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The Adoption of Contraceptives in Rural Latin America*

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* The findings reported in this paper emerged from the efforts of several individuals who worked together, first in a series of training seminars held at the Latin American Demographic Center (CELADE) in Santiago, Chile over the period 1972-74, and later more independently in the preparation of research reports on a number of specific analysis topics related to the Pecfal-Rural Fertility Survey. I am indebted to the following collaborators and colleagues, whose as yet unpublished mimeo reports provide many of the findings discussed in the present paper. Elsa Alcantara, Arthur M. Conning, Mauricio Culagovski, Johanna deJong, Michaela Krumholtz, Vilma Medica, Anna Ponce, Carlos Raabe, Shea Rutstein, Cesar Torrealba and Miguel Villa.

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Despite high and increasing levels of urbanization, half or more of the population in Latin America live in rural hamlets, towns, and small urban areas with less than 20,000 inhabitants, where fertility is still high. What are the levels and patterns of contraceptive adoption in these areas? What can one duduce from these levels and patterns for future fertility trends? In this paper I seek to provide a partial answer to these questions based on findings from the Pecfal-Rural survey, carried out in 1969-70 among representative samples of women between 15 and 49 years of age in rural and small urban areas of four nations: Colombia, Costa Rica, Mexico and Peru.[1] This summary of findings should be of particular interest because few facts on contraceptive adoption are known for rural areas in Latin America;[2] because the findings come from a comparative survey of large representative samples of rural areas in four countries; and because the four countries studied, despite their considerable differences in levels and patterns of development, all fall into a "middle level" of development within Latin America, and as such may be particularly suitable for research into the initial stages of contraceptive adoption and fertility decline.[3]

The Research Context

As Table 1 indicates, the Pecfal-Rural fertility surveys provide some information on the social and economic characteristics of the rural populations of the four nations studied. There is significant variation between countries in the extent to which modern services and socio-economic institutions had penetrated rural areas by 1969-70. It is apparent that radio receivers and newspapers had been introduced into these formerly more isolated towns and hamlets, although significant proportions of the population still remained untouched by them. Employment and market structures also revealed significant variation from one country to another. The majority of rural workers in all but Peru now depend entirely or in part on paid employment rather than self-employed (often "subsistence") farming alone. Rather large minorities of rural women have no schooling whatsoever. Electricity and piped water are increasingly available in rural areas, but by 1969-70 high proportions of rural families, especially in Peru, were without such services. Infant mortality in rural Peru for the period (1960-68) was estimated to be about double that of Costa Rica and Colombia and approximately 50 percent greater than that of Mexico. Estimates of rural fertility levels derived from the survey ranged from "high" (a gross reproduction rate of 3.4 in Costa Rica) to "very high" (a gross reproduction rate of 3.8 in Peru).

Insert Table 1 about here

These high fertility levels suggest that few couples in these rural areas deliberately attempted to control their fertility. The survey data indicate this to be the case (see Table 2). In Mexico and Peru only about one-tenth of mated women living in rural areas had ever used a contraceptive method. In Costa Rica, in contrast, one-third of rural couples had at some time practiced contraception. The relatively high level of practice in Costa Rica appeared to be the result of a recent trend, hence not yet fully reflected in measures of cumulative fertility, such as those shown in Table 1. The contraceptive methods used also varied from "traditional" to "modern". "Withdrawal" was used by a significant proportion of women in all countries, especially Colombia where 32 percent of users indicated that this was the last method they had employed (or current method, for those practicing at the time of the survey). Similarly, "rhythm" was important, especially in Peru. Across all countries, however, the pill was the most widely used method. Levels of IUD use in 1969-70 were so low that they need not be reported (less than 2 percent in any country).

There is no doubt from the above information that the rural areas in these four countries were, in 1969-70, at an early stage of contraceptive adoption, corresponding to a development situation in which modern services and socio-economic institutions were present only to a weak degree and infant mortality was still high in some regions. An important research question is the extent to which institutional patterns at that time had encouraged or discouraged the development of preconditions for further

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Insert Table 2 about here

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contraceptive adoption. Some investigators, such as Stycos, have argued on the basis of limited data on family size preferences for one or more rural communities that the motivational preconditions for contraceptive adoption exist at least in a "latent" form.[6] He suggests that the major blocks to further contraceptive adoption involve contraceptive ignorance, traditional taboos on sexual matters, and segregated sex-roles which inhibit mutual husband-wife decision-making. The broader samples and the detailed information available in the Pecfal-Rural study allow a more thorough appraisal of this hypothesis.

An Analytic Framework

The schema which underlies the following presentation of results is directed toward explaining contraceptive adoption among women living in predominantly agricultural areas where deliberate fertility control is not yet widely understood or practiced. The schema stems from the hypothesis that various distinct preconditions must be present to some degree in conjunction before contraceptive adoption will take place. Stated as simply as possible, the following three preconditions must be met: parents must be motivated to limit their fertility; they must have knowledge of how this may be done; and the available methods must be perceived as "legitimate," that is, acceptable on moral and health grounds. A pattern of mutual decision-making by which the husband and wife communicate on common problems and their solution will reinforce each of the other three preconditions.

Further details on this schema are outlined in Diagram 1. The schema draws attention to hypotheses concerning the social, economic and cultural factors which may influence each of the preconditions for contraceptive adoption. These influencing factors are assumed to be somewhat different for each precondition. For example, childbearing motivation appears to be influenced at least in part through the perceived values and costs of children, assessed either in direct economic terms or in terms of emotional gratifications. Thus, the social and economic roles of children in family life, their participation in household production, the security they provide to aging parents, and the educational and other "investments" which the parents must make to equip their children for these tasks may be particularly relevant to explaining childbearing motivation. In contrast, contraceptive knowledge in rural areas would seem to be influenced by the parents' exposure to mass media, to friends and to institutions where information on contraception may be found. Knowledge will also be influenced by acquired skills to absorb information, as measured indirectly through schooling. All such influencing factors may be considered at two levels of analysis: the individual level (the economic circumstances, mass media exposure, education, etc. of the respondent) and the social level (features of the more general institutional context surrounding the individual).

Insert Diagram 1 about here

This general analytic schema provides an outline of a number of themes which can be at least partially explored with the Pecfal-Rural data. Since the survey was exploratory, it was not developed to "test" this model in any detailed way. As in many KAP surveys, particular attention was placed on exploring alternative measures of the "precondition" variables -- childbearing motivation, contraceptive knowledge, 'legitimacy' and other related factors -- and on measuring contraceptive use, fertility and infant mortality. Social-institutional background and position were measured only roughly in terms of the respondent's access to "modern" goods and services (radio receivers, electricity, running water in the home, etc.), schooling, husband's occupation, and so on.

Altogether, the survey data permit three kinds of analysis in relation to the schema: (1) an interpretation of the extent to which each of the preconditions exists; (2) an assessment of the relationship of these preconditions to contraceptive adoption; and (3) some exploratory analysis with regard to the influence of social-institutional development on the preconditions. These results from these three analysis steps are described in the following sections.

Do the Preconditions for Contraceptive Adoption Exist?

Assessing the nature of the hypothesized preconditions for contraceptive adoption leads us immediately to problems associated with conceptualizing and measuring specific variables. Measures for most of the variables in the Pecfal-Rural study were exploratory in the sense that they had been pretested only to determine whether rural Latin American women could respond to them. They were not tested to see whether the responses were reliable and valid. For that reason, several different questions were used to tap each of the major preconditioned variables. In analysis we have placed particular attention on the interpretation of clusters of questions pertaining to each precondition. The picture which emerges from a detailed analysis of the response to several questions on a given theme is often quite different from the conclusion that one would come to from looking at a single question in isolation.

Motivation. As Table 3 indicates many questions were asked to determine beliefs and values concerning family size. First there were questions to determine what people might consider to be "large" as opposed to "small" families. Then there were questions to determine beliefs about the respective advantages and disadvantages of large and small families. Finally, there was a series of more conventional questions to determine respondent's family size preferences and

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Insert Table 3 about here

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desire for more children. Our interpretation of these data emphasize the following conclusions:

(1) Definitions of what constitute "large" and "small" families reflect the very wide extremes in family size that one can find in rural Latin America. Large families were typically defined as ten to twelve children, while small families were defined as three to four children. In other countries, such as Taiwan, three or four children would be considered a "large" family.[7] Perhaps these definitions of large and small families constitute a range of perceived alternatives, and this definitional range is one of the factors encouraging rather large family size preferences.

(2) A clear majority of respondents saw large families, with as many as ten to twelve children, as providing advantages, particularly in terms of economic assistance to parents. Large families were also seen by the great majority of women to be a burden on family resources and, ultimately, of detriment to the children themselves. Small families were more widely perceived as having some advantages and few if any disadvantages.

(3) Overall, the respondents revealed considerable ambivalence in their beliefs about the relative advantages of small and large families. When forced to choose between these extreme alternatives somewhat more than half of the respondents chose the smaller family, but this may be an artifact of the measurement technique, since underlying belief patterns suggest that most parents would want a family falling intermediate between "small" and "large", with some bias towards the small end of this range. Not surprisingly, views on the "best number of children for a women to have" tended to be large enough (around five children) to produce high fertility and rapid population growth.

(4) The numerical responses in particular to some of the family size motivation questions are of uncertain validity. For example, a separate analysis showed that between 16 and 24 percent of respondents (depending on the country) who said that they wanted additional children did not give a numerical answer to the number wanted, despite insistence from the interviewer that a numerical response be given. Other data suggest that anywhere between one-fifth and one-half of the respondents (depending both on the criterion and on the country) either had no clear idea of a preferred family size or could not state their preference in numerical terms. This conforms to the fact that only a minority of respondents in all countries except Costa Rica had ever spoken to their husbands about the number of children they would like to have (see Table 5). In this context it would seem better not to place too much emphasis on the numerical estimates of family size preference. Perhaps greater emphasis can be placed on findings suggesting uncertainty, lack of awareness and ambivalence regarding alternatives, such that most respondents saw at least some advantages to very large families.

The above data suggest that small family size preferences were held by only a minority of women in the rural areas of the four countries studied in 1969-70. For the moment at least it would appear that Stycos' assertion that a latent motivation for reduced fertility exists among women in rural Latin America must be questioned.

Contraceptive Knowledge. Knowledge of any matter varies from "good" to "poor" or from "functional" (adequate enough to be applied) to "non-functional." The measures of contraceptive knowledge used in most fertility surveys simply are not sufficiently detailed to indicate the degree to which the respondent understands a given method. In the Pecfal-Rural survey three measures were used. One question asked whether the respondent was aware that it was possible to postpone or avoid becoming pregnant. Another asked whether the respondent could name or describe any method to do this. And the final question asked whether the respondent could recognize the names of any contraceptive methods read to her from a list. Of course, functional knowledge implies more than either awareness, ability to name or describe a method, or simply recognition. The survey provides no easy way to determine depth of knowledge. However, the following points do emerge from analysis of the data in Table 4.

Insert Table 4 about here

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(1) Between one-third and two-thirds of mated women (depending on the country) could not independently mention a single method. When a list of methods was read to them, a significant number of women who appeared to be completely ignorant did in fact recognize one or more methods. But "knowledge" of this kind would appear to be extremely superficial. Sixty-two percent of the respondents in Peru could not even recognize one method from the list read to them.

(2) Of those who did mention a method a high proportion knew only one method. An analysis of the methods which the women knew indicated that the "pill" was by far best known. Between 12 and 30 percent of women could independently name or describe this method. The next best known method was the condom, but only between 3 and 21 percent could independently name or describe it. In all countries, less than 10 percent of the women could independently name or describe any of the other methods.

From the above we may tentatively conclude that contraceptive knowledge was very weak indeed in the rural population in the four countries studied.

Legitimacy. The data in Table 5 allow several conclusions about the prevalence of such taboos and fears about contraception.

(1) In no country were attitudes to the use of birth control overwhelmingly positive. In Costa Rica and Colombia a bare majority of respondents favored contraceptive use, in Peru about half of the respondents favored use, but in Mexico only 36 percent favored use. Attitudes favoring contraceptive practice presumably reflect a wide variety of beliefs, such as the importance of limiting fertility, the morality of using birth control, health dangers, and so on.

Insert Table 5 about here

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(2) In Mexico and Peru in particular, moral issues constituted a significant barrier to the formation of positive attitudes towards contraceptive use. In both these countries levels of discussion with husbands on the use of contraceptive were very low, but this may reflect in good part the very low levels of contraceptive knowledge in both countries. More significant, perhaps, is that in both countries only a minority of respondents favored teaching "young women" (the concept implies women who are not yet married) about such matters as pregnancy, childbirth and sexual intercourse. Women in Colombia and Costa Rica were found to have much more open discussions of these matters.

(3) In all the countries there were substantial levels of fear and anxiety about the moral and health implications of contraceptive practice, with more than two-thirds of the respondents in all countries voicing such fears. These fears were not exclusive to those who did not favor birth control. Roughly one-half of the respondents who favored use also expressed fears. Fears concerning morality were roughly as common as fears concerning health, and an independent analysis has revealed that religious respondents (measured in terms of church attendance) and thos who expressed relatively traditional attitudes on other matters were more likely to express views emphasizing the negative moral and health aspects of contraception. Naturally, all these traditional attitudes were more prevalent among less educated women in smaller rural hamlets.

The above findings suggest that the third precondition for contraceptive practice, namely the absence of fears and taboos on contraceptive adoption, did not apply to most women in the rural areas of the four countries studied. It particularly did not apply to the women in Mexico and Peru.

Do The "Preconditions" Influence Contraceptive Practice?

Two of the three "precondition" variables -- "knowledge" and "legitimacy" -- are empirically associated with contraceptive practice, while the third -- "family size motivation" -- is not. Moreover, even when a relationship exists between a preconditioned variables and contraceptive practice it cannot always be unambiguously interpreted. The following findings are suggestive both with respect to the validity of the empirical measures and with respect to the adequacy of the schema on which our analysis is based.

Family Size Motivation as a Precondition to Practice. The impact of family size motivation on contraceptive practice was assessed among currently mated women who indicated that they were fecund (i.e., they had borne at least one child and knew of no reason why they could not bear more) and had at least a minimal level of contraceptive knowledge (i.e., they independently named or described at least one contraceptive method). Several measures of family size motivation were analyzed and all were found to have only a very weak (statistically non-significant) association with levels of contraceptive practice. For example, considering all four national samples together, approximately one-half of the

respondents claimed to want no more children, while the other half claimed to want at least one more child. Current levels of contraceptive practice were not related to these desires: 35 percent of those who claimed to want no more children were practicing contraception at the time of the survey, while 32 percent of those who claimed to want at least one more child were also practicing. Similar findings were observed for other measures of family size motivation, such as: (a) whether or not the respondent had borne "fewer" or "as many or more" children than the number she felt "best for a woman to have," and (b) whether or not the respondent observed more relative advantages to "small families" as opposed to "large families."

These findings should caution us against simplistic interpretations of the nature of family size motivation and its influence on contraceptive adoption. As previously noted the measures of family size motivation stress long-term, abstract notions of the preferred size of a completed family. Such concepts may not correspond to the way in which many rural Latin American women think. This view is reinforced by the previously noted findings questioning the validity of answers given by some respondents, particularly those with little or no schooling, to questions requiring numerical responses. Even if such concepts exist, and the measures are valid, as they may be for the majority of respondents, they may have little to do with the reasons why women practice contraception at a particular moment in time. The assumption that deliberate fertility control in developing nations is first sought by "desperate" women who have borne as many or more children than they ever want may not be correct. Contraceptive practice

appears to be concentrated heavily among a minority of better educated, more well-to-do rural respondents, many of whom were using contraceptives despite the fact that they would, according to various measures, prefer larger families. This suggests that they were using contraceptives in relation to a number of more immediate, demanding health or financial roles, and that they may have been simply seeking to avoid pregnancy at the moment, leaving open the possibility (not necessarily a plan) of having more children in the future. This is an hypothesis for future exploration. For the moment, we may merely conclude that contraceptive adoption in rural Latin America has little to do with abstract family size preferences and goals of the kind measured in the Pecfal-Rural survey.

Contraceptive Knowledge as an Antecedant to Practice. There is no doubt that greater knowledge and greater contraceptive practice are linked. Of course, a two-directional relationship may exist: women who are relatively ignorant of contraception may be less likely to practice, and women with some knowledge who begin practice may in the process learn more. For example, among Colombian women who independently named or described only one method of birth control, 17 percent had used a method. Among the Colombian women who had independently named or described three or more methods, 69 percent had at sometime used a method. Logically, women who could not name any method had never used one; such women constitute sizeable minorities in three of the national samples and a majority in the fourth (Peru), as previously noted.

"Legitimacy" as an Antecedant to Practice. The analysis results clearly show that contraceptive practice is empirically related to the strengths of attitudes favoring contraception and rejecting common sexual taboos. Since negative attitudes may reflect ignorance of contraception, we analyzed the association between contraceptive practice and legitimacy for mated, fecund women, who had at least some contraceptive knowledge (i.e., they had independently named or described at least one contraceptive method). Considering such women from all four national samples together, the results reported in Table 6 were obtained.

Insert Table 6 about here

Not surprisingly, further analysis revealed that attitudes favoring the use of birth control are empirically correlated (Gamma's for the contingency tables range from .13 to .25) with variables such as: favorable attitudes towards teaching young women about various sexual matters, more favorable attitudes towards education for girls and lower levels of religiousity (as measured by frequency of attendance at church and mass). A favorable attitude to contraceptive practice reveals an even higher correlation with "husband-wife agreement to use" (the correlation between these two, each considered as dichotomous variables, is r .45). This raises the question of whether or not husband-wife agreement to use constitutes part of the "legitimacy" variable or whether it is a function of more general family decision-making patterns.

Joint Husband-Wife Decision-Making as an Antecedant to Practice. The decision to use contraceptives is seldom taken unilaterally by one partner without consulting the other. Of those respondents who had never talked to their husbands about contraceptive practice, only a low proportion (between 2 and 12 percent, depending on the country) had ever practiced contraception, while in every country one-third or more of the women who at least discussed the matter had practiced contraception at some time. A principal reason why a higher proportion of those who discussed the matter did not subsequently use is that in only 50-60 percent of the cases (depending on the country) where such discussion took place did it result in a joint favorable attitude; in the other cases the couple either agreed not to use contraceptives or the husband and wife were in disagreement with one another. Considering only mated, fecund women with at least some contraceptive knowledge, joint husband-wife agreement to use contraception has a correlation of r .43 with current contraceptive practice (both variables in dichotomous form). The correlation would be higher except for the fact that roughly two-fifths of the respondents who indicated that such agreement had been reached had not as yet begun to practice.

Further analysis indicated that husband-wife agreement to use contraceptives was very poorly related to a number of other indicators of joint husband-wife decision-making, such as the extent to which the wife participates in decisions on "major family purchases" and on "the education of their children" (Pearsonian r's between these variables, each considered in dichotomized form, for mated, fecund, knowledgeable respondents were below .10 in all countries). The best

predictor of a favorable decision to use contraception is the respondent's favorable attitude towards birth control (the Pearsonian r between these two variables, considered in dichotomous form, for mated, fecund, knowledgeable women in all four countries is .49). Thus, one comes to the conclusion that husband-wife communication and joint decision-making on contraceptive use may be less a function of general family decision-making patterns and more a matter of a web of traditional attitudes and sexual taboos, only some of which bear upon the role and status of women.

Social-Institutional Determinants of Contraceptive Practice

As indicated previously, information on social background and context of the respondents in the Pecfal-Rural survey is limited to a small number of rather general development indicators, such as the respondent's schooling, access to electricity, and running water, exposure to mass media, and ownership of selected modern consumer durables, including radios and sewing machines. These data allow a rough exploration of the extent to which contraceptive adoption in rural Latin America can take place independently of broader social-institutional development. One hypothesis is that economic development must precede contraceptive adoption. Our findings provide some support to this view but also suggest some important qualifications. Select elements of the following summary points are supported by the data in Table 7.

Insert Table 7 about here

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(1) Indicators of "development" tend to cluster together, both for individuals and for geographical regions. This is hardly surprising. At the individual level, respondents in all countries with higher levels of schooling tended also to have greater access to mass media electricity, running water and modern consumer durables. At the regional level, municipios and cantones (or the portions of these which form the primary sampling units for the Pecfal-Rural survey) with overall higher levels of education were more developed on other indicators such as the proportion of homes with electricity, running water and so on. Contraceptive knowledge, favorable attitudes and practice were higher among the most privileged respondents living in the country with the most developed rural regions (Costa Rica). These "family planning" variables all decline as one moves to less privileged families, less developed regions and to countries where overall their rural sector is less developed. Moreover, the effects of individual social position, local community development and level of rural development in the country are independent and additive. This pattern gives considerable support to the hypothesis that contraceptive adoption is at least in part a simple function of social-institutional development.

(2) It is easy to understand why a more "privileged" rural woman, with higher levels of schooling, greater mass media exposure, and so on, may score higher on the indicators of contraceptive knowledge, attitude and practice. Explanations of the independent influence of community

and national rural development on family planning are less clear and must remain largely hypothetical. Regardless of their own social position and background, individuals appear to take on the dominant characteristics of the community in which they live. Thus, if the community is in general relatively modern, even a less educated, low status woman is likely to know about contraceptives, favor them, and even to have used them. In contrast, a well-educated, privileged women living in a more isolated, less developed community, where limited contraceptive knowledge and traditional sexual taboos prevail, may as a consequence also know little about contraceptives and be negative toward them. Such patterns would seem to reflect informal communication patterns and normative pressure between friends, relatives and neighbours within these communities. Thus, we have an important qualification to the hypothesis that social institutional change is a necessary precondition for contraceptive adoption. Even the least educated, least privileged woman, with low personal levels of exposure to sources of knowledge and modern attitudes, may learn about contraceptives, favor them and adopt them, provided that broader institutional development has taken place in the community or country where she lives.

(3) Levels of community development, national development and individual social position do not by themselves explain all the variation in contraceptive knowledge, attitudes and practice. For example, the low levels of contraceptive acceptability and practice in Mexico are all out of proportion to the development indicators for rural areas in that country. It would seem that a number of "cultural" factors largely independent of socio-economic development, may be responsible. As another example, it may be observed that, while family planning activities had not yet been fully developed in the rural areas of Costa Rica by 1969-70, initial efforts undertaken by that date may have influenced knowledge, attitude and practice levels throughout the rural areas of the country. This may explain why levels of contraceptive knowledge, acceptance and practice are high in all communities and among all social classes, even the less developed and least privileged in Costa Rica. Thus, we have another important qualification to the institutional and developmental hypothesis. Contraceptive adoption seems to be encouraged or be inhibited by cultural and program factors largely independent of overall economic development.

The above points are suggestive of hypotheses to be investigated in greater detail in future research.

Summary

This paper summarizes the results from a series of separate analyses of data from a comparative survey of representative samples of women, between 15 and 49 years of age, in the rural and small urban areas of four Latin American countries: Colombia, Costa Rica, Mexico and Peru. These countries are neither among the most developed, low fertility nations of the region, nor are they among the least developed. The rural areas of these countries show considerable variation in the penetration of "modern" social and economic institutions, within what may be termed an "intermediate" stage of development. Corresponding to this, contraceptive adoption rates also vary from the rural regions in one country to those in another, but are low even in the most developed rural regions.

The results point to many unresolved problems of conceptualizing and measuring the socio-institutional and individual variables that may explain levels and patterns of contraceptive adoption. Despite limitations, the data permit a particularly detailed review of selected features of family size motivation, contraceptive attitudes and contraceptive knowledge which theoretically will assume to predict adoption. The data point to surprising findings and several hypotheses for future research.

Abstract notions of "best" or "preferred" family size may not exist clearly for many respondents; ambivalence seems to be widespread on the relative merits of small and large families; and measures of family size preference do not predict contraceptive adoption. Presumably, couples who do not use birth control are influenced by more immediate, short-term health and financial considerations. Large proportions of rural women in some countries are ignorant of contraceptive methods; attitudes towards contraception are uncertain or negative among sizeable minorities; and even those who favored birth control revealed fears and anxieties with respect to their moral and health implications.

The preconditions for contraceptive adoption would seem to be weak in most regions included in the survey. The preconditions seem particularly weak among the least privileged respondents, in the smaller less-developed communities. The preconditions are also weaker in those countries whose rural areas are least developed economically. But, there are some limited, preliminary findings which suggest that an important part of the variation in contraceptive knowledge, attitudes towards contraception, and actual adoption is independent of simple measures of economic development and social position. The cultural and social-institutional sources of such variation will require further investigation.

Table 1 Selected socio-economic development indicators for rural and small urban areas

Percent of respondents:	Costa Rica	Colombia	Mexico	Peru
With a radio in their home	77	66	74	38
Who read a newspaper occasionally or frequently	74	77	74	53
With electricity in their home	41	29	41	20
With running water (piped) available in or near their house	60	32	21	11
Without any schooling	18	27	38	47
Whose husbands* rely on:				
(1) paid employment only	83	80	59	18
(2) farming plus paid employment	11	13	24	26
(3) farming only	6	7	17	56
Fertility				
(1) Gross reproduction rates *	3.4	3.6	3.7	3.8
(2) Mean number live born children *	5.3	5.2	5.3	4.9
(3) Mean number surviving children	4.6	4.5	4.5	3.7
Infant Mortality Rate (1960 - 68)*	80	79	94	148

Source PECFAL RURAL SURVEY. See text, footnote 1. Figures based on all women age 15 - 49, unless otherwise noted.

* Based on ever mated women

Table 2 Contraceptive Practice for Ever Mated Women in Rural and Small Urban Areas, by Country.

Percent Who:	Costa Rica	Colombia	Mexico	Peru
Have ever used a contraceptive method	34	20	11	11
Were using a method at the time of the survey	29	18	7	9
Of those who had used a method, the last method used was (percent)				
- condom	10	4	6	4
- withdrawal	11	32	19	10
- rhythm	15	23	18	31
- pill	35	18	32	15
- douche	3	6	5	22
- sterilization	13	4	8	7
- other	13	13	12	11
Total (Women who had used)	100	100	100	100

Source PECFAL RURAL SURVEY.

Table 3 Family size definitions and preferences among currently mated women living in rural and small urban areas

	COSTA RICA	COLOMBIA	MEXICO	PERU
Definitions of large and small families				
mean number of children in "large" family	10.2	10.4	11.4	9.5
mean number of children in "small" family	3.4	3.2	4.0	3.2
Which do you like better, a small family, a large family, or doesn't it matter?				
small	57	58	57	59
large	10	14	20	17
doesn't matter	33	28	23	24
Percent who saw:				
Advantages to a large family	76	83	79	76
Disadvantages to a large family	88	88	82	62
Advantages to a small family	95	95	92	77
Disadvantages to a small family	39	42	37	30
Advantages and disadvantages to both large and small families	32	34	27	20
How many children is the best number for a women to have? mean best number	4.8	4.6	6.0	5.2
Do you want more children? How many more?	51	65	54	64
Percent who want no more children				

Table 4 Contraceptive Knowledge Among Currently Mated Women, in Rural and Small Urban Areas, by Country

	COSTA RICA	COLOMBIA	MEXICO	PERU
Percent of all respondents who:				
-recognized at least one contraceptive method from a list read to them	82	67	50	28
-independently named or described at least one method before the list was read out	68	40	31	18
Of those respondents who independently named at least one method, percent who named:				
- one method	44	55	74	43
- two methods	32	28	16	14
- three or more	24	17	10	43
Total	100	100	100	100
Percent of all respondents who independently named:				
- the pill	63	32	28	14
- condom	21	4	3	3

Source: PECFAL RURAL SURVEY

Table 5 Attitudes, taboos and husband wife agreement related to the "legitimacy" of contraceptive practice. In currently mated women in rural and small urban areas, by country.

	COSTA RICA	COLOMBIA	MEXICO	PERU
Attitudes Percent who:				
Favour the use of birth control	57	62	36	48
Would like to know more about birth control	66	65	36	42
Have fears about the use of birth control	75	67	84	75
Of those who favour birth control, percent who have fears about using them	55	45	53	43
Taboos Percent who favour teaching young women about				
Menstruation	91	90	68	59
Pregnancy and Childbirth	74	79	34	41
Sexual Intercourse	66	74	21	27
Husband-wife Agreement Percent who				
Have discussed with husbands the number of children they would like to have	53	39	44	41
Have discussed with husband the use of contraceptives	68	48	31	22
Have come to a favourable agreement with their husbands to use birth control				

Source: PECFAL RURAL SURVEY

Table 6 Percent currently practicing birth control among mated, fecund women who know at least one method of birth control *

Respondents Who:	PERCENT CURRENTLY PRACTICING BIRTH CONTROL
1. Do not favour birth control	14
Do favour birth control	44
2. Do not want more children	19
Do want more children	39
3. Do not favour teaching young women about menstruation	12
Do favour teaching young women about menstruation	36

Source: PECFAL RURAL SURVEY

Table 7

Perecent of women who know, accept and have used a method of contraception, according to country

		COSTA RICA				COLOMBIA				MEXICO				PERU				ALL				
		High SES*	Med. SES	Low SES	ALL	High SES	Med. SES	Low SES	ALL	High SES	Med. SES	Low SES	ALL	High SES	Med. SES	Low SES	ALL	High SES	Med. SES	Low SES	ALL	
High CDL**		91.0	78.9	68.0	83.3	69.9	40.5	45.7	58.8	57.7	33.3	28.3	55.7	70.8	37.3	26.5	56.8	75.4	51.8	45.1	64.9	
M. High CDL		81.3	64.0	67.6	71.9	73.0	47.1	33.3	52.3	64.8	55.8	25.9	49.4	58.0	37.7	13.6	36.3	72.1	54.7	43.1	57.3	
M. Low CDL		88.1	63.3	52.4	64.6	73.6	57.0	34.3	47.6	52.5	36.8	27.0	35.0	35.5	9.2	3.7	16.0	60.9	42.5	30.1	39.9	KNOW
Low CDL		66.0	62.5	35.4	47.5	54.0	32.0	24.2	28.4	41.2	31.7	20.0	23.4	40.3	19.3	8.3	12.4	46.6	27.8	15.6	21.0	
ALL		85.6	68.5	61.4	72.7	69.5	45.3	29.6	42.8	60.5	39.8	24.3	37.9	56.5	20.6	9.8	24.1	68.4	44.0	27.1	42.6	
High CDL		69.6	62.0	55.1	64.9	68.3	66.7	63.0	66.6	48.0	26.2	26.4	40.3	62.4	47.1	49.0	57.2	61.4	49.8	48.7	55.6	
M. High CDL		56.4	50.0	42.5	51.2	67.0	59.6	61.8	63.2	42.3	37.8	27.6	36.1	56.8	50.4	34.6	49.3	56.7	51.4	41.7	50.8	
M. Low CDL		62.7	58.3	59.2	59.9	58.8	62.3	58.6	61.6	42.9	36.8	32.9	36.0	60.5	53.9	49.1	52.9	56.2	49.3	46.9	49.5	ACCEPT
Low CDL		90.0	50.0	45.5	57.5	61.9	51.6	59.7	58.6	26.5	34.2	28.0	28.9	59.7	46.2	39.8	42.5	60.9	44.8	43.1	44.5	
ALL		65.1	54.7	50.0	57.1	67.1	59.1	59.7	61.5	43.6	34.8	30.0	34.9	60.5	50.7	41.6	48.0	52.7	48.9	44.5	49.4	
High CDL		59.8	46.5	23.1	48.9	47.2	26.2	13.0	35.6	30.9	9.8	3.8	22.3	48.3	19.6	12.2	35.7	46.3	28.7	14.2	36.2	
M. High CDL		40.9	27.3	22.4	30.6	53.9	21.8	16.7	32.2	20.4	12.2	4.3	13.0	23.5	13.2	4.9	14.0	35.9	20.3	14.3	24.4	
M. Low CDL		41.8	23.3	17.0	25.6	37.6	21.1	10.8	18.8	20.9	10.8	5.4	10.1	22.4	1.5	3.0	7.5	29.0	14.6	8.3	14.4	HAVE USED
Low CDL		20.0	25.0	13.6	17.5	23.8	11.5	5.1	8.6	5.9	6.1	1.6	2.7	19.4	6.7	2.5	4.5	18.4	8.2	3.6	5.6	
ALL		48.1	32.2	20.4	34.2	42.7	18.8	9.2	19.6	23.5	10.0	3.7	10.7	33.6	9.0	3.3	12.0	36.5	16.9	7.7	17.9	

* SES - Socio-economic Status

** CDL - Community Development Level

Chart 1 A general model for the analysis of selected determinants of contraceptive practice.