

KNOWLEDGE, ATTITUDES & PRACTICES SURVEY on FAMILY LIFE and FERTILITY in BELIZE



GOVERNMENT OF BELIZE

MINISTRY OF HEALTH

IN COLLABORATION WITH



UNFPA

REPORT ON A SURVEY ON FAMILY LIFE
AND FERTILITY IN BELIZE

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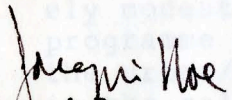
November 20th, 1987

Dear Colleague,

The project entitled Strengthening of the Maternal and Child Health and Family Spacing Programme sponsored by the United Nations Fund for Population Activities and the Government of Belize (U.N.F.P.A-G.O.B.), is pleased to present you with a copy of the Knowledge Attitudes and Practices (K.A.P.) Survey on Family Life and Fertility in Belize, conducted by Dr. Joseph Palacio, Ph.D

We hope the information will prove valuable in your work.

Sincerely


Jacqui Roe
Family Life Educator

EXECUTIVE SUMMARY

There are three main parameters that define the scope of the knowledge, attitude and practices (KAP) survey on family life and fertility in Belize. The first is the lack of data on fertility and family spacing, especially at the micro level of districts and communities. The second is the distribution of the population into ethnic groups that predominate in different geographical parts of the country as well as into three types of communities, Belize City, district towns, and villages. The third is the aim of the Ministry of Health to determine the needs for a maternal/child health programme incorporating family spacing as it affects the health status of child bearing age women and their offspring.

The survey provides baseline data on all three parameters by analysing sets of variables under family life; fertility; health, pregnancy, and childbirth; and family spacing.

The results of the survey confirm that there is a high rate of fertility throughout the country. There is a high level of awareness of family spacing methods and relatively modest use in some areas, despite the lack of any programme on family spacing. Differences arising from the urban/rural dichotomy and among ethnic groups are seen in the relative role of men in decision-making on family life, depending on their presence within the household. There are fewer conjugal households and more extended women-headed households among some groups than others.

Generally, women are ambivalent on the exact number of children that is satisfactory, being especially reluctant to admit that they have more than they would want. They respond, however, to problems as they see them affecting their satisfaction with their family size. The main variable to which they respond readily is economic, or, as they put it, the number that they "can afford". Health takes a considerably lower priority in their perspective as a factor that is causing them to limit family size.

There is overwhelming consensus on the need for training at the health centre and through other media of public education on family life and spacing.

The following are recommendations forthcoming from the survey.

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There is overwhelming consensus on the need for training at the health centre, and through other media of public education on family life and spacing.

The following are recommendations forthcoming from the survey.

1. The rationale for a family spacing programme. The need for a family spacing programme in Belize stems from:

- (a) The selectivity of information presently available about family spacing. Presently, women, who can afford to pay for services or travel to the neighbouring countries for medical attention, have greater access to family spacing services. These services should be made available to the public.
- (b) The currently high rate of knowledge and use of family spacing methods nationwide. The proper channelling of services would lead to better awareness and more effective use.
- (c) The economic reason the women give for having the number of children they would want. Economic factors would seem to be the currently predominant problem that causes women to use family spacing methods.
- (d) Health reasons. Presently, there is minimal awareness of health as a major factor to use family spacing method. If the government will focus on health as a primary factor, more epidemiological studies will have to be done. Subsequently the results will have to be translated to the women so that they can define them as a problem.

2. Target Group

The target group for a family spacing programme would depend on the rationale behind the programme. But the demographic subdivisions of women will have to be kept in mind. In urban/rural dichotomy the subdivisions are as follows:- Belize City and Belmopan 29%, the district towns 22%, and villages 49%. In terms of age distribution some areas have a higher proportion of younger child bearing age women than others. Healthwise, there are minimal differences throughout, although there are pockets of greater prevalence in pregnancy related illness, especially in the rural areas.

3. Avenues and sources of resistance to family spacing.

- (a) The concept of being responsible for family sizes. This is a fundamental problem that occurs more in the rural areas, where more women attribute to fate the number of children they can have.
- (b) Little institutional resistance. Presently there is minimal pressure being exercised on women against the use of family spacing by formal institutions. Besides, there is no evidence of pressure groups directed against family spacing.
- (c) Role of men. In areas where there is a prevalence of conjugal households, such as the north and extreme south, male partners would have to be brought into the picture. Our information shows that women defer to them in decision making about family spacing. Close women relatives of those in child bearing age should also be included as they are a source of major influence on child bearing.

4. Methods of intervention.

- (a) Health Centre. Because women make extensive use of pre-natal and post-natal clinics they could be primary sources of intervention.
- (b) Health personnel. More women use the services of midwives than private doctors, the former should be included as sources of assistance.
- (c) Educational institutions. Secondary schools should be used for formal classes. Most women confirm that high school students should be included in classes on family life and family spacing.
- (d) Mass media. Most women give priority to evening classes as preferred forum for education on family life and spacing. Other sources include radio, TV, and voluntary organizations.

5. What to be taught

- (a) Conception and pregnancy to young women. Respondents are not specific on what all to be taught on this specific topic. Most said that "everything" should be taught.
- (b) The pros and cons of the use of all family spacing methods.
- (c) Family Life. This should be given high priority in terms of the roles of family members and how they can interrelate for the welfare of everyone. This would help in forming better family life and lessen the overall ambivalence of the women about the quality of family life within the home.
- (d) Family size. The question of how many children are enough is one that needs to be examined with women at the levels of specific target groups. It should be done taking into consideration age, economic well being, health, and moral constraints.

Chapter One

Introduction

This is a report of a knowledge, attitude, and practices (KAP) survey done in Belize in 1985. The objective of the survey is to provide base line information on fertility, family spacing, and other conditions related to maternal and child health. The results of the study will be used within a wider Ministry of Health ongoing project to determine the scope for maternal/child health and family spacing programme for Belize. It is funded by UNFPA with PAHO and Ministry of Health serving as local executing agencies.

The report starts by discussing the survey procedures. It continues by describing the major findings under the sub-heading of basic characteristics; family life; family size; fertility; health, pregnancy and childbirth; and family spacing. It ends with a summary of the findings and a list of recommendation

The Survey

A five percent sample (1500) of all Belizean women between the ages of 15 to 47 were selected to be interviewed. The unit of sampling was the household. There were two stages of sampling. During the first stage 52 Enumeration Districts (E.D's) from the total number used in the 1980 census were selected with a bias on those having a larger number of households (i.e. the method of probability proportional to size). During the second stage specific households were chosen through a simple random process with replacement.

The instrument of investigation was a questionnaire administered by forty women interviewers during April-July, 1985. The interviewers worked under six supervisors, one for each district. Both interviewers and supervisors were all women, mostly school teachers resident in the target communities. Before going into the field they were trained by the Field Coordinator using a manual, copies of which were distributed widely. Throughout the fieldwork the Field Coordinator maintained close touch with all the workers, visiting the districts at least twice to check on their progress.

We received from the statistician who had responsibility for sampling, an initial list of 1500 households with an additional 215 reserves from which we would choose, should respondents be needed. Before doing the interviews, the workers did a first count to identify potential respondents and verify with the Field Coordinator what would be done to adjust the numbers. After receiving addresses of more households where they were needed, we did a second count narrowing closer the number of eligible women (E.W.'s).

The biggest problem in the first count was threefold - the impossibility to do the survey in some E.D.'s, some households were vacant in others, and yet others did not have sufficient E.W.'s. It was necessary to request additional randomly selected households to meet this shortfall. Despite receiving additional names, there were insufficient E.W.'s in some E.D.'s.

Appendix 1 outlines the changes in the first count, second count, and eventually the numbers of interviewees in the rural/urban sections of the districts. From an initial list of 1715 households our first count showed that there were only 982 E.W.'s. We requested additional names resulting in being able to include 187 more E.W.'s. We eventually ended up with 1146 usable questionnaires. The very low numbers of refusals and incomplete questionnaires are a tribute to the fieldworkers who excelled in their task, despite difficult logistic problems.

It is necessary to elaborate briefly on the field problems affecting the end number of interviewees. In two E.D.'s one in the Corozal District and the other in the Orange Walk District, it was not possible to conduct the survey. One was a Mennonite community, whose elders requested that their womenfolk should not be interviewed. The other was a Mestizo village that was so badly torn by electioneering politics that interviewers were unable to work freely. We received another E.D. as replacement for the latter also in the same District.

In the western and southern parts of the country there is an outmigration of men and women in search of wage labour, leaving behind a disproportionate number of women who are younger or older but not within the the complete child bearing age range. This is the case in Punta Gorda, for example, where out of 35 households, 19 did not have E.W.'s. Later, we shall see that our sample from Danriga has an unusually large number of younger women.

Table 1.1.

**COMPARISON OF RELIGION AND ETHNICITY BETWEEN
THE 1980 CENSUS FIGURES AND THE STUDY SAMPLE IN PERCENTAGE**

	<u>Census</u>	<u>Study Sample</u>
Religion		
Roman Catholic	62	58
Anglican	12	13
Methodist	6	7
Mennonite	4	3
Seventh Day Adventist	3	4
Pentecostal	2	5
Nazarene	1	5
Ethnicity		
Creole	40	42
Mestizo	33	31
Garifuna	7	7
Maya/Ketchi	9	7
Caucasian	4	5

There was another problem we encountered in a community of mostly migrant workers in the Stann Creek District. Out of 35 households 23 did not have E.W.'s. Many of these were occupied solely by men labourers. A few had women who refused to be interviewed probably because of their status as foreigners in the country. As a result, we ended up with only seven respondents.

The added significance of mentioning these problems is that they underline cultural and demographic constraints that have to be borne in mind in terms of any programmes on maternal/child health and family life in Belize. At various stages of the report these points will be further developed.

There is close similarity in the incidence of some variables between the figures in the 1980 census and those in the study sample. Appendix 2 presents a comparison in the distribution of households between the figures in the 1980 census, the randomly selected sample, and the actual study sample of E.W.'s. The 1980 census distribution of households and that in the randomly selected sample is similar in percentage. There are slight differences between the actual study sample and the randomly selected sample with larger representation in the Belize, Corozal, Cayo, and Toledo Districts, and less in the other districts. In ethnicity and religion the percentage distribution in the country with that in the study sample is similar (see Table 1.1.).

The Variables

A brief overview of five survey studies (Harewood 1978, Kar and Gonzales-Cerruti 1978, Omran et al. 1976, Powell et al. 1978, and Rosero 1981) on family life, fertility and contraceptive use shows that although they cover similar topics, the orientation in each is distinct. The differences arise from the stated objectives, the bias of the investigators, and the level of the data base that is already available.

We have already seen that the objectives, of the survey is to provide base line data on fertility and family spacing to contribute to an overall larger effort that is determining the need for maternal/child health and family spacing programmes in Belize.

Appendix 3 provides an overview of the main topics included in the questionnaire. The section on fertility includes bio-cultural and health subtopics. There is presently some gross data on the rates of fertility, infant mortality, and population growth (see GIS/PAHO 1985). But there are no figures at the micro level of districts and communities nor on the whole question of family spacing. This survey is the first attempt to do so.

There is even less available data on family life. The subtopics included under family life are social experiences related to childbirth and family life information. Because of the diversity of cultural groups in Belize it is especially important to focus on the cultural component of family life.

This is a survey on knowledge, attitude, and practices. Our thrust in framing the questions, however, was on practices and then to make some extrapolations about knowledge and attitudes. Fertility and family spacing are not issues that women speak about openly, especially in Belize where there has been no public awareness on family spacing spearheaded by government or voluntary organizations. On asking women what they do, one can more easily get them to divulge information on such topics. One can then make reflective statements about their attitude and knowledge.

The survey instrument was pre-coded. After editing, we entered the codes into a microcomputer using a programme called Survey Mate produced by Henry Elkins and Associates. This programme is especially useful for data entry allowing for exceptions, minimum/maximum in the label and range specification menu. It produces an output of frequency distribution by variants, their numeric frequency, percentage, and cumulative percentage. It also produces cross-tabulations. In all there was a total of 304 data fields for data entry and 47 variables for crosstabulation for each questionnaire.

Family Life & Fertility in Belize - a background statement

There are three main factors affecting the population dynamics within Belize. They are a high rate of natural increase, migration, and the personal use of family spacing methods.

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Improvements in health services and within the overall socioeconomic environment have resulted in lowering of infant mortality rate from over 50 per thousand live births in 1960 to under 25 in 1984. There has been a drop in the overall death rate from 10 per 1,000 in 1960 to under 25 in 1984. There has also been a drop in the overall death rate from 10 per 1,000 in 1960 to about 5 per 1,000 in 1984. Concurrently the crude birth rate has fluctuated between 40 and 35 per 1,000. The sustained high fertility and low mortality results in a high rate of natural increase of about 3% per year (GIS/PAHO 1985). The 1980 census places the median age of the nation as between 15 and 19 years.

Emigration to the United States became much more noticeable since the early 1960's. At first the escape valve for upper class Creoles, it was used increasingly by other groups throughout the 1970's and 1980's. Estimates of the number of Belizeans now residing in the United States range between 20,000 and 50,000. Those leaving are mostly child bearing age men and women. They are being replaced by thousands of refugee/migrants also of child bearing age from Central America. The United Nations High Commission for Refugees estimates that there are between 10 to 15 thousand Central American refugee/migrants in the country, who arrived since 1979 (GIS/PAHO 1985). A recent study of immigrants from El Salvador, Guatemala, and Honduras shows that about half are younger than 30. Besides, their tendency of high fertility is heightened by their desire to have children born in Belize to legitimize their status (Palacio 1985).

The picture of major increases in the national population ultimately translates into women having large families. Women resort to their resources to take care of their own family spacing needs, as there are no specialized government services on family spacing in Belize. This report, however, shows that there is very high awareness of family spacing methods among the women and that significant proportions are contraceptors.

Despite the lack of government policy, there are several sources of information on family spacing, which operate selectively. Private medical practitioners dispense contraceptives and do counselling to their patients. Because of the cost of such services, they are available only to those who can afford to pay for them.

Ministry of Health personnel perform tubal ligation among other family spacing services. Presently, there do not seem to be any comprehensive guidelines for these practices.

Belizeans seek medical attention in neighbouring countries. Those in the northern districts travel extensively to the Mexican cities of Chetumal and Merida. Those in the south and west travel to towns in Guatemala. In those countries where there is a more open approach to contraceptive use, women have options to the kinds of services they want.

For example, in Mexico, one of the first countries in the region to approve the use of depo-provera, the injection is available for as low as \$1.00 Bze. each.

There are foreign non-governmental medical teams that are stationed in Belize while others make periodic visits. They provide their own services not necessarily in keeping with those offered by the Ministry of Health.

Within the current situation of the selective availability of information and the lack of guidelines set by the government, there is large scope for ignorance and misinformation among the public. There are women who believe in folk methods. For example, with the relatively easy availability of the pill (one pack costs about \$4.00 and is sold without prescription even at grocery stores) women do not use them according to directions. Yet others are using induced abortion, which is illegal in Belize, as a last resort. There are reports of an increasing use of induced abortion within the last few years in Belize City.

The official position by the government on family spacing was stated at a meeting of the Regional Population and Development Project cosponsored by USAID, the International Agency for Planned Parenthood Federation, and the CARICOM Secretariat in Barbados late January,, 1985. At the meeting Belize took a stand similar to that of Guyana, which disapproves of the use of family spacing for an overall reduction of population growth. Rather, the focus should be to use it within a programme of improving maternal/child health, primarily to reduce the number of high risk pregnancies. The government's argument is based on the need for Belize to increase its population in view of its low person to land ratio (presently at 17.2 persons per square mile) while improving its maternal/child health services.

The significance of this statement is the admission by the government probably for the first time of a need to use family spacing methods. It is worth suggesting to widen the scope on the use of family spacing methods. Should they be directed only towards improving maternal/child health? Or should they be directed to improve the overall quality of family life where one looks at the social and economic advantages and disadvantages of increasing one's family size? The answers to these questions, among others, are dealt with in the body of the report. The report presents summary statements on the current knowledge attitude, and practices which the government could use as it reexamines its directions toward fertility, family spacing, and family life.

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Chapter 2

Basic Characteristics and Family Life

Basic Characteristics of Respondents

For the purposes of this report we selected six areas of the country to be units for analysis. They are Belize City, Toledo Rural, Corozal Town, Cayo Rural, Orange Walk Rural, and Dangriga. Belize City, Corozal Town, and Dangriga are urban communities. Toledo Rural, Cayo Rural, and Orange Walk Rural consist of villages found in the districts with the same name. In selecting these six areas we took into consideration their representation in terms of the rural/urban dichotomy of Belizean communities, geographical parts of the country, and ethnicity. Together the six areas contained 810 respondents of 70.7% of the total study sample of 1146.

Belize City is the largest urban area in the country with a population of a little over 40,000 or about one-fourth of the country's population. It has the largest concentration of secondary and tertiary level industries, which attract people from other parts of the country. As the main port of entry it serves as a channel through which influences from metropolitan countries are diverted to other parts.

With respect to its size, function within the country, and exposure to the outside world, Belize City is the only community approaching some "urban" status in Belize, as the term is generally used. The towns, such as Corozal Town and Dangriga - two of those selected for analysis - are better classified as semiurban communities. They serve as administrative and commercial centres for surrounding villages. Their social and economic orientation is very much inwardly directed toward the rural parts of their respective districts. The population of all district towns ranges from 2,500 to 8,500. Their aggregate population is 32,446 or 22% of that of the whole country. The population of the towns selected for the report is as follows- Corozal Town 6,900 and Dangriga 6,661.

Table 2.1

RURAL VILLAGES AND RESPONDENTS

<u>District</u>	<u>Village</u>	<u>Total 1980 pop.</u>	<u>No. of Respondents</u>
Orange Walk	Guinea Grass	1291	25
	London - Carmelita	228	3
	San Jose	1164	21
	San Roman	352	20
	Subtotal		69
Cayo	Bullet Tree Falls	438	30
	Esperanza	845	30
	Georgeville	405	30
	Spanish Lookout	1276	29
	Subtotal		119
Toledo	Laguna - Jacinto	312	22 + 6
	Elridge	135	24
	San Antonio	1087	27
	Subtotal		79

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There are about 250 rural villages with more than 50 inhabitants dispersed throughout the country. They have a combined population of 70,201 or 48.3% of the national population. The main source of livelihood consists of small farming and wage labour. The larger and growing villages are in the Orange Walk and Corozal Districts, where the residents have been sugar cane cash croppers. In the Belize, Cayo, and Stann Creek Districts there had been less population increase in the villages between 1970 and 1980 census. In the Toledo District the villages are smaller in size and more dispersed. The inhabitants rely primarily on milpa cultivation.

The villages in the Cayo Rural, Orange Walk Rural, and Toledo Rural - areas included in this report - are listed in Table 2.1. The number of inhabitants ranges between 135 to 1291. The villages of London and Carmelita have only 228 inhabitants consisting mostly of older folk, the younger men and women having migrated to Orange Walk Town or Belize City. It is a pattern more often seen in the southern part of the country.

Table 2.2 contains several parts which are listed vertically in alphabetical order. These are variables selected from the survey instrument. The frequency distribution in percentage for the global study population and the six geographical areas are placed horizontally. The variables are age cohorts, ethnicity, education, union status, religion, types of cash earning activities for women, socioeconomic status for urban areas. The horizontal subdivision of tables in discussing the other subtopics. In Table 2.2 the total number of respondents in each area for all the variables is the same except in F, where they are included.

Age

The distribution in age cohorts for the entire country shows a slight rise in the number of those younger than 24 and stabilizing until it drops in the 35 and older age group (Table 2.2A). The mean age of all respondents is 30.6. Dangriga shows the youngest mean age of 26.6 stemming from disproportionately large numbers who are younger than 24. It most probably results from the outmigration of working age women between the ages of 25 to 40.

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Table 2.2

BASIC CHARACTERISTICS OF RESPONDENTS

	<u>Global</u>	<u>Bz.</u>	<u>Tol. R.</u>	<u>Czl.U .</u>	<u>Cayo R.</u>	<u>O.W.R.</u>	<u>Dang.</u>
No. of Respondents	1146	401	79	90	119	66	55
A (Age Cohorts)							
15-19	11.2	12.5	13.9	10.0	8.4	5.0	23.6
20-24	18.6	19.5	15.1	18.9	16.8	26.7	29.1
25-29	17.9	17.5	16.5	16.7	20.2	31.7	14.5
30-34	18.7	20.9	20.3	20.0	17.6	15.0	12.7
35-39	14.7	13.5	10.1	15.6	15.1	15.0	5.5
40-44	10.2	7.5	5.1	6.7	15.1	13.3	12.7
45-49	8.7	8.7	19.0	12.2	1.6	3.3	1.8
Mean age	30.6	30.1	30.1	31.0	31.3	29.9	26.6
B (Ethnicity)							
Creole	42.5	66.8	10.1	32.2	35.1	5.0	21.8
Mestizo	31.2	20.2	5.1	58.9	30.7	83.3	12.7
Garifuna	7.1	5.8	1.3	-	1.8	-	60.0
Maya/K.	7.3	-	50.6	2.2	6.1	10.0	3.6
Caucasian	4.7	3.5	1.3	1.1	24.6	1.7	-
Other	7.1	3.5	31.7	5.6	1.8	-	1.8
C (Education)							
Fin. Primary	42.6	34.0	21.5	47.8	71.8	53.1	36.3
Fin. H/S	14.5	24.8	3.8	13.3	5.1	-	21.8
Post Sec.	5.0	9.8	-	2.2	.9	1.6	5.5
D (Union Status)							
Married	50.4	43.4	62.0	61.1	59.7	69.7	30.9
Com. Law	20.0	20.5	15.2	12.2	19.3	24.2	12.7
Never Union	9.2	8.5	6.3	8.9	10.9	1.5	25.5
Visiting	11.9	18.2	5.1	9.0	5.9	-	25.5
Separated	4.7	2.7	5.0	7.8	3.4	4.6	.3.6

Table 2.2. contd.

	<u>Global</u>	<u>.Bz.</u>	<u>Tol. R.</u>	<u>Czl. U.</u>	<u>Cayo R.</u>	<u>O.W.R.</u>	<u>Dang.</u>
E (Religion)							
R. Catholic	58.3	50.3	63.3	73.3	42.9	62.1	78.2
Anglican	12.7	23.4	2.5	1.1	16.0	3.0	3.6
Methodist	7.0	13.0	10.1	11.1	.8	-	3.6
Mennonite	3.0	.3	1.3	-	25.2	1.5	-
Adventist	4.1	2.7	1.3	1.1	.8	6.1	3.6
Pentecostal	4.7	2.5	16.5	1.1	9.2	16.7	-
No. of Respondents	419	176	31	29	25	11	24
F (Types of cash earning)							
Unskilled	19.0	20.5	22.6	31.0	24.0	18.2	12.5
Lower Level	61.8	54.0	77.4	55.2	64.0	45.5	70.8
Middle Level	16.0	21.6	-	13.8	12.0	18.2	16.7
Higher Level	2.4	4.0	-	-	-	-	-
G (Socio-economic Status Urban)							
High	6.8	6.3		3.3			5.5
Medium	34.8	34.4		40.0			23.6
Low	58.3	59.4		56.7			70.9
H (Main Livelihood Rural)							
Agriculture	46.7		53.2		39.0	44.0	
Wage Labour	20.9		17.7		32.2	10.6	
Mixture	1.7		13.9		6.8	25.8	
Own Business	9.0		5.1		12.7	18.2	

Ethnicity

Belize has two main ethnic groups, Creoles, and Mestizo, and at least three other small groups, the Garifuna, Maya/Ketchi, and Caucasian. Their percentage distribution is seen in Table 1.1. Traditionally the groups have concentrated in different parts of the country. The effect is seen in the predominance of some groups in the communities in Table 2.2.B. In Belize City it is the Creole; Toledo Rural it is Maya/Ketchi; Corozal Town and Orange Walk Rural are Mestizo; and Dangriga is Garifuna. Cayo Rural has three main groups, Creole, Mestizo, and Caucasian. The Caucasian are Mennonites who remain isolated in their own communities.

Education

The level of education was measured at three levels, finishing eight years of elementary school, four years of high school, and some post-secondary school. Post-secondary school education consists of attending two or more years of professional training at the Belcast School of Education or the Belize School of Nursing. Generally more women have higher levels of education in the urban than in the rural areas (Table 2.2D).

Religion

Most respondents were Roman Catholic in all areas. The Mennonites have their own Christian sect as seen in the representation in the Cayo Rural area (Table 2.2.E)

Cash Earning Activity

Most women (73.1%) said that they were housewives having full responsibilities for the housework. Only 37.1% said that they had cash earning activity outside of the home. The distribution of the types of occupation is seen in Table 2.2.F. Most of the respondents were concentrated in unskilled and lower level skill positions.

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Examples of unskilled labour were domestic help, janitorial staff, and sewing machine operator. Lower level skill jobs require preparation at least at the level of finishing elementary school. Examples are store clerk, ward maid in the hospital, waitress, lower level nursing staff and teachers. Middle and higher level skills are basically professional positions for which one has to receive some secondary school education and additional job qualification. Examples are middle and higher level teachers, nurses, policewomen, bank tellers, government clerks, etc. Apart from education we also paid attention to the years of experience the respondent had and the grade she had acquired in her position.

Socioeconomic Status

Socioeconomic status was used for respondents in urban areas. It is a weighted value on the co-occurrence of the following variables within the household - number of accessories, size of the house by the number of bedrooms, the occupation of the household head, and his/her level of education. There were three possibilities - high, middle, or low status. Dangriga showed the highest representation at the lower socioeconomic stratum and Corozal Town had the highest at the middle level (Table 2.2G).

Means of livelihood

The indicator of economic productivity in the rural areas was the main means of livelihood of the household head. It was agriculture in most areas. However, there was a substantial proportion (32.2%) of wage labourers in the Cayo District (Table 2.2H).

Extent of Representation

Having reviewed some basic characteristics of respondents in the six areas of the country selected for detail analysis in the rest of the report, it is worth asking the extent to which these areas are representative of the entire study population.

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Firstly, they reflect the distribution of Belizeans into three main types of habitats - Belize City, district towns, and villages.

Secondly, the areas provide a fairly wide spread of ethnicity, education, union status, and socioeconomic indicators. As types the areas reflect the gross classification that is used commonly by Belizeans. There is the Mestizo urban north represented by Corozal Town, which has had greater economic growth as against the southern town of Dangriga that has been afflicted by relatively minimal sustained economic activity during the past twenty years. There is Orange Walk Rural, which is a mixture of Creole and Mestizo. It has also been the centre of development through the sugar industry; but it is presently undergoing a recession with mayor cutbacks in sugar production. There is Belize City, the main metropolitan centre in the country. There is the Cayo area with a mixed ethnic population and a mixture of agriculture and wage labour. Finally, there is Toledo Rural, which is most remote from the Belize City - Belmopan axis and remains probably the least understood part of the country.

There are patterns in these six areas that would fit others not included in the report. They are the rural areas of Belize, Corozal, and Stann Creek Districts and the urban areas of Cayo, Orange Walk, and Toledo Districts.

Family life

The figures for the section on family life are in Table 2.3. The total number of respondents in Table 2.3B and 2.3C for each area is the same as that in Table 2.3A.

Most households in all the areas were male-headed. Female-headed households were found most often in Belize City and Dangriga (Table 2.3A).

In terms of the relationship among the household members we divided the households into two main types, conjugal and extended (Table 2.3.B). Conjugal households consist of men and women living in union - whether married or common-law - with or without children. It also refers to women living by themselves with their own children. This definition is taken from Hammel and Laslett (1974: 73-110). Extended households include cases where a relative other than the offspring of the head or housewife is cor-resident. They may be siblings, parents, cousins, etc.

Table 2.3

FAMILY LIFE

	<u>Global</u>	<u>Bze.</u>	<u>Tol.R.</u>	<u>Czl. U.</u>	<u>Cayo R.</u>	<u>O.W.R.</u>	<u>Dang</u>
No. of Respondents	1146	401	79	90	119	66	55
A (Household Type Headship)							
Male Headed	77.6	63.3	88.6	88.8	91.6	97.0	69.0
B (Household Type Conjugal Ties)							
Conjugal	50.4	47.1	53.2	56.7	54.6	63.6	23.6
Extended	48.6	51.6	45.8	43.3	43.7	34.9	76.4
C (Mean No. of Persons per Household)							
	6.5	5.6	7.2	6.2	8.0	7.1	6.7
D (Mean No. of Children per Household)							
# Respondents	3.9 1071	3.2 363	4.5 78	3.4 88	5.0 113	4.5 63	4.2 50
E (Mean No. of Children of Mother/Guardian)							
# Respondents	8.4 1130	7.2 395	8.9 78	8.1 90	10.0 118	9.9 63	7.3 55
F (kind of Family Life)							
# Respondents	1129	397	77	88	118	63	55
Good	48.9	52.4	38.9	35.2	65.3	47.6	69.1
Bad	13.8	9.3	11.7	13.6	5.1	9.5	12.7
In-between	37.3	38.3	49.4	51.1	29.7	42.9	18.2

Table 2.3. contd. . . .

	<u>Global</u>	<u>Bz.</u>	<u>Tol. R.</u>	<u>Czl. U.</u>	<u>Cayo R.</u>	<u>O.W.R.</u>	<u>Dang.</u>
G Whether No. of Children Affect Family Life)							
# Respondents	1082	384	70	89	110	61	51
Yes	37.9	27.6	30.0	52.8	30.9	29.5	33.3
Not Sure	28.9	32.3	40.0	38.2	30.9	36.1	21.6
No	32.9	40.1	30.0	1.1	37.3	34.4	45.1
H (Expected to Care for Parents)							
# Respondents	1107	388	77	86	117	62	52
Yes	82.2	82.7	67.5	86.1	96.6	100.0	94.2
I (Expected Care from Children)							
# Respondents	1118	390	77	90	118	63	55
Yes	60.9	54.6	41.6	65.5	78.8	77.8	63.6
If they want	33.6	38.5	55.8	32.2	19.5	20.6	30.9
No	5.5	6.9	2.6	2.3	1.7	1.6	5.5
J (Teaching Parenthood and Family Life at Health Centre)							
# Respondents	1160						
Yes	93.8						
No	6.2						
K (Other Ways of Learning Family Life)							
# Respondents	1111	394	75	90	113	64	52
Class	50.0	50.8	61.3	50.5	24.8	51.6	48.1
Vol. Organ.	37.2	32.5	42.7	37.9	29.2	31.3	55.8
Radio	34.7	32.7	53.3	17.2	51.3	17.2	38.5
TV	34.7	53.3	-	32.1	16.8	40.6	15.4
L (Teaching Parenthood at High School)							
# Respondents	1121						
Yes	94.8						
No.	5.2						
M (Teaching Conception at High School)							
# Respondents	1110						
Yes	92.0						
No	8.0						

Extended households were most frequent in Dangriga (76.4%) followed by Belize City at 51.6%. In the other areas conjugal households exceeded extended households. For the whole study sample the percentage of either sibling or single households was less than one percent.

The mean number of persons in all households was 6.5 (Table 2.3C). The households in the rural areas were generally larger than those in the urban areas. Cayo Rural had the highest mean number at 8.0. Children made up the most numerous residents. Again, the rural areas had higher mean numbers of children in the household (Table 2.3.D).

The current generation of child bearing age women came from large families. The mean number of children for the mother or female guardian of the respondent ranged from between 10 in Cayo Rural to 7.2 in Belize City (Table 2.3E). With women coming from such large families it is worth asking whether they feel that the number of their siblings affected the quality of family life they had experienced while growing up. We asked two questions. One was about the respondent's impression on the quality of family life they had as children. The other was whether they felt that there was any association between the quality of family life and the number of children. With respect to the quality of family life one answer came through unequivocally. The least percentage of responses was that the type of family life was "bad" (Table 2.3.F).

There was a mix in the percentages saying that it was "good" and that it was "in between". In other areas the difference between the two answers was small. Thus, there would seem to be some ambivalence among women about the quality of the family life in their natal home.

The ambivalence was carried over to the following question on the association between the quality of family life and the number of children (Table 2.3G). The breakdown of answers for the whole country is as follows - 37.0% "no". The higher rates of "not sure" came from the rural areas where the numbers of children per household were higher. The suggestion forthcoming would seem to be that women are in doubt whether the number of children contributes to an improvement or deterioration in the quality of family life. The doubt is more pronounced when there are more children in the household.

There were slight changes in the notion of perceived dependence between the generations. Most women, especially in the rural areas, said that they were expected to provide care for their parents (Table 2.3H). There was a smaller percentage of those who expected to be cared for by their children, ranging between 41.6% to 78.8% (Table 2.3I). The case of Toledo Rural, incidentally should be mentioned for being the lowest (41.6%) of those who said that they expected to be cared for by their children. It indicates a prevailing attitude of less dependence by women on their children in that area. However, 55.8% of the women in Toledo Rural said that they would accept assistance if the children wanted to provide it. The generally large proportion of women throughout the country who said that they expected to be cared for by their children is no doubt a main reason for having so many children.

Over 90% of all women said that parenthood and family life should be taught at the health centre (Table 2.3J). Other forms through which they would like to learn about these topics are shown in Table 2.3K. Nationwide in order of preference they were evening classes and voluntary organizations, such as Red Cross, Lions, and Rotary. As third preference radio and TV received the same proportion. Belize City differed with the highest preference being for TV. Dangriga showed preference for voluntary organizations followed by evening classes.

Finally, there was countrywide approval in the ninety percentile range for the teaching of lessons on parenthood, family life, conception, and childbirth to students attending high school (Tables 2.3L and 2.3M).

F (Reason Want More)						
Respondents	122	10	35	31	39	16
Personal pref	78.1	48.7	80.0	68.6	80.7	87.5
Pref. Husband	11.0	5.6	20.0	31.4	9.7	6.3
Maternal Fate	4.7					
To be healthy	1.3					

Chapter 3

Family Size and Fertility

Family Size

A major question to ask in any discussion on family life and spacing is the extent to which women feel they can determine the number of their own children. The answers are seen in Table 3.1A. The percentage of women who said that they could determine the number of their children for the whole country is 56.4. The lowest proportions were in the Toledo District (26%) and the highest 70% in Dangriga and Belize City.

For those who said that they could not determine the number of their children there were three alternatives - God/fate, husband/partner and husband/partner along with the respondent (Table 3.1B.). The highest percentages who said God/fate were in the rural areas. In Corozal Town and Belize City there were more women who said that the decision was with their husband/partner and themselves. On the determination of family size there are three patterns. The women in Dangriga feel that they could do so more on their own and with less reliance on others. Those in Corozal Town and Belize City see it as being their own prerogative or that of themselves along with their partners. In other areas women felt that it was beyond them and their partners to determine the number of their children.

The ideal number of children that all women would want for themselves is a mean of 4.3 (Table 3.1C). Rural area women would like to have more children, ranging from 5.9 in Orange Walk Rural to 5 in Toledo Rural. Indeed, child bearing is a major aspect of the role definition of women. As many as 84% of all respondents said that they would be sorry if they did not have children (Table 3.1D).

We probed further to investigate the level of satisfaction with the current number of children and the reasons.

Table 3.1

FAMILY SIZE

	<u>Global</u>	<u>Bze.</u>	<u>Tol. R.</u>	<u>Czl. U.</u>	<u>Cayo U.</u>	<u>O.W.R.</u>	<u>Dang.</u>
A (Determining No. of Children)							
# Respondents	1088	384	73	89	113	61	54
Yes	56.4	70.1	26.0	60.7	59.3	36.1	70.1
B (Who should Determine No. of Children)							
# Respondents	497	118	56	55	69	48	17
God/Fate	49.1	30.5	82.1	16.4	81.2	50.0	47.1
Husb/partner	12.5	10.2	7.1	9.1	5.5	16.7	11.8
Husb/partner with "R"	36.1	54.2	10.7	74.6	13.0	33.3	29.4
C (Ideal No. of Children)							
# Respondents	1061	375	62	88	113	60	55
# Children	4.3	3.6	5.0	4.3	5.5	5.9	3.8
D (Sorry if Had No Children)							
# Respondents	1034						
Yes	84.0						
No	15.2						
E (Already Had No. Wanted)							
# Respondents	940	316	66	79	99	58	39
Yes	53.9	60.0	63.6	44.4	49.5	46.6	51.3
More than want	9.3	3.5	9.1	11.4	16.2	8.6	7.7
Want More	36.8	39.6	27.3	44.3	34.3	44.8	41.0
F (Reason Want More)							
# Respondents	319	122	10	35	31	39	16
Personal pref.	78.1	48.7	80.0	68.6	80.7	38.4	87.5
Pref. Husband	11.0	6.6	20.0	31.4	9.7	31.6	6.3
Maternal Fate	4.7						
To be healthy	1.3						

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Table 3.1. contd

	<u>Global</u>	<u>Bz.</u>	<u>Tol. R.</u>	<u>Czl. U.</u>	<u>Cayo R.</u>	<u>O.W.R.</u>	<u>Dang.</u>
G (Reasons For as Many)							
# Respondents	501	117	42	35	49	22	18
Personal pref.	10.2	17.0	7.1	14.3	4.1	7.0	-
Age	5.4	6.8	9.5	2.9	6.1	3.7	-
Pref. Husband	2.4	1.1	-	17.1	-	-	-
Health	11.6	6.8	4.8	2.9	26.5	7.4	22.2
Can afford	67.1	65.0	76.2	62.9	63.3	51.9	77.8

H (Reasons have more)

# Respondents	106
Fate	51.8
Pressure from husb/partner	19.3
Religion	6.0
Benefits from husb/partner	1.2
Other	21.7

I (How Affect Wellbeing)

# Respondents	106
Economic	72.4
Health	14.9
h/hld space	3.5
No problem	3.5

The respondents were asked a three-pronged question - whether they already had as many children as they would want, or they had more than they would want, or they did not have as many as they wanted. The answers are in Table 3.1E. Most women confirmed that they already had as many as they would want. The variant that received the second highest number of answers was that respondents would like more children. The variant receiving the least is that they had more than they would want.

The answers did not take a direct association with urban and rural areas as the previous questions on family size. Women were stating their impressions about the current numbers of their children on criteria other than those based on their type of community. As we shall see further below, there is an underlying personal factor among women when discussing their level of satisfaction with the numbers of their children.

Another point that comes from the answers is that generally women were reluctant to admitting that they had more children than they would want. Out of the 1146 respondents there were only 106 or 9.3%. The highest percentage was in Cayo District (16.2). Women were more at ease to say that they already had enough or that they would like to have more. The ethos that seems to be coming through is that children are a blessing with whom one should be happy and not complain.

The women who said that they would want more were asked why (Table 3.1F). In all areas they said overwhelmingly that it was their own personal preference. Examples given were that they wanted to have a right number of boys and girls; they wanted companionship especially as older children would leave the home; the children themselves would want siblings to play with; the respondents would like to have as many or fewer children than their mothers; and they were happy with a certain number. Other possible reasons received far fewer responses. These were the preference of husband/partners, maternal fate of women, and the need to have children to be healthy.

Women in Orange Walk Rural and Corozal Town attached more importance to the preference of their husband/partner than women in other areas. This substantiates the relative importance of the men in these two areas in decision making concerning family size, which has already been seen for Corozal Town in answer to the question on whom should determine the number of children in Table 3.1.B.

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In Belize City and Dangriga, the preference of the partner was given much lower rating at 6%.

Whereas personal preference was crucial as a criterion for wanting more children, economic factors took predominance in determining satisfaction with the current number of children. Table 3.1G shows that in all areas women said that they were satisfied with the number of children they had because it was the amount that they "can afford". The respondents elaborated with examples, such as being able to prepare for the children's education, to feed and clothe them, and generally being able to provide for their welfare. Other reasons given were health (as a deterrent to having more children), personal preference, age (being too old to have more), and preference of husband/partner.

There are some patterns that should be highlighted. Next to economic considerations health was important for women in Cayo Rural and Dangriga. The preference of husband/partner takes as much as 17% in Corozal Town but only 1.1% in Belize City. This again shows the relatively important role of the male partner in Corozal Town. On the other hand, personal preference received 17% in Belize City, which emphasizes the relative importance of the women themselves. We have already seen that women headed households are more common in Belize City than in any other areas (see Table 2.2A).

The women who said that they had more than they would want gave as their main reason maternal fate (Table 3.1H). It means that they continued having them because they felt that it was inevitable. Another 21.7% gave "other" reasons. They include "not knowing how to prevent having more children"; and "they just kept coming". The other reasons in Table 3.1.G are pressures from husband/partner (19.3%), religious belief (6%), and the need to acquire benefits from partner. In analysing the importance of these reasons, the reader should bear in mind that the proportions are percentages out of a total number of only 106 respondents. These were the women who said that they had more than they wanted.

The above 83 women were asked whether they felt that having so many children affected their well being. Again economic factors (72.4%) took precedence over health (14.9%) and household space (3.5%).

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The fact that so few women among all the respondents admit to having more children than they would want reinforces an observation that we had made earlier in discussing family life, namely on the ambivalence of women on the question of how many children are enough. Whereas women admit to having as many children as they would want or to wanting more, they are reluctant to admit that having too many children is a definite disadvantage. On the other hand, they respond positively when relating the number of children to economic disadvantages, which takes much higher level of importance in their mindset than health.

In brief, the size of the family itself assumes a definite problem only when it is juxtaposed to other factors of immediate importance.

Fertility

The section on fertility includes a description of ways of learning about conception; attitude about the age to start child bearing and type of male/female relationship; age specific pregnancy rate; and actual union status during first five pregnancies. The figures are in Table 3.2.

Respondents were asked how they learned about conception at the time of their first pregnancy (Table 3.2A). The answers indicate that they learned mostly from friends, mother's explanation, and reading. They learned least from school classes and explanations by their husband/partner. There were slight differences among the areas. Mother's explanation was the main source in Dangriga, Cayo Rural, Corozal Town, and Toledo Rural. In Belize City friends and reading were more common sources. Generally women were satisfied with the adequacy of the explanations for their own experience in having their first pregnancy (Table 3.2B). This observation indicates that information about topics such as conception and pregnancy should be spread widely, as learning is very much a highly interactive process throughout the Belizean society.

The question what should be taught young women about conception was one that drew several "no answers" and "don't know", together being 73.7% of all those who answered. It was an open-ended question to which respondents were asked to state their own opinion.

Table 3.2

FERTILITY

	<u>Global</u>	<u>Bze.</u>	<u>Tol. R.</u>	<u>Czl. U.</u>	<u>Cayo R.</u>	<u>O.W.R.</u>	<u>Dang</u>
A (Learning Conception)							
# Respondents	925	312	69	75	90	60	35
Friends	36.7	41.0	17.4	41.3	38.9	46.7	28.6
Mother	35.0	32.4	49.3	44.0	41.1	20.0	77.1
Reading	32.5	36.5	24.6	40.0	16.7	30.0	34.3
School	16.4						
Husb/partner	12.1						

B (Adequacy for Experience)

# Respondents	912
Yes	64.3
Not certain	15.2
No	20.4

C (What to be Taught re Conception)

# Respondents	609
Everything	42.2
Act of Concep- tion	10.5
Care of Body	9.2
Contraceptive Use	8.2
Family Life	4.4
Male/Female relationship	1.3

D (Ideal Age to Start Childbearing)

# Respondents	942
16 - 19	33.4
20 - 23	60.3

Table 3.2 cont...

E (Ideal Relationship)

# Respondents	948.
Visiting	5.2
Com. Law	4.5
Married	87.1

F (Mean No. of Pregnancies per Woman Who Has Ever Born Children)

	<u>Global</u>	<u>Bz.</u>	<u>Tol. R.</u>	<u>Czl. U.</u>	<u>Cayo R.</u>	<u>O.W.R.</u>	<u>Dang.</u>
Mean # per woman	4.8	3.6	5.8	4.4	6.4	5.9	4.0

G (Mean # of Live Births per Woman Who Has Ever Born Children)

	4.3	3.3	5.4	4.0	5.3	5.8	3.6
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H (Mean # of Pregnancies by Age Cohorts)

	979	323	70	79	99	61	37
# Respondents							
15 - 19	1.5	1.4	1.3	2.0	1.8	1.5	1.0
20 - 24	2.5	2.4	3.1	2.1	2.5	3.4	2.3
25 - 29	3.7	3.2	3.6	3.4	4.7	4.7	2.4
30 - 34	4.7	3.5	6.4	4.2	7.2	6.2	3.9
35 - 39	5.9	4.3	7.4	6.3	7.7	9.2	4.7
40 - 49	7.6	5.5	8.5	6.4	9.9	8.7	6.0

I (Union Status in First Five Pregnancies)

	<u>Pregnancy One</u>						
# Respondents	954	323	70	79	99	61	36
Married	54.6	44.9	64.3	72.2	61.6	68.9	36.1
C/Law	27.8	27.9	30.0	13.9	28.3	29.5	25.0
Visit	17.6	27.2	5.7	13.9	10.1	1.6	38.9
Mean Age	19.7	20.2	18.6	19.7	18.8	18.3	19.9

Pregnancy Two

	841	274	63	70	94	57	29
# Respondents							
Married	58.6	49.3	68.3	74.3	60.6	70.2	51.7
C/Law	29.6	32.1	27.0	12.9	33.0	29.8	20.7
Visit	11.8	18.6	4.8	12.9	6.4	-	27.6
Mean Age	21.7	22.5	20.6	21.8	20.8	19.8	23.0

Table 3.2. contd

	<u>Global</u>	<u>Bz.</u>	<u>Tol. R.</u>	<u>Czl. U.</u>	<u>Cayo R.</u>	<u>O.W.R.</u>	<u>Dang.</u>
<u>Pregnancy three</u>							
# Respondents	675	192	54	55	86	53	23
Married	62.8	52.1	70.4	81.8	62.8	71.7	52.2
C/Law	29.0	33.9	25.9	12.7	31.4	28.3	21.7
Visit	8.2	14.1	3.7	5.5	5.8	-	26.1
Mean Age	23.5	24.2	22.4	24.3	22.7	21.3	25.3
<u>Pregnancy four</u>							
# Respondents	532	135	49	42	78	45	12
Married	63.7	53.3	73.5	78.6	61.5	73.3	58.3
C/Law	29.3	34.1	22.5	14.3	32.1	26.7	33.3
Visit	7.0	12.6	4.0	2.1	6.4	-	9.3
Mean Age	25.2	26.3	24.5	25.8	24.4	23.0	27.8
<u>Pregnancy five</u>							
# Respondents	407	186	38	33	70	35	9
Married	65.4	55.8	79.0	78.8	61.4	71.4	55.6
C/Law	28.3	31.4	18.4	15.2	31.4	28.6	33.3
Visit	6.4	12.8	2.6	6.1	7.1	-	11.1
Mean Age	26.7	27.4	26.8	27.6	26.0	25.0	29.3
<u>Pregnancy one</u>							
# Respondents	242	79	70	323	254	254	254
Married	61.6	72.2	64.3	44.9	54.6	54.6	54.6
C/Law	28.3	13.9	30.0	27.9	27.8	27.8	27.8
Visit	1.6	10.1	5.7	27.2	17.6	17.6	17.6
Mean Age	18.3	18.8	18.8	18.8	18.8	18.8	18.8
<u>Pregnancy two</u>							
# Respondents	242	79	63	274	242	242	242
Married	61.6	72.2	64.3	44.9	54.6	54.6	54.6
C/Law	28.3	13.9	30.0	27.9	27.8	27.8	27.8
Visit	1.6	10.1	5.7	27.2	17.6	17.6	17.6
Mean Age	18.3	18.8	18.8	18.8	18.8	18.8	18.8

Establishing codes for the answers proved problematic because respondents were either vague or wanted to say too much. It reflects the difficulty women had in pinpointing a specific response to the question. Table 3.2C has a breakdown of the answers for the whole study population.

A little more than 42% said "everything". Examples include, "explain about the facts of and life", and "pregnancy can happen at the onset of menses". Ten percent said "the act of conception - how it takes place and when". "Care of the body" received 9.2%; examples given were regular checkups and cleanliness. Contraceptive use (8.2%) was stated as "knowing how to protect yourself". Family life (4.4%) meant "unity among members of the family" and "how to be a good mother. Examples of male/female relationship (1.3%) were "to be subject to your husband" and "orgasm" as it relates to becoming pregnant".

In all areas more respondents agreed that the ideal age to start child bearing was between 20 and 23 (Table 3.2D). Besides, the ideal male/female relationship should be marriage (Table 3.2E).

At the time of the survey the mean number of pregnancies among women who had been pregnant nationwide was 4.8 (Table 3.2F). Only Belize City had fewer at 3.6. Cayo Rural had the highest at 6.4, followed by Orange Walk Rural at 5.9 and Toledo Rural at 5.8.

The mean number of live births for women who had ever born children follows in Table 3.2G. It shows that Cayo Rural had slightly fewer than Orange Walk Rural and Toledo Rural. There is greater wastage in pregnancy through still births and miscarriages in Cayo Rural than in Toledo Rural and Orange Walk Rural (see Table 4.1). We have already seen that health was a prevalent reason for women in Cayo Rural saying that they had as many children as they would want in Table 3.1G. Probably their experiences with still births and miscarriages may be a main reason.

The mean number of pregnancies by age cohorts for all women shows that there is a gradual increase from 1.5 for women 15-19 to 7.6 at 40-49 (Table 3.2H). But it is worth pinpointing some significant differences. By the time a woman reaches 29 in Dangriga she has had two pregnancies whereas in Cayo Rural or Orange Walk Rural her counterpart is approaching her fifth.

The rural areas showed higher mean numbers throughout all age cohorts and end with higher cumulative mean numbers of 9.9 at Cayo Rural, 8.7 at Orange Walk Rural, and 8.5 at Toledo Rural. Belize City and Dangriga had lower cumulative numbers at 5.5 and 6.0 respectively. Another pattern that can be seen is that in all areas women start early and maintain about the same mean number until around age 29 when fertility in the towns declines markedly compared to that in the rural areas.

There are two patterns on the association between union status and pregnancy forthcoming from Table 3.2I. One concerns the prevalence of married unions. The other is about changes in the types of union status women undergo with increasing number of pregnancies. The vast majority of pregnancies resulted from unions that were married. Common-law and visiting unions were fewer. Notable differences occurred in Belize City and Dangriga where common-law and visiting unions were more common.

Generally, there was decline in the proportion of visiting unions as a woman had more pregnancies, with corresponding increases in the married and common-law unions. Table 3.2I shows that globally the proportion of visiting unions declined from 17.6 in the first pregnancy to 6.4 by the fifth pregnancy. Married unions increased with each pregnancy while common-law unions fluctuated. By the fifth pregnancy the rate of common-law unions declined in favour of married unions. Thus there is a preference for women to consolidate their unions by marriage as they have more children. It confirms the earlier statement about marriage being the ideal union for most women during child bearing. Women attain this ideal earlier in some areas than in others.

The case of Dangriga and Belize City need special mention, since they deviate markedly from the norm set by other areas. At the first pregnancy in Dangriga 38.9% resulted from visiting unions, 36.1% married, and 25% common-law unions. By the second pregnancy the proportion had changed to 51.7% married and 27.6% visiting unions. The proportion of visiting unions continued to decrease between the third and fifth pregnancies, while that of the common-law increased. The rate of married unions remained at about 50%.

In brief, the ideal union for the women in Dangriga and Belize City remains being married. By the second pregnancy half of them are married. During the other pregnancies there is a fluctuation between living common-law and having visiting unions, with a gradual decrease in the latter.

Chapter 4

Health, Pregnancy, and Childbirth, and Family Spacing

Health, Pregnancy, and Childbirth

During the survey there were 101 women who were pregnant or 8.8% of the total sample. The breakdown in each area is in Table 4.1A.

The information on health, pregnancy, and childbirth was obtained from 979 women who had already born children. More specifically the questions were asked about their last pregnancy. They were asked about their impressions of their health status during the pregnancy. Most said that they felt "well"; 16.8% said that they were "sickly". Women in the Toledo Rural and Orange Walk Rural areas reported the highest proportion of being "not too well" and "sickly" (Table 4.1B).

The significance of this response lies not in pinpointing the actual incidence of ill health but on how women themselves felt. Further below we see that women in Toledo Rural do indicate suffering most from pregnancy related illnesses. But it is also a fact that individual impressions are not the best indicators of the presence or absence of disease. Furthermore, the definition of being "not too well" or "sickly" is culture bound, especially as related to a myth-laden state, such as pregnancy. The response of the women may be a factor of cultural interpretation of how one should feel during pregnancy.

While pregnant most women (90.2%) in all areas attended the prenatal clinic regularly, showing up for most of their appointments (Table 4.1C). Apart from attending the pre-natal clinic women receive attention from midwives and private doctors. Generally, more go to midwives than to private doctors. The figures in Table 4.1D indicate that this is the case in all areas except in Belize City and Corozal Town. Hardly any said that they went to a bush doctor or an off-duty nurse, the other two alternatives mentioned in the questionnaire.

Table 4.1

HEALTH, PREGNANCY AND CHILDBIRTH

	<u>Global</u>	<u>Bze.</u>	<u>Tol. R.</u>	<u>Czl. U.</u>	<u>Cayo R.</u>	<u>O.W. R.</u>	<u>Dang.</u>
A (Respondents Currently Pregnant)							
# Respondents	101	29	5	10	10	12	3
% of total #	8.8	7.2	6.3	10.0	8.3	18.2	5.5
B (Health During Pregnancy)							
# Respondents	867	401	64	72	92	50	36
Well	69.8	84.4	56.3	73.6	87.0	62.0	75.0
Not too well	16.8	8.1	28.1	6.9	4.4	28.0	16.7
Sickly	13.4	7.5	15.6	19.4	8.7	10.0	8.3
C (Attendance - Pre-natal Clinic)							
# Respondents	865						
Regularly	90.2						
Irregularly	5.1						
Didn't attend	.1						
D (Other Source of Medical Attention)							
# Respondents	772	272	62	65	66	49	28
Midwife	42.4	18.8	48.4	26.2	63.6	83.7	53.6
Priv. Doc.	30.5	37.1	25.8	29.2	30.8	26.5	28.6
E (Health Problems)							
# Respondents	809	284	59	68	77	50	36
Oedema	25.8	16.2	40.7	38.2	24.7	22.0	27.8
Pressure	11.2	8.8	5.1	14.7	16.9	-	16.7
Anaemia	8.8	3.5	13.6	10.3	7.8	20.0	2.8
F (Stillbirths and Miscarriages)							
% of total Pregnancies	7.8	7.1	6.1	8.8	11.7	7.0	6.7

Table 4.1. contd

	<u>Global</u>	<u>Bz.</u>	<u>Tol. R.</u>	<u>Czl. U.</u>	<u>Cayo R.</u>	<u>O.W.R.</u>	<u>Dang.</u>
	(Place of Delivery)						
# Respondents	830	289	58	64	88	46	36
Hospital	71.2	86.2	39.7	87.5	42.1	54.4	86.1
	(Post-natal Clinic)						
# Respondents	820	286	55	61	88	48	35
Yes Regularly	86.7	91.6	85.5	83.6	72.7	87.5	91.4
Yes Irregular	6.5	4.2	7.3	13.1	10.2	6.3	-
	(Infant Mortality)						
Per 100 live births	4.2	2.7	8.9	3.1	4.3	4.8	6.5
# Dying in first year	177	29	34	10	24	16	9
	(Respondents with Infants Dying)						
# R's with chn. dying in 1st year	111	16	22	10	15	6	6
# R's ever born chn.	979	330	71	80	105	62	38
	(Breastfeeding)						
# Respondents	827	289	55	63	88	48	36
Yes	80.7	77.5	90.9	74.6	87.5	89.6	80.6
Mean Months	8.7	6.2	13.8	9.7	11.2	11.3	9.4
	(Feeding)						
# Respondents	765	219	52	55	81	45	33
Other/Milk mean months	6.2	6.0	6.8	6.1	5.7	9.5	6.2
Weaning Mean months	16.0	14.0	18.6	17.9	20.4	15.3	13.9

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The types of diseases that women reported are shown in Table 4.1E. They are oedema, high blood pressure, and anaemia.

Oedema is the most common affecting 40.7% of the women in the Toledo Rural area, 38.2% in Corozal Town, and 27.8% in Dangriga. Belize City and Orange Walk Rural were the only two areas reporting proportions lower than those of the total study sample, which stands at 25.8%. With respect to high blood pressure Cayo Rural, Dangriga, and Corozal Town reported the highest proportions. Anaemia, the least commonly reported disease, occurred most frequently in Orange Walk Rural, and Toledo Rural. There is a wide geographical spread of these diseases, although they were reported in proportionately small numbers, except for oedema.

Within the entire study sample 7.8% of all pregnancies resulted in stillbirths and miscarriages. The highest incidences were in Cayo Rural at 11.7% (Table 4.1F).

The place of delivery was the hospital for 71.2% of the women nationwide. The highest proportion of hospital deliveries was in Corozal Town (87.5%) followed by Belize City (86.2%) and Dangriga (86.1%). As would be expected, the rural areas had the least number of such deliveries because of distance from the towns where the hospitals are located. Toledo Rural, which has the most remote communities, reported the least number at 39.7%. The non-hospital deliveries took place within the home (Table 4.1G).

As in the case of pre-natal clinic attendance, a very high percentage of the women took their infants to the post-natal clinic. the least number of regular attendance was 72.7% reported in Cayo Rural (Table 4.1H).

The figures on infant mortality are recorded in terms of the infants as well as that of their mothers. In the whole country 177 infants died during their first year from among 4,188 live births. Taken as a proportion per 100 live births, the 177 deaths came up to 4.2. In all the areas Toledo Rural (8.9) and Dangriga (6.5) reported the highest numbers of deaths per 100 live births (Table 4.1I).

One hundred and eleven women out of 979 reported having infants dying in their first year (Table 4.1J). In the case of Toledo Rural, which has the highest rate of infant mortality, there were 22 women who had 34 infants dying. This gives a mean of 1.5 deaths for each woman.

In Dangriga, six women reported having 9 infants dying, which also gives a mean of 1.5. Although Orange Walk Rural had an infant mortality rate of 4.8, less than Toledo Rural and Dangriga, the mean number for each woman was 2.7. In other words, women who had infants dying in their first year had more on the average in Orange Walk Rural than in the other areas.

This leads to the question of what type of women tend to have infants dying in their first year. Is it possible to make any association between child bearing and infant mortality? A full treatment of this topic lies beyond the scope of this report. However, it is possible to make some suggestions based on the data collected.

We reviewed the records of the six women who reported nine deaths in Dangriga. One woman had four deaths and the others one each. The woman with four deaths along with another one were over 40 years and had 12 and 11 pregnancies respectively. The others had between one and five pregnancies. Generally, the deaths occurred between the first and fourth pregnancies, except for the one with four deaths, where they occurred at the third pregnancy and after the fifth. Thus, the age of the woman is not directly related to having infant deaths. There would seem to be direct association with the cumulative number of pregnancies, i.e. the more children a woman has the more the possibility of their dying in the first year. There is also an indication that infant deaths occur more often in the first three pregnancies for those who have fewer pregnancies and within subsequent pregnancies for women having more than five. Finally, the suggestion comes through sharply that some women are more prone to having infants dying in more numbers than others. In such cases, it would be necessary to review the associations with socioeconomic and health variables. It did not seem necessary for us to do such statistical cross-tabulation because of the small numbers coming from the total sample.

Most women said that they breastfed their infants, the least numbers were Corozal Town (74.6%) and Belize City (77.5%) (Table 4.1K). Women were also breastfeeding for extensive periods ranging between 6.2 months in Belize City and 13.8 months in Toledo Rural. They gave feeds other than milk at around 6.2 months (Table 4.1L). The age of the infants at weaning (i.e. completely dependent on foods that everyone else in the household is eating) ranges between 13.9 months in Dangriga to 20.4 months in Cayo Rural.

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Family Spacing

The women's attitude on most satisfactory and least satisfactory time interval between births is shown in Table 4.2A. The interviewers probed on the opinion about the length of time the women felt the body needed to recover from childbirth. Women in Orange Walk Rural and Toledo Rural gave the shortest most satisfactory interval of 28.8 and 32.9 months respectively. The longest periods were stated by women in Dangriga (45 months) and Corozal Town (40.3 months). Toledo Rural women also reported the shortest most unsatisfactory interval of 12.4 months followed by Corozal Town and Orange Walk Rural women. In brief, women in the rural areas felt that birth intervals should be shorter than urban women. Not only do rural women have more children they also feel that spacing should be shorter than urban women.

The mean time interval in years between the first ten births is in Table 4.2B. This was computed by finding the mean age at each birth and the difference between the age at two consecutive births. The first figure in the table is the interval between the first and second birth, the second figure the interval between the second and third, and the last is the interval between the ninth and tenth births. For the whole study sample there were longer intervals between the first three births than among the others, ranging between 21 and 24 months. After the fifth birth the interval shortens to between 13 to 19 months. The case of Dangriga is unusual for showing the longest time interval up to the fourth birth. Afterwards it declined sharply.

Although there was little concurrence between the stated ideal in Table 4.2A and the actual interval in time period, there was generally a pattern of women who want longer intervals being able to keep them. Thus, the Dangriga and Corozal Town women, who stated the longest ideal periods maintained longer periods than other women, at least up to the fifth and sixth births.

The fact that the first three births have longer intervals shows that there is an association between age and spacing. There are more women who are younger having first three births than those having more than three. In Table 3.2I we saw that the mean age of women nationwide for the first three pregnancies is between 19.7 to 23.5. These are the women who are better able to maintain the ideal interval they would want than older women.

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Table 4.2

FAMILY SPACING

Global Bze. Tol. R. Czl. U. Cayo R. O.W. R. Dang.

A (Interval Most Satisfactory/Unsatisfactory)

# Respondents satisfied	606	116	48	53	79	44	20
Time in mths.	36.3	36.0	32.9	40.3	36.8	28.8	45.0
# Respondents unsatisfied	546	145	35	47	77	42	19
Time in mths.	16.4	17.5	12.4	14.0	16.2	15.3	16.3

B (Actual Spacing in Years)

1	2.0	2.3	2.0	2.1	1.9	1.5	3.1
2	1.8	1.7	1.8	2.5	2.0	1.5	2.3
3	1.7	2.1	2.1	1.5	1.7	1.7	2.5
4	1.5	1.1	2.3	1.8	1.5	2.0	1.5
5	1.3	1.1	1.7	1.2	2.0	1.8	.7
6	1.6	2.1	.6	2.0	.5	1.6	1.9
7	1.3	.5	2.3	.6	1.6	1.3	.6
8	1.4	1.8	1.0	1.9	1.9	1.8	.9
9	1.1	.7	2.8	1.5	.4	1.4	-

C (Knowledge and Use of Family Spacing)

<u>Global</u>	<u>Knowledge</u>	<u>Had Used</u>	<u>Using</u>
	<u>Pill</u>		
Global	97.0	42.9	14.9
Bze. U.	99.0	55.0	22.6
Tol. R.	72.7	10.3	3.9
Czl. U.	100.0	60.6	28.0
Cayo R.	99.1	35.9	7.8
O.W. R.	96.9	13.8	3.0
Dang.	94.5	18.1	5.4

Table 4.2 cont...

<u>Injection</u>			
Global	92.3	8.2	1.5
Bze. U.	96.0	5.6	.8
Tol. R.	59.7	1.3	-
Czl. U.	95.5	16.8	1.1
Cayo R.	89.4	7.0	3.5
O.W. R.	93.8	4.6	-
Dang.	87.2	3.6	-

<u>IUCD</u>			
Global	83.9	6.9	1.8
Bze. U.	90.0	6.4	2.3
Tol. R.	38.9	1.3	-
Czl. U.	95.5	5.6	-
O.W. R.	83.0	6.1	1.5
Dang.	76.3	-	-

<u>Rhythm</u>			
Global	70.1	11.2	3.5
Bze. U.	83.8	12.0	4.3
Tol. R.	25.9	1.3	-
Czl. U.	75.2	10.1	2.2
Cayo R.	57.8	22.8	6.1
O.W. R.	72.3	4.6	1.5
Dang.	70.9	5.4	3.6

<u>Abstinence</u>			
Global	65.3	5.0	2.0
Bze. U.	80.4	6.6	3.0
Tol. R.	54.5	9.0	2.6
Czl. U.	49.4	2.2	2.2
Cayo R.	55.2	1.7	.9
O.W. R.	73.8	-	-
Dang.	74.5	1.8	1.8

Table 4.2. cont...

Withdrawal

Global	70.1	10.1	1.2
Bze. U.	86.3	11.3	.3
Tol. R.	40.2	6.4	3.9
Czl. U.	70.7	11.2	-
Cayo R.	62.2	4.3	1.9
O.W. R.	70.7	3.0	1.5
Dang.	65.4	9.0	1.8

Condom

Global	83.1	14.1	2.0
Bze. U.	95.1	17.2	1.5
Tol. R.	42.8	2.6	1.3
Czl. U.	91.0	22.4	1.1
Cayo R.	77.1	7.8	2.6
O.W. R.	73.8	7.6	3.0
Dang.	69.0	3.6	-

Breast Feeding

Global	91.0	17.8	4.1
Bze. U.	94.8	12.6	2.0
Tol. R.	74.0	16.8	9.0
Czl. U.	96.6	11.2	1.1
Cayo R.	92.1	30.7	9.6
O.W. R.	95.3	20.0	3.0
Dang.	81.8	12.7	9.0

Tubal Ligation

Global	92.1	11.0	11.0
Bze. U.	95.3	8.7	8.7
Tol. R.	66.2	6.4	6.4
Czl. U.	97.7	16.8	16.8
Cayo R.	92.9	7.8	7.8
O.W. R.	96.9	12.3	12.3
Dangriga	89.0	7.2	7.2

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Table 4.2 cont ...

Vasectomy

Global	61.1	.1	.1
Bze. U.	80.9	-	-
Tol. R.	40.2	-	-
Czl. U.	51.6	-	-
Cayo R.	59.6	-	-
O.W. R.	50.7	-	-
Dang.	49.0	-	-

Foam

Global	51.2	4.1	.8
Bze. U.	64.0	3.0	.5
Tol. R.	28.5	6.4	1.3
Czl. U.	66.2	5.6	-
Cayo R.	29.8	2.6	-
O.W. R.	44.6	-	-
Dang.	60.0	1.8	-

	<u>Global</u>	<u>Bze.</u>	<u>Tol. R.</u>	<u>Czl. U.</u>	<u>Cayo R.</u>	<u>O.W. R.</u>	<u>Dang.</u>
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D (Approximate % of Current Users of All Methods)

	42.9	43.9	28.4	52.5	43.3	25.8	28.8
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E (% Contraceptors)

	61.6	66.6	32.9	72.2	61.3	43.9	36.4
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F (Influence to Use)

# Respondents	691	267	26	65	73	29	20
Respondent	59.3	69.3	69.2	49.2	60.3	44.8	70.0
Husb/partner	25.8	22.9	26.9	29.2	20.8	37.9	20.0
Doctor	20.5	12.7	12.0	27.7	25.0	27.6	15.0

G (Influenced Against)

# Respondents	369	109	50	15	34	36	33
No	82.7	87.2	92.0	93.3	88.2	52.8	93.9

Table 4.2. contd

	<u>Global</u>	<u>Bz.</u>	<u>Tol. R.</u>	<u>Czl. U.</u>	<u>Cayo R.</u>	<u>O.W.R.</u>	<u>Dang.</u>
	H (Other Factors Discouraging Use)						
# Respondents	375	110	50	15	31	36	34
Rumour	36.3	24.6	36.0	40.0	42.4	63.9	32.5
Not need	30.9	42.3	18.0	13.0	33.3	13.9	50.0
Not occur	30.9	37.8	46.0	20.0	27.3	19.4	14.7
Not know	29.1	14.6	44.0	53.0	22.6	36.1	29.4

I (Teaching of Family Spacing at Health Centre)

# Respondents	1044
Yes	95.9

J (Other Sources of Learning)

# Respondents	1072	383	73	86	109	60	52
Private Doctor	59.0	56.2	43.8	77.9	41.3	80.0	63.5
Husb/Partner	20.7	26.4	12.3	8.1	34.9	13.3	19.2

K (Methods of Public Information)

# Respondents	1102	387	74	88	111	64	55
Classes	345	152	45	27	18	31	14
Literature	343	146	25	61	42	5	26
Radio	305	100	27	15	60	6	14
TV	289	192	1	18	29	18	7
Workshop	272	102	12	22	15	35	11

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Further association between age and spacing is seen more sharply in Dangriga. The women who had more than five births were more than 30 years old. They were also fewer. From a total of 36 women who had ever born children, the number declined to nine by the fifth pregnancy. The fact that fewer women were giving more births lowered the mean time interval. Hence, there were time intervals of six months and a little more between the last two births. These were the women who were also doing the least about their family spacing.

The reasons why younger women maintain longer birth intervals can be explained by the possibility that they are using more family spacing methods, including abstinence. Another explanation may come from the fact that they are found in more visiting unions than in married and common-law unions (see Table 3.21, especially the case of Dangriga). Such unions would seem to be resulting in fewer births.

Table 4.2C gives an overview of the knowledge and use of eleven family spacing methods. They are the pill, injection (depo-provera), IUCD, rhythm, abstinence, withdrawal, condom, prolonged breast-feeding, female sterilization (tubal ligation), male sterilization (vasectomy), and foam. Respondents were asked whether they knew of each one, had used it, and were using it.

Table 4.2D shows the approximate percentage of women who were using family spacing methods in each area at the time of the survey. This was done by adding the percentage of those who were using each method, since women were most often using only one at a given time. Throughout the study sample about 42.9% of all women were using family spacing methods. The highest percentage was in Corozal Town (52.5%) and the lowest Toledo Rural (28.4%). Dangriga, among the three urban areas, had the lowest at 28.8%.

The two methods least used were foam and vasectomy. The two methods most commonly used were the pill and tubal ligation. There was greater use of the pill in the urban areas, except Dangriga while there was greater use of tubal ligation in the rural communities. The pattern in Dangriga followed that of the rural areas where women more used tubal ligation. The indication is that women in the urban communities of Belize City and Corozal Town were using family spacing methods to space their pregnancies, whereas those in the rural areas and Dangriga were using them to terminate their fertility.

# Respondents	369	109	50	15	34	36
No	82.7	87.2	92.0	93.3	88.2	52.8



A word should be said about prolonged breastfeeding, which was the third most often used method (4.1%) nationally, especially in the rural areas and Dangriga. There would seem to be a prevalent belief about its usefulness. We have already seen that respondents breastfed for extended periods of up to 14 months (Table 4.1K). They were doing so also for family spacing purposes.

Breastfeeding is termed as one of the unsafe methods of family spacing in terms of its reliability, likewise rhythm and withdrawal. There was minimal use of the latter two methods.

Table 4.2E indicates that on the average more than half of all women in the country had used the family spacing methods mentioned earlier. The areas where there were fewer contraceptors than the national figure of 61.6% were in Orange Walk Rural, Dangriga and Toledo Rural. But there is marked inconsistency between past and current use. In all areas women used methods and then discontinued. In Corozal Town, for example, whereas 60.6% of the women had used the pill only 28% were presently using it during the survey. The pattern seems to be to use methods when they are most thought to be needed and then to stop using them afterwards.

The tendency to use methods during crisis situations is confirmed by the use of tubal ligation, the second most frequently used method. Usually it is older women who have tubal ligations as a last resort to stop having children altogether. Hence, its relative popularity in Toledo Rural and Orange Walk Rural, two areas where women have proportionately higher fertility.

We were advised by Ministry of Health personnel not to include induced abortion as a family spacing method. Discussions with medical practitioners revealed, however, that there are several cases of abortions in Belize City among other communities. It would fall into the pattern we have observed of the use of methods during crisis and not on a consistent, pre-meditated basis. We were told that there is a greater use of abortion among younger urban women. Earlier we saw that birth intervals are also longer among this group. One of the methods they are using may include induced abortion.

We can make some suggestions on the types of family spacing methods that women use as they have more children. Earlier we saw that younger women, especially those with one or two pregnancies, would seem to be using family spacing more than older women who have several children. They may be using methods, such as the pill, condom, and abortion. However, they may also be abstaining for prolonged periods because of the nature of their visiting relationships. After the first two pregnancies the women use methods designed to space their children, such as the pill. Later, on having as many as "they can afford" (see discussion on Table 3.1G) the women resort to tubal ligation. In rural areas where there is limited use of artificial methods, the women use breastfeeding and then may receive tubal ligation in the later child bearing period.

The gap between the knowledge of methods and their use should also be mentioned. Among all women the method they least knew about was the foam, even then 51.2% of them knew about it. The percentage of those who knew about the other methods ranges between 61% and 97%. The area where there was noticeable ignorance was Toledo Rural. The highest level of knowledge there was 74% about breastfeeding and the lowest at 28.5% about the foam. Some of the reasons why the high rate of knowledge does not lead to use are discussed further below.

The women claimed that they themselves were the main influence to use family spacing methods. This is seen in Table 4.2F. The other sources of influence were the husband/partner and the doctor. Women who took the initiative on family spacing were most found in Dangriga, Belize City, and Toledo Rural. The role of the husband/partner was more pronounced in Orange Walk Rural and Corozal Town than in Dangriga and Belize City. In the first two there were high proportions of women who were married (Table 2.21) and live in conjugal households (Table 3.1B). Thus, we are seeing a direct association of the role of the men in decision-making on spacing with their presence in conjugal households.

The women who had never used family spacing methods were asked whether they felt that they were being influenced not to use them. The vast majority said that they were not pressured against family spacing methods (Table 4.2G).

We probed further to discover whether there were any factors that discouraged them from family spacing methods (Table 4.2H). The number of respondents for the whole country was only 375. The percentage of answers was divided almost equally between rumour about methods, not needing them, not occurring to the respondent to use them, and not knowing about them. The distribution of these answers, as seen in Table 4.2H, takes different patterns in some areas.

In Dangriga and Belize City most women claimed that they did not need them. We observed that there was tendency for younger women who were not in married or common-law unions to say that they did not need family spacing methods or that it did not occur to them to use them. Indeed, most pregnancies for younger women, for example, in Dangriga (see Table 3.21) resulted from visiting unions. This fact by itself indicates that contrary to what they were saying about not needing them, they should be informed about the methods to avoid the incidence of unwanted pregnancies.

In Toledo Rural and Corozal Town large proportions of women said that they did not know about them. In the case of Toledo Rural it is a case of a general lack of awareness among most women. In the case of Corozal Town, it is more a case of certain pockets not knowing among a predominant set of child bearing age women who are highly knowledgeable about methods. These small groups of the uninformed were most probably younger women, who had not yet been pregnant, or older women who were well advanced in their child bearing.

In other areas, notably Cayo Rural and Orange Walk Rural, rumour about methods took precedence in discouraging their use. Examples of rumour include causing sterility, cancer, hyper-tension, and abortion.

The vast majority of respondents confirmed that they would want family spacing methods to be taught at the health centre (Table 4.21). Other sources of learning include private doctor and husband/partner (Table 4.2J). The response to the question of the sources of public information about family spacing are given in raw scores and not percentages in Table 4.2K. The three most popular media are evening classes, literature, and radio. Each area has its own sequence of preferences.

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Chapter 5

Summary

Six areas representing different parts of the country were selected to provide a comparative framework using the percentage distribution of certain variables. The topics are basic characteristics; family life; family size; fertility; health, pregnancy, child birth; and family spacing.

Under basic characteristics there are main differences among the selected areas originating mainly from the rural/urban dichotomy and ethnicity. In the socioeconomic stratification system that we used, Dangriga, among the other urban communities, has the highest concentration of respondents in the lowest stratum. Agriculture and wage labour are the two main sources of livelihood in the rural communities. The level of education of urban respondents is higher than that of the rural.

Ethnicity is a main source of differentiation in terms of one group predominating in each area. It does not hold for Cayo Rural, however, where there are three main groups, Creol, Mestizo, and Caucasian (i.e. Mennonite).

Religion, union status, and frequency distribution by age cohorts display more similarities than differences among the areas. The predominant religion is Roman Catholicism. Most respondents live in married unions with a much smaller minority in common-law and even fewer in visiting and never-in-union categories.

The age distribution shows a curve where most are found between the ages of 25 to 34, except for Orange Walk Rural and Dangriga where there are more women younger than 29.

In family life we see features that follow patterns of ethnicity as outlined earlier. There is a predominance of male headed and conjugal households, except in Dangriga and Belize City. The former is predominantly Garifuna and the other Creole. But in all areas family life at the level of the household is characterized by large families with several children. The respondents themselves were born into families having between 7 to 10 children.

The co-residence of so many persons in the household results in the formation of patterns of dependency between the generations. The respondents were expected to provide care for their parents. They also looked forward to receiving assistance from their children.

There is nevertheless an ambivalence among the women about the quality of family life they experienced in their natal home. There is similarly an ambivalence on whether they feel that the number of children affect the quality of family life. This grey area of uncertainty is suggesting that women are not attributing improvements in family life to increased numbers of children. In other words, the number of children is no longer an independent variable for good family life for the respondents, as it might have been for their mothers.

Finally, there is overwhelming consensus among the respondents on the teaching of family life education at the health centre, through other media of public education, as well as at the high school level.

With respect to family size, the respondents confirm that child bearing is a major component of their role definition as women. Rural women more than urban women do not see it within their own power to limit their fertility. Rather it lies more in their fate to bear as many children as possible. Most women admitted however that they already had as many children as they would want. A smaller number said that they wanted more and only a small fraction admitted to having more than they would want. The main reasons expressed by the three groups reveal their attitude toward family size.

Those who wanted more said that it was their own desire to have a certain number (or set) of boys and girls. Those who already had as many as they wanted claimed that they had the number that they "could afford" economically. Those who had more than they would want added that they could not "stop them from coming".

These reasons establish three main parameters that would have to be kept in mind in introducing any family spacing programme - the personal attitude of women toward child bearing as their own self-fulfillment, the overwhelming economic conditions that cause some women to say "I have had enough", and the belief among others that they cannot limit their fertility. It should be mentioned that health took a much lower priority among women as a fact affecting the number of children.

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Women learn about conception least from classes and more from friends, reading, and their mother's explanation. The importance of this observation is that education about such topics, as conception, will have to be targeted not only toward child bearing age women but also to a more general audience since learning is a highly interactive process within the community. The question on what should be taught about conception drew one of the largest numbers of "no answer" and "don't know" responses. The suggested topics also took a very wide spectrum. This is no doubt because of its extreme importance and to express immediacy that women feel about it.

The other topics under fertility, the age-specific pregnancy rate and the associated union status, present marked differences between rural and urban communities and among the latter. Generally, women start child bearing between the age of 15 and 19. The rates remain fairly the same in all areas until the women are between 25 to 29. Subsequently the fertility of rural women surpasses that of the urban women. The differential continues and ends with higher cumulative pregnancies in rural than in urban women.

The ideal union status stated for child bearing is marriage. Generally, there is a decline in the proportion of pregnancies resulting from visiting unions with age in favour of married and common-law unions. This pattern is noticeable throughout, although common-law and visiting unions occur in larger numbers in Belize City and Dangriga than in the other areas.

The discussion on health, pregnancy, and childbirth starts with a folk definition of health status during the respondents last pregnancy. This focus on the folk concept is important because pregnancy is traditionally surrounded by myths among ethnic groups. It is also a truism that on inducing any intervention one has less resistance in working through the culturally accepted paradigm.

Most women are currently using the prenatal and postnatal clinics. They also receive attention from midwives and doctors, with the former being utilized more in most parts of the country. Among the pregnancy related diseases in the survey instrument oedema is reported more often than either high blood pressure or anaemia. Women in the Cayo Rural area reported a higher rate of miscarriages and stillbirths than in other areas.

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Infant mortality is a problem that has greater significance in some areas than in others, notably the rural communities and Dangriga. Although it seems to increase with the cumulative number of pregnancies among some women, both socio-economic and health variables will have to be considered in dealing with it. There are indications that some individuals are prone to having multiple cases than others. Such cases, however, seem to be limited and do not fall within the overall norm among the respondents.

In all areas most women are breast-feeding and are doing so for extended periods, except in Belize City and Corozal Town. The survey also has data on the periods when food other than milk is introduced and on the time periods of weaning.

There is a pattern of longer spacing between the first three pregnancies than among the others. Women in the rural communities want closer spacing than urban women and actually are doing so. There are indications of the use of different kinds of methods of family spacing with increasing pregnancies. Among younger women, they are using abstinence along with artificial methods. The types of methods increase with the number of pregnancies until women resort to tubal ligation to terminate their fertility. The role of men also increases with age of the women, depending on the type of union. In Belize City and Dangriga where there are more visiting unions, the onus on spacing is more on the women. In other areas, especially Corozal Town and Orange Walk Rural, where the unions are consolidated for longer periods into married unions, the husband/partner exercises a greater part in family spacing.

About 61.6% of all women in the country have used at least one type of family spacing method. At the time of the survey about 43% were using at least one method. The two main types are the pill and tubal ligation. Women in rural areas, notably Toledo Rural, use breastfeeding most often as a method.

Women themselves are the main source of influence to use family spacing method. Those who have never used any say that they are not being pressured not to use them. Some factors that are discouraging the use of family spacing methods are rumour about their ill effects, not needing them, not occurring to the respondent to use them, and not knowing about them.

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Almost all women would like to learn about family spacing at the health centre and through other sources.

In planning any family spacing programme, it would be advisable to learn more about the methods that are currently being used to advise about their more effective application. This would include the pill, tubal ligation, and breast-feeding. It would also be advisable to study in greater detail what the methods younger women are using resulting in longer spacing between the first three pregnancies. The underlying theme in such efforts would be to have women be informed about effective use and to discourage them from resorting to methods under crisis situations, a practice that so far characterizes the use of family spacing methods in Belize.

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Footnotes

Footnote 1:-

One woman was interviewed from a household. In instances where there were two or more E.W.'s, one was selected randomly. The names were written on a piece of paper and placed in a bag, and one was picked.

Footnote 2:-

The elders gave as reasons that it would be difficult to recruit interviewers who could speak the language and that their homesteads were so widely dispersed that it would be difficult to reach the interviewees. However, it seems that the real reason was that being a reclusive sect they did not want their womenfolk to reveal publicly information asked in the questionnaire. The attitude of the elders contrasts with that of another group of Mennonites in the Cayo District, who cooperated fully with the survey.

Footnote 3:-

In this light Belmopan, the national capital city, can be included as an extension of Belize City. Its population in the 1980 census was 2,935. During the survey Belmopan was classified as an urban community within the Cayo District.

Footnote 4:-

There should be a qualification for Dangriga which is far less inwardly oriented economically than Corozal Town. Citrus has been the main industry for the Stann Creek District. However, its influence within Dangriga, the district town, has been minimal. Rather, remittances sent by relatives in the United States are a main source of cash.

Footnote 5:-

In Belmopan there was one woman who was using both rhythm and withdrawal. The use of any two methods, however, was rare.

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APPENDIX 1

NUMBER OF RESPONDENTS BY DISTRICTS

DISTRICT	RESULTS OF FIRST COUNT			RESULTS OF SECOND COUNT			RESPONSE TO QUESTIONNAIRE		
	No. of Hhds received	No. of vacant households	No. of Hhds. with no F.W.'s	No. of E.W.'s	No. of Addi Hhds. required	No. of addi E.W.'s used	refused	incomp.	completed
Belize Urban	560	6	199	355	110	51	1	4	401
Belize Rural	105	13	41	51	34	16	-	4	63
Cr. Walk Town	70	3	17	50	-	-	-	-	50
Cr. Walk Rural	175+	24	50	66	-	-	-	-	66
Prozal Town	105	-	15	90	-	-	-	-	90
Prozal Rural	140	6	47	87	26	19	5	-	101
Cayo Urban	105	-	59	46	55	47	4	-	119
Cayo Rural	140	-	35	105	35	16	1	1	119
Angruga	105	9	51	45	32	10	-	-	55
Stann Cr. Rural	70	5	50	15	-	-	-	-	15
Santa Gorda	35	7	19	9	19	9	-	-	18
Stledo Rural	105	-	42	63	34	19	2	1	79
Totals	1715	73	625	982	345	187	13	10	1146

This includes 35 households that could not be visited for the survey in a Mennonite community.

Appendix 2

COMPARISON IN THE DISTRIBUTION OF HOUSEHOLDS IN THE 1980 CENSUS,
THE RANDOMLY SELECTED SAMPLE, AND ACTUAL SAMPLE OF E.W.'S

<u>Distrib. of h/hld in the 1980 Census</u>			<u>Random</u>		<u>Actual</u>		<u>Difference</u>
<u>H/hold by Dist.</u>	<u>%</u>		<u>No.</u>	<u>%</u>	<u>No.</u>	<u>%</u>	<u>%</u>
Belize	10,634	37.8	570	38	464	40.5	2.5+
Czl.	4,056	14.4	210	14	191	16.6	2.6+
O.W.	4,003	14.2	240	16	116	10.1	5.9+
Cayo	4,196	14.9	210	14	208	18.2	4.2+
S.C.	2,933	10.4	150	10	70	6.1	3.9-
Toledo	2,289	8.1	120	8	97	8.5	.5+
Total	28,111	99.8	1,500	100	1,146	100.0	

*The total is not 100% because of rounding

Appendix 3

MAIN SETS OF VARIABLES IN THE SURVEY INSTRUMENT

Basic Characteristics

Biographical Data
Union Status
Education
Economic activity
Religion
Household structure

Family Life

Experience at first childbirth
Experience at last Childbirth
Family Life information

Fertility

Bio-Cultural

Pregnancy history
Family Size
Family Spacing

Health

Pregnancy and health
Childbearing and health
Family spacing method and health

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