender and the Caribbean Family: Organisation and Relationships

Semester 3

- i. Feminist Theorising: The Connection between Theory and Practice.
- ii. Gender and Development: Social and Economic Considerations
- iii. Issues of Gender and Social Policy: Health, Education and Empowerment.

Year 2

Semesters 1 and 2

Research Project

(B) Training Materials

The Centre for Gender and Development Studies has developed training materials in the following areas that may be of interest to the UNFPA:

- i. Gender Analysis in Policy and Planning.
- ii. Gender Issues in Caribbean Education.
- iii. Gender and Management.
- iv. Understanding Gender in Caribbean Society.

(C) Graduate Degrees

The Centre runs programmes for M.Sc. / M.Phil / Ph.D. degrees in Gender and Development Studies.

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UWI, MONA

Department of Sociology, Psychology and Social Work

- Programme Booklet 2003-2004.
- Masters Programme in Demography Brochure.

Advanced Training and Research in Fertility Management Unit

- Caribbean Professionals for Caribbean Health Care: Two Decades of Service 1979-1998.
- M.Sc. Programme in Counselling by Distance Education Brochure.

Centre for Gender and Development Studies

- Certificate in Gender and Development Studies Brochure.
- Graduate Studies Programme Information Brochure.

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