Situational Analysis of Older Persons Belize 2010

Situational Analysis of Older Persons Belize 2010

NATIONAL COUNCIL ON AGEING

UNFPA

Pan American Health Organization

Regional Office of the World Health Organization

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The National Council on Ageing (NCA) needs to express its appreciation to so many people in Belize for their participation in the planning and implementation process that has guided the production of this document. Their encouragement and sustained interest has been most stimulating.

First and foremost, gratitude must be expressed to all the older persons across the country who willingly participated in the survey by agreeing to be interviewed and who provided the most valuable information found in this document.

To all the interviewers, who are mentioned in the Appendix, for the time they spent in the field with the older people, not only collecting information but listening to stories and expressing their own concerns about what they found. For many it was an enlightening experience.

To the Chairperson, Executive Board and staff of the National Council on Ageing for their continued support and commitment, especially in the pursuance of resources, that made this process possible.

To Mr. Gustavo Perera, consultant for SUMMA Research Agency, Mr. Jorge Aldana, Dean of Sacred Heart Junior College and all their colleagues who worked many hours to prepare and produce this document.

To the United Nations Population Fund (UNFPA) for providing the funds that made this Situational Analysis Research Study possible. Appreciation is also extended for the technical cooperation provided by Pan American Health Organization/World Health Organization (PAHO/WHO).

And lastly to all the people that continue to work with and for older persons in all parts of Belize because they acknowledge the joy that it brings.

A sincere THANK YOU to you all.

FOREWORD

This document has been initiated by the National Council on Ageing, a mechanism of the Government of Belize and the Ministry of Human Development and Social Transformation, which is challenged with responding to all the issues most pertinent to older persons in Belize.

It was seen as a very important task to undertake a Research Study of Older Persons in Belize, residing in both rural and urban areas, to determine how they are living and what they consider the most important issues affecting their lives.

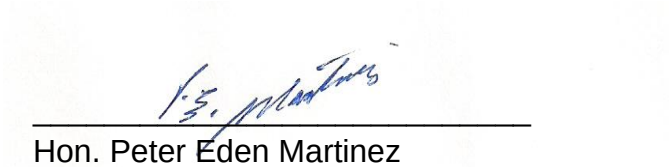
The NCA acknowledges the importance of population ageing as a global phenomenon but, more importantly, its concern is for the continuing population growth of older persons in Belize and how this sector of society is managing its existence on a daily basis.

This document sets out to enlighten the reader about 4 main issues that are of greatest concern to older persons in Belize:

- Healthcare
- Financial Security
- Family and Social Support
- Housing and Safe Environment

The NCA considers that Older Persons in Belize are entitled to basic human rights, as detailed in the Belize Constitution and strengthened in the National Policy for Older Persons, adopted by the GOB in June 2002. Therefore every effort should be made to ensure that these rights are upheld in order for older persons to age with comfort and dignity in their later years, now and for future generations.

I would like to acknowledge and express my appreciation and thanks to all the individuals and organizations who contributed their time and knowledge to this document, as it will serve to instruct a further National Plan of Action for Older Persons in Belize for the period 2010-2015, to be developed by the National Council on Ageing.



Hon. Peter Eden Martinez
Minister of Human Development and Social Transformation
Chairperson of National Council on Ageing

ACRONYMS

BSSB	**Belize Social Security Board**
CPA	**Country Poverty Assessment**
GOB	**Government of Belize**
NAVCO	**National Association of Village Council Organizations**
NCA	**National Council on Ageing**
NCP	**Non-Contributory Pension**
NEMO	**National Emergency Management Organization**
NGO	**Non- Government Organization**
NHI	**National Health Insurance**
NPOP	**National Policy for Older Persons**
PAHO	**Pan American Health Organization**
SABE	**Salud, Bienester y Envejecimiento (Health, Well-Being and Ageing)**
SIB	**Statistical Institute of Belize**
UN	**United Nations**
UNFPA	**United Nations Population Fund**
WHO	**World Health Organization**
YWCA	**Young Women Christian Association**

EXECUTIVE SUMMARY

The *"Situational Analysis of Older Persons Belize 2010"* report presents and discusses the main findings of a research study conducted in Belize between November 2009 and May 2010. This study was a collaborative undertaking with the full support of the Ministry of Human Development and Social Transformation, Pan American Health Organization (PAHO), United Nations Population Fund (UNFPA) and the National Council on Ageing (NCA). The report, which includes a foreword by the Minister of Human Development and Social Transformation, Honorable Eden Martinez, is presented in four parts.

Part 1 serves as an introduction to the report and briefly discusses the trends in ageing in the Caribbean where the estimated population of people aged 60 and over is estimated at 3.6 million and is forecasted to exceed 7.4 million by the year 2025.

Against this background, and as far back as 1999, with the International Year of Older Persons, the Government of Belize (GOB) recognized the importance of addressing the issue of population ageing in Belize and started a national consultation process with a view to developing a National Policy for Older Persons, which was eventually adopted through Cabinet in February 2002. By June 2003, GOB had established the National Council on Ageing (NCA) and within its first year of operation, the Council rolled out the National Plan of Action for Older Persons 2003-2008.

Part 2 provides a contextual analysis of population ageing – global, regional, and national. At the global level, and based on 2010 figures, the proportions of older persons, especially those over 80 years of age, will begin to rise rapidly in most developed and many developing countries.

A report by the U.S. National Institute on Ageing and the U.S. Department of State jointly issued a publication entitled: *"Why Population Ageing Matters."* The report highlights nine trends that will pose challenges for countries across the globe; these include an ageing world population, increasing life expectancy, rising numbers of persons over 80 years, increasing ageing of world population but declining population sizes in some countries, increase in non-communicable disease, changing family

structures, shifting work and retirement patterns, evolving social insurance systems, and new and emerging economic challenges.

In the regional context and at the *"Caribbean Symposium on Population Ageing"* that was held in Trinidad and Tobago in 2004, Caribbean governments, civil society, and academia at large were awakened to the many challenges that confront our countries – the negative impact of the global meltdown on small economies, poverty, health issues, demographic ageing, and the need for inter-generational support systems.

In the national context, the findings of the 2003 baseline assessment conducted by HelpAge Belize/International are re-visited. The study, which was part quantitative and qualitative in design, focused on similar issues – income and livelihood, health and coping mechanisms, education, housing, socialization, family, and community support.

Part 3 presents a summary of the significant findings of the 2010 Situational Analysis. It describes the scope of the study, methodology, and demographic profiles and includes several *'dashboards'* of key findings in FOUR key areas: Healthcare, Financial Security, Family and Social Support, and Housing and Safety.

Part 4 is the conclusion of the report. At a National Forum held at the Radisson Fort George Hotel in June to present the findings of the study to stakeholders, a list of critical conclusions and recommendations was developed and which should serve as a guide for future action. These are summarized below.

Area	Conclusions	Recommendations
1.0 HEALTH	Health is everyone's responsibility and should not be confined to just one sector. Maintaining a healthy lifestyle is vitally important throughout the life span and education and promotion starts at a young age. There are insufficient, inaccessible and unavailable health services, particularly for older persons.	• *Emphasis should be placed on prevention of diseases at a young age;* • *NHI sensitization, information, and tutorials should be given to those persons who are eligible to access it;* • *There is a need for a monitoring mechanism for hospital faculty to evaluate how services are rendered to older persons;* • *There is a need to address the responsibility of people for their health and their participation in the provision of health services;*

		• *Make available alternative services and medications more pertinent to older persons;* • *Promote organized activities that address mental and social health;* • *There is a need to conduct an audit of services to insure that service providers are not duplicating efforts / resources by catering to the same people.*
2.0 FINANCIAL SECURITY	The current provisions for benefits to older persons are inadequate to meet basic needs. The non-contributory pension (NCP) and NHI is not available to all, while social assistance is limited to $10.00 per week. To avoid old age dependency alternative forms of income generation / employment should be encouraged	• *Increase NCP from $100.00 to $160.00* • *Grant universal access to pension across the country;* • *Educate self-employed persons to pay Social Security contributions to safe guard their future;* • *NHI to be made accessible for older persons across the country;* • *Ensure proper documentation of persons at birth to guarantee access to services;* • *Make micro-financing available to older persons*
3.0 FAMILY AND SOCIAL SUPPORT	There is a need to create a culture of respect and consideration for older people and make them more visible in society. Loneliness and depressions is common and could be alleviated by greater social interaction	• *Educational programs on ageing should be included in school curriculum starting at the Primary School level;* • *There is a need for a range of options for older persons ranging from social activities, to day care to live in facilities where health care services are available;* • *There is a need to increase the number of social centres in each district with priority given to those areas with limited financial resources;* • *Facilities and resources for older persons should extend beyond just "care" facilities and should provide for recreation and other activities in both urban and rural areas*

4.0 HOUSING AND SAFE ENVIRON-MENT	Resources should be available to older persons to assure home safety especially against crime and during times of national emergency – hurricanes, floods, etc.	• *The NCA should lead a lobby with government ministries and organizations to address the housing needs of older persons;* • *The VOICE organization should, as a rural committee, conduct an assessment of the housing situation of older persons;* • *The National Emergency Management Organization (NEMO) should consider the specific needs of older persons in times of impending disaster designating special shelters for older persons who live alone and who are handicapped and those who need special attention or have special needs;* • *Community Policing Units country-wide should make contact with VOICE and other groups representing older persons to gain a greater understanding of the vulnerabilities of older persons and to provide reassurance in the security available to older persons.*

1.0 INTRODUCTION

As far back as 2003, social scientists observed that the Caribbean population was ageing rapidly and that the number of people aged sixty years and over exceeded 3.6 million; by 2025, it would exceed 7.4 million. Although Belize has a smaller than average percentage of older persons, much like the rest of the Caribbean, the elder population should increase considerably over the next twenty years (UN Population Figures).

In 1999, the Government of Belize (GOB) recognized the importance of population ageing and initiated consultations around the idea of developing a National Policy for Older Persons. Following this process, the GOB officially adopted the policy document on June 21, 2002. By February of 2003, the *National Council on Ageing (NCA)* became a functioning organization and within its first year of operation, introduced its first plan of action entitled, *National Plan of Action for Older Persons (2003-2008).*

Around that same period, there were some developments taking place internationally that had implications for the elderly, globally, regionally, and locally. The 2nd World Assembly on Ageing convened in Madrid in 2002 and adopted what is now known as the *Madrid International Plan of Action on Ageing*, which is officially recognized as the document that should direct all actions for improvement of life for all older persons worldwide.

On the heels of this Plan of Action, the first Regional Intergovernmental Conference on Ageing was held in Santiago, Chile, where a second declaration was adopted known as the *Regional Strategy for the Implementation in Latin America and the Caribbean of the Madrid Plan of Action.* This second initiative emphasized the importance of collecting data to assess the situation of older persons at both the regional and national levels. Against this background, HelpAge International initiated the first situational assessment of older persons in five Caribbean countries, including Belize.

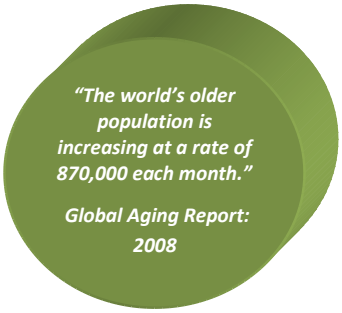
This study is the second situation assessment of older persons in Belize. It was commissioned by the NCA and supported by UNFPA and PAHO/WHO.

2.0 CONTEXTUAL ANALYSIS

2.1 Global Context

Population ageing has emerged as a major demographic worldwide trend. Declining fertility and improved health and longevity have generated rising numbers and proportions of older population in most of the world. As education and income levels rise, increasing numbers of individuals reach older age with markedly different longevity and personal expectations than their forebears.

While population ageing represents, in one sense, a human success story of longevity, the steady, sustained growth of older populations poses many challenges to policymakers. As at 2010, the numbers and proportions of older people (especially those over 80 years) will begin to rise rapidly in most developed and many developing countries.



In 2007, the U.S. National Institute on Ageing and the U.S. Department of State jointly issued a report entitled *'Why Population Aging Matters.'* Using data from the U.S. Census Bureau, the United Nations, the Statistical Office of European Communities, as well as from regional surveys and scientific journals, the report identified nine trends that offer a snapshot of challenges (Kisella, Wan, 2008):

1. *The world's population is aging* – people aged 65 and over will soon outnumber children under age 5 for the first time in history;
2. *Life expectancy is increasing* – most countries show steady increase in longevity over time;
3. *The number of the oldest is rising* – the world's population aged 80 and over is projected to increase 233 percent between 2008 and 2040, compared to 160 percent for the population aged 65 and over and 33 percent for the total population of all ages;
4. *Some populations are aging while their size declines* – while the world's population is aging, total population size is simultaneously declining in some countries;

5. *Non-communicable diseases are becoming a growing burden* – chronic non-communicable diseases are now the major cause of death among older people in both developed and developing countries;
6. *Family structures are changing* – as people live longer and have fewer children, family structures are transformed and care options for older persons are changing;
7. *Patterns of work and retirement are shifting* - shrinking ratios of workers to pensioners and people spending a larger portion of their lives in retirement increasingly tax existing health and pension systems;
8. *Social insurance systems are evolving* – as social insurance expenditures escalate, an increasing number of countries are evaluating the sustainability of these systems and re-vamping old-age security provisions;
9. *New economic challenges are emerging* – population ageing has had, and will have, large effects on social entitlement programs, labor supply, and total savings around the globe.

2.2 Regional Context

Following the afore-mentioned trends, almost all countries in the Caribbean have experienced a rapid transition from a rather young population to an increasingly older population over the past decade. This so-called "*demographic transition"* began with continuously declining fertility and mortality rates in France in the mid-eighteenth century and has now reached most developing countries, with the exception of a few (Carl, 2004).

In addition to physical and mental well-being, quality of life is very much dependent on the availability of a social network; a factor that becomes even more important with older age if health deteriorates as the need for support through the informal family network increases.

With globalization and changing socio-economic environments, past and present living and care-taking arrangements might no longer be efficient; the disintegration of families and informal community support systems due to urbanization and migration call for new approaches to cope with these changing realities. At the *Caribbean Symposium on Population Ageing* held in Port of Spain, Trinidad and Tobago, in November 2004, Caribbean governments, civil society and academia had a unique opportunity to learn about ageing in the region.

The symposium highlighted that common to almost all Caribbean countries are the challenges to their small developing economies posed by the global economic meltdown. Poverty, both rural and urban, continues to be a developing phenomenon. The poverty line in the Caribbean ranges from 5% in the Bahamas to 65% in Haiti, with an average of 30% across Caribbean countries. The 2009 Country Poverty Assessment Report for Belize estimates that 41% of the population is living at or below the poverty line (CPA 2009).

Two other very significant ageing issues that arose in the symposium were 1) the health and well-being of the elderly and 2) demographic ageing and inter-generational support systems.

2.2.1 Health & Well-being of Older Persons

Most people do not see ageing as a natural process but rather, as something that happens after a person reaches a certain age range or experiences a life changing event such as retirement or eligibility for age-related discounts or welfare benefits. In addition, many understand the beginning of ageing as the onset of age-related and irremediable physical and/or mental deficiencies, which are expected to become more severe with increasing age.

This general tendency to relate ageing to becoming increasingly senile and frail has been challenged by most recent academic research. People at very advanced ages are

quite often in better shape than the younger old in their late 60s or early 70s and a fair number of centenarians have been found to be active and enjoying their late life years (Perls, 2004). There is evidence that a healthy lifestyle, including a balanced diet, regular physical activity, avoidance of tobacco and harmful alcohol use, and favorable genetic dispositions allow many to not only add numbers of years to their lives, but to also add quality to the years gained.

According to information published by the World Health Organization, the leading causes of morbidity and premature death for people over age 60 worldwide are now chronic cardio-vascular diseases as shown in table one. According to the WHO Report (2003), these lifestyle-related illnesses are mainly caused by five risk factors: elevated blood pressure, tobacco use, harmful alcohol consumption, elevated cholesterol levels, and obesity or overweight.

Mortality - adults aged 60+		Deaths	Disease burden - adults aged 60+		Deaths
Rank	Cause	('000)	Rank	Cause	('000)
1	Ischemic heart disease	5,825	1	Ischemic heart disease	5,825
2	Cerebrovascular disease	4,689	2	Cerebrovascular disease	4,689
3	Chronic obstructive pulmonary disease	2,399	3	Chronic obstructive pulmonary disease	2,399
4	Lower respiratory infections	1,396	4	Alzheimer and other dementias	1,396
5	Trachea, bronchus, lung cancers	928	5	Cataracts	928
6	Diabetes Mellitus	754	6	Lower respiratory infections	754
7	Hypertensive heart disease	735	7	Hearing loss, adult onset	735
8	Stomach cancer	605	8	Trachea, bronchus, lung cancers	605
9	Tuberculosis	495	9	Diabetes Mellitus	495
10	Colon and rectum cancers	477	10	Vision disorders, age related & other	477

Source: WHO,2003,P.17 **Table 1**

2.2.2 Demographic Ageing & Intergenerational Support Systems

"…the largest burden for care and support of the elderly is taken on by relatives and families."

All over the world the majority of the elderly lives in private homes, and if not with their kin under one roof, have children or grandchildren who step in to assist, when necessary. Institutional care arrangements are, in most cases, considered only if around-the-clock assistance and care is needed, especially later in life. With the growing number of older persons and the steady increase in chronic diseases, the need for long-term health care that cannot be provided or afforded at home is expected to grow. While part of these services can be supplied through public and private institutions, the largest burden is to be taken on by relatives and families. This is especially true in the Caribbean, where this responsibility is often entirely taken on by the family network, usually supported through an informal community-based support system (Carl, 2004).

Another critical factor with respect to support systems is migration, particularly return migration of the elderly and the continued departure of younger people. Growing numbers of elderly (retired) are returning home from jobs overseas, while steady and even growing numbers of skilled younger people are leaving in search of a better life abroad. As migrants remit cash and kind, they are no longer available to physically assist the sick and frail in their country of origin. Research conducted shows that women seem to be providing the largest share of support and care to family members and relatives, whereas men tend to contribute more in terms of cash and less in kind (United Nations, 2000).

In 2009, Belize's older population totaled 23,800 representing 7.1% of the general population. The male to female ratio was 1:00 to 0:92.

Belize Mid-Year Population by Age-Group and Sex, 2009

	Total	Male	Female
0-4	35,400	18,000	17,400
5-9	43,500	21,900	21,600
10-14	43,800	22,700	21,100
15-19	38,700	19,700	19,000
20-24	27,100	13,600	13,500
25-29	22,700	10,500	12,200
30-34	21,500	9,900	11,600
35-39	20,600	9,700	10,900
40-44	19,000	9,200	9,800
45-49	16,200	8,200	8,000
50-54	12,000	6,000	6,000
55-59	8,900	4,700	4,200
60-64	6,800	3,600	3,200
65-69	5,500	3,000	2,500
70-74	4,300	2,200	2,100
75-79	3,300	1,700	1,600
80-84	2,000	1,000	1,000
85+	1,900	900	1,000
Total	**333,200**	**166,500**	**166,700**

During the period 2003 – 2010, life expectancy has risen considerably from 66.7 years to 72.5 years for males and from 73.5 years to 77.5 years for females. The percentage of older persons in Belize has risen from 6.0% to 7.1%

2.3 National Context

In 1999, the Government of Belize, realizing that population ageing was an issue that could no longer be ignored, embarked upon an examination of this subject in greater detail by organizing a national consultation process, primarily to discuss the need for the development of a policy that would recognize older people in the country. This process took three (3) years but on June 21st, 2002, the *National Policy for Older Persons* (NPOP) was adopted by the Cabinet and was the first step towards recognizing the human rights of older persons in Belize.

This document focused on the achievement of goals in nine (9) key areas that drew attention to specific needs and concerns that would ultimately require changes to take place. These areas are:

- National Mechanism
- Education and Media
- Health and Nutrition
- Social Welfare
- Income Security
- Housing and Environment
- Family
- Legal
- Research

On February 10th 2003, the first area of the NPOP was realized with the swearing in of the National Council on Ageing (NCA), as the mechanism mandated by government to be responsible for the promotion, implementation, monitoring and evaluation of the National Policy for Older Persons.

One of the first undertakings of the NCA was to develop a *National Plan of Action for Older Persons 2003-2008*, which elaborated upon the National Policy by adding 2 more areas of concern, which were HIV/AIDS and Disaster Management and Preparedness.

In the same year the NCA developed a *Strategic Plan* which complimented the National Plan of Action by detailing the activities and programmes necessary for the implementation of the NPA.

2.3.1 Older Persons and Human Rights

When the NPOP was developed it drew attention to the need to provide greater consideration of the basic human rights of older persons.

In 2005 the NCA organized a 2 Day National Forum entitled *Human Rights and Fundamental Freedoms of Older Persons in Belize,* facilitated by Mr. Javier Vasquez, Human Rights lawyer and Mr. Enrique Vega, Ageing Specialist, both from PAHO/WHO Headquarters in Washington DC. This was the first such activity in the Caribbean Region and provided stakeholder organizations and older persons themselves, the opportunity to discuss and identify the major concerns that needed change in Belize.

As a result of this Forum older persons participating decided that they needed a voice in society; a representative organization comprising of all older persons that could take action and advocate for the changes that were needed to improve their quality of life.

On 1st October 2007, International Day of Older Persons, VOICE, the Representative Organization of Older Persons in Belize, was launched. This organization became a registered NGO in 2008 and continues to operate at a National and Local level to advocate on older persons issues.

In 2006 the National Council on Ageing obtained funding from UNFPA to seek the assistance of a lawyer to draft an Older Persons Act for Belize. This document was subsequently viewed by Mr. Vasquez and Mr. Vega from PAHO/WHO Washington to place greater emphasize on the human rights of older persons in this Act. This document still needs certain amendments before being submitted for Cabinet approval.

2.3.2 Older Persons and Financial Security

Having insufficient funds to maintain a healthy and active life is always a major concern of older persons.

In 2003 Belize saw the introduction of the Non Contributory Pension (NCP) for Older Persons. This government initiative was first promised to all older women over 65 years in recognition of their contribution to society. This benefit of $75.00 per month was administered through Belize Social Security Board (BSSB) but on actuarial advice this benefit was scaled down and provided to those considered most in need in the community. In 2008 this benefit was increased to $100.00 per month and included men aged 67 years.

Non-Contributory Pensioners by District and Sex in 2009

	Corozal	Orange Walk	Belize	Cayo	Stann Creek	Toledo	Total
Total	654	893	981	929	425	415	**4,297**
Female	403	520	709	611	285	262	**2,790**
Male	251	373	272	318	140	153	**1,507**

Source: Social Security Board: September 2010

2.3.3 Older Persons and Health

It is generally considered that one of the main reasons for the increase in longevity of older persons is through the improvement and access to healthcare facilities by older persons.

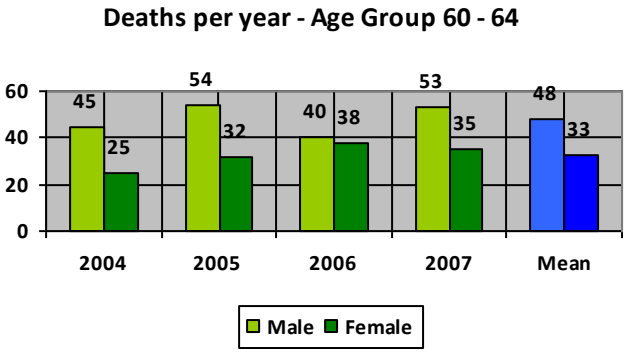
In 2003 the Government of Belize introduced the National Health Insurance (NHI) programme as a pilot project on the southside of Belize City. In 2006 this was extended to the southern Districts of Toledo and Stann Creek. The people in these areas were considered to be poorer and therefore in need of improved access to free healthcare facilities as a means of improving their health. The introduction of NHI meant that

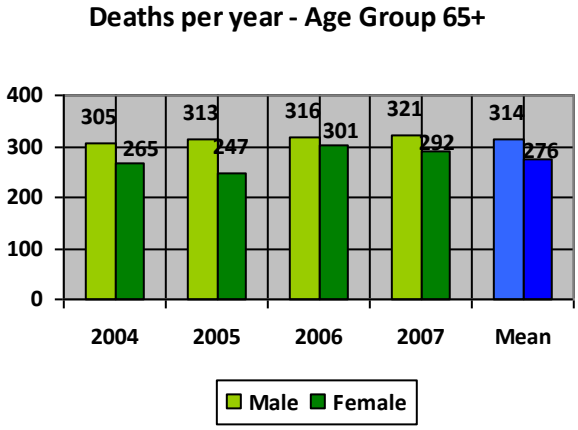
healthcare services became available to all older persons in these stipulated areas who had previously encountered difficulties obtaining appropriate health care when a financial charge was levied.

In 2009 the NHI programme recognized the Mercy Care Centre in Belize City as a new provider of health services specifically to older persons who qualified for this free service. As an NHI service provider the Mercy Care Centre has been able to up-grade its facilities and provide improved medical services to older persons in the locality.

2.3.5 Illness and Deaths by Age Group and Sex: 2003 - 2009

The following charts show mortality statistics for two age groups – 60-64 and 65 years and over, for the period 2004 to 2007.





During the four years, the average number of deaths in the age group 60-64 years is 48 for males and 33 for females; in the age group 65 and over, the average number of deaths is 314 for males and 276 females. This is consistent with regional and global data that, overall, women outlive men, making gender issues as important for older persons as for the general population. These older women are often faced with loss of financial support, limited employment opportunities and greater dependence on them by family members regarding care giving duties. According to the Ministry of Health the most prevalent chronic diseases affecting older persons in Belize are diabetes mellitus, heart disease and hypertensive disease. Charts detailing the morbidity and mortality trends relating to these conditions and other common illnesses from 2003 – 2009 can be found on the following pages.

Leading Causes of Hospitalization For Persons 60 Years and Over Belize 2003 - 2009

Causes	2003		2004		2005		2006		2007		2008		2009	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Diabetes Mellitus	244	11.5	243	11.4	214	10.1	288	13.2	290	13	222	12	254	12
Diseases of the Pulmonary Circulation and Other Forms Heart Diseases	204	9.6	178	8.3	180	8.5	166	7.6	96	4.3	173	9.4	175	8.3
Injury, Poisoning and Certain Other Consequences of External Causes	121	5.7	104	4.9	103	4.8	62	2.8	31	1.4	76	4.1	112	5.3
Hypertensive Diseases	154	7.3	153	7.2	152	7.2	172	7.9	164	7.3	150	8.1	118	5.6
Other Chronic Pulmonary Diseases, Diseases due to External Agents and Residuals	48	2.3	90	4.2	92	4.3	92	4.2	96	4.3	76	4.1	104	4.9
Acute Respiratory Infections	107	5	119	5.6	132	6.2	131	6	129	5.8	116	6.3	156	7.4
Diseases of Other Parts of the Digestive System	136	6.4	136	6.4	148	7	122	5.6	126	5.6	105	5.7	131	6.2
Cerebrovascular Diseases	93	4.4	115	5.4	125	5.9	111	5.1	126	5.6	88	4.8	119	5.6
Sub Total	**1,107**	52.2	**1,138**	53.4	**1,146**	54	**1,144**	52.3	**1,058**	47.3	**1,006**	54.4	**1,169**	55.4
Symptoms, Signs and Ill-Defined Conditions	130	6.1	98	4.6	91	4.3	93	4.2	62	2.8	53	2.9	66	3.1
Residual	200	9.4	208	9.8	165	7.8	188	8.6	186	8.3	150	8.1	182	8.6
Total Other Causes	**685**	32.3	**689**	32.3	**722**	34	**764**	34.9	**931**	41.6	**640**	34.6	**693**	32.8
Total All Causes	**2,122**	100	**2,133**	100	**2,124**	100	**2,189**	100	**2,237**	100	**1,849**	100	**2,110**	100

Source: The Epidemiology Unit, MOH

Leading Causes of Deaths in Persons 60 Years and Over: Belize 2003-2009

Causes	2003		2004		2005		2006		2007		2008		2009	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Cerebrovascular Disease	35	5.6	32	4.8	53	8.2	62	8.9	62	8.9	53	8.3	76	11.1
Diseases of Pulmonary Circulation and Other Forms of Heart Diseases	64	10.2	53	8	40	6.2	57	8.2	59	8.4	59	9.3	51	7.5
Hypertensive Disease	77	12.2	112	17	74	11.5	68	9.8	50	7.1	38	6	44	6.4
Diabetes Mellitus	47	7.5	61	9.2	73	11.3	98	14.1	79	11.3	66	10.4	80	11.7
Ischaemic Heart Diseases	58	9.2	45	6.8	64	9.9	50	7.2	63	9	69	10.8	91	13.3
Acute Respiratory Infections	53	8.4	48	7.3	33	5.1	34	4.9	42	6	35	5.5	50	7.3
Sub Total	**334**	**53**	**351**	**53**	**337**	**52**	**369**	**53**	**355**	**51**	**320**	**50**	**392**	**57**
Signs, Symptoms and Ill-Defined Conditions	9	1.4	15	2.3	7	1.1	3	0.4	23	3.3	8	1.3	6	0.9
Residual	9	1.4	8	1.2	15	2.3	5	0.7	23	3.3	18	2.8	20	2.9
Total Other Causes	**278**	**44**	**286**	**43**	**287**	**44**	**318**	**46**	**299**	**43**	**290**	**46**	**315**	**46**
Total All Causes	**630**	**100**	**660**	**100**	**646**	**100**	**695**	**100**	**700**	**100**	**636**	**100**	**683**	**100**

Source: The Epidemiology Unit, MOH

2.3.4 The First Situation Analysis of Older Persons in Belize

In 2003 HelpAge Belize conducted the first situational assessment of older persons in Belize. The main objectives of the study were to ensure that policy development as it related to older persons took into consideration the livelihood realities of the elderly in Belize; to sensitize policy makers and planners to these realities; and to disseminate the findings to the wider stakeholders – government, private sector, and civil society – to inform policy and program planning, implementation and evaluation.

The research focused on six key areas: income and livelihood, health and coping with the ageing process, education, housing, socialization, and contribution to family and the wider community. A summary of the key findings of this assessment entitled *A Situational Analysis of Older Persons in Belize: Research Study Report 2003,* can be found in the Appendix

3.0: 2010 SURVEY DEVELOPMENT AND IMPLEMENTATION

3.1 Scope of Survey

From the population figures available through Statistical Institute of Belize (SIB), the National Council on Ageing recognized that the population of older persons in Belize was increasing rapidly and that people are living longer. However, there are concerns that living longer cannot be equated with living a good quality life. The research study therefore set out to determine if the basic needs of older persons in Belize are being met and to assess if there is a need to implement more appropriate programs, policies, and services, which will contribute to improved quality of life for older persons.

The research specifically sets out to identify the major needs and concerns of older persons in six areas: health, income security, family support, contribution to community and respect, housing and living conditions, and social support and personal security.

The targeted sample population was 600 spread across six districts. However, and due to some limitations in the implementation of the survey, the net total number of respondents was 492.

3.1.1 Methodology

The survey methodology was adapted from the PAHO/WHO supported multi-country study SABE, implemented in Barbados and four Latin American countries in 2003, which concentrated on health related issues of older persons.

The NCA developed a questionnaire based on 6 major expressed concerns of older people in Belize that were designed to illicit qualitative as well as quantitative information.

The areas covered were:

i: ***Health*** – a self assessment of the participants' physical and mental condition and access to healthcare

ii: ***Income Security*** – access to benefits that contributed /provided daily living expenses

iii: ***Family Support*** – availability of family to provide regular oversight of well being

iv: ***Contribution to Community/ Respect*** – the acceptability of older person's inclusion in decision making in family and community

v: ***Housing/ Living Conditions*** – the ability to maintain an adequate and comfortable shelter

vi: ***Social Support/ Security of Person*** - the availability of and access to social facilities providing peer companionship and personal security in community

It was the intention of the NCA to carry out interviews with 600 older people born prior to 1948, which would have made them 60 years plus and to stratify participants by age into 60's, 70's, 80's & 90's The interviews were to be carried out in the six Districts of Belize by teams of interviewers from the VOICE Organization and NAVCO (Community representatives from the National Association of Village Councils)

The six districts included Corozal, Orange Walk, Belize, Cayo, Stann Creek and Toledo and would comprise of 100 respondents in each District: 50 from major Towns/Cities and 50 from 5 randomly chosen villages in each District. The rural communities were chosen to reflect the diversity of Belize through ethnicity and demography.

As far as possible it was intended for the names of the participants to have been chosen from the electoral registers in each community. However, it transpired that only 2 Districts were given access to electoral registers and therefore the interviewers used their local knowledge to identify qualifying participants from within their Towns or Villages.

The six areas chosen for the collection of information were done so on the basis that, during countrywide consultations with organizations working with older persons and with older persons themselves, it was found that the primary concern was the provision of an appropriate, adequate and affordable healthcare system that was accessible to older persons. VOICE Orange Walk had implemented a quick response survey of older persons attending public health facilities which had indicated that essential medications used by older persons were generally not available in public facilities.

Income security was seen as a particularly pertinent issue, since beneficiaries of the Non-Contributory Pension Scheme were being re-assessed and cuts were being implemented in an effort to cut back on expenses. The NCA was also aware that there was an increase in the reported cases of neglect and abuse of older persons which indicated that family support was not as strong as it should be and older persons were often left to fend for themselves. Older persons themselves repeatedly complained about their treatment in a society that does not consider them or acknowledge their existence.

Therefore, the questionnaire attempted to cover all the most pertinent issues that addressed the basic human rights of older persons in Belizean society. The study was conducted as follows:

Urban: 50 Questionnaires carried out by VOICE members and Service Provider Organizations in each of the District Towns except Cayo which has 3 major centers: Benque Town 10/ San Ignacio Town 20/Belmopan City 20

Rural: Interviews were conducted with the assistance from NAVCO community volunteers in 5 villages in each district = 10 questionnaires per village making a total of 50

The Villages

Corozal:	San Joaquin/ Patchakan/ Paraiso/ San Narciso/ Sarteneja
Orange Walk:	Guinea Grass/ Chan Pine Ridge / Santa Martha/ San Estevan/August Pine Ridge
Belize District:	Burrell Boom/Lucky Strike/Crooked Tree/Caye Caulker/Gracie Rock
Cayo District:	San Antonio/ Succotz/ Spanish Lookout/ Armenia/Cotton Tree
Stann Creek:	Maya Centre/ Hopkins/ Pomona/Sittee River/ Independence
Toledo:	San Pedro Columbia/ Barranco/ Forest Home/ Jalacte /Big Falls

It was necessary to seek the assistance of a person skilled in data collection to oversee the project and coordinate activities given that this project needed to be completed in 4 months.

Pretesting of the Questionnaire

The National Council on Ageing conducted a sample survey with 5 older persons in Belmopan and surrounding catchment areas, for example, 3 in Belmopan, 1 in San Martin and 1 in Maya Mopan and all within the 4 age ranges of 60's, 70's, 80's and 90's. This sample also identified older persons from various ethnic backgrounds and origins. For example the participants were Maya, Garifuna, Mestizo and Creole persons from Belize and Guatemala. From the sample survey it was necessary to make adjustments and add a few extra questions to improve the flow of the interview process.

The questionnaire was reviewed by all members of the National Council on Ageing, the Statistical Institute of Belize (SIB) and Mr. Gustavo Perera, from SUMMA Research Agency, who would be compiling the research document. All comments contributed to the final drafting of the questionnaire.

3.1.2 Data Management

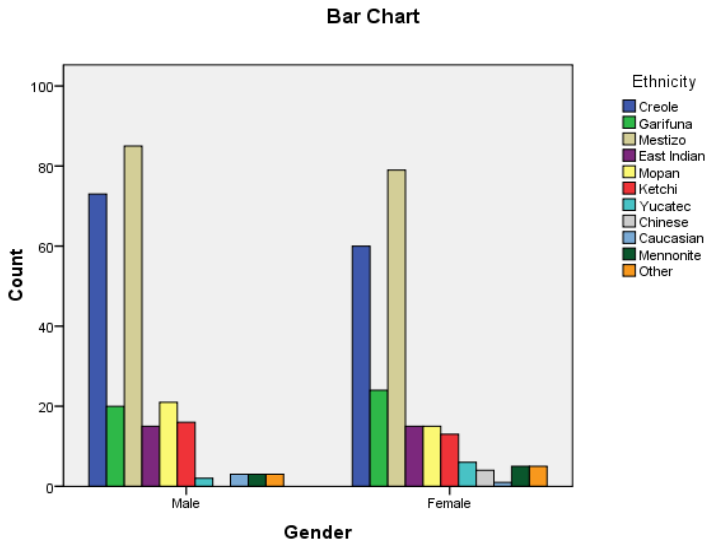
The data management service was provided by Mr. Jorge Aldana, M. Sc., and Dean of Sacred Heart Junior College. Using the SPSS Data Management Programme, Mr. Aldana conducted a verification of all completed questionnaires and produced a first set of data outputs which formed the basis of an evaluative discussion between Lindy Jeffery of NCA, Gustavo Perera of Summa Research Agency and Jorge Aldana. During this discussion consensus was achieved on final data outputs and range of data analysis including frequencies, cross-tabulations, and demographic profiles.

4.0 SUMMARY OF KEY FINDINGS

4.1. Demographic Profiles

Ethnicity & Gender

Four hundred sixty eight (468) elderly persons participated in the survey. The biggest group comprised of Mestizos (35%) followed by Creoles (28.4%), Mayans (14.1%), Garifuna (9.4%), East Indian (7.4%), and the other 5.7% comprising of Chinese, Caucasian, Mennonite, and others.

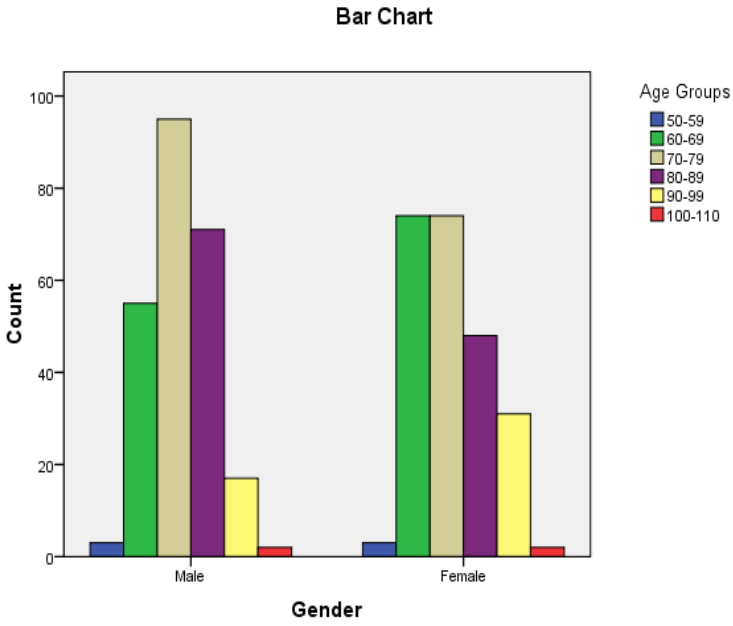


The male to female ratio was 51.5% male; 48.5% females.

Age Group & Gender

The age group 70 to 79 was the largest respondent group (35.6%) followed by age group 60 to 69 (27.2%), and then the group 80 to 89 (25.1%); the fourth largest group was 90 to 99 (10.1%).

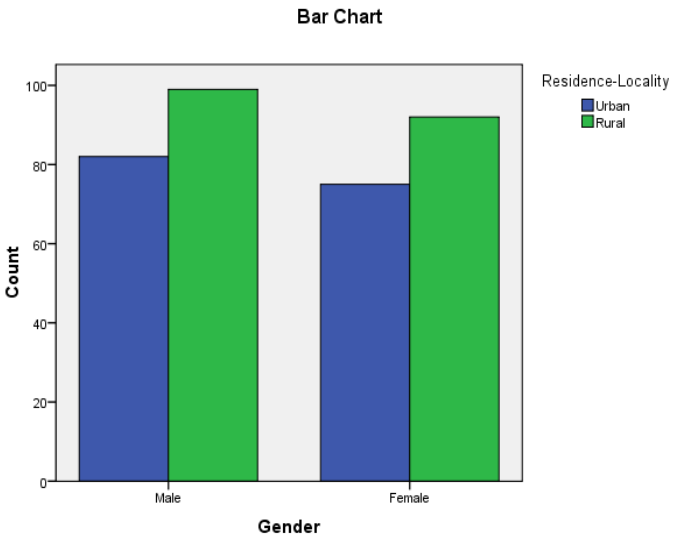
The male to female respondent ratio was 51.2% Male: 48.8% Female.



Locality and Gender

A higher percentage of respondents came from the rural areas (54.9%) compared to 45.1% from urban areas.

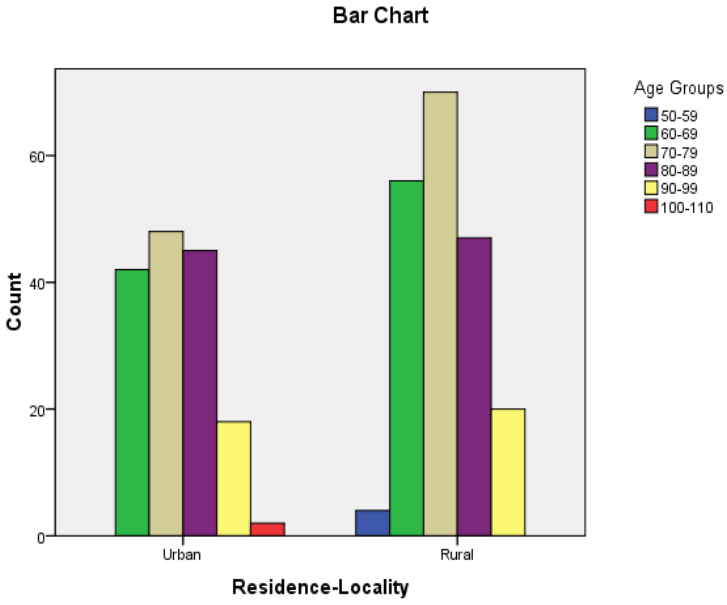
The male to female respondent ratio was Male 52%: Female 48%.



Age Group & Locality

Of the total number of respondents, a larger sample came from the rural areas (56%). The sample sizes by age groups were consistent with those in the 'age group and gender' chart above.

The biggest age group was 70 to 79 (35.5%), 60 to 69 (28.4%), 80 to 89 (23.9%), and 90 to 99 (11.6%).



In order to make the report as fluid as possible we have adopted the *"dashboard"* format for summarizing the key findings, with the results presented in the six areas using the table format. Subsequently, the analysis of the results is presented in narrative format.

4.2 Dashboard of Key Findings: General Health

General Health				
Indicators	Good	Fair/Ok	Poor	
> State of health	*96*	236	159	
	19.5%	48.1%	32.4%	
> Smoking	Yes	No	In the past	
	47	353	87	
	9.6%	72.5%	17.9%	
>Drinking	Yes-Regularly	Occasionally	No	
	28	99	361	
	5.7%	20.3%	74.0%	
> Exercise	Yes-Everyday	Occasionally	No	
	159	144	171	
	33.5%	30.4%	36.1%	
> Medical Problems	Yes	No		
	338	103		
	76.6%	23.4%		
> Medication	Yes, Daily	Weekly	Other Period	No
	234	29	60	126
	52.1%	6.5%	13.4%	28.1%

4.2.1 Analysis: General Health

Less than twenty percent (20%) of the elderly population consider themselves to be in good health; the other eighty percent (80%) rate their health condition as fair to poor. Only a very small percentage smoke (9.6%) and consume alcohol (5.7%), and the majority engage in some type of exercise (63.9%) either daily or occasionally.

Almost the entire eighty percent of the elderly population who say that their health is fair to poor (76.6%), also state that they have some medical problem and have to take medication either daily, weekly, or occasionally.

The most prevalent medical condition is hypertension or high blood pressure followed by diabetes and associated symptoms – “pressure” and vision problems. Arthritis and associated joint pains is the third most common of medical problems reported. Medical problems linked to hearing, vision, and other symptoms are associated with the natural ageing process.

The type of medication taken by those with medical conditions fall within four general categories: 1) hypertension 2) diabetes 3) arthritis and joint pains and 4) other (see table 2 below).

Table 2:	Type of Medication		
Hypertension/Pressure	**Diabetes**	**Arthritis/Joint Pains**	**Other**
Pills for heart	Pills for sugar	Painkillers	Neurostress
Injections	Sugar & pressure pills	Tylenol	Nerve food
Pressure & cholesterol pills	Insulin	Paracetamol	Nikzon
Doctor prescription	Doctor prescription	Ibuprofen	Motodoframide
		Rantidine/Tylenol	Adalar
			Omega-3 Iboprin
			One A Day
			Kidney infection
			Prostate
			Sleeping Pills
			Stones

4.3 Dashboard of Key Findings – Access to Healthcare 1

Dashboard: Access to Healthcare 1			
Indicator	**Hospital/Clinic**	**Community Pharmacy**	**Both**
> Buy medication	241	142	16
	60.3%	**35.7%**	**4.0%**
> Free of Cost	**Yes**	**No**	**Sometimes**
	159	260	16
	37.3%	**61.0%**	**1.7%**
> Availability	**Yes**	**No**	
	331	89	
	78.8%	**21.2%**	
> Alternative	**Purchase Privately**	**Go Without**	**Other**
	102	32	11
	70.3%	**22.1%**	**7.6%**
> Visits Doctor	**Hospital/Clinic**	**Private**	**Don't Visit**
	261	40	113
	63.0%	**9.8%**	**27.2%**
> Cost per Treatment	**Yes**	**No**	**Range**
	249	139	*$10 to $150*
	64.2%	**35.8%**	$500 - $2000

4.3.1 Analysis: Access to Healthcare 1

The majority of the elderly populations (60.3%) get their medication at the hospital or clinic while a smaller number (35.7%) purchase from the community drug stores. Only a very small number (4%) get their medication from both the hospital or clinic and the pharmacy.

Only a small percentage 37.3%, obtain their medication free of cost, while 61% have to pay for theirs. The monthly amount spent on medication ranges from a low of one dollar to a high of one thousand five hundred dollars. However, the average spending clusters are as follows: $26 to $50 (32%), $1 to $25 (20%), $76 to $100 (16%), and $51 to $75 and $101 to $200 at 10% respectively.

For the most part, medication is always available and in those instances (21%) where it is unavailable at the hospital, clinic, or drugstore, most do without. In isolated cases, the medication is purchased from a family doctor, and across the immediate borders - in Melchor and Chetumal.

In cases where persons become sick 63% seek medical attention at the hospital or clinic while only 9.8% visit a private clinic; just over a quarter of the population (27.2%) say they do not visit a physician. In those cases where the sick person chooses not to (or is unable) to visit the hospital or a private clinic, they seek medical attention at nursing homes, the Mercy Clinic, or use bush medicine or herbal therapy.

The cost of treatment for those who can afford it, range from a minimum of $45 to a high of $2,000 per month, however, the main cost cluster is between the range of $1 to $100 with prominent sub-clusters of $25, $30, $50 and $75 per month.

Treatments varied from the most common which was high blood pressure related symptoms to cases of asthma and lung complications, stomach ulcers, kidney and gall stones, pneumonia, prostate glands, cancer, surgeries – eye and limb amputations, fractures, and dental.

4.4 Dashboard of Key Findings: Access to Healthcare 2

Dashboard: Access to Healthcare 2				
Indicator	Once Per Month	Once every 6 months	When Necessary	
> Visits to Doctor -Last 6 Mths.	130	85	163	
	34.4%	22.5%	43.1%	
> Hospitalized last 6 Mths.	Yes	No		
	85	368		
	18.8%	81.2%		
> Use bush medicine	Yes	No		
	209	251		
	45.4%	54.6%		
> Visit a bush doctor	Yes	No	Self-medicate	
	27	311	113	
	6.0%	69.0%	25.0%	
> Visit other country	Yes - Regularly	When Necessary	No	
	38	104	322	
	8.2%	22.4%	69.4%	
> Last Complete Medical Check-up	6 Months	1 Year	2 Plus Years	Never
	153	103	119	89
	33.0%	22.2%	25.7%	18.1%
> If check up offered free of cost?	Yes	No		
	390	47		
	89.2%	10.8%		
> Difficulty visiting the doctor	Yes	No		
	143	318		
	31.0%	69.0%		
> Do you have health insurance	Yes	No		
	29	442		
	6.2%	93.8%		

4.4.1 Analysis: Access to Healthcare 2

In terms of frequency of visits to the doctor, 34.4% visit their doctor once per month and 22.5% do so once every six months; another 43.1% visit their doctor only when it becomes necessary. With respect to the need for hospitalization only 18.8% were hospitalized during the past six months; the majority (81.2%) was not hospitalized during this same period. Reasons included stomach and digestive ailments, bladder and urinary infections, high blood pressure and high cholesterol, fever and pneumonia, diabetes and associated symptoms, asthma and bronchial infection, heart palpitations and failure, hernia, and physical injuries such as fractures as a result of falls.

4.5 Dashboard of Key Findings: Physical & Mental Health

Dashboard: Physical & Mental Health			
Indicator	Yes	No	
> Describe as disabled	118	364	
	24.5%	75.5%	
> Visually Imparied	Yes	No	
	175	292	
	37.5%	62.5%	
> Limited Mobility	Yes	No	
	151	313	
	32.5%	67.5%	
> Use Wheel Chair/Walker/Cane	Yes	No	
	92	218	
	29.7%	70.3%	
> Fall in last six months	Yes	No	
	135	342	
	28.3%	71.7%	
> Family members with similar conditions	Yes	No	Don't Know
	101	258	93
	22.3%	57.1%	20.6%
> Suffer from feelings of depression	Never	Sometimes	Regularly
	226	230	29
	46.6%	47.4%	6.0%
> Family who suffered dementia/Alzheimer's	Yes	No	Don't Know
	59	344	75
	12.3%	72.0%	15.7%
> Presently or in the past is (was) caregiver	Yes	No	
	210	250	
	45.7%	54.3%	

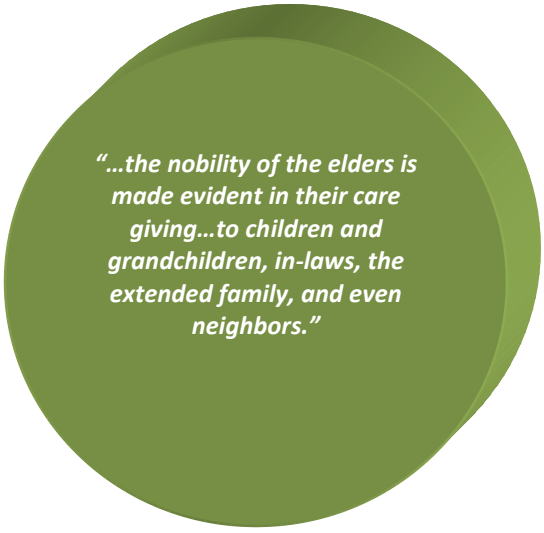
4.5.1 Analysis: Physical and Mental Health

One quarter of the elderly population claim to have some type of disability caused by stroke, Alzheimer's disease, lack of arm mobility due to accident, back and spinal conditions, general weakness associated with the ageing process, poor vision including blindness, confinement to wheel chairs due to limb amputations, memory loss, and deafness. Those with visual impairment suffer from glaucoma, cataracts, and progressive loss of sight due to the ageing process.

Wheel chair confinement affects up to almost one third of the elderly population and most have sustained injuries due to falls that occurred within the past six months. Injuries sustained range from minor bruises and scratches to broken limbs – legs, hands, ribs, and including hip dislocations. The challenge within the household is that other family members also have medical conditions that fall within those described earlier. These family members include children, grandchildren, kindred, and spouse.

More than one-half of the populations say they suffer from feelings of depression (self-diagnosed) but only a quarter experiences this on a regular basis. Those who suffer from dementia and Alzheimer's disease describe manifest symptoms, which include memory loss, confusion, illogical or incoherent speech and thought processes, and intolerance associated with frustration.

However, and this deserves an applause – the nobility of the elders is made evident in their care giving. Almost one half of the population are care givers – providing for family especially to children and grandchildren, assisting with school expenses, giving to the needy, in-laws, the extended family, and even the neighbors.



4.6 Dashboard of Key Findings: Nutrition, Diet & Health Resources

Dashboard: Nutrition, Diet, & Health Resources		
Indicator	Yes	No
Eat balanced nutritious meal with FRUIT	406	70
	85.3%	14.7%
> Eat balanced nutritious meal with VEGGIES	Yes	No
	425	48
	89.9%	10.1%
> Eat balanced nutritious meal with MEAT	Yes	No
	399	67
	85.6%	14.4%
> Eat balanced nutritious meal with FISH	Yes	No
	396	70
	85.0%	15.0%
> Cooks own food	Yes	No
	247	228
	52.0%	48.0%
> Own piece of land or garden	Yes	No
	231	258
	47.2%	52.8%
> Do you grow vegetables	Yes	No
	107	382
	21.9%	78.1%
> Do you own livestock	Yes	No
	107	382
	21.9%	78.1%
> Do you have fruit trees	Yes	No
	311	172
	64.4%	35.6%
> Would accept assistance for a yard garden	Yes	No
	215	151
	58.7%	41.3%

4.6.1 Analysis: Nutrition, Diet, and Health Resources

The majority of the elderly population, over 85% says they eat a balanced nutritious meal everyday that consists of fruits, vegetables, meat and fish. The remaining 15% does not have the same diet; the main reasons for this are primarily economic (just cannot afford); unavailability; it does not form a part of their normal diet, and in the case of meat, due to dietary restrictions imposed by a medical doctor.

Just over half of the population cook their own food which typically includes rice and beans with chicken, tortillas, beans and chicken, baked chicken with vegetable salad, beans soup, eggs, fish and meat with bread, cereal, callaloo, ground food, noodles, macaroni and cheese, potatoes, green bananas and plantains. There are a few instances where the diet is below nutritional standards (consist of bread and butter only) and with some sugar added.

Just under half of the older population (47.2%) own a piece of land and have a garden but only a very small percentage (22%) grow vegetables or have livestock; those who have livestock have mostly chickens, with a few cattle, pigs, ducks, and turkeys. A larger number though, grow fruit trees. When asked if they would accept assistance to grow a garden, 58.7% said they would.

4.7 Dashboard of Key Findings: Income & Benefits

Dashboard: Income/Benefits				
Indicator	Yes	No		
> Receives a pension	167	292		
	36.4%	63.6%		
> Type of Pension received	Government	Private	Overseas	Combination
	131	18	14	3
	78.9%	10.8%	8.4%	1.8%
> Receives benefit	Non-contributory	Social	No	
	98	90	258	
	22.0%	20.2%	57.8%	
> Receives employment income	Yes	No	Not Sure	
	59	398	15	
	12.5%	84.3%	3.2%	
> Receives income from family	Yes	No	Not Sure	
	194	266	13	
	41.0%	56.2%	2.8%	
> Helps family with cooking	Yes - Paid	Yes - No Pay	No	
	28	145	279	
	6.2%	32.1%	61.7%	
> Helps with cleaning	Yes-Paid	Yes - No Pay	No	
	24	147	272	
	5.4%	33.2%	61.4%	
> Helps with 'baby-minding'	Yes-Paid	Yes - No Pay	No	
	17	92	317	
	4.0%	21.6%	74.4%	
> Helps with gardening	Yes-Paid	Yes - No Pay	No	
	131	75	333	
	3.1%	17.8%	79.1%	
> Average monthly income	1-100	101-500	501-1000	Over 1000
	126	101	27	28
	44.6%	35.8%	9.7%	9.9%
> Adequacy of income for needs	Yes	No		
	113	306		
	27.0%	73.0%		
> Have regular bills to pay	Yes	No		
	330	127		
	72.2%	27.8%		
> Does income cover bills	Yes	No		
	154	270		
	36.3%	63.7%		
> Considers himself/herself poor	Yes	No		
	360	117		
	75.5%	24.5%		
> Worries about money...	Yes	No		
	311	166		
	65.2%	34.8%		

4.7.1 Analysis: Income & Benefits

A significant 63.6% of the older population does not receive a pension or benefit and an even greater number (84.3%) does not receive employment income. Those who receive a pension do so primarily from the Government of Belize (78.9%) with 19.2% receiving private and overseas pensions. Those who received benefits get these from the NCP or from Social Department (Social Assistance).

In terms of income from family, only 41% say they receive an income from family so in order to sustain themselves, they rely on income they receive from property rental, small intermittent contributions from their children, assistance from the church, operating small 'mom 'n pop' shops, sundry jobs, and baking and selling of buns and Johnny cakes. Some engage in farming activities or sell fruits and vegetables including corn and beans.

Only one third of the elders say they help with cooking, cleaning, and baby-sitting chores and only a few receive payment for it. In terms of general income or monthly average income, these range from a low of $4 per month to a high of up to $3,750. However, the main or more frequent clusters are $150, $200, $300, $500 to $800, and $1,000.

For seventy five percent (75%) of the population, the income is not sufficient to meet their needs; the main reason is that they all have bills to pay. The bills include credit at grocery shop, cable, light, water, telephone, and gas bills, food, house mortgage, hospital and medical bills including cost of medication, property taxes, tithes, and other loan payments.

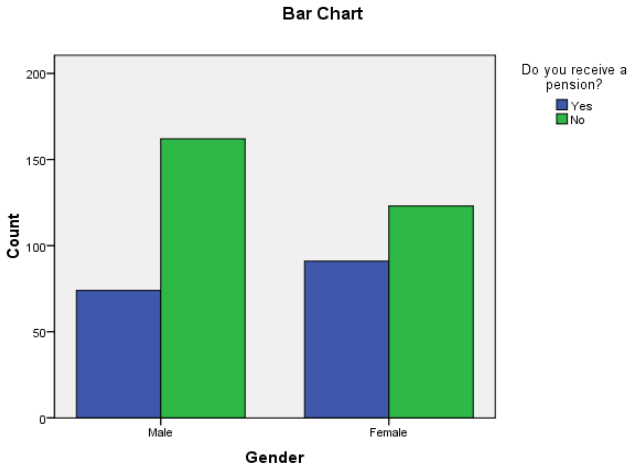
In order to make up for the difference in income, the elders seek assistance from neighbors, children and grandchildren, friends, and they usually ask the landlord for an extension on rent payment deadline. A desperate few just ask God to intervene in their situation, sleep it off, or in the words of a few – just 'beg.' It is therefore not surprising that this population (65.2%) define themselves as 'poor' and are always preoccupied about not having enough money to meet their livelihood needs.

4.8 Issues: Gender and Locality

A further analysis was done to try and determine the co-relations between the economic factors and gender and locale (urban/rural).

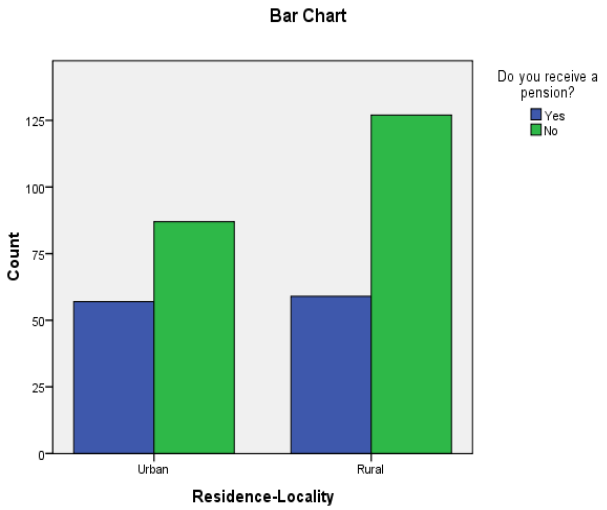
Gender

A higher number of women (55.2%) receive pensions than do men (44.8%). More women receive a government pension than do the men although there is a higher incidence of men getting pensions from overseas. A higher number of women receive NCP pension and social assistance than men. In terms of employment income, there is a marginal difference in favor of men.



Locality

Not surprisingly, there is a much higher rural population that does not receive pensions, benefits, or employment income. However, both urban and rural populations that do receive pension do so primarily from government and private entities.



4.9 Dashboard of Key Findings: Family Support

Dashboard: Family Support				
Indicator	1 to 4	5 to 7	8 to 10	Over 10
> Number of children	141	139	120	58
	30.7%	29.9%	26.2%	13.2%
> Do children live in Belize	Yes	No	Some	
	36	60	17	
	31.8%	53.1%	15.1%	
> Lives alone	Yes	No		
	108	366		
	22.8%	77.2%		
> Lives with…	Spouse/Partner	Family	Friends	Other
	167	204	48	38
	36.5%	44.6%	10.5%	8.4%
> Has own room…	Yes	No		
	404	53		
	88.4%	11.6%		
> Talks to family regularly…	Daily	Weekly	Monthly	Yearly
	345	64	45	11
	72.2%	13.4%	9.4%	2.3%
> Contributes to family	In Kind	Financially	No	
	203	70	201	
	42.8%	14.8%	42.4%	
> Would like to contribute more…	Yes	No		
	338	101		
	77.0%	23.0%		
> Feels appreciated by family	Yes	No		
	451	34		
	93.0%	7.0%		
> Feels neglected by family	Yes	No		
	63	420		
	13.0%	87.0%		
> Visited by family members…	Yes	No		
	63	40		
	87.0%	13.0%		
> Have grandchildren	Yes	No		
	435	39		
	91.8%	8.2%		
> Feels lonely…	Yes - sometimes	A Lot	No	
	221	32	227	
	46.0%	6.7%	47.3%	
> Feels respected by family…	Yes	No		
	472	17		
	96.5%	3.5%		

4.9.1 Analysis: Family Support

Just under thirty percent (30%) of the older population have between one to four children and an almost similar percentage have between five to seven children followed closely by another twenty five percent (25%) that have between eight to ten children. A very small percentage (13%) has over ten children.

The ratio of boy to girls is almost 1:1 and a high percentage of the children live abroad, primarily in the USA with some living in Canada, England, and some Central American countries. Only about one quarter of the population, live with a spouse or partner only but the majority share the home with other family members and to a lesser extent with friends.

Communication with family members is for the most part, a daily occurrence. More than fifty percent of the elders contribute to the family – either in kind or financially although the majority feel like their contribution is not enough and would like to contribute more to the home.

With the exception of a tiny group (7%), the older population feels appreciated by their family; those who feel less appreciated say they feel that after all they have done for their children the latter have turned their backs on them. Some cite other reasons such as their drinking habit, or some family members wanting to have privacy in their own house, or because of remote location. Feelings of neglect stem from being excluded from conversations or from not receiving telephone calls or visits.

For the most, part though, family members, mostly kindred - children, daughters and sons in laws, and grandchildren, visit the majority. The grandchildren seem to communicate daily with elders and certainly not for periods that extend beyond one week. Despite this, more than one-half of the population says they feel lonely; some would like to visit family members living abroad but the constraints are both financial and physical. There is no doubt that elders feel respected by family members, community, and country.

4.10 Dashboard of Key Findings: Housing

Dashboard: Housing				
Indicator	Yes	No		
> Owns own house	348	138		
	71.6%	28.4%		
> Where those who do not own live…	Rented	Family	Other	
	19	91	23	
	14.3%	68.4%	17.3%	
> Condition of home	Good	Satisfactory	Poor	
	139	222	119	
	29.0%	46.3%	24.8%	
> House in need of repairs…	Major	Minor	None	
	139	159	155	
	30.7%	35.1%	34.2%	
> House has electricity	Yes	No		
	432	57		
	88.3%	11.7%		
> House has water supply	Yes	No		
	450	34		
	93.0%	7.0%		
> House has toilet	Indoor	Outdoor	None	
	455	159	155	
	93.8%	3.1%	3.1%	
> Has telephone	Yes	No		
	262	216		
	54.8%	45.2%		
> Thinks house is structurally safe	Yes	No	Not Sure	
	258	144	88	
	52.7%	29.3%	18.0%	
> Thinks house will withstand strong winds	Yes	No	Not Sure	
	189	187	14	
	38.6%	38.2%	23.2%	
> Thinks house will withstand flooding	Yes	No	Not Sure	
	199	189	95	
	41.2%	39.5%	19.3%	
> Emergency Plan	Shelter	Family	Friends	Church
	180	178	27	24
	40.5%	40.1%	6.1%	7.9%
> Will leave District/City/Town/Village	Yes	No	Don't Know	
	89	360	31	
	18.5%	75.0%	6.5%	
> Had to leave home last year - emergency	Yes	No		
	55	419		
	11.6%	88.4%		

4.10.1 Analysis: Housing

An impressive seventy two percent (72%) of elders own their own house which is significant when one considers the economic and physical challenges that the older population faces.

Those who do not own their own house live mostly with family and in houses provided by their children or in-laws, then the church. About fifteen percent (15%) pay rent. Three quarters of the older population says that their house is in good or satisfactory state of repair with twenty five percent (25%) saying that the house is in poor condition. Repairs are both minor (35%) and major (30%) and range from everything needing repair, to stairways, bathrooms and plumbing, kitchens, windows and doors, ceilings, floors, and leaking roofs.

One-half of the populations believe that their home is structurally safe but this number decreases when asked if the house could withstand strong winds or flooding. Emergency plans include going to shelters (40%); going with family (40%), with friends (6.1%) and the church (7.9%). However, most would stay in their respective city, town, or village.

For those who plan to leave their homes during an emergency, they would rely on bus or public transport to move. They will also require assistance that range from financial, higher vehicles, wheel chairs, securing the home prior to leaving, help with packing and carrying luggage, money to buy food and clothing, and physical help for those with handicaps or who are too weak to walk.

In the last year, only eleven percent (11%) had to leave their homes and they would definitely leave again should any emergency arise. Only fifty percent (50%) have telephone service and this consists mostly of landlines and then cell phones.

4.11 Dashboard of Key Findings: Social Support

Dashboard: Social Support				
Indicator	Yes	No		
> Member of Social Club/Community Org.	70	396		
	15.0%	85.0%		
> Would join if one existed	Yes	No	Not Sure	
	95	162	164	
	22.6%	38.4%	39.0%	
> Activities would like to be involved in	Dance	Sing	Exercise	Games
	76	103	151	112
	17.1%	23.3%	34.1%	25.5%
> Attends church	Yes	No		
	360	109		
	76.8%	23.2%		
> Active member in the church	Yes	No		
	209	231		
	47.5%	52.5%		
> Active in the community	Yes	No		
	116	340		
	25.4%	74.6%		
> Feel safe in the community	Yes	No		
	430	46		
	90.3%	9.7%		
> Visited by community police	Yes	No		
	69	400		
	14.7%	85.3%		
> Harassed or threatened in home	Yes	No		
	23	448		
	4.9%	95.1%		
> Feel vulnerable in the home	Yes	No		
	95	371		
	20.4%	79.6%		
> Feels happy	Yes	No		
	410	58		
	87.6%	12.4%		

4.11.1 Analysis: Social Support

Only fifteen percent (15%) of the older population are members of a social club or community organization; these organizations consist of the church primarily, and then others such as HelpAge, village council, and YWCA.

Those who are not involved in a social club or community organization are prevented from doing so because of old age, physical disabilities, and other health reasons, and for a few – a general lack of interest.

There is a small group (25%) willing to join a *new* organization and who are interested in exercise, playing games, dancing and singing. Other activities include agriculture, swimming, arts and crafts, bible study, church going, cooking club, fishing, gardening, and playing dominoes.

Over seventy five percent (75%) attend churches, which are multi-denominational – Roman Catholic, Adventist, Anglican, Assembly of God, Baptist, Mormon, Jehovah's Witnesses, Methodist, and Nazarene. However almost half of the entire populations are not active members in the church; those who are active members serve in different capacities – altar guild, assistant to the pastor, give communion, sing in the choir, clean the church building, serve as deacons and deaconesses, fundraising, lay leadership, and novena prayers.

In contrast, only one quarter of the population is active in the community and activities include serving on advisory boards, assisting the village council, contribute fruits and vegetables from garden, cook for the Red Cross, prayers, visit the sick, and neighborhood watch.

The majority (90%) feels safe in the community and those who do not feel safe cite reasons such as fear of home invasion, thieves, rising incidence of crime, conflict with neighbors, gangs and shootings, and high number of unsolved crimes. To reduce the feeling of vulnerability elders would like to see increased police patrols and presence in their neighborhoods, increase the security in their homes by erecting fences and installing burglar bars, and through neighborhood watches.

Almost the entire older population say they are happy and the very small number that say they are not happy wish they were better off financially, had better health, better homes, and better living conditions.

5.0 DISCUSSION OF FINDINGS

On 2 June, 2010, the National Council on Ageing held a National Forum to present and discuss the findings of the '*Situational Analysis on Older Persons in Belize*.' Four working groups were formed to review and discuss the findings of the research study in the following areas: health, financial security, family and social support, and housing and safe environment.

5.1 Health

Despite the fact that life expectancy has risen and older persons are living longer, much of the discussion about health services concentrated upon access to facilities, appropriate medication and diagnosis of specific conditions of older persons by healthcare professionals. Belize does not have geriatric trained healthcare professionals and neither does the Ministry of Health place any emphasis on providing training either in country of through providing scholarships to train outside of Belize. Therefore it was felt that until such time as this matter is addressed seriously by the Ministry of Health, the general healthcare facilities available will continue to ignore the specific needs of older persons.

Participants were dismayed to see how much older persons were spending on medication which, on a limited income, must mean that older persons are facing hardship in being able to afford their basic needs, particularly if they make the choice to purchase medication at the expense of buying food.

Despite the efforts of the Ministry of Health to improve services through the Health Reform Plan, it is evident that the more remote rural communities still face disadvantages when it comes to access to healthcare facilities. Interviewers from many rural communities spoke about having to travel long distances to obtain treatment because even when a health post exists in a village it is not open. For example, in Jalacte Village in the Toledo District, the interviewer discovered that many of the old people did not know what their health condition was because they did not visit a doctor,

they only knew what they did not feel well, but faced with the possibility of having to travel to find a doctor they preferred to take what they could find locally.

It was felt that, through the introduction of NHI to south side Belize City, Stann Creek and Toledo Districts, access to facilities, treatment and medication had been improved for the majority of older people in these Districts but more still needed to be done and suggested that NHI should be made available to all older persons countrywide.

Diabetes and hypertension remain the leading health concerns of older persons as the tables on pages 19 and 20 indicate and therefore greater public awareness is needed, particularly directed towards the younger population so that changes in lifestyles will improve these conditions in the future.

5.2 Financial Security

The introduction of the Non-Contributory Pension, initially to women of 65 years and subsequently the inclusion of men 67 years was seen as a very necessary benefit to those older persons most in need. However, the general consensus was that $100.00 per month was insufficient to meet even the basic needs of older persons.

The NCP is only available to older people who are not supported by family members and at the end of 2009 the number of recipients totaled 4,297, which is approximately 18.05% of the population of older persons in Belize. As the survey concluded, the majority of older persons live with family members and with an overall poverty rate of 41% it could be concurred that the majority of the older persons live within poor family homes and therefore continue to face hardship. This is supported by the CPA, which on page 106 states, '… older persons living on their own are much less likely to be income poor.'

It was felt that this is certainly an unsatisfactory situation and in order to address the poverty of older persons it was felt that a more just and inclusive benefit scheme should be introduced such as a Universal Pension for all.

5.3 Family and Social Support

One interesting observation noted from the National Forum was that the older persons interviewed in 2010 overwhelmingly felt respected by their families and community, whereas representatives from stakeholder organizations disputed this information making a point that, from their experiences, they worked with the poorer older persons in the community who had been neglected and abandoned by their families. It should be noted that the majority of stakeholder organizations operate from Belize City and District Towns and so the experiences may differ from urban and rural participants.

One of the issues that transpired from the 2010 survey was that very little existed for older persons in rural areas particularly as it related to social or medical centers. 85% of people interviewed did not belong or attend any social centre; the church being their main source of social interaction.

The issue of respect from the country is one that should be noted since if could be suggested that if older persons were offered the respect they deserve they would not be facing issues of poor health and financial insecurity for example, as the survey implies.

5.4 Housing and Safe Environment

At a time of National Emergency there is a tendency to overlook the needs and welfare of older persons in an effected community. Those older persons who do not live with or close to family members have to fend for themselves and this is made even worse if hampered by mobility issues that restrict the necessary quick response. Whereas older persons, realizing that their homes may be affected by storms and flooding, will wish to move from their homes, the issue of *how* to move is a concern and the survey shows that these older persons will need assistance. It was therefore felt that a directory of older persons is necessary in all localities so that a check can be made upon them to warn of any impending danger.

In rural communities this can be done with the village council and in towns through the establishment of zones from within the NEMO structure of CEMO and DEMO. It was

also felt that VOICE volunteers could provide assistance and work more closely with NEMO.

In order to limit certain anxieties experienced during an emergency situation, greater consideration should be given to the prevention or exacerbation of health conditions. Therefore it was felt that specific, age appropriate, shelter accommodation should be considered by NEMO that was sensitive to older persons and would afford greater privacy in a less stressful environment.

Although it was shown that the majority of older persons own their own homes, their financial status would determine if the up-keep and maintenance was being carried out. Those older persons on a fixed income or benefit that only provided for their basic needs would have difficulty locating extra cash to make necessary repairs. Many interviewers expressed concern about the conditions of some of the homes they visited as they saw houses that were leaning and unstable as well as roofing that had holes and let the rain in. The condition of homes was definitely seen as a concern to the older persons interviewed.

It was also stated that, although the majority of older persons considered their homes and community safe, this was not necessarily the case of older persons in Belize City. Representative stakeholders working in Belize City often felt uncomfortable and even threatened when making home visits in certain areas. Older persons had seen their community change over the years and likewise felt more vulnerable now, preferring to stay at home than walk the streets to visit family and friends. It was therefore suggested that a greater community policing presence was necessary in the more difficult areas of Belize City in order to provide greater confidence to older persons.

6.0 CONCLUSIONS & RECOMMENDATIONS

The conclusions and recommendations based on the four working groups are detailed in the following pages.

Area	Conclusions	Recommendations
1.0 HEALTH	Health is everyone's responsibility and should not be confined to just one sector. Maintaining a healthy lifestyle is vitally important throughout the life span and education and promotion starts at a young age. There are insufficient, inaccessible and unavailable health services, particularly for older persons.	• *Emphasis should be placed on prevention of diseases at a young age;* • *NHI sensitization, information, and tutorials should be given to those persons who are eligible to access it;* • *There is a need for a monitoring mechanism for hospital faculty to evaluate how services are rendered to older persons;* • *There is a need to address the responsibility of people for their health and their participation in the provision of health services;* • *Make available alternative services and medications more pertinent to older persons;* • *Promote organized activities that address mental and social health;* • *There is a need to conduct an audit of services to insure that service providers are not duplicating efforts/resources by catering to the same people.*
2.0 FINANCIAL SECURITY	The current provisions for benefits to older persons are inadequate to meet basic needs. The non-contributable pension and NHI is not available to all, while social assistance is limited to $10.00 per week. To avoid old age dependency, alternative forms of income generation / employment should be encouraged and supported.	• *Increase NCP from $100.00 to $160.00* • *Grant universal access to pension across the country;* • *Educate self-employed persons to pay Social Security contributions to safe guard their future;* • *NHI to be made accessible for older persons across the country;* • *Ensure proper documentation of persons at birth to guarantee access to services;* • *Make micro-financing available to older persons*

Area	Conclusions	Recommendations
3.0 FAMILY AND SOCIAL SUPPORT	There is a need to create a culture of respect and consideration for older people and make them more visible in society. Loneliness and depressions is common and could be alleviated by greater social interaction	• *Educational programs on ageing should be included in school curriculum starting at the Primary School level;* • *There is a need for a range of options for older persons ranging from social activities, to day care to live in facilities where health care services are available;* • *There is a need to increase the number of social centre in each district with priority given to those areas with limited financial resources;* • *Facilities and resources for older persons should extend beyond just "care" facilities and should provide for recreation and other activities in both urban and rural areas*
4.0 HOUSING AND SAFE ENVIRON-MENT	Resources should be available to older persons to assure home safety especially against crime and during times of national emergency – hurricanes, floods, etc.	• *The NCA should lead a lobby with government ministries and organizations to address the housing needs of older persons;* • *The VOICE organization should, as a rural committee, conduct an assessment of the housing situation of older persons;* • *The National Emergency Management Organization (NEMO) should consider the specific needs of older persons in times of impending disaster designating special shelters for older persons who live alone and who are handicapped and those who need special attention or have special needs;* • *Community Policing Units country-wide should make contact with VOICE and other groups representing older persons to gain a greater understanding of the vulnerabilities of older persons and to provide reassurance in the security available to older persons.*

REFERENCES

Helpage International/Helpage Belize, (2003), "The Situation of Older Persons in Belize, Research Study Report", March 2003

Kinsella, Kevin; He, Wan, (2008), *"An Aging World: 2008, International Population Reports,"* June 2009

Carl, L.C. (2004), *"Population Ageing in the Caribbean: Longevity and Quality of Life,"* December 2004

Halcrow Group Limited & Belize National Assessment Team, *"Country Poverty Assessment (Draft Final Report,* December 2009

Government of Belize, Epidemiology Unit, Ministry of Health, Belize (2009), "*Leading Causes of Hospitalization in People aged 60 Years and over 2003-2009 and Leading Causes of Death of People aged 60 years and over 2003-2009."*

PAHO/WHO*, "Salud, Bienester y Envejeciemiento (Health, Well-Being and Ageing), SABE Report", 2003*

APPENDIX

A: 2003 Situation Assessment: Summary of Key Findings

Income and Livelihood

Because of the high cost of living, older persons had to find work to survive, in most cases, just to be able to meet basic needs. Males in the rural areas were employed to do farming activities and the women worked mostly as domestics. Family members provided the greatest form of support, with additional resources coming from personal employment, government benefits, friends, neighbors, the church, and in some instances, Help Age.

Health and Coping with the Ageing Process

The majority of older persons surveyed at the time was experiencing some form of illness and were using medication on a regular basis. Impaired vision and high blood pressure were the most common complaints and the condition was prevalent in both the male and female population. Most indicated that they were well nourished and most of those who stated otherwise were females. The elderly sick used both public and private clinics to obtain medical treatment, although the women were more likely to seek out private healthcare.

Bush medicine was commonly used among both sexes. The general perception was that the cost of medication was too high and not always available within the public health system. Those who could not afford the medication simply did without it. Some NGOs filled some of the existing gaps by providing some level of healthcare services, but the need for specialist geriatric care was expressed. There is neither gerontologist nor geriatric healthcare services in Belize.

Education

Of the total sample population of 200 elderly persons, only 40 percent reported that they completed standard six. The reasons given for constraints to completing their education

included lower number of schools in their area, poverty, and work-related responsibilities within and outside of the home.

Housing

Fifty one percent (51%) of Belize's elderly population were living in inadequate housing situations, characterized by inadequate space, inadequate ventilation, lack of indoor toilet and water facilities, no electricity, and the inability to withstand a hurricane.

Socialization

The elderly population experienced high feelings of abandonment, exclusion, and lack of caring on the part of general society. They believed that in the past, qualities such as discipline and respect were associated with age, therefore older persons were treated better, cared for, held positions of importance, and were able to maintain their livelihood standards for longer periods of time.

Contribution to Family and Community

Elders were not being given the opportunity to become involved in the community. They expressed some frustration over their lack of involvement, but accepted this as part of the ageing process. Some older persons felt exploited by their family in terms of their finances, housing, and land. In addition, some felt their roles as babysitters, cleaners, and cooks were often taken for granted.

B: Interviewers of the Situational Analysis Study Research 2010

A: Corozal District

1:	Corozal Town:	Mrs. Glenda Francis:
		Mrs. Benigna Wesh:
		Mr. John Rochester
		Mrs. Elda Sutherland
2:	Paraiso:	Mr. Anatolio Reyes
	Patchakan:	Mr. Eloy Ak
	San Joaquin:	Mrs. Elda Sutherland
	Sartenaja:	Ms. Manissa Pedrossa

B: Orange Walk District

1:	Orange Walk Town:	Mrs. Dollis Reynolds
		Mrs. Victoria Hernandez
		Mr. Elvis Reynolds
		Ms. Sharon Reynolds
2:	Guinea Grass:	Mrs. Rosa Carillo
	San Estevan:	Mr. Feldemar Hernandez
	Santa Marta:	Ms. Dollis Reynolds, Mr. Elvis Reynolds,
		Ms. Sharmaine White
	August Pine Ridge:	Ms. Dollis Reynolds, Mr. Elvis Reynolds

C: Belize District

1:	Belize City:	Andre Perera & Marcy Watson
2:	Crooked Tree:	Ms. Caresa Tillett
	Burrell Boom:	Mrs. Dawn Flowers
	Caye Caulker:	Ms. Maria Vega
	Lucky Strike:	Mr. Oscar Pollard
	Gracie Rock:	Mr. Derek Martinez:

D: Cayo District

1:	Belmopan:	Ms. Jennifer Dunn
		Mr. Paul McCord
		Ms. Vin Gladden
		Mrs. Eloisa Phillips
		Ms. Lindy Jeffery
		Ms Ix-Chel Poot
		Mr. Jose Chacon
2:	San Ignacio / Santa Elena:	Dr. Alfonso Ayala
3:	Benque Viejo:	Mrs. Isabel Segura

4:	Spanish Lookout:	Ms. Susana Wolfe
	Succotz:	Mrs. Emeteria Torres
	Cotton Tree:	Ms. Elma Moralez
	San Antonio:	Ms. Romelia Howe

E: Stann Creek District

1:	Dangriga Town:	Mr. Rudolf Sorano
		Mrs. Martha Hill
		Mrs. Felicia Nunez
		Matilda Ramos
		Valentina Marin
2:	Pomona:	Mr. Winston Taylor: `
	Sittee River	Ms. Vernette Andrews
	Hopkins:	Mr. George Ramirez
	Independence:	Ms. Kimberly Bol
	Maya Centre:	Mr. Daniel Bolon

F: Toledo District

1:	Punta Gorda Town:	Ms. Sharane Palley
		Mr. George Mai
		Mr. Kendrick Ramclam
2:	Forest Home:	Mr. Timothy and Mrs. Nora Bardalez
	Barranco:	Mrs. Irma Gonzalez
	Jalacte	Ms. Maria Ical
	Big fall:	Ms. Claudia Tut
	San Pedro Columbia:	Ms. Stephanie Lara

Research Study Questionnaire

A copy of the questionnaire document, used for the collection of information from older people, has not been included in this Situational Analysis document, however, should the reader require a copy for reference purposes, this can be obtained from the NCA office as detailed below:

The National Council on Ageing
Unit 17, Garden City Plaza
Mountain View Boulevard
P.O. Box 372
City of Belmopan
Belize
Central America

Telephone: 501-822-1546
Fax: 501-822-3978
Email: ncabze@yahoo.com
Website: www.ncabz.org